



Staff Educational Training Program and Toolkit

**Use of Antipsychotics for
Those Who Have a Diagnosis
of Alzheimer's or a Dementia-
Related Condition and Live in a
Nursing Facility**



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Introduction

Overview of Problem, Impact of Problem, and Those Affected

Dementia is an umbrella term used to describe a set of symptoms, ranging from a decline in memory or other thinking skills to permanent impairment of cognitive function. Alzheimer's disease is the most common type of dementia, affecting more than 5.4 million Americans¹. Texas is ranked fourth in the nation for the number of cases, with 350,000 Texans affected. Additionally, Texas is ranked second in the nation in the number of deaths related to Alzheimer's disease.

In fiscal year 2015, over 90,000 people were living in Texas nursing facilities (NFs). Of those, over 49,000 had a diagnosis of Alzheimer's disease or another dementia-related condition. Many of these individuals experience out-of-character behaviors as a symptom of their disease process. These symptoms include agitation (such as calling out with raised voice, hitting, pinching, and cursing), decreased appetite (refusal to eat), and refusing activities of daily living (personal care, grooming, bathing, and dressing). These behaviors often lead to a resident's isolation and poor quality of care/life. The common treatment modality to combat these behaviors is often the prescription of antipsychotic medications. This has become a significant problem in recent years, as evidenced by Texas being named 49th in the country for quality of care and quality of life in 2014 by the AARP Report *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*².

In 2011, the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services reported that among nursing home residents, there was a high use of atypical antipsychotic medications for "off-label" indications³. The indication most used was for the treatment of out-of-characteristic behaviors.

The use of these medications has led to significant concerns for the health and safety of the geriatric population, so much so that in 2008, the Food and Drug Administration⁴ (FDA) issued a black box warning against the use of these medications in the elderly population due to the increased risk of mortality. despite

¹ Alzheimer's Association. (2017). Latest Facts and Figures. https://www.alz.org/documents_custom/2017-facts-and-figures.pdf

² AARP. Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers. https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2014/raising-expectations-2014-AARP-ppi-ltc.pdf

³ Department of Health and Human Services. Office of Inspector General. Medicare Atypical Antipsychotic Drug Claims For Elderly Nursing Home Residents. <https://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf>

⁴ Food and Drug Administration (FDA). Information for Healthcare Professionals: Conventional Antipsychotics. <https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm124830.htm>

the FDA's warnings of increased mortality, the use of antipsychotics in NF residents with dementia persists. Significant morbidity (including higher blood sugar and cholesterol levels, weight gain, increased risk of falls, and decreased cognition) are associated with the use of antipsychotics. These complications can lead to a worsening of other chronic medical conditions.

In addition to the OIG report in 2011, other organizations such as the Centers for Medicare and Medicaid Services (CMS) and the Governmental Accountability Agency (GAO) have also stated that antipsychotics were over prescribed and should not be used with those who have dementia and are living in a NF. In 2012, CMS launched the National Partnership to Improve Dementia Care in Nursing Homes, with the mission to improve quality of care for NF residents living with dementia. This Partnership includes federal and state agencies, NFs, other providers, advocacy groups and caregivers, and continues to focus on the delivery of health care that is person-centered, comprehensive and interdisciplinary. In addition, the Partnership focuses on protecting residents from being prescribed antipsychotic medications unless there is a valid, clinical indication and a systematic process used to evaluate each individual. Utilizing a multidimensional strategy, the Partnership promotes rethinking approaches that are utilized in dementia care, reconnecting with people using person-centered care approaches and restoring good health and quality of life in NFs.

In an effort to combat the current and increasingly prevalent issue of the inappropriate use of antipsychotics to treat the out-of-character behaviors that are symptomatic of Alzheimer's disease and other dementia-related conditions, nurses (along with other disciplines) must be provided with the resources that will educate them on the alternate non-pharmacological activities/therapies that can be implemented to work through these displayed behaviors.

Data/Magnitude of the Problem

In Texas NFs, there is a significant issue with the inappropriate use of antipsychotic medications in those with Alzheimer's disease or other dementia-related conditions⁵. According to CMS data, in Quarter 1 of 2014, Texas was ranked the worst, 51st in the nation, for the use of antipsychotics in NF residents.

Because of Texas' ranking, the Texas Health and Human Services (HHSC) Quality Monitoring Program (QMP) conducted an iceberg analysis to gain a deeper understanding of the system factors and root causes of the issue. This analysis looked at those causes that were below the surface of the problem and were not immediately seen. In doing this analysis, each piece of infrastructure that touches

⁵ Centers for Medicare and Medicaid Services (CMS) 2014 National Partnership Data.
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-19.html>

the NF resident was examined in its entirety, including nursing, certified nurse aides, pharmacists, and prescribers (MD, PA, and APRN).

This analysis revealed that across all of the disciplines working with the resident, there was a lack of knowledge on how best to care for a person with Alzheimer's disease or other dementia-related condition who displayed out-of-character behaviors. This education is not commonly provided during the education and/or training phases for each of these disciplines. Consequently, the inappropriate use of antipsychotic medications in NF residents with Alzheimer's disease and other dementia-related conditions is a symptom of a generalized issue: a lack of knowledge, skills, and abilities to care for these residents in ways that include alternatives to antipsychotic medications.

Reason for the Training Program Toolkit

To effectively address the need for more alternatives to antipsychotic medications discovered during the root cause analysis, all parts of the infrastructure (different disciplines working with the resident) need to be addressed. An infrastructure wheel was created using the systems thinking approach that identified four specific pieces of the system that influence the care that is provided to facility residents (prescriber, nursing, pharmacists, and the certified nurse aide).

This training program/toolkit will provide an approach to working with these disciplines to address the educational deficit that was noted in the root cause analysis. Ensuring that these four disciplines receive comprehensive education will help eliminate practices noted in each discipline as common practice. Without this education, the problem will only continue to get worse, for two very significant reasons: the number of individuals with Alzheimer's disease and other dementia-related conditions is projected to increase significantly in the coming years and all healthcare disciplines are being faced with caring for individuals who have out-of-character behaviors related to an unmet need or as a result of their disease process.

One important component in reducing the use of antipsychotics in NF residents is the use of alternate interventions. Through this training program/toolkit, individuals from all four disciplines will be provided with education related to interventions such as Music Therapy, Reminiscence Therapy, Art Therapy, Doll Therapy, etc. that can be implemented instead of an antipsychotic medication for their out-of-character behaviors. The benefits of this information extend beyond the reduction of antipsychotic medications in the NF and directly to the resident by allowing them to reconnect the world that they have been all but removed from.

This training program/toolkit will include education on the care of the individual with Alzheimer's disease or other dementia-related condition, out-of-character

behaviors and what the resident is really trying to tell us, clinical guidelines for the use of antipsychotic medications in these residents, and alternate interventions.

Once all these resources are put together, all Texas NFs will be able to take the training program/toolkit, in its entirety, and educate their staff so that they can integrate the alternate interventions into the care that they provide for the residents.

Section 1: Orientation to the Training Program/Toolkit

Orientation to the Training Program/Toolkit

This training program/toolkit will provide NFs with information related to antipsychotic medication use in nursing facility residents with dementia, including:

- What it is:
 - What are antipsychotic medications
- Assessment of the Resident:
 - Assessing admission orders for antipsychotic medications that are not appropriate for the resident
- Prevention:
 - Alternate interventions in the place of antipsychotic medications
- Staff Roles:
 - Nursing
 - Direct Care Staff (CNA, CMA)
 - Physician
 - Administrative Staff
- Handling the issue:
 - What to do if a resident is admitted on antipsychotic medications
- Resources:
 - Evidence Based Practices from nationally known sources
 - ✓ Pioneer Network
 - ✓ Centers for Medicare and Medicaid Services (CMS)
 - ✓ American Geriatrics Society (AGS)
 - ✓ Centers for Disease Control and Prevention (CDC)
 - ✓ The Society for Post-Acute and Long-Term Care Medicine (AMDA)
 - ✓ TMF Quality Innovation Network-Quality Improvement Organization (TMF QIN-QIO)
 - ✓ National Nursing Home Quality Improvement Campaign
 - ✓ Alzheimer's Association

Instructions on Use of the Training Program/Toolkit

In order to effectively use this training program/toolkit, it is imperative that the NF staff conduct a root cause analysis⁶ (RCA) related to the use of antipsychotics to determine why residents are being prescribed these medications, why they are being admitted with a prescription for these medications, and what changes need to be made to ensure that these residents don't continue to be prescribed antipsychotics and receive the highest level of care possible. RCA can be an early step in a performance improvement project (PIP), helping to identify what needs to

⁶ Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs).
<https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf>

be changed to improve performance. Once the changes that need to be made are identified, the steps that are followed are the same as those that would be used in any type of PIP.

Seven Steps to RCA

Use the following steps to walk through a RCA to investigate problems/situations:

1. Identify the problem/situation to be investigated and gather preliminary information: Problems/situations can be the result of many different things. There should be a process in place to determine which problems/situations will undergo an RCA.
2. Charter and select team facilitators and team members: Leadership should provide a project charter to launch the team. The facilitator is appointed by leadership. The team members involved should be those with personal knowledge of the processes and systems involved in the problem/situation that is being investigated.
3. Describe what happened: Collect and organize the facts related to the problem/situation to fully understand what happened.
4. Identify the contributing factors: Determine what other situations, circumstances, or conditions increased the likelihood of the problem/situation.
5. Identify the root cause: A thorough analysis of contributing factors leads to identification of the underlying process and system issues (root causes) of the problem/situation.
6. Design and implement changes to eliminate the root causes: The team works together to determine how best to change processes and systems to reduce the likelihood of another similar problem/situation.
7. Measure the success of changes: Like all improvement projects, the success of improvement actions need to be evaluated.

RCA Tools

There are many tools that can be used when conducting RCA. The tool you ultimately use depends on which one works best for the current problem/situation. These tools include:

1. Five Why Analysis⁷: A tool to drill down to the root cause of a problem by asking “why” five times. The purpose of the 5 Why’s is not to arrive at a single root cause but to uncover as many contributing why’s as possible, as most complex healthcare problems are multifactorial.
2. Brainstorming⁸: Bringing together a group of people to jointly discuss the problem/situation in a facilitated manner. It is important that the individuals brainstorming have some knowledge about the problem/situation. It is important to encourage as much participation as possible. When facilitating

⁷ Determine the Root Cause: 5 Whys. <https://www.isixsigma.com/tools-templates/cause-effect/determine-root-cause-5-whys/>

⁸ DADS Quality Monitoring Conference April 2014. Melody Malone-Brainstorming.

brainstorming it is best to have a flip chart and markers, but it can be done with a white board and have someone take notes of what was recorded. Be sure to go around the room and ask each person to throw out an idea without having anyone else comment (positively or negatively) on the idea. The faster you move, the more the participants will add ideas and be encouraged to speak up. The wilder the better, because you never know which idea may be THE ONE that is the solution. Silent brainstorming works as well to generate ideas. Give the team a pad of paper or sticky notes and ask them to write down all of their ideas, one on each page. Collect all of the papers and work with the team to group similar ideas and confirm meanings to anything that might not be clear.

