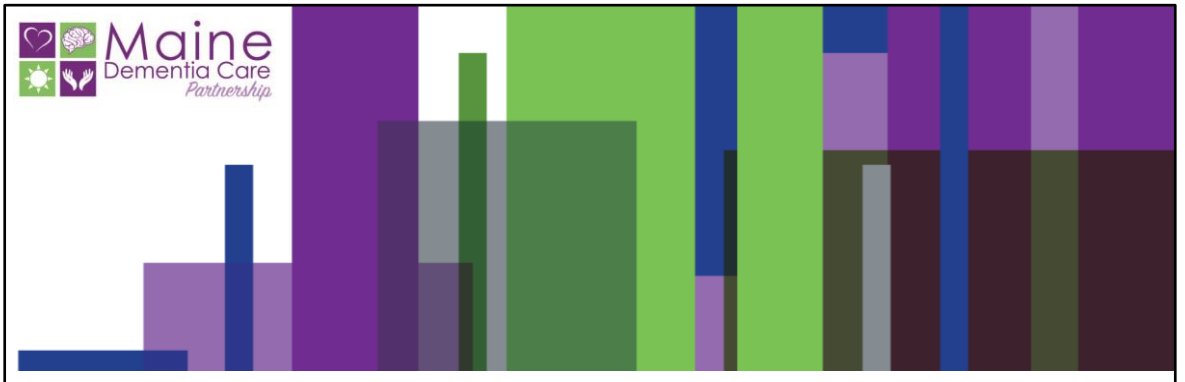

Rethinking Antipsychotic Medication Use

Is it for me or for you?

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Psychotropic drugs include:

- **Anti-psychotics**
- **Anti-depressants**
- **Anti-anxiety**
- **Sedative/Hypnotics**

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Why all the focus?

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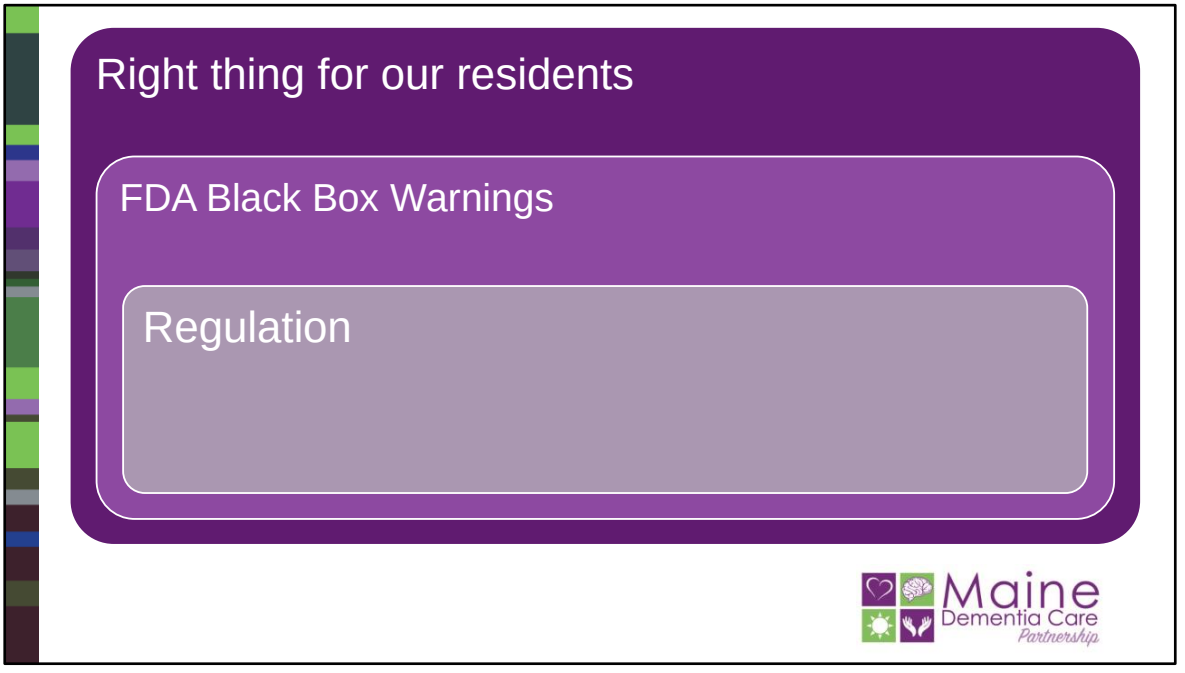
Black box warnings are the strictest labeling requirements that the FDA can mandate for prescription drugs. First implemented in 1979, **black box warnings** highlight serious and sometimes life-threatening adverse drug reactions within the labeling of prescription drug products.

