

## **INTRODUCTION**

AMDA is pleased to be able to support the *CMS initiative to Improve Behavioral Health and Reduce the Use of Antipsychotic Medications in Nursing Home Residents* with this excerpt from the [AMDA Clinical Practice Guideline for Dementia](#).

The purpose of this clinical practice guideline is to offer practitioners and care providers in LTC facilities a systematic approach to the recognition, assessment, treatment, and monitoring of patients with dementia, including impaired cognition and problematic behavior. It will provide a guide to appropriate management that maximizes function and quality of life, thereby minimizing the likelihood of complications and functional decline.

The excerpts will focus on assessment, non pharmacologic treatment and monitoring of a resident with dementia, including impaired cognition and problematic behavior. These excerpts will assist the care provider with appropriate management that maximizes function and quality of life and thereby minimizing the likelihood of complications and functional decline.

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## **ASSESSMENT**

It is challenging to quantify behavior, cognition, and mood. Different observers may describe or rate the same situation very differently. To ensure objectivity and accuracy as far as possible, choose and consistently use standardized terminology and appropriate evaluation tools. For example, level of consciousness (alert, lethargic or drowsy, stuporous, comatose) is different from and should not be confused with orientation (ability to correctly identify time, place, person and situation). Do not describe a patient as “alert and oriented” unless both are true.

Mood alterations may be characterized by their onset, duration, and severity. Describe cognition by its specific aspects, such as short-term memory, immediate recall, and calculation abilities (as categorized in the MMSE, BIMS or a comparable instrument). Behaviors may be described by specific characteristics to maximize objectivity and consistency. Table 11 offers an example of a scale for objectively grading the scope and severity of a patient’s behavior. Several scales can be used to assess the stage and overall scope of the patient’s condition; Table 12 in the AMDA guideline provides an example of one such scale. In addition, several available instruments are designed to measure a patient’s behaviors (e.g., the Neuropsychiatric Inventory, Cohen-Mansfield Agitation Inventory).

No matter what else has been identified as a potential cause of problematic behavior or altered mental state, always review the patient’s medications. Many medications can cause or contribute to impaired consciousness, increased confusion, and problematic behaviors. The Care Area Assessments in the MDS 3.0 has triggers for behavioral symptoms that may flag due to adverse effects of medications. Be particularly vigilant for any medications that have anticholinergic or centrally acting properties. In addition, AMDA’s medication management manual has entire chapter devoted to appropriate antipsychotic prescribing and discusses evaluating anticholinergic load (See Chapter 5: Appropriate

Prescribing of Psychoactive Agents in the Long-Term Care Setting in *Multidisciplinary Medication Management Manual: A Resource for the Long Term Care Continuum*<sup>1)</sup>

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**TABLE 11. Example of a Scale for Describing the Scope and Severity of Behavior**

**Scope**

1. Occurs rarely (irregularly, no more often than a few times a month)
2. Occurs occasionally (irregularly, as often as a few times a week)
3. Occurs often (regularly, almost daily)
4. Occurs continuously (regularly, many times daily)

**Severity**

1. Poses minimal risk to the patient or others, or is rarely socially disruptive (e.g., anxiety, safe wandering)
  2. Poses slight risk to the patient or others, or is sometimes socially disruptive (e.g., throwing food, engaging in mild verbal abuse, uncontrollable crying or laughing)
  3. Poses moderate risk to the patient or others, or is often socially disruptive (e.g., going into others' rooms, wandering unsafely)
  4. Poses major risk to the individual or others, or is always socially disruptive (e.g., defecating in public, engaging in violence)
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Define as accurately and fully as possible the nature, scope, severity, and causes of the patient's behaviors and cognitive and functional impairments. Before addressing management, determine the significance of the symptoms or impairments to the patient. Rule out medical and psychiatric disorders that may be causing additional symptoms or exacerbating existing symptoms in a patient with dementia (see AMDA's clinical practice guideline, *Delirium and Acute Problematic Behavior in the Long-Term Care Setting*.<sup>2)</sup>

Pharmacologic treatment of medical or psychiatric illnesses underlying behavioral and psychological symptoms of dementia" (BPSD), may be appropriate and effective. Traditionally, socially unacceptable behaviors in patients with dementia have been treated with medications. However, if no treatable underlying medical or psychiatric conditions can be identified, nonpharmacologic measures are preferable. Many behaviors are consistent with the patient's stage of dementia and previous history, and should be anticipated and accommodated rather than seen as a symptom to be treated. Behaviors generally regarded as socially unacceptable may be tolerable because they are expected manifestations

