Antipsychotic Use in the Elderly: Time to Change Established Practice
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I have no conflicts of interest related to the development of this program to report.

Historically

- Antipsychotic medications have been utilized for the management of behavioral symptoms in older adults that have been diagnosed with various types of dementia (Alzheimer's, Lewy Body, Pick's, Vascular).
- Antipsychotic medications have not been approved for the management of dementia associated behaviors and use of such medications in the elderly has been associated with an increased risk of death.
- Use of antipsychotic medications in the elderly with dementia is off-label use of these medications.
- In most cases, may be considered “convenience drugging.” (Cowles, 2015)
Partnership to Improve Dementia Care in Nursing Homes

- In 4th quarter of 2011, antipsychotic use among nursing home residents reached a high of 23.9%.
- Initiative to reduce antipsychotic use began with the 2nd quarter of 2012.
- Data obtained from MDS data submitted by facilities, compiled quarterly.
- Official measure is the percentage of long stay nursing home residents who are receiving an antipsychotic medication, excluding those diagnosed with schizophrenia, Huntington’s disease or Tourette’s Syndrome.
- Information on individual facilities can be obtained at www.medicare.gov/nursinghomecompare.

Partnership results

- Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-to-Improve-Dementia-Care-in-Nursing-Homes.html
- At beginning of partnership, rate of use was 23.9%.
- At the conclusion of 1st quarter 2015, use had reduced to 18.7% nationally.
  - Oregon (18): 2011–21.5%, 2015–16.79%

Best Performers

- 1. Hawaii
- 2. District of Columbia
- 3. Michigan
- 4. New Jersey
- 5. Wisconsin
- 6. Wyoming
- 7. Alaska
- 8. Delaware
- 9. Minnesota
- 10. South Carolina

Worst Performers
- 50. Texas and Louisiana
- 49. Illinois
- 48. Mississippi
- 47. Kansas
- 46. Alabama
- 45. Tennessee
- 44. Kentucky
- 43. Ohio
- 42. Nebraska
- 41. Missouri
- 40. Missouri
- 49. Illinois
- 48. Mississippi
- 47. Kansas
- 46. Alabama
- 45. Tennessee
- 44. Kentucky
- 43. Ohio
- 42. Nebraska
- 41. Missouri
- 40. Missouri
- 39. Louisiana
- 38. Texas
- 37. Alabama
- 36. Mississippi
- 35. Louisiana
- 34. Texas
- 33. Alabama
- 32. Mississippi
- 31. Louisiana
- 30. Texas
- 29. Alabama
- 28. Mississippi
- 27. Louisiana
- 26. Texas
- 25. Alabama
- 24. Mississippi
- 23. Louisiana
- 22. Texas
- 21. Alabama
- 20. Mississippi
- 19. Louisiana
- 18. Texas
- 17. Alabama
- 16. Mississippi
- 15. Louisiana
- 14. Texas
- 13. Alabama
- 12. Mississippi
- 11. Louisiana
- 10. Texas
- 9. Alabama
- 8. Mississippi
- 7. Louisiana
- 6. Texas
- 5. Alabama
- 4. Mississippi
- 3. Louisiana
- 2. Texas
- 1. Alabama

Confusion for Nursing Home
- F329—guideline to surveyors relating to the appropriate diagnosis for use of antipsychotic medications
  - Schizophrenia
  - Schizoaffective disorder
  - Bipolar disorder
  - Mood disorder, bipolar disorder, depression with psychotic features, treatment requiring regular medication
  - Schizophreniform disorder
  - Psychosis NOS
  - Atypical psychosis
  - Brief reactive disorder
  - Dementia or delirium with associated behavioral symptoms
  - Medical illness or delirium with mood psychotic symptoms, treatment related psychosis or mania (thyrotoxicosis, neoplasms, high fever, etc.)
- Appropriate Diagnosis for Antipsychotics relating to Quality Measures utilized by Nursing Home Compare
  - Schizophrenia
  - Tourette's syndrome
  - Huntington's disease

Surveyor Guidance
- Did staff describe behavior (onset, duration, intensity, possible precipitating events or environmental triggers, etc.) and related factors (appearance, alertness, etc.) in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible?
- If the behaviors represent a sudden change or worsening from baseline, did staff contact the attending physician/practitioner immediately for a medical evaluation, as appropriate?
- If medical causes are ruled out, did staff attempt to establish other root causes of the behavior, using individualized knowledge about the person and when possible, additional information from the resident, family, previous caregivers and medical and care staff?
- As part of the comprehensive assessment did facility staff evaluate:
  - The resident's usual and current cognitive patterns, mood and behavior, and whether these present a risk to the resident or others?
  - How the resident typically communicates a need such as pain, discomfort, hunger, thirst or frustration, as provided by family, caregivers, and others who are familiar with the resident before or after admission?
  - Prior life patterns and preferences customary responses to triggers such as stress, anxiety or fatigue, as provided by family, caregivers, and others who are familiar with the resident before or after admission?
- Did staff, in collaboration with the practitioner, identify risk and causative/contributing factors for behaviors, such as:
  - Presence of co-existing medical or psychiatric conditions, or decline in cognitive function?
  - Severe consequences related to the resident's current medications?
Current recommendations

- In a recent addition to the Choosing Wisely list (2013), AMDA recommended: “don’t prescribe antipsychotic medications for behavioral psychological symptoms of dementia in individuals with dementia, without an assessment for an underlying cause of the behavior.”

