CHANGED BEHAVIOUR IN DEMENTIA

Training workbook

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Independent, not-for-profit and evidence based, NPS MedicineWise enables better decisions about medicines and medical tests.

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Acknowledgments

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- HALT team
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WHAT IS THIS PROGRAM ABOUT?

Why are we doing this?

As you know, people with dementia can exhibit changed behaviours, such as wandering, aggression, restlessness, socially inappropriate behaviour and a range of others. We will be using the terminology 'changed behaviours' in line with peak bodies who work in the area of dementia education and training.

Antipsychotic and benzodiazepine medicines (which fall under the umbrella of psychotropics) are often prescribed for people with dementia to manage these changed behaviours. In some instances, these medicines are used as chemical restraint, due to their ability to 'dampen' behaviours through sedation. The use of antipsychotics and benzodiazepines occurs despite only modest efficacy for certain behaviours. In addition to limited efficacy, there is also increased risk of side effects, including cognitive decline, stroke and death.

NPS MedicineWise has developed an education and support program focused on the quality use of medicines for changed behaviour that targets aged care facilities, general practice and consumers/carers directly. Our program, entitled *Dementia and changed behaviours: A person-centred approach,* aims to reduce unnecessary use of antipsychotics and benzodiazepines in dementia, and to improve use of non-pharmacological management techniques to ensure consumer/residents are adequately supported.

The evaluation of this program will look at how this has occurred, whether the use of antipsychotics and benzodiazepines was reduced, and whether other areas improved, such as increases in knowledge, skills and confidence in each of our audiences.

What are we doing with aged care facilities?

As part of the broader NPS MedicineWise program, a specific activity targeted at the barriers and needs of aged care facilities has been developed.

Based on the learnings from two successful studies aimed at reducing the use of antipsychotics, the University of Tasmania's Reducing Use of Sedatives (RedUSe) project and the University of New South Wales' Halting Antipsychotic use in Long Term care (HALT) study, NPS MedicineWise has developed an educational and support activity that is offered to residential aged care facilities (RACFs). The activity aims to:

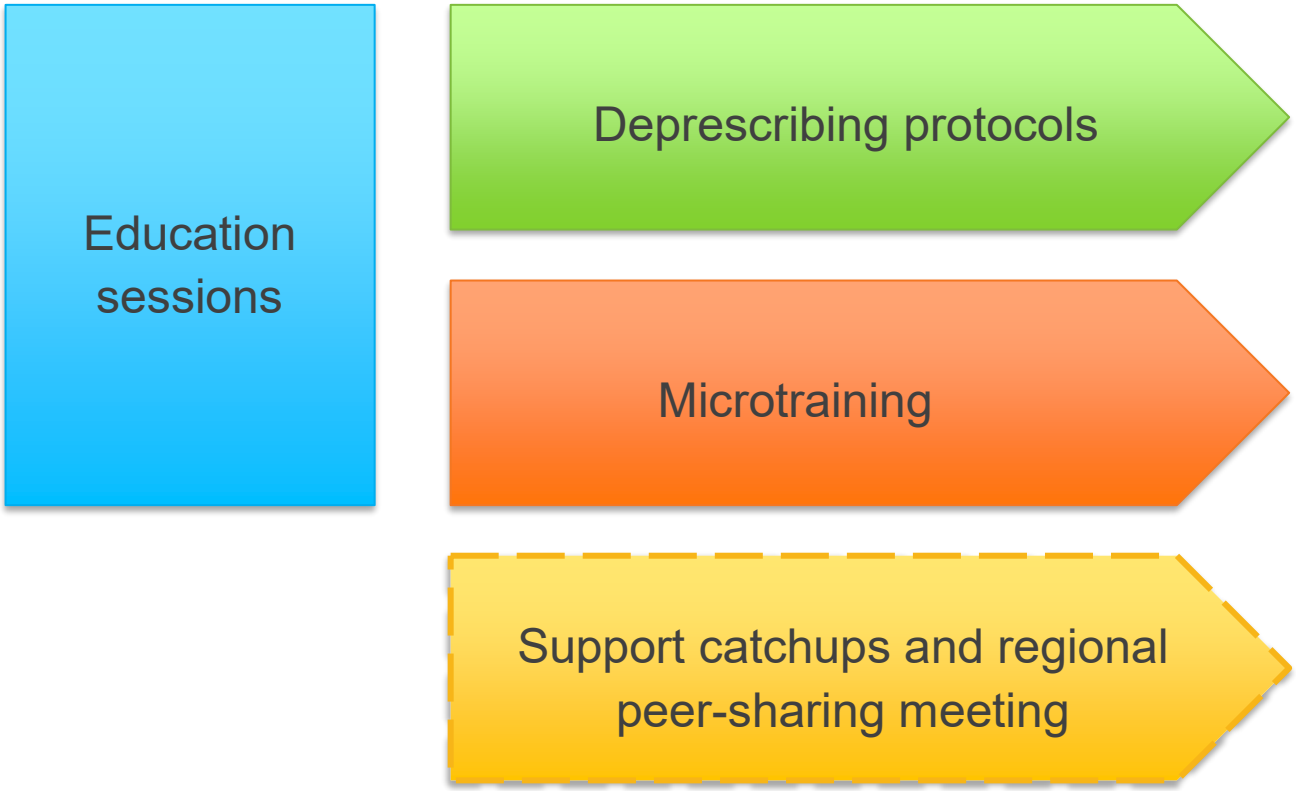
- improve understanding of how to use person-centred approaches for the management of changed behaviours
- increase knowledge of when to use antipsychotics or benzodiazepines in the management of consumers/residents with changed behaviours
- use existing systems in your RACF for the management of consumers/residents with dementia to identify areas to reduce the risk of harm
- identify opportunities to implement peer-to-peer learning within your RACF.