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<sup>1</sup> American Medical Directors Association *Multidisciplinary Medication Management Manual: A Resource for the Long Term Care Continuum*. Columbia, MD

<sup>2</sup> American Medical Directors Association. *Delirium and Acute Problematic Behavior in the Long-Term Care Setting*. Clinical Practice Guideline. Columbia, MD.

of the disease or are inconsequential to the patient or to others. For example, a patient may wander, display anxiety, or make repetitious comments that may be perceived by others as annoying. Although such behaviors may not be preventable, they may be managed through basic behavioral techniques or environmental changes. In some cases the most appropriate strategy may be to work with the patient's caregivers and family members to help them understand and accept the behaviors.

In some cases a patient's behavior may be a response to the actions of a caregiver. The following are examples of caregiver actions that may be a trigger for challenging behaviors:

- Setting the day's schedule based on the caregiver's needs rather than the patient's.
- Touching the patient without first announcing the intention to touch and obtaining permission to do so.
- Using the words "Do you remember," which challenge the patient to "perform" when he or she is unable to do so.
- Asking the patient to accomplish tasks that are beyond the level of his or her cognitive ability.
- Telling the patient "No," either verbally or through caregiver behaviors that are meant to stop the patient from accomplishing what he or she wishes to do.

An impairment may become disruptive or dangerous to the patient's function or may cause the patient considerable distress. Moreover, an impairment may have excessively disruptive or dangerous effects on family members or caregivers, or may infringe on other patients' rights or on the ability of staff to care for other patients. Such situations may require more aggressive management, including the use of medications.

Identify triggers for disruptive behavior. Behavioral symptoms in dementia patients often are triggered or exacerbated by physical, environmental, or psychosocial factors (Table 14). Identifying these triggers enables the use of targeted interventions to prevent or manage the disruptive behavior. The interdisciplinary team should assess how the environment may affect the patient with dementia. It may be helpful to record the events related to a challenging behavior episode. Table 15 offers examples of factors that may be relevant.

The correct identification of triggers for disruptive behavior requires substantial coordination among interdisciplinary team members. Although all staff can help to identify possible and potential causes for such behavior, the determination of exact causes should be made by team members who are familiar with the patient and can recognize multiple or less obvious causes. With certain neurological conditions, including dementias, behavioral responses can be incongruent or exaggerated. Do not assume that a behavior is triggered by environmental or other nonmedical factors until alternate causes have been considered. This is especially important when patients are newly admitted, have recently been hospitalized, or have a significant change of condition.

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**TABLE 14. Examples of Triggers for Disruptive Behaviors and Possible Nonpharmacologic Approaches to Their Management**

<b>Problem</b>	<b>Cause</b>	<b>Approach to Management</b>
Patient frequently does not sleep, wanders at night	<ul style="list-style-type: none"> <li>• Patient may need to void</li> <li>• Patient is awakened at night by noise, bright light outside window, or by staff coming into his or her room</li> <li>• Patient may be napping or sedentary during the day</li> </ul>	<ul style="list-style-type: none"> <li>• Scheduled toileting</li> <li>• Indirect light</li> <li>• Provide window shade</li> <li>• Reduce noise</li> <li>• Review sleep routine; obtain sleep log*</li> <li>• Educate staff to change their care routines</li> </ul>
Patient is combative when being bathed	<ul style="list-style-type: none"> <li>• Patient is anxious because he or she misinterprets the event, or because he or she is cold or hot, or because of modesty concerns, or because the movement of joints causes pain</li> </ul>	<ul style="list-style-type: none"> <li>• Staff reassurance</li> <li>• More flexible bathing methods and schedule (e.g., towel bath)</li> <li>• Staff training in how to appropriately approach and calm an anxious patient</li> <li>• Same-sex attendant</li> <li>• Pre-treatment with pain medication</li> </ul>
Patient is exhibiting agitated behavior throughout the day	<ul style="list-style-type: none"> <li>• Patient is in pain or is depressed</li> <li>• Patient is experiencing environmental overstimulation</li> <li>• Patient is reacting to an unsuitable or inappropriate action by a caregiver or family member</li> </ul>	<ul style="list-style-type: none"> <li>• Pain assessment</li> <li>• Depression screening</li> <li>• Staff training in observing for nonspecific signs and symptoms of pain in persons with dementia</li> <li>• Determine if symptoms are incongruent or exaggerated relative to setting)</li> </ul>
Patient makes inappropriate sexual advances toward other residents and staff members	<ul style="list-style-type: none"> <li>• May represent an exaggeration of previous personality trait, loss of social inhibitions</li> <li>• Patient has a basic drive for intimacy and love</li> </ul>	<ul style="list-style-type: none"> <li>• Seat aggressive patient away from residents he or she has targeted during social gatherings</li> <li>• Assign care of the aggressive patient to a staff member who is not likely to be a target of advances if possible</li> <li>• Educate staff on issues related to geriatric sexuality</li> <li>• Educate family members about the sexual needs of geriatric patients and encourage them to show physical affection (e.g., caressing, hugging) during visits, when appropriate</li> <li>• Educate staff on management of situations involving sexuality</li> </ul>

