STAR-VA Intervention for Managing Challenging Behaviors in VA Community Living Center Residents with Dementia

Manual for STAR-VA Behavioral Coordinators and Nurse Champions

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INTRODUCTION

STAR-VA is an interdisciplinary behavioral approach to managing challenging dementia-related behaviors. STAR-VA is based on Teri and colleagues' (2005) Staff Training in Assisted Living Residences (STAR) intervention, originally developed for training direct care workers in assisted living residences to improve the care of older adults with dementia by improving their interactions and successfully managing the challenging behaviors commonly exhibited by these residents. STAR has been reported in the literature and shown to be efficacious for reducing problematic behaviors of residents with dementia, improving the care they receive, and decreasing staff problems (Teri, 2009; Teri, Huda, Gibbons, Young, & van Leynseele, 2005; Teri, McKenzie, Lafazia, et al., 2009; Teri, McKenzie, Pike, et al., 2009).

STAR-VA was developed at the request of the VA National Mental Health Director for Psychotherapy and Psychogeriatrics in order to increase the capacity of staff in VA Community Living Centers (CLCs; formerly known as "Nursing Home Care Units") to manage challenging dementia-related behaviors and improve the care provided to Veteran residents. STAR-VA was developed by Mental Health Services and field-based staff with expertise in psychogeriatrics, in collaboration with Dr. Linda Teri at the University of Washington, as part of a pilot dissemination and implementation initiative within the Veterans Health Administration (VHA). Program evaluation data from the STAR-VA pilot revealed that Veterans enrolled in STAR-VA demonstrated significant reductions in the frequency and severity of challenging dementia-related behaviors. In addition, these Veterans exhibited decreases in symptoms of depression and anxiety. Moreover, CLC Mental Health Providers participating in the pilot reported, overall, that STAR-VA helped them and their teams to better manage challenging behaviors, including agitation, disruptive vocalization, physical aggression, and resistance to care/ADLs (Karlin, Visnic, McGee, & Teri, 2014).

Implementation of STAR-VA was expanded to an additional 66 CLC sites between 2013 and 2016. Program evaluation has repeatedly demonstrated that Veterans enrolled in STAR-VA experience significant decreases in the frequency and severity of target behaviors, depression, anxiety, and agitation, and improved staff confidence (Curyto, McCurry, Luci, Karlin, Karel, 2017; Karel, Teri, McConnell,Visnic, & Karlin, 2016; Karel, Visnic, Curyto, Galkowski, McConnell, 2016).

This intervention manual presents the STAR-VA protocol, which is based on the framework of the original STAR intervention. As detailed further below, the STAR-VA intervention was developed specifically for Mental Health Providers (psychologists and psychiatrists) that have been integrated into a number of CLCs throughout VHA. Over time, the STAR-VA intervention developed to entail close collaboration between a CLC Mental Health Provider (referred to as a "Behavioral Coordinator" in the STAR-VA approach) and a Nurse leader (referred to as a STAR-VA "Nurse Champion") who, together, form the STAR-VA Leadership Team at their CLC. The STAR-VA Nurse Champion may hold a range of nursing roles, such as a CLC Nurse Manager, a steady Charge Nurse, a Clinical Nurse Leader, or a CLC staff Registered Nurse. The most important considerations for both the Behavioral Coordinator and the Nurse Champion

are that they have: (1) daily presence on the CLC unit(s) on which STAR-VA is being implemented; (2) excellent leadership and communication skills; (3) respect of one's interdisciplinary peers/staff; and (4) a collaborative working relationship with one another.

This STAR-VA leadership team promotes the delivery of psychosocial approaches to managing challenging resident behaviors and advancing culture transformation efforts within CLCs designed to provide home-like and person-centered environments and approaches to care. Behavioral Coordinators and Nurse Champions help educate the team, promote engagement of CLC staff in the intervention, and reinforce STAR-VA strategies with the team and with CLC leadership.

At its core, STAR-VA is a collaborative, interdisciplinary intervention that is informed and guided by the behavioral expertise of a Behavioral Coordinator. In the STAR-VA intervention, the Behavioral Coordinator and the Nurse Champion work closely together with a variety of other CLC staff members (referred to as "Staff Partners" in the intervention) in the development and implementation of behavioral intervention plans to decrease challenging dementia-related behaviors and enhance Veteran care. Specifically, the roles of the Staff Partners are to inform the development of behavioral intervention plans and to actively engage in their implementation. The assistance of Staff Partners is essential to successful implementation and sustainability of the STAR-VA intervention. Over time, as Staff Partners become increasingly familiar with the intervention, they may have an increasing role in contributing to the development of behavioral intervention plans and implementing appropriate components of these plans, such that the Behavioral Coordinator and Nurse Champion may assume more of a consulting role.

This manual, initially designed to support the competency-based training program for the CLC Mental Health Provider (Karlin et al., 2010), provides the STAR-VA Behavioral Coordinators and Nurse Champions with the foundational theoretical and applied components of the STAR-VA intervention. The manual supplements STAR-VA training in an experientially-based clinical workshop, followed by weekly Behavioral Coordinator and monthly Nurse Champion consultation calls for six months on the implementation of the STAR-VA protocol led by expert training consultants. The manual is comprised of the following Sections:

SECTIONS OF STAR-VA INTERVENTION MANUAL

Section	Focus Area
Section 1 An Introduction to Understanding Dementia	Overview of dementia and dementia-related behaviors, and realistic expectations for persons with dementia
Section 2 Communicating With and Without Words	Verbal and nonverbal communication strategies
Section 3 The ABC's of Dementia	Description of activators (As), behaviors (Bs), and consequences (Cs) of challenging behaviors
Section 4 Problem Solving: Get Active!	Identification of goal behaviors and the ABC Card
Section 5 Increasing Pleasant Events	The role of pleasant events and increasing pleasant events to improve mood and achieve goal behaviors
Section 6 Get Active! With the Environment	The role of the environment in shaping behaviors and modifying the environment to facilitate goal behaviors
Section 7 Creating a STAR-VA Team: Leadership and Staff Partners	Promoting motivation and involvement of Staff Partners in STAR-VA
Section 8 Families	The role of families and strategies for including family participation, when appropriate
Section 9 Putting STAR-VA Into Action	An overview of implementing the STAR-VA intervention in CLCs

Each Section is organized in the following manner: At the beginning of each Section, a box highlights the Section objectives and topics covered. A listing of relevant handouts located at the end of the Section that may be usefully shared with Staff Partners is also provided. Handouts are provided to facilitate discussion with Staff Partners and are not meant to be "handed out" without introduction and discussion. Section handouts and additional handouts are located in Appendix A. At the conclusion of each Section is a list of "summary tips" meant to facilitate ways to share STAR-VA information to Staff Partners; these "tips" summarize key concepts, principles, and strategies covered in the Section.

SECTION 1
AN INTRODUCTION TO UNDERSTANDING DEMENTIA

CORE CONCEPT:
Understanding Dementia

Objectives:

I. Provide an overview of dementia.
II. Share information related to understanding dementia and realistic expectations to Staff Partners.

Outline:

I. Introduction
II. Dementia Overview
    - Definition of Dementia and Diagnostic Criteria
    - Common Etiologies of Dementia
    - Delirium
    - Potentially Treatable Etiologies of Cognitive Decline
    - Understanding Challenging Dementia-Related Behaviors
    - Psychosocial Interventions for Challenging Dementia-Related Behaviors
III. Core Concepts about Dementia to Communicate to Staff Partners
    - The Human Brain is Complex
    - Dementia is a Brain Disease
    - Dementia-Related Behaviors Have Meaning and Purpose
    - People with Dementia Can Get Anxious and Depressed
    - Anxiety
    - Depression
    - You Can Help People with Dementia!
IV. Helping Staff Partners to Develop Realistic Expectations
V. Summary Tips

Handouts:

I. Stages of Dementia
II. VA Dementia Training Resources
III. Managing Our Reactions to Challenging Behaviors
IV. Anxiety Symptoms
V. Depression Symptoms

I. Introduction

Dementia is one of the major health challenges faced by health care systems throughout the world. It is estimated that there are over 30 million individuals with dementia world-wide, with the number projected to reach over 100 million by 2050 (Alzheimer's Disease International, 2008). In the United States, it is estimated that approximately 250,000 individuals are diagnosed with Alzheimer's disease (AD), the most common form of dementia, each year and that 5.3 million people are currently living with this disease (Alzheimer's Association, 2010). The estimated number of U.S. Department of Veterans Affairs (VA) patients with all types of dementia in 2014 is 262,899 and ranges from a low of 135,216 to a high of 390,567. The low and high values are estimated based on the lower and upper bounds of the 95% confidence interval of prevalence rates reported in the research. These numbers are based on national prevalence rates for all types of dementia, applied to the VA patient population estimates (Cooley, 2014).

Persons with dementia experience a complex constellation of mood, behavioral, cognitive, and perceptual changes, which tend to evolve over time and vary depending upon dementia type. These changes are often referred to as neuropsychiatric symptoms, or behavioral and psychological symptoms, of dementia (Kales, Gitlin, & Lyketsos, 2014; Lyketsos et al., 2011; Moniz-Cook, De Vugt, Verhey, & James, 2009; O'Neill et al, 2011).

Some of the most frequently experienced behaviors in individuals with dementia include agitation or aggression (physical or verbal), apathy, withdrawal, psychosis (delusions and/or hallucinations), and disrupted motor functioning (American Psychiatric Association, 2013; Lyketsos et al., 2011). The majority of persons with advanced dementia experience one or more of these behaviors (Kverno, Black, Nolan, & Rabins, 2009), and this group comprises approximately 40% of persons with dementia residing in long-term care settings in the United States (Gruneir, Lapane, Miller, & Mor, 2007).

CLC Mental Health Providers and Nurse Leaders are frequently asked to identify and address these behaviors as well as convey this complex information to a diverse group of Staff Partners. This Section of the STAR-VA Manual has two purposes: (1) to provide the STAR-VA Behavioral Coordinator and Nurse Champion Leadership Team with an overview of dementia; and (2) to provide tips for communicating this complex information to Staff Partners who assist in implementing the STAR-VA intervention.

II. Dementia Overview

Definition of Dementia and Diagnostic Criteria

The dementias include a wide range of disorders that affect memory and other cognitive abilities. According to the National Institute of Health (NIH) "dementia is not a specific disease. It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain" (NIH, 2011). In the DSM-5, the term "dementia" was replaced with "Major Neurocognitive Disorder" (APA, 2013). According to the DSM-5, Major Neurocognitive Disorder is characterized by a significant decline in

one or more of the following cognitive domains: complex attention, executive function, learning and memory, language, perceptual motor, or social cognition. See Table 1.1 below for the general characteristics of Neurocognitive Disorder according to the DSM-5. It should be noted that while the DSM-5 employs the term “Major Neurocognitive Disorder”, “dementia” remains an acceptable alternative (p. 591), especially in settings where staff may be accustomed to the term “dementia.” Given the greater familiarity and use of the term “dementia” by Staff Partners, it may be preferred for use in STAR-VA.

Table 1.1

General Characteristics of Major Neurocognitive Disorder (DSM-5; American Psychiatric Association, 2013)

A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:

   1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and

   2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The cognitive deficits interfere with independence in everyday activities (i.e., at a minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications).

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia).

Note that Major Neurocognitive Disorder may have varying causes. Diagnosis is coded according to etiology (see below). In addition, diagnosis may be specified as occurring with or without behavioral disturbance, and as mild, moderate, or severe.

Memory difficulties are often prominent and demonstrated early in the course of dementia. Individuals may have difficulty learning new information, recalling recent conversations or events, misplace important items, and/or forget the names of loved ones. These memory difficulties may cause distress and confusion for the person with dementia and result in challenging behaviors such as accusing a loved one of stealing valued items or repetitive questioning. Difficulties with spatial skills, language (expressive and receptive), and executive functioning (e.g., skewed reasoning skills,

problems with insight, poor judgment) are common and may lead to challenging dementia-related behaviors in CLC settings. For example, an individual may become tearful if she has trouble identifying where the dining room is, yell out if she is unable to express the need to go to the bathroom, or become confused about the appropriateness of expressing feelings of intimacy towards another resident or staff member.

Common Etiologies of Dementia

There are multiple potential causes of dementia (Alzheimer's Association, 2013). Although it is beyond the scope of this manual to provide a detailed account of all possible etiologies of dementia, a list of some of the more common dementias are provided in the table below in Table 1.2 .

Table 1.2

Common Etiologies of Dementia (APA, 2013)

Alzheimer's disease
Frontotemporal lobar degeneration
Lewy body disease
Vascular disease
Traumatic brain injury
Substance/medication use
HIV infection
Prion disease
Parkinson's disease
Huntington's disease
Another medical condition

The most prevalent form of progressive dementia is Alzheimer's disease (AD), accounting for approximately 60-80% of all cases and is followed by vascular dementia, which accounts for about 10% of all cases (Alzheimer's Association, 2014). Note that about half of older individuals with dementia have some evidence of vascular pathology. The most prominent differences between AD and vascular dementia are listed in the table below. Of note, the relationship between AD and vascular dementia is complex, and both dementias may occur together. Thus, in reality, symptoms may not necessarily present as depicted in Table 1.3.

Delirium

Delirium, which is not a symptom of dementia, reflects an underlying medical condition which can be treated and is often mistaken as dementia. When working with Veterans with challenging behaviors, it is important to rule out delirium before employing STAR-VA or other approaches designed for *dementia-related* behaviors. Delirium is characterized by:

- Disturbed consciousness (e.g., reduced clarity of awareness of environment; reduced attention)
- Abrupt changes in thinking or development of perceptual disturbance
- Quick onset, with fluctuation in symptoms fairly common

Table 1.3

Alzheimer's Versus Vascular Dementia

ALZHEIMER'S DISEASE	VASCULAR DEMENTIA
• Gradual Onset • Initial symptoms are memory impairment (trouble with memory consolidation and rapid loss of new memories) • Gradual Progression that involves loss of other cognitive abilities	• Abrupt Onset • Initial symptoms are likely to be impaired judgment or ability to make decisions, plan or organize • A stepwise or fluctuating course • Focal or patchy cognitive or neurological deficits

Delirium has both predisposing and precipitating factors (Marcantonio, 2011). Predisposing factors include: advanced age; male sex; illnesses such as dementia, stroke, Parkinson's disease; sensory issues such as impaired vision or hearing; and history of alcohol abuse. More immediate precipitating factors include: medical issues such as a new acute medical illness or infection, acute stroke, urine retention/fecal impaction, electrolyte disturbance, sepsis; surgery/anesthesia; pain; dehydration; and new psychoactive medication (e.g., narcotic analgesics, benzodiazepines) or other medication adverse effects/interactions.

Potentially Treatable Etiologies of Cognitive Decline

There are a myriad of potentially treatable medical conditions and other factors that can lead to cognitive changes in older adults. These conditions may occur during the course of dementia making cognitive and/or behavioral symptoms more pronounced if left untreated. Likewise, they may lead to symptoms that are mistaken for dementia if undiagnosed. Some of the most frequently occurring conditions which should be taken into consideration when assessing for dementia include depression, normal pressure hydrocephalus, hypothyroidism, sleep disordered breathing, and vitamin deficiencies (such as B12 and thiamine).

Understanding Challenging Dementia-Related Behaviors

There are currently three primary paradigms for understanding the etiology of challenging dementia-related behaviors which serve as the basis for most psychosocial approaches to intervention in long-term care settings (Curyto, Trevino, Ogland-Hand, & Lichtenberg, 2012; McCurry & Drossel, 2011; O'Conner, Ames, Gardner, & King, 2009). First, according to the unmet needs paradigm, challenging dementia-related behaviors stem from the unmet physical, emotional, and social needs of persons with dementia (Cohen-Mansfield, 2001). These unmet needs may be related to physical and environmental factors (e.g., the need for reduced level of restraints, proper pain management, appropriate lighting, etc.) and psychosocial issues (e.g., loneliness, isolation, and boredom, among others). Second, approaches that have their roots in the learning/behavior paradigm tend to focus on learned behaviors, desired or undesired,

which may be inadvertently reinforced by staff in long-term care. This approach teaches staff about the relationship between activators, specific behaviors, and consequences (e.g., ABC Model) (Teri & Logsdon, 1990; Teri et al., 2005). Third, approaches arising from the environmental vulnerability paradigm (Lawton & Nehemow, 1973) are based on the assumption that as dementia progresses, there is a greater vulnerability to environmental stimuli, and that modulation of these stimuli may serve to decrease challenging dementia-related behaviors (e.g., reducing or increasing the sensory demands of the person with dementia).

Psychosocial Interventions for Challenging Dementia-Related Behaviors

There are a number of ways to classify psychosocial interventions for addressing challenging dementia-related behaviors, and the list that follows is not mutually exclusive or exhaustive (e.g., O'Neil et al., 2011). Specific approaches include: (a) Sensory enhancement/relaxation (e.g., message/touch, music during meals, bathing), white noise, sensory stimulation; (b) Social contact which may be real or simulated (e.g., animal companioning, one-on-one interaction, or simulated interaction such as family videos); (c) Staff training on dementia education, sensitivity, and stress management for staff; (d) Structured activities such as life enrichment, physical activities, and nature therapies; (e) Environmental design (e.g., building wandering areas, natural/enhanced environments, and reduced stimulation); (f) Medical/nursing care interventions (e.g., light therapy/sleep strategies, pain management, hearing/vision aids, restraint removal); (g) Behavioral interventions including differential reinforcement (e.g. reinforcing quiet behaviors), stimulus control (e.g., placing mirrors in front of doors to prevent exiting), and cognitive (e.g., orientation) modalities; and (h) Combination approaches including individualized treatment plans and intervention programs.

In clinical practice, the challenging dementia-related behaviors experienced by a particular individual with dementia can have multiple overlapping etiologies resulting in a complex clinical scenario. Likewise, when identifying appropriate ways of responding to challenging dementia-related behaviors, it is necessary that interventions be based on sound multi-factorial interdisciplinary functional assessment which takes into consideration biological, emotional, social, and spiritual factors, so that clinical interventions can be tailored to meet the needs of persons with dementia. ***STAR-VA is a multi-component, interdisciplinary-based intervention that incorporates many of the approaches identified above, tailored to the individual needs of particular CLC residents.***

III. Core Concepts about Dementia to Communicate to Staff Partners

The Human Brain is Complex

A core component of the STAR-VA intervention involves the Behavioral Coordinator and Nurse Champion working in close partnership with CLC staff, referred to as "Staff Partners" in this intervention, to effectively manage resident behaviors using a structured, individualized behavioral approach. For Staff Partners to assist in implementing this intervention, it is essential that they have an accurate understanding of dementia and how dementia can impact behaviors. Many staff not trained as

behavioral experts may, for example, try to reason with or convince a person with dementia to behave differently, reflecting limited understanding of dementia. If such staff were better informed about why certain behaviors may occur and held realistic expectations for persons with dementia, their interactions and approaches to these individuals could change. Research on and experience with the original STAR intervention has clearly indicated this to be the case. The remainder of this Section provides suggested information and messages to convey to nursing staff and other Staff Partners, based on the information used in the original STAR intervention for training nursing assistants.

When beginning a discussion about the human brain, it is helpful to acknowledge the complexity and importance of the brain to every action we take, every thought we have. With approximately 100 billion cells, the human brain makes roughly 100 trillion connections using 300 million feet of "wiring". This system is all packed with other brain tissue into the one-and-a-half-quart volume of our skulls. Normal brain functioning depends on all those connections and "wires" being in good working order. When describing the workings of the human brain to Staff Partners, the following example may be helpful:

Example of How to Discuss the Workings of the Human Brain with Staff Partners

Think of the brain as working like a finely tuned radio. For example, the music that we hear depends on radio waves, radio towers, multiple circuits, electrical wires and switches. It is very complex to think of every piece of equipment and technology needed to produce the sounds we hear from the radio. The working of our brains is even more complex. Basically, our memories are stored in our brains, and our ability to use our memories and to control our bodies depends on different parts of our brains sending and receiving signals to and from the other parts.

Dementia is a Brain Disease

Some people think developing dementia is a normal part of getting old. That isn't true. Only some people develop dementia. Dementia is not a normal part of aging but instead a disease which adversely affects the brain. The essential features of dementia are multiple changes in thinking such as problems with memory, speaking or understanding, moving, and making good judgments. Symptoms of dementia can include delusions (e.g., thinking that something has happened when it has not) and hallucinations (e.g., seeing, hearing, smelling, or feeing things that others do not see, hear, smell, or see). Cells in the brain get damaged and reduced over time in many types of dementia, such as Alzheimer's disease. The disease keeps marching through the brain, causing more and more problems in memory, problem solving, and judgment. How this disease affects an individual is difficult to predict because the effects on each person are unique. No two people experience exactly the same changes. Some people have serious memory problems, but seem to retain their social skills and get along pretty well with their normal routine. Others experience profound changes in their personality.
When discussing the concept that dementia is a progressive disease rather than a usual

part of the aging process, it is important to convey to Staff Partners that dementia involves a gradual deterioration of the tissue in the brain and that this slow and gradual process results in different behavioral changes over time. Table 1.4 below is a simple way of conveying some of the behavioral changes that occur over time by stage of dementia in Alzheimer's disease – which is the most common form of dementia. Of course, it is important to remind Staff Partners that we work with individuals and not diseases, so any person's presentation will vary based on their unique characteristics.

Table 1.4

Changes in Social and Task Behaviors by Dementia Stage

	Social Behaviors	**Task Behaviors**
Early Dementia	• Initiates and responds to social greetings and interactions • Carries on a conversation without much prompting • Seeks out unfamiliar activities when comfortable but familiar activities when distressed • Can use verbal and visual cues • Can select among options	• May lack initiation of a task • Relies on routines • Can easily choose among options • May discontinue challenging tasks • Can perform ADLS • Has difficulty with some IADLs
Middle Dementia	• Can initiate social greetings • Can respond to social • Greetings • Has very short conversational exchanges • Can make simple choices	• Can start or repeat task with cueing • Relies more on visual cues • Responds to brief verbal cues • Easily forgets the task at hand • May forget activities already complete
Advanced Dementia	• Minimal ability to converse • Avoids or resists unpleasant stimulation through nonverbal means • Unable to put together complete picture	• Focus on tactile cues, colors • Stimulus bound • Utilization bound • Scattered attention • May put non-food items in mouth

Adapted from Snow (2008) with permission.

From this information, it is clear that a Veteran with dementia may have difficulty interacting with staff and completing day-to-day tasks. However, these difficulties may be overlooked in a clinical setting and lead to frustration on the part of the person with dementia and staff. Thus, it is important for Staff Partners to have realistic expectations about each Veteran's abilities, and the STAR-VA Leadership Team can help staff understand Veteran strengths and limitations.

Note that VA has a number of dementia education resources that the STAR-VA leadership team may utilize to complement the information in this manual, in a manner that addresses Staff Partner learning needs. Please see the handout at the end of this section for information about select resources that may be helpful for your team.

Dementia-Related Behaviors Have Meaning and Purpose

The STAR-VA Behavioral Coordinator and Nurse Champion Leadership Team plays an important role in helping Staff Partners to understand that dementia-related behaviors have meaning and purpose. As we know, when people with dementia act in ways that are upsetting to others, it is not because they are trying to be difficult. These behaviors are typically an attempt to communicate an underlying need or emotion. The STAR-VA intervention provides a way for CLC Staff Partners to understand and address such behaviors. At the outset, however, it will be helpful to convey to Staff Partners that dementia can affect a range of behaviors.

Dementia changes what individuals remember, how their senses process information, and how much control they have over their moods and actions. It is important, however, to remember that, in spite of these changes, people with dementia are trying to make sense of the world around them in the best way that they can. The type of dementia a person has, and the parts of the brain that are affected, influence how each individual behaves.

For example, a Veteran who has lost the ability to recognize or remember nursing staff may become very agitated when a “stranger” tries to undress him. A Veteran who is disoriented (and perhaps with hearing and/or vision loss) may feel threated or scared when touched without warning, and strike out. A Veteran who misses his wife and cannot remember where he is living now may call out for her.

In addition, each person also has a lifelong history of responding to other people and situations in certain ways, and the brain disease may exaggerate these patterns. For example, a Veteran who was held captive during wartime may respond aggressively to other Veterans or Staff Partners who try to stop him from an unsafe behavior such as leaving. A Veteran who always took showers in the evening before bed may resist attempts to help bathe him in the morning before getting dressed. A Veteran who for many years stood on night “watch” at 2 am may have difficulty sleeping through the night and be prone towards nocturnal wandering.

Finally, dementia lowers an individual’s ability to tolerate stress and fatigue. Problem behaviors may reflect a Veteran’s frustration at being unable to communicate verbally something that is troubling him or her (e.g., physical pain or feeling frightened). It is very important that Behavioral Coordinators and Nurse Champions work with Staff Partners to help them understand that Veterans with dementia are often trying to get their needs met. The STAR-VA program offers a number of tools that can help Staff Partners begin to figure out what the Veteran is attempting to communicate by his behavior. The better we understand what the underlying message is, the more effectively we can respond.

People with Dementia Can Get Anxious and Depressed

Symptoms of anxiety and depression are frequently experienced by persons with dementia. These symptoms may be difficult for residents with dementia to communicate and may contribute to challenging behaviors. Since dementia causes significant memory loss, residents may tend to get confused more easily. They may forget where things are, have difficulty remembering or identifying their room, and/or have difficulty recalling names of familiar people. When these things happen, they can get anxious or depressed. They can also become frightened, angry, or sad. This, in turn, may have an effect on Staff Partners. The STAR-VA Leadership Team play an important role in educating staff about these reactions and provide training on basic techniques for reacting and responding to these behaviors.

Anxiety

When someone without cognitive impairment is anxious, they can sometimes calm themselves by reminding themselves that they are safe and not in danger. Persons with dementia may not be able to do this. They often need the help of others. Behavioral Coordinators and Nurse Champions can help Staff Partners identify anxiety in residents by educating them about the following cues listed below. With some basic training, Staff Partners can learn to recognize the following symptoms of anxiety and to soothe anxious Veterans:

- Irritability (more easily annoyed than usual, short tempered and angry outbursts)
- Restlessness (fidgeting, cannot sit still, leg jiggling, pacing, wringing hands)
- Repetitive calling out
- Fearfulness
- Physical signs (sweating, shortness of breath)
- Observed affect (e.g., eyes wide, tight facial muscles)

Depression

It is also important to educate Staff Partners that depressed feelings experienced by persons with dementia are not uncommon. In fact, a certain amount of depression is a normal reaction to some life events and losses. Persons with dementia frequently experience loss. Many of them have outlived close friends and loved ones and may experience sadness about these losses. Individuals with dementia also experience major changes due to life circumstances such as admission to a care facility and changes in physical or cognitive functioning. Depression may come on suddenly, especially in response to specific traumatic or sad life events, though often depression builds layer by layer and develops over time.

Depression in dementia is treatable. As experts on the identification and treatment of depression, Behavioral Coordinators may not only identify and treat depression directly, but also indirectly through their work with Staff Partners. As part of the STAR-VA intervention, the STAR-VA Leadership Team can educate Staff Partners about depression, dispel myths of depression, and train staff on how depression may influence behaviors. Staff Partners can be helped to identify the following signs of depression:

- Feeling sad or hopeless
- Crying, sighing
- Losing interest in activities or people that they used to enjoy
- Withdrawal and social isolation
- Changes in sleep or appetite (increase or decrease)
- Observed affect (frowning; downturned eyes, mouth, and head; head held in hand; face expressionless)

Behavioral Coordinators can further share that depression can be viewed as a downward spiral. The goal is to stop this downward slide. Sadness is a normal reaction when something bad happens. If we experience a loss, we often become sad. We also know how to stop ourselves from getting sad by using our brain to think about something else. Persons with dementia get sad and anxious, but they may be unable to pull themselves out of it like we would. Because of this, sad feelings lead to more sad feelings spiraling downward. But, just like we can pull ourselves up when we feel sad or anxious, residents with dementia can reverse the spiral. They just need some help from their healthcare team!

Finally, in helping Staff Partners to better understand anxiety and depression, it can be helpful to ask Staff Partners how taking care of a resident who is anxious or depressed compares with taking care of a resident who is not anxious or depressed. These differences can be written down by the Staff Partner and discussed in detail. The example presented on the next page can also be used to help staff better understand how anxiety and depression can add to the problems of a person with dementia.

Describing the Effects of Anxiety and Depression on a Person with Dementia

Imagine someone with a broken leg. The person will need crutches. If you have ever had to use crutches, you know that being on crutches changes your everyday life. You have to move slower, be more careful, and concentrate on just getting around. Now imagine being on crutches, and then having that bad leg stuck in a trashcan! Or how about having your good leg getting caught on a cord? It would almost be funny if it weren't so frustrating! But this is a way to imagine persons with dementia who also suffer from anxiety or depression. Having memory loss and confusion is bad enough; feeling worried, frightened, or sad makes those problems much worse.

You Can Help People with Dementia!

To help encourage and empower Staff Partners, the Behavioral Coordinator and Nurse Champion may point out specific strengths that each Staff Partner possesses that can help them work successfully with a person who has dementia and is experiencing challenging dementia-related behaviors, depression, or anxiety. Some of those positive attributes are listed in Table 1.5 below.

