Clinical Trends in Long-Term Care

Presented By
Behavioral Care Solutions

WHCA
April 11, 2018

Behavioral Care Solutions (BCS)

BCS was established in 2007 and is an organization dedicated to the provision of geriatric and older adult behavioral healthcare and wellness. BCS offers comprehensive on-site psychiatric and psychological services to individuals residing in nursing home facilities, assisted living, and other domiciliary care settings. BCS currently services over 300 facilities located in Michigan, Ohio, Wisconsin, Indiana, and Illinois. BCS staff are comprised of psychiatrists, psychologists, neuropsychologists and psychiatric nurse practitioners. BCS provides specialized programs in dementia care, dealing with difficult behaviors, and OBRA oversight including GDR reviews and tracking, staff training. BCS now offers tele-psychiatric services to supplement and enhance on-site care.

Presentation Objectives

To obtain a better understanding of the history of, and recent changes to, the CMS regulatory guidelines governing the use of psychotropic medications in the nursing home setting.
To obtain an understanding of a clear set of strategies facilities can implement to enhance documentation and compliance with these guidelines.
To obtain a basic knowledge of behavior and non-pharmacological management principles with a focus on dealing with difficult behaviors.
To obtain a basic understanding of pharmacological management of common psychiatric conditions in the nursing home population.
I. LTC FACILITY TRENDS

LTC Facility Trends

- Changing patient demographic
  - Increased prevalence of dementia at later stages; as median age of NH resident increases
  - Over 85 years: 50% chance of AD
- Chronically Mentally Ill (CMI)
  - State Inpatient facility closures
- Traumatic brain injury, stroke and other conditions that require rehabilitation most commonly provided in LTC rather than hospital-based setting
- Recent studies have suggested that over 70% of residents in long-term care (LTC) facilities have some form of psychiatric disorder or disturbance that requires specialized treatment.
- Study in the Journal of Long-Term Care (2016) indicated that over 51% of residents in long-term care (LTC) facilities receive some type of psychoactive medication.

LTC Facility Trends

- The most common psychiatric disturbances reported in nursing homes often take the form of verbal and emotional outbursts and distress such as inappropriate crying, laughing, and anger (“emotional agitation”) or physical agitation and aggression.
- The prominent cause of these conditions is often related to the diffuse neurodegenerative nature of Alzheimer’s disease and other forms of dementia or deteriorative neurological conditions, but may also include schizophrenia, depression, mood disorders, and other conditions.
- As a response to the increased incidence of such conditions, psychiatric consultation models have become a more common part of resident care in LTC settings.
- While this has provided relief to many, it has also resulted in an explosion of the use, and often misuse, of psychoactive agents, in particular the atypical antipsychotics (AAP) due to the historical lack of other available alternatives to identify and treat those disturbances related to Alzheimer’s and other neurodegenerative conditions.
LTC Facility Trends

- These measures have brought attention to the issue of overmedication, use of medications for sedating effects and established punitive actions for misuse (including monetary fines levied daily until facility is in compliance and/or suspension of ability to bill Medicare).
- Despite the significant increase in admissions to nursing homes of residents with psychiatric and behavioral disturbances, facilities are being evaluated on efforts to reduce or eliminate the very medications often used to treat these conditions.
- Congress and other state and federal regulatory bodies enacted the Omnibus Budget and Reconciliation Act (OBRA) in 1987 to develop broad guidelines to address the misuse of psychotropic medications in the nursing home population.
- These guidelines have continued to evolve and change over the years.

2. OMNIBUS RECONCILIATION ACT (OBRA)
Omnibus Reconciliation Act

- OBRA Psychotropic Utilization Guidelines of 1987 (F-329) have specific rules to regulate long-acting benzodiazepines, medication used for sleep induction and atypical antipsychotic medication.

- The major objective of the guidelines is to ensure that each resident's entire drug/medication regimen be managed and monitored to achieve the following goals:
  - Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s).
  - Non-pharmacological interventions (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to, medication.
  - Clinically significant adverse consequences are minimized, and
  - The potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate.

