New CMS Surveyor Guidance: Care & Services for a Resident with Dementia

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Dementia Care Principles
1. Person–Centered Care. CMS requires nursing homes to provide a supportive environment that promotes comfort and recognizes individual needs and preferences.

Dementia Care Principles
2. Quality and Quantity of Staff. The nursing home must provide staff, both in terms of quantity (direct care as well as supervisory staff) and quality to meet the needs of the residents as determined by resident assessments and individual plans of care.
Dementia Care Principles
3. Thorough Evaluation of New or Worsening Behaviors. Residents who exhibit new or worsening BPSD should have an evaluation by the interdisciplinary team, including the physician, in order to identify and address treatable medical, physical, emotional, psychiatric, psychological, functional, social, and environmental factors that may be contributing to behaviors.

Dementia Care Principles
4. Individualized Approaches to Care. Current guidelines from the United States, United Kingdom, Canada and other countries recommend use of individualized approaches as a first line intervention (except in documented emergency situations or if clinically contraindicated) for BPSD. Utilizing a consistent process that focuses on a resident’s individual needs and tries to understand behavior as a form of communication may help to reduce behavioral expressions of distress in some residents.

Dementia Care Principles
5. Critical Thinking Related to Antipsychotic Drug Use.
   ▪ In certain cases, residents may benefit from the use of medications. The resident should only be given medication if clinically indicated and as necessary to treat a specific condition and target symptoms as diagnosed and documented in the record.
   ▪ Residents who use antipsychotic drugs must receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.
Dementia Care Principles

6. Interviews with Prescribers.
   - None of the guidance to surveyors should be construed as evaluating the practice of medicine. Surveyors are instructed to evaluate the process of care.
   - Surveyors interview the attending physician or other primary care provider (NP, PA), behavioral health specialist, pharmacist and other team members to better understand the reasons for using a psychopharmacological agent or any other interventions for a specific resident.

Dementia Care Principles

7. Engagement of Resident and/or Representative in Decision-Making.
   - In order to ensure judicious use of psychopharmacological medications, residents (to the extent possible) and/or family or resident representatives must be involved in the discussion of potential approaches to address behavioral symptoms.
   - These discussions with the resident and/or family or representative should be documented in the medical record.

Entrance Conference

Surveyors will request a list of the names of residents who have a diagnosis of dementia and who are receiving, have received, or presently have PRN orders for antipsychotic medications over the past 30 days.
Entrance Conference

If the facility population includes residents with dementia, the surveyor will ask the administrator or director of nursing to describe how the facility provides individualized care and services for residents with dementia and to provide policies related to the use of antipsychotic medications in residents with dementia.

At least one resident with dementia, AND who is currently receiving, or has PRN orders for, antipsychotic medication MUST be included in the survey sample.

F309 – Quality of Care

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
F309 – Quality of Care - Intent
The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident’s right to refuse treatment, and within the limits of recognized pathology and the normal aging process.

Investigative Protocol
There is no specific investigative protocol for care of a resident with dementia.
• For the traditional survey, the surveyor may use the surveyor checklist titled, “Review of Care and Services for a Resident with Dementia” to assist in investigating the care and services provided to a resident with a diagnosis of dementia.
• For the QIS survey, the surveyor will use the general CE pathway and may use the checklist as a guide to completing that pathway.

Definitions Related to Recognition and Management of Dementia
• Behavioral interventions are individualized approaches (including direct care and activities) that are provided as part of a supportive physical and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident’s distress or loss of abilities.
Definitions Related to Recognition and Management of Dementia

Person-Centered or Person-Appropriate Care is care that is individualized by being tailored to all relevant considerations for that individual, including physical, functional, and psychosocial aspects.

For example, activities should be relevant to the specific needs, interests, culture, background, etc. of the individual for whom they are developed and medical treatment should be tailored to an individual's risk factors, past history, and details of any present symptoms.
Definitions Related to Recognition and Management of Dementia

Behavioral or Psychological Symptoms of Dementia (BPSD) is a term used to describe behavior or other symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause. The term "behaviors" is more general and may encompass BPSD or responses by individuals to a situation, the environment or efforts to communicate an unmet need.

What is behavior?