Antipsychotic use peaked in 1990s to a high of nearly 1 in 3 dementia residents receiving an antipsychotic

Established in 2012 in response to prior year's OIG report showing 83% " off-label" non-FDA approved use of antipsychotic medications in LTC.



A black box warning is the most severe warning a medication can receive. It indicates the med poses an increased risk of death.
Study of over 5000 dementia patients in 2006 started on anti-psychotics. Demented Elders taking AP had a death rate 2 times higher within 30-180 days of use including heart failure, heart attack and pneumonia. Many regulations regarding when one can be used, how it can be used, documentation needed and required attempts to reduce. Right thing because it is not approved for use in demented elders, it doesn't treat the symptoms we're trying to alleviate. It doesn't stop a person from wandering, exit seeking, looking for their family, reacting to misunderstood cues in their environment, reacting to staff not handling a situation of anxiety and agitation with sensitivity. They only sedate the behavior but with many seriously side effects and potentially negative or fatal outcomes. When used for staff convenience they are a chemical restraint.

Anti-psychotics (AP)

Not FDA approved to treat agitation in dementia patients

Types of AP include:

- Haldol, Mellaril, Thorazine, Olanzapine(Zyprexa), Risperidone, Quetiapine(Seroquel), Aripiprazole(Abilify), the combination drug - Perphenazine-Amitriptyline…….and more.

TIP: Look up medications. Know what you're giving!

