



# Habilitation Therapy Toolkit

## *Maintaining Positive Resident Emotions*

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**A Competency-Based Approach to Providing Care to People with Dementia**  
*For Use in Skilled Nursing Facilities*

September 2016 Edition

*This material was adapted from resources obtained from the  
Alzheimer's Association Habilitation Therapy Program*



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*This material was prepared by Healthcentric Advisors, the Medicare Quality Innovation Network-Quality Improvement Organization for New England, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. CMSQIN\_C2\_032816\_0481*

## Executive Summary

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### Background

In 2015, an estimated 5.3 million Americans of all ages have Alzheimer’s disease. This includes 5.1 million people ages 65 and older and 200,000 individuals younger than 65 who have earlier-onset Alzheimer’s disease. Only 45% of people with Alzheimer’s disease have been told they have the disease<sup>1</sup>. By 2025, the number of people ages 65 and older with a dementia is expected to increase by 40 percent over current levels. By 2050, the level of affected individuals is expected to triple to a projected 13.8 million people, barring the development of a medical breakthrough.

Dementia is a catch-all phrase used to describe age-related senility. Alzheimer’s disease is included as a form of dementia. The number of Americans with Alzheimer’s disease and other dementias will grow as the population ages. In fact, Alzheimer’s disease represents 41 percent of all dementia cases. Other common dementias include Lewy-body disease, vascular dementia, fronto-temporal dementia (FTD), supranuclear palsy, and posterior cortical atrophy.

Unfortunately, Alzheimer’s disease and the other forms of dementia are seldom diagnosed, and each form of dementia presents with unique symptoms. Due to the lack of a specific diagnosis, the health provider’s approach to care needs to be person-centered, focusing on the individual’s physical and emotional needs. Care goals need to preserve as much function as possible and assist in maintaining a positive emotional state in the resident throughout the day.

Habilitation Therapy is an approach to dementia care that focuses on emotionally connecting with the person. In most forms of dementia the person’s ability to feel emotion, to respond to emotions and to perceive emotion in others remains intact even into late stages of dementia. Habilitation is a milieu therapy that is broken into six domains. Each domain contributes to the emotional state of the individual. Attention must be given to each domain. The goal of Habilitation Therapy is to bring about positive emotion (without the use of antipsychotic medication) and to sustain that emotion over the course of the day. Even though Alzheimer’s disease is a terminal disease, the focus of everyday care is on living with the highest possible level of wellbeing and quality-of-life.

<sup>1</sup> Alzheimer’s Association, 2015 Alzheimer’s Disease Facts and Figures. Alzheimer’s and Dementia 2015; 11 (3) 332.

## Habilitation Therapy Domains

Domain	Goal	Positive Emotion Because Individual Has...
<b>1. Physical</b>		
	Environment will direct cognition without patient's awareness	Improved master of environment
<b>2. Social</b>		
	Hold on to cognitive and social skills longer via practice	Meaningful activity and sense of purpose
<b>3. Communications</b>		
	Improve capacity to understand and be understood	Less frustration
<b>4. Functional Assistance</b>		
	Decrease excess disability	Improve perception of independence
<b>5. Behavioral</b>		
	Reduce unsafe/annoying behavior	Fewer negative interactions with staff and other patients
<b>6. Perceptual</b>		
	Make sensory cues more easily received	Less confusion

*Table developed by Life Care Center in Plymouth, MA*

### About This Toolkit

This toolkit has been developed using a Competency-Based Education (CBE) and Training framework. Learners will be able to focus on one competency at a time to help provide self-paced and practice-setting learning. The competencies can also be used to help facilitate group learning sessions within your practices and identify those areas in which you may benefit from spending more time and conducting more education session. Within each section you will find references and tools. The references can be used to provide more in-depth information on each competency, while the tools can be used in your individual practice setting to help master that competency.

The *Competency-Based Approach to Providing Care to people with Dementia: For Use in Skilled Nursing Facilities* is an education tool, based on Habilitation Therapy, designed to identify caregiver and support staff approaches for communicating with and caring for people with dementia. Communication with individuals having dementia is obtainable and can be accomplished by tapping into emotions!

This toolkit outlines the domains and approached recommended in *Habilitation Therapy: A New Starscape*, by Paul Raia, PhD, Alzheimer's Association Mass./N.H. Chapter. The approaches are translated into competencies that are needed to effectively care for individuals with dementia.

The majority of competencies are pertinent to all care staff—some specifically for nurses, and a few for building maintenance personnel.

Each domain is broken down into key competencies that can be achieved through knowledge, skill, and attitude. Some of the competencies may require mastery of one or more of these qualities.

-  **Knowledge** refers to what is needed to be learned. This learning is accomplished through professional education and ongoing training. When you see a checkmark in this column, it means that the individual must have some related education to achieved mastery of this competency.
-  **Skill** refers to demonstrated ability to perform the task in the skill area. This ability is acquired through professional education and applied practice. When you see a checkmark in the column, it means that the individual must have a practice skill (e.g., operating equipment or leading a group) to achieve mastery of this competency.
-  **Attitude** refers to the behavioral approach of the person to his/her work or task. This refers to how a person approaches his or her work. When you see a checkmark in this column, it means that the individual must not have a negative attitude and is willing to take on new or unfamiliar tasks (e.g., taking the time to get to know the patient).

### Steps in Using the Competency-Based Tool:

1. Review the competencies and check which ones you and your staff are already doing, or have staff members review to identify areas needing individual improvement.
2. Highlight the competencies that need to be addressed or need further work-up.
3. Educate staff members on each competency needing more work or to be learned.
4. Make sure staff members successfully demonstrate use of one competency before tackling another.
5. Include competency attainment in job expectations and evaluations.
6. Be sure to recognize workers when competencies have been achieved.

## What is Competency-Based Education?

Competency-based education is a systematic approach to improving clinical staff performance. It is learner-focused and allows an individual to work on one competency at a time at his/her own pace. Staff members have the option to skip a competency entirely if they are able to demonstrate mastery.

A competency differs from a learning objective in that an objective stated what you want the learner to know, while the competency indicated how you can be certain the learner knows it. Competency-based learning is used by many colleges, universities, education systems, and quality-based organizations.

Competencies are structured to provide care direction by identifying what it takes – knowledge, skill, and attitude – to achieve each competency. The tool can be used as an outline in identifying those techniques that are needed to address problematic behavior.

## Special Thanks

We thank Sandra Fitzler for the development of the April 2016 Edition of the **Habilitation Therapy Toolkit: *Maintaining Positive Resident Emotions.***

## Goals of Habilitation Therapy

- ✓ To bring about a positive resident emotion and to maintain that emotional state over the course of the day.
- ✓ To reframe the approach for care of individuals with progressive debilitating disease to delivering care in the “here and now”.



## Domain 1: Physical

**Definition:** Refers to staff responsibility to reduce the potential for fear and disorientation.

Competency 1: Maximize Resident Performance by Directing Cognition Without the Person's Awareness.	Knowledge 	Skill 	Attitude 
<b>Competency-Based Objectives</b>			
1. Check for physical triggers of behavior by reviewing and answering the Questions for Caregivers. <b>RESOURCE 1</b>			✓
2. Identify tasks/situations, using a behavior log, that cause residents fear and disorientation. <b>RESOURCES 2, 3</b>		✓	✓
3. Simplify directions to residents to enable function by breaking down tasks into segments (e.g., “put on sock” and after that is accomplished, “put on shoe”).	✓	✓	✓
4. Reduce the number of resident choices (e.g., offer one or two choices of clothing to wear).	✓		✓
5. Check for positive resident emotion before initiating care (e.g., look for smiling or body language that is relaxed – or not).			✓
6. Assess for adequate room lighting (e.g., 80-foot-candle power).	✓	✓	
7. Reduce glare and shadows from outside windows.	✓		✓
8. Use a behavior plan to note how physical enhancements can increase levels of functioning (e.g., resident has an easier time finding his room when his shadow box contains the car picture). <b>RESOURCE 5</b>	✓	✓	
9. Use color and textural contrast to draw attention to important environmental features (e.g., painting the bathroom door a primary color).	✓	✓	
10. Use camouflage to hide or distract dangerous elements (e.g., electrical outlets).	✓	✓	

### Tools & Resources:

1. **Questions to Pose When Caring for People with Dementia, Questions to Assess the Physical Domain:** *Page 9-10*
2. **Unit Behavior Investigation Log – Sample:** *Page 11*
3. **Individual Behavior Log – Sample:** *Page 12*
4. **Behavioral Analysis Protocol for Nursing Homes Interdisciplinary Team:** *Page 13*
5. **Habilitation Behavioral Plan – Sample:** *Page 14*

Please see **Appendix B:** for Blank Templates of Resources 2, 3 and 5

## Questions to Assess the Physical Domain

### Questions to Pose When Caring for People with Dementia: A Guide for Caregivers

When the behavior team is attempting to understand the trigger(s) of a resident's behavior, the domains of Habilitation Therapy can be useful as a framework for possible triggers to consider. By asking yourself the following questions to help determine root cause and by making approach correction (s) as needed, you will be able to bring about a positive emotion in the person with dementia, maintain it over the course of the day, and better handle resistance to care.

Focus on space design to automatically direct the person's behavior to allow function as independently as possible.

#### Lighting

- Is the lighting at the appropriate level?
- Are there shadows on the wall that may alarm or confuse the resident?
- Is the outside/ambient lighting glaring and affecting vision?
- Are there reflections of overhead light on the floor?
- Are residents walking into or toward a light source?

#### Noise

- Is there an overhead paging system agitating the resident?
- Is the noise level controlled?

#### Visual

- Are there color cues in place to aid in way-finding and using the environment more independently?
- Is there a clear visual distinction between the walls and floors?

#### Floor

- Is the floor patterned or visually complicated?
- Are there dark colored borders in the flooring or darker areas surrounded by lighter colored areas that might be interpreted as a hole in the floor?
- Are the transitions in flooring all within the same hue and without thresholds?

#### Living Environment *(continued on next page – please turn over)*

- Are resident rooms identifiable by a personalized visual cue or bright colored drapes or target wall?
- Is the common space large enough to accommodate the activity program and the number of residents?
- Is there enough common space to accommodate parallel activity programming?
- Is the crow's nest a space where the resident is uncomfortable sitting in a group, can sit apart from a group and large enough as not to be perceived as threatening?
- Are there dead-ended corridors that lead pacers into other resident's rooms?

