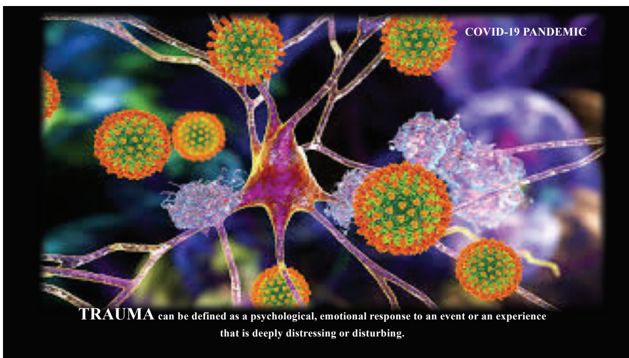


The Relationship Between Trauma and Grief

Trauma is an event.

- It can be any event that causes psychological, physical, emotional or mental harm; such as a death or abuse.
- A traumatic event could also be called a loss event. If someone dies, that’s a loss. If someone was abused, that too is a loss. A loss of trust.
- The result of a traumatic event is **grief**.

Source: https://www.griefrecoverymethod.com/blog/2015/02/what-difference-between-trauma-and-grief

The Relationship Between Trauma and Grief

Grief is the normal and natural response to loss.

- It's the conflicting emotions that result in the end of, or change in, a familiar pattern or behavior.
- Grief is the feeling of wishing things would have ended different, better, or more.
- Grief is the normal and natural feelings after a **trauma**.

Source: https://www.griefrecoverymethod.com/blog/2015/02/what-difference-between-trauma-and-grief

F699
Trauma-Informed care

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.

What is Trauma-Informed Care?

Trauma-Informed Care understands and considers the pervasive nature of trauma and promotes environments of **healing and recovery** rather than practices and services that may inadvertently re-traumatize.

A Trauma-informed Approach (The 4 R's)

- 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 policies, procedures, and practices
- Resists re-traumatization

https://www.integration.samhsa.gov/clinical-practice/trauma-informed

The **Five Principles of Trauma-Informed Care**

- The **Five Guiding Principles** are;
  - Safety;
  - Choice;
  - Collaboration;
  - Trustworthiness; and
  - Empowerment.
- Ensuring that the physical and emotional safety of an individual is addressed is the first **important** step to providing **Trauma-Informed Care**.

http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

What Does Trauma-informed Care Look Like?

- Explain why you're asking sensitive questions.
  - "I need to ask you about your sexual history, so I know what tests you may need."
- Explain why you need to perform a physical exam, especially if it involves the breasts or genitals. If someone is nervous, you can let them bring a trusted friend or family member into the room with them.
- You can tell them that if they need you to stop at any time, they can say the word.
- If someone refuses outright to have a certain exam or test, or if they're upset about something (like having vaccinations), you can respond with compassion and work with them, rather than attempting to force them or becoming annoyed.

https://www.health.harvard.edu/blog/trauma-informed-care-what-it-is-and-why-its-important-2018101613562

Alzheimer's Disease or Dementia?

Dementia is an overall term for a particular group of symptoms. The characteristic symptoms of dementia are difficulties with memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities. Changes to the brain cause dementia, and many different brain changes can lead to dementia

Alzheimer's disease is one cause of dementia. The brain changes of Alzheimer's disease include the excessive accumulation of the protein fragment beta-amyloid and an abnormal form of the protein tau, as well as damage to and destruction of neurons. The brain changes of Alzheimer's disease are the most common contributor to dementia. Dementia caused by Alzheimer's disease is called Alzheimer's dementia.

https://www.alz.org/alzheimers-dementia/facts-figures

Alzheimer's Disease

- In Alzheimer's disease, the neurons damaged first are those in parts of the brain responsible for memory, language and thinking, which is why the first symptoms tend to be memory, language and thinking problems.
- Although these symptoms are new to the individual affected, the brain changes that cause them are thought to begin 20 years or more before symptoms start.
- When symptoms become severe enough to interfere with a person's ability to perform everyday tasks, a person is said to have Alzheimer's dementia.

