LTC-Mental Health Framework

Toronto Region

How-To Guide

ALL BEHAVIOURS HAVE MEANING

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5. Dementia Education Needs Assessment (DENA), 2007 by OLTCA & OANHSS
6. 3D's: Delirium, Depression, Dementia Resource Guide, Jan 2007 by Toronto Best Practice in LTC Initiative
7. Canadian Coalition for Seniors' Mental Health – National Guidelines for Seniors' Mental Health, May 2006 "The Assessment and Treatment of Mental Health Issues in Long-Term Care Homes"
8. High Intensity Needs Fund, MOHTLC
9. Casa Verde Inquest Coroner's Report
10. Pressing Needs and Emergency Possibilities: The Alzheimer Society, Ontario, March 2007
11. Creating Welcoming Communities in Long-Term Care Homes, Support for Ethno-Cultural and Spiritual Diversity, Feb 2007 by Concerned Friends

7.0 References

1.0 OVERVIEW AND INTRODUCTION

1.1 Introduction

Literature suggests that there is an extremely high prevalence of mental health and behavioural disorders and responsive behaviours among long-term care home residents. One report suggested 80-90% of nursing home residents live with some form of mental illness and/or cognitive impairment (Rovner et al., 1990; Drance, 2005). The survey conducted in 2006 among LTCHs in the Toronto region reported that 32.5% of residents display serious mental health illness and severe responsive behaviours.

It is acknowledged that a number of responsive behaviours are as a result of serious mental illness. However, long-term care homes also care for a large (and growing) population of individuals with dementia, who exhibit significant responsive behaviours.

In 2006, there were over 155,000 people with dementia in Ontario. Researchers estimated that in ten years, by 2016, there will be an additional 51,500 people with dementia, representing a 33% increase. In addition, for the next eight years, the number of people in Ontario with dementia will increase at a faster rate than the number of seniors (aged 65 and over) compared to 2006 levels.

Throughout Ontario, the prevalence of individuals with dementia will vary among the province's Local Health Integration Networks (LHIN). By 2016, most LHINs serving areas of Toronto will have either the highest prevalence of people with dementia in the province, with each caring for about 25,000 people with dementia (Central LHIN; Central East LHIN), or above the significant increase forecast of 33%. (Alzheimer Society, Ontario: *Projected Prevalence of dementia: Ontario's local health integration networks*, April 2007).

Central LHIN - 48%
Central East LHIN - 36%
Mississauga-Halton and Central West LHINs - 56%
Central Toronto LHIN - 21%

The implications of the growing number of persons who will be affected by dementia cannot be overstated. Understanding the needs of individuals with dementia and planning how best to address those needs is critical for us if we are to be effective in maintaining a high quality of life both for persons with dementia and those supporting them in their care. There is an immediate need to identify, collaborate and share knowledge related to effective mental health and dementia care management and practices.

1.2 Background

In November 2005, in response to a number of risk issues facing the MOHLTC and the LTC and mental health systems (including the Coroner's Report from the Casa Verde Inquest and the MOHLTC Toronto Region Office's LTCH Bed Strategy), the MOHLTC initiated a LTC-MH Framework Steering Committee to create an integrated LTC-MH framework for the MOHLTC's Toronto Region.

After extensive consultation with key stakeholders and lengthy inter-sectoral deliberations, the Steering Committee developed the LTC-MH Framework Report, which was released by the MOHLTC in May, 2007. The MOHLTC endorsed the report's implementation and asked the newly formed LTC-MH Framework Implementation Committee to guide its implementation.

The LTC-MH Framework promotes an ***integrated collaborative model*** that outlines the current available resources in the system and defines roles and responsibilities of key partners. There were 21 recommendations proposed on the LTC-MH Framework Report. The overall theme is to ***promote relationship-building between partners*** and to take on ***a system approach to integrate and enhance current structure and processes.***

The LTC-MH Framework implementation has a twelve-month mandate. Its ***goals*** are to:

1. Support organizations and individuals to implement the framework within their own organizational structures and capabilities (e.g. LTCHs, CCACs, hospitals, G-MHOT and community agencies);

2. Promote a ***consistent coordinated system*** while organizing and appropriately addressing the diversity and capability of organizations, and individuals;

3. Establish ***processes*** to enable ongoing change to ensure sustainability; and

4. Consider viability of future implementation of a similar framework in the community.

1.3 Purpose of the Guide

This guide is intended to be a simple, user-friendly and practical tool kit for long-term care homes to build, strengthen and sustain an integrated and collaborative system with mental health and other health care partners in order to effectively manage responsive behaviours and recognize that ***All Behaviours Have Meaning***.

After extensive literature search and long-term care home consultations, the Core Development Team responsible for the development of this "How-to Guide" found that a vast body of knowledge and tools was already available in the field to assist in managing seniors' responsive behaviours. There were also successes and lessons learned among peers that could be shared. Thus, this Guide is not a research product. It does not contain new data. Instead, this Guide collects and condenses the most essential information, tools and experiences to support homes to build a better behavioural support model for their residents, staff and families.

Furthermore, the Core Development Team of this Guide highly recommends readers use this Guide in conjunction with the LTC-MH Framework Report (CD collection item #3). Since the LTC-MH Framework Report is indeed very comprehensive, this Guide does not duplicate information that has already been detailed in the framework report.

1.4 Target Audiences

The success in establishing and sustaining an effective behavioural support model for seniors in a LTCH greatly relies on the pre-existing establishment of a ***caring culture***, in which the entire team operates with a set of ***shared values*** (including quality and safety) and embraces the concept of a learning organization. An effective behavioural support care model requires leadership and commitment from the LTCH's management to inspire the team, pave the ground, provide supports, foster a culture and maintain sustainability.

Therefore, the primary targeted audience for this Guide are those who hold responsibilities in responsive behavioural management in the LTCH. This may include the Administrator, the Director of Care/Nursing and the designated behavioural support role (BSR) staff and/or the PIECES-trained staff.

The material in this Guide is ready for immediate use for:

- ***The LTCH management*** to quickly pull out information from the Guide to modify policies and procedures and develop protocols for its home,
- ***An educator*** to find information to prepare an education program for staff, and
- The front line staff of the ***multidisciplinary team*** to use as a quick reference as there are many tools included that can be laminated.

1.5 Guide's Contents

The Guide contains three components:

1. ***Key Elements:*** This section outlines the concept of key elements for creating a behavioural support model within a long-term care home. It touches on the fundamental aspects of care philosophy, key principles, organizational culture, and change management in paving the ground to adopt and sustain a behavioural support system.

2. ***Process:*** This section describes the methods and the critical steps necessary to develop a behavioural support model within a LTCH. It provides tips, templates, process charts and decision trees of best practice to build/expand LTCH internal capability and to establish collaborative partnerships with existing available external resources.

3. ***Tool Collection***: This is an inventory section that puts together a collection of useful tools, checklists, forms and other helpful information resources. Many of them are samples that have been used successfully in individual LTCHs. They are made available to other LTCHs for consideration and use. The LTC-MH Framework Implementation Committee accepts no responsibility for the comprehensiveness (or lack thereof) of any of the collected tools or for the results of implementation in any individual LTCH. This section is provided solely as an inventory of existing tools and successful practices, in the spirit of knowledge exchange and shared learning.

   Some of these tools and resource materials are attached in the ***Appendix*** section of this Guide. For easy access and quick extraction/adaptation of information/material for home's specific need and use, a ***compact disc (CD)*** is also provided. The CD contains a complete set of collected tools, and mental health and responsive behaviour related materials, reports and other Resource Guides.

   Note: an Abbreviation List is developed and included in the appendix for your reference (Appendix 19).

2.0 KEY ELEMENTS

2.1 Long-term Care – Mental Health Framework

The LTC-MH Framework Steering Committee developed a framework to:

1) Focus on expanding and strengthening internal cultural capacity, knowledge and processes to better manage residents' responsive behaviours within the homes in a sensitive and timely fashion; and
2) Enhance a collaborative model with external resources to facilitate residents to receive appropriate services along the care continuum.

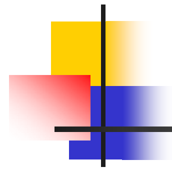
The framework calls upon all key care providers serving LTCH residents with serious mental health and/or severe responsive behaviours to work together, to improve coordination, collaboration, timeliness, responsiveness, and to expand options for the LTCH to access assistance.

The re-designed system describes roles and processes starting from seniors in the community applying to CCAC for LTCH placement, to ongoing management of residents with responsive or challenging behaviours within the LTCH, to emergency management and the transfer of residents to and from a LTCH to other care settings across the care continuum.

The key success factors for the LTC-MH framework to effect a system change are:

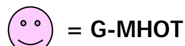
- ***integration*** of available resources,
- promotion and use of ***best practices***,
- ***clear roles and responsibilities*** of care providers, and
- utilization of ***existing resources*** by reconfiguration and re-design.

LTC-MH Framework – Toronto Region

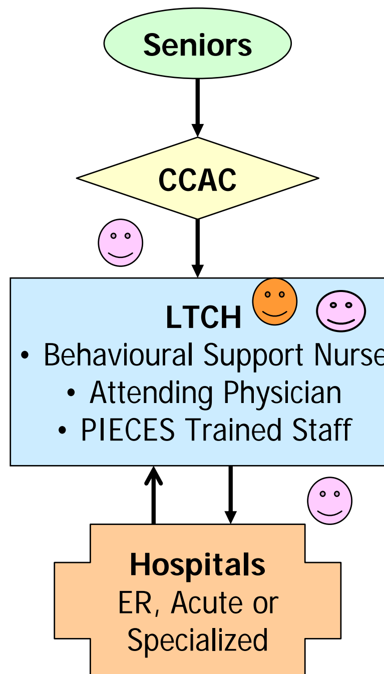


Framework Elements

- Integrated
- Best Practice based
- Clear Roles & Responsibilities
- Use existing resources
- Emphasis on LTCH responsibility


= G-MHOT

= PRC



Resources

- In-patient psychiatric units
- G-MH Outreach Team
- COTA G-MH Team
- St. Elizabeth Health Services
- G-Psychiatrists & Independent Practitioners

- G-MHOT 8am-8pm emergency consultation
- G-MHOT regular consultation
- PRC
- G-Psychiatrists & Independent Practitioners
- Toronto Police Service
- EMS
- MOHTLC HINF & Compliance Advisor

2.2 Care Philosophy

The LTC-MH Framework encourages Long-term Care Homes to endorse a care philosophy that promotes an environment where all care providers recognize that **ALL BEHAVIOURS HAVE MEANING**. Such a philosophy that:

- recognizes individualized person-centered care including the consideration of culture, ethnicity, race, gender, spiritual needs and sexual orientation;

- respects equity, social justice, culture, relationships and personal dignity (Government of Canada, 2005);

- integrates care for biological, psychological and social needs;

- includes principles of psychosocial rehabilitation to maximize quality of life;

- shifts the primary focus from tasks to relationship – creates a supportive and assistive social and physical environment and be responsive to residents' changing needs to maintain function and or compensate for functional decline;

- promotes preventive intervention to maintain wellness and early interventions;

- engages the whole inter-disciplinary care team to provide behavioural support;

- focuses care on the overall well-being and the quality of life of the resident that include the aspects of ADLs and symptom/disease management.

A few **Key Principles** underpin the care philosophy/model described above and must be realized in practice. They are:

- Know the person
- Offer choice and control
- Understand the principles for general care
- Provide culturally responsive care
- Adapt the environment
- Involve families/partners/significant others

The following further elaborates on each of these **key principles** regarding behavioural support with concrete examples:

- ***Know the person*:** (Kitwood, 1997) By knowing the person, staff can better understand the presenting behaviour (***all behaviours have meaning***). For many residents, their behaviour presentation may be an expression of unmet needs – triggers (Talerico & Evans, 2000; Smith & Buckwalter, 2005). Residents who have limitations in their ability to communicate and make their basic needs known require staff to determine the meaning behind the behaviour.

