

**Psychotropic Medication Use  
In Long-Term Care**

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**Malcolm Fraser,  
MD, CMD**

Bay Geriatrics

Synergy Health  
Solutions

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**Richard A. Marasco,  
Pharm., FASCP, CGP, HRM**

seniorpharm.com

Pharmaceutical Care &  
Management Services

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## Learning Objectives

- Review the unique pharmacologic requirements of the elderly and the most commonly utilized medications and frequent drug-to-drug issues.
- Discuss different treatment options for mental disorders including anxiety, epilepsy, bi-polar, and schizophrenia.
- Discuss the pharmacology of antipsychotic therapy, its impact on metabolic changes and cognitive function, and the differences and side effect profiles of the available antipsychotic agents.
- Discuss current studies and practice guidelines evaluating the use of atypical antipsychotics in the elderly.
- Review OBRA Guidelines and recommendations for LTC residents. Discuss and review OSCAR numbers and information.

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## Psychopharmacohazardology

- Definition: navigating the major hazards of the new generation of psychotherapeutic drugs



Zetin M. *Int J Clin Pract.* 2004;58(1):58-68.

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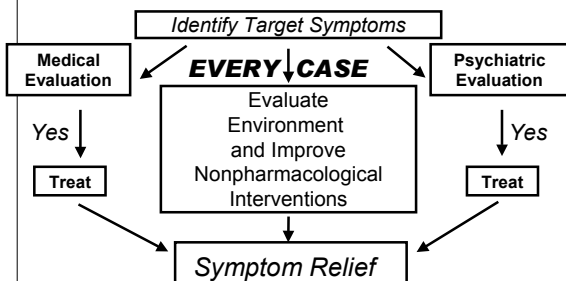
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## Paradigm for Comprehensive Behavioral Assessment



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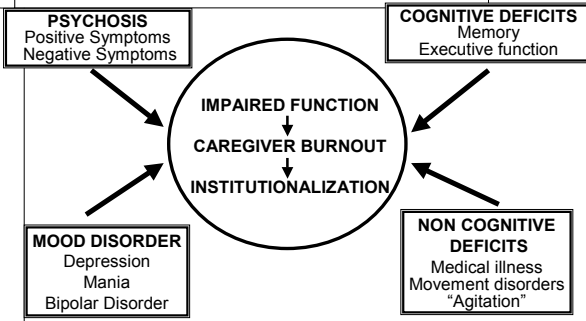
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## Psychiatric Disorder in Late Life




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## Schizophrenia

- Schizophrenia is a severe, progressive mental illness
- Symptoms can be severely disabling and are classified as:
  - **positive** (hallucinations, delusions, disorganization)
  - **negative** (reduction in drive, motivation, interest)
  - **affective** (depression, anxiety)
  - **cognitive** (problems with learning, memory, etc)
- Early diagnosis and therapy may improve prognosis

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## Spectrum of Bipolar Illness Course

Episodic ←————→ Unstable

### Purely episodic course:

- interepisode stability
- no mixed states
- infrequent episodes
- good recovery
- low incidence of complications

### Radical mood instability:

- 'interepisode' instability
- mixed states
- frequent episodes
- incomplete recovery
- high incidence of complications
- early onset
- stronger genetic loading?

Course of illness dictates treatment strategies

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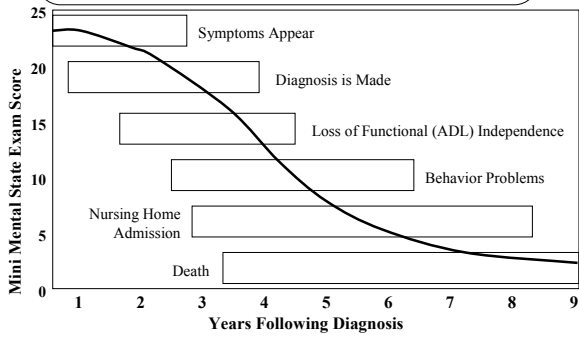
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## Alzheimer's Disease Prognosis



Feldman & Gracon, 1996. Clinical Diagnosis and Management of Alzheimer's Disease

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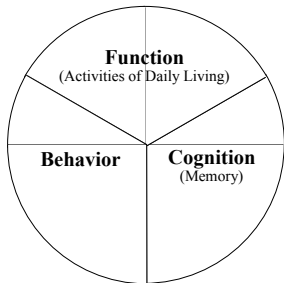
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## Key Symptom Areas of Dementia



LTC-3

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## Common Behavior Problems Described by Nurses in LTC

- Verbal or Physical Aggression
- Personality Clashes
- Wandering
- Depression
- Resistance to help with ADL's
- Screaming
- Suspiciousness, accusations, paranoia
- Not sleeping at night
- Recklessness, careless behavior
- Repetitive questions or demands
- Sexually inappropriate behavior

1) Baumgarten M, et al. Ann Intern Med 1994

2) International Psychogeriatric Association, Behavioral and Psychological Symptoms of Dementia Educational Pack, Module 4, 1998

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## Types of Behavior Problems

Type	Examples
Physically Aggressive	Pushing, biting, hitting, scratching, grabbing, throwing objects, spitting, kicking
Physically Nonaggressive	Wandering, pacing, elopement, intruding on others rooms, constant searching, inappropriate voiding, repetitious mannerisms
Verbally Aggressive	Screaming, yelling, cursing, swearing, making strange noises, temper outbursts
Verbally Nonaggressive	Constant requests for attention, complaining, whining, negativism, repetitive questioning, repetitively calling out, rambling disjointed sentences

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## Potential Causes of Behavior Problems

- Medical Problems
  - Infection
  - Cold symptoms
  - Dehydration
- Physical Problems
  - Pain
  - Discomfort
  - Constipation
  - Lack of sleep
  - Vision or hearing losses
- Medications
  - Antipsychotics
  - Antianxiety
  - Anticholinergic
  - Many others
- Other Causes
  - Environment
  - Other residents
  - Staff issues
  - Others

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## “Facility” Factors That May Contribute to Behavior Problems

- Changes in schedule
- Changes in caregivers
- Rushing with care provided
- Not talking to and comforting the resident
- Surprising the resident
- Noisy areas – or areas with many sources of noise at one time
- Poor lighting
- Rooms that are too hot or too cold
- Being left alone for long periods of time
- Others...

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## Behavior Management Principles

- Clearly identify the behavior(s)
- Treat the primary illness or problem
- Identify and remove causative agents
- Utilize non-drug interventions first (and continue them even if a medication is needed)
- Set realistic goals
- Allow for a realistic time frame
- Reassess, reassess, reassess

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## Non-Medication Strategies for Behavior Management

Behavior	Potential Management Strategy
Wandering	<ul style="list-style-type: none"><li>• Reduce or remove noise, stress, clutter and crowded situations</li><li>• Provide meaningful activities that match the residents abilities</li></ul>
Resisting Care	<ul style="list-style-type: none"><li>• Give less choices (ie: dressing)</li><li>• Break tasks into small steps and go slow</li><li>• Give simple directions</li><li>• Reassure and comfort</li><li>• Distract with conversation or music</li></ul>

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## Non-Medication Strategies for Behavior Management

Behavior	Potential Management Strategy
Inappropriate Sexual Behaviors	<ul style="list-style-type: none"><li>• Avoid mixed messages (even in joking) during care and at all times</li><li>• Respond calmly and firmly</li><li>• Distract and redirect</li></ul>
Suspiciousness or Paranoia	<ul style="list-style-type: none"><li>• Offer to help locate "stolen" items</li><li>• Do not argue, distract and try not to take accusations personally</li><li>• Re-introduce yourself and explain what you are doing for the resident</li></ul>

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## Non-Medication Strategies for Physically Aggressive Behaviors

Behavior	Potential Management Strategy
Fighting, Hitting, Slapping, Biting, Pushing, (etc)	<ul style="list-style-type: none"><li>• Respond calmly and firmly</li><li>• Do not argue or strike back at the resident</li><li>• Distract and redirect</li><li>• Reassure the resident of their safety</li></ul>

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## When is a Medication Indicated?

