# Non-Pharmacological Interventions

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# Financial Disclosure

I have no relevant relationships with commercial interest companies to disclose.

# Learning Objectives

You will take home:

Skills you can use immediately to enhance quality of life for PWD

PWD = Person with Dementia

# Dementia: What is It?  What is it not?

- Instead of dubbing dementia as a “memory disease”, start calling it a **brain disease**
- Dementia is a disease that, in the early stages, one can adapt their life to.
  - Depending on progression and type of dementia, the early stage and ability to cope will vary.
- Dementia is not a solo disease.
  - It affects the whole family

# Communication is Key

- In order to prevent over-usage of pharmacological interventions, we must first understand how to avoid the need for them.
- Learning how to communicate with a PWD is your number one priority in caregiving.
- Communication makes you or breaks you!

# Communication 101

- Speak clearly and tone-appropriate
  - If the person is hard-of-hearing on top of having dementia, this step is even more critical
- K.I.S.S.
  - Keep It Simple, Sweetie
  - About 2 or 3 words of your sentence will be recognized, depending on stage of dementia.
- If you must repeat, repeat it exactly as you said it the first time
- Ask “Can you tell me about it?”

# When words are no longer…

- Behavior becomes the mode of communication
- What is the behavior saying?
  - Anger/Agitation
  - Fear
  - Boredom
  - Physiological processes *(infection, pain, sleep)*
- The PWD is always right, except…

# Anger/Agitation

- Early to middle stages: PWD may feel frustration because they are not being understood. As speech and language skills deteriorate, communication does, too.
- Surroundings
  - Is the environment person-centered?
  - Angry at new placement?
  - Angry at no longer being able to travel to familiar locations/drive/etc
- Physiological needs met?
  - Pain/Discomfort
  - Constipation
  - Hunger/Thirst
  - Fatigue

# Boredom

- PWD need to be stimulated, which can become a catch-22. Not over- or under-stimulated, mind you.

*"Nursing home residents often find themselves in an understimulating environment, spending the majority of their time unengaged in any meaningful activity. When coupled with a lack of social contact, this state of inactivity results in boredom, loneliness, and behavioral problems, which can then translate to depression"* (The Impact of Stimuli... Journal of Clinical Psychiatry)

# Fear

- Combative behavior and agitation can manifest from fear.
- Imagine having a strange environment with strange faces and an unfamiliar routine.  Would you be scared?

- Person-Centered Care is the answer.

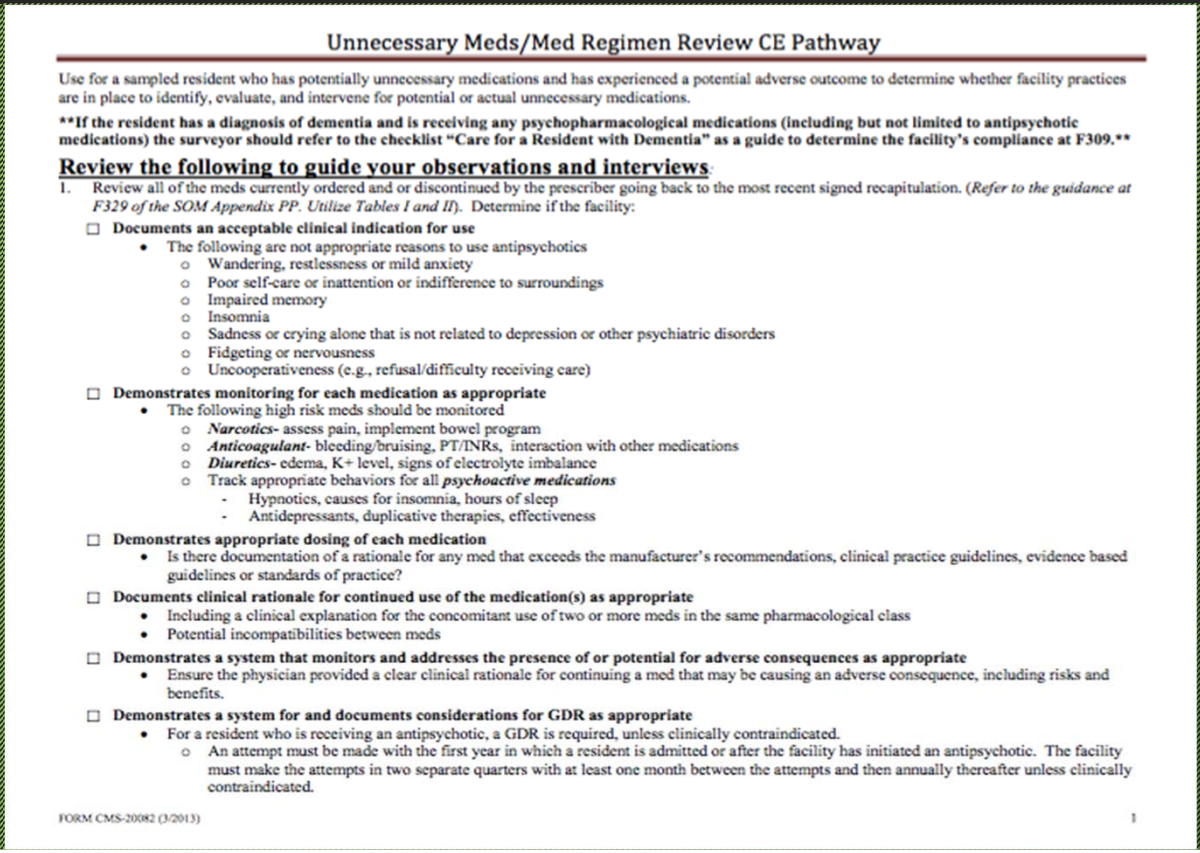
# Why do we medicate?

