

SIGNS & SYMPTOMS OF DYING PROCESS

By Michael Holmes, R.N.

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unexpected way, such as a more acute perception of physical pain, or unexplained anxiety. Lying to ourselves about our feelings does not make them go away, it only makes them more unmanageable.

When a dying person accepts that s/he will have some fear, then that fear can be handled much more easily when it appears. Allowing oneself to feel the fear, admitting its presence, and seeking the support of friends and loved ones is the most effective way to handle it. When approached in that way, the fear of death can be resolved in a relatively short period of time and with little difficulty.

SEEING PEOPLE WHO HAVE GONE BEFORE

Nearly everyone has heard of dying people seeing or talking to people who have already died. This is so common as to be expected at some point in virtually everyone's dying process. Whether we can explain it or not is beside the point; it happens, with or without an explanation. Also, it is not the prerogative of people who are not yet dying to pass judgment on the validity of the experiences being reported by people who are dying. When dying people report seeing dead people, then the rest of us had better pay attention.

Unfortunately, the reports of dying people are sometimes written off as "hallucination" or "senility", or blamed on a lack of oxygen to the brain, over medication, or metabolic imbalance. That isolates the patient and makes them feel like there is something wrong with them. That is a real shame because what they are experiencing is quite normal from a statistical point of view, and really very wondrous from a spiritual point of view.

Sometimes dying people are reluctant to speak of their perceptions because they are afraid of being labeled "crazy". It can be an enormous relief for them to discover that they are normal and that their perceptions are accepted by those around them. It can

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also be an enormous relief when they discover that their "dead" friends and relatives are very much alive. Caregivers to the dying are in a position to learn a great deal from dying people. The dying process is the most intense learning experience in life. Therefore, caring for people as they move through that intense learning experience is very educational. Learning about death from people who are dying is very important, because always remember and never forget, you too are going to die.

SYMBOLOLOGY

As people approach death, they begin spending more time "on the other side" so to speak. Contrary to popular opinion, dying process is usually a gradual process. Sudden, unexpected death is tragic because it bypasses normal dying processes. Normal dying process enables the dying person to approach his or her transition at their own pace.

As dying process evolves, the person moves back and forth between being fully awake and conscious, asleep and dreaming, semiconscious, and unconscious. The patient may become increasingly withdrawn, or more accurately, "internally focused". When not awake and conscious, they are frequently restless; i.e., moving their fingers, hands, arms and legs about aimlessly, or "picking at the air". It is also common to hear them moaning, mumbling or even crying out. All of this is indicative of how hard they are working as they process all the unresolved issues in their lives. As this process continues, their statements (if they make any at all) may become increasingly symbolic in nature. That is because what they are experiencing and perceiving has less and less to do with the physical world. Our language is based upon our familiarity with the physical world, so therefore our everyday language is

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not really adequate to describe what they are perceiving. Since they have no words for what they are perceiving, they tend to speak in symbolic terms.

The language of symbolism is unique to the individual. For example, I grew up on a farm, so when I am dying I would tend to use language and expressions typical for a farm boy. A person born in the big city would tend to use terms and expressions typical of city life. When it gets right down to it, every person is a unique individual and is likely to make unique conceptual connections.

Consequently, any given individual's symbolic language may be difficult to decipher. Still, there are common threads, and if the listener is familiar with the dying person and their background, the meaning behind a particular statement may be quite clear. One of the most common of all statements made by dying people has to do with "going home". Regardless of age, color or creed, when people get close to death they tend to conceptualize it as "going home". How they "go home" varies a great deal, but the idea that dying involves "going home" is very common.

When people get close to death, they begin to conceptualize how they will get there. Some people talk about catching a train, others mumble about having enough change to purchase a bus ticket, some talk about crossing a river, while still others may mumble something about riding a truck. Again, how a person conceives of their crossing has a lot to do with their background. I knew a guy who loved his mules and kept talking about riding his mules along a canyon wall. Sometimes a person's symbolic language is so unique that it simply cannot be comprehended, but most of the time, if you know the person fairly well, the general idea comes through.

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THE STAGES OF GRIEF

Grief, like life and death, is a process. Everyone experiences grief, including caregivers and professionals. Grief runs a general course, but is not necessarily linear. In other words, a person can be in the acceptance stage one day and jump back into anger the next. In fact, people tend to hop around from one stage to another quite frequently.

Grief is actually very common. By that I mean we are grieving more regularly than we realize. We grieve each and every loss or disappointment that we experience in every day life. The intensity of the grief depends upon the intensity of the loss, and we generally are not aware of our grief unless it is intense. When grief does become intense, it may seem overwhelming, and we fear that we will never be free of it again. The intensity of our grief will ebb and flow, but it is a part of who and what we are. Not only do we grieve our losses after they occur, we grieve our losses before they occur in anticipation of their occurrence.