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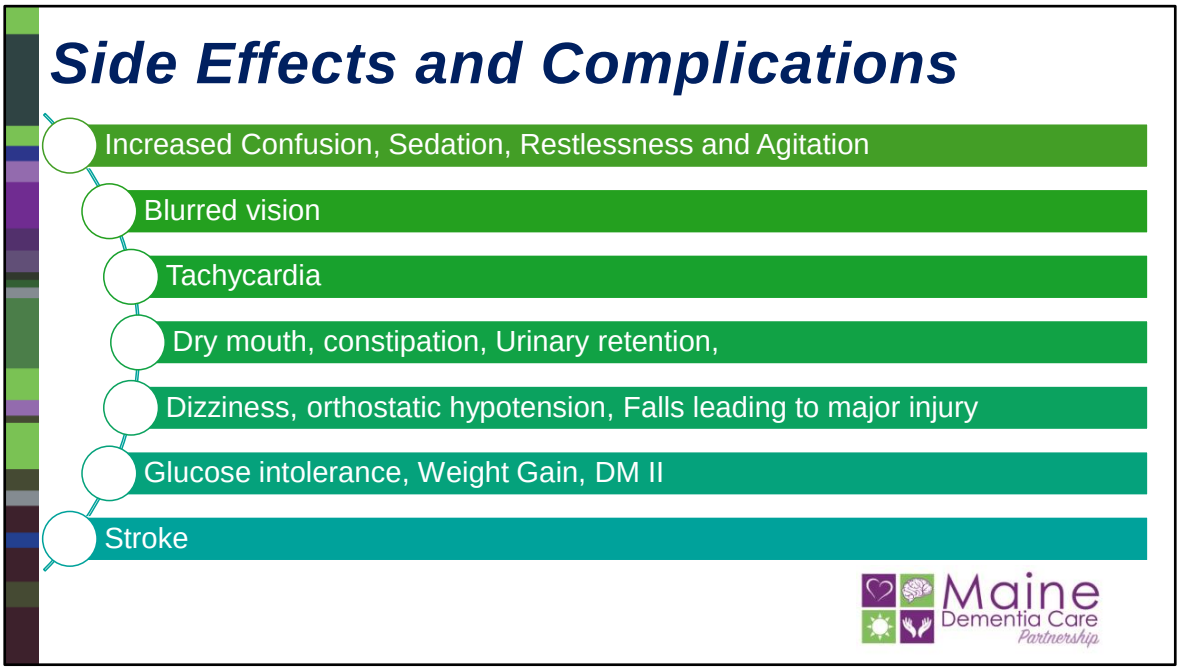
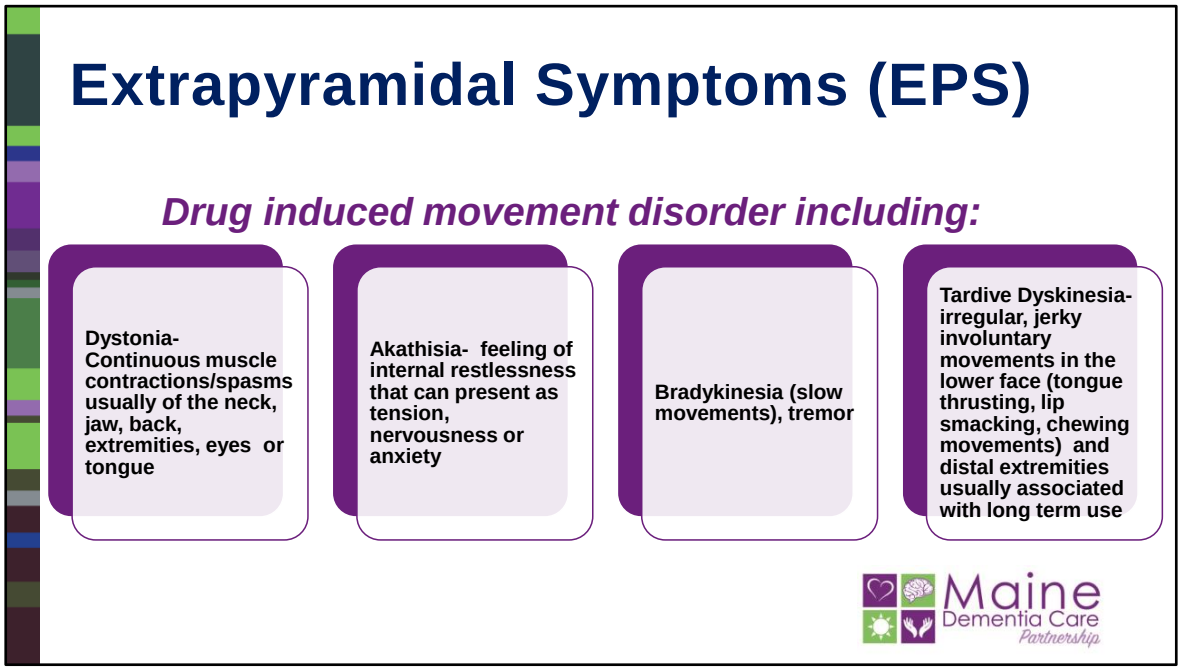
First generation drugs (Mellaril, Haldol, Thorazine) carry a higher risk of negative side effects and are very sedating. They are seeing a resurgence in prescribing in some areas of the state. Second generation (Zyprexa, Risperidone, Seroquel) are less sedating and have lower risk than 1st gen of some side effects like EPS but have a high risk of Metabolic side effects i.e. hyperglycemia, and weight gain. None treat the anxiety and confusion that occur with dementia,



The side effects of APs contribute to anxiety and agitation in residents. Imagine if your vision was blurred or your heart was racing or when you stood up you felt dizzy. All of the side effects occur with any AP drugs 1st, 2nd or 3rd generation

