Help Me!! Help Me!! Help Me!! The Common Sense Approach to Challenging Behavior

Cat Selman, BS
The Cat Selman Company

Compliance Issues

- F578 – Right to refuse treatment
- F580 – Notification of physician
- F622 – Transfer and discharge
- F604 – Freedom from physical and chemical restraints
- F600 – Freedom from abuse & neglect
- F602 – Freedom from Misappropriation/Exploitation

Compliance Issues

- F550 – Residents Rights/Exercise of Rights
- F679 – Activities
- F745 – Provision of Medically-related Social Services
- F636 – Comprehensive Assessment
- F637 – Comprehensive Assessment after significant change
- F656 – Comprehensive Care Plan
- F658 – Services to meet professional standards
- F659 – Qualified Persons

Compliance Issues

- F742 – Treatment/Services for Mental/ Psychosocial Concerns
- F757 – Drug Regimen is free from unnecessary drugs
- F758 – Free from Unnecessary Psychotropic Meds/PRN Use
- F730 – Nurse Aide Performance Review - 12 hr/Year in-service education
- F947 – Required In-service Training for Nurse Aides

Assessing Residents who Exhibit Challenging Behavior

Cognitive assessment challenges

- There should be a consistent and effective approach for determining such things like whether the resident is forgetful, a wanderer, an elopement risk, and so on.
  - Early assessment of the mental status of resident will help you more effectively care for these residents and potentially prevent them from becoming difficult.

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Assessing Residents who Exhibit Challenging Behavior

Signs of Depression

- Depression is one of the most common and undiagnosed problems in the elderly.
  - Early screening for depression may help staff better handle a resident's complex care planning needs.

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Behavior Analysis

Undesirable or inappropriate behaviors are often reflection of the person's emotion, intentions or expressive desires.

- Factors related to the environment
  - Loud noises, excessive stimuli, large spaces, unfamiliar or new environment

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Behavior Analysis

Factors related to physical and emotional health

- Coexisting diseases
- Persons with dementia have difficulty expressing physical discomfort, which may induce emotional disturbance and agitation

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Behavior Analysis

Factors related to physical and emotional health

- Drugs can cause confusion & physical discomfort
  - Symptoms related to impaired vision or hearing
    - Cognitive decline may cause spatial disorientation of time, place and person

Behavior Analysis

Factors related to communication

- Persons with dementia may have difficulty in receiving and understanding the message during communication

Behavior Analysis

Factors related to task-induced stress

- When a person is no longer able to perform simple tasks, such as bathing or grooming, they may become withdrawn, frustrated, depressed and even angry

Changing Staff Attitude – Whose Problem is it?

- Problem behaviors then, are not an inevitable consequence of cognitive decline.
  - Most facility staff continue to REACT to behavioral issues, rather than make the attempt to prevent them.

What does it take to change your attitude?

- Assess your own personal feelings about the elderly
  - View the resident as a real, human being – like your own mother, father, grandmother, or grandfather

What does it take to change your attitude?

- Walk a mile in their shoes… ask yourself – what would I do if I were in this same situation?
  - Accept that their behavior may be normal and appropriate

What does it take to change your attitude?

- Take your personal feelings out of the equation – it's not about you!
  - What does it hurt to let them behave in the manner in which they choose?
    - Long term care is more than "just a job" – it is a choice, or you don't make it!

What does it take to change your attitude?

- Walk the walk, and talk the talk – whatever is at the "top," ALWAYS trickles down…

Care Team Questions

- Can we correct or resolve the issue? If not…
  - Can we "control" or "maintain" the behavior, outcome, or result? If not…
    - Can we live with it?

Evaluation/Assessment

- Identify the symptom. Define the behavior specifically.
  - Determine the impact of the behavior. Does the behavior prevent the elder or the staff from functioning optimally? Why? How? Be specific. Consider both common and worst case scenarios.

Evaluation/Assessment

Record and review information relevant to the behavior.

- Record a complete description of the symptoms
  - Review all medical and psychiatric diagnoses and medication history, including recent medication changes

Evaluation/Assessment

Record and review information relevant to the behavior.

- Identify any circumstances preceding the behavior
  - ✓ Is behavior predictable?
  - ✓ Does any action seem to prevent or diminish the behavior?
  - ✓ Does any action seem to provoke or precipitate the behavior?

Evaluation/Assessment

- Monitor the behavior using a structured behavioral monitoring instrument.
- The most basic behavior log should include:
  1. time of day
  2. exact location of the behavior
  3. exact description of the behavior
  4. thorough description of environmental elements such as odors, sights, and sounds
  5. other persons present
  - Generally, within 10 entries, a pattern will emerge

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Evaluation/Assessment

Consider known medical conditions that could manifest behavioral symptoms.

- Look for a rapidly fluctuating level of awareness and worsening attention span that often signals delirium

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Evaluation/Assessment

Consider known medical conditions that could manifest behavioral symptoms.

- Perform a BIMS or other mental status test, and note changes from most recent baseline
  - Review the social history – look for ANYTHING that could explain symptoms

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Evaluation/Assessment

Consider known medical conditions that could manifest behavioral symptoms.

- Perform a focused physical exam and lab tests to look for possible medical causes. Some conditions that manifest as changes in behavior:
  - ✓ Acute infections (pneumonia, sinus, UTIs)
  - ✓ Bowel dysfunction
  - ✓ Disturbed sleeping pattern
  - ✓ Drug toxicity/side effects
  - ✓ Pain
  - ✓ Dehydration

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Successful behavior management "musts"

1. Identify elder's strengths and abilities on which behavioral therapy may be based.
2. Provide behavior management training for all facility staff, including non-caregiving staff.
3. Use a goal planning approach. With awareness of a elder's abilities, staff members can identify and plan for realistic, achievable behavioral management goals.

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Successful behavior management "musts"

4. Allocate staff time sufficient for adequate elder supervision.
5. Provide ongoing, scheduled reevaluation of each person who has behavioral symptoms.
6. There MUST be consistency among staff across all shifts – all departments.

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Implementation of the behavior management plan

- ✓ Use behavioral and environmental interventions before pharmacological interventions.
- ✓ Make specific and individualized interventions part of the elder's care plan.
- ✓ Monitor changes in the elder's target symptoms as you implement the plan.
- ✓ When there are multiple behavioral symptoms, work on one or two symptoms at a time.
- ✓ Be patient! Behavior management programs take time to produce positive results.

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Alternatives for residents who become anxious

- Utilization of volunteers to provide companionship and diversional activities.
  - Activity carts within each unit have been highly successful.
    - Planning activities to be held throughout the day and early evening can be especially effective in reducing the effects of "sundowning."

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Alternatives for residents who become anxious

- Utilize pet therapy in your workplace
  - Make "busy boxes" an integral part of your unit. These are boxes/bags/ aprons that are full of familiar items for residents experiencing confusion to keep their hands busy. These tasks have been shown to reduce the resident's level of anxiety.

Alternatives for residents who become anxious

- Utilize music. It has been shown to have a calming effect on many residents. Keep headphones and radios on hand to use when residents become anxious or agitated.
  - Encourage family members to send photos, a cassette recording of their voices talking to the resident. This will, at times, reduce a resident's anxiety level.

