

Building Palliative Care in Dementia

- NYC Health+ Hospitals | Coler



Building Palliative Care in Dementia

Objectives

- Discuss Palliative Care in Dementia
- Describe National partnership's goals and CMS regulatory standards to improve Dementia Care
- Identify Key elements and outcomes of successful Palliative Care programs



Palliative Care

- Sherry Humphrey, MD., CMD.



What is Palliative Care?

- *Adjective* (of a medicine or medical care)
 - relieving pain without dealing with the cause of the condition.
 - synonyms: soothing, alleviating, sedative, calmative, calming
 - *Noun*
 - a palliative remedy, medicine,
 - etc. painkiller, analgesic, pain reliever, sedative, tranquilizer, calmative, opiate
 - *Palliate*
 - To make (a disease or its symptoms) less severe or unpleasant without removing the cause
 - allay or moderate (fears or suspicions).
 - Medical care that focuses on alleviating the intensity of disease symptoms.
-
- Palliative care focuses on reducing the prominence and severity of symptoms.



WHO Definition of Palliative Care

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;

The information provided on this slide can also be found at
<http://www.who.int/cancer/palliative/definition/en/>.



WHO Definition of Palliative Care (cont.)

- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

<http://www.who.int/cancer/palliative/definition/en/>



Palliative Care

- Examples
 1. Providing Percocet after a medical procedure
 2. Offering psychological counseling for a patient struggling with taking insulin four times a day
 3. Patient with terminal cancer receiving radiation to decrease the size of a lung mass to improve SOB
- Palliative care can be provided from the time of diagnosis
- Palliative Care can be given simultaneously with curative treatment.



Comfort Care

- Comfort care vs comfort measures only
- Comfort measures only goal of care has changed no longer seeking curative treatment. Comfort measures - medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering.
- Comfort measures only
 - Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as needed for comfort



End of life care

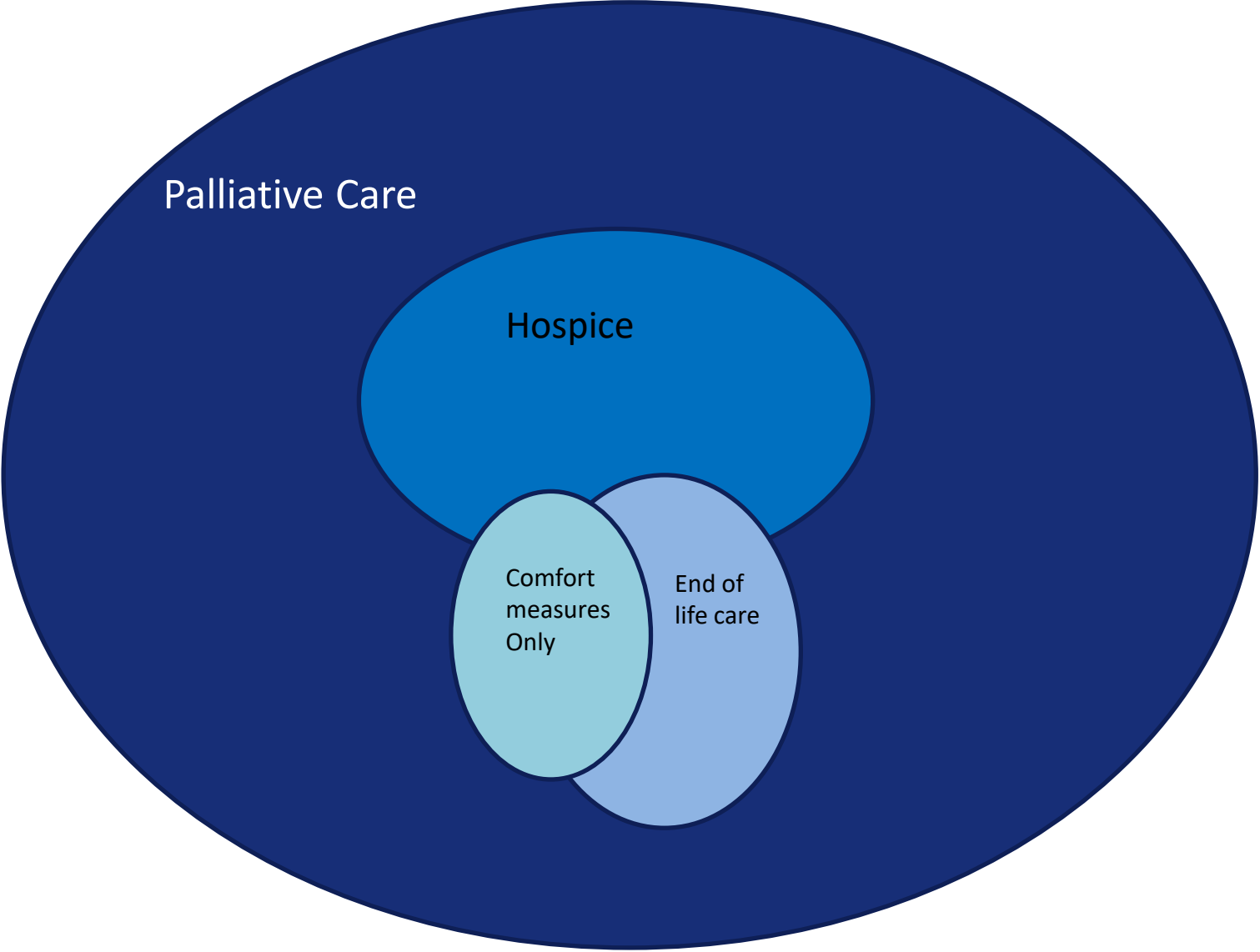
- the support and medical care given during the time surrounding death
- It's for people who are thought to be in the last year of life, but this timeframe can be difficult to predict. Some people might only receive end of life care in their last weeks or days
- End of life care aims to help patients live as comfortably as possible in the time they have left. It involves managing physical symptoms and getting emotional support the family and friends.



