

Supporting the Professional Caregiver



caregivers

PREVENT  PROTECT  PROMOTE
abuse/neglect *clients* *dignity*

FACILITATOR GUIDE

DHFS/DQA/OCQ

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Learning Points

Let's review the main learning points.

- Encouraging Cooperation and Teamwork among Staff Members
- Providing Effective Feedback
- Supporting Caregivers through Challenging Situations
- Preventing Medication Diversion

Encouraging Cooperation and Teamwork



Leadership, cooperation and communication are key factors in creating a successful organization.

[Point out Learning Point #1: Encouraging Cooperation and Teamwork among Staff Members]

Establishing Leadership

What is the number one success factor for leaders in any organization?

[Encourage participants to state answers. Common answers include:

- ability to relate to others*
- being trustworthy*
- respecting the opinions of others]*

The number one success factor for leaders in any organization is “**relationships with subordinates.**” (Taylor, 1998). Center for Creative Leadership studies have shown that the most important reason managers fail is their insensitivity and inability to understand the perspectives of others.

Encouraging Teamwork

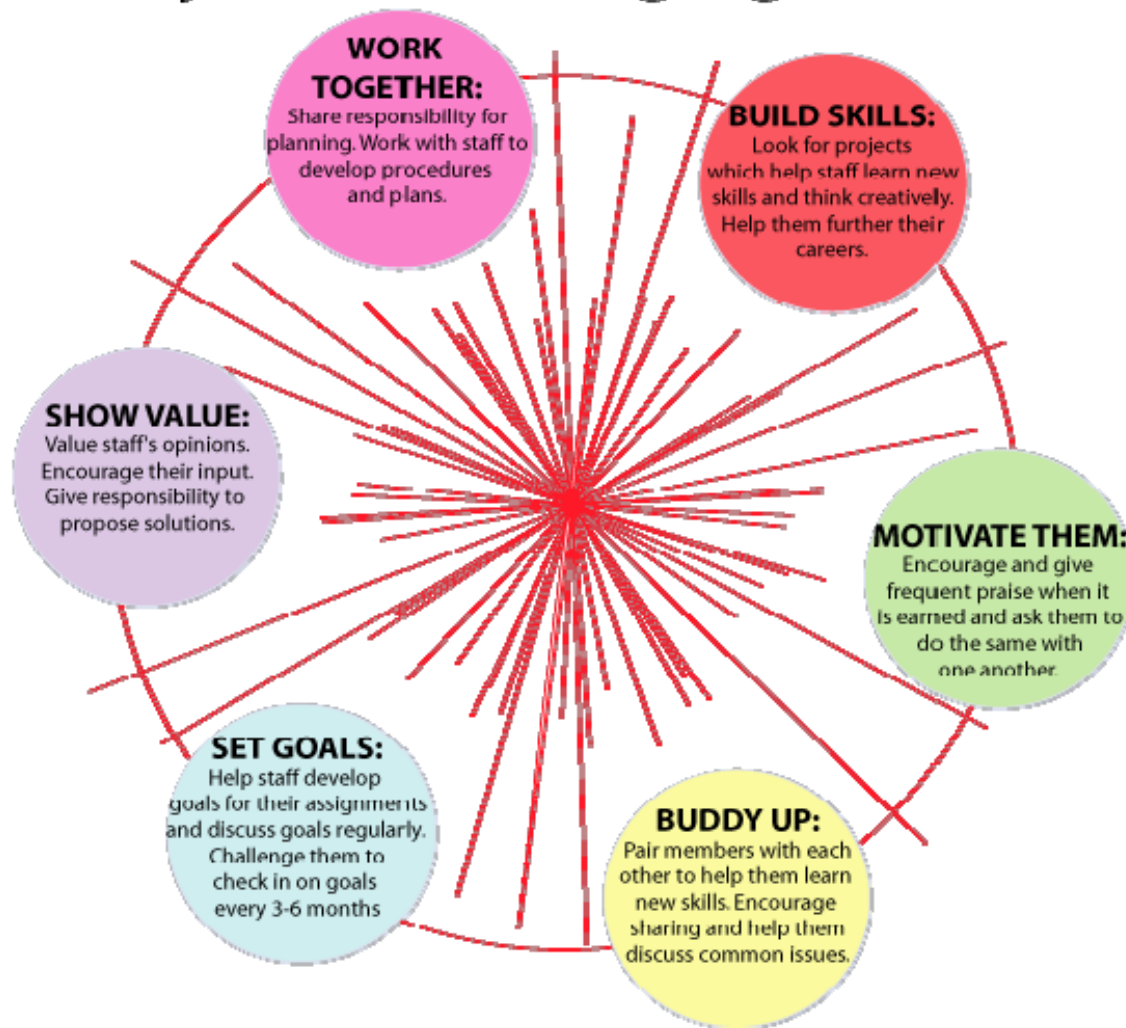
[Ask participants to get together in small groups (of 3-4 people) and answer the following question:]

What are some ways to develop cooperation and teamwork in your staff members?

[Ask each group to assign a scribe and reporter – provide them with large tear-off sheets and markers if available so they can write out their answers and show to the group.]

[Give participants about 5 minutes to answer the question. After 5 minutes, ask each group to share the responses.]

Keys to Encouraging Teamwork



[Briefly discuss each of the above points and draw comparisons to the answers that participants gave in their small groups. The graphic is contained in the participant guide.]

Key Leadership Behaviors

Below are some key behaviors of great leaders as identified by employees. Identify how often you practice these behaviors by circling the appropriate numbers below.

Source: Moran, L. "Getting Real: The Need for Genuine Leaders," 2003.

[Next, ask participants to work on the self-quiz that follows. This will NOT be turned in or viewed by anyone else. This is for participants to do a self-evaluation of their leadership skills.]

	Rarely	Sometimes	Often	Always
Makes and keeps realistic promises.	1	2	3	4
Shows concern for the feelings of others.	1	2	3	4
Avoids actions that bring personal benefit at the expense of others.	1	2	3	4
Helps when responsibilities are rapidly changing and not always well defined.	1	2	3	4
Consistently applies skills in ways that encourage positive participation from others.	1	2	3	4
Expresses confidence in the ability and potential of others.	1	2	3	4
Gives freely of time and attention.	1	2	3	4
Recognizes the good work of others.	1	2	3	4
Takes positive action on behalf of staff.	1	2	3	4
Takes logical steps to help solve problems.	1	2	3	4
Responds quickly to requests and issues.	1	2	3	4
Identifies new ways of doing things.	1	2	3	4
Values learning and mastering necessary skills.	1	2	3	4
Helps employees map paths towards goals.	1	2	3	4
Readily admits mistakes.	1	2	3	4
Is aware of how behavior affects others emotionally, cognitively and operationally.	1	2	3	4

Score Interpretation

- 55-64 You are an excellent leader. Keep it up!
40-54 Good job, but you have room to improve.
25-39 Significant improvements can be made.
below 25 You need to do some concentrated work.

Total score: _____

Factors Affecting Job Satisfaction

Take a look at the following factors affecting job satisfaction (in order of most important to least important):

1. Sense of achievement
2. Recognition
3. The work itself
4. Responsibility
5. Advancement opportunities
6. Professional and personal growth
7. Company policy and administration
8. Supervision (the person and the degree of oversight)
9. Relationship with peers
10. Personal life
11. Relationships with subordinates
12. Status
13. Job security

Salary is neither a motivator nor a de-motivator, as long as the company pays within the range of the marketplace, plus or minus 10%.

These are the primary reasons that people stay with, or leave, their jobs.

Source: Mink, O.G.; Owen, K.Q.; and Mink, B. P. Developing High Performance People: The Art of Coaching

Encouraging Cooperation and Teamwork by Understanding Style

We know the primary reason managers fail is their inability to build relationships with their staff members. To better understand the motivation of our co-workers, we can develop a better understanding of their communication styles.

Understanding communication styles can help us to resolve conflict. When we understand our own style and the style of others, we are able to be more flexible and skilled at handling conflicts.

- Understanding style is essential to working well with your staff, co-workers, friends and clients.
- When we increase our understanding of different styles and see things from the perspective of others, we reduce the amount of tension over style in our work and personal lives.
- To begin increasing our understanding, we will first work to identify our own styles.

T.E.A.M. Talk: Communicating with Style



Communication styles have been studied for thousands of years. The ancient Greeks characterized peoples' styles using designations of body fluids! In more modern times, many serious students of the subject agree that there are primarily four basic communication styles. Of course, we are all a combination of the four styles and the style we use at any one time may vary depending on the situation.

Conflict among team members often occurs because of a difference in style, not a difference in content. In other words:

It's not **what** we say, but **how** we say it!

In this training, each of the four communication styles is represented by the letters in T.E.A.M.

T=Thinker **E**=Engager **A**=Adventurer **M**=Mover

Which T.E.A.M style best expresses the way you communicate? Let's find out!

T.E.A.M. Talk
Cards
Handouts

Activity: T.E.A.M. Talk Cards

[Distribute the Team cards.]

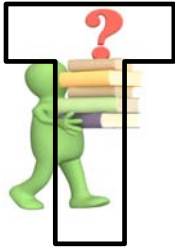
Each person has four cards, each one representing a different communication style. Look at each of the cards and sort them in the order

in which they seem most like you (on top) to least like you (on the bottom). Don't spend too much time; let your first impressions be your guide.