Mrs. B., 85-year old lady, wanders the unit every afternoon starting at 3pm and gets very anxious. A staff member re-directs her and spends 1:1 time with her talking informally and in a supportive manner in order to determine the reason for her anxiety. Mrs. B. has regressed to when her children were young and she prepared for their return from school, as per her daily routine. The staff member assures her that her children are safe and talks to her about her family and the happy memories she has. This re-assurance distracts her, allows the staff members to redirect and encourage her to participate in other activities. Knowing and respecting the resident's past history and routine helps in managing anxiety and present behaviour.

- ***Offer choice and control*** based on the person's existing abilities. Alter pace of care by recognizing the person's rhythm and adapting to it. Assist the resident to experience a sense of control and meaning by offering choice whenever possible with all aspects of activities of daily living (i.e. when to have a bath, what to wear, what to eat).

Mrs. S. has a left below-the-knee amputation. She has mild cognitive impairment and limited ability in self-care. However, she is a proud woman, wants to do her own activities of daily living. She likes to have a bath instead of a shower – and she always took her bath in the evening when she lived at home. She likes to wear dresses instead of pants.
She becomes easily agitated and argumentative when staff "do for her" without asking or involving her in choice. A number of the staff prefer to do all care themselves – the unit is very busy and they say it is quicker to do all of the personal care for her and it "gets done better and faster". Mrs. S. wants to do some of the care herself. She wants more choice.
After a team conference, all staff realize the preference of Mrs. S. and respect her choice.

- ***Understand the principles for general Care*****:** Often non-verbal behaviours/expressions, such as agitation, restlessness, aggression and combativeness are due to *unmet physical needs (triggers)*; e.g. hunger, thirst, pain or toileting needs. Care providers must try to identify when this is the case and address unmet needs. Therefore, a clinical assessment should be done to rule out an underlining medical problem. This assessment will prevent and minimize behavioural symptoms that are a reflection of unmet needs/clinical problems.

Mr. R. became restless and refused to eat a day ago. Today, he still does not have an appetite and appears to be even more agitated. The PSW observed this behaviour – it is quite different for Mr. R. She reports her observations to the RN. An assessment is done and the RN determines that Mr. R. has not had a bowel movement for a number of days. After treatment to eliminate his constipation, his behaviour returns to the less agitated, usual state.

- ***Provide culturally responsive care***: Care provided should respect and honour residents' and families' cultural backgrounds, ethnicity, values and health beliefs. To support this principle in care, staff of the care team should be provided with cultural competency education with a specific focus on diverse views on aging, cross cultural communication, and skills in discussing resident/family practices and traditions (Srivastava, 2007). The only way that people with dementia can make sense of the "present" is by connecting with the form that occurred in the past. If staff do not understand the resident's cultural background and experiences and how they might relate the current behaviour, they will not be successful in providing care. For example, entering a washroom and using a century tub might trigger memories of experiences in a concentration camp for a Jewish resident; hearing loud voices through the PA system might trigger memories of the war and internment camp for a Japanese resident; telling a gay male that he cannot close the door of his room might bring back memories and fears of gay-bashing and discrimination.

An applicant who has undergone a partial gender reassignment has been accepted for admission to your home. Before the day of admission, the nurse manager and social worker met with the future resident's family while the registered nurse and the recreation person met with the resident and his partner to determine their needs and how the home could best respond. The applicant is severely cognitively impaired, but recognizes that his partner is a loving way to him. Before and after admission, information/education sessions on Lesbian, Gay, Bisexual and Transgender (LGBT) issues were provided for other staff.

Ina, the PSW caring for Mr. C., asked to have his bath day changed from Saturday morning to Friday morning to honour his Jewish beliefs and values. Although cognitively impaired, Mr. C. demonstrates an understanding of his religious traditions and is less agitated when care routines reflect these traditions.

- ***Adapt the environment*** positively impacts residents. An environment that is familiar and homelike will assist in decreasing behavioural symptoms and increase feelings of security and safety. Environments with excessive stimulation and/or lack of orientating cues may increase behavioural symptoms. It is important to consider how the environment influences residents and to identify ways to create a balance between environmental stimulation and the resident's tolerance (Dawson et al., 1993). The LCTH may facilitate environments that are enabling by the use of familiar home-like settings and consistent staffing.

Ms. T. is a 65-yr. old, single lady who resided on a quiet area of a small unit in a home, and developed a relationship with a male resident. She displayed inappropriate behaviour. The male resident and both families were upset. This behaviour was unusual for her and her family was very shocked; her SDM asked that she be moved to another unit. Immediately on transfer, the behaviour disappeared. An environmental change impacted her inappropriateness. Her SDM and the team think that she may have been bored and created an activity for herself. Now, there are more stimuli where she is living. She is busily occupied and can better relate to her past living habits.

- ***Involve families/partners/significant others*** to the extent that they wish to and are able to participate, and as appropriate to the resident's wishes/needs. Provide families with both education and support to deal with feelings and stressors.

Mrs. Y. (diagnosis: Alzheimer Disease) was admitted to the home accompanied by her daughter who has devoted the last 20 years in caring for her mother. The daughter told a staff member on the admission day that her mother enjoyed certain routines - a bubble bath, a warm bath robe, her apple-scented shampoo in evening before going to bed. The care plan was developed accordingly to include these preferences of the resident. Furthermore, her daughter was encouraged to be present during the bath time of her mother if she so wished.

3.0 PROCESS

It requires a concerted effort to integrate all supporting strategies to build an effective behavioural support system. This section of the Guide elaborates on the processes and approaches for a LTCH to implement strategies for

- building and expanding its capability to manage residents' behaviour issues, and
- enhancing relationship and collaboration with partners to achieve outcomes.

3.1 Implement and Nurture a Behavioural Support Culture

Though LTCHs may vary in size, appearance and governance model, once a home is determined to adopt and nourish the behavioural support care philosophy, it requires leadership to foster an enabling atmosphere by:

- Enhancing Policies & Procedures specific to behaviour care,
- Preparing a home environment (both physical and social) to support the behavioural care model,
- Promoting behaviour care education and knowledge transfer to the whole interdisciplinary care team,
- Implementing a Quality Management Program to evaluate behaviour care performance,
- Encouraging relationship building and collaboration with partners,
- Identifying and facilitating human resource needs for the behavioural support care model, and
- Do not forget ***change management***. Changes take time. Both patience and re-enforcement are important for a team to embrace any changes.

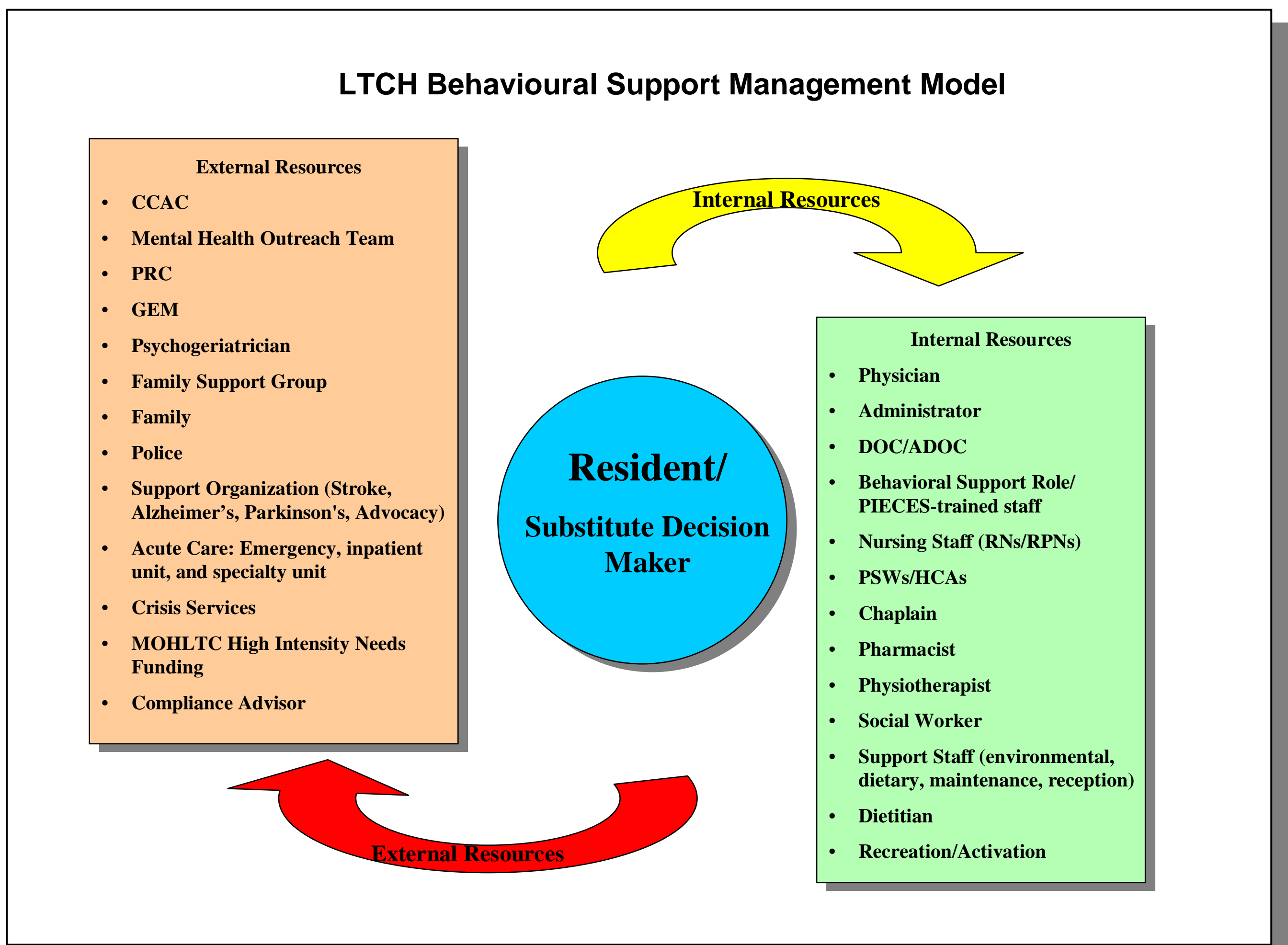
For reference, a comprehensive behavioural support culture checklist was developed and is included in the appendix (Appendix 1). The list can be used when a LTCH decides to endorse and establish the behavioural support care model. It will also be a useful tool for a LTCH to measure strengths and weaknesses on an ongoing basis to ensure sustainability of the care model.

3.2 Adopt the Behavioural Support Model

The Behavioural Support Model emphasizes that the **resident is the center of care delivery.** It identifies and asks for the LTCH to coordinate internal and external resources to support the management of residents with mental illness and behavioural issues.

Items categorized in the model diagram below under both columns of internal and external resources are not meant to be a comprehensive list. It is recognized that there are differences in LTCHs' staffing structure and organization. Similarly, external resources vary geographically in service delivery approach and staffing complement. Each LTCH should make use of existing internal and external resources to create an effective model.

Within a LTCH, the behavioural support model can be achieved by engaging the whole in-house interdisciplinary team that includes a team lead and or the designated behavioural support role to support the behaviour care delivery covers 24 hours, if possible.



3.3 Understand the Roles and Responsibilities of the Interdisciplinary Behavioural Support Team

The “internal” and “external” resources mentioned in the behavioural support model must work effectively together to serve residents with behavioural issues. Clear understanding of each care provider’s role and responsibilities will help to improve communication and to promote a interdisciplinary team working complementarily with each other.

The LTC-MH Framework Report has described in detail the roles and responsibilities of each of these partners providing care to residents with behavioural issues. The following summarizes the responsibilities of a few key care providers for quick reference:

LTCH

- To explore, implement and evaluate appropriate treatment options for residents with mental health and responsive behaviours in collaboration with other practitioners in the system;
- To identify and effectively utilize the internal designated behavioural support role and or PIECES trained staff to coordinate, liaise and manage behavioural issues within the home;
- To collaborate with external resources to provide appropriate care to residents with behavioural issues facilitated by the behavioural support role
- To establish priorities and clear processes based on urgency of need for referrals for crises interventions and or hospital transfer;
- To respond to urgent situations using a pre-determined, risk-based approach;
- To promote behavioural support knowledge and skill education/training to staff.

