

Behaviors and Unmet Needs in the Assisted Living Environment: Room of Requirement



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What is the room of requirement??



- In the Harry Potter world, it is a secret room within Hogwarts Castle that a person can only enter if they have real need of it. Sometimes it is there and sometimes it is not. But when it appears, it is always equipped for the seeker's needs.
- The room of requirement is also known as the Come and Go room.
- The room is located on the seventh floor in the left corridor of Hogwarts castle and the way to open the room is to walk past it three times thinking about what you need and the door will appear.



Objectives:

1. Identify the common unmet needs leading to undesirable behaviors, and their likely origin
2. Examine contributing factors to behaviors we can impact right away, to reduce power struggles and promote a more positive care environment
3. Explore tools you can use to proactively anticipate resident preference and communicate information to all staff members
4. Discuss self-medication challenges and tools to use for monitoring

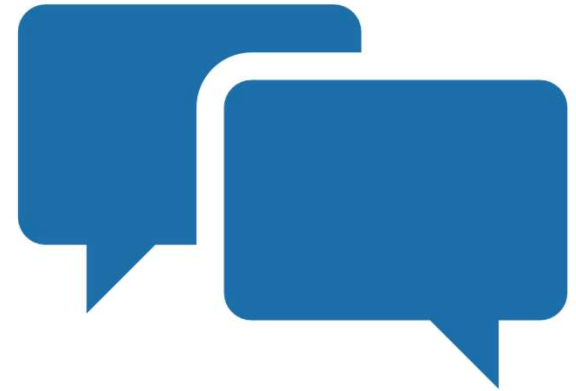


What are behaviors?

A range of actions and mannerisms made by individuals in conjunction with themselves or their environment which includes other systems around as well as the physical environment- Wikipedia

A Word about Behavior

- All Behavior is communicating something:
- An Attempt to
 - Express an unmet need
 - Affect/Change what's happening around us
- Keep in mind:
 - 5 W's- Who, what, where, when, why
 - Who has potential to change
 - Whose problem is it?



Unmet Needs

Stem from a decreased ability to communicate needs/wants and to provide for oneself. Most common Unmet Needs may pertain to:

- a. Pain/health/physical discomfort- pain, illness, wet, cold/hot, hungry, thirsty, tired
- b. Mental discomfort- delusions, psychosis, hallucinations, scared, anxiety, depression
- c. Need for social contacts- touch, speaking with others
- d. Uncomfortable environment- clutter, too bright/dim lighting, too loud
- e. Inadequate level of stimulation (bored) or a combination of any of the above

Unmet Needs Model

Cohen-Mansfield and Werner, 1995



The model, developed by Cohen - Mansfield and Werner postulates that the majority of unmet needs occur mostly because the environment and care staff, in turn, either do not provide for the needs or do so in a way that does not accommodate one's preferences, habits and disabilities

