Bridge Over Trouble Waters: Dealing with Difficult Patient and Family Encounters in SNFs

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NO DISCLOSURES TO REPORT
Difficult Patient and Family Encounters

• **Purpose:** The purpose of this activity is to enable the learner to develop skills in handling difficult patients and family encounters.

• **Learning Objectives:** At the end of this presentation, the learner will be able to:
  1. List sources that can contribute to making interactions with patients and families challenging.
  2. List components of emotional intelligence that can help providers understand their role in challenging encounters with families and patients.
  3. List benefits of taking a team approach in the skilled nursing facility to approach difficult situations with families and patients.
  4. Outline an approach to dealing with difficult encounters
Facts about difficult encounters

- Clinicians report between 15-18% of their patients/families as difficult
- Up to 40% of doctor-patient encounters may involve conflict
- Patients/families perceived as difficult are associated with provider burn-out, frustration and poor short term outcomes

“All patients make me happy, some when they come to the office, others when they leave”

Quote from a practicing MD
Difficult Encounter

Better to conceive an encounter as difficult rather than to label patients or families as problematic.

Difficulties are perceptions, similar encounters may be perceived as difficult by one clinician, but not another.

Allows for an approach to handle the difficult encounter.
Examples of potentially difficult encounters

1. Angry patients and families.
2. Overprotective families.
3. Over-controlling or domineering families.
4. People with unusual beliefs or personalities.
5. Patients with diagnostic challenges.
6. Patients and families that cannot explain what is going on without starting from when they or their family member was born.
7. Patients and families demanding certain treatments we don’t see as effective.
8. Difficult patient to take care of in the SNF you send to the hospital and they don’t want to take care of the patient anymore than you do.
Coping with Difficult Situations

• We have several choices
  – Do nothing
  – Walk away
  – Change our attitude
  – Change our behavior

• Changing our behavior is the most-effective approach
  – The difficult person will have to learn different ways of dealing with us
Case Example 1

• Betty is a 89 yo female currently residing in a secure dementia unit with Lewy Bodies Dementia
  – Consistent/worsening behaviors of impulsiveness, delusions, eradicate sleep patterns. resistance to care with overall decline in health with wt loss, and gradual loss of ADLs
  – Increase in falls
  – Additional Pm hx – HTN, CHF, PVD, OA OP, Kyphosis
  – Medications –Aricept, Namenda, Lisinopril, Furosemide, ASA, OsCal with Vitd3, PRN Ativan (moderated by dght)
  – The resident was difficult for the staff to manage her care needs and the Daughter presented another complexity to the care itself.
Daughter Interactions or Challenges

- Overbearing toward staff and mother – demanding, appeared very unappreciative, critical of care given
- Felt she knew “what was best” for mom
- Difficult to have open discussion with
- Demanding of unnecessary testing – mom always has a UTI
- Not open to various treatment modalities – didn’t want to see mom “snowed”
- Had a medical background – can be a positive or a negative at times
- Only child and this was her last living parent
- Not accepting of disease trajectory – behavioral changes starting happening quite quickly.
Case Example 2

• 56 yo gentleman in SNF for long term care
• History of seizure disorder, head trauma, unable to participate in any decision; functionally dependent in ADLs except is able to feed self after being set up
• Resident cooperative
• Sister appointed guardian
• Sister adamant about dose of phenytoin her brother should be on and other issues
• Her demands around the phenytoin dose were not based on any facts but on what dose he was on as a child
• Called several times a day to the floor her brother was on
• Called the president of the hospital this SNF was associated several times a day
• Her calls made it difficult to care for other residents on the floor
Case 3

• 28 yo Type 1 DM on dialysis

• Admitted to SNF because of multiple medical admissions related to her DM and renal failure

• She had a personality disorder.

• Sullen, not communicative; often not showing for dialysis

• Did not have a supportive family; had relatively few social support systems
## What makes an interaction challenging?

