Utilization Of Substitute Drugs For Some Dementia Behaviors

- *Anticholinergics*
- *NMDA antagonists for severe dementia with behavioral disturbance or loss of basic functions. not indicated for early dementia*
- *Nuedexta (dextromethorphan/Quinidine) for PBA*

Post Admission Dose Reduction Principles

- *Beware of automatic dose reduction requests by pharmacy for recent admits if patients have long standing Schizophrenia or recent psych hospitalization related to dementia with psychosis.*
- *Delirium cases take up to two months to stabilize so slow med reduction maybe needed*
- *Dementia with subacute or chronic psychosis will needs weeks to months to reassess, NOT days to weeks*

On Call Provider Protocol

- *Limit ordering antipsychotics if no clear psychotic symptoms (resist the pressure to say yes)*
- *If you must, Give "one time" orders OR orders with "stop dates"*
- *Requesting follow up (patient to be put on the problem list to ensure follow up and further med adjustments). Nursing should consider such add-ons even when not ordered.*

Routine Dose Reduction Principles

- *Every recert visit is an opportunity for dose reduction*

- *Prior failures of dose reductions are not an absolute contra-indication especially a few months out.*

- *Stability is a prerequisite for dose reduction. Behaviorally unstable patients should not undergo routine med reduction unless provider feels that the medications are part of the problem.*

Administration Role

- *Antipsychotic dose reduction can not succeed without full buy in by administration (Admin and DON)*
- *Facility needs to be prepared to manage patients non-pharmaceutically, beyond the QI meetings*
- *Facility needs to expect and be tolerant of a few bad days for a few patients*
- *Facility should be always in search of non-pharmaceutical interventions tailor made for specific residents*

- *Minimizing ER visits and transfers for "behaviors" requires admin buy in. "When in doubt ship them out" may still be a tempting approach.*

- *Working on unit structures and staffing structure (not necessarily numbers). This has dual benefit in combined SNF-NF facilities, as SNF patients don't like being exposed to dementia patients with behaviors, and the extra stimulation of SNF unit can exacerbate behaviors in NF patients*

- *Changing meal time structure, facility lighting, coves or rest zones for residents needing less stimulation, consistent assignment, etc*

Nursing Principles

- *A call or on-site request for management of difficult behaviors should NOT start with a drug request*
- *The goal is to develop a better plan of care with the help of the providers*
- *Recommendations for drugs from nursing staff is discouraged*
- *Baseline behaviors that don't constitute a pre-crisis or crisis situation should be handled by day team and not on-call*

What Happens When Staff Are Tempted To Do It The Old Fashion Way?

- *Does the unit manager follow up with a nurse who requested drugs over night when the situation didn't warrant it?*

- *Does the DON follow up with the unit managers and nurses directly when such cases occur?*

- *Is everyone reviewing the case also reviewing provider notes and talking to providers at every step of the process?*

Nursing Inservices

- *Structured Education around appropriate and inappropriate use of antipsychotics in Dementia patients*
- *Follow up education sessions to discuss specific cases as learning opportunities to point out successes and failures*
- *Convincing the nursing staff that reducing antipsychotic use in Dementia patients is consistent with best practices in Geriatric Medicine. Nurses can be a great advocates, once they buy in.*
- *Avoiding justification of high antipsychotic use based on population mix.*
- *Case specific feed back with DON and Administrator involvement. NOT MANY PLACES DO THAT*

Nursing

- *Pre-crisis interventions*
- *Proper documentation (starting with consent) around antipsychotics to help guide treatments and future dose reductions*
- *Avoiding HS and weekend calls for dementia related behaviors except for crisis and pre-crisis patients*
- *Feedback to nursing when routine medication changes are made using the on-call system. This should involve the DON and Admin.*

Nursing

- *You know you're making sustainable progress when nurses start asking providers for dose reduction on stable patients or when behaviors are treatable with nonpharmacutical interventions.*

- *Often times nurses are the first to notice when the anti-psychotics have had no positive contribution to the care, i.e. when residents are hard to manage before and after the meds.*

CNAs

- *Based on importance, this section should have been the first slide*
- *CNAs won't buy in if Nurses are not on board*
- *A dose reduction can be Hardest for CNAs if there is no specific changes to the care plan*
- *Adjusting Care time, like showers, may negatively impact the CNAs work*
- *More training in Dementia care and non-pharmaceutical interventions*
- *Nurses should be able to answer CNAs questions about the treatment plan for difficult patients*

- *If we didn't teach anything else we should at least teach this:*
  - *Speed of care impacts residents behavior. Sometimes all it takes is for the CNAs to slow down or leave the tough ones for last*
  - *There are many ways to stay safe and avoid injury caused by dementia residents. Every time there is an incident involving a CNA being hit or bitten by a resident we should revisit the approach even when it involves our best staff.*
  - *We can't joke and use first names when dealing with sexually inappropriate and disinhibited residents*

At The End Of The Day If Evening Shifts And The CNAs weren't on Board (willingly or unwillingly), This Project wouldn't have Succeeded

Case 1

- *81 YOWM Bipolar, PTSD, Alzheimer's with delirium 2 to Lithium*
- *Multiple ER visits before final admission then SNF*
- *Physical with staff*
- *Delusional at times*

Case 2

- *78 YOWM with vascular dementia, ex-truck driver, Anger and agitation around care and during daily routines*
- *Psych admission times one, antipsychotics tapered off after 6 months of stability and due to presence of EPS, Depakote used as primary drug to manage his anger and short fuse.*
- *Called after hours out of the blue to use topical risperdal to calm him down. It only takes one call to undo months of work!*

Case 3

- *86 YOWF with Severe Alzheimer's Dementia in a wheelchair, and behaviors limited to wondering and approaching residents and pulling on everything*

- *Seroquel (Quetipine) started by a provider upon request from unit manager due to patient constantly pulling on table cloths that were new to the unit.*

- *DON contacts me the next day to review the case.*

- *Circumstances of the order reviewed with provider and unit manager.*

Case 4

- *82 YOWF with Severe Alz Dementia with Depression. Still mobile, Prior Psych Hospitalization for behaviors.*
- *6 months out she tolerated a taper and eventual DC of Antipsychotics*
- *Doing well with no Psychosis. Confused, wants to go home and asks family to take her home every chance she gets. Bahaviors worse after her weekly visit home*
- *Family insists on Giving her antipsychotics even months after being stable without them.*

Don’t Forget To Register For The NH AMDA conference

WWW.NHMDA.org

Oct. 25th in Concord