A Person-centered Approach to Antipsychotic Reduction: One-size does not fit all

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Objectives:

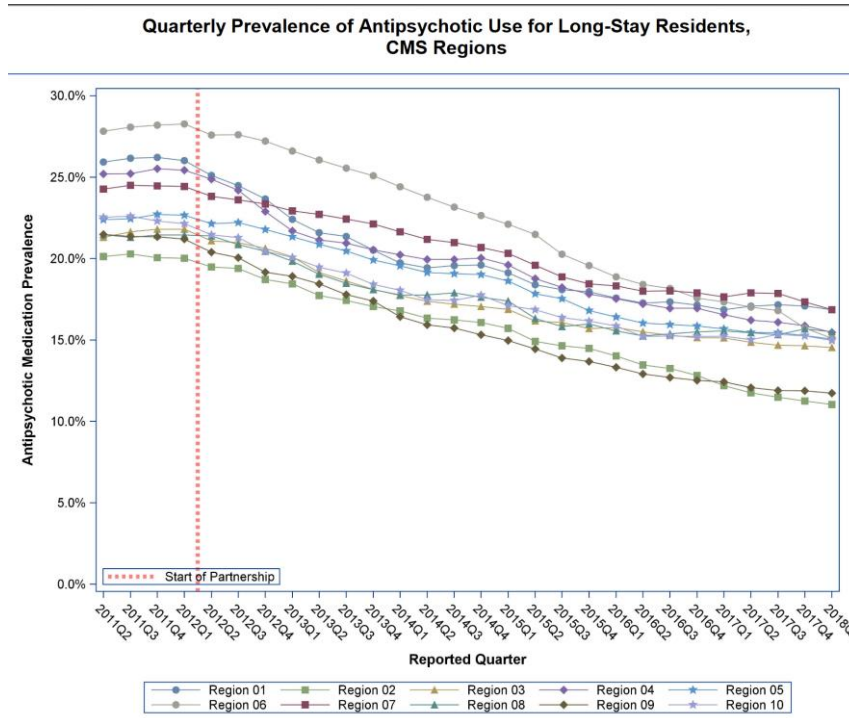
By the end of this program the participant will be able to:

- List the regulations regarding person-centered care and anti-psychotic use/reduction.
- Describe the essential elements of person-centered care and apply them to an anti-psychotic reduction program.
- Create 2-3 new interventions for a resident to utilize before an anti-psychotic reduction plan is implemented.

CMS Anti-Psychotic Reduction Efforts

- PA has had a 31% decrease overall
- Ranked 32/50 (lower is better)

- ~74 facilities are "late adopters"
- 4.5% increase
- Goal is 15% reduction in next year



State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities *(Rev. 11-22-17)*

§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;

(ii) Anti-depressant;

(iii) Anti-anxiety; and

(iv) Hypnotic

Conditions Anti-psychotics are indicated:
Schizophrenia
Bipolar Disorder
Tourette's Syndrome/Huntington's Disease
Acute psychosis

§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--

- Residents who have not used psychotropic drugs are **not given these drugs unless the medication is necessary to treat a specific condition** as diagnosed and documented in the clinical record;
- Residents who use psychotropic drugs receive **gradual dose reductions**, and **behavioral interventions**, unless clinically contraindicated, in an effort to discontinue these drugs;
- Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and
- **PRN orders for psychotropic drugs are limited to 14 days**. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.
- PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the **attending physician or prescribing practitioner evaluates the resident** for the appropriateness of that medication.

Gradual Dose Reduction

Frequency:

- 2x in first year of use of the drug (at least a month apart)
- Annually thereafter

Clinically Contraindicated

Dementia: is defined as 2 failed dose reductions attempts in a 12-month period. The reduction attempt resulted in a return or worsening of symptoms after the most recent attempt in the facility and the physician documents the clinical rationale.

Know psychiatric disorder: defined as 2 failed dose reductions attempts in a 12-month period. The continued use is in accordance with relevant current standards of practice and the physician has documented clinical rationale or the resident's targeted symptoms returned/worsened after the most recent attempt in the facility and the physician has documented clinical rationale

Chemical Restraint

§483.10(e) Respect and Dignity.

