alzheimer's QUEENSLAND

Dementia and Aged Care Services (DACS)

CHCCCS020

Respond effectively to behaviours of concern

Module Workbook

NATIONALLY RECOGNISED TRAINING

RTO No. (30213)

CHCCCS020

Respond effectively to behaviours of concern

This unit describes the skills and knowledge required to respond effectively to behaviours of concern for clients and others.

Disclaimer

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Designed and produced by the Alzheimer's Association of Queensland Inc.

Acknowledgments:

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1. Identify behaviours of concern in line with work role and organisation policies and procedures
2. Identify appropriate response to potential instances of behaviours of concern
3. Ensure planned responses to behaviours of concern maximise the availability of other appropriate staff and resources
4. Give priority to safety of self and others in responding to behaviours of concern

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1. Ensure response to instances of behaviours of concern reflect organisation policies and procedures
2. Seek assistance as required
3. Deal with behaviours of concern promptly, firmly and diplomatically in accordance with organisation policy and procedure
4. Use communication effectively to achieve the desired outcomes in responding to behaviours of concern
5. Select appropriate strategies to suit particular instances of behaviours of concern

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1. Report incidents according to organisation policies and procedures
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3. Access and participate in available debriefing mechanisms and associated support and/or development activities
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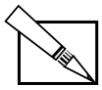
Introduction

Welcome to CHCCCS020 - Respond effectively to behaviours of concern.

This unit has three elements of competency. The learning outcomes and overview describe the content of each section. To assist you in using these learning materials, a number of symbols or icons have been used. Each icon will direct you to a particular activity or highlight a particular feature of the text.



Activity

As you study each section, you will be asked to complete a number of activities. These activities will assist you to answer the assessment questions. If you don't understand an activity, there are resources available from the Alzheimer's Association of Queensland Inc. that may assist you. Details on accessing resources are in the Student Handbook.

Resources

Resources that may assist you to complete the unit are available from the Alzheimer's Association of Qld Inc.

Assessment

When you have completed each activity, proceed to the Assessment Booklet, and complete the relevant assessment questions. You also will be asked to provide evidence signed by your supervisor that you are competent in each of the elements of this unit.

CHCCCS020 Element 1: Identify behaviour and plan response

Learning objectives:

On successful completion of this section, you will be able to:

1. Identify behaviours of concern in line with work role and organisation policies and procedures
2. Identify appropriate response to potential instances of behaviours of concern
3. Ensure planned responses to behaviours of concern maximise the availability of other appropriate staff and resources
4. Give priority to safety of self and others in responding to behaviours of concern

Overview:

This section will outline types of behaviours of concern, the causes of this behaviour, particularly for clients experiencing dementia, and safety of self and others when responding to behaviour.

- What is a behaviour of concern?
- What causes a behaviour of concern?
- Safety of self and others

What do we mean by behaviours of concern?

Behaviour in a person with dementia is the combined result of the brain damage and the messages the environment gives. People with Alzheimer's disease may display a number of concerning behaviours because:

- they have difficulty understanding and controlling interactions with their environment
- they have difficulty communicating their needs

These behaviours include wandering, rummaging, hoarding, intrusive behaviour, physical and verbal aggression, or catastrophic reactions. Behaviour can vary greatly between individuals and during the course of the day.

Behaviours of concern

Behaviours of concern that a person with dementia may exhibit, fall into three categories. These are:

1. Persistent behaviours of concern
2. Triggered behaviours of concern and
3. Persistent triggered behaviours of concern

Persistent behaviours of concern

Persistent behaviours are those which occur over and over and are seated deep in the damaged brain causing constant disorder in the way information is processed. These are challenging behaviours that occur almost daily or several times in a day. Solutions are not likely to be found by removal of a single stimulus.

- Persistent wandering
- Repetition of words or actions
- Regular physical or verbal aggression
- Persistent rummaging
- Persistent hoarding

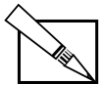
Triggered behaviours of concern

Triggered behaviours are those that are unusual for the client or deviate from their normal demeanor. These challenging behaviours occur occasionally and are unusual in that they do not occur with regularity and appear to be the result of an external stimulus. Interventions can often be found for triggered behaviours.

- Unusual crying
- Whimpering
- Angry verbal outbursts
- Uncommon aggressive behaviour
- Uncommon anti-social behaviour

Triggered Persistent Behaviours of Concern

These behaviours occur frequently and are a result of an external stimulus. A solution or reduction of the behaviour can often be found by monitoring the behaviour to find out what is triggering the behaviour for this individual.



Activity
Select a person with dementia for whom you care. Describe an incident in which the person had behaved in a way that was difficult or challenging for staff.

Would you categorise this incident as:

- Persistent behaviour of concern
- Triggered behaviour of concern
- Persistent triggered behaviour of concern

Catastrophic Reactions

When people with dementia are under stress they often over-react with anger, crying, stubbornness, or even striking out at someone. This behaviour is called a catastrophic reaction. A catastrophic reaction is an over-reaction to major or minor stressors and is common among people with brain-damage. Even seemingly tiny amounts of stress can set off these reactions, therefore they are not easy to predict. However, the avoidance of stress is possibly the best preventative measure.

