Road Map to Success:

Reducing Antipsychotic Medications Workshop

Resources

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Lake Superior Quality Innovation Network
MICHIGAN | MINNESOTA | WISCONSIN

SWG seniors wellness group

Introduction

Welcome to our reducing antipsychotic medications workshop!

Our goal is to provide you with strategies and resources to help you reduce the use of antipsychotic medications in your facility.

MPRO

MPRO is a nonprofit organization and national leader in healthcare quality improvement and medical review. Our goal is simple - we are helping healthcare get better. MPRO provides medical consulting and review, as well as data analysis to federal agencies, state Medicaid and public health organizations, healthcare facilities, private health plans and other third party payers. In addition, MPRO represents Michigan in Lake Superior Quality Innovation Network (QIN), which also serves Minnesota and Wisconsin under the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization (QIO) Program.

Lake Superior Quality Innovation Network

MPRO serves in collaboration with MetaStar of Wisconsin and Stratis Health of Minnesota as Lake Superior Quality Innovation Network (QIN) to assist the Centers for Medicare & Medicaid Services (CMS) in improving health care for Medicare beneficiaries in each organization's respective state.

Under this contract Lake Superior QIN works to convene and connect providers, practitioners, patients and families to build and share knowledge, spread best practices and achieve rapid, wide-scale improvements in patient care, increases in population health and lower health care costs for Medicare beneficiaries and all Americans.

Learn more about Lake Superior QIN by visiting www.lsqin.org.

Seniors Wellness Group

Seniors Wellness Group provides comprehensive, evidence-based and cost-efficient mental health care to residents of extended care facilities. The Group was established in 1995 and currently services over 200 long-term care facilities. The practice maintains a philosophy that attends to the integrity of each individual while applying the most modern and advanced treatment concepts, a recognition of a capacity for positive change throughout the life cycle, and goals of restoring and maintaining a strong sense of self-worth and meaningful life experience for each elderly person under the Group's care.

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Long-term Care Regulations

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

Use for a resident who has potentially unnecessary medications, is prescribed psychotropic medications or has the potential for an adverse outcome to determine whether facility practices are in place to identify, evaluate, and intervene for potential or actual unnecessary medications. Use also to evaluate the medication regimen review (MRR) process.

NOTE: If the resident has a diagnosis of dementia and is receiving any psychotropic medications (including but not limited to antipsychotic medications) the surveyor should refer to the Dementia Care Critical Element Pathway as a guide to determine the facility's compliance at F744.

Review the Following in Advance to Guide Observations and Interviews:

☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAs for areas pertinent to the medications ordered such as adverse consequences and behaviors.

☐ Review all medications currently ordered or discontinued going back to the most recent signed recapitulation. Determine if the facility:

- ✓ **Documents an acceptable clinical indication for use.**
  - Medication is prescribed for a diagnosed condition and not being used for convenience or discipline.
  - Medication is clinically indicated to manage a resident's symptoms or condition where other causes have been ruled out.
  - Signs, symptoms, or related causes are persistent or clinically significant enough (e.g., causing functional decline) to warrant the initiation or continuation of medication therapy.
  - Intended or actual benefit is sufficient to justify the potential risk(s) or adverse consequences associated with the medication, dose, and duration.
- ✓ **Demonstrates use of written protocols or resources to guide antibiotic use.**
  - The use of infection assessment tools for antibiotic use for one or more infections (e.g., use of a Situation, Background, Assessment and Recommendation (SBAR) communication tool for UTI assessment, application of the Loeb minimum criteria for initiation of antibiotics).
- ✓ **Demonstrates monitoring for each medication as appropriate.**
  - The following medications pose a high risk for adverse consequences and should be monitored:
    - **Opioids –** assess pain, implement bowel program.
    - **Anticoagulant –** bleeding/bruising, protime/international normalized ratio (PT/INR), interaction with other medications, facility must have policies around monitoring, lab work, communication of lab values, implementation of new orders in response to lab values and/or symptoms.
    - **Diuretics –** edema, potassium level, signs of electrolyte imbalance.
    - **Insulin –** monitoring of blood glucose levels, hemoglobin A1c (HbA1c), and symptoms of hyper/hypoglycemia.
    - **Antibiotics –** interactions with other medications (e.g., warfarin), adverse events (e.g., rash, diarrhea); prescriptions must include documentation of indication, dose, route and duration and be reviewed 2-3 days after antibiotic initiation to assess response and labs, and prescriber should reassess antibiotic selection as appropriate.

- **All psychotropics –** monitor behavioral expressions or indications of distress.

- Facility staff, along with the pharmacist and prescribing practitioner recognize and evaluate the onset or worsening of signs or symptoms, or a change in condition to determine whether these potentially may be related to the medication regimen; and follow up as necessary upon identifying adverse consequences.
- Facility staff monitor the effectiveness of each medication and make changes to the pharmacological intervention, when necessary.

✓ **Demonstrates appropriate dosing for each medication.**

- Is there documentation of a rationale for any medication that exceeds the manufacturer's recommendations, clinical practice guidelines, evidence based guidelines or standards of practice?

✓ **Documents duration for each medication.**

- Medications are not used for an excessive duration.

✓ **Documents clinical rationale for continued use for the medications, as required.**

- Tapering when clinically indicated in an effort to discontinue or reduce the dose.
- Concomitant use of two or more medications in the same pharmacological class.
- Potential incompatibilities between medications.

✓ **Demonstrates a system that monitors and addresses the presence of or potential for adverse consequences.**

- A clear clinical rationale from the attending physician/prescribing practitioner for continuing a medication that may be causing an adverse consequence, including risks and benefits.

✓ **Demonstrates a system for and documents gradual dose reduction (GDR) for psychotropic medications, unless contraindicated.**

- Within the first year in which a resident is admitted on a psychotropic medication or after the facility has initiated a psychotropic medication:
  - GDR attempts in two separate quarters with at least one month between the attempts.
  - The GDR must be attempted annually thereafter unless clinically contraindicated.
  - Non-pharmacological approaches must be attempted and documented instead of using psychotropic medications, along with use of psychotropic medications, and while GDR is attempted.

✓ **Demonstrates adherence to requirements for as needed (PRN) psychotropic and antipsychotic medications.**

- Residents do not receive PRN psychotropic medications unless necessary to treat a diagnosed specific condition which must be documented in the record.
- PRN orders for psychotropic medications which **are not** antipsychotic medications are limited to 14 days. The attending physician/prescriber may extend the order beyond 14 days if he or she believes it is appropriate. If the attending physician extends the PRN for the psychotropic medication, the medical record must contain a documented rationale and determined duration.
- PRN orders for psychotropic medications which **are** antipsychotic medications are limited to 14 days. A PRN order for an antipsychotic cannot be renewed unless the attending physician/prescriber evaluates the resident to determine if it is appropriate to write a new PRN order for the antipsychotic medication. The evaluation entails direct evaluation of the resident and assessment of the

resident's current conditions and progress to determine if the PRN antipsychotic medication is still needed. Attending physician/prescribing practitioner documentation of the evaluation should address:
- Whether the antipsychotic medication is still needed on a PRN basis?
- What is the benefit of the medication to the resident?
- Have the resident's expressions or indications of distress improved as a result of the PRN antipsychotic medication?

☐ Review the care plan for medications, especially high risk medications, and individualized approaches to care, including non-pharmacological interventions.

Observations:

☐ Are care planned interventions implemented for medications that pose a high risk for adverse consequences?

☐ What non-pharmacological approaches to care are used? Are they effective?

☐ What pharmacological interventions are used? Why was the medication used and was it effective (e.g., pain is relieved, distress is addressed)?

☐ How does staff respond and interact with the resident?

☐ Does the resident continue to show expressions or indications of distress? If so, how does staff respond?

☐ Are staff using a medication for convenience or discipline? If so, describe. (For concerns related to a medication that involves an inadequate indication for use and evidence shows the medication is also being used for the purpose of discipline or convenience rather than to treat the resident's medical symptoms, surveyors should assess compliance with §483.10(e)(1) and §483.12(a)(2), F605, Right to Be Free From Chemical Restraints.)

☐ Does the resident have psychosocial, behavioral, mental, or physical adverse consequences that may be related to a medication:
- ○ Anorexia/unplanned weight changes, edema;
- ○ Decline in physical functioning (e.g., mobility or activities of daily living (ADLs));
- ○ Rash, pruritus;
- ○ Bleeding or bruising, spontaneous or unexplained;
- ○ Respiratory changes;
- ○ Bowel dysfunction (e.g., cramping abdominal pain);
- ○ Urinary retention, incontinence;
- ○ Dehydration or swallowing difficulty;
- ○ Falls, dizziness, or headaches;
- ○ Muscle/nonspecific pain or unexplained abnormal movement;
- ○ Psychomotor agitation (restlessness, pacing, hand wringing);
- ○ Psychomotor retardation (slowed speech, thinking, movement);
- ○ Subdued, sedated, lethargic, or withdrawn;
- ○ Insomnia or sleep disturbances;
- ○ Mental status changes;
- ○ Behavioral changes or unusual behavior patterns; or
- ○ Depression, apathy or mood disturbance.

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

Resident, Family or Resident Representative Interview:

- ☐ What medications do you get and why do you need to take them?
- ☐ What are your goals for your medications?
- ☐ What information on the risk, benefits and potential side effects of medications were you provided?
- ☐ What changes in your medications have occurred, including gradual dose reductions for psychotropic medications?

  NOTE: Permission given by or a request made by the resident and/or representative does not serve as a sole justification for the medication itself.

