Person Centered Dementia and Behavior Care: Clinical Impact, Staffing Efficiencies, and Quality Measures

Speaker:

Tonya Moore, PTA

Vice President

ABSOLUTE REHABILITATION

Objectives:

- Identify reasons that therapy referrals can be made for behavioral interventions
- Identify quality measures affected by behaviors
- Be exposed to actual case studies with successful behavior reduction techniques, quality initiatives, and staffing efficiencies

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About dementia

Dementia is not a single disease; it's an overall term — like heart disease — that covers a wide range of specific medical conditions, including Alzheimer's disease. Disorders grouped under the general term "dementia" are caused by abnormal brain changes. These changes trigger a decline in thinking skills, also known as cognitive abilities, severe enough to impair daily life and independent function. They also affect behavior, feelings and relationships.

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Alzheimer's disease accounts for 60-80% of cases. Vascular dementia, which occurs because of microscopic bleeding and blood vessel blockage in the brain, is the second most common cause of dementia. Those who experience the brain changes of multiple types of dementia simultaneously have mixed dementia. There are many other conditions that can cause symptoms of dementia, including some that are reversi

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An estimated 6.7 million Americans age 65 and older are living with Alzheimer's in 2023. Seventy-three percent are age 75 or older. About 1 in 9 people age 65 and older (10.7%) has Alzheimer's. Almost two-thirds of Americans with Alzheimer's are women.

Alzheimer's Association
https://www.alz.org › alzheimers-dementia › facts-figures

Alzheimer's Disease Facts and Figures

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Dementia is an umbrella term for loss of memory and other thinking abilities severe enough to interfere with daily life.

- Alzheimer's
- Vascular
- Lewy body
- Frontotemporal
- Other, including Huntington's

* Mixed dementia: Dementia from more than one cause

National Partnership to Improve Dementia Care in Nursing Homes

Overview

The CMS is partnering with federal and state agencies, nursing homes, other providers, advocacy groups, and caregivers to improve comprehensive dementia care. CMS and its partners are committed to finding new ways to implement practices that enhance the quality of life for people with dementia, protect them from substandard care and promote goal-directed, person-centered care for every nursing home resident. The Partnership promotes a multidimensional approach that includes public reporting, state-based coalitions, research, training and revised surveyor guidance.

What's New?

Since the launch of the National Partnership, significant reductions in the prevalence of antipsychotic use in long-stay nursing home residents have been documented. The National Partnership continues to work with state coalitions and nursing homes to reduce that rate even further. Recently, CMS established new national goals for reducing the use of antipsychotic medications in long-stay nursing home residents by 25 percent by the end of 2015, and 30 percent by the end of 2016. These goals build on the progress made to date and express the Partnership's commitment to continue this important effort.

While the initial focus was on reducing the use of antipsychotic medications, the Partnership's larger mission is to enhance the use of non-pharmacologic approaches and person-centered dementia care practices. CMS plans to monitor the reduction of antipsychotics, as well as the possible consequences, review the cases of residents whose antipsychotics are withdrawn to make sure they don't suffer an unnecessary decline and add the antipsychotic measure to the calculations that CMS makes for each nursing home's rating on the agency's Five Star Quality Rating System.

June 3, 2016 - Update

Quote

"By improving dementia care through the use of individualized, person-centered care approaches, CMS hopes to reduce the use of unnecessary antipsychotic medications in nursing homes and eventually other care settings as well."

-CMS, 2013


Microsoft Bing
to be best in any
point of view.
Behavior
the way a pers
acting or contro
person behaves
Visual Search
Save
View image
More

What is Behavior?

- Everything that people do (actions; things you can see or hear)
- Behavior is learned...*over time*
  - "shaping"
- Behavior occurs for a reason. It does not happen randomly
  - "function" vs. "form"

Understanding Behaviors

- Behaviors becomes a form of communication (Behavioral Expressions)
- Exhibits behavioral expressions to communicate their needs.
- A cry for “help”.
- Can be a response to poor behavior from others.

Quote

"Evidence shows that a large proportion of these so-called behavior problems stem from an **incongruence between the needs of people who suffer from dementia and the degree to which their environment fulfills those needs.** Thus, many "problematic behaviors" represent a cry for help, a result of unmet needs, or an inadequate attempt to fulfill those needs."

Cohen-Mansfield, J. & Mintzer, J. E. (2005). Time for change: The role of non-pharmacological interventions in treating behavior problems in nursing home residents with dementia. *Alzheimer's Disease and Associated Disorders, 19*(1), 37-40.