[Give the group 2 or 3 minutes to sort the cards. Ask people to identify their predominant style. If you have a smaller group, it's likely that each style may not be represented.]

Let's learn a bit more about each of the four styles by reviewing each one in more detail.

Thinkers thrive on information.



Thinkers seek facts to understand a situation. They value analysis, and like to plan before moving into action. They may be uncomfortable with impulsive decisions. Thinkers play by the rules and respect accuracy and accountability in themselves and others.

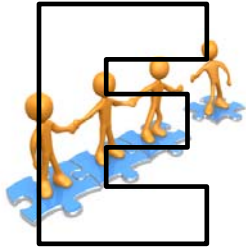
The **Thinker** might:

- Use longer, more complex sentences
- Like to review written materials, especially in advance of any decision or meeting
- Consider the consequences of the team's decisions
- Ask lots of questions to clarify or get more information
- Show an understated demeanor and speak in an unemotional tone
- Question change – unless there are facts to support it!

[Describe the Thinker's approach at the grocery store. Thinkers will arrive at the grocery store with a list of items organized by aisle. They might bring a calculator along to figure out the best bargains or total the final cost. They might be more apt to look over their receipt for errors than a Mover who just wants to get the task done.]

Describe the Thinker's approach at a team meeting. A Thinker prefers to get an agenda and any meeting materials ahead of time to think both over in advance. S/he pays attention to detail and may ask for more information to get a better understanding of the topics.]

Engagers thrive on personal connections.



Engagers value relationships and thrive on positive attention from others. They like to be regarded as people who make connections. They tend to be concerned with how a decision will affect all people involved.

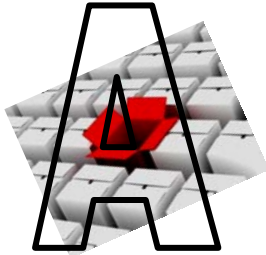
The **Engager** might:

- Begin the conversation with personal inquiries (“How are you?” “How was your weekend?” “How’s your family?”)
- Speak in terms of feelings (“Here is how I feel about the situation. How do you feel?”)
- Show a range of emotions
- Ask questions about how other people might feel or be affected
- Express concern about change – how will it affect everyone?

[Describe the Engager’s approach at the grocery store. The Engagers might know many of the staff at the grocery store and make sure to greet and ask about each one. They might ask about or take the time to check out any specials. They are happy to see an acquaintance and may stop to chat.]

Describe the Engager’s approach at a team meeting. The Engagers want to make sure everyone is involved and on board with ideas. They value input and want to hear everyone’s point of view. They are sensitive to other people’s thoughts and feelings.]

Adventurers thrive on excitement.



Adventurers tire of boring explanations, and find lectures very painful. They like to move quickly, and tend to do their work in a flurry of activity. They value creativity, freedom and flexibility. Adventurers tend to be very creative in their communication and rely on their intuition.

The **Adventurer** might:

- Tell stories or gives examples to support their point
- Use dramatic gestures
- Speak rapidly
- Use humor to make a point
- Use exaggeration (“I’m starving!”)
- Offer new ideas and approaches—think “outside the box”
- Embrace change – it can be “interesting”

[Describe the Adventurer’s approach at the grocery store. Adventurers might go to the store without a list, pick up whatever strikes their fancy, and crisscross aisles to pick up things they forgot. They like to look for new or unusual items to try out and might enjoy cooking creatively.]

Describe the Adventurer’s approach at a team meeting. The Adventurer likes to have options and resist rules without explanation. Adventurers may offer ideas that seem “out-of-the-box” to others but offer creativity. They like to have fun at a meeting.]

Movers thrive on quick results.



Movers make decisions easily and may become impatient with people who can't make up their minds. They often focus on the big picture. They are very goal-oriented and can be competitive. Movers value time, action and getting the job done.

The **Mover** might:

- Use short, direct sentences
- Ask closed questions (requiring “yes” or “no” answers)
- Use words that tell you to get to the point (“What’s your point?” “Let’s move ahead.”)
- Show impatience with long-winded explanations
- Multi-task while speaking with you
- Welcome change—if it will improve efficiency!

[Describe the Mover’s approach at the grocery store. Movers see grocery shopping as a time-consuming chore. They want to get in and get out. They go directly to what’s on their list, don’t do much impulse shopping, and use the express lines or self-serve checkouts to avoid waiting in line.]

[Describe the Mover’s approach at a team meeting. Movers want to have an agenda, address each item and not “waste” time on details. Movers like action item charts where each task is assigned to a person with a deadline. They want to stay on topic and not stray to personal stories, etc.]

Activity: Analyzing the T.E.A.M. Talk Styles

[Prior to the training, post four large sheets of paper or flip charts in different “style stations” around the room. Write a communication style at the top of each paper and list a column for “strengths” and a column for “limitations.” For example:

Engager	
Strengths	Limitations

While every member of your team brings value to the group, it's helpful to analyze how each style affects teams differently. Let's try an activity designed to explore both the strengths and limitations of your own style.

[Direct participants to the station of the top style they chose earlier. Encourage them to take their style cards and participant materials with them. Ask each group to appoint a recorder and a reporter. With very small groups you may have no one or just one person at a style station. If you have just one person representing a style, join that person yourself to support them in the process.]

Since we now understand the basic characteristics of each style, we'll use that knowledge to consider the following questions:

What strengths does each style bring to the team?

[To elaborate, how might some of the traits have a positive influence on the team? If you notice a group having trouble getting started, offer one example: E.g. an Engager might

ensure that everyone has input; a Mover might keep the group on task; a Thinker might bring up important details; an Adventurer might contribute an original, unique idea.]

How could each style limit the team?

[To elaborate, how might some of the traits limit the team? Can some traits be “too much of a good thing”? If you notice a group having trouble getting started, offer one example: E.g. an Engager might focus too much on everyone’s feelings, sidetracking progress; a Mover might be impatient with others; a Thinker might get bogged down in “what-ifs”; an Adventurer might lose interest, get bored with details or offer “off the wall” ideas (rather than outside the box ideas)

Give each group 5 minutes or so to list their thoughts. Ask each group to report out to the larger group when they’re done. Direct participants back to their seats. If a style(s) is not represented, ask the group in general to answer the same questions from their seats while a volunteer recorder documents the groups’ thoughts at the style station. They should refer to their participant guides and style cards to form responses.

NOTE: To avoid conflict, following the steps above prevents a participant of one style from commenting on the style of another participant. Because your audience will be comprised mainly of caregivers, expect that a large percentage will self-identify as Engagers with smaller numbers spread across the other 3 categories.]

Avoiding Stereotypes



Because the four communication styles are very simple and straightforward, it is sometimes tempting to stereotype a person based on the limitations of his/her dominant style.

We may say things like:

“Thinkers can’t see the forest for the trees!”
“Engagers are over-emotional do-gooders!”
“Adventurers are flighty and unreliable!”
“Movers are bossy know-it-alls!”

In order to have effective teams, it’s helpful to focus on the strengths instead.

[Ask participants to look at the statements above and suggest examples that focus on strengths instead of the limitations. For example, Thinkers don’t miss the details. Movers get the job done. Adventurers give us great ideas. Engagers make sure everyone feels part of the team. Jot some suggestions on a flip chart.]

It’s important to understand that we are a blend of all four styles, and it takes a combination of styles to make an effective team. While under stress, we may show more of our limitations than our strengths. Sometimes we behave differently in certain situations. For instance, someone might show Thinker traits at work, gathering information before making a decision, but may demonstrate Mover traits with children at home. This is perfectly normal.

Also, style is never an excuse for bad behavior. Someone who is a dominant Adventurer shouldn’t show up late for a meeting and say, “Get over it, I’m an Adventurer! Time is relative!” A Mover shouldn’t tell everyone what to do and then say, “I’m a Mover. It’s my way or the highway!”

Reducing Conflict with Others



While it's quite natural for us to focus on our own strengths and minimize our limitations, it might be helpful to find some "middle ground" that takes our communication to the most effective level.

The Golden Rule says that you should do unto others as you would have them do unto you. In other words, treat others as YOU would like to be treated. The Platinum Rule®, coined by Dr. Tony Alessandro, suggests that you should do unto others as THEY would have you do unto them. In other words, treat others as THEY would like to be treated.

Understanding others' styles gives you a chance to improve your communication and reduce conflict. But the most important key to successful communication is recognizing your own strengths and limitations. Reducing limitations allows others to appreciate those fabulous strengths!

Communicating with Other T.E.A.M Talk Styles

Showing respect in your communication with other team members is crucial to the success of the team, and ultimately, the care of your clients and residents. Translate your message into a "universal" style using these tips:

Communication Tip	Example
Listen	<ul style="list-style-type: none"> • Give your full attention • Make eye contact • Refrain from interrupting
Understand	<ul style="list-style-type: none"> • Ask questions to clarify • Respect others' perspectives
State preference, purpose	<ul style="list-style-type: none"> • Say what you think • State why you think it • Explain the outcome you expect
Outline a problem, suggest a solution	<ul style="list-style-type: none"> • Avoid accusations • Propose a solution to the problem

Confirm agreements/plans	<ul style="list-style-type: none"> Restate matters in your own words. “This is what I’m hearing...”
Respect the needs of others	<ul style="list-style-type: none"> Include statements/questions such as “Do you want to think this over first?” or “I know this will take some time”
Express appreciation	<ul style="list-style-type: none"> Don’t just think nice thoughts, say them out loud!
Agree to disagree	<ul style="list-style-type: none"> Smile and accept the differences all bring to work

[Ask participants to take a private moment to consider and circle the tips they might use more often.]

