Appropriate Use of Antipsychotics Project

Responsive Behaviours and Sleep

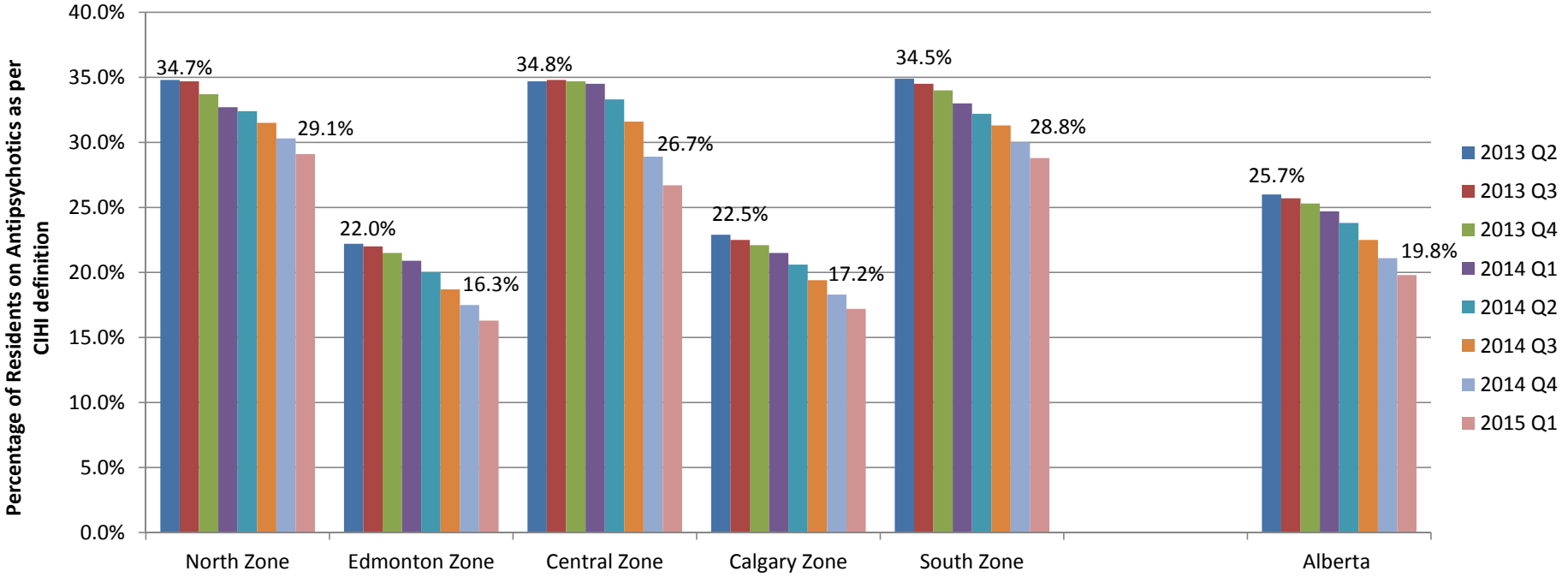
Seniors Health Strategic Clinical Network (SCN)

In collaboration with Addiction & Mental Health SCN

Alberta Health Services

Alberta LTC Reduction of Antipsychotics

Q1 2015-16 (CIHI) Provincial average 19.8%



You've accomplished so much!

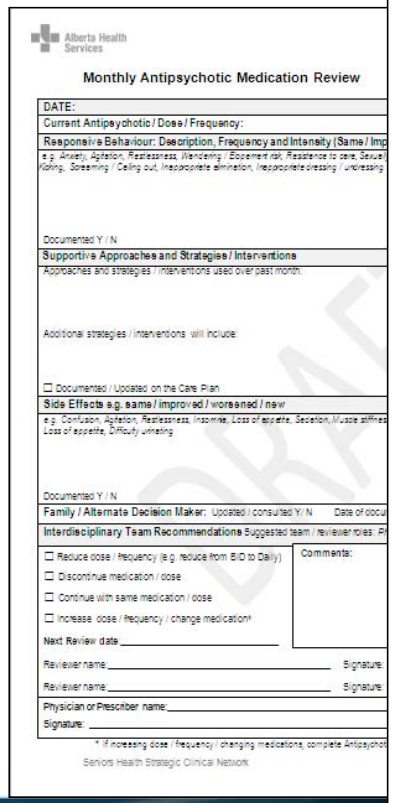
Team Introductions

- Introduce your team/family member
  - Names and roles
- Provide a quick overview
  - Current antipsychotic use
  - Successes/Stories/Ideas
  - Challenges
  - Confidentiality

Resources to Support Sustainability

Continue Monthly Antipsychotic Reviews

- Trial new AUA worksheets
  or continue current processes
- Send feedback on drafts to
  aua@albertahealthservices
  by November 30, 2015



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Monthly Antipsychotic Medication Review

DATE:

Current Antipsychotic / Dose / Frequency:

Responsive Behaviour: Description, Frequency and Intensity (Same / Imp

e.g. Anxiety, Agitation, Restlessness, Wandering / Elopement risk, Resistance to care, Sexual
Kicking, Screaming / Calling out, Inappropriate elimination, Inappropriate dressing / Undressing

Documented Y / N

Supportive Approaches and Strategies / Interventions

Approaches and strategies / interventions used over past month:

Additional strategies / interventions will include:

☐ Documented / Updated on the Care Plan

Side Effects e.g. same / improved / worsened / new

e.g. Confusion, Agitation, Restlessness, Insomnia, Loss of appetite, Sedation, Muscle stiffnes
Loss of appetite, Difficulty urinating

Documented Y / N

Family / Alternate Decision Maker: Updated / consulted Y / N Date of docu

Interdisciplinary Team Recommendations Suggested team / reviewer roles. Pl

☐ Reduce dose / frequency (e.g. reduce from BID to Daily)
☐ Discontinue medication / dose
☐ Continue with same medication / dose
☐ Increase dose / frequency / change medication*

Comments:

Next Review date _____

Reviewer name _____ Signature

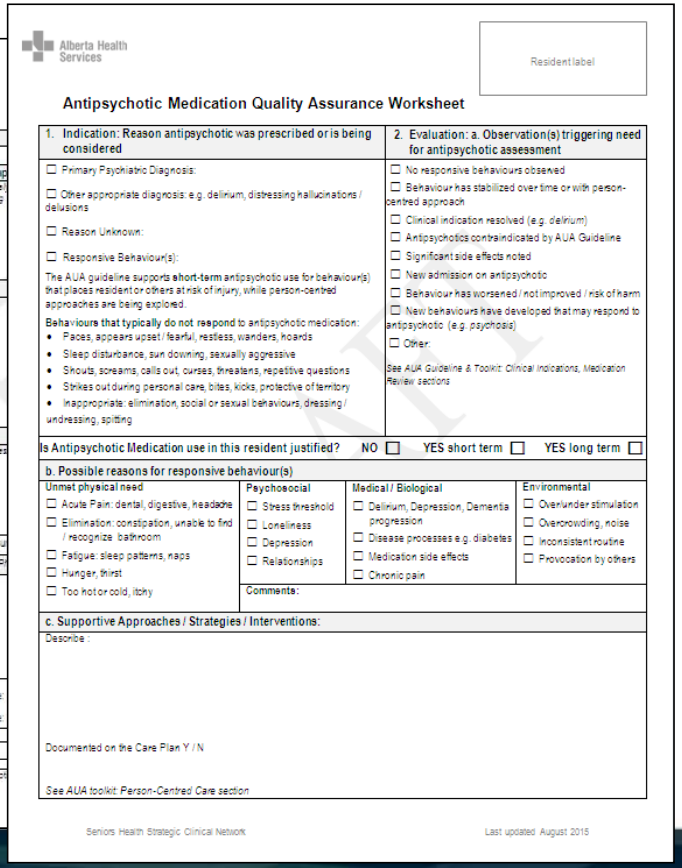
Reviewer name _____ Signature

Physician or Prescriber name: _____

Signature: _____

* If increasing dose / frequency / changing medications, complete Antipsychot

Seniors Health Strategic Clinical Network



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Resident label

Antipsychotic Medication Quality Assurance Worksheet

1. Indication: Reason antipsychotic was prescribed or is being considered	2. Evaluation: a. Observation(s) triggering need for antipsychotic assessment
☐ Primary Psychiatric Diagnosis: ☐ Other appropriate diagnosis: e.g. delirium, distressing hallucinations / delusions ☐ Reason Unknown: ☐ Responsive Behaviour(s): The AUA guideline supports short-term antipsychotic use for behaviour(s) that places resident or others at risk of injury, while person-centred approaches are being explored. Behaviours that typically do not respond to antipsychotic medication: • Paces, appears upset / fearful, restless, wanders, hoards • Sleep disturbance, sun downing, sexually aggressive • Shouts, screams, calls out, curses, threatens, repetitive questions • Strikes out during personal care, bites, kicks, protective of territory • Inappropriate: elimination, social or sexual behaviours, dressing / undressing, spitting	☐ No responsive behaviours observed ☐ Behaviour has stabilized over time or with person-centred approach ☐ Clinical indication resolved (e.g. delirium) ☐ Antipsychotics contraindicated by AUA Guideline ☐ Significant side effects noted ☐ New admission on antipsychotic ☐ Behaviour has worsened / not improved / risk of harm ☐ New behaviours have developed that may respond to antipsychotic (e.g. psychosis) ☐ Other: *See AUA Guideline & Toolkit: Clinical Indications, Medication Review sections*

Is Antipsychotic Medication use in this resident justified? NO ☐ YES short term ☐ YES long term ☐

b. Possible reasons for responsive behaviour(s)