Hospice

- Hospice care focuses on a person's last six months of life or less
- When curative treatment is no longer an option
- Medicare (or private insurance) benefit
- provides care focused on comfort and quality of life
- Provided in patients' homes or care facilities
- Palliative care can be provided from the time of diagnosis.
- Palliative care can be given simultaneously with curative treatment.
- Both services have foundations in the same philosophy of reducing the severity of the symptoms of a sickness or old age.



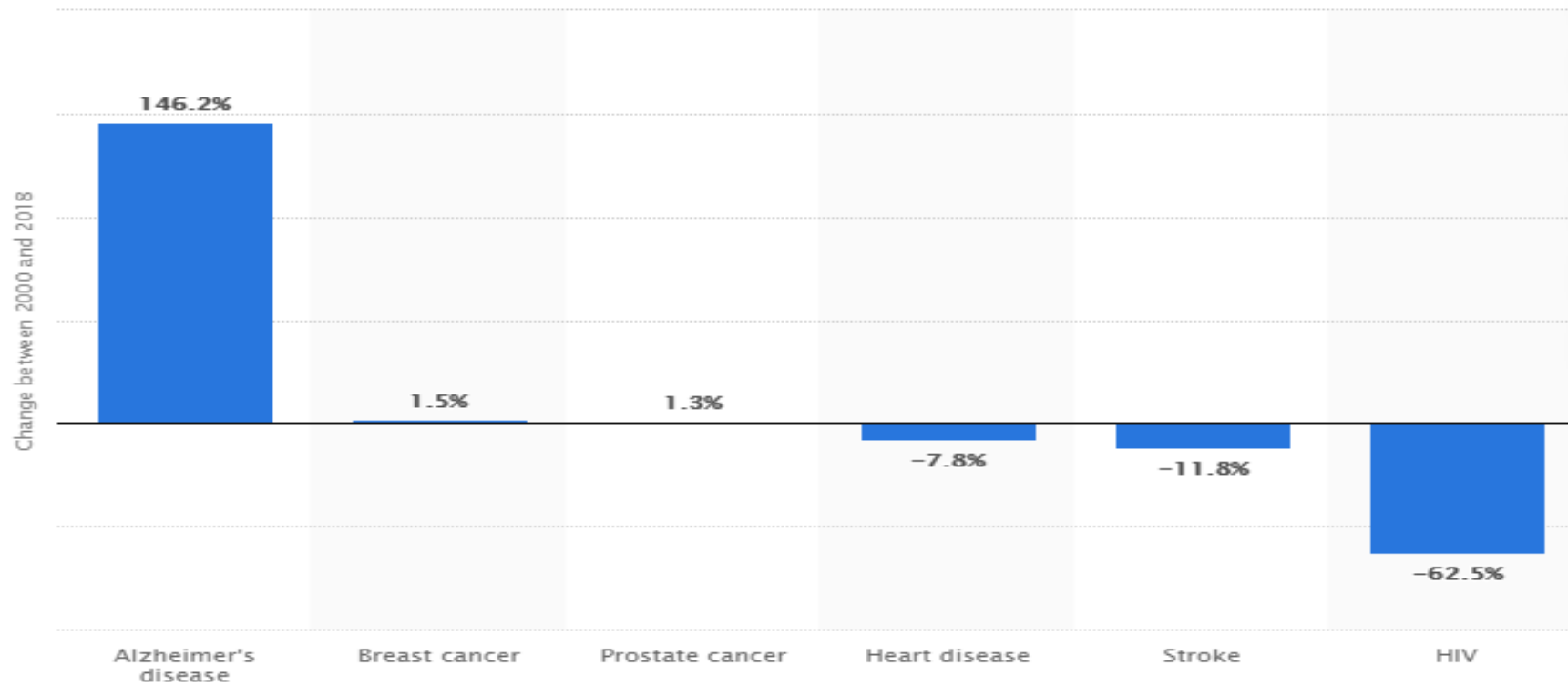


Palliative Care in Dementia

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Percentage changes in selected causes of death in the U.S. between 2000 and 2018, by disease



Prevalence of Alzheimer's disease in the US

- 5 .8million people with Alzheimer's disease in US
- One in 10 people age 65 and older has Alzheimer's Dementia
- Every 65 seconds someone in the US develops Alzheimers Disease
- 2 million people with Alzheimer's disease live in a nursing home in USA
- Over 60 % of Nursing home residents with dementia present with behavioral problems
- *Alzheimer's Disease Facts and Figures*, an annual report released by the Alzheimer's Association ;2019



Most adults report they would not want aggressive medical interventions if they had advanced dementia.

