BEHAVIORS AND CARE PLANNING

CAROL SIEM MSN, RN, BC, GNP
Clinical Educator
SHARON THOMAS, BSN, RN, RAC-CT
Clinical Educator

OFFICE OF INSPECTOR GENERAL (OIG)

- Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents - published May 2011
- Six month review of atypical antipsychotic drugs usage in nursing homes

FINDINGS

- 14% of elderly nursing home residents had Medicare claims for atypical antipsychotic drugs
- 83% of Medicare claims for atypical antipsychotic drugs for elderly nursing home residents were associated with off label conditions; 88% were associated with the condition specified in the FDA boxed warning

FINDINGS

- 51% of Medicare antipsychotic drug claims for elderly nursing home residents were erroneous, amounting to $116 million
- 22% of the atypical antipsychotic drugs claimed were not administered in accordance with CMS standards regarding unnecessary drug use in nursing homes
RECOMMENDATIONS

- Facilitate access to information necessary to ensure accurate coverage and reimbursement determinations
- CMS response: CMS did not concur with this recommendation and expressed several general concerns with the report due to lack of diagnosis information for prescriptions

RECOMMENDATIONS

- Assess whether survey and certification processes offer adequate safeguards against unnecessary antipsychotic drug use in nursing homes
- CMS response: CMS concurred and stated it has already assessed and made improvements in the survey and certification process

RECOMMENDATIONS

- Explore alternative methods beyond survey and certification processes to promote compliance with federal standards regarding unnecessary drug use in nursing homes
- CMS response: CMS concurred and is exploring alternative strategies (contractual agreements among drug manufacturers)

RECOMMENDATIONS

- Take appropriate action regarding the claims associated with erroneous payments identified in our sample
- CMS response: CMS concurred and will consider what appropriate actions need to be taken when the claims data are received from OIG
### What Drugs at What Cost?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quetiapine (Seroquel)</td>
<td>$86 million</td>
</tr>
<tr>
<td>Risperidone (Risperdal)</td>
<td>$87 million</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa)</td>
<td>$94 million</td>
</tr>
<tr>
<td>Ariprazole (Abilify)</td>
<td>$29 million</td>
</tr>
</tbody>
</table>

### What Drugs (Cont.)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ziprasidone (Geodon)</td>
<td>$10 million</td>
</tr>
<tr>
<td>Clozapine (Clozaril)</td>
<td>$1.5 million</td>
</tr>
<tr>
<td>Olanzapine/Fluoxetine (Symbyax)</td>
<td>$431,000</td>
</tr>
<tr>
<td>Paliperidone (Invega)</td>
<td>$207,000</td>
</tr>
</tbody>
</table>

### What About the Residents?

- Side effects: drowsiness/sedation, restless, somnolence, low blood pressure, impaired judgment
- Increase risk of death in the elderly:
  - Abilify, Clozaril, Zyprexa, Symbyax, Invega, Seroquel, Risperdal, and Geodon

### Now What???
## Surveyor Guidelines Checklist

- Used to review the care and services for a resident with dementia
- It is to be used with Interpretive Guidance for F309: Quality of Care: Provide Care/Services for Highest Well-Being

## Assessment and Underlying Cause Identification

- Behavior description: onset, duration, possible precipitating events or environmental triggers and related factors (appearance, alertness, etc.)
- Sudden change or worsening from baseline; was MD notified for medical evaluation?

## Assessment and Underlying Cause Identification

- Medical causes ruled out: attempt to find root causes with a comprehensive assessment
  - Usual and current cognitive patterns, mood and behavior, risk to resident or others
  - Typical communication for basic needs
  - Prior life patterns and preferences

## Comprehensive Assessment

- Assessment needs to include the physical, mental, and psychosocial needs of the resident, and also identify risks and/or determine **underlying causes of the behavior and impact upon the residents function, mood and cognition**
- If not, could be cited F272 - Comprehensive Assessment
CARE PLANNING

- Resident and family involvement (to the extent possible)
- Reflects individualized team approach with measureable goals, timetables and specific interventions

DOCUMENTATION BEYOND THE CARE PLAN

- Documentation of the meeting and what was discussed
- If resident/family/representative refuse recommendations, was counseling on consequences and alternative approaches discussed?

