Younger Adults in Long Term Care

Meeting the Challenge and Setting the Standard

A growing concern

- Adults 18-64 are the fastest growing subpopulation in long term care.
- 20 years ago, those under age 65 were 8% of long term care, now they are 16.5%.
- Younger adults
  - longer lengths of stay,
  - Medicaid payor
  - Male, black or Hispanic
  - higher rates of anxiety, depression, and suicidal behaviors.
  - *Living in for-profit nursing homes with lower star ratings.*
  - *Less likely considered in research and regulatory decision making*

Separate populations with different needs.

- The majority of younger adults are male, whereas older adults and seniors are mostly female. White people make up the majority of older residents and black and Hispanic make up the younger group.
- Serious mental illness and psychiatric medications are far more common among younger adults.
- Younger adults also have greater rates of cerebral palsy, paralysis, traumatic brain injury, multiple sclerosis, diabetes and ventilator use.
- Nursing homes may not even be able to care for younger adults, but there are limited options.

On the Cutting Edge

- Edgemoor has a higher number of younger adults and more experience caring for them as a safety net facility.
- PALTCM gathered a group of those caring for younger adults from all over the US and found little literature, but a lot of experience and "best practices" and developed a toolkit.
- Nursing homes are highly challenged to care for many younger adults with the current financial and regulatory environment. These are often LONG TERM patients.

What are the pillars of success?

- Don't admit what you cannot care for
- Know the residents well. Invest early
- Know the regulations well.
- Know its not the best fit—expect long term stays, privacy concerns, complaints, and struggles
- Rules cannot be enforced; Influence behavior through relationships.
- Work as interdisciplinary team.
- Exercise creativity, attention to detail and documentation skills.

How do they get into nursing homes?

- Developmental disability.
- Gradual decline due to neurodegenerative disorders (MS, HD).
- Sudden change in lifestyle (accident).
- Long term mental illness and associated decline.
- Long term poor behaviors (drug addiction, poor self care, smoking, alcohol) culminating in cognitive loss, physical abilities and decline.

Different than older adults

- Psychologically, socially, developmentally, medically, and cognitively
- Activities preferred
- Foods preferred
- Ways of communicating
- Expectations
- Developmental/life stage
- Worldview
- Medical problems
- Discharge Options

Young people have unique medical problems (some of which keep them from getting too old!)

- Fertility and birth control
- Sexually transmitted diseases (though this is a growing problem in the elderly as well)
- A lack of comorbidities
- Substance abuse may be more prominent

Also more common in the young…

- Night owls
- Fashion ideas
- Social media, technology
- More physical strength
- Minor children
- Goals for the future (education)
- Ideas about privacy
- Different expectations, entitlements
- Different attitudes toward tube feeding and cognitive loss and code status

Meet Martin

Martin suffered a traumatic spinal cord injury resulting in quadriplegia. He now is developing limited use of the upper extremities, but is totally dependent. He is withdrawn, angry and irritable, and complains frequently about staff. He wants to go out daily to drink or use marijuana and sometimes brings it inside. He uses a power chair. His care needs are heavy and he is often unkind to caregivers. He is sure he doesn't belong with all these old people in the SNF.

A framework for analysis

- Understand their individual perspective.
- Know the regulations.
- Develop and nurture the relationship to influence behavior (relationship-based influence versus "compliance") .
- Be clear about staff roles and responsibilities.

Keep your eye on the situation as it evolves and repeat as needed, get to win-win.

INDIVIDUAL PERSPECTIVE

- Stephen Covey "Seek first to understand, then be understood"
- Know me and let me know you care for me before telling me what you need and want.

Getting to Know people

- Educate your staff on listening first. Make time for it. Monitor and watch. It saves so much time later,
- Consider teaching Nonviolent communication--behaviors are reflection of needs and focusing on the need is better
- Put yourself on the same side of the equation—the rules are tough "for both of you"—you are on their side –you want their needs met too. You are looking for a compromise. You are an advocate.
- Find out how they like to be told bad news, rules, how they deal with conflict, what their goals are. BEFORE you need it.

4 principles of Nonviolent Communication

- Observation helps us communicate what we see and hear without judgment.
  - I'm seeing you come in slurring your speech and not as friendly as usual, and I am concerned.
- Feelings help us connect with others emotionally and build understanding.
  - I'm worried about you and want to assure you are safe. Because of your medications and condition, I am worried there are special risks you may not be aware of.
- Needs to help us identify what we value and what we need to feel satisfied.
  - Its part of my job as your nurse to learn about what is happening with you and how it impacts your body and then to see what we can do to keep you safe.
- Requests help us communicate what we need from others in a clear and non-threatening way
  - Would you talk to me about what is happening and what you need from me?

"Everything we do is in service of our needs."

"Max-Neef's model where needs may be categorized into 9 classes:

- sustenance,
- safety,
- love,
- understanding/empathy,
- creativity,
- recreation,
- sense of belonging,
- autonomy and
- meaning.

Quick practice

- There is nothing to do
- You guys are just here for the money and don't care at all for me.
- Staff are stealing my stuff.
- What's the point in talking, no one here ever listens. Its all rules, rules.
- I'm out of here.
- I hate the food here.
- It doesn't matter anyway, so leave me alone.

- sustenance,
- safety,
- love,
- understanding/empathy,
- creativity,
- recreation,
- sense of belonging,
- autonomy and
- meaning.

REGULATIONS

- Younger Adults push the limits of regulations which are not designed for them.
- But that's your problem
- Know the regulations and interpretive guidance well and speak to it in your planning and documentation.

What regulations?

- **Admission**—assure we can provide care for what may be a long time
- **Resident Rights**—so many! including activities of interest, right to refuse, right to daily choices, home like, grievances,
- **Clinician responsibilities**
- **Care planning and assessment**
- **Trauma informed care/Behavioral Health care**
- **Discharge** when there are few safe options most times

Balance between autonomy and safety

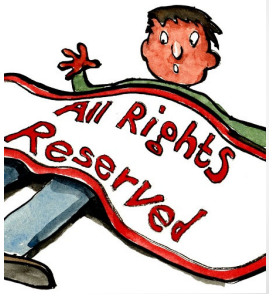
- Clarify the tension between the facility need for protection and safety protect and the resident's right to exercise autonomy.
- Enhance processes of assessment, care planning for risk mitigation and documentation (and get used to doing it over and over again).

You let them do what?

Or, "do we have the authority to stop this?"

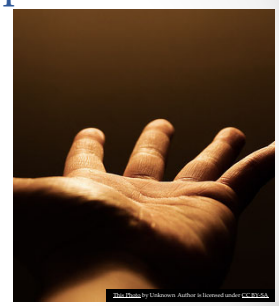
I have a right to make bad choices.

- I have the right to experience expected consequences of my choices.
- Punishment isn't ever allowed.
- Expression of my rights end where yours begin.