Unwanted Behaviors

- Bathing: refusal, hitting, screaming
- Entering other rooms: looking through personal items, taking items, disturbing other patients
- Combative: hitting, pinching, biting
- Exit seeking
- Toileting: hygiene, refusal, pinching, biting
- Hoarding
- Screaming/yelling
- Attention seeking
- Eating: refusal, playing with food, throwing food, disruptive
- Dressing: refusal, taking off clothes, hitting, pinching, biting,
- Wandering
- Sundowning

Quality measures for nursing homes

The quality measures star rating measures parts of nursing home performance in certain areas of care, like if residents have gotten their flu shots, are in pain, or are losing weight. By comparing scores, you can see how nursing homes may be different from each other.

The quality measures star rating is calculated from 2 different types of quality measures: short- and long-stay resident quality measures.

Short-stay quality measures

Much above average

The short-stay quality measures rating reflects the average level of a nursing home's performance in certain areas of care for those who stayed in a nursing home for 100 days or less or are covered under the Medicare Part A Skilled Nursing Facility (SNF) benefit, and whose typical goal is to improve their health status so they can return to their previous setting, like their home.

Long-stay quality measures

Much above average

The long-stay quality measures rating reflects the average level of a nursing home's performance in certain areas of care for those who stayed in a nursing home for 101 days or more, and whose typical goal is to maintain or attain their highest possible well-being while residing in the facility.

What Quality Measures can unwanted behaviors impact??

Short Stay QM

Percentage of short-stay residents who were re-hospitalized after a nursing home admission

Lower percentages are better

16.2%

National average: 22.1%

Ohio average: 23%

Percentage of short-stay residents who have had an outpatient emergency department visit

Lower percentages are better

11.9%

National average: 11.8%

Ohio average: 12.8%

Short Stay QM

Percentage of short-stay residents who got antipsychotic medication for the first time ⬇ *Lower percentages are better*	**0.8%** National average: 1.7% Ohio average: 1.7%
Percentage of residents with pressure ulcers/pressure injuries that are new or worsened ⬇ *Lower percentages are better*	**0%** National average: 2.8%
Percentage of short-stay residents who improved in their ability to move around on their own ⬆ *Higher percentages are better*	**81%** National average: 74.1% Ohio average: 75.2%

Short Stay QM

Percentage of SNF residents who experience one or more falls with major injury during their SNF stay *Lower percentages are better*	1.4% National average: 1%
Percentage of SNF residents whose functional abilities were assessed and functional goals were included in their treatment plan *Higher percentages are better*	100% National average: 98.8%
Percentage of residents who are at or above an expected ability to care for themselves at discharge *Higher percentages are better*	27.5% National average: 46.7%
Percentage of residents who are at or above an expected ability to move around at discharge *Higher percentages are better*	9.8% National average: 40.1%

Short Stay QM

Change in residents' ability to care for themselves

Higher scores are better

4.8

National average: 7.2

Change in residents' ability to move around

Higher scores are better

6.2

National average: 16.6

Short Stay QM

Rate of successful return to home or community from a SNF

⬆ *Higher rates are better*

Rate of potentially preventable hospital readmissions 30 days after discharge from a SNF

⬇ *Lower rates are better*

Medicare Spending Per Beneficiary (MSPB) for residents in SNFs

● *Displayed as a ratio*

1.04

National average: 1.03

Long-stay quality measures

Much above average

The long-stay quality measures rating reflects the average level of a nursing home's performance in certain areas of care for those who stayed in a nursing home for 101 days or more, and whose typical goal is to maintain or attain their highest possible well-being while residing in the facility.

Long Stay QM

Percentage of long-stay residents who got an antipsychotic medication *Lower percentages are better*	0% National average: 14.4% Ohio average: 13.1%
Percentage of long-stay residents experiencing one or more falls with major injury *Lower percentages are better*	0.9% National average: 3.4% Ohio average: 3.7%
Percentage of long-stay high-risk residents with pressure ulcers *Lower percentages are better*	5.5% National average: 8.1% Ohio average: 7.4%
Percentage of long-stay residents with a urinary tract infection *Lower percentages are better*	0.5% National average: 2.3% Ohio average: 1.5%

Long Stay QM

Percentage of long-stay residents whose ability to move independently worsened

Lower percentages are better

16.4%

National average: 16.2%

Ohio average: 14%

Percentage of long-stay residents whose need for help with daily activities has increased

Lower percentages are better

15.5%

National average: 14.8%

Ohio average: 15%

Long Stay QM

Percentage of long-stay residents who were physically restrained

Lower percentages are better

0%

National average: 0.1%

Ohio average: 0.1%

Percentage of long-stay low-risk residents who lose control of their bowels or bladder