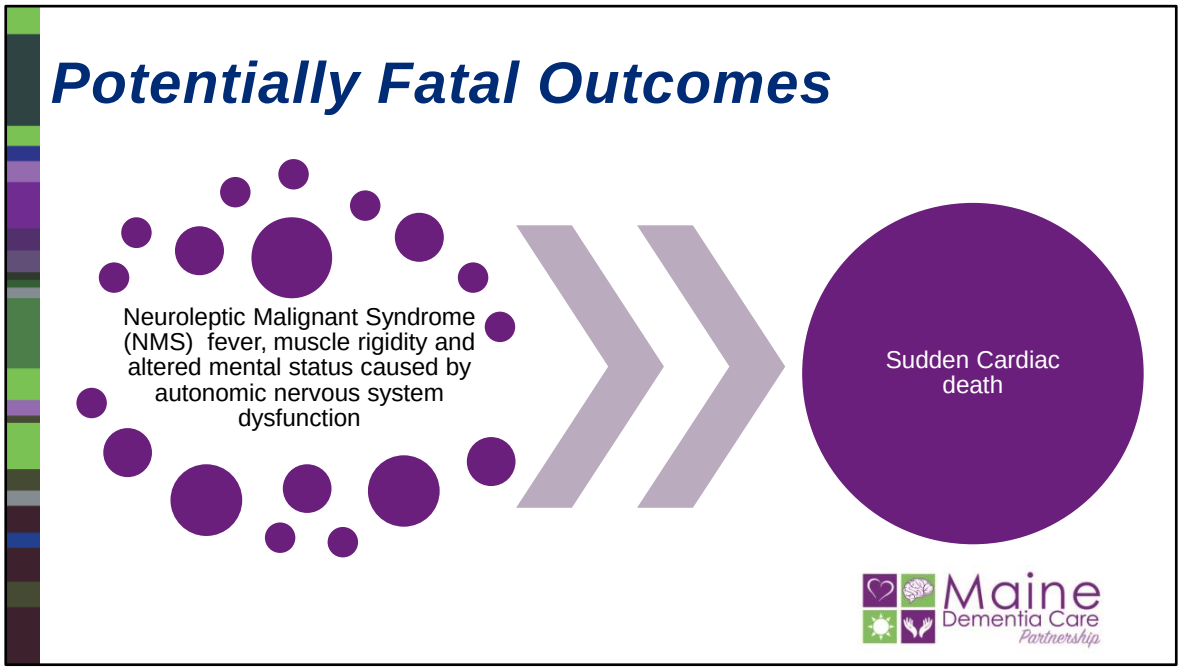


Often associated with First generation Anti-psychotics (i.e.Haldol) Lower risk with 2nd generation AP but still occur. Be sure to document a baseline AIMS test (Abnormal Involuntary Movement Scale) upon admission or before beginning treatment with AP. Recheck AIMs per your facility's policy.

Residents with akathisia experience an internal feeling of extreme restlessness. This can manifest in pacing and other types of psychomotor agitation which is sometimes mistaken as a sign the AP isn't working and the resident needs more. Adding more only makes it worse!!

Tardive Dyskinesia is considered medical neglect. It happens usually after prolonged treatment but can occur after just a few weeks of AP use. Notify the provider at the first sign of TD.

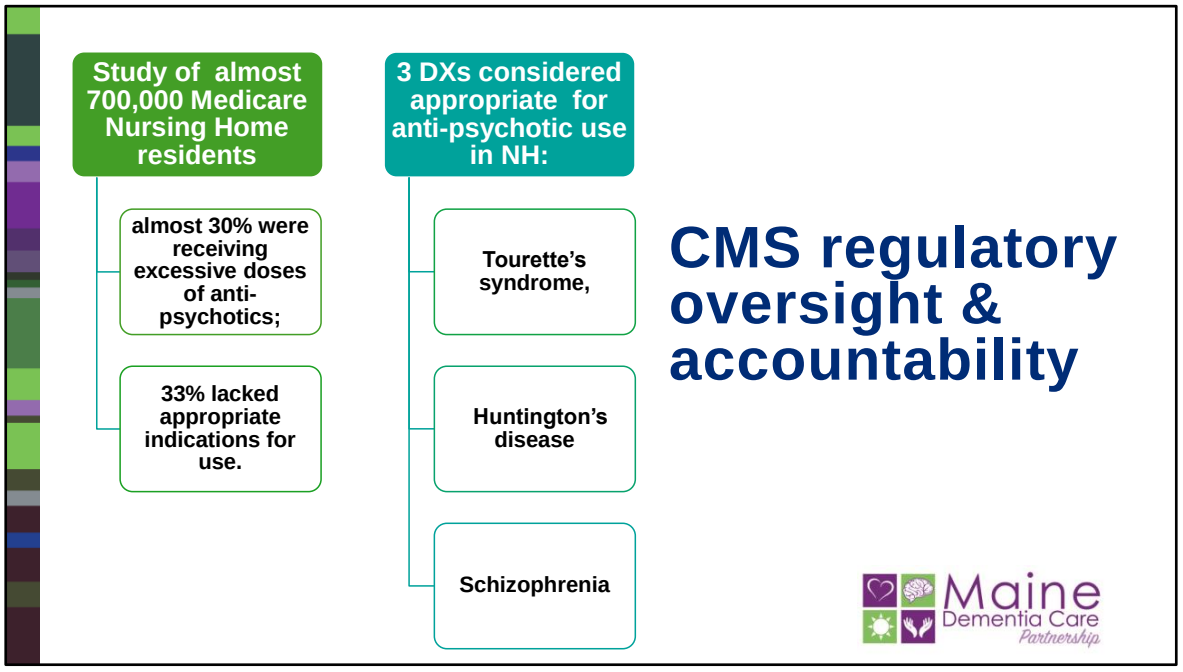
All these symptoms require changing or tapering the medication to stop this from progressing in severity. Once someone has TD it rarely completely resolves.



