2-18-21 Deer Oaks live webinar

Sensing neurocognitive impairment, quite a mouthful for you who are here in Indiana.

0:09

Welcome to the frozen tundra.

0:12

It says, We've got quite the winter going on at the moment.

0:17

My name is Betsy Daffron, and I am the task order director for ...

0:22

Source, which is the quality improvement organization for Medicare here in Indiana.

0:28

With me, I have Teresa Hostettler.

0:30

Here's one of my teammates, who is one of our nursing home quality improvement advisors. And she's going to help monitor chat during the session.

0:39

Yeah.

0:40

Our speaker today, is Cynthia Baker.

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She has practicing psychotherapy for 17 years.

0:49

And as the regional clinical Director for Deer Oakes Behavioral Health, she is a behavioral health expert and often presents educational courses about behavioral health and long term care culture change, and person centered care.

1:04

Cynthia serves on the Missouri State arm of Pioneer networks', Missouri Coalition, celebrating Care Continuum Change, Executive Board of Directors, the National Association of Social Work, National Aging Practice Specialty Committee, and there's a Rush Rossier, Doctor of Education student at the University of Southern California.

1:28

We're really glad to have Cynthia.

1:30

She's taken us through three sessions, this is the final one, we're wrapping up.

1:35

Just a reminder to you all, you can put questions in either the questions section over on the right hand of your screen, or in the chat section, and we'll be happy to get those to Cynthia.

1:50

I will also mention that we're going to have several polling questions throughout this presentation, so be watching for those, and we hope that you participate in those.

2:01

With that, I'm going to turn it over to Cynthia to kick us off and get us started.

2:08

Great, thank you all, and welcome to, to our third webinar in this series.

2:14

As Nancy said, it is a mouthful, but I felt like managing difficult behavior is a complex, and it is a common, a common denominator for many of our long term care community. And then, you know, the language around constructive responses, right?

2:35

A little different than behavior management.

2:38

It's kind of like, just managing the behavior, right, and helping with responses to the resident that improves their quality of life and person centered care. And this is going to be focused, primarily, on folks that have some level of neurocognitive impairment. So they may not have a formal dementia diagnosis.

3:00

But we know that these techniques, and kind of this insight and problem solving can work for most level of intelligence, as well as folks with a dementia and health stroke, Parkinson's disease, and other issues, just really help reduce, reduce, behaviors, but also, to improve their quality of life.

3:30

So, we'll get started. There are, there is a handout available to you as well as a PDF of the slides, and you're welcome. Welcome to have those downloads. They will not be available after the course. Go ahead and download your campaign.

3:47

The learning objectives for today are at least a few of those learning objectives are the participant. She'll be able to gain some important information about the types of behaviors and then kind of the root causes or ideology.

4:02

You'll be able to lift at least six regions for that inappropriate or difficult behavior. Then you'll be able to utilize it.

4:11

And you'll have at least five preventative, or kind of, problem solving approaches to reduce problem behavior.

4:23

The evidence tells us that we basically just break, and there's all kinds of different kinds of behaviors that may come out.

4:32

But, we kind of grouped them into for verbal type agitation, which may, well, and we'll be discussing the repetitive questions, calling out frequent requests, and maybe complaining of kind of verbal agitation. And then, basically, non aggressive behavior, but restlessness, maybe \*\*\*\*\*, apathy, withdraw, making noises, maybe exit seeking or resident may be monitoring.

5:03

And they're looking for, then the third section is, is verbal and physical aggression.

5:09

So that might be more towards staff or other residents around kersting, threats, screening for the sexual inappropriateness and, you know, physical touching that, that would be inappropriate.

5:31

No.

5:33

Defining behaviors. I really, really like this slide because I think it promotes some discussion, especially much amongst your care team.

5:41

Regarding need to ask not just one individual right, not not only the foreigners, but maybe the team as a whole who's involved in the care planning.

5:53

Asking these questions when we're looking at the behavior, right?

5:57

and versus making assumptions as to what is causing a behavior, or something that we can't fix?

6:06

So what is happening? So what is the of that? Right, just concretely what has happened? And then, who is involved?

6:14

Because sometimes, when we look at who is involved, and then we look at, where does the behavior occur?

6:21

one example I have is in the dining room, and now that folks are there, some dining rooms are starting to open up, and even though their people are six feet apart, you know, the dining room.

6:35

Present, excellent, socialization and support, but we'll know that some people may, especially in the past or now, they may get agitated at the level of noise.

