Considerations For Reducing and Eliminating Antipsychotic Medications for Behaviors in Elderly Nursing Home Residents With Dementia

Learning Objectives

1. Describe key features of the boxed warning for antipsychotics
2. Identify regulations related to the use of antipsychotic medications for the treatment of behavioral symptoms of dementia;
3. Define the types of distressed behaviors usually associated with dementia;
4. List non-pharmacologic approaches to distressed behaviors in residents with dementia; and
5. Choose between medications to treat various distressed behaviors, as highlighted in the 2011 American Geriatrics Society’s “Guide to the Management of Psychotic Disorders and Neuropsychiatric Symptoms of Dementia in Older Adults”

A Case Example From A Nursing Home

Nursing Home A

- 86 year-old woman with Alzheimer’s disease who had a history of wandering, agitation, and fighting
- Over previous 6 months, she had received increasing doses of quetiapine (Seroquel®) [475 mg/day] and venlafaxine (Effexor®) [225 mg/day]
- Staff reported that resident wandered into others’ rooms, slept in their beds, fought with other residents over a baby doll, and occasionally struck staff upon awaking or upon incontinence care
- Due to these behaviors, she was discharged to Nursing Home B

A Case Example From A Nursing Home

Nursing Home B

- Upon admission, she was somnolent, slouched in a wheelchair, and unable to walk. She required assistance with all activities of daily living.
- Over the next 2 weeks, the quetiapine and venlafaxine were tapered and discontinued.
- Her level of alertness improved over this period, and routine acetaminophen was initiated due to her diagnosis and history of osteoarthritis.
- She regained the ability to ambulate, and although she still exhibited some of her previous behaviors, the staff managed these through a variety of behavioral interventions such as redirection and walking.

Why Are We Focusing On This?

A “hot topic”:

- Office of the Inspector General (OIG) Report (May 2011) – “83% of Medicare claims (2007 data) for atypical antipsychotic drugs for elderly nursing home residents were associated with off-label conditions; 88% were associated with the condition specified in the FDA boxed warning.”
- As a result of the OIG report, the use of antipsychotics for “off label” conditions (e.g., behaviors associated with dementia) will be an area of increased scrutiny for nursing home surveyors.
- American Medical Directors Association response (May 2011) - “AMDA acknowledges that psychotropic drug use remains a challenge in this setting and continues to make this a priority issue. Currently, the organization has many educational efforts to reduce and even eliminate the inappropriate use of these medications.”

Why Are We Focusing On This? (cont’d)

- American Health Care Association (AHCA) Talking Points document (May 2011) - “we agree that the number of patients using antipsychotic drugs in nursing facilities should be less, and that more efforts need to be done to look at how to manage dementia patients with behavior problems without medications.”
- Omnicare Position Statement (July 2011) – “Omnicare’s efforts at reduction of antipsychotic drug use are consistent with evidence-based clinical practices and CMS nursing facility regulations. If a prescriber determines that drug therapy is necessary to manage behavioral symptoms associated with dementia, the prescriber should use the lowest effective dose for the shortest duration necessary. Response to therapy should be monitored and documented frequently, and treatment evaluated for GDR, tapering, or discontinuation.”
Why Are We Focusing On This? (cont’d)

Senate Special Committee on Aging Hearing, 11/30/11

- Title of meeting: “Overprescribed: The Human and Taxpayers’ Costs of Antipsychotics in Nursing Homes”
- Statements from Senator Herb Kohl:
  - “While antipsychotic drugs have been approved by the FDA to treat an array of psychiatric conditions, numerous studies have concluded that these medications can be harmful when used by frail elders with dementia who do not have a diagnosis of serious mental illness. In fact, the FDA issued 2 “black box” warnings citing increased risk of death when these drugs are used to treat elderly patients with dementia. Improper prescribing not only puts patients’ health at risk, it also leads to higher health costs.”