Before a medication is ordered the following questions should be considered:

- ✓ Does the behavior warrant drug therapy? Why?
- ✓ Will this behavior respond to a medication?
- ✓ Which category of medications is most suitable for this behavior?
- ✓ What are the potential adverse effects of the medication?
- ✓ How long should the medication be used?
- ✓ Is a psychiatric consultation needed?

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## F329 - Unnecessary Meds: Regulations

- Each resident's medication regimen must be free from unnecessary medications. An unnecessary medication is any medication when used:
  - In excessive doses (including duplicate therapy); or
  - For excessive duration; or
  - Without adequate monitoring; 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

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## F329 - Unnecessary Meds: Regulations (con't)

- Antipsychotics - Based on a comprehensive assessment of a 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

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## F329 - Unnecessary Meds: General

- Diagnosis alone may not warrant treatment with medication
- PRN meds - important to evaluate and document:
  - Indication(s)
  - Specific circumstances for use
  - Frequency of administration
- Orders from multiple prescribers can increase resident's chances of receiving unnecessary meds
- Although the guidelines generally emphasize the older adult resident, adverse consequences can occur at any age; therefore, these requirements apply to residents of all ages

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## Medications Commonly Used for Behavior Management

- Antipsychotics (Atypical)
  - Risperidone (Risperdal), Olanzapine (Zyprexa), Quetiapine (Seroquel), Aripiprazole (Abilify)
- Antipsychotics (Conventional)
  - Haloperidol (Haldol), Chlorpromazine (Thorazine)
- Benzodiazepines
  - Lorazepam (Ativan), Alprazolam (Xanax), Diazepam (Valium), Clonazepam (Klonopin)
- Mood Stabilizers (Anticonvulsants)
  - Divalproex Sodium (Depakote ER), Carbamazepine (Tegretol), Gabapentin (Neurontin)

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## The Impact of Medication Selection

### Resident Impacts

- Effectiveness
- Adverse Reactions
- Coverage/Cost

### Facility Impacts

- Effectiveness
- Adverse Reactions
- Coverage/Costs
- Efficiency
- Regulatory/Survey Concerns
- Quality Indicators

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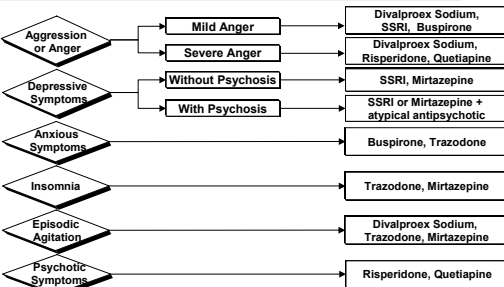
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## Medications for Long-Term Use in Selected Behavior Problems



Modified from: *A Pocket Guide to Dementia and Associated Behavioral Symptoms: Diagnosis, Assessment, and Management*. 2nd Ed. Insight Therapeutics, LLC, 2003.

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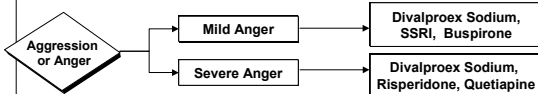
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## Medications for Long Term Use in Aggression and Anger

- Aggression at caregivers, other residents or family
- Fighting, Hitting, Slapping, Biting
- Severe outbursts, threats



Modified from: *A Pocket Guide to Dementia and Associated Behavioral Symptoms: Diagnosis, Assessment, and Management*. 2nd Ed. Insight Therapeutics, LLC, 2003.

