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ABOUT THE CLINICAL CONSIDERATIONS OF ANTIPSYCHOTIC MANAGEMENT TOOLKIT

The Clinical Considerations of Antipsychotic Management Toolkit is a clinically-focused resource containing steps and objectives, expectations at each step, and offers or identifies tools and resources that will help you meet performance expectations and outcomes. It identifies the steps that need to be taken in order to clinically manage individuals who are taking antipsychotic medications, in attempting gradual dose-reduction, and to lower the off-label use of medications.

The model used for the toolkit framework is the Nursing Process, also referred to as the Care Delivery Process, with the addition of two steps. The Nursing Process steps include: recognition/assessment, diagnosis/clinical judgment, outcomes planning, implementation, and evaluation. The additional steps include: leadership and staff training. This model was chosen because it is one that nurses are familiar with, it is comprehensive and ongoing, and incorporates input from various disciplines. The model is a universally acknowledged method used to identify and address complex issues. It is consistent with standard problem-solving and quality improvement.

In keeping with recommended quality improvement approaches, the Leadership and Staff Training sections were added to the toolkit. Nursing center leaders/supervisors need to be invested and lead this quality improvement effort with input from all staff, residents, families and practitioners. This section of the framework details the support leadership must provide to ensure quality improvement success.

The Staff Training section was added to support the need for staff education in order to meet the center’s quality expectations to safely lower antipsychotics.

This toolkit is designed to assist centers in moving toward a more appropriate decision-making process for antipsychotic medication use. However, it does not provide a comprehensive package of all aspects of care.
## THE CLINICAL CONSIDERATIONS OF ANTIPSYCHOTIC MANAGEMENT FRAMEWORK

To access the tools or resources, click on the tool/resource name appearing in each section of the framework.

<table>
<thead>
<tr>
<th>STEPS / OBJECTIVES</th>
<th>EXPECTATIONS</th>
<th>TOOLS / RESOURCES</th>
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</table>
| Leadership                       | • Know your facility’s antipsychotic prevalence rates (short & long-stay) by using CMS Quality Measures (QM) when available, AHCA and/or facility data  
• Set a facility antipsychotic quality measurement goal – focus on outcomes  
• Make sure all supervisors, staff and physicians are aware of and understand the goal  
• Make sure employees know their performance expectations  
• Hold employees accountable for following care process steps  
• Make regular employee rounds to address questions about the goal  
• Ensure all staff are trained on how to identify unmet needs and nurses are trained on recognizing common antipsychotics  
• Recognize departments and staff doing well in implementing process and using tools | • Nursing Process Approach for Antipsychotic Drug – Gradual Dose Reduction  
• Antipsychotic Prescription Log  
• Sample Facility Policy for Use of Antipsychotic Medications  
• Sample Antipsychotic Physician Memo  
• LTC Trend Tracker: [www.lctrendtracker.com](http://www.lctrendtracker.com) |
| Recognition/Assessment           | • Be able to recognize antipsychotic drugs commonly used in the LTC setting and the issues surrounding the use of these drugs  
• Observe resident behaviors  
• Describe behavior/symptom details like onset, intensity, duration, severity to self and/or others  
• Identify change in level of consciousness (e.g. alert, drowsy, stuporous, comatose)  
• Determine the necessity to control or limit behavior  
• Assess mood, thinking, function, and behavior within 24 hours of admission if an individual is taking an antipsychotic or identified as having a behavior problem  
• For individuals taking antipsychotics, identify where and why treatment started and how effective/problematic the treatment has been | • INTERACT Care Path for Mental Status Change: [www.INTERACT2.net](http://www.INTERACT2.net)  
• Other Resources  
  Individual's medical record, progress notes, hospital discharge summary, MAR, Stop and Watch Reports, and latest MDS assessment |
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| **Diagnosis/Clinical Judgment**  
Use existing medical information and assessment data to form an opinion about probable cause(s) of behavior/symptom | • Review assessment and observation data  
• Evaluate psychiatric reports  
• Contact family and/or others who may provide insight about behavior or add to medical history  
• Systematically determine if the behavior/symptom(s) are likely related to:  
  o medical condition  
  o use of an antipsychotic drug  
  o the current medication regimen  
  o psychosocial/unmet need  
  o environmental cause | [Approach to Considering Causes of Behavior Algorithm](#)  
[Guidance to Using the Behavioral Approach Algorithm](#)  
INTERACT Change in Condition Cards: [www.INTERACT2.net](http://www.INTERACT2.net) |
| **Outcomes Planning**  
Collect pertinent information as the basis for having identified a specific cause or causes of the problematic behavior/symptom | • Contact your consultant pharmacist to identify/verify high risk medications most likely related to behavior/symptom  
• If antipsychotic drug use is likely part of the problem, consider discussing possible gradual dose reduction or drug discontinuance with the physician | [Antipsychotic Medication Tapering Checklist](#) |
| **Implementation**  
Organize and prepare assessment findings and information to be discussed with the physician  
Identify specific goals for managing the behavior/symptom  
After consultation with the physician, document the basis for having identified the problem/symptom(s) and basis for the cause of behavior/symptom | • Collaborate with practitioners to identify possible urgent situations such as delirium or psychosis  
• Discuss your finding with the practitioner and work together to form a care plan and next steps  
• Discuss and document why causes were not sought or efforts to identify them were not fruitful  
• Implement/update care plan to address causes of behavior/system(s)  
• If indicated, develop a plan to taper or discontinue antipsychotic treatment  
• As much as possible, the plan should include non-pharmacological and behavior management strategies  
• Adapt or adjust the environment to minimize related causes  
• Include family in the plan development and approval of plan  
• Document in the medical record the basis for interventions | [Antipsychotic SBAR](#)  
**What Is CHAT?**  
**Relevant CHATs**  
Agitation CHAT  
Altered Mental Status CHAT  
Dizziness/Unsteadiness CHAT  
Fall CHAT |
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<td><strong>Evaluation</strong></td>
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<tr>
<td>Monitor responses to interventions for each individual and adjust them accordingly</td>
<td>• Monitor for care plan effectiveness</td>
<td>Antipsychotic Medication QA Review Tool</td>
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<td></td>
<td>• Review each resident’s medication regimen for high risk medications and the appropriateness of continued use of any antipsychotic or other psychopharmacological medications</td>
<td>Assessment of Resident Receiving Psychotropic Medication</td>
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<tr>
<td></td>
<td>• Form a Behavior Management Team to identify unmet needs and monitor and document the effectiveness of interventions</td>
<td></td>
</tr>
<tr>
<td>Identify and address complications related to interventions</td>
<td></td>
<td></td>
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<tr>
<td>Monitor facility frequency of antipsychotic drug use and the effectiveness of strategies</td>
<td></td>
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<tr>
<td><strong>Staff Education</strong></td>
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<tr>
<td>Ensure that staff have the knowledge and skills needed to appropriately provide care to individuals with behavior/symptom(s)</td>
<td>• Instruct clinical staff on how to recognize and identify antipsychotic drugs commonly used in the LTC setting</td>
<td>Antipsychotic Drugs Common Terms and Definitions</td>
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<td>• Instruct clinical staff on how to apply a systematic approach to collecting, analyzing, documenting, and reporting medical information and clinical findings for potential cause for behavior/symptom</td>
<td>Case Study 1: Behavior Issues in a Resident Who is Already Receiving Psychopharmacological Medications</td>
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<tr>
<td></td>
<td>• Educate all staff in identifying unmet needs</td>
<td>AHCA’s Suggested Tools for Reducing Off Label Use of Antipsychotics: How These Tools Can Improve Regulatory Compliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>University of Iowa – Improving Antipsychotic Appropriateness in Dementia Patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="https://www.healthcare.uiowa.edu/igec/IAADAPT">https://www.healthcare.uiowa.edu/igec/IAADAPT</a></td>
</tr>
</tbody>
</table>
USING THE NURSING PROCESS APPROACH TO CONSIDER GRADUAL DOSE REDUCTION (GDR)
Tapering For Off-Label Use of Antipsychotic Medications

The best approach to considering GDR is person-centered. Before contacting the individual’s physician to discuss potential dose reduction, it is important for the nurse to follow the nursing process and gather observations and pertinent information. The nursing process uses clinical judgment to strike a balance between personal interpretation and research evidence. The process fosters the use of critical thinking to categorize clients issue and course of action. Below, the nursing process is applied to the nurse’s role when considering the potential for GDR for off-label use of antipsychotic medication.

Nurse/Interdisciplinary Team Assessment

- Conduct an assessment and identify conditions possibly related to drug side-effect(s).
- Review most recent MDS assessment for mood, function, behavior, evidence of delirium and facility-based behavior tracking record. Compare to findings of the just completed assessment. Review most recent scoring tool (e.g., AIMS) and compare to prior score.
- Review medical record taking note of:
  - Psychiatric conditions, psychiatric hospitalizations, abnormal clinical and lab findings, and related physician, pharmacist, and psychologist notes.
  - Any GDR attempts during past 6 – 12 months and the outcome
- For individuals staying in the facility for longer periods of time:
  - Check the pharmacist’s recommendations recorded on the monthly medication regimen review for information related to drug doses, duration and continued need.
- Review the CNA Stop and Watch reports for changes in behavior, cognition, mood, ADL performance, and daily routine. (Stop and Watch is an INTERACT II tool).

