ANTIPSYCHOTIC MEDICATION REDUCTION IN LONG TERM CARE

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Background

- Preponderance of research evidence that psychotropic medications are not useful for most of the symptoms associated with dementia

- Literature suggests that 5-15% usage in PCHs is appropriate; Interlake-Eastern is at ~ 30%

- Inappropriate usage of antipsychotic medications for individuals with dementia is a national concern

- In Interlake-Eastern RHA, we had already invested $$ and time to teach P.I.E.C.E.S™ (dementia model of care)

- We were seeing no appreciable differences in level of drug use since the implementation of P.I.E.C.E.S™ in over 7 years of education
Background (cont’d…)

• Original project to ↓ antipsychotics was from an EXTRA fellowship intervention project completed in the WRHA PCH Program in 2012

• EXTRA is Executive Training for Research Application and is funded through Health Canada and administered by the Canadian Foundation for Healthcare Improvement (CFHI)

• Project adopted by the Interlake-Eastern RHA in 2014
What is the problem with antipsychotics?

- Antipsychotic medications were first used in the 1950s
- Initially used as an anesthetic during surgery and the antipsychotic activity was discovered accidently
- Marketed to treat psychotic conditions such as schizophrenia
- Also known as ‘neuroleptics’ or ‘tranquilizers’
- Never intended for people with dementia
What are the RISKS of antipsychotic medications?

↑ death in elderly persons with dementia
  • Health Canada warning in 2005 and again in 2015 for Risperidone and Olanzapine
  • 1.6x increased risk of death
  • Causes: heart related events (e.g. heart failure, sudden death) or infections (e.g. pneumonia)

↑ Hip fractures
  • Increased risk of 50% for falls and fractures

↑ Side effects with chemical restraint usage

Oderda LH. Ann Pharmacotherapy 2012; 46:917-928.
Antipsychotics are **NOT** effective for:

- Aimless wandering
- Inappropriate urination/defecation
- Inappropriate dressing/undressing
- Vocally repetitious behaviour (calling out)
- Hiding/hoarding
- Eating in-edibles
- Tugging/removing restraints
- Pushing wheelchair bound co-resident

*These are typically the most often seen behaviors for which antipsychotics are prescribed...*
Why Reduce Antipsychotics?

- **Improved quality of life for the resident**
  - Reduction of potentially serious side effects*
  - More engaged in surroundings
  - Potentially better relationships
  - Fewer falls related to less sedation
  - Reduction of chemical restraints

- **Significant adverse effects**
  - Stroke and increased mortality

- **Cost savings**
  - Antipsychotics can cost up to $3.00 per pill
  - Estimated for all 16 homes we are spending approx. $60,650 annually
  - Fewer falls can lead to fewer hospital transfers

- **Time to care**
  - Reduction of med pass times
Interlake-Eastern RHA PCH Program

- 16 Personal Care Homes – over 700 beds

- 12 are owned and operated by the RHA; 4 are privately operated

- PCHs are smaller than in WRHA – largest one in WRHA is 309 bedded; most in IERHA are between 20 to 80 beds

- Communities are small; health care resources are not always available in every community (hospital, specialists, diagnostics, etc.)

- Staff live within these small communities: PCH residents are often well known by staff
The Project:

Pilot Site – Whitemouth PCH

• 26 bedded facility located in the beautiful Whiteshell area
• 40% of the residents (10 residents) were being prescribed antipsychotics without an underlying mental health diagnosis.

• All of the nurses and most of the HCAs had been trained in P.I.E.C.E.S™.

• Knowledge translation into practice was not consistently occurring. The culture shift to resident centered care from staff’s perspective:

  “Was difficult to implement due to task oriented routines, perceived time restrictions, staff inflexibility to altered work practices and structured shifts that did not necessarily meet resident needs.”

• In 2014, Whitemouth was spending over $800.00 per month on antipsychotics for 10 residents (over $3,000.00/ year)*
What Did We Do?