The program is underpinned by strong partnerships with other organisations already working in this area, ensuring that the education is fit for purpose and considers all the barriers of working in the aged care space.

The activity itself involves:

- Online and face-to-face training that encompasses a range of issues including highlighting where medicines are (or are not) appropriate, identifying a range of non-pharmacological management strategies that can be used in place of medicines, education in how to practically review and taper, and how to deliver feedback and microtraining to your peers in the facility.

- Once training is complete, nurses and pharmacists are then asked to use their new skills in microtraining and tapering, within their facility, to educate others and provide best practice examples of how to work with residents who have changed behaviours.
- Over the next six months, your NPS MedicineWise educational visitor will also provide monthly support calls at a time convenient to each facility, in order to share learnings from other facilities to help overcome barriers.
- Along with the support calls, a regional peer meeting will be held. At this meeting, all participating nurses and pharmacists from your region will be invited to connect, share their learnings, and develop a regional network of support.



Champion nurses and pharmacists

Your facility has agreed for you to participate in this program in order to focus on best practice care in the management of changed behaviours for people with dementia. This is a wonderful step by your management to support you in making small but meaningful changes that will improve the quality of life of your residents.

As part of the program, champion nurses will:

- work with other staff in the facility to model best practice care
- look for opportunities to create continuous review cycles for residents on antipsychotic and benzodiazepines
- look for opportunities to review individual residents' use of antipsychotics and benzodiazepines
- promote attendance at, and conduct microtraining sessions
- proactively provide positive and constructive feedback to staff on the best practice use of antipsychotics and benzodiazepines and non-pharmacological management
- where possible, inform attendant GPs or other medical staff of the program, and seek to involve them actively in review.

As part of the program, champion pharmacists will:

- work with other staff in the facility to model best practice care
- look for opportunities to create continuous review cycles for residents on antipsychotics and benzodiazepines
- look for opportunities to review individual residents' use of antipsychotics and benzodiazepines
- where possible, inform attendant GPs or other medical staff of the program, and seek to involve them actively in review.

Based on the description above, what would you like to get out of participating in this activity?

For further information

For further information on the *Dementia and changed behaviours: A person-centred approach* program, you can go to the program materials at https://www.nps.org.au/professionals/antipsychotic-medicines

ONLINE TUTORIAL

This is an online tutorial delivered by Professor Lynn Chenoweth from the Centre for Healthy Brain Ageing at the University of New South Wales. Lynn is a nurse who has extensive experience in delivering training on person-centred care and actively contributes to aged care nursing education.

The tutorial will discuss the theories behind changed behaviours, presents possible models that can be used to assess changed behaviours and provide practical examples of techniques and strategies for managing changed behaviours using case scenarios. The online tutorial is approximately 3 hours in length and allows time for concept-checking and personal reflection.

Pre-reading and activity

Before commencing the online tutorial, we ask that you:

1. Complete P-CAT questionnaire – a self-report tool that helps participants to identify understanding of person-centred practices and their application in practice.
2. Read 'Basic rights of persons with dementia' (Bradford University PCC manual 2.6)
3. Read 'Key principles of person-centred care' (Alzheimer's Australia NSW)

Outline of online tutorial

You can access the online tutorial through details provided by your educational visitor from NPS MedicineWise.

Introduction to session

In this introduction, Lynn will introduce herself and tell you a bit about her nursing background and experience with person-centred care training and research. She will also run through the objectives of the session and the resources she will refer to.

There will also be an opportunity to reflect on your response to the P-CAT questionnaire and how these correspond with the person-centred care principles and basic rights of persons with dementia.

Personhood – the basis for person-centred care

This will lead you through a discussion about 'personhood' and what this entails for those with dementia. This will be exemplified through two short video clips of person-centred and non-person-centred care and communication.

Lynn will also invite you to consider the different approaches in caring for these residents and the outcomes arising.

Person-centred communication

This includes the basic principles of communication, and vocal communication requirements, with examples in real world scenarios.

Changed behaviour in dementia

This session includes a reflection on reasons for changed behaviour in persons with dementia and demonstrates how these relate to brain changes.

After this, there will be some time for applying knowledge through two scenarios (Veronica and Michael). Consider how they may interpret real world situations differently because of their dementia.

Understanding triggers for changed behaviour

This is a hands-on session that will provide an opportunity to apply your knowledge through two scenarios (Mrs Smith and Mrs Osbourne). This will help you understand messages that people with dementia may be trying to convey through their behaviour, and how this relates to key theories (eg, Kitwood's theory of reasons for changed behaviour in dementia).

Person-centred responses to changed behaviour

This item will provide an outline of key person-centred principles when responding to changed behaviours, and how staff can provide person-centred care for a person with changed behaviour through their communication responses.

Person-centred responses to aggression incidents

Aggression incidents can be common in dementia-related changed behaviour. This session uses two scenarios (Kate and Bernard) to exemplify why residents may behave in this way, including staff (non)actions. This session then provides an explanation of the 'ABC' approach to understanding aggression incidents, using a further case study (Valerie). It also provides a reflection on questions to ask after an aggressive incident.