The resident has a right to be treated with respect and dignity, including:

- The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).

§483.12(a) The facility must—

- Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

Person-Centered Care

Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

Includes:

- trying to understand what each resident is communicating, verbally and nonverbally
- identifying what is important to each resident about daily routines and preferred activities
- understanding the resident's life before coming to reside in the nursing home.

Person-Centered Care

§483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

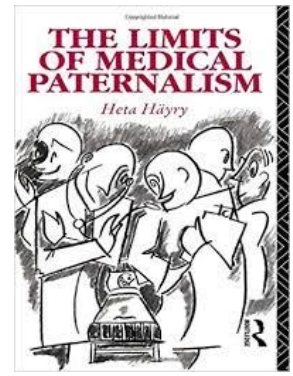
- The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.
- The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.
- The right to be informed, in advance, of changes to the plan of care.
- The right to receive the services and/or items included in the plan of care.
- The right to see the care plan, including the right to sign after significant changes to the plan of care.

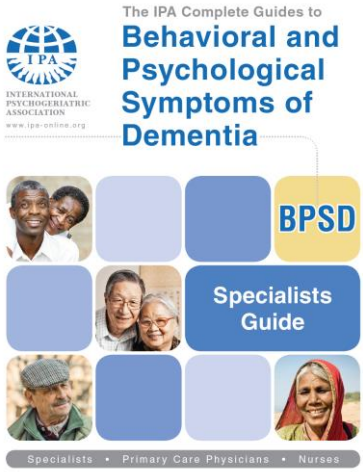
Root Cause: Anti-Psychotic Problem

(according to me)

DRG
DECISION RESOURCES GROUP

HELPLESS





BPSD

Defined behavioral expressions as a medical condition.

Medical conditions get drug treatment.

Facilities increased anti-psychotic drug use to “manage” the medical condition.

Regulators noted an significant increase in anti-psychotic medication use.

Reduction program implemented.

What we know now…

Anti-Psychotic medications have Black Box Warning

Brain changes impact communication

Person-centered care practices work

https://pleasantvalleynursingandrehab.org/signature-programs/dementia-care/

Black Box Warning

Increased Mortality in Elderly Patients With Dementia-Related Psychosis

- 1.47 relative risk ration of death than placebo (Schneeweiss S, 2007)
- 1.55 relative risk ration of death than placebo with atypical antipsychotics (Gill S, 2007)
  - Even higher with typical antipsychotics

Other challenges with anti-psychotic use (Johnell K, 2017)

- Increased risk of hospitalization
- Increased risk of fall injuries

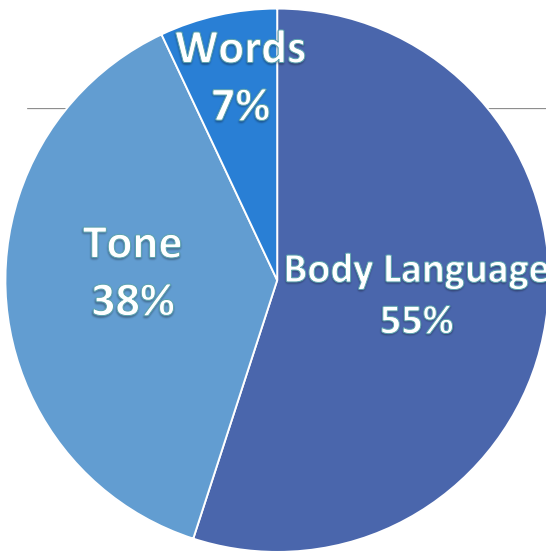
Increased risk of osteoporotic fracture and hip fracture (Fraser LA, 2015)

Brain Changes and Communication

Limbic System- responsible for memory and emotion
- Ability to "control" emotions is diminished
- Ability to associate an emotion to a previous experience is retained (Sabat S, 2018)

