Australian Journal of DementiaCare Research Focus

This section aims to provide a channel of two-way communication between researchers and practitioners in the expanding field of social, psychological and nursing research in dementia care, including all aspects of nursing and care practice, communication and the environment.

The Research Focus section of the *Australian Journal of Dementia Care* aims to keep readers up to date with the fast expanding field of social, psychological and nursing research in dementia care. By this we mean every aspect of person-to-person communication, nursing and care practice and organisation, and the influence of all aspects of the environment. The aim is to provide a channel of two-way communication between researchers and practitioners, to ensure that research findings influence practice and that practitioners' concerns are fed into the research agenda. We would like to hear from you, specifically with:

- notice of the publication (recent or imminent) of peer reviewed papers with practical relevance to dementia care;
- research reports available for interested readers;
- requests or offers for sharing information and experience in particular fields of interest.

Leading the change in medication management

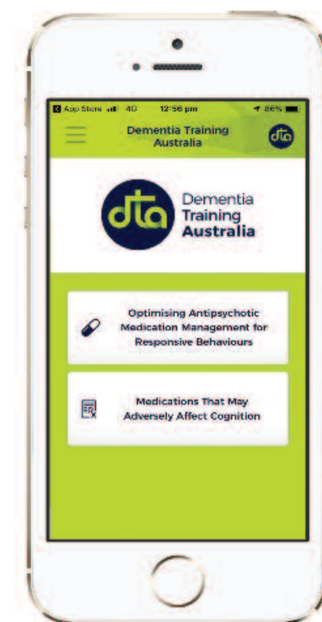
Kate Fulford and **Andrew Stafford** report on the findings from the first two years of the Dementia Training Australia Medication Management Consultancy; a pivotal pharmacist-led consultancy service reducing antipsychotic usage in Residential Aged Care Facilities across Australia

Responsive behaviours are experienced by the majority of people living with dementia at some point throughout their journey with the condition. For decades, antipsychotic medications have been used in residential aged care to alleviate responsive behaviours. This is despite these medications being of limited effectiveness for most responsive behaviours, and concerns regarding an increased risk for injury and death for a person with dementia who is prescribed an antipsychotic (TGA 2015).

There is also an increasing body of evidence that addressing responsive behaviours with non-pharmaceutical approaches is at least as effective as using antipsychotic medications (TG Ltd 2016). Consequently, most clinical guidelines that address responsive behaviours recommend that antipsychotic medications should only be considered when all non-medication approaches have failed, and only for severe symptoms of aggression and agitation. However, many residential aged care sites report difficulties in adhering to these guidelines due to various barriers. These include a lack of knowledge regarding the safe withdrawal of these medications, organisational processes that inadequately support decision making for responsive behaviour management, and lack of commitment to changing staff behaviour.

In response to this body of evidence, Dementia Training Australia (DTA) developed a pharmacist-led, evidence-based service that aims to embed knowledge and processes to optimise the use of antipsychotic medications for responsive behaviours. The Medication Management Consultancy (MMC) is a three-tiered process which benchmarks and then follows over time two key measures relating to antipsychotic use. These are: the number of residents prescribed antipsychotic medications for responsive behaviours; and staff knowledge about the appropriate use of psychotropic medications for responsive behaviours within the residential aged care facility (RACF).

The MMC has been undertaken by three large residential aged care organisations across Australia over the past two years, where considerable benefits in both measures have been identified. Across 10 locations, five RACFs have seen greater than a 50% reduction in the proportion of residents using antipsychotics, with up to 60% reduction facility-wide at one location, and 67% reduction across the dementia support unit (DSU) within another.



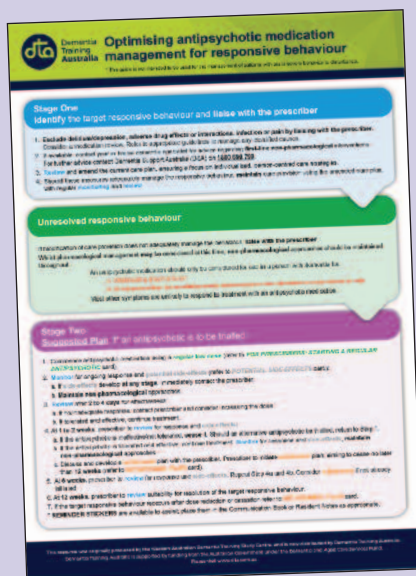
The Medication Management Consultancy

The MMC is a six-month-long quality improvement activity undertaken by individual RACFs which aims to embed knowledge and processes that optimise the use of antipsychotic medications prescribed for people living with dementia experiencing responsive behaviours. The consultancy builds upon the skills of a diverse range of staff members within the facility who implement a comprehensive antipsychotic