\* See AMDA's clinical practice guideline, *Sleep Disorders in the Long-Term Care Setting*.<sup>3</sup>

<sup>3</sup> American Medical Directors Association. *Sleep Disorders in the Long-Term Care Setting. Clinical Practice Guideline.* Columbia, MD

**TABLE 15. Examples of Factors That May Be Relevant to Disruptive Behaviors**

- What was the patient doing when the behavior occurred?
- What was happening just before the behavior occurred?
- What made the patient’s behavior better or worse?
- Was there a change in the environment just before the behavior occurred?
- Who was with or near the individual at the time of the incident?
- What was the impact of the behavior on other people?
- Did a specific circumstance cause recurrence of the behavior?
- Has the patient experienced any recent physical illness/changes?
- Is there a past history of this type of behavior?

## TREATMENT

Optimize the patient’s function and quality of life; capitalize on his or her remaining strengths. Patients with dementia often benefit from efforts to optimize their function and quality of life. Such efforts often include activities that target cognitive function (e.g., puzzles, arts and crafts), physical function (e.g., exercise, games), and spiritual well-being (e.g., attendance at religious services). For example, when feasible, enable individuals with musical aptitude to play instruments or provide arts and crafts supplies to those with artistic interests, or provide opportunities for physical activity and exercise (e.g., walking outside, attending a movement group).

Select individualized, person-centered interventions. Determine what the patient likes and enjoys and what will capture his or her attention. An understanding of the patient’s cognitive ability will assist in the selection of appropriate activities, which will help to ensure that the patient is not asked to accomplish tasks that are beyond his or her ability. Knowing the patient’s past occupation, hobbies, interests and musical preferences will also help tailor appropriate interventions to optimize their impact.

- Consider the use of complementary and alternative methods

Complementary and alternative methods may help to optimize function and quality of life in patients with dementia. Although such techniques should not replace effective, evidence-based therapy, they may be helpful when used in a complementary fashion, and in most cases are unlikely to cause adverse effects. For example, sensory stimulation may help to preserve meaningful contact with the outside world. Arts, crafts, peg-board activities, music, aromatherapy and pet therapy may be appropriate for some patients.

Pet therapy may increase the home-like atmosphere of the facility, provide experiences that encourage life review, increase socialization and participation in activities, allow the patient to express affection without adverse consequences, and motivate the patient to be more physically active (e.g., walking

toward the pet, throwing a ball, engaging in range of motion while touching the pet). Music therapy may help to stimulate memory; increase verbal expressions of feelings; stimulate decision-making about musical selections; encourage participation and purposeful use of instruments and other objects; motivate patients to engage in exercise and physical activity (e.g., a lively march or big-band music); and provide a relaxed, pleasurable environment.

Massage and touch therapy has been shown to help with the management of agitated behavior and with normalization of nutritional intake. The use of massage may require appropriate staff training. Aromatherapy may help to stimulate appetite, reduce agitation and depression, diminish pain, and energize the patient. Massage may be combined with aromatherapy to promote relaxation. Guided imagery uses auditory, olfactory, tactile, and taste images to elicit feelings of relaxation and empowerment, and may assist in pain management. Diaphragmatic breathing exercises may improve concentration, mood, memory, and energy levels.

Address socially unacceptable or disruptive behaviors. The management of socially unacceptable or disruptive behavior should be based on a careful evaluation and description of the behavior (Table 21). Acute changes in behavior or cognition in patients with dementia may represent delirium or other medical conditions or psychiatric disorders. Practitioners are advised to refer to AMDA's clinical practice guideline *Delirium and Acute Problematic Behavior in the Long-Term Care Setting*<sup>4</sup> for guidance on the assessment and management of patients with delirium and acute problematic behavior in the LTC facility.