- ☐ What alternatives to taking some of the medications, including non-pharmacological approaches, has staff told you about?
- ☐ Do you think the medication has helped (e.g., pain control, improvements in function, decrease in edema, mood)? If not, why?
- ☐ What side effects have you had from the medication (ask about specific medications)? Have you experienced any changes in what you are able to do since starting or changing a medication(s)? Do you have allergies to any medication(s)?
- ☐ Have you participated in discussions and/or care plan meetings about your medications?

Staff Interviews (Nursing Aides, Nurse, Director of Nursing (DON), Social Services):

- ☐ What, when, and to whom do you report changes in the resident's status (e.g., indications of distress or pain)?
- ☐ How do you learn what the resident's daily care needs are?
- ☐ What non-pharmacological approaches are used?
- ☐ What is the clinical indication for the medication?
- ☐ How does the facility monitor the medication?
  - ○ What monitoring tools or systems are used?
  - ○ How did the interdisciplinary team (IDT) determine what should be monitored?
  - ○ For psychotropic medications, how did you determine what behavior to monitor?
  - ○ How do you assure orders for medication monitoring are implemented (e.g., HbA1c, PT/INR)?
  - ○ How do you communicate relevant information regarding medication monitoring for this resident to other team members?
- ☐ How do you assess whether each medication is effective?
- ☐ Why does the resident have two medications in the same class?
- ☐ How does the IDT determine what dose and duration is clinically indicated?
- ☐ If the amount of any medication exceeds the manufacturer's recommendations, clinical or evidence-based practice guidelines, or standards of practice, what is the rationale?
- ☐ How do you monitor for significant adverse consequences?
- ☐ Has the resident had a change in condition, diet, weight loss, dehydration, or acute illness? If so, what was done to assess the possible complications for these changes due to medications?
- ☐ Has the resident had an adverse reaction? If so, what and how was the adverse reaction addressed?
- ☐ How do you evaluate whether medications should be initiated, continued, reduced, discontinued, or otherwise modified? How often is the evaluation for modification conducted?

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

- ☐ How does the facility ensure a review of medications for GDRs?
- ☐ If the resident is on a psychotropic medication: When did you attempt to reduce the medication in the last year and what were the results?
- ☐ If the practitioner denied a GDR: Did the practitioner provide a risk-benefit statement describing the contraindications for a GDR?
- ☐ How do you monitor staff to ensure they are implementing care planned approaches?
- ☐ What was the rationale for the practitioner's decisions in managing the resident's medications or medication-related concerns?
- ☐ How did you involve the resident in decisions regarding medications?
- ☐ How often is the MRR conducted and are medical charts included in this review?
- ☐ Under what circumstances is the MRR conducted more often than monthly?
- ☐ Are there policies and procedures in place to address issues which include the different steps in the MRR process and steps to take when an identified irregularity requires immediate action?
- ☐ How are medication-related issues communicated to other staff, the attending practitioner or prescribing practitioner, and resident and, if appropriate, resident representative?
- ☐ How is the MRR process conducted for short-stay residents?
- ☐ Has there been a change in the resident's overall function and mood that potentially may indicate unnecessary medications or adverse reactions? If so, describe.
- ☐ If the resident is receiving PRN psychotropic or antipsychotic medication(s): How is this medication monitored and how does the IDT determine if the PRN medication is clinically indicated and ensure the PRN orders are consistent with PRN requirements for psychotropic and antipsychotic medications?
- ☐ Ask about any other related concerns the surveyor has identified.

Pharmacist Interview:

- ☐ Do you perform a monthly MRR (or more frequently if needed)?
- ☐ Do you include each resident's medical record in this monthly review?
- ☐ How do you evaluate PRN medications, specifically PRN psychotropic and antipsychotic medications?
- ☐ What are you reviewing (e.g., adequate indication, dose, continued need, and adverse consequences)?
- ☐ Did you identify and report to the attending physician, medical director, and DON any irregularities with this resident's medication regimen? Did you use a separate, written report?
- ☐ If the pharmacist didn't identify a specific issue, ask why the issue was not identified as an irregularity on the MRR.
- ☐ What is the MRR process for short-stay residents?
- ☐ What protocols to do you have in place (e.g., lab to monitor for adverse events and drug interactions related to use of antibiotics and other high-risk medications)?
- ☐ Are you part of the IDT who reviews this resident's medication?
- ☐ What steps do you take when an irregularity requires immediate action? Are these steps part of facility policy?

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

Attending Practitioner, Medical Director, and DON Interviews:

- ☐ Did you receive a written report of irregularities identified during the MRR?
- ☐ Did you make a change in the resident's medication in response to the identified irregularity(ies) or document a rationale if you didn't make a change in the medication regimen?
- ☐ What is the rationale behind why the medication is being used (e.g., antipsychotic for dementia or other high risk medications)?
- ☐ What other approaches were attempted prior to the use of a psychotropic medication and/or while attempting a GDR?
- ☐ When was a GDR last completed? What was the result?
- ☐ Are you included in the IDT meeting for this resident?

Record Review:

- ☐ Was the underlying cause (medical, environmental, or psychosocial stressors) of the conditions or symptoms requiring the medication identified?
- ☐ If a medication was discontinued, was there evidence of a GDR, if applicable (e.g., for psychotropic and antipsychotic medications)?
- ☐ Did the pharmacist conduct an MRR for the resident at least once a month that included a review of the resident's medical record?
- ☐ Did the pharmacist identify and report all medication irregularities to the attending physician, medical director, and DON? Were the irregularities documented on a separate, written report? Were the reports acted upon?
- ☐ Did the attending physician document in the medical record that the irregularity was reviewed? What, if any, action was taken? What rationale was documented if no change was made to the medication regimen?
- ☐ If the resident had a change in condition such as, dehydration or acute illness, was the medication regimen reviewed? Did the pharmacist complete a MRR?
- ☐ Is there evidence of actual or potential adverse events, such as allergic reactions, inadequate monitoring? (Refer to the CMS Adverse Drug Event Trigger Tool).
- ☐ Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
- ☐ Is the MAR accurate, complete and followed according to standards of practice?
- ☐ For antibiotics: Are signs or symptoms of infection documented? Have appropriate diagnostic tests been obtained to inform antibiotic selection and continuation?
- ☐ What is the facility response when monitoring indicates a lack of progress toward the therapeutic goal?
- ☐ What individualized, non-pharmacological approaches were documented, specifically for residents who receive psychotropic medications?
- ☐ Review the facility's policies regarding psychotropic medications and MRR. Are they updated and maintained? Does the policy include timeframes for the steps in the process? Does the policy include the steps the licensed pharmacist must take for a medication irregularity that requires urgent action?

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

Critical Elements Decisions:

1. For the **Medication Regimen Review (MRR)**:
   A. Did the licensed pharmacist:
      - Conduct an MRR, at least monthly, that included a review of the resident's medical record;
      - Conduct an MRR more frequently, as needed; and
      - Report irregularities to the attending physician, medical director, and the DON?

   B. Did the attending physician document:
      - Review of identified irregularity(ies);
      - The action, if any, taken;
      - A rationale if no action is taken?

   C. Has the facility developed and implemented MRR policies and procedures?
      - Do they address, at a minimum:
        - Time frames for steps in the MRR process;
        - Steps the pharmacist must take when an irregularity requires urgent action.

   If No to any of the above, cite F756

2. For **Unnecessary Medications**: Did the facility ensure that each resident's medication regimen was free from unnecessary medications? (Note: If the unnecessary medication is a psychotropic medication, cite F758)
   If No, cite F757

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

3. For **Psychotropic Medications**, did the facility ensure that:
   - they are used only to treat a specific, diagnosed, and documented condition;
   - a GDR was attempted, unless clinically contraindicated, and non-pharmacological approaches to care were implemented;
   - PRN use is only if necessary to treat a specific, diagnosed, and documented condition;
   - PRN orders for psychotropic medications which **are not** for antipsychotic medications are limited to 14 days,unless the attending physician/prescribing practitioner documents a rationale to extend the medication;
   - PRN orders which **are** for antipsychotic medications are limited to 14 days, without exception and the attending physician/prescribing practitioner did not renew the order without first evaluating the resident?

   If No to any of the above, cite F758
   NA, the resident was not prescribed psychotropic medications.

4. Did the facility conduct ongoing review for antibiotic stewardship?
   If No, cite F881

5. For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655.
   NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

6. If the condition or risks related to medications were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

7. If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed therefore a significant change in status assessment is not required OR the resident did not have a significant change in status.

8. Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

9. Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

10. Did the facility reassess the effectiveness of the approaches and review and revise the resident's care plan (with input from the resident and, if appropriate, the resident representative) to meet the resident's needs?
    If No, cite F657
    NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to be Informed and Participate F552, F553, Notification of Change F580, Chemical Restraints F605, Choices (CA), Social Services F745, Admission Orders F635, Professional Standards F658, Pain (CA), General Pathway (CA) for Diabetic Management, Dementia Care (CA), ADLs (CA), Urinary Incontinence (CA), Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Physician Services F710, F711, Pharmacy Services F755, QAA/QAPI (Task).

Adverse Drug Event Trigger Tool

Intended use of this tool:
This tool is intended to assist surveyors to identify:
1. The extent to which facilities have identified resident-specific risk factors for adverse drug events,
2. The extent to which facilities developed and implemented systems and processes to minimize risks associated with medications that are known to be high-risk and problem-prone, and
3. When a preventable adverse event has occurred, and evaluate if the nursing home identified the issue and responded appropriately to mitigate harm to the individual and prevent recurrence.