The DTA antipsychotic resources suite

As part of the MMC, staff receive a comprehensive antipsychotic resources suite which contains:

- A one-hour online course that summarises current evidence-based information regarding the introduction, management and withdrawal of antipsychotic medication use for responsive behaviour, when all other non-drug strategies have been unsuccessful.
- Two sets of quick reference cards:
  – *Optimising Antipsychotic Medication Management For Responsive Behaviour cards* (pictured right) provides detailed evidence-based suggestions to manage responsive behaviour, and to start, monitor and withdraw antipsychotic medications for an unresolved responsive behaviour.
  – *Medications That May Adversely Affect Cognition cards* summarises medications commonly prescribed in Australian RACFs which can adversely affect cognition, and adverse effects to monitor for.



- An antipsychotic poster (pictured left) summarising suggested steps to support a person with new responsive behaviour and considerations when starting, monitoring and withdrawing antipsychotic medications for a responsive behaviour.
- Antipsychotic reminder stickers to effectively communicate antipsychotic withdrawal plans and review dates.
- Antipsychotic information sheets for family, friends and staff members.
- Access to the DTA Medication Management app providing recommendations on the optimal use of antipsychotic medications for people with dementia and guidance on medications that adversely affect cognition.
- Access to the Antipsychotic Tracking Tool which graphs and follows over time changes to antipsychotic usage within an organisation.

review process to ultimately contribute towards reducing the number of antipsychotic medications used to support people experiencing a responsive behaviour. To achieve this goal the consultancy works closely with staff members to transition through four key phases of knowledge translation: discovery of new ideas; awareness-raising across all levels of staff; adoption of new processes; and adherence to a sustainable plan.

Phase 1: benchmarking and training

The initial phase of the MMC is targeted at collating baseline information on how antipsychotic medications are managed within the facility. This includes assessing staff knowledge on psychotropic medications through a validated quiz, the baseline antipsychotic usage rates (T1 antipsychotic usage), as well as reflecting on procedures and policies which shape how staff currently manage antipsychotic medications.

This is followed by a period of training and development. During this time, staff are provided with a comprehensive resource suite designed to upskill staff across the entire facility on evidence-based approaches used in supporting a person experiencing responsive behaviour (see box above).

By the completion of this phase staff will have gained an appreciation of the limited role antipsychotic medications play in helping to support a person with dementia. They also have an expanded knowledge of alternative strategies which could be adopted in preference to antipsychotics.

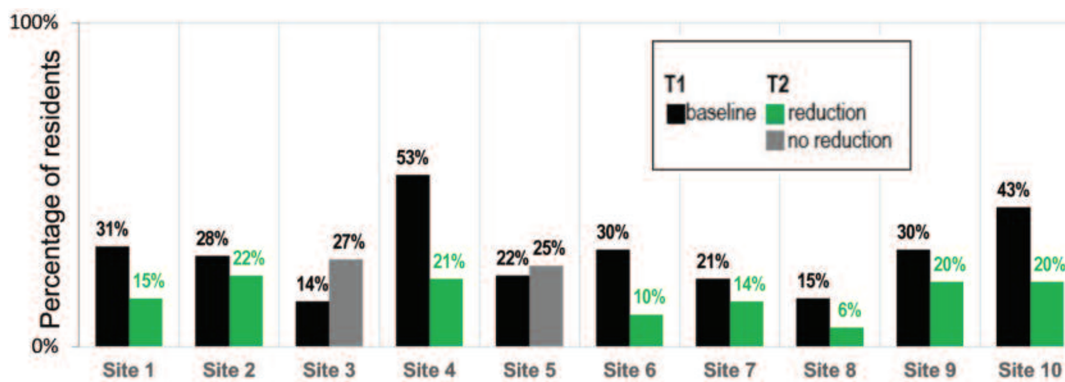
Phase 2: implementation

In phase 2 a multidisciplinary action group within the RACF is convened, representing various providers of care. This may include nurses, care workers and occupational therapists. The group meets via videoconference regularly with the DTA MMC consultant, who provides intensive support and guidance to develop and implement a facility-wide procedure for managing antipsychotic medications within the RACF. This phase of the consultancy takes three to four months. By the completion of this phase the action group will have developed a comprehensive process for identifying, monitoring and reviewing residents' prescribed antipsychotic medications.