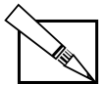
Some examples of what might cause a catastrophic reaction are:

- being surprised by sudden noise, activity or a series of events that come too quickly to be processed
- fatigue or stress
- confusing instruction
- not wanting to be touched at a particular time or by an unfamiliar person or other unexpected physical contact
- not understanding what is expected of them or their attention span is too short for the set task
- too many things going on at once, this could be people, noise or activity, and could lead to sensory overload
- being asked to respond to several things at once

- caregiver's impatience, stress or irritability
- not being able to make themselves understood
- frustration over inability to do something or go somewhere
- being scolded, confronted or contradicted
- being treated like a child, or asked to participate in an activity that is perceived as too childlike
- being pushed to do something they don't understand or don't want to do

Intervening in a Catastrophic Reaction

1. Don't argue. Attempting to explain the situation may be perceived by them as arguing, they will not understand and may get even more upset.
2. Retain a calm and pleasant manner and speak in a soothing, but not childish, way.
3. If you are in an area that has a lot of activity or people in it, take them to a place that has a calm atmosphere.



Activity
What is a Catastrophic Reaction?

Causes of behaviours of concern

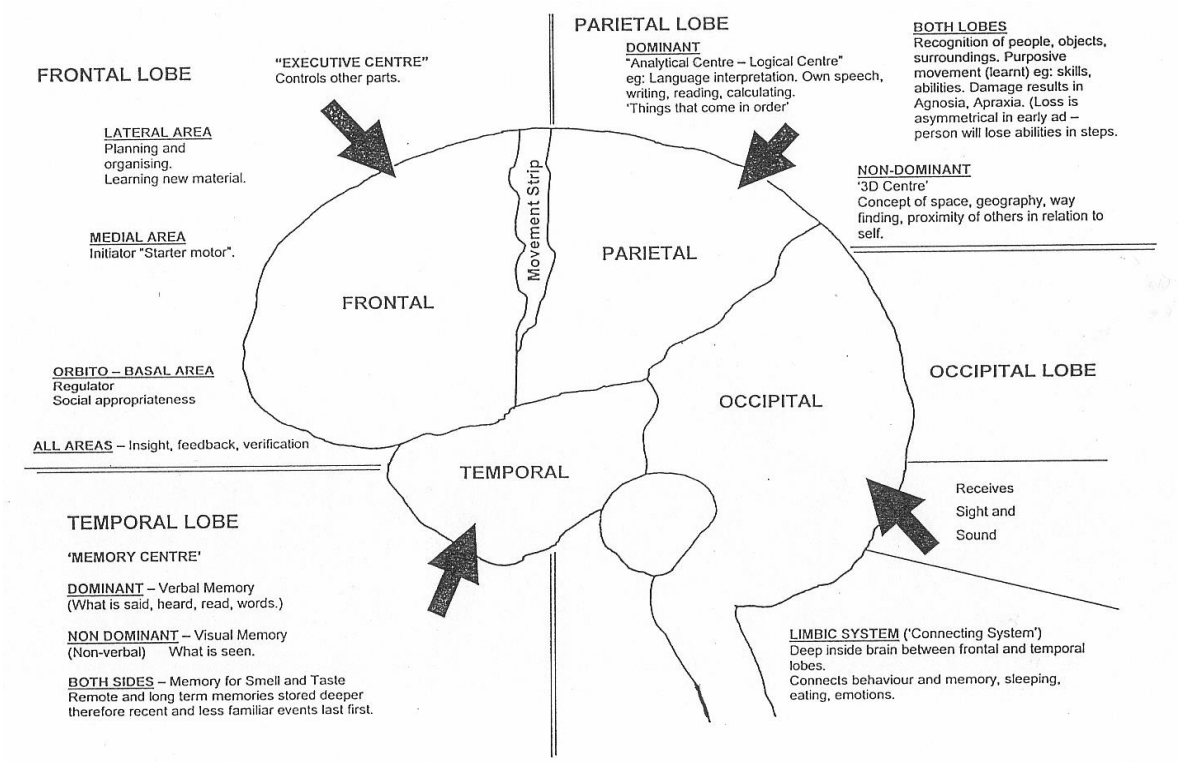
Behaviours of concern may be the result of many causes ranging from:

1. neurological impairment
2. physical illness
3. past history / personality
4. the physical environment

Prevention is the key. To prevent these behaviours, it is important to understand the reason for the behaviour and identify the cause. A comprehensive assessment of past and present roles and interests will provide an understanding of the person's behaviour.

1. ***Neurological Impairment***

The diagram below illustrates the functions of the primary areas of the brain. Damage in these areas results in loss or disruption of the related function(s).



