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Dementia capable care insights

The DRNO protocol: Adopting an analytical approach to behavioral intervention

Editor's note: "Dementia capable care insights" is a new, semi-regular column written by ***Kim Warchol, OTR/L, DCCT,*** *president and founder of Dementia Care Specialists, a specialized offering of CPI, a Milwaukee-based training and consulting firm. It explores the latest research, best practices, and regulations to help long-term care providers navigate the evolving dementia care landscape. To submit a dementia care question or topic for discussion, email Associate Editor Delaney Rebernik at* drebernik@hcpro.com.

What is a negative behavior? More often than not, it is a response to a person or a situation and a communication that something is wrong. Many times, this response is clear and reasonable, albeit not always pleasant to encounter. But the ability of observers (and instigators) to identify the root of a negative behavior often seems to ebb when the person expressing this behavior has dementia.

A dementia diagnosis is like a shroud that hangs over all aspects of a person's being and actions, tainting reality and obscuring the affected individual's intentions from the people with whom he or she attempts to communicate. Lapses in understanding of this individual's experiences can fuel judgment that further distances us from the true message in their behavioral communications. But if we learn how to put aside this knee-jerk negativity, we can often uncover a wealth of knowledge and logic in individuals with dementia.

Such discoveries can be particularly powerful for nursing home professionals, who are currently contending with CMS' crackdown on the antipsychotic drugs historically used in the setting to curb negative behaviors associated with dementia.

Moving away from antipsychotics

According to Advancing Excellence in Nursing Homes—a national initiative to improve nursing home care—nonpharmacologic interventions can promote

the highest possible levels of mental, psychosocial, and bodily functioning in residents with dementia, enhancing their interpersonal relationships, reducing their risk of medication-related declines, and generally promoting their overall well-being. These benefits can, in turn, help nursing home staff deliver care that is efficient, effective, and person-centered in nature.

For these reasons, movements to diminish the use of antipsychotics among vulnerable nursing home populations are picking up speed across the country. A prominent player in these efforts has been CMS' National Partnership to Improve Dementia Care in Nursing Homes, of which Advancing Excellence is a part.

After helping facilitate a near 20% reduction in antipsychotic use by nursing homes across the country over a two-year span, the Partnership announced in March a new aim: To see a 30% drop in antipsychotic use nationwide from the initial benchmark by the end of calendar year 2016.

To advance this goal and fuel progress in other service areas CMS considers integral to "providing competent and comprehensive" dementia care (e.g., symptom management, decision-making, and caregiver stress relief), the agency has introduced a number of regulatory initiatives, including the recent addition of two antipsychotic measures to *Nursing Home Compare* star rating criteria and an expansion of the focused dementia care survey pilot program.

As CMS sets increasingly ambitious goals for antipsychotic medication reduction—and attaches more regulatory weight to achieving them—nursing home providers will have no choice but to tune in to the individual needs, desires, and perspectives of their residents with dementia to find alternative methods of behavior management.

What you should know about antipsychotics

In addition to recognizing the accumulating regulatory incentives to steer clear of antipsychotics and understanding the clear perks of nonpharmacologic approaches, providers should reflect on the comparative and pervasive costs of excessive or improper drug prescription.

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According to the Alzheimer's Association, medications can sometimes stoke the very symptoms providers are attempting to treat. In addition, the organization cites a recent analysis that found certain atypical antipsy-chotics are associated with an increased risk of stroke and death in older adults with dementia. Fittingly, the FDA has asked manufacturers to include a "black box" warning on such medications, as well as a disclaimer that they aren't approved to treat dementia symptoms. Other adverse effects linked to inappropriate antipsy-chotic administration include heart attack, falls, and hospitalizations.

Clearly, there are many reasons providers should resist the urge to reach for the prescription pad at the first sign of a person with dementia's negative behavior expression.

Table 1: Decoding the DRNO protocol

Phase	Description
Describe the behavior expression	Answer all relevant "W" questions to capture the key elements of the behavior expression. For example, consider *what* the behavior expression is, *when* and *where* it's expressed, and *who* is or isn't present at the time of expression.
Uncover the **R**eason	Based on analysis of the expression's attributes (identified during the "Describe" phase) and evaluation of any other relevant information known about the person exhibiting the behavior, point to possible reason(s) or trigger(s) for the negative communication.
Identify appropriate **N**on-pharmacologic intervention(s)	Identify one or more nonpharmacologic interventions that can address the specific reasons and/or triggers to facilitate a more positive behavior response in the future.
Observe outcomes of chosen intervention(s)	Record, monitor, and observe the impact of each implemented nonpharmacologic intervention. Determine whether it has reduced the severity and/or frequency of the negative behavior. Facilities should develop their own systems for conducting these evaluative activities using information about their unique community and input from its constituents, including leadership, frontline staff, and, when appropriate, residents and their families. Generally speaking, these processes should involve a universal tool for recording negative behavior frequency, severity, and all other relevant "W" information on a shift-by-shift basis. They should also designate a specific methodology for tracking outcomes and define the roles each individual staff member plays in carrying out related tasks. If these activities reveal the tested intervention was ineffective, the team should either brain-storm another intervention associated with the probable behavior trigger or, depending on the specific findings of the monitoring activities, seek to identify a new trigger/intervention pair altogether. Despite the inherent guesswork involved in this approach, efforts shouldn't completely hinge on trial and error. Interventions should be both reasonable and based on knowledge of the dementia stages and how they are affecting the specific individual. *Note: Despite the proven power of non-drug intervention, sometimes it's not enough. When a dangerous behavior persists or seems beyond the scope of analytical intervention, clinical play-ers across disciplines may come together to conceive a nonpharmacologic plan. For example, a resident's occupational therapist could call on nursing staff to develop an integrative ap-proach to alleviating a negative behavior and its trigger, and that in turn may promote optimal safety and function for the individual.*