Phase 3: adherence

As staff confidence with managing antipsychotic medications increases, the multidisciplinary action group starts to develop a sustainable plan which will shape long-term change within the facility. This plan may form the foundations of a formal antipsychotic policy or procedure, and in some cases may progress into an organisation-wide antipsychotic policy.

Towards the completion of phase 3 the benchmarking process is repeated to measure changes in staff knowledge of psychotropic medications and antipsychotic usage across the facility (T2 antipsychotic usage).



Antipsychotic usage, showing reductions at 8 out of 10 sites from baseline (T1) after delivery of tailored training in medication management (T2)

The results

Over the past two years the MMC has been undertaken by three large residential aged care organisations across Australia, resulting in considerable beneficial changes at a majority of sites. Across 10 sites, there was an average 27% reduction in antipsychotic usage, based on the proportion of residents taking these medications. This reduction was a statistically significant change from T1 to T2 ($p=.037$, Wilcoxon signed-rank test for related pairs). Five of the 10 sites achieved greater than a 50% reduction in the proportion of residents using antipsychotics, with a range between 21% and 67% (see graph above). However, not all sites reported a reduction in antipsychotic use, with two of the 10 sites having an overall increase in the proportion of residents using antipsychotics.

One of the first RACFs to complete the MMC was a small facility with only 39 residents at the commencement of the consultancy. The consultancy took 12 months to complete due to the inherent delays caused by high staff turnover. The facility started with 31% of all residents being prescribed an antipsychotic. At the completion of the consultancy this number had reduced to 15%; however, this almost exclusively comprised new residents transferred to the facility immediately prior to T2. This reduction in antipsychotic medications was coupled with a 30% increase in nursing staff knowledge on psychotropic medications.

The second organisation to engage in a MMC selected three RACFs in NSW to undertake the intensive training which would shape the development of an organisation-wide antipsychotic policy. Two of the three sites focused on developing a robust antipsychotic review process in just the DSU, which was expanded to the rest of the facility following the MMC. Both sites saw a significant reduction in antipsychotic usage in their DSUs, with the proportion of residents prescribed antipsychotics reduced by approximately two thirds when compared to the commencement of the MMC. By the completion of the consultancy a comprehensive antipsychotic policy was developed and forwarded to the organisation's quality assurance team to be rolled out organisation-wide.

The third organisation to engage in a MMC identified four sites across NSW to undertake the service, championed by an in-house dementia specialist who was to work on developing organisation-wide policy change. These four sites have seen the proportion of residents prescribed antipsychotics reduced by between 33% and 60%.

All four sites have anecdotally noted a considerable increase in staff confidence and increased collaboration between professions. This organisation's MMC was run in parallel with a DTA Fellowship, which is another consultancy service offered by DTA that develops leadership and change management skills within an organisation to champion sustainable change. (See p18 for more on the Fellowship Program). In this case, the Fellowship was undertaken by the organisation's dementia specialist, who developed and implemented a new psychotropic consent form and policy. The specialist noted that combining the two DTA consultancies helped build momentum for change by fostering an inclusive relationship with prescribers and family members, engaging them in the stages of change.

This inclusive approach helped to overcome one of the greatest challenges faced in the MMC, that being resistance from families and prescribers. By deeply involving all key stakeholders in the MMC process, they were more informed about the project and why the facility was trying to change, which led to their acceptance of it.

Reshaping how we measure success

Two of the 10 RACFs had an overall increase in antipsychotic usage. The first RACF's usage increased by 14% which, ultimately, was attributed to admissions into the facility. The second site was a relatively small site and undergoing significant

General considerations as to why antipsychotic usage didn't reduce by 100%

Whilst antipsychotics are generally not required for a majority of people with responsive behaviour, a minority experience significant beneficial effects that may justify the use of these medications (for example, a person experiencing severe agitation which puts them at risk of harm).

The MMC is a six-month-long process. Inherently, over this time there are a number of new admissions into the RACF, many of whom may be prescribed antipsychotic medications. As a result, the percentage of residents prescribed antipsychotic medications may increase.

Some residents were prescribed antipsychotic medications for reasons other than a responsive behaviour and therefore withdrawing the antipsychotic medication was clinically inappropriate.

Each action group worked with the consultant to develop an individual plan for the implementation phase of the consultancy. For some, particularly the larger facilities, the developed plan involved focusing on a small section of the RACF. This process was then expanded to the rest of the facility, after T2, distorting the results for this period.

