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## **Reducing the Amount of Antipsychotic Medication among Older Adults with Dementia in Skilled Nursing Facilities in the Twin Cities Area**

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Reducing the Amount of Antipsychotic Medication among Older Adults with  
Dementia in Skilled Nursing Facilities in the Twin Cities Area

By

Stephanie D. Marshall, B.S.W.

MSW Clinical Research Paper

Presented to the faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members  
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Laura Anfinson, LSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/ University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

**Reducing the Amount of Antipsychotic Medication among Older Adults with Dementia  
in Skilled Nursing Facilities in the Twin Cities Area**

By Stephanie D. Marshall

Research Chair: David J. Roseborough, MSW, Ph.D., LICSW

Committee Members: Laura Anfinson, LSW; Alexis Soine, RN

**Abstract**

There are many stereotypes that older adults in nursing homes are “snowed” and not cared for properly by “burnt out” and “careless” nursing staff. The purpose of this project was to explore professionals in skilled nursing facilities attempting to meet the Minnesota Department of Health mandate to decrease the amount of antipsychotic medication usage among older adults with dementia. The research placed a focus on non-pharmacological interventions with an emphasis on music therapy. Using a qualitative design, six subjects were interviewed regarding their experiences, successes, challenges and non-pharmacological efforts that are being implemented in their facility. Data were analyzed using an inductive approach and then through the lens of the mandate and were categorized by theme and subthemes. The data were related back to the literature and the findings indicated that all participating facilities were having success in their attempts to meet this mandate or were beginning to make attempts to meet this mandate. These findings emphasize the importance of taking a non-pharmacological approach with older adults with behaviors related to dementia but further training, research and practice are needed for continued and future success in relation to antipsychotic medication reduction and non-pharmacological approaches for older adults with dementia in these settings.

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*“Don’t wait until you reach your goal to be proud of yourself. Be proud of every step you take toward reaching that goal.” – Unknown*

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## Introduction

Are older adults who are placed in nursing homes truly “snowed” due to multiple medications administered by “careless” and “burnt out” nursing staff to control behaviors related to dementia? Has society placed a stigma or stereotype against skilled nursing facilities that all they do is push medications to cause older adults with challenging behaviors to be easier to deal with? This is a frightening and alarming picture to portray in the media especially with the increasing older adult population. “A recent epidemiologic assessments based on the U.S. Census data estimated that, in 2010, there were 4.7 million individuals in that country aged 65 years or older with Alzheimer’s disease dementia. The same study reported that the total number of people with dementia in the U.S. in 2050 is projected to be 13.8 million. A similar pattern has been observed in other developed and developing countries; dementia is a global issue” (Balakrishnan, Browne, Marley, Heim, 2013). The media and various articles portray a sense that the elderly who have challenging behaviors in nursing homes are forgotten by their loved ones and placed in nursing homes to ultimately be put on various medications that put a stop to their behaviors related to their dementia. Often accusations are made that an elder’s identity is portrayed to be lost and labeled as a standard nursing home patient. In many to most nursing homes, this is not the case. It is important that society has an understanding of what nursing homes are doing to help older adults who may have challenging behaviors, because in many nursing homes, medicating is the last plan of care that professionals want to utilize. This stereotype is not true for every nursing home and many older adults in North American society have caregivers that have their best interest in mind and dedicate their professional lives to help this population maintain their highest quality of life.

As evidence of this, professionals in skilled nursing facilities, in the Twin Cities area, are focusing on non-pharmacological interventions and creating documentation that analyzes the effectiveness of these interventions to meet new Minnesota Department of Health criteria in skilled nursing facilities that mandates behavior monitoring. “The rising prevalence of dementia, allied closely with the aging of the population, poses distinct social, economic, and health care challenges.” (Balakrishnan, Browne, Marley, Heim, 2013). These authors speak to one particular, non-pharmacological intervention in particular: music therapy. Music therapy shows particular promise in these settings. Balakrishnan, et. al. go on to explain that some advantages of music therapy include low cost and presumed absence of adverse side-effects. These non-pharmacological interventions may not only be a more beneficial approach to difficult behaviors associated with dementia, but may also be more cost effective. Its effect on an older adult’s overall mood and behaviors, along with maintaining the unique identity of the person they were before their illness has been a topic that has been studied in multiple setting with elderly adults. A cohort study in two veterans’ homes in Taiwan carried out in 2011 used music therapy as a non-pharmacological intervention with 104 older men with behaviors related to dementia. It was found that music therapy had a “positive effect on behavioral and psychological symptoms of dementia, not only in outward symptoms like agitation, but also intrinsic psychotic symptoms like hallucination, delusion and agitation in older Chinese men with dementia” ( Chen, Liu, Lin et. al, 2014) . This reference provides a more global perspective on this topic and a view of what other nations are exploring in terms of non-pharmacological interventions for older adults with dementia. Kimmo Lehtonen, PhD, professor of education at the University of Turku and a clinical music therapist for more than 25 years uses old wartime songs that tend to bring many lively memories to their minds. “Music has a close relationship with unconscious emotions,

which are activated by musical movement. To me, music represents a microcosmos which has a close relationship to our inner feelings. These feelings are so strong; they're meaningful even if patients cannot remember who they are" (Schaeffer, 2014).

These studies shed a positive and powerful light on behavioral management that avoids over-medicating the elderly as the media has sometimes displayed. From observed experience, the power of non-pharmacological interventions works in powerful ways. The author has seen responses to music that they once enjoyed is one that is happy, positive and often brings the person ease during the challenging times related to their illness. Music can turn a manic patient throwing items at others into a smiling, swaying, singing and happy individual. Filmmaker Michael Rossato-Bennett created a documentary to display music's power titled "Alive Inside" which follows older adults with a dementia diagnoses and their experience with music therapy. "His camera reveals the uniquely human connection we find in music and how its healing power can triumph where prescription medication falls short" (Rossato- Bennett, 2014). This documentary follows social worker Dan Cohen who is the founder of the non-profit organization *Music and Memory* which is described as fighting against the current healthcare system to demonstrate music's ability to combat memory loss and restore a sense of self to older adults who suffer from memory issues. This documentary explores the financial expenses of medication management and music as an example of an affordable and powerful non-pharmacological intervention. Through this documentary it is shown that music is not only affordable for professionals and caregivers to utilize, but its power over human emotion among older adults with dementia and positive influence on difficult behaviors is remarkable. Music is said to restore a sense of self which comes alive in this documentary.



This research asked a sample of professionals in nursing home settings around the Twin Cities area what their facilities are doing to meet this new Minnesota Department of Health mandate in terms of behavior monitoring, minimizing psychotropic medications and utilizing non-pharmacological interventions. In addition, examples of the non-pharmacological interventions these facilities are utilizing and their effectiveness were explored, with particular attention to music therapy. Lastly, the challenges and successes that these facilities are having with these interventions and meeting the MDH mandate and what they suggest for good practice were explored as well.

### **Literature Review**

#### *Minnesota Department of Health Mandate*

In 2010 more than 17 % of residents on antipsychotic medications in nursing homes across the nation had antipsychotic drug doses exceeding the recommended levels (Wergin, Nott, Reyes, 2014). Not only were these doses prescribed higher than recommended, but many of these drugs also had black box warnings posted on their labels. Black box warning labels are labels placed on medications approved by the FDA that have serious risks associated with them. These higher doses can have a significant impact on the older adult population. “Since 2008 all antipsychotic medications have had a black box warning which states that the use of antipsychotics in elderly demented individuals may increase their fatality rate by 60-70%” (Januszewski, 2012). Data suggest that there are serious side effects that coincide with antipsychotic usage that have the potential to cause great harm and possible mortality among the older adult population ( Liperoti, Pedone, Corsonello, 2008). “Side-effects such as sedation, falls and extrapyramidal signs are well-known, and more recent work indicates that neuroleptic treatment of dementia leads to reduced well-being and quality of life and may even accelerate

cognitive decline” (Simon, Ian & Ballard, 2004). Current skilled nursing facilities would benefit from monitoring psychotropic use to ensure that it is needed and at appropriate level. The latest Center for Medicare and Medicaid Services (CMS) initiative regarding antipsychotic use in nursing homes could potentially cause skilled nursing facilities to be faced with increased pressure to reduce these levels and possible citations (Januszewski, 2012).

In light of the above, the Minnesota Department of Health has developed a mandate that requires skilled nursing facilities to closely monitor antipsychotic use and behaviors related to dementia. On March 29, 2012, the Centers for Medicare & Medicaid Services (CMS) developed the National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Homes (this is now referred to as the Partnership to Improve Dementia Care in Nursing Homes). “The goal of this Partnership is to optimize the quality of life and function of residents in America’s nursing homes by improving approaches to meeting the health, psychosocial and behavioral health needs of all residents, especially those with dementia” (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). The CMS has joined with various stakeholders to improve dementia care in nursing homes. They are doing several things to support this development, including producing surveyor training videos as well as updating Appendix P and Appendix PP of the State Operations Manual (SOM). Appendix P covers the revised sampling process that state surveyors must complete for a traditional survey and Appendix PP provides sample of and information on revised requirements that need to be met when working with patients with dementia including a check list for state surveyors. Appendix PP provides information on “F309 Interpretive Guidance for Care and Services of a Resident with Dementia; F329 Interpretive Guidance for Drug Regimen Free from Unnecessary Drugs, Surveyor Checklist for Review of Care and Services for a Resident with Dementia”

(Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). CMS goes on to state that, “it has been a common practice to use various types of psychopharmacological medications in nursing homes to try to address behaviors without first determining whether there is a medical, physical, functional, psychological, emotional, psychiatric, social or environmental cause of the behaviors. Medications may be effective when they are used appropriately to address significant, specific underlying medical or psychiatric causes or new or worsening behavioral symptoms” (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). The risk that antipsychotic use imposes is of growing concern and the importance of monitoring the risks, benefits and harm of any intervention is crucial. To further focus on the use of antipsychotics the CMS states, “this concern is that nursing homes and other settings (i.e. hospitals, ambulatory care) may use medications as a “quick fix” for behavioral symptoms or as a substitute for a holistic approach that involves a thorough assessment of underlying causes of behaviors and individualized, person-centered interventions (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). CMS goes on to state that when antipsychotic medications are used without adequate reason, there is little chance that they will be effective. There are many serious risks involved with antipsychotic use including: movement disorders, falls, hip fractures, and cognitive impairment. To further stress the importance of quality of life, “Sections 1819 and 1919 of the Social Security Act (the Act) and current regulations already require a number of essential elements to be in place in order for facilities to be in compliance with federal requirements on quality of care and quality of life” (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013).

