Maine Dementia Care Partnership

Mission/Vision | Therapeutic Environment | Data Driven Process | Competent Staff | Smooth Transfers of Care | Families as Partners | Non-Med Approaches | Physician Support

EXAMPLE GRADUAL DOSE REDUCTION POLICY

PURPOSE

1. To ensure the facility follows CMS regulations for proper management of antipsychotic medications in residents with dementia who have behavioral issues/concerns.
2. To provide the facility with a deeper understanding and recommendations regarding the management of responsive behaviors associated with cognitive impairments in older adults undergoing a gradual reduction in antipsychotic medication.

POLICY

[Name of Facility] will use antipsychotic medications appropriately working with an interdisciplinary team to ensure appropriate use, evaluation, monitoring and person-centered programing.

1. The facility will comply with State and Federal CMS regulations related to the use of antipsychotic medications in the long-term care environment to include regular review for continued need, appropriate dosage, side effects, risks and /or benefits.
2. The facility supports the appropriate use of antipsychotic medications that are therapeutic and enabling for residents suffering from mental illness.
3. The facility supports the belief that all behaviors are communication and will investigate the underlying causes of behavioral symptoms so the appropriate treatment of environment, medical, and/or behavioral interventions can be utilized to meet the individual needs of the resident.
4. Efforts to reduce dosage or eliminate of antipsychotic medications will be performed by an interdisciplinary team and ongoing as appropriate for the clinical situation of the resident.

PROCEDURE

To comply with this policy, each employee of the interdisciplinary team must comply with the following requirements:

ADMISSION:

1. All residents admitted to the facility on a previously prescribed antipsychotic will be immediately reviewed for drug appropriateness. The nurse will collaborate with an interdisciplinary team to attempt to determine the reason why the antipsychotic medication(s) was initiated and confirm diagnosis.
2. If the antipsychotic medication started led to a delirium, tapering/discontinuing the antipsychotic medication if the underlying cause of delirium has been treated. Physician orders will be obtained for recommended gradual dose reductions. The order will reflect the following information:
3. The nursing staff will initiate a behavior sheet with specific behaviors for which the antipsychotic medication was originally prescribed.
4. An interdisciplinary care plan will be established and include person-centered non-pharmacological interventions. The care plan should address any underlying causes of responsive behaviors, non-pharmacological approaches and interventions/approaches in managing responsive behaviors. The non-pharmacological interventions should include family input.
5. Involve available resources if management of responsive behaviors continues to be a challenge. Follow the outline noted for non-pharmacological approaches to care.
6. Include [Name of Facility] consultant pharmacist
7. Consider all team members and discuss the care approaches to trial, risks and benefits, intended goal(s) and the observation period. All members of the team including family should be included in the discussion.

LONG-TERM CARE RESIDENTS:

1. Monthly interdisciplinary meetings will review all residents on antipsychotic medications and/or on a gradual dose reduction. This includes anti-anxiety/hypnotic, antipsychotic and antidepressant classes of drugs).
2. Physician orders will be obtained for recommended gradual dose reductions. The order will reflect the following information:
3. Systematically determine if the behavior/symptom(s) are likely related to medical condition, use of an antipsychotic drug, the current medication regime, psychosocial/unmet need an/or environmental cause.
4. The nursing staff will initiate a behavior sheet with specific behaviors for which the antipsychotic medication was originally prescribed.
5. An interdisciplinary care plan will be established and include person-centered non-pharmacological interventions. The care plan should address any underlying causes of responsive behaviors, non-pharmacological approaches and interventions/approaches in managing responsive behaviors. The non-pharmacological interventions should include family input. Involve available resources if management of responsive behaviors continues to be a challenge. Follow the outline noted for non-pharmacological approaches to care.
6. Include [Name of Facility] consultant pharmacist.
7. Involve available resources if management of responsive behaviors continues to be a challenge. Follow the outline noted for non-pharmacological approaches to care.
8. Consider all team members and discuss the care approaches to trial, risks and benefits, intended goal(s) and the observation period. All members of the team including family should be included in the discussion.

NON-PHARMACOLOGICAL APPROACH:

1. A life story of the resident will be completed and utilized to identified person-centered interventions for resident engagement. This approach ensures that interventions are tailored to meet the unique situation for each resident recognizing their life experiences, preferences, routines and cultural traditions.
2. The monthly therapeutic recreation calendar will be reviewed to identify person-center activities of interest to the resident.
3. An occupational and/or speech therapy consult should be considered to support the team during the gradual dose reduction. An assessment for cognitive function should be performed. A physician's order should be obtained to assist the interdisciplinary team on possible approaches during activities of daily living such as; peri-care, bathing, un-dressing, eating and sleeping.
4. A person-centered tool kit should be developed either by the Occupational Therapist and/or Therapeutic Recreation Specialist to assist all staff in engaging the resident in a positive manner.
5. Social services, nursing and therapy should engage family members in conversation regarding responsive behavior and to help problem-solve strategies to prevent or better manage the resident when responsive behavior occurs.

MONITORING:

1. Team members should spend time tracking the frequency and severity of the responsive behavior(s) to help the team in determining if there are possible triggers.
2. All interdisciplinary team members will monitor the efforts of non-pharmacological approaches and interventions on responsive behavior that is the focus of treatment. Continue with these interventions if any movement toward the desire outcome(s) as identified in the care plan is observed.
3. Document all non-pharmacological approaches and interventions that achieve the desired outcome in the resident health record.
4. Document all the gradual dose reductions attempts, failures or unsuccessful non-pharmacological interventions in the resident health record.
5. Consult with the facility pharmacist using a tracking tool.
6. The following is a list of behaviors that antipsychotic medications are not indicated to manage:
    a. Wandering
    b. Insomnia
    c. Unsociability
    d. Poor self-care
    e. Impaired memory
    f. Fidgeting or nervousness
    g. Inappropriate voiding
    h. Hoarding
    i. Repetitive vocalizations
    j. Restlessness or pacing
    k. Indifference to surroundings

CATEGORIES FOR SPECIFIC NON-PHARMALOGICAL INTERVENTIONS:

The focus on non-pharmacological interventions and activities is considered best-practice and is considered the first line of defense in the management of most behavioral and psychological symptoms dementia. The categories are as follows:

1. Environmental Modifications
    a. Natural wandering areas
    b. Reduced stimulation
    c. Light therapy
    d. Enhanced environment
2. Sensory Enhancement /Relaxation
    a. Massage/touch
    b. Individualized music: Music and Memory
    c. Music Therapy
    d. Acupuncture
    e. Controlled multi-sensory therapy: Snoezelen
    f. Aroma therapy
3. Social Contact
    a. Pet therapy
    b. Stimulated interactions: Family videos, pictures
    c. Individualized social contact
4. Cognitive/Emotional-oriented Interventions
    a. Reminiscence Therapy
    b. Stimulated Presence Therapy
    c. Validation Therapy
5. Behavior Therapy
    a. Differential reinforcement
    b. Stimulus control
6. Structured Activities
    a. Outdoor walks
    b. Exercise
    c. Physical activities
    d. Recreational activities
7. Training and Development
    a. Understanding of resident specific underlying causes of responsive behavior(s)
    b. Understanding of the functional cognitive assessment
    c. Review of resident specific life story; recognize resident life experiences, preferences, routines and cultural traditions incorporating them into the resident's daily life.
    d. Knowledge/skill of person-center interventions: communication/approach and environmental factors.
    e. Encourage person-center activities/programs
    f. Knowledge of resident person-centered tool kit