Person-centred approaches to resistance in care

This session takes some common facility scenarios, such as resistance getting dressed, and considers possible approaches to dealing with forms of resistance. The session then considers the concept of 'contextual cueing' and how this approach can help to understand and overcome resistance.

Using knowledge of individual and identity and needs to plan person-centred care

This session uses two care plans as examples for how to convey information in plans for people with dementia and changed behaviour. This outlines the importance of focusing on the person's strengths in planning their care. This session will also touch on the TOP-5 care planning tool and questions to ask family/ carers/ friends when seeking information about the person's individual identity and needs in preparation for care planning

Reinforcing person-centred care requirements

This concluding session will recap the person-centred care principles and their purpose of supporting personhood, particularly the importance of person-centred communication, using information provided by family/carers in planning and delivering care, and investigating and responding to changed behaviours.

FACE-TO-FACE TRAINING

This section of the workbook outlines the pre-reading and a number of sections that you will follow along with during the face-to-face session.

The face-to-face training component will cover a range of areas.

- Common presentations that may mimic changed behaviours in dementia.
- Medicines and their limited role in changed behaviour.
- How to review medicines for people who exhibit changed behaviours, and the practical ways to deprescribe antipsychotics and benzodiazepines.
- The multidisciplinary team and how it contributes to safe management of changed behaviours.
- How to deliver microtraining, and what to look out for.

Pre-reading and activity

Before the face-to-face training today, you should have:

- completed P-CAT questionnaire – a self-report tool that helps to identify understanding of person-centred practices and application in practice
- read ‘Basic rights of persons with dementia’ (Bradford University PCC manual 2.6)
- read ‘Key principles of person-centred care’ (Alzheimer’s Australia NSW)
- completed the person-centred care online tutorial as delivered by Prof Lynn Chenoweth
- reviewed the handouts provided in Appendix B of the workbook.

What new things did you learn from the pre-reading and activity? Try to outline three learnings.

Medicines and their role in changed behaviour

There are three quality use of medicine principles.

1. Only use a medicine where necessary.
2. If necessary, use the right medicine.
3. Use the medicine safely and effectively by using the right dose and monitoring over time.

These are particularly relevant when thinking about the management of changed behaviours among people with dementia.

In this section we're going to talk about the role that medicines play – and do not play – in changed behaviours. We will discuss how consumer/residents present and what the causes might be (beyond dementia), the specific role of antipsychotics and benzodiazepines and how this impacts the care of the person with dementia.

What can cause changed behaviour in people with dementia?

Changes in behaviour of people with dementia are not always solely because of their dementia. There can be other reasons for the behaviour – the person may be in pain, be dehydrated or have an infection. These changes in behaviour are ways to express that something is wrong that needs to be addressed.

A structured approach to the assessment of changed behaviours can help you better understand the person, their behaviours and potential triggers. As part of the comprehensive assessment, it is important to consider clinical, environmental and psychosocial factors and medicines that can contribute to changed behaviours. Examples of these factors are outlined in Box 1 on the next page.

After taking a history, a full clinical examination will help determine the possible underlying cause of the changed behaviour.[2, 3] This examination should ideally include: a mental state exam, a review of medicines, observations (including vital signs) and other charts (eg, bowel or fluid). Depending on the clinical findings, investigations such as blood tests may be warranted.[2]

If you are keen on further information on what is changed behaviour and assessing the underlying causes of behaviour, please go to the Dementia Training Australia course 'Understanding responsive behaviours'. It provides a good overview of the different aspects of managing changed behaviours in people with dementia.

- Module 1 'Frameworks and models for understanding' has a number of useful frameworks to help you with assessing changed behaviours.
- Module 2 'The assessment process' provides detailed information on how to undertake an assessment for changed behaviours and provides a case scenario on how this occurs in a real-life setting.
- Modules 3 'Early intervention', 'Implementing person-centred care', 'Interventions' illustrate the importance of planning for interventions, putting the person at the centre of the intervention and provides a case scenario to illustrate how this can be implemented clinically.
- Modules 4 'Evaluating effectiveness' 'Agitation', 'Case Study Part 1 and Part 2' provide useful practical applications of assessing, planning and implementing interventions in changed behaviours.

Please note that these modules are not required readings, just general information if you would like to explore further information and education in this area.

Box 1: Examples of clinical factors and medicines that may contribute to changed behaviours

Clinical factors[2]

- Delirium: delirium is an acute confused state (while dementia is considered as a chronic confused state). These two conditions can occur simultaneously, and dementia is a risk factor for delirium. Delirium usually comes on quite suddenly (over hours or days) and it is characterised by inattention and a fluctuating level of consciousness. Causes of delirium vary and may include drug toxicity, trauma and more.
- Pain: Pain may be unrecognised in people with dementia, which can lead to inadequate pain management. Poorly controlled pain can contribute to sleep disturbances, depression, agitation and slow recovery after surgery. The person may not be able to communicate accurately that they are experiencing pain and may express it using non-specific and/or non-verbal changed behaviours, such as vocal disruptions. Pain may be nociceptive or neuropathic arising from a variety of causes.
- Physical illness (including infection).
- Constipation and faecal impaction.
- Dehydration, hunger and malnutrition.
- Urinary retention.
- Sensory issues (impaired vision and hearing).
- Communication difficulties: People with dementia may have trouble communicating with others. A person with dementia may have adequate verbal skills but be unable to relay information reliably, or they may have issues with expressing or understanding information (expressive or receptive language disturbance). Common reasons for communication difficulties include sensory issues, disturbances in language, and can also tie into environmental factors (eg, excessive background noise).