Various authors and clinicians have compiled different lists of the stages of grief. The list given here is fairly thorough and includes some categories or stages which are not always mentioned.

	Acceptance	
Shock		Hope
Denial		Sadness
Confusion		Relief
Bargaining		Depression
Fear		Anger
	Blaming	

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The intensity of our grief reflects the intensity of our loss. We can expect to go through at least some of these stages with every loss we encounter, but if the loss is severe we can expect to go through virtually all of them sooner or later. Sometimes, when we avoid dealing with the feelings associated with the little losses we experience every day, the big losses we encounter act as triggers for the release of accumulated grief. Also, major losses tend to remind a person of all the major losses he or she has experienced in life. In other words, when a major loss occurs, it seems like all the losses of one's life time are recalled and grieved again.

Some of the emotions of grief are surprising. For example, it is common to feel anger towards the person who has died. It is also common to feel relief that they have died. These emotions may seem confusing for friends and relatives of the deceased because these emotions do not always seem to make sense. Also, we often are surprised to discover what a feeling feels like.

In today's world, most of us have heard of the stages of grief and know what they are intellectually. However, when we are feeling them it is an entirely different experience. It is typical for a person to feel and be affected by the shock and confusion of grief for quite some time before figuring out what is going on.

Since everyone experiences grief at his or her own pace, and because every individual jumps around from one stage to another, it is not reasonable to expect that everyone in a family will be experiencing the same thing at the same time. In fact, it is seldom that everyone is on the same page when grieving the loss of a friend or family member. At any given moment, one family member might be angry, while another is bargaining, while still another is in shock and a friend might be in acceptance. An hour later, they may all have switched places and be acting very differently. It is good to

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recognize this and allow each other room for individual expression of grief.

Some of the emotions of grief are more difficult to deal with than others. Anger, for example, may be difficult for some people to acknowledge within themselves. It may also be difficult for some people to accept it in others. It may help to remember that the emotion being expressed is just a part of the grieving process and that it is better to get the emotion out than to hold it inside.

Sadness is another difficult emotion. It is not uncommon for concerned family members to request sedation for one another when the sadness becomes intense and the tears are flowing freely. Actually, weeping is healthy when intense loss is experienced (even for men). Burying emotions only delays their expression and is likely to make them more harmful than if they had been expressed appropriately in the first place.

If a person threatens harm to him or herself, or another in response to their grief, then they do need professional assistance. Barring that, the frank expression of grief is a good thing and should be encouraged. The healthiest families are the ones which encourage the appropriate expression of emotion. The emotionally supportive family encourages its members to recognize and communicate their individual feelings. This allows everyone within that family to resolve his or her grief and move on with their lives.

Children should also be included and encouraged to participate in expressions of grief and loss. They should not be forced to participate, but they should be allowed to participate if they so desire. Grieving is a part of every day life and therefore, good grieving skills should be taught to children by the adults in their lives. As with most other things, the best way to teach children something is to demonstrate it to them. In other words, for children

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to learn good grieving skills, they must be able to see good grieving skills being practiced around them. Excluding children from loss only deprives them of the opportunity to learn how to deal with loss.

Also, children should not be banished from seeing death or dying people. Their imaginations can and will create far worse images than reality could ever produce. Reality can be tough to deal with, but the imagination is much worse. Dealing with reality is relatively easy compared to dealing with what the imagination might conger up.

There is no time limit on grief. How long it takes to grieve can vary greatly and depends on a wide variety of factors. Strictly speaking, one never "gets over" a serious loss.

Human beings are innately social and need to share at least some of their feelings in order to process them effectively. Spending time alone is important after experiencing a loss, but it may be just as important to grieve with someone else at some point. The need to recall the stories of our losses is important, common, normal, and an effective way of processing grief. Some people may find grief support groups to be effective in accomplishing this task. Others may pick out a close friend with whom to share his or her feelings. Still others may utilize professional help as a means by which to ventilate their feelings. Clergy can be very useful for this purpose, as can prayer or meditation.