Alternatives for residents who become agitated

- First, rule out the possibility of infection, always consider an acute illness.
- For residents who are nonverbal, the only cue that they are in pain may be their acting out.

Alternatives for residents who become agitated

- With neurological diseases, such as Alzheimer's, you don't usually see abrupt changes in a resident's condition; so a sudden change signifies that something else is happening.

Alternatives for residents who become agitated

- Recent medical studies have shown that a whiff of lavender, or exposure to bright light might be enough to relieve some of dementia's most disturbing symptoms, including agitation, aggression, depression, and sleep disturbances.

Alternatives for residents who become agitated

- Three recent studies have indicated that the use of aromatherapy, specifically lemon balm and lavender oil, reduced agitation and improved the resident's quality of life.

Alternatives for residents who become agitated

- Bright light, known to be effective in treating seasonal affective disorder, was also used in the studies.
  - Studies have show that full-spectrum light can also reduce the effects of sundowning.

Alternative for dementia residents Validation therapy

- The idea behind validation therapy is to join residents on their mental journeys to the past instead of vainly trying to snap them back to the present.
  - The result is better communication with less frustration and agitation for both residents and the staff.

Alternative for dementia residents
Validation therapy

- Affecting the resident's environment to reflect a time period or event with which they are comfortable assists with this process.
  - The idea behind validation therapy is to validate, or accept, the values, beliefs, and "reality" of the resident who has dementia.

General Recommendations for Pharmacological Management of Behavioral Symptoms

- Begin treatment for behavioral symptoms using non-pharmacological interventions unless the behavioral symptoms are clearly a mental illness such as Major Depressive Disorder or Schizophrenia for which drug therapy is necessary.
  - When pharmacological therapy is needed, start low, go slow, and increase only if necessary.

General Recommendations for Pharmacological Management of Behavioral Symptoms

- Choose medications on the basis of side effect profiles.
- Avoid polypharmacy (the administration of many drugs together, or excessive medication – especially for the treatment of the same disease)
  - Do not use medications to treat behavioral symptoms when there is little or no research evidence that shows such treatment is effective for those symptoms.

General Recommendations for Pharmacological Management of Behavioral Symptoms

- Do not use medication to treat behavioral symptoms that neither impair resident function nor create a danger to self or others or cause distress for the resident such as fear or dysphoria (an emotional state characterized by anxiety, depression, or unease)

Preventing Problem Behaviors

- Constantly assess the resident and the environment – being sure that it is calm, comforting, and reassuring – neither over-stimulating or under-stimulating.
  - Be consistent in scheduling and approach.
    - Distract rather than confront.
    - Never shout or display anger.

Preventing Problem Behaviors

- Use gentle humor as part of the nonverbal approach.
  - Isolate the person from a group – briefly – for disruptive or disturbing behavior.
    - Analyze the circumstances surrounding the behavior and try to prevent them from happening again.

Preventing Problem Behaviors

- Provide a bridge from one event to the usual routine of the day, and vice versa.
  - Pay particular attention to nonverbal communication such as tone of voice, facial expression, and gestures.

Preventing Problem Behaviors

- If the behavior is unusual for the person, report it to other team members.
  - Build self-esteem by providing success experiences.
    - Offer meaningful activities, walks, and exercise to reduce boredom and frustration.

Preventing Problem Behaviors

- Explain all procedures, especially changes of location, to those who are wheelchair dependent.
  - Speak slowly, in short simple sentences.
    - Never lie, make false promises, or give insincere reassurances.
      - Evaluate interventions and responses and try to understand what works best with each person.

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Preventing Problem Behaviors

- Schedule activities at times of the day when the person is most alert, usually in the morning, or most in need of activity, often at the end of the afternoon or after supper.
  - Provide the necessary cues and explanation for expected behavior.

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De-escalating anger in Difficult Residents

- Maintain proper distance (3 to 6 feet) from residents who have a history of violence or combativeness.
  - Respect the resident's personal space.

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De-escalating anger in Difficult Residents

- Maintain an open stance. Stand at an angle, palms open – no hands on hips, crossing of arms or pointing fingers.
  - Maintain appropriate eye contact and facial expressions.

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De-escalating anger in Difficult Residents

- Project a calm attitude
- Utilize active listening skills, acknowledging the resident is upset and asking for their recommendations to correct the problem.

De-escalating anger in Difficult Residents

- Don't take it personally – it's not about you! Manage your own frustration and anger.
- Listen without interrupting and try to validate his/her feelings.

De-escalating anger in Difficult Residents

- When the resident pauses, say something like "I understand you are upset."
- Remain nonjudgmental, show empathy, and let the resident know you want to address his/her concerns.

De-escalating anger in Difficult Residents

- Be aware of your tone of voice, volume and rate that you speak. Be calm, speaker clearly and slowly in a moderate tone. Speaking too fast or too slowly conveys agitation and loss of control.

De-escalating anger in Difficult Residents

- Use the resident's name in a respectful manner.
- Set non-negotiable limits. Give residents clear choices and consequences for their actions. For example, "If you refrain from using profanity, we can discuss your concerns."

Memorize the Four Ds…

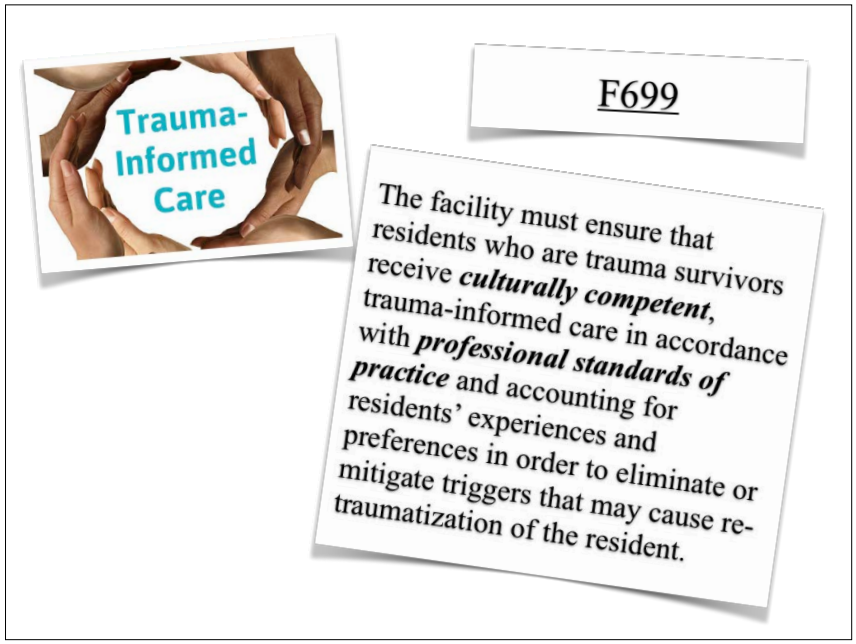
1. Disarming: engage in conversation with a resident only after he/she has "cooled down."
2. Diverting: shift the focus from the resident's angry behavior to the issues behind the angry behavior.

Memorize the Four Ds…

3. Diffusing: remain calm and refuse to escalate angry behavior by reinforcing it with verbal retaliation or aggressive body language.
4. Deflecting: Use silence selectively as a means of ignoring verbal attacks.

