2026 Annual PADONA Conference

Behavior as Communication: Reframing How We Understand Resident Needs

PADONA
PENNSYLVANIA ASSOCIATION OF DIRECTORS OF NURSING ADMINISTRATION

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Learning Objectives

1. Recognize common misconceptions and assumptions that contribute to the overuse of medication when addressing resident behaviors.
2. Explore evidence-based assessment strategies to identify the underlying causes of behavioral expressions in residents.
3. Implement person-centered approaches that emphasize empathy, curiosity, and individualized care over reflexive interventions.

Case

93-year-old female is admitted to your facility after a hospitalization for PNA and UTI.

Med hx: HTN, HLD, dementia

Meds: ASA, amlodipine, metoprolol, donepezil

Nursing calls the medical director in the morning after the resident is admitted because she is not being cooperative with care or therapy. She will not let the medical director examine her and kicks the medical director in the chest during the attempt to examine her.

Tramadol 50g BID
ASA 81mg QD
Olanzapine 2.5g BID
Insulin
Metformin 1000mg BID
B12 Inj
Meloxicam 15g QD
linaclotide 145mcg QD
Duloxetine 60g QD
Clonazepam 0.5g QD
Trazodone 50g BID
Rosuvastatin 20g QD
Pantoprazole 20g QD
Depakote 250g BID

The Snickers Story

Peanuts Nutritional Facts

- A serving size of peanuts is 1 ounce (35 peanuts) which contains:
  - 161 Calories
  - 7.3 grams of protein
  - 2.4 grams of fiber
  - 14 grams total fat
  - **5 mg sodium**
- There are approximately 16 peanuts in 1 Snickers Bar (about **2.5 mg of sodium)**
- The American Heart Association recommends no more than **2300 mg** of sodium per day and an “ideal limit” of less than **1500 mg** per day for most adults

Let’s Talk About Cognitive Biases

What is a Cognitive Bias?

- A systematic pattern of deviation from norm or rationality in judgment[1]
- Bias is the evaluation of something or someone that can be positive or negative and implicit or unconscious bias is when the person is unaware of their evaluation.
- Negative implicit bias is concerning in Healthcare (implicit implies that it is unconscious)

1.Haselton MG, Nettle D, Andrews PW (2005). "The evolution of cognitive bias.". In Buss DM (ed.). *The Handbook of Evolutionary Psychology*. Hoboken, NJ, US: John Wiley & Sons Inc. pp. 724–746.

Examples of Cognitive Biases

Anchoring bias: Giving weight and reliance on initial information/impressions, and not adjusting from this (anchor) despite availability of new information. "Jumping to conclusions" can lead to missed/delayed diagnoses.

Ascertainment bias: Shaping decision-making based on prior expectations (e.g., stereotyping, gender bias). "Frequent flyers" with recurrent complaints can affect decision-making or, in the case of falls, a patient who "always uses the call bell" may predispose staff to expect that behavior.

Availability bias: Judging likelihood of a diagnosis based on the ease with which examples can be retrieved (more familiar, common, recent, memorable) (e.g., diagnosing a patient based on frequently seen conditions such as the flu, or not considering less common diagnoses)

Examples of Cognitive Biases

Diagnostic momentum (bandwagon effect): Once a label (diagnosis) has been assigned, momentum takes hold and reduces ability to consider other alternatives. Can affect future work-up of patient and how handoffs are "framed

Framing effect: How information is presented, and how a question is framed can impact future decisions (e.g., framing in probabilities as to whether patient might "die" or "live"). Source of information (e.g., superior, trusted source); and context can influence framing.

Search satisficing/premature closure: Cease looking for findings/signals (e.g., disease processes, fracture, retained object) once something has been identified. Accepting a diagnosis before considering all information and verifying diagnosis

How We Make Medical Decisions

Type 1 processes

- Fast, “intuitive”
- Require little cognitive reasoning
- Short cuts
- Vulnerable to error

Type 2 processes

- Slower, “conscious”
- Analytic, require more cognitive resources

Abdulmohdi N, Mcvicar A. Investigating the clinical decision-making of nursing students using high-fidelity simulation, observation and think aloud: A mixed methods research study. J Adv Nurs. 2023 Feb;79(2):811-824.