Omnibus Reconciliation Act

- Guidelines identify six ways in which psychotropic medication use can be deemed unnecessary. These recommendations support another significant goal, which is to employ the least restrictive and intrusive interventions possible. Any medication use outside the OBRA Utilization Guidelines must be based on a sound assessment and risk/benefit analysis of the patient’s psychiatric problems and the potential adverse effects of the medication.
  - Use of excessive doses (including duplicate therapy) or sub-therapeutic doses
  - Use in excessive duration,
  - Use without adequate behavioral monitoring,
  - Use without adequate indications,
  - Use in the presence of adverse consequences which indicate the dose should be reduced or discontinued,
  - Any combination of the above reasons

- State Survey Teams audit medical charts and care in the LTC facilities for evaluating adherence to these guidelines on at least an annual basis.

- LTC facilities are mandated to conduct regular Dose Reduction Reviews (DGR) on all psychoactive medications.

Omnibus Reconciliation Act

- Despite the introduction of OBRA Guidelines in 1987, AAP use has continued to increase in the LTC setting as a primary means to address agitation secondary to dementia and admission of more residents with a CMI.
- AAP use was often initiated to address a target symptom but was not monitored or d/c’d following abatement of symptoms or non-response to treatment.
- AAP’s were used as a means of “chemical restraint”.
- Concurrent 2nd Gen Atypical Antipsychotic & Alzheimer’s Disease Treatments
- FDA Black Box Warning on All AAPs

WARNING

Increased Mortality in Elderly Patients with Dementia-Related Psychosis — Elderly patients with dementia-related psychoses 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 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the risk of death in drug-treated patients was about 4.5%, compared to a rate of about 2% in the placebo group. 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. ZYPREXA (olanzapine) is not approved for the treatment of patients with dementia-related psychosis (see WARNINGS).
4. PREVIOUS CMS MANDATES

Regulations Are Changing….

Expanded F-329 OBRA Guidelines

In response to this trend, the “Expanded f-329 OBRA guidelines” were introduced to further mandate more specific protocols to be conducted by LTC staff in monitoring, documenting, and justifying ongoing psychoactive medication use. These mandates included:

- Regular Dose Reduction Reviews to be completed by the LTC Interdisciplinary Team at admission and bi-annually thereafter.
- Clear rationales as to the necessity to maintain the psychoactive regimen as demonstrated by previous attempts to remove medication or ongoing objective behavioral tracking.
- Greater emphasis on the physician oversight of this class of medications.
- Increased fines and punitive actions were made available to “Survey Teams” who evaluate LTC facilities annually on compliance with the OBRA standards.
- Violations of the f-329 guidelines have become one of the most cited tags during facilities annual surveys.
CMS Mandates

Calculation:
- Numerator:
  - # of residents identified on most recent assessment as receiving antipsychotic drug
- Denominator:
  - All residents except those with diagnoses of schizophrenia, Huntington’s Disease, Tourette’s Syndrome or with hallucinations indicated on the most recent assessment

2012 CMS Initiative

- CMS will increase focus on use of AAP’s during Survey.
- CMS will bolster enforcement of the mandated 15% reductions through increased fines and penalties to the LTC facility.
- CMS will develop public reporting of overuse of AAP’s which may impact census of those non-performing facilities.
5-Star Quality Rating System

- Since 2005, CMS took steps to reduce the use of antipsychotics in residents with dementia. Studies do not support the use of these medications in the treatment of dementia-related agitation.
- Despite early efforts, antipsychotic prescribing levels in nursing homes remained high. To combat this problem, CMS added antipsychotic prescribing to the CMS Nursing Home 5-Star Quality Rating System in 2015.
- The 5-Star Quality Rating System measures nursing home performance by awarding 1 to 5 stars in 3 areas: Health Inspections, Staffing, and Quality.
- The only exceptions for prescribing antipsychotics are residents with Schizophrenia, Huntington's chorea, and Tourette's syndrome.
- This quality mandate will have its intended effect of reducing antipsychotics in patients with dementia but will also make it difficult to prescribe when needed for other conditions including terminal agitation and other behavioral symptoms.

The Problem Continues.....

- The seminal research article in the NEJM (2006) has been further substantiated by multiple additional studies over the last decade.
- 2014 article in the American Journal of Geriatric Pharmacotherapy indicates that 24.8% (0.36 million) of individuals in these settings are currently prescribed a psychoactive medication for symptom management and this number is expected to double over the next ten years.
- Very sparse base of evidence regarding the safety and efficacy of many medications commonly used to treat psychiatric symptoms. Many of these medications are used off-label for the secondary properties rather than primary mechanism of the medication.
- 2016 article in The Journal of Psychiatric Services found that 86.3% of AAP use in the NH setting is for off-label indications.
- Facilities continue to struggle due to the inadequate availability of mental health resources.

