3-220 Staff fearful

TIPS Question:

What suggestions do you have for dealing with a staff member that is frightened of a LTC resident with dementia and aggressive behaviour that she received from him? We have tried education and Seniors' Mental Health has brought in education material. We are working as a team with Seniors' Mental Health but in the meantime this staff member is very anxious when having to work in the same area as the resident.

Response:

It is great to hear that you are working as *team* – that is what U-First! is all about, team problem solving! I commend you for taking steps to assist your team member by recognizing (*flagging)* the fear triggered by her *interaction* with this resident and then following with attempts to provide her with meaningful education to enhance her *understanding* of what this gentleman's aggression might mean i.e. what he is trying to communicate through his behaviour.

It is unfortunate that she continues to be anxious when in the resident's presence. Not uncommonly, however, persons with dementia do respond with agitation, anxiety or even aggression when receiving care from staff who are obviously apprehensive when interacting with him/her. We can understand this response if we consider how much of our interaction with other people is influenced by our nonverbal behaviour e.g. tone of voice, facial expression, posture, eye contact, etc. In fact, approximately 80-90% of our communication with others is nonverbal.

Consider the person with dementia, (reflecting on those 7 A's found under Question #5 in the P.I.E.C.E.S. Guide), who becomes easily overwhelmed with activities of daily living, whose access to information may be 30 or more years ago when he was still able to do things for himself, who does not know that he needs help and who is having increasing difficulty understanding the spoken word. It only makes sense that he might become "defensive" in his behaviour when staff approach him for care. He is simply acting on what his brain is telling him – that is his "reality." Understanding his reality is what helps us to develop the most meaningful and *supportive care strategies*. Knowing what he can and cannot do for himself, what specific help he requires and what aspects of his care need direct hands-on assistance is of course very important. However, even more critical is the way in which the staff member interacts with him.

- Does she know enough information about this gentleman's remote past (i.e. those memories that he is most likely to have access to, that might reflect his present reality; such as those "mountain top" experiences that may trigger a happy response) to engage him in conversation *before* attempting any care?

- What tips has she received in terms of nonverbal communication i.e. making eye contact first and smiling before saying anything to him (giving time for it to register), telling him in a friendly, gentle but *confident* manner how nice it is to see him, reminding who she is (while still smiling), and then initiating conversation about his remote memories, always moving slowly one step at a time, and taking cues from him?

I am sure your educational material reflects suggestions such as these. I wonder if you might consider some of the following strategies to further enhance the understanding of this staff member and indeed any of those other team members who are experiencing similar anxieties when interacting with the resident.

- Have a case-based staff "support session" (avoid calling it an "in-service) and ensure that it is scheduled when the staff who are having the most difficulty can be present – you may have to repeat the session. Staff usually are happy to attend when they know the session is not going to be a lecture and that they will have an opportunity to talk about their frustrations, concerns, fears as they relate to a specific resident or care situation. You also want to ensure that you have staff present who feel confident and successful interacting with the resident.

- At the session you might begin by asking the team members as a group to identify their concerns and he behavioural issues – get them out on the table, so to speak. Then ask them as a group what they

think might be the possible causes of the behaviour – you need to start where they are at in terms of their understanding. Use the U-First! wheel to help them think in terms of P.I.E.C.E.S. You may focus more on "I" and ask them what they think is the resident's "reality." I always find it helpful to use the following experiential exercise:

1. Walk through the following with a staff member at the session, allowing the person time to respond.
    - What if I were to say to you this is not ___ (whatever the current date is) and you are not a staff member working at this facility.
    - How do you feel?
    - What if I was persistent? What if over the course of the day all of us start saying the same thing to you?
    - What if we wouldn't let you leave the room?
    - Now imagine that I also then approach you to say it is time for you bath and start to remove your clothing.
    - What is your reaction? Is your behaviour aggressive or defensive?

2. Ask the group to think about it! Comments to add:

    - Remember, your reality is as real to you as the person with dementias reality is to him! This helps us when faced with challenges related to the changes in behaviour. Whenever confronted with these challenges, remember to ask yourself; what do I understand about this person's reality here and now (remember, can fluctuate too); where is the person in place and time? Point out that this gives them a starting point to guide the way they are *interacting* with the resident!

3. Brainstorm together as a group the possible strategies – what works and what doesn't work – both verbal and nonverbal.

4. Other concepts to try and share with staff include the concepts of *response* and *perceived control.* You may even want to use some of the strategies for staff learning that were included in Day 4-5 of the P.I.E.C.E.S. session to assist staff to understand and appreciate that *we teach each other to behave* (under Question #6 P.I.E.C.E.S. Guide). 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.

    - You might also try to buddy the staff member who is still very anxious with a staff member who interacts confidently and skilfully with the resident, so that she can see the interaction being modelled for her.

    - Try having the staff member then interact using these effective communication strategies in a non-care situation e.g. approaching the resident to simply initiate contact without trying to administer care.

    - Have you shared the results of the DOS to help recreate a chain of events to show how the resident's behaviour (i.e. response) is influenced by the team members who are involved in his care at the time? Keep in mind, however, that you need to interact with the staff in a supportive and validating manner so she does not view this as a reprimand or in any way punitive.

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.*