VCAFC April 9, 2024, Lunch and Learn:

Care Approaches for People with Dementia and other Complex Neurocognitive Disorders

Presented by:

Joseph Sun

He is a RN, Clinical Nurse Specialist, an integral part of VCH LTC and AL Professional Practice Team,

Has completed various studies and degrees with UBC/SFU and BCIT

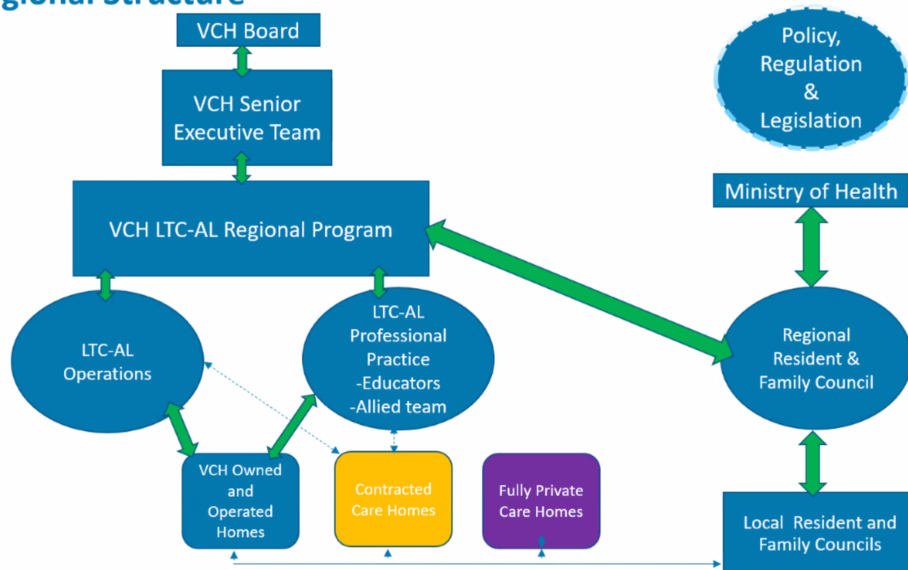
He holds a Post Baccalaureate Diploma in Gerontology,

Providing care and support for LTC residents since 2010.

Carla Filippone is VCH Regional Lead, LTC, assisted living and Co-Chair of the RRFCN

Carla bridges the path between the professional practise team and the long-term care home. She can help us understand more about the team who put this all together.

Tenzin Yanki Professional Practice Director, Nursing and Allied Health, Long-Term Care and Assisted Living



Professional Practice Team

Role:

To ensure nurses and allied health professionals have the **knowledge**, **skills**, and **competencies** to practice safely and provide evidence based care at the highest standard for our residents.

Provides:

Practice Consultations
Resource Development
Building Communities of Practice
Education and Knowledge translation

Team Includes:
Director, Manager and Regional Practice Initiatives Leads, Clinical Nurse Specialists, Regional Clinical Educator, Education Coordinators, Nurse Wound Clinicians, Peer Care Aid Mentors, Clinical Nurse Mentors (new role)

DOCUMENT FOR BASIS OF THIS PRESENTATION: Care Approaches for People with Dementia and other Complex Neurocognitive Disorders

"Care Approaches for People with Dementia and other Complex Neurocognitive Disorders" Decision Support Tool (DST)

Site Applicability

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

Practice Level

Basic Skill:

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

Background:

This regional association of family councils has, over the last year, shared and gathered

systemic issues; ideas for solutions and examples of what is working in their care homes to improve resident experience.

VCAFC reported into the provincial association of family councils the number one issue was staffing: staffing mix, lack of basic staffing hours, and lack of training on the kinds of mental and physical health issues our residents are challenged by. Lack of training conversations were primarily around neurological disorders and the additional challenge of reducing antipsychotics While we wait for groundbreaking news from our MOH, VCH has come up with this decision support tool (DST) for its VCH long-term care homes.

There existed a document about handling behaviours of this nature but it contained outdated language, ideas, and procedures – they were updated. Changes reflect a shift away from the prescription focussed behavioural management to a more compassionate approach viewing the resident for what they can do instead of what they cannot do.

This document was peer reviewed and included a family member – this too is new. This approach views family as part of the care team and. As long-term care homes are the residents' homes, a shift in in how the staff view their behaviour and interactions are also changing. Relationships are being fostered for improved interaction as opposed to the less compassionate and more clinical model of care.

