PSYCHOTROPIC MEDICATIONS IN LTC

CHALLENGES AND OPPORTUNITIES FOR
BEST PRACTICES

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Conflicts of Interest

- None to report
Objectives

- Examine the impact of the current regulatory environment
- Understand the benefit of comprehensive/team approach to psychotropic medication use in LTC
- Recognize the critical role of the Nurse Assessment Coordinator in proper documentation of psychotropic medication use
§483.24 Quality of Life:
- Fundamental principle that applies to all care and services

§483.25 Quality of Care:
- Based on comprehensive assessment; professional standards of practice; person-centered; resident choice
- Must include, but not limited to...

§483.25 (k) Pain Management

§483.25 (l) Dialysis

§ 483.40 (b) Resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being
- Will be implemented November 28, 2017 (Phase 2)
■ **Intent:** facility must ensure resident...
  - *Obtains optimal improvement or does not deteriorate within the limits* of a resident’s right to refuse treatment, and *within the limits of recognized pathology and the normal aging process*

■ **Note:** Tag F309 includes, but is not limited to, care such as care of a resident with dementia, end-of-life, diabetes, renal disease, fractures, congestive heart failure, non-pressure related skin ulcers, pain, fecal impaction

■ **Interpretive Guidelines:** if lack of improvement or a decline, survey team must determine if occurrence was unavoidable or avoidable
Determination of unavoidable decline or failure to reach highest practicable well-being may be made only if **ALL OF THE FOLLOWING** are present:

- An accurate and complete assessment (see §483.20)
- A care plan that is implemented consistently and based on information from the assessment
- Evaluation of the results of the interventions and revising the interventions as necessary

Resident/Representative Interview

- **Awareness** of condition(s) or diagnosis/diagnoses
- **Involvement** in development of care plan, goals, and if interventions reflect choices and preferences
- **Effectiveness** of interventions and alternative approaches tried
Nursing Staff Interview
- Knowledge of specific interventions for resident
- Whether Nursing Assistants know how, what, when, and to whom to report changes in condition
- How the Charge Nurse monitors for the implementation of the care plan, and changes in condition

Care Plan Revision
- Achieving desired outcome
- Resident failure or inability to comply with or participate in a program
- Change in resident condition, ability to make decisions, cognition, medications, behavioral symptoms or visual problems
Interview with Health Care Practitioners and Professionals

- How was it determined that chosen interventions were appropriate
- Risks identified for which there were no interventions
- Changes in condition that may justify additional or different interventions
- How staff validated the effectiveness of current interventions
Review of Care and Services for a Resident with Dementia
  - Definitions of behavior, dementia, delirium
  - Therapeutic Interventions or Approaches
  - Medication Use in Dementia (F329)
  - Resident and/or Family/Representative Involvement
  - Care Process for a Resident with Dementia
    - Recognition and Assessment
    - Cause Identification and Diagnosis
    - Development of Care Plan
    - Individualized Approaches and Treatment
    - Monitoring, Follow-up and Oversight
    - Quality Assessment and Assurance (QAA)
Criteria for Compliance

- **Obtained details** about the person’s behaviors and discussed potential underlying causes with care team, resident, family or representative
- **Excluded potentially remediability causes** of behaviors and determined if symptoms were severe, distressing, or risky enough to adversely affect safety
- **Implemented** environmental and other **approaches**
- Implemented the **care plan consistently** and communicated across shifts, caregivers, resident and family/representative
- **Assessed effect** of approaches, identified benefits and complications in a **timely fashion**, involved attending physician and medical director as appropriate, and adjusted treatment accordingly
Gitlin LN, Kales HC, Lyketsos CG. Nonpharmacologic Management of Behavioral Symptoms in Dementia. JAMA, November 2, 202; 308(9): 2020-2029. © 202 American Medical Association
RNAC on a good day 😊
§483.45(d) Unnecessary Drugs – General
- Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used...
- §483.45 (d) (1) In excessive dose (including duplicate drug therapy); or
- §483.45 (d) (2) For excessive duration; or
- §483.45 (d) (3) Without adequate monitoring; or
- §483.45 (d) (4) Without adequate indications for its use; or
- §483.45 (d) (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- §483.45 (d) (6) Any combination of the reasons stated in paragraphs (d) (1) through (5) of this section
- §483.45 (e) Psychotropic Drugs
- §483.45 (e) (3) – (5) will be implemented beginning November 28, 2017 (Phase 2)
- Based on a comprehensive assessment of the resident, the facility must ensure that...
  - §483.45 (e) (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record
  - §483.45 (e) (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
§483.45 (e) (3) Resident does not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45 (e) (4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided is §483.45 (e) (5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident’s medical record and indicate the duration for the PRN order.

