Care Approaches for People with Dementia and other Complex Neurocognitive Disorders

Site Applicability

VCH and PHC Long-Term Care (LTC) homes.

Practice Level

Basic Skill:

- All regulated nursing and allied health professionals within scope of practice, role and competencies
- All unregulated professionals within their employer training and job descriptions
- All unregulated care providers within their employer training and job descriptions and under direction of appropriate regulated/unregulated health care professional

Requirements

- All persons living with dementia/other complex neurocognitive disorders will have the following developed and implemented by the interdisciplinary LTC home team:
    - Within the first week of move-in to a LTC home: An initial support tool to enable person-centered care, such as, “Getting to Know Me” / “Who am I” or equivalent (Appendix A)
    - Within 72 hours of move in day (or according to the organizational/discipline specific processes): An individualized care plan, such as, “My Daily Care Needs” or equivalent (Appendix B), completed based on the best available information. See Appendix C for an example of a completed “My Daily Care Needs”
- All persons and/or their families/substitute decision makers (SDM) (as appropriate) will be invited to collaborate or provide information to the fullest extent possible when making care decisions.
- The interdisciplinary team will develop and implement an individualized care plan that will be reviewed with each Resident Assessment Instrument-Minimum Data Set 2.0 (RAI-MDS) and when there is a change in condition. See Appendix D for Care Planning Decision Support Algorithm which can be used to guide care planning and implement appropriate Care Approaches when the person in care has a change in condition / behavior due to an unmet need
- A comprehensive holistic assessment framework such as PIECES™ (Appendix E) or equivalent framework will be used to problem solve and inform the care plan when a person exhibits physical or emotional expressions (formerly referred to as, “responsive behaviours”) due to an unmet need.

- All LTC home operators provide appropriate training during orientation and on an ongoing basis to keep staff's skills and knowledge current. Training should include (but not be limited to) the following topics:
    - **Assessment:** Staff know how to use assessment tools or support other interdisciplinary team members when using assessment tools that recognize a person's abilities and strengths as well as identify priority needs and concerns. Examples of assessment frameworks include PIECES™.
    - **Care planning:** Staff understand the care planning process, including how to collaboratively develop, implement, and update an individualized care plan based on a person's current health status and care needs.
    - **Documentation:** Staff know how to complete proper documentation of a person's needs and care plans to ensure high quality care is provided and relevant information is shared with appropriate interdisciplinary team members in a timely manner.
    - **Care Approaches:** Staff are able to apply care approaches and strategies to support all persons, using principles of strengths based care, cultural safety, cultural humility, relational care, trauma informed care, and person-centered care.
- The health, safety, and well-being of staff is as important as a person's care needs (VCH OH&S website; PHC OH&S website). All care homes will ensure staff have the environment, tools, skills, and knowledge to work safely while providing care.
- The following education is recommended for all staff: PIECES™, Gentle Persuasive Approaches (GPA™), U-FIRST™, and "Care Approaches" sessions provided by Education Coordinators.

Need to Know

Care Approaches acknowledge Personhood which involves the respect, support, and trust given from one person to another in a caring relationship and recognize all persons living with dementia and other neurocognitive disorders as persons first, with unique experiences, values, beliefs, needs, and many remaining strengths.[1, 2]

Persons with dementia and other neurocognitive disorders have the same needs as any other persons in an LTC home. When a person with dementia or other neurocognitive disorders has an unmet need, they may exhibit physical and/or emotional expressions and negatively respond to care activities or other stimuli.[1, 3]

When persons with dementia and other neurocognitive disorders exhibit physical or emotional expressions, the primary goals of communication are to take a moment to connect with the person, to validate and respect the person's feelings, to clarify the person's unmet needs, and to provide an opportunity for the person to feel acknowledged.[1, 4]

Quicklinks

- ASSESSMENT
- Care Planning
- Care Approaches Strategies
- Pharmacological Approaches
- Support for Escalation of Distress

- Appendix A: Getting to Know Me
- Appendix B: My Daily Care Needs
- Appendix C: "My Daily Care Needs" Example
- Appendix D: Care Planning Decision Support Algorithm
- Appendix E: PIECES™ framework
- Appendix F: BSO-DOS™
- Appendix G: 24 HOUR CLOSE OBSERVATION RECORD (PHC LTC homes)
- Appendix H: Sleep Pattern Record
- Appendix I: The Geriatric Depression Scale (DGS) – Short Form

Guideline

ASSESSMENT

Assessment of persons with dementia or other complex neurocognitive disorders requires a holistic interdisciplinary systematic approach, which includes reviewing medical history, social history, life story, observation and analysis.[5]

Assessment should include (but is not limited to):

- Identifying priority concerns
- Assessing area(s) of risk
- Exploring possible contributing factors

A comprehensive holistic assessment framework such as PIECES™ or equivalent will be used:

- To generate and update a person's individualized care plan
- When assessing a person exhibiting physical or emotional expressions

See Appendix E for an example of a PIECES™ framework.

CARE PLANNING

An individualized care plan such as "My Daily Care Needs" or equivalent (Appendix B) will be created/updated based on assessment findings. The care plan will be evaluated (regularly or when the person in care has a change in condition/behavior) to ensure effectiveness and changes should be reflective of the person's current care needs.

Care planning includes selecting and implementing care approach strategies that will build on the person's strengths, prevent unnecessary decline and/or reoccurrence, and reduce the risk of harm to the person and/or others. An individualized care plan provides consistent care approaches that are specific and meaningful to the person and followed by all team members and other supports, e.g., family and friends.

