Rethinking Behavioral Management

Presented by:

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Key Objectives:

- Understanding Contributing Factors & Diagnoses
- Tips to Support the Resident
- Psychotherapy Support
- Medication Management & Support
- De-escalating Significant Incidents & Reportable Events
- Caregiver Burn-out

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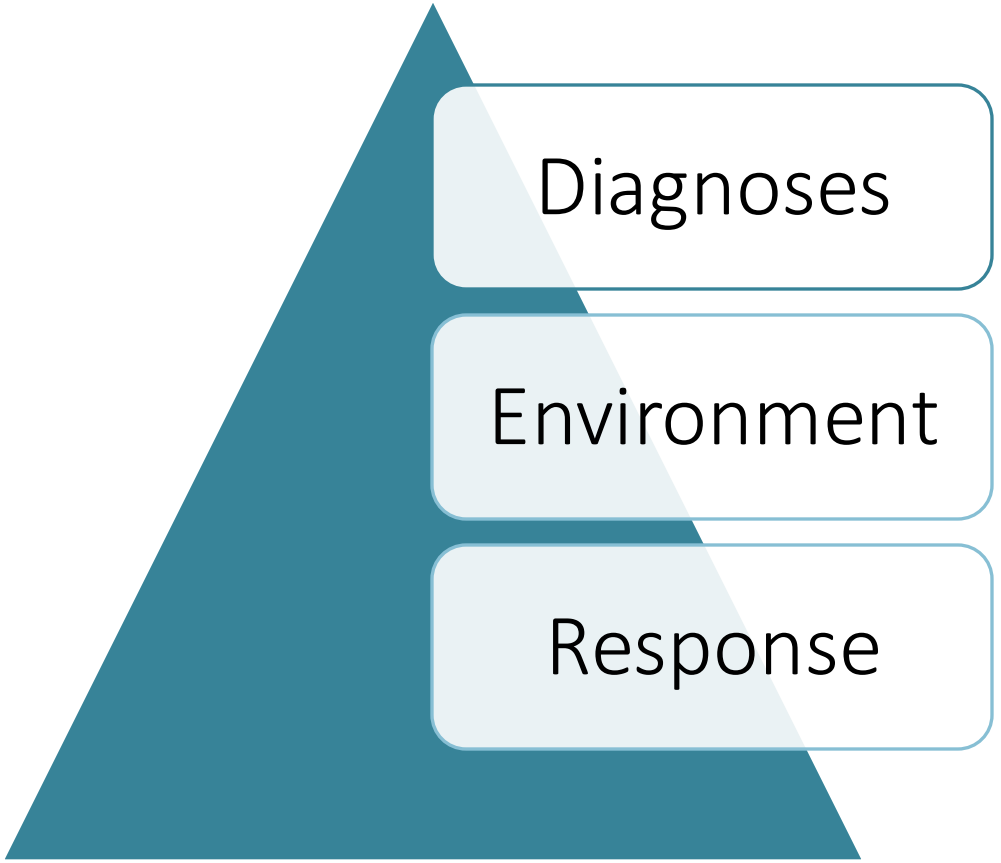
Understanding Contributing Factors



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Understanding Contributing Factors

Scenario 1

You are in a very long line at the movie theater….

Scenario 2

You enter a resident's room and witness him slamming down the phone and acting irritable….

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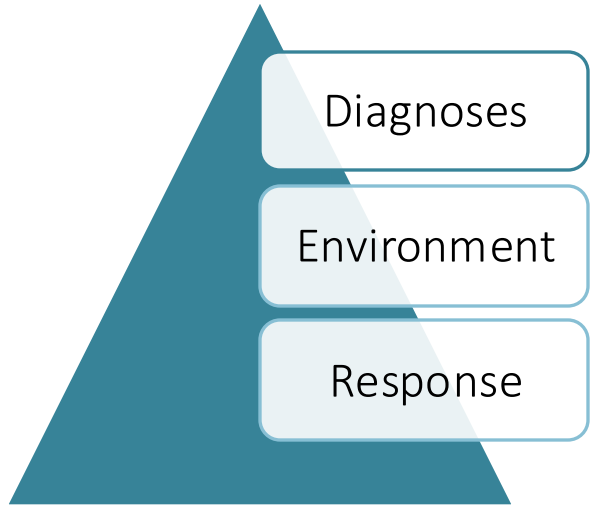
Understanding Contributing Factors

Fundamental Attribution Error

When judging a behavior, there is a tendency to overestimate personal characteristics and underestimate the influence of the situation
(Psychologist Lee D. Ross)

"It's WHERE you are (not WHO you are) that counts: Behavior is situation specific" Spiegler & Guevremont, 2003

