



TRAINERS: This module has been developed to include information primarily related to facility care. If you are teaching staff who work in community you will need to adapt some of the examples and discussion to be more community based. However the basic concepts are the same , whether the person is in the home or in facility care.



TIME REQUIRED: 1 hour 45 min

SUPPLIES NEEDED:

CD/ Radio - optional

Flip Chart/ Markers

LCD Projector and laptop.

Optional Activity Related to Restraint Use (Facility staff only)

In addition to your regular room set up please add the following items:

- yarn to tie arms and leg
- 3 wheelchairs (2 with chair alarms)
- 1 chair with arm rests
- extra transfer belts on chairs as lap restraint
- incontinence products (staff put on over their pants)
- clothing protectors (bibs)

Video clips : ‘Confession of an Old Cowboy’

‘Bringing Sexy Back’

“Freedom of Sexual Expression” (optional - for facility)

Trainer Note: Carewest Instructors usually bring a “bib” and put it on themselves and ask the participants how they view them.

CLIENT CARE SIMULATION EXERCISE (Optional for facility staff)

As the participants come into the room, use the yarn to tie one arm or leg to their chair (all or some of them) (This is to help staff experience being restrained without their permission). Once they are placed in restraints they may not remove or disable the restraints, they must ask for assistance if they need to use the washroom, etc. The staff is to remain in these restraints until the section on restraints is covered. Allow time for discomfort.

Put a chair alarm under some participants. The alarms will sound every time they shift position or move to get refreshments during the session.

Place one in a wheelchair and put on the seatbelt.

Place a ‘bib’ on some participants. Ask others to sit on an incontinence product (‘if they ask to be excused tell them to ‘just go’ in their diaper. You could ask them to do this.)



BEST PRACTICE – These are some points to incorporate into the discussion. Best practices that relate to this module include the following environmental considerations to provide for normalized living which includes the provisions for the physical and emotional needs of each client:

VISUAL

Removal of sheen from flooring
Reduced glare from windows
Home like environment
Uncluttered but items available to interact with
Safely secured and visible rugs
Good (indirect) lighting- especially bathroom, no shadows.
Contrast color/ dark is better e.g. black toilet seats
Warm colors

NOISE

Appropriate use of TV/music
Soft music of their era
Noise reduction related to paging alarms, call bells, telephones, crushing meds and staff voices
Housekeeping equipment noise/time of use considered
Staggered shift changes (low noise/activity) when possible


ODORS

Smells that promote normalized living e.g. bread maker

HOMELIKE

Adjustable meal times/bed times etc. (related to client's lifestyle and needs)
Continuity/consistency of staff
Dignified protection of clothes (no bibs)

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.



If the Trainer is using the optional radio /noise exercise proceed as follows.

The trainer turns on the radio / CD or cassette loudly. Have loud music playing as you review the objectives on the overhead. See if anyone asks to have it turned off.

Ask: Does anyone mind the music?

Who liked the music? (some staff might feel like dancing when they hear the music)

Did anyone want to leave?

DISCUSS HOW BACKGROUND NOISES AFFECT THE CLIENTS:

ability to hear, concentrate

agitation (getting on their nerves)

Discuss that many of our clients can't control noises in their environment. What we like may be agitating and distracting for others (e.g. TV's). Discuss that caregivers in the home may not be aware of how noise can contribute to agitation.

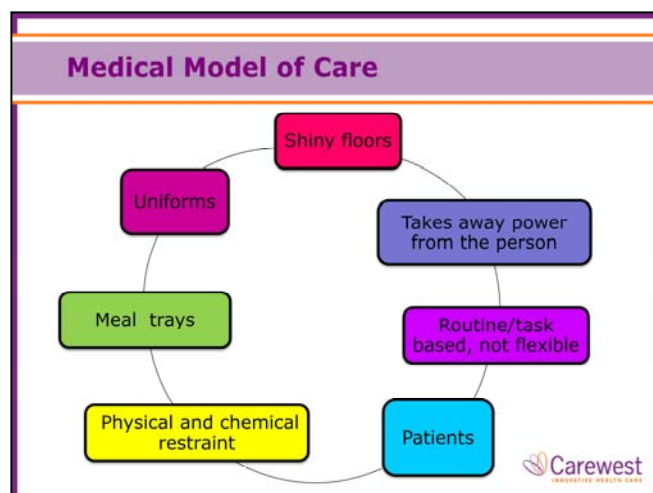
(Note: you may have to review the objectives after you turn off the music and have debriefed the exercise).

Confessions of an Old Cowboy

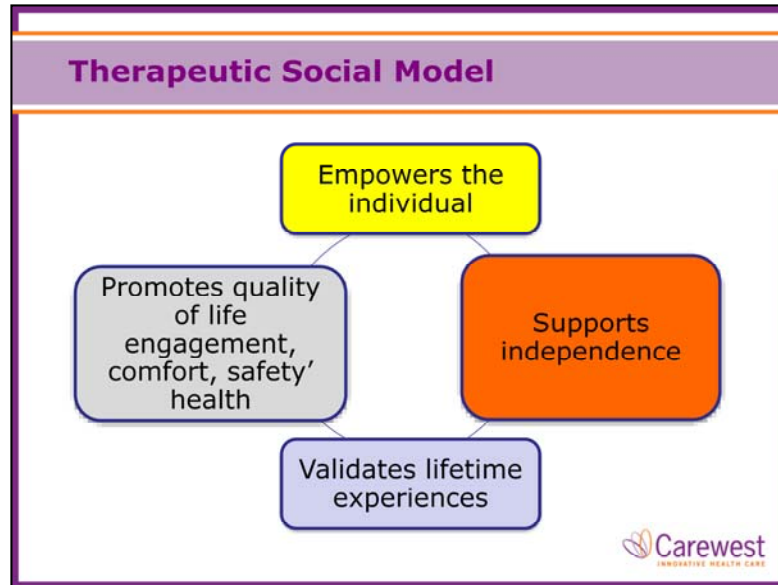


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Show the video- (approx 3 min)



Do you think the medical model was a good way to support what the Cowboy is saying?