The CMS has put a focus on state surveyor training and revisions to section P and PP of CMS guidelines. Some key principles of this include: person-centered care, quality and quantity

of staff, thorough evaluation of new or worsening behaviors, individualized approaches to care, critical thinking related to antipsychotic drug use, interviews with prescribers, and engagement of resident and/or representative in decision-making (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). The revisions to Appendix P of the State Operations Manual (SOM) made changes to the state surveyor's assessment for compliance with requirements related to nursing home residents with dementia and unnecessary drug use. "In Appendix P, we have made changes to the resident sampling process for the traditional survey. The change is intended to ensure that the survey sample includes an adequate number of residents with dementia who are receiving an antipsychotic medication" (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). For those residents on antipsychotic medications that are flagged, there are further questions that surveyors will seek to find answers to relating to dementia care. The next task is for surveyors to do an entrance conference where a survey team coordinator will request a list of names of residents who have a diagnosis of dementia and who are either taking or have taken a PRN (as needed) antipsychotic medication over the past 30 days. If there are residents with dementia, the surveyors will ask the lead team of the facility being surveyed to indicate how the facility is providing individualized care for the selected resident with dementia. In addition, the facility is required to provide policies related to the use of antipsychotic medications in residents with dementia (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). The next task is the sample selection that surveyors will determine. This sample will be derived from a list of every resident in the facility being surveyed that receives or has received a PRN antipsychotic medication and have a diagnosis of dementia. "The surveyor will then compare this list to the off-site resident sample and determine if a resident from this list is already included and ensure that at least one

of the residents on the list receiving an antipsychotic medication is in the sample for a comprehensive review. If the sample does not indicate at least one resident that is on the facility provided list, the team should consider switching a resident. For the Quality Indicator Survey (QIS), an electronic checklist titled Review of Care and Services for a Resident with Dementia is available to the surveyors to guide investigations to ensure that the program's goals are being met" (principles listed above) (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013).

Revisions to Section PP of the State Operations Manual (SOM) for tag F309- Quality of Care and tag F329- Unnecessary Drugs were made to include "a new section of interpretative guidance at F309 related to the review of care and services for a resident with dementia. Tags are citations that state surveyors give facilities if they are not in requirement with that specific quality measure. At F329, new severity examples have been added at the end of the interpretative guidance and revisions to the antipsychotic medication section have been made" (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). F309, relating to quality of care, makes sure that the necessary care and services are provided to maintain the highest physical, mental and psychosocial well-being within the plan of care. "Tag F309 includes, but is not limited to, care such as care of a resident with dementia, end-of-life, diabetes, renal disease, fractures, congestive heart failure, non-pressure related skin ulcers, pain, and fecal impaction" (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). The checklist that surveyors utilize to make sure that care of residents with dementia is being met include: recognition and assessment, cause identification and diagnosis, development of care plan, individualized approaches and treatment, monitoring, follow-up and oversight and quality

assessment and assurance (QAA). Resident and/ or family representative and medical team involvement are also analyzed in the survey process.

In conclusion, the mandate broadly, and specifically the CMS and F309 states that to meet compliance with these new changes facilities must identify that they have obtained details about the person's behavior and risks of those behaviors along with discussing potential causes with the care team involved along with the resident and family representative. The facility must implement personalized approaches in an attempt to understand and address behaviors along with meeting the daily care needs of the resident, and implement a consistent care plan to reflect this to staff that is caring for the resident. Next, the facility must assess the effectiveness of the approaches in a timely fashion involving the medical team and adjust treatment accordingly (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). It is clear that the revisions made to this newly developed mandate are complex. Behavior monitoring has become of great importance to decrease the amount of psychotropic medications that are prescribed to the older adult population with dementia.

#### *Dementia behaviors and monitoring*

“Ninety percent of patients with dementia will experience behavioral and psychological symptoms of dementia at some point during their illness” (Januszewski, 2012). It is considered best practice by professionals working with patients with behaviors related to dementia to first rule out any psychosocial changes that may be causing behaviors. These possible changes can include but are not limited to: change in environment (recent move to a skilled nursing facility), loss (loss of independence, loved one, home), change in ability to complete activities of daily living, lack of caregiver support, and previous patterns of isolation (Aggression & Anger, 2014). It is important that skilled nursing facilities are monitoring these behaviors, including those

residents that are taking an antipsychotic. According to *The Journal of Advances in Psychiatric Treatment*, nursing facilities and providers struggle to determine if prescribing antipsychotics for behaviors due to dementia is in violation of CMS guidelines. “Dementing illnesses with associated behavioral symptoms are one of ten CMS approved indications for antipsychotic use in skilled nursing facilities” (Simon, Ian & Ballard, 2004). This article goes on to suggest that the possible misinterpretation of appropriate diagnoses relating to dementia with behaviors could result in discontinuation of an antipsychotic even though there may have been a documented benefit. The research suggests that behavior monitoring incorporated into the use of antipsychotics is important to show that this medication is needed and is of benefit to the resident. Behavior monitoring consists of identifying behaviors a patient with dementia may display and attempt to find out why this behavior is occurring.

There are many behaviors related to the diagnosis of dementia that can be difficult for providers and caregivers to manage. Some of the more common behaviors are agitation, aggression, mood disorders and psychosis. Other behaviors may include sexual disinhibition, eating problems and abnormal vocalizations. These have been grouped together under the umbrella term ‘behavioral and psychological symptoms of dementia’ (BPSD) by the International Psychogeriatric Association (Simon, Ian & Ballard, 2004). These behaviors can sometimes be the reason that skilled nursing placement is needed because these behaviors can become too difficult for caregivers to manage.

“Behavioral and psychological symptoms of dementia (BPSD) describes a wide spectrum of non-cognitive manifestations of dementia, including verbal and physical aggression, agitation, psychotic symptoms (hallucinations and delusions), sleep disturbances, oppositional behavior, and wandering” (Liperoti, Pedone, Corsonello, 2008). This study goes on to suggest that BPSD

is present in up to 90% of patients with Alzheimer's disease and it can be estimated that about one-third of Alzheimer's disease patients have severe problems. It is important to note that BPSD is not only present in Alzheimer's disease, but also in dementia syndromes.

Alzheimer's Association Caregiver Center describes a common symptom of Alzheimer's disease and dementia called "sun downing." In the media, sun downing is often referred to the "full moon syndrome" meaning that persons may act out of the norm or unusual events may occur. There is no research indicating why sun downing occurs but possible causes could be: end-of-day exhaustion (both mental and physical), an upset in the "internal body clock," causing a biological mix-up between day and night, reduced lighting and increased shadows causing people with Alzheimer's to misinterpret what they see and become confused and afraid. Other potential explanations include reactions to nonverbal cues of frustration from caregivers who are exhausted from their day, disorientation due to the inability to separate dreams from reality when sleeping and less need for sleep, which is common among older adults (Sleep Issues and Sun downing, 2014).

Another behavior mentioned by the research is wandering. "In general, people with dementia wander because they are disoriented, restless, agitated, or anxious; because they are looking for something (e.g., the bathroom, something to eat, or a familiar person or place); or because they think they need to fulfill former obligations, such as work or child care" (Silverstein & Flaherty, 2012). Wandering can place an older adult at high risk for injury and abuse. An older adult may wander to an unsafe place and not know how to get back to where they belong. Silverstein states that once a confused older adult is lost, they are in danger of injury and even death from falls, accidents, and exposure to the elements. Many skilled nursing facilities have secured units so that patients with dementia cannot wander off of the unit they



reside on. Behavior monitoring is put into place to ensure that the patient is in need of the secured unit and the frequency of attempted elopement is documented. Overall, there are many behaviors that occur among older adults with dementia that providers and caregivers attempt to prevent in the event that injury may occur.

### *Non-pharmacological interventions*

“It is increasingly recognized that pharmacological treatments for dementia should be used as a second-line approach and that non-pharmacological options should, in best practice, be pursued first” (Simon, Ian & Ballard, 2004). This research also states that it is important that the clinician excludes the possibility that the behavioral symptoms are not the consequence of physical illness (like infections or constipation) and to try non-pharmacological approaches before considering pharmacological interventions. Non-pharmacological interventions are “any intervention intended to improve health or well-being that does not involve the use of any drug or medicine” (Laurence, 2010).

There are many types of non-pharmacological interventions available to providers to treat many different illnesses and behaviors. A study by Lips & Ooms (2000) describes non-pharmacological intervention for osteoporosis to alleviate pain and prevent fractures and falls. Some of these interventions include: a wide spectrum of treatment modalities to decrease pain, correct postural change, improve mobility, enable the patient to follow a normal social life and exercise programs to increase muscle strength and balance in order to decrease the risk of falls. The organization, *Health Technology Assessment*, conducted a qualitative study to determine the effectiveness of non-pharmacological interventions in the prevention of wandering in people with dementia, in comparison with usual care. There was no concrete evidence found to recommend any non-pharmacological intervention to reduce wandering in dementia but there

was evidence found that re-direction and exercise therapies were successful non-pharmacological interventions (Robinson, Hutchings, Corner, et. al., 2006). *The European Manual of Hypertension* states, “Lifestyle modifications, in particular dietary and non-pharmacological measures, are commonly recommended by experts and clinical guidelines both for the prevention as well as therapy of hypertension. Such approaches are of great potential importance in a disease with a very high prevalence” (Mancia, Grassi, Kjeldsen, 2008). Dietary modifications were the most effective non-pharmacological interventions to reduce hypertension and high blood pressure among adults. Research shows that non-pharmacological interventions are used in many different ways to treat a variety of illnesses.