6:47

For example, right, and there may be behaviors that happen only in the dining room, only happen at a certain time of day, and maybe they happen with certain staff or with certain residents.

7:01

Then, when you look at that, when does it occur, right, We know that there could be and we're going to talk about undoubting that there could be times of day that that individual may not be as cognitively no, kind of together to realize or to stop or to prevent their own behavior.

7:23

So, where does it occur? And then, why is that behavior happening?

7:27

We may not get to that until we answer these first four Ws and then, kind of link, then, what needs to be done?

7:36

And so, oftentimes, the reason I was talking about care planning, is that the fact that what needs to be done may have to be, it's generally recommended to be consistent, right across, um, a crop different times a day and different shifts.

7:55

So, or different service providers.

7:58

So, it, so this is kind of anticipate, this is a really good kind of starting point when you look at behaviors, that it's not one size fits all ever, as you know, and this is the kinda good, good began.

8:13

Let's see, I think you have a polling question.

8:28

Question, What is the most common disruptive behavior that you have to address, or your team, when working with residents who may have neurocognitive impairment?

8:41

It's a good call, and there'll be a section.

8:45

Or you can also, actually, anytime you want, when we have these polls, if an answer is not present there, you can always put that chat.

8:59

Your question.

9:16

So, you're over half.

9:21

These are about 60% describe verbal agitation.

9:26

And then you've got another 40% that may be verbal, and, or physical.

9:32

aggressive behavior.

9:34

Thank you.

9:38

Will only define the behavior we're looking at.

9:42

Today we'll be looking at solutions with donation misinterpretations, late day confusion, or sundown sleep disturbance.

9:53

And then there's this piece of the comorbid if someone has a diagnosis of depression anxiety, or other chronic mental illness or PTSD. And, so, we will not be discussing those, specifically, but, I think, when you're looking at your six Step, you have to take that into consideration.

10:12

As, Well, if there's something comorbid going on, with our mental health, emotional health, in addition to their medical condition, and coughing that behavior, when you look at your six Studies.

10:31

We look at, as behavioral expert, When we look at behavior, Keep in mind that every behavior has a purpose, and it's not always the purpose that someone may think, you know, we may commonly use words like while their attention, right? But, it could be a combination of things. So, when you're looking at your six W, you know, then you also want to look at, why is this behavior happens? And so, they may, this individual may be seeking attention. They may be quite well.

11:04

Social isolation the co-pay and quarantine this may absolutely be something that comes up escape, kind of escaping, possibly from the thoughts that they may have.

11:21

And it turns into inappropriate um, discussion is different polarization and it may be that they literally want to escape, you know some other thought but also to it.

11:34

No escaping wants to speak to gain tangible items.

11:40

Express feelings.

11:42

And that comes across a lot that neurocognitive condition continues at different stages, and depending on the type, their communication is impaired.

11:55

And so how they express feelings, habits, individual expresses feelings may not be the fact that I feel bad, It may come across, actually, and no one loves it, right.

12:09

Or it may come across as yelling for help.

12:13

So, it's not always a tension, right. It can also be expressing some sort of feeling.

12:18

Yeah.

12:20

And then communicate that that communication may not be the way you and I communicate.

12:28

So as we get to know our residents, what are they trying to communicate in addition to that behavior?

12:35

What is the message?

12:38

Then behavior sometimes anxiety reduction are really restless and we're not always going to do that physically with our older adult.

12:47

Like, we would know a six year old, right running around the room, trying to get rid of that restlessness older adults, you know, a lot of that suicide, and they don't have the physical ability or they don't have a way right to radical agitation.

13:06

Then, the control P, we know that there's been a, there's a lot of losses, and there's lots of independent semi the loss of mobility.

13:14

And then, as we know, as people move into, whether it's a memory care situation from home, or they're moving into long term care, for another reason, to the medical diabetes or another problem, they've lost a lot of their control, attempted behaviors are acted out to feel some sort of control, or to seek some kind of control.

13:48

I am very much, I do a lot of consultation with nursing homes and just my own clinical staff.

13:58

And one of the things is, if we could get out in front of a maladaptive behavior, it's so much better for that resident, and for everyone involved.

14:10

Because then there's not the potential to have feel guilt and shame following a behavior or everyone being up bad or whatever, you know, may occur.

14:21

So I always kinda say, if educators happen, it's happened twice.

14:26

It gets to three times. Well, guess what?

14:28

We need to figure out what's happening, right? The six W and we need to identify precursors to that case.