The good news is that there is movement from the medical model to a more social model in care centres.

This does not mean people with dementia do not require good medical care but the environment and daily activity should resemble home life.

Do the social, sensory and physical aspects of the environment support the residents' quality of life?

How does the social model support what the cowboy is saying?

SOCIAL ASPECTS

comfort
attachment
spirituality

SENSORY ASPECTS

noise /smells
taste of food
touch – hugs, massage

PHYSICAL ASPECTS

secure/familiar
freedom to move
outdoor access

Optional Activity:

ASK: Those of you wearing clothing protectors or incontinence products – how do you feel? (Participants can now remove these items if they wish)

Therapeutic Social Environment

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

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



Marlene Collins 200

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Sensory Aspects

For the person with dementia visual cues in the environment may become more important as verbal skills decline. Our goal is to have the environment seem familiar. **What are visual elements in the environment? Can they see a caregiver? Is there enough light? Is the light shining in their eyes? Can they see and smell food preparation? Do caregivers look rushed? Is there interaction with the person? Is the television on?**

Are there odors- pleasant or unpleasant?

Breakfast Routine

Often mealtimes are seen by caregivers as something to get through as quickly as possible and are rushed with little socialization. ***Do we rush through the meal so they can sit and do nothing?***

David Sheard recommends that caregivers:


- Sit down- engage with the person during the meal (have conversation items available). **Discuss what are the barriers to doing this? Could we overcome those barriers?**
- Don't put food down without verbal or non-verbal contact

Example of verbal contact- Giving a slice of toast - talk about how you love the smell of toast, your memories of eating toast, talk about making jam.


David Sheard “ Enabling

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



A sense of predictability and routine can be comforting to the person but the routine needs to be flexible to meet the needs of the person.

Inclusion and choices- It is important for the person to feel included in what is happening in the home or on the unit. Do we let them help? Do they feel a sense of belonging? Do we ask their opinion? Are we giving enough choices?

Occupation

Doing household chores can boost the person's self-esteem. When the person helps you, don't forget to say "thank you."

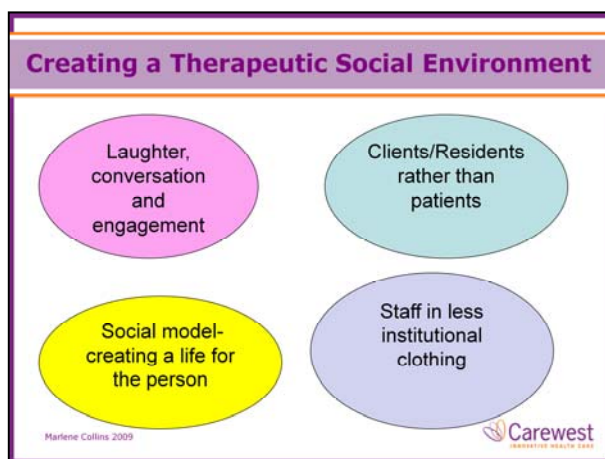
- Wash dishes, clear the table
- Sweep the floor
- Polish shoes
- Sort socks and fold laundry – put their own clothes away
- Sort mail and clip coupons
- Sort recycling materials or other things

Cooking and baking

- Cooking and baking can bring the person with AD a lot of joy

Normalized Living

- Read a morning newspaper with a cup of coffee in hand



This slide shows some examples of things you can do to promote a Therapeutic Environment

Therapeutic Social Environment

What does “comfortable” look like?

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

Marlene Collins 2009

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Social Aspects

ASK: What does ‘comfortable’ mean to you?

- *fewer routines*
- *no uniforms*
- *less structure – able to do things at your own pace*
- *freedom to do what you want to do*
- *own belongings in client’s rooms*
- *chairs for visiting, etc.*
- *privacy*

The *physical aspects* of the environment also include sensory aspects - *noise, smells, tactile, taste, visuals* as well as strictly physical structure or layout. The challenge in the home environment is to adapt the home environment to the changing needs of the person with dementia while maintaining a sense of familiarity and freedom.

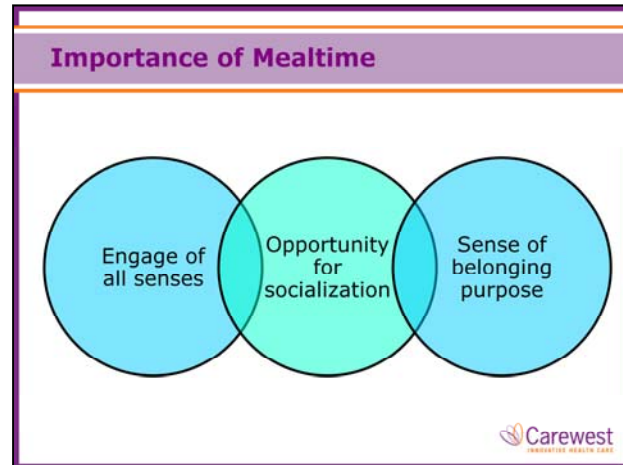
Meals Begin Before Food is on the Table



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A meal begins before food on the table:

- food preparation
- dining room arrangement and atmosphere
- how people are invited and brought to meals
- greetings and conversation at the table
- other social aspects of an occasion
- taste, color, aroma, feel and presentation of food
- food nutritional value
- support given in a way to preserve dignity and independence
- clearing away dishes and washing up



Mealtimes:

- Stimulate the senses - Smell, taste, touch, vision and hearing
- Opportunity to socialize
- Triggering memories - “comfort food”
- Eating together creates a sense of belonging between family, clients or staff
- Sense of purpose if allowed to participate - Community caregivers should be encouraged to allow the person to participate e.g. let them wash dishes (put them in dishwasher later if needed), peel vegetables, set the table, put dishes in the sink.
- In facilities - kitchens that are visibly open encourage residents to join in if it is safe to do so.

