

Supportive Pathways Education Program

Welcome
and
Enjoy
the
Participant
Refresher



The History of Supportive Pathways



Supportive Pathway Certificate Modules

1. Personal and Organizational Beliefs and Values
2. Individual and Family Care
3. Normal Aging Changes and Disease Process
4. Effective Communication
5. Responding to Altered Behavior
6. Supporting Quality of Life
7. Making Life Meaningful (Activities)



Refresher Topics to be Covered

- Distressed Families
- Effective Communication
- Respect
- Altered Behaviours/Use of related Medications
- Safety
- Sexuality/Intimacy
- Positive Social Interactions



Carewest's Philosophy of Care

In support of the Carewest Frame of Reference,
our Philosophy of Care is:

**"To provide our residents and clients with quality care
in safe, comfortable and supportive environments."**



Philosophy of Care - Guiding Principles

The Guiding Principles to the Philosophy include working
together to:

Preserve and promote **dignity through respectful**,
individualized approaches to care;

Provide **kind and compassionate care and service**;

Foster supportive **relationships between all staff,**
clients, families and communities;

Foster an environment of **learning to promote**
excellence in care and service.



Supportive Pathways Model of Care



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



Family - Coping With Dementia

"Featherhead" Video



"Featherhead" Debriefing

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

Did the caregiver experience grief and guilt?

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/staff?



Understanding Distressed Families

Some families already have:

- Elevated expectations
- Wishes for the person to be back to normal
- Different Beliefs/Values
- Conflicting demands on their time/energy (i.e. sandwich generation)
- Experienced lack of community support due to the community at large having limited knowledge and experience with dementia

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Feeling Distressed Families may Experience

Fear- some may feel
'That's me in 20
years'.

Feelings of **Guilt**
for not providing
the care needed
themselves

Anger at themselves,
the person or other
family members



Difficulty coping with
their new role
and sense of
obligation

Conflict with their
own feelings and
amongst family

Frustration with family
who don't help out or live
afar

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Distressed Families

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

Liken & Collins, 1993



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



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Things We Do That Distresses Families?

- Appear to ignore family or be judgmental
- Not include clients in conversations
- Talk on our cell phone in a client area
- Appear to be having non-work related chats with co-workers
- Appear to ignore call bells
- Not follow through when we say we will do something



How do we turn these actions into positives?



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

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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

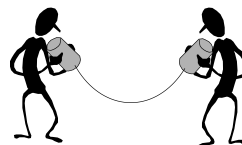
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Effective Communication

Good Communication is Key with Clients and Families

- to create positive trusting relationships
- to help avoid distressful situations and behaviors



'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

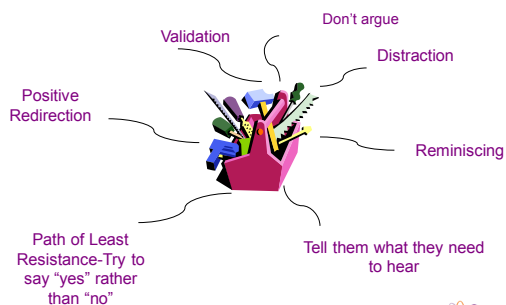


How do we communicate non-verbally?

- 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



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 over and over again.)



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...

This is how we learn



Key Message

When two people are required to provide 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
- ✓ Always give the client time to respond/understand



Key Message

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 related to Communication

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



Respect



*Everyone wants it
Everyone deserves it*



Respect for the Person's Home

How do you show respect for the person's home?

- Knocking
- Wait to be invited in
- Obtain permission
- Ensure they have control
- Offer suggestions not orders
- Take care with their possessions
- Avoid calling their possessions 'clutter'



Respect for the Person's Home

Should it be any different in the care centre?

"We work in their home.

They don't live where we work."



