Staff Educational Training Program and Toolkit

Antipsychotic Medications

July 2019
# Table of Contents

**Introduction** ........................................................................................................... 1  
  Overview of Problem, Impact of Problem, and Those Affected .................. 1  
  Data/Magnitude of the Problem ................................................................. 2  
  Reason for the Training Program Toolkit .................................................. 3  

**Section 1: Orientation to the Training Program/Toolkit** ......................... 5  
  Orientation to the Training Program/Toolkit ............................................. 5  
  Instructions on Use of the Training Program/Toolkit ................................ 5  
  How to Use the Resource Toolkit ............................................................... 8  
  Organizational Change ............................................................................. 9  
  Target Audiences .................................................................................. 13  

**Section 2: Overview of the Population** ......................................................... 14  
  Most Common Types of Dementia ........................................................... 14  
  Signs and Symptoms of Dementia ............................................................ 14  
  Stages of Alzheimer’s Disease ................................................................. 15  
  Out of Character Behaviors and Challenges ......................................... 16  
  Overview of Person-Centered Care ......................................................... 18  
  Overview of Antipsychotic Use in People with Dementia ....................... 19  

**Section 3: Roles and Responsibilities of Members of the Care Team** .... 23  
  Certified Nurse Aide (CNA) ..................................................................... 23  
  Nursing Staff (RNs and LVNs) ................................................................. 23  
  Prescribers (Physicians, PA-Cs, APRNs) ............................................... 24  
  Pharmacists ........................................................................................... 24  
  Family and Others ................................................................................ 25  

**Section 4: Interventions by Care Team Members** ........................................ 27  
  Non-Pharmacological Approaches to Antipsychotic Medication Use .......... 27  
  Alternative Activities .............................................................................. 28  

**Section 5: Resources, Tools, and Trainings** .................................................. 37  
  Resources from HHSC ........................................................................... 37  
  Resources from Other Organizations ...................................................... 38  
  Tools ....................................................................................................... 38  
  Trainings ................................................................................................. 39  

**Section 6: Evaluation of the Training Program/Toolkit** ............................. 41  

**Federal Regulations** ....................................................................................... 43  
  F841 Physician Services ......................................................................... 43  
  F711 Physician Visits .............................................................................. 43  
  F712 Frequency of Physician Visits ....................................................... 43  
  F757 Unnecessary Drugs ....................................................................... 43
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>F758 Psychotropic Drugs</td>
<td>44</td>
</tr>
<tr>
<td>F756 Drug Regimen Review</td>
<td>44</td>
</tr>
<tr>
<td>F760 Significant Medication Errors</td>
<td>45</td>
</tr>
<tr>
<td>F655 Comprehensive Person-Centered Care Plan</td>
<td>45</td>
</tr>
<tr>
<td>F656 Comprehensive Care Plans</td>
<td>46</td>
</tr>
</tbody>
</table>

References ........................................................................................................ 47
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 5.8 million Americans. By 2050, that number will increase to nearly 14 million people. Texas is ranked fourth in the nation for the number of cases, with an estimated 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 people exhibit behaviors as a symptom of their disease process. These symptoms include agitation (such as calling out, 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 isolation and poor quality of care/life. A common treatment to combat these behaviors has been the prescription of antipsychotic medications. This became 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.

In 2011, the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services reported that among people residing in nursing homes, there was a high use of atypical antipsychotic medications for "off-label" indications. The indication most cited for the use of these medications was to manage 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 Administration (FDA) issued a black box warning against the use of these

---

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](https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2014/raising-expectations-2014-AARP-ppi-ltc.pdf)
medications in the elderly population due to the increased risk of mortality. Despite the FDA's warnings, the use of antipsychotics in people 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. In 2012, CMS launched the National Partnership to Improve Dementia Care in Nursing Homes, with the mission to improve quality of care for people residing in nursing facilities who are 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 avoiding the use of antipsychotic medications unless there is a valid, clinical indication and a systematic process used to evaluate each person. Utilizing a multidimensional strategy, the Partnership promotes rethinking approaches that are used in dementia care, using person-centered care approaches and restoring good health and quality of life for people residing in NFs.

In an effort to combat the inappropriate use of antipsychotics, direct care staff (including nurses, CNAs and other disciplines) must be provided with training on alternative non-pharmacological activities/therapies that can be used to work through unwanted 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 conditions. According to CMS data, in Quarter 1 of 2014, Texas was ranked the worst, 51st in the nation, for the inappropriate use of antipsychotics in nursing facilities.

