ACFI Informed Education Tool (ACFIIET):

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The views expressed in this work are the views of its author/s and not necessarily those of the Commonwealth of Australia. The reader needs to be aware that the information in this work is not necessarily endorsed, and its contents may not have been approved or reviewed, by the Australian Government.
The Aged Care Funding Instrument (ACFI)-informed education tool (ACFliET) was developed after an initial review of the pre-test ACFI-BEH data and care plans for participating residents. A team of aged and dementia care experts worked in collaboration to develop a clinical pathway that facilitates the use of the ACFI in care planning and the development of management strategies to address identified behavioural and psychological symptoms of dementia (BPSD).

The ACFliET was developed utilising the philosophy of person centred care (PCC) framework and comprised of five components:

i) Viewing the DVD “Understanding the Brain and Behaviour” (Alzheimer’s Australia) which aims to provide a better understanding of the connection between the damage occurring in the brain and the behaviour and abilities of people with dementia;

ii) A one hour presentation on dementia, need driven behaviour (NDB) and PCC delivered by a Clinical Nurse Consultant (CNC);

iii) Four hours of training for staff involved in care planning on the assessment of BPSD symptoms and care plan prevention/management strategies delivered by an expert in PCC and management of BPSD. A resident behaviour management plan chart, which included four key components (resident’s medical and life history, identification and assessment of behaviour, assessment of needs and management and intervention) was utilised to facilitate this process.

iv) Algorithm: This algorithm consists of both immediate and preventative/on-going management strategies for the four ACFI-Behaviour domains; wandering, aggression (physical and verbal) and depression (see attachment). Depending on the individual needs of each of the residential aged care facilities (RACF) copies of the Algorithm were stored either in the residents file or at the Nurses station.

v) Resource Cards (A5 size- see attachment) which summaries key resources and outlines strategies on how to:
   a. Implement person centre care;
   b. Identify BPSD;
   c. Identify possible triggers; and
   d. Ideas for behavioural strategies.

The Resource Cards were given to staff members and encouraged to carry them during their shift.

Each of the five components was implemented consecutively at each of the sites over an eight to twelve week period. Table one described staff participation rates.

Table 1: RACF staff member participation in ACFI-informed education tool (ACFliET)

<table>
<thead>
<tr>
<th>Number and type of beds</th>
<th>Information Session*: Algorithm and Resource Cards</th>
<th>DVD*</th>
<th>One hour presentation*: BSPD, NDB and PCC</th>
<th>Assessment and Care Planning Training**</th>
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</thead>
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<tr>
<td></td>
<td>1 session 2 sessions</td>
<td></td>
<td></td>
<td>1 session 2 sessions</td>
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<tr>
<td>Facility 1</td>
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<td>16</td>
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<tr>
<td>Facility 3</td>
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<td>1</td>
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<tr>
<td>Total</td>
<td>74</td>
<td>110</td>
<td>83</td>
<td>11</td>
</tr>
</tbody>
</table>

1 ACFI-BEH – measures levels of care needs in terms of cognitive skills, wandering, verbal behaviour, physical behaviour and depression


Feedback on the content and usefulness of the Algorithm and Resource Cards was sought. However, feedback was provided from only one site. This site reported positively on the content and use of information and strategies.

**Notes:**

Key factors that determine success of the implementation have been identified including support and active engagement of management and their capacity to engage RNs and other clinical leaders in the project.
Management of Physical & Verbal Behaviours (ACFI Physical & Verbal Behaviour B,C or D)

Preventive and on-going Management

Does Resident have Behaviour Management Chart for Physical & Verbal Behaviours?

YES

Use Behaviour Management Chart
Use key principles & communication strategies

NO

Start Behaviour Management Chart - "Teamwork"
- Describe behaviour
- Find out about life and medical history - speak to family and friends; review behaviour and clinical charts
- Identify triggers & needs (physical, emotional, interactional, environmental)
- Plan strategies (use PERSON tool*)
Use key principles & communication strategies

Look out for any changes: Is this usual behaviour of Resident?