Unmet physical need	Psychosocial	Medical / Biological	Environmental
☐ Acute Pain: dental, digestive, headache ☐ Elimination: constipation, unable to find / recognize bathroom ☐ Fatigue: sleep patterns, naps ☐ Hunger, thirst ☐ Too hot or cold, itchy	☐ Stress threshold ☐ Loneliness ☐ Depression ☐ Relationships	☐ Delirium, Depression, Dementia progression ☐ Disease processes e.g. diabetes ☐ Medication side effects ☐ Chronic pain	☐ Overlunder stimulation ☐ Overcrowding, noise ☐ Inconsistent routine ☐ Provocation by others

Comments:

c. Supportive Approaches / Strategies / Interventions:

Describe :

Documented on the Care Plan Y / N

See AUA toolkit: Person-Centred Care section

Seniors Health Strategic Clinical Network Last updated: August 2015

Resources to Support Sustainability

Continue Monthly Antipsychotic Reviews

- Enter data on the new excel tracking tool (optional) and share graphs with staff
- Discuss expectations for reporting with your organization, area or zone leaders

Alberta Health Services

Measures of Success of Appropriate Use of Antipsychotics (AUA)

Month	Number of residents admitted on antipsychotic this month	Number of residents on unit	Number of residents with Dx of Schizophrenia, Huntington's chorea, Hallucinations, Delusions	Number of residents without indication as per RAI 2.0 definition	Looking ONLY at column C, record the number of residents on antipsychotics	Calculation D/C	Percent of residents receiving an antipsychotic medication without indication as per RAI 2.0 definition	Looking ONLY at Column D, record the number of residents who had an inter-professional team medication review	Calculation E/D	Percent of residents on antipsychotics with a medication review	Looking ONLY at Column E, record the number of residents with Gradual Dose Reduction (GDR)	Looking ONLY at Column F, record the number of residents whose behaviour improved or had no change	Looking ONLY at Column E, record the number of residents who had antipsychotic medication discontinued	Looking ONLY at Column H, record the number of residents whose behaviour improved or had no change	Looking ONLY at columns F & I record the number of residents with worsened behaviours	Looking ONLY at Column D, record the number of family/alternate decision maker who had AUA education	Number of F/T P/T staff on unit	Number of staff who had AUA education
		A	B	A-B=C	D	Calc	%	E	Calc	%	F	G	H	I	J	K	L	M
Baseline (month/yea																		
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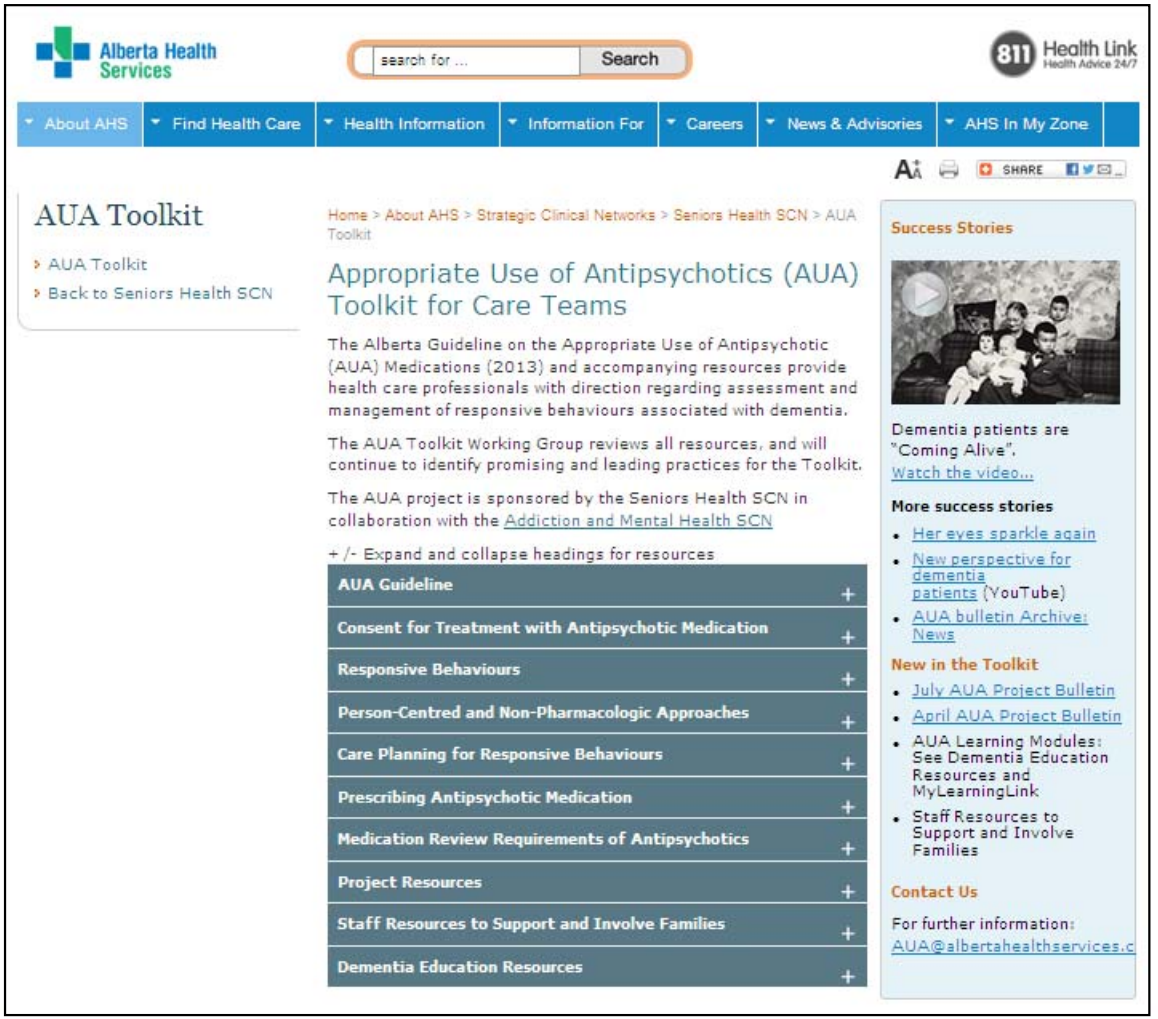
Goal							< 20%			100%		100%		100%	0 - 10%	100%		100%

AUA Toolkit

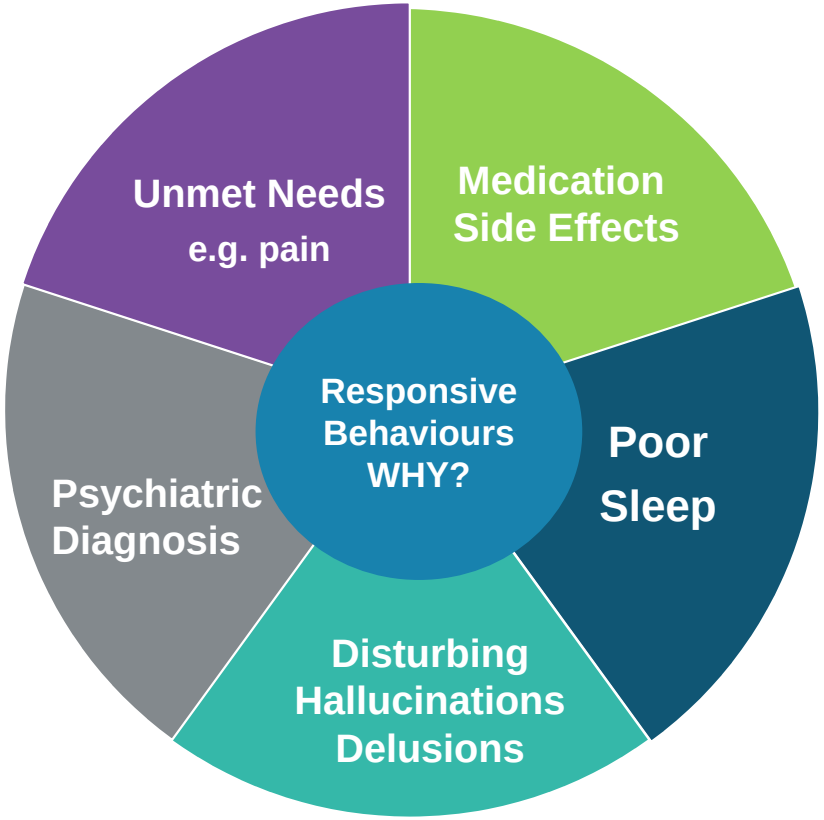
Google
AUA Toolkit or
search on AHS
External Web



Let’s take a 15 minute break

Why Focus on Sleep?

- Responsive behaviours may be caused by poor sleep
- People with dementia often sleep poorly
- Antipsychotics are often prescribed for sleep
- There are better solutions



How do you feel when you haven't slept well?

What does it affect your…

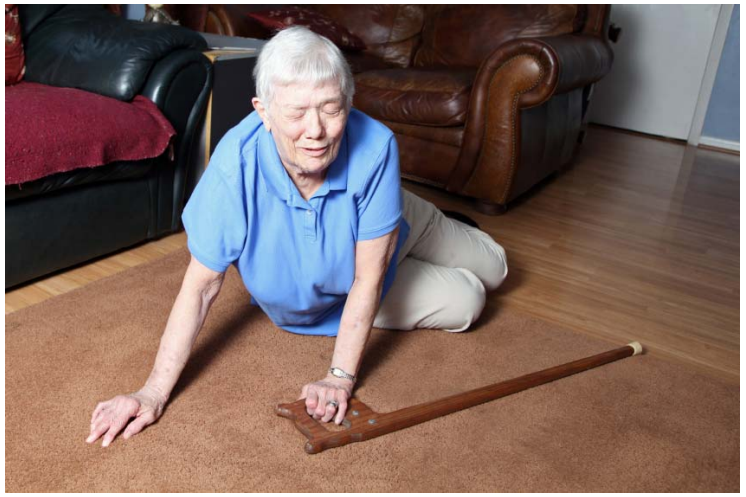
- Mood?
- Outlook on life?
- Ability to deal with stress?
- Health and immunity?

