Non-Pharmacological Interventions in Long-term care: Feasibility and Recent Trends

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Abstract:

Numerous studies have found excessive or in appropriate use of antipsychotic drugs in nursing home patients with cognitive impairment or perceived behavioral issues. Inappropriately medicating this vulnerable population can lead to several negative outcomes, including failure to have needs met, injury, illness, and even death. In response to recent literature and government reports highlighting this issue, in 2012, the Centers for Medicare and Medicaid Services (CMS) launched an initiative called the *National Partnership to Improve Dementia Care*. This article discusses the CMS initiative, as well as the feasibility and recent trends in the use of nonpharmacological interventions that could be implemented when working with patients with cognitive impairment and behavioral and psychological symptoms associated with dementia.

Keywords: Nursing | Nonpharmacological interventions | Older Adults | Dementia

Article:

A survey conducted in 2010 by the National Center for Health Statistics found that approximately 971,900 individuals in the United States were residing in residential care facilities (Caffrey et al., 2012). By 2050, the numbers are expected to rise to 27 million (Caffrey, Sengupta, Moss, Harris-Kojetin, & Valverde, 2011). Ninety percent of individuals in the 2010 survey were 65 and older; 28% were diagnosed with depression, and 42% were diagnosed with Alzheimer's disease and other dementias (Caffrey et al., 2012). People with dementia may have difficulty communicating their thoughts and needs to other residents, family members, and staff. In many cases, in their efforts to communicate, patients with dementia may exhibit behaviors that are misunderstood, and as a result, patients may be labeled as "difficult." Family, staff, and primary care providers (PCPs) may consider pharmacological interventions as simple and quick solutions to what they perceive as a problem, although medications may not resolve the real issue or address patients' unmet needs.

Pharmacological approaches involving inappropriate and unnecessary antipsychotic drugs are used in patients with cognitive impairment or perceived behavioral issues as first-line treatment, even though clinical trials show only modest evidence of efficacy compared to high placebo effects (Ballard & O'Brien, 1999; Douglas, James, & Ballard, 2004; Margallo-Lana et al., 2001). A study conducted by the Centers for Medicare and Medicaid Services (CMS, 2010) from July to September 2010 found that 39.4% of residents in nursing homes across the nation were given antipsychotic drugs despite the fact they were never diagnosed with psychosis. Inappropriately medicating this vulnerable population can lead to several negative outcomes, including failure to have needs met, injury, illness, and even death. This article discusses the feasibility and recent trends in the use of nonpharmacological interventions that could be implemented when working with patients with cognitive impairment and behavioral and psychological symptoms associated with dementia.

What Are Nonpharmacological Interventions?

Nonpharmacological interventions are strategies that are used for the purpose of preventing, reducing, or eliminating behavioral and psychological symptoms associated with dementia without the use of, or in conjunction with, pharmaceutical agents. These interventions are based on the specific needs, preferences, and the functional abilities of the older adult (Cohen-Mansfield, Libin, & Marx, 2007; Janzen, Zecevic, Kloseck, & Orange, 2013). Nonpharmacological interventions fit three broad categories: (a) unmet needs interventions that assume the behavior is a form of communicating an underlying need, such as pain reduction or sensory stimulation; (b) behavioral interventions that assume the individual's behavior has been inadvertently reinforced (e.g., screaming to get attention); and (c) reduced stress-threshold interventions that assume a mismatch between the individual's abilities to cope and demands of the environment (Cohen-Mansfield, 2001; Lawton & Nahemow, 1973). Interventions could be seeking underlying causes of the behavior, staff education, modification to the environment, providing for a basic unmet need, or having patients engage in a diversional or active engagement activity based on their specific profile, with consideration for their behaviors and needs.

Feasibility of Nonpharmacological Interventions

Historically, the feasibility of using nonpharmacological interventions in residential settings has been limited. Resident barriers may include perceived unwillingness to participate, unresponsiveness, or sleeping when the intervention is offered. Mealtimes, personal care, and medication passes also may impede participation in a nonpharmacological intervention (Cohen-Mansfield, Thein, Marx, & Dakheel-Ali, 2012). Environmental barriers include lack of a quiet space, the activity being bothersome to others, and the room's temperature or atmosphere (e.g., too hot, too cold, too small, noisy) (Cohen-Mansfield et al., 2007).