Alzheimer's disease	Accumulation of the protein beta-amyloid outside neurons and twisted strands of the protein tau inside neurons are hallmarks. They are accompanied by the death of neurons and damage to brain tissue. Inflammation and atrophy of brain tissue are other changes.
Cerebrovascular disease	Blood vessels in the brain are damaged and/or brain tissue is injured from not receiving enough blood, oxygen or nutrients. People with these changes who develop dementia symptoms are said to have vascular dementia.
Frontotemporal degeneration (FTD)	Nerve cells in the front and temporal (side) lobes of the brain die and the lobes shrink. Upper layers of the cortex soften. Abnormal amounts or forms of tau or transactive response DNA-binding protein (TDP-43) are present.

Hippocampal sclerosis (HS)	HS is the shrinkage and hardening of tissue in the hippocampus of the brain. The hippocampus plays a key role in forming memories. HS brain changes are often accompanied by accumulation of the misfolded protein TDP-43.
Lewy body disease	Lewy bodies are abnormal aggregations (or clumps) of the protein alpha-synuclein in neurons. When they develop in a part of the brain called the cortex, dementia can result. This is called dementia with Lewy bodies or DLB.
Mixed pathologies	When an individual shows the brain changes of more than one cause of dementia, "mixed pathologies" are considered the cause. When these pathologies result in dementia symptoms during life, the person is said to have mixed dementia or mixed etiology dementia.

Mixed pathologies	When an individual shows the brain changes of more than one cause of dementia, "mixed pathologies" are considered the cause. When these pathologies result in dementia symptoms during life, the person is said to have mixed dementia or mixed etiology dementia.
Parkinson's disease (PD)	Clumps of the protein alpha-synuclein appear in an area deep in the brain called the substantia nigra. These clumps are thought to cause degeneration of the nerve cells that produce the chemical dopamine.[29] As PD progresses, alpha-synuclein can also accumulate in the cortex.

Percentage of dementia cases	Symptoms
Alzheimer's is the most common cause of dementia, accounting for an estimated 60% to 80% of cases. Most individuals also have the brain changes of one or more other causes of dementia.[21,22] This is called mixed pathologies, and if recognized during life is called mixed dementia.	Difficulty remembering recent conversations, names or events; apathy; and depression are often early symptoms. Communication problems, confusion, poor judgment and behavioral changes may occur next. Difficulty walking, speaking and swallowing are common in the late stages of the disease.
About 5% to 10% of individuals with dementia show evidence of vascular dementia alone.[21,22] However, it is more common as a mixed pathology, with most people living with dementia showing the brain changes of cerebrovascular disease and Alzheimer's disease.[21,22]	Slowed thoughts or impaired ability to make decisions, plan or organize may be the initial symptoms, but memory may also be affected. People with vascular dementia may become less emotional and have difficulty with motor function, especially slow gait and poor balance.
About 60% of people with FTD are ages 45 to 60.[23] In a systematic review, FTD accounted for about 3% of dementia cases in studies that included people 65 and older and about 10% of dementia cases in studies restricted to those younger than 65.[24]	Typical early symptoms include marked changes in personality and behavior and/or difficulty with producing or comprehending language. Unlike Alzheimer's, memory is typically spared in the early stages of disease.

HS is present in about 3% to 13% of people with dementia.[25] It often occurs with the brain changes of other causes of dementia. An estimated 0.4% to 2% of dementia cases are due to HS alone.[25]	The most pronounced symptom of HS is memory loss, and individuals are often misdiagnosed as having Alzheimer's disease. HS is a common cause of dementia in individuals age 85 or older.
About 5% of older individuals with dementia show evidence of DLB alone, but most people with DLB also have the brain changes of Alzheimer's disease.[26]	Early symptoms include sleep disturbances, well-formed visual hallucinations and visuospatial impairment. These symptoms may change dramatically throughout the day or from day to day. Problems with motor function (similar to Parkinson's disease) are common. Memory loss may occur at some point in the disease.
More than 50% of people diagnosed with Alzheimer's dementia who were studied at Alzheimer's Disease Research Centers had mixed dementia.[22] In community-based studies, the percentage is considerably higher.[21] Mixed dementia is most common in people age 85 or older.[27,28]	Symptoms vary depending on the combination of brain changes present.
A systematic review found that 3.6% of dementia cases were due to PD and 24.5% of people with PD developed dementia.[30]	Problems with movement (slowness, rigidity, tremor and changes in gait) are common symptoms of PD. Cognitive symptoms may develop later in the disease, typically years after movement symptoms.