When an assessment is carried out in response to a person experiencing a change in condition/behavior, the interdisciplinary team will develop a plan of action based on the possible contributing factors identified through the assessment process. The plan of action will include (but is not limited to) the following:

Investigations

- Investigations should include (but are not limited to): delirium screen, pain, trauma Informed, abnormal lab results, mental health conditions, possible substance use, co-morbidities, medication (such as polypharmacy), goals of care, change in daily routine, etc.
- A behavioural observation tool such as BSO-DOS (Appendix F) for 5 days as recommended
- Other observation tools as indicated such as 24 Hours Close Observation Record (for PHC only) (Appendix G) and Sleep Pattern Record (Appendix H).

Interactions

- Consider how interdisciplinary team members will interact with each other (such as in a team huddle) to continue learning about the person and care approach strategies as well as sharing and updating information as per site process
- Once the observation period is complete, gather the team to review and analyze the data
- Consider how interdisciplinary team members can support the person's choices when the risk of harm to the person and/or others as well as benefits of the choices have been considered, addressed, and documented as per Supporting choices through informed decision-making and collaboration Guideline. If the person's choices are related to sexual needs, staff should follow the guidance in Supporting Sexual Health and Intimacy in Long Term Care Homes: A Pocket Reference Guide or contact Ethics Services (VCH Ethics Services; PHC Ethics Services) for additional support.
- Consider priority concerns and other contributing factors identified by the interdisciplinary team

Consultation

Based on the person's identified care needs, consider consultation as needed with, for example:

- LTC home managers/administrators/clinical leads
- Older Adult Mental Health & Substance Use Team (for VCH)/Geri Psychiatry (for PHC)
- Care Home Consultants
- Professional Practice Team [including Nurses Specializing in Wounds/Ostomy/Continence (NSWOCs), Clinical Resource Therapists (CRTs), Peer RCAs, Clinical Nurse Specialists, and Regional Practice Initiatives Leads]
- Palliative Care Resource Nurses (for VCH) / Palliative Outreach and Consult Team (POCT) (for PHC) for pain/end of life
- VCH Ethics Services; PHC Ethics Services
- The ReAct Adult Protection Program. The ReAct Adult Protection Program supports the adult protection response in VCH and PHC through education, coordination, consultation, and is the central coordinating office for all statutory property guardianship processes.

CARE APPROACHES STRATEGIES

Below are examples of care approach strategies, which can be used to support people with dementia or other complex neurocognitive conditions when they exhibit physical or emotional expressions.[1, 3, 5] Also, perform and continue Point of Care Risk Assessment (PCRA) before and during all care. The specific care approach strategies to be used will be identified in the person's individual care plan.

Non-Verbal Communication

- Be aware of your tone, own body language, and facial expressions and whether you are feeling rushed as well as use non-verbal gestures to help clarify points.
- People with dementia and neurocognitive disorders recognize and often reflect the non-verbal communication of their caregivers.

Approach

Use a gentle and respectful approach, such as:

- Approach from front, greet and make eye contact, position yourself at the same level as the person, if safe to do so.
- Ask for permission to enter room or space. If engaging in a care, conversation or other activities, ask for permission before commencing.
- When entering personal space (1.5 – 3 feet of a person) maintain a supportive stance (ready posture) with one additional stride backwards (stand in a bladed position towards the person with one foot back).
- Address the person by their preferred name, avoid terms such as “dear” or “love”.
- Speak calmly and clearly, use simple questions, e.g., ones that require “yes” or “no” responses or short easy to understand statements.
- Be aware of the person’s response to your presence, observe their reaction and reassure as indicated.
- Make a personal connection, engage in day-to-day conversation.
- If a person is disoriented, consider using approaches that validate their concerns rather than attempting to re-orient.
- Provide choice based on the person’s preferences, as much as possible.
- If the person does not want to do something or participate in care activities, use the *“Stop and Go”* approach (below) and return when the person is more open to participate:

  Stop and Go[3]

  S – Stop: Whatever you are doing can wait

  T – Think: Give your full and undivided attention and think about the person’s possible triggers

  O – Observe: Recognize the cues and acknowledge the emotional message from the person

  P – Plan: Consider when to resume care and how to modify your approach strategies
- Do not speak over the person but engage with them in a conversational tone
- Ensure that glasses and hearing aids are in place.
- Use communication aids (e.g. talking board or book, pictures/cue cards/pictograms, and the virtual interpreter [Decision Tool in LTC; Quick Guide] etc.).

- Consider scripts or redirection/distraction techniques that are known to be effective for the person.

Physical Considerations

- Manage symptoms (e.g. pain, breathlessness, fatigue, hunger, thirst, toileting, etc.).
    - Consider strategies to manage fatigue and breathlessness e.g. pacing activities throughout the day and alternating with rest periods.
- Ensure person's physical comfort and dignity when providing personal care (e.g. provide a warm blanket when assisting with bathing before undressing, use a face cloth or toothbrush to hold as a reminder/cue to participate in care, etc.).
- Consider if a two person approach to care is needed:
    - If two people involved in care, have one person provide care while second observe and provides calming reassurance.
    - If having two caregivers causes distress, re-consider approach.
    - Be sure not to have conversations with each other that excludes the person being cared for as this can add to distress.
- Engage person in meaningful conversation and describe what care is about to be performed.

Environmental Considerations

- Create an environment that is meaningful for the person by encouraging personal items that have meaning (e.g. photos, art, religious, cultural or spiritual symbols or furniture from their previous home as space allows).
- Consider creating treasure or memory boxes that can be used to reminisce and provide meaningful distraction and conversation.
- Place personal items within easy reach.
- Consider whether the person likes to be with others or alone and facilitate their preference.
- Provide a calming environment: consider location of person's room, lighting, noise level.
- Consider objects or other risks within the environment and make adaptations that support independence and meet the person's needs.

Social Support

- Engage in activities that are meaningful and build on the person's remaining strengths.
- Share with other team members what is meaningful for the person and include in care plan.
- Consider when and how other people and/or pets can support a positive relationship (e.g. spiritual leader in the morning, spouse at dinner time, visits with a volunteer, private companion support).