Most proxy decision-makers report that comfort is the primary goal of care for their person with advanced dementia.

And yet.....

People with advanced dementia have

- Fewer completed advanced directives
- More distressing symptoms amenable to treatment (pain, neuropsychiatric symptoms)
- More costly and burdensome interventions with ***little to no clinical benefit***
- Higher mortality after hospitalization



Cure sometimes, treat often
comfort always.

Hippocrates



High Quality Palliative Dementia Care?

- Provide decision-making education / support
 - Identify decision-makers & complete Advance Directives
- Educate & support all care partners (disease progression, common complications & available resources)
- Simplify medications & avoid unnecessary interventions
- Maximize comfort w/ effective symptom management
- Liberalize diets - hand feed rather than feeding tubes



- Approx 40% of time spent with significant disabilities and complex care needs (adv stage can last 1-3 years)
- Failure to recognize as a terminal illness contributes to more aggressive & burdensome treatments with little to no benefits
- Terminal condition that deteriorates the brain *and body*
- Commonly suffer more pain, dyspnea, pressure ulcers, constipation & depression
- Requires surrogate decision-makers



Traditional versus comfort models of care

Traditional Model	Comfort Model
Focused on the physical body and cure	Focused on body, mind and spirit
Care/service is driven by the medical provider	Care/service is driven by the person receiving care/service
Emphasis on staff for task completion	Tasks are scheduled according to a person's needs and wants
Staff members are instructed not to get close to "patients"	Staff members are encouraged to "know the person"



Regulatory Standards-Activities

- Every resident must receive activities
 - Residents who do not join or are unable to join group activities must have individual activities provided to them
-
- For residents with dementia, the lack of engaging activities can cause boredom, loneliness and frustration, resulting in distress and agitation.
 - Activities must be individualized and customized based on the resident's previous lifestyle (occupation, family, hobbies), preferences and comforts.
 - https://www.caringkindnyc.org/_pdf/CaringKind-PalliativeCareGuidelines.pdf

Management of Challenging Behaviors in Dementia; Non pharmacological Approach

- Behavioral disturbances among persons with dementia, including agitation, aggression, and psychosis, form a constellation of symptoms referred to as behavioral and psychological symptoms of dementia (BPSD).
- BPSD impacts heavily on resident's
 - Quality of life
 - Caregiver stress
 - Management options for the team



In Dementia Behavior - Communication

Antecedent ↔

(lonely)
(pain, hunger)
(wet, soiled)
(constipation, UTI)
(new medical problems
(perception of being
forced)
(dehydration)

Behavior

(How often?)
(when?)
(around who?)
(where?)
(observation!)

↔ Consequence

(distracting)
(redirecting)
(stay calm)
(reassurance)
(close ended Q's)
(communicate differently)
(understanding patient's needs)

In Dementia Behavior – Communication

- Record behaviors and look for patterns
- Change A or C in order to change B



Managing Behavior

- Recognize/Understand that behavior manifestations could be an expression of unmet needs such as pain, hunger, thirst, bladder problems, bowel irregularity, boredom, loneliness, etc.
- For new onset behaviors, evaluate medical needs such as pain, hydration status, infections, constipation/impaction, and adequacy of sleep.

Behavior vs. Distress

- The fundamental premise underlying all care for people with dementia is that **behavior is communication**.
- These **behavioral expressions are almost always signs of distress**, and as the disease advances, behavior rather than words become the primary mode of communication for most people living with dementia



Delirium

Delirium is caused by disturbance in brain functioning due to an underlying medical problem such as:

1. Infections are the most common cause: UTI, pneumonia (tests: CBC, U/A, CXR)
2. Dehydration, sleep deprivation
3. Medication interactions
4. Fracture
5. Systemic illnesses: e.g. heart, lung, liver dysfunction
6. Environmental changes

Key Concepts in Dementia Care

- Comfort Care; Refers to the care required to meet broad spectrum of needs of persons with Dementia, includes medical, physical, social emotional and spiritual needs.
- Assessing and Addressing Pain
- Magic of making Connections
- Know the person; individuals important life events, past daily routines and vocation, as well as family members and friends.
- Staff Empowerment: Give staff members “go ahead “to do what is best for individuals with Dementia .Staff members who are empowered become the voice of the person with Dementia.



Assessing and Addressing Pain in Dementia

- Pain is common in older people and is associated with a number of chronic and acute conditions.
- There is evidence that as many as 83% of nursing home residents experience pain that often goes unrecognized or inappropriately treated.
- Pain has a powerful effect on mood, sleep quality and functional ability, and overall quality of life.
- Rejecting care due to pain is especially likely first thing in the morning
- Pain assessment/ Pain AD/Behavioral pain Assessment tool

Hospitalizations

- The burdens of hospitalization for people with advanced dementia outweigh the benefits and should be avoided.
- Immediate survival and mortality rates are similar whether treatment is provided in a long-term care facility or a hospital.
- at risk for infections and bedsores.
- The environment and virtually everyone in it is unfamiliar, it can be frightening and overwhelming for the person
- many hospital staff have had limited or no training in dementia care
- person with advanced dementia more at risk for delirium



Building Palliative Care at NY City Health+ Hospitals/ Coler : **Background**

- 2 protective Care Units with 47 residents with Dx.of Dementia
- 2010: Usage of Antipsychotics (C14) : 64%
Usage of Antipsychotics (C13) :46%
- Rate of Physical Altercations, Falls, Staff call out due to work related Injury, Transfer of residents to Psych.ER due to Dementia related behavior were high.



Building Palliative Care in Dementia at NY City Health+ Hospitals/ Coler : Background

- 2008-2011 :Study at Coler: Bathing Without a Battle: Creating a Better Bathing Experience for Persons with Alzheimer's Disease and Related Disorders
(Brown University Center for Gerontology & Healthcare Research, Foundation for Long Term Care)
- 2010 : Antipsychotic Stewardship initiated
- 2011: Usage of Antipsychotics reduced to 46% (C14) from 64%
Usage of Antipsychotics reduced to 26% (C13) from 46%
- 2012 :Music &Memory program Initiated.



Building Palliative Care in Dementia at NY City Health+ Hospitals/ Coler : Background

- Rate of Physical Altercations, Falls, Staff call out due to work related Injury remained unchanged.
- 2014:Development of Full fledged Memory Care Programs
- Memory Care Project team came together in October 2014 to review current dementia care practices
- “Identified” the gaps and created a structured Memory Care Program
- Implemented Memory Care Programs.



Building Palliative Care in Dementia at NY City Health+ Hospitals/ Coler

- 2018: Received a grant on “Building Palliative Care in Dementia” at Coler.
- 2018: Collaborated with “Comfort Matters” and “Caring Kind” on Building Palliative Care In Dementia at Coler.
- 2018: Training by “Comfort Matters” , 100% of all Interdisciplinary staff were trained in dementia Care.
- 2019 :Partnered with CAPC and trained staff on Palliative Care.
- 2019: received accreditation by comfort matters



Building Palliative Care in Dementia

Methods/Interventions

- This Project was conducted in six Memory care units with 150 residents at an 815-bed long-term nursing care facility.
- All admitted residents in Memory Care Units from May 2017 to Decemb2019 were individually assessed for , usage of psychotropics, falls physical altercations. Pain management, 1;1 observation, hospital admission ,Rejection of Care, weight loss
- Baseline data collected from residents included demographics, diagnoses, preexisting mental illness, and presence of concurrent mood symptoms



Building Palliative Care in Dementia at NY City Health+ Hospitals/ Coler

- Consistent staffing
- Created a Memory Care “Neighborhood” and a Coordinator to integrate the services
- Modified Job Functions of interdisciplinary staff to improve meaningful engagement
- Cross Training
- Consistent huddle with interdisciplinary staff



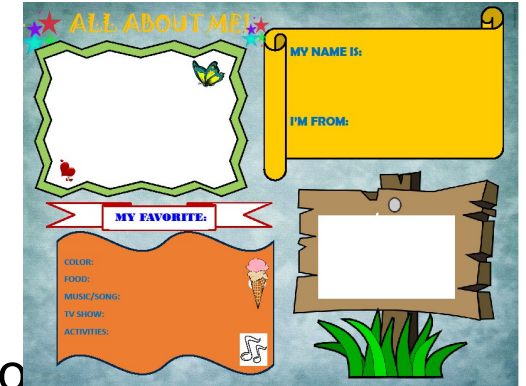
Palliative Care Programs

- Resident-centered structured program
- Meaningful activities for short duration and multiple activities in different stations
- Liberalized Diet
- Snack on Demand
- Music and Memory program around the clock



Palliative Care Programs

- Developed I-Glance and I-Care Plan as a resident-centered communication tool.
- 90% of Interdisciplinary staff are Certified Dementia Practitioners by NCCDP
- Structure standardized in vivo training



Palliative Care Programs

- Memory Care Garden
- Therapeutic walk in the garden if weather permits
- Enhancement of student volunteer participation in Memory Care
- Daily Nursing Rehab
- Bathing without Battle



Palliative Care Programs



Palliative Care Programs

- Doll Therapy
- Pet Therapy
- Therapeutic Dog
- Sensory Room/Quiet Room



Comfort Care



Case Study 1

- 40 year old African American male resident with Dx. AIDS induced Dementia with psychosis and aggressive behavior, cortical blindness, aphasia, Partial hearing impairment, Resistive to care, was on multiple psychotropic medication, on 1:1 for the past 1.5 years for his aggressive behavior. Coler's Behavior Rapid Response team used to be called almost everyday for aggressive behavior. Many staff were out due to work related injury secondary to his physically aggressive behavior during care.



Case Study 1

- Resident was transferred to Memory Care unit . Interdisciplinary team had multiple huddles to explore the antecedents of his behavior and tried different approaches of care and treatment. Contacted next of kin (mother) to identify likes/dislikes and the history of the resident.
- The team consulted an Infectious Disease physician, who placed him on a highly active Antiretroviral therapy regiment. Among other improvements, this has helped reduce HIV-reduced psychosis .
- Educated team about different approaches, encouraging staff feedback as they experimented with different ways of working with resident.