• Human behavior is the response of an individual to a wide variety of factors.
• Behavior is generated through brain function, which is in turn influenced by input from the rest of the body.
• Specific behavioral responses depend on many factors, including personal experience and past learning, inborn tendencies and genetic traits, the environment and response to the actions and reactions of other people.
• A condition (such as dementia) that affects the brain and the body may affect behavior.

What is dementia?

• Dementia is not a specific disease. It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain.
  • People with dementia have significantly impaired intellectual functioning that interferes with normal activities and relationships.
What is dementia?

- People also lose their ability to solve problems and maintain emotional control, and they may experience personality changes and behavioral problems, such as agitation, delusions, and hallucinations.
- While memory loss is a common symptom of dementia, memory loss by itself does not mean that a person has dementia.
- Doctors diagnose dementia only if two or more brain functions - such as memory and language skills – are significantly impaired without loss of consciousness.

Dementia and Behavior

- Behavioral or psychological symptoms are often related to the brain disease in dementia; however behavior and other symptoms may also be caused or exacerbated by environmental triggers.
- Behavior often represents a person’s attempt to communicate an unmet need, discomfort or thoughts that they can no longer articulate.

Dementia and Behavior

- Knowing detailed cultural, medical and psychosocial information about a person can help caregivers identify potential environmental or other triggers in order to prevent or reduce, to the extent possible, behavior or other expressions of distress.
What is delirium?

A resident may have undiagnosed delirium, which is an acute confusional state that includes symptoms very similar to those of dementia and psychiatric disorders.

The diagnostic criteria for delirium include a fluctuating course throughout the day, inattention as evidenced by being easily distracted, cognitive changes, and perceptual disturbances.

What is delirium?

Classic delirium is often characterized as hyperactive (e.g., extreme restlessness, climbing out of bed); but more commonly delirium is hypoactive often leading to the misdiagnosis of dementia or a psychiatric disorder.

What is delirium?

Delirium and dementia are now recognized as being related. Individuals with dementia are at higher risk for developing delirium and it now appears that delirium increases the risk of developing dementia over time.

Recognizing delirium is critical, as failure to act quickly to identify and treat the underlying causes may result in poor health outcomes, hospitalization or even death. A psychiatric disorder.
Therapeutic Interventions & Approaches
• The use of any approach must be based on a careful, detailed assessment of physical, psychological and behavioral symptoms and underlying causes as well as potential situational or environmental reasons for the behaviors.

Therapeutic Interventions & Approaches
• Caregivers and practitioners are expected to understand or explain the rationale for interventions/approaches, to monitor the effectiveness of those interventions/approaches, and to provide ongoing assessment as to whether they are improving or stabilizing the resident’s status or causing adverse consequences.

Therapeutic Interventions & Approaches
• Describing the details and possible consequences of resident behaviors helps to distinguish expressions such as restlessness or continual verbalization from potentially harmful actions such as kicking, biting or striking out at others.
Therapeutic Interventions & Approaches

- Identifying the frequency, intensity, duration and impact of behaviors, as well as the location, surroundings or situation in which they occur may help staff and practitioners identify individualized interventions or approaches to prevent or address the behaviors. Individualized, person-centered interventions must be implemented to address behavioral expressions of distress in persons with dementia.

Therapeutic Interventions & Approaches

In many situations, medications may not be necessary; staff/practitioners should not automatically assume that medications are an appropriate treatment without a systematic evaluation of the resident.

Examples of techniques or environmental modifications that may prevent certain behavior related to dementia may include:

Arranging staffing to optimize familiarity with the resident (e.g., consistent caregiver assignment);
Examples of techniques or environmental modifications that may prevent certain behavior related to dementia may include:

Identifying, to the extent possible, factors that may underlie the resident’s expressions of distress, as well as applying knowledge of lifelong patterns, preferences, and interests for daily activities to enhance quality of life and individualize routine care.

Examples of techniques or environmental modifications that may prevent certain behavior related to dementia may include:

- Understanding that the resident with dementia may be responding predictably given the situation or surroundings.
  - For example, being awakened at night in his/her bedroom by staff and not recognizing the staff could elicit an aggressive response; and

Examples of techniques or environmental modifications that may prevent certain behavior related to dementia may include:

- Matching activities for a resident with dementia to his/her individual cognitive and other abilities and the specific behaviors in that individual based on the assessment.
Resident & Family/ Representative Involvement

CMS expects that the resident and family/representatives, to the extent possible, are involved in helping staff to understand the potential underlying causes of behavioral distress and to participate in the development and implementation of the resident’s care plan.