It is important to remember that grieving is something we all do from time to time. Learning to grieve effectively is an important life-skill that we need to learn and pass on to our children. It enables us to cope more effectively with our world. When our grief is intense, we can quickly become overwhelmed with the intensity of our emotions and begin to think that there is something wrong with us. There is nothing wrong with feeling intense emotion. Reaching

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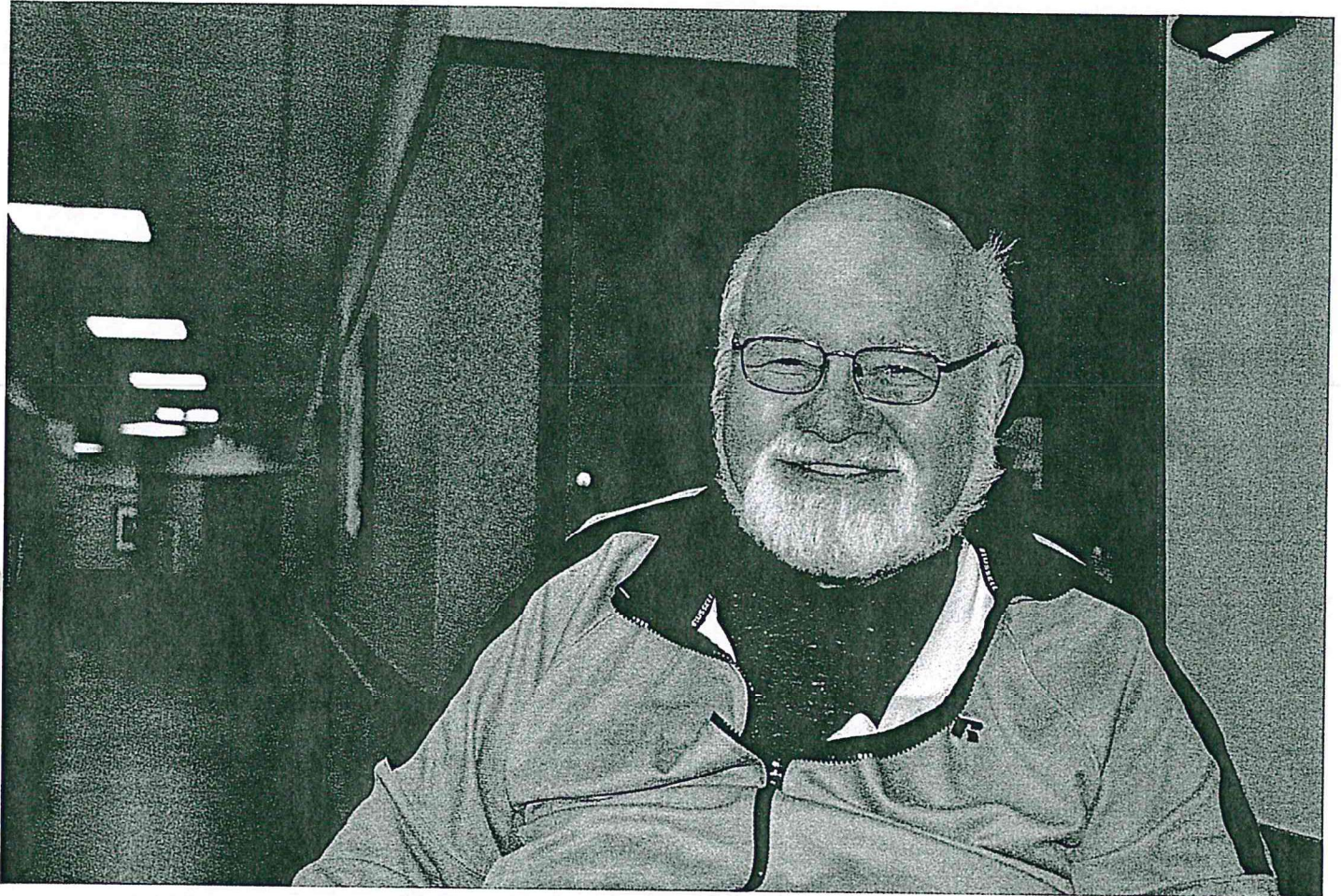
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out to one another is the best thing we can do when feeling overwhelmed with our own feelings.

http://www.lakegenevanews.net/news/county-may-say-cheers-to-nursing-home-happy-hours/article_fa2b0ba1-4c4b-5915-8caf-5fa712b86137.html

County may say 'cheers' to nursing home happy hours

By Scott Williams swilliams@lakegenevanews.net Mar 14, 2018



Michael Gaglione is president of the resident council at the county-owned Lakeland Health Care Center. (Photo by Scott Williams/Regional News)

ELKHORN — Michael Gaglione is definitely old enough to drink.

As a resident of Walworth County's nursing home for senior citizens, the 76-year-old Gaglione faces strict rules against drinking with his friends and neighbors on the property.

But the era of prohibition could be ending soon.

County officials are considering relaxing their no-alcohol policy so that residents at the county's Lakeland Health Care Center can imbibe in adult beverages with one another.

In fact, Gaglione and some of his fellow residents would like to hold regular "happy hour"-style gatherings inside the nursing home.

"It's a good chance for everybody to get together and be normal," Gaglione said.