§483.45 (e) (5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
■ **Intent** – each resident’s entire drug/medication regimen be managed and monitored to achieve the following goals...

- *Help promote or maintain* the resident’s highest practicable mental, physical, and psychosocial **well-being** as identified by the resident/representative in collaboration with attending physician and facility staff

- *Each resident receives only those medications*, in doses and for the duration **clinically indicated** to treat the resident’s assessed condition(s)

- *Non-pharmacological interventions* (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to, medication

- *Clinically significant adverse consequences are minimized*; and

- *The potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate*
Note – This guidance applies to all categories of medications including antipsychotic medications
So Really...What’s the Problem with Using Antipsychotics?

PRESS THAT CALL BUTTON AGAIN...
There are no “good” and “bad” antipsychotics per se
  - *e.g.* haloperidol vs. quetiapine

There ARE “good” and “bad” scenarios for utilization of these agents

There is a definite role for anti-dopaminergic agents
  - *Hospice and palliative symptom management*
    - N/V, Delirium, EOL distress
  - *Management of true psychotic behavior*
    - Delusions and hallucinations
    - Established pre-dementia mental health issues
Keys to medication effectiveness at any age

- Absorption
- Distribution
- Metabolism
- Elimination
Some *Common* Adverse Effects of Antipsychotics

- Anticholinergic effects
- Dyslipidemia
- Extrapyramidal symptoms
- Postural hypotension
- Prolonged QT interval
- Sedation
- Seizures
- Type 2 diabetes mellitus
- Weight gain
Benefit vs. Burden
The National Partnership to Improve Dementia Care in Nursing Homes

AGS 2015 Updated Beers Criteria
  - *PIM: Potentially Inappropriate Medications*

State Operations Manual/CMS
The Focused Audit:

- All necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (quality of care) and maintain their sense of individuality (quality of life)
  - Mary Ann P. Leonard, RHIA, RAC-CT/Health Information Professionals
Don’t use antipsychotics as the first choice to treat behavioral and psychological symptoms of dementia...
Challenge: Resident
Challenge: Licensed Staff

- Focus on the cause of target behaviors – the “important stuff”
- Avoid unnecessary and duplicative documentation
Avoid Having an “Agenda”

- Listening and assessment should be free of bias
- Residents “report” not “complain of”
- Enlist social worker support and input
  - What psycho-social influences are affecting the resident
- Avoid defensiveness when GDR is discussed
- Be ready to answer these questions:
  - Was the medication really helpful?
  - Were the goals for use of the medication met?
  - Did the resident’s function and quality of life improve?
  - Were there adverse effects?
Challenge: Physician/Prescriber

Communication

- **Nurses**
  - Taught to report in narrative form, providing all details known about the patient

Communication

- **Physicians**
  - Taught to communicate using brief “bullet points” that provide only the key information to the listener
■ Situation
  - State the issue

■ Background
  - Provide concise background information

■ Assessment
  - Your assessment of the problem

■ Recommendation
  - What course of action would you like me to take?
“We’ve been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being. And well-being is about the reasons one wishes to be alive.”