To gain a more specific understanding of non-pharmacological interventions for older adults with behaviors related to dementia, Simon, Ian & Ballard (2004) conducted a review in *The Journal of Advances in Psychiatric Treatment* that examined current non-pharmacological interventions that are available. This review categorized such interventions into standard therapies, alternative therapies and brief psychotherapies. Standard therapies include behavioral therapy, reality orientation, validation therapy and reminiscence therapy. Behavior therapy consists of analyzing a client’s behavior and what triggers those behaviors. Once triggers have been identified, interventions or modifications can be put into place to help prevent undesired behaviors. Emerson (1998) suggests focusing on three features when designing an intervention: taking account of the individual’s preferences; changing the context in which the behavior takes place and using reinforcement strategies and schedules that reduce the behavior. Reality orientation aims to help people with memory loss and disorientation by reminding them of facts about themselves and their environment. The originator of Validation therapy, Naomi Feil emphasizes that, “some of the features associated with dementia such as repetition and retreating

into the past were in fact active strategies on the part of the affected individual to avoid stress, boredom and loneliness” (Simon, Ian & Ballard, 2004). The goal of validation therapy is for the therapist to be empathic towards the feelings of older adults with dementia and the confusion they are experiencing. Reminiscence therapy involves helping older adults with dementia relive past experiences that brought them happiness and distinguished themselves and their personalities in their younger life. Books, television shows, movies and music from the older adult’s younger years can bring happiness to their lives.

Alternative therapies include: Art therapy, music therapy, activity therapy, complementary therapy, aromatherapy, bright-light therapy and multisensory approaches. Research shows that music therapy can be a powerful non-pharmacological intervention for older adults with behaviors related to dementia. Music groups like Buddy’s Glee Club give older adults the chance to listen and sing music from their past (Clementa, 2013). This can provide re-direction and a spiritual awakening of an older adult’s soul. “Aromatherapy is an alternative therapy that uses volatile plant materials and other aromatic compounds for the purpose of improving a person's mood, cognitive function, behavioral symptoms, or health” (Ballard, O’Brien, et. al., 2002). For aromatherapy, there are two main oils used for dementia: lavender and melissa balm which is a lemon scent. These scents can be inhaled, bathed in, massaged and applied as a topical cream (Simon, Ian & Ballard, 2004). Aromatherapies are low-cost interventions and are easy to apply in most long-term care settings.

Some older adults may benefit from bright light therapy which is applying warm light to an older adult. Light therapy is commonly used to treat general depression. Bright light therapy has been used with older adults with dementia to treat disorders including behavioral symptoms (sun downing), sleep disorders, depression and circadian rhythm disruption (Ancoli-Israel, Martin, et.

al., 2003). Snoezelen is another unique non-pharmacological intervention that consists of an environment that is safe, nonthreatening and uses multiple stimulation sources to provide comfort. Stimulation can include calming waterfalls and objects that are easy and safe to manipulate. Baker, Dowling, et. al. (1997) state that older adults with dementia who are experiencing agitation or anxiety can be calmed when provided with a Snoezelen room.

Further non-pharmacological interventions are: using natural environments, white noise treatments, reduced stimulation environments and therapeutic touch. Natural environment intervention consists of providing sounds and sights of nature. Examples can include: recordings of sounds of birds, pictures of birds, sounds of running streams. "The appeal of natural environments is often termed 'biophilia', which literally means love of life or living systems. It was first used by Erich Fromm to describe a psychological orientation of being attracted to all that is alive and vital" (Whall, Black, et. al., 1997). White noise treatments consist of the use of sound machines that produce background noises such as the sound of a fan blowing. These sounds can be soothing for older adults with dementia (Burgio, Scilley, et. al., 1997). Similar to Snoezelen environments, reduced stimulation environments have been tested for aggressive and agitated behaviors. Cleary, Clamon, et. al. (1988) describe these environments, which are based on theories which give attention to the person-environment fit, as reduced noise level and including visually appealing stimuli such as colors. Therapeutic touch consists of massage that can be done in as little as three to five minutes and has been found to decrease agitated behaviors (Woods, Craven, et. al., 2005). A unique approach that involves caregivers or important persons in an older adult with dementia's life is simulated presence therapy (SPT). This therapy focuses on long-term memories that bring back positive emotions and valuable memories for the older adult with dementia. An example can be recordings of a loved one's voice telling a positive story

from the past and playing this recording for the older adult with dementia when they become distressed. This can be a great source of comfort for the older adult (Bayles, 2006).

Lastly, brief psychotherapies commonly used are cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT). With both of these therapeutic approaches, “many of the behaviors encountered emerge through one or more of the following cognitive features: cognitive misinterpretations, biases, distortions, erroneous problem-solving strategies and communication difficulties” (Simon, Ian & Ballard, 2004). Many of the challenges older adults with dementia face are due to their individual thinking style or cognitive capabilities which are addressed in CBT. The research goes on to describe CBT as a framework that allows the clinician to understand the older adult’s distressing experiences which will allow for a more targeted and individualized intervention. There are many non-pharmacological interventions available to clinicians which can aid in eliminating unnecessary antipsychotic usage and provide a strong path for behavior monitoring.

*What are skilled nursing facilities doing to meet this mandate?*

Minnesota Geriatrics (Januszewski, 2012) identifies antipsychotic usage as being a major concern within long term care for over 30 years. Recently, the Centers for Medicare and Medicaid Services (CMS) launched an initiative called the Partnership to Improve Dementia Care in Nursing Homes. Minnesota Geriatrics goes on to explain that the goal of this initiative was a 15% reduction in antipsychotic use in nursing facilities by the end of 2012. In this article, CMS stated that 2012 is quickly coming to a close and that there has been very little to no activity by surveyors or skilled nursing facilities to try to reach this goal. The delay may have been due to lack of training or focus on this topic. The initial target date was not achieved due to lack of knowledge and resources in skilled nursing facilities. In the forthcoming years, “CMS

will attempt to obtain this goal by: 1) enhancing Nursing facility and surveyor training, 2) publish individual nursing facility antipsychotic use data, and 3) provide information regarding alternatives to antipsychotic use” (Januszewski, 2012). As of this year (2014), state surveyors have spent a great deal of time focusing on this topic and skilled nursing facilities are being pressured to meet this new mandate. “There are probably a number of reasons for this renewed interest, but undoubtedly they involve antipsychotic’s unique black box warning (BBW), their associated frequent off label use (OLU), and high noncompliance of unnecessary drug use guidelines” (Januszewski, 2012).

Referring back to non-pharmacological interventions as being the first attempt at reducing behaviors related to dementia, these approaches can be of limited value in residents with severe symptoms. In addition, “factors contributing to the limited effectiveness of non-pharmacological approaches include high staff turnover in nursing facilities as well as a scarcity of available resources for staff training and program implementation” (Januszewski, 2012). Training along with a more structured support program can have a significant impact and reduce these potential problems identified by the research.

To address caregiver burnout and further training in home settings, the STAR-C treatment was established and consists of 8 weekly training session conducted in the home with the caregivers. The first three sessions focus on problem-solving and behavior management strategies. Actual examples of challenges from the caregiver’s weekly documentation are reflected upon to develop written behavior management plans to provide better future care. Further sessions include training on communications, increasing pleasant events, and enhancing caregiver support. After the sessions are complete, telephone calls are provided to ensure further support and success after the program (Logsdon, McCurry & Teri, 2005). In addition, the

Resources for Enhancing Alzheimer's Caregiver Health (REACH) were established. This project consists of testing interventions for caregivers of older adults with dementia. "The intervention includes: 1) information and support strategies; 2) group support and family systems therapy; 3) psychoeducational and skill-based training; 4) home-based environmental interventions; and 5) enhanced technology support systems" (Schulz, Burgio, et. al., 2003). These interventions are delivered in the home setting of the older adult with dementia and group interventions in the form of support groups are provided.

To gain a further knowledge of resources for long term care settings, a program in Iowa called Improving Antipsychotic Appropriateness in Dementia Patients (IA-ADAPT) was established in 2012. This program was designed specifically for long term care facilities to train their staff on addressing the needs of residents with dementia. This program consists of an eight-hour intensive program divided into 8 units. There are two audio presentations with slides and six interactive lessons with real-life stories. The topics covered are: an introduction to Alzheimer's disease, person-centered care, agitation and resistance to care, wandering and elopement, intimacy and sexuality, fall prevention and restraint-free care, late-stage comfort care and resident rights and dementia (Iowa Geriatric Education Center, 2012).

Wergin, Nott and Reyes (2014), three registered nurses in the state of Minnesota, designed a presentation on reducing the use of antipsychotics in skilled nursing facilities. The purpose of this presentation is to identify what is going on in Minnesota skilled nursing facilities, support the reduction of inappropriate antipsychotics and to emphasize the successful strategies that nursing homes are using currently to reduce this problem. The presentation goes on to describe the risks with prescribing antipsychotics such as injury or even death. Why is this important?, "Because these medications may be used as a chemical restraint for nursing home

residents, these medication may destroy the quality of life and dignity of nursing home residents and these medications cost all long-term care billions of dollars” ( Wergin, Nott, Reyes, 2014). This presentation emphasizes the National Partnership to Improve Dementia Care which was launched in 2011 with a focus on delivering health care that is person-centered, comprehensive and interdisciplinary, along with reducing the use of unnecessary antipsychotics. There are many organizations within Minnesota that are already a part of this organization. Stratis Health, a company that carries out this organization’s program, reports that 171 nursing homes nationally are using this philosophy to reduce the inappropriate use of antipsychotics. There was success in the program as evidenced by: as of September 30, 2013 there was a 13.1% reduction in the use of antipsychotic medication for long stay nursing home residents (now 20.75%) and 21 states have hit or exceeded the 15 percent target (Wergin, Nott, Reyes, 2014). Overall, between 2012 and 2013, there were 472 fewer nursing home residents receiving an antipsychotic medication. Skilled nursing facilities in Minnesota are implementing programs internally to reduce the use of antipsychotic medication.