Why Are We Focusing On This? (cont’d)

Senate Special Committee on Aging Hearing, 11/30/11

Statements by Dr. Jonathan Evans, geriatrician and Vice-President of the American Medical Directors Association (AMDA):

- “I do not prescribe antipsychotic drug for the treatment of agitation or other behaviors in patients with dementia, and I know that the leadership of AMDA acknowledges the use of these medications in patients with dementia only as a last resort, and only when all else has been tried and failed, which is rare”
- “there should be ‘near zero’ use of antipsychotics for persons with dementia”

Antipsychotic Utilization Data in Nursing Facilities

- From 2011 CMS OSCAR data released in February, 2012:
  - 25.2%
- Exactly the same percentage as 2010 data
- How does your facility compare?
ANTIPSYCHOTIC SAFETY CONCERNS

The Antipsychotic Boxed Warning

- ALL antipsychotics carry the following Boxed Warning specifically addressing their use in patients with dementia-related psychosis:

  "Warning: Increased Mortality in Elderly Patients With Dementia-Related Psychosis

  Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. DRUGNAME is not approved for the treatment of patients with dementia-related psychosis."

Selected Additional Antipsychotic Warnings

Common to ALL antipsychotics:
- Neuroleptic malignant syndrome (can be fatal)
- Tardive dyskinesia (highest among elderly, especially women)

Common to ALL atypical antipsychotics:
- Hyperglycemia (can be fatal)
- Orthostatic hypotension (can lead to falls)
- Seizures (Alzheimer’s disease can lower seizure threshold)
- Dysphagia (can lead to aspiration pneumonia)
- Leukopenia, neutropenia, and agranulocytosis
- Potential for cognitive and motor impairment

Common to aripiprazole, olanzapine, and risperidone:
- Cerebrovascular adverse events, including stroke (can be fatal)
Other Important Antipsychotic Adverse Effects

- Sedation (can lead to immobility and pressure ulcers, or limited mobility with dizziness, balance issues, and falls)
- Clinical worsening, suicidality, and unusual changes in behavior, especially in first few months of therapy and with dosage changes (increases or decreases)
- Hyperlipidemia
- Dizziness
- Fatigue
- Increases in liver enzymes

A Telling Story: Length of Antipsychotic Package Inserts

- Risperdal® - 43 pages
- Seroquel® - 51 pages
- Zyprexa® - 49 pages

Many of these pages are related to adverse effects of these drugs!

As a comparison:
- Coumadin® (warfarin) - 21 pages
- Digoxin - 16 pages
- Methotrexate - 16 pages
- Amiodarone - 21 pages
- Duragesic® - 26 pages
- Pradaxa® - 13 pages

F329: Unnecessary Drugs- Enforcing The Right Thing To Do Clinically!

1. "General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
   - in excessive doses (including duplicate therapy); or
   - for excessive duration; 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"

2. "Antipsychotic Drugs. Based on a comprehensive assessment of the resident, the facility must ensure that:
   - residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
   - residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs"
F329: Definition Of Gradual Dose Reduction (GDR)

"Gradual dose reduction (GDR) is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued."

F329: Table 1- Antipsychotics (Indications)

Although “Dementing illnesses with associated behavioral symptoms” is listed as one of the 10 conditions/diagnoses for which antipsychotics may be used, additional requirements must be met:

- the symptoms are identified as being due to mania or psychosis (such as: auditory, visual, or other hallucinations; delusions (paranoia, grandiosity)); OR
- the behavioral symptoms present a danger to the resident or others; OR
- The symptoms are significant enough that the resident is experiencing one or more of the following: inescapable or persistent distress (e.g. fear); continuously yelling, screaming, distress associated with end of life, or crying); a significant decline in function; and/or substantial difficulty receiving needed care (e.g., not eating resulting in weight loss, fear and not bathing leading to skin breakdown or infection).

Definition of “Distressed Behavior” (F329)

"Distressed behavior is behavior that reflects individual discomfort or emotional strain. It may present as crying, apathetic or withdrawn behavior, or as verbal or physical actions such as: pacing, cursing, hitting, kicking, pushing, scratching, tearing things, or grabbing others. "
What Is A “Behavior”?  

• A form of communication  
• A reaction to frustration or boredom  
• A reaction to stimuli (internal- e.g., pain, constipation; external- e.g., sounds, physical surroundings, people)  
• A sign of an underlying condition (e.g., depression, insomnia)

What Does AMDA Say About Behavioral Symptoms of Dementia?  

