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**Antipsychotic Drug Monitoring Deficiencies
Driving You Crazy??
&
Psychotropic Drug Monitoring:
Is it *Still* Driving You Crazy?**

**Antipsychotic Drug Monitoring Deficiencies
Driving You Crazy??**

As facilities continue to experience ever increasing surveyor scrutiny of F329 Unnecessary Drugs, especially antipsychotic drug usage and the programs in place to monitor their usage, many facilities are still compliance-challenged. Especially when staff don't understand or have lost sight of how the program's components are to be integrated.

Let's take a look at some of the reasons for antipsychotic drug monitoring deficiencies and strategies to avoid them:

- **Reason:** The resident's diagnosis, types of behaviors, etc. appear not meet the criteria for use as outlined in the revised guidance to surveyors.

There are several layers of criteria that must be met regarding residents with dementia to support clinical justification for use of an antipsychotic. Facilities are advised to review these criteria with unit-based staff as well as to implement oversight/monitoring/quality assurance processes to ensure compliance.

- **Reason:** The resident continues on an antipsychotic but, month after month, the behavior monitoring records do not reflect any behaviors.
- **Reason:** The resident continues on an antipsychotic but, month after month, the behavior monitoring records *and* staff report that the resident does not exhibit behaviors.

In the first scenario, it is possible that the resident may still be exhibiting behaviors but staff are not adequately documenting them. The behavior flow sheet consistently appears to be the *most under utilized and/or poorly implemented component* of the entire psychotropic drug monitoring process and yet, when used properly, provides the essential and objective information upon which to make care and treatment decisions. (Many long term care pharmacies provide facilities with an individual Behavior Monitoring Sheet monthly for each psychotropic drug that a resident is receiving.)

The optimal form/format provides space to:

- List the resident's **target behaviors**. *Remember, target behaviors are identified in the initial psychotropic assessment and incorporated in the care plan and are those behaviors that the drug regimen should conceivably address. As previously stated, when the initial assessment does not identify target behaviors or staff are not advised to refer to the initial assessment for guidance, the facility runs the risk of some creative entries, i.e. antipsychotic monitoring sheet with target behaviors listed as 'poor personal hygiene' or hypnotic monitoring sheet with target behaviors listed as 'crying spells.'* OR target behaviors listed may vary from month to month. Numerical codes can be assigned to the target behaviors to minimize repetitive documentation.
- List or refer to a pre-printed list of **behavior management interventions** that staff are to implement when the target behavior occurs. Remember, these behavior management strategies can be referenced from the initial psychotropic assessment and care plan. Numerical codes are typically assigned to the interventions to minimize repetitive documentation. *Make sure that staff are utilizing interventions that relate to the resident's individualized care plan. This may require adding interventions to the pre-printed list.*
- **Record each occurrence** of the target behavior under the respective date using the designated numerical code.
- **Record the behavior management intervention** implemented by staff in response to the behavioral occurrence.
- **Record the resident's response** to the behavior management intervention. Was the intervention effective? Did staff then attempt an alternate intervention? Etc.
- In many cases, the Behavior Monitoring form also provides a format to document observation of the presence/absence of **side effects**.
- *Consistent 'zeroes' indicating that no target behaviors were manifested/observed begs the question 'why is the resident still on the psychotropic medication or still at the same dosage?' And hence... a deficiency.*

In the second scenario, the resident is apparently really not demonstrating any behaviors. So why has the antipsychotic been continued?

- Some facilities are initiating reduction or discontinuation based upon the calendar versus the resident's clinical picture. Trying to justify this approach to a surveyor will not preempt a survey deficiency.

- Some physicians' rationale for continuing a medication and/or continuing the same dosage falls short of providing adequate clinical justification. "Previous attempts at reduction resulted in return of symptoms" may be accurate some of the time but not necessarily. If the reduction attempt was a considerable time ago, if use of the antipsychotic was for dementia-related behaviors which over time have been extinguished, if the resident has changed in overall condition since the previous reduction attempt, etc., then the aforementioned documentation may not be sufficient to convince a surveyor that the resident (without behavioral display) still requires the antipsychotic. Collaborative discussion with the physician is highly recommended. (Often, when the facility is confronted with an imminent deficiency, the physician will then agree to a reduction. This does not usually help the facility escape the deficiency; it probably further convinces the surveyor that their concern was well placed.)
- Some facilities do not have sufficient oversight/quality assurance processes in place to review unit-based clinical decision making. Even if the facility has implemented a review of 'calendar' timeframes for reduction, this may not be sufficient to avoid a deficiency if the resident has not demonstrated behaviors for a period of time well before their 'calendar' reduction date. It is recommended that oversight activities include resident-specific review of clinical status.