A facility in Saint Paul Minnesota has implemented the Behavioral Symptoms Review Committee (BSRC) to meet the new CMS guidelines and state survey process focusing on antipsychotic use among older adults with dementia. Before exploring the BSRC, it is important to note that this facility has also implemented a dementia care policy effective January 1, 2014. The policy states that: the facility will provide individualized person-centered care to the residents. “Staff along with the collaboration of the resident, resident family and physician will create a resident specific care plan and appropriate, individualized approaches to resident care. Residents will be free of psychotropic medication use if at all possible, or will utilize the lowest possible dose for the shortest period of time if psychotropic medications are in use” (Cerenity



Senior Care, 2014). The facility has also developed a psychotropic medication use policy to coincide with dementia care and the BSRC. The psychotropic medication policy begins with obtaining and documenting informed consent from the resident and/ or family member. If the medication is a routine psychotropic medication use then drug monitoring forms will be utilized by nurse managers along with a behavior/ intervention monthly flow record listing specific target behaviors, expected outcomes and appropriate non-pharmacological interventions. Nurses will utilize this form on a daily basis. A psychotropic medication log for each psychotropic medication will be developed which will document any further changes to the medication. Nursing staff will utilize the Abnormal Involuntary Movement Scale (AIMS) to monitor the risks associated with these medications. The physician will be notified if any adverse side effects are noted and a gradual dose reduction may be considered. A gradual dose reduction is the slow tapering of a medication until it is completely discontinued. If a sleep or hypnotic medication is utilized, nursing staff will initiate a 7-day weekly sleep pattern document and the physician will be updated on the results. For non-routine or no psychotropic medication, behavior monitoring will be less intense and documented by incident or exception only.

The Behavioral Symptoms Review Committee has many components to meet the new and mandated requirements of dementia care and behavior monitoring. The BSRC policy states that, “Residents receiving psychotropic medication will be reviewed by the interdisciplinary team upon admission and/or initiation of medication, and then reviewed by the BSRC on a bi-monthly basis and as needed to determine if current and/or continued medication therapy is medically appropriate, in accordance with current regulations” (Cerenity Senior Care, 2013). Similar to the dementia care policy, the goal of this committee is to assure appropriate and timely resident-specific interventions and ensure psychotropic medications are being utilized at the

lowest possible dose for the shortest period of time. To carry out this policy, first a monthly report of all psychotropic medications used by residents will be generated by the pharmacy and given to community managers or nurse managers on each floor of the facility. Next, the community managers will make any appropriate adjustments as needed to the psychotropic medication logs based on the monthly pharmacy generated psychotropic medication report and current physician orders. During bi-monthly and PRN BSRC meetings, a copy the current month's psychotropic medication report along with each floor of the facilities' resident psychotropic medication logs will be reviewed by committee members (community managers, social workers, director of nursing, assistant director of nursing and director of social services). Behavior/ Intervention monthly flow records from the past 30-60 days for resident that are on routine psychotropic medications will be reviewed during committee meetings. Social services will complete behavior rounds based on facility protocol and provide the most recent results during committee meetings. The information listed will then be presented during bi-monthly BSRC meetings. At these meetings a discussion of current medications, dosing in correspondence with maximum daily dose thresholds, specific behaviors warranting the use of the medications, resident response to the medications including changes in behavior, current or on-going behaviors and adverse consequences that have been observed, if any will be reviewed and documented; along with any residents that were added to the agenda based on interdisciplinary team review of new behaviors and/or incidental documentation. Resident specific non-pharmacological interventions will be discussed along with the effectiveness of these interventions and any suggestions for adjustments to the interventions. If behavioral/ mood symptoms are not resolving or have increased in nature, social services along with the BSRC will determine if a referral or follow up with Geriatric Psychiatry or the primary physician is

appropriate. Calls, updates and changes to the plan of care will be made accordingly. If behavioral/ mood signs/ symptoms are stable or have decreased in nature, the BSRC along with recommendations from the pharmacist consultant will entertain a Gradual Dose Reduction (GDR) with the primary physician as appropriate. Notifications and updates to the plan of care will be made accordingly. Auditing will also be completed by the director of nursing and director of social services every six months to assure that the program is complete and treatment remains appropriate. The pharmacist will also conduct monthly drug reviews including psychotherapeutic medications and provide recommendations regarding these medications as appropriate.

This facility has also developed a wandering and elopement (when a patient with dementia wanders from the facility and can potentially lead to an unsafe place) policy and procedure which include: a picture of all residents identified at risk for wandering or elopement that will be taken upon admission (with consent) and displayed on medical chart. A wander guard will be placed on all residents identified as wander and elopement risks and each unit will have a sign-in/out book for residents leaving the unit. Social services will complete an admission and as needed elopement assessment to assess the risk. A wandering and elopement care plan for caregivers to see will be developed as well. The interdisciplinary team will be informed of a list of wandering residents and will maintain an updated list. Maintenance staff will monitor all wander guard door alarm systems on a scheduled basis to ensure their functioning. The nursing staff will ensure that wander guards are tested prior to application to resident.

It is apparent that facilities and organizations are working hard to implement changes to meet the new regulations regarding anti-psychotic medication and behavior monitoring more specifically, in the twin cities area of Minnesota. An in-depth review of the mandate placed to minimize psychotropic medication among older adults with dementia and non-pharmacological

interventions and what facilities in the twin cities area are doing to meet these new requirements has been conducted. CMS (2014) reports that as of September, 2014, the National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Homes has exceeded the goal to reduce use of antipsychotic medication in nursing homes and further reductions are expected. While these settings demonstrate success, I am focusing on a better understanding of the new mandate with the goal of understanding skilled nursing facilities in the twin cities area responses to this mandate.

### **Conceptual Framework**

This study used the perspective of the Minnesota Department of Health mandate to reduce the amount of unnecessary anti-psychotic medication among older adults with dementia in skilled nursing facilities for purposes of data analysis. This mandate is a new requirement that was implemented in 2012, but since then more proactive training, research and requirements for skilled nursing facilities have been put into place to reduce the amount of unnecessary antipsychotic medication used. State surveyors have been assigned to evaluate skilled nursing facilities' responses to this mandate ensuring an overall reduction in unnecessary antipsychotic use. This study utilized interviews with professionals in skilled nursing facilities in the twin cities area to gain an understanding of what facilities have done in response.

The Minnesota Partnership to Improve Dementia Care was developed in October 2012 to implement action after researching a 2011 report from the Office of the Inspector General indicating that nationally 83 percent of nursing home residents on antipsychotic medications did not have diagnoses that warranted the use of such medications. "CMS established the National Partnership to Improve Dementia Care in Nursing Homes and began

collaborating with state, various agencies, and stakeholder organizations to encourage nursing homes to reduce inappropriate and unnecessary antipsychotic medications” (Ecumen Communications, 2014) . CMS made this a national mandate to decrease unnecessary antipsychotic use by 15 percent.

As of 2014, the Minnesota Partnership to Improve Dementia Care has: completed a needs assessment, developed and distributed a physician letter that explains the reduction goal and asks for physician assistance in the efforts to reduce the use of inappropriate antipsychotic medications, developed a family resource that explains why antipsychotic medications are used and the importance of eliminating inappropriate use, provided technical assistance to reduce the use of antipsychotic medications in Minnesota nursing homes that have high rates of use, and disseminated best practice alternatives nursing homes can use in place of antipsychotic medications (Ecumen Communications, 2014). This study researched how these developments along with the mandate have trickled down into skilled nursing facilities and what facilities have done with this new information.

Skilled nursing facilities have had great success meeting this new mandate as evidenced by First quarter 2014 data recently released by CMS showed a reduction of 15.7 percent in Minnesota nursing homes. This success exceeded CMS’s national goal to reduce the use of antipsychotic medications for long-stay residents in nursing homes by 15 percent. Examining the study through the lens of the mandate itself has offered an additional lens for the data analysis and has helped increase understanding of what skilled nursing facilities in the Twin Cities area have done to meet this requirement and their own personal experiences, successes, challenges and implementations they encountered.

## **Methodology**

### **Research Design**

The purpose of this study was to identify what professionals in skilled nursing facilities in the Twin Cities area have done to meet the new MDH mandate to reduce the use of antipsychotic medication among the older adult population. Professionals were described as a nurse or social worker that is in some way involved in behavior monitoring, non-pharmacological interventions or management of the older adult's plan of care in these settings. The literature discussed the issue of using medication, and sometimes too much medication, to control an older adult with dementia and the behaviors that can associate with this diagnosis. The literature discussed the current MDH mandate to reduce antipsychotic use, offered a description of different non-pharmacological interventions and a brief introduction of what facilities are doing to meet this mandate. For the purposes of this study, six qualitative interviews were conducted to gain an understanding of what has been done to meet this mandate.