<http://www.health.vic.gov.au/dementia/changes/dining.htm>



Recommended Design Features

- small size, in terms of the numbers of people accommodated in a dementia specific unit
- familiar building style, that is, domestic and home like
- plenty of scope for ordinary activities (unit kitchens, washing lines, garden sheds)
- unobtrusive inclusion of safety features
- rooms for different functions that are equipped with furniture and fittings familiar to the age and generation of the client
- a safe outside space
- single rooms big enough for a reasonable amount of personal belongings;
- good signage and multiple cues where possible; e.g.. sight, smell, sound
- use of objects rather than colour for orientation
- enhancement of visual access
- control of stimuli, especially noise

Dementia Care and the Built Environment

Position Paper 3 June 2004 Alzheimer's Australia

http://www.fightdementia.org.au/common/files/NAT/20040600_Nat_NP_3DemCareBuiltEnv.pdf



**Ask: How do you respect a person's home when working in the community?
Would it be different in a care centre?**

Possible answers:

- Knocking
- Waiting to be invited to enter unless previous agreement to just walk in
- Asking permission to throw away or move items
- Allowing them control
- Giving suggestions not orders- involving them in care decisions
- Careful of possessions e.g. hearing aids, clothing, glasses



Would you go into someone's home and demand they clean up all their "clutter"? What looks like clutter to you may have meaning for them.


We work in their home they don't live where we work. In other words we need to fit with their concept of home whenever we can

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?





Trainer: Use this slide with Facility staff and the story of Ellen (next slide) with Community Care staff.

For Facility staff: Ask a few volunteers to share what they are bringing. Respond to what they bring by saying “Sorry I knocked that off your bureau and it broke” or “that got put in the garbage/laundry by mistake” “I think George took it”. How did they feel? Also remind staff that we shouldn’t call their possessions ‘clutter’ in front of them . Would we like to have someone refer to our possessions that we value as ‘clutter’?

Possessions may have great meaning to the person- e.g. An ornament their mother loved, a 50th anniversary gift from their husband who died, something they created they are proud of, a scrapbook of memories. Staff need to be aware of the importance of belongings.

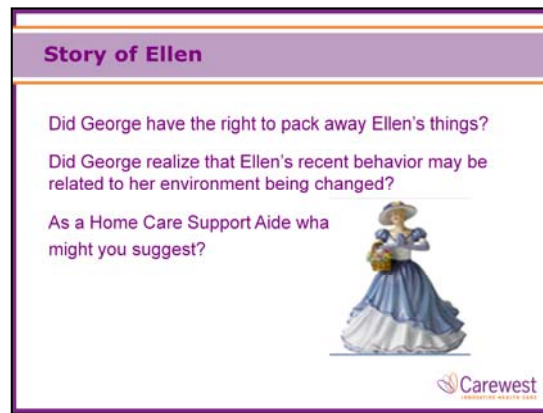
Results from the Long Term Care Family Experience Survey Nov. 2011 were that 34% of family members stated medical belongings (hearing aides, glasses, dentures) were lost in the previous 6 months and 59% said clothes were lost or damaged.

“The survey found what most influenced families’ overall care ratings were:

- Nursing home staffing levels
- Care of residents’ belongings
- Assistance with daily living activities such as toileting, drinking and eating.”

Health Quality Council of Alberta

<http://www.hqca.ca/assets/files/HQCA%20LTC%20Family%20Experience%20Survey%20Final%202010-11.pdf> p. 5



Skip this slide if you are teaching facility staff – let them know it is a story related to community care so you will move on.

Community Trainer: Read the Story. Discuss following using the questions on the slide.

George had been married to Ellen for 49 years but had been providing more and more care for her for the last year-since she was diagnosed with a dementia. He wasn't too sure of the kind of dementia but he did know that she was deteriorating.... And he was determined to keep her at home.

For most of their marriage, Ellen had collected the Royal Doulton figurines and they filled the living room. Family pictures of their three (3) children also covered the walls and tables adding to the décor of their loving home. A crystal vase graced their dining room table - one that was an original wedding gift.

In the early stages, he tried to keep their normal routine. Their home stayed just the way it had been for 49 years. The disease, however, continued to progress. Ellen became more and more disorientated and found pleasure in not only handling her "precious" ladies" but also carrying them around and packing them away. She was also very fond of the photos and George was forever returning them to their location from her purse or carrying bag. George was also very aware that the crystal vase that had meant so much to Ellen prior to her illness would soon be the next item to catch Ellen's eye.

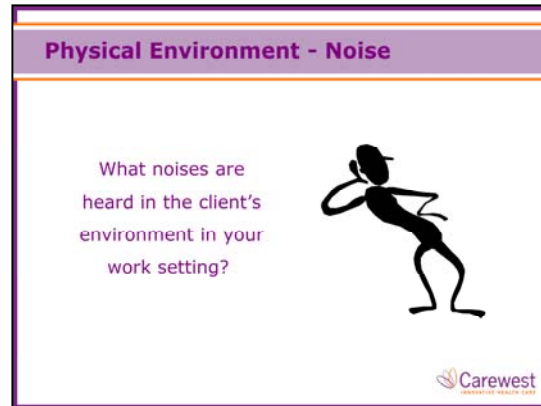
George knew that the Royal Doulton, crystal vase and family photos meant a lot to Ellen and she would be devastated if they became broken or lost....if she did not have dementia. He also knew that Ellen had talked about the heirloom she was creating for her two (2) daughters. George, trying to protect Ellen's very breakable belongings, did what he thought best. He had his daughter pack the valuables away.

So what did Ellen do? - You guessed it. She spent most of the time “looking for her ladies”. She became more agitated and started rummaging through drawers and closets-leaving behind a mess for George to clean up. She started to accuse her children of stealing. Her agitation escalated many times, making it difficult for George and his home care support aide to provide care for Ellen. He called the physician and explained Ellen’s behavior. The physician examined Ellen and did the normal tests- urine etc. All of these came back normal. He concluded that her disease had progressed and George consider placement, at a facility. George, exhausted and frustrated, placed Ellen in a nursing home.

Food for thought

- Leave Ellen with one “lady”.
- Replace the heirlooms with other items. Other figurines of ladies and a plastic vase that looks like crystal.
- Photocopy old pictures and put the photocopies in non breakable frames
- Make Ellen a small photo album to carry around

Source: Story and discussion items provided by Heather Hart .