The county-owned nursing home at 1900 County Road NN houses about 120 senior citizens who live in private rooms and spend time together for meals, activities, social hours and special occasions.

But they cannot share a beer or cocktail together because Walworth County has a longstanding policy against alcoholic beverages on county-owned property. The only way a Lakeland resident can have a drink is with a doctor's approval and if the resident keeps the beverage in his or her own room.

Walworth County Board member Ken Monroe, who chairs the Lakeland oversight board, said he does not anticipate any opposition when the relaxed alcohol policy goes before county supervisors on March 13.

Although it would be a significant break from the county's longstanding practice, Monroe said he is confident the nursing home residents can manage an occasional happy hour.

· "It just something that should be tried," he said. "Let the people enjoy themselves — it's their home."

Gaglione is president of the Lakeland resident council, which meets with administrators to discuss ways of improving life on the property.

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When the resident council pitched the idea of alcoholic beverages, Interim Administrator Karen Sautbine was open to the suggestion. Sautbine is asking the county board to lift the prohibition so that Lakeland can allow drinking at happy hours or other occasions, including St. Patrick's Day.

Lakeland residents would not be permitted to overindulge, employees would not drink at all, and no county funds would be spent purchasing alcohol.

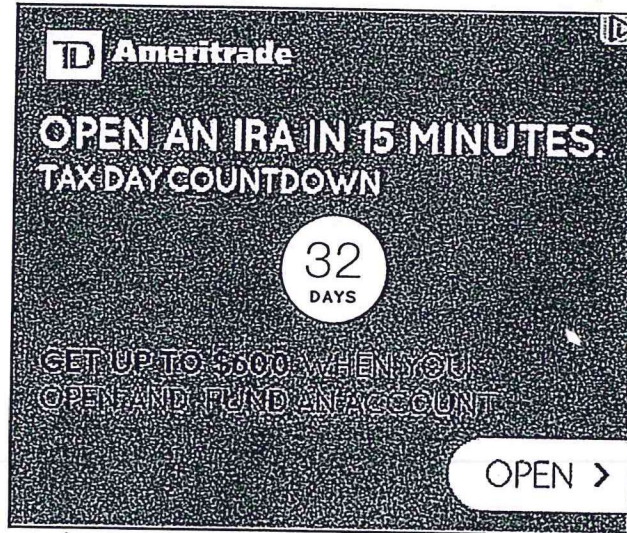
Other occasions that might include drinking include New Year's Eve, Sunday football games and birthday parties. Sautbine said it is a reasonable quality-of-life improvement that is in keeping with federal policies to provide social activities at nursing homes.

"If the residents wish to have it, we need to provide it," she said. "This is their home. And why not do what you would do in your home?"

Gaglione, who has lived at Lakeland for about four years, said he has been known to enjoy an occasional beer or cocktail in his day. He estimates that 30 or 40 other residents probably would turn out, too, for a regular happy hour.

Although he is already very happy at Lakeland, Gaglione said having a drink now and then would make life even sweeter inside the nursing home.

"It picks up the morale a little bit," he said. "It'd be like living on the outside again."



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Scott Williams

Guidelines for End-of-Life Care in Long-Term Care Facilities



**With Emphasis on Developing
Palliative Care Goals**



Consequences of Untreated Pain — What Happens If Pain Isn't Properly Treated

A person with untreated pain may experience other symptoms besides pain:

- poor appetite and weight loss
- disturbed sleep
- withdrawal from talking or social activities
- sadness, anxiety or depression
- physical and verbal aggression, wandering, acting-out behaviors, resist care
- difficulty walking or transferring; may become bedbound
- skin ulcers
- incontinence
- increased risk for use of chemical and physical restraints
- decreased ability to perform ADL's
- impaired immune function

The caregiver should remember these signs and symptoms when caring for residents who are unable to tell the nurse about their pain. Many of the experiences linked to untreated pain can affect facility quality indicators and survey findings.

Pain Assessment

Healthcare providers have developed several standard pain assessment tools. Sample tools are provided in the appendixes to this document. Of course, asking about pain is an important part of any assessment. In the past, asking about pain was not done routinely. Some caregivers feared that asking about pain would put the idea of pain in the resident's mind. Others were unsure about what they would do if their questions elicited a pain report. It is, however, the responsibility of everyone caring for the resident to report pain.

The charge nurse is then responsible to further assess the reports of pain from all sources, including the family, direct caregivers, clergy, or other facility staff, and obtain treatment orders. Assessments to identify and treat pain must be ongoing. Elderly residents require frequent monitoring. Monitoring may have major implications for quality assurance, quality of care, and quality of life among this population of residents.