Diagnosis/Clinical Judgment

- Identify symptoms that may be related to antipsychotic medication side-effects.
  - e.g. orthostatic hypotension, increase weight gain, increase glucose level, urinary retention, constipation, sedation, akathisia (restlessness, pacing, inability to sit still, anxiety, sleep disturbance), dystonia/torticollis - stiffness of neck, pseudoparkinsonism (drooling, tremors, rigidity, bradykinesia - slowness of movement, cogwheel rigidity - jerk responses of body muscles when force is applied while bending a limb), tardive dyskinesia (lip smacking/chewing, abnormal tongue movement, involuntary movement of arms/legs), dry mouth, blurred vision, worsening confusion/delirium, edema, blood abnormalities (increased triglycerides)
  - Evaluate if symptoms are old or new
- Is the individual at optimal ADL function and quality of life?
- Will GDR/tapering possibly improve the individual’s symptoms and functioning?
Outcomes/Planning

- Gather clinical information and diagnoses.
  - Include all medications currently taken by the individual, including:
    - Dosages and times of administration
    - Which of these medications may be contributing to issues and concerns?
- Gather information about drug considered for GDR
  - Current dose, time(s) of drug administration, and method of administration (tablets, capsules, liquid, injectable, IV).
  - How long has the individual been taking this drug?
  - Is the current drug dose at the lowest available dose? If so, does the dose provide the individual optimal quality of life and ADL functioning?
- Identify the non-pharmacological approaches used to help address challenging behavioral responses.
  - Did these approaches work?
- Note assessment findings in the medical record.

Implementation

- Complete the SBAR designed for nurse consideration of antipsychotic medication GDR.
- If the individual is over-sedated:
  - Hold the drug until the physician is contacted.
  - A lower dose or a different medication may be used if behaviors or symptoms requiring antipsychotic treatment emerge.
- Attempt non-pharmaceutical approaches to help address challenging behavioral responses (examples include: music therapy, exercise).
- When possible, inform the individual and his/her family and care staff about the plan for GDR to gain their understanding and support.
- Call the physician to discuss possible medication discontinuance or tapering.

Evaluation

- Assess the individual’s response to medication discontinuance or tapering.
- After one month, determine if the individual is at optimal ADL functioning and has an improved quality of life.
  - Repeat any clinical tests and labs ordered by the physician, and evaluate for improvement.
  - Evaluate the effectiveness of non-pharmaceutical approaches to challenging behavioral responses that have been employed, document and change if needed.
- Continue to evaluate and note medication reduction responses in the medical record. Notify the physician about further tapering or drug maintenance as necessary.
RECOMMENDED PHYSICIAN GUIDELINES FOR GDR

• Periodically review the progress of any resident receiving antipsychotic medications, including the frequency, duration, and intensity of any symptoms
• Review the resident’s overall condition and symptoms, to identify anything else that may be impairing behavior or mood stability
• At any time, if it is uncertain whether a psychopharmacological medication (including antipsychotic medications) is making a difference, consider initiating a trial reduction (e.g., lower dose, lesser frequency of administration) to see the effects
• If behavior is worse or at least not stable within 72 hours of initiating a psychopharmacological medication (including antipsychotic medications), review the working diagnosis and treatment to see whether a change in treatment may be indicated.
• For an antipsychotic medication prescribed for an acute episode (for example: during a recent hospital stay), consider a trial dose reduction if the medication's effectiveness or the need for continued treatment is uncertain.
• If the drug is currently at the lowest dose, consider a different approach to dose reduction (e.g., fewer doses per day, treatment every other day).
• It is generally prudent to reduce doses gradually (over several days to several weeks), to be able to observe for effects of medication reduction and to allow the brain to adjust to changes in chemical balances.
• For individuals taking an antipsychotic drug for one year, attempt dose reduction in two separate quarters with at least one month apart unless the individual is at optimal functioning.
• After longer than one year of drug therapy, attempt drug reduction once per year. If GDR is unsuccessful after two or more attempts, further reduction may be “clinically contraindicated.” Documentation is needed in the individual’s record why additional dose reduction will cause impairment, psychiatric instability, or exacerbate the underlying psychiatric disorder.

RESOURCES


The Long Term Care Survey, F-TAG 329. AHCA October 2010 Edition, pp. 441-555


Ryan Carnahan, Phar.D., M.S., BCPP, Assistant Professor (Clinical), The University of Iowa College of Public Health, Recommendations offer to Dr. Gifford, February 27, 2012
ANTIPSYCHOTIC PRESCRIPTION LOG

Download this Excel tool to help keep track for antipsychotic medication use in your organization.
SAMPLE FACILITY POLICY FOR USE OF ANTIPSYCHOTIC MEDICATIONS

(Facility Name)________________________________ recognizes that antipsychotics benefit only some residents and can be associated with side effects and risks. Therefore, when antipsychotic medications are used in our facility, the facility will identify target behaviors and implement a care plan with both non-pharmacological and pharmacological interventions. Potential adverse drug reactions and side effects will also be evaluated along with a plan for periodic attempts at dose reduction, where indicated or unless clinically contraindicated.
Date:

To: Facility Physicians
From: Facility Administrator / DON

Dear Doctors:

On May 30, 2012 Centers for Medicare and Medicaid (CMS) announced the Partnership to Improve Dementia Care, an initiative to ensure appropriate care and use of antipsychotic medications for nursing home patients. This partnership consists of federal and state entities, nursing homes and other providers, advocacy groups, and caregivers. The initiative was spurred by research showing that one quarter of Medicare beneficiaries in nursing homes are prescribed antipsychotic medications and that the use of these drugs may be beneficial but may also be associated with increased risk of death.

According to federal guidance, antipsychotics should not be used if the only indication for drug use is one or more of the following issues: wandering, poor self care, restlessness, impaired memory, anxiety, depression (without psychotic features), insomnia, unsociability, indifference to surroundings, fidgeting, nervousness, uncooperativeness, or agitated behaviors that do not represent a danger to the resident or others. CMS requires attempted gradual dose reductions of the antipsychotic and the use of behavioral interventions (unless clinically contraindicated).

In keeping with the Partnership to Improve Dementia Care, _____________________________ Nursing Center is focusing on dementia care and reducing the use of antipsychotic medications, when possible, to address disruptive behaviors. We would like you to be aware of our effort and to support our clinical staff in managing behavioral issues with the limited use of antipsychotics and to consider gradual dose reductions or eliminate medication use for individuals without a history of psychiatric illness or current psychiatric symptoms.

We appreciate your support in helping us provide the best possible care to the individuals we serve. If you have any questions or need further information, please contact _____________________________ (DON) at _____________________________ (phone number).

We cannot achieve success without you!
Approach to Considering Causes of Behavior

Rule out underlying potentially treatable conditions

Does the individual have delirium or other medical causes?

Yes

Identify and manage specific medical causes (e.g., medications, fluid/electrolyte imbalances, infections)

No

Does the individual have delusions and/or hallucinations?

Yes

IF severe psychotic symptoms, consider aggressive medication treatment. IF less severe symptoms: consider nonpharmacological interventions primarily

No

Does the individual have symptoms of a mood disorder?

Yes

IF mild to moderate: start with nonpharmacological measures. IF severe, consider medication

No

Does behavior of concern persist?

Yes

Is behavior causing substantial distress or risk of harm to self/others?

Yes

Review and reconsider diagnosis and any current interventions. Identify and address underlying needs

No

Identify and address underlying needs on ongoing basis

No

Consider new or modified medication regimen, as indicated, based on appropriate protocols
GUIDANCE TO USING THE CONSIDERING CAUSES OF BEHAVIOR ALGORITHM

How to Use the Algorithm

This algorithm, entitled, “Approach to Consider Causes of Behavior,” is intended to provide a framework for thinking about medical and psychiatric conditions that cause or contribute to behavior, especially when:

• The situation is not simple (that is, something other than a straightforward intervention that readily corrects an identifiable cause).
• The causes are unclear.
• Interventions have been based mostly on conjecture.
• Behavior details or patterns are markedly different than baseline or anticipated.
• Behavior is accompanied by other symptoms, abnormalities or changes in condition, such as falling, loss of appetite, unstable vital signs, breathing difficulty, and change in level of consciousness.
• The individual is getting worse despite interventions, or initial or previous interventions are not working or not working as well as anticipated.

How to Do Cause identification

The algorithm focuses on cause identification. Cause identification is always preceded by recognition, description (organizing a story of what is happening) and assessment (gathering details). Effective cause identification (including, for doctors, diagnosis) depends heavily on the clarity and pertinence of information gathered by the nurse during assessment and the organization and completeness of the “story” of the situation.

The cause identification steps include:

• **Observe** and describe the situation in detail (what happened, in what sequence, who was involved, when, how often, how severe, etc.) and give the sequence of events before, during, and after the behavior occurred.
• **Gather** more details about the individual (past history, medications, environment, specific findings such as presence of hallucinations or paranoia, etc.).
• **Organize** the information.
• **Plan** by identifying appropriate interventions, based as much as possible on the thinking about likely causes.
• **Review** the information with a practitioner and discuss what the information leads to about possible or likely underlying causes.