### **Living Environment** *(continued)*

- Are the exit doors visually obvious and need to be better camouflaged?
- Does staff leave at the end of their shift from the unit with their coats on and inadvertently signal the message “leaving you and going home”?
- Is there unnecessary traffic going through your unit?
- Do the toilets stand out from the wall visually or does the toilet have a contrasting colored seat?
- Are all the bathroom doors on the unit painted the same bright color so that the residents can easily identify the bathroom?
- Are the tables in the dining are rectangular?
- Do you use colored place mats?
- Do you use light colored dishes with dark colored food and dark colored dishes with light colored food?
- Does furniture visually contrast with the color of the floor and walls?
- Do you have a low stimulation/quiet room or area?
- Are activity materials in reach or in view so residents can independently use them?
- Is there an outside area that residents can regularly utilize?
- Is the art interesting and framed with non-glare, shatter-proof glass?
- Do you have shadow boxes by the resident’s room so that families can decorate the boxes with the resident’s personal items?

## Unit Behavior Investigation Log

When	Name of Resident	<ul style="list-style-type: none"> <li>What is the behavior?</li> <li>Where did it happen?</li> <li>Who was there?</li> <li>What was going on before the behavior?</li> </ul>	Possible Cause Or Trigger	What can I change? Approach? Body language? Tone of voice? Etc.	Ex. Of The Physical Altercation (e.g. Pinch, Push, Strike You) Give Details	Reporter's Initials
5/12/16 7:10 am	Al Smith	<ul style="list-style-type: none"> <li>Slapped CNA during am care</li> <li>Occurred in resident room</li> <li>CNA and resident present</li> <li>Aid asked Al to get out of bed for am care and tried to remove his comforter</li> </ul>	<ul style="list-style-type: none"> <li>CNA did not take extra time to interact before care started</li> <li>CNA started instruction while AL was still in bed</li> <li>Al appeared to be threatened by the removal of the comforter</li> </ul>	<ul style="list-style-type: none"> <li>Start am care by spending 5 minutes to save 20 minutes</li> <li>Have CNA sit by AL, at eye level, and explain what needs to be done</li> <li>Give Al a choice to sit for a few min before getting out of bed</li> </ul>	<ul style="list-style-type: none"> <li>Al slapped the CNA's hand as she tried to fold back his comforter</li> </ul>	SC
4/3/16 3:35 pm	Mary Cataldo	<ul style="list-style-type: none"> <li>Repetitive vocalization -"Home"</li> <li>Occurred at change of shift</li> <li>CNA, other residents, &amp; children and grandchildren visiting another resident</li> <li>Mary was participating in activities</li> </ul>	<ul style="list-style-type: none"> <li>Mary saw CNA &amp; other staff leave unit at change of shift</li> <li>Children on unit may have reminded Mary of a past experience</li> </ul>	<ul style="list-style-type: none"> <li>Have staff leave belongings outside of unit</li> <li>Have staff changes occur away from resident areas</li> <li>Check with Mary's family about her history related to childcare</li> <li>Engage Mary in another a personal activity during change of shift</li> </ul>	<ul style="list-style-type: none"> <li>None noted</li> </ul>	AF

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## Individual Behavior Log

**NAME:** Stephanie Locke **ROOM:** 14B **DATE:** 02/30/16

### Background Info/Getting To Know Me:

I was a 3<sup>rd</sup> grade teacher and active in my community. I like to wear slacks and my favorite color is pink. I wear glasses. I have 3 children and 6 grandchildren. I am one of four children and my entire family lives close by. I like to go to bed by 8 pm and up at 6 am. I like to have morning coffee before getting ready for the day.

### Activities I Enjoy:

Listening to country music, reading newspapers, Bingo, and attending daily mass.

**BEHAVIORS:** 1. Agitation during day and when sitting by window 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**INTERVENTIONS:** 1. Reduce glare by repositioning 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**OUTCOMES:** 1. **Positive** 2. Some Effect 3. No Effect

Date	Shift	Behavior	Trigger	Intervention	Outcome	Additional Comments, Interventions, Suggestions	Nurses' Initial
2/28/26	7am-3p	Agitation when sitting by or in front of window	Blinded by glare from window	Reposition on day shift to glare not an issue	Good – agitation has decreased	Stephanie is sensitive to glare. Make sure she doesn't sit in areas of direct sun	
	3pm-11p						
	11pm-7a						

Triggers: what happened before the behavior started (E.g. Noisy room)

# Behavioral Analysis Protocol for Nursing Home Interdisciplinary Team (IDT)

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## *Thought Sequencing Steps in Writing a Behavioral Plan*

**This is a step-by-step guide for the IDT in determining how to address problem behaviors and interventions**

1. Develop a statement of the problem.
2. State the goal of the plan/intervention.
3. Describe the behavior (detailed description not interpretation). Note: the description of the behavior is not always the same as the problem – for example: John yells (behavior) others are agitated (problem).
4. Note any observed patterns in behavior attained in the behavioral log – for example: John yells after family visitors leave.
5. Check with family for previous behavior history and interventions used by the family.
6. Look at most recent or relevant Minimum Data Set (MDS) assessment – for example: Customary/Routine section, Care Area Triggers (CATs) and Care Area Assessments (CAAs).
7. State a working hypothesis as to the cause or triggers of the behavior.
8. Describe the intervention. Be specific.
9. Estimate the duration of the intervention to be implemented.
10. Estimate what percent of the behavior(s) you anticipate the intervention will address and how you plan to address the remaining behavior(s).
11. Identify who has been informed of this problem and how you are meeting regulatory standards in your immediate response to the problem.
12. Decide who will inform authorized family/guardian and medical professionals that the behavior intervention plan is in progress.
13. Identify who will chart progress of the intervention and how often.
14. Indicate if the behavioral log will be used to implement the intervention while it is being tested.
15. Once the intervention has been found to work, enter the intervention in the resident's behavior care plan – behavior logs are NOT retained.

## **Thought Sequencing Steps to be addressed in the Behavior Team Performance Improvement Plan**

- Identify how staff (all staff or selected caregiver) training will occur (in-service and during stand-ups, who provides the training, and the date for training to be completed).
- State how often the team will meet to assess interventions, outcomes, and the measures/methods used to assess the outcomes – for example: weekly.
- Identify what performance improvement process (like PDSA) will be used to determine plan success and areas needing further refinements.

## Habilitation Behavioral Plan

<b>Name:</b>	<i>Jane Doe</i>	<b>Date:</b>	<b>02/01/16</b>
<b>Identified Behavior:</b>	<ul style="list-style-type: none"> <li>• <i>Repetitive vocalization of "Ouch"</i></li> </ul>		
<b>Underlying Emotion:</b>	<ul style="list-style-type: none"> <li>• <i>Frustration or Pain</i></li> </ul>		
<b>Cause/Triggers:</b>	<ul style="list-style-type: none"> <li>• <i>Lack of engagement</i></li> <li>• <i>Boredom</i></li> <li>• <i>Pain</i></li> </ul>		

## Interventions for Prevention

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- Provide structured engagement
- Encourage storytelling
- Provide 1-1 (including family provided personnel)
- Provide touch (hug, hand holding, run shoulders)
- Listen to Jane
- Asses pain frequently
- Allow Jane to move freely on the unit
- Jane enjoys time behind the nurses station with staff

## Intervention for De-Escalation

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- Allow Jane to rock in her wheelchair
- Provide 1-1
- Include Jane in an activity

## Domain 2: Social

**Definition:** Refers to developing a failure-free activities plan.

<b>Competency 2:</b> Apply Skill in Structuring Activities.	<b>Knowledge</b> 	<b>Skill</b> 	<b>Attitude</b> 
<b>Competency-Based Objectives</b>			
<b>1.</b> Check for meaningful activities by reviewing and answering the Questions for Caregivers. <b>RESOURCE 1</b>			✓
<b>2.</b> Understand the importance of activities and that people who are inactive do nothing and experience more psychiatric symptoms such as anxiety and depression.	✓		
<b>3.</b> Confer with the behavior team and use resident biographical information to note importance of meaningful activity.	✓	✓	✓
<b>4.</b> Assess cognitive strengths and weaknesses (e.g., use/refer to the MDS 3.0 Section C – Cognitive Patterns)	✓	✓	✓
<b>5.</b> Identify on the behavior log what will evoke and what will inhibit positive emotions (e.g., resident gets agitated when family visitors leave). <b>RESOURCES 2, 3</b>	✓	✓	✓
<b>6.</b> Select and utilize activities having personal meaning for the resident and that foster a sense of belonging and purpose (e.g., have a retired school teacher prepare lesson plans).	✓	✓	
<b>7.</b> Identify the need for reminiscent opportunities (e.g., reviewing family pictures).	✓		✓
<b>8.</b> Arrange meaningful activities in the late afternoon to distract from dimming light.	✓		✓
<b>9.</b> Demonstrate an understanding that activity cannot be introduced once agitation exists.	✓		
<b>10.</b> Demonstrated the need to try an activity later in the day when the resident may be more cooperative	✓		
<b>11.</b> Use a behavior plan to note that activities are individually selected and based on previous interest. <b>RESOURCE 5</b>	✓		✓
<b>12.</b> Demonstrated and understanding that musical activities can very quickly change emotions.	✓		

### Tools & Resources:

1. **Questions to Pose When Caring for People with Dementia, Questions to Assess the Social Domain:** *Page 17*
2. **Unit Behavior Investigation Log – Sample:** *Page 18*
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## Questions to Assess the Social Domain

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### Questions to Pose When Caring for People with Dementia: A Guide for Caregivers

When the behavior team is attempting to understand the trigger(s) of a resident's behavior, the domains of Habilitation Therapy can be useful as a framework for possible triggers to consider. By asking yourself the following questions to help determine root cause and by making approach corrections(s) as needed, you will be able to bring about a positive emotion in the person with dementia, maintain it over the course of the day, and better handle resistance to care.

Involve the development of individualized, failure-free activities programs to fully engage the person, without the risk to self and others, and provide a sense of self-worth and accomplishment.

- Did you use information in the resident's personal bio provided by the family to determine how you introduce the resident to care tasks?
- Have you reviewed the Minimum Data Set for activities that are customary and routine?
- Did you consider resident characteristics (age, sex, ambulatory) and dementia type when dealing with aggressive behavior and risk to others?
- Have you planned activities that are resident-specific and meaningful?
- Does the resident excessively nap during the day?
- Is the resident bored, lack adequate sleep at night, or take medication impacting wakefulness?
- Do the resident's family or friends visit on a regular basis? If not, is this contributing to problem behavior?
- Have you noted personally meaningful activities that helped address behavioral issues in the resident's behavior plan?
- Do you arrange activities in the late afternoon to distract from dimming light?
- Do you try an activity later in the day when an agitated resident may be more cooperative?
- Do you know what kind of music the resident likes and do you play that music for calming or during activities associated with problem behaviors?
- Do you arrange for an opportunity for the resident to reminisce?