14:38

So this is a good time if you've got residents at No, that you really should address some things are looking into it deeper, write their name down.

14:49

And as we go through this kind of be thinking about this because the precursors are or causes, or things that might happen ahead of time.

14:59

Um, that's the elements.

15:02

You're going to be able to provide your intervention to prevent kinda, host behavior, right? compatible.

15:11

Because with, with neurological, when people with neurological difficulties, they may not remember.

15:18

Now, what have you told them after last time, that they help out in an activity or they knock appears, bingo card off the table or and inappropriate Kirsty know in a group or touching someone and appropriately? They may not remember that.

15:41

So, if you can get out some of that behavior ahead of time, knowing that it may occur in certain environments.

15:48

And that's going to be helpful because work, aside from what Kovac did with social isolation, we're not allowed to socially isolate people we meet and socialize.

15:58

So, how do we, How do we help them do that with a level of degree of quality? Why?

16:07

So, you want to So, then, we talked about determining the purpose of the problem behavior, then active listening to the resident, then, I always say, validate the feeling, not validating the behaviors that are, right?

16:25

See, validating, I can see that that you're upset.

16:31

No, win, you just know, for example, when you talk to fans. Right.

16:37

Or you're upset when it's time for your shower, and you, you refuse your shower and you give excuses And, you know, kind of these kind of whether it's rejection of care, whether it's other types of things, there's a feeling that height.

16:56

And you know, and then build rapport because that's why the tough part is because if we're always reactive in a situation then we feel like the bad guy.

17:08

And I think we have to, in order to build rapport, I think we have to get out in front of those and help prep people, whether it's specialization, type, things that are coming up.

17:19

And we call that forecasting.

17:23

So I do a lot of work around this. And what you want to do is?

17:30

When an event is getting ready to come off, let's say, shower rejects ..., right So we have a shower and shower day and we've put it on the calendar.

17:42

We created a visual, um, and the shower shower eight counts as It's time for you to take your shower. Are you ready to take your shower, or however this cross, right?

17:55

They say no, I'm just going to take my shower then the aid No, can't make them take shower so No, they leave the room, and then we get a note that they refuse shower that thing. Right.

18:10

one of the things that is to really, if you can get into forecasting during your staff, get used to it. And a lot of them are doing, and I am absolutely certain that you all do very well.

18:23

But it's kind of an idea that we get so busy, we may forget that if we went to mister ..., and we knew, you know, she's difficult for us to get to know to accept her shower, for example.

18:37

Then, I will go through our protocol equally, the Care plan that about a half hour, 15 minutes before the shower.

18:45

I'll actually go to McNair, Showering, or another staff and say, I'm going to come back to get you in 15 minutes for a shower or How outbreak outcome get you for your shower after lunch?

19:00

I want to make this as clear as I can anyway that we're not asking whether she takes the shower.

19:07

We're giving her the toy of an either or and if you can.

19:12

if you could do that with your residents either or versus now or never, you know kind of stuff, they will choose, right? Then you've got a commitment.

19:24

So if they say, Ah, I don't want to do it after lunch. I'd rather do it now.

19:30

Or they may just put it off and go, OK, well, I'll be here after lunch to come get you, then when you return after lunch, No.

19:38

I'd have staff say to me, What if she refuses then, and she can't, but there's an assumption that she agreed to the shower after lunch, so that's kind of how this works.

19:49

So you're building, you're also building rapport.

19:53

In fact, that, know, you tell her that, no, we indeed gave you a choice, and this is a good time, and can we, can we please do it, you know, that kind of thing.

20:05

So it's not perfect, but when I'm trying to kind of get across, is that if you're actively listening to the resident, you might kind of get down to why they're refusing certain showers are certain things and, know some of these folks without getting into specific cases.

20:23

Some of them have symmetry type issues where they hate the hot water. Or, worse yet, they hate the cold when they come out of the hot water.

20:31

So, there's a lot different job right related to that.

20:36

But what we're kind of talking about in general is if you know what behaviors happening, that you're going to, um, that you're going to kind of stand, right?

20:46

And try to get down to ways to provide intervention.

20:53

So, defining behavior and triggers, so I kinda touched on this during our first couple of slides, because now there are different triggers, And so there could be the physical changes.

21:09

Physical pain, excuse me, or medical changes that they experience, so that individual, if it's physical pain, or they've had a recent medical medication change, or they make it a review in medical treatment, right or nursing.

21:26

And then the basic need, is there a need for social context?