Concept of a need versus a want or preference

- "We are here to meet all your needs and some of your wants."



"all your needs and some of your wants"

- Identify the difference between needs (food, clothing, pain management, assistance) and wants or preferences (dilaudid 4 mg, clothing too small, transfers any time requested, help holding a cigarette).
- Re-examine resident rights:
  - "They have a right to…" gives way to "your right to ___ is limited by the other resident's right to ___."
  - Know what is a right versus a preference (or "want").

The perfect answer varies on a continuum

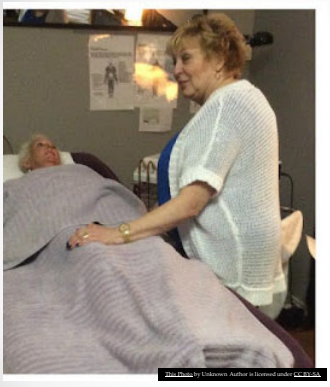
- Finding the right balance between safety and autonomy is highly related to decision making capacity assessment.
- The balance is situational. We need to assess, and we need to at least attempt to offer choice and make things safer. We need a plan.
- Sometimes we need to violate rights, but when we do, we need exceptional documentation that is patient centered and caring and honoring the struggle.
- Other times when we really have little we CAN do, we need to document well why we are so ineffective at changing a risky situation.

Concept of staff being important too

If behavior impacts staff morale, performance, well being, then this impacts other resident care and cannot be permitted. Cannot run a facility without engaged and safe staff.

Achieving balance when…

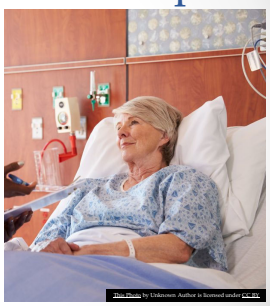
- Patient refuses all care and examinations and is conserved.
- Patient with capacity is leaving and coming back intoxicated
- Patient is highly demanding/disruptive with their behaviors impacting the care of other residents and staff wellbeing
- Patient keeps being found vaping in bed with oxygen on
- Patient is driving even though you don't think it is safe.



Developing Relationships

Stages of relationships

- Initiating
- Sustaining
- Repairing
- Ending



Ways to enhance relationships

- **Becoming familiar with life in the LTC home to support social connection**—Orientation, aligning expectations, enhancing mobility, interesting activities.
- **Physical and virtual access beyond the LTC home as strategies to maintain contact**—e.g internet, technologies
- **Getting to know residents to deepen relationships:** benefits of using routine care and interactions as opportunities for social contact, using family and friend knowledge as a resource, and fostering resident relationships.
- **Person-centered approaches to build social connection** included considering physical, mental, cognitive, and sensory impairments, accounting for adjustment and sociability, using communal spaces well, and prioritizing psychosocial needs.

The framework we recommend

- Understand their individual perspective.
- Know the regulations.
- Develop and nurture the relationship to influence behavior (relationship-based influence versus "compliance") .
- Be clear about staff roles and responsibilities.
- Through engagement and meaning, get to win-win.

Staff Roles and Responsibilities

Facility Leaders have responsibility

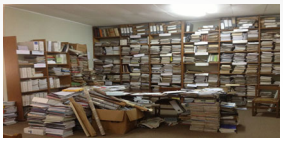
- Make sure our staff are appropriately trained and supported in caring for our complex younger residents.
- Consistent staff is highly recommended. Nut we still need to teach staff boundaries.
- Watch out for transference—they feel like our children sometimes. But they are not
- Leadership can be the "bad guy" to protect the primary relationships.

You have to develop new skills

Capacity assessment, documentation, setting boundaries, listening, negotiating, conflict management, technology and keeping one step ahead.

Staff responsibilities

- Follow the regulations or have a VERY GOOD reason not to
- Offer a mechanism for care plan requests and input
- Do appropriate assessments
- Have people who are very good write comprehensive summary notes with compassion notes, review care plans. Then others can learn
- Make certain all IDT members are involved
- Have a care plan that is person-centered and trauma informed.



DOCUMENTATION IS CRITICAL

Care planning, progress notes, why you made the decision you did and what else you considered…

Unique challenges

Younger adults bring unique challenges to the nursing home and almost all are informed by psychosocial issues.

Relationships are key to solving them.

Challenges you may face

- Manipulative, demanding, use of profanity.
- Substance abuse, drug seeking (prescription drugs more often the "drug of choice").
- Frequent complaints or demands.
- Noise, clutter, night-owl schedules.
- Operating a business in your facility?
- Non-adherence, pushing the limits.
- Challenges with technology that they know more about it than we do.
- Stronger and scarier when angry
- Driving, Sexual expression, ?pregnancy
- Poor curb appeal.

Let's practice with SCI

- Individual perspective: imagine paralysis, little hope, loss of autonomy
- Regulations: choice; rights, behavioral health, trauma informed care, assessments, input into care plan.
- Relationships: long term, many risks, adaptation
- Staff roles: understanding medical issues—spasm, autonomic instability, the need to be "straight" in lifts, pressure relieving cushions, protect power chair, capacity assessments, boundaries
- Getting to win-win: celebrate milestones, tell a positive story.

Power chairs	Driving	Tech challenges	Pregnancy
Substance Use	WHAT'S YOUR CHALLENGE?		Operating a business
Leaving the facility for unsafe reasons	clutter	Mental illness	Frequent complaints to the state of abuse
Verbal or Physical aggression to staff	Bad influence on others	Highly demanding	Sexual expression

Power chair

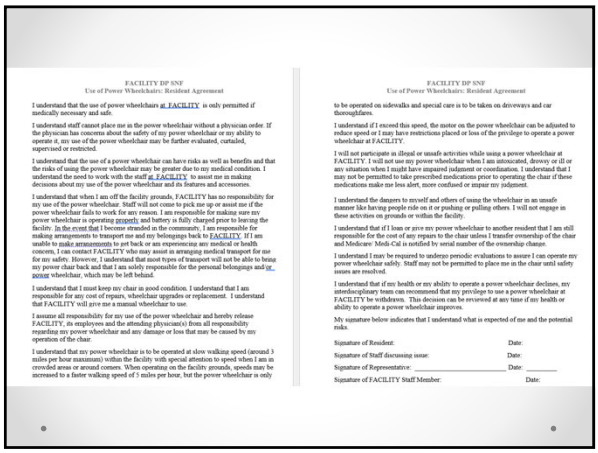
Sally's power chair broke and the company is so delayed in fixing it. She thinks staff broke it. She has an old one, but it has a battery that keeps dying and it is too big for her, but she insists on being put in that one daily. Her skin is open because the cushion got deflated. She keeps getting stranded in the community and wants you to pick her and the chair up.