Published in March 2011, AMDA’s Multidisciplinary Medication Manual for long-term care cites similar domains and features of dementia symptoms:  

• Apathy (withdrawal, lack of interest/motivation)  
• Aggression (aggressive resistance, physical, verbal)  
• Depression (hopelessness, anxiety)  
• Psychomotor agitation (pacing, restlessness, repetitive actions)  
• Psychosis (hallucinations, delusions)

Common Neuropsychiatric Symptoms Associated With Dementia  

In April, 2011, the American Geriatrics Society published “A Guide to the Management of Psychotic Disorders and Neuropsychiatric Symptoms of Dementia in Older Adults” which identifies the following common symptoms associated with dementia:  

• psychotic symptoms (hallucinations, delusions)- 20% of patients  
• depressive symptoms (sadness, anxiety, irritability)- up to 40% of patients  
• apathy  
• manic-like behavioral syndromes (disinhibition, intrusiveness, hyperactivity)  
• agitation or aggression (up to 80% of patients)
What Are The Symptoms Of “Agitation”

• Walking aimlessly, pacing
• Psychomotor agitation/general restlessness (which could be akathisia, a movement side effect from antipsychotic drugs)
• Repetitive actions (dressing/undressing)
• Sleep disturbances
• Excessive worrying (e.g., about toileting, etc.)

Evaluating Problematic Behavior: The ABC’s

A - what are the Antecedents of the behavior?
• communication
• emotional
• environmental
• physical
• task

B - what is the Behavior?
• anxiety and/or depression
• psychosis-related
• “agitation”

C - what are the Consequences of the behavior

Approaches To Behavioral Symptom Management: More Alphabet Soup

D - describe the behavior
R - reasons for the behavior
N - nonpharmacologic approach
O - order medication as last step
General Approach For Residents with Dementia: “Approach Is Almost Everything”

- Display a positive, comforting demeanor (smile, calm/non-threatening voice and body language; praise often)
- Treat resident with respect
- Be aware of resident’s need for personal space, and historical way of doing things (“my way”)
- Care must be individualized

Nonpharmacologic Approaches to Behavior Management

Examples of nonpharmacologic treatment categories and strategies:

- Sensory: music therapy, massage, light therapy
- Environmental: adequate space, reduction in disruptive stimuli
- Behavioral: positive reinforcement, redirection, avoid reality orientation
- Communication: use short sentences, give adequate time for response, awareness of non-verbal communication

Nonpharmacologic Approaches to Agitation

- Avoid confrontation
- Remove environmental triggers
- Create calm, quiet environment (offer gentle help)
- Structure daily routine
- Address pain, discomfort
- Use aromatherapy
- Use scheduled or prompted toileting
Pharmacologic Approaches For Distressed Behaviors: General

- Minimize anticholinergic load
- Maximize response to non-pharmacologic interventions
  - “the effectiveness of many nonpharmacologic interventions is enhanced when the patient has a higher degree of cognition. Consider using agents approved to treat Alzheimer’s disease (acetylcholinesterase inhibitors, memantine) to maximize patients’ cognition and thus their response to nonpharmacologic behavioral interventions.”
- Optimize treatment of comorbid conditions (e.g., pain, constipation)
- Treat depression and anxiety (the “two-thirds phenomenon”)

Pharmacologic Approaches to Agitation: Appropriate Pain Management

- Study from September 2011: “Efficacy of treating pain to reduce behavioral disturbances in residents in nursing homes with dementia: cluster randomised clinical trial”
- 352 nursing home residents with moderate to severe dementia and clinically significant behavioral disturbances randomized to receive either a stepwise protocol for pain treatment for 8 weeks or usual care
- Stepwise pain protocol included acetaminophen, morphine, transdermal buprenorphine, or pregabalin
- Primary outcome measure was agitation, while secondary outcomes were aggression, pain, ADL’s and cognition.