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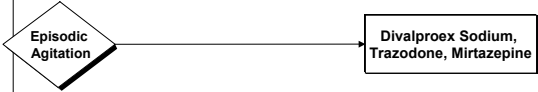
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## Medications for Long Term Use in Episodic Agitation

- Often presents as wandering confusion or disorientation
- May start in the late afternoon (“sundowning”)



Modified from: *A Pocket Guide to Dementia and Associated Behavioral Symptoms: Diagnosis, Assessment, and Management*. 2<sup>nd</sup> Ed. Insight Therapeutics, LLC. 2003

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## Medications for Long Term Use in Psychotic Behavior

- Often presents with hallucinations, paranoia and delusional behavior



Modified from: *A Pocket Guide to Dementia and Associated Behavioral Symptoms: Diagnosis, Assessment, and Management*. 2<sup>nd</sup> Ed. Insight Therapeutics, LLC. 2003

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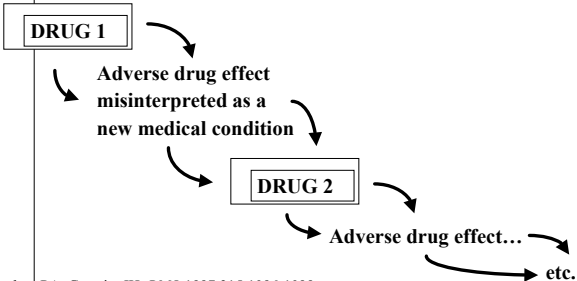
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## Polypharmacy: Challenge to Diagnosis



Rochon PA, Gurwitz JH. *BMJ*. 1997;315:1096-1099.

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**F329 - Unnecessary Meds:  
Indication**

- Lots of opportunities for or circumstances that warrant evaluation of medication's indication:
  - Admission or re-admission
  - Multiple prescribers
  - New medication order, especially if used as emergency measure
  - Psychiatric disorder or distressed behavior
  - Change in condition, decline in function, new symptom/condition

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**F329 - Unnecessary Meds:  
Indication (con't)**

- Considerations include whether...
  - An appropriately detailed evaluation/assessment has occurred
  - Other causes of symptoms have been ruled out
  - Signs, symptoms are persistent or clinically significant enough to warrant medication use
  - Non-pharmacological interventions were considered
  - Particular medication is indicated to manage that symptom/condition

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**F329 - Unnecessary Meds:  
Indication (con't)**

- Considerations include whether...
  - Intended or actual benefit justifies potential risks
  - Resident's goals and preferences (including end-of-life needs) have been considered
  - Resident has allergies to the medication or the potential for interactions
  - Effectiveness and adverse consequences from previous and current therapy have been considered

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## F329 - Unnecessary Meds: Monitoring

- TABLE of sample monitoring tools and sources/references
- What is the purpose of monitoring?
  - To incorporate medication-related goals and monitoring parameters into the resident's comprehensive care plan
    - In some cases, can refer to facility's established protocols or P&Ps
  - To optimize medication therapy (BENEFITS) while minimizing adverse consequences (RISKS)
  - To establish parameters for evaluating the ongoing need for the medications
  - To verify or differentiate the underlying diagnoses/causes of signs and symptoms

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## F329 - Unnecessary Meds: Monitoring (con't)

- What are the steps or components of monitoring?
  - Identify the essential information and how it will be obtained and reported
  - Determine the frequency and duration of monitoring
  - Define the methods for communicating, analyzing, and acting upon relevant information
  - Re-evaluate and update monitoring approaches
- Using QUANTITATIVE and QUALITATIVE monitoring parameters facilitates consistent and objective collection of information by the facility

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## Which Medications are Associated with ADR's in LTC?

