

Alternatives to Antipsychotic Medication

Dementia is a progressive condition where behavioral and psychological markers are anticipated. In individuals with Alzheimer's disease up to 75% will experience depression, psychosis, or agitation. This statistic is also consistent in other forms of dementia, namely vascular dementia and mixed types of dementias. Alzheimer's and other dementia-related conditions have predictable symptoms of which tend to occur at different stages of the disease.

Mild cognitive impairment

Memory deficits	Declining Functionality
Modified independence of ADLs	Declining Social skills

Moderate cognitive impairment

Increasing problems with managing daily life	Hygiene related difficulties
Increased reliance upon others for functional tasks	Assistance with finances
Challenges in taking medications properly	Intermittent mood/behavioral changes

Severe cognitive impairment

Behavioral disturbances which are frequent	Depression or social withdrawal
Inability to make decisions for one's self	Increased risk of falls
Psychosis-related psychiatric changes	Caregivers providing total assistance
Problems understanding and being understood by others	

a. Cognitive and functional changes occurring over the various stages

Deficits in decision making skills

- Forgetful of important matters
- Difficulty in making reasonable choices
- Difficulty in taking medications properly
- Inability to recognize the presence of infections or health related conditions

Complications due to an inability to understanding or be understood by others

- Inability to follow simple instructions
- Inability to find the right words in basic conversations
- Inability to express unmet needs (Thirst, hunger, urinary or fecal urgency)
- Diminished awareness of pain or discomfort
- Inability to communicate an uncomfortable environment (Too cold or warm, or too noisy)

Emotional changes such as social withdrawal and depression become more apparent

- Loss of interest or initiative
- Inability to concentrate
- Lack of concern about one's self
- Deepening fatigue
- Loss of emotions or feelings
- Loss of appetite
- Fear or panic

- Poor concentration

The risk of falling may contribute to:

- Diminished motor skills
- Light headedness (orthostatic hypotension) or drowsiness due to medications
- Confusion of surroundings (disorientation)
- Wandering or pacing due to restlessness
- Imbalanced walking

Functional tasks requiring more assistance from others:

- Remembering the location of room
- Assistance with toileting
- Brushing hair or teeth
- Unable to feed or take medications due to difficulty with swallowing

Behavioral disturbance

- Sleep-wake cycle disturbances
- Emotional distress
- Delusions**
- Hallucinations (auditory and/or visual)**
- Agitation (which is defined more descriptively as: irritability or anger, restlessness, anxiety, compulsive behaviors, repetitive questions, or wandering without purpose)
- Aggression (which is defined more descriptively as: lashing out at others, verbal outbursts or cursing at others, yelling out without purpose, threatening to harm others, physically resisting help with needed care, sexually inappropriate behaviors, disrobing in front of others or in public places, or dressing inappropriately)

** Hallucinations and delusions can be antecedents of both verbal and physical aggression towards others. Caution must be taken when applying these terms due to visual/perceptual impairments and misinterpretations of the individual. Examples such as mistaking clothing in a closet for an intruder, or believing that the staff is stealing items when they are simply misplaced can lead to the wrong conclusions.

b. Evidence-based Best Practice (EBBP)

Non-pharmacological interventions (non-drug therapies, excluding physical restraints) are considered the first-line approach toward behavior disturbances. “A behavioral management program that complies with federal nursing home surveyor guidelines includes five components:

- 1) identification of problem behavior
- 2) patient assessment
- 3) specific systematic behavioral interventions
- 4) documentation of outcomes for behavioral interventions
- 5) necessary adjustments of program based on observed results

The use of an interdisciplinary team may be beneficial in implementing preventative approaches that use non-pharmacological interventions to reduce the behavioral and psychological symptoms of dementia. These symptoms are often triggered by communication problems that

may not be fully comprehended by the staff. Antecedents of behavior are seldom discussed with the interdisciplinary team, and rarely documented by the nursing staff as to the possible triggers or root causes. The staff can supply answers to the following three questions when a behavioral disturbance occurs:

- What is the the reason for the behavior?
- What is the description of the behavior?
- What are the consequences of the behavior?

