CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

Effective Strategies for Managing Psychotropic Medications in Nursing Facilities: Navigating New CMS Requirements of Participation

April 15, 2025

Host

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Nikki serves as the training and education lead for the Center of Excellence for Behavioral Health in Nursing Facilities (COE-NF). For the past 20 years, Nikki has provided program implementation, development, management, external and internal trainings, policy development, quality assurance, and managed training coordination and technical support throughout the southeast region.

Previously, she served as the program manager for the Division of Behavioral Health and Substance Use Services within the South Carolina Department of Corrections.

She has a B.A. in psychology from the University of South Carolina, a M.A. in counseling from Webster University and is a certified behavioral specialist.

Presenter

Jacob Berelowitz, LNHA, LMSW, CPHQ, CCM
Program Director, COE-NF

Jacob serves as the program director of the Center of Excellence for Behavioral Health in Nursing Facilities (COE-NF). He has 15 years of clinical and administrative leadership experience as a nursing home administrator, director of social work, and social worker.

He has served at nursing homes ranging in size from 700+ beds to 50 beds and has designed and implemented specialized nursing home units and programs to serve behavioral health needs of residents.

Dually licensed as a nursing home administrator and master social worker, he holds a master's degree in social work from New York University and is also a certified professional in healthcare quality and a certified case manager.

Presenter

Jennifer Massey, PharmD
Technical Advisor, Pharmacy Services
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Jennifer is the pharmacy services technical advisor for Alliant Health Solutions. Prior to her current role, she spent 10 years as a clinical pharmacist in the acute care setting.

She previously served on the opioid transformation team at the North Carolina Association of Pharmacists and is currently a member of the Antibiotic Stewardship Subcommittee for the Georgia Department of Public Health.

She also previously led the antibiotic stewardship, adverse drug event, and opioid work for HQIC and QIN-QIO contracts at Alliant. Jennifer earned her Doctor of Pharmacy from the University of Arkansas for Medical Sciences.

Presenter

Jennifer Goodpaster, BS, RN, DNS-CT, QCP, CPHQ
Program Manager, COE-NF

Jennifer serves as the program manager for the Center of Excellence for Behavioral Health for Nursing Facilities (COE-NF). As an experienced nurse, manager, and leader, here clinical experience includes long-term care with a special focus on the MDS/RAI process, quality improvement, leadership, direct resident care, and Medicare/managed care.

Previously, Jennifer was the long-term care (LTC) quality director for a quality improvement organization where she led a multidisciplinary team, supporting quality improvement initiatives for LTC staff to enhance the quality of care and life. She has also worked as a continuous quality improvement advisor, assisting multiple homes in improving healthcare delivery, and also served as a director of nursing, working closely with the multidisciplinary team within the facilities.

Objectives

- Understand the latest CMS guidelines regarding the use of psychotropic medications and the significance of informed consent to ensure compliance and quality of care.
- Establish and apply protocols for the gradual reduction of psychotropic medications when appropriate, ensuring personalized assessment and ongoing evaluation of the resident's needs.
- Promote teamwork among physicians, pharmacists, nurses, and other healthcare providers to enhance medication management practices and ensure comprehensive care for residents receiving psychotropic medications.

Disclaimer

Although the Center of Excellence for Behavioral Health in Nursing Facilities (COE-NF) was created by CMS and SAMHSA, we are not speaking on their behalf. This training is for educational purposes and is not official CMS guidance. For official policies and guidance please refer to CMS publications and regulations, including the State Operations Manual (SOM) and CMS official guidance memos.

Overview of F605: Chemical Restraints/Unnecessary Psychotropic Medications

Effective Date: Surveyors will begin using this guidance to determine compliance with requirements on surveys beginning **April 28, 2025**. This allows ample time for surveyors and nursing home providers to be trained on this new information.

Quote from CMS Guidance Memo

Chemical Restraints/Unnecessary Psychotropic Medication:

- *The regulations and guidance for the unnecessary use of psychotropics (F758) have been **incorporated into F605**. This change will help to streamline the survey process, increase consistency, and strengthen our message that facilities must prevent the unnecessary use of psychotropic medications.*

- *The guidance regarding **"convenience"** has been revised to include situations when medications are used to cause symptoms consistent with sedation and/or require less effort by facility staff to meet the resident's needs.*

- *Additional guidance has been added to emphasize requirements related to the **right to be fully informed** of and participate in or refuse treatment, noting that before initiating or increasing a psychotropic medication, the resident must be notified of and have the right to participate in their treatment, including the right to accept or decline the medication.*

- *Unnecessary Medications (F757) has been revised to only include guidance for non-psychotropic medications. The revised Unnecessary Medications, Chemical Restraints/Psychotropic Medications, and Medication Regimen Review **Critical Element Pathway** also includes investigative elements to align with the revised guidance.*

Key Psychotropic Guidance Updates

F758 incorporated into F605

- The guidance on psychotropic usage moved to a different area of the state operations manual.

Convenience

- CMS Definition: "CONVENIENCE" is defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care, and is not in the resident's best interest.

Informed Consent

- Documentation must be present demonstrating that the resident/representative was informed of proposed change, risks/benefits, and consented.

Updated Critical Element Pathway

Chemical Restraints: Convenience and Discipline

"In accordance with §483.10(e)(1) and §483.12(a)(2), ***residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.*** *Facilities are responsible for knowing the effects medications have on their residents. If a medication has a sedating or subduing effect on a resident and is not being administered to treat a medical symptom, the medication is acting as a chemical restraint. These effects could indicate an intentional action to discipline or make care more convenient for staff, or the facility did not intend to sedate or subdue a resident, but an unnecessary medication is being administered that has that effect."*

What is a Chemical Restraint?

- A chemical restraint refers to any drug used for **discipline** or that makes it more **convenient** (I.e., less effort) for staff to care for a resident and **not required** to treat medical symptoms.

- This includes instances when a psychotropic medication may be approved to treat certain symptoms, however, nonpharmacological interventions should be used or attempted, unless clinically contraindicated, because they are less dangerous to a resident's health and safety.

- In these instances, a medication would be deemed not required to treat a resident's symptoms, because a safer alternative should be used.

Staff Convenience or Discipline

- **Convenience** is defined as the result of any action that has the effect of altering a resident's behavior.
  - Example: The resident requires a lesser amount of effort or care, and it is not in the resident's best interest.

- **Discipline** is defined as any action taken by facility staff for the purpose of punishing or penalizing residents.

Examples of a Chemical Restraint:

Staff administer medication to "calm down" the resident to prevent the resident from displaying behaviors like:

- Wandering
- Quiet the resident due to calling out without attempting alternative interventions
- Continually requesting assistance
- Restrict the resident to a seated or lying position
- Resisting care

Informed Consent

Residents, family, and/or resident representatives have the right to:

- **Be informed** of and participate in their treatment.
- **Be informed of the benefits, risks, and alternatives** for the medication, (including any black box warning for antipsychotic medications) in advance of such initiation or increase.
- **Accept or decline** the initiation or increase of a medication.

Documentation:

- Medical record must include informed consent obtained in advance, including the risks and benefits of the proposed care, the treatment alternatives, or other options.
- A written consent form may serve as evidence of a resident's consent to medication, but other types of documentation are also acceptable.
- If a medication has been initiated or increased, and there is no documentation demonstrating compliance with the resident's right to be informed and participate in their treatment, noncompliance exists.

Informed Consent Example

DEPARTMENT OF HEALTH SERVICES
Division of Care and Treatment Services
F-24277 (05/2024)

STATE OF WISCONSIN
42 CFR483.420(a)(2)
DHS 134.31(3)(o)
DHS 94.03 & 94.09
§§ 51.61(1)(g) & (h)

INFORMED CONSENT FOR MEDICATION

Dosage and / or Side Effect information last revised on 08/19/2020

Completion of this form is voluntary. If informed consent is not given, the medication cannot be administered without a court order unless in an emergency.
This consent is maintained in the client's record and is accessible to authorized users.