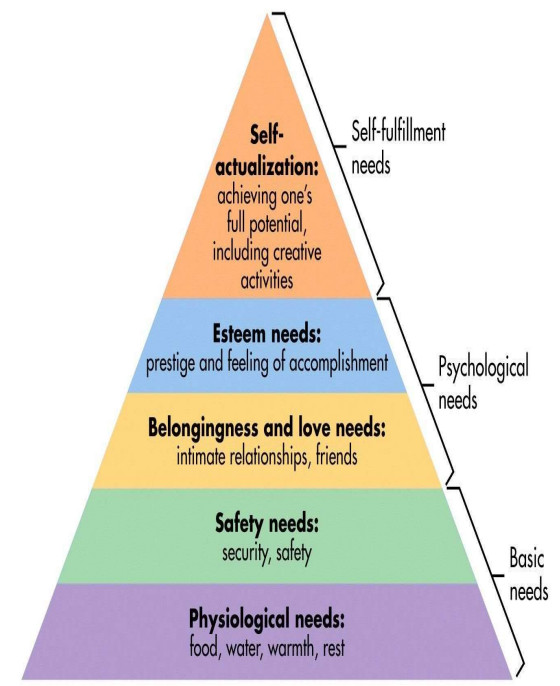
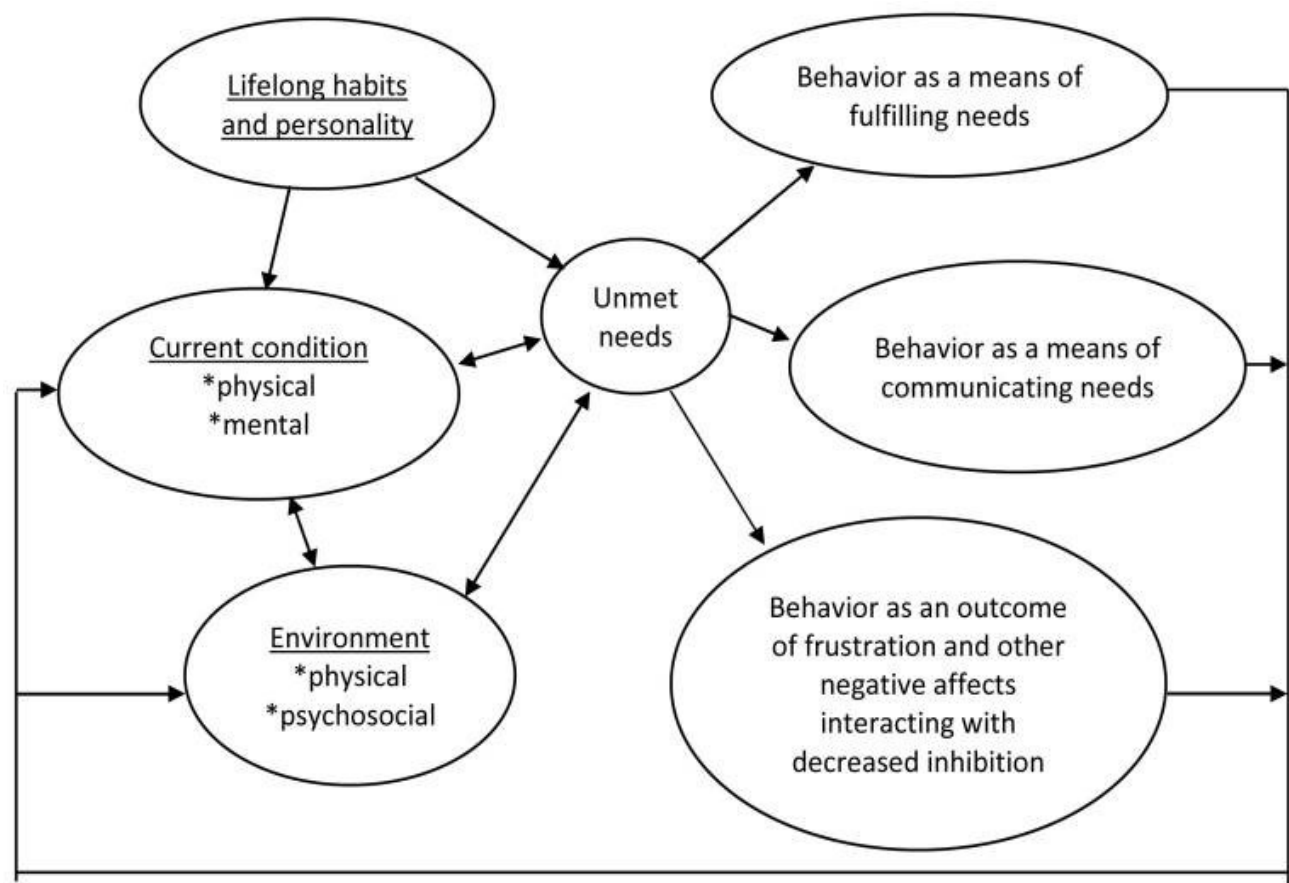
What is the level of confidence your assisted living facility has in the determination of resident unmet needs? What is the difference between “want” and “need”? Do residents require both?