- Lack of:
  - Education
  - Time
  - Staff
  - Understanding

# What does CMS say about medicating?

- "Acceptable clinical indication"
- "Appropriate Monitoring"

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/CMS-20082-Critical-Elements-Unnecessary-Medication.pdf



## Unnecessary Meds/Med Regimen Review CE Pathway

Use for a sampled resident who has potentially unnecessary medications and has experienced a potential adverse outcome to determine whether facility practices are in place to identify, evaluate, and intervene for potential or actual unnecessary medications.

****If the resident has a diagnosis of dementia and is receiving any psychopharmacological medications (including but not limited to antipsychotic medications) the surveyor should refer to the checklist "Care for a Resident with Dementia" as a guide to determine the facility's compliance at F309.****

**Review the following to guide your observations and interviews:**

1. Review all of the meds currently ordered and or discontinued by the prescriber going back to the most recent signed recapitulation. (*Refer to the guidance at F329 of the SOM Appendix PP. Utilize Tables I and II*). Determine if the facility:

☐ **Documents an acceptable clinical indication for use**
- The following are not appropriate reasons to use antipsychotics
  - Wandering, restlessness or mild anxiety
  - Poor self-care or inattention or indifference to surroundings
  - Impaired memory
  - Insomnia
  - Sadness or crying alone that is not related to depression or other psychiatric disorders
  - Fidgeting or nervousness
  - Uncooperativeness (e.g., refusal/difficulty receiving care)

☐ **Demonstrates monitoring for each medication as appropriate**
- The following high risk meds should be monitored
  - ***Narcotics***- assess pain, implement bowel program
  - ***Anticoagulant***- bleeding/bruising, PT/INRs, interaction with other medications
  - ***Diuretics***- edema, K+ level, signs of electrolyte imbalance
  - Track appropriate behaviors for all ***psychoactive medications***
    - Hypnotics, causes for insomnia, hours of sleep
    - Antidepressants, duplicative therapies, effectiveness

☐ **Demonstrates appropriate dosing of each medication**
- Is there documentation of a rationale for any med that exceeds the manufacturer's recommendations, clinical practice guidelines, evidence based guidelines or standards of practice?

☐ **Documents clinical rationale for continued use of the medication(s) as appropriate**
- Including a clinical explanation for the concomitant use of two or more meds in the same pharmacological class
- Potential incompatibilities between meds

☐ **Demonstrates a system that monitors and addresses the presence of or potential for adverse consequences as appropriate**
- Ensure the physician provided a clear clinical rationale for continuing a med that may be causing an adverse consequence, including risks and benefits.

☐ **Demonstrates a system for and documents considerations for GDR as appropriate**
- For a resident who is receiving an antipsychotic, a GDR is required, unless clinically contraindicated.
  - An attempt must be made with the first year in which a resident is admitted or after the facility has initiated an antipsychotic. The facility must make the attempts in two separate quarters with at least one month between the attempts and then annually thereafter unless clinically contraindicated.