Because of Texas’ ranking, the Texas Health and Human Services (HHS) Quality Monitoring Program (QMP) conducted an iceberg analysis to gain a deeper understanding of the root causes of the issue. In doing this analysis, the disciplines that impact the care of people living in NFs were examined, including nursing, certified nurse aides, pharmacists, and prescribers (MD, PA, and APRN).

---

This analysis revealed that across all disciplines, there was a lack of knowledge on how best to care for people with dementia who displayed unwanted behaviors. This education is rarely received during training. Consequently, the inappropriate use of antipsychotic medications is a symptom of a generalized issue: a lack of knowledge, skills, and abilities to care for people with dementia in ways that include alternatives to antipsychotic medications.

The collaboration between HHS, providers, advocacy groups, industry groups and many others has resulted in a significant, sustained reduction in the inappropriate use of antipsychotic medications. As Quarter 3, 2018 Texas was ranked 10\textsuperscript{th} in the nation, with 12.6 percent of NF residents receiving antipsychotic medications.\textsuperscript{6} Despite this notable achievement, challenges remain. Progress in reducing these medications has plateaued, and there are still facilities in Texas that are considered “late adopters”.

**Reason for the Training Program Toolkit**

To effectively address the need for more alternatives to antipsychotic medications, all parts of the infrastructure (different disciplines working with the person) 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 people residing in NFs (prescriber, nursing, pharmacists, and the certified nurse aide).

This training program/toolkit will provide an approach to address the educational deficits noted in the root cause analysis. Ensuring that these four disciplines receive comprehensive education will help eliminate common practices that impact the use of antipsychotics. Without this education, the problem will get worse, as the number of individuals with Alzheimer’s disease and other dementia-related conditions is projected to increase significantly in the coming years. As a result, all healthcare disciplines will be faced with caring for people who have behaviors related to an unmet need or as a result of their disease process.

Alternative interventions are key to reducing the use of antipsychotics in NFs. With this 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 antipsychotics. The benefits of this information extend beyond the reduction of antipsychotic medications, and directly impact people living in the NF by allowing them to reconnect with the world.

---

\textsuperscript{6} CMS. National Partnership to Improve Dementia Care in Nursing Homes: Antipsychotic Medication Use Data Report. [https://www.nhqualitycampaign.org/files/Antipsychotic_Medication_Use_Report.pdf](https://www.nhqualitycampaign.org/files/Antipsychotic_Medication_Use_Report.pdf)
This training program/toolkit will include education on the care of people with Alzheimer’s disease or other dementia-related conditions, viewing behaviors as a means of communication, clinical guidelines for the appropriate use of antipsychotic medications, and alternative interventions.

All Texas NFs will be able to use the toolkit to educate their staff so that they can improve the quality of care and increase the quality of life for people residing in their facilities.
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 people with dementia, including:

• What are antipsychotic medications?
• Assessment processes and review of admission orders for antipsychotic medication that are not appropriate.
• Identifying alternative interventions that can be used instead of antipsychotics.
• The roles of facility staff (including nurses, CNAs, CMAs, and administrative staff) and physicians.
• What to do is a person is admitted to the NF with an order for antipsychotic medications.
• Resources and evidence-based practices from nationally known sources.

Instructions on Use of the Training Program/Toolkit
In order to effectively use this training program/toolkit, the NF must conduct a root cause analysis\(^7\) (RCA) to determine why antipsychotic are being prescribed, what changes need to be made to ensure people residing in the NF are not prescribed antipsychotics, and how to ensure they 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 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: 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 to fully understand what happened.
4. Identify the contributing factors: Determine what situations, circumstances, or conditions increased the likelihood of the problem/situation occurring.

5. Identify the root cause: A thorough analysis of contributing factors leads to identification of the underlying system issues (root causes).

6. Design and implement changes to eliminate the root causes: The team works together to determine how best to change processes and systems to address the problem and reduce the likelihood of another similar issue occurring.

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 Analysis**: 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. **Brainstorming**: 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. Encourage as much participation as possible. When facilitating brainstorming it is best to have a flip chart and markers, but it can be done with a white board and someone to take notes of the information gathered. 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 Diagram**: 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 Toolkit can be accessed here: [http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx](http://www.ihi.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 of 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 consideration because they couldn’t be easily seen.