Medicines[2]

- Anticholinergic medicines (eg, tricyclic antidepressants, oxybutynin, benztropine, olanzapine, chlorpromazine, antihistamines).
- Opioids.
- Anaesthetics: pethidine appears to have a higher risk of delirium due to accumulation in impaired renal function.[4]
- Benzodiazepines: higher doses and benzodiazepines with a longer duration of action have a higher risk of inducing delirium.[4]

Environmental factors

- Loud and/or sudden noises.
- Clutter.
- Lighting (or lack of).
- Mirrors.
- Temperature extremes.
- Unfamiliar environment and/or people.
- Reminders of past institutionalisation.

Psychosocial factors

- Changes to normal routine.
- New carers/staff members.
- Family or friends absent or changes in availability.[5]

Antipsychotics and benzodiazepines in dementia related changed behaviour

We're not going to demonise the use of antipsychotic and benzodiazepines, as there are instances when non-medicine options are trialled and fail when medicines may be required. However, there are also instances where risk outweighs ongoing benefit.

It is important to remember that:

- antipsychotics and benzodiazepines have a limited role in management of changed behaviours[2]
- international data suggests that only 20% of people experiencing changed behaviours from dementia benefit from antipsychotic treatment[6]
- antipsychotics and benzodiazepines have serious safety risks.[2]

Indications for antipsychotic medicines may include:

- when there is a complex and severe risk of harm to the patient or others[7]
- when symptoms are unresponsive to non-pharmacological strategies[8]
- when there are comorbid pre-existing mental health conditions[8]
- symptoms are psychotic in nature (delusions and hallucinations)[8] or
- the person has severe agitation and aggression that may present a risk of harm.[8]

There is increasing literature on which behaviours respond well and poorly to antipsychotics. Table 2 clearly lists those behaviours that may respond, versus those that are unlikely to respond to antipsychotics. However, remember – even in those behaviours that respond to medicine, the literature suggests this response will only occur 20% of the time.

Behaviours that may respond	Behaviours that respond poorly
Hallucinations	Apathy
Delusions	Low mood
Persistent angry, anxious or aggressive states	Inappropriate toileting
	Inappropriate sexualised behaviour
	Wandering
	Calling out

Table 1. Behaviours and their likely response to antipsychotic medicines.[9-11]

Gaining consent before prescribing any psychotropic medicine is important. There is more on consent later, but to note now the Aged Care and Quality Commission has published information and a number of useful tools on its website that discuss consent and decision-making in relation to changed behaviours.

- Six steps for safe prescribing antipsychotics and benzodiazepines in residential aged care - https://www.agedcarequality.gov.au/resources/six-steps-safe-prescribing-antipsychotics-and-benzodiazepines-residential-aged-care
- Decision-making tool: Supporting a restraint free environment in residential aged care – https://www.agedcarequality.gov.au/sites/default/files/media/Decision-Making%20Tool%20-%20Supporting%20a%20restraint-free%20environment.pdf

  Consent issues (page 22–24) and chemical restraint (page 24–27).

Safety and antipsychotics and benzodiazepines

In addition to the likely response to antipsychotic and benzodiazepine use, it is also important to consider how the use of medicines can play a role in safety and the overall quality of life of residents.

There are benefits of not prescribing (or deprescribing) antipsychotics and benzodiazepines. As people age, their goals of therapy change from extending their life expectancy to improving their quality of life. For this reason, we want to ensure that we do not increase their risk of harm through continued use of a medicine that may no longer be indicated. By reducing the use of antipsychotics, we are decreasing:

- risk of falls and fractures
- sedation, somnolence and confusion
- drug interactions.

And ultimately by not using antipsychotics (and psychotropic medicines more broadly) we are contributing to improvements in the quality of life for people.

Antipsychotics that are commonly used to manage changed behaviours in a person with dementia[2, 9, 12]

It is important to note that risperidone is the only antipsychotic medicine that has Therapeutic Goods Administration (TGA) approval and is listed on the Pharmaceutical Benefits Scheme (PBS) for behaviour disturbances in people with Alzheimer disease.[9, 13] It is not indicated for use in people with vascular or mixed dementias due to higher risk of cerebrovascular events.[14]

	Medicine Dosing and titration	Considerations for older people	Monitoring
TGA approved and PBS listed	**Risperidone*** Start with a dose of 0.25 mg twice daily. Increase by 0.25 mg every ≥ 2 days as needed, up to a maximum of 2 mg daily.[9]	While risperidone has the strongest evidence for its effectiveness in managing changed behaviours overall,[8] there is modest evidence for the use of risperidone 0.5–2 mg daily for treating aggression on its own.[2] There is only limited evidence of benefit for other agitated behaviours.[2]	Review behaviours and adverse effects weekly in the early treatment phase. Adverse effects to monitor include sedation, postural hypotension, extrapyramidal symptoms and anticholinergic effects.[9] Discontinue antipsychotic if no improvement seen within a relatively short timeframe (usually 1–2 weeks).[5] Review the need for ongoing antipsychotic use every 4–12 weeks.[5]
No TGA approval or PBS listing	**Olanzapine** 2.5 mg daily Increase by 2.5 mg every ≥ 2 days as needed, up to a maximum of 10 mg daily in 1 or 2 divided doses[9]	Olanzapine and quetiapine are more sedating than risperidone, which may be more sedating than aripiprazole.[12] Both quetiapine and olanzapine have anticholinergic adverse effects, particularly olanzapine, which may worsen confusion.[2, 12] Both quetiapine and olanzapine cause weight gain, and it may be significant with olanzapine.[12] In Lewy body dementia, antipsychotics (even low doses) can cause deterioration in cognitive and motor function and increase agitation.	
	Quetiapine[2, 5] For dosing, seek specialist advice.[10]		