When to Use the Algorithm

The algorithm is designed for nurses and practitioners. It can be used at a safety meeting/huddle or any interdisciplinary team meeting about the resident where the underlying causes of behavior are discussed.

For more direction on how to identify the causes of behavior, go to the [Case Study 1: Antipsychotic Drug issues](#).
## OUTCOMES PLANNING

### ANTIPSYCHOTIC MEDICATION TAPERING CHECKLIST

<table>
<thead>
<tr>
<th>Tapering More Likely to Succeed If</th>
<th>Potential Problems If</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a clear and detailed picture of the individual’s cognition, mood, and behavior, including accurate diagnoses and identification of underlying causes</td>
<td>The picture of the individual’s cognition, mood, and behavior are muddled, with vague descriptions, questionable or unconfirmed diagnoses, and unclear identification of underlying causes</td>
</tr>
<tr>
<td>The individual does not have delirium or acute psychosis</td>
<td>The individual has delirium or acute psychosis</td>
</tr>
<tr>
<td>The individual was not recently ill or hospitalized with significant medical illness that has affected mood, behavior, cognition, or function</td>
<td>The individual was recently ill or hospitalized with significant medical illness that has affected mood, behavior, cognition, or function</td>
</tr>
<tr>
<td>Individual’s behavior and mood have been stable for an extended period (weeks to months)</td>
<td>Individual’s behavior and mood have been unstable in recent weeks or only stable for several weeks</td>
</tr>
<tr>
<td>The reason why an antipsychotic was started is clear, based on reliable information</td>
<td>The reason why an antipsychotic was started is unclear and/or speculative</td>
</tr>
<tr>
<td>The individual is not taking any other medications that can cause psychosis and/or adversely affect behavior or mood</td>
<td>The individual is taking other medications (in any category, not just psychopharmacological medications) that can cause psychosis and/or adversely affect behavior or mood</td>
</tr>
<tr>
<td>There are specific goals related to target symptoms and a pertinent approach to documenting, monitoring, and reporting those target symptoms</td>
<td>There are no specific goals, or only vague ones, related to target symptoms and a pertinent approach to documenting, monitoring, and reporting those target symptoms</td>
</tr>
<tr>
<td>A practitioner is available and willing to help staff reassess the individual’s status during the period of medication tapering</td>
<td>A practitioner is unavailable, unable, or unwilling to help staff reassess the individual’s status during the period of medication tapering</td>
</tr>
<tr>
<td>The individual (where feasible) and family (or other substitute decision maker) are involved in the plan for tapering medication and monitoring results</td>
<td>The individual (where feasible) and family (or other substitute decision maker) are not involved in the plan for tapering medication and monitoring results</td>
</tr>
<tr>
<td>Effective non-pharmacological interventions have been instituted</td>
<td>Non-pharmacological interventions have not been successful in preventing or controlling symptoms</td>
</tr>
<tr>
<td>Previous attempts at tapering psychopharmacological medications were successful, and symptoms have not recurred to any significant extent</td>
<td>Previous attempts at tapering psychopharmacological medications were unsuccessful, and/or medications have had to be restarted previously or added, due to recurrence of significant symptoms</td>
</tr>
</tbody>
</table>

Using of the checklist:
1. Check off the applicable boxes for each of the 10 rows above.
2. Count the number of boxes checked in each column.
3. Tapering of an antipsychotic medication is more likely to succeed if substantially more items in the left-hand column are checked compared to the right-hand column.
4. To the extent possible, address the issues checked off in the right-hand column before or while attempting to taper an antipsychotic medication, in order to make successful tapering more likely.
IMPLEMENTATION

SBAR

Physician/NP/PA Communication and Progress Note

To Discuss Possible Drug Reduction for an Individual

Already Receiving an Antipsychotic Drug for Off-Label Use

Patient Name:

Date of Birth:

Medical record #:

Before Calling the MD/NP/PA:

- Evaluate the patient and complete the SBAR form
- Check VS: BP, pulse, respiratory rate, neurological check, lung sound, temperature, pain level
- Review chart for:
  - psychiatric conditions and/or hospitalizations
  - abnormal clinical and laboratory findings
  - recent physician or psychologist progress notes
  - notes on possible drug side-effects
  - pharmacist medication regimen review notes
- Be prepared to report on dosing changes, changes in target symptoms and potential side effects
- Have relevant information available when reporting (medication list including doses, method and time(s) of administration)
- Be prepared to have a list of all medications, including PRNs, and the individual's medical record

Situation

The drug and behavior (if problematic) I am calling about is _________________________________

Date drug started ___/___/___

Date of last dose adjustment and dosage change made ___/___/___

Individual’s symptoms has gotten worse/better/stayed the same since the drug started ________________

Have any potential side effects been noticed? __No __Yes (If yes describe)

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Things that make the symptoms worse

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Things that make the symptoms better (non-pharmacological approach)

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Other things that have occurred related to this symptom and treatment

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Background

Primary diagnosis and/or reason person is at the nursing home

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Pertinent mental health history

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Behavioral concerns identified by family

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Vital signs  BP______/______  HR______  RR ______  Temp______

Individual is on a scheduled pain management program ___Yes ___No

If yes, what medication interventions is the individual receiving?
Conditions (check all those that apply)

- orthostatic hypotension
- weight gain
- increase glucose level
- urinary retention
- constipation
- sedation
- restlessness
- pacing
- drooling
- tremors
- rigidity
- slowness of movement
- jerk body responses
- lip smacking/chewing/abnormal tongue movement
- involuntary movement of extremities
- worsening confusion/delirium
- fall

Other __________________________________________

Medication changes or new orders in the last two weeks __________________________________________

Recent Labs ____________________________________________________________________________

Allergies ________________________________________________________________________________

Any other data _____________________________________________________________________________

Assessment (RN) or Appearance (LPN)

(For RNs): The individual's symptoms appear (better/worse/same) ________________________________

I think the symptoms may be related to __________________________________________________________

Do you believe the individual has achieved a therapeutic dose? ___ No ___ Yes If yes: Do you believe dose reduction may be needed? __________________________________________________________

(For LPNs): The individual's symptom(s) appear (better/worse/same) ________________________________

Request

I suggest or request (check all that applies):

- Other (start/change non-pharmacological approach)
- Change in/stop current med order(s)
- Provider visit (MD/NP/PA)
- Continued monitoring
- Lab work

Staff name ________________________________ RN/LPN

Reported to: Name ________________________________ (MD/NP/PA)

Date ___/___/___ Time ___AM/PM

If to MD/NP/PA, communicated via: ________________________________

Phone (____) ____ - ______  In-person __

Progress Note (complete and place SBAR/progress note in medical record)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

__ Family or health care proxy notified

Return call/new orders from MD/NP/PA Date___/___/___ Time___/___AM/PM

________________________________________________________________________________________

Signature ________________________________ RN/LPN Date___/___/___ Time___/___AM
WHAT IS CHAT?

CHAT stands for Communicating Health Assessments by Telephone. It is a quality improvement program to enhance telephone communication between the nurse and the physician.

The quality improvement program was developed by Heather Whitson, MD, S. Nicole Hastings, MD, Deborah Lakan, RNC, MSN, Richard Sloane, MPH, Heidi White, MS and Eleanor McConnell, RN, PhD from the Department of Medicine and the Center for the Study of Aging and Human Development and School of Nursing at Duke University, Durham, NC. The program was studied and conducted at Extended Care and Rehabilitation Center, Durham Veterans Affairs Medical Center. Funding support was provided by the AMDA Foundation and the John A. Hartford Foundation.

The purpose of the study program was to improve the communication of health assessment by telephone and determine whether satisfaction of on-site nurses improved after the CHAT intervention.

