

***CPI Unrestrained* Transcription**

Episode 31: Lori Blaire and Carolyn Garrett

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Host: Terry Vittone

Terry: Hello, and welcome to *Unrestrained*, the CPI podcast series. This is your host, Terry Vittone, and today my guest is Lori Blaire of Tender Touch Rehab Services. Hello and welcome, Lori.

Lori: Hi.

Terry: All right. Let me tell you about our guest. Lori Blaire is the vice president and compliance officer for Tender Touch Rehab Services. Lori is a registered occupational therapist, with 38 years' experience as a certified healthcare compliance officer by the Compliance Certification Board, and Health Care Compliance Association. Lori is a graduate of the Downstate Medical Center in New York in occupational therapy, and has worked in the acute care, outpatient school, and skilled nursing facility settings. She has been an adjunct professor for several OT and COTA programs, and is presently on the advisory board for Salus University OT program, and Raritan Valley Community College OTA program.

All right, Lori, so then let's begin. Could you describe your organization for our listeners? And talk about your roles as a vice president and compliance officer for Tender Touch.

Lori: Okay. Well, Tender Touch Rehab Services is a contract rehab company servicing over 160 skilled nursing facilities in the New York, New Jersey, Pennsylvania, Maryland, Massachusetts, and Connecticut areas. We offer occupational therapy, physical therapy, and speech therapy staffing, as well as comprehensive rehabilitation management services. Tender Touch is considered an industry leader, in that we offer an excellent clinical product and services. We focus on providing excellent hands-on therapy services, and the patient outcomes that they obtain. Our motto is "excellence is our only outcome."

Terry: I like that.

Lori: As the vice president, I have several roles. First and foremost, as the compliance officer, I am responsible to develop and implement the compliance program,

policies, procedures, and training. I am also responsible to lead by example, and continually encourage our culture of compliance, and ensure that Tender Touch always demonstrates good corporate behavior and citizenship. In this role, I have the opportunity to design a lot of training modules. So it was just natural for me to also manage our education department. In this role, I am the company representative who chooses, of course with the staff input, which continuing education courses we should host, and I arrange for those courses. I am always looking for courses to host that are new and exciting, and geared for our customers and their residents in the skilled nursing facility arena.

Terry: I see. So you do a lot of strategic planning. That's excellent.

Lori: I do.

Terry: Excellent. How did Tender Touch determine that DCS training would be appropriate or helpful, prior to choosing us? I mean what were your expectations going in, and what sort of specific needs drove your decision?

Lori: Well, each year I attend the AOTA Convention. First, out of my personal interest in courses offered there, as well as I look for new state-of-the-art equipment, services, etc., to bring to our team to keep Tender Touch current. It was there that I met Kris, the representative at the DCS booth. We began to talk, and I quickly realized that there had been so many advances and approaches to dementia care that I would love to learn about.

When I got back to the company, I polled the regional management team, and asked them if they thought that becoming Dementia Capable Care Therapists would benefit our clients, their residents, and our company at large. And it was a resounding yes. We as a team felt we had only basic clinical knowledge of how to treat the dementia patient. However, we lacked a theoretical base, a good evaluation, and the treatment foundation that was practical, measurable, and would give us better outcomes. This is what we thought we could expect going in, and the specific reason that drove the decision to have our team of therapists attend the two courses to become Dementia Capable Care Therapists.

Terry: Well, I'm glad you responded so well to our program. We certainly are. I mean, to spread our person-centered message and to have professionals like yourself recognize it is certainly gratifying to us. What has been the value to date then of that DCS training for your therapists, your business, and the clients that you serve? I mean has the training accomplished what you hoped it would, based on that impression you got at the conference?

Lori: Oh, certainly. So last year, a total of 38 staff members—and that included occupational therapists, physical therapists, and speech therapists—completed the

program. We immediately saw the value of the course, as these individual attendees left the course with a much better understanding of the Allen Cognitive Levels, and the strategies for how to stage and treat these patients within a "what they can do rather than what they can't do" attitude, and this includes myself. And each therapist was so excited to return to their facility with a renewed passion and interest in the dementia treatment.