	Medicine Dosing and titration	Considerations for older people	Monitoring
	Aripiprazole[2] For dosing, seek specialist advice.[10]	However, low-dose quetiapine is sometimes prescribed as it has a lower potential for extrapyramidal side effects.[12] Aripiprazole may be less likely to increase the QT interval compared to other antipsychotics.[12]	

* Risperidone is PBS-listed for aggression AND psychotic symptoms. See the PBS website for more information.

Benzodiazepines that are commonly used to manage changed behaviours in a person with dementia

Medicine dosing and titration	TGA-approved indication	Considerations for older people
Oxazepam 7.5 mg 1–3 times daily[3] Half-life of 6–12 hours[4]	Short-term relief of severe anxiety and agitation[3]	Limit use to 2 weeks.[3] Benzodiazepines may cause: • worsening cognition in dementia[8] • rebound insomnia[5] • increase in the risk of falls and associated injury.[3]
Temazepam 5–10 mg at night[4] Half-life of 6–12 hours[4]	Short-term treatment of insomnia[4]	
Lorazepam 0.5–1 mg daily[5] Half-life of 12–24 hours[4]	Short-term management of agitation[5]	

Consent and medicines

We've included this section on consent because we simply can't talk about medicines without talking about consent and how this is obtained within RACFs.

The Aged Care Quality and Safety Commission has stated that obtaining informed consent is essential.[15] It is best practice to obtain and document informed consent from the consumer/resident or substitute decision-maker, before prescribing of a psychotropic medicine.[2]

Consent for prescription and administration of medicines, including who may give consent and in what circumstances, is governed by State and Territory laws. These laws differ between jurisdictions. Prescribers and people who administer medicines should be aware of their local legislative requirements.[16]

It should not be assumed that all people with dementia lack capacity. A person with dementia may have the capacity to make simple decisions, but not more complex decisions. The clinician should assess the person's ability to provide informed consent.[2]

The process of obtaining consent should start with a discussion about the possible benefits and risks of treatment with the person or their substitute decision-maker. It is important to then check that this information is understood by the person/substitute decision-maker. When psychotropics are prescribed in the case of an emergency, informed consent can be obtained as soon as is practical, if treatment is to be continued.[8]

A barrier to seeking consent may be lack of awareness of who can provide consent. In non-urgent situations, where the person may not be able to provide consent to treatment, the *Guardianship Act 1987* states that consent must be given by a 'person responsible'.[2]

In order of hierarchy (from the *Guardianship Act 1987*):[2]

1. guardian (including enduring guardian) who can consent to medical treatments
2. most recent spouse or de facto spouse including same sex partner with whom the person has a continuing relationship
3. unpaid carer who provides support or provided support before the person entered into residential aged care
4. a relative or friend (unpaid) with a close personal relationship and a personal interest in the welfare of the person

Provider responsibilities and chemical restraint – the Quality of Care Principles

We've included this section on chemical restraint with regards to provider and prescriber responsibilities as a reminder of the Quality of Care Principles legislation - https://www.legislation.gov.au/Details/F2020C00096

The legislation states that an approved provider must not use a chemical restraint unless:

- a medical or nurse practitioner has assessed the consumer/resident as requiring one and has prescribed the medicine
- the practitioner's decision to use the restraint has been recorded in accordance with the Aged Care Quality Standards set out in Standard 2 (in the care and services plan)
- the consumer's (resident's) representative is informed before the restraint is used if it is practicable to do so.

The legislation also states that if an approved provider uses a chemical restraint, the provider must:

- inform the consumer's (resident's) representative as soon as practicable after the restraint starts to be used (if the consumer's presentative has not been informed of the use of the restraint)
- ensure the care and services plan is documented in accordance with the Aged Care Quality Standards set out in Standard 2 identifying the following:
    - behaviours that are relevant for the need of the restraint
    - alternatives to restraint that have been used
    - reasons the restraint is necessary
    - information provided that informed the decision to prescribe the medicine
- monitor the consumer regularly for signs of distress or harm and provide information to the practitioner while the consumer is subject to the restraint.

For detailed information, please see the Federal Register of Legislation F2020C00096, Part 4A *Physical and chemical restraint to be used only as a last resort.*

What new things did you learn from this section? Try to outline three learnings.

What are some opportunities to change psychotropic use at your facility?

Reviewing medicines for people with changed behaviours

In this section, we talk about the importance of routinely reviewing and monitoring for improvement in symptoms/behaviour and for adverse effects, if antipsychotics and/or benzodiazepines are being used. These medicines have serious harms associated with their use; therefore, they should be regularly reviewed to determine their continued need and if no longer required, they should be tapered with the aim of stopping.