Trauma Informed Care: What Your Staff NEED to Know!

Cat Selman, BS
www.catselman.com


Trauma-Informed Care
F699
The facility must ensure that residents who are trauma survivors receive ***culturally competent***, trauma-informed care in accordance with ***professional standards of practice*** and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

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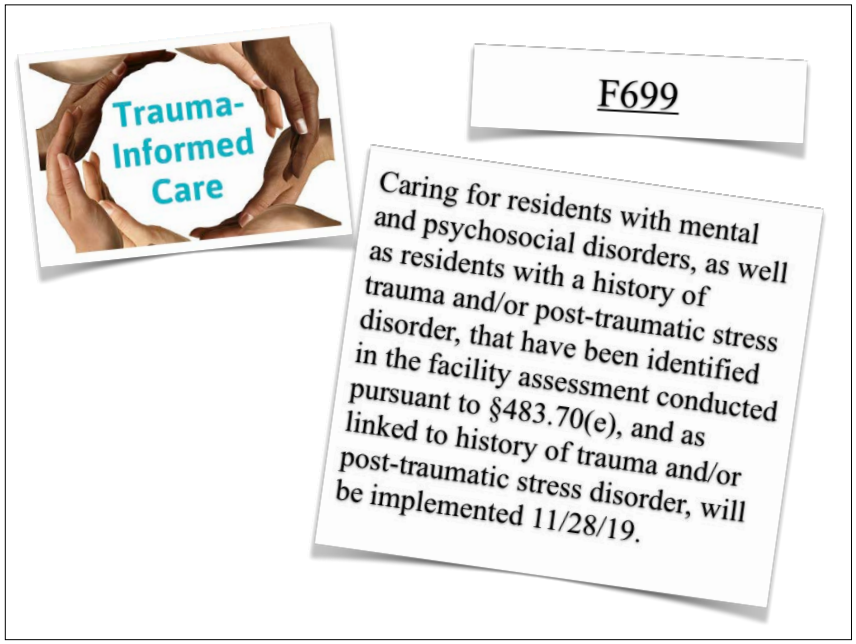
Trauma-Informed Care
F699
Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and as linked to history of trauma and/or post-traumatic stress disorder, will be implemented 11/28/19.

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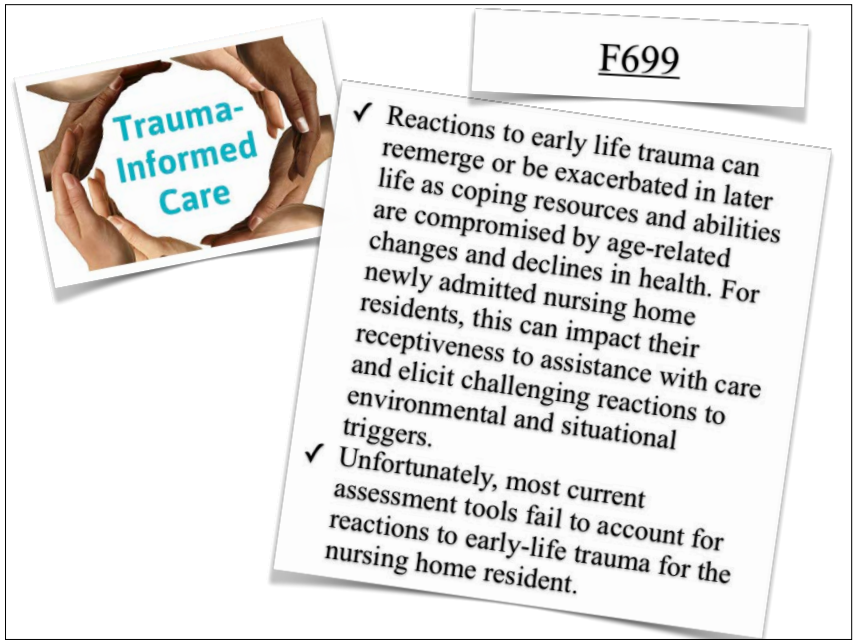
Trauma-Informed Care
F699
✓ Reactions to early life trauma can reemerge or be exacerbated in later life as coping resources and abilities are compromised by age-related changes and declines in health. For newly admitted nursing home residents, this can impact their receptiveness to assistance with care and elicit challenging reactions to environmental and situational triggers.
✓ Unfortunately, most current assessment tools fail to account for reactions to early-life trauma for the nursing home resident.

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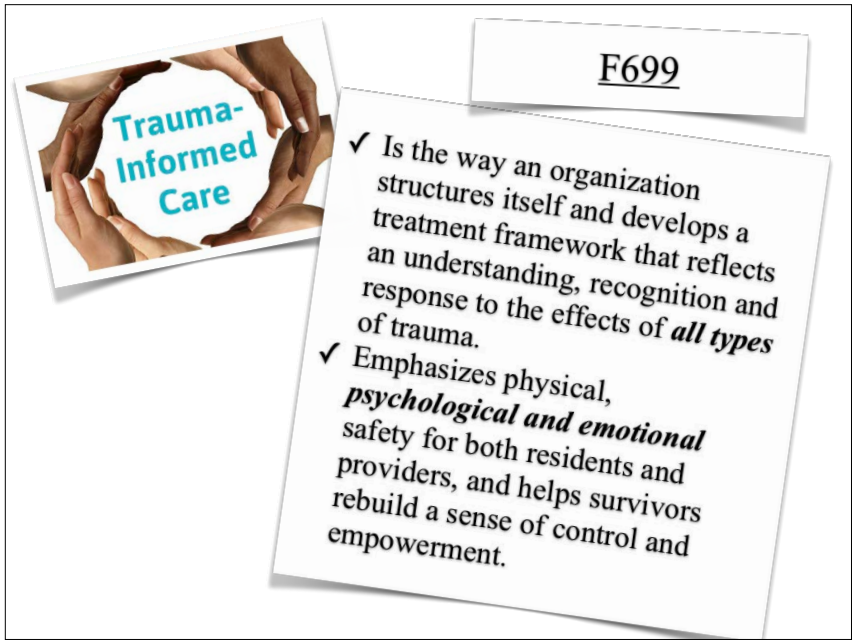
Trauma-Informed Care
F699
✓ Is the way an organization structures itself and develops a treatment framework that reflects an understanding, recognition and response to the effects of ***all types*** of trauma.
✓ Emphasizes physical, ***psychological and emotional*** safety for both residents and providers, and helps survivors rebuild a sense of control and empowerment.

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F699

- ✓ Includes an awareness of a resident's history of traumatic events (psychological and physical) that can influence how the resident relates to their care setting, care givers and treatment plan.
- ✓ It also includes environmental and interpersonal approaches that consider the effects of trauma on the resident.

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What is trauma?

Results from an **event**, series of events, or set of circumstances

experienced by an individual as physical or emotionally harmful or life threatening

has lasting adverse **effects**

on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

SAMHSA, 2014

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Definitions

- ➡ **COMPLEX TRAUMA:** results from extended exposure to traumatizing situations, often during childhood.