Improving Communication with Clients

Clients are an important member of your caregiving team. Some clients are able to make their own decisions and have no cognitive impairments. These clients may clearly show an identifiable communication style. Other clients, however, may have cognitive disabilities or disorders as a result of conditions such as mental illness, Alzheimer’s disease or other dementia, autism spectrum disorder, deafness, blindness, brain injury, etc.

Persons with cognitive disorders and other emotional or behavioral disabilities may not demonstrate an identifiable communication style. But knowing your own style will help you communicate with those clients. For example, Movers may have a tendency to rush and may cause anxiety in clients, while Engagers may be intimidated by a client who acts out aggressively and fail to perform necessary cares.

Tips for Improving Communication with Your Clients

[Ask participants to review the list—don’t read it to them. Ask if they see any tips that they have used in the past or find

meaningful. Perhaps they might offer other tips as well. If you are not getting a response, choose a few of the tips and mention them briefly.]

- Think about how your client may interpret your style.
- Remember that a client's communication style may be due to illness or disability. Don't take it personally.
- Resist the urge to push forward with a resistive client. Clients have the right to have choices.
- Refrain from arguing with clients with cognitive impairments—they may not be able to process your point, even if it's a good one.
- Watch for non-verbal communication if the ability to speak is diminished. Concentrate on body language and facial expressions instead.
- Always consider re-approaching a client who is uncooperative or upset at a later time.
- Practice empathy—try to put yourself in your client's place.
- Know your client's care plan so that you are fully aware of their physical and emotional condition. A thorough care plan also will provide good tips for communication.
- Use simple language and short sentences. If assisting a client, simplify steps and list them one at a time.
- Repeat words and sentences as needed. You can't assume that a client understands your words, even if the client understood them yesterday.
- Project a calm and friendly approach. A client may sense a tense or hurried approach and become more resistive.
- Make sure that your client can hear you. Don't automatically write it off as dementia. Ensure that an assessment has been done.
- Always ask yourself: Are my actions geared to my client's needs or my own?

Improving Communication with Family Members



Like other members of your team, family members demonstrate communication styles as well. However, it may be more difficult for family members to communicate successfully because of the strong emotions many experience over the illness or disability of a loved one. What are some of the feelings that may cloud family members' ability to communicate?

- Grief – feeling sad about the loved one's declining health
- Stress – assuming additional responsibilities or financial burdens at home due to the absence of the client
- Guilt – being unable to continue to care for the loved one at home
- Anger – feeling upset about being left alone or blaming the loved one for becoming ill

In these instances, it may be best to focus on the universal communication techniques that we discussed earlier. And above all – don't take it personally.

Team Building Exercise

[Give participants about 5 minutes to work independently on the questions below. Then ask participants to team up with at least one other person to review the ideas each person has about building teamwork and cooperation (Question 3 below). Participants have a worksheet in their participant guides.]

1. Think about the members of your team – what styles do you see in them?

[A high percentage of your participants (and their staff) may self-identify as Engagers. This seems to reflect the idea that Engagers highly value other people and are naturally attracted to the health care field. Take care to emphasize the importance of all communication styles, as in the next question.]

2. What skills and strengths does each communication style bring to a team?

[Possible answers:

- Thinker = attention to details, logic, skill in planning]*
- Engager = warmth, caring, consideration of others]*
- Adventurer = creativity, excitement, fun]*
- Mover = efficiency, organization, attention to deadlines]*

3. How can you help to build more teamwork and cooperation among staff members by understanding a team's communication style?

[Possible Answers:

- Have staff review the T.E.A.M. Talk cards and complete this exercise]*
- Ask staff for ways that everyone can contribute]*
- Think of ways to pull out the strengths of the members of your team. E.g., think about how a Thinker may not contribute much in a meeting. Now you know they may need more prep time.]*

After participants have discussed ways to use communication styles to build teamwork and cooperation, ask for volunteers to share some ideas.]

Wrap-Up

[Review the following:

- Learning Point #1: Encouraging Cooperation and Teamwork among Staff Members*
- Keys to Encouraging Teamwork*
- Using Communication Styles to Build Teams]*

Providing Effective Feedback



The following is a guide to providing effective feedback to your staff members.

- Ask open-ended questions and listen actively
- Communicate observations
- Practice positive reinforcement
- Communicate responsibilities and expectations
- Establish goals and follow up

[Point out Learning Point #2: Providing Effective Feedback]

Asking and Answering Questions

Why Ask Questions?

- To create independence in others
- To establish ownership of the ideas, and a greater investment
- To determine the person's awareness of the problem
- To foster agreement that a problem exists
- To aid in exploring possible solutions

When Asking Questions

- Ask general, open questions. Questions that begin with “What” and “How” help you to get more information.
- “Why” is not recommended because it probes for a motive and may result in defensiveness.
- If the other person has difficulty in answering, say: “Let me rephrase the question...” and ask another question that provides additional clues.
- Ask permission before directly providing information. Ask: “Could I make a suggestion?”

Examples of Questions to Ask

- “What are your concerns about this task?”
- “What do you think we can do to improve this situation?”
- “What changes would you like to see in the way it is done?”
- “What other changes could be made?”
- “What improvements can be made to the way we do things here?”
- “Which of these changes should be tackled first?”
- “What were the results of that action?”
- “What is the first thing that needs to be done?”
- “If you do that, what might the consequences be?”
- “How could you prevent that problem from occurring?”
- “If the problem occurs in the future, what could you do now to reduce its seriousness?”
- “What support do you need from me?”
- “How can I help?”

Instead of...	Try this one...
“Are you sure you like doing this?”	“How do you like doing this?”
“Do you think you need to do this better?”	“Are there ways to do this even better?”
“Don’t you think things could be changed here?”	“What concerns do you have about doing this?”
“Why do you have such a hard time with this part?”	“What parts of this are the most challenging for you?”
“Why is this so challenging for you?”	“What do you see as the reasons that make this challenging?”

Questions To Ask When Following Up

Once a project has been completed, or a goal has been reached, be certain to follow up with your staff.

- “How do you feel about your progress in carrying out your plan?”
- “What did you learn from this experience?”
- “In hindsight, what would you do differently if you had to do it all over again?”
- “How else could I have helped you?”
- “Now that you have completed your original plan, what do you see as the next step?”

Listening

Give your full attention.

- Stop what you are doing and keep good eye contact

Clarify what is being said and confirm your understanding.

- Briefly paraphrase the substance of what was said

Be respectful.

- Use both verbal and non-verbal responses

The more interested you are in what the other person has to say, the more that person will be interested in what you have to say.

Communicate Observations

- When you see it, say it—never let good work go unnoticed
- Don't beat around the bush. Be gentle but direct. Say exactly what you observe in a non-judgmental way. Get to the point quickly.
- Be specific and concise by stating **expectations followed by observations**. State what was agreed upon and exactly what you observe.
- Be objective and non-threatening
- Be aware of your body language, voice intonation, and facial expressions
- Avoid sending someone else to do your job for you (i.e. asking a supervisor who “knows the person better than you” to address the issue)
- Avoid using the “good news/ bad news” ploy
- Do not use sarcasm, insults, or accusations

Prepare preliminary questions.

When you observe an individual's behavior, think about answers to the following questions:

- What is the person doing or not doing effectively? Be as precise as you can.
- What impact does the person's behavior have on achieving your group's goals or individual objectives?
- What impact does the behavior have on other members of the team?

Avoid premature judgments. Be very careful not to make premature judgments about the person. Try to be a neutral observer.

Test your theories. Continue to observe, particularly if you don't feel comfortable with your perceptions. Where appropriate, discuss the situation with others—trusted peers or colleagues—to get their perspectives. Consider any cross-cultural issues that might help you better understand the situation or person involved.

Examine your motives. When coaching someone you think is a problem performer, take a close look at your own behavior first. Ask yourself how you might be contributing to the problem.

Unrealistic expectations. Ask yourself, *"Am I using my own performance as a yardstick to measure others?"* You've probably progressed in your career by setting high expectations and achieving an outstanding track record. Assuming that others have identical motivations or identical strengths may be unrealistic and unfair.

Interfering feelings. Ask yourself, *"Is it hard for me to identify with someone who's having a problem?"* Be self-aware and recognize when your own feelings, such as anger or frustration, may keep you from appreciating what someone else might be feeling—and may cloud your observation and analysis skills.

Failing to praise. Ask yourself, *"Have I remembered to give positive feedback?"* Often managers forget to take the time and look for opportunities to give positive feedback. Over time, an absence of positive feedback could contribute to problem behaviors or attitudes.

Activity: Providing Feedback

Please consider the following situation:

You are the administrator of a CBRF. Recently one of your staff, Michael, has established a pattern of arriving late for work. At first, he was only about 5 minutes late once or twice a month. At this point, he is arriving 15 minutes late two or three times a week. Other caregivers have noticed Michael's tardiness and have begun to complain to you and each other. Last week you frowned at Michael when he was late, hoping he would get the idea. But today, he was 20 minutes late!