- Followed a cohort of 10 residents
- Implemented an intense application of P.I.E.C.E.S.™ education for ALL staff, at ALL levels
- Intense coaching for individual teams called “the huddle” to help foster interdisciplinary team discussion and problem solving
- Developed LEAN Six Sigma Quality Improvement Team made up of site staff from all departments
- Feedback surveys, focus groups from staff
The LEAN Angle
Analyze

**Occurrences of Reactive Behaviors**
Whitemouth PCH, Whitemouth MB
November 17th to December 6th, 2014

<table>
<thead>
<tr>
<th>Area of occurrence</th>
<th>Early morning</th>
<th>Med Pass (D)</th>
<th>Med Pass (Eve)</th>
<th>Bath</th>
<th>Dietary Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of occurrence</td>
<td>15</td>
<td>12</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Cum Percent</td>
<td>38.5%</td>
<td>69.2%</td>
<td>84.6%</td>
<td>94.9%</td>
<td>100.0%</td>
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</tbody>
</table>
Anywhere from 3 to 14 residents were in the dining room prior to breakfast service starting at 8:15.

The longest breakfast wait time for a resident waking at 5:30 and remaining awake is 2hrs45 minutes.
Dietary Breakfast Service Cycle Time
Whitemouth PCH, Whitemouth MB
November 17th - December 7th, 2014

RELEVANT DATA:
- Average number of residents in the dining room at start of breakfast service = 9.4.
- 10 residents in dining room on the dates of both the longest and shortest breakfast cycle times; 5 and 8 were present when the time increased from the average of 45 to 50 minutes.
Length of Resident Bath
Whitmouth PCH, Whitemouth MB
November 17th to December 6th, 2014

Total number of baths = 50
Longest bath time = 40 minutes; Shortest bath time = 15 minutes
Antipsychotics are provided on a prn basis 8% of the time pre-bath
Analyze/Improve

Non Mealtime Medication Pass Cycle Times
Whitemouth PCH, Whitemouth MB
November 17th - December 6, 2014

Time in minutes

Observation

1300 Med Pass
1600 Med Pass
HS Med Pass

UCL
Average
Data
LCL
+2 SD
+1 SD
-1 SD
-2 SD
Mealtime Medication Pass Cycle Times
Whitemouth PCH, Whitemouth MB
November 17th - December 6th, 2014

0800 Med Pass
1200 Med Pass
1700 Med Pass

Data
UCL
Average
LCL
+2 SD
+1 SD
-1 SD
-2 SD

Date of Observation
Results

- 5 residents had medications completely discontinued with no ill effects
- 2 resident came off, but had the meds re-prescribed due to severe aggression
- 3 others are being titrated down
- Improved QoL for residents
- 15 Action Plan items for improvement (LEAN) were identified by the team
- The LEAN Action Plan continues to be implemented at the site
- Improved teamwork
- Collaborative work atmosphere
- Growing leaders in all departments
- Evidence based practice
- Looking at new residents moving-in with a different lens
Spread & Sustainability

In the Interlake-Eastern RHA:
• Continue to work with Whitemouth PCH to implement Action Plan items

• Currently working with Pioneer Health – Arborg (40 beds)
• In October, begin the project with Fisher PCH

• Have expanded the education to include:
  • Experiential workshops
  • Enhanced education modules on Teamwork, Communication, Conflict resolution, and Leadership
  • Family education and surveys

Goal is to work with 2-3 homes/year until all homes have adopted this new philosophy and culture of care – a paradigm shift to elicit a true culture of resident centered care
Nationally:

- CFHI has partnered with the project author to create a 2 year national collaborative beginning in 2014 and ending in the fall of 2015.

- 15 partners across Canada from BC to Nfld are involved and include discrete organizations and health authorities.

- 2 year collaborative, already showing remarkable results - All 15 partners are demonstrating significant reductions in antipsychotic usage. Some, like York Care Center in New Brunswick have shown a 50% reduction in their usage.
Final Words

Health Innovation does not need to be costly.

With the proper support, the creative energy of invested stakeholders can make major differences in the lives of the residents we care for.