Lower percentages are better

40.9%

National average: 47.2%

Ohio average: 43.2%

Percentage of long-stay residents who lose too much weight

Lower percentages are better

5.7%

National average: 6.2%

Ohio average: 6.9%

Percentage of long-stay residents who have symptoms of depression

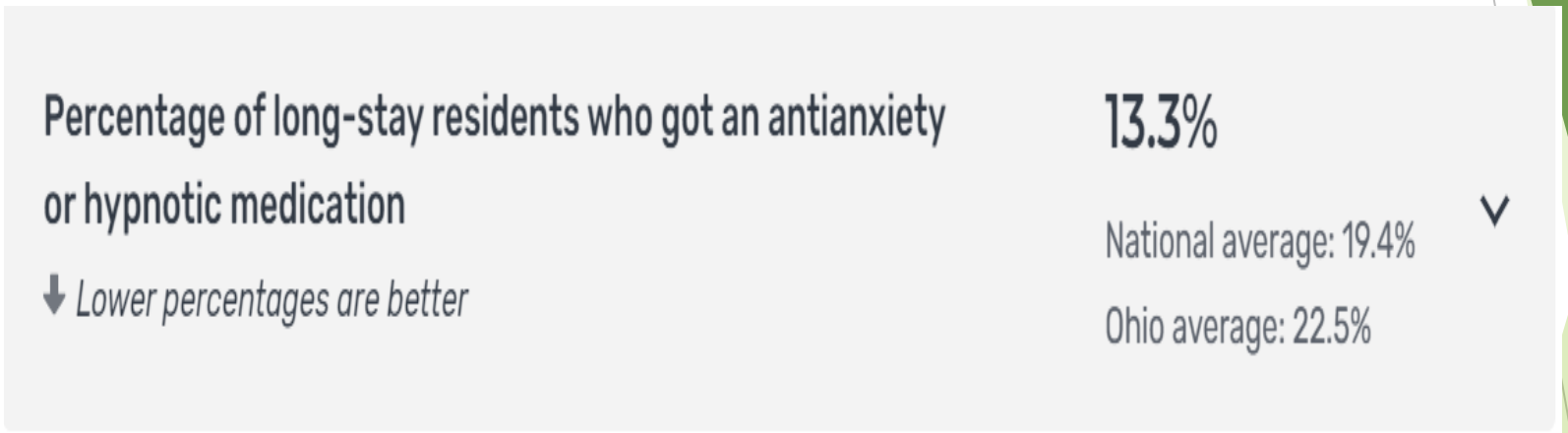
Lower percentages are better

52.9%

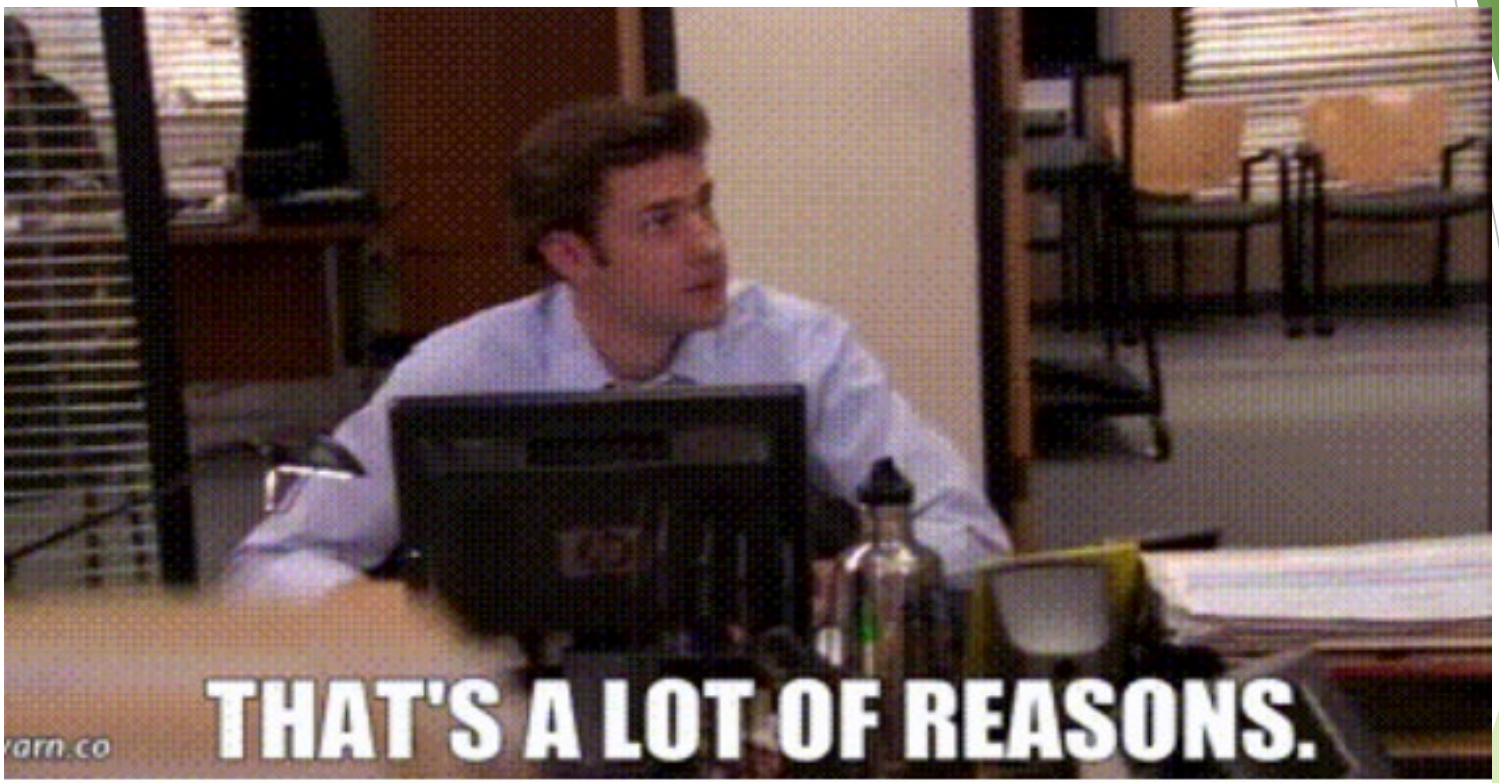
National average: 7.9%

Ohio average: 21.6%

Long Stay QM


Percentage of long-stay residents who got an antianxiety or hypnotic medication
Lower percentages are better
13.3%
National average: 19.4%
Ohio average: 22.5%

What are some reasons for therapy referrals?


THAT'S A LOT OF REASONS.

THERAPY

- **Therapy is funded for one on one care**
- **The root cause of any given behavior can be simple, but may also be complex**
- **Utilize the skills and knowledge of your therapists to benefit your residents!**
- **A therapist can/should take the time to "investigate" the root cause of the behavior**
- **This can include, but is not limited to:**
  - **Gaining an in depth understanding of the resident's medical record**
  - **Interviewing nursing staff**
  - **Interviewing family members**
  - **Reviewing past history of therapeutic intervention (What has worked in the past? What didn't work?)**

Sometimes Simple Tips Matter… Can Therapy Teach Common Sense Approaches to Care?

- Approach from the front
- Minimize distractions
- Lead with the person's name
- Watch your body language
- Avoid pronouns
  - "Caroline, can you put *your shirt* in the basket?