**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.
In order to affect change with the issue of antipsychotic use, improve quality of care, 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, focus must be placed on the cause rather than the effect (antipsychotic use).

**How to Use the Resource Toolkit**

As you read through the information in this toolkit, you will find sample assessments, sample care plans and algorithms, as well as specific information on topics such as assessment, ways to decrease risk factors, steps towards prevention, alternative interventions, and what to do is a person is admitted to the NF already on antipsychotic medications.

The roles of the different disciplines providing care for people 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 play in the reduction of antipsychotics in your facility. This information can be used to create educational trainings for your staff to help them make changes in the care they provide.

If you need additional information to use in coordinating training for your staff, there are resource lists at the end of the toolkit.
Organizational Change
As you use the toolkit in your facility, it is important that the changes made are sustainable. The best way to ensure sustainability is to make the changes at the system level versus the person level. Below, you will find how this can best be accomplished.

System Change vs. Individual Changes
As changes begin to be implemented in your facility, it is important that the changes are made at a systemic level and not just the staff level. What does this mean? Simply put, it means that it is not enough to train the staff on the changes that are being made throughout the NF, but also to put in place policies and procedures that reflect those changes. When an NF experiences staff turnover, changes that have been made at the staff level tend to be lost as a result.

The only effective way to ensure that the change will be maintained is to imbed it throughout NF policies and procedures that detail the way that the NF will operate. To guide the changes that will be needed, ask the following four questions:

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 new practices into place? It may be helpful to begin the process in just one area of the NF to determine if it will be effective before rolling it out facility-wide. 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. The 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 the continued educational needs of staff. Any plans for new staff education related to the changes being made in the NF should be developed in close collaboration with experts on the content.

The most important concept in organizational change is sustainability. This can only happen if the change is made at the system level in the form of policies and procedures.

---

12 Preventing Pressure Ulcers in Hospitals.
**Empowerment**

Empowerment is the practice of sharing information 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, and holding them accountable for the 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 and they are determined to do a good job.
- **Sense of impact** - the work they are doing has a positive impact on the lives of people 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.
- **Tolerance of imperfections** - understanding that as humans, mistakes are inevitable and that no one is perfect.
- **Sense of 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, but it is possible to develop an environment where people will take the initiative to empower themselves and where 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):\(^\text{13}\) 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, 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)

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)\textsuperscript{14}: 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.

Target Audiences
This toolkit is designed to be used with any NF staff member, including 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. Providing training to all 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 people 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 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 are\[^{15}\]:

- 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 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 dementia:\[^{15}\]

- 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 (difficulty talking, understanding, writing, and reading, for example: being unable to talk, saying the wrong words, and being unable to 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 (inability 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 include:

- **Mild Alzheimer’s (the early stage)**: In this stage, a person may still be able to function independently, 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 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. People in this stage may begin to require more care as they become less independent. One may start to notice that the person in this stage confuses words more frequently, gets easily frustrated or angry, or acts in ways they would not typically act, for 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

---

16 Alzheimer’s Association: Stages of Alzheimer’s. 
their own personal history, no longer participating in social activities or acting withdrawn when they do, confusion to time, , and the need for assistance with simple tasks such as choosing clothing that is suitable for the season. They may have an increase in getting lost, wandering without purpose, and have changes in 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 conversations, and are unable to control their movements. They may use words or phrases that are not consistent with what is going on around them. Extensive assistance with daily activities also becomes necessary. Symptoms one might see in individuals at this stage include 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 having 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, needing to use the bathroom, feeling too hot or 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 a person with dementia starts to display behaviors, 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, we can understand how hard it must be for a person whose parietal lobe is damaged by dementia to cope with the unfamiliar, such as moving into a new environment (like 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 try not to take offense.

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 keep staff from becoming angry when a person behaves inappropriately towards them.

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 people have dual diagnoses such as Parkinson’s and depression. They can be challenging to treat. It is important to work with the interdisciplinary team to assess the person for unmet needs and to determine the cause of the behavior. A few of the basic points include:

- Unwanted behaviors are a way of getting needs met, directly or indirectly.
- Multiple factors are at play which makes it necessary to look at these behaviors carefully in order to choose the best intervention for the person.
- 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 people’s needs, the less likely the out-of-characteristic behavior is going to happen again.
All Behavior Has Meaning

It is important to understand that all behavior has meaning. It may not be immediately apparent, even to the person who is displaying the behavior. The behavior is not random or just a symptom of dementia.