3. Fishbone Diagram⁹: Also known as a cause and effect diagram, this tool can be used to identify the many possible causes for a problem. Using a fishbone diagram allows for ideas to be sorted into useful categories.

More information and resources related to RCA are available through the Institute for Healthcare Improvement (IHI). The Quality Improvement Essentials Toolkit¹⁰ can be accessed here: <http://www.ihl.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx>. Registration is required to access the toolkit.

Once the RCA has been completed, processes must be put into place to eliminate the root cause of the problem/situation. This can best be accomplished through the use of Evidence-Based Practices (EBP).

RCA Example

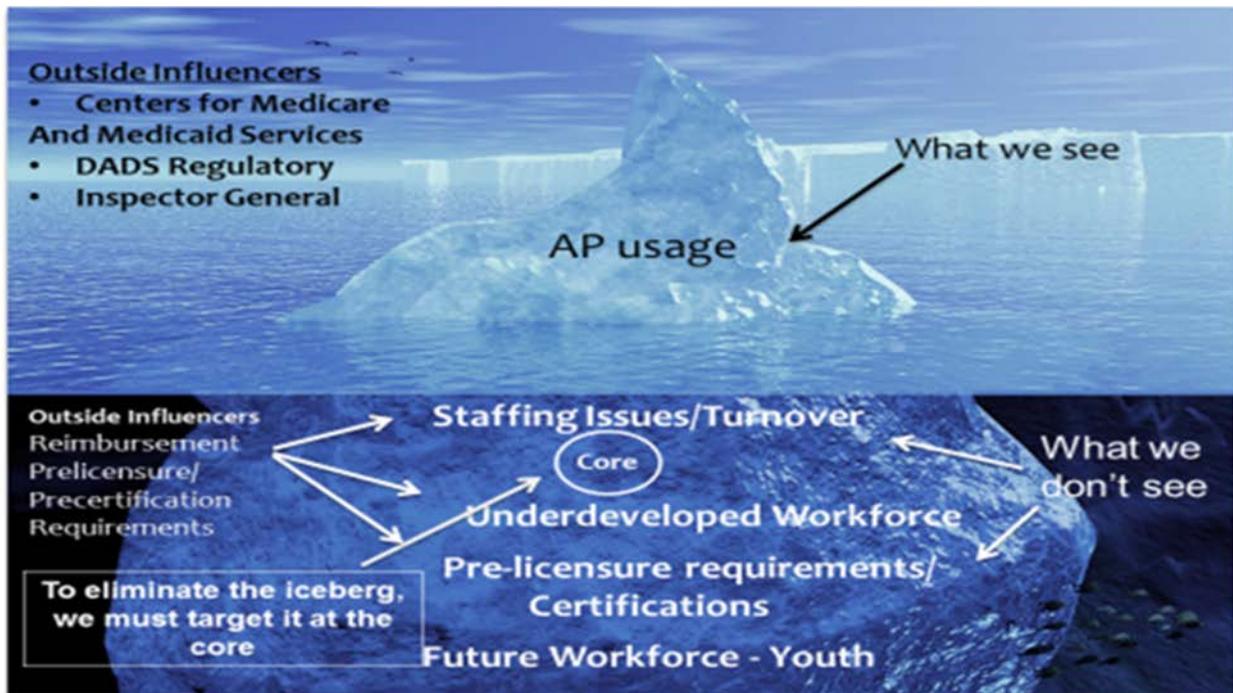
The issue of antipsychotic medication use in Texas was evaluated extensively in 2014, including a root cause analysis to determine the cause of the problem in a general sense. Over the course of several months, and in looking at many different variables, the root cause of the problem was determined.

Look at the iceberg below. We typically view the iceberg from the tip that is above the surface of the water. In this case, the antipsychotic use was all that was being seen. The issues below the surface weren't taken into too much consideration because they couldn't be easily seen.

⁹ Fishbone (Ishikawa) Diagram <http://asq.org/learn-about-quality/cause-analysis-tools/overview/fishbone.html>

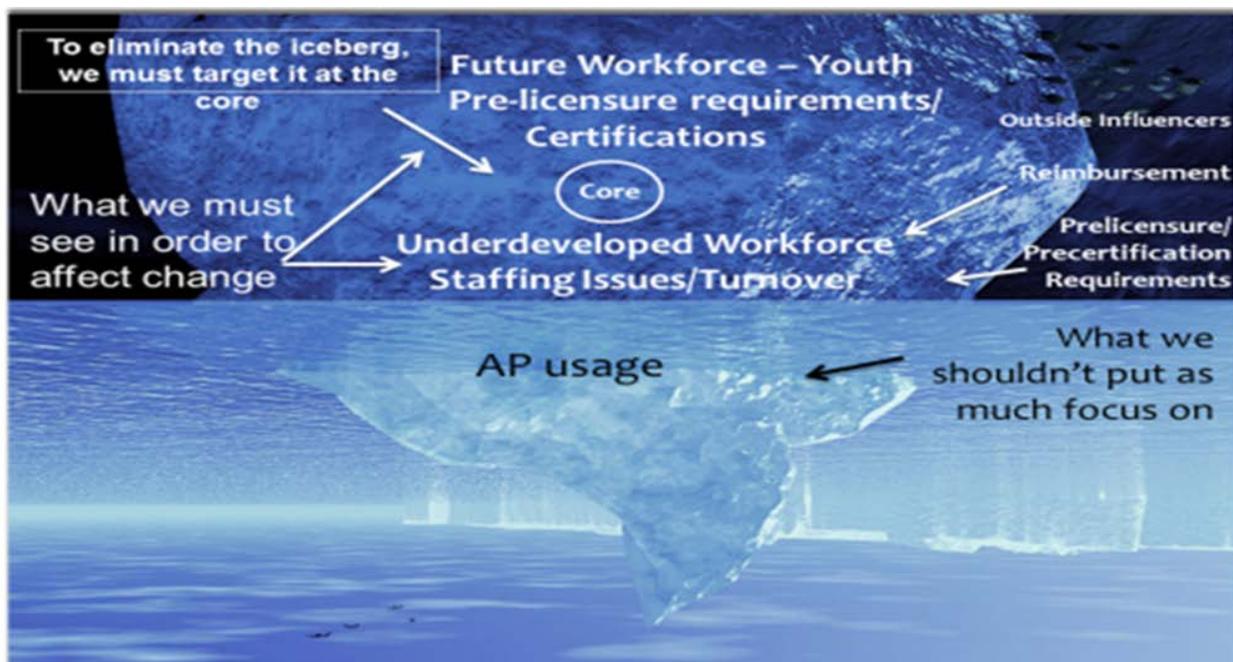
¹⁰ Institute for Healthcare Quality Improvement: Quality Improvement Essentials Toolkit. <http://www.ihl.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx>

Figure 1: Issues Related to Antipsychotic Use – The Tip of the Iceberg?



In performing a RCA, the iceberg is viewed in a way in which all of the issues below the surface come to light and are now seen so that they can be addressed. As you look at Figure 2, you will see that the root cause of the issue is now above the surface and includes items such as staffing issues/turnover, an underdeveloped workforce, pre-licensure/certification requirements, and a lack of attention paid to the future workforce - youth.

Figure 2: Issues Related to Antipsychotic Use – What's Below the Surface?



In order to affect change with the issue of antipsychotic use, improve quality of care for NF residents, and improve quality measure (QM) data related to antipsychotic use, the iceberg must be eliminated at the core (the initially unseen part of the iceberg).

When performing a RCA, the issue should be taken into consideration; however much more focus must be placed on the cause rather than the effect (antipsychotic use).

How to Use the Resource Toolkit

Once you have received the training program/toolkit, you will want to read through the material as it will begin by providing you with general information related to the topic of antipsychotics. As you read through the information you will notice that there is specific information related to how to assess the resident, ways to decrease risk factors, steps to take towards prevention, alternate interventions that are recommended for the residents and how to care for the resident if they come to the facility already on antipsychotic medications.

The roles of the different disciplines providing care for the residents are also described. As you go through the training program/toolkit you will want to note the specific role that each of your staff may have with regards to improvements in the QMs. This information may be used to create in-service educational trainings for your staff to provide them with the knowledge needed to make changes to the care provided to the residents.

Additionally you will find that there are sample assessments, sample care plans, and algorithms in this training program/toolkit that will allow your staff to have a better understanding of how best to assess resident risk factors, provide care for the residents, and how to evaluate the resident for different issues that could lead to a decrease in care based on the quality measures.

As you review the training program/toolkit, if there is information that is not available that you would like to use in coordinating training for your staff, there are resource lists at the end where additional information may be obtained.

Organizational Change

As you use the toolkits in your facility, it is important that the changes made to the processes related to the QIPP QMs are sustainable. The best way to ensure sustainability is to make the changes at the system level versus the person level. As you continue below, you will find how this can best be accomplished.

System Change vs. Person Changes

As change begins to be implemented in your facility, it is important that the change is made at a systemic level and not just the staff level. What does this mean? Well it quite simply means that it is not enough to only train the staff on the changes that are being made throughout the NF, but to put in to place policies and procedures that reflect those changes as well. When an NF experiences staff turnover, change that has been made at the staff level tends to be lost as a result.

The only effective way to ensure that the change will be maintained is to imbed it throughout the NF policies and procedures that detail the way that the NF will operate. How can an NF best put practices into operation? To guide the changes that will be needed, ask the following four questions¹¹:

1. How do we manage the change process at the front line? Staff will need to understand their new roles and have the knowledge and resources to carry them out. To manage the change process effectively, an Implementation Team will need to guide, coordinate, and support the implementation efforts as the new practices roll out across the NF.
2. How do we put in to place new practices? It may be helpful to begin the change process in just one area of the NF to determine if it will be effective before rolling it out facility-wide. If changes need to be made, they get made prior to NF wide roll-out. Once the change has been rolled out across the NF, observe for problems or issues that may hamper successful implementation of the change.
3. How do we get staff engaged and excited about the changes? Engaging the buy-in, commitment, and ongoing participation of staff members is particularly important for staff who are involved in hands-on care and whose involvement will be needed to achieve implementation of the change. An important aspect of engaging staff and is key to success in any change made at a systemic level is clear communication. Be sure staff know the change is coming and are familiar with the available resources and their new roles prior to the change taking place.
4. How can we help staff learn new practices? Once the initial change takes place, assess what educational needs staff have. Providing this education will enhance their knowledge. Any and all plans for new staff education related to the changes being made in the NF should be worked out in close collaboration with experts on the content.