Power chair safety

- Individual perspective:
- Regulations:
- Relationships:
- Staff roles:
- Finding win-win:

Power chair safety

- Individual perspective: chair is life, mobility, independence
- Regulations: privilege; assessment
- **§ 483.70 Administration.**
- A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
- Relationships: treat chair with respect
- Staff roles: assessment, monitoring, cleaning, maximize safety for self and others, repairs,rescues negotiating loss of privileges
- Finding win-win: assessments for capacity, use, community integration; statements of understanding, ongoing monitoring for change, cleaning policies, education



FACILITY DP SNF
Use of Power Wheelchairs: Resident Agreement

I understand that the use of power wheelchairs at FACILITY is only permitted if medically necessary and safe.

I understand staff cannot place me in the power wheelchair without a physician order. If the physician has concerns about the safety of my power wheelchair or my ability to operate it, my use of the power wheelchair may be further evaluated, curtailed, supervised or restricted.

I understand that the use of a power wheelchair can have risks as well as benefits and that the risks of using the power wheelchair may be greater due to my medical condition. I understand the need to work with the staff at FACILITY to assist me in making decisions about my use of the power wheelchair and its features and accessories.

I understand that when I am off the facility grounds, FACILITY has no responsibility for my use of the power wheelchair. Staff will not come to pick me up or assist me if the power wheelchair fails to work for any reason. I am responsible for making sure my power wheelchair is operating properly and battery is fully charged prior to leaving the facility. In the event that I become stranded in the community, I am responsible for making arrangements to transport me and my belongings back to FACILITY. If I am unable to make arrangements to get back or am experiencing any medical or health concern, I can contact FACILITY who may assist in arranging medical transport for me for my safety. However, I understand that most types of transport will not be able to bring my power chair back and that I am solely responsible for the personal belongings and/or power wheelchair, which may be left behind.

I understand that I must keep my chair in good condition. I understand that I am responsible for any cost of repairs, wheelchair upgrades or replacement. I understand that FACILITY will give me a manual wheelchair to use.

I assume all responsibility for my use of the power wheelchair and hereby release FACILITY, its employees and the attending physician(s) from all responsibility regarding my power wheelchair and any damage or loss that may be caused by my operation of the chair.

I understand that my power wheelchair is to be operated at slow walking speed (around 3 miles per hour maximum) within the facility with special attention to speed when I am in crowded areas or around corners. When operating on the facility grounds, speeds may be increased to a faster walking speed of 5 miles per hour, but the power wheelchair is only

FACILITY DP SNF
Use of Power Wheelchairs: Resident Agreement

to be operated on sidewalks and special care is to be taken on driveways and car thoroughfares.

I understand if I exceed this speed, the motor on the power wheelchair can be adjusted to reduce speed or I may have restrictions placed or loss of the privilege to operate a power wheelchair at FACILITY.

I will not participate in illegal or unsafe activities while using a power wheelchair at FACILITY. I will not use my power wheelchair when I am intoxicated, drowsy or ill or any situation when I might have impaired judgment or coordination. I understand that I may not be permitted to take prescribed medications prior to operating the chair if these medications make me less alert, more confused or impair my judgment.

I understand the dangers to myself and others of using the wheelchair in an unsafe manner like having people ride on it or pushing or pulling others. I will not engage in these activities on grounds or within the facility.

I understand that if I loan or give my power wheelchair to another resident that I am still responsible for the cost of any repairs to the chair unless I transfer ownership of the chair and Medicare/ Medi-Cal is notified by serial number of the ownership change.

I understand I may be required to undergo periodic evaluations to assure I can operate my power wheelchair safely. Staff may not be permitted to place me in the chair until safety issues are resolved.

I understand that if my health or my ability to operate a power wheelchair declines, my interdisciplinary team can recommend that my privilege to use a power wheelchair at FACILITY be withdrawn. This decision can be reviewed at any time if my health or ability to operate a power wheelchair improves.

My signature below indicates that I understand what is expected of me and the potential risks.

Signature of Resident: Date:

Signature of Staff discussing issue: Date:

Signature of Representative: _____ Date: _____

Signature of FACILITY Staff Member: Date:

Resources

- Sample policy on power chairs
- Sample statement of understanding
- Sample Assessment
- Sample care plan

Kevin

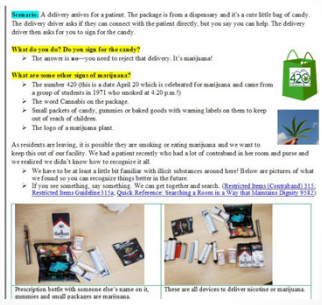
Kevin asks for a marijuana prescription and insists it is all that works for him. He is leaving the facility daily to smoke and you think it is both cigarettes and marijuana and at times he is intoxicated. Staff keep finding lighters, vape pens. Once another resident was high and stated Kevin gave him some. He has 10/10 pain and insists only dilaudid works and will call the state if you don't prescribe it.

Use of Drugs or Alcohol

- Individual perspective:
- Regulations:
- Relationships:
- Staff roles:
- Finding win-win:

Use of drugs or alcohol

- Individual perspective: suffering, desire for control, escape, passive aggressive
- Regulations: pain control program, but not dilaudid, provider ethics and standards, pain control needs to increase quality of life
- Relationships: need to believe you care
- Staff roles: assess, offer help; monitor, capacity assessment, trials, avoid punishing
- Finding win-win: persistence, creativity, celebrate success


Scenario: A delivery arrives for a patient. The package is from a dispensary and it's a cute little bag of candy. The delivery driver asks if they can connect with the patient directly, but you say you can help. The delivery driver then asks for you to sign for the candy.

What do you do? Do you sign for the candy?
- The answer is no—you need to reject that delivery. It's marijuana!

What are some other signs of marijuana?
- The number 420 (this is a date April 20 which is celebrated for marijuana and came from a group of students in 1971 who smoked at 4:20 p.m.!)
- The word Cannabis on the package.
- Small packets of candy, gummies or baked goods with warning labels on them to keep out of reach of children.
- The logo of a marijuana plant.

As residents are leaving, it is possible they are smoking or eating marijuana and we want to keep this out of our facility. We had a patient recently who had a lot of contraband in her room and purse and we realized we didn't know how to recognize it all.
- We have to be at least a little bit familiar with illicit substances around here! Below are pictures of what we found so you can recognize things better in the future.
- If you see something, say something. We can get together and search. (Restricted Items (Contraband) 315; Restricted Items Guideline 315a: Quick Reference: Searching a Room in a Way that Maintains Dignity 9582)

Prescription bottle with someone else's name on it, gummies and small packages are marijuana.

These are all devices to deliver nicotine or marijuana.

How to communicate around substance use.

