FHCA 2022 Annual Conference & Trade Show

CE Session #44 – Improving Behavioral Health in Florida's Nursing Centers Using Non-Pharmacological Interventions

Wednesday, August 3 – 2:15 to 3:15 p.m.

Celebration 8 – Clinical/Person-Centered Care Practices

Upon completion of this presentation, the learner will be able to:

- Identify problematic behaviors associated with behavioral health diagnoses
- Analyze problematic behaviors to identify the root cause
- Manage problematic behaviors through non-pharmacological interventions

Seminar Description:

Approximately 65-90% of nursing center residents have some form of mental or behavioral health problem. Such diagnoses are frequently associated with challenging, aggressive or care-resistant behaviors. These behaviors often lead to increased caregiver burden with the potential of leading to burnout and ultimately turnover. According to a recent study published by the American Geriatrics Society, 30% of nursing center providers suggest behavioral health service needs are unmet, citing lack of staff education as a major contributing factor. This session will help providers identify behavior problems associated with mental/behavioral health diagnoses and manage through non-pharmacological interventions.

Presenter Bio(s):

Dr. Kelly Smith holds a doctoral degree in Aging Studies, is a Certified Professional in Healthcare Quality, and holds a Lean Six Sigma Black Belt Certification. Through her knowledge of quality improvement methodologies and professional experience, Dr. Smith focuses on quality and process improvement across the long term care continuum.

Stephanie Witt holds a Masters Degree in Healthcare Management and has over 15 years of experience working as an executive director for skilled nursing and assisted living facilities. As the Director of Clinical Operations of Huntingdon Behavioral Health, she works with the Psychiatry and Psychology team in managing behavioral health across the state.

Improving Behavioral Health in Florida's Nursing Homes Using Non-Pharmacological Interventions

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Objectives

- Identify problematic behaviors associated with a behavioral health diagnosis
- Analyze problematic behaviors to identify the root cause
- Manage problematic behaviors through non-pharmacological interventions

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Background

- Of the 1.4 million older adults residing in nursing homes (NHs) approximately half have moderate (26.2%) to severe (38.6%) cognitive impairment[1]
- Individuals with cognitive impairment often exhibit undesirable behaviors which may include resistiveness or rejection to care due to:
  - Difficulty communicating needs
  - May result in increased burden on caregivers
- Treatment historically centered around the use of antipsychotic medications to alter neurotransmitters in the brain

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Background

- In 2005, the U.S. Food and Drug Administration issued a Black Box Warning indicating older adults with dementia-related psychosis are at an increased risk of death[2]
- Negative consequences and potential adverse effects have been identified through subsequent research[3] including:
  - Stroke
  - Death
  - Increased risk of falls
  - Further cognitive decline

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Background

- According to CMS (2021), 14.4% of long stay NH residents were treated with an antipsychotic medication in 2021[4]
  - 10% decrease over the past decade
- Older age is still associated with higher frequency of off-label prescription use[5]
- Non-pharmacological interventions are the key to:
  - Reduce unnecessary and inappropriate medication use
  - Keep residents safe
  - Improve resident's quality of life and dignity

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Background

- Research suggests the quality of staff interaction with residents exhibiting behaviors due to severe or moderate cognitive impairment directly impact a resident's quality of life[6]
- Non-pharmacological interventions are beneficial for a vast and wide array of diagnoses that cannot be treated with medical interventions
  - Psychotherapy or "talk therapy" can help explore the situation and get to the root of the problem
  - Create individualized treatment
- Potential barriers include lack of staff education and comfort level with engaging in talk therapy

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Objective I: Identifying Problematic Behaviors

Overview of Typical Problematic Diagnoses

- Basic definition
- Distinguishing behaviors and/or characteristics individuals with the diagnosis may exhibit
- Treatment potential with non-pharmacological interventions

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Objective I: Identifying Problematic Behaviors

Insomnia

- Lack of/or inability to sleep (2 Types)
  - *True* insomnia - trouble falling and/or staying asleep
  - *Pseudo* insomnia – characterized by excessive sleeping during the day
- Distinguished by fatigue or malaise, mood disturbances, lack of concentration, and/or social issues
- True insomnia can be treated with medication; however, it may be easier to let someone sleep through the day rather than wake them

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Objective I: Identifying Problematic Behaviors

Post Traumatic Stress Disorder (PTSD)