YES: Use Behaviour Management Chart
NO: Identify triggers and needs (physical, emotional, interactional, environmental) and review personal life history
Plan strategies (use PERSON tool*)

Reflect on and record the incident
Debrief and discuss with colleagues
Plan for further management - are changes needed?
Revise Behaviour Management Chart if necessary

KEY PRINCIPLES

✓ Go slow
✓ Give them space
✓ Know Resident
✓ Be respectful
✓ Maximise independence
✓ Make eye contact
✓ Involve in meaningful activities
✓ Don’t argue
✓ Don’t ask too many questions
✓ Show genuine interest and concern
✓ Avoid excess stimulation

COMMUNICATE IN A CALM, NON-CONFRONTING WAY (verbal & non-verbal)

✓ Speak gently
✓ Use simple sentences and questions
✓ Look for signs of agitation
✓ Tell Resident what you are going to do
✓ Wait 9 seconds for Resident to respond
✓ Try not to reason with Resident
✓ Reassure Resident
✓ Be empathetic; validate feelings e.g. "I can see you are angry"
✓ Give Resident time to talk about their feelings
✓ Ask questions to identify immediate needs (e.g., hungry, thirsty, in pain, fearful, sad, lonely)
✓ Observe body language
✓ Find and use distraction

*PERSON tool: Strategies addressing Physical, Emotional, Relational, Surroundings, Occupational, & Neurological needs
Acknowledgement: This algorithm has been developed using materials from Alzheimer’s Australia NSW, The EN_ABLE education program, The ReBOC guide, The A-B-C model, Loveday et al. (1998), Merrett (2003), and The TECH approach to dementia care.
For details of the references, please refer to the full reference list in the ACFIDELITI Resource Cards.
Management of Physical & Verbal Behaviours (ACFI Physical & Verbal Behaviour B,C or D)

For Immediate Management

Check Safety
Is there an immediate risk of harm to themselves or to others?

YES
NO

Protect yourself and others: Call for help; Distance yourself; Report to supervisor

- Assess and secure the immediate environment
- Remove potentially harmful objects
- Remove other people from danger
- Give the resident space and time to settle down, observe and monitor the situation
- Listen to the resident. Ask what their concerns/issues are and meet needs

Look out for any changes: Is this usual behaviour of the resident?

YES: Use Behaviour Management Chart
NO: Identify triggers and needs (physical, emotional, interactional, environmental) and review personal life history
Plan strategies (use PERSON tool*)

Has the management worked?

YES
NO

Reflect on and record the incident
Debrief and discuss with colleagues
Plan for further management - are changes needed?
Revise Behaviour Management Chart if necessary

Back away
Give them time and space - Come back later

COMMUNICATE IN A CALM, NON-CONFRONTING WAY
(verbatim & non-verbatim)

- Speak gently
- Use simple sentences and questions
- Look for signs of agitation
- Tell the resident what you are going to do
- Wait 9 secs for Resident to respond
- Try not to reason with him/her
- Reassure Resident
- Be empathetic; validate feelings e.g. "I can see you are angry"
- Give the resident time to talk about their feelings
- Ask questions to identify immediate needs e.g., hungry, thirsty, in pain, fearful, sad, lonely
- Observe body language

KEY PRINCIPLES

- Go slow
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Management of Wandering (ACFI Wandering B,C or D)

Preventive and on-going Management

Does Resident have a Behaviour Management Chart for Wandering?

YES

Use Behaviour Management Chart
Use key principles & possible strategies

NO

Start Behaviour Management Chart - "Teamwork"
- Describe behaviour
- Find out about life and medical history - speak to family and friends; review behaviour and clinical charts
- Identify triggers & needs (physical, emotional, interactional, environmental)
- Plan strategies (use PERSON tool*)

Use key principles & possible strategies

Look out for any changes: Is this usual behaviour of Resident?

YES: Use Behaviour Management Chart

NO: Identify triggers and needs (physical, emotional, interactional, environmental) and review personal life history
Plan strategies (use PERSON tool*)

Reflect on and record the incident
Debrief and discuss with colleagues
Plan for further management - are changes needed?
Revise Behaviour Management Chart if necessary

KEY PRINCIPLES
- Contain wandering
- Promote safety
- Aid navigation
- Minimize restrictions
- Support abilities
- Distract Resident
- Provide physical and emotional comfort
- Encourage appropriate social interactions

POSSIBLE STRATEGIES
- Engage them in activities they like
- Remove items which may trigger the desire to go out (e.g. handbag, hat, jacket, shoes for outings)
- Camouflage entrance or exit
- Make doorways less obvious
- Provide walking tracks
- Use door alarms or electronic monitoring devices
- Use fencing and security gates

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Management of Wandering (ACFI Wandering B,C or D)

Immediate Management

1. Is Resident exiting, eloping or getting lost?
   YES
   - Promptly respond to alarms
   - Recognise absence, rapidly locate and return to supervised care
   - Assess health
   - Assess and secure immediate environment to prevent further risk

   LOOK OUT FOR ANY CHANGES: IS THIS USUAL BEHAVIOUR OF THE RESIDENT?
   YES: Use Behaviour Management Chart
   NO: Identify triggers and needs (physical, emotional, interactional, environmental) and review personal life history
   Plan strategies (use PERSON tool*)
   Use key principles

2. Is Resident lingering near exit; Trespassing; stating intent to leave or preparing to leave?
   YES
   - Redirect using verbal and non-verbal cues & diversion
   - Conceal cues for leaving
   - Alert staff of heightened risk - intensify supervision
   - Use wandering registry

3. Is Resident excessively wandering, which disrupts necessary ADL; losing one’s way indoors?
   YES
   - Engage in meaningful activities
   - Use diversion; verbal re-direction
   - Train Resident to use same route
   - Give Resident finger food/drink to prevent dehydration and hunger

Reflect on and record the incident
Debrief and discuss with colleagues
Plan for further management - are changes needed?
Revise Behaviour Management Chart if necessary

KEY PRINCIPLES
- Contain wandering
- Promote safety
- Aid navigation
- Minimize restrictions
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- Distract the resident
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Preventive and on-going Management

Does Resident have Depression Management Chart?

YES

Start Management Chart - "Teamwork"
- Describe Resident's depression - conduct or review Cornell Depression Scale for Dementia
- Find out about life and medical history - speak to family and friends; review behaviour and clinical charts
- Identify triggers & needs (physical, emotional, interactional, environmental)
- Plan strategies (use PERSON tool*)

NO

Use Depression Management Chart
Use key principles & possible strategies

Look out for any changes: Is this usual behaviour of Resident?

YES

Use Depression Management Chart
Use key principles & possible strategies

NO

• Identify triggers and needs (physical, emotional, interactional, environmental)
• Review personal life history
• Plan strategies (use PERSON tool*)
• Medical / psychological assessment
• Supportive psychotherapy
• Plan for alternative therapies: Talk therapies; Reminiscence; Music; Art

Reflect on and record the incident
Debrief and discuss with colleagues
Plan for further management - are changes needed?
Revise Management Chart if necessary

KEY PRINCIPLES
- Listen
- Use clear and simple communication
- Allow 9 seconds for responses
- Know Resident
- Be non-judgemental
- Give support and positive assistance
- Take an interest
- Talk to Resident

POSSIBLE STRATEGIES
- Keep to a daily routine
- Offer activities that Resident has enjoyed in the past
- Have realistic expectations of what Resident can do
- Do important tasks when Resident is least fatigued
- Promote use of glasses/hearing aids
- Reduce isolation while maintaining privacy
- Be positive, frequently praise & encourage efforts
- Facilitate socialising, but don’t force it
- Promote independence
- Ensure appropriate diet and rest

*PERSON tool: Strategies addressing Physical, Emotional, Relational, Surroundings, Occupational, & Neurological needs

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Management of Depression (ACFI Depression B,C or D)

Immediate Management

**Check Safety**
Is there an immediate risk of self harm/ suicide?

- **YES**
  - Promptly respond
  - Assess and secure the immediate environment to prevent further risk
  - Seek assistance; Contact supervisors

- **NO**
  - Is there evidence of suicidal thought or plans? e.g. Saying 'life is not worth living'
    - Notify appropriate staff to ensure safety
    - Make the environment safe
    - Medical /Psychological assessment
    - Supportive psychotherapy
    - Plan for alternative therapies: Talk therapies; Reminiscence; Music; Art
    - If unsuccessful: Specialist review, refer to BASIS

  - Reflect on and record the incident
  - Debrief and discuss with colleagues
  - Plan for further management - are changes needed?
  - Revise Behaviour Management Chart if necessary

  - Look out for any changes: Is this usual behaviour of the resident?
    - **YES**: Use Depression Management Chart
    - **NO**: Identify triggers and needs (physical, emotional, interactional, environmental) and review personal life history
      - Plan strategies (use PERSON tool*)
      - Use key principles and possible strategies

**KEY PRINCIPLES**

- ✓ Listen
- ✓ Use clear and simple communication
- ✓ Allow 9 seconds for responses
- ✓ Know Resident
- ✓ Be non-judgemental
- ✓ Give support and positive assistance
- ✓ Take an interest
- ✓ Talk to Resident
- ✓ Validate their feelings/emotions

**POSSIBLE STRATEGIES**

- ✓ Keep to a daily routine
- ✓ Offer activities that Resident has enjoyed in the past
- ✓ Have realistic expectations of what Resident can do
- ✓ Do important tasks when Resident is least fatigued
- ✓ Promote use of glasses/hearing aids
- ✓ Reduce isolation while maintaining privacy
- ✓ Be positive, frequently praise & encourage efforts
- ✓ Facilitate socialising, but don’t force it
- ✓ Promote independence
- ✓ Ensure appropriate diet and rest

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RESOURCE CARD

PERSON CENTRED CARE
FOR PEOPLE WITH
BEHAVIOURAL DISTURBANCES ASSOCIATED WITH DEMENTIA

Resource produced as part of ACFI instructed DEmentia Learning and Information Trial Initiative (ACFIiDELITI)
Care Planning: What should I consider in planning the person's care?

Care planning is an integral part of person-centred care. It is important that care plans are positive and consider the perspective of the resident with dementia. Things to consider when developing a care plan are the residents:

- Likes and dislikes
- Previous and current lifestyle (including culture, religion and sexuality)
- Interests, past and present
- Strengths and abilities
- Difficulties and disabilities
- Psychological, social, emotional, spiritual and physical care needs
- Positive ways of responding the challenging behaviour

(Person-centred care in practice: What do people with dementia need us to do?

People with dementia need us to:

- Understand what reality is for them
- See past their disability and find their strengths
- Relate to them as one human being to another
- Help them hold on to and express their individual and cultural identities
- Help them to make the most of their strengths and abilities
- Help them to be as independent as possible while depending on us for any assistance they need
- Enable them to make choices and take reasonable risks
- Help to compensate for the effects of their dementing illness
- Help them to feel included and stay part of the social world
- Help them to feel respected, valued and wanted
- Help them to feel safe and secure
- Support them while they express their feelings
- Make an effort to understand their communication and help them to understand us
- Treat them as we would wish to be treated ourselves

(Person-centred care in practice: What do people with dementia need us to do?

People with dementia need us to:

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- Help them to feel respected, valued and wanted
- Help them to feel safe and secure
- Support them while they express their feelings
- Make an effort to understand their communication and help them to understand us
- Treat them as we would wish to be treated ourselves

(Loveday, Kitwood and Bowe, 1998, p.3.5)
To successfully support the resident with dementia it is important to obtain information about their personal life history.

1. How does he/she like to be called (e.g. Mrs...., first name, nickname, etc)?
2. Where was he/she born?
3. Does he/she have religious beliefs?
4. What did his/her parents do for a living?
5. Where did he/she go to school? Did he/she like school?
6. Does/did he/she have any brothers or sisters? What are/were their names?
7. Does/did he/she have any special friends? What are/were their names?
8. Did he/she get married or have a long-term partner? What is/was their name?
9. Did he/she have any children? Is so, what are their names?
10. What did he/she do for a living?
11. What is the favourite place that he/she has lived in?
12. Has he/she ever had any pets?
13. What is his/her favourite food?
14. What is his/her favourite drink?
15. What is his/her favourite type of music or song?
16. What are his/her favourite clothes?
17. What are or were his/her hobbies or interests?
18. What was his/her favourite holiday or day out?
19. Is there anything he/se has achieved in their life (big or small) that they are proud of?
20. What sorts of things make him/her laugh?
21. What sorts of things make him/her angry?
22. What sort of things can make him/her feel embarrassed?
23. What sort of things can make him/her feel upset?
24. What, if anything does he/she worry about?
25. What are his/her favourite toiletries/perfumes?
26. What is/are his/her favourite colour(s)?
27. What helps him/her to relax?  

(Loveday et al, 1998, p.3.3)
“Problem behaviour” is nearly always an attempt at communication, usually related to feelings, needs and wishes. Rather than trying to stop the behaviour, try to interpret its message.

It is important to consider the following when supporting the person with dementia:

- In order to be effective and caring when responding to behaviour which is challenging, it is helpful if we know as much as possible about him/her and their history.
- In the face of any behaviour we must be clear about exactly why it’s a problem and who is it a problem for.
- The response to a resident’s behaviour should focus on meeting their needs, not “managing” their behaviour.
- We should avoid the use of medication to try to control his/her behaviour since all it usually does is squash the message that are trying to communicate – it does not usually address their needs and it often causes negative side effects.
- We need to have a keen awareness of what is happening around the resident and how these different factors can contribute to any given situation.
- We need to be aware of what we contribute to any situation – are they frightened, upset or embarrassed by the resident’s behaviour, or has the carer inadvertently done something to provoke it? If so, apologise.
- Our experiences with each individual can teach other staff new ways of responding and meeting needs. We can use this knowledge to expand our thinking and problem solving resources.
- Feelings can be uppermost for the resident and are often the main route of communication. If we fail to respond to the message they can be the ones to create the problem.
- We must be aware of the fact that the resident is constantly living with the difficulties which his/her disability causes; his/her emotional response to their disability (e.g. frustration) will often be reflected in their behaviour.
- However well we care for someone they may not be able to understand their behaviour or respond in a way that seems to make a difference. However, we must keep striving to understand, meet their needs and help each individual achieve a sense of well-being.
- We must demonstrate a willingness to become closely involved and be capable of offering emotional and practical help in a sensitive, creative, flexible and loving way.
- We can be most effective in helping someone express their feelings if we empathise and demonstrate that we are interested and caring about his/her experiences and feelings.

\(\text{(Loveday et al, 1998, p.5.4)}\)
Communication Strategies: How should we communicate with the resident?

How can we understand what he/she is trying to convey to us?
- Observe and listen to everything that he/she is saying, doing and expressing. Look for any possible underlying meaning/message, especially when words are unclear or incorrect.
- Pay particular attention to all non-verbal language, including tone of voice, posture and facial expression.
- Get to know everything we can about the resident - the more we know, the easier it will be to pick up on what they mean. If he/she may difficulty finding words, encourage then to use gestures to demonstrate what they mean.
- As we are attempting to understand what the resident is trying to convey to us, it is often possible to make guesses about what they might mean and then check that the guesses out with them - their response may show us if we are right and if not, we can try again.
- Residents can often communicate what is going on for them by expressing their emotions, so carers should encourage this expression. Carers should never try to stop a resident showing what they feel, unless they are creating danger for themselves or others.

How can I help a resident to understand what I am trying to communicate to them?
- Make sure that we can be seen clearly. (Is the resident wearing their glasses?)
- Make sure that we can be heard. (Is there a lot of background noise? Is the resident’s hearing air working? Are we close enough to him/her?)
- Be at the same physical level as the resident (i.e. sitting or standing). Try to make eye contact.
- Use his/her name.
- Use touch when appropriate and acceptable.
- Speak clearly and slowly.
- Use gestures and body language which help to back up what we are saying.
- Use phrases and expressions which are familiar to the resident we are talking to.
- Be sure to give him/her any information they may need to know – e.g. who are we.
- We need to be prepared to repeat what they are saying as many times as the resident may need to hear it. If necessary, try rephrasing it. It might take him/her quite a while to understand what we mean.
- Be concise and to the point. Keep sentences short and only make on point at a time.
- Make sure that he/she has as much time as they need: if they feel rushed, it can often make it harder for them to understand.

(Loveday et al, 1998, p.4.2)
General behavioural triggers:

What triggers behaviour? What should I look for? How do I look for triggers?
When looking for behavioural triggers it is important to consider the affect that the individual, the interaction between the individual and others and environment has on behaviour. Therefore, it is important to consider the following:

(Colour Code: black = general factors, red = factors associated with aggression, green = factors associated with wandering)

Personal Factors:
- Cultural background/values/language
- Social history
- Impact of changes to family or work roles
- Personality traits
- Tiredness/sleeping problems
- Hungry/thirsty
- Impact of feelings (frustration, sadness, anger, grief)
- Pain/discomfort
- Hearing problems/hearing impairment
- Eye problems/visual impairment
- Infections/new illness
- Physical movement problems
- Incontinence issues
- Poor dental health
- Blood pressure (high or low)
- Pre-existing illness
- Medication side effects and interactions
- Non-compliance with or incorrect medication dose
- Progression of dementia
- Effects of dementia
- The person might be feeling unheard or misunderstood.
- The person might be feeling threatened or frightened.
- The person might be feeling lonely or bored.
- The person might be feeling restless, in need of exercise, or might simply enjoy walking.
- The person might be having delusion or hallucination, which could have a physical cause.
- The person might accuse others of stealing, hiding or tampering with something because they find it too painful to accept that they have forgotten where they put it.
- The person might be expressing a deep sense of insecurity, mistrust or unhappiness.
- The person may not have any opportunity for appropriately expressing their sexuality, perhaps because they no longer have a sexual partner.
- The person may have lost their inhibitions which would have previously prevented them from acting on sexual desires.
- The person may be looking for closeness, affection or acceptance.
- Reduced stress threshold
- The person might be lost and trying to find their bearings.
- The person might be looking for someone or something (which may or may not be there).
- The person might be reliving an old routine.
- The person might be trying to cope with troubling emotions of physical pain.
- The person might be lonely or bored.
- The person might be feeling restless, in need of exercise, or might simply enjoy walking.
Interaction between the individual and others:

- Poor verbal communication (speaking too fast, slurring works, mumbling)
- Language too complex (confusing)
- Language demeaning and condescending
- Not enough information and prompting given
- Poor eye contact
- Hostile or defensive tone
- Hostile or defensive body language (gestures and stance)
- Inappropriate or misunderstood verbal or non-verbal cues
- Personal space invaded
- Tasks or activity too complex
- Task or activity demeaning
- Changed to routine or activities
- Social isolation or too much socialisation
- Minimal activity/overwhelming levels of activity
- Unfamiliar people/carers

- Cultural or religious influences not considered
- Preferred language not used
- Feelings of person with dementia not acknowledged
  (red = factors associated with aggression)
- The person might be asserting their own wishes when others are trying to make them do something they don’t want to do.
- The person might have forgotten crucial information such as agreements that have been made, or who the caregiver is.
- Too many questions/questions beyond resident’s capabilities
- Being stopped from what they are doing
- Altered routines

Environmental Factors:

- Unfamiliar surroundings
- Too much noise (TV or radio left on, engine sounds and building sounds)
- Competing noise
- Too much clutter and dangerous obstructions
- Visual distractions (patterned carpet)
- Poor lighting (glare from reflective surfaces, confusing shadows or shapes)
- Decor and fittings confusing
- Lack of visual prompts (e.g. not obvious where toilet is located)

- Visual prompts that cue unwanted behaviour (e.g. coats or hats hung by the door which cue people to go out)
- Unsafe environment
- Uncomfortable temperature (hot/cold)
- Lack of personal belongings
- Culturally inappropriate environment
- Lack of privacy and personal space
- Environment not sensitive to perceptual changes of dementia

Interaction between the individual and others:

- Poor verbal communication (speaking too fast, slurring works, mumbling)
- Language too complex (confusing)
- Language demeaning and condescending
- Not enough information and prompting given
- Poor eye contact
- Hostile or defensive tone
- Hostile or defensive body language (gestures and stance)
- Inappropriate or misunderstood verbal or non-verbal cues
- Personal space invaded
- Tasks or activity too complex
- Task or activity demeaning
- Changed to routine or activities
- Social isolation or too much socialisation
- Minimal activity/overwhelming levels of activity
- Unfamiliar people/carers

- Cultural or religious influences not considered
- Preferred language not used
- Feelings of person with dementia not acknowledged
  (red = factors associated with aggression)
- The person might be asserting their own wishes when others are trying to make them do something they don’t want to do.
- The person might have forgotten crucial information such as agreements that have been made, or who the caregiver is.
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(ReBOC, 2003, p.13; Loveday et al, 1998, p. 5.3; EN-ABLE, slide 7&15)
General behaviour strategies: What strategies can I use to support the resident?

Alzheimer’s Australia NSW describes the following strategies as examples for managing the behavioural symptoms of dementia:

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<td>• Meaningful activity (e.g. gardening, regular exercise)</td>
<td>• Do not overreact or confront the person</td>
</tr>
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<td>• Use intact skills and abilities</td>
<td>• Respond calmly and firmly</td>
</tr>
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<td>• Routine</td>
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</tr>
<tr>
<td>• Distraction</td>
<td>• Offer privacy</td>
</tr>
<tr>
<td>• Diversion</td>
<td>• Remove</td>
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<tr>
<td>• Socialisation</td>
<td>• Meet basic needs</td>
</tr>
<tr>
<td>• Avoid fatigue</td>
<td>• Style of bathing (e.g. thermal bath – use of wash cloth, hot water and sproam (non rinse skin cleanser), towel bed bath – use towel to cover residents body, use non rinse soap to wash body with wash cloth)</td>
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<td>• Simple steps</td>
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</tr>
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</tr>
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Summary of behaviour management strategies:

Aggression:

How can I assess the resident’s aggressive behaviour?

• Assess for the presence of any contributing factors/triggers.
• Assess the resident’s health status.
• Check the resident’s medicines to see if either single drug or any combination of drugs might be contributing to the aggression.
• Check the resident’s vision and hearing as impairment may be contributing to behaviour.
• Using the Cohen Mansfield Agitation Inventory (CMAI)- Long Form to assess the level of agitation and to monitor change over time.
• Explore the background to the aggression – what happened previously
• Times/dates incidents occur
• People involved
• Identify if any pattern

(EN-ABLE, slide 9 &22)
What strategies can I use when a resident is being aggressive?

The following are possible strategies for the management of aggression:

- Know the resident.
- Be respectful; maximise ability and independence.
- Minimise unexpected activity/noise.
- Involve the person in activities that are meaningful to them.
- Avoid excess stimulation.
- Keep calm and try to convey tenderness and caring.
- If necessary, reassure him/her that they will not be harmed.
- Give him/her plenty of personal space. Don’t try to move them. If appropriate and possible, make sure that other resident draw back and do not get involved.
- Ask him/her what is troubling them. Try to identify the reason for their behaviour and what they are trying to communicate through it.
- Use skills of listening and empathy to encourage him/her to express their feelings verbally and find ways of showing the person that you empathise.
- If he/she is angry because they believe something isn’t true (e.g. a resident believes she hasn’t been given anything to eat for two days) it might help if you give them information about the truth. But if this doesn’t seem to be helping, don’t persist with it or you might just end up making the person angrier. It is much more important to show that you understand and believe their feelings.
- If you realise that he/she is angry or distressed because of something you have done apologise.
- Is there any practical solution to what he/she is expressing? (e.g. if they are frustrated be their dependence on others, you could help them find things they could do independently).
- Having worked through the above points, it may be possible to find alternative uses of his/her energy.
- Once he/she has calmed down, see if there is any more they can tell you about what caused their strong feelings – this might help you avoid such situations in the future.

(Loveday et al, 1998, p. 5.7, EN-ABLE, slide 18)

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(Loveday et al, 1998, p. 5.7, EN-ABLE, slide 18)
More specific strategies to particular situations include:

Resistance to personal care:
- Keep routine as familiar as possible for the resident: e.g. showering at a certain time of the day
- Provide a couple of options about how tasks may be competed: e.g. wearing a red dress or blue dress
- Break down and simplify tasks: e.g. place clothes to be worn in dressing order
- Encourage him/her to maintain their independence and provide prompts when required to initiate task: e.g. place flannel in hand to prompt washing

Sexually inappropriate:
- Consider all the possible reasons for this behaviour: e.g. sexually related or the needs to go to the toilet, discomfort, pain
- Reinforce who you are and why you are there. Consider wearing a uniform and name badge
- Try to gently discourage the behaviour: e.g. distract or redirect the person to another activity
- Consider other ways in which he/she can receive physical contact: e.g. massage, holding hands

Socially inappropriate:
- Gently remove the resident if in a public area and change activities
- Ignore the behaviour and involve him/her in another activity
- Keep calm and respond in a calm manner
- Inform (when appropriate) recipient of the behaviour that he/she has an illness which causes this type of behaviour; e.g. use of a small standard card with this information written on it.

(ReBOC, 2003, p. 15-16)
What strategies can I use if a resident is at risk of harming himself/herself or others?

- We may need to take steps to protect themselves or others – e.g. getting help from a colleague. But, we should never forget that they are dealing with someone who is very confused and distressed. Make sure that the resident does not end up feeling that carers are attacking them.
- We need to make sure that they have nothing visible which could be potentially harmful if the resident were to grab it.
- Speak gently and in a matter of fact manner. If the resident is attacking someone else, carer to explain that they are going to separate them from the other person, keep talking to the person, telling them what you are doing so that you minimise the risk of misunderstandings. Alternatively, it may help if you can find a temporary distraction.
- We need to do all that we can to encourage the resident to express their feelings verbally, rather than physically.
- If the resident remains agitated or does not wish to talk, back away and give them room and time. After a while, we should try again to make contact with the resident and see how we can help. (Loveday et al, 1998, p. 5.7)

What strategies can I use when a resident is being verbally aggressive?

- Check that he/she is comfortable: e.g. not in pain or discomfort
- Give reassurance: e.g. verbally say who we are, why I am there and what I am doing
- Minimise noise and over stimulation: e.g. turn down radio, limit the number of people present
- Distract by involving in an activity which they like and are capable of undertaking: e.g. drying dishes, playing cards, reminiscing
- Holding hands
- Allow the resident some ‘time out’ to meet this perceived or real sexual need: e.g. give the person some privacy (ReBOC, 2003, p. 15)

What strategies can I use when a resident is being physically aggressive?

- Check safety and risk of harm: e.g. remove self and others from a dangerous situations
- Allow time for him/her to settle down, observe and monitor the situation
- Keep the resident informed: e.g. who you are, where the carer is
- Try not to reason with him/her as they may not be able to comprehend what is happening
- Keep in mind communication techniques to avoid further confusion; e.g. speak in a calm manner, ensure that short, simple sentences and questions are used (ReBOC, 2003, p. 15)
Wandering:

How can I assess the resident’s wandering behaviour?

- Identify contributing factors/triggers
- Asking whether there is a history of wandering
- Assessing the level of risk posed by the wandering
- Identifying the type and intensity of the wandering
- Identifying the pattern associated with the wandering

What strategies can I use if a resident is wandering?

Possible management strategies include:
- Ask him/her where they are going and use this information to develop ‘distracting’ strategies
- Check if there is a pattern from the wandering; e.g. occurs at certain times of the day, when they are upset or inactive
- Remove items which may trigger the desire to go out: e.g. coat, bag
- Reassure him/her frequently about where they are and why they should stay (note from carer or GP may help)
- Use of distraction techniques by involving him/her in a task which they like doing
- Provide walking tracks for residents to enjoy wandering
- Camouflage all by one main point of entrance or exit. Camouflage may include curtains over doors or full length mirror being attached to the door.
- Discourage residents from entering particular areas by making the doorway less obvious. This can be done by painting the door the same colour as the walls, making them appear to be part of the wall. Alternatively, encourage residents into particular areas by making a doorway stand out with the use of bright contrasting paint
- Use door alarms to alert staff that a resident has opened a door leading to an unsafe area
- Use discerned electronic monitoring devices, attached to the resident, to alert staff if the resident passes beyond a particular area
- Use fencing and security gates on the perimeter of the site; to confine residents who are at risk of harm should they wander beyond the premises. Fences and gates can appear less obvious by the use of creative landscaping.
- Appropriate security measure may include the use of tamper proof locks which are out of sight or disguised and complex to open.
- Give the resident some finger food and a drink to ensure that they do not get dehydrated/hungry.  
  (ReBOC, 2003, p.16; TECH)
Depression:

What are the key features of depression?

Depression is a pervasive and persistent change in mood characterised by depressed mood and loss of interest or pleasure in life. The key features include:

- Depressed mood
- Loss of interest
- Loss of energy
- Reduced concentration
- Reduced self esteem
- Guilt
- Pessimism
- Tendency to underestimate cognitive functioning
- Altered sleep
- Decreased appetite
- Irritable and/or easily frustrated
- Self harm/suicide
- Psychotic features

(Merrett, 2003)
What does a depressed person look or act like?

- Poor eye contact
- Sad face, no smiles, mouth turned down, or blank expression. Some may hide their sadness.
- May act as if irritable
- May look untidy, unshaven or not made up
- Talk and move slowly (or be very agitated and restless)
- Cry, call out
- Ask for help
- Act distressed and fearful
- Say they want to die, complain of being worthless, helpless, hopeless
- Say they feel guilty
- Complain about pain or illness
- Complain about poor memory or concentration
- In very severe cases they may lose touch with reality (seeing or hearing things which are not there or having beliefs which are not based in reality)

(Merrett, 2003)
Management strategies:

Management of depression will vary for each individual, however, some possible management strategies include:
- Medical assessment
- Supportive psychotherapy
- Exploration of family and social circumstances
- Management of anxiety
- Medication

What can I do to support a resident with depression?
- Listen
- Use clear, uncomplicated communication and allow time for responses
- Ask simple question that only need a brief response
- Be non-judgemental in your approach
- Identify if there is evidence of suicidal thought or plans – notify appropriate staff to ensure the safety of the person
- Notify appropriate management regarding observations of signs of depression
- Make the environment safe
References:


