Disclosure of Commercial Interests

I have no commercial interests to disclose.

SEX, DRUGS, and ROLLING WALKERS

Barbara Speedling
Quality of Life Specialist
ACHCA – November 19, 2017

Assessing Human Needs

What is Quality of Life?

- Subjective, multidimensional, encompassing positive and negative features of life.
- A dynamic condition that responds to life events

http://www.forbes.com/sites/iese/2013/09/04/quality-of-life-everyone-wants-it-but-what-is-it/

Person-Centered Care

"…a framework for heath and social care assessment, including risk assessment, within a comprehensive, person centered, multi-disciplinary care planning process.' (Thiru et al., 2002, p. 11)

Quality of Life Concerns in Long Term Care

- Many facilities try to avoid admitting residents with complicated mental health or psychosocial issues;
- Staff is often unprepared to care appropriately for residents with dementia, mental disorders, intellectual and developmental disorders, addictions or other psychosocial challenges

NEW FEDERAL REGULATIONS
FINAL RULE, PHASE 2 (11/28/17)

F675
§ 483.24 Quality of life

Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

NEW FEDERAL REGULATIONS
FINAL RULE, PHASE 2 (11/28/17)

F675
§ 483.24 Quality of life

INTENT

The intent of this requirement is to specify the facility's responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by:

- Ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and
- Ensuring that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.

F675 § 483.24 Quality of life
(11/28/17)

Definition: "Quality of Life"

- An individual's "sense of well-being, level of satisfaction with life and feeling of self-worth and self-esteem.
- For nursing home residents, this includes a basic sense of satisfaction with oneself, the environment, the care received, the accomplishments of desired goals, and control over one's life."

F675 § 483.24 Quality of life (11/28/17)

Interpretive Guidelines:

In order to identify whether staff supports each resident's quality of life, leadership should observe and evaluate verbal and nonverbal interactions between staff and residents.

Negative observations could include staff actions such as the following:

- Verbalizing negative or condescending remarks, or refusing to provide individualized care to a resident due to his/her age, race, or cognitive or physical impairments, his/her political or cultural beliefs, or sexual preferences;
- Dehumanizing an individual through verbal and nonverbal actions such as talking to others over a resident without acknowledging his/her presence, treating the resident as if he/she were an object rather than a human being, mistreating, or physically, sexually or mentally abusing a resident.

Example of Non-Compliance

A complaint investigation revealed facility staff members **posted unauthorized videos and photographs** on social media of several residents during bathing, going to the bathroom, and grooming, including nude photos and photos of genitalia.

As a result, the residents suffered public humiliation and dehumanization. Facility staff interviewed were aware of this abuse, but did not report to administration due to fear of retaliation by the perpetrators and fear of losing their jobs.

Example of Non-Compliance

During a resident council meeting, several residents reported that they heard staff describing the photos, laughing about the postings and had seen staff passing around cell phones.

As a result, the **residents stated that they were afraid** to take a shower or bath, and extremely uncomfortable when requesting assistance to go to the bathroom because they thought it might happen to them, and that they had shared these concerns with other resident's in the facility.

Example of Non-Compliance

When discussing going to the bathroom, the residents stated that in addition to **being afraid of asking for help**, when they did, there were **not enough staff** to answer call lights.

They said that staff would ignore their call light, walk by or would answer the light and leave without assisting the residents. This had resulted in episodes of incontinence of urine and feces, which they stated was extremely **embarrassing, humiliating and degrading** to them.

Example of Non-Compliance

Several residents stated that they were afraid to ask for staff assistance for the need to use the bathroom, based on their fear related to the postings on social media.

In addition, they stated that **when they were receiving care, if staff pulled out a cell phone**, they didn't know if staff were taking and posting pictures of them.