Percentage Of People With Dementia and A Mental Illness

- According to a 2022 study, 6.1% of people with a mental health condition also have dementia. This is compared to 1.8% of people without mental health conditions who develop dementia. The study also found that the association between mental health and dementia was consistent across age groups and genders.
- Other studies have found similar results, including:
  - A 2021 study of a national Medicare database found that 27.9% of people with schizophrenia at age 66 also had dementia, compared to 1.3% of people without a serious mental illness.
  - A 2022 meta-analysis found that depressive episodes after age 60 nearly double a person's risk of developing dementia.
- Some possible reasons for the increased risk of dementia among people with mental health conditions include: Genetic risk factors, Chronic stress, and Difficulty living a healthy life.

https://www.nytimes.com/2023/11/08/well/mind/mental-illness-depression-dementia.html#:~:text=Backing%20this%20up%2C%20a%202022,risk%20increased%20by%2017%20percent.

What Is Relocation Stress Syndrome, or Transfer Trauma?

- Home is where the heart is. In a study by the American Society on Aging, 63% of those 75 years or older, say that their homes' "emotional" value is more important to them than its monetary value.
- Being forced to uproot from a familiar place — a home that they know intimately, and where they might have decades upon decades of happy memories — can be deeply upsetting to older adults. And the effects that come with an unpleasant move can last for far longer than you might think.
- Medical researchers have described "relocation stress syndrome" as a *nursing diagnosis characterized by symptoms such as anxiety, confusion, hopelessness, and loneliness. It usually occurs in older adults shortly after moving from a private residence to a nursing home or assisted-living facility.*

https://companionsforseniors.com/2021/01/relocation-stress-syndrome-costs-of-uprooting-elderly/

Symptoms Associated with Transfer Trauma

Transfer trauma, also known as **relocation stress syndrome**, includes a cluster of symptoms that occur in a senior after moving. The mood, behavior and physiological symptoms include:

- Sadness
- Anger
- Irritability
- Depression
- Anxiety
- Confusion
- Combativeness
- Screaming
- Complaining

- Wandering
- Withdrawal
- Refusing care
- Poor appetite
- Weight loss/gain
- Increased coping through bad habits
- Indigestion
- Nausea
- Sudden onset of irritable bowel syndrome

https://www.carepatrol.com/blog/What-Is-Transfer-Trauma-And-How-To-Avoid-It_AE315.html

Who Is At Risk For Relocation Stress Syndrome?

- Any older adult can experience transfer trauma when moving.
- Transfer trauma is centered around the loss of control and choice producing fear.
- The risk increases for people with dementia because they have a hard time taking in the new information, and are not able to actively participate in the decision making process.
- Seniors that do not have dementia but have severe physical issues that force a move are also at risk.

How Transfer Trauma Affects Dementia

- Transfer trauma can exacerbate the symptoms of dementia.
- For patients already struggling with memory loss and physical deterioration, moving to an entirely new place can be stressful.
- This is especially true if the senior wasn't entirely aware that the move was taking place or wasn't able to be involved in the decision-making process.

Complications of Transfer Trauma

- Increased elopement risk.
- Over an extended period of time, the risk for isolation and depression, anxiety, resistance to care, and similar behavior disturbances increases.
- The common option to use psychotropic drug therapies in addressing behavior disturbances may produce many side effects.

https://www.crisisprevention.com/Blog/transfer-trauma-dementia

How Long Does Transfer Trauma Last?