    (not "it")

Other Tips That Therapy Can Teach Caregivers

Does your staff enter the patient's reality?

Patient: "My kids will be getting off the bus soon."

Caregiver: "Yes, and they know to come right home."

Patient: "My purse is missing."

Caregiver: "Ok, I will go look for it."

Why is the Level of Cognition so important?

OCCUPATIONAL THERAPY
LEVELS 3.6 – 3.8 CAREGIVER GUIDE

Allen Cognitive Level Screen (ACLS):

Supervision requirements
Medication requirements
Nutrition
Dressing and Hygiene
Safety
Activities

How to refer to therapy

Therapy completes screens according to MDS schedule.

Morning meeting.

Screen/notification form.

Say something.

Nursing documentation goes a long way to support therapy services provided.

Retained Abilities

- To experience human emotions
- Recognize the mood of facial expressions
- Respond to contact with nature
- Capacity to form relationships
- Engage with and respond to touch
- Distinguish different kinds of touch (inpatient touch vs soothing touch)

Compassionate Touch

- Touch is one of our most fundamental human needs.
- Touch deprivation is real and can lead to:
  - Isolation
  - Anxiety
  - Poor trust in caregivers
  - Insecurity
  - Decreased sensory awareness

Leads to behavioral responses or expression

Instrumental Touch vs Expressive Touch

- Instrumental touch: touch necessary to perform a task or procedure (doing to or for)
- Expressive touch: offered spontaneously to show care, concern, reassurance, affection and empathy (more about being with)

Case Studies

"MRS. SMITH"