3. OBRA GUIDELINES CONTINUE TO CHANGE
Changing Guidelines
- On November 28, 2017, the Centers for Medicare and Medicaid Services (CMS) implemented several regulatory changes for skilled nursing facilities (SNFs).
  - CMS has updated the definition of a psychotropic medication to be:
    - Any drug that affects brain activities associated with mental processes and behavior.
    - These drugs include, but are not limited to, drugs in the categories of antipsychotics, antidepressants, antianxiety, and sedatives or hypnotics.
  - In addition, drugs that may affect brain activity in the following categories may also be considered psychotropics by State surveyors:
    - CNS agents
    - Mood stabilizers
    - Anticonvulsants
    - Muscle Relaxers
    - Anticholinergic Medications
    - Antihistamines
    - NMDA Receptor Modulators
    - Melatonin and other nutritional supplements

Changing Guidelines
- F-757 (Previously F-329) Drug Regimen is Free from Unnecessary Drugs
  - Core F-329 guidelines similarly defined
  - Definition of psychotropic drug expanded
  - Greater emphasis on behavior indication and tracking
  - Care planning to indicate more person centered language e.g. "specific expressions or indications of distress and behavior"
  - Documentation of specific non-pharmacological approaches to care.
  - Indication in the medical record of regular interdisciplinary coordination and/or behavioral committee meetings.
  - Facility has defined psychoactive medication reduction program
  - Diagnosis consistent with psychoactive medication prescribed.
  - Potential underlying medical causes of psychiatric condition ruled out and documented in medical record.

Antipsychotic medication shall only be used with the following diagnosis:
- All Schizophrenia Codes
- Paranoid States
- Paraphoria
- Shared Psychotic Disorder
- Other Specified Paranoid States
- Unspecified Paranoid States
- Depressive Psychosis
- Excllusive Psychosis
- Hypochondriacal Psychosis
- Delirium Psychosis
- Acute Paranoid Reaction
- Other and Unspecified Reactive Psychosis
- Tourette’s Syndrome
- Huntington’s Chorea

Please note these diagnosis differ from those indicated under the 5 Star Quality Rating Initiative.
Changing Guidelines

- **F 758 Free from Unnecessary Psychotropic Medications-PRN Use**
  - 14 day limitation on all PRN orders (except antipsychotic’s). Orders may be extended beyond 14 days if the prescribing clinician:
    1) Believes it is appropriate to extend the order– and–
    2) Documents clinical rationale for the extension– and–
    3) Provides a specific duration of use

- **F 14 day limitation on all PRN antipsychotic orders. Order may not be extended beyond 14 days. A new order may be written if the prescribing clinician:**
  1) Directly examines the resident. Evaluation by facility staff is not permitted – and–
  2) Documents a clinical rationale for the new order indicating the benefits of the medication and objective indicators of improvement as a result of the PRN medication.

Changing Guidelines

- The items indicated must be completed every 14 days for a resident receiving an antipsychotic. There are no exceptions for Hospice residents.
- This regulation does NOT mean a facility cannot use these medications, or initiate a PRN in emergent situations.
- Per regulation, “When a resident is experiencing an acute psychiatric emergency (e.g. the resident’s behavior or expression poses an immediate risk to self or others), medications may be required and diagnosed as delirium induced psychosis or similar. As always, medications should only be used in the presence of active clinical symptoms and after non-pharmacological interventions and less restrictive measures have been attempted.” (CMS)

Changing Guidelines

- **Additional F Tags Associated with Behavioral Healthcare Provided to a Resident in a Skilled Nursing Facility (SNF)**
  - F 605 Free from Physical or Chemical Restraints
  - F 657 Adequate Care Planning
  - F 676-677 Activities of Daily Living
  - F 679-680 Activities Provided to Meet Needs and Functional Level of Resident
  - F 947 Facility Staff Education and Competency in Dementia Care
  - F 840 Provision of Outside Services
    • Mental Health Services to be Added as Separate Requirement (No F code yet assigned)
  - As of November 2018, CMS shall require and assign an F code to ensure all SNF’s provide training in dementia care and understanding to all staff providing services at the facility. This includes consultants, volunteers, and other individuals that may not be direct staff employed by the SNF.
4. STRATEGIES TO ENHANCE FACILITY COMPLIANCE

