2025 TD Podcast Series
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TITLE	Facing a Long-Term Care Challenge: A Look at the Impact, Identification, and Treatment of Tardive Dyskinesia
PODCAST FORMAT	Monologue
HOST	Fay H. Bembry, FNP, PMHNP Regional Clinical Director TeamHealth Post Acute Behavioral Health Knoxville, Tennessee
EPISODE DESCRIPTION	Join Fay Bembry, a dual-certified family nurse practitioner and psychiatric mental health nurse practitioner, as she discusses the impact of tardive dyskinesia (TD) in long-term care—both its effects on residents and the challenges it poses to the care team. Fay will emphasize the importance of identifying TD in a timely manner in long-term care and share educational resources to help the care staff do so. She will also discuss some considerations for selecting treatment for residents with TD. For access to the resources discussed in this podcast, please visit www.mind-td.com, www.mind-td.com/discover-td, and www.dimdcourse.getlearnworlds.com.

SCRIPT

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Introduction

(Word count: 174 words; approximate time based on 150 WPM: 1min 10sec)

Hi, thanks for tuning in. My name is Fay Bembry. I'm the regional clinical director of TeamHealth Post Acute Behavioral Health in Knoxville, Tennessee, and am dual-certified as a family nurse practitioner and psychiatric mental health nurse practitioner. I've worked in long-term care for more than 30 years now, with the majority of that time spent focusing on

the care of psychiatric patients. I also have extensive experience treating movement disorders.

So, today we're going to talk about long-term care facilities and the impact of the drug-induced movement disorder *tardive dyskinesia* in this setting. We'll discuss how undiagnosed and untreated tardive dyskinesia can affect residents in long-term care, and how it can affect long-term care staff.

From my experience, the bottom line is this: tardive dyskinesia can have a substantial impact on the lives of long-term care residents, and it can substantially increase the burden placed on care staff who may already be stretched thin.

But there's good news: simple assessment tools can help identify tardive dyskinesia, and effective medications are available to help treat it.

Let's dive in.

Overview of TD, With Emphasis on the LTC Setting

(Word count: 365 words; approximate time based on 150 WPM: 2min 26sec)

First, let's review what tardive dyskinesia is. We'll call it TD for short. TD is a persistent and disruptive movement disorder linked to the use of first- and second-generation antipsychotic medications, as well as other medications that block dopamine receptors, like metoclopramide.[1]

TD can affect many different parts of the body. Common signs of TD include involuntary movements of the mouth, jaws, and face (called orofacial movements), as well as involuntary movements of the trunk or lower extremities.

The severity of TD can range from mild to severe, but even mild movements can be bothersome and can negatively affect residents' quality of life, and could potentially complicate their care. For example, a resident with lower extremity movements may pose a fall risk and may require assistance with bathing or dressing.

TD can affect not only residents' physical wellness, but also their emotional and social well-being. Involuntary orofacial movements from TD can make it difficult to eat or swallow, which poses a health and safety concern in addition to potentially causing embarrassment for the resident in social situations, such as during communal dining.

Other kinds of TD movements can cause issues as well. One of our residents with TD who is in a wheelchair had truncal movements that caused her to constantly rub her lower back against the chair, causing her skin to break down in that area.

So, how common is TD? It's estimated to affect at least 800,000 adults in the U.S. But of that number, about 60% remain undiagnosed.[2-4] And TD may be even more likely to go undetected in long-term care, where residents may have numerous medical conditions.

TD can add another layer of challenges among residents who already have complex care needs. And the needs of our residents in the long-term care (or LTC) setting seem to be getting more complex over time. For example, the proportion of LTC residents with serious mental illness has nearly doubled over a decade.[5] Based on an analysis of data from 2013 to 2019, about 20% of residents have serious mental illness.[6] And I think much of the increase has been due to the reduction in the number of mental health facilities providing long-term care.

Overview of the Ways in Which TD Adds to the Burden of Care in the LTC Setting

(Word count: 403 words; approximate time based on 150 WPM: 2min 41sec)

Let's take a closer look at how unaddressed TD can increase the burden on the already taxed LTC team.

First, let's briefly review the potential members of this multidisciplinary LTC care staff:

- The floor nurse administers medication, can give bedside care, and can perform basic assessments.
- The minimum data set nurse, who is usually an RN, does higher-level assessments.
- The certified nursing assistant supports the bedside nurse by giving hands-on care, such as helping with feeding, bathing, dressing, and transferring residents.
- An advanced practice nurse or other clinician assesses resident health, including monitoring of those taking antipsychotics for movement disorders such as TD.
- Speech therapists, occupational therapists, or physical therapists may be part of the team too, depending on the individual resident's impairments.

If you work in LTC, you already know that these care teams often face substantial barriers to providing optimal resident care. As I mentioned, resident care is becoming increasingly complex. And it all becomes even more difficult when faced with staff shortages,[7] turnover,[8] and associated burnout.[9]

Unfortunately, TD can make this situation even worse. TD's effects can complicate caregiving, give rise to resident safety issues,[10] and require additional time and attention from already-stretched staff.

Let's consider swallowing difficulties resulting from involuntary orofacial movements caused by TD. If there are 20 residents in one wing and 10 need feeding assistance due to

TD or another medical issue, it can be challenging for the staff to provide the help needed. And this challenge would be faced 3 times a day, 7 days a week.

During the COVID-19 pandemic, we admitted a resident who had been hospitalized for aspiration pneumonia. His orofacial movements were limiting his swallowing ability so much that he needed to have medications sprinkled into his applesauce or yogurt. When he came to our facility and his TD was finally treated, he was able to eat on his own with less supervision and assistance from staff.