Change the Place, not the Person



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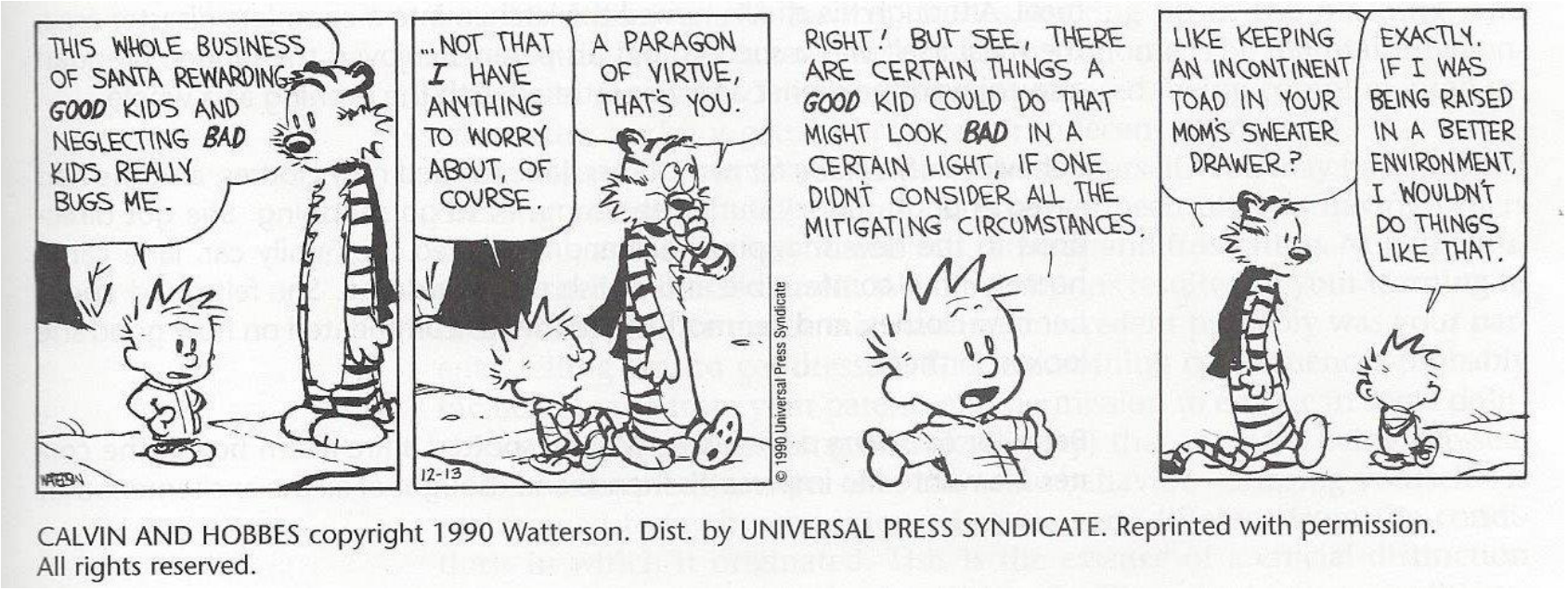
Understanding Contributing Factors



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- Diagnoses
- Environment
- Response

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Understanding Contributing Factors:

Psych Support

Internal World

Facility Support

External World

Diagnoses

Environment

Response

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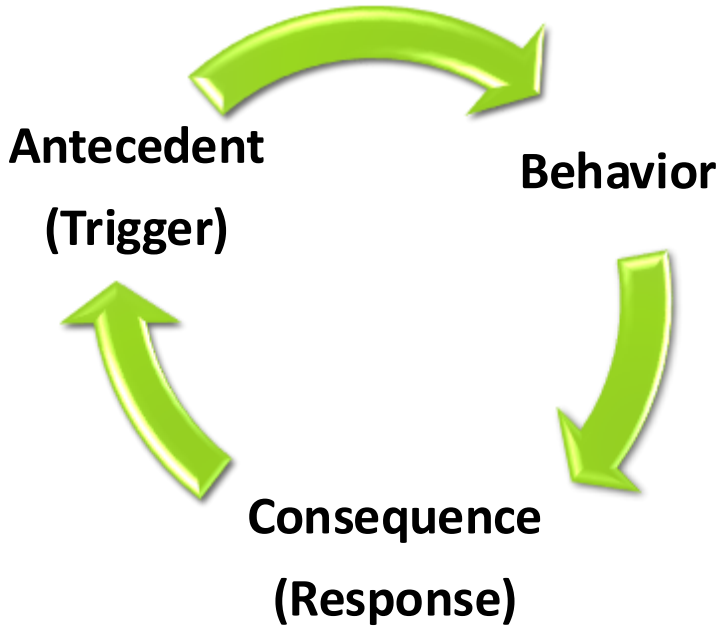
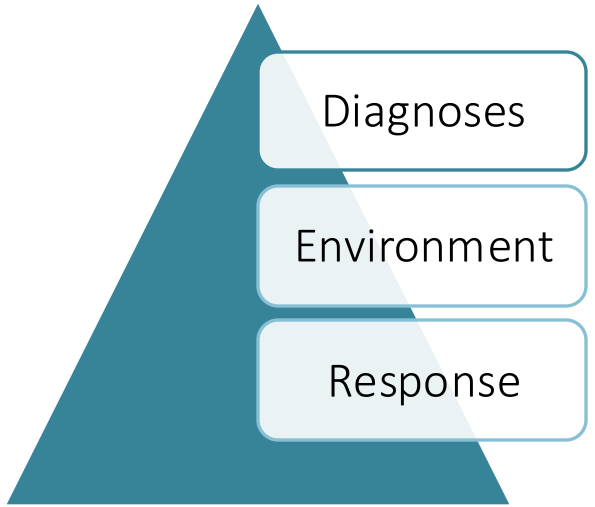
Understanding Contributing Factors: Environment & Response

Change the Place, not the Person

By interrupting the cycle





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Dementia

Cognition & Functional Changes

- Confusion to time/place/situation
- Poor judgment
- Repetition
- Misplacing items
- Forgetting to take medications
- Difficulty finding words
- Inability to follow routine tasks such as ADLs
- Difficulty problem-solving

Behavioral Changes

- Increased anxiety
- Increased depression
- Social withdrawal
- Suspicion/paranoia
- Possible hallucinations
- Apathy
- Irritability/aggression

NOTE: *The behavioral health team can use screening tools such as BCAT, functional assessment, etc to help guide individual plan of care and ensure safety.*

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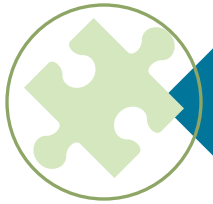
Dementia:
Supporting the Resident



Keep residents busy with activities available.