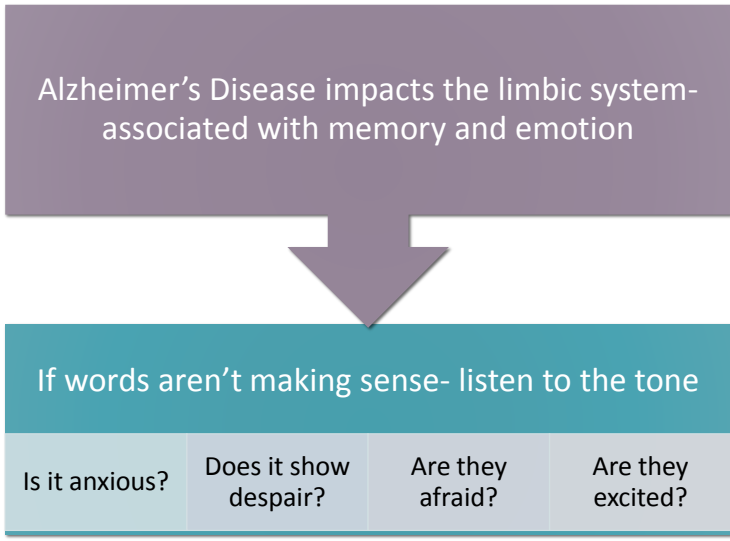
Ventral Striatum- pain pathway (Achtreberg, 2013)
- Pain may present as distress without ability to specify "where"
- Hyperalgesia- response to chronic pain with increased sensitivity to painful stimuli
- Allodynia- painful response to nonpainful stimuli

Brain area?
- As verbal language decreases reliance on body-language and environmental input increases



Communication

- Mehrabian 1971 first quantified that generally communication is generally split between 3 channels.
- Does not apply to all circumstances- however when information is incongruent- that larger percentage areas are more often the accurate determinant.
- Other key factors: (Thompson 2011)
  - Context
  - Clusters
  - Congruent



Tone

Research on Applying Person-Centered Care: OASIS Training

OASIS Training (http://www.oasis.today)

- 5 module staff training
- $400 to complete certification as a trainer
- Tija (2017) studies 93 nursing homes enrolled in the OASIS intervention
  - 22.3% relative reduction in psychotropic usage at end of study
  - No increase in behavioral 'disturbances" during study

Research on Applying Person-Centered Care: Interdisciplinary QI Project (Tawiah P, 2016)

Single Facility, 48 bed unit in not-for-profit facility

Direct care staff were asked their thoughts on resident routines (sleep, adl, meals)

Staff education (person-centered care, sleep quality, communication, harnessing spontaneity)

Practice Changes

- Move wake time from 5am to 7am
- ADL for AM care anytime between 8am and 11 am based on resident preference
- Increased resident-guided activities in daytime
- Decrease medication administration between 9pm and 7 am
- Adoption of permanent resident assignments

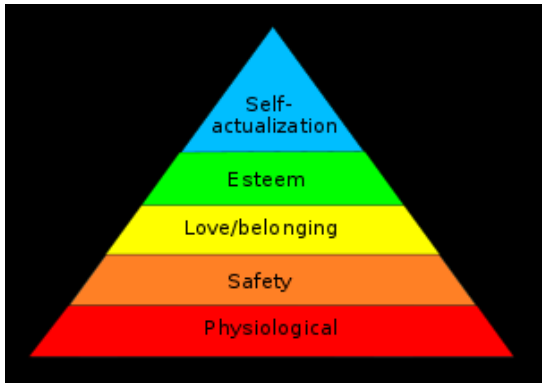
Outcomes

- Antipsychotic medication reduced from 18% to 3% at 3 month mark

Alzheimer's Association- Practice Recommendations for Person Centered Care

(Fazio 2018)

1. Know the person living with dementia
2. Recognize and accept the other person's reality
3. Identify and support opportunities for meaningful engagement
4. Build and nurture authentic and caring relationships
5. Create and maintain supportive community for individuals, family and staff
6. Evaluate practice regularly and make appropriate changes



Comparison: Maslow's Hierarchy of Needs and The Eden Alternative Domains of Well-Being

"Wandering"

Maslow's Hierarchy (Well-Being)	Why is this happening?
Self-Actualization (Joy)	Was walking their stress reliever or spiritual connection to nature?
Esteem (Growth and Meaning)	Are they intent on performing a previous work duty at this time and need to get there?
Love and Belonging (Identify and Connectedness)	Are they looking for home or family?
Safety (Security and Autonomy)	Are they free to walk when/where they want? Do they feel trapped?
Physiological	Are they hungry searching for food? Do the need to go to the bathroom?

han·gry

(han-gree) adj.

a state of anger caused by lack of food; hunger causing a negative change in emotional state.