PHARMACOLOGICAL APPROACHES

Nurses collaborate and liaise with the most responsible physician (MRP) and pharmacist to choose the most appropriate medication and monitor the response and effectiveness. P.I.E.C.E.S. Canada recommends using the "Detect-Select –Effect" process when initiating psychotropic medications.

Pharmacological approaches should only be considered when:

- There is significant distress experienced by the person that has not resolved with the identified care plan interventions and through using de-escalation techniques and a gentle approach to care **AND,**
- The probability of harm to the person and/or others is intolerable (such as, in the red categories/zones in the Risk of Harm Assessment Matrix) after assessing by Risk of Harm Assessment Guide (See page 12 of Supporting choices through informed decision-making and collaboration Guideline)

SUPPORT FOR ESCALATION OF DISTRESS

Escalations of distress usually follow a predictable pattern and can be de-escalated. If the change in behavior or cognition is sudden, consider delirium first (Delirium DST).

The "Individualized Behavioural Escalation Prevention Plan" (IBEPP Tool) can be used to recognize when a person's level of distress is changing.[3] This includes:

- Determining what has changed.
- Performing and continuing a Point of Care Risk Assessment process prior to engagement and throughout the interaction.
- If the verbalization includes yelling or using of swear words that distress staff and others, initiating a care conference with the person's and/or the family/SDM input to develop an individualized care plan that will promote a positive living and working environment
- If there is an intolerable risk of harm (such as, in the red categories/zones in the Risk of Harm Assessment Matrix) to the person and/or others, initiating de-escalation techniques, and alert other care staff to assist in maintaining the safety of others

Related Documents

Related Policies

- BC Residential Care Regulations [BC. Reg. 96/2009]
- Consent to Health Care – PHC [B-00-11-10110]
- Consent to Health Care – VCH [D-00-11-30016]
- Cultural Competency and Responsiveness Policy [D-00-11-30045]
- Documentation Policy [BCD-11-11-41002]
- Incident Management (Patient/Client/Resident) Policy [D-00-11-30018]
- Indigenous Cultural Safety Policy [D-00-11-30044]

Guidelines/Procedures/Forms

- Delirium: Screening, Assessment and Management
- Falls: Promoting Independence and Reducing Risk of Falls Related Injury in Long-Term Care [BD-00-07-40028]
- Harm Reduction and Substance Use Safety Planning - Community and Long Term Care [D-00-13-30292]
- Harm Reduction Practice Guideline
- Least Restraint: Guideline for Maximizing Independence (in Residential Care) [D-00-07-30045]
- Responding to Abuse, Neglect or Self-Neglect of Vulnerable Adults: For Designated Responder (DR) and Designated Responder Coordinators (DRCs) [D-00-07-30012]
- Supporting Choices Through Informed Decision-Making and Collaboration Guideline [BD-00-07-40103]
- Supporting Sexual Health and Intimacy in Long-term Care Homes, Assisted Living, Group Homes, Supported Housing [BD-00-07-40114]
- Supporting Sexual Health and Intimacy in Long Term Care Homes: A Pocket Reference Guide
- Trauma Informed Practice

Resources

Immediate strategies and supports

- Residents' Bill of Rights
- "10 communication tips" from Alzheimer Society
- "5 communication tips for conversations with people living with dementia" from Alzheimer Society
- BCCDC COVID-19 Language Guide: Guidelines for inclusive language for written and digital content
- BC Provincial Behavioural & Psychological Symptoms of Dementia (BPSD)
- "Behavioural Escalation Chart and the IBEPP Tool" from Advanced Gerontological Education (AGE) Inc.
- Behavioural Supports Ontario – Dementia Observation System (BSO-DOS©)
- Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care: A Person-Centered Interdisciplinary Approach (2012)
- "Communication" from Alzheimer Society
- "Communication strategies: Ways to maximize success when communicating with someone with dementia (Video)" from brainXchange
- "Person-centered language guidelines" from Alzheimer Society
- "Successful Verbal Redirection" from Advanced Gerontological Education (AGE) Inc.

- Teepa Snow - Gain Awareness About Dementia
- "The ABC of Brain Function and the Personal Space Activity" from Advanced Gerontological Education (AGE) Inc.
- "The Importance of Personhood" from Advanced Gerontological Education (AGE) Inc.
- The 'Stop and Go' Approach from Advanced Gerontological Education (AGE) Inc.
- "Tip sheet: how to communicate with a person living with dementia" from Government of Canada

Patient and Family Education

- "When Your Loved One Has Dementia: A Roadmap for Families" from Interior Health

References

1. Alzheimer Society of Canada (2019). *Dementia and responsive behaviours*. Alzheimer Society.
2. Kitwood, T. M., & Brooker, D. (2019). *Dementia reconsidered, revisited: The person still comes first* (Second ed.). Open University Press.
3. Bell, V., & Troxel, D. (2001). *The best friends staff: Building a culture of care in Alzheimer's programs*. Health Professions Press.Advanced Gerontological Education (2019). *Gentle persuasive approaches (GPA) in dementia care: Supporting persons with responsive behaviours* (4th ed.). Advanced Gerontological Education (AGE) Inc.
4. Feil, N., & Klerk-Rubin, V. d. (2012). *The validation breakthrough: Simple techniques for communicating with people with Alzheimer's and other dementias* (3rd ed.). Health Professions Press.
5. Hamilton, P., LeClair, J.K., Collins, J., Sturdy-Smith, C., & O'Connell, M. (2020). *PIECES Resource Guide: Guiding Collaborative Engagement, Shared Assessment, and Supportive Care* (7th ed.). Sportswood Printing. Canada.
6. BC Ministry of Health. (2012). *Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care*. BCMOH.
7. Canadian Coalition for Seniors Mental Health (2006). National Guidelines for Senior's Mental Health: the assessment and treatment of mental health issues in long-term care homes (focus on mood and behaviour symptoms). *Canadian Journal of Geriatrics, 9*, S 59-64.
8. Canadian Institute for Health Information. (2021). *How Many Long-Term Care Beds are there in Canada?* Retrieved from https://www.cihi.ca/en/how-many-long-term-care-beds-are-there-in-canada
9. Health Standard Organization. (2023). *Long-Term Care Services*. Health Standard Organization.
10. Mohr, W., Rädke, A., Afi, A., Edvardsson, D., Mühlichen, F., Platen, M., Roes, M., Michalowsky, B., & Hoffmann, W. (2021). Key intervention categories to provide person-centered dementia care: A systematic review of person-centered interventions. *Journal of Alzheimer's Disease, 84*(1), 343-366. https://doi.org/10.3233/JAD-210647
11. Reinhardt, J. P., Burack, O. R., Cimarolli, V. R., & Weiner, A. S. (2020). Dementia-focused person-directed care training with direct care workers in nursing homes: Effect on symptom reduction. *Journal of Gerontological Nursing, 46*(8), 7-11. https://doi.org/10.3928/00989134-20200707-01