Responding to Altered Behaviors



All Behaviour Has Meaning

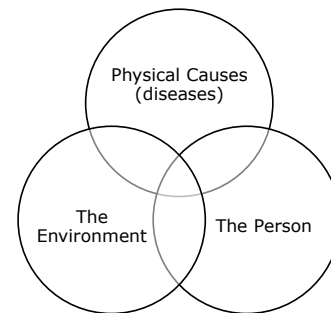
Behaviour is a means of communication



**Our challenge is to
discover what they are
communicating**



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 meaningful 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!

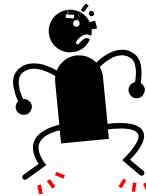
Is the behavior related to:

- 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?
- our belief that medications are our first option?
- our willingness to make their day and time special?



Do You Have a Pet Peeve?

What behaviour causes you to react?



Then 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)

Can we find a way to avoid confrontation?

**Can we find a way to avoid distress
- for the client with dementia?**



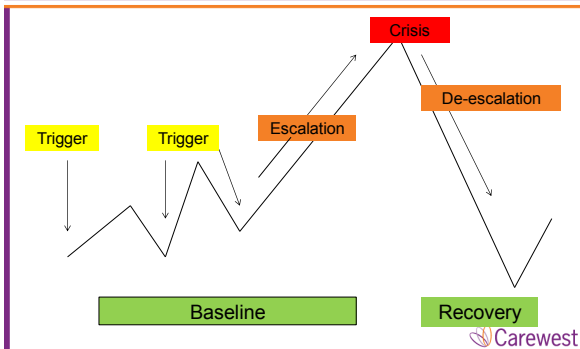
Signs of Distress – what are they?

Watch for:

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



Crisis Cycle



Intervention

Only
intervene
if risk to
self or
others

Don't gang
up on the
person

Remove
the victim
rather
than the
aggressor

Use staff
they know
best

One
person
talks



Debriefing

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



Can We Support the Client with Dementia?

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

Do we have tools?

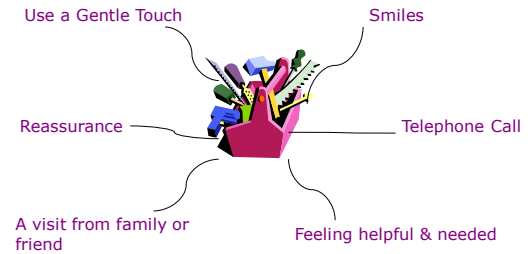


What is in the Caregiver's Toolbox?

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



Support Strategies



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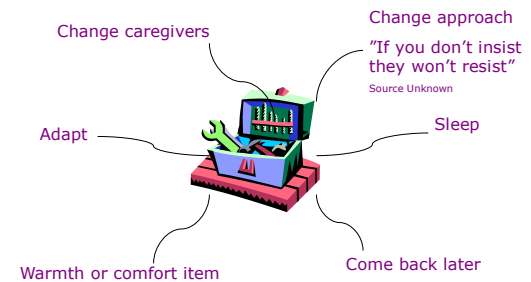
Support Strategies



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Support Strategies



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The Art of Positive Redirection

Don't tell them "they can't". Don't say "no".



Offer a positive alternative to what they want to do.
"Come with me ..."



Are Some Behaviors Normal?



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Support Strategies

You cannot medicate for these, nor should you want to!



Instead ...
we need to find ways to support their needs

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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 (AUA)

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/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 self or others
(and everything else has been tried)

Antipsychotic use must be:

- reviewed frequently
- at the lowest dose possible
- for the shortest time possible then gradually reduced/discontinued



Falls Injury Prevention

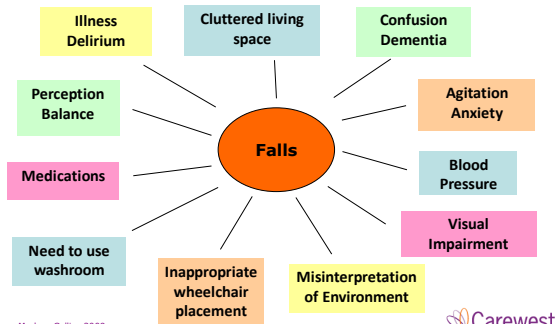
- Understand reality of falls risk with dementia
- Develop strategies to reduce injury risk