Example of Non-Compliance

- When asked if these concerns had been **reported** to the administration, the residents stated that they identified the issue with the call lights and not enough staff **multiple times** during council meetings, but that the administration only said, we will look into it, and **nothing was done**.
- They said they were **afraid to report** the cell phone concerns. One resident said that an aide told him/her that if they didn't quit complaining to the administrator, **no one would help** them and **they would be transferred** to another facility.
- When the resident began to cry, **the aide laughed and walked out of the room**, verbally taunting him/her for crying.

Respecting Privacy and Dignity

The resident described frequent occurrences of **disregard of her personal privacy** including not covering her body completely, allowing full view of her arms, legs and buttocks when transporting her to the shower.

The surveyor observed, on one occasion, staff not pulling the privacy curtain when assisting her to dress, resulting in anyone walking in the hallway being able to view her as she was dressed.

Respecting Religious Beliefs

Excerpt from F675 Quality of Life:

On multiple occasions, the resident reported that she was assigned a **male care giver, which is against her religious belief** that a person of the opposite sex cannot provide care. On these occasions, the resident would tearfully refuse to get dressed, or call her family to assist her.

On at least one occasion, the resident was **forced** to receive a shower with the assistance of a male aide, which resulted in the resident crying uncontrollably until her family arrived. Progress notes in her medical record noted this occasion as the resident becoming uncontrollable while receiving a shower.

Respecting Religious Beliefs

Excerpt from F675 Quality of Life:

- The surveyor observed the meal tray set up and found it did not honor the resident's preferences identified on the meal tray card and care plan. The resident reported that this happened on most days, and **even if she requested an alternative, she would be given a food item that was prohibited according to her religion**, and therefore, she would not eat that meal. The resident's family stated that they frequently brought food in to the resident because she could not eat what was brought to her.
- On interview, dietary **staff stated they did not have the time to prepare a special diet** for this one resident, and stated to the surveyor, "They should have thought of that before they came to this country." Additionally, the dietary staff reported that he/she was not aware of the dietary requirements of this resident's religion.
- An interview with the consulting **dietitian** revealed that he/she **was not aware** that this resident had been admitted to the facility, and she agreed that the menu did not meet this resident's religious preferences.

Respecting Cultural Beliefs

CHINA

Health and Wellness: Countless Chinese people, especially the middle-aged and elderly, have developed the habit of exercising each morning to improve their health.

The Importance of Face: The concept of 'face' roughly translates as honor', good reputation or respect. There are four types of Face:

1) Diu-mian-zi: this is when one's actions or deeds have been exposed to people.
2) Gei-mian-zi: involves the giving of face to others through showing respect.
3) Liu-mian-zi: this is developed by avoiding mistakes and showing wisdom in action.
4) Jiang-mian-zi: this is when face is increased through others, i.e. someone complementing you to an associate.

It is critical you avoid losing Face or causing the loss of Face at all times.

Respecting Ethnic Customs

CHINA

- **Learn to use chopsticks**.
- Wait to be told where to sit. The guest of honor will be given a seat facing the door.
- You should try everything that is offered to you.
- Never eat the last piece from the serving tray.
- Be observant to other peoples' needs.
- Chopsticks should be returned to the chopstick rest after every few bites and when you drink or stop to speak.
- **Do not put bones in your bowl. Place them on the table or in a special bowl for that purpose**.
- **Hold the rice bowl close to your mouth while eating.**
- Do not be offended if a Chinese person makes **slurping or belching sounds**; it merely indicates that they are enjoying their food.
- There are no strict rules about finishing all the food in your bowl.

SYSTEM FAILURES

- Diagnosis is not always known at the time of admission screening or condition is misdiagnosed as simply dementia;
- Staff education and training in caring for the residents with mental and behavioral health needs is lacking;
- Understanding of the differences between dementia, mental disorder, traumatic brain injury, and ID/DD is poor in many environments;
- Staff lack basic understanding of symptoms and how this impacts responses and other aspects of function; and

SYSTEM FAILURES

- Assessment procedures often fail to distinguish symptoms, reactions, and personality from *behavior.*
- Assessments often fail to identify the antecedents to behavior;
- Communication between disciplines is weak in tracking mood and behavioral patterns;
- Care teams rarely introduce behavior modification plans;
- Medication is the often the preferred intervention; and
- Little consideration is given to how boredom and a lack of meaningful activity impact mood, behavior and function.