## Unit Behavior Investigation Log

When	Name of Resident	<ul style="list-style-type: none"> <li>• What is the behavior?</li> <li>• Where did it happen?</li> <li>• Who was there?</li> <li>• What was going on before the behavior?</li> </ul>	Possible Cause Or Trigger	What can I change? Approach? Body language? Tone of voice? Etc.	Ex. Of The Physical Altercation (e.g. Pinch, Push, Strike You) Give Details	Reporter's Initials
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Triggers: what happened before the behavior started (E.g. Noisy room)

# Behavioral Analysis Protocol for Nursing Home Interdisciplinary Team (IDT)

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4. Note any observed patterns in behavior attained in the behavioral log – for example: John yells after family visitors leave.
5. Check with family for previous behavior history and interventions used by the family.
6. Look at most recent or relevant Minimum Data Set (MDS) assessment – for example: Customary/Routine section, Care Area Triggers (CATs) and Care Area Assessments (CAAs).
7. State a working hypothesis as to the cause or triggers of the behavior.
8. Describe the intervention. Be specific.
9. Estimate the duration of the intervention to be implemented.
10. Estimate what percent of the behavior(s) you anticipate the intervention will address and how you plan to address the remaining behavior(s).
11. Identify who has been informed of this problem and how you are meeting regulatory standards in your immediate response to the problem.
12. Decide who will inform authorized family/guardian and medical professionals that the behavior intervention plan is in progress.
13. Identify who will chart progress of the intervention and how often.
14. Indicate if the behavioral log will be used to implement the intervention while it is being tested.
15. Once the intervention has been found to work, enter the intervention in the resident's behavior care plan – behavior logs are NOT retained.

## **Thought Sequencing Steps to be addressed in the Behavior Team Performance Improvement Plan**

- Identify how staff (all staff or selected caregiver) training will occur (in-service and during stand-ups, who provides the training, and the date for training to be completed).
- State how often the team will meet to assess interventions, outcomes, and the measures/methods used to assess the outcomes – for example: weekly.
- Identify what performance improvement process (like PDSA) will be used to determine plan success and areas needing further refinements.

## Habilitation Behavioral Plan

<b>Name:</b>	<i>Jane Doe</i>	<b>Date:</b>	<b>02/01/16</b>
<b>Identified Behavior:</b>	<ul style="list-style-type: none"> <li>• Repetitive vocalization of “Ouch”</li> </ul>		
<b>Underlying Emotion:</b>	<ul style="list-style-type: none"> <li>• Frustration or Pain</li> </ul>		
<b>Cause/Triggers:</b>	<ul style="list-style-type: none"> <li>• Lack of engagement</li> <li>• Boredom</li> <li>• Pain</li> </ul>		

## Interventions for Prevention

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- Provide structured engagement
- Encourage storytelling
- Provide 1-1 (including family provided personnel)
- Provide touch (hug, hand holding, run shoulders)
- Listen to Jane
- Asses pain frequently
- Allow Jane to move freely on the unit
- Jane enjoys time behind the nurses station with staff

## Intervention for De-Escalation

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- Allow Jane to rock in her wheelchair
- Provide 1-1
- Include Jane in an activity

## Domain 3: Communications

**Definition:** Refers the increase use of body language for effective communication.

<b>Competency 3: Understand That Eliciting Positive Emotions is Critical.</b>	<b>Knowledge</b> 	<b>Skill</b> 	<b>Attitude</b> 
<b>Competency-Based Objectives</b>			
1. Check for communication triggers of behavior by reviewing and answering the Questions for Caregivers <b>RESOURCE 1</b>			✓
2. Use body language (gestures, demonstrations, drawings) to communicate with the resident.		✓	✓
3. Understand that behavior can have internal and external causes (e.g., internal – pain causing resident to cry out, external – wrong approach by caregiver causing resident to cry out).	✓		
4. Understand that behavior can never be changed with words – only by changing what one does.	✓	✓	
5. Demonstrate the elimination of the word “no” from staff-to-resident communication.	✓		✓
6. Demonstrate the use of distraction to refocus and redirect negative behavior (e.g., resident asking to go outside in a snow storm and caregiver saying “That sounds fun, let’s make a sandwich first”).	✓	✓	
7. Understand that reality orientation is not useful (e.g., resident asking for mother and reminding that mother is deceased).	✓		
8. Acknowledge the underlying emotion to reduce fear (e.g., resident insisting someone took her purse and caregiver stating “I feel lost when I lose my purse. Let’s go look for your purse”).	✓	✓	
9. Understand the need to make the resident feel loved and safe.			✓
10. Use listening techniques to identify emotions that are driving behavior.	✓	✓	✓
11. Demonstrate application of the basic rules of communication <b>RESOURCES 2,3</b>	✓		✓
12. Demonstrate use of therapeutic fiblettes.		✓	✓
13. Demonstrate the need to approach a resident from the front left so that the resident turns to his or her right and uses the more active side of the brain.	✓	✓	
14. Understand that residents can be accessed through their emotional memory.	✓		✓

### Tools & Resources:

1. **Questions to Pose When Caring for People with Dementia, A Guide for:** Page 24
2. **Habilitation: Basic Rules of Communication:** Page 25
3. **Reducing Care-Resistant Behavior in Oral Hygiene:** Page 26-27  
[www.uab.edu/smsfiles/video/cgi?OU=SON&VIDEO=Grants/Jablonski/DNT.mp4](http://www.uab.edu/smsfiles/video/cgi?OU=SON&VIDEO=Grants/Jablonski/DNT.mp4)

## Questions to Assess the Communication Domain

### Questions to Pose When Caring for People with Dementia: A Guide for Caregivers

When the behavior team is attempting to understand the trigger(s) of a resident's behavior, the domains of Habilitation Therapy can be useful as a framework for possible triggers to consider. By asking yourself the following questions to help determine root cause and by making approach correction(s) as needed, you will be able to bring about a positive emotion in the person with dementia, maintain it over the course of the day, and better handle resistance to care.

Focus on non-threatening communication techniques to elicit positive resident emotion.

- Did you approach the resident from the front so you can be seen?
- Did you startle the resident?
- Did you say the resident's name and then your name?
- Did you assume the resident remembered you or what you did with him/her earlier in the day or week?
- Did you approach slowly and then sit or stand by the resident's left side in order to engage the resident's right side of the brain?
- If the resident is seated, did you ask permission to sit by him/her?
- Did you stand if the resident is standing or get down to the resident's eye level if they are seated?
- Were you mindful of your body language and tone of voice?
- Are you smiling and using a friendly tone of voice?
- Are you speaking slowly, loud enough and clearly so that you are understood?
- Did you violate the resident's personal space?
- Did you assume the resident can learn something new?
- Did you assume the resident could change his/her behavior by telling him/her not to do it again?
- Did you argue with the resident?
- Did you use the word "no" or say "don't do that" or "you can't do that"?
- Did you refocus the resident's thinking to something away from what they wanted to do rather than saying "don't do that"?
- Did you try to correct the resident when he/she thinks something is true but you know is not true or accurate – like time, place, and person?
- Were you able to use "therapeutic fiblette" so as to avoid a negative emotion?
- Were you able to connect with the resident emotionally using language or body language?
- Were you able to validate the resident's feeling even if his/her feeling were not being logical?
- Are you able to look beneath the resident's words to understand what he/she is really saying emotionally?
- Did you use appropriate gesturing to make your interventions known to the resident?
- Did you give one or two step directions?
- Did you limit choices verbally?
- If the resident is having a difficult time making a choice, did you start by saying, "I know you like \_\_\_\_\_, would you like it now"?
- Did you hug the resident when appropriate to communicate a feeling?

# Habilitation Therapy

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## Basic Rules for Communications

- Always approach the resident from the front.
- Always indicate your name and say the resident's name every time you have an exchange – even if it is several times during the course of the day.
- Be aware of body language – make sure you are smiling and using a positive tone of voice.
- Always say something positive about the person every time you interact.
- Try to maintain eye contact with the resident even though the resident may be looking at your mouth. As individuals lose the ability to understand language, they become inadvertent lip readers. Having female staff wear lipstick will facilitate lip reading.
- Be at the same level as the resident – sitting or standing.
- Never position residents so that a light source (window or lamp) is behind you as you face them. A light source behind you makes it difficult for the resident to see your face.
- Always “chunk” information into short, explicit commands.
- Do not use metaphors or abstract phrases.
- If the resident loses train of thought – reorient him/her.
- If the resident is struggling to find a word – offer it.
- If the resident cannot remember something – offer a reassuring pat on the hand and comment (for example, “It’s alright, it will come back to you later”).

## Reducing Care-Resistant Behavior (CRB) In Oral Hygiene

Threat-Reduction Strategies	
Description of Strategy	Rationale
Approach the resident at eye level and within his/her visual field.	Towering over resident may invoke a threat response CRB.
Provide mouth care in a quiet environment with a minimum persons present.	Excessive noise and additional persons may cause elder to interpret situation as threatening.
Establish a rapport with the resident by engaging in affirming and simple conversation (ex: compliment a resident on his shirt).	Nonthreatening and personable caregiver behaviors help to establish the situation as safe, and prevents elder from assigning threat to a neutral encounter.
Use gentle touch judiciously.	Gentle touch reassures and reduces anxiety.
Smile when interacting with resident	Research supports the relationship between caregiver facial expression and instigation of CRB in persons with dementia. Only smiling and relaxed faces were associated with happy emotional stated. Neutral, surprised, sad, angry, and frustrated faces were categorized as fearful.
Avoid “elderspeak”, a term to describe “baby talk” speech patterns. (ex: sing-song cadence, patronizing tone, and infantilizing terms like baby, honey, dearie)	Elderspeak is a documented trigger to CRB because its dehumanizing approach heightens threat perception in persons with dementia.
Distraction.	Singing, talking, or providing a stuffed animal prevents or reduces CRB.
Use bridging: Having the elder hold the same item being used in mouth care by the caregiver such as toothbrush or denture cup.	Bridging may access implicit memories that surround specific tasks learned in early childhood and repeated during adult life. Elder perceived that he/she is involved in mouth care and self-care is unlikely to be perceived as threatening.
Priming: Using objects from the environment to help elder to initiate or complete mouth care.	Priming, like bridging, accesses implicit or procedural memories. Ex: provide mouth care in front of a sink and placing toothbrush in resident’s hand instead of brushing their teeth. Rationale – self-care is unlikely to be perceived as threatening.
Chaining: The initiation of a specific oral hygiene activity by the caregiver with expectation that the elder complete the activity.	Chaining used in conjunction with priming to encourage self-care because self-care is unlikely to be perceived as threatening.
Hand-over-hand: the placement of the caregiver’s hand over the elder’s and guiding the elder’s hand.	Hand-over-hand reduced the perception of assault by the caregiver. Found to be especially useful when removing or inserting dentures.
Cueing: The use of polite, one-step commands.	Cueing prevents verbal overload and subsequent perception of threat since the ability to process verbal communication erodes with the progression of the disease.