The most important concept in organizational change is to ensure that it is sustainable. This can only happen if the change is made at the system level in the form of policies and procedures, as these will not leave the NF as turnover happens like it will if the changes are made at the staff level.

¹¹ Preventing Pressure Ulcers in Hospitals.
<https://www.ahrq.gov/professionals/systems/hospital/pressureulcer/toolkit/putool4a.html>

Empowerment

As you work through making changes in your facility to improve the quality of care for your residents, it is important that your staff feel empowered to assist in the implementation of the changes. As you read through the below, information will be provided to you defining what empowerment is and the benefits that it will have on your staff.

Empowerment is a practice of sharing information, rewards, and power with employees so that they can take initiative and make decisions to solve problems and improve service and performance. The concept of empowerment is based on the idea that giving employees skills, resources, authority, opportunity, motivations, as well as holding them responsible and accountable for outcomes of their actions will contribute to their competence and satisfaction. Empowering staff gives them a:

- Sense of meaning - the staff cares about what they are doing and ultimately, they feel as if their work is important.
- Sense of competence - staff members are confident in their abilities to do their job. They are trusted to do their job right.
- Sense of determination - they are able to choose how to do the work that they have been assigned to do and they are determined to do a good job for their residents.
- Sense of impact - the work they are doing has a positive impact on the lives of their residents as well as their own. They ultimately become comfortable taking risks to improve day-to-day operations.
- Sense of ownership, commitment, and teamwork - no one staff member works by him/herself; everyone works together to ensure the best care is given. Peers are comfortable with challenging each other to be the best they can be.
- Tolerate imperfections - understanding that as humans, mistakes are inevitable and that no one is perfect.
- Accountability - being accountable for the choices one makes, understanding that in many instances, the results of the choices made can be used as learning opportunities for the future.

Empowerment can't be delegated. It is possible to develop an empowering environment where people will take the initiative to empower themselves. Changes are seen as opportunities for growth.

Use of Standardized Assessment Tools to Determine Understanding

When looking in to any type of training, it is important to ensure that those receiving the training understand what they have been taught. The best way to do this is through the use of a standardized assessment tool. This could be a pre and post-test on the information, questionnaire set, or case study. In the case of antipsychotic medication use, there is research to support several different types of assessment tools. Two such tools will be discussed in this training program/toolkit:

1. Psychotropic Education and Knowledge Test for Nurses in Nursing Homes (PEAK)¹² : The PEAK test for nurses in acute geriatric care (PEAK-AC) was originally created as a Dutch language instrument, used to measure the knowledge a nurse had related to geriatric pharmacotherapy. More specifically, their knowledge on the use of antipsychotic and hypnotic medications in the acute geriatric care environment. The instrument is comprised of 24 questions aimed at determining a nurse's general knowledge. The content for the questions, based on a literature survey, was developed by Wauters, et al. and subsequently refined using the Delphi Technique that consisted of 10 experts to ensure validity. The instrument was then adapted for the NF setting using a second round Delphi Technique with eight experts in psychotropic use working together to ensure content validity. The content of the PEAK-NH instrument includes 19 of the 24 original PEAK-AC questions, randomly ordered:
 - a. As a result of a change in metabolism and heightened receptor sensitivity, older people often need only a lower dosage of both antipsychotics and sleeping and calming medicines in order to achieve the same/desired effect. (true)
 - b. In case of anxiety disorders, sleeping and calming medicines must be initiated in addition to nonpharmacological therapies in order to normalize the symptoms. (not true)
 - c. The recommended daily dose of the antipsychotic risperidone (Risperdal) for older people with severe behavioural disorders in cases of dementia is 0.52.0 mg. (true)
 - d. In cases of sleep disorders, pharmacological interventions must always accompany or take priority over nonpharmacological interventions. (not true)
 - e. Older people are less sensitive to the side-effects of antipsychotics. (not true)
 - f. Long-term use (greater than 3 months) of antipsychotics increases the risk of cerebrovascular events in older people. (true)
 - g. Sleeping pills can be administered over a short period of time and in low doses. (true)
 - h. Most antipsychotics can cause extrapyramidal symptoms in older people. (true)
 - i. Sleeping pills with long half-lives are not indicated in older people. (true)
 - j. If undesired effects result for psychotropic medicines, it is best to immediately stop their use. (not true)
 - k. Antipsychotics can cause disorientation in older people. (true)
 - l. One of the side-effects of the antipsychotic haloperidol (Haldol) is akathisia, resulting in restless patients who continuously walk back and forth. (True)

¹² Perehudoff, K., Azemari, M., Wauters, M., Van Acker, S., Versluys, K., Steeman, E., & Petrovic, M. (2015). The Psychotropic Education and Knowledge Test for Nurses in Nursing Homes: Striving for PEAK Performance. *Aging and Mental Health*. doi: 10.1080/13607863.2015.1068738

- m. There is a relationship between the long-term use (greater than 3 months) of antipsychotics and falling in older people. (True)
- n. Sleeping and calming medicines may be briefly administered to older people only in cases of severe insomnia and when alternative therapies with proven effectiveness fail. (True)
- o. Sleeping and calming medicines can lead to urine retention in older people. (Not true)
- p. Antipsychotics should be given priority over behavioral change therapy in older people with behavioral disorders resulting from dementia. (Not true)
- q. The recommended daily dose of olanzapine (Zyprexa) in older people with severe behavioral disturbances in the scope of dementia is 5-10 mg. (True)
- r. Older people who use antipsychotics are especially sensitive for orthostatic hypotension at the onset of treatment. (True)
- s. The use of sleeping and calming medicines can lead to both physical and emotional dependence in older people. (True)

Perehudoff, et.al, concluded that the PEAK-NH assessment instrument is valid and reliable in determining a nurse's knowledge of psychotropic medications in the nursing home. It was also determined, through the testing of the instrument that the knowledge that nurses and nursing assistants possess, related to psychotropic medication use, is limited at best. This instrument is one of many tools that can be used to educate and train staff with the goal of improving the appropriate use of psychotropics in the NF setting.

2. Older Age Psychotropic Quiz (OAPQ)¹³: This instrument was devised to assess the knowledge health practitioners have related to the recommended use of psychotropic medications. The OAPQ was created and used as a prototype in 2009 to determine if education and training on appropriate use of psychotropic medications in nursing homes was successful. The original version of this instrument was revised and updated as necessary, with the validation process taking place to ensure that the questions asked in the instrument measure what they are designed to measure. This instrument originally contained 12 questions, however, the finalized version contains 10 multiple choice questions. It was concluded that the OAPQ is an instrument that can be used in a multitude of capacities in the NF setting by all staff to assess their knowledge of psychotropic medication use in the resident population.

¹³ Brown, D. & Westbury, J. (2016). Assessing Health Practitioner Knowledge of Appropriate Psychotropic Medication Use in Nursing Homes Validation of the Older Age Psychotropic Quiz. *Journal of Gerontological Nursing*, 42. doi:10.3928/00989134-20160701-01

Figure 3: Older Age Psychotropic Quiz (OAPQ)

Older Age Psychotropic Quiz (OAPQ)

Circle one answer for each of the following questions.
When you have finished, check to make sure you have completed all 10 questions.

1. Risperidone is most effective for the treatment of which behavior?
 - a) calling out
 - b) wandering
 - c) aggression
 - d) repetitive questioning
 - e) don't know
2. The maximum recommended daily dose of risperidone in older people with dementia is:
 - a) 2 mg
 - b) 1 mg
 - c) 4 mg
 - d) 3mg
 - e) don't know
3. Which of the following adverse effects is NOT usually associated with the use of olanzapine?
 - a) stroke
 - b) falls
 - c) raised blood sugar
 - d) reflux
 - e) don't know
4. Regular reviews of antipsychotics in residents with dementia should be performed every:
 - a) 6 weeks
 - b) 3 months
 - c) 6 months
 - d) 12 months
 - e) don't know
5. The drug diazepam is mainly used to treat:
 - a) depression
 - b) agitation
 - c) infection
 - d) anxiety
 - e) don't know
6. Which of the following adverse effects is NOT commonly associated with oxazepam use?
 - a) falls
 - b) memory impairment
 - c) nausea
 - d) confusion
 - e) don't know
7. What is the recommended duration of temazepam treatment for sleep disorder?
 - a) 1-2 weeks
 - b) 6 weeks
 - c) 1 month
 - d) 3 months
 - e) don't know
8. The recommended medication for long-term treatment of anxiety in older people is:
 - a) temazepam
 - b) an SSRI (e.g. sertraline)
 - c) risperidone
 - d) oxazepam
 - e) don't know
9. Amitriptyline (Endep) is recommended as a night time sedative in older people.
 - a) true
 - b) false
 - c) don't know
10. Quetiapine (Seroquel) is licensed to treat:
 - a) dementia
 - b) schizophrenia
 - c) anxiety
 - d) insomnia
 - e) don't know

Target Audiences

This training program/toolkit is designed to be used with any NF staff member, including the direct care workers (Nurse Aides, Medication Aides, etc.), Licensed Vocational Nurses (LVNs), Registered Nurses (RNs), NF Administrators, Activities Staff, Social Workers, Housekeeping Staff, and Maintenance Staff. It is important that when changes are made in the NF that they are made at the system level and not the person level; it is possible that the changes will not be sustained if the person leaves the organization. Providing this training to all the staff in the NF and ensuring that the changes are reflected in the facility's policies and procedures is the most effective way to ensure that changes will be made and sustained going forward.

Section 2: Overview of the Population

The population residing in a NF is primarily made up of older adults. In many instances, these residents have chronic illnesses and diagnoses including Alzheimer's disease and other dementia-related conditions.

Dementia is an umbrella term for a group of symptoms that describe a decline in a person's mental ability that is severe enough to interfere with their daily life. There are over 100 different types of dementia, with Alzheimer's disease being the most common. Some additional facts about dementia include the following:

- Over 46 million people worldwide were living with dementia in 2015, with this number almost doubling every 20 years. By the year 2050, over 131 million people are expected to be affected by dementia.
- Around the world, a person develops dementia every 3 seconds.
- The total estimated cost of dementia worldwide in 2015 was \$818 billion, with an anticipated rise to \$2 trillion by the year 2030.
- At this time, there is no cure for dementia.

Most Common Types of Dementia

There are many different disorders and conditions that can lead to dementia. There are also many different types of dementia, with some being significantly more common than others. The three most common types of dementia are¹⁴:

- Alzheimer's Disease: The most common type of dementia, accounting for approximately 60-80% of cases;
- Vascular Dementia: A less common form of dementia, accounting for about 10% of the dementia cases; and
- Dementia with Lewy bodies: A far less common form of dementia, accounting for approximately only 4% of cases.