CHATs are point-of-care decision support tools adapted from the 2004 American Medical Director’s Association (AMDA) protocols. They represent 16 common clinical problems found in long term care settings. The common conditions include:

<table>
<thead>
<tr>
<th>Abdominal Pain</th>
<th>Agitation</th>
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</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>Altered Mental Status</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Low Blood Pressure</td>
</tr>
<tr>
<td>Chest pain</td>
<td>Constipation</td>
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<tr>
<td>Diarrhea</td>
<td>Dizziness/Unsteadiness</td>
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<tr>
<td>Dyspnea/Shortness of Breath</td>
<td>Fall</td>
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<tr>
<td>Fever</td>
<td>Hyperglycemia</td>
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<tr>
<td>Hypoglycemia</td>
<td>Musculoskeletal Complaint</td>
</tr>
<tr>
<td>Nausea or Vomiting</td>
<td>Urinary Complaints or Positive urinalysis</td>
</tr>
</tbody>
</table>

Each CHAT is designed to identify pertinent information that needs to be assessed and communicated for the specific clinical issue. The tools focus on the questions needing to be answered and the examinations needing to be conducted before calling the physician.
Patient Name: ____________________
Date of Birth: _________________
Medicaid Record Number: ______

CHAT: AGITATION/CONFUSION/ALTERED MENTAL STATUS

History
How long ago did the symptoms start? Tell the story: ________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Other symptoms or events in the last 24 hours:
Fall
Constipation
Medication changes
Cough
Fever
Pain
Urinary symptoms

Exam
Current vital sign ________________________________________________________________
Oxygen saturation ______________________________________________________________
Finger stick (blood glucose), if diabetic _____________________________________________

Other pertinent information may include neurological assessment, signs of injury, dehydration or infection.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Staff Name: _____________________________________________________________ RN/LPN

Reported to:
Name: ______________________ (MD/NP/PA) Date: __________ Time: ____ am ____ pm
If to MD/NP/PA, communicated via: __________ Phone __________ In person __________

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University)
CHAT Progress Note

Progress Note (complete and place CHAT/progress note in medical record)

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Family or health care proxy notified
Return call/new orders from MD/NP/PA ___________________________
Time___/___AM/PM ___________________________
Date___/___/___ ___________________________

Signature________________________________RN/LPN             Date___/___/___
Time___/___AM/PM ___________________________

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University)
CHAT: DIZZINESS/UNSTEADINESS

History
How long ago did this symptom start? Tell the story: ___________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Has the patient had these symptoms on other occasions? Tell the story: ________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Any changes to the medication list or doses in the last week? ____________________________
If yes, what medication changed? __________________________________________________

Any PRN medication doses given in the last 24 hours?
If yes, what medication? _________________________________

Exam
Blood pressure and pulse (sitting and standing): ______________ and _____________________
Finger stick (blood sugar), if diabetic: _______________________________________________

Other pertinent information may include a neurologic exam and assessment of mental status.
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Staff Name: _______________________________________________________________

Reported to:
Name: _______________________________(MD/NP/PA)  Date: _______ Time: ______ am __pm __
If to MD/NP/PA, communicated via: __________ Phone _______________ In person ______

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University.)
Patient Name: ___________________________
Date of Birth: ___________________________
Medicaid Record Number: _________________

CHAT Progress Note

**Progress Note** (complete and place CHAT/progress note in medical record)

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__Family or health care proxy notified

Return call/new orders from MD/NP/PA Date___/___/___
Time___/___AM/PM

Signature________________________________RN/LPN Date___/___/___
Time___/___AM/PM

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University)
Patient Name: ___________________________
Date of Birth: ___________________________
Medicaid Record Number: _________________

CHAT: FALL

History
Is the patient having new pain anywhere since the fall? Tell the story: _________________
_____________________________________________________________________________
_____________________________________________________________________________

Did the patient hit his/her head? Tell the story: _________________
_____________________________________________________________________________
_____________________________________________________________________________

Any loss of consciousness before or after the fall? Tell the story: _________________
_____________________________________________________________________________

Exam
Can the patient ambulate as well as he/she could before the fall? _________________

Any obvious injuries (lacerations, deformities)? _________________

Blood pressure and pulse (sitting and standing) _________________

Other pertinent information may include joint assessment for range of motion, assessment of mental status (level of consciousness, orientation, speech), blood glucose if patient is diabetic.
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Staff Name: ______________________________________________________(RN/LPN) _________

Reported to:
Name: ____________________ (MD/NP/PA) Date: _______ Time: ______ am __ pm __

If to MD/NP/PA, communicated via: _______ Phone _______ In person

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University.)
Patient Name: ___________________________
Date of Birth: _________________________ 
Medicaid Record Number: _________________

CHAT Progress Note

Progress Note (complete and place CHAT/progress note in medical record)
_____________________________________________________________________________________
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____Family or health care proxy notified
Return call/new orders from MD/NP/PA Date___/____/___
Time___/____AM/PM

Signature________________________________RN/LPN Date___/____/___
Time___/____AM/PM

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University)

Developed by
Heather Whitson, MD; Susan N. Hastings, MD; Eleanor McConnell, RN, PhD (GRECC)

ECRC Steering Committee:
Cheryl Barker, RN; Alison Bingman, GNP; Nicole Davis, GNP; Linda Fish, RN; Lily Foster, RN; Mary 
Francis, RN; Ruth Frank, RN; Lorraine Galkowski, RN; Linda Heeg-Krause, RN, Carol Paniccia, RN;
Jennifer Shaffer, RN; Mary Tatum, RN; and Janette Warsaw, RN

Designed by
Lesa Hall, Medical Illustrator

Reference:
AMDA – Protocols for Physician Notification 2004

Funding Support:
AMDA Foundation and the John A. Hartford Foundation
EVALUATION

ANTIPSYCHOTIC MEDICATIONS QA REVIEW TOOL

The Antipsychotic Medications QA Review Tool is intended to be used by centers to help evaluate prescribing and gradual dose reduction decision making practices. The tool is structured to follow nursing process and should be used to evaluate adherence to process with regard to treatment and care plan decisions involving medication use, reduction or discontinuation. Evaluate question responses to determine practice improvement areas.

<table>
<thead>
<tr>
<th>RECOGNITION</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there documentation of the details of any potentially problematic behavioral responses?</td>
<td></td>
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<tr>
<td>2. Is there a clearly documented rationale for why a behavioral response is considered problematic?</td>
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<tr>
<td>3. Is there documentation of a careful review of the medication regimen, including review for medications that impact behavior, mood, and cognition?</td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CAUSE IDENTIFICATION</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Is there documented effort to review underlying medical and nonmedical causes of problematic behavioral responses, beyond attributing them to dementia or sundowning?</td>
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<tr>
<td>5. Did you ask the resident and/or the family directly about a possible cause/trigger of their behavior?</td>
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<tr>
<td>6. Are direct caregivers consulted about possible cause/trigger of behavior?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MANAGEMENT</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
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<tbody>
<tr>
<td>7. Are there specific goals and objectives for responding to a resident’s behavioral expressions?</td>
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<tr>
<td>8. Is there a documented rationale for choosing and implementing specific interventions, including non-pharmacological approaches?</td>
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<tr>
<td>9. Is there a documented rationale for initiating or continuing to use any medications in any category that can affect mood, cognition, level of consciousness, or behavior?</td>
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<tr>
<td>10. Is the resident and family involved in the decision to stop or continue medication and other care plan decisions?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MONITORING</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
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<tbody>
<tr>
<td>11. Is there evidence of ongoing monitoring/documentation of an individual’s responses to interventions and related adjustment of interventions?</td>
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<tr>
<td>12. Is there evidence of ongoing monitoring/documentation for complications of any interventions and for addressing the causes of such complications?</td>
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<tr>
<td>13. Is there a documented rationale, included in the care plan, for initiating, continuing, or modifying any interventions, including antipsychotics?</td>
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</table>
ASSESSMENT OF RESIDENT RECEIVING PSYCHOTROPIC MEDICATION

The goal of this assessment is to review residents who are receiving psychopharmacological medications. The tool can be used to guide discussion in reviewing resident behavior during Risk or Care Management and/or Standards of Care Committee meeting where appropriate interdisciplinary members are in attendance, for example, Pharmacy Consultant, Medical Director, Behavioral Health Specialists, etc.

Use this tool for all residents admitted on psychotropic drugs and periodically after the medication has been started and/or severity of symptoms noted.

Resident Name: ________________________________________________________________

Date of Admission: _____________ Date of initial medication assessment: _______________

Previous living arrangements prior to admission (check appropriate selection):

Home ___  AL ___  SNF ___  Other _______________ ______________

BIMs Score * _______ Date ________ or    MMSE Score*__________Date _________

List psychotropic drugs including antipsychotics, anxiolytics, sedative/hypnotics, antidepressants, and other drugs used to treat psychiatric/behavioral disorders or symptoms

<table>
<thead>
<tr>
<th>Drug Name/Dose</th>
<th>Directions</th>
<th>Diagnosis/Indication</th>
<th>Start Date (If known)</th>
<th>Effective/Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Behaviors that prompted initiation of above medications; if not known, describe behaviors observed since admission: _______________________________________________________

_____________________________________________________________________________

Discussion at meeting is focused on effectiveness and relevance of continuing the medication. Also consider potential benefits of tapering and/or a trial off of psychotropic drugs, especially of antipsychotics and hypnotics. The following questions may prompt discussion.

- Have non-drug interventions been attempted in the past? If so, what have been the results and what interventions have been used?
- Has pain been assessed and managed?
- What are the possible needs the resident may be trying to communicate behaviorally?
- Are behaviors causing negative outcomes/ disturbing for the resident?
- Could behaviors be addressed by staff intervention instead of medication?
Could behaviors be addressed by staff intervention instead of medication?

Can these interventions be implemented routinely? If not, what are the barriers?

Have medical causes been addressed? (i.e. metabolic and endocrine disorders, infections, etc.)

Is staff response contributing to or increasing behaviors?

Are families concerned about behaviors typically found in AD?

Are family interactions with resident contributing to or increasing behaviors?

Previous successes or failures with medications?

Is the resident experiencing side effects from the medications? Are there other medications that might be contributing to behaviors?

Would a tapering or trial off antipsychotic or hypnotic meds be appropriate at this time?

If so, why? If not, why not?

Note: If a tapering or trial off is implemented, monitor carefully using behavior monitoring sheets.

Summary of discussion:

Recommendation(s) and Action Plan:

Identify team members completing this assessment: ______________, ______________, ______________, ______________, ______________, ______________.