Review what happens at the facility level and at the resident level

When considering review of antipsychotics and benzodiazepines, it is important to think how you do this at an individual level, but also how you do this across all your facility's residents. At a facility level you should consider these aspects.

- **Who** will benefit from review – using your facility's data, you can review your residents to understand who may benefit from psychotropic review. Keeping in mind that this is a cyclical process, try to identify a range of residents (eg, don't put all of your complex consumer/residents in one review cycle!).
- **When** you will review them – depending on your rosters or other staffing considerations, identify an appropriate way to commence reviews. You might stagger this, or develop another way to best commence review to make it achievable for your facility.
- **How** you will review them – ascertain the history of each of your residents for review and ensure any tapering and/or cessation is done safely. Looking at each resident's history will also tell you a lot about them as a person, non-pharmacological strategies to use and how you might work with them during the review cycle.

What is the review process for antipsychotics and benzodiazepines at your facility?

Your facility's pharmacy provider may have a software system that enables your facility to receive reporting data on psychotropic medicines prescribed to the residents. Examples of pharmacy reporting systems include WebsterCare, MPS or Best Health Solutions (see Table 2 below).

Provider	Psychotropic specific reports	Features	Further information
WebsterCare	Yes	• Regular reporting cycles • Incorporates evidence-based recommendations on prescribing of medicines for residents • Includes information on residents using antipsychotics for all conditions	https://www.webstercare.com.au/reports/

MPS	Yes	• Regular reporting cycles
		• Counts of residents being prescribed antipsychotics
		  • As required vs continuous antipsychotics
		  • Atypical vs typical vs other antipsychotics
			http://mpsconnect.com.au/

Best Health Solutions	Yes	• Regular reporting cycles	http://besthealthsolutions.com.au/index.html

Table 2. Examples of pharmacy reporting systems that can be used to help review residents at your facility

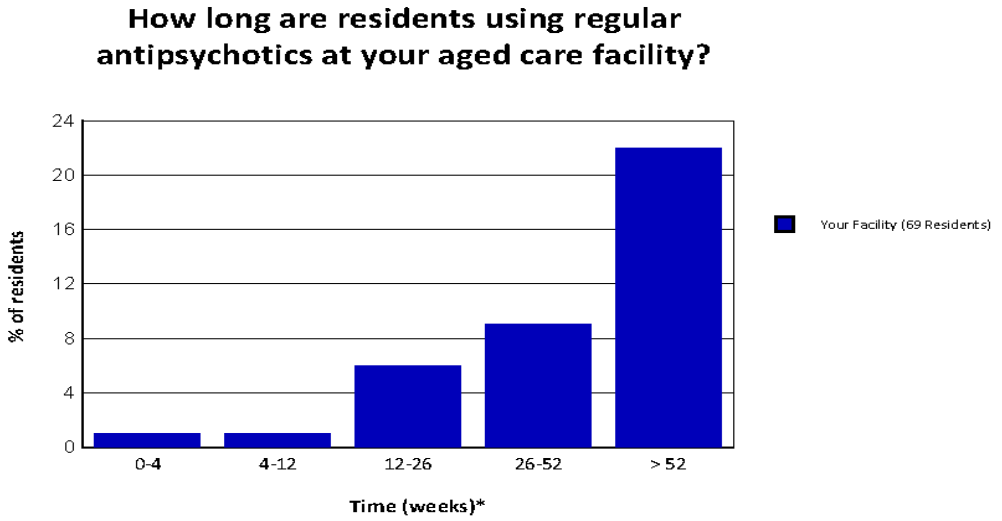
Reports can provide the facility with objective data between current practice and target performance actioned by the individual facility:

Examples of data reporting that can be used for the purpose of measuring your facility's performance against the national facility average include:

- percentage of residents at the facility prescribed any antipsychotic over time.
- percentage of residents at the facility prescribed an antipsychotic either regularly, as needed 'prn' only use, or both in 3 monthly time intervals
- percentage of residents at the facility prescribed an antipsychotic and a benzodiazepine
- consumer/resident lists showing the residents at the facility currently prescribed an antipsychotic either regularly, prn only or both.

Consumer/resident lists can identify consumer/residents for review of antipsychotic and/or benzodiazepine use. Where possible the condition for prescribing the medicine should be included.

A graph available from a WebsterCare report on antipsychotic use is shown below:



How does your pharmacy provider currently provide your facility with reports to review residents prescribed antipsychotics? If not, can your QUM pharmacist assist?

Are these reports provided continuously at regular review cycles?

What is the current process at your facility for reviewing this data?

How could data on psychotropic use at your facility be used more effectively?

How do you review, taper and cease antipsychotics?

The process of initiating, reviewing and ceasing medicines can be seen in Figure 1 below.