Assessing Pain in Residents with Dementia or Communication Difficulties

The resident's report of pain is the best method for assessing pain but sometimes the resident is unable to report pain. Residents with dementia or other cognitive disabilities will have difficulty communicating their pain symptoms.

Facility staff should consider the following guidelines when assessing residents with dementia or communication problems:

- **Ask the resident if he or she is having pain.** You might be surprised at the resident's level of understanding and response. Residents with significant cognitive impairment can often understand a simple question about pain and respond to the caregiver. You might want to use a term other than the word "pain." Try using hurt, discomfort, uncomfortable, aching, or soreness. The assessor should ask concrete questions rather than abstract questions. For example, an abstract question is "are you having pain?" A concrete question might be, "does your arm hurt?" Or, "does your back ache?" Residents with cognitive impairment will need to be assessed in the present moment. They will not remember past pain. It must be frequently assessed on an ongoing basis.
- **Consider the disease condition and procedures that may be causing pain.** A skin tear on the leg from the wheelchair's rough edge, a fractured hip, a fall that results in a bruise on the elbow, physical therapy goals for ambulation daily following a hip fracture are among likely reasons for pain treatment. It may help caregivers to think, "if I were that resident, would I want something for pain?"

- **Use proxy pain reporting.** Families often report to the nurse that their loved one is in pain. Housekeepers, the maintenance person, social workers, activity aides, and dietary staff are often extended family who observe and interact with the resident frequently throughout the day. They should be encouraged to report the resident's pain.
- **Be alert for behaviors that may indicate pain.** Actions speak louder than words when residents are in pain. Pay particular attention to physical aggression, verbal aggression, facial expressions, restlessness, and resistance to caregivers. When implementing a facility behavior intervention program, start with considering the pain assessment of each resident. The following list of actions may represent pain.
 - **Facial expressions:** frown, grimace, fearful, sad, teeth clenched, eyes wide open or shut tight
 - **Physical movements:** restless, fidgeting, absence of movement, slow or cautious movements, guarding, rocking, rigidity, rubbing, holding parts of body, wandering
 - **Vocalizations:** groaning, moaning, repeated phrases, yelling out, noisy breathing
 - **Social:** sleepless or sleeping most of the time, irritability, agitated, combative, crying, trying to get attention, refusal to go to activities, loss of appetite, withdrawn, resist care
 - **Aggression:** physical or verbal

excessive heat (such as on the back of a bedfast resident) as that can affect the absorption of the patches. In addition, these patches may be contraindicated for residents with exceptionally low body fat.

Pain Management Risk for LTC Residents

Frail and elderly residents are at particular risk for both under- and over-treatment of pain. Age-related changes in the resident can contribute to a variety of adverse drug effects that have been reported. Non-opioid analgesic drugs, including NSAIDs and acetaminophen, are effective and appropriate for a variety of pain complaints. However, it is recognized that the risk for gastric and renal toxicity from NSAIDs is increased among elderly residents, and unusual drug reactions including cognitive impairment, constipation, and headaches are also more common in the elderly population.

Facility staff should be aware of drug side effects. All members of the IDT should be aware of all possible side effects and monitor the resident for their occurrences. The pharmacist is a key member of the team for recognizing and communicating the side effects to facility staff. The facility needs an ongoing method for communicating the drug side effects to all staff. The care plan could be one communication method for staff to know the adverse drug reactions.

What Everyone Can Do to Manage Pain

It is the role of the doctors, nurse, therapist, and family to determine the medical treatment for pain. Treatment may include medication, whirlpools, braces, ultrasound, or massages. But there are important things that everyone can do:

- Show that you care. A kind reassuring word and a soft touch go a long way.
- Let the resident know what you are going to do, even if he or she doesn't understand. Talk to, not around, the resident. Remember hearing is the last sense to go.
- Make the room pleasant. A comfortable temperature, soft lighting, soft music, and noise control can all increase pain tolerance.
- Take care of the basics. Repositioning, glasses and hearing aides, dry clothes, a comfortable bed or chair, toileting, food and fluids are often more important to the resident than any pill.
- Communicate with your team. Let others know what works best for the resident.
- Always report pain to the charge nurse or team. Pain is not a normal part of aging and all residents should have their pain managed.
- Understand the care plan for pain. Not all pain can be cured, but it can be treated in a thought out, effective fashion. A care plan for any resident with problem pain should involve a team approach.

- Relaxation methods can include a variety of techniques to help decrease anxiety and muscle tension; for example, imagery, distraction, and progressive muscle relaxation.
- Tactile strategies, for example, stroking and massage, can provide comfort through the sense of touch.
- Music and art therapy, meditation, and other relaxation techniques can be very helpful.
- Don't forget the team. Physical therapy can help with mobility and safety issues. Occupational therapy can help with difficult positioning and splints.