You have to admit that Michael is not your favorite employee, but the residents seem to like him and he provides good cares. You know you need to provide feedback to Michael and wonder how you will approach the issue.

[Ask participants to team up with another person and then consider the following questions. Ask them to provide feedback to one another using the material covered in this section. There is a worksheet in the participant guide.]

1. Why is it important to provide feedback to Michael?
2. What concerns do you have about the interaction?
3. How might you open the conversation with Michael?

[Give participants about 5 minutes to discuss the questions. Ask participants to volunteer ideas for each question.]

Using Communication Effectively



Being able to communicate effectively with others does not come naturally for most people. Most of us need to learn how to be assertive communicators, rather than passive or aggressive.

- Assertiveness is about standing up for yourself, but also about respecting the opinions and needs of others.
- When we communicate assertively, we are clear about our opinions and wishes in relating to others, but we are also open to their opinions and wishes.

About the Three Different Styles – Passive, Aggressive, Assertive

Let's discuss the characteristics of each style.

Passive

Characteristics of a person with a passive interpersonal style may include:

- easily intimidated by others
- believe that his/her rights and opinions are not as important as those of other people
- avoids eye contact
- appears shy and has difficulty saying “no” when asked to do a favor
- overly-courteous and might do just about anything to avoid a fight, argument or disagreement
- gets angry when someone violates her rights, but isn't likely to stand up for herself directly
- feels put down, taken advantage of, or abused
- feels depressed or anxious due to fear of others getting angry or feeling like a “doormat”

- develops a passive-aggressive approach, i.e., won't stand up to someone directly, but talks about them behind their back or sabotages the outcome
- intimidated by authority and has a hard time dealing with supervisors
- at high risk for being used or taken advantage of
- rarely gets what she wants or needs

NOTE: It is important to note that in some situations in which there is potential danger, it is appropriate to behave passively in order to protect yourself.

Aggressive

Someone with an aggressive interpersonal style behaves very differently than the person with a passive style.

Some characteristics of a person using an aggressive interpersonal style may include:

- Believes that her rights, opinions and needs are more important than those of others (her way or the highway)
- Violates others' rights and boundaries in an effort to get what she wants
- Sends the message: "I matter more than you do, so get out of my way"
- Uses a loud tone of voice, violates personal space, generally "in your face"
- Is demanding, angry, and hostile in getting to her goal
- Exaggerates the facts
- Ignores others' feelings and rights
- Alienates others through her hostile style or gets into arguments
- Often does not get her needs met because she offends others or makes them angry

Assertive

The assertive style is the middle ground between being passive and aggressive. Some characteristics of a person who uses an assertive interpersonal style may include:

- Believes in her own opinion and right to be heard (self-respect)
- Respects the opinions and needs of others (empathy)
- Uses a calm tone of voice
- Makes eye contact and respects the personal space of others
- Avoids labels and judgments
- Asks rather than demands
- Values herself and values others equally
- Is neither a “doormat” (passive) or a “steamroller”(aggressive)
- Uses “I” statements to get the message across
- Does not exaggerate the situation
- Sticks to the facts
- Often get their needs met because they are respectful of others

Making Assertive Statements

Here’s a great formula that puts it all together:

“When you [their behavior], I feel [your feelings].”

When used with factual statements, rather than judgments or labels, this formula provides a direct, non-attacking, more responsible way of letting people know how their behavior affects you. For example:

“When you *raise your voice*, I feel *threatened*.”

Does anyone have another example of using this assertive, nonjudgmental style?

A more advanced variation of this formula includes the results of their behavior (again, put into factual terms), and looks like this:

“When you [their behavior], then [results of their behavior],
and I feel [how you feel].”

Here is one example:

“When you arrive late, I have to wait, and I feel frustrated.

An assertive person may also need to tell the person what they want:

“When you arrive late, I have to wait, and I feel frustrated. Can I count on you be on time tomorrow?”

Does anyone have another example of this formula?

Why Assertiveness Is Important

Can you think of some reasons why it may be better for you to use an assertive communication style, rather than passive or aggressive?

[Write answers on flip chart. Participants have space to write in their guide.]

Sample answers:

- *Others are more likely to listen to you.*
- *Others admire your sense of self-respect.*
- *You’re more likely to get what you want.*
- *Others see you as an honest person.*
- *Co-workers see you as cooperative and caring.*
- *Managers see you in a positive light.*
- *Clients think of you as a professional.*
- *You appear to be a fair person.*
- *You seem thoughtful and caring.*
- *Others are less likely to take advantage of you.*
- *People welcome you into their environment*
- *You feel better about yourself and release stress*
- *You won’t be angry with yourself for not speaking up*
- *Others understand you more clearly]*

When communicating assertively...

Do:

- Express feelings honestly – take ownership of your feelings
- Be realistic, respectful and honest
- Express preferences and priorities
- Choose your response carefully, especially when emotions are high

Don't:

- Depersonalize feelings or deny ownership
- Say "You make me mad"
- Exaggerate, minimize, or use sarcasm
- Agree just to be sociable or agree unwillingly

Assertive Demeanor

Posture: Erect but relaxed, shoulders straight

Facial expression and gestures: Relaxed, thoughtful, caring, genuine smile

Voice: Firm, pleasant, smooth, even-flowing, moderate volume

Wrap-Up

[Review the following:

- *Learning Point #2: Providing Effective Feedback*
- *Assertive, Passive, Aggressive Styles*
- *Asking and Answering Questions*
- *Listening and Communicating Observations]*

Supporting Caregivers through Challenging Situations



We've talked about understanding communication styles and learned how to communicate assertively with those around us. Next we're going to talk about some guidelines for maintaining a positive and helpful relationship with your clients or residents. These guidelines are called professional boundaries.

[Point out Learning Point #3: Supporting Caregivers through Challenging Situations]

The caregiver has a powerful role in the relationship between caregiver and client. This power comes from:

- 1) Control over the services provided to the client
- 2) Access to private knowledge about the client

It's important not to let the balance of power slide heavily onto the caregiver's side of the relationship. Maintaining professional boundaries helps the caregiver maintain a helpful or "**therapeutic**" relationship with the client.

**Professional
Boundaries
Handout**

Professional Boundaries

*[Direct participants to the "**Professional Boundaries for Caregivers**" handout. Briefly review each boundary type along with the comments/definition for each. Point out tips for "staying in bounds" in the right column for participants to look over later.]*

Professional Boundaries for Caregivers

Type of Boundary Crossing	Staying In-bounds
<p>Sharing Personal Information: It may be tempting to talk to your client about your personal life or problems. Doing so may cause the client to see you as a friend instead of seeing you as a health care professional. As a result, the client may take on your worries as well as their own.</p>	<ul style="list-style-type: none"> • Use caution when talking to a client about your personal life • Do not share information because you need to talk, or to help you feel better • Remember that your relationship with your client must be therapeutic, not social
<p>Not Seeing Behavior as Symptomatic: Sometimes caregivers react emotionally to the actions of a client and forget that those actions are caused by a disorder or disease (symptomatic). Personal emotional responses can cause a caregiver to lose sight of her role or miss important information from a client. In a worst case, it can lead to abuse or neglect of a client.</p>	<ul style="list-style-type: none"> • Be aware that a client's behavior is the result of a disease or disorder • Know the client's care plan! • If you are about to respond emotionally or reflexively to the negative behavior of a client, step back and re-approach the client later • Note that the client may think their action is the best way to solve a problem or fill a need • Ask yourself if there is a way to problem solve and help the client communicate or react differently
<p>Nicknames/Endearments: Calling a client 'sweetie' or 'honey' may be comforting to that client, or it might suggest a more personal interest than you intend. It might also point out that you favor one client over another. Some clients may find the use of nicknames or endearments offensive.</p>	<ul style="list-style-type: none"> • Avoid using terms like honey and sweetie • Ask your client how they would like to be addressed. Some may allow you to use their first name. Others might prefer a more formal approach: Mr., Mrs., Ms, or Miss • Remember that the way you address a client indicates your level of professionalism

<p>Touch: Touch is a powerful tool. It can be healing and comforting or it can be confusing, hurtful, or simply unwelcome. Touch should be used sparingly and thoughtfully.</p>	<ul style="list-style-type: none"> • Use touch only when it will serve a good purpose for the client • Ask your client if he/she is comfortable with your touch • Be aware that a client may react differently to touch than you intend • When using touch, be sure it is serving the client's needs and not your own
<p>Unprofessional Demeanor: Demeanor includes appearance, tone and volume of voice, speech patterns, body language, etc. Your professional demeanor affects how others perceive you. Personal and professional demeanor may be different.</p>	<ul style="list-style-type: none"> • Clients may be frightened or confused by loud voices or fast talk • Good personal hygiene is a top priority due to close proximity to clients • Professional attire sends the message that you are serious about your job • Off-color jokes, racial slurs, profanity are never appropriate • Body language and facial expressions speak volumes to clients
<p>Gifts/Tips/Favors: Giving or receiving gifts, or doing special favors, can blur the line between a personal relationship and a professional one. Accepting a gift from a client might be taken as fraud or theft by another person or family member.</p>	<ul style="list-style-type: none"> • Follow your facility's policy on gifts • Practice saying no graciously to a resident who offers a gift that is outside your facility's boundaries • It's ok to tell clients that you are not allowed to accept gifts, tips • To protect yourself, report offers of unusual or large gifts to your supervisor
<p>Over-involvement: Signs may include spending inappropriate amounts of time with a particular client, visiting the client when off duty, trading assignments to be with the client, thinking that you are the only caregiver who can meet the client's needs. Under-involvement is the opposite of over-involvement and may include disinterest and neglect.</p>	<ul style="list-style-type: none"> • Focus on the needs of those in your care, rather than personalities • Don't confuse the needs of the client with your own needs • Maintain a helpful relationship, treating each client with the same quality of care and attention, regardless of your emotional reaction to the client • Ask yourself: Are you becoming overly involved with the client's personal life? If so, discuss your feelings with your supervisor