Strategies to Enhance Facility Compliance

State Surveyors make Compliance Decisions by Evaluating the Following Six Critical Elements:

1) Did the facility comprehensively assess the resident’s physical, mental, and psychosocial needs to identify risks or underlying causes of the resident’s condition and the impact of use of a medication on function, mood, and cognition? (If no, cite F272)

2) Did the facility develop a plan of care based on the assessment of the resident’s condition, risks, needs, and behaviors that was consistent with the resident’s therapeutic goals and considered the need to monitor for effectiveness to address the use of medications and prevent adverse consequences? (If no, cite F279)

3) Did the facility provide or arrange for services to be provided by qualified persons per the written care plan and did the facility implement the care plan adequately? (If no, cite F282)

4) Did the facility regularly assess the effectiveness of the interventions and review and revise the care plan as necessary? (If no, cite F280)

5) Did the facility ensure that each resident’s medication regimen was free from unnecessary medications? An unnecessary medication is a medication used:
   - In excessive doses
   - For excessive duration
   - Without adequate monitoring
   - Without indications for its use
   - In the presence of adverse consequences which indicate the dose should be reduced or discontinued
   - Comply with PRN guidelines
   (If no, cite F757 or 758)

6) Did the facility conduct a regular review of the resident’s drug regimen, including GDR efforts, and report any irregularities to the attending physician, prescribing clinician, or director of nursing? (If no, cite F428)
Strategies to Enhance Facility Compliance

- **Document an Acceptable Clinical Indication for Use**
  - Diagnosis consistent with use of medication (e.g., anti-depressants used for depression, anti-anxiety medications used for anxiety, etc.)
  - Objective and observable behavior or emotional features of diagnosis clearly indicated and documented:
    - Baseline of frequency, duration, and content of observable behavior or mood established
    - The following are not appropriate reasons to use antipsychotics:
      - Wandering, restlessness, or mild anxiety
      - Poor self care
      - Impaired memory
      - Insomnia
      - Sadness or crying alone that is not related to depression
      - Fidgeting or nervousness
      - Uncooperativeness
  - If antipsychotics being utilized then facility must:
    - Ensure acceptable diagnosis indicated and symptoms are due to mania or psychosis and/or
    - Symptoms present a danger to resident or others and/or
    - Resident is experiencing inconsolable or persistent distress and/or
    - Resident is experiencing a significant decline in function or inability to receive needed care.

- **Demonstrates Monitoring for Each Medication as Appropriate**
  - Behavior or mood indicators clearly identified and tracked for all psychoactive medications:
    - Antidepressants-crying, isolation, appetite, etc.
    - Antianxiety—Restlessness, panic symptoms, etc.
    - Antipsychotics-delusions, hallucinations, agitated behavior (clearly defined), etc.
    - Hypnotics—Hours of sleep
  - Effectiveness clearly documented (e.g., behavior or mood symptoms response to treatment as indicated via tracking tools)

- **Demonstrates Appropriate Use and Dosing of each Medication**
  - Evidence of less restrictive medications used prior to initiation of more restrictive medications (particularly when using antipsychotics)
  - Rationale for duplicative medication use clearly documented
  - Rationale clearly documented when exceeding manufacturer’s guidelines or standards of care.

- **Documents Clinical Rationale for Continued Use of Medication**
  - Medical record includes clear explanation for ongoing use of medication.
  - Prescribing clinician writes new order at least every 90 days except for antipsychotics which should be reordered every 14 days.
  - Prescribing clinician documents potential incompatibilities between medications.

- **Documents a System that Monitors and Addresses the Presence of or Potential for Side Effects**
  - Prescribing clinician documents a clear clinical rationale for continuing a medication that may be causing an adverse consequence, including a risk-benefit analysis.
  - If using an antipsychotic, an AIMS test completed every 90 days.