Table 1.5

Some Positive Attributes of Staff

Good listener	Caring	Friendly
Calm	Creative	Responsible
Consistent	Dependable	Respectful
Flexible	Patient	Humorous
Honest	Conscientious	Supportive

IV. Helping Staff Partners to Develop Realistic Expectations

Providing education to Staff Partners about how dementia affects behavior and what can and cannot be expected is a critical aspect of STAR-VA. Helping Staff Partners to develop "realistic expectations" of people with dementia may help them to be more tolerant and patient when a Veteran is slow to respond or behaves in a challenging way. Sometimes, a Staff Partner (or others) can take a Veteran's distressed behavior personally – none of us likes to be yelled at, treated aggressively, misunderstood, or otherwise responded to with seeming disrespect. If a Staff Partner feels hurt, frustrated, or angry in response to a Veteran's behavior, it may be more difficult to respond in a constructive and therapeutic manner.

Staff Partners may attribute challenging behaviors to negative characteristics of the Veteran as a person (e.g., "he is mean;" "he is disrespectful;" "he is annoying;" "he is just trying to upset me"). Such interpretations may indicate that the Staff Partner does not have realistic expectations of the person with dementia. When Staff Partners react personally to challenging behaviors, their responses may be less helpful.

Case Example: Fred and Eileen

Eileen, a nursing assistant, was near the end of her shift and checked in on Fred before leaving for the day. He was in bed and appeared angry. She asked if there was anything she could do to help him and he yelled out "I can't find my papers. You all keep stealing my things. You're all a bunch of thieves. Get out of here." Eileen was exhausted and felt angry. She couldn't believe Fred called her a thief, as she prides herself on her integrity and commitment to taking care of Veterans. She shouted back to him, "Don't you dare call me a thief…I would never take anything that belonged to you." Fred then kept yelling for her to get out.

In this scenario, Eileen was clearly upset when this Veteran accused her of stealing his belongings. Of course, negative emotional reactions to challenging dementia-related behaviors are entirely normal, i.e., it is normal to feel angry, hurt, or scared in response to aggressive, disrespectful, or threatening behavior. These reactions are understandable, even if there are good reasons that the Veteran with dementia may

behave in certain ways. In most cases, when a Veteran with dementia does or says something that is upsetting to others, it is not because they were trying to upset others. Helping Staff Partners understand how dementia is affecting the Veteran's behavior can help them to be more realistic, cope with upsetting feelings that are generated, and respond to the resident in a constructive manner.

Developing realistic expectations of individuals with dementia may go a long way in helping Staff Partners to avoid or lessen negative reactions (e.g., not yelling back at an angry Veteran). But, of course, such negative reactions may still happen on occasion. The Behavioral Coordinator and/or Nurse Champion can talk with a Staff Partner after an upsetting incident, and use a series of questions to help the Staff Partner develop strategies for responding more effectively in the future. These questions can help to validate the Staff Partner's reactions during a difficult incident, reinforce education about the impact of dementia on behaviors, and explore alternative strategies for responding if a similar incident happens again.

1. **Validate Staff Partner feelings**

   That was a very upsetting interaction with Mr. X, right?

   How are you doing now? Sounds like you were/are feeling very [angry/upset, frustrated/fearful] about your interaction with Mr. X?

   It can feel really [awful/scary/disappointing/sad] to have someone respond to you like that.

2. **Reinforce education about dementia**

   As we know, Mr. X has dementia, which makes it difficult for him to [remember, understand, communicate, express his needs…]. Given what you know about dementia, how might that affect his behavior?

   Given his dementia illness, what are some other possible reasons that Mr. X acted in that way with you?

   I wonder if his behavior might reflect that Mr. X is not able to… [provide dementia education relevant to the case and situation]

3. **Explore alternative strategies for responding next time**

   If Mr. X should become [agitated, angry, accusatory, aggressive] again, what might be a helpful way to respond?

   What reasons can you think of that would explain why Mr. X is acting this way? Can you remind yourself of these if it happens again? (For example, might you say to yourself [Insert helpful self-statement, e.g., "I wonder what is making Mr. X so upset." "He has dementia and something must be bothering him." "Let me stay calm." "His behavior is not really about me."]

What might help you to remain calm if Mr. X becomes [agitated, angry, accusatory, aggressive] again? Might it help to…? Take a few deep breaths before responding? Seek help from your team? Let Mr. X know, in a calm tone of voice, that you can see he is upset and want to help him? Leave the situation for a brief time and check back later?

Returning to the case of Fred and Eileen

How might the Behavioral Coordinator OR Nurse Champion help Eileen to evaluate her interaction with Fred and work to cope with his challenging behavior?

1. **Validate feelings:** Eileen became upset when Fred called her a thief. She could be helped to express her feelings at the time, such as feeling angry and disrespected when he accused her of unethical behavior, and feeling disappointed in Fred with whom she typically had good rapport.

2. **Reinforce education about dementia**: Help Eileen evaluate if her expectations about Fred are accurate. To do this, you may ask *"Given what you know about dementia, do you think it's possible Fred may not understand or know what is happening with his papers?" "Is it possible he may be confused about where he puts his belongings?" "Fred's dementia makes it difficult for him to understand and remember things. Fred might be feeling scared and helpless. It makes sense for him to think that other people may be taking his things when he can't find them."*

3. **Explore alternative strategies for responding**: Ask Eileen about possible approaches to take next time. For example, *"Given what you know about Fred's dementia, what can you say to yourself if this happens again? Perhaps something like 'Fred is feeling scared. This is not about me.'" "What can you do to help yourself stay calm? Would it help to take a slow, deep breath? What other ideas do you have?"*

Section 1

Summary Tips

- The STAR-VA intervention is an effective, team approach to resident care. By working together, interdisciplinary teams can improve the lives of residents with dementia.
- Understanding dementia and why individuals with dementia may display challenging behaviors is important for reducing such behaviors.
- Dementia is an illness that affects all brain activity – how we think, how speak, how we behave, and what we feel.
- Some dementias worsen over time and have at least three stages – early, middle, and advanced.
- Challenging dementia-related behaviors have meaning and purpose and may reflect an attempt to communicate an underlying need.
- Residents with dementia may experience anxiety and/or depression, which may contribute to challenging behaviors and can be reduced through behavioral strategies.
- If Staff Partners can understand the message underlying a behavior, they can respond effectively to or prevent the behavior.
- Staff Partners can be helped to evaluate their responses to challenging dementia-related behaviors and to develop realistic expectations for persons with dementia.
- Staff Partners can make a big difference in improving the lives of Veterans with dementia.

Section 1
STAR-VA Handouts

Stages of Dementia

Early Stages	Middle Stages	Late Stages
◆Something seems to be different about the resident, but the changes are subtle.	◆ The changes in the resident have become more obvious and are affecting their day-to-day functioning.	◆ The resident's abilities have declined dramatically.
The resident may:	**The resident may:**	**The resident may:**
◆Seem forgetful ◆Be irritable or sad ◆Have trouble with words	◆Have significant problems with memory, especially for recent events ◆Be irritable or sad ◆Need help with daily tasks, such as bathing, dressing, and taking medications	◆Have little or no memory ◆Be unable to use words properly ◆Be unable to use the toilet independently ◆Not recognize you or family members
You can help by:	**You can help by:**	**You can help by:**
◆Making requests one at a time ◆Making requests slow and clearly ◆Providing friendly reminders ◆Starting pleasant conversations	◆Using simple words ◆Guiding the resident through the necessary tasks ◆Speaking in a kind and reassuring tone of voice ◆Discussing pleasant memories with the resident ◆Starting pleasant conversations	◆Increasing your level of involvement ◆Using simple words ◆Speaking in a kind and reassuring tone; speak slowly ◆Using gentle body language and proceeding calmly ◆Bringing up happy events from the resident's past ◆Starting pleasant conversations and chat with the resident even if they are unable to vocally respond

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

VA Dementia Training Resources

Title of Resource	Purpose/Description	How to Access
Veterans With Dementia: Skills for Managing Challenging Behaviors	A set of 10 EES-produced video clips that demonstrate "customary" approaches to common care situations, and then a "preferred" approach, that more effectively manages activators of challenging behaviors. Each video-clip is 2-3 minutes in length, accompanied by a voice-over that describes how to engage in the preferred care approaches. The five scenarios include: (1) Dressing, (2) Grooming, (3) Mealtime, (4) Managing individual distress, and (5) Managing individual distress in a group setting. Target group is front-line caregivers.	Veterans with Dementia: Skills for Managing Challenging Behaviors
Hand-in-Hand Dementia Training Modules	A set of 6 modules and accompanying trainers guide developed by Centers for Medicare and Medicaid Services (CMS) for nursing home staff to understand dementia. Modules include excellent video resources. VA Pulse site contains training manual and instructions for how to access DVDs by ordering through TMS for no charge. The VA pulse site also serves as a community of practice for CLC educators involved in dementia training. It includes other useful materials such as how to use TMS to track attendance for staff.	https://www.vapulse.net/groups/hand-in-hand-dementia
A Systematic Review of Non-pharmacological Interventions for Behavioral Symptoms of Dementia	This seminar provides an overview of an HSR&D Evidence Synthesis conducted through July 2009. Investigators identified 28 systematic reviews and 25 primary articles in order to answer three key questions regarding non-pharmacological interventions for behavioral symptoms of dementia. The 3 questions were: How do non-pharmacological treatments of behavioral symptoms compare with each other and with pharmacological treatment and with no treatment in: 1. Effectiveness? 2. Safety? 3. Cost? Target group is CLC providers who want to understand the evidence-base for non-pharmacologic interventions for behavioral symptoms of dementia.	HSR&D Systematic Review Non-Pharmacological Interventions for Behavioral Symptoms of Dementia
Information and Support for In-Home Caregivers	This educational series is designed to aid caregivers who are helping a loved one suffering from dementia. Follow Harold and Margaret as they face common	http://www.ruralhealth.va.gov/education/dementia-caregivers/index.asp

Title of Resource	Purpose/Description	How to Access
	issues surrounding dementia in-home care, including home safety, legal matters, dealing with problem behaviors and learning relaxation techniques. There are 20 videos, each lasts between 4 and 6 minutes. These videos may help VA staff better understand how to partner with family members, particularly for Veterans who are receiving respite care, or who have recently relocated to a CLC on a more permanent basis. They can also be used as "trigger tapes" to help staff become accustomed to analyzing challenging behaviors. Learning materials need to be adapted for use with VA staff, as described above.	
An Orientation to STAR-VA: Improving Care for Veterans with Dementia in the Community Living Center (CLC)	This My VeHU broadcast provides an overview of STAR-VA core principles with case illustrations. It is a 90-minute broadcast featuring three STAR-VA leaders: Dr. Linda Teri, Professor at the University of Washington who developed the STAR (Staff Training in Assisted Living Residences) program from which STAR-VA is adapted; Dr. Kathleen Matthews, CLC psychologist and STAR-VA Training Consultant at the Des Moines VA Medical Center; and LeShea Nixon, CLC Nurse Manager and STAR-VA Training Consultant at the Houston VA Medical Center. Target audience is all members of the CLC team.	Orientation to STAR-VA: MyVeHU Broadcast
Implementing STAR-VA in the CLC: Meet Lester Porter	This DecisionSim Virtual Patient Case allows the learner to play the role of a nursing assistant who works with the team to provide care for "Lester Porter." In this approximately 20-minute simulation, the learner meets this fictional Veteran and, through making decisions about his care, is orientated to core principles of STAR-VA. The case includes video illustrations of Lester's behaviors and the team's approach to care. Target audience is CLC nursing assistants; any member of the team would benefit.	DecisionSim STAR-VA virtual training case - Lester Porter

Managing Our Reactions to Challenging Behaviors

Challenging dementia-related behaviors can sometimes make us feel frustrated, angry, hurt, or scared. It can help to recognize our feelings, remember that people with dementia have an illness than can affect how they behave, and "keep our cool" even if we feel upset.

(1) How were you feeling when the Veteran behaved in that way? What was most upsetting for you?

(2) Given what you know about dementia, what are some possible reasons that the Veteran acted in that way?

(3) What might be some helpful ways to "keep your cool" if this type of situation happens again? How could you respond?

Anxiety Symptoms

A person with dementia who is experiencing anxiety may appear worried, fearful, or nervousness.

Anxiety may also be expressed through the following behaviors:

- Yelling
- Arguing
- Repetitive calling out
- Trembling
- Sweating
- Shortness of breath
- Noise sensitivity
- Irritability
- Restlessness
- Wringing one's hands
- Distractibility
- Eyes wide, tight facial muscles

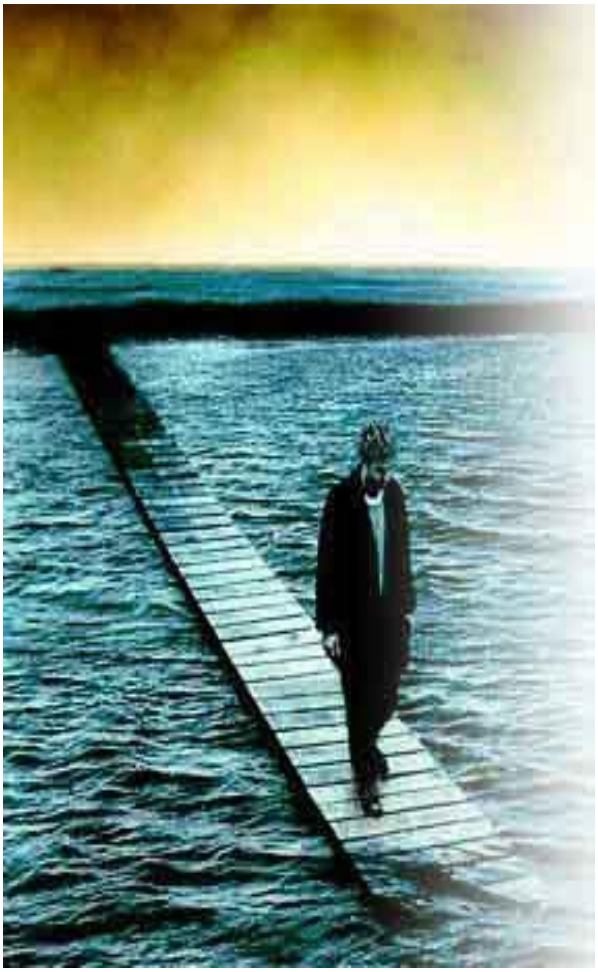
Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

Depression Symptoms

Someone who is depressed looks sad, seems tired, and doesn't enjoy anything.

Depression can also be expressed through the following behaviors:

- Talking about being hopeless
- Crying, sighing
- Not participating in previously enjoyed activities
- Thinking differently than before
- Looking distracted
- Eyes, face, mouth downturned
- Talking about being guilty, hopeless, or worthless
- Being pessimistic
- Talking or writing about death or suicide
- Complaining or arguing
- Having sleep problems
- Not eating or eating too much
- Being tired



One depressed behavior can lead to another depressed behavior, resulting in a severe cycle that gets worse and worse.

But Staff Partners can help stop the cycle in depressed residents with dementia if they take action!

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

SECTION 2
COMMUNICATING WITH AND WITHOUT WORDS

CORE CONCEPT:
Enhancing Communication Skills

Objectives:

I. Describe and demonstrate verbal and nonverbal communication strategies for interacting with persons who have dementia.
II. Use and demonstrate the “Listen with Respect; Comfort and Redirect” strategy with residents demonstrating behaviors consistent with anxiety or depression.

Outline:

I. Introduction
II. Communicating With and Without Words
III. Practical Communication
IV. Listen with Respect; Comfort, and Redirect
V. Summary Tips

Handouts:

I. Practical Communication
II. Listen with Respect; Comfort & Redirect (LRCR)

I. Introduction

Effective, resident-centered communication is a core component of the STAR-VA protocol. In this intervention, a primary role of the STAR-VA Leadership Team (i.e., Behavioral Coordinator and Nurse Champion) involves helping Staff Partners to effectively communicate with residents with dementia. To engage in resident-centered communication, Staff Partners need to have a clear understanding of a resident's cognitive strengths and limitations, as well as accurate expectations regarding a resident's abilities in language comprehension and expression.

Communication with residents who have dementia can be challenging due to the cognitive and behavioral changes that occur throughout the progression of dementing illnesses. Therefore, it is important for staff to be attuned to each resident's communication style and to adjust their own styles of communication to fit with the needs of each resident. For example, due to cognitive deficits, residents with dementia process information differently and thus will need information presented at a rate which is appropriate to their ability. Residents may need more time to process information due to cognitive slowing. Staff may have their greatest success in communicating and interacting with residents by adjusting the pace of communication.

Likewise, some residents understand and respond to nonverbal communication better than verbal communication. Residents may have difficulty understanding spoken words and may better understand the meaning of physical gestures. Thus, paying attention to and utilizing positive non-verbal facial cues and slow, fluid movements, for example, is critically important. Furthermore, it can be helpful for Staff Partners to explain tasks and breakdown complex tasks into smaller components, especially when engaging in multi-step behaviors (e.g., dressing, bathing, toileting) with residents.

It is also important for Staff Partners to appreciate that there may be additional physical and environmental challenges inhibiting the communication process and to keep in mind that clear and compassionate communication is the cornerstone to care. Examples of potential physical and environmental challenges that can affect resident communication are presented in Table 2.1.

Table 2.1

Physical Challenges	**Environmental Challenges**
• Lack of Sleep • Medications • Chronic Pain • Physical Illnesses • Depression • Hunger • Constipation • Vision/Hearing Difficulties	• Noise • Light • Temperature • Boredom • Unfamiliar People/setting

II. Communicating With and Without Words

The ability to verbalize one's thoughts and feelings can greatly influence the quality of relationships in one's life as well as the ability to navigate the social environment and get one's needs and desires met. So, what happens when a person with dementia loses the ability to communicate their needs and desires verbally? Likewise, how do others communicate their needs and desires to the person with dementia in a way that they can understand?

Although **verbal behaviors** such as words, statements, and questions are ways to convey what a person needs and desires, **nonverbal behaviors** can also convey a similar message. Specific nonverbal behaviors include sounds, gestures, facial expressions, body postures, and the rhythm and tone of one's voice.

In addition, the way a person behaves sends a strong message about what they are thinking and feeling. Indeed, there is much truth in the oft repeated adage, "***Actions speak louder than words***," and sometimes an individual's verbal and nonverbal behaviors communicate two very different (and sometimes conflicting) messages. This disconnect becomes a problem when the sender conveys a different nonverbal message than what was intended and is particularly problematic when working with individuals with dementia.

To further illustrate the potential disconnect between actions and words to Staff Partners, it can be useful to present concrete examples or vignettes. The following case scenarios provide a way to discuss complex staff-resident interactions.

Case Example: Pearl

A staff member told Pearl, "Don't worry about knocking that glass over," in a loud voice while looking away from Pearl, when Pearl accidentally knocked over her glass of orange juice one morning. Pearl took his statement as, "I'm really angry that you spilled your drink Pearl. You have inconvenienced me by making me clean up your mess," and began to cry. Both the staff member and Pearl were upset by the miscommunication.

Case Example: Frank

A staff member was trying to help Frank figure out where to sit at the dinner table, and said, "No Frank, over here", while rushing out of the room. Frank became upset and knocked over his chair, because he interpreted the staff member's quick statement and abrupt departure as conveying the message, "I am really annoyed right now Frank because you do not know where to sit at the table".

III. Practical Communication

As an important part of promoting staff-resident communication, the STAR-VA Leadership Team may provide and model practical communication strategies to Staff Partners aimed at enhancing interactions with residents who have dementia. For example, they may demonstrate the strategy of asking one question or making one request at a time, waiting for a response from the resident, and then moving onto the next question or request. This strategy is particularly important given that residents with dementia may become overwhelmed or confused when given too much information at once.

Although this strategy appears simple, it is actually a difficult skill to master in the fast-paced environment of a CLC. Sometimes Staff Partners may be rushed and need reminders to be more measured in their communications. Communication which is clear and slower in rate can reduce the likelihood of misperception by residents who are experiencing delusions or hallucinations. Also, there may be language barriers between the Staff Partner and resident which can interfere with communication. The Behavioral Coordinator or Nurse Champion can demonstrate just how long it takes for a given resident to respond, which may serve to alleviate frustration in the resident and/or Staff Partner. Also, it is important to remind the Staff Partner that it is often helpful for them to introduce themselves each time they greet a resident.

Residents with dementia can also have problems with vision or hearing that can lead to decreased understanding of what is being conveyed to them. The STAR-VA Leadership Team may work with Staff Partners to identify these potential barriers to communication and recommend that the resident with dementia receive a comprehensive evaluation of vision and hearing from an optometrist or audiologist as part of their plan of care.

The Behavioral Coordinator and Nurse Champion can provide techniques to Staff Partners to enhance communication with residents who are sensory challenged. For example, Staff Partners can be encouraged to start out each interaction with a visually challenged resident by making sure the resident is aware that they are in the room and telling the resident who they are. Gentle and appropriate touch can also let the visually challenged resident know that the Staff Partner is there to support them. It is best for Staff Partners to tell the visually challenged resident what they are going to do with simple and clear communication before carrying out any procedure. They can also describe the environment to the resident when taking them to activities or meals (e.g., who is present, what they are doing, how the room looks, what sort of food is on their plate, what the weather is like, if there are any birds present, etc). Staff Partners will want to keep in mind the strategies of practical communication and understand when too much information provided can become challenging for the resident to understand.

For residents with hearing impairments, Staff Partners can be encouraged to use appropriate and gentle touch to gain the resident’s attention. Eye contact is especially important for these residents as is the opportunity for them to read the lips of the Staff Partner. Additionally, it can be helpful for the Staff Partner to position themselves at eye level with these residents rather than standing over them. Hand gestures and visual

cues and signage may prove helpful when communicating with residents who have problems with hearing.

Case Example: Greg

Greg is a 90-year-old CLC resident with dementia, blindness, and severe osteoarthritis which has resulted in the use of a wheelchair to ambulate. Every time Greg's Staff Partner takes him out of his room, he yells, "Help me! Help me!" and becomes inconsolable. The Behavioral Coordinator is contacted to figure out how to assist Greg. After speaking with Greg, the Behavioral Coordinator learns that the Staff Partner has not alerted Greg to his presence before wheeling him out of the room. Greg believes that the Staff Partner is someone who wants to harm him. He believes that the Staff Partner has placed him at the edge of a staircase and that at any moment his wheelchair will be pushed forward resulting in his crashing to his death. The Behavioral Coordinator is able to discuss Greg's concerns with the Staff Partner who is then able to come up with some practical communication strategies to alleviate Greg's concerns. He begins by introducing himself to Greg every time he enters his room, describing exactly where he is planning to take him and making sure he is open to going there, discussing the surroundings in detail with Greg as he pushes him along, and leaving him next to another resident who is able to interact with Greg and assure him that he has not been seated in front of a staircase. Through trial and error, the Staff Partner also learns that Greg is much more comfortable when seated at a table given that he is able to feel the table in front of him. This is a win-win situation for all. The Staff Partner feels validated in his ability to problem solve with the support of the Behavioral Coordinator, and Greg is able to leave his room and enjoy the company of other CLC residents.

IV. Listen with Respect; Comfort and Redirect

Behavioral Coordinators and Nurse Champions can assist Staff Partners who tell them that they feel "stuck" when communicating with a particular resident through the use of a strategy called "Listen with Respect; Comfort and Redirect" (LRCR; see the Handout at the end of this Section):

Listen:
When listening to a resident, it is important to ensure that the resident is aware that the Staff Partner is listening to them. This involves elements of effective nonverbal communication, such as good eye contact, staying at the resident's level, giving them full attention and nodding to show interest. Good verbal communication skills are also important while listening, including summarizing the resident's responses, laughing when appropriate, and following up with clarifying questions. Remind Staff Partners to keep things simple by focusing on the resident. Listening lets the resident know that the Staff Partner is paying attention, which can diffuse a difficult situation.

Respect: It is usually a good idea to treat others as we would like to be treated ourselves. However, different people have customs or preferences that are different from our own. Some residents, because of their generation or culture, may not be

comfortable with being addressed by their first name by someone much younger than they are. Some residents may also be uncomfortable with gestures of affection, such as hugging. Some good rules of thumb to convey respect to residents with dementia are:

Start with formality.

- "Hello Mr. Jones, how are you?"
- Later, ask the resident how he would like to be addressed. "Would you prefer I address you, as Mr. Jones or would you prefer something else?"
- Suggest that Staff Partners avoid very familiar expressions, such as "sweetie" or "Pop" unless they are certain that the resident prefers them.

It is important to remind and educate Staff Partners about important cultural and generational issues. Just like everyone else, a resident with dementia is a product of their culture and age cohort. This means that depending on the culture with which the resident identifies, they will be familiar with and favor a particular way of communication. There are different customs or preferences when communicating with elders. Be aware of the resident's nonverbal communication – this can you tell you a lot about how a resident is responding to your communication.

Comfort: Staff Partners can be encouraged to pay attention to when someone is feeling anxious or depressed and provide them with a sense of comfort and safety through emotional support. Let the resident know that you are listening and that you care. Reassurance or gentle touch can help a resident to calm down and feel safe.

Encourage Staff Partners to ponder what a resident is thinking and feeling when they appear anxious or depressed (without going into too much detail), leaving the resident with the feeling that the Staff Partner cared, heard, and understood. The use of reflecting and summarizing statements can be especially effective for demonstrating in this context.

Consider, for example, a resident with dementia who might be looking for his deceased wife. The Staff Partner knows that his wife died years earlier. It will not provide the resident comfort to be told that his wife is deceased. However, it may provide comfort to reflect or restate the resident's feelings by saying "You miss your wife…it seems like she has meant a great deal to you…" Depending on the circumstances, the Staff Partner may ask, "What have you enjoyed doing together" or "What was she like?"

Occasionally, residents need to be reminded that they are in a comfortable and safe place. This message can be conveyed with statements such as: "We are here to help you with whatever you need. What can I do for you?" A resident who is paranoid, anxious, or suspicious can be comforted by these words of support.

Redirect: Sometimes we need to do more than listen with respect and comfort a resident who is upset. After providing support, distract a resident by changing the subject or redirect them to a pleasant activity. For example, the depressed resident with dementia who misses his wife may become absorbed in a behavior such as repeatedly demanding to know his wife's whereabouts. After providing the resident with some

support, it might be a good idea to redirect him, or distract him by changing the subject. This goal may be accomplished by suggesting that a Staff Partner accompany the resident on a walk or some other activity that the resident enjoys. Redirection is an important tool and can be effectively modeled by the Behavioral Coordinator and Nurse Champion.

Don't Argue: It is not uncommon for Staff Partners or families to become frustrated with a resident's behavior and end up in an argument with the resident. The following example may be helpful in conveying the idea that it is not helpful to argue.

Case Example: John

A resident named John approaches a Staff Partner and tells her that he is waiting to be picked up from school by his mother. The Staff Partner tells John that his mother is not coming. John insists that his mother is coming. The Staff Partner continues to state that John's mother is not coming. John becomes upset with the Staff Partner and begins yelling even louder.

Residents who are confused can become more distressed when they are told that what they are thinking or believing is not correct. It can be helpful for the Staff Partner to stop and ask: "Am I arguing with a resident and is this making things better or worse?"

Arguing never helps. In situations such as that with John described above, the Behavioral Coordinator or Nurse Champion may empathize with the Staff Partner about how easy it is to get stuck when communicating with a resident and use this as an opportunity to teach the LRCR approach to the Staff Partner and even role-play and practice how to use it. This type of situation may present an opportunity to remind Staff Partners about having realistic expectations of the person with dementia. For example, John is disoriented, believing he is a child and waiting for his mother. This can happen in dementia and it is not important to insist on "the truth" but rather to help the person with dementia feel comforted.

After teaching the components of the LRCR approach, the Behavioral Coordinator or Nurse Champion may present the case of John above (or use a real case the Staff Partner is confronted with). After presenting the case, ask the Staff Partner: "Now, how could you use the Listen with Respect, Comfort, and Redirect approach in this situation"? After discussing the Staff Partner's ideas, you may present them with the resolution of the situation with John, using the LRCR approach, presented on the next page.

Case Example: John – RESOLVED

A resident named John approaches a Staff Partner and tells her that he is waiting to be picked up from school by his mother. The Staff Partner stops typing on the computer, stands up, walks around the desk to where John is standing, and listens to him. She gently touches his arm, looks John in the eye as he talks, and reassures him that his mother will know that he is here when she arrives to pick him up. The Staff Partner then asks John about his school and his favorite subjects to study. As they are talking, the Staff Partner walks with John down the hall to the nurses' station and asks him to help her organize some newspapers and magazines. The Staff Partner has John sit with her and organize the periodicals while she resumes charting in the computer.