Signs and Symptoms of the Most Common Types of Dementia

Because different types of dementia affect the brain differently, the signs and symptoms may also be vastly different. The following are the signs and symptoms of the most common types of dementia⁷:

- Alzheimer's Disease: Individuals with Alzheimer's Disease often have trouble remembering things, including conversations, names, what they had for breakfast, familiar objects, etc. In addition, these individuals may also have impaired communication (talking, understanding, writing, and reading, for example: being unable to talk, saying the wrong words, and unable to

¹⁴ Alzheimer's Association: Types of Dementia. <http://www.alz.org/dementia/types-of-dementia.asp>

understand what they hear), poor judgment (dressing for summer in the cold winter, inability to pay their bills, walking down the middle of a busy road), disorientation (not knowing where they are, whether it's day or night, not recognizing familiar faces), confusion, behavior changes, and difficulty speaking, walking (balance problems, shuffling of feet, spontaneous falls in late stage), and swallowing (changes in the digestive system make swallowing difficult and eventually not possible which increases the chances of choking).

- Vascular Dementia: The symptoms that may be seen in individuals with this type of dementia may include: impaired judgment, problems with planning (unable to put together a grocery shopping list, follow a recipe, complete work assignments if still working), concentrating and thinking.
- Dementia with Lewy bodies: Those who suffer from this type of dementia often have memory loss and thinking problems (ability to focus or concentrate on a topic, process and understand information). These individuals are also likely to have issues with sleep disturbances (vivid dreams that seem real; difficulty staying asleep), visual hallucinations, and muscle rigidity.

Stages of Alzheimer's Disease

Alzheimer's disease is progressive and there is no cure, so the symptoms worsen over time. The rate at which the disease progresses will vary, but the average time a person lives with Alzheimer's is four to eight years. Depending on other factors, a person can live for as long as 20 years with the disease.

The Alzheimer's Association details that Alzheimer's disease typically progresses in three general stages. Since this disease affects people in different ways, their experience with the symptoms, or progression through the disease will also be different. The three stages of Alzheimer's disease and some of the related symptoms include¹⁵:

- Mild Alzheimer's (the early stage): In this stage, a person may still be able to function independently; still engaging in social activities and performing complex tasks such as driving. Even though the individual is "functioning", they may struggle with memory lapses and forgetfulness which family and friends may begin to notice. Some of the common symptoms that one may notice in the individual are: problems coming up with the right word; trouble remembering someone's name; losing or misplacing a valuable object; and increasing trouble when trying to plan or organize, just to name a few.
- Moderate Alzheimer's (the middle stage): For most individuals, this is typically the longest stage and can last for many years. Individuals who are in this stage may begin to require more care as they become less independent. One may start to notice that the individual in this stage confuses words more frequently; gets easily frustrated or angry; or acts in ways they would not typically act, for

¹⁵ Alzheimer's Association: Stages of Alzheimer's.
http://www.alz.org/alzheimers_disease_stages_of_alzheimers.asp

example refusing to perform daily activities of living like bathing and dressing. You may see very specific symptoms in this stage that include: forgetfulness of events or one's own personal history; no longer participating in social activities, or withdrawn when they do; confusion to time, for example not remembering what day it is; the need for assistance with simple tasks such as choosing clothing that is suitable for the season; an increase in getting lost or wandering without a purpose; and changes to their personality and/or behavior including becoming suspicious, delusional, or compulsive.

- Severe Alzheimer's (the late stage): For individuals in the late stage of Alzheimer's, you may find that they have lost their ability to respond to the environment around them, are no longer carrying on a conversation and being unable to control their movements. They may say words or phrases that are not consistent with what is going on around them, as their cognitive skills continue to worsen. Extensive assistance with daily activities also becomes necessary. The following are symptoms one might see in individuals at this stage: requiring full-time, around-the-clock assistance with their daily care needs; loss of awareness of recent experiences; eventual changes in their physical abilities, being unable to walk, sit, and swallow; and become at an increased risk for infections.

As mentioned previously, the symptoms of Alzheimer's disease present differently in everyone with the disease, as does the progression. It is important to continue to allow someone with Alzheimer's disease or any other dementia-related condition to continue to function to their full capacity.

Out of Character Behaviors and Challenges

Changes in Behavior

As with any disease process that affects the brain, there are bound to be behavioral issues. The same is true when discussing the behavioral changes noted in someone with dementia. As their condition progresses, these individuals may start to display behaviors that are out of their normal character.

These behaviors are often the result of the individual being unable to effectively communicate a need such as hunger, thirst, use of the bathroom, hot, cold, or many others. The behaviors that may be seen as a result of these unmet needs include: aggression, agitation, confusion, depression, hallucinations, suspicions, repetition in speech or actions, and wandering. Understanding these behaviors is the first step in being able to assist someone with potential unmet needs, and could possibly decrease the behavior or eliminate it altogether.

When an individual with Alzheimer's disease or another dementia-related condition starts to display behaviors that are out of character, they are at an increased risk

for instances of abuse, neglect, or exploitation. This can come in many forms and often includes the inappropriate prescription of medications such as antipsychotics, which can significantly decrease the individual's quality of life.

Brain-Behavior Relationships

We have a fair amount of knowledge about the brain. For example, we know that the parietal lobe is important for keeping us oriented to where we are. Knowing this, it is known how hard it must be for a person with a parietal lobe damaged by dementia to cope with the unfamiliar such as moving into a new environment such as a NF.

It is also helpful to know that Alzheimer's disease affects the hippocampus, the part of the brain needed for short term memory. When short term memory fails, it's hard for the person to track what's going on around them. This confusion can cause a lot of frustration for a person with dementia, even causing paranoia. It may be why persons with dementia so often accuse people of stealing; when they misplace something, even when there is no evidence a theft has occurred. Staff should not be offended.

It's also worth remembering that paranoia may become even more pronounced when the person's amygdala is affected. The amygdala, one of the very oldest parts of the brain, regulates basic emotions such as fear, anger and cravings. It's affected quite early in Alzheimer's. Once Alzheimer's disease disrupts the brain's emotional center, a person may display apathy, emotional outbursts and even inappropriate sexual advances. This knowledge may help you become less angry when a resident behaves inappropriately towards you.

The frontal lobe, which helps us carry out purposeful behaviors and complex reasoning, can also be affected. When any form of dementia strikes the frontal lobe, people lose the ability to plan, make choices, and initiate complicated activities. The frontal lobe helps us to shift gears when we have a lot of different things going on. Frontal lobe problems, when combined with amygdala problems, may also lead to a loss of inhibition, which may cause behaviors such as undressing in public, swearing and making inappropriate statements.

Sometimes these individuals have dual diagnoses such as Parkinson's and Depression. They can be challenging to treat due to their out-of-character behaviors; therefore, it is important to work with the interdisciplinary team to assess the resident for unmet needs and to determine the cause of the behavior. A few of the basic points include:

- Out-of-character behaviors are a way of getting needs met, directly or indirectly.
- Multiple factors are at play which makes it necessary to look at these out-of-character behaviors carefully in order to choose the best intervention for the resident.

- Figuring out the unmet need from the out-of-character behavior in the moment also allows us to make a care plan that addresses that need.
- The better we are at meeting residents' needs, the less likely the out-of-characteristic behavior is going to happen again.

All Behavior Has Meaning

All behavior has meaning and is an attempt to communicate. The three assumptions underlying this framework include:

1. First, all behavior has meaning. It may not be immediately apparent, even to the person who is having an out-of-character behavior. The behavior of the resident is not random or just a symptom of dementia.
2. Second, all behavior attempts to communicate. Many people, including ourselves, do not always ask directly for what we want or need. Often, what is described as "difficult behavior" is an indirect attempt to communicate a need or a feeling. When residents are resisting care, they're trying to tell us something. Quite simply, they could be telling us to stop. It could be they are in pain. It could be they are frightened. It could be they are just having a bad day and it's too early in the morning to get dressed. The first question to ask when we come up against a distressing behavior is; "What is this person trying to tell me?"

Let's look at a few behaviors in the table below and see what they mean:

Table 1: Uncharacteristic Behaviors and Possible Causes

Behavior	Meaning
Wandering	Boredom
Calling out	Loneliness
Grabbing	Fear of pain
Pushing	Desire for privacy
Agitated	Overstimulated
Withdrawn	Understimulated
Intrusiveness	Hunger/Thirst

3. All behavior seeks to effect change. It's not enough to explain or even understand residents' out-of-character behaviors. We have to use that understanding to better meet residents' needs. In other words, residents communicate for a reason. It is every staff members' job to figure out both what the resident wants and why. The more time that is taken getting to know the resident and the more of a relationship you have, the better you will be able to do this.

Overview of Person-Centered Care

Person-centered care¹⁶ is a care concept that recognizes that individuals have unique values, personal histories and personalities and that each person has an equal right to dignity, respect, and to participate fully in their environment. In person-centered care, it is important to remember that all individuals are typically the same now as they were when they were younger, in that most often they still have the same goals for their lives of being independent, self-sufficient, active, maintaining personal relationships, and wanting to continue to have fun. The goal of person-centered care honors the importance of this by keeping the person at the center of their care and decision making process. In this care model, caregivers must actively listen and observe to be able to adapt to each individual's changing needs, regardless of their condition or disease process.

People with dementia make up a significant proportion of the older adult population. The person-centered care approach is extremely important when caring for these individuals; seeing everyone as individuals and not placing the focus on their illnesses or on their abilities or inabilities. Making sure that people are involved and central to their care is now recognized as a key component of providing for a high quality of healthcare. There are many aspects of person-centered care that should be taken into account, including:

- Respecting one's values and putting them at the center of care;
- Taking into account someone's preferences and expressed needs;
- Coordinating and integrating care;
- Working together to make sure there is good communication with the individual and that information and education is effectively passed along;
- Making sure people are physically comfortable and safe;
- Providing emotional support;
- Involving the individual's family and friends;
- Making sure there is continuity between and within the services that the person is receiving; and
- Making sure people have access to appropriate care when they need it.

Put simply, being person-centered is about focusing care on the needs of the person rather than the needs of the service/provider.

Overview of Antipsychotic Use in Residents with Dementia

The use of antipsychotic medication for people with dementia has been a national problem and has become a concern for the safety of those residents with dementia. Antipsychotic medications are largely ineffective and dangerous for these residents. There is no chemical rationale for using an antipsychotic medication for anything

¹⁶ National Nursing Home Quality Improvement Campaign
<https://www.nhqualitycampaign.org/goalDetail.aspx?g=pcc>

other than sedation. Additionally, studies show that at best, fewer than 1 in 5 people show an improvement in aggressive behaviors, and that there is little to no benefit for residents who are taking these medications.