CCAC

- To assess and determine eligibility for LTCH applicants with behavioural issues.
- To ensure collected applicant’s information reflects the applicant’s existing behavioural response issues that will assist LTCHs in:
  - decision-making re acceptance of an applicant,
  - developing and on-going management plan if the applicant is accepted
- To provide on-going information to the LTCH on the status of applicants with mental illness and related behavioural response issues who are on the LTCH waitlist;
- To participate with geriatric mental health outreach teams and LTCH staff in a pre-admission review of applicants with known mental illness and related behavioural issues to assist with the applicant’s transition to the LTCH.

Geriatric-Mental Health Outreach team (G-MHOT)

- To provide consultation and assistance to LTCHs and the LTCHs' attending physicians for residents identified prior to admission, as having known behavioural issues to successfully integrate into the home and minimize related risks;
- To provide consultation to LTCHs and the LTCHs' attending physicians regarding seniors not responding to interventions provided by the LTCH, and/or approved for High Intensity Needs Funding program supplementary staffing. This includes assessment, treatment, follow-up, and referral/access to other services for the resident as needed, as well as education for LTCH staff related to their clinical consultation;
- To consider the LTCH Behavioural Support Decision Tree to support in facilitating appropriate treatment in the Event of Emergencies, after the LTCH completes the internal process;
- To serve as the LINK/liaison for the LTCH and the Hospital Emergency and inpatient/specialty units;
- To facilitate admissions to specialized geriatric mental health/behavioural management programs;
- To develop relationships with Emergency Departments, and relationships/partnerships with specialized hospital programs and in-patient units (to the extent possible) to facilitate required transfer of residents to the most appropriate care setting; and
- To work with the LTCH attending physician to facilitate a resident's discharge back to his or her LTCH.

Psychogeriatric Resources Consultant

- To provide education and knowledge to practice regarding the care of seniors with dementia and other mental heath issues to staff in LTCHs, CCACs and other programs;
- To provide provincial curriculum training: PIECES, U-First, and Enabler training: traditional topic and case-based education.

Toronto Police Service

TPS is often involved when a LTCH resident becomes violent, uncontrolled or wanders and/or when a Form 1 is used for a resident. It is important to ensure that Toronto Police Service is able to provide the most appropriate response in each situation. In most cases, this includes diversion of the senior with serious mental health with related behavioural issues from the justice system to the mental health system.

3.4 Build Relationship with Key Partners

Community Care Assess Center, Psychogeriatric Resources Consultant
Geriatric-Mental Health Outreach Team, Crisis Team, Police,
Compliance Advisor, Emergency Management Service,
Emergency Department, Acute-care Hospital,
Specialty Hospital, and
Other solo practitioners – psychiatrists, geriatricians

The LTC-MH Framework emphasizes integrating and enabling a collaborative model. It calls upon LTCHs to work with their partners. The LTC-MH Framework Report was distributed to all LTCHs in the Toronto Region. Likewise, it was also circulated and promoted to the above listed groups of external resources. Positively, the framework garnered an extensive support and willingness among these stakeholders. The LTCH is encouraged to extend their working circle to include these external resources in serving seniors with responsive behavioural, prior to a behavioural crisis occurring.

> **Building Relationships is one key element to make the LTC-MH framework successful. You should call your partners and strategize with them about processes, protocols, communication methods and documentation approach (follow the why, what, who, when and how approach).**

It is worthwhile to work out a process and build a good working relationship with your partners in advance. When an incident of responsive behaviour happens at your home, the team will then be able to quickly engage with your partners to deal with the situation in an organized and timely manner with confidence.

Furthermore, you will find it handy, particularly under crisis circumstances, if the contact information of your working partners is available at the finger tips of your care team.

- ***Do you know all your key partners?***
- ***Do you have the most up-to-date contact information of your partners including HINF contact?***
- ***Have you discussed with your partners your internal process and worked with them to develop a cooperative protocol?***

In the appendix, you will find information of

- The Toronto Police Community Mobilization Unit Contact List (Appendix 2),
- Toronto Mental Health Crisis Services Contact Information (Appendix 3), and
- A template for "External Resources Contact Information" (Appendix 4).
  LTCH should complete information on this template and maintain the list with the most updated information.

3.5 Implement the Behavioural Management Decision Tree

Dealing with an unknown and unexpected crisis in a LTCH is difficult to manage without preparation. It exhausts resources, drains physical and emotional efforts and can result with a disastrous outcome for both residents and care providers. LTCH should take on a proactive approach to mitigate these adverse effects and turn these types of situations and outcomes around.

There is an increase in seniors with responsive behaviours and the need for behavioural support care is increasing. LTCHs should bravely acknowledge the challenge of **"All Behaviours Have Meaning"** to pre-plan and prepare the care team to confidently manage residents' behavioural situations. Thus, identifying triggers, making decision at the right time, developing protocols to address different levels of risk and activating the appropriate actions of the multidisciplinary team are critical.

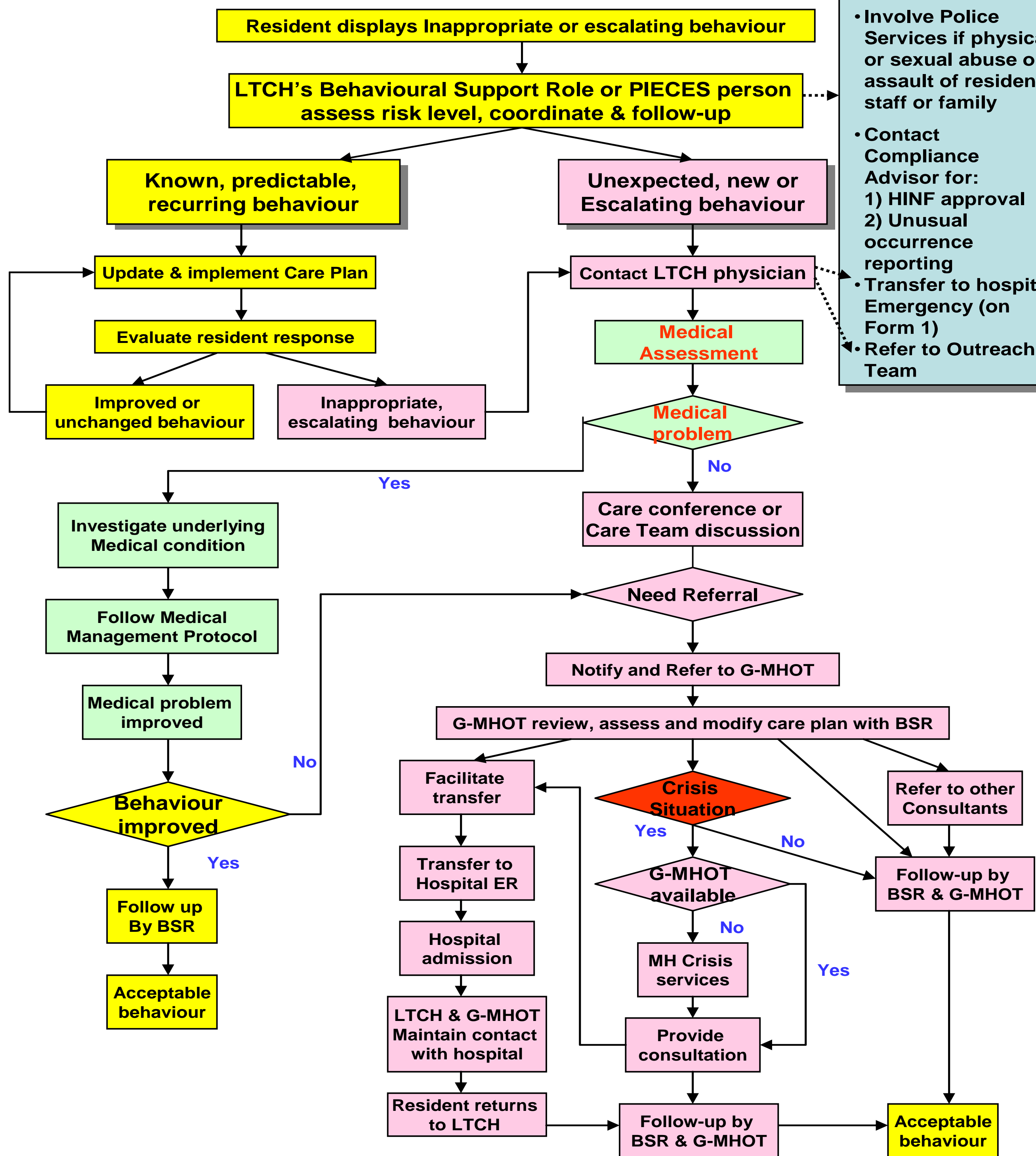
The LTC-MH Steering Committee has developed a behavioural management decision tree. It highlights ***key triggers and steps*** to manage behavioural issues within the home (CD item #4).

Seniors experiencing behavioural issues do better in a familiar environment with the least disruption. Therefore, LTCHs should attempt to keep the seniors at the LTCH as appropriate. LTCHs can consider mobilizing resources to come into the home to provide assessment and treatment needs prior to transferring residents out of the home. The decision tree follows this care principle and uses a "scenario" approach to develop a flow to support the LTCH care team in making decision at the right time to manage both routine and challenging/at risk behavioural situations.

Following the Decision Tree, it is a behavioural support matrix table that precisely condenses actions to manage known, predictable to unexpected, new or escalating behaviours at different stages of care for residents with behavioural issues. ***The matrix table with a simple crisis management process flow intends to serve as a quick reference*** for the front-line staff. LTCH may consider laminating this table to post at the nursing station for convenience of the care team.

Many of the action items described in the behavioural support matrix table are discussed in details in other areas of this Guide. A simple quick reference is also collected to support front-line staffs to work with residents with responsive behaviour. It is a quick reminder to prepare the mind set of staff to serve behavioural residents (Appendix 5).

As for the various assessment tools mentioned in the table, they can be found in the PIECES Manual and in the 3D's: Delirium, Depression, Dementia Resource Guide (CD collection item #6).


Responsive Behaviours Decision Tree
Resident displays Inappropriate or escalating behaviour
LTCH's Behavioural Support Role or PIECES person assess risk level, coordinate & follow-up
As warranted:
• Involve Police Services if physical or sexual abuse or assault of resident, staff or family
• Contact Compliance Advisor for: 1) HINF approval 2) Unusual occurrence reporting
• Transfer to hospital Emergency (on Form 1)
• Refer to Outreach Team
Known, predictable, recurring behaviour
Unexpected, new or Escalating behaviour
Update & implement Care Plan
Evaluate resident response
Improved or unchanged behaviour
Inappropriate, escalating behaviour
Contact LTCH physician
Medical Assessment
Medical problem
Yes
No
Investigate underlying Medical condition
Follow Medical Management Protocol
Medical problem improved
Behaviour improved
No
Yes
Follow up By BSR
Acceptable behaviour
Care conference or Care Team discussion
Need Referral
Notify and Refer to G-MHOT
G-MHOT review, assess and modify care plan with BSR
Facilitate transfer
Transfer to Hospital ER
Hospital admission
LTCH & G-MHOT Maintain contact with hospital
Resident returns to LTCH
Crisis Situation
Yes
No
G-MHOT available
No
Yes
MH Crisis services
Provide consultation
Follow-up by BSR & G-MHOT
Refer to other Consultants
Follow-up by BSR & G-MHOT
Acceptable behaviour

