Dear Dr. Jeff:
The niece of one of our residents has thrown a pall over the entire facility with her complaints and threats. She consumes most of the time of our social worker and ombudsman and regularly calls the abuse hotline. Two certified nursing assistants have quit because of her racist insults and smeers. She insists on meeting with the administrator over every petty complaint, most of which are totally unfounded. The physician and floor nurses refuse to take her calls, insisting that the director of nursing and medical director handle them. The niece appears plausible, but [she] is behaving inappropriately. Survey is coming and she will certainly volunteer for a meeting with the surveyors. What can we do?

Dr. Jeff responds: Take heart! Your situation is not unique; it is not even unusual. Although the details vary, nearly every facility experiences family members or entire families like this from time to time. Surveyors are very familiar with these interview volunteers and will generally take their complaints for what they are worth. The state abuse hotline operators probably already know her by her first name, but are legally obligated to listen without hanging up. They are probably struggling, as you are, to cut off her verbal flow.

These problematic individuals should not be allowed to overwhelm our enjoyment of our work or distract us from the core task of providing quality care to all our residents. The social worker consumed with one family member isn’t providing needed services to other residents. Recruiting quality staff is difficult enough without losing them to an intolerable work environment. Moreover, her behavior should not distract you from caring for your aunt, which is difficult in the midst of all this chaos. Who wants to answer her call bell if the encounter is likely to lead to abuse? In these cases, the squeaky wheel often doesn’t get the grease it needs when overwhelmed by background noise.

The solution begins — as it so often does in long-term care — with a thoughtful assessment. Is the resident alert and able to speak for herself? If so, can most decisions and concerns be referred back to the resident? Sometimes the involved resident is totally mortified by the behavior of their supposed representative. Indeed, the resident might be mourning the loss of familiar staff and suffering from her niece’s tantrums as well.

Who Fans the Flames?
Out-of-control family members are often as verbally abusive to their loved ones as they are to the staff. They might have an abusive relationship that preceded nursing home placement. The financial strain of placement on the family caregiver may exacerbate these issues, particularly when the resident’s social security and pension are necessary for family finances. Sometimes, a family may be hoping for a discount or even to avoid payment completely due to alleged poor care, possibly in return for not filing a lawsuit. The resident may need protection and assistance in learning how to speak up for herself. Alternatively, the resident may be feuding with the flames. Sometimes, difficulty adjusting to nursing home placement encourages seemingly contented residents to complain to family members about the poor care and neglect they experience, probably in an attempt to convince the family to take them home. Residents may tell families that unnamed staff members are “rough” or even frankly abusive. Obviously, hearing these complaints — often accompanied by tears — can drive a family member to behave outrageously, particularly if the family member was volatile to begin with. The resident may be secretly enjoying the family attention and the tumult her accusations produce. Although fear of retaliation can deter some residents from complaining about staff, it is important that resident behaviors be addressed by encouraging residents to complain promptly and directly to supervising nurses, so dysfunctional staff can be retrained or eliminated.

Determine the Health Care Agent
If the resident lacks the capacity to advocate for herself, it is important to clarify exactly who should be her representative. In this instance, is the niece a legally designated health care proxy or health care agent or designee of a durable power of attorney for health care? If, for example, another family member has that role, the offensive niece is actually interfering with the resident’s expressed wishes. For once, the powers of HIPAA could actually protect the facility and the resident. If there are no advance directives, is the niece the appropriate proxy for the resident? Often, a spouse, sibling, or child has allowed another family member to volunteer for the role due to reticence or a reluctance to fight within the family. This is not in the best interest of the resident, the solution might come from a direct family intervention and a change of the designated representative.

Unfortunately, however, the problematic family members often are legally entitled to be involved in multiple aspects of facility life. The representative family member is required by the Minimum Data Set 3.0 process to provide input in the assessment, including provision of information regarding resident preferences in virtually every aspect of daily life. The representative also must be involved in decision making and care planning. This may include refusal of medications or treatments. Furthermore, the family has the right to access the resident at any time, regardless of facility schedules or convenience. Although there may be recommended visiting hours, the facility has no right to exclude the representative at any time, completely short of legal action and an order of protection. Although visiting rights apply to all family members (unless the resident refuses), involvement in all other aspects of care applies only to the legal representative.

Some difficult family members simply require education regarding appropriate mechanisms to obtain information or raise complaints, but the most difficult ones may have diagnosable mental health disorders. This applies particularly to those who attempt to intimidate staff, interfere in the care of other residents, target individual staff members, manipulate staff into disagreements, create scenes, spread rumors, complain about staff to other families, use social media to complain about the home, insist on constant attention to their needs, or repeatedly threaten legal actions. Although it is obviously impossible to do a formal psychological evaluation of a problem family member, it is still possible to identify some of the sources of their challenging behaviors, particularly those as toxic as described above.

Family Members at Fault
Frequently, the underlying source is a personality disorder, which in many cases is a borderline personality disorder (BPD), also known as an emotionally unstable personality disorder. The prevalence of BPD is estimated to be between 1% and 6.2% of the general population. It is characterized by an inability to form stable relationships, having episodes of extreme anger and irritability, displaying tendencies to idealize some individuals and devalue others, and having feelings of emptiness. Coexisting substance abuse is common, as is a history of suicidal threats or attempted. Mood disorders and other personality disorders or traits (e.g., histrionic or narcissistic) may be comorbid conditions for up to half of those with BPD. These individuals often have little or no insight into their own behaviors. Medication is ineffective for the core symptoms, but mood stabilizers, antipsychotics, and antidepressants may be helpful for some behaviors and for coexisting psychiatric disorders. There is also substantial evidence that a variety of long-term psychotherapeutic modalities, such as dialectical behavior therapy, may produce significant benefits or even remissions. However, the facility is in no position to offer treatment or usually even suggest it. Sadly, in my experience, the suggestion that a massively unhappy family member transfer their loved one to another facility is never accepted.

The solution is to have the facility create the structure that these individuals lack. The facility should establish a regular meeting usually 30 minutes long and no more than an hour, generally weekly, with a single individual who will be the point person for communication. This protects staff time and prevents the contradictory information that contributes to splitting the staff into heroes and villains. There should be an agenda, preferably in writing, and strict time limits must be observed. Shared written minutes with specific details of all decisions are advisable. The approach of the facility representative should be firm, but not antagonistic. Listening is not the same as agreeing. Remember that the designated representative has the right to be involved and informed of the care plan, but not the right to dictate it.

Similarly, the facility should establish firm rules regarding family behavior on the unit. Interference with the care of other residents and abuse of staff is totally unacceptable. Even if it is known internally that some staff members are less capable than others, it is not acceptable for them to be insulted by family members. Profanity and racial slurs cannot be tolerated. Although families have the right to private meetings with their relatives, such contact is not necessarily appropriate in resident care areas; the lobby, resident lounge, or an unoccupied dining room may be better venues.

Individuals with BPD create tumult, chaos, and crisis. When stable rules are enforced and antagonistic episodes disappear, and when the excitement is replaced by a calm, business-like approach, the conflict that fuels outbursts disappears and the flames of controversy die down. Often, the angry outbursts are redirected toward new targets, the meetings become less frequent, and peace is restored to the facility.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.