Definitions:
• **Adverse Event:** An untoward, undesirable, and usually unanticipated event that causes death, serious injury, harm, or the risk thereof.
• **Adverse Drug Event:** An injury resulting from drug-related medical interventions.
• **Adverse Drug Reaction:** Harm directly caused by a drug at normal doses.
• **Anticholinergic Effects:** Physical symptoms resulting from drugs that counter the action of acetylcholine including increased blood pressure, respiratory distress, clumsiness/unsteadiness, bloating/constipation/ileus, nausea/vomiting, dry mouth, delirium, drowsiness/lethargy/fatigue, urinary retention, hallucinations, memory problems, and blurred vision.
• **Prescribing Cascade:** Adverse reaction to one drug that goes unrecognized or is misinterpreted resulting in the prescriber inappropriately prescribing a subsequent drug to treat the signs/symptoms of the adverse reaction.
• **Polypharmacy:** Multiple definitions exist, but most include reference to drugs without indication and the number of medications used (e.g., more than 10).
• **Risk Factor:** Issue or condition that increases the potential for an adverse event to occur. Risk factors include resident level issues such as medications prescribed, age, and concurrent conditions as well as system level issues such as lack of staff knowledge related to high risk medications and unclear protocols to address lab results.

Disclaimer: Use of this tool is not mandated by the Centers for Medicare & Medicaid Services (CMS) for regulatory compliance nor does its use ensure regulatory compliance.

Adverse Drug Event Trigger Tool

Adverse Drug Event (ADE)	**Risk Factors** - These increase the potential for ADEs. Multiple factors increase risk.	**Triggers: Signs and Symptoms (S/S)** - Any of these may indicate an ADE may have occurred.	**Triggers: Clinical Interventions** - These actions may indicate an ADE occurred.	**Surveyor Probes -** These questions are designed to assist in the investigation. A negative answer does not necessarily indicate noncompliance.
psychotropic medication use (including antipsychotics, antidepressants, anxiolytics, and hypnotics)	psychotropic medication including more than one drug from the same class or different classes • Advanced age • Polypharmacy	• Orthostatic hypotension • Destabilized blood sugar • Akathisia • Parkinsonism • Anticholinergic effects	symptoms • New order for restraint • Abrupt stop order for medication	• If receiving PRN and routinely, is there consideration for the timing of administration of the PRN? • Is there evidence of a system for ensuring the resident is routinely assessed for effectiveness of the medication and signs/symptoms of adverse drug reactions/events? • Is there a system for monitoring for involuntary movements? • Is there evidence that the facility has attempted gradual dose reduction or rationale documented if not attempted? • Is there evidence the facility implements non-pharmacological approaches and interdisciplinary management of the condition that the medication targets? • Is there evidence in the medical record that the resident or representative were involved in decisions related to medication use? • Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)?

PSYCHOTROPIC MEDICATION PRESCRIBING GUIDELINES: November 2017

SWG seniors wellness group

MEDICATION TYPE	F-758 GUIDELINES FOR DURATION OF USE AND GRADUAL DOSE REDUCTIONS (GDR)	DOCUMENTATION FOR CONTINUATION AND EXCEPTIONS
Routine Psychotropic • Anti-psychotic • Anti-depressant • Anti-anxiety • Hypnotic • Other Any medication that affects brain activities associated with mental processes and behaviors	**Gradual Dose Reductions (GDR):** • Within the first year : Must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated • After the first year, a GDR must be attempted annually, unless clinically contraindicated Ongoing assessment and documentation of GDR: • Admission or within 2 weeks: (at the time of the initial MDS assessment) on new admissions who do not require PASRR screening • During quarterly care plan meeting if not more often • Identification as possibly causing or contributing to an adverse consequence or change in condition	• Psychotropic GDR Contraindication Justification for use Dementia Diagnosis (include but not limited to): o The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; AND o The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. • Psychotropic GDR Contraindication Justification for Disorder OTHER THAN Dementia Diagnosis (Schizophrenia, Bipolar Mania, Depression with Psychotic Features, or other disorder which may cause Psychosis: o The continued use is in accordance with relevant current standards of practice AND the Physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder; OR o The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility AND the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder. o Long term treatment for specific disorders with psychotropic meds: Clinical goal is to have no symptoms of Disorder – Clinical Rationale ▪ Even though symptoms have subsided, long term treatment is required so that symptoms do not return. Reducing or eliminating medication may be contraindicated and must be individualized.. ▪ Chronic depression Parkinson's disease psychosis ,recurrent seizures, chronic psychiatric illness (schizophrenia, schizoaffective disorder, post-traumatic stress Disorder); Neurological disorders (Huntington's and Tourrette's); Psychosis and psychotic episodes • Antipsychotics: Require clear documentation of diagnosis and indication for use; multiple attempts at care planned non-drug interventions that have failed and ongoing evaluation of these approaches. Diagnoses alone do not warrant use. Indication may be warranted if: o Behavioral symptoms present danger to self or others o Expressions or indications of distress that are significant to the resident o If not clinically contraindicated, non-pharmacological approaches previously attempted have failed and/or o GDR was attempted, but clinical symptoms returned • Potential Adverse Reactions of Psychotropic Medications for Monitoring: o General: anticholinergic effects which may include flushing, blurred vision, dry mouth, altered mental status, difficulty urinating, falls, excessive sedation, constipation o Cardiovascular: signs and symptoms of cardiac arrhythmias such as irregular heart beat or pulse, palpitations,lightheadedness, shortness of breath, diaphoresis, chest or arm pain, increased blood pressure, orthostatic hypotension o Metabolic: increase in total cholesterol and triglycerides, unstable or poorly controlled blood sugar, weight gain o Neurologic: agitation, distress, EPS, neuroleptic malignant syndrome (NMS), parkinsonism, tardive dyskinesia, cerebrovascular event (e.g., stroke, transient ischemic attack (TIA). • Emphasis is on seeking lowest effective dose and duration and minimizing risk of adverse consequences
PRN Psychotropic (EXCEPT Anti-Psychotics)	• Limited to 14 days OR • Can extend duration beyond 14 days with prescribing practitioner's rationale and duration	• Effectiveness • Ongoing specific diagnosed condition • Indication • Duration
PRN Anti-Psychotic	• Limited to 14 days (without exception)	Direct evaluation by prescriber including the following in the resident's medical record with every order and continuation : • Ongoing specific diagnosed condition and indication: Is the antipsychotic medication still needed on a PRN basis? • What is the benefit of the medication to the resident? • Effectiveness: Have the resident's expressions or indications of distress improved as a result of the PRN medication? • Duration cannot exceed 14 days

- Always consider outside factors that may be contributing to symptoms; Initiate meaningful Non-drug interventions unless clinically contraindicated ; Evaluate for adverse consequences
- PRN Psychotropic exceptions are NOT made for residents on Hospice; PRN antipsychotics used for other non-psychotropic indications such as nausea, hiccups, etc. have not been given exception and are still subject to the 14 day limit.
- Other *medications which may affect brain activity such as central nervous system agents, mood stabilizers, anticonvulsants, muscle relaxants, anticholinergic medications, antihistamines, NMDA receptor modulators, and over the counter natural or* herbal *products must also only be given with a documented clinical indication consistent with accepted clinical standards of practice*
- Unnecessary Drugs—General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used— In excessive dose (including duplicate drug therapy); or For excessive duration; or Without adequate monitoring; or Without adequate indications for its use; or In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
  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
  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 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

Effective 11.28.2017

PSYCHOTROPIC MEDICATION PRESCRIBING GUIDELINES: November 2017

Final Rule for Reform of Requirements Phase II (Effective 11/28/17)

F758: Free From Unnecessary Psych Meds/ PRN use **

PRN Orders for Psychotropic and Antipsychotic Medications

In certain situations, psychotropic medications may be prescribed on a PRN basis, such as while the dose is adjusted, to address acute or intermittent symptoms, or in an emergency. However, residents must not have PRN orders for psychotropic medications unless the medication is necessary to treat a diagnosed specific condition. The attending physician or prescribing practitioner must document the diagnosed specific condition and indication for the PRN medication in the medical record.

The required evaluation of a resident before writing a new PRN order for an antipsychotic entails the attending physician or prescribing practitioner directly examining the resident and assessing the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed. As part of the evaluation, the attending physician or prescribing practitioner should, at a minimum, determine and document the following in the resident's medical record:

- Is the antipsychotic medication still needed on a PRN basis?
- What is the benefit of the medication to the resident?
- Have the resident's expressions or indications of distress improved as a result of the PRN medication?

KEY ELEMENTS OF NONCOMPLIANCE If any of the elements the sections below involve psychotropic medications

- Use of psychotropic medication(s) without documentation of the need for the medication(s) to treat a specific diagnosed condition; or
- PRN psychotropic medication ordered for longer than 14 days, without a documented rationale for continued use; or
- Failure to implement person-centered, non-pharmacological approaches in the attempt to reduce or discontinue a psychotropic medication; or
- Administering a new PRN antipsychotic medication for which the resident had a previous PRN order (for 14 days) but the medical record does not show that the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the new order for the medication.

Requirement: PRN Orders for Psychotropic Drugs (psychotropic drug definition changed to any drug that affects brain activities associated with mental processes and behavior (i.e., anti- psychotic, anti-depressant, anti-anxiety, hypnotic)

- Are limited to use only when necessary to treat a diagnosed specific condition documented in clinical record
- Added 14-day limitation on **PRN** orders for **psychotropic drugs** with option for extension if attending physician or prescribing practitioner documents rationale in medical record **and** indicates duration of PRN order

- Prescriber documents rationale in progress notes (may be handwritten or electronic)
- Prescriber indicates the duration on the PRN order

Requirement: 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.