People with dementia may have normal hearing, but they may lose their ability to interpret what they hear accurately. This may result in confusion or over-stimulation. If the person has a hearing aid, check the batteries and hearing aide function frequently.

Ask: What are noises in the client's environment?

Use a flip chart to write down what the group identifies as noises in the client's environment?

- **TV, radio** - not on at meal times or left on. People with dementia may not be able to interpret TV as to what is real. Difficulty dividing their attention so may not attend to eating if TV is on.
- **Pets** in the home. Barking, birds, cats
- **Alarms, timers in the home.** Bed and chair alarms – try to reduce number used (look for new technology – less noisy)
- **Visitors leaving/Shift change-** this can generate a lot of noise. Consider staggering shift start times. Cueing for clients to want to go home when staff seen to leave. Use the stairs and not the elevator to move the 'exit' away from the desk.
- **Outside noises** - be sensitive to the amount of noise going on outside, and close windows or doors, if necessary.
- **Voices – staff/families** may need to talk less, avoid large gatherings of people in the home if the person with AD shows signs of agitation or distress in crowds.

- **Meal times-** Do the clients all eat together at your site – ‘banquet’ style with all meals? May be too stimulating for clients with dementia. Try: smaller dining locations for a smaller number of clients or use of dividers to cut down on noise and visual distractions.
- **Paging** (aim for no overhead paging)
- **Call bells** (new technology: room motion sensors results in staff pocket pager vibrating.
- **Crushing medications** (try to use a ‘silent crusher’)
- **Telephones/ cell phones-** turn down loudness of the ringer
- **Calling for help** from other staff- don’t yell down the hallway
- **Floor washer/vacuum** – try to find a good time to clean the floor (Is 6am good?)
- **Stair alarms** (decorate doors to camouflage them)
- **Oxygen tanks** being filled
- **Other client’s calling out**
- **Footsteps**

Labels and Reminders



Other things that create a supportive environment

– see next slides (photos taken at Carewest Signal Pointe)

Physical Design Features

More Visible



Less Visible



Making the toilet visible from the bedroom can help the person find it independently.

Safe Access to Outside



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Safe outside access is important to community dwelling persons as well as for those who live in a facility.

Wayfinding Cues



Use objects rather than color for way finding. Signs may work for some residents as well as visitors.

Physical Design Features



Dining Next to Kitchen



Smell of food can stimulate appetite.

Increases opportunities for participation.

Personalizing



Personal items can help keep treasures safe and provide cues re: where their room is. Allows staff to be reminded of the person's past life and gives staff topics of conversation.

Community caregivers need to ensure they don't sterilize the environment by "decluttering" too much.

Strategies for Success at Home



Slides 28-33 Spend more time on these if home support workers are attending otherwise just briefly talk about any concerns related to facility

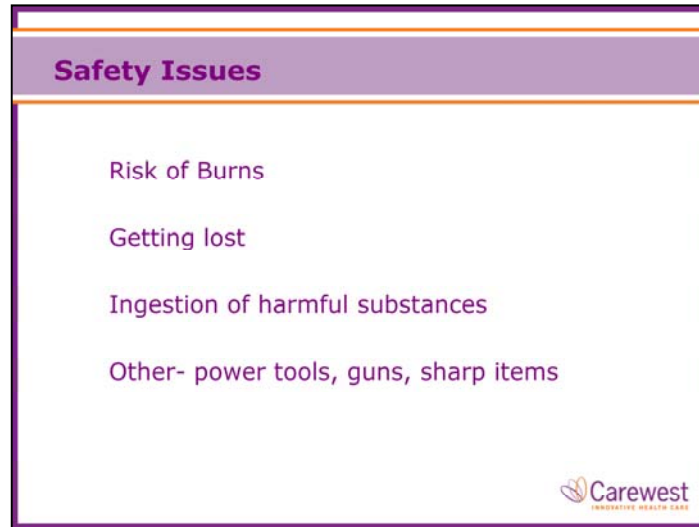
Is it Safe to Leave the Person Alone?



The caregiver at some point will need to make a difficult decision if the person can be left at home alone while they go to work or run errands. Some caregivers will restrict the person too much. The following questions can help caregivers decide.

Does the person with dementia:

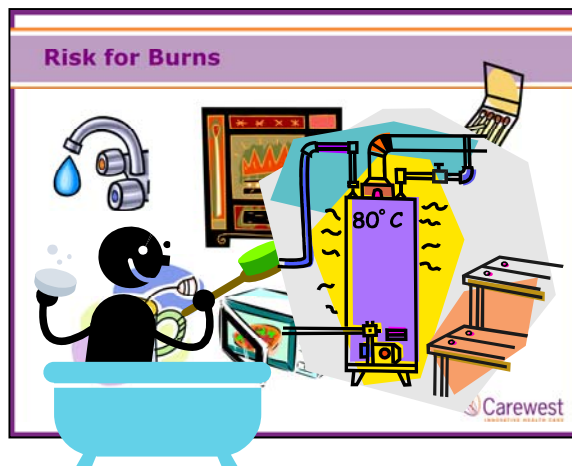
- Become confused or unpredictable under stress?
- Recognize a dangerous situation; for example - fire or flood?
- Know how to use the telephone in an emergency?
- Know how to get help?
- Stay content within the home?
- Wander and become disoriented?
- Show signs of agitation, depression, or withdrawal when left alone for any period of time?
- Attempt to pursue former interests or hobbies that might now warrant supervision such as cooking, appliance repair, or woodworking?



Safety: People in the community living alone will need admission to DAL, long term care or a full time caregiver during the Middle stage. For some people with little family involvement they will come to the attention of the community during this stage, if not earlier (getting lost, spoiled food, not eating, leaving stove on, not taking medications, unkempt).