<table>
<thead>
<tr>
<th>Patient</th>
<th>Clinician</th>
<th>Disease</th>
<th>System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric disorders</td>
<td>Attitudes</td>
<td>Working up conditions in the SNF</td>
<td>Resources</td>
</tr>
<tr>
<td>Angry</td>
<td>Conditions</td>
<td>Complex, unusual diseases vs. straightforward</td>
<td>Finances</td>
</tr>
<tr>
<td>Demanding</td>
<td>Knowledge</td>
<td>Goals of care issues</td>
<td>Time pressures</td>
</tr>
<tr>
<td>Categories of patients</td>
<td>Skills</td>
<td>Risk:Benefit issues</td>
<td>Facilities with high turnover</td>
</tr>
<tr>
<td>Bottom line: Raise negative feelings in us</td>
<td></td>
<td></td>
<td>Staff-family interactions</td>
</tr>
</tbody>
</table>
Approach

When difficulty is perceived we should treat it like a diagnostic problem. Perceptions of potential difficulties should lead to diagnostic trials similar to those arising from key elements of history and physical exam

APPROACH

1. Recognize there is a problem
2. Decide what might be causing the issue
3. Come up with a Plan
4. Implement the plan
5. Evaluate what is working
6. Change the plan as needed based on what is working or not working
1. Recognizing Difficult encounters

No two difficult encounters are alike.

An ability to work with uncertainty and complexity is critical

• This requires reflective self-aware practitioners who can examine what they are doing (Epstein Fam Med 2002; Hass et al Am Fam Phy 2005, Reiss JAMA 2010)

• Cultivating Emotional Intelligence – the capacity to recognize and adapt to one’s own and others’ emotional states- can help temper, analyze and de-escalate problematic interactions (Straton et al Teach Learn Med 2008)
- **Neocortex and Amygdala**

- **Neocortex**
  - Complex thinking
    - Decision Making
    - Strategizing
    - Prioritize
    - Big picture

- **Amygdala/Limbic System**
  - Emotions
    - Fight or flight
    - 100x faster than neocortex
    - No differential between real or perceived threat
Emotional Intelligence

• One’s ability to recognize, understand and manage one’s personal emotions to then recognize, understand and influence the emotions of others.

• Three main components
  – Self Awareness
    • Self assessment, emotional self assessment, self regard
    • Knowing one’s own responses, avoid the “emotional hijack”
  – Emotional Management
    • Impulse control, flexibility/adaptability, authenticity
    • Controlling oneself to be able to most appropriately respond, S.O.S.S strategy
  – Emotional Connection
    • Empathy, communication, coaching others
    • Establishing collaboration to do what's best for the resident

Goleman 1998
EI Observational Behaviors

• Self Awareness
  – Readily accepting feedback and criticism; is aware of strengths; knows how their emotions impacts behavior; is aware of theirs emotions; speaks confidently; handles setbacks effectively

• Emotional Management
  – Does not act impulsively; can overcome difficult emotions in pursuit of goals; maintains a sense of humor; keeps promises; remains flexible and adaptable to changing situations and problem solving; enjoys challenges; is goal oriented

• Emotional Connection
  – Non-judgmental; sees from others perspective; provides clear and concise feedback; does not personalize disagreements; treats others with respect

• Goleman 100
2. What is the problem?

Approach just like diagnosing a problem

– History
– Exam
– Talk with patient, family, staff

Approaches that can help: skills and techniques

• Good communication skills/Active listening
• Addressing emotions
• Avoid the Righting Reflex
• Perspective of the team
Listen with the intent of hearing instead of responding
Am I Taking Time to Understand?

• Communication Breakdown
  – 7% is verbal
  – 38% is from tone of voice
  – 55% is from body language

• Poor versus good communication
  – Poor
    • Hurried
    • No engaged
    • Being distant
    • Using medical terminology
  – Good
    • Not rushed
    • Simple words
    • Mostly listening
    • Being empathetic
Recognizing and attending to Emotions

- Acknowledgement of emotions: our own and patient/family
  - Enable people to process their emotions
  - Enable people to realize what they are most concerned with

- Mnemonic: NURSE
  - Name
  - Understand
  - Respect
  - Support
  - Explore
Resist the Righting Reflex

I AM NOT ARGUING, I’M JUST EXPLAINING WHY I AM RIGHT.
Discussion with team: the problem and the plan

• Get everyone's perspective; entire team
• Are there staff that do not see this as difficult
  – What is their perspective
  – What works for them
• Avoids splitting
Discussion with Team

Problem
• Get everyone's perspective; entire team
• Are there staff that do not see this as difficult
  – What is their perspective
  – What works for them
• Avoids splitting

Plan: Collaborative effort
• Entire team
• Creates consistent message
• Demonstrates a level of increased communication, empathy and reassurance
• Avoids miscommunication
• Support to staff
3. Plan: examples

The plan is based on outcome of your evaluation

1. Seek out Consultation
   – Utilize your collaborating Services (Psych, Cards, Neuro)

3. Setting limits
   – Designate family spokesperson and interact with that person

4. Set specific meeting time
   – Initially frequent, over time usually can space out

5. Education: Knowledge gap

6. Behavioral plan if it is a behavior of a resident

7. Change providers

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TIPS for Providers to Implementation