Name – Patient / Client (Last, First MI)	ID Number	Living Unit	Date of Birth
,			

Name – Individual Preparing This Form	Name – Staff Contact	Name / Telephone Number – Institution

MEDICATION CATEGORY	MEDICATION	RECOMMENDED DAILY TOTAL DOSAGE RANGE	ANTICIPATED DOSAGE RANGE
Antipsychotic Antidepressant Bipolar/Mood Stabilizing Agent	Abilify, Abilify Maintena, Abilify MyCite, Aristada, Aristada Initio (aripiprazole)	Abilify Tablet: 2 mg -30 mg Abilify Oral Solution: 30 mg Abilify MyCite Tablet: 2 mg-30 mg Long Acting Injection: *Abilify Maintena* (300 mg-400 mg IM every 4 weeks) *Aristada* (441 mg-662 mg IM every 4 weeks, 882 mg IM every 4-6 weeks, 1064 mg every 8 weeks) *Aristada Initio* (675 mg)	

The anticipated dosage range is to be individualized, may be above or below the recommended range but no medication will be administered without your informed and written consent.
Recommended daily total dosage range of manufacturer, as stated in *Physician's Desk Reference* (PDR) or another standard reference.
This medication will be administered ☐ Orally ☐ Injection ☐ Other – Specify:

1. Reason for Use of Psychotropic Medication and Benefits Expected (note if this is 'Off-Label' Use)
Include DSM-5 diagnosis or the diagnostic impression ("working hypothesis.")

2. Alternative mode(s) of treatment other than OR in addition to medications include
Note: Some of these would be applicable only in an inpatient environment.

- ☐ Environment and/or staff changes
- ☐ Positive redirection and staff interaction
- ☐ Individual and/or group therapy
- ☐ Rehabilitation treatments/therapy (OT, PT, AT)
- ☐ Treatment programs and approaches (habilitation)
- ☐ Use of behavior intervention techniques

Other Alternatives:

3. Probable consequences of NOT receiving the proposed medication are

Impairment of ☐ Work Activities ☐ Family Relationships ☐ Social Functioning

Possible increase in symptoms leading to potential

- ☐ Use of seclusion or restraint
- ☐ Limits on access to possessions
- ☐ Limits on personal freedoms
- ☐ Limit participation in treatment and activities
- ☐ Limits on recreation and leisure activities
- ☐ Intervention of law enforcement authorities
- ☐ Risk of harm to self or others

Other Consequences:

Note: These consequences may vary depending upon whether or not the individual is in an inpatient setting. It is also possible that in unusual situations, little or no adverse consequences may occur if the medications are not administered.

See Page 2

Client Initial _____ Date _____

4. Possible side effects, warnings, and cautions associated with this medication are listed below. This is not an all-inclusive list but is representative of items of potential clinical significance to you. For more information on this medication, you may consult further with your physician or refer to a standard text, such as the PDR. As part of monitoring some of these potential side effects, your physician may order laboratory or other tests. The treatment team will closely monitor individuals who are unable to readily communicate side effects in order to enhance care and treatment.

Continued – Possible side effects, warnings, and cautions associated with this medication.

Most Common Side Effects: increased cholesterol; weight gain; having a sense of inner restlessness or feeling like you cannot sit still; headache; constipation; nausea; dizziness; increased glucose; rash; anxiety; fatigue; tremor; vomiting.

Less Common Side Effects: bloating or swelling of face, arms, hands, lower legs, or feet; blurry vision; body aches or pain; airway congestion; coughing; difficulty with movement; fever; increased salivation- drooling (children); joint pain; muscle aching or cramping; muscle stiffness; stuffy nose (children); swollen joints; trouble swallowing; unusual weight gain or loss; acid or sour stomach; belching; dry mouth; fear; irregular heartbeat; irritability; loss of strength; lightheadedness; nervousness; sleepiness or unusual drowsiness; difficulty falling asleep or staying asleep; stomach discomfort, upset, or pain; back pain; increased risk of upper respiratory tract infections; bloody nose; loss of bladder control; orthostatic hypotension (dizziness or lightheadedness when standing from a seated or lying position).

Rare Side Effects: Although rare, please call your doctor as soon as possible if any of the following side effects occur: difficulty speaking; loss of balance control; muscle trembling, jerking, or stiffness; shuffling walk; severe muscle stiffness; twisting movements of body; uncontrolled movements, especially of face, neck, and back; worsening of behavior; increased need to urinate; seizures or convulsions; difficulty in breathing; fast heartbeat; high fever; high or low blood pressure; excessive sweating; lip smacking or puckering; puffing of cheeks; rapid or worm-like movements of tongue; sudden loss of consciousness; extreme fatigue; uncontrolled chewing movements; uncontrolled movements of arms and legs; unusually pale skin; changes to menstruation; swelling of face, tongue, or throat; difficulty achieving erection; hair loss; blood coagulation disorders; generalized skin itch; loss of sexual desire or function; chest pain; heart fluttering; double vision; suicidal thoughts or actions (if you do experience this, please call your doctor immediately); yellowing of the skin or eyes.

Caution

- **Extrapyramidal symptoms (EPS)**
  Patients have reported muscle spasms of the neck and back; shuffling walk; tic-like (jerky) movements of the head, face and neck; trembling and shaking of the hands and fingers; inability to move eyes; mask-like face; loss of balance control; blurred vision; difficulty speaking or swallowing. Additionally, though not common, Tardive Dyskinesia has been reported. Tardive Dyskinesia presents with lip smacking or puckering, puffing of cheeks, rapid or fine worm-like movement of tongue, uncontrolled chewing movement, or uncontrolled movements of arms and legs may occur and may not go away after stopping use of the medication.
- **Neuroleptic Malignant Syndrome (NMS)**
  Use may be associated with NMS. Monitor for changes in thinking, fever, muscle stiffness, and/ or autonomic instability (unable to exercise, abnormal sweating, loss of appetite, loss of bladder control, difficulty with ejaculation, burry vision). Call your doctor as soon as possible if you believe you may have NMS.
- **Driving and operating heavy machinery**
  Aripiprazole may cause drowsiness or dizziness, which could make driving, operating heavy machinery, or participating in other activities requiring alertness dangerous. Be sure you know how this medication affects you before participating in these activities.
- **Blood disorder**
  Check with your doctor immediately if you develop fever, chills, sore throat, or sores in the mouth. These may be signs of a very serious blood problem that has occurred rarely in patients taking aripiprazole. This medication also has the potential to increase bleeding.
- **Orthostatic hypotension**
  Orthostatic hypotension is when one feels dizzy while standing up from a lying or sitting position. Getting up slowly may help. If this problem continues or gets worse, check with your doctor.
- **Fall risk**
  This medication increases the risk of experiencing a fall due to drowsiness and dizziness. Caution should be exercised by those who have a history of falls.
- **Weight gain**
  This medication has been associated with increased appetite and weight gain.
- **Seizure**
  This medication may, in rare cases, cause a seizure. Caution should be exercised in those who have a history of seizures.
- **Withdrawal**
  This medication should not be suddenly stopped as doing so may cause an individual to experience symptoms of withdrawal. Please speak with your physician before stopping this medication.

Client Initial _____ Date _____

Warning: [Black Box Warning]: Increased Mortality in Elderly Patients with Dementia Related Psychosis:
Elderly patients with dementia related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of 17 placebo controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in the drug treated patients of between 1.6 to 1.7 times that seen in placebo treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug treated patients was about 4.5% compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. Aripiprazole is not approved for the treatment of patients with dementia-related psychosis.

Warning: [Black Box Warning]: Suicidality and Antidepressant Drugs:
Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of adjunctive Abilify or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Abilify is not approved for use in pediatric patients with depression.

See standard reference text for an all-inclusive list of side effects.

By my signature below, I GIVE consent for the named medication on Page 1 and anticipated dosage range. My signature also indicates that I understand the following:

1. I can refuse to give consent or can withdraw my consent at any time with written notification to the institution director or designee. This will not affect my right to change my decision at a later date. If I withdraw consent after a medication is started, I realize that the medication may not be discontinued immediately. Rather, it will be tapered as rapidly as medically safe and then discontinued so as to prevent an adverse medical consequence, such as seizures, due to rapid medication withdrawal.
2. Questions regarding this medication can be discussed with the Interdisciplinary Team, including the physician. The staff contact person can assist in making any necessary arrangements.
3. Questions regarding any behavior support plan or behavior intervention plan, which correspond with the use of the medication, can be directed to the client's social worker, case manager, or psychologist.
4. I have the right to request a review at any time of my record, pursuant to § 51.30(4)(d) or § 51.30(5)(b).
5. I have a legal right to file a complaint if I feel that client rights have been inappropriately restricted. The client's social worker, case manager, or agency/facility client rights specialist may be contacted for assistance.
6. My consent permits the dose to be changed within the **anticipated dosage range** without signing another consent.
7. I understand the reasons for the use of the medication, its potential risks and benefits, other alternative treatment(s), and the probable consequences that may occur if the proposed medication is not given. I have been given adequate time to study the information and find the information to be specific, accurate, and complete.
8. This medication consent is for a period effective immediately and not to exceed fifteen (15) months from the date of my signature. The need for and continued use of this medication will be reviewed at least quarterly by the Interdisciplinary Team. The goal, on behalf of the client, will be to arrive at and maintain the client at the minimum effective dose.