<p>Romantic or Sexual Relationships: A caregiver is never permitted to have a romantic or sexual relationship with a client. In most cases, sexual contact with a client is a crime in Wisconsin.</p>	<ul style="list-style-type: none"> • While it may be normal to be attracted to someone in your care, know that it is never appropriate to act on that attraction • Do not tell sexually oriented jokes or stories. It may send the wrong message to your client • Discourage flirting or suggestive behavior by your client • If you feel that you are becoming attracted to someone in your care, seek help from your supervisor or other trusted professional right away
<p>Secrets: Secrets between you and a client are different than client confidentiality. Confidential information is shared with a few other members of a team providing care to a resident. Personal secrets compromise role boundaries and can result in abuse or neglect of a client.</p>	<ul style="list-style-type: none"> • Do not keep personal or health-related secrets with a client • Remember that your role is to accurately report any changes in your client's condition

Why Professional Boundaries Are Important

Can you think of some reasons why maintaining professional boundaries is important for caregivers?

[Ask the group for some reasons. Document answers on a flip chart. If needed, offer some of the following examples.]

- Assure a therapeutic relationship with clients, rather than a social relationship.*
- Avoid burnout.*
- Avoid legal trouble.*
- Caregivers maintain a helpful relationship, not too personal and not too aloof.*
- Caregivers avoid emotional entanglements.*
- Caregivers treat all clients fairly.*
- May reduce allegations of caregiver misconduct.*
- The caregiver is seen as a professional.*
- Supervisors see the caregiver as competent.]*

Activity: Explore Boundary Crossings

Using what you've learned about professional boundaries so far, we're going to explore some examples of boundary crossings. Please select your handout titled "**Examples of Boundary Crossings.**"

[Have large group break into small groups. Assign each group a different scenario. Point out the scenario in their handout. If you have a small audience, you may assign each person a scenario.]

Please choose one person to take notes about your discussion and report back to the larger group at the end of your discussion. When you look at the examples, please discuss:

- What observations can you make about the situation?
- As a supervisor, how would you coach the caregiver in the situation?

You'll have about 10 minutes for discussion. You can begin now.

[Before asking each group to report back, read the scenario to the whole group—point out the scenario in their participant guide also. The facilitator version of the Examples of Boundary Crossing Handout contains possible observation examples and coaching points if needed.]

Examples of Boundary Crossings

Sharing Personal Information

Polly is a 28 year-old home health aide with two children. Bess, a 90-year old widow, is one of Polly's patients. Polly is going through a divorce and seems to be on an emotional roller coaster lately. Polly feels better when she can talk about her situation. Recently, she has begun to share her experiences with Bess, including details of her ex-husband's infidelity, his failure to pay child support, her dire financial situation, and her children's unhappiness. Bess seems to be a sympathetic "ear" for Polly and listens attentively when Polly shares her experiences.

[Possible Observations:

- Polly is treating Bess as a friend.*
- Polly's focus on her own problems may result in neglecting some of Bess's cares.*
- Bess may worry about Polly's situation.*
- Bess may try to help Polly by offering money, food or other necessities.*
- Polly's detailed accounts may offend Bess.*
- Bess might complain to Polly's boss.*

Possible Coaching Points:

- Offer Employee Assistance Program (if available) to Polly.*
- Ask, "When you share your problems with Bess, might it cause her to worry?"*
- Ask, "What is your measuring stick for sharing information with those in your care?" (Some caregivers share only good news.)*
- Try role play to give Polly some language/responses to Bess's questions without giving Bess too much personal, negative information.]*

Not Seeing Behavior as Symptomatic

Carlos, a 40 year-old CNA in a nursing home, often provides cares for Jerry, a 72 year-old resident with Alzheimer's disease. Carlos has come to Jerry's room to assist him to the dining room for supper.

CNA Carlos says to Jerry, "It's dinnertime. Are you ready to go?" Jerry smiles at Carlos and says, "Ready." But then Jerry returns to watching TV. Carlos brings Jerry's walker to him, but Jerry continues to stare at the TV.

After several attempts to get Jerry up, Carlos becomes angry. He walks out of Jerry's room, muttering to himself, "The heck with Jerry, he can just go hungry tonight. I hate it when he ignores me like that! He knows it's dinnertime. He's just trying to annoy me!"

[Possible Observations:

- Carlos is assuming that Jerry understood his words and intention.*
- Jerry may be experiencing aphasia, the inability to understand written or spoken word.*
- Although Jerry repeated the word "ready," he doesn't recall what it means.*
- Carlos' conduct could result in Jerry being neglected, going hungry.*
- Carlos did not consider the possibility that Jerry's response was a symptom of his illness.*
- Carlos' impatience affected the quality of Jerry's care.*
- Jerry senses Carlos' frustration and becomes agitated.*

Possible Coaching Points:

- More training for Carlos in recognizing the signs of aphasia.*
- Review the care plan with Carlos if there are successful approaches to Jerry listed there.*
- Talk about alternatives to getting dinner for Jerry: bring dinner to his room; re-approach later.*
- Use the moment to reinforce the need for caregivers to share challenging situations or changes in a resident's behavior with the supervisor. Sometimes direct caregivers are the first to recognize changes in behavior.]*

Using Nicknames/Endearments

Edward Maxwell is an 85 year-old resident of a nursing home. Professor Maxwell taught American History at the UW-Stout for many years and after retirement traveled widely with his wife. However, he is no longer able to care for himself and must rely on nursing home staff to assist him with eating, toileting, bathing, etc.

A new CNA, Melanie, age 19, enters Professor Maxwell's room and says, "Good morning, Sweetie. Are we ready for our bath?" Professor Maxwell says to Melanie in a gruff voice, "I'm not having a bath today, young lady. Get out of my room!" Melanie leaves, wondering why it's her bad luck to get stuck with such a crabby old man!

[Possible Observations:

- Melanie reminds Edward of his students, who always addressed him as Professor, not Sweetie!*
- Edward is offended by Melanie's overly familiar manner.*
- Melanie's question may seem condescending or demeaning to Edward.*
- Melanie's use of an endearment diminishes her professionalism in Edward's eyes.*
- Edward resents having to rely on strangers for personal cares.*
- In Edward's day, calling someone "sweetie" intended something more, as in "sweetheart."*

Possible Coaching Points:

- Suggest alternative/more respectful ways to approach residents.*
- Talk to Melanie about adult to adult communication rather than the adult to child style that Melanie used.*
- Meet people where they "are." Stress the importance of knowing the resident's life history.*
- Find out how Edward prefers to be addressed.*
- Consider the intimate nature of bathing. Ask Melanie to put herself in Edward's shoes, how would she feel if a man she didn't know had to help her with her bath?*
- Talk about how easily terms of endearment may be misunderstood.]*

Touch

Michael is a 30 year-old caregiver in a CBRF. Marla is a 25 year-old woman with cerebral palsy and a cognitive disability. Unknown to Michael, Marla was assaulted several years ago by a former boyfriend.

One day, Michael walks into the kitchen and sees Marla, crying softly over her breakfast. Michael bends down and places his arm around Marla who suddenly begins to scream and cry harder. She shrinks away from Michael and looks at him with fear in her eyes. You come out of your office and want to know what Michael has “done” to Marla.

[Possible Observations:

- Michael didn’t stop to consider how Marla might react to his touch.*
- Michael intended his touch to be comforting.*
- Although Marla knew Michael and liked him, his touch startled her.*
- Marla was reminded of her rough treatment by an abusive male in her life.*
- Marla may have thought Michael was making a sexual advance.*
- Caregivers must be aware that clients might perceive an intimate gesture as a sexual advance.*
- Michael never intended to startle or injure Marla, but his uninvited touch was mistaken for something else.*
- Although Michael did not intend to harm Marla, it may create questions in his boss’s mind.*

Possible Coaching Points:

- Provide training on the impact of sexual assault on victims.*
- Ensure that Michael knows Marla’s history. (Is her care plan accurate and up-to-date?)*
- Discuss being sensitive to the unique issues that come up between caregivers/clients of the opposite sex.*
- Even the best intentions can be misunderstood.*
- You, as the supervisor, should take responsibility for judging the situation too quickly.*
- Help Michael think of alternative approaches to soothe Marla.]*

Professional Demeanor

Susie is a 22 year-old CNA at a nursing home in a small town. She is from a large family with four older brothers and a younger sister. As a child, Susie developed an aggressive and loud manner in order to stand up to her older siblings. But her loud voice and “salty” language have now landed Susie in trouble with her supervisor. In the last few months, three different residents have complained that Susie is being verbally abusive to them. Susie can’t understand it—she always gets her cares done on time and even helps out others. She really cares about the residents, but she doesn’t see any reason to pretend to be something she’s not!