## Threat-Reduction Strategies

Description of Strategy	Rationale
<p>Mirror-mirror: Evidence shows that elders who resisted care by not opening their mouths would open their mouths automatically if the caregiver placed them before a mirror and provided mouth care by standing behind the elders and reaching around to brush and floss their teeth.</p>	<p>Mirror-mirror is another version of priming. Its success may be related to the removal of the caregiver between the elder and his/her image.</p>
<p>Recuing: The replacement of one caregiver for another caregiver during an unsuccessful mouth care activity where CRBs are escalating.</p>	<p>CRBs during mouth care may be related to the first caregiver is perceived as threatening. When replacing the caregiver, the second caregiver is perceived as the rescuer who saved the elder. The elder usually becomes more willing to engage in mouth care when assisted by the rescuer.</p>
<p>Strategies and Rationales are adapted from <i>An Intervention to Reduce Care-Resistant Behavior in Persons with Dementia During Oral Hygiene: A Pilot Study</i>, led by Rita Jablonski, PhD, CRNP, Penn State University and published in <i>Special Care Dentist</i> 31(3) 2011.</p> <p><b>Oral Hygiene &amp; Care-resistant Behaviors: Making a Difference, Video:</b>  <a href="http://www.uab.edu/smsfiles/video.cgi?OU=SON&amp;VIDEO=Grants/jablonski/DNT.mp4">http://www.uab.edu/smsfiles/video.cgi?OU=SON&amp;VIDEO=Grants/jablonski/DNT.mp4</a></p>	

## Domain 4: Functional

**Definition:** Refers to avoiding environmental cases contributing to decline.

Competency 4: Apply Skill in Preventing Excessing Disability	Knowledge 	Skill 	Attitude 
<b>Competency-Based Objectives</b>			
1. Check for functional trigger of behaviors by reviewing and answering the Questions for Caregivers. <b>RESOURCE 1</b>			✓
2. Understand the importance of customary/routine (what side of the bed the resident uses, in what order does the resident put on clothes, etc.) and uses MDS findings, Section F.	✓		✓
3. Assess resident ADL ability and uses MDS Section G.	✓	✓	
4. Simplify routine tasks when needed (e.g., rather than telling a resident to brush his or her teeth, give the resident a toothbrush with the toothpaste loaded) <b>RESOURCE 2</b>	✓	✓	✓
5. Identify customary/routine tasks that are the most important to the resident (e.g., listening to music) or based on social history and use tools such as MDS Section F.	✓	✓	
6. Demonstrate the need to take 5 minutes (to save 20 minutes) to talk to a resident and build rapport before engaging in ADL care.		✓	✓
7. Provide verbal cues (chinking) – short, simple calmly stated commands (since proposing an activity as a questions leads to “no”).	✓	✓	
8. Perform difficult tasks (e.g., bathing) when the resident is in the best frame for mind, alert, and cooperative.	✓	✓	✓
9. Demonstrate the importance of washing hair and face at different times.	✓		
10. Demonstrate the importance of showering a resident by starting at the feet and working up.	✓	✓	
11. Identify with the resident’s family successful ways to calm the resident.	✓	✓	
12. Use person-specific calming techniques.	✓	✓	✓
13. Understand that prematurely taking over ADL tasks, before needed, causes loss of resident’s ability.	✓		
14. Understand the need to tach the family how to visit so that positive emotions are maintained (e.g., teaching the importance of using “Therapeutic fiblettes” and not trying to orient to person, place, and time) <b>RESOURCES 3, 4</b>	✓	✓	

### Appendix: Tools & Resources:

1. **Questions to Pose When Caring for People with Dementia, A Guide for Caregivers:** *Page 29-31*
2. **Reducing Care-Resistant Behavior (CRB) in Oral Hygiene-Video, Jablonski, Oral Hygiene & Care-Resistant Behaviors: Making a Difference Video, University of Alabama in Birmingham:**  
[www.uab.edu/smsfiles/video/cgi?OU=SON&VIDEO=Grants/Jablonski/DNT.mp4](http://www.uab.edu/smsfiles/video/cgi?OU=SON&VIDEO=Grants/Jablonski/DNT.mp4)
3. **Teaching the Family How to Visit a Person with Dementia: A Guide For Nursing Home Staff:** *Page 32-33*
4. **The Therapeutic Visit:** *Page 34-35*

## Questions to Assess the Functional Domain

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### Questions to Pose When Caring for People with Dementia: A Guide for Caregivers

When the behavior team is attempting to understand the trigger(s) of a resident's behavior, the domains of Habilitation Therapy can be useful as a framework for possible triggers to consider. By asking yourself the following questions to help determine root cause and by making approach correction(s) as needed, you will be able to bring about a positive emotion in the person with dementia, maintain it over the course of the day, and better handle resistance to care.

Focus on the application and use of techniques to foster engagement and prevent additional disability.

#### General

- Did you use the "spend five to save twenty" rule before introducing the reason why you are there with the resident?

#### Showering

- Was the shower room warm enough?
- Was the water a comfortable temperature?
- Did you stop when the resident began to become agitated, and then try again later in the day?
- Did you use a hand-held shower wand?
- Did you work from the feet up and stop at the neck, not getting the face or hair wet?
- Did you provide step by step verbal instructions?
- Did you allow the resident to participate in the act of showering to the extent that he or she is able?
- Did you provide too little support?
- Was there an echo in the shower room that was distracting to the resident?
- Did the resident have a problem with privacy or modesty?
- Would the resident prefer a same-sex aid assisting him or her in the shower?
- Would music help the resident with the showering experience?
- Was the resident overwhelmed because there was more than one person assisting in the shower?
- Did you proceed too quickly?

#### Dressing *(continued on next page)*

- Did you assess what degree of assistance the resident needs with dressing before introducing the task to the resident?
- If choosing an outfit from among many options is a problem for the resident, did you limit the options to two outfits?
- Did you provide verbal cues as needed?
- Did you "chunk" the verbal cues into short one-step directions?
- Did you lay out the clothing on the bed in the order it would be put on? For example, under-clothing on top, blouse and skirt below?

### **Dressing** *(continued)*

- Did you provide visual cues to assist the resident with dressing?
- Did you provide hands-on assistance when needed?
- Did you praise the resident as he or she performed each step of dressing?
- Did you remove soiled or frequently worn clothing in the evening to prevent an argument the next morning?

### **Eating**

- Did you review the resident's personal bio provided by the family to determine food preferences, daily schedules for meals, handedness, portion preferences, and level of independence at mealtime before providing assistance?
- Was there an assessment by speech therapy of the resident's swallowing capacity?
- Did you consult dietary requirements of the resident could tolerate in the dining room?
- Is vision loss an issue that requires verbal cueing?
- Does the resident eat better with one food offered at a time on the dish?
- Does the resident eat better when food is served on a contrasting colored dish?
- Does the resident find it easier to maintain attention at meal time if brightly colored place mats are used?
- Does the resident require verbal cueing with each step of eating and chewing?
- Has there been an OT assessment to determine the type of utensils that would be most appropriate to allow the resident to feed himself or herself independently?
- Are you recording the percentage of meal consumed, if there is weight loss or significant weight gain?
- Have you considered changing the resident's table, table-mates, dining area, or time of meals?
- If the resident is an assisted hand on hand eater, have you investigated where you sit in relation to the resident? In front, left, or right side?
- If providing verbal cues, do you also demonstrate the desired activity by mimicking the activity that you are verbally cueing?
- Are you using "chunking"?

### **Toileting** *(continued on next page)*

- How are you phrasing toileting reminders? Are reminders given in the presence of other residents?
- Have you tried simply saying, "Come with me I have something for you to do, but first \_\_\_\_\_"?
- Should the resident be on a toileting schedule?
- Have you had staff who knows the resident discuss how they assist him or her with toileting? Do they share best approaches?
- If the resident is incontinent overnight, have you tried restricting liquid an hour before bedtime and toileting just before going to bed?
- Are you assuming, perhaps incorrectly, that overnight incontinence requires wearing incontinence undergarments during the day?

### **Toileting** *(continued)*

- If the person is suddenly incontinent are you looking for a medical and/or pharmacological cause?
- Do you go into the bathroom with the resident and help him or her with their clothing and then leave?
- Do you help the resident clean themselves after a bowel movement?
- Is the resident incontinent because he or she cannot quickly find the bathroom?
- Does the resident's diet need to be changed if he or she is incontinent?
- Would incontinence best be dealt with by using incontinence undergarments around the clock or during set intervals over the course of the day?
- Are incontinence undergarments compatible with the resident's clothing?
- Do incontinence undergarments cause a rash or skin irritation?
- Does overzealous staff put on two incontinence undergarments on at the same time causing the resident to be uncomfortable?
- Is the incontinent resident being changed in a timely fashion?

### **Ambulation**

- Has the resident had a Physical Therapy evaluation?
- Has the resident had a vision evaluation under different levels of light?
- How confident does the resident feel about walking on his/her own or assisted by staff?
- Is the resident accompanied regularly on outside walks?
- Does the resident receive regular physical therapy to maintain balance and muscle capacity?
- Are your corridors and common spaces adequately illuminated without shadows or reflections on the floor?
- Are chair alarms causing residents to fall?
- Do you regularly use a gait belt with those residents who require it?

### **Grooming**

- Are you assessing what aspects and tasks associated with grooming the resident can still achieve independently, and what aspect of grooming the resident needs assistance with on an ongoing basis?
- Are you only providing assistance with those aspects of grooming that the resident requires assistance with?
- Are you providing both verbal and visual cues?
- Are you standing behind and to the side of the person facing the mirror when you provide visual and verbal cues?
- Are you using appropriate "chunking" techniques, short, single step-by-step verbal and visual cues that the resident can follow?
- Are you doing too much of the grooming task, thus causing excessive disability" in the resident to independently perform the grooming task?
- Is there an ongoing Occupational Therapy assessment of the resident's needs around grooming activities?
- Does the resident have a regular appointment with the hairdresser, barber or podiatrist whom is trained in Habilitation Therapy and communication techniques?

# Teaching the Family How to Visit a Person with Dementia

## A Guide for Nursing Home Staff

### Preparing the Family for a Visit

- The goal is to help families make a reasonable transition to care provided in the nursing home.
- Meet with the family on admission or when the resident is newly diagnosed with dementia and educate them about the disease, disease stages, medication use or non-use, and goals of care – primarily to ensure the resident has a positive emotion and sustains that emotion throughout the day.
- Let the family know about the importance of maintain regular visits and contact with the resident even though the resident may not remember the contacts – it is the positive feeling the resident retains from family contact that is important.
- If you use consistent assignment, introduce the family to the care staff that will be taking care of their family member.
- Give family members a copy of The Therapeutic Visit and ask them to review it and discuss with other family members and visitors.
- Be prepared to share contact information with the local Alzheimer’s Association and/or other dementia organizations and support groups. Families can benefit from referral and participation in a local support group.

### The Family: What Nursing Home Staff Need to Keep in Mind

- Loss of resident memory and identity is traumatic to families.
- Accepting a diagnosis of dementia produces anxiety – for the resident and for the family member who may be concerned for their own future.
- A family member taking care of a person with dementia can feel guilty about the decision for nursing home care and can be overly demanding as a means in dealing with the guilt. Let families know that individuals with dementia do positively adjust to living in a nursing home and do bond with staff and other residents.
- Problematic resident behaviors can be embarrassing to family members and may result in a family’s decision to use or oppose withdrawal of antipsychotic medication.
- A family member may take personally changes in the resident’s personality, behavior, relationship with them, ability to do thing, and ability to recognize the,. This is upsetting to families. They need to be taught not to react to the lack of recognition. Help families understand that the resident will always be aware that there is a special emotional bond with family, even though he/she may not appear to recognize family members. Communicating this point will take multiple conversations with the family in order for them to fully realize and accept this consequence of dementia.
- Sometimes, family visits are too long or too frequent and as a result, prevents the resident from participating in activity programming and bonding with staff and other residents. Help families understand the need to trust staff and build friendships with other residents.
- A family member who has taken care of a person with dementia may have neglected his/her own care and may need support and encouragement from the nursing facility staff to take time to rest and meet their own needs. This is one of the benefits of having family members understand the need of taking shorter and less frequent visits.

### **The Family: How They Can Help You**

- Encourage families to help keep the resident engaged in life and feel valued.
- Engage families to be actively involved in care so that they feel part of ongoing care and decisions.
- Ask families to help personalize resident activities that are meaningful and enjoyable.
- Ask families to be a resource to you by giving suggestions about ways to address negative behavior.
- Encourage family members to reminisce with the resident.
- Ask families to bring in or share information about the person's past like occupation, childhood home/school/pets, family traditions, favorite foods/music/possessions, etc.
- Reinforce the need to always show and express positive emotion when communicating with the resident.
- Show families how to redirect the resident if he/she gets fixated on an issue causing agitation.

# The Therapeutic Visit

## A Guide for Families

Family visits with a loved-one with dementia can be a wonderfully therapeutic event, if it is orchestrated well. A good visit can have lasting positive effects that improve mood, reduce disorientation and help the person feel connected to family and friends. A well-intentioned, but uninformed visitor can cause the person with dementia to become more upset and disoriented as a result of the visit, unless the goals of a therapeutic visit are well understood.

The ultimate goal of a visit is to leave your loved-one with a positive emotion. The intention of the visit should not be that the person remembers that you visited. The emotion you create in your loved-one during a visit will linger long after the visit is ended, but the memory of the specific visit may be only fleetingly recalled. Your goal for the visit should not be to reorient the person, bring her back to your sense of reality, or to drill her on things you would like to have her remember.

A successful visit is one where you connect with the person emotionally or spiritually, but not necessarily one where you expect to communicate with the person in the ways you have in the past.

The person with dementia may not be able to recall your name or the name of other family members and friends, but she will always know that there is a special relationship between you and her, because of your tone of voice, your body language, your touch and your demonstration of caring. Love doesn't have to be named.

### Do's

- Have a plan for your visit. If, for example, goodbyes are difficult for your loved one and likely to cause a negative emotion, you may plan ahead with the staff to come into the room at an appointed time to distract the person while you leave quietly. Or, if conversation is a problem, bring something that the two of you can do together. For example, a game, artwork, folding laundry, looking at a picture book, an easy game, a video you can watch together, perhaps a sport the person enjoys, eating a favorite food together, and so on.
- Do rely on music to improve mood. Sing with the person, play music you know they like, dance with the person if she is able, attend a musical event at the facility with the person.
- Do bring in children for short, carefully managed visits.

***This list is continued on the next page.***

### Don'ts

- Don't ask how are you? Say, you look terrific.
- Don't quiz the person about what she did today, rather tell her that you heard she had a wonderful day.
- Don't ask do you know who I am? Always tell the loved-one the names of visitors and what their relationship to the person is.
- Don't visit during times when the person might enjoy participating in a facility organized activity.
- Don't have too many family or friends visit at the same time. It may be better to coordinate visits among the family so that the person received visits more often.
- Don't bring your loved-one bad news, like the death of a family member or a pet.

***This list is continued on the next***

### Do's (continued)

- Do hug, hold hands, cuddle, give back or foot rubs, touch.
- Do tell the person with dementia that you love her and remind her about all the people who also love her.
- Do reminisce with the person, especially on events that you remember.
- Do go to where the person is, and do not try to bring her back to your sense of reality.
- Do bring the person a favorite food or flowers or a wrapped present.
- Sometimes it is easier to visit your loved-one and several other residents at the same time and do something as a group.
- Do tell your loved-one about happy, positive family events.
- Do blame the doctor if the person asks: Why am I here? You can answer: When the doctor says it is oaky, then you can come home. Then change the subject quickly by asking the person with dementia a question.
- Always apologize if the person with dementia is blaming you for something.
- If the person with dementia complains about a staff person or another resident always say that you are sorry that happened. Do not try to explain the event in a rational way or to take the other person's side. Your loved one is always right.

### Don'ts (continued)

- Don't ask how the food is here or what did you have for lunch? The person with dementia is unlikely to remember and that inability to recall what they ate for lunch will only cause a negative emotion.
- Don't bring in a photo album and ask: Do you know who this is? Rather, say Oh Look, here is Uncle Joe and you when you were children at the beach. It looks like you were having a wonderful time.
- Don't correct the person with dementia, unless you are sure the correction you offer will be accepted and remembered.
- Don't try to reposition or walk with the person with dementia unless you are certain that it is safe to do so.
- Don't take the person with dementia to their former home, it is likely to be disorienting and cause a negative emotion.

## Domain 5: Behavioral

**Definition:** Refers to changing the caregiver’s approach technique or the resident’s physical environment to manage problematic behaviors – adopting a dementia-centered perspective.

<b>Competency 5:</b> <b>Demonstrate Focused Behavior Management techniques.</b>	<b>Knowledge</b> 	<b>Skill</b> 	<b>Attitude</b> 
<b>Competency-Based Objectives</b>			
1. Check for behavior approach triggers by reviewing and answering the Question for Caregivers . <b>RESOURCE 1</b>			✓
2. Understand that difficult behaviors are often defensive in nature (assess for pain first)	✓		
3. Understand that behavior is a form of communication – rarely a random act.	✓		
4. Understand the importance of the behavior team and consult the team when needed.	✓		✓
5. Understand that there are external and internal causes of behavior (internal – delusions, hallucinations, paranoia, pain, hunger, dehydration, constipation, infect, fever, sleep deprivation, etc.) <b>RESOURCES 2, 3</b>	✓	✓	
6. Use the behavior team in assessing external and internal causes of behavior.	✓	✓	✓
7. Demonstrate use of behavioral log (what happened, when, where, who was around). <b>RESOURCES 4, 5</b>			✓
8. Demonstrate identification of behavioral patterns using feedback from the behavior team (e.g., team identifies that resident will yell, flail arms, and resist morning care if started before she has a morning coffee).	✓	✓	
9. Understand that the behavior team meets as frequently as needed.			✓
10. Understand the importance of developing a behavioral plan based on behavior patterns and communicate plan changes to care staff. <b>RESOURCE 6</b>	✓	✓	
11. Understand that antipsychotic medication can be harmful and is not recommended for use in individuals with dementia. <b>RESOURCES 7</b>	✓		
12. Demonstrate the importance of teaching families about the use of antipsychotic medications in people with dementia. <b>RESOURCES 8, 9</b>	✓	✓	✓
13. Review all new admissions who were prescribed an antipsychotic medication while in the hospital for possible medication discontinuance.			✓
14. Recognize that ambulatory males with vascular dementia, who wonder and who have fixed delusions, are at higher risk for altercations – potentially causing harm to self and others.	✓		

## Appendix: Tools & Resources:

1. **Questions to Pose When Caring for People with Dementia, A Guide for Caregivers:** *Page 38*
2. **INTERACT Tools: Stop and Watch, Change is Condition File Cards, Care Path for Change in Behavior, Acute Mental Status Change, and Urinary Tract Infection (UTI)** [www.interact2.net/tools.html](http://www.interact2.net/tools.html)
3. **Behavior Assessment/Care Planning Process Chart for Nursing Homes:** *Page 39*
4. **Unit Behavior Investigation Log – Sample:** *Page 40*
5. **Individual Behavior Log – Sample:** *Page 41*
6. **Behavioral Analysis Protocol for Nursing Home Interdisciplinary Team:** *Page 42*
7. **Adverse Effects With Antipsychotic Medications & Behavior Modification Interventions:** *Page 43-44*
8. **For the Caregiver – Behaviors Related to Dementia:** *Page 45*
9. **What You Should Know: Antipsychotics Used for Behavior Changes in Dementia:** *Page 46*