12. Sachdev, P. S., Blacker, D., Blazer, D. G., Ganguli, M., Jeste, D. V., Paulsen, J. S., & Petersen, R. C. (2014). Classifying neurocognitive disorders: The DSM-5 approach. Nature Reviews. *Neurology, 10*(11), 634-642. https://doi.org/10.1038/nrneurol.2014.181

13. Sefcik, J. S., Madrigal, C., Heid, A. R., Molony, S. L., Van Haitsma, K., Best, I., Resnick, B., Galik, E., Boltz, M., & Kolanowski, A. (2020). Person-centered care plans for nursing home residents with behavioral and psychological symptoms of dementia. *Journal of Gerontological Nursing, 46*(11), 17-27. https://doi.org/10.3928/00989134-20201012-03

Definitions

Dementia: A chronic, progressive disease of the brain that affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, judgment, and executive function[6].

Individualized care plan: A documented plan that outlines the integrated activities required to meet a person's goals, preferences, and needs. An individualized care plan is developed collaboratively with the person and and/or the families/SDM and informed by ongoing holistic interdisciplinary assessments of basic, physical, mental, social, and spiritual needs. The individualized care plan needs to be re-evaluated for its effectiveness and made adjustments based on a person's changing health status and care needs as needed. The individualized care plan is shared with appropriate team members.

Long-term care (LTC) home: A setting where people with complex health care needs live. Also referred to as continuing care, personal care, or nursing homes, LTC homes are formally recognized by jurisdictions with a license and are partially funded or subsidized to provide a range of health and support services, such as lodging, food, and personal care for their residents 24 hours a day, 7 days a week[8].

Neurocognitive disorders: Comprises three syndromes, each with a range of possible etiologies: delirium, mild neurocognitive disorder and major neurocognitive disorder. Neurocognitive disorders are characterized by decline from a previously attained level of cognitive functioning. These disorders have diverse clinical characteristics and etiologies, with Alzheimer disease, cerebrovascular disease, Lewy body disease, frontotemporal degeneration, traumatic brain injury, infections, and alcohol abuse representing common causes[12].

Substitute Decision Maker (SDM): In British Columbia there are the following types of SDMs and they are listed below in the order of hierarchy:

- **Committee of Person (Patients Property Act):** If there is a court ordered Committee of Person for the person, the Committee has the authority to make decisions regarding risk choices for the person.
- **Representative (Representation Agreement Act):** If there is a Representative appointed by the person by way of a Representation Agreement, the Representative may have authority depending on the provisions in the agreement.
- **Temporary Substitute Decision Maker ("TSDM") and Substitute for Facility Admissions ("Substitute") (Health Care (Consent) and Care Facilities (Admission) Act) (HCCCFAA):** TSDMs for health care and Substitutes for care facility admission decisions are determined through the HCCCFAA.

Note: Power of Attorney **(Power of Attorney Act)** and Committee of Estate **(Patients Property Act)**: Powers of Attorney and Committee of Estates pertain only to financial matters

Appendices

Appendix A: Getting To Know Me

GETTING TO KNOW ME

Let Me Share My Life Story With You

Name: _____ Date: _____

My early home and family life:
_____
_____
_____

My education and life's work was:
_____
_____
_____

My family and friends:
_____
_____
_____

How you can comfort me is:
_____
_____
_____

I lived in the following places:
_____
_____
_____

My favourite foods are:
_____
_____
_____

I speak the following languages:
_____
_____
_____

In a typical day, I like to:
_____
_____
_____

My talents, hobbies and interests include:
_____
_____
_____
_____

I like to get up at _____
I like to go to bed at _____
My normal sleep/napping pattern is:
_____
_____
_____

Things that give me pleasure include:
_____
_____
_____

Three words that describe me are:
_____
_____
_____
_____

Things that make me unhappy are:
_____
_____
_____

Other things I would like you to know about me are:
_____
_____
_____
_____

I am/have been a part of the _____ faith.
_____

Adapted for the Provincial Best Practice Algorithm for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia from the Long Term Care Program, Providence Healthcare, Toronto, Ontario & the Helping Elders in Adapt in Residential Transitions (HEART) Team, Vancouver Coastal Health.

Appendix B: My Daily Care Needs

Vancouver CoastalHealth Providence Health Care

MY DAILY CARE NEEDS

IDENTIFICATION LABEL

Please read my "Getting To Know Me" before reading My Daily Care Needs.