Re-direct residents with tasks such as “can you go down the hall…?”

Keep environment safe with less clutter and no trip hazards.

Keep distance between residents to respect personal space.

Consider behavior as communication (i.e. pain, cold, overstimulated).

Use soft words and keep a calm, quiet environment at all times.

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Case Study: Diagnosis Dementia

Case:

81 y.o. female with severe Dementia. She displays word-finding difficulties and disorganized thought processes. Virgie is observed at the nurses' state in a wheelchair with a bedside table in front of her. She is holding a doll.

Behavior:

Frequent attempts to stand and ambulate without assistance resulting in multiple falls.

Consequence:

Staff place Virgie at nurses station. They rush over as Virgie begins to stand and verbally re-direct- "Virgie, sit down! You're going to fall"! She hits, punches, and swears at staff. As soon as Virgie sits, the staff return to the nurses station.

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Case Study:
Diagnosis Dementia

Nurses' Note

Call received from COTA re pt and another pt interaction. It was reported that just after lunch, approximately 1pm pt's wheelchair was hit by another pt's wheelchair as that pt was rushing to get to an activity. It was reported that the pt was startled, made a loud noise and started to swat his hand towards the pt who hit his wheelchair while rushing. It was reported the pt also started to swat his hand back towards the pt. No physical contact was made by either pt. It was reported both pts were separated from each other for approx 5 -10 mins with no further issues. It was reported pts were both talking in each other's presence with no issues/concerns after 5 minutes had passed. Upon interviewing both pts neither had any recollection re situation and reported having a great day.

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Case Study:
Diagnosis Dementia

Nurses' Note

C/o back pain, but refused pain medication or intervention. Education provided w/no verbal understanding. Fluids provided, voided, and refused for this writer to bladder scan. Refused a.m. care and endorsed to nursing. Verbally aggressive, agitated, and calling out throughout the night. Redirection, reassurance, and comfort provided w/no effect. Bed is in the lowest position, and safety and comfort maintained.

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Substance Use Disorder

WARNING SIGNS

- Attitude Changes
- Increased Anxiety
- Behavioral Changes
- Mood/Emotional Changes
- Thought Changes
- Neglecting Support Systems
- Returning to people or places associated with the past
- Minimizing the negative consequences of using

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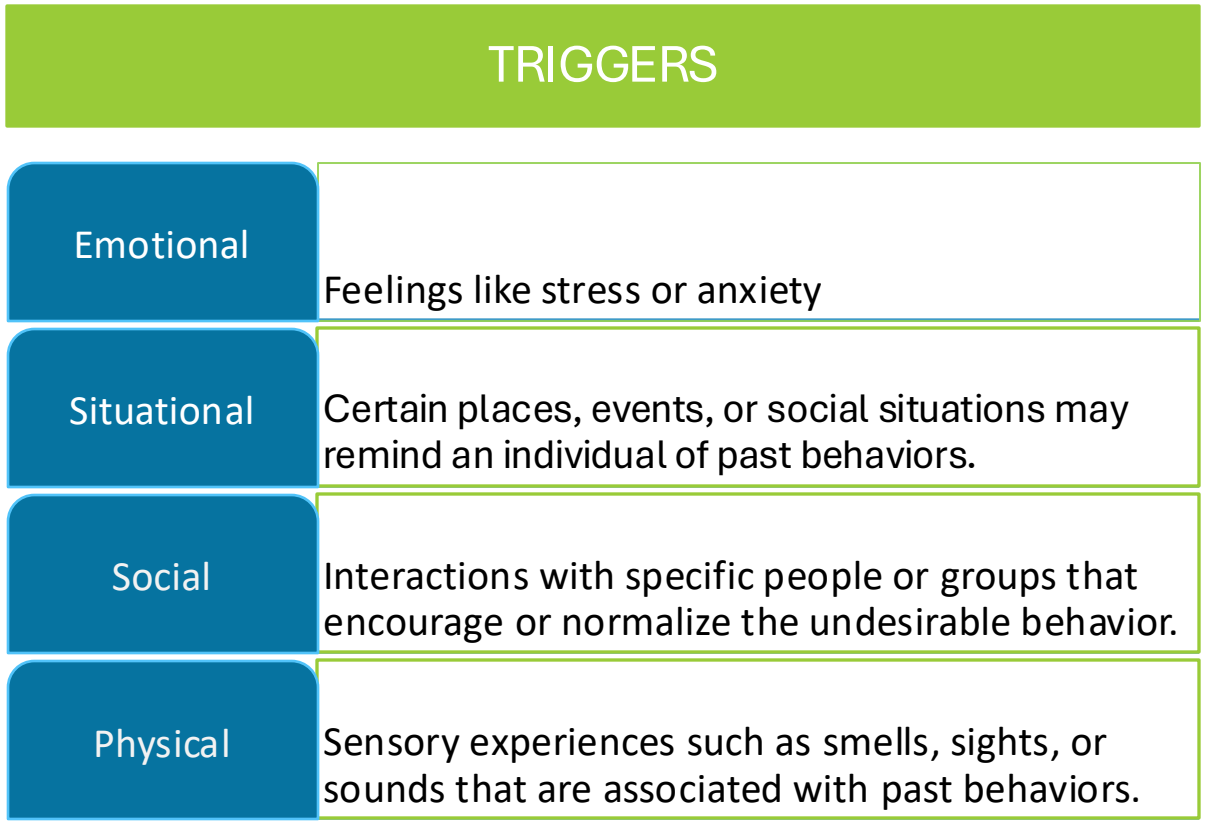
Substance Use Disorder



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Substance Use Disorder

BEFORE

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Substance Use Disorder

AFTER

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Substance Use Disorder:
Supporting the Resident

Identify high-risk situations in which the patient might be more likely to engage.