21:31

So addressing those basic needs, increased social interaction and reassurance.

21:37

So it's, then you kinda look at the need for simulations.

21:44

So, stimulation, or is there overstimulation, or is that board?

21:52

So you want to kind of break that down And it's going to identify new activity, maybe something that means something to them versus if they don't like what they know, and they refuse. Because then they'll say, well, there's no activities for, me.

22:07

Know, what is a one-on-one, what is an interest.

22:10

And I know, again, you all do a great job with that, because whether it's like the Richmond, whether whoever's doing a one-on-one quarterly, you're getting some of this information.

22:21

But just keep in mind that behaviors often come from this kind of the situation, and we can get up in front of them, And then that need for control, I mentioned.

22:34

And you kinda offer choices, and that, again, isn't: Do you want to take your shower or not write it?

22:41

Do you want to take your shower at 11 45, or do you want to take it, you know, after lunch?

22:48

Then any tasks that you can provide to ask for control.

22:53

Then, misinterpretation of situations and we'll talk about misinterpretation today and then a buyer mental type changes. No, we need to take a look, you know, there might be changes hearing or vision that forecasting, I was talking about what you're doing.

23:11

Kind of do the T but no kind of method A comment coming up in front of that individual, getting it face level, so they can understand you and talk to them, versus right, coming from behind.

23:28

And trying to talk to the back of their head. No tickets, real difficult. So, if you've heard of tickets, now, you probably have, that teach us now also has lots and lots of YouTube.

23:40

So, there can also be a refresher, Know, that we start to do is, we, kind of come out of the social isolation component as a coping, now that we have available vaccines.

23:53

And because we do want to help our best to kind of, get back into a socialization type routine.

24:04

Via the quarantine, infection control.

24:09

So, specific behavioral problems that are associated with the dementia, we're going to talk about delusion, misinterpretations, late day confusion, or some downy. We'll talk about want.

24:28

And that Theresa and the teacher, let me know if any questions come in between our company.

24:36

So specific, behavioral problems.

24:40

And it also included repetitive questioning, altered sleep pattern.

24:45

In some cases, sexually inappropriate behavior, and physical and verbal aggression, we'll be able to talk about I'll be happy.

24:56

So the type of delusion may be there if abandonment, suspicion that possessions are being stolen, feeling that they're not at home, or they need to return home.

25:13

And they make the result, one of your residents may be experiencing trauma, or unresolved conflict earlier periods in their lives.

25:25

What I find often is that it doesn't always make sense, But sometimes in the middle stages.

25:33

Later stages.

25:34

That all old hurt, old harms, bubble up that they hadn't thought about in years and years.

25:43

But as a short-term memory, in some cases, as the short-term memory weekend, this kind of stuff starts to come to the top.

25:51

So you're going to see that was what we call constructive effect. No. Some worrisome. Look. I'm not going to always talk about whatever it is, and it's not always going to make perfect sense to people.

26:05

But it is absolutely something to manage and to deal with.

26:11

And at some level, depending on the state, how advance, the neurocognitive impairment is recommended psychological assessment.

26:23

Especially when either mcnitt or you do that quarterly, and you asked about trauma history, and they answered, yes, no to that question.

26:33

Around trauma.

26:35

Doesn't mean they have a diagnosis of PTSD or or anything, but and it does mean that that they may indeed need someone to listen because it may make some unusual behaviors come across. Hoarding.

26:53

Often happens in these cases, but the delusional thinking can be misinterpreted and so you definitely want to look at all the medical and other conditions because it may actually be an event that occurs. They just have all the, you know, all those memories kind of jumbled up.

27:17

So what I find with dilution is there is often some sort of foundation Felicia.

27:26

So, make sure you have a license that's available.

27:31

Check it out.

27:33

Some misinterpretation misinterpreting the Bible and are non-verbal.

27:40

Uh, no action is threatening or negative, then they kind of respond in a negative manner.

27:47

And so, I have a patient who has Alzheimer's disease, and I create I have a few.

27:54

In this case, she is often has misinterpretation, and she's also giving her stuff away.

28:02

Then she's forgetting that she gets it away.

28:05

So, with that Foundation, as we talk about misinterpretation, know, you'll want an app with you've got an approach, you know, them with respect and kind of front face, listening, you know, just kind of an overall effect that you're willing to listen to them, even though you probably know that it's not accurate information.

28:29

But you want to specify your intentions and forecast actions because misunderstandings happen, even in my sessions with her, that she would come back to the next week with a significant misunderstanding.