Changing Demographics

- The Woodstock Generation
- Opioid Addiction and Substance Abuse
- Mental Health Challenges
- Young adults
- Ethnic and Cultural Groups
- Homelessness
- Short-term Rehab populations

Increased Numbers of Disabled Young Adults

- The number of children and young adults with disabilities is increasing.
- Life-saving and life-prolonging medical care and new technologies have increased the survival of seriously ill younger people.
- These children, teens and young adults will need long-term care to assist them in their homes or in nursing homes and residential facilities.

LTC Panel Report 2009

New Considerations

- Capacity determinations for medical and psychosocial decision making;
- Medical Marijuana;
- Pain management – opioids and addiction;
- Sexuality/LGBT populations;
- Short-term vs. Long-term needs and practices;
- Complicated discharge planning/housing/financial concerns.

Potential Risks Associated with a Changing Demographic

- Elderly residents and younger residents have very different needs in terms of care.
- Elderly residents require a great deal of specialized medical care and supervision, while younger residents may need more attention to socialization or behavior.
- If nursing homes are not properly staffed and trained, it may be impossible for all age and need levels to get the care they really need.
- Most nursing homes are geared toward older adults, their interests and needs. This can lead to younger residents feeling resentful, restless, or lonely. These emotions coupled with physical or mental disability can easily result in negative attitudes and behavior, and are clear risk factors for substance abuse.

Regulatory Expectations

- Final Rule – Trauma Informed Care
- Identification of Stress-Related Illness
- Recognition of Substance Use and Addictions
- Dementia Care Standards/Dementia Focused Survey
- PASRR Coordination
- Non-Pharmacologic Interventions

Caring for the Woodstock Generation

- Four million baby boomers suffer from substance abuse/addiction
- About half of all baby boomers have experimented with illicit drugs
- Nearly 5 percent, or 4.3 million, of adults 50 years and older have used an illicit drug in the last year
- About 26.2 percent of new addictions started in the last five years among baby boomers involved cocaine

Caring for the Woodstock Generation

- Following close behind cocaine, about 25.8 percent of new addictions in this age group involved prescription drugs
- Nearly 75 percent of baby boomer admissions to rehab centers are for addictions that began before the age of 25
- Illicit drug use among this age group has increased by over 3 percent in the last eight years

http://www.promises.com/articles/addiction/drug-use-surges-among-baby-boomers/

Caring for the Woodstock Generation

Some baby boomers feel compelled to self-medicate with drugs to lower the impact of stress related to:

- Caring for family
- Dealing with potential health issues
- The uncertainty of retirement in a stagnant economy

Symptoms of Addiction in the Elderly

- Memory trouble after having a drink or taking a medication
- Loss of coordination (walking unsteadily, frequent falls)
- Changes in sleeping habits
- Unexplained bruises
- Being unsure of yourself
- Irritability, sadness, depression
- Unexplained chronic pain

NEW FEDERAL REGULATIONS
Final Rule, Phase 2 (11/28/17)

F742

Treatment and Services for Mental/Psychosocial Concerns:

§ 483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that—

§ 483.40(b)(1)
A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;

NEW FEDERAL REGULATIONS
Final Rule, Phase 2 (11/28/17)

"Mental and psychosocial adjustment difficulty" refers to the development of emotional and/or behavioral symptoms in response to an identifiable stressor(s) that has not been the resident's typical response to stressors in the past or an inability to adjust to stressors as evidenced by chronic emotional and/or behavioral symptoms.

(Adapted from Diagnostic and Statistical Manual of Mental Disorders - Fifth edition. 2013, American Psychiatric Association.).