Case Study 1

- Outcomes
- Resident has been medically stable
- Physically aggressive behavior has been significantly reduced
- Discontinued 1:1
- Less psychotropic medication
- No Behavior RRT was called since resident is in Memory Care Unit.



Building Palliative Care in Dementia: RESULTS

Residents-

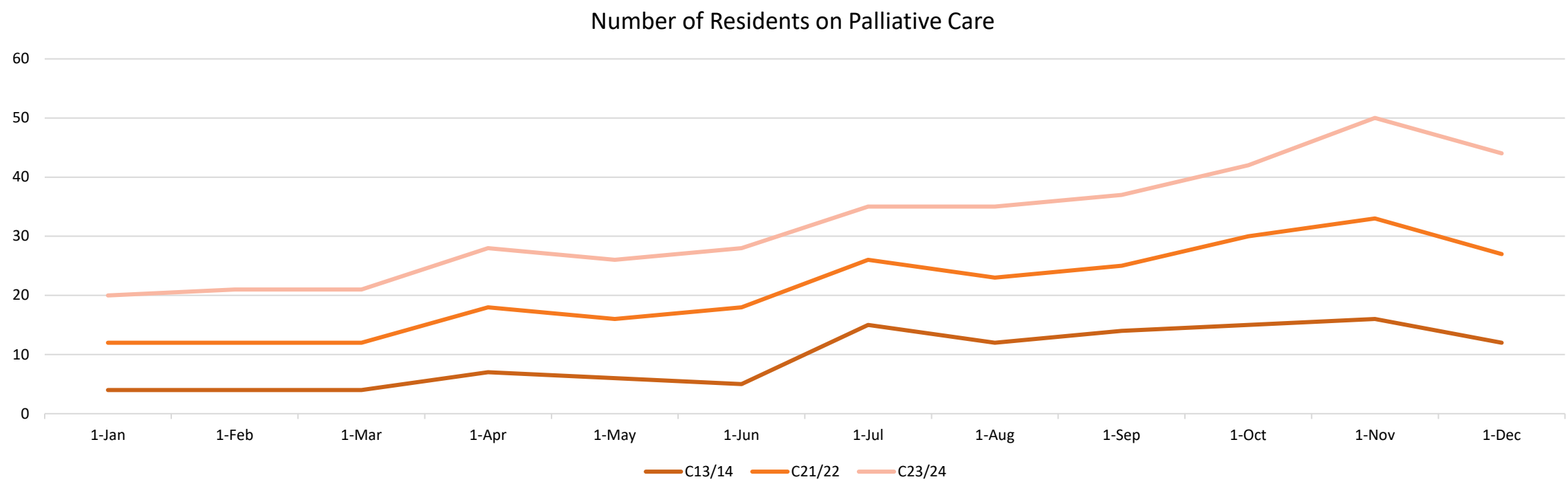
- Improved quality and safety of 150 persons with the diagnosis of Dementia

Family-

- Improved family involvement
- Verbalized high level of satisfaction



Results



RESULTS

- Physical altercation from 12% to 0%
- Rejection of Care reduced by 27%
- Pain Management improved by 30%



RESULTS

- Significant Reduction in transfer to Psych ER for dementia related behavior
- Palliative Model Care: Reduced transfer to acute hospital
- Reduction of 1:1 from 6 to 1



Memory Care Programs: RESULTS

Staff Verbalized-

- Increased level of satisfaction
- Decreased level of stress
- Increased staff morale
- Enhanced bonding between staff, residents and family members
- Enhanced team work
- Provided an opportunity for more meaningful, **personal connections** with individuals in their care



RESULTS

“Happy Staff = Happy Residents”



Case study 2

Palliative Care

An 84 year old Asian resident with moderate Dementia stood by the nurses' station, tapping her fingers on the counter in time to music playing on her iPod. Curious about what the resident might be trying to communicate, staff found a portable piano keyboard and placed it before her. To everyone's astonishment, the resident began to play the piano, had never before indicated to anyone that she was a musician, commenced playing for her fellow residents. Everyone sang along.



Palliative Care Care



Case study

Palliative Care

- Eventually her Dementia advanced, she deteriorated medically and functionally, had a stroke and was on palliative care. Resident was at end of life care, she stopped eating, stopped responding, at her death bed the unit team stood around and sang her favorite songs, she moved her hand, keeping time with the music, and had a peaceful death in the presence of the unit team listening to her favorite music



Palliative Care

- “Kindness is the language which the deaf can hear and the blind can see”
- It transcends the boundaries of cognitive impairments too
- Be mindful of the ‘energy’ you bring into a room



Voices of People Living with advanced Dementia

- Keep me comfortable
- Recognize & evaluate my pain & other symptoms
- Uphold my dignity
- Be frank to my family re: realistic outcomes for chronic illnesses & acute events.
- Provide me staff skilled in palliative dementia care