Any additional care we provide for residents with TD must be customized to the needs of the individual. For example, as I mentioned, those with orofacial movements may require additional care if they have trouble feeding themselves or swallowing medications. As noted earlier, many residents with TD present an increased fall risk and require extra monitoring or help when they are moving about the facility. And TD can contribute to the inability to walk for many LTC residents, so they may require wheelchair transfers.

Factors to Consider Around the Diagnosis of TD in the LTC Setting

(Word count: 435 words; approximate time based on 150 WPM: 2min 54sec)

Now let's talk about how we can help identify TD in our residents, to get them the treatment they need to help control their symptoms and maximize their independence. Diagnosis can be challenging due to residents' overlapping comorbidities, but fortunately we have tools at our disposal to help.

The Abnormal Involuntary Movement Scale (or AIMS) is the standard assessment tool used in most states, and it can be administered by the minimum data set nurse, an advanced practice provider, or a physician.

The AIMS is a 12-item scale that assesses the severity of orofacial movements as well as extremity and truncal movements.[11] The first 7 items on the scale assess the severity of movements—that severity is rated by the provider as: none, minimal, mild, moderate, or severe. Items 8 through 10 are used to assess the severity of the movements overall, the incapacitation caused by the movements, and the patient's awareness of the movements. Finally, Items 11 and 12 are yes/no questions where the provider can record details of the patient's dental status. This tool has been used extensively in clinical trials of antipsychotic medications to monitor for the presence of TD. It is designed to be simple and quick to administer.

Remember that the AIMS may need to be modified for LTC residents, depending on their comorbid conditions. For example, it can be difficult to observe involuntary movements in the lower extremities in our many residents who use wheelchairs or walkers.

It's important to educate all LTC staff about the availability of the AIMS and how to use it to document notable involuntary movements. At my facility, all newly hired nurses are required to receive training so they can identify and assess for TD. We use a free, online educational resource called MIND-TD for this training. I'll provide a link to this resource at the end of the episode, and you can find all the resources I mention today in the episode notes.

Without sufficient staff training, a resident's involuntary movements may often be mistaken for something else. Here's an example of how the movements might be misinterpreted: My staff advised me that a resident was periodically exhibiting challenging behavior—such as throwing a cup on the floor at mealtime. What they attributed to behavioral "acting out" was actually a sign of the resident's TD! So it's important to be informed, consider the big picture, and take a closer look.

Another touchpoint when residents should be assessed for TD is when their antipsychotic medications are being adjusted. This is often a time when potential side effects such as involuntary movements may be discussed.

TD Treatment and Its Effects on the Burden of Care for LTC Care Staff

(Word count: 296 words; approximate time based on 150 WPM: 1min 58sec)

Now let's talk about management of TD in LTC residents. There are a lot of considerations, including comorbidities, pill burden, and polypharmacy. But an important point is that there are treatment options available. With the right interventions, TD symptoms can be improved and this can potentially lessen the burden on residents and LTC staff.

Prescribers should consider the guidance of the American Psychiatric Association (or APA) when selecting treatment for residents with TD. The APA recommends that those with TD that is at least moderate in severity be treated with a reversible inhibitor of the vesicular monoamine transporter 2 (called a VMAT2 inhibitor for short).[1] The APA also states that treatment with a VMAT2 inhibitor can be considered for patients with mild TD as well, depending on patient preference, associated impairment, or effect on psychosocial functioning. There is data that shows that even patients with mild TD are impacted by their movements.[3] In my practice, I often evaluate patients with mild movements if their symptoms are limiting their function or are bothersome to them.

Treatment selection should be customized to the resident, with considerations for comorbid conditions like renal/hepatic impairment, ease of use and complications with titration, contraindications, and drug-drug interactions, to name a few. For example, a resident who has difficulty swallowing may require unique medication considerations.

In short, proactive management of TD with a VMAT2 inhibitor may help reduce burden on both LTC residents and staff. One of our residents with TD who previously required assistance with eating can now enjoy meals unaided. And a resident with TD who previously required a wheelchair due to involuntary movement in her extremities can now walk through the facility without a wheelchair or any assistance. These improvements are so important to our residents and to our staff.

Summary of the Podcast and a Brief Overview of Available Resources for Listeners

(Word count: 226 words; approximate time based on 150 WPM: 1min 30sec)

So, to wrap up, it's really important to do everything we can to uncover TD in our LTC residents. And for those who *have* TD, the full care team should collaborate to ensure these residents get the appropriate treatment they need. From my clinical experience, it helps tremendously, and it benefits the LTC care team. We should all be vigilant in looking for signs of TD and advocating for timely treatment with a VMAT2 inhibitor, if appropriate.

Let me leave you with some great resources to support your efforts to identify and treat TD. I'll mention the web addresses here but don't worry if you don't catch them all; you can access them in this episode's notes. Each of these resources is sponsored and developed by Neurocrine Biosciences, Inc.

I've already mentioned the program called MIND-TD, which provides an educational booklet about the AIMS assessment tool and much more. You can access MIND-TD by visiting MIND hyphen TD dot com.

Another great resource for learning about TD is the Discover TD Educational Experience. You can access that at MIND hyphen TD dot com.

And there is a great multipart program about drug-induced movement disorders called the "diamond" course. This is available at dimdcourse dot getlearnworlds dot com.

Thanks for listening and for doing everything you can to help our residents with tardive dyskinesia get appropriate care.

References

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