Changes to chemical restraint legislation

On July 1 2019, new legislation was introduced that affects how Australia's residential aged care organisations must monitor and review medications which may be deemed to be a chemical restraint. These changes are to ensure that these medications are reviewed regularly and used for the shortest possible period.

Chemical restraint is defined as, "the use of medication or a chemical substance for the purpose of influencing a person's behaviour other than medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition".

An example of a chemical restraint is using an antipsychotic medication prescribed to stop a resident with dementia 'wandering' at night-time.

The new legislation requires RACFs to provide significant additional documentation regarding residents when restraint is being considered or used. This includes:

- efforts taken to support individuals with non-pharmacological strategies *prior* to commencing a chemical restraint;
- proof of continuous monitoring and withdrawal attempts taken by the facility to minimise the use of restraint.

For more information on the legislation change, see the Australian Government Department of Health website http://bit.ly/31zLJOt

A sustainability plan

By the completion of the consultancy each facility will have developed a sustainability plan which will help embed the changes made through the consultancy into everyday practice. The sustainability plan is individualised to the RACF; plans developed to date include:

- Regular meetings to identify, discuss and review all residents with dementia prescribed antipsychotic medications.
- Inclusion of the DTA antipsychotic resources suite in new staff induction training.
- Monthly antipsychotic usage audits to track changes to antipsychotic usage over time (as aligned with recent changes to the Aged Care legislation, described in the box above).
- Increased collaboration between multidisciplinary team members, both internal and external to the facility.

changes in physical structure and staffing during the MMC. At the start of the MMC this site had a relatively low antipsychotic usage rate (14%), yet at its completion the prevalence of antipsychotic usage had nearly doubled. However, whilst the overall usage increased, the average dose per resident had reduced in alignment with best practice guidelines, which may be considered to be a successful outcome.

Nonetheless, moving forward, a key focus for this site will be reducing the number of residents using antipsychotics.

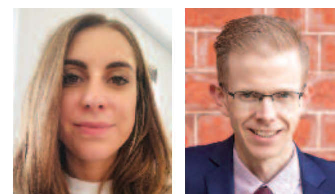
Both sites had progressed to developing an antipsychotic sustainability plan, one which formed part of an organisation-wide policy which will drive future changes to antipsychotic usage.

Both of these results have changed the way DTA assesses the success of MMCs and will shape future improvements in the type of data collected during the antipsychotic auditing process.

The future

As at October 2019, DTA has three MMCs in progress, with a further 21 RACFs scheduled to commence an MMC over the next 12 months.

DTA offers the MMC along with a range of other consultancies and educational services through Tailored Training Packages (TTPs) which are designed to bring about sustainable change within organisations to improve the wellbeing of people living with dementia and the staff who care for them. DTA is currently engaged with about 400 facilities across Australia to deliver tailored training in dementia care.



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Call to action

Begin your journey to improving the use of antipsychotic medications used to support people with dementia you care for by requesting a callback from one of the DTA experts. Visit the DTA website www.dta.com.au or phone (02) 4221 5555. ■

References

Therapeutic Goods Administration (2015) Risperidone And Risk Of Cerebrovascular Adverse Events In Dementia Patients. *Medicines Safety Update* 6(4). Canberra: Therapeutic Goods Administration. Available at: https://bit.ly/2D5G9KQ.

Therapeutic Guidelines Ltd (eTG November 2016 edition). *Dementia: Treatment of Mood And Behavioural Disturbances In Dementia*. Melbourne: Therapeutic Guidelines Ltd. Available at: https://bit.ly/2DmOUBt.

New resources on use of physical and/or chemical restraint

The Aged Care Quality and Safety Commission has released new resources on the use of physical and/or chemical restraint. The *Restraint Scenarios* is a series of 15 case examples: each scenario deals with specific circumstances of an aged care consumer and explores whether the provider's response can be defined as a chemical or physical restraint (each concludes by saying either, 'This IS restraint' or This IS NOT restraint').

There is also an explanation of what kind of ongoing assessment and monitoring is required, as well as the need for documentation and the seeking of consent. The examples are presented as illustrative examples only.

The Commission has also published a new *Regulatory Bulletin: Regulation of Physical and Chemical Restraint* (Issue 8). It outlines the requirements that must be met before and during the use of restraint, and how the Commission will assess the use of restraint in the context of the new quality standards and the Quality of Care Principles. Find both resources under 'Resources' at www.agedcarequality.gov.au.