2. ***Excess disability/ physical health***

Excess disability is term used to describe the deterioration in behaviour or functioning that goes beyond the impairment that can be explained by dementia alone. *It is when something other than dementia is affecting the person with dementia.*

People with dementia are vulnerable to developing excess disability. Often the only symptom we can see is a rapid deterioration in behaviour and functioning. Direct care staff are in the best position to spot a change in level of functioning as they know their client and what is deemed "normal" for them. Excess disability in individuals who have dementia may be due to:

a. Illness and pain
b. Medication
c. Delirium
d. Sensory impairment
e. Psychiatric symptoms
f. Fatigue and/or stress

a. Illness and Pain

An individual with dementia often has co-existing medical problems. The effect of minor illnesses such as a cold or the flu can result in increased confusion and lethargy. Constipation is another common problem in the aged, if left untreated it can be painful, lead to bowel impaction and in some cases, delirium. Constipation can affect the "normal" demeanor of a person with dementia and may cause reactions not anticipated by those providing their care.

Major illnesses such as diabetes, heart failure, infections and respiratory disorders can cause rapid changes of functioning and behaviour over a period of hours or days.

The pain of arthritis or muscle cramps may cause the person with dementia to become additionally or unusually agitated. Pain could result in them screaming or in an unusual refusal to participate in their care or activities. As people age their bones become more fragile and even minor falls or bumps can result in bruising or broken bones. You should be alert for signs of anxiety, anger and hostility as these emotions can all be manifestations of pain.

b. Medications

The elderly, due to reduced organ mass and fat and lean body mass changes, are vulnerable to overmedication, reactions from combinations of drugs and their side effects. These physiological changes that occur during the ageing process can increase the risk of adverse drug reactions and drastically alter the pharmacodynamics (what the drug does to the body) and pharmacokinetics (how the body deals with the drug) of medication. The elderly can have an enhanced sensitivity to medication because of changes in the quality or quantity of drug receptors (Pharmacodynamics). A decline in metabolism and elimination can also increase an individual's response to medication (Pharmacokinetics).

Confusion and a sudden change in level of functioning may be due to the side effect of a prescribed medication. Commonly prescribed behaviour modification drugs (Psychotropic medications) such as Largactil, Modecate, Stelazine, Melleril, Seranace, Risperidol and Zyprexia, have a variety of unpleasant and unwanted side effects. These include postural hypotension, muscle stiffness, tremors, urinary difficulties, dry mouth and sedation. The side effects can vary according to the type of medication used and the individual. Some individuals experience a paradoxical effect to psychotropic medication and instead of improving the behavioural disturbances, the individual may experience deterioration in cognitive and functional levels which could, in turn, create additional behavioural disturbances.

General physical illnesses and the associated treatment regime can also predispose an elderly person to developing excess disability. Any change, withdrawal or addition of medications can produce cognitive and behavioural changes. Direct care staff should be alert for cognitive or behavioural changes that occur after a change in medication and refer the individual to their treating doctor for further investigation.

c. Delirium

Delirium affects 15 to 56% of older people. Signs of delirium include a rapid onset of symptoms, impairment of attention, change in cognitive function or development of perceptual disturbances. Delirium resembles dementia in that the person has trouble thinking and may act strangely. A further sign of delirium is a sudden deterioration in the person's mental state that can fluctuate over hours or days. The person is not fully alert or able to focus attention. Delirium may result from conditions that disturb cerebral metabolism eg. systemic infection, poisoning, drug intoxication, and fluid and electrolyte imbalances.

d. Sensory Impairment

Elderly persons can also experience sensory impairment such as poor vision and hearing. Impaired eyesight and hearing can impact on communication with others and contribute to a sense of isolation. Cataracts cause clouding of the lens that blocks or changes the amount of light available for vision. Individuals can have an increased sensitivity to glare that causes irritation or pain. Dry eyes or excessive tears may also obscure vision.

Hearing loss can also be part of the normal ageing process, the result of disease or of a blockage in the ear canal. An elderly person with a hearing impairment can misinterpret noise in their environment and become distressed. If they are unable to correctly hear a conversation they may act in a suspicious or stubborn manner and become accusatory towards others.

e. Psychiatric Symptoms

Vision and hearing impairment may predispose an elderly individual to sensory hallucinations or illusions.

Hallucinations are distortions of perception that occur in the absence of external stimuli. They can involve any of the senses with auditory and visual hallucinations being the most common. A person who is experiencing hallucinations may talk or argue with themselves, or have unusual facial expressions or posture. They may question others about whether they heard, saw or smelled something unusual.

Illusions are a misinterpretation of a real external sensory experience. To an individual who is experiencing an illusion, a hat stand may appear to be a man or a friendly greeting is misinterpreted as criticism. People who are distressed by their symptoms will need reassurance and clarification as to what is reality.

Delusions are also frequent in middle to late stage Alzheimer's disease. Delusions are firmly held beliefs that cannot be altered by logic and are not shared by others of the same cultural background. An individual may believe the room is bugged or that others are stealing their possessions. Social isolation, hearing impairment or cerebrovascular lesions can cause these late-life delusions. Arguing about the delusional content is pointless, as these ideas will not be altered by reasoning with the person. It is important to make it clear that you don't share the person's views.