- **Demonstrates Potential Underlying Medical Causes of Behavior or Mood Disturbance have been Ruled Out**
  - Delirium
  - Neurological event
  - Other neurological condition (e.g., PBA, etc.)
  - Medication side effects (e.g., Akathisia, etc.)
  - Drug-drug interactions
  - Overuse of Anticholinergic Medications
A Prescribing Cascade Involving Cholinesterase Inhibitors and Anticholinergic Drugs

Gill SS, et al.

Background: The prescribing cascade model involves the misinterpretation of an adverse reaction to 1 drug and the subsequent, potentially inappropriate prescription of a second drug. We present a new example of the prescribing cascade involving cholinesterase inhibitors and anticholinergic drugs used to manage urinary incontinence.

Methods: 44,884 older adults with dementia; 3 year period. Retrospective study analysis.

Conclusions: Use of cholinesterase inhibitors is associated with an increased risk of receiving an anticholinergic drug to manage urinary incontinence. The use of an anticholinergic drug in this setting may represent a clinically important prescribing cascade. Clinicians should consider the possible contributing role of cholinesterase inhibitors in new-onset or worsening urinary incontinence and the potential risk of co-prescribing cholinesterase inhibitors and anticholinergic drugs to patients with dementia.

Chronic Exposure to Anticholinergic Medications Adversely Affects the Course of Alzheimer Disease

Ching-ju, Lu, B. and Larry E. Tune, MD
Emory University, School of Medicine,

Objective: Authors examined the effect of chronic exposure to anticholinergics in a cohort of Alzheimer disease (AD) patients.

Methods: All patients were examined annually with standard neuropsychologic tests and received the cholinesterase inhibitor donepezil hydrochloride at a dose of 10 mg/day. The study population (N=69) was divided into two groups: those receiving one or more concomitant medications with significant anticholinergic properties (N=16) and those receiving no concomitant medications with anticholinergic properties (N=53). Results: At 2 years, MMSE scores were significantly worse for patients receiving anticholinergic medications than for those not on anticholinergics.

Conclusion: Although very preliminary, these data suggest that concomitant therapy with anticholinergics may be associated with significant deleterious effects on acetylcholinesterase therapy, or, more speculatively, that chronic exposure to anticholinergics may have adverse effects on the clinical course of AD.

Dementia Therapies

Involuntary Weight Loss Associated with Cholinesterase Inhibitors in Dementia

Jonathan Stewart, MD and Asher Gorelik, MD
University of South Florida College of Medicine, Geropsychiatry Section
Bay Pines VA Medical Center

The American Academy of Neurology’s Dementia Guidelines assert that “Cholinesterase inhibitors should be considered in patients with mild or moderate AD (Standard), although studies suggest a small average degree of benefit” and a recent large double-blind, placebo-controlled study of donepezil found little meaningful improvement.

Cholinesterase inhibitors are not without side effects, which are mostly gastrointestinal in nature. Anorexia and weight loss are reported in 17% of patients, but are seldom given much attention in the literature; these are ominous symptoms in older patients in general and in demented patients in particular, being associated with decreased quality of life, functional decline, institutionalization, and mortality.

Given the relatively modest benefit of Cholinesterase Inhibitors in AD (and limited evidence of efficacy in other dementias) thoughtful consideration must be given to even modest risk, much less to the potentially devastating risk of significant weight loss in an at-risk patient.
Strategies to Enhance Facility Compliance

- Demonstrates efforts to provide disease state education and health education material to:
  - Family Members
  - Responsible Parties
  - Nursing Staff & Clinicians

Strategies to Enhance Facility Compliance

- Demonstrates a System for and Documents Considerations for Gradual Dose Reductions (GDR)

Strategies to Enhance Facility Compliance

- Demonstrates an Interdisciplinary Team (IDT) / Behavioral Management Process
Strategies to Enhance Facility Compliance

- Demonstrates non-pharmacological interventions being used and incorporated into care planning.
- When using psychoactive medications, it is critical to clearly document in the resident care plan all efforts to employ less restrictive techniques to manage behavior or mood disturbances. This can include:
  - Availability of activity therapy that is specific to resident level of functioning and cognitive capacity.
  - Specific program references are available upon request.
  - Documentation of staff training in dementia care.
  - Environmental modification.
  - Access to mental health services for the provision of supportive based therapeutic interventions for residents with the cognitive capacity to participate in active treatment.
  - Family-based interventions.
  - Individualized behavior management planning specific to the resident’s target behavior(s) and clearly documented in the care plan.
  - Example plans have been provided for reference.

