Behaviors and Unmet Needs in the Assisted Living Environment: It's All About The Speed Limit

New Mexico Health Care Association Winter Conference

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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?

Adapted from: Mental Health Ombudsman Training Manual. New York State Long-Term Care Ombudsman, Commission of Quality Care for the Mentally Disabled: Used with permission from New Mexico Long Term Care Ombudsman Program.

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

* Pain is the number one trigger for behaviors in dementia residents, especially those residents unable to communicate verbally

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?

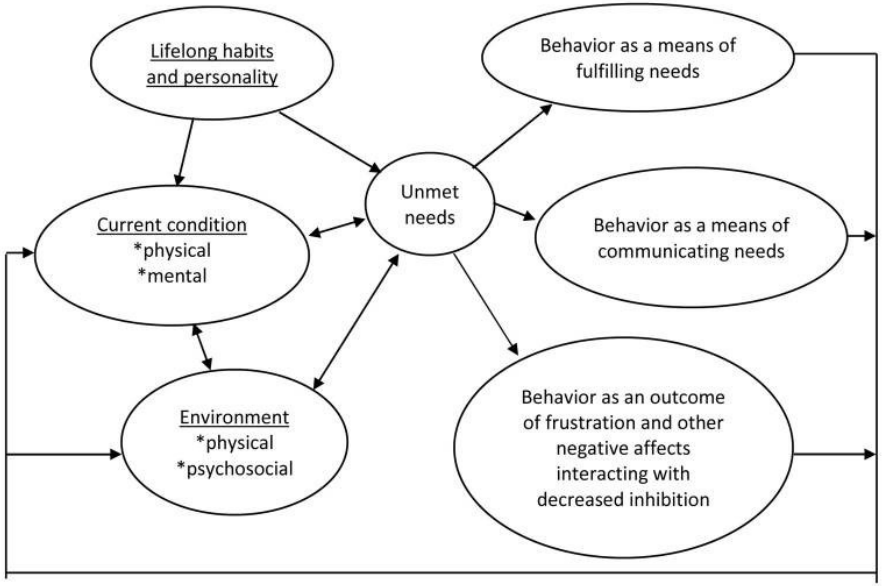
Unmet Needs Model cont'd

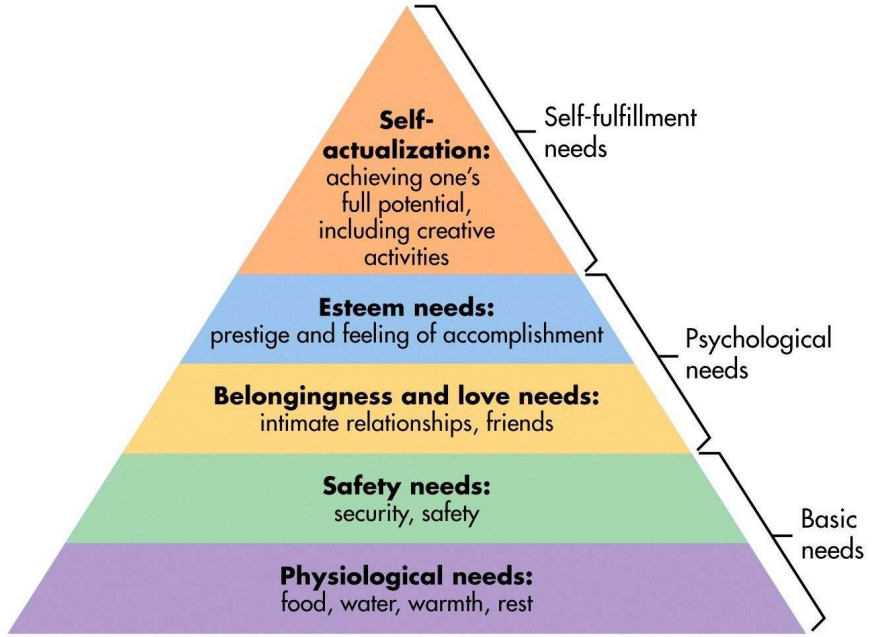
According to the Unmet Needs Model:

- 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 ISPs, especially for residents with dementia, forming a basis for non-pharmacological interventions.