Challenge the patient's expectation of perceived positive effects of use.

Examine risk factors such as environmental and cognitive.

Help identify ways to achieve treatment goals.

Give praise to reinforce coping skills.

Understand safety as a priority and have plans in place.

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Case Study:
Substance Use Disorder

Social Service Note

SS met with resident. She is alert and oriented, able to make her needs known. Resident provided with 211 information and contact for community assistance and resources available as resident is pre planning for discharge. Resident continues on IV treatment for sepsis. Resident is requesting to go LOA to purchase cigarettes. Resident states she can go to the ED to have PICC removed. SS remains for 1:1 visits, support, communication and follow up as needed.

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Personality Disorder

Antisocial Personality Disorder

- Disregards and violates the rights of others
- Criminal behavior
- Struggle to learn from negative consequences of their actions

Borderline Personality Disorder

- Frantic efforts to avoid abandonment
- Unstable and intense relationships
- Identity disturbance
- Impulsivity that is self-damaging
- Recurrent suicidal and self-mutilating behavior
- Affective instability and reactive moods
- Transient paranoia or severe dissociative symptoms

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Antisocial Personality Disorder:
Supporting the Resident

Concrete, simple statements when talking with the patient

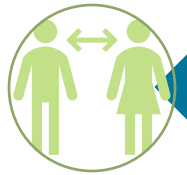
Use calm, neutral facial expressions

Be civil and polite, but avoid being overly friendly

Explain each step as you work with the patient

Don’t engage in a back and forth with the patient even if the patient is escalating. “I am going to step out, but I will be back.”

Try to have 2 staff in the room where possible



Give the patient extra personal space

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Borderline Personality Disorder:
Supporting the Resident

Consistent boundaries

Enforce all facility policies

Follow through with consequences

Be direct, but neutral in expression

Do not discuss yourself or other staff members with the patient

Praise when behavior is appropriate

Do not engage in discussions about the patient's rationalizations, do emphasize what the patient is feeling "I can tell this is upsetting for you"

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Case Study:
Diagnosis Personality Disorder

Nurses' Note

Nurses note for resident with diagnosis of borderline personality disorder: resident with behaviors this evening. states he will not allow his assigned CNA to put him to bed and then stated he wanted another CNA who did not have him on assignment. became agitated and stated he was calling the police to have the CNA he wanted put him to bed. after discussion, resident refocused on the number of assists required instead of the specific CNA and then allowed his assigned CNA to put him to bed.

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Chronic Mental Illness

Chronic and severe mental illnesses can make adjusting to new situations even more difficult due to perceptual disturbances and limited coping skills.

Medication management consistency is key in severe mental disorders (Schizophrenia, Schizoaffective, etc.)

Observe closely for worsening delusions, hallucinations, changes in behavior, and other stereotypical behaviors.

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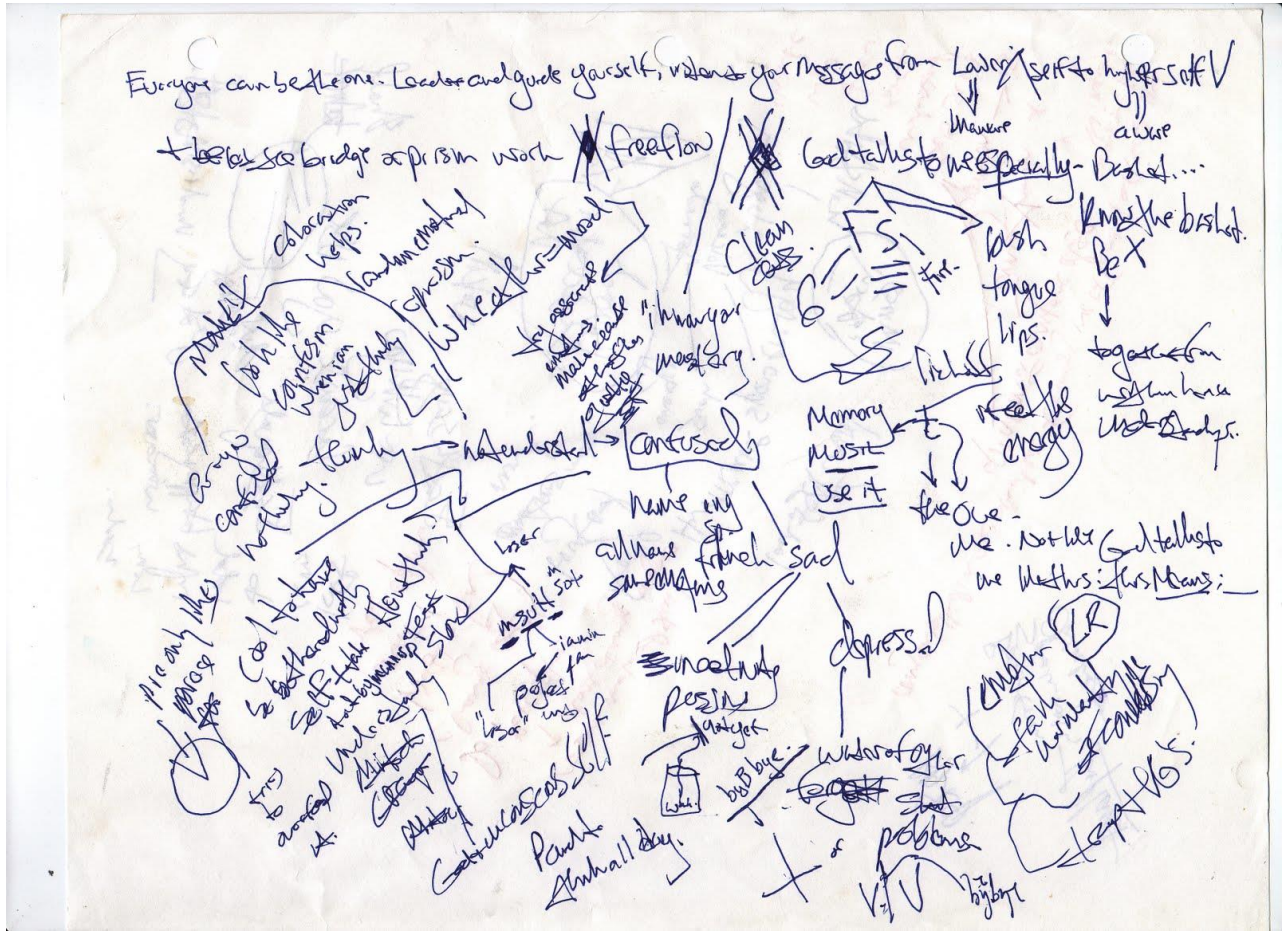
Chronic Mental Illness