- Be honest about what you observe, try not to judge or preach.
- Ask questions, seek to understand.
- Develop a relationship--accepting them as they are but caring enough to tell them the hard truths.
- Talk about how much you care.
- Ask them to help you by suggesting what they want (goals) and what they plan.
- Do NOT threaten discharge.
- Tell them calmly what YOU will do if they are intoxicated.
- Explain risks—both short term and long term, to themselves and others.
- Evaluate their medication profile to see if there are any medications which interact with alcohol
- Evaluate decision making capacity Get permission to speak with family.
- Consider what interventions you can put in place to make this safer
- Educate, encourage reduction in quantity or strength or frequency of intake, encourage more positive relationships, discontinue medications that interact, try to reduce access to funds, if possible, try to meet needs in another way, search and remove contraband from rooms, offer treatment (often off campus—AA or perhaps online…https://www.smartrecovery.org/community/)

Brief Intervention Model: FRAMES*

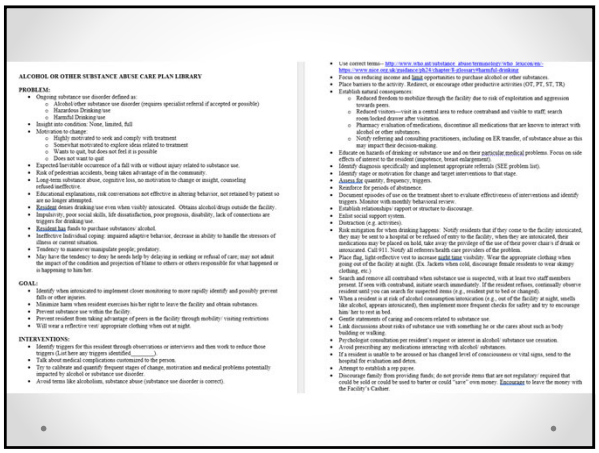
- **F**eedback of personal risk
- **R**esponsibility (of the patient to change)
- **A**dvice to change (without judging)
- **M**enu of change options (choices)
- **E**mpathy (“it's tough”)
- **S**elf-efficacy (optimism -“you can do it”)

Miller & Sanchez, 1993; World Health Organization manual for Brief Intervention

- http://apps.who.int/iris/bitstream/handle/10665/67210/WHO_MSD_MSB_01.6b.pdf;jsessionid=43A6AF05FABF9940991CC06B5B71BB12?sequence=1

DEALING WITH INTOXICATION

- First, assess the situation and make sure you know what you are dealing with.
  - Do they appear intoxicated from alcohol or illegal drugs? Signs of intoxication: smell of alcohol, poor coordination, slurred speech, nausea, vomiting, flushed face, seizures.
  - Are substances visible, e.g., can of beer in wheelchair?
  - Could they have a medical condition that makes them appear intoxicated?
  - Ask them:
    - Did they use alcohol or drugs?
    - How much?
    - When they last used?
      - Note: they may or may not be truthful, but still ask and watch them.
- This is not a good time for confrontation, avoid setting limits, education or confrontation. SAFETY FIRST
- Make sure there are always two staff when interacting with the intoxicated resident. Intoxicated people are often unpredictable and may become violent without provocation.
- An intoxicated person may not recall accurately, e.g., they fall and “remember” that you pushed them (again, always two staff).
- Try to ensure the resident's safety. Move the person to a safer environment (their room) and remove all harmful objects (anything they can hurt themselves or others with). Remove power chair!
- Assess for signs of injury.
  - Head trauma or other injuries. Abrasions, bruises.
  - Low or high blood glucose.
- Watch and expect behaviors: confrontational, argumentative, irrational, uncooperative, belligerent, sleepy and emotionally unstable.
- Monitor for possible alcohol poisoning
  - Full effect of drug or alcohol may take time. It may get worse before better.
  - Wake them up at intervals (every 20 minutes).
  - Put them on side with pillow behind them in case of vomiting.
  - When to call an ambulance (911): if they are physically abusive, if they cannot wake up, if they have seizures, if vitals become unstable (low temp, irregular breathing).
- Have medications reviewed by pharmacy in light of possible interactions before giving them to a potentially intoxicated person (for instance ask pharmacy to review and discontinue all medications that potentially interact with alcohol).



ALCOHOL OR OTHER SUBSTANCE ABUSE CARE PLAN LIBRARY

PROBLEM:

- Ongoing substance use disorder defined as:
  - Alcohol other substance use disorder (requires specialist referral if accepted or possible)
  - Hazardous Drinking/use
  - Harmful Drinking/use
- Insight into condition: None, limited, full
- Motivation to change:
  - Highly motivated to seek and comply with treatment
  - Somewhat motivated to explore ideas related to treatment
  - Wants to quit, but does not feel it is possible
  - Does not want to quit
- Expected/inevitable occurrence of a fall with or without injury related to substance use.
- Risk of pedestrian accidents, being taken advantage of in the community
- Long-term substance abuse, cognitive loss, no motivation to change or insight, counseling refused ineffective.
- Educational explanations, risk conversations not effective in altering behavior, not retained by patient so are no longer attempted.
- Resident denies drinking/use even when visibly intoxicated. Obtains alcohol/drugs outside the facility.
- Impulsivity, poor social skills, life dissatisfaction, poor prognosis, disability, lack of connections are triggers for drinking/use.
- Resident has funds to purchase substances/ alcohol.
- Ineffective Individual coping: impaired adaptive behavior, decrease in ability to handle the stressors of illness or current situation.
- Tendency to manever/or manipulate people; predatory.
- May have the tendency to deny he needs help by delaying in seeking or refusal of care; may not admit the impact of the condition and projection of blame to others or others responsible for what happened or is happening to him/her.

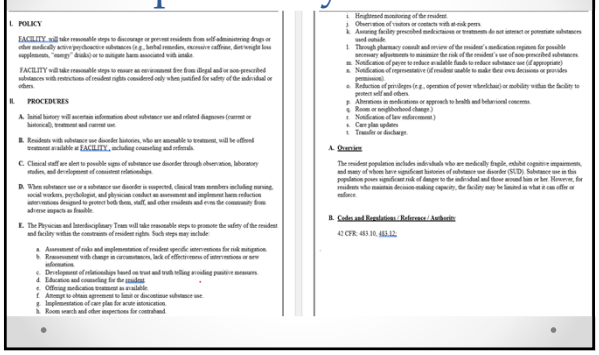
GOAL:

- Identify when intoxicated to implement closer monitoring to more rapidly identify and possibly prevent falls or other injuries.
- Minimize harm when resident exercises his/her right to leave the facility and obtain substances.
- Prevent substance use within the facility.
- Prevent resident from taking advantage of peers in the facility through mobility/ visiting restrictions
- Will wear a reflective vest/ appropriate clothing when out at night.