- Mental health condition triggered by experiencing or witnessing a terrifying event
- Characterized by nightmares, flashbacks, severe anxiety, and/or dissociated experiences
- Often treated with off-label medication (e.g., SSRIs, insomnia, anti-anxiety)
- Requires psychotherapy to assist with coping mechanism development

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Objective I: Identifying Problematic Behaviors

Bi-Polar Disorder

- Mental health condition caused by chemical imbalance within the brain
- Characterized by unusual shifts in mood, energy, activity levels, and concentration. Resident may seem non-cooperative, combative, crying, screaming, disruptive, false allegations, inappropriate, hyper-sexual, paranoid, and/or conflictual
- Medications can be helpful
- Psychotherapy also beneficial

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Objective I: Identifying Problematic Behaviors

Dementia

- Loss of cognitive function due to neurodegeneration of the brain
- *Without* behaviors
  - May be characterized by loss of memory, inability to make decisions or solve problems
- *With* behaviors
  - May be characterized by agitation, apathy, repetitive questioning, aggression, sleep problems, wandering, etc.
- Medications can be helpful
- Psychotherapy also beneficial

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Objective I: Identifying Problematic Behaviors

Depression

- Mood disorder which causes persistent feeling of sadness and loss which can interfere with daily life
- Characterized by crying, attention seeking, excessive complaining, irritability, non-compliance, and/or hygiene issues
- Medication can be helpful
- Psychotherapy also beneficial

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Objective I: Identifying Problematic Behaviors

Anxiety

- Feelings of worry, nervousness or unease which interferes with daily life
- Characterized by feelings of restlessness, difficulty sleeping, tension, increased worry, recurring thoughts or concerns, and/or elevated blood pressure
- Medication can be helpful
- Psychotherapy also beneficial

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Objective I: Identifying Problematic Behaviors

Sexual Behaviors

- Characterized by disinhibition, disrobing, or inappropriate interactions with staff/peers
- Treatable with medication but studies have demonstrated they are more effective on males than females
- Psychotherapy and behavioral approaches are beneficial

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Objective I: Identifying Problematic Behaviors

Adjustment Disorders

- A disorder related to an emotional or a behavioral reaction to a stress event or change in a person's life
- Characterized by feelings of sadness, lack of appetite, feeling overwhelmed, withdrawal from social support, and/or suicidal thoughts
- Psychotherapy can very beneficial with medication used in chronic cases

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Objective II: Analyzing Problematic Behaviors

Above the surface you see the **Symptoms** of the problem

Dig deeper to find the **Root Cause** of the problem

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Objective II: Analyzing Problematic Behaviors

ABC Model

Antecedent
(Trigger)

Behavior
(Action you want to change)

Consequence
(What is resident getting out of behavior?)

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Objective II: Analyzing Problematic Behaviors

Common Scenarios:

- Resident refuses to get a bath
- Resident is hoarding sugar packets
- Resident refuses to take medication
- Resident is barricading him/herself in their room
- Resident is inappropriately touching staff
- Resident acts out on weekends
- Resident cooperates with one CNA but not others
- Resident suddenly doesn't get along with his/her roommate
- Resident refuses to go to therapy
- Resident is suddenly irritable most of the time

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Objective II: Analyzing Problematic Behaviors

First Step: What is triggering the behavior?

- What happened before the behavior occurred?
- Where was the resident?
- What was he/she doing?
- Who was his/her caregiver?
- Has this occurred before?
  - In same location? Similar circumstances? Same caregiver?

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Objective II: Analyzing Problematic Behaviors

2nd Step: Identify Consequence: *What is the resident getting out of the behavior they are displaying*?

- Does the resident have an unmet need?
- Are they getting [*could fill in the blank with any of below*] when they exhibit this behavior?
  - More attention
  - A specific caregiver
  - ER visit
  - Walks outside
  - More food choices
  - More trips to the doctor
  - Family visit

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Objective III: Managing Problematic Behaviors

- Develop a plan using interdisciplinary approach
- Select intervention to reduce unwanted behavior
- Design plan
  - Define timeframe to deploy intervention
  - Define team of who will be involved
  - Define target goal & data collection tools
  - Set specific date to reassess
- Modify plan if/as needed
- Repeat plan modification process until desired results are achieved or new plan is identified and implemented

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Objective III: Managing Problematic Behaviors

Strategies to Try:

- Use of common courtesies go a long way
  - Being polite, kind, using quiet voice, slow movement
- Communication
  - Tell the resident what is being accomplished and give them the right to say no
- Distraction
- Redirection
- Reassurance

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Objective III: Managing Problematic Behaviors

Strategies to Try:

- Count to 10
  - Key is to "respond" NOT "react"
- Seek first to understand
  - Is there a need you can fill?
  - Is there a team member who may be exacerbating the situation?
- Brainstorm/ Household model
  - Who are the key players that interact with the resident
  - Be sure to include housekeepers, CNAs, etc.