3.6 Apply the Behavioural Support Matrix

	BEHAVIOURS	
	Known, Predictable ------------------------	**----- Unexpected, New or Escalating**
Community Care Access Centre (CCAC)	• Completes MDS/RAI • Face-to-face interview - behavioural assessment • Follow up triggers – mental health, psychiatric diagnosis • Flags potentially problematic applicants • Reviews clinical and mental health history • Reviews medications • Determines issues relating to culture/ language	**Follows process as indicated in "Known, Predictable" plus steps below:** • **Involves LTCH with G-Mental Health Team and or Psychogeriatric Resource Consultants (PRC)** • **Involves LTCH Medical Director** • **Conducts pre-admission meeting with G-MHOT**
LTC Home Review of the Application	• Determines if resident's needs can be met within the long term care environment	• Reviews and ask for detailed information as needed • Involves LTCH Physicians and Outreach Team for the complex application
Behavioural Assessment Process at LTCH	• Determines behaviours that are habitual and develops appropriate intervention plan • Develops individualize care plan based on identified triggers by asking questions such as: ➢ **How do you respond to anger and** ➢ **How do you deal with conflict?** • Ongoing monitoring of behaviour and level of risk • Identifies behaviour change and level of risk • Completes Standardized Assessments (clinical and mental health) • Arranges for an interdisciplinary care conferencing Asks questions (see PIECES - three-questions templates): ➢ **What has changed?** ➢ **What are the RISKS and possible causes?** ➢ **What is the action?**	**Behaviours (e.g., History of Assault, Suicide, Injury to Self or Others, Acute Personality Disorders, Addictions, Physical Aggression)** **Follows process as indicated in "Known, Predictable" plus steps below:** • Determines level of risk and safety issues (residents, staff and others) • Implements strategies to address behaviours • Mobilizes and meet with in-home* and external** resources • **Considers the eligibility to apply for HINF** • Educates family/SDM on care processes • Monitors and records accurately all behaviours, and communicate at shift report • Be flexible and change care as needs present • Determines education needs of staff and involve PRC
Ongoing Management at LTCH	• Ongoing monitoring and recording of behaviours by all staff • Reports any changes in behaviour to registered nursing staff • Involve other disciplines in care (e.g., recreation for activities) • Determines education needs of staff and involve PRC • Documents and shares behaviour triggers and interventions with team	**Follows ongoing management as indicated in "Known, Predictable" plus steps below:** • Completes further clinical and mental assessments as required and implement strategies based on team decision • Reviews of behaviours by Behavioural Support Role (BSR) or RN/RPN/PIECES RN • Reviews of regular and **PRN** medications • Maintains family involvement • Have ethical and social support available for staff as needed
Crisis Management at LTCH	• **Involves BSR and Medical Director/attending physician** • **Address safety issues** ➢ Safe environment ➢ One-to-one staffing (apply High Intensity Needs Funding) • **Seeks guidance from in-home* and external** resources** • **Contact G-MHOT, if not available contact MH Crisis Service** • **Monitors, accurately record behaviours, and communicate at shift report** • **Transfers to hospital acute and/or specialty unit based on need** • **Utilizes Form 1 when appropriate** • **Conducts staff debriefing**	

<table>
<tr><td></td><td colspan="2">BEHAVIOURS</td></tr>
<tr><td></td><td>Known, Predictable ------------------------</td><td>----- Unexpected, New or Escalating</td></tr>
<tr><td>Resources Available for Care</td><td colspan="2">*In-home: Interdisciplinary team that includes Medical Director, attending physician, LTCH Administrator, Director of Care, PIECES Trained Staff/ Behavioural Support Role, Nursing Staff (RNs/RPNs), PSWs/HCAs, Chaplain, Pharmacist, Physiotherapist & Occupational Therapist, Support Front-Line Staff (Dietary, Environmental Services, Maintenance, Reception Staff), Social Worker, Dietitian, Recreation/Activation Staff, Family/Substitute Decision Maker/ Significant Others

**External: Community Care Access Centre (CCAC),
Geriatric - Mental Health Outreach Team (G-MHOT)
Psychogeriatric Resource Consultant (PRC),
Geriatric Mental Health Psychiatrist, Geriatrician,
Mobile Mental Health Crisis Services
Police (Crime Prevention and Community Relation),
Emergency Management System (EMS),
Hospital that includes Emergency Department and Acute Care/Behavioural Specialty Units,
MOHLTC High Intensity Needs Funding,
Compliance Advisor,
Community Family Physician,
Family Support Groups and other External Support Organizations</td></tr>
<tr><td>Mental Health Assessment Tools

(Examples)</td><td colspan="2">Dementia Cognition: Mini-Mental Status Examination (MMSE), Clock, Moca
Delirium: Confusion Assessment Method (CAM)
Depression: Geriatric Depression Scale (GDS), SIG E CAPS, Cornell Depression Scale,
Agitation: Cohen-Mansfield Agitation Inventory (CMAI)

(See appendix 6-12)</td></tr>
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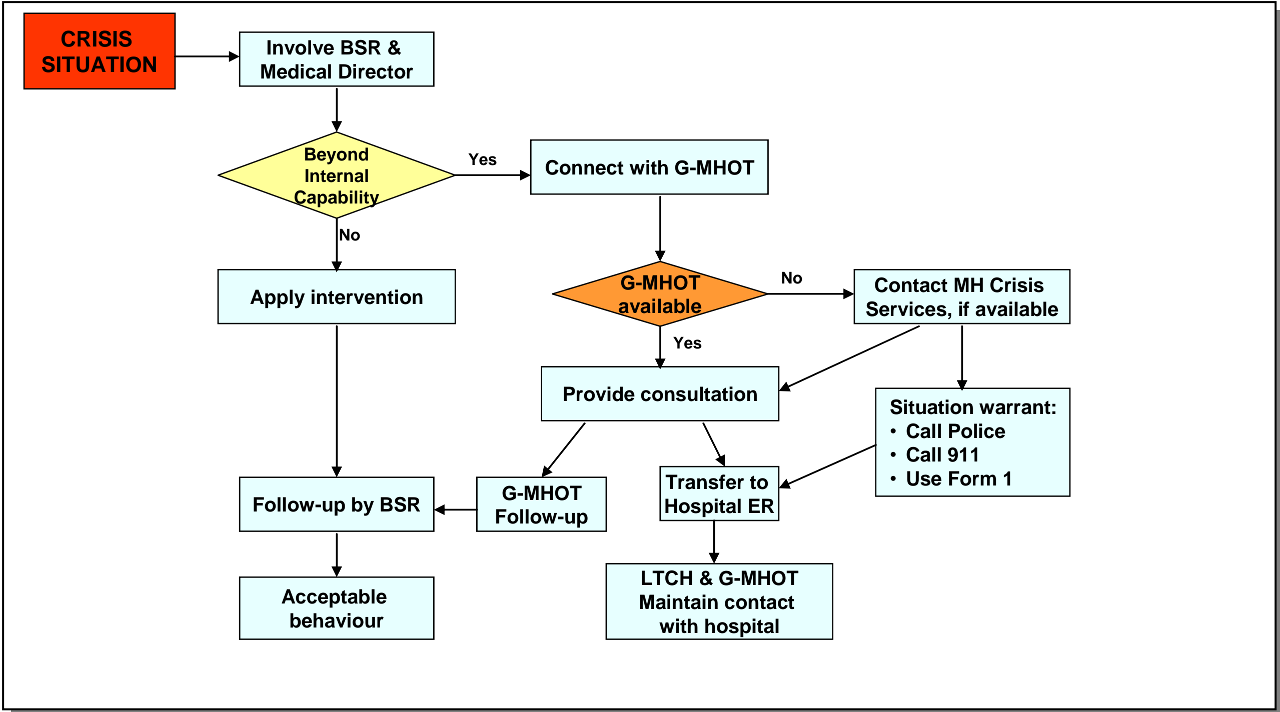
CRISIS MANAGEMENT FLOW



3.7 Connect with the Geriatric- Mental Health Outreach Team (G - MHOT)

The MOHLTC realigned the G-MHOT with LTCHs in July 2006 and provided with additional funding to expand their services. This new Accord funding (05/06) was the "backbone" of the plan that allowed the MOHLTC Toronto Region Office to formally align each LTCH with a G-MHOT and expand and improve the timely response from G-MHOTs to mental health issues that arise in LTCHs.

Each Geriatric Mental Health Outreach Team consists of a psychiatrist and at least one expert practitioner, e.g. registered nurse, social worker or occupational therapist. The roles and responsibilities of a G-MHOT to a LTCH include providing services to manage severe behavioural residents at the points of:

1. pre-admission
2. regular ongoing consultation,
3. in the event of an emergency, and
4. resident transfer to hospital as required

The G-MHOT is an excellent resource to support LTCH to manage severe mental health and severe behavioural issues. LTCH should tap onto this resource until internal capability is established. Even after expanding internal capacity, the G-MHOT has significantly more expertise than any LTCH and should be used as a referral for challenging situations.

The following provides a quick reference for a LTCH to "get connected" and establish an effective on-going process/protocol to work collaboratively with the aligned G-MHOT.

When	What	How
Pre-admission	***Review*** applicant with mental health or severe behavioural issues	• Involve the BSR/PIECES-trained staff • ***Involve G-MHOT with CCAC to conduct a pre-admission meeting*** • Involve Medical Director • Carefully review application information, focus on behaviour triggers • Identify behavioural issues • Request all PERTINENT behavioural information if not adequate or complete • Ask the CCAC to consider visiting or re-visiting the applicant (to re-assess as required) • Encourage family to tour the LTCH • Engage the family in pre-admission planning, • Negotiate the involvement of family in admission day and ongoing support to assist with transition

When	What	How
	Accept applicant with mental health or severe behavioural issues	• LTCH admission Team/BSR/PIECES-trained staff meet with G-MHOT to ***develop care plan and interventions to transition the applicant*** • Consider all identified issues related to environmental and/or personal safety • Consider other possible external resources, e.g. psychiatrist, PRC • If the applicant presents considerable RISK to other residents and this risk cannot be mitigated and controlled, consider ***REJECTING THE APPLICATION; if you reject the application for a LEGITIMATE safety reason, be prepared to collaborate with the CCAC and G-MHOT to suggest other options*** • Communicate the care plan and interventions with the LTCH interdisciplinary team including the Medical Director/attending physician, consulting therapist(s) and pharmacist • If the application is approved, work with CCAC, G-MHOT and family to prepare the home environment to install familiar items in the resident's room • Communicate with the Compliance Advisor if warranted • Apply for HINF, if appropriate, based on the results of the pre-admission and admission assessment, and/or at any time throughout the resident's stay in the home **The key is to prepare ahead and be proactive**
Regular Consultation	New admission	• Conduct ***Behavioural Assessment immediately*** (e.g. within 8 hrs – a suggestion – following admission) by BSR/PIECES-trained staff • Plan and complete ongoing monitoring and documentation (more frequent at the beginning, e.g. every 15-30 min) • ***Update G-MHOT*** on mutually agreed time interval and communication mechanism, e.g. daily/every two days/weekly by phone or follow-up visit, etc. • Contact other external resources as required, e.g. psychiatrist, PRC • ***Establish regular G-MHOT weekly visit/clinic to take on new referral(s) and follow-up on existing referral cases*** • Involve the G-MHOT and family in care planning and care conferencing as appropriate

When	What	How
	New or Escalating behaviours	• After review and assessment performed by BSR/PIECES-trained staff, collect all pertinent information and ***refer to G-MHOT*** - ***Do you have an established protocol for this type of referral?*** - ***Do you have an established documentation process/charts/forms to relate and refer information to G-MHOT?*** - ***Have you set up a regular visiting schedule with the G-MHOT?*** • Contact the G-MHOT with details of the reason for referral, including the presenting behaviour(s) and the risk factors to the referred resident and others; determine and negotiate the anticipated G-MHOT response time • If the suggested response time is not timely to mitigate the assessed risk (1) negotiate with the G-MHOT and clearly advise the G-MHOT of the risk; (2) ask to speak to someone else on the G-MHOT to determine if more timely response is possible; (3) consider consulting via phone with the G-MHOT regarding possible strategies that the LTCH has not yet considered • Contact the LTCH Administrator/designate and Medical Director for advice throughout the process
	G-MHOT not available, e.g. after hours	• Consult the medical director • ***Leave G-MHOT a message re: situation and actions*** • Call MH-Crisis team in your area for assistance • ***Activate established crisis management procedure*** • Call 911, if situation warrants • Use Form 1, if situation warrants - ***Do you have an established crisis procedure?*** > ***Who is in-charge?*** > ***Who to contact at when?*** > ***How to do it? e.g. by phone*** > ***What information to relate?*** - ***Do you have the contact information handy?***