28:44

Thinking.

28:44

I've said one thing when I don't think that ever came out of mouth, then getting down in front of the best. Let's say the vaccination because that was the big topic for her, and she is vaccinated.

28:56

But, you know, she's worried and worrying worried about getting back.

29:02

And so, you want to forecast those actions.

29:05

You want to kind of specify and be specific that you may have to create visual in order and handouts and things like that, which we did with her. Just so there's not misunderstanding the important facts that can really get her paranoid and use.

29:26

Then, the misplacing, I see, we found, we figured out finally, that she was giving things away.

29:32

And so then they're found.

29:35

But she was still concerned that they were stolen.

29:39

And then return now. So we'd really talk to the staff and to keep an eye on any of that behavior and get out of it.

29:50

And then I've also talked to her about keeping kind of thing.

29:54

You know what?

29:57

It's kind of an ongoing thing, and we can't always prevent, no, she wants to give that away to a resident.

30:04

But with the staff, we had to have a really we had to have a discussion. I talk to the charge nurse, and we decided we would talk to the DNA's, and they would kinda talk at shift change.

30:17

Because, I don't think anybody was accepting it, but they also weren't giving it back. You know what I mean? It was like, we had to figure out, we actually the envelope bucket, if she tries to give stuff away. But the best thing to do, obviously, tonight, not accept that item.

30:37

We, we can't accept gifts, I can't accept gifts, so, I made that clear to her and achieve to stop trying.

30:46

Accusing family members of stealing your money, asking about financial, and then, you know, I think the family, especially, in her case, helped her with that, then she does have a small purse.

30:58

That should carry, and just, kinda, that continued reassurance that her bills are paid.

31:06

Those are common.

31:08

Then we talk a lot about CVT in our case, because we try to help with the overall misinterpretations of role and people in Hawaii.

31:19

But also the behavior of healing, in the case of rehearsal, you know, helping her, be more mindful.

31:36

I'm going to talk a little bit about wandering.

31:40

We'll have another poll on the next slide, But I know, I think the wandering people were either searching.

31:48

And they're looking for home, or someone familiar.

31:53

And then, no, there also, probably trying to satisfy a basic need.

32:01

And I, I don't, I don't suggest that, Gwen, that we truly understand exactly what is happening with an individual who's searching, that I will say, what has really been working, And we've seen a lot of models around that home, like, kind of, features of comfort, or that individual with visual that they may recognize.

32:25

But if they're up at night, or they're at different times of the day, it really works when the floor staff when that person starts to wander. Again, getting out in front of the behavior, if they're going to start going to the door and hitting the buzzer on the door.

32:41

Or if they are in a, you know, an opening section of the home, and we encourage them, we suggest bathroom, a drink, food.

32:55

And the other thing we do is we have visual that show where the bathroom.

33:00

The other thing I'll bring up and this kind of goes with Sleep disturbance, too, I frequently Awakened. Not every night, But I think the weekend and I get up and have a bowl of cereal.

33:11

So, when I think about, if you think about, if you have any habits like that at night or any kind of, you know, bathroom routine at night, are getting a drink or something, when you think about that person with neurocognitive impairment, they may have some of those same habits some years ago.

33:31

But they, but they aren't so self-aware of them, and they don't remember where to get the Cheerios right or they don't.

33:41

They forget where they're ... because it's not the same as their home, no back home.

33:46

So, visual with putting the name of the bathroom on the door, which helped, helps find the door.

33:56

Also, talking a little bit about might be low lighting.

34:01

Then, drink! And Food! Is cheerio's snack? Should it already being in the room ready for them? Know, and just, again, kind of getting out in front of the fact that they're searching for something?

34:13

So they may not always tell you, but I think it's a great way versus, know, kind of ordering that, people back to back. Right. Which, these are adults should not.

34:26

So finding ways to make their nighttime better.

34:28

And then the escaping could be some stress anxiety.

34:33

And different things with the environment that you want to check on. one of the things, we did a sleep study through NSC five, in Missouri and sleep study outcomes, shown think environmental noises after a certain hour.

34:51

We're disturbing the resident and increasing that level, Agitation Wanderings yelling out.

34:59

And so, they have quiet time after 8 0 PM.

35:02

The other thing, I'll bring up these cases to maybe having a later eat meat activity, like seven o'clock. So, normally, activities may, Tweet, right, or four, and it says you want to take a look at, Maybe you're going to have a quiet activity with the movie.

35:21

Just academic, the things, things like that, and we'll talk about more.