- ➡ **DEVELOPMENTAL TRAUMA:** multiple or chronic exposure to one or more forms of interpersonal trauma (abandonment, betrayal, physical assault, sexual assault, threats to bodily integrity, coercive practices, emotional abuse, witnessing violence or death).

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Definitions

- ➡ **ACUTE TRAUMA:** results from exposure to a single overwhelming event
- ➡ **POST-TRAUMATIC STRESS DISORDER (PTSD):** a recognized mental health condition that's triggered by a terrifying event.
- ➡ **VICARIOUS/SECONDARY TRAUMA/ COMPASSION FATIGUE:** different but related secondary stress injuries.

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Definitions

- **RETRAUMATIZATION:** a conscious or unconscious reminder of past trauma that results in a re-experiencing of the initial trauma event. It can be triggered by a situation, an attitude or expression, or by certain environments that replicate the dynamics (loss of power/control/safety) of the original trauma.

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Definitions

- TRIGGERS: Signals that act as signs of possible danger, based on historical traumatic experiences, and which lead to emotional, physiological, and behavioral responses that arise in the service of survival and safety.

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Psychosocial Trauma

- Direct personal experience of an event that involves actual or threatened death or serious injury; threat to one's physical self
- Witnessing an event that involves threat of death, injury to self or others
- Learning about unexpected or violent death, serious harm, or threat of death, or injury experienced by a family member or friend/ associate

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Psychosocial Trauma

- Include both physical and psychological events
- Overwhelms the person's ability to cope with their environment in the immediate present
- Occur immediately and over time
- Cause long lasting impairment in functioning and lead to serious consequences; mental, physical and emotional
- Have varying effects based on the individual

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Physical Trauma

- ➡ Serious injury to the body:
  - ✓ Blunt force trauma - the body struck with an object or force, causing concussions, lacerations or fractures
  - ✓ Penetrating trauma - an object pierces the skin or body, usually creating an open wound
  - ✓ Can also include sexual assault, wounds from natural disasters, wars, terrorism, etc.

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What kind of trauma might be found in nursing homes?

- Adverse Childhood Experiences
- The Holocaust
- Historical Trauma
- Disaster
- Sexual Abuse
- Transfer Trauma
- Homelessness
- Grief/Loss
- Intimate Partner Violence

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What kind of trauma might be found in nursing homes?

- Immigrants leaving their native countries
- Bullying
- Systemic Racism
- PTSD
- Substance abuse in family
- Surgery or other invasive medical procedures
- Life-threatening medical conditions
- Falls/ Accidents

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Some horrific facts…

- **23 veterans a day commit suicide**
- **An estimated 5 percent of Americans, more than 13 million people, have PTSD at any given time.**
- **More than 100,000 Holocaust survivors live in the U.S. today.**
- **1 in 14 children have been physically abused**
- **On average, 24 people per minute are victims of rape, physical violence or stalking by an intimate partner**

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Symptoms

➡ **Biological:**

- ✓ Brain function
- ✓ Headaches, backaches
- ✓ Stomach aches
- ✓ Appetite changes
- ✓ Cold susceptibility
- ✓ Intestinal problems
- ✓ Sleep changes

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Symptoms

➡ **Psychological:**

- ✓ Fearfulness, anxiety
- ✓ Loneliness
- ✓ Helplessness
- ✓ Dissociation
- ✓ Outbursts
- ✓ Flashbacks
- ✓ Nightmares

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Symptoms

➡ **Social/Behavioral:**

- ✓ Apathy
- ✓ Isolation
- ✓ Difficulty trusting
- ✓ Detachment
- ✓ Suicide ideation, self-injury, aggression

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Symptoms

➡ **Spiritual:**

- ✓ Struggle to find meaning
- ✓ Anger at God
- ✓ Desolation
- ✓ Giving up on faith or questioning lifetime beliefs

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Trauma & Ageism

- Age itself is stigmatized and feared
- Differential Treatment
- Masking and coping mistaken for absence of trauma
- Pressure to remain silent and not disrupt family systems
- Loss of power and voice associated with trauma and old age
- Age dramatically affects resources available

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Trauma Informed Care

- ➡ **Realizes** the widespread impact of trauma and understands potential paths for recovery.
- ➡ **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
- ➡ **Responds** by fully integrating knowledge about trauma into procedures, and practices.
- ➡ **Seeks** to actively resist re-traumatization.

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Trauma Informed Care

Six principles:

1. Safety
2. Trustworthiness & Transparency
3. Peer Support
4. Collaboration & Mutuality
5. Empowerment, voice & choice
6. Cultural, historical and gender issues

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Trauma Informed Care

1. Safety:

   Throughout the organization, staff and the people they serve feel physically and psychologically safe.

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Trauma Informed Care

2. Trustworthiness and transparency:

Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.

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Trauma Informed Care

3. Peer Support and mutual self-help:

These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment. (Interdependence)

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Trauma Informed Care

4. Collaboration and mutuality:

- ✓ There is true partnering and leveling of power differences between staff and clients and among organizational staff, from direct care staff to administrators.
- ✓ There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
- ✓ The organization recognizes that everyone has a role to play in a trauma-informed approach.
- ✓ One does not have to be a therapist to be therapeutic.

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Trauma Informed Care

5. Empowerment, voice, and choice:

- ✓ Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary.
- ✓ The organization aims to strengthen the staff's, clients', and family members' experience choice and recognize that every person's experience is unique and requires and individualized approach.
- ✓ This includes a belief in resilience ad int he ability of individuals, organization, and communities to heal and promote recovery from trauma.
- ✓ This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.

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Trauma Informed Care

6. Cultural, historical, and gender issues:
   - ✓ The organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

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Steps to meet the requirements:

Know and assess the residents you care for: histories, mental health, coping skills/abilities, preferences. (Record reviews, observations, interviews.)

Train everyone! Staff, residents, family members, volunteers.

Identify and build on strengths of staff, residents, family members.

Build partnerships with mental health professionals and community-based resources.

Promote positive engagement among residents, family and staff.

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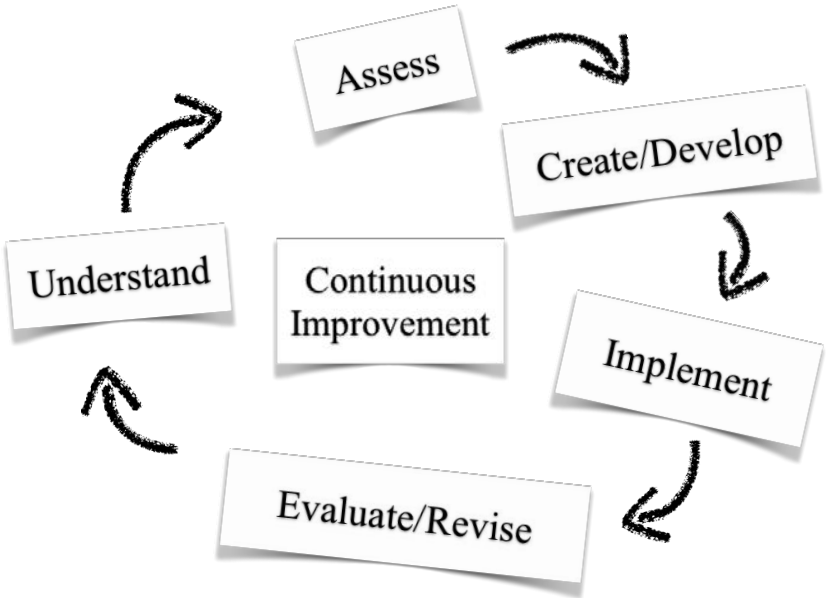

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One size does not fit all. The past matters and it influences today and tomorrow.