• Be sure the goals are workable
• Time frame
  – Commit to when this will be implemented
  – When will you reevaluate the plan
• Check in with SNF to see what is going on: course correction
  – Shows your commitment to the facility, you are part of the team
• If a crucial conversation needs to happen: Do It.
• If you have set up specific meeting times follow through on them.
  – Shows accessibility and develops trust
SNF: Our and staff reflex is to run away

Include in any approach with difficult encounters

1. Staff seek families out to share information
2. Staff communicating face to face about resident’s condition without family having to request
3. Staff informing families when there is a change in condition
4. Staff expressing an interest in how the family members coping with residents stay
5. Staff providing explanations in a treatment in a non-threatening and relaxed manner

(Utley-Smith et al. J Aging Stud 2009)
5. Evaluate the plan.
   – Your assessment
   – Staffs assessment
   – Family’s assessment
     • Ask family how everything is going

6. Change the plan as needed based on the outcome
Back to the Cases
Approach Case 1

- Communication, communication, communication
- A new face
- Validation and empathy – asking for and utilizing her input instead of resisting it or completing shutting it down
- Understanding the why to her thinking
- Risk/benefit conversations
- Leveraging what medical background she had
- Comprehensive review of medication and disease trajectory
- Collaborative effort / interdisciplinary approach
- Staff education regarding disease process – approaches to the patient and family
- Time, weekly meetings/interactions initially
Outcome Case 1

• Improved communication with staff, provider, daughter
• Daughter more open to alternative treatment plans and medication adjustment
• More understanding of the disease trajectory and what was going to happen to her mother over time
• Time frame: several months; still an ongoing issue but with the work up front interactions were less frequent and far less contentious
Approach Case 2

- Team approach
  - Consistent approach to the sister
- Limits set on number of calls
- Regular follow up with sister to discuss medical issues
- Involved neurology
Outcome Case 2

• Not successful at all
• Calls continued and escalated
• Decision after months of trying to improve situation to remove the sister as the guardian
• Timeframe: probably about 10 months
Approach Case 3

- Team meeting with how we were going to address issues
- Came up with a plan
  - Psychiatric Clinical Nurse Specialist
  - Consistent staff
  - Consistent approach
  - Support for the staff in caring for her
Outcome Case 3

• After several months began to see a change in her; more interactive
• Engaged in her health care
• Staff became her family/support system
• Saw regression in her behavior for a short time after her family would come to visit
• After about 10 months she decided she wanted to go and live independently
Rules for Crossing the bridge/ Generic approaches

1. First Impressions count
2. Assume positive intention: we as professionals should be trained and competent in communication
3. Never get angry; if we get angry recognize it and use it as a flag to consider why
4. Listen
5. Stay calm
6. Strive to never appear rushed (no matter how rushed you feel)
7. Consistent approach by all including staff at facility; may need to get everyone on the same page
8. Discuss difficult patients with a colleague or with peers in a group (Balint groups)
References


O’Dowd TC. Five years of heartsink patients in general practice. BMJ 1988;297:528


References


## SOSS: Stop the hijack

<table>
<thead>
<tr>
<th>STOP</th>
<th>Do something to disrupt the hijacking and; relax your shoulders, open up your hands and place them on your legs, take a drink of water.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OXYGENATE</td>
<td>Deep breathing always helpful!</td>
</tr>
<tr>
<td>STRENGTHEN APPRECIATION</td>
<td>Brain cannot experience appreciation and fear/anger at the same time</td>
</tr>
<tr>
<td>SEEK INFORMATION</td>
<td>Asking questions seek clarification, this engages the neocortex</td>
</tr>
</tbody>
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# NURSE: Mnemonic for addressing emotions

<table>
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<th>Skill</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>N: name the emotion</td>
<td>It sounds like you are frustrated.</td>
</tr>
<tr>
<td>U: understand</td>
<td>This helps me understand what you are thinking.</td>
</tr>
<tr>
<td>R: respect</td>
<td>You are doing all the right things and asking the right questions.</td>
</tr>
<tr>
<td>S: support</td>
<td>I am going to walk this road with you.</td>
</tr>
<tr>
<td>E: explore</td>
<td>Could you say more about what you mean when you say that…..</td>
</tr>
</tbody>
</table>
Angry family member/patient

- Anxiety or Grief
- Bad experience with the health care system
- Poor communication and conflicting information

- Approach
  - Acknowledge anger and distress as soon as possible
  - Listen intently
  - Invite them to raise all their concerns without interruption unless to clarify what they are saying