[Possible Observations:

- *Susie has applied her personal demeanor to her professional life.*
- *She has failed to see herself as others see her.*
- *Residents feel threatened by her loud voice and aggressive mannerisms.*
- *Susie’s youth and inexperience may contribute to her lack of professional demeanor.*
- *Susie doesn’t realize that some people are offended by her profanity.*
- *Susie’s demeanor has protected her in her personal life. It’s hard to put on a different face.*
- *Susie’s demeanor may result in her losing her job or being charged with caregiver misconduct.*

Possible Coaching Points:

- *Review the policy/work rule that prohibits profanity.*
- *Help Susie consider that some people are offended by profanity.*
- *Teach Susie that when she uses a loud voice, some people think she is angry or mean.*
- *Suggest that Susie “mirror” the resident’s tone of voice, e.g. when the resident speaks quietly, she speaks quietly.*
- *Susie must understand that good interpersonal skills are as important as clinical skills.*
- *Examine your own response to residents. Are you a good role model?]*

Accepting Gifts/Favors/Tips

Heidi is a 40 year-old personal care worker who travels to the homes of several clients each week. One of her clients is Marion, a 79 year-old single woman. Marion has no children but enjoys the company of her niece, Darla, on holidays.

Marion seems very lonely to Heidi. It's clear that Marion looks forward to the caregiver's visits. For the past few months, Marion has been insisting that Heidi take gifts from her. It started with a few small things, like a candle that Heidi admired. Now, Marion is offering Heidi her dining room table and chairs. Marion jokes that if Heidi doesn't take them, she will think that Heidi doesn't love her anymore. Heidi finally agrees to take the table and chairs, justifying that the furniture will get more use at her house.

[Possible Observations:

- Marion might feel that she needs to give Heidi gifts in order to keep her*
- By accepting the gifts, there may be a perception that a patient can buy better quality of care.*
- Heidi has allowed the relationship to become personal by accepting gifts.*
- Every facility has a gift policy—Heidi doesn't seem to know it!*
- Heidi should have told her supervisor the first time Marion offered a gift.*
- Heidi's supervisor might fire Heidi for taking unauthorized gifts, against the agency's policy.*
- Heidi was not prepared to decline Marion's offer gracefully.*

Possible Coaching Points:

- Review your agency's gift policy with Heidi.*
- Help Heidi come up with language to gracefully decline gifts.*
- Discuss Heidi's motives-she's justifying taking gifts.*
- Talk about the dangers of accepting even small gifts—puts Heidi on a “slippery slope”.*
- Ask Heidi to think about what Marion's family might think of the gifts. Could they accuse Heidi of defrauding Marion?]*

Over-Involvement

Kia is a 25-year old hospice aide. About six months ago, she began to care for a terminally ill patient, Harry, in his home. Harry's wife, Brenda, is such a trooper and both of their children and grandchildren visit frequently. Kia admires Harry and his family—they seem like such a nice, loving group. Last month, Harry insisted on inviting Kia to a family birthday party at Harry and Brenda's home. Kia felt flattered that Harry invited her—she's feeling a little like family. Not only did Kia attend the party, but she stopped by on her day off to help Brenda prepare the meal and do a little vacuuming. Brenda asked Kia to pick up the birthday cake before the party, which Kia was happy to do.

Last week, Harry took a turn for the worse and Kia knows the end is very near. Kia finds herself very depressed at the thought of Harry's death. She will miss Harry and his family very much.

[Possible Observations:

- *Kia allowed the family to see her as more than a caregiver.*
- *Kia was attracted to the family and welcomed their interest in her.*
- *It may cause Brenda and other family members to feel additional feelings of loss and pain when Kia's employment ends.*
- *Brenda also seemed to be taking advantage of Kia (picking up the cake).*
- *Kia might miss important medical signs because the prospect of Harry dying causes her pain.*

Possible Coaching Points:

- *Refer to Employee Assistance Program or other counseling if Kia seems depressed; provide training on the grieving process.*
- *Discuss whether Kia's clients are meeting a personal need in her life.*
- *Review therapeutic relationships with Kia. Has she moved from a helpful relationship to an over-involved relationship?*
- *Pair Kia with a more experienced aide to talk about setting boundaries.*
- *Check back with Kia frequently-this job may not be a good fit.]*

Sexual Attraction/Relationships

Sheila is a 32 year-old CNA who works in a CBRF that serves clients undergoing rehabilitation for addiction to controlled substances. One of the CBRF residents is Ray, a 25 year-old man with an addiction to prescription pain killers. Lately, Sheila finds herself “dressing up” more for work than usual. She is spending more time with Ray than other residents. Ray enjoys jogging, so Sheila has begun to stay after work to jog with him. Sheila says to herself that she’s being supportive of Ray. He seems to appreciate Sheila’s efforts, and Sheila has begun to touch or hug Ray more often. He’s asked her if she would like to go have pizza next week, just the two of them.

Yesterday, one of the other residents asked Sheila if she was “going steady” with Ray. You overheard the comment and now Sheila is worried that you will misunderstand her relationship with Ray.

[Possible Observations:

- *Sheila’s focus on Ray may leave other clients neglected.*
- *Staying after work, extending her hours indicates that she is becoming over-involved.*
- *Sheila could lose her job or be charged with caregiver misconduct.*
- *Residents and patients in certain long-term care settings cannot legally consent to sexual contact.*

Possible Coaching Points:

- *Talk about the legal ramifications and facility policies.*
- *Tell Sheila it is never okay to have a romantic/sexual relationship with a client under any circumstances.*
- *Explore whether Sheila is using Ray to meet a personal need; refer to EAP or counselor.*
- *Discuss therapeutic, helpful relationships; Sheila has become over-involved and is justifying her behavior.*
- *Consider the negative impact on Ray’s therapy if Sheila becomes disinterested or changes jobs.*
- *Talk about Ray becoming distracted from his focus of dealing with his addiction.*
- *Consider reassigning Sheila.]*

Keeping Secrets

Gloria is a 78-year old woman with Alzheimer's-related dementia and hypertension who receives services from a home health agency. During a recent home visit, the agency RN supervisor noted that Gloria's dementia is progressing to a point where she may soon need full-time skilled nursing care. Gloria is very upset at the prospect of leaving her home and refuses to consider a different living arrangement.

Yesterday, one of Gloria's home health aides, David, arrived at Gloria's home and discovered a burned dish towel in the kitchen sink. When David asked Gloria what happened, she says she turned on the stove and that someone must have left the dish towel on the burner. David also notices that Gloria has forgotten to take her medication again. Gloria begs David not to tell anyone about the towel or the meds. David isn't sure what to do. He wants to respect Gloria's rights and maintain patient confidentiality, and he doesn't blame her for wanting to stay at home.

[Possible Observations:

- David's sympathetic view of Gloria's situation could result in harm to Gloria.*
- If David reports Gloria's situation accurately, the agency can suggest some safety measures (a marked pill box, disconnecting the stove—using the microwave instead).*
- It's hard to make decisions that will make the patient unhappy.*
- If Gloria is hurt or has a stroke, e.g., David will feel guilty.*
- David could be charged with caregiver neglect for failing to report.*

Possible Coaching Points:

- Patient confidentiality does not include failing to report changes in a client's condition. David's first responsibility is Gloria's safety.*
- Use this opportunity to reinforce the importance of immediately reporting any changes. Caregivers are the "eyes and ears."*
- Help David think of language to use when Gloria asks him to keep secrets.*
- Consider sending a social worker to speak with Gloria about living arrangements-this is beyond David's job responsibilities.]*

Wrap-Up

[Review the following:

- Learning Point #3: Supporting Caregivers Through Challenging Situations*
- Why observing professional boundaries is important to caregivers (what's in it for them)*
- What to do if the caregiver feels s/he might have crossed a boundary]*

Preventing Medication Diversion



It's estimated that over 6 million people in America use prescription drugs for non-medical purposes. In other words, the medication is “diverted” – used for another purpose or by a different person.

The abuse of prescription drugs, especially controlled substances, is not restricted to any particular socio-economic class, culture or geographic location. It may seem that health care professionals would be the last group to abuse prescription drugs. Unfortunately, that is not the case.

Think about the reasons why caregivers may be even more susceptible to drug diversion than others?

[Give the group a minute or two to jot down their thoughts. Then ask for answers from the whole group.]

Possible responses:

- Access*
- They see residents taking meds with no ill-effects*
- Realize the euphoria, pain relief that may occur*
- They are familiar with meds; don't see them as addictive or harmful*
- Job stress]*

Because of the availability of prescription drugs in long-term care facilities, it's important that managers, supervisors and staff are aware of the dangers and outcomes of diverting medication.

Controlled Substances

The federal Controlled Substances Act created five schedules or lists of controlled substances based on the drug's potential for abuse, accepted medical use, and the potential for dependence. A controlled substance is generally defined as a drug that is regulated by the government.

Schedule I – The drug has a high potential for abuse, has no currently accepted medical use in treatment in the United States, and there is a lack of accepted safety for use of the drug under medical supervision.