Family Attitudes

In our society, eating and drinking together or giving food and drink is a symbolic gesture of giving love. The sharing of food is almost always associated with social events and celebrations. When a relative enters the dying stage of life, the family should be encouraged to understand that refusing food is not a rejection of their love. This concept of food as a symbol of love can make it difficult for caregivers and family to accept the resident's decrease in food consumption during the dying process. The resident in the imminent death phase often accepts, even welcomes, not being pressured to eat. But family and caregivers may have difficulty accepting the resident's refusal of food and fluid. Staff should explain the decreasing desire for food and fluid during the end of life and the comfort and distress associated with it. It is important to help the family refocus its energy into nourishing the loved one's emotional relationships. Encourage the family to replace their desires to provide nourishment and nurturing for the body by providing nourishment and nurturing for the mind and spirit.

During the end of life, the resident is not the only person who may need help. The family must also cope with the emotional and psychological aspects of their loved one's condition. The facility staff needs to expand their assessment to include the needs of family members. Often families don't know how to act when the resident can no longer carry on a conversation.

For example, a wife who visited her husband after he had suffered a stroke, had no rehab goals, and was unresponsive, said to the nurse: "I don't know what to do in there." After all the usual responses in such situations, the nurse asked her what her husband had enjoyed doing before he had the stroke. The woman said that he had loved sports and always read every word in the sports section of the paper. The nurse suggested she read some of the paper to him. This suggestion gave the wife a sense of direction, and she was delighted. Bringing the paper to her husband gave purpose to her visits.

Often the family is at a loss for something to do when they can no longer offer food or fluids. The facility staff can suggest activities that family members can do during their time at the bedside, including, for example,

- applying lotion to hands and feet,
- giving a back massage,
- applying moisturizer to the lips,
- remembering earlier times and happenings that bring back good memories,
- playing audiotapes with nature sounds and appropriate music.

- talking about past life memories and experiences
- sitting in silence and sharing the time

Facility Staff Becomes Like Family

The facility's professional staff should be aware of one another's emotional attachment to these residents. This emotional attachment is the caring quality that allows us to show love and concern for one another. Often the facility staff becomes a surrogate family to the resident. This caring quality needs to be nurtured, and staff, too, should go through a healthy grieving process when the residents they care for enter the last stages of life. Such a process will help them express these same caring emotions time after time as residents die at the facility.

In one facility, for example, a resident lived for many years with no family or friends to visit him. His diagnosis was Huntington's Chorea, which made it considerably difficult for him to eat or for staff to feed him. One nurse aide had developed an emotional attachment to him and was his most successful caregiver. She could always get him to eat with the least amount of difficulty and the most enjoyment for both the resident and the nurse aide. When he died, the Director of Nurses recognized the aide's grief. The DON talked with the administrator about it, and the facility held a memorial service for the resident. Staff purchased a willow sapling (the resident's favorite tree), and everyone helped the nurse aide plant the tree in memory of the resident.

LTC facilities can develop a network of resources within their community who can provide grief counseling for their staff and families. The administrative staff should monitor the needs of staff and families so that all aspects of the death and grieving process are addressed in a healthy manner. During this time, everyone needs good memories and support as they deal with the difficult situations of living and helping others during their time of dying.

Psychosocial and Spiritual Care Interventions

Psychosocial and spiritual care interventions can be categorized in two ways: basic caregiving involves listening, and professional caregiving involves listening and seeking further explanation of "life stories involving fear, anger, and other affective states," frequently with referrals to other professionals. The following interventions can be helpful.

- Put aside your schedule and tasks. Offer your presence as a comfort and an opportunity for communication. Encourage the family or significant others to sit with the resident, even if nothing is said.
- Arrange for the clergy, rabbi, or other spiritual leader to visit the resident if the resident or family members so desire.
- Listen to stories or life reviews. Doing so is an excellent way to acknowledge the person's value to self and others.
- Allow expressions of anger, guilt, hurt, and fear without minimizing or explaining them away. Encourage the resident to acknowledge these feelings, and then let them go.
- Avoid clichés such as "It is God's will," "Time heals all wounds," "God wants him in heaven," and so forth. Such messages may not match the resident's beliefs. Never say, "Everything is going to be all right" or "You shouldn't feel that way."
- Read scriptures or other materials if the resident or family wishes to hear them.
- Encourage appropriate joy and humor. Laughter brings a lift to the spirit, celebrates life, and keeps things in perspective.
- Share prayers, meditation, or music if the resident and family desire them.
- Use massage and relaxation to help the resident relax and deal with disturbing psychosocial or spiritual matters. These techniques also help relieve pain and other distressing symptoms.
- Encourage completion of funeral arrangements.
- Encourage the resident to accept gratitude from others.
- Identify what constitutes a "good death" to the resident.
- Identify specific rituals or ceremonies important to the resident and family.
- Identify cultural issues that affect the resident and family.
- Encourage the family to give the resident permission to let go, when appropriate.
- Explain that it is all right to cry; tears are normal, and show caring.
- Encourage expressions of affection.
- Be present with the resident and family if they want support.
- Listen to the last wishes and regrets of the resident.