INTERVENTIONS:

- Identify triggers for this resident through observations or interviews and then work to reduce those triggers (List here any triggers identified_____).
- Talk about medical complications customized to the person.
- Try to calibrate and quantify frequent stages of change, motivation and medical problems potentially impacted by alcohol or substance use disorder.
- Avoid terms like alcoholism, substance abuse (substance use disorder is correct).
- Use correct terms-- http://www.who.int/substance_abuse/terminology/who_lexicon/en/; https://www.asam.org/quality-practice/definition-of-addiction
- Focus on reducing income and limit opportunities to purchase alcohol or other substances.
- Place barriers to the activity. Redirect, or encourage other productive activities (OT, PT, ST, TR)
- Establish natural consequences:
  - Reduced freedom to mobilize through the facility due to risk of exploitation and aggression towards peers.
  - Reduced visitors—visit in a central area to reduce contraband and visible to staff; search room/locked drawer after visitation.
  - Pharmacy evaluation of medications, discontinue all medications that are known to interact with alcohol or other substances.
  - Notify referring and consulting practitioners, including on ER transfer, of substance abuse as this may impact their decision-making.
- Educate on hazards of drinking or substance use and on their particular medical problems. Focus on side effects of interest to the resident (impotence, breast enlargement).
- Identify diagnosis specifically and implement appropriate referrals (SEE problem list).
- Identify stage or motivation for change and target interventions to that stage.
- Assess for quantity, frequency, triggers.
- Reinforce for periods of abstinence.
- Document episodes of use on the treatment sheet to evaluate effectiveness of interventions and identify triggers. Monitor with monthly behavioral review.
- Establish relationships/ rapport or structure to discourage.
- Enlist social support system.
- Distraction (e.g. activities).
- Risk mitigation for when drinking happens: Notify residents that if they come to the facility intoxicated, they may be sent to a hospital or be refused of entry to the facility, when they are intoxicated, their medications may be placed on hold, take away the privilege of the use of their power chairs if drunk or intoxicated. Call 911. Notify all referrers/health care providers of the problem.
- Place flag, light-reflective vest to increase night time visibility. Wear the appropriate clothing when going out of the facility at night. (Ex. Jackets when cold, discourage female residents to wear skimpy clothing, etc.)
- Search and remove all contraband when substance use is suspected, with at least two staff members present. If term with contraband, initiate search immediately. If the resident refuses, continually observe resident until you can search for suspected items (e.g., resident put to bed or changed).
- When a resident is at risk of alcohol consumption intoxication (e.g., out of the facility at night, smells like alcohol, appears intoxicated), then implement more frequent checks for safety and try to encourage him/ her to rest as bed.
- Gentle statements of caring and concern related to substance use.
- Link discussions about risks of substance use with something he or she cares about such as body building or walking.
- Psychologist consultation per resident's request or interest in alcohol/ substance use cessation.
- Avoid prescribing any medications interacting with alcohol/ substances.
- If a resident is unable to be aroused or has changed level of consciousness or vital signs, send to the hospital for evaluation and detox.
- Attempt to establish a rep payee.
- Discourage family from providing funds; do not provide items that are not regulatory required that could be sold or could be used to barter or could "save" own money. Encourage to leave the money with the Facility's Cashier.

Sample Policy elements



I. **POLICY**

FACILITY will take reasonable steps to discourage or prevent residents from self-administering drugs or other medically active/psychoactive substances (e.g., herbal remedies, excessive caffeine, diet/weight loss supplements, "energy" drinks) or to mitigate harm associated with intake.

FACILITY will take reasonable steps to ensure an environment free from illegal and/or non-prescribed substances with restrictions of resident rights considered only when justified for safety of the individual or others.

II. **PROCEDURES**

A. Initial history will ascertain information about substance use and related diagnoses (current or historical), treatment and current use.

B. Residents with substance use disorder histories, who are amenable to treatment, will be offered treatment available at FACILITY, including counseling and referrals.

C. Clinical staff are alert to possible signs of substance use disorder through observation, laboratory studies, and development of consistent relationships.

D. When substance use or a substance use disorder is suspected, clinical team members including nursing, social workers, psychologist, and physician conduct an assessment and implement harm reduction interventions designed to protect both them, staff, and other residents and even the community from adverse impacts as feasible.

E. The Physician and Interdisciplinary Team will take reasonable steps to promote the safety of the resident and facility within the constraints of resident rights. Such steps may include:

a. Assessment of risks and implementation of resident specific interventions for risk mitigation.
b. Reassessment with change in circumstances, lack of effectiveness of interventions or new information.
c. Development of relationships based on trust and truth-telling avoiding punitive measures.
d. Education and counseling for the resident.
e. Offering medication treatment as available.
f. Attempt to obtain agreement to limit or discontinue substance use.
g. Implementation of care plan for acute intoxication.
h. Room search and other inspections for contraband.
i. Heightened monitoring of the resident.
j. Observation of visitors or contacts with at-risk peers.
k. Assuring facility-prescribed medicinal/non or treatments do not interact or potentiate substances used outside.
l. Through pharmacy consult and review of the resident's medication regimen for possible necessary adjustments to minimize the risk of the resident's use of non-prescribed substances.
m. Notification of payee to reduce available funds to reduce substance use (if appropriate)
n. Notification of representative (if resident unable to make their own decisions or provides permission).
o. Reduction of privileges (e.g., operation of power wheelchair) or mobility within the facility to protect self and others.
p. Alterations in medications or approach to health and behavioral concerns.
q. Room or neighborhood change.)
r. Notification of law enforcement.)
s. Care plan updates
t. Transfer or discharge.

A. Overview

The resident population includes individuals who are medically fragile, exhibit cognitive impairments, and many of whom have significant histories of substance use disorder (SUD). Substance use in this population poses significant risk of danger to the individual and those around him or her. However, for residents who maintain decision-making capacity, the facility may be limited in what it can offer or enforce.

B. Codes and Regulations / Reference / Authority

42 CFR: 483.10, 483.12.

This is my home and I need this stuff!

Mr. G has been in LTC for 2 yrs. He has a power wheelchair and a second one that is broken, but he may want to fix it. He shops on Craigslist and has purchased a laptop, desktop, large TV, and stereo system. He has his own coffee pot (he doesn't like decaf) and a large bottled water dispenser and requests staff to purchase the water and put the five gallon bottle on the dispenser. He has a large collection of sock monkeys. He is quadriplegic and uses a Hoyer lift. He refuses to part with anything, has a big "do not enter" sign on his door, and only lets certain staff he trusts touch his things.

Clutter

- Individual perspective:
- Regulations:
- Relationships:
- Staff roles:
- Finding win-win:

Clutter

- Individual perspective: *This is all I have—limits are tight. Electronics are expensive but needed! Its not that hard to care for my stuff correctly. It is not fair!*
- Regulations: right to belongings, but limits. Staff must be able to do care safely
- §483.10(l);
- §483.15(e), F252 §483.15(h)
- §483.15(h)(2)) F323 §483.25(h)
- Relationships: sorting, sustaining together
- Staff roles: who manages the belongings, loss
- Finding win-win: pride at the appearance, involved in finding solutions, feeling of helping the nurses.

