3-136 Dealing with staff attitudes

TIPS Question:

There were a lot of mixed reactions from the staff at all levels & all departments when a male resident began making sexual advances toward a female resident. How could we have minimized the emotional turmoil due to widely differing beliefs, values, attitudes, etc. of staff before an assessment was completed and a care strategy developed?

What are the significant factors you have learned as a result of working through the six-question template?

- This behaviour has meaning – to view it in the context of the whole person
- Need to look seriously at the possible causes of the behaviour in order to understand it and to develop a strategy - important to look at resident's possible cognitive losses – these losses can be huge.
- I was particularly impressed by the implications of agnosia and anosognosia

Response:

The expression of affection by residents with dementia who are living in long term care can represent a number of challenges for care, both for staff and family members, and certainly the resident(s) as well; particularly if a relationship involves sexual contact and intimacy. At the same time as recognizing and supporting residents' needs for human contact and sexual expression we recognize the emotional dilemma staff and families often face.

Complications in decision-making regarding care and team distress usually result whenever the values, wishes and beliefs of team members (including family) conflict. You want to avoid having the care directed by any one team member (based on his/her own personal values/beliefs) in isolation of shared team problem solving or without considering of the needs and wishes of the resident(s) involved. Unfortunately this is what often occurs and not uncommonly because there is an absence of meaningful guidelines regarding sexuality and intimacy within the facility. In order for the needs of residents to be met in any meaningful way there must be effective communication between and among the partners in care, ensuring that all issue/concerns are addressed and decision-making is informed with complete and accurate information. It is important to take a step back as a team to reflect and refocus on the issues using the 6-QuestionTemplate. This will help you to more objectively and systematically identify the issues that need to be addressed and understand the behaviour – it is this *shared understanding* that should drive the care planning, not individual beliefs and values.

Remember to use the U-First! wheel with the team to help get you started in this 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).

Using the wheel and the 6-Question template you want to ask the following questions:

- Have you clearly and objectively identified all of the care/behavioural issues that exist at this time?
- Once the issues have been identified, what assessments have been undertaken thus far to help understand and describe this resident's behaviour, in the context of P.I.E.C.E.S.
- Do you have a clear impression of his cognitive function (MMSE/clock; 7 'A's) and how this affects his decision making and the way he is experiencing the world around him? You have clearly consider the 7 A's yourself – how have you shared this with the team using the wheel? Considering this **"I"** in P.I.E.C.E.S., objectively discuss issues related to the competencies of the residents involved re: ability to participate in decision making, ability to avoid exploitation, etc.

- Have you considered doing a DOS to help objectively capture his behaviour – when, how often, where, etc?
- What are the risk issues for the resident, other residents and the staff and family members? It is essential to consider this question objectively – not just the perceived risk based on the personal values, wishes of particular team members.
- You need to have this discussion with the team and think about the different opportunities for coming together to talk e.g. during report, scheduling a staff support session (do not call it an in-service), asking your PRC to attend and help, etc.
- Involve the Specialty Outreach teams and/or Compliance Advisor proactively.
- Remember to use the RISK acronym as this is a helpful way of identifying where there is risk and as critically where the risk is minimal or no risk (put it on flip chart and brainstorm together as a group). It will also help you to meaningfully weigh out the pros and cons associated with decisions regarding care.
- Regarding specific concerns about the issue of sexual expression and intimacy between residents in long term care, it is extremely valuable to review the process your facility uses to promote healthy, supportive and open communication between and among team members (including family members and the residents involved) when sexual behaviours emerge. How do you respond, is there a policy or framework in place that will meaningfully guide you, if one exists does it need to be revised, etc? You will find an "*Intimacy, sexuality and sexual behaviour in dementia"* guide posted on the P.I.E.C.E.S. website (www.pieces.cabhru.com). This document can be downloaded for your review and to determine if it will assist you. There are several tools included in the guide that you might find helpful, including a Worksheet (found in Appendix C) designed to help enhance communication between and among family and other members of the care team re: how to objectively describe the behaviour, assessment of risk associated with the sexual behaviour, and how to meaningfully consider the various viewpoints regarding the sexual behaviour. There is also an excellent reference list contained within the document including a reference to a video called *Freedom of Sexual Expression: Dementia and Resident Rights in Long-Term Care Facilities."* I have often incorporated this video into a case-based staff support session to help re-frame the discussion and ensure that it keeps the focus on the resident(s) at the centre of the discussion and problem solving and not the individual values, wishes and beliefs of the various team members.
- Finally, I always find it helpful to ask the question as a team – do you consider the facility to be a facility managed by the staff, in which the residents live, or do you as staff come to work each day in the residents' "home"?

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.*