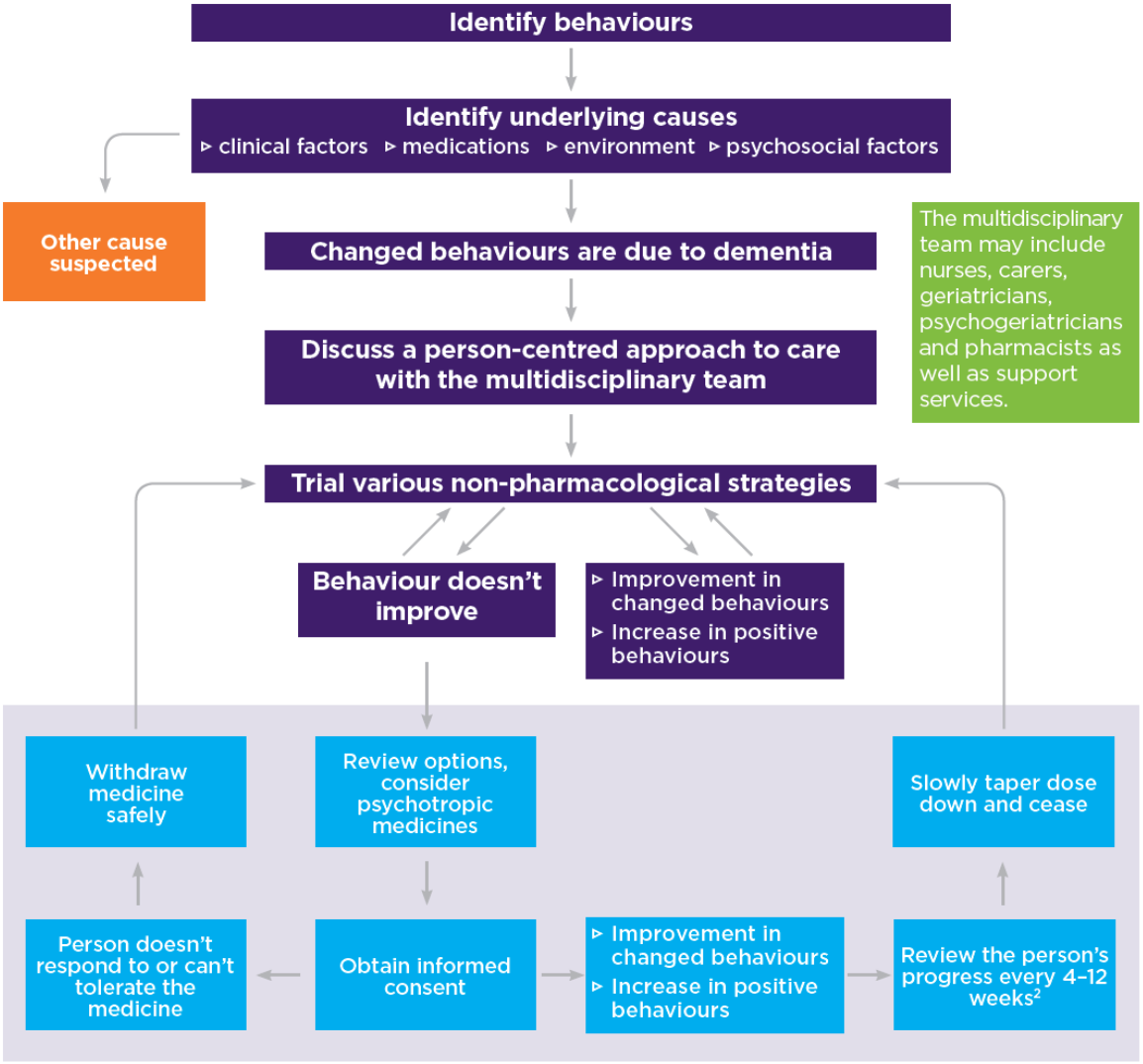


Figure 1. Management algorithm for changed behaviours among people with dementia.[2]

When antipsychotics are started for a person with dementia, a low dose should be used and increased slowly as necessary. In the early treatment phase, there should be at least weekly review of the target behaviour and adverse effects resulting from treatment (such as sedation, postural hypotension, extrapyramidal symptoms and anticholinergic effects).[9]

During review points, look to see if tapering is possible. At these points, consider:

- was the indication for the antipsychotic use correct, or might there be another underlying cause of the behaviour that may benefit from different treatment?
- the resident's response to the medicine (eg, an improvement in changed behaviours, an increase in positive behaviours, or nil change)
- side effects, drug interactions, poor tolerance or risk of adverse event
- the preference of the resident (eg, would they prefer not to take the medicine?)
- the resident's drug burden.

If there is an opportunity to taper, conduct this in a safe manner.

NPS MedicineWise has a deprescribing tool available at https://www.nps.org.au/assets/NPS1407b-Antipsych-Review-Checklist-v14-jg-281020-ACC.PDF, currently being promoted by the Society of Hospital Pharmacists Australia (SHPA), that can be used to follow the process of tapering and ceasing an antipsychotic medicine. When tapering it is important to consider the following:[1]

- decrease dose by 25% every 1–4 weeks
- continually monitor for:
  - withdrawal symptoms (Box 2)
  - recurrence of behaviours or new changed behaviours (Box 3)
  - benefits from tapering – improved alertness or gait, fewer falls
- use non-medicine alternatives when tapering
- continue to taper and cease if no worsening of symptoms
- slower tapering (12.5% of dose) when reducing to final lowest dose
- finish treatment 2 weeks after lowest dose
- consider alternate day dosing.

Box 2. Withdrawal symptoms (can occur within 1–3 days)[1]

These are usually mild, highly variable and can last for up to 6–8 weeks.

- irritability
- anxiety
- insomnia
- sweating.

If severe symptoms or behaviours emerge (as listed below) during dose reduction, the antipsychotic may need to be restarted at the lowest effective dose:

- dysphoria
- nightmares
- memory impairment
- hallucinations
- hypertension
- tachycardia
- psychosis
- tremors
- seizures
- profuse and persistent sweating
- severe anxiety
- severe insomnia.