I prefer to be called/pronouns that I use:

Goals of Care:

How To Interact With Me / Keeping Me Safe	How I Like To Communicate
What I Can Do On My Own (Strengths)	Things I Find Challenging
My Personal Aids	My Transfer & Mobility
My Bathroom Needs	I like To Look Good & Feel Good By (Personal Hygiene)

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MY DAILY CARE NEEDS

IDENTIFICATION LABEL

I Enjoy My Meals By	How I Take My Medications
Things I Love To Do / Things That I Find Calming	My Sleep & Rest Needs
Important People & Things in My Life	

Please sign and date, after you read My Daily Care Needs:

Date/Initials							

Initiated by: _____ Date Initiated: _____ Updated: _____

Appendix C: "My Daily Care Needs" Example

Vancouver CoastalHealth Providence Health Care

MY DAILY CARE NEEDS

IDENTIFICATION LABEL

Please read my "Getting To Know Me" before reading My Daily Care Needs.

I prefer to be called/pronouns that I use: **Goals of Care:**

How To Interact With Me / Keeping Me Safe - Please remove clutter and ensure there's enough lighting - I always need to proper fitting shoes - Please say "Hi" and approach me from the front and don't yell my name out because it startles me - Make eye contact with me, speak clearly and slowly	**How I Like to Communicate** - Verbally and through gestures - I speak and understand English, my first language is French
What I Can Do On My Own (Strengths) - I can wash my face - I can use a toothbrush when you put toothpaste on it - I can use the washroom/toilet/bathroom/comfort room/rest room - I can stand on my legs - I have a strong grip	**Things I Find Challenging** - Seeing colors - Walking for too long - Waiting for a long time - Instructions that are too fast; and too many steps
My Personal Aids - Hearing aids - Dentures - Glasses	**My Transfer & Mobility** - I use a walker but I forget to use it; please remind me - Please use a mechanical lift (standing/Hoyer/ceiling) for my transfers
My Bathroom Needs - When you see attempting to open doors, ask me if me I need to use the toilet - i.e. toileting routine, schedule	**I Like To Look Good & Feel Good By (Personal Hygiene)** - I take a shower on Sundays - I like my combed and parted to the side - Wearing dresses - Shaving every other day - Wearing my favorite shade of lipstick

EXAMPLE

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Vancouver CoastalHealth Providence Health Care

MY DAILY CARE NEEDS

IDENTIFICATION LABEL

I Enjoy My Meals By

- I eat breakfast in my pyjamas
- I like to sit at a table with table cloth and flowers
- I like to eat next to my friends
- Having juice, coffee, and hot water with every meal
- Sitting next to the window, facing the door/TV
- In a quiet environment
- I use a weighted spoon, a built up plate, a nosey cup

How I Take My Medications

- I want them crushed
- I only take it after I have eaten my meal
- I take my meds with hot water/tea
- I hate taking medications in the dining room

Things I Love to Do / Things That I Find Calming

- Hobbies - Knitting, planting, gardening
- Listening to Abba
- Hugs
- Sit next to me and rub my back
- Walks in the garden
- Talking out my feelings

My Sleep & Rest Needs

- Don't wake me to give me meds if I'm sleeping
- I get really hot at night / I need an extra blanket
- I like to sleep with a night light, I like the window open
- I like to wear socks
- I sleep with the TV on

EXAMPLE

Important People & Things in My Life

- Family members, pets
- Special items such as a plush dog or cat or doll
- Appointments, punctuality
- Cars, coin collection; Sports – baseball, basketball, golf, rugby, soccer

Please sign and date, after you read My Daily Care Needs:

Date/Initials							

Initiated by: _____ Date Initiated: _____ Updated: _____

Appendix D: Care Planning Decision Support Algorithm

When the person in care has a change in condition/behavior, e.g. repetitively exhibiting physical and/or emotional expressions due to an unmet need:
- An individualized care plan, such as "My Daily Care Needs" or equivalent (Appendix B), needs to be reviewed and updated.
- Involve all persons and/or their families / SDMs and ID team in care planning.

- Change in condition / behavior **Has Delirium already been ruled out?**

No → Initiate Delirium screening and assessment (Delirium: Screening, Assessment and Management)

Yes

- A systematic approach such as a PIECES™ or equivalent, will be used to problem solve and develop a plan of care to collaboratively work with and to share with all team members, family and other supports.
- Appendix E: an example of a PIECES™ framework which can be used to guide assessment.

- What is (are) the target symptom(s)? _____
- Is it a **CHANGE** for the person? □ YES □ NO

- Describe and document the situation surrounding a specific personal expression / target symptom.

- What is/are the area(s) of **RISKS** concern(s) the team the most? _____
- What is the potential impact of the risk? _____
- What is the probability of harm to the person and/or others? _____

What has been explored or investigated?

□ Delirium	□ Pain
□ Trauma Informed	□ Abnormal Lab Results
□ Mental Health Conditions	□ Possible Substance Use
□ Co-morbidities	□ Medication, Polypharmacy
□ Goals of Care	□ Change in Daily Routine

Are there other services/team/resources already involved with the Person? If not, based on the person's identified care needs, consider consultation as needed with, for example:
- □ Older Adult Mental Health & Substance Use Team (VCH) or Geri Psychiatry (PHC)
- □ Nurses Specializing in Wounds/Ostomy/Continence (NSWOCs)
- □ Clinical Resource Therapists (CRTs)
- □ Peer RCAs
- □ Regional Practice Initiatives Leads or Clinical Nurse Specialists
- □ Care Home Consultants
- □ Palliative Care Resource Nurses
- □ LTC home managers/Administrators/Clinical Leads

Explore and investigate possible contributing factors include (but not limit to) below:
- **Physical -** Review medical history (Delirium, Disease, Discomfort, Drugs, Disability), pain or other symptoms, continence routines… etc.
- **Intellectual -** Neurocognitive changes, Cognitive Performance Scale (CPS)… etc.
- **Emotional -** Mood (e.g. Depression Rating Scale (DRS), Geriatric Depression Scale [GDS] - Appendix I), adjustment, suicidality, psycho-social history, mental health concerns, psychosis, anxiety, past traumas, losses, history/or risk of suicide, use of substances, … etc.
- **Capabilities -** Daily routines, coping mechanisms, abilities / strengths, and ability to participate in ADLs and IADLs… etc.
- **Environment** - Enabling/disabling factors, transitions
- **Social -** Engage person, family and friends to understand more about the person's life story, their relationships, social and work history, values, beliefs, cultural / spiritual religious practices, likes and dislike, sexuality, gender identity, ISE… etc.

