Trust, Consistency, Engagement: Meeting the Complex Needs of Younger Residents and Staff Who Care for Them

By Christine Kilgore

When Rebecca Ferrini, MD, MPH, CMD, set out to develop AMDA – The Society for Post-Acute and Long-Term Care Medicine’s tool kit The Younger Adult in the Long-Term Care Setting (https://bit.ly/3tS7hUM) almost 10 years ago, she and her coauthors found no research to guide them. “We put out all our questions, all our problems, and we talked through our solutions. We actually had many of the same solutions,” said Dr. Ferrini, the full-time medical director of the County of San Diego’s Edgemoor skilled nursing facility, which serves a largely younger population.

Such is the case today: little if any evidence-based guidance exists on the care of younger residents in nursing homes. However, there is a continually growing collective experience with meeting their social, psychological, psychiatric, and basic human needs while continuing to meet the needs of older residents and complying with federal regulations.

Caring for the Ages spoke with Dr. Ferrini and three other leaders who have varying professional perspectives and experiences about what they deem to be best practices with this growing and strikingly diverse group of residents. Younger residents, for example, may have degenerative neurological diseases, spinal cord injuries, significant psychiatric illnesses, including personality disorders, or chronic diseases that have advanced way too early.

Institutional Placebo Effect: Tapping Into the Mind-Body Connection for Better Outcomes

By Travis Neill, PA-C, MMS

I often fantasize about the ideal long-term care facility: a facility without regulations or the resulting need to document everything. In this dream facility — we will call it Nirvana — the nurses, certified nursing assistants, dieticians, therapists, and social workers spend very little time on a computer and more time interacting with the residents. Freed from the burden of documentation, the nurses and certified nursing assistants can do what they do best: provide compassionate care. Of course, because Nirvana is such a wonderful place to work, it is always fully staffed. The staff support each other, and resident conflicts are resolved with forgiveness and accountability. Everyone at Nirvana is an active part of the community, no matter how small, and this leads to a greater sense of purpose and an interconnected sense of family.

The longer I work in long-term care, the more I imagine Nirvana and how to make it a reality. While the lack of regulations and documentation will stay a fantasy, physicians, physician assistants, and nurse practitioners working...
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Staff Relationships
Dr. Ferrini is intimately familiar with young residents who have extensive physical needs, psychological needs, a lot of preferences and demands, and challenging behaviors. Resident relationships with staff — having “at least one person on their side” — and the creation of a “therapeutic milieu,” where all staff model effective communication and unconditional caring in every interaction are “the most important pieces, the only way you’ll survive.”

“I really think we underestimate the value of being in a family, a household,” she said. “But that’s what’s going on ... every action you take, your interactions with other staff and residents — they’re watching everything.”

Some certified nursing assistants (CNAs) will be more comfortable than others with the younger residents who are demanding and have difficult behaviors. “Set up structures in your facility that promote the development of long-term relationships, like not rotating staff,” she said, or adjusting the duties of a CNA who feels uncomfortable with a particular resident. CNAs can be celebrated, she added, by asking them to speak first at care conferences.

Individualized Care Plans
Dr. Ferrini also advises taking a careful and meticulous approach to individualized care plans. “Many people do care plans by template, but they’re not geared to the unique challenges these young adults may bring to your facility,” she said. “Developing a good care plan that is patient-centered, trauma-informed, and practical, and that will withstand regulatory scrutiny, is one of the hardest things we do.”

Her interdisciplinary care plans for younger residents who have numerous demands are driven by questions, such as What are her needs? What are her wants? How can we meet as many of her preferences as possible and maintain a good relationship while not promising what we can’t deliver? How can we balance her needs with the needs of our other residents?

Care plans should be practical and should detail “how you found a way to meet all of the patient’s needs and some of her wants” while not denying other residents’ rights and needs. “You can’t justify [decisions] by just saying, we don’t have enough staff,” she said.

If the resident rejects certain care or interventions — such as measures that would prevent him or her from becoming lost while outside the facility — care plans should document that the resident has been informed of the risks and of alternatives, and is accepting these risks and exercising his or her right to make a particular decision, she said.

