

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Should Antipsychotics' Risks Be Accepted by Clinicians on Behalf of Patients to Achieve Benefits of Mitigating Older Adults' Behavioral Symptoms in Short-Staffed Units?

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Abstract

This commentary on a case considers risks and benefits of pharmacological and nonpharmacological management of agitation in patients with dementia. Specifically, it considers beneficence and nonmaleficence in treatment decisions that affect both patients and staff as well as autonomy and surrogate decision making.

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Case

The Joint Commission audits—based on US Food and Drug Administration (FDA) and Substance Abuse and Mental Health Services Administration (SAMHSA) guidance—antipsychotic use in inpatient geriatric mental health settings and will soon be reviewing, during an upcoming site visit, University Hospital's geriatric psychiatric unit's practices. Among older adults, antipsychotics can increase morbidity and mortality risk from falls and cerebrovascular events,^{1,2} so their use is discouraged by the FDA³ and SAMHSA.⁴ Although antipsychotic use to manage delirium, dementia, and agitation helps decrease use of physical restraints and their risks of harm,⁵ Dr A remains concerned about the unit's clinicians' escalating use of antipsychotics as behavior modification agents. Dr A asks unit staff to decrease use of antipsychotics on an "as-needed" basis and encourages more reliance on verbal redirection and other nonpharmacological techniques for managing patients' behavioral symptoms.

However, staff burnout and an insufficient number of staff members with time to implement nonpharmacological symptom management techniques with patients undermine the feasibility of Dr A's recommendations. Antipsychotics help overburdened unit staff respond with more efficiency and less disruption to patients' agitation. Dr A struggles to balance the benefits to staff of increased antipsychotic use against the risks to patients and wonders how to represent self-study documentation, especially about the unit's antipsychotics overuse, in preparation for the Joint Commission's upcoming site visit. Specifically, Dr A considers how to represent the reality that the unit's clinicians are aware of the risks to patients and accept those risks to their patients as

necessary to keeping patients on the unit as safe as possible, given the unit's labor, time, and management constraints.

Commentary

While there is no gold standard of care for managing agitation in the geriatric inpatient population, there is broad consensus that health care workers should first assess the patient on a case-by-case basis to identify and remove potential causes of the agitation, attempt to reduce agitation through nonpharmacological interventions, and reserve the use of pharmacotherapy for patients who do not respond to behavioral approaches.^{6,7} This commentary considers the risks and benefits of antipsychotics and which cultural, regulatory, or other changes could facilitate clinicians' more appropriate and widespread use of nonpharmacological treatments to humanely manage older patients' agitation and other behavioral symptoms that compromise their quality of life.

Possible Interventions

Successful nonpharmacological interventions take a person-centered approach and can range from actions as simple as verbal redirection or reorientation to offering food or validation or even to specific evidence-based therapies, such as multisensory stimulation, aromatherapy, cognitive behavioral therapy, animal-assisted therapy, physical exercise,⁸ massage and touch therapy, music therapy, and pet robot interventions.⁹ A Delphi panel agreed that the DICE (describe, investigate, create, and evaluate) intervention, used for assessing root causes, planning care, and training and empowering caregivers, was one of the most promising nonpharmacologic methods, along with music therapy.¹⁰

The American, Canadian, and European Union associations of geriatric psychiatrists recommend that nonpharmacological interventions for agitation in people with dementia of any degree of severity be first-line treatments; however, their use in clinical practice remains limited.^{8,11} This underutilization is due not only to inadequate funding and staffing, but also to the need for behavioral interventions to be individualized to the patient and setting, variability in implementation requirements, delays in onset of action, and negative perceptions of efficacy by patients, family, and health care practitioners.¹¹

There is no FDA-approved agent for the neuropsychiatric symptoms (NPS) of **dementia**; in 2005, the FDA issued a black box warning based on a meta-analysis that showed that antipsychotic use in older patients with dementia was associated with a significantly higher risk of death.^{12,13} Common side effects of antipsychotics include sedation, cognitive impairment, orthostasis, weight gain, dyslipidemia, diabetes mellitus, hypertension, and cardiovascular events, as well as urinary retention or incontinence.¹⁴ Effects on movement and gait—such as dystonia, parkinsonism, and tardive dyskinesia—can also contribute to elderly patients' morbidity and mortality by increasing fall risk,² which raises the risk of broken hips or femurs.¹⁵ The risk of side effects—ranging from dry mouth to death—is complicated further by older adults' increased sensitivity to antipsychotics resulting from changes in metabolism, fat distribution, dopaminergic pathways, and the blood-brain barrier.¹⁶

Risks and Benefits to Patients

Clinicians must carefully weigh the significant risks associated with antipsychotics against the potential benefits of their use. In 2016, the American Psychiatric Association advised that antipsychotic use in patients with dementia can be appropriate, as it can “minimize the risk of violence, reduce patient distress, improve patient's quality of life,

and reduce caregiver burden.”¹⁷ Accordingly, on this view of beneficence, exposing an agitated patient to the myriad risks of pharmacotherapy may at times be for the greater good. Beneficence in this case is most apparent in situations in which the need for action is urgent, such as when a patient’s agitation jeopardizes the safety of self or others (eg, patients or staff in a hospital setting).¹⁸ Even in the absence of impending physical harm to the patient or others, a patient’s distress could be seen as emotional harm and suffering, which might also be treated ethically with medication.¹⁹ This extension of the principle of beneficence is complicated by the confused patient’s impaired capacity or **lack of capacity** to understand or consent to the treatment. Frequently, a discussion with the patient’s family or primary caregivers is not feasible, and even when caregivers are available to comment, physicians must distinguish true patient distress from caregiver distress. In making a decision about antipsychotic use, the ethical physician should account for the benefit to the patient and to all involved in the care of the patient.