Symptoms of hallucinations, illusions and delusions can increase behavioural disturbances, anxiety and distress. These phenomena are almost always distressing for the person leading to diminishing and deteriorating communication with others, as the individual becomes preoccupied with their symptoms. A person experiencing these symptoms needs to be referred to their treating doctor for further investigation. These interventions may include an examination for visual and hearing impairments. Symptoms will usually decrease once treatment is commenced.

Anxiety and depression are common in persons with dementia. A person can develop anxiety as the result of a medical illness, depression, abuse, social losses or cognitive decline. Depression can resemble dementia and presents as impaired concentration, apathy, sleep disturbance and thoughts of hopelessness or worthlessness. Individuals with dementia who are anxious can get upset and agitated. Interventions should focus on improving the person's self-esteem and decreasing their anxiety. Individuals need an opportunity to talk about their thoughts and feelings. Involving the person in activities that provide acceptance, reduce the likelihood of failure and increase opportunities for success will diminish their levels of anxiety and hopelessness.

f. Fatigue and stress

Elderly people tire easily, even when they do not appear to have "done" anything. As we all know, there are days that a person can wake up feeling tired. Fatigue will result in stress.

Stress can have a variety of causes. It could be that the person with dementia is not sleeping well, is not responding well to changes in their environment such as new staff or it could be the result of changes to the medication regime. Whatever the cause of their fatigue and/or stress, the result will be manifested in changes in their level of functioning and behavioural disturbances.

3. Past History & Personality

The past history and personality of people with dementia may predetermine their reactions and impact on their current behaviour. For example, a person who was a policeman may always react with authority and suspicion of people's motives. An understanding of their prior occupation, hobbies, interests and behaviour will assist staff to interpret current responses and develop interventions that are targeted to meet individual needs. It is important to acknowledge the unique contribution that family can make in the care for a person with dementia. The family carer has information based on years of contact with the client and providing the answers to the topics below will assist staff to understanding what motivates the client and their possible responses in a given situation.

- Preferred name
- Where did the client grow up
- Client's occupation
- Names of children and grandchildren
- What type of activities does the client enjoy
- How do they spend their time at home
- Type of hobbies or interests
- Is there any person, topic, event that should be avoided?
- How does the person respond to physical contact?
- Does the person prefer the company of others
- What was the usual time of day for a bath or shower?
- What is their favourite food or drink
- Does this client identify with a specific cultural group?
- Are there cultural practices that should be continued?
- What can the staff do to make this person feel more at home?

4. <u>Physical Environment/Sensory Environment</u>

The physical environment consists of the things that surround us all the time, and what we can see, hear, smell, touch or otherwise sense. Elements of the physical environment can influence the behaviours of a person with dementia as the environment provides clues as to its purpose and therefore the behaviour expected within that space. For example, at lunchtime, the dining room has tables set with crockery and cutlery indicating that it is a place to eat.

The environment should be easily identified and understood by the person with dementia and offer comfort, pleasure and familiarity. Consider the following:

- Textured furnishings can stimulate the sense of touch for comfort.
- A home-like environment contributes to a sense of security, assists memories and recall. Reality orientation such as clocks, calendars and signs promote the person with dementia's ability to respond more naturally and appropriately.

- Furniture, signs, and the layout of a room provides clues as to the expected behaviour within that environment.
- A physical environment that is subdued in colour and noise can still provide adequate stimulation and pleasure and diminish over-stimulation and stress.
- Music can provide stimulation, as it lifts the spirit and increases the attention span. However, there will be individual variation in people's response to environmental stimuli. Music that is soothing to one individual may be irritating to another.
- As stated previously, space is an important aspect of the environment. Boundaries between public and private areas should be clearly defined. Acknowledging personal space reinforces a person's dignity and self-concept.
- People with dementia should have access to a safe and adequate area where they can wander. Wandering can reduce agitation and promote healthy exercise.

The negative aspects of the physical environment, those that the person with dementia cannot identify nor understand, will result in behavioural disturbances. Environmental factors that contribute to confusion and disorientation include sensory deprivation, sensory overload, lack of privacy, noises, lighting, shadows.

- A lack of touch, mental stimulation and sensory impairments can lead to withdrawal, boredom, and physical complaints.
- Sensory overload is a condition resulting from too much sensory input at any one time and over which the impaired brain cannot exercise control. A lack of privacy and excessive noise levels can both cause over-stimulation and stress.
- Poor lighting and shadows can result in perceptual disturbances such as hallucinations and illusions.

Elements in the physical environment play an important role in the behaviour of impaired people and therefore the many elements of the physical environment can be controlled by staff to support the impaired person's remaining abilities and reduce behavioural disturbances. Supportive environments can be created by observation of the individual's behaviour, review of past information and interventions, and the development of several options.

Angry or agitated behaviour

Angry or agitated behaviours are not deliberate responses. These behaviours can indicate that the person is feeling a loss of control over their life or that they are frustrated. Medications can reduce agitated behaviour, however there can be adverse side effects. The best effect will be achieved by identifying and eliminating or managing the cause of the anger.