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Objective III: Managing Problematic Behaviors

Strategies to Try, Cont'd:

- Stay positive
  - Removes yourself emotionally; this is a behavior not the person
- Be aware of burnout
  - Staff who are overwhelmed may have difficulty remaining positive in interactions with residents
  - Promote self-awareness
- Wipe your feet at the door
  - Having a clear head when entering a resident room prepares the mind to deal with what is ahead
  - Remember, you are working in THEIR home

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Objective III: Managing Problematic Behaviors

Reduce Environmental Triggers

- Residents diagnosed with dementia should not experience room changes unless it is absolutely necessary
- Shut televisions off at night, have headphones to use, or have televisions set on timers
- Overnight staff should not wake up residents for vitals unless ordered by the physician

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Objective III: Managing Problematic Behaviors

- Have a behavior management plan
- Non-pharmacological interventions with an interdisciplinary approach is best
- Mental health experts should be consulted to determine what interventions might work and who needs therapy
- A team strategy should be developed to meet individual resident needs

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Let's Practice!!

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Case Study #1: Group Activity

- As a group, review Case Study #1
- Using the Antecedent-Behavior-Consequence Model, identify the following:
  - Antecedents
    - What is triggering/causing/occurring before the behavior?
  - Behavior
    - Increase if positive / Decrease if negative
  - Consequence
    - What is the person getting after the behavior?

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Let's Share

- What antecedents were you able to identify?
- What was the unwanted behavior(s)?
- What were the consequences of the unwanted behavior(s)?
- What potential interventions might you deploy?

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Case Study #2: Group Activity

- As a group, review Case Study #2
- Using the Antecedent-Behavior-Consequence Model, identify the following:
  - Antecedents
    - What is triggering/causing/occurring before the behavior?
  - Behavior
    - Increase if positive / Decrease if negative
  - Consequence
    - What is the person getting after the behavior?

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Let's Share

- What antecedents were you able to identify?
- What was the unwanted behavior(s)?
- What were the consequences of the unwanted behavior(s)?
- What potential interventions might you deploy?

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References

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Thank you for your time!

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Improving Behavioral Health in Florida's Nursing Centers Using Non-Pharmacological Interventions

Case Study 1

Mr. Smith has been admitted to a skilled nursing facility for the first time. He is a highly functioning, family-oriented, retired CEO who is used to being in a position of control and relied upon for advice/guidance by his adult children and colleagues. Prior to his admission, he was active in the community and played golf until he underwent a below-the-knee amputation due to a diabetes complication. He is consistently irritable toward staff, including CNAs, non-compliant with his care plan and meds, and doesn't follow recommendations of his physical therapist. Mr. Smith may be depressed but refuses a psychiatric consult. He does not like the food in the facility and often refuses to eat which poses additional issues with his diabetes. His behavior is also putting a strain on his marriage because he consistently is barking orders at his wife, telling her what to say and what to do. He is making staff and his family crazy because no one knows how to deal with him. As a result, staff avoids him. Mrs. Smith continues to come in twice a day to visit and make sure he is okay.

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Case Study 2

Mrs. Gonzalez is a 91-year-old widow. She has lived at the facility for a year and a half. She has a history of dementia, is currently staging and showing signs of additional cognitive decline. Mrs. Gonzalez is also experiencing hallucinations and becomes agitated easily. She often misinterprets staff, is delusional, and paranoid with feelings that the staff is stealing from her and/or out to get her. Often, she is seen crying and has mood issues when staff tries to provide care. Her favorite CNA, Lucia, takes her for a walk instead of making her take her bi-weekly shower. Mrs. Gonzalez has no family in town to visit so there is no social support outside of what the staff provides. She is currently taking psychotropic meds for dementia and a mood disorder. Recently lab work was performed and she was cleared for any infection. Her CBC was also within normal limits. She does not participate activities but often thinks of the past and ruminates wishing she could be with her mom. This often results in Lucia and/or another CNA sitting with her to let her talk about her younger years.

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