Infection Control and Prevention of COVID19 in MCU

Challenges

- Social distancing
- Mask
- Meaningful engagement
- Hand washing



Infection Control and Prevention of COVID19 in MCU

- Consistent routines and environment
- Dedicated Personnel to work in MCU
- Limit personnel to only those essential for care
- Structured activities at bedside or be scheduled at staggered times throughout the day to maintain social distancing

Infection Control and Prevention of COVID19 in MCU

- Limit the number of residents in the common area and space residents at least 6 feet apart.
- Gently redirect residents who are ambulatory and are in close proximity to other residents.
- Frequently clean often touch surfaces.
- Clean hands of the residents q 2hours and PRN



Activities during Pandemic

- Face time with Family
- Window visits
- Small group activities
- Courtyard walk



Psychotropic Stewardship in Dementia

Dr. Ravindra Amin



National Partnership's progress and current goals

- **2011: OIG of the Department of HHS: 83% of atypical antipsychotic drug claims were for elderly residents who had not been diagnosed with a condition for which antipsychotic medications were approved by FDA**
- **2012: The Partnership to Improve Dementia Care in Nursing Homes to promote comprehensive dementia care**
- **Antipsychotic medication use: the national rate decreased from 23.9% in 4Q 2011 to 14.6% in 3Q 2018.**
- **The goal includes further reduction in antipsychotic use.**

Antibiotic stewardship vs psychotropic stewardship: common elements

1. **Leadership commitment**
2. **Accountability:** identify physician, nursing and pharmacy leads
3. **Drug expertise:** access to consulting pharmacist or other individual with experience in the medication use
4. **Action:** implement at least one policy or practice to improve the medication use
5. **Tracking/data:** monitor at least one process measure of the medication use and at least one outcome from the medication use
6. **Reporting:** provide regular feedback to the prescribing clinicians, nursing and other relevant staff
7. **Education:** to the clinicians, nursing, family

CMS

Regulation pertinent to psychotropic medications:

- **Effective November 2017**

CMS: State Operating Manual: Issued 11/22/17, Effective 11/28/17

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Psychotropic drugs: F758

A drug that affects brain activities associated with mental processes and behavior. These drugs include, **but are not limited to:**

- Antipsychotic
- Anti-depressant
- Anti-anxiety
- Hypnotic

i.e. antiepileptics are included when used for behavioral indications

CMS: State Operating Manual: Issued 11/22/17, Effective 11/28/17

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Unnecessary psychotropic medications: F758

- **Excessive dose**
- **Excessive duration**
- **Without adequate monitoring**
- **Without adequate indications for its use**
- **In the presence of adverse consequences that indicate that the dose should be reduced or Rx discontinued**
- **Any combination of the above**

If the resident has a diagnosis of dementia and is receiving any psychotropic medications (including but not limited to antipsychotics) the survey will also include F744 - Services for Dementia

PRN psychotropic medications: F758

Limited to 14 days

Type or psychotropic	Time limitation	Exception	Required actions
PRN psychotropic Rx excluding antipsychotics	14 days	Order may be extended beyond 14 days if the prescriber believes it to be appropriate	Document rationale for the extended time period and indicate a specific duration
PRN antipsychotic Rx	14 days	None	For any new PRN order there must be an updated resident evaluation/documentation that the new order is appropriate

Gradual dose reduction (GDR): F758

Within the first year of:

- Admission on a psychotropic, or
- Initiation of a psychotropic

The facility must attempt a GDR in two separate quarters (with at least one month between attempts), unless clinically contraindicated

Clinically contraindicated... in dementia

GDR contraindications include, but not limited to:

- **Target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and**
- **The physician has documented the rationale for why additional dose reduction would be likely impair function or worsen distressed behavior**

Clinically contraindicated... in other psychiatric disorders

Schizophrenia, bipolar mania, depression with psychotic features, or other conditions that may cause psychosis

contraindications to GDR include, but not limited to:

- **The continued use is in accordance with relevant current standards of practice *and* the physician has documented the rationale for why attempted dose reduction would be likely to impair function or exacerbate the disorder; or**
- **The target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented that dose reduction would impair the function or exacerbate the disorder.**
- **No specific exceptions for schizophrenia, Tourette's disorder or Huntington's disease**

Medication Regimen Reviews: F756

Licensed pharmacist conducts MRR:

- At least once a month for every resident
- Documents the review
- Irregularities are conveyed to the attending physician, the medical director and the director of nursing

Attending physician:

- Must document review of the irregularity and action taken; if no change in medication, document rationale in the medical record

Facility:

- Policies and procedures for MRR time frames, and the steps the pharmacist must take when an irregularity requires urgent action

