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HEALTH QUALITY BC

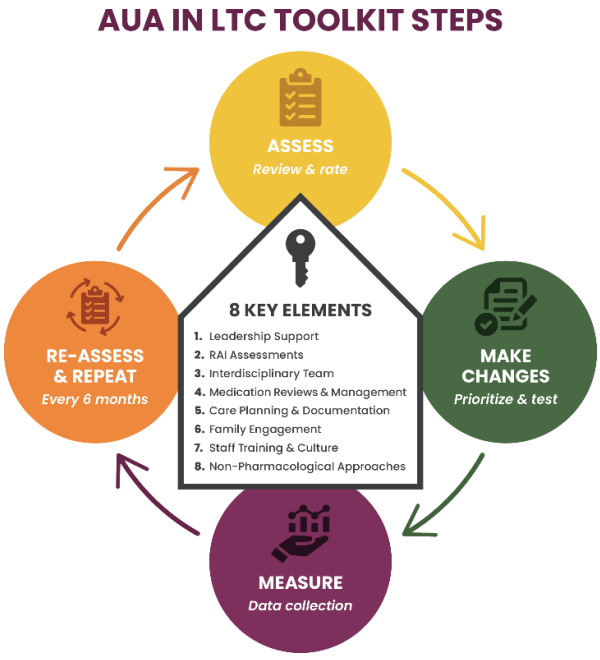
IT STARTS WITH ASKING WHY

Appropriate Use of Antipsychotics in Long-Term Care

TOOLKIT

Thank you for prioritizing the eight key elements to improve the appropriate use of antipsychotics in your long-term care home. Please use this toolkit as a guide for your care team to help identify strengths and opportunities to support quality-of-life improvement efforts for residents, family and staff who live and work there.

The first step is to complete the online self-assessment. The results of the self-assessment will help prioritize actions towards the appropriate use of antipsychotics to manage behaviours. The goal is to identify improvements that your care home can then embed as sustainable practices in your day-to-day operations to reduce unnecessary medications in a safe manner, when appropriate, and to monitor your progress every six months.



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KEY ELEMENT # 1: LEADERSHIP SUPPORT

Why Is Key Element 1 Important?

Long-term care (LTC) homes find great success with the appropriate use of antipsychotics when leadership at all levels prioritize and support staff with the tools to improve this area of care. It is critical that the leadership team model a culture and mindset for staff that embraces a non-pharmacological approach to care. Research shows that effective leadership is directly linked to improved staff outcomes, job satisfaction and reduced turnover which results in continuity, high quality and responsive care.[1]

Self-Assessment Question(s)

1. Leadership at all levels prioritize improving the appropriate use of antipsychotics at your LTC home.

Quality of Life Improvement Strategies

Provided are strategies and resources to consider when working on this key element. You don't need to do all of them at once! Try one or two things at a time so you know what is resulting in an improvement.
Review the items below as a guide for the leadership team to use when supporting staff with a person-and-family centred approach to care.

Knowledge, Skills and Training:

All members of the leadership team:

- Have basic training on how to lead quality improvement initiatives.
- Have enhanced training using non-pharmacological approaches to care with residents who are receiving medications to manage behaviours associated with dementia.
- Have established processes in place to ensure a psychiatric diagnosis must be documented before using antipsychotics to manage behaviours.

Supports:

- The LTC home leadership team works with the respective Health Region LTC senior leadership team to support prioritizing appropriate use of antipsychotics.
- The LTC home leadership team has a communication plan for staff to enhance awareness and implementation of the:
    - BC LTC Services Quality Framework.
    - BC Ministry of Health Home and Community Care Policy: Chapter 6 LTC Services: Policy 6.L: Use of Medications to Manage Behaviours policy to enhance awareness and implementation for staff.
- The LTC home manager has a clinical nurse leader(s) (or similar position) with dedicated time allocated to the appropriate use of antipsychotic work with responsibilities outlined in their job description. This role ideally will have behavioural specialist training and therefore can offer supports to staff for ongoing improvement efforts.
- The LTC home offers onboarding and ongoing training to staff that increases their confidence and competence with using non-pharmacological approaches to manager behaviours, (e.g. Internal training offered by clinical supports, PIECES, UFirst, DementiAbility, GPA) with a process in place to track training completion and evaluation of respective training.