### **Population and Sample**

The population of interest consisted of professionals working with older adults in skilled nursing facilities in the Twin Cities area with dementia patients and the sample consisted of professionals in a snowball sample of providers in skilled nursing facilities in the Twin Cities area. One skilled nursing facility had expressed interest in the research and the author of this research used to be a part of this facilities' behavioral symptoms review committee. This facility agreed to be a participant in this study and provide information to other professionals who were invited to be a part of the study as well. The researcher chose a snowball sample because it was important for the purpose of the research to provide an overview of what professionals are doing

to meet this new mandate and to hear from those who have experience with behavior monitoring, non-pharmacological interventions and person-centered care by being involved in the plan of care to hear about what accounted for the initial success in reduction described in the conceptual framework. Names of potential interviewees were obtained from committee members, additionally, because they have experience with behavior monitoring and a network within the Twin Cities area.

Those that participated answered the interview questions in person. I explained the purpose of the study, voluntary nature and the measures that would be taken to ensure confidentiality. These measures included keeping the facility name and professional(s) confidential and generalizing the location of the facility to the twin cities area. An informed consent form was developed and reviewed by the research chair and committee members. This consent form was provided to each participant prior to beginning the interview. The informed consent form was developed from a template approved by the University of Saint Thomas Institutional Review Board (IRB) for expedited review. This research was approved by the research committee that consists of Laura Anfinson, Alexis Soine and David Roseborough. After the committee reviewed and approved the study, the IRB then reviewed and approved the research content before formally recruiting and beginning interviews with participants began. Participants were given the opportunity to ask questions after the form was reviewed and were given the option to opt out of the research without consequence. If a participant chose to opt out of the research, any data obtained was deleted and not included in the study. The names of the facilities and professionals were kept confidential in any data obtained. After the participants agreed to the terms of the informed consent, interviews began. There were no known risks to professionals participating in the research. Possible benefits were providing the professional with

knowledge about the mandate if not already known and providing information on what surrounding skilled nursing facilities are doing to meet this mandate for further research.

### **Data Collection**

Qualitative interviews were conducted in person with professionals in skilled nursing facilities around the Twin Cities area. The study consisted of a snowball sample of six professionals working in this setting. The semi-structured interviews consisted of 11 questions, using four categories of questions asking: how much the professional knows about the mandate; what the facility is doing to try and meet this mandate; successes and challenges the professional has observed while trying to meet this mandate, and how non-pharmacological techniques are used in the professional's facility. These interview questions were approved by the committee and University of Saint Thomas IRB prior to interviews. The main goal of this study was to analyze what facilities in the Twin Cities area are doing to meet this new mandate and their practice with non-pharmacological interventions. The research also indicated what is needed to help facilities meet this mandate and/or what professionals are struggling with to meet this mandate. After gathering this data, the researcher transcribed the recorded interviews and utilized a qualitative descriptive phenomenological approach for the data analysis.

### **Data Analysis**

For the purpose of this study, the data analysis strategy was qualitative descriptive phenomenology. This means that qualitative interviews were conducted with professionals in skilled nursing facilities that are affected by this mandate, and that their responses were primarily described at the level of manifest or overt content versus giving attention to latent or suggested content. The professional's interpretation and response to this mandate in terms of what their



facility is (or is not) doing, their understanding of the mandate and non-pharmacological interventions were described by professionals. After gathering data from the eight professionals the researcher transcribed the interviews and looked for common themes across the interviews. The researcher also listened for similarities, but also for any differences. This process allowed for descriptive features and personal experiences of the professionals experience that related to this topic. I tried to capture important, general themes, but also notable individual examples.

### **Timeline & Protection of Human Participants**

The researcher sent the proposal for the study along with a list of interview questions and consent form to the research committee who met in December 2014. Once the proposal, interview questions and informed consent form were approved by the committee and the IRB, the researcher contacted participants and begin collecting data for those participants who agreed to the terms of the research as stated on the informed consent form. The respondents were sent a list of questions to review and consent form prior to the interview. The researcher also asked permission to use an audio recording device during the interview to ensure accuracy in data collection.

The data obtained for this study was kept confidential by storing all data (recordings, hard copies of interview, contact information for participants, consent forms and any other documents containing sensitive information) in a locked filing cabinet at the researcher's home. Any electronic data collection was kept in password protected files on the researcher's password protected personal computer. Research participants were identified by facility number and not by facility or professional's name. Once again it is important to note that no names of facilities or professionals within those facilities were mentioned in the research. All electronic records for

this study will be deleted and all paper records for this study will be shredded by December 2015. In addition to informing participants they can opt out of the research at any time, participants were given the option to choose to not answer questions that they were uncomfortable with. The participants were sent a thank you card at the end of the research to thank them for their time and commitment to this important research.

### **Strengths/ Limitations**

There were some limitations of this study. The data gathered pertained to this metropolitan region and not all of Minnesota or the United States. Professionals may have felt inclined to answer interview questions a certain way because professionals may not have had a lot of information on their facility's interventions relating to the mandate and to non-pharmacological interventions. However, I sought out people in a good position to speak to these questions, for instance, people who have roles on their setting's committees instituting these changes, employees who have roles in behavioral monitoring, etc. The institutions that were used were based on snowball sampling and limited demographics of the facility were included in the study.

There were strengths to this study. This research provided information to other professionals who are working to meet this mandate. Professionals may be struggling to adhere to the requirements and this information could have provided direction to them as it gives information about what other facilities are doing. This research provided information that does not support the media or stereotypes of older adults in nursing homes with "behaviors." This research showed some of the efforts that facilities are making to minimize antipsychotic medication use and implementing non-pharmacological interventions along with behavior

monitoring that may offer ideas to other sites attempting to do the same. Lastly, this study provided information for further research on this topic.

### **Findings**

This study had the following research questions: what have facilities done to meet the Minnesota Department of Health mandate in terms of behavior monitoring, minimizing antipsychotic medications and utilizing non-pharmacological interventions. In addition, examples of the non-pharmacological interventions these facilities are utilizing and their effectiveness were explored, with particular attention to music therapy. Lastly, I talked about the challenges and successes that these facilities are having with these interventions and meeting the MDH mandate.

This study was conducted through the framework of the Minnesota Department of Health mandate to reduce the amount of unnecessary anti-psychotic medication among older adults with dementia in skilled nursing facilities for purposes of data analysis. The goal of this study was to gain a better understanding of what facilities in the Twin Cities area are doing to meet this mandate. Six professionals agreed and responded to a thirty to forty-five minute audio-taped interview.

The sample included six female professionals in skilled nursing facilities in the Twin Cities area. These six participants were all licensed social workers. Data were gathered through transcribed audio-taped interviews. Themes emerged from the interviews and were identified using both inductive and deductive methods. The transcripts were analyzed in an inductive manner, which disclosed themes in a natural manner. The transcripts were then analyzed in a

deductive manner to determine themes surrounding the successes and challenges professionals have experienced through meeting this mandate.

There were three main themes with three subthemes under each theme that were identified from the transcripts. The first major theme was communication and the three subthemes that emerged related to it were: working as a team, importance of documentation and more training needed. The second theme was reaching a common goal and the three associated subthemes that emerged were: medication reduction success, individualized care and determining cause of behavior before medication. The third theme was non-pharmacological efforts/ successes and the three related subthemes were: iPod pilot project, music therapy and non-pharmacological intervention forms that facilities are utilizing. In addition to these themes, differences or barriers and further findings were identified.

Communication was a common theme that emerged from the data. Communication was described as a crucial component in facilities' attempts to meet this mandate. There are so many pieces to the new requirements that involve all disciplines. Communication can be broken down into three subthemes: the whole team, documentation and more training.

The professionals involved in the study frequently reported that meeting this mandate requires the whole team. Each facility has some type of committee or team of professionals involved in this process to ensure that there is a reduction in antipsychotic medications and that effective non-pharmacological interventions are utilized. Below is a table of direct quotes from the transcribed audio-taped interviews conducted with the six professionals interviewed. This table is organized by theme, subtheme and the direct quotes.

<b>THEME</b>	<b>SUBTHEME</b>	<b>QUOTE</b>
Communication	Whole Team	“it’s about really working with our whole IDT team looking at who that person is and collaborating with the whole team”
Communication	Whole Team	”really working with the team making sure that we’re having required documentation done with the patient and family”
Communication	Whole Team	“We have monthly behavior rounds as a team”
Communication	Whole Team	“We meet together as a team”
Communication	Whole Team	“When you pull staff together as a team because we do our monthly meetings it’s with the nursing assistants and nurses on the floor, the dietary staff, maintenance, therapies”
Communication	Whole Team	“We are working closely with our pharmacy um uh to uh to try to figure out who is on antipsychotic medications and then work on a possible gradual dose reduction and we do behavior tracking and monitoring and we are trying to reduce medications”
Communication	Whole Team	“We all review and look to improve care plans and um discontinue unnecessary medications. We also have someone from Geri Psych and a Pharmacist present that also offer recommendations. Once recommendations are given, the community manager speaks to the resident’s nurse practitioner or physician to inquire about changes and their perspective on it.”

The next subtheme under communication is the process of documentation as each facility attempts to meet this mandate. During the process of these new implementations, they would not be valid without documentation by professionals. Documentation is needed to provide individualized care and letting all staff involved know what is going on. The table below reflects direct quotes from the transcribed interviews of the six professionals involved in the study.

<b>THEME</b>	<b>SUBTHEME</b>	<b>QUOTE</b>
Communication	Document	“We are doing an abundance of documentation”

Communication	Document	“we have target behavior care plans that are not only in the medical chart but on the floor for direct care staff for specific interventions regarding what is the target behavior and what are the non-pharm interventions utilized”
Communication	Document	“We have sheets that we are doing so we’re working on analyzing all that information some key things that the regulation requires you know what’s working what’s not working”
Communication	Document	“I have a lot of documentation to do on each patient”
Communication	Document	“All team members bring their required documentation to the meeting and we bring it all together you know review and make any necessary changes”

The third subtheme of communication that was evident in the data was more training needed by professionals in skilled nursing facilities. Each of the six professionals expressed some type of ambiguity of the requirements of this mandate and stated that more training would have been beneficial. The table below reflects direct quotes from the transcribed interviews.