Please see **Appendix B:** for Blank Templates of Resources 4 and 5

## Questions to Assess the Behavior Domain

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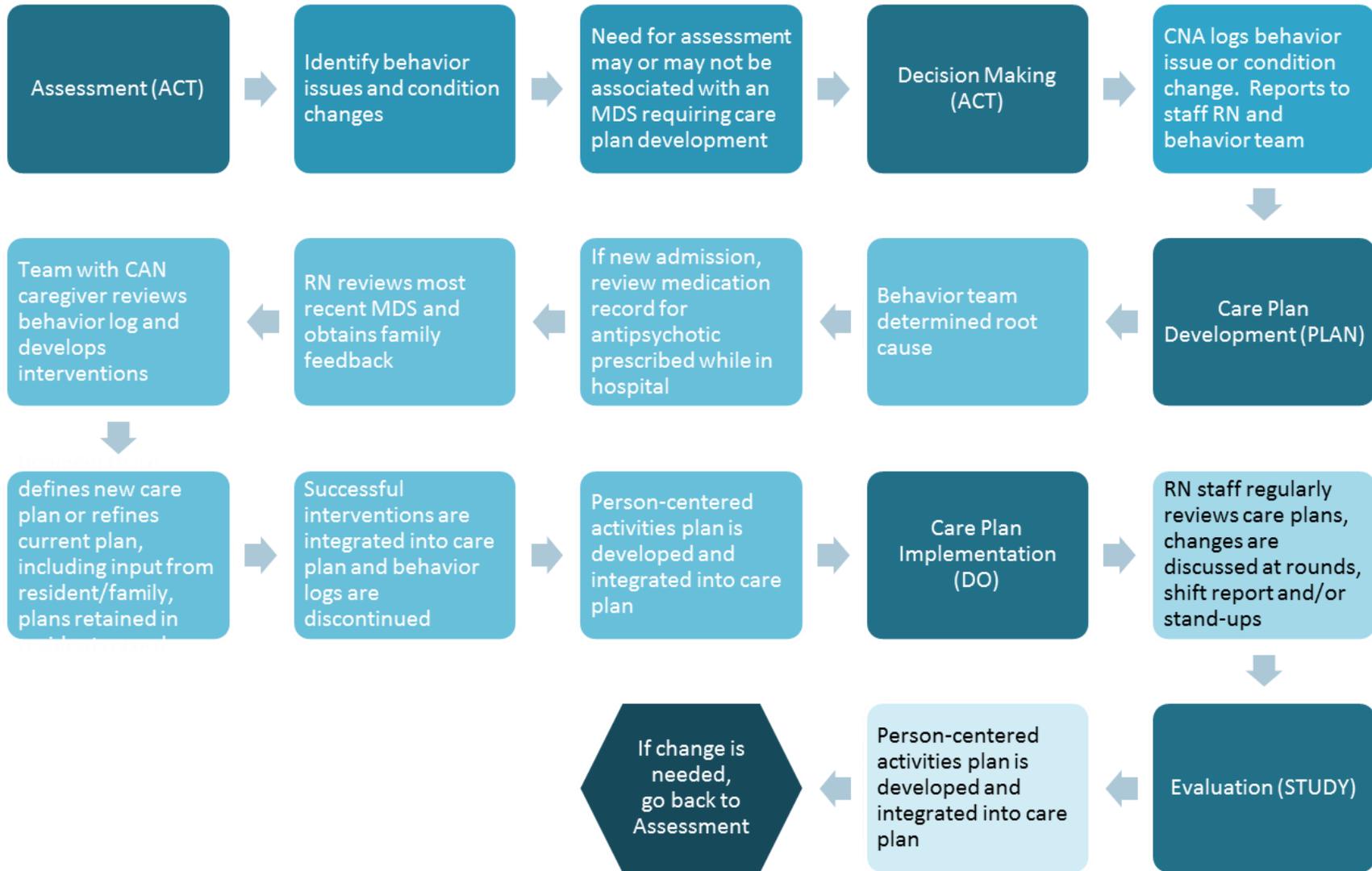
### Questions to Pose When Caring for People with Dementia: A Guide for Caregivers

When the behavior team is attempting to understand the trigger(s) of a resident's behavior, the domains of Habilitation Therapy can be useful as a framework for possible triggers to consider. By asking yourself the following questions to help determine root cause and by making approach correction(s) as needed, you will be able to bring about a positive emotion in the person with dementia, maintain it over the course of the day, and better handle resistance to care.

Focus on managing behaviors by understanding and using a behavior team to track behaviors and approaches to determine root cause and achieve positive outcomes.

- Did you first assess the behavior for internal and/or external causes?
- Is the behavior significant enough to warrant a planned intervention, or is it a behavior that is merely a nuisance or a problem only for the staff?
- Did you look for medication that may be contributing to the behavior (agitation, excessive sedation, etc.)?
- If the person is taking an antipsychotic, has the medication been reviewed for a possible gradual dose reduction or discontinuance?
- Is a behavior log being kept on the resident, and if so, have you checked it?
- Is there a behavior plan in place?
- Have you considered resident characteristics (age, sex, ambulatory) and dementia type as a risk for aggressive behavior and risk to self and others?
- Are you making sure that you and other staff are not blaming the resident for problematic behaviors?

## Behavior Assessment: Care Planning Process Chart for Nursing Homes



## Unit Behavior Investigation Log

When	Name of Resident	<ul style="list-style-type: none"> <li>• What is the behavior?</li> <li>• Where did it happen?</li> <li>• Who was there?</li> <li>• What was going on before the behavior?</li> </ul>	Possible Cause Or Trigger	What can I change? Approach? Body language? Tone of voice? Etc.	Ex. Of The Physical Altercation (e.g. Pinch, Push, Strike You) Give Details	Reporter's Initials
5/12/16 7:10 am	Al Smith	<ul style="list-style-type: none"> <li>• Slapped CNA during am care</li> <li>• Occurred in resident room</li> <li>• CNA and resident present</li> <li>• Aid asked Al to get out of bed for am care and tried to remove his comforter</li> </ul>	<ul style="list-style-type: none"> <li>• CNA did not take extra time to interact before care started</li> <li>• CNA started instruction while AL was still in bed</li> <li>• Al appeared to be threatened by the removal of the comforter</li> </ul>	<ul style="list-style-type: none"> <li>• Start am care by spending 5 minutes to save 20 minutes</li> <li>• Have CNA sit by AL, at eye level, and explain what needs to be done</li> <li>• Give Al a choice to sit for a few min before getting out of bed</li> </ul>	<ul style="list-style-type: none"> <li>• Al slapped the CNA's hand as she tried to fold back his comforter</li> </ul>	SC
4/3/16 3:35 pm	Mary Cataldo	<ul style="list-style-type: none"> <li>• Repetitive vocalization -"Home"</li> <li>• Occurred at change of shift</li> <li>• CNA, other residents, &amp; children and grandchildren visiting another resident</li> <li>• Mary was participating in activities</li> </ul>	<ul style="list-style-type: none"> <li>• Mary saw CNA &amp; other staff leave unit at change of shift</li> <li>• Children on unit may have reminded Mary of a past experience</li> </ul>	<ul style="list-style-type: none"> <li>• Have staff leave belongings outside of unit</li> <li>• Have staff changes occur away from resident areas</li> <li>• Check with Mary's family about her history related to childcare</li> <li>• Engage Mary in another a personal activity during change of shift</li> </ul>	<ul style="list-style-type: none"> <li>• None noted</li> </ul>	AF

*This material was prepared by Healthcentric Advisors, the Medicare Quality Innovation Network-Quality Improvement Organization for New England, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. CMSQIN\_C2\_032816\_0478*

## Individual Behavior Log

**NAME:** Stephanie Locke **ROOM:** 14B **DATE:** 02/30/16

### Background Info/Getting To Know Me:

I was a 3<sup>rd</sup> grade teacher and active in my community. I like to wear slacks and my favorite color is pink. I wear glasses. I have 3 children and 6 grandchildren. I am one of four children and my entire family lives close by. I like to go to bed by 8 pm and up at 6 am. I like to have morning coffee before getting ready for the day.

### Activities I Enjoy:

Listening to country music, reading newspapers, Bingo, and attending daily mass.

**BEHAVIORS:** 1. Agitation during day and when sitting by window 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**INTERVENTIONS:** 1. Reduce glare by repositioning 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**OUTCOMES:** 1. **Positive** 2. Some Effect 3. No Effect

Date	Shift	Behavior	Trigger	Intervention	Outcome	Additional Comments, Interventions, Suggestions	Nurses' Initial
2/28/26	7am-3p	Agitation when sitting by or in front of window	Blinded by glare from window	Reposition on day shift to glare not an issue	Good – agitation has decreased	Stephanie is sensitive to glare. Make sure she doesn't sit in areas of direct sun	
	3pm-11p						
	11pm-7a						

Triggers: what happened before the behavior started (E.g. Noisy room)

# Behavioral Analysis Protocol for Nursing Home Interdisciplinary Team (IDT)

---

## Thought Sequencing Steps in Writing a Behavioral Plan

**This is a step-by-step guide for the IDT in determining how to address problem behaviors and interventions**

16. Develop a statement of the problem.
17. State the goal of the plan/intervention.
18. Describe the behavior (detailed description not interpretation). Note: the description of the behavior is not always the same as the problem – for example: John yells (behavior) others are agitated (problem).
19. Note any observed patterns in behavior attained in the behavioral log – for example: John yells after family visitors leave.
20. Check with family for previous behavior history and interventions used by the family.
21. Look at most recent or relevant Minimum Data Set (MDS) assessment – for example: Customary/Routine section, Care Area Triggers (CATs) and Care Area Assessments (CAAs).
22. State a working hypothesis as to the cause or triggers of the behavior.
23. Describe the intervention. Be specific.
24. Estimate the duration of the intervention to be implemented.
25. Estimate what percent of the behavior(s) you anticipate the intervention will address and how you plan to address the remaining behavior(s).
26. Identify who has been informed of this problem and how you are meeting regulatory standards in your immediate response to the problem.
27. Decide who will inform authorized family/guardian and medical professionals that the behavior intervention plan is in progress.
28. Identify who will chart progress of the intervention and how often.
29. Indicate if the behavioral log will be used to implement the intervention while it is being tested.
30. Once the intervention has been found to work, enter the intervention in the resident's behavior care plan – behavior logs are NOT retained.

## Thought Sequencing Steps to be addressed in the Behavior Team Performance Improvement Plan

- Identify how staff (all staff or selected caregiver) training will occur (in-service and during stand-ups, who provides the training, and the date for training to be completed).
- State how often the team will meet to assess interventions, outcomes, and the measures/methods used to assess the outcomes – for example: weekly.
- Identify what performance improvement process (like PDSA) will be used to determine plan success and areas needing further refinements.