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[1] Edvardsson D. Systems research in long-term care special interest group session: Leadership in long-term care and its association to care worker outcomes in four countries. *Gerontol*. 2016;56:283. [Google Scholar]

Standard Practice:

- All members of the leadership team are part of the Interdisciplinary Team supporting medication management for BPSD and attend bi-weekly huddles.
- The LTC home has established processes in place for staff to discuss care issues with the leadership team, for example:
  Each week, one member of the leadership team conducts a regular leadership walkaround with the goal of spending time with direct care staff, residents, families/caregivers to hear about issues and concerns on the unit/village/home. Leaders are visible, engaged and interactive with staff and ask questions, such as:
  - What can I do to help?
  - What do you need to make this better?
  - How could we have done this another way?
  - What matters to you (get specific about the appropriate use of antipsychotics)?

How Do We Know We Are Making an Improvement?

All improvement requires change, but not all change is an improvement! Measurement is an essential part of improvement. Your data needs to accurately reflect what changes you will try as part of your quality-of-life improvements focused on the appropriate use of antipsychotics. Provided are some data collection examples for this key element:

- % of leadership staff with basic training in Quality Improvement
- % of nursing staff certified in the PIECES Program
- % of staff certified in DementiAbility
- % of residents with a documented psychiatric diagnosis in care plan before prescribing antipsychotics to manage behaviours.
- Attendance rates of leadership staff at Interdisciplinary Team huddles focused on supporting medication management for BPSD
- # of weekly walk arounds completed each month

Additional Quality Improvement Resources

Healthcare Excellence Canada and Health Quality BC – Quality Improvement Workshop Workbook
This workbook is supplemental to a QI workshop delivered by Healthcare Excellence Canada and created in partnership with Health Quality BC. It is intended to assist your quality improvement learning journey and guide quality improvement efforts.

Sharpen Your Skills with Health Quality BC workshops - watch for upcoming sessions
Interactive workshops provide opportunities for learners to dive deep into specific topics related to improving quality of care.

KEY ELEMENT # 2: INTERDISCIPLINARY TEAM – SUPPORTING MEDICATION MANAGEMENT FOR BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD)

Why Is Key Element 2 Important?

An interdisciplinary team approach is when different types of staff work together in a structured way to share expertise, knowledge and skills to manage physical, psychological and spiritual needs of the resident. This approach to care is extremely important when working with older adults with more complex needs where there is an increase in complexity of skills and knowledge required to provide the care that is needed. Evidence shows that an interdisciplinary team approach improves outcomes such as: communication; leadership and management; personal development; quality of care; appropriate skill mix, process and resources; relationships; respecting and understanding roles; and clarity of vision and values[2].

Self-Assessment Question(s)

1. LTC home has an active Interdisciplinary Team who supports medication management for residents with Behavioural and Psychological Symptoms of Dementia (BPSD).
2. LTC home has a Clinical Nurse Leader(s) or designate with allocated time in their role to coordinate efforts towards the appropriate use of antipsychotics.

Quality of Life Improvement Strategies

Provided are strategies and resources to consider when working on this key element. You don't need to do all of them at once! Try one or two things at a time so you know what is resulting in an improvement.
Review the items below as a guide to support your care home with the implementation of an active Interdisciplinary team whose role is to support medication management for residents with BPSD.

Interdisciplinary Team in LTC Homes:

- Are engaged and actively involved to address complex needs in residents, often due to behavioural and psychological symptoms of dementia (BPSD).
- Meet regularly (e.g. weekly, bi-weekly, minimum monthly behaviour rounds/huddles depending on the needs of the care home) for 30 minutes to support appropriate medication use, specifically antipsychotics, to ensure successful outcomes.
- Are empowered with the time, resources and accountability for this area of focus to help implement a sustainable path for the long-term.
- Includes diverse skills and perspectives to promote communication and a shared understanding of the opportunity the care home has to improve the safety and care of the residents. Roles and responsibilities are clearly defined.

[2] Nancarrow SA, Booth A, Ariss S, Smith T, Enderby P, Roots A. Ten principles of good interdisciplinary team work. Hum Resour Health. 2013 May 10;11:19. doi: 10.1186/1478-4491-11-19. PMID: 23663329; PMCID: PMC3662612.

Interdisciplinary Team Member Roles and Responsibilities:

An Interdisciplinary Team will assess, coordinate and manage each resident's comprehensive health care, including their medical, psychological, social and functional needs[3]. The resident and/or family/caregivers meet with the team. (e.g. care conferences, informed consent) to provide information when needed and participate in family meetings when appropriate.

Use the Interdisciplinary Team Roles and Responsibilities Template to identify the most appropriate person for each role and add or remove responsibilities based on your care home structure.

