Find the low-hanging fruit: look for low doses. An order such as “Quetiapine 25 mg QHS” (every night at bedtime) is a red flag that this medication is being used for sleep. Due to its histamine and alpha blocking activity (think Benadryl + Terazosin), sedation will be produced, but so will a high risk of falls via orthostasis and a decent potential for constipation. This is a common new admission order, and the best practice would be to perform a one- to two-week taper down to discontinuation.

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Be patient. Many psychotropic medications can take two to four weeks to have an impact, with the full effects kicking in up to two months later. Resist the temptation to consider any changes within those time frames as markers of absolute success or failure. For example, if we try a dose reduction on Monday and the resident has an episode on Tuesday, it’s not the medication’s fault. On the other hand, be careful to declare a medication a success if the symptoms disappear on the third day of treatment. This is more likely related to side effects of the medication — namely, sedation — which they will grow accustomed to over time. Side effects are first, then efficacy.

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Be realistic. There are no medications that are approved for the treatment of agitation in dementia. Clearly spell out the goals of treatment, and ask, “Is this medication backed by realistic, evidence-based science that supports its use in this resident?” It is more likely that, as above, a side effect of the medication is being used to address a symptom.

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Be aware of prescribing cascades. The ever-increasing quantity of medications prescribed to our seniors heightens the likelihood of medication-induced disease. This is a situation where a medication is prescribed that has unintended effects, which are determined to be symptoms of a previously untreated or undertreated disease. A new medication is then added, which carries its own side effects and interactions, and the

cycle continues.

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Don’t be afraid of not prescribing. Sometimes there are no pharmaceutical answers to complex clinical questions. Be an advocate for the judicious use of psychotropic medications. Medications should be the *last* step in any process that is designed to treat behaviors causing distress to the resident or others. Although survey regulations may use the term “nondrug interventions,” its use should be avoided. Instead, focus on naming the actual interventions (e.g., “behavior management plan to reduce hoarding”) and make sure that the interventions are tailored to the particular resident. All residents are unique, so the solutions to what is ailing them should be as well.

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Have a purpose. Ask the question, “For what specific reason am I prescribing this medication?” Be exact in your rationale, what the treatment goals are, and what clinical outcomes will represent treatment success or failure. For example, “I am prescribing this medication for severe aggression that is causing significant distress to the resident and her fellow residents. I will reevaluate this dose in two to four weeks for evidence of improvement. I will measure improvement by the frequency of physical and verbal aggression to others as reported by the clinical team.”

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Think of the federal GDR psychotropic regulations as minimal standards. Federal regulations require that a GDR of a psychotropic medication is attempted twice in the first year of admission or initiation of the medication, then annually thereafter. But the timing of GDR attempts should not be limited by these strict rules. Instead, they should be individualized to the specific needs of each resident. In other words, if you think that a particular medication can be lowered, don’t wait until the next required GDR.