All behavior attempts to communicate. Most people do not always ask directly for what they want or need. Often, what is described as “difficult behavior” is an indirect attempt to communicate a need or a feeling. When people 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?”

Table 1: Uncharacteristic Behaviors and Possible Causes

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wandering</td>
<td>Boredom</td>
</tr>
<tr>
<td>Calling out</td>
<td>Loneliness</td>
</tr>
<tr>
<td>Grabbing</td>
<td>Fear of pain</td>
</tr>
<tr>
<td>Pushing</td>
<td>Desire for privacy</td>
</tr>
<tr>
<td>Agitated</td>
<td>Overstimulated</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>Understimulated</td>
</tr>
<tr>
<td>Intrusiveness</td>
<td>Hunger/Thirst</td>
</tr>
</tbody>
</table>

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

Overview of Person-Centered Care

Person-centered care is a care 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

---

17 National Nursing Home Quality Improvement Campaign
https://www.nhqualitycampaign.org/goalDetail.aspx?q=pcc
of person-centered care honors the importance of this by keeping the person at the center of their care and the decision-making process. In this care model, caregivers must actively listen and observe to be able to adapt to each person’s changing wants and 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 about seeing everyone as individuals and not placing the focus on their illnesses or on their abilities or inabilities. Making sure that people are involved in and central to their care is now recognized as a key component of providing high quality healthcare. There are many aspects of person-centered care that should be taken into account, including:

- Respecting the person’s values and putting them at the center of care;
- Incorporating the person’s preferences, routines, and expressed needs;
- Working together to make sure there is good communication with the person 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 in the planning process;
- Making sure there is continuity between and within the services that the person is receiving;
- Making sure people have access to appropriate care when they need it; and
- Ensuring the person has a life that is meaningful to them.

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 People with Dementia**

The use of antipsychotic medication for people with dementia has been a national problem and raises concerns for their safety. Antipsychotic medications are largely ineffective and are dangerous for these people. There is no chemical rationale for using an antipsychotic medication in dementia for anything 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 people 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 inappropriate use of antipsychotic medication.
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 for managing behaviors in people with dementia. Off-label use of medication is considered an approved medical practice. However, when a doctor, physician assistant, or nurse practitioner prescribes something that is off-label, getting informed consent and weighing the risks and benefits becomes even more critical. Anytime a medication is prescribed, there are two critical questions 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, tremors, difficulty walking, and falls;
  - Dehydration;
  - Chest Infections;
  - Accelerated cognitive decline;
  - Increased risk of strokes and mortality; and
  - Extrapyramidal side effects such as apraxia, tardive dyskinesia, and 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 people with dementia-related psychosis as they were at an increased risk of death.
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, it has been found that some people in their 80s and 90s (with no history of mental health issues) have been given a new diagnosis of schizophrenia, a disease usually 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

Antipsychotics should not be prescribed unless absolutely necessary to treat a specifically diagnosed condition which is documented in the clinical record. People 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 someone 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.

Antipsychotics should be seen as a last resort after all non-pharmacological interventions have failed. 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 person’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 for 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 interdisciplinarity 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 person 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.
All staff members who provide care to those who live in the NF play an important role in ensuring that they receive the highest level of care possible. Reducing the use of antipsychotics is a multi-disciplinary task. All team members are responsible for understanding their role in ensuring antipsychotics are not prescribed when not medically indicated.

**Certified Nurse Aide (CNA)**
CNAs have one of the most important roles in the reduction of antipsychotic medications in the NF. The CNA must understand that there is no a “one-size-fits-all” intervention for the people for whom they provide care. How CNAs react to behaviors is essential to the overall care provided. The CNA should stop and listen to the person to determine what is going on and what individual needs he/she 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 person in the past that I can try?

When a person exhibits an unwanted behavior, think about what could be causing it: infection, hunger, thirst, fatigue, needing to use the bathroom, boredom, etc. As the staff member with the most hands-on interaction with people, 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, the person with dementia may not be able to communicate effectively, prompting the change in behavior. If this is the case, the use of communication tools may decrease the person’s frustration.

Ultimately, the CNA’s role in the reduction of antipsychotic medications is one of significant importance and should be valued. CNAs have a tremendous impact on the person’s quality of care, advocating for him/her and sharing information with nursing staff.