Common Name Examples: Cocaine, Marijuana, LSD, Quaalude

[Note: States have the ability to create their own schedules and the federal and state schedules do not always match up. For example, medical marijuana may be legally prescribed in some states; but the federal schedules prohibit its sale for any use.]

Schedule II – The drug has a high potential for abuse, has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions, and abuse of the drug may lead to severe psychological or physical dependence.

Common Name Examples: OxyContin, Percocet, Duragesic, MS Contin

Schedule III – The drug has a potential for abuse less than the drugs in schedules I and II, has currently accepted medical use in treatment in the United States, and abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

Common Name Examples: Vicodin, Lorcet

Schedule IV – The drug has a low potential for abuse relative to the drugs or other substances in schedule III, has a currently accepted medical use in treatment in the United States, and abuse of the drug may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.

Common Name Examples: Xanax, Ativan, Sonata, Ambien, Lunesta

Schedule V – The drug has a low potential for abuse relative to the drugs or other substances in schedule IV, has a currently accepted medical use in treatment in the United States, and abuse of the drug may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.

Common Name Examples: Robitussin A-C, Lomotil, Lyrica

Commonly Abused Prescription Medications

There are three types of prescription drugs that are most commonly abused because of the effects they may produce. Most are classified as Schedule II drugs:

Opioids are most often prescribed to treat pain. They have a high risk for addiction and overdose. Opioids become even more dangerous when abusers override the newer time-release versions by crushing the pills and snorting or injecting the medication to increase the effect. Used or discarded Fentanyl patches are attractive to abusers because a significant level of the drug remains. Theft of liquids is often disguised by refilling the container with another non-medical liquid.

Dangers: Opioid abuse can lead to respiratory distress and even death, especially when combined with other drugs, including alcohol.

Central Nervous System (CNS) Depressants are used to treat anxiety and sleep disorders. In addition to becoming addictive, they pose the added danger of significant withdrawal symptoms if a long-term user stops taking them abruptly.

Dangers: Overdose can cause significant breathing problems or death, especially when combined with other drugs, including alcohol.

Stimulants are prescribed to treat certain sleep disorders and attention deficit hyperactivity disorder (ADHD). Stimulants are not likely to be prescribed for the average resident in long-term care.

Dangers: Abusing stimulants can lead to dangerously high body temperature, seizure and cardiovascular distress.

Take a look at the chart. Draw a circle around any of the prescription drugs that have ever been prescribed for your residents:

Some Commonly Abused Prescription Medications

Opioids	CNS Depressants	Stimulants
<ul style="list-style-type: none"> • Oxycodone (OxyContin, Percodan, Percocet) • Propoxyphene (Darvon) • Hydrocodone (Vicodin, Lortab, Lorcet) • Hydromorphone (Dilaudid) • Meperidine (Demerol) • Diphenoxylate (Lomotil) • Morphine (Kadian, Avinza, MS Contin) • Codeine • Fentanyl (Duragesic) • Methadone 	<p><u>Barbiturates:</u></p> <ul style="list-style-type: none"> • Mephobarbital (Mebaral) • Pentobarbital sodium (Nembutal) <p><u>Benzodiazepines:</u></p> <ul style="list-style-type: none"> • Diazepam (Valium) • Chlordiazepoxide hydrochloride (Librium) • Alprazolam (Xanax) • Triazolam (Halcion) • Estazolam (ProSom) • Clonazepam (Klonopin) • Lorazepam (Ativan) 	<ul style="list-style-type: none"> • Dextroamphetamine (Dexedrine and Adderall) • Methylphenidate (Ritalin and Concerta)

[Ask participants how many of the drugs they circled? More than 5? More than 10?]

This exercise emphasizes the need for vigilance in maintaining strict procedures for handling controlled substances in your facility.

The Wisconsin Division of Quality Assurance estimates that three of the most commonly diverted medications in long-term care settings are:

- Oxycodone
- Morphine

- Fentanyl

It's likely that medications prescribed for residents in long-term care are most often taken by caregivers for personal use. However, prescription drugs definitely have value on the street. For example, Oxycodone may be sold illegally for \$1 to \$5 per milligram. A 40 mg. tablet could be worth up to \$200 in some areas.

Preventing Medication Diversion

The old saying about an ounce of prevention being worth a pound of cure certainly holds true in this situation. Let's take a look at some of the ways both facility procedures and staff responses can help prevent diversion.

Observing the Rules and Regulations

Chapters DHS 132 and DHS 83 Wisconsin Administrative Code outline requirements for the storage and handling of controlled substances for some long-term care facilities:

Nursing Homes

<http://www.legis.state.wi.us/rsb/code/dhs/dhs132.pdf>

Assisted Living

http://dhs.wisconsin.gov/rl_dsl/MedManagement/contrldSubsts.pdf

Knowing Your Responsibilities

As an employee of a long-term care facility, it is your ethical responsibility to ensure the safety and well-being of residents. That includes caregivers reporting suspicions of drug diversion to a supervisor and managers aggressively investigating allegations.

You have a professional responsibility to store, administer and dispose of controlled substances appropriately, guarding against abuse while ensuring that patients have medication available when they need it.

No one likes to face the prospect of an employee stealing a resident's much-needed medication. But keep in mind that drug dependence and addiction are powerful motivators for staff to circumvent your rules and regulations.

It may be difficult to approach this sensitive topic with employees. However, it's critical that facilities maintain an awareness of the potential for drug diversion and create a culture that not only encourages reporting but insists on it!

Increasing Awareness: Recognizing Red Flags



The following “red flags” may indicate that a person is drug-impaired and/or may be diverting a resident's medications for personal use. It's important to note that these signs are not absolute proof, just indicators. However, observing several signs in one person demonstrates a need for further action.

- Excessive absenteeism, especially last minute call-ins or no shows
- Frequent disappearances from the work site, e.g. unexplained or questionable absences; long trips to the bathroom or secured area where drugs are kept
- Insistence on caring for specific residents who are prescribed controlled substances, especially residents with cognitive impairments
- A history of theft, shoplifting, multiple small claims for unpaid bills, disorderly conduct or driving infractions
- Poor interpersonal relations with co-workers, supervisors, and residents' family members. (Interestingly, residents who have been victims of medication diversion often report liking the perpetrator.)
- Sloppy record keeping, frequently “forgetting” to chart or count meds
- Failure to complete tasks on time
- Volunteering to work nights or in settings with few other staff
- A consistent decline in personal hygiene and appearance
- Personality changes or mood swings, depression, lack of impulse control, etc.
- Visits by friends or relatives of the caregiver, especially when few staff are on duty

What Employers Can Do

If you recognize any of these signs, confronting an employee suspected of using drugs or diverting controlled substances is critical. Sometimes, the threat of job loss can be a motivator for an abuser to seek help. As part of any job action, encourage your employee to seek drug treatment assistance.

There are a wide variety of programs available that vary from self-help to in-patient recovery programs. The federal Substance Abuse and Mental Health Services Administration maintains an online resource for finding local treatment options: <http://dasis3.samhsa.gov/>

What Employees Can Do

If you suspect that a co-worker is using drugs or diverting controlled substances, don't help the user avoid facing the consequences. Report your suspicions to your supervisor right away. Well-meaning caregivers who cover up or protect a user are enabling that person's behavior.

It may be hard to report to a supervisor, but not reporting endangers you, your job and those in your care.

Developing Best Practices

[Asking your audience for input will likely produce unique ideas. You may still direct the discussion by offering any strategies you have identified prior to the training or use suggested responses listed below.]

Think about some best practices that facility managers and supervisors can utilize to discourage/prevent diversion of medications by employees. Here are a few ideas to get you started:

- Include appropriate medication administration and handling procedures into job duties of caregivers. E.g. Follow formal charting procedures; have 2 people count meds at the end of every shift, etc.

- Make unexpected rounds yourself; stay in touch with staff and residents daily
- Aggressively safeguard medications slated for disposal; count them regularly; staff with access to locked storage units must maintain keys on his/her person

Now jot down some ideas of your own:

[Give participants several minutes to jot down their thoughts. Ask the group for responses individually. Record responses on a flip chart. If you have a larger audience, consider breaking the group into smaller teams. Ask them to appoint a recorder and reporter. Ask each group to report out on their suggestions. Document responses on a flip chart. At the end of the exercise, give participants an opportunity to copy new ideas into their own training materials. There are multiple responses possible. If the group does not include the following, suggest them yourself:

- *Institute a drug testing policy; although you may not be able to require the test, many times a perpetrator will agree to it*
- *Contact law enforcement when drug diversion is suspected*
- *Incorporate medication diversion awareness training into new employee orientation and/or consider using this training as continuing education for staff*
- *State zero tolerance for medication diversion to all staff*
- *Make it clear that caregivers must report suspected medication diversion immediately; ensure that each caregiver knows to whom they should report*
- *Receive reports from caregivers in a positive way; let the reporter know you will investigate further*
- *Immediately intervene when you suspect drug or alcohol impairment or medication diversion*

- *Develop resources for intervention and treatment]*

Applying Best Practices – Activity

The following examples are based on cases reported to the Wisconsin Division of Quality Assurance. Keep in mind the best practices that we just discussed when completing this activity.

[A small group may discuss each example together. Break larger groups into smaller teams and give an example to each team. Ask teams to choose a recorder and reporter for reporting back to the larger group. Keep your flip chart from the best practices discussion available. Students may wish to add to the list after completing this activity.]