AAP Reduction Trials

- 37.5% GDR Rate

Nonpharmacological Approaches to Behavior Management
Causes and Contributing Factors

- Physiological/Psychological
  - Dementia
  - Pain/discomfort
  - Delirium
  - Mental Health/Mental Disorders – when unmanaged, poorly managed, or unstable
  - Hunger/Hydrated Hydration Concerns
  - Fear

- Environmental
  - Noisy
  - Crowded
  - Lighting
  - Availability of stimulating activity/ boredom
  - Social interactions, support and available social network

BioPsychoSocial Approach

- Biological
- Psychological
- Sociological
- Holistic Perspective and is in major contrast to the historically used biomedical approach (disease model).
- First introduced by Dr. George Engel MD

BioPsychoSocial Approach - continued

- The body can affect the mind and the working of the mind affects the body.
- Utilizes every aspect of the Interdisciplinary Team (IDT) and is successful only when each team members specialization/area of study is recognized, respected and utilized.
Importance of Full Evaluation

- Disruptive/inappropriate/aggressive behaviors hinder care needs and result in noncompliance.
- Often disrupts living environment
- Disrupts peers routine/daily activity
- Can be harmful to resident, peers and staff

Assessing Physiological Components

- Resident’s ability to communicate
- Is resident showing signs of discomfort/pain?
- Resident’s medical history
- Presentation of fever, constipation, urinary retention, new onset of cough/SOB
- Is the resident hungry, thirsty, or need to use the bathroom?
- Any hearing/visual impairments
- Internal Stimuli – delusions/hallucinations
Assessing Environmental/Psychosocial Components

- Environment supportive to that particular resident's needs
- Compatibility of his/her roommate
- Functional & dignified daily activities
- Adequate/positive social interactions with family, peers and/or staff
- Decisions made by resident about care & routine
- Bored or lonely
- Sad, angry or afraid
- Refusing ADLs
- Resident bothered by any particular resident on consistent basis
- Looking for something/someone

Appropriate Safety Awareness

- Working with known aggressive residents
  - NEVER provide care to an aggressive resident without a peers knowledge.
  - NEVER attempt to handle a violent situation alone. Get help.
  - Notify your supervisor prior to attempting to engage a known violent resident.
  - Bring a coworker to assist you whenever possible.
  - If resident is agitated and violence seems imminent, do not attempt care.

Finding Yourself in a Violent Situation

- Remain Calm
- Get Help
- If you have to restrain someone temporarily, do so with your hands (for their safety and yours).
- Remember to document the occurrence per your facility/company's established protocol.
  - If situation requires it, notify appropriate authorities.
Verbal and Nonverbal Communication

• Use the name of the resident and make sure you have their attention.
• When referencing an alternate staff member, use that staff member’s name and title.
• Be mindful of rate, tone, and volume.
• Rule of 5
  • Use statements & questions with 5 words or less, using words with 5 letters or less.
  • Reasoning: “Magical Number Seven +/- two” – Studies have found that people are able to process up to 7 (+/- two) different types of stimuli within an environment or interaction.

Interventions When Working With Patients Who Present with Manipulative Behaviors
Manipulative Behaviors

- Potential for staff manipulation is high among patients who:
  - Have a formal diagnosis of a personality disorder (especially cluster B).
  - Have a chemical dependence.
  - Experiencing a manic or hypomanic episodes related to a Bipolar Diagnosis.
  - Have a long history of physical complaints without a hx of physical causes.
  - Who had been diagnosed with “conduct disorder” or “oppositional defiance disorder” as a child or adolescent.

- Most common manipulative behavior within health care settings is pitting one person or group against another (this may be seen from family members of patients as well).

- Examples:
  - “Nurse A really understands my situation, so she lets me (fill in the blank). Why can’t you? Please don’t tell anyone I told on nurse A. I don’t want them to get in trouble”
  - “The night staff is awful. They just sit around and drink coffee, yell at the patients when they ask for help, and really say some nasty stuff about you day staff.”