Guide to Interdisciplinary Team Meeting:

- Schedule a reoccurring 30-minute meeting for the interdisciplinary team (adjust time accordingly).
- Review documentation for each resident on antipsychotic medication.
- Round table input from each interdisciplinary team member for each resident.
- Strategize and document an action plan with clear delegation for each team member, including updates to care plans.
- Use a binder to file documentation alphabetically and put a copy in resident chart.

Sample Documentation:

- Review all Referral Forms, if no referrals pull from list of residents on antipsychotics
- Resident specific pertinent information: e.g. RAI Outputs (sections E, F, M, pain management, social isolation), triggered Clinical Assessment Protocols (CAPs) (new or existing), ADL sheet, Care Plan/Kardex
- Pharmacological Restraint Management Worksheet
- Geriatric Interdisciplinary Review Team (GIRT) Round Summary

External Supports:

Accessing external roles can be extremely helpful with sustainability of the appropriate use of antipsychotics in your care home. These roles can provide additional education, data/measurement and quality improvement supports. Ensure you are connecting with your respective health authority/region support staff:

- Behavioural Care Specialists
- Clinical Nurse Specialists
- Educators
- Quality Resource Leaders, Quality Improvement Advisors, Regional Knowledge Coordinators
- Regional Practice Leads

How Do We Know We Are Making an Improvement?

All improvement requires change, but not all change is an improvement! Measurement is an essential part of improvement. Your data needs to accurately reflect what changes you will try as part of your quality-of-life improvements focused on the appropriate use of antipsychotics. Provided are some data collection examples for this key element:

- # of Interdisciplinary Team huddles held per month
- Monthly attendance rates at Interdisciplinary Team huddles

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[3] Stefanacci R, Brown G, Reich S. Behind the Scenes at Nursing Facilities. In: *Post-Acute and Long-Term Medicine*. 2nd ed. Fenstemacher PA, Winn P, eds. Springer International Publishing; 2016:51-72.

Additional BPSD Resources

BPSD Algorithm

The BC BPSD algorithm is a practical, electronic and interactive tool that supports interdisciplinary, evidence-based, person-centered care for persons with behavioural and psychological symptoms of dementia (BPSD). The BC BPSD tool has a specific focus on non-pharmacological interventions and the appropriate use of antipsychotic drugs in long-term care settings. Care staff, family physicians, clinical experts, and health care settings in all of British Columbia's health authorities are encouraged to review the guideline and algorithm, as they offer evidence-based tips and tools to deliver best practice, non-pharmacological approaches to person-centred dementia care. Click here to access the tool. The algorithm is intended to be combined with the BPSD Best Practice Guideline.

Canadian Clinical Practice Guidelines for assessing and Managing Behavioural and Psychological Symptoms of Dementia (BPSD)

These guidelines provide evidence-based recommendations to assess and manage BPSD and are intended to inform shared decision-making among people living with dementia, caregivers of people living with dementia and health care providers (e.g. nurses, family physicians, specialist clinicians, and providers from other health disciplines), in Canada. The guidelines are also meant to support health care leaders, policymakers and researchers to understand future areas to develop health services and interventions to prevent and reduce BPSD.

Depresribing.org - Antipsychotic Deprescribing Algorithm

It is essential to start with asking why, why is the resident taking an antipsychotic. Depresribing.org has an antipsychotic deprescribing algorithm to assist your care home with efforts including: recommendations on how to taper and stop antipsychotics, monitoring, alternate drugs, tapering doses, engaging residents and families, antipsychotic side effects, sleep management, BPSD management and relapse suggestions.

High Five Report and Huddle Preparation Check List

Use this tool to guide your person-centred care approaches, especially in caring for residents living with BPSD. Share by Island Health LTC team.

KEY ELEMENT # 3: MDS RAI/INTERRAI ASSESSMENTS

Why Is Key Element 3 Important?

RAI assessments are an important tool to identify the mental, physical and social needs of the resident you are caring for, improving their quality of life and enhancing their independence[4]. Information from RAI assessments collect critical information on Clinical Assessment Protocols (CAPs) and Outcome scales that inform an individualized person-centered care plan. RAI assessments inform data that is used as performance measures and targets such as the potentially inappropriate use of antipsychotics. If assessments are not completed for each resident quarterly or are coded incorrectly, this could lead to inaccurate reflection of what is happening at the care home level.

Fun Fact: The three BC LTC homes with the biggest overall reduction in their potentially inappropriate use of antipsychotics rates after participating in the Reimagining LTC program in 2023 focused their efforts on RAI coding and training. Overall decreases in the top three homes were 30.8%, 30.6% and 27.1% respectively.

Self-Assessment Question(s)

1. Clear processes are established to ensure timely and accurate MDS-RAI/interRAI assessments are completed for each resident on a quarterly basis.