CARE PLANNING

- Includes
  - Involvement of resident/representative
  - Description of targeted behaviors and how to prevent them
  - Why behaviors should be prevented or otherwise addressed
  - Monitoring the effectiveness of any/all interventions

CARE PLANNING

- Develop plan of care with measureable goals and interventions to address the care and treatment for a resident with dementia related to behavioral and/or mental/psychosocial symptoms in accordance with assessment, resident’s wishes and current standards of practice
- If not, may cite F279 - Development of a Comprehensive Care Plan
IMPLEMENTATION OF THE CARE PLAN

- Identify, document, and communicate specific targeted behaviors and expressions of distress as well as desired outcomes
  - Person-centered interventions
  - Communication between staff and consistency with care
  - Investigate potential causes of any sudden changes in behavior
  - Sufficient numbers of trained staff

IMPLEMENTATION OF THE CARE PLAN

- Facility provided or arranged provision of services by qualified persons in accordance with the resident’s written plan of care? If not, can cite F282 - Services by Qualified Persons

CARE PLAN REVISION AND MONITORING

- Adjust interventions based on impact
- Care plan modified as necessary

- If above not done, could be cited F280 Right to Participate in Planning Care – Revise Care Plan

CARE PLAN REVISION/MONITORING

- Ensure that the physician responds in a timely fashion and if not, the medical director should be contacted for assistance
CARE PLAN
Revision/Monitoring

- Facility provided necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental and psychosocial well being in accordance with the assessment and care plan
- If not, cite F 309 - Provide Care/Services for Highest Well-Being

QUALITY ASSESSMENT AND ASSURANCE

- Resident care policies and procedures outline a systematic process of care for residents with dementia
- Monitoring of consistent implementation
- Correct any identified quality deficiencies
- Provide monitoring and oversight for the care

NOW WHAT

- Rules vs Reality
- How would you like to be treated???
- Does Dementia take away our feelings?
- Does Dementia mean that we no longer care how we are treated?

LOOK IN THE MIRROR

- What would you like people to know about you??
- What will make or break your day??
What Does the Person with Dementia Need?

- **Attachment**: Without the reassurance that attachment provides, it’s difficult for any person to function well.
- **Inclusion**: It’s possible for people to be together but profoundly alone; care plans sometimes overlook this.

What Does the Person with Dementia Need?

- **Occupation**: To be involved in the process of life in a way that is personally significant and uses one’s abilities.
- **Identity**: To some extent, identity is conferred by others with subtle messages about his or her being.

What Does the Person with Dementia Need?

- **Comfort**: Feelings of closeness and security.
- **Love**: A blending of all of the above that enhances self-worth and well-being.

Physical Needs of the Person with Dementia

**Physical Comfort**: Could pain, illness, or discomfort be an issue?

Has the person been assessed for new or worsening of other progressive disease, besides dementia, that may cause pain or discomfort?
### Physical Needs of the Person with Dementia

#### Nutrition/Hydration:
- Is the person hungry or thirsty?
  - Why?
  - Is this a regular pattern?
  - Medication issue?

#### Sleep/rest:
- Is the person sleepy in the day time?
  - Possible reasons?
- Is the person not sleeping at night?
  - Possible reasons?
- Is the person getting needed rest during the day?
- Is this a life pattern?
- Medication issue?

#### Elimination:
- Does this person have a regular toileting or cueing schedule?
- Has there been a change in elimination patterns, either urinary or bowel?
- Is the person accepting of toileting or cueing?
- Could approach for toileting be an issue?
- Medication issue?

