

Unit Participation Resource Materials



Content

- Handout material for the units
- in addition to those found in the Supportive Pathways Participant Manuals

Outline

- Module 1: Participant manual/handouts
- Module 2: Participant manual/handouts
- Additional handouts included:
- Getting to Know You Forms
 - Cross - Cultural Profile Resource
- Module 3: Participant manual/handouts
- Additional handouts included:
- Normal Changes of Aging
- Module 4: Participant manual/handouts

Outline (Continued)

- Module 5: Participant manual/handouts
- Additional handouts included:
- Behavior Maps
 - Helpful Techniques for Bathing/Dressing
 - Behavioral symptoms and Bathing
 - Resident Bathing Guide: Worksheet
- Module 6: Participant manual/handouts
- Additional Handouts included:
- Home Safety Room by Room
 - Carewest Intimacy and Privacy Guidelines
- Module 7: Participant manual/handouts



Welcome to Supportive Pathways

Please do the pretest included in your handout

Introductions:

- Name
- Where you work
- Dementia care experience
- Challenges you've encountered



Day One Outline

Personal and Organizational Beliefs

Individualized Care

Family as Partners in Care

Normal Changes of Aging

Disease Process



Day Two Outline

Effective Communication

Responding to Altered Behaviours

Supporting Quality of Life

Providing Meaningful Activities



Share and Relate To Your Practice

Please share your knowledge and expertise with the others

- tell your stories as they relate to the topics discussed

Write down the names of two (2) people you know who have dementia and whose actions were a challenge for you



Throughout the sessions, we will ask you to think about these people and how the information relates to them and could improve their quality of life



Supportive Pathways Education Program

Module 1
Personal and Organizational Beliefs and Values



Objectives

To discuss personal beliefs and values about caring for clients with dementia

To recognize how beliefs and values can affect the care provided

To acknowledge and identify common stereotypes that contribute to ageism and 'dementiaism'

To discuss the importance of organizational values on quality of care



"What Do You See Nurse?"

- What are **your impressions** of this caregiver?
- Why do you think the caregiver **acted the way she did?**
- What do you think the **client is thinking** about the care she is receiving?
- **How do we change** this type of care giving?



Definitions



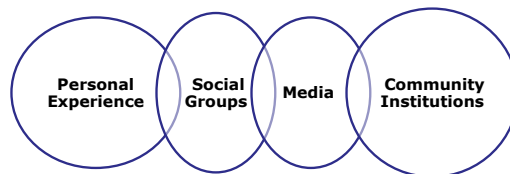
BELIEF - conviction, opinion, expectation that certain things are true (E.g. "I believe in luck".)



VALUE - something that is meaningful, desirable, or has worth (E.g. I value my privacy. I value nature)



Where do **BELIEFS** and **VALUES** come from?



Personal Value Awareness

Exercise:

On each of five (5) pieces of paper, write one thing you value (for a total of five (5) values)



Personal Value Awareness

What did you lose?



How did you feel about losing it?



Losses

Our clients may have experienced losing many of the things we value

They may have also lost many of their memories

Can we imagine what that must be like?



Memory Activity

Write down the answer to these questions

What is on the front and back of the Toonie?

What was the name of your Grade 4 teacher?



Debriefing

How did it feel to not remember?



What strategies did you use to answer?

Do you think our clients who have dementia may use similar strategies?



Stereotypes

Widely held beliefs about a group of people

"All old people end up in a nursing home."

"All old people develop dementia."



Other Stereotypes

Other Stereotypes are often the basis for jokes

☺ **"You know you are getting old when....."**



Stereotypes

What are some more stereotypes about older adults?

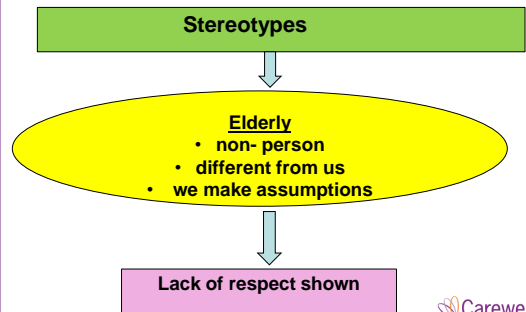


Century Club Video

Did the ladies in the video match your expectation of someone over 100?



Do Stereotypes Affect Care?



Ageism

Ageism is defined as prejudice or discrimination against a particular age group.



Dementiaism

Thinking of the person differently because they have dementia

Not being as "polite" as to a capable person

Calling the person "cute" names

Not expecting that the person can have good days and bad days



Quote From A Nurse

"Once you are diagnosed with dementia you never walk again
- ***you only wander.***"

Source Unknown



Supportive Pathway's Organizational Principles

Our programs value: dignity, individuality, respect, independence and the opportunity (for the clients) to make choices.



Supportive Pathways Organizational Principles

Clients will benefit from an environment that: supports individual needs, focuses on celebrating success, fosters hope, and promotes social involvement.



Supportive Pathway's Organizational Principles

Families and friends will be welcomed as partners; working together to support the client's quality of life.



Supportive Pathway's Organizational Principles

Clients will have the opportunity to live in an environment that is *comfortable*.



Supportive Pathway's Organizational Principles

Clients will have the opportunity to maintain and develop community ties.

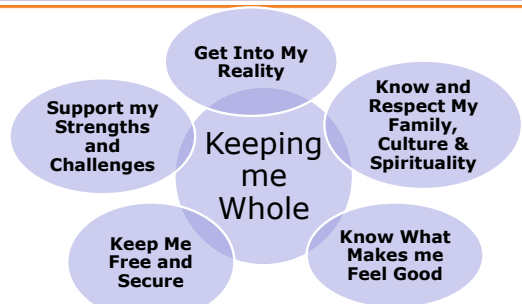


Supportive Pathway's Organizational Principles

Clients will benefit from educated staff who will support each person to live their life to the fullest.



Supportive Pathways Model of Care



(Source: M. Woloshchuk, M. Collins, C. Blake 1999)



Alzheimer's Bill of Rights



To be treated as an individual, with dignity and respect.

To be informed of one's diagnosis.

To have appropriate, ongoing assessments and medical care.

To live in an environment designed for an individual's abilities and interests.



Alzheimer's Bill of Rights



To be involved in work and play as long as possible.

To be out-of-doors on a regular basis.



To have physical contact including hand-holding, hugging and caressing, based on individual comfort and need.

To be with people who know and understand one's life story, including family, cultural and religious traditions.



Alzheimer's Bill of Rights



To be cared for by individuals willing to participate in ongoing training in dementia care.



Questions?



Please refer to your handouts



Appendix : What do you See Nurse?

"What do you See Nurse?" poem

The Carewest Response to ...

"What Do You see Nurse?" by Marlene Collins

(See handout for a copy of both)



References

A profile of Alberta seniors. (2010).

Retrieved March 5, 2012

from http://www.seniors.gov.ab.ca/policy_planning/factsheet_seniors/factsheet-seniors.pdf

Rising Tide: The Impact of Dementia on Canadian Society (2010).

Retrieved from <http://www.alzheimersociety.ca>



What Do You See Nurse? Poem in video

What do you see, what do you see?
What are you thinking when you're looking at me?
A crabby old woman, not very wise,
Uncertain of habit, with far away eyes.
Who dribbles her food and makes no reply
When you say in a loud voice, "I do wish you'd try?"
Who seems not to notice the things that you do,
And forever is losing a stocking or shoe.
Who, unresisting or not; lets you do as you will.
With bathing and feeding, the long day to fill.
Is that what you're thinking, is that what you see?
Then open your eyes, you're not looking at me.
I'll tell you who I am as I sit here so still!
As I rise at your bidding, as I eat at your will.
I'm a small child of 10 with a father and mother,
Brothers and sisters, who loved one another.
A young girl of 16 with wings on her feet,
Dreaming that soon now a lover she'll meet.
A bride soon at 20 – my heart gives a leap,
Remembering the vows that I promised to keep.
At 25 now I have young of my own
Who need me to build a secure happy home.
A woman of 30, my young now grow fast,
Bound to each other with ties that should last.
At 40, my young sons have grown and are gone,
But my man's beside me to see I don't mourn.
At 50 once more babies play around my knee,
Again we know children, my loved one and me.
Dark days are upon me, my husband is dead,
I look at the future, I shudder with dread.
For my young are all rearing young of their own.
And I think of the years and the love that I've known.
I'm an old woman now and nature is cruel,
'Tis her jest to make old age look like a fool.
The body is crumbled, grace and vigor depart,
There is now a stone where I once had a heart.
But inside this old carcass, a young girl still dwells,
And now and again my battered heart swells.
I remember the joy, I remember the pain,
And I'm loving and living life over again.
I think of the years all too few – gone too fast,
And accept the stark fact that nothing can last.
So open your eyes, people, open and see,
Not a crabby old woman, LOOK CLOSER, SEE ME.

What Do We See? Response by Carewest

Author: Marlene Collins

"What do we see?" you ask. What do we see?
Yes, we need to look deeper when looking at thee.
We may seem to be hard when we hurry and fuss
We need to move slower and garner your trust.

We should spend far more time to sit by you and talk
To bathe you and feed you and help you to walk.
To hear of your lives and things you have done—
Your childhood, your husband, your daughter, your son.

But time is against us; there's too much to do.
We need to pay attention and see the real you!
We grieve when we see you so sad and alone,
With nobody near you, no friends of your own.

We feel all your pain and know all your fear.
That nobody cares now that your end is so near.
We should sit and show love when you feel so afraid
Instead of just caring whether the beds get made.

Of the dearest old Gran in the very end bed
And the lovely old Dad and the things that he said.
We speak with compassion and love and feel sad.
When we think of your lives and the joy that you've had.

Note:

There is indications in the literature that the poem, 'Look closer - See me', was found in a lady's locker after she passed away.



Supportive Pathways Education Program

Module 2

Individual
and
Family Care




Objectives

To understand the value of "seeing" the person behind the disease and how to individualize care

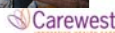

To understand how culture and spiritual values can impact care

To discuss how to work with families to create quality partnerships

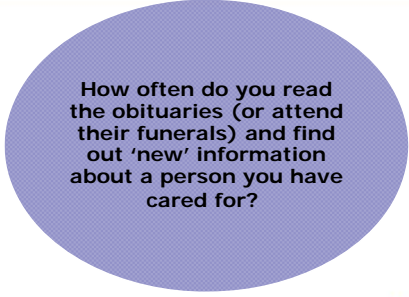


Understanding the Person behind the Disease


- A person with Alzheimer Disease talking to his wife said:
" Jean, don't forget I'm still in here"
- Staff need to keep in mind that:
"Everybody has a story."



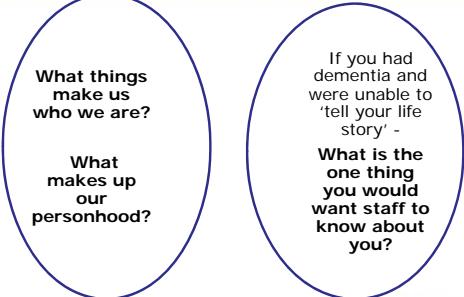
Did we know them?



How often do you read the obituaries (or attend their funerals) and find out 'new' information about a person you have cared for?



Who am I?




What things make us who we are?

What makes up our personhood?

If you had dementia and were unable to 'tell your life story' -

What is the one thing you would want staff to know about you?



Depersonalizing

Can our words and actions be depersonalizing?

Can these 'labels' effect our care?

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Labels – are there more?

Labels don't help us:

- Think of the person and who they are
- Help us understand the meaning behind a behavior
- Think of alternatives to physical restraints
- Think of alternatives to chemical restraints such as antipsychotics

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What can we learn?

"Honey, I've been through 2 world wars, the Great Depression, taught 3,297 children, administered 4 elementary schools and outlived every one of the pastors I worked with."

"I'm 89 years old and you're telling me it's bedtime?"

... to respect the person and who they are

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Supporting 'Personhood'

- To support 'personhood' we provide individualized care.
- Caregiver Golden Rule: Treat others as they would like to be treated.

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Supportive Pathways Model of Care

(Source: M. Woloshchuk, M. Collins, C. Blake 1999)

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Cultural/Spiritual Considerations

Cultural and Spiritual beliefs and practices can influence care

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Cultural Considerations

Mode of Dress



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Cultural Considerations

Dietary/Food Preferences



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Cultural Considerations

Recreation



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Cultural Considerations

Use of Touch



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Cultural Considerations

Privacy



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Cultural Considerations

Communication

Staff need to communicate :



- appropriate to person's cultural etiquette and their language (not speak any foreign language that they can't understand around them)
- to utilize a translator if necessary

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Spiritual Considerations

Spiritual Beliefs and Practices



Cultural Considerations

Health and Healing Practices

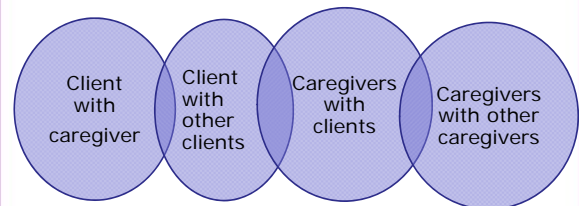


Cultural Considerations

End of Life Care



Conflicts May Arise



Cultural Considerations

- Do you have any additional stories about different cultural beliefs in the clients you care for? Alternative health care practices?
- How are cultural considerations communicated to the staff in your work place?



Family as Partners in Care



Living With Dementia



Family - Coping With Dementia

"Featherhead" Video



"Featherhead" Debriefing

When he took the bread from her do you think he was abusive?

Could a similar situation occur while the person was in care – with family or staff?



Risk of Abuse - Warning Signs

Suspicious injuries

Poor physical appearance or signs of neglect

Fearful of the caregiver

Discrepancy between known income/standard of living

Worrying about documents they have signed

Caregiver concerned more about the financial status of the person not their health status

New friend or caregiver isolating the person from family or friends



Featherhead Debriefing

Was he responding to a loss? Was he distressed?

What supports are needed/available in the community and in care centres
– for family and staff?



"Featherhead " Debriefing

Have you worked with situations the video portrayed?

What are some supports caregivers need?



Risk of Abuse - Warning Signs

Suspicious injuries

Poor physical appearance or signs of neglect

Fearful of the caregiver

Discrepancy between known income/standard of living

Worrying about documents they have signed

Caregiver concerned more about the financial status of the person not their health status

New friend/caregiver is isolating the person from others



Why Families Need to Seek Support

Some caregivers have described dementia as the "longest goodbye".

(Bourgeois 2002)



Family

How would you define family?

"Family are who they say they are"

Wright & Leahey, 1994



Who knows the client best?

Do we as staff or does the family know the person best?

Family



Program Goals

Family will be encouraged to be involved to their desired level



Why should we Partner with Families?



- To help us provide **individualized care**
- To **share** in the care and care decisions
- To exchange **information** with each other
- To **build trust** and an **understanding** of expectations between family and staff



What Families can Share

- the person's life story – **who they are**
e.g. important people, events, routines and activities
- their likes and dislikes
– **'what makes them smile'** 
- changes that seem to be due to their dementia
and any other conditions they have
- what they were like before these changes occurred
- the person's cultural and spiritual beliefs/practices



Other Helpful Information

- tips or strategies that have helped the person with dementia
- what family feels is important in regards to the person's care
- any questions and concerns the family have

(Family Input is so Valuable)



Effective Partners in Care - An Example

If an antipsychotic is being considered /reduced/stopped

- the **health team and family** will discuss:
 - Reason for the medication change
 - Risks and benefits related to the change
 - How it will be monitored and how family can help
 - Care strategies (Brainstorming together)



Family: Friend or Foe?



See handout for this activity



Our Relationship with Families

- **How many of us think of 'partners' when we think of families?**
- **What do we think of when we think of families?**
Helpful? Loving? Dedicated? Uninvolved? Dysfunctional? Demanding? Having unrealistic expectations? In denial?
- **Will it help us to be more understanding when we realize that family members may be 'distressed'?**



Things We Say That Distresses Families?

- NOT my job!
- NOT my shift!
- I'm on my break!
- I'm just back today
- We're short staffed today
- We have lots of clients



Marlene Collins 2009



Things We Do That Distresses Families?

- Appear to ignore family when they visit
- Not include clients in conversations
- Not follow through when we say we will
- Seem to be chatting with co-workers (non-work related)
- Talking on our cell phone in a client area
- Appear to ignore call bells



How do we turn these actions into positives?



Understanding Distressed Families

Some families already have:

- Elevated expectations
- Wishes for the person to be back to normal
- Different Beliefs/Values
- Experienced lack of community support due to the community at large having limited knowledge and experience with dementia

Marlene Collins 2009



Distressed Families

"Grief is a constant part of the process of caring for a loved one with Alzheimer disease."

Liken & Collins, 1993



Distressed Family Strategies

Include in activities, care planning, care to their desired level

Be Proactive



Support them to not feel guilty. Invite to Family Support groups.

Have empathy for their losses

Don't judge them

Educate on normal progression of the disease

Marlene Collins 2009



Distressed Family Strategies

Staff need to greet family in a friendly manner

Provide care which is in line with the Care Plan



If there is disagreement over the Care Plan, then set up a meeting with the family

Be careful of your tone of voice

Marlene Collins 2009



Distressed Family Strategies

Be careful of your tone of voice

Provide care which is in line with the Care Plan



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If there is disagreement over the Care Plan, then set up a meeting with the family

Marlene Collins 2009



Jack and Lucy's Story



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Partnering with Lucy

What does Lucy value?

Do you think staff were aware of her feelings?

From our previous discussion what things could we do to partner with Lucy?

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Questions?



Please refer to your handouts

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References

- Andrews, M.M., &Boyle, J.S. (2003). Transcultural Concepts in nursing care (4th ed.).Philadelphia: Lippincott, Williams & Wilkins.
- Kellett, U. (2000). Bound within the limits: Facing constraints to family caring in nursing homes. *International Journal of Nursing Practice* 6, 317-323.
- Kitwood, T (1997). Dementia Reconsidered-the person comes first. Buckingham, UK: Open University Press.
- Lustbader, W. (1996). Tales from individualized care. *Journal of Gerontological Nursing*, March, 43-46.

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Getting To Know You

Please fill out and bring with you on the day of admission. This information will make it easier for us to help your family member feel more comfortable.

What does he / she like to be called? First Name: _____ Nick Name: _____

Mr / Mrs / Miss / Ms (circle one) Maiden Name: _____

Where was he / she born? _____

Where has he / she lived? _____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced (name of previous spouse _____)
☐ Never Married

Name of Spouse: _____

Names of children and where they live:

Names of brothers and sisters, significant friends or grandchildren he / she is close to:

Significant information related to occupation and education:

Significant Past Experiences (e.g. major life events, achievements, favourite places visited, people he / she may talk about: _____

What gives him / her pleasure? (e.g. topics of conversation, activities, pets, certain foods, spiritual activities)

What kind of music does he / she enjoy? _____

What hobbies did he / she enjoy? What ones does he / she still enjoy?

What things does he / she dislike?

Are there customs / spiritual practices that are important to you and your family member?

How does he / she indicate pain?

What has helped when he / she has pain?

Other Information:

Typical Day

Usual morning wake up time? _____

Amount of assistance needed to get out of bed:

☐ Independent

☐ Needs help (*describe*) _____

Please mark each of the following with either Y=yes, N=no, or S=sometimes

Washing and Dressing

- Able to wash self independently
- Able to wash with cueing (reminders)
- Needs to be washed
- Able to choose clothes and put on
- Able to dress if clothes put out in order
- Needs to be dressed
- Able to shave self / comb hair
- Needs help with shaving / combing hair
- Able to brush teeth / dentures
- Needs help with brushing teeth / dentures
- Needs incontinence pads
- Resists are (*specify*) _____

Nutrition and Eating

- Unable to sit
- Sits at table and eats independently
- Trouble swallowing
- Does not take time to chew
- Holds food in mouth
- Needs minced food
- Eats finger foods only
- Walks while eating
- Other (*specify*) _____

Meals

Breakfast:	usual time _____	usually likes _____
Lunch:	usual time _____	usually likes _____
Dinner:	usual time _____	usually likes _____
Snacks:	usual time _____	usually likes _____

Food Dislikes / Intolerance / Allergies _____

Appetite: ☐ Poor ☐ Fair ☐ Good

Please indicate which of the following he / she likes to do:

<u>Daily Activities</u>	Morning	After Lunch	Evening	Comments
Outside walks				
Radio				
Television – specify program				
Newspaper				
Games / Hobbies				
Car Rides				
Other (specify)				

Does your family member have any difficulty with any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Large groups | <input type="checkbox"/> Night wandering |
| <input type="checkbox"/> Noise | <input type="checkbox"/> Using the toilet |
| <input type="checkbox"/> Small groups | <input type="checkbox"/> Using incontinence products |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Bathing |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Falling |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Other (<i>specify</i>) _____ |
| <input type="checkbox"/> Daytime wandering | |

If "Yes" to any of the above, please describe:

What works best in dealing with these problems?

Night / Nap Activities

Naps: Time _____ ☐ Chair ☐ Bed

Bedtime routine: Time _____

☐ Snack

☐ Nightlight

☐ Radio – What Station? _____

Anything else needed to help him / her sleep?

On admission, please bring with you the medications he / she is presently taking.

☐ Able to swallow pills whole

☐ Pills need to be crushed

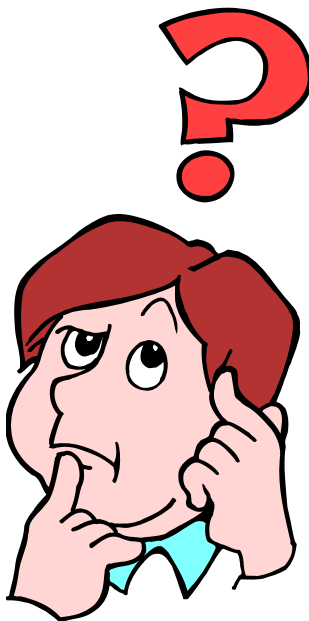
Any other information that you think might be helpful?

Enhancing Family Visits

Families may find visiting their impaired relative more and more difficult as their relative becomes more impaired, less communicative, and less like the person they once knew. Families may believe that their visits no longer matter to the relative, since the relative does not recognize them. Some may feel frustrated by the fact that their relative does not remember previous visits.¹

Questions that families and friends often ask about visiting:

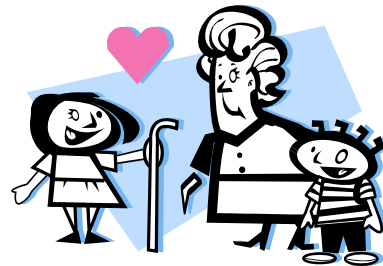
- What should I talk about with my cognitively impaired relative?
- How do I deal with my relative who claims I never visited before, or have not visited for a long time?
- How do I deal with the relative who no longer recognizes me?
- What should I do with my relative during the visit?
- How do I communicate with someone who no longer is able to verbally respond?
- What do I do if my relative becomes aggressive during a visit and hits someone?



1. O.W. Malott, ed., Alzheimer Resource Manual (Waterloo, ON: University of Waterloo, 2000)

Tips to Enhancing Family Visiting

- Time visits to maximize resident responsiveness
- Mealtime schedules and procedures, special events, down times, and gaps in activity programming are good times to visit
- Determine if the family would like to have visits scheduled so they can participate in care (example – mealtime)
- Some families may appreciate visiting when they can help reassure the resident (example – bedtime)
- Encourage visiting when families can observe activities, or during a time when things are not so hectic
- Encourage and support family members' desire to help out by asking them to contribute their special talents to the activities program
- Have materials available to promote visiting
- If possible, providing a visiting room
- Help families leave without difficulty
- Encourage family members to volunteer
- Encourage the creation of a memory box





CROSS-CULTURAL PROFILES (2003)

This package was originally prepared by Carrie Bon Bernard of the Multicultural Awareness Program, Peter Lougheed Hospital.
The information has been updated by the Health Care Interpreters, Calgary Health Region.

Multicultural Awareness Program

Peter Lougheed Centre

It is necessary to consider that while the following information is regarding specific cultures, that the Cross Cultural Profiles be used only as a guide in inquiring about clients' beliefs, values, and practices. Each family is unique in their orientation and functioning, and families often alter traditional ways of life as they adapt to life in Canada. Be cautious about making general assumptions based on culturally specific information.

Full copies or copies of a cultural section in this document may be made to ensure accessibility. Please use the cover page which includes references.

CULTURAL GROUP	LANGUAGE GROUP(S)	PAGE NUMBERS
Cambodians	Khmer (Cambodian), sometimes Chinese	2-3
Central and South Americans	Spanish	4-6
Chinese	Mandarin and Cantonese (main)	7-10
Iranians	Persian / Farsi	11-14
South Asian	Hindi, Urdu, Punjabi, Gujarati, Kachi, Swahili	15-19
Vietnamese	Vietnamese, French, Chinese	20-22
Koreans	Korean	23-24
Somalis	Somali, Arabic, French, English, Italian	25-26
Filipinos	Filipino (Tagalog), other dialects, English	27-28

Multicultural Awareness Program – PLC

CAMBODIANS

CAMBODIANS

CULTURE	HISTORY, BELIEFS & HEALTH PRACTICES
<p>Family structure</p> <ul style="list-style-type: none"> The family is the primary social and economic unit in traditional culture. Extended family act as a financial and emotional support network. <i>Traditional role of women:</i> subordinate, responsible for child-rearing, household duties, and often managing family finances. Women usually not employed outside the home in South East Asia, but many were forced to support the family when men died in the war or were involved in the military. <i>The husband:</i> head of the household, decisionmaker and breadwinner. <p>Acculturation Issues</p> <ul style="list-style-type: none"> Many Cambodian families struggle with settlement issues as they may have had only 2 years or less of formal education. The dramatic contrast between Canadian and Cambodian society magnifies intergenerational issues, socioeconomic and literacy issues, lack of health prevention, and access to health care. <p>Cross-Cultural Interactions</p> <ul style="list-style-type: none"> It is very disrespectful to touch the head or shoulder of another person in casual contact, especially if he or she is older. The head is believed to house the soul. It is best to minimize direct eye contact, thus showing a sign of respect. It's impolite to disagree; he/she may verbally agree but not follow through. Use soft tone of 	<p>Immigration History</p> <ul style="list-style-type: none"> Arrived primarily after 1975 during Pol Pot Regime and policy of annihilation of educated or influential individuals/families. Many faced war, trauma, hardship, grief/loss, and torture. Documentation such as consent forms might provoke anxiety, as they were used in Cambodia before execution. Languages spoken may include Khmer (Cambodian), French and Chinese. <p>Traditional Health Practices & Beliefs</p> <ul style="list-style-type: none"> Self-medication and traditional remedies common. Coin rubbing: traditional practice - area of the body is rubbed with metal object such as a coin or spoon until the skin becomes red. Sometimes an ointment such as Tiger Balm is used. <p>Prevalent Diseases</p> <ul style="list-style-type: none"> Tuberculosis, intestinal parasites, anemia, hepatitis B, and dental problems. Recently arrived Cambodians often experience poor health because of the severe deprivation. A lack of food, shelter and medical care have each had an impact. Lactose intolerance is common. <p>Health Care Systems</p> <ul style="list-style-type: none"> Families had access to little or no formalized health care and preventative health services. Many Cambodians in Canada previously spent time in refugee camps - undernourished. <p>Patient - Professional relationship</p> <ul style="list-style-type: none"> Typically in Cambodian cultures, the patient is expected to be more passive and dependent. Health professional is viewed as the authority, expected to diagnose and offer a quick treatment/cure. Doctors are highly respected. It is not viewed to be culturally acceptable for a health professional to imply that nothing is seriously wrong or that time will heal remedy the concern, or a physician may be seen as uncaring and unhelpful. Women most likely would prefer female physicians, especially for obstetrics and gynecology. They may otherwise be reluctant to discuss complaints and access regular checkups. Individuals are reluctant to seek early medical attention, unless seriously ill. This may be a result of language difficulties and discomfort regarding cross-cultural differences. <p>Mental Health</p> <ul style="list-style-type: none"> Highly stigmatized, and a family experiences shame when one member has mental health problems. Mental illness is often feared or avoided. As emotional weakness is unacceptable, more often, somatic complaints may be used to express psychological and emotional distress including headaches, insomnia, aches and pains, fatigue and dizziness, and individuals generally expect to receive medication.