Pharmacologic Approaches to Agitation: Appropriate Pain Management (cont’d)

Study Results
- Agitation was significantly reduced compared to control group at 8 weeks
- Significant benefit for aggression, overall severity of neuropsychiatric symptoms, and pain
- No significant differences in ADL’s or cognition

Conclusion
- “A systematic approach to the management of pain significantly reduced agitation in residents of nursing homes with moderate to severe dementia. Effective management of pain can play an important part in the treatment of agitation and could reduce the number of unnecessary prescriptions for psychotropic drugs in this population.”
Pharmacologic Approaches For Distressed Behaviors: Agitation

Pharmacologic Treatment of Agitation

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety, mild-moderate irritability</td>
<td>buspirone 15-60 mg/day</td>
</tr>
<tr>
<td>Agitation in context of depression</td>
<td>SSRI (e.g., citalopram 10 – 30 mg/day)</td>
</tr>
<tr>
<td>Agitation/aggression unresponsive to first-line treatment</td>
<td>divalproex 500 – 1500 mg/day</td>
</tr>
<tr>
<td>Agitation in context of psychosis</td>
<td>low-dose atypical antipsychotic</td>
</tr>
</tbody>
</table>

Management of Neuropsychiatric Symptoms of Dementia: Some Key Points

- “Medication treatment of behavioral disturbances of dementia is of limited efficacy and should be used only after environmental and nonpharmacologic techniques have been implemented”

- “No psychoactive medication prescribed to treat neuropsychiatric symptoms of dementia should be continued indefinitely, and attempt at drug withdrawal should be made regularly (e.g., every 3-6 months)”

- “The goal (of treatment) is reduction, rather than elimination, of the distressing behavior…”


Are Antipsychotics Actually Effective For Behaviors Associated With Dementia? (cont’d)

Landmark Clinical Trial: “Effectiveness of Atypical Antipsychotic Drugs in Patients with Alzheimer’s Disease” (The “CATIE-AD Trial”)

- double-blind, placebo-controlled, 36-week trial in 421 patients with Alzheimer’s disease and psychosis, aggression, or agitation
- 75% of patients required a level of care at least equivalent to that provided in assisted living facilities, 17% at a nursing home level of care
- patients randomly assigned to placebo, olanzapine (mean dose, 5.5 mg/day), quetiapine (mean dose 26.5 mg/day), or risperidone (mean dose, 1.0 mg/day)
- main outcome measures: 1) time from initial treatment to discontinuation of treatment, 2) number of patients with at least minimal improvement on the Clinician’s Global Impression of Change (CGIC) scale at 12 weeks

Are Antipsychotics Actually Effective For Behaviors Associated With Dementia? (cont’d)

Landmark Clinical Trial: “CATIE-AD Trial” (cont’d)

Results
• No significant differences among treatment groups with regard to time to discontinuation or improvement on the CGIC scale
• 63% treatment discontinuation rate at 12 weeks; 82% at 36 weeks
• Significantly higher percentage of patients discontinued antipsychotic treatment due to intolerability versus placebo

Conclusions
• Adverse effects offset advantages in the efficacy of atypical antipsychotic drugs for the treatment of psychosis, aggression, or agitation in patients with Alzheimer’s disease


Can Residents Receiving Antipsychotics For Behaviors Be Successfully Taken Off Them?

“A Randomised, Blinded, Placebo-Controlled Trial in Dementia Patients Continuing or Stopping Neuroleptics”. (The “DART-AD Trial”)

• 12 month study in nursing home or residential home patients receiving antipsychotics for behavioral or psychiatric disturbances in dementia for at least 3 months
• Patients randomised equally to either continue receiving antipsychotic or switch to placebo

Results
• At both 6 and 12 months, no overall differences in cognitive decline or change in neuropsychiatric symptoms (NPS) were seen between groups
• Patients with severe NPS at baseline did better on antipsychotic vs. placebo, but this was not statistically significant
• Significant decline in verbal fluency in those who continued antipsychotics


Can Residents Receiving Antipsychotics For Behaviors Be Successfully Taken Off? (cont’d)

DART-AD Conclusions
• for most patients with Alzheimer’s disease, withdrawal of antipsychotics had no overall detrimental effect on functional and cognitive status
• Antipsychotics, with their known safety issues, should not be used as first-line treatment of agitation or aggression

Can Residents Receiving Antipsychotics For Behaviors Be Successfully Taken Off? (cont’d)

DART-AD Long-Term Follow-Up Study
- Followed patients enrolled in DART-AD Trial for 36 months to determine whether continued treatment with antipsychotics was associated with an increase in mortality