PW1


Lifelong habits and personality
Behavior as a means of fulfilling needs
Unmet needs
Current condition
*physical
*mental
Behavior as a means of communicating needs
Environment
*physical
*psychosocial
Behavior as an outcome of frustration and other negative affects interacting with decreased inhibition


Self-actualization: achieving one's full potential, including creative activities
Esteem needs: prestige and feeling of accomplishment
Belongingness and love needs: intimate relationships, friends
Safety needs: security, safety
Physiological needs: food, water, warmth, rest
Self-fulfillment needs
Psychological needs
Basic needs

Slide 8

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

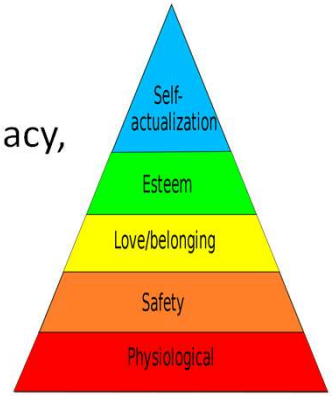
Level 3- Love and belongingness

-Need for interpersonal relationships which motivates 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-Actualiztion 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

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, hunger, thirst, 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

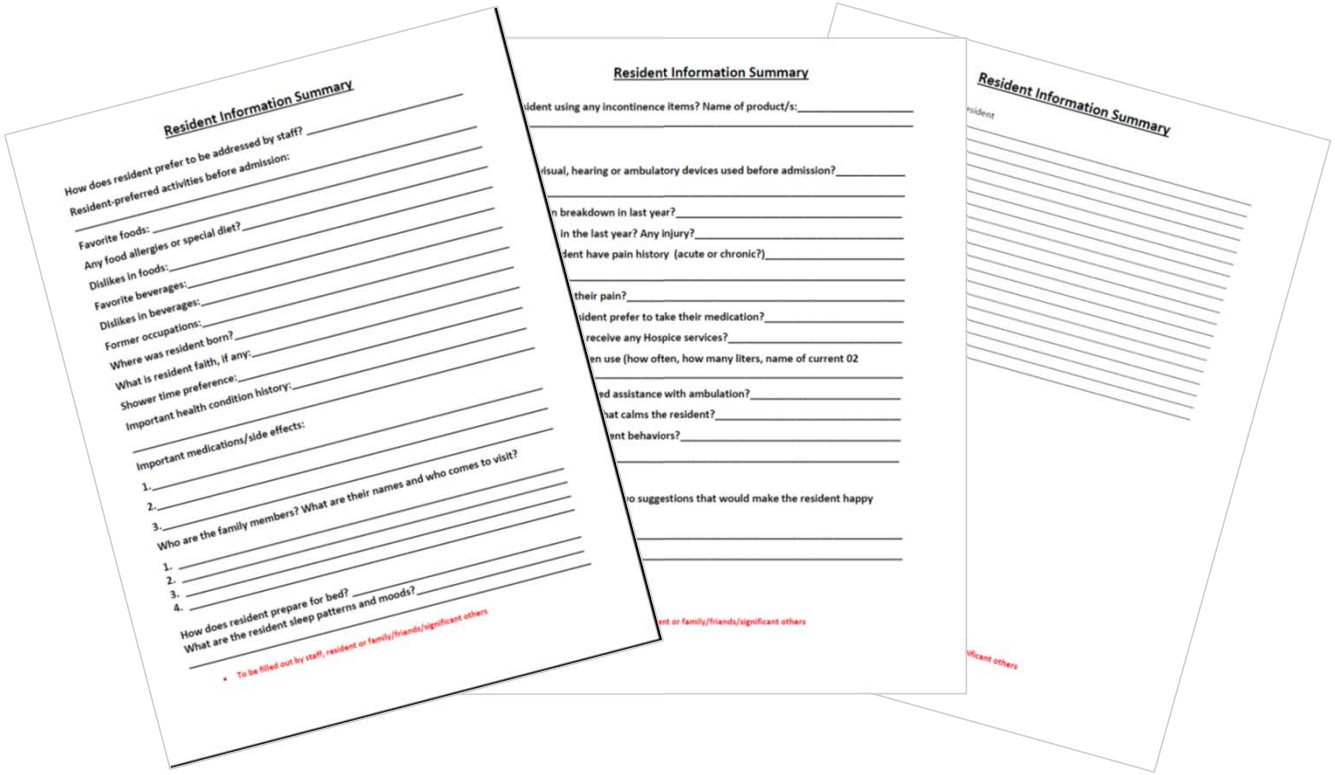
How does your facility identify resident preferences?