Consider how ID team members will interact to continue learning as well as sharing and updating information.

Adapted from PIECES Canada (Hamilton, et al, 2020)

IMPORTANT to CONSIDER
- Harm Reduction and Substance Use Safety Planning - Community and Long Term Care [D-00-13-30292]
- Harm Reduction Practice Guideline
- Indigenous Cultural Safety Policy [D-00-11-30044]
- Supporting Choices Through Informed Decision-Making and Collaboration Guideline [BD-00-07-40103]
- Trauma Informed Practice
- Supporting Sexual Health and Intimacy in Long Term Care Homes: A Pocket Reference Guide

Care Planning - An individualized care plan, such as "My Daily Care Needs" or equivalent (Appendix B), needs to be updated based on recent assessment findings.

Care Planning includes selecting and implementing **Care Approaches** that will build on the person's strengths, prevent unnecessary decline and / or reoccurrence, and mitigate the probability of harm to the person and/or others.

The care plan needs to be re-evaluated to ensure effectiveness and changes should be reflective of the person's current care needs.

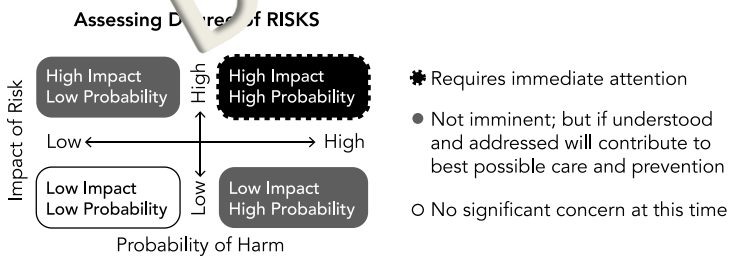
Appendix E: PIECES™ framework

P.I.E.C.E.S. 3 Question TEMPLATE Guide can be found at this link

P.I.E.C.E.S. Practical Application

The Practical Application **(PA)** is an opportunity to collaborate with the Person, Care Partner, and other members of the Team in the shared application of the P.I.E.C.E.S. approach.

	Q1 What are the **priority** concerns**;** is it a **change** for the Person?

	Q2 **What are the RISKS and possible contributing factors (Think P.I.E.C.E.S.)**		
	Prioritizing RISKS (related to the identified priority concerns)		
	To help **prioritize** RISKS consider the following for each area of RISKS that is identified: ○ **Potential impact** on Person and/or others? ○ **Probability of harm** to Person and/or others? 		*Flag priority* ***action*** *Q3*
R: Roaming (searching, seeking exit)			☐
I: Imminent harm due to: Fire; Falls, Frailty, Firearms			☐

S: Suicidal Ideation			☐
K: Kinship (risk of harm by the Person or to the Person by others)			☐
S: **S**elf-neglect; **S**afe driving; **S**ubstance use/misuse; **S**ecurity (food/housing/finances)			☐

	Prioritizing contributing factors (Think P.I.E.C.E.S.)	
	Behavioural assessment: ☐ Yes ☐ No – What tool(s)? :	
	P.I.E.C.E.S. – Prioritize **	*Flag Priority* ***Action Q3***
P – Physical • Delirium • Disease • Drugs • Discomfort • Disability		☐
I – Intellectual (neurocognitive changes) • Anosognosia • Amnesia • Aphasia • Agnosia • Apraxia • Altered Perception • Apathy		☐

E – Emotional • Mood, adjustment, suicidality, overall emotional health, substance use • Psychosis • Mental health/trauma history		☐
C – Capabilities • Abilities overwhelmed • Underused strengths		☐
E – Environment • Enabling/disabling factors • Recent move or transitions in care		☐
S – Social • Life story • Social network • Cultural, spiritual • Gender identity • Sexuality		☐

Q3 What are the actions?	
Remember, this is a ***priority action plan*** addressing **priority** RISKS and **priority** contributing factors that have been identified. Consider: • How the plan will be implemented and shared • How it will be monitored	
	Team Member(s)
Priority Investigations (including assessment tools)	
Priority Interactions (including communication strategies, Team interactions)	
Priority Interventions (including biopsychosocial and pharmacological)	

Notes Captured by:	**Team Review Date:**

Appendix F: Behavioural Supports Ontario-Dementia Observation System (BSO-DOS)

BSO-DOS© Vancouver CoastalHealth Providence Health Care

Behavioural Supports Ontario-Dementia Observation System

Worksheet

Step #1: Background *(Complete prior to Data Collection Sheet)*

Reason for Completing BSO-DOS©:

- ❑ Baseline/Admission
- ❑ Transition/Move
- ❑ New behaviour: _____
- ❑ Change in behaviour(s)
- ❑ Implementation of a new strategy/intervention
- ❑ Adjustment of medications
- ❑ Support for urgent referral/transfer
- ❑ Other: _____

BSO-DOS© start date: _____ Section completed by (print name): _____

BSO-DOS© stop date: _____ Signature: _____

Step #2: Complete the Data Collection Sheet & highlight the numbers according to the colour-coded legend

Step #3: Analysis & Planning *(Use completed Data Collection Sheet)*

		Total the Blocks for Each Day (Add up the number of blocks for each category per day)						Total the ½ Hour Blocks (Add up the number of blocks for each category over 5 days)		Calculate the Average Hours Per Day (Divide the total ½ hour blocks by 10) Hint: Move the decimal point one space to the left	Concerns		
		Day #1	Day #2	Day #3	Day #4	Day #5					Frequency	Duration	Risk
1	Sleeping						=		÷10		❑	❑	❑
2	Awake/Calm						=		÷10		❑	❑	❑
3	Positively Engaged						=		÷10		❑	❑	❑
4	Vocal Expressions						=		÷10		❑	❑	❑
5	Motor Expressions						=		÷10		❑	❑	❑
6	Sexual Expression of Risk						=		÷10		❑	❑	❑
7	Verbal Expression of Risk						=		÷10		❑	❑	❑
8	Physical Expression of Risk						=		÷10		❑	❑	❑
9							=		÷10		❑	❑	❑
10							=		÷10		❑	❑	❑