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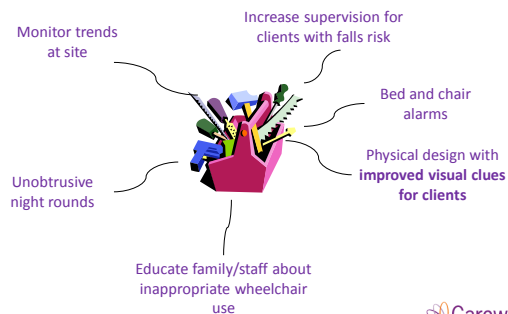
Falls - Possible Causes



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Toolbox – Falls Injury Prevention



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Physical Design Features

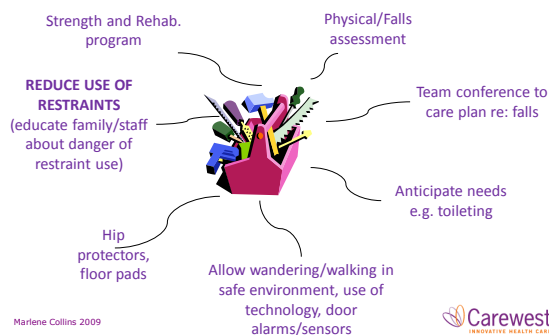
More Visible



Less Visible



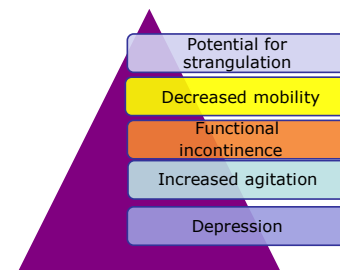
Toolbox – Falls Injury Prevention



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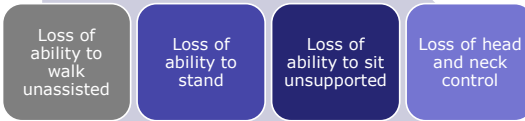
Restraints are Dangerous



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Progressive Loss of Mobility



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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?



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



The Issue of Consent

Are people with dementia able to give consent?

YES

NO

MAYBE



When are people vulnerable?

What does 'yes' look like?

Why is it important to involve families?



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



Privacy, Intimacy & Sexuality Policy

It is important to know any related policies in place where you work

At Carewest:

The Carewest's Privacy, Intimacy and Sexuality Policy is located in the Care & Services Manual, Policy #CS-03-02-01)



Positive Social Interaction

Confessions of an Old Cowboy



Positive Social Interactions



What is everyone
thinking?

What did the old cowboy say about positive social interactions?

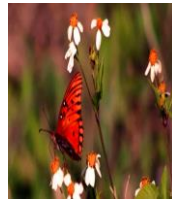
Are positive social interactions important to you? Why?



Positive Social Interaction

Butterfly Moments

- initiating brief meaningful interactions throughout the day



David Sheard- Dementia Care Matters



Positive Social Interaction

What's in your pocket?

David Sheard- Dementia Care Matters



**“ We need to have things for clients to do
- or we may not like what they find to do”**

Quote by: Marlene Collins



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)



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.

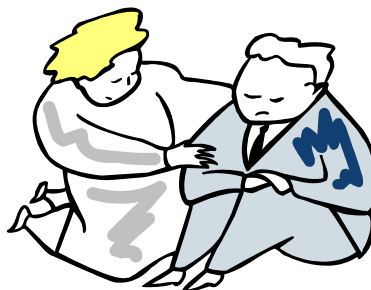
Respond creatively to help them find comfort in a situation – even if this means telling a “therapeutic fib” (source: Mary Lucero) e.g. if someone wants to catch a bus to leave, encourage them to have a cup of coffee while you check on the bus schedule – then return to let them know the bus won't come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

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 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)