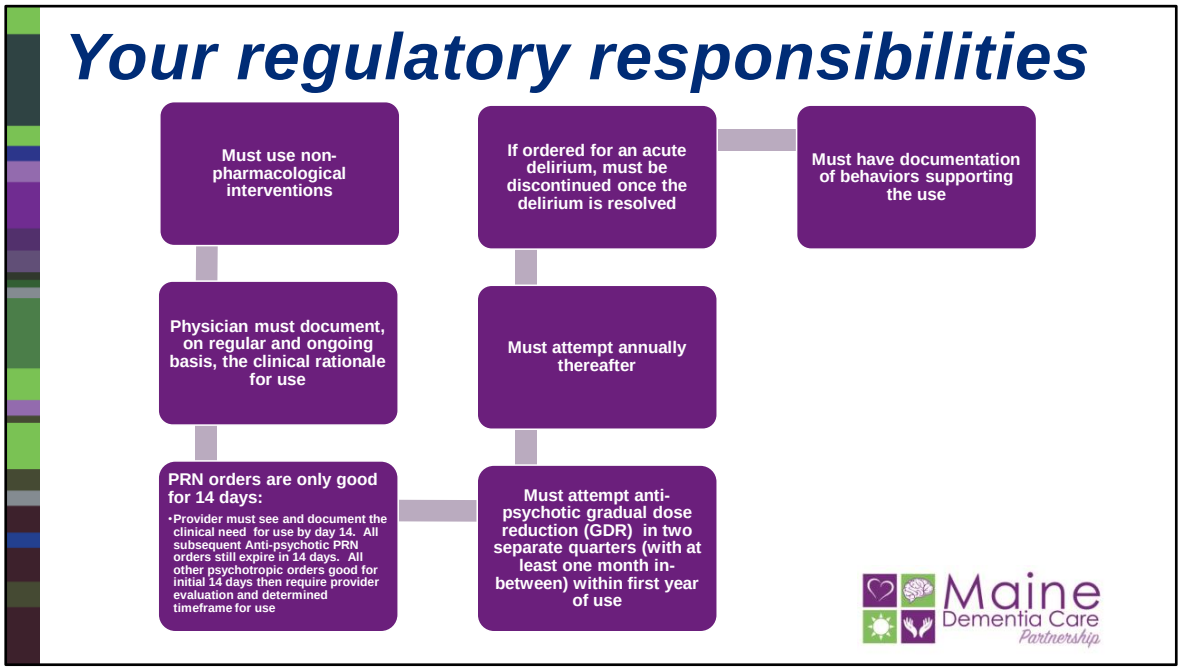
The ANS is a control system that influences the function of internal organs and regulates unconscious bodily function i.e. heart rate, respiratory rate, digestion, pupil response, urination, temperature, etc. Anti-psychotics affect your Autonomic nervous system thereby can affect several areas of function. Anti-psychotics can cause disruption to the heart's electrical impulse system which can lead to an arrythmia causing cardiac arrest.

APs can cause a rare but deadly syndrome of affects on several body systems, NMS in the vast majority of cases develops within the first week of initiation of Aps. But can occur with an increase in dose or months to years into AP use.

Typical Symptoms include severe muscle rigidity, Fever, sudden mental status changes i.e. hallucinations, agitation or decreased level or loss of consciousness. Gait and swallowing difficulties may be noted as well. If you suspect NMS , hold AP dose and call provider. This is a medical emergency!



All other uses of Anti-psychotics must be well documented and justified in physician and nursing documentation



What we've learned is that by applying non-pharm interventions and teaching our staff how to use personal interventions, many residents can come off antipsychotic drugs. We also recognize that despite our best efforts, sadly, for some residents it might not be possible. To the degree possible, CMS would like to see a minimal number of residents on these high-risk medications.

