

risk reporter

for senior living

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Case of depression or post-holiday blues

Family members have gone home, and the decorations are down. Your facility is returning to its everyday routine after the hubbub of the holidays, and you might be noticing that residents seem a bit let down.

"For many, the holidays are a respite from the struggles they deal with on a day-to-day basis, such as ill health, loneliness and financial problems," said Lisa Furst, director of education at the Center for Policy, Advocacy and Education at the Mental Health Association of New York City. "But when the holidays are over, residents find that the problems they put on hold are still there, and it can be a hard time for them."

Distractions, such as additional activities and programs, can be helpful, but it's also important to dig deeper.

"Try to help your residents understand what's making them unhappy and find ways to address it," Furst said.

If a resident is missing faraway loved ones, find ways for them to connect more frequently: encourage the resident to call or write or to use a journal to capture his/her feelings. If there are financial concerns that have been exacerbated by the flurry of holiday gift giving, help residents think of ways they can share with loved ones that don't involve money.

But if "the blues" continue for more than a few weeks, it could be a sign that your resident is suffering from something much more serious.

Depression: a dangerous problem

According to the Geriatric Mental Health Foundation, chronic or serious illness is the most common cause of depression in the elderly, and it can also be triggered by biological changes in the brain. Other triggers can include lack of control and reminders of loss—whether of loved ones or abilities.

Experts say depression is linked to 87 percent of suicide cases in the elderly, and the suicide rate is highest among white males 75 years and older.

Warning signs

Your resident might not verbalize how he/she is feeling, so it's important to look for other clues.

"They grew up in an era where people didn't understand mental health issues and the value of treatment. Many aren't comfortable talking about their feelings," said Laine Young-Walker, M.D., associate

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medical director for the Missouri Department of Mental Health.

"You'll often hear that someone is 'not themselves,'" Furst said. "Your biggest clues are that a resident seems different and that this has lasted for a period of time and is affecting their daily lives."

Common signs of depression include: changes in personality, sleeping patterns, appetite or weight; a lack of enjoyment in things that previously interested them; unusual weepiness or irritability; and expressions of worthlessness, helplessness and anxiety.

Recommended policies

Train staff

All staff should be trained to recognize signs and behaviors that might indicate depression; those who are involved in actual mental health screening will need additional training. Good places to look for all levels of training include local agencies on aging, conferences on geriatric depression and the various associations that deal with mental health, especially those with a focus on the elderly.

"It's important for staff to realize that a lot of problems have a mental health component," said psychologist Deborah Heiser, Ph.D., president of the State Society on Aging of New York and a researcher for ThinkScan, a New York City company that does research in psychology and neuroscience. "The person who's always pressing the call button, always calling 911, might be suffering from anxiety. The irritable man who's agitated and hard to work with might suffer from psychosis. The resident with lots of aches and pains might be depressed. Improved training and awareness allow your staff to be much more effective."

Mental health screening

Mental health should be screened upon admission and checked on an ongoing basis.

"Whenever you do a physical assessment, do a mental health assessment too," Furst recommended. "If you see changes that concern you, act in the moment—don't wait for the next scheduled assessment. Once you make this part of the routine, it just becomes second nature for staff to monitor this."

A recent article in *Geriatric Nursing* warns that the assisted living environment can actually be detrimental to the mental well-being of residents, "The privacy so valued in ALs by all the stakeholders is the very thing that 'protects' the resident from being observed, thus preventing or delaying the diagnosis from being made and increasing isolation."

Connect with residents

Take time to check in. "When you ask a resident 'how are you doing today?' really mean it," Furst said. "Use everyday

words to acknowledge that you're noticing behaviors that concern you and try to draw the resident out. Many times, people feel depressed when they feel they don't have any control over their lives.

"At one facility, we ran what we called a 'support group,'" Heiser said. "We had coffee and doughnuts and talked about how people were feeling and ways that they could get help."

Two-week policy

With mental health elements built into your daily checks, it's easy to track when a resident first began to exhibit signs that could indicate depression. At the two-week mark, it's time to get additional help.

Reach out to the experts

"There are some medications that can mimic the signs of depression—such as steroids and some of the medications used to treat thyroid problems," Young-Walker said. "A complete physical will help determine if there's an underlying cause for the signs you're seeing."

It's important to keep the resident's regular doctor in the loop, but a mental health professional should also be involved. Options include licensed professional counselors (LPC), licensed clinical social workers (LCSW) and psychologists or psychiatrists (the only mental health resource that can prescribe medication).

"In an ideal world, someone on your staff would have mental health training, but that's not always possible," Furst said. "If that's the case, try to form partnerships with professionals in your community, so you have a ready source when a resident needs help."

■ Depression assessment tools

These tools *must be administered by skilled clinicians* who have been trained in their usage; pain, fatigue or confusion can distort the scores.

Geriatric Depression Scale (GDS)

A 30-item screening tool. Learn more at: http://en.wikipedia.org/wiki/Geriatric_Depression_Scale

Beck Depression Inventory (BDI)

Learn more about this tool at: <http://www.fpnotebook.com/Psych/Exam/BckDprsnInvntry.htm>

■ Mental health resources

Your local agency on aging or county mental health association can be good resources for training and information.

Other resources include:

- National Institute of Mental Health (NIMH) www.nimh.nih.gov
- Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov
- American Association for Geriatric Psychiatry www.aagppa.org
- National Institute on Aging www.nia.nih.gov



Managing Your Risks

Avoiding illness

I have four words for you to remember when considering vaccinations to combat illnesses from infecting your senior living facility—*influenza, pneumonia, diphtheria and tetanus.*

The Centers for Disease Control and Prevention (CDC) reports 36,000 people, many of them elderly, die from influenza-related complications every year. Another 5,000 lives are claimed from pneumonia.

A vigilant strategy is needed to keep illness from infecting your residents and employees. Although the effectiveness of an annual flu shot is dependent on how well the shot is matched to prevalent virus strains and the overall health of the recipient, it is recommended.

CDC estimates the shots effectiveness in preventing hospitalization for pneumonia and influenza ranges from 30 percent to 70 percent for adults over 65 years of age and that it's 80 percent effective in preventing influenza-related deaths for that age group.

Studies show when residents and employees receive flu immunization, the risk of illness in that facility can drop up to 60 percent.

Another area for concern is diphtheria and tetanus. Both can be addressed with one vaccine. Adults who have never received the initial three-shot series should get the vaccine plus boosters every 10 years. Diphtheria is especially troubling as it's a respiratory disease that can lead to pneumonia. Elderly are most susceptible to this.

The best way to create a program for immunization at your facility is to make it easy for employees and residents. Arrange for the vaccinations to take place at your facility. There is a wealth of information you can pass along to employees and residents that points out the risks of not being vaccinated. Go to www.cdc.gov/vaccines for more information.

Richard J. Schaber, CPCU
Risk Control Manager



seasonal spotlight fall

Don't risk safety when decorating for holidays

Nothing says "the holidays" like festive touches around your facility, but it's important to consider the potential risks of some common decorating practices. The following tips can help ensure the safety of residents, staff and visitors during the holiday season.

Christmas trees

Real or artificial? Although artificial trees tend to be less of a fire hazard, they can still burn. The National Fire Protection Association reports that Christmas tree fires—both real and artificial—cause more than 200 fires each year that result in more than two dozen deaths and \$13 million in direct property damage.

If you opt for real, cut your own tree, if practical, to ensure that it's as fresh as possible. Otherwise, look for a tree that isn't shedding its needles. Give the tree a good shake in the tree lot: if you end up with a pile of needles on the ground, choose another tree. Needles should be hard to pull out of the tree, and the National Safety Council reports that pine and spruce needles should bend, not break, and fir needles should snap like a carrot. Tree limbs should be flexible, and the presence of sap by the trunk cut is also a good sign. Cut off about two inches of the trunk to ensure that the tree can absorb water. Keep your tree stand filled with water.

To see how quickly a dry tree can go up in flames, go to:
http://www.usfa.dhs.gov/downloads/media/tree_fire.mpeg

If you prefer an artificial tree, choose one marked "fire retardant." These trees can still catch fire, but they'll resist burning and be easier to extinguish. Look for a sturdy center pole and even weight distribution to avoid tipping your tree.

Lights

Look for the UL label to ensure the lights have been tested for safety. Before putting up your lights, replace those with frayed wires, burned out lights and damaged sockets. Never leave lights on overnight and don't use more than three strands of lights per extension cord. Make sure that lights are fastened securely but never use staples or nails to hang them. Outdoor lights should be labeled for outdoor use—as should any extension cords used to power them.

Candles

While the holidays might seem like an ideal time for the warm, cozy glow of a candle, be aware of the potential for fire damage. The U.S. Fire Administration reports that candles cause roughly \$200 million in direct property damage and 200 civilian deaths each year. Use unlit candles for decoration or opt for flameless candles that use an LED light to provide the look of a flickering candle without the fire danger.

Location

Think before you decorate! Don't block high-traffic areas or exits, limit extension cord use and go low instead of high to limit the need for ladders. Also make sure that decorations don't block sprinkler heads, smoke detectors or handrails.

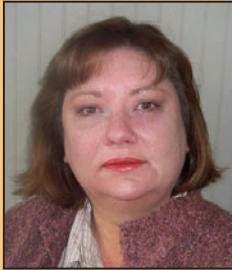
Q | a

A Perspective

Safety committees can be an important tool for improving organizational safety.

They typically involve staff from a variety of departments who are responsible for monitoring and improving both site safety and worker/resident safety and are an excellent way to show administration's support of a safety culture. Although many states mandate safety committees for

companies with more than 25 employees, facilities of any size can benefit from one. Candice Sanders, administrator at the 16-resident Autumn Park Assisted Living in Mount Pleasant, Utah, is proof that size isn't a factor when it comes to effective use of safety committees.



Risk Reporter: How often does your safety committee meet?

C. Sanders: We meet quarterly, and our committee has four members: the administrator of our sister facility, two supervising aides and me.

Risk Reporter: What is your committee responsible for?

C. Sanders: We conduct site surveys, which include a walk-through both inside and outside the facility. The aides have a standard checklist of items driven by state regulations that they review each quarter. If there's a problem, the aides address it and then look deeper to see what caused it and how we can avoid a repeat in the future. We also review incident reports and investigate and address the underlying causes.

After Hurricane Katrina, we decided to use our meetings to evaluate our planning for catastrophic events and review one per meeting. We look at what steps we would take if the event occurred, the roles for each staff member and if there are gaps that we need to address. We have a disaster booklet that we update each meeting that lists each resident and his/her next of kin. Our plan includes both what we'd do for an in-house disaster that required us to leave the facility and for a communitywide disaster when we would remain at the facility.

Risk Reporter: What's an example of something that changed because of a safety committee recommendation?

C. Sanders: Our incident reports showed that resident falls were our top problem and that 30 percent of the falls were happening in the bathroom. To avoid falls, it's now our policy that a staff member has to be in the room while the resident is showering. In the first quarter after we made this change, we had an 84 percent drop in the number of falls.

Risk Reporter: How do you share information from these meetings?

C. Sanders: Our quarterly meetings are always scheduled to occur the week before our monthly all-staff meeting, and we bring our findings and recommendations to that meeting.

Risk Reporter: What are some ways you can make safety everyone's business—not just the people who are on the safety committee?

C. Sanders: We work very hard to integrate safety into everything we do. We want all of our employees to understand that our policies and procedures are designed to keep the residents and staff as safe as possible—we're not just doing these things to satisfy regulations. From the first day of employee orientation, safety is a consistent message. Our monthly employee meetings begin with a fire drill, and safety is a topic of discussion at each meeting. Staff know that it's their responsibility to bring attention to any safety concerns. If it's something urgent, they come directly to me or the maintenance staff; if it's important but not urgent, we have a maintenance log that's checked daily. We also keep a clipboard by the medication book for staff to note issues that they want the safety committee to discuss.