- Antipsychotics 25%
- Anti-infectives 20%
- Antidepressants 13%
- Sedative/hypnotics 13%
- Anticoagulants 9%
- Cardiovascular 6%
- Hypoglycemics 5%
- Non-opioid analgesics 4%
- Opioid analgesics 3%
- Anti-Parkinson's 2%

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## Potential Adverse Effects from Antipsychotic Medications

- Antipsychotic induced extrapyramidal symptoms and tardive dyskinesia
- Sedation
- Metabolic syndrome
- Hyperprolactinemia
- Lipid abnormalities
- Cardiac effects (QTc prolongation)
- Orthostasis
- Stroke
- Falls

Nasrallah, H et al, A rational approach to antipsychotic pharmacology.  
www.medscape.com online educational program 2675, release 9/26/03

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## Tardive dyskinesia (TD) rates in the elderly

- Conventional antipsychotics
  - 26% after 1 year
  - 52% after 2 years
  - 60% after 3 years
- Atypical antipsychotics
  - lower EPS rates with atypical antipsychotics predicted to result in a lower risk of TD (some data show risk of approximately 5%)

Jeste et al 1995, Salliz et al 1991

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## Risk factors for antipsychotic-related tardive dyskinesia (TD)

- Gender (women at greater risk than men)
- Age (elderly at much greater risk than younger patients)
- African American
- Unipolar depression and bipolar disorders
- Comorbidity (eg, alcohol and tobacco product abuse, diabetes mellitus)
- Prior use of antipsychotics

Jeste et al 1995; Casey 1999

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## Summary

- The defining characteristic of atypical antipsychotics is at least equal efficacy with a significantly lower liability of EPS than conventional agents
- The implications of EPS reduction touch virtually every domain of pathology in schizophrenia
  - short-term movement disorders
  - relapse rate
  - long-term movement disorders
  - cognitive dysfunction
  - negative symptoms
  - dysphoria
  - noncompliance

Jibson and Tandon 1998

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## Tardive Dyskinesia Rating Scales

- **A.I.M.S.** (Abnormal Involuntary Movement Scale)
- **DISCUS** (Dyskinesia Identification System – Condensed User Scale)
- Simpson Angus Rating Scale
- **DIS-Co** (Dyskinesia Identification System – Coldwater)
- Schooler-Kane criteria
- Glazer-Morgenstern criteria

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## Management of Tardive Dyskinesia

- Assess the need for the antipsychotic
- Assess the duration of therapy
- Use the lowest effective dose
- Initiate with or switch to an atypical agent
- Utilize a standardized scale to monitor
- Obtain informed consent

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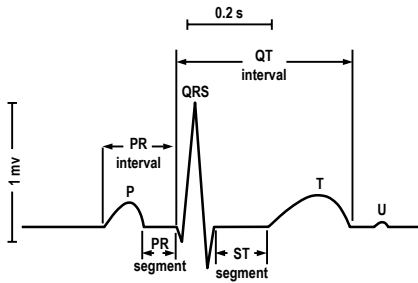
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## Review of electrocardiogram (ECG) and intervals



Guyton and Hall 2000

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## Effects of antipsychotic drugs on QTc (steady state) (Pfizer Study)

QTc change from baseline (ms)

	Zipras- idone	Risper- idone	Olanz- apine	Quetia- pine	Halo- peridol	Thiori- dazine
Baseline correction	15.9	3.6	1.7	5.7	7.1	30.1
Bazett's correction*	20.3	9.1	6.8	14.5	4.7	35.6
FDA-proposed correction	16.5	4.3	2.3	6.9	6.8	30.8
Fridericia correction	15.5	3.0	1.1	4.8	7.3	29.6
Hodges correction	14.9	3.3	2.5	7.5	7.4	28.7
Framingham correction	14.9	3.7	1.6	4.4	6.1	28.5
Linear baseline correction	14.6	3.3	1.2	3.8	6.3	28.1

\*Bazett's has consistently been found to be inaccurate

FDA Psychopharmacological Drug Advisory Committee 19 July 2000

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## Cerebrovascular Adverse Effects (Stroke, TIA)

- Reported in trials with elderly patients with Risperidone in dementia related psychosis
- Higher incidence of cerebrovasuclar adverse effects (CAE) when compared to placebo
- This study was not designed to determine incidence or risk factors for strokes or CAE's