"Care Approaches for People with Dementia and other Complex Neurocognitive Disorders" Decision Support Tool (DST)

Requirements

- All persons living with dementia/other complex neurocognitive disorders will have the following developed and implemented by the interdisciplinary LTC home team:
    - Within the first week of move-in to a LTC home: An initial support tool to enable person-centered care, such as, "Getting to Know Me" / "Who am I" or equivalent (Appendix A)
    - Within 72 hours of move in day (or according to the organizational/discipline specific processes): An individualized care plan, such as, "My Daily Care Needs" or equivalent (Appendix B), completed based on the best available information. See Appendix C for an example of a completed "My Daily Care Needs"

“Care Approaches for People with Dementia and other Complex Neurocognitive Disorders” Decision Support Tool (DST)

- All persons and/or their families/substitute decision makers (SDM) (as appropriate) will be invited to collaborate or provide information to the fullest extent possible when making care decisions.
- The interdisciplinary team will develop and implement an individualized care plan that will be reviewed with each Resident Assessment Instrument-Minimum Data Set 2.0 (RAI-MDS) and when there is a change in condition. See Appendix D for Care Planning Decision Support Algorithm which can be used to guide care planning and implement appropriate Care Approaches when the person in care has a change in condition / behavior due to an unmet need
- A comprehensive holistic assessment framework such as PIECES™ (Appendix E) or equivalent framework will be used to problem solve and inform the care plan when a person exhibits physical or emotional expressions (formerly referred to as, “responsive behaviours”) due to an unmet need.

“Care Approaches for People with Dementia and other Complex Neurocognitive Disorders” Decision Support Tool (DST)

All LTC home operators provide appropriate training during orientation and on an ongoing basis to keep staff’s skills and knowledge current. Training should include (but not be limited to) the following topics:

- **Assessment:** Staff know how to use assessment tools or support other interdisciplinary team members when using assessment tools that recognize a person’s abilities and strengths as well as identify priority needs and concerns. Examples of assessment frameworks include PIECES™.
- **Care planning:** Staff understand the care planning process, including how to collaboratively develop, implement, and update an individualized care plan based on a person’s current health status and care needs.
- **Documentation:** Staff know how to complete proper documentation of a person’s needs and care plans to ensure high quality care is provided and relevant information is shared with appropriate interdisciplinary team members in a timely manner.
- **Care Approaches:** Staff are able to apply care approaches and strategies to support all persons, using principles of strengths based care, cultural safety, cultural humility, relational care, trauma informed care, and person-centered care.

Care Approaches Decision Support Tool (DST)

Need to Know

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

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

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

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Care Approaches Decision Support Tool (DST)

Guideline

ASSESSMENT

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

Assessment should include (but is not limited to):

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

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

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

Example of Care Approaches Strategies

CARE APPROACHES STRATEGIES

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

Example of Care Approaches Strategies

CARE APPROACHES STRATEGIES

Non-Verbal Communication

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

Approach

Use a gentle and respectful approach, such as:

- Approach from front, greet and make eye contact, position yourself at the same level as the person, if safe to do so.
- Ask for permission to enter room or space. If engaging in a care, conversation or other activities, ask for permission before commencing.

Example of Care Approaches Strategies

- Provide choice based on the person's preferences, as much as possible.
- If the person does not want to do something or participate in care activities, use the *"Stop and Go"* approach (below) and return when the person is more open to participate:

  Stop and Go[3]