NEW FEDERAL REGULATIONS
Final Rule, Phase 2 (11/28/17)

INTENT § 483.40(b) & § 483.40(b)(1)

•The intent of this regulation is to ensure that a resident who upon admission, was assessed and displayed or was diagnosed with a mental or psychosocial adjustment difficulty or a history of trauma and/or post-traumatic stress disorder (PTSD), receives the appropriate treatment and services to correct the initial assessed problem or to attain the highest practicable mental and psychosocial well-being.

•Residents who were admitted to the nursing home with a mental or psychosocial adjustment difficulty, or who have a history of trauma and/or PTSD, must receive appropriate person-centered and individualized treatment and services to meet their assessed needs.

NEW FEDERAL REGULATIONS
Final Rule, Phase 2 (11/28/17)

****KEY ELEMENTS OF NONCOMPLIANCE § 483.40(b) & § 483.40(b)(1)**

To cite facility deficient practice at F742, the surveyor's investigation will generally show that the failed to:

•Assess the resident's expressions or indications of distress to determine if services were needed;

•Provide services and individualized care approaches that address the assessed needs of the resident and are within the scope of the resources in the facility assessment;

•Develop an individualized care plan that addresses the assessed emotional and psychosocial needs of the resident;

•Assure that staff consistently implement the care approaches delineated in the care plan;

•Monitor and provide ongoing assessment as to whether the care approaches are meeting the emotional and psychosocial needs of the resident; or

•Review and revise care plans that have not been effective and/or when the resident has a change in condition and accurately document all of these actions in the resident's medical record.

****Most long-term care facilities fail to meet one or more of these regulatory standards.****

Staff Competency and Skill

F726

§ 483.35 Nursing Services

The facility must have sufficient nursing staff *with the appropriate competencies and skills sets* to provide nursing and related services to *assure resident safety and* attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care *and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.70(e).*

PASRR COMPLIANCE

- **F644 § 483.20(e) Coordination**. A facility must coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:
  - § 483.20(e)(1) Incorporating the recommendations from the PASRR level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care.
  - § 483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

Behavioral Health Regulations vs PASRR Specialized Services Quality and Compliance

- Every long-term care facility is required by Federal and State regulations to identify and address the behavioral health needs of its residents. The quality, consistency, and benefit of the services provided will vary based on the clinical knowledge and skill sets of the professional caregivers.
- The primary difference between behavioral health services that are required of the nursing facility by regulation and behavioral health services that fall under Specialized Services is that the latter are specifically spelled out, must be tracked, and are required to be included as part of the treatment plan.

Behavioral Health Regulations vs PASRR Specialized Services Quality and Compliance

- Evaluation of regulatory compliance in behavioral health is subjective and random. Regulatory guidelines leave the decision to provide those same services to the professional caregivers. Unless those caregivers have education and experience in mental health, the need for services may be overlooked.
- Too often, necessary services are overlooked in favor of medication. A requirement for specialized services minimizes the potential for mistreatment.

Case Study - Cindy

Description:

•Forty-one-year-old woman with a diagnosis of traumatic brain injury (TBI) secondary to heroin overdose, cardiovascular accident (CVA), multiple sclerosis (MS), bipolar depression, and anxiety disorder.

Behavior:

•Described by staff to be difficult, resistive to care routines, demanding of attention, foul-mouthed, inconsiderate and abusive to her peers, manipulative, and a hoarder.

Case Study - Cindy

Situation:

- This is her third admission to this nursing home after two previous unsuccessful discharges to the community.
- Cindy is divorced and is mother to four children. She lost her first two children to foster care when she was a teenager.
- Her childhood history includes living with alcoholic/substance using parents, physical abuse, and, later, domestic violence as a teen bride.
- Her current living situation finds her in a four-bedded room, surrounded by three women in their 80s and 90s who all have a diagnosis of dementia. The facility is small, with only one common room that serves as a dining room and a dayroom. Access to the outdoor areas of the building requires staff supervision.
- Cindy is also a smoker. Supervised smoking is scheduled three times a day in the designated outdoor area.