- Prescriber writes a new PRN prescription every 14 days after the resident has been evaluated, if deemed appropriate

Dementia Care Critical Element Pathway

Use this pathway for a resident who displays or is diagnosed with dementia to determine if the facility provided appropriate treatment and services to meet the resident's highest practicable physical, mental, and psychosocial well-being.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Most current comprehensive and most recent quarterly (if the comprehensive is not the most recent) MDS/CAAs for Sections C – Cognitive Patterns, D – Mood, E – Behavior and N – Medications.
- ☐ Physician orders.
- ☐ Care plan.

Observations over Various Shifts:

- ☐ Are appropriate dementia care treatment and services being provided? If so, what evidence was observed?
- ☐ Are staff consistently implementing a person-centered care plan that reflects the resident's goals and maximizes the resident's dignity, autonomy, privacy, socialization, independence, and choice?
- ☐ Are staff using non-pharmacological interventions to attain or maintain the resident's well-being?
- ☐ How does the facility modify the environment to accommodate the resident's care needs?
- ☐ Are there sufficient staff to provide dementia care treatment and services? If not, describe the concern.
- ☐ Does staff possess the appropriate competencies and skill sets to ensure the resident's safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being? If not, describe.

Note: If sufficient/competent staffing concerns exist that fall within the scope of meeting a resident's behavioral health care needs, also determine compliance with F741.

Resident, Family, and/or Resident Representative Interview:

- ☐ Can you tell me about your/the resident's current condition or diagnosis and the history of the condition?
- ☐ How did the facility involve you/the resident in the care plan and goal development process?
- ☐ How did the facility consider your/the resident's choices and preferences?

Note: If the resident lacks decisional capacity and also family/representative support, contact the facility social worker to determine what type of social services or referrals have been implemented.

Dementia Care Critical Element Pathway

Staff Interviews (Interdisciplinary team (IDT) members) Across Various Shifts:

- ☐ How do you ensure care is provided that is consistent with the care plan?
- ☐ Can you tell me about the resident's care plan and his/her condition (including underlying causes)?
- ☐ What are the facility's dementia care guidelines and protocols?
- ☐ What types of dementia management training have you completed?
- ☐ How, what, when, and to whom do you report changes in condition?
- ☐ How do you monitor care plan implementation and changes in condition?
- ☐ How are changes in the care plan and the resident's condition communicated to staff?
- ☐ Ask about any other related concerns the surveyor has identified.

Record Review:

- ☐ Are the resident's dementia care needs adequately assessed?
- ☐ Is the care plan comprehensive? Does it address the resident's specific conditions, risks, needs, preferences, interventions, and include measurable objectives and timetables? Has the care plan been revised to reflect any changes?
- ☐ Are pharmaceutical interventions used only if clinically indicated, at the lowest dose, shortest duration, and closely monitored?
- ☐ Was dementia management training provided to staff?

Dementia Care Critical Element Pathway

Critical Element Decisions:

1) A. Did the facility comprehensively assess the physical, mental, and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes:
   - Did staff identify and assess behavioral expressions or indications of distress with specific detail of the situation to identify the cause;
   - If the expressions or actions represent a sudden change or worsening from baseline, did staff immediately contact the attending physician/practitioner;
   - If medical causes are ruled out, did staff attempt to establish other root causes of the distress; and/or
   - Did facility staff evaluate:
     - The resident's usual and current cognitive patterns, mood, and behavior, and whether these present risk to resident or others; and/or
     - How the resident typically communicates an unmet need such as pain, discomfort, hunger, thirst, or frustration?

   B. Did the facility develop a care plan with measurable goals and interventions to address the care and treatment for a resident with dementia:
   - Was the resident and/or family/representative involved in care plan development;
   - Does the care plan reflect an individualized, person-centered approach with measureable goals, timetables, and specific interventions;
   - Does the care plan include:
     - Monitoring of the effectiveness of any/all interventions; and/or
     - Adjustments to the interventions, based on their effectiveness, as well as any adverse consequences related to treatment?

   C. In accordance with the resident's care plan, did qualified staff:
   - Identify, document, and communicate specific targeted behaviors and expressions of distress, as well as desired outcomes;
   - Implement individualized, person-centered interventions and document the results; and/or
   - Communicate and consistently implement the care plan over time and across various shifts?

   D. Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and care plan?

   If No to A, B, C, or D, cite F744

2) For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
   If No, cite F655
   NA, the resident did not have an admission since the previous survey OR the care or services was not necessary to be included in a baseline care plan.

3) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
   If No, cite F636
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a Significant Change in Status Assessment OR the resident was recently admitted and the comprehensive assessment was not yet required.

4) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
   If No, cite F637
   NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant changed in status.

5) Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
   If No, cite F641

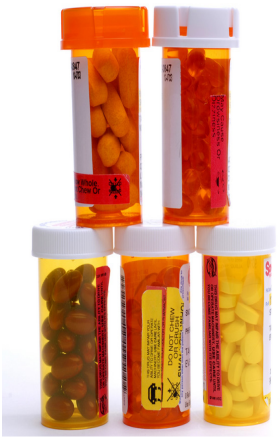
6) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
   If No, cite F656
   NA, the comprehensive assessment was not completed.

7) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
   If No, cite F657
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Behavioral-Emotional Status (CA), Participate in Planning Care F553, Notification of Changes F580, Chemical Restraints F605, Qualified Persons F659, QOL F550 or F675, QOC F684, Physician Services F710, Social Services F745, Unnecessary/Psychotropic Medications (CA), Sufficient and Competent Staffing (Task).

Quality Measure Tip Sheet: Antipsychotic Medication—Long Stay

Quality Measure Overview



- Reports the percentage of long-stay residents who are receiving antipsychotic drugs in a **7-day look-back period**.

Exclusions:

– Residents with a diagnosis of schizophrenia, Tourette's syndrome, or Huntington's disease.

MDS Coding Requirements

In the Minimum Data Set (MDS):

- Indicate the number of days the resident received antipsychotic medications during the last seven days (or since admission/entry/re-entry if less than seven days).

Ask These Questions ...

- Is the MDS coding accurate?
- Are psychotropic medications only being used when appropriate to enhance the resident's quality of life while maximizing his or her functional potential and well-being?
- Have the least restrictive interventions been attempted first?
- Have staff members analyzed the resident holistically to rule out underlying conditions, such as medical causes, that are affecting behavior?
- Are activities individualized and specific to the resident to alleviate boredom?
- Are basic needs being met?
- Are dementia residents hungry/thirsty and instructed when to eat/drink?
- Are dementia residents dressed appropriately for the weather and their age?
- Is the resident's incontinence being managed?
- Is the resident's pain being managed?
- Is the nursing home environment calming? Are there areas for private space? Is clutter managed? Are residents' belongings organized to decrease confusion?
- Do residents have a sense of trust with their caregivers?
- Are there consistent staff member assignments?
- Are there consistent routines?
- Are orders received from outside vendors, such as hospice, monitored? *(These vendors may use antipsychotic medications to control conditions such as nausea and vomiting that could be controlled by a less restrictive medication or antiemetic.)*
- Are gradual-dose reductions completed per regulation?
- Does the facility involve direct-care staff members, physicians, and pharmacists in pharmacy and therapeutic meetings at least quarterly?
- Is a behavior-tracking process in place to monitor for changes?
- Are adverse side effects of drugs monitored and treated accordingly?
- Do residents obtain psychological services for treatment if indicated?
- Are staff members and family educated on behavior management and nonpharmacological interventions?

For guidance on your quality measures, reach out to Health Services Advisory Group (HSAG).

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canursinghomes@hsag.com

In Florida, contact:
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HSAG HEALTH SERVICES ADVISORY GROUP

Best Practice Strategies

Evidence-Based Nonpharmacological Practices to Address Behavioral and Psychological Symptoms of Dementia

Criteria to Rate Investment Required for Nonpharmacological Practices to Treat BPSDs*

	Low Investment	Moderate investment	High investment
Time required for training and implementation	<1 hr of training <15 min to implement	1-4 hr of training 15-60 min to implement	>4 hr of training >60 min to implement
Specialized care provider requirements	None	Implemented by usual care provider but requires specialized knowledge	Not implemented by usual care provider
Equipment or capital resources	Material purchase <$100 with no ongoing cost No environmental modification	Material purchase $100-$500 Ongoing cost <$100/month Some environmental modification	>4 hr of training >60 min to implement Not implemented by usual care provider Extensive environmental modification

Sensory Practices

Practice	Description	Summary of evidence	Implementation and investment
Aromatherapy	Administration of scented oils (e.g., lavender or lemon balm), via diffusion, patches, or skin cream, to induce calm and positive affect.	Moderate evidence base Evidence is mixed; indicates positive effect on agitation More high-quality research required, using consistent implementation protocols and outcome measures	Well accepted by participants No known harmful effects Autonomic nervous system regulation and social/ physical contact may be key elements of effectiveness Low investment
Massage	Tactile or therapeutic touch applied to back, shoulders, necks, hands, or feet by qualified massage therapist or by trained staff or family members, to induce calm and positive affect.	Small evidence base Evidence indicates positive effects on agitation, aggression, anxiety, depression, disruptive vocalizations More high-quality research required, using consistent implementation protocols and outcome measures and conducted with larger samples	Well accepted by participants No known harmful effects, although individual preference regarding physical touch should be assessed and honored Physiological response and social/physical contact may be key elements of effectiveness Low investment
Bright Light Therapy	Exposure to simulated or natural lighting designed to help synchronize circadian rhythms with environmental light–dark cycles	Moderate evidence base Evidence is mixed, showing both positive and negative effects Better research required, especially with natural light	Acceptance varies by light source Potential for harmful effects Circadian rhythm change may be key element of effectiveness Moderate investment