- Identify the problem(s)
  - Resident consistently refused showers
  - Became very agitated and upset with any bathing task
  - Consistently yelled and cried during any bathing task
  - Nursing Aides were unable to bathe the resident without a significant "battle"
  - Resident at risk for further health complications per poor hygiene

"MRS. SMITH" continued

- Resident referred to Speech Therapy for swallowing difficulties
- Speech therapist was aware of the bathing behaviors, and took the initiative to analyze the medical record
- See patient's current and past medical diagnoses:

Action	ICD-10	Description		Prelim?	Date Diagnosed
	Z47.89	Encounter for other orthopedic aftercare **Note:** lt hip fracture	**Primary/Admission**		01/25/2017
	S72.142D	Displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing			01/25/2017
	I50.23	Acute on chronic systolic (congestive) heart failure			01/25/2017
	M25.552	Pain in left hip			01/25/2017
	M15.0	Primary generalized (osteo)arthritis			01/25/2017
	I22.2	Subsequent non-ST elevation (NSTEMI) myocardial infarction			01/25/2017
	J18.9	Pneumonia, unspecified organism			01/25/2017
	R29.6	Repeated falls			01/25/2017

“Mrs. Smith” continued

M62.81	Muscle weakness (generalized)
R13.12	Dysphagia, oropharyngeal phase
R41.841	Cognitive communication deficit
Z51.89	Encounter for other specified aftercare
F41.9	Anxiety disorder, unspecified
R13.11	Dysphagia, oral phase
R48.9	Unspecified symbolic dysfunctions
R53.81	Other malaise
N39.0	Urinary tract infection, site not specified
A41.9	Sepsis, unspecified organism

E78.2	Mixed hyperlipidemia
I50.22	Chronic systolic (congestive) heart failure
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance
N32.81	Overactive bladder
J96.01	Acute respiratory failure with hypoxia
H35.30	Unspecified macular degeneration
I10	Essential (primary) hypertension
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
E78.2	Mixed hyperlipidemia
D64.89	Other specified anemias

“Mrs. Smith” continued

K59.01	Slow transit constipation
E07.89	Other specified disorders of thyroid
F32.89	Other specified depressive episodes
E87.6	Hypokalemia

- What can we infer from this long list of diagnoses?

“Mrs. Smith” continued

- **Medically complex patient**
- **Hx of falls, hip fx**
- **Limited mobility**
- **Dementia**
- **Cognitive communication deficits**
- **Anxious (Fear of falling?)**
- **Challenges with urinary and bowel continence**

What did the Speech Therapist find during the evaluation?

- Behaviors may be a result of inadequate communication with the resident
- Per dementia diagnosis, SLP used the following strategies to improve communication
  - 1) **Simple sentences with one step commands to increase comprehension-**patient did not respond appropriately to 2 step commands
  - 2) **eye contact and face level interactions** to improve verbal understanding, improve effectiveness of non-verbal cues, and reduce anxiety
- Per cognitive communication deficit diagnosis and through interaction during evaluation, SLP also understood that the patient had a receptive language impairment, which indicated need for 3rd communication strategy…

-While the left cerebral hemisphere contains our language centers,
the right cerebral hemisphere is responsible for visuospatial processing/skills

- **In practice, our SLP understood that the resident likely still had ability to understand demonstration very well**
- **Patient responded exceptionally well to visual demonstration when asked to complete steps of a task, indicating right brain function was still well intact**

RESULTS

- **Speech Therapists made specific recommendations to improve communication and reduce behaviors and provided education to co-workers and family members**
  - 1.Use simple one step commands
  - 2.Utilize eye contact and face level interactions
  - 3.Use demonstration to demonstrate tasks to improve comprehension

- **How did the patient respond when these communication strategies were implemented?**
  - Patient is now able to bathe without behaviors consistently
  - Patient participates in bathing tasks and is no longer dependent
  - Patient rarely exhibits any “yelling”, or “agitation” during bathing tasks

Mary

- 99 Year Old Female
- Medical Diagnosis: Dementia in other Diseases classified with Behavior Disturbance
- Treating Diagnosis: Dementia with Psychosis
- Severe Receptive and Expressive Language Deficits
- Profound Attention and Concentration Deficits

Mary

- Noted Behaviors:
  - Yelling out, “mamma” and “take me home”
  - Visual and Auditory Hallucinations

Mary

- Physician evaluated Mary for a full physiological work up and recommended Exelon for medication management of behaviors
- Family requested all other interventions be implemented prior to possibly initiating medications
- Speech Therapy assessed to administer standardized assessments and analyze findings to determine the best approach for individualized communication and person centered care

Mary

- Speech Therapy Standardized Assessments utilized
  - Cognitive Assess Tool Guide
    - Staff interviews with Nursing and Activities
  - Claudia Allen Mat Placement
    - Allen Low Level 3/Adapted FAST Stage 6/Low Middle Stage

Mary

- Therapeutic Interventions/Skilled Services Provided
  - Objective and Standardized Testing
  - Therapeutic trials of strategies to facilitate language and cognitive skills- DECREASE BEHAVIORS
  - Caregiver and Staff interviews and training on recommended compensatory strategies
  - Development of Functional Maintenance Program (FMP) to improve communication and decrease behaviors

Mary

Pt seen on this date at bedside. SLP completed interview with pt's primary day nurse related to pt's limitations related to language and attention. Per nursing pt at times presents with visual hallucinations that become upsetting to her. SLP provided education on validation strategy to decrease distractions, nursing verbalized understanding. Pt was perseverating on something that was on her bed that she thought should not be there. SLP stated to pt, "ok, ill move it now". Strategy was effective in eliminating agitation. Nursing also reported that pt responds well to change in environment/location and oral stimulus such as hard candy provided by pt's family to distract her from perseverations and non sensical thoughts.

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BRAIN & NERVOUS SYSTEM > ALZHEIMER'S > SUPPORT & COPING

Using Validation Therapy for People With Dementia

Validation therapy is a way to approach older adults with empathy and understanding. It is often used to comfort and reassure people who are living with Alzheimer's disease or another kind of dementia.

The basic idea behind validation therapy is that people who are in the late stages of life may have unresolved issues that drive their behaviors and emotions. The way caregivers or family members respond to these behaviors and emotions can either make them worse or help resolve them.

Validation therapy is more than simply validating a person's feelings, although that is one component of it. Validation therapy focuses on helping the person work through the emotions behind challenging behaviors. These behaviors are viewed essentially as a way to communicate those emotions, especially in people with memory loss, confusion, disorientation, and other symptoms of dementia.[1]

Mary

Pt was seen in activities area on this afternoon. SLP completed staff interviews with 2 STNA's that regularly care for pt to obtain pt preferences and obtain recommendation from staff from successful interventions related to behavior management. STNA's both recommended pt likes to have oral stimulation in hard candy form to help calm her down and attend as well as responds well to simple yes/no questions vs complex language questions. Pt demonstrated ability to answer simple yes/no questions with 60% accuracy level on this date.

Mary

- Functional Maintenance Program- 3 Interventions that successfully decreased her behaviors

1. Validation Strategy
2. Ask simple yes/no questions
3. Offer resident snack or beverage as part of re-direction
4. Change location

Mary

- No Medication- Physician and Family content and agreed with FMP

Virginia

- 89 Year Old Female
- Medical Diagnosis: Alzheimer's Disease
- Treating Diagnosis: Cognitive Communication Deficit
- Demonstrates increased confusion and difficulty locating her room
- Demonstrates attention and concentration deficits
- Oriented to Self, Year, and State
- Able to follow 2-step commands

Virginia

- Noted Behaviors
  - Increases symptoms of Anxiety when unable to locate her room
  - Standing without assistance
  - Yelling out

Virginia

- Therapeutic Interventions/Skilled Serviced Provided
  - Objective and Standardized Testing
  - Staff Involvement and Education to establish strategies to improve ADL completion and orientation to the building
  - FMP

Virginia

- Therapy Standardized Assessments utilized
  - Mini Mental State Exam
    - 19 of 30
  - BCRS (Brief Cognitive Rating Scale)

    Score 25, correlating with Stage 5 on the Global Deterioration Scale

Virginia

- Primary Behavior(s) Related to Visual Deficits
- Unable to see her room number
  - Increased symptoms of anxiety, yelling out
  - Standing alone to try to read room number
    - Increased fall risk

Virginia

- Interventions
  1. Talk resident through ADLs
  2. Engage resident to talk about past likes/dislikes
  3. Brightly colored orange sign at resident's door to identify her room

Virginia

- Intervention- **Large Orange Neon Sign** on her door to identify her room
  - Therapy, Activities, and Nursing provided consistent cues to look for “ORANGE” to identify her room

Virginia

- Facility embraced Cognitive Leveling and Functional Maintenance Programs
- All departments educated regarding the program and Allen's Cognitive Levels-Color Coding
- Holistic Team Approach for success to reduce behaviors
- Facility decreased anti-psychotic mediation use- below state average

Maxine

- Therapy and Facility decided to implement a “Bathing without a Battle” Program
- Identified residents, including Maxine (4 year resident) who might benefit
- Obtained Physician order for Occupational Therapy

Maxine

- OT completed an evaluation and established a plan of care to assess cognitive leveling and appropriate interventions
- A long term goal was established for completion of ADL routine with full shower, dressing and transfers without behaviors noted 100% of time.
- Initial technique noted on evaluation was to communicate prior to completing transfer

Maxine

- Diagnoses present include:
  - dementia with behaviors,
  - history of UTI's,
  - history of falls
  - depression
  - epilepsy
  - glaucoma

Maxine

- Behaviors demonstrated during the shower session include: yelling and resisting different aspects of self care with no pattern noted by STNA's
- Therapist discussed bathing history with her daughter. Pt had never showered but took baths previously to admission to nursing home

Maxine

- Therapist gave Maxine a whirlpool bath with no behaviors.
- Later in day still thanked therapist for bath
- STNA's educated on process and participated with therapist in future baths, no behaviors

Maxine

- Seen for a total of 11 visits including evaluation.
- Goal met of no behaviors 100% of time.

Joy

- Pt was standing up from wheelchair, resulting in multiple falls
- Falls repeatedly occurring after lunch

Joy

Nursing interventions included:

- Sitting patient at the nurses station
- Laying down after lunch
- Toileting her immediately after lunch

Joy

Occupational Therapy:

- Root cause analysis: time of falls was between 1:30 and 2:30 pm with majority around 2:00
- Patient seems very anxious after lunch
- Attempts at different wheelchair cushions
- Called family to see what her schedule was at home prior to admission

Joy

Patient called her son everyday at 2:00pm

Joy

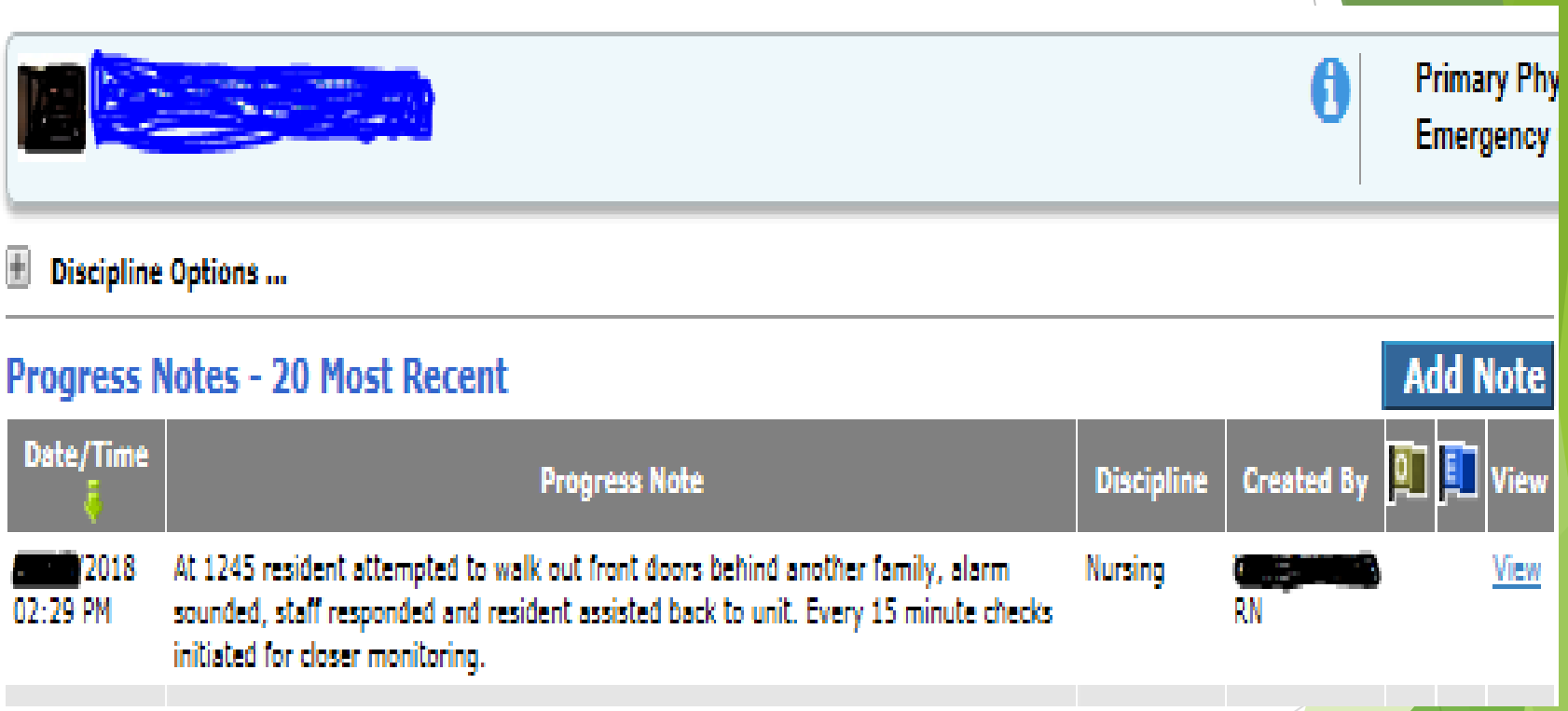
New intervention:

- Staff called her son around 2:00 pm
- Pt was given a portable phone by nursing or STNA
- Pt was noticeably less anxious
- Pt made no attempts to get up
- Therefore, no falls

Donald

- New Admission(3 wks.): Mr. Donald
- 63 y.o. male
- Diagnosis: G30.0 Alzheimer's with early onset
- Medications: Seroquel oral tab, 1tab 12.5mg twice a day.
- Referral to therapy: "R" attempting to exit facility. Increased agitation, anxiety and combativeness.

Case: Exit Seeking



Donald

- Therapy assessment: “R” demonstrated high anxiety trying to exit the facility, repeatedly saying “I need to take care of the kids”
- “R” agitation increases as STNAs tries to redirect him.
- Personal and Social History of “R” was reviewed by Therapist..

Donald

- Educated caregivers about “R” impairments to better understand behavior.
- Educated caregivers on how to communicate with “R”.
- Key phrase: “*Donald, there is no school today. It’s Spring break*”.

Staffing

How can these programs improve staffing efficiencies?

- Increased communication
  - Resident/caregiver
  - Resident Participation in activities
    - Quality of life
- Decreased unwanted behaviors
  - Bathing
  - Dressing
  - Mouth Care
  - Other
- EASY, efficient interventions/TOOLS

STATE Survey

- Person-Centered Approaches
- Individualized interventions
- Quality
- Care Planned for Success
  - Efficient
  - Flexible
  - Doable
- Skilled Therapy Documentation
  - Support skilled services and interventions provided

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
F310 cont.	§483.25(a)(1)(v) Use of Speech, Language, or Other Functional Communication Systems	**Interpretive Guidelines §483.25(a)(1)(v)** This corresponds to MDS, section C; MDS 2.0 sections B and C when specified for use by the State. "Speech, language or other functional communication systems" is defined as the ability to effectively communicate requests, needs, opinions, and urgent problems; to express emotion, to listen to others and to participate in social conversation whether in speech, writing, gesture or a combination of these (e.g., a communication board or electronic augmentative communication device).

State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities

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(Rev. 211, 02-03-23)

Transmittals for Appendix PP

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F741

(Rev. 211; Issued: 02-03-23; Effective: 10-21-22; Implementation: 10-24-22)

§483.40(a)(1) 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 [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]

§483.40(a)(2) Implementing non-pharmacological interventions.

INTENT §483.40(a), (a)(1) & (a)(2)

The intent of this requirement is to ensure that the facility has sufficient staff members who possess the basic competencies and skills sets to meet the behavioral health needs of residents for whom the facility has assessed and developed care plans. The facility must consider the acuity of the population and its assessment in accordance with §483.70(e). This includes residents with mental disorders, psychosocial disorders, or substance use disorders *(SUDs)*, *and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment*. Facility staff members must implement person-centered care approaches designed to meet the individual *goals and* needs of each resident. Additionally, for residents with behavioral health needs, non-pharmacological interventions must be developed and implemented.

"Non-pharmacological intervention" refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident's mental, physical, and psychosocial well-being.

GUIDANCE §483.40(a), (a)(1) & (a)(2)
Sufficient Staff to Provide Behavioral Health Care and Services
The facility must address in its facility assessment under §483.70(e) (F838), the behavioral health needs that can be met and the numbers and types of staff needed to meet these needs.

Once *the necessary skills and competencies are* identified, staff must be aware of those disease processes *and disorders (e.g. SUDs)* that are relevant *to each resident* to enhance *the resident's* psychological and emotional well-being. Competency is established by observing the staff's ability to use this knowledge through the demonstration of skill and the implementation of specific, person-centered interventions identified in the care plan to meet residents' behavioral health care needs. Additionally, competency involves staff's ability to communicate and interact with residents in a way that promotes psychosocial and emotional well-being, as well as meaningful engagements.

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Dementia is a call for all of us to be more patient in a busy world.
Alzheimer Society

Thank you!!

Tonya Moore, PTA

Vice President