Section 2

Summary Tips

- Both verbal and nonverbal behaviors send important messages to residents.
- Nonverbal behaviors can enhance communication with residents who have dementia. These can include a kind gesture, a positive/pleasant tone of voice, a smiling face, and a relaxed body posture.
- The messages we send to others is not always the message received. This is often especially the case with individuals with dementia.
- Communication can be a powerful activator of a resident's behavior.
- When there is a problem, check the nonverbal messages being sent.
- Residents may become overwhelmed or confused when asked too many questions or given too many instructions.
- Routinely announcing who you are and what you are going to do can be helpful with residents with dementia.
- Vision or hearing difficulties can affect a resident's comprehension.
- Use "Listen with Respect; Comfort and Redirect" to structure interactions with residents.

Section 2

STAR-VA Handouts

Practical Communication

Face and head movements

- Keep your expression calm and encouraging.
- Nod appropriately and positively.
- Smile.

Hand and arm movements

- Use hand movements gently for emphasis.
- Use appropriate touch to help the resident focus.

Speech rate and tone

- Speak slowly and clearly.
- Use short sentences.
- Ask one question at a time.
- Be patient.

Eye Contact

- Make eye contact with the other person when speaking or listening unless they appear uncomfortable.
- Move eyes spontaneously and naturally.

Body Position

- Make sure you have the person's attention.
- Gently approach the person from the front and move to the person's side.
- Place yourself on the same level with the other person as much as possible.
- Position yourself close enough to be seen and heard clearly.

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

Listen with Respect; Comfort and Redirect (LRCR)

After introducing yourself at the beginning of the interaction, use the following communication skills:

1. Listen

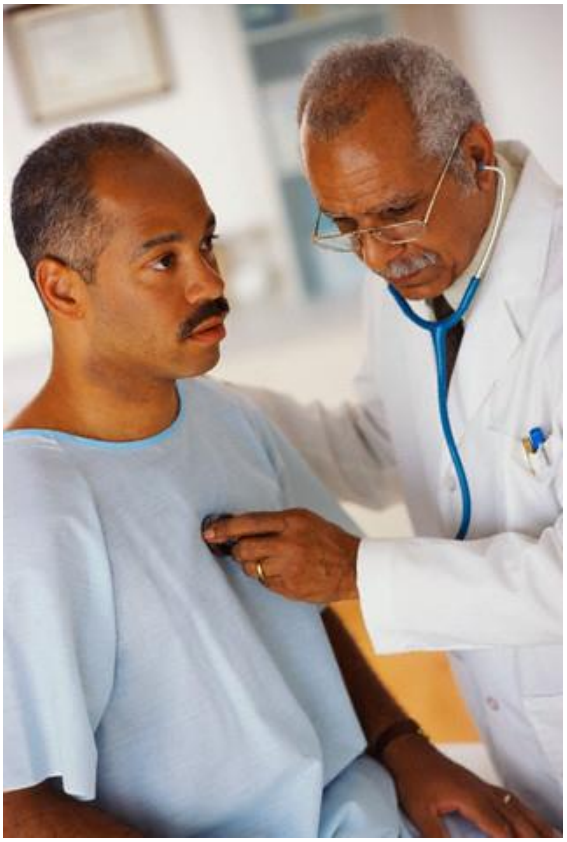
Make sure that the resident KNOWS you are listening.

- **Make eye contact with the resident.**
- **Focus on the resident; don't try to do two things at once.**

2. Respect

Sometimes being too casual with residents can be viewed as disrespect.

- **Start with formality**
- **Later, ask the resident how he or she likes to be addressed.**
- **Pay attention to the resident's nonverbal communication. If he or she is bothered by your communication style try a different way.**



3. Comfort

What we say and how we say it can provide comfort to residents who are anxious or depressed.

- **Pay more attention to what the resident may be thinking or feeling than what he or she might be saying.**
- **Let the resident know that you understand.**
- **Persons with dementia who are anxious and depressed need help to calm down.**

4. Redirect

Sometimes providing comfort is not enough. Try to redirect or distract the resident from his or her problem behavior.

- **Attempt to change the subject after you have shown respect and tried comfort measures.**
- **Try to involve the resident in pleasant events.**
- **Whatever you do, DON'T ARGUE.**

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

SECTION 3
The ABC's of DEMENTIA

CORE CONCEPT:
Identifying Problem Behaviors and their Circumstances

Objectives:

I. Understand and address residents' challenging dementia-related behaviors using the ABC approach.
II. Identify activators and consequences of challenging dementia-related behaviors in CLC residents.

Outline:

I. Introduction
II. The ABC Way of Understanding Resident Problems
III. Using the ABC's
    Behaviors are Observable Events
    Identifying Activators and Consequences
    Identifying the Activator
    Identifying the Consequence
IV. Summary Tips

Handouts:

I. STAR-VA ABC Card
II. Tip Sheet – ABC Assessment Side
III. Behavioral Tracking Form

I. Introduction

Many mental health providers receive didactic training and clinical supervision in the use of behavioral analysis and behaviorally-oriented clinical interventions as part of their clinical training. However, few mental health providers receive specialized training in systematically applying these principals and techniques in long-term-care settings, such as CLCs. Likewise, many STAR-VA Nurse Champions may not have training in behavioral assessment and treatment. In this Section, an overview of important behaviorally-oriented concepts for understanding and planning interventions for addressing challenging dementia-related behaviors is provided. In the Sections that follow, methods for applying these concepts are addressed.

II. The ABC Way of Understanding Resident Problems

To effectively understand a challenging dementia-related behavior, it is crucial to understand the circumstances surrounding the behavior. The greater the specificity with which CLC staff can characterize the circumstances surrounding a behavior, the better the chances they will have in developing an effective clinical strategy to address the behavior. The STAR-VA Behavioral Coordinator and/or Nurse Champion may serve as the catalyst for uncovering the etiologies of, or contributors to, a particular behavior by asking Staff Partners clarifying questions about the behavior.

At the core of the underlying theory and application of the STAR-VA intervention is the **ABC behavior chain**, where “A” stands for activator, “B” stands for behavior, and “C” stands for consequence. The **A-activator** is what happens just before the **B-behavior** and contributes to the challenging behavior. The **C-consequence** is what occurs just after the behavior and can maintain the behavior, cause it to get worse, or cause it to get better.

While information about the A, B, and C can be gathered from others on the interdisciplinary team, it may also require direct observation by the Behavioral Coordinator and Nurse Champion. If Staff Partners report more than one problem behavior, it can help to prioritize the behaviors based on severity or level of disruption to decide which to address first. Typically, one would address the most prevalent and easily described behaviors first. In identifying and describing behaviors, it is important for Staff Partners to be as specific as possible. Further, it is important that behaviors be described in observable terms. For example, rather than using the term “agitation” to describe a challenging behavior, it would be better to briefly describe the specific behavior (e.g., “threw tray on the floor”). Using specific observable descriptors is also useful for tracking change in the behavior.

The Behavioral Coordinator can appreciate the complexities of behaviors seen in dementia and using the ABC behavior chain can make characterizing the problems easier and more understandable to Staff Partners, so that the behavior can be addressed to improve the quality of care. When analyzing the situation, an important question to consider is for whom is the behavior a problem? Interventions for behaviors are needed when the behaviors are dangerous, cause disruption or problems for the

resident or other residents, negatively impact or interfere with the care of the resident or other residents, or lead to increased isolation and lowered quality of life of the resident. Obtaining a good frequency count or baseline of the behavior before intervening is often important for tracking improvement. Behavior frequency can then be graphed over time and shown to the Staff Partners working with the resident to provide visual reinforcement for their successful behavior management. This reinforcement can help maintain the morale of Staff Partners under difficult and challenging circumstances.

One way to suggest that Staff Partners track the frequency of behaviors is by obtaining a behavioral count, such as through the use of a behavioral tracking form. An example of a behavioral tracking from is provided on the next page in Figure 3.1. [This form is also included at the end of this Section and in Appendix A for easily copying and may be adapted for local use.] Of course, frequency of behavior is just one important piece of information that may be tracked; in additional to frequency, a behavioral tracking form may also include the *severity* of the behavior exhibited. The behavioral tracking form provided herein may be adapted to include this and other information to be tracked locally (e.g., time behavior occurred, where behavior occurred, activators/consequences, etc.). Furthermore, once an intervention is developed and applied (discussed later in this manual), there can be space provided on the tracking form for indicating what, if any, intervention was used. A behavioral tracking form may be best maintained at the nurses' station or on the medication cart that is assigned to the resident that day and handed off between the various shifts. The form can then be collected by the Behavioral Coordinator and simple bar graphs (or other visual representations of the data) developed. It is often very helpful to provide reminders to Staff Partners during nursing report to help encourage the use of the behavioral tracking form and to reinforce Staff Partners when they do take the time to note these behaviors in this way.

III. Using the ABC's

The following guidelines will be useful for the STAR-VA Leadership Team in discussing core concepts with Staff Partners in implementing a behavior management plan based on the ABC approach.

Behaviors are Observable Events

Dementia often causes people to act in ways that don't make sense to others. People with dementia may get very emotional over something that may be considered to be minor by others, or they may act in ways that don't fit the way they typically behave. Sometimes, it seems as if persons with dementia do things for no obvious reason. This, of course, makes it difficult to know how to respond since the behavior can appear difficult to predict. However, behaviors rarely occur without some type of precipitating event. By thinking of behaviors as a series of observable events, one can begin to think about possible causes of the behavior. Once a cause is identified, a plan to change the behavior can be developed.

Figure 3.1

Behavioral Tracking Form

Date: __/__ /____

	AM Shift	PM Shift
Behavior 1: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Behavior 2: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

Date: __/__ /____

Behavior 1: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Behavior 2: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

Date: __/__ /____

Behavior 1: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Behavior 2: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

Instructions: Please write in each of the behaviors you are tracking on the left-hand side of the Behavioral Tracking Form. Each time the behavior occurs during a shift, circle the number of times it has occurred. Make sure to put in the dates that the behaviors were tracked and provide to the Behavioral Coordinator, so that s/he can monitor or graph out progress towards reducing the behavior.

The first step is to be clear about what is meant by B-behavior (i.e., to distinguish problem behaviors from safe, trivial behaviors that do not meet the definition of a problem behavior as described in the section above). Not all dementia-related behaviors are problems that need to be changed. Making this distinction will help the Staff Partner “pick their battles” and focus attention on the most concerning behaviors.

After determining that the behavior is a problem, it is important to describe the behavior. This description must be observable and specific, i.e., as detailed as possible. A resident's behavior may be described simply as "angry." However, angry is not a specific behavior. Instead, in the description write, “The resident is angry; he is raising his voice and saying that he doesn’t want to take his medicine.” With this description the resident’s behavior is clearer; it is almost like “seeing” it happening.

The **STAR-VA ABC Card** (or simply ABC Card), is a very useful tool in the STAR-VA intervention that is used when working with residents with problem behaviors. The card can be found in Appendix B. Briefly, side one of the ABC Card, “ABC-Assessment,” is used for identifying and describing the problem, and side two of the card, the “Get Active!” side, is used to develop the plan to address the problem. Side one of the card can be found as a handout at the end of this Section. Side two of the ABC Card is

described further in Section 4 of this manual. Both sides of the STAR-VA ABC Card can be found in Appendix B.

Describing the behavior is facilitated by posing a series of questions. The questions that help describe the behavior can be framed as the 4W's: "What, Who, Where, and When and are described further in Table 3.1.

Table 3.1

The 4W's

"**What** was the resident doing?"
Write the specific, observable problem behavior

"**Who** was present?"
Enter all the people who were present at the time of the problem behavior.

"**Where** was this happening?"
Write the specific location where the behavior occurred.

"**When** was this happening?"
Enter the time of day and how often the behavior occurs.

Identifying Activators and Consequences

In addition to understanding the behavior, one must understand the circumstances around the behavior. To change a problem behavior it is necessary to see and understand the whole picture. As discussed earlier, people do not act randomly.

To understand a person's actions, one must observe what happened **before and after** a specific behavior. Every behavior is part of a process with a beginning, middle, and an end. We have already talked about the B-behavior, the middle puzzle piece on the ABC Card.

Identifying the Activator

The beginning of a problem, the **A-activator**, is something that happens immediately before a behavior. An activator is a cause or a trigger of the behavior. The activator can be internal or external. With activators, as with behaviors, the description must be as specific as possible. Often, it is difficult to know what the activator is because only the behavior is noticed. By being attentive to precursors to behaviors, activators can be identified. Identifying activators often requires collecting collateral information from Staff Partners and sometimes family members.

Internal activators include medical activators and psychological activators. Examples of medical activators that can alter a person's behaviors include fluctuations in blood sugars, urinary retention, pain, and indigestion (Table 3.2). Many individuals with

dementia do not have the capacity to express their physical or medical distress in words so it is expressed behaviorally. For this reason, it is essential that residents who exhibit challenging behaviors receive an appropriate medical workup by the medical staff to check for possible medical causes for challenging behaviors. This is especially important in residents that do not have a history of exhibiting problem behaviors. Psychological activators include sadness or depressed mood, loneliness, feeling scared or anxious, and feeling angry.

Table 3.2

Types of Activators of Challenging Behaviors	
Medical Activators may include:	• Infection • Pain or physical discomfort • Medication side effects • Incontinence or constipation • Hunger or dehydration • Lack of sleep or fatigue • Sensory loss
Psychological Activators may include:	• Sadness (or reminders of a sad event) • Loneliness • Feeling scared or anxious • Anger
Environmental Activators may include:	• Too much noise, activity, clutter, and/or people • Unfamiliar persons, places, and/or things • Startling movements, noise, or touch • Insufficient lighting • Changes in schedules and routines • Shift changes • Being left alone for too long, boredom
Interpersonal Activators may include:	• Repeated questions or demands • Caregiver impatience, tone of voice • Inability to perform simple tasks (becoming frustrated) • Being rushed • Being touched or held in ways that are frightening or confining • Verbal reasoning and logical explanations • Activities perceived as insulting or child-like

External activators include interpersonal activators and environmental activators. Examples of interpersonal activators are rude behaviors or gestures, attacking behaviors, and yelling. Environmental activators include loud or bothersome noises, extreme temperature, and over stimulating or under stimulating surroundings. Examples of activators to challenging behaviors in CLC residents are summarized below, though

this is not intended as an exhaustive enumeration of potential activators.

When identifying activators, it is also important to recognize that individuals do not live or behave in a vacuum; behaviors in the here-and-now may be influenced by historical factors, such as cultural background, past habits and preferences, family and social routines or roles, and traumatic events. Specifically, a person's history may predispose someone to exhibiting a challenging behavior, particularly in the presence of one or more psychological, medical, interpersonal, or environmental activators.

Identifying the Consequence

C-consequences are what follow a behavior. **Consequences cause behaviors to get better, continue, or get worse.** They may include reactions of staff or other residents to the challenging behavior. Specifically, consequences may include comforting a resident, yelling at or arguing with a resident, providing something of value or meaning to the resident, taking something from the resident, or placing the resident in a different environment or location.

Activators and consequences occur immediately before and after the behavior like a snapshot. A snapshot captures something that happens in an instant. When working with a problem behavior one would want to know and focus change on what is happening in that snapshot. It might be tempting to refer to periods of time that do not relate to the current behavior. It is up to the Behavioral Coordinator and Staff Partners to recognize when this is happening and to look at relevant activators and consequences.

Consider an example of a resident arguing and refusing his medications. This scenario is demonstrated in a role play exercise on the DVD developed as part of the original STAR training program. After identifying the behavior on the ABC Card, proceed with identifying the activator and answer the question, "What happened just before B?" Many things **could** have happened before the B. Maybe the resident had a bad lunch. Maybe the resident was mad at the staff member from an earlier visit. Or, maybe the resident has not liked taking medicines since he was child. These things may have happened, but they do not provide any clues about how to fix the situation now. What is needed is to identify what is observable—what we see. As stated before, we want to focus on what happened right before the behavior. The purpose of this is not to identify problem behaviors among Staff Partners, but to try to figure out how to better approach the resident.

One way to go about identifying the behavior would be to interview the Staff Partner that interacted with the resident and ask her about what happened. It may also help to interview other Staff Partners that were present during the expressed behavior. The difficult part can be maintaining focus on specifics that can be identified and measured. This can be accomplished by asking the Staff Partner closed ended questions.

Now go to the last section on the card, the consequence section. The consequence is very important because it has a significant impact on whether the problem behavior gets better, maintains, or gets worse. In identifying the consequence, consider what

happened immediately after the problem behavior. For example, the Staff Partner might have insisted that the resident take his pills if he was declining to do so, and the resident might have become angry and knocked the pills out of her hand.

After identifying the consequence, consider whether the consequence made the behavior better, maintained the behavior, or made it worse. Consequences that worsen or maintain the behavior should be eliminated while consequences that improve behavior can be incorporated into the behavior plan. The information on the activator, behavior, and consequence is often best written on the ABC Card while meeting with the Staff Partner(s) so that they better grasp the connections.

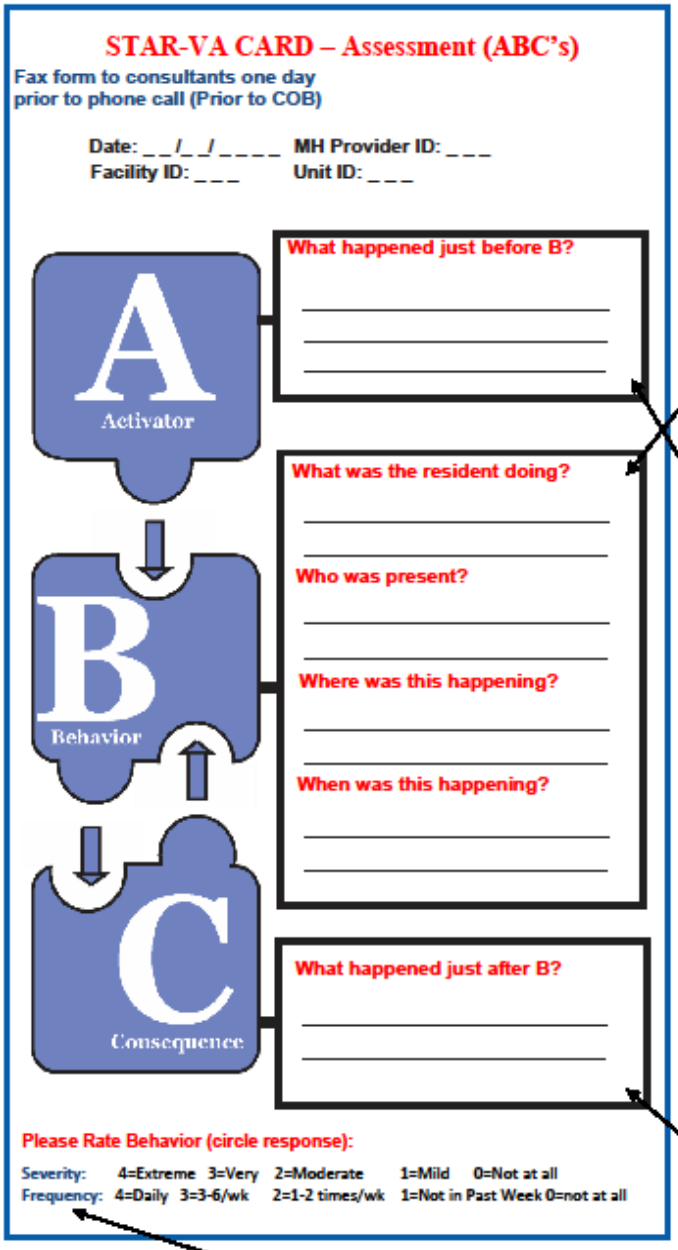
Note: Initially, the Behavioral Coordinator, in collaboration with the Nurse Champion, will be primarily involved in identifying the ABC's; however, over time, it is expected that Staff Partners, with training and experience in using the ABC Card, will be able to identify ABC's, as well as implement behavioral intervention plans with decreasing direct involvement of the Behavioral Coordinator and Nurse Champion.

Section 3
Summary Tips

- Behaviors are observable acts.
- Behaviors can be considered challenging if they are physically harmful, emotionally distressing, or reduce the quality of life of the person with dementia or the people with whom they interact (e.g., other residents, CLC staff, and family members).
- Use the 4W's (Who, What, Where, and When) to understand and describe challenging dementia-related behaviors.
- Use the ABC's and the ABC Card to better understand challenging behaviors and help formulate an intervention:
    - Activator – What happened immediately before the resident's challenging dementia-related behavior?
    - Behavior – Use the 4W's to describe the challenging dementia-related behavior in detail.
    - Consequence - What happened immediately after the resident's challenging dementia-related behavior?
- Activators can be internal (medical, psychological) or external (environmental, interpersonal) to the resident.
- The consequences of a challenging behavior can have a significant impact on whether the problem behavior gets better, maintains, or gets worse.
- By focusing on identifying and changing activators and consequences, the Behavioral Coordinator, Nurse Champion, and Staff Partners together can reduce challenging behaviors even if the dementia cannot be cured.

Section 3

STAR-VA Handouts



The severity of the behaviors refers to the level of distress that is caused by the behavior that affects the staff, the patient, and other residents. The behavior can affect one or all of the above. Frequency refers simply to the number of times the behavior occurs.

Using the STAR –VA CARD "Assessment"

Step one:

Identify a challenging behavior and write it on the lines next to "B" or Behavior. Make sure the behavior is identifiable by anyone looking at the card. Don't use generalizations such as "the Veteran appears Angry" when asked to take medication. Use specific descriptions such as "the patient hit Staff Partner when Staff Partner put medication in front of him." Utilize the behavioral rating and frequency scales below to help keep track of the behaviors and any subsequent changes.

Step Two:

Identify an Activator in section "A". This would be anything said or done just prior to the behavior that may contribute to the behavior. Sometimes the behavior is difficult to identify because the person involved in it does not realize that what they do or say can affect another person. This will often require an interview with the Staff Partner or an observation of the interactions. You may have to redirect the Staff Partner to talk about specific behaviors and what they said to the Veteran rather than how they felt about the situation. It often helps to talk to more than one Staff Partner about recurrent behavior.

Step Three:

Identify the consequence "C" of the behavior. This would be any behavior that occurred immediately after the target behavior such as the nurse leaving the Veteran alone or talking with Veteran more that they did prior to the incident.

Tip Sheet - ABC Assessment Side

Activators, Behaviors, and Consequences

Review the ABC Card and how the Staff Partner used it. If the Staff Partner has any difficulty or confusion using the card, provide assistance by asking the following questions.

1. Did you work with the resident in this past week?

2. Did the resident have any problem behaviors? For example:
   - In the past week, has the resident appeared angry, anxious, worried or irritable?
   - Did the resident isolate in his or her room, appear sad, or cry?
   - Did the resident refuse care, or yell out without reason?

3. Pick out a particular behavior and describe what happens. This is the problem behavior.

If the Staff Partner indicates a judgment or assumption that describes the resident instead of the behavior, direct the Staff Partner to focus on what the resident is doing.

4. Once you've identified the specific problem behavior, write the answer on the ABC Card to:
   a) What was the resident doing?
   b) Who was present?
   c) Where was this happening?
   d) When was this happening?

5. Right before the behavior occurred, what was going on with the resident? What might have triggered this behavior? Write your answer next to A on the front of the ABC Card.

6. What happened right after the behavior occurred? Write your answer next to C on the front of the ABC Card.

7. Did the C make the behavior better or worse?

8. Do these ABC's make sense? Do the activator, behavior, and consequences as they are written describe what happened?

If the ABC's as written do not make sense, review other ways of stating them until the ABC's reflect what the Staff Partner describes.

9. Completing the front of the ABC Card will help you better understand the resident's behavior and gives you ideas about how to resolve problems. Now you can get to work on changing the problem behavior to a goal behavior. Turn over the ABC Card to the Get Active side!

Behavioral Tracking Form

Date: __/__ /____

	AM Shift	PM Shift
Behavior 1: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Behavior 2: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

Date: __/__ /____

Behavior 1: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Behavior 2: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

Date: __/__ /____

Behavior 1: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
Behavior 2: _____	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

Instructions: Please write in each of the behaviors you are tracking on the left-hand side of the Behavioral Tracking Form. Each time the behavior occurs during a shift, circle the number of times it has occurred. Make sure to put in the dates that the behaviors were tracked and give to the Behavioral Coordinator, so that s/he can graph out progress towards reducing the behavior.

SECTION 4
PROBLEM SOLVING:
GET ACTIVE!

CORE CONCEPT:
Changing Problem Behaviors to Goal Behaviors

Objectives:

I. Understand and identify goal behaviors.
II. Recognize how to change activators and consequences of challenging dementia-related behaviors.
III. Build a skill set for using the Get-Active! side of the ABC Card and develop behavioral care plans.

Outline:

I. Introduction
II. Identifying and Activating Goal Behaviors
III. Get Active! – Change Problem Behaviors to Goal Behaviors
    Case Example: Sexually Inappropriate Behavior
    Applying the ABC Card with Staff Partners
    Applying the Get Active! side of the ABC Card with Staff Partners
IV. Summary Tips

Handouts:

I. STAR-VA Card – Get Active! Side
II. Tip Sheet – Get Active! Side

I. Introduction

This Section addresses how to develop a care plan to decrease the problematic behavior (B) and increase a new positive "goal" behavior. You will use the knowledge gained by identifying the ABC's of a challenging behavior (discussed in Section 3 of this manual) to now alter the A (activator/trigger) and C (consequence) that contribute to the problem B and thereby improve care. Remember, the first step in the ABCs is to identify the B-behavior in as objective a way as possible. Behaviors typically targeted are those which cause self-harm, distress, make life difficult for the resident, or are potentially harmful to others. Next, identify the A-activator or what triggered the behavior. The activator occurs right before the behavior. Then, identify the C-consequence which is what happens right after the behavior occurs. Consequences are analyzed to determine if they made the behavior better, maintained the behavior, or made the behavior worse.

It may be helpful to have the sample "Get Active!" side of the ABC Card (available at the end of this Section and in Appendix B) in front of you while reading this Section.

II. Identifying and Activating Goal Behaviors

Once the ABC's of the problem behavior have been identified, the next step is to think about what needs to change to attain a goal behavior by completing the "Get Active" side of the ABC Card.

Consider the following common challenging behavior that happens in CLCs: A resident is reluctant to get dressed in the morning. After completing the ABC Card, go to the "Get Active!" side and complete the questions in **the B-behavior "Change the B"** box that asks "What do you want the resident to do?" Write down the behavior you **would like** to see from the resident. This is the **goal behavior**. Goal behaviors should not just be the absence of a problem behavior. For example, we would not want the goal behavior in this case to be "Veteran doesn't refuse to get dressed in the morning." Rather, the goal behavior should be what you would like to see, such as, "Veteran dresses himself in the morning," or "Veteran will let staff assist with some dressing activities."

III. Get Active! – Change Problem Behaviors to Goal Behaviors

Once the goal behavior has been identified, go up to the **A-activator "Change the A"** box. This box is where to write what will be done differently that may increase the likelihood that the resident will engage in the goal behavior. Quite often possible activators for the goal behavior are determined based on what the activator was for the problem behavior. In the example above in which the resident did not wish to get dressed in the morning, the goal behavior may be "the resident dresses himself in the morning". If you look at the ABC Card and notice in the activator section that Staff Partners are quite abrupt when they wake the resident in the morning, then the new activator identified on the Get Active! side of the card may be a change in how the resident is approached in the morning. For example, the new activator for the goal behavior may be to provide the resident with a choice of what to wear for the day and/or to provide the resident with enough time to get oriented to where they are before they

are expected to get dressed. Once an Activator is examined and modified, the behavior is observed again.

Identifying a key activator will often result in a swift change in behavior. But other times it may take a number of tries to find that "key." There can also be more than one activator influencing the behavior so different steps will need to be taken to modify the problem. Thus, being creative and persistent is essential. If, for example, changing one activator in the case where the resident would not get dressed does not modify the problem behavior then further assessment of what is causing the problem will be needed. It might later be discovered through discussions with family members that the resident has never been a morning person and that they prefer to get up at 9:00 am rather than 7:00 am. You might find that the resident has had several experiences when their breakfast was cold, so they did not feel motivated to get out of bed to eat, or that the resident otherwise had little to look forward to for getting out of bed. Continue brainstorming potential activators with Staff Partners until the problem behavior is modified.

Changing the consequence can also change behavior. Taking a closer look at the ABC Card, one will note that B interlocks with C, and C interlocks B. This indicates that a consequence has an impact on the behavior. How a Behavioral Coordinator and/or Staff Partner responds to a resident's behavior can determine if the behavior gets better or if it gets worse. For example, some Staff Partners do not understand that what they perceive as punishment intended to stop a behavior (i.e., loudly or repeatedly telling the Veteran to "stop it") can actually be reinforcing for a problem behavior. What the Staff Partner sees as punishment, the resident experiences as attention. In this case, the resident may be more likely to present the behavior again in order to get some desired attention from staff.

In other cases, modifying the consequences (responses to) a behavior may help encourage or maintain the goal behavior. Often, this may involve positive reinforcement, negative reinforcement, or both. Statements that acknowledge and praise a resident's new behavior may be reinforcing of goal behaviors. This may be used in conjunction with ignoring negative behaviors. On the following page is an example of modifying a resident's behavior through modifying the consequence of his behavior.