## Review the following to guide your observations and interviews (continued)

2. Did the pharmacist conduct a MRR (medication regimen review),
   - Did the pharmacist identify and report any med irregularities?
   - Did the MD and DON act on the reported irregularities?
3. Allergies,
4. The most recent comprehensive MDS/CAAS (focus on areas pertinent to the meds ordered such as adverse consequences and behaviors, etc.), and
5. Care plan for high risk meds and individualized interventions, including non-pharmacological interventions.

## Observation

*Make observations as appropriate, over various shifts to corroborate the information obtained during the record review. You may also find it important to make further observations for information obtained from staff interviews. Potential pertinent observations are listed below. If further guidance is needed, surveyors should refer to the regulation and IG as they conduct the investigation.*

- ☐ Are care planned interventions implemented for meds that pose a high risk for adverse consequences?
- ☐ Are non-pharmacological interventions being used?
- ☐ Observe for med effectiveness such as;
  - Analgesics – is pain relieved?
  - Psychoactive – is identified behavior/mood addressed?
- ☐ How does staff respond and interact with the resident?
- ☐ Does staff address the resident request for a med appropriately?
- ☐ Does the resident show mood or behavior concerns?
  - Does staff appropriately interact when the resident shows mood or behavior concerns (e.g., redirected, invited to an activity)?
- ☐ Observe for side effects and/or adverse consequences that may be related to the resident's current medication regimen.
  - Anorexia/unplanned weight changes, edema;
  - Behavioral changes or unusual behavior patterns;
  - Mental status changes or decline in physical functioning;
  - Sedation (excessive), changes in alertness;
  - Insomnia or sleep disturbances;
  - Rash, pruritus;
  - Bleeding or bruising, spontaneous or unexplained;
  - Respiratory changes;
  - Bowel dysfunction, urinary retention, incontinence;
  - Dehydration or swallowing difficulty;
  - Fall, dizziness, or headaches; and
  - Muscle/nonspecific pain or unexplained abnormal movement.

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/CMS-20082-Critical-Elements-Unnecessary-Medication.pdf

# Non-Pharmacological Interventions

- Environment:
  - Lighting
  - Noise
  - Aromatherapy
  - In a study conducted by researchers Koulivand and Ghadiri, it was found that "*relaxing effects with increases of alpha wave activities after administering lavender; indicating the EEG evidence of relaxation by lavender aromatherapy*". [3]

# Non-Pharmacological Interventions: Person-Centered Care

- Music Therapy
- Pet Therapy
- Massage, Manicures, Curling Hair
- 1:1
- Bathing
- Take a Walk
- Play a board game
- Snack

# The Eden Alternative Values

- **The Ten Principles of The Eden Alternative:**
- The three plagues of loneliness, helplessness, and boredom account for the bulk of suffering among our Elders.
- An Elder-centered community commits to creating a Human Habitat where life revolves around close and continuing contact with people of all ages and abilities, as well as plants and animals. It is these relationships that provide the young and old alike with a pathway to a life worth living.
- Loving companionship is the antidote to loneliness. Elders deserve easy access to human and animal companionship.
- An Elder-centered community creates opportunity to give as well as receive care. This is the antidote to helplessness.

# The Eden Alternative Values cont'd

- An Elder-centered community imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictable interactions and happenings can take place. This is the antidote to boredom.
- Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health.
- Medical treatment should be the servant of genuine human caring, never its master.
- An Elder-centered community honors its Elders by de-emphasizing top-down, bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the Elders or into the hands of those closest to them.
- Creating an Elder-centered community is a never-ending process. Human growth must never be separated from human life.
- Wise leadership is the lifeblood of any struggle against the three plagues. For it, there can be no substitute.

# Resources


- 1) Aggression and Anger. https://www.alz.org/help-support/caregiving/stages-behaviors/agression-anger. (2018 September.)
- 2) Cohen-Mansfield J, Marx MS, Thein K, Dakheel-Ali M. The Impact of Stimuli on Affect in Persons With Dementia. *The Journal of clinical psychiatry*. 2011;72(4):480-486. doi:10.4088/JCP.09m05694oli.
- 3) Koulivand, P. H., Khaleghi Ghadiri, M., & Gorji, A. (2013). Lavender and the Nervous System. *Evidence-Based Complementary and Alternative Medicine : eCAM*, *2013*, 681304. http://doi.org/10.1155/2013/681304
- Mission, Vision, Values, Principles. http://www.edenalt.org/about-the-eden-alternative/mission-vision-values/. (2018 September.)