Resident & Family/ Representative Involvement

- Facilities should be able to identify how they have involved residents/families/representatives in discussions about potential approaches to address behaviors and about the potential risks and benefits of a psychopharmaceutical medication (e.g., FDA black box warnings), the proposed course of treatment, expected duration of use of the medication, use of individualized approaches, plans to evaluate the effects of the treatment, and pertinent alternatives.
- The discussion should be documented in the resident’s record (See F15).

Care Process for a Resident Who Has Dementia

Fundamental principles of care for persons with dementia include an interdisciplinary team approach that focuses holistically on the needs of the resident as well as the needs of the other residents in the home.
Care Process for a Resident Who Has Dementia

It is important for the facility to have systems and procedures in place to assure that assessments are timely and accurate; interventions are described, consistently implemented, monitored, and revised as appropriate in accordance with current standards of practice.

Care Process for a Resident Who Has Dementia

- It is expected that a facility’s approach to care for a resident with dementia follows a systematic care process in order to gather and analyze information necessary to provide appropriate care and services, and that the resident and/or family or representative is engaged throughout the process.

The resident’s record should reflect the implementation of the following care processes:

A. Recognition and Assessment;
B. Cause Identification and Diagnosis;
C. Development of Care Plan;
D. Individualized Approaches and Treatment;
   Monitoring, Follow-up and Oversight; and
   Quality Assessment and Assurance (QAA).
It’s more than just Ftag 309!
- The following guidance aggregates requirements in a number of other F-tags such as:
  - comprehensive assessment,
  - activities,
  - resident rights,
  - unnecessary medications and others,

**Recognition & Assessment**
This step includes collecting detailed information about a resident. The resident’s record should reflect comprehensive information about the person including, but not limited to:
- past life experiences,
- description of behaviors,
- preferences such as those for daily routines, food, music, exercise and others;
- oral health,

**Recognition & Assessment**
This step includes collecting detailed information about a resident. The resident’s record should reflect comprehensive information about the person including, but not limited to:
- presence of pain,
- medical conditions;
- cognitive status and related abilities and
- medications.
When reviewing the comprehensive assessment (see F272), the Care Area Assessment (CAA) Resources, particularly those related to Activities and Behavioral Symptoms, found in the Long-Term Care Facility Resident Assessment Instrument User’s Manual, Version 3.0 may be helpful.

• How the resident typically communicates physical needs such as pain, discomfort, hunger or thirst, as well as emotional and psychological needs such as frustration or boredom; or a desire to do or something that cannot be articulated.

• 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 displays personal distress such as anxiety or fatigue.
Recognition & Assessment
• This and other information enables an understanding of the individual and provides a basis for cause identification (based on knowing the whole person and how the situation and environment may trigger behaviors) and individualized interventions.

Recognition & Assessment
• If the resident expresses distress, staff should specifically describe the behavior (including potential underlying causes, onset, duration, intensity, precipitating events or environmental triggers, etc.) and related factors (such as appearance and alertness) in the medical record with enough detail of the actual situation to permit cause identification and individualized interventions (See F514)

Recognition & Assessment
• For example, noting that the resident is generally “violent,” “agitated” or “aggressive” does not identify the specific behavior exhibited by the resident.
• Noting instead that the resident responds in crowded, busy group activities by yelling or throwing furniture reflects not only a potential safety issue but should result in the resident being provided alternative activities to meet his/her needs.
Cause Identification & Diagnosis

• This step uses the information collected about an individual to help identify the physical, functional, psychosocial, environmental, and other potential causes of behavior and related symptoms, including how they interact with each other.

Cause Identification & Diagnosis

• Staff, in collaboration with the practitioner, should identify possible risk and causal/contributing factors for behaviors, such as:
  • Presence of co-existing medical or psychiatric conditions, including acute/chronic pain, constipation, delirium and others, or worsening of mental function; and/or
  • Adverse consequences related to the resident’s current medications (See F329).