The use of power chairs, she notes, should be established in plans and policies “as a privilege that can be taken away.” (“Behavioral contracts,” described by the Society’s 2013 younger adult tool kit, are tools that mental health professionals and nursing home leaders have since moved away from. Goals are achieved through care plans rather than contracts.)

Personality Impairments
Personality disorders or severe personality impairments are believed to be common among younger residents who live in nursing homes, particularly among those who have chronic mental illnesses such as bipolar disorder, major depression, and substance dependence.

“All human beings have some traits of personality disorders when they’re in stress. But people with severe personality disorders have no emotional regulation or ability to manage their external environment,” said psychiatrist Lea Watson, MD, MPH, co-chair of the Society’s new Behavioral Health Council. “They constantly externalize their needs, they create havoc for caregivers, and they [excessively] seek health care utilization.”

Severe impairments in the ability to relate to others are characteristic of Cluster B personality disorders, which include borderline, narcissistic, and anti-social personality disorders. However, “personality disorders are kind of elusive in the psychiatry lexicon [to be begin with] ... and diagnoses are [often hidden] or not made,” she said. “So I talk about it in terms of traits and behaviors, and not diagnoses.”

Dr. Watson works as a consultant, advising nursing home leaders who often do not have access to the direct provision of mental health care. She teaches how to care for residents with personality impairments — almost all of whom have histories of abuse and other trauma — using a “BOLD” paradigm. “It means being ‘the calm,’ having ‘one quarter-back’ to manage all the decision-making, ‘limit setting,’ and being ‘dependable’ — saying what you will do and doing what you will say,” she said.

Boundaries can be successfully set and relationships built using this paradigm, she said, relaying the case of a young resident in her 30s with morbid obesity and a long list of medical problems and medications. The resident constantly demanded pain medications and referrals to specialists, purposefully urinated in her bed, and routinely refused facility-prepared food, demanding that the staff order out for her. “She basically had the entire facility run ragged,” Dr. Watson said.

A care plan developed through an all-stakeholders meeting identified one provider to manage all referrals and medication changes. “We also started a program where one staff member would visit her at the same time every day for 10 minutes and she could talk about whatever she wanted,” Dr. Watson said. “But as soon as she started ringing the call light all the time every day, that planned visit would stop.”

The approach successfully set boundaries while addressing the resident’s needs to know that the staff would be there for her, which is a common need among individuals with personality impairments. “She developed a trust- ing relationship with one staff member in particular,” she said. “We were able to reduce medications and trips to the emergency department, and she has kept the same primary care practitioner for almost a year now.”

Holding the Line on Antipsychotics
In caring for younger residents with chronic psychiatric disorders — with or without concomitant personality impairments — medical directors and other prescribers should hold the line on maintaining the use of antipsychotic medications that are keeping these patients stable, Dr. Watson said.

“With older adults we spend so much energy talking about reducing antipsychotics and lowering the overall medication burden ... But we’ve gotten to a bad place in many facilities where the pharmacy will call for a dose reduction on [a resident] with schizophrenia, [for example], and then they destabilize,” she said. “People with chronic psychiatric disorders often need to stay on their medications for their lifetime. You absolutely do not have to make changes or reduce doses when they’re stable.”

Practitioners should be sure to document why the benefits of not making a change outweigh the risks, Dr. Watson advised.

Activities: Thinking Outside the Box
Ideally, sources said, younger residents would live in nursing homes devoted to younger individuals or in smaller cottage-like structures that group people by their age, functional status, and interests. Making the best of the current one-size-fits-all nursing homes means the activities staff must strive to develop age-appropriate activities. The Society’s tool kit includes a table on activities that have been shown to engage younger adults living in long-term care.

Dr. Ferrini’s facility recently restructured its activities schedule to focus on “large exciting activities” such as drumming circles and choir groups that engage multiple staff members who interact with each other in addition to the residents. These larger activities

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occur less often than previously scheduled smaller activities, but they seem to appeal to her facility’s younger residents. In general, the younger residents “are able to manage their recreational time largely on their own with their tablets and recreational devices.”