Psychosocial Practices

Practice	Description	Summary of evidence	Implementation and investment
Validation Therapy	Individual or group practice designed to validate the perceived reality and emotional experience of the individual.	Small evidence base Evidence is mixed; some evidence of positive effects on agitation, apathy, irritability, night-time disturbance More high-quality research required on the specific effects on BPSDs	Well accepted by participants No known harmful effects, although care providers should ensure that negative emotions are not exacerbated through validation Alleviating negative feelings and enhancing positive feelings may be key elements of effectiveness Low investment
Reminiscence Therapy	Individual or group practice designed to induce positive affect through a focus on happy memories, often using photographs or other prompts.	Moderate evidence base Evidence indicates positive effects on mood, depressive symptoms More high-quality research required on the specific effects on BPSDs	Well accepted by participants No known harmful effects, although care providers should help focus reminiscence on positive memories Increasing well-being and providing pleasure and cognitive stimulation may be key elements of effectiveness Moderate investment
Music Therapy	Receptive or participatory activities designed to promote well-being, foster sociability, create familiarity, and reduce anxiety.	Moderate evidence base Evidence indicates positive effects on a range of BPSDs, including anxiety, agitation, and apathy, particularly with personalized music practices More high-quality research with larger samples required	Degree of acceptance varies by participant's preference for music No known harmful effects Promoting well-being and sociability, aiding reminiscence, reducing anxiety/stress, and providing distraction may be key elements of effectiveness Moderate investment
Pet Therapy	Structured or unstructured time with animals, primarily dogs, to promote well-being, socialization and emotional support, and sensory stimulation.	Small evidence base Evidence is preliminary, with some evidence of positive effects on agitation, apathy, disruptive behavior Stuffed or robotic pets may be an effective substitute for live animals	Degree of acceptance varies by participant's preference for animals Negative outcomes may include allergic reactions, hygiene concerns, or anxiety/agitation Socialization/bonding, emotional support, and

		More research with larger samples and consistent implementation protocols required	sensory stimulation may be key elements of effectiveness Low - moderate investment
Meaningful Activities	Provision of activities designed to enhance quality of life through engagement, social interaction, and opportunities for self-expression and self-determination.	Moderate evidence base Evidence is mixed, but shows some positive effects on agitation; larger for activities that are individually tailored Some evidence for positive effect of physical exercise on agitation and depressive symptoms More high-quality research with larger samples and longer duration required	Degree of acceptance varies by appropriateness of activity No known harmful effects, except for expected risks associated with physical engagement in activities Enhancing quality of life, social interaction, and opportunities for self-expression and self-determination may be key elements of effectiveness Low - moderate investment

Structured Care Protocols

Practice	Description	Summary of evidence	Implementation and investment
Mouth Care	Structured protocols for providing mouth care include person-centered communication, interaction strategies and technical skills.	Small evidence base Evidence is preliminary; one study found positive effects on care-resistant behaviors More high-quality research required	Well accepted by participants No known harmful effects Reducing threat, anxiety, fear, and pain may be key elements of effectiveness Low investment
Bathing	Structured protocols for providing bathing care that include person-centered communication and interaction strategies as well as technical skills.	Small evidence base Evidence indicates positive effects on agitation, aggression, irritability, anxiety Better research required, using consistent implementation protocols and outcome measures	Well accepted by participants No known harmful effects Reducing fear and pain may be key elements of effectiveness Low investment

Antipsychotic Alternatives

The following information suggests ideas for reducing antipsychotic drug use. A carefully monitored use of the alternatives with frequent reassessment is suggested. Always start by assessing the resident for pain*.

General Principles

- Start with a pain assessment.
- Provide for a sense of security.
- Apply the 5 Magic Tools (Knowing what the resident likes to See, Smell, Touch, Taste, Hear).
- Get to know the resident, including their history and family life, and what they previously enjoyed. Learn the resident's life story. Help the resident create a memory box.
- Play to the resident's strengths.
- Encourage independence.
- Use pets, children and volunteers.
- Involve the family by giving them a task to support the resident.
- Use a validated pain assessment tool to assure non-verbal pain is addressed.*
- Provide consistent caregivers.
- Screen for depression & possible interventions.
- Reduce noise (paging, alarms, TV's, etc.).
- Be calm and self-assured.
- Attempt to identify triggering events that stimulate behaviors.
- Employ distraction methods based upon their work and career.
- Offer choices.

What to try when the resident resists care

Therapeutic Intervention

- Evaluate recent medication changes, especially if the behavior is new.
- Determine if the resident is in pain, and if so, why? Treat the pain.*
- Evaluate whether the care can be performed at a different time.
- Determine if the resident is trying to communicate a specific need.
- Evaluate the resident's sleep patterns.
- Place the resident in bed when he or she is fatigued.
- Evaluate if there has been a change in the resident's routine.
- Provide a positive distraction, or something the resident enjoys.
- Is the resident hungry? Offer the resident a snack prior to providing care.
- Provide a periodic exercise program throughout the day (e.g. A walk to dine program).
- Encourage wheelchair/chair pushups, or assist the resident to stand periodically.
- Provide activities to assess and provide entertainment.
- Encourage repositioning frequently.

Environmental & Equipment Intervention

- Use assistive devices (wedge cushion, solid seat for wheelchair, side or trunk bolsters, pommel cushion, Dycem, etc.).
- Evaluate the resident for an appropriate size chair and proper fit.
- Evaluate alternative seating to relieve routine seating pressure/pain.
- Use an overstuffed chair, reclining wheelchair, non-wheeled chairs, or wingback chair.
- Place a call bell in reach of the resident.
- Provide an over-bed table for to allow for diversional activities.
- Place a water pitcher in reach of the resident.
- Place the resident's favorite items in their room to provide them comfort.
- Allow access to personal items that remind the resident of their family, especially photos.
- Encourage routine family visits with pets.
- Provide consistent caregivers.
- Evaluate if the resident's environment can be modified to better meet their needs. (i.e. Determine if the resident's environment can be more personalized.)

* A pain assessment should include non-verbal signs of pain. If you do not have a pain assessment that includes non-verbal identifiers, go to: http://www.dads.state.tx.us/qualitymatters/qcp/pain/painad.pdf

Continued →

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What to consider when resident is disruptive in group functions

Therapeutic Intervention

- Evaluate new medications, antibiotics especially, and asses pain.
- Remove resident from group, evaluate for group stress
- Determine if resident requires toileting.
- Determine if resident is hungry, and if so, provide them with a small snack. If the resident is thirsty, provide the resident a beverage.
- If this is a new behavior in a group, evaluate what is different this time.
- Assure resident has had a rest period prior to group activity.
- Assure there are no medical complications (low/high blood sugar).
- Assure resident is not in pain.*
- Return resident to group function, if possible.

Environmental & Equipment Intervention

- Determine whether clothing is appropriate for a particular function.
- Evaluate is the resident has well-fitting shoes, and ensure they do not rub the resident's feet.
- Evaluate ambulation devices (wheelchair, walker) that are in good working condition.
- Ensure there is adequate lighting, especially at night.
- Ensure room/function is not overly crowded.
- Ensure room is not too warm or cold.
- Consider providing snacks and refreshments for all group functions.
- Ensure sound in group functions is loud enough so the resident can hear.
- Provide consistent caregivers.
- Evaluate if this program fits into the resident's area of interest.

What to consider with a sudden mood change, such as depression

Therapeutic Intervention

- Evaluate any new medications and assess pain*.
- Evaluate for orthostatic hypotension and change positions slowly.
- Reevaluate physical needs such as toileting, comfort, pain, thirst and timing of needs.
- Rule out medical problem (high/low blood sugar changes).
- Engage resident in conversation about their favorite activity, positive experiences, pets, etc.
- Touch if appropriate while recognizing personal body space.
- Anticipate customary schedules and accommodate personal preferences.
- Evaluate balance for sub-clinical disturbances such as inner ear infections.
- Validate feelings and mobilize the resident. For instance, if the resident states, I want to get up, reply, You want to get up? to confirm you heard them correctly. If so, act on the resident's request.
- Evaluate hearing and vision.
- Discern if talk therapy is possible.
- Assess sleep patterns.

Environmental & Equipment Intervention

- Assess for changes in the resident's environment.
- Assess for changes in the resident's equipment.
- Involve family members to assure them that there have been no changes within the family, without the facility's knowledge.
- Provide routines for consistency.
- Provide consistent caregivers.
- Provide nightlights for security.
- Employ the use of a memory box.
- Employ functional maintenance / 24-hour plan.
- Encourage the resident, if able, to verbalize his or her feelings.
- Eliminate noise and disruption.
- Employ the use of a sensory room or tranquility room.