Cause Identification & Diagnosis

Staff must make an ongoing effort to identify and document the new onset or worsening behavioral symptoms, including whether or not the behavior presents a significant risk for adverse consequences to the resident and/or others.
The attending physician is responsible for supervising each resident's medical care. In addition, the facility must immediately consult with the resident’s physician when there is a significant change in the resident’s physical, mental, or psychosocial status (See F157).

If the behaviors observed represent a change or worsening from the baseline, the attending physician/practitioner and staff are expected to consider potential underlying medical, physical, psychosocial, or environmental causes of the behaviors (See F385).

If the resident has experienced two or more areas of decline or improvement, including a change related to behavior, a Significant Change in Clinical Status Assessment (SCSA) should be considered (see F274).
Cause Identification & Diagnosis

If medical causes are ruled out, the facility should attempt to establish other root causes of behavior using individualized, holistic knowledge about the person and when possible, information from resident, family or previous caregivers, and direct care staff.

Possible Causes:

- Boredom; lack of meaningful activity or stimulation during customary routines and activities;
- Anxiety related to changes in routines such as shift changes, unfamiliar or different caregivers, change of (or relationship with) roommate, inability to communicate;
- Care routines (such as bathing) that are inconsistent with a person’s preferences;

Possible Causes:

- Personal needs not being met appropriately or sufficiently, such as hunger, thirst, constipation;
- Fatigue, lack of sleep or change in sleep patterns which may make the person more likely to misinterpret
Cause Identification & Diagnosis

Possible Causes:

• Environmental factors, for example noise levels that could be causing or contributing discomfort or misinterpretation of noises such as overhead pages, alarms, etc. causing delusions and/or hallucinations.

• Mismatch between the activities or routines selected and the resident’s cognitive and other abilities to participate in those activities.

• For example, a resident who has progressed from mid to later stages of dementia may become frustrated and upset if he/she is trying but unable to do things that she previously enjoyed, or unable to perform tasks such as dressing or grooming.

Development of Care Plan

This step identifies the approaches, interventions, therapies, medications, etc. for a specific resident.

The care plan should include a well-defined problem-statement and should outline the goals of care.

It should include measurable objectives and the individualized implementation plan.
Development of Care Plan

The Care Plan should reflect:
• Baseline and ongoing details (e.g., frequency, intensity, and duration) of common behavioral expressions and expected response to interventions (See F279);

Development of Care Plan

The Care Plan should reflect:
• Specific goals for and monitoring of all interventions for effectiveness in responding to target behaviors/expressions of distress (See F279); and

Development of Care Plan

The Care Plan should reflect:
• For any medications, indication/rationale for use, specific target behaviors and expected outcomes, dosage, duration, monitoring for efficacy and/or adverse consequences and (when applicable) plans for gradual dose reduction (GDR) if an antipsychotic medication is used (See F329).
Development of Care Plan

- In developing the plan of care, the interdisciplinary team, in collaboration with the resident or family/representative, reviews the results of the assessment and cause identification above in order to develop individualized, person-centered interventions. Staff should determine, in collaboration with the practitioner, resident, and family/resident representative if and why behaviors should be addressed (e.g., severely distressing to resident and unrelieved by other approaches or interventions).

Development of Care Plan

Individualized, person-centered approaches should be implemented to address expressions of distress.

- Non-pharmacological approaches. Section 483.25 (l)(2)(ii) - F329, requires that “Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.”

Development of Care Plan

Individualized, person-centered approaches should be implemented to address expressions of distress.

- The guidance at F248, §483.15(f)(1), Activities, provides examples of non-pharmacological approaches for several types of distressed behavior such as constant walking, yelling, going through others' belongings, etc.

- Certain behavior may be anticipated and sometimes may be preventable based on understanding the underlying causes and possible triggers for each individual.
Development of Care Plan

Individualized, person-centered approaches should be implemented to address expressions of distress.

• Current published clinical guidelines recommend use of non-pharmacological interventions for BPSD. Utilizing a consistent process to address behaviors that focuses on the resident’s individual needs and tries to understand their behaviors as a form of communication may help to reduce behavioral expressions of distress in those residents.