Gaining perspective

The first step in shifting the dementia care paradigm from drug to human intervention is trying to see the world from the vantage point of a person with dementia—a perspective that is more relatable than one might think.

Consider the following scenario:

> *You are traveling alone and staying in an unfamiliar hotel for a few days. The first evening you are there, you hear unusual noises outside your door. A few minutes later, a stranger walks in and instructs you to get up and go with him to the bathroom to take a shower.*

What are all the things that would run through your mind if the above events occurred? How would you respond to this stranger who has come into your private space uninvited? If pushed against your will, would you resist, scream, and maybe even fight him off?

I imagine this scenario is akin to the experience of certain residents with dementia upon moving into a long-term care facility and being asked by an unfamiliar staff member to go to the shower room. When viewed through the lens of an unnerving hotel encounter, responding to the prospect of a shower with fear, resistance, and bewilderment seems downright normal. This basic understanding of behavior and its roots can be extraordinarily empowering for dementia care partners and counteract initial inclinations to suppress, medicate, and sedate a person with drugs.

If we stop seeing adverse behavior as a rote symp-

Table 2: Targeted nonpharmacologic interventions for Mr. Smith's shower-related behaviors

Potential reason or trigger	Viable intervention
Mr. Smith perceives the nursing home's young, female CNAs are threatening his autonomy and invading his privacy.	Assign an older, male care partner to assist with Mr. Smith's baths.
Mr. Smith is embarrassed by the fact that his loss of control is made evident to peers.	Instruct the new care partner to invite Mr. Smith to take a shower when he is in a more private area rather than a social setting.
Nursing home staff have failed to gain Mr. Smith's agreement to shower and to establish trust.	Train dementia care partners to learn Mr. Smith's typical routines; build a rapport and trusting relationship; and provide an adequate amount of control, choice, and privacy throughout all care interactions, particularly those surrounding shower activities. Fostering this relationship may require a few additional minutes during daily interactions—the time it takes to think up a thoughtful inquiry based on background information found in Mr. Smith's medical record, or to locate his favorite shampoo before a shower—but it's often well worth the extra exertion. If care partners don't make this effort up front (or facilities discourage it), they may pay for it later in the need for backup to defuse a tense situation or the increased chance of an injury. If, despite best efforts, a care partner loses Mr. Smith's trust and agreement during a shower (or any other activity), he or she should step back and utilize another approach, but should never push back against significant resistance just to get an assigned task done. Care partners should also learn to recognize and appropriately react to all of Mr. Smith's usual verbal and non-verbal expressions of agitation and fear in order to prevent risk of escalating behavior.
Nursing home staff have failed to accommodate Mr. Smith's typical routine.	Change Mr. Smith's shower schedule to align with the routine he had established prior to nursing home residency.

tom of dementia, and start instead asking questions to affirm its validity—"Could this be a normal response to the situation?" "What can be done to help this person feel better?"—we will facilitate more positive behavior expressions and become far less reliant on medications.

A better way

Over the years, I have successfully used a simple protocol to help me investigate behavior responses and identify nonpharmacologic interventions; it has had a powerful and positive impact on many individuals with dementia whose communications have been misunderstood. I first came across this dynamic protocol long ago during the regular course of my consulting work and have since applied its principles in numerous care situations, becoming more adept at achieving transformative outcomes with time and practice.

The process begins as it should. We gather information about the person: cognitive level, life history, priorities, preferences, relationships, personality, etc. All of this matters, and should first be collected upon admission. It should then be revisited quarterly and/or as needed throughout the year to ensure it remains current and able to provide valuable insight during care-related decision-making. We then use a four-phased protocol known by the acronym DRNO to organize and analyze our observations about the behavior. See Table 1 on p. 5 for a rundown of the core DRNO elements.

Let's practice: Case study

To better illustrate the power and utility of the DRNO principles, let's use them to discover why Mr. Smith, a fictional nursing home resident in the low early stage of dementia, acts out violently during showers. (See the "Dementia capable care insights" column in the February 2015 issue of **PPS Alert for Long-Term Care** for an in-depth discussion on the different stages of dementia.)

Here's the situation: Last night, Mr. Smith struck Sheila, a young CNA in the SNF I work at as the director of nursing, during his shower. Unharmed but shaken, Sheila called on Sarah, another young CNA, to help with the rest of the shower. Together, the two aides were able to complete the shower, but Mr. Smith's behavior situation got progressively worse. Both aides were eventually struck, and Mr. Smith used profanity throughout the entire ordeal. After the shower, Mr. Smith continued to curse. He also began to throw things and appeared to put others in harm's way.

As an intervention, Mr. Smith was given lorazepam to control his verbal and physical agitation, as well as to promote compliance during future showers. However, since this is just the latest in a long series of adverse outcomes related to Mr. Smith's showers and not the first to result in the filing of an incident report, I'm looking for a new way to approach the situation. To uncover a more sustainable and person-centered solution, I'll apply the DRNO protocol to the events surrounding Mr. Smith's shower outbursts.

Preliminary legwork: Gathering information

- *Locating relevant background information:* Based on care notes and discussions with my employees, I know that Mr. Smith is currently functioning in the low early stage of dementia due to his Alzheimer's disease. In terms of personal history, he is a retired Army colonel who never married, and his siblings call him a "very private, reserved man." Upon admission, they told the intake nurse, "He is a sweet man who would never hurt a fly." Intake notes also indicate that he has always preferred showers in the morning to "start his day fresh."
- *Reviewing the facility's response:* Sandra, one of Mr. Smith's regular nurses, has confided to me that, "Mr. Smith has Alzheimer's/dementia, and this type of behavior is common. We have no other choice than to give him a drug. He can't be allowed to hurt someone, and he certainly can't go without a shower." According to Sandra, nursing took no further steps beyond asking Mr. Smith's physician for a medication script to reduce this behavior.

Steps to a better intervention: Applying the DRNO protocol

1. **Describe the behavior expression**

- *What is the behavior?* Mr. Smith refuses to take a shower. If pushed against his will, his negative behaviors escalate. He becomes verbally and then physically aggressive, often striking one or more care partners and screaming some variation on "Leave me alone" that's often laced with expletives.

- *When does the behavior occur?* Showers have been offered to Mr. Smith late in the afternoon or at night since his arrival nearly two weeks ago, and each time the activity is posed, his negative behavior has occurred.
- *Where does the behavior occur?* Mr. Smith is typically approached about taking a shower when he is in the day room, where many residents gather to socialize. His refusals begin when he is first asked to go to the shower room and continue to escalate as he is led there, during the shower, and in the immediate aftermath.
- *Who is or isn't present when the behavior occurs?* The CNAs who have been on the receiving end of Mr. Smith's shower refusals have all been young females. Sheila, a 20-year-old CNA, has been the most involved in Mr. Smith's shower care, and has often recruited Sarah, another young female caregiver, to assist her when Mr. Smith shows resistance.

2. Uncover the reason

By synthesizing what I know about Mr. Smith and the specific W's of the event, I'll attempt to identify the potential triggers and/or reasons behind his behavior response.

- *Analyzing what I know about Mr. Smith:* Mr. Smith is performing in the low early stage of dementia, which means he may lack reasoning ability, but still retains a clear sense of his values, wants, and needs. When I ask my nursing staff to speak with his siblings about the shower difficulties, they tell us he likely wouldn't be comfortable with a young woman showering him due to his private nature. As a high-ranking veteran, he's also used to displaying dominance and power, so he's not comfortable being subject to another person's authority, especially someone who is much younger and exerting control in a public space.
- *Identifying logical reasons behind and/or triggers for Mr. Smith's response:*
  - Mr. Smith perceives the nursing home's young, female CNAs are threatening his autonomy and invading his privacy
  - Mr. Smith is embarrassed by the fact that his loss of control is made evident to peers
  - Nursing home staff have failed to gain Mr. Smith's agreement to shower and to establish trust
  - Nursing home staff have failed to accommodate Mr. Smith's typical routine

3. Identify appropriate non-pharmacologic intervention(s)

Match interventions to potential reasons and triggers. See Table 2 on p. 7 for viable interventions that I will implement through collaboration with the facility's staff educator and my own nursing team.

4. Observe outcomes of chosen intervention(s)

Observe and monitor whether the new approaches minimize the frequency and/or severity of Mr. Smith's refusals and aggressive outbursts.

Key takeaways

There are indeed times where a severe behavior requires a drug intervention to keep the person exhibiting it and others in the nursing home community safe, particularly when such an action is caused by a psychiatric illness rather than an alterable outside trigger. In these circumstances, medications are likely required. However, given the far-reaching costs of behavior management medications and their historic overabundance in the nursing home setting, we owe it to all we serve to reflect on the necessity of these drugs before administering them wholesale to our residents.

The first step in this process is recasting negative behaviors as communications rather than symptoms. We must see residents with dementia first and foremost as people with normal emotions, wants, needs, and responses rather than as powerless victims of a disease. This new approach can aid and empower us to address many negative behaviors without leaping to antipsychotic drugs at the first sign of agitation.

For these reasons, I suggest we take concrete actions—like conducting DRNO-driven investigations—to remove the metaphorical shroud of dementia that envelops and restricts persons with the disease. Take it off, fold it, put it neatly in a closet, and close the door. Allow logic and compassion to grow in its absence.

Source

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