Brodaty, H et al; A randomized placebo controlled trial of risperidone for the treatment of aggression, agitation and psychosis of dementia. *J Clin Psychiatry* 2003;64(2):134-43

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## Glucose Control and Triglyceride Levels

- Certain atypical agents can cause elevations in glucose levels and triglycerides
- This may lead to new onset diabetes and ketoacidosis, sometimes in the absence of weight gain
- Monitoring is the most appropriate intervention

Wirshing, DA et al. The effects of novel antipsychotics on glucose and lipid levels. *J Clin Psychiatry*, 2003;63(10):856-65

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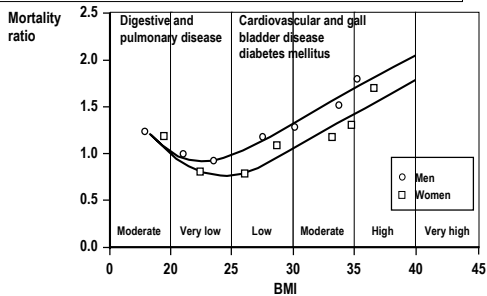
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## Obesity and mortality risk



Adapted from Gray 1989

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## ADA Consensus on Antipsychotic Drugs

### Atypicals and Metabolic Abnormalities

Drug	Weight Gain	Diabetes Risk	Dyslipidemia
Clozapine	+++	+	+
Olanzapine	+++	+	+
Risperidone	++	D	D
Quetiapine	++	D	D
Aripiprazole	+/-	-	-
Ziprasidone	+/-	-	-

+ = increase effect; - = no effect; D = discrepant results

American Diabetes Association. *Diabetes Care*. 2004;27:596-601.

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## Anticholinergic Adverse Effects

### Central

- Sedation
- Cognitive impairment
- Delirium

### Peripheral

- Dry mouth
- Blurred vision
- Constipation
- Sexual dysfunction
- Urinary hesitation
- Decreased sweating and salivation
- Tachycardia

Chouinard G et al. Collaborative working group on clinical trial evaluations. *J Clin Psychiatry* 1998

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## Fall Rates with Medications for Agitation and Aggression in LTC

- 1-year retrospective analysis of residents in Beverly facilities taking a benzodiazepine, antipsychotic or Divalproex for agitated and aggressive behaviors
- Observations were from 11/1/00 thru 10/31/01
- 93% were age 65 or older (range = 20-109)
- Residents received the medications > 14 days
- Falls determined by Section J, Question 4A on the MDS
- MDS was completed at least 30 days after initiation of therapy and residents were still receiving the medication

Musher, et al; Fall Rates with Medications Used for Agitation and Aggression in the LTC Setting: Safety and Economic Implications; ASCP Annual Meeting 2002

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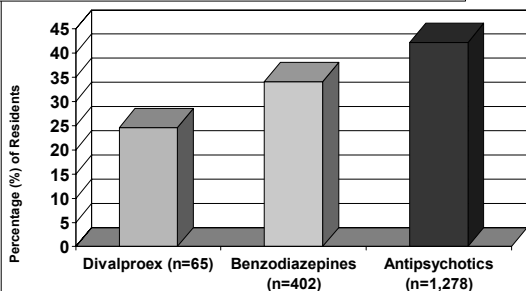
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## 30-Day Fall Rate



Musher, et al; Fall Rates with Medications Used for Agitation and Aggression in the LTC Setting: Safety and Economic Implications; ASCP Annual Meeting 2002

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## Risperidone and Olanzapine in Nursing Facilities

- 730 patient charts reviewed retrospectively
- Sample sizes were equivalent for both groups and treatment was for behavioral disturbances
- Average age was 81 years (range 55-06)
- Average initial dose Risperidone 0.67 mg/day and Olanzapine 3.3 mg/day
- Average dose at 91 days Risperidone 1.0 mg/day and Olanzapine 4.66 mg/day
- Examined the incidence of falls in patients having no falls, no history of falls and no restraint use