Development of Care Plan

• Pharmacological interventions: In certain cases, residents may benefit from the use of medications.

• For example, a person who has a persistent, frightening delusion that she has left her children unattended and that they are in danger is inconsolable most of the day or night despite a number of staff and family approaches to address this fear.

Development of Care Plan

• If other potential causes are ruled out, the team may determine that a trial of a low dose antipsychotic medication is warranted.
Individualized Approaches & Treatment

• This step implements the care plan interventions to address the needs of a resident with dementia. It includes addressing the causes and consequences of the resident’s behavior and staff communication and interactions with residents and families to try to prevent potentially distressing behaviors or symptoms.
• Surveyors will conduct sufficient observations in order to determine if the care plan is being implemented as written.

Individualized Approaches & Treatment

Observations should focus on whether staff:
• Identify and document specific target behaviors, expressions of distress and desired outcomes (See F279 and F514); and

Individualized Approaches & Treatment

Observations should focus on whether staff:
• Implement appropriate, individualized, person-centered interventions and document the results (See F240, F309, F329 and F514);
Individualized Approaches & Treatment

Observations should focus on whether staff:

• Communicate and consistently implement the care plan, over time and across various shifts (See F282 and F498).

Staffing and Staff Training

• During observations, determine whether there are sufficient numbers of staff to consistently implement the care plan (See F353).
• The nursing home must provide staff, both in terms of quantity (direct care as well as supervisory staff) and quality to meet the needs of the residents as determined by resident assessments and individual plans of care.
• The facility must strive to staff in a way that optimizes familiarity with residents.

Staffing and Staff Training

• The principles for quality include, but are not limited to, the facility ensuring that nursing assistants are able to demonstrate competency in skills and techniques necessary to care for residents’ needs as identified through resident assessments, and as described in the plan of care (See F498).
• Surveyors should focus on observations of staff interactions with residents who have dementia to determine whether staff consistently applies basic principles for quality in the provision of care.
Monitoring & Follow-up

• It is important that surveyors evaluate whether or not a facility used the steps identified above to develop the plan of care.

• To meet requirements related to monitoring and follow-up of care plan implementation, surveyors evaluate whether or not the interdisciplinary team reviewed a resident’s progress towards defined goals, adjusted interventions as needed, and identified when care objectives were met.

Monitoring & Follow-up

• Staff monitors and documents (See F514) the implementation of the care plan, identifies effectiveness of interventions relative to target behaviors and/or psychological symptoms and changes in a resident’s level of distress or emergence of adverse consequences.

• In collaboration with the practitioner, staff adjusts the interventions based on the effectiveness and/or adverse consequences related to treatment (See F280, F329 and F428).

Monitoring & Follow-up

• If concerns are identified related to the effectiveness or potential or actual adverse consequences of a resident’s medication regimen, staff must notify the physician and the physician must respond and, as necessary, initiate a change to the resident’s care (F157, F385, F428);
Monitoring & Follow-up

• If the physician does not provide a timely and appropriate response to the notification, staff must contact the medical director for further review, and if the medical director was contacted, he/she must respond and intervene as needed (See F501).

Quality Assessment & Assurance

• NOTE: Refer to F520 Quality Assessment and Assurance for guidance regarding information that is obtainable from the QAA committee.

Quality Assessment & Assurance

• This guidance addresses the evaluation of a facility’s systemic approaches to deliver care and services for a resident with dementia.

• The medical director and the quality assessment and assurance committee can help the facility evaluate existing strategies for coordinating the care of a resident with dementia and ensure that facility policies and procedures are consistent with current standards of practice.
Quality Assessment & Assurance

• Has the QAA committee identified and corrected, as indicated, any quality deficiencies related to the care of residents with dementia.

Quality Assessment & Assurance

• Do resident care policies reflect the facility's overall approach to the care of residents with dementia including a clearly outlined process for their care (see also F501);

Quality Assessment & Assurance

How does the facility monitor whether staff follow related policies and procedures in choosing and implementing individualized plans for the care of each resident with dementia;
Quality Assessment & Assurance

• Has the facility trained staff (such as nursing, dietary, therapy or rehabilitation staff, social workers, activity professionals) in how to communicate with and address behaviors in residents with dementia and were the trainings evaluated for effectiveness, including initial and annual dementia care training for CNAs (See F495 and F497);

• Is there sufficient staff to implement the care plan for residents with dementia, so that medication is not used instead of pertinent non-pharmacological interventions, unless clinically contraindicated (See F353 and F222);

• Does staff collect and analyze data to monitor the pharmacological and non-pharmacological interventions used to care for residents with dementia; and
Quality Assessment & Assurance

• How does the committee help the facility monitor responses to the issues and concerns identified through the consultant pharmacist medication regimen review? (See F329 and F428).