SIGNATURES		DATE SIGNED
Client – If Presumed Competent to Consent/Parent of Minor/Guardian (POA-HC)	Relationship to Client ☐ Self ☐ Parent ☐ Guardian (POA-HC)	
Staff Present at Oral Discussion	Title	

Client / Parent of Minor / Guardian (POA-HC) Comments

As parent/guardian (POA-HC) was not available for signature, he/she was verbally informed of the information in this consent.

Verbal Consent

Obtained by – PRINT – Staff Name	Date Obtained	Written Consent Received ☐ Yes ☐ No
Obtained from – PRINT – Parent / Guardian (POA-HC) Name	Date Expires	Date Received

Client Initial _____ Date _____

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

Schizophrenia and Antipsychotics

Professional Standards and Medical Director

- Instructions for investigating adherence to professional standards of practice when concerns arise regarding residents diagnosed with a condition without sufficient supporting documentation for which antipsychotic medications are an approved indication were added to the guidance at Professional Standards (F658).

Accuracy/Coordination/Certification

- Instructions for investigating Minimum Data Set (MDS) assessment accuracy and determining whether noncompliance exists when a concern related to insufficient documentation to support a medical condition is identified for a resident receiving an antipsychotic medication were added to the guidance in Accuracy of Assessment (F641).

Unnecessary Medication Critical Element Pathway

- Record Review (Schizophrenia diagnosis only)
  - In these situations, does the medical record include documentation that meets the criteria in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for diagnosing schizophrenia:
  - Symptoms, disturbances, or behaviors consistent with and for the required period of time in accordance with the DSM criteria.
  - Evaluation of the resident's physical, behavioral, mental, psychosocial status, and comorbid conditions, ruling out physiological effects of a substance (e.g., medication or drugs) or other medical conditions, indications of distress, changes in functional status, resident complaints, behaviors, and symptoms.

Gradual Dose Reduction (GDR)

- **CMS Definition:** "Gradual Dose Reduction (GDR)" refers to the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued."

- **Regulatory Requirement:** "For any resident who is receiving a psychotropic medication, the facility must show evidence that a GDR has been attempted **unless clinically contraindicated**."

GDR Clinical Contraindication

CMS SOM Examples of clinical contraindication:

The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any **attempted dose reduction would be likely to impair** the resident's function or exacerbate an underlying medical or psychiatric disorder; or

The **resident's target symptoms returned or worsened** after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function, exacerbate an underlying medical or psychiatric disorder or increased distressed behavior.

Psychotropic Compliance Myths

If a resident has any nonpharmacological interventions in their care plan, they may not be prescribed any psychotropic medications.

- False. Any resident can be prescribed psychotropic medication if the physician documents a corresponding diagnosis, clinical need, and contraindication of nonpharmacological interventions.

Every resident on psychotropics must complete a GDR.

- False. Every resident must have either an attempted GDR **OR** documentation from a physician of a clinical contraindication to a GDR including the rationale.

Critical Element Decisions

Did the facility ensure that:

- The **medication is necessary** to treat a specific, diagnosed, and documented condition which includes symptoms which may be causing distress to the resident or others.
- The medication is **not sedating** the resident, but rather is treating the resident's medical symptoms;
- **Alternative treatments**, such as behavioral (nonpharmacological) interventions, were attempted and these interventions have been deemed clinically contraindicated;
- A **GDR was attempted** and non-pharmacological approaches to care were implemented, **unless clinically contraindicated**;
- **PRN use is only if necessary** to treat a specific, diagnosed, and documented condition;
- PRN orders for psychotropic medications which are not for antipsychotic medications are **limited to 14 days**, unless the attending physician/prescribing practitioner documents a rationale to extend the medication;
- PRN orders which are for antipsychotic medications are limited to 14 days, without exception and the attending physician/prescribing practitioner **did not renew the order without first evaluating the resident**?
- If **NO** to any of the above, cite **F605**.

Unnecessary Medication Critical Element Pathway

Record Review:

Does documentation of the resident's conditions or symptoms support the necessity of the medication?
Is there evidence that a GDR has been attempted and/or is clinically contraindicated as documented in a rationale in the medical record?
Does the medical record documentation reflect the date of the GDR attempt, the outcome of the dose reduction attempt, and the plan regarding future GDR attempts?
Does the medical record show a change in the resident's behavior such as increased sedation, withdrawal from activities, or cognitive decline related to psychotropic medication?
Were individualized, non-pharmacological approaches attempted? If not, or if discontinued, is there documentation that describes why?
Is there evidence of actual or potential adverse events, such as allergic reactions?
Is there documentation to confirm that residents are being adequately monitored and re-evaluated for adverse consequences and the need for tapering?
Is there evidence that the limitations for use of PRN psychotropic and antipsychotic medications have been met?
(Is there evidence of informed consent?)

Psychotropic Medication Management

Should include the following:

- **General medication management principles**
- Gradual Dose Reduction (GDR)
- Pharmacokinetics and utilizing your pharmacist

Psychotropic Medication Definition

CMS Definition 483.45©(3):

- A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
  - (i) Anti-psychotic;
  - (ii) Anti-depressant;
  - (iii) Anti-anxiety; and
  - (iv) Hypnotic.

- **Note:** Other medications that can affect brain activity, are subject to the same guidance as psychotropic medications, if they are used to treat a mental health disorder (e.g. Valproic Acid).

Psychotropic Medication Management Principles

- Medical record must show **documentation of the diagnosed condition** for the which the psychotropic is prescribed.
- Antipsychotic meds **should be avoided** when possible.
- If indicated, dosage should be **started as low as possible** with modest increases only when necessary.
- Second-generation antipsychotics are preferable over first-generation antipsychotics due to more favorable side effect profiles.
- Medications should be **discontinued if no clinical benefit** is observed.
- Discontinuation or taper may need to be considered for those who experience side effects if there is an improvement in behavioral symptoms.
- Taper should be attempted for all patients **within 4 months** of treatment with close monitoring.

Source: https://library.samhsa.gov/sites/default/files/pep19-inappuse-br.pdf

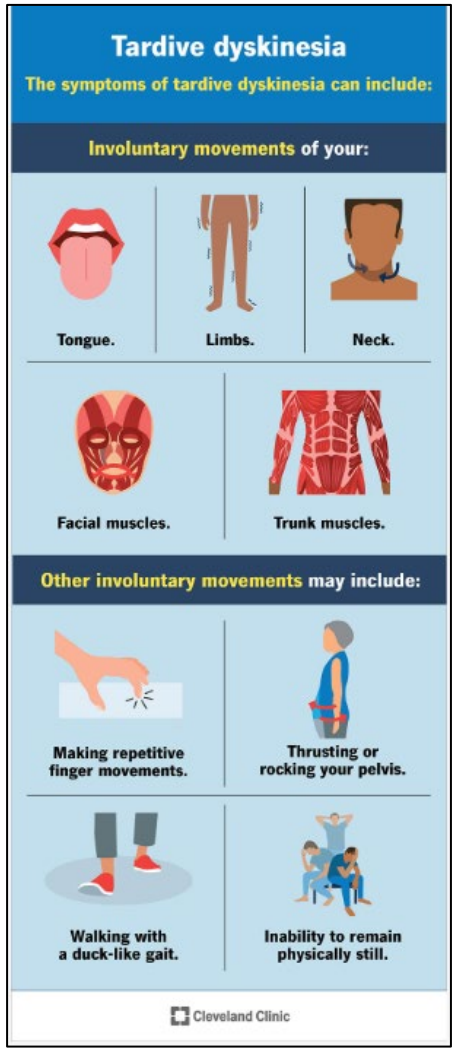
Antipsychotic Side Effect Profile

First Generation: Higher risk of neurological side effects

- Tardive dyskinesia
- Extrapyramidal symptoms
- Dystonia

Second Generation: Higher risk of metabolic side effects

- Hyperglycemia
- Weight gain
- Dyslipidemia



Psychotropic Medication Management Best Practices

- Obtain **informed consent**.
- Select medications by assessing **benefits and risks**.
- Evaluate residents to **identify underlying causes**, including medication side effects.
- Choose medications in **appropriate doses and durations** based on clinical condition, age, and individual goals.
- Avoid increasing non-antipsychotic psychotropic medications while reducing antipsychotics.
- Use **nonpharmacological approaches** to minimize medication needs and enable lower doses or discontinuation.
- Monitor medications for **effectiveness and side effects**, along with nonpharmacological intervention outcomes.