Unmet Needs Model cont'd

According to the Unmet Needs Model:

- problem behaviors result from an imbalance in the interaction between lifelong habits and personality, current physical and mental states, and less than optimal environmental conditions.
- understanding unmet needs is central in formulating treatment plans for especially residents with dementia, forming a basis for non-pharmacological interventions.





Slide 9

PW1

Pat Whitacre, 8/13/2019

Maslow's Hierarchy of Needs

Level 1- Physiological Needs

-Biological requirements for human survival, e.g. air, food, drink, shelter, clothing, warmth, sleep

Level 2-Safety Needs

-Protection from elements, security, order, law, stability, freedom from fear

Level 3- Love and belongingness

-Need for interpersonal relationships which motivate behavior, e.g. friendship, intimacy, trust, acceptance and giving affection and love

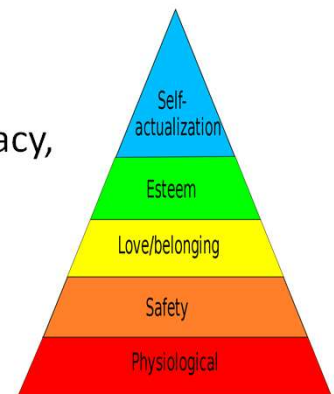
Level 4-Esteem Needs

-Esteem for oneself (dignity, achievement, mastery, independence)

-The desire for reputation or respect from others (status, prestige)

Level 5- Self-Actualization Needs-

-Self actualization; achieving one's full potential, self-fulfillment, seeking personal growth and peak experiences. A desire "to become everything one is capable of becoming" (Maslow, 1987, p. 64)





Know Your
Residents



What do
you **NEED**?

How can you assist or anticipate unmet needs if you don't know what the resident needs are to begin with?

The most common unmet needs of residents:

1. IF VOCAL/VERBAL BEHAVIORS:

a. Pain/Discomfort stemming from fatigue, wetness, hungry, thirsty, illness (what kind of pain scale are you using for your dementia residents (pain AD, Baker-Wong face scale)?

b. Loneliness/Fear (recent death in family, fear of abandonment)

c. Depression (must alert clinical staff if symptoms are identified by others)

d. Boredom

2. IF PHYSICALLY NON-AGGRESSIVE BEHAVIORS:

a. Need of activity and stimulation (appropriate activities, not always current events)

3. IF AGGRESSIVE BEHAVIORS:

a. Evasion of discomfort (wet, hungry, tired, cold/hot, fatigued, illness)

b. Attempt to communicate needs (be patient, don't play charades, watch non-verbals)

c. Personal space



How does your facility identify resident preferences?

How many of you have a resident summary form?

Who collects the resident information? Who do you obtain the information from? Part of your admission process?

How does the facility disseminate resident information to all staff and where will information be accessible? (computer, binder)

Who is responsible to ensure the information is up to date?





Know
Yourself first,
then know others

Reducing our contribution to “behaviors”: Communication

- Respect
- Adapt your communication style, pace to what the person needs (Simplify, open v. closed ended questions)
 - Ensure person’s attention before speaking
 - Be patient and allow adequate time to respond
 - Pay attention to body language
 - Speak to them face to face (they sit, you sit)
- Be accommodating when an individual’s reality differs from your own

Adapted from: Working with Challenging People presentation. New Mexico Long Term Care Ombudsman Program.



Reducing our contribution to “behaviors”: Environment cont’d

- Determine if person has optimal time of day (i.e. CHF- a.m. best)
- Reduce competing stimuli/distractions when possible (TV heard)
- Approach from front/remain in person’s line of vision, let person know when you are arriving and leaving
- Attune to individual’s personal space needs, your location in his/her living environment
- Position yourself for the individual’s comfort when possible
- Leave furniture/items where you find them



Adapted from: Working with Challenging People presentation. New Mexico Long Term Care Ombudsman Program. Used with permission.