After addressing causes of problematic behavior associated with treatable medical conditions and psychiatric disorders, the practitioner and interdisciplinary team should define the target symptoms to be treated (e.g., self-injury, severe agitation related to delusions) and identify care goals. Generally, unless the behavior potentially endangers the patient or others, consider nonpharmacologic interventions first while making efforts to identify the causes of the problematic behavior.

Some dementia-related behaviors that result in injury may be preventable. For example, patients with dementia who feel threatened may exhibit aggressive behaviors. Staff may reduce or eliminate these reactions by altering approaches to activities such as bathing, or by altering the patient's environment to suit specific needs or concerns. Behavioral outbursts may also be caused by catastrophic reactions, sudden emotions the patient exhibits when he or she feels frightened, confused, or overwhelmed. These behaviors tend to occur suddenly and resolve quickly when the source of distress is removed or the patient's attention is diverted. Behavioral problems such as hoarding or hiding objects, inappropriate social behavior, repetitive questioning, wandering, and withdrawal may respond better to behavioral therapy than to medication management. A randomized controlled trial in patients with Alzheimer's disease demonstrated improved physical function and reduced depression with exercise training and caregiver training in the management of behavioral problems.

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<sup>4</sup> American Medical Directors Association. *Delirium and Acute Problematic Behavior Clinical Practice Guideline*. Columbia, MD.

Although antipsychotic medications are commonly used in the LTC setting to treat behavior problems in patients with dementia, this use is “off-label” (i.e., not FDA-approved). Medication therapy for nursing facility patients is often complex. Since antipsychotic medications are all psychoactive medications they should be used with caution, and no medication has been FDA approved to treat dementia related behaviors.

Careful differentiation of cause of the symptoms (physical or neurological versus psychiatric, psychological) will define appropriate treatment options. Some evidence suggests symptoms of emotional lability may be modulated by medications affecting glutamate, serotonin and norepinephrine receptors. As of June 2008, the labeling for both conventional and atypical antipsychotic agents includes a boxed warning that these agents have been associated with an increased risk of death when used in elderly patients to treat dementia-related psychosis. On May 5th 2011, the Office of Inspector General released a report titled, “Medicare Atypical Antipsychotic Drug Claims For Elderly Nursing Home Residents” which claimed that atypical antipsychotic drug use in long term care facilities is generally inappropriate. The study determined that 83 percent of Medicare claims for atypical antipsychotic drugs for elderly nursing home residents were associated with off-label conditions; 88 percent were associated with the condition specified in the FDA boxed warning; and 22 percent of the atypical antipsychotic drugs claimed were not administered in accordance with CMS standards regarding unnecessary drug use in nursing homes.

One systematic review suggests that, if behavioral interventions have failed, neuropsychiatric symptoms of dementia show statistically significant improvement with treatment using the atypical antipsychotic agents olanzapine and risperidone. The authors considered the efficacy and safety evidence for the treatment of behavioral disturbances in dementia to be strongest for these agents. Other studies, however, have demonstrated no significant differences in the efficacy of atypical antipsychotics and have found that that patients receiving atypical antipsychotics had a risk of death (mostly from cardiovascular and cerebrovascular events) 1.6 to 1.7 times greater than those receiving a placebo; in patients with Alzheimer’s disease, adverse events may offset any efficacy advantages in atypical antipsychotics used to treat agitation, aggression, or psychosis.

Although the conventional antipsychotics are less well studied, they seem to carry a similar, if not greater, risk of death and perhaps a greater risk of adverse events when compared with the atypical antipsychotics. Traditional agents have a high risk of development of tardive dyskinesia in the geriatric population. Available evidence does not support switching patients with dementia from atypical to conventional antipsychotics to reduce the risk of stroke or death.

In some patients, both conventional and atypical antipsychotics may contribute to a worsening of behavior and other side effects. Although these agents may help to control agitation and hostility, they will not improve dementia-specific memory impairment. Second-generation antipsychotics are often associated with metabolic side effects, including weight gain and diabetes mellitus. Clozapine and olanzapine carry the highest risk, whereas other agents (e.g., aripiprazole, quetiapine, risperidone) are considered less prone to cause weight gain and pose a lower risk for diabetes. Other possible side effects of both conventional and atypical antipsychotics include extrapyramidal symptoms such as

akathisia (internal sense of motor restlessness), dyskinesias (involuntary motor movements), dystonia (spastic contractions of muscle groups), and parkinsonism (rigidity, shuffling gait, tremors); anticholinergic symptoms such as blurry vision, constipation, confusion, dry mouth, and urinary retention; orthostatic hypotension, sedation, and weight gain.

