Interventions in Managing Behaviors in Nursing and Assisted Living Facility Residents

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What I do

- Full time long term care physician
- Specialize in Hospice and Palliative Medicine
- Medical Director of 2 local nursing facilities
- Hospice Medical Director
- Regional Medical Director for Golden Living

Our Mission

- Take care of people
- Help caregivers take care of people
- Help doctors take care of people
- Help health care systems take care of people
- Help effect change in the culture of caring

Behaviors

- Often the most challenging issue in a nursing facility or assisted living community

Behaviors

- Often seen as a medical problem
- Often brought to the doctor's attention
- Often treated with medications because that's what we do as doctors

Behaviors

- Take an inordinate amount of staff time
- Generate many phone calls
- Result in polypharmacy= many medications
- Often persist despite our best efforts

“Behaviors”

- Yelling
- Wandering
- Getting up unassisted
- Inappropriate disrobing
- Inappropriate toileting
- Breaking things

“Behaviors”

- Exit seeking
- Pulling the fire alarm
- Resisting ADL cares
- Calling for help
- Repeating the same phrase over and over
- Bothering other residents
- Throwing food

“Behaviors”

- Hitting, scratching, kicking, biting
- Fidgeting
- Using inappropriate language
- Not sleeping at night
- Inappropriate sexual behaviors
- Calling people names

“Behaviors”: What’s the problem?

Residents aren’t doing what we want them to do, when we want them to do it, where we want them to do it, and/or how we want them to do it

Our expectations are the problem

We need to change

What's the problem?

How many of these behaviors are really dangerous problems?

How many are inconveniences for caregivers?

How many are just annoying to us?

Behaviors

- Very rarely unprovoked
- Usually start when we want to do something to a resident that they don't want to do
- Often escalate if we persist in what we're trying to get them to do
- Almost always get better if we stop doing what is upsetting our resident

-An individual is in conflict with their environment

-An individual is in distress

-An individual is trying to communicate

Our job is to understand and help them not feel distressed

Behavior is communication

- We need to figure out the message

Behaviors can mean:

- I’m in pain
- I’m hungry
- I’m wet/soiled
- I’m lonely
- I’m bored
- I’m scared

Pressure to prescribe

- "We're short-staffed"
- "We don't have enough time to do our job"
- "She's hurting staff"
- "He's hurting other residents"

“This is an emergency and we need to do something right now!!!”

Pressure to prescribe

- What's going on?
  - Staff feel threatened
  - Staff feel pressured
  - Staff feel unprepared
  - Staff are frightened
  - Staff become agitated
  - Staff exhibit behaviors

What do we prescribe?

- Anti-anxiety drugs
  - Lorazepam, diazepam, alprazolam
  - (a.k.a. Ativan, Valium, Xanax)
- Atypical antipsychotic drugs
  - Quetiapine, risperidone, olanzapine
  - (a.k.a. Seroquel, Risperdal, Zyprexa)
- Drugs that try to stop the behavior that is a problem

What do these drugs do?

- Make the resident sleepy
- Make the resident “easier to handle”

Why is that a problem?

- The medication is used as a chemical restraint
- We aren't allowed to use chemical restraints

Problems with antipsychotic use

- They're dangerous
- They don't work
- They're expensive
- They are a regulatory risk
- They are a legal risk

2005

FDA Black Box Warning: Increased risk of death in elderly patients with dementia

FDA WARNING

- *Increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 and 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-related patients was about 4.5%, as compared to a rate of about 2.6% in the placebo group.*

FDA WARNING

- *Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g. heart failure, sudden death) or infectious (e.g. pneumonia) in nature. [This drug] is not approved for the treatment of patients with dementia-related psychosis.*

Antipsychotic drugs

- FDA approved for treatment of
  - Schizophrenia
  - Bipolar Disorder

*“Off-label use” is everything else

Recent OIG and CMS activity

- May 2011 OIG Report – Daniel Levinson
- 6-month review of Medicare drug claims in 2007
  - *14% of elderly NF residents had claims for atypical antipsychotic drugs*
  - *83% of claims were for off-label conditions*
  - *88% of claims were associated with the condition specified in the FDA black box warning*

May 2011 OIG Report

- *22% of atypical antipsychotic drug claims were not administered in accordance with CMS standards regarding unnecessary drug use in nursing homes (excessive doses or excessive duration)*