  S – Stop: Whatever you are doing can wait

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

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

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

Example of Care Approaches Strategies

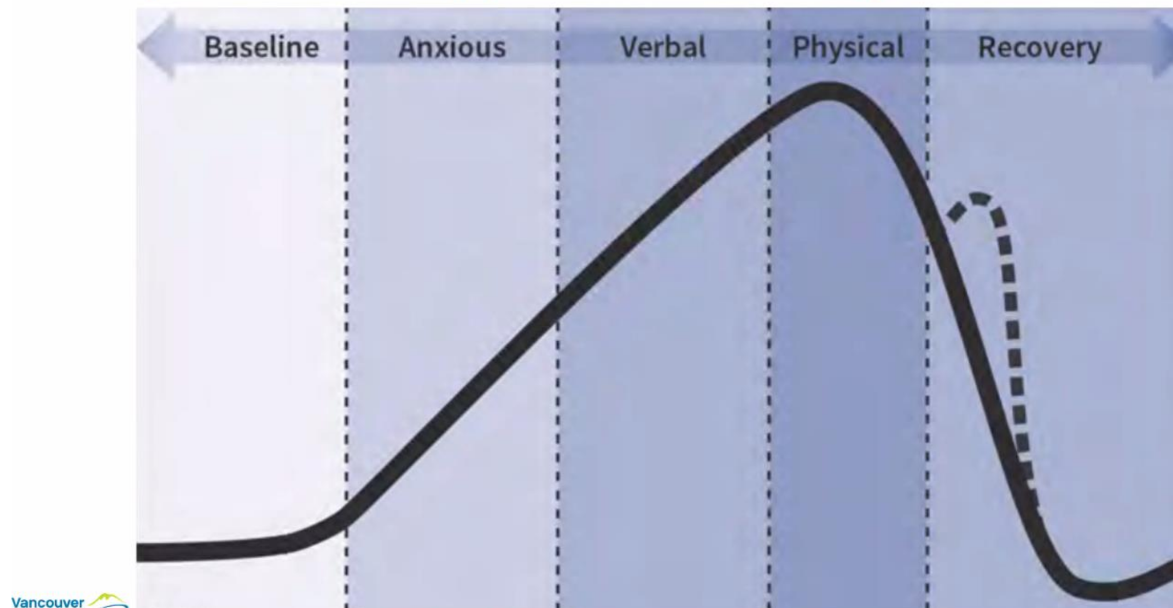
SUPPORT FOR ESCALATION OF DISTRESS

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

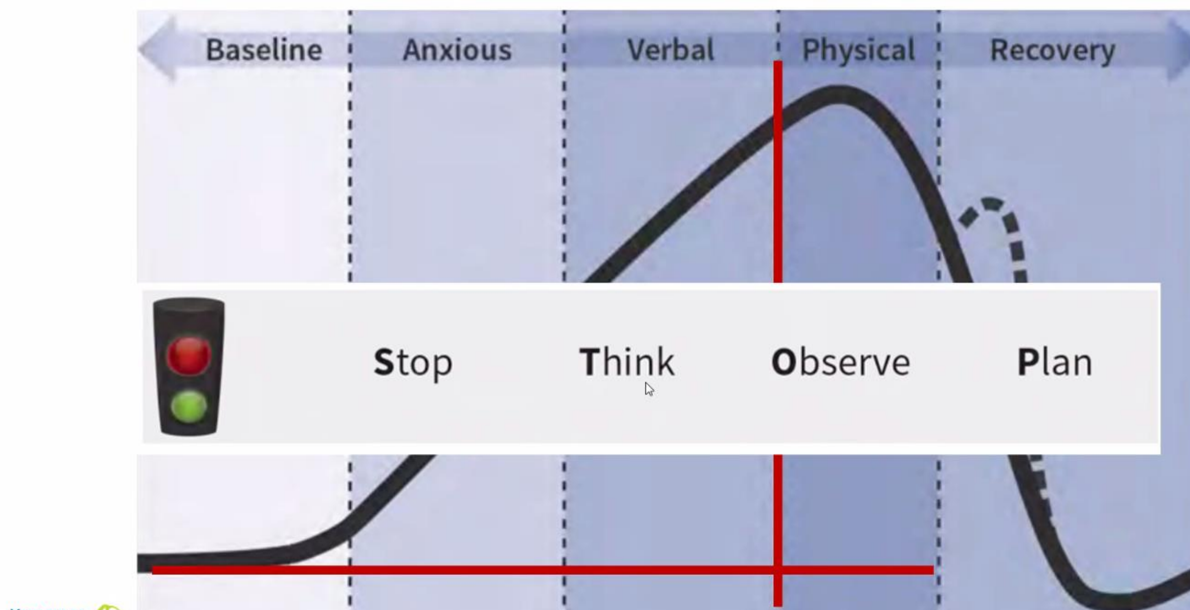
The "Individualized Behavioural Escalation Prevention Plan" (IBEPP Tool) can be used to recognize when a person's level of distress is changing.[3] This includes:

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

Example of Care Approaches Strategies

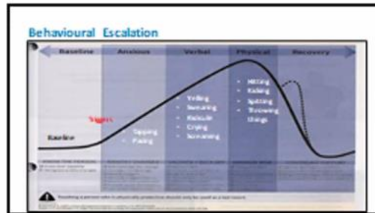


Example of Care Approaches Strategies



Plan of Implementation

In addition to PIECES™ and U-FIRST™



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fraserhealth
Interior Health
northern health
Vancouver Coastal Health
island health

GETTING TO KNOW ME
Let Me Share My Life Story With You

Name:
Date:
My early home and family life:
My education and life's work was:
My family and friends:
How you can comfort me is:

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DOS/BSO DOS

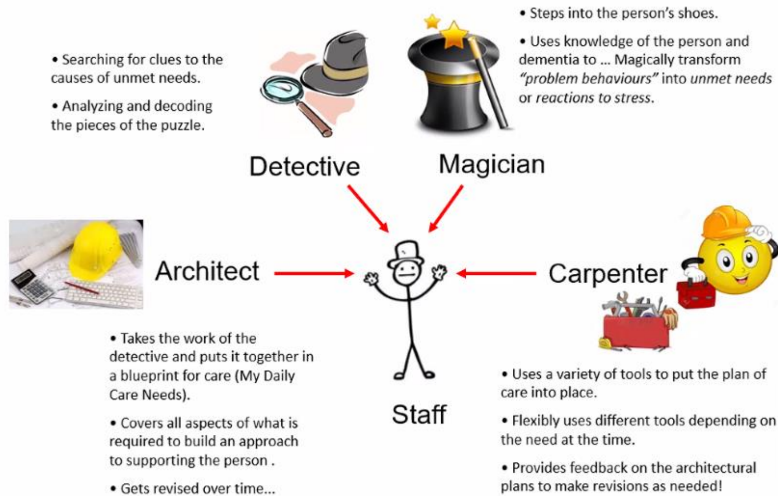
MY DAILY CARE NEEDS

Vancouver

Plan of Implementation

In addition to PIECES™ and U-FIRST™

We play 4 other different "roles" in our work:



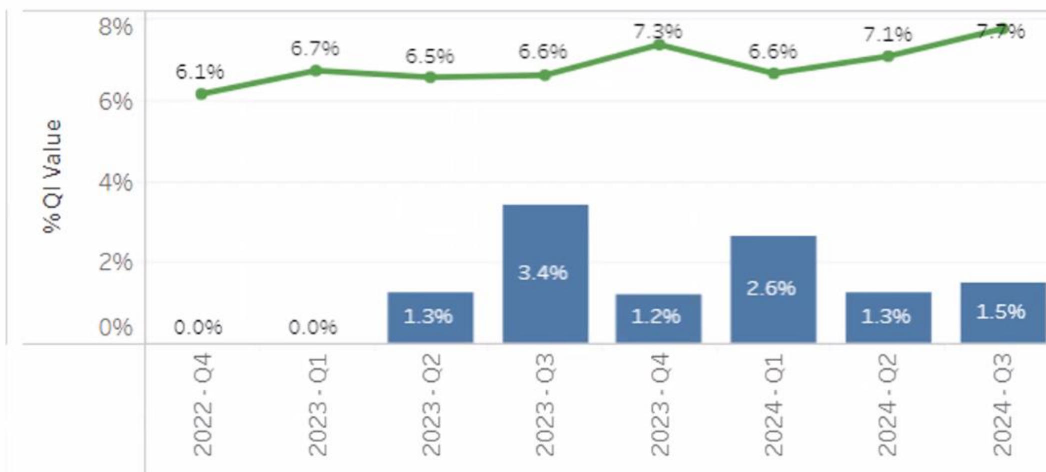
Vancouver

Some Measures or Milestone Benchmarks

Potentially Inappropriate Use of Antipsychotics in LTC

Some Measures or Milestone Benchmarks

Restraint Use in LTC



Questions and Answers:

1 “Site Applicability”
2 “Time line for implementation”

1. After this Care Approaches DST was officially signed-off last November, the Regional Professional Practice DST Team sent out an announcement re this new DST to all Regional teams.
Thus, all VCH owned & operated LTC homes should have received this announcement last November.
After we received this announcement, our team soon shared/distributed this announcement with our contracted LTC homes. Private LTC homes have their own organizational structures including own policies and guidelines. We highly respect their autonomy, the right of self-government, and their independence; thus, we rarely send out our announcements to them.
However, anyone can use this DST as this Care Approaches DST is open to public. https://shop.healthcarebc.ca/PHCVCHDSTs/BD-00-07-41010.pdf

Since last year, we've also used different venues/meetings to socialize/promote this Care Approaches DST (including its related lesson plans) with our LTC homes.

In addition, our education coordinators have regular check-ins with their allocated LTC homes. I know our Education Coordinators have helped several LTC homes to deliver several sessions already. Normally, each LTC home has its unique implementation plan including timeline based on current initiatives and priority lists.

Family councils are best to contact the DOC/ADOC or delegates in LTC homes to find out more details re implementation plan/timeline.