Physiological or medical

- Fatigue
- Disruption of sleep patterns
- Physical discomfort or pain
- Medications
- Impaired vision or hearing
- Hallucinations

Environmental

- Sensory overload
- Unfamiliar people, place, sounds
- Sudden movements
- Feeling lost

Other

- Being asked to respond to several things at once
- Caregivers' impatience, stress or irritability
- The person is scolded, confronted or contradicted
- Unexpected physical contact
- Changes to schedule or routine
- Attention span too short for the task set
- Task not broken down into manageable steps
- Activity perceived as too childlike or insulting

Management strategies for angry or agitated behaviours

- Medical evaluation including a medication check
- Check for sensory deficits
- Plan outings and activities for when the person is rested
- Reduce sensory overload
- Keep the daily routine as consistent as possible and avoid changes
- Use orientating information
- Remove the person from a stressful situation, person or place
- Try distracting
- Exercise regularly to help reduce stress
- Try music, massage, or quiet readings as a way to calm the person
- Avoid reasoning and rationalising which can lead to frustration or increase the agitation or aggression
- Do not express your anger. Beware of demonstrating impatience with verbal and non-verbal messages.
- Anger is often a sign that the person is feeling a loss of control of his or her life. Acknowledge these feelings. If you feel that your physical safety is threatened, stand out of reach, leave the scene and call for help.

Helpful reminders

1. Realise that the behaviour is not the result of willful acts by the person with dementia.
2. Solutions lie with us, not in asking the person with dementia to change.
3. Look for warning signs. These are often in the form of non-verbal signs.
4. Intervene when you first see the signs, do not wait until it is a full-blown catastrophic reaction.
5. Look for signs of physical illness, pain or discomfort, particularly if the outbursts are occurring with frequency.
6. Try to think of what might have happened before the outburst, with the thought of trying to prevent a reoccurrence.

Behavioural intervention strategies

When planning responses to behaviours of concern, staff need to have a consistent approach. A consistent approach requires staff to consult as a team and to avail themselves of the services of health professionals and behaviour management advisors such as the Alzheimer's Association of Queensland. Once a response has been chosen all staff must consistently apply the intervention so as to be able to identify if the response did, or didn't achieve the elimination or reduction of the behaviour.

The four R's of behavioural intervention strategies are:

- reconsider,
- redirection,
- reassurance and
- restrain.

Reconsider

Look at the behaviour from the person with dementia's point of view. Consider the aspect of having little or no control over your life. Consider the effect of the illness in rendering objects and people that surround you as unfamiliar.

Speak to family and friends learn to understand the reasons behind some of the behaviours. By involving the person in activities or roles they previously enjoyed this may reduce behaviours. Additionally, if there were activities that they didn't enjoy or trigger memories of bad situations, try to avoid these.

Example: *John, a resident in a dementia unit, was constantly removing furniture from the dining room and stacking it against the wall. He would become physically aggressive if attempts were made to stop him.*

Reconsider: *John had been a furniture removalist. By stacking the furniture, he was simply continuing to fulfill his role in life and giving himself a purpose for his existence.*

Redirection

This is when you change the focus from the unwanted negative behaviour to a preferred positive behaviour. To be effective, the alternate behaviour should be of equal importance, interesting and desirable to the person with dementia.

Example: *Clearly, John's behaviour was interrupting the routine of the unit especially the provision of meals.*

Redirection: *John was given a 'job number' before each mealtime. His job was to set up the furniture in the dining room ready for meals, which he did with enthusiasm. Afterwards, he once again would restack the furniture.*

Reassurance

Remember that some behaviours are a result of brain damage. As a result, people with dementia are distressed regarding their feelings of confusion, frustration and terror. Feelings need to be acknowledged and validated.

Strategies to respond to challenging behaviour include:

- Distraction
- Discussion of current events
- Reminiscence
- Music and dancing
- Walking

- Talking about familiar and favourite things
- Alternative therapies such as aromatherapy, art therapy, pet therapy, sensory therapy.
- Orientation to the day, date, time of day, place, person, carer, family relationships, weather, to decrease risk of misinterpreting their environment
- Manipulate stimuli such as activity, noise, music, lighting, decor
- Adequate lighting

The aim is to use creative and least restrictive approaches to behaviours of clients with dementia.

Restrain

Restraint - can be direct or indirect and will control behaviour by restricting movement and controlling. There are two main types of restraint:

- Mechanical/physical
- Chemical

Examples of mechanical restraints are:

- vests,
- "Geri" chairs,
- recliners,
- bed rails.

Examples of chemical restraints are:

- medications,
- psychotropic drugs.

The use of restraints is a violation of the human right to receive care in the least restrictive environment and is illegal, except in extreme cases. These extreme cases include:

- when all other strategies and interventions have failed
- as a last resort to prevent harm to self or others
- in situations of immediate high risk or emergency

In most cases, restraint is the least effective intervention for long term management of behaviours of concern. Indeed, restraint often makes the behaviour worse and can lead to injury and even death.

Things to remember

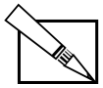
- The same behaviours can be caused by different things
- The same cause can lead to different behaviours
- You need to be able to develop your problem solving skills to prevent or reduce behaviours of concern.