Poor Sleep can Lead to …

- Personality changes
- Delirium / hallucinations
- Decreased immunity
- High blood pressure
- More medical instability
- Increased heart disease, strokes, problems with circulation to the brain

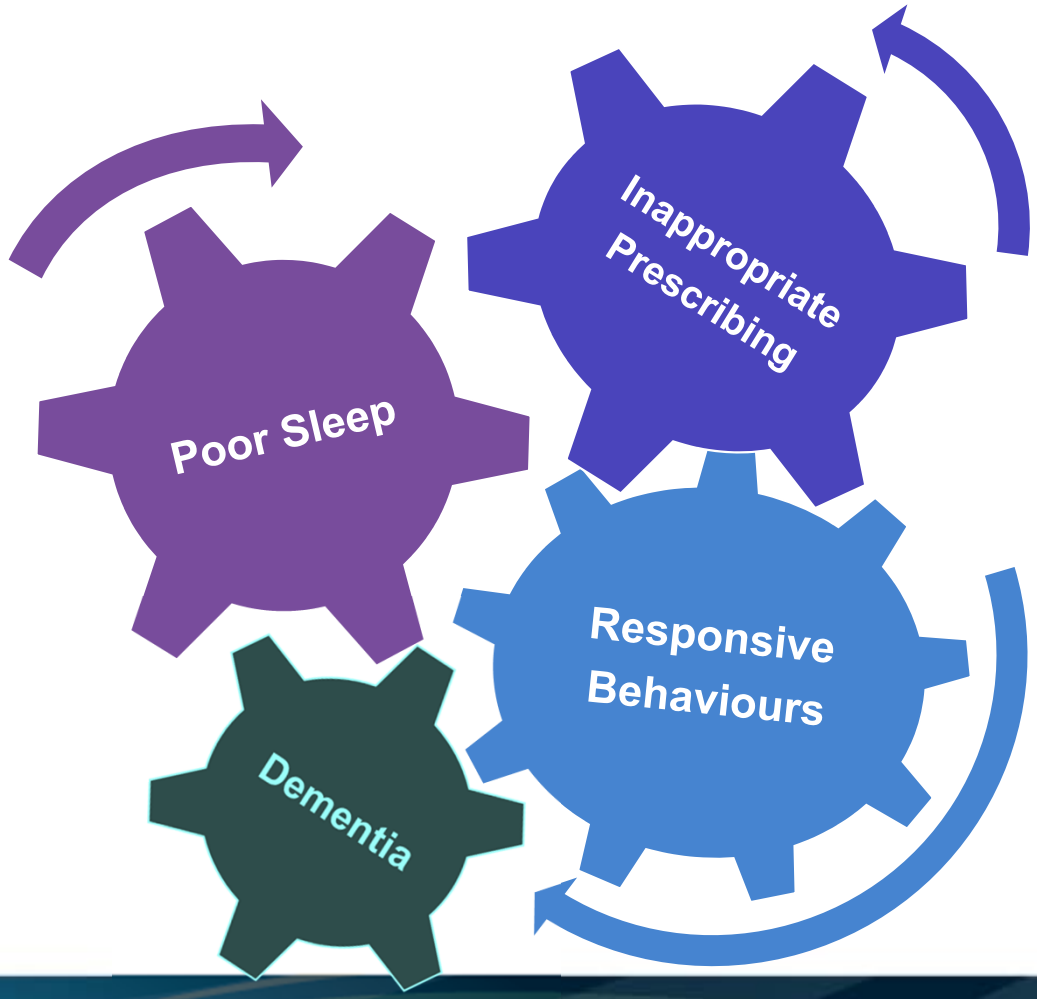
Poor Sleep can Cause …

- Irritability, aggression, anxiety, inability to cope with stress (which could lead to **antipsychotic** use**)**
- Increased depression
- Increased loss of independence
- Confusion, new cognitive difficulties
- Falls (which could lead to increased **restraint** use)
- Pain e.g. headaches
- Delayed wound healing

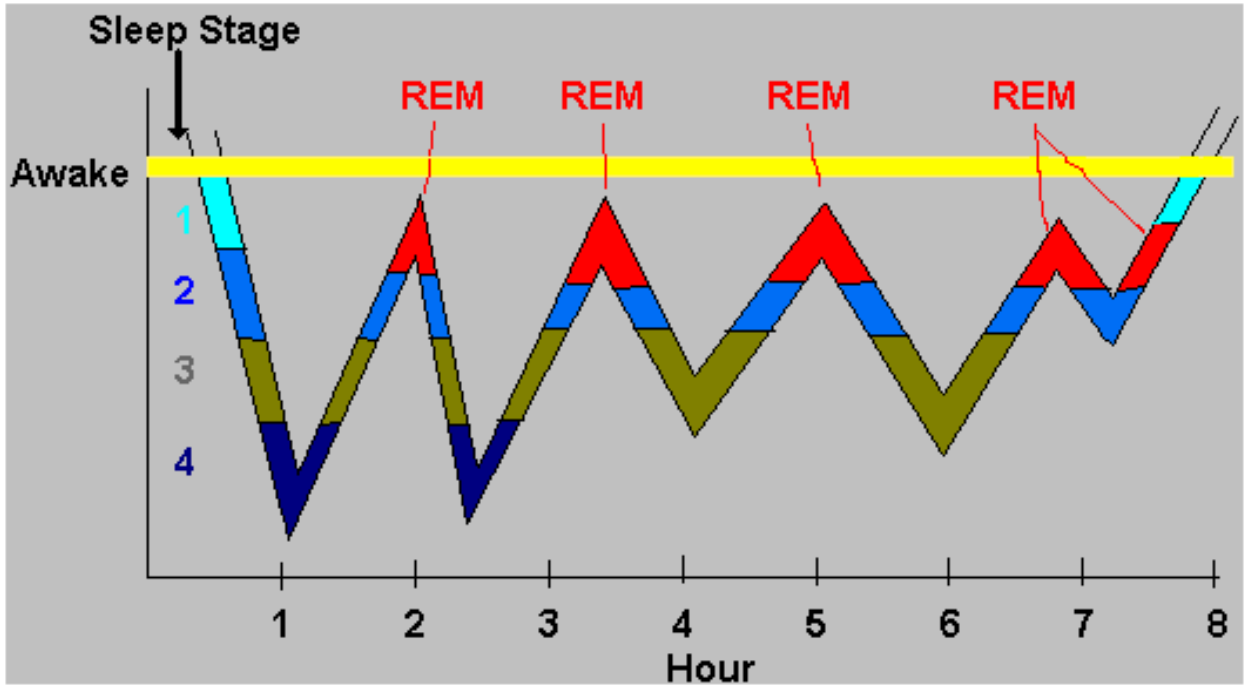


What can we do?

- Understand the basics (physiology) of sleep
- Support sleep: know what helps, what doesn't



Stages of Sleep: 90 minute sleep cycles



The Stages of Sleep ©University of Washington

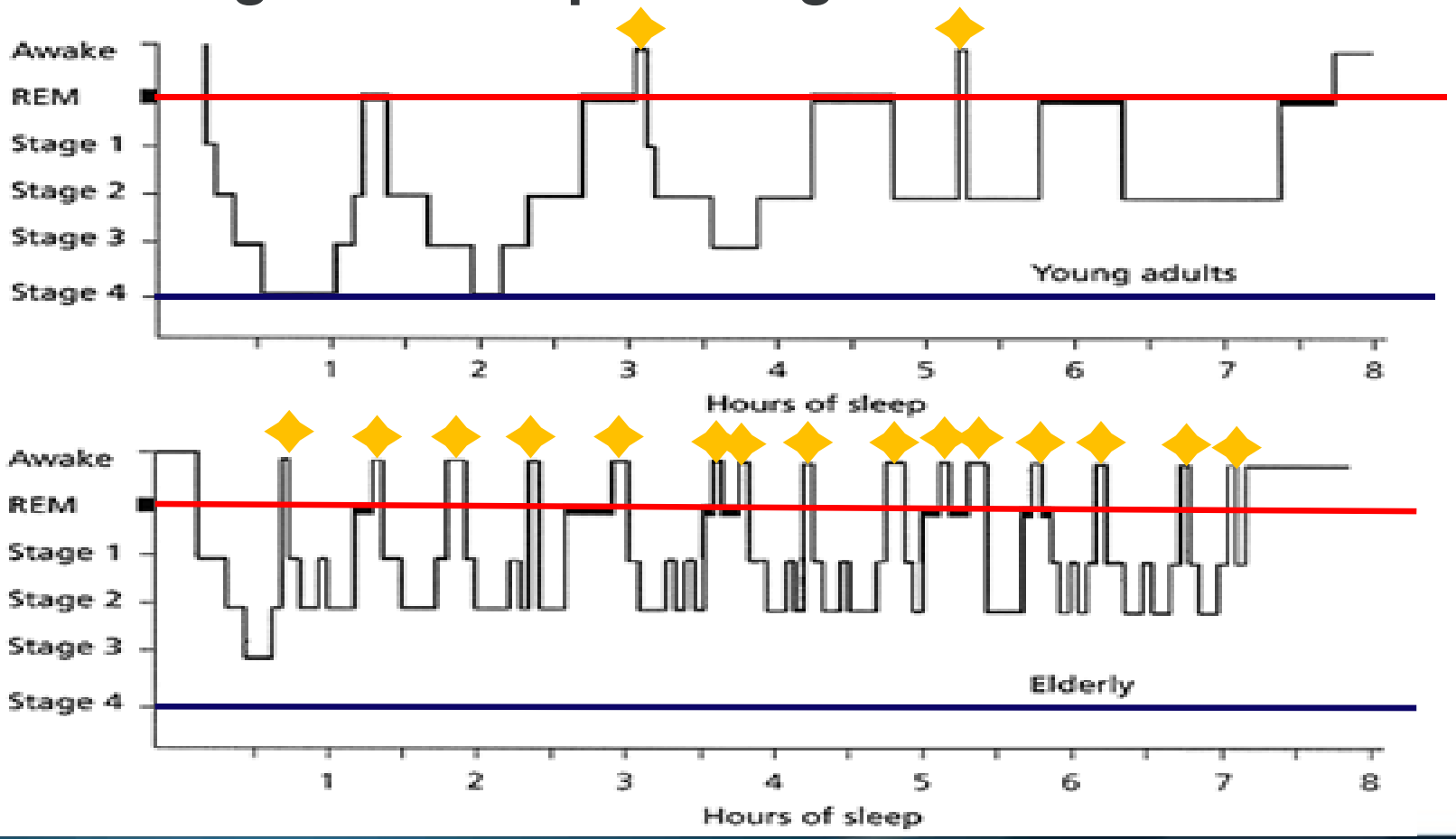
Sleep and Health

- REM sleep: memory, brain health
- Stage 3 & 4: healing/cell repair

Sleep acts as the brain's "dishwasher", cleaning the brain so it is ready to return to optimal functioning when the person wakes up.