In 2012 CMS, along with other stakeholders began the National Partnership to Improve Dementia Care in Nursing Homes. Through much research, it was determined that nursing homes were using antipsychotic medications for the treatment of behavioral and psychosocial symptoms of dementia (BPSD). Through this partnership, a goal was developed to reduce the use of antipsychotic medication for residents who have dementia.

Currently, there is no FDA approved treatment for BPSD. Cholinesterase inhibitors and memantine can have beneficial effects on dementia, but are generally not useful in curbing behavioral disturbances.

A Look at the Problem

Below are some of the problems with the use of antipsychotic medications.

- There is no “anti-agitation/anti-aggression” medication.
- All medications used in this way are ‘off-label” which means they haven’t been approved by the Food and Drug Administration (FDA) to be used in control residents with dementia-aggressive behavior. This is not uncommon. It’s considered an approved medical practice. However, when a doctor or nurse practitioner prescribes something that is off-label, getting informed consent and weighing the risks and benefits becomes even more critical. Anytime a physician prescribes any medication, there are two questions that are critical to ask: 1) Will it help? (What are the benefits?) and 2) Will it hurt? (What are the risks?).
- Antipsychotic medications are associated with considerable side effects including, but not limited to the following:
 - Sedation
 - Stiffness
 - Difficulty walking
 - Dehydration
 - Falls
 - Chest Infections
 - Tremors
 - Accelerated cognitive decline
 - Increased risk of strokes and mortality
 - Extrapyramidal Side Effects (these are permanent)
 - ✓ Apraxia
 - ✓ Tardive Dyskinesia
 - ✓ Akathisia
- From the perspective of person-centered care, prescribing antipsychotic medication misses the point of behavior as communication. Prescribing

antipsychotics too soon may keep us from learning what the person is trying to tell us.

- In 2008, the FDA issued a black-box warning against the use of conventional and atypical antipsychotic medications in elderly residents with dementia-related psychosis as they were at an increased risk of death.

Figure 4: FDA Black Box Warning on Antipsychotic Medications

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. RISPERDAL[®] (risperidone) is not approved for the treatment of patients with dementia-related psychosis. [See Warnings and Precautions (5.1)]

- Although antipsychotic medication use in this population has decreased across the state, these medications continue to be used, despite the warnings and the National Partnership.
- In an attempt to continue to use antipsychotics in this population of residents, it has been found that residents in their 80s and 90s with no history of mental health issues have been given a new diagnosis of Schizophrenia, a disease that is normally diagnosed in individuals between 16-30 years of age. The onset of Schizophrenia in someone over the age of 45 is very rare.

Reducing Unnecessary Antipsychotic Medications

Residents should not be given antipsychotics unless it is absolutely necessary to treat a specifically diagnosed condition which is documented in the clinical record. Residents with dementia who are on antipsychotics must receive gradual dose reductions and behavioral interventions (unless clinically contraindicated by the attending physician) in an effort to discontinue the drug's use.

When a resident is admitted or re-admitted to the NF from a hospital, another NF, or community setting with an order for an antipsychotic, the facility is responsible for seeking out and verifying why the drug was started. The NF is responsible for evaluating the necessity of the antipsychotic at the time of admission, or within two weeks after admission. During this timeframe, a determination is made whether or not a medication reduction (tapered or discontinued) will take place.

If an antipsychotic is deemed necessary, initial doses are started low and then titrated slowly to maintain the highest level of functioning with the lowest effective

dose. Dosages are then monitored regularly with considerations of adverse reactions while examining the resident's response and level of functioning. The medication is used at the lowest possible effective dose, for the shortest possible time, ideally less than 12 weeks.

The medical necessity of the antipsychotic must be reviewed routinely, with at least quarterly considerations of gradual dosage reductions (GDR). Data gathered from the behavior monitoring system should be to identify decreasing trends in behavior. These dosage considerations are both discussed and documented with input from an interdisciplinary team. The information gleaned from reductions is used in determining if a lower dose may have the same outcome. Reductions are titrated slowly, unless clinically contraindicated with the ultimate goal of discontinuation.

Downward titration is best started when behaviors have greatly diminished, and the resident is considered to be at a stable baseline with continued behavioral techniques in place. When stabilization is reached and the targeted behavior is re-directed with continued behavioral techniques, GDRs are attempted.

Dosage titrations downward usually occur at 1 to 2 week intervals.

- The staff is made aware of the step down in dose, to ensure that protocols of the non-pharmacological interventions and preventative approaches are still in place.
- At the end of each 1 to 2 week interval, notations of clinical outcomes are documented in the clinical record.
- Longer intervals (at 3 to 4 weeks) between adjustments may be considered, if behaviors are deemed to be of negative consequence. Keep the dose at a standstill, and continue to perform non-pharmacological interventions.

Section 3: Roles and Responsibilities of Members of the Care Team

All staff members who provide care for the residents in the NF have a very important role in ensuring that residents receive the highest level of care possible. Reducing the use of antipsychotics in NF residents is a multi-disciplinary task; everyone in the facility plays a part in the effort. All team members are responsible for understanding their role in ensuring residents are not given medications that are not medically indicated.

Certified Nurse Aide (CNA)

CNAs have a very important role in the reduction of antipsychotic medications in their residents. The CNA must understand that there is no a “one-size-fits-all” intervention for the residents. How CNAs react to the residents in the midst of their out-of-character behaviors is essential to the overall care provided. The CNA should stop and listen to the resident to determine what is going on and what individual needs the resident may have. The CNA would then need to ask themselves questions related to the situation: What is the behavior? How often is it occurring and when? What are the circumstances surrounding the behavior? What are some non-medication things that have worked with this resident in the past that I can try?

There are things about the care that is provided that can be enhanced. When a resident has an out-of-character behavior, think about what could be causing it: infection, hunger, thirst, tired, have to use the bathroom, etc. As the staff member with the most hands-on interaction with the resident, the CNA must provide information to the nurse about what he/she thinks may be causing the behavior so that it can be addressed. Communication is another important role of the CNA. Often times, the resident with Alzheimer’s disease or dementia may not be able to communicate effectively, prompting the change in behavior. If this is the case, try to assist with the use of communication tools to decrease the resident’s frustration.

Ultimately, the CNA’s role in the reduction of antipsychotic medications is one of significant importance and should be valued. If you have information that could impact the resident’s quality of care, speak up and advocate for the resident, providing the nursing staff with that information.

Nursing Staff (RNs and LVNs)

Nursing staff are responsible for ensuring that there is a thorough assessment for each one of their residents. This will allow for issues with the resident to be identified prior to the resident having any out-of-character behaviors that may lead to a prescription for an antipsychotic medication.

In working with residents who have Alzheimer's disease or other forms of dementia, it is important that the nursing staff are aware of what alternate interventions the individual would benefit from. This will ultimately ensure that the resident is being provided with every available alternate intervention to prevent the possible out-of-character behaviors.

Nursing staff are also responsible for questioning orders that they receive for a resident. If the prescriber (Physician, PA, or NP) writes a prescription for an antipsychotic medication, the nurse, with the knowledge of the inappropriate usage of antipsychotic medications in those with Alzheimer's disease or other dementia related conditions, should question the resident's actual need for the prescribed medication. The nurse should be especially sure to question the medication if it poses more harm to the resident than good.

Prescribers (Physicians, PA-Cs, APRNs)

Practitioners with prescribing privileges have a key role in reducing the inappropriate use of antipsychotic medications in residents with dementia. As members of the interdisciplinary team, prescribers should:

- Evaluate each resident to determine the continued appropriateness of the resident's current medical regimen.
- Review prescribed medications closely and monitor need based on validated diagnoses for active and new problems.
- Monitor specific behaviors and possible adverse drug reactions to justify changes in medication and treatment orders.
- Update diagnoses, conditions and prognoses to help residents attain the highest possible level of functioning in the least restrictive environment possible.
- Document relevant conditions that affect quality of life, especially in residents with dementia.
- Reduce off-label antipsychotic use gradually, documenting person-centered, non-drug interventions implemented and other approaches for eventual discontinuation.
- Avoid potential liability by using antipsychotic medications in residents with dementia as a last resort in the lowest possible dose, for limited time and for a defined rationale.
- If an antipsychotic medication is prescribed, document the specific condition and the targeted behavior for the drug's use.
- Review and discuss recommendations from the consultant pharmacist.
- Verify the nursing staff has assessed for pain or medication side effects.
- Review behavioral and side effect monitoring.
- Discuss and encourage gradual dosage reduction when appropriate.
- Challenge the facility to increase implementation of non-drug interventions.
- Inquire about care plans with specific and individualized interventions and approaches.

Pharmacists

Pharmacists are a valuable resource for physicians. By adhering to long-term care facility regulations, pharmacists can help NF staff evaluate the use of antipsychotics and identify unnecessary use. In addition, by emphasizing the treatment of dementia with non-pharmacological approaches, they can reduce the use of potentially harmful medications in NFs and other care settings.

Pharmacists evaluate and coordinate all aspects of pharmaceutical services provided to residents by all providers (e.g., pharmacy, prescription drug plan, prescribers). In this role, pharmacists also promote safe, effective medication use by alerting facility staff to excessive or prolonged dosages, inadequate monitoring or indications, and adverse conditions or consequences indicating that dosages need to be reduced or discontinued.

In long-term care facilities, pharmacists should:

- Determine the appropriateness of every dose.
- Assist facility staff in identifying inappropriate antipsychotic use.
- Advocate for improving the residents' quality of care.
- Partner with medical directors and prescribers to continually evaluate the outcomes of drug therapy.
- Evaluate every dose.
- Promote gradual dosage reduction (GDR) when appropriate.
- Encourage documentation of the specific condition and the targeted behavior for the antipsychotic.
- Encourage and review behavioral and side effect monitoring.
- Challenge the facility to increase implementation of non-drug interventions.
- If there is no evidence for an intervention or approach, speak up!

Family and Others

The resident's family members or other loved ones play an important role in the decreased usage of antipsychotic medications. These include:

If the resident is already taking these drugs, the family member can ask:

- What type of drug is my loved one on?
- What caused the drug to be prescribed?
- How has the care team tried to help solve the problem without drugs?
- What is the plan to decrease or stop the drug?

If the resident is not currently on an antipsychotic, BEFORE any are prescribed, ask:

- What is causing the drug to be prescribed?
- What has the care team tried to respond to my loved one's challenging behaviors?

- How will they track the behaviors once the drug is started?
- What is the plan to decrease or stop the drug?

The NF staff will never know all that the family knows. Family members and loved ones can help by providing answers to questions such as:

- How does your family member express themselves when they are scared, angry, anxious, and hungry?
- What, in the past, has comforted them?
- What is their typical daily routine?
- Are there any behaviors that you have found more difficult to respond to than others?
- What have you tried to prevent them?
- Stay involved in your loved ones care and attend care plan meetings.
- Get to know staff – their names and duties
- Attend care plan or service plan meetings
- Talk to staff about concerns you have with the care being provided to the resident.
- Join or organize a resident or family council

Section 4: Interventions by Care Team Members

The interventions discussed in this section can be provided by the majority of the NF staff and in most cases do not require a significant amount of money to accomplish.