Quality of Life Improvement Strategies

Provided are strategies and resources to consider when working on this key element. You don't need to do all of them at once! Try one or two things at a time so you know what is resulting in an improvement.
Review the items below as a guide to ensure processes are in place to embed best practice when completing, monitoring and utilizing information from RAI assessments to best inform each residents individualized care plan and monitor the appropriate use of antipsychotics.

- All nurses are trained to complete RAI assessments and have most current training (each Health Authority/Region offers RAI training, contact your respective RAI team for this information).
- RAI assessments for every resident are completed quarterly.
- A review process is in place to ensure RAI assessment coding and interpretations are accurate.
- Assessments are updated when a resident's condition and/or behaviour changes.
- RAI assessment results are monitored and shared with staff, including the Interdisciplinary team.
- To support the Interdisciplinary team, include what RAI indicators need to be reviewed to measure the appropriateness of antipsychotics.
  Examples:
  - If outputs (Outcome Scales and Clinical Assessment Protocols) of the RAI are triggered then it would cue residents to be reviewed at the weekly Interdisciplinary team huddle.
  - If targeting certain indicators e.g. pain, ABS, DRS, functional decline/improvement - use RAI outcome Scores for medication.

[4] Canadian Institute for Health Information. About the interRAI Long-Term Care Facilities Assessment [info sheet]. Ottawa, ON: CIHI; 2023.

How Do We Know We Are Making an Improvement?

All improvement requires change, but not all change is an improvement! Measurement is an essential part of improvement. Your data needs to accurately reflect what changes you will try as part of your quality-of-life improvements focused on the appropriate use of antipsychotics. Provided are some data collection examples for this key element:

- % of nursing staff who have current MDS RAI/interRAI training
- RAI assessment completion rates
- % of RAI coding errors

Additional RAI Coding Resources

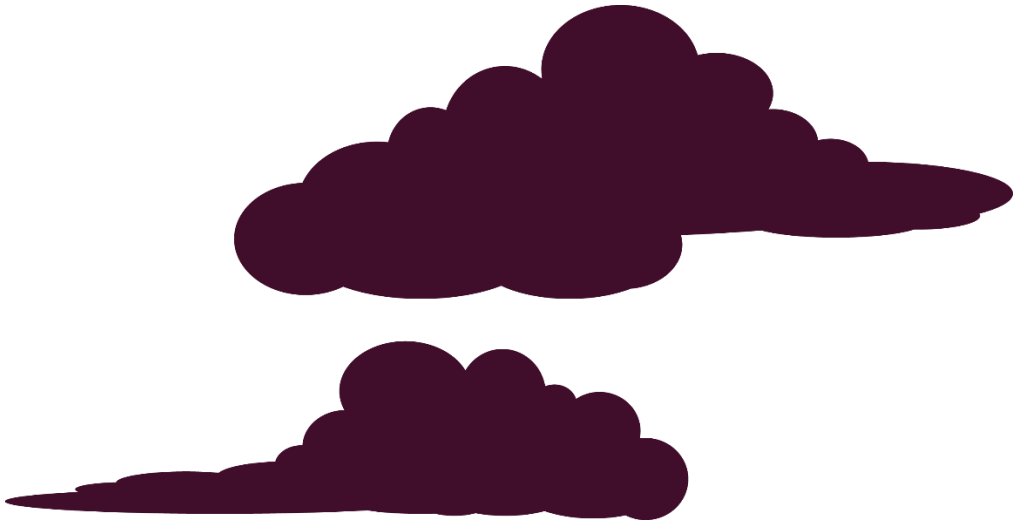
Describing Outcome Scales (RAI-MDS 2.0)

interRAI LTCF: Understanding the Potentially Inappropriate Use of Antipsychotics Quality Indicator

interRAI LTCF: What's Different

RAI-MDS 2.0: Understanding the Potentially Inappropriate Use of Antipsychotics Quality Indicator

Webinar Recording: Benefits of Implementing and Using the interRAI LTCF: What's Different



KEY ELEMENT # 4: MEDICATION REVIEWS AND MANAGEMENT

Why Is Key Element 4 Important?

Medication reviews and appropriate medication management are important processes to ensure medications like antipsychotics are used at the right time and the right place – a key component of person-and-family centred care. It's an opportunity to identify medications that may no longer be needed or medications that can be optimized.

Self-Assessment Question(s)

1. LTC home has a standardized behaviour tracking process established to review and document all residents on antipsychotics without a diagnosis **within 6 weeks of admission**.
2. Once a resident is stable, LTC home has a standardized behaviour tracking process established to review and document all residents on antipsychotics without a diagnosis on a **quarterly basis**.