Effects Resulting from Sedating or Subduing a Resident

- Loss of autonomy, dignity, self-respect, and orientation
- Confusion, cognitive decline, withdrawal, depression
- Decreased activity levels, including social activities
- Decline in skin integrity
- Decline in continence level
- Decline in physical functioning, ADLs, ROM, contractures
- Increased risk in falls
- Weight loss

Psychotropic Medication Management

Should include the following:

- General medication management principles
- **Gradual Dose Reduction (GDR)**
- Pharmacokinetics and utilizing your pharmacist

Gradual Dose Reduction (GDR)

- **CMS Definition:** "Gradual Dose Reduction (GDR)" refers to the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.

- **Regulatory Requirement:** For any resident who is receiving a psychotropic medication, the facility must show evidence that a GDR has been attempted **unless clinically contraindicated**.

- If there is no evidence of a GDR and there is no description of the clinical contraindications, then noncompliance exists.

Gradual Dose Reduction (GDR)

Purpose of the required GDR:

- Find an optimal dose or
- Determine whether continued use of the medication is benefiting the resident or could have dangerous side effects

GDR may be indicated when:

- The resident's clinical condition has improved or stabilized
- The underlying causes of the original target symptoms have resolved, and/or
- Non-pharmacological approaches have been effective in reducing the symptoms

Gradual Dose Reduction (GDR) Contraindications

- **Example:** Compliance with required GDR may be met if, within the first year in which a resident is admitted on a psychotropic medication, or after the prescribing practitioner has initiated a psychotropic medication, a facility attempts a GDR in two separate quarters (with at least one month in between the attempts), unless clinically contraindicated.

- **Clinical Contraindications to GDR can include, but are not limited to, the following:**
  - The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder; or
  - The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function, exacerbate an underlying medical or psychiatric disorder or increased distressed behavior.

Gradual Dose Reduction (GDR) Documentation

- Medical record documentation should reflect the following:
  - **Date of the GDR attempt**
  - The outcome of the dose reduction attempt
  - The plan regarding future GDR attempts

- Physician documentation should contain the **rationale for why GDR attempts are clinically contraindicated** for the resident.

- Surveyor guidance: If there is no documented date for a GDR or a clinical contraindication on the most recent MDS assessment, review the medical record to determine if a GDR may have been attempted or a clinical contraindication rationale has been provided since the last MDS assessment. If there is no evidence of a GDR and there is no description of the clinical contraindications, then non-compliance exists.

Appropriate Gradual Dose Reduction (GDR)

- Resident must be responding to the psychotropic favorably

- If multiple behaviors still exist, why ask to reduce the dose?
  - Medication change may be appropriate vs. GDR
  - Know what non-pharmacologic measures are in place
  - Be familiar with the plan of care and goals for the resident
  - Know the medication prescribed and the disease it is prescribed for

- Behavior monitoring – must include specific behaviors to the resident that can be quantitatively and objectively **documented** by the nursing staff

Antipsychotic Management

Switching antipsychotics:

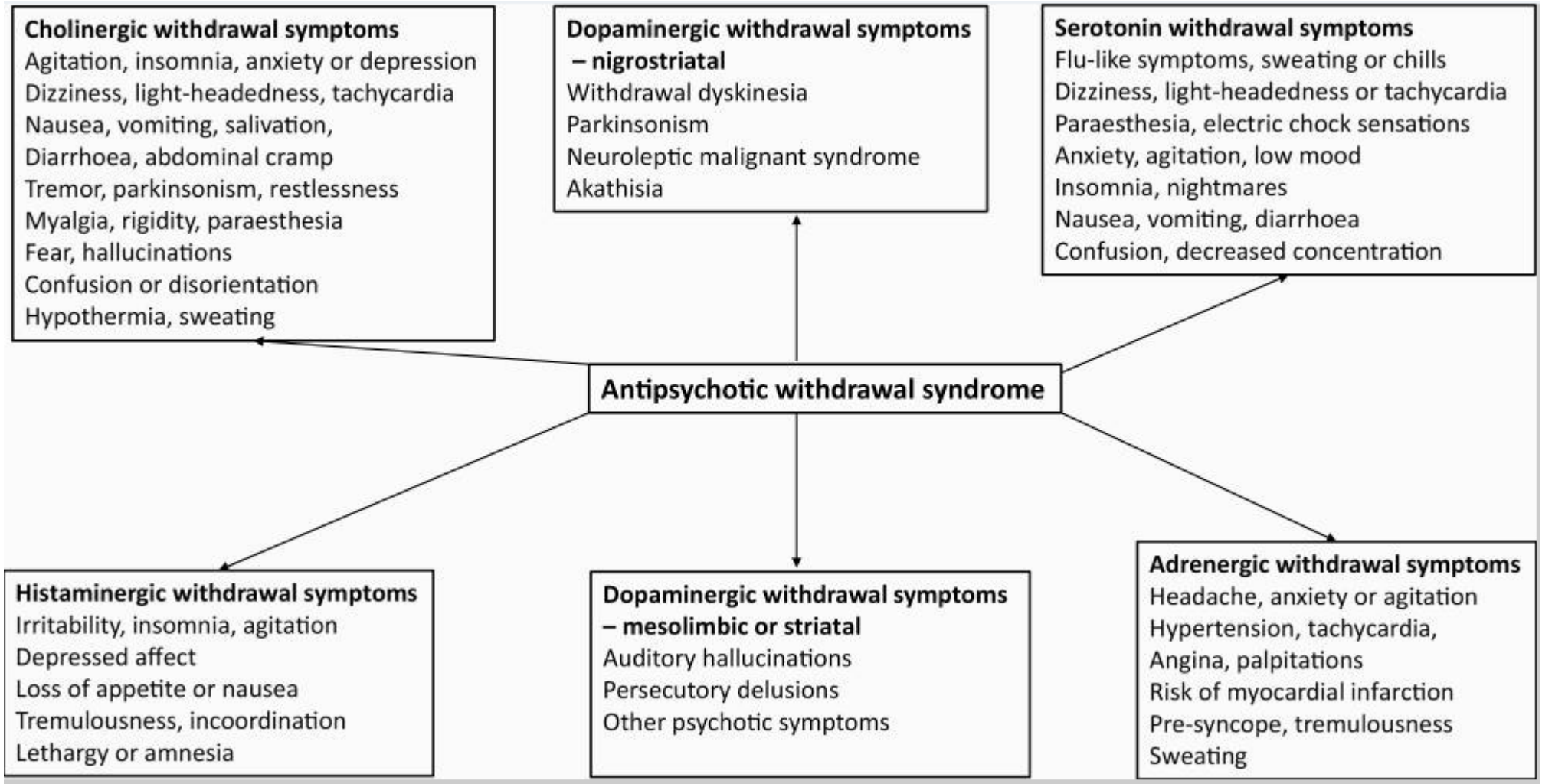
- An optimal universal strategy for switching antipsychotic drugs has not been established.