From Challenge to Success



<https://youtu.be/ZpXeefZ2jAM>

<https://www.nhqualitycampaign.org/goalDetail.aspx?g=med#tab4>



De-escalation



What Can Assisted Living Facilities Do?

- Policies and procedures
- Risk assessment and monitoring
- Environment of care
- Care practices
- Staffing
- Training

Adapted from: De-escalation Strategies. Presented by C. Burmeister. March 23, 2018. Half Hour Hot Topics Webinar Series.
<https://healthinsight.org/nh-collaborative/nursing-home-resources#antipsychotics-and-behavioral-health>

Before: Assess and monitor potential risk

When do incidents tend to occur?

- When resident needs are unmet
 - Changes in resident composition
 - Times of day
 - During transitions/changes in activity
 - Unfamiliar staff or low numbers of staff (weekends)
 - Environmental stressors present
-
- Track patterns and be proactive



During an escalating situation

- Understand your role in crisis (don't become part of the problem)
- Pay attention to:
 - Body language and facial expression (yours and theirs)
 - Space, position and proximity in environment
 - Tone of voice, volume, cadence
 - Language used
- Depersonalize—not about you
- Avoid power struggles
 - Set aside your agenda
- Listen



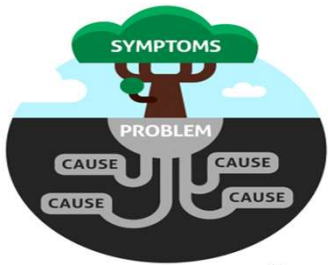
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After an incident happens

- Ensure immediate safety of all involved
- Assess and provide support services needed
- Identify root causes
 - Who/what/where/when/why
 - Help you learn from crises/incidents
- De-brief
 - With staff
 - With residents
- Evaluate care practices
 - Document and update ISPs
 - Make sure all staff understand new ISP information
- Training, is this a state reportable incident? 5-day F/U?



Non-Pharmacological Approaches to Care addressing Resident Issues:



1. Assess the problem- must be mixed team effort, include dietary, housekeeping, admin., maintenance etc. instead of just clinical staff
2. Hypothesize the cause (i.e., Root Cause Analysis)
3. Analyze the treatment options- first look at non-pharmacological approaches, physiological problems, labs, medication review, resident preference summary
4. Treat...keep trying
5. Assess

Non-Pharmacological approaches to consider include:

- Assess and manage comfort (i.e., temperature, resident's position)**
- Offer food and fluids (walkaround foods are excellent)
- Provide one-on-one social interactions
- Provide music based on preferences of resident
- Offer walk outside- identify times best for resident
- Offer a walking program and gentle exercises
- Play videotapes provided by family (Skype, Facebook, family albums)
- Introduce distracting stimuli such as favorite movies, conversation, touch





How to ensure ALF staff knowledge and training supports the Information:

- Who determines the need to educate staff regarding identification of needs/preference?
- Excellent information for facility assessment, resident centered ISPs, families, volunteers, Hospice
- Knowing resident preferences can initiate better outcomes through identification of issues and ability of staff to follow-through with interventions. Can your staff adequately initiate a response/action to resident unmet needs?
- **Suggestion> at monthly staff meetings, choose one resident summary for detailed discussion and input from staff**

Antipsychotic Alternatives: Pages 1-3

Antipsychotic Alternatives

The following information suggests ideas for reducing antipsychotic drug use. A carefully monitored use of the alternatives with frequent reassessment is suggested. Always start by assessing the resident for pain.

General Principles

- Start with a pain assessment.
- Provide for a sense of security.
- Apply the 5 Magic Tools (Knowing what the resident likes to see, smell, touch, taste, hear).
- Get to know the resident, including their history and family life, and what they previously enjoyed. Learn the resident's life story. Help the resident create a memory book.
- Play to the resident's strengths.
- Encourage independence.
- Use pets, children and volunteers.