And to be frank, as a business, it gave us a new marketing strategy that we could talk about. It's a specialty program that few of our competitors can boast about. We have so many clients and potential clients that have dementia units looking for direction and new programming. And our company efforts, to have so many clinicians become skilled in this area, has really helped us to keep our clients happy, and more importantly, their residents and their families, as well as to recruit new clients. And so the training certainly paid off, and we're happy that we hosted the course, as well as the individual therapists are really happy and proud to display their new initials as DCCT on their signature.

Terry: Oh, that's excellent.

Lori: And again, myself included.

Terry: So this idea of remaining abilities, that treating patients, and celebrating, and really working with what they can do rather than what they can't, was new to not only yourself but to some of your therapists there at Tender Touch as well.

Lori: Absolutely.

Terry: That's a paradigm shift we love, and I'm glad that it was so attractive to Tender Touch and yourself as an administrator. So going forward, Lori, what changes and improvements do you think you'd like to see occur at Tender Touch? Is ongoing DCS training for your therapists something you feel is important to be part of your business development there?

Lori: Absolutely. Going forward, we hope to continue to utilize this information and strategies we all learned, and continue to treat our patients with the best possible care and passion that they deserve. Many of us are interested in becoming Instructors, and are looking forward to arranging the course for the company in the near future.

So the DCS training is not only important, it should become a requirement in some form for all students and new graduates. They need to learn the DCS philosophy. I believe it's one of knowledge and respect for the patients who live with dementia. It also teaches the clinician to look past the old views of the dementia patient, that

they will never improve, to let's see what they can do, will do, and may do. So I say thank you wholeheartedly to Kim, Kate, Kris, and the DCS team for our training.

Terry: Oh, well thank you, Lori. That's certainly an excellent recommendation. And it seems like you guys are completely convinced on the value of DCS, and that it should be, as you said, a requirement in some form for all students and new graduate therapists. We couldn't hope for a better recommendation than that. Thank you.

Lori: You're very welcome.

Terry: All right, Lori. Do you have any last thoughts that you'd like to share with our listeners today? I mean where do you see Tender Touch in five years?

Lori: Well, I see Tender Touch as being an industry leader, or an example of dementia care; to treat those patients with honor; and also be most current with our technology and our strategies; and hope that Kim and her team will constantly lead us to be better clinicians.

Terry: Well, thank you for choosing DCS training, and thank you for joining us today on *Unrestrained*, Lori.

Lori: Thank you.

Part II – Carolyn Garrett

Terry: All right. Thanks to our listeners. Hello, and welcome to *Unrestrained*, the CPI podcast series. This is your host, Terry Vittone, and we're about to begin Part II of our interviews with staff from Tender Touch Rehab Services of Lakewood, New Jersey. My guest for this interview is Carolyn Garrett, a regional manager at Tender Touch for speech-language pathology. Hello and welcome, Carolyn.

Carolyn: Hi, Terry.

Terry: All right. Let me tell you a little bit about our guest. Carolyn Garrett is a speech-language pathologist with 17 years' experience working with adult patients with cognitive, communication, and swallowing disorders, in a variety of settings. She has worked with Tender Touch Rehab Services for over 10 years, and as a regional manager for speech-language pathology. Carolyn completed training to become a Dementia Capable Care Therapist in 2015. She was also selected for and completed ASHA's Leadership Development Program for Health care.

So then, Carolyn, let's begin. My first question is could you talk about your role at Tender Touch as a speech-language pathologist, who works closely mentoring

other SLPs during their fellowship year, and how that work brings you in daily contact with clients living with Alzheimer's and dementia?

Carolyn: Sure, absolutely. And thanks so much, Terry, for talking with me today.

Terry: Thank you.

Carolyn: As a speech-language pathologist and a regional manager for Tender Touch, I work very closely with our therapists for clinical mentoring, and program development, and providing services to patients in the skilled nursing setting. Many of the patients that we encounter in this setting have Alzheimer's or a related dementia.