Hunger/Thirst

- Putting things towards their mouth
- Holding their stomach
- Eating inappropriate things
- Taking other people's food or drink
- Repeated swallowing
- Searching for things

Need For Bathroom

- Touching in groin area
- Pulling on pants
- Undressing
- Searching for room/bathroom
- Anxiety

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Other interventions for "wandering"

Creating outside walking and seating areas and using them on a regular basis (dress for the weather)

Record messages from family that can be played for the person at strategic times.

Have a "bus stop" in the facility for people to gather to "wait for the bus"

Learn the code language that works for the individual to relieve them of a work/family responsibilities. (Example: take care of Betsy)

Agitation and Aggression

Maslow's Hierarchy (Well-Being)	Why is this happening?
Self-Actualization (Joy)	
Esteem (Growth and Meaning)	Do they need to feel needed?
Love and Belonging (Identify and Connectedness)	Has there been any touch that is not directed at providing basic care?
Safety (Security and Autonomy)	Are they overstimulated?
Physiological	Are they in pain? Are they tired?

Pain

Pain is under-reported and under-treated in people with dementia

If they are showing aggressive expressions during ADL or bathing- assess for pain DURING the activity (not just on nursing rounds)

Pain Assessment in Advanced Dementia (PAINAD) Scale

Items*	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Lowlevel speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
			Total**	

* Five-item observational tool (see the description of each item below).
** Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0="no pain" to 10="severe pain").

Signs of Poor Sleep

Difficulty concentrating*

Sleep changes*

Anxiety*

Suspiciousness*

Hallucinations*

Disorganized speech*

Depression*

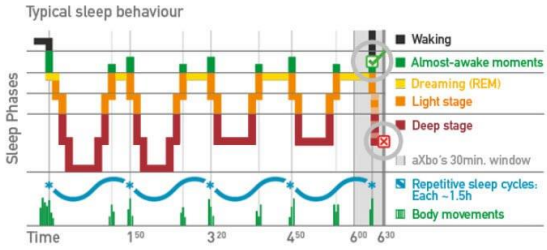
Anxiety*

Difficulty functioning*

*Is also a sign of psychosis

- Are your residents experiencing "dementia with psychosis" or just side effect of sleep fragmentation?
- Are we causing it?

Sleep Cycles



Full sleep cycle takes ~2 hours. 4-5 cycles/night

Stage 3 (Deep)
- physical healing

REM
- psychological healing
- longer phase in later cycles

Interruption = start over

Other interventions for aggression

Create quiet rooms or sensory rooms to match the amount of stimulation.
- Calming music
- Aromatherapy
- Hand or foot massage

Activities that engage previous life roles
- Desk space
- Food directed activities (even if they can't be eaten, have a back up!)
- Exercise
- Montessori method

Inappropriate Vocalization

Maslow's Hierarchy (Well-Being)	Why is this happening?
Self-Actualization (Joy)	
Esteem (Growth and Meaning)	
Love and Belonging (Identify and Connectedness)	Has there been any communication that is not directed at providing basic care?
Safety (Security and Autonomy)	Are they over or under stimulated? Do they feel safe?
Physiological	Do they need to go to the bathroom?

Key Messages:

Know the person!
- PELI is a great tool to help you!
- Medically stable, is this the right time?

Collect Data:
- ID triggers that lead to expressions that are challenging
- Objective assessment of expression (Cohen Mansfield Agitation Inventory or other)

Think outside of the box for interventions:
- You are not limited to your "drop down" menu of your documentation software
- Surveyors want to see individualized approach

What questions do you have?

For more information please contact me:

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