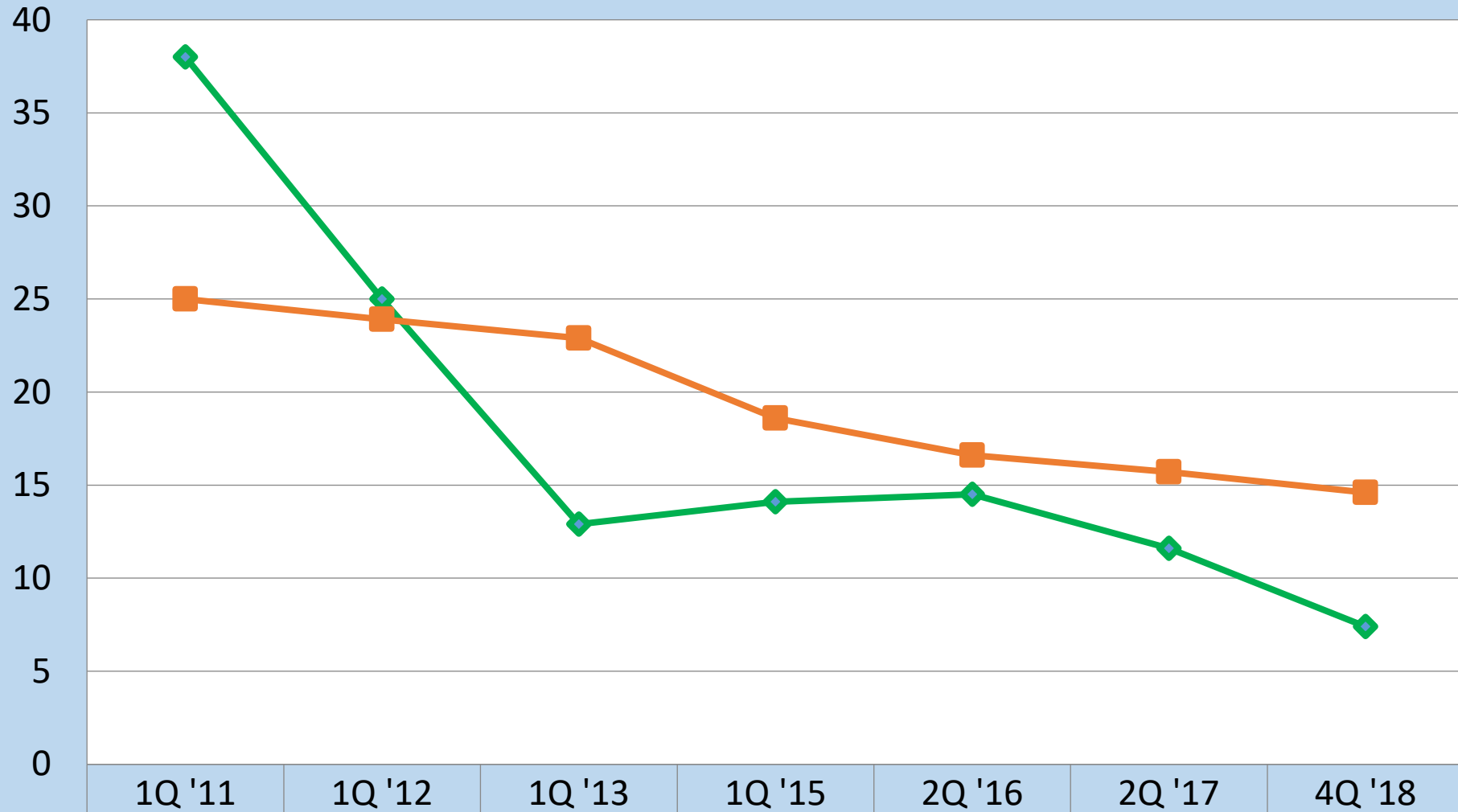
Psychotropic policy : NYC H+H/Coler

800 beds facility. 2016 prevalence: dementia 60%; TBI dementia 10%; severe mental illness 13.5%, substance use disorders 28%; personality disorders 15%; depressive disorders 22%; anxiety disorders 6%

The psychiatrist:

- a co-treater along with the PCP responsible for the management of any co-existing behavior health issues;
- writes orders for meds, pertinent labs, behavior management
- phone coverage 24 x 7
- 3 monthly follow up for all residents on a psychotropic Rx

% long stay residents who received anti-psychotic medication



◆ Coler	38	25	12.9	14.1	14.5	11.6	7.4
■ National Benchmark	25	23.9	22.9	18.6	16.6	15.7	14.6

Practice guideline on the use of antipsychotics to treat agitation or psychosis in patients with dementia:

American Psychiatric Association (APA), May 2016

“the benefits of antipsychotic medications are at best small...”

1. Assess type, frequency, severity, pattern, and timing of symptoms
2. Assess for pain and other modifiable contributors, as well as subtypes of dementia that may influence the medication choice
3. **Assess using quantitative measure**
4. Comprehensive treatment plan including person-centered non-medication interventions
5. Treat only if the symptoms are dangerous, and/or cause significant distress
6. Review response to nonpharmacological interventions prior to treatment
7. Discuss risk/benefits with the patient/surrogate
8. Use low dose, titrate up to minimum effective dose
9. Monitor for side effects; determine if tapering and discontinuation is indicated.
10. **Non-response for 4 weeks: taper and discontinue**
11. In a patient with positive response, decision to taper should be accompanied by the input from the patient/surrogate regarding their preferences and goals, discuss risk/benefits and past experience
12. **Adequate response: taper within 4 months unless past taper attempts resulted in recurrence**
13. During the taper and after discontinuation: monitor for recurrence monthly
14. **Do not use haloperidol as a first line agent**
15. **Do not use long-acting injectable antipsychotic unless it is otherwise indicated for a co-occurring chronic psychotic disorder**