Results
- Those patients who received antipsychotics had a significantly increased risk of mortality compared to the placebo group
- Additionally, of the patients assigned to the placebo group, only 7 patients (9%) were subsequently restarted on antipsychotics, and they remained on placebo for a minimum of 12 months

Conclusion:
- There is an increased long term risk of mortality in AD patients who are prescribed antipsychotic medications


Research in Progress: “The Antipsychotic Discontinuation in Alzheimer Disease Trial”
- Randomized, double-blind, placebo-controlled trial in patients with AD who have target symptoms of psychosis or agitation. Patients can reside either in the community or in nursing home/assisted living settings
- Open-label treatment for 16 weeks with risperidone (0.25 – 3.0 mg daily); treatment responders then randomized into 3 groups: 1) continuation of risperidone for 32 weeks; 2) continuation of risperidone for 16 weeks followed by placebo for 16 weeks; 3) placebo for 32 weeks
- Goal is to provide clinically relevant data on the likelihood and time to symptom relapse, predictors of relapse, and the optimal duration of treatment that confers the greatest benefit to risk ratio


New Antipsychotic Safety Data
- "Cognitive Effects of Atypical Antipsychotic Medications in Patients With Alzheimer’s Disease: Outcomes From CATIE-AD"
- Cognitive outcomes compared for 357 patients from CATIE-AD Trial for whom data were available for at least 1 cognitive measure at baseline and on follow-up assessment that occurred after they had been on antipsychotic medication or placebo for at least 2 weeks
- Results: Overall, all patients showed steady, significant declines over time in most cognitive areas; cognitive function declined more in patients receiving antipsychotics than in those given placebo on multiple cognitive measures
- Conclusions: Atypical antipsychotics were associated with a worsening of cognitive function; further cognitive impairment is an additional risk of treatment with antipsychotics

New Antipsychotic Safety Data (cont’d)

"Risk of Cerebrovascular Accident Associated with Use of Antipsychotics: Population-Based Case-Control Study" ¹¹
- database analysis of patients 65 years and older with dementia (mean 81 yrs)
- findings included that long-term (> 90 days) use of antipsychotics significantly increased CVA risk vs. those who were not receiving antipsychotics

"Are All Commonly Prescribed Antipsychotics Associated with Greater Mortality in Elderly Male Veterans with Dementia?" ¹³
- database analysis of elderly veterans with dementia diagnosis (mean age 78 yrs)
- findings included that commonly prescribed doses of haloperidol, olanzapine and risperidone, but not quetiapine, were associated with a short-term increase in mortality

The Facility (Nursing) Burden of Antipsychotics!
Monitoring For Adverse Consequences (from F329: Unnecessary Drugs)
- Anticholinergic effects
- Akathisia
- Neuroleptic malignant syndrome
- Cardiac arrhythmias
- Falls
- Lethargy
- Increase in total cholesterol and triglycerides
- Parkinsonism
- Blood sugar elevations (including diabetes mellitus)
- Orthostatic hypotension
- Stupor
- Tardive dyskinesia (routine AIMS or DISCUS tests)
- Excessive sedation

[Documentation, documentation, documentation]

Algorithm for Reducing or Eliminating Antipsychotics for Residents with Behavioral Symptoms of Dementia

- Assess ongoing use of non-pharmacologic interventions throughout process.
- Monitor and document use of non-pharmacologic interventions throughout process.
- Assess for condition that may have caused or contributed to behaviors that now resolved.
- Assess for condition that may have contributed to behaviors that now resolved.
- Avoid recommending increase in antipsychotic dose if possible.
- If symptoms improve, consider decreasing antipsychotic dose in 3 – 4 months.
- If symptoms re-emerge, assess effectiveness of non-pharmacologic interventions. If ineffective, recommend addition or dosage adjustment of adjunctive medication (e.g. antidepressant, etc.).
Suggested Targeted Facility Approach To Residents Receiving Antipsychotics For Dementia-Related Behaviors

• Carefully review each resident receiving antipsychotics for behaviors on at least quarterly basis
• Review should consist of analysis of documented behaviors that have occurred since last review, any trends related to these behaviors, and what non-pharmacologic interventions have been tried (and which have worked a not worked; those approaches that have worked need to be documented for other caregivers to follow!!!)
• Care team members to include in this review: nursing, nursing assistants, activities, social services, consultant pharmacist. Team can make recommendations to prescriber regarding potential reduction or discontinuation of antipsychotic therapy, and other recommendations

Suggested Targeted Facility Approach To Residents Receiving Antipsychotics For Dementia-Related Behaviors (cont’d)

• Have a contingency plan for each resident if behaviors recur THAT IS NON-PHARMACOLOGIC- be creative and don’t “knee jerk” to increasing or re-starting the antipsychotic unless the behavior is potentially harmful to the resident and/or others
• Each review can be conducted in as little as 5-10 minutes!!!!
• This process can and does work!!