F329 – Unnecessary Drugs

Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- In excessive dose (including duplicate 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 above.
F329 – Unnecessary Drugs

- Residents who haven’t used antipsychotics are not given them unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed/documentated in the clinical record.

F329 – Unnecessary Drugs

- Residents who use antipsychotics receive gradual dose reductions, and behavioral interventions (unless clinically contradicted) in an effort to discontinue these drugs.

Antipsychotic Medications

New Medical Conditions* (other than dementia) added to surveyor guidance for use of antipsychotics:

- Schizophreniform disorder
- Delusional disorder
- Mood disorders (e.g. bipolar disorder, severe depression refractory to other therapies and/or with psychotic features)
- Psychosis in the absence of dementia
Antipsychotic Medications

New Medical Conditions* (other than dementia) added to surveyor guidance for use of antipsychotics:

- Medical illnesses with psychotic symptoms (e.g., neoplastic disease or delirium) and/or treatment related psychosis or mania (e.g., high-dose steroids)
- Tourette’s Disorder
- Huntington disease
- Hiccups (not induced by other medications)
- Nausea and vomiting associated with cancer or chemotherapy

*Must meet the definition of mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV TR) or subsequent editions

Behavioral or Psychological Symptoms of Dementia (BPSD)

- Antipsychotic medications are only appropriate for elderly residents in a small minority of circumstances (unless the antipsychotic is prescribed to treat previously diagnosed mental illness such as schizophrenia or possibly other conditions listed in the previous slides).

Behavioral or Psychological Symptoms of Dementia (BPSD)

All antipsychotic medications carry a Food and Drug Administration (FDA) Black Box Warning.
Behavioral or Psychological Symptoms of Dementia (BPSD)

• Since June 16, 2008, FDA warned healthcare professionals that both conventional and atypical antipsychotics are associated with an increased risk of death in elderly patients treated for dementia-related psychosis.

Behavioral or Psychological Symptoms of Dementia (BPSD)

• A black box warning means that medical studies indicate that the drug carries a significant risk of serious or even life-threatening adverse effects.

Behavioral or Psychological Symptoms of Dementia (BPSD)

• It is the strongest warning that the U.S. Food and Drug Administration can require a pharmaceutical company to place on the labeling of a prescription drug, or in the product literature describing it.
Behavioral or Psychological Symptoms of Dementia (BPSD)

- Antipsychotic medications may be considered for elderly residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes have been identified and addressed.

Behavioral or Psychological Symptoms of Dementia (BPSD)

- Antipsychotic medications must be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review.

Inadequate Indications

Antipsychotic medications in persons with dementia should not be used if the only indication is one or more of the following:

- Wandering
- Poor self-care
- Restlessness
Inadequate Indications
Antipsychotic medications in persons with dementia should not be used if the only indication is one or more of the following:
- impaired memory
- mild anxiety
- insomnia
- inattention or indifference to surroundings

Inadequate Indications
Antipsychotic medications in persons with dementia should not be used if the only indication is one or more of the following:
- sadness or crying alone that is not related to depression or other psychiatric disorders
- fidgeting
- nervousness
- uncooperativeness (e.g. refusal or difficulty receiving care).

Inadequate Indications
All of the previous slides highlight conditions/diagnoses where antipsychotic medications may possibly be appropriate, but diagnoses alone do not warrant the use of an ant unless the criteria
Inadequate Indications

- The behavioral symptoms present a danger to the resident or others, AND one or both of the following:

- The symptoms are identified as being due to mania or psychosis (such as: auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); OR

- Behavioral interventions have been attempted and included in the plan of care, except in an emergency.

