3-185 Procedure for moving to locked unit

TIPS Question:

We have an 82-year old cognitively impaired resident in our LTC facility. He exhibits numerous behavioural problems, is dependent for all ADLs. Wife as the main caregiver is unable to care for him, due to his outbursts and frequent falls. What procedures can a multi-disciplinary team do to help move this resident from an active unit to our Alzheimer's locked unit? We hope to use this procedure for future residents.

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

- Communicate with staff common goals for resident & family
- Need for continuous evaluation of what works or doesn't
- Need to reinforce positive improvements

Response:

1. **What is the behaviour- cognitive/ mental health need?**
   My understanding of this situation is that the staff wish to transfer this resident to a locked unit for cognitively impaired individuals. It would be important to do a thorough assessment of this individual's abilities, identify challenges, triggers to the behaviour, difficult times of the day, and to develop strategies for the care which would be appropriate for either unit in the facility. In this case it is not stated what the challenging behaviours are.
2. **Who is it affecting?**
   There is no indication of whether this client's spouse is also living in the LTC facility however it is stated that she is the primary caregiver, and cannot manage. It sounds as though she is suffering from caregiver burden. Are the co-residents and staff being affected by the behaviour/risk?
3. **What is the degree or risk?**
   Is the resident a risk to co-residents and staff? Is the client a wandering risk presently? What is the cause of the falls?
4. **How do we describe and record what we see?**
   An excellent tool to track behaviour and determine challenging times of the day is the Dementia Observation System (DOS). It documents a complete picture of the resident's functioning for a 7-day stretch, 24 hours a day. The Cohen Mansfield Agitation Inventory may also be useful.
5. **What are the possible causes?**
   It would be important to determine any reversible causes of the resident's behaviour. When did the behaviour and outbursts start? What is the pattern of the cognitive decline? Is it a long-standing decline or an abrupt change in the resident's condition?

   P. Is there any reversible component of the cognitive decline? A review of lab work, medical conditions and medications (start dates, and necessity) needs to be completed. BP lying and standing.

   I. A Folstein Mini Mental Status would be helpful as a screen to determine cognitive impairment. The Confusion Assessment Method can be used to screen for delirium.

   E. Is there evidence of anxiety, depression (SIGECAPS), or psychosis (7 D's)?

   C. What are the client's abilities? The Abilities Assessment Instrument may be helpful to determine the client's capabilities. Do they need an OT or physio assessment? Has recreation found activities/stimulation that capitalize on his past interests?

   S. Are there any family members, volunteers, students, recreationists, or pastors who can assist in the care of this gentleman? Is the spouse the substitute decision-maker for the resident's personal care? What are their wishes in this case? Is there a power of attorney?

6. What are the steps for providing the best care strategies?

It would be a good idea for the Multidisciplinary team to meet and review the resident's case using the P.I.E.C.E.S. framework and then brainstorm together regarding the appropriate care and living situation. It would be important to do the assessments and implement a plan of care to address the issues, and evaluate the efficacy of the interventions prior to moving the resident. Moving a resident can be very disorienting and can cause delirium and increased behavioural difficulties. The degree of risk for the resident, co-residents, family and staff will determine the rapidity with which assessment/implementation/evaluation take place.
The behaviour, level of cognitive impairment, risks, care needs, mix of residents, and assessments of professional and care-giving staff as well as the wishes of the substitute decision maker will all need to be taken into consideration in the decision for the appropriate living situation for this resident.

Other suggestions:

Remember to use the U-First! wheel to promote team conversations about resident as they seek to understand the behaviour and what this resident is trying to tell them through the behaviour.

1. Orientation of families and residents to the LTC facility to include education regarding different levels of care, cognitive decline, and behaviour to be anticipated in residents with dementia. Pamphlets and fact sheets may be useful.

2. Baseline assessments of clients upon admission using a holistic framework and tools to quantify assessments. Tools to be repeated if there is a change in the resident's function or behaviour.

3. Implement screening for reversible causes of cognitive impairment/delirium and behavioural changes.

4. Streamline medications. Use non-pharmacologic approaches for dementia care.

5. Use mini-case conferences for review of challenging cases and pro-active care.

6. Support & educate family members as appropriate. Use fact sheets, pamphlets, social workers. Establish monthly meetings for support and education of families and friends of residents. Invite family members and friends to join these sessions when their loved one is admitted to LTC.

7. Consult with substitute decision-makers in care decisions.

8. Use the partners in care, multidisciplinary team/family/volunteers to assist in the assessments, strategies and implementation of care.

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.*