When	What	How
Hospital Transfer	Unexpected crisis behaviour	• Medical and behavioural assessment • ***Involve BSR and Medical Director*** • ***Refer and phone G-MHOT*** for assistance • Based on assessment results and assessed risk(s), work with G-MHOT to determine and facilitate new interventions and/or hospital transfer as appropriate • Advise Toronto Police Service as per the LTCH crisis management procedure • Advise EMS as per the LTCH crisis management procedure • Advise EMS of the facts of the impending crisis transfer • Collect all pertinent, relevant information for transfer to hospital Emergency or other settings • When/if time permits, call the receiving hospital (if EMS can verify offload location) to advise of risk factors • ***If case of G-MHOT not available, proceed with alternative, e.g. crisis team or Form 1. Leave a message for G-MHOT regarding this transfer for the G-MHOT to follow-up with both the home and Emergency Department (ED).*** - ***Do you have a check-out list of information to send with the resident to Emergency Department?*** - ***Have you established a mutual agreeable protocol with G-MHOT to manage hospital transfer?***

As described above, it is absolutely critical to have a mutually agreeable protocol developed in advance to guide both LTCH and aligned G-MHOT to manage severe behavioural issues and at crisis situations. The above description is summarized in a flowchart format for your reference (Appendix 13). There are a few samples of protocol collected in the appendix (Appendices 14 - 16) as a reference for home to consider and adopt. They include:

- A Behavioural Management using internal and external resources policy and procedure
- Internal Behavioural Support Management Check List
- PIECES Admission Referral Form

3.8 Establish the Behavioural Support Role (BSR)

To serve residents with behavioural issues requires specialized knowledge, patience, and flexibility from LTCH staff. Residents experiencing serious mental illness and related behaviours need to be evaluated and monitored through comprehensive assessment and ***ongoing*** follow up. The PIECES-trained staff or the Behavioural Support Role person should initiate the assessment and, based on the complexity of the case and the internal capacity of the team, consult with the relevant external specialized resources. The team needs to collaborate and develop individualized behavioural interventions and care plan to address the underlying contributing factors to the behaviour.

Each LTCH should also assess their past experience in the management of responsive behaviours, the number of residents with mental health and/or issues in responsive and/or unpredictable behaviours currently residing in the home and the LTCH's staff's level of knowledge and expertise. Based on the outcome of this overall assessment, the LTCH should then contact their aligned mental health outreach team and PRC to jointly develop a plan to deal with current and future needs.

The Framework recommends each LTCH considers utilizing existing resources to create and maintain a Behavioural Support Role person. This role acts as an internal resource for in-house staff and provides a **LINK** between the geriatric mental outreach team, the PRC, other external consultants and the resident's unit.

The behavioural support role can be fulfilled by one person ***with alternate coverage*** or by up to a few individuals depending on the size of the LTCH. The approach for this role arrangement can be similar to designating a staff at a home to take on pain management or infection prevention and control. A detailed description of the roles and responsibilities is attached for your reference (Appendix 17).

In general, this role involves the following key functions:

1. Consultation to the care team,
2. Teaching and support to the care team regarding responsive behavioural management,
3. Case Management, particularly on the high risk situations,
4. Interdisciplinary collaboration of all care providers within and outside the facility, and
5. Liaison with external consultants and ensuring follow-up.

3.9 Practice Supportive Verbal and Non-Verbal Communication

Communicating with a person with dementia can be a difficult and emotionally overwhelming activity. Often, the “person behind the dementia” is not represented the behaviours presented to be seen. The following simple “tips and tools” will help to have more successful interactions with dementia residents and ease the person’s anxiety.

Often, in the early stages of dementia, people have a hard time finding the right words to express their thoughts – or may be unable to remember the meaning of simple words or phrases. The later stages may be much more difficult – language skills may be quite impaired, resulting in nonsensical or garbled statement that are hard for you to understand. When the person cannot comprehend what is being said or cannot find the words to express their own thoughts, it can be painful, frustrating and embarrassing for everyone.

Cognitive thought is the message system in our brain that gives us the ability to process new information and act on it, store information (memory), create, problem-solve systematically in order to guide our actions and behave in a socially acceptable manner. Cognitive thought occurs through a complicated network of nerves in the brain which transmit thought messages from one nerve to the next. It is believed that individuals with cognitive impairment have certain neurotransmitters that are not working effectively, which leads to behaviours and responses that require special approaches.

If a person with cognitive impairment perceives that an action is not understood or might cause harm, he/she will likely resist, in an attempt to protect him/herself. It is a natural reaction. He/she may react and strike out, either verbally or physically, in an attempt to regain control of his/her environment.

Staff and family members interacting with residents with dementia provide the key to residents achieving a sense of well being and comfort. To respect and support residents, staff and family members need to use caring communication and gentle approaches. This will help to minimize emotional and psychological discomfort and manage safety. Try these approaches to set the tone and **improve communication:**

Remember to introduce yourself. Maintain a calm re-assuring voice. Communicate at the person’s level, but speak with respect. Because word recall is difficult for some residents, use paralanguage (i.e. volume and tone of voice, rate of speech).

Smile People with dementia are often extremely aware of non-verbal signals such as facial expression, body tension and mood. If you are tense or a bit “bossy”, the person is likely to become resistive, anxious or annoyed. Are you prone to frowning? Make a concerted effort to smile before you go to see the resident.

Use a calm, gentle approach. You set the mood for the interaction – your warm smile and relaxed manner will put the resident at ease and will help achieve a positive visit. Often, it is contagious and the resident will be happier too.

Use humour. Humour or gentle teasing often helps. Use a non-demanding approach, using humour, cajoling and cheerfulness.

Go at his/her pace. People with dementia often need more time than us to respond. Use slow, gentle motions. Approach the person from the front before speaking. Make sure that you have his/her attention – use gentle touch. Give him as much time as needed to respond.

Begin conversations socially. Winning trust can make a task much simpler. When approaching, spend a few minutes chatting about the weather, a familiar family member – or find a way to acknowledge what the person is holding in his/her hand: "That's a lovely purse you are holding!" or give a sincere compliment: "Your dress is a very nice colour". Then invite the person to come with you or engage in whatever task you need to get done…and remember to use a quiet voice and lots of smiles.

Explain what you are going to do in a way that the resident understands. Use an unhurried manner; it is more reassuring. Address the resident by his/her preferred name, to gain his/her attention. Guide (do not control) resident's responses. Respect the resident's space; Remember – every person has his/her own defined "personal space" – comprised of a "public zone, a social zone, a personal zone and an intimate zone". If you do not understand the resident's personal space and/or if you use body language or movement unexpectedly, disastrous consequences may result. Use flexible care giving techniques – if the resident is not ready for the care or service intervention, you may need to retreat and try again later. Acknowledge the resident's feelings (e.g. you look frightened) and provide reassurance. Give directions within the resident's attention span.

Give instructions one at a time. Rather than saying "Come and have lunch – what do you want – are your hungry?" which is too much information for the person to absorb, try saying: "It's time for lunch!" (with enthusiasm); bring the resident to the table; pat the chair to provide a physical cue and sit down in the chair next to her.

Use a gentle touch. Sometimes a hug or a gentle touch can show that you care, even when words are not being understood. Say thank you and offer praise sincerely. We all like to know that we are appreciated.

Use pampering. We all like to be pampered – try a hand, shoulder or temple massage. Look through a picture book with your loved one, talking about memories. Explore a "treasure box" together. Give a manicure – put on make-up – comb her hair – do all of the things that you like for yourself!

Remember – he is responding to you. When the resident behaves in a way that you are unaccustomed to, remember that he/she is simply responding to things in the environment that he/she does not recognize or understand. The more you make your approach and the environment familiar to him/her, the more relaxed he/she will be.

If you are having trouble*……*Ask for help – do not hesitate to ask your colleagues for ideas – while something might not work for you, a colleague may have found an effective approach. The team learns together. A colleague may be able to tell you about an approach that worked last evening that might help today.

It is important to use these proactive techniques for communication in advance of a crisis – with the intent of avoiding the crisis. Below are some **effective "tips"** and "strategies" for ongoing care to manage behaviours:

- Provide meaningful encounters – as simple as a "hello" or compliment.
- Use consistent staff assignments.
- Use clear signage and cueing.
- Offer an environment that feels "comfortable".
- Respect and adopt cultural and ethnical rituals.
- Develop life stories or life panels.
- Identify behavioural "triggers" – know that these are varied (e.g. hunger, pain thirst, lack of social interaction, wrong approach by staff, visual, hearing).
- Use non-pharmacological interventions first.
- Acknowledge and accept a resident's experience and document and or report it.
- Use options for: privacy; "busy activities"; sufficient lighting; pleasant music; multiple opportunities to eat and drink (in various locations).
- Develop "points of interest" – e.g. fish tanks, textured tapestry.
- Develop and encourage staff and families to use "theme boxes".
- Decorate homelike tub and shower rooms.
- Use clothing that is easy for the resident – e.g. in toileting.
- Understand mobility and movement – encourage walking.
- De-emphasize the entrance/exit door of a secure unit.
- Provide opportunities for safe wandering 24/7.
- Avoid unnecessary noise – no PA system!
- Hold activities in a quiet room, free of distractions and with good lighting, temperature and comfort.
- Use approaches such as music and art therapy and complementary care – light massage, relaxation, and aromatherapy.
- Have "quiet time" – look at photos, letters, etc. and reminisce.
- Learn from the residents – past careers give cues regarding behaviors.
- Be flexible – respond to mood changes; develop skill in re-directing.
- Encourage to use remaining skills.
- Have specific "welcome" activities – but avoid overwhelming the new resident.
- Create a low-stimulus setting for rest periods and bed time.
- Provide substitutes for physical activities – e.g. rocking chairs.
- Promote a regular sleep-wake cycle – bedding, lighting, quiet.
- Make night-time activities available for those who need them.
- Pay attention to pain – e.g. mood changes, sighing, grimacing, moaning, slow movement and use a pain scale.

3.10 <u>Behavioural Management Education /Training and Knowledge Transfer</u>

Behavioural care delivery needs to be provided in a consistent and ongoing manner. It is important to build capacity to assess and intervene with the medical and physical needs and develop greater understanding regarding the interplay of physical illness on behavioural presentation. To build/expand team capacity, it requires education, mentoring and coaching to integrate new learning into practice.

Education/training is recognized as one important venue to upgrade knowledge and skill set for the care delivery team. It helps to promote common notion and approach to a destined goal for a vast group of care providers. However, it will not effect changes unless knowledge is transferred to practice by the whole care team.

When developing the “behavioural support” education program in a LTCH, the following aspects shall be considered:

- Take the opportunity to send registered staff to receive **PIECES** training.
- Incorporate the **U-First** program into the home’s education scheme for the care team including frontline staff.
- Various common disease processes and the PIECES and U-First program should be promoted to provide staff with knowledge about the different illnesses and a framework to guide the assessment and intervention process.
- An organized orientation and refresher program to periodically review established protocols regarding responsive behaviours management and working process with external partners in a timely manner should be re-enforced.

Besides PIECES and U-First, the followings resources are helpful in developing a comprehensive behavioural support program:

1. ***Dementia Education Needs Assessment***
   There are many tools available. Each has its strengths, focus, targeted audiences and forms of delivery. The LTCH should first take time to assess and determine what types of program the teams need, for what specific reasons/areas, and whether they are able to support and sustain the practice change.

   The OANHSS and OLTCA have just jointly issued a release on *Dementia Education Needs Assessment (DENA), 2007*. It will guide the home to prepare, select and organize its education program (CD collection item #4).

2. ***Education Programs***
   As suggested above, the OANHSS and OLTCA have also issued a document called *Dementia Training Available in Ontario, 2007* recently. It references dementia education program and offered a brief description of each program following a format that includes headings - keywords, outcomes, targeted learner, method of delivery format, teachers/trainers, length of training and contact information for each program. The LTCH should review these programs and based on the results from

the needs assessment, identify which programs would be the most useful for the teams and the home (CD collection item #4).