Date of follow up assessment: ____________________________

Summary of behaviors since changes implemented:

Further recommendation(s) and Action Plan:

Identify team members completing this assessment: ______________, ______________, ______________, ______________, ______________, ______________.

* MMSE – Mini Mental State Exam     BIMs – Brief Interview of Mental Status
ANTIPSYCHOTIC DRUGS – COMMON TERMS & DEFINITIONS

Atypical Antipsychotic (Second Generation) – Is a newer class of antipsychotic medication approved by the U.S. Food and Drug Administration (FDA) primarily for the treatment of schizophrenia and bipolar disorder.

There are currently 9 FDA-approved atypical antipsychotic drugs including:

1. Aripiprazole (Abilify) – Schizophrenia, Bipolar, and as added therapy for major depressive disorder
2. Asenapine (Saphris) – Schizophrenia and bipolar disorder
3. Clozapine (Clozaril) – Schizophrenia (restricted distribution)
4. Iloperidone (Fanapt) – Schizophrenia
5. Olanzapine (Zyprexa) – Schizophrenia, Bipolar, and as added therapy for treatment-resistant major depressive disorder
6. Paliperidone (Invega)– Schizophrenia and schizoaffective disorder
7. Quetiapine (Seroquel) – Schizophrenia, Bipolar, and as added therapy for major depressive disorder (Seroquel-XR)
8. Risperidone (Risperdal) – Schizophrenia and Bipolar
9. Ziprasidone (Geodon) – Schizophrenia and Bipolar

Behavioral Interventions are individualized non-pharmacological approaches (including direct care and activities) that are provided as part of a supportive physical and psychosocial environment, and are directed toward preventing, relieving, and/or accommodating a resident’s distressed behavior.

Black Box Warning refers to the FDA warning to communicate the risks associated with increased mortality in elderly patients with dementia-related psychosis treated with antipsychotic drugs.

Environmental Causes of Behavior are situations or factors external to the individual that may cause or contribute to exacerbations of behavior and psychiatric symptoms; for example, level/type of stimulation, noise, confusion, lighting, caregiver approach, institutional routines/expectations, and lack of cues.
Extrapyramidal symptoms (EPS) are neurological side effects of medications (including, but not limited to, antipsychotic medications) that result from an imbalance of the extrapyramidal nervous system. EPS includes various syndromes such as:

- Akathisia, which refers to a distressing feeling of internal restlessness that may appear as constant motion, the inability to sit still, fidgeting, pacing or rocking.

- Pseudoparkinsonism is a syndrome of Parkinson-like symptoms including tremors, shuffling gait, slowness of movement, expressionless face, drooling, postural unsteadiness and rigidity of muscles in the limbs, neck and trunk.

- Dystonia, which refers to an acute, painful, spastic contraction of muscle groups (commonly the neck, eyes and trunk) that often occurs soon after initiating treatment and is more common in younger individuals.

Gradual Dose Reduction (GDR) is the stepwise tapering of a dose of medication to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.

Off-Label use of Antipsychotic Antipsychotic drug used for indications other than those that are approved by the FDA.

Psychiatric Causes of Behavior are commonly recognized disorders (e.g., depression, delirium, psychosis, personality disorders) that appear to cause or contribute to behavior and related symptoms.

Psychoactive Medication (or Psychotropic Medication) is a chemical substance that crosses the blood-brain barrier and acts primarily upon the central nervous system where it affects brain function, resulting in changes in perception, mood, consciousness, cognition and behavior.

Typical Antipsychotic (First Generation Antipsychotics, Neuroleptics, or Major Tranquillizers) refers to the original group of medications that were first used successfully to treat primary psychotic disorders such as schizophrenia. Common First Generation drugs include Compazine, Haldol, Loxitane, Mellaril, Moban, Navane, Orap, Prolixin, Stelazine, Thorazine, and Trilafon.

Unmet Physical Needs are basic human physical conditions or needs that have yet to be satisfied, for example; pain, illness, hunger, sleep disturbance, constipation, elimination needs. {NOTE: Medication is not a physical need; it is a treatment for physical or other needs.}

Unmet Psychological Needs are imbalances related to basic human emotions, for example; loneliness, boredom, apprehension, worry, fear, lack of socialization, loss of intimacy.
CASE STUDY 1: BEHAVIOR ISSUES IN A RESIDENT WHO IS ALREADY RECEIVING PSYCHOPHARMACOLOGICAL MEDICATIONS

The Story - Part 1

The Patient: Mr. Donald Lee, born in February 1925, admitted to the facility in September 2011.

Problem Statement: Donald is an 87-year-old male with advanced dementia who has been a resident in the facility for 5 months. Until recent weeks, he had been relatively stable. In the past few weeks, his behavior issues have become more frequent, problematic and unpredictable. He had become increasingly restless and combative over several weeks. Sleep was very poor with continuing restlessness throughout the night. He has had a colostomy for several years. Recently, he had begun pulling on and dislodging his colostomy. He has become increasingly combative and restless, with a shorter than usual attention span. Repeated efforts to redirect his behavior failed. He talks incessantly and despite being asked repeatedly about personal needs, his responses were not relevant. He has a very short attention span. Staff was unable to keep him engaged in any activities.

“The Story” – Background:

- Donald was admitted to the facility immediately after hospitalization due to a fall down steps at home that caused a subdural hematoma.
- Admission diagnoses included cerebellar mass, subdural hematoma, dementia, dysphagia, atrial fibrillation, peripheral vascular disease, hypertension, COPD, hypothyroidism, polymyalgia rheumatica, glaucoma, history of resected rectal carcinoma with colostomy and depression.
- Donald had lived at home with his wife, who comes and visits him daily. He has a daughter who is very involved in his care.
- During his working days, Donald was a Marine. He has been retired for many years. He was a smoker and has significant chronic obstructive pulmonary disease (COPD) and heart disease.

Medications and Outcomes:

- On admission to the facility, his key medications included Sertraline 25 mg hs for mood disorder, Levothyroxine 0.050 mg qd for hypothyroidism, Namenda 10 mg qd for dementia, Prednisone 10 mg qd for COPD, Digoxin 0.125 mg qd for atrial fibrillation, and Tramadol 25 mg q8h PRN for pain.
- Namenda was subsequently increased some time after admission to b.i.d. Olanzapine 2.5 mg qd PRN was added for severe agitation. Melatonin 2 mg hs was added to help with sleep.
- On 4/1/12, Olanzapine 2.5 mg qd PRN was discontinued. There was no improvement noted.
- On 4/2/12, Sertraline was changed to every other day. No improvement was noted.
- On 4/19/12, Melatonin was increased from 2 to 3 mg hs. No improvement in his sleep was noted.
- On 4/23/12, Risperdal 0.25 mg was ordered for 3 days. A psychiatric consultation was requested.
- On 4/30/12, the psychiatrist recommended discontinuing Melatonin and Zoloft and starting Risperdal 0.25 mg qhs for possible dementia with mania. No improvement was noted.
- On 5/1/12, a Digoxin level was within the therapeutic range. Donald was restless and up much of the night.
- On 5/2/12, Trazodone 25 mg qhs was ordered with no improvement in sleep noted.
- On 5/7/12, staff noted an acute change in mental status and found Donald difficult to arouse.
Teaching: Part 1

Communicating with the Attending Physician about the Resident’s Change in Condition

Have nurses review the background information for Donald Lee and then instruct them to respond to the questions below.¹

1. What information is least relevant to have in preparation for the call?
   - a. Resident history of advanced dementia
   - b. He has a history of COPD
   - c. Increasing incidents of restlessness and problem behavior
   - d. Recent history of dislodging his colostomy

2. When using the SBAR communication technique, the nurse’s initial statement to the physician should be?
   - a. I’m sorry to bother you about the resident
   - b. One of your residents seems to have a problem
   - c. Resident has a history of dislodging his colostomy
   - d. I’m concerned about Mr. Lee, he has an acute change in mental status and is difficult to arouse

3. In this situation, what patient data should be reported first?
   - a. Details of the current mental status change
   - b. Admission diagnoses
   - c. Outcomes of medication changes
   - d. Psychiatric consultation recommendations

4. Before discussing subsequent treatment or testing with the physician, the nurse should be prepared to
   - a. Discuss potential causes of the acute change in mental status
   - b. Review the resident’s story in chronological order
   - c. Review the current medication regimen
   - d. All of the above

Answers

1. B – The resident’s COPD history is not immediately relevant to this situation. A list of diagnoses is not nearly as helpful as a clear and concise description of current mental status, including behavior, mood, and cognition.
2. D – The first part of the SBAR is to clearly and concisely describe the situation. Giving the resident’s name, a clear and meaningful statement of the clinical problem and the nurse’s concern, alerts the physician to the problem.
3. A – Since the change in mental status is the primary current issue, this information should be presented first and will then set the foundation for offering and evaluating additional pertinent information.
4. D – The nurse’s communication with the physician, regardless of clinical problem, should always give enough information so that the practitioner can begin to think about possible causes of the symptom or problem, in order to identify, to the extent possible, parameters for monitoring and the need for possible diagnostic testing, follow-up, and changes in treatment. It is important to

¹ Questions adapted from NURSE.com, Nursing Spectrum (DC/Maryland/Virginia), Clinical Vignette, June 18, 2012, page 31.
give the practitioner time to think through the situation in order to do more than just guess about what is going on or what to do next.

Continuing Case of Donald Lee

- On 5/7/12, Donald was transferred to the hospital Emergency Room. Lab and diagnostic tests that were done in the hospital were unremarkable. The resident was returned to the facility without hospitalization.
- On 5/8/12, Trazodone was discontinued and Namenda was reduced from b.i.d. to daily.
- On 5/9/12, Risperdal was discontinued.

The Story – Part 2

How to Apply Critical Thinking/Reasoning to Determine Problem Cause:

Every discipline can contribute to cause identification, by following an appropriate process. When done by a health care practitioner, cause identification is referred to as “diagnosis.” Nurses and those of other disciplines can help practitioners by providing enough of the right information to allow thoughtful diagnostic decision making. Every discipline, including nursing, can potentially apply the same thoughtful approaches to improve other cause identification activities.

Once the nurses/interdisciplinary team have completed the “Communicating with the Physician about the Resident's Change in Condition” questions section, and have identified and discussed the correct answers, have the group focus on their Critical Thinking/Reasoning in trying to understand the cause of the resident’s issues. Critical Thinking/Reasoning can be accomplished by asking basic questions about the resident to distinguish between potential causes of the problem.

Clinical Thinking/Reasoning Question for Donald Lee

1. Could Mr. Lee have a medical cause of his behavior?
   - Could he be hypothyroid? He was taking a relatively low dose of thyroid replacement. His TSH on 9/19/11 was WNL (3.06). A repeat TSH on 3/23/12 was also WNL. Probability of hypothyroidism as a cause: very low.
   - Could he have an infection or heart failure? Chest X-ray 9/30/11 had shown small bilateral infiltrates and an L pleural effusion. In early 2/12, he had been hospitalized with pneumonia. However, there was no current clinical evidence of infections and lab tests were negative. Breathing and vital signs were unchanged. Probability of infectious or cardiac cause: unlikely.
   - Could Donald have delirium? The resident had a shortened attention span, frequent fluctuation in behavior and level of consciousness, increased level of involuntary motor activity (restlessness), and altered sleep cycle. All of these findings are consistent with delirium. Possibility of delirium: high.
   - Could Donald have some other contributing medical problem? He was not anemic. Despite his COPD, he was not hypoxic enough to account for these symptoms. Also, behavior issues fluctuated regardless of oxygen levels. Possibility of hypoxia: unlikely.

2. Could Mr. Lee have a medication cause for his behavior?
   - Could he have digoxin toxicity? Digoxin toxicity can cause various psychiatric symptoms. However, the serum digoxin level was in the middle of the therapeutic range. Probability of Digoxin toxicity: very low.
   - Could he have other medication-related adverse consequences? Prednisone can cause psychosis and other behavioral and mood changes. However, his dose was about equal to what the body produces
normally, and the dose had remained constant for years. Probability of prednisone-related cause: very low.

- Could he have side effects from his psychopharmacological medications? Sertraline had been continued under the presumption that the resident had a diagnosis of depression. However, it was not clear why or when this was started. There was no clear evidence that he had a mood disorder. Any psychopharmacological medications, including antidepressants and antipsychotic medications, can potentially exacerbate behavior and psychiatric symptoms. In this case, they were not helping improve the symptoms. His behavior was getting worse. Possibility of adverse effects from existing medication regimen: likely.

3. Could Mr. Lee have a psychiatric basis for his behavior?

- Could Donald have psychosis? He could have psychosis, although the condition was fluctuating more than it was escalating steadily. Hallucinations, delusions, and paranoia were noticeably absent. Antipsychotic medications did not result in symptom improvement. Possibility of psychosis: low.
- Could he have a mood disorder? He was already receiving an antidepressant, despite lack of evidence for a mood disorder. His symptoms represented more than simple anxiety. Possibility of mood disorder: unlikely.
- Could he have a personality disorder? There was no evidence of a personality disorder during his earlier years, and the symptoms were not compatible with that. Possibility of personality disorder: unlikely.
- Could he have simple dementia-related symptoms? The determination of dementia-related symptoms is reached by first ruling out other possible causes. In this case, other likely causes were identified. Possibility that this was simply related to dementia: unlikely.

4. Could Mr. Lee have a psychosocial or environmental cause for his behavior?

- Could Mr. Lee have unmet personal needs causing his behavior? Between staff and family, his needs had been addressed consistently since admission. His worsening behavior was ongoing regardless of his personal needs being met. When asked about personal needs and comfort, Mr. Lee’s responses were not coherent or relevant. Possibility of unmet personal needs: unlikely.
- Could he have environmental causes? His environment had not changed since admission. Throughout his stay, multiple psychosocial interventions were implemented without success. Symptoms persisted and were not correlated with the presence or absence of such interventions. Nothing was working. Effort to redirect behavior failed. Possibility of environmental factors: unlikely.
- Was he indicating that he did not want the colostomy by trying to remove it? From the time of admission until his recent episodes started, he had never expressed or shown discomfort with the colostomy previously. It had never caused him any complications. The pulling on the colostomy was not an isolated activity, but was associated with increasing restlessness and uncontrolled motor activity. He seemed unaware about what he had done. Possibility of behavior relating to not wanting his colostomy: unlikely.

Outcome of Critical Thinking/Reasoning

Based on the above critical thinking questions, the answers indicating Yes/Likely help narrow down the thinking about likely causes of the behavior. These outcomes include:

- Primary: He has delirium and side effects from psychopharmacological medications
- Secondary: He has a baseline of chronic, dementia-related behavior

The reporting nurse gives the practitioner enough information to engage in a meaningful conversation about these potential causes. Before and after the specific incident that is reported, the entire staff works with the

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AHCA/NCAL Quality Initiative - Antipsychotic Management Toolkit
practitioner to identify next steps (medication changes, monitoring, etc.) to test these hypotheses about causes.

The Subsequent Story of Donald Lee

After stopping his Sertraline and Trazodone and reducing the Namenda dose, there was a remarkable and rapid improvement. Donald became calmer, stopped pulling on his colostomy, slept much better at night, was easily directable, sat out in the hallway with his family, attended some activities, and was generally pleasant and responsive. He has remained stable for several months. However, he was just as confused and disoriented as before.

Teaching: Section 2

How to Apply Critical Thinking/Reasoning to Determine Problem Cause:

• When teaching a group of caregivers, consider using a Learning-Circle* approach. Ask clinicians to frame a question (Could the resident have …) and repeat the exercise until all possible questions are identified. Keep a list of the questions.

• Once all the questions are put forth, consolidate them by eliminating redundancies. It will be helpful to categorize question based on possible Medical Causes, Medication Causes, Psychiatric Causes, and Psychosocial/Environmental Causes.

• Discuss the answers to the questions and ask clinicians to identify and help staff understand the reasoning behind answers to the various possibilities, including Yes/Likely, Unlikely/No, and Probability High, Probability Low

• From the critical thinking exercise, have clinicians develop the key clinical assumption(s) and develop a SBAR in preparation for reporting to the physician on this case.

• Have clinicians use this approach in reporting to the physician in other cases (not just behavior or psychiatric issues).

*Learning Circle Resources
http://www.pioneernetwork.net/Data/Documents/LearningCircleKeane.PDF

http://www.iearn.org/circles/lcguide/ A teachers’ guide to cross-classroom collaboration on projects integrated with curriculum.
AHCA’S SUGGESTED TOOLS FOR REDUCING OFF-LABEL USE OF ANTIPSYCHOTICS:
How These Tools Can Improve Regulatory Compliance

AHCA suggests a number of tools that can be used in a facility to assist in the reduction of off-label use of antipsychotics. To help achieve compliance with some regulatory requirements that relate to the off-label use and reduction of antipsychotics, the ideal is to use all of these tools or tools with similar components. By using them effectively, a facility may not only reduce the off-label use of antipsychotics but may also receive improved regulatory compliance related to their use.

“Clinical Guideline: Managing Behaviors Expressed by Residents with Dementia” directs the nurse to assess and evaluate a resident using the SBAR algorithm. The review must include, at a minimum, seven specified areas. Communication with professionals as well as with the patient and the patient’s family are important elements of this Guideline.

The SBAR is a communication tool that assists a nurse effectively convey to a physician the assessment process that has been used to reach certain conclusions and recommendations. This tool may be used when a patient has experienced a significant change and when the nurse would like to discuss a different approach for the care or a patient.

Antipsychotic Medication Tapering Checklist provides a systematic way to determine the likely success of tapering an antipsychotic. When completed and added to a patient’s medical record, this provides strong support for the decisions made related to each patient and implementing a tapering regimen.

Both the Antipsychotic Medications QA Review Tool and the Assessment of Psychotropic Medications will provide necessary information and guide discussion and decision-making related to the use of psychotropic medications for individual patients. This can be done within or independent of the QA&A process.

Taken in total, these tools will assist a facility to be in compliance with the following F-Tags:

F157 – Notification of Changes
F154, F155 – Notice of Rights and Services
F272, F273, F274, F275, F276, F278 – All related to assessments, reassessments, or coordination of assessments
F279 – Comprehensive Assessments
F281 – Professional Standards of Care
F309 – Pain Management
F329 – Unnecessary Medications
F281 – Professional Standards
F428 – Medication Regimen Review
F520 – Quality Assessment and Assurance
The best approach to considering Gradual Dose Reduction (GDR) is person-centered. Before contacting the individual’s physician to discuss potential dose reduction, it is important for the nurse to follow the nursing process and gather observations and pertinent information. The nursing process uses clinical judgment to strike a balance between personal interpretation and research evidence. The process fosters the use of critical thinking to categorize clients issue and course of action. Below is the nursing process applied to the nurse’s role when considering the potential for GDR for off-label use of antipsychotic drugs.

**Nurse/Interdisciplinary Team Assessment**
- Conduct an assessment and identify conditions possibly related to drug side-effect(s).
- Review most recent MDS assessment for mood, function, behavior, evidence of delirium and facility-based behavior tracking record. Compare to findings of the just completed assessment. Review most recent scoring tool (e.g., AIMS) and compare to prior score.
- Review medical record taking note of:
  - Psychiatric conditions, psychiatric hospitalizations, abnormal clinical and lab findings, and related physician, pharmacist, and psychologist notes.
  - Any GDR attempts during past 6 – 12 months and the outcome
- For individuals staying in the facility for longer periods of time:
  - Check the pharmacist’s recommendations recorded on the monthly medication regimen review for information related to drug doses, duration and continued need.
- Review the CNA Stop and Watch reports for changes in behavior, cognition, mood, ADL performance, and daily routine. (Stop and Watch is an INTERACT II tool).

**Diagnosis/Clinical Judgment**
- Identify symptoms that may be related to antipsychotic drug side-effects.
  - E.G., orthostatic hypotension, increase weight gain, increase glucose level, urinary retention, constipation, sedation, akathisia (restlessness, pacing, inability to sit still, anxiety, sleep disturbance), dystonia/torticollis - stiffness of neck, pseudoparkinsonism (drooling, tremors, rigidity, bradykinesia - slowness of movement, cogwheel rigidity - jerk responses of body muscles when force is applied while bending a limb), tardive dyskinesia (lip smacking/chewing, abnormal tongue movement, involuntary movement of arms/legs), dry mouth, blurred vision, worsening confusion/delirium, edema, blood abnormalities (increased triglycerides)
  - Evaluate if symptoms are old or new
- Is the individual at optimal ADL function and has quality of life?
- Will GDR/tapering possibly improve the individual’s symptoms and functioning?
Outcomes/Planning

- Gather clinical information and diagnoses.
  - Include all medications currently taken by the individual, including:
    - Dosages and times of administration
    - Which of these medications may be contributing to issues and concerns?
- Gather information about drug considered for GDR
  - Current dose, time(s) of drug administration, and method of administration (tablets, capsules, liquid, injectable, IV).
  - How long has the individual been taking this drug?
  - Is the current drug dose at the lowest available dose? If so, does the dose provide the individual optimal quality of life and ADL functioning?
- Identify the non-pharmacological approaches used to help address challenging behavioral responses. Did these approaches work?
- Note assessment findings in the medical record.

Implementation

- Complete the SBAR designed for nurse consideration of antipsychotic drug GDR.
- If the individual is over-sedated:
  - Hold the drug until the physician is contacted.
  - Keep in mind that the half-life for most antipsychotic drugs is several days to a week or more.
  - A lower dose of the drug or a different drug may be used if behaviors or symptoms requiring antipsychotic drug treatment emerge.
- Attempt non-pharmaceutical approaches to help address challenging behavioral responses (examples include: music therapy, exercise).
- When possible, inform the individual and his/her family and care staff about the plan for GDR to gain their understanding and support.
- Call the physician to discuss possible drug discontinuance or tapering.

Evaluation

- Assess the individual’s response to drug discontinuance or tapering.
- After one month, determine if the individual is at optimal ADL functioning and has an improved quality of life.
  - Repeat any clinical tests and labs ordered by the physician, and evaluate for improvement.
  - Evaluate the effectiveness of non-pharmaceutical approaches to challenging behavioral responses that have been employed, document and change if needed.
- Continue to evaluate and note drug reduction responses in the medical record. Notify the physician about further tapering or drug maintenance as necessary.
Recommended Physician Guidelines For GDR

- For an antipsychotic drug prescribed for a short period (example: during hospital stay or up to one month), if the drug is not effective and the need for continued treatment is uncertain, the drug may be stopped if no signs of distress.
- If the drug is currently at the lowest dose, follow FDA guidelines for dose reduction.
- For drug prescribed over a long period, reduce the drug slowly. It may take 3-6 months to find the lowest effective dose.
- For individuals taking an antipsychotic drug for one year, attempt dose reduction in two separate quarters with at least one month apart unless the individual is at optimal functioning.
- After longer than one year of drug therapy, attempt drug reduction once per year. If GDR is unsuccessful, consider reduction “clinically contraindicated.” Documentation is needed in the individual’s record why additional dose reduction will cause impairment, psychotic instability, or exacerbate the underlying psychiatric disorder.

Resources


The Long Term Care Survey, F-TAG 329. AHCA October 2010 Edition, pp. 441-555


Ryan Carnahan, Phar.D., M.S., BCPP, Assistant Professor (Clinical), The University of Iowa College of Public Health, Recommendations offer to Dr. Gifford, February 27, 2012
SBAR
Physician/NP/PA Communication and Progress Note
To Discuss Possible Drug Reduction for an Individual
Already Receiving an Antipsychotic Drug for Off-Label Use

Before Calling the MD/NP/PA:
___ Evaluate the patient and complete the SBAR form
___ Check VS: BP, pulse, respiratory rate, neurological check, lung sound, temperature, pain level
___ Review chart for:
   • psychiatric conditions and/or hospitalizations
   • recent physician or psychologist progress notes
   • pharmacist medication regimen review notes
___ Be prepared to report on dosing changes, changes in target symptoms and potential side effects
___ Have relevant information available when reporting (medication list including doses, method and time(s) of administration)
___ Be prepared to have a list of all medications, including PRNs, and the individual’s medical record

Situation
The drug and behavior (if problematic) I am calling about is ___________________________________________
Date drug started ___/___/___
Date of last dose adjustment and dosage change made ___/___/___
Individual’s symptoms has gotten worse/better/stayed the same since the drug started _____________
Have any potential side effects been noticed? __No __Yes (If yes describe) __________________________________________

Things that make the symptoms worse ____________________________________________________________

Things that make the symptoms better (non-pharmacological approach) _________________________________

Other things that have occurred related to this symptom and treatment ____________________________________

Background
Primary diagnosis and/or reason person is at the nursing home ________________________________
Pertinent mental health history __________________________________________________________________

Behavioral concerns identified by family __________________________________________________________
Vital signs   BP_____/_____   HR_____   RR_____   Temp_____
Individual is on a scheduled pain management program __Yes __No
If yes, what medication interventions is the individual receiving? _______________________________________

Conditions (check all those that apply)
☐ orthostatic hypotension   ☐ pacing   ☐ lip smacking/
☐ weight gain                ☐ drooling   chewing/abnormal tongue
☐ increase glucose level    ☐ tremors     movement
☐ urinary retention          ☐ rigidity    ☐ involuntary movement of
☐ constipation               ☐ slowness of movement
☐ sedation                   ☐ jerk body responses
☐ restlessness              ☐ fall

Other __________________________________________________________

Signature________________________________ RN/LPN   Date___/___/___ Time___/___AM/PM
Patient Name: 
Date of Birth: 
Medical record #: 

Medication changes or new orders in the last two weeks ______________________________________________________
Recent Labs ____________________________________________________________________________________________
Allergies _____________________________________________________________________________________________
Any other data _________________________________________________________________________________________

Assessment (RN) or Appearance (LPN)
(For RNs): The individual’s symptoms appear (better/worse/same) ____________________________________________
 I think the symptoms may be related to ________________________________________________________________
 Do you believe the individual has achieved a therapeutic dose? ___ No ___Yes  If yes: Do you believe dose reduction may be needed? ____________________________
(For LPNs): The individual’s symptom(s) appear (better/worse/same) __________________________________________

Request
I suggest or request (check all that applies):
☐ Other (start/change non-pharmacological approach) ☐ Continued monitoring
☐ Change in/stop current med order(s) ☐ Lab work
☐ Provider visit (MD/NP/PA)

Staff name __________________________ RN/LPN ___________
Reported to: Name ______________________________________ (MD/NP/PA) Date___/___/___ Time___ AM/PM
If to MD/NP/PA, communicated via: _______________________ Phone (____) ____ - ______ In-person

Progress Note (complete and place SBAR/progress note in medical record)
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

☐ Family or health care proxy notified
Return call/new orders from MD/NP/PA Date___/___/___ Time___/___ AM/PM

Signature __________________________________________ RN/LPN Date___/___/___ Time___/___ AM/PM