Don't wait for the regulatory timeframe, attempt a GDR when the opportunity arises. Pick the low hanging fruit! i.e.

At admission if only used for delirium that has cleared, ask for a D/C. No need to taper if only used for a few days

Originally started on AP at home or ALF for wandering or exit seeking but now on a secure dementia unit, start GDR

Dementia has advanced to later stages rendering a resident incapable of being physically aggressive any longer, start GDR

Resident reacting to environment or staff approach, correct issues with environment and approach, start GDR

No documentation in the record that supports the use of AP, start GDR

Other drugs with negative side effects

Anti-depressants:

Nausea, increased or decreased appetite, fatigue. weight gain, drowsiness, insomnia. Dry mouth, blurred vision, constipation

Anti-anxiety:

Headache, drowsiness, *nervousness*, GI upset, dry mouth, constipation

Sedative/Hypnotics:

drowsiness, dry mouth, confusion

All psychotropic meds cause increased risk for falls due to blood pressure changes, sedation and dizziness

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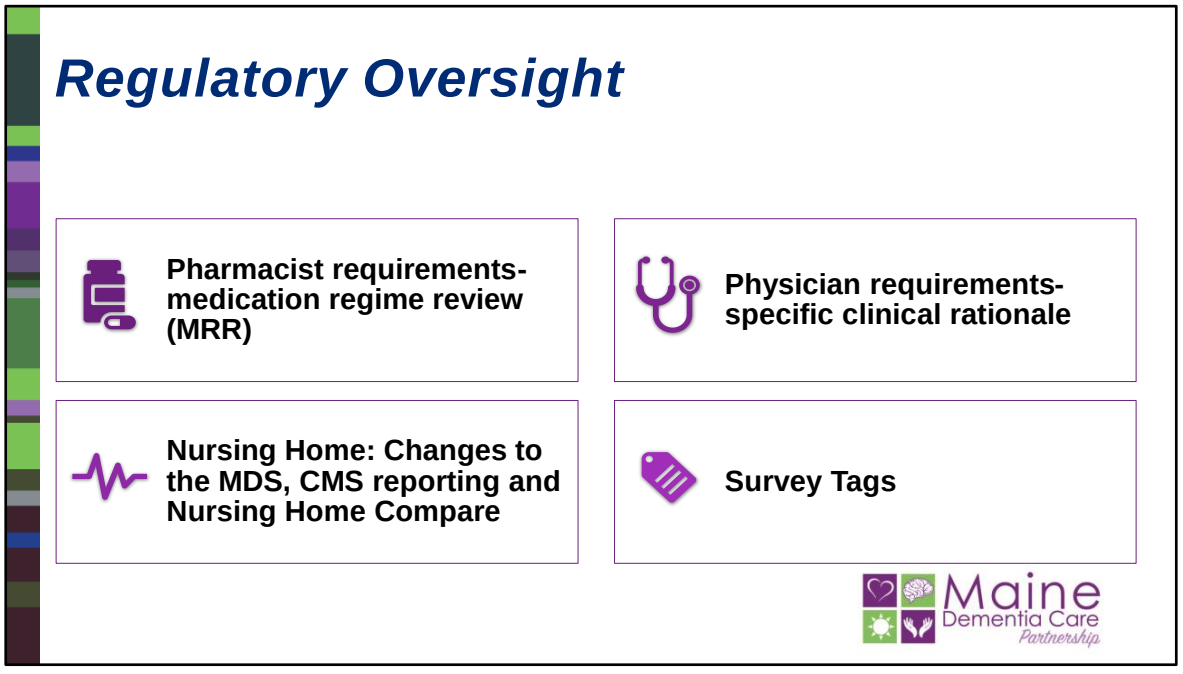