Non-Pharmacological Approaches to Antipsychotic Medication Use¹⁷

Unlike pharmacological therapies, non-pharmacological therapies have not been shown to alter the course of Alzheimer's disease. Non-pharmacological therapies are used instead with the goal of maintaining a resident's cognitive function, as well as improve the quality of life or reduce out-of-character behavioral symptoms such as depression, apathy, wandering, sleep disturbances, agitation and aggression.

The nurse should use the following guidelines, as outlined by the National Partnership to Improve Dementia Care in Nursing Homes, when intervening on the use of antipsychotic medications:

- Start with a pain assessment.
- Provide for a sense of security.
- Apply the 5 Magic Tools (Knowing what the resident likes to See, Smell, Touch, Taste, Hear).
- Get to know the resident, including their history and family life, and what they previously enjoyed. Learn the resident's life story. Help the resident create a memory box.
- Play to the resident's strengths.
- Encourage independence.
- Use pets, children and volunteers.
- Involve the family by giving them a task to support the resident.
- Use a validated pain assessment tool to assure non-verbal pain is addressed.
- Provide consistent caregivers.
- Screen for depression and possible interventions.
- Reduce noise (paging, alarms, TV's, etc.).
- Be calm and self-assured.
- Attempt to identify triggering events that stimulate behaviors.
- Employ distraction methods based upon their work and career.
- Offer choices.

Once the nurse has obtained this information, it is important document it in the resident's medical record so that it can be used in the care planning process when

¹⁷ Alzheimer's Association: Success for Less – Reducing the use of antipsychotic medications in nursing homes. [http://www.alz.org/sewi/documents/Psych_Meds_Rept_\(2\).pdf](http://www.alz.org/sewi/documents/Psych_Meds_Rept_(2).pdf)

working to determine which interventions would be best suited for this resident, most especially those that help to decrease the out-of-character behaviors.

There are additional practices that all NF staff can implement that will help to decrease the use of medications, including:

- Changing their own behavior:
 - Staff have the power to escalate or de-escalate most situations. De-escalation is usually possible, and it's a very valuable skill to practice. Monitoring our body language and our own fear response can help avoid triggering a fear response in a resident.
 - Look at environmental ways to make sure basic needs are met.
 - Take time to get to learn about the residents' lives before they entered the nursing facility. This happens spontaneously all the time with residents who have pleasant and outgoing personalities and can talk about their interests and show an interest in the staff. The staff's job is to make sure they make the same effort with residents with dementia who may not be able to initiate conversation, but who have the same basic need for affection, inclusion and identity.
- Changing their practices:
 - Look at the person with dementia rather than at the symptoms of dementia.
 - Use the paradigm of behaviors as communication of unmet needs.
 - Anticipating and meeting core psychological needs to prevent behaviors.
 - Addressing the risks of boredom, helplessness and loneliness that continue to plague many nursing homes.
 - Creating individualized care plans that reflect a person's wishes and emphasize strengths and choice.
 - Addressing stress in caregivers.

Alternate Activities

There are many different types of activities that NF residents can engage in that are considered alternatives to medications. These alternative activities allow for residents to experience a higher quality of life, often changing the way that they communicate and behave. Alternatives should always be considered prior to the use of antipsychotics as the benefits have been proven to significantly outweigh those of the medications.

MUSIC & MEMORY¹⁸

MUSIC & MEMORYSM is a non-profit organization whose mission is to bring personalized music into the lives of those with dementia or other cognitive disorders to vastly improve their quality of life. The organization was founded in

¹⁸ MUSIC & MEMORYSM. <http://musicandmemory.org/>

2006 by Dan Cohen after he discovered that none of the 16,000 long-term care facilities in the U.S. used iPods for their residents.

Through this program, NF staff are trained in how to create and provide personalized playlists using iPods and related digital audio systems that enable those struggling with Alzheimer's, dementia, and other cognitive and physical challenges to reconnect with the world through music-triggered memories.

In 2012, the documentary *"Alive Inside: A Story of Music and Memory"* was created to showcase the work that was being done by the organization, and has since boosted awareness and enthusiasm for the program. A clip of the video "Alive Inside", the "Henry" video can be viewed by visiting: <https://www.youtube.com/watch?v=fyZQf0p73QM>.

Facility staff, along with the resident, benefit greatly from this project in the following ways:

- Increase in participation by the resident in their care
- Decrease in the number of falls
- Decrease in the use of psychotropic medications
- Decrease in the signs of anxiety and depression in the residents
- Increase in staff job satisfaction

Implementing the MUSIC & MEMORYSM program in a facility is a rather simple process and information can be found at <http://musicandmemory.org/>.

There are many stories that show how successful this program can be inside a nursing facility. Below is a list of several such stories and the links to access them:

- This story features a group of nursing students who brought the MUSIC & MEMORYSM program to a local nursing home in their area: <https://www.youtube.com/watch?v=jU2YxlUx5vA>.
- Reducing Antipsychotics: The Story of Hope: <https://www.youtube.com/watch?v=wjSVY3kf9S8>.
- MUSIC & MEMORYSM: The Student Experience: <https://www.youtube.com/watch?v=-X223bdQEJA>

NFs may find that implementing this program can be rather time consuming as there is a need to ensure that each resident is provided with a personalized playlist. To successfully implement this program, many facilities turn to volunteers to assist them. There are many ways to get volunteers involved in the program, such as having them work with residents to determine their favorite music, loading the playlists on the iPods, fundraising for equipment to expand the program, etc. For more information on how volunteers can assist in this program, visit <http://musicandmemory.org/get-involved/for-volunteers/>.

The approach is simple, elegant and effective. NF staff are trained to set up personalized music playlists, delivered on iPods and other digital devices, for those in their care. These musical favorites tap deep memories and can bring residents back to life, enabling them to feel like themselves again, socialize and stay aware of their environment.

Reminiscence Activities

This activity involves reaching the memories that reside in regions of the brain that are still viable. This method of therapy can be both comforting and therapeutic for the individual with Alzheimer's disease or other forms of dementia. Reminiscence activities involves the discussion and sharing of memories, reviewing and evaluating those memories, and recapturing the emotions and feelings that are associated with and are an integral part of the memories.

Reminiscence activities can be done one-on-one or in groups. However, when reminiscing with someone with dementia, it's often better to use a one-on-one approach as opposed to a group setting. Also, when reminiscing with individuals with Alzheimer's disease or dementia, it's often better to eliminate the evaluation part, and focus more heavily on the emotions that are inherent in the memories. This activity should be enjoyable for the resident and non-threatening. The conversation should not be forced; however, the individual conducting the activity may have to lead the conversation by making suggestions. Props or other visual aids are good tools that can be used to initiate and sustain the process.

There are many different ways that facilities can implement a Reminiscence Activity program for their residents. This can be done using specific themed bags, boxes, or books. Themes for these items can be anything that the facility identifies as being important to the resident such as a beach, travelling, sports, military, gardening, food, seasons (winter, spring, summer, and fall), etc.

- Creating a memory book¹⁹: A memory book is simply a way to organize memories and mementos; photographs, stories, genealogy, significant documents, etc. Creating and completing such a book can be an invaluable life review, especially as an activity for people in earlier stages of any progressive cognitive disorder. Later, it can be used over and over again to stimulate reminiscences. There are several good books that have been designed to prompt and contain memories of one's life. They have questions about genealogy, friends, marriage and all of those things that make up personal history, and they provide space to write answers as well as post photographs and other memorabilia. Take into consideration the following when creating a memory book for your residents:
- How to Begin: Start by asking the following questions:

¹⁹ Best Alzheimer's Products Reminiscences and Alzheimer's disease; Retrieved from : <http://www.best-alzheimers-products.com/remembrance-and-alzheimers-disease.html>

- What does the resident feel proud of in their life?
- What do they want other people to know about them?
- What are their favorite memories?
- What can family and friends to share what they like and admire about them?
- Getting Started:
 - Write information in the first person.
 - The amount of decoration on each page would depend on what stage of the disease the person is in. Less is usually better than more. Too much decoration makes it harder to concentrate on the content.
 - Only have one picture per page. You can have the opposite page blank or use it for writing or journaling.
 - If at all possible, have a family member write his/her name on one of the pages.
 - Make copies of each completed page. This book needs to be out where it can be used, but have back up pages if they should get lost or damaged.
 - You do not have to do it all at once. Begin with a few pages. Ask family and friends to make a page as a gift.
 - If you are more comfortable writing a story, it does not have to be the whole story to begin with. Pictures do help job our memories but there are not always pictures for each event.
 - Write one page where you tell them what is so special to you about them.
 - Caption each page:
 - ✓ Early stage example: "Connie's first day of kindergarten at Saylor School in Des Moines."
 - ✓ Middle Stage example: "Connie's first day at Saylor School."
 - ✓ Late Stage example: "Connie loved school."

Animal Therapy²⁰

Researchers have long suggested that pets are good for us, even offering health benefits such as lowering blood pressure and heart rate, reducing the stress hormone cortisol, and boosting levels of the feel-good hormone, serotonin. It stands to reason then, that finding four-legged friends in Alzheimer's and dementia units are becoming commonplace. In fact, some facilities are hiring pet coordinators to as part of an Animal Therapy program to aid in the care of residents' pets. Therapy dogs and other animals can stimulate social interaction and ease agitation in the residents with dementia. There are many benefits of animal therapy, including the following:

- Stimulates a social response.
- Reduces agitation: Agitation behaviors, common among residents with dementia, are reduced in the presence of a dog.

²⁰ Alzheimer's.net; How can Pets Benefit Alzheimer's Patient's?; Retrieved from: <http://www.alzheimers.net/2013-05-17/alzheimers-pet-therapy/>

- Encourages physical activity: Depending on the resident's mobility, they may be able to groom the animal, toss a ball, or even go for a short walk.
- Improves eating: Residents with dementia have been shown to eat more following a dog's visit.
- Increases pleasure: Some residents enjoy the presence of the dog and its human companion, as well as the tricks therapy dogs can do.

There is a lot of planning, training and work that a facility must do prior to implementing a successful animal-assisted therapy visit. Below are a few issues that are involved in the development of a beneficial animal visit.

