Reducing Antipsychotic Use through Behavioral Care Planning And Activities Programming
Establishing our Dementia Unit & Care Initiatives

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The Dementia Residents in a Long Term Care Facility
What’s the Problem & Why is a Dedicated Dementia Unit Necessary?

What The Management Team at The Pines at Catskill Identified:

Long term residents admitted to our facility without a dementia diagnosis as well as families & loved ones of these non-dementia residents began to voice concerns regarding those residents who were experiencing memory impairment and the impact to the non-dementia population. Common voiced concerns included:

1. Public displays of memory impaired behavior which non-memory impaired residents were exposed to in facility common areas such as the dining rooms or activities.
   A. Public dining edicate (table manners)
   B. Poor attention-span and/or public disruptions during such activities as worship services, Bingo or even resident council meetings

2. Co-habitation with dementia residents to include varying sleep patterns, room mate issues, privacy and differing care requirements.
   A. Dementia Residents calling out at night
   B. Dementia Residents requiring a higher level of ADL care at night which disrupted non-dementia residents sleep hygiene
   C. Dementia Residents inability to respect privacy or personal belongings of a non-dementia roommate, wandering, overt displays of agitation, and increased incidents such as falls.
**Dementia: The Perceived Impact to the Sub acute Population**

**Census Control Issues:**

**What The Management Team at The Pines at Catskill Identified:**

Often times during periods of peak rehab census, residents choosing to come to our facility were temporarily assigned a bed on a long term care unit.

We found that these “overflow” rehab residents, like many of our non-dementia long term care residents were not content to be intermingled with our dementia resident population.

1. Rehab residents perceived other care areas as “institutional.”
2. Rehab residents did not want to be in a room with “any old people that yelled out”
3. There remained somewhat of a public negative stereotype among sub acute residents regarding their counterparts in the “nursing home” part of the building. (Those old people are just here to die).

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**The Establishment of our Dementia Unit:**

**Hearing our non-dementia Long Term Care & Sub acute Resident populations’ concerns:**

**Ideas for Our Dementia Unit began to Take Shape**

Through our Quality Assurance Performance (QAPI) Improvement Program, the interdisciplinary care team exchanged ideas with respect to the establishment of a dementia specific care unit. We looked at:

1. Resident Population Selection
2. Physical Plant Challenges
3. Staff Suitability & Staff Education Requirements
4. Family Involvement & Resource Management
5. Rehabilitation Services contributions to dementia care
7. Dementia – specific Activity Programs
8. Non-pharmacological interventions in Behavior Management
9. Anti-psychotic medication use & reduction
10. Case Studies
The Establishment of our Dementia Unit:

**Resident Selection**
Residents were chosen based on diagnosis, stage of dementia and ability to benefit from staff’s training and activities.

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The Establishment of our Dementia Unit:

**Physical Plant Challenges**
Our Dementia Unit is 28 Beds
Our Dementia Unit is a secured unit (wander guard system)
The Unit’s physical plant was altered to establish
the following care areas: All Appropriate residents were
Relocated to the dementia unit within a week
1. A Dementia Unit Specific Activity Room
2. A Dementia Unit Specific Dining Area
3. A multi-sensory area
4. Facilitation of common areas on the unit to foster socialization
The Establishment of our Dementia Unit:

**Staff Suitability & Staff Education**

1. Staff selection for our dementia unit was determined based on the particular staff members desire to work with dementia residents, their overall employee performance and recommendations from Nursing Administration.

2. CMS’ “Hand in Hand” Dementia Training Program is our tool of choice for educating our staff on working with this population.

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**Family Involvement & Resource Management**

Our families were involved in every aspect of the establishment of our dementia unit. They were educated on the potential benefits to their loved one’s welling being as well as the roles our interdisciplinary team members would play in their relatives’ care in such areas as assessment. Most proved an invaluable resource in helping us get to know our residents better and establishing an effective care plan.
The Establishment of our Dementia Unit:

A Family Members’ Perspective:

Go to Video Link

Getting to Know You: An Individual Person Centered Approach
The Family Interview

We utilized an initial family interview as an opportunity to gain insight:
1. How much do our families know about dementia?
2. What were their loved ones’ routines and preferences in such care areas as:
   A. Daily Routines
   B. Past occupation, friends, family and past socialization structure & organization
   C. Pets, hobbies, habits
   D. Past value systems, religious preferences
   E. Food preferences, overall likes and dislikes
   F. What techniques did the family utilize when caring for the resident? What frightened the resident?
      What behaviors occurred when and what techniques worked for the family in managing those behaviors. What calmed their loved one?
   G. Customary routines: When did the resident go to bed, get up in the morning, bathe, toilet,
      preferred hair style
   H. Any other considerations we needed to be aware of to elicit a successful integration of the resident to the unit were explored.
Getting to Know You: An Individual Person Centered Approach
The Role of our Rehabilitation Services Department

Our Rehabilitation Services Department works collaboratively with the interdisciplinary team to help establish a care plan that matches the level of dementia.