Morley, Sleep and the Nursing Home, 2015

Stages of Sleep: Younger vs Older Adults



Healthy Sleep, Mood and Brain Chemistry

Day time:

- **Increased Serotonin** = calm and happy
- **Increased Cortisol** = energetic & motivated
  (too much cortisol = on edge)
- **Decreased** melatonin = more awake

Night time:

- **Increased Melatonin** = relaxed and sleepy
- **Increased GABA** = deep sleep and good dreams, sense of well-being, relaxed muscles and nerves
- **Decreased** serotonin, cortisol = better sleep

Sleep and Circadian Rhythm is Regulated by:

- **Light:** Lux 2000 for more than 1 hour (e.g. outside in sun), or 1000 for more than 3 hours

  Melatonin is converted to Serotonin as our eyes are exposed to light (then we feel more awake in the day)

- **Activity:** work and exercise

- **Temperature:** warmer during the day, cooler at night

Sleep and Circadian Rhythm is also Regulated by:

- **Darkness:** Less than 30-40 Lux

  Serotonin converts to melatonin
  - we feel relaxed and sleepy

- **Quiet:** < 35 Decibels (dB)

- **Temperature:** should be cooler than day time

  Body temperature drops slightly during sleep

Sleep in a Care Facility

Day time

- **Light is too dim** to convert melatonin to serotonin
- **Inactivity**: up to 17 hours per day in bed; 83.5% of time sitting or lying flat
- Day time **napping**
- Early **bedtimes**

"Try to get some rest. I'll be in every few minutes to make sure you don't."

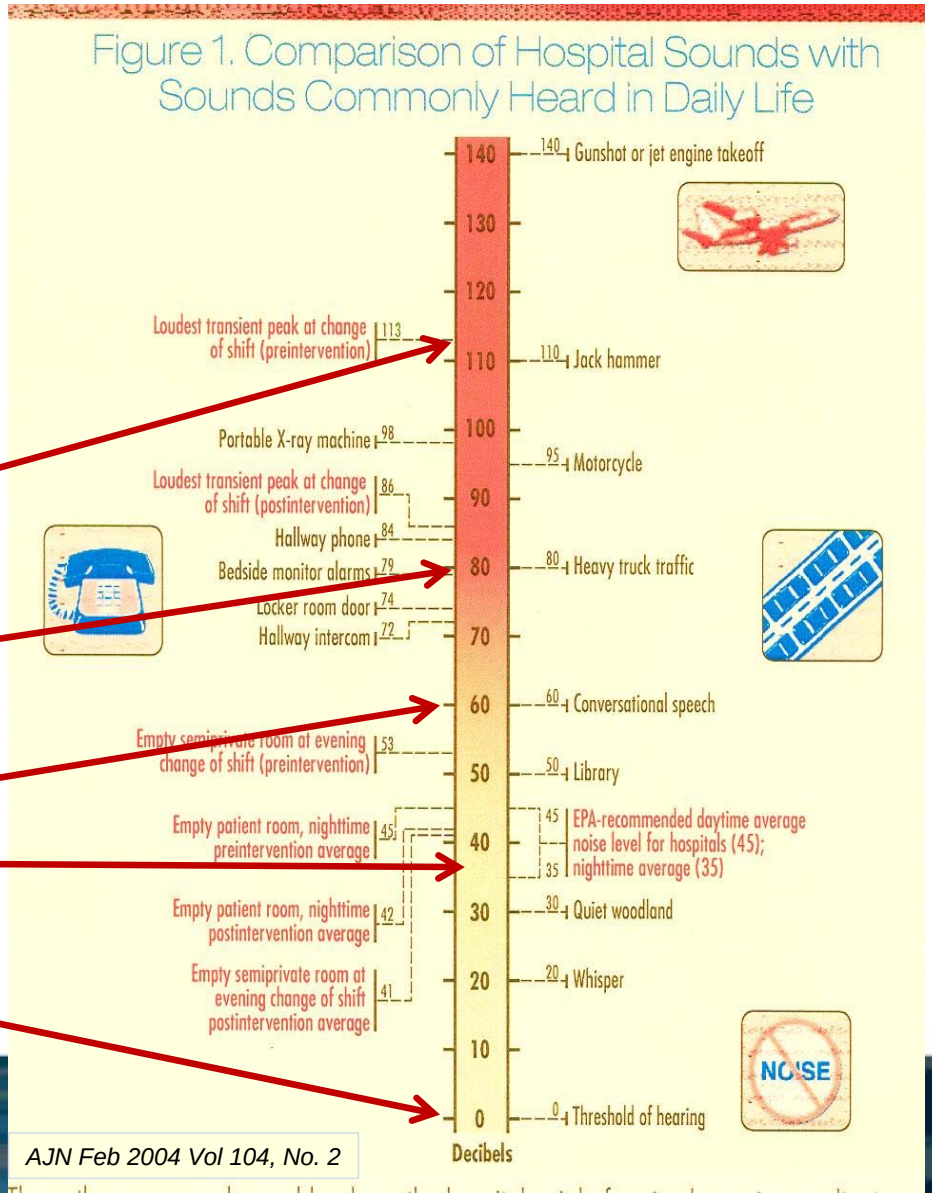
Night time

- **Light is too bright.** Melatonin suppressed with light greater than 30-40 Lux
- **Noise:** Each resident hears 32 noises per night louder than 60 dB. Less than 30 dB is required for sleep
- **Interruptions:** 76% of all incontinence care practices resulted in awakenings
- **Temperature:** too warm

Noise

Excessive or unexpected noise interrupts sleep and increases cortisol and adrenalin (fight or flight)

- Shift change = Jack hammer
- Bedside alarm, phone, locker room door = heavy truck traffic
- Conversational speech is twice the recommended night time noise level
- Threshold of hearing



AJN Feb 2004 Vol 104, No. 2

Noise Awareness Activity

What sounds in your facility would affect sleep?

- Pill crusher
- Food cart
- Shift change/Team discussion
- One person talking/calling down hall
- Door closing
- Music playing
- Equipment (floor cleaner, vacuum)
- Ticking clock
- Other?

Remember:

- ***Threshold of hearing: Zero***
- ***Recommended level for sleep: 35 Db or less***
- ***Recommended maximum for day time: 35-45 dB***

Why do we call them “Sleeping Pills”?

- Minimal or no improvement in sleep
- Day time grogginess / hangover
- Increased day time napping
- The pills stop helping within weeks
- Many side effects such as falls/confusion
- Interferes with important stages of sleep crucial for cognitive-emotional function (REM)

Antipsychotics

- Don’t improve total sleep time, time to fall asleep, day time alertness or sleep satisfaction
- Increased risk of dizziness, restlessness, nervousness, restless leg syndrome, falls
- Examples: quetiapine (Seroquel), olanzapine (Zyprexa)

“Widespread use of quetiapine as a sleep aid is occurring in the absence of evidence for effectiveness or safety.” Herper 2004

Antihistamines

- Risk of confusion, urine retention, delirium, constipation, day time drowsiness **(highly anticholinergic)**
- Increased restless leg syndrome
- Tolerance develops quickly (no further benefit to sleep)
- Shouldn’t be taken by older persons but widely used
- Examples include:
  - diphenhydramine (Benadryl), dimenhydrate (Gravol), Tylenol Night, Sleep Eze, ZzzQUIL

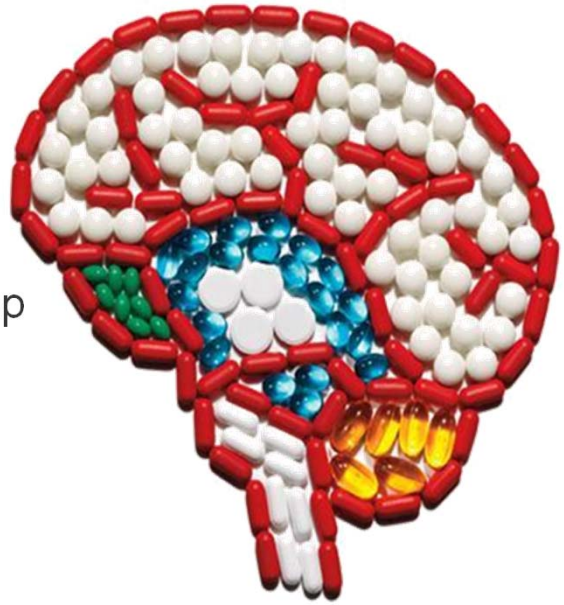
Antidepressants – Common Side Effects

- Should only be used to treat insomnia associated with clinical depression
- Can *cause* insomnia
- Side effects include:
  - increased day time sleepiness
  - falls
  - blurred vision
  - confusion

- Examples:

  trazodone (Desyrel), mirtazapine (Remeron), amitriptyline (Elavil), nortriptyline (Aventyl HCL)

Benzodiazepines and "Z-drugs"



- First 2-4 weeks:
  - Fall asleep 10-20 min sooner, sleep ~ 25 min longer
  - Increase in stage 2 (light sleep), decreased REM and deep sleep
- **Occasional use usually leads to constant use/dependence**
  - Examples: lorazepam (Ativan) and temazepam (Restoril)
- Another example: **zopiclone (Imovane)**
  - Less addictive but similar side-effects including: confusion, memory loss, falls, delirium

Sleeping Pills: Not a Long Term Solution

Reminders:

- ✓ use low doses for as short a period of time as possible
- ✓ avoid if possible in the elderly
- ✓ use with caution and monitor for side-effects
- ✓ timing must be considered

Long term use of hs sedation can result in a '*perpetual hangover*' - this reduces day time activity and increases day time napping, which further impairs night time sleep.