BEST PRACTICE – ideas on safety to thread into the discussions

- Use hip protectors and floor pads by bed to prevent falls/injury
- Chairs with arms
- Opportunity to lock drawers, doors etc.
- Security system
- Opportunity to enjoy a secure outdoor area and gardens.
- Curtains and blinds that are safe and able to be managed by the clients.
- Safety i.e. avoid sharp objects and corners, chemicals labeled and stored out of reach (WHMIS labels on products)
- Consider ways of reducing risks of harming themselves, (e.g. suicide or harming others)



Difficulty adjusting the temperature of the bath water is the classical earliest deficit in bathing capacity in Alzheimer's disease. Remind the participants they must follow their organization policy related to regulating bath temperatures. TRAINER: no need to cover this – just remind them that they have a policy. The info below is just for your reference.

At home and in a facility the temperature of hot water needs to be regulated to prevent burns. At home the water temperature should be turned down to 120F to prevent scalding . In Alberta facilities the Accommodation Standards and Facility Bathing policies mandate checking and recording water temperatures prior to baths or showers. Organizations base their policies on this standard.

Carewest Sample Policy- Our current standard is 41 C

Prior to each bath, water temperature checks will follow a 3-step procedure before the client enters the tub. The same staff member testing and recording the water temperature must complete the actual bath.

Step 1 - test and record the temperature of the water flowing into the tub using the integral tub thermometer or the supplied thermometer.

Step 2 - test and record the temperature of the water once the tub is filled with a second and different thermometer (exception: Parker tubs where the water is checked once the foot well is filled).

Step 3 - test temperature of water in the tub by immersing staff forearm for 10 sec

Shower - test temperature of water by holding forearm in running water for 10 Sec.

The caregiver needs to be aware of other burn hazards like lighters and matches; stoves and microwaved food, fireplaces, space heaters, heating pads, barbeques. Persons who still smoke will need careful supervision.



People with Alzheimer's Disease may lose taste sensitivity. As their judgment declines, they also may place dangerous or inappropriate things in their mouth.

INTERVENTIONS

Survey the environment inside and outside to look for potential problems:

- medications, alcohol
- bathroom products- mouthwash, toothpaste
- cleaning supplies
- plants
- pesticides, fertilizers
- spoiled food
- small objects-choking hazard
- look alike objects e.g. fake fruit, fridge magnets

Keep items that can be harmful out of reach-locked cupboard.

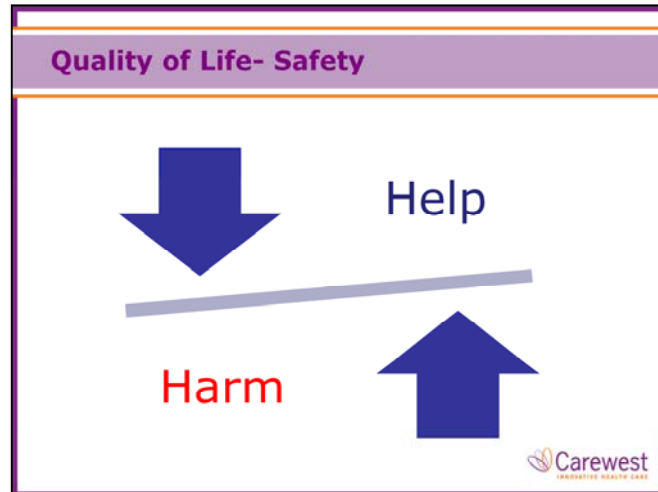
Keep the *poison control number* by the telephone. Keep a bottle of Ipecac (vomit inducing) available but use only with instructions from poison control or 911. (Ensure it is locked up)

In facility care don't leave open medication carts unsupervised.



Survey the environment for guns, power tools, sharp objects, electrical hazards (rinsing electric razor under the tap, objects poked into electrical outlets).

In the later stage small objects may pose a choking risk.



If using with support worker staff let them know they can ignore facility based points

SAFETY AND SECURITY IN THE HOME

Safety is an important component of caring for persons with dementia for both institutional and home care. As the disease progresses there is a lack of judgment that we need to compensate for. The difficult *balance is between safety and autonomy* so that the person still feels a measure of freedom and ability to make choices.

HELP OR HARM

Ask the **group to look at the page in the participants handout** with these items listed. Ask them to check off if each of these items are helpful or harmful. As a large group, debrief by quickly asking one person at a time whether or not it is helpful or harmful. Use flip chart with items listed and a help and harm column. Put check marks in appropriate column as you discuss (Please add to the list if you wish.

Interject any stories you may have in any of these areas) – the point of the exercise is that *most*

items could be helpful or harmful depending on the situation.

NON-SKID SOCKS (help: good on lino harm: not good on carpet if person shuffles their feet)

SHINY, REFLECTIVE FLOORS (harm: some clients may see it as water or ice and try to step over it. May create glare. help: families and staff may feel it shows cleanliness)

OBSTACLES IN ROOMS/HALLS (harm: clients may trip, bump into as they are often looking down in latter stages. help: some clients may use furniture to help them walk but generally not recommended to have clutter/obstacles.)

BATHROOM LIGHTS ON/OFF (harm: might keep person awake help: may help prevent falls at night)

BED SENSORS (harm: noise may agitate other clients, wake the person help: may alert caregiver that person is moving)

SIDE RAILS (harm: person can climb over and fall from a greater height. help: may be appropriate for some non- mobile clients Siderails should be exception not the rule – half rails less dangerous.

MEDICATIONS (harm: may cause increased confusion and falls, can be a restraint help: may be necessary – e. g to treat hallucinations and pain)

SCATTER RUGS (harm: may be a tripping hazard help: if rubber backed may help some clients whose feet slide on lino, absorb urine so they don't slip on it-might be a good visual clue to where your room is)

MUSIC (help: may calm some people harm: can agitate others – may depend on how loud? The right type of music?)

CLOTHING PROTECTORS (bibs)(help: keep clothing clean - ask if there are other ways to accomplish same goal- napkins, aprons harm: loss of dignity, family may have difficulty seeing family member in a clothing protector

There will be quite a lot of disagreement so please take the time to explain the pros and cons of each item.

Explain to the group that because we are unique individuals we all have different beliefs and values. Staff, clients and their families may all interpret what is harmful and helpful differently. We may put our beliefs ahead of what is appropriate. Give specific examples of where we have used or done some of the things on the list just because we have always believed it was helpful when in fact it has been quite the opposite, e.g. siderails, restraints.



