Interventions in Managing Behaviors in Nursing and Assisted Living Facility Residents

Mary P. Evans MD CMD
President, Virginia Medical Directors Association

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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
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
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
References


- “Overprescribed: The Human and Taxpayers’ Costs of Antipsychotics in Nursing Homes,” Testimony before the US Senate Special Committee on Aging, Nov 30, 2011
- [http://aging.senate.gov/hearing_detail.cfm?id=335005](http://aging.senate.gov/hearing_detail.cfm?id=335005)