Verbally Abusive/Physically Abusive

Therapeutic Intervention

- Begin with medical evaluation to rule out physical or medication problems.
- Evaluate the resident for acute medical conditions such as urinary tract infections, upper respiratory infections, ear infections or other infections.
- Evaluate the resident for pain, comfort and/or other physical needs such as hunger, thirst, position changes, bowel and bladder urges.
- Attempt to identify triggering events or issues that stimulate the behavior.
- Consider using a behavior tracking form to assist in identification of triggers and trending patterns.
- Consult with the resident's family regarding past coping mechanisms that proved effective during times of increased stress levels.
- Provide companionship.
- Validate feelings such as saying, You sound like you are angry.
- Redirect.
- Employ active listening skills and address potential issues identified.
- Set limits.
- Develop trust by assigning consistent caregivers whenever possible.
- Avoid confrontation. Decrease you voice level.
- Provide a sense of safety by approaching in a calm/quiet demeanor.
- Provide rest periods.
- Provide social services referral if needed.
- Provide a psychologist/psychiatrist referral if needed.
- Provide touch therapy and/or massage therapy on the hands or back.
- Reduce external stimuli (overhead paging, TV, radio noise, etc.).
- Evaluate staffing patterns and trends.
- Evaluate sleep/wake patterns.
- Maintain a regular schedule.
- Limit caffeine.
- Avoid sensory overload.

Environmental & Equipment Intervention

- Use relaxation techniques (i.e. tapes, videos, music etc.).
- Help the resident create theme/memory/reminiscence boxes/books.
- Help the resident create a magnification box to create awareness of the resident's voice level and provide feedback.
- Use a lava lamp, soothe sounders, and active mobile.
- Play tapes and videos of family and/or familiar relatives or friends.
- Move to a quiet area, possibly a more familiar area, if needed. Decrease external stimuli.
- Use fish tanks.
- Encourage family visits, and visits from favorite pets.
- Identify if another resident is a trigger for this behavior.

Pacing/ Wandering At Risk for Elopement

Therapeutic Intervention

- Find ways to meet a resident's needs to be needed, loved and busy while being sensitive to their personal space.
- Provide diverse activities that correspond with past lifestyles/preferences.
- Consider how medications, diagnoses, Activites of Daily Living schedule, weather or how other residents affect wandering.
- Evaluate the need for a Day Treatment Program for targeted residents.
- Help resident create theme/memory/reminiscence boxes.
- Provide companionship.
- Provide opportunities for exercise particularly when waiting.
- Pre-meal activities.
- Singing, rhythmic movements, dancing, etc.
- Identify customary routines and allow for preferences.
- Help the resident create a photo collage or album of memorable events.
- Provide structured, high-energy activities and subsequent relaxation activities.
- Take the resident for a walk.
- Provide distraction and redirection.
- Provide written/verbal reassurance about where he/she is and why.
- Alleviate fears.
- Ask permission before you touch, hug etc.
- Assess/evaluate if there is a pattern in the pacing or wandering.
- Assess for resident' personal agenda and validate behaviors.
- Ask family to record reassuring messages on tape.
- Evaluate for a restorative program.
- Perform a physical workup.

Environmental & Equipment Intervention

- Remove objects that remind the patient/resident of going home (hats, coats, etc.).
- Individualize the environment. Make the environment like the resident's home. Place objects within the environment that are familiar to the resident.
- Place a large numerical clock at the resident's bedside to provide orientation to time of day as it relates to customary routines.
- Ensure the courtyard is safe for the resident.
- Decrease noise level (especially overhead paging).
- Evaluate floor patterns.
- Evaluate rest areas in halls.
- Evaluate camouflaging of doors.
- Evaluate visual cues to identify safe areas.
- Play a favorite movie or video.
- Put unbreakable or plastic mirrors at exits.
- Place Stop and Go signs.
- Evaluate the WanderGuard system.
- Use relaxation tapes.
- Evaluate and use, as necessary, visual barriers and murals.
- Evaluate wandering paths.
- Evaluate room identifiers.

Quality Improvement Tools and Resources

How to Quantify Your Quality Improvement Goals

Step 1: Determine your desired relative improvement rate for the quality measure of interest. For example, your home's goal may be to reduce your long-stay antipsychotic medication measure by 15%.

Step 2: Obtain your current quality measure (QM) score of interest along with associated numerator and denominator counts from CASPER reports.

Step 3: Multiply your current QM numerator by (100 – desired relative improvement percent), then divide by 100 and round down to the nearest whole number. This will be your target numerator count to achieve your desired improvement.

Step 4: Subtract your target numerator from your current QM numerator to obtain your resident reduction goal.

Example:

1. Goal is to reduce long-stay antipsychotic medication measure by **15%**
2. Current score: **21/82 = 25.61%**
3. Target QM numerator:
   $\frac{\mathbf{21 * (100-15)}}{\mathbf{100}}$ **= 17.85** → rounded down to nearest whole number means **17** is the target numerator.
4. Resident reduction goal: **21 – 17 = 4** less residents on unnecessary antipsychotic medications.

In the example above, the home would need to reduce their numerator by 4 residents from 21 at baseline down to 17 at follow-up to achieve a 15% relative improvement rate for the antipsychotic medication measure.

These calculations are assuming that the number of residents meeting denominator criteria at baseline and follow-up remains the same. In the above example, the reduced rate would be 17/82 = 20.73%.

This material was adapted from materials created by Telligen, Inc. This material was prepared by the Lake Superior Quality Innovation Network, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The materials do not necessarily reflect CMS policy. 11SOW-MI-C2-18-51 022818

Partnership to Improve Dementia Care in Nursing Homes
State Coalition Provider Question Worksheet
(Self-Assessment Tool)

Appropriate dementia care includes more than managing individuals with dementia-related behavior. It also requires minimizing and managing the various factors that maintain overall health and physical stability and optimize function in residents who are often complex and may suffer from multiple chronic conditions. How do caregivers collaborate with practitioners to properly assess behavior carefully and systematically, to help rule out critical underlying causes, including (but not limited to) environmental, functional, and other possibly correctable causes or serious medical conditions such as delirium? Does the facility have detailed process guidance for staff regarding the assessment, documentation, and reporting of all symptoms and changes in condition, including behavior? Are they reviewing and addressing staff performance in these areas, based on individual cases?

Direct Caregivers

1. How does staff address behavioral responses by persons with dementia in your facility, such as anxiousness or aggressiveness?

2. Do you know if your facility has policies and procedures in place that you are supposed to follow when a resident with dementia exhibits certain behaviors, or those behaviors worsen?

3. What training have you received about how to care for persons with dementia?
    a. Who provides the training?
    b. Do you know what materials are used?
    c. Does the training give you a chance to practice how you would respond?

4. When a resident with dementia demonstrates certain behaviors such as anxiety or aggression, is he or she given a medication to treat them?
    a. Do you know whether the team at your facility is trying to reduce the use of these drugs?

5. Are residents and families given information about care options for persons with dementia, including those that do or do not use medications?

Leadership- (Nursing Home Administrator, Director of Nursing, Medical Director)

1. How will your facility measure success in improving dementia care and reducing or optimizing antipsychotic drug use?

2. What do you see as the major barriers to accomplishing this?

3. Are you currently reviewing data related to antipsychotic drug use for all residents, including residents that are returning or were recently discharged from an acute care setting?

4. Are there tools/resources/support that would assist you in analyzing and interpreting data?
   For example, telephone or in-person support from:
   a. A member of your state nursing home association;
   b. A consultant;
   c. A quality improvement organization;
   d. Other state-based nursing home specialist?

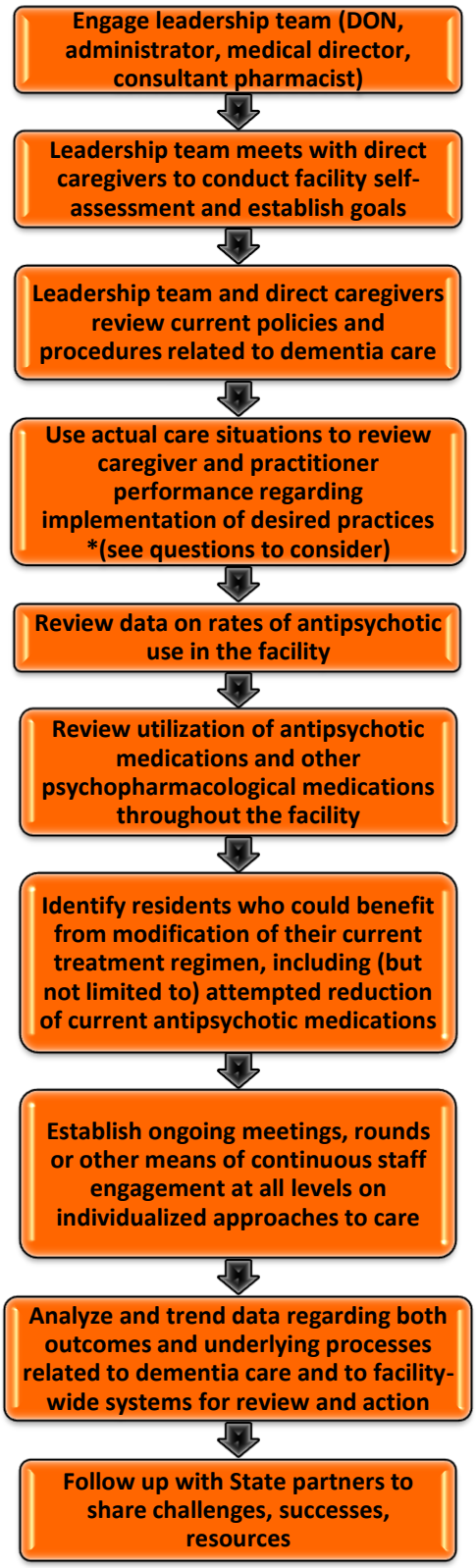
5. If your facility is part of a corporation, does the corporation provide educational materials, clinical support or data analysis related to dementia care and/or antipsychotic drug use?