Justify clutter reduction

- There are limits to the amount of possessions that can be stored and difficult decisions must be made as to what items are the highest priorities.
- Resident items must fit in their rooms;
- Possessions require care. They need to be kept clean, moved frequently, folded, sorted and moved.
- If a resident (or family member) can be completely independently responsible for their personal possessions then more items can be accommodated. However, in situations where the resident cannot be responsible for their items due to physical or mental disability, the time spent on caring for personal possessions falls on clinical staff.
- When clinical staff spend time caring for possessions they have less time to care for residents. As a result, personal possessions that require staff time/maintenance may be limited. Clutter can be a safety hazard both for residents and staff who need extra clear side walkways and workspaces for safety. Housekeeping has to maintain a high level of cleanliness and the presence of excessive personal items may unreasonably interfere with this duty and place staff at increased risk of injury due to the need to move personal items.

Resources

- Sample facility inspection form
- Sample "clutter letter"

Tech support

- Toby uses the facility internet to access pornographic websites; he shows them to others—for a price.
- Shakira's iPod is lost again; she wants it replaced.
- Dylan is paralyzed and needs staff to help him set up the computer and to load software for him. He keeps getting scammed.
- Portia posts info about the facility on her blog and takes photos/videos of staff without their knowledge.

Rational Use of Technology

- Individual perspective:
- Regulations:
- Relationships:
- Staff roles:
- Finding win-win:

Rational use of technology

- Individual perspective: *I am not disabled on the internet.*
- Regulations: privacy, rights, needs versus wants
  Relationships: let them teach you
- Staff roles: staff have the right to be free of resident/family harassment, hostile workplace, privacy; can electronics make staff lives easier
- Finding win-win: they can teach each other, cleanup computers, clear expectations on who pays for loss. Wireless. Promote autonomy using technology (arrange appointments)

Out on the town

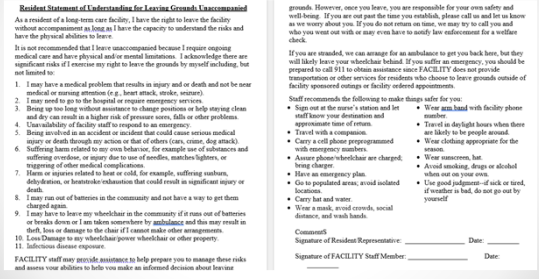
Martin goes out all day in his power chair and returns late at night. He has a pressure ulcer, but he doesn't want to "rot in bed." He smokes on his own, and burns his fingers or has holes in his pants. He sometimes buys food for his friends or drags them along behind him to help them get to the 7-11.

Out on the town

- Individual perspective:
- Regulations:
- Relationships:
- Staff roles:
- Finding win-win:

Out on the town

- Individual perspective: self destructive, immature coping, hopeless, depression, avoidance
- Regulations: autonomy, safety, undue influence or danger to others
- Relationships: influence behavior
- Staff roles: capacity and community assessment, making it safer, monitoring, assuring safety of peers with lower capacity
- Finding win-win: community integration and discharge, enhanced happiness, relationships with peers (altruism), cooling off



Resident Statement of Understanding for Leaving Grounds Unaccompanied

As a resident of a long-term care facility, I have the right to leave the facility without accompaniment as long as I have the capacity to understand the risks and have the physical abilities to leave.

It is not recommended that I leave unaccompanied because I require ongoing medical care and have physical and/or mental limitations. I acknowledge there are significant risks if I exercise my right to leave the grounds by myself including, but not limited to:

1. I may have a medical problem that results in injury and or death and not be near medical or nursing attention (e.g., heart attack, stroke, seizure).
2. I may need to go to the hospital or require emergency services.
3. Being up too long without assistance to change positions or help staying clean and dry can result in a higher risk of pressure sores, falls or other problems.
4. Unavailability of facility staff to respond to an emergency.
5. Being involved in an accident or incident that could cause serious medical injury or death through my action or that of others (cars, crime, dog attack).
6. Suffering harm related to my own behavior, for example use of substances and suffering overdose, or injury due to use of needles, matches/lighters, or triggering of other medical complications.
7. Harm or injuries related to heat or cold, for example, suffering sunburn, dehydration, or heatstroke/exhaustion that could result in significant injury or death.
8. I may run out of batteries in the community and not have a way to get them charged again.
9. I may have to leave my wheelchair in the community if it runs out of batteries or breaks down or I am taken somewhere by ambulance and this may result in theft, loss or damage to the chair if I cannot make other arrangements.
10. Loss/Damage to my wheelchair/power wheelchair or other property.
11. Infectious disease exposure.

FACILITY staff may provide assistance to help prepare you to manage these risks and assess your abilities to help you make an informed decision about leaving grounds. However, once you leave, you are responsible for your own safety and well-being. If you are out past the time you establish, please call us and let us know as we worry about you. If you do not return on time, we may try to call you and who you went out with or may even have to notify law enforcement for a welfare check.

If you are stranded, we can arrange for an ambulance to get you back here, but they will likely leave your wheelchair behind. If you suffer an emergency, you should be prepared to call 911 to obtain assistance since FACILITY does not provide transportation or other services for residents who choose to leave grounds outside of facility sponsored outings or facility ordered appointments.

Staff recommends the following to make things safer for you:

- Sign out at the nurse's station and let staff know your destination and approximate time of return.
- Travel with a companion.
- Carry a cell phone preprogrammed with emergency numbers.
- Assure phone/wheelchair are charged; bring charger.
- Have an emergency plan.
- Go to populated areas; avoid isolated locations.
- Carry hat and water.
- Wear a mask, avoid crowds, social distance, and wash hands.
- Wear arm band with facility phone number.
- Travel in daylight hours when there are likely to be people around.
- Wear clothing appropriate for the season.
- Wear sunscreen, hat.
- Avoid smoking, drugs or alcohol when out on your own.
- Use good judgment--if sick or tired, if weather is bad, do not go out by yourself

Comments\$

Signature of Resident/Representative: _____ Date: _____

Signature of FACILITY Staff Member: _____ Date: _____

Resources

- Sample statement of understanding for leaving the facility unattended
- OT/PT develop standardized assessment.
- Sample Physician order:

the resident has been assessed and determined to have the decision making capacity to exercise their right to leave the facility unattended and been informed of recommendations to make this safer.

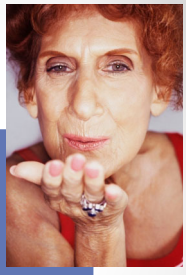
Driving?

- Fernando lets you know he is driving now and wants to park his new van in the parking lot. He shows you his drivers license. He said his van has hand controls (he is a quadriplegic with some use of hands). He is a daily drinker despite being in the nursing home and can be aggressive when drunk. He is taking medications for chronic pain.