- Presentations to look for:
  - Playing one person against another (Can be a family member against staff).
  - Attempts to get “special treatment”.
  - Somatic complaints to get out of specific tasks.
  - Lack of insight (not related to presenting medical etiologies).
  - Denial of problems.
  - Frequent focus on others problems (patients, staff, or unit dynamics).
  - Uses intimidation to control or feel superior.
  - Frustration that appears to result in increased manipulative behaviors.
  - Exploits with little concern for others.
  - Quick to recognize vulnerabilities in others.
  - Demeaning statements about others.
  - Resists limits set on negative behaviors.
Interventions

• Guidelines for Nursing Interventions
  • Anger is a natural response to being manipulated. Deal with your own feelings of anger or dismay towards a patient. Peer supervision can be helpful in doing so.
  • Assess your feelings towards patients who use manipulation, work on being assertive in stating/establishing boundaries and expectations.
  • Verbalize boundaries and expectations in a matter-of-fact, non-threatening tone.
    • Should be a team decision in order to maintain consistency.
  • Ensure that boundaries are:
    • Appropriate and non-punitive
    • Enforceable
    • Stated in a non-personal way

Interventions

• Guidelines for Nursing Interventions—Continued
  • State the consequences if behaviors are not forthcoming.
    Written boundaries and associated consequences can be useful.
  • Ensure that all members of the team understand the boundaries, expectations, and consequences discussed with the patient to provide consistency.
  • Be sure to follow through.
  • Enforce all unit, hospital, group, or community center policies.
    State reasons for not bending rules.
  • Be direct and assertive, if necessary, in a neutral, factual manner and not in anger.

Interventions

• Guidelines for Nursing Interventions—Continued
  • Do not:
    • Discuss yourself or other staff members with the patient.
    • Promise to keep a secret for the patient.
    • Accept gifts from the patient or family members.
    • Attempt to be liked, “the favorite” or to be popular with the patient.
    • Withdraw your attention when the patient’s behavior is inappropriate.
    • Give attention and support when the patient’s behavior is appropriate and positive.
    • Emphasize what the patient is feeling. Do not get into a discussion about his/her rationalizations or intellectualizations.
Interventions

• Guidelines for Nursing Interventions—Continued
  • Encourage the expression of feelings.
  • Encourage identification of feelings or situations that trigger manipulative behaviors.
  • Role-play situations so that the patient can practice more direct and appropriate ways of relating.
  • Provide positive feedback when the patient interacts without the use of manipulation.
  • Where appropriate, see that the patient and families have names and numbers of appropriate community resources.
  • Keep detailed records in the patient's chart as to his/her response to boundary setting and any increase/decrease in undesirable, unacceptable, manipulative behavior. Identify and communicate what seems to work and what shows to trigger negative behaviors.

Nonverbal Communication

• Approach in a slow and calm manner.
  • Keep your hands visible.
  • If at all possible, do not approach from the back or the side.
  • Be mindful of posture—open and relaxed.
  • 10-5-3 Rule

Sensory Based

• Massage/Therapeutic Touch
• Music
• White Noise
• Pet Therapy
• One on One interactions
• Baby Dolls/Stuffed Animals
Trauma Informed Care

• What is Trauma?
  • Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.
  • Even more simply put, when our internal and external coping mechanisms are overwhelmed by outside event(s).

Types of Trauma

• Complex Trauma:
  • Exposure to sequential or simultaneous occurrences of psychological maltreatment, neglect, physical and sexual abuse, and domestic violence resulting in emotional dysregulation and loss of safety, direction, and ability to detect or respond to danger cues. Often setting off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood. The above has the potential to result in Developmental Trauma Disorder.

• Developmental Trauma Disorder:
  • Multiple or chronic exposure to trauma has pervasive effects on the development of the brain. Chronic trauma can interfere with neurobiological development and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole. Results in increased unfocused responses to subsequent stress leading to increases in the use of medical, criminal justice, social and mental health services. Experienced trauma is often interpersonal in nature.

Elders/People Living With Dementia (PLWD)-Specific Traumatic Experiences

• Loss of significant other, spouse and/or peers.
• Chronic and life-threatening diagnoses.
• Physiological changes, limitations and disability.
• Cognitive and memory loss.
• Increased dependence on others.
• Adverse childhood experiences.
• Traumatic combat experiences.
• Residing in a war zone.
• Falls/injury
• Elder abuse-Physical or Mental
• Sexual Abuse
• Motor Vehicle Accidents
• Neglect
• Abandonment (being placed in long term care may be perceived as abandonment by a resident).
• Loss of role, responsibilities and resources.
Trauma Informed Care

- Understanding the cumulative impacts of trauma on individuals and organizations, creating an environment of safety, promoting resilience and healing, promoting effective/open communication, asking “what happened to you?” in place of “what’s wrong with you?”
- Trauma Informed Care with people living with dementia (PLWD): Recognizes that everyone experiences difficulties, understands that adversity shapes how we react and behave, believes that everyone possesses resilience and the ability to heal, and asks the question, “what happened to you?”