Quality of Life Improvement Strategies

Provided are strategies and resources to consider when working on this key element. You don't need to do all of them at once! Try one or two things at a time so you know what is resulting in an improvement.

Review the items below as a guide to ensure processes are in place to embed best practice for medication management when documenting and monitoring information from medication reviews for residents prescribed antipsychotic medication without a diagnosis.

Staff Education

- Ensure an education and implementation plan is in place for all staff to understand and adhere to the Use of Medications to Manage or Modify Behaviours Home and Community Care Policy 6.L. Health Authority/Regional supports are available for communication and implementation of this policy.
  LTC home Leadership teams can review examples of education to support staff with implementation of best practice:
  - Clinical Practice Guides, decision support tools, algorithms to provide a standard way to support staff;
  - Standardized checklists, tools/forms, e.g informed consent;
  - Specific job descriptions with clear roles and responsibilities to reduce the use of antipsychotics; and
  - Quality Assurance/evaluation measures and oversight.

Medication Reconciliation

- Clear processes are outlined to ensure medication reconciliation is completed by Interdisciplinary Team on admission and with each transition of care including:
  - Information from informed consent is received from resident or substitute decision maker prior to decision to start new medication.
  - Standardized behaviour tracking process established to review and document for all residents on antipsychotics without a diagnosis.
- When reconciling antipsychotic medication, ensure documentation includes:
  - Physician communication and sign off;

- Physician input and documentation on diagnosis (e.g. prescribers may include a diagnosis, but it may not be on the exclusion criteria list. If we state person is end of life/end stage disease (not necessarily actively dying) and antipsychotics is for comfort care, then this would be an exclusion criterion); and
- Follow up items and communication are assigned and completed.

Medication Management

- Monitor behaviour trends and adverse effect changes from resident baseline functioning.
- When behaviours are stable, Interdisciplinary Team works together to consider reduction with goal of discontinuation if appropriate or alternate approved medication.
- Document using best practice tools used for responsive behaviour assessment and tracking (other examples: Dementia Observation System (DOS), Richmond Agitation-Sedation Scale, Cornell Assessment Scale for Depression in Dementia)
- Interdisciplinary Team conducts monthly assessments for identified residents on antipsychotics without diagnosis.
- Monthly assessments include monitoring active review list by assessing indication for each resident and drug (if indication is BPSD or no indication is available, resident is included in monthly review, if resident has approved diagnosis, they are excluded from review)
  Examples:
  - Antipsychotic medications are used only if appropriate and following recurrent assessment.
  - Antipsychotic medications will be considered only after non-pharmacological strategies have been trialed and reviewed.

Medication Reviews

- Quarterly re-assessment medication reviews are conducted with RAI assessments. Why every 3 months? There are many instances of having residents go on antipsychotics and never be reassessed for efficacy and multiple (pages even) medication administration record (MAR) entries of no effect for a specific behaviour but still medication is administered.
- Include medication needs assessments and prescribing.
- Ensure assessment/medication review occurs following subtle (episodic) changes in behaviours or condition.
- Use tools to monitor and review resident following recognition of changes in behaviour or medication initiation.

How Do We Know We Are Making an Improvement?

All improvement requires change, but not all change is an improvement! Measurement is an essential part of improvement. Your data needs to accurately reflect what changes you will try as part of your quality-of-life improvements focused on the appropriate use of antipsychotics. Provided are some data collection examples for this key element:

- # and % of residents in the target group with reduced dose of antipsychotics
- # and % of residents in the target group discontinued from antipsychotics, and not returned
- % of targeted residents on more than 9 medications
- % of residents with updated medication review in last 30 days
- # of residents who received a PRNs for antipsychotics

KEY ELEMENT # 5: CARE PLANNING AND DOCUMENTATION

Why Is Key Element 5 Important?

Care plans provide staff with guidance on how best to meet the unique needs of each individual living in long-term care. Care plans provide a comprehensive picture of what matters to a person and their family and is used to communicate information that is important in the care journey of the person. Care planning reduces harm and can increase safety, particularly around the appropriate use of antipsychotics.

Self-Assessment Question(s)

1. Upon admission, clear processes are in place to include family and caregivers with developing and updating a care plan that best prevents or responds to distressed reactions and triggers.
2. All residents have an effective person-centered, individualized care plan that is updated on a quarterly basis.

Quality of Life Improvement Strategies

Provided are strategies and resources to consider when working on this key element. You don't need to do all of them at once! Try one or two things at a time so you know what is resulting in an improvement.
Review the items below as a guide to ensure processes are in place to embed best practice when developing and maintaining individualized person-centred care plans to support residents with the appropriate use of antipsychotics.