What to try when the resident resists care

Therapeutic Intervention

- Evaluate recent medication changes, especially if the behavior is new.
- Determine if the resident is in pain, and if so, why? Treat the pain.
- Determine whether the care can be performed at a different time.
- Evaluate the resident's sleep patterns.
- Evaluate the resident in just when he or she is fatigued.
- Evaluate if there has been a change in the resident's routine.
- Evaluate if there has been a change in the resident's routine.
- Place the resident in a quiet room.
- Provide a positive distraction, or something the resident enjoys.

Environmental & Equipment Intervention

- Use assistive devices (wedge cushion, Dycem, etc.).
- Trunk bolsters, padded cushion, Dycem, etc.).
- Evaluate the resident for an appropriate size chair and proper fit.
- Evaluate alternatives seating to relieve routine reading pressure/pain.
- Use an oversized chair, reclining wheelchair, non-wheeled chair, or wingback chair.
- Place a call bell in reach of the resident.
- Place an over-bed table for to allow for diversional activities.
- Place a water pitcher in reach of the resident.

* A pain assessment should include non-verbal signs of pain. If you do not have a pain assessment that includes non-verbal identifiers go to: <http://www.hhs.gov/ohrt/qualitymatters/ohrt/qualitymatters/>



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Verbally Abusive/Physically Abusive

Therapeutic Intervention

- Begin with medical evaluation to rule out physical or medication problems.
- Evaluate the resident for acute medical conditions such as urinary tract infections, upper respiratory infections, ear infections or other infections.
- Evaluate the resident for pain, comfort and/or other physical needs such as thirst, position changes, bowel and bladder urges.
- Identify triggering events or issues that stimulate the behavior.
- Use a behavior tracking form to assist in identification of triggers and patterns.
- Discuss the resident's family regarding past coping mechanisms that were helpful during times of increased stress levels.
- Use "I" statements as saying, "You sound like you are angry."
- Use "I" statements to discuss skills and address potential issues identified.

- Set limits.
- Develop trust by assigning consistent caregivers whenever possible.
- Avoid confrontation. Decrease your voice level.
- Provide a sense of safety by approaching in a calm/quiet demeanor.
- Provide rest periods.
- Provide social services referral if needed.
- Provide a psychologist/psychiatrist referral if needed.
- Provide touch therapy and/or massage therapy on the hands or back.
- Reduce external stimuli (overhead paging, TV, radio noise, etc.).
- Evaluate staffing patterns and trends.
- Evaluate sleep/wake patterns.
- Maintain a regular schedule.
- Limit caffeine.
- Avoid sensory overload.

Prevention

- Use tapes, videos, music etc.).
- Use memory/remembrance boxes/books.
- Use a communication box to create awareness of the resident's location and back.
- Use a mobile phone.
- Use a mobile phone for familiar relatives or friends.

- Move to a quiet area, possibly a more familiar area, if needed.
- Decrease external stimuli.
- Use fish tanks.
- Encourage family visits, and visits from favorite pets.
- Identify if another resident is a trigger for this behavior.

Management

- Provide structured, high-energy activities and subsequent relaxation activities.
- Take the resident for a walk.
- Provide distraction and redirection.
- Provide written/verbal reassurance about where he/she is and why.
- Alleviate fears.
- Ask permission before you touch, hug etc.
- Assess/evaluate if there is a pattern in the pacing or wandering.
- Assess for resident personal agenda and validate behaviors.
- Ask family to record reassuring messages on tape.
- Evaluate for a restorative program.
- Perform a physical workout.

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- Evaluate camouflaging of doors.
- Evaluate visual cues to identify safe areas.
- Play a favorite movie or video.
- Put unbreakable or plastic mirrors at exits.
- Use Stop and Go signs.
- Evaluate the WanderGuard system.
- Use relaxation tapes.
- Use and use, as necessary, visual barriers and murals.
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- Evaluate room identifiers.

