Why and how we reduced the use of anti-psychotic medication from 30% to 5% in two residential care facilities

Essential oils and music when you bathe!!
How it started

• The morning CBC news of February 8th 2011

• Later in the day Kathy Tomlinson on THE NATIONAL with Peter Mansbridge!!
The patient

- She was no different than many others with moderately severe vascular dementia, emotionally labile and anxious.
- Would be upset with other residents
- Would be physically aggressive with staff and other residents but was a perfect angel when her family were around.
- Eventually Loxapine 5mg prn was prescribed given 20 doses over some time
- Had been transferred out of our facility 18 months prior
Crystallizing the issue

• At that time 30% of residents were on an antipsychotic and some like this patient on a PRN dose
• In our own review of the case we felt we were following standard treatment paradigms for our community
• Independently the administrator and I reviewed the literature on the use of antipsychotic medications in BPSD
The learning

Reviewing the literature we discovered

- Most behaviours were not responsive to antipsychotics
- They were generally no better than placebo
- They killed people and caused long term disability in the form of strokes and fractures
- They were appropriate if there was a psychotic illness predating the dementia
Strategy #1

Our response to the CBC program was

- Make a list of all residents on antipsychotics
- Write orders to wean them all down and off the medication.
- We managed a significant reduction but hit a wall at around 20% usage then after a few weeks realized we had restarted the medications in most!
A re-think

Reassess the change strategy

• Placebo responders???

• We realized that care aides were very apprehensive of the change and anticipated the behavioural problems they would encounter.
The effective change strategy

• There was a problem that we wanted to resolve
• A strong cohesive management team with a clear strongly worded and enacted policy
• We created champions for the change
• We identified the stakeholders and the potential wreckers of our policies
• We gave the immediate care-givers tools and resources to replace a reliance on drugs
• Families were involved
Education

• Staff were paid to attend two one hour sessions on
1. Dementia
2. Resident centred care in dementia
• Staff were made aware of why the policy change was necessary.
Family involvement

- Family case conferences particularly the initial meeting had a different focus
- We were explicit in our care philosophies
  - Resident care aimed at the resident on any day having the best, most comfortable day they could
  - Least medications all enhancing function today not in the future
  - Openness to talking about issues
- Personalised care we asked families to share their stories of how they got to here and the new resident’s life story
Non Pharmacological Alternatives

Aromatherapy

• Melissa and Chamomile
• Has to be massaged into volar aspect of wrist.
• Turned out to be effective (most are surprised) probably about 30% response rate (massage is most effective tactile instrument)
• We ask for consent for this, we feel it is experimental and signing the consent does raise awareness in families of behavioural problems
Music Therapy

- Good literature regarding the use of music therapy.
- Had the great fortune to have a music therapist apply for an activities job.
- A revelation.
Music Therapy

- Has to be personalized
- Has to be available one to one when needed
- It is not group singing and performances.
- It was incorporated into situations we knew escalated behaviour such as bathing
- Good evidence it reduces BPSD at meal times
- Ipods : Alive inside

https://www.youtube.com/watch?v=NKDXuCE7LeQ
Other carrots

- Staff were given the ability to call in extra care aide
- This allowed effective 1:1 care.
- It was possible then to take aides in rotation for $\frac{1}{2}$ to one hour each to give 1:1 care until crisis was over.
- Frequent (weekly) reviews of personalized care plans with staff
- Listening and not denigrating suggestions from care-aides
- Management by walk about!
- Acknowledging the importance of “chit –chat”
Impediments

- Accessing the doctor
- LPNs had to contact RN on call before requesting a medication from the doctor
- If a once off or PRN medication was being requested a serious incident report had to be filled in describing the events leading up to the request
- If there are continuing behaviour issues a behaviour chart must be kept to help assess the problem. Everyone is expected to add to that chart
- Only then was the physician contacted
- Families were made aware of the issue and asked to sign consent for us to use the medication
Staff Safety

- Staff safety was a major consideration in the change strategy
- 30% of care staff left the facility.
  - We were putting them at risk!
  - We were interfering with their professional independence not allowing direct contact with GP
- Reality: in 3 years only 1 WorkSafe claim for personal injury
- Encourage reporting of incidents. Good charting of behaviours not just accepting that the behaviour is the residents norm
- Debrief incidents and strategize around them
The graph
Where we are today

• In Glenwood 3 of 36 residents are on antipsychotics and two had pre-existing psychiatric conditions
• In Cheam Village 2 of 58 are on the drugs and one of them has a pre-existing psychiatric issue.
• 50 % of new admissions arrive on at least one antipsychotic
• Staff who have lived through this with us no longer look for a medication for behavioural problems
  – “There is no difference we have the same problems we no longer give them drugs. Why did we give them drugs in the first place.”
  – “I just don’t think about it anymore!”
Summary of what worked for us

1. Strong Leadership Team
   - Administrator – reallocate $ across programs
   - Director of Care – change care routines & clinical policy and procedures
   - Medical Director – consent form and medication review

2. Staff Education, Training and “on the floor” Support
   - FHA Clinical Nurse Educator – person centred care & dementia
   - Weekly Care Rounds – focus on care aide contributions
   - Staff Safety and Well-being – debriefing & incident reporting

3. Working Differently
   - Alternate Therapies – aromatherapy, music therapy, exercise
   - Treat Pain; Regular Toileting; Backing Off
   - Stop Calling the Doctor
Thoughts

• This takes TIME
• This takes persistence
• This takes upsetting a few people
• Care Aides are your important allies
• Care Aide education must include dealing with BPSD, how to distract and talk to demented residents, how to get your insights to the physician
• Purposeful activities are the key to less behaviour problems
This was a collective response to the issue

- I acknowledge:
  - The care aides and LPNs who were at the hard edge of this initiative
  - Elsie Duncan our director of care
  - Ann-Marie Liejen our administrator and team leader whose presentations on what we have done I have unashamedly plagiarised