**Nursing Staff (RNs and LVNs)**
Nursing staff are responsible for ensuring that there is a thorough assessment for every person residing in the NF. This will allow for issues to be identified before any unwanted behaviors are exhibited that may lead to the use of an antipsychotic medication.
In working with people who have dementia, nursing staff must ensure that the person is being provided with every available non-pharmacological intervention to eliminate or prevent the unwanted behaviors.

Nursing staff are also responsible for questioning orders that they receive for the people for whom they provide care. If the prescriber (Physician, PA, or NP) writes a prescription for an antipsychotic medication, the nurse should question the medical need for the prescribed medication. The nurse should be especially sure to question the medication if it poses more harm to the person than good.

**Prescribers (Physicians, PA-Cs, APRNs)**
Practitioners with prescribing privileges have a key role in reducing the inappropriate use of antipsychotic medications in people with dementia. As members of the interdisciplinary team, prescribers should:

- Evaluate each person to determine the continued appropriateness of the 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 people attain the highest possible level of functioning in the least restrictive environment possible.
- Document relevant conditions that affect quality of life, especially in people 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 people 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 people residing in the NF, by all providers (e.g., pharmacy, prescription drug plan, prescribers). In this role, pharmacists promote safe, effective medication use by alerting NF 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 person’s 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 person’s family members or other loved ones also play an important role in the decreased usage of antipsychotic medications.

If the person is already taking these drugs, the family member should 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 person 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?

Other things family members can do:
• Stay involved in their loved one’s care.
• Get to know staff – their names and duties.
• Attend care plan or service plan meetings.
• Talk to staff about concerns with the care being provided to the person.
• 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 Use\textsuperscript{18}

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 person’s cognitive function, and to improve the quality of life or reduce unwanted 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, to prevent the use of antipsychotic medications:

- Start with a pain assessment.
- Provide for a sense of security.
- Apply the 5 Magic Tools (Knowing what the person likes to See, Smell, Touch, Taste, Hear).
- Get to know the person, including their history and family life, and what they previously enjoyed. Learn his/her life story. Help the person create a memory box.
- Play to the person’s strengths.
- Encourage independence.
- Use pets, children and volunteers.
- Involve the family by giving them a task to support the person.
- Use a validated pain assessment tool to assure 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 that it is documented it in the person’s medical record so that it can be used in the care planning process.

\textsuperscript{18} Alzheimer’s Association: Success for Less – Reducing the use of antipsychotic medications in nursing homes. 
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 people.
  - Look at environmental ways to make sure basic needs are met.
  - Take time to get to learn about people’s lives before they entered the nursing facility. This happens spontaneously all the time with people 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 people 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.
  - Anticipate and meet core psychological needs to prevent behaviors.
  - Address the risks of boredom, helplessness and loneliness that continue to plague many nursing homes.
  - Create person-centered care plans that reflect a person’s wishes and emphasize strengths and choice.
  - Address stress in caregivers.

**Alternative Activities**

There are many different types of activities that people can engage in that are considered alternatives to medications. These alternative activities allow for people to have 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 & MEMORY**¹⁹

MUSIC & MEMORY℠ 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 2006 by Dan Cohen after he discovered that none of the 16,000 long-term care facilities in the U.S. used iPods.

---

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 living with 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" showcased the work that was being done by the organization, and has since boosted awareness and enthusiasm for the program. A clip from the film can be viewed by visiting: https://www.youtube.com/watch?v=fyZQf0p73QM.

Facility staff, along with the people for whom the care, benefit greatly from this project in the following ways:
- Increase in participation by the people in their care;
- Decrease in the number of falls;
- Decrease in the use of psychotropic medications;
- Decrease in the signs of anxiety and depression; and
- Increase in staff job satisfaction.

Implementing the MUSIC & MEMORY℠ program in a facility is a 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 & MEMORY℠ program to a local nursing home in their area: https://www.youtube.com/watch?v=jU2YxlUx5vA.
- MUSIC & MEMORY℠: The Student Experience: https://www.youtube.com/watch?v=-X223bdQEJA

NFs may find that implementing this program can be time consuming since each person 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 people 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 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 into deep memories and can bring people “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 person with 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 people with 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 person and non-threatening. The conversation should not be forced; however, the person 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.

Reminiscence activities can be developed using specific themed bags, boxes, or books. Themes can be anything that the facility identifies as being important to the person such as a beach, travelling, sports, military, gardening, food, seasons (winter, spring, summer, and fall), etc.