- Communicate to the resident that what is happening is natural and that he or she is not alone.
- Assist the resident in reframing goals that are attainable and meaningful; for example, explore the strengths, priorities and past experiences that helped the resident cope with life in earlier stages.
- Help the resident identify relationships that need closure.



Emily Mongan, Staff Writer

Follow @Emmongan

May 10, 2017

Lawsuit seeks \$1 million from SNF after employee took Snapchat video of resident

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The family of a Texas nursing home resident who appeared in inappropriate Snapchats is suing the facility, claiming it was negligent to hire the certified nursing assistant who posted the videos.

The CNA at the center of the incident, Carlos Alberto Santa Cruz, was suspended from Windsor Nursing and Rehabilitation Center of Duval after he allegedly posted a video to Snapchat in March. It showed an 83-year-old resident with Alzheimer's sleeping with what appears to be feces on her hands. He then reportedly posted videos of someone tickling the resident's nose, causing her to rub her face with her soiled hand.

X

Requests for comment from Windsor and its parent company, Regency Integrated Health Services, LLC, were not returned by production deadline Tuesday.

Next Article in News

Cruz was suspended from the facility after the incident was reported by one of his acquaintances; he was charged with assault by contact in April.

Also in the News for Wednesday, May 10

The lawsuit, filed Monday, seeks \$1 million in damages and court costs against Windsor and Regency. The resident's family claims Cruz's arrest record of fraud, marijuana possession and criminal mischief should have prevented him from being hired by Windsor. Cruz is "a despicable human being who proved himself to be someone who has no business caring for another helpless and defenseless human being," the lawsuit reads.





Eleanor Feldman Barbera, Ph.D.

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For Activities Class

January 16, 2018

Self-disclosure: What your staff needs to know about revealing personal information to residents

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As "Eileen" suggested in the comments section of a recent "Dr. El" blog, disclosing personal information can be a good way to establish a more intimate connection with residents. While self-disclosure can create warmer relationships, there also can be unintended and unwanted consequences to revealing such details.



Dr. Eleanor Barbera

In contrast to psychologists who study interpersonal interactions for a living, staff members are unlikely to have fully considered the impact of their self-disclosures. Doing so can improve their relationships with residents and avoid unanticipated pitfalls.

Here's a guide* to the ups and downs of self-disclosure along with a handy flow chart (see below) to help you and your team decide when it's the right move in any given situation. My inclination toward privacy is reflected in the flow chart, so consider it a starting point for discussion among team members or in a staff training session.

The ups

Part of the pleasure in working with elders is hearing about their lives and learning from their experiences. Sometimes revealing a detail or two from our own lives can help a reticent resident open up.