Driving

- Individual perspective:
- Regulations:
- Relationships:
- Staff roles:
- Finding win-win:

Poster on driving?



Sexuality

Let's get physical

The supervisor was called to the nursing unit by the charge nurse one evening. One of the staff nurses had been passing by a resident room that had the door open. The curtain was drawn around the bed but the nurse could see that the ceiling lift was being pulled along the track with jerking movements. She knocked on the open door and called out the resident's name who resides in the room. When no one answered, she became alarmed and pulled the curtain aside to make sure the resident was okay. The resident is a woman with quadriplegia and moderate cognitive deficits. Her boyfriend, also a resident, with hemiparesis from a CVA was using the lift to support himself while they were engaged in sexual activity.

Or for the advanced…

- *31 year old man who is a quadriplegic but has intact sensation. He cannot masturbate and has purchased a sleeve device that goes over the penis. He needs staff help to apply it. He asks, can you help me?*
- *28 year old found using her personal computer to take videos of herself topless and post on line for money. Also, finding "dates" who give her things.*

Sexuality

- Individual perspective:
- Regulations:
- Relationships:
- Staff roles:
- Finding win-win:

Sexuality

- Individual perspective: sexuality is normal, nursing homes have no privacy—all gossip
- Regulations: activities of interest, privacy, reasonable accommodation, assessment, safety
- Relationships: Know them and what is going on. Help counsel on unsafe situations (not preach).
- Staff roles: What is part of my job? What is optional? What is not allowed? Capacity assessment, identifying and preventing liaisons that are not mutual.
- Finding win-win: achieving privacy, intimacy without harm to staff or peers

Sample care plan interventions

- Staff can provide privacy but not assistance
- What assistance are staff comfortable with—all staff required, or volunteers?.
- Have indicator of needing privacy.
- Checking parameters—how often, and how
- Beds are designed for one person; lifts can only be operated by staff.

Mental Illness

Mina is 42 and has schizophrenia with multiple psychiatric hospitalizations and suicide attempts since age 18. Her family stays away because she is so angry at them as a result of their being her conservator on and off for years and her lack of insight into her need for assistance. When homeless, she was victimized. She used drugs, smoked and drank, and was likely a prostitute for drugs. She speaks in wild delusional statements, gets irritable, and mostly keeps to herself. She refuses to be touched in any way.

if staff argue with her delusions, she may get frustrated and slap them, and she occasionally gets angry at a peer who gets incorporated into a delusion. She is on two antipsychotics, a mood stabilizer, and an antidepressant. She ambulates, but needs prompting to do ADLs. She needs a modified diet. Her cognition seems poor. She looks like she is in her 60s.

Mental Illness

- Individual perspective:
- Regulations:
- Relationships:
- Staff roles:
- Finding win-win:

Mental Illness

- Individual perspective: fear, low motivation, desire for connection
- Regulations: Mandated medication reductions, keeping others safe justifying her to stay at your facility. Discord between mental and physical health systems.
- Relationships: build trust, don't push, do not argue delusions
- Staff roles: Understand dementia, prevent harm to self and others, learn about co-management of mental illness and dementia. MDS coding, documentation critical.
- Getting to win-win: Can become facility expert! Families can reconnect when loved one in stable environment, and function improves. Dementia diagnosis reduces pressure for rehab.

Sample care plan for serious mental illness.

- **Goal:**
- To assure that psychosis does not result in any distress to the resident or harm to self or others.
- Avoid acute psychiatric hospitalization for 90 days.
- Avoid metabolic complications of antipsychotics.
- **Interventions:**
- PASRR on admission and with change in diagnosis—review recommendations and document those which can and cannot be accommodated, accepted or refused by the patient.
- Obtain informed consent for psychotropic medications
- Monitor for risks such as: Elopement, psychiatric exacerbation, aggression, non-compliance, medication side effects.
- Document triggers, non-pharmacological interventions and outcomes of use of psychotropic medications.
- Do not challenge delusions or argue with them (like with dementia, validate the feeling behind it) -e.g. "that sounds scary!"
- Monitor signs of psychosis that the individual exhibits (delusions, responding to internal stimuli, irritability, aggression, misperceptions, auditory hallucinations. Report any withdrawal or refusal of care, poor impulse control, low frustration tolerance, unable to think clearly, difficulty communicating needs.
- Assure that medications are swallowed/ingested and not pocketed.
- Provide music or television viewing to drown out auditory hallucinations.
- Provide a structured environment with consistent staff.
- Activities of interest - encourage participation.
- Interdisciplinary psychotropic reviews quarterly and as needed.
- Weight, lipid and glucose values to be measured periodically to evaluate for side effects of antipsychotics. (exception: comfort care status; monitor for SX only)
- Routine measurements of levels of lithium and anticonvulsants used for diagnoses. (exception: comfort care status; monitor for SX only)
- Drug reductions as indicated if patient is stable over a period of time and benefits outweigh risks, but not mandated for those with schizophrenia, Tourette's, HD and schizoaffective disorder.
- Monitor behaviors (CNA), Ln to assess and document new behavior with triggers
- Assess daily routine of resident and, develop/create a structured environment/routine with consistent staffing that the resident can easily adapt to himself/ herself without forcing him/ her.

Demanding excessive use of resources

Constance wants her care done a certain way. She has quadriplegia so she needs your help. She wants her vulva and legs shaved every other day, daily showers which take more than an hour and extensive help straightening her clothing, applying tight garments and applying make up and fixing her hair. "Just one more thing before you go."

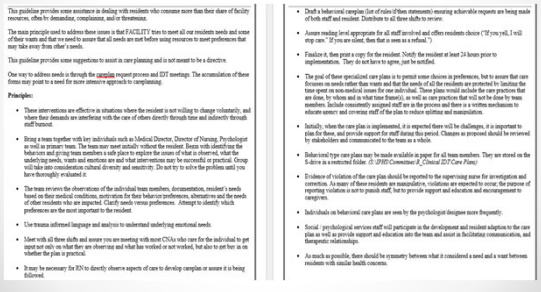
I want it now

- Individual perspective:
- Regulations:
- Relationships:
- Staff roles:
- Finding win-win:

I want it now!

- Individual perspective: *I need help to do everything. I want things that I can no longer get. I am suffering from being sick and see you as a servant.*
- Regulations: Our mandate is "all your needs and some of your wants," your wants cannot take away others' needs.
- Relationships: Keeping your caregiver is key to your health and quality of life. "I am on your side, but I need to make sure that this happens or I may be reassigned."
- Staff roles: staff burnout and feelings matter, support staff in setting limits and providing "standard" care
- Finding win-win: celebrate compliance, offer choice of what to take away for new requests, celebrate staff and residents who can work it out together

How to do behavioral care plan



This guideline provides some assistance in dealing with residents who consume more than their share of facility resources, often by demandina, complainina, and/or threatening.