Melatonin *Might* Help

- At bedtime: may improve sleep, fall asleep faster, increase REM sleep
- In late afternoon: may help with agitation/confusion/sundowning
- May improve cognitive function and mood
- May slow progression of the damage to the brain in Alzheimer's Disease
- Works best when combined with day time light and activity

Other possible benefits:

- Help taper off benzodiazepines
- Reduce tardive dyskinesia symptoms
- Help reduce agitation in delirium
- Reduce hypertension
- Anti-inflammatory

Key Message: It is crucial to develop a unit culture that supports the importance of sleep

Sleep and Responsive Behaviours In a Nutshell

- The elderly sleep lightly; those with dementia sleep poorly and are extra sensitive to light and noise at night
- Still only need ~ 8 hours sleep in 24 hours
- Day time light and activity, and night time darkness and quiet are required to regulate circadian rhythms
- Disrupted sleep leads to responsive behaviours/aggression and increased use of antipsychotics/other sedatives

Table Discussion

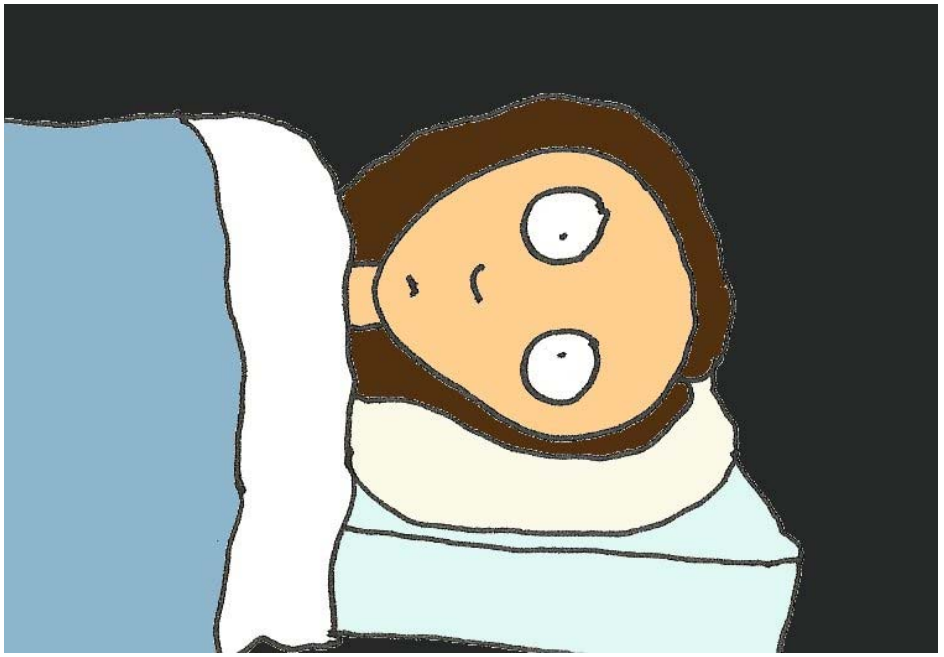
What interferes with sleep in your facility?

What do families/residents notice?

- **Routines:**
  naps, bed times, rounds, continence care/turning?
- **Light:**
  day time, evening, night time?
- **Noise:**
  day time overstimulation, evening and night noise?
- **Understimulation**:
  how active are residents during the day?
- Use of "**sleeping pills**" including **antipsychotics**?

Report Back

What's one thing that's preventing good sleep in your facility?



Lunch

Strategies to Support Sleep

Support the Body's Natural Circadian Rhythm

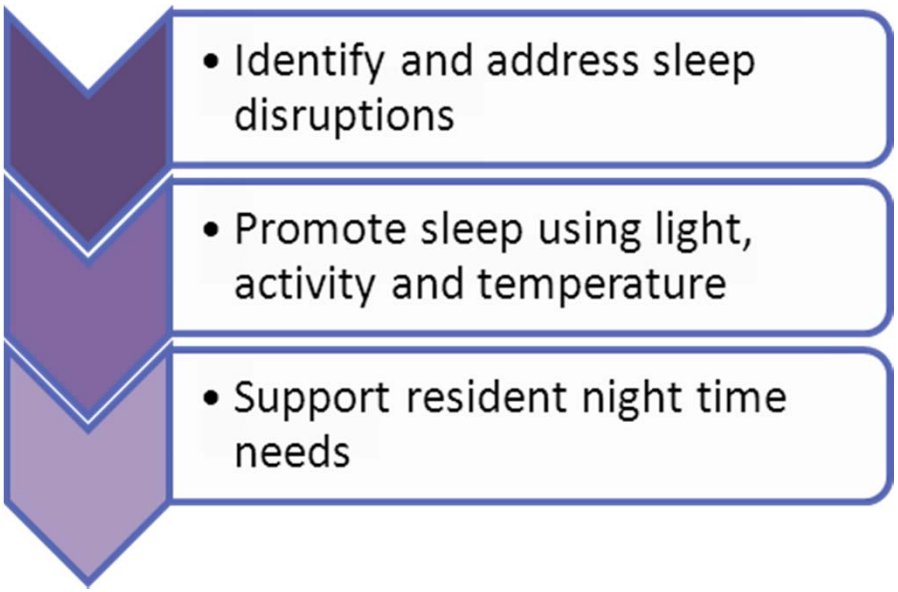
Unit Interventions

- Identify and address sleep disruptions
- Promote sleep using light, activity and temperature
- Support resident night time needs

Interventions for Individuals

- Decrease use of antipsychotics and other sedatives
- Person-Centred strategies to enhance sleep
- Collaborate between all shifts

Unit Interventions



- What unit routines wake people up?
- How can you support circadian rhythms?
- How will you support/occupy residents who are awake and up during the late evening or night?

Unit Level QI

- Replaced 3 AM rounds with individualized care: ~ 10% residents turned
- Incontinence care: resident-specific incontinence briefs applied on last round of evening shift
- Encouraged residents to go to bed later (more evening activities)
- Reduced noise at night, lights dimmed, everyone whispered

OUTCOMES:

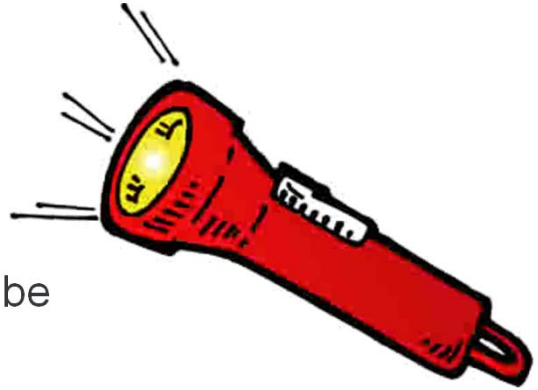
- Residents slept more!!
- HCAs more available to respond to individual resident needs
- Night staff job satisfaction with less busy work, a more relaxed pace, more time for important care work (e.g. individualized palliative care)
- Unit budget savings (less laundry, less incontinence products)

Bethany Care Society,
1998-2001
Dr. Susan Slaughter

What are your Night Routines?

Repositioning

- What is the purpose of repositioning?
- Who does/doesn't need to be repositioned?
- What is the most effective and least disruptive way to reposition?



Incontinence Care

- What is the purpose of incontinence care?
- Who needs to be woken for incontinence care?
- What is the most effective and least disruptive way to provide incontinence care?

Unit Level QI

- Noise:
  - Change in shift responsibilities: stocking, retrieval of commodes/ wheelchairs
  - Addressograph used in closed room
  - Ice machine turned off at night
  - Garbage man asked to come in quietly
- Safety Rounds:
  - Curtains drawn
  - Doors left ajar on last evening round for visual checks
  - Flashlights instead of overhead lights
- If awake:
  - Assessed for needs

    e.g. bathroom/changed/repositioned

OUTCOMES:

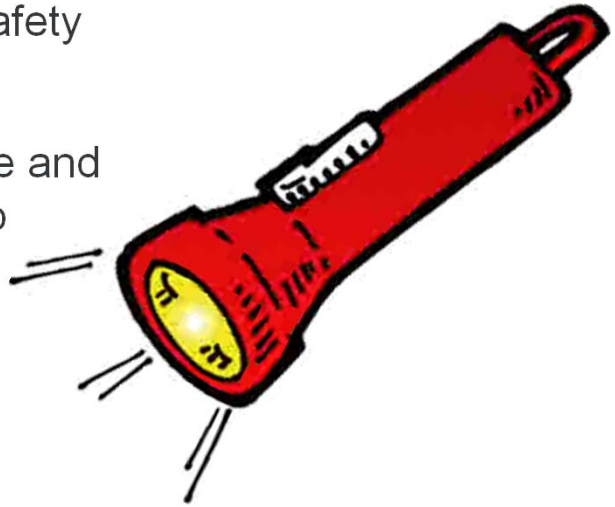
- Reduction of:
  - 43% in physical aggression
  - 42% in verbal aggression
- Residents were:
  - More rested in the morning
  - More tired/ cooperative by bedtime
  - More alert in the evening
  - More pleasant to visit with

Medicine Hat Hospital
Dementia Unit,
Heather Hart RN

Other Night Routines/Tasks?