Example #1:

Laurie, a caregiver at a nursing home, was in resident Marie's room changing linens. While Marie was in the bathroom with the door closed, medication aide Michael entered Marie's room with a cupful of meds. Michael shouted through the door for Marie to be sure to take her meds and left the room.

After Laurie finished changing the linen, she began to think it suspicious that Michael was delivering the meds in the first place. There was a student medication aide that was supposed to be delivering meds that week. Laurie also knew that a different medication aide usually delivered Marie's meds. Laurie called the LPN on duty who confirmed that an 80 mg dose of oxycodone was missing from the med cup. Michael later stated he had taken the oxycodone to Marie in the bathroom. Both CNA Laurie and resident Marie insisted that had not happened.

The facility administrator asked Michael to provide a urine sample, which tested positive for oxycodone and morphine.

The facility reported the incident to the state as well as local law enforcement.

What best practices did the facility and staff demonstrate in this example?

[Suggested responses include:

- Staff were aware of “red flags” that something didn't seem right*
- Staff felt comfortable taking her concerns to a supervisor*
- Supervisor included interview with the resident who was very alert*
- Facility asked for urine sample*
- Facility reported incident to both law enforcement and the state]*

Example #2:

Residential Care Apartment Complex (RCAC) director Judy had been receiving reports for about 6 weeks that medication counts were off or residents complained about not receiving PRN meds. The busy director wrote it off as sloppy record-keeping or forgetful residents.

After one resident's family complained loudly about their mother's claim of not receiving her pain medication, the director began to question staff. Resident Assistant (RA) Juanita admitted that she suspected her co-worker, medication aide Ashley, might be taking medications. Juanita had observed that Ashley insisted on delivering meds to certain residents and it seemed to Juanita that Ashley sometimes disappeared for long periods of time. Juanita said she didn't know what to do and never mentioned her suspicions to anyone. Shortly after the director began interviewing staff, Ashley quit her job. She is now working in a CBRF in a nearby city.

The director breathed a sigh of relief that Ashley was no longer her employee and considered the problem solved.

What best practices did the facility fail to observe in this example?

[Suggested responses include:

- Supervisor disregarded red flags, complaints of missing meds*
- The caregiver Juanita did not report her suspicions to management*
- Juanita said she didn't "know what to do." Did the facility have clear policies about observing red flags and reporting?*
- Did facility staff receive training on recognizing signs of drug impairment and/or drug diversion?*
- Supervisor failed to report an incident that may meet the definition of misappropriation to the state*
- Supervisor did not report as a crime to law enforcement]*

Should a facility report an incident to the state or law enforcement when a suspected caregiver quits or is fired? Why or why not?

[Suggested responses include:

- Substantiated finding of caregiver misconduct follow caregivers to other facilities statewide and minimize repeat behavior at a new location*
- Even complaints that cannot be substantiated are maintained by DQA and sometimes indicate a pattern of behavior by a caregiver if repeat allegations are made by different employers*
- Medication diversion that does not meet the administrative definition of caregiver misconduct may be a violation of the law.]*

Example #3:

Louise is a resident assistant (RA) who starts her shift at 6:30 a.m. at a small CBRF. Her first task of the day is to count medications with RA Chai, who works nights. It seems Chai is always in a hurry to leave. He sometimes tries to convince Louise not to “waste time” counting the meds. Louise usually gives in and just signs off on the medication count.

Today, Supervisor Barbara asks to see Louise in her office. Barbara says that medication counts between the a.m. and p.m. shifts are indicating missing medications, most often Vicodin and Percocet.

On one hand, Louise is pretty sure that Chai is the one stealing medications. But if she discloses her suspicions to her supervisor, Louise will have to admit that she didn't really count the meds in the first place.

Why do you think Louise agreed to Chai's request?

[Suggested responses:

- Louise wanted to cooperate with her co-worker*
- She didn't realize that it could reflect on her*
- She didn't know how to say no]*

How could the CBRF have prevented this incident?

[Suggested responses:

- Conduct spot checks of med counts on all shifts*
- Ensure that staff feel confident about refusing a request from a co-worker*
- Give caregivers the power to avoid awkward situations by suggesting language they might use in such a situation. For example, Louise could then respond to Chai's request by stating: “Hey—that's a serious work rule violation. I don't want to lose my job!”]*

Reporting Drug Diversion by Caregivers

Significant and long-lasting penalties await caregivers in Wisconsin who divert medications from those in their care. Both administrative and criminal penalties may apply. For that reason, the Division of Quality Assurance strongly urges facilities to contact law enforcement in addition to reporting to the state.

Wisconsin's Caregiver Law



Wisconsin's Caregiver Law defines caregiver misconduct as abuse or neglect of a resident or misappropriation of a resident's property. Drug diversion meets the definition of misappropriation when the following criteria are met:

MISAPPROPRIATION OF PROPERTY

The intentional taking, carrying away, using, transferring, concealing or retaining possession of a client's movable property without the client's consent and with the intent to deprive the client of possession of the property.

Therefore, facilities regulated by the Division of Quality Assurance are required to report suspected cases of drug diversion to the state when the facts may meet the definition outlined above. As always, if in doubt, report it out!

If Wisconsin's regulatory agencies (the Wisconsin Department of Health Services or the Department of Regulation and Licensing) substantiate a finding of misappropriation against a caregiver, that caregiver may be temporarily or permanently barred from working in a health care facility. In effect, the caregiver loses not only his/her current job, but any opportunity for future jobs in the field of health care.

Criminal Charges and Penalties

In some cases, medication diversion may constitute caregiver misconduct, a criminal violation or both.

When caregivers divert prescription drugs belonging to a resident or a facility, local law enforcement may initiate investigations and file charges. The Wisconsin Department of Justice Medicaid Fraud Unit also prosecutes cases. There are a wide range of criminal charges that may be pursued depending on the facts of the case.

Contacting law enforcement in cases of suspected drug diversion is **strongly** encouraged by the Wisconsin Division of Quality Assurance. Criminal charges and convictions in Wisconsin are permanently maintained by the Department of Justice Crime Information Bureau as law enforcement records. And caregiver background checks always include a query of these records. Therefore, if a finding cannot be substantiated, there will still be a record of any criminal cases involving wrongdoing by a caregiver.

Consider the following incident:

During a routine traffic stop, a police officer discovers that the driver, Ashley, is in possession of a large bag of unidentified pills. Ashley admits to the officer that she took the pills from the healthcare facility where she works.

An interview of staff at the facility revealed that Ashley was sometimes responsible for destroying medications no longer used by residents. A co-worker admitted that Ashley had convinced him to sign the medication destruction form without actually witnessing the disposal of the meds.

The incident may not clearly meet the definition of caregiver misappropriation since the meds were no longer in the possession of the client. However, there is a clear violation of the law. In this case the caregiver was charged with multiple counts of Theft-Movable Property <\$2500 (Class A Misdemeanor) and Possession of Illegally Obtained Prescription (Class U Misdemeanor).

Wrap-Up

Detecting and preventing medication diversion is another step in providing safe and effective care to residents in long-term care. As we also see, observing the behavioral signs of drug impairment and/or diversion also protects employers and staff.

Let's review the learning points from today's training:

- Understanding Medication Diversion in Long-Term Care
- Protecting Controlled Substances
- Learning Best Practices for Preventing Diversion
- Reporting Drug Diversion by Caregivers

Resources

Goleman, D. “Working with Emotional Intelligence”

Mink, O.G.; Owen, K.Q.; and Mink, B. P. “Developing High Performance People: The Art of Coaching”

Moran, L. “Getting Real: The Need for Genuine Leaders”

Neilson, S., Thaelke, S. “Conflict Resolution through Winning Colors®”

Witherspoon, R. “Coaching for Leadership: How the World's Greatest Coaches Help Leaders Learn”

UCLA WRC-Effective Communication
www.thecenter.ucla.edu/assertmid.html

UW-Eau Claire Counseling Services
www.uwec.edu/Counsel/pubs/assertivecommunication.htm

National Council of State Boards of Nursing, “Professional Boundaries”
www.ncsbn.org

Alberta Association of Registered Nurses, “Professional Boundaries for Registered Nurses: Guidelines for the Nurse-Client Relationship”
www.nurses.ab.ca

Council of State Governments
Drug Abuse in America—Prescription Drug Diversion
<http://www.csg.org/pubs/Documents/TA0404DrugDiversion.pdf>

National Institute on Drug Abuse
Research Report Series
<http://www.drugabuse.gov/index.html>

US Department of Justice
Drug Enforcement Administration
Drug Diversion Control Program
<http://www.dea.gov/diversion/>

http://www.deadiversion.usdoj.gov/pubs/brochures/drug_hc.htm

US Dept. of Health and Human Services
Substance Abuse and Mental Health Services Administration
National Center for Alcohol and Drug Information

<http://ncadi.samhsa.gov/>

<http://ncadi.samhsa.gov/govpubs/workit/efs3.aspx>

Wisconsin Department of Health Services
Division of Quality Assurance

http://dhs.wisconsin.gov/rl_dsl/BQAinternet.htm

<http://dhs.wisconsin.gov/caregiver>

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All project materials may be downloaded and re-printed from the internet at www.dhfs.state.wi.us/caregiver/training/trgIndex.HTM.

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