Case Study - Cindy

Care Plan Interventions for Mood/Behavior:

- Medication as ordered: Ativan, Depakote
- Psychiatry evaluation, as needed;
- Approach in a calm manner when agitated;
- Remind resident of care schedules and routines;
- Remind resident to respect the rights of others;
- Provide resident with individual activity supplies, as requested;
- Notify MD of changes in behavior.

Case Study - Cindy

- Admitting Level I PASRR does not indicate need for Level II evaluation;
- Psychiatry order for psychology evaluation is not satisfied due to facility's rural location and lack of access to services;
- Facility Social Worker is not trained in addiction services and has limited direct experience with residents with mental disorders or ID/DD;
- Interdisciplinary team fails to identify a significant change resulting from her progressing MS.

What is Behavior?

Regina – 57-year-old nursing home resident:

"When you don't get what you want,
you get an attitude."

Behavioral Health

New Federal Regulations

§ 483.40 Behavioral health services.

- Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
- Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the ***prevention and treatment of mental and substance use disorders***.

Behavioral Health

New Federal Regulations

(a) The facility must have ***sufficient staff*** who provide direct services to residents with the appropriate ***competencies and skills sets*** to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and ***considering the number, acuity and diagnoses*** of the facility's resident population in accordance with § 483.70(e).

Behavioral Health

New Federal Regulations

These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

- Caring for residents with mental and psychosocial disorders, as well as residents with a history of ***trauma and/or post-traumatic stress disorder***, that have been identified in the facility assessment conducted pursuant to § 483.70(e), and
- ***Implementing non-pharmacological interventions.***

Behavioral Health

New Federal Regulations

(b) Based on the comprehensive assessment of a resident, the facility must ensure that—

- A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;

Behavioral Health

New Federal Regulations

- A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder ***does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors,*** unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; and

Dementia Focus Survey

- Is behavior acknowledged as a form of communication?
- Is it expected that all staff strives to understand the meaning behind these behaviors?
- Are non-nursing staff (particularly recreational therapy staff) trained in dementia care practices?

Dementia Focus Survey

- Does the overall philosophy of care in the nursing home acknowledge behaviors as a form of communication and is there an expectation that all staff strives to understand the meaning behind these behaviors?

Dementia Focus Survey

- Does the QAA Committee monitor for consistent implementation of the policies and procedures for the care of residents with dementia?
- Has the QAA Committee corrected any identified quality deficiencies related to the care of residents with dementia?

Assessment: Understanding the Individual

Who is the person behind the behavior?

- Personality
- Ego
- Common triggers
- Responses
- Rituals
- Preferences

Understanding the Individual

- Known or potential triggers to behavior
- Known self-soothing remedies
- The pre-dementia or pre-illness personality
- Social and occupational history
- Family dynamics
- Preferences and routines

Assessment

- Impact of neurodegenerative disease, mental illness, and stress on behavioral health and social functioning;
- Assessment of symptoms and behavioral triggers;

What Is Behavior?

- **Symptom**: Related to or caused by clinical diagnosis, such as dementia, mental illness, pain, etc. Behavior in this category should be anticipated, based on what the clinical team understands about the diagnosis.
- **Reaction**: Related to or caused by circumstance or environment. Behavior in this category should also be anticipated, based on what the team understands about human nature and human response.
- **Personality**: This type of "behavior" is usually the caregiver's issue, not the resident's. In many circumstances, the expression of a preference is labeled **behavior**.

Behavioral Health Assessment Considerations

Psychosocial Adjustment:

The "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM/IV)," specifies that adjustment disorders develop within 3 months of a stressor (e.g., moving to another room) and are evidenced by significant functional impairment.

*Bereavement with the death of a loved one is not associated with adjustment disorders developed within 3 months of a stressor.