The Three “E’s” of Trauma

- Events: A PLWD may experience these events or circumstances as a single occurrence or repeatedly over a period of time.
- Experience of Events: A PLWD’s experience of these events/circumstances aids in determining if the event/circumstance was traumatic. We all experience events differently and assign different labels, meanings to and are impacted physically/psychologically differently.
- Effect: Adverse effects can be long lasting and a critical component of trauma. Examples of adverse effects of trauma that may be observed with PLWD’s include an inability to tolerate normal stresses of daily life, an inability to build trust in others, memory impairment, difficulty expressing feelings, an inability to take advantage of opportunities to engage in new situations, altered neurophysiological makeup due to a history of trauma, the potential for a PLWD’s neurophysiological makeup to alter the presentation of trauma, for example, PLWD presenting with motor hyper-activity or frequent state of constant hypervigilance or tendencies to isolate/withdraw self from others or facility life.

The four “R’s” of Trauma Informed Care

- Realization: A basic realization of trauma and understanding as to the impact trauma can have on individuals, families, groups, organizations and communities. A PLWD’s behaviors are understood in the context of scoping strategies developed in effort to successfully navigate adversity and overwhelming events/circumstances. This includes circumstances from their past, a current manifestation or they are related to emotional distress that is a result of hearing first-hand about the traumatic experiences of another.
- Recognize: Staff are able to recognize the signs of trauma. These may be gender, age or setting specific.
The four “R’s” of Trauma Informed Care

• **Responds**: Facility staff coupled with organizational structure responds by applying trauma-informed principles to all areas of functioning. An organization and/or staff understand that traumatic events impact all involved, whether directly or indirectly. Organizations and staff responses involve a universal precautions approach in which one expects the presence of trauma in the lives of PLWD being served, ensuring not to replicate past traumas.

• **Resist Re-traumatization**: A trauma-informed approach seeks to resist the re-traumatization of PLWD. Staff are trained to recognize how organizational or industry practices, language or environments may trigger painful memories or re-traumatization.

Six Key Principles of a Trauma-Informed Approach

• **Safety**: Staff and those we serve feel physically and psychologically safe. Physical environment as well as interpersonal interactions promote safety.

• **Trustworthiness and Transparency**: Operations, policies and decisions are conducted with transparency. The goal is to build and maintain trust with those that we serve, their families, other staff/peers, and the community as a whole.

• **Peer Support**: Peer support and mutual self-help are key avenues for instilling safety and hope, building trust, collaboration and utilizing PLWD’s stories and lived experiences to promote recovery and healing. “peers” refers to individuals with lived trauma experiences. We can also reference “peers” as “trauma survivors”.

• **Collaboration and Mutuality**: Partnering with PLWD’s is greatly important. Further, an emphasis is placed on removing power differences not just between staff and PLWD’s, but between organizational staff, clerical, professional/clinical staff, housekeeping and administration. This demonstrates that healing occurs in relationships, in the sharing of power and in mutual decision making.

• **Empowerment, Voice and Choice**: A strengths focus is taken. Individuals strengths and experiences are identified and built upon to further their recovery. Operations and policies are developed in a manner to foster empowerment for staff and clients alike. Increased focus on client’s voices and choices are heard which historically have been diminished or minimized by long standing policy and culture. PLWD are supported and encouraged in shared decision making, choice and goal setting to best determine a plan and path to healing and being able to move forward.
Six Key Principles of a Trauma-Informed Approach

• Cultural, Historical, and Gender Issues: Change is made to move past cultural stereotypes and biases ex. Race, ethnicity, sexual orientation, age, faith, or gender identity. Organizations make available gender responsive services and leverages the values of traditional cultural connections. Policies and protocols are responsive to racial, ethnic, gender and cultural needs. Recognizes and establishes plan/processes to address historical trauma.

QUESTIONS?