Some side effects of antipsychotic medications are infrequent but potentially fatal if not recognized and treated promptly. Because of these potential side effects, practitioners should generally avoid writing ongoing orders for antipsychotic medication to be given as needed (PRN).

- Neuroleptic malignant syndrome (NMS) is a life-threatening neurologic disorder that is almost exclusively caused by antipsychotic medications. This complication typically occurs within a month of treatment initiation, but it may occur at any time during treatment. Symptoms include an acute change in mental status, fever, muscle rigidity, and significant changes in blood pressure and heart rate. An elevation in creatine phosphokinase will help to confirm the diagnosis. The treatment of NMS is generally supportive in nature; the offending medication should be discontinued.
- The atypical antipsychotic clozapine, which has a low likelihood of causing parkinsonian symptoms, requires weekly monitoring of WBC and absolute neutrophil count due to the risk of agranulocytosis (a severe reduction in white blood cells) and other blood dyscrasias
  - The therapeutic goal of the use of antipsychotic medications is to treat psychosis versus nonspecific agitation or other forms of lesser distress, and thus improve the patient's quality of life. Treatment of psychosis includes identifying and treating underlying causes, ensuring safety, reducing distress, and supporting the patient's functioning. Antipsychotic medications when used in appropriate patients with dementia-related psychotic symptoms (versus repetition, chanting, agitation) may improve rather than worsen the quality of life of those individuals treated. The goal should always be to optimize quality of life, not merely to sedate the person. Although acute psychotic symptoms are unlikely to respond adequately to non-pharmacologic interventions alone, the implementation of non-pharmacologic approaches may permit the use of lower doses of antipsychotic medications.
  - The goal is *not* to sedate or restrain. The prescribing of antipsychotic medications for simple agitation, confusion, delirium, and aggression should not occur without thoughtful evaluation of whether there is a target symptom that is likely to respond to an antipsychotic agent, and with consideration of the risks involved. The goal of using antipsychotic medications, as with any psychopharmacological medications, is to address behavioral or mood symptoms and/or their underlying causes while preserving or enhancing function and quality of life. If the medication causes excessive or unwanted sedation or impairs function and diminishes quality of life, then its use may not be appropriate and should be reconsidered. Prescribing an antipsychotic medication, except in an emergency, should be done only after an attempt to determine if there are other environmental or medical factors causing these types of symptoms, and after taking appropriate actions when other causes are suspected (e.g., treating a urinary tract infection or providing medication for arthritis pain).

The use of these medications are often time-limited and therefore gradual dose reduction (GDR) every 6 months as required in the surveyor guidance may be too infrequent. The risk benefit assessment of these medications medication for non-psychiatric conditions should by the practitioner occur

practitioner at every scheduled visit if not more frequently, dependent on the individual risk factors. While there is no regulatory requirement for informed consent for antipsychotic therapy, the relatively high risk to benefit ratio and the lack of indication for behavioral and psychological symptoms of dementia make it prudent to pursue a reasonable and thoughtful discussion of the value and risks of these medications, as well as alternatives, with responsible parties. Such conversations should be documented in the clinical record. In some states it is required by statute that the physician or prescriber obtain and document informed consent for psychotropic medications.

Manage risks and complications related to dementia, other conditions, or treatments. Patients with dementia often have complications directly related to their disease (e.g., impaired mobility, urinary incontinence). They also may be at risk for indirect complications such as adverse medication reactions, aspiration with or without a feeding tube, delirium, and falls. For example, the onset of fever and diarrhea may affect alertness, which may necessitate a temporary reduction in doses of psychoactive medications until the acute illness resolves. Undergoing surgery under general anesthesia may further impair a patient's cognitive function. The medical treatment of problematic behavior and impaired cognition also may cause complications that resemble an acute illness or a worsening of the underlying condition (Table 24).

