3-714 Resident refusing care

TIPS Question:

A resident has refused care continuously and when approached cries, runs away, strikes out and tries to kick. The resident now has an infected toe and needs treatment to this area. We have tried many different approaches, using one staff, two staff and now three staff. One staff to provide the treatment and the other two to hold resident and try to provide reassurance. The resident continues to cry during the treatment. My question is “When do you cross the line from providing care to committing abuse".

Response:

In response, I am assuming that your resident has been diagnosed with a dementia. Using the P.I.E.C.E.S. Template will of course help you to understand the resident’s refusal for care and distressed behaviour by considering h/she’s cognitive function, and by trying to identify all possible causes for the distress. When looking for triggers remember to think P.I.E.C.E.S. as this will help you to explore, for example, the ways in which you can modify your approach, the care environment, and incorporate into the care plan what is known about the person’s previous likes/dislikes, the most meaningful comfort measures, etc. Studies suggest that as high as 92% of elders living in long term care who suffer from dementia will display self-protective behaviours during or actively resist bathing and grooming at some point (Kovach & Meyers-Arnold, 1997, 1997). Very high prevalence, isn't it?! Therefore, what you are experiencing with your resident is very common, leading to the necessity for care providers to discover alternative strategies that will be more acceptable to her. These behaviours should be interpreted as the resident's attempts to defend herself from a perceived threat (Bridges-Parlet, Knopman Thompson, 1994). Our job is always to reduce the perception of the threat, and if your care plan explicitly lists all the things you are doing to support her, then your care attempts cannot be interpreted as assault or abuse from an external auditor. Just as it would be unethical for formal care providers to withhold care because it is threatening to her, it is also unethical to not have a highly developed care plan that explicitly states what you will do to reduce the stress that you can predict will occur during care (see the Kovach reference above). Ethically, you are not in a position to withhold care simply because it is distressing to her and she displays objecting behaviours. She is a vulnerable adult who is misunderstanding your attempts to do what is right and good for her. She is not able to make these decisions for herself. Remember to ask yourselves, as a team, who are the partners that can help in identifying the best care strategies and implementing the plan? Is there anyone else who should be involved who currently is not and how are we going to ensure good communication with the resident and with the members of the team? Here are some suggestions for developing the care plan that would document your strategies for reducing her distress:

1. Hold a meeting with the substitute decision-maker and discuss with them treatment options.

2. Have a written list of comfort measures you will institute to ensure that you are reducing the stress on your resident as much as possible during the foot care procedure. Share this with every member of your care team so that they know what to do. As follow-up ask your team colleagues to add to the list and tell you what works the best.

   Some examples include:
   - playing relaxing music in the background before you start any personal care procedure
   - starting with a massage of her hands with a perfumed lotion (the substitute decision-maker can provide this) to get her used to being touched in a comforting and non-threatening way
   - trying a foot soak with a bubble solution prior to the treatment on the toe, including her substitute decision-maker in the room while you are offering the foot treatment so that she can see a familiar face (it could be that person's job to do the comforting talk)
   - stopping and giving her a break every couple of minutes or so (called the "stop and go" approach to care) so that there is less of a chance that she feels assaulted, more of a chance that she would interpret this as "hard, difficult work" but we will give you a chance to de-stress

An analogy here is the dentist's office. Think of the last time you were in the chair having an uncomfortable procedure. The excellent dental practitioner will be attuned to your building tension, and say to you, okay, time for a breather here, you look pretty tense. It is perfectly okay for you to say

these things to the resident with dementia, you may be surprised at how they understand this type of reassurance.

3. Offer her lots of praise and encouragement, and GO SLOW, making sure that the pace of your care matching her capacity to remain engaged.

4. Consider pain levels by offering an analgesic before the treatment for her toe (I am certain you are probably already doing this) because again, it would demonstrate to an auditor that you are offering ethical treatment by considering all the possible interventions that would reduce the stress of the experience.

5. Lastly, whenever you are a containing an individual, ensure that there is a member of your team is the "captain" who can gauge when a break is going to be necessary. The captain does all the talking to the resident, offers comfort talk, encouragement, praise, but also will give instructions like, "Okay, stop touching that toe for about 30 seconds, she is too unhappy and is beginning to kick. Slow down you're moving to fast for her, she is getting agitated again."

The key to ensuring ethical care will be in how clearly you can demonstrate to others a consistent approach that takes into account her need for comfort and explicitly states how you will address her distress.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*