Box 3. Recurrence of behaviours/appearance of new behaviours (may take one week or more to appear)[1]

Recurrence of previous behaviours or new behaviours may occur within 2 weeks of reducing the dose of antipsychotic.

New behaviours that may emerge:

- anxiety
- depression.

Further information

- Dementia Training Australia Deprescribing module – https://dta.com.au/online-courses/too-much-of-a-good-thing-fundamentals-of-deprescribing/
  This is a 30 minute free module that outlines the process of deprescribing. It is part of a wider course entitled ‘Too much of a good thing: fundamentals of deprescribing’.
- Dementia Training Australia Antipsychotic tracking tool - https://dta.com.au/resources/antipsychotic-tracking-tool/
  This is a free tool that can be used in aged care settings to generate audit reports to determine the use of antipsychotic medicines.
- Aged Care Quality and Safety Commission Self-assessment tool for recording consumers receiving psychotropic medications https://www.agedcarequality.gov.au/resources/self-assessment-tool-psychotropic-medications
  This tool aims to help aged care services to manage their use of psychotropic medicines.

Microtraining and feedback

Microtraining and feedback are the two ways in which you will be able to identify opportunities for change and pass along your knowledge.

Microtraining is pretty much what it sounds like: training provided at small scale. This can be used at shift handover, or in groups when discussing a resident.

Feedback is a more informal process, by which you can provide information in a safe and objective way to staff when you are working side-by-side during the shift.

What is microtraining?

Microtraining, also called microlearning, is a process of education that involves short, bite-sized pieces of information. This kind of training is becoming increasingly popular as an approach to learning for a number of reasons.

- The likelihood of retaining information is higher. A short 5-minute conversation is much easier to understand and digest the key point, than a full-day training session with a range of information.
- Delivery can be much more attuned to the learners' experience. This means that a trainer can identify an opportunity for learning as it occurs on the job and address it immediately. This alignment between learning and doing increases the chance of understanding.
- Delivery can be much more attuned to the resident's experience. Each resident has a unique set of circumstances that affects how their care should be delivered. Microtraining can help you discuss specific approaches that meet that person's needs.
- Microtraining is easier to deliver as a peer-to-peer method. Many people report enjoying learning from their peers, and some research suggests that people are more likely to action information when it comes from a peer (as opposed to a formal 'teacher').
- Our general approach to information consumption is becoming shorter and more targeted. Many people are used to this way of consuming information now, particularly in our busy world.

How do you do microtraining?

Microtraining is a structured flow of information that provides users with a shortened lesson format. You will find that once the RACF staff get used to the format it will flow more easily, as they will know the format works, and what is expected of them.

	Process	**Example**
Active start (0.5–1 minute)	Mental activity – ask a question to help people identify, reflect, organise thoughts, compare ideas about behaviour they have experienced when providing resident care. Communicate the goal of the session.	I have noticed a few residents are pretty tense lately. So today we are going to talk about decreasing arousal and aggression using touch. I would like you to think of the last time that you dealt with a situation that needed to be calmed, and how you dealt with that. Take a couple of seconds to just think about that situation.
Demonstration (2–4 minutes)	Use different teaching methods to connect with different learners where possible (eg, pictures, text, case studies).	This is one way that you could calm the resident if you are physically able to. You run the hand firmly up and down the back, following the spine from the base of

	Stimulate learning by presenting concrete examples of the lesson topic.	the neck to the hips in a rhythmic manner [demonstrate]. It is best to perform in a quiet environment if you are able. And again, best to do lying down, but you can do it with the resident sitting up. This sensory distribution of the back actually leads to a calming effect through the sympathetic chain of the autonomic nervous system. This will help the resident slow their breathing and release muscle tension. You can use this with a resident who you think is tense and is at risk of acting out, or to calm a resident down who has acted out.
Discussion (2–4 minutes)	Facilitate/ invite direct positive feedback on messages conveyed. Stimulate discussion and knowledge sharing among attendees on the topic.	It is a really simple process, with a biological rationale… but what do you think? Have you tried this before? [invite conversation]
Conclusion (0.5–1 minute)	Discuss how the knowledge can be retained (eg, through practice or other application). Stimulate involvement in change by asking attendees to formulate a clear goal for the week.	Okay, so I would like you to find the opportunity to try this at least three times over the next week. And by the way, tomorrow I will provide some microtraining on…

What things would you focus microtraining on?

There are a range of things that you might focus microtraining on. Below is a list of potential topics, based on the scope of the NPS MedicineWise program. Of course, selecting the topic for microtraining will depend on your facility and the interests and knowledge of your staff.

Throughout the next six months, when we check in through the support calls, we will ask you what microtraining you have found that really works. We will also provide examples of microtraining that your peers in other facilities have delivered, just in case you need some inspiration.

- Provide examples of alternate (underlying) reasons for changed behaviour. These might include microtraining on delirium, pain, urinary retention and others as outlined in Box 1 on page 13. Keep these very short, focused only on one issue and how you might tell the difference between dementia-related changed behaviours and this underlying cause.
- Changed behaviours that do and do not respond to psychotropic medicines.
- Using TOP5 to engage carers and individuals in their care.
- How to review, taper and cease antipsychotics, broken down into microsections, such as:
