

Riding the T.R.A.I.N. Down the G.D.R. Line

Proper Assessment & Documentation: Reducing Unnecessary Psychotropics

**Presented by:
DADS Quality Monitoring Program**

Why are we here today?

- ❖ Describe strategies to monitor and target behaviors in the long-term care population
- ❖ Explain the relationship between pain management and psychotropic medications
- ❖ Explain best practice pain management strategies
- ❖ Stress the importance of good documentation and a supportive interdisciplinary team

Chemical Restraints

1987 OBRA Legislation

- ❖ Specified that residents in nursing homes must be free from physical and chemical restraints imposed for the purposes of discipline or convenience
- ❖ The Federal Congress reacted to public outcry noting that nursing home residents were over-medicated and excessively restrained
- ❖ Many residents received psychotropic medications (esp. antipsychotics) without indication or monitoring

What are psychotropic medications?

Drugs that affect brain activity by altering either mood or behavior

Antipsychotics

Anti-anxiety meds

Anticonvulsants

Hypnotic meds

Antidepressants

Consent for Psychotropics

- ❖ Texas law states that there must be signed consent before administering psychotropic drugs, unless it is a documented emergency
- ❖ TAC Rule §19.1207 Prescription of Psychoactive Medication
 - Must outline the condition being treated
 - Note beneficial effects expected on that condition
 - State probable significant side effects of the drug
 - Indicate proposed duration of treatment
- ❖ The right to revoke is noted in writing
- ❖ Refusal to consent must be documented in the clinical record

Current Focus: Antipsychotics

Emphasis on reducing the inappropriate use of antipsychotics to treat behaviors

Aripiprazole (Abilify®)

Haloperidol (Haldol®)

Olanzapine (Zyprexa®)

Quetiapine (Seroquel®)

Risperidone (Risperdal®)



Why Antipsychotics First?

- ❖ In the nation, Texas has the second highest antipsychotic use in the nursing home setting
- ❖ Antipsychotics have the strongest evidence for negative consequences when used in older individuals, especially those with dementia
- ❖ The FDA has warned medical professionals that using antipsychotics for dementia-related behaviors or dementia-related psychosis puts residents at a risk for possible death -FDA Black Box Warning

Antipsychotic Mechanism of Action

- ❖ Block neurotransmitters in the brain at dopaminergic, histaminic, cholinergic, and serotonergic receptors in the brain
- ❖ The main action is to block dopaminergic pathways to reduce the core symptoms of psychosis: hallucinations, delusions, and paranoid ideation

Dementia Disease Process

- ❖ Permanent degenerative changes in the brain
 - Lack of acetylcholine presence
 - Beta-amyloid plaques causing inflammation and brain cell death
 - Tau protein tangles causing brain cell dysfunction and cell death
- ❖ The “psychosis-like” symptoms seen in dementia are unlike the psychoses in chronic mental illness (e.g. schizophrenia)
- ❖ Disturbances arise from short-term memory/recall problems causing disorientation to time, place, and environment

Antipsychotic Side Effects

- ❖ sedation; drowsiness/dizziness; disorientation
- ❖ confusion; memory or functional impairment
- ❖ risk of delirium
- ❖ fall risk; orthostatic hypotension (sudden drop in blood pressure when standing)
- ❖ constipation, urinary retention, dry mouth; blurred vision
- ❖ restlessness; inability to sit still; anxiety; sleep disturbances

Antipsychotic Side Effects

- ❖ tremor; slowed movements; muscle rigidity; strong muscle spasms (neck, tongue, face, or back); drooling
- ❖ tardive dyskinesia
- ❖ low white blood cell count; irregular heart rate; seizures; metabolic issues; neuroleptic malignant syndrome; increased risk of sudden cardiac death

Antipsychotic Risks

- ❖ Worsening or complications with dysphagia
- ❖ Increased risk of aspiration pneumonia and upper respiratory infections
- ❖ Increased risk of urinary tract infections
- ❖ Contribute to the risk of developing delirium
- ❖ Increased risk for pressure ulcers

Antipsychotic Risks

- ❖ Declines with decision-making capability (think about safety awareness)
- ❖ Increased risk of falls
- ❖ Decreased ability to be understood/understand
- ❖ Declines in functional ability and independence

Antipsychotic Challenges for Dementia

- ❖ Behavioral disturbances tend to be episodic and can diminish spontaneously
- ❖ Antipsychotics are likely to be prescribed with comorbid conditions and many medications
- ❖ Antipsychotics are more likely to be prescribed for those already on psychotropic medications
- ❖ Over time, antipsychotics are barely more effective than placebo

Diagnoses

CMS sets the approved diagnoses for antipsychotics in the nursing home setting

- ❖ Schizophrenia (plus: schizo-affective & schizophreniform)
- ❖ Delusional disorder
- ❖ Mood disorders (e.g., bipolar disorder + MDD)
- ❖ Huntington's disease
- ❖ Tourette's disorder

CMS also lists other acute short-term diagnoses

Dementia: Unapproved/Off-Label

- ❖ CMS recognizes that antipsychotics are started in hospitals or in the community setting
- ❖ CMS places the responsibility on the nursing home to evaluate the continued need for the antipsychotic
- ❖ Evaluations for continued necessity must be in the clinical record on admission or within 14 days after admission to the nursing home

Anti-anxiety & Hypnotic Medications

- ❖ Can be utilized as potential chemical restraints by administering for discipline or convenience
- ❖ Are subject to the same standards as antipsychotic drugs with monitoring, care planning, gradual dosage reductions, and periodic review for necessity
- ❖ Indicated for long-term scheduled use for diagnoses of primary anxiety disorders or primary insomnia disorders (generalized anxiety disorder (GAD), panic disorders, parasomnia, etc.)

The Rising Use of Anticonvulsants

- ❖ Potential chemical restraints by administering for discipline or convenience due to their sedating effects
- ❖ Considered off-label prescribing as a “mood stabilizer” in dementia care
- ❖ Subject to the same standards as antipsychotic drugs with monitoring & care planning, gradual dosage reductions, and periodic review for necessity

Unmet Needs

- Underlying medical issues
- Pain and discomfort
- Environmental triggers
- Not being heard by others
- Not being understood
- The need for toileting
- Thirst or hunger
- Tired or exhausted
- Boredom
- Worry or fear
- Loss of independence
- Frustrations with abilities
- Control over personal decisions
- The need for a purpose/meaning
- Activities of their choice
- The need to feel wanted

Importance of Documentation

- ❖ Permanent record of key healthcare facts
- ❖ Excellent nursing practices for patient safety
- ❖ Core of every patient/resident encounter
- ❖ History of the nursing services that were delivered
- ❖ Form of communication with other healthcare personnel*
- ❖ Determines the basis for future decisions
- ❖ Quality reporting in public health and reimbursement
- ❖ Best evidence that staff members have adhered to the standards of care

Pre-psychotropic Documentation

- ❖ Target the behavior first as a problem/risk in the care plan before starting medications
- ❖ Discuss interventions and approaches with all members of the interdisciplinary team and obtain input from family members
- ❖ Document individualized person-centered non-pharmacological interventions and therapeutic approaches in the care plan
- ❖ Implement those interventions and approaches across various disciplines

Documenting Targeted Behavior

- ❖ Without good documentation, there is the potential that psychotropic drugs are viewed as possible chemical restraints when the diagnosis is off-label
- ❖ When antipsychotics or other psychotropic drugs are prescribed for behaviors there is a possibility of keeping them unnecessarily and longer than needed
- ❖ When an antipsychotic drug is used for behavior(s) causing significant distress or harm to self or others in an unapproved or off-label diagnosis such as dementia, documentation is especially important

Who's on your IDT?