CAMBODIANS

<p>voice.</p> <p>Marriage</p> <ul style="list-style-type: none"> Concern regarding prospective husband's character, family background & social status. Dating is rare; often couples will meet in the form of group activities. Non-acceptance of premarital sex; a pregnant unwed girl results in family shame. <p>Religion</p> <ul style="list-style-type: none"> Cambodians are predominantly Buddhist, but some have converted to Christianity. Host several celebrations during the year with Cambodian New Year (Apr. 12-13) being a major event. Monks are highly respected, supported by the community, and are not to be within close distance of females or to touch them. <p>Children</p> <ul style="list-style-type: none"> Most families will quickly access medical care for their children because it is available and inexpensive. <p>The Elderly</p> <ul style="list-style-type: none"> As elders are highly respected, it is traditionally common for their children to provide care for them, especially women. Older men are involved in making important decisions/providing advice for family. <p>Food and Diet</p> <ul style="list-style-type: none"> Rice is the primary food for Cambodians, along with fish, poultry, beef, pork, vegetables, and fruit. Most families do not use milk/milk products in their diets. <p>Literacy</p> <ul style="list-style-type: none"> Many are not literate in Khmer or English as they often have had less than 2 years formal education, and lived in rural areas. <p>Census Data</p> <ul style="list-style-type: none"> About 900 immigrants from Cambodia reside in Calgary. 	<p>Treatment and Medication</p> <ul style="list-style-type: none"> Strong belief in the effectiveness of injections verses other treatments. Some fear blood tests, believing that the loss of blood causes dizziness, fatigue, or worsens illness; reassurance may be needed. Invasive procedures including surgery and post mortems, are not as acceptable, thus needing careful explanation. Often first try traditional medicines and treatments or use them in combination with other medicines. <p>Hospitalization</p> <ul style="list-style-type: none"> Family involvement extremely important. The entire family is often expected to visit each day. In Cambodia, a relative is able to remain with the patient and helps to provide care. Visitors often bring food to the patients to substitute for hospital food. Cambodians in Canada may expect a doctor to visit two times per day, and may feel that less contact is indicative of a lack of concern. Family feels the patient should not be left alone, and the patient may use a passive role. <p>Death and Dying</p> <ul style="list-style-type: none"> Prefer for the individual to die at home, but are also comfortable with death in hospital. Serious or terminal illness should be discussed with the family first, and allow them to discuss it with the ill family member. Funeral is often by cremation, but ethnic Chinese may bury their deceased. Families prefer to have their family member die at home. Following a death, a 3-day festive wake is held, and family and friends visit. The cremation takes place at the temple following the wake. 	<p>Family Planning</p> <ul style="list-style-type: none"> The preferred methods of contraception are birth control pills and the IUD. In refugee camps, women often had injections of Depo-Provera and may request it. <p>Childbirth</p> <ul style="list-style-type: none"> In rural areas, a midwife often stays 3-4 days with a mother and newborn. Hospital births - usually a female family member stays with her. Traditionally the father does not participate in the birth, but he may wish to participate in Canada. General fear of invasive procedures such as Cesarean section and episiotomy; thus it is most helpful to have these carefully explained. Circumcision is not often chosen. <p>Post-partum Care</p> <ul style="list-style-type: none"> Based on the principles of yin and yang, which considers internal balance, women are to keep warm after childbirth. Women may perceive the hospital to be cold, and a woman usually covers her head. The traditional belief is that after having a baby, women should not shower or cut their hair for the first month. In Cambodia a woman washes in a medicinal mixture of warm water and a special wine. During the post-partum period some Cambodian women may avoid beef, chicken and raw vegetables. <p>Culturally Sensitive Health Care</p> <ul style="list-style-type: none"> A polite and formal approach is most effective. Many experience Post Traumatic Stress as a result of violence and living in refugee camps. In addition, Cambodians will present with many significant health concerns and/or somatic complaints. Avoid using many abstract concepts and difficult terminology (non-translatable).
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Multicultural Awareness Program – PLC

CENTRAL AND SOUTH AMERICANS

CULTURE

Family Structure

- Large families are accepted and promoted.
- Independent households with strong family ties on both sides.
- Husband is head of the family, but important decisions like those regarding health care, will involve consultation with the larger family.

Acculturation Issues

- Traditional family roles: women as family caregiver, husband/father as decision maker and provider. This is challenged in Canada as women integrate into the work place, and may be threatening to the husband/father.
- Increased incidence of depression and/or substance abuse among men.
- Sometimes men may prevent their wives from various opportunities like learning English, or they may become abusive.
- Youth and children are perceived as being out of control as they acculturate quickly with their peers and adopt new values & behaviours. It is important to normalize teen behaviours where appropriate.
- Like many immigrant communities, individuals may come to Canada with professional skills and experience unemployment or underemployment due to language barriers, recognition of credentials, and lack of Canadian experience.

Cross-Cultural Interactions

HISTORY, BELIEFS & HEALTH PRACTICES

Immigration History

- May have experienced trauma, violence, torture, grief/loss and limited access to health care in their country of origin.
- Literacy levels may be lower among refugees and those who previously lived in rural areas.
- Documentation and assessments are sometimes of concern for refugees in the health care system for fear of reports being made to government and affecting their status in Canada. Parameters of confidentiality should be clearly explained.
- Languages spoken may include Spanish and Portuguese.
- In this group you can find members of the middle class, they represent a “brain drain” of doctors, dentists, economists, agronomists, engineers, and other beneficiaries of higher education in Latin America, which produces more professionals than it can absorb.

Political Violence and Torture

- Physicians often view evidence of torture and brutality among refugee patients. It is not necessarily best to confront the patient, even with sincere intentions, as it may cause distress.
- The painful experience is much more in-depth, and a lengthy period of perhaps 2 or 3 years may be needed before professional and patient develop the necessary degree of trust. However, it may be helpful to provide information regarding accessing support for such issues.

Traditional Health Practices and Beliefs

- View ill health as an imbalance relating to hot/cold & strong/weak, or may be aggravated by strong emotions. Treatment of a hot condition (i.e. fever) with a “hot” medicine (some

Patient – Professional Relationship

- Patients defer to and respect positions of authority, including doctors.
- They feel uncomfortable about making immediate eye contact with strangers. Their lowered yes should not be interpreted as lack of interest or docility, but rather as simple good manners.
- It is not appropriate to call a professional by his/ her first name, as it is perceived to be patronizing.
- It is very important for health professionals to promote awareness of the health services and system, as it may be very new and complex.
- Patients believe successful recovery is related to treatments including shots, tablets or creams, and feel unconfident in the physician when a prescription is not provided.
- It is often customary for a female relative to accompany a woman when she sees her male doctor, as such a relationship may be seen as inappropriate or cause jealousy for the husband.
- A female physician may be preferred for women, but presence of a female nurse in the room may also increase the woman’s comfort.
- Usually visit a doctor when they have a concern, even though many of the problems appear minor to Canadian health professionals.
- Latin cultures often believe that physicians assist in overall well-being in addition to treating medical problems, and it is important to listen and develop rapport.

Mental Health

- Other than pregnancy and childbirth, mental health issues and related physical symptoms are the primary reason for Central Americans accessing the

CENTRAL & S. AMERICANS

- It is acceptable to shake hands and to touch the patient for support/comfort.
- It is most appropriate to first use more formal titles when addressing the patient (Mr., Miss etc).
- Open and accepting of physical warmth and closeness between opposite sex and friends/family of the same sex.
- Counselling in Canada can be difficult because of the language barrier and the lack of Spanish speaking practitioners.

Marriage

- Often couples marry at a younger age: women may be 16-19 years of age, while men are more likely to be in their early 20s.

Religion

- Most families are Catholic, but some may be affiliated with Pentecostal or Mormon religions.

Children

- Both boys and girls are happily received, but expectations for children are gender-based.
- Sometimes women wish to give a newborn the father's name as they feel it places financial responsibility on the father; they require information about Canadian.
- Women may be in Canada with one or more children remaining in Central/South America.
- Parents feel they should determine what is best for their children.

The Elderly

- There are no homes for the elderly in Central America as younger generations are expected to care for older members. A family not providing such care is shamed.
- Great respect is given to elders.

- antibiotics) will be seen as counterproductive.
- Sometimes menstruating women will not bathe or wash their hair, as they believe it will stop menstrual flow.
- External influences are believed to have an effect such as curses, spirits, "bad wind", or other forces. These beliefs are more common among those with a lower socioeconomic background.
- Taboo topics - sexuality not openly discussed, especially with the opposite sex. It may not be seen as culturally appropriate for a male physician to be alone with a female patient.
- Believe that people with fevers should not get wet.

Prevalent Disease

- Serious diseases are not common because they were screened before applying to immigration.
- Evidence of torture, such as broken legs or cigarette burns, is not unusual among Central Americans.
- Parasites and worms are chronic problems as a result of prior health conditions.
- Sometimes tuberculosis is observed, but most often inactive cases are found on x-rays.
- Malnourishment can also be an ongoing problem and is linked to low income of refugee claimants and poor conditions.

Health Care Systems

- Health care available depends greatly on location and family income. Rural with low income – access to few Western-style medical personnel and facilities. Cities often have modern hospitals and treatment facilities.
- While some countries offer public health care, its coverage is not extensive and may only include basic immunization and emergency care.

Medication and Treatment

- Some Latin Americans are used to various medicines being available over the counter (e.g. Pencillin).
- Often will pursue traditional remedies before

Canadian health system. Depression, forgetfulness and withdrawal are frequently reported.

- Abnormal behaviour may be linked to significant life events or sometimes to the supernatural.
- For chronic/serious mental illness in Central America, people are institutionalized with the expectation that they will never recover or be discharged.
- If the patient is male, family stress levels may be higher due to social expectations and lack of financial support to the family.

Family Planning

- Open discussion not common.
- Sometimes women will consult a physician regarding contraception. Many women, especially depending on background and class, do not know information regarding fertility and reproduction.
- The pill is widely accepted, and the IUD may be used, but diaphragms are unpopular. Withdrawal is probably the most commonly practiced method.
- In the event of unwanted pregnancy, about 50% of women choose abortion.

Pregnancy

- Prenatal classes are generally non-existent in Central & South America, but many women respond very positively to participating in classes in Canada.
- Pregnant women are often given much attention, are encouraged to eat well and rest.

Childbirth

- Mother of labouring woman may wish to be present
- Fathers are not normally involved in delivery in Central America, but may be willing to participate here in a passive role, with encouragement.
- Belief: newborn babies should have their waists tied with a belly band or they have a coin placed on the umbilicus to prevent a hernia; while it may seem unnecessary, it brings comfort to the new parents.
- Infant sons are not circumcised. Baby girls often

<ul style="list-style-type: none"> • Women generally care for the sick. <p>Food and Diet</p> <ul style="list-style-type: none"> • A very social part of their lives, food is usually accompanied by a fruit juice, involves few vegetables, and uses various meats. • Prefer hot or warm drinks in the morning and may prefer warm bland foods when ill. • Food preferences vary by region and may include tortillas, bread, rice, beans, soups, tamales, and other ethnic dishes. Raw fruits and vegetables are often thought to cause illness. • With respect to children, it is helpful to promote healthy nutrition, as some families prefer fast foods high in fat content, and it is culturally acceptable to provide such things as coffee to young children. <p>Literacy</p> <ul style="list-style-type: none"> • Literacy levels vary depending on socioeconomic background. • Silence may represent misunderstanding or insecurity about disagreement. <p>Census Information</p> <ul style="list-style-type: none"> • Approximately 7% of the immigrant population residing in the NE and SE areas of Calgary are from Central and South America. • 6, 550 Calgarians in the 1996 Census identified themselves as Latin Americans. 	<p>using biomedicines.</p> <ul style="list-style-type: none"> • Common home remedies that people bring to Canada include herbal teas and the use of Vicks VapoRub for headaches, feverish babies, and a multitude of other discomforts. <p>Hospitalization</p> <ul style="list-style-type: none"> • Some Central Americans may perceive hospitalization to be associated with death rather than recovery. • Often model hospital patients. May assume passive role. Family members may also be used to being involved in the care of patients. • Patients with fever may resist bathing due to the belief that it is related to the illness. • Tests are not often done unless for complicated problems. <p>Death and Dying</p> <ul style="list-style-type: none"> • Important to consult a family member regarding the illness of the patient – they may recommend that family tell the patient or that health service providers inform the patient. • Sometimes consulting the father or eldest male is most appropriate. • Traditionally, family look after a dying relatives. • If a condition is stable, the person will be taken home from the hospital to die. • In urban areas, after a death occurs the body is taken to a funeral chapel for burial preparation. A wake for family, close friends and sometimes a priest is organized, usually in the presence of the open casket and people generally stay up all night with the body. • It is seen to be very important for the family to have the time together with the deceased. Burial is the norm. • A stillborn baby of religious parents will be baptized and given a burial service. Autopsies are not well accepted, but organ donation may be acceptable. 	<p>have their ears pierced after 2 or 3 months.</p> <ul style="list-style-type: none"> • Women are familiar with Cesarean sections and generally accept procedures the doctor feels is best to deliver a healthy baby. Women will tolerate considerable pain before asking for an anesthetic; it is helpful to advise them of their options. <p>Postpartum Care</p> <ul style="list-style-type: none"> • Bathing considered risky because of its potential for chilling the new mother. • She may feel it is necessary to wear a special girdle to prevent help the uterus to return to its original size. • Sick infants cause great concern, and any physical deformity on the baby may be attributed to the mother's behaviour during pregnancy such as attempted abortion, excessive emotion, or an unsatisfied food craving. • It is believed that new mothers should avoid cold foods & drinks as the mother is thought to be in a cold state. Certain foods and herbal teas/baths are thought to return mother's strength. • Bottle-feeding and disposable diapers are favoured as these are believed to be a sign of financial security and Westernization; women have been led to believe that infant formula is better for the baby's growth. <p>Culturally Sensitive Health Care</p> <ul style="list-style-type: none"> • Families may have had traumatic experiences in their country of origin and may have been victims or witnesses of violence. • For the Canadian Health Professional it is very important to take account of this background but to wait until the patient raises the subject. • It is important to consider that there is often suspicion of government authority, making consent issues challenging. It is necessary to be sensitive to the refugee experience.
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Multicultural Awareness Program – PLC

CHINESE

CHINESE		
CULTURE	HISTORY, BELIEFS & HEALTH PRACTICES	
<p>Family Structure</p> <ul style="list-style-type: none"> • often large, extended, lives together, and is headed by the eldest working male. • Elderly are highly respected and the young are obliged to take care of them. • Male head of family: works, takes care of finances and usually disciplines the children, primary family decisions. • Wife runs the household and care for the children, and is usually responsible for routine health decisions. Decides on the choice of birth control, in consultation with her husband. • Serious decision-making may involve husband, wife and extended family. <p>Acculturation Issues</p> <ul style="list-style-type: none"> • Acculturation of Chinese families in Canada often depends on their level of education, and region of origin. A family from rural mainland China will likely experience greater barriers than an entrepreneur from Hong Kong. • Intergenerational issues are common as youth acculturate and parents wish to maintain traditional cultural values. • “Satellite families” are not uncommon where one parent, usually the father, returns to the country of origin for employment purposes. This will affect the involvement of family in supportive and decision-making roles. <p>Cross-Cultural Interactions</p>	<p>Immigration History</p> <ul style="list-style-type: none"> • As many families immigrated as early as 60 years ago, several practice Western medicine. • Currently, most Chinese speaking families are arriving from Hong Kong, mainland China, & Taiwan. Mandarin and Cantonese are the most common dialects spoken. <p>Traditional Health Practices and Beliefs</p> <ul style="list-style-type: none"> • Beliefs based on Chinese medicine: 3 distinct types – classical Chinese medicine, Chinese folk medicine and medicine in contemporary China. • Various parts of the human body correspond to the principles of yin and yang. Yang - positive male energy that produces light, warmth and fullness. Yin – female negative energy, the force of darkness, coldness and emptiness. • Illness Viewed as a loss of balance in yin and yang or in hot and cold foods. • Causes of illness may include foods that are excessively hot/cold, or those believed to be “poisonous”. • Illness is linked to presenting symptoms and the goal is to then get rid of the symptoms. • Difficulty understanding the implications of chronic illnesses where symptoms persist for a long time and there is no absolute cure. <p>Health Care systems</p> <ul style="list-style-type: none"> • Treatment often includes herbal medicine, acupuncture, acupressure, oxibustion (the burning of small quantities of dried herbs on the body) and chiropractic care. Two types of hospitals: expensive private hospitals and government hospitals used by those who are not wealthy. <p>Medication and Treatment</p>	<p>Patient – Professional Relationship</p> <ul style="list-style-type: none"> • In China patients usually request their preferred treatments from their doctors. These same patients may aggressive in Canada when they use this approach. • The concept of preventive medicine may be unfamiliar to some who only will seek help when they feel ill, and thus impacts annual check-ups and the continual monitoring of health. • Health professionals in Canada must ensure that patients adequately understand the diagnosis, treatment, and medical procedures, as they may be hesitant to ask questions. <p>Mental Health</p> <ul style="list-style-type: none"> • Explain the causes of mental illness in terms of external factors or events; problem presented in the form of somatic complaints. • Pre-migratory trauma and stress, separation from family and community, unemployment, underemployment, and language barriers are considered additional risk factors. Youth and mothers with absent parents/spouses also have elevated rates of mental health issues. • Traditionally, different emotions are perceived to be related to different organs. For example, anger is associated with the liver, and joy and depression with the heart. Clients may seek relief of physical symptoms but not discuss mental health problems. • Mental health issues such as depression are considered shameful and are not discussed. • Family members have a great influence on how

CHINESE

- Greet one another by bowing heads & smiling. It is most polite to use Mr. & Mrs. particularly with older patients, so as to show respect.
- Indirect eye contact may be a sign of respect.
- Out of respect, patients may nod, and not ask questions. It is important to clarify understanding.
- Privacy is highly valued as it is important for families to “save face” maintain respect.
- Body contact beyond a handshake, for example kissing and hugging, is uncommon.
- May not be familiar with the need to make appointments with health professionals.

Religion

- Many Chinese are Buddhists, but Catholic and Protestant religions are also common.

Children

- Traditionally, the male child is considered most desirable - carries the family name and is entitled to family inheritance.
- Children are valued and generally are the focus of family attention in their early years.
- Parenting and early education traditionally take place within the home. Chinese families highly value the education of their children.

The Elderly

- Traditional responsibility for care of the elderly lies with the family and the oldest son and his wife; otherwise unmarried children have the greatest obligation.

Food and Diet

- Lactose intolerant and dislike milk.
- Rice and noodles are common foods. Cooked

- Chinese want immediate results from medications. May question prolonged Western treatment regimes and may prematurely discontinue taking an antibiotic prescribed for two weeks without immediate results. There is a need for explanation of the importance of follow-up.
- Injections regarded as more effective than pills. Pills considered more effective than drops.
- They may refuse blood tests as they believe loss of blood will weaken their bodies and that these tests are too invasive.
- Value the wholeness of the body and thus they may avoid surgery because it is seen as a form of mutilation; surgery is resorted to only if all other treatments fail.

Hospitalization

- Elderly often associate hospitalization with death, & may prove reluctant hospital patients.
- Family members may rush an elderly parent to hospital thinking that he or she may receive better treatment for the illness.
- Death of a person at home is considered to bring bad luck.
- A patient may not complain of pain, so it is important to offer pain medication.
- Common for many guest to visit a patient and bring food or gifts.
- Sick role is common for the Chinese patient – behaves passively and expects others to care for him/her.
- Some are fearful of having blood drawn, as they believe it will weaken the body, and they may be inclined to avoid surgery.

Death and Dying

- Death is viewed as natural and inevitable.
- Families often prefer that health professionals do not reveal the prognosis to dying patients so their last days should be free of worry and pain.
- Family wish to be present when addressing serious

mental health is viewed. Overprotectiveness common. May refuse treatment because they view mental illness as bringing shame on the family.

- Talk therapy is often less effective in contrast with a concrete solution-focused intervention.

Family Planning

- Traditional Chinese prefer large families.
- Male children especially the first born are highly valued because the family name is assured.
- Intrauterine devices and birth control pills are commonly used.

Pregnancy

- Women may avoid hot foods or “poisonous” foods such as shellfish during pregnancy.
- Chinese mothers may avoid cold and try to eat more hot foods, sweet vinegar, chicken, eggs, certain types of herbs in an attempt to balance yin and yang.

Childbirth

- A woman may be more stoic during labour, though it is acceptable to demonstrate pain by moaning.
- Usually female family members are involved, with fathers not often playing an active role.

Postpartum Period

- Postpartum period considered dangerous as the woman is susceptible to excessive coldness.
- Must avoid cold foods and cold winds, and stay inside – a practice called “sitting for the month”.
- The current trend in mainland China is to breastfeed; immigrants from Hong Kong may prefer to bottle-feed, but some women feel it is not healthy for the baby to breastfeed during the first 3 days after birth.
- Cold water is avoided by not bathing or washing hair for one month, and heavy lifting is avoided to protect the uterus. Sponge baths acceptable.

CHINESE

<p>vegetables are common as well as poultry and fish.</p> <ul style="list-style-type: none"> Many hot liquids consumed, especially tea, when sick. Cold water believed to shock the system. Believe that hot and cold foods should not be eaten at various periods depending upon the illness, so as to maintain balance in the body – <i>Yin</i> and <i>Yang</i>. <p>Literacy</p> <ul style="list-style-type: none"> The elderly are less likely to be literate in either Chinese or English. Families of rural areas or lower socioeconomic backgrounds may not be literate in Chinese. Avoid using a male interpreter for an older female patient due to modesty issues. <p>Census Information</p> <ul style="list-style-type: none"> Mainland China and Hong Kong were among the top ten source countries for immigrants arriving to Calgary in 1998. 44, 670 Calgarians in the 1996 Census identified themselves as part of the Chinese community. 	<p>or terminal illness. Ensure involvement of the male head of household.</p> <ul style="list-style-type: none"> Postmortems may be refused by family members as they are viewed to be unnecessarily invasive. Family members, relatives and friends gather to mourn the deceased. Pregnant women are often not allowed to attend funerals for fear of harming their health. Relatives of the deceased may not wish to visit others for a certain period for fear of bad luck. 	<ul style="list-style-type: none"> Any problems with the baby should be addressed with the male head of the household. Male circumcision is quite common. Infants may be bathed very frequently as cleanliness is highly valued. <p>Rehabilitation</p> <ul style="list-style-type: none"> Rehabilitation services for family members who are physically/mentally handicapped may be avoided as they are thought to be painful. <p>Delivering Culturally Sensitive Health Care</p> <ul style="list-style-type: none"> May seldom ask questions and thus need encouragement to express concerns. Professionals should also be cognizant of the somatic ways in which clients portray illness or the way they blame illness on external causes. Approaching the head of the family should be considered in order to respect family structure and decision-making.
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Multicultural Awareness Program – PLC

IRANIAN

CULTURE

Family Structure:

- The family is the most important element in Iranian culture and life is usually dominated by family values and relationships. The word "family" in Persian refers to the extended family and an Iranian usually judged by the name of his or her family, including grandparents, aunts, uncles and cousins.
- Father continues to be the major breadwinner and the head of household, though he has diminished power and authority.
- Even though women have become emancipated and educated and have acquired more decision-making power in the home and out, the Iranian family remains a patriarchal unit in which sex roles are almost immune to change. This means that modern Iranian women are expected to take on most household responsibilities and maintain outside jobs.
- Two major characteristics shared by families are the value placed on extended family advice and support, for example, regarding major health problems, and the respect and dutifulness shown the elderly.

HISTORY, BELIEFS & HEALTH PRACTICES

Acculturation Issues

- The major problem faced by Iranian in Canada are unemployment, underemployment, loss of status, financial loss, in short, downward socio-economic mobility and language barriers.
- Iranian, in general, are fearful of Western influences, specially on their children. The tendency to shelter and protect children from Western influence and values is strong.
- In the Iranian families in Canada, generation gaps and conflicts tend to increase. Children usually the first ones to learn English and lose their mother tongue, grow farther and farther apart from their families.

Cross- Cultural Interaction

- Prefer formal relationships. Should use Mr., Mrs. or other pronouns and the last name unless the patient requests differently.
- Men and women do not touch each other in public settings.
- Touching, embracing, and kissing are very common among persons of the same sex.

Immigration History

- Iranian immigrants comprise a steadily growing ethnic group in Canada, and many

of them are settling in the Greater Vancouver area and Toronto

- The flow of people from Iran began in 1979, during and after the Islamic Revolution. Thus, most Iranians in Canada are first generation immigrants who share many of the beliefs, values, and characteristic of their compatriots in Iran.
- The most important reasons for migration have been, and continue to be, the political, religious, and economic situation in Iran.
- The vast majority of Iranians residing in Canada come from large urban areas and belong to upper and middle-class families, and are relatively familiar with Western education and values. Hence, the transition is probably smoother for this group of immigrants than for their counterparts from other countries. For this reason, the Iranian immigrant population of Canada is probably in a relatively advantageous position when dealing with Canadian public services, particularly medical and health services.

Traditional Health Practices and beliefs

- Iranian immigrants generally do not refute scientific theories about underlying causes of disease. However, coming from a fatalistic society, as they do, may place them side by side

IRANIANS

with their strong belief in the will of God, specially in the event of death.

- Food and other natural substances are believed to play a role in health. The use of “hot” and “cold” foods to prevent or cure minor illnesses is also common. Certain food such as honey, sugar, and nuts are considered hot, whereas yogurt, berries, and watermelon are considered cold. Consuming too much of one and too little of the other is believed to cause stomach upsets or other minor disorders.

Relationship Between Doctor and Patient

- In general, Iranian patients seek a more personal relationship with their doctors than do mainstream Canadians. They expect their physicians to listen to long stories about their health and personal problems. Also they expect a great deal of understanding since they regard family doctors as confidants
- In order for a Canadian physician to gain his or her Iranian patient’s confidence and trust, he or she must take the time to listen and respond sympathetically. Trust can be established during the first few visits and once this is achieved, the patient becomes a “believer” in his or her doctor.