The main principle used to address these issues is that FACILITY tries to meet all our residents needs and some of their wants and that we need to assure that all needs are met before using resources to meet preferences that may take away from other's needs.

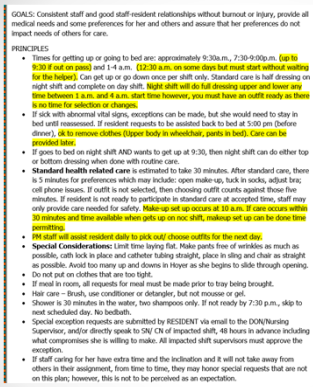
This guideline provides some suggestions to assist in care planning and is not meant to be a directive.

One way to address needs is through the careplan request process and IDT meetings. The accumulation of these forms may point to a need for more intensive approach to careplanning.

Principles:

- These interventions are effective in situations where the resident is not willing to change voluntarily, and where their demands are interfering with the care of others directly through time and indirectly through staff burnout.
- Bring a team together with key individuals such as Medical Director, Director of Nursing, Psychologist as well as primary team. The team may meet initially without the resident. Begin with identifying the behaviors and giving team members a safe place to explore the issues of what is observed, what the underlying needs, wants and emotions are and what interventions may be successful or practical. Group will take into consideration cultural diversity and sensitivity. Do not try to solve the problem until you have thoroughly evaluated it.
- The team reviews the observations of the individual team members, documentation, resident's needs based on their medical conditions, motivation for their behavior/preferences, alternatives and the needs of other residents who are impacted. Clarify needs versus preferences. Attempt to identify which preferences are the most important to the resident.
- Use trauma informed language and analysis to understand underlying emotional needs.
- Meet with all three shifts and assure you are meeting with most CNAs who care for the individual to get input not only on what they are observing and what has worked or not worked, but also to get buy in on whether the plan is practical.
- It may be necessary for RN to directly observe aspects of care to develop careplan or assure it is being followed.

- Draft a behavioral careplan (list of rules if/then statements) ensuring achievable requests are being made of both staff and resident. Distribute to all three shifts to review.
- Assure reading level appropriate for all staff involved and offers residents choice ("If you yell, I will stop care." If you are silent, then that is seen as a refusal.")
- Finalize it, then print a copy for the resident. Notify the resident at least 24 hours prior to implementation. They do not have to agree, just be notified.
- The goal of these specialized care plans is to permit some choices in preferences, but to assure that care focuses on needs rather than wants and that the needs of all the residents are protected by limiting the time spent on non-medical issues for one individual. These plans would include the care practices that are done, by whom and in what time frame(s), as well as care practices that will not be done by team members. Include consistently assigned staff are in the process and there is a written mechanism to educate agency and covering staff of the plan to reduce splintaz and manipulation.
- Initially, when the care plan is implemented, it is expected there will be challenges, it is important to plan for these, and provide support for staff during this period. Changes as proposed should be reviewed by stakeholders and communicated to the team as a whole.
- Behavioral type care plans may be made available in paper for all team members. They are stored on the S-drive in a restricted folder. *(S:\PHS\Committees\E_Clinical IDT\Care Plans)*
- Evidence of violation of the care plan should be reported to the supervising nurse for investigation and correction. As many of these residents are manipulative, violations are expected to occur; the purpose of reporting violation is not to punish staff, but to provide support and education and encouragement to caregivers.
- Individuals on behavioral care plans are seen by the psychologist designee more frequently.
- Social / psychological services staff will participate in the development and resident adaption to the care plan as well as provide support and education into the team and assist in facilitatar communication, and therapeutic relationships.
- As much as possible, there should be symmetry between what it considered a need and a want between residents with similar health concerns.



GOALS: Consistent staff and good staff-resident relationships without burnout or injury, provide all medical needs and some preferences for her and others and assure that her preferences do not impact needs of others for care.

PRINCIPLES

- Times for getting up or going to bed are: approximately 9:30a.m., 7:30-9:00p.m. (up to 9:30 if out on pass) and 1-4 a.m. (12:30 a.m. on some days but must start without waiting for the helper). Can get up or go down once per shift only. Standard care is half dressing on night shift and complete on day shift. Night shift will do full dressing upper and lower any time between 1 a.m. and 4 a.m. start time however, you must have an outfit ready as there is no time for selection or changes.
- If sick with abnormal vital signs, exceptions can be made, but she would need to stay in bed until reassessed. If resident requests to be assisted back to bed at 5:00 pm (before dinner), ok to remove clothes (Upper body in wheelchair, pants in bed). Care can be provided later.
- If goes to bed on night shift AND wants to get up at 9:30, then night shift can do either top or bottom dressing when done with routine care.
- **Standard health related care** is estimated to take 30 minutes. After standard care, there is 5 minutes for preferences which may include: open make-up, tuck in socks, adjust bra; cell phone issues. If outfit is not selected, then choosing outfit counts against those five minutes. If resident is not ready to participate in standard care at accepted time, staff may only provide care needed for safety. Make-up set up occurs at 10 a.m. If care occurs within 30 minutes and time available when gets up on noc shift, makeup set up can be done time permitting.
- PM staff will assist resident daily to pick out/ choose outfits for the next day.
- **Special Considerations:** Limit time laying flat. Make pants free of wrinkles as much as possible, cath lock in place and catheter tubing straight, place in sling and chair as straight as possible. Avoid too many up and downs in Hoyer as she begins to slide through opening.
- Do not put on clothes that are too tight.
- If meal in room, all requests for meal must be made prior to tray being brought.
- Hair care – Brush, use conditioner or detangler, but not mousse or gel.
- Shower is 30 minutes in the water, two shampoos only. If not ready by 7:30 p.m., skip to next scheduled day. No bedbath.
- Special exception requests are submitted by RESIDENT via email to the DON/Nursing Supervisor, and/or directly speak to SN/ CN of impacted shift, 48 hours in advance including what compromises she is willing to make. All impacted shift supervisors must approve the exception.
- If staff caring for her have extra time and the inclination and it will not take away from others in their assignment, from time to time, they may honor special requests that are not on this plan; however, this is not to be perceived as an expectation.

A sample

Note level of detail.

Note offering choices but also limits.

Nurses can point to "following the care plan." Exceptions must be CONSIDERED.

resources

- Sample behavioral care plan
- Sample policy on behavioral care plan

Further Reading

- Oliver, S., Gosden-Kaye, E. Z., Jarman, H., Winkler, D., & Douglas, J. M. (2020). A scoping review to explore the experiences and outcomes of younger people with disabilities in residential aged care facilities. *Brain Injury*, *34*(11), 1446–1460. https://doi.org/10.1080/02699052.2020.1805124

- Chapman, H., Bethell, J., Dewan, N. *et al.* Social connection in long-term care homes: a qualitative study of barriers and facilitators. *BMC Geriatr* **24**, 857 (2024). https://doi.org/10.1186/s12877-024-05454-8