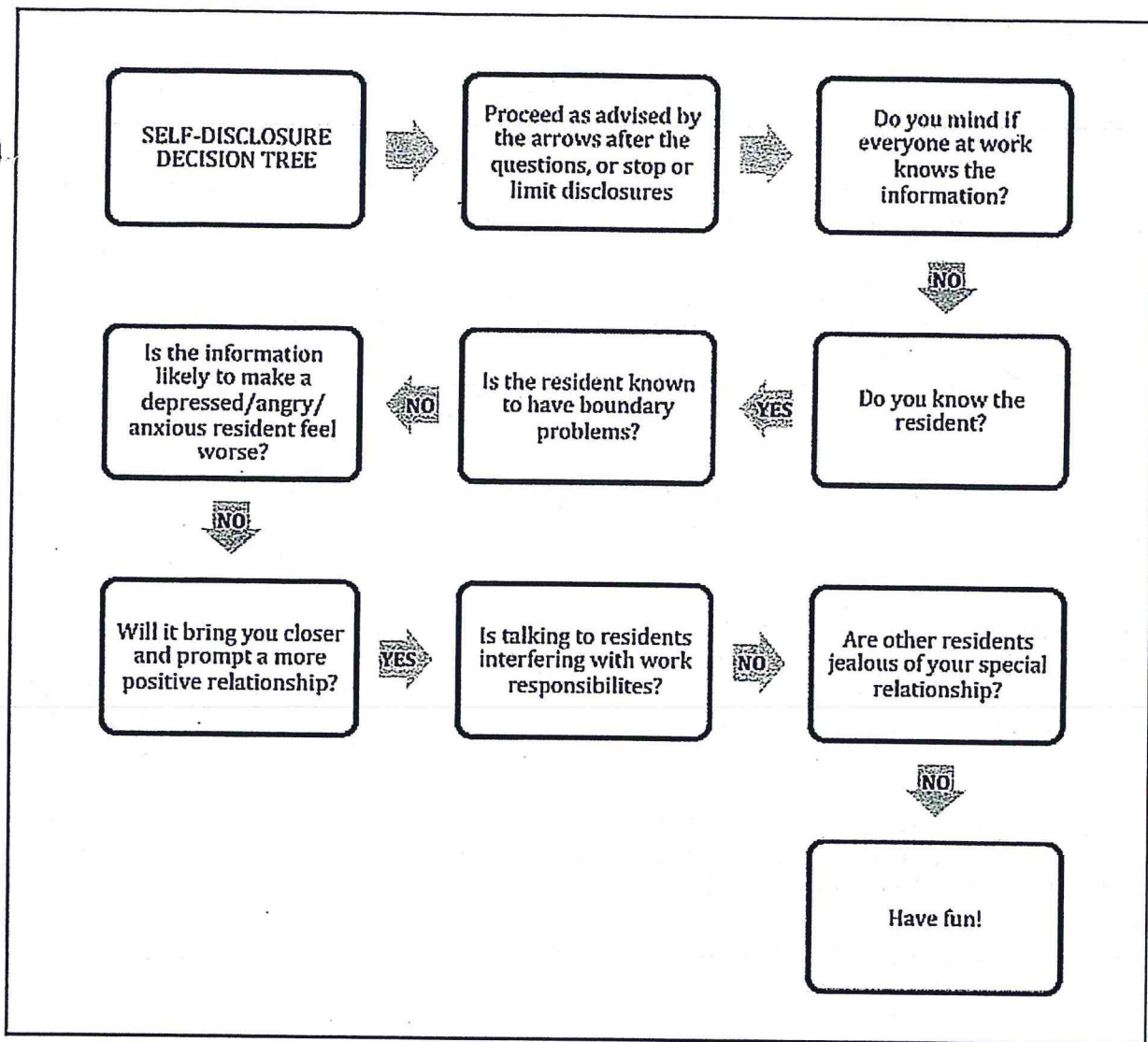
Self-disclosure allows workers to be more open and relaxed at work and to establish deeper relationships with those in their care.

Being "real" with residents can reduce the somewhat artificial boundaries between people in different phases and roles in their lives and can be part of a healthy organizational culture.

The downs

On the other hand, self-disclosure can sometimes get workers in trouble.

Consider the employee who tells a resident something in confidence that the resident later shares with others in the facility. The employee may still need to provide care to that individual despite the tension caused by the betrayal of a confidence.



*Reprints are available for multiple copies

Eleanor Feldman Barbera, PhD, author of *The Savvy Resident's Guide*, is an Award of Excellence winner in the Blog Content category of the APEX Awards for Publication Excellence program. She also is the Gold Medalist in the Blog-How To/Tips/Service category of the American Society of Business Publication Editors Midwest Regional competition. A speaker and consultant with over 20 years of experience as a psychologist in long-term care, she maintains her own award-winning website at MyBetterNursingHome.com.

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Or perhaps a resident learns sensitive information about a worker and uses it in a manipulative fashion. For example, an aide might reveal their involvement in a 12-step program in a well-meaning attempt to encourage a resident to address a drinking problem, but the resident could subsequently threaten to share that private information with the aide's coworkers unless special treatment is provided.

At other times, boundaries can be crossed in a different way, such as a resident offering unsolicited and overbearing advice to a staff member who has admitted that their child is having trouble in school.

Yet another possibility is that the personal information revealed is disturbing to a resident. This could occur, for instance, when an elder who is feeling particularly upset about his or her physical confinement becomes more distressed after hearing details about the vacation travels of a worker.

Finding a balance

The key to self-disclosure is determining what you're comfortable revealing and using it in the service of establishing genuine, healing relationships with residents. Some residents respond better to staff revelations than others; some staff members are naturally more open.

It's often possible to moderate the amount of information shared, depending on the situation. For example, when speaking with a resident with known boundary problems (such as asking overly intrusive questions), a worker might share that she was going on vacation, but not specifics of the trip or her fellow travelers. The same journey could be described in some detail to another resident with better boundaries who might enjoy reminiscing about their own visit to that particular location.

Other factors when revealing personal information include whether the amount of time spent discussing one's life with the resident is interfering with accomplishing necessary tasks or whether the closeness of the relationship with a particular elder makes a worker noticeably less available for other residents in their care.

Using the decision tree below can help workers think about the factors involved in establishing a friendly, professional persona that succeeds with a variety of residents.