3. ***3D's: Delirium, Depression, Dementia Resource Guide, Jan 2007, Toronto Best Practice, LTC Initiative***
   This Resource Guide is developed by The Toronto Best Practice Implementation Steering Committee, LTC Initiative. It includes many useful behavioural management tables, charts and assessment tools. With permission from this Committee, some of these charts and tools are attached in the appendix for your information.

4. ***Fox Learning Program***
   The Fox Learning Program, FarSight Solutions for Long Term Care, is an interactive computer, web-based series of modules for long-term care home staff training. The modules incorporate a technique called InterDoc, which utilizes video-based presentations similar to that used in television documentary programs to deliver the educational content. It also tests staff trainees on the subjects being discussed with questions and interactive exercises. Trainees answers are recorded in a database and this database can be viewed by LTC Home Administrators and Directors of Care by using the Solutions for Long Term Care Administrator function.

   In 2006, the Ministry of Health and Long-Term Care, through the Centre for Addiction and Mental Health (CAMH), agreed to purchase 1-year site licenses from Fox Learning Systems, for all 85 LTC Homes within Toronto Region. The agreement included access to the following six modules, based on best practices, to help LTC staff manage resident behavioral response issues:

   1. The Aging Process
   2. Understanding Depression
   3. The Treatment of Depression
   4. Understanding Dementia and Alzheimer's Disease
   5. Working with Dementia
   6. Behavioral Management of Agitation and Aggression

   Refer to the appendix for detailed information regarding target audience and delivery method etc. (Appendix 18)

5. ***Web-learning opportunities***

   a. *The Canadian Coalition for Seniors' Mental Health issued National Guidelines for Seniors' Mental Health* that includes the assessment and treatment for "Delirium, Depression, Mental Health Issues in LTCH (focus on Mood & Behaviour Symptoms) Suicide Risks and Prevention of Suicide".
      http://www.ccsmh.ca/

   b. *The Alzheimer Society*
      http://www.alzheimertoronto.org/

c. *The e-Health Ontario*: under the “Senior” section, there are two very informative resources
   i. Seniors’ Health Research Transfer Network (SHRTN), and
   ii. Alzheimer Knowledge Exchange (AKE) that provide teleconferences, education programs, materials and discussions.

   https://www.ehealthontario.ca

d. *The Regional Geriatric Program:* to learn about the PRC Program, GEM Program and related materials and information.
   http://rgp.toronto.on.ca/

e. *The Toronto Dementia Network*
   http://www.dementiatoronto.org/

f. *The Ontario Safety Association for Community and Health Care Gentle Persuasive Approaches*
   http://www.osach.ca

4.0 FINAL THOUGHTS

Good responsive behavior care requires an effective collaborative model of care – solid linkages and partnerships are essential. It also requires the use of a person-centred, compassionate and gentle persuasive approach, tailored to the individual's circumstances. Quality of life for a person with dementia depends on the quality of the relationships he/she has with care staff – LTCHs should assess, realign and monitor the home's resources in order to develop the best possible model for managing issues related to mental health and responsive behaviours.

If your LTCH is not successful on the first attempt to strengthen relationships, do not give up – try again and again. A strong collaborative relationship is necessary to make a positive difference in your home's operation and your residents' lives.

Optimal care occurs within an environment that supports healthy relationships between staff, clinicians, PRCs, mental health outreach team members, families and residents and when the environment is adapted to support the persons with responsive behaviour.

Each person with responsive behaviour is unique, having a different constellation of abilities and need for support, which changes over time. Staff can help by knowing as much as possible about each resident's life story, preferences and abilities and by building and sustaining effective inter-sectoral processes. To enhance effective communication with the residents, LTCHs can consider accessing the Interpreter Services (Appendix 20).

APPENDIX 1

Implement and Nurture a Behavioural Culture Check List

Items	Done	Items	Done
Review of		**Care Philosophy**	
Vision		Key principles	
Mission		Multidisciplinary team	
Value			
Policies & Procedures		**Activity**	
Behavioural Care Model		Promote psychological intervention	
BSR job description		Promote social intervention	
Response to crisis situation		Promote flexibility	
Behaviour and incident documentation		1:1 program	
High Intensity Needs Fund			
Use of Chemical restraint		**Quality Program**	
Use of Physical restraint		Track indicators	
Physical & social environment – as a therapeutic milieu		Measure outcomes	
Abuses/assaults		Improvement actions	
Emergency responses			
Education		**Human Resources**	
Clinical assessment		Care & supportive environment	
Behaviour assessment		Debriefing process	
Transfer knowledge		Promote an interdisciplinary team	
Use of PIECES		Incorporate a behavioural support role	
Use of U-First			
Use of Fox Learning System			

APPENDIX 2

COMMUNITY MOBILIZATION UNIT

CRIME PREVENTION and COMMUNITY RELATIONS

Headquarters: *Fax: 8-7222*

S/Sgt. Sharon **DAVIS**(4724)	Community Mobilization		8-7028
P.C Claudine **THOMAS** (671)	Community Mobilization (Crime Prevention)		8-7033

Divisional:

DIV.	CRIME PREVENTION	LOCAL	COMMUNITY RELATIONS	LOCAL
11	Russ **GOLDING** (3791)	8-1108	Russ **GOLDING** (3791)	8-1108
12	Jim **LAMBE** (3746)	8-1208	Jim **LAMBE** (3746)	8-1208
13	Paul **COCULUZZI** (2606)	8-1387	Michael **JANDER** (314)	8-1308
14	Gordon **REID** (1703)	8-1529	Jim **McFEDRIES** (7363)	8-1508
22	Al **BENSON** (6122)	8-2208	Kevin **McALEER** (2540)	8-2251
23	Robin Lynn **HARVEY** (7896)	8-2308	Bill **MESSEL** (7028)	8-2366
31	Phil **HARRIS** (3991)	8-3133	Tony **McKENZIE** (7257)	8-3108
32	Wayne **PEIRCE** (6541)	8-3256	Bill **STEED** (6752)	8-3208
33	Kelly **DOWNIE** (5535)	8-3395	Rodcliff **CHUNG** (8037)	8-3325
41	Ian **CAMERON** (1228) Jill **DAVEY** (3965)	8-4127	Alan **McDONALD** (4394)	8-4108
42	Gary **GOMEZ** (6528)	8-4220	Jack **WIELD** (7229)	8-4296
43	Gordon **HAYFORD** (4496) Randy **BESTED** (6838) **CMU**	8-4339 8-4330	Dave **GRAY** (6836)	8-4321
51	Joseph **SMITH** (4475)	8-5187	Paul **NADEAU** (3879)	8-5108
52	Mark **WILLIAMS** (1308)	8-5208	Mike **MOFFATT** (6175)	8-5291
53	Richard **LANGSTONE** (6281)	8-5337	Joe **MONCADA** (4359)	8-5308
54	Gary **POWELL** (1142)	8-5429	Austin **FERGUSON** (7196)	8-5408
55	Robert **McDONALD** (7290)	8-5579	Vince **HENDERSON** (1342)	8-5508

APPENDIX 3

Mental Health Crisis Services Information

A) MOBILE CRISIS SERVICES IN THE CITY OF TORONTO:

- If you live in the former cities of North York, York-north of Eglinton (also south of Eglinton west of Jane), and Etobicoke,
  Call the Integrated Community Mental Health Crisis Response Program: 416-498-0043

- If you live in the former city of Scarborough,
  Call the Scarborough Crisis Program: 416-289-2434

B) MENTAL HEALTH CRISIS LINES

- **Gerstein Crisis Centre. (416) 929-5200.** 24/7 Serves former cities of Toronto and York. Provide mobile response to the home or in the community for an acute mental health crisis who are not in immediate danger to themselves or others.
- **St. Elizabeth Health Care Integrated Community Mental Health Crisis Response Program. (416) 498-0043.** 24/7 Serves Etobicoke and North York. Provide a mobile response team and emergency short term housing doe a serious mental illness experiencing an acute psychiatric crisis.

C) Assertive Community Treatment Teams (ACTT)

The ACT teams provide treatment, rehabilitation and support services that assist people with severe mental illness in their recovery and their desire to live in the community. The teams are multidisciplinary including a social worker, nurses, psychiatrist, vocational specialist, occupational therapist, peer support specialist and an addictions specialist.

ACT teams are able to provide services in the community, including people's homes. Support can be very intensive and a 24-hour on-call system is available to clients. Toronto has three ACT teams

- **West Metro ACT Team**
- **East Metro ACT Team**
- **New Dimensions ACT Team**

Contact Information:

For **West Metro ACT Team**
tgordon@cmha-toronto.net
416-789-7957 ext. 282

For **New Dimensions and East Metro ACT Teams**
tmckay@cmha-toronto.net
416-289-6285 ext. 243

APPENDIX 4

External Resources Contact Information

	Name	e-mail Address	Contact #
CCAC			
G-MHOT			
PRC			
Police Division			
EMS			
Mobile Crisis Team			
Compliance Advisor			
Hospital Emergency			
Specialty Hospital			
Psycho-geriatrician			

APPENDIX 5

TIPS FOR WORKING WITH RESIDENTS
With Escalating Responsive Behaviour

Remember:BEHAVIOUR HAS MEANING

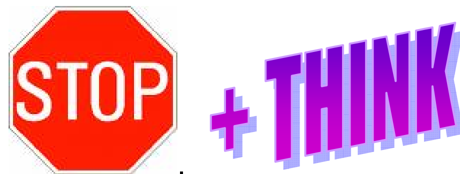
(There is a reason behind why the resident is acting a certain way)

Residents with dementia need more time to understand what you're trying to do with them. If they are resistive, they probably perceive you as threatening or they are physically uncomfortable, making them agitated.

If a resident appears to be upset:

- Approach the resident slowly, calmly, letting the resident know who you are and what you're doing every step of the way
- **Don't just leave him/her! If possible, attempt to see if there is something physically wrong with the resident. You may need the help of the nurse. If you don't bother, the resident's aggression could get worse!**
- Use a ***different*** approach when trying to give care a second time. Examples include using different words, offering gentle touch, a massage, or something to drink before care.

If a resident starts fighting with you or paralyzes (freezes up),



Immediately

- **Move away for a few moments. Offer care using a different approach the next time.**

THINK!

- **How can my approach be improved? Could the resident be in pain or tired? Can the resident do what I want him/her to do? Does he/she understand? How do I look/sound? Can the resident do more to participate in care – even if it takes a little longer? Am I entering the resident's personal space at eye level**

Addressograph with Resident's Name:

APPENDIX 6

Assess for Causes of Delirium

Assessor: ____________________
Date Administered (d/m/y): ____________________

Mnemonic: I WATCH DEATH		Presenting Symptoms	Yes	No
I	**I**nfections	Urinary tract infection (UTI)		
		Pneumonia		
		Encephalitis		
		Other Infections: Specify:		
W	**W**ithdrawal	Alcohol		
		Benzodiazepines		
		Sedatives-hypnotics		
A	**A**cute metabolic	Electrolyte disturbance		
		Dehydration		
		Acidosis/Alkalosis		
		Hepatic/Renal failure		
T	**T**oxins, drugs	Opiates		
		Salycilates		
		Indomethacin		
		Lidocaine		
		Dilantin		
		Steroids		
		Other drugs:		
		Digoxin		
		Cardiac medications		
		Anticholinergics		
		Psychotropics		
C	**C**NS pathology	Stroke		
		Tumor		
		Seizures		
		Hemorrhage		
		Infection		
H	**H**ypoxia	Anemia		
		Pulmonary/Cardiac failure		
		Hypotension		
D	**D**eficiencies	Thiamine (with alcohol abuse)		
		B12		
E	**E**ndocrine	Thyroid		
		Hypo/Hyperglycemia		
		Adrenal insufficiency		
		Hyperparathyroid		
A	**A**cute vascular	Shock		
		Hypertensive encephalophathy		
T	**T**rauma	Head injury		
		Post-operative		
		Falls		
H	**H**eavy Metals	Lead		
		Mercury		
		Magnesium poisoning		

APPENDIX 7

Addressograph with Resident's Name:

Mini-Cog Dementia Screen

Assessor: ______________________

Date Administered (d/m/y): _____________________

The Mini-Cog is a 3 question validated tool to screen for dementia.