How many of you have a resident summary form?

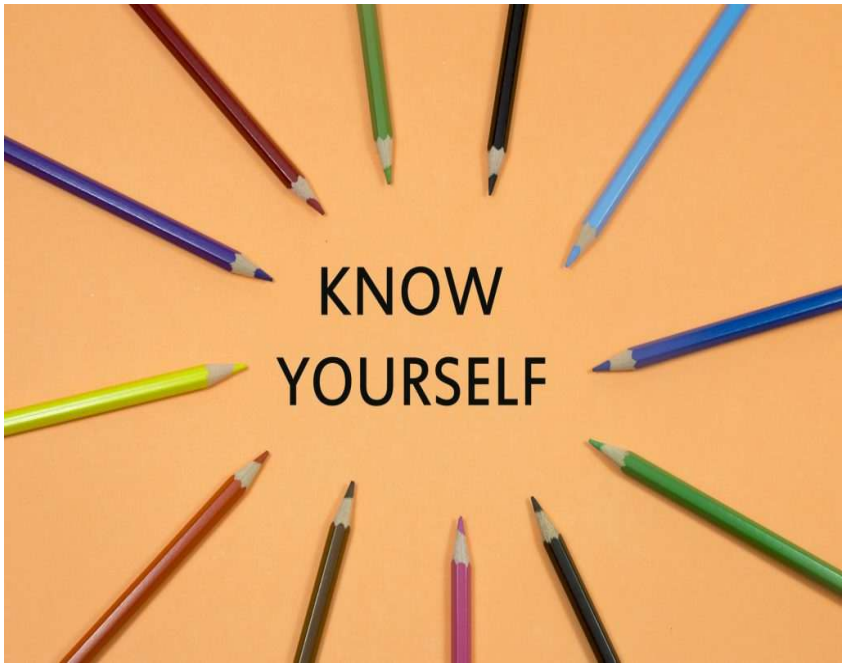
Who collects the resident information? Who do you obtain the information from? Part of your admission process?

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?



Resident Information Summary



Know
Yourself first,
then know others

Reducing our contribution to “behaviors”: Communication

- Respect
- Adapt your communication style, pace to what the resident needs (Simplify, open v. closed-ended questions)
  - Ensure the 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- ill recently? Pain issues? Increased cognitive decline, medication effects (new?)
- Times of day
- During transitions/changes in activity (restless, boredom)
- Unfamiliar staff or low numbers of staff (weekends)
- Environmental stressors present

- Track patterns and be proactive

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De-escalation Steps for Crisis:

- Remove perceived threats
- Create Space- don’t crowd them
- Join the person’s side
- Lower eye level,
- Use calm body language and voice
- Reassure verbally
- Address immediate needs (e.g., warmth, hydration) while following the resident’s pace

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

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

After an incident happens

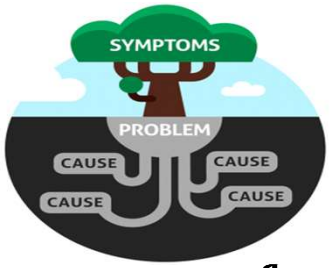
- Ensure immediate safety of all involved
- Assess and provide support services needed
- Identify root causes
  - Who/what/where/when/why
  - Help you learn from crises/incidents
- De-brief
  - With staff
  - With residents
- Evaluate care practices
  - Document and update ISPs
  - Make sure all staff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

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

Key Direct Caregiver tips:

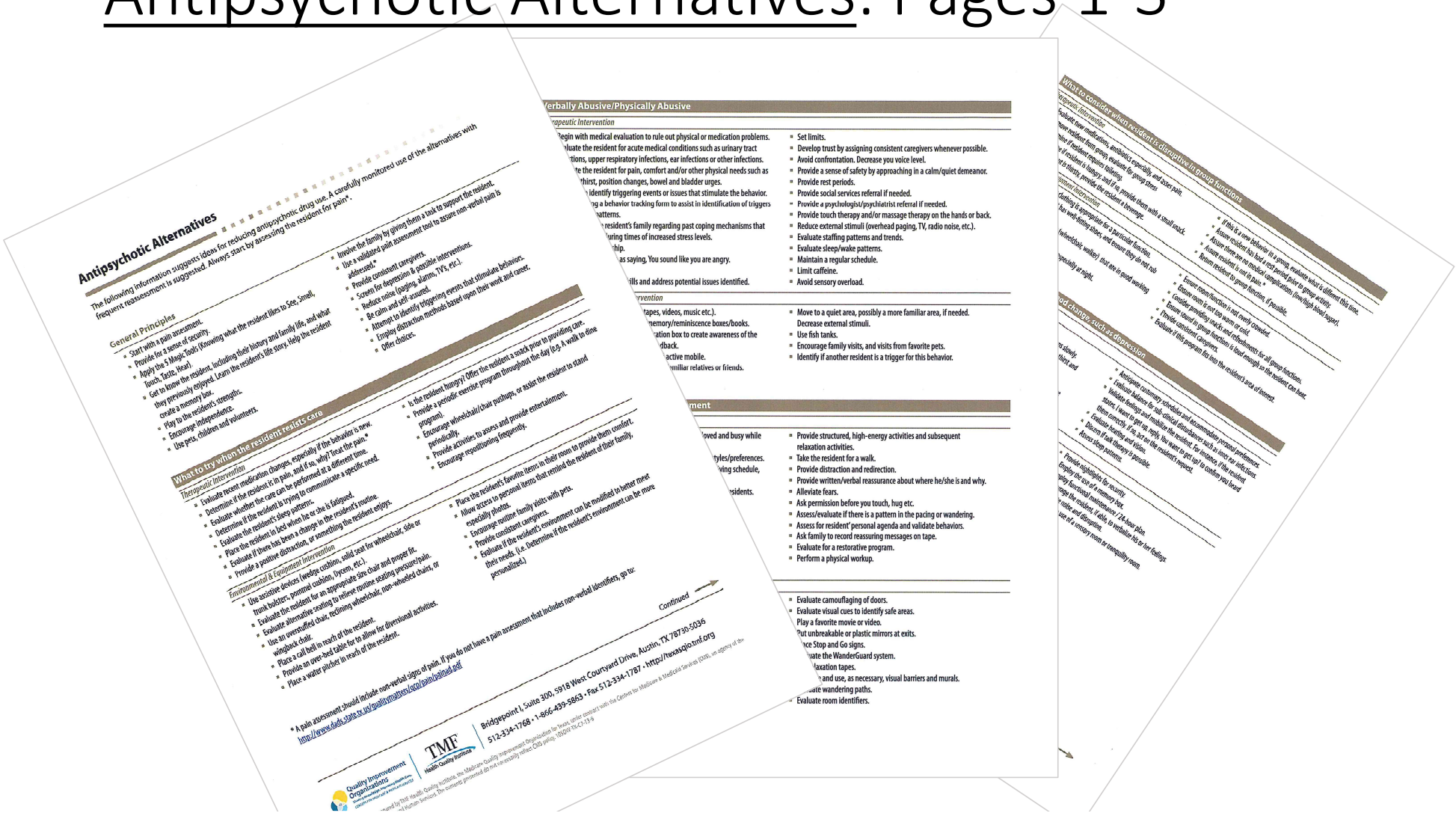
- **Step Back:** Pause when situations become frustrating. Analyze the person's abilities, possible unmet needs, and underlying emotions before reacting. This shifts the caregiver role from directive to supportive.
- **Respond, Don't React:** Avoid raising your voice or repeating instructions. Reflect the person's words back to them, acknowledge their feelings, and gently guide rather than correct, which strengthens the connection and reduces conflict
- **Flexible Planning:** Create a plan with contingencies. Dementia care often requires adapting when routines or responses do not go as expected. Always have Plan B or C ready.
- **Control What You Can:** Focus on modifying the environment, sensory input, and activity pacing, rather than trying to change the person's behavior or cognitive decline. Provide a safe and structured space that supports independence.
- **Self-care for Caregivers:** Take breaks, practice deep breathing, and ask for help when needed. Your emotional state directly influences the person with dementia. Calm caregivers promote a calmer environment for the person they are supporting.