Martin, et al. Poster at the Annual Meeting Am Assn for Geriatr Psych, 2001

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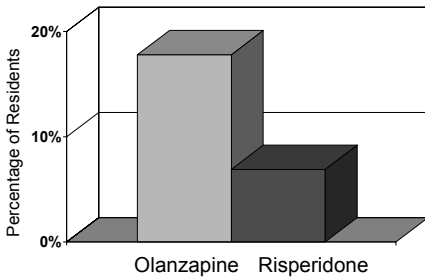
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## Residents Experiencing Falls



Martin, et al. Poster at the Annual Meeting Am Assn for Geriatr Psych, 2001

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## Lorazepam and Divalproex in Nursing Facilities

- 146 patient charts reviewed
- 81 patients (55.5%) received lorazepam; 65 patients (44.5%) received divalproex
- 37 patients (56.9%) treated with divalproex showed improvement
- 25 patients (30.9%) treated with lorazepam showed improvement

Frenchman IB et al. Curr Ther Res Clin Exp 2000;61:621-9.

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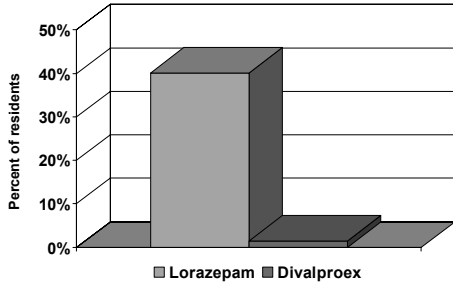
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## Residents Experiencing Falls



Frenchman IB et al. Curr Ther Res Clin Exp 2000;61:621-9.

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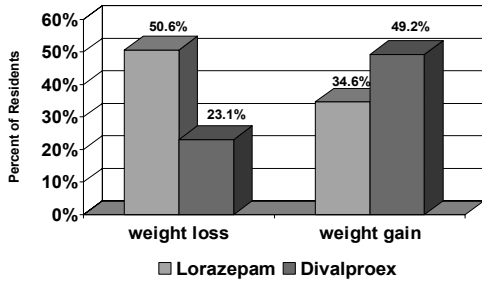
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## Residents Experiencing Weight Gain or Loss



Frenchman IB et al. Curr Ther Res Clin Exp 2000;61:621-9.

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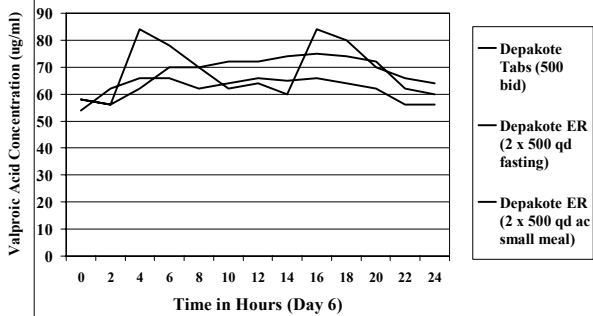
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## Divalproex Blood Levels



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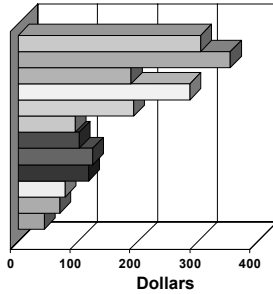
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## Medication Cost Per Month (AWP)

- Abilify 10 mg qd
- Seroquel 200 mg qd
- Seroquel 100 mg qd
- Zyprexa 10 mg qd
- Zyprexa 5 mg qd
- Risperdal 1 mg qd
- Risperdal 0.5 mg qd
- Depakote DR 500 mg bid
- Depakote DR 250 mg tid
- Depakote DR 250 mg bid
- Depakote ER 500 mg qd
- Depakote ER 250 mg qd




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## Nursing Home Medication Administration Average Time