Safety Rounds

- What is the purpose of safety rounds?
- What is the most effective and least disruptive way to do safety rounds?



Night Activities, Noise

- What night activities (e.g. cleaning, stocking) may be disruptive to resident sleep?
- What are your options?

What are your day time Routines?

What could you do to expose residents to **bright light** during the day?

- Face a sunny window
- A blue light on the table at meals
- Blinds open in the dining room
- Other?

What opportunities do residents have for **activity** and **exercise**?

- Walking
- Sit to stand
- Other?

What are your Evening Routines?

Light, Stimulation and Bedtime

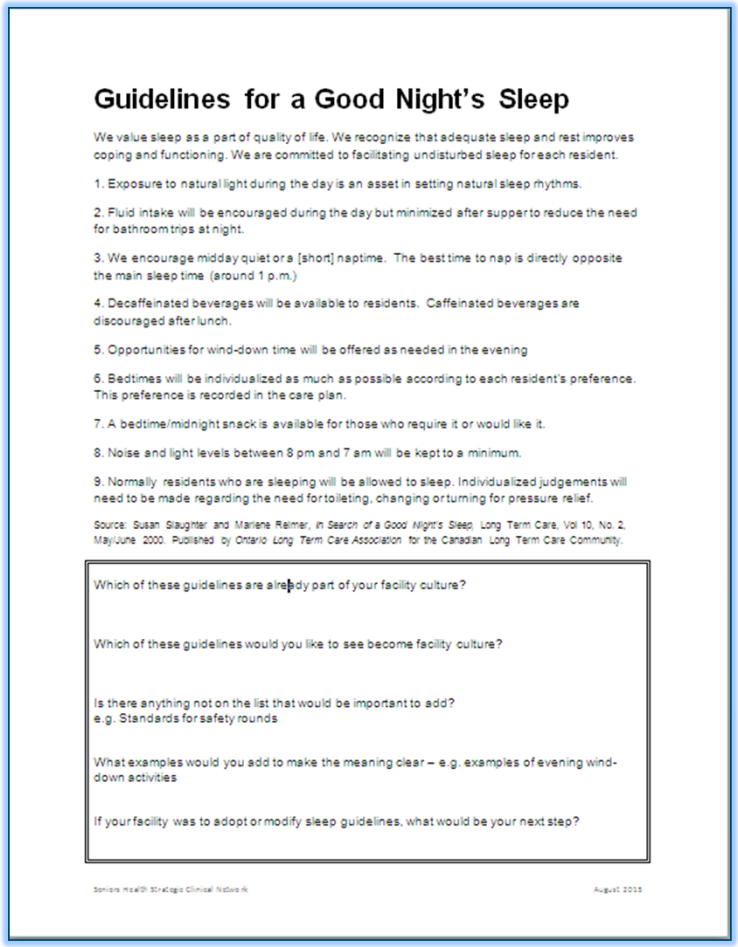
- What lights could be dimmed in the evening to signal the brain to produce melatonin?
- What sources of stimulation could be reduced to avoid cortisol production?
- What could you do to help prepare residents for bed/sleep?

Goals: Allow sleep to occur at night; optimize daytime functioning

Sleep Guidelines

- Does your facility or organization already have a policy or guideline on sleep?
- What do Continuing Care Standards say?
- Consider the Sleep Guideline handout and discussion questions to consult and involve staff at your facility

HAND OUT



Guidelines for a Good Night's Sleep

We value sleep as a part of quality of life. We recognize that adequate sleep and rest improves coping and functioning. We are committed to facilitating undisturbed sleep for each resident.

1. Exposure to natural light during the day is an asset in setting natural sleep rhythms.

2. Fluid intake will be encouraged during the day but minimized after supper to reduce the need for bathroom trips at night.

3. We encourage midday quiet or a [short] naptime. The best time to nap is directly opposite the main sleep time (around 1 p.m.)

4. Decaffeinated beverages will be available to residents. Caffeinated beverages are discouraged after lunch.

5. Opportunities for wind-down time will be offered as needed in the evening

6. Bedtimes will be individualized as much as possible according to each resident's preference. This preference is recorded in the care plan.

7. A bedtime/midnight snack is available for those who require it or would like it.

8. Noise and light levels between 8 pm and 7 am will be kept to a minimum.

9. Normally residents who are sleeping will be allowed to sleep. Individualized judgements will need to be made regarding the need for toileting, changing or turning for pressure relief.

Source: Susan Slaughter and Marlene Reimer. *In Search of a Good Night's Sleep.* Long Term Care, Vol 10, No. 2, May/June 2000. Published by *Ontario Long Term Care Association* for the Canadian Long Term Care Community.

Which of these guidelines are already part of your facility culture?

Which of these guidelines would you like to see become facility culture?

Is there anything not on the list that would be important to add?
e.g. Standards for safety rounds

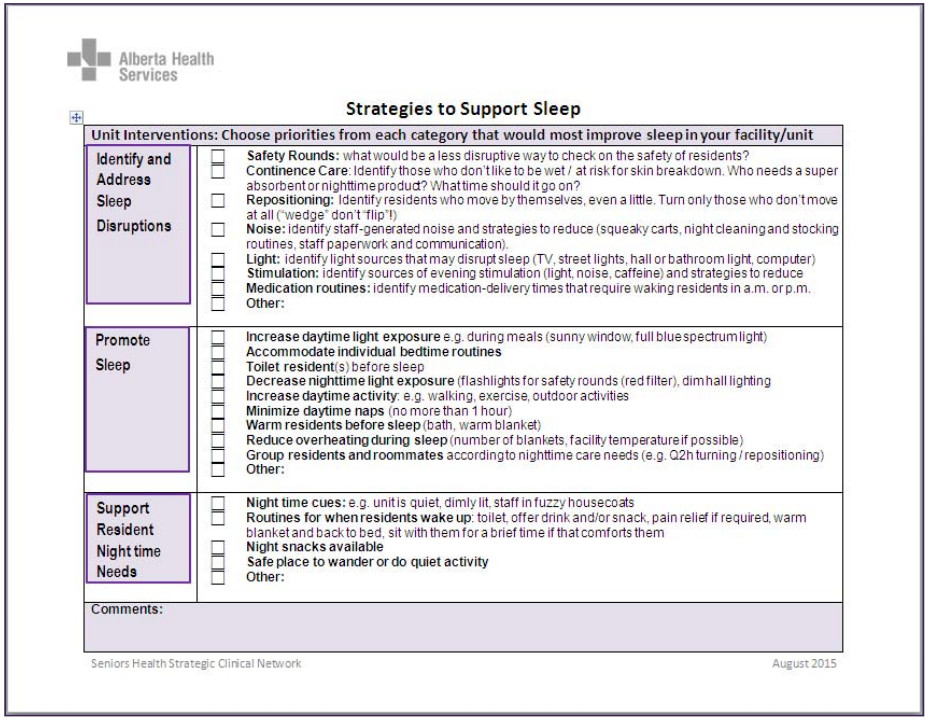
What examples would you add to make the meaning clear – e.g. examples of evening wind-down activities

If your facility was to adopt or modify sleep guidelines, what would be your next step?

Seniors Health Strategic Clinical Network August 2015

Unit Interventions

- Identify and address sleep disruptions
- Promote sleep using light, activity and temperature
- Support resident night time needs



Alberta Health Services

Strategies to Support Sleep

Unit Interventions: Choose priorities from each category that would most improve sleep in your facility/unit	
Identify and Address Sleep Disruptions	☐ **Safety Rounds:** what would be a less disruptive way to check on the safety of residents? ☐ **Continence Care**: Identify those who don't like to be wet / at risk for skin breakdown. Who needs a super absorbent or nighttime product? What time should it go on? ☐ **Repositioning:** Identify residents who move by themselves, even a little. Turn only those who don't move at all ("wedge" don't "flip"!) ☐ **Noise:** identify staff-generated noise and strategies to reduce (squeaky carts, night cleaning and stocking routines, staff paperwork and communication). ☐ **Light:** identify light sources that may disrupt sleep (TV, street lights, hall or bathroom light, computer) ☐ **Stimulation:** identify sources of evening stimulation (light, noise, caffeine) and strategies to reduce ☐ **Medication routines:** identify medication-delivery times that require waking residents in a.m. or p.m. ☐ Other:
Promote Sleep	☐ **Increase daytime light exposure** e.g. during meals (sunny window, full blue spectrum light) ☐ **Accommodate individual bedtime routines** ☐ **Toilet resident**(s) before sleep ☐ **Decrease nighttime light exposure** (flashlights for safety rounds (red filter), dim hall lighting ☐ **Increase daytime activity**: e.g. walking, exercise, outdoor activities ☐ **Minimize daytime naps** (no more than 1 hour) ☐ **Warm residents before sleep** (bath, warm blanket) ☐ **Reduce overheating during sleep** (number of blankets, facility temperature if possible) ☐ **Group residents and roommates** according to nighttime care needs (e.g. Q2h turning / repositioning) ☐ Other:
Support Resident Night time Needs	☐ **Night time cues:** e.g. unit is quiet, dimly lit, staff in fuzzy housecoats ☐ **Routines for when residents wake up**: toilet, offer drink and/or snack, pain relief if required, warm blanket and back to bed, sit with them for a brief time if that comforts them ☐ **Night snacks available** ☐ **Safe place to wander or do quiet activity** ☐ Other:
Comments:	

