TIPS Question:

How do I get all staff to communicate on what we can do about this resident? Staff are getting angry and some are refusing to do her. The physician has tried many psychotropics and they are not working. This has been over a long period of time.

Response:

This is a very difficult situation. You have identified a very important piece of information: "staff are getting angry". This is a common staff response to difficult behaviours and goes unnoticed much of the time. It is excellent that you are aware of the staff's feelings and have identified it as an issue. This issue must be dealt with before you can get to the issue of "how do I get all staff to communicate". Before staff can be efficient and creative on communication strategies, they must feel positive and committed to the care plan.

1. Dealing with staff's feelings:

   How do you know how staff are feeling? Are they telling you, each other, or is it their behaviour of "refusing" to do care for this lady? Try to meet with as many staff as you can and allow staff to vent their feelings of frustration. Tell them its O.K. to feel negative about the person's behaviour, it does not mean they are not good health care providers. Facilitate this so that the staff are talking about the person's behaviours, not the person herself. For example, "when she says this to me, I feel _____"; instead of "she is very mean because she insults me". If a group starts to label the person then it is more difficult to have them feel positive about the care plan. After the group has vented. Ask them why they think she may be exhibiting these behaviours. Let them brainstorm on this for a few minutes. Keep a list on a flipchart if you think it is appropriate. Usually staff list such things as loneliness, loss of control, disease process, past personality, environment, pain. At this point you may have some background information you can briefly share about the person. This helps staff see the person as an individual with a background, family, feelings, etc. It is sometimes difficult for us to remember that the person was once like us, not always in a facility with difficult behaviours. Think back to the spring training when we talked about personhood and the "Hello In There" video. Staff report that they have more tolerance for the same behaviours when they know more about the person. End this discussion with staff asking them to think about what we can do to decrease some of these behaviours based on some of the possible causes that were listed. This entire session could be brief, 15-20 minutes long. You want to send the message to staff that they are supported and you hear what they are saying. There are no easy answers for this lady that can be decided in one session. You can get together again in the future to brainstorm on some of their ideas on how the environment, their approaches, etc. can be altered to decrease some of the behaviours. Write a one page point-form summary of the discussion for staff to read that could not attend. I often ask those staff to initial the top to show that they have seen it and are aware of what is happening.

2. Communication issues:

   Communication sounds so much easier than it actually is. Invariably there are people that 'never heard' of the new care plan, behaviour approach, etc. This is a product of human dynamics and cannot be completely avoided. You and your care team must decide on which behaviours you wish to deal with. To help you, use the Dementia Observation System (DOS) and the Cohn-Mansfield Agitated Inventory-found in section #7 of manual. Then have your second meeting to discuss staff's thoughts on what seems to work with her and what doesn't. Again, this meeting can be 15-20 minutes long and have a point-form summary for the rest of the staff. Different facilities have come up with various communication aides: communication book, bulletin board, photocopies for all staff, etc. The most important thing you can do, regardless of which communication aide you choose, is to have ONE PERSON in charge of facilitating a behaviour plan for this lady. This way no-body 'drops the ball' and this one person can follow-up on meetings that should occur and people that need to be notified. This person does not have to do everything, but should facilitate everything: make sure it gets done. This seems to be the most important for success in communication. There will also be staff that do not 'buy in' to the behaviour plan. Try to identify who these individuals are

and see what their ideas are in relation to others. Usually, these people have very good ideas that are not too far off what the others think, they just are not feeling supported. Be open to everyone's ideas and give them a try. This is sometimes difficult when you feel it is not the best idea. I have learned from experience that it is more important to go with the staff's ideas, even if they are not exactly what I would do, because then they feel more committed and invested into the care plan. As everyone implements the plan/approach, they will see if it working or not and you can gently suggest variations to the approach.

3. Psychotropics not working: It sounds like you have tried a lot of things with this person. This is probably a good time to step back and look at her with fresh eyes. She also may have changed since you originally tried different interventions. Work through the 6-question template and look for contributing factors you may not have tried before. Does she suffer from a depression? Is there a pain issue? Would she benefit from a Pro-Attention Plan? Are there Care Partners that could be more involved? Remember that 'consistency' is very important when attempting to alter behaviours. Charting helps staff measure whether or not they are as consistent as they feel they are. The DOS will be very good for that. Also, give some interventions time to work, sometimes we are too quick to say something did not work when, in fact, we weren't consistent and we didn't try long enough.

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.*