GROUP COLLABORATION

RESTRAINTS (If you used the optional exercise at the start)

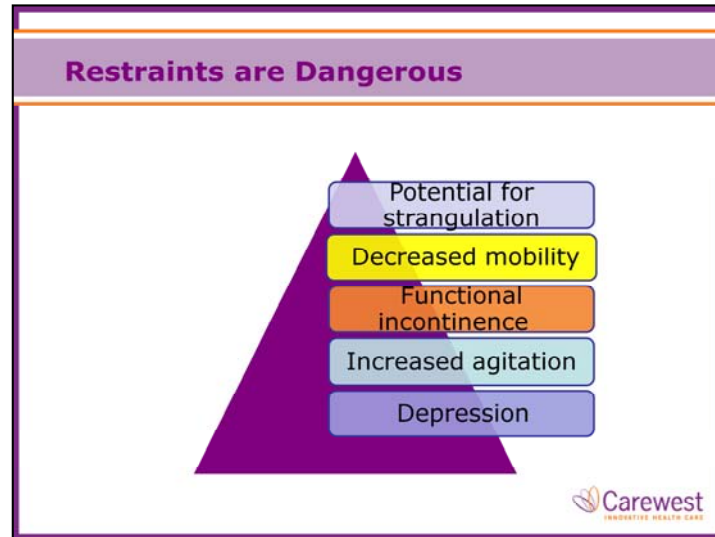
Ask: What it was *like to be restrained without their permission* at the beginning of the session? (Imagine what it would be like to be restrained for an entire day!). Write responses on the flip chart and relate back to the lack of choice clients are given regarding restraints. Allow time for debate and examples of use with their clients. (They may remove the restraints now if they wish).

If you didn't use the exercise:

Ask: What *makes a person feel secure*? Did being restrained make you feel safe? Would the use of side rails? Locking the doors to the unit so people can't escape does nothing to provide an atmosphere that they don't want to escape from - You just have people standing by the door banging to get out!

DISCUSS-

- Restraint use in the home has not been studied. Clients are restrained by family often using makeshift items or may use dangerous bed rails. Staff need to educate families re the dangers of restraints and report if they are used in an abusive manner.
- Restrained persons have reported feelings of anger, fear, humiliation, embarrassment and loss of self esteem
- Some clients may initially fight against their restraints. When they see they can't get free they may quit fighting, give up and become depressed.
- Most older hospitals and nursing homes were built to treat clients with physical problems, not frail, mobile, confused older adults
- People at risk of choking are still allowed to eat- people who are at risk for falls should still be permitted to mobilize!



Facts

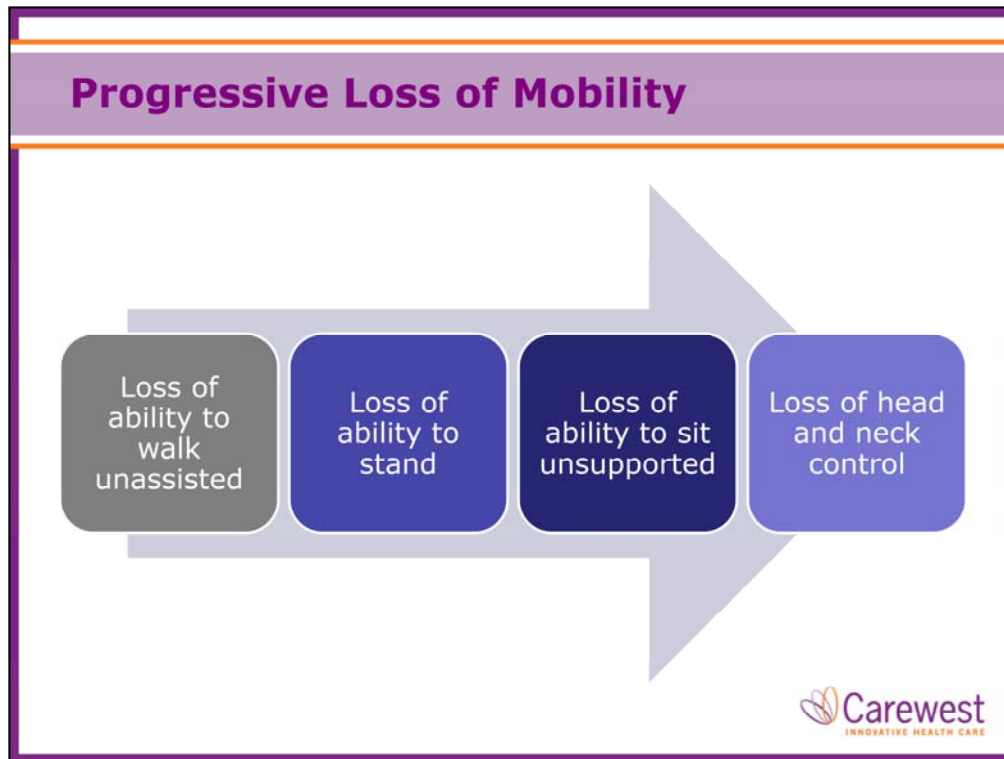
Restraint use is more expensive than alternatives if frequency of checking is maintained.

Many studies have documented negative responses for those who are restrained - incontinence, contractures, loss of bone and muscle mass, increased agitation, more behavioural symptoms, injuries and death. Consider the person who is restrained all day and then tries to walk to the bathroom at night – high risk of falls!

Under the Protection of Persons in Care Act (PPIC) we know that abuse to clients also includes inappropriate use of restraints both **physically** and medically with **chemical restraints**. Therefore, it is important to be mindful of the legal implications re: inappropriate use of restraints.