In the presence of worsening behavioral symptoms in a patient with dementia, a request for a urinalysis may come from nursing staff or even family members. However a urinalysis and urine culture should only be ordered *if* clinical signs and symptoms of urinary tract infection are present (e.g., fever, back pain, dysuria, frequency or urgency of urination, hematuria, hesitancy, persistent malodorous urine, pyuria). (See AMDA's Common Infections in the Long Term Care Setting clinical practice guideline<sup>5</sup> and AMDA's Urinary Incontinence in the Long Term Care Setting clinical practice guideline<sup>6</sup>) Evidence suggests, however, that urinary tract infections are not prominently associated with physical or verbal aggression in patients with dementia. Moreover, there is good evidence that asymptomatic bacteriuria should not be treated with antibiotics, even when there is significant bacterial growth in the urine culture, and the use of unnecessary antibiotics is to be discouraged for multiple reasons. The onset or worsening of medical illnesses or other problems in patients with dementia often precipitates a series of events, including altered nutritional status, functional decline, and hospitalization, that affect many aspects of the patient's life and care. Understanding these risks and promptly addressing problems can sometimes prevent hospitalization and its related risks. It is well accepted that sending a dementia patient to the emergency room can precipitate delirium and result in other bad outcomes, compared to treating them in their familiar surroundings with caregivers known to them, in the nursing home. When feasible, treatment in place for changes of condition is preferable. (Refer to AMDA's clinical practice guideline Acute Change of Condition in the Long-Term Care Setting<sup>7</sup>)

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<sup>5</sup> American Medical Directors Association. Common Infections in the Long Term Care Setting. Clinical Practice Guideline. Columbia, MD.

<sup>6</sup> American Medical Directors Association. Urinary Incontinence in the Long Term Care Setting. Clinical Practice Guideline. Columbia, MD.

<sup>7</sup> American Medical Directors Association. Acute Change of Condition in the Long-Term Care Setting. Clinical Practice Guideline. Columbia, MD

**TABLE 24. Examples of Complications From Medical Treatment of Problematic Behavior and Impaired Cognition**

- Adverse drug effects and interactions
  - Cardiac arrhythmias
  - Sudden cardiac death
  - Increased lethargy or confusion
  - Stroke
  - Falls
  - Metabolic abnormalities
  - Orthostatic hypotension
  - Worsening of disruptive or socially unacceptable behavior
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**MONITORING**

Monitor the patient's condition and adjust management as appropriate. Monitor the patient's condition periodically, using the same methods and criteria used in the initial assessment (see Assessment section). Staff should continue to be as objective as possible and should use consistent terminology and designated assessment tools and procedures to make and document their observations of patients with dementia. A Neuropsychiatric Inventory (NPI) can be used to track symptom progression or reduction. The BIMS is done on a quarterly basis for the MDS, and an individual patient's scores can be tracked and trended. Nursing staff should report significant changes in the patient's condition promptly to the practitioner after completing an appropriately detailed nursing assessment.

Typically, dementia will either stabilize or progress gradually. Following an acute condition change, the patient may return partially or completely to his or her baseline state or may decline further. If the patient's condition remains stable, continue pertinent interventions. If he or she declines progressively or rapidly, the practitioner, other direct care providers, and possibly a consultant psychiatrist should assess the patient and review the medical record to identify possible reasons for the decline. (Refer to AMDA's clinical practice guidelines on acute change of condition<sup>8</sup> and delirium and acute problematic behavior.<sup>9</sup>) Periodically, the practitioner should document functional decline that appears to be medically unavoidable (i.e., decline that results from the effects of aging or illness, including the progression of dementia that cannot or should not be treated). In addition, the practitioner should periodically review the patient's status and ongoing management with the nursing staff and the family. Components to monitor are listed in Table 25 in the AMDA guideline. As appropriate, review the staging of a patient whose behavior or function changes (improves or declines) significantly from a previous baseline.

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<sup>8</sup> American Medical Directors Association. Acute Change of Condition in the Long-Term Care Setting. Clinical Practice Guideline. Columbia, MD.

<sup>9</sup> American Medical Directors Association. Delirium and Acute Problematic Behavior in the Long-Term Care Setting. Clinical Practice Guideline. Columbia, MD.

Periodic attempts to taper one or more psychoactive medications are sometimes warranted, unless the nature of the condition (e.g., psychotic delusions) or past experience suggest that doing so may result in a return or an exacerbation of the patient's symptoms. Gradual dose reduction (GDR) efforts should follow published recommendations, except when contraindicated, and should be consistent with the guidelines in the OBRA '87 federal nursing facility regulations and future supplements (see §483.25, Quality of Care (I), Unnecessary Drugs). It should be noted that most dementia patients exhibit less behavioral symptoms as their disease progresses to the more advanced stages, so that by the time most dementia patients are bedbound, they usually do not require medication for psychotic symptoms or behavior.

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