The barriers from nursing staff may include inconsistency in staffing, the inability of staff members to implement nonpharmacological interventions, and requirements for staff training about the interventions (Seitz & Gill, 2013). Poor educational approaches, including repetitive information and training in lecture format rather than active learning, may result in disinterest and inability to understand how to implement nonpharmacological interventions. Not every staff member has access to information about the nonpharmacological interventions in a resident's care plan; therefore, staff may be uninformed (Janzen et al., 2013).

In a qualitative study of 44 staff in five long-term care facilities, Janzen et al. (2013) identified other common barriers to nonpharmacological interventions including perceived lack of time, low staff-to-resident ratios, and the perceived unpredictable and short-lasting effectiveness of nonpharmacological interventions. The belief by staff that residents with limited functional status would not benefit from nonpharmacological interventions was another reason given for not attempting these interventions (Cohen-Mansfield et al., 2007). Staff perceptions of agitation; inconsistency in assessing, describing, and addressing agitation; and nursing preference for medication have been shown to be additional reasons for avoiding nonpharmacological interventions. Nursing staff note that medications were used to allow staff to perform activities of daily living, such as bathing (Janzen et al., 2013). Nurses also expressed a preference for medication use due to the urgent need to deal with behavioral and psychological symptoms, particularly when many such behaviors are occurring at the same time.

In a descriptive study of barriers to intervention implementation, Cohen-Mansfield et al. (2012) found that PCPs ($N = 89$) did not have enough information to make recommendations for nonpharmacological interventions, as they lacked training, knowledge, and skills. This caused a lack of confidence in recommending nonpharmacological interventions and more comfort in writing prescriptions for medications without consideration of the efficacy of nonpharmacological intervention use. Seitz and Gill's (2013) systematic review of the use of nonpharmacological interventions noted that many PCPs believed these interventions were too time-consuming and too expensive and that motivating the residents was too difficult. In a study of 948 family physicians, many providers thought that residents and their families expected them to write prescriptions for difficult behavior (Anthierens et al., 2010).

Cohen-Mansfield et al. (2012) also noted that the feasibility of implementing nonpharmacological interventions was limited by family and administrator issues. Families often requested a medication be prescribed and cited a fear of injury while participating in a nonpharmacological intervention activity. Administrators had little, if any, understanding of nonpharmacological interventions; therefore, they often did not wish to invest the time the staff required for training and mentoring or did not provide funding for implementation.

Two systematic reviews concluded that system issues, such as the perception that nonpharmacological interventions are too costly, threatened the feasibility of implementing nonpharmacological strategies (Knapp, Iemmi, & Romeo, 2013;Seitz & Gill, 2013). Janzen et al.

(2013) noted a lack of communication between disciplines and a lack of standardized practices in this area. Some caregivers felt unable to individualize interventions due to competing job responsibilities and high turnover of staff (Clark, 2012). Research on nonpharmacological interventions is limited, and the research that has been done was in smaller studies, which do not provide the evidence necessary to implement system changes (Clark, 2012; O'Neil et al., 2011).

CMS Initiative

In response to a report by the Office of the Inspector General (U.S. Department of Health and Human Services, 2011), a group of nursing home consumer advocates met with senior leaders at CMS to discuss their concerns about the overuse of antipsychotic drugs in nursing home residents with dementia. Leaders from for-profit and not-for-profit nursing home organizations, the American Medical Directors Association, the American Society for Consultant Pharmacists, several nursing organizations, the national ombudsman program, and others joined forces to form the *National Partnership to Improve Dementia Care*. The overarching goal of the partnership is to identify ways to improve dementia care broadly and in all settings.

Over several months and through numerous telephone outreach calls, state coalitions were established in every state, often led by the quality improvement organization (QIO), the state local area network for excellence (LANE), or other entities working on quality improvement. In all cases, advocates, residents and families, ombudsmen, and others were invited to participate. CMS held quarterly conference calls to share best practices and to enable state coalitions to learn from each other and integrate their efforts with the fundamental quality improvement work being done with the QIOs, LANEs, and in anticipation of the new regulation for Quality Assurance Performance Improvement.