System	Average Time/Dose
30-Day Bingo (Punch) card distribution system	69.86 Seconds
24-Hour Unit Dose distribution system	93.27 Seconds

Gonzalez, E et al: Cost Analysis of Solid Oral Medication Distribution And Administration: Applications for Chronic Nitrate Therapy, TCP 1997, 12: 690-702

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## Quality Indicators: 11 Domains

- Accidents
- Behavior/Emotional Patterns
- Clinical Management
- Cognitive Patterns
- Elimination/Incontinence
- Infection Control
- Nutrition/Eating
- Physical Functioning
- Psychotropic Drug Use
- Quality of Life
- Skin Care

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## Quality Indicators by Domain

- Accidents
  - Incidence of new fractures
  - Prevalence of falls

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## Quality Indicators by Domain

- Behavior/Emotional Patterns
  - Prevalence of behavioral symptoms affecting others
    - High risk
    - Low risk
  - Prevalence of symptoms of depression
  - Prevalence of symptoms of depression without antidepressant therapy

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## Quality Indicators by Domain

- Psychotropic Drug Use
  - Prevalence of antipsychotic use, in the absence of psychotic or related conditions
    - High risk
    - Low risk
  - Prevalence of antianxiety/hypnotic use
  - Prevalence of hypnotic use more than two times in last week

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### F329 - Unnecessary Meds GDR/Tapering for Antipsychotics

- Frequency of GDR: Within 1st year after admission on antipsychotic or after initiation:
  - GDR in 2 separate quarters, with at least one month between attempts
  - After 1st year, once per year
- GDR is clinically contraindicated if:
  - **(Behavioral Symptoms of Dementia)** Residents target symptoms returned or worsened after MOST RECENT GDR attempt within the facility AND physician has documented clinical rationale
  - **(Psychiatric Disorder)** Continued use is in accordance with relevant current standards of practice AND physician has documented clinical rationale, OR
  - Resident's target symptoms returned or worsened after MOST RECENT GDR attempt WITHIN facility, AND physician has documented clinical rationale

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### F329 - Unnecessary Meds GDR/Tapering for Sedatives/Hypnotics

- Conditions that must be present before GDR/tapering attempt is required:
  - Used routinely and beyond the manufacturer's recommendations for duration of use
- Frequency of GDR/tapering: QUARTERLY (approximately every 3 months)
- GDR/tapering is clinically contraindicated if:
  - Continued use is in accordance with relevant current standards of practice AND physician has documented clinical rationale, OR
  - Target symptoms returned or worsened after MOST RECENT GDR attempt within facility AND physician has documented clinical rationale
- Sedatives/Hypnotics now include...
  - New agents (non-benzodiazepine)
  - Sedating antidepressants (e.g., trazodone)
  - Sedating antihistamines (e.g., diphenhydramine, hydroxyzine)

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### F329 - Unnecessary Meds GDR/Tapering for Psychopharmacological Meds

- Psychopharmacological meds now grouped together, so they include more than just benzodiazepines
- Psychopharmacological is defined as "any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders" and includes
  - Benzodiazepines
  - Buspirone
  - Antidepressants
  - Anticonvulsants
- Tapering requirements are the same as for antipsychotics.

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## Regulations - Key Messages

- Increased responsibility of facility, prescribers, consultant pharmacist, and dispensing pharmacy regarding medication management, including between monthly pharmacist visits
- Policies and Procedures will be the key, and they actually need to be followed!!
- Consultant Pharmacist role as coordinator/evaluator of all pharmaceutical services
- Tapering/GDRs have changed significantly - it's more about how the medication is being used rather than in which class it is categorized
- Check your state regulations/rules too!
- The focus is on the **Care Process**...looking at patient and medication regimen holistically

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## Summary

- Clearly identify the problem behaviors
- Use non-drug interventions first
- Use drug therapy if indicated and continue the non-drug interventions
- Select medications based on the evidence and guidelines for care



"The red are for the illness, the blue are for the side effects of the red and the green are for the effects of the blue."

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