- Temperament of the animal: An animal's personality will dictate whether they can be a good therapy animal. The animal should not be easily startled and be comfortable interacting with unpredictable strangers in a calm manner.
- Individual strengths of the animal: Each animal has its own strengths. Some animals are good on a one-to-one basis, and other animals are better in group situations. Whereas, some animals are good with children and some are good with residents with dementia.
- Training of the animals: Animals should be trained to be comfortable with hospital equipment, tubing, wheelchairs and the crowded situations they might encounter in an Alzheimer's unit.
- Registration or certification of animals: Seek out therapy animals and human companions that are registered with the Delta Society or Therapy Dogs International. Delta Society retests both human and pets every two years.
 - Delta Society: http://www.themondaylife.org/pet-therapy?gclid=Cj0KEQjw4J-6BRD3h_KloqijwvkBEiQAfcPiBU5iUmJ7eqW496Nj_2rJJp2HAELg24XL_J9A4QN-Rs0IaAlkn8P8HAQ
 - Therapy Dogs International: <http://www.tdi-dog.org/>
- Cleanliness of the animals: The animals should be bathed at least once a month and have 30 minutes of grooming before each visit. This includes cleaning their ears and mouths, clipping their nails, washing their feet, and brushing them thoroughly.
- Infection control: Infectious agents such as MRSA, C. difficile, E. coli, and Salmonella are a concern in NFs. These agents affect the resident with dementia and the therapy dog teams that visit them. Infection control measures include:
 - Properly cleaning the therapy animals before and after a visit.
 - Cleaning the hands of everyone who will touch the animal before and after contact.
 - Preventing animals that eat raw foods from being therapy animals.
 - Avoiding contact with the animal's mouth.
 - Using sheets and barriers, such as a rolled towel, bedding or furniture, to keep some distance between the animal and the resident with dementia.
- Giving treats: Feeding is a universal bonding behavior, and many residents want to give the therapy animal treats. The companion of the animal should provide

the residents with the treats so that residents may give them to the animal. The animal should do some kind of trick in exchange for the treat.

- Flexibility: Visits with residents that have dementia visits can be unpredictable. The resident who knows the animal very well one day may not recognize the animal on another day and push the animal away. Human and animal have to be able to adjust to changing situations.

Properly trained and prepared therapy animals can be a real blessing to residents with dementia in the nursing home setting.

Humor/Laughter Therapy²¹

The whole person does not disappear with dementia. Humor and laughter is about reaching the person behind the dementia. Humor and laughter has been proven to be as effective, and a lot gentler, than antipsychotic medication. Laughter calms and reassures and sends a message of light-hearted joy. Beyond the direct health benefits, it often relaxes the caregiver which, in turn, impacts the residents positively.

Researchers have made some discoveries resulting in recommendations that can be used at any age. The key to growing a better brain is to look for new challenges, because learning stimulates rapid growth in the connections of the brain, creating a surplus of brain tissue that can compensate for cells damaged by disease. Playing, laughing and being active while accepting new challenges do just that.

Benefits from laughter:

- Eases anxiety and fear and activates happy feelings
- Prevents heart disease
- Increases and improves social interactions and bonding
- Lowers stress hormones
- Lowers blood sugar levels
- Opens inner cellular pharmacy which strengthens all immune functions
- Opens lungs and ventilates spirit

Laughter helps caregivers by:

- Allowing them to enjoy the moment (laughter is fun).
- Easing tension and lightening the mood, breaking the cycle of psychological negativity.
- Relieving stress.
- Promoting mental health.
- Strengthening family relationships.
- Strengthening the immune system so caregivers can stay healthy.

²¹ Laughter on Line University; Why and How Laughter can Help Alzheimer's, Parkinson's, and Lewy Body Dementia. <http://www.laughteronlineuniversity.com/lewy-body-dementia/>

Laughter helps improve the quality of life for residents. Residents with Alzheimer's and related types of dementia can suffer from confusion, frustration and depression. These strong emotions can bring anything from negative feelings to anxiety which can often lead to behavior problems and even aggression. Laughter can reduce some of these symptoms by improving the quality of life for those with dementia by:

- Allowing them to redirect negative emotions.
- Improving social interactions.
- Easing the symptoms of depression.
- Tempering signs of aggression.
- Reducing stress.

Multiple studies have shown a 20% reduction in agitation for residents who participated in the studies. The improvement is comparable to the use of antipsychotic medication. Studies show that humor therapy should be considered before medication for agitation, especially when taking into account the side effects of the antipsychotic medication.

Art Therapy²²

Art intervention has been proven to be a powerful tool as an alternate intervention for those with Alzheimer's disease. Art gives the residents more than something pretty to look at or an exercise to keep them busy. It stimulates the brain, stirs memories and can bring language back into the life of someone who struggles to speak. Art activities have also been noted to awaken residents with cognitive decline. It can inspire a resident with limited speech to use a paintbrush to communicate, and it can lessen aggressive behavior. Art therapy will not eliminate Alzheimer's disease, but it can stimulate the brain in a new direction. The creativity and happiness that art brings can make all the difference in the life of a resident who has been progressively declining.

Painting, drawing, and even sculpting, are common hobbies. All are excellent ways to relax, but creating art is more than a recreational past time. Art provides a way for residents to reach inside themselves; to put on paper or some other medium a representation of their thoughts and feelings that they may otherwise not be able to express. Suggestions for art activities in the NF include painting, drawing, dancing, weaving and sculpting. After artwork has been created, the NF can work to develop an exhibit for the resident's work for visitors to see when they come to the NF. Another way to integrate art as an activity in the NF could also be by taking the residents to visit art museums.

²² Alzheimer's.net; How art therapy Enhances the Quality of Life for patients with dementia.
<http://www.alzheimers.net/2014-04-29/art-therapy-for-alzheimers/>

Doll Therapy²³

The use of dolls is quickly becoming an alternative intervention that shows an increase in the positive behaviors and a decrease in the negative behaviors seen in individuals with Alzheimer's disease or other dementia-related conditions. The use of dolls as an alternative activity allows the individual to provide love and affection to a doll that he or she thinks is a real person. These are instincts that the individual has that are very strong and powerful and can drive their interaction with the doll in a positive way. Providing a doll to someone with dementia has been associated with a number of benefits which include a reduction in the following:

- Episodes of distress
- Wandering
- Aggressive behaviors
- The need for antipsychotic medication

Additionally, facility staff and families may see increases or improvements such as the following:

- An increase in general well-being
- Improved dietary intake
- Higher levels of engagement with others
- An improvement of communication
- Increase in positive social interactions

The range of doll interventions may include an individual provision of dolls as well as programs in which groups of residents take part in various forms of care-provision and nurturing activities to the dolls which should be soft and cuddly. In providing doll-based interventions, caregivers may find that residents may exhibit the abilities to express affection, physical nurturing and emotional attachment that are still a part of their nature and personalities.

One of the most important benefits of dolls is that it provides residents with dementia social interactions and allows them to have the chance to care for someone again instead of just being the person that is being taken care of. Residents with dementia are calmed by their baby doll, and it can often create a distraction for them from upsetting events. Having a baby doll often reminds the resident with dementia of fond memories from when they were a new parent which can have a positive effect on them. Residents with dementia will enjoy rocking their baby doll which can also help them fall asleep if they have trouble sleeping themselves.

Guidelines for Providing Doll Activities:

- It is not for everyone. More women than men will choose a doll to nurture, but some men do benefit greatly from holding a doll.
- Choose a doll that is life-like, that looks like a real baby.

²³ Annals of Long-Term Care; More than Child Play: Ethics of Doll Therapy in Dementia.
<http://www.annalsoflongtermcare.com/blog/michael-gordon-doll-therapy-dementia>

- The doll should represent an age from new born to a year or so in age.
- Don't hand the person with dementia a doll; people don't like responsibility imposed on them. Place the doll where it can be discovered, or hold it yourself. Allow the person to choose the responsibility for caring for the baby.
- Some people with dementia will think that the doll is a real baby. Others may know that it's just a doll, but love it just the same. Some will think it's alive one day, and know it's a doll the next. If the doll has a name, refer to the doll by its name. Allow the resident to pick the name.
- Family members can be encouraged to buy real baby clothes for the doll for their loved one to put on the doll. They may also want to buy a stroller for the doll so the resident can push it around the facility and get some exercise while playing with it.

Precautions to the Use of Dolls:

- Make sure family members are educated on how doll therapy works and the benefits that their loved one may receive from doll intervention.
- The resident should have their own doll, and even then, ownership issues may lead to arguments between residents.
- Anxiety can result from the dolls being mislaid or mishandled by caregivers.
- There is also a possibility that the resident could become over-invested in caring for their doll. Make sure the resident has other activities that he or she can participate in.

Activities that Resident's Allow Residents to "Give Back"

Residents with dementia who become involved with community activities, such as attending a concert or interacting with children, continue to feel they are part of society as a whole.

Residents who are involved have a feeling of usefulness and of purpose such as in activity programs like "Helping Hands" at Mission View Health Center in San Luis Obispo, CA; residents with dementia make soap and then sell it at the local farmer's market. The proceeds are used to buy and prepare meals for the homeless shelter. This program allows the residents to be a part of the community and help improve their community. Giving back to the community brings meaning to residents' lives, and they begin to feel as though they are not just receivers of care, but caregivers.

Depending on the resident's cognitive and functional level, he or she may still wish to participate in specific activities such as voting and going to church. The facility can also offer opportunities for families and other community volunteers to participate in activities. Additional activities include starting a food drive, participating in a toy drive and participating in an intergenerational program.

Providing care for an individual with Alzheimer's disease or other dementia related condition may be rather challenging at times, therefore it is important to have a variety of different activities and treatment options to be able to provide them with the highest level of care possible. If one activity or treatment doesn't work with one person, it may work with someone else.

Section 5: Resources, Tools, and Trainings

Resources from HHSC

- Antipsychotic Medications and Dementia Care provides information about off-label use of antipsychotics to treat behaviors associated with dementia, including potential side effects. <https://hhs.texas.gov/sites/default/files//assets/doing-business-with-hhs/provider-portal/ltc/qmp/ap-dementia.pdf>
- Improving Dementia Care: Strategies for Prescribers was developed as a resource for consultant pharmacists, as they work with prescribers to reduce the use of antipsychotics. <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/qmp/ltc-pharmacists.pdf>
- Improving Dementia Care: The Role of Prescribers was developed as a resource for prescribers who care for residents in NFs. <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/qmp/prescribers-flyer.pdf>
- Improving Dementia Care: Strategies for Prescribers is a resource for physicians and other prescribers that can be utilized to improve dementia care and reduce antipsychotic use. <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/qmp/ltc-prescriber-strategies.pdf>
- Antipsychotic Medication Tracking Tool helps NF staff reduce the inappropriate use of psychotropic medications. It can be helpful in documenting pre-psychotropic medication root-cause analysis, promoting a proper decision-making process by identifying targeted behaviors, adjusting dosages accordingly, and reducing the length of time unnecessary medications are used. <https://hhs.texas.gov/sites/default/files//assets/doing-business-with-hhs/provider-portal/ltc/qmp/psych-med-tracking-tool.pdf>
- Antipsychotic Education Form includes the potential benefits, risks and burdens of antipsychotic medications and presents alternatives to antipsychotic medications. <https://hhs.texas.gov/sites/default/files//assets/doing-business-with-hhs/provider-portal/ltc/qmp/antipsychotic-education-form.pdf>
- Be Wise with the Use of Antipsychotics provides helpful information about antipsychotics and reducing their inappropriate use in long-term care settings. <https://hhs.texas.gov/sites/default/files//assets/doing-business-with-hhs/provider-portal/ltc/qmp/dadswisewithantipsychotics.pdf>
- Basic Guidelines for Quarterly Psychotropic Medication Evaluation provides guidance for conducting quarterly psychotropic medication evaluations and assessing the effectiveness of non-pharmacological interventions. <https://hhs.texas.gov/sites/default/files//assets/doing-business-with-hhs/provider-portal/ltc/qmp/basic-guidelines-qtrly-eval.pdf>
- Basic Guidelines for Behavior and Side Effect Monitoring describes techniques for conducting effective behavior and medication side effect monitoring.

<https://hhs.texas.gov/sites/default/files//assets/doing-business-with-hhs/provider-portal/ltc/qmp/basic-guidelines-behavior-side-effect.pdf>

- “Antipsychotics: What's the Big Deal?” includes types of antipsychotic medications, side effects, prescribing considerations, risk factors in dementia, behaviors, and quality of life issues.

<https://hhs.texas.gov/sites/default/files//assets/doing-business-with-hhs/provider-portal/ltc/qmp/ap-whats-the-big-deal.pdf>

More information related to reducing antipsychotic use in NFs and on HHSC Antipsychotic Reduction Initiatives can be found on the QMP website at <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf/quality-monitoring-program-qmp/evidence-based-best-practices-qmp/appropriate-use-antipsychotic-medications>.

Resources from Other Organizations

AMDA The Society for Post-Acute and Long-Term Care Medicine

- Joint Summary Statement-Diagnosing Schizophrenia in Skilled Nursing Centers <https://paltc.org/newsroom/joint-summary-statement-diagnosing-schizophrenia-skilled-nursing-centers>
- New Guidelines Help with Schizophrenia Diagnosis [https://www.caringfortheages.com/article/S1526-4114\(17\)30192-0/fulltext](https://www.caringfortheages.com/article/S1526-4114(17)30192-0/fulltext)

American Geriatrics Society (AGS) Note: To access the free content on this website, you must first register.

- Updated Beers Criteria <https://geriatricscareonline.org/toc/american-geriatrics-society-updated-beers-criteria-for-potentially-inappropriate-medication-use-in-older-adults/CL001>

The Pioneer Network <https://www.pioneernetwork.net/>

TMF QIN-QIO Resource Center

- Reducing Antipsychotic Medication Use <https://www.tmfqin.org/Resource-Center?fi=1371>

Tools

Many tools are available for use in determining the preferences of individuals with Alzheimer’s disease or other dementia-related conditions. That information is then used to care plan the appropriate non-pharmacological interventions for them.

These tools include:

- Preferences for Everyday Living (PELI)²⁴: The PELI is a scientifically validated tool that is used to assess individual preferences for social contact, personal development, leisure activities, living environment, and daily routines. NFs can access either the full length PELI or a mid-level version. Both versions are designed to spark conversations about the resident's preferences, lay the foundation for building trusting relationships between the resident, family, and NF staff, and promote person-centered care plans and service, honoring the resident's preferences as the highest priority. Both versions of this tool can be found at <https://preferencebasedliving.com/pe-li-tools>.
- "This is Me"²⁵: The Alzheimer's Society's booklet "This is Me", will help support a person who is being cared for in an unfamiliar place. The use of this tool will enable NF staff to see the person as an individual and deliver person-centered care that is tailored specifically to the resident's needs. That information can help reduce distress for residents with dementia, and help prevent issues with out-of-character behaviors. "This is Me" can be downloaded at https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/this_is_me.pdf.
- "A Passport Into My Life: Understanding My Journey Will Help You Understand Me"²⁶: The Behavior Management Task Force created the Passport to provide information about the resident, painting a picture of who the person really is. Passport information includes interests, accomplishments, daily routines, familiar names, traumatic life events, and a number of expressions of needs. A sample of this tool can be found in the LVN Educator/New LVN toolkit on the QMP website, in Module 3 at: <https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/provider-portal/QMP/AssessmentModule.pdf>.

Trainings

There are many training opportunities available to NF staff **free of charge** that will provide education related to dementia care and person-centered thinking. The QMP provides training opportunities such as:

- Alzheimer's Disease and Dementia Care Training (ADDCT);
- Texas OASIS: Dementia Training Academy;
- Virtual Dementia Tour (VDT); and
- Person Centered Thinking Training (PCT)

You can obtain more information about these trainings by visiting

<https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf/quality-monitoring-program-qmp/evidence-based->

²⁴ Preference Based Living. PELI Tools. <https://preferencebasedliving.com/pe-li-tools>

²⁵ Alzheimer's Society. "This is Me". <https://www.alzheimers.org.uk/thisisme>

²⁶ A Passport to Better Care. http://www.providermagazine.com/archives/2014_Archives/Pages/0814/A-Passport-To-Better-Care.aspx

[best-practices-qmp/alzheimers-disease-dementia-care](#). To schedule one of these trainings for your staff, please email the request to QMP@hhsc.state.tx.us.

Additional free trainings are available through the UT Center for Excellence in Aging Services and Long-Term Care. Information about these can be found at <http://www.utlongtermcare nurse.com/>.

Section 6: Evaluation of the Training Program/Toolkit

Training program evaluation is a continual and systematic process of assessing the value or potential value of a training program. Results of the evaluation are used to guide decision-making around various components of the training (e.g. instructional design, delivery, results) and its overall continuation, modification, or elimination.

In order to determine if this training program is helpful in providing NF staff with information related to antipsychotic medications, Alzheimer's disease and dementia, caring for residents with a form of dementia, person-centered care, and non-pharmacological interventions, an evaluation can be done in several ways:

- Measuring a change in knowledge, skill, or attitudes. This can be done both before and after the training in the form of a pre and post-test.
- Measuring a change in behavior. This evaluation technique may take more time; however, it may show a more consistent change in what the participant did with what they learned. Did the participant put any of the information to use? Is the participant able to teach their new knowledge, skills, and attitudes to others? Is the participant aware that their behavior has changed? Evaluating for this information would be done by conducting observations and interviews of the participants, over the course of time. It would be helpful to have a baseline of their behavior(s) prior to their receipt of the training to compare to their behavior(s) after the training.
- Measuring results. This evaluation may be the most time consuming, as results cannot be measured right away. In the case of antipsychotic medications, the result that would be measured is the CMS long-stay antipsychotic medication usage QM on both the State level and the NF level. This data has a 3-month lag time from when it is collected to when it is released by CMS. Also, it takes time for the data in a QM to adjust to show positive or negative change. An NF could conduct the training one month and begin making changes, however, the data may not show significant positive change for several months due to the number of assessments being performed for the data that relates to the QM. This method of evaluating the training program, however, is probably the most significant in terms of the actual changes that are taking place to the care being provided to NF residents.

Figure 5: Evaluation of Staff Educational Training Program/Toolkit

Measure	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The content is relevant to the stated objectives	1	2	3	4	5
The content is well organized into clearly labeled sections	1	2	3	4	5
The resources and links provided in the sections are evidence based and credible organizations/resources	1	2	3	4	5
The content is appropriate and free from bias, stereotypes or insensitivity	1	2	3	4	5
The links to the CMS and HHSC provide useful information relevant to the misuse of Antipsychotics with those who have a diagnosis of Alzheimer’s disease or a dementia-related condition and reside in a nursing facility	1	2	3	4	5
The content of the Education/Resource Tool Kit addressed prescribing patterns	1	2	3	4	5
The content of the Education/Resource tool kit addressed alternate interventions that can be used prior to introducing or prescribing an antipsychotic	1	2	2	4	5
I will make/implement change based on what I have learned from this Education/Resource Tool Kit	1	2	3	4	5
Overall, I am satisfied with the content of this Education/Resource Tool Kit	1	2	3	4	5
Comments:					

Federal Regulations²⁷

F841 Physician Services

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.

Physician Supervision

The facility must ensure that:

- The medical care of each resident is supervised by a physician; and
- Another physician supervises the medical care of residents when their attending physician is unavailable.

F711 Physician Visits

The physician must:

- Review the resident's total program of care, including medications and treatments, at each visit required as per frequency of physician visits;
- Write, sign and date progress notes at each visit; and
- Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

F712 Frequency of Physician Visits

The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

All required physician visits must be made by the physician personally. There are exceptions. At the option of the physician, required visits in skilled nursing facilities (SNFs), after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist.

F757 Unnecessary Drugs

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate drug therapy); or for excessive duration; or without adequate monitoring; or

²⁷ CMS State Operations Manual, Appendix PP Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R173SOMA.pdf>

without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons stated.

F758 Psychotropic Drugs

A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: Anti-psychotic; Anti-depressant; Anti-anxiety; and Hypnotics.

Psychotropic Drugs:

Based on a comprehensive assessment of a resident, the facility must ensure that:

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;
2. residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
3. residents do 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;

PRN orders for psychotropic drugs are limited to 14 days, except 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; and
- 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.

F756 Drug Regimen Review

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. This review must include a review of the resident's medical chart. The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

- Irregularities include, but are not limited to, any drug that meets the criteria for an unnecessary drug.
- Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing, and lists, at a minimum, the resident's name, the relevant drug and the irregularity the pharmacist identified.

- The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

F760 Significant Medication Errors

The facility must ensure that its residents are free of any significant medication errors.

F655 Comprehensive Person-Centered Care Planning

The facility must ensure that its residents are free of any significant medication errors.

Baseline Care Plans:

The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must:

- Be developed within 48 hours of a resident's admission.
- Include the minimum healthcare information necessary to
- Properly care for a resident including, but not limited to:—
- Initial goals based on admission orders;
- Physician orders;
- Dietary orders;
- Therapy services;
- Social services; and
- PASARR recommendation, if applicable.

Replacement Baseline Care Plan:

The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan:

- Is developed within 48 hours of the resident's admission; and
- Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

Baseline Care Plan Summary:

The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

- The initial goals of the resident;
- A summary of the resident's medications and dietary instructions;
- Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and
- Any updated information based on the details of the comprehensive care plan, as necessary.

F656 Comprehensive Care Plans

The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

Comprehensive Care Plan contents: The comprehensive care plan must describe the following:

- Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;
- Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment;
- Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of PASARR, it must indicate its rationale in the resident's medical record; and
- In consultation with the resident and the resident's representative(s):
 - The resident's goals for admission and desired outcomes;
 - The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose; and
 - Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements.

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