6. Is staff in all departments educated on person-centered care for individuals with dementia?

7. How is the Consultant Pharmacist involved in the overall care of residents?
   For example, does the Consultant Pharmacist routinely engage in:
   a. Data analysis;
   b. Staff education;
   c. Routine interaction with residents and/or families?

8. How is the Medical Director involved in the overall care of residents with dementia?

PARTNERSHIP TO IMPROVE DEMENTIA CARE IN NURSING HOMES
Provider Implementation Flow Diagram



Why is our use of antipsychotics high for individuals with dementia?

- Has the use of antipsychotics risen over the last three months?
- Is our use of antipsychotics more than the average for our state?
- How does our rate compare to the national average?

Which groups are affected?

a. Residents

- Are the individuals with dementia long stay or short stay?
- Are individuals on the same unit?
- Are residents on scheduled antipsychotics, as needed (PRN) antipsychotics or both?
- Do we discuss the use of anti-psychotics with residents and/or families and gain their consent for their use?

b. Prescribers

- Do the prescriptions for antipsychotics come from the same prescriber or are there different prescribers?
- Are antipsychotics started outside of the nursing home (for example - hospital, outside consultant) or are the drugs started after people are in the nursing home?
- For those whose medications are started in the nursing home is there an assessment done prior to, or shortly after the initiation of an antipsychotic medication?
- Have there been conversations with the prescribers about reducing or stopping antipsychotics?
- Have there been any consulting pharmacist recommendations to reduce the antipsychotics and were these recommendations followed?

Processes and Resources to Consider

What practices do we have in place to minimize the use of antipsychotic medications?

- Is there an optimum number of staff and do staffing patterns support individualized, person-centered care?
- Does our staffing pattern provide for flexibility based on the number of persons with dementia, and/or the severity of their illness?
- Does our staffing pattern provide adequate coverage for crisis management?
- Is there adequate staff training on dementia and on understanding and responding to behavior as a means of communication?
- Does support exist within the nursing home to change the utilization of antipsychotics?
- Do staff request antipsychotics prior to assessment of a resident?
- Do staff request antipsychotics prior to systematic attempts to identify and address unmet needs that may be triggering behavioral responses?
- Are there patterns of use?

Are there patterns of use?

- Are there clear and acceptable clinical rationale for use of medications?
- Are gradual dose reductions being conducted at our home?
- Are the medications being monitored by objective measures?
- If so, are the outcomes positive for the individual?
- Are the medications causing adverse effects for the resident and/or change in function?

Antipsychotic Prescription Log

Facility Name: _____

Date: _____

Resident Room #	Antipsychotic Medication	Date antipsychotic medication was started.	What setting was the medication started in?	Primary mental health diagnosis?	Does the resident have dementia?	Primary behavioral problems?	Does the resident have symptoms of possible drug side effects? Explain.	Has GDR been attempted?	Date of most recent GDR attempt	Outcome of GDR

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Five Whys Tool for Root Cause Analysis

Overview: Root cause analysis is a structured team process that assists in identifying underlying factors or causes of an event, such as an adverse event or near –miss. Understanding the contributing factors or causes of a system failure can help develop actions that sustain corrections.

The Five Whys is a simple problem-solving technique that helps to get to the root of a problem quickly. The Five Whys strategy involves looking at any problem and drilling down by asking: "Why?" or "What caused this problem?" While you want clear and concise answers, you want to avoid answers that are too simple and overlook important details. Typically, the answer to the first "why" should prompt another "why" and the answer to the second "why" will prompt another and so on; hence the name Five Whys. This technique can help you to quickly determine the root cause of a problem. It's simple, and easy to learn and apply.

Directions: The team conducting this root cause analysis does the following:

- Develops the problem statement. (See Step 1 of Guidance for RCA for additional information on problem statements.) Be clear and specific.
- The team facilitator asks why the problem happened and records the team response. To determine if the response is the root cause of the problem, the facilitator asks the team to consider “If the most recent response were corrected, is it likely the problem would recur?” If the answer is yes, it is likely this is a contributing factor, not a root cause.
- If the answer provided is a contributing factor to the problem, the team keeps asking “Why?” until there is agreement from the team that the root cause has been identified.
- It often takes three to five whys, but it can take more than five! So keep going until the team agrees the root cause has been identified.

Tips:

- Include people with personal knowledge of the processes and systems involved in the problem being discussed.
- Note that the Five Whys technique may not always help you to identify the root cause. Another technique you might consider is the fishbone diagram. The fishbone diagram forces you to think broadly across various categories that could be causing or contributing to the problem (See How to Use the Fishbone Tool for Root Cause Analysis tool).

Problem statement	One sentence description of event or problem
Why? ⇨	
Why? ⇨	
Why? ⇨	
Why? ⇨	
Why? ⇨	
Root Cause(s)	1. 2. 3. To validate root causes, ask the following: If you removed this root cause, would this event or problem have been prevented?

Example:
Here is an everyday example of using the Five Whys to determine a root cause:
Problem statement – your car gets a flat tire on your way to work.

1. Why did you get a flat tire?
    - You ran over nails in your garage
2. Why were there nails on the garage floor?
    - The box of nails on the shelf was wet; the box fell apart and nails fell from the box onto the floor.*
3. Why was the box of nails wet?
    - There was a leak in the roof and it rained hard last night. (Root cause=leak in the roof)

*IF YOU STOPPED HERE AND "SOLVED" THE PROBLEM BY SWEEPING UP THE NAILS, YOU WOULD HAVE MISSED THE ROOT CAUSE OF THE PROBLEM.

Sample Psychotropic Medication Policy and Procedure

Shared with Permission of Karyn Leible, RN, MD, CMD

Policy:

Physicians and mid level providers will use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring.

Standards:

1. The facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in the long term care facility to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits.
2. The facility supports the appropriate use of psychopharmacologic medications that are therapeutic and enabling for residents suffering from mental illness.
3. The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical, and/or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of the individual resident.
4. The facility supports the goal of determining the underlying cause of residents having difficulty sleeping so the appropriate treatment of environmental or medical interventions can be utilized prior to psychopharmacologic medication use.
5. Efforts to reduce dosage or discontinue of psychopharmacological medications will be ongoing, as appropriate, for the clinical situation.
6. Psychopharmacological medications will never be used for the purpose of discipline or convenience.
7. Psychotropic medications include: anti-anxiety/hypnotic, antipsychotic and antidepressant classes of drugs.

Responsible Party – Actions Required:

Primary care physician, PA or APN

1. Orders for psychotropic medication only for the treatment of specific medical and/ or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by the use of non pharmacologic approaches.
2. Documents rationale and diagnosis for use and identifies target symptoms.
3. Documents discussion with the resident and/or responsible party regarding the risk versus benefit of the use of these medications included in the discussion and documentation must be the presence of any black box warning or off label use of the medication affecting the prescribing of the medication to the resident.

4. Evaluates with the interdisciplinary team, effects and side effects of psychoactive medications within one month of initiating, increasing, or decreasing dose and during routine visits thereafter.
5. Monitors the resident for lack of drug efficacy clinically and in discussions with the interdisciplinary team within one month of initiating and during routine visits.
6. Attempt a gradual dose reduction (GDR) decrease or discontinuation of psychotropic medications after no more than 3 months unless clinically contraindicated. Gradual dose reduction must be attempted for 2 separate quarters (with at least one month between attempts). Gradual dose reduction must be attempted annually thereafter or as the resident's clinical condition warrants.
7. Sedative/ hypnotics will be reviewed quarterly for gradual dose reduction. GDR must be attempted quarterly unless clinically contraindicated.
8. Orders for PRN psychotropic medications will be time limited (i.e., times 2 weeks) and only for specific clearly documented circumstances.
9. Obtains psychiatric consultation as resident's clinical condition requires.

Psychiatrist/mental health (When available to a facility)

1. May assist the facility in establishing appropriate guidelines for use, dosage and monitoring of psychotropic medications.
2. Uses the above standards (1-9) in recommendations to physicians.
3. Provides in service training to nursing, medical, and other staff as appropriate.
4. Is available for consultation.
5. Helps develop behavior management plans.

Nursing

1. Monitors psychotropic drug use daily noting any adverse effects such as increased somnolence or functional decline.
2. Will monitor for the presence of target behaviors on a daily basis charting by exception (i.e., charting only when the behaviors are present).
3. Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behaviors and or the presence of any adverse effects of the medication use.
4. AIMS will be performed on any resident on and antipsychotic on a quarterly basis changes will be reported to the physician.
5. May develop behavioral care plans.

Social Services

1. Maintains a list of residents in the facility on psychoactive medications.
2. Coordinates the interdisciplinary team resident reviews of psychoactive medications.
3. May develop behavioral care plans.

