HALT UPDATE

We have now passed the halfway point in the project which is a tremendous milestone. We have over 100 residents involved across the 23 HALT aged care facilities and have recently completed the 12 month follow up on our first HALT participant. This is a really exciting time for the project as we begin to see the positive and sustainable effects of deprescribing for HALT participants.

In addition to talking to aged care facilities, GPs and residents and families about the project, it is important to take opportunities to share information from this project with fellow researchers. Recently, our research psychologists Fleur and Monica attended and presented at the Alzheimer’s Disease International conference in Perth. They spoke about the project and took questions from nurses and care workers about how to manage challenging behaviours without the use of antipsychotic medication. Family members of persons with dementia shared the stories of their loved ones who have been prescribed antipsychotic medications, and the detrimental impact this has had on their health.

In September, the Dementia Collaborative Research Centres will host the National Dementia Research and Knowledge Translation Forum 2015 in Sydney. This will be an exciting 2-day event, with one day dedicated to research presentations and the second day all about how we can translate research knowledge into policy and practice. For more information about this forum please go to www.dementiaresearch.org.au/forum2015

Finally, in October, the International Psychogeriatric Association (IPA) will hold their annual conference, this year in Berlin. We have been invited to give an oral presentation at this conference to talk about early results from our project and the benefits we have seen for many participants. This is a fantastic forum to network with researchers, and get new ideas and direction from international peers about how we can improve on what we are doing.

We would also like to welcome a new collaboration with medication management experts at WebsterCare. In partnership with WebsterCare, we will be looking at patterns of psychotropic medication use more broadly across aged care facilities to try and identify opportunities for education and improved use of these medications.

Best wishes,

Tiffany Jessop
(HALT Project Coordinator)
**FOCUS ON PERSON CENTRED CARE**

“Person Centred Care” (PCC) is a buzz term thrown around haphazardly in residential aged care because it is the model of care considered ‘best practice’. It is also the standard of care set by the government, and therefore all accredited aged care facilities must report its practice; however, there are different perspectives about what constitutes PCC, and whether it is “being done”.

**What is a PCC?**

PCC is an approach to care that assesses each resident as an individual and tailors care approaches to account for a person’s life history, culture, spirituality, values and preferences – there is no ‘one size fits all’. It is an interactive process and a partnership between the person with dementia, the family and care staff which is mutually beneficial and an enriching experience for all parties. Person-centred approaches to dementia care are based on the notion that the unique identity, personality and subjective reality of person living with dementia remain, despite the presence of a disease process (Kitwood, 1997). This approach enables carers to interpret the behaviours of a person with dementia, not as a function of their illness, but rather as a response to what is happening to and occurring around them in their psychosocial environment. For this reason, the PCC model proposed by Kitwood rejects the term “Behavioural and Psychological Symptoms of Dementia (BPSD)” which medicalises the person’s reaction to a situation. Instead, the preferred term is “need driven behaviour”. Agitated behaviours and anxiety, aggression, wandering, noisiness and apathy most often occur when aspects of the person's bio-psychosocial needs are not being fully met. When carers reduce/remove these sources of stress, and provide care which seeks above all else to meet the person's bio-psychosocial needs, behavioural symptoms will in most cases be reduced or eliminated (Chenoweth L, 2015). Care staff can underestimate the impact of their own actions on a residents’ wellbeing and consequently their behaviour. A gentle, considered approach that promotes feelings of safety, enablement and independence, making the most of a person’s remaining abilities can have a remarkable impact on quality of life (diagram and content below from Prof L Chenoweth).
Achieving these desirable outcomes is not only a matter of individuals learning the skills of PCC. It requires senior and middle management leadership to address the structural barriers that prevent the adoption and maintenance of a system-wide person-centred service.

The core concepts to be supported across every department and at every level of the organisational are described in the VIPS model (Røsvik, Brooker, Mjorud & Kirkevold, 2013), which encompasses:

**Valuing:** a value base that asserts the absolute value of all human lives.

**Individual care:** an individualised approach to care services, recognising the person’s uniqueness.

**Perspectives:** understanding the world from the perspective of the person living with dementia.

**Social psychology:** promoting a positive social psychology in which the person living with dementia can experience relative well-being.

PCC’s main aim is to maintain and nurture personhood for which the guiding principles in care services:

1. Create and strengthen a positive relationship with the person through warm and accepting human contact
2. Communicate respectfully, value and honour the person
3. Treat the person as a unique human being, by valuing their innate nature and assisting them to retain their remaining strengths
4. See the person's world from their perspective in all interactions with them
5. Help the person to feel socially confident and to maintain emotional attachment to others
6. Assist the person to have choice and to make decisions about their own life
7. Make use of the person’s positive memories to help improve their self-esteem and maintain their identity
8. Treat the person’s behaviour as a way of communicating their feelings and needs and respond to the behaviour with empathy (Brooker, 2007)

**Does providing PCC take a lot of time?**

PCC does not require a lot of time, just a commitment to understanding each resident on a deeper level, being flexible and encouraging a shift away from “task-oriented” care. It means moving the goal posts and changing the way we think about “quality care”. Is quality achieved by having every resident showered and dressed by 9am or is it about all residents feeling happy, independent and content even if that means Mrs Jones is still in her pyjamas at 11am because she didn’t feel like getting dressed yet? The first option is easily measured by the tick of a box, the benefits of the second approach is harder to capture and also relies on changing expectations from families.
The majority of people with dementia will experience BPSD (need-driven behaviours) at some point. As mentioned on page 2, BPSD can be triggered by a variety of things outside of the dementing process itself including pain, loneliness, boredom, environment stimuli and frustration. Considering the importance and value of understanding each resident as an individual with a personal history full of experiences that shape the way the view and interact with the world around them, family members and close friends are essential partners in developing PCC approaches.

Types of information to collect from family and friends that may be useful in developing non-pharmacological strategies to manage BPSD

- What job/career/profession did the person with dementia have?
- Are there any significant life events or experiences that may be important to know about eg: in the armed forces, prisoner of war, accident, death of a child, abuse, trauma.
- What type of temperament / personality did the person have before they were diagnosed with dementia?
- What did the person enjoy doing in their spare time prior to being diagnosed with dementia? Hobbies? Travel?
- On an average day, what sort of routine did the person with dementia have when they lived independently?

These preferences, interests and experiences still remain with the person with dementia and can be used to provide insight into behaviours and develop non-pharmacological interventions.

STUDY UPDATE

This table provides available information about our study sample (first 100 participants).

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<thead>
<tr>
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<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Standard deviation</th>
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<tr>
<td>Age of resident - in years</td>
<td>65.7</td>
<td>101.8</td>
<td>86.4</td>
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<td>Time since admitted as resident to facility (years)</td>
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<td>Duration of current course of anti-psychotic medication - in years</td>
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<td>2.0</td>
<td>1.6</td>
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