The National CONSUMER VOICE for Quality Long-Term Care

FACT SHEET

# Individualized Assessment with Behavior Symptoms

## THE MEANING OF INDIVDUALZED CARE

The federal Nursing Home Reform Law, passed in 1987, is part of the Social Security Act. It protects each nursing home resident and requires that nursing homes "provide service and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of **each resident** in accordance with a written plan of care." What this means is that each resident's **individualized needs** must be discovered and addressed.

*Mary lived alone for almost 20 years after her husband died. She was fiercely independent and, although frail at 87, was still able to tend her garden. Her daughter, though, began to notice that her mom was not able to remember recent events. Then, her mom forgot to turn off the stove and dinner went up in flames. Sometime later, Mary was found 5 miles from her home, lost and disoriented. Mary went through a battery of tests and was diagnosed with dementia. Her daughter, fearful for her mom, searched for the best nursing home. Within a month,*

*Mary moved to Sunnyside Manor and her daughter felt great relief because her mom was safe and secure. Unfortunately, her euphoric feeling was short-lived. One month after moving into the nursing home, the daughter was presented with a litany of things her mom was doing wrong. "She wandered into other resident's rooms… she became disruptive and screamed when nurse aides wanted her to go to the TV room…she tried to sneak out the back door." The next time the daughter visited, Mary was tied in a chair. Staff explained to the stunned daughter that her mom was quite a problem and that today, "she hit the nurse aide." When the daughter demanded that her mom be released from the chair, staff explained that they had a right to protect themselves from her outbursts and that the only other option was to discharge her from the home.*

## RESIDENT ASSESSMENT PROCESS

The nursing home must carefully and thoroughly assess each resident in order to meet her needs. Many things should be taken into account. A partial list follows:

- Life history, daily routine, strengths, interests, food preferences, and other personal information;
- Functional abilities including walking, dressing, using the toilet and eating;
- Physical or mental conditions that affect a resident;
- Potential for improvement;
- Communication abilities;
- Nutritional status and medications.

A thorough assessment is vital to knowing the resident, so staff can care for her in a manner that enhances her quality of life. The assessment must be completed within 14 days of admission into the home, or 7 days for Medicare residents. Thereafter, an annual assessment must take place or be conducted if the resident's condition changes.

## DEVELOPING A CARE PLAN

After the assessment is completed, the information is analyzed and a care plan is developed to address all the needs and concerns of the resident. An interdisciplinary team–nurse, nurse aide, activities and dietary staff, social worker, **with critical input from the resident and/or family members**–should work together at a care plan conference to make certain that all medical and non-medical issues are agreed upon and addressed. The resident and family members concerns should be listened to and addressed in the care plan meeting. A good care planning session takes time. It should not be rushed and could take at least one hour. Every 90 days after development of the initial plan, a care plan conference is held to determine how things are going and if changes need to be made.

## BEHAVIORAL SYMPTOMS VS. RESIDENT AS PROBLEM

In the preceding story, Mary, the resident, was perceived as the problem. From this negative, blame-the-victim perspective, staff can do little to no constructive problem-solving to address Mary's needs. It is necessary for staff to look at the resident from a new vantage point--through Mary's perspective. (Mary cannot tell you what is wrong. She expresses much of her distress in behavioral symptoms.)

The assessment and care plan should emphasize two main points: the uniqueness of each resident and the staff's responsibility in meeting each individual resident's needs. With these points as the focus, the question can be reframed from "Why is the resident a problem?" to "What do Mary's behavioral symptoms mean (unmet need) and how can staff help her?" Mary's symptoms included "aimless" wandering, disruptiveness, and striking other residents and staff. Restraining her will lead to decreased mobility and ability, listlessness, increased agitation, physical problems, and more work for nursing home staff. Instead of using restraints, staff can ask questions which will help find the cause of Mary's behavior and point to appropriate responses. Some potential questions follow with a plausible answer:

***Q: Why is Mary wandering? Does Mary have a history of spending time outside? If she enjoys wandering, can staff help her do this safely? Are staff taking her outside for exercise?***

**A:** Mary previously spent many hours outside taking long walks, visiting neighbors and caring for her garden. This is a life-long routine and should be continued. Staff have instead assumed that Mary should sit and watch TV. Mary had not been taken outside at all during her month at the nursing home.

***Q: Why would Mary scream? Is there a physical reason for the behavior (pain or infection)? What types of activities did Mary enjoy before the dementia? Is the TV room too noisy?***

**A:** Mary never enjoyed watching TV. She likes to look at the garden from the window in her room. Despite her dementia, she is still aware of her likes and dislikes and these should be respected.

***Q: What happened when the nurse aide was hit? Was she trying to get Mary to do something she didn't want to do? Did Mary feel threatened? Are staff trained to work with residents with dementia?***

**A:** The nurse aide yelled at Mary as she approached and Mary felt threatened. It is important for the nurse aide to be gentle and soft spoken in her approach.

## WHAT SHOULD BE DONE

Most nursing home staff want to do a good job. It is important that you first approach addresses the issues in a positive, non-confrontational manner. Take the following steps:

- Ask for a care plan conference;
- Make sure the right questions are asked. Use why, when, where, and how questions to help staff think of as many reasons for the behavior as possible;
- Keep the focus on the needs of the resident;
- Know your rights under the law. Residents cannot be forced to leave the home without specific notice and appeal rights; physical restraints cannot be used to treat symptoms treatable by individualized care;
- Monitor implementation of the care plan and address lack of implementation immediately;
- Work closely with aides and professional nurses to orient them to the resident;
- Make sure the resident's doctor is aware of and supportive of the resident's care plan;
- Request outside consultation from the ombudsman, if necessary.

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