Case Example: John

John had a tendency to lose his temper frequently and to shout profanities at nursing staff when his needs were not attended to immediately. This resident was mildly demented and had several health problems. He enjoyed eating candy bars as often as he could get them. The activating event in these cases was always related to the resident wanting something such as being pushed in his wheel chair from the dining room to his bedroom. He expected nursing staff to drop whatever it was they were doing to push him back to his room. Initially it was believed that the Staff Partners were being abrupt with him causing him to become irritated and then lash out, however after several interviews and observations it was noted that the resident used profanities and yelled out regardless of how he was addressed following his requests. A plan for the resident was developed with the staff and the resident. Part of the plan required that staff ignore his yelling and profane language while the other aspect of the plan involved the resident being provided a piece of candy each time he was able to refrain from yelling and/or using profanity. This plan took a bit of persistence to implement and required the cooperation of different shifts and staff members, but proved quite effective in reducing John's outbursts. Of note, during an interview with the resident he had expressed some guilt regarding his behavioral outbursts and a desire to get along better with people.

While the activators and consequences are clearly outlined above, they are not outlined in the following case example. Try to identify the activators and consequences in the following example. Consider alternate methods of working with such a resident.

Case Example: Tom

Tom had a mild to moderate level of dementia. He quite often refused to take showers. He would become quite irate if he were asked more than one time to take a shower. Several approaches were attempted with this resident including offering him different choices of days and times, but he would often forget that he agreed to a time and continued to refuse the shower. Upon further investigation, it was discovered that he found the shower rooms to be rather cold. A new plan was developed that included the shower being turned on 10 minutes prior to his shower time to warm up the shower area like a steam room. Several staff members were typically aware of his shower time and would complement him and provide him with positive attention after his showers. He appeared to enjoy the positive attention immensely. This intervention was very successful. While he still occasionally refused to shower, he took showers much more often than he had prior to the intervention.

Of course, there will be some problem behaviors that require more time and discussion than others in order to change them. *In these situations, the question will be what can the Behavioral Coordinator and Staff Partner do next?* When working with more complicated cases, it is important to involve all of the STAR-VA Leadership Team and Staff Partners in the process of developing and implementing the behavioral

intervention plan. It may be helpful to include staff from different shifts when developing the behavioral intervention plan. There may be activators and consequences occurring at different times that the Behavioral Coordinator and staff from only one shift are unaware of. Family members are a good resource to recruit when identifying and implementing goal behaviors and new consequences. Suggestions for different ways of partnering with family members are described further in Section 8.

Case Example: Sexually Inappropriate Behavior

Individuals with dementia may sometimes display inappropriate sexual behaviors. These behaviors may include exposure, obscene sexual language, unwanted propositioning to Staff Partners, excessive or public masturbation, unwanted touching, and/or grabbing Staff Partners during ADL care. Triggers of sexual behaviors may consist of or be a reflection of attempts at normal etiquette, delusions, hallucinations, misidentifications, sensory impairment, lack of usual sexual partner(s), lack of privacy, an under- or over-stimulating environment, personality style, misinterpretation of cues, and/or changes in mood state (e.g., depression and/or anxiety).

VA CLCs are different from most community nursing homes in that the majority of residents are male and receiving care for their ADL's primarily by women. It is important for the Behavioral Coordinator and Nurse Champion to understand the etiology of inappropriate sexual behaviors and interventions to best assist Staff Partners.

The following is a case example adapted from the original STAR Manual and includes the steps necessary for completing the ABC Card.

A Staff Partner tells you that a resident inappropriately grabbed her chest while she was helping him with a shower. The Staff Partner is upset and angry, and says that she does not want to give the resident any more showers. When you ask the Staff Partner why he grabbed her, she answers, "That's just the way he is."

As part of the STAR-VA Leadership Team you remain mindful of several issues, such as the availability of appropriate sexual outlets, the relationship of sexuality to self-esteem, lowered inhibitions in many individuals with dementia, and other related issues. However, the behavior described is disruptive and your help has been asked for.

In order to determine the ABC's, the following information will be useful. Consider questions that you might use in asking your Staff Partner about this situation to get the information you need. Note the presence of the 4W's related to the B-behavior, as well as attention to the A-activators and the C-consequences.

B–what: Resident makes an inappropriate grab
B–who: Staff Partner and resident
B–where: In the bathroom
B–when: While assisting resident with shower, in the evening
A: Resident undressed, being told nice things, called "sweetie"
C: Staff Partner yells at resident to stop, resident is anxious and worried

Some of the questions that you might ask yourself and your Staff Partner include the

following: What do you remember about residents with dementia that can explain what happened here? What is the goal behavior? How would you change your approach and/or the environment? If the resident completes the goal behavior what would you do next? If not, what might you do?

Applying the ABC Card with Staff Partners

(Discuss with the Staff Partner and if possible and fill out the ABC Card together.)

> *In order to determine the ABC's, what questions might you ask your Staff Partner about the situation? (Ask the B questions – what, who, where, and when – as well as what was going on before and after the resident grabbed the Staff Partner.)*

As you ask questions, the Staff Partner lets you know that she was giving the resident a shower in the evening as she does every Thursday. She and the resident were the only ones present in the resident's bathroom. The resident was sitting on a shower chair unclothed with nothing in his hands. The Staff Partner was talking to him, telling him what to do. She told the resident to close his eyes, that the water was coming down, and that he was doing fine.

Sometimes we call people affectionate names to be nice and they are misinterpreted. Could that be the case here? You ask the Staff Partner if she ever call him honey. She says that she calls the resident "honey" and "sweetie" at times and that she was extra-nice to the resident before he grabbed her.

After the resident grabbed the Staff Partner, she yelled loudly for him to stop, which made the resident upset, and unsure what to do. The Staff Partner then silently and quickly finished the shower. The only other thing she said to him was, "I'm very upset with you, Bill. I can't believe you did that to me."

> *From what you just heard, what are the ABC's? What would you write down with your Staff Partner on your ABC Card?*

B – what:	Resident makes an inappropriate grab at the staff member's chest
B – who:	Staff Partner and resident
B – where:	In the bathroom
B – when:	While Staff Partner is assisting resident with shower, in the evening
A:	Resident undressed, being told nice things, being called "sweetie" and "honey"
C:	Staff Partner yells at resident to stop, resident is anxious and worried

When working with Staff Partners, reinforce the idea that this resident has dementia. What does the Staff Partner remember about residents with dementia that can explain what happened here? The Behavioral Coordinator and Nurse Champion can assist Staff Partners with remembering that residents who suffer from dementia will tend to be more

impulsive and uninhibited. Residents may act out sexually without concern (e.g., masturbate in public or grab at staff members), which are behaviors that they probably never would have exhibited earlier in life. It is important to convey to Staff Partners that these behaviors, as upsetting as they may be, are a result of the resident's illness. It is important for Staff Partners to work at not making judgments about a resident because of their now impulsive behaviors.

Applying the Get Active! Side of the ABC Card with Staff Partners

(Discuss with the Staff Partner and if possible fill out the Get Active side together.)

Now turn the card over to the Get Active! side. What would be the goal behavior?

Write this goal behavior in the Change the B box.

Keeping in mind this is a resident with memory problems and dementia, what do you and your Staff Partner think could be done differently in this situation to prevent such a behavior from occurring again? Think about how your Staff Partner would change her approach, her communication with the resident, the environment, or both.

With a plan in place after completing the Get Active! side we can imagine that the resident would be less likely to grab at your Staff Partner.

If the resident completes the goal behavior (not grabbing and cooperating with the showering assistance) what would you and your Staff Partner do next? Write your suggestion next to C.

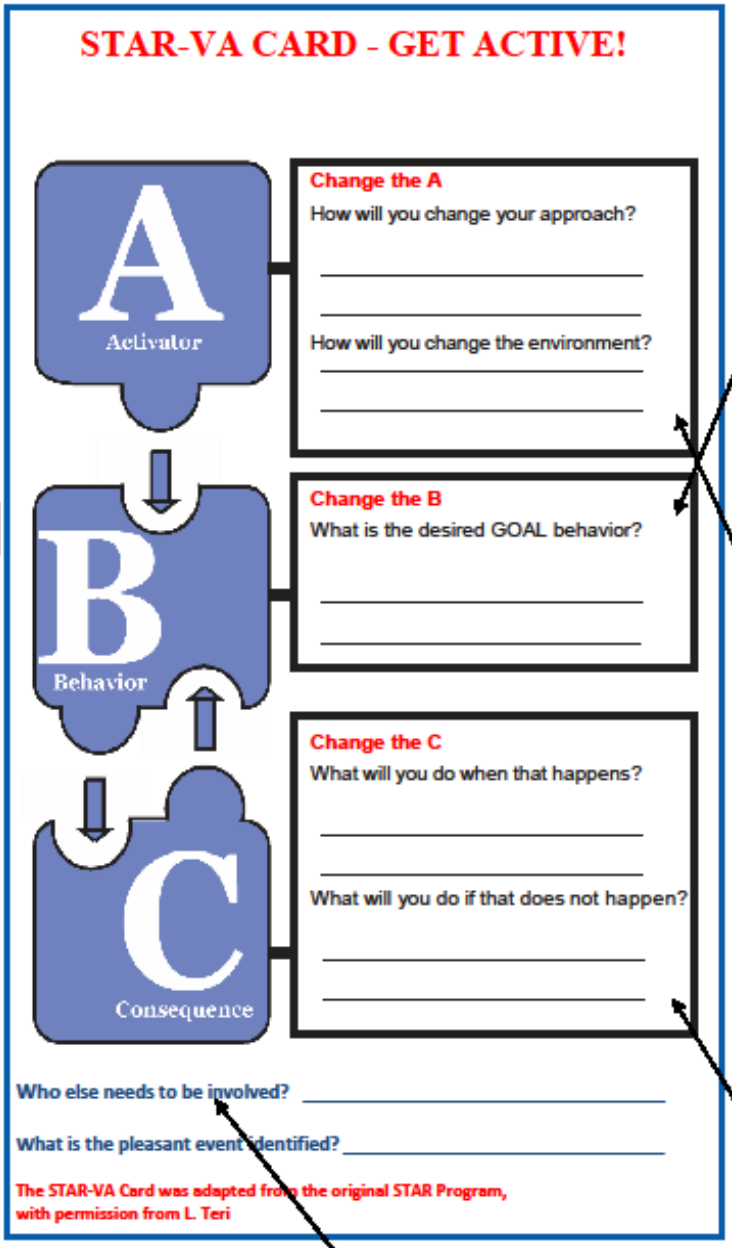
Imagine that the resident still made a grab at your Staff Partner, despite all that you and your Staff Partner did to prevent it from happening. What might be suggested as a consequence of this behavior? Write one or two ideas next to C on the Get Active! side of the ABC Card where it asks, "What would you do if this does not happen?"

As part of the STAR-VA Leadership Team, it will be important to work with the Staff Partners to help modify the residents' behaviors and to have empathy for difficult and disturbing situations like this one. It is understandable that the Staff Partner would be upset following a situation like the one discussed in this scenario. It is important to help Staff Partners understand that the problem behaviors of residents with dementia are a result of an illness; we can model how to use the ABC's to change problem behaviors – preventing them from occurring (changing the A), shortening the duration and/or frequency (changing the C), and increasing positive behaviors in their stead.

Section 4
Summary Tips

- Choose one problem behavior to work on at a time.
- Start with the easiest and most identifiable behavior first.
- Identify and observe the challenging behavior (“4 Ws”).
- Brainstorm with Staff Partners to identify activators and consequences.
- Compose the ideas: What can be changed?
- Help Staff Partners understand that the problem behaviors of residents with dementia are a result of an illness
- Model how to use the ABC’s to change problem behaviors – preventing them from occurring (changing the A), shortening the duration, severity, and/or frequency (changing the C), and increasing positive behaviors in their stead
- Evaluate the impact of the change.
- Refine the plan as needed.

Section 4
STAR-VA Handouts



Using the STAR –VA CARD "Get Active"

Step one: Change the "B"

You must first identify a desired behavior and then describe the behavior in "B". This is best accomplished by working with the Staff Partner that is most familiar with the patient, but may also include other Staff Partners. Remember to keep the described behavior identifiable. Rather than the "the patient will comply with nursing request" be specific with what "comply"- should entail.

Step Two: Change the "A"

This section focuses on what will be done differently with regard to the Veteran that will elicit a different behavior. How will you and the Staff Partner change the what, where, when, and or who related to the behavior? Not all of the 4 W's may need to be changed to encourage the goal behavior.

Step Three: Change the "C"

In order to maintain the new behavior it will be important to consider what will be done once the new behavior is exhibited. As an example, the Staff Partner can be encouraged to use praise to reinforce the new goal behavior. Additionally, an alternate plan may be developed in case the behavior does not change.

This refers to identifying anyone that needs to be involved in modifying the behavior whether it is the recreation therapist, family member, etc.

Tip Sheet - *Get Active! side*

1. We'll start with the B again. Now that we have identified the problem behavior, we can start thinking of what we want to happen instead. What resident behavior would you like to see instead of the problem behavior? Write this next to B on the Get Advice! side of the card. This is the goal behavior. (Note: the absence of a problem behavior is not the same as a goal behavior.)

2. What can you do to activate this behavior?
- Is there a way you might change your approach, such as how you communicate with the resident?
- Is there any way you could change the resident's environment, or would adding a pleasant event help the situation?
- Once you've identified the change, write this idea next to A on the Get Advice! Side of the card. You can provide an answer for the approach question, the environment question, or both.

If the Staff Partner is struggling to come up with an idea, you can offer suggestions. Encourage creativity with this task.

3. Do you think the activator will help trigger the goal behavior?

If you or the Staff Partner does not feel confident with this plan to help decrease the frequency or severity of the problem behavior, consider other activators for the problem. When satisfied with the activators to be changed, move on to the next step.

4. If the resident's goal behavior occurs, what will you do?
- You could do a brief pleasant event for the resident, such as offering a compliment, or offering thanks for their cooperation.
- Write an answer next to the question, "What will you do when that happens?" next to C.

Although the answer might seem obvious (such as the Staff Partner would continue with his or her work day), emphasize how much better this result would be than the consequence that was described on the other side of the card.

5. It is hard to know for sure if our A will result in the goal behavior. It is good to make a plan in case it does not. What else could you do if the goal behavior does not occur?
- Is there another way you might change your approach or the environment?
- What pleasant event might you add?
- If the problem behavior still occurs, is there a way you can change your response (C) that might reduce the duration or severity of the behavior?

If the Staff Partner is struggling for an idea, you can offer suggestions. Encourage creativity.

6. Your suggestion(s) for A. (state the activator suggestions) can lead to the goal behavior of (as written). If the plan works out, you will then (state what was written on the first part of C). If the goal behavior does not occur, you can still do (the second part of C), which can further help achieve the goal behavior.

SECTION 5
INCREASING PLEASANT EVENTS

CORE CONCEPT:
Increasing Pleasant Events

Objectives:

I. Describe the benefits of pleasant events and how to implement pleasant events with residents.
II. Continue to build skill set using the ABC Card to manage negative thoughts and behaviors.

Outline:

I. Introduction
II. Identifying and Promoting Pleasant Events in Dementia
    - Getting started with Pleasant Events
    - Reminiscing as one Type of Pleasant Event
    - Using ABC's to Increase Pleasant Events
    - How to Arrange a Pleasant Event for a Person with Dementia
    - Overcoming Barriers to Pleasant Events
III. Summary Tips

Handouts:

Pleasant Events for the CLC
Pleasant Events Schedule-Alzheimer's Disease
Pleasant Events Schedule-Nursing Home

I. Introduction

Promoting resident involvement in pleasant events is another core component of the STAR-VA intervention. Over three decades ago, Peter Lewinsohn posited the significant relationship between pleasant events and depression, examining changes in mood as a function of identifying and increasing pleasurable activities (e.g., Lewinsohn, Sullivan, & Grosscup, 1980). Since then, clinical investigations and empirical research have supported this relationship and shown how promoting engagement in pleasant events can significantly enhance a patients' mood (e.g., Cuijpers, van Straten, & Warmerdam, 2007; Teri & Logsdon, 1991; Teri, Logsdon, Uomoto, & McCurry, 1997), which, in turn, can have an impact on behaviors.

The process of promoting and facilitating identification of and engagement in pleasurable activities is often especially important and valuable with individuals with with dementia in light of changes in executive functioning and other cognitive and physical changes that typically accompany dementia. As a result of these changes, individuals with dementia may have difficulty identifying pleasurable and/or meaningful activities and independently planning or engaging in such activities. Individuals with dementia may also have difficulty communicating these activities or interests to others.

Individuals with dementia often experience a cycle of inactivity and depressed mood. Because of their cognitive impairment, they lose the ability to do many of the activities they once enjoyed, or they may be in environments that hold little opportunity for them to engage in activities they enjoy. Consequently, an important component of STAR-VA is to identify current skills and preferences of the person with dementia, and to increase the level of pleasant social and physical activity available to them. This often means identifying, planning, and systematically introducing pleasant activities into the day-to-day life of persons with dementia and then helping them and staff maintain and modify these experiences as needed over time. By necessity, these activities must be simple, inexpensive, and easy-to-do. They also must be individualized.

Pleasant events are activities an individual finds enjoyable. While there are some activities that may come to mind as generally enjoyable to many, pleasant events are very subjective. Just as we do not all enjoy the same things, people with dementia do not enjoy all of the same things. Therefore, pleasant activities MUST be individualized. Individualization of pleasant activities also entails matching activity complexity to the person's abilities, with realistic expectations regarding what the person is able to do.

This Section will review the process of identifying and implementing pleasant events with residents with dementia and in working with Staff Partners to most effectively do so. Key Staff Partners involved in helping to identify and implement pleasant events in most CLCs are nursing and recreation therapy staff. Other potential important Staff Partners include occupational therapy, physical therapy, and social work staff.

II. Identifying and Promoting Pleasant Events in Dementia

Getting Started with Pleasant Events

Persons with dementia can retain many abilities – including the ability to derive pleasure from the activities – even though they experience changes in cognition. However, it often falls to staff to identify, plan, and help them engage in such activities.

As with other interventions, the first step is to identify what constitutes a pleasant event for a particular resident. There are a variety of pleasant event schedules available that can help with this process, including schedules adapted for individuals with Alzheimer's Disease (Pleasant Events Schedule-Alzheimer's Disease (PES-AD; Logsdon, R.G. & Teri, 1997) and for nursing home residents (Pleasant Events Schedule-Nursing Home (PES-NH; Meeks, Shaw, & Ramsey, 2009). Copies of these measures are included at the end of this Section, along with a brief handout ("Pleasant Events for Veterans in VA CLCs") that may be helpful for identifying pleasant events for CLC residents. .

The PES-AD and PES-NH are simple-to-use checklists that help you, with the input of staff and family familiar with the interests, preferences, and previous experiences of the resident, to identify activities that the resident can enjoy. In addition, the PES-AD and PES-NH can form a basis for discussion with family and staff and help you generate more ideas about different pleasant events that might be scheduled to improve the resident's mood. As you examine the PES-AD and PES-NH, you will see that items involve both solitary and social activities. Both are important and will appeal to different residents in different ways.

Table 5.1 on the next page lists examples of activities events are often enjoyable to individuals with varying degrees of dementia. These are intended merely as examples. Pleasant event schedules and personalized assessment of pleasant activities will be particularly useful in identifying pleasant activities for a specific individual.

Remember that regardless of the stage of dementia, persons with dementia are capable of experiencing positive emotions through pleasant events. It is our job to ensure these events are available.

Another excellent resource that may help with identifying and implementing pleasant events is the Electronic Dementia Guide for Excellence (EDGE) Project, supported by the New York Department of Health. This resource provides categories of activities often found pleasurable by individuals with dementia, information and tips on how to implement each activity, suggestions for troubleshooting, and summary of research outcomes, forms, and references. This resource can be accessed at: http://www.health.state.ny.us/diseases/conditions/dementia/edge/interventions/index.htm

Table 5.1

Examples of Pleasant Events at Different Stages of Dementia

Early-Mid Stages

- Reading magazines, newspapers
- Going on outings (to the park, a picnic, etc.)
- Playing music, singing
- Recalling and discussing past events
- Exercising (walking, dancing, etc.)
- Gardening
- Spending time with friends

Mid-Late Stages

- Being read to (magazines, newspaper, book, etc.)
- Being outside
- Going for a ride in the car
- Listening to music
- Watching favorite videos
- Getting a hand or shoulder massage
- Watching birds, squirrels
- Spending time with friends

When identifying pleasant events for a particular resident, consider activities that the resident previously enjoyed and adapt the pleasant activities to the resident's current life circumstances and abilities (Karlin, 2011). Identify the thematic area (e.g., baseball, singing, automobiles, artwork) and incorporate this in the resident's current life. Doing so will allow the resident an opportunity to (re-) connect with something that was previously quite enjoyable and may be a part of their self-identity. Family members can be very helpful in identifying a Veteran's previously enjoyable activities. Furthermore, family members can help to implement and reinforce resident involvement in pleasant activities.

In addition to identifying unique experiences for each resident, it is important to teach others that every interaction has the potential to be a pleasant event. Each time we speak with another person we have the ability to create a pleasant event even by smiling or cheerfully greeting them. This type of pleasant exchange can be positively experienced by persons with dementia at any stage. Behavioral Coordinators and Nurse Champions may share examples with their Staff Partners about the positive influence of simple, non-verbal pleasant events such as asking the Staff Partner how they feel when a neighbor simply smiles and waves at them or when a stranger opens a door for them. While these gestures may sound trivial, they go a long way towards improving the lives of our residents and ourselves.

For our purposes, pleasant activities must be simple, inexpensive, and easy-to-do. They also must be individualized. Just as we do not all enjoy the same things, residents with

dementia do not enjoy all the same things. Therefore, pleasant activities MUST be individualized. Of course, this is not to suggest that group activities cannot be included. Such activities are often valuable because they offer opportunities for social interaction and are cost-effective. However, it is critical to ensure that that the activities chosen are for the benefit of the resident. Residents with dementia will "tell" you whether they find an activity enjoyable by their reaction to it. Be creative in identifying activities that are potentially pleasant. They need not be elaborate. In fact, the simpler and more routine they are, the more likely that they will be easy to carry out on a regular basis.

For example, if a resident previously enjoyed crossword puzzles but is no longer cognitively able to complete the complex ones he did in the past, children's puzzles might be of interest. The physical stimuli related to puzzles might be relevant – i.e., writing with pencil and paper and engaging in simple word games. Occupational and recreational therapists are well trained to help in this endeavor. They are key Staff Partners in identifying and implementing pleasant activities. Talk with them and see what you can discover together.

Pleasant events can be social or solitary; passive or active; complex or simple (depending on the level of cognitive skill the resident possesses) and require more or less supervision. The individual resident's interests, preferences, cognitive skills and deficits, past and present experiences will all contribute to determining and maintaining engagement in pleasant events. Remember, we can all benefit from such planning – pleasant events will decrease depression, agitation, and anxiety in residents and will enable staff to interact around pleasant experiences rather than negative. The environment of the CLC for staff and residents will benefit.

Reminiscing as One Type of Pleasant Event

While the literature on reminiscence therapy is varied, reminiscence is one activity that can be enjoyable to some residents (Teri, McKenzie, & LaFazia, 2005; Woods, Spector, Jones, Orrell, & Davies, 2005). Certainly, engaging residents in pleasant conversations, and encouraging residents to talk about things they experienced in the past that they enjoyed, often leads to enhanced mood. This can be done in individual or group format. Reminiscence typically does not require much of an investment other than time, though there are several books, magazines, and games that can be used as part of reminiscence. Additionally, a Veteran may be reintroduced to music or watch clips from old films to help stimulate memories and generate topics for discussion. It may be helpful to suggest to Staff Partners that simply speaking with a resident for a few minutes about their past can be a pleasant event in itself that can improve their relationship and the resident's mood. Remember, of course, the key is PLEASANT. With some Veterans, past memories may trigger extremely unpleasant feelings and thoughts. Be sure to know where you expect the conversation to go and to plan for what to do should the conversation take a turn for the worse.

Using ABC's to Increase Pleasant Events

You can consider increasing engagement in a pleasant event as yet another behavior you wish to promote. Using the ABC model, think through what is the behavior you wish to stimulate (B), what are potential activators that would increase the likelihood of this

behavior occurring (A), and what are potential consequences that could reinforce the behavior and help maintain it over time?

Pleasant events can also be incorporated into your behavioral plans for increasing or decreasing other behaviors of interest. Think about how a pleasant activity might be used as a consequence when trying to encourage behaviors or as a distraction when trying to alter an agitated or disruptive situation.

How to Arrange a Pleasant Event for a Person with Dementia

To arrange a pleasant event for a person with dementia, it is necessary to:

1. Determine what is/was fun for the resident with dementia.
2. Be sure the event is easy, accessible, and reasonable.
3. Select specific activities that match the resident's current abilities.
4. Determine how to offer the event and how to engage the resident.
5. Divide the activity into small steps that can be achieved.
6. Be concrete in identifying activities to implement.
7. Be specific as to when and where the activity will occur – and provide visual cues, as appropriate, so that the resident and staff can anticipate and recall the event.

When planning a pleasant event, plan it as you would any other experience. Consider the factors that lead up to the activity; what possible obstacles might be encountered, what sequence of steps and contextual factors (e.g., time of day) might increase the likelihood of success. Brainstorm with residents and staff as to possible obstacles that may interfere with the activity being carried out.

Overcoming Barriers to Pleasant Events

Identifying pleasant events can be relatively straightforward, though it can also be challenging. The key is to involve others and use the resident's response as your gauge of success (or lack thereof).

With dementia, problems occur that make engaging in pleasant activities difficult. One problem can be inspiring the person with dementia to participate in the event. Another problem is deciding what the resident is able to do, and how to simplify activities so they are enjoyable. In many cases, residents with moderate to severe dementia lack the ability to initiate activities and therefore may require additional guidance just to get started. There are also persons with dementia who seem to constantly reply with "no" to every offer of engaging in pleasurable activities. In these cases, modeling the behavior or simply escorting the resident to the activity may be helpful. Staff often have considerable experience in this regard. Talk with them. Learn from them.

Although pleasant events should not be demanding, staff may be concerned about encouraging residents to participate in activities that will require additional time. Staff

jobs are already demanding and to suggest adding one more activity may be met with concern. As part of this process, it is important to understand the demands on their time and to work together to ensure you are making suggestions for improving resident care in a way that is reasonable and realistic. Moreover, it is important for Staff Partners to understand the link between mood and behavior, and improving the former can enhance the latter. Further, Staff Partners are likely to be convinced of the value of promoting resident engagement in pleasant activities once they *see* the effect these activities can have. In addition, involve multiple Staff Partners (e.g., recreation therapy and occupational therapy staff) to assist with pleasant activities. Lastly, pleasant activities have the potential to make the CLC environment more pleasant for everyone! Finally, consider modeling for Staff Partners small, everyday pleasant behaviors (e.g., smiles and compliments) to brighten their day and observe how this changes their behaviors, even if for a brief moment. It is often time the smallest of behavioral investments that yield the greatest dividends!

Section 5
Summary Tips

- Decades of research has shown that pleasant events can help to reverse depression and anxiety, which can contribute to challenging behaviors in individuals with dementia.
- Pleasant events are a fundamental part of the CLC goals of increasing resident independence, autonomy, and a sense of community.
- Staff Partners can play a key role in helping to identify and implement pleasant activities for residents.
- Pleasant events should be fairly simple and need not require a lot of effort to make happen.
- Every interaction has the potential to be a pleasant event.
- Pleasant events are different for different people, so pleasant event identification should always be individualized.
- Involve family in identifying and implementing pleasant activities for residents.
- When scheduling pleasant events, be concrete and specific!
- Pleasant events can be used to change an activator or a consequence of a behavior.
- Pleasant events are everyone's job!

Section 5
STAR-VA Handouts

Pleasant Events for Veterans in CLCs

- Watching a sunset
- Reading a good story, play, or poem
- Breathing fresh air
- Being understood
- Watching TV
- Thinking about something good from the past
- Laughing
- Eating a snack
- Snuggling in a comfortable chair
- Holding hands
- Eating lunch with friends
- Taking a walk
- Being complimented
- Hearing about family activities
- Wearing new clothes
- Listening to the radio
- Getting letters, cards or notes
- Getting a manicure
- Visiting with staff
- Having hair brushed or combed
- Looking at a newspaper
- Having makeup applied
- Being offered hand lotion or a massage
- Being told he or she is needed
- Seeing or smelling a flower or a plant
- Reminiscing, talking about old times
- Listening to music
- Praying
- Singing
- Hearing the chirp of birds
- Smelling freshly baked bread

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

Pleasant Events Schedule: AD

(Short Version)

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Instructions: This schedule contains a list of events or activities that people sometimes enjoy. It is designed to find out about things your relative has enjoyed during the past month. Please rate each item twice. The first time, rate each item on how many times it happened in the past month (frequency); the second time, rate each event on how much your relative enjoys the activity.