<b>THEME</b>	<b>SUBTHEME</b>	<b>QUOTE</b>
Communication	More training	“We probably rolled out later than we should have”
Communication	More training	“I am fairly familiar with the new regulation so we are developing a policy and procedure relating to patients with dementia”
Communication	More training	“Maybe have more of an onset of the requirements”
Communication	More training	“We had videos and online trainings and multiple teleconferences but maybe providing more like one-on-one in person type trainings which maybe they had and I missed them.”
Communication	More training	“I would say that’s the biggest thing is just doing it that way, reading the papers and figuring it out maybe a follow-up training would be helpful”

Communication	More training	“I think we could’ve been more prepared in terms of having more direction from the department of health”
Communication	More training	“We have not had any training our um regional director has just educated us on it”

The next theme of the data collected is reaching a common goal. All six professionals have one common goal they are attempting to reach and that is to reduce the amount of antipsychotic medication usage among residents in skilled nursing facilities. There were three subthemes that were evident in this research that fall under this theme: reduction success, individualized care and determining other underlying causes of behaviors before medicating.

The subtheme of reduction success can be described as each of the six professional’s facility successes in reducing the amount of antipsychotic medication usage through the changes they have implemented. This is the overall goal of the MDH mandate and also a reason why non-pharmacological interventions are stressed under individualized care. The table below displays actual quotes from the data that emphasize the importance of this subtheme.

<b>THEME</b>	<b>SUBTHEME</b>	<b>QUOTE</b>
Common goal	Reduction success	“Really looking at stable behavior and working with the pharmacist and the doctor and having that documentation to determine a gradual dose reduction”
Common goal	Reduction success	“We are below the national average in terms of long-term residents with dementia with antipsychotics so it’s kind of you know we have seen a decrease but it just kind of trends depending on who our population is”
Common goal	Reduction success	“It’s been really successful because you’re targeting the direct care staff and the ones who are working day in and day out”

Common goal	Reduction success	“I’ve noticed a reduction of behaviors for residents with dementia and that’s because the direct care staff are more knowledgeable about non-pharm interventions”
Common goal	Reduction success	“The direct care staff reached a comfort level on how to intervene on behaviors effectively”
Common goal	Reduction success	“I think the biggest success is really empowering the direct care staff and giving them the tools and resources to work with resident who have dementia and who have behaviors”
Common goal	Reduction success	“It can be very stressful and challenging and really have seen a reduction of behaviors for people”
Common goal	Reduction success	“Our antipsychotic medication use is well below the national average”

The next subtheme which is crucial in reaching the common antipsychotic reduction goal is individualized care. Each professional seemed to relate individualized care with non-pharmacological interventions which is crucial in behavior management. The table below displays direct quotes from the data that support individualized care.

<b>THEME</b>	<b>SUBTHEME</b>	<b>QUOTE</b>
Common goal	Individualized care	“finding out what are their behaviors what has worked what hasn’t worked”
Common goal	Individualized care	“There’s also a little bit of the social history in there about who the resident is, what was their job, their interests.. because a lot of it is just meeting with people one-on-one and engaging in conversation especially about the past”
Common goal	Individualized care	“Again working on the individual approaches to each specific resident”



The final subtheme of reaching a common goal is determining possible underlying causes of behaviors before medicating. A resident can exhibit anger or sadness for many reasons. Some of these reasons could be that the resident is hot or cold, the resident may need to go to the bathroom or the resident may be experiencing pain. It is important to determine if the resident is exhibiting behaviors due to underlying issues before assuming a resident needs medication to help manage their behaviors. The table below displays direct quotes from the data that support this subtheme.

<b>THEME</b>	<b>SUBTHEME</b>	<b>QUOTE</b>
Common goal	Determining underlying causes	“Providing the direct care staff with tools on how to approach residents with dementia to make sure that you’re at their level and that they can hear you that they understand you I want to know maybe if somebody with cognitive deficits if they say they have to go to the bathroom and its quite frequently and if staff points out that they just went residents can become irritated because they don’t remember”
Common goal	Determining underlying causes	“Really looking at any unmet needs that they need to be toileted or if they are hungry or thirsty or really trying to identify all those potential causal factors that lead to behaviors”
Common goal	Determining underlying causes	“We try not to you know medicate as a first course of action we try to address pain, being cold, hot or uncomfortable”
Common goal	Determining underlying causes	“We document a lot to try to um determine what the resident is trying to communicate. There is a lot of communication between staff to try and determine what the resident is trying to tell us from their behavior. There is a trial and error but we keep adjusting until we find something that is effective.”
Common goal	Determining underlying causes	“Take the time to determine what the resident may be trying to communicate instead of medicating.”

The final theme that emerged from the data is non-pharmacological intervention efforts. “It is increasingly recognized that pharmacological treatments for dementia should be used as a second-line approach and that non-pharmacological options should, in best practice, be pursued first” (Simon, Ian & Ballard, 2004). All of the six professionals described some type of non-pharmacological interventions that are utilized in their facilities. There are many forms of these interventions that were described in the research. The data parallels with the research as most of the non-pharmacological interventions that facilities are utilizing are described in the research as well as common and successful approaches. There are three subthemes that emerged from the research: the iPod pilot, music therapy and other methods.

The iPod pilot is one of the more well-known non-pharmacological interventions that are being utilized with older adult with dementia. The documentary *Alive Inside* previously described in the research is one that is well known and informs society of the power that this approach has. The table below contains direct quotes from the data that support this subtheme.

<b>THEME</b>	<b>SUBTHEME</b>	<b>QUOTE</b>
Non-pharmacological efforts	iPod pilot	“We are also doing an iPod project right now if you’ve seen alive inside it’s a documentary so we are doing the studies right now”
Non-pharmacological efforts	iPod pilot	“Right now the iPod study is just in research mode so there’s volunteers that are doing it with the residents and their documenting positive interactions and this is connecting with the family to refining our music to what the resident really enjoys so that we’re downloading onto their iPod what they like and we’re looking at what kind of memories it is triggering”
Non-	iPod pilot	“The goal is by the end of February the iPod project will

pharmacological efforts		roll out and iPods will be accessible for the residents at any time with the goal to utilize that as a non-pharm intervention”
Non-pharmacological efforts	iPod pilot	“If it was music before bedtime that will help them be more relaxed and more compliant with cares so it’s been really awesome to see the results”
Non-pharmacological efforts	iPod pilot	“We have um new music players that connect with the internet for streaming”

The next subtheme of non-pharmacological efforts is music therapy. Music therapy is the most common non-pharmacological intervention and can be utilized in many forms outside of the iPod pilot. Music therapy is found to be a successful and powerful non-pharmacological intervention as evidenced by resident’s positive reactions to music. The table below displays direct quotes from the data that support the power of music therapy on undesired behaviors.

<b>THEME</b>	<b>SUBTHEME</b>	<b>QUOTE</b>
Non-pharmacological efforts	Music therapy	“I think music therapy is one of the most important interventions that is probably 99% effective with all resident especially those with cognitive deficits”
Non-pharmacological efforts	Music therapy	“Fortunately we have a lot of music therapy at our facility we do one-one music therapy for residents we have a lower cognitive group or music therapist does music therapy interactions with the residents and we see a great success with that in terms of positive facial expressions, laughing, not as many complaints of care, patients sleep better at night”
Non-pharmacological efforts	Music therapy	“We use a lot of music in our activities department”
Non-pharmacological efforts	Music therapy	“When people are on hospice they bring a harp in”

Non-pharmacological efforts	Music therapy	“I know music has helped on the MCU for both staff and residents. Staff seems to be less tense.”
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The final subtheme of non-pharmacological efforts is non-pharmacological methods. In addition to music, there are many other forms of non-pharmacological interventions that can be utilized. There are multiple forms of this type of intervention that is evident in the research and the data collected from the six professionals coincides with the research. Some examples are: sensory touch, aromatherapy, desired environment, photo albums and voice recordings from family. The table below displays direct quotes from the data that relate to non-pharmacological methods.

<b>THEME</b>	<b>SUBTHEME</b>	<b>QUOTE</b>
Non-pharmacological efforts	Methods	“Setting her up with sensory fabrics- sensory items can be very effective in reducing anxiety”
Non-pharmacological efforts	Methods	“Another time that we see a lot of behaviors is bath time... the patient can go to the spa tub with music and battery operated candles and making sure that the room is very warm for each resident”
Non-pharmacological efforts	Methods	“We have aromatherapy in the room with music playing”
Non-pharmacological efforts	Methods	“I have heard that essential oils are effective. I did use lavender oil for an anxious resident a couple of times but I haven’t been consistent. Some nurses have a little felt pouch they pin on resident’s shirts with different essential oils.”
Non-pharmacological efforts	Methods	“photo albums are huge things we have a lot of families make photo albums of the residents”

There were many differences and barriers that emerged from the data. One difference that was encountered was that some of the facilities that were included in the data were already below the national average of residents utilizing antipsychotic medications and were below that amount before the mandate was established. Although these facilities were below the national average, they did make reductions and are continuing to meet the requirements of the mandate and utilizing non-pharmacological medications. Another difference was that one facility was just beginning to look into reducing antipsychotic medications. This facility was the only facility included that is in a rural setting near the Twin Cities. This rural facility had a smaller capacity for residents along with only one social worker as opposed to urban facilities closer to the city that had almost double the capacity for residents and multiple social workers.

In terms of barriers, there were quite a few facilities included in the study that stated their biggest barrier is when residents come from the hospital on an antipsychotic medication and determining if that medication is needed and why the resident was on it. Residents will admit from the hospital with medications that do not have appropriate diagnosis which makes it difficult for facilities to determine if this medication is needed and also obtaining an appropriate diagnosis that fits with the mandate criteria. Another barrier that emerged from the data was patient and family concern around reducing a medication. Respondents described how some patients and families believe that the antipsychotic medication is necessary and that the patient will change once the medication is reduced. This can cause a lot of anxiety for patients and families. From a facility standpoint, if a medication is not proven to be effective or needed then changes must be made under the requirements of the mandate. The last barrier that emerged from the data is some facilities are having difficulty gaining access to iTunes for the iPod pilot that

they are implementing in their facilities. Some companies do not allow iTunes to be accessed on facility computers so professionals are downloading music from iTunes at home.