- **Strategies include:**
  - **Cross-titration** - gradually discontinuing the first antipsychotic while gradually increasing the new antipsychotic

  - **Abrupt change** - abruptly discontinuing the first antipsychotic and either increasing the new antipsychotic gradually or starting it at a treatment dose

  - In patients with schizophrenia at high risk of relapse, the current medication may be maintained at full dose as the new medication is increased (overlap); once the new medication is a therapeutic dose, the first medication is gradually decreased and discontinued over 1-2 weeks

Antipsychotic Withdrawal Symptoms

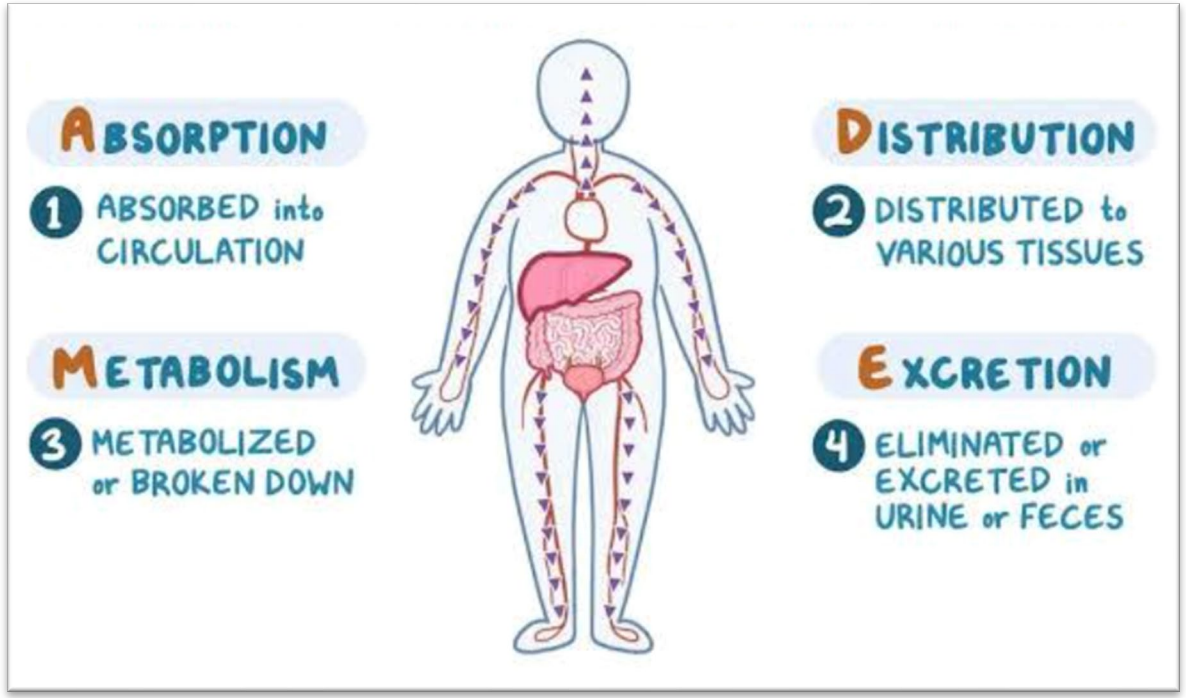


Psychotropic Medication Management

Should include the following:

- General medication management principles
- Gradual Dose Reduction (GDR)
- **Pharmacokinetics and utilizing your pharmacist**

Pharmacokinetics



Definition: The relationship between the dose of a drug and its measured concentration in the body

- **Steady state**: when drug concentrations consistently stay within therapeutic limits for long periods (usually take 4-5 half-lives to reach steady state)
- **Half-life (t ½)**: the time required to reduce the concentration of a drug in steady-state by 50% (takes 4-5 half-lives to eliminate a drug)

Psychotropic: Half-Life Examples

Second Generation Antipsychotics

- Olanzapine (Zyprexa): 30 hours (approx.1.5x greater in elderly)
- Risperidone (Risperdal): oral 20 hours (prolonged in elderly), IM 3-6 days, SubQ 9-11 days

First Generation Antipsychotics

- Haloperidol (Haldol): decanoate 21 days, lactate IM 20 hours
- Chlorpromazine (Thorazine): 30 hours

Anxiolytics:

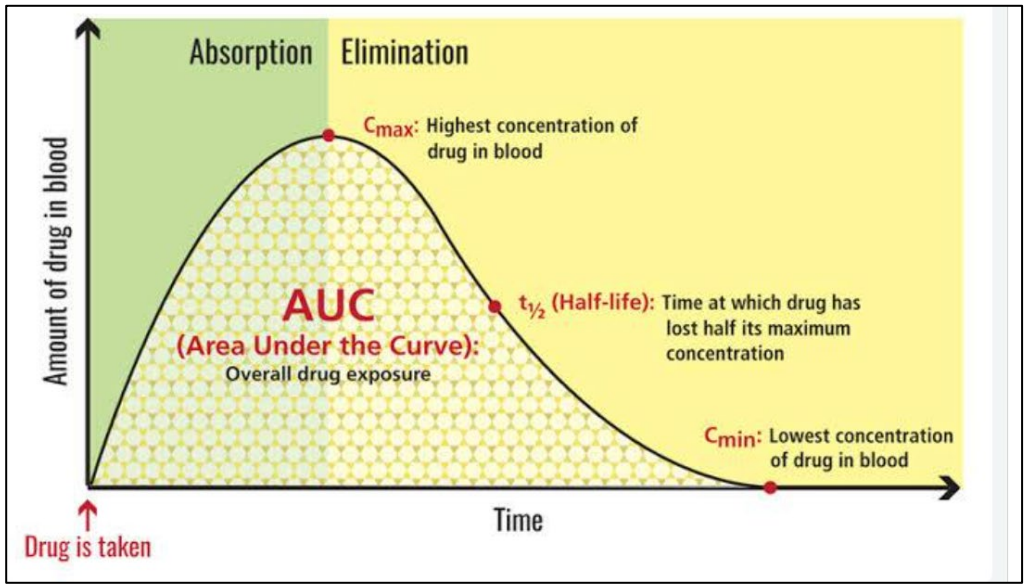
- Alprazolam (Xanax): 16 hours
- Diazepam (Valium): 48 hours

Antidepressants:

- Fluoxetine (Prozac): ~5 days
- Amitriptyline (Elavil): 13-36 hours

Antipsychotic Pharmacokinetics

- **Drug:** Aripiprazole (Abilify)
- **Pharmacologic Category:** Second generation antipsychotic
- **Half Life:** 75 hours
  - Steady State: 300-375 hours (12.5-15.6 days)
  - Elimination: 300-375 hours (12.5-15.6 days)
- **Half Life for CYP2D6 poor metabolizers:** 146 hours
  - Steady State: 584-730 hours (24.3-30.4 days)
  - Elimination: 584-730 hours (24.3-30.4 days)



Resident Example

- 72 y/o male admitted on Abilify 20 mg daily
  - Absence of reliable diagnosis
- Evaluate appropriateness of GDR
  - Stability of patient
  - Present behaviors
  - Resident plan of care
- Consult the pharmacist – come with knowledge!
  - Concomitant medications
  - Kinetic and Pharmacologic profile
  - Dose reduction recommendation and expected timeline
- Make appropriate recommendation to the physician
- Document, document, document