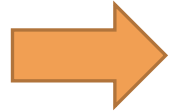
A consensus guideline for antipsychotics for dementia care:

International Psychogeriatrics, 2015

- Limit treatment to 12 weeks
- Discontinuation should be a “standard principle”
- Withdraw the medication when an acute situation has resolved, or
- Withdraw through GDR
- Exceptions:
 - Prior failed discontinuation, or
 - Psychosis/Schizophrenia

Zuidema SU et al, A consensus guideline for antipsychotic drug use for dementia in care homes. Bridging the gap between scientific evidence and clinical practice. Int Psychogeriatr, 2015

Efficacy and tolerability literature review:



Review article 2016: Zdanys K et al. The Treatment of Behavioral and Psychological Symptoms of Dementia: Weighing Benefits and Risks, Current Alzheimer Research, 2016

Sultzer DL et al.. Clinical symptom responses to atypical antipsychotic medications in Alzheimer's disease: phase I outcomes from the CATIE-AD effectiveness trial. Am J Psychiatry, 2008

Ma H et al. The efficacy and safety of atypical antipsychotics for the treatment of dementia: a meta-analysis of randomized placebo-controlled trials. J Alzheimers Dis, 2014

BPSD Rx: Efficacy and tolerability literature review:

Antipsychotics

- **Most used, and extensively studied**
- **Statistically significant improvement in aggression, disinhibition, impulsivity and disruptive behaviors**
- **Benefits attenuated by significant adverse events: EPS, somnolence, cerebrovascular, UTI, abnormal gait, edema. Typical antipsychotics with net greater adverse events. FDA black box warnings for atypical (2005) and typical (2008) antipsychotics**
- **No single medication is superior; medication choice must be individualized based on patient factors, adverse effect profile, possible drug-drug interactions**
- **Dementia of Lewy Body disease: visual hallucinations common; high sensitivity to psychotropics, especially antipsychotics**

BPSD Rx: Efficacy and tolerability literature review:

Antidepressants

- **SSRIs: well tolerated, but conflicting evidence on efficacy**
- **SNRIs: limited studies for any meaningful inference**
- **TCAs: not recommended (orthostasis, anticholinergic effects)**
- **Bupropion: not studied**
- **Trazodone: not efficacious for BPSD, well tolerated**

BPSSD Rx: Efficacy and tolerability literature review:

Benzodiazepines

- **2012: Beers criteria updated: benzodiazepines not advised due to risk of falls, cognitive impairment and other adverse effects**
- **1975 – 2002 studies: limited data, do not support the use**

“Mood stabilizers”:

- **Valproate, carbamazepine, oxcarbamazepine, gabapentin, topiramate, lamotrigine**
- **Not enough evidence to support the use**
- **Varying tolerability**

BPSD Rx: Efficacy and tolerability literature review:

Acetylcholinesterase inhibitors: donepezil, rivastigmine and galantamine

- Statistically significant improvement on NPI and BEHAVE-AD scores; well tolerated.

NMDA receptor antagonist: memantine

- conflicting evidence, well tolerated.

Melatonin: limited evidence to support its use

Psychostimulants:

- For apathy: methyl phenidate - significant benefit for apathy. Modafinil - conflicting results
- Possible adverse effects: anxiety, irritability, weight loss

Facility guideline for the use of psychotropic medications in the management of **BPSD** (behavioral and psychological symptoms of dementia)

- **Applies to any psychotropic (antipsychotic, benzodiazepines, mood stabilizers, antidepressants)**
- **Input from a psychiatrist is advisable but non-essential at the start and discontinuation of the medication**
- **Medication treatment for comorbid specific psychiatric disorders e.g. schizophrenia, bipolar disorder, major depression not covered in this guideline**

Facility guideline for the use of psychotropic medications in the management of **BPSD** (behavioral and psychological symptoms of dementia)

When to start the medication: A, B, C and D all are required

- A. Comfort needs are addressed, behavior interventions are provided**
- B. Pain, depression, delirium are assessed (preferably using validated tools e.g. PainAD, PHQ9-OV, CAM) and addressed**
- C. Behavior results in distress or a potential for harm to self or others**
- D. Target behavior is defined (physical aggression, psychosis, verbal behaviors with distress, aggressive resistance to care); preferably measured by an objective tool such as NPI (Neuro-Psychiatric Inventory)**

Facility guideline for the use of psychotropic medications in the management of **BPSD** (behavioral and psychological symptoms of dementia)

When to continue a medication: each of the A, B and C are required:

- A.** The medication results in comfort or improved function for the resident without any adverse effects;
- B.** Is monitored for any adverse effects
- C.** *A dose reduction is attempted in at least two separate quarters in a year*

GDR: considered every three months, rationale documented if not done

Facility guideline for the use of psychotropic medications in the management of **BPSD** (behavioral and psychological symptoms of dementia)

When to discontinue a medication: only one of the A or B or C is required:

A. Adverse effects

B. Goal is attained

C. Ineffective medication

Ineffective medication / persistence of target behaviors: a comprehensive re-evaluation of unmet comfort/psychosocial needs, medical issues, pain, delirium and depression. Change medication/adjust the dose

-
- Q & A