Constance Rose, MSN, CRNP, a director of clinical operations for the Provider Partners Health Plan, a Medicare Advantage Institutional Special Needs Plan (I-SNP), said that investments made in technology during the COVID-19 pandemic — new computer labs and information technology equipment, for instance — have significantly benefitted the younger members. Still, interactive activities have huge value. She has seen cornhole tournaments successfully implemented by activities staff who were “thinking outside the box.”

Dr. Watson has seen facilities take out small groups segregated by age and ability to shop together at the dollar store or for other outings. “And if there’s a way to create a job, albeit unpaid, for a younger person with major mental illness,” she said, “this can be potentially rewarding because it provides them with purpose.”

Goals-of-Care Discussions
In the past 10 to 12 years, the I-SNP that Ms. Rose works for has been caring for an increasing number of members who are 40 to 50 years old. “We’re dealing with medically complex individuals who are pretty young compared to what long-term care looked like 10 years ago,” Ms. Rose said. “These are patients with uncontrolled diabetes that led to amputations, or patients with chronic kidney disease at a younger age. They are cognitively intact, but their bodies are failing them.”

End-of-life goals-of-care discussions are “really difficult to have with families,” she said. Leaders are responding with continuing education for families — and for staff — about disease processes and prognoses, more frequent care planning, and a stronger embrace of palliative medicine.

“We’re seeing a shift away [from traditional quarterly care plans], to pulling in family members and doing care planning with this population more frequently,” Ms. Rose said. “They’re doing more sit-down meetings to check in, [to ask] where are we with this, and how do you feel about the appointment you just came back from. They’re having conversations early and often ... The issues discussed take some time to comprehend and process.” With the help of mental health experts, nursing home staff “need to create a shared agenda with the resident,” she said.

For some long-term care residents, such as those with substance use or psychiatric issues, an early assessment of discharge potential is important. “Sometimes, there is little standing in the way of them being in another setting,” Richard Juman, PsyD, said. “Many younger people are highly motivated to get back to the community ... Coming into long-term care doesn’t mean they’ll be there for the rest of their life. We should begin with the end in mind.”

The “Tremendous Sense of Loss”
Dr. Juman, director of behavioral health policy and regulation with TeamHealth, a provider of nursing home care, and co-director with Dr. Watson of the Society’s Behavioral Health Council, emphasizes that regardless of the reason for nursing home placement, younger residents have significant psychological needs.

“We tend to snap into management mode when we bring in a population we’re not used to [caring for], which can unfortunately ignore the overwhelming sense of loss that anyone who is in a nursing home prior to older age will experience,” Dr. Juman said.

“Each of these people is someone who had a plan ... and they’re grieving about what might have been. It doesn’t matter whether the resident’s behavior led to the cause or not. The sense of loss is enormous,” he said. “We’re not going to make progress with this population until we help them process that loss and accept living a different life than the one they’d planned.”

For psychological support, in-house psychosocial rounds have been successfully employed, and facilities increasingly “have added psych telehealth, so residents can set up a therapy session...”

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We are reminded every day in our own practices and settings that there is a substantial, growing number of older adults seeking health care services. We are all well aware of the statistics: 10,000 baby boomers will turn 65 every day until 2030 (R. Hemlick, “Baby Boomers Retire,” Pew Research Center, Dec. 29, 2010; https://pewrsrc.ch/3rJN5TI). At this pace the older population is projected to exceed the available health care resources. The fastest-growing segment of the United States population is the oldest-old (80 and older). The oldest-old growth rate is twice that of those 65 and older, as well as almost four times that for the total population (J.M. Ortmann, V.A. Velkof, and H. Hogan, “An Aging Nation: The Older Population in the United States,” U.S. Census Bureau, May 2014; www.census.gov/prod/2015pubs/p25-1140.pdf).