- Approach each behaviour individually
- Be creative and flexible
- If one thing doesn't work, you might have to try another
- Not all behaviours of concern have a solution

Mr Jones, a returned serviceman, is 82 years of age. Currently he resides in Heavenly Home for the Aged. He has a long and complicated medical history of cardiovascular disease, Hepatitis C, chronic anaemia, and suspected cancer of the prostate.

Mr Jones, known as Alf to his close friends and family, is an avid horse lover. He has always lived on property, breeding horses. Alf has been a hard worker all of his life and remained very active on the property until the diagnosis of dementia five years earlier. In the late afternoon, Mr Jones insists on going home, even though he has lived in the residential care facility for 3 years.

He becomes very agitated, banging on the door saying he's being held prisoner, yells "help, help', and threatens to call the police. When approached by staff, Mr Jones physically hits, punches and pinches staff.



Activity
Why do you think Mr Jones behaves in this way? Consider his diagnosis of dementia, physical health, past history and personality, environment, and the interaction with staff.

Safety of self and others *(Should I go or should I stay?)*

Behaviours of concern are difficult for everyone involved, and whilst managing these behaviours may be part of your duties, it is not acceptable for staff and other clients to be hurt. The health and well-being of staff and other clients is paramount when dealing with concerning behaviours with the potential of physical violence. When responding to behaviours of concern, your safety, and the safety of others, must be your main priority.

Workplace Health & Safety

Obligations under the Act

- S28 Obligations of workers

Obligations of Employers

1. An employer has an obligation to ensure the workplace health and safety of each of the employer's workers in the conduct of the employer's business or undertaking.

<u>Obligations of workers and other persons at a workplace</u>

A worker or anyone else at a workplace has the following obligations at a workplace:

a) Comply with WH&S instructions
b) Use PPE where provided and instruction given
c) Not willfully or recklessly interfere with or misuse anything provided for WH&S
d) Not willfully place at risk the workplace health and safety of any person at the workplace
e) Not to willfully injure himself or herself

Staff sometimes think that their duty of care requires them to stay with the person exhibiting challenging behaviour. This is not always the case. If after attempting an initial response to resolve the situation you feel there is a strong possibility that they may become physically violent it is far better for staff to distance themselves, and others in the immediate vicinity, and allow the person time to cool down or run out of steam.

Duty of Care

Individuals who are dependent upon health care workers for physical and mental care are owed a 'duty of care'. This is based on the principle that health care workers must take reasonable care to avoid acts or omissions which would be likely to harm any person. If they fail in their duty of care, they may be subject to the civil action of negligence. Gross negligence may be viewed as a criminal offence.

Those treating or caring for others have a responsibility:

- To have knowledge and expertise in their field
- To act in a way which does not harm any person in their care
- To undertake all necessary actions which they can be reasonably expected to undertake given their field of expertise and the responsibility which they have at the time for the person in their care

Acts of commission may lead to malpractice suits.

Acts of omission may lead to claims of negligent practice.

Duty of care is not a list of rules that we must adhere to but a framework which we should work within. This is because there could not be one rule that applies to every situation that you may come across in your work.

Occasionally, the law has to consider if duty of care has been met or not met (breached) in certain cases. This will be decided on a case by case basis as every situation will be different. Essentially, the law will be looking at whether:

- Staff have worked in the best interests of the person who is in their care
- Staff have acted within the limits of their position
- Other professional carers with similar experience and training would also have acted in this manner

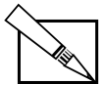
In some instances, when responding to concerning behaviours which have the potential of physical violence, asking for and obtaining, assistance from other staff members may be sufficient to diffuse the situation. However, you must be mindful that the person who is agitated may feel threatened by what they perceive as a show of strength. This could cause the situation to escalate.

Evasive self-defence assists staff to safely remove themselves from a violent situation and minimise the risk of injury to themselves and others. When applying evasive self-defence, the degree of force used must be proportionate to the degree of potential harm faced and must not be applied for longer than is reasonably required to control the risk.

Evasive self-defence strategies may provide staff with a controlled physical response when:

- retreat is blocked
- all other non-physical strategies have failed
- the person is under threat of attack
- or is being attacked.

The key to responding effectively to behaviours of concern is finding a sensible balance between quality of life for the clients, duty of care and the safety of staff. Your responses should reflect your organisational policies and procedures. If your client has repeated episodes of concerning behaviour then advice from other health professionals such as the GP, medical specialist, community health services, psychologist may be required.



Activity

Describe how your organisation's policy & procedure addresses the safety of staff and others.

CHCCCS020 Element 2: Apply response

Learning objectives:

On successful completion of this section, you will be able to:

1. Ensure response to instances of behaviours of concern reflect organisation policies and procedures
2. Seek assistance as required
3. Deal with behaviours of concern promptly, firmly and diplomatically in accordance with organisation policy and procedure
4. Use communication effectively to achieve the desired outcomes in responding to behaviours of concern
5. Select appropriate strategies to suit particular instances of behaviours of concern

Overview:

This section will outline the manner and methods you will use to implement an appropriate response to eliminate or reduce the incidence of behaviours of concern.