Trauma is highly individual. Everyone experiences life events and stressors differently.

Understand that residents may be reliving or experiencing the impact of trauma even if the trauma is not recent.

Behaviors and signs need to be considered through a lens of trauma and resilience.

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Understand that everyone adopts coping mechanisms and everyone has strengths.

Resilience is highly individual. Everyone copes differently.

Knowing residents' strength and resources is key to growing our residents' resilience.

Joy, curiosity, activities, and positive social connections change the brain, too.

Trauma-Informed Care is a process, not a destination.

The Nuts & Bolts of Cultural Competency

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The Cat Selman Company
www.catselman.com

Cultural Competence

- Cultural competence is defined as the ability of providers and organizations to effectively deliver health **care** services that meet the social, cultural, and linguistic needs of patients.
- A **culturally competent** health **care** system can help improve health outcomes and quality of care, and can contribute to the elimination of racial and ethnic health disparities.

Cultural Competence

- Cultural competence can be defined as the level of knowledge-based skills required to provide effective clinical care to patients from a particular ethnic or racial group.
- To provide **culturally competent care**, health**care** professionals must be willing and able to provide family - and patient-centered **care** by adjusting their attitudes and behaviors to the needs of diverse patient groups.

The Need to Know

- Race, age, and gender have obvious impacts on our ways of thinking and communicating.
- There are also many other aspects of our individual cultures which play a great part in how we care for others and how we accept care.

The Need to Know

- Cultural competence is a developmental process.
- Beyond awareness of subtle expectations or assumptions, there is a need for knowledge about different cultural norms, lifestyle needs, and personal preferences of individuals from different groups.

Definitions

- **Culture** refers to norms and practices of a particular group that are learned and shared and guide thinking, decisions, and actions.
- **Cultural values** are the individual's desirable or preferred way of acting or knowing something that is sustained over a period of time and which governs actions or decisions.
- **Ethnic** relates to large groups of people classified according to common traits or customs .

Definitions

- ***Cultural Knowledge:*** **Familiarization with selected cultural characteristics, history, values, belief systems, and behaviors of the members of another ethnic group**
- ***Cultural Sensitivity:*** **Knowing that cultural differences as well as similarities exist, without assigning values, i.e., better or worse, right or wrong, to those cultural differences**

Definitions

- ***Cultural Awareness:*** **Developing sensitivity and understanding of another ethnic group. This usually involves internal changes in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others. Cultural awareness must be supplemented with cultural knowledge.**

Health Care and Diversity

- Despite notable progress in the overall health of Americans, there are continuing disparities in health status among African Americans, Hispanics, Native Americans, and Pacific Islanders, compared to the U.S. population as a whole.
- In addition, the health care system is becoming more challenged as the population becomes more ethnically diverse.

Health Care and Diversity

- Cultural, ethnic, linguistic, and economic differences impact how individuals and groups access and use health, education, and social services.
- They can also present barriers to effective education and health care interventions.
- This is especially true when health educators or health care practitioners stereotype, misinterpret, make faulty assumptions, or otherwise mishandle their encounters with individuals and groups viewed as different in terms of their backgrounds and experiences.
- The demand for culturally competent health care in the United States is a direct result of the failure of the health care system to provide adequate care to all segments of the population.

Health Care and Diversity

- Due to the increase of racial/ethnic diversity within the elder population, caregivers will need to go beyond lumping all older individuals into one category “Old,” or “Old and Sick.”
- In the future, the discussion on aging related needs/issues may show greater diversity across racial/ethnic groups of elders than has previously been documented.

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Cultural Insensitivity

- Is usually not intentional. It is, rather, caused by not having the knowledge we need to understand another person’s frame of reference.
- Can sometimes be a result of our fear of the unknown or of something new, or we try to deny that there are differences by viewing everyone as the same.
- Can sometimes be simply due to time constraints; have to much to do and feel pressured to complete our tasks and move on to the next resident who is waiting.
- When these events happen, misunderstandings can result between the resident and/or family’s expectations and ours.
- Miscommunication can occur. It becomes difficult for us to provide the best and appropriate care.

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Cultural Insensitivity

- Cultures vary in their beliefs of the prevention, cause, and treatment of illnesses as well as in their understandings of the processes of life and death.
- These beliefs dictate the practices used to maintain health and to prepare for and experience the processes of life, including pregnancy, birth, postpartum, infant care illness, aging and death.

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Cultural Insensitivity

- Too often we interpret the behaviors of others as negative because we don’t understand the underlying value system of their culture.
- It is a natural tendency for us to assume that our own values and customs are more sensible and right.
- It is necessary, then, for us to become aware of the cultural assumptions from which we develop our judgments.
- This is the first step to becoming more culturally sensitive.

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The Health Care Provider Culture

Beliefs	a) Standardize definitions of health and illness b) The omnipotence of technology
Practices	a) Maintenance of health and prevention of disease via mechanisms such as the avoidance of stress and the use of immunizations b) Annual physical examinations and diagnostic procedures such as Pap smears
Habits	a) Charting b) Constant use of medical jargon c) Use of a systematic approach and problem solving methodology
Likes	a) Promptness b) Neatness and organization c) Compliance

The Health Care Provider Culture

Dislikes	a) Tardiness b) Disorderliness and disorganization
Customs	a) Professional deference and adherence to the "pecking order" found in autocratic and bureaucratic systems b) Hand washing c) Employment of certain procedures attending birth and death
Rituals	a) Physical examination b) Surgical procedure c) Limiting visitors and visiting hours

The Health Care Provider Culture

- Western medicine, by its very nature, often treats patients as though they were objects - machines to be put back into "proper working order" or which fail.
- Elders who are hospitalized, or "institutionalized," as well as their families, are removed from their own lives and life stories and taken from their familiar homes into the strange and often fearful world of the facility.
- Numerous different people come uninvited into their room to treat them.

Cultural Identity includes:

SYMBOLIC OBJECTS, such as spiritual or religious items of clothing.

- *When encountering objects with which you are not familiar, politely ask about their significance, but don't press the issue if the resident or family does not appear willing to explain.*

LANGUAGE, which includes slang terms, words that indicate status, and level of intimacy.