- **Reason for a G-Level Deficiency:** The resident is receiving an antipsychotic and exhibits areas of decline i.e. lethargy/decreased socialization, decreased oral intake of foods/fluids, multiple falls, decrease in mobility and ADL abilities, new-onset or increase in incontinence, etc. The facility does not appear to consider the decline to be related to the medication and/or takes no action.
- **Reason for a G-Level Deficiency:** The resident appears to be having extrapyramidal side effects of the antipsychotic medication, i.e. drooling, involuntary movements of the mouth, extremities, etc. These effects may or may not be identified via AIMS testing. The facility and physician take no documented action.

A deficiency is certain, likely at the G-level, when either of the above occur and *especially* if the resident has not been exhibiting behavioral symptoms and a reduction has not occurred for some time. It is strongly recommended that staff be inserviced on a regular basis regarding signs of decline in residents taking antipsychotic medications, as indicated above. If the resident is having behaviors and signs of decline occur that may be related to the medication, it is essential that clinical staff, including the physician, document the risk/benefits of continued use at the same dosage, develop interventions to address the decline OR reduce/discontinue the medication. Extrapyramidal side effects must be communicated to the physician promptly as these could become permanent, i.e. tardive dyskinesia. It is essential that the physician be required to review and sign-off on AIMS tests. If extrapyramidal side effects exist, the physician should explicitly document the risks/benefits of continued antipsychotic drug use and, if continued, plans for managing the extrapyramidal effects.

Documentation, or lack thereof, is often at the root of the deficiency. But sometimes it really is about clinical decision-making.

Psychotropic Drug Monitoring: Is it *Still* Driving You Crazy?

(Received several requests to re-run the 'prequel' to last weeks' article)

As facilities continue to experience ever increasing surveyor scrutiny of psychotropic drug usage and the programs in place to monitor their usage, many facilities are still compliance-challenged. Especially when staff don't understand or have lost sight of how the program's components are to be integrated.

Let's try to put some sanity back into the psychotropic drug monitoring process by identifying common pitfalls and reviewing the optimal flow and integration of information. The following processes applies equally to antipsychotics, anti-anxiety drugs, sedatives, hypnotics, etc.

Initial Psychotropic Drug Assessment::

This form should be completed when a resident is admitted/readmitted to the facility on a psychotropic and/or prior to the initiation of a psychotropic drug regimen. The assessment process should include the following:

- Identification of the resident's behaviors that the psychotropic drug could conceivably address (target behaviors). *The absence of clear articulation of target behaviors is a common problem. Without identifying target behaviors at the beginning of the process, it is virtually impossible to assess resident response to the psychotropic drug regimen and to non-medication behavior management interventions. The process goes further awry when staff 'guess' at or mis-identify target behaviors on the Behavior Monitoring Sheets, discussed below, because of the absence of clear identification in the initial assessment phase.*
- Assessment of potential causes of the behaviors that, if addressed, could eliminate the behaviors without the use of psychotropic drugs, i.e. medical, environmental, family stresses, adjustment reactions, etc. *Facilities have received Immediate Jeopardy citations for administering psychotropic medications to control 'problem behaviors' that were actually symptoms of acute infection.*
- Discussion of non-medication behavior management strategies that have been implemented in an attempt to reduce/eliminate the behaviors prior to initiation of drug treatment and the resident's response to these interventions. *All too often staff's immediate reaction to 'problem behaviors' is to request a medication order from the physician before non-medication interventions are attempted.*
- Behavior management strategies planned to be implemented in conjunction with drug treatment.

The Care Plan:

Once the determination has been made to initiate psychotropic drug treatment, the care plan should be developed.

- An example of a Problem statement = Alteration in Behavior related to _____ and manifested by _____. The 'related to' and 'manifested by' are the causal factors and target behaviors identified in the initial Psychotropic Assessment.

- The ultimate goal is for the resident to be maintained on no or the lowest dose of psychotropic medication possible.
- It is recommended that other Goal Statements indicate/describe the behavioral parameters to be achieved that would precipitate a recommendation for dosage reduction/discontinuation.
- Behavior management interventions should include those already developed in the initial Psychotropic Assessment and additional strategies as applicable. *Interventions should be directed toward dealing with the manifested target behaviors and expressed in practical, concrete terms. Direct care staff are usually the ones who are confronted with these difficult behaviors. Esoteric psychobabble will not help them! Often direct care staff can offer practical and 'implementable' interventions themselves.*

While psychotropic drugs are an intervention, they are also a problem. I suggest keeping the behavioral problem separate from the 'use of' problem. *When the behavior problem includes 'use of' often there is more emphasis on side effects, and monitoring than on behavior management strategies.*

- An example of a Problem statement = Use of Psychotropic Medication.
- Goal Statements should address adverse reactions, side effects, etc.
- Interventions are then directed toward monitoring of medical/physical condition, completion of the AIMS test, documentation of side effects, etc.