- = $63 million over 6 months

Senate Special Committee on Aging

- Senator Richard Blumenthal:
  - *The use of antipsychotic drugs in the elderly constitutes elder abuse*

May 2011 OIG Report

- Directed CMS Survey and Certification to increase surveillance
- F-329 Free from unnecessary drugs
- F-501 Responsibilities of Medical director
- F-522 Right to be free from chemical restraints
- Quality of Life, Quality of Care, Physician Services, Pharmacy Services tags

Possible causes of “behaviors”

- Boredom, fatigue
- Hunger, thirst
- Wet, soiled
- Pain

Possible causes of “behaviors”

- Anxiety
- Illness – UTI, URI, constipation
- Social irritation
- Sensory deprivation – hearing, sight

Approaches to behaviors

- Take a deep breath and relax
- Identify the cause of the distress
- Modify the cause of the distress
- Stay calm, be patient
- Talk to the family about what has worked before
- If what you're doing doesn't work, try something else

Approaches to behaviors

- Discover bathing and grooming preferences
- Discover other schedule preferences
- Try again later
- Try a different caregiver
- Be flexible in our schedule
- Remember that they can’t remember

Approaches to behaviors

- Find a routine that works for the resident – may be different from “our schedule”
- Consistency of schedule
- Consistency of staff

- The solution is what works for the individual resident

Behavior solutions for us:

- Model appropriate behavior for staff
- Encourage peer mentoring of staff to staff
- Educate our staff
- Help our staff see our residents as individuals
  - Story boards
  - Memory boxes

Other interventions

- Look at our approach to residents
- Listen to our voice
- Look at our facial expressions
- Watch our posture
- Stay relaxed
- Minimize noises, bells, buzzers

Activities: Beyond Bingo

Meaningful roles

- Help our resident find a meaningful role in this new setting such as:
- Assisting other residents
- Folding towels
- Choosing an activity
- Sharing a talent

Others…

- Reminiscing
- Story-telling
- Music
- Aromatherapy
- Quiet atmosphere

Can this approach work?

Yes!

“Person-centered care”

Find what works for each resident

Honor their preferences and wishes

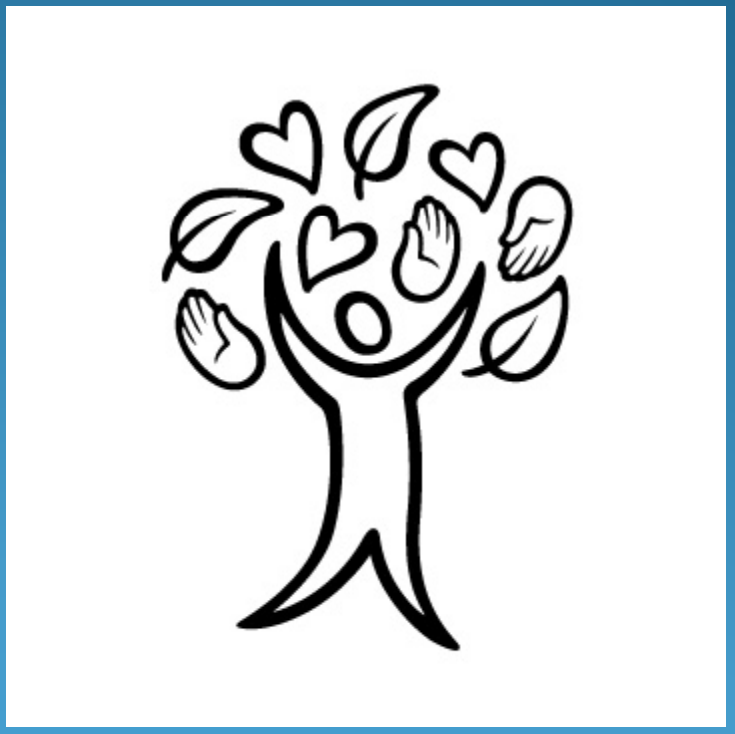
Learn how to change our behavior

Learn how to change the environment to meet the needs of our residents

Caring for Our Elders

- Sixth Annual Senior Care Conference

- April 16 and 17, 2013
- Holiday Inn
  1901 Emmet St.
  Charlottesville



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