What the BSO-DOS© data reveal (e.g. types of behaviours expressed, patterns, time of day, broken sleep): _____

Possible causes and contributing factors (consider collected context and personhood information): _____

Next Steps (check all that apply):

- ❑ Continue BSO-DOS© for another 5 days
- ❑ Repeat BSO-DOS© in 4-6 weeks
- ❑ No further BSO-DOS© completion at this time
- ❑ ABC charting around particular events/behaviour
- ❑ Clinical huddle/meeting
- ❑ Progress note written
- ❑ Consult/meet with Substitute Decision Maker (SDM)
- ❑ Medication adjustment/review
- ❑ Non-pharmacological interventions suggested: _____
- ❑ Care plan updated
- ❑ Referral: _____
- ❑ Other: _____

Section completed by (print name): _____ Signature: _____

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

DOS Working Group (2019). *Behavioural Supports Ontario-Dementia Observation System (BSO-DOS©).* Behavioural Supports Ontario Provincial Coordinating Office, North Bay Regional Health Centre, Ontario, Canada.
VCH.0876 | OCT.2023

BSO-DOS® Vancouver Coastal Health Providence Health Care

Behavioural Supports Ontario-Dementia Observation System

Data Collection Sheet

	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*
D/M/Y															
0700															
0730															
0800															
0830															
0900															
0930															
1000															
1030															
1100															
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0400															
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0500															
0530															
0600															
0630															

*Mandatory column

Observed Behaviours	
1	Sleeping
2	Awake/Calm
3	Positively Engaged

For #3-8 check as you observe:

- ❑ Activity
- ❑ Conversing
- ❑ Hand holding
- ❑ Hugging
- ❑ Singing
- ❑ Smiling
- ❑ Other:

4 Vocal Expressions (Repetitive)

- ❑ Crying
- ❑ Grunting
- ❑ Humming
- ❑ Moaning
- ❑ Questions
- ❑ Requests
- ❑ Sighing
- ❑ Words
- ❑ Other:

5 Motor Expressions (Repetitive)

- ❑ Banging
- ❑ Collecting/Hoarding
- ❑ Disrobing
- ❑ Exploring/Searching
- ❑ Fidgeting
- ❑ Grinding teeth
- ❑ Pacing
- ❑ Rattling
- ❑ Rocking
- ❑ Rummaging
- ❑ Other:

6 Sexual Expression of Risk

- ❑ Explicit sexual comments
- ❑ Public masturbation
- ❑ Touching others - genitals
- ❑ Touching others - non-genitals
- ❑ Other:

7 Verbal Expression of Risk

- ❑ Insults
- ❑ Screaming
- ❑ Swearing
- ❑ Threatening
- ❑ Other:

8 Physical Expression of Risk

- ❑ Biting
- ❑ Choking others
- ❑ Grabbing
- ❑ Hair pulling
- ❑ Hitting
- ❑ Kicking
- ❑ Pinching
- ❑ Punching
- ❑ Pushing
- ❑ Scratching
- ❑ Self-injurious
- ❑ Slapping
- ❑ Spitting
- ❑ Throwing
- ❑ Other:

9	
10	

Context	
A	Alone
L	Loud/busy environment
Q	Quiet environment
F	Family/visitors present
C	Personal Care (e.g. bathing, incontinent care, toileting)
N	Nutrition - eating/drinking
M	Medication for behaviours given
P	Pain medication given
T	Treatment (e.g. wound care, creams)
R	Expressions directed at Resident/patient/visitor(s)
S	Expressions directed at Staff
X	
Y	

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

DOS Working Group (2019). *Behavioural Supports Ontario-Dementia Observation System (BSO-DOS®).* Behavioural Supports Ontario Provincial Coordinating Office, North Bay Regional Health Centre, Ontario, Canada.

Appendix G: 24 HOUR CLOSE OBSERVATION RECORD (PHC LTC homes)

Place Patient Label Here

Nursing Assessment

RESIDENTIAL CARE:
24 HOUR CLOSE OBSERVATION RECORD
GETTING TO KNOW YOU BETTER

1708

Rationale: (tick all appropriate)

- ☐ Delirium
- ☐ Falls risk
- ☐ Potential for self injury
- ☐ Other: _____
- ☐ Newly Moved-in
- ☐ Behaviour symptoms
- ☐ Suicide risk

Relevant Information/Strategies to test:

_____
_____
_____
_____

Date: _____

Use codes from legends at right

Time	Behaviours	Underlying cause	Interventions	Initial	Action & Evaluation Q4H by Most Responsible Nurse	Initial
1400						
1500						
1600						
1700						
1800						
1900						
2000						
2100						
2200						
2300						
2400						
0100						
0200						
0300						
0400						
0500						
0600						
0700						
0800						
0900						
1000						
1100						
1200						
1300						

CODES

Behaviours observed

1. Awake & cooperative
2. Asleep
3. Calling out
4. Pulling off tubes/clothes
5. Wandering
6. Pacing
7. Not sleeping (at night)
8. Striking out
9. Resisting touch/movement
10. Unsteady
11. Self harm
12. Forgetful
13. Seeing things I can't see
14. Suspicious
15. Talking nonstop
16. Unsafe/risky movements
17. Keeps asking the same thing
18. Poor safety awareness
19. Drowsy
20. Other: _____