Admission:

- Hold a care meeting with resident and family as soon as possible to discuss strategies for the resident, ideally before the resident moves into LTC home. If a resident lives in another community, this might not be possible prior to moving.
- Ensure an open-door approach during the process of moving in as the resident is settling in. This can be helpful for the team to learn together.
- Standardize admission/intra-admission procedures and forms for residents coming in on antipsychotics, include tapering plan and response to distressed reactions and triggers.
- Ensure admissions procedures are coordinated with family and caregivers, which includes education around looking past the purple dot and avoiding stigmatism related to dementia behaviours.
- Scheduling a care conference within the first month helps optimize shared learnings and build a foundational plan that looks at the year ahead.

Staff Supports:

- Provide staff with a guide for care planning and a behaviour mapping tool to prevent and manage responsive behaviours.
- Ensure all care plans include a comprehensive geriatric assessment.
- Non-pharmacological individualized strategies are to be included in all care plans with input from family/resident, documentation includes what therapies have been trialled for effectiveness. Include triggers and distressed reactions for a resident exhibiting BPSD.
- Use a template for visual cues (e.g. laminated cards, My Story, All About Me) and place at points of care delivery to remind all team members about successful approaches to comfort and reduce stress for resident.
- Embed a process that supports prescribers to have access to care plans to provide documentation.

How Do We Know We Are Making an Improvement?

All improvement requires change, but not all change is an improvement! Measurement is an essential part of improvement. Your data needs to accurately reflect what changes you will try as part of your quality-of-life improvements focused on the appropriate use of antipsychotics. Provided are some data collection examples for this key element:

- % of residents who have individualized person-centred care plans
- % of residents with All About Me posters in their room
- % of residents with Behaviour Mapping documentation in care plan
- % of care plans with resident and/or caregiver input

Additional Comprehensive Geriatric Assessment Resources

- Interprofessional Comprehensive Geriatric Assessment Toolkit
  Online toolkit providing foundational information and learning resources related to Comprehensive Geriatric Assessment.

KEY ELEMENT # 6: FAMILY ENGAGEMENT

Why Is Key Element 6 Important?

Family members know the resident and have the best insight for alternative ways to deal with situations other than medication. Loved ones want to trust the home that their family members are in, and this trust grows when they are involved and part of the care team.

Self-Assessment Question(s)

1. Families and caregivers are provided education on dementia care and risks of using antipsychotics.
2. LTC home has a process in place to ensure informed consent is received by resident or substitute when antipsychotic medications are used as part of a health care treatment.

Quality of Life Improvement Strategies

Provided are strategies and resources to consider when working on this key element. You don't need to do all of them at once! Try one or two things at a time so you know what is resulting in an improvement.

Review the items below as a guide for your care home staff to use when supporting families with understanding the impact antipsychotic medications have when used to manage behaviours.

Education and Resources:

Compile a list of resources and learning opportunities for residents, families and caregivers:

- Offer family education sessions on dementia and antipsychotics. Ideally facilitated by care home physician and/or pharmacist at family council meetings.
- Provide resources and education materials to support residents and families:
    - Dementia resources
    - Delirium Prevention and Care With Older Adults
    - Antipsychotic Medication use
    - Advanced care planning and Medical Orders for Scope of Treatment (MOST)

What Matters to You (WMTY):

Embrace a WMTY culture to support staff with family engagement:

- A WMTY focus helps us see the person and their story, to support meaningful conversations around medication use.
- Residents and families are the true experts on their own needs and experiences. Asking, listening and responding to what matters to residents and families is a key feature of person-and family-centred care. Download or order resources to share with your staff.
- Make the medication fit with the person's story – find and encourage sharing of a person's story to give greater understanding of the medications needed.
- Design care conferences to tease out how WMTY fits with each part of the team for the year ahead. It can be useful to have a care conference cheat sheet to help staff with preparation and examples of open-ended questions to understand each resident's unique story.

Informed Consent:

Informed consent is critical to obtain for care plans to be effective. Residents or substitute decision makers need to be informed on the rationale for considering antipsychotic medications, the benefits and potential side effects, along with detailed timeframe of review and reassessment for the medication being given.

- Use the Informed Consent template to document standardized information before giving antipsychotic medication as part of a health care treatment.

How Do We Know We Are Making an Improvement?