Quality improvements for successful behavior management may require changes in facility policies and nursing care practices. Education and training on behavior management techniques for all staff, including non-caregivers, will allow all employees to assist when behaviors occur. The social worker and recreational therapist may need extensive training to provide guidance for direct-care staff when a resident’s behavior changes.

Family caregivers can have a great deal of information to offer regarding the likes and dislikes of their loved ones. Non-pharmacological interventions can be structured via discussions with the family. Alternative approaches and methods which are valid yet unfamiliar to the general public can be discussed to educate family members.

c. Standards

Non-pharmacological interventions are considered first-line treatment in dementia, after medical and physical causes of the behavior have been ruled out. In circumstances where risk of harm is evident, medications may need to be initiated in addition to non-pharmacological interventions. In Appendix PP of the State Operations Manual CMS guidelines promote:

Assess: Complete a comprehensive assessment to identify any underlying reasons for behavioral manifestations and confirm that behaviors are not being caused or worsened by any unmet medical, physical, or social needs.

Comprehensive assessments include the following information:

- Rule out delirium, a condition which may require prompt medical attention
- Address underlying *medical conditions* (some may need lab work or validated assessment scales to confirm)

Medical Conditions

Infections	Electrolyte imbalances	Seizure or stroke
Dehydration	Metabolic disturbances	Abrupt arrhythmias
Urinary retention	Acute or chronic pain	Weight loss
Fecal impaction	Poorly controlled diabetes	Depression
Sleep disturbances	Breathing difficulties	Incontinence issues

- Consider the adverse effects of medications (side effects or potential toxicities)
- Inherent changes in the brain which are part of the disease process
- Evaluate for uncorrected visual or hearing problems
- Inability to reposition one’s self causing discomfort

- Lack of access to enjoyable foods or beverages(may be culturally related)
- Lack of enjoyable music (may be culturally or generationally related)
- Environmental conditions or triggers which may not be acceptable to the resident

Environmental Triggers

Special events (over-stimulation)	Overall noise level
Loud bells or alarms	Poor lighting causing shadows
Lack of bright sunlight	Poorly marked halls/rooms
Poorly marked restrooms	Food and beverage offerings
Smoking conflicts/restrictions	Lack of meaningful hobbies
Lack of spiritual activities	Boredom (under-stimulation)
Temperature (too warm/cool)	Personal conflicts with others
Lack of attentive staff	Timing of ADLs (resident control)
Unpleasant smells in facility	The need for scheduled toileting

- Lack of individual choices or controls
- Recent transfer from home to a nursing facility
- Transfers to a nursing facility from a hospital or other nursing facility
- Interpersonal conflicts with caregivers (may be gender related)
- Conflicts with room location or being able to locate one’s room
- Fear (alleviating worry and anxieties)
- Emotional or physical fatigue (others not understanding the limitations of the resident)
- Lack of knowledgeable staff (may cause resident frustration)
- Lack of family education about the disease process
- Stress related family conflicts (between resident & family or within the family)

Problems or triggers need to be addressed with the initiation of interventions to prevent the frequency of behavioral occurrences. If behavioral interventions are not individually tailored to treat targeted behaviors, then applied interventions may prove to be ineffective and/or lead to the unnecessary use of psychotropic medications.

- ABCs of behavior are identified:
 - Antecedents of the behavior (understanding a cause)
 - Behavior (Identify the specific target)
 - Consequences of the behavior (learning how to remedy it through modification of the environment or adaptation of the caregiver)

Guardians/family members need to provide input as to the personal likes and dislikes of their loved ones. Interventions can be structured to what works best, so that all facility staff and family members know how to address specific behaviors. CMS recommends a “prescription activity”, where targeted behaviors have a specific set of interventions for treatment. These interventions can be linked with behaviors, in much the same way that medications are linked with the treatment of specific behaviors. Having this information readily available for all (i.e., MDs, RNs, LVNs, CNAs, CMAs, Administrators, Regulatory, and family members/guardians) to review and apply will improve outcomes.