Pharmacist and/or consulting pharmacist

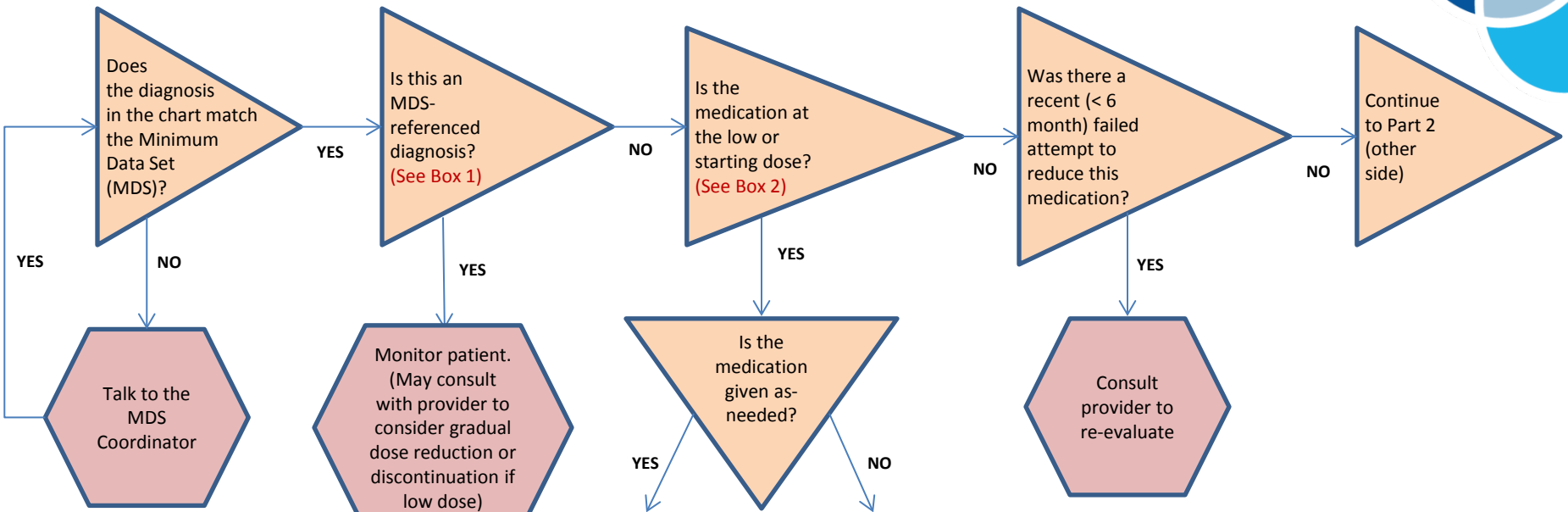
1. Monitors psychotropic drug use in the facility to ensure that medications are not used in excessive doses or for excessive duration.
2. Participates in the interdisciplinary quarterly review of resident's on psychoactive medications.
3. Notifies the physician and the nursing unit if whenever a psychotropic medication is past due for review.

Medical Director

1. Reviews psychotropic medication policy with the interdisciplinary team at least annually.
2. Monitors the overall use of these medications in the facility through the QAPI process.
3. Identifies any resident care or potential regulatory issues with the use of psychotropic medications in the facility and discusses with the medical staff as appropriate.
4. Participates in the interdisciplinary quarterly review of resident's on psychoactive medications and facilitates communications with attending physicians of any recommendations from the IDT.

Antipsychotic Reduction | Resident Prioritization Tool Part 1*

The actions in the pink hexagons are intended to be addressed before moving to Part 2



Box 1
MDS-Referenced Diagnosis

Schizophrenia
Schizoaffective disorder
Tourette syndrome
Huntington disease

Consult MDS for more information.

Box 2
Common Low or Starting Dose

Quetiapine (Seroquel) 12.5-25mg
Olanzapine (Zyprexa) 2.5-5mg
Risperidone (Risperdal) 0.25-0.5mg
Aripiprazole (Abilify) 2-5mg
Ziprasidone (Geodon) 20-40mg

This material was prepared by Health Services Advisory Group, the Medicare Quality Improvement Organization for Arizona, California, Florida, Ohio, and the U.S. Virgin Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, from material originally prepared by Telligen, under contract with CMS. The contents presented do not necessarily reflect CMS policy. Publication No. QN-11SOW-C.2-01152016-01

Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

Antipsychotic Reduction | Resident Prioritization Tool Part 2*

Use this ONLY to evaluate residents after completing Part 1 (other side)

List Residents | Target Symptom

Non-Aggressive Target Symptom Absent

Target Symptom absent for less than three months**

RANK

Rank residents in order of who has been symptom-free the longest (longest is #1)

1_____
2_____
3_____
4_____

RANK

Time it took to become free of target symptom (shortest time is #1)

1_____
2_____
3_____
4_____

RANK

How long resident has been on medication (longest time is #1)

1_____
2_____
3_____
4_____

RANK

Dose of medication (highest dose is #1)

1_____
2_____
3_____
4_____

Aggressive Target Symptom*
Behavior that causes physical or emotional harm to others or one's self, or threatens to.

Non-Aggressive Target Symptom Persists**
Hallucinations, delusions (do not mistake delusions for memory problems)

Target Symptoms Where Antipsychotic Treatment May Be Inappropriate
Wandering, not being social or friendly, poor self-care, restlessness, uncooperativeness without aggression. *Consult provider.*

These lists are not comprehensive and are intended to be used only as guidance.

Add up points for each resident in the green boxes above (#1 is 1 point etc.)

Resident_____ Points_____
Resident_____ Points_____
Resident_____ Points_____
Resident_____ Points_____

The resident with the LOWEST point total should be considered first for dose reduction.

-This flowchart was developed in part utilizing documentation with permission from Dr. Thomas Magnuson of the University of Nebraska Medical Center published article "Reductions in Antipsychotics in Long Term Care"

-Always consult the provider
-Dose reductions should be approached with awareness and caution for symptoms of withdrawal
-Documentation is key for target symptom management and outcomes tracking

*In aggressive residents, six months of stability may be needed.
**In non-aggressive residents, three months of stability is reasonable before a reduction is attempted.

MULTIDISCIPLINARY MEDICATION MANAGEMENT COMMITTEE

ANTIPSYCHOTIC USE IN DEMENTIA ASSESSMENT

RESIDENT NAME: _____ **ROOM:** _____ **PHYSICIAN:** _____

ASSESSMENT DATE: _____ □ Initial assessment □ Continuation assessment
PHQ-9 Score/date: _____ BIMS/CPS Score/date: _____

A. **ANTIPSYCHOTIC** (name/dosage/directions): _____

- Start Date: _____ Last Dosage Change: _____ (Decrease/Increase)

B. **OTHER CONCURRENT CLINICAL CONCERNS:**

❑ *Pain*	❑ *Infection*	❑ *Constipation*	❑ *Weight loss*
❑ *Falls*	❑ *Parkinson's*	❑ *Depression*	❑ *Insomnia*
❑ *Other:*			

C. **REASON FOR ANTIPSYCHOTIC INITIATION:**

- ❑ *Dementing Illness with associated behavioral symptoms*
- ❑ *Dementia alone*
- ❑ *Other:* _____
- ❑ *No Indication Identified*

D. **TARGETED SYMPTOMS OR BEHAVIORS (why was it started):**

_____
_____

E. **NONPHARMACOLOGICAL INTERVENTIONS:**

_____
_____

F. **BEHAVIORAL TRENDS SINCE LAST ASSESSMENT** (In Documentation**):**

❑ Behavioral symptoms Decreased	❑ Behavioral symptoms Increased
❑ No Change in Behavioral symptoms	

***SUMMARY*: _____**

G. **ADVERSE EFFECT MONITORING** (changes from baseline functioning) [**AIMS=** _____ date_____]

❑ *Drowsiness, sedation or confusion*	❑ *Dizziness or loss of balance*	❑ *Falls*	❑ *Constipation*
❑ *Muscle spasm, tremor, shaking*	❑ *Uncontrolled movements*	❑ *Tardive dyskinesia*	❑ *Vision changes*
❑ *Swallowing difficulty*	❑ *Speech difficulty*	❑ *Headache*	❑ *Weight gain*
❑ *Dry mouth*	❑ *Drooling*	❑ *Increased skin sensitivity*	❑ *Restlessness or anxiety*
Other:	*Other:*	❑ *NO Apparent ADR's reported*	

M3 COMMITTEE SUMMARY OF BEHAVIORAL TRENDS & ANTIPSYCHOTIC USAGE:

_____
_____
_____

ANTIPSYCHOTIC USE IN DEMENTIA ASSESSMENT

H. **M3 COMMITTEE RECOMMENDATION** (Date:_____):

[*Always consider a dose reduction even if it may have failed in the past*]

☐ ***Gradual Dosage Reduction at this Time:***

- Recommended dose reduction (write new orders):
  _____

☐ ***Gradual Dosage Reduction NOT indicated due to (BOTH requirements must be met):***

- Previous attempt at GDR resulted in reoccurrence of behavioral symptoms (documented date: _____) ; **AND**
- Clinical rationale why an attempt at GDR would likely impair this resident's function or increase their distressed behavior:
  _____
  _____

☐ ***Recent Dosage Change*** *(<60 days)*: _____

☐ ***Will Consider GDR when Resident is Clinically Stable:***

- Clinical Rationale: _____

☐ ***Recommend Additional Clinician Assessment of Behavioral Symptoms with Follow-up Report at Next Scheduled Meeting***

M3 Committee Members:

Medical Director: _____ Executive Director: _____ D.O.N.: _____

Consultant Pharmacist: _____ Social Services: _____ Nurse Manager: _____

I. **ATTENDING PHYSICIAN ASSESSMENT** (Date:_____):

☐ ***I Agree with M3 Committee's recommendation (follow recommendation above)***

☐ ***I Agree with M3 Committee's recommendations*, but with these orders:**

- _____

☐ ***I Disagree with M3 Committee's recommendations because (specific clinical rationale for this resident required):***

- _____
  _____
  _____

PHYSICIAN SIGNATURE: _____ **Date:** _____

ORDERS CONFIRMED BY: _____ Date: _____

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