Activity	Frequency			Enjoy		
	Not At All	1 to 6 Times	7 or more Times	Not At All	Some-what	A Great Deal
1. Being outside						
2. Shopping, buying things						
3. Reading or listening to stories, magazines, newspapers						
4. Listening to music						
5. Watching T.V.						
6. Laughing						
7. Having meals with friends or family						
8. Making or eating snacks						
9. Helping around the house						
10. Being with family						
11. Wearing favorite clothes						
12. Listening to the sounds of nature (birdsong, wind, surf)						
13. Getting/sending letters, cards						
14. Going on outings (to the park, a picnic, etc.)						
15. Having coffee, tea, etc. with friends						
16. Being complimented						
17. Exercising (walking, dancing, etc.)						
18. Going for a ride in the car						
19. Grooming (wearing make up, shaving, having hair cut)						
20. Recalling and discussing past events						

Pleasant Events-NH
INITIAL ASSESSMENT

(Suzanne Meeks, PhD; Adapted From Logsdon & Teri, 1997)

Rate the following items according to whether they are now (or would be) a pleasant activity. The rate whether they were **AVAILABLE during the PAST MONTH**, and then the **FREQUENCY with which you did them in the PAST WEEK**. Add other activities as appropriate on the bottom of the form.

Activity	**Now pleasant** 0=no 1=yes	**Available past month** 0=not at all 1=Yes	**Frequency past week** 0=not at all 1=1-6 times 2=7+ times
1. Sitting, walking, or rolling wheelchair outside			
2. Reading or listening to books on tape			
3. Listening to music in your room			
4. Having someone read you something in your room, such as the newspaper, cards			
5. Watching T.V.			
6. Doing crossword, jigsaw, word games puzzles, etc.			
7. Talking on the telephone			
8. Doing handwork (crocheting, woodworking, crafts, drawing, ceramics, clay work, etc.)			
9. Laughing			
10. Having a visit from family or friends			
11. Shopping or buying things			
12. Sharing a meal with friend or family			
13. Making or eating snacks			
14. Wearing favorite clothes			
15. Listening to the sounds of nature			
16. Getting or sending cards, letters			
17. Going on an outing (e.g., visit home, out to eat, visit to family/relative)			
18. Having coffee, tea, cocoa with others			
19. Being complimented			
20. Being told I am loved			

Activity	**Now pleasant** 0=no 1=yes	**Available past month** 0=not at all 1=Yes	**Frequency past week** 0=not at all 1=1-6 times 2=7+ times
21. Exercising (walking, stretch class, physical therapy)			
22. Going for a ride in a car			
23. Grooming (wearing make-up, shaving, having nails done)			
24. Having a shower or bath			
25. Recalling or discussing past events			
26. Participating in a group activity (e.g., Bingo, current events, Trivia)			
27. Attending religious services			
28. Listening to a musical performance (e.g., in dining room)			
29. Talking with another resident			
30. Watching others in hallway			

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INSTRUCTIONS FOR USING THE PLEASANT EVENTS PLANNING FORM

On the Pleasant Events Schedule: AD and the Pleasant Events-NH forms, MARK OUT all events THAT ARE NOT CURRENTLY PLEASURABLE, OR ARE NOT AVAILABLE. From the remaining list, then identify those specific activities that will be targeted for the following week, and fill out the Pleasant Events Planning Form (next page) for those activities. In planning events, remember to consider the following:

1. *Is the event feasible and easy for next week?*
2. *Is the event one that will be particularly enjoyable to the resident?*
3. *Is the event appropriate for this resident's abilities?*
4. *Is the event easy for staff to facilitate, or will it pose extra burden on staff?*
5. *What are the barriers to making this event happen? How can staff minimize these barriers?*

PLEASANT EVENTS PLANNING FORM

Date of Session: _____
# of Events Planned for Next Week: _____

	Fill out these columns THIS week:		Fill out these columns NEXT week:	
	Describe Event	**Time/Day**	**Did Event Occur?**	**If Not, Why not?**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Notes: (who will assist, potential barriers to be dealt with, etc.): _____

_____

_____

_____

SECTION 6
GET ACTIVE!
WITH THE ENVIRONMENT

CORE CONCEPT:
Getting Active with the Environment --
Focusing on the A-activators of the ABC's

Objectives:

I. Understand the role of environment in STAR-VA
II. Identify aspects of the environment important in improving resident care
III. Determine how to best identify and alter the environment as part of STAR-VA (ABC Card: Side 2 - Get Active! side)

Outline:

I. Introduction
II. Defining the Environment
III. The Environment as a Contributor to Pleasant Events
IV. The Environment as a Factor in the ABC's: Environment as Activator and/or Consequence
    - Common Environmental Activators or Consequences
    - Sensory Deprivation and Over-Stimulation as Aspects of Environmental Modification
V. Applying the ABC's & Get Active! Working with Staff Partners to Identify the Environmental Activators and Consequences
    - Applying the ABC Card With Staff Partners

Handouts:

ABC Card (electronic submission version sample)
Managing Challenging Behaviors

I. Introduction

The environment is the complex social and physical world in which residents, staff, and the STAR-VA Leadership Team reside and work. The environment can significantly contribute to negative (and positive) emotions and behaviors of residents – and staff. Thus, it is important to consider the environment when identifying and implementing pleasant events and when identifying and changing activators to and consequences of challenging behaviors. This Section addresses how Behavioral Coordinators, Nurse Champions, and Staff Partners can use the environment to better understand and reduce challenging behaviors using the core processes of the STAR-VA intervention.

II. Defining the Environment

The environment includes the social and physical world of the CLC resident. To help you and Staff Partners define this environment, consider the following questions:

> *What makes up your environment on a typical day? What makes up a resident's environment on a typical day?*
>
> *How would a new visitor describe the environment (what it looks like, sounds like, feels)?*
>
> *How might you change a resident's environment in a way that can help the resident?*

The previous Sections of this manual have discussed ways for the STAR-VA Leadership Team and Staff Partners to address challenging behaviors, including: understanding of dementia and having realistic expectations, communicating effectively with and without words, understanding the ABC's, problem solving with Get Active!, and identifying and implementing pleasant events. A resident's environment can also have a significant impact on their behavior. It is important to consider how one might change a resident's environment to change their challenging behavior.

Observing trends in a resident's behavioral difficulties can lead to clues about what impact the environment is having. Does a resident act out more after lunch or before dinner? Can the problem behavior thereby be addressed by attending to what specifically happens during meals? Is the room noisy?

Alternatively, a resident may become agitated during quiet times of the day. Can activities (preferably pleasant activities) be scheduled at these times to increase the resident's enjoyment and activity and thereby decrease the agitation they experience during times of quiet and inactivity?

The resident's environment consists of social interactions (with family and friends, staff, and other residents), as well as the physical (noise, temperature, furniture, lighting, etc.). Each of these should be taken into account when implementing various aspects of STAR-VA.

Consider social and physical changes to the environment in the same way you consider pleasant events: Keep things simple, easy-to-accomplish, and developed in conjunction with Staff Partners. For example, some simple environmental changes that might affect behavior include adding music or simply turning the volume down on the television. While some CLCs have added music to their dayrooms, others have integrated what is known as Care Television. Care Television is a channel that is programmed only with soft music and primarily nature scenery. In considering the impact the environment has on residents and staff and potential modifications thereto, consider this from the perspective of all senses (sight, smell, touch, sound, and taste).

Additional home-like environmental changes CLCs have implemented include creating small gardens for residents, baking bread or cookies, and using warm contrasting colors, a variety of textured furnishings, and artwork to enhance the décor of and engagement with the surroundings. In enhancing the décor and homelike aspects of environment, consider ways to enhance the familiarity of environment, as familiar environments often lead to a greater sense of comfort and perception of control (Day, Carreon, & Stump, 2000; Karlin & Zeiss, 2006).

For those interested in more in-depth information on enhancing the physical environment of the CLC, a VA Community Living Centers Design Guide (Department of Veterans Affairs, 2011) and VA Mental Health Design Guide (Department of Veterans Affairs, 2010) have been developed that provide home-like and recovery-oriented guidelines for designing new facilities. These Design Guides also include strategies for making relatively straightforward improvements to the physical environment. Facility interior designers (in consultation with CLC leadership) can also be an excellent resource for enhancing the physical environment of the CLC.

III. The Environment as a Contributor to Pleasant Events

Looking at the array of pleasant events discussed in the preceding Section, it is not difficult to see the role of the environment in identifying and increasing pleasant events in the resident's day-to-day experiences. Does the resident respond well to being outdoors? Do they seem calmer in their own room than in the common areas? Is silence a pleasant event? Or, does it cause distress?

The environment may itself be an important part of the pleasure or meaning that residents derive from pleasant activities. For example, being in outdoor environments closer connected with nature may provide a sense of meaning to residents that is not as present in indoor environments. Furthermore, the environment may serve as an important contextual factor that moderates the pleasure residents receive from pleasant activities. For example, reading may be more pleasurable for some residents after dinner and in more quiet surroundings.

Just as an individualized approach is important for identifying pleasant events, understanding each resident's unique relationship with and response to his or her environment will yield most useful and personally-relevant information for identifying the types of surroundings or contexts (e.g., quiet, sociable, bright, dim) that will maximize residents' experiences with pleasant activities.

IV. The Environment as a Factor in the ABC's: Environment as Activator and/or Consequence

The environment can play an important role in initiating (activator) or maintaining (consequence) challenging or desired behaviors. When trying to assess the role of environment as a potential activator or consequence to the resident's behavior, consider the same questions you would consider in defining the ABC's. That is, answering the what, where, who, and when of the behavior as outlined in Section 3.

Common Environmental Activators or Consequences

Individual sleep and wake cycles can be influenced by the environment: Is the room too warm? Too cold? Are hallway sounds or light preventing sleep? What was the resident's pattern of sleep prior to coming to the CLC? Were they a night owl? An early bird? Can the environmental expectations and demands of the CLC be altered to support the individual resident's needs? Some CLC's have integrated kitchenettes that allow residents to obtain snacks throughout the day. This allows residents to decide on whether or not they want to wake up early for breakfast.

Some specific environmental aides for behavioral disturbances include wander guard bracelets and soft barriers. If you have a resident that wanders into other resident's rooms, do a careful ABC analysis. Is there something you can alter in the environment to influence the A: Activator? For example, some residents wander into other rooms because they can't find their own. In this case, using visual aids can be helpful. For example, a motorcycle enthusiast that had severe short term memory deficits and difficulty reading was redirected to his room with pictures of motorcycles with directional arrows.

When assessing behavioral problems, it will be important to consider any recent changes to the resident's environment such as a recent room change or a change in roommate. Remember that sometimes, making a change in the environment can be very simple, such as turning down a loud television or putting a sign outside a resident's room.

Sensory Deprivation and Over-Stimulation as Aspects of Environmental Modification

Limited or excessive activity in the environment can contribute to sensory deprivation or over-stimulation, respectively, which in turn can contribute to challenging behaviors. While a detailed examination of sensory deprivation and over-stimulation are beyond the scope of this manual, it is important to note that different residents respond in different ways to stimulation in the environment, or lack thereof. Understanding these individual differences – decreasing an overly stimulated environment for a resident that reacts negatively to it or increasing a poorly stimulated environment for a resident that needs more activity – will be important to monitor and integrate into your ABC plans and pleasant event planning.

A helpful analogy to use with Staff Partners is one that addresses "overload". When we are "overloaded", even the most cognitively-healthy individual will respond with anxiety, distress, depression and possibly outright anger or hostility. When a person with

dementia is “overloaded” (e.g., asked to do too much, asked to do things that they find stressful), they will respond in the same way. And frequently, they will respond that way quickly without much advance warning, so it is important that you and staff keep a watchful eye to help read the environment and learn what distresses residents before they have adverse reactions. Some staff may have heard the term catastrophic reactions. You yourself may want to explain that oftentimes such reactions are extreme responses to distressing situations. By controlling the environmental activators and consequences, such reactions may be significantly decreased.

IV. Applying the ABC’s & Get Active! Working with Staff Partners to Identify the Environmental Activators and Consequences

Very often, individuals (and busy health care staff, in particular) tend to make internal attributions for behaviors and under-recognize the role that the environment has on behavior. This is akin to the fundamental attribution error well known to mental health providers. Therefore, when working with Staff Partners, help them to recognize the array of factors in their environment and how such factors affect them. Then, make the link to how factors in a resident’s environment might affect them.

Below are some suggestions for discussing the environment with Staff Partners:

Ask:
What makes up the environment on a typical day?

To help Staff Partners understand the environment and its influence on mood and behavior, you may want to begin by explaining what environment is and then ask what **they** think **the CLC environment** is. Once you have **identified** environmental factors together (e.g., noise, lighting; conversation, laughter; clothes that are rough, photos that are pleasing, etc.), then discuss how it might affect behavior. Then, you have set the stage for discussing how the environment can be changed in order to change behavior.

You might conclude with the following summary statement: “When you think about it, there certainly are a lot of things that make up your daily environment. All of these things affect you. If traffic is especially bad on the way to work, you may begin work irritated; if your favorite song is playing on the radio, you may begin work in a good mood. A number of things can influence us – big and small; with and without our knowing it.”

Ask:
What makes up a resident's environment on a typical day?

You might conclude with the following summary statement: Just as the environment has an impact on us, it also can have a huge impact on residents. You can imagine how loud noises, clutter in the hallways, poor lighting, or bright sunshine might affect a resident. By changing the environment, you can have a positive effect on residents.

Ask:
Can you think of a way that you have changed a resident's environment that has helped a resident?

As part of the STAR-VA Leadership Team and with your Staff Partners, identify a situation in which the environment for the resident has changed and how that positively impacted the resident.

Applying the ABC Card with Staff Partners

As discussed earlier, you will work closely with Staff Partners to identify possible aspects of the environment that can become part of your ABC plan. As always, fill out the ABC Card together, if possible.

As you identify different activators and consequences, point out how often staff have control over them. Elicit examples from your Staff Partners regarding how in the past they have changed the environment in order to help residents. If they have difficulty coming up with examples, ask if they have ever put up a sign to help residents find their rooms, or if they have ever moved furniture around to keep residents from bumping and falling. Perhaps they have realized that a resident reacts strongly to unexpected noise so have learned to approach quietly; or the reverse, another resident may be startled so, they ensure they announce their arrival. They may have noticed that a resident becomes highly agitated when there is a high level of noise in the room and taking them to a quieter room offers more comfort and decreases the agitation. Make sure a staff member has identified a situation in which he or she changed an aspect of the environment and helped change a behavior. As you do this, be careful not to assign blame to this control. It is neither good nor bad. It simply is. And, it can be used to improve care.

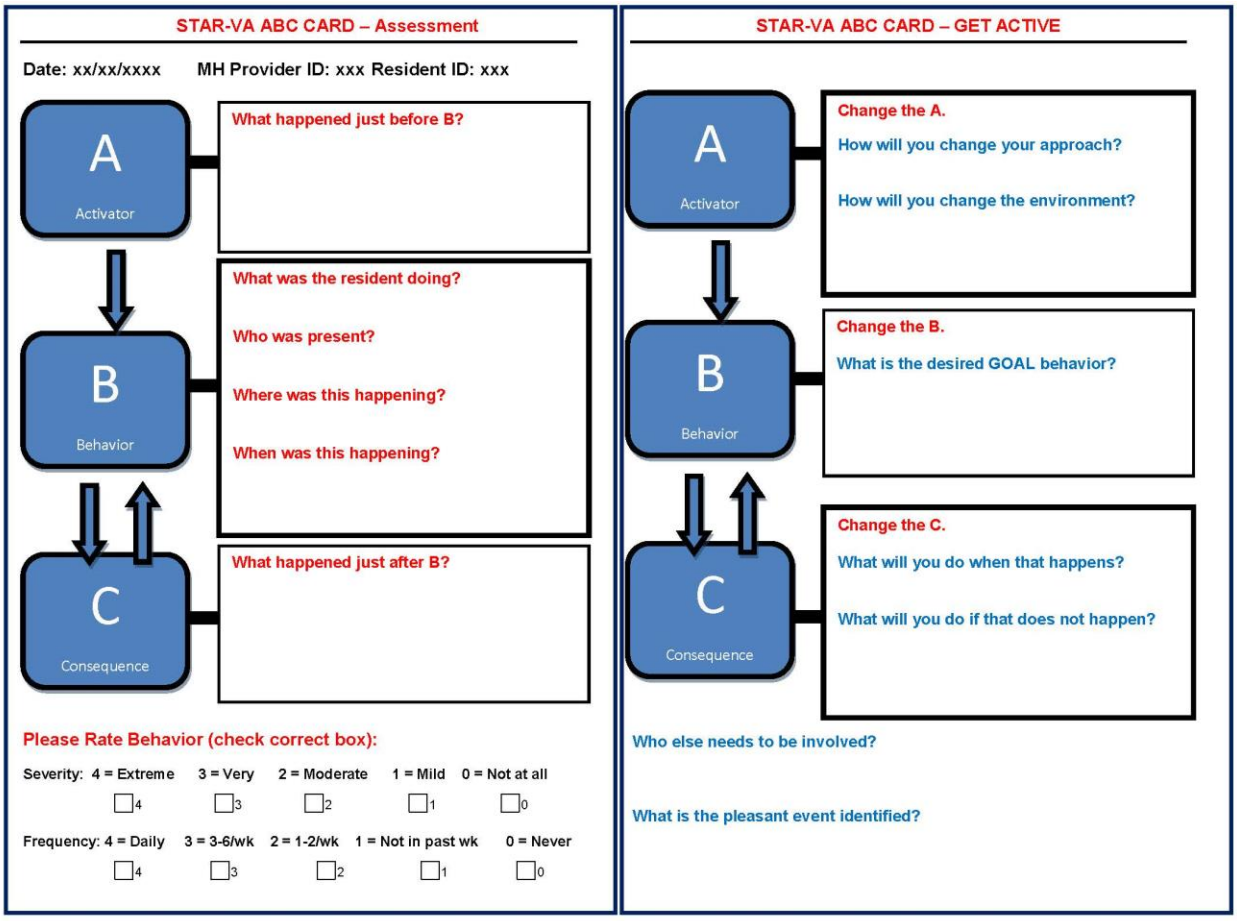
Section 6

Summary Tips

- Understanding the environment is critical to more fully understanding behavior.
- The environment is made up of any and all aspects of the physical and social world in which we live (e.g., physical includes lighting, noise; social includes staff, other residents, family interaction and solitary isolation).
- We are affected by our environment, and so are CLC residents.
- Environmental factors can serve as important behavioral Activators and/or Consequences.
- The environment can also be used to promote pleasurable or meaningful experiences for residents, as well as serve as an important contextual factor that moderates the pleasure residents receive from pleasant activities.
- Use the ABC card to incorporate aspects of the environment that you see as important in initiating, shaping, and maintaining both undesired and desired behaviors, and to problem-solve strategies to reduce these behaviors.

Section 6
STAR-VA Handouts

ABC Card (electronic submission version sample)



Managing Challenging Behaviors

All of us behave differently depending on the situation. If we become upset or confused, we can act in ways that others find challenging. People with dementia are no different. This handout describes some simple techniques to help people with dementia during different types of care activities or when they become upset or confused as a result of the dementia. Try to remember that people with dementia are not purposely trying to be challenging. They are just trying to make sense of their situation, and you can be a key to helping them feel more comfortable, happy and calmer.

Bathing

Residents with dementia may forget that they need to bathe. They may feel frightened of bathing or feel uncomfortable having someone help them with such a private task. To make bathing as easy as possible try to:

- **Ensure privacy.**
- **Let the resident touch the water.**
- **Go slowly.**
- **Give one instruction at a time.**
- **If a resident won't cooperate, give a choice: "do you want to take a bath or shower"?**
- **Schedule baths around upcoming events: when residents have reasons to be clean such as going to church or having visitors, they are often more willing to bathe.**
- **Consider providing sponge baths.**
- **Make sure that the temperature is comfortable. Persons with dementia may not be able to detect changes in temperature.**

Dressing

Being comfortably and nicely dressed is important to a resident's sense of well being. With clear suggestions and directions, residents are often able to do a fair amount for themselves. Encourage residents to do as much as possible. Eliminate frustrations by limiting choices and providing items that are easy to fasten. When assisting a resident with dressing:

- **Lay articles of clothing out in the order they will be put on.**
- **Give one simple instruction at a time and wait until the resident is finished before moving on.**
- **Undress only one part at a time; have the next article of clothing ready to put on.**

(Continued on next page)

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

Toileting

Good toileting habits can prevent an array of health and behavioral problems. Some things to consider:

- **If the resident begins having trouble with incontinence, take him or her to the bathroom every 2 to 4 hours; do this on a routine basis.**
- **Make sure the bathroom is clearly marked with a sign (use a picture if s/he doesn't understand signs).**
- **Provide adequate lighting along the way to the bathroom.**

Eating

Many residents with dementia have difficulty with eating. Here are some ways to prevent such problems:

- **Offer one food at a time.**
- **Provide a relaxing eating area.**
- **Provide enough fluids; serve Jello, popsicles, juices, and ice cream to increase fluids, and avoid caffeine.**

Angry or Agitated Behavior

Residents can demonstrate angry or agitated behaviors. The best strategy is to prevent these behaviors to begin with. Potential triggers include:

- **Too many demands or questions at once**
- **Too much noise and activity**
- **Fatigue**

You can decrease the behaviors by:

- **Completing each demand before moving on to the next**
- **Speaking slowly and softly**
- **Taking a break and trying again later**

Once the behaviors have begun, there are some ways to potentially stop them. Try to:

- **Soothe the resident by trying to see the situation from their view point.**
- **If possible, remove the resident from the scene of conflict**
- **Distract or redirect the resident—offer an alternative activity the resident enjoys**

Keep your responses kind and supportive during a crisis and remember to give praise and pay attention to the resident at times when he or she is cooperative and pleasant. You will reinforce the resident's behavior when he or she is behaving well and make it more likely that he or she will behave well more often.

(Continued on next page)

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

Paranoia or Suspicious Behavior

About one-third of residents with dementia develop paranoid or suspicious behaviors. It is important not to take these behaviors personally. Be aware of factors that can make paranoia worse.

- **Problems with hearing or vision can cause the resident to withdraw or to misunderstand events**
- **Dim lighting and loud noises**
- **Changes in daily routine or the environment**

When the behavior occurs, don't try to correct or argue with the resident. Instead, try to:

- **Use gentle touch when appropriate**
- **Reassure the resident that he or she is safe and you will take care of him or her.**

Some ways to avoid paranoid or suspicious reactions are to:

- **Maintain a daily routine and minimize changes**
- **Regulate people contact**
- **Increase lighting and decrease noise**

Hallucinations and Delusions

Hallucinations are seeing, hearing smelling, tasting, or feeling, things that aren't there. Some residents with dementia have hallucinations. The most common hallucinations are visual or auditory. Delusions are ideas that are not true.

Both hallucinations and delusions are symptoms of the disease and do not mean that the resident is "going crazy". It is important to remain calm, consistent, and supportive of the resident when hallucinations or delusions occur. The following are some suggestions for managing these symptoms:

- **Respond to the fears and the feelings being expressed by saying, "that must be scary" or "it must be difficult."**
- **Don't argue with the resident about what they are seeing, hearing, or believing.**
- **Check the environment for glare, shadows, or objects that might be triggering the hallucination or delusion (sometimes events or people on television seem real to residents with dementia; mirrors may also be confusing).**
- **Don't say, "you are imagining things"—this often just upsets the resident.**

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

SECTION 7

CREATING A STAR-VA TEAM: LEADERSHIP AND STAFF PARTNERS

CORE CONCEPT: Partnership is the Key to Success!

Objectives:

I. Consolidate the Behavioral Coordinator-Nurse Champion STAR-VA leadership team
II. Define STAR-VA Staff Partners
III. Communicate with leadership
IV. Introduce STAR-VA to Staff Partners
V. Engage and sustain Staff Partner involvement with the STAR-VA intervention

Outline:

I. The STAR-VA Leadership Team: Behavioral Coordinator-Nurse Champion Collaboration
   - Behavioral Coordinator and Nurse Champion Roles
   - Strategies for Behavioral Coordinator – Nurse Champion Collaboration

II. Overview of Partnering at Different Levels
III. Communicating with Leadership
IV. Introducing STAR VA to Staff Partners
V. Engaging Staff Partners with Implementation of STAR-VA
   - Promoting Initial Motivation and Engagement of Staff Partners
   - Using Motivational Enhancement Techniques in Creating Partnerships
   - Recognizing and Addressing Barriers/Ambivalence
   - Recognizing and Reinforcing Good Work

VI. Sustaining STAR-VA
VII. Summary Tips

Handouts:

I. STAR-VA Program for Managing Challenging Dementia-Related Behaviors
II. What is STAR-VA?
III. Dementia and Realistic Expectations
IV. Communication is Key!
V. The ABC's of Dementia
VI. Pleasant Events
VII. STAR-VA Sustainability Worksheet

I. The STAR-VA Leadership Team: Behavioral Coordinator – Nurse Champion Collaboration

The Behavioral Coordinator and Nurse Champion function as the local "STAR-VA Leadership Team." Their collaboration is essential to the success of STAR-VA. The role of the Nurse Champion was developed to provide support for and promote engagement of nursing staff participation in the intervention, and to serve as a Nursing advocate to help communicate that "dementia care is everyone's job" and that behavioral approaches can work. It is important that the Behavioral Coordinator and Nurse Champion work closely together in introducing STAR-VA to their CLC team and modeling effective teamwork in order to promote and encourage team participation.

Both Behavioral Coordinators and Nurse Champions are likely to be successful if they have: (1) daily presence on the CLC unit(s) on which STAR-VA is being implemented; (2) excellent leadership and communication skills; (3) respect of one's interdisciplinary peers/staff; (4) a collaborative**,** working relationship with one another, and (5) an expectation of staying in one's CLC role for *at least* six months implementation following the consultation period. In addition, successful Nurse Champions and Behavioral Coordinators will have some control over their schedules to allow for staff training, program planning, and consultation activities.

Behavioral Coordinator and Nurse Champion Roles

The STAR-VA Behavioral Coordinator and Nurse Champion have both distinct and overlapping roles. It is important for each to understand and acknowledge his/her particular roles and responsibilities, strengths, resources, and availability for collaboration.

Shared roles for the STAR-VA leadership team include:

- Communicating enthusiasm and positive expectations for implementing the STAR-VA approach in the CLC
- Modeling effective interdisciplinary collaboration and problem-solving
- Presenting a united front to introduce and update facility leadership about STAR-VA implementation
- Training nursing and other Staff Partners in STAR-VA concepts
  - Due to differences in availability, shifts worked, and other job responsibilities, it may be necessary to "divide and conquer" in training Staff Partners
- Involving Staff Partners in the STAR-VA intervention, including being in the CLC setting, assisting with ABC assessment and Get Active planning
- Modeling core STAR-VA components, coaching staff, and providing feedback
- Co-presenting at least one initial STAR-VA case on either a Behavioral Coordinator or Nurse Champion consultation call

Distinct roles for the Nurse Champion include:

- Introducing nursing leadership, including the Nurse Manager, to STAR-VA and updating on implementation progress or barriers
- Ensuring that the STAR-VA Get Active plan is integrated into the resident's nursing care plan

- Facilitating communication of the behavioral care plan across shifts
- Developing/encouraging nursing documentation of ABC assessment and plan in CPRS
- Helping to identify neighborhood/shift champions, i.e., staff nurses who can be program advocates and encourage their peers
- Collaborating with nursing staff, Nurse Manager, and relevant leadership to problem-solve around barriers faced in implementing STAR-VA
- Participating in monthly Nurse Champion consultation calls for six months

Distinct roles for the Behavioral Coordinator include:

- Introducing behavioral/mental health leadership to STAR-VA and updating on implementation progress or barriers
- Determining CLC resident enrollment into STAR-VA consultation program, ensuring that cases suggested by the team meet inclusion and exclusion criteria
- Overseeing the ABC care plan
    - Guiding formulation of ABC assessment using information obtained from Staff Partners (in collaboration with Nurse Champion)
    - Coordinate formulation of the Get Active plan
- Completing and submitting demographic and clinical assessment measures, with Staff Partner input regarding symptom and behavioral observations
- Participating in weekly Behavioral Coordinator consultation calls for six months

The Behavioral Coordinator and Nurse Champion may adjust responsibilities and their partnership to their own working relationship and facility. Each leader will have creative ideas for advocating for STAR-VA and inspiring CLC teams to participate and should support each other in these efforts.

Strategies for Behavioral Coordinator – Nurse Champion Collaboration

During the STAR-VA workshop training, the Behavioral Coordinator and Nurse Champion have an opportunity to work together in a series of experiential exercises and brainstorm about implementing STAR-VA at their facility. This collaboration is important to sustain during the course of STAR-VA implementation. Below are some possible strategies for collaboration.

- When home from STAR-VA training, schedule a meeting together to strategize for introducing STAR-VA to leadership and Staff Partners at your facility.
- Work together to plan presentations for various CLC, GEC, Mental Health, Nursing, and facility leaders (see below). Decide which leadership groups you wish to present together versus separately.
- Work together to plan in-services with nursing staff and other team members (e.g., recreation therapy, social work). You may decide that it would help to offer in-services together, or to “divide and conquer” in some manner.
- Brainstorm regarding which Veterans might benefit from STAR-VA enrollment.
- Schedule a regular (e.g., weekly) meeting together to discuss progress and any barriers being faced. Share perspectives on how the CLC team and key Staff Partners are responding to STAR-VA.
- Discuss how each enrolled Veteran is responding to the intervention and any systemic barriers to progress.