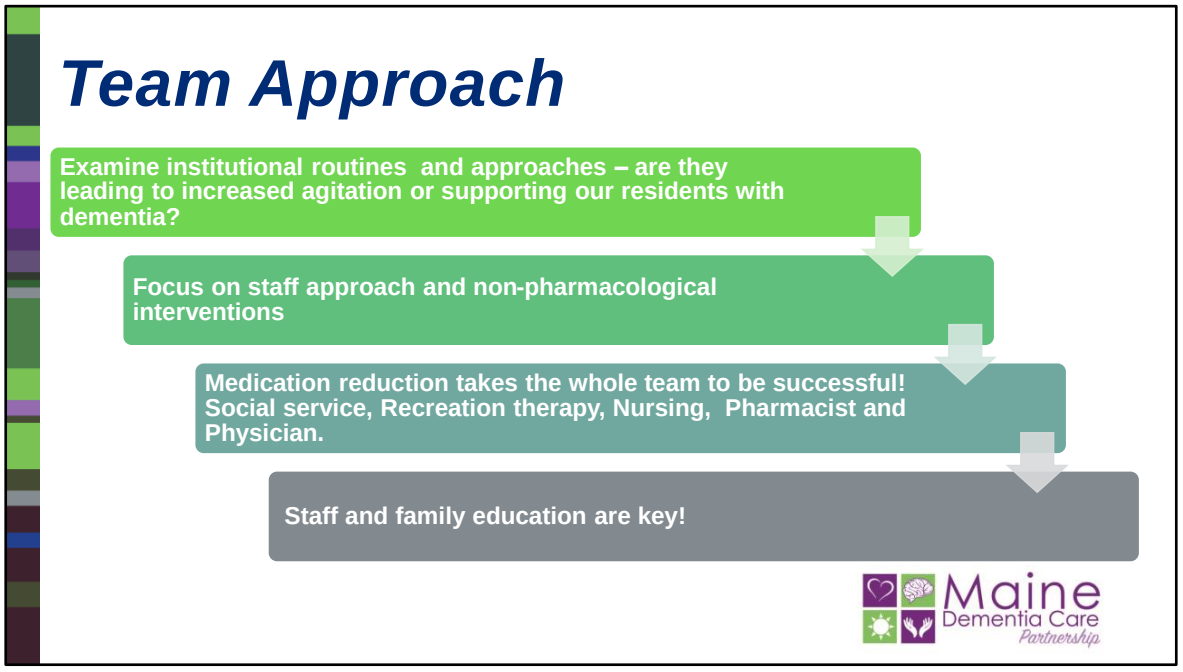
A Pharmacist reviews medication upon admission and monthly thereafter until a resident discharges. They pay special attention to psychotropic medication use, in particular anti-psychotics. They review the record for any signs of side effects or drug interactions, they review the physician documentation to ensure there is a valid clinical rationale for use. If you have missed an opportunity to do a GDR, the pharmacist will alert the facility. Be sure you have a good system in place for following up on pharmacist recommendations.

If the physician disagrees with the pharmacist recommendations regarding psychotropic meds, they can't just write "disagree". They must provide a specific, valid clinical rationale in their documentation why attempting a GDR is not in the residents best interest.

Required to report to CMS via the MDS re Anti-psychotic use and GDR attempts.

% of Anti-Psychotic use, compared to state and national use is reflected in the facility's Quality Measures and quality measures are part of our Nursing Home compare star rating calculation.

MDS Quality Measures along with resident level detail is used by survey team to prepare for annual survey before coming to your building. If Anti-psychotic use is high, it will be a focus during survey to determine if all requirements are being met. If not, will result in survey deficiencies



Are units/neighborhoods/households loud? Do staff shout across the room, walk fast, talk and laugh loudly? Are there large and loud activities going on or are there smaller unit based activities?
How do staff approach care- pull off the covers without warning? Or use soothing touch and tone before attempting care? Do you attempt to use reality orientation instead of validation? Insist on providing care that is agitating the resident or back off at the first sign of agitation?
Do we know the residents likes/dislikes and routines with family, friend and resident input? Or do we provide institutional, assembly line care?

When is maintenance done i.e. deep cleaning carpets and other noise producing activities? Is resident sleep protected?

Put yourselves in the shoes of the resident. Ask how would I react in these circumstances? Could I live here comfortably? How can I respond to this resident to avoid causing agitation?
Always ask before medicating, " Is this for you or for me?"
Each department has a role in helping to ensure an environment that supports residents with dementia without resorting to the use of unnecessary psychotropic

drugs.

Educating and supporting your direct staff will lead to success with GDR of anti-psychotics and other psychotropic medications.

Every day, every situation, every psychotropic medication administration ask yourself, is there something different I can do to diffuse this situation? What do I need for help with this situation? Is there someone else who may get a better response from this resident right now? Is there another department or a distraction that could help?

Always ask yourself, Is it for you or for me?