#### Exercise:
- Is this person getting appropriate exercise to maintain their highest level of independence?
- If not, what are some possible reasons?
- Medication issue?
**Physical Needs of the Person with Dementia**

**Physical Hygiene:**
- Are the person’s hygiene needs being met (bathing, oral care, etc.)?
- If not, why?
- Is there a mismatch of assistance to ability?
- Could approach be an issue?
- Could environment be an issue?
  - Water/air temp too hot or too cold, lighting, institutional bathroom

**Resident’s Perspective**
- All behaviors have meaning and are a form of communication
- Focus on assessment and not the reaction
- What is the resident trying to tell us?

**Staff’s Perspective**
- What can I do to take care of this person?
- How can I care for him without feeling threatened, or punched or kicked?
- Is there help when I need it?

**Assessment and Cause Identification**
- Documentation of the behavior in relationship to:
  - Onset, duration, intensity, possible precipitating events, or environmental triggers
- Related factors:
  - Appearance, alertness, etc.
ASSESSMENT AND CAUSE IDENTIFICATION

- Medical causes ruled out:
  - Review the Behavioral Symptoms CAA (#9)
  - An excellent baseline for the identification of potential cause or causes
- Don’t forget, pain could be the issue (or at least a contributing factor)

CARE PLANNING
SET THE STAGE

- How are your care plans set up?
- Can you tell who the resident is simply by the care plan?
- Can you “see” the PERSON who is the resident?

CARE PLANNING
SET THE STAGE

- A picture of the resident
- A story of who they are:
  - What they want to be called: nick names, formal name, etc.
  - Occupation
  - Family names
  - Favorite things to do
  - What brings them joy
CARE PLANNING
- What behaviors are we talking about for this individual?
- What triggers the behaviors?
- What calms the resident?

Be specific and give examples

BEHAVIOR EXAMPLES
- Joe becomes anxious (wringing hands, pacing) when a room gets too crowded
- Charlotte “searches” for her clothes in other rooms and does not like to be told that she is doing anything wrong

BEHAVIOR EXAMPLES
- Sam is very suspicious and food containers need to be opened in his presence
- Julie becomes physically aggressive (kicking, hitting, etc.) if she does not understand what you are doing (i.e. being toileted, time for a meal)

MEASURABLE GOALS
Think about the coding of the MDS:
- Physically aggressive: Carol will have less than 4-6 days a week of kicking and hitting staff
- Verbal: John will have verbal outbursts (shouting and cussing) less than daily
MEASURABLE GOALS

- Problem: Daily crying
  - Progressive goals:
    - Episodes will decrease from daily to 4-6 days per week
    - Episodes will decrease to 1 to 3 days per week
    - No further episodes

INTERVENTIONS

- Start with what the person has shown is important to them
  - Enjoys watching police shows such as CSI and NCIS
  - Takes a nap every afternoon
  - Eats slowly (so try to have Joan in the dining room promptly)
  - Enjoys a cup of coffee or dish of ice cream

INTERVENTIONS

- Then move to potential triggers
  - Don’t sit Susan next to John in the dining room, as it upsets his wife
  - George does not like when the dining room is very noisy, move him to the assist dining area
  - June will only shower on Saturday evening so she is ready for “church” on Sunday

INTERVENTIONS

- Then what to do if the individual does start having behavioral expressions
  - If Joe starts cursing/yelling ensure his safety and leave the room; come back 5-10 minutes later, he will apologize, accept it and move on
  - Susan will start wringing her hands if she is getting upset; take her back to her room and put on the TV and give her some quiet time
**DOCUMENTATION**

- Paint a picture of what happened
- What happened **before, during, and after**
- Even if it happens everyday we need to note it **everyday** (if we don’t why are having problems)
- Interventions **MUST** be tried **each and every time**
- If PRN medications are given, document on why it was used and what interventions were tried

**RESOURCES**


**RESOURCES**

- Dementia Care Mapping class: August 24 through August 27, 2015 and will be at the Primaris; more information will be available later this spring
- Dementia Care Mapping will also be the topic at the MidMO MC5 meeting on 2/11/15