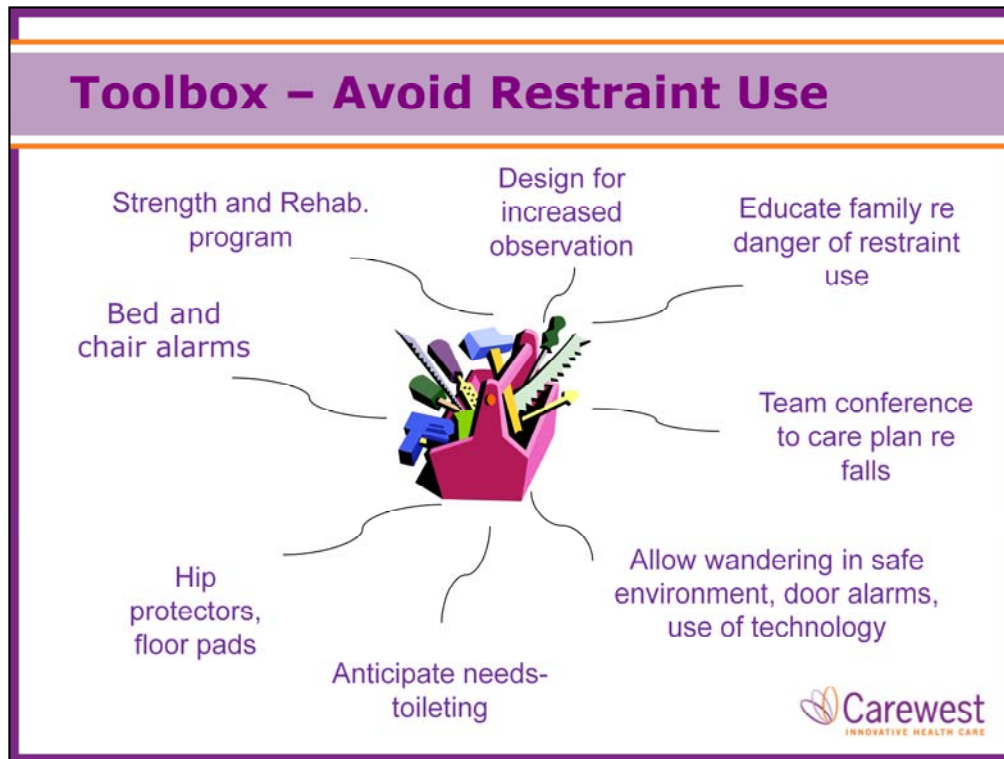
"It is the position of CARNA that policies of least restraint will be implemented in all client care settings. 'Least restraint practice' means that a registered nurse will exhaust all possible alternative interventions before deciding to use a restraint."

Caregivers must set a program in place to assess, monitor, and evaluate the use of restraints. We cannot continue to use restraints just because (we or the family) believe we might be preventing injury – **they cause injury**. An Alberta case that received wide publicity found that strangulation from a back fastening seat belt had occurred. We need to learn from this and other tragedies.



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- prevent 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!




IN ORDER TO ELIMINATE RESTRAINTS CAREGIVERS NEED TO:

- provide individualized care - anticipate needs
- optimize individual function and mobility
- consider alternatives such as: chair/bed alarms - hip protectors, floor pads
- we may need to educate families about the risks of restraints
- allow wandering (anxious) clients to walk freely in a safe environment
- utilize expertise of architects and therapists to change the environment to meet needs of clients
- increase the ability to observe the client

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.



Trainer tip: Ask half of the participants to discuss (with a person near them) scenario number 1 and the rest to do the second one for 3 minutes.

Have them report back and debrief with them.

Answer – question 1:

- Refer to the policy of no or least restraint
- Refer to the care plan
- If no agreement go to the team leader together for direction

Answer – question 2

- Share the facility philosophy of care
- Discuss how restraints put people at more risk and influence their quality of life
- Refer the family to the team leader or unit manager
- Sign a risk agreement with family if they can't be convinced of the risks related to restraints

(At Carewest - staff must consult with the Director of Care prior to developing a risk management agreement with a family member on behalf of a client with dementia)



FAST FACT:

40% of all Nursing Home admissions are the result of a fall.

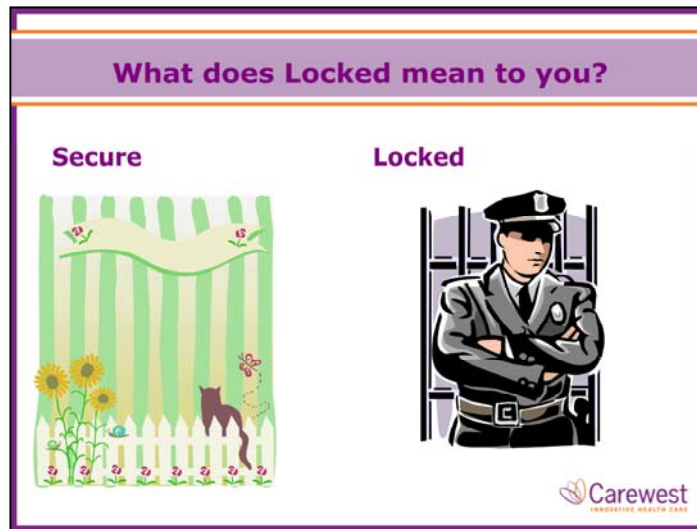
1 in 3 seniors living in the community and 40-50% of those living in institutions will experience a fall each year.

10% of LTC falls result in serious injury.

Those elderly with cognitive impairment or dementia are twice as likely to fall as those without.

In a population-based cohort study, which used health care databases from Ontario, **the use of cholinesterase inhibitors was associated with increased rates of syncope, bradycardia, pacemaker insertion, and hip fracture in older adults with dementia.**¹⁸ These findings highlight this class of medications as a potential risk factor for falls; these risks should be weighed carefully and discussed with patients and caregivers.”

Fall mats are a good option if the foam is dense and safe to walk on if the resident gets up or if the person is immobile and wouldn't attempt to walk across it.



The trainer reviews the different annotations of these similar words.

LOCKED - Denotes punishment/ criminals/ animals

SECURE - Denotes safety not punishment. Someone to accompany them not that they can't go at all.

Secure environments don't mean the person can't leave but that they need to be accompanied.


Families should be encouraged to register with the Alzheimer Society "Safely Home" program. New technology can be used to help find the person if lost (GPS) or allow safe walking- sensor alarms if they leave a set area.