Notes written by an individual with a diagnosis of schizophrenia.

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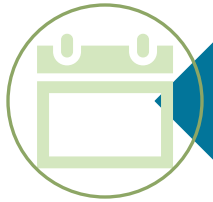
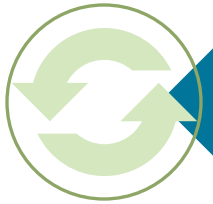
Chronic Mental Illness:
Supporting the Resident

Establish a consistent routine and ensure staff are aware.



Add meaningful activity to the day for a sense of purpose.



Use a lot of repetition (orient to time, location several times a day, where their room is, etc.)

Use social activities to provide positive distraction.

Use brief phrases with positive reframing. Instead of “That’s not your room!”, Say with a smile “Let’s find your room”

Give them a sense of control within their environment: “Would you like your shower now or in 1 hour?”

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Case Study: Diagnosis Schizophrenia

Case

74 y.o. male diagnosed with schizophrenia and Parkinson's Disease. Ed has a history of delusions in the context of schizophrenia.

Behavior

Ed barricaded himself in the PT room and refused to return to his unit/room yelling "There are gunman in the building!" He attempted to punch staff as they approached.

Consequence

Staff verbally reassured Ed stating "There is no one here with guns." Ed attempted to hit staff as they approached.

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Case Study:
Diagnosis Bipolar Disorder

Nurses' Note

Pt agitated, yelling profanities at nursing staff. Pt walked behind Rn while at med cart and it appeared as though she was getting ready to physical strike at me with her fist. Told pt to go to her room and redirected pt with much difficulty.

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Other Stress Factors & Trauma

Adjustment Disorder
Fatigue impacts healthy sleep patterns and ADLs
Loss of independence
Anxiety
The aging process and the unknown
Grief
Depression
Effects of dialysis

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Stress & Trauma:
Supporting the Resident

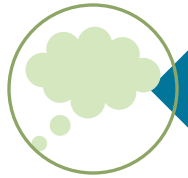
Establish a routine early on.

Encourage social activities to expend energy and provide distraction.

Find opportunities to add meaningful activities to the day.

Invite the resident to have a sense of control to their environment when possible.

Offer choices such as “would you like your shower now or in an hour?”



Involve them in care by asking “what do you think?”

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Case Study:
New Admission

Nurses' Note

Resident yells and screaming with care, becomes very stiff and acts if going to strike however does not. In Spanish repeatedly yelling profanities. PT in to eval with assistance from this writer and inappropriately began to cry. Placed in Psych book. Music and cola used to redirect with + outcomes.

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Suicidal Ideation

Process Statement

- "If they don't fix this pain, I'll shoot myself."
- Develop more adaptive ways to express emotions.

End of Life Thoughts

- "Yes, I think about dying."
- Therapy support

Suicidal Ideation

- Active suicidal thoughts with plan and intent.
- Immediate action, possible higher level of care, frequent follow ups

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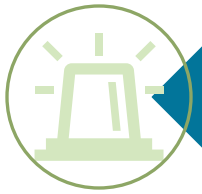
Suicidal Ideation:
Supporting the Resident

Psychotherapist utilizes PHQ-9 as screening tool to proactively identify risk.



Resident may express SI. Refer to your psych team immediately.

Risk assessment: worsening depression due to new factors, history of attempts, current behaviors.

Suicide Safety Plan is initiated.

Identify environmental factors related to safety.

Provider will support resident in utilizing coping strategies.