1. Rehab assessment as to function (Restorative Nursing)
2. Rehab assessment as to stage of dementia. Global Deterioration scale 7 stages.
   Also use Function, Reason, Orientation, Memory Arithmetic, Judgement, and Emotion status. (FROMAJE) assesses 7 aspects of mental status.
3. There are specific “Do’s and Don’t for approach, care and communication.
   Example: Level 5 – DO ask simple Questions/ DON’T give too many choices
   Example: Level 6 – DO utilize pictured language/DON’T Expect the resident to remember who you are
   Example: Level 7 – DO speak in a calm voice/DON’T appear frustrated or worried

Getting to Know You: An Individual Person Centered Approach
Simple Communication techniques in Dementia

Staff should avoid saying to a dementia resident, “don’t you remember?” Staff should always approach the resident from directly in front of them and wait for acknowledgement. Do allow extra time for responses, Pay attention to nonverbal behavior, use simple words, break down tasks into steps, Example “We are going to get dressed now” Put on you shirt”, Repeat your name and what you are doing with the resident, only ask yes/no questions. Always provide Praise at Task Completion.
Getting to Know You: An Individual Person Centered Approach
Recreational Services

Dementia Appropriate Activities provide the following sensory stimulation:

1. Olfactory (lavender, Raspberry, Mint,)
2. Touch/Textures (Smooth, Rough, soft, warm, cold, shapes)
3. Taste (sweet vs bitter)
4. Puzzles
5. Parachute, Ball (ROM)
6. Current Events and Weather
7. Imagination
8. Ambulation
9. Music

Getting to Know You: An Individual Person Centered Approach
A day at 3West “Beach”

Go to Video File
Getting to Know You: An Individual Person Centered Approach
Live from Pines Stadium

Go to Video File

Getting to Know You: An Individual Person Centered Approach
Non-Pharmacological Interventions in Behavior Management

To Manage Behaviors:
1. Safety is first priority
2. Identify Trigger (Elicit family and C.N.A. Assistance to identify root causes for behavior)
3. Identify Likes and dislikes
4. Incorporate in care plan approaches that give security and are familiar to the resident.
4. Avoid Medications, if necessary lowest effective, shortest duration. Involve medicine & psychiatry
Getting to Know You: An Individual Person Centered Approach
The Care Plan

In developing a comprehensive care plan, we reviewed the family interview, the dementia scale rating from the rehab assessment and feedback from C.N.A. Staff. All information was pooled into an individualized care plan that is fluid as the residents improve in behavior and function. What a care plan should be is a timeframe model specific to the resident and one that establishes a comfortable environment for the resident. Keeping them occupied and not bored. The care plan encompasses care, ADL’s specifics, eating, activities, restorative nursing or rehab, and family interaction and participation.

Case Study #1 – Mr. W.
Jade O’Leary, C.N.A.

#1 - Mr. W.
Diagnosis – Herpes Zoster Encephalopathy. Dementia – Stage 6
On admission would not speak, frequently agitated, Yelled out, Frequent falls, No participation in ADL’s
Small dose of Risperdal initiated. Followed by Psychiatry and interdisciplinary team. Risperdal titrated down over a period of 6 months
Restorative Nursing brought him to a level where he was able to walk short distances and participated with care and became continent and could feed himself
Currently able to participate in sports activities. Able to recognize visitors. Able to request toileting. Laughs and Jokes with staff. Significant decrease in falls and agitated behavior.
#2 – Mrs. M.
On admission – nonverbal. Frequent outbursts of crying. No participation in ADL’s.

Interdisciplinary team reviewed records from previous nursing home. Resident had been receiving Lorazepam 1mg TID from previous facility. In collaboration with psychiatry, Lorazepam discontinued along with Celexa.

Resident now feeds herself. Anxiety and Depression are treated. Resident now participates in unit activities.

#3 – Mrs. A.
Upon admission – yelled out constantly and was disruptive

Family related resident had been in a Dementia Day Care Program
Family related resident enjoyed music and it was thought to calm the resident.
Small dose of Risperdal titrated down over 6 months.
Resident now ambulates 50 feet. Participates in the unit’s music program. Family can now sit and converse with her.
A Word about Antipsychotic Medication Use

The Pines at Catskill supports CMS initiatives to reduce/eliminate the use of antipsychotic medications in dementia patients. To that end:
1. If these medications are used, the lowest dose possible is initiated
2. There is appropriate family consent
3. The resident is always followed by psychiatry
4. The residents’ response to these therapies is closely monitored
5. Titration is always trialed at established intervals individualized to the resident
6. Interdisciplinary Team review at Standard of Care Meetings.

The Outcomes Speak for Themselves

Comparison Data

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