Behavioral Health Assessment Considerations

Other manifestations of mental and psychosocial adjustment difficulties may, over a period of time, include:

- Impaired verbal communication;
- Social isolation (e.g., loss or failure to have relationships);
- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);
- Spiritual distress (disturbances in one's belief system);
- Inability to control behavior and potential for violence (aggressive behavior directed at self or others); and
- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

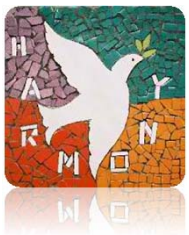
Is Your Family DYSFUNCTIONAL?

The Nature of Relationships

- Assessing personalities, office politics, and respect issues.
- What sort of first impression does your organization make?
- What resources or support systems does your organization foster to improve relationships?

Relationships

- How well do staff interact with residents?
- How well does the team do at pairing roommates?
- How effective are the procedures for resolving grievances and conflicts?



Social Groups

1. Are you selective about choosing friends?
2. How do you choose a seat at a gathering where you don't know many people?

SOCIAL REACTIONS

Have you ever:

- Declined an invitation because you didn't know anyone else who would be attending or because you learned someone you didn't like would be there?
- Moved from your original seat because of the behavior of someone else at the table?
- Left a gathering or program because you found it wasn't as interesting as you'd thought it would be or because another guest arrived wearing your dress?

Behavioral Health

Assessment & Care Plan Considerations

Clinical conditions that may produce apathy, malaise, and decreased energy levels that can be mistaken for depression associated with mental or psychosocial adjustment difficulty are: (This list is not all inclusive.)

- Metabolic diseases (e.g., abnormalities of serum glucose, potassium, calcium, and blood urea nitrogen, hepatic dysfunction);
- Endocrine diseases (e.g., hypothyroidism, hyperthyroidism, diabetes, hypoparathyroidism, hyperparathyroidism, Cushing's disease, Addison's disease);

Behavioral Health
Assessment & Care Plan Considerations

- Central nervous system diseases (e.g., tumors and other mass lesions, Parkinson's disease, multiple sclerosis, Alzheimer's disease, vascular disease);
- Miscellaneous diseases (e.g., pernicious anemia, pancreatic disease, malignancy, infections, congestive heart failure);
- Over-medication with anti-hypertensive drugs; and
- Presence of restraints.

Evaluate Existing Medications

- Consider the following issues:
  - Drug induced cognitive impairment
    - **Anticholinergic Load**
  - Medication induced electrolyte disturbance
  - Recent medication additions that may alter metabolism of a drug that the person has been taking for a while
  - Withdrawal reaction to a recently discontinued medication

65

Behavioral Health
Unnecessary Drugs: Evaluation

To determine if each resident receives:

- Only those medications that are clinically indicated in the dose and for the duration to meet his or her assessed needs;
- Non-pharmacological approaches when clinically indicated, in an effort to reduce the need for or the dose of a medication; and
- Gradual dose reduction attempts for antipsychotics (unless clinically contraindicated) and tapering of other medications, when clinically indicated, in an effort to discontinue the use or reduce the dose of the medication.

Behavioral Health
Unnecessary Drugs: Evaluation

To determine if the facility in collaboration with the prescriber:

- Identifies the parameters for monitoring medication(s) or medication combinations (including antipsychotics) that pose a risk for adverse consequences; and for monitoring the effectiveness of medications (including a comparison with therapeutic goals); and
- Recognizes and evaluates the onset or worsening of signs or symptoms, or a change in condition to determine whether these potentially may be related to the medication regimen; and follows-up as necessary upon identifying adverse consequences.

EVALUATE HOW THE FACILITY MANAGES MEDICATIONS FOR THE RESIDENT

Does the facility policy and procedure include the following standards?

- Clinical indications for use of the medication
- Consideration of non- pharmacological interventions
- Dose, including excessive dose and duplicate therapy
- Duration, including excessive duration
- Consideration of potential for tapering/GDR or rationale for clinical contraindication
- Monitoring for and reporting of:
  - Response to medications and progress toward therapeutic goals
  - Emergence of medication-related adverse consequences
- Adverse consequences, if present and potentially medication-related, was there:
  - Recognition, evaluation, reporting, and management by the facility
  - Physician action regarding potential medication-related adverse consequences

Behavioral Health

Inadequate Indications for Use of Anti-Psychotic Medication

- Failure to document a clinical reason or demonstrate a clinically pertinent rationale, verbally or in writing, for using medication(s) for a specific resident;
- Prescribing or administering a medication despite an allergy to that medication, or without clarifying whether a true allergy existed as opposed to other reactions (e.g., idiosyncratic reaction or other side effect);
- Failure to provide a clear clinical rational for continuing a medication that may be causing an adverse consequence.

Behavioral Health

Inadequate Indications for Use of Anti-Psychotic Medication

- Initiation of an antipsychotic medication to manage distressed behavior without considering a possible underlying medical cause (e.g., UTI, congestive heart failure, delirium) or environmental or psychosocial stressor;
- Initiation of a medication presenting clinically significant risk without considering risks and benefits or potentially lower risk medications; or
- Concomitant use of two or more medications in the same pharmacological class without a clinically pertinent explanation.

Behavioral Health
Clinical Documentation

Did staff describe the behavior in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible?

- Onset
- Duration
- Intensity
- Possible precipitating events
- Environmental triggers
- Related factors (appearance, alertness, etc.)

Behavioral Health
Clinical Documentation

- If the behaviors represent a sudden change or worsening from baseline, did staff contact the attending physician/practitioner immediately for a medical evaluation, as appropriate?
- If medical causes are ruled out, did staff attempt to establish other root causes of the behavior using individualized knowledge about the person and when possible, information from the resident, family, previous caregivers and/or direct care staff?

Behavioral Health Clinical Documentation

- As part of the comprehensive assessment did facility staff evaluate:
  - The resident's usual and current cognitive patterns, mood and behavior, and whether these present a risk to the resident or others?
  - How the resident typically communicates a need such as pain, discomfort, hunger, thirst or frustration?
  - Prior life patterns and preferences customary responses to triggers such as stress, anxiety or fatigue, as provided by family, caregivers, and others who are familiar with the resident before or after admission?

Behavioral Health Clinical Documentation

- Did staff, in collaboration with the practitioner, identify risk and causal/contributing factors for behaviors, such as:
  - Presence of co-existing medical or psychiatric conditions, or decline in cognitive function?
  - Adverse consequences related to the resident's current medications?

Behavioral Health Care Plan Strategies

Appropriate treatment and services for psychosocial adjustment difficulties may include:

- Providing residents with opportunities for self-governance;
- Systematic orientation programs;
- Arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices; and
- Maintaining contact with friends and family.

Appropriate treatment for mental adjustment difficulties may include crisis intervention services; individual, group or family psychotherapy, drug therapy and training in monitoring of drug therapy and other rehabilitative services.

Non-pharmacological Interventions

- Increasing the amount of resident exercise;
- Reducing underlying causes of distressed behavior such as boredom and pain;
- Individualized bowel regimen to prevent or reduce constipation and the use of medications;

Non-pharmacological Interventions

- Improving sleep hygiene;
- Accommodating the resident's behavior and needs by supporting and encouraging activities reminiscent of lifelong work or activity patterns;
- Using massage, hot/warm or cold compresses to address a resident's pain or discomfort; and
- Enhancing the dining experience.

Activities for a New Age

- Diversify therapeutic activity offerings to include education, self-help, and support programs;
- Collaborate with community addiction services;
- Promote positive self-esteem through meaningful socialization and therapeutic activity;
- Collaborate with community vocational services organizations in discharge planning;
- Foster opportunities for volunteerism.

101 ACTIVITIES ANYONE CAN DO

1. Listen to music
2. Make homemade lemonade
3. Count trading cards
4. Clip Coupons
5. Sort poker chips
6. Rake leaves
7. Write a poem together
8. Make a fresh fruit salad…

Source: Alzheimer's Association Web Site – www.alz.org

Combining ADL, Leisure and Therapeutic Activity

The simplest way to begin improving the manner in which meaningful activity is made available to residents is by redefining what "meaningful" is.