- *Always use surnames unless you are given permission by the resident or family member to use their first name.*

Cultural Identity includes:

TOPICS AND PATTERNS OF CONVERSATION

- *In many cultures, it is inappropriate to initiate a serious conversation immediately. Take a few moments to introduce yourself to the resident and family in order to build rapport and trust.*

TONE OF VOICE

- *Use a soft tone of voice, emphasize courtesy and respect, and refrain from harsh criticism or confrontation.*

NON-VERBAL CLUES SUCH AS GESTURES, FACIAL EXPRESSIONS, BODY LANGUAGE AND PERSONAL SPACE

- *A handshake is customary among many Americans, however it is not always welcome among other cultures where it may be considered rude or intrusive, especially between opposite genders.*

Cultural Identity includes:

CONCEPT OF TIME, INCLUDING PASSAGE, DURATION AND POINTS WITHIN

- *Individuals who are past-oriented value tradition and doing things the way they have always been done. They might be reluctant to try new procedures.*
- *Present-oriented people focus on the here and now and may be relatively unconcerned with the future, dealing with it when it comes. They may show up late or not at all for appointments.*
- *Future-oriented people may become so caught up in the "what-ifs" of the future that focusing on the present moment may be difficult.*

Cultural Identity includes:

FAMILY AND KINSHIP STRUCTURE, COMPOSITION AND AUTHORITY

- *How the family is constructed determines one's values, the decision-making patterns within the household, and who will be responsible for the resident and health care decisions.*

COOKING AND DINING TRADITIONS

- *What time of day does the resident eat their main meal? Do they have special needs for preparation, utensils, or diet? Some cultures place great value on the meal as an event when the entire family gathers together.*

SPIRITUALITY AND RELIGION

- *What one believes affects one's responses to health, illness, birth, dying, death and other life events.*
- *A person's source of meaning and purpose fosters a sense of well-being as well as solace and comfort during times of crisis.*

Cultural Competence

- Refers to the ability to work effectively with individuals from different cultural and ethnic backgrounds, or in settings where several cultures coexist.
- Includes the ability to understand the language, culture, and behaviors of other individuals and groups, and to make appropriate recommendations.

Cultural Competence

- Cultural competence is the possession of knowledge and skills that enable providers to deliver culturally appropriate care and services, understand the preferences of older adults, and be aware of customary practices of specific racial, ethnic and cultural groups.
- Cultural competence advocates suggest redesigning and implementing approaches that include the elder's culture in the relationship with service providers.
- This relationship is greatly influenced by the perceptions that service providers have about older adults which impact the clients' health outcomes.
- Cultural competence approaches are an effort to eliminate inaccurate assumptions or ideas that result in older adults receiving suboptimal health care, long term care or supportive services

Cultural Competence

Cultural competence is achieved by:

- developing an understanding of individuals and groups of people;
- incorporating that understanding into practices and policies used in appropriate cultural settings.
- Cultural competence goes beyond cultural awareness, respect and sensitivity. It also means using that knowledge and respect effectively in cross-cultural situations.

Cultural Competence

- **Cultural competency emphasizes the idea of *effectively* operating in different cultural contexts.**
- **Knowledge, sensitivity, and awareness do not include this concept.**

Four Major Challenges:

1. Recognizing clinical differences among people of different ethnic and racial groups (e.g., higher risk of hypertension in African Americans and of diabetes in certain Native American groups).
2. Communication. This deals with everything from the need for interpreters to nuances of words in various languages.
   - Many elders, even in Western cultures, are reluctant to talk about personal matters such as sexual activity or chemical use.
   - Some elders may not have or are reluctant to ask for assistance or indicate when they experience pain.

Four Major Challenges:

3. Ethics. While Western medicine is among the best in the world, we do not have all the answers. Respect for the belief systems of others and the effects of those beliefs on well-being are critically important to competent care.
4. Trust. For some elders, authority figures are immediately mistrusted, sometimes for good reason. Having seen or been victims of atrocities at the hands of authorities in their homelands, many people are as wary of caregivers themselves as they are of the care.

Over-coming the Challenges

- We need to learn to ask questions sensitively and to show respect for different cultural beliefs.
- We must listen to our elders carefully. The main source of problems in caring for elders from diverse cultural backgrounds is the lack of understanding and tolerance.
- Very often, neither the caregiver nor the elder understands the other's perspective.

Comparison of Cultures

Aspects of Culture	Mainstream American Culture	Other Cultures
Sense of Self & Space	Informal: Handshake	Formal: Bows, handshakes
Communication & Language	Explicit, direct. Emphasis on content – meaning found in words	Implicit, indirect. Emphasis on context – meaning found around words
Dress & Appearance	"Dress for success" ideal. Wide range of accepted dress	Dress seen as a sign of position, wealth, prestige. Religious rules
Food & Eating Habits	Eating as a necessity – fast food	Dining as a social experience. Religious rules.
Time & Time Consciousness	Linear and exact time consciousness. Value on promptness. Time = money.	Elastic and relative time consciousness. Time spent on enjoyment of relationships.

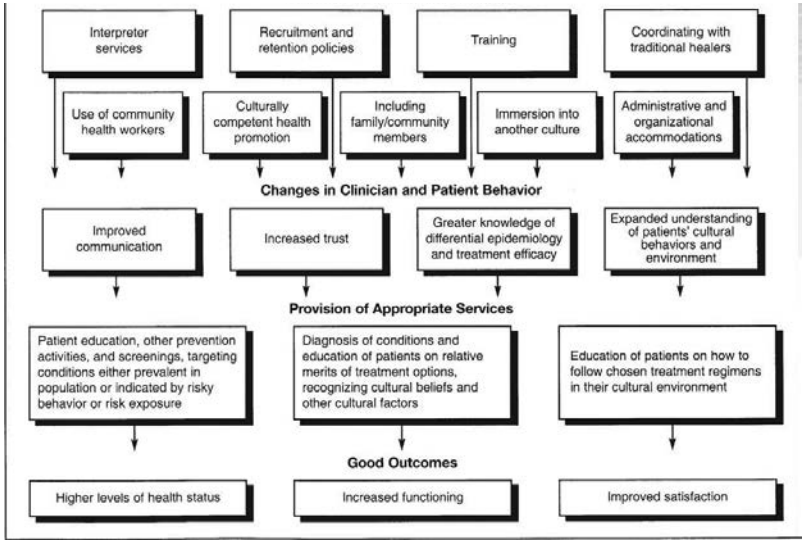
Comparison of Cultures

Aspects of Culture	Mainstream American Culture	Other Cultures
Relationships, Family, Friends	Focus on nuclear family. Responsibility for self. Value on youth, age seen as a handicap.	Focus on extended family. Loyalty and responsibility to family. Age given status and respect.
Values & Norms	Individual orientation. Independence. Preference for direct confrontation of conflict	Group orientation. Conformity. Preference for harmony
Beliefs & Attitudes	Egalitarian. Challenging of authority. Individuals control their destiny. Gender equality.	Hierarchical. Respect for authority and social order. Individuals accept their destiny. Different roles for men and women.

Comparison of Cultures

Aspects of Culture	Mainstream American Culture	Other Cultures
Mental Process & Learning	Linear, logical, sequential, problem-solving focus.	Lateral, holistic, simultaneous. Accepting of life's difficulties.
Work Habits & Practices	Emphasis on task. Reward based on individual achievement. Work has intrinsic value.	Emphasis on relationships. Rewards based on seniority, relationships. Work is a necessity of life.

Cultural Competency Techniques



Providing Interpreter Services

- ✓ Interpreter services improve communication between patient and provider.
- ✓ Organizations should always test the competency of those providing language assistance and avoid using untrained or minors as interpreters.
- ✓ It is also helpful to supplement interpreter services with print materials and signage in languages most commonly used by the population.