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Case Study: Suicidal Ideation

Risk Assessment Note

Pt is a 90 y.o. female dx with Dementia With Behavioral Disturbance. Pt has no prior psych history. Family visits often. Pt on 1:1 after stating to nursing home staff "I want to die. I am going to kill myself."

Staff report pt is very confused and disoriented with disorganized thinking. Pt frequently makes statements about hurting herself, but when asked how she would carry this out she responds in non-sensical ways. For example, "Put the spoon in my ear, then it goes in the drawer."

Upon assessment with the APRN, the pt did not remember saying she wanted to commit suicide, but stated she wanted to die.

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Case Study: Suicidal Ideation

Risk Assessment Note

Dring a routine follow up session with a 74 y.o. male, the pt expressed experiencing chronic pain and decreased functional abilities. The pt stated, “There’s no purpose to my life; I don’t want to be a burden on my family.” The pt added, “I’ve been thinking about ending it. I know the nurse has a lot of pills in her cart.”

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Psychotherapy Support

Build therapeutic relationship	Validate, then regulate emotions	Encourage regular routines when possible	Acknowledge positive changes
Teach coping strategies	Identify new goals	Reframe thinking	Practice self-advocacy
Create comfort by problem solving	Utilize screening tools	Identify interests and positive hobbies	Support with interpersonal skills

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Medication Support

- Mood Stabilizers
- Sedative/Hypnotics
- Antidepressants
- Anxiolytics
- Antipsychotics

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Medication Support:

Behavioral Monitoring

- Demonstrate necessity of medication
- Identify behaviors and document
- Make a referral to the psych team
- Behaviors include hitting, yelling, pushes staff away
- Symptoms of behaviors are different such as anxious, insomnia

When residents are combative/aggressive consider:

- Pain
- Overstimulation
- Hunger/Thirst
- Environment
- Poor communication
- Conditioned response to care

Improving Interactions

- Avoid power struggles
- Re-frame and lead with statements in the positive
- Listen for un-met needs
- Pay attention to language that could be perceived as judgmental
- Validate first, then redirect

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Medication Support

F605: Unnecessary Use of Medications, Chemical Restraint

- Emphasizes psychotropic medications should be the last resort for treatment.
- There must be documentation that the facility has attempted behavioral (i.e., nonpharmacological) interventions AND
- That these interventions have been deemed clinically contraindicated or unsuccessful.
- PRNs must be documented for specific use and be limited to 14 days

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Unnecessary Medications, *Chemical Restraints/*Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

2. ***Psychotropic Medications,*** *did the facility ensure that:*
   - *the medication is necessary to treat a specific, diagnosed, and documented condition which includes symptoms which may be causing distress to the resident or others*
   - *the medication is not sedating the resident, but rather is treating the resident's medical symptoms;*
   - *alternative treatments, such as behavioral (nonpharmacological) interventions, were attempted and that these interventions have been deemed clinically contraindicated;*
   - *a GDR was attempted and non-pharmacological approaches to care were implemented, unless clinically contraindicated;*
   - *PRN use is only if necessary to treat a specific, diagnosed, and documented condition;*
   - *PRN orders for psychotropic medications which **are not** for antipsychotic medications are limited to 14 days, unless the attending physician/prescribing practitioner documents a rationale to extend the medication;*
   - *PRN orders which **are** for antipsychotic medications are limited to 14 days, without exception and the attending physician/prescribing practitioner did not renew the order without first evaluating the resident?*

   If No to any of the above, cite F605.
   N/A, the resident was not prescribed psychotropic medications.

3. *For the **Medication Regimen Review (MRR)**:*

   A. Did the licensed pharmacist:
   - *Conduct an MRR, at least monthly, that included a review of the resident's medical record;*
   - *Conduct an MRR more frequently, as needed; and*
   - *Report irregularities to the attending physician, medical director, and the DON?*

   B. Did the attending physician document:
   - *Review of identified irregularity(ies);*
   - *The action, if any, taken;*
   - *A rationale if no action is taken?*