Bias in Healthcare

- Using the Harvard Implicit Association Test (IAT), US medical students (n=4,732) and doctors (n=2,284) were demonstrated to have weight bias (prejudice against those who are overweight or obese)[2]
- A systematic review assessing associations between cognitive biases and medical decisions found cognitive biases were associated with diagnostic inaccuracies in 36.5%–77% of case scenarios[3]
- Better appreciation of biases in clinical reasoning could help clinicians reduce clinical errors and improve patient safety

2. Phelan SM, Dovidio JF, Puhl RM et al. Implicit and explicit weight bias in a national sample of 4,732 medical students: the medical student CHANGES study. Obesity (Silver Spring) 2014;22:1201–8. 28
Sabin JA, Marini M, Nosek BA. Implicit and explicit anti-fat bias among a large sample of medical doctors by BMI, race/ethnicity and gender. PLoS One 2012;7:e48448. 29
Rubin R. Addressing medicine's bias against patients who are overweight. JAMA 2019;321:925–7.
3. Saposnik G, Redelmeier D, Ruff CC, Tobler PN. Cognitive biases associated with medical decisions: a systematic review. BMC Med Inform Decis Mak 2016;16:138

A DECISION CHECKLIST

- Consider whether data are truly relevant, rather than just obvious.
- Did I consider causes besides the obvious ones?
- How did I reach my diagnosis?
- Did a patient or colleague suggest the diagnosis?
- Did I ask questions which would disprove, rather than confirm, my current hypothesis?
- Have I been distracted while caring for this resident?
- Is this a resident that I do not like for any reason?
- Am I stereotyping the resident or the presentation?

Remember that you are wrong more often than you think!

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Who Decides Which Behaviors are Problematic?

- A resident continually tries to exit the facility saying, “I need to go home”
- A resident refuses to sleep in bed and appears to be comfortable sleeping on the floor
- A resident takes food from the dining room at meals and stores the food in cups in their room
- A resident makes racist remarks to staff and other residents
- A resident repeats expletives to staff members during care
- A resident violently attacks their roommate
- A resident tells a nurse that they are stupid and don’t know what they are doing
- A resident wears a bikini while walking through the facility

Case

👩 Patient: 64-year-old female

🏥 Initial Admission: Lithotripsy

⚡ Complication: Acute CVA → dysphagia & aphasia

🍲 Diet: Pureed + thickened liquids

🏥 Hospital Stay:

- Develops agitation → haloperidol started

Case

Discharge to SNF:
- Agitation worsens, multiple falls
- Haloperidol ↑ to 5 mg TID

After 4 Weeks:
- Labs ordered → CRITICAL:
  - Na 164, K 5.9, BUN 102, Cr 4.8

Emergency:
- Sent to ED → Diagnosed with:
  - Acute Kidney Injury
  - Hypernatremia
  - Hyperkalemia

Antipsychotics Started in the Hospital

- Cohort study of 5835 patients aged 65 and older who were admitted for infection-related diagnosis January 1, 2004, to May 31, 2022.
- Patients had no prior psychiatric diagnosis.
- All patients had either haloperidol or an atypical antipsychotic (aripiprazole, olanzapine, quetiapine, risperidone, etc) initiated during their hospital stay to treat delirium.
- Researchers followed these patients to determine discontinuation rates over time.

Zhang Y, Wilkins JM, Bessette LG, York C, Wong V, Lin KJ. Antipsychotic Medication Use Among Older Adults Following Infection-Related Hospitalization. *JAMA Netw Open.* 2023;6(2):e230063. doi:10.1001/jamanetworkopen.2023.0063

Results

- 790 patients were prescribed haloperidol, 5045 patients were prescribed at atypical antipsychotic.
- 52.1% of patients prescribed haloperidol had the medication discontinued at 30 days.
- 11.4% of patients prescribed atypical antipsychotics had the medication discontinued at 30 days.
- Why was haloperidol discontinued at such a higher rate at 30 days compared to atypical antipsychotics?

Adverse Side Effects That May Be Related to Resident's Medication Regimen

- Anorexia/unplanned weight changes
- Behavioral changes (agitation, aggression)
- Sedation, changes in alertness
- Insomnia or sleep disturbance
- Rash, pruritis
- Bleeding or bruising
- Falls
- ADL decline

Adverse Side Effects That May Be Related to Resident's Medication Regimen

- Respiratory changes
- Fall, dizziness, headaches
- Muscle pain/nonspecific pain/unexplained movements
- Dehydration or swallowing difficulty
- Bowel dysfunction, urinary retention, incontinence

Choosing Wisely® AMDA Recommendation 4

Don’t prescribe antipsychotic medications for behavioral and psychological symptoms of dementia (BPSD) in individuals with dementia without an assessment for an underlying cause of the behavior.

- Careful differentiation of cause of the symptoms (physical or neurological versus psychiatric, psychological) may help better define appropriate treatment options.
- The therapeutic goal of the use of antipsychotic medications is to treat patients who present an imminent threat of harm to self or others, or are in extreme distress – not to treat nonspecific agitation or other forms of lesser distress.
- Treatment of BPSD in association with the likelihood of imminent harm to self or others includes assessing for and identifying and treating underlying causes (including pain; constipation; and environmental factors such as noise, being too cold or warm, etc.), ensuring safety, reducing distress and supporting the patient’s functioning.

https://res.cloudinary.com/paltc/image/upload/v1666280559/docs/AMDA_Choosing_Wisely_Statements_10_xtww3e.pdf

Why Might a Person with Dementia Become Aggressive?

Cognitive, Communication, Physical, and Environmental Factors

Cognitive Challenges

Deterioration of brain function causes confusion, fear, and defensive behaviors in dementia patients.

Communication Difficulties

Inability to express needs or understand others leads to frustration and potential aggression.

Physical Discomfort

Undiagnosed pain and sensory impairments increase irritability and agitation in dementia patients.

Environmental Stressors

Loud noises, crowded or chaotic spaces, and sudden changes can trigger aggression and agitation.

Psychological, Autonomy, and Medication-Related Factors

Psychological Challenges	Loss of Autonomy	Medication Side Effects
Depression, anxiety, paranoia, and hallucinations distort reality, causing fear and aggressive behavior in dementia.	Increasing dependence on others leads to frustration, helplessness, and resistance to personal care in dementia patients.	Multiple medications and drug interactions can cause mood changes and increased agitation in dementia patients.

PERSON-CENTERED CARE

Person-Centered Care

Definition and Descriptors

- Treating patients as individuals and equal partners in the business of healing
- Personalized, coordinating, empowering
- Recognizes an individual's potential to manage their own health

Main Components

Autonomy: Illustrated through informed consent and the right to refuse, taking into account the individual's situation, limitations, and capabilities.

Respect: The deliberate and intentional demonstration of regard for another person's interests and well-being.

Empathy: Understanding and sharing other people's feelings is the core concept that facilitates the development of a therapeutic relationship with the health care user, providing the basis for therapeutic change.

Comparing Traditional Care to Person-Centered Care

Traditional Care	Person-Centered Care
Decisions about policies, procedures, and work environment are made exclusively by management.	Management works with staff, residents, and family members to accommodate resident's choice and preferences.
Frontline staff are not involved in the decision-making process.	Staff are empowered with relevant knowledge and included in the decision-making process.
Traditional medical model where care is driven by diagnosis, care tasks, and the individuals who perform the tasks.	Residents are given choice and input around their care and care plan based on their needs and preferences.

Source: AHRG Safety Program for Long-Term Care: HAIs/CAUTI Long-Term Care Safety Modules, 2017.

PSC Benefits to Residents

- Enjoying personal autonomy and the ability to direct care.
- Having access to choices that promote engagement and enhance quality of life.
- Residing in an environment that encourages trust and respect.
- Collaborating with attentive staff who prioritize resident preferences and needs.
- Pursuing the best possible quality of life opportunity.

Source: AHRG Safety Program for Long-Term Care: HAIs/CAUTI Long-Term Care Safety Modules, 2017.

Person-Centered and Person-Directed

- The environment reflects a home and community environment for everyone who lives and works there.
- Leadership is dedicated and committed to creating and cultivating an environment that feels like home in setting and ambiance.
- Direct care workers are engaged and empowered to make decisions and are supported by leadership.

Source: Texas Health and Human Services, 2024.

Resident Direction in Care and Activities

- Allowing residents to go to sleep and wake up when they choose
- Preferences list
- Life story interview and document
- Ensure that preferences are truly “important and met”

Staff Benefits

- Establishing better partnerships with residents and their families.
- Understanding resident preferences makes staff better equipped to anticipate resident and family needs and act accordingly.
- Feeling valued in person-centered care organizations.

Source: Agency for Healthcare Research and Quality (AHRQ), Module 5: Resident and Family Engagement, 2017.

Tips

- Attempt to engage family members as part of the “team” that is providing care for the resident.
- Encourage staff who have positive interactions with all family members to share their “tips” with all staff and create a learning environment.
- Create an atmosphere where staff can bring their own family members to events and interact with residents and families.
- Understand that communication at the beginning of a resident’s stay is very important.

Staff Empowerment

"As we look ahead into the next century, leaders will be those who empower others." ~ Bill Gates

"Leading well is not about enriching yourself - it's about empowering others." ~ John C. Maxwell

"If your actions inspire others to dream more, learn more, do more, and become more, you are a leader." ~ John Quincy Adams

Staff Attitudes and Residents' Social Well-being

- 291 care staff members across 15 long-term care facilities in the Netherlands
- Care staff attitudes toward residents with dementia varied between facilities.
- Facilities where care staff had more hopeful attitudes saw:
  - ✓**Higher** social well-being among residents.
  - ✓**Lower** challenging behaviors.

Gerritsen DL, van Beek APA, Woods RT. Relationship of care staff attitudes with social well-being and challenging behavior of nursing home residents with dementia: a cross sectional study. Aging Ment Health. 2019 Nov;23(11):1517-1523. doi: 10.1080/13607863.2018.1506737

Hopeful Attitudes

Belief in Remaining Abilities 🌟

Focusing on what residents *can* still do rather than what they've lost.

2. Seeing the Person, Not the Disease ❤️

Treating residents as individuals with unique histories, preferences, and emotions.

3. Assuming Purpose Behind Behaviors 🔍

Viewing "challenging" behaviors as expressions of unmet needs rather than problems.

4. Encouraging Autonomy and Dignity 🙌

Supporting residents' ability to make choices whenever possible.

Hopeful Attitudes

5. **Belief in Quality of Life Despite Dementia** 🌿

   Recognizing that residents can still experience joy, meaning, and connection.

6. **Using Empathy and Curiosity** 🤝

   Approaching interactions with understanding rather than frustration.

7. **Hope for Positive Change Through Care** 🌈

   Believing that the right environment, activities, and approaches can improve well-being.

Culture Change

- Culture transformation is a continuous process in which a nursing home transitions from being a facility driven by tasks and schedules to a place that honors the residents' desires and requirements.
- Culture transformation comes with a shift in mindset: prioritizing residents' strengths, choices, and daily routines to deliver care that is tailored to their needs.
- Culture change reflects certain values, including choice, dignity, respect, self-determination, and purposeful living.

Source: Texas Health and Human Services, 2024.

Elements of Culture Change

- Resident Direction in Care and Activities
- Close Relationships between Residents, Family Members, and Staff
- Staff Empowerment
- Collaborative Decision-Making
- Quality Improvement Process

Source: Alzheimer's Association, Person Centered Care in Nursing Homes and Assisted Living, 2017.

The Language of Culture Change

Old Language	New Language
Victims of…suffering from	Living with
Wing, unit, floor, division	Community, neighborhood, household
Allow	Encourage, offer, help with
Feeder, feeder table	Assist/help with dining
Admission	Move in
"You need to…"	"Would you like to…I would like you to"
"They are a fall risk"	"There is a good chance they will fall"
Supplement, nourishment	Snack, treat, food, drink, shake
Wanderers	People who like to walk around

Source: Alzheimer's Association, Person Centered Care in Nursing Homes and Assisted Living, 2017.

Case

- A 52-year-old is admitted to the facility following a hospitalization for complications from liver cirrhosis.
- He becomes progressively more depressed and combative due to the lack of activities during the covid pandemic as bingo was his favorite activity.
- The director of activities resigns from the facility.
- Activities are resumed a few months later but are disorganized due to the lack of a director.
- A CNA suggests that the 52-year-old resident described above call the bingo game.
- The resident helps organize the activity, enjoys the experience, and asks to continue helping with organizing activities.

Unmet and Unimportant Preferences

- Data from 2012-2017 MDS assessments of long-stay residents in 295 Minnesota nursing homes was collected. There were 51,859 assessments completed from 25,668 residents.
- 3.3% to 5.1% of residents reported that at least one or more preferences were important but unmet, and 10.0% to 16.6% reported that four or more out of the eight preferences were unimportant.
- Residents with depressive symptoms and poor physical and sensory function were more likely to report unmet preferences.
- Residents with poor physical and sensory function, living in rural facilities, and facilities with fewer activity staff hours per resident day were more likely to report unimportant preferences.

Duan Y, Shippee TP, Ng W, Akosionu O, Woodhouse M, Chu H, Ahluwalia JS, Gaugler JE, Virnig BA, Bowblis JR. Unmet and Unimportant Preferences Among Nursing Home Residents: What Are Key Resident and Facility Factors? J Am Med Dir Assoc. 2020 Nov;21(11):1712-1717. doi: 10.1016/j.jamda.2020.06.033. Epub 2020 Jul 29. PMID: 32739282; PMCID: PMC9129870.

Innovative Activities Programs

Most important principles of a highly successful activities program:

1. Residents are never left alone in the activities area, but are always engaged with staff in casual conversation, exercise, or other meaningful activities.
2. Activities are (almost) continuous.
3. Program must involve staff from all disciplines, especially CNAs.

Volicer L, Simard J, Pupa JH, Medrek R, Riordan ME. Effects of continuous activity programming on behavioral symptoms of dementia. J Am Med Dir Assoc. 2006 Sep;7(7):426-31. doi: 10.1016/j.jamda.2006.02.003. Epub 2006 May 11. PMID: 16979086.

"The Club"

Continuous activity program implemented on a dementia unit with 28 residents.

"All staff, including licensed staff, nursing assistants, social work, activities, housekeeping, and rehabilitation received … [an] education includ[ing] team-building exercises that explored what makes staff members feel good about their jobs, provided staff empowerment, and discussed quality of life for their residents with suggestions on how to make it happen for their residents."

Volicer L, Simard J, Pupa JH, Medrek R, Riordan ME. Effects of continuous activity programming on behavioral symptoms of dementia. J Am Med Dir Assoc. 2006 Sep;7(7):426-31. doi: 10.1016/j.jamda.2006.02.003. Epub 2006 May 11. PMID: 16979086.

“The Club”

- Continuous programming which starts with breakfast.
- Formal activities (exercise, reading current events) are alternated with non-formal activities (having residents help move chairs and tables).
- One “special event” each day such as craft or music event.
- Staff have the opportunity to independently lead a group once they receive training and co-lead a group with an occupational therapist.

Examples

- Staff member with an interest in gardening brought flowers from home for a flower arranging class
- The NHA led a poetry reading group
- A VFW club meeting was organized once a month
- A ladies “tea” was organized
- A barbershop was created by a staff member
- Staff were encouraged to make almost anything a “meaningful activity”

Results

Variable	# of Residents Before	# of Residents After
Psychoactive medications	20	8
Neuroleptics	19	6
Antidepressants	4	0
Benzodiazepines	2	1
Mood stabilizers	4	1
Weight Loss	9	1
Weight Gain	1	11
Social Isolation	15	5

Activity hours were doubled without an increase in staffing!

Volicer L, Simard J, Pupa JH, Medrek R, Riordan ME. Effects of continuous activity programming on behavioral symptoms of dementia. J Am Med Dir Assoc. 2006 Sep;7(7):426-31. doi: 10.1016/j.jamda.2006.02.003. Epub 2006 May 11. PMID: 16979086.

MIND Diet
The Mediterranean-DASH Intervention for Neurodegenerative Delay

Foods

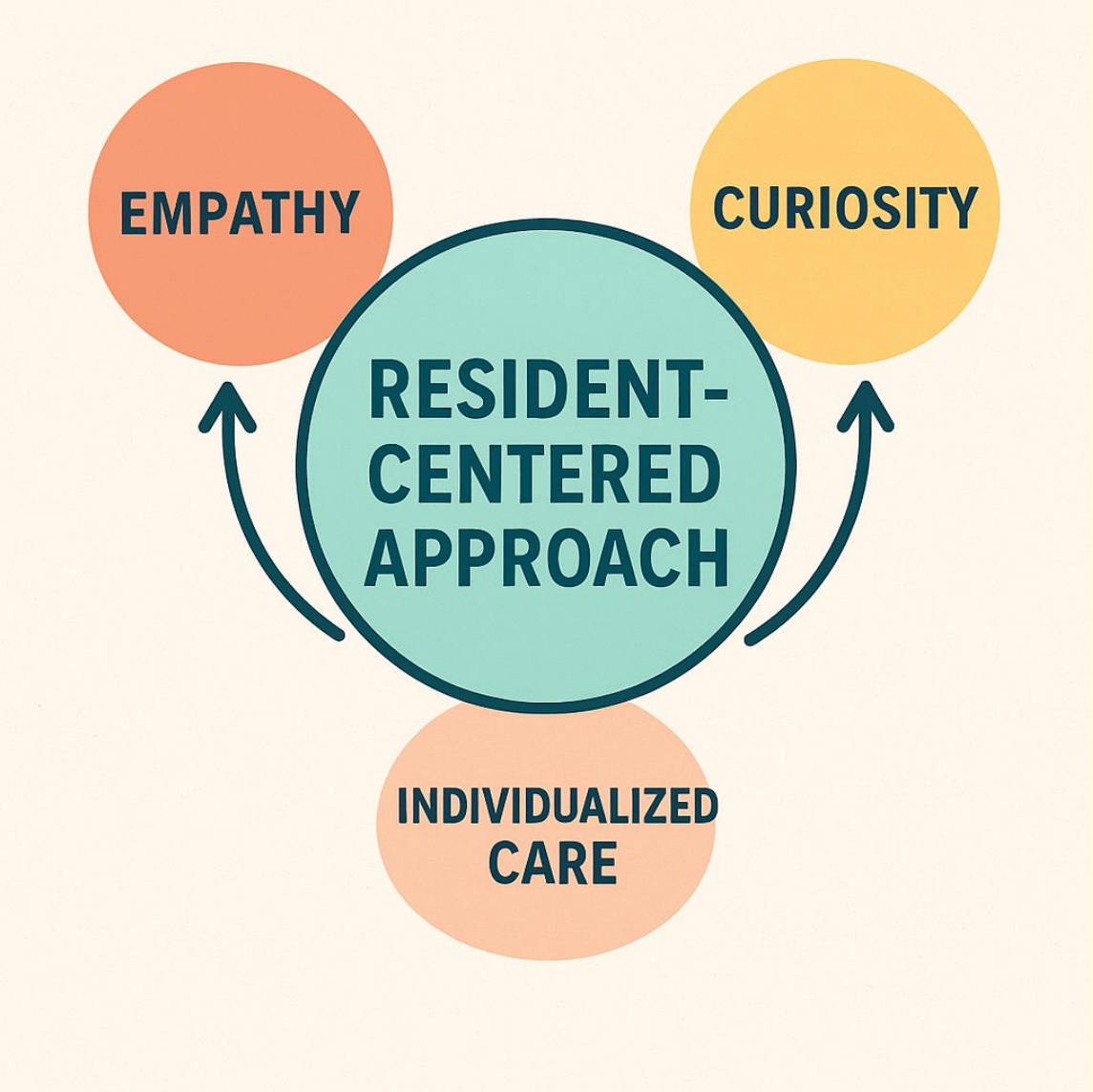
- **Leafy green vegetables** (e.g., spinach, kale)
- **Other vegetables** (e.g., carrots, broccoli)
- **Berries** (especially blueberries and strawberries)
- **Nuts** (e.g., almonds, walnuts)
- **Whole grains** (e.g., oats, brown rice, whole wheat)
- **Fish** (especially fatty fish like salmon)
- **Poultry** (e.g., chicken, turkey)
- **Beans** (e.g., lentils, chickpeas, black beans)
- **Olive oil** (as the primary cooking oil)

Results

- **Goal**: Studied the link between the MIND diet and dementia risk.
- **Data**: Used three cohort studies and a meta-analysis of 11 studies.
- **Findings**: Higher MIND diet scores were tied to lower dementia risk.
- **Conclusion**: MIND diet may help prevent dementia; more research needed.

Chen H, Dhana K, Huang Y, Huang L, Tao Y, Liu X, Melo van Lent D, Zheng Y, Ascherio A, Willett W, Yuan C. Association of the Mediterranean Dietary Approaches to Stop Hypertension Intervention for Neurodegenerative Delay (MIND) Diet With the Risk of Dementia. JAMA Psychiatry. 2023 Jun 1;80(6):630-638.

Resident-Centered Approach



Empathy

Emotional Understanding	Notice when a resident looks anxious and ask if they'd like support.
	Listen attentively when residents share stories and validate their feelings.
Respecting Personal Preferences	Honor daily routines like preferred mealtimes and coffee preparation.
	Adapt care plans to match cultural, religious, or personal values.
Nonverbal Empathy	Use eye contact, smiles, and a calm tone when interacting with residents.
	Sit at eye level rather than standing over the resident

EMPATHY

Supporting Emotional Needs

- Recognize signs of loneliness or sadness and arrange social interaction.
- Offer comfort through small gestures like holding hands or reassurance

Advocacy Through Understanding

- Notice when a resident is uncomfortable and speak up to adjust practices.
- Ensure residents' voices are heard in care planning meetings.

Curiosity

Asking Open-Ended Questions

- Encourage residents to share stories by asking, 'Can you tell me more about that?'
- Show genuine interest in their life experiences and preferences.

Understanding Individual Needs

- Ask resident what they would prefer rather than assuming
- Explore what brings a resident joy

Explore Personal Histories

- Learn about a resident’s background, culture, and traditions
- Incorporate personal history into care plans

Curiosity

Seek Resident Input

Ask residents for feedback on their care experience

Involve them in decision-making

Continuous Learning

Be curious about changes in a resident’s condition and adapt accordingly

Stay open to new approaches

Individualized Whole Person Care

- Mental: Cognition, Depression, Anxiety, Fear, Anger, Suicidal Ideation, Impulsivity
- Physical: Pain, Nausea, Appetite, Shortness of breath, Sleep, Fatigue
- Social: Relationships, Roles, Financial Burden, Caregiver Burden, Community Support
- Spiritual: Purpose, Hope, Dignity, Meaning, Love, Faith, Forgiveness, Gratitude

Take Home Points

🧠 **Rethink Assumptions** – Challenging behaviors often have deeper causes; medication isn't always the answer.

🔍 **Look Beneath the Surface** – Use thorough assessments to uncover medical, emotional, and environmental triggers.

❤️ **Lead with Empathy and Curiosity** – Person-centered, individualized care improves outcomes and enhances residents' quality of life.

Questions?

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