TIPS Question:

In a recent in-service on abuse, we touched upon the types of abuse and maintaining residents rights in relationship to abuse and the core values of our facility, the residents' home. We currently have a floor that has a mixture of residents with dementia and an increasing number of "psych" residents. The "psych" residents are often aggressive both verbally & physically and pose a threat to staff and residents alike. With this in mind, my question is:

How do you maintain the rights of one resident, who does not behave "appropriately" to participate in activities & dine with dignity when the rights of others are being challenged? We provide care for a number of residents who are often removed from the dining room and other social gatherings primarily because of inappropriate behaviour. These behaviours are often in the form of yelling & swearing. These residents are often not given the chance to be in social places and if their behaviour is deemed inappropriate they are briskly sent back to their room so they will not disturb others. It concerns me that that we are very quick and eager at times to put the rights of others over theirs. How do you maintain their rights to participate in activities, live in dignity and dine with dignity without jeopardizing the rights of others? By segregating these residents is this not a form of abuse?

Response:

Caring for residents with diverse cognitive/mental health and physical needs can indeed be a challenge for the team, not only for the staff but the residents and families as well. It is particularly difficult when the behaviours of one resident are seen to have a negative impact on other residents whose behaviour is not a concern – especially if there is felt to be a safety risk associated with the behaviours or they are considered to be socially problematic.

However, if the focus is only on what the behaviour *looks like* and not the *meaning* of the behaviour then a "good resident"/ "bad resident" approach to the problem solving can sometimes occur. In the absence of a thoughtful exploration of the possible underlying causes of the behaviour (i.e. P.I.E.C.E.S.) we may move beyond the "psych" resident labelling and viewing behaviour as either "appropriate" or "inappropriate." Yes, people with mental health issues can display behaviours that are a challenge and sometimes even threatening in nature, but having a history of mental illness should never remove their need for or right to a full and comprehensive assessment. You have recognized the importance of moving beyond simply what the behaviour looks like to the person behind the behaviour and an *understanding* of what the behaviour means for him/her; by examining all the possible contributing factors – physical, intellectual, emotional, capabilities (do you have a good fit between what the person can/can't do and what is expected of him/her?), environmental, and social (what do you know about the person's life story and how are you using this information to understand the behaviour and make the interactions and activity planning more meaningful?)

It is important for team members to ask themselves the question: Do we believe the residents live in a LTCF and that we as staff "manage" (i.e. we manage the care which suggests an "us" and "them" approach) or do we consider the LTCF as the residents' "home" and we come to work each day in their "home"? The latter of course suggests that every resident deserves the best possible care and that includes making every attempt to understand behaviour and undertake a comprehensive assessment when there are concerns – not simply react.

U-First! and the wheel were designed specifically to help you and the team get started in the assessment process together. It may help the team to see the wheel in two parts – the bottom part i.e. P.I.E.C.E.S. represents the resident (or person) and as you turn the wheel it reveals a window into each part of the person i.e. physical well being, intellectual abilities, emotional health, etc. The top of the wheel i.e. U-First acronym reminds of what good *team problem solving* needs to look like - working together as a team to arrive at a *shared understanding* of the issues, flagging (observing) resident behaviour in an objective and holistic way, reporting to each other what you are seeing and what you know about the resident, and letting this guide the care strategies (rather than individual values and beliefs based on reactions to what the behaviour looks like without a good understanding of what it means and the possible causes).

Begin with one of the residents for whom there are concerns regarding behaviour related to his/her

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mental health/cognitive functions. Using U-First! to guide your problem solving and keep you anchored, you might try to bring the staff together for a "support session" to discuss the resident and their concerns (people usually come willingly when there is a need). You might begin by asking them to identify what the behavioural issues are and then ask them what they understand to be going on and what might be causing the behaviour (it is important to start where they are at!) You may have to have several of these sessions over a few days to capture as many staff as possible. You can also have 1:1 discussions to get started.

Keep in mind that when behaviours occur that are perceived as verbally and physically abusive staff often experience fear, frustration and sometimes even anger. If the behaviours require considerable staff time this may evoke feelings of unfairness; why should we be spending so much time with this resident at the expense of other residents, particularly when we get so little in return in terms of positive response?

One of the first questions you will want to ask is what information do we know about this resident and what information do we still need to gather – or need to re-think? Even if staff believe nothing will work and the behaviour has been present for sometime, using a structured and comprehensive approach to re-visit the issues including staff expectations, possible causes, talking about successful ways to interact with the resident and identifying those approaches more likely to aggravate can never make things worse – I have yet to see when some creative suggestion, whether a new idea or the sharing of a strategy that works, did not emerge from the reassessment.