Non-Pharmacological Approaches to Care addressing Resident Issues:



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

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 box.
- Play to the resident's strengths.
- Encourage independence.
- Use pets, children and volunteers.
- Involve the family by giving them a task to support the resident.
- Use a validated pain assessment tool to assure non-verbal pain is addressed.*
- Provide consistent caregivers.
- Screen for depression & possible interventions.
- Reduce noise (paging, alarms, TV's, etc.).
- Be calm and self-assured.
- Attempt to identify triggering events that stimulate behaviors.
- Employ distraction methods based upon their work and career.
- Offer choices.

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.*
- Evaluate whether the care can be performed at a different time.
- Determine if the resident is trying to communicate a specific need.
- Evaluate the resident's sleep patterns.
- Place the resident in bed when he or she is fatigued.
- Evaluate if there has been a change in the resident's routine.
- Provide a positive distraction, or something the resident enjoys.
- Is the resident hungry? Offer the resident a snack prior to providing care.
- Provide a periodic exercise program throughout the day (b.g. A walk to dine program).
- Encourage wheelchair/chair pushups, or assist the resident to stand periodically.
- Provide activities to assess and provide entertainment.
- Encourage repositioning frequently.

Environmental & Equipment Intervention

- Use assistive devices (wedge cushion, solid seat for wheelchair, slide or trunk bolsters, pommel cushion, Dycem, etc.).
- Evaluate the resident for an appropriate Stre chair and proper fit.
- Evaluate alternative seating to relieve routine seating pressure/pain.
- Use an overstuffed chair, reclining wheelchair, non-wheeled chairs, or wingback chair.
- Place a call bell in reach of the resident.
- Provide an over-bed table for to allow for diversional activities.
- Place a water pitcher in reach of the resident.
- Place the resident's favorite items in their room to provide them comfort.
- Allow access to personal items that remind the resident of their family, especially photos.
- Encourage routine family visits with pets.
- Provide constant caregivers.
- Provide the resident's environment can be modified to better meet their needs. (i.e. Determine if the resident's environment can be more personalized.)

* 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.dads.state.tx.us/qualitymatters/qro/pain/painad.pdf

Continued

Quality Improvement Organizations
TMF Health Quality Institute
Bridgepoint I, Suite 300, 5918 West Courtyard Drive, Austin, TX 78730-5036
512-334-1768 • 1-866-439-9863 • Fax 512-334-1787 • http://texasqio.tmf.org

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.
- Develop a behavior tracking form to assist in identification of triggers and patterns.
- Interview resident's family regarding past coping mechanisms that worked during times of increased stress levels.
- Evaluate relationship.
- Reflect back what is saying, You sound like you are angry.
- Review skills and address potential issues identified.

Intervention

- Provide tapes, videos, music etc.).
- Provide memory/reminiscence boxes/books.
- Provide aquation box to create awareness of the feedback.
- Provide active mobile.
- Contact familiar relatives or friends.

Intervention

- 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 workup.

- Set limits.
- Develop trust by assigning consistent caregivers whenever possible.
- Avoid confrontation. Decrease you 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.

- 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.

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

What to consider when resident is disruptive in group functions

- If this is a new behavior in a group, evaluate what is different this time.
- Assure resident has had a rest period prior to group activity.
- Assure there are no medical complications (low/high blood sugar).
- Assure resident is not in pain.*
- Return resident to group function, if possible.

- Ensure room/function is not overly crowded.
- Ensure room is not too warm or cold.
- Consider providing snacks and refreshments for all group functions.
- Ensure sound in group function is loud enough so the resident can hear.
- Provide consistent caregivers.
- Evaluate if this program fits into the resident's area of interest.