A memory book[^20] is a simple way to organize memories and mementos, such as 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 memories. There are several books that have been designed to prompt and contain memories of one’s life. They include questions about genealogy, friends, marriage and all of those things that make up personal history. They often provide space to write answers and post photographs and other memorabilia.

Start by asking the following questions:
- What does the person 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 share about what they like and admire about him/her?

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 use one picture per page. You can leave the opposite page blank or use it for writing or journaling.
• If 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 can help jog our memories but there are not always pictures for each event.
• Write one page where you tell the person what is so special to you about them.
• Caption each page:
  o Early stage example: “Connie’s first day of kindergarten at Saylor School in Des Moines.”
  o Middle Stage example: “Connie’s first day at Saylor School.”
  o Late Stage example: “Connie loved school.”

Animal Therapy\textsuperscript{21}
Researchers have long suggested that pets are good for us, 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 using our four-legged friends in Alzheimer’s and dementia units is becoming commonplace. In fact, some facilities are hiring pet coordinators as part of an Animal Therapy program to aid in the care of the pets belonging to people who live in the NF.

Therapy dogs and other animals can stimulate social interaction and ease agitation in the people with dementia. There are many benefits of animal therapy, including the following:
• Stimulates a social response.
• Reduces agitation: Agitation behaviors, common among people with dementia, are reduced in the presence of a dog.

\textsuperscript{21} 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 person’s mobility, they may be able to groom the animal, toss a ball, or even go for a short walk.
• Improves eating: People with dementia have been shown to eat more following a dog’s visit.
• Increases pleasure: Some people 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 to consider 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. Some animals are good with children and some are good with people 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.
  
  o Delta Society: [http://www.themondaylife.org/pet-therapy?gclid=Cj0KEQjw4J-6BRD3h_KIogijwvkBEiQAcPiBU5iUmJ7eqW496Nj_2rJJp2HAEgLg24XL_J9A4QN](http://www.themondaylife.org/pet-therapy?gclid=Cj0KEQjw4J-6BRD3h_KIogijwvkBEiQAcPiBU5iUmJ7eqW496Nj_2rJJp2HAEgLg24XL_J9A4QN)
  
  o Therapy Dogs International: [http://www.tdi-dog.org/](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 person with dementia and the therapy animals that visit them. Infection control measures include:
  
  o Properly cleaning the therapy animals before and after a visit.
  o Cleaning the hands of everyone who will touch the animal before and after contact.
  o Preventing animals that eat raw foods from being therapy animals.
  o Avoiding contact with the animal’s mouth.
  o Using sheets and barriers, such as a rolled towel, bedding or furniture, to keep some distance between the animal and the person with dementia.

• Giving treats: Feeding is a universal bonding behavior, and many people want to give the therapy animal treats. The companion of the animal should provide
treats, so people may give them to the animal. The animal should do some kind of trick in exchange for the treat.

- **Flexibility:** Visits with people that have dementia visits can be unpredictable. The person 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 extremely beneficial to people with dementia in the NF setting.

**Humor/Laughter Therapy**

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 people in a positive manner.

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.

Laughter can:

- Ease anxiety and fear, and activate happy feelings.
- Prevent heart disease.
- Increase and improve social interactions and bonding.
- Lower stress hormones.
- Lower blood sugar levels.
- Open inner cellular pharmacy which strengthens all immune functions.
- Open lungs and ventilate 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.

---

22 Laughter on Line University; Why and How Laughter can Help Alzheimer’s, Parkinson’s, and Lew Body Dementia. [http://www.laughteronlineuniversity.com/lewy-body-dementia/](http://www.laughteronlineuniversity.com/lewy-body-dementia/)
Laughter helps improve the quality of life for those living in NFs. People with 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 percent reduction in agitation for people 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 Therapy**

Art intervention has been proven to be a powerful tool as an alternate intervention for those with dementia. Art gives people 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 people with cognitive decline. It can inspire a person 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 person 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 people 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 of the work for visitors to see when they come to the NF. Taking people to visit art museums or shows is another way to incorporate art into facility activities.

---

Doll Therapy\textsuperscript{24}

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 people with dementia. The use of dolls as an alternative activity allows the person to provide love and affection, which are instincts that the individual has that 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; and
- 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; and
- Increase in positive social interactions.

The range of doll interventions may include providing dolls to individual people, as well as programs in which groups of people take part in various forms of care-provision and nurturing activities. Caregivers may find that people exhibit the abilities to express affection, nurturing and emotional attachments that are still a part of their nature and personalities.