Potential underlying cause of behaviour

1. Hungry
2. Thirsty
3. Constipated
4. Needs toilet
5. Seems to be _____
6. Seems to be in pain
7. Seems to be afraid
8. Is ill
9. Seems to be angry
10. Bothered by _____
11. Seems lonely
12. Seems to be bored
13. Overwhelmed, can't cope
14. Too much stimulation
15. ↓family support/contact
16. Disoriented
17. Not enough restful sleep
18. Very sleepy
19. Medications changed
21. Unknown

Interventions attempted

1. Checked in, is OK
2. Toileted
3. Shifted position (SP)
4. Turned- major position change
5. Pain medication
6. Comforted physically
7. Put things within reach
8. Food
9. Fluid
10. Removed unnecessary irritants
11. Oriented, helped find way
12. Oriented to time
13. Diverted, redirected
14. AM care
15. PM care
16. Reassured
17. Provided company
18. Engaged in activity
19. Included socially
20. Behaviour medication

At end of 24 hours: RN/RPN/CNL/Allied Health review and decision:
I have reviewed this Record and the Progress Notes and feel confident that daily bedside care as noted in the Care Guide / Care Plan **promotes a balance of safety/comfort /contentment.**

- ☐ Yes - Discontinue 24 hour observation. Note concerns on Care Plan for regular review
- ☐ No - Begin new 24 Hour Close Observation Record

Signature: _____ Printed name: _____ Designation: _____ Date: _____

FORM ID - 1708 VERSION 2014 APR 01

Page 1 of 2

Place Patient Label Here

RESIDENTIAL CARE:
24 HOUR CLOSE OBSERVATION RECORD
GETTING TO KNOW YOU BETTER

Nursing Assessment

Hourly Close Observation is shown by research to help health care workers better minimize falls and associated injuries when residents are at high risk for falls: moving-in, change in condition, after a fall. It also: helps to make care proactive rather than reactive, reduces call bell use, saves walking for the health care worker.

To understand cause of underlying behaviours, ask yourself?	**CONSIDERATIONS**
• Does the resident need to use the bathroom? • When was their last bowel movement? • Is the resident thirsty or hungry? • Does the resident need to go for a walk? • Would the resident benefit from distraction? • TV, food, conversation, walk • Does the resident need medication? • Does the resident have an understanding of where they are and plan of care? • How is your approach influencing the behaviour? • Does the resident smoke, consider smoking cessation? • Are there gender/cultural considerations? • Are there language or other communication barriers?	**Establishing a rapport** • Eye contact • Friendly tone, calm manner • Approach slowly • Listen to verbal and non verbal communication • Establish and maintain consistent care plan • Provide communications aids • Involve family members as appropriate • Ensure appropriate communication tools/aids are present (e.g. hearing aids, corrective lenses, pictogram tools, interpreter etc.) **Environmental stimuli** • Adjust stimuli: lighting, excess noise, • Consider room mate selection, proximity to nursing station
Additional resources: • Local professional staff - OT • POCT team especially for pain/end of life • Geri Psychiatry • Geriatric Medicine Consult Service	**Related Nursing Care Standards** (located on PHC intranet) • Suicidal patients • Delirium • Least Restraint • Managing Unsettled Behaviour

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Page 2 of 2

Appendix H: Sleep Pattern Record

Vancouver CoastalHealth Providence Health Care

LONG-TERM CARE:
SLEEP PATTERN RECORD

Connect the dots to indicate awake or asleep for the full 24 hours.
Each dot represents a 15-minute interval.
Indicate with an asterisk (*) when a person exhibiting physical or emotional expressions.

Time	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300	2400	0100	0200	0300	0400	0500	0600	0700
Date:																								
Asleep	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••
Awake	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••
Date:																								
Asleep	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••
Awake	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••
Date:																								
Asleep	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••
Awake	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••
Date:																								
Asleep	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••
Awake	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••
Date:																								
Asleep	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••
Awake	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••
Date:																								
Asleep	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••
Awake	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••	••••

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Appendix I: The Geriatric Depression Scale (GDS) – Short Form

Choose the best answer for how you felt over the past week		Circle One
1.	Are you basically satisfied with your life?	YES NO
2.	Have you dropped many of your activities and interests?	YES NO
3.	Do you feel that your life is empty?	YES NO
4.	Do you often get bored?	YES NO
5.	Are you in good spirits most of the time?	YES NO
6.	Are you afraid that something bad is going to happen to you?	YES NO
7.	Do you feel happy most of the time?	YES NO
8.	Do you often feel helpless?	YES NO
9.	Do you prefer staying at home to going out and doing new things?	YES NO
10.	Do you feel you have more problems with memory than most people?	YES NO
11.	Do you think it is wonderful to be alive now?	YES NO
12.	Do you feel pretty worthless the way you are now?	YES NO
13.	Do you feel full of energy?	YES NO
14.	Do you feel that your situation is hopeless?	YES NO
15.	Do you think that most people are better off than you?	YES NO

Scoring: A score of 0-5 is normal.
A score of 5 suggests depression.
One point for each of the following answers:

1. NO	5. NO	9. YES	13. NO
2. YES	6. YES	10. YES	14. YES
3. YES	7. NO	11. NO	15. YES

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Approved By: *(committee or position)*	PHC	VCH
	PHC Professional Practice Standards Committee	VCH: (Regional DST Endorsement - 2nd Reading) Health Authority & Area Specific Interprofessional Advisory Council Chairs (HA/AIAC) Operations Directors Professional Practice Directors Final Sign Off: Vice President, Professional Practice & Chief Clinical Information Officer, VCH
Owners: *(optional)*	PHC	VCH
	Clinical Nurse Specialist, Long Term Care and Assisted Living	Clinical Nurse Specialist, Long-Term Care and Assisted Living Professional Practice Team, Clinical Educator – Nursing (PIECES Lead, VCH), Long-Term Care and Assisted Living Professional Practice Team