35:25

Then, that thing, in the past, when you're just keeping in mind, that they worked overnight hours, or they did an 8 to 5 job.

35:32

Or, I think these hours may actually be, you know, kind of, they don't know why, necessarily, but they're there in the brain.

35:43

That's routine.

35:45

So be sure in a dress, potential triggers and identifying, provide those visual cues that I just mention, descriptive photos.

35:56

And this is anywhere this can be in a regular part of your building.

36:02

Then claiming those activities, using distractions and trying to minimize any triggers that may increased fat and even use the example of the basket of towel or something that is familiar to that individual.

36:19

I have a veteran, uh, that I've been working with and we got him.

36:25

We just tried it out and got him a birdhouse walnut Wal-Mart kind that you can camera together with a hammer and paint and he had a single room.

36:36

So, he was able to do that, that he could have done activities wants to open, But he he, he went from one to like five of these things. If you started making them from people, so keep it.

36:49

Like he went from agitated upset on his life all the time, too enthusiastic about a project.

36:58

So, you just kinda got it, find that.

37:03

Then.

37:06

Kinda talk about repetitive questions.

37:09

I love, I love this discussion about repetitive question because, you know, it's often misunderstood as a need for information, so we're giving that information, and we may have to repeat that information.

37:24

But it's really talked about, it's found as a need for reassurance.

37:29

So if you kind of keep that in mind, when people are asking questions over and over, because, well, honestly, they don't remember, or if they're highly anxious to that family member, which is starting.

37:43

Again, you know, they're starting to begin, depending on your facilities. one of the facilities I serve here, Missouri, and the now having, in your business, at a distance, with math.

37:55

But they've been Coventry for awhile now and just an anticipation of whatever's coming up next, Or even just the fact that people are very lonely in general and asking questions?

38:13

You want to be home.

38:27

There are no questions at this time.

38:30

OK, thank you very much.

38:31

So, I'm gonna go ahead and release Paul regarding environmental changes.

38:38

What environmental changes are you able to make to minimize or eliminate a person's disruptive behavior and look at these?

38:47

If they apply, And then as many as apply it, and I think you have another idea for that group.

38:55

I love it, You put it in the chat because, I think, if we were in a more interactive in person environment, I'd be asking you all.

39:04

Oh, tell me about somebody, right?

39:07

And what, you know, Waller are there, and you're going to have some great ideas.

39:16

So, as you get to answer the call All right.

39:22

There we go.

39:26

So, when you look at repetitive questions, you want to identify the cause, so you want to recognize the underlying reasons for those questions.

39:37

So, if they're asking what time it is, maybe they're anxious about being left alone, I know that shift change, some residents, they anticipate that shift change.

39:50

And so it's just then changing of staff, you know, just things like that. And the re-assuring that they will not be left alone when that doctor Combs.

40:04

Physically 100% of the youth use all these different applications OK, thank you.

40:17

I may have to come up with more challenging webinar, that's on it.

40:23

So, managing talked about that.

40:26

So, also just tracks that this might be one way to look at this, is to track that repetition repetition of few days.

40:36

And does it increase at certain times of the day, or with the number of people around maybe you can occupy that patient with new activity during those times of the day.

40:47

Um, and then maybe keep the number of people to a minimum.

40:52

So one of the things they're talking about is kind of bad overstimulation that might lead to repetitive questions.

41:05

I really like this next slide.

41:08

So, looking at displaying a daily schedule, which you all do, utilizing a calendar, and may be on that calendar, schwall, select certain days, and when family visits come up. And the patient, that, she was kinda telling me, Well, I think, today, I think, tomorrow. And then, it was just as easy as I talk to the DNA.

41:32

And we put it on her calendar with the circle, You know, when her son was going to come to the build. Or when she was going to do for videos.

41:41

So, those are things that quite simply, help everybody, because then the staff can see it, and they can remind her, and that's a positive thing in her life, that's coming up.

41:53

Um, then also just trying to change the subject as well, and I bring that up because sometimes redirection isn't good idea, you know, these are topics that you may not be able to change, the fact that they have to take a pill. No or the fact that there should be some sort of hygiene and they don't want to do it, or the fact just wants of different things that may come up for them. So what I say is, you know, for example, you could say to share a story about your grandchildren and what. I love about this.

42:29

As you all know, your resident.

42:31

So it's nearly just picking up on something you already know about that residents, and having a short conversation about it, and it's worth everything, because it can make such a difference, and how that resident makeup.