Seniors Health Strategic Clinical Network — August 2015

Person-Centred Interventions

- Decrease use of antipsychotics and other sedatives
- Person-Centred strategies to enhance sleep
- Collaborate between all shifts

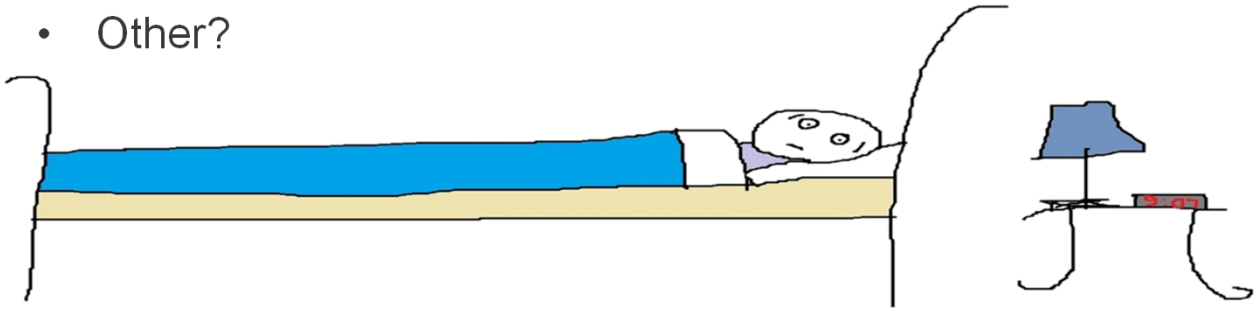
Disorders that can Disrupt Sleep

- Circadian Rhythm Disorder
- Sleep Apnea
- Restless Leg Syndrome
- Periodic Limb Movement Disorder
- REM Behaviour Disorder

Other Things that Disrupt Sleep

- Itchiness
- Nocturnal cough
- Acid reflux
- Hot flashes
- Nightmares
- Untreated pain
- Too hot or cold
- Caffeine in the evening

- Unexpected noises: call bells, door snapping
- Confusing stimuli: flashing red light, reflections
- Uncomfortable bed
- Congestive heart failure
- Benign prostate hypertrophy
- Other?



Medications that May Affect Sleep

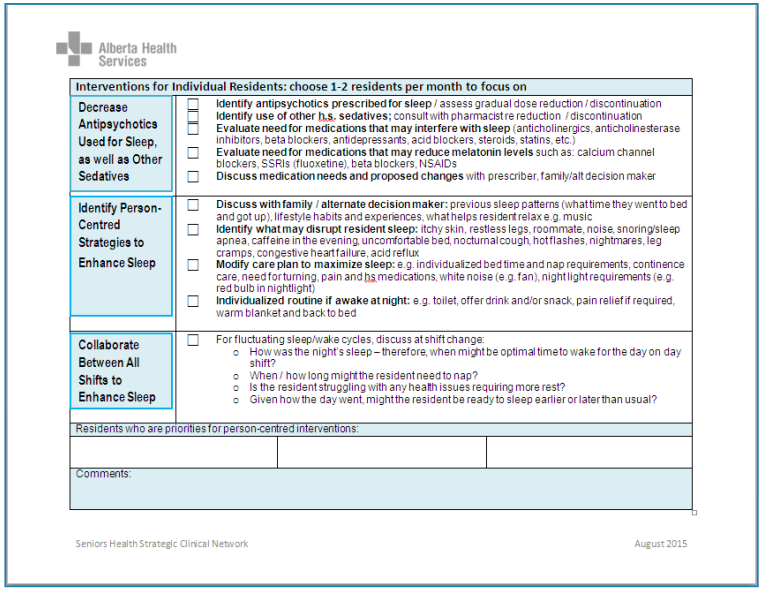
- **Anticholinesterase inhibitors** (memantine): INSOMNIA, DISTURBING DREAMS
- **Blood pressure** (B-Blockers): altered sleep physiology, nightmares
- **Anticholinergics** (hundreds of drugs): DAY TIME SEDATION
- **Antidepressants / SSRIs**: Insomnia **Statins:** MUSCLE PAIN
- **Histamine H2 Blockers** (Zantac, Tagamet): confusion, anxiety, hallucinations **Corticosteroids**: AGITATION
- **Proton Pump Inhibitors** (Losec): Rebound acid reflux
- **Diuretics**: nocturia – avoid late in the day
- **Levodopa, carbadopa**: NIGHTMARES, INSOMNIA
- **Theophylline, decongestants**: STIMULANT EFFECTS

Relaxing Bedtime Routines

- Person-centred night routines:
  music, snack, special hand lotion
- Use white noise (e.g. fan)
- Darken room: block hall/street lights
- Slow stroke back massage
- Warm blanket ½ hour before bed

Person-Centred Interventions

- Decrease use of antipsychotics and other sedatives
- Person-Centred strategies to enhance sleep
- Collaborate between all shifts



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Interventions for Individual Residents: choose 1-2 residents per month to focus on	
Decrease Antipsychotics Used for Sleep, as well as Other Sedatives	☐ **Identify antipsychotics prescribed for sleep** / assess gradual dose reduction / discontinuation ☐ **Identify use of other h.s. sedatives;** consult with pharmacist re reduction / discontinuation ☐ **Evaluate need for medications that may interfere with sleep** (anticholinergics, anticholinesterase inhibitors, beta blockers, antidepressants, acid blockers, steroids, statins, etc.) ☐ **Evaluate need for medications that may reduce melatonin levels** such as: calcium channel blockers, SSRIs (fluoxetine), beta blockers, NSAIDs ☐ **Discuss medication needs and proposed changes** with prescriber, family/alt decision maker
Identify Person-Centred Strategies to Enhance Sleep	☐ **Discuss with family / alternate decision maker:** previous sleep patterns (what time they went to bed and got up), lifestyle habits and experiences, what helps resident relax e.g. music ☐ **Identify what may disrupt resident sleep:** itchy skin, restless legs, roommate, noise, snoring/sleep apnea, caffeine in the evening, uncomfortable bed, nocturnal cough, hot flashes, nightmares, leg cramps, congestive heart failure, acid reflux ☐ **Modify care plan to maximize sleep:** e.g. individualized bed time and nap requirements, continence care, need for turning, pain and hs medications, white noise (e.g. fan), night light requirements (e.g. red bulb in nightlight) ☐ **Individualized routine if awake at night:** e.g. toilet, offer drink and/or snack, pain relief if required, warm blanket and back to bed
Collaborate Between All Shifts to Enhance Sleep	☐ For fluctuating sleep/wake cycles, discuss at shift change: o How was the night's sleep – therefore, when might be optimal time to wake for the day on day shift? o When / how long might the resident need to nap? o Is the resident struggling with any health issues requiring more rest? o Given how the day went, might the resident be ready to sleep earlier or later than usual?
Residents who are priorities for person-centred interventions:	
Comments:	

Seniors Health Strategic Clinical Network — August 2015

- The above handout can be used to discuss ways to improve sleep for individual residents
- How might you use this handout to engage co-workers in your facility?

How will you shift your unit/facility culture?

- Resources
- Sleep QI Project option/measurement
- Action Plan

Change Management Action Plan

Get Started

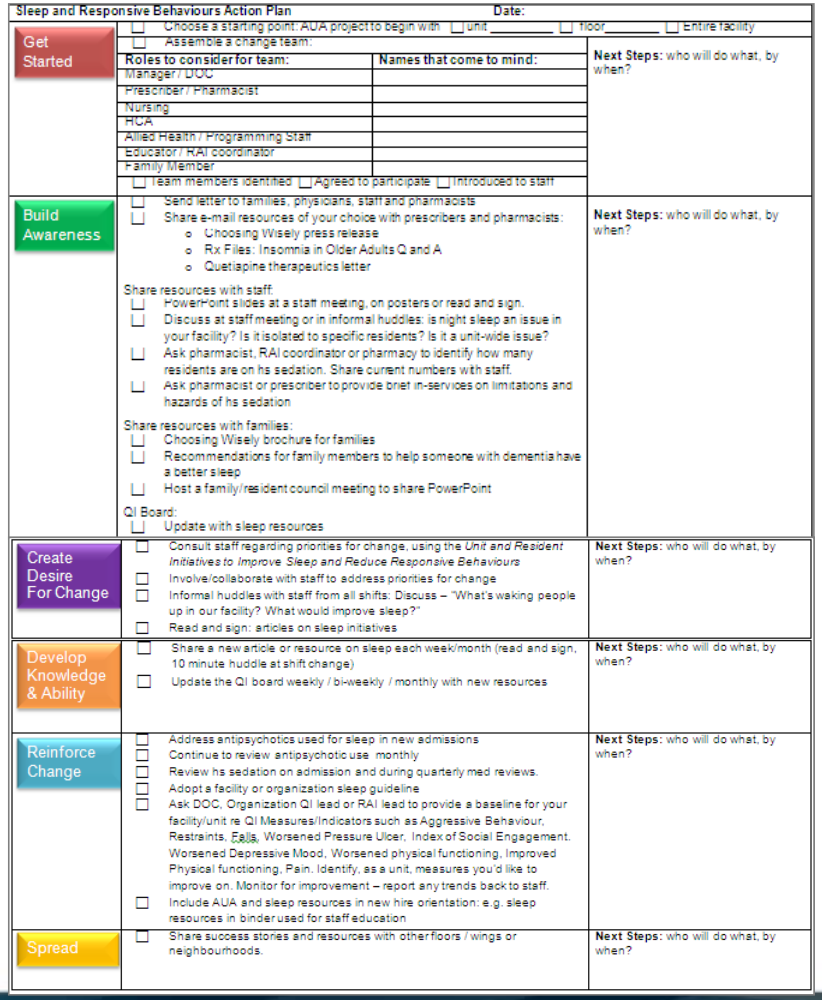
Build Awareness

Create Desire for Change

Develop Knowledge & Ability

Reinforce Change

- Use the Sleep and Responsive Behaviours Action Plan to discuss your next steps
- Be prepared to report at least one next step



Sleep and Responsive Behaviours Action Plan **Date:**

Get Started

☐ Choose a starting point: AIA project to begin with ☐ unit _____ ☐ floor _____ ☐ Entire facility

☐ Assemble a change team:

Roles to consider for team:	Names that come to mind:
Manager / DOC	
Prescriber / Pharmacist	
Nursing	
HCA	
Allied Health / Programming Staff	
Educator / RAI coordinator	
Family Member	

☐ Team members identified ☐ Agreed to participate ☐ Introduced to staff

Next Steps: who will do what, by when?