A. Immediate registration (3 words) _________________ __________________ _______________

B. Clock Drawing Test (CDT) *[see attached]*
- ☐ Normal
- ☐ Abnormal

Comments:

C. Recent recall (3 words) __________________ ___________________ ___________________

Reference: Borson, S., Scanlan, J., Brush, M. et al. (2000). The Mini-Cog: A Cognitive Vital Signs Measure for Dementia Screening in Multi-Lingual Elderly. *International Journal of Geriatric Psychiatry* ***15***, 1021-1027

Scoring:

The Mini-Cog combines a three-item word-learning and recall task (0-3 points; each correctly recalled word = 1 point), with a simple clock drawing task (abnormal clock = 0 points; normal clock = 2 points) used as distraction task before word recall.

The CDT is considered normal if all numbers are present in the correct sequence and position and the hands readably display the requested time of ten past eleven.

Results:

Mini-Cog total possible scores range from 0 to 5.
0 to 2 = high likelihood of cognitive impairment
3 to 5 = low likelihood of cognitive impairment.

Resident Score: ___ /5

Comments/Plan:

APPENDIX 8

Addressograph with Resident's Name:

Confusion Assessment Method (CAM) Instrument Shortened Version Worksheet

Assessor: ______________________________

Date Administered (d/m/y): ________________

ACUTE ONSET AND FLUCTUATING COURSE — **Box 1**

Question	No	Box 1
a) Is there evidence of an acute change in mental status from the person's baseline?	No_____	Yes ___
b) Did the (abnormal) behaviour fluctuate during the day, that is, tend to come and go or increase and decrease in severity?	No_____	Yes ___
INATTENTION Did the person have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?	No_____	Yes ___

Box 2

Question	No	Box 2
DISORGANIZED THINKING Was the person's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?	No_____	Yes_____

ALTERED LEVEL OF CONSCIOUSNESS

Overall, how would you rate the person's level of consciousness?

___Alert (normal)

___Vigilant (hyper-alert) ___Lethargic (drowsy, easily aroused) ___Stupor (difficult to arouse) ___Coma (can't arouse)

Question	No	Box 2
Do any checks appear in this box?	No____	Yes____

If all items in Box 1 are checked and at least one item in Box 2 is checked, a diagnosis of delirium is suggested.

Adapted from: Inouye, SK, et al., (1990). Clarifying Confusion: The Confusion Assessment Method. A new method for detection of delirium. Annals of Internal Medicine, 113, 941-948.

APPENDIX 9

Addressograph with Resident's Name:

Geriatric Depression Scale – GDS-4: Short Form

Assessor: ____________________________

Date Administered (d/m/y): ______________

Ask the following 4 questions:		
1. Are you basically satisfied with your life?	□ Yes	□ **NO**
2. Do you feel that your life is empty?	□ **YES**	□ No
3. Are you afraid that something bad is going to happen to you?	□ **YES**	□ No
4. Do you feel happy most of the time?	□ Yes	□ **NO**
Total Score		

Answers in capitals score 1.

For GDS-4 score of 1 or more indicates possible depression.

APPENDIX 10

Addressograph with Resident's Name:

Cornell Scale for Depression

Assessor: ______________________________

Date Administered (d/m/y): _________________

Mood-related Signs

1. Anxiety……………………………______
   anxious expression, ruminations, worrying

2. Sadness…………………………_______
   sad expression, sad voice, tearfulness

3. Lack of reactivity to pleasant events…____

4. Irritability……………………………_______
   easily annoyed, short tempered

Behavioural Disturbance

5. Agitation………………………________
   restlessness, handwringing, hairpulling

6. Retardation…………………...._______
   slow movements, slow speech, slow reactions

7. Multiple physical complaints
   (score 0 if GI symptoms only)……______

8. Loss of interest
   less involved in usual activities (score only if change occurred acutely, e.g., less than month)……_____

Physical Signs

9. Appetite loss
   eating less than usual………..._______

10. Weight loss
    (score 2 if greater than 5 lbs. in 1 month)
    ……………………………………_______

11. Lack of energy
    fatigues easily, unable to sustain activities (score only if change occurred acutely, e.g., in less than 1 month)………………………_______

Cyclic Functions

12. Diurnal variation of mood symptoms,
    worse in the morning……………..._______

13. Difficulty falling asleep
    later than usual for resident………..______

14. Multiple awakenings during sleep…….______

15. Early morning awakening
    earlier than usual for this resident……______

Ideational Disturbance

16. Suicide
    feels life is not worth living, has suicidal wishes, or makes suicide attempt…..______

17. Poor self-esteem
    self-blame, self-depreciation, feelings of failure………………………………________

18. Pessimism
    anticipation of the worst……………________

19. Mood-congruent delusions
    delusions of poverty, illness, or loss…______

Scoring System

Ratings should be based on symptoms and signs occurring during the week prior to interview. No score should be given if symptoms result from physical disability or illness.

0 = absent
1 = mild or intermittent
2 = severe
N/A = unable to evaluate

APPENDIX 11

SIG E CAPS

Assessor: ________________________

Addressograph with Resident's Name:

Depressive Symptoms	Initial Assessment Date:		Re-Assessment Date:	
At least five (5) of the following symptoms* have been present nearly every day, for most of the day, during the same two-week period and represent a change from previous functioning:				
S – Sleep is disturbed.	☐ Yes	☐ No	☐ Yes	☐ No
I – Interest is decreased.	☐ Yes	☐ No	☐ Yes	☐ No
G – Guilt (feelings of guilt are common, having regrets, etc.).	☐ Yes	☐ No	☐ Yes	☐ No
E – Energy is lower than usual.	☐ Yes	☐ No	☐ Yes	☐ No
C – Concentration is poor and memory problems may be exacerbated.	☐ Yes	☐ No	☐ Yes	☐ No
A – Appetite is disturbed, usually a loss of appetite accompanied (or not) by weight loss.	☐ Yes	☐ No	☐ Yes	☐ No
P – Psychomotor retardation or agitation (agitation may be misconstrued as a result of anxiety only).	☐ Yes	☐ No	☐ Yes	☐ No
S – Suicidal ideation, at least a passive wish to die, is frequently present.	☐ Yes	☐ No	☐ Yes	☐ No
Additional symptoms: At least one of the symptoms is either (1) Depressed Mood	☐ Yes	☐ No	☐ Yes	☐ No
(2) Loss of interest in pleasure	☐ Yes	☐ No	☐ Yes	☐ No
SIG E CAPS Score (Total number of "Yes" answers)				

(Adapted from DSM-IV, American Psychiatric Association, 1994.)

*Symptoms cause significant distress or impairment in daily activities, social life, or other important areas of functioning.

*Symptoms are not due to the direct effects of a substance (e.g., drugs of abuse or medication) or a general medical condition.

Comments:

____

____

____

____

____

APPENDIX 12

Addressograph with Resident's Name:

Cohen-Mansfield Agitation Inventory (CMAI)

Assessor: ___________________________
Date Administered (d/m/y): ____________

Frequency Disruptiveness
1 = Never1 = Not at all
2 = Less than once a week2 = A little
3 = Once or twice a week3 = Moderately
4 = Several times a week4 = Very much
5 = Once or twice a day5 = Extremely
6 = Several times a day9 = Don't know
7 = Several times an hour
9 = Don't know

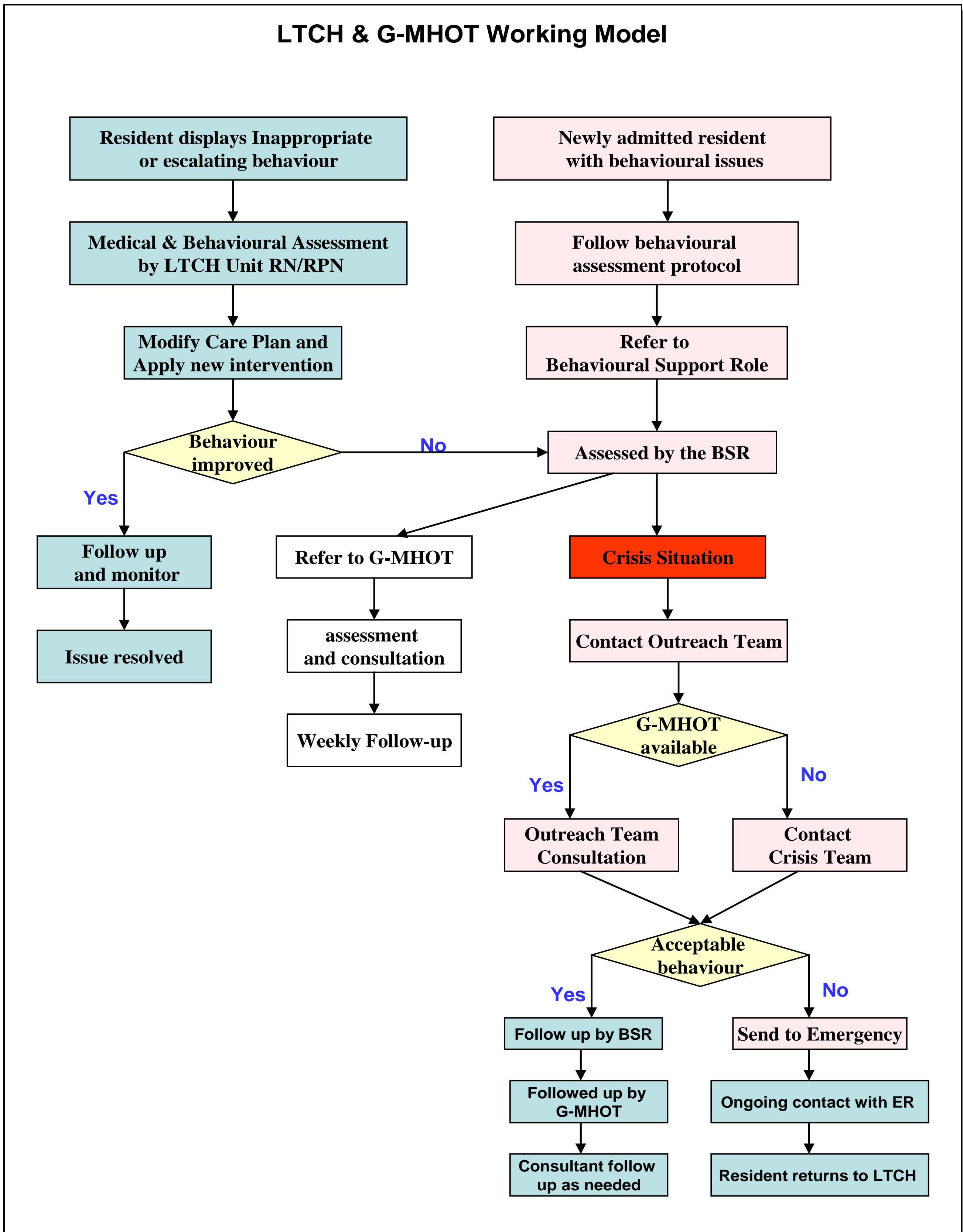
Please read each of the 30 agitated behaviours, and circle the frequency and disruptiveness of each during the past two weeks. (Level of disruptiveness: How disturbing it is to staff, other residents, or family members. If disruptive to anyone, rate the highest it is for those for whom it disrupts).