Find ways to turn ADL activity into activity that occurs between leisure and therapeutic groups. Consider all the disciplines that could contribute real and valuable programming to the day. There may be more resources than you think.

There are hundreds of tasks that make up a person's daily routine. Evaluate what already happens in your environment with regard to common sense ADL and leisure tasks.

Behavioral Health Care Plan Evaluation

- Did your plan succeed?
- If yes, what will the resident's next goal(s) be?
- If not, why not?
- How will you modify it to improve your opportunity for success?

Behavioral Health Quality Monitoring

Probes: For those residents exhibiting difficulties in mental and psychosocial adjustment:

- Is there a complete accurate assessment of resident's usual and customary routines?
- What evidence is there that the facility makes accommodations for the resident's usual and customary routines?
- What programs/activities has the resident received to improve and maintain maximum mental and psychosocial functioning?
- Has the resident's mental and psychosocial functioning been maintained or improved (e.g., fewer symptoms of distress)?

Behavioral Health Quality Monitoring

Probes: For those residents exhibiting difficulties in mental and psychosocial adjustment:

- Have treatment plans and objectives been reevaluated?
- Has the resident received a psychological or psychiatric evaluation to evaluate, diagnose, or treat her/his condition, if necessary?
- Identify if resident triggers CAAs for activities, mood state, psychosocial well-being, and psychotropic drug use. Consider whether the CAAprocess was used to assess the causal factors for decline, potential for decline or lack of improvement.
- How are mental and psychosocial adjustment difficulties addressed in the care plan?

Behavioral Health Quality Monitoring

Probes : For sampled residents whose assessment did not reveal a mental or psychosocial adjustment difficulty, but who display decreased social interaction or increased withdrawn, angry, or depressed behavior, determine, as appropriate, was this behavior unavoidable.

- Did the facility attempt to evaluate whether this behavior was attributable to organic causes or other risk factors not associated with adjusting to living in the nursing facility?
- What care did the resident receive to maintain his/her mental or psychosocial functioning?
- Were individual objectives of the plan of care periodically evaluated, and if progress was not made in reducing, maintaining, or increasing behaviors that assist the resident to have his/her needs met, were alternative treatment approaches developed to maintain mental or psychosocial functioning?
- Identify if resident triggers CAAs for behavior problem, cognitive loss/dementia, and psychosocial well-being. Consider whether the CAA process was used to assess causal factors for decline, potential for decline or lack of improvement.

Behavioral Health Quality Monitoring

Probes : For sampled residents whose assessment did not reveal a mental or psychosocial adjustment difficulty, but who display decreased social interaction or increased withdrawn, angry, or depressed behavior, determine, as appropriate, was this behavior unavoidable.

- Did the facility use the CAA process for behavior problems, cognitive loss/dementia, and psychosocial well-being to assess why the behaviors or change in mental or psychosocial functioning was occurring?
- Impaired verbal communication;
- Social isolation (e.g., loss or failure to have relationships);
- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);
- Spiritual distress (disturbances in one's belief system);
- Inability to control behavior and potential for violence (aggressive behavior directed at self or others); and
- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

Steps to Creating a Livable Environment

- Evaluate Relationships
- Evaluate the Environment
- Educate Everyone
- Structure the Environment
- Consider the ***Boredom Factor***
- Increase Pleasure

Becoming The Change You Want To See

Changing the nature of relationships is the best foundation for changing the way the organization achieves its goals.

- Demonstrate respect
- Educate equally
- Give everyone a voice in addressing challenges
- Be prepared to try, try again
- Acknowledge a job well done
- Express your gratitude

Barbara Speedling
Quality of Life Specialist
917.754.6282
Bspeedling@aol.com
www.innovationsforqualityliving.com

Innovations for Quality Living

Creating Meaningful, Satisfying Lives One Person at a Time