- Since Iranians belong to a strongly patriarchal society, it is only natural that male physician are trusted and esteemed more than their female counterparts. Female doctors, however, are trusted equally, even preferred in certain areas of medicine. Women gynecologist and obstetrician, pediatrician and eye specialists are preferred.
- Generally Iranian men prefer seeing a male physician to a female one.

Mental Illness

- Iranian generally resist seeking help from psychiatrists and other professionals in mental health agencies, mainly because of the stigma associated with mental illness.
- The majority of families tend to conceal such problems for fear of jeopardizing their children’s chances of marriage.
- Many people in Iran also attribute insanity to evil spirits.
- Iranians are much more comfortable with physical than with mental illness.

Pregnancy

- Pregnancy is considered a blessing and expectant Iranian women become the focus of much attention and care.

- The traditional belief among all classes of Iranians is that pregnant women must abstain from heavy physical work, rest frequently and eat rich and healthy foods. Extensive weight gain often becomes a problem.
- Health professionals in Canada may encounter difficulty in convincing pregnant Iranian women to exercise regularly.
- Because of the relatively high level of education among younger Iranian women in Canada, they generally recognize early signs of pregnancy and therefore go to the doctor at an early stage.
- Information about pregnancy is passed on from mother to daughter or daughter –in-law, usually immediately after the onset of pregnancy.

Childbirth and Postpartum

- In Iran, childbirth takes place in hospitals, private clinics, and in homes and delivery is attended by physicians and certified midwives.
- Close female relatives keep mothers company at childbirth.
- In Canada, more and more Iranian fathers are now present in delivery rooms.
- In Iran infants are brought to their mothers only to be breast fed, since new mothers are believed to need rest and quiet.

IRANIAN

- Certain foods such as barley, and water drained from boiling rice are considered good for increasing the milk flow and mothers are fed these and other rich foods.
- The mother and infant are not secluded and usually begin socializing outside the home within two or three weeks of childbirth.
- Regular visits by public health nurses in Canada are highly valued by Iranian women who, although unfamiliar with the idea, fully appreciate the information and support they receive.

Marriage

- Marriages are not arranged and children have the last word in choice of partner. Nevertheless, parental consent is essential to the decision.
- Women typically marry between twenty-two and twenty-five. Iranian women are generally five to ten years younger than their husbands.
- Chastity is highly revered and premarital sexual activities are considered sinful, specially for women.
- While the Muslim religion allows men to take several wives, this practice has fallen into virtual abeyance.

Religion

- More than 98 percent of Iranian are Muslim and believe in one God, Allah.

- The 2 percent of the population which is not Moslem probably belongs to the more modern middle class. In this group are the Bahai, Zoroastrians, Jews and Christian, comprising Armenians and Assyrians.

Children

- Children are taught to be obedient and respectful.
- Iranian children, both male and female are expected to do extraordinary well and achieve high marks at school.
- Unmarried children of any age and of both sexes usually live with the family and move out only after they are married.

The Elderly

- The elderly are the most respected members of the family. The deep sense of duty towards the elderly includes responsibility for the care of old and dying family members.
- There are very few nursing homes in Iran and sending elderly people to them is considered disrespectful and cruel.

Food and Diet

- A staple in Iran is rice and Iranian boast about their many rich and lovely rice dishes and spend much time preparing them.

- Meat is an essential part of Persian dishes, lamb, veal, beef and chicken are the most popular. Fish is eaten in moderation but other seafood like crab, lobster and oysters is not commonly eaten.
- The consumption of pork is forbidden by Islam.
- Persian food is not hot or spicy.

Literacy

- The elderly are less likely to be literate in either Farsi or English.
- Families of rural areas or lower socioeconomic background may not be literate in Farsi.

Census Data

- About 3000 immigrants from Iran reside in Calgary and they mostly reside in the NW and SW areas of Calgary.

Death and Dying

- "God gives life and god takes life." This belief is commonly held by almost all Iranians.
- It is believed to be best to die at home in the presence of the whole family, for dying in loneliness and solitude is disgraceful.
- Communication of a grave diagnosis to the patient is also done in stages and with utmost tact. Iranian families feel that much harm can come from bluntly confronting the patient with a poor prognosis.

IRANIANS

- Iranians often complain that doctors in the West are insensitive to this issue and condemn the physician's directness in presenting the bad news.
- Canadian physicians may call in a single family member, preferably a male, to reveal the diagnosis to him tactfully and gradually.
- Most Iranian religious sects prescribe certain bathing rituals for the dead and place the body in the white clothing
- A section of Koran is read to the dying individual.
- Prayer are stated.

Medication and Treatment

- Drugs are the preferred means of treatment among Iranians and physicians in Canada will have little difficulty in convincing Iranian patients to take prescribed medication. However, convincing an Iranian to exercise regularly or to cut down on certain foods may be a different matter.
- Pills and injections are most popular, injections are believed to render faster results.

Hospitalization

- Iranian are very sociable and hospital visits to friends and relatives are considered a moral duty.

- Visitors come in large numbers, bring sweets, flowers and gifts and stay for long hours.
- Iranian have a tendency to disregard hospital regulations about visiting hours, staying with the patient overnight or bringing forbidden food. Should these problems arise, asking the family doctor or a trusted specialist to intervene gently may be the most effective solution.
- Iranian women may experience great discomfort in the presence of male nurses. Whenever possible female nurses should be used.

Family Planning

- The favorite methods of contraception, generally chosen by women, are birth control pills and the IUD.
- Abortions are illegal in Iran and take place only for medical reasons in an attempt to save the life of the mother.
- Male children are generally preferred.

Rehabilitation

- Like mental illness, mental and physical handicaps are stigmatized in Iran.
- Most kinds of prenatal and perinatal disabilities are viewed as hereditary and hence are concealed from the eyes of the public.

- Because of Iranian attitudes to disability and the scarcity of rehabilitation and self-care services In Iran, mentally and physically disabled individuals in Iran lack the motivation to adapt.
- Rehabilitation professionals in Canada may find working with Iranian clients and their families extremely difficult.

Culturally Sensitive Health care

- Respect for cultural beliefs and values, which are linked to the Muslim religion.
- Iranian women will feel most comfortable with female health service providers.

Multicultural Awareness Program – PLC

SOUTH ASIANS

CULTURE

Family Structure

- Family is the most important social unit, and includes parents, children, and grandparents, brothers, sisters, and their families.
- Traditionally the extended family lives together in one household. The extended family provides the identity of the individual as well as economic and emotional security. Interdependence valued.
- Earnings are often pooled in an extended family. Sometimes, either the grandmother or the eldest son manage the finances.
- Most decisions are made by the head of the household – often the most established financially secure male.
- Close relatives are consulted for all important decisions. Health care decisions, like seeing a doctor with an ill child, are made by the senior members of the family.
- Care for ill family members is the responsibility of the wife or mother.
- The opinions of relatives and other members of the community are held in high regard and gossip can be used to effect social control.

Acculturation Issues

- South Asian families experience many significant acculturation issues. Grandparents often become primary caregivers and have feelings of lost and respect, youth face racism from their peers, many professionals are underemployed, and sometimes women who did not previously work enter the workplace.
- Many intergenerational issues and conflicts present in adjusting to life in Canada as parents and grandparents wish to maintain the same traditions.
- Traditional dominance or authority held by the elderly within the family is frequently weakened after moving to Canada. Usually sponsored by a son or daughter, elderly people arrive

HISTORY, BELIEFS & HEALTH PRACTICES

Immigration History

- Majority of South Asians are from India, Pakistan, Bangladesh, Sri Lanka, East Africa, and Fiji.
- Over 400 dialects are spoken. India alone has 15 official languages. The most common languages are Hindi, Punjabi, Urdu, Gujarati, Kachi, and Swahili.
- South Asians come to Canada in various immigration categories including independent, family class, and refugee status.

Traditional Practices & Beliefs

- Illnesses are seen as the result of imbalance in the body humors, bile, wind and phlegm, and the purpose of treatment is to re-establish the balance.
- Dietary imbalance is thought to be a common cause of illness. Often specific foods are used to re-establish bodily balance. Foods are classified as “hot” or “cold” or “neutral” not in terms of temperature or spiciness.
- It is generally thought that bathing in still water (bathtub) is unclean. South Asians use running water such as a stream, shower or by pouring buckets of clean water over their bodies.
- Bathing (or its avoidance), massage and rubbing oil on the body are other ways to rebalance and thus thought to cure. In South Asian villages it is common to explain stressful circumstances by the supernatural.
- Many methods are believed to treat illness. Traditional medicines, vows, rituals, and biomedicine may all work, and may be used for the same illness.
- Even for those of higher socioeconomic status who may not believe in such traditional medicines, many habits, treatments, foods, and the day-to-day health practices are based on these traditional beliefs, and they may hesitate

Relationship Between Doctor and Patient

- Extensive trust in both traditional and modern physicians. Patient may expect the doctor to have all the answers and make all the decisions.
- Patient takes a passive role, often not asking questions and waits for the physician to determine diagnosis and recommendations. Medical advice often accepted without question.
- Patient expects treatment in the form of medicine, injection, pills or tonics. Otherwise patient may be skeptical and unsatisfied. May prefer the physician to take charge.
- South Asian women hesitate to be seen by male physicians; they and their husbands believe that women should have a female doctor.
- South Asians may be less familiar with the professional role of nurses in Canada, and health practitioners may need to provide some orientation regarding this aspect.

here in a dependent role, not knowing the language or culture.

Cross-Cultural Interactions

- Traditional greeting: palms of the hands pressed together in front of the chest. Shaking hands particularly by women or between women and men is not common.
- Direct eye contact may be considered rude and disrespectful, especially with elders. Physical affection rare even among family and close friends, and is considered extremely inappropriate between members of the opposite sex, including husband and wife.
- For some groups, it is not appropriate for a woman to even state her husband's name in public, and many women are expected to walk a few steps behind men.
- It is more acceptable for elders to give commands or orders to younger individuals, but older individuals expect to be treated with respect.

Marriage

- Often still, many arranged marriage take place among South Asians in Canada.
- Couples are expected to stay together; this and the additional stress of immigration can sometimes result in violence. Sometimes a woman is in Canada without her extended family and is more isolated without support for such issues.
- A South Asian woman who has separated from her husband is unlikely to initiate divorce proceedings because it is more acceptable for a man to leave his wife and children and initiate divorce.
- In some cases, if a woman leaves her children with her husband she is considered a bad mother. For a Muslim family, however, it is expected that the husband's family maintain custody of the children.
- Sometimes even after a divorce, a couple will continue in many ways as if still married. A man may occasionally stay with his ex-wife and children, and the community continues to address them as husband and wife.

Religion

- The most common religious groups in the South Asian communities in Canada are the Hindus, Sikhs and Muslims,

to utilize biomedicine for particular illnesses.

- Traditional ways of making health decisions persist particularly initially while in Canada.

Prevalent Disease

- Infections and parasitic diseases are the most prevalent.
- South Asian immigrants may have experienced typhoid, dengue fever, cholera, tuberculosis, hepatitis, and amoebic dysentery.
- Most South Asians have had their immunizations and medical exams before coming to Canada.

Treatment and Medicines

- The concern that biomedicines may be too strong or upset the body's balance leads many South Asian patients to avoid their use or stop taking them prematurely.
- Many traditional remedies are used, and elderly women often recommend home treatments. Elderly members and the male household head are consulted about the need to see a doctor.

Health Care Systems

- A visit to a biomedical doctor is very costly for rural families and is avoided unless the disease is serious and the family can afford the fees, medicines and travel. Government sponsored social services, such as those in Canada are non-existent.
- People most often access hospitals for more serious illnesses. The ratio of available hospital beds in India is 1 to 1310 people, versus 1 per 110 people in Canada.
- Use of traditional medicines often continues even where the family has health insurance and easy access to biomedicine.
- Home remedies such as massage, bathing, and herbal medicines (either made at home or purchased from an Indian shop) may be used first, while a physician is sought out only for serious illnesses.
- Families are accustomed to being very involved in the daily care of the patient in hospitals in South Asia.

Mental Illness

- Mental illness is sometimes believed to have supernatural causes, particularly spells or curses cast by jealous relatives or acquaintances, and are resolved by visiting temples.
- Mental illness is stigmatized and is generally hidden for the sake of arranged marriages.
- Severely ill family members are not ignored or rejected, but may be kept hidden and untreated until a crisis.
- While most South Asians prefer medicines for treatment, some patients in Canada do resort to psychiatric help. Western "talk" therapy is not usually compatible. Instead it may be more appropriate to provide direction and clear advice about patient and family involvement.
- Inquiries regarding family interactions and issues is not very culturally acceptable as the family operates in a close unit and maintains privacy.
- The Western therapeutic value of independence from the family is less appropriate in intervention for South Asian families.

Family Planning

- Often the husband makes decisions about family size. The favorite methods of contraception are the IUD and contraceptive pill; diaphragms and condoms are seldom used.

although there are some Jains and Christians.

Hinduism

- Concept of the unity of life; all life is interdependent, both human and animal, and is a continuous circle.
- After death, the soul is reborn in another life form which is determined by behaviour in former lives. This is the law of Karma.
- High caste Hindu men participate in a religious ceremony in their youth in which a sacred thread (or string) is tied around the body; it goes over one shoulder around the chest and is tied at waist level. This thread should not be cut or removed without the permission of the patient or his family.

Sikhism

- Sikhism includes Hindu concepts of reincarnation as well as Karma. However, representation of God in pictures and the worship of idols are forbidden.
- The most important ceremony for a Sikh is that of baptism. Baptized Sikh men wear turbans and do not cut their hair or beards. They wear a comb, white undershorts symbolic of chastity and typical of soldiers, and in their home country a small symbolic sword.
- Strictly practicing Sikh men do not cut their hair. If it must be cut it is important to explain the need fully both to the patient and the family.
- The Sikh man's bracelet and kirpan must also not be removed or permission should be obtained.

Islam

- "Islam" means "submission" and a Muslim is one who submits to the will of God, rejects all other gods and follows the teachings of the Koran, the holy book.
- Ethical conduct requires: generosity, fairness, honesty and respect.
- Muslims are required to pray five times daily, facing the direction of Mecca, after a ritual washing. They should additionally attend a mosque to pray together on Friday.
- Muslims sometimes wear 33 beads around their necks or wrists and these represent the 93 names of God. They should not be

Hospitalization

Visiting:

- Family, friends and neighbours want to visit a hospitalized person, which the patient is happy about; patient may be upset if certain people do not appear.
- If necessary to limit the number of visitors, it is best for hospital staff to speak with the patient's husband, father or a male elder to explain the situation and to seek the cooperation of visitors.
- Family may wish to stay with the patient and assist in providing care.
- Some individuals feel uncomfortable providing written consent, and it may be necessary to provide an explanation.

Hospital Food:

- Religious dietary restrictions can present problems for South Asians having hospital food. For example a vegetarian may not accept a vegetarian meal if it was prepared in a kitchen where meat was also cooked, or if the meat has simply been removed from the plate.

Hospital Clothing:

- Some South Asian patients in Canada hesitate to wear clothing that others have worn before them, even where it has been washed and sterilized; they prefer their own clothing where possible.
- Women may prefer not to use hospital clothing for new babies since they may have superstitions about clothing previously worn by another.

Hospital Treatments and Surgery:

- Surgery is sometimes felt to be threatening - only after detailed explanations about the surgical procedure and its necessity will the family agree.
- The decision is made not by the individual patient but by the whole family.
- There is no religious or other belief that prevents blood

Pregnancy

- Viewed as a very natural process, some South Asian women do not see the need for prenatal care. Visits to a doctor are associated with problems or abnormalities.
- Sex not openly discussed with strangers. Prenatal classes are embarrassing for both women, who feel they should not exercise in front of others, and for men.

Childbirth

- In South Asian women often utilize midwives who encourage women to be active, walk around, and sometimes herbal medicines are given. Delivery is often in a squatting or sitting position.
- Labouring woman may take a passive role, following instructions.
- Most commonly fathers are not present for delivery, but female family members may be involved.
- Canadian hospital practices will be unfamiliar to many women from South Asia.
- Women prefer natural delivery and often will not request an anesthetic or know little info.
- Decisions are left to the physician. Forceps and Cesarean section are usually accepted if clearly explained by the doctor.

Postpartum Period

removed unless absolutely necessary.

Children

- South Asian families are patriarchal, and male children are often preferred as they carry on the family name as well as tradition.
- It is not uncommon for children up to the age of 12 to share a bedroom with their parents or with siblings of the opposite sex.

The Elderly

- When South Asian parents grow old they expect to be cared for by children, particularly sons, and the sons recognize this obligation. Women are more commonly involved in the daily care.
- The reversal of traditional patterns of dependence and authority can cause conflicts and a loss of self-esteem/depression in the elderly.

Food and Diet

Hindu Food Practices

- Strict Hindus believe in non-violence against living things and abstain from meat or fish. The more orthodox, especially women, also do not eat eggs.

Muslim Food Practices

- Muslims follow dietary laws of the Koran – forbidden to eat pork or the blood of any animal.

Sikh Food Practices

- No significant dietary restrictions, but many Sikhs are vegetarians by choice.

Food and the Prevention of Illness

- Diseases are thought of as cold, for example arthritis. Rheumatism, respiratory infections, upset stomach and other gastrointestinal problems and circulatory problems.
- It is considered important for ill people to be given easily digested soft food such as cream of wheat, lentils without spices, khichari (lentils and rice) and soup made of whole wheat

transfusions or organ transplants.

- Most South Asians prefer that catheterization or enemas be performed by a staff member of the same sex.

Death and Dying

- Accept death as part of a life cycle, and that it occurs when it is time.
- A peaceful death at home surrounded by family is strongly preferred to death in hospital.
- Generally, South Asian physicians do not inform the patient that he or she will soon die, and the family might wish to be informed first, so they are able to make the decision to tell the patient.
- Families and friends are expected to express their grief openly by moaning and crying.

Hindu

- Before death relatives of the dying person may bring clothing and money for him to touch before distributing them to the needy.
- A passage from a holy book or chant prayers may be read to the dying patient to help them in the next life.
- The eldest surviving son plays an important part in the rituals after death. He, along with other relatives, washes the body and dresses it in new clothing.
- In the case of a married woman red clothing and jewelry signifying her married state are used.
- When a person dies in a Canadian hospital, the family prefers to wash and dress the body before it is removed from the hospital. Bodies are cremated, usually on the same day as the death and ashes are kept until they can be thrown on to the surface of the sacred river, the Ganges. In Canada the family may also throw the ashes into a local river or the sea.
- Traditionally cremation ceremonies are attended only by men. Mourning period lasts 40 days.

Muslim

- As a person nears death, Muslims repeat the words of the Koran to the person.

- After the birth of a Muslim child, a family member is to recite a prayer in the baby's ear as soon as possible.
- A male Muslim baby must be circumcised. For other groups circumcision is by choice.
- South Asian women expect the baby to stay with them, and may have concern regarding the baby being in a nursery.
- South Asian women are to eat hot foods and to avoid cold foods.
- Hot foods are to strengthen the body, balance the system and promote bleeding and discharge so that a flat stomach results. Cold foods are thought to cause weight gain.
- It is believed that excessive admiration or compliments about the baby may have a negative effect.
- Breastfeeding is preferred, although the baby may be bottle fed if the mother has to return to her job and the grandmother is the primary caregiver. Women breastfeed for at least six months and sometimes up to 2 to 3 years.

Culturally Sensitive Health Care

- Religious practices play a critical role. It is important for health practitioners to ask families about their beliefs and values.
- Many who are of higher education and socioeconomic

SOUTH ASIANS

- flour and milk. These are the foods a South Asian family might bring a patient in hospital.
- Most common foods are rice or chapatti (flat baked bread) with vegetables, meat or lentil curry.
 - During Ramadan (Dec. – Jan: dates vary according to the calendar) Muslims fast from sunrise to sunset, children and the ill are considered exempt. Fasting may also be recommended for fever, cold, or arthritic pain.

Literacy

- South Asians from urban settings are more likely to be fluent and literate in both English and their first language.
- Women are sometimes less fluent in English and may not be literate in their first language, as education for males is emphasized more than education of females.
- South Asians may prefer that family members act as interpreters, and the individual is preferred to be of the same gender but older in age.

Census Information

- India and Pakistan were among the top 10 source countries of immigrants arriving in Calgary in 1998.
- 25, 525 Calgarians in the 1996 Census identified themselves as part of the South Asian community.

- Once death has occurred the body is ritually washed before being buried with the face pointing towards Mecca.
- If death occurs in hospital, it is preferred that staff not wash the body but that they turn the head towards the right shoulder before wrapping the body in a plain sheet.
- During these procedures family members may wish to read passages of scripture or to make lamentation.
- Religious rules stipulate that the body should be cremated as soon as possible after death and that it be complete and whole. For these reasons, Muslims will agree to a post mortem only if it is legally necessary and will request that the organs be returned to the body for burial.

Sikh

- After death, members of his or her family prefer to wash the body and prepare it for cremation. The body is viewed at the hospital if that is where death occurred.
- Sikhs do not readily agree to post mortems nor do they agree to donate organs.
- After the cremation there is a memorial service at the Sikh temple, at which time prayers are said for the soul of the person.

- status are well aware of biomedical practices, though family members expect to be very involved in the patient's care and in decision-making.
- Families from rural areas will be less exposed such health care systems.
 - For many, there is little experience with social service agencies and sometimes distrust of government or sponsored agencies.

Multicultural Awareness Program – PLC

VIETNAMESE

VIETNAMESE		
CULTURE	HISTORY, BELIEFS & HEALTH PRACTICES	
<p>Family Structure</p> <ul style="list-style-type: none"> Identity is related to the family unit, and there is strong loyalty to a family. Family may include the elderly, an adult couple and their children, and spouses of married children. In Vietnam women have fewer rights than men relating to education, political influence and employment. Family obligations are strong, even toward those members outside Canada which may impact a family's ability to become established in Canada. Father or eldest son represent the family and make decisions. Women are responsible for the care of an ill family member. <p>Acculturation Issues</p> <ul style="list-style-type: none"> While many families from the Vietnam have been in Canada for several years, they face issues in intergenerational relationships, language, employment, and settlement. <p>Cross-Cultural Interactions</p> <ul style="list-style-type: none"> Prefer formal relationships; Use the title and first name (e.g. Mrs. May). Avoid joking and pointing a 	<p>Immigration History</p> <ul style="list-style-type: none"> While some Vietnamese families come from more established backgrounds with professional skills, a number of Vietnamese in Canada have had experiences as refugees and have been in refugee camps. Languages: Three major languages spoken are Vietnamese, French and Chinese. <p>Traditional Health Practices & Beliefs</p> <ul style="list-style-type: none"> Many traditional methods are used in addition to Western biomedicine. Physical exercise is often not perceived to be a part of healthy living. Hot and Cold - like the Chinese belief regarding two opposite forces of yin and yang - hot and cold. The body must have an equilibrium to avoid illness. Illnesses are believed to be the result of excess body heat or cold. Hot illness might include constipation, dark urine or hoarseness. Wind and Water – may result in headache, cough, nausea. The bad wind is thought to be released by creating small bruises on the body with a coin or a spoon or by cupping - placing a hot cup on the body and letting it cool until the air contracts and draws the skin upward. Bathing is thought to be risky as it cools the body and may create illness. <p>Traditional Medical Practitioners</p> <ul style="list-style-type: none"> Vietnamese try home remedies before going to a doctor. If they do not work, he/she may approach herbal practitioner. <p>Prevalent Diseases</p> <ul style="list-style-type: none"> Hepatitis B is prevalent in the refugee camps where water is often contaminated. Pulmonary tuberculosis is sometimes present in immigrants from Vietnam – usually inactive. Leprosy found only in tuberculoid form in Vietnam can be 	<p>Relationship Between Doctor and Patient</p> <ul style="list-style-type: none"> Vietnamese defer to health professionals. Doctors are highly regarded, and Vietnamese trust and rely on doctors for medical decisions. Nurses are perceived as support to physicians when they are present, not to initiate activities. The role of nurses may need to be clarified for Vietnamese. Expectations of physician: formal and unhurried, with quick diagnosis with few questions or an elaborate physical. Detailed questions about their lives, past or their families are not openly accepted. The act of talking too much about an illness is thought to induce it. Patients do not expect detailed explanation of the diagnosis nor the purpose of the recommended treatment. Many people may be unable to give detailed medical histories from their life in Vietnam because doctors did not generally provide such information. Do not like to remove more clothing than is absolutely necessary for a physical examination. Family, who are usually with the patient, are to be informed of the diagnosis and treatment, as family and elders in particular make decisions for treatment. Married women often prefer female physicians and will accept a female nurse in the examining room, but not usually a family member. Unmarried women often are extremely reluctant to have pelvic examinations unless they are absolutely necessary and clearly explained. Politeness does not necessarily mean agreement, and patient may disregards treatment recommendations and further appointments. May find it difficult to adapt to appointment system. <p>Mental Health</p>

V I E T N A M E S E

<p>finger, which may be disrespectful.</p> <ul style="list-style-type: none"> • The importance of politeness may hide an individual's disagreement or misunderstanding. • Prefer glances in contrast to continual direct eye contact. • While gentle touch is acceptable, the head is believed to be sacred and should not be touched on a child or adult unless explained. It may be less appropriate to use touch with the elderly. • Feet are considered profane and should not be pointed directly towards another person. <p>Marriage</p> <ul style="list-style-type: none"> • Marriages are generally arranged by both sets of parents. • Husband and wives do not expect to have close nurturing marriage. • Husbands and wives tend to socialize separately and the wife may avoid confronting her husband regarding drinking or extramarital affairs. The marriage itself is not usually threatened. <p>Religion</p> <ul style="list-style-type: none"> • Many families are Buddhist; may also worship a variety of shrines and practice Confucianism or Catholicism. <p>Children</p> <ul style="list-style-type: none"> • Vietnamese families are very 	<p>easily as it may appear like skin diseases.</p> <ul style="list-style-type: none"> • Malaria is sometimes brought from Vietnam. <p>Health Care Systems</p> <ul style="list-style-type: none"> • In Vietnam the hospital is the last choice and used for emergencies when all other treatments are unsuccessful and the family cannot provide care. • In Vietnam, a family member usually stays with the hospitalized individual to assist in providing personal care. Many family members visit the patient at all times except at night or during physician's rounds. • Family has considerable control over decisions and treatment. • As families are less involved in the hospital care in Canada, they may feel powerless and that they are abandoning their family member. <p>Hospitalization</p> <ul style="list-style-type: none"> • Elderly are reluctant to be admitted to hospital because it is perceived to be linked with death. • Vietnamese prefer privacy and often want curtains pulled around the bed. Often do not reveal the body area between waist and knees, even to closest relatives. Will wear hospital gowns, but with discomfort. • Concern regarding effects of wind in hospital rooms from windows and the impact on health. • Admission to hospital in Canada may be delayed beyond the optimal point of treatment and a patient may be taken home as soon as he appears to have improved. • Elderly patients in particular may avoid hospitalization or try to go home to avoid dying in hospital. • Nurses and doctors are highly respected. • Patient may prefer family member of the same sex to assist with personal care – privacy and modesty are critical issues. • Patient acts passively and expects to be cared for by a family member. • If needed, family members are willing to donate blood. <p>Treatment and Medications</p> <ul style="list-style-type: none"> • May be stoic when experiencing pain, and often do not request medication. • Hold the belief that medications may lead to addiction, and may not want to take pills. • Home remedies are often practiced before going to the 	<ul style="list-style-type: none"> • Mental illness is often equated with severe disorders verses other depression or anxiety. It is believed that there is no cure for a mentally ill individual. • Supernatural Beliefs – forces are often used in explaining mental illness, and it is thought that a mentally ill person's behaviour may have offended a god, who then punishes him or her with the illness. • A cure is thought to be reached by remaining at a temple to ensure that spiritual forces forget the ill individual. • Mentally ill people are both feared and rejected, and their family members feel shame. • Consulting a psychiatrist is seen as equivalent to diagnosing a family member as insane. Often a Vietnamese individual will resist treatment after the first contact with a psychiatrist or mental health clinic until they become ill again. At this time it may be possible for the patient to accept treatment, especially if rapport and trust were developed in the initial contact. • Most often individuals are not willing to discuss personal feelings about family or other more senior persons, most will describe their childhood as satisfactory. • "Talk therapy" is not acceptable as it investigates family relationships and is the primary method of intervention. Open-ended questions are threatening. • Intervention most appropriate when combined with medical treatment such as drug therapy or with some kind of social intervention. Sometimes, a referral to a spiritual leader, in combination with other interventions, is appropriate. • Consider psychosocial factors that may have contributed to the illness by discussing the following: 1) life, problems and stresses in the home country; 2) escape or departure, who came, who remains overseas, the experience; 3) refugee camp experience; 4) attitudes towards and problems of being in Canada; 5) current worries and outlook for the future. • It is important to consider that the patient may have experienced trauma as a refugee, and that timing affects the reopening of these issues. <p>Family Planning</p> <ul style="list-style-type: none"> • Traditionally in Vietnam contraception was not valued nor
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V I E T N A M E S E