Acute Situations/Emergency

When an antipsychotic medication is being initiated or used to treat an emergency situation (i.e., acute onset or exacerbation of symptoms or immediate threat to health or safety of resident or others) related to one or more of the aforementioned conditions/diagnoses, the use must meet the above criteria and all of the following three requirements.

1. The acute treatment period is limited
Acute Situations/Emergency

2. A clinician in conjunction with the interdisciplinary team must evaluate and document the situation within 7 days to identify and address any contributing and underlying causes of the acute condition and verify the continuing need for an antipsychotic medication.

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Acute Situations/Emergency

3. If the behaviors persist beyond the emergency situation, pertinent non-pharmacological interventions must be attempted, unless clinically contraindicated, and documented following the resolution of the acute psychiatric event.

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Enduring Conditions

- Antipsychotic medications may be used to treat an enduring (i.e., non-acute; chronic or prolonged) condition, if the clinical condition/diagnosis meets the criteria in Section B (BPSD guidance for antipsychotics).
Enduring Conditions

• Before initiating or increasing an antipsychotic medication for enduring conditions, the target behavior/s must be clearly and specifically identified and documented.

Enduring Conditions

Monitoring must ensure that the behavioral symptoms are:

- Not due to a medical condition or problem that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued; AND

Enduring Conditions

Monitoring must ensure that the behavioral symptoms are:

- Not due to environmental stressors alone that can be addressed to improve the symptoms or maintain safety; AND
Enduring Conditions

Monitoring must ensure that the behavioral symptoms are:
- Not due to psychological stressors alone, anxiety or fear stemming from misunderstanding related to his or her cognitive that can be expected to improve or resolve as the situation is addressed; **AND**

Enduring Conditions

Monitoring must ensure that the behavioral symptoms are:
- Persistent. In this case, there must be clear documented evidence in the medical record that the situation or condition continues or recurs over time (persists) and that other approaches that have been attempted have failed to adequately address the behavioral/psychological symptoms and that the resident's quality of life is negatively affected by the behaviors/symptoms as described above.

New Admissions

Many residents are admitted to a SNF/NF already on an antipsychotic medication. However, the facility is responsible for:
- Preadmission screening for mentally ill and intellectually disabled individuals, and;
- Obtaining physician's orders for the resident's immediate care.
New Admissions

- This PASRR screening (F285) should provide pertinent information including appropriate clinical indications for the use of an antipsychotic.
- For residents who do not require PASRR screening and are admitted on an antipsychotic medication, the facility must re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks of admission (at the time of the initial MDS assessment) and consider whether or not the medication can be reduced (tapered) or discontinued.

Dosage

- When dosing an antipsychotic, the treatment should be at the lowest possible dose to improve the target symptoms being monitored.
- It is important to note that doses for acute indications (e.g. delirium or acute psychosis) may differ from those used for long-term treatment of various conditions.

Monitoring

Facilities should:
- ongoing effectiveness
- potential adverse consequences
- evaluate the use of any other psychopharmacological medications (e.g. mood stabilizers, benzodiazepines) being given to the resident
Monitoring
Surveyors will review the record to:
- Determine whether the facility can explain the rationale for adding, or switching from an antipsychotic to another category (or categories) of psychopharmacological agents;

Monitoring
Surveyors will investigate further in cases where more than one antipsychotic agent has been prescribed.

Monitoring
Surveyors should investigate further in cases where more than one antipsychotic agent has been prescribed, or where an antipsychotic has been discontinued and a medication such as a mood stabilizer has been added.
Effectiveness

After initiating or increasing the dose of an antipsychotic medication, the behavioral symptoms must be reevaluated periodically (at least during quarterly care plan review, but often more frequently, depending on the resident’s response to the medication) to determine the effectiveness of the antipsychotic and the potential for reducing or discontinuing the dose based on target symptoms and any adverse effects or functional impairment.

Adverse Consequences

If the antipsychotic medication is identified as probably causing or contributing to adverse consequences as identified in the previous slide, the facility must act upon this.

Adverse Consequences

In some cases, the benefits of treatment will still be considered to outweigh the risks or burdens of treatment, so the medication may be continued; however, the facility and prescriber must document the rationale for the decision and also that the resident, family member or legal representative is aware of and involved in the decision to continue the medication.
Contact Information

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