Recruiting and retaining professionals with minority backgrounds

- ✓ A successful recruitment strategy invites human resources and other hiring staff to present a culturally mixed set of eligible candidates.
- ✓ To retain a diverse workforce, an organization must incorporate cultural attitudes and messages in internal communications leading to increased trust in the workplace.

Training staff to improve cultural awareness and skills

- ✓ Because each minority group is composed of subcultures, it is impossible to train employees in-depth about all cultures.
- ✓ A more successful approach is to educate healthcare providers on traditional beliefs and behaviors among the cultures most commonly served by that organization.
- ✓ Consistent training expands a staff's knowledge base so that they can provide the most culturally appropriate treatment options.

Coordinating with traditional healers

- ✓ Not all cultures accept Western medicine as their primary source of healthcare.
- ✓ Therefore, it is necessary to understand the role of traditional healers and coordinate with them to provide adequate patient care.
- ✓ This allows patients to follow their treatment program within their cultural parameters, which leads to patient satisfaction and improved health.

Incorporating culture-specific attitudes in health promotion

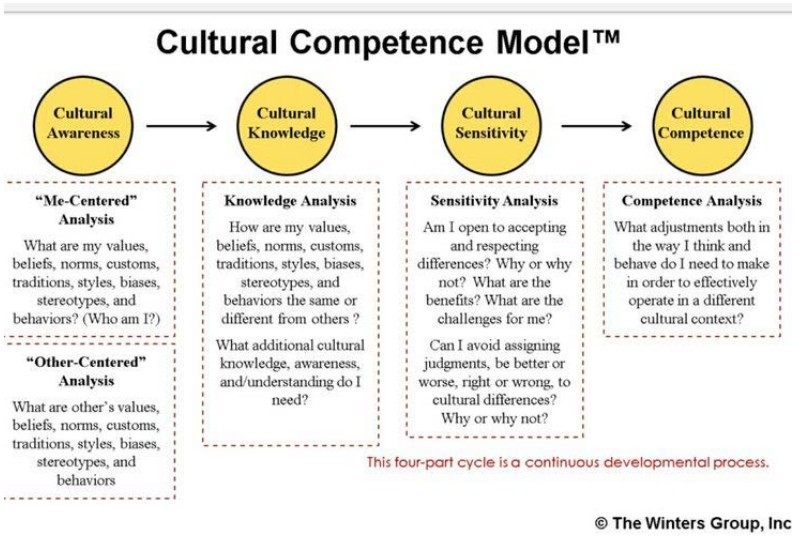
- ✓ Before implementing health-promoting programs, organizations must acknowledge any existing imbalance between minority groups.
- ✓ If one group is more at risk of a particular health concern, that should be addressed and presented from that specific cultural perspective.
- ✓ This helps the health institution establish credibility among the minority population.

Including family and community members in healthcare decision-making

- ✓ Involving family and community members in healthcare issues builds trust and breaks down disparities between cultural groups.
- ✓ This can be accomplished with something as simple as an advisory committee.
- ✓ For optimal results, these committee members should represent a diverse set of values and perspectives.

Establishing linguistic competency among administrative and operational staff

- ✓ All staff are all key players in the healthcare experience.
- ✓ Through cultural training and interpreter services, staff members can provide much more attentive care.
- ✓ As a result, the patient walks away satisfied with the entire healthcare team.



5 essential elements that contribute to a facility's ability to become more culturally competent

1. Valuing diversity;
2. Having the capacity for cultural self-assessment;
3. Being conscious of the dynamics inherent when cultures interact;
4. Having institutionalized cultural knowledge; and
5. Having developed adaptations of service delivery reflecting an understanding of cultural diversity.

Becoming Culturally Competent

- A developmental process that requires a long-term commitment.
- Not a specific end product that occurs after a two-hour workshop, but it is an active process of learning and practicing over time.
- Individuals working with different ethnic and cultural groups can become more culturally competent by advancing through three main stages: developing awareness, acquiring knowledge, and developing and maintaining cross-cultural skills.

Becoming Culturally Competent

Developing Awareness

- Admitting personal biases, stereotypes, and prejudices
- Becoming aware of cultural norms, attitudes, and beliefs
- Valuing diversity
- Willingness to extend oneself psychologically and physically to the client population
- Recognizing comfort level in different situations

Becoming Culturally Competent

Acquiring Knowledge

- Knowing how your culture is viewed by others
- Attending classes, workshops, and seminars about other cultures
- Reading about other cultures
- Watching movies and documentaries about other cultures
- Attending cultural events and festivals
- Sharing knowledge and experiences with others
- Visiting other countries

Becoming Culturally Competent

Developing and Maintaining Cross-Cultural Skills

- Even though the United States is a **pluralistic** society, most health professionals have been trained in a **monocultural** tradition.
- Many continue to practice as if ethnic and cultural differences are insignificant.
- Cross-cultural skills are developed through formal coursework, informal interaction and networking, and experience.

Becoming Culturally Competent

Developing and Maintaining Cross-Cultural Skills

- Making friends with people of different cultures
- Establishing professional and working relationships with people of different cultures
- Learning another language
- Learning verbal and nonverbal cues of other cultures
- Becoming more comfortable in cross-cultural situations
- Assessing what works and what does not
- Assessing how the beliefs and behaviors of the cultural group affect the client or family

Becoming Culturally Competent

Developing and Maintaining Cross-Cultural Skills

- Learning to negotiate between the person's beliefs and practices and the culture of your profession
- Being more flexible
- Attending continuing education seminars and workshops
- Learning to develop culturally relevant and appropriate programs, materials, and interventions
- Learning to evaluate culturally relevant and appropriate programs, materials, and interventions
- Ongoing evaluation of personal feelings and reactions
- Overcoming fears, personal biases, stereotypes, and prejudices

Multicultural Health Care Tips

- **Don't treat others as YOU would want to be treated.** *Try to learn how THEY want to be treated. What is viewed as polite, caring, quality health care in one culture may be considered rude, uncaring, or even evidence of poor standards of care in another.*
- **Address all adult patients from other cultures by their surnames unless specifically asked to use a first name.**

Most other cultures are more formal than American culture and many people who were born and brought up in another cultural environment consider it a lack of respect to address others (or be addressed) by their first names.

Multicultural Health Care Tips

Mind your tone of voice.

- *When speaking to a resident who seems to have a limited knowledge of English, don't shout!*
- *Remember the patient is hard of understanding, not hearing.*
- *Speak slowly and softly.*
- *Try to avoid words and expressions that are dependent upon one's knowledge and familiarity with*
- *American life and culture.*
- *You can help improve a person's comprehension of what you are saying by repeating it several times in different ways and using gestures, pictures and other non-verbal forms of communication.*

Multicultural Health Care Tips

Every culture has it's own rules for touching and distance.

- *When either you or the other person breaks any of these rules, the other will feel uncomfortable. For example: Americans often feel uncomfortable when someone stands less than three feet away from them, while most people from the Middle East need to stand almost nose to nose with the person to whom they are speaking.*
- *Traditional Koreans believe that the soul rests in the head and may become uncomfortable, even fearful if a provider or staff member pats their child on the head or ruffles his or her hair.*

Multicultural Health Care Tips

Don't ask a limited English-speaking patient or family member: "Do you understand?"