In conclusion, there were further findings from the data worth noting that may not have corresponded with one of the major themes or subthemes. One facility launched a program called “Advancing in excellence” which is a committee that spends time analyzing residents and their individualized care. Non-pharmacological interventions are discussed during this meeting along with any improvements or changes that need to be made. This program was launched before the mandate was established. A facility that was part of the data collected is not only providing music to residents but also to staff. From the perspective of those interviewed, this has been successful in the reduction of staff turnover and staff burnout.

### **Discussion**

It is apparent from the data that facilities that were included in the study are putting forth great effort to reach this mandate. Professionals are working as a part of a team to cover all of the components of the new requirements and completing an abundance of documentation to support their work. As stated in the data, one facility is just beginning to look at meeting this mandate but professionals in this setting are paying closer attention to antipsychotic medication usage and providing more individualized care. During my experience with behavior monitoring, behaviors were monitored in a more generalized manner but since this mandate was put into place, a more systematic approach is being conducted to monitor behaviors more specifically.

Each professional interviewed expressed excitement over the changes that are being made in their facilities, specifically more individualized care and utilization of non-pharmacological interventions. These interventions are not only effective but also cost effective.

Facilities are seeing a reduction in the usage of antipsychotic medications among older adults with dementia. While this reduction has been a great success, it is also important to keep in mind that residents have individual preferences and the right to continue on their medication and make decisions on their care. Individualized care, as stated, may look different for some residents and a reduction in their antipsychotic medication may not always be necessary. Residents have the right to make their own choices or those that they have appointed to make decisions for them in the case that they may not be able to.

The first theme of communication and subtheme of the whole team working together is evident for these professionals in their settings. This subtheme can be related back to the literature multiple times as the literature stresses the importance of the whole team being involved in a successful reduction and successful non-pharmacological interventions for each individual resident. This is in keeping with the CMS and F309, that state that to meet compliance with these new changes facilities must identify that they have obtained details about the person's behavior and risks of those behaviors along with discussing potential causes with the care team involved along with the resident and family representative. The facility must implement personalized approaches in an attempt to understand and address behaviors along with meeting the daily care needs of the resident, and implement a consistent care plan to reflect this to staff that is caring for the resident. Next, the facility must assess the effectiveness of the approaches in a timely fashion involving the medical team and adjust treatment accordingly (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). The involvement of the entire team is mentioned often by CMS and it is a requirement that each facility needs to meet. As evidenced by the professionals' responses, each facility is meeting this requirement of communication as a whole team. To gain a more specific understanding of the importance of the

whole team, the Behavioral Symptoms Review Committee (BSRC) discussed in the literature review states often that the whole team is involved: “Staff along with the collaboration of the resident, resident family and physician will create a resident specific care plan and appropriate, individualized approaches to resident care” (Cerenity Senior Care, 2014). Lastly, working as a whole team and all members of the team having an understanding of what each patient needs is crucial because as the literature states, “factors contributing to the limited effectiveness of non-pharmacological approaches include high staff turnover in nursing facilities as well as a scarcity of available resources for staff training and program implementation” (Januszewski, 2012).

To relate the subtheme of documentation under the theme of communication back to the literature, some facilities have secured units for residents who are at risk of wandering. For a patient to reside on a secured unit, documentation must reflect that there is a need for this placement. The literature review states that behavior monitoring is put into place to ensure that the patient is in need of the secured unit and the frequency of attempted elopement is documented. The literature discusses dementia care policies and antipsychotic medication reduction policies which are a form of a documentation that is communicated to professionals in skilled nursing facilities. The dementia care policy in the literature review states that “The psychotropic medication policy begins with obtaining and documenting informed consent from the resident and/ or family member. If the medication is a routine psychotropic medication use then drug monitoring forms will be utilized by nurse managers along with a behavior/ intervention monthly flow record listing specific target behaviors, expected outcomes and appropriate non-pharmacological interventions” (Cerenity Senior Care, 2014). At the Behavioral Symptoms Review Committee (BSRC) “During bi-monthly and PRN BSRC meetings, a copy the current month’s psychotropic medication report along with each floor of the facilities’



resident psychotropic medication logs will be reviewed by committee members (community managers, social workers, director of nursing, assistant director of nursing and director of social services). Behavior/ Intervention monthly flow records from the past 30-60 days for resident that are on routine psychotropic medications will be reviewed during committee meetings. Social services will complete behavior rounds based on facility protocol and provide the most recent results during committee meetings” (Cerenity Senior Care, 2013).

The direct quotes from the data make it apparent that the professionals feel that they would have benefited from further training in order to meet this mandate and a possible lack of training contributed to the delay in attempts to meet this mandate. Januszewski (2012) stated that recently, the Centers for Medicare and Medicaid Services (CMS) launched an initiative called the Partnership to Improve Dementia Care in Nursing Homes. The goal of this initiative was a 15% reduction in antipsychotic use in nursing facilities by the end of 2012. CMS stated that 2012 is quickly coming to a close and that there has been very little to no activity by surveyors or skilled nursing facilities to try to reach this goal in Minnesota. The delay may have been due to lack of training or focus on this topic. The initial target date was not achieved due to lack of knowledge and resources in skilled nursing facilities. In the forthcoming years, “CMS will attempt to obtain this goal by: 1) enhancing nursing facility and surveyor training, 2) publish individual nursing facility antipsychotic use data, and 3) provide information regarding alternatives to antipsychotic use” (Januszewski, 2012).

The subtheme of reduction success under the theme of reaching a common goal is evident in the data by facilities reducing the amount of antipsychotic medications and this is supported in the research literature. This was consistent with national trends. There was success in the program as evidenced by: as of September 30, 2013 there was a 13.1% reduction in the use of

antipsychotic medication nationally for long stay nursing home residents (now 20.75%) and 21 states have hit or exceeded the 15 percent target (Wergin, Nott, Reyes, 2014). Overall, between 2012 and 2013, there were 472 fewer nursing home residents receiving an antipsychotic medication. CMS (2014) reports that as of September, 2014, the National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Homes has exceeded the goal to reduce use of antipsychotic medication in nursing homes and further reductions are expected.

Findings in this study were also consistent with the larger literature in terms of both discussing the importance of individualized care with the goal of reaching reaching a common goal with a recognition that not all residents are the same. Emerson (1998) suggests focusing on three features when designing an intervention: taking account of the individual's preferences; changing the context in which the behavior takes place and using reinforcement strategies and schedules that reduce the behavior. There are interventions that may work with one resident due to who they are as an individual that may not work with another resident. It is important to take the time to gather information through one-on-one time with the patient or their family to find out what the resident may like or dislike. Respondents in this study similarly showed evidence of doing this by way of having an initial care conference with the resident and family and establishing rapport with the resident.

The subtheme of determining underlying causes before medicating under the theme of reaching a common goal is crucial in reducing antipsychotic medication usage. It is important to emphasize the commonality of behaviors among residents with dementia in skilled nursing facilities, in that according to Januszewski (2012), "Ninety percent of patients with dementia will experience behavioral and psychological symptoms of dementia at some point during their

illness.” The literature supports determining underlying causes of behaviors before medicating as it is considered best practice by professionals working with patients with behaviors related to dementia to first rule out any psychosocial changes that may be causing behaviors. These possible changes can include but are not limited to: change in environment (recent move to a skilled nursing facility), loss (loss of independence, loved one, home), change in ability to complete activities of daily living, lack of caregiver support, and previous patterns of isolation (Aggression & Anger, 2014).

Facilities nationally are launching an iPod pilot which is the next subtheme under the theme of non-pharmacological intervention efforts. Filmmaker Michael Rossato-Bennett created a documentary to display music’s power titled “Alive Inside” which follows older adults with a dementia diagnoses and their experience with music therapy. Each resident that is filmed is provided with headphones connected to an iPod and the care provider plays music for the resident to listen to. Like magic, the residents who exhibit behaviors related to dementia are calm, singing and swaying to the music. In the documentary, “His camera reveals the uniquely human connection we find in music and how it’s healing power can triumph where prescription medication falls short” (Rossato- Bennett, 2014). This documentary is an extremely powerful representation of the iPod pilot. The iPod pilot ties in to individualized care because staff are reaching out to the resident or the resident’s family to find out what type of music the patient likes and reflecting on the memories that their preferred music exhibits.

There is strong support in the literature for music therapy which is the next subtheme of the theme of non-pharmacological intervention efforts. Balakrishnan, et. al.(2013) explains that some advantages of music therapy include low cost and presumed absence of adverse side-effects. These non-pharmacological interventions may not only be a more beneficial approach to

difficult behaviors associated with dementia, but may also be more cost effective. In terms of the effect of music therapy on older adults with dementia, I found in the broader literature that music therapy had a “positive effect on behavioral and psychological symptoms of dementia, not only in outward symptoms like agitation, but also intrinsic psychotic symptoms like hallucination, delusion and agitation in older Chinese men with dementia” (Chen, Liu, Lin et. al, 2014). Music therapy brings out positive emotions from residents which combat undesired behaviors like agitation, combativeness and paranoia. “Music has a close relationship with unconscious emotions, which are activated by musical movement. To me, music represents a microcosmos which has a close relationship to our inner feelings. These feelings are so strong; they’re meaningful even if patients cannot remember who they are” (Schaeffer, 2014).