Providing the person with regular exercise opportunities may decrease the desire to leave.

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?



Trainer Tip: Show video “Bringing sexy back”

Encourage some participation to answer the question.

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?

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Yes, we need to protect those who are vulnerable and not indicating consent.

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



Source: Bradford Dementia Group, University of Bradford 2005

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



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



Ask for a group response but if none, click for the answers – suggestion cover this briefly

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>



We also need to protect the person who is inappropriate with their advances because they have dementia and it isn't done with intent to harm but due to their diseased brain function

Ensuring we document facts versus judgement is one way to protect the individuals involved

Be careful of what and how you chart

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>



Again we see the negative effect of labels



Trainer Note – either play the video Freedom of Sexual Expression or do an optional group exercise with the following case studies.

Facility Case Study #1

You are working in a LTC facility with patients with dementia. You notice that Mary has befriended Elmer. She calls him “Bert”, her husband’s name and he does not mind either the wrong name or the extra attention. She holds his hand when they walk, kisses him when she greets him and dotes on him. She always initiates the encounters. The relationship goes no further and appears innocent. Mary’s husband Bert, however, is not pleased and wants Elmer to leave his wife alone.

What can you do?

1. Inform Mary’s family if they are not aware.
2. Work with Bert to understand the Mary’s need for intimacy.
3. Help Bert to have intimate moments with Mary-hand holding, kissing, hugging
4. See if there are Recreation programs that can provide sensual touching-pet therapy, handling soft or silk materials, dancing, games with hand holding
5. Put a name tag on Elmer so Mary does not misidentify him

Facility Case Study #2

You work in a secure unit with a resident that was a pastor in the past. He has a Dutch door (can be opened on the top and closed on the bottom). You notice that he has his shirt and tie on and is looking very neat. However when he comes out of his room he does not have any clothes on from the waist down. This is a pattern that repeats itself. Staff have also observed him masturbating in front of the desk.

What can you do?

1. Look for medical reasons-UTI
2. Check that his clothes (pants) are not too tight
3. Provide him with colorful suspenders to entice him to wear his pants
4. If masturbating, try to remove him to the privacy of his room or cover him with a blanket.

Facility Case Study #3

Bill is a patient with Frontotemporal dementia. He was already labeled as a “pervert” by the previous facility where he resided. He was particularly difficult to cope with during his morning care when he will grab at the staff’s breasts and make very suggestive remarks to them. Staff do not want to get assigned to him.

What can you do?

1. Frontotemporal Dementia may have hypersexuality
2. Ensure all staff are aware of the problem
3. Ask him to help you with the bath and fill his hands with towels
4. Ask staff to remove the “label”

Facility Case Study #4

Stella was recently admitted to your facility. Prior to admission her husband Matt cared for her in their own home. Stella has dementia. Since coming into the facility, Stella wants nothing to do with Matt. He visits regularly and tries to hold and kiss her but she is very fearful of him and resists his attentions. Staff have asked him not to push his attentions on her when she is fearful. He is very insistent and tells staff that he has a right to do this as he is the husband.

What can you do?

1. Meet with Matt privately and explain that Stella is fearful.
2. Ask him to come in during the activities that Stella is involved with to volunteer.
3. Gradually have him do more and more during the activities with Stella.

Homecare Case Study #1

Sandra and Howard are married and live at home with their 2 teenage sons. Howard was diagnosed with dementia 6 months ago. Sandra has been struggling to raise her sons and look after their home and Howard who needs total assistance with all his ADL's. Howard is constantly asking Sandra for intercourse. Sandra no longer sees Howard as her sexual partner. She is quickly tiring of constantly saying "NO" to his advances.

What can you do?

1. Have Sandra try some one to one time with him with intimacy-hand holding, hugging
2. Have Howard keep busy-assist with meals, laundry folding, setting the table to relieve her of all the household duties.
3. Ensure Howard has some physical activity daily-walk with his sons before supper, etc.

Homecare Case Study #2

Rita and Morris have been married for 45 years. Morris has dementia and forgets that Rita is his wife. He believes her to be his cleaning lady. He is constantly requesting her to do the dishes or make the bed. When on their daily trip to Tim Horton's, Morris is constantly flirting with anyone and making suggestive requests to come home with him. Rita is embarrassed and is nervous about taking him on outings.

What can you do?

1. Ensure pictures of their wedding is out and reminisce about their marriage.
2. Buy a Tim's coffee and drink it elsewhere-in the park.

Homecare Case Study #3

Marvin is caring for his wife Pat who was diagnosed with Lewy Body Dementia 2 years ago. Marvin has been married for 41 years and their relationship has been very intimate and close. Marvin continues to want intercourse with his wife and intimacy. Pat wants nothing to do with intimacy. She is very happy without it. Pat is very upset with Pat's reaction to his efforts at intimacy.

What can you do?

1. For intimacy he may consider giving her a back rub when caring for her, or holding her hand when walking or watching TV, dancing with her.
2. He might consider telling her when they go out, they are on a date.
3. If Marvin wants further intimacy, he may have to consider getting a "girlfriend".

Homecare Case Study #4

Bonnie has a problem. She is presently caring for Mike, her husband who was diagnosed with Korsakoff's Dementia. She is lucky to have many friends who still drop by to visit her. Unfortunately, Mike has begun to masturbate and she is very upset with this behavior and is concerned if her friends are there when it happens, her friends will stop visiting.

What can you do?

1. Perhaps Bonnie could get some respite hours so that she could meet her friends for lunch or an outing.
2. Depending on her and her friends relationship, she could explain the situation and cover him up with a blanket, should it occur when they are there.
3. It is important she realize that the behavior is not the problem, only the location and Mike is unable to remember that.

Questions?



Please refer to your handouts



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

Intimacy and Sexuality Practice Guidelines for LTCHs in LLT: Draft #17 7 Revised with permission from Shalom Village LTCH. Hamilton, Ontario.

Carol A. Miller. *Nursing for Wellness in Older Adults* (5th Ed.) Guidelines for Assessing Sexual Function in Older Adults