**RESOURCES**

- QIPMO Educators and Leadership Coaches – Contact Jessica Mueller at (573) 882-2041 or muellerjes@missouri.edu
- QIPMO website: [www.nursinghomehelp.org](http://www.nursinghomehelp.org)
Checklist

Review of Care and Services for a Resident with Dementia
(for use with the Interpretive Guidance at F309)

Assessment and Underlying Cause Identification

✓ Did staff describe behavior (onset, duration, intensity, possible precipitating events or environmental triggers, etc.) and related factors (appearance, alertness, etc.) in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible?
✓ 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?
✓ 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?
✓ 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?

1. If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the physical, mental and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes (to the extent possible) of the resident’s behavioral and/or mental psychosocial symptoms, and needed adaptations, and the impact upon the resident’s function, mood and cognition?
   If No, cite F272

Care Planning

✓ Was the resident and/or family/representative involved (to the extent possible) in discussions about the potential use of any interventions, and was this documented in the medical record?
✓ Does the care plan reflect an individualized team approach with measurable goals, timetables and specific interventions for the management of behavioral and psychological symptoms?
✓ Does the care plan include:
  • Involvement of the resident/representative to the extent possible?
  • A description of and how to prevent targeted behaviors?
  • Why behaviors should be prevented or otherwise addressed (e.g., severely distressing to resident)?
  • Monitoring of the effectiveness of any/all interventions?
✓ If the resident or family/representative refused a recommended treatment or approach, was counseling on consequences and alternative approaches to address behavioral symptoms provided?

Note: If the resident lacks decisional capacity and lacks effective family/representative support, contact the facility social worker to determine what type of social services or referrals have been attempted to assist the resident.

2. Did the facility develop a plan of care with measurable goals and interventions to address the care and treatment for a resident with dementia related to the behavioral and/or mental/psychosocial symptoms, in accordance with the assessment, resident’s wishes and current standards of practice? If No, cite F279
Implementation of the Care Plan
Did staff:
Identify, document and communicate specific targeted behaviors and expressions of distress as well as desired outcomes?

✓ Implement individualized, person-centered interventions by qualified persons and document the results?
✓ Communicate and consistently implement the care plan, over time and across various shifts?
✓ If there is a sudden change in the resident’s condition and medical causes of behavior or other symptoms (e.g., delirium or infection) are suspected, is the physician contacted immediately and treatment initiated?
✓ Is there a sufficient number of staff to consistently implement the care plan? (Surveyors should focus on observations of staff interactions with residents who have dementia to determine whether staff consistently applies basic dementia care principles in the care of those individuals).

3. Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident’s written plan of care? If No, cite F282

Note: If during the survey a concern is identified that an antipsychotic medication is given by staff for purposes of discipline or convenience and not required to treat the resident’s medical symptoms, review F222 – §483.13(a).

Care Plan Revision/Monitoring and Follow up
✓ Does staff, in collaboration with the practitioner, adjust the interventions based on the impact on behavior or other symptoms as well as any adverse consequences related to treatment?
✓ When concerns related to the effectiveness or adverse consequences of a resident’s treatment regimen are identified:
  • Does staff modify the care plan and, if appropriate, notify the physician and does the physician respond and initiate a change to the resident’s care as necessary?

4. Did the facility reassess the effectiveness of the interventions and review and revise the plan of care (with input from the resident or representative, to the extent possible), if necessary, to meet the needs of the resident with dementia? If No, cite F280

  • If the physician does not respond to the notification, does staff contact the medical director for further review? If the medical director was contacted, does he/she respond and intervene as needed?

5. Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care? If No, cite F309

Quality Assessment and Assurance
Note: Please refer to F520 Quality Assessment and Assurance for guidance regarding the information that may be obtained from the QAA committee.

✓ Do resident care policies and procedures clearly outline a systematic process for the care of residents with dementia?
✓ 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?
✓ Has the QAA committee provided monitoring and oversight for the care and services for a resident with dementia?