- Transfer trauma affects each senior differently, depending on their experiences, coping skills and health status. A 2019 study published in Aging and Mental Health, for instance, suggests that how the senior interprets the transfer – as a harm, loss, challenge or threat – shapes their response.
- Cognitively impaired adults have more difficulty coping with a move, the study reiterates. Plus, the researchers suggest that relocation stress should be considered a risk factor for depression within the first year after relocation.

https://health.usnews.com/senior-care/articles/what-is-transfer-trauma

SYSTEM FAILURES

- Diagnosis is not always known at the time of admission screening or condition is misdiagnosed as simply dementia
- Staff education and training in caring for the mentally ill is lacking; care of residents with dementia is weak in many environments
- Staff lack basic understanding of symptoms and how this impacts all aspects of function
- Assessment procedures often fail to distinguish symptoms from behaviors

SYSTEM FAILURES

- Assessments often fail to identify the antecedents to behavior
- Communication between disciplines is weak in tracking behavioral patterns
- Care teams are weak in practicing behavior modification
- Medication is the often the preferred intervention
- Little consideration is given to how boredom and a lack of meaningful activity impact behavior and function

F675 Quality of life

Definition: "Quality of Life"

•An individual's "**sense of well-being**, level of **satisfaction with life** and feeling of **self-worth and self-esteem**.

•For nursing home residents, this includes a basic sense of satisfaction with oneself, the environment, the care received, the accomplishments of desired goals, and **control over one's life**."

What Keeps Us from Better Behavior? *Reactions*

"When you don't get what you want (*or need*),
you get an attitude."

-Regina, (57), Brooklyn, NY
Nursing Home Resident

F742
ADJUSTMENT DIFFICULTIES

Manifestations of mental and psychosocial adjustment difficulties that may occur over a period of time:

- Impaired verbal communication;
- Social isolation (e.g., loss or failure to have relationships);
- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);
- Spiritual distress (disturbances in one's belief system);
- Inability to control behavior and potential for violence (aggressive behavior directed at self or others); and
- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

GRIEF AND LOSS OF ROLE

- Role loss is not just missing that something or someone, it also means missing our relationship to that something or someone.
  - For example, I don't just miss my wife who died last year, I also miss being a part of a couple, a husband, the other half.
- With this in mind, grief becomes a much larger arena.
  - We grieve not being a helpful leader at work, not being able to support the new hire, and not being able to throw that work birthday party with the cookies that everyone likes.

Tips For Avoiding Transfer Trauma

- Prepare your staff to address transfer trauma by ensuring that there is a protocol in place for assessment and ongoing monitoring.
- Include the resident in the decision-making process, as much as possible.
- Arrange a visit for the new resident before moving.
- Make the new place feel like home by decorating with family photos, comfortable items from their last home, and familiar scents.
- Encourage family to visit frequently to provide a sense of familiarity.

CULTURE:
The set of *shared attitudes, values, goals, and practices* that characterizes a company, corporation, or community.

Cultural Competence
the ability to understand, communicate with and effectively interact with people across cultures.

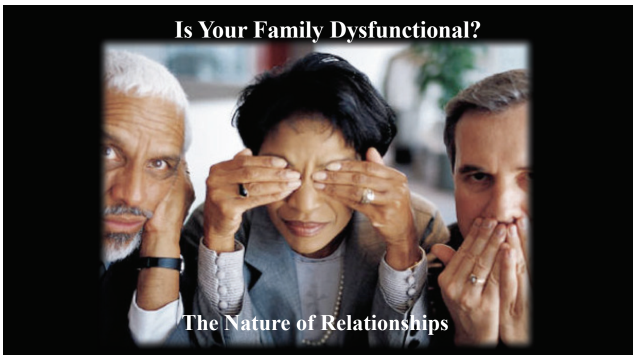
Relationships

- How well do staff interact with residents?
- How well does the team do at pairing roommates?
- How effective are the procedures for resolving grievances and conflicts?

SOCIAL REACTIONS

Have you ever:

- Declined an invitation because you didn't know anyone else who would be attending or because you learned someone you didn't like would be there?
- Moved from your original seat because of the behavior of someone else at the table?
- Left a gathering or program because you found it wasn't as interesting as you'd thought it would be or because another guest arrived wearing your dress?



Common Triggers to Altercations and Discontent

REGULATORY EXPECTATIONS

The facility must have ***sufficient staff*** who provide direct services to residents 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…***considering the number, acuity and diagnoses*** of the facility's resident population.