- Brainstorm together if facing barriers to STAR-VA implementation – e.g., leadership not supporting staff time to participate, changing staff, some nurses resisting involvement, lack of participation by other important team members.
- Decide what is needed to implement and sustain STAR-VA successfully, and present these needs to key leadership.
- Work together to plan and provide updates to CLC, GEC, Mental Health, and facility leadership regarding status of STAR-VA implementation.

II. Overview of Partnering at Different Levels

The support and involvement of staff from various disciplines is critical to the success of STAR-VA. As discussed throughout this manual, STAR-VA is an interdisciplinary intervention in which the CLC Mental Health Provider, functioning as the STAR-VA Behavioral Coordinator, and a Nurse leader, functioning as the STAR-VA Nurse Champion, collaborate as the STAR-VA leadership team who works closely with Staff Partners in implementing the STAR-VA intervention. Specifically, this involves:

- Gaining facility leadership support for staff training and including STAR-VA implementation into job responsibilities of all levels of staff,
- Educating Staff Partners about dementia and cultivating realistic expectations of individuals with dementia,
- Helping Staff Partners to communicate effectively (verbally and non-verbally) with residents,
- Working with Staff Partners to identify activators, behaviors, and consequences and developing and implementing a behavioral intervention plan to decrease challenging dementia-related behaviors,
- Ultimately, working to integrate STAR-VA core components into usual CLC care practices.

The role of Staff Partners is to inform the ABC assessment and development of the behavioral intervention plan (i.e. the “Get Active” plan) and assist with its implementation. Over time, as Staff Partners become increasingly familiar with the intervention, they may have an increasing role in developing the behavioral intervention plan and implementing appropriate components of this plan, while the Behavioral Coordinator and Nurse Champion remain available for consultation and support as needed.

Staff Partners include front-line staff that work most closely with the resident and are in a critical position for informing and implementing a behavioral intervention plan. Nursing aides or assistants, who closely interact with and care for residents, including providing assistance with daily tasks such as toileting, bathing, dressing, eating, and/or transferring, are integral to STAR-VA implementation. Likewise, other CLC nurses, who work in a wide range of clinical and administrative roles, are critical STAR-VA Staff Partners. Other members of the CLC interdisciplinary team may have less frequent contact with the resident but, as a function of their professional expertise or role in the CLC, may provide valuable input into the development of a behavioral intervention plan (e.g., identification of activators or consequences, identification of pleasant events) and provide information about residents’ strengths and limitations. These team members may also be helpful in implementing and sustaining components of the behavioral

intervention plan (e.g., implementing a pleasant activity, modifying the environment, providing praise and positive reinforcement of goal behaviors). Staff Partners may include the following members of the CLC team, who could each support STAR-VA in the following ways:

- Recreation therapists are uniquely suited to partner with the STAR-VA leadership team in identifying and implementing personally-meaningful pleasant events. They can help adjust a preferred activity to the Veteran's current level of physical and cognitive functioning, in collaboration with the occupational therapist.
- Social workers often have access to important information about a Veteran's psychosocial history that can help in identifying potential behavioral activators and pleasant events. They also can facilitate partnership with families in obtaining information and materials for engaging the Veteran in pleasant activities and personalizing their environment.
- Dieticians assess dietary preferences in addition to making dietary recommendations to maintain/enhance overall functioning, and have information that could help improve the mealtime experience and use of snacks as enjoyable experiences.
- Occupational therapists can assist with assessing functional ability and providing recommendations regarding engaging Veterans in activities of daily living and pleasant activities, contributing to increased independence, engagement and sense of control.
- Physical therapists can assist with assessing and improving gait, balance, and ability to ambulate which can serve to increase independence, sense of control, and may also be a pleasant event.
- Chaplains offer unique expertise in identifying ways to support and facilitate engagement in personally meaningful religious or spiritual practices.
- Pharmacy staff can assist with reviewing medications for effectiveness, interaction effects and side effects which may serve as potential activators and contributors to behavioral challenges.
- Psychiatrists and other psychiatric providers can collaborate regarding the assessment of challenging behaviors and, in particular, helping to identify and treat potential psychiatric activators (e.g., anxiety, depression, psychosis) and may encourage use of the Get Active! plan by including it in their own treatment plans and discussions with nursing staff.
- Physicians including geriatricians, physician assistants and nurse practitioners can collaborate regarding the assessment of challenging behaviors and, in particular, helping to identify and treat potential medical activators (e.g., delirium, pain, breathing difficulties) and may encourage use of the Get Active! plan by including it in their own treatment plans and discussions with nursing staff.

Note that less traditional members of the CLC team have, at times, been able to play an important role in a behavioral plan. For example, some STAR-VA teams have encouraged motivated volunteers, facilities management staff, unit secretaries and, of course, family members (see Section 8) to play a role in a Get Active! Plan, as appropriate.

Implementing STAR-VA often requires a shift in how Staff Partners view their job duties. STAR-VA will be most successful if all Staff Partners see the implementation of the

interdisciplinary STAR-VA intervention as an important part of their job. Consequently, it is critical to build relationships with Staff Partners, engage them in shared goals for care, and communicate that they can make an important difference in quality of care for our Veterans.

It is also important to build relationships with VAMC clinical and administrative leaders, as these individuals can help to support the intervention and Staff Partners' involvement in training and implementing the intervention. Nurse Champions and Behavioral Coordinators are co-leaders in efforts to educate, support, and reinforce STAR-VA strategies with the team and with leadership. The remainder of this Section focuses on strategies for promoting motivation and engagement of facility leadership and Staff Partners in the STAR-VA intervention – both initially as well as over time.

Before discussing strategies for engaging leadership and promoting Staff Partners' motivation and engagement in the STAR-VA intervention, it is important to focus on partnership within the STAR-VA leadership team. A strong Behavioral Coordinator – Nurse Champion collaboration will facilitate local STAR-VA implementation and allow for a "united front" in bringing this new approach to the CLC.

III. Communicating with Leadership

The support of clinical and administrative leadership is essential to successful implementation of STAR-VA and the active involvement of Staff Partners. One of the first things the Behavioral Coordinator and Nurse Champion must plan to do upon return to their local site after the in-person STAR-VA training is to meet with and brief leaders about the STAR-VA program, review the requirements for implementation, and ask for support as needed. The STAR-VA Site Liaison, designated on each CLC's application, may be helpful in connecting with key leadership to discuss STAR-VA implementation. Key clinical and administrative leaders to elicit support from may include, but are not necessarily limited to:

- CLC Nurse Manager
- CLC Nurse Educator
- CLC Nurse Leader/Associate Chief Nurse
- CLC Medical Director
- Chief of Geriatrics & Extended Care (or equivalent)
- Chief of Mental Health
- Social Work Leadership
- Recreation Therapy Leadership
- Associate Director for Patient Care Services
- Members of the Director's Office (e.g., Chief of Staff, Medical Director, Nurse Executive, Director of Public Affairs)

Chiefs, associate chiefs, and/or directors may or may not be involved with the daily care of Veterans in the CLC. They are, nonetheless, instrumental in providing organizational support for any staff training, particularly new initiatives that involve patient-centered care practices, environmental changes, and/or workplace practices. Most sites have several leadership staff members who are able to influence the direction of care in the CLC, such as chiefs, associate chiefs, directors, and/or managers.

Behavioral Coordinators and Nurse Champions must begin introducing STAR-VA as soon as possible, in order to support its implementation in the CLC. Upon returning home from the in-person training, it can help to send an email to all the site leaders who signed the application, to thank them for the opportunity to attend the training, summarize briefly the plans for implementation, and ask for opportunities to brief them. An example email will be made available to adapt for local use.

STAR-VA may be introduced to leadership staff in a number of ways. One manner of introducing leadership staff to STAR-VA is to provide a brief overview of the intervention and a review of its demonstrated effectiveness. The following information may be useful to provide to leadership:

- There is a significant need for effective approaches for managing challenging behaviors associated with dementia in VA CLCs.
- Medications like antipsychotics are of limited use for behavior management.
    - Limited efficacy (Seitz, Gill, Herrmann, Brisbin et al, 2013; Schneider et al., 2006; Sink, Holden, & Gaffe, 2005)
    - Increased death risk associated with the use of antipsychotics with older persons with dementia (Schneider, Hagerman, & Inset, 2005)
        - Due to this risk, FDA “black box” warnings issued for:
            - 2005: Conventional antipsychotics
            - 2008: Atypical antipsychotics
    - American Psychiatric Association (2013) recommendation that antipsychotic medication not be used as first choice to treat behavioral and psychological symptoms of dementia
- National VA Workgroup was charged to review literature on psychosocial approaches to managing dementia-related behaviors in regards to
    - Efficacy
    - Utility with Veteran population
    - Implementation issues and feasibility
- Recommendation and decision made to develop pilot initiative to disseminate an adapted version of STAR (developed by L. Teri and colleagues) for VA CLCs, known as STAR-VA.
    - STAR has demonstrated success in management of dementia-related behaviors in assisted-living centers and other settings.
- STAR-VA:
    - Is based on a very effective non-pharmacological approach (STAR) to managing challenging behaviors in assisted living and other community residences and shown to be efficacious in a number of research studies.
    - Has significantly reduced challenging behaviors, depression, and anxiety symptoms to improve the quality of life of Veterans with dementia.
    - Is consistent with Patient-Centered Care and the Holistic Approach to Transformational Change (HATCh) Model being implemented in VA CLCs.
    - Was adapted to address issues specific to VA CLC setting and resident population.
    - Is based on and promotes an interdisciplinary care approach in CLCs.
    - Is designed to increase CLC capacity to manage dementia-related

behaviors using a systematic approach.
    - Is consistent with the Joint Commission Memory Care Standards for Nursing Care Centers (The Joint Commission, 2014) http://www.jointcommission.org/assets/1/18/JCP0114_Memory_Care_NCC.pdf
    - STAR-VA training and implementation is supported by VHA Dementia Steering Committee, Geriatrics and Extended Care (GEC) and Nursing Services program offices.

Materials including a PowerPoint overview located on the STAR-VA SharePoint site and a flyer included at the end of this section can be helpful tools when communicating with leadership the overall vision and aims of STAR-VA. CLC leadership, in particular, should be encouraged to raise any questions they may have about the intervention, principles, key concepts, and roles of staff in the intervention. These discussions will hopefully assist with promoting the implementation of STAR-VA and the communication between Staff Partners, Nurse Managers, and other CLC and facility leadership. Share STAR-VA "success stories" to further promote interest and sustainability. Just as the STAR-VA Implementation Team is encouraged to work with Staff Partners on an **ongoing** basis, VA leadership should also be informed of the implementation, needs, successes, challenges, and sustainment of STAR-VA over time.

As you introduce STAR-VA to leadership, it will be helpful to learn about the strategic goals they are working toward and how STAR-VA may be able to facilitate their achievement. For example, STAR-VA core components support many goals of culture transformation and may help meet the Artifacts of Change criteria http://www.artifactsofculturechange.org/Data/Documents/artifacts.pdf, including:

- Identifying and supporting individualized wake and sleep times
- Introducing pleasant interactions and activities to bathing, supporting ideas from Bathing without a Battle.
- Identifying personalized items such as photos, awards, gifts, etc. to decorate their own bedroom.
- Identifying and facilitating use of key spaces to support the resident's individual preferences and promote engagement in pleasant events (i.e. gift shop, restaurant, kitchen, workout room, garden/patio, etc).
- Providing feedback from residents and/or family members on quality of care issues.
- Offering opportunities to learn from staff and share ideas (learning circles).
- Providing an observable measure of supporting individual resident preferences and choice.

It will likely be helpful to point out how STAR-VA can help your facility meet the Joint Commission Memory Care Standards. A cross walk between STAR-VA and these memory care standards is included at the end of this section in the handouts. In summary, STAR-VA can help to meet these Joint Commission standards: STAR-VA can help teams meet the below standards, helping leadership meet the goals they are responsible for helping their clinical teams attain:

- Collaboratively assessing, planning and providing care that is consistent with current advancements in dementia care practices

- Providing staff with the qualifications, skills, training and education to assess and provide care for a resident population with memory impairment.
- Providing activities that match the resident's cognitive ability, memory, attention span, language, reasoning ability and physical function.
- Emphasizing the use of non-pharmacological interventions as alternatives to antipsychotic medication use.
- Modifying the physical environment to promote safety and minimize confusion and overstimulation.

IV. Introducing STAR-VA to Staff Partners

The first step in promoting motivation and engagement of Staff Partners in STAR-VA is to introduce the STAR-VA intervention. This introduction may occur in a variety of contexts – team meetings, nursing huddles, brief in-service, 1:1 briefings. Key messages to convey in this initial introduction are as follows:

- STAR-VA is based on a behavioral approach to reducing challenging behaviors related to dementia in individuals in the community (STAR).
- A number of research studies have shown the STAR approach to be effective.
- Evaluation of STAR-VA has demonstrated success in decreasing challenging behaviors, anxiety and depression in CLC Veterans.
- STAR-VA is a team approach to caring for residents diagnosed with dementia and experiencing behavioral challenges (e.g., agitation, vocal outbursts, aggression, etc.).
- As a team approach, the involvement of nursing assistants, other nursing staff, and staff from many other disciplines is essential.
- The overall goal is to implement the best care for residents with dementia and simultaneously make it easier for team members to deliver care.
- This approach can improve resident quality of life, dignity, and autonomy and make the work of caring for residents with dementia more enjoyable.

Following the introduction of STAR-VA, it can be useful to review the overall components of the STAR-VA intervention:

- Identifying and reducing residents' challenging behaviors related to dementia.
- Maintaining realistic expectations for residents with dementia.
- Using effective verbal and non-verbal communication strategies with residents with dementia.
- Increasing residents' involvement in pleasant events, which are tailored to the resident.
- Fostering relationships among Staff Partners.

Handouts provided at the end of this chapter can be used to help introduce Staff Partners to core STAR-VA concepts. Use of posters provided on the SharePoint site can be used in key locations to serve as reminders of these core concepts. Lanyard cards, also on the SharePoint site, can be distributed so that Staff Partners have reminders of these skills when interacting with Veterans.

V. Engaging Staff Partners with Implementation of STAR-VA

It is quite common for people to resist change, and adapting a new approach to care like STAR-VA is no exception! It is important to recognize that some staff may view working to reduce challenging behaviors as outside of their responsibility, which may in part be related to a lack of familiarity or comfort with working with challenging behaviors. Further, Staff Partners work hard, have challenging jobs, and may perceive anything new as adding to their workload. On the other hand, many Staff Partners will express hopefulness and openness to learning a new approach. Our experience is that some of the most ambivalent or pessimistic staff can become great partners once their concerns are acknowledged, they have the opportunity to witness success of new approaches, and they realize that they can have a very important role in implementing these approaches. Moreover, demonstrating how STAR-VA can make their jobs more enjoyable and save them time in the long run will foster adoption of the intervention.

In the early stages of implementation, the Behavioral Coordinator and Nurse Champion leadership team is advised to be visible and accessible by spending time on the floor, at the nursing stations, and/or in the break rooms. Discuss your roles in the CLC, and with STAR-VA, and communicate respect and recognition for the care they provide for the residents on a daily basis. The goal is for Staff Partners to realize you are a colleague, a team member, and that their efforts are critical to the success of STAR-VA. The Nurse Champion can help to reinforce the key role of nursing Staff Partners in behavioral assessment and planning and encourage nursing staff to actively collaborate in completing ABC Cards and Get Active! plans.

In addition, it is important to convey respect for the role of the Staff Partner. Make it a point to understand what their responsibilities are and communicate your appreciation for what they do. Identify and reinforce the positive attributes that each Staff Partner brings to their work that can facilitate STAR-VA (See Table 1.5 “Positive Attributes of Staff” on page 20). Recognize and openly discuss concerns about fitting in a new role into already existing job responsibilities and other barriers, and then focus on finding solutions. Set realistic expectations for what can be achieved, and practice the use of good communication skills and creating pleasant interactions with Staff Partners in an effort to model key components of STAR-VA.

Behavioral Coordinators and Nurse Champions are encouraged to invest time in understanding which resident behaviors are most challenging to the Staff Partners and then build upon Staff Partners’ existing skill sets to address those behaviors. It is important to be aware of the vulnerability some Staff Partners may feel when they talk about residents’ behavioral problems. Despite one’s best efforts, some Staff Partners may experience implied blame or culpability for a resident's challenging behavior. It is important to recognize and empathize with this vulnerability and reinforce to staff that the goal is to create a positive and genuine partnership, a core component of STAR-VA. Emphasize that they can be part of the solution, when the resident with dementia cannot change on their own.

The process of engaging Staff Partners in the STAR-VA intervention will involve informal, one-on-one discussions, as well as more formal, small group interactions including:

- Individual discussions with staff about specific instances of resident behavior
- Interdisciplinary care plan meetings
- Shift report
- Informal group discussions with nursing staff at the nursing station or in break rooms
- Formalized meetings with nursing staff, such as in-services and/or nursing staff meetings
- All staff meetings
- Debriefings after a challenging behavior has occurred
- Modeling and practicing STAR-VA components and specific interventions with Staff Partners

During the initial stages of the STAR-VA intervention discussions, non-directive approaches to eliciting support and engagement of Staff Partners, discussed in more detail below, are likely to be particularly effective. Over time, modeling and role play exercises can be very useful in providing education on the STAR-VA core concepts and teaching new skills. For example, the importance of the ABC Card in STAR-VA can be reinforced if it is used frequently as a teaching tool and as a means of reaching goal behaviors.

When implementing STAR-VA, it is important to look for formal and informal opportunities to discuss a resident's behaviors and behavioral intervention plan with Staff Partners. These are opportunities to plan and implement the ABC's and the Get Active! plan. Keep the ABC Card readily available so that it can be utilized spontaneously in any setting. This approach reinforces their routine use, re-emphasizes the STAR-VA concepts, and will serve to acculturate the Staff Partners to the practice of STAR-VA components.

Promoting Initial Motivation and Engagement of Staff Partners

The use of non-directive, open-ended questions can be a very effective means of promoting initial motivation and engagement of Staff Partners, particularly nursing assistants and other front-line Staff Partners. The goals of such questioning are to provide the Staff Partner with an opportunity to talk about their experiences working with challenging behaviors and to begin to recognize the potential value of the STAR-VA intervention through their own eyes. The following questions may be helpful in drawing out the existing knowledge Staff Partners have about their CLC residents:

- What are some difficult or challenging behaviors you have observed in some of the residents you care for?
- What has it been like working with these residents? What would you like to see change?
- What have you found that works?
- What have you found that does not work?

The following is a possible discussion between a Behavioral Coordinator (BC) or Nurse Champion (NC) and the Staff Partner (SP) using some of the questions above:

BC/NC: *What kind of behaviors are you seeing in the residents you're working with?*

SP: *Well, I think maybe being confused, not very interested in doing anything, and not wanting to take the medications the doctor gives.*

BC/NC: *Of the ones you just mentioned, which is the most difficult to work with?*

SP: *Well, taking medications maybe, depends I guess.*

BC/NC: *Can you think of a particular resident who does not want to take medication?*

SP: *Well, Mr. Jones, at least some of the time. He refuses and if I ask him twice he might yell, and one time he even threw the medication on the floor.*

BC/NC: *What have you found that works best with him?*

SP: *Nothing really, I just go away and come back later and hope he is in a better mood. Sometimes he still does not want it, so I just give up if I have to. I have a lot of other meds that I need to pass so I can't spend too much time with him, especially since we are always working short staffed.*

BC/NC: *You have gathered important information that Mr. Jones' mood affects his willingness to take medication. Is there anything that you've tried that does not work for him?*

SP: *Well, telling him the medication is good for him, and that the doctor says he should take it doesn't do anything at all.*

BC/NC: *What would you like to see change on those days he does not want to take his medication?*

SP: *Well….I'd like him to be more willing to take his medication, I really feel bad if he doesn't take it—I am afraid he will get sicker. Even if he doesn't say thank you, but that would be nice too!*

BC/NC: *Let's look at this issue using the ABC approach from the STAR-VA intervention you have heard me talk about in meetings. Let's see if we can work together to fix this. Ok with you?*

SP: *OK, I suppose so.*

After receiving some commitment from the Staff Partner to be involved in the intervention, it is important to ask about potential barriers to participating in the intervention so that you and the Staff Partner can problem solve at the outset and offset such potential barriers. In the dialogue above, though the Staff Partner agrees to help support the intervention, her level of commitment is questionable. It would be important to discuss, at the outset, her sense of the feasibility of being involved and potential barriers to involvement. It is typically best to do this after reviewing the overall components of the intervention and the role of the Staff Partner.

Using Motivational Enhancement Techniques in Creating Partnerships

Motivational Interviewing (MI) techniques can be particularly useful for promoting initial motivation and engagement of Staff Partners, particularly Staff Partners who express or exhibit some ambivalence or resistance in participating in the STAR-VA intervention. The purpose of MI is to enhance another's willingness to change by exploring and resolving their ambivalence about change. For example, different CLC disciplines may hold the belief that psychologists are solely responsible for finding ways to decrease challenging behaviors in CLC residents. Other staff may feel that behavioral interventions may be "more work" than they are worth and thus resist implementation. These concerns can contribute to ambivalence about engaging in partnerships. Motivational enhancement techniques can help to increase staff buy-in and foster a collaborative, non-coercive, active team while respecting staff members' autonomy, skill, and knowledge.

Widespread changes can be challenging to staff who are familiar with a particular approach to care or style of working. While a detailed discussion of MI is beyond the scope of this manual, a brief discussion of the core concepts is presented here. For a more detailed discussion, readers are referred to the seminal work of Miller and Rolnick (2002). MI consists of four steps: (1) Express empathy; (2) Develop discrepancy; (3) Roll with resistance; and (4) Support self-efficacy.

When **expressing empathy**, use reflective listening techniques to express genuine acceptance of the Staff Partners' point of view. For example, if a Staff Partner stated "I want my residents to bathe without a battle," you could respond empathically "You would like it if your residents realized you are trying to take good care of them and would not resist your efforts." When Staff Partners feel their views are taken seriously, they tend to be more open to hearing the views of others.

Developing discrepancy is a technique for getting another to present the arguments for change versus telling them how to change a situation. The goal is to use people's own words in reflecting both their current behavior and how that might differ from their own goals or values. For example, the Staff Partner who states "I think I can do this if I just have more time" might benefit from hearing "You see some real value in this approach and are wondering how you can possibly fit it in with all your other work."

Rolling with resistance is an important stance for those using MI. One wants to avoid arguing for a change since that often elicits an argument from another about why the change should not occur. The goal of rolling with resistance is to frankly acknowledge another's reluctance as understandable and to shift one's approach when such resistance occurs. For example, if a Staff Partner said "I just don't have time for this!", one could roll with the resistance by stating "You are already really busy and can't imagine adding any more to your day."

The last step is **supporting self-efficacy**, which has been mentioned before in this manual. When you listen to Staff Partners and treat them as the behavioral expert for their residents, you are supporting their self-efficacy or belief in their own competence. If a Staff Partner stated, "I think I could try that at least this week", think about some ways you could respond that would support their confidence and capability in creating

change. The next Section discusses other common instances of ambivalence to change. Consider how MI might be useful in these situations as well.

The following are examples of Staff Partners' views that might be heard at different phases of implementing STAR-VA. As you read through these comments, reflect on whether the speaker is expressing ambivalence about their work or expressing talk that would facilitate implementation of STAR-VA. Think about how you might apply MI techniques to any of these statements.

- Desire
  - "I want my residents to bathe without a battle"
  - "I wish he wouldn't hit me when I lean over to tie his shoes"
  - "When I tell him to shave I want him to just do it now"
- Ability
  - "I think I can do this if I just have more time"
  - "I have good rapport with most of my residents"
  - "I like to help people have a good life here"
- Reasons
  - "I would like my job better if residents weren't so difficult"
  - "I'd feel better about myself if I can just get things done more easily"
  - "I'd feel much better if all my residents were happy"
- Need
  - "Some of my residents get worse and worse"
  - "I've got to cut down on my stress level because I need this job"
  - "If I can't make this go better I might have to find other work"
- Commitment
  - "I think I could try that at least this week"
  - "We can help him if we try together"
  - "I really like my residents so I will try"
- Taking Steps
  - "I wrote it down this week when he had a hard time"
  - "I figured out where I can keep a copy of the plan to make it easier to use"
  - "I am coming to the team meetings to talk about my residents"

Recognizing and Addressing Barriers/Ambivalence

As above, it is normal to encounter some ambivalence when implementing STAR-VA. This ambivalence needs to be recognized and addressed. The following are some examples of the types of challenges or barriers the team may experience:

- Staff reinforcing the status quo
  - "Things have been fine here for a long time. I don't see the point of this."
  - "My job has nothing to do with changing a resident's behavior. That's your job."
  - "I have been working here a long time. Nothing is going to change how the residents behave."
- Hearing staff say:
  - "I'd love to but I don't have the time."
  - "I don't know…our communication never works."

    - ”I would if we weren't working short.”
- Passive agreement from staff
    - “Sure, okay. Whatever you say.”

MI techniques can also be very helpful in situations like these. We encourage you to think about which of the 4 components of MI you could use in such situations. Behavioral Coordinators and Nurse Champions may want to role-play ways to address expressed ambivalence on STAR-VA consultation/conference calls.
Signs that Staff Partners are reluctant or resisting implementing STAR-VA may mean that more work is needed to improve the professional relationship between Staff Partners and the STAR-VA leadership team. Techniques that can be used to respond to some challenges include:

- **Reinforce Staff Partners’ autonomy** (their ability to make decisions and act on them). This can be helped by asking open-ended versus close-ended questions (close-ended can be answered with a simple “yes”, “no”, “I did it on Wednesday” sort of response). For example, “If we could find a way to get Joe dressed without a struggle, how might that affect your work in the mornings?”
- **Simple reflection** is accurately reflecting or restating what the person just said so they know you understand. An example might be, “So let me see if I have this right. You are really frustrated that he is still yelling at night.”
- **Amplified reflection** is a restatement of what another just said but one also responds by amplifying some portion of what was said with the hope that the speaker will disagree with the restating. For example, if a Staff partner said “If I can’t make this go better I might have to find other work” one could amplify by saying “Sometimes this job gets so difficult you actually think of quitting!”
- **Shift the focus** is a technique where one responds by changing the focus of the discussion from reasons for resistance to creating positive changes. For example if a Staff Partner stated “What is the point of trying to work with him, he’s just getting worse and worse” one could respond with “So right now you are thinking about his long-term prognosis. How about we just focus on this one behavior and see if it improves things for the two of you in the near future.”
- **Have patience** while working through these challenges. Continue listening in open discussions of resistance and barriers, and then focus on and restate ideas about what can be done. Sometimes, despite best efforts, a Staff Partner may continue to resist implementation of STAR-VA. Using these techniques will help keep communication open to discuss observations of what works and what does not work in managing challenging behaviors.

When working on challenges to implementation, it may be helpful to: elicit discussions with the Staff Partner that focus on the Partner’s previous successes and strengths; brainstorm with the Staff Partner; and imagine the change with the Staff Partner. Attempt to balance fostering staff autonomy with providing enough direction and support. Some ideas for working through these challenges with a Staff Partner may include the following:

- Using the "4 Ws" (What, Who, Where, and When) as outlined Section 3 of this manual

- Asking questions like:
    - What would you really like to have happened?
    - If we can get this behavior to change, how might that affect your work with him?
    - What if nothing changed at all?
    - Is this worth some additional work? I know in the past you were very successful in helping a resident with angry outbursts. Is there something we could apply from that experience to this one?

Recognizing and Reinforcing Good Work

The STAR-VA leadership team is encouraged to find ways to recognize Staff Partners for demonstrating STAR-VA core components and positive behaviors. These could be informal, impromptu recognitions of Staff Partners one-on-one and in team meetings, and more systematic ways of recognizing and celebrating successes (such as reduced frequency or severity of a disruptive behavior). You can provide reinforcement by letting the Staff Partner's supervisor know about their good work, or use peer or nursing recognition awards already established. Finally, the team may choose to use STAR-VA specific recognitions such as posting staff on a "You're a Star" bulletin board, providing pins or other way of recognizing good work amongst the team.

VI. Sustaining STAR-VA

The STAR-VA training program aims to train the CLC team to integrate this interdisciplinary behavioral approach as part of usual daily care of residents in the CLC. To sustain a new approach, it is important to consider needs for ongoing reinforcement of STAR-VA core components, continued staff training, and recognition of successes and progress.

Staff Partners benefit from having their efforts to learn and use STAR-VA recognized and respected. **A key component of sustaining Staff Partner motivation and engagement is the provision of regular praise and feedback**. This feedback can be provided during one-on-one interactions and in staff meetings. Recognition of even small, positive behaviors or the implementation of newly-learned skills by the Staff Partner (e.g., implementation of an identified pleasant event) can go a long way in sustaining Staff Partner interest, motivation, and engagement in the intervention. Express frequent appreciation as Staff Partners employ STAR-VA skills. Also use the opportunity to offer guidance and review the core concepts of STAR-VA such as the ABC's and pleasant events. Applaud the successes, reframe perceived failures as learning experiences, and help staff to try a different Get Active! plan.