Steps of the problem solving process

The objective of the problem solving process is to develop interventions which will eliminate, or at least to reduce behaviours of concern. There are five steps involved in the problem solving process:

1. Assess the behaviour
2. Diagnosis
3. Plan interventions
4. Implement the plan
5. Evaluate

1. Assessing the behaviour

Establish a database of facts. The first step in solving a problem is getting a detailed and accurate description of the problem to be solved. A thorough assessment of the problem is needed. To do this, certain questions need to be addressed.

WHY	is it a problem to you/ the family/ the person with dementia? Who owns the problem?
WHAT	A full description of the behaviour
WHERE	is the person saying or doing it?
WHEN	is it time related, does it occur when certain things happen?
WHO	was involved?
HOW	is the person with dementia saying or doing it?

Is it the dementia or other health/medical problem? Is it the physical or human environment? Is it to do with the task? Is it a communication problem?
What happened immediately before the behaviour (the antecedent)? It might be necessary to keep a daily log to monitor the behaviour. Other sources from which to establish a database may include:

- health history, medical record, admission history
- physical assessment
- colleagues, family and friends
- research, journals and text books

Of importance: Any sudden change in behaviour should <u>firstly</u> be regarded as having been caused by a physiological change, requiring a thorough medical assessment.

2. Diagnosis

A. Analyse the data
B. Compare and look for consistencies
C. Determine a behavioural diagnosis that you and your colleagues understand

Is the behaviour a:

A. triggered behaviour
B. persistent behaviour
C. persistent triggered behaviour such as rummaging, hoarding and/or wandering
D. catastrophic reaction

3. Plan interventions

A. Determine appropriate interventions. Interventions must be appropriate for the individual, the behaviour and the environment in which the behaviour is occurring.
B. It is best to limit applied interventions to one at a time.
C. Ensure a team approach
D. Devise a care plan

4. Implementation

A. Carry out the planned intervention
B. Ensure a team approach and consistency of interventions
C. Reassess client continuously and update the data collection

5. Evaluation

A. Collect data about the person with dementia's response to the intervention
B. Assess the effectiveness of interventions
C. Modify the care plan if necessary.

By following the problem solving process and selecting and implementing strategies appropriate for the individual, the behaviour and the environment in which it is occurring, you are applying the principles of best practice.

Communication

Communication involves both understanding and producing language. A person with dementia may have difficulties in either or both of these areas. You may not understand what the person with dementia is saying but you might recognise the emotional state from the tone of the voice. The person may sound angry or upset but is unable to express their distress. It is important that their feelings are acknowledged and validated and that staff remain calm and accepting of their concerns.

Tips for Talking to a Person with Dementia

- Get their attention BEFORE trying to communicate a message. Call the person by name, touch gently or both.
- Address the person from the front where you can make eye contact
- Always identify yourself
- Think about your style of speech, the tone of your voice. Speak slowly and clearly. Keep it simple (depending on the level of communication difficulty), but always on an adult level. Give the person with dementia plenty of time to process the information. Deal with one thing at a time, and do not put more than one thought in a sentence that anticipates a response.
- Repeat what you said if you think the person with dementia did not understand. Use the same words unless you think the person did not understand the words you used. Do not raise your voice or speak more loudly, as loudness may be misinterpreted as anger or disapproval.
- Remember that language is dynamic, it changes from generation to generation. Be familiar with the words used in the client's formative years and in which they were educated.

- If you ask questions (depending on the level of communication difficulty), try to ask yes/no specific choice questions rather than open-ended questions. Use gestures or direct their attention to particular objects to help reinforce your words.

- Reinforce your verbal communication with appropriate facial expressions and body language. People with dementia who have trouble understanding words are sensitive to non-verbal communication. If you convey your impatience or unhappiness non-verbally while you are trying to provide care, the person with dementia will get a mixed message and may become more confused or react badly.

- If your client responds well to touch, don't hesitate to communicate through warm, sensitive and supportive touching.

- If you are going to do something (eg. an activity) announce to the person what you are going to do. This can avoid upset later.

- Do not say things in the presence of the person with dementia that you do not want them to hear. We cannot assume that because a person has dementia that he or she does not understand what is being said. Assume the person with dementia understands everything. Do not talk about the person with dementia in their presence as though they weren't there.

- To encourage on-going communication with the person with dementia, adapt your speech to topics you believe the person with dementia can relate to. This means trying many different things. When asking for opinions and feelings be as concrete as you can.

- Your speech and non-verbal communication should be responsive to what the person with dementia may be communicating to you. Sometimes the person's words may not make sense, but the body language or facial expression may give a clearer message. Try to respond to the real message rather than pushing the person with dementia to finding the right words.

- Do not ignore what the person with dementia is trying to tell you, even if it is off the topic you want to talk about or the activity you want the person with dementia to engage in.

- Do not interrupt the person with dementia unless you are doing so to distract the person from distressing feelings, disruptive behaviour or emotional over-reaction.