- In the nursing home setting collaborative care models have been shown to be effective in reducing the behaviors related to dementia, as well as reducing stress on the individual and their informal caregivers (e.g. family members). This consists of:
 - Continuous monitoring
 - Individualized care protocols
 - Utilizing practical clinical tools
 - Accurate data collection
 - Detecting responses to care planning
 - Having a sensitivity to change when needed

- Thorough assessment requires an examination of detailed information.
 - Clinical history
 - Resident's subjective experiences
 - Objective views of a resident's behavior(s)
 - Reliable family or caregiver information

- Assessments must consider any handicaps with communication and social skills, while always encouraging the resident to express their own concerns.
 - Open-ended questions are best to promote free-formed descriptions
 - This information is not influenced by the interviewer and/or caregiver
 - Emotional states are considered when descriptions are given

- Take a social assessment
 - Individualized senses (what do they like to see, smell, touch, taste, hear)
 - Know stories/topics that make the person happy
 - What do they like to do (individualized meaningful activities)
 - Where do they like to sit (favorite location or at favorite nurse's station)
 - Know the topics and situations that make them unhappy (triggers)

- Resident and caregiver interactions can be observed to better determine how a resident's behaviors manifest. A caregiver's emotional state may play a large part. Discrepancies between resident and caregiver descriptions can be noted to determine the usefulness and limitations of the information gathered.
 - Dysfunctional interactions are noted
 - Apathy of the resident may affect the caregiver
 - Deterioration of relationships over time can also be noted
 - Recognize that caregiver characteristics can contribute to misunderstandings
 - Young age of caregivers
 - Lifestyle differences
 - Civilian caregivers with military based residents
 - Educational disparities
 - Working a greater number of hours per week
 - Caregiver stress level and depression

Target behaviors: Identifying and document the specific behavior(s) to be addressed

Behaviors which are causing a danger to self or harm to others must be addressed with the attending physician. Medications may be necessary to stabilize the individual.

Targeted behaviors can be laid out in a behavior monitoring system or sheets before medications are started to structure and apply individualized person-centered techniques. Simply documenting generalized interventions such as “re-direct” may not be enough. More specifics as to “how” the staff can approach the resident, allow for time to communicate, offer cares, etc. are needed. The staff may need to specify the likes and dislikes of the resident, to tailor meaningful activities to distract and avoid negative behaviors or triggers.

- Defining the resident specific targeted behavior(s) to be treated (avoid the use of a broad terms such as “agitation” , “combative”, or “mood swings”)
 - Provide relevant information such as antecedents or any possible triggers
 - When and where did the behavior occur
 - Was that behavior a danger to the resident themselves or others
 - Were others (nursing staff, caregivers, or other residents) affected by that behavior
 - Give detail of the severity, duration, and frequency of the occurrence
 - With hallucinations, delusions, or paranoia, it is best to describe the content (doing this may lead to possible causes which can be either minimized or resolved)

- Psychosis can be a normal part of the dementia disease process, and not every type of psychosis is treated with an antipsychotic drug. Unless those hallucinations or delusions are causing the resident distress or causing harm to other residents, no drug treatment is necessary.
 - Do not argue with the resident about these delusions or hallucinations, try to deflect and comfort the resident.
 - Educate the staff and family about validation techniques, to accept the beliefs of the resident so that medications can be avoided for as long as possible.
 - Provide clear documentation if the psychosis causes distress or harm. This can substantiate evidence that antipsychotic treatment is necessary to stabilize the resident.
 - Document the result of the distressing or harmful psychosis (e.g., resident is refusing food because they believe they are being poisoned)

- Management techniques work best when “appropriate” behaviors are strengthened
 - Consistently using low-toned slow speech and simplified statements
 - Graded assistance plus positive reinforcement can improve daily activities
 - Use positive statements (avoid all negative speak, don’t argue, deflect by asking questions that make the individual converse, change the location)
 - Don’t wait until behaviors escalate
 - Use the four Rs
 - Repeat (verbally prompt)
 - Redirect (introduce pleasant stimuli such as important life events, prayers, poems, hobbies, interests, photographs, music of the person’s choice)
 - Reinforce (assist the resident by maintaining the person’s independence and try to enhance physical ability)
 - Reassure (defuse the situation, offer comfort, address emotional needs)

Monitor: Measure the number of episodes of behavior daily through behavior monitoring

- Performing shift-by-shift monitoring can make trends in time of day more noticeable
- When reviewable data is collected behaviors may be able to be narrowed down to special events, noise related activities, etc.
- Progress can be tracked according to the application of non-pharmacological intervention techniques and/or pharmacological interventions
- Document the non-pharmacological interventions that work best. Documentation is important especially do to staff turnover, because this valuable information could be lost. CMS emphasizes the need to see written evidence of these techniques.
 - Specify the particular ways of redirecting, performing 1 on 1, etc.
 - Consider scheduled toileting and prompted voiding to reduce urinary incontinence (if this is a specific problem with the resident)
 - Document various Cognitive Behavioral Therapies (CBTs) as resident specific non-pharmacological interventions for targeted behaviors:
 - Music (resident's choice) reduces agitation, aggression, and mood disturbance even while bathing and eating
 - Audio relaxation tapes (the beach, the outdoor sounds, etc.)
 - Aromatherapy can stimulate appetite, and can add to a pleasant bathing
 - Walking & light exercise to reduce wandering, aggression, and agitation
 - Pet therapy to improve socialization
 - Document reminisce therapy
 - Old photo albums for recall of the past and diversion from behaviors
 - Audiotapes of family members can have a calming effect
 - Videotapes of family members to reduce verbally disruptive behaviors
 - Videotapes which recall former occupation or hobby (e.g., farming or fishing)
 - Consider repositioning, hand massage, backrub, or other muscle relaxation techniques
 - Perform and document pain assessments when behaviors occur (behaviors could be a sign of discomfort and/or pain)
 - Document and offer any security items, religious trinkets, the need for a blanket or shawl, or a particular item of apparel (e.g. favorite hat or scarf)
 - Document and offer the resident's favorite beverage or snack (as long as there are no medical restrictions)
- If pharmacological interventions are utilized, at least daily side effect monitoring must be documented (to be discussed later and in other sections separately)

Evaluate: Have a system to evaluate and review the non-pharmacological and/or the pharmacological interventions on episodes of behavior

- Evaluations are completed at least quarterly and involve input from an interdisciplinary team
- Re-address all potential environmental causes (e.g., improper lighting, temperature of room, level of noise, etc.)

- Re-address potential boredom and ensuring that meaningful activities are provided (spiritual activities, art or hobbies, pet therapy, etc.)
- Review the progress seen with restorative programs (input regarding positive outcomes is multi-disciplinary)
 - Occupational therapy
 - Physical therapy
 - Speech therapy
- Gain input from the social worker. Social services personnel can provide insight into unmet needs, worries and fears, and family related issues.
- Discuss progress/or lack thereof with the activities director. Activities may be offered in the facility but there may be barriers. Barriers to actual participation: such as cognitive ability, physical incompatibilities, the need for cueing to participate, or group size and level of noise may also be a deterrent for some. Find these barriers and attempt to minimize them if possible.
- Is there new or relevant input from the staff, interdisciplinary team, or family members
 - Review the reports from psychotherapists, psychiatrists, and physician's progress notes (changes in diagnoses may have been overlooked)
 - If any medications were changed since the last evaluation, are there any new complications or changes in condition (directly or indirectly related)
 - "Necessary medications" in the drug profile may be causing complications (e.g. anticholinergic side effects or orthostatic hypotension)
 - Discuss all alternative therapies that were performed (both effective and ineffective therapies) with other medical disciplines for professional input
 - Discuss the family's views, needs, and concerns regarding both non-pharmacologic and drug therapies
 - Has the family noticed any significant changes from baseline (either positive or negative)
 - Is there any input from auxiliary staff which may be useful (i.e., housekeeping or maintenance staff)
- Review the quarterly MDS to discuss care area triggers (CATs) which may be indicators of potential problems or changes in condition (e.g., cognition, depression, pain, etc.)
- Review the current care plan for any changes of condition which could explain new behaviors. Individually tailored care plans that help caregivers and staff address behavioral challenges are developed, recorded, and reviewed regularly by an interdisciplinary team.
 - Have there been any recent falls since the last quarter's review (possible unrecognized pain)?
 - Is there a change in continence requiring new cares?
 - Are there newly discovered pressure ulcers?
- Do non-pharmacological therapies need to be adjusted or changed due to a change of condition, functionality, or cognitive ability?
 - Simplify tasks
 - Don't overestimate the person's ability to complete or engage in tasks
 - Allow rest between stimulating events
 - Provide cues or reminders routinely
 - The need for a security object (e.g., meaningful religious item, photograph, favorite apparel item, plush or textured item, baby doll, etc.)

- Review the observations noted on the behavior/side effect monitoring system for both non-pharmacological and/or pharmacological interventions. There is a high rate of spontaneous recovery (placebo effect) in trials. Watchful waiting may be useful in less severe problems, since behavioral issues may be self-limiting.

During the daily morning meetings, discuss any residents exhibiting negative behaviors and decide whether monitoring of behaviors (pre-medication) may be necessary.

- Discuss the targeted behaviors which need to be addressed
- Discuss the non-pharmacological strategies which can be attempted
- Discuss the behavior monitoring process and the expected observational data which needs to be documented

Review sections of the MDS, particularly those related to behavioral issues before starting any new psychotropic medications. New relevant information or significant changes can be gleaned from a thorough quarterly review which may bring to light unmet needs or changes of condition. Additions or alterations in the resident's care plan may need to be discussed to minimize conflicts which may be unrecognized.

- Section B: Hearing, Speech, and Vision
 - Can identify individuals with hearing or visual difficulties which are either minimized or resolved
 - Can identify individuals with communication issues (inability to be understood and or inability to understand)
- Section C: Cognitive Patterns (calculation of the BIMS score)
 - Inattention problem can be identified
 - Orientation difficulties can be established
 - Inability to register and recall information can be recognized.
- Section D: Mood (the PHQ-9 interview)
 - Can identify individuals with mood/depressive distresses
 - Can be a screening indicator for potential depression
 - Mood/depressive distress, when identified is treatable
 - Mood/depressive distress when untreated can lead to deterioration in health
- Section E: Behavior
 - Can identify behaviors which are distressing to either the resident or others
 - Early identification can diminish risk of injury (harm to self or others)
 - Identify the risk of behaviors escalating or worsening functional abilities
 - Can be helpful in identifying the behavior's frequency and impact on others
 - Can be helpful in establishing an early plan of action (including the need for non-pharmacological and/or medical interventions)
- Section F: Preferences for Customary Routine and Activities
 - Information can be gathered directly from the resident or the family (if the resident is not able to communicate)
 - This information is also known as "hearing the resident's voice"
 - Use as a guide toward resident-centered preferences

- Section G: Functional Status
 - Can identify changes in functional status with the activities of daily living
 - Loss of independence can be seen as a loss of personal controls
 - Behavioral issues can arise if changing needs are not identified
 - Identifying issues that reduce frustrations for both the resident and staff
- Section H: Bladder and Bowel
 - Can identify issues with dignity and discomfort associated with elimination
 - Can establish the need for a toileting program
- Section J: Health Conditions (pain, shortness of breath, and falls)
 - Can identify health conditions that impact the resident's functional status
 - Can identify pain or discomfort which may not be addressed properly
 - Can identify other health conditions such as shortness of breath, and increasing number of falls
 - Changes in medication needs can be recognized in this section

Run internal reports to identify those residents already on psychotropic medications so individualized person-centered non-pharmacological interventions can be re-addressed routinely.