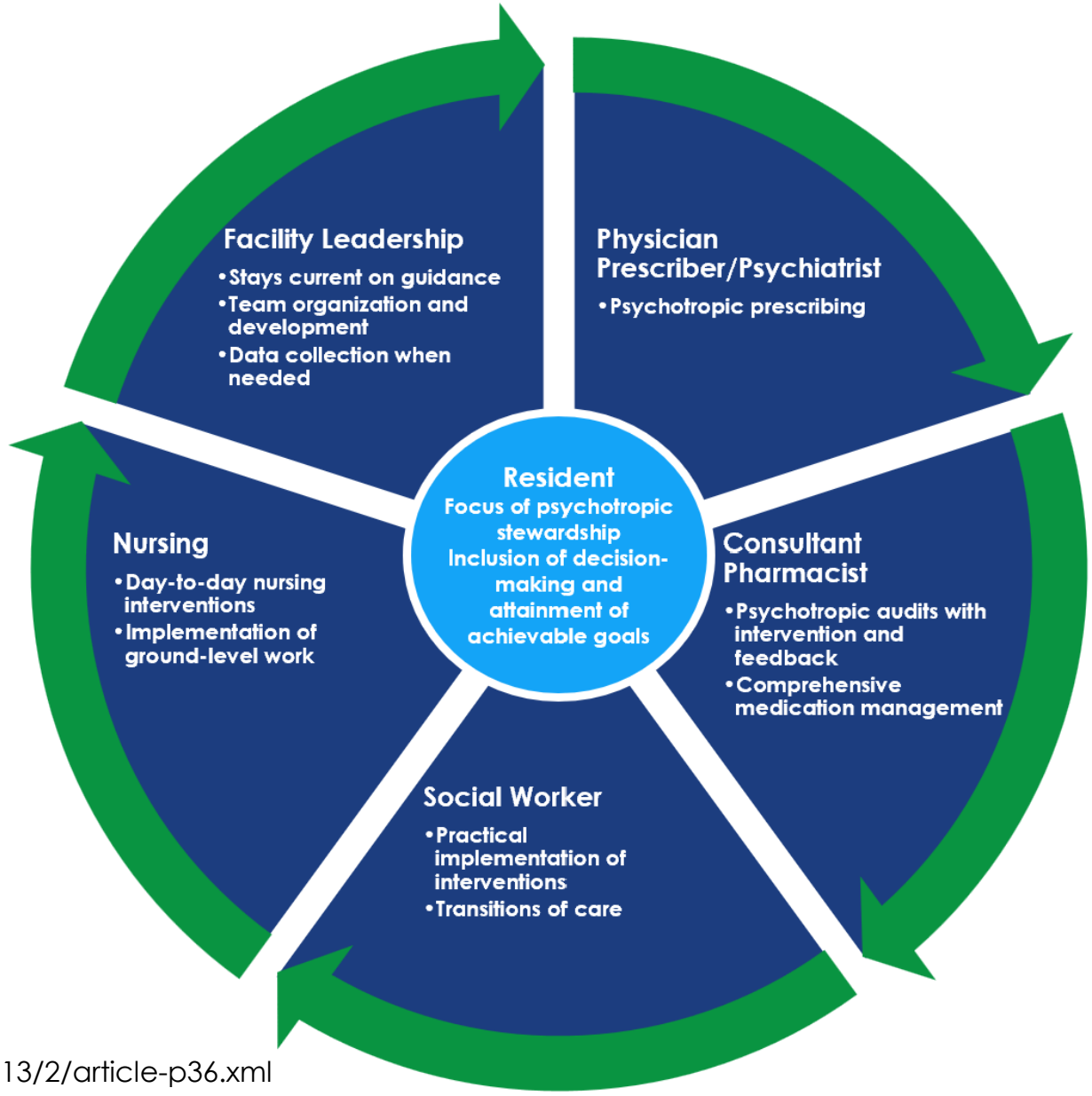
Psychotropic Stewardship

Why psychotropic stewardship?

- ✓ Promotes the safe and appropriate use of psychotropics
- ✓ Minimizes unintended consequences
- ✓ Improves resident outcomes

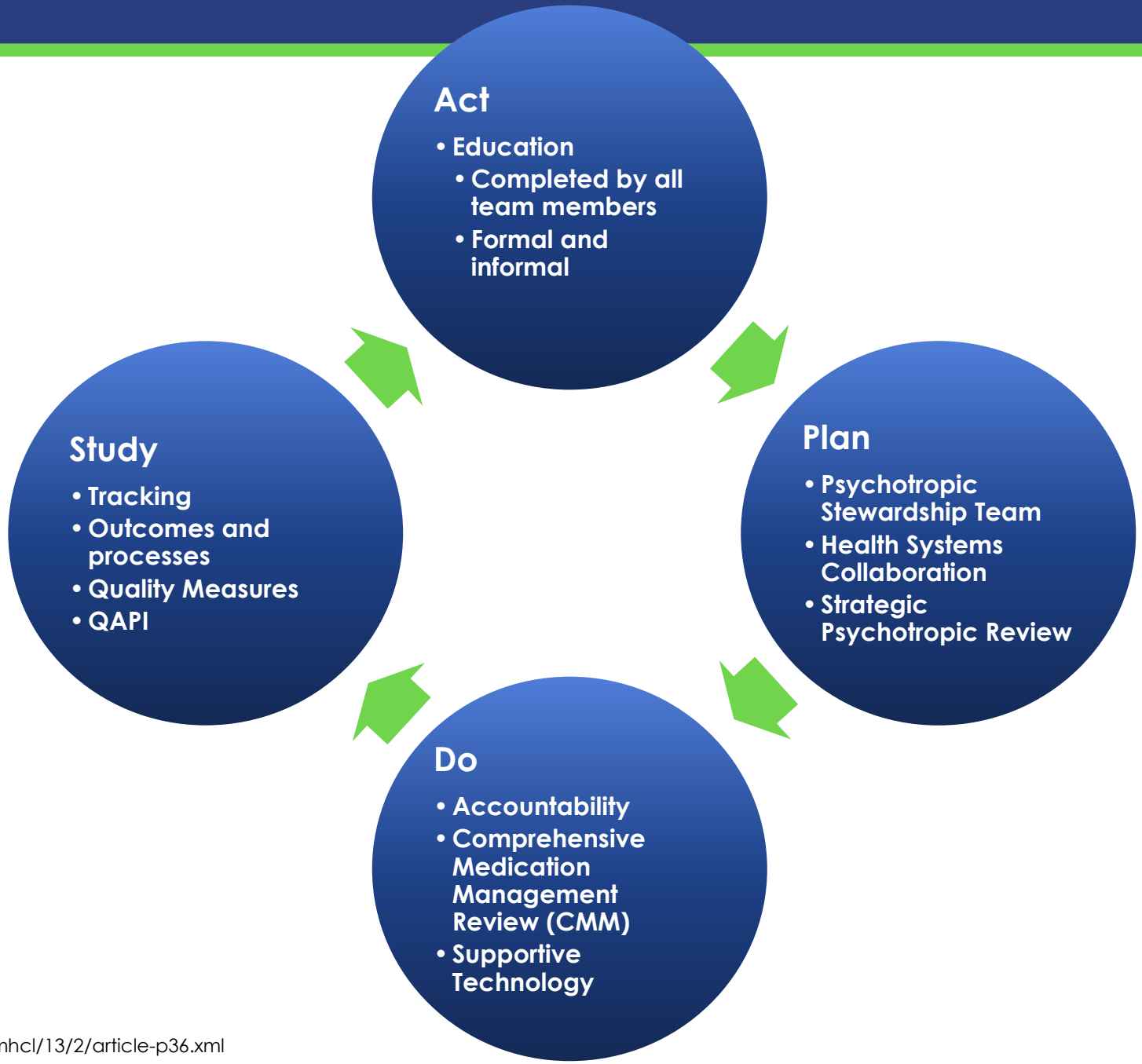
Model the CDC's Core Elements of Antibiotic Stewardship for Nursing Homes, which offers an established and practical approach

Psychotropic Stewardship Team



Adapted from https://mhc.kglmeridian.com/view/journals/mhcl/13/2/article-p36.xml

Core Elements of Psychotropic Stewardship Program



Adapted from: https://mhc.kglmeridian.com/view/journals/mhcl/13/2/article-p36.xml

Action Steps for a Psychotropic Stewardship Program

Step 1: Leadership Commitment

- Creating a culture to support new programs begins with leadership
- Executive leadership sets the tone and provides the resources
- Demonstrates support and commitment to safe and appropriate psychotropic prescribing

https://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html
https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiataglance.pdf

Step 2: Accountability

- Identify team to include Psychiatric prescriber, consultant pharmacist, resident, social worker, nurse, activities, and facility leadership responsible for promoting and overseeing psychotropic stewardship activities

- Key Characteristics:
  - Clear purpose
  - Defined roles
  - Committed to active engagement

Step 3: Drug Expertise

Leverage relationship with consultant pharmacist, social worker, nurses, or other individuals with experience or training in psychotropic management for your facility

Step 4: Action

- Review facility policies and procedures related to psychotropic medications to ensure they are current, reflect updated requirements, and resources are available to follow these policies and procedures.