CMS also began publicly reporting data for each nursing home on the Nursing Home Compare website in July 2012 (http://www.medicare.gov/nursinghomecompare/search.html). The Nursing Home Compare website has recently been redesigned with substantial input from consumers. The new website provides additional information about the use of antipsychotic medications for dementia to assist consumers who may be trying to choose a nursing home for a loved one.

With input from national experts and dementia care practitioners, CMS also revised the surveyor guidance at F309 Care and Services for a Resident with Dementia and F329 Unnecessary Drugs. The updated guidance provides more detailed information about state-of-the-art dementia practices; the involvement of residents, families, and direct care workers in dementia care plan development and implementation; and ways to evaluate the use of antipsychotic medications in cases where they are used for residents with dementia. The programs stress the critical role of direct care workers (e.g., certified nursing assistants [CNAs]) and the importance of obtaining input from the family about patients' previous routines and life preferences. Three training programs are currently available on the surveyor training website; they are open access and may

be viewed by providers and the public (http://surveyortraining.cms.hhs.gov/pubs/AntiPsychoticMedHome.aspx).

Several national organizations have contacted their members via e-mail or sent letters providing information on the initiative and encouraging engagement in review of any residents with dementia on an antipsychotic medication for potential gradual dose reduction (GDR). Tools and resources to support potential GDRs are available on the Advancing Excellence in America's Nursing Homes website (http://www.nhqualitycampaign.org). Numerous educational programs for providers and prescribers have been held throughout the country, and many webinars have been archived and remain available.

Nursing Implications For The Use Of Nonpharmacological Interventions

To better control or regulate the use of nonpharmacological interventions, there are expectations of staff and facilities when using nonpharmacological interventions with their residents. Based on the new guidance and training, surveyors will be evaluating processes and outcomes such as consistent CNA assignments to provide patient-centered care. CNAs play a critical role in detecting actual or potential manifestations of dementia and reporting them to nursing supervisors. Therefore, surveyors will be looking for CNA involvement in using nonpharmacological interventions to address residents' needs. Nurses should make certain that CNAs attend care planning meetings whenever possible, to ensure multidisciplinary involvement as well as provide key information for planning care. It is also vital that CNAs are aware of all the goals for the residents under their care. Participation in these meetings and in ongoing dialogue with the team will provide CNAs with the information they need. Family members should be asked for any input or recommendations to help staff understand the reasons for a particular behavior that does not respond to initial nonpharmacological interventions.

Providing nonpharmacological interventions for behaviors in individuals with dementia is the responsibility of all departments and all staff members. Physicians and nurse practitioners are being encouraged to consider recommending non-pharmacological interventions prior to considering medication. More detailed needs assessments reflecting individualized needs and preferences will help staff better facilitate nonpharmacological interventions with older adults. Nurses should therefore be performing environmental, basic needs, and physical assessments to determine the potential underlying causes when there is a behavior change. Specific charting on behaviors, the nonpharmacological interventions attempted, and the specific outcomes can be used to make future behavioral interventions more effective for residents. A change in behaviors is often the first sign of an acute medical condition. Identifying medical causes such as infections or delirium should be ruled out. For the individual with dementia, behavioral symptoms may be the only means of communicating a change in condition or illness, unmet needs, or person–environment incompatibility.

Summary

Nonpharmacological interventions must be better integrated into individualized care in all nursing homes to achieve the goals of the CMS initiative. Although progress is being made, more work needs to be done. Studies have consistently reported that a lack of essential information about nonpharmacological interventions is a substantial yet remediable problem (Hoffmann, Erueti, & Glasziou, 2013). Research articles discussing statistics on the use of nonpharmacological interventions are available, but essential details about selecting and implementing a nonpharmacological intervention are seldom provided. More systematic research is needed to identify the benefits of specific nonpharmacological interventions for specific behaviors. The next three articles in this series will provide guidelines on implementation of 20 nonpharmacological interventions that are feasible for caregivers to perform. The second article will discuss the essential skills and knowledge necessary to perform these interventions; articles three and four will address the specific interventions with protocols and the best evidence for their effectiveness.

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