## Adverse Effects with Anti-Psychotic Medications

**Warnings and precautions • Elderly Patients with Dementia-Related Psychosis:** Increased incidents of cerebrovascular adverse events (e.g., stroke, transient ischemic attack, including fatalities)

*Follow facility procedures for reporting adverse effects of medications*

Risk:			
Minimal	Low	Medium	High

\* Second generation “atypical” anti-psychotic medications

	Aripiprazole*	Asenapine*	Chlorpromazine	Clozapine*	Fluphenazine	Haloperidol	Iloperidone*	Olanzapine*	Papiperidone*	Perphenazine*	Quetiapine*	Risperidone*	Thioridazine	Thiothixene	Trifluoperazine	Ziprasidone*
<b>Cardiovascular</b>																
Orthostatic Hypotension: Use with caution in patients with known cardiovascular or cerebrovascular disease.																
QT Prolongation: avoid use with drugs that also increase the QT interval and in patients with risk factors for prolonged QT interval. A prolonged QT interval may cause fatal arrhythmias.																
<b>Endocrine/Metabolic</b>																
Dyslipidemia: Undesirable alterations in lipid levels.																
Hyperglycemia/Diabetes: Monitor glucose regularly in patients with and at risk for diabetes.																
Hyperprolactinemia: May cause breast enlargement (gynecomastia) and sexual dysfunction.																
Weight Gain: Monitor weight at least quarterly.																
<b>Risk of Falls and Fractures</b>																
Fracture risk: Increases with duration of use which is generally longer with atypical medications.																
<b>Neurologic</b>																
Extrapyramidal Symptoms (EPS): Movement disorders such as acute, sustained muscle contractions causing twisting, repetitive movements or abnormal postures (dystonic reactions); pseudoparkinsonism; and inability to initiate movement (akinesia) and/or ability to remain motionless (akathisia).																
Sedation: Monitor for signs and symptoms of sedation.																
Seizures/Convulsions: Use cautiously in patients with a history of seizures or with conditions that lower the seizure threshold.																
<b>Systemic</b>																
Anticholinergic Effects: Dry mouth, dry eyes, difficulty urinating, constipation, blurred vision, confusion, memory impairment, drowsiness, nervousness, agitation, rapid heart rate, weakness.																
Tardive Dyskinesia (with high doses): Involuntary, repetitive body movements such as lip smacking, tongue protrusion and grimacing. Discontinue is clinically appropriate.																

	Abilify	Saphris	Thorazine	Clozaril, FazaClo ODT	Prolixin	Haldol	Fanapt	Zyprexa (Zydis, Relprevv)	Invega	Trilafon	Seroquel (XR)	Risperdal	Mellaril	Navane	Stalazine	Geodon
Aripiprazole*																
Asenapine*																
Chlorpromazine																
Clozapine*																
Fluphenazine																
Haloperidol																
Iloperidone*																
Olanzapine*																
Papiperidone*																
Perphenazine*																
Quetiapine*																
Risperidone*																
Thioridazine																
Thiothixene																
Trifluoperazine																
Ziprasidone*																

**Table adapted from:** A Guide to the Management of Psychotic Disorders and Neuropsychiatric Symptoms of Dementia in older Adults: The American Geriatrics Society. April 2011. Mehta S, Chen H, Johnson M, Aparasu R. Risk of falls and fractures in older adults using antipsychotic agents: a propensity-matched retrospective cohort study. • *Drugs & Aging* [serial online]. October 1, 2010;27(10):815-829. • Muench J, Hamer A. Adverse effects of antipsychotic medications. *American Family Physician* [serial online]. March 1, 2010;81(5):617-622.

## Behavior Modification Interventions

Recognize non-verbal communication of need(s), e.g., “Agitation”: - Clapping, yelling, slapping thighs, and screaming. Address the individual’s needs. Consider common causes.

- |                     |              |                |                                    |
|---------------------|--------------|----------------|------------------------------------|
| • Noisy environment | • Discomfort | • Hearing loss | • Abrupt, tense or impatient staff |
| • Pain              | • Infection  | • Boredom      | • Frustration                      |
| • Constipation      | • Drugs      | • Loneliness   |                                    |

Aggression (hitting, swearing, biting, etc. in contrast to agitation, is a fear based behavior. Communication is pretty clear. The resident most likely feels threatened. Try an alternative approach. Utilize de-escalation techniques, as appropriate. Neither you nor the resident should be of feel backed into a corner.

- Signal breath – If you are upset when approaching the resident, it will only make the situation worse. Stop. “Take a step back.: Slowly count the three (3) as you inhale, count to three (3) as you exhale. Repeat. You are now ready to approach the resident.
- Body language and tone of voice – Your body language and voice should communicate that the resident is safe and that you are not going to hurt him/her. Use a soft, neutral, calming tone of voice. Speaking almost in a whisper is sometimes helpful. Relax your shoulder; place your hands by your side. If assault is likely, the thinking stance is preferred: one hand cupping your elbow and the other hand touching your chin. This positions you hand to block punches or kicks without looking threatening.
- Monitor your proximity to the resident – Maintain a socially comfortable distance (generally 3-5 feet). Approach from the side and to the front of the resident – remain in the resident’s visual field of view. Stay close enough to be heard, but not close enough to be struck.
- Ask, don’t tell the resident to walk with you to a comfortable location where you can both sit. Walk slowly. As with whispering, walking slowly is incompatible with agitation and aggression. Ask, don’t tell the resident to sit down with you to talk about what is bothering him or her.
- Identify with the resident; identify solutions to address the unmet need that triggered the behavioral communication. If possible, offer the solution immediately. Consider an intermediate solution if necessary.
- Listen actively. When a solution is not clear or available, simply listen, write it down, and make a plan with the resident to address the concern.
- Diversion and distraction. There may be occasions in which it is not possible to identify the unmet need. In those circumstances, it may be possible to turn the resident’s attention toward something pleasurable. The better you know your resident’s strengths and interests, the better able you will be to select a distraction that is actually likely to engage them positively.

**Adapted from:** “Oasis” Mass Senior Care Foundation Antipsychotic Initiative 2001-12

## For the Caregiver: *Behaviors Related to Dementia*

**What is Dementia:** Dementia is an illness that makes it hard for a person to remember things. There are many types of dementia – the most coming type is Alzheimer’s Disease.

**Behaviors Linked to Dementia:** There are many types of behaviors a person with dementia can have. Below is a chart with some of the behaviors and their meanings.

Behaviors	Definition
<b>AGGRESSION</b>	Aggression is when a person becomes angry quickly. The person may hit, shout, kick, bite or swear. People with dementia can become angry because of stress or anxiety.
<b>ANXIETY/AGITATION</b>	Anxiety and agitation can be caused by unfamiliar situations or when a person becomes frustrated. A person may feel restless, have a fast heartbeat or have a hard time breathing.
<b>CONFUSION</b>	Confusion is when a person has a hard time remembering places, names or faces of people. The person may also not remember how to do things he/she used to be able to do.
<b>DELIRIUM</b>	Delirium is when a person becomes confused quickly (within 1 hour to 2 days). If a person has delirium he/she should see a doctor right away for treatment.
<b>DELUSIONS</b>	Delusions are when a person believed something that is not true. The person may be suspicious and think someone is trying to hurt him/her or steal his/her things.
<b>DEPRESSION</b>	Depression is when a person feels sad or hopeless, or may not want to do things he/she used to like. A person may also have a hard time sleeping or not want to eat. If a person feels like this for longer than 2 weeks he/she should see their doctor.
<b>HALLUCINATIONS</b>	Hallucinations are when a person hears voices or sees things that are not there. A person may also smell, feel or taste things that are not there.

### Changes in behavior can be caused by:

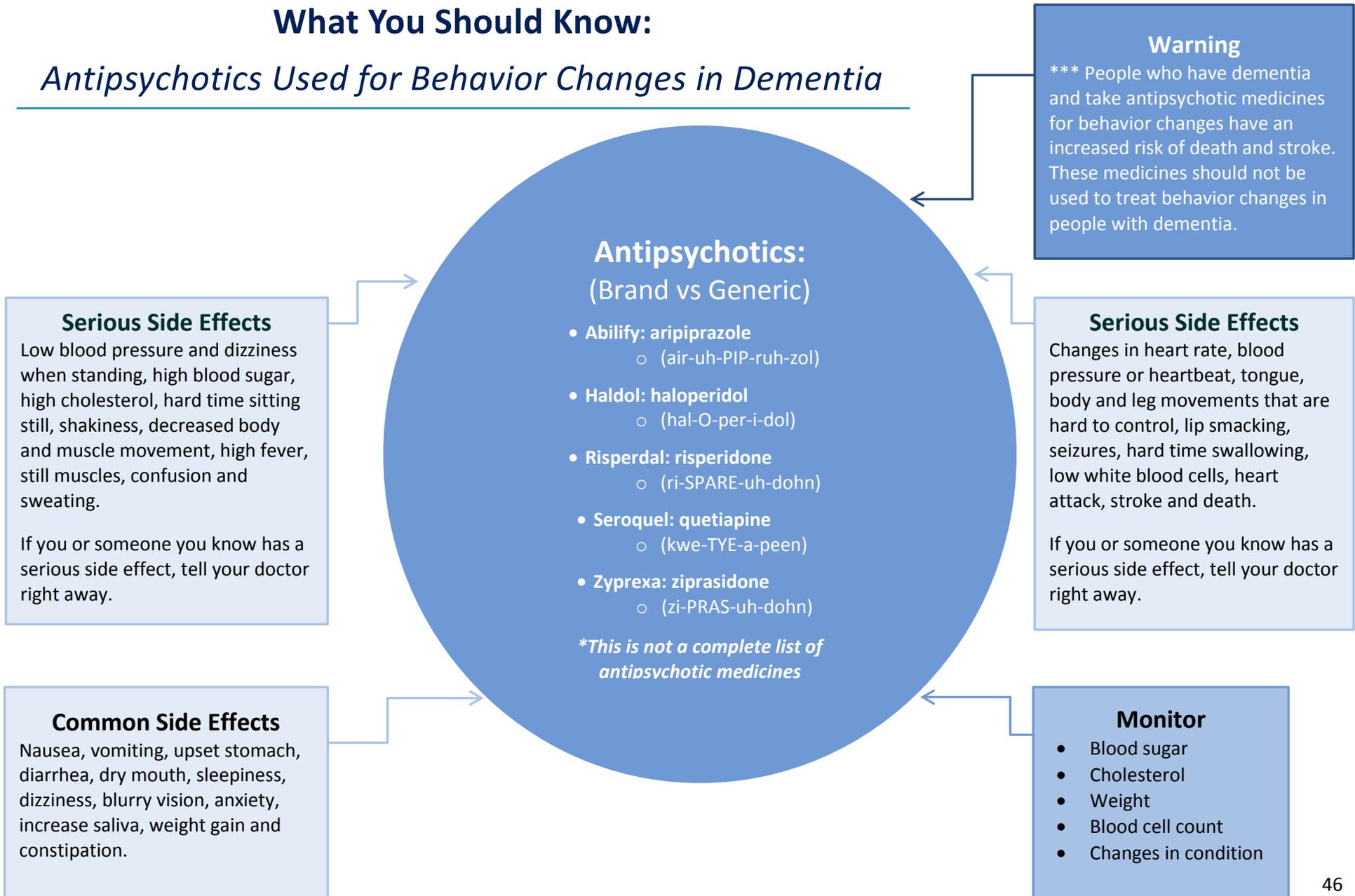
- Medicines
- Illness or pain
- Loud noises or busy surroundings
- Changes in surroundings
- Changes in daily routine
- Life changes (for example, going to the hospital)
- Not enough food (poor nutrition)
- Not drinking enough water (dehydration)
- Frustration because of difficulty in communicating

These behavior changes can be hard for family and friends. It is important to know that these changes can be hard to predict, are not done on purpose, and cannot always be controlled.