And we see patients at every stage of dementia. Some of the patients we see have been living in the community and have come to the facility for rehab after being hospitalized. Others are long-term care residents, who may be in the later stages of dementia, and need a significant amount of assistance for all of their daily needs. One of the most rewarding parts of my role with Tender Touch is to provide clinical training to newly graduated SLPs during their clinical fellowship year. This involves working alongside these SLPs, and evaluating and training both the sub-acute rehab patients as well as long-term care residents that are on their case lists.

So I work with individuals with dementia just about every day. New therapists may not have had experience in working with dementia during their student internships. Dementia certainly presents many challenges for caregivers and health care providers. Even experienced therapists and team members benefit from assistance and resources, in particular situations. I really enjoyed using the training and the resources that I've received through Dementia Care Specialists to help our Tender Touch therapists, and our clinical teams, in better serving our individuals with dementia that we see in the facilities.

Terry: Excellent. Following up on that, could you tell our listeners about a meaningful takeaway from dementia care therapy training, and how it applied in the clinical setting? I know we talked a little bit about, in our pre-interview, about a fellow named Bob.

Carolyn: Absolutely, absolutely. And there was so much information during the training that was very helpful. I remember one of the first activities that our Instructor had us do was to brainstorm how we would describe dementia, and sure enough, most of the words and phrases that we all came up with were negative. Then we took those words and shifted them to a positive focus. And that perspective shift was really powerful and important in working with individuals who are diagnosed with dementia. It gives us the tools to help that person who has certainly lost some or many of their abilities, to be able to function. That activity really set the tone for the training really well.

One of the first words that came to mind for me when describing dementia was wandering. And wandering is a pretty frequent problem that we face in the skilled nursing setting. Looking at it negatively, it presents a huge challenge to keep the patient safe and from disrupting others in the facility. And wandering is a common reason that individuals come to the facility for long-term care, because their families can no longer be able to keep their loved ones safe. The dementia training really changed how I view some of those most challenging behaviors associated with dementia.

I'd like to share two situations of patients with wandering that I really feel helped—that dementia training helped me to think through. So one was Rose. Rose was referred to speech therapy because of weight loss, and poor intake at meals, and wandering. And I went to evaluate her at lunchtime, and found her sitting in the dining room at the facility. And the nursing aide was sitting next to her and feeding her. Within two or three minutes, Rose stood up and turned to leave the table, and the aid redirected her to sit back down, and attempted to feed her more lunch. I observed from a corner of the room, and watched for about 10 minutes as Rose continued to stand up, and then be redirected to sit back down. Each time she sat back down, she accepted fewer bites of her meal, and eventually accepted none of it.

So it was very busy. The dining room was very busy and crowded, and it became clear that it was becoming more and more of a problem. I approached Rose and the aide, and asked if I could bring Rose and her lunch to the room to evaluate her swallowing, which was why I had been referred. Once we were in the room, Rose ate some of her meal, and appeared a lot calmer. She didn't have any trouble swallowing. It really seemed to me that her weight loss was probably really caused by her cognition, the difficult processing and attending in that mealtime environment.

So during those next few days—and sometimes it does take a few days to really problem solve a behavior, and apply or try different strategies to make it work. But I was able to understand over the few days that, besides meals, Rose had really been wandering out of group settings consistently. We were able to work as a team to realize that her wandering was a communication that she needed to go to a quieter, less stimulating area. I used those therapy sessions to help her have a meal, and structure her meal in her room.

Terry: I see. Because you said when you took her, you redirected her away from where she typically ate. She did calm down and eat more, and probably because of the change of venue to a more peaceful and sort of private location.

Carolyn: Absolutely, absolutely. And redirecting her in a positive way. When she did lose focus on the meal, redirecting her in a pleasant communication: "Boy, that pasta looks good," you know, as opposed to "No, stay here," where she clearly was uncomfortable. It was really successful, and certainly that changed her mealtime behavior, and also gave us some information to look at how we can improve the rest of her day, in terms of helping her to participate in activities, and remain happy. So we were able to structure her.

Another patient that I'd like to share with you is Bob. And Bob had been admitted for rehab from the hospital after a heart attack, and he was very weak and unsteady on his feet, and somewhat confused. And during the first day or two of rehab, Bob had begun to get up frequently during the day and wander in the facility, and occasionally in and out of other residents' rooms.

Terry: Carolyn, may I ask you relative ages of Rose and Bob, just so we get more of a picture of them?

Carolyn: Sure. Rose was in her 80s, and I would say that Bob was in his early 70s.

Terry: Okay, sorry to stop you.

Carolyn: Yeah, no, absolutely. In the first day or two, he was getting up and wandering. And we were really concerned. The team was concerned about his safety, both in terms of elopement, wandering out of the facility, and falling, because certainly from his cardiac event and his hospitalization, he was weakened. So the team had transferred Bob to a locked unit in the facility to keep him safe, and we started talking with the family as they were involved in the therapy process. And they had shared that he had begun wandering over the last few months, and that it was a huge challenge for them.

Terry: So this wasn't just hospital delirium after the heart incident.

Carolyn: No, but something that, I think, the facility didn't realize would become an issue in the health care setting, and impact his ability to participate in rehab. And certainly weakened, whereas he was wandering at home, and certainly safety in terms of keeping him safe in the home and the community was a concern for them. They weren't worried about him falling as much because he was physically strong until this hospitalization.

So it was a real challenge, and as a therapy team to work on identifying, one, what his typical routine was at home and his interests, and then structuring his day to provide briefer periods of therapy, maybe more frequently, so that we were able to avoid those long periods where he wouldn't be engaged in activities. And then find activities for him that were able to be presented at the right level. So that just-

right challenge that we talked about in the training, where he would be able to stay engaged and be successful as opposed to either feeling frustrated or bored, and remove himself from it.

So it certainly wasn't easy for the team, but structuring his time with the right activities at that right cognitive level allowed him to be more successful in rehab, and also helped the team be able to work with him.

Terry: So a combination of clinical observation, and then applying some of the concepts that you learned in the dementia care therapy training helped to really unravel the problems that you were seeing.

Carolyn: Absolutely, absolutely.

Terry: Excellent. Can you talk about a problem or issue you had before the dementia care therapy training, and how the training helped you better address it? And I think we talked in our pre-interview about a man named Ed.

Carolyn: Absolutely. I think family members and helping family members to cope with loved ones that are dealing with Alzheimer's disease and dementia can be really challenging. And Ed's case certainly brings that out for him, for me. It can feel hopeless and difficult. It can feel hopeless for the families, and very difficult to know how to counsel them, but I think it's one of the most important roles that we have. And the dementia care training really helps in focusing on our patients from an abilities perspective, and that really helped me with Ed.

I had worked with Ed a few years ago, and before attending the dementia care training. Ed had come to rehab from the hospital, and his wife was with him that first morning at the facility. I remember that I introduced myself as a speech therapist, and gave my typical introduction, and would try to explain my role, and that I work with concerns for swallowing, communication, and cognition. And Ed's wife very quickly and frankly told me that Ed couldn't do anything. He couldn't do anything anymore because he was confused, and he wouldn't be able to use my help. And I remember Ed's face and how apologetic he was as I asked a few more follow-up questions. It really stuck with me.

I remember in that initial interview where I'm gathering information that it became clear that Ed had declined over the past two or three months, and that his days, at this point, were pretty empty. He had lost his independence, he seemed very aware of that, and it took actually some convincing for me to convince his wife that he might benefit from an evaluation and some therapy, even though the dementia was not going to go away, and his memory wouldn't "get better."

Ed there was a good example. He certainly was disoriented, and he couldn't remember what happened earlier in the day. And his wife was very upset and frustrated. And during that evaluation, in which I really look and analyze his communication and his cognitive strengths, I remember being surprised. He was able to speak and communicate pretty well, read, even write some short phrases. And that surprised me. And I felt the challenge to know how to help him use and maintain those skills. This was a real example of someone with a significant excess disability, because of the dementia being viewed from that negative perspective.

Certainly, I involved his wife in therapy, tried to help her see those remaining abilities, what he could do, and how he could participate in his day. So I guess, certainly, as Ed's therapist, I had used his strengths to help him function, and improve his quality of life. And now, with dementia care training, you know, certainly I can look back at this case, which really did stick with me, and realize where he was, and how important that is. So knowing that he was performing at an Allen Level 4, and what that means when I have that knowledge in terms of being able to look at realistic abilities, and how to structure and support that person.

That knowledge and being able to share it with caregivers from that positive perspective, I think, is so important even if it's as simple as familiar routines, and repetition for information and such. It would give me the framework to be able to counsel and empower the family member from that perspective.

Terry: I was wondering about—excuse me, Carolyn. Go ahead.

Carolyn: It's so meaningful for them to be able to have that perspective shift.

Terry: And were you able to communicate that to Ed's wife? It's such a poignant moment, you said, where you saw that change, that apologetic look on his face as her frustration became evident. Was she able to grasp the remaining abilities concept, and to maybe feel more optimistic about celebrating and helping Ed to use those remaining abilities?

Carolyn: And she was. You know, it did take involvement in therapy consistently. And over those weeks that he was there with us for rehab, engaging her, and eventually when he was planning discharge home, we used the newspaper as a time for them—it's something they had done before—to sit and talk about the newspaper, and something that they haven't been doing anymore. And so practicing that, to facilitate his communications—certainly not that he was going to be able to recall the specifics of things. But he was able to enjoy sitting with his wife and communicating about those events that were there in the headlines at a very simple level, and it gave them back an activity that they were able to do, and maintain that function.

So I think it really did improve his quality of life, and although he wouldn't have remembered the specifics of the news events of that day later, that time that they had together there, and that he could participate, was a really meaningful thing for them, and obviously for me, to be able to help with that.

Terry: Yes. So how rare or typical is it that you'll have an opportunity when you have a client like Ed that you actually get to interact to the level that you did with a family member to sort of illuminate them about the concept of remaining abilities?

Carolyn: It is always the intent for us to do that if the family is available. Sometimes families will say, "That's okay. I'll let you take them to therapy," or, "That's okay. I'll leave." And involving the family as much as possible is really important. One, it helps the patient. We get better information, and we can see the communication styles and interactions and such. Certainly, in thinking about Ed, that first interaction really stuck with me in terms of going "Okay, I have a challenge here, and I really want to be able to help."

Terry: To affect that perspective shift, from lost abilities to remaining abilities in a family has got to be one of the critical points of improvement, or process improvement, as they care for their loved one.

Carolyn: Absolutely. And when you have a diagnosis of dementia, it really can be devastating. The family is trying to cope with what's been lost, and fearing what is going to decline. And so taking that, and being able to say, "Okay, here is what we have and let us facilitate that," because that concept of excess disability, which certainly Ed—Ed was being restricted from a lot of things that he was able to participate in, because his family didn't see his abilities. And they were quite clear. We didn't have to dig deep to uncover that. So that is always the focus with families and trying to involve them to do that.

Terry: Excellent, excellent. Has the training helped you use non-pharmacologic approaches to reduce negative or aggressive behavior by those living with Alzheimer's and related dementias?

Carolyn: Absolutely. Each patient that we serve, we're part of a team. And one of the most helpful parts of the training was to really learn to approach negative behaviors as forms of communication. So we spent time analyzing some of those negative behaviors, and the meaning behind them. So sometimes that's pain, boredom, fear, frustration. Physical aggression during personal care is an example. So helping staff members understand that personal care may be really stressful for the patient, and putting in place strategies to ease that.

So communication techniques, having familiar caregivers and routines, those approaches can be helpful to reduce some of those negative responses. So you

know, understanding the behavior, as challenging as it can be, and the triggers, is the first step in addressing that need, you know, instead of quickly moving to medication to reduce or eliminate it.

Terry: Do you see out there that there's more understanding and maybe willingness to try non-pharmacologic approaches to reduce these kinds of behaviors? Is awareness starting to grow out there on a general level, do you think, or is a chemical solution still primary in a lot of minds?

Carolyn: I think it is increasing. And certainly when we look at a behavior and look at the number of medications that some of our residents are on, and start to look at how they may be interacting. It takes that team approach, both the medical team, the physician, the psychiatrist, the nurses, as well as the rehab and activities team, to put our heads together and say, "Okay, how can we approach this? Can we withdraw some of these medications? Can we look at this a different way before adding another medication?" So I do think it is certainly a challenge. I am positive that in terms that those discussions do happen, but a lot more of them need to happen for sure.

Terry: I see, I see. And just so I understand it, how many different facilities would you say that you go out into in your community, and the surrounding communities?

Carolyn: Sure. I oversee the speech programs in about 30 facilities.

Terry: Oh my. Shifting here a little bit to an "aha" moment during training. I mean with your 17 years of experience, and you're in this course, did you have a memorable "aha" moment during training?

Carolyn: I did. And right, I have. I've been a therapist for more than 15 years, and certainly worked with a lot of patients with severe limitations to help them facilitate their best functioning. I think the dementia care training really helped me expand my approach. One of those "aha" moments probably came in looking at the remaining abilities in the latest stages of dementia. For example, a patient at Allen Cognitive Level 1 is maybe only—needs total assistance, and is maybe only out of bed to a Geri chair, and can no longer speak, and has difficulties swallowing. So over the years I've worked with many of these patients at this level, in terms of feeding and swallowing.

But I think an "aha" moment for me came in really looking at it from a different standpoint of facilitating their remaining abilities, instead of looking at all of the—what can the patient not do, what is more difficult now. So you know, for example at that level, recognizing the ability to still express their emotions. And maybe it's vocalization that they're no longer talking, but able to voice, and change the

expression on their face when we take the time and facilitate the stimulation in a way that's meaningful, and that they can process.

And so looking at that, and thinking again back to caregivers and families, in terms of how to help them understand how to engage their loved ones. Because they may feel that there is nothing left there. And there really is. And being able to help facilitate them to elicit that response, engage that loved one who is at the end stage of dementia, it was an "aha" for me, and made me realize there were some opportunities there that I could use. So that was one of those moments.

Terry: So maybe you could see recognition even at Level 1 of, say, in that facial expression of joy, or frustration, or of some sort of satisfaction.

Carolyn: Absolutely. Absolutely. And not just—often we'll get the referral for feeding or swallowing difficulties, and certainly that's an interaction. And I will be able to watch and read for cues when the patient may be ready or when they're not. But taking that perspective shift to those other remaining abilities in terms of facilitating voicing and expression, and so maybe it is the pictures in the room. For the families often at that level, they know how to—what might still be meaningful there, what will engage. And helping them to provide that in the way that they can understand and engage the patient is really helpful.

Terry: I would imagine that—that just impressing upon somebody the value of that sort of engagement with their loved one is a huge win for the quality of life for everyone concerned in this scenario.

Carolyn: Yes, yes. And I certainly—you know, I believe the patient and the family benefit there just—it's a huge role that we can have that I certainly am challenging myself to use as much as I can. This training gave me that, certainly.

Terry: All right. Would you recommend dementia care therapy training to other clinicians and mentors?

Carolyn: Yeah, absolutely. It helped me to become a more functional and positive therapist. We all became therapists because we wanted to help other people. And this training really has given me tools to help people remain as functional as possible during a progressive disease that affects a lot of people. And so, certainly as a mentor, I think this training is so valuable. Now, you know, when a therapist tells me that they have a challenging patient with dementia, my first question is "Well, let's talk about what the patient can do." And with that approach, we are set for a better outcome, absolutely.

Terry: Excellent. Well, thank you, Carolyn. Do you have any last thoughts that you'd like to share with us today?

Carolyn: I really appreciate talking with you. This training is something I go back to a lot, to use the resources both as my manual and my notes, and even the resources online to be able to give family members and other team members information. So it's been something I'm very grateful that I had the opportunity to do.

Terry: Excellent. And we were very grateful that you took time out of your day today, Carolyn, to speak to us. Our guest today on *Unrestrained* has been Carolyn Garrett. She's a speech-language pathologist with Tender Touch Rehab Services, Lakewood, New Jersey. Carolyn, thank you.

Carolyn: Thank you, Terry.

Terry: All right. And thank you for listening.