42:47

And it can lead to several questions.

42:52

So the cost of late day, and confusion, and signing downie are often fatigued and low lighting increase chateaus disruption at the body's internal clock.

43:08

Some tips for reducing and downing photos may include plan for activities and exposure to light during the day to encourage nighttime cuisine.

43:19

So what happens is sometimes in the afternoon, know, that they pull their own curtains or curtains are pulled, darker, and they really are having some difficult to differentiate day for night.

43:32

And they end up sleeping all afternoon when they're having so much trouble, you know, already sleeping tonight, This time, residents make their own choices and some of these areas, as much as you can do, the tasks are going to limiting caffeine and sugar to morning hour is excellent.

43:52

Um, surf dinner early, then offer, and which you all do, But then maybe offer like, math, know, before that, the 10 hour right around the time, depending on their bedtime, when men surpassed.

44:09

Keep a nightlight on to reduce agitation that occurs when may be, they awaken and things feel dark or unfamiliar.

44:22

Then this kind of this link and Altruistically pattern, you're looking at, there could be a lot of exhaustion and overstimulation, an ability to recognize inability to recognize night from day, reduce the need for sleep.

44:39

Because sometimes look, older people are finding, you know, they may wait 4 to 6 hours.

44:44

And I know it's Kinda, and they're not maybe not doing a whole lot of activity.

44:51

Increased disorientation, unable to distinguish dreams from reality was sleeping. This happens a lot with my Parkinson's patients, that they have specific dream and they feel like, you know, and then their awakening.

45:07

And, um, they really wake up, can be quite confusing, then they make more, and then over doing daytime nappi, then other existing medical prompts, no cost determined.

45:26

There are some tips for that And cleaning and, maybe toileting them later if you're helping with that, or encourage toiling leading as possible. That way. They're not either.

45:37

Awakening, wet or using the call light when, you know, probably in the first few hours of sleep, you know, things like that, trying to help them get a longer range of uninterrupted sleep, four hours or more.

45:54

Then essential oils have really become popular.

45:57

The ministers, you know, the small little diffusers with some, you know, a little lavender, You know, things like that, that are acceptable to, you know, in communities.

46:10

Definitely recommend it.

46:12

Then asking a doctor to review the medications in their sleep disturbance.

46:18

We all know we avoid that routine use of senators or slate tablets.

46:23

But some people are doing Tylenol.

46:25

You know, the Tylenol at night is part of the routine, chronic pain is involved as it.

46:32

Then, you know, there is some of these people going back to my, I have a Parkinson's patient. I saw this morning, Keith Weights in a recliner. He got a new mattress. And a new recliner.

46:46

This, she last year and he prefers to bed.

46:51

But he sleeps better in the recliner.

46:56

And he says it because if he needs to use the restroom, she's able to go do that.

47:02

Or he might have bigger, as well.

47:06

So he's choosing, and he's been doing that on and off for years, because of tickets his legs in the pain.

47:22

Now, let's talk about aggression.

47:24

So aggression kersey, yelling hitting, flapping.

47:30

Fighting with your staff as a resident, wish, you know, the research is telling us that the most aggressive behavior towards staff occurs during personal care.

47:40

So I'm not exactly sure your experience that, that appears to be the the time when you might have your most agitated individual.

47:49

And so, if it can occur towards other residents, it can occur when that like a respite enters, another resident's room.

48:00

So getting into their space, and that might be coming up as well, perhaps.

48:09

So, when providing personal care, I know I've had some varied experiences, so I've done services around really encouraging the staff at the care staff, the DNA, staff, and a staff, to really engage with that resident when they're providing personal care.

48:30

Also, folks with ..., that lead to person, no transfer, or personal care.

48:38

No, it.

48:40

It's really important to talk to the rest of it, and not teach us.

48:45

Unless you're awfully talking together, I had a patient post stroke that was so upset because she said they don't care about me, they don't talk to me.

49:00

And, frankly, she said some other things that, you know, just really were negative about herself.

49:07

And she did not film or theater values.

49:12

Bad at math, whether she lived or died.

49:16

Personal care.

49:17

It's an absolutely critical point to build rapport, to talk with us about anything.

49:25

And even that whole redirect is helpful to just, if there's nuggets of information that have or that you can gain about.

49:34

that individual. But a pleasant on.

49:37

I mean, I think it very, very helpful.

49:48

The point that the resident, and I know that you have, we have rules around this and regulations that you follow.