	Frequency	**Disruptiveness**
1. Pace, aimless wandering	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
2. Inappropriate dress, disrobing	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
3. Spitting (include at meals)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
4. Cursing or verbal aggression	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
5. Constant unwarranted request attention for help	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
6. Repetitive sentences/questions	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
7. Hitting (including self)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
8. Kicking	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
9. Grabbing onto people	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
10. Pushing	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
11. Throwing things	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
12. Strange noises (weird laughter or crying)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
13. Screaming	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
14. Biting	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
15. Scratching	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
16. Trying to get to a different place (e.g., out of the room or building)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
17. Intentional falling	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
18. Complaining	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
19. Negativism	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
20. Eating/drinking/inappropriate substances	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
21. Hurt self of others (with cigarette, hot water, etc.)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
22. Handling things inappropriately	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
23. Hiding things	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
24. Hoarding things	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
25. Tearing things or destroying property	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
26. Performing repetitious mannerisms	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
27. Making verbal sexual advances	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
28. Making physical sexual advances	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
29. General restlessness	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
30. Other inappropriate behaviour. Specify: ____________________	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
Cohen-Mansfield, 1986. All rights reserved.		

Reference: Cohen-Mansfield, J. (1986). Agitated behaviours in the elderly II: Preliminary results in the cognitively deteriorated. *Journal of the American Geriatrics Society, 34*(10), 722-727.

Cohen-Mansfield, J., Marx, M. S., & Rosenthal, A. S. (1989). A description of agitation in a nursing home. *Journal of Gerontology, 44*, M77-M84.

APPENDIX 13



APPENDIX 14

Behavioural Support Policy & Procedures – SAMPLE ONLY

POLICY:

The Home is committed to providing a safe living and working environment.

PREAMBLE:

Residents with delirium, depression or dementia, exhibit a variety of behaviours. A resident exhibiting a "**severe escalating"** responsive behaviour is one who poses a significant risk to himself, other residents, staff and/or visitors. When a resident exhibits this type of high risk behaviour and poses unmanageable behaviour that interferes with care or threatens the safety of others, intervention must be initiated.

PROCEDURE:

1. Intervene and calm the resident while protecting the resident and staff.

2. Remove other residents to safety.

3. Report the behaviour or the potential behaviour to the Attending Physician and the Behavioural Support Role (BSR)/ Director of Care (DOC)/Nursing Director (ND).

4. Inform the DOC/ND/BSR, who will inform the Compliance Advisor if it is an actual, "severe" responsive behavioural act; e.g. abuse, assault etc. Ongoing communication with the Compliance Advisor will be done by the DOC/Nursing Director for **High Intensity Needs Funding** for one to one staffing if required, as well as status reports.

5. Notify the Administrator on call for further direction, if it off-hours.

6. Complete all incident reports for both the aggressor and victim, including the Home's Incident/Accident Report, the Ministry of Health and Long term Care Unusual Occurrence Report.

7. Assess the resident and commence the assessment tools used in the Home.

8. Request the Physician to rule out any medical and physiological causes i.e. delirium which could be contributing to the change in behaviour.

9. Review and revise the plan of care and develop short and long term goals using all members of the multidisciplinary team.

10. Make the following referrals when the resident needs "***referral for behaviour management"***. Use the following as a guideline to assist the team. ***All referrals are initiated in consultation with the physician.***

    - Request the behavioural support staff (BSR)/PIECES-trained staff to review and assess the behavioural concerns.
        - Review the resident chart including behaviour, laboratory results, pain assessments, and possible triggers and contributing factors
        - BSR will initiate monitoring tools for data collection to further identify and individualize the care needs
        - BSR consults with the pharmacy to review the medications and request a formal review of all the medications
        - Complete review of resident past consultations and medical notes
        - Consider involving the PRC for education/case management support
    - Refer to the Geriatric - Mental Health Outreach team, in consultation with the Attending Physician/Medical Director.
    - Refer to other external consultations; e.g. geriatricians and psychiatrist following discussion with Geriatric Mental Health Outreach Team (G-MHOT)
    - Follow-up and monitor by both the BSR and the G-MHOT on a mutually agreed time intervals to occur until the situation is resolved.

11. Revise the plan of care reflecting recommendations made by external experts once the behaviour has been identified and reviewed/supported by the Attending Physician. Reflect the recommendations in the resident plan of care.

12. Initiate any recommendations made by disciplines referred to for consultation and document in the resident plan of care.

13. Notify the Attending Physician if there is an additional resident action that poses an immediate risk to him/herself, other residents, staff and visitors. Communicate with the G-MHOT and ask for immediate assistance. If the G-MHOT is not available immediately, contact the Mobile Mental Health Crisis service.

14. Complete a Form 1 to apply for psychiatric assessment if no external resources are available, and the situation is warranted an immediate action.

15. Leave a message for the G-MHOT to follow-up. If the risk is confirmed and physical aggression is present, the police should be called to deal with and remove the resident from the premises as the welfare of the community within the facility is in jeopardy.

16. Communicate with the G-MHOT and ask for assistance at any time during the assessment or during the development of the plan of care.

17. Call 911 immediately if the degree of risk is severe. If the degree of risk is low, contact the police reporting department.

APPENDIX 15

INTERNAL BEHAVIOURAL SUPPORT MANAGEMENT CHECK LIST

CRITERIA: Utilize internal resources before consulting external resources.

	YES	NO	REMARK
BSR or PIECES-trained staff is aware of resident's condition			
Behavioural Assessment was done			
Current interventions effective			
Psycho tropics **P.R.N.** effective			
Resident's behaviour related to medical/physical condition e.g. UTI, URI, Constipation, pain, dehydration etc.			
Environment Stresses e.g.: Resident stationed in a noisy area.			

If all of the above are not effective External resources are contacted.

Signatures:

Date:

APPENDIX 16

PIECES ADMISSION REFERRAL FORM	
All new admissions with a history of an identifiable challenging behaviour will have a PIECES assessment completed within ___ (suggestion: 12 hours) of admission to identify baseline measurements and strategies.	
Resident Name:	Date:
Rm. #	Doctor:
Assessment completed by:	
Diagnosis:	
Psychiatric Contacts:	
Last Date Assessed/Seen:	
By Who:	
Current Psychiatric Medication (psychotropics, anti-depressants, mood stabilizers) **ATTACH CURRENT MAR SHEETS**	
What is the behaviour?	
Who is it affecting?	
What is the degree of **RISK**? (**R**oaming, **I**mminent physical risk, **S**uicide, **K**inship relationships, **S**elf-neglect)	
What are the possible causes?	

Identify Resident's Strengths/Needs following PIECES:

P (physical)

I (intellectual)

E (emotional)

C (capabilities)

E (physical environment)

S (social environment)

Are there current behaviours that strategies need to be developed for? Yes ☐ No ☐

Assessment Tools Used	Date Completed
Mini Mental State Exam (MMSE)	
The Clock Drawing Test	
Confusion Assessment Method (CAM)	
Cornell Scale for Depression	
Geriatric Depression Scale (GDS)	
Cohen – Mansfield Agitation Inventory (CAMI)	
Physical Examination	
Pain Management	
Others	

Note: Team meeting should be completed after Behavioural Support Role/PIECES-Trained Staff completed assessment.

Team Meeting Date:

Attended by:

What are the best **Strategies**?

Note: Charge RN is responsible for documenting meeting and development of strategies in the Care Plan.

APPENDIX 17

BEHAVIOURAL SUPPORT ROLE PROFILE

1. CONSULTATION, TEACHING AND SUPPORT

- Provides clinical and management consultation, teaching and support to the nursing staff who care for residents with responsive behaviours (examples: management of difficult behaviours, environmental issues related to dementia, use of psychotropic medication, special approaches)
- Provides clinical expertise to the needs of residents with responsive behaviour and their families/significant others, and initiates nursing practices to maintain and improve the care delivery.
- Assists staff in crisis/emergency situations related to responsive behaviour management
- Participates/assists in the review, updating and development of policies and procedures, guidelines, assessment tools, protocols and programs to provide guidance to the staff and to ensure that standards are maintained in providing care to residents with responsive behaviour
- In collaboration with Staff Development, develops and organizes teaching activities to orientate new staff and to maintain and/or improve the knowledge and skill of staff who provide care to residents with responsive behaviour

2. CASE MANAGEMENT

- Ensures that residents with responsive behaviour receive quality care by making regular rounds and observing the care provided to residents with responsive behaviour and implements changes or improvements as necessary
- Audits care plans and documentation for residents with responsive behaviour and corrects deficiencies identified
- Ensures that policies, procedures, guidelines, protocols and programs related to the care of residents with dementia are followed by staff

3. INTERDISCIPLINARY COLLABORATION

- Participates in care conferences and care review meetings as required and when resident care plans for residents with responsive behaviour are challenging for the staff
- Represents the facility on committees related to the care of individuals with responsive behaviour
- Participates in projects related to the development and/or evaluation of care for residents with dementia

4. LIAISON

- Liaise with external resources and stakeholders to work towards a continuum of care for seniors with responsive behaviour
- Follow up with ER, hospital, CCAC, outreach team etc. on the transfer in & out of seniors with responsive behaviour

APPENDIX 18

Fox Learning Systems, Inc.

Education Initiative FarSight Solutions for Long Term Care Interactive computer-based software for long-term care home staff training

Brief Description

FarSight Solutions for Long Term Care is an interactive computer, web-based series of modules for long-term care home staff training. The modules incorporate a technique called InterDoc, which utilizes video-based presentations similar to that used in television documentary programs to deliver the educational content. It also tests staff trainees on the subjects being discussed with questions and interactive exercises. All trainees answers are recorded in a database and this database can be viewed by LTC Home Administrators and Directors of Care by using the Solutions for Long Term Care Administrator function.

In 2006, the Ministry of Health and Long-term Care, through the Centre for Addiction and Mental Health (CAMH), agreed to purchase 1-year site licenses from Fox Learning Systems, for all 85 LTC Homes within Toronto Region. The agreement included access to the following six modules, based on best practices, to help LTC staff manage resident behavioural response issues:

1. The Aging Process
2. Understanding Depression
3. The Treatment of Depression
4. Understanding Dementia and Alzheimer's Disease
5. Working with Dementia
6. Behavioural Management of Agitation and Aggression

Target Learner

All levels of LTC staff (e.g., RNs, RPNs, PSWs, HCAs, staff trained in PIECES and U-first!)

Method of Delivery

Training available 24 hours a day/ 7 days a week. Learning modules are web-based and LTC staff creates their own login and password during their first session. Modules are restricted to 85 LTC Homes in Toronto and active trainees only. Teaching method combines full-screen video, animations and interactivity. Testing features include: pre-test, true and false questions, interactive exercises and post-test—all with interactive feedback for trainees. Modules run best on a computer system that includes: CPU: 800 MHz Intel Pentium III or equivalent; hard disk space of 5 GB free space; 128 MB RAM memory; SVGA video card; sound care and speakers; and a printer (for reports).

Teachers/Trainers

CAMH staff will assist in launch of system through information sessions with Administrators/Directors of Care from Toronto's designated 85 LTC Homes. CAMH has also enlisted support from the Psychogeriatric Resource Consultants group for ongoing assistance.

Length of Training

Each module will take approximately 30 minutes to complete, but may take longer if trainee is unfamiliar with computers.

Cost per Participant

None

Other Partners in Delivery

Centre for Addiction and Mental Health (CAMH); Regional Geriatric Program (PRC)

APPENDIX 19

ABBREVIATION LIST

BSR	Behavioural Support Role
CCAC	Community Access Center
EMS	Emergency Management Service
ED	Emergency Department
GEM	Geriatric Emergency Management
G-MHOT	Geriatric-Mental Health Outreach team
HINF	High Intensity Needs Fund
LGBT	Lesbian, Gay, Bisexual and Transgender
LHIN	Local Health Integration Network
LTC	Long-term Care
LTCH	Long-term Care Home
MOHLTC	Ministry of Health and Long-term Care
PRC	Psychogeriatric Resource Consultant
TPS	Toronto Police Service

APPENDIX 20

INTERPRETER SERVICES

This is a paid service.

Multilingual Community Interpreter Services (ON)
1185 Eglinton Avenue East, #605
Toronto, Ontario M3C 3C6
Tel: 416-426-7051
Fax: 416-426-7118
Website: www.mcis.on.ca
Contact: Latha Sukamar, E.D. of MCIS

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