– Being Mortal; Atul Gawande
Challenge: Pharmacist

- Should be actively engaged in Behavior Management Committee
- Should be actively engaged in Pain Management consultations
- Should be involved in policy development around the use of all medications targeted in the new focused surveys
- Should be supportive of staff and family/POA education regarding the impact of medications and their safe use in dementia residents’ care
Aging usually involves a slow process of numerous losses. It is not death that the very old tell me they fear, it is what happens short of death – losing their hearing, their memory, their best friends, their way of life.

– Being Mortal; Atul Gawande
Why do we think the residents feel any differently?

“We want safety for others but autonomy for ourselves”

Keren Brown Wilson
Challenge: Family and POA

- Resident’s personal history
  - With and without medication intervention
- Family member history
  - What was the relationship like prior to admission?
  - Did medications help or merely make the intolerable, tolerable?
- Environmental influences
  - Other people’s experiences with or without medication
  - Social media, internet and TV
- Education, education, education!!!
Who Is Missing From the Equation?

- Frontline staff/CNA
- Administration
- Activities

- Are we listening to their feedback?
- Have resident behaviors become “white noise”?
- Is there more emphasis on the F Tag than on the individual resident?
- Are the activities meaningful and do they achieve real change in the environment?
Transforming the Tool Box: DICE

- D: Describe
- I: Investigate
- C: Create
- E: Evaluate
  - University of Michigan Health System
Describe

- Asking the caregiver, and the patient if possible, to describe the “who, what, when and where” of situations where problem behaviors occur and the physical and social context for them. Caregivers could take notes about the situations that led to behavior issues, to share with health professionals during visits.

Investigate

- Having the health provider look into all the aspects of the patient’s health, dementia symptoms, current medications and sleep habits, that might be combining with physical, social and caregiver-related factors to produce the behavior.
Create

■ Working together, the patient’s caregiver and health providers develop a plan to prevent and respond to behavioral issues in the patient, including everything from changing the patient’s activities and environment, to educating and supporting the caregiver.

Evaluate

■ Giving the provider responsibility for assessing how well the plan is being followed and how it’s working, or what might need to be changed.
No Intervention...

- Is universally effective for disruptive behaviors
- Nonpharmacological approaches are generally preferred to pharmacological agents and/or physical restraints
Pain Management

- Consistently positive association between pain and disruptive behaviors
  - Higher pain intensity ratings increased risk of aggression in residents with dementia
    - Verbal aggression
    - Frequency of agitation
- Evidenced-Based Non-Pharmacologic Interventions for Pain
  - Important to diagnose and appropriately treat depression, anxiety, insomnia, other underlying illness, loss and bereavement
- Focus on improvement in QOL, maintaining function and cognition, alleviating or reducing pain
The merest schoolgirl, when she falls in love, has Shakespeare or Keats to speak her mind for her; but let a sufferer try to describe a pain in his head to a doctor and language at once runs dry.

Virginia Woolfe
# Pain Assessment in Advanced Dementia Scale (PAINAD)

**Instructions:** Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

<table>
<thead>
<tr>
<th>Behavior</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing</td>
<td>Normal</td>
<td>Occasional labored breathing</td>
<td>Noisy labored breathing</td>
<td></td>
</tr>
<tr>
<td>Independent of vocalization</td>
<td></td>
<td>Short period of hyperventilation</td>
<td>Long period of hyperventilation</td>
<td></td>
</tr>
<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan</td>
<td>Repeated troubled</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low-level speech</td>
<td>calling out</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>with a negative</td>
<td>Loud moaning or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or disapproving quality</td>
<td>groaning</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Crying</td>
<td></td>
</tr>
<tr>
<td>Facial expression</td>
<td>Smiling or</td>
<td>Sad</td>
<td>Facial grimacing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>expressive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frowning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body language</td>
<td>Relaxed</td>
<td>Tense</td>
<td>Rigid</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Distressed pacing</td>
<td>Fists clenched</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fidgeting</td>
<td>Knees pulled up</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pulling or pushing away</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Striking out</td>
<td></td>
</tr>
<tr>
<td>Constolability</td>
<td>No need to</td>
<td>Distracted or</td>
<td>Unable to console,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>console</td>
<td>reassured by voice or touch</td>
<td>distract, or reassure</td>
<td></td>
</tr>
</tbody>
</table>

(Warden et al., 2003)

**Scoring:**
The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3 = mild pain; 4-6 = moderate pain; 7-10 = severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool.

**Source:**
Disruptive Behaviors

- **Wandering**
  - *Most common type of locomotive disruptive behavior*
  - *Lapping, pacing, elopement attempts*
  - *Exhibited in over 60% of dementia residents*

- **Aggression**
  - *Most common type of non-locomotive disruptive behavior*
  - *Verbal, physical, threatening behavior*
  - *Not accidental: adaptive, violent, functional reaction*
  - *Exhibited in 50 to 80% of dementia residents*
Disruptive Behaviors

- **Agitation**
  - *Unpleasant state of excitement*
    - Excessive, inappropriate, repetitive, nonspecific and observable
    - Manifests as irritability, restlessness, frustration, excessive anger, constant demands for attention and reassurance, repeated physical movements or questions, and inappropriate/excessive motor or vocal activities
  - *Exhibited in 55 to 83% of residents with dementia*

- **Cognitive Impairment**
  - *Significantly correlated with the 5 subscales of wandering, spatial disorientation, attention shift, negative outcomes, persistent walking*
Disruptive Behaviors

- **Functional Impairment**
  - *Impairment of ADLs and dependence on others*
  - *Mixed studies on relationship to disruptive behaviors*

- **Sociodemographic Factors**
  - *Age and gender relationship with disruptive behaviors is inconsistent*
Non-pharmacologic Interventions

- What does the evidence say?

- AHRQ

- Agency for Healthcare Research and Quality: March 2016
Non-pharmacologic Interventions

- **Music**
  - AHRQ: low-strength evidence
  - Other studies showed effectiveness in reducing agitation and anxiety
  - Live vs recorded music had greater impact

- **Aromatherapy**
  - AHRQ: low-strength evidence for lavender oil
  - AHRQ: insufficient evidence with Melissa (lemon balm)
    - Complicated by some trials using touch
  - Other studies looked at melissa aromatherapy, donepezil, and placebo...all were equal in reducing agitation in dementia
Non-pharmacologic Interventions

- Bright light therapy
  - AHRQ: low-strength evidence
  - Similar to standard light
  - Other studies indicated positive results in nighttime sleep and cognitive performance

- Therapeutic touch
  - AHRQ: insufficient evidence
  - Other studies showed statistically significant effect in reducing BPSD

- Tailored vs non-tailored interventions
  - AHRQ: insufficient evidence to draw conclusions
Non-pharmacologic Interventions

- Unique comparisons
  - Acupuncture, acupressure, structured activities, reminiscence, exercise, humor therapy, multisensory stimulation, etc.
  - AHRQ: insufficient evidence – limited trials
- Dementia care mapping
  - AHRQ: low-strength evidence
- Person-centered care
  - AHRQ: low-strength evidence
- Emotion-oriented care
  - AHRQ: insufficient evidence
- Unique comparisons
  - Staff education and training for dementia, resident awareness, non-verbal sensitivity, CNA communication skills, advanced illness care teams, etc.
  - AHRQ: insufficient evidence
Now What???
Remember the Most Important Thing...

Versus...

- Multiple nonpharmacological interventions with inconsistent positive outcomes but **little harm** to residents

- Pharmacological interventions with inconsistent positive outcomes and **well documented risks** to residents
What Is Needed...

- More research
- Continued commitment to use of non-pharmacological interventions
- Shared experiences
- Documentation of positive outcomes resulting from systematic application of the aforementioned techniques
- What else?
“A few conclusions become clear when we understand this: that our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer; that the chance to shape one’s story is essential to sustaining meaning in life; that we have the opportunity to refashion our institutions, our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone’s lives.”

Being Mortal: Atul Gawande
Comments – Questions - Discussion