- *If the resident nods his or her head or answers "yes" to your question, it only means that she/he has heard you, not that she/he has understood your question and agrees with your diagnosis or plan of treatment.*
- *Try to ask questions beginning with the words "when, where, why, how". Then listen carefully to the answer for clues to the resident's degree of understanding or real agreement.*
- *You can also check understanding by and agreement by asking the resident to repeat to you, step by step, exactly what you have said.*

Multicultural Health Care Tips

Resident and family compliance with treatment is heavily dependent upon

- *The 'fit' of the treatment plan with the resident's lifestyle and eating habits.*

Informed consent forms and regulations can be extremely upsetting and frightening.

- *For residents and families who believe that talking about an event may make the event take place or for those whose conceptual framework does not include the concept of "what if..."*
- *Anyone administering any type legal document should patiently and completely explain each form, process or plan, as well as the likelihood of a negative outcome.*

Multicultural Health Care Tips

Making a telephone call is just about the most difficult thing to do in a foreign language.

- *Make a concerted effort to lower the stressfulness of making a phone call.*
- *When speaking to anyone who has a foreign accent over the telephone, speak especially simply, slowly and clearly.*
- *Don't show impatience, and give that person all your attention.*

Multicultural Health Care Tips

English-speaking cultures, as reflected in our language, tend to be precise and ruled by the dates and the clock.

- *Many other cultures think globally and pay less attention to a particular hour or day than to events or seasons.*
- *If a person seems to have difficulty relating to a particular time, day or hour, help this to first connect to another event, such as season, meal time, sunshine, moonlight, etc.*

3 Things to Remember…

1. **Different is different; it's not right or wrong.**

   Applied to you:

   - Each of us is unique because of our own cultures and experiences.
   - We are all more comfortable with what is familiar to us.
   - We have individual comfort levels for dealing with what we don't know.
   - It's okay if you aren't comfortable with something; it just means you have something new to learn about.
   - Residents, families – and staff – can be your best teachers in the areas of cultural diversity and spirituality.

3 Things to Remember…

1. **Different is different; it's not right or wrong.**

   Applied to residents and families:

   - Being human, we all have a tendency to think that what we do/think/know is "better", but that's only because it's the lens we happen to look through.
   - Residents and families feel the same way about what they do/think/say
   - Nobody's better or worse, we're all just wonderfully, beautifully and fascinatingly different.

3 Things to Remember…

2. **I'm not afraid to ask (even if I feel uncomfortable)**

   Applied to you:

   - None of us can know absolutely everything about everyone.
   - We have a tendency to feel like we look stupid if we have to ask, but the truth is that asking only makes us look interested and caring
   - People generally *really appreciate being asked about themselves.*
   - Find your resources for cultural and spiritual traditions and use them.

3 Things to Remember…

2. **I'm not afraid to ask (even if I feel uncomfortable)**

   Applied to residents and families:

   - What's true for us is true for residents and families
   - They don't want to look stupid and they don't want to "bother" anyone.
   - But, because they often get information that
     - They don't want to hear
     - Have never heard before, and
     - Scares the heck out of them
   - They don't always actually hear it, so they don't understand it, and may need to hear it again
   - A critical part of our job as caregivers is to make sure that they know they should not be afraid to ask.

3 Things to Remember…

3. It's not about me!

Applied to you:

- Sometimes we operate out of our own zones, and our own "to-do" lists, and forget that everything we do here is for the resident
- Remembering that "it's not about me" means remembering that our contact with the resident is about what the resident (and family) needs to know and understand, not *our schedules, timelines, and agendas.*

3 Things to Remember…

3. It's not about me!

Applied to residents and families:

- People often need to blame someone when the news is bad, or they are unhappy:
  - ➢ If not the doctor, then the nurse, or God, or themselves…whoever comes in the room…
  - ➢ As professional caregivers, we should be comfortable with being uncomfortable
  - ➢ We should know how to redirect people's feelings, to help their healing and to assist them in identifying and utilizing their coping strategies and resources.

An Easy, "Extra" Step….

Travel! Anywhere outside your home-town or the community in which you live. Expose and immerse yourself in diversity.

When I see you through my eyes,
I think that we are different.

When I see you through my heart,
I know we are the same.
~Doe Zantamata

Staff Sufficiency & Competency: What does CMS Expect?

Cat Selman, BS
www.catselman.com

F725 Nursing Services

✓ The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

F726 Nursing Services

The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

F726 Nursing Services

Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as;

✓ Resident Rights;
✓ Person centered care;
✓ Communication;
✓ Interview process;
✓ Documentation;

F726 Nursing Services

Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as;

- ✓ Medications;
- ✓ Pain management;
- ✓ Infection control;
- ✓ Identification of changes in condition;
- ✓ Cultural competency
- ✓ Knowledge of advocacy agencies/ community resources.

Sufficient & Competent Nurse Staffing Review

- ✓ Surveyors should evaluate if the facility has sufficient and competent nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. States who have mandatory nurse-to-resident ratios are not exempt from this regulation.

Competencies for the Social Worker/ Designee

- ➡ Dementia-related behaviors/Dementia Care
- ➡ Vulnerable adult abuse prevention and reporting Elder Justice Act
- ➡ Resident Bill of Rights
- ➡ Infection Control and TB guidelines
- ➡ Employee Right to Know/Hazardous Substances Blood Borne Pathogens

Competencies for the Social Worker/ Designee

- ➡ HIPPA/Health Records Act
- ➡ Alzheimers Training
- ➡ Customer Service
- ➡ QAPI
- ➡ Facility Mission/Philosophy
- ➡ Communication

Competencies for the Social Worker/ Designee

- ➡ Safety/Infection Control
  - ✓ Utilizes standard precautions
  - ✓ Follows universal infection control precautions/procedures
  - ✓ Follows Isolation precautions/ policies

Competencies for the Social Worker/ Designee

- ➡ Regulations/Requirements
- ➡ Residents' Rights
- ➡ Survey Process
- ➡ Documentation
- ➡ MDS 3.0/RAI Process
- ➡ Care Planning
- ➡ Abuse/Neglect

Competencies for the Social Worker/ Designee

- ➡ Complaints/Grievance Process
- ➡ Communication
- ➡ Interview process
- ➡ Comprehension/Understanding of Standardized Testing
- ➡ Knowledge of Medicare/Medicaid Program and Application/Eligibility Process

Competencies for the Social Worker/ Designee

- ➡ Knowledge of Specialty Areas
  - ✓ Represented mental illness diagnoses
  - ✓ Emotional Disorders
  - ✓ Advanced Directives
  - ✓ Hospice Services
  - ✓ Behaviors

Competencies for the Social Worker/ Designee

- ➡ Knowledge of Specialty Areas
  - ✓ Dementia Care
  - ✓ End of Life
  - ✓ PASARR (Pre-Admission Screening & Resident Review)

Competencies for the Social Worker/ Designee

- ➡ Knowledge of Community-Based Programs
- ➡ Dynamics of Interdisciplinary Care Team & Coordination of Services
- ➡ Education to Residents/Families
- ➡ Education/Training to Facility Staff
- ➡ Coordination of Resident and/or Family Councils/Groups