All improvement requires change, but not all change is an improvement! Measurement is an essential part of improvement. Your data needs to accurately reflect what changes you will try as part of your quality-of-life improvements focused on the appropriate use of antipsychotics. Provided are some data collection examples for this key element:

- # of family education sessions focused on risks of antipsychotics
- Satisfaction rates of family education sessions
- % of residents/family care partners satisfied with experience of care
- % of substitute decision makers providing consent before medications are used as part of a health care treatment

Additional Family Engagement Resources

- Plain language dementia resources to print and share-filtered by language
- "What Matters to Me" – a new vital sign – Jason Leitch – Ted Talk

KEY ELEMENT # 7: STAFF TRAINING AND CULTURE

Why Is Key Element 7 Important?

A well-trained workforce is critical to providing high-quality, person and family-centred care. Training ensures that staff are both competent and confident in managing the appropriate use of antipsychotics in their care homes.

Self-Assessment Question(s)

1. All staff who interact with residents receive onboarding and ongoing education for person-centered approach to care delivery (e.g. DementiAbility, GPA, PIECES, UFirst, Palliative Care approach).
2. All staff who interact with residents embed person-centered approaches to care delivery into daily practice and workplace culture.

Quality of Life Improvement Strategies

Provided are strategies and resources to consider when working on this key element. You don't need to do all of them at once! Try one or two things at a time so you know what is resulting in an improvement.
Review the items below as a guide to equip staff with the tools and resources to embed person-centred care into daily practice.

Staff Training and Education:

It is critical that training happens during orientation, but also ongoing to ensure there are opportunities for staff to build skills, confidence and strengthen team culture supporting the appropriate use of antipsychotics.

- Ensure staff have access to a list of available training opportunities and resources, which includes palliative care approaches, palliative symptom management guidelines, health authority/region education and other person-centred care training. Include orientation guides for training of new hires.
- Provide a guide to support practical application of BPSD and person-centred non-pharmacological approaches:
    - Access free dementia resources
    - Have visual cues for staff e.g. PIECES approach, BPSD Algorithm
    - Include ongoing practice scenarios to incorporate with care team (e.g. at huddles) to improve helpful responses and the use of care principles to reduce BPSD
    - Implement a care coach model to offer mentorship support for staff.

Workplace Culture:

Evidence shows that workplace culture is correlated with resident outcomes and rates of adverse events. If we can improve culture, we can improve outcomes and decrease adverse events.

- Provide resources to staff on workplace culture with a plan on how to measure to inform action.
- Explore training programs like the Teamwork and Communication Action Series for interdisciplinary teams who want to improve their teamwork and communication.

How Do We Know We Are Making an Improvement?

All improvement requires change, but not all change is an improvement! Measurement is an essential part of improvement. Your data needs to accurately reflect what changes you will try as part of your quality-of-life improvements focused on the appropriate use of antipsychotics. Provided are some data collection examples for this key element:

- % of staff reporting confidence in person-centred management of responsive behaviours
- % of staff reporting confidence with using medications as last resort to manage specific behaviours (e.g. extreme aggressiveness, agitation)
- # of HCA staff trained in UFirst program.
- # of staff trained/certified in DementiAbility program

Additional LTC Standards Resources

Long-Term Care Services HSO Standards

Focus is on LTC Services and building a healthy workforce to promote person-centred care.

Mental Health and Well-Being in Long-Term Care and Assisted Living

The 3rd national standard CSA Z2004:24 includes people who live in Assisted Living as well. The standard is free to download!! This standard is complementary to the other two national LTC standards.

Media release July 23, 2024

KEY ELEMENT # 8: NON-PHARMACOLOGICAL APPROACHES TO CARE

Why Is Key Element 8 Important?

Non-pharmacological approaches must be exhausted before using medications to manage behaviours. The only time medications should be used to manage behaviours is "when there is a significant risk of harm to the person or others, or when agitation with aggressive symptoms are persistent, recurrent or severe enough to cause significant suffering and distress to the person or may cause significant interference with the delivery of care"[5].

Self-Assessment Question(s)

1. All staff are trained to know that non-pharmacological interventions are best practice to managing behaviours and the use of medications to manage specific behaviours, (e.g. extreme aggressiveness, agitation) are used as a last resort, and only to be considered when all other interventions have been exhausted and a clinical assessment rules out remedying other possible causes (e.g. pain, discomfort, urinary tract infection, delirium).
2. All staff support, model and prioritize non-pharmacological interventions before using medications to manage behaviours.

Quality of Life Improvement Strategies

Provided are strategies and resources to consider when working on this key element. You don't need to do all of them at once! Try one or two things at a time so you know what is resulting in an improvement.

Review the items below as a guide to equip staff with non-pharmacological strategies to mange behaviours without antipsychotic medication.