Build Awareness

☐ Send letter to families, physicians, staff and pharmacists

☐ Share e-mail resources of your choice with prescribers and pharmacists:
- Choosing Wisely press release
- Rx Files: Insomnia in Older Adults Q and A
- Quetiapine therapeutics letter

Share resources with staff:

☐ PowerPoint slides at a staff meeting, on posters or read and sign.

☐ Discuss at staff meeting or in informal huddles: is night sleep an issue in your facility? Is it isolated to specific residents? Is it a unit-wide issue?

☐ Ask pharmacist, RAI coordinator or pharmacy to identify how many residents are on hs sedation. Share current numbers with staff.

☐ Ask pharmacist or prescriber to provide brief in-services on limitations and hazards of hs sedation

Share resources with families:

☐ Choosing Wisely brochure for families

☐ Recommendations for family members to help someone with dementia have a better sleep

☐ Host a family/resident council meeting to share PowerPoint

QI Board:

☐ Update with sleep resources

Next Steps: who will do what, by when?

Create Desire For Change

☐ Consult staff regarding priorities for change, using the *Unit and Resident Initiatives to Improve Sleep and Reduce Responsive Behaviours*

☐ Involve/collaborate with staff to address priorities for change

☐ Informal huddles with staff from all shifts: Discuss – "What's waking people up in our facility? What would improve sleep?"

☐ Read and sign: articles on sleep initiatives

Next Steps: who will do what, by when?

Develop Knowledge & Ability

☐ Share a new article or resource on sleep each week/month (read and sign, 10 minute huddle at shift change)

☐ Update the QI board weekly / bi-weekly / monthly with new resources

Next Steps: who will do what, by when?

Reinforce Change

☐ Address antipsychotics used for sleep in new admissions

☐ Continue to review antipsychotic use monthly

☐ Review hs sedation on admission and during quarterly med reviews.

☐ Adopt a facility or organization sleep guideline

☐ Ask DOC, Organization QI lead or RAI lead to provide a baseline for your facility/unit re QI Measures/Indicators such as Aggressive Behaviour, Restraints, Falls, Worsened Pressure Ulcer, Index of Social Engagement, Worsened Depressive Mood, Worsened physical functioning, Improved Physical functioning, Pain. Identify, as a unit, measures you'd like to improve on. Monitor for improvement – report any trends back to staff.

☐ Include AIA and sleep resources in new hire orientation: e.g. sleep resources in binder used for staff education

Next Steps: who will do what, by when?

Spread

☐ Share success stories and resources with other floors / wings or neighbourhoods.

Next Steps: who will do what, by when?

Resources to Support Sleep in LTC Residents

Change Management Resources

- Strategies to Support Sleep
- Sleep and Responsive Behaviours Action Plan
- Generic Letter
- Guidelines for a Good Night Sleep
- Sleep map

QI Board Resources

- Posters: light, activity, passive warming, sleep hygiene
- Articles
- PowerPoint slides
- Recommendations for family members

AUA Toolkit

- Sleep and Responsive Behaviours Section
- Medication Review Section

Noise/Sound Measurement

- Lux meter
- dB meter

Sleep QI Project (Optional)

- Separate tab in Excel Tracking Sheet
- Consider adopting facility or organizational sleep guidelines
- Consider RAI indicators for outcome measures
  Monitor for improvement as you implement your action plan

  Examples include:
  - Worsened Depressive Mood
  - Index of Social Engagement
  - Falls
  - Aggressive Behaviour
  - Restraint use
  - Worsened physical functioning
  - Sleep
  - Other?

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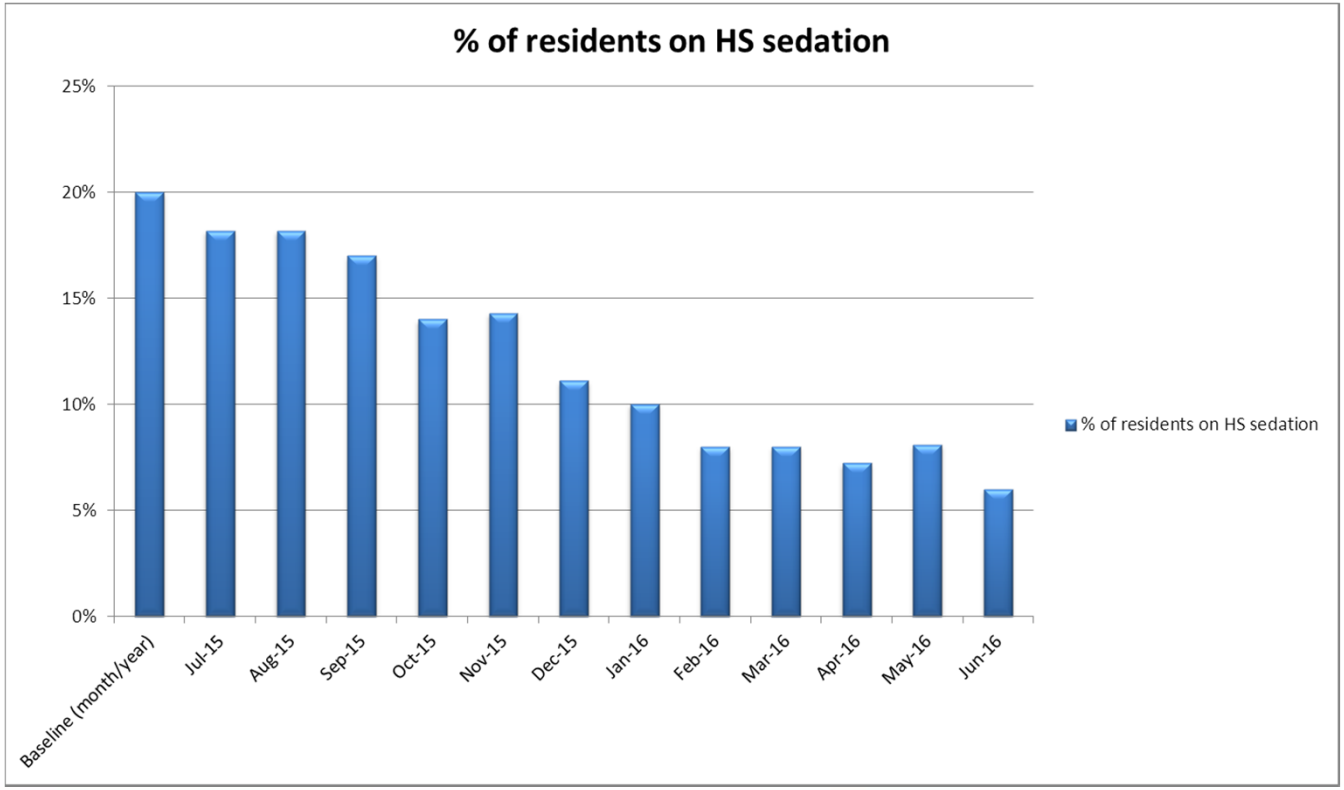
Month	Number of residents on unit	Number of residents on HS sedation including any antipsychotic prescribed for sleep	Percent of residents receiving HS sedation	Looking at column B, record the number of residents who had Gradual Dose Reduction or Dsicontinued HS sedative	Looking at column C, record the number of residents with improved night sleep	Looking at column D, record the number of residents with improved verbal/physical aggression
	A	B	%	C	D	E
Baseline (month/year)	100	20	20%	0	0	0
Jul-15	99	18	18%	1	1	0
Aug-15	99	18	18%	0	0	0
Sep-15	100	17	17%	1	1	0
Oct-15	100	14	14%	2	1	1
Nov-15	98	14	14%	1	0	1
Dec-15	99	11	11%	1	1	1
Jan-16	100	10	10%	1	1	0
Feb-16	100	8	8%	2	2	0
Mar-16	100	8	8%	0	0	0
Apr-16	97	7	7%	1	1	0
May-16	99	8	8%	1	1	0
Jun-16	100	6	6%	1	0	0
Goal						

Graph of HS Sedation



Team Planning and Report Back

Strategies to Support Sleep:

- Priority Unit Intervention
- Priority Person-centred Intervention

Change Management Action Plan:

- Your Team's Next Step

Next Workshop: Feb/March 2016

Come prepared to share:

- What you did and how it worked
- Success stories/challenges
- Percent of residents on antipsychotics without a diagnosis of psychosis (RAI 2.0)

Don't Forget

- Evaluations
- Turn in Sign-In Sheets

If you have something to share in the AUA bulletin, please forward it to: aua@albertahealthservices.ca

References

- http://dem.sagepub.com/content/12/2/210.long
- http://www.sleep-dementia-resources.info/
- Common Sleep Problems Affecting Older Adults http://www.annalsoflongtermcare.com/article/8100
- Improving Sleep Management in the Elderly http://www.annalsoflongtermcare.com/article/8283