REGULATORY EXPECTATIONS

These competencies and skills sets include knowledge of and appropriate training and supervision for:

- Caring for residents with mental and psychosocial disorders, as well as residents with a history of ***trauma and/or post-traumatic stress disorder***; and
- ***Implementing non-pharmacological interventions.***

F740-F744
Behavioral Health

- §483.40 Behavioral health services.
- Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
- Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the **prevention and treatment of mental and substance use disorders**.

F741
Behavioral Health

- §483.40(a) The facility must have sufficient staff who provide direct services to residents 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 §483.70(e).
- These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:
  - **§483.40(a)(1) 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.**
  - **§483.40(a)(2) Implementing non-pharmacological interventions.**

F741
Behavioral Health

Sufficient Staff to Provide Behavioral Health Care and Services

The facility must address in its facility assessment under §483.70(e) (F838), the behavioral health needs that can be met and the numbers and types of staff needed to meet these needs.

F742
Behavioral Health

- §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that—
- §483.40(b)(1)
  A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;

F742
Behavioral Health

INTENT §483.40(b) & §483.40(b)(1)

- Upon admission, residents assessed or diagnosed with a mental or psychosocial adjustment difficulty or a history of trauma and/or post-traumatic stress disorder (PTSD), receive the appropriate treatment and services to correct the initial assessed problem or to attain the highest practicable mental and psychosocial well-being.
- Residents who were admitted to the nursing home with a mental or psychosocial adjustment difficulty, or who have a history of trauma and/or PTSD, must receive appropriate person-centered and individualized treatment and services to meet their assessed needs.

F743
Behavioral Health

- §483.40(b)(2) A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post- traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; and

F744
Behavioral Health

- §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

Post-traumatic Stress Disorder (PTSD)

PTSD (post-traumatic stress disorder) is a mental health problem that some people develop after experiencing or witnessing a life-threatening event, such as:

- Combat and other military experiences;
- Sexual or physical assault;
- Learning about the violent or accidental death or injury of a loved one;
- Child sexual or physical abuse;
- Serious accidents, like a car wreck;
- Natural disasters, like a fire, tornado, hurricane, flood, or earthquake; or
- Terrorist attacks

Primary Care PTSD Screen

- The Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5) is a 5-item screen that was designed to identify those with probable PTSD.
- Those screening positive require further assessment from a mental health professional.
- The results of the PC-PTSD-5 should be considered "positive" if a client answers "yes" to any three of the five items about experiences in the past month related to an event.

Source: https://www.ptsd.va.gov

Primary Care PTSD Screen

- **Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:**
  - A serious accident or fire
  - A physical or sexual assault or abuse
  - An earthquake or flood
  - A war
  - Seeing someone be killed or seriously injured
  - Having a loved one die through homicide or suicide
- **Have you ever experienced this kind of event? YES or NO**
  - If no, screen total = 0. Please stop here.
  - If yes, please answer the questions below.
- **In the past month, have you ...**
  - **Had nightmares about the event(s) or thought about the event(s) when you did not want to?** YES or NO
  - **Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?** YES or NO
  - **Been constantly on guard, watchful, or easily startled?** YES or NO
  - **Felt numb or detached from people, activities, or your surroundings?** YES or NO
  - **Felt guilty or unable to stop blaming yourself of others for the event(s) or any problems the event(s) may have caused?** YES or NO

What are the symptoms of PTSD?

- Reliving the event
- Avoiding things that remind you of the event
- Having more negative thoughts and feelings than before
- Feeling on edge

How is PTSD Treated?

- Cognitive Processing Therapy (CPT) or Talk Therapy
- Medication
- Prolonged Exposure Therapy (PE) exposure to the thoughts, feelings, and situations that the person has been avoiding.
- Stress Inoculation Training (SIT) SIT teaches skills for handling stressful situations that can help manage PTSD symptoms.

Obsessive compulsive disorder: symptoms and behaviors

OCD -
- A psychiatric disorder characterized by obsessive thoughts and compulsive actions, such as cleaning, checking, counting, or hoarding.
- OCD, one of the anxiety disorders, is a potentially disabling condition that can persist throughout a person's life.
- The individual who suffers from OCD becomes trapped in a pattern of repetitive thoughts and behaviors that are senseless and distressing but extremely difficult to overcome.
- OCD occurs in a spectrum from mild to severe, but if severe and left untreated, can destroy a person's capacity to function at work, at school, or even in the home.