- By your verbal and non-verbal behaviour always communicate your respect for the person with dementia, not only for what he or she is at the moment, but also for what the person with dementia may have been before illness struck. Try to convey the notion that you are a "helper" or a concerned "friend". That is, do not send messages that you are a "keeper" or a "boss" or, for that matter, a "servant".

- Do not use nicknames, diminutives or infantising names like "baby", "good girl" or "big boy". First names or nicknames that were acquired previously may be alright if that's what the person wants to be called or if that is what he/she recognises best.

- Reality orientation is a technique that is often discussed in literature as a useful communication strategy. This involves reminding the person of the current day, time, year, relationship and occasions. Its effectiveness is limited when used with people with dementia who have short-term memory loss. The organic changes in dementia preclude the effectiveness of this strategy because lost memory cannot be restored. Reality orientation can therefore increase the confusion felt by a person with dementia.

Tips for Listening to a Person with Dementia

- Engage in active listening. Active listening requires giving full attention to the person with dementia. Listen with your eyes as well as your ears. Watch facial expressions and body language. Listen not only to the sense of the words, but to the tone and the attitude.

- Always assume that the person with dementia wants to communicate something, even if the words do not make sense. REMEMBER: Brain damage can interfere with communication in different ways.

- Encourage all efforts to communicate. When you can, help the person with dementia find the "missing word". Avoid correcting the person in a critical manner. Listen carefully to sounds, clue words or made up words that may be a substitute for the "missing word".

- If a person with dementia wanders away from the topic you were talking about in the middle of a ramble, "remind" the person gently about the subject matter you were talking about.

- Encourage reminiscence or repetition of poems, stories and past events if the person with dementia wants to tell you the same thing again and again. Repeated reminiscences may be like a visit to a familiar place providing comfort and reassurance.

- If you do not understand the person with dementia, ask them to repeat what they said. If that seems irritating or too difficult, try guessing and ask the person if that was what was meant. Try to get at the general thought the person with dementia was trying to convey.

- Try to ensure your listening expectations are consistent with the person's communication skills. If they are too high, your frustration might show. If they are too low, you subconsciously "talk down" to the person with dementia.

CHCCCS020 Element 3: Report and review incidents

Learning objectives:

On successful completion of this section, you will be able to:

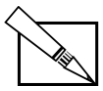
1. Report incidents according to organisation policies and procedures
2. Review incidents with appropriate staff and offer suggestions appropriate to area of responsibility
3. Access and participate in available debriefing mechanisms and associated support and/or development activities
4. Seek advice and assistance from legitimate sources as and when appropriate

Overview:

This section will outline the reporting of incidents and debriefing mechanisms according to organisational policy and procedures for self and others when responding to behaviours of concern.

Incident reporting

All staff are responsible for identifying and reporting incidents to their immediate supervisor/manager. In your organisation the supervisor/manager may be the person responsible for recording the occurrence of the incident on an incident report form. It may be that in your organisation both you and your supervisor will complete the incident report form or it could be your responsibility to complete the form and submit the completed form to your supervisor. It is important that you know and follow your organisation's policies and procedures. If anyone has been injured as a result of the incident involving behaviours of concern, it is essential that appropriate first aid/medical measures will be taken as applicable. It is your responsibility to know your organisation's policies and procedures and to follow the process required.



Activity
Describe the incident reporting procedure for your organisation.

Critical incident debriefing

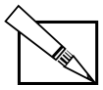
What is a critical incident?

A "critical incident" is any event that causes an unusually intense stress reaction.
Critical incidents usually occur suddenly and unexpectedly. The distress people experience after a critical incident limits their ability to cope, impairs their ability to adjust, and negatively impacts the work environment.

Examples of traumatic events that produce such reactions include:

- A violent or threatening incident in the work setting
- Severe verbal aggression
- Natural or manmade disaster that affects the workers ability to function in the workplace
- Deprivation of liberty
- Robbery
- Death or serious injury
- Suicide or threat of suicide
- Fire
- Bomb or hostage threat
- Explosion, gas, or chemical hazard

Critical incidents in the workplace need to be managed in line with established Workplace Health and Safety objectives, Emergency or Disaster procedures.



Activity
Describe an example of a critical incident that you may have witnessed or heard about.

Following an incident, there will be a need for staff, and any others involved in the incident, to debrief and address problems arising from the incident. Critical incident debriefing is a process that prevents or limits the development of post-traumatic stress in people exposed to critical incidents.

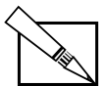
Professionally conducted debriefings help people cope with, and recover from, an incident's aftereffects. It enables participants to understand that they are not alone in their reactions to a distressing event, and provides them with an opportunity to discuss their thoughts and feelings in a controlled, safe environment. Optimally, debriefing occurs within 24 to 72 hours of an incident.

Debriefing

A closed confidential discussion of a critical incident relating to the feelings and perceptions of those directly involved in a stressful event is intended to provide them with:

- support
- education
- an outlet for views and feelings associated with the event.

Debriefings are not counselling nor an operational critique of the incident.



Activity
Describe the debriefing process for your organisation.

Resources
Alzheimer's Association of Queensland has a comprehensive library of dementia resources to assist you to complete your assignment. Please contact them directly for a full list of resources available.