- ❖ Include the physician, pharmacist, nurses, CNAs and med aides, social worker, activities director, and on occasion get input from housekeeping and maintenance personnel
- ❖ Other disciplines may have more information to offer, or possibly add to brainstorming solutions
- ❖ Get input from family members, because behaviors can be misinterpretations from the person's past experiences

Finding Your Quality Measure Data

❖ Medicare Nursing Home Compare

- www.medicare.gov
- Click on “Finding nursing homes”
- Search for your facility

❖ Calculation:

of residents on AP (exclude Schiz, Hunt, Tour) **X** 100

Current census

Eliminate Barriers

- ❖ Address preconceived notions and fears of staff
- ❖ Educate staff about long-term effects of medication
- ❖ Assure accurate documentation of behavior
- ❖ Educate and inform family members about:
 - The dementia process
 - Benefits and risks of medication
 - Consultant pharmacist recommendations
- ❖ Discuss your goals with physicians and consultant pharmacist

Interaction with Physician and Pharmacist

- ❖ Physicians may not be up-to-date with current guidelines for treating dementia
- ❖ Primary care physicians may feel awkward about changing medications
- ❖ Psychiatrists may feel threatened by possible consequences of reduced prescribing
- ❖ Pharmacists may feel threatened when making recommendations

Alternatives to Antipsychotics

❖ Non-medication Interventions and Treatments

- Recommended first-line therapy for behavioral signs and symptoms of dementia (BPSD)

❖ Antidepressants

- SSRIs and SNRIs are preferred
- SSRIs are FDA approved for anxiety
- Consider delayed effectiveness

❖ Anti-anxiety medications

- Buspirone—delayed effectiveness
- Short-acting benzodiazepines

Getting Started

- ❖ Evaluate need for medication on admission.
- ❖ Identify ALL residents on antipsychotic medications
- ❖ Determine which antipsychotic medications are clinically appropriate
- ❖ Implement gradual dose reduction as needed/indicated
- ❖ Manage unmet needs (behaviors) through improved dementia care using person-centered interventions and treatments

The GDR Process

- ❖ Titration of the dose downward occurs slowly at 1 to 2 week intervals by physician's orders.
- ❖ All staff should know that dosage reduction is occurring and allow for periods of adjustment to new doses
- ❖ Use non-medication interventions & treatments for behavior that occurs
- ❖ Keep documenting and communicate with other staff members what does and does not work

Strategies for Success

- ❖ Target specific behavior(s) and link them with treatment of a specific medication
- ❖ Monitor for presence of targeted behavior(s) and side effects on each shift
- ❖ Monitor resident for changes in cognition and function
- ❖ Document non-drug interventions implemented and their effectiveness for targeted behavior occurrences
- ❖ Periodically evaluate (at least quarterly) targeted behavior(s), effectiveness of drug and non-drug therapy, undesirable effects, and consider GDR

Resources

Advancing Excellence in America's Nursing Homes

<https://www.nhqualitycampaign.org/goals.aspx>

Survey & Certification Letters 13-35-NH and 14-19-NH

http://www.dads.state.tx.us/providers/communications/sc.cfm?PageNum_prosclist=2

Provider access to surveyor training on antipsychotics

<http://surveyortraining.cms.hhs.gov/pubs/Archive.aspx>

Serial Trial Intervention (STI) approach at GeriatricPain.org

<http://www.geriatricpain.org/pages/SearchResults.aspx?k=sti>

TexasQualityMatters.org QMP Nursing Home site

<http://www.dads.state.tx.us/qualitymatters/qcp/nf/index.html>



TexasQualityMatters.org

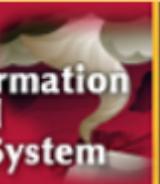
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QRS
Quality Reporting
System



FIVES
Facility Information
Vacancy and
Evacuation System



QMP
Quality Monitoring
Program



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The Texas Quality Matters website was developed by the Center for Policy and Innovation (CPI) at the Texas Department of Aging and Disability Services (DADS). This website will direct you to a variety of resources and initiatives. Texas Quality Matters will be our way to provide information to you.

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