As Staff Partners become more adept at contributing to the creation and implementation of Get Active! plans, one way to sustain their engagement is to provide increasing levels of recognition of their skills and increasing levels of responsibility in establishing and implementing the plans. Staff Partners who have excelled in this manner may be interested in helping to train and motivate new Staff Partners on the STAR-VA intervention. For example, neighborhood or shift nurse champions may be identified as role models, advocates, and teachers for the rest of the team. Providing ongoing support to staff is important. Working with residents with

challenging behaviors is stressful and associated with caregiver burnout. With support, staff may become increasingly more comfortable with trying new interventions and providing input into the Get Active! plan. In addition, staff can learn from one another about different approaches and interventions. The STAR-VA leadership team can encourage such mutual learning among Staff Partners and help to enhance the relationships between different levels of nursing and other staff.

As above, the STAR-VA leadership team may wish to consider more formal mechanisms to recognize Staff Partner performance. Feedback may be integrated into formal performance appraisals, to the extent that supervisors are aware or informed about Staff Partner engagement with the STAR-VA program. You may consider establishing a STAR-VA Staff Partner of the week/month program, posted in a nursing station or break room. You may nominate Staff Partners or teams for facility awards.

In many ways, team training is never done, both because repetition and reinforcement of new concepts is important and because staffing continues to change in the CLC. The intervention will benefit from ongoing discussions and review of STAR-VA core components with all Staff Partners. The research literature demonstrates that direct care staff benefit from reviewing intervention concepts after they have been implemented so that their hands-on experience can be incorporated into learning the material (e.g., Bolton & Mayer, 2008). In addition, it is strongly recommended that discussions and teaching be repeated to ensure that new Staff Partners have sufficient opportunity to acquire new knowledge and skills. Hands-on modeling and practice helps to solidify training in adult learners, and demonstrates the importance of problem-solving, flexibility, trial and error, and practice.

Once the six-month formal STAR-VA consultation and implementation period has been completed, it will be important to establish an interdisciplinary "sustainability team." This team may be formed according to local needs, but would optimally include the Behavioral Coordinator and Nurse Champion, representatives from nursing staff and management, CLC leadership, other Staff Partners who have been positively engaged (e.g., Recreation Therapist, Social Worker), and perhaps liaisons to groups that support the STAR-VA mission (e.g., local Cultural Transformation Committee, Dementia Steering Committee). This team will consider ongoing needs for staff training, integration of STAR-VA processes into usual care practices, communications with leadership to convey successes and particular needs for support, and potential expansion of STAR-VA to other CLC units/neighborhoods.

Sustainability will entail booster training and new staff training in order to ensure that Staff Partners contribute to ABC assessments, understand and support Get Active! plans and use core components of realistic expectations, good communication, and pleasant events when providing care. Some CLC sites have integrated STAR-VA concepts into new CLC employee orientation and into employee performance plans. It will help to encourage ongoing utilization of key forms (e.g., the ABC Card, manual handouts to facilitate staff learning) as well as documentation and communication of behavioral care plans. A sustainability worksheet is provided at the end of the section, which can help the team to consider and plan for key sustainability issues.

Section 7

Summary Tips

- A strong Behavioral Coordinator-Nurse Champion "STAR-VA Leadership Team" is essential to the success of STAR-VA.
- Behavioral Coordinators and Nurse Champions collaborate to build partnerships to support STAR-VA.
- Working to build the support and involvement of staff from various disciplines and of leadership at different levels is critical to the success of STAR-VA.
- Talk with key leaders to educate them about STAR-VA and promote buy-in and active support for the intervention and for your and Staff Partners' involvement in STAR-VA. Maintain communication with leaders and regularly share STAR-VA "success stories" to further promote sustainability.
- Direct care nursing staff who work most closely with residents are central to STAR-VA implementation; they are in the best position to inform and implement a behavioral intervention plan because of their close level of ongoing involvement with the resident.
- Other CLC team members may have less frequent involvement with the resident may provide valuable input into the development of a behavioral intervention plan (e.g., identification of activators or consequences, identification of pleasant events) and provide information about residents' strengths and limitations.
- Foster strong working relationships with Staff Partners, reinforce their successes consistently (both privately and publicly), and encourage them to see obstacles as challenges that the team can overcome and learn from.
- Convey to Staff Partners that STAR-VA is everyone's job; our shared goal is to improve resident quality of life, dignity, and autonomy and make caring for residents with dementia more enjoyable for staff.
- Use the ABC Card as the foundation for discussing all resident problematic behaviors with Staff Partners.
- Know your Staff Partners' strengths and weaknesses and build on them.
- Building and sustaining motivation and engagement of all Staff Partners in STAR-VA is crucial. Non-directive communication strategies can be particularly effective for helping to motivate Staff Partners and help them to see their key role in the intervention.

Section 7
STAR-VA Handouts

STAR-VA Program for Managing Challenging Dementia-Related Behaviors

STAR-VA

What is STAR-VA?

STAR-VA is an interdisciplinary behavioral intervention for managing challenging dementia-related behaviors among Veterans residing in Community Living Centers (CLCs).

- STAR-VA, supported by Mental Health Services, Geriatrics and Extended Care, and Nursing Services in VACO, is being implemented throughout VHA.
- STAR-VA helps CLC team members understand the meaning and purpose of behaviors, and develop behavioral plans to address or prevent those behaviors.
- In STAR-VA, a CLC Mental Health Provider serves as Behavioral Coordinator. He/she works with the CLC team to develop and implement behavioral intervention plans.
- A STAR-VA Nurse Champion provides local advocacy and support for program implementation.

What is the Background to STAR-VA?

STAR-VA is based on STAR, developed by Dr. Linda Teri and colleagues at the University of Washington. Research shows that STAR is effective in decreasing problem behaviors and supporting caregivers in assisted living and community settings.

STAR-VA was developed specifically to meet the needs of Veterans and teams in CLC settings. The intervention has 4 core components:

- Creating realistic expectations among staff for individuals with dementia
- Promoting effective communication
- Identifying and changing activators and consequences of behaviors (ABCs)
- Increasing resident-centered pleasant events through a structured process

STAR VA includes involvement by Mental Health, Nursing, Recreation Therapy, Social Work, and other members of the CLC team.

How Effective is STAR-VA?

STAR-VA has been implemented in 79 CLCs, in a 2010 pilot and annually from 2013 to 2016. STAR-VA resulted in:

- Significant reductions in the frequency and severity of challenging dementia-related behaviors
- Decreases in symptoms of depression, anxiety, and agitation
- Behavioral Coordinators, Nurse Champions, and CLC staff report that STAR-VA helps team to manage behaviors and improve care.

What will Local Implementation of STAR-VA Involve?

STAR-VA implementation sites were selected to participate based on strong interest and commitment conveyed via competitive application process. Implementation includes:

- CLC Behavioral Coordinator and Nurse Champion provide training to CLC team members via in-services, team meetings, staff huddles,1:1 coaching
- Nursing, CLC, and facility leadership convey commitment to STAR-VA intervention
- CLC team develops and implements behavioral intervention plans with Veterans with challenging dementia-related behaviors
- Behavioral Coordinators attend weekly consultation calls and Nurse Champions attend bi-monthly consultation calls for 6 months
- CLC teams sustain STAR-VA intervention after formal 6-month implementation and evaluation period

Local Contacts:

MH Provider Name: Phone/E-mail
Nurse Champion Name: Phone/E-mail

What is STAR-VA?

STAR-VA is a team approach to working with Veterans who live in the CLC and have challenging behaviors as a result of their dementia. This resident-centered approach helps us to understand the meaning and purpose of behaviors, increase quality of life for residents, and improve our work environment.

The CLC team will learn and practice together these four components of STAR-VA:

1. **Remember that dementia is a brain disease that can change the way people behave, and be sure that we have realistic expectations for our residents with dementia.**
2. **Communicate with and without words in ways that are clear and comforting to residents with dementia.**
3. **Use the "ABC's" of behavior to understand and change the Activators, Behaviors, and Consequences of behaviors.**
4. **Increase pleasant events for our residents, and for ourselves: Every interaction can be a pleasant event!**

Dementia and Realistic Expectations

- Dementia is an illness that affects all brain activity – how we think, how we speak, what we feel, and how we behave.
- Often, dementia gets worse over time and has at least 3 stages: early, middle, and advanced.
- Challenging dementia-related behaviors have meaning and purpose, and may reflect an attempt to communicate an underlying need.
- Residents with dementia can also experience anxiety and depression, which can also contribute to challenging behaviors. Anxiety and depression can be reduced!
- If we have realistic expectations of residents with dementia, it may be easier for us to "keep our cool" when we feel upset by difficult behaviors.
- STAR-VA teaches us to use strengths and skills to care for residents with dementia, reduce anxiety and depression, and improve care and quality of life.

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

Communication is Key!

- Communication occurs with and without words.
- We communicate with our eyes, body, tone of voice, and facial expressions.
- The message we intend to send through our verbal and nonverbal communication is not always the message received.
- Communication can be an activator for a resident's behavior.
- Good communication in response to problem behaviors can reduce their severity and duration.
- Nonverbal messages may be accidental. Make sure you mean what your body is saying.
- STAR-VA reminds us to use **Practical Communication** strategies with residents.
- STAR-VA teaches us to "**Listen with Respect; Comfort and Redirect**" (LRCR)

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

The ABC's of Dementia

- **Challenging dementia-related behaviors can interfere with our ability to care for residents and their ability to enjoy life.**

- **Behaviors are observable events. We can describe them using the four W's:**
  - **What was the resident doing?**
  - **Who was present?**
  - **Where was this happening?**
  - **When was this happening?**

- **We can use the STAR-VA ABC Card to better understand behaviors and develop a plan:**
  - **A - Activator: What happened immediately before the resident's challenging behavior?**
  - **B – Behavior: (as above)**
  - **C – Consequence: What happened immediately after the resident's behavior?**

- **We then develop a Get Active! plan: How will we change the activator and consequences of the challenging behavior?**

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

Pleasant Events

- A pleasant event is anything that can add pleasure to a person's day
- Pleasant events are a key part of CLC goals of increasing individualized care and quality of life for residents
- Every interaction can be a pleasant event!
- Pleasant events are a way to help prevent challenging behaviors and to reverse depression and anxiety
- Pleasant events should be simple and easy to do
- STAR-VA provides tools to help identify pleasant events for each resident
- Family members can help to identify and implement pleasant activities for residents
- All CLC team members can help to implement pleasant events (e.g., nurses, recreation therapists, social workers, as well as volunteers and administrative staff)
- **Pleasant events are everyone's job!**

Adapted with permission from Teri, L., Huda, P., Gibbons, L., Young, H., & van Leynseele, J. (2005). STAR: A dementia-specific training program for staff in assisted living residences. Gerontologist, 45, 686-693.

Joint Commission Memory Care Requirements for Nursing Care Center Accreditation vis a vis STAR-VA

Joint Commission Standard #1: **Care coordination*—Staff collaboratively assess, plan, and provide care that is consistent with current advances in dementia care practices.

- **STAR-VA:**** STAR-VA is based on a behavioral approach to reducing challenging behaviors related to dementia in individuals in assisted living and home community settings.
  - STAR-VA is derived from the evidence-based Staff Training in Assisted Living Residences (STAR) program and is in line with best-practices for dementia care.
  - STAR-VA program evaluation results show reductions in the frequency and severity of target challenging dementia-related behaviors, as well as decreased symptoms of depression, anxiety, and agitation.
  - STAR-VA is a team approach to caring for residents diagnosed with dementia and experiencing behavioral challenges (e.g., agitation, vocal outbursts, aggression, etc.). In addition to the STAR-VA Behavioral Coordinator and Nurse Champion, team members often include:
    - Nursing staff at all levels
    - Recreation therapists
    - Physical therapists
    - Occupational therapists
    - Social workers
    - Chaplains
    - Pharmacy staff
    - Dieticians
    - Physicians/Physician Assistants/Nurse Practitioners
  - As a team approach, the involvement of nursing assistants, other nursing staff, and staff from many other disciplines is essential.
  - The overall goal is to implement the best care for residents with dementia and simultaneously make it easier for team members to deliver care.
  - This approach can improve resident quality of life, dignity, and autonomy and make the work of caring for residents with dementia more enjoyable.

Joint Commission Standard #2:* *Staff knowledge and competency*—Staff have the qualifications, skills, training, and education to assess and provide care for a patient or resident population with memory impairment.

- **STAR-VA:**** STAR-VA provides staff training in 4 core intervention components:
  1. Providing dementia education and promoting realistic expectations of individuals with dementia.
  2. Promoting effective verbal and non-verbal communication with residents with dementia.
  3. Identifying and changing activators and consequences of challenging behaviors (ABCs).
  4. Increasing personally-relevant pleasant events through a structured process.

Developing the STAR-VA program in the CLC entails not only formal education and skills training in these four areas, but also regular in vivo training that helps to develop staff knowledge and competency when working with individuals with cognitive impairment.

Joint Commission Standard #3:* *Activity programming based on abilities*—Staff provide activities that match the patient's or resident's cognitive ability, memory, attention span, language, reasoning ability, and physical function.

- **STAR-VA:** ** Increasing pleasant events is a resident-specific core component of STAR-VA. Pleasant events are defined as activities and interactions that the person finds meaningful or enjoyable, and are adjusted to his or her level of ability. The interdisciplinary team works in a systematic manner, often with the assistance of family members, to identify personally relevant pleasant events that are then incorporated into the Veteran's individualized behavior plan.

Joint Commission Standard #4:* *Behavior management*—The organization places emphasis on the use of non-pharmacological interventions as an alternative to antipsychotic medication use.

- **STAR-VA**: ** All 4 core components of STAR-VA (outlined below) are critical non-pharmacological alternatives to behavior management for individuals with dementia. Below is a description on how each core component can effectively contribute to decreased challenging dementia-related behaviors.

    1. Providing dementia education and promoting realistic expectations of individuals with dementia among staff.

        Unrealistic expectations of individuals with dementia can also activate challenging behaviors. It is important to educate staff partners about brain changes that cause dementia and the ways that these changes affect an individual's functioning. This understand can increase staff ability to respond to dementia-related behaviors with patience, understanding, and effective use of communication, ABC planning, and pleasant events to reduce challenging behaviors.

    2. Promoting effective verbal and non-verbal communication with residents with dementia.

        Ineffective interpersonal communication can activate challenging behaviors. By educating staff partners on effective verbal (e.g., respectful use of language, speech pacing, tone of voice) and non-verbal (e.g., facial expressions, body language) communication strategies for individuals with dementia, we can reduce challenging behaviors that may be activated by ineffective communication. Staff partners learn to "Listen with respect, then comfort and redirect" as a guideline for maximizing effective communication with residents.

    3. Identifying and changing activators and consequences of challenging behaviors (ABCs)

        At the core of the underlying theory and application of the STAR-VA intervention is the **ABC behavior chain**, where "A" stands for activator, "B" stands for the challenging behavior, and "C" stands for consequence. The **A-activator** is what happens just before the **B-behavior** and contributes to the challenging behavior. The **C-consequence** is what occurs just after the behavior and can maintain the behavior, cause it to get worse, or cause it to get better. Once the ABC's of the

problem behavior have been identified, the next steps are to identify a desired alternative positive goal behavior, and to develop a "Get Active" plan for reaching this goal. As part of the "Get Active" plan, staff partners identify ways to change the activators and consequences of the problem behavior by changing their approach to the Veteran and/or modifying the environment. The aim is to increase the likelihood of the positive goal behavior occurring, and to reduce the frequency, severity, and duration of the challenging behavior. "Get Active" plans are implemented and adjusted as necessary to achieve an effective and sustainable plan.

4. Increasing personally-relevant pleasant events through a structured process
   A lack of meaningful and pleasant events in residents' lives can contribute to boredom, depression, and other challenging behavior problems. By systematically introducing personally relevant and meaningful events that fit with individual's current life abilities and interests, behavior problems can be reduced.

Joint Commission Standard #5:* *Safe and supportive physical environment*—The organization modifies the physical environment to promote safety and minimize confusion and overstimulation.

> **STAR-VA**:** The environment can significantly contribute to negative (and positive) emotions and behaviors of residents. The resident's environment consists of social interactions (with family and friends, staff, and other residents), as well as the physical setting (noise, temperature, furniture, lighting, etc.). Each of these is taken into account when implementing various aspects of STAR-VA. A cluttered physical environment, rotating staff or shift changes, and under- or overstimulation are common activators of challenging dementia-related behaviors. The ABC approach frequently focuses on changing these activators through environmental modifications. An important component of STAR-VA is creating a safe environment that meets the individual's needs, reduces stress, and is aimed at improving their overall quality of life.

*Information taken directly from Joint Commission Perspectives®, January 2014, Volume 34, Issue 1

**Information taken directly from Karlin, B. E., Teri, L., McGee, J. S., Sutherland, E. S., Asghar-Ali, A., Crocker, S. M., Smith, T. L., Curyto, K., Drexler, M., & Karel, M. J. (2014). STAR-VA Intervention for Managing Challenging Behaviors in VA Community Living Center Residents with Dementia: Manual for STAR-VA Behavioral Coordinators and Nurse Champions. Washington, DC: U.S. Department of Veterans Affairs.

Thanks to Dr. Kathleen Matthews, CLC psychologist and STAR-VA Behavioral Coordinator at the Des Moines VA Medical Center, for creating this cross-walk.

STAR-VA Sustainability Worksheet

THEME **What areas do you want to focus on?**	***GOAL*** **What specific goals do you have for each theme?**	***ACTION ITEMS*** **List the action items (i.e. a 'to do' list) for each theme/goal.**	***TIMELINE/FREQUENCY*** **What is the due date for these items?**
Sustainability team Form interdisciplinary team to work on sustainability plan	•	•	•
Leadership support Identify local leaders who can help support STAR-VA	•	•	•
Process/Procedures Develop tools and procedures to integrate STAR-VA into CLC care process	•	•	•
Team Training Continue to train current and new CLC Staff Partners	•	•	•
Expansion Bring STAR-VA to other CLC units?	•	•	•
Nurse Champions Identify Nurse Champions across units and shifts	•	•	•
Other?	•	•	•

SECTION 8

FAMILIES

CORE CONCEPT:
Involving and Engaging Family Members as Part of the CLC Team!

Objectives:

I. Identify ways for staff partners to effectively partner with family members in STAR-VA and overall care.
II. Recognize the experiences of family members of residents with dementia.
III. Identify verbal and non-verbal communication strategies for effectively communicating with families.

Outline:

I. Introduction
II. Appreciating the Experiences of Family Members
III. Effective Communication Strategies with Family Members
    Practical Communication with Family Members
    Listen with Respect
    Comfort
IV. Partnering with Family Members
V. Summary Tips

I. Introduction

Family members are important contributors to effective care. They know the Veteran far better than we do and often have insights and ideas that can help develop and implement effective behavioral plans. They can be valuable allies in implementing STAR-VA. The successful engagement of family members by Staff Partners and the STAR-VA Leadership Team is likely to facilitate and improve the accuracy and success of the behavioral intervention. Family members can provide key information related to a challenging behavior, and possible activators, as well as help to identify pleasurable activities. Additionally, family members can help to reinforce and promote resident engagement in pleasant events and other aspects of the STAR-VA intervention. Involving family members in these ways can also yield an added benefit: It may reconnect and strengthen the bond between residents and their family members. This Section provides information and strategies for your and Staff Partners' successful engagement of family members in the care of Veterans and in STAR-VA, specifically.

II. Appreciating the Experiences of Family Members

Family members have often been perceived as the backbone of long-term care facilities in that they can contribute greatly to the successful transition of a Veteran from home life to living in a CLC. Behavioral Coordinators and Nurse Champions may have different experiences with families, depending on where they work and the residents they see. For example, some CLCs may see many family members present regularly whereas other CLCs may have many residents without family, or with limited contact with family members for a myriad of reasons. For the CLCs that have family members present, relatives can be a powerful treatment resource.

Over the years much attention has focused on family members as caregivers and the degree of burden they experience. This burden includes the psychological state of the individual as a result of the combination of physical work, emotional pressure, social restrictions, and financial demands. Appreciating the psychological experiences of family members can be valuable for bringing Behavioral Coordinators, Nurse Champions, Staff Partners, and family members together!

III. Effective Communication Strategies with Family Members

Effective communication with families can improve clinical process, direct care, and the resident's overall quality of life. Working with families is an important part of the work of Staff Partners, and the STAR-VA Leadership Team can assist Staff Partners to have more positive relationships with families which would ultimately improve the care provided to residents.

Staff Partners provide the day-to-day care of residents and often interact with family members who are also concerned about the care and happiness of the resident. It is important for the Staff Partner, along with other staff members, to keep open communication with the family and help them feel comfortable. There are times, however, that family members who are experiencing a great deal of stress and internal

turmoil will unfortunately project these feelings onto the front line workers resulting in conflict. The Behavioral Coordinator and/or Nurse Champion, depending upon role, may be called upon to work with family members and, more likely than not, work with the staff as well who may be greatly affected by the conflict. The cultural differences and family dynamics between the residents, the family members, and the staff can become stressful for everyone involved in the residents care. Improving communication with family members may help the family, the staff, and ultimately the resident.

Practical Communication with Family Members

As mentioned in previous Sections, communication is both verbal and non-verbal. It will be important to remind Staff Partners that communication also includes nonverbal behaviors such as:

- Facial expressions
- Gestures
- Body postures
- Rhythm and tone of voice

Review with Staff Partners that our behaviors send a message about what we are thinking and feeling as much our words do. Sometimes what our words say are not matched by what our nonverbal behavior communicates. These two may be in conflict.

As you begin to talk with Staff Partners about communicating with family members of residents, you may consider asking the following:

> *"If you were a family member visiting your loved one in a nursing home, how would you want staff to communicate with you?"*

Prompt for specific verbal and non-verbal behaviors they would hope to see.

Listen with Respect

Discuss with Staff Partners that when listening to a family member, it is important to make sure that the family member KNOWS they are being heard. To ensure this, the Staff Partner may need to momentarily stop what they are doing in order to give the family member his/her full attention. If the Staff Partner is busy with another resident, then the Staff Partner may need to ask the family member if he/she can talk with them in a few minutes when the Staff Partner is finished with the task at hand. Convey to the Staff Partner that listening with his/her full attention shows the family member that their communication is valued.

It may also be helpful to address the tendency for some Staff Partners to take family member's comments personally. Family members might question how the Staff Partner interacts with the resident, or the family member may give direction about how they would like something done. Staff Partners may find that reflecting on the family member's intention here can be helpful. Most family members are just trying to care of their family member in the CLC even if that intention is not skillfully communicated.

Reflecting on how one would like their own mother or father to be treated if a resident in a nursing home can be useful. Keeping in mind the family member's perspective can improve communication and help the Staff Partner to feel less reactive.

Comfort

Behavioral Coordinators and Nurse Champions may want to initiate discussion about how family members may be feeling anxious, upset or depressed about their relative. Making the decision to move a loved one from home and into the CLC can be a difficult experience. Family members often experience feelings of loss as their relative loses the ability to manage life on his or her own. These feelings of loss can be compounded when a relative suffers from memory loss. Many staff members feel empathy for the difficult situation and the STAR-VA Leadership Team may also hear from staff members about their own internal conflicts with regard to their own family members.

IV. Partnering with Family Members

Involving families with care can be helpful to the CLC team, and give the family members a sense of usefulness and value. Behavioral Coordinators and Nurse Champions can work with Staff Partners to empower family members by asking them about a resident's routine, likes, and dislikes in order to provide care. Family can share with the team information about a resident's sleep patterns and eating habits, and the types of pleasant events and social activities that the resident may enjoy currently or activities they previously enjoyed that can be adapted to their current abilities and life circumstances. Further, family members may already be familiar with a particular problem behavior and may have found a way to modify that behavior that they can share with the team.

The treatment team may consider including family members in the CLC care planning meetings (i.e., in-person or via conference call) that are held at the time of admission and then every 90 days, as appropriate and with the resident's permission.

There may be times during family meetings that may cause the CLC treatment team to experience a number of feelings, including anxiety, anger, or increased empathy towards the family and/or resident. If a family meeting is scheduled and you, as part of the STAR-VA Leadership Team, are aware of the CLC team's internal conflict regarding a resident or their family, it may be desirable to the team to meet prior to the family arriving. During such a meeting, the team can be encouraged to discuss what they are experiencing in anticipation of the meeting as well as what feelings may come up during the meeting. By making the implicit explicit, the angst of the team may be alleviated so they can move on to continuing to provide the best care for the resident.

In short, working as a team to engage and successfully involve family members will typically yield much more than the investment of time and effort in promoting the success of STAR-VA and overall care.

Section 8
Summary Tips

- Family members can be key STAR-VA allies to Staff Partners and the STAR-VA Leadership Team.
- Behavioral Coordinators and Nurse Champions can help Staff Partners to recognize the experiences and perspective of family members.
- Staff Partners can help family members to feel recognized, understood, and respected as they make the emotional adjustment to having a family member in a CLC.
- Staff Partners can learn to utilize effective verbal and non-verbal communication skills with family members, which can facilitate care and partnering with family members in implementing STAR-VA.
- Family members can provide key information related to a challenging behavior, and possible activators, as well as help to identify pleasurable activities.
- Family members can help to reinforce and promote resident engagement in pleasant events and other aspects of the STAR-VA intervention.
- Family members can provide valuable information about residents' behaviors and preferences, as well as about challenging behaviors and strategies used in the past to address them.

SECTION 9

PUTTING STAR-VA INTO ACTION

CORE CONCEPT:

How to Implement STAR-VA in Your CLC

Objectives:

I. Provide tools and resources for implementing STAR-VA in local CLCs.

Outline:

I. Introduction
II. STAR-VA Flowchart
III. Determining Veteran Eligibility for STAR-VA
IV. Initial Resident Assessment
    Assessment Procedures
V. Post-Intervention
VI. STAR-VA Tools
    STAR-VA ABC Card
    STAR DVD
    Final Thoughts

I. INTRODUCTION

The goal of this Section is to provide an overview for Behavioral Coordinators (BCs) and Nurse Champions (NCs) on how to implement the STAR-VA intervention as part of their practice in the CLC setting. This includes determining which CLC residents are most appropriate for the STAR-VA intervention, initial and ongoing assessment procedures, use of the STAR-VA Card and how best to conduct all aspects of the intervention, including working closely with Staff Partners. Each of these steps is summarized in the STAR-VA Program Flowchart on the next page.

II. STAR-VA INTERVENTION FLOWCHART

IMPORTANT NOTE:
Don't begin STAR-VA intervention until a medical evaluation has been conducted to rule out/treat any medical contributors to challenging behaviors.

Determine Veteran Eligibility **for STAR-VA**

- **Veteran resides in a CLC (not respite or short stay rehabilitation)**
- **Veteran has a dementia diagnosis**
- **Veteran has a challenging dementia-related behavior that:**
  - is distressing to the Veteran, other residents, staff, and/or family
  - is able to be identified
  - occurs repeatedly (e.g., at least once per week)
  - does not constitute an immediate crisis, such as suicidal or homicidal ideation or highly dangerous activity
- Veteran is not receiving end-of-life care, such as hospice
- Veteran's challenging dementia-related behavior is not related to a delirium or other untreated medical issue
- Veteran does not have one of the following *active*, primary serious mental illness (SMI) diagnoses:
  - Schizophrenia-related disorder
  - Bipolar disorder
- Veteran's challenging behavior is not due to recent TBI (in the absence of dementia)

Eligible:
If Veteran meets above criteria, then Behavioral Coordinator should enroll Veteran in STAR-VA and set appointment to conduct an initial evaluation.

Unsure of Eligibility:
If Veteran does not meet above criteria, but Behavioral Coordinator and Nurse Champion still thinks that Veteran could benefit from STAR-VA, the case should be discussed with Training Consultant.

Not Eligible:
If Veteran is not eligible then Behavioral Coordinator should make arrangements for alternative mental health services as appropriate.

Initial Behavioral Evaluation & Develop Intervention Plan

BC/NC meet with/observe Veteran

BC/NC meet with primary Staff Partners

BC completes pre-intervention measures
FAST, BOMC, CMAI-SF, RAID, Cornell

BC/NC completes STAR-VA ABC Card
ABC Behavioral Assessment
Get Active! Intervention Side

Timeframes: BC submits completed measures within 48 hours of evaluation;
BC/NC completes behavioral assessment/plan within 1 week of enrollment;
BC/NC submits ABC Card and Process Tools to Consultant , via portal, prior to consultation call.

Ongoing Intervention

BC/NC continue to meet with/observe Veteran
BC/NC continue to meet/work with Staff Partners
BC submits ABC Card for/attends weekly telephone consultation group
NC submits ABC Card and Nursing forms for/attends monthly telephone consultation group

Timeframes:
BC/NC continue to submit ABC Card and Forms to Consultant prior to consultation call.