Understanding the Resident:

- Understand and address the cause of the symptoms and resolve or minimize challenges to the resident's comfort and experience.
- Ensure a sufficient trial of non-pharmacological approaches has been completed prior to the discussion of pharmacotherapy. Use a decision-making tool to determine causes of behaviour.

Understanding the Staff:

- Survey staff to understand confidence levels when using non-pharmacological approaches to replace medications (should include questions regarding fear-based decisions).
- Develop a process that supports action planning to address any barriers to staff confidence in this area. Use same survey tool to re-assess and monitor improvements in this area.

Support Tools:

- Share with staff some support tools for the management of BPSD using non-pharmacological intervention strategies.

[5] Home and Community Care Policy Chapter 6, Section L: Use of Medications to Manager or Modify Behaviours

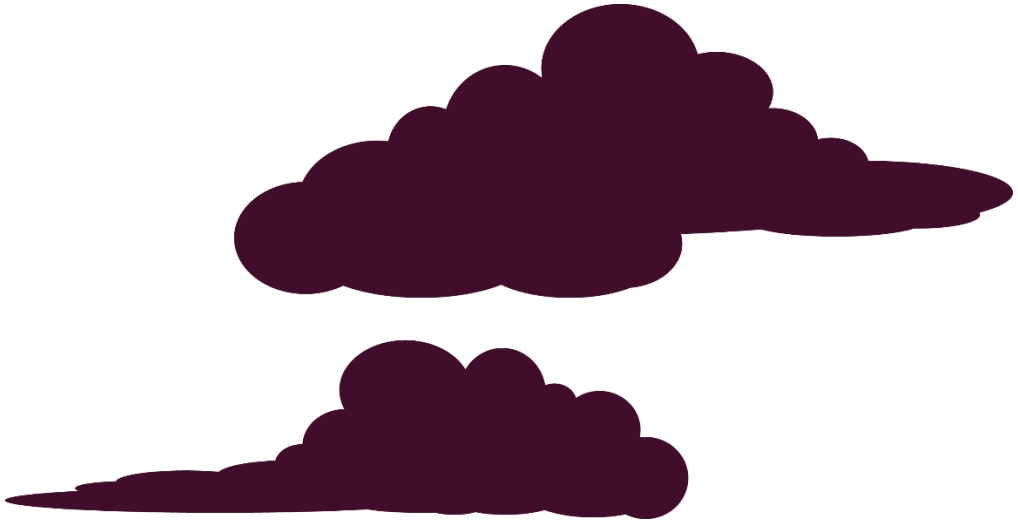
How Do We Know We Are Making an Improvement?

All improvement requires change, but not all change is an improvement! Measurement is an essential part of improvement. Your data needs to accurately reflect what changes you will try as part of your quality-of-life improvements focused on the appropriate use of antipsychotics. Provided are some data collection examples for this key element:

- # of targeted residents engaged in music program activity
- # of residents participating in social programming per month
- % of 1:1 contact time in target group with student ambassador

Additional Non-Pharmacological Resources

- Alternative Treatments for Dementia from The Alzheimer's Society
- BC Guidelines for Non-Pharmacological Approaches for Managing Pain
- Categories for Specific Non-Pharmacological Approaches for BPSD and Possible Approaches
- Interactive Projection and Sensory tables
    - The Tovertafel console
    - Lucynt magic table dementia games | Alzheimer's care | Interactive Games
    - Obie For Seniors
    - Budii Eldercare At-Home Interactive Activity Projector | SensoryOne
- Student Ambassador role e.g.; high school student, volunteer or casual paid position(s) to increase 1:1 contact time with residents on antipsychotics and at risk for social isolation.
- Virtual Reality in LTC Implementation Guide – targeted therapeutic intervention



ABOUT HEALTH QUALITY BC

Our purpose is improving health care quality across British Columbia.

Our work is to build a foundation of quality, and our impact means better health care for British Columbians.

We do this by delivering the latest knowledge from home and abroad to champion and support high-quality care for every person in BC. This system-wide impact requires creativity, innovative thinking, and evidence-informed strategies to shift culture, improve clinical practice and accelerate health care partners' improvement efforts.

We are uniquely positioned to build strong partnerships with patients and communities, care providers, health leaders, policymakers, senior executives, academics and others. These connections enable us to nurture networks, recognize the needs of BC's health care system and build capacity where it is needed the most. We provide advice and make recommendations to the health system, including the Minister of Health, on matters related to quality of care across the province.

If you have specific questions about this toolkit, please contact us at longtermcare@healthqualitybc.ca.