<p>attentive to their babies who are not often allowed to cry, but instead are held by mother or sibling.</p> <ul style="list-style-type: none"> Parents traditionally believe they have the right to beat a child without intervention, but it rarely occurs. <p>The Elderly</p> <ul style="list-style-type: none"> Elderly are respected and privileged. Ill parents are often cared for at home. Children are expected to provide care and support for their parents. Institutional care is viewed as disrespectful. <p>Food and Diet</p> <ul style="list-style-type: none"> Foods are classified as hot, cold or neutral; balance prevents illness. Prefer warm soft foods when ill. Never consume cold drinks, like ice water. Many are lactose intolerant. <p>Literacy</p> <ul style="list-style-type: none"> Many elderly Vietnamese and several women are not literate in Vietnamese. There is often a need for interpreters. <p>Census Data 1996</p> <ul style="list-style-type: none"> 9, 870 Calgarians listed themselves as from the Southeast Asian community, which includes but is not limited to Vietnam. 	<p>doctor – examples include cupping and coin rubbing. Be aware that some of the bruising from these treatments may seem similar to bruises from abuse.</p> <ul style="list-style-type: none"> In Vietnam good doctors are expected to give medicine – both pills and injections are acceptable. May be resistant to Western medicine. As there is a tendency to stop taking medicines prematurely, it may be helpful to reduce the recommended dosage of biomedicines. Vietnamese may feel Western medicines do not apply to them. People often insist on x-rays, and most laboratory tests are acceptable such as urinalysis. Many Vietnamese fear and resist blood tests that require even small samples of blood, feeling that it is not able to be replenished. May feel headaches or weakness are related to blood tests. Great reluctance to surgery, as the soul is believed to be attached to parts of the body. If those parts are removed or if the body is merely cut, the soul might escape maybe leading to death. <p>Death and Dying</p> <ul style="list-style-type: none"> Among the Vietnamese there is a very strong feeling that death should occur at home with dignity unless it is an acute illness. If death does occur in the hospital, it is important to move the body home as soon as possible. Inform the head of the family – parents or adult child. Generally the family wishes to be told about a terminal illness, but may not tell the patient. It is important to consult the head of the family. For traditional mourning family members wear white clothing for fourteen days, followed afterwards by their wearing of black armbands. A wake is held 49 days later. A spiritual or religious rite may take place after death. It may be important to involve a priest or monk. Family may wail loudly and need extra time with the deceased. Traditionally, organ donation/autopsies are not permitted. 	<p>legal.</p> <p>Pregnancy</p> <ul style="list-style-type: none"> Believed to be a normal condition, but care should be taken to maintain the body's equilibrium. Much attention given to pregnant woman. Strenuous activity not allowed. During pregnancy, sex is considered taboo. Once in Canada most women are willing to make regular prenatal visits to the physician and even attend prenatal classes, particularly where classes are conducted in Vietnamese or Cantonese. <p>Childbirth</p> <ul style="list-style-type: none"> If pain relief methods are made available, Vietnamese women use them and even request. May appear self-controlled and stoic during labour. Father may participate if he has been involved in prenatal programs, but will likely take passive role. Much support from labouring woman's mother or close female family member. Both male and female babies are openly accepted. Strongly prefer vaginal delivery. <p>Post Partum Care</p> <ul style="list-style-type: none"> Mother expects to be with baby at all times. Care during this period is viewed to be very important, and women are to rest and have nourishing soup. Woman is not to shower for 2-4 weeks, but sponge baths are acceptable. Traditionally breastfeed for one year, and the mother is to follow a strict diet without "cold" or "windy" foods. Male circumcision varies by family beliefs. Woman's body viewed to be in a cold state, so women are reluctant to bathe or wash their hair. Sponge baths are acceptable. It is important to avoid cold foods such as water, fruit juices, raw vegetables and fruit, and drafts/cold air.
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Multicultural Awareness Program – PLC

KOREANS

KOREANS

CULTURE	HISTORY, BELIEFS & HEALTH PRACTICES	
<p>Family Structure</p> <ul style="list-style-type: none"> Family is very important, and self-esteem stems from family and its honour/respect within the community. Much life focus on family roles and obligations. Important family values: cohesion, interdependence, hierarchy in relations, and harmony. Decision-making historically patriarchal, though there is now more focus on family involvement. Husband, father or eldest adult child usually acts as the family spokesperson. Woman often considered caregiver responsible for the home, while most decision-making is by the father. <p>Acculturation Issues</p> <ul style="list-style-type: none"> Many families experience intergenerational issues as youth acculturate at a faster rate than their parents, and parents wish to maintain traditional roles and values. <p>Cross-Cultural Interaction</p> <ul style="list-style-type: none"> When comfortable with another person, it is acceptable to use touching, friendly pushes, or hugs. Touching is considered disrespectful among strangers unless for medical purposes. Like within Vietnamese culture, it is considered rude to direct the sole of a person's foot or shoe towards another individual. Direct eye contact not used unless the person is very comfortable with another. Silence will exist among strangers, while it is less common among those familiar with each other. Should use Mr., Mrs. or other pronouns and the last name unless the patient requests differently. Respect for elders is important and is often demonstrated by slight bow. Tone of voice varies, with loudness placed on what is considered important, it may seem like arguing. Commands are louder and authoritative when directed to someone younger while may be softer and quieter with an 	<p>Immigration History</p> <ul style="list-style-type: none"> Many families have left Korea seeking new opportunities in Canada and arrive as independent class immigrants or entrepreneurs. <p>Traditional Health Practices and Beliefs</p> <ul style="list-style-type: none"> Illness and death are accepted as a natural part of the life cycle, but many see illness as bad luck related to something they may have done in the past (Karma). Patients may be stoic as they feel their fate is determined, and thus may experience depression, helplessness, or denial. Illness traditionally believed to be related to an imbalance of hot and cold – Yin and Yang. May practice both Eastern and Western medicines congruently. Holistic concept of health with harmony and balance between soul and physical health, as well as having balance with family, finances, & home. <p>Health Care Systems</p> <ul style="list-style-type: none"> Koreans usually have access to comprehensive health care and pay premiums. May not be used to obtaining prescriptions from a doctor as pharmacists in Korea can also prescribe medicines. Health system in Korea recognizes both traditional and modern medicine. <p>Hospitalization</p> <ul style="list-style-type: none"> Patients may be less familiar with the training, qualifications, and role of nurses in Canada. Older patients may have family members involved in some patient care – often the duty of children. Privacy is a very highly maintained value, and an 	
	<p>Relationship Between Doctor and Patient</p> <ul style="list-style-type: none"> Much respect for health professionals. Clarity is needed for development of rapport and patient comfort level. May even need to discuss simple procedures with family members. Females may prefer to work with a female gynecologist. <p>Mental Health</p> <ul style="list-style-type: none"> Mental health issues or depression are viewed as shameful and are not openly revealed. May be hesitant to use anti-depressants. May be believed to be linked with behaviour in a previous life, or may be linked to spirits. <p>Pregnancy</p> <ul style="list-style-type: none"> Prenatal care is expected, and woman believes in following advice provided. Avoidance of cold soups or liquids, and traditionally, some meats/seafood are avoided as they are believed to harm the baby's appearance. Rest and restriction of activities are promoted. <p>Childbirth</p>	

<p>elder.</p> <ul style="list-style-type: none"> Note: January 1 is considered every Korean's birthday, and they add a year to their age on this date regardless of the date they were born. <p>Marriage</p> <ul style="list-style-type: none"> Wife traditionally stays within the home after marriage. The husband is expected to hand over all or most of his salary to the wife, who manages the family finances. <p>Religion</p> <ul style="list-style-type: none"> Predominantly Christian, though influenced by Shamanism – spirit worship, and Taoism, Buddhism, and Confucianism were originally practiced. Chanting and praying are common, and often people utilize a mixture of faiths. <p>Children</p> <ul style="list-style-type: none"> Expected to be obedient and responsible. Focus on family interdependence. Education highly regarded. <p>The Elderly</p> <ul style="list-style-type: none"> Have high amount of respect, welcomed to live with the family. Grandparents often involved in care of grandchildren. <p>Food and Diet</p> <ul style="list-style-type: none"> Cold fluids may not be consumed as it is felt to be linked with the cold/hot balance of the body. Diet high in fiber and spice with rice, beans, vegetables, seafood, and lean meats. Many meals include soups with meat, vegetables, and noodles. Often lactose intolerant. <p>Literacy</p> <ul style="list-style-type: none"> Elder first generation and recent immigrants may not speak English, or may use limited spoken English.. It is important to use family members as interpreters when possible, as the patient is more comfortable. Gender issues are less of an issue in the professional setting. <p>Census Information</p> <ul style="list-style-type: none"> Korea was one of the top 10 countries of origin for immigrants arriving to Calgary in 1998. 2, 220 Calgarians in the 1996 Census identified themselves as part of the Korean community. 	<p>embarrassed patient will be less likely to disclose information. Establishment of trust assists more difficult or personal assessments.</p> <ul style="list-style-type: none"> Patients prefer sponge bathing while in hospital and are often very clean. Patient may have a sick role in which they behave very ill, maybe even worse than they actually are. May be more expressive or dramatic regarding their illness when family are present. Patient, and men in particular, may appear stoic when experiencing pain. It may be most useful to ask how bad pain is rather than using a pain scale which may seem less concrete. Family and other visitors will frequently come to see the patient out of respect. Family may expect to stay with the hospitalized patient, and will bring food/feed the patient. <p>Treatment and Medications</p> <ul style="list-style-type: none"> Some view surgery as an illness in itself. Pain medications are not often used for fear of addiction or complications. IV is viewed as less invasive. Herbal therapies are often used, and a traditional herbal medicine doctor may be accessed. <p>Death and Dying</p> <ul style="list-style-type: none"> A palliative illness should be discussed first with the head of the family, who will then tell the family. Family likely to prefer that the patient remain in the hospital if it is best for their care. Common for family to mourn or cry loudly, and chanting and praying may take place. Family wishes to spend time with the patient after death; cleansing may or may not be requested. Cremation not common as it is seen to destroy the spirit. Organ donation and autopsies are not very acceptable. 	<ul style="list-style-type: none"> Birthing support may be anyone in the family, and often husbands will participate. Lukewarm water, no ice, will be preferred during labour. Pain control may not be seen as important in case it affects the baby. Vocalization common, though elders may discourage loudness. <p>Post Partum Care</p> <ul style="list-style-type: none"> Breastfeeding may or may not be chosen or freezing, storage, and pumping may not be considered. Family focuses on rest for the new mother. Problems with a baby should be discussed with the family spokesperson, like the baby's father. Mother may view a problem as her fault related to her behaviour. Parents usually have a male baby circumcised. <p>Culturally Sensitive Health Care Practice</p> <ul style="list-style-type: none"> It is important to acknowledge the roles of family members in making health care decisions. Showing much concern and spending time with the patient and family will help develop trust. Health practitioners should be aware that combined use of medical and traditional therapies is common.
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Multicultural Awareness Program – PLC

SOMALIS

SOMALIS		
CULTURE	HISTORY, BELIEFS & HEALTH PRACTICES	
<p>Family Structure</p> <ul style="list-style-type: none"> Living with extended family is common, and a woman goes to live with her husband's family or clan. <p>Acculturation Issues</p> <ul style="list-style-type: none"> Though several Somali families have been living in Calgary for a number of years, many families are experiencing difficulty with settlement issues including housing, employment, education, large family size, and sometimes issues related to multiple marriages. Families have difficulty affording accommodation to include extended family, which places strain on the family. Often face various acculturation issues linked with intergenerational differences in values and practices. <p>Cross-Cultural Interactions</p> <ul style="list-style-type: none"> Men and women do not touch each other in public settings. It is appropriate for members of the same gender to shake hands. <p>Marriage</p> <ul style="list-style-type: none"> Married women are to cover their bodies including their hair in traditional dress called a hejab. Marriages are sometimes arranged, but also may be based on choice. Common age to marry is 14-15 yrs. of age. It is common for men to have up to 4 wives, if it is possible to afford it, and sometimes in urban areas, he will have separate homes with different families. 	<p>Immigration History</p> <ul style="list-style-type: none"> Somalia consists of one ethnic group with a common language, religion and culture. May speak Somali, Arabic and/or French. Older Somalis may speak either English or Italian due to colonization. Beginning in 1991 people began leaving due to existing hunger, assaults, death, and refugee camp conditions. <p>Traditional Health Practices and Beliefs</p> <ul style="list-style-type: none"> Illnesses are seen as resulting from angry spirits; a ceremony may be held to appease the spirits – the Koran is read, special foods may be eaten, and incense is burned. One person can give another the “evil eye” by giving praise - for example saying someone is beautiful. Traditional doctors - often male elders, perform herbal remedies, prayer and “fire-burning”. Fire burning involves the burning of a stick from a special tree which is pressed to the skin. During Ramadan, medicines are often taken only at night. Ill pregnant women and children are exempt. <p>Prevalent Disease</p> <ul style="list-style-type: none"> May have been exposed to TB in refugee camps. <p>Health Care Systems</p> <ul style="list-style-type: none"> Most Somalis are familiar with Western medicine, but nurses and doctors are associated with care for the ill, rather than 	<p>Patient-Professional Relationship</p> <ul style="list-style-type: none"> Somali women prefer female health care providers. Important to encourage ongoing contact with health care providers for health promotion and prevention. <p>Mental Health</p> <ul style="list-style-type: none"> May connect mental health issues with the “evil eye” placed on individuals by others or by spirits. Less familiarity with Western mental health diagnoses and treatment. <p>Family Planning & Pregnancy</p> <ul style="list-style-type: none"> Family planning has little relevance. Childbearing begins shortly after marriage, and the more children a woman has enhances her status. Men may adopt more than one wife in order to have additional children. Sex during pregnancy is not viewed as acceptable. <p>Childbirth</p> <ul style="list-style-type: none"> Strong support network for new mothers. In Somalia, a party before the birth takes place to show support. The birth is usually at home with a midwife. <p>Post Partum Care</p> <ul style="list-style-type: none"> Newborns are given warm water baths, sesame oil massage, and herbal treatment for the umbilicus. Baby may wear a bracelet of herbs and string to ward away any evil spiritual influence. A new mother and baby stay indoors for 40 days, while

SOMALIS

- Men are to work while women are to stay home and raise children.
- Divorce may occur, though it must be initiated by the husband.

Religion

- Almost all Somalis are Muslim and believe in one God, Allah. Celebrate Ramadan between December and January (depends on the calendar year), where daytime fasting occurs.

Children

- Children in Somalia have the same educational opportunities.
- Anniversaries of one's death are celebrated instead of birthdays.

Food and Diet

- Large component of rice, vegetables, corn and beans. Region of origin has an influence on diet. Teas and hot beverages common.

Literacy

- Literacy in first language among women and men is relatively high.

Census Information

- Somalia was one of the top ten source countries in 1998 for convention refugees (those supported by government) arriving to Canada, but this category included less than 25 Somali individuals.

with routine prenatal care and preventative health aspects.

- Families may expect to go to the emergency department for vomiting, diarrhea, colds, or fever, for antibiotics.

Death and Dying

- A physician who provides a palliative diagnosis to the patient or family is considered uncaring. It is, however, more acceptable to describe the extreme seriousness of the illness.
- A section of the Koran is read to the dying individual.
- Following death, someone from the same gender cleans and perfumes the body, and places it in white clothing. Prayers are stated.

female friends and family visit. After this a party is held and the baby is then named. Sometimes a naming ceremony occurs 2-3 weeks after birth.

- Diet for mother involves soups, porridge, and special teas.
- Health practitioners should be aware that some compliments might be seen as placing an "evil eye" on the baby. It is acceptable to describe the baby as healthy.
- Incense is burned to protect the baby from ordinary smells believed to make the baby ill.
- Breastfeeding common until 2 years of age. Milk may be given to babies, and within the first few days after birth, the mother's milk is considered unhealthy. Women uncomfortable with breast pumps and storing milk.
- Circumcision traditionally practiced for both males and females and is seen as a rite of passage in order to become an accepted adult of the community. It is viewed as necessary for marriage, otherwise, the individual is viewed as unclean.
- Circumcision takes place between birth and 5 years of age, and for girls it is traditionally performed by female family members or another woman in the community. This remains to be a sensitive, and physicians and nurses should maintain open communication with the family.
- It is important for nurses and physicians to provide education as to the risks and consequences of female circumcision, and the legal/child protective service aspects of such practices in Canada.

Culturally Sensitive Health Care

- Respect for cultural beliefs and values, which are linked to the Muslim religion, is paramount in establishing rapport.
- Somali women will feel most comfortable with female health service providers, and it is helpful to have awareness of their health beliefs and values.

FILIPINOS

FILIPINOS		Members of the Philippines - though the language is most commonly spelled as Filipino.
CULTURE	HISTORY, BELIEFS & HEALTH PRACTICES	
<p>Family Structure</p> <ul style="list-style-type: none"> Family oriented with both extended and nuclear family. Sometimes 3 generations live in one home. Father or eldest son/daughter is the family spokesperson, but the whole family usually makes decisions. Men are expected to make decisions or arrangements regarding patient transfer, long-term care, or burial arrangements, while women are the main caregivers at the bedside. <p>Acculturation Issues</p> <ul style="list-style-type: none"> May experience a number of intergenerational issues as youth are raised as bicultural in the Canadian context and families may wish to preserve traditional beliefs and practices. <p>Cross-Cultural Interactions</p> <ul style="list-style-type: none"> Often shy yet affectionate Respectful to elders and figures of authority. Direct eye contact not often used, especially when interacting with authority figures or elders. Polite and will not likely openly disagree. Be aware of the use of silence; it does not necessarily mean agreement. Handshakes are commonly used. Filipinos smile a great amount, and often use animated facial expressions. Elderly are greeted with a kiss to the hand, forehead or cheeks. Tone of voice is changed to show emotion and may be loud when agitated or nervous. Feel strongly about being shamed or losing face. <p>Religion</p> <ul style="list-style-type: none"> Predominantly Catholic and like to use 	<p>Immigration History</p> <ul style="list-style-type: none"> Most Filipinos in Calgary have been in Canada for a longer period of time (i.e. over 10 years) The national language spoken is Filipino (Pilipino – spelling in the Philippines) also known as Tagalog. There are 85 major languages and dialects spoken including Ilocano, Cebuano, Bicolano, Pampango, and Chabacano. English is very common and is used in schools, media and business. <p>Traditional Health Practices and Beliefs</p> <ul style="list-style-type: none"> Belief in fate, where one must accept what life and death bring. Illness is a result of an imbalance in the body. Some feel illness results from bad behaviour or punishment. Health promotion is linked with maintaining balance and keeping warm. Believe in and practice both traditional medicine and Western medicine. Eating well (not necessarily a balanced diet) is linked with good health. Being overweight is not seen as unhealthy but represents prosperity and happiness. Exercise not considered a regular activity. <p>Treatment and Medication</p> <ul style="list-style-type: none"> Because of Chinese influence, some families use herbal medicine s before seeking medical attention. It is important to emphasize the need to follow a medication schedule, as the perception of time may be less strict. Fear of becoming addicted to narcotics and may not like to take medications. <p>Hospitalization</p> <ul style="list-style-type: none"> In hospital, Filipinos often rely on biomedicine. Often will not seek medical attention until it is 	<p>Patient-Professional Relationship</p> <ul style="list-style-type: none"> Respect given to health professionals. May need to emphasize the importance of keeping appointments and being on time. Should consider modesty issues with screening. Most patients willing to share medical history and important related information. <p>Mental Health</p> <ul style="list-style-type: none"> Occurs if there is a disruption of harmony between the individual and the spiritual world. May feel that contact with another life force, soul, or environmental factor can cause mental illness. Others believe that physical or emotional strain, sexual frustration, or genetically inherited conditions are responsible for mental illness. Traditional healers are seen to help with placating or exorcising spiritual influences. Feel shame when experiencing mental health issues such as depression. <p>Pregnancy</p> <ul style="list-style-type: none"> Prenatal care is expected. Family gives much attention to pregnant woman, who is not generally allowed to continue working. Sexual intercourse is taboo in the last 2 months of pregnancy. Near delivery, woman is encouraged to fresh eggs and slippery foods to help the baby slip out during delivery. <p>Childbirth</p> <ul style="list-style-type: none"> Believe that making noise or movement will increase labour pain.

FILIPINOS



<p>medallions, rosary beads, or religious figures.</p> <ul style="list-style-type: none"> Some are protestants or Muslims. <p>Children</p> <ul style="list-style-type: none"> Highly protective environment for children. Parenting style may be to offer warnings (frightening or shaming) regarding misconduct. Taught to be quiet, avoid confrontations, be obedient and respectful. Strong emphasis on education. <p>The Elderly</p> <ul style="list-style-type: none"> Respect given, softer tone of voice used. Care provided by family to elderly. Often feel that placement in a nursing home is disrespectful. <p>Food and Diet</p> <ul style="list-style-type: none"> Prefer soft warm foods when ill. Do not like cold or iced drinks. Usual diet includes rice, fish, meats and vegetables. Enjoy fried foods and those with flavor; like sauces and broth with food. Drink a good deal of room temperature water. Some are Lactose intolerant. Often abstain from meat on Fridays, especially during Lent. Do not like cold or acidic foods in the morning including fruit and fruit juices. <p>Literacy</p> <ul style="list-style-type: none"> Most Filipinos speak and understand English. Some individuals with less education may need assistance reading/writing in English. It may be best to use family members in interpretation for sensitive issues including sex, diagnosis/prognosis and socioeconomic status. <p>Census Data</p> <ul style="list-style-type: none"> 11,800 Calgarians identified themselves as belonging to the Filipino community in 1996. 	<p>advanced with severe pain.</p> <ul style="list-style-type: none"> Procedures and consents must be explained clearly. It is helpful to elicit feedback, or the patient may not voice concerns. Value cleanliness and therefore may wish to shower daily. Also prefer using the bathroom for reasons of privacy and cleanliness. May have high pain threshold or may be stoic when experiencing pain. Female family members provide support and may inhibit self-care or ambulatory activities. May wish to remain at the patient's bedside at all times. The entire family may come to visit. It is often very important for patient to see the chaplain/priest. Family will often provide food from home. <p>Death and Dying</p> <ul style="list-style-type: none"> Diagnosis should not be explained to the patient without family consultation, or discussion with the oldest son or daughter. Patient's family may wish to disclose the prognosis, but may wish to have a health professional present. Notify chaplain for patient to receive the Sacrament of the Sick. Do not resuscitate is a difficult choice often made by the entire family. May request that religious symbols or figures are kept near the patient, and family may pray at the bedside. Family may cry loudly or uncontrollably. Death is given very high regard. Family members may wish to wash the body and for all family members to say goodbye before the body is moved to the morgue. Cremation is not common, and the family may refuse organ donation or autopsy. 	<ul style="list-style-type: none"> Fathers will not usually participate. A female family member who is a mother is preferred as labour coach. Vaginal delivery preferred. Woman assumes active role in labour and may give direction to family or caregivers. Some women will moan or grunt as socially acceptable, but others may scream and become hysterical. <p>Post Partum Care</p> <ul style="list-style-type: none"> Breastfeeding expected possibly until the child is a toddler. Working mothers may breastfeed and formula feed concurrently. Mother expected to be with baby 24 hrs./day Mother encouraged to rest and drink nourishing soup. Seafood usually avoided. New mothers discouraged from showering, though sponge baths are acceptable. If there is a problem with the baby, it is recommended that the father and family be consulted first. It is important for the MD to discuss these issues with the mother. Parents may choose to have baby boy circumcised. <p>Culturally Sensitive Health Care</p> <ul style="list-style-type: none"> Important to ask about the support of family within the home, which is usually very strong. Modesty issues should be considered and feedback requested in order to ensure patient comfort. Issues regarding sex and poor prognosis are most sensitive.
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Supportive Pathways Education Program

Module 3

Normal Aging Changes
&
Disease Processes in Dementia


The slide has a purple header bar with the text 'Supportive Pathways Education Program'. Below this, 'Module 3' is underlined. The main title 'Normal Aging Changes & Disease Processes in Dementia' is centered. To the right is a black and white icon of a human head profile with three interlocking gears inside. The Carewest logo is in the bottom right corner.

Objectives

To increase knowledge of normal aging changes


To increase knowledge of the types of dementia

To discuss the stages of dementia


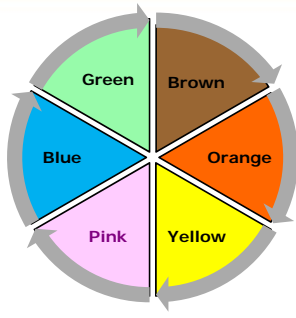
The slide has a purple header bar with the text 'Objectives'. Below this, there are three horizontal lines, each followed by an objective. The Carewest logo is in the bottom right corner.

Normal Changes of Aging Challenge

- **Brown** – digestive and urinary system
- **Orange** – sleep/rest and sexuality
- **Yellow** – senses
- **Pink** – skin and temperature control
- **Blue** – respiratory and cardiovascular
- **Green** – mobility and safety

The slide has a purple header bar with the text 'Normal Changes of Aging Challenge'. Below this is a bulleted list of six items, each with a color-coded word in bold. The Carewest logo is in the bottom right corner.