- Implement at least one policy or procedure to improve psychotropic medication use

Step 5: Tracking & Reporting

- Review medical records of residents receiving psychotropic medications for appropriate diagnosis and indication for use
- Ensure PRN psychotropic medications are only used for 14 days and evaluated by the provider before extending
- Behaviors and side effects are monitored daily
- Informed consent is obtained before initiating a new psychotropic medication
- Medication Regimen Review is done on admission and then at least monthly, with evidence of a GDR unless contraindicated
- Assessment is accurate and care plan reflects pharmacological and non-pharmacological interventions
- Monitor at least one process measure and one outcome measure from psychotropic medication use. (e.g., % of residents receiving at least one psychotropic medication)
- Provide feedback on usage rates to the team and any gaps or areas of improvement to the QAA/QAPI Committee

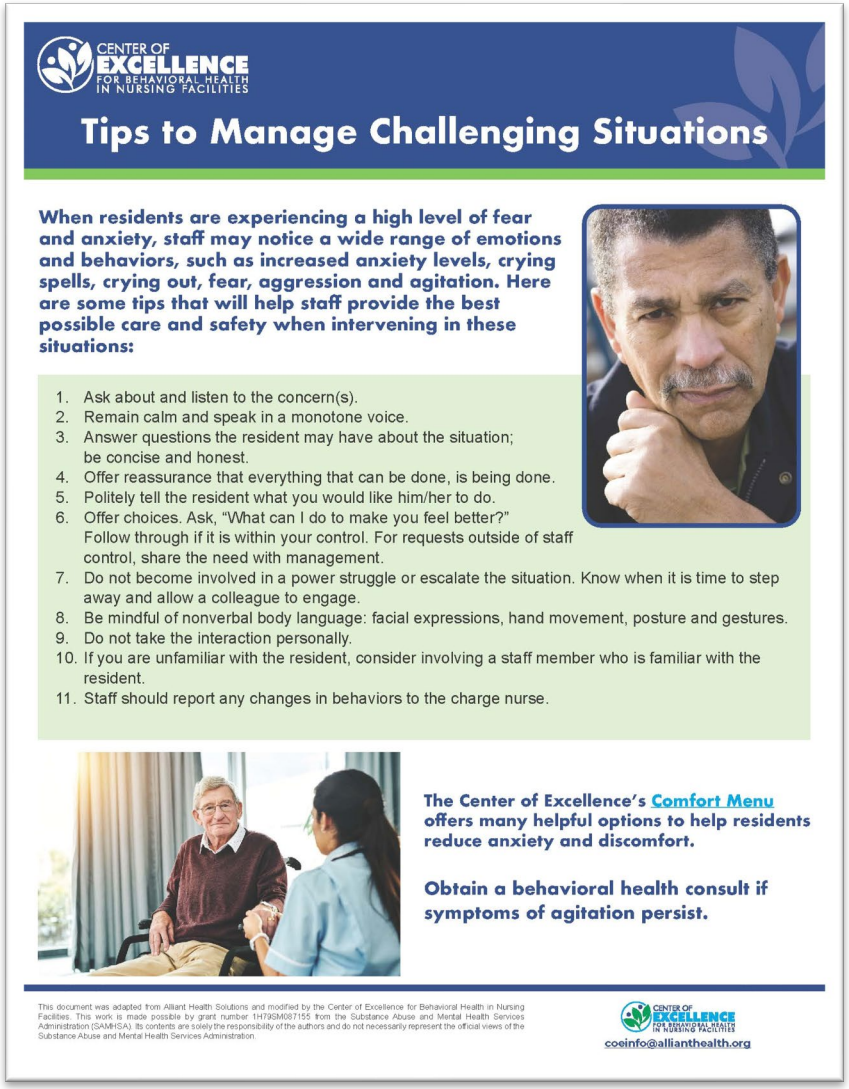
Step 6: Education

- Provide resources to all nursing facility staff, residents, and/or resident representatives
- Access the resources and educational offerings from the COE-NF
- Post flyers promoting program initiatives

Tips for Success

- **Top-down approach**
  - Start with leadership
- **Utilize a step-wise, systematic approach**
  - Bite-sized PDSA
- **Get your quick wins first**
- **Be intentional**
- **Not one-size-fits-all**
  - Individualize the program for your facility

De-Escalation Resources



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Tips to Manage Challenging Situations

When residents are experiencing a high level of fear and anxiety, staff may notice a wide range of emotions and behaviors, such as increased anxiety levels, crying spells, crying out, fear, aggression and agitation. Here are some tips that will help staff provide the best possible care and safety when intervening in these situations:

1. Ask about and listen to the concern(s).
2. Remain calm and speak in a monotone voice.
3. Answer questions the resident may have about the situation; be concise and honest.
4. Offer reassurance that everything that can be done, is being done.
5. Politely tell the resident what you would like him/her to do.
6. Offer choices. Ask, "What can I do to make you feel better?" Follow through if it is within your control. For requests outside of staff control, share the need with management.
7. Do not become involved in a power struggle or escalate the situation. Know when it is time to step away and allow a colleague to engage.
8. Be mindful of nonverbal body language: facial expressions, hand movement, posture and gestures.
9. Do not take the interaction personally.
10. If you are unfamiliar with the resident, consider involving a staff member who is familiar with the resident.
11. Staff should report any changes in behaviors to the charge nurse.

The Center of Excellence's Comfort Menu offers many helpful options to help residents reduce anxiety and discomfort.

Obtain a behavioral health consult if symptoms of agitation persist.

This document was adapted from Alliant Health Solutions and modified by the Center of Excellence for Behavioral Health in Nursing Facilities. This work is made possible by grant number 1H79SM087155 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Substance Abuse and Mental Health Services Administration.

coeinfo@allianthealth.org

Scan the QR code or
visit the link below to view this resource..

https://nursinghomebehavioralhealth.org/wp-content/uploads/2023/02/COE-NF-Tips-to-Manage-Challenging-Situations_508.pdf

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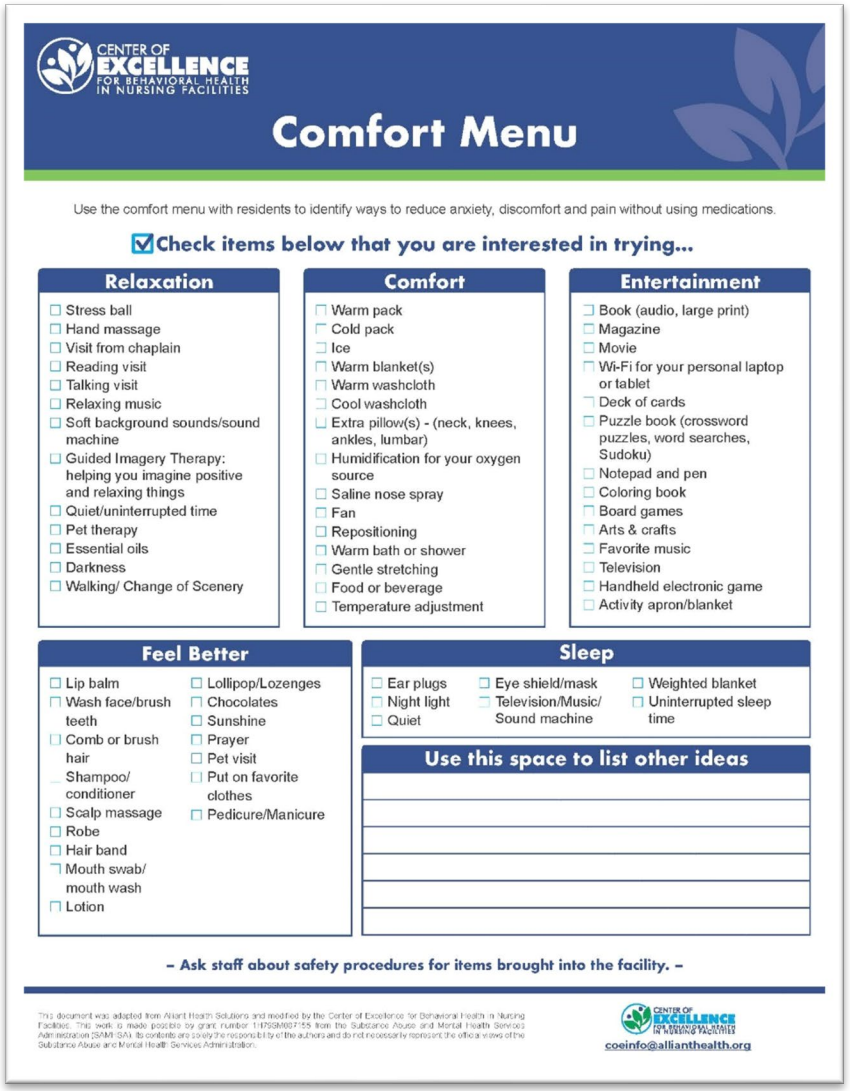
De-Escalation Resources



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Comfort Menu

Use the comfort menu with residents to identify ways to reduce anxiety, discomfort and pain without using medications.

☑Check items below that you are interested in trying...

Relaxation

- ☐ Stress ball
- ☐ Hand massage
- ☐ Visit from chaplain
- ☐ Reading visit
- ☐ Talking visit
- ☐ Relaxing music
- ☐ Soft background sounds/sound machine
- ☐ Guided Imagery Therapy: helping you imagine positive and relaxing things
- ☐ Quiet/uninterrupted time
- ☐ Pet therapy
- ☐ Essential oils
- ☐ Darkness
- ☐ Walking/ Change of Scenery

Comfort

- ☐ Warm pack
- ☐ Cold pack
- ☐ Ice
- ☐ Warm blanket(s)
- ☐ Warm washcloth
- ☐ Cool washcloth
- ☐ Extra pillow(s) - (neck, knees, ankles, lumbar)
- ☐ Humidification for your oxygen source
- ☐ Saline nose spray
- ☐ Fan
- ☐ Repositioning
- ☐ Warm bath or shower
- ☐ Gentle stretching
- ☐ Food or beverage
- ☐ Temperature adjustment

Entertainment

- ☐ Book (audio, large print)
- ☐ Magazine
- ☐ Movie
- ☐ Wi-Fi for your personal laptop or tablet
- ☐ Deck of cards
- ☐ Puzzle book (crossword puzzles, word searches, Sudoku)
- ☐ Notepad and pen
- ☐ Coloring book
- ☐ Board games
- ☐ Arts & crafts
- ☐ Favorite music
- ☐ Television
- ☐ Handheld electronic game
- ☐ Activity apron/blanket

Feel Better

- ☐ Lip balm
- ☐ Wash face/brush teeth
- ☐ Comb or brush hair
- ☐ Shampoo/ conditioner
- ☐ Scalp massage
- ☐ Robe
- ☐ Hair band
- ☐ Mouth swab/ mouth wash
- ☐ Lotion
- ☐ Lollipop/Lozenges
- ☐ Chocolates
- ☐ Sunshine
- ☐ Prayer
- ☐ Pet visit
- ☐ Put on favorite clothes
- ☐ Pedicure/Manicure

Sleep

- ☐ Ear plugs
- ☐ Night light
- ☐ Quiet
- ☐ Eye shield/mask
- ☐ Television/Music/ Sound machine
- ☐ Weighted blanket
- ☐ Uninterrupted sleep time

Use this space to list other ideas

– Ask staff about safety procedures for items brought into the facility. –

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coeinfo@allianthealth.org

Use ideas from the Comfort Menu to identify ways to reduce anxiety, discomfort, and pain without medications

Scan the QR code or
visit the link below to view this resource..

COE-NF On-Demand Training Videos

EVENT

Practical Strategies for Managing Behavioral Health Needs of Nursing Home Residents

Event Date: August 7, 2024

2 - 3 p.m. ET

Residents with serious mental illnesses and substance use disorders continue to be admitted to nursing homes, yet staff often lack skills and confidence in meeting their needs. This session will

WATCH RECORDING **SLIDES**

EVENT

Changing Behaviors from a Rolling Boil to a Simmer: De-escalation Strategies to Defuse Difficult Situations

Event Date: March 25, 2025

2 - 3 p.m. ET

ACCME & NAB CREDITS ARE AVAILABLE

This training will outline factors that contribute to escalating behaviors and strategies to safely defuse

WATCH RECORDING **SLIDES**

We invite you to join us!

SCAN ME

SESSION 2

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

Center of Excellence for Behavioral Health In Nursing Facilities (COE-NF)

The COE-NF focuses on increasing the knowledge, competency and confidence of nursing facility staff to care for residents with behavioral health conditions.

- Provides mental health and substance use trainings, 1:1 customized technical assistance and resources at no cost
- Services are available to all CMS certified nursing facilities throughout United States
- Established by the Substance Abuse and Mental Health Services Administration (SAMHSA) in collaboration with the Centers for Medicare and Medicaid Services

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

For assistance, submit a request at nursinghomebehavioralhealth.org

Contact us:
National Call Center: **1-844-314-1433**

Email: coeinfo@allianthealth.org

COE-NF Services & Support

- **Technical Assistance**
  - 1:1 support from COE-NF Behavioral Specialist
  - Program design
  - Care planning
  - Provider search
  - Implementation strategies

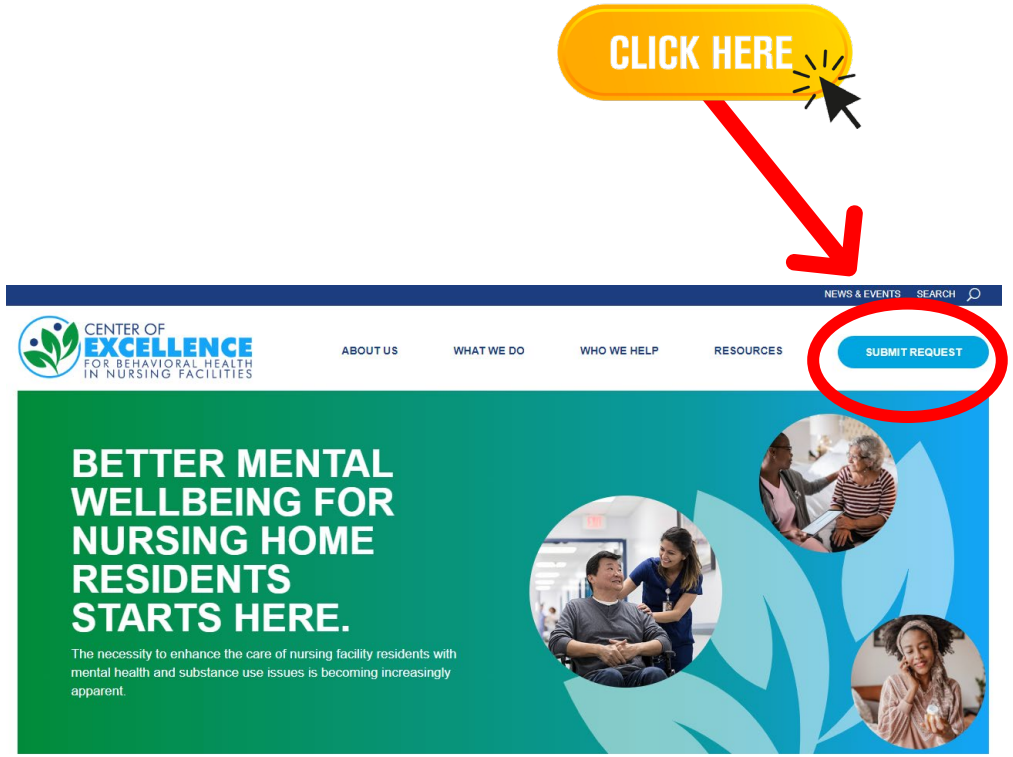
- **Training**
  - Live Virtual (Webinars)
  - Cohort Learning Series
  - On Demand Videos

- **Resources**
  - Online Resource Hub: Toolkits, flyers, tip sheets

How to Submit a Request

Website

- Online form where nursing facilities can submit consultation requests
- Include CCN number and full facility name
- Online requests are responded to within **48 hours**
- https://nursinghomebehavioralhealth.org/request-assistance



COE-NF Voicemail Box: (844) 314-1433

- Messages will be responded to within **two (2) business days**

Connect with COE-NF

Monthly Newsletter

- Shares behavioral health resources
- Provides nursing facility behavioral health regulatory updates
- Announces upcoming training opportunities

Social Media Profiles

- LinkedIn: www.linkedin.com/company/nursinghomebh/
- X: twitter.com/NursingHomeBH
- Facebook: www.facebook.com/NursingHomeBH
- YouTube: www.youtube.com/channel/UCgnRi9EFB9rXApnIUwS09sw

Text Messaging Platform

- Enables nursing facility staff to receive COE-NF updates on their smartphone

SCAN ME

Scan QR code to sign up for the COE-NF newsletter.

Additional Information Related to GDR

- Guidelines and Implementation. (2025). The American Psychiatric Association Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia. https://doi.org/10.1176/appi.books.9780890426807.ap02

- Bain, K. T., Holmes, H. M., Beers, M. H., Maio, V., Handler, S. M., & Pauker, S. G. (2008). Discontinuing medications: a novel approach for revising the prescribing stage of the medication-use process. *Journal of the American Geriatrics Society*, *56*(10), 1946–1952. https://doi.org/10.1111/j.1532-5415.2008.01916.x

Thank You!

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH IN NURSING FACILITIES

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