...d change, such as depression

- Anticipate customary activities and accommodate personal preferences.
- Evaluate balance for sub-clinical disturbances such as inner ear infections.
- Validate feelings and mobilize the resident. For instance, if the resident states, I want to get up, reply, You want to get up? to confirm you heard correctly. If so, Are on the resident's request.
- Evaluate hearing and vision.
- Discern if talk therapy is possible.
- Assess sleep patterns.

- Provide nightlights for security.
- Display clocks and calendars.
- Display the use of a memory bee.
- Provide functional maintenance / 24-hour plan.
- Encourage resident, if able, to verbalize his or her feelings.
- Evaluate routine and disruption.
- Evaluate if a sensory room or tranquility room.

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**

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% 2-4 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 hospitalisations of the elderly. Arch Intern Med. 1990; 150:841-5 6 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 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

Self-Medication Tracking Tool for Assisted Living: Page 1

SELF-ADMINISTRATION OF MEDICATIONS TRACKING TOOL

Resident_____

Apt_____Year_____

Responses: (Y) Yes (N) No (N/A) Not Applicable	JAN	FEB	MAR	APRIL	MAY	JUN	JUL	AUG	SEP	OCT	NOV
CRITERIA TO BE ASSESSED:											
1. Can see time and accurately tell time											
2. Can distinguish colors, shapes											
3. Can read their medication labels											
4. Can open medication containers											
5. Can grasp tablets/capsules and remove or pour liquids in specific amounts											
6. Can swallow medications without difficulty											
7. Can administer eye medications											
8. Can administer ear medications											
9. Can administer nasal medications											
10. Can administer inhaler medications											
11. Can administer nebulizer medications											
12. Can administer vaginal medications											
13. Can administer rectal medications											
14. Can administer transdermal patch											
15. Can administer topical medications											
16. Can prepare/administer subcutaneous meds											
Can state reason for use of ALL MEDICATIONS											
Can state amount to take ALL MEDICATIONS											
Can state frequency to take ALL MEDICATIONS											
SELF-ADMINISTRATION OF MEDICATIONS IS ADVISABLE:											

Self-Medication Tracking Tool page 2

Comments:												
JAN:												
FEB:												
MAR:												
APRIL:												
MAY:												
JUNE:												
JULY:												
AUG:												
SEPT:												
OCT:												
NOV:												
DEC:												
Assessor's Sig/Title:							Assessor's Sig/Title:					
Eval Date:							Eval. Date:					
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Dementia Care Training Resources

Teepa Snow YouTube Trainings

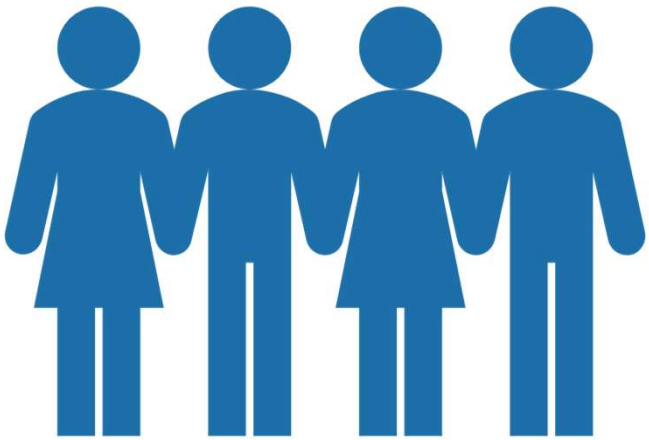
- https://www.bing.com/search?q=https%3A%2F%2Fwww.youtube.com%2Fwatch%3Fv%3D6Zfv5UkuQFM&form=IPRV10

Cares Dementia Specialist Training Program

- https://www.hcinteractive.com/CDS?gclid=EAIaIQobChMI98LO7vGW4wIVlZOzCh15aAWcEAAYASAAEgIqCvD_BwE

Alzheimer's Association

Alzheimer's Association | Alzheimer's Disease & Dementia Help



"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**"