This SBAR is developed specifically for antipsychotic, off-label use. Facilities are encouraged to modify/adapt changes to the SBAR as needed.
**New Mental Status Change Noted**
- New symptoms or signs of increased confusion (e.g., disorientation, change in speech)
- Decreased level of consciousness
- Inability to perform usual activities (due to mental status change)
- New or worsened physical and/or verbal agitation*
- New or worsened delusions or hallucinations*

**Take Vital Signs**
- Temperature
- BP, pulse, apical HR (if pulse irregular)
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)

**Vital Sign Criteria (any met?)**
- Temp > 100.5°F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Oxygen saturation < 90%
- Finger stick glucose < 70 or > 300

**Further Nursing Evaluation**
- Mental Status
- Functional Status
- Cardiovascular
- Respiratory
- Gastrointestinal/abdomen
- Genitourinary
- Skin

**Evaluate Symptoms and Signs**
- Not eating or drinking
- Acute decline in ADL abilities
- New cough, abnormal lung sounds
- Nausea, vomiting, diarrhea
- Abdominal distension or tenderness
- New or worsened incontinence, pain with urination, blood in urine
- New skin condition (e.g., rash, redness suggesting cellulitis, signs of infection around existing wound/pressure ulcer)

**Consider Orders for:**
- Portable chest X-ray
- Urinalysis and C&S if indicated
- Blood work (Complete Blood Count, Basic Metabolic Panel)

**Evaluate Results**
- WBC > 14,000 or neutrophils > 90%
- Infiltrate or pneumonia on chest X-ray
- Urine results suggest infection and symptoms or signs present

**Manage in Facility**
- Monitor vital signs, fluid intake/urine output every 4-8 hrs for 24-72 hrs
- If on diuretic, consider holding
- Offer frequent small fluids (2-4 oz q 2h)
- If on tube feeding, give more water with flushes
- Consider IV or subcutaneous fluids
- Update advance care plan and directives if appropriate

**Notify**
MD / NP / PA

**Monitor Response**
- Vital signs criteria met
- Worsening condition

*Refer also to INTERACT Change in Behavior Care Path
**Refer also to the other INTERACT Care Paths as indicated by symptoms and signs
According to recent government analyses, antipsychotic medications are frequently prescribed “off label” to residents with dementia related behavioral and psychological symptoms (BPSD). This has led to increased attention to the behavioral health management of nursing facility residents and the potentially inappropriate use of antipsychotics in this population. Evidence suggests that antipsychotics have limited benefits in this population, and the potential for adverse consequences such as the risk of movement disorders, falls, hip fractures, cerebrovascular accidents, and death. Additionally, nursing facility residents are medically complex and take multiple medications that increase their risk of adverse effects and drug interactions. Based on continued evidence that nursing facility residents are at risk for adverse events due to polypharmacy and overuse of many different types of medications, CMS has undertaken a national initiative that will focus initially on one particular class of medications, antipsychotics, in an effort to reduce the overall use of these agents in nursing facilities. The CMS is taking a multidimensional approach to the problem of inappropriate use of antipsychotic medications in nursing facilities.

Considerations

Regulatory Considerations

F329 §483.25(l) Unnecessary Drugs
1. General. Each resident’s drug regimen must be free from unnecessary drugs, which is any drug when used:
   (i) In excessive dose (including duplicate therapy); or
   (ii) For excessive duration; or
   (iii) Without adequate monitoring; or
   (iv) Without adequate indications for its use; or
   (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
   (vi) Any combinations of the reasons above.

Antipsychotic Drugs: Based on a comprehensive assessment of a resident, the facility must ensure that:
(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

Policy Considerations OR Policy/Process Considerations

Policies formulated based on F329 §483.25(l) Unnecessary Drugs
Behavior Management programming
Pharmacy audits
Medication Monitoring
Gradual Dose Reductions

Alternatives to antipsychotic medication: CMS is emphasizing non-pharmacological alternatives for nursing facility residents, including potential approaches such as consistent staff assignments, increased exercise or time outdoors, monitoring and managing acute and chronic pain, and planning individualized activities.

Educational Considerations

Staff education
Physician education
Resident & Family education
Education provided by Ohio Kepro, QIO

July 30, 2013
Enhanced training: CMS has developed Hand in Hand, a training series for nursing facilities that emphasizes person-centered care, prevention of abuse, and high-quality care for residents. CMS is also providing training focused on behavioral health to state and federal surveyors;

Additional Information

- ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS) http://www.atlantapsychiatry.com/forms/AIMS.pdf

The initiative, entitled, the “Partnership to Improve Dementia Care” includes launching a new nursing facility staff training program focused on high quality care and abuse prevention; ensuring data on antipsychotic use in nursing facilities is available on Nursing Facility Compare, effective July 2012; emphasizing nonpharmacological alternatives over antipsychotics for nursing facility residents such as consistent staff assignments, increased exercise and outdoor time, acute and chronic pain oversight and management, and planning individualized activities.
White Paper

Unnecessary Medications

Introduction and Background
Medications are an integral part of the care provided to residents of nursing facilities. They are administered to try to achieve various outcomes, such as curing an illness, diagnosing a disease or condition, arresting or slowing a disease process, reducing or eliminating symptoms, or preventing a disease or symptom. Any medication or combination of medications—or the use of a medication without adequate indications, in excessive dose, for an excessive duration, or without adequate monitoring—may increase the risk of a broad range of adverse consequences such as medication interactions, depression, confusion, immobility, falls, and related hip fractures. While assuring that only those medications required to treat the resident’s assessed condition are being used, reducing the need for and maximizing the effectiveness of medications are important considerations for all residents. F329 – Unnecessary Medications has steadily become a top citation for facilities during the survey process.

Legal/Risk Management Considerations
Potential negative outcomes of unnecessary drugs may include but are not limited to those that are directly a result of the medication effect, i.e. side effects, allergies, inadequate monitoring, or a more indirect result of decline in function. These might include: decline in the resident’s physical condition (ability to ambulate), contractures, increased incidence of pressure ulcers, delirium, agitation, and incontinence. In addition the use of unnecessary medications may increase the potential for falls and accidents.

Regulatory/Survey Considerations
F329 states that each resident’s drug regiment 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 implications for use; or in the presence of adverse consequences that indicate the dose should be reduced or discontinued.
The intent of this requirement is that each resident’s entire drug/medication regimen be managed and monitored to achieve the following goals:

- The medication regimen helps promote or maintain the resident’s highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or his/her representative(s) in collaboration with the attending physician and the facility interdisciplinary team.
- Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident’s assessed condition(s);
- Non-pharmacological interventions (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to, medication;
- Clinically significant adverse consequences are minimized; and
- The potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate.

Additional potential survey citations, if Unnecessary Medications tag is being investigated at your facility include but are not limited to:

- F154, F155, Notice of Rights & Services, Free Choice
- F157, Notification of Changes
- F272, Comprehensive Assessments
- F279, F280, Comprehensive Care Plans
- F281, Resident Assessment
- F309, Quality of Care
- F310, Decline in ADL
- F315, Urinary Incontinence
- F319, F320, Mental & Psychosocial Functioning
- F325, Nutritional Parameters
- F327, Hydration
- F385, Physician Supervision
**Policy/Process Considerations**

Facilities should assure that the following systems are in place:

- Evaluation and assessment of the selection of medication(s) based on assessing relative benefits and risks to the individual resident.
- Evaluation of the resident’s signs and symptoms, in order to identify the underlying cause(s) including adverse consequences of medication(s).
- Identification of which classes of medications need special monitoring such as lab work, vital signs, behavior tracking, etc.
- Identification and monitoring of those meds where gradual dose reductions (GDR) need to be attempted or documentation is present to show GDR is contraindicated.
- Identification and monitoring of residents for EPS (extrapyramidal symptoms) or tardive dyskinesia. Monitoring of the care plan to assure one is initiated and updated to reflect medication management goals.
- Monitoring of the care plans/nursing notes to assure that non-pharmacological interventions are included in documentation to minimize the need for medications, permit the use of the lowest possible dose or allow medications to be discontinued.
- Addressing the Medication Regimen Review (MRR) recommendations where there is no response from the physician

**Educational Considerations**

- Staff education appropriate to the monitoring considerations for various classes or types of medications, including associated documentation
- All Staff education regarding non-pharmacological approaches prior to medicating for a symptom, including a system for communication to direct care staff (i.e., sign/symptoms of bleeding for resident on coumadin)
- Proper assessment of each resident’s drug regimen by all disciplines to assure each medication is necessary, including Consultant Pharmacist and Physician.
- Proper care planning of medication management; upon admission and timing of necessary updates.
- Annual inservice on Unnecessary Medications and medication pass audits.
- Staff education on communicating with pharmacy provider any questionable medication order.
- Educational programming addressing documentation of all aspects of the systems and processes for managing and monitoring medication regimes

**Resources**

- RAP for Psychotropic Drugs
- State Operations Manual Appendix PP, Interpretive Guidelines
- Suggested Laboratory Monitoring Parameters for Commonly Used Medications
- Suggested Non-Pharmacological Considerations for Common Conditions in LTC
- AIMS, DISCUS
- Current drug reference manuals
- OHCA White Paper: Use and Risks of Coumadin Therapy
- Consultant Pharmacist

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