There has to be a reason

- The most common cause of behavioral symptoms in patients with dementia is an unmet need.
- Behavioral symptoms should be considered a form of communication
- A thorough and complete evaluation must be completed in order to identify the unmet need that leads to the behavior
- Interventions or approaches that works today may not work next week or next month
- Facility behavior modification plans are too generic and may not address the needs of the patient.

Is it an UTI?

- In the presence of worsening behavioral symptoms in a patient with dementia, a request for a urinalysis may arise from nursing staff or even family members. However, a urinalysis and urine culture should only be ordered if clinical signs and symptoms of urinary tract infection are present. Evidence suggests, however, that urinary tract infections are not prominently associated with physical or verbal aggression in patients with dementia. Moreover, there is good evidence that asymptomatic bacteriuria should not be treated with antibiotics, even when there is significant bacterial growth in the urine culture, and the use of unnecessary antibiotics is to be discouraged for multiple reasons.

- The onset or worsening of medical illnesses or other problems in patients with dementia often precipitates a series of events, including altered nutritional status, functional decline, and hospitalization, that affect many aspects of the patient’s life and care. Understanding these risks and promptly addressing problems can sometimes prevent hospitalization and its related risks.

- It is well accepted that sending a dementia patient to the emergency room can precipitate delirium and result in other bad outcomes. Compared to treating them in their familiar surroundings, with caregivers known to them, in the nursing home. When possible, treatment in place for changes of condition is preferable.
Examples of Complications From Medical Treatment of Problematic Behavior and Impaired Cognition

- Adverse drug effects and interactions
- Cardiac arrhythmias
- Sudden cardiac death
- Increased lethargy or confusion
- Stroke
- Falls
- Metabolic abnormalities
- Orthostatic hypotension
- Worsening of disruptive or socially unacceptable behavior

Remember!

- There is NO one component of culture change and/or programming that will act alone to support a reduction in antipsychotic usage.
- BUT through assessment, person-centered care, resident engagement and the support of a multidisciplinary team it can be done.

Use the ABCs

- Antecedent (trigger)
  - Internal
  - External
- Behavior
- Consequence
Triggers

- Internal
  - Boredom
  - Hunger
  - Thirst
  - Toiletting
  - Unfamiliarity with surroundings
  - Revenge

- External
  - Environmental temperature
  - Hand/Voice of God
  - Facility schedules
  - Actions of caregivers
  - Fight or flight

Inappropriate reasons for antipsychotic medication use

- Wandering
- Poor self care
- Refusal of self care assistance
- Impaired memory
- Insomnia
- Indifference or inattention to surroundings
- Sadness/crying unrelated to depression or other psychiatric disorders
- Fidgeting/nervousness

Remember

- Antipsychotic medications should not be given to a patient who is uncooperative and refuses care UNLESS
  - The behavior presents a danger to the resident and others
  - And/or the symptoms are due to mania or psychosis
  - And/or behavioral interventions have been attempted and included in the plan of care
Inappropriate documentation of risks vs benefits

- Pt continues to be psychologically unstable despite significant doses of mood stabilizing (seroquel) meds and other psychotropic medications. He becomes resistant to nursing requests to behave and remain seated in his w/c with a personal alarm (apparently not functioning today).
- Plan: No changes in current meds (eg. decreasing dose), and since he is not agreeable to transfer to geropsyche, we may consider additional interventions and discontinuation of Neudexta (sic).

Inappropriate documentation of risks vs benefits

- Pt has been on Neudexta (sic) since 3 1/2 weeks ago with some improvement per staff. However, during my last two visits to SNF, his personal alarm has sounded when he has attempted to get up out of chair. No falls or injuries were sustained. We would like to consider reducing seroquel dose from 300 mg per day by 50 mg reductions.
- Exam: No acute changes, obvious signs of dementia and confusion but pt is not belligerent or abusive.
- Plan: consider reduction in meds (quetiapine) next week or so.

If antipsychotics are used

Facilities must attempt a gradual dose reduction in two separate quarters unless clinically contraindicated.

To be considered clinically contraindicated, if the target symptoms returned or worsened.

MUST—attempt non-pharmacological behavior management strategies

Be familiar with the guidance in the state operations manual
Case Study

- 76 year old man, with hx of dementia, gait instability. Wheelchair mobile. Is currently prescribed quetiapine for behavioral issues such as exit seeking, inappropriate attempts to stand and transfer from wheelchair per nursing staff. Patient has been assessed as being unsafe to leave facility alone.
- Approaches exit to facility, attempting to exit without assistance. When approached by nursing staff, states he wishes to leave obtain a cup of coffee. Staff attempts to re-direct, he becomes agitated and angry. Other staff members arrive to assist, patient becomes angrier. Situation continues to escalate.
- What could have been done differently? What triggers could have been modified?

A final exercise

- You have been given 12 pieces of paper. Please write 12 things that are important to you (family, career, pets, etc) on these pieces of paper, one item on each.
- When done, please place them face up in front of you.

References