FRONTAL LOBE DEMENTIA: The Hidden Liability Risk

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"It just came out of nowhere. She hit Mr. Smith at the dinner table!"
"I told him he is NEVER to touch her again, and he agreed. Then he immediately reached out and tried to grab her!"

"We have to watch him every minute. Just now, I had to tell him again, 'You must call for help before you get up!'"

" I told the aides to be careful and don't make her mad."

These illustrate the problem encountered when assisted living staff are not aware of dementia-related behaviors. Too often, assisted living administrators tell us that they do not have residents with dementia because they "don't have an Alzheimer's unit." Sadly, many directors of assisted living residences are still unaware of the 50% incidence of dementia in assisted living residents which excludes Alzheimer's units and dementia-specific facilities. This estimate of fifty-percent also includes dementia characterized only by the usual symptoms such as memory loss. But there were no signs of dementia in the comments above, were there? Actually, there were. Dementia is more than just memory loss. One type of dementia is often unexpected and unrecognized among elders – Frontal Lobe Dementia.

Frontal Lobe Dementia

The term "frontal lobe dementia" is used to describe a number of diseases of the frontal lobes of the brain. In order to really grasp the concept of frontal lobe dementia, you must first understand that the frontal lobes are responsible for "executive function," which means that they coordinate functions such as planning, motivation, ability to carry through a task, and sequencing of multiple actions. The frontal lobes also serve the very important function of doing or saying socially inappropriate things. At Dignity First ™ we like to call this function the "hand over the mouth." For example, a two year old will point and say, "Look at that ugly lady!" Mother shushes the child (maybe even literally putting her hand over his mouth) and over time, as his frontal lobes develop, the child is able to control his impulses to shout out the first thing that comes to his mind. Knowing this, you can predict the behavioral problems associated with frontal lobe dementia: sexually inappropriate behavior, self-stimulation, sudden aggression or violent outbursts, refusal of care (due to the lack of recognition of one's problems and needs), and inability to sustain a task such as eating. These frontal lobe symptoms can occur without memory loss or "confusion." The comments in the introduction demonstrate a number of these symptoms.

Ms. Wendy Hazel, Executive Director of Freedom House, a premier dementia care facility in the Air Force Village II community in San Antonio, knows the importance of

recognizing frontal lobe dementia. The vision of Freedom House from its conception has been to group residents according to cognitive/physical functioning. This offers the benefit of making care more efficient and allowing staff to become more specialized. "You can't just say, 'It's dementia,' and expect to know what problems the person really has," says Ms. Hazel. "There are different types of dementia, which can be manifested differently. To lump all behavior problems as simply 'dementia' can be misleading."

Liability Issues

Assisted living communities, as places specializing in the care of elders, are expected to recognize dementia, including frontal lobe dementia. Failure to recognize and address frontal lobe dementia can result in legal and health risks to the resident, staff, other residents, and visitors.

A resident with frontal lobe dementia can quickly become aggressive when triggered or stressed. He won't stop to reason through his actions, because he has lost the frontal lobes where that reasoning ability lives. Unchecked, such aggression can lead to a tragic outcome.

Lack of self-control ("the hand over the mouth") might lead such a resident to insult workers, other residents, and visitors with racial epithets, curses, or degrading remarks. Sometimes staff will not report sexually inappropriate behavior because it is embarrassing for them.

Physical injuries to staff can lead to increased worker's compensation claims and higher turnover.

Understanding how dementia affects the residents, the staff at Freedom House know that it is important to try to prevent problem behaviors. "We don't fix the residents' problem behaviors, we manage the behaviors." Ms. Hazel notes that beautiful surroundings are great, but an appropriate assisted living environment must also take into account the cognitive needs of the residents. According to Ms. Hazel, placing residents in the appropriate environment based on level of cognitive dysfunction and social abilities allows the staff to provide better care.

Reducing the Risk of Liability

Pay Attention in the Intake

Families are typically in a difficult position or even a crisis when they seek placement for their loved ones, especially those with dementia. They can also be likely to minimize problems if they think their family member may not be accepted due to his or her behavior. They feel sure that everything will be better once the family member is placed in your facility. Pay attention to their comments about how difficult it has been to manage the person, or how their behavior is "different now."

Wendy Hazel believes family education can one prevent problems and make the intake process easier. "When families are more knowledgeable about dementia and related behaviors, then they aren't embarrassed about their loved one. They know that their loved one has a disease that needs to be managed. Those families are more forthcoming with us from the very beginning. That prevents a lot of problems."

Pay very close attention to the prospective resident's behavior. In order to detect residents with more subtle cognitive problems, spend more time than just a few minutes with the person, and talk to him without family present.
Many communities regularly employ the Folstein's Mini Mental Status Exam (MMSE) or the CLOX to assess for cognitive dysfunction. The difficulty is that a person with frontal lobe dementia may score within the normal range on these tests because the person with predominantly frontal lobe impairment has almost no memory loss (MMSE) or loss of spatial relations (CLOX).

Staff Training

There are several ways to manage risk with frontal lobe dementia. Staff training can empower direct caregivers to promptly identify problem situations. Dignity FirstTM utilizes the Three P's of Behavioral InterventionTM to enable the staff to become the frontal lobes for the resident. That means that the staff cannot expect the resident to behave in a rational, logical, socially appropriate way at all times.

Improving Communication with Families

Like staff, families can be embarrassed by the behaviors of a resident with frontal lobe dementia, or they can feel that you are not doing an adequate job of making their relative "behave." As Wendy Hazel noted, family education is vital to risk management. How much do your families know about dementia—especially frontal lobe dementia?

Asking a resident to leave the facility is not an adequate response to behavior problems. After all, families placed their loved one in your residence because they believed that you would be able to handle problems, so why do you now say that you can't take care of them? Including the family in formulating a care plan strategy is the first step in managing the frontal lobe dementia risk. Involving everyone in the process will make all parties feel they are being heard and respected, and families and staff will view each other as valued care partners. Better that than adversaries in court.

Implementing a Treatment Plan

Treatment plans for residents with dementia cannot be cookie-cutter. At Freedom House, the staff look for input from a variety of sources. A basic strategy follows.
Evaluation by health care professionals such as the patient's physician, a neurologist, a neuropsychologist, or a geriatric psychiatrist.
Document what works in addition to what doesn't work, and communicate successes as well as failures. Patterns will emerge that will empower the staff to be more consistent in their approaches. The need for defensive documentation will diminish.
Regular meetings between family and staff to go over problems, because dementia behaviors will change over time.
The Schedules, Activity, and Structure (SAS) TM approach is vital to reducing problem behavior. This does not mean one-on-one constant monitoring, but does mean engaging the resident in existing activities and giving a reliable structure to his day.

Judicious use of medication may be helpful to reduce the volatility of the resident. Again, documentation is essential in helping physicians prescribe and monitor medications properly.

Frontal lobe dementia remains an area that is misunderstood and under-recognized. As you can see, there is more to caring for residents in assisted living than just providing a beautiful homelike environment. With the high level of dementia among assisted living residents, it is incumbent upon directors of all assisted living residences to be educated about the various forms of dementia. Knowing the basics of frontal lobe dementia will enable you to reduce liability costs, family and resident dissatisfaction, and staff turnover as well as provide better care for your residents.