Post-Intervention

BC complete post-intervention measures with on each case: CMAI, RAID, Cornell, MDS 3.0
BC completes BC case summary form for each case

BC/NC complete post-consultation training participant survey, 6-month feedback, and Staff Partner feedback at end of 6-months

Timeframes: Submit completed measures within 48 hours of final evaluation;
Submit final program evaluation materials [within two weeks of program completion]

III. DETERMINING VETERAN ELIGIBILITY FOR STAR-VA

Veterans can be referred to for the STAR-VA intervention in several different ways. The initiation of a formal consult may drive the referral, a Veteran's behavioral problems may be discussed during an interdisciplinary team meeting, or a Staff Partner may informally approach the Behavioral Coordinator or Nurse Champion and describe a problem. Additionally, the Behavioral Coordinator or Nurse Champion may simply observe a Veteran with a challenging dementia-related behavior that he or she believes would be appropriate for STAR-VA.

To be an appropriate candidate for the STAR-VA intervention, the Veteran must be a resident of a CLC. The Veteran should not be enrolled in a hospice program, and their behaviors should not be related to delirium or other untreated medical issues. It is very important that Veterans receive a full medical evaluation to rule out and treat any medical etiologies for challenging behaviors, including delirium, prior to be enrolled in the STAR-VA intervention.

Furthermore, the initial STAR intervention, on which the STAR-VA intervention is based, was designed and shown to be effective specifically for individuals with dementia-related behaviors. Therefore, Veterans whose behaviors are due to a recent TBI, in the absence of dementia, would not be appropriate for the STAR-VA intervention. Likewise, Veterans with an active, primary diagnosis of serious mental illness (SMI; i.e., schizophrenia or bipolar disorder), or with an SMI diagnosis that appears to be driving their challenging behaviors, are typically not the most appropriate candidates for the STAR-VA intervention.

Before enrolling the Veteran in STAR-VA, it can be helpful to ask yourself a few questions: Is the behavior being considered distressing to the Veteran, other residents, staff and/or family? Does the behavior occur at least once per week? Does the behavior have to be addressed immediately to ensure the safety of the Veteran or others? If the answer is "yes" to any of the previous questions, then the Veteran is likely a good candidate for the intervention. If it is determined that the Veteran (or others) are in immediate danger, more immediate intervention should be initiated (e.g., medication management, crisis intervention, etc.).

If the Veteran does not meet eligibility criteria and you still believe s/he could benefit from the STAR-VA intervention, then it would be appropriate to discuss the case with your STAR-VA Training Consultant. If the Training Consultant and you decide that the Veteran could benefit from STAR-VA, then he or she may be enrolled in the program. If it is decided that the Veteran is not eligible, then the Behavioral Coordinator should make arrangements for alternative services to be provided as appropriate.

IV. INITIAL RESIDENT ASSESSMENT

The initial resident assessment contributes to creating and evaluating the Get Active! plan. During initial assessment, the CLC Behavioral Coordinator (BC) will review the chart, observe the Veteran's behavior and interview the Veteran in person about their behavior, if feasible. The Behavioral Coordinator should also talk with the Nurse Champion and interview the primary Staff Partner(s) who work with the Veteran. The information obtained is utilized to begin to understand the specifics and context of the behavior and to complete the STAR-VA ABC Card Assessment side.

Assessment Procedures

In addition to information gathered from Staff Partners, the Veteran, and other available informants (e.g., family members), the CLC Behavioral Coordinator should complete the following assessment measures prior to implementing the behavioral intervention plan:

- STAR-VA Demographic Form
- Functional Assessment Staging Tool (FAST; reprinted with permission from Reisburg, 1988)
- Blessed-Orientation-Memory-Concentration Test (BOMC; Meiran, et al., 1996; reprinted with permission from N. Meiran)
- Cornell Scale for Depression in Dementia (CSDD; Alexopoulos, et al., 1988; reprinted with permission from G. Alexopoulos)
- Rating Anxiety In Dementia (RAID; Shankar, Walker, Frost & Orrell,1999; Snow, Huddleston, Robinson, et al 2012; reprinted with permission from K. Shankar)
- Cohen-Mansfield Agitation Inventory- Short Form (CMAI-SF; Werner, Cohen-Mansfield, Koroknay, & Braun, 1994; reprinted with permission from J. Cohen-Mansfield)
- Minimum Data Set 3.0 (MDS 3.0) Behavior Section (Saliba & Buchanan, 2008).

Review the resident chart, including documentation of resident participation in activities of daily living (ADLs) and instrumental ADLS (IADLs) to complete the FAST. Reviewing records on appetite, sleep, mood, and behaviors will help when rating items on the CMAI, RAID, and CSDD. Use your clinical judgment to determine how to weigh the chart review, resident's answers, Staff Partner's answers, and your own observations to arrive at the best score for each item. If you are sure a symptom is due to a medical problem only, do not rate it; if in doubt, rate it. If a symptom is not reported or observed, then rate it as not present. Only select unable to evaluate if you were not able to observe or interview the resident and Staff Partner(s). Rate each item listed; do not leave items blank. When in doubt between two scores, always use the higher score.

Once administered, a copy of Demographic Form should be sent directly, via email with PKI encryption, to the Program Evaluator, Stephanie Visnic. The Behavioral Coordinator should enter data from the other clinical measures into the data entry portal that will be provided. This information will also be shared on Behavioral Coordinator consultation calls (with no Veteran identifying information) and with the Program Evaluator (Stephanie Visnic).

V. POST-INTERVENTION

Disengagement of the Veteran from the formal STAR-VA intervention occurs when the CLC STAR-VA Leadership Team and STAR-VA Training Consultant determine that the behavior has been successfully modified or reduced, or it is believed that the Veteran will no longer benefit from the intervention. Discussions of when the Veteran should become “inactive” for STAR-VA program evaluation should take place with the Training Consultant during consultation calls. Required post-intervention measures include the following:

- CMAI-SF
- RAID
- CDS
- MDS 3.0 Behavior Section

Debriefing with Staff Partners is important at this time, and asking them about their experiences with the program can be valuable. Staff Partners are also asked to provide formal, anonymous feedback if they wish to, through a Staff Partner feedback form. The Behavioral Coordinator and/or Nurse Champion should distribute the Staff Partner feedback form to Staff Partners who have participated in STAR-VA, along with an envelope in which they may seal the anonymous feedback. One trusted individual at the site should be assigned to collect the sealed envelopes and mail them all, in one larger package, to the Program Evaluator.

Also, it may be worthwhile to discuss successes and challenges of the case with the Training Consultant and other consultees of the STAR-VA consultation group. Ideally, each VA CLC Behavioral Coordinator will carry a total of six cases, but at least four cases, during the six month STAR-VA training consultation period.

VI. STAR-VA TOOLS

STAR-VA ABC CARD

The ABC Card is an integral component of the STAR-VA intervention. As described earlier in the manual it consists of two sides; 1) the ABC Assessment side; and 2) the Get Active! intervention side. For detailed instructions that can be shared with Staff Partners, please refer to the sample ABC Card in Appendix B and to Sections 3 and 4 of this manual. A brief description is offered below.

The first side of the ABC Card is used for the assessment of behaviors and is called the “ABC Assessment” side. It is intended to help the STAR-VA Leadership Team and Staff Partners identify and break down the different components of the Veteran’s challenging dementia-related behavior. The second side of the card is called the “Get Active!” side and helps the CLC Behavioral Coordinator and Staff Partners plot out their course of action for a behavioral intervention. Both sides of the ABC Card may be completed on the same day but should take no longer than a week to complete. The ABC Card must be faxed to the CLC Behavioral Coordinator’s assigned consultant prior to the weekly consultation call, following enrolment of the Veteran in the STAR-VA intervention, and weekly thereafter.

STAR DVD

A DVD with case vignettes was developed for the original STAR intervention (Teri & Huda, 2004) and may be a useful additional teaching aid. The DVD includes eight scenes of interactions between residents and staff members that depict common behaviors. Each scene is presented twice, showing two versions of the same situation. In the first version, only the problem is shown. The second version shows the same situation with a successful way of handling the challenging dementia-related behavior. A brief discussion of the situation immediately follows each version and provides a springboard for further discussion with Staff Partners during training. Each STAR-VA Leadership Team are provided with a copy of the STAR DVD that they may utilize for themselves and/or for demonstrating skills and scenarios with Staff Partners.

VII. FINAL THOUGHTS

We hope this manual is of help to you as you work toward effectively implementing STAR-VA in your CLC. As you read this manual, please contact us with any thoughts or suggestions you may have. Our intent for this manual is to be as helpful as possible. This manual was developed as part of a pilot initiative to disseminate STAR-VA in selected CLCs and has been updated as the program has grown. Your feedback is very much welcome and appreciated. Together, we will surely improve the care we provide to our Veterans with dementia residing in our CLCs!

Appendix A
STAR-VA Measures

STAR-VA: Veteran Demographic/Background Information
Send by encrypted e-mail to Stephanie.Visnic@va.gov

1. What is Veteran's gender? 1__Male 2__Female 2. What is Veteran's date of birth? ___ /___ /___

3. What is the Veteran's marital status?

1	2	3	4
Married/Partnered	Divorced/Separated	Widowed	Single/Never Married

4. In what historical era did the Veteran serve in the military (check all that apply):

1	2	3	4
WWII	Korean War	Vietnam	Post-Vietnam

5. Was the Veteran exposed to combat during military service? (per medical record data)

0	1	2
No	Yes	Unknown

6. How many years of education has the Veteran had? Check here if unknown: _____

1	2	3	4	5	6
Less than High School	High School Graduate	Some College	College Graduate	Some Grad School	Graduate Degree

7. Does the Veteran consider him/herself to be (circle more than one if applicable)?
   1. White/Caucasian
   2. African-American/Black
   3. Hispanic/Latino
   4. Asian
   5. Asian Indian
   6. American Indian or Alaskan Native
   7. Pacific Islander (Hawaii, Guam, Tonga, Samoa)
   8. Other (write in):_____

8. What is the Veteran's dementia diagnosis (if known)? Check all that apply
   1. Alzheimer's disease___
   2. Vascular dementia___
   3. Parkinson's___
   4. Lewy Body___
   5. Frontotemporal___
   6. Alcohol-related ___
   7. Mixed ___
   8. Dementia NOS ___
   9. Other ___
   10. Not sure, not well documented ___

10. Please indicate if the Veteran has any of these mental health diagnoses (check all that apply):
    1. Psychotic disorder (e.g., schizophrenia, schizoaffective disorder) ___
    2. Mood disorder (e.g., major depression, bipolar disorder) ___
    3. Anxiety disorder other than PTSD (e.g., GAD, OCD) ___
    4. PTSD ___
    5. Other? _____

11. On what type of CLC unit does the Veteran reside?
    1. Long-term care, general
    2. Long-term care, dementia
    3. Long-term care, focus
    4. Other? Please specify: _____

12. Is Veteran currently prescribed a prn (as needed) medication to manage behavior? 0__No 1__Yes
13. Is Veteran currently prescribed an antipsychotic medication (standing or prn)? 0__No 1__Yes
14. Is Veteran currently prescribed a benzodiazepine medication (standing or prn)? 0__No 1__Yes

Blessed Orientation-Memory-Concentration Test

	Maximum Error	Score	Weight	Total
1. What year is it now?	1		X 4	
2. What month is it now?	1		X 3	
Memory phrase: Repeat this phrase after me exactly as I say it: “John Brown, 42 Market Street, Chicago”				
3. About what time is it? (within one hour without looking at clock or watch)	1		X 3	
4. Count backwards from 20 to 1	2		X 2	
5. Say the months in reverse order	2		X 2	
6. Please say the phrase I told you to repeat just before	5		X 2	

Interpreting Results of BOMC

- With cutoff score $\geq$ 9 or 10
  - 95% with dementia will be detected
  - 77% without dementia will be correctly classified
- With cutoff score $\geq$ 15
  - 87% will be correctly classified as dementia or no dementia
- With any errors
  - Consider causes other than dementia (hearing impairment, aanxiety, depression, inattention, etc.)

Meiran, Stuss, Guzman, Lafleche, Wilmer; *Arch Neurol*, 1996; 53: 1043-54.

Functional Assessment Staging (FAST): Check highest consecutive level of disability

	Stage	
☐	1	(Normal) **No difficulty**, either subjectively or objectively.
☐	2	(Normal Aging) Complains of forgetting location of objects. **Subjective work difficulties**.
☐	3	(Early Dementia) Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. **Decreased organizational capacity**.
☐	4	(Mild Dementia) **Decreased ability to perform complex tasks**, e.g. planning dinner for guests, handling personal finances (such as forgetting to pay bills), difficulty marketing, etc.*
☐	5	(Moderate Dementia) **Requires assistance in choosing proper clothing** to wear for the day, season, or occasion, e.g. patient may wear the same clothing repeatedly, unless supervised.*
☐	6	(Moderate Dementia)
	6a	**Improperly putting on clothes without assistance or cuing** (e.g. may put street clothes on over night clothes , or put shoes on wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.*
	6b	Unable to bathe (shower) properly (e.g., **difficulty adjusting bath-water (shower) temperature**) occasionally or more frequently over the past weeks.*
	6c	**Inability to handle mechanics of toileting** (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.*
	6d	**Urinary incontinence** (occasionally or more frequently over the past weeks).*
	6e	**Fecal incontinence** (occasionally or more frequently over the past weeks).*
☐	7	(Severe Dementia)
	7a	Ability to speak limited to approximately **a half a dozen intelligible different words or fewer**, in the course of an average day or **in the course of an intensive interview.**
	7b	Speech ability limited to the use of **a single intelligible word** in an average day or **in the course of an interview** (the person may repeat the word over and over).
	7c	Ambulatory ability lost (**cannot walk without personal assistance**).
	7d	**Cannot sit up without assistance** (e.g., the individual **will fall over if there are no lateral rests [arms] on the chair**).
	7e	**Loss of ability to smile**.
	7f	**Loss of ability to hold up head independently**.

*Scored primarily on the basis of information obtained from a knowledgeable informant and/or caregiver.

FAST scoring instructions: The **FAST Stage** is the highest consecutive level of disability. For clinical purposes, in addition to staging the level of disability, additional, non-ordinal (nonconsecutive) deficits should be noted, since these additional deficits are of clear clinical relevance.

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Date: _____ Time: _____
Interviewer: _____ Informant: _____

CORNELL SCALE FOR DEPRESSION IN DEMENTIA (CSDD)

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

Scoring System: 0=absent 1=mild or intermittent 2=severe 9=unable to evaluate

A.	Mood Related Signs					
	1.	Anxiety anxious expression, ruminations, worrying	0	1	2	9
	2.	Sadness sad expression, sad voice, tearfulness	0	1	2	9
	3.	Lack of Reactivity to Pleasant Events	0	1	2	9
	4.	Irritability easily annoyed, short tempered	0	1	2	9
B.	Behavioral Disturbance					
	5.	Agitation restlessness, handwringing, hairpulling	0	1	2	9
	6.	Retardation slow movements, slow speech, slow reactions	0	1	2	9
	7.	Multiple Physical Complaints (score 0 if GI symptoms only)	0	1	2	9
	8.	Loss of Interest less involved in usual activities (score only if change occurred acutely i.e. less than one month)	0	1	2	9
C.	Physical Signs					
	9.	Appetite Loss eating less than usual	0	1	2	9
	10.	Weight Loss (score 2 if greater than 5 lbs in one month)	0	1	2	9
	11.	Lack of Energy fatigues easily, unable to sustain activities (score only if change occurred acutely i.e. less than one month)	0	1	2	9

D. Cyclic Functions

12.	Diurnal Variation of Mood symptoms worse in the morning	0	1	2	9
13.	Difficulty Falling Asleep later than usual for this individual	0	1	2	9
14.	Multiple Awakenings During Sleep	0	1	2	9
15.	Early Morning Awakening earlier than usual for this individual	0	1	2	9

E. Ideational Disturbance

(For items 16-19, probe to see how much the informant knows. If the informant does not know or is unsure, code items as 9.)

16.	Suicide Feels life is not worth living, has suicidal wishes, or make suicide attempt	0	1	2	9
17.	Self-Depreciation self-blame, poor self-esteem, feelings of failure	0	1	2	9
18.	Pessimism anticipation of the worst	0	1	2	9
19.	Mood Congruent Delusions Delusions of poverty, illness, or loss	0	1	2	9

Reprinted with permission from G. Alexopoulos

RATING ANXIETY IN DEMENTIA – (RAID)

Date:_____ Time: _____
Interviewer:_____ Informant: _____

Status at Evaluation:
1 = Inpatient 2 = Outpatient 3 = Day Hospital/Day Center 4 = Other (specify)

Scoring System:
U = Unable to Evaluate 0 = Absent 1 = Mild of Intermittent 2 = Moderate 3 = Severe

Rating should be based on symptoms and signs occurring during two weeks prior to the interview. No score should be given if symptoms result from physical disability or illness. Total score is the sum of Items 1 to 18. A score of 11 or more suggests significant clinical anxiety.

			Score
WORRY	1	Worry about physical health.	
	2	Worry about cognitive performance (failing memory, getting lost when out, not able to follow conversation).	
	3	Worry over finances, family problems, physical health of relatives.	
	4	Worry associated with false belief and/or perception.	
	5	Worry over trifles (repeatedly calling for attention over trivial matters).	
APPREHENSION AND VIGILIANCE	6	Frightened and anxious (keyed up and on the edge).	
	7	Sensitivity to noise (exaggerated startle response).	
	8	Sleep disturbance (trouble with falling or staying asleep).	
	9	Irritability (more easily annoyed than usual, short tempered and angry outbursts).	
MOTOR TENSION	10	Trembling.	
	11	Motor tension (complain of headache, other body aches and pains).	
	12	Restlessness (fidgeting, cannot sit still, pacing, wringing hands, picking clothes).	
	13	Fatigability, tiredness.	
AUTONOMIC HYPERSENSITIVITY	14	Palpitations (complains of heart racing or thumping).	
	15	Dry mouth (not due to medication) sinking feeling in the stomach.	
	16	Hyperventilating, shortness of breath (even when not exerting).	
	17	Dizziness or light-headedness (complains as if going to faint).	
	18	Sweating, flushes or chills, tingling or numbness of fingers and toes.	

Phobias: (Fears which are excessive, that do not make sense and tends to avoid – like afraid of crowds, going out alone, being in a small room, or being frightened by some kind of animals, heights, etc.). ***Describe:*** _____ _____ _____ _____	
Panic attacks: (Feelings of anxiety or dread that are so strong that they think they are going to die or have a heart attack and they simply have to do something to stop them, like immediately leaving the place, phoning relatives, etc.). ***Describe:*** _____ _____ _____ _____	

Shankar, K. K.., Walker, M., Frost, D., & Orrell, M.W. (1999). The development of a valid and reliable scale for rating anxiety in dementia (RAID). *Aging & Mental Health, 3,* 39-49. Reprinted with permission.

COHEN-MANSFIELD AGITATION INVENTORY (CMAI) short form
© Cohen-Mansfield, 1986. All rights reserved.

Informant name: _____
Note: Give to current caregiver or family as indicated.

Instructions: Please read each of the agitated behaviors, and check how often (1-5) they were manifested by the resident over the last 2 weeks; if more than one occurred within a group, add the occurrences. E.g. if hitting occurred on 3 days a week, and kicking occurred on 4 days a week, 3+4=7 days, circle 4 for 'once or several times a day.'

If filling out with the person say: **"In the last 2 weeks, how often has the resident demonstrated . . ."**

---

1 = Never
2 = Less than once a week
3 = Once or several times a week
4 = Once or several times a day
5 = A few times an hour or continuous for half an hour or more

---

	1	2	3	4	5
1. Cursing or verbal aggression					
2. Hitting, kicking, pushing, biting, scratching, aggressive spitting					
3. Grabbing onto people, throwing, tearing, or destroying things					
4. Other aggressive behaviors, including: intentional falling, making verbal/physical sexual advances, eating/drinking/chewing inappropriate substances, hurt self or other					
5. Pacing, aimless wandering, trying to get to a different place (e.g., out of the room, building)					
6. General restlessness, repetitious mannerisms, tapping, strange movements					
7. Inappropriate dress or disrobing					
8. Handling things inappropriately					
9. Constant request for attention or help					
10. Repetitive sentences, calls, questions, or words					
11. Complaining, negativism, refusal to follow directions					
12. Strange noises (weird laughter or crying)					
13. Hiding or hoarding things					
14. Screaming					

COHEN-MANSFIELD AGITATION INVENTORY scoring sheet

Client name: _____ Date: _____

	Aggressive Behavior score	Physically Non-Aggressive score
Item	1: _____	5: _____
	2: _____	6: _____
	3: _____	7: _____
	4: _____	8: _____
	14: _____	
Subtotal (number):	_____	_____

	Verbally Agitated score	Other Behavior score
Item	9: _____	12: _____
	10: _____	13: _____
	11: _____	
Subtotal (number):	_____	_____

Overall Total Number of Behaviors: _____**/14**

Interpretation/Criteria for Memory Support:

Aggressive Behavior occurring at least several times a week
- At least one aggressive behavior scoring 3 or higher
- At least three aggressive behaviors scoring 2

Physically Non-Aggressive Behavior occurring at least once a day
- At least one physically non-aggressive behavior scoring 4 or higher
- At least two physically non-aggressive behaviors scoring 3
- At least four physically non-aggressive behaviors scoring 2

Verbally Agitated Behavior occurring at least once a day
- At least one verbally agitated behavior scoring 4 or higher
- At least two verbally agitated behaviors scoring 3
- At least four verbally agitated behaviors scoring 2

Reprinted with permission from J. Cohen-Mansfield. See Instruction Manual for the Cohen-Mansfield Agitation Inventory (CMAI) at http://www.dementia-assessment.com.au/symptoms/CMAI_Manual.pdf

Minimum Data Set 3.0 Behavior Section

Resident _____ Identifier _____ Date _____

Section E Behavior

E0100. Potential Indicators of Psychosis

↓ Check all that apply

- ☐ **A. Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- ☐ **B. Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- ☐ **Z. None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

↓ Enter Codes in Boxes

- ☐ **A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
- ☐ **B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
- ☐ **C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0300. Overall Presence of Behavioral Symptoms

Enter Code ☐

Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?
0. **No** → Skip to E0800, Rejection of Care
1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

E0500. Impact on Resident

Did any of the identified symptom(s):

Enter Code ☐ **A. Put the resident at significant risk for physical illness or injury?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly interfere with the resident's care?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly interfere with the resident's participation in activities or social interactions?**
0. **No**
1. **Yes**

E0600. Impact on Others

Did any of the identified symptom(s):

Enter Code ☐ **A. Put others at significant risk for physical injury?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly intrude on the privacy or activity of others?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly disrupt care or living environment?**
0. **No**
1. **Yes**

E0800. Rejection of Care - Presence & Frequency

Enter Code ☐

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

Resident _____ Identifier _____ Date _____

Section E Behavior

E0900. Wandering - Presence & Frequency

Enter Code ☐

Has the resident wandered?

0. **Behavior not exhibited** → Skip to E1100, Change in Behavioral or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

E1000. Wandering - Impact

Enter Code ☐

A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?

0. **No**
1. **Yes**

Enter Code ☐

B. Does the wandering significantly intrude on the privacy or activities of others?

0. **No**
1. **Yes**

E1100. Change in Behavior or Other Symptoms

Consider all of the symptoms assessed in items E0100 through E1000

Enter Code ☐

How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or Scheduled PPS)?**

0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior MDS assessment

Appendix B

STAR-VA ABC Card

STAR-VA ABC CARD – Assessment

Date: BC ID: Veteran ID:

A Activator

What happened just before B?

B Behavior

What was the resident doing?

Who was present?

Where was this happening?

When was this happening?

C Consequence

What happened just after B?

Please Rate Behavior (check correct box):

Severity: 4 = Extreme 3 = Very 2 = Moderate 1 = Mild 0 = Not at all

☐4 ☐3 ☐2 ☐1 ☐0

Frequency: 4 = Daily 3 = 3-6/wk 2 = 1-2/wk 1 = Not in past wk 0 = Never

☐4 ☐3 ☐2 ☐1 ☐0

STAR-VA ABC CARD – GET ACTIVE

A Activator

Change the A.

How will you change your approach?

How will you change the environment?

B Behavior

Change the B.

What is the desired GOAL behavior?

C Consequence

Change the C.

What will you do when that happens?

What will you do if that does not happen?

Who else needs to be involved?

What is the pleasant event(s) identified?

Appendix C

STAR-VA Case Summary Form

STAR-VA Case Summary Form

BC ID _____ Veteran ID _____ Case Ending Date _____

Complete this form for each Veteran as part of closing up the case. You may enter this information at the on-line portal at the SharePoint site (link sent separately) and save the document there so that your Training Consultant may review it. Please enter this information no more than one week following completion of the case.

ABC Card

1. Can you briefly describe the target behavior for this case, including the four W's (e.g., "Veteran pushes nursing assistant away when approached to get dressed at 7:00 am in his bedroom"):

2. In what category would you place this behavior? (please select only one primary target)
   a. Verbal Non-Aggressive (verbal refusal, repetitive vocalizations, negative statements) ☐
   b. Verbal Aggressive (cursing, yelling, verbal threats, verbal sexual advances) ☐
   c. Physical Non-Aggressive (repetitive movements, pacing, problematic wandering, inappropriate eating, un/dressing, restlessness) ☐
   d. Physical Aggressive (hitting, pushing, grabbing, biting, spitting, throwing, tearing) ☐
   e. Behavior Deficit (declining an ADL, inactivity, isolation, refusing treatment) ☐

3. In addition to the required baseline clinical assessments, on average how much time have you spent each week observing or interacting directly with the Veteran to aid in the ABC assessment or developing/facilitating the Get Active plan?

Not at all	A little (1-15 min)	Somewhat (15-30 min)	A good amount (30-60 minutes)	A great deal (> one hour)
☐0	☐1	☐2	☐3	☐4

Comments: _____

4. Over the course of this case, to what extent did you work with and engage Staff Partners in developing and implementing a Get Active! Plan to address the targeted challenging behavior?

Not at all ☐0 Somewhat (1-4 times) ☐1 A great deal (5 or more times) ☐2

→ 4b. Which Staff Partners? (Check all that apply)

Nurse Champion	☐	MD	☐
Nurse Manager	☐	NP, PA	☐
Floor nurses	☐	Chaplain	☐
Nursing aids	☐	PT, OT	☐
SW	☐	Family	☐
RT	☐	Other	☐ Describe: _____

Go to 4d

STAR-VA Case Summary Form

BC ID _____ Veteran ID _____ Case Ending Date _____

4c. How did you coordinate implementation of the Get Active! Plan with Staff Partners? (Check all that apply)

- ☐ Individual meetings with staff partners
- ☐ Team meetings → Nature of meeting → Informational ☐; Problem-solving ☐; Care planning ☐; Other _____ ☐
- ☐ Modeling/demonstration
- ☐ Nurse Champion facilitated
- ☐ Tracking tool to document implementation
- ☐ Other _____

4d. Why not? _____

Staff Training

5. To what extent have you worked with staff to provide formal or informal training/modeling on any of the following STAR-VA clinical skills during the course of this case?

Not at all ☐0 Somewhat (1-4 times) ☐1 A great deal (5 or more times) ☐2

→ 5b. If yes, check all that apply.

- Identify desired goal behavior ☐
- Realistic Expectations ☐
- Used improved communication (verbal, nonverbal) ☐
- Encouraged pleasant events ☐
- Modified environmental activators/consequences ☐
- Modified interpersonal activators/consequences ☐
- Modified medical activators/consequences ☐

Go to 5e

If yes, 5c. Which Staff Partners? (Check all that apply)

Nurse Champion	☐	MD	☐
Nurse Manager	☐	NP, PA	☐
Floor nurses	☐	Chaplain	☐
Nursing aids	☐	PT, OT	☐
SW	☐	Family	☐
RT	☐	Leadership	☐
Staff Educator	☐	Other ☐	Describe: _____

5d. How did you provide training to Staff Partners? (Check all that apply)

- ☐ Individual training
- ☐ Group training
- ☐ Modeling/demonstration
- ☐ Nurse Champion facilitated
- ☐ Other _____

5e. Why not? _____

STAR-VA Case Summary Form

BC ID _____ Veteran ID _____ Case Ending Date _____

Evaluation

6. Rate the targeted challenging behavior as compared to the start of the case.

Much worse	Somewhat worse	The same	Somewhat better	Much better
☐1	☐2	☐3	☐4	☐5

7. Do you think the STAR-VA clinical skills have been helpful to you during this case?
No ☐ 0 Yes ☐ 1 → 7b. In what way have they been helpful?

7c. Can you explain why not?

7d. Which specific STAR-VA clinical skills did you find most helpful in achieving success with this case? (Rank the top 3)

- ABC Card – identify an objective target challenging behavior ☐
- ABC Card – identify the four Ws ☐
- ABC Card – identify the activators ☐
- ABC Card – identify the consequences ☐
- ABC Card – rated frequency & severity of behavior ☐
- Identify desired goal behavior ☐
- Realistic Expectations ☐
- Used improved communication (verbal, nonverbal) ☐
- Encouraged pleasant events ☐
- Modified environmental activators/consequences ☐
- Modified interpersonal activators/consequences ☐
- Modified medical activators/consequences ☐
- Other: _____ ☐

8. Any other feedback/observations you'd like to share about your team's work with this case?

Appendix C
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