However, staff may be reluctant to initiate such an assessment/reassessment, or the implementation of behavioural strategies once identified because they already feel overburdened and after all they are "psych" residents and nothing will work. In response to these concerns it will be important to help your team members reframe the way in which they perceive the assessment process and any behavioural interventions that might result. While the effort may seem daunting to staff it is the only way to improve the quality of life for the resident and at the same time reduce their stress and workload; in fact, no less important than undertaking a physical assessment or administering a medical treatment. The bottom line is; if what they are presently doing does not seem to be working to change the behaviour, and they feel under significant stress, something has to change – so why not change their approach to solving the problem!

Clearly identifying who the behaviours are affecting (and specifically how), will help to determine where the focus needs to be. This is an opportunity to identify how staff are being affected and to validate their feelings (the goal of course being to gradually reshape those perceptions as their understanding of the behaviours improves). Encouraging your team to consider who are the partners involved in the resident's care will be important; this is a good time to identify those partners who could (should) be involved but are not. I strongly urge you to think as inclusively as possible (both internal partners and external e.g. PRC, Specialty Geriatric Programs, etc.) and to write down a list of those partners; again, this helps to develop a plan of involvement, communication strategies, and follow-through; most importantly, it helps to know you are not alone. I suggest you keep referring back to that list.

Assessing the specific area and degree of risk (and for whom) associated with the behaviours using the RISK framework question will also assist in identifying priorities and focusing the intervention in a meaningful and stepwise manner. Remember to use Quick Start in those situations where there is some urgency to decision making to help you respond to the immediate safety and at the same time assist you to develop a stepwise plan over the next few days, week, etc.

Using objective behavioural recording to describe the target behaviours (clearly identifying what constitutes "verbally" and "physically abusive" behaviour for this resident) is critical e.g. DOS, ABC, etc. Here again staff will often express reluctance because of the perceived commitment of time. However, this is their opportunity to "capture" what the behaviours look like in a way that progress notes cannot i.e. when they occur, how often, etc. After all, they know the resident best and it is their observations that will help to shape the care plan, and focus interventions when they are most needed and likely to be effective. When the DOS is colour-coded and your team members have an opportunity for verbal and visual feedback it can be very validating and promote discussion and brainstorming about possible triggers and behavioural strategies.

Considering all possible causes is essential and using P.I.E.C.E.S. will help to systematically assess potential contributing factors. Use the wheel to help the team consider what the P.I.E.C.E.S. means for the person. Communication will be important to re-visit – what do the staff understand *now* about why the behaviours are occurring? What information re: assessment findings have you shared with them,

and *how* (using both verbal and visual methods of communicating results e.g. MMSE, Clock, DOS, etc.) to help them understand better? As you attempt to explain (or re-explain) to others how this resident is experiencing the world around him/her and how it is affecting the person's behaviour, it will be helpful to use the *7 – A's of dementia* if dementia is thought to be a concern. This will be important in shaping staff expectations.

Keeping in mind that all behaviour has meaning, it is our task to determine what the resident is trying to communicate to us through his/her behaviour – what is the need, the emotion, fear, etc behind the aggression? Is the behaviour aggressive or in fact defensive? When trying to identify specific behavioural strategies with the team it is critical that staff understand the concept of "Perception is Reality"; i.e. staff need to ask the question, how is the resident perceiving the actions of others, e.g. the way staff react/respond to him/her, what they say, how they approach and interact during care, when the resident becomes distressed and frustrated, etc?" Trying to understand the resident's perception is important because that perception is his/her *reality* and it is as real to the person as the staff's perception of reality is to them. This can be a very effective and positive exercise to work through with staff in report, a care conference, team meeting or support/education session. However disruptive, wilful and sometimes even vengeful the aggressive behaviour may appear, it represents the resident's attempt to cope. Therefore, strategies that include direct confrontation of that reality, attempts to argue, rebuke, or instil remorse, are at best ineffective, and at worse likely to alienate the resident and exacerbate the behaviours staff are trying to diminish. Keep in mind anosognosia i.e. the person doesn't know h/she doesn't know and has little or no insight that h/she needs help or how their behaviour is affecting others. Is this the case for this resident? Remind staff that the behaviour <u>always</u> makes sense to the person.

When helping staff to appreciate the concepts of *response* and *perceived control* you may want to use some of the strategies for staff learning that were included in the P.I.E.C.E.S. Learning (refer to the section on Behaviour Interventions in the P.I.E.C.E.S. Guide) to assist staff to better understand and appreciate that *we teach each other to behave.* There are a number of examples offered in the teaching notes that will allow staff to reflect on their own circumstances and how their behaviour is influenced by the response they receive from others. Similarly there are suggestions for how you might help your colleagues to consider how this resident's behaviour is being exacerbated by his/her perceived lack of control over his/her situation and decision-making. Helping staff to *recreate a chain of events* will be useful in demonstrating how this resident's behaviour has been shaped by staff response.

Reference: *Practical Psychiatry in the Long-Term Care Facility – A handbook for Staff*; edited by D.K. Conn, N.H. Herrmann, A.Kaye, D. Rewilak, B. Schogt; Hogrefe & Huber Publishers, 2001.

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.*