One of the most important benefits of dolls is that it provides people with dementia social interactions and allows them to have the chance to care for someone again instead of just being the person receiving care. People with dementia are often calmed by their baby doll, which can create a distraction for them during upsetting events. Having a baby doll often reminds the person of fond memories from when they were a new parent. People with dementia may 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.
- The doll should appear to be anywhere from newborn to a year in age.

\textsuperscript{24} 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
• 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 it.
• 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 person to pick the name.
• Family members can be encouraged to buy real baby clothes for their loved one to put on the doll. They may also want to provide a stroller, so the person can push it around the facility and get some exercise.

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.
• The person should have their own doll, and even then, ownership issues may lead to arguments between people.
• Anxiety can result from the dolls being mislaid or mishandled by caregivers.
• There is also a possibility that the person could become over-invested in caring for their doll. Make sure the person has other activities that he or she can participate in.

**Activities that People to “Give Back”**
People 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.

One example is “Helping Hands” at Mission View Health Center in San Luis Obispo, CA; people 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 people to be a part of and help improve the community. Giving back to the community brings meaning to their lives, and they begin to feel as though they are not just receivers of care, but caregivers.

Depending on the person’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 examples include starting a food drive, participating in a toy drive and participating in an intergenerational program.

Providing care for a person with dementia may be challenging at times, therefore it is important to have a variety of different activities and treatment options available to provide them with the highest level of care possible. If a particular 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](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](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 people in NFs. [https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/qmp/prescribers-flyer.pdf](https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/qmp/prescribers-flyer.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](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](https://hhs.texas.gov/sites/default/files//assets/doing-business-with-hhs/provider-portal/ltc/qmp/antipsychotic-education-form.pdf)
- Basic Guidelines for Behavior and Side Effect Monitoring describes techniques for conducting effective behavior and medication side effect monitoring.
“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.

More information related to reducing antipsychotic use in NFs and on HHSC Antipsychotic Reduction Initiatives can be found on the QMP website at

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):** 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 people’s preferences, lay the foundation for building trusting relationships between the person, family, and NF staff, and promote person-centered care plans and service, honoring the person’s preferences as the highest priority. Both versions of this tool can be found at [https://preferencebasedliving.com/peli-tools](https://preferencebasedliving.com/peli-tools).

• **“This is Me”:** 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 his/her needs. That information can help reduce distress for people with dementia, and help prevent issues with unwanted behaviors. “This is Me” can be downloaded at [https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/this_is_me.pdf](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”:** The Behavior Management Task Force created the Passport to provide information about the person, painting a picture of who he/she 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](https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/provider-portal/QMP/AssessmentModule.pdf).

### Training

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)


---

26 Alzheimer’s Society. “This is Me”. [https://www.alzheimers.org.uk/thisisme](https://www.alzheimers.org.uk/thisisme)
To schedule the ADDCT, Texas OASIS, or the VDT please email the request to QMP@hhsc.state.tx.us. To schedule the PCT, email the request to kittie.farmer@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.utlongtermcarenurse.com/.
Section 6: Evaluation of the Training Program/Toolkit

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

In order to determine if this training program is effective in providing NF staff with information related to antipsychotic medications, 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 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, therefore it takes time for the data to show positive or negative changes. An NF could conduct the training one month and begin making changes, however, the data may not show significant positive change for several months. Although this method of evaluating the training program is probably the most significant in terms of the actual changes that are taking place to the care being provided to people living in the NF.
# Figure 5: Evaluation of Staff Educational Training Program/Toolkit

<table>
<thead>
<tr>
<th>Measure</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The content is relevant to the stated objectives</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The content is well organized into clearly labeled sections</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The resources and links provided in the sections are evidence based and credible organizations/resources</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The content is appropriate and free from bias, stereotypes or insensitivity</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>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</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The content of the Education/Resource Tool Kit addressed prescribing patterns</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The content of the Education/Resource tool kit addressed alternate interventions that can be used prior to introducing or prescribing an antipsychotic</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I will make/implement change based on what I have learned from this Education/Resource Tool Kit</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Overall, I am satisfied with the content of this Education/Resource Tool Kit</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 every30 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

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.


Alzheimer’s Society. (2016). This is Me – A support tool to enable person-centered care. Retrieved from: https://www.alzheimers.org.uk/thisisme