Physicians should seek input from all members of the treatment team while being vigilant for—and resistant to—any pressures to “medicate to make a person more manageable.”¹⁹ Following through on such requests would only be an attempt to mask the symptoms while ignoring underlying etiologies like short-staffed units. Patients should not be punished for the inefficiencies or failures of the hospital system they find themselves in. This dictum is underscored by the fact that members of this patient population often lack the capacity to choose their treatment or which health care ecosystem they will receive it in. They are in fact trapped through no fault of their own.

Risk to Staff and Other Patients

Adding to the complexity of the decision to use antipsychotics in inpatient units is the need to consider staff members’ and other patients’ safety and well-being. Patients with advanced dementia have impaired judgment and a reduced capacity to understand consequences, which can result in unintended harm to others. Specifically, when patients with dementia and severe NPS are mixed with frail older patients in understaffed units, the potential for assaults and injuries increase significantly, as a ward’s degree of overcrowding is a strong predictor of poor patient-patient interactions.²⁰

Staff working in acute geriatric wards are also at higher risk of experiencing workplace violence,²¹ burnout,²² and poor professional quality of life.²³ A cross-sectional survey comparing staff caring for patients with dementia in long term-care facilities and hospital wards showed that hospital staff had higher scores on measures of emotional exhaustion and depersonalization and lower scores on measures of personal accomplishment in addition to reporting more frequent stressful events related to behavioral disorders.²⁴ Moreover, when staff members work in this extremely challenging and pressured environment, their ability to provide compassionate care is hindered and may lead to attrition and unplanned sick leave, worsening the issue of short-staffed units.²⁵

When increasing resources is not a feasible option, employers often fall back on staff education and training to try to improve patient outcomes because they likely presume that behavioral changes would be easier to implement than tackling a larger system-wide issue. However, focal strategies to boost workforce compassion have not been enough to ensure adequate care in these challenging environments.²⁵

Cultural and Regulatory Changes

Since the late 1980s, there have been policies and agencies that have focused on reducing the use of chemical restraints, including antipsychotics and sedatives. The Nursing Home Reform Act of 1987 was enacted to provide oversight and empowered regulators to identify and issue citations for excessive use of physical or chemical restraints.²⁶ Toward this end, the Minimum Data Set system enables public reporting of quality measures at the state and facility level using the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare Data Set.²⁷ In 2012, CMS—along with state agencies, nursing homes, advocacy groups, and other stakeholders—started the National Partnership to Improve Dementia Care in Nursing Homes not only to decrease the use of psychotropics but also to improve quality of life for patients with dementia.²⁸ One of the issues highlighted by this program was that facilities that were relatively understaffed with respect to registered nurses had difficulty decreasing the use of psychotropics.²⁸

The insufficiency of nursing staff to care for older patients has been observed for decades and remains a challenge without a clear single solution. One key factor in the nursing staff shortage is that the training of new nurses has not kept pace with demand due to the shortage of nursing educators.^{29,30} Four strategic domains to address the nursing faculty shortage have been identified: advocacy, funding, educational partnerships between schools and health care organizations such as Project WINNER (Workforce Increases in Nursing and Nursing Education Excellence in Resources), and academic innovations such as recruiting retired nurses or educators without a nursing background.^{29,31}

Advocacy by professional organizations can also lead to significant legislative and regulatory changes. For example, the American Medical Association recently voted in favor of a “Nursing Shortage D-360.991” directive that aims to better understand the extent of the shortage, what factors are impacting it, and how best to address those factors.³² Advocacy on this issue has already led to increased public awareness and funding, including the passage of the Nurse Reinvestment Act of 2002, which authorized funds for education, training, and retention³³; the Affordable Care Act of 2010³⁴; and the American Rescue Plan Act of 2021, which authorized additional funds for nursing education and workforce development programs.³⁵

As other evidence-based techniques to help patients with significant agitation or aggression are explored, regulatory agencies actively include them in their standard of care guidelines. The adoption of such guidelines can promote a culture of safety and guide responses to critical events. Additional facility-level options include providing staff with continuing education and training, maintaining a safe environment free of breakable hardware and sharp objects, and creating a designated “retreat” space if patients elect to be separate from others.³⁶

To further promote patients’ self-determination, advance directives (ADs) can include decisions related to the use of antipsychotic medications for symptoms related to **dementia management**.³⁷ Unfortunately, it is estimated that only 37% of American adults have completed an AD, and only approximately 70% of older adults complete ADs prior to their death.^{38,39} Barriers to implementation include difficulty integrating a new practice into existing agency culture, legal misunderstandings, and limited access to ADs when needed.⁴⁰ Patients from minoritized populations generally have lower AD completion rates.⁴¹ Moreover, that AD documents are not culturally acceptable to

certain minority populations,⁴² including those that consider family and community to be the primary source of treatment decisions, further illustrates the complexity of antipsychotic use in dementia patients.⁴³

Conclusion

Public policy, funding, and institutional choices may create unjust situations in which clinicians like Dr A are forced to pragmatically rebalance the risks of overmedicating with the potential harm of agitation and aggression in crowded, understaffed units. However, it is vital that this realism does not blind one to the truth of the situation—that the status quo has fallen short of the ethical ideal of beneficence. While there is no one simple answer, individual clinicians and health systems have opportunities to advocate for prevention of this all-too-common scenario in geriatric care.

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