49:56

Um, this is just kind of, you know, the idea that that the wandering resident and you'll want to remove them as quickly as possible to kind of help prevent a graph an outburst and then kinda assure the resident that, know, that that had the person come into the room.

50:20

That you'll do all you can to ensure that wondering with net will not enter the room uninvited.

50:26

And really importantly, we have to maintain respect to both of the facts.

50:31

And we use a common understanding for why.

50:34

Again, going back to the reactive approach. Right.

50:39

Um, no, kind of.

50:44

Getting on to that resident who's wandering or not.

50:48

You're not really, it's just not the time to really address anything.

50:51

I think you have to get out in front of that behavior and try to observe them more and try to like, you know, try to prevent.

51:00

I know a lot of times, I've had this happen, and we use the stop sign balko stop by.

51:07

And sometimes that doesn't keep an individual out, but there could be relocation changes.

51:14

But I also think that, as we look at every behavior has a reason, why is a wandering into that particular, what is of interest to them? And kind of just taking a look at those pieces regarding that individual.

51:31

Then it has two more polling question.

51:34

And we are happy.

51:36

You have a few minutes, and we're happy to I'm going to go ahead and repeat the question.

51:44

I know we had Internet issues everywhere.

51:51

Sure.

51:52

This question is really, Do you feel the frontline staff have the tool to recognize behaviors, know, on an individual resume?

52:07

I think, you know, this, this goes back to just, you know, do they, do they feel equipped.

52:31

I think it's OK to say whether we know you are equipped or not.

52:38

Look at situations that are going to kind of arise as we get back to the new normal.

52:45

Socialization of residents, um, there'll be quite a bit that we'll start at, probably learn things right before their neurocognitive increased decline. Right, Or the other type, the, kinda getting out in front of, the fact that people may not always get along, as we call people back together.

53:17

So, over half, 56% of you say yes, your staff is equipped, and to recognize that behaviors.

53:28

And then, go ahead, OK.

53:33

And then the last question, uh, it's really, that's your community have, or you already have individualized care plan or intervention?

53:43

To just scrap, to, decrease disruptive behaviors.

53:47

In other words, course, you have care plan.

53:50

This is going to be about, kind of person centered type care plan that may be related to right.

53:58

It could be related to physical, verbal, agitation, all these different behaviors we got, Do you does your organization feel?

54:28

Thank you so much.

54:31

one of our attendees talked about, she felt like she would have less.

54:36

There would be less behavior sheet, if the staff understood neurocognitive behavior, I think that's really critical, because I think there absolutely is a difference, because, again, that kind of write that reactive piece of behavior, and then expecting that individual not to do the behavior again.

54:58

Is risky, right? Because that's not you're going to have. It has to be proactive.

55:06

Once the behaviors happen: 1, 2, 3 times, It's really back to get together, even on the floor and go: OK, what's happening here?

55:16

Know, are you all seeing this, you know, when staffing happen, stand-up, Whatever, because the answer could be really right in front of you, and it's something that's going to improve that. Resident.

55:31

Quality of life.

55:32

Not about us, right? It's not about what works.

55:35

What we're tired of doing in dealing with the behavior.

55:41

They're probably not very satisfied, either.

55:45

I think it's going to be really great.

55:49

As staff, you know, you continue to build your rapport.

55:52

Can you come up with the answers, and I think that's exciting?

55:56

Yes, that education, neurocognitive behavior.

56:00

So, everyone says that your community has what they need.

56:09

And I think when you're on this course, literally, because we were talking about behaviors and neurocognitive, So.

56:20

I encourage you to take a look at the slides, the references.

56:25

There are some other, definitely some great resources out there.

56:30

There might be maybe some ongoing training to consider to do live Some recorded webinars or things like that and kind of honing in on it because just because you're you may not have a memory care, you can see that for neuro cognitive challenges, I mean, there's just such a wide range.

56:53

And they're not all traditional dementia.

56:57

And for people to understand that dementia has rage.

57:01

All right.

57:04

Levels, you know, from mild, moderate to more severe.

57:10

But also the different dimensions, which I have a training on that as well. The different dimensions really affect the brain different, as you might need different, different behavior.

57:32

Thank you!

57:33

I'm going to turn off the record, and Thanks.

57:39

Thank you, Cynthia, for your presentation today.

57:42

And I'd like to thank all that who are who participated in this session, and remind them that there will be a post event survey that will be sent out to them.

58:02

Thank you, all for joining us today.

58:08

Thank You, Kim, for all you do, and thank you, again.

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