Managing Symptoms and Reactions

1. Compulsions:
   - Learn Patterns and Reasoning
   - Channel Hoarding Behavior to Productive Activity
2. Rituals and Routines:
   - Validation vs. Reality Orientation
   - Practice Behavior Modification/Reward Systems
3. Building Bridges:
   - Reassurance
   - Encourage Diversionary Activity to Address Anxiety

HOARDING

Reasons for Saving

- Sentimental –
  “This represents my life. It’s part of me.”
- Instrumental –
  “I might need this. Somebody could use this.”
- Intrinsic –
  “This is beautiful. Think of the possibilities!”

SUBSTANCE ABUSE
F740 – Behavioral Health Services

- **"Substance use disorder"** is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems or disability.
  - (Adapted from: Substance Abuse and Mental Health Services Administration (SAMHSA) definition found at http://www.samhsa.gov/disorders/substance-use).

SUBSTANCE ABUSE
Assessing Trauma

Trauma and trauma-related problems are common risks factors in substance abuse.

- About 60% of men and 50% of women experience at least one trauma such as a disaster, war, or a life-threatening assault or accident at some point in their lives.
- Nearly 8% of the population has PTSD in their lifetimes, and PTSD is highly comorbid with other disorders such as panic, phobic, or generalized anxiety disorders; depression; or substance abuse.

ADMISSION WELCOME PROCEDURE

Permitting the new Resident to meet and bond FIRST with the initial CNA who will be providing care will help to minimize the trauma of admission.

The CNA:

- Communicates the resident's preferences and lifestyle routines to the charge nurse who will document this information in the resident's plan of care and on the CNA assignment.
- Shares this information with the caregiver team at shift report. New or clarified information will be corrected at this time.
- The caregiver team will utilize the information obtained by the CNA to personalize interventions in the baseline care plan.

Communication Deficits

Aphasia
Apraxia of Speech
Agnosia

Vision Deficits
Perception - Motion
Depth - Color

Hearing Loss

THE GLOBAL DETERIORATION SCALE

Assessing The Degree Of Dementia

GLOBAL DETERIORATION SCALE (GDS)

Stage	Deficits in cognition and function	Usual care setting
1	**Subjectively and objectively normal**	Independent
2	Subjective complaints of mild memory loss. Objectively normal on testing. No functional deficit	Independent
3	**Mild Cognitive Impairment (MCI)** Earliest clear-cut deficits. Functionally normal but co-workers may be aware of declining work performance. Objective deficits on testing. Denial may appear.	Independent
4	**Early dementia** Clear-cut deficits on careful clinical interview. Difficulty performing complex tasks, e.g. handling finances, travelling. Denial is common. Withdrawal from challenging situations.	Might live independently – perhaps with assistance from family or caregivers.
5	**Moderate dementia** Can no longer survive without some assistance. Unable to recall major relevant aspects of their current lives, e.g. an address or telephone number of many years, names of grandchildren, etc. Some disorientation to date, day of week, season, or to place. They require no assistance with toileting, eating, or dressing but may need help choosing appropriate clothing.	At home with live-in family member. In seniors' residence with home support. Possibly in facility care, especially if behavioural problems or comorbid physical disabilities.
6	**Moderately severe dementia** May occasionally forget name of spouse. Largely unaware of recent experiences and events in their lives. Will require assistance with basic ADLs. May be incontinent of urine. Behavioural and psychological symptoms of dementia (BPSD) are common, e.g. delusions, repetitive behaviours, agitation.	Most often in Complex Care facility.
7	**Severe dementia** Verbal abilities will be lost over the course of this stage. Incontinent. Needs assistance with feeding. Lose ability to walk.	Complex Care

Adapted by Dr. Doug Drummond from Reisberg B, Ferris SH, Leon MJ, et al. The global deterioration scale for assessment of primary degenerative dementia. American Journal of Psychiatry 1982;139:1136-1139.

What to Ask

Significant social/personality information:

- How do you feel about being in large groups of people?
- Are there any specific things that turn you off about other people?
- What causes you to feel stressed?
- How do you express yourself when you are angry, frustrated or upset?
- What things do you do to comfort yourself at times when you feel this way?
- Is there anything about your sexual needs or preferences that you want to share?
- What are your goals now?

