3-77 Risks of companionship

TIPS Question:

A resident in the secure unit for residents with Alzheimer Disease is frequently exit seeking. He has on occasion banged his fist on the glass window or tried and kick out the small screened section, and if he happens to be near the locked exit when someone is leaving, he will race to get out, fighting to get through the door. He also will occasionally follow female residents around thinking they are his wife, or will ask everyone if they have seen his wife. He has also been found in bed with other residents. He does not believe that he lives with us, or that his wife is gone; in his mind he has a wife and children to go home to. I was very surprised to discover that he scored 29 on the Mini-Folstein, and after the P.I.E.C.E.S. training I realize that his emotional/intellectual needs are not being met and I'm trying to make accommodations for this. In the process, he seems to become more attached to female staff who try giving him a little more time/attention that is not work related. He now wants to know if we're coming to bed, where we're going to sleep, are we going to eat dinner with him etc.? I don't feel he is being sexually inappropriate, just looking for the lost companionship of his wife and family. I have never seen any visiting family.

My question is: Are there any risks involved if, in trying to meet his needs, he sees female staff as his "companions".

Response:

This is an interesting situation and I think that it is very important to consider the risks of this misinterpretation.

This is much like any other intervention that we may use. There are risks associated with its use but there are also risks of not using this approach. Perhaps a risk of correcting him when he misinterprets staff as companions is an increase in his overall level of anxiety with the potential for escalation.

A quote from the P.I.E.C.E.S. guide states that: “RISKS should always be considered in the context of the person's values, wishes, beliefs, and life experiences.”

What is known about this man's social history, the 'S' in his P.I.E.C.E.S.? What type of work did he do? Was a certain level of familiarity the norm in his experience? If he was connected to a fairly tight-knit yet casual group, this intervention may have low risk. If he worked in a more formal, reserved work setting then there may be some risk to manage in the use of this type of strategy.

I assume that you have already worked through the P.I.E.C.E.S. six-question template and I comment only on the 'S' because this strategy relates to social interaction.

You are attempting to support this man's emotional needs and perhaps your efforts would be enhanced by gathering more information from a social perspective. While you have not seen family visiting, who is his primary contact? What can they tell you about his past? What can this man himself tell you about his career, his family and connections?

What do those people involved in his care *understand* about his abilities, losses and needs? Has there been an opportunity for staff to discuss how they approach this man and whether or not they feel comfortable with the idea of his misinterpretation of them as companions? There may be a great diversity in *interaction* and therefore in what staff *report/record*. A very detailed discussion about what is okay and what is not will allow you to monitor this situation over time to ensure that it remains an acceptable strategy to *support* this resident. By using your U-First! Wheel, you may facilitate a dialogue on an ongoing basis as you unravel the best care strategies for this man.

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.*