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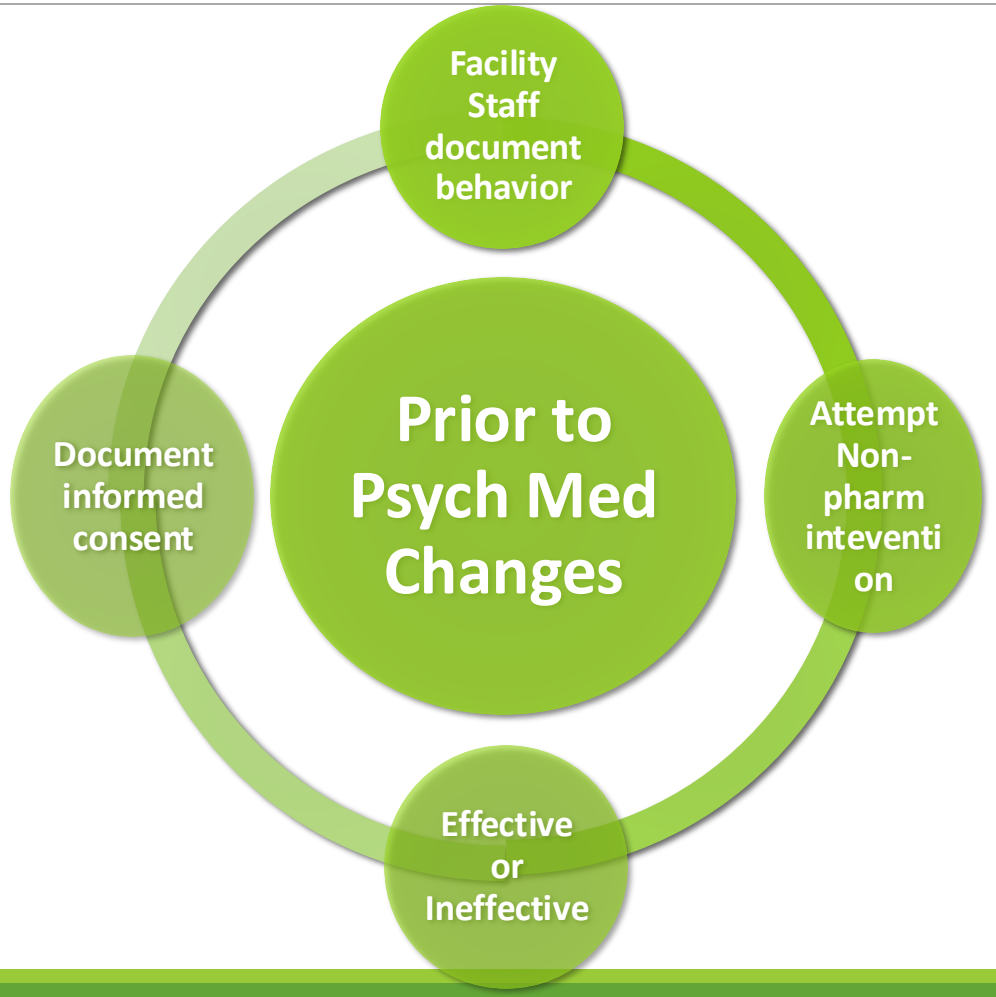
Medication Support



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Medication Support: Psychotropics

An effective behavioral program can

- Minimize the need for medications.
- Ensure a GDR is successful.
- Empower staff and give them tools to re-direct and de-escalate patients with fewer medications.
- Mediate the adverse side effects of polypharmacy.
- Demonstrate that behavioral interventions were attempted thus providing ample justification when meds do need to be used.

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Medication Support: Psychotropics

A GDR may be considered clinically contraindicated if the:

- Resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility
- Clinician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.
- GDR would impair the resident's function or exacerbate an underlying medical or psychiatric disorder

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Medication Support:
Documentation

Example:

- PRN Trazodone x 14 days to help with episodes of increased anxiety, restlessness, increased behavioral disturbance, screaming, combative. Staff reports at times gets up during the night, wanders, some difficulty with redirection at times. Staff also report increased anxiety and irritability in morning, often repetitive questions

NOTE: *"Repetitive questions" would not be a symptom warranting treatment with a medication and could give the impression it is an inconvenient behavior for the staff to have to address.*

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Medication Refusals

Strategies

- ❖Look for opportunities that offer choices
- ❖Try not to highlight the refusals.
- ❖Keep interactions simple and positive.
- ❖Consider if the dosing regimen can be simplified.

Examples

- ❖Would you like the blue one first or the white one?
- ❖I am thinking your blood pressure pill is a really important one, what do you think?

This is very common with residents with mental health diagnoses, especially severe mental illness and dementia.

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De-escalation

What to Say

- ”How can I help you?”
- “Let’s…”
- “OK. No problem, I will come back.”
- “OK. We will see what we can do.

What to Signal

- Smile
- Nod head yes. Palms down and lower calmly.
- Handshake to enter resident’s space.
- Inviting gestures to re-direct non-verbally.

What to Do

- 3 feet of personal space at all times.
- Re-direct with a task to do.
- Approach calmly. Speak slowly and
- Keep the unit as quiet as a library.

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De-escalation: Nonpharmacological Interventions

Q: Name a non-pharmacological intervention

Change the Place, not the Person

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De-escalation: Nonpharmacological Interventions

Psycho-therapy	Provided validation	Memory stimulation	Re-directed	Re-assured	Social activity
Re-approached	Deep breathing techniques	Art activity	Calm approach	Music	Pet therapy
Snack offered	Oriented to surroundings	Take for a walk	Toileting offered	Offered distraction task	Media activities
	Remove from noisy areas	Reminiscing activity	Positive praise		

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De-escalation: Nonpharmacological

Change the place	• Take resident to a separate or quiet area. • Provide space from other residents. • Allow resident to express needs and behaviors to resolve.
Gradually increase tolerance to stimuli	• Gently hold the resident's hand, touch their arm, or make eye contact. • Modify environmental stimuli such as noise, lighting, temperature, etc.
Re-enforce calm moments	• Provide verbal praise when the resident is calm. • Redirect by offering a snack, diversional mobility such as assisted ambulation, wheelchair propelling, or other activities.

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De-escalation: Keep it Simple

USE SOFT SOUNDING WORDS.

USE GESTURES, NOT WORDS.

KEEP 3 FEET OF SPACE.

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Reportable & Significant Incidents:
Support from Behavioral Health Team

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Reportable & Significant Incidents:
Support from the Behavioral Health Team

FOCUS DURING SESSION

- Is the patient an **imminent risk**?
- Is the patient having **any trauma or after effects** from any incidents?
- Does the patient need **any interventions** to prevent further issues

DOCUMENTATION

- Chief Complaint: Alleged incident
- Summary Session: **Pt affirmed feeling safe**. Pt with **no latent psych sequela** from the alleged incident. Pt remains at baseline with no worsening mood symptoms is **not an imminent risk to self or others at this time**, but will need ongoing medication and psychotherapy interventions to mange mood/behavioral symptoms.

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Case Study:
Resident to Resident Allegation

Psych Note

- Pt was initially irritable and yelling but was responsive to de-escalation techniques. Pt was disoriented to time, place, and situation and repeated several times his frustration with being unable to recall the reason for this admission. Pt was able to recall in general the alleged incident with peer but displayed poor insight, suspiciousness, agitation and low frustration tolerance. He denied any significant negative thoughts or intent to harm others thus he is not an imminent risk to self or others at this time but will need ongoing interventions to better manage his mood and behavioral symptoms.
- Indications are, pt exhibits cognitive deficits and mood symptoms that likely precipitated a behavioral outburst. Continue with behavioral interventions such as ensuring adequate personal space, observing for overstimulation and medication adjustments to treat suspiciousness/paranoia and agitated depression symptoms.

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Case Study:
Resident to Resident Allegation

Nursing Note

- This undersign writer f/u and spoke with resident regarding allegations made from roommate regarding statement of "threatening to choke roommates neck". Resident stated "I would never do that" Resident explain she was to be move to another room away from roommate, place on 1:1. No behavior upon transfer to new room, no bruises/marks noted. APRN called/notified, 911 called/updated, son made aware of resident allegations along with room change, no concerns noted.

Psych Note

- ATSP for f/u with alleged incident. She is alert and oriented to baseline, forgetful, confused and anxious at times. She appeared calm and cooperative, but confused on exam. Reports good mood/sleep/appetite. She has no memory of the alleged incident. Staff report PRN Lorazepam was effective for anxiety. Recommend calm approach and redirection. Recommend utilizing PRN for symptoms. She is tolerating med well with no ADR. No acute concerns for safety at this time. Will continue with same plan and monitor for worsening symptoms.

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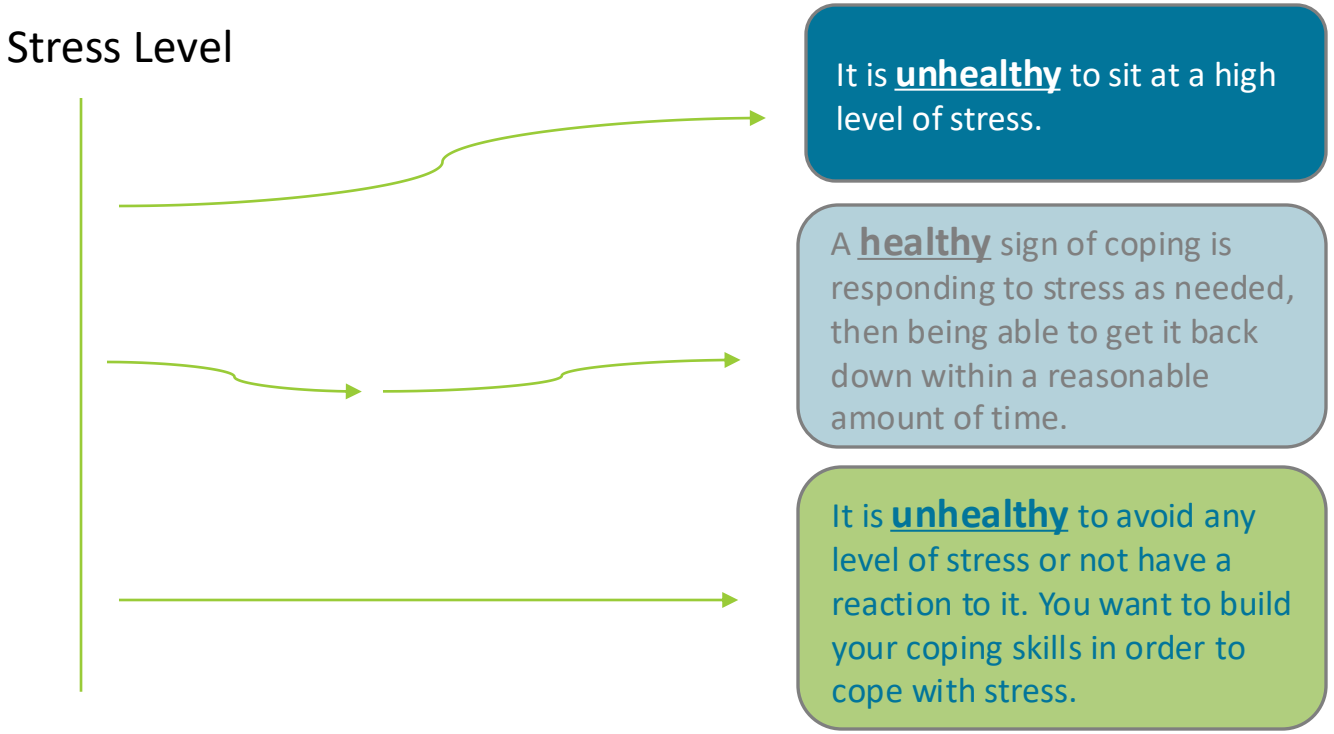
Leading Change & Caregiver Burnout

Being able to lead change happens when we can demonstrate the ability to cope with and manage stress. Sometimes we have to be able to absorb the stress temporarily for someone else until they are ready to make adjustments. In order to do so, we must manage our own burnout.



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Leading Change & Caregiver Burnout

Creating healthy dips in stress levels

- Take deep breaths
- Venting to your supports
- Do not drain yourself
- Refill your jar
- Take needed time off
- Shift perspective and don’t take things personally

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Questions?

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