3-2 Dealing with family concerns

TIPS Question:

How do you deal with a situation where a 69 year old, with diagnoses of cerebellar ataxia, secondary to alcohol abuse and also the possibility of M.S. Currently he is in a ward room with 3 other beds. There are no curtains on the windows as he pulls the curtains off. He usually refuses to bath or change clothing even when incontinent. He changes himself when he wants to. His lack of hygiene creates a very unpleasant environment for the other two residents in his room. His clothes are thrown all over the room and he strips his bed linens off his bed and very often will sleep on a bare mattress. He can be verbally aggressive when staff try to assist him or clean his room and can be physically aggressive if other residents are in his way. He denies causing any damage in the room. The facility only has three beds in the four bed room because of the chaos in the room. He has been seen by a psychiatrist and medications were recommended, however, do not seem to have much of an impact. This gentleman would benefit from a private room; however, he does not have the funds to pay for one. It is hard to develop strategies for the LTC staff to deal effectively with this gentleman and there is certainly concern about meeting his needs.

Response:

When given a complicated and difficult situation such as this one, I like to start with the PIECES Six-question template:

1. What is the behavior-cognitive mental health need?

   This gentleman displays a lot of behaviours which makes it difficult to isolate one specific behavior on which to focus.

Physical aggression :	Pulls curtains off Throws clothes around room Strips bed Physical aggression to co-residents “in his way”
Verbal aggression:	Toward staff if they try to assist him or clean his room.

2. Who is it affecting?

   This is very important. There are many Partners in Care involved: the client, family, the nursing staff, co-residents, family physician, community partners. This is a good opportunity to look for other Partners that may not be as actively involved as possible.

   It would be important to discuss with staff who they think each behavior is affecting. This would help prioritize behaviors. When reviewing the list of behaviours, one can see there is an immediate concern of physical aggression and how it affects the co-residents. Of lesser concern is his behavior of stripping the bed and sleeping on a bare mattress and how this affects others.

3. What is the degree of RISK?

   This framework will help prioritize the issues. From your information there is clear risk to others. Is there also risk to this client due to potential aggression in response to his behavior? When working through the RISK framework, determine how frequent his striking out behaviors actually are at this time. Is it more a threat to hit or actual active hitting out? If the actual degree of imminent risk is low, this would help staff relax, step back, and work through this issues in a systematic way.

4. Do we describe and record what we see?

   When a client presents with these types of behaviors there is usually a discrepancy in staff’s perception regarding the type and frequency of behaviors. A Cohen-Mansfield Agitation

Inventory (CMAI) would be very valuable. You would be able to get a clear understanding of exactly what behaviors are occurring. It is recommended to have each shift fill this out to determine if there are different behaviors for different shifts/staff. After it is determined exactly what the behaviors are, it would be beneficial to complete a DOS (Dementia Observation System) for approximately three days. This would show pattern in more detail. For this particular client this is very important because your team is probably feeling a lot of stress, frustration and particular feelings of "we tried that and it didn't work". Step back and get objective data and help everyone re-focus. You state that there is concern about meeting his needs. This concern can be brought to the rest of the Partners in Care in a more objective manor if properly documented and described.

5. What are the possible causes?

Physical: We assume your team has ruled out possible physical causes. Sometimes physical issues do not cause the behaviors, but the behaviors are worsened. Check to see that this client is at his best physically and then target the behaviors. Do the staff know the implications of his physical complications?

Emotional: Look for possible depression. Remember, older people may deny feeling depressed but is more irritable. A Cornell Depression Scale or SIGECAPS can lead the assessment. It would be interesting to know if this gentleman has had emotional difficulties in the past. The alcohol use may be indicative of a depression and subsequent self-medicating.

Intellectual: This is a good opportunity to first ask staff what they think this client's cognitive status is and then present results from such assessments as the Folstein Mini Mental Status Examination and the Clock Drawing Test. Often staff over-estimate a client's abilities. Acknowledge that his cognitive status may fluctuate throughout the day as well. From your behavior mapping you would see his best/worst times of day. It would be important to ascertain the intellectual capabilities of this individual before determining a response to his behaviors. You state that he "denies causing any damage in his room". This sounds like it is purposeful behavior in that "he knows what he is doing" and refuses to admit to it. As he is probably cognitively impaired to some degree, it is important to acknowledge with staff that he may not always be aware of what he is doing. This helps lower staff's level of frustration. This gentleman's behaviors sound like impulsive and frontal-lobe type of behaviors. If this is the type of dementia he has then he may score high on the Folstein Mini Mental Status Examination. Individuals with this type of dementia generally score lower on questions requiring reasoning, abstraction, judgment and problem solving skills. Do not let a 'normal' Folstein score lead staff into thinking all his behaviours are purposeful.

Capabilities. This gentleman is a perfect example of difficult behaviors with, seemingly, no strengths. When you talk to staff and family try to brainstorm on strengths this individual has, i.e. can he do any part of care by himself, is he mobile, does he have any cognitive strengths?>

Environment. You mentioned he would benefit from a private room. It would be interesting to list what those benefits would be and see if they may be obtained in another way. With regard to the private room, it is very common for a lack of finances to limit one's options. There have been exceptions in the past when the facility have felt that the benefits of placing someone in a private room out-weighed the financial loss. It may be worth looking into, at least for the short term, especially if the facility is losing the ability to fill the fourth bed in that bedroom.

Social. Is there any staff that feel they have better interactions with this gentleman? If this is the case, try to see if the facility can assign the client's care to these staff members.

Personalizing this gentleman is probably the most important part of your involvement. How often have you heard someone refer to another person's odd behavior by saying "oh, that's just so and so, he's always been like that". It is amazing how patient people become whey they understand more about the person and where the behaviours are 'coming from'.

6. What are the steps for providing the best care strategies?

   Meet with the team, share your information and discuss the following:

   1. The possible causes for these behaviors. Do not forget that there are multiple reasons for behaviors. Brainstorm with the group and see what you come up with as possible causes. Usually these types of behaviors are due to cognitive impairment. When individuals have difficulties putting their world together they become more agitated. Also, check this client's daily activities and see if he ever has opportunity for control.

   2. Institute potential interventions according to the above discussion. Is there anyway that he can be given PERCEIVED CONTROL (as noted in training manual). Give him some minor choices during care, meds and meals. Giving him some control and compromising with him is more likely to decrease the inappropriate behaviors. Talk with your team and see what is feasible in your environment. Try to alter the environment to decrease the behaviors, rather than trying to change the client's thoughts. Staff will feel less stress about a client if they feel they are actually doing something about the behavior. Instituting the perceived control will give the staff something to do with this person that is positive.

   3. Ask staff to think objectively about their responses to the behaviors. Include all involved staff in this discussion, even if you have to leave notes for staff on alternate shifts. Note YOUR RESPONSE summary. The most common reason behavior plans do not work is inconsistency.

   4. Talk to staff about their perception of the behaviors. These behaviors are exhausting for staff. Validate their feelings on this topic. Some facilities have granted an extra break to the staff who deal with the exceptionally difficult behaviours. This makes staff feel supported and increases their reserve to deal with complex situations.

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.*