Many residents with dementia remember the address of the home they most identify with.

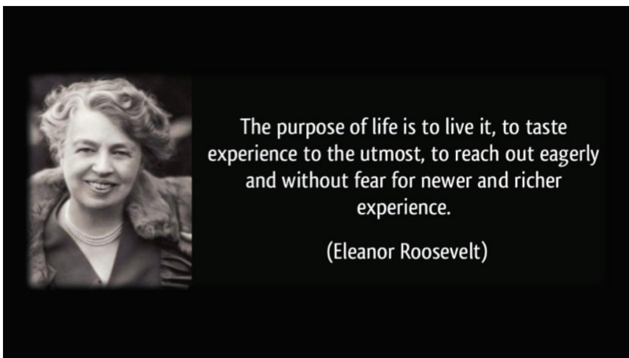
- Locate a picture of the house of their memory on the Internet
- Install it on their door with the street address
- The visual of the home they remember along with the address may help them to feel an increased sense of belonging and familiarity.

Help Me Find My House

Use Technology To Your Advantage

Ask family to email photographs that you can then print and display in the new resident's room.

When the new Resident arrives, the familiar photographs will provide comfort, as well as the foundation for conversation about who he/she is and how we can best help them.



Activities for a New Age

- Diversify therapeutic activity offerings to include education, self-help, and support programs;
- Promote positive self-esteem through meaningful socialization and therapeutic engagement and productivity;
- Foster opportunities for volunteerism.

F620 Admissions Policy

- The facility must not

  (i) request or require residents or potential residents to waive their rights, including but not limited to their rights to Medicare or Medicaid; and

  (ii) request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

  (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property.

- The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility.
- May request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

F620 Admissions Policy

- In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility.
- States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.
- ***A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.***
- A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section.

F621 Equal Access To Quality Care

- §483.15(b)(1) A facility must establish, maintain and implement identical policies and practices regarding transfer and discharge, and the provision of services for all individuals regardless of source of payment.
- §483.15(b)(2) The facility may charge any amount for services furnished to non-Medicaid residents unless otherwise limited by state law and consistent with the notice requirement in describing the charges; and
- §483.15(b)(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

Aggression

Biological, psychological, and socioeconomic influences must be considered when discussing the etiology of aggression.

Biological causes include:

- Genetics;
- Medical and psychiatric diseases;
- Neurotransmitters;
- Hormones;
- Substance abuse; and
- Medications.

Soreff SM, Gupta V, Wadhwa R, et al. Aggression. [Updated 2023 Apr 8]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK448073/

Managing Escalating Behavior

- Usually violent incidents follow a series of smaller incidents or warning signs.
  - Identifying the triggers to the behavior, including the person or persons who may incite the individual, is the most important step to preventing escalation of a behavioral episode.
- The inappropriate behavior of a person prone to violence usually escalates over time.
  - A diagnosis of mental illness or cognitive impairment will complicate any circumstance in which the potential for violence exists.
- Ensuring your safety and that of others is the most important action you can take.
  - Know and understand behavioral warning signs.
  - Practice good assessment skills.
  - Anticipate behaviors identified as symptoms of a particular diagnosis and plan proactively.

Dealing With Escalating Behavior

- Stay calm, listen attentively, make the person feel comfortable, and ask the person to sit down.
- Treat the person with dignity and respect. Understand that delusions and suspicions are symptoms of the mental illness, and very real for the person.
- Ask, "What can I do to help you?" Focus your attention on meeting the person’s needs.
- Acknowledge the person's concerns.

Dealing With Escalating Behavior

- Maintain eye contact.
- Speak slowly, softly, and clearly.
- Avoid being defensive.
- Set ground rules/boundaries, such as," When you shout at me, I can't understand what you're saying."
- Do not argue.

Dealing With Escalating Behavior

- Signal a co-worker *quietly*, if you need help.
- If the person has an urgent need to communicate, don't put it off.
- Keep the situation in your control.
- Notify your supervisor immediately.

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Creating Meaningful, Satisfying Lives
One Person at a Time