There are many forms of non-pharmacological interventions that are reflected in the broader literature which were also found in this study that lead to the final subtheme of non-pharmacological interventions methods under non-pharmacological efforts. For aromatherapy, there are two main oils used for dementia: lavender and melissa balm which is a lemon scent. These scents can be inhaled, bathed in, massaged and applied as a topical cream (Simon, Ian & Ballard, 2004). Aromatherapies are low-cost interventions and are easy to apply in most long-term care settings. Bright light therapy has been used with older adults with dementia to treat disorders including behavioral symptoms (sun downing), sleep disorders, depression and circadian rhythm disruption (Ancoli-Israel, Martin, et. al., 2003). Snoezelen is another unique non-pharmacological intervention that consists of an environment that is safe, nonthreatening and uses multiple stimulation sources to provide comfort. Stimulation can include calming waterfalls and objects that are easy and safe to manipulate. Baker, Dowling, et. al. (1997) state that older adults with dementia who are experiencing agitation or anxiety can be calmed when

provided with a Snoezelen room. There are many other forms of non-pharmacological interventions previously discussed in the literature that support the use of these interventions as opposed to medicating. Consistent with the literature, respondents from several of these sites noted using aromatherapy, Snoezelen rooms and bright light therapy each of which was similarly referenced in the literature.

After interpreting the data, there are some implications for future research, practice and training in social work. For future research, a focus on the continued success of facilities' attempts to meet the mandate should be explored. From this research, it is apparent that the facilities sampled in this study, in the Twin Cities area from the data are having success meeting this mandate and improving the overall quality of care to patients with dementia without medication. This mandate was put in place not that long ago so future research as facilities further their attempts to reduce antipsychotic medication is important. In terms of practice, it can be beneficial for other facilities that may be at the beginning stages of meeting this mandate to have a knowledge base of what other facilities have done to meet this mandate and what has worked or not worked. It is important that social workers remember to advocate for resident's rights and that they make the decision for themselves. Residents have the choice to stay on their antipsychotic medication even if a gradual dose reduction is recommended. It is important to keep in mind that while this mandate has had reduction success, a medication reduction is not always necessary or appropriate. Overall, individualized care looks different for each resident. Also, having a knowledge base of existing practice toward this mandate can provide professionals with information on how to have best practice in their facilities. As stated in the beginning of this paper, the purpose of exploring this topic is to provide readers with a knowledge base of some examples of what facilities are doing locally to try and maintain the best

quality of life for residents in nursing homes and to go against the stereotype that older adults in nursing homes are drugged and lost in society. Lastly, it is apparent from the professionals interviewed that further training would have been beneficial to meet this mandate sooner as opposed to two years after it was put into place. Professionals reported not having a lot of training which can be improved in the future for other facilities that will implement changes to meet this mandate. With further training, facilities will be more successful in reducing antipsychotic medications and implementing effective non-pharmacological interventions through individualized care.

There were strengths and limitations to this study. One strength is that the professionals interviewed have direct practice with individualizing care and direct connection to professionals involved in resident care. These professionals are part of interdisciplinary teams that meet regularly to reduce antipsychotic medication and behavior management through non-pharmacological interventions. Another strength of this study is that there were many non-pharmacological interventions mentioned in the interviews which supported the research. Overall, the data supported the research provided in the literature review.

A limitation of this study is that only six professionals were interviewed for this study as opposed to the original goal of eight professionals. Not all facilities that the researcher reached out to responded to be a part of the research. Another limitation is that the sample is limited to the twin cities area in Minnesota. This study focused on one small area of the state of Minnesota and cannot be generalized for the entire state or further regions. Another limitation is that only one facility was considered a rural setting while the other five facilities were within the city or a close suburb. There may be differences that arise between urban and rural settings but this is not reflected in the research.

There are many suggestions that I have as the researcher of this study. The first suggestion is that facilities, even nationally, be included in future research to see if and/or how other regions are attempting to reduce antipsychotic medications and if different cultures/ beliefs have an impact on this. I would also like to know what types of non-pharmacological interventions are being utilized. I would also like to know if other regions have mandates in place similar to Minnesota and how they may be similar and different. I would like to see further research reflecting the success of facilities that are meeting this mandate and if any further training is provided to facilities. It was apparent in the research that further training was needed and that some facilities are just beginning this process or will begin this process in the future.

In conclusion to this research, a sample of practitioners in facilities in the Twin Cities area was interviewed to learn more about their experience with meeting this mandate along with any successes and challenges they may have encountered. The data were analyzed and categorized into themes and subthemes. The data were related back to the literature review and were found to support the broader literature. Representatives from facilities interviewed are either beginning the process of meeting the mandate or have had success meeting this mandate and have interventions in place. In this sample, facilities are placing more of an emphasis on non-pharmacological interventions and using a wide variety of techniques as opposed to medicating. The research exemplifies the work that professionals are putting in to provide the best care and quality of life for residents in skilled nursing facilities with dementia. The data support the idea that older adults in nursing homes are not being drugged and are still able to be a part of society. There were many strengths and limitations to this study along with implications for further practice, training and research. It appears from this study, that the perception among those interviewed is that skilled nursing facilities in the Twin Cities area have placed a lot of effort into

meeting the Minnesota Department of Health Mandate to reduce antipsychotic medication among residents with dementia.



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**CONSENT FORM**  
**UNIVERSITY OF ST. THOMAS**  
**GRSW682 RESEARCH PROJECT**

**[Reducing antipsychotic use]**

IRB# (689308-1)

I am conducting a study about the new Minnesota Department of Health mandate to reduce the amount of antipsychotic medication used in skilled nursing facilities in the twin cities area. I invite you to participate in this research. You were selected as a possible participant because you are a professional in a skilled nursing facility in the twin cities area. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Stephanie Marshall, a graduate student at the School of Social Work, College of St. Catherine/University of St. Thomas and supervised by Dr. David J. Roseborough.

**Background Information:**

The Minnesota Department of Health has developed a mandate that requires skilled nursing facilities to closely monitor antipsychotic use and behaviors related to dementia. On March 29, 2012, the Centers for Medicare & Medicaid Services (CMS) developed the National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Homes (this is now referred to as the Partnership to Improve Dementia Care in Nursing Homes). “The goal of this Partnership is to optimize the quality of life and function of residents in America’s nursing homes by improving approaches to meeting the health, psychosocial and behavioral health needs of all residents, especially those with dementia” (Center for Clinical Standards and Quality/ Survey & Certification Group, 2013). The CMS has joined with various stakeholders to improve dementia care in nursing homes. CMS has reported high levels of antipsychotic use in the past and there is a requirement for these levels to decrease.

The purpose of this study is to identify what professionals in skilled nursing facilities in the twin cities area are doing to meet the new MDH mandate to reduce the use of antipsychotic medication among the older adult population. Professionals can be described as a nurse or social worker that is in some way involved in behavior monitoring, non-pharmacological interventions or management of the older adult’s plan of care in these settings.

**Procedures:**

If you agree to be in this study, I will ask you to do the following things: A 30 minute interview to discuss what your facility is doing to meet this new Minnesota Department of Health mandate in terms of behavior monitoring, minimizing psychotropic medications and utilizing non-pharmacological interventions. In addition, examples of the non-pharmacological interventions these facilities are utilizing and their effectiveness will be explored, with particular attention to music therapy. Lastly, the challenges and successes that your facility may be experiencing with these interventions and meeting the MDH mandate and what they suggest for good practice will be explored as well.

**Risks and Benefits of Being in the Study:**

There are no known risks to professionals participating in the research. Possible benefits could be providing the professional with knowledge about the mandate if not already known and providing information on what surrounding skilled nursing facilities are doing to meet this mandate for further research.

The study has no direct benefits. Your knowledge and opinion are valued in this research.

**Confidentiality:**

The data obtained for this study will be kept confidential by storing all data (recordings, hard copies of interview, contact information for participants, consent forms and any other documents containing sensitive information) in a locked filing cabinet at the researcher's home. Any electronic data collection will be kept in password protected files on the researcher's password protected personal computer. Research participants will be identified by facility number and not by facility or professional's name. Once again it is important to note that no names of facilities or professionals within those facilities will be mentioned in the research. All electronic records for this study will be deleted and all paper records for this study will be shredded by December 2014.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will be erased. Please just let me know by [give date here – generally about 1 week after the interview].

**Contacts and Questions**

My name is Stephanie Marshall. You may ask any questions you have now. If you have questions later, you may contact me at 651-890-6198. The instructor's name and telephone number is: Dr. David J. Roseborough at 651- You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

**You will be given a copy of this form to keep for your records.**

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

\_\_\_\_\_  
Signature of Study Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Study Participant

\_\_\_\_\_  
Signature of Researcher

\_\_\_\_\_  
Date

## Interview Questions

What is your role?

### *Knowledge of Mandate*

1. What do you know about the mandate?
2. Has training been provided to your facility on how to meet this mandate? If so, what did it include?
3. If your facility was not prepared well for this mandate, what would you suggest?

### *Facility Response to Mandate*

4. What is your facility doing to try and meet this mandate?
5. Has your facility had a decrease in anti-psychotic medication usage since this mandate was put into place? What has been the result of your attempts to meet this mandate? If not, what is your impression? Did you have any results at all?
6. How well do you feel that your facility was prepared in terms of developing interventions to meet this mandate? Do you have any suggestions for other sites?

### *Successes and Challenges*

7. What are successes you have encountered with this mandate?
8. What are challenges you have encountered with this mandate?
9. Were there any unexpected or adverse effects for residents of your facility from a decrease in medication related to the mandate?

### *Non-pharmacological Interventions*

10. How do you utilize non-pharmacological interventions in your facility?
11. Can you speak to facility experiences with music therapy?



12. What non-pharmacological interventions has your facility used? Have you had any success from the use of non-pharmacological interventions?
13. Do you have any examples pertaining to non-pharmacological interventions being effective?
14. Is there anything further you would like to speak to? Do you have any advice in regards to meeting this mandate?