Behavior Monitoring:

This consistently appears to be the *most under utilized and/or poorly implemented component* of the entire psychotropic drug monitoring process and yet, when used properly, provides the essential and objective information upon which to make care and treatment decisions. (Many long term care pharmacies provide facilities with an individual Behavior Monitoring Sheet monthly for each psychotropic drug that a resident is receiving.)

The optimal form/format provides space to:

- List the resident's **target behaviors**. *Remember, target behaviors are identified in the initial psychotropic assessment and incorporated in the care plan and are those behaviors that the drug regimen should conceivably address. As previously stated, when the initial assessment does not identify target behaviors or staff are not advised to refer to the initial assessment for guidance, the facility runs the risk of some creative entries, i.e. antipsychotic monitoring sheet with target behaviors listed as 'poor personal hygiene' or hypnotic monitoring sheet with target behaviors listed as 'crying spells.'* OR target behaviors listed may vary from month to month. Numerical codes can be assigned to the target behaviors to minimize repetitive documentation.
- List or refer to a pre-printed list of **behavior management interventions** that staff are to implement when the target behavior occurs. Remember, these behavior management strategies can be referenced from the initial psychotropic assessment and care plan. Numerical codes are typically assigned to the interventions to minimize repetitive documentation. *Make sure that staff are utilizing interventions that relate to the resident's individualized care plan. This may require adding interventions to the pre-printed list.*
- **Record each occurrence** of the target behavior under the respective date using the designated numerical code.

- **Record the behavior management intervention** implemented by staff in response to the behavioral occurrence.
- **Record the resident's response** to the behavior management intervention. Was the intervention effective? Did staff then attempt an alternate intervention? Etc.
- In many cases, the Behavior Monitoring form also provides a format to document observation of the presence/absence of **side effects**.
- *Consistent 'zeroes' indicating that no target behaviors were manifested/observed begs the question 'why is the resident still on the psychotropic medication or still at the same dosage?'*

A **monthly summary** can be developed based upon the information from the Behavior Monitoring flow sheet:

- How many times did the target behavior occur? That's right, count the occurrences.
- Is there a trend/pattern by shift, day of the week, clustering versus isolated, etc.?
- Were behavior management interventions effective? Which ones were more effective? Which ones were consistently ineffective?
- When compared to previous months, are occurrences lessening or increasing?
- *Nursing monthly summaries don't typically include the above depth of analysis of the Behavior Monitoring Sheet information. Not to say that they couldn't or shouldn't, but the reality is that, in most facilities, they just don't! If not there, then is this valuable analysis being done and, if so, were is it being documented?*

Quarterly Reassessment:

The resident's response to psychotropic drug treatment and behavior management interventions should be reviewed quarterly, ideally coordinated with the care plan review schedule.

- The Quarterly Assessment should incorporate assessment of the results of behavior monitoring as summarized in the aforementioned monthly documentation. Example: Each month of the previous quarter represented a decreasing number of occurrences of the target behaviors. The resident consistently responded well to redirection away from sources of agitating stimuli and being given a snack.
- The care plan team can now make informed decisions as to whether a drug reduction/discontinuation recommendation to the physician/psychiatrist is appropriate and/or whether to change or maintain the existing behavior management interventions. Did the quantified occurrences, resident response to behavior management interventions, etc. meet the parameters included in the Care Plan Goal Statements and therefore meet the criteria for dosage reduction/discontinuation? Should the care plan interventions be continued or should some/all be modified and tested for effectiveness? *Use Behavior Monitoring Sheet information and resident response as the triggers for dosage reduction or discontinuation, NOT the calendar. Facilities may be compliant with the minimum number of dosage reduction attempts within a defined time period but may NOT be compliant in the bigger picture, i.e. resident received unnecessary drugs because their behavior/condition/response indicated that a dosage reduction could have been made months prior.*

The cycle continues:

If the care plan team and physician/psychiatrist have implemented a dosage reduction, the next three months of behavior monitoring documentation and monthly summaries will reflect the affect of the dosage reduction on the number of occurrences of target behaviors, the effectiveness of the various behavioral management interventions, etc. The care plan team will have objective information upon which to assess the resident's response and whether or not additional changes should be recommended to the physician/psychiatrist.

Yes, this process takes you around in circles. But, for once, going in circles is the sanest path to follow.

About the Author:

Dorrie J. Seyfried is Vice President of Method Management, Risk Management & LTC Consultants, now part of Insurance Program Managers Group, based in St. Charles, Illinois. Under her directions, the Method Management team provides the risk management services to LSN's Workers Compensation Trust and LSN's liability insurance Risk Retention Group as well as a comprehensive array of consultation services to long to term care providers including mock surveys, plan of correction & informal dispute resolution development, incident management, and leadership development and a 24-hour risk management hotline exclusively for LSN members.

For questions about the contents of this newsletter, contact Jacque Thornton, at the Aging Services of Georgia office at 404-872-9191.