Normal Aging Changes Game

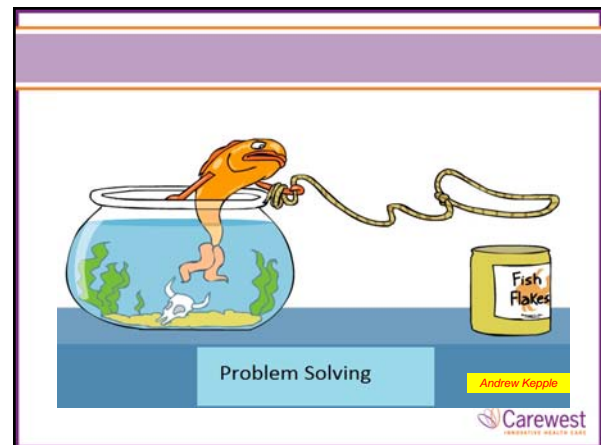
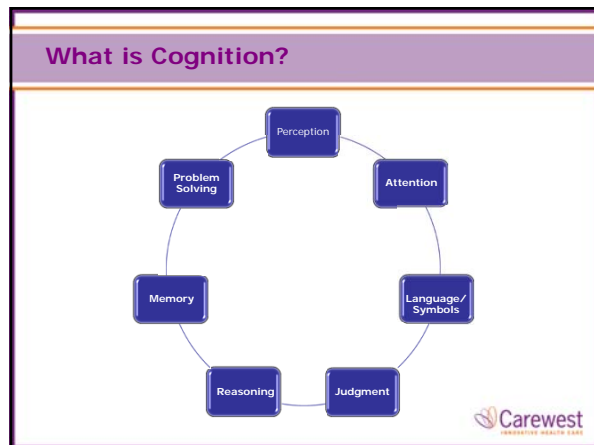
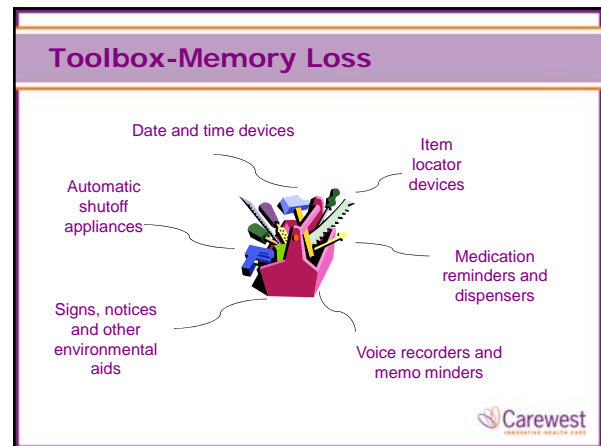
The slide has a purple header bar with the text 'Normal Aging Changes Game'. Below this is a circular diagram with six colored segments: Green, Brown, Orange, Yellow, Pink, and Blue, arranged in a circle with arrows indicating a clockwise flow. The Carewest logo is in the bottom right corner.

Dementia

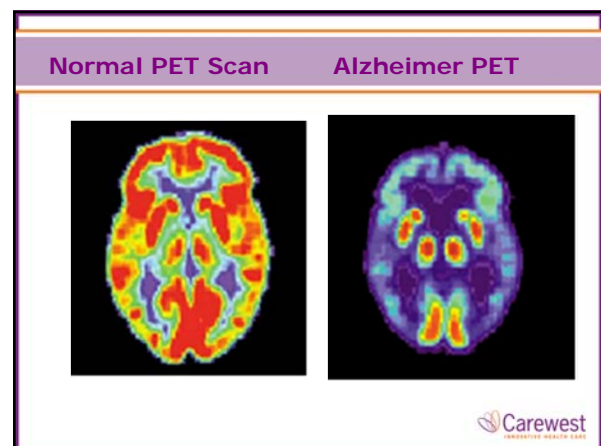
Dementia is a disease process that affects memory and cognition

These changes impact normal daily routines

The slide has a purple header bar with the text 'Dementia'. Below this, there are two lines of text. The Carewest logo is in the bottom right corner.



- ### Medical Work-up for Cognitive Problems
- Not all memory loss is dementia
 - Other possible causes include:
 - Low B12
 - Low thyroid
 - Brain tumours
 - Side-effects of medications
 - Alcohol abuse
 - Poor vision and/or difficulty with hearing
 - Delirium
 - Correcting these conditions may result in improved memory/cognition
- Carewest
IMPROVING HEALTH CARE



Mild Cognitive Impairment (MCI)

- Have problems with memory that are noticeable to themselves or others but do not interfere with daily life
- Not everyone diagnosed with MCI will develop Alzheimer's Disease but their risk is increased



Dementia/Delirium/Depression

- Often referred to as the 3 Ds
- It is important to know the differences as individuals may have one or a combination of two or three of these conditions
- They all can effect memory and cognition



Delirium

A temporary reversible or correctable state of confusion that is treatable.



Delirium and Dementia Quiz

1. Can delirium occur in people with dementia?
2. What could cause delirium? (give 4 examples)
3. Is it reversible? (How long could it last?)
4. What are the presenting signs that help us recognize it is delirium not just dementia? (How are they different than dementia?)



Signs and Symptoms of Delirium

- Starts **suddenly** and changes throughout the day (often worse at night)
- **Inattention:** can't focus on instructions
- **Disorganized thinking:** jumps from topic to topic
- **Change in awareness:**
 - hyper-alert (wide eyes, jumpy), OR
 - very withdrawn, sleepy (may have both)



Depression - a treatable condition

Symptoms may include:

- confusion
- depressed mood
- loss of interest or pleasure in life nearly everyday and for most of the day
- social isolation
- irritability
- physical complaints
- suicidal thoughts



Depression and Dementia

Depression is common in persons with dementia but what are the differences?

With depression:

- There is a change in their level of interest
- Treatment can be effective
- Likely to be concerned about their memory impairment
- Frequent physical complaints are common
- Sleep is often affected
(e.g. early waking or sleeping excessively)



Dementia Umbrella



Degenerative Dementias

- Alzheimer's Disease
- Vascular
- Lewy Body
- Frontotemporal
e.g. Pick's

Secondary Dementias

- Parkinson's
- Huntington's
- MS
- Down's Syndrome



Dementia Umbrella



Toxicity

- Alcohol-Korsakoff's
- Lead and Mercury
- Drug Abuse

Infectious

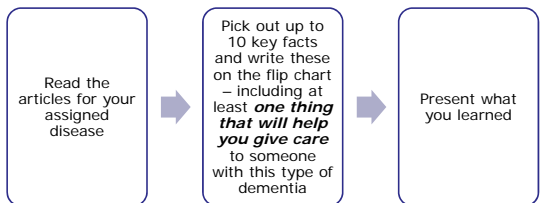
- Aids
- Creutzfeldt-Jacob
(Mad Cow)

Other

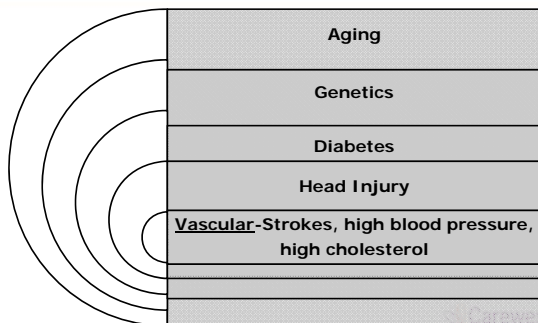
- Brain Tumor
- Head Injury
- Normal Pressure Hydrocephalus (NPH)



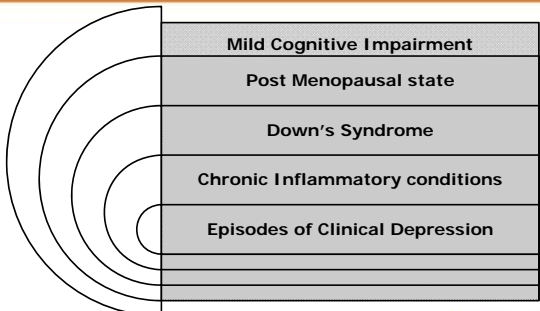
Learning About The Diseases



Risk Factors



Risk Factors




Reduce your Risk

- Being physically active
- Eating healthy foods
- Keeping your brain challenged
- Reducing stress
- Maintaining normal blood pressure, cholesterol, blood sugar
- Avoid brain injury-wear your helmet, reduce fall risk
- Keep socially active

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Alzheimer's Disease


"Death by a thousand subtractions"




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Answer these questions as you watch the video

 The left side of the brain is responsible for:

 The right side of the brain is responsible for:

 The 6 major areas of the brain are:

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Stages of Alzheimer's Disease - Early

- Forgetfulness
- Communication difficulties
- Changes in mood and behaviour
- Diagnosis may occur or may not be confirmed until later stage
- Live in the community and need little help

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Personality Changes

"I can suddenly become anxious or angry for no apparent reason."

"I cry easily and often feel oversensitive when I have a day with too many tasks to do."

"Sometimes I feel frustrated."

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Stages of Alzheimer's Disease - Middle

- Thinking and memory continue to deteriorate but many are still somewhat aware of their condition
- Need help with many daily tasks - ADL and IADL
- Disorientation to time and place
- Sense of loss or insecurity E.g. Velcro stage

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Stages of Alzheimer's Disease - Late

- Severe memory loss. Lose recognition of family.
- Loss of communication abilities- words or phrases
- Incontinence
- Lose ability to walk without help
- Swallowing problems, weight loss
- Require total care so often are in a facility



FAST (Functional Assessment Scaling Tool)

- Another tool used to describe the progression of **Alzheimer's Disease**
- Developed by Dr. Barry Reisberg in 1982
- Includes Stages 1-7
- Based on the concept that people with Alzheimer's Disease lose their abilities to do things in the opposite order that we gained them
- This awareness helps us understand what types of assistance may be needed



FAST Stages

FAST Stage	Description
Stage 1,2,3	Normal Function Stage 1,2. Stage 3 Mild Cognitive Impairment
Stage 4	Mild Alzheimer Disease Decrease in memory apparent. Needs help for complex tasks.
Stage 5	Moderate Alzheimer Disease Remote memory loss starts. Unable to live alone.
Stage 6 (has 5 sub-stages)	Moderately Severe Alzheimer disease Incontinence. Fear of bathing. Increase in behavioural disturbances.
Stage 7 (6 sub stages)	Severe Alzheimer disease Speech limited. Physical rigidity. The client will die in this stage.

End of Life for Those with Dementia

- Dementia is a terminal disease
- No longer accept food or drink
 - tube feeds or IVs are not appropriate
- Can still experience pain and anxiety
- Can still hear what is being said around them
- Often feel cold – need warmth
- Require palliative care - comfort/kindness
- Families often need our care and support

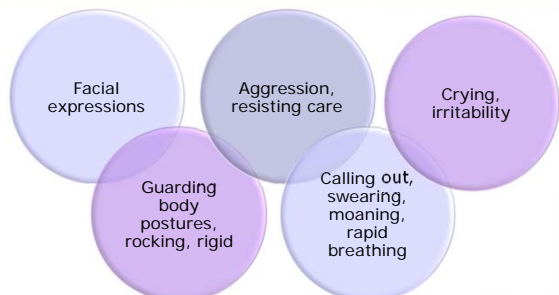


Pain

Myth:
People with Dementia do not feel pain.



Common Pain Behaviours



Dementia

"You wouldn't ask a person with COPD to 'just breathe better' would you?"

Of course not,

but we do catch ourselves expecting someone with dementia to 'behave better'

– this is a disease of the brain!





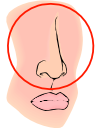
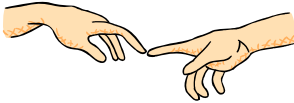
Questions?






Please refer to your handouts (references are included)



	NORMAL CHANGES OF AGING	
	Normal Changes	Care Implications
Vision 	Cornea is flatter resulting in loss of clarity and ability to focus.	Ensure glasses are worn. Use larger print. Color contrast on background paper. Reduced clutter.
	Lens is stiffer – less ability to accommodate.	Give resident time to adjust when going from different light conditions. Pause when going into bright sunlight. Risk of falls.
	Increased opacity of lens – light rays gets scattered.	May be less tolerant of glare – adjust blinds in dining room / non glare floors. Sunglasses when outside.
	Decrease in diameter of pupil – less light gets in.	The resident will need more light to see well. Keep facility well lit. Use of nightlights to increase safety.
	Yellowing of the lens – less ability to perceive different colors (blue, green and violet) and depth.	Increase contrast to improve vision, e.g. Have a good contrast between plate and tablecloth or print and paper. Warm colors like red, orange and yellow are seen better.
	Decrease in peripheral vision – narrows field of vision	Be aware that approaching resident from the side may startle. Sit across from the person when conversing / feeding. Don't line up chairs side by side in lounges.
Hearing 	Decrease in acuity – loss of higher frequencies	Resident may only hear partial words. Speak slowly, don't raise your voice; use a lower pitch (like a man's voice) as the person may hear lower frequencies. Face the person directly and don't cover your mouth (helps with lip reading). Hearing deficits may result in increased confusion and paranoia. If a resident has a hearing device ensure it is used and functioning properly.
	Less ability to mask extraneous sounds	Keeping dining room free of background noise as much as possible. Keep TV and radio off. If you are having conversations go to a quiet area.

Taste and Smell  <small>The Nose</small>	<p>Decrease in taste especially for salty and sweet. Reduction in numbers of taste buds.</p>	<p>Good oral hygiene can improve taste. Monitor intake and weight as appetite can be decreased. Medications can alter taste as well.</p>
	<p>Less saliva flow</p>	<p>May need to add more sauces to food or drink fluids with dry items to compensate.</p>
	<p>Decreased sense of smell</p>	<p>May result in decreased appetite. Tell the resident what you are feeding. Especially if pureed.</p>
Touch and Pain Sensitivity 	<p>Decreased sense of touch, vibration and pressure</p>	<p>More prone to skin breakdown. Decreased ability to perceive where body is in relation to the floor may alter mobility.</p>
	<p>Decreased response to pain / temperature</p>	<p>May be more prone to injury, e.g. hot water, heating pads, ice packs.</p>
Gastrointestinal System	<p>Decrease in: motility of esophagus, stomach and intestines and in digestion and absorption</p>	<p>More prone to constipation and indigestion.</p>
Skin	<p>Loss of subcutaneous fat.</p>	<p>Less padding on bony prominences so more prone to skin breakdown. Change position often / special mattress.</p> <p>Less ability to maintain body temperature – use sweaters, keep room temperatures warm, warm blankets after tub bath.</p>
	<p>Decrease in capillary blood flow</p>	<p>Wound healing will be slower.</p>
	<p>Thinning of the skin due to atrophy of the dermis</p>	<p>Increase gentleness during care as prone to skin tears. Use paper tape when doing dressings. More prone to sunburn.</p>
	<p>Decreased moisture due to decreased oil gland output</p>	<p>More prone to dry, itchy skin. Moisturize skin daily.</p>
	<p>The connection between the epidermal and dermal layers is significantly weakened.</p>	<p>Limit shearing forces. Lift, don't drag! Proper positioning and use of special cushions in wheelchairs.</p>

Sleep	More frequent awakenings as there is a greater amount of time spent in lighter stages of sleep	Keep the environment as quiet as possible
	Change in timing of body clock – earlier to bed and earlier to rise	Bright light (especially sunlight) later in the day may adjust body clock. Adapt your routines to resident's sleep patterns. Avoid use of sedatives.
Bladder Function	Incontinence is not a normal part of aging but aging changes in estrogen levels and increased prostate size make the elderly more prone to incontinence.	Assess for causes of incontinence. Toilet residents at frequent intervals. Incontinence in Alzheimer's in late stages is related to disease process.
	Decrease in bladder capacity	Nocturia, frequency and urgency are more frequent. Ensure safety for nighttime toileting.
	Less sensitivity to bladder signals. May not get urge until bladder is already full.	Residents may not be able to wait long periods once they get the urge to go. Try to toilet right away when they ask.
Kidney Function	Decrease in number of glomeruli and in structure of glomerular filter results in decreased glomerular filtration rate.	Residents will have less ability to filter out drugs. Watch for drug toxicity. Increased excretion of protein may increase need for dietary protein.
	Thickening and shortening of the tubules as well as a decrease in aldosterone levels lead to decreased ability to maintain water and electrolyte balance if the system is stressed	Observe for dehydration or electrolyte imbalance. May result in delirium. Ensure adequate fluids.
Muscle and Bones	Loss of bone mass	More prone to fractures when falling. Use hip protectors for residents with fall risk. Keep side rails down if resident is mobile.
	Slower reaction time. Decreased balance.	Watch for hazards on the unit like spills and residents walking without footwear. Use a transfer / walking belt when walking residents.
	Decreased muscle strength due to loss of contractile tissue. Decreased flexibility.	Walk residents. Mobilizing residents keeps muscles stronger. Immobility will increase the loss of strength.

Immune System	Decrease in function of T-lymphocytes and interleukins (needed to stimulate immune response)	Resident will be more susceptible to infection so immunizations are important. You may not see typical reactions to infections, e.g., fever. Observe for increased level of confusion or behaviour changes.
Respiratory System	Decrease in effectiveness of the larynx as a seal. (This is exacerbated by drugs like Benzodiazepines). Ciliated cells lining the upper airway become less functional.	The residents may be more susceptible to pneumonia as these changes allow bacteria to enter the airway.
	Chest wall stiffens and the aged rely more on the diaphragm to expand chest volume	Elevating the head of the bed if residents have difficulty breathing allows gravity to pull the abdominal contents away from the diaphragm.
	Decrease in amount of O ₂ in the blood	Normal elderly have sufficient reserve capacity to function normally but exercise capacity may be reduced and they may experience SOB. Pace activity.
Circulatory System	An increase in cardiac mass, decrease in coronary blood flow and prolongation of contraction increase the total amount of work so reserve capacity is reduced in the aged	Decrease in reserve capacity
	There is a loss of pacemaker cells	There may be changes in normal rhythm
	Loss of elasticity in blood vessels	Decrease in reserve capacity as the heart has to work harder. More prone to hypertension.
	Decrease in baroreceptor sensitivity (baroreceptors regulate activity in the sympathetic nervous system which regulates BP using Alpha and Beta receptors)	This can results in hypotension (low BP) when the person stands up quickly. This can result in fainting and falls. Allow residents to adjust to position changes. Dangle on side of bed before standing. Hypotension can also occur after a meal, after defecating or urinating. Beta-blockers can also cause hypotension.

Nervous System	The number of neurons decreases. The aging brain shrinks. Age related decline may not affect function under normal circumstances but in times of stress, the lack of reserve may mean the system is unable to cope.	Aged are more likely to develop delirium when stressed
	Decrease in the speed of central processing	Don't rush the resident! Allow time to process new information.
	<u>Aging sensitive Memory Changes</u> New learning occurs at a slower pace	Allow time for new learning
	Recall of details of new information and events is decreased but there is no gross distortion of content or gist of information.	
	Decrease in non-verbal memory – misplacing things	
Sexual Function	Male - Decrease in sperm and semen production	Desire for sexual expression is normal.
	Decrease in quality and length of time for erections. Increase in time between erections.	
	Female – Decrease in estrogen production.	Increased risk of UTI's
	Decrease in lubrication and in intensity of orgasms. Pubic hair loss.	

Dementia	Delirium	Depression
<u>Onset</u> : Months to years, slow progression	<u>Onset</u> : Sudden, within hours or days	<u>Onset</u> : Weeks or months
<u>Memory</u> affected: Short and then long term	<u>Memory</u> : MAY be affected (may remember after!)	<u>Memory</u> : MAY be affected
<u>Cognition affected</u> : language; perception; motor abilities; judgement	<u>Cognition</u> : impaired +, Problems: inattention, disorganization of thoughts	<u>Cognition</u> : feelings of hopelessness often present
<u>Awareness</u> : Usually normal	<u>Awareness</u> : Affected & fluctuates! HYPER or HYPO alert	<u>Awareness</u> : May be impaired (agitated or ↓energy)
<u>Sleep</u> : May have fragmented sleep – more confused at bedtime	<u>Sleep</u> affected (Delirium worse at night)	<u>Sleep</u> : Disrupted often: sleep more, or very little with early waking

Types of Dementia

It is important to know what type of dementia the client has as it may help in planning care and knowing what symptoms are parts of the disease process. The following are just some of the causes of dementia. Refer to the slides “dementia umbrella” for other causes. Some clients may have more than one type of dementia as Alzheimer’s and Multi-infarct dementia often occur in the same person.

ALZHEIMER DISEASE – Alzheimer disease is believed to be caused by abnormal proteins collecting in the brain (plaques and tangles) that cause brain cells to die and interfere with the transmission of messages throughout the brain. Decline in function is generally described as a gradual loss of abilities over several years. (Genetically inherited Alzheimers Disease affects less than 10% of those diagnosed.)

DEMENTIA WITH LEWY BODIES – This is now thought to be a frequent cause of dementia. There is no test to diagnose Dementia with Lewy Bodies so diagnosis is based on clinical features. It usually progresses more rapidly than Alzheimer disease. Hallucinations (usually visual) and early gait disturbance and falls are a feature of this type of dementia. Abnormal cells called Lewy bodies are found in an area of the brain stem also affected in Parkinson’s disease (PD) as well as in the cerebral cortex. They may exhibit many of the features of Parkinson’s disease but are milder than classical PD. The person with this type of dementia may experience fluctuations in their mental status, level of alertness and syncopal spells. Because confusion is not always there, caregivers may think they are pretending or may ask too much from them thinking they are capable. Psychotic features such as delusions and sleep disturbance (excessive sleep or abnormal movements during sleep) are also features of the disease.

These clients may benefit from cholinesterase inhibitor agents such as Aricept. Neuroleptic drugs should not be used or used with extreme caution with this type of dementia as they may cause a dramatic worsening of the condition.

DOWN’S SYNDROME - Is attributed to triplication and over-expression of amyloid precursor protein (APP) – believed to be influenced by chromosome 21, earlier age onset. Decreased risk of Alzheimer’s associated with increased survival with partial, trisomies and atypical karyotypes. (1) Men with Down’s Syndrome are 3 times as likely to develop Alzheimers by age 65. More study is needed with larger sample sizes.

KORSAKOFF’S SYNDROME – This disorder is caused by a lack of thiamine (Vitamin B1), which affects the brain and nervous system, rather than by alcohol directly. Brain damage occurs in the mid part of the brain resulting in severe short term memory loss. Many other abilities may remain intact. They may have a lack of insight re: their memory loss.

FRONTOTEMPORAL DEMENTIA – Can be genetically inherited, differs from Alzheimer’s Disease in that there are no amyloid senile plaques or tangles.

PICK’S DISEASE – Pick’s disease is a rare disorder which has an early onset (age 40 to 60). Brain cells are found to be swollen and abnormal (Pick cells). This type of dementia affects mainly the frontal and temporal lobes. They have less memory loss and more personality change and socially inappropriate behaviour. There is a failure to recognize objects, changes in sexual behaviour and sometimes there is a craving for carbohydrates. There is early language loss and eventually mutism. There is no cure or treatment.

VASCULAR DEMENTIA (MULTI-INFARCT DEMENTIA) – Vascular dementia is caused by a single or multiple small infarcts (strokes) that interrupt blood flow causing the brain tissue to die.

It is often described as progressing in a step-wise manner. The person may have a sudden decline, level out or improve for awhile then decline again if a new infarct occurs. Deficits seen will depend on the areas of the brain affected. Some of these infarcts produce no obvious symptoms and a person may have several before noticing changes in function.

Sometimes it is difficult to distinguish multi-infarct dementia from Alzheimer disease as the symptoms are similar and it is possible for a person to have both diseases at the same time. A CT scan of the head may be ordered to detect small areas of infarct. More severe deficits, verbal sequencing and executive function than Alzheimer's Disease.

Functional Stages of Alzheimer Disease

Researchers have identified a pattern of decline for people with Alzheimer Disease. Some people describe this pattern of decline as mild, moderate or severe while others describe it as early, middle or late. Reisberg has developed a 7-stage tool called Functional Assessment Staging Tool (FAST) that can be used to assess what stage the person is in. These stages describe a loss of functional ability that seems to occur in a predictable pattern. This pattern also has been observed to be related to declining cognitive function. This loss of ability appears to researchers to be opposite to the order in which we gain abilities. For example, we learn to feed ourselves, walk and speak at a young age. These abilities are usually retained until late in the disease process.

We can use this information to assist us in caring for the resident with Alzheimer Disease. For example, using techniques required to communicate with us in our early developmental stages (when we had no language or early language skills) may help us understand how to communicate with a resident who is losing language ability. At that time, long explanations weren't appropriate. We were given simple instructions supplemented with non-verbal communication. We preserve our resident's dignity by changing our approach to meet their changing needs.

The functional stages are significant when we are looking at the resident's ability to perform ADL's. If a resident is in an earlier stage and is more disabled in function, we need to look for reasons for "excess disability". Have we made the person more dependent by helping too much or not assisting them to walk? Is there visual, hearing loss or a language barrier? Is there another disease process? Overmedication? Anxiety? Depression?

Although there is a predictable progression in the disease, care activities may compensate for the loss. For example, frequent toileting may maintain continence in an otherwise incontinent resident. Frequent cueing during feeding or providing one food item at a time may help retain self-feeding abilities longer. Understanding that behaviour may be their way to communicate things like hunger, thirst, discomfort and emotions will allow us to anticipate and provide for their needs. Helping the family understand that there is a "natural" course to this disease may help them cope with the progression they are seeing.

FUNCTIONAL ASSESSMENT SCALING (FAST)

FAST Stage	Description	Min-Mental Status Exam
Stage 1, 2, 3	Normal function in Stage 1, 2. Mild Cognitive impairment in Stage 3. Symptoms only apparent in performing complex job functions, new learning. Mild memory impairment.	24 - 28 in Stage 3
Stage 4	Mild Alzheimer Disease. Decrease in memory more apparent. Decreased capacity to manage finances. Needs assistance for complex tasks. May try to hide deficits by withdrawing from activities. This stage lasts about 2 years.	19 - 20
Stage 5	Moderate Alzheimer Disease. Requires assistance in choosing proper clothing for the season. May wear same clothing day after day if not reminded to change. Can no longer live on their own. Can't recall their current address, may not know correct year. Remote memory also starts to suffer. Unable to calculate even simple math problems. Lasts about 1 ½ years.	15
Stage 6 (has five sub-stages)	Moderately severe Alzheimer Disease. 6a – Difficulty putting on clothes without assistance. 6b – unable to bathe properly; may develop a fear of bathing. Needs help to adjust water temperature. Difficulty brushing teeth. 6c – Inability to handle mechanics of toileting (e.g. flushing, wiping) 6d – Urinary incontinence, occasional or more frequent. 6e – Fecal incontinence, occasional or more frequent. Increased difficulty identifying family members. Increase in behavioural disturbances. May fear being left alone. Decrease in ability to articulate speech. The sixth stage lasts about 2 ½ years.	1 - 9
Stage 7 (6 sub-stages)	Severe Alzheimer Disease. Speech becomes limited to about a half dozen words in a day and declines to a single word. Will require assistance to ambulate then will progress to being unable to sit up independently, unable to smile, unable to hold up their head. Physical rigidity is evident. This stage can last for several years. The resident will die during this stage.	0

Issues in Early / Moderate Stage Dementia

Driving – One of the most difficult things family caregivers may have to deal with is when the person with dementia is no longer safe to drive. A diagnosis of dementia does not automatically mean they cannot still drive safely. As a general rule, those with early or mild dementia who wish to continue driving should have their skills evaluated. A person often adjusts better if involved in the discussion and decisions re when to stop driving. Some will stop driving on their own as their abilities deteriorate but others will lack the insight to recognize a problem and will be resistant to stopping. Family members can ask the physician to instruct the person not to drive and send a letter to Motor Vehicles. Use simple explanations for loss of driving abilities such as “You have a memory problem and are no longer able to drive”, “The doctor has said that you can no longer drive” or “You cannot drive because you are on medication.” Sometimes having it written for a person to read will be helpful E.g. letter from the doctor’s office. If this fails to stop the person from driving, family members may, as a last resort, have to take further measure like hiding the keys, disabling the motor or parking the car out of sight. It is very important that alternate transportation methods be put in place so that the person does not feel severely restricted.