Actual Case Study: “Mrs. S”

Mrs. S is an 87 year-old resident of a facility who decided to really focus on non-pharmacologic approaches to dementia-related behaviors. She has diagnoses of Alzheimer’s disease, depression, and arthritis. Her current medications include:
- Citalopram 10 mg QD for depression
- Seroquel 25mg AM and HS for combative behaviors
- Acetaminophen 1000mg TID PRN pain (which she rarely received)

During the facility’s review of her behaviors, she was noted to have 4 episodes of combative in the past month, 2 in the morning during AM care and dressing, and 2 around 9PM when receiving help with getting ready for bed. The activities coordinator noted that she did not seem to actively participate in morning exercise activities, but did participate in similar activities in the afternoon.
Actual Case Study: “Mrs. S” (cont’d)
Her nursing assistant said that Mrs. S often “grunted and groaned” when she helped her get dressed in the morning, but that she seemed to be most combative when a turtleneck top was chosen to be worn that day.

Considering this information and the fact that she has a diagnosis of arthritis, the team checked and verified that she had not received any acetaminophen in the mornings, and decided to ask her physician if a routine dose could be tried each morning for a month. Nursing assistants were asked not to dress her in a turtleneck during that period as well.

Upon review the following month, Mrs. S was noted to have no episodes of combative behavior in the mornings, but that she had 3 episodes around bedtime. The care team then asked her physician if the AM dose of Seroquel could be discontinued on a trial basis, and that the AM dose of acetaminophen be continued routinely.

Upon review the following month, there were no noted episodes of AM combativeness after the discontinuation of Seroquel, and her nursing assistant noted that she appeared to “moan and groan” less often upon dressing and AM care.

Excited about these results, the team now wanted to address the PM Seroquel. The nursing assistants that usually cared for Mrs. S in the evenings noted that she often liked to listen to music after dinner, and look at family photo albums. The team asked this nursing assistant to attempt to offer to turn on some music during any episodes of PM combativeness, and also offer to look at a photo album with her after getting dressed for bed. This approach was successful, with only 1 minor episode of combativeness over the next month.

The team then asked her physician if for a trial discontinuation of her PM Seroquel dose, which occurred.

While occasional episodes of AM and PM combativeness still occur, the nursing assistants state that “they can handle it”, and are very engaged and excited about their success with Mrs. S, and want to try it on other residents. The nursing assistants were brought into the facility’s next Quarterly Quality Assurance Meeting and asked to explain what they had been able to accomplish with Mrs. S, and were applauded by all for their success, which was very rewarding for them.

Mrs. S remains off of her antipsychotic to this day.
SUMMARY

• Antipsychotics present significant safety risks to elderly residents with
dementia, and as such should generally be reserved for those patients with
distressing psychotic symptoms (delusions, hallucinations) or aggressive
behavior that presents a danger to self or others

• Non-antipsychotics (e.g., antidepressants) should be attempted initially for
other behaviors for which non-pharmacologic interventions have not been
optimally effective

• Despite the frequency of GDR attempts mandated in Tag F-329: Unnecessary
Drugs, a GDR for those receiving antipsychotics for behaviors in dementia
should be attempted:
  a) within the first 60 days for a newly admitted resident, or sooner (e.g., 3-4
weeks) if initiated due to an acute problem (e.g., delirium from UTI); and
  b) every 3-4 months for those residents who have tolerated previous GDR

• The goal should be the discontinuation of these drugs whenever possible

Nurses, nursing assistants, other facility staff (e.g.,
activities, social services) and your consultant pharmacist can
play a very important role in reducing or eliminating the use of
these dangerous medications in residents with dementia-
related behaviors!!!