More older adults are living with multiple chronic conditions for longer periods of time. Older adults comprise a significant portion of the population with chronic disease, with 60% having at least two chronic conditions (“Older Population and Aging,” U.S. Census Bureau, Oct. 7, 2019; www.census.gov/topics/population/older-aging.html). At the same time, the largest portion of older adults are living longer, healthier lives than previous generations.

The Consensus Model

The shortage of geriatrician and gerontological advanced practice nurses has steadily exacerbated over the past two decades. It is projected that there will be a 45% increase in the demand for practitioners specializing in geriatrics by 2025 (National Center for Health Workforce Analysis, “National and Regional Projections of Supply and Demand for Geriatricians: 2013–2025,” May 2017; https://bit.ly/3doK85R). Advanced practice registered nurses (APRNs) specializing in gerontology first appeared in 1970, and the first gerontological nurse practitioner (GNP) was certified in 1976.

To provide structure and uniformity to the APRN role, the APRN Consensus Model for Regulation, Licensure, Accreditation, Certification and Education (known as the Consensus Model) was adopted in 2008. With the adoption of the Consensus Model, the GNP certification was retired in December 2013, and new Adult-Gerontology Nurse Practitioner and Clinical Nurse Specialist certifications were introduced by American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners Certification (AANPBC). These certifications demonstrated the APRN competencies of caring for older adults and increased the workforce capacity for advanced practice nurses providing care to older adults.

Although these changes did result in an increase in APRNs with geriatric knowledge in the care of older adults, there was a significant loss of expertise in the care of older adults with complex medical needs, which includes the oldest-old and frail older adults.

The Consensus Model left oversight of the competencies and the recognition of the specialty practice to professional nursing organizations. The Gerontological Advanced Practice Nurses Association (GAPNA) is the sole organization specifically for advanced practice nurses with geriatric expertise. GAPNA endorsed the Consensus Model and has led the effort to define and recognize the gerontological advanced practice nurse specialty. A practice analysis was conducted by GAPNA to define the knowledge and skills for the APRN gerontological specialist. GAPNA convened an expert consensus panel of gerontology nursing leaders to develop gerontological advanced practice nursing competencies beyond the entry-level competencies for practice. The consensus panel identified 12 proficiency statements that were then developed into the “GAPNA Consensus Statement on Proficiencies for the APRN Gerontological Specialist” published in 2015 (https://bit.ly/3Hl6YzG). Advanced practice registered nurses (APRNs) specializing in gerontology first appeared in 1970, and the first gerontological nurse practitioner (GNP) was certified in 1976.

The GC-C validates advanced knowledge and practice proficiencies beyond the entry level for APRNs who work with older adults with complex care needs. APRN GS-Cs have an up-to-date knowledge base, in part due to their required ongoing professional development. The GC-C offers employers the opportunity to promote positive outcomes and position an organization to provide targeted marketing for ensuring quality and safety.

Eligibility for the APRN GS-C

The GC-C requires the applicant to have completed a minimum of 500 hours of supervised clinical experience in the gerontological specialty.

How Can I Learn More?

The application process with eligibility requirements, testing content outline, and resources for the GC-C can be found on the GNCC website (www.gerocert.org). Resources to prepare for the GS-C can be found on the GAPNA website (www.gapna.org).

The Benefits of APRN GS-C

Specialist certification promotes professional recognition, self-confidence in decision-making, and enhanced credibility. Certification has been associated with patient safety, optimal patient outcomes, decreased errors, improved patient satisfaction, increased staff retention, and job satisfaction (J Nurs Care Qual 2020;35:E1–E5).

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A Therapeutic Milieu

Staff, in the meantime, need the same compassion and attention from nursing home leaders that younger residents need, so that these staff can be successful in creating the therapeutic milieu that’s essential, Dr. Ferrini said.

“I’m so pro-resident. I love my patients, but I’ve really come around to be focused on staff. ... We need to model the patience with staff that we want them to show with residents,” she said. “We need to have a good-quality organization where there’s good trust and good morale, and people working kindly together, because this is a risky population and you need all hands on deck.”

Christine Kilgore is a freelance writer for Caring for the Ages.