This tool was developed using information provided by the Alzheimer’s Association, Alzheimer’s Foundation of America, American Psychological Association, and Dementia Care Central. For more information please refer to the Alzheimer’s Association at [www.alz.org](http://www.alz.org).

## What You Should Know:

# Antipsychotics Used for Behavior Changes in Dementia



## Domain 6: Perceptual

**Definition:** Refers to changing the caregiver’s approach to support sensory messaging.

### Competency 6:

Understand How Loss of Proprioceptual memory (a procedural memory of a specific task accomplished through repetition – e.g., riding a bike) Impacts Muscle Function.

### Knowledge



### Skill



### Attitude



### Competency-Based Objectives

1. Check for approach triggers of proprioceptual memory by reviewing and answering the Question for Caregivers.

#### RESOURCE 1

2. Assess for loss of motor function (e.g., ability to open a door or bend knees in order to sit, etc.).
3. Use hand gestures to communicate a motor command like grasping a cup.
4. Use gentle manual pressure, when needed, to indicate a desired action (e.g., a gentle touch behind the knees for knee bending or sitting).

✓

✓

✓

✓

✓

✓

✓

### Appendix: Tools & Resources:

1. **Questions to Pose When Caring for People with Dementia, A Guide for Caregivers – Questions to Assess the Physical Domain:** *Page 48*

## Questions to Assess the Perceptual Domain

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### Questions to Pose When Caring for People with Dementia: A Guide for Caregivers

When the behavior team is attempting to understand the trigger(s) of a resident's behavior, the domains of Habilitation Therapy can be useful as a framework for possible triggers to consider. By asking yourself the following questions to help determine root cause and by making approach correction(s) as needed, you will be able to bring about a positive emotion in the person with dementia, maintain it over the course of the day, and better handle resistance to care.

Focus on approached to support sensory messaging and muscle function accomplished through repetition.

- Are you assessing if the resident has lost ability with basic motor function?
- If you suspect loss of motor function, has physical therapy been used to evaluate the resident?
- Do you use hand gestures or apply gentle pressure when needed to the area where a motor function is desire – for example, gently touching behind the knees to signify bending the knees for sitting?
- Are you taking into account the resident's visual acuity by providing information in large bold print, by providing the activities in a way that takes the resident's visual capacity into account, and are you always identifying yourself to the resident?



## **Appendix A:**

### **Additional Resources**

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## Additional Resources

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### Habilitation Therapy

Habilitation Therapy: A New Starscape, Chapter 2, Paul Raia, PHD

[https://www.nhqualitycampaign.org/files/Habilitation\\_Therapy\\_a\\_New\\_Starscape2.edit.pdf](https://www.nhqualitycampaign.org/files/Habilitation_Therapy_a_New_Starscape2.edit.pdf)

Habilitation Therapy in Dementia Care, Age in Action: Activities in Geriatrics and Gerontology Education and Research, Paul Raia, PhD, Virginia Center on Aging and Virginia Department for the Aging, Volume 26, Number 4, Fall 2011 [http://scholarscompass.vcu.edu/cgi/viewcontent.cgi?article=1062&context=vcoa\\_case](http://scholarscompass.vcu.edu/cgi/viewcontent.cgi?article=1062&context=vcoa_case)

Sleuthing Troublesome Behaviors *a la Sherlock Holmes*, Paul Raia, PhD

[http://www.alzmass.org/newsletter\\_pdfs/04-05.pdf](http://www.alzmass.org/newsletter_pdfs/04-05.pdf)

### Alzheimer's/Dementia Care

Accepting the Challenge, Being With and Learning From Persons with Dementia, Teepa Snow, Greenhouse Project: <https://youtu.be/i4pQaZykZIs>

CMS Hand in Hand: A Training Series for Nursing Homes Toolkit,

<http://www.cms-handinhandtoolkit.info/Index.aspx>

Seven Stages of Alzheimer's, Alzheimer's Association

[http://www.alz.org/alzheimers\\_disease\\_stages\\_of\\_alzheimers.asp](http://www.alz.org/alzheimers_disease_stages_of_alzheimers.asp)

Mass. Senior Care Association, OASIS: Reducing Off-Label Use of Antipsychotics in Nursing Homes,

<http://www.maseniorcarefoundation.org/OASIS.aspx>

Alzheimer's Association, 2015 Alzheimer's Disease Facts and Figures. *Alzheimer's and Dementia* 2015; 11 (3) 332.

Alzheimer's Caregiving Tips: Coping with Agitation and Aggression

[http://champ-program.org/static/NIA\\_Alzheimers\\_Caregiving\\_Tips\\_Coping\\_with\\_Agitation\\_and\\_Aggression.pdf](http://champ-program.org/static/NIA_Alzheimers_Caregiving_Tips_Coping_with_Agitation_and_Aggression.pdf)

Alzheimer's Caregiving Tips: Managing Personality and Behavior Changes

[http://www.nia.nih.gov/sites/default/files/Alzheimers\\_Caregiving\\_Tips\\_Managing\\_Personality\\_and\\_Behavior\\_Changes.pdf](http://www.nia.nih.gov/sites/default/files/Alzheimers_Caregiving_Tips_Managing_Personality_and_Behavior_Changes.pdf)

Improving Antipsychotic Effectiveness in Dementia Patients – University of Iowa Web Site:

<https://www.healthcare.uiowa.edu/igec/IAADAPT>

### Oral Care Dementia

The Society for Post-Acute And Long-Term Care Medicine. Oral Health in the Long Term Care Setting: LTC Physicians Information Tool Kit. Available through <http://www.paltc.org/> and resource compendium through <http://www.paltc.org/product-store/oral-health-long-term-care-setting>

Elder Loving Care: Oral Hygiene Caregiver Training: Nursing -

<https://nursing.uth.edu/coa/community.htm>

Jablonski R, et al. An Intervention to Reduce Care-Resistant Behavior in Persons With Dementia During Oral Hygiene: A Pilot Study. *Special Care Dentist* 31(3):77-87, 2011.

Jablonski R. Oral Hygiene and Care Resistance: Making a Difference (Video), University of Alabama at Birmingham, <http://www.uab.edu/smsfiles/video.cgi?OU=SON&VIDEO=Grants/jablonski/DNT.mp4>

Mouth Care Without a Battle (Video) – [www.mouthcarewithoutabattle.org](http://www.mouthcarewithoutabattle.org)

## Regulation

Dementia Care in Nursing Homes: Clarification to Appendix P State Operations Manual (SOM) and Appendix PP in the SOM for 309 – Quality of Care and F329 – Unnecessary Drugs -  
<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-35.pdf>

Minimum Data Set (MDS) 3.0 RAI Manual and MDS for Nursing Homes and Swing Bed Providers -  
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

Commonwealth of Mass., Department of Public Health, 105 CMR; Section 150.000 Standards for Dementia Special Care Units, 150.002-150-029 –  
<http://www.mass.gov/eohhs/docs/dph/regs/105cmr150.pdf>

Commonwealth of Mass., Department of Public Health, Guidelines for Dementia Special Care Unit Regulations – [Circular Letter: DHCQ-14-5-615 Guidelines for Dementia Special Care Unit Regulations.](#)

## Competency-Based Education

Competency Assessment: Methods for Development and Implementation in Nursing Education -  
<http://www.nursingworld.org/nursingcompetencies/>

Competency-Based Education in the Health Professions: Implications for Improving Global Health -  
<http://deepblue.lib.umich.edu/bitstream/handle/2027.42/85362/CompBasedEd.pdf?sequence=1>



## **Appendix B:**

### Templates

---

## Unit Behavior Investigation Log

When	Name of Resident	<ul style="list-style-type: none"> <li>• What is the behavior?</li> <li>• Where did it happen?</li> <li>• Who was there?</li> <li>• What was going on before the behavior?</li> </ul>	Possible Cause Or Trigger	What can I change? Approach? Body language? Tone of voice? Etc.	Ex. Of The Physical Altercation (e.g. Pinch, Push, Strike You) Give Details	Reporter's Initials

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## Individual Behavior Log

NAME: \_\_\_\_\_ ROOM: \_\_\_\_\_ DATE: \_\_\_\_\_

### Background Info/Getting To Know Me:

### Activities I Enjoy:

BEHAVIORS: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

INTERVENTIONS: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

OUTCOMES: 1. Positive 2. Some Effect 3. No Effect

Date	Shift	Behavior	Trigger	Intervention	Outcome	Additional Comments, Interventions, Suggestions	Nurses' Initial
2/28/26	7am-3p	Agitation when sitting by or in front of window	Blinded by glare from window	Reposition on day shift to glare not an issue	Good – agitation has decreased	Stephanie is sensitive to glare. Make sure she doesn't sit in areas of direct sun	
	3pm-11p						
	11pm-7a						

Triggers: what happened before the behavior started (E.g. Noisy room)

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## Behavior Log

Date	Shift	Behavior	Trigger	Intervention	Outcome	Additional Comments, Interventions, Suggestions	Nurses' Initial
	7am-3p						
	3pm-11p						
	11pm-7a						
	7am-3p						
	3pm-11p						
	11pm-7a						
	7am-3p						
	3pm-11p						
	11pm-7a						
	7am-3p						
	3pm-11p						
	11pm-7a						
	7am-3p						
	3pm-11p						
	11pm-7a						

Triggers: what happened before the behavior started (E.g. Noisy room)

## Habilitation Behavioral Plan

<b>Name:</b>		<b>Date:</b>
<b>Identified Behavior:</b>		
<b>Underlying Emotion:</b>		
<b>Cause/Triggers:</b>		

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