What to consider when residents disruptive in group functions

- Evaluate recent medication changes, especially if the behavior is new.
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- Evaluate if there has been a change in the resident's routine.
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Monitoring of Residents who Self-Medicate:

- What is your policy and procedure regarding self-medication with your facility?
- What is your protocol for monitoring residents who self-medicate?
- Challenges with self-medicating residents? Helps to identify residents who need higher level/tier of care
- See handout for self-medicating tracking tool



Data- Non adherence to self-medication

- It is estimated that 50% of all prescribed medication is not used by patients as intended by the prescriber, this behavior is believed to make a significant contribution to health service costs.
- The frequency of drug-related hospital admissions is reported to range from 2.9% to 5% and research has shown that between 11% and 30% of such hospital admissions are due to patients not using their medication as intended by the prescriber.

- Col, N, Fanale, J.E, Kronholm, P. The role of medication non-compliance and adverse drug reactions in hospitalizations of the elderly. Arch Intern Med. 1990; 150:841-5
Wasserefallen, J.B, Livio, F, Buclin, T Tillet, L, Yersin, B, Biollaz, J. Rate, type, and cost of adverse drug reactions in emergency department admissions European Journal of Internal Medicine 2001; 12(5):442-447

Resident Challenges with Self-Medication:

1. Drug administration difficulties

-manual dexterity, arthritis of hands

2. Sight Impairment

-macular degeneration, cataracts, wrong glasses prescription

3. Confusion, forgetfulness

-adverse outcomes with antibiotics/stop and start dates
- blood thinners, blood pressure medications, diabetic medications
- thyroid medications, once weekly bisphosphonates (Fosamax, Evista, Boniva)

4. Complexity of treatment regimen

- polypharmacy, swallowing problem

5. Intentional/unintentional adherence to medication regimen

-related to forgetfulness
- "medications aren't working", stopped because "I'm fine" (i.e. antidepressants, antibiotics)
- medication side effects

- Indications for Multi compartment Compliance Aids (MCA) -also known as Monitored Dosage also known as Monitored Dosage Systems(MDS) – provision, Dr Debi Bhattacharya, D.Bhattacharya@uea.ac.uk January 2005

Dementia Care Training Resources

Cares Dementia Specialist Training Program

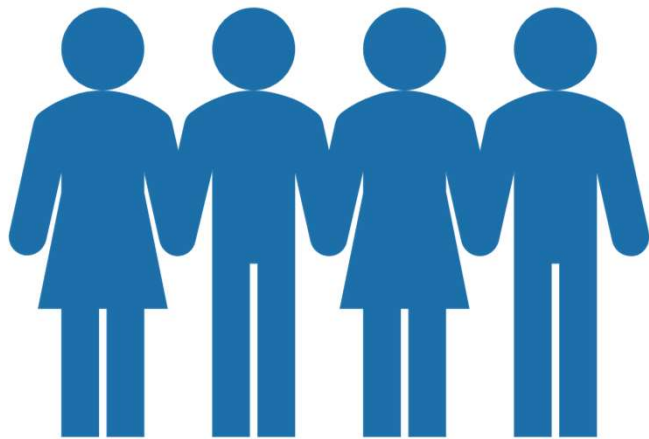
- https://www.hcinteractive.com/CDS?gclid=EAlaIQobChMI98LO7vGW4wIVIZOzCh15aAWcEAAYASAAEglqCvD_BwE

Dementia Care Practice Recommendations for Assisted Living and Nursing Homes

- https://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf

Comagine/NMHCA Half-Hour Hot Topics

- <https://healthinsight.org/nh-collaborative/nursing-home-resources#antipsychotics-and-behavioral-health>



“I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

— Maya Angelou

Let's begin to look at our residents as “human beings with needs, not as residents with problems”.

“Residents are not giving you a hard time, they are having a hard time”