Compensating for Memory Deficits – Early in the disease process memory aids may be helpful to maintain the person’s independence.

- Some people use a calendar and mark off the days and note appointments and special events. Some use Post-it notes as reminders
- Develop a routine. A daily routine can be written out.
- Dressers and drawers can be labeled with their contents or pictures can be used to jog memory if the person is not able to read.
- Photographs of family and friends can be labeled to aid memory. Use a dispenser for medications.
- Set the timer when using the stove or oven. Use a sign reminding them to check if it is off.
- Have appliance like irons and kettles that shut off automatically.

(Alzheimer Disease: A handbook for Alberta Caregivers, 2002, p.30)

Personality Changes – The person with dementia often experiences changes to mood and behaviour. There can be mood swings, apathy, anxiety, depression, suspiciousness, misinterpretation of visual or auditory stimuli and irritability. There may be a decrease in emotion and a flattening of affect. One person with Alzheimer’s described the changes as “you don’t smile like you used to.” (Shared Experiences, p.21). Personality changes are difficult for family members to deal with. Some family and friends may stop visiting the person as they no longer see them as the same person. Family members may not understand the disease process and may attribute the person’s actions as being deliberate or against them (“She is just trying to make me feel guilty”). Family and caregiver education re: the disease process is very important.

Risk of Abuse – Staff working in the community need to be alert for risk factors for or signs of abuse or neglect. A 1999 study in Ontario found a 4% rate of abuse for community dwelling seniors (McNaught, 1999, p. 3). Being mentally impaired puts the person with dementia at risk. Abusers may choose victims they feel would be unable to report or who will be disbelieved. In Canada, adult children are the largest category of abusers for all forms of abuse (National Elder Abuse Incidence Study, 1996). Financial abuse is the most prevalent type of abuse. The best predictors of abuse were:

- Mental health issues or substance abuse
- Dependence on the elderly person for financial assistance, housing or other necessities and a
- History of violence or antisocial behaviour outside the family.

(Lachs and Pillemer, 1995)

Often the least capable family member is designated as the caregiver. Elder abuse may be a continuation of previous family violence. Efforts need to be made to prevent abuse when situations are felt to be high risk. Wolf (2000) found that: “some of the studies on the relationships between caregiver stress, Alzheimer Disease, and elder abuse suggest that the long-term or pre-abuse nature of the

relationship between the caregiver and care recipient may be the important factor in predicting instances of mistreatment” (p.3). A caregiver reacting to stress with violence may be indicative of how the person generally reacts to stress, and not be situational to care giving duties (Lukawiecki 1993, p.11).

Warning Signs:

- Suspicious injuries
- Poor physical appearance or signs of neglect (neglect may be a result of a lack of knowledge)
- Seeming fearful of the caregiver
- Discrepancy between known income and standard of living
- The older person is worrying about documents they have signed
- Caregiver is concerned more about the financial status of the person than their health status
- A new friend or caregiver is isolating the person from family or friends and promising care in exchange for deeding property

Caring For the Client with End Stage Dementia

Loss of ambulation, swallowing difficulties and severe communication deficits characterize the terminal stage of dementia. Although presenting symptoms may vary between dementias, there is not much difference clinically in the terminal stage. Our goal for care at this stage is comfort. Reisberg says; *“If we are going to keep people alive, we owe them a life of opposed to suffering. They need not suffer if we understand their condition.”* (Wagner, 2000). Some advocate that persons in end stage of dementia be treated with a palliative care approach. The word “palliative” is defined as “to ease without curing”.

LOSS OF MOBILITY – Loss of mobility will be progressive-loss of ability to walk, ability to stand, ability to sit unsupported and eventually loss of head and neck control. Maintaining the ability to ambulate for as long as possible is an important goal – prevents medical complications and outlet for physical energy. How do we achieve this – no restraints and staff keeping them walking as long as possible. Use hip protectors to increase safety. Use it or lose it!

INFECTIONS – An infection is an inevitable consequence of terminal dementia due to impairment of immune function, incontinence, inability to ambulate, and aspiration. Pneumonia is the most common cause of death in demented individuals. Infections are often recurrent and antibiotics become less effective. There are ethical issues that arise re treatment or non-treatment of infections. The main question we need to ask is if the treatment contributes to the comfort of the person.

CONTRACTURES – Contractures occur as the person becomes immobile and can be a source of pain. Contractures make it more difficult to provide care. Experience with people who are kept moving, even in the final stages of AD, has shown that contractures can be avoided for many years. (Wagner, 2000)

SWALLOWING DIFFICULTIES / REFUSAL TO EAT – Food refusal may be a result of decreased appetite, dislike of the food, inability to open the mouth or swallow. They may forget to chew and swallow or pouch food in their cheeks. They may eventually be unable to take even a modified diet. This may be a natural consequence of the dying process during which all body functions are gradually terminated. We need to educate the family re the disease progression and prepare them for the time when the client will no longer take food. It is much better to have these issues discussed before a crisis situation. The dying individual does not feel hunger or thirst and the only discomfort is dryness of the mouth (Volicer, 2001, p.383). As dementia is a terminal disease feeding tubes are not appropriate. Research has shown that aspiration pneumonia was found to increase among patients with feeding tubes. Use of tube feedings to prevent malnutrition, improve survival time, prevent or improve pressure ulcers, reduce infections or improve comfort is not supported by the literature (Head, 2003, Panke & Volicer, 2002).

PAIN – Clients often have severe communication deficits so are unable to verbalize pain. They may show as restlessness, repetitive calling out, and irritability that can escalate to aggression during care if the care is causing pain. Caregivers have to watch for non-verbal signs of pain.

For good pain management staff must:

- Report pain
- Be committed to pain management
- Communicate amongst shifts to establish clients pain baseline
- Administer medication in a timely fashion

Adapted from source: Monoly, et. al. (2005), p. 22

PRESSURE SORES – Immobility, incontinence, weight loss and decreasing nutritional status cause end stage residents to be extremely high risk for pressure sores.

COMMUNICATION – There is severe impairment in communication. Clients who cannot comprehend what is being said and are unable to express themselves are often frustrated. Those providing care may not attempt to understand their communication. In the late stages, we need to use different means to reach them – touch, massage, music.

ACTIVITIES – Although some individuals become mute and interact very little with the environment, they may never reach a stage that they cannot respond to stimulation. They have been found to respond to touch, music, pet therapy. We'll be discussing appropriate activities more in Day 2.

SLEEP DISTURBANCE – Sleep studies have shown that sleep patterns are changed in persons with dementia. An individual in the latter stages of a dementing illness has polyphasic sleep patterns similar to those of a newborn infant. There is an increase in day time drowsiness, waking at night. Avoid waking for routine changing. Change when they are awake. We would not use drugs to alter an infant's sleep pattern so should not try to "normalize" the sleep / wake pattern of those with dementia (Northwood, 2002).

FAMILY – Staff working with clients at the end of life need to embrace the mission of palliative care-comfort. We need to communicate this clearly to the family to assist them through the difficult decision making and grieving process associated with AD. The trust you build with the family throughout the client's stay will ease the struggle families feel when making difficult decisions in the end stage of the disease

References Module 3

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Supportive Pathways Education Program


Module 4

Effective Communication



Objectives

- To discuss the importance of non-verbal communication
- To understand how the disease process affects communication
- To discuss different strategies to use when communicating with persons with dementia



Have any of your Clients ever asked this?

" Can I go home now?"



" Where is my mother?"




Communication Exercise



Communication

The most important skill we have is the ability to 'listen' to verbal and non-verbal communication

Never assume a client does not understand you or what is being said around them



What effects our ability to listen?

- Impatience - not waiting
- Distractions
- Thinking we know the answer
- Focused on own problems
- Workload/ routines



What effects our client's ability to listen?

- May not see the person talking to them
- Hard of hearing/background noise
- Stressed / worried/in pain/not feeling well
- English is not their first language
- We give too much information at once
- We don't give them time to respond
- Dementia disease processes

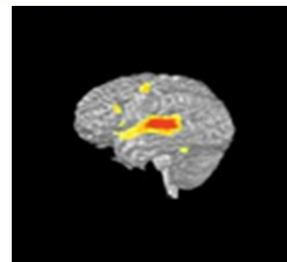


Communication Difficulties

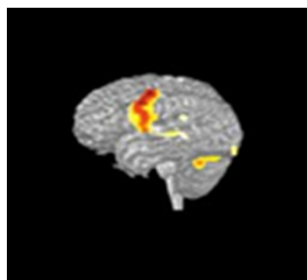
- Are often a result of damage to the brain caused by the disease processes of dementia
- Problems with communication can depend on what part of the brain the disease has affected
- The next 4 slides will illustrate this



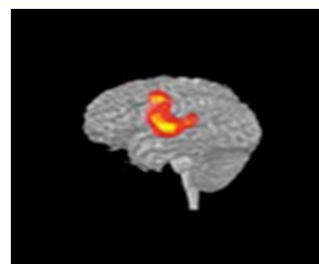
Hearing Words



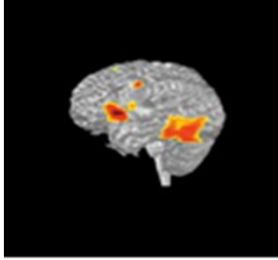
Seeing Words



Speaking Words



Thinking of Words



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How do we communicate non-verbally?

- body language (posture; space)
- gestures or props
- touch/eye contact / facial expressions
- use of social rules e.g. handshake
- tone of voice
- pictures / signs / symbols / orientation boards
- environmental clues e.g. smells can ↑ appetite

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Key Message

We need to watch for the person's reaction to our body language/communication to ensure we are not causing them more distress...

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"Communicating with Confused Older Adults"

During the video clip:

Observe the verbal and non-verbal communication skills of the staff person



Also note how long it took to have a meaningful conversation – can we find 5 minutes to 'make someone's day'?

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Verbal/Nonverbal Communication Skills

What did you observe?

- Touch
- Eye contact/Closeness
- Warm tone of voice
- Short Sentences – Waiting for the answer
- Full attention
- Quiet environment
- Validation
- Reminiscing
- Giving her value – making her feel good

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Validation

Respects the individual's sense of reality.

Validates what they may be feeling

So we need to

Join their journey – go to their reality

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Reality Orientation

- Orientates to person, place, time
- Is more useful in early stages
- Can provide cues

Should not be used if it creates distress



Toolbox-Communication Strategies



How could we respond?

" Can I go home now?"

"I need to go to work!"

" Where is my mother?"

"Can you call my wife?"
(Asks every 15 min)



Practice Exercise - Reminiscing



'NICE and EASY' Communication tips

- | | |
|-----------------------|-----------------------|
| N - Name they prefer | E - Enter their world |
| I - Identify yourself | A - Avoid arguments |
| C - Contact | S - Smile |
| E - Explain | Y - You are the key! |

Source: Alzheimer Society



Communication Exercise



Exercise Debriefing - Key Messages

When two people are providing care together it is essential that:

- ✓ Only one of the two people provides any instructions
- ✓ All conversation includes the client (observe for body language)
- ✓ Staff speak English or in the client's native tongue



Key Messages

**Persons with Dementia may be
cognitively impaired
but remain
emotionally sensitive**

- they feel our kindness,
- they know if we care,
- they know if we are upset



Best Practices for Communication

- Ensure you follow these practices for the benefit of your clients
- Be a good role model for families and other staff



Questions?



Please refer to your handouts



Message to Family Members, Friends and Staff

- Please don't correct me. I know better – the information just isn't available to me at the moment
- Remember, my feelings are intact and I get hurt easily
- I usually know when the wrong word comes out, and I'm as surprised as you are.
- I need people to speak a little slower on the telephone.
- Try to ignore off-hand remarks that I wouldn't have made in the past. If you focus on it, it won't prevent it from happening again. It just makes me feel worse.
- I may say something that is real to me but may not be factual. I am not lying, even if the information is not correct. Don't argue, it won't solve anything.
- If I put my clothes on the chair or the floor, it may be because I can't find them in the closet.
- If you can anticipate that I am getting into difficulty, please don't draw attention to it, but try to carefully help me through it so nobody else will be aware of the problem.
- At a large gathering, please keep an eye on me because I can get lost easily! But please don't shadow my every move. Use gentle respect to guide me.

Best Practices for Communication

Staff will **use the appropriate best practices** when communicating with clients, recognizing each person as an individual. Adapt communication strategies to the stage of dementia.

Best practices include the following strategies:

- Ensure you have the person's attention
- Approach within their **field of vision**
- Obtain and use **direct eye contact**
- Converse with the resident at **eye level** e.g. if in a wheelchair squat down
- Identify yourself**
- Eliminate background noise
- Remove distractions**

Use cueing (verbal or physical)

- Use **short** simple **sentences**
- Use **one-step directions**
- Use **gestures** e.g. washing face
- Use **props** e.g. hair brush
- Hold out **items** to ensure items are **visible**
- Label the door with written labels or diagram
- Communicate using environmental cues such as personal belongings and photos

Be aware of **tone voice**

Put the resident at ease with a **calm manner** and tone of voice (client will usually pick up more from your emotions than your words)

Be **aware of body language**

Use an **open gentle approach** e.g. offer your hands palm up

Use appropriate **gestures** e.g. nodding, beckoning

Use facial expressions e.g. **smiles**

Attend completely when listening

Be patient – give the resident time to respond

Listen for what the person is not saying – watch body language for pain, fear, hunger, etc.

Watch for signs of increasing **frustration**

Do not argue or criticize

Limit questions to yes / no answers and then validate what the person is saying

Empathize with the person and validate feelings and joining the person where they are in their reality (joining their journey):

- nodding, holding hands, verbalize their feelings e.g. “you sound sad”
- when responding to a client who is looking for her mother you might say: “Tell me about your mom...”
- Look past the behaviour to the person within and connect.



Respond creatively to help them find comfort in a situation – even if this means telling a “therapeutic fib” (source: Mary Lucero) e.g. if someone wants to catch a bus to leave, encourage them to have a cup of coffee while you check on the bus schedule – then return to let them know the bus won't come until tomorrow).



Supportive Pathways Education Program


Module 5

Responding to Altered Behaviour



Objectives

- To understand that behaviours may occur when interacting with persons who have dementia
- To discuss strategies to prevent and intervene when behaviours including aggression occur
- To learn a problem solving approach to support persons with dementia who are distressed
- To consider delirium as a cause if there is a change in behaviour



All Behaviour Has Meaning

Behaviour is a means of communication


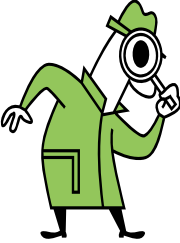
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Our challenge is to discover what they are communicating


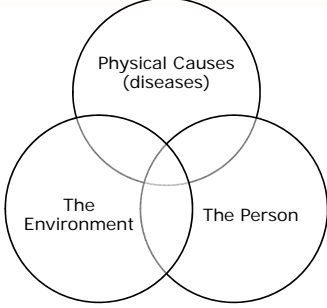


Behaviour Mapping

Be a detective



Three Factors to Consider



Physical Causes

Is the behavior related to:

- medical history, chronic pain, psychiatric illness?
- depression or delirium?
- UTI, pneumonia, constipation, dehydration, acute pain?
- medications such as antipsychotics?
- changes related to the type of dementia they have?
- what the disease has taken away?



The Person

Is the behavior related to:

- fears (e.g. post traumatic stress)?
- hunger, thirst, other unmet needs such as intimacy?
- things that upset them (triggers)?
- boredom – nothing to do?
- their personality, family relationships, culture or religion?
- abilities/disabilities to understand, communicate or function?
- past routines/ lifestyle (e.g. went for a daily walk outside)?



The Environment

Is the behavior related to:

- a rushed, noisy, hospital-like environment?
- unfamiliar caregivers/surroundings?
- no opportunity for choices or to do something?
- task focused versus resident focused care culture?
- minimal social interaction with staff?



What is the Fourth Factor?



The Fourth Factor - You!

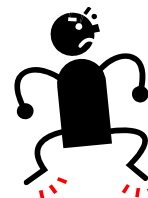
Is the behavior related to:

- how you react to the behavior?
- your approach (beliefs and values)?
- your non-verbal communication?
- whether you anticipate their needs?
- the way you reinforce the behavior?
- a belief that medications are our first option?
- your willingness to make their day and time special?



Do You Have a Pet Peeve?

What behaviour causes you to react?



How Can We Support The Client with Dementia?

Behavior can be an indication
that the person with dementia
is **distressed** and needs our support.



We need to ask

Is this behaviour a problem?

Whose problem is it?

When do we need to intervene?



Intervene When the Behaviour:

Could cause *harm to themselves*

Could cause *harm to others*

Interferes with the *rights* of others
(*Peaceful enjoyment of their home*)



How Should We Respond?

- **Ask:** Do we HAVE to do something right now?
'So what' if they don't want their bath today?
- **Follow:** the *'Path of Least Resistance'*
(Whatever works)

Do we have tools to help avoid causing distress?

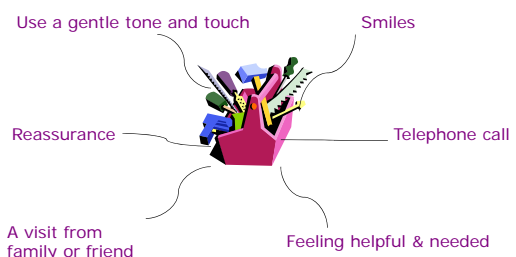


What is in the Caregiver's Toolbox?

- Knowledge
- Personal Strengths
- Caring/Patience
- Sense of humor
- Communication skills
- Supportive environment
- Creativity
- Team support

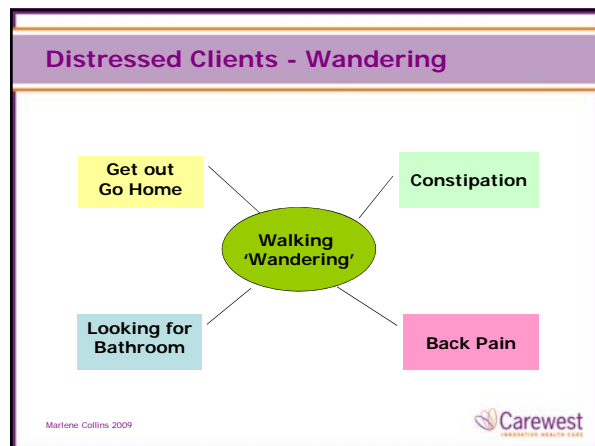
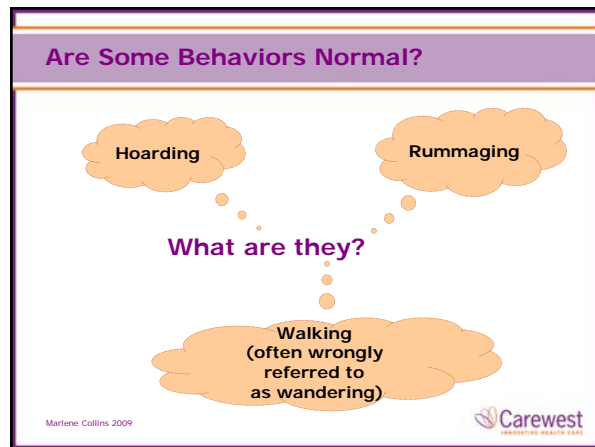
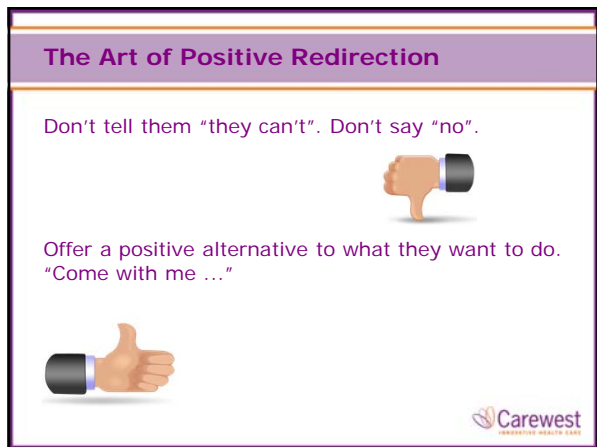
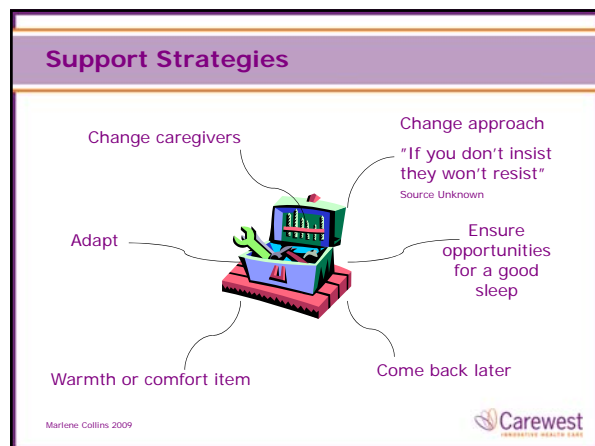


Support Strategies



Marlene Collins 2009





Support Strategies for "Wandering"



Marlene Collins 2009



Where to Search

Most are attempting to return home

To places in their past

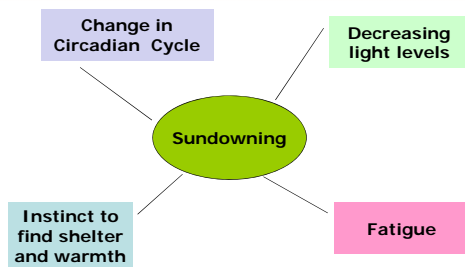
"Florida Factor" - travel south

Follow the "path of least resistance".

They go until they "get stuck"



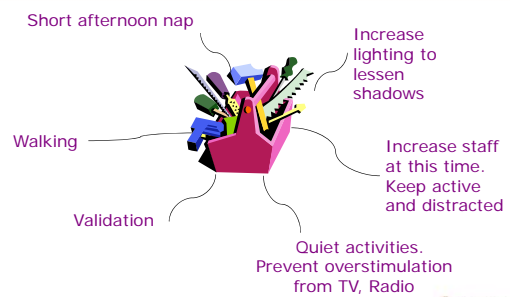
Distressed Clients - Sundowning



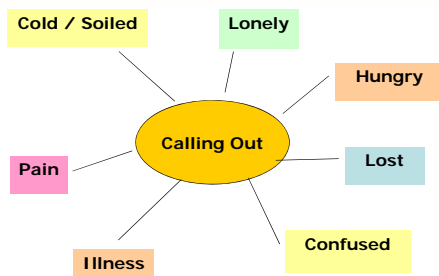
Marlene Collins 2009



Support Strategies for "Sundowning"



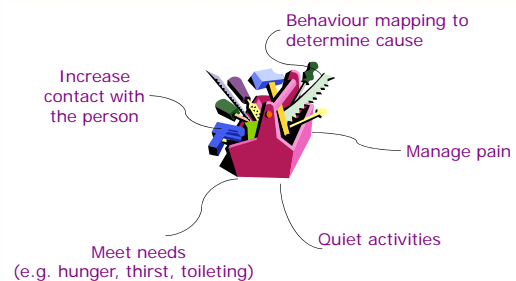
Distressed Clients - "Calling Out"

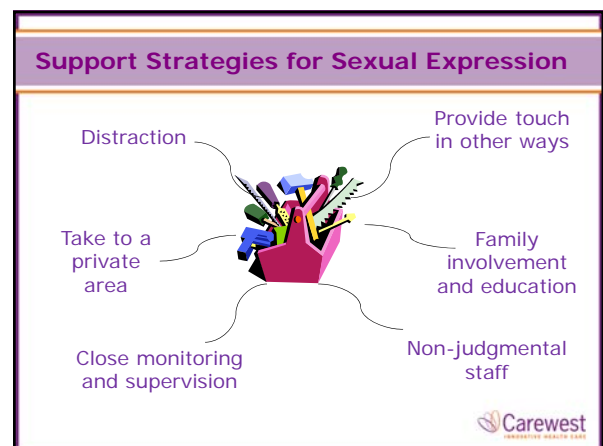
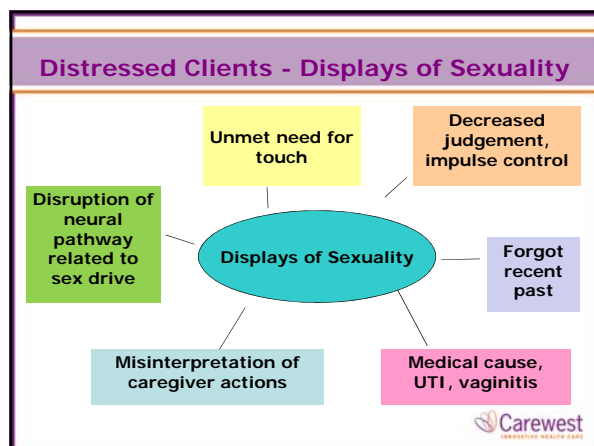
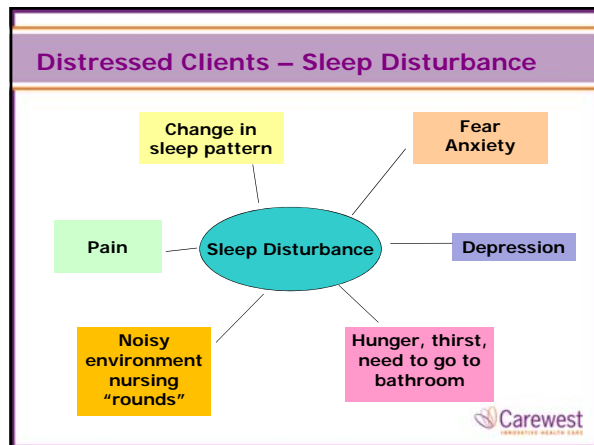
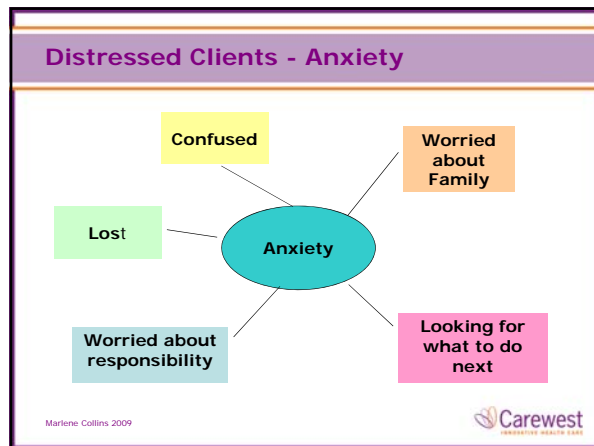


Marlene Collins 2009



Support Strategies for "Calling Out"





Inappropriate Clothing Could be a Trigger



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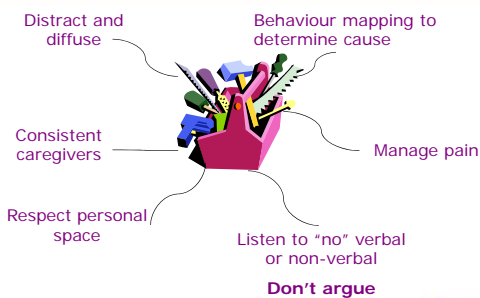
Distressed Clients - Aggression



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Support Strategies for "Aggression"



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"Choice and Challenge" Video

As you watch the video clips look for the "triggers" causing the aggressive behaviour

- Noise
- Rushing
- Too many caregivers
- No choices given
- Rough care - face washing
- Others?

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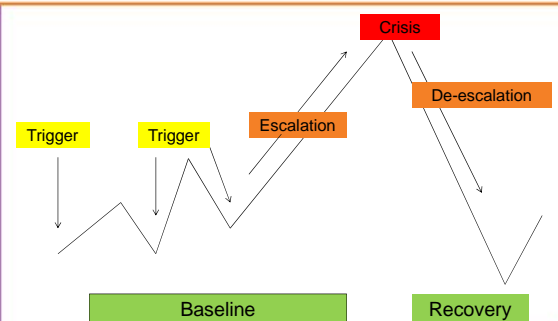
Signs of Distress and Possible Crisis

Watch for:

- Calling for help
- Trying to leave
- Tense muscles, clenched teeth, clenched fists
- Increased questioning
- Louder, faster talking or cursing
- Walking faster
- Interfering with others

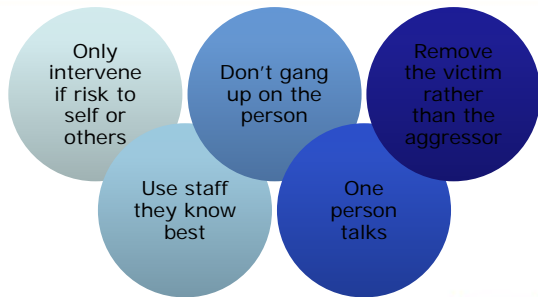
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Crisis Cycle



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Interventions



Debriefing

- Help to realize that the situation was not personally directed
- Empathize
- Should be about learning and problem solving not blaming



Medications as a Last Resort

Did you notice that ...
medication was not listed as a strategy for
altered behaviors in our tool kits?

Why would that be?

Medication has to be used appropriately
– right reason/right dose



Appropriate Use of Antipsychotics

What is all the fuss?



- In the past antipsychotics have been used to help manage behaviours for persons with dementia but with more evidence and research this is now being reconsidered



Are Antipsychotics Effective For...?

- Interfering with other residents - NO
- Inappropriate dressing/undressing - NO
- Perseveration, doing something over/over - NO
- Repetitive screaming/calling out - NO
- Eating items unsafe to eat - NO
- Trouble sleeping - NO
- Voiding, etc. in inappropriate places - NO
- Elopement (trying to leave) - NO
- Poor social skills - NO

That's why we need other strategies



Antipsychotics - Possible Hazards

- Decrease in cognitive function and the ability to engage
- Mobility impaired - increase in falls
- Metabolic implications - diabetes
- Strokes/Aspiration Pneumonia/Cardiac problems
- Mortality (death)

Therefore....

**Health Canada issued Warnings
about the use of Antipsychotics**



The Appropriate Use of Antipsychotics

Antipsychotics should only be considered when:

- the person has a mental illness or a psychosis (e.g. delirium)
- the person is at risk of harming themselves/others
(and everything else has been tried)

Antipsychotics

- must be reviewed frequently
- used at the lowest dose possible
- used for the shortest time possible
then gradually reduced and discontinued



Safety in Caregiving

Prevention is the best strategy



Safety in Caregiving

Attending to a client in a wheelchair

From the side is safer



Safety in Caregiving

Hair pulls, pinches and bites

Press in rather than pull away



Safety in Caregiving

Releasing yourself from a grab

Frail Elder

- effective to distract or wait

Strong aggressive grab

- use element of surprise to get out of grip.



Safety in Caregiving

Moving away from a **punch**

- **Block** the punch with two hands
- **Move** away from the person
- Do not grab the person's hand



Safety in Caregiving

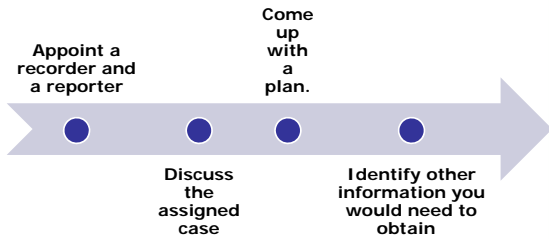
Releasing from a choke

- Quickly raise both of your arms
- Rotate away to safety



Use your Knowledge-Case Studies

If breaking into groups



Goals for Care

To help clients feel content and secure.

Reduction or elimination of “triggers” that lead to distressed behaviours.

To interact effectively with the person when behaviors occur.

Aim for a win/win solution.



Learning

- What is one thing you learned that will change how you support a person with distressed behaviour?



Questions?

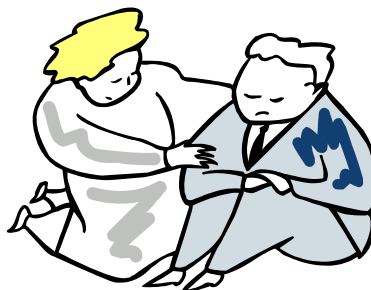


Please refer to your handouts – includes references



Best Practices for Responding to Altered Behaviour

- ☆ *Staff* will know the clients' usual patterns of behaviours
- ☆ *Staff* will understand that every behaviour has a meaning and the importance of assessing to rule out physical causes (look for meaning)
- ☆ *Staff* will recognize potential triggers to behaviours
- ☆ *Staff* will stay calm, monitor their own level of fear and anxiety, and establish a relaxed mood
- ☆ *Staff* will respect a clients' personal space
- ☆ *Staff* will allow clients to remain where they are unless it is an unsafe situation
- ☆ *Staff* will provide reassurance to the clients that they will not be harmed and encourage them to talk rather than act out his anger
- ☆ *Staff* will listen to concerns, be flexible and accepting and ask what is troubling the clients
- ☆ *Staff* will provide alternatives to the behaviour, distract or divert the person's attention – state the action you want (e.g. avoid saying: "don't go there")
- ☆ *Staff* may use appropriate humour and laughter to stimulate a sense of relief and provide comfort through a sense of belonging
- ☆ *Staff* may use touch and hugs as a form of communication whenever appropriate or possible
- ☆ *Staff* will not argue, but will "let things be" or ignore behaviours if the situation is not harmful
- ☆ *Staff* will accept behaviours which are normal for a person with a dementing illness
- ☆ *Staff* will pre-plan their intervention especially when more than one caregiver is required
- ☆ *Staff* will know that approach is important



"We all boil at different degrees." Ralph Waldo Emerson

STAFF WILL USE THE FOLLOWING WAYS TO INTERVENE:

- Redirect whenever possible
- Minimize or eliminate triggers
- Validate feelings
- Invite the client to a quiet / peaceful place
- Recognize need for pain management
- Use “Path of least resistance”
- Support families
- Minimize moves / changes
- Make environment familiar
- Re-approach at a later time
- Try a different caregiver
- Go with the client rather than pull away
- Use a quiet tone
- Provide care with least number of staff possible
- Only one staff talk at a time



STAFF WILL USE THE FOLLOWING WAYS TO INTERVENE WHEN INAPPROPRIATE SEXUAL EXPRESSIONS OCCUR:

- Redirect attention if possible
- Provide privacy
- Provide protection for non-consenting partners
- Facilitate discussions with families and team to reach a common understanding
- Ensure confidentiality related to circumstances
- Do not label clients (e.g. as aggressor or a victim)

CONSIDER LANGUAGE CAPABILITY OF THE RESIDENT:

- use words, phrases, and language most familiar to the person
- be aware of culturally specific information
- use reminding
- use redirecting
- make eye contact
- use comforting words and touch
- negotiate with the resident (only if you can follow through)

Staff can be injured by aggressive acts of residents

- Examples:
 - a staff member is struck by a resident wielding a cane
 - while bathing a resident, the staff member is grabbed, loses her balance and falls resulting in a work related injury
 - a resident pinches a staff person so hard that a severe bruise results
- staff member is pushed into a door by a resident, resulting in injury the reasons why these incidents occur is not always clear
- every such incident should be reviewed to identify ways it might have been averted
- it is important to pay attention to what preceded the incident, since this may have triggered the aggression
- if particular staff behaviours or situational circumstances lead to incidents of aggression, these should be modified to prevent a recurrence of the aggressive incident
- staff training can help in preventing these incidents
- environmental triggers can be difficult to identify as sometimes the most minor of stimuli can lead to aggressive reaction
- it may take some time to discover the trigger to aggressive behaviours

TIPS FOR STAFF TO PREVENT AGGRESSION

- a few residents may be especially prone to act out aggressively when they are frightened, frustrated, or faced with new situations
- all staff should be made aware of these residents, including activity, housekeeping, dietary, etc.
- these residents should always be approached from the front so that they have a direct view of who is coming toward them
- always inform the resident about what you are about to do (e.g., "I am going to help you out of the chair")
- tone of voice can be a trigger therefore, speak to the resident in a soothing voice
- touch can be interpreted as aggression by some residents; staff need to be gentle and calm in their approach
- always maintain eye contact with the resident
- if the resident resists care or treatment, do not insist, rather return at a later time and try again

BEHAVIOUR MAP A

Details of Behaviour _____

ADDRESSOGRAPH

Date	Time	Events Leading Up to Behaviour	Description of Behaviour	Action Taken	Events Following Behaviour	People Involved	TTR Y/N

Instructions:

For each occurrence of the behaviour, document details of the circumstances leading up to the behaviour (i.e., requests to bathe, take medications, etc.); the exact behaviour; the events that followed (i.e., staff/other's response to the behaviour, any reinforcement for patient); the names of people involved in the situation. Indicate if additional details were charted on the Total Team Record (TTR) – chart on the Total Team Record only if additional source is required.

Note: Complete Behaviour Map B when behaviour usually occurs more than once in 24 hours.

BEHAVIOUR MAP B – FREQUENCY / INTENSITY

Instructions:

1. Establish defining characteristics for at least minimum, maximum and middle range intensity (e.g., mutters/talks loudly/screams or every 5 minutes/every 15 minutes/constantly).
2. Mark a dot (●) for the behaviour within any hour the behaviour occurs. Draw lines between dots to form a graph.
3. For more than one behaviour use different colours or change Day 1, 2, 3 to Behaviour 1, 2, 3

Details of Behaviour _____

ADDRESSOGRAPH

Defining Characteristics

Intensity		Day 1										Day 2										Day 3																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																														
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Helpful Techniques for Bathing Residents who are Cognitively Impaired

- use a calm, personal gentle manner
- don't rush and keep directions simple
- if the resident begins to get agitated, slow down or stop
- cover all parts of the body you are not directly working with
- always explain what you are going to do (unless the resident is made more agitated by the explanation). Providing information is less threatening
- engage the resident in conversation about a topic of interest
- begin bath when the resident is more cooperative and calm
- always try to give choices
- honour bathing preferences: time, day, type of bath
- ensure privacy
- use same-sex caregiver if possible
- use the caregiver who is most likely to be successful
- use familiar bathing accessories (bubble bath, scented soaps)
- always have empathy toward the resident
- always make every effort to preserve the individual's dignity¹

1. O.W. Malott, ed., Alzheimer Resource Manual (Waterloo, ON: University of Waterloo, 2000)

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Bathing Residents Who Have A Dementia

Bathing can be one of the most unsettling times for people with Alzheimer's disease and related dementias.

Possible causes of disruptive behaviour at bathing time:

- resident may not understand why bathing is necessary
- resident may be reminded of his / her loss of independence
- resident may be intolerant of feeling cold
- resident may want more privacy
- resident may interpret bathing as a physical assault
- resident may be embarrassed

Remember:

- disruptive behaviour is not something the resident with dementia can control
- reactions are a result of a lowered ability to handle stressful situations
- for more information, refer to Chapter 3
 - Behaviour Management: the Six R's
 - Steps for Managing Difficult Behaviours
 - Guide for Identifying and Solving Problem Behaviours



General Guidelines for Bathing

Employ **consistent bathing practices**, as much as possible.

- day and time of day
- sex of caregiver
- type of bath: tub, shower or bed bath
- proper water temperature
- use of the bathing products preferred by the person

Be person centered, not task oriented.

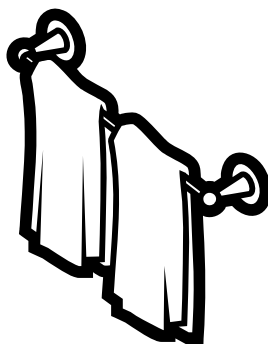
- always protect the residents dignity, privacy and comfort
- explain each step of the process
- encourage residents active participation, e.g., "Would you like to wash your face or would you like me to do it?"
- gently request the persons cooperation for each task
- pay close attention to cues about the persons comfort level, e.g., "Your cold. I'm sorry. Let's warm the water up."

Make it simple, never rush.

- eliminate tasks that can be completed outside of the bath
- always speak calmly, simply and slowly and stay in full view
- take short-cuts, such as using no-rinse soap

Determine **bathing goals**.

- maintaining personal independence
- cooperation
- comfort and relaxation
- cleanliness and personal hygiene
- the reduction or elimination of specific problematic behaviours²



2. O.W. Malott, ed., Alzheimer Resource Manual (Waterloo, ON: University of Waterloo, 2000)

Behavioural Symptoms and Bathing

BEHAVIOURAL SYMPTOM	SUGGESTED INTERVENTION
Resident does not want to bathe.	<ul style="list-style-type: none"> determine if this refusal is a new behaviour try later or try another caregiver assess the “cooperative spirit” of the resident and suggest bathing when it is at its maximum request suggestions from a family member offer a reward to the resident “create” a reason – time for work or visitors are coming ask if they would prefer a shower, tub or bed bath assess whether someone or something in the bathing area is upsetting for the resident spend a few minutes walking or talking with the resident before inviting to bathe
Resident refuses to get undressed.	<ul style="list-style-type: none"> bathe in the morning before getting dressed “create” a reason – “Your clothes are dirty.” Or “Fresh clothes will make you feel good.” offer choices; “Shall I undo your shirt or can you?” move slowly and gently; avoid rushing begin bath while partially clothed undress under a covering distract resident; talk about something enjoyable, offer a treat start with the shoes and move upwards, leaving shirt until last
Resident is incontinent during bath.	<ul style="list-style-type: none"> take resident to the bathroom first know residents toileting schedule and bathe around it run water before resident enters room use a “commode” shower chair if a movement occurs in tub, calmly stand resident up and finish up as best you can
Resident hits, slaps, bites or grabs onto objects.	<ul style="list-style-type: none"> get to know what behaviours typically occur prior to hitting / biting and take action or back off at that point give the resident something to hold – a wash cloth, or a large sponge engage resident in conversation, singing or humming
Resident refuses to sit in tub.	<ul style="list-style-type: none"> use shower chair bath the resident standing up while he / she holds onto bars for support try a different kind of bath; bed bath or shower consider using no-rinse soap to shorten the bath time

BEHAVIOURAL SYMPTOM	SUGGESTED INTERVENTION
Resident indicates or complains of being cold.	<ul style="list-style-type: none"> • warm the room, heat towels and fresh clothes in the dryer, close all doors and windows • ensure water is kept warm throughout the bath • use a towel to cover the resident during the bath, especially head and back • acknowledge the residents' experience and take immediate steps to help warm them
Resident doesn't want / like hair washed.	<ul style="list-style-type: none"> • try using a hand-held shower head or cloth to rinse in a controlled manner • use a cloth or visor to protect resident's eyes • keep wet hair wrapped in a towel and dry as soon as possible • resident may prefer beauty salon for shampoo • consider use of dry shampoo
Resident hollers or screams during bath.	<ul style="list-style-type: none"> • ensure resident is informed about what you are doing at all times • warn of upcoming sensations • use music to create a soothing atmosphere • sing or ask questions or / converse with resident • do not prolong bath time • provide a distracter such as a sucker
Resident indicates or complains of pain.	<ul style="list-style-type: none"> • transfer carefully, wash gently and pat dry • even though you may accidentally cause discomfort, apologize • if resident has chronic pain ensure medication has been received • provide constant reassurance • pad shower chairs³



3. O.W. Malott, ed., Alzheimer Resource Manual (Waterloo, ON: University of Waterloo, 2000)

Resident Bathing Guide: Worksheet

NAME:

BEHAVIOURAL SYMPTOM	SUGGESTED INTERVENTION

References Module 5

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Supportive Pathways Education Program

MODULE 6

Supporting Quality of Life




A photograph showing two pairs of hands clasped together, suggesting support and care. The hands are weathered, indicating they belong to older individuals.




Objectives


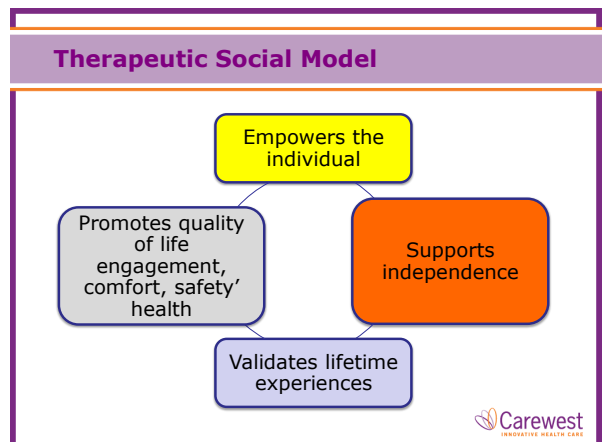
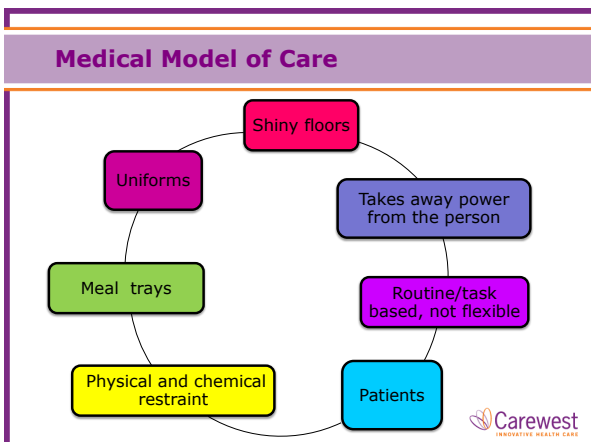
- To understand the importance of providing quality to the lives of persons with dementia.
- To understand that the environment consists of physical as well as social elements.
- To understand safety issues when caring for persons with dementia.
- To understand that individuals should have opportunities to have their needs for intimacy met.
- To recognize the danger in restraint use.



Confessions of an Old Cowboy



A photograph of an elderly cowboy wearing a white hat and a plaid shirt, standing next to a brown horse. The cowboy is holding the horse's lead rope.

Therapeutic Social Environment

What does your Unit/Home look like at 7:30 am?

- Noise
- Odors
- Lighting
- Caregiver Activity
- Person's Involvement
- Breakfast Routine



Marlene Collins 200



Social Environment – Unit Routines

- Does the person decide when they want to get up?
- Is breakfast at a set time or determined by their preference?
- Are any baths done before 7:00 am or when they preferred?
- How often are residents redirected from activities they chose?



Marlene Collins 2009



Creating a Therapeutic Social Environment

Laughter,
conversation
and
engagement

Clients/Residents
rather than
patients

Social model-
creating a life for
the person

Staff in less
institutional
clothing

Marlene Collins 2009



Therapeutic Social Environment

What does "comfortable" look like?

- Privacy
- Familiarity, comfort
- Positive feeling
- Minimized restrictions, access to outside
- Freedom to choose and do (if it is safe)
- Purpose specific rooms - kitchen, living room
- Reduced background noise

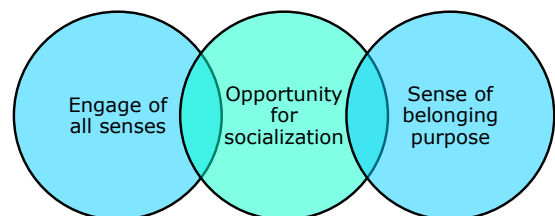
Marlene Collins 2009



Meals Begin Before Food is on the Table



Importance of Mealtime



Supporting Quality of Life - Physical Environment

- Freedom to move within a safe environment (restrictions only from real at-risk areas)
- Opportunities to interact (artwork, plants, items to rummage)
- Comfortable, relaxed atmosphere
- Barrier free
- Welcoming and friendly



Marlene Collins 2009



Respect for the Person's Home

How do you show respect for the person's home/or their room in a care facility?

- Knocking
- Wait to be invited in
- Obtain permission
- Respect their need to be in control
- Offer suggestions not orders
- Take care with their possessions



Remember:

**"We work in their home,
they don't live where we work"**



Importance of Possessions - Activity

You have had a stroke and are moving into a care facility

What is one item you would want to bring in to your new room?



Story of Ellen

Did George have the right to pack away Ellen's things?

Did George realize that Ellen's recent behavior may be related to her environment being changed?

As a Home Care Support Aide who might you suggest?



Physical Environment - Noise

What noises are heard in the client's environment in your work setting?



Physical Design Features

More Visible



Less Visible



Safe Access to Outside



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Wayfinding Cues



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Physical Design Features



Dining Next to Kitchen

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Personalizing



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Strategies for Success at Home

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Is it Safe to Leave the Person Alone?



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Safety Issues

- Risk of Burns
- Getting lost
- Ingestion of harmful substances
- Other- power tools, guns, sharp items



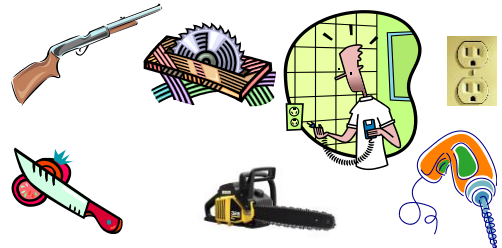
Risk for Burns



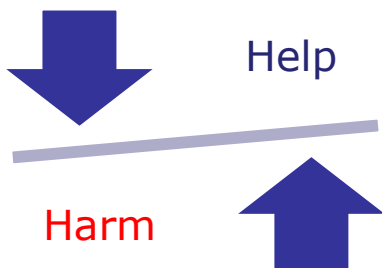
Ingestion of Harmful Substances



Other Hazards



Quality of Life- Safety



Helpful or Harmful?

- Non-skid socks
- Shiny, reflective floors
- Obstacles in room/halls
- Bathroom Light on/off
- Bed sensors
- Side rails
- Medications
- Scatter rugs
- Music
- Clothing Protectors



Set Me Free

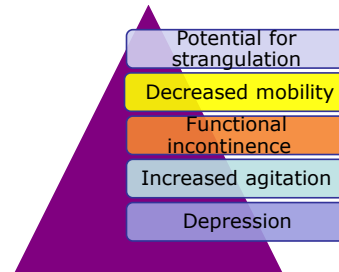
Most people are restrained because they live in unsafe or inadequate environments.



Marlene Collins 2009

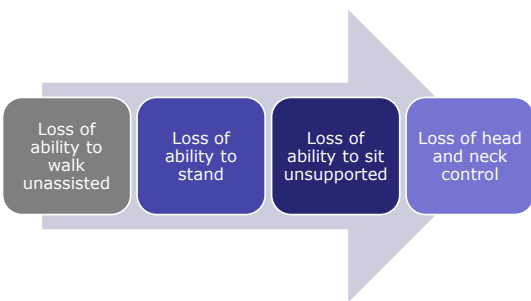
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Restraints are Dangerous



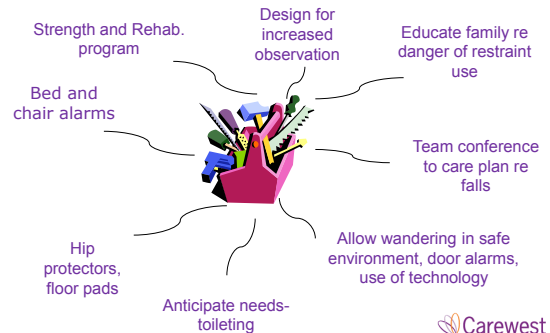
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Progressive Loss of Mobility



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Toolbox – Avoid Restraint Use



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What would you say and do?

1. You are a new staff member and a co-worker is insisting that you need to restrain the residents to keep them safe.
2. A family member is insisting that their mother be kept in restraints to keep them safe.

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Falls Injury Prevention

- Understand reality of falls risk with dementia
- Have strategies to reduce injury risk
 - Fall mats
 - Hip protectors (around the clock)
 - Minimize restraints
 - Encourage walking/exercise
 - Review medications



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What does Locked mean to you?

Secure



Locked



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Quality of Life – Intimacy/Sexuality Needs

Video: 'Bringing Sexy Back'

As you watch the video think
about people you care for ...



Sexuality

Intimacy

How can we support the need
for intimacy/sexuality?

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What is Intimacy?

- The experience of being known, understood and loved
- Includes talking loving words, kissing, hugging, and body contact
- A sense of connection or relationship

Source: Bradford Dementia Group, University of Bradford 2005

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The Issue of Consent

Are people with dementia able to give consent?

YES

NO

MAYBE



When are people vulnerable?

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Consent

- A person with dementia can agree (has the capacity to decide) to participate in sexual activity
- They are capable of expressing a full range of emotions, both 'positive' and 'negative'
- They are able to show mutual affection
- Agreement to participate is indicated by their verbal and non verbal communication

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Signs of Wellbeing

- Body relaxation
- Sensitivity to the emotional needs of others
- Positive mood: smiling, laughing, happy
- Initiation of social contact
- Affection

Source: Bradford Dementia Group, University of Bradford 2005

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Meeting Needs for Intimacy

What ways can we support their needs?

- Involve family and ask for their suggestions
- Provide opportunity for privacy
- Include touch and kindness in your care
- Offer options e.g. a body pillow if they seem lonely in bed

What strategies do we need in place so that all individuals involved are protected?

- Non judgemental staff
- Close supervision and monitoring



Judgemental vs. Factual Documentation

Judgemental	Factual
I discovered him in her room...	<i>I entered the room and saw Tom and Mary...</i>
He looked guilty	<i>He looked away when I walked up to him</i>
He repeatedly groped her	<i>He touched her breast several times</i>
She stalked the corridor waiting for the staff to go to tea	<i>She was observed walking in the corridor</i>



Judgemental vs. Factual Documentation

Judgemental	Factual
I saw him lurking outside her room	<i>I observed Tom standing outside Mary's room</i>
He is a deviate who doesn't belong here. He should be in a psych hospital	<i>Keep your opinions to yourself!</i>
He is a predator	<i>Don't write this ever!</i>



Video – Freedom of Sexual Expression

or

Case studies



Questions?



Please refer to your handouts



Home Safety Room – By - Room

Prevention begins with a safety check of every room in your home. Use the following room-by-room checklist to alert you to potential hazards and record any changes you need to make. You can buy products or gadgets necessary for home safety at stores carrying hardware, electronics, medical supplies, and children's items.

Keep in mind that it may not be necessary to make all of the suggested changes. This booklet covers a wide range of safety concerns that may arise, and some modifications may never be needed. It is important, however, to re-evaluate home safety periodically as behaviour and abilities change.

Your home is a personal and precious environment. As you go through this checklist, some of the changes you make may impact your surroundings positively, and some may affect you in ways that may be inconvenient or undesirable. It is possible, however, to strike a balance. Caregivers can make adaptations that modify and simplify without severely disrupting the home. You may want to consider setting aside a special area for yourself, a space off-limits to anyone else and arranged exactly as you like. Everyone needs private, quiet time, and as a caregiver, this becomes especially crucial.

A safe home can be a less stressful home for the person with AD, the caregiver, and family members. You don't have to make these changes alone. You may want to enlist the help of a friend, professional, or community service such as the Alzheimer's Association.

THROUGHOUT THE HOME

- ☐ Display emergency numbers and your home address near all telephones.
- ☐ Use a telephone answering machine when you cannot answer calls. The person with AD often is unable to take messages or may be a target for telephone exploitation by solicitors. When the answering machine is on, turn down the phone bell to avoid disruptive ringing.
- ☐ Install smoke alarms near all bedrooms; check their functioning and batteries frequently.
- ☐ Avoid the use of flammable and volatile compounds near gas water heaters. Do not store these materials in an area where a gas pilot light is used.
- ☐ Install secure locks on all outside doors and windows.
- ☐ Hide a spare house key *outside* in case the person with AD locks you out of the house.
- ☐ **Avoid the use of extension cords** if possible by placing lamps and appliances close to electrical outlets. Tack extension cords to the baseboards of a room to avoid tripping.
- ☐ **Cover** unused outlets with **childproof plugs**.
- ☐ Place **red tape** around floor vents, radiators and other heating devices to deter the person with AD from standing on or touching a hot grid.
- ☐ Check all rooms for adequate lighting.
- ☐ Place **light switches** at the **top** and the **bottom of stairs**.
- ☐ **Stairways should have at least one handrail** that extends beyond the first and last steps. If possible, stairways should be carpeted or have safety grip strips.
- ☐ Keep all **medications** (prescription and over-the-counter) **locked**. Each bottle of prescription medicine should be clearly labeled with the resident's name, name of the drug, drug strength, dosage frequency, and expiration date. Child-resistant caps are available if needed.
- ☐ Keep all alcohol **in a locked cabinet** or out of reach of the person with AD. Drinking alcohol can increase confusion.

- ☐ If smoking is permitted at all, **monitor while the person with AD is smoking**. Remove matches, cigarettes and ashtrays. With these reminders out of the sight, the person may forget the desire to smoke.
- ☐ **Avoid clutter**, which can create confusion and danger. Throw out / recycle newspapers and magazines regularly. Keep all walk areas free of furniture.
- ☐ **Keep plastic bags out of reach**. A person with AD may choke or suffocate.
- ☐ **Remove all guns or other weapons** from the home or safety proof them by installing safety locks or by removing ammunition and firing pins.
- ☐ **Lock all power tools** and machinery in the garage, workroom or basement.
- ☐ **Remove all poisonous plants** from the home. Check with local nurseries or poison control centers for a list of poisonous plants.
- ☐ **Keep fish tanks out of reach**. The combination of glass, water, electrical pumps, and potentially poisonous aquatic life could be harmful to a curious person with AD.

OUTSIDE APPROACHES TO THE HOUSE

- ☐ Keep steps sturdy and textured to prevent falls in wet or icy weather.
- ☐ Mark the edges of steps with bright or reflective tape.
- ☐ Consider a ramp with handrails into the home rather than steps.
- ☐ Eliminate uneven surfaces or walkways, hoses, or other objects that may cause a person to trip.
- ☐ Restrict access to a swimming pool by fencing it off with a locked gate, covering it, and keeping it closely supervised when in use. In the patio area, remove the fuel source and fire starters from any grills when not in use, and supervise use when the person with AD is present.
- ☐ Place a small bench or table by the entry door to hold parcels while unlocking the door.
- ☐ Make sure outside lighting is adequate. Light sensors that turn on lights automatically as you approach the house are available and may be useful. They also may be used in other parts of the home.
- ☐ Prune bushes and foliage well away from walkways and doorways.
- ☐ Consider a NO SOLICITING sign for the front gate or door.

ENTRYWAY

- ☐ **Remove scatter rugs** and throw rugs.
- ☐ **Use textured strips** or nonskid wax on hardwood floors to prevent slipping.

KITCHEN

- ☐ Install childproof door latches on storage cabinets and drawers designated for breakable or dangerous items. Lock away all household cleaning products, matches, knives, scissors, blades, small appliances, and valued china.
- ☐ If prescription or nonprescription drugs are kept in the kitchen, store them in a locked cabinet.
- ☐ **Remove scatter rugs** and foam pads from the floor.
- ☐ **Remove knobs from the stove**, or install an automatic shut-off switch.

- ☐ Do not use or store flammable liquids in the kitchen. Lock them in the garage or in an outside storage unit.
- ☐ Keep a night-light in the kitchen.
- ☐ Remove or secure the family “junk drawer.” A person with AD may eat small items such as matches, hardware, erasers, plastic, etc.
- ☐ Remove artificial fruits and vegetables or food-shaped kitchen magnets, which might appear to be edible.
- ☐ Insert a drain trap in the kitchen sink to catch anything that may otherwise become lost or clog the plumbing.
- ☐ Consider dismantling the garbage disposal. People with AD may place objects or their own hands in the disposal.

BEDROOM

- ☐ Use a night-light.
- ☐ Use an intercom device (often used for infants) to alert you to any noises indicating falls or a need for help. This also is an effective device for bathrooms.
- ☐ Remove scatter rugs.
- ☐ Remove portable space heaters. If you use portable fans, be sure that objects cannot be placed in the blades.
- ☐ Be cautious when using electric mattress pads, electric blankets, electric sheets, and heating pads, all of which may cause burns. Keep controls out of reach.
- ☐ Move the bed against the wall for increased security, or place the mattress on the floor.

BATHROOM

- ☐ Do not leave a severely impaired person with AD alone in the bathroom.
- ☐ **Remove the lock from the bathroom door** to prevent the person with AD from getting locked inside.
- ☐ Place nonskid adhesive strips, decals, or mats in the tub and shower. If the bathroom is uncarpeted, consider placing these strips next to the tub, toilet and sink.
- ☐ Use washable wall-to-wall bathroom carpeting to prevent slipping on wet tile floors.
- ☐ Use an extended toilet seat with handrails, or install grab bars beside the toilet.
- ☐ Install grab bars in the tub / shower. A grab bar in contrasting color to the wall is easier to see.
- ☐ Use a foam rubber faucet cover (often used for small children) in the tub to prevent serious injury should the person with AD fall.
- ☐ Use plastic shower stools and a hand-held showerhead to make bathing easier.
- ☐ In the shower, tub, and sink, use a single faucet that mixes hot and cold water to avoid burns.
- ☐ **Adjust the water heater to 120 degrees** to avoid scalding tap water.
- ☐ **Insert drain traps in sinks** to catch small items that may be lost or flushed down the drain.
- ☐ Store medications (prescription and nonprescription) in a locked cabinet. Check medication dates and throw away outdated medications.

- ☐ **Remove cleaning products** from under the sink, or lock them away.
- ☐ **Use a night-light.**
- ☐ Remove small electrical appliances from the bathroom. Cover electrical outlets. If men use electric razors, have them use a mirror outside the bathroom to avoid water contact.

LIVING ROOM

- ☐ Clear all walk areas of electrical cords.
- ☐ **Remove scatter rugs** or throw rugs. Repair or replace torn carpet.
- ☐ Place decals at eye level on sliding glass doors, picture windows, or furniture with large glass panels to identify the glass pane.
- ☐ Do not leave the person with AD alone with an open fire in the fireplace, or consider alternative heating sources. Remove matches and cigarette lighters.
- ☐ Keep the controls for cable or satellite TV, VCR and stereo system out of sight

LAUNDRY ROOM

- ☐ Keep the door to the **laundry room locked** if possible.
- ☐ Lock all **laundry products in a cabinet.**
- ☐ **Remove large knobs** from the washer and dryer if the person with AD tampers with machinery.
- ☐ Close and latch the doors and lids to the washer and dryer to prevent objects from being placed in the machines.

Carewest Intimacy and Privacy Guidelines

RATIONALE

Carewest recognizes that, throughout our lifespan, a sense of well-being is achieved, in part, through connection with others. This policy exists to provide guidelines to support the human right of individuals to meet their needs for love, companionship, intimacy and sexual expression.

APPLICABILITY

All healthcare providers and contracted service providers.

DEFINITIONS

Abuse: “Abuse of a resident means any action or inaction or power and/or betray of trust or respect by a person against a resident, that the person knew or ought to have known, would cause (or could reasonably be expected to cause) harm to the resident's safety or well-being. Abuse includes, but is not limited: Physical abuse, Sexual abuse and sexual assault, emotional abuse, verbal abuse, financial abuse, exploitation of a resident's property or person, neglect, prohibited use of restraints, measures used to discipline a resident” (revised by neglect, prohibited use of restraints, measures used to discipline a resident (revised by Lanark, Leeds and Grenville with permission from Shalom Village, LTCH, Hamilton ON)

Capacity: “Capacity is the ability to understand information relevant to a decision and to appreciate the reasonably foreseeable consequences of (i) making a decision or (ii) the failure to make a decision” (Alberta Guardianship and Trusteeship Act 2009)

Consent: (2) Subject to the subsection (3), “consent” means, for the purpose of this section, the voluntary agreement of the complainant to engage in the sexual activity in question. (3) no consent is obtained, for the purposes, of this section, if (a) the agreement is expressed by the words or conduct of a person other than the complainant; (b) the complainant is incapable of consenting to the activity; ... (Canadian law, Sexual offences Section 150.1)

Intimacy: “The experience of being known, understood and loved. Includes talking loving words, kissing, hugging, and body contact. A sense of connection or relationship” (Bernie McCarthy MAPS)

Sexual Orientation: “A term for the emotional, physical, romantic, sexual, spiritual attraction or affection of another person. Examples include heterosexuality, homosexuality and bisexuality.”(Revised by Lanark, Leeds and Grenville with permission from Shalom Village, LTCH, Hamilton ON)

Sexuality: “Sexuality is an expression of personhood (our sense of who we are in a relationship with others), our sexual, emotional and spiritual self involving touching, talking and engaging in sexual behaviour” (Bernie McCarthy MAPS)

***The Criminal Code of Canada also has definitions of sexual assault, sexual assault with a weapon, threats to a third party of causing bodily harm, punishment, aggravated sexual assault, and the meaning of “consent”, where no consent is obtained.

POLICY

1. Privacy, Intimacy and Sexuality education will be provided to staff at orientation and on an ongoing basis so that the importance of sexuality and intimacy as part of a normalized life experience, regardless of age or disability, and sexual orientation is recognized. Staff will be expected to offer non-judgmental, supportive care to residents.
2. Clients will be invited to discuss their individual needs and rights as sexual beings, in a confidential and supportive manner, with health professionals. This will be done with sensitivity and respect for the individual's cultural, religious, ethical and personal beliefs and/or values.
3. As part of the general admission assessment process, clients will have the opportunity to share information about the resident's sexual and intimacy needs. Clients will be made aware of their right to have private time and space. Relevant information will be incorporated into the *Care Plan and be reviewed on a regular basis*.
4. Carewest staff will demonstrate supportive and non-judgmental attitudes towards the sexual orientation and expression of clients. Staff will offer to assist clients in identifying options and solutions to meeting their sexual and intimate needs.
5. If a staff member recognizes that he/she is experiencing some difficulty with objectivity and/or internal conflict in regards to the sexual/intimate activity or needs of client, he/she has a responsibility to bring this to the attention of their manager.
6. There will be provision of private time and space for intimacy and sexual expression of clients.
7. Clients involved in companionship and physical intimacy, of a sexual nature, must be in a consensual relationship. Both parties must consent to being involved in sexual relations or other intimate activities. Should the individual's capacity come into question, a formal assessment may be required to determine client's ability to give legal consent.
8. If signs of ill-being of a client related to intimacy of a sexual nature are observed, an *Unusual Occurrence Report will be completed*.
9. Sexual abuse will not be tolerated and requires intervention by staff to nullify any unwanted or harmful expression of sexuality towards another client.
10. If staff suspect a client is being abused, it must be reported to Protection for Persons in Care.

GUIDELINES

1. The Wellbeing model (Kitwood, 1997) will be used to guide staff in supporting the client's need for sexual expression and intimacy. Staff will observe for indications

and signs of ill-being and well-being.

2. When signs of ill-being are observed, staff will intervene with the least restrictive alternative when intervention is required in order to ensure the safety and dignity of all clients. Strategies may include:

- discussion -with the client
- consultation -with the physician
- a change in the physical environment
- referral to Social Work
- development of social supports, activities, hobbies
- referral to Pastoral Care/Spiritual Care
- referral to Geriatric Mental Health Consulting Service
- referral to the Carewest Ethics Committee
- discussion with the client/agent/guardian

3. Should the client's capacity come into question, the Client Service Manager or designate, in conjunction with the team, shall arrange for formal capacity

assessment. If the client is unable to give legal consent, the agent or guardian will be informed of the situation. A legal guardian may also give consent on behalf of

the individual. Under the Adult Guardianship and Trusteeship Act, the Office of the Public Guardian may also be consulted for "specific decision~ making". (See

Alberta Guardianship & Trusteeship Act)

4. Needs or issues which arise subsequent to the admission process will be appropriately addressed on a timely basis. Education will be provided.

5. In the event that there is uncertainty, distress, or disagreement regarding clients' privacy, intimacy and sexuality issues, any staff member may contact the Executive

Secretary to make a referral to the Carewest Ethics Committee for guidance.

6. Private time and space will be made available in a variety of ways, based on individual needs and site resources. This may include the provision of items such

as: a furnished couples' room with a queen-size bed, couch, TV, music, call button and privacy signage. Hourly staff checks will be completed. If risk is present,

parties may consider the use of a Shared Risk Agreement, and if necessary, a *Release of Liability, Waiver of Claims, Assumption of Risks and Indemnity Agreement*.

7. Staff members will maintain an awareness of client's sexual and intimate behaviour, in order to promote the client's well-being and safety. Consideration

will be given to:

- contraception
- sexually transmitted infections
- universal precautions

REFERENCES

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Supportive Pathways Education Program

Module 7

Making
Life
Meaningful



Objectives

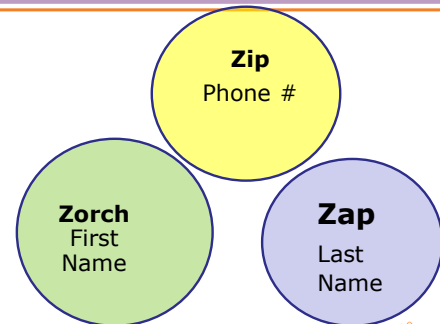
To recognize the importance of providing meaning to each person's day.

To discuss factors to consider when trying to help people feel useful and occupied.

To understand the different needs of individuals with early, middle and late stages of dementia.



Zip, Zap, Zorch



Zip, Zap, Zorch Debriefing

- *Did you want to participate? Did you mind being forced to participate?*
- *What was it like to perform under pressure?*
- *How many could not remember how to respond in the new language?*
- *Would having more time to think about the right response be helpful?*



Activities or Being Occupied?

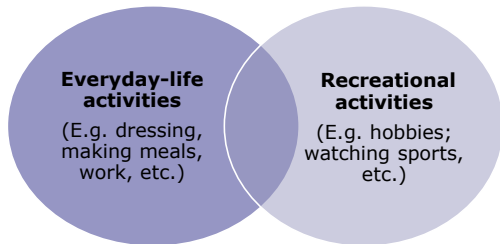
Being Occupied - "filling the day with things that are meaningful to us - they can be spontaneous, singular, needing little skill, take seconds, minutes or hours. "

Activities - organized, more than one person, set time, need someone to coordinate and run them.

David Sheard- Dementia Care Matters



Types of "Activities"



Activity Exercise



Recreation Activities

On one piece of paper **list the recreational activities you enjoy doing or observing** (E.g. sports, hobbies, watching movies)

"Everyday" Activities

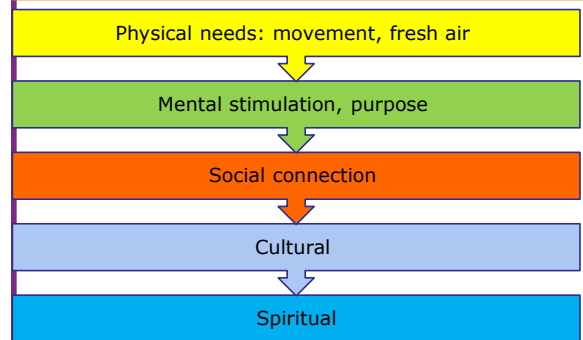
On second piece of paper **list "everyday" activities" that help you feel good about yourself** (E.g. making meals, reading the paper, grooming)



Debriefing the Activity Exercise



Activities Meet Many Needs



Meaningful Life Roles

- 'Everyone needs to feel needed'
- Our clients need meaning/purpose in their life - a job, activity or role



- Differs from basic need and leisure activities
- May connect to past interests/roles
- May be a new opportunity



Meaningful Life Roles

The role must:

- be flexible and match the person's comfort level
- be set up for success
- have a clear agreement on the reward
- meet legal or regulatory restrictions
- have full team support/understanding (all departments)



Meaningful Life Roles

How can we help our clients who have dementia find a meaningful life role at our work place?

Please share your ideas/examples



Toolbox – Meaningful Activities



Keeping Life Meaningful

Whose job is it to help our clients keep life meaningful?

How can we do fit this into our workloads?



Positive Social Interaction

Butterfly Moments

Initiating brief interactions throughout the day



David Sheard- Dementia Care Matters



Positive Social Interaction

**What's
in your
pocket?**



David Sheard- Dementia Care Matters



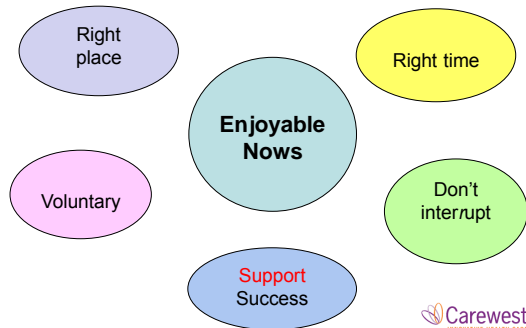
Enjoyable Now (Positive Interactions)

Video:

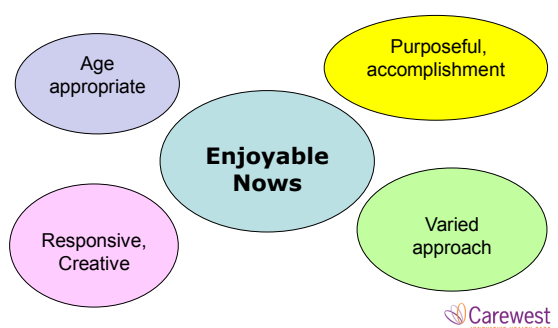
"One Thousand Tomorrows"



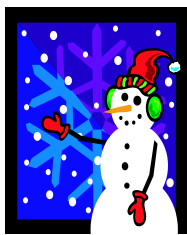
Tips for Creating "Enjoyable Nows"



Tips for Creating "Enjoyable Nows"



Use your Creativity



TV - Friend or Foe



Joy of Music

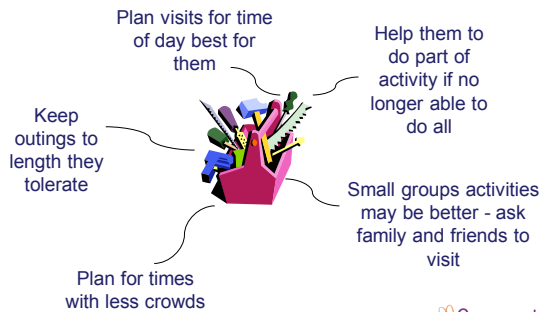


What Else Can We Do?

**101 Things
to do
With the Person
Who has Dementia**
(see handout)



Toolbox - Meaningful Activities



Carewest
INNOVATIVE HEALTH CARE

Clients Who Have Apathy

These clients may have:

- a lack of interest
- decreased initiative
- flat affect

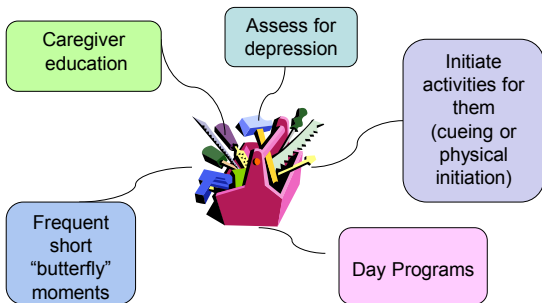
Why?

- damage to frontal lobe - lack of initiating action
- damage to limbic system - emotional centre

How can we provide meaningful interaction to help these clients?

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Supporting Clients with Apathy



Carewest
INNOVATIVE HEALTH CARE

Family and Volunteer Involvement



Marlene Collins 2009

Carewest
INNOVATIVE HEALTH CARE

Wind -Up

- Questions?
- Refer to Handouts
- Do post test
- Fill in Evaluation



THANK
You!

Carewest
INNOVATIVE HEALTH CARE

1101 Things To Do With A Person Who Has Dementia

- Clip coupons
- Sort poker chips
- Count tickets
- Rake leaves
- Use the carpet sweeper
- Read out loud
- Bake cookies
- Look up names in the phone book
- Read the daily newspaper out loud
- As a friend, neighbour, church acquaintance who has a baby or young child to visit
- Listen to polka music
- Plant seeds indoors or out
- Look at family photographs
- Toss a ball
- Color pictures
- Make homemade lemonade
- Wipe off the table
- Weed the flower bed
- Make cream cheese mints
- Have a spelling bee
- Read the Reader's Digest out loud
- Fold clothes
- Have a calm pet visit
- Cut pictures out of greeting cards
- Wash silverware
- Bake homemade bread
- Sort objects such as beads by shape or color
- Sing Christmas carols
- Say "Tell me more" when they talk
- Put silverware away
- Make a Valentine Collage
- Play favourite songs and sing together
- Take a ride
- Make a cherry pie
- Read aloud from labels
- Dye Easter eggs
- Fold a basket of socks
- Take a walk
- Reminisce about the first day of school
- String Cheerios to hand outside for birds
- Make fresh fruit salad
- Sweep the patio
- Color paper shamrocks green
- Fold towels
- Have afternoon tea
- Remember great inventions
- Play pictionary
- Paint a sheet
- Cut out paper dolls
- Identify provinces and capitals
- Make a family tree poster
- Color a picture of our flag
- Cook hot dogs outside
- Grow magic rocks
- Water house plants
- Reminisce about the first kiss
- Play horseshoes
- Dance
- Sing favourite hymns
- Make homemade ice cream
- Plant bulbs for winter blooming
- Make Christmas cards
- Sort playing cards by their color
- Write a letter to a family member
- Dress in red on a football Saturday
- Pop popcorn
- Name the Prime Ministers
- Give a manicure
- Make paper butterflies
- Make a May basket
- Make homemade applesauce
- Finish famous sayings
- Feed the ducks
- Mold with Play Doh
- Look at pictures in a National Geographic
- Put a simple puzzle together
- Sand Wood
- Rub in hand lotions with a pleasant scent
- Decorate paper place mats
- Arrange fresh flowers
- Remember famous people
- Straighten underwear drawers
- Finish nursery rhymes
- Make peanut butter sandwiches
- Wipe off patio furniture
- Cut up used paper for scratch paper
- Take care of a fish tank
- Trace and cut out leaves
- Ask simple questions
- Finish Bible quotes
- Paint with string
- Cut out pictures
- Read classic short stories
- Put coins into a jar
- Sew sewing cards
- Put bird feed out for birds
- Clean out a pumpkin
- Roll yarn into a ball
- Make a birthday cake
- Reminisce about a favourite summer

Source Unknown

Planning Activities

When planning activities it is important to look at what abilities are retained until late in the disease process. We can use these to guide us in planning appropriate activities.

What Has Been Lost?	What is Often Retained?
Recent memory	Remove (long term) memory (until late)
Ability to learn new material	Old skills
Ability to perform previously learned motor tasks	Continually repeating one movement.
Use and understanding of verbal language	Ability to use and recognize non-verbal language
Reasoning and judgment	Ability to experience appropriate feelings
Ability to make logical decisions	Ability to respond to interesting stimuli
Ability to initiate	
Ability for spontaneous actions and communication	Capacity to enjoy (and to fear etc.)
Ability to plan and sequence tasks	Ability to help with self care
Ability to judge their body position in space	

Source Unknown

Meaningful Activities Should...

- help to restore familiar and meaningful roles
- appeal and interest adults
- give pleasure
- promote dignity
- make use of retained skills
- have a purpose or are a way to be helpful
- promote independence
- develop or maintain self-esteem
- incorporate the confused persons need for structure and repetition
- provide an opportunity to share their knowledge and experience through the activity
- provide an opportunity to socialize¹



PERSONAL REFLECTION:

Who decides if an activity is meaningful?

1. O.W. Malott, ed., Alzheimer Resource Manual (Waterloo, ON: University of Waterloo, 2000)

Guidelines for Implementing Activities...

- be patient – confused persons work at a slower pace
- make it easy – activities that result in success build on skills and provide immediate satisfaction
- kept it simple – give instructions for one step at a time and bring out the items only needed for each step
- keep it short – the resident may not stay interested for long periods of time
- demonstrate the activity
- repeat successful activities – this offers reassurance and increases learning
- be consistent in the way activities are done
- match the activity to the individuals abilities – adapt to their needs
- keep your assistance to a minimum – easy tasks ensure the individual can do them independently
- give a lot of praise, compliments and encouragement to efforts made
- provide a peaceful environment – limit distractions such as noise and crowds that can upset a confused individual
- anticipate areas of difficulty – assistance or encouragement at these points can limit the residents confusion or frustration
- get input from the residents when planning an activity
- be sympathetic to the fact that abilities and interest in activities can change from day to day or from hour to hour

To provide meaningful activities, assess residents individually for their interests and abilities. Look at:

- what the individual presently does – interview the resident, caregivers and observe to assess functional ability, preferences, habits, lifestyle and current interests
- past employment, hobbies, roles and interests to gauge preferences and abilities
- what the residents think they can do
- factors that may help or hinder participating in activities – health problems, disabilities, the environment, motivation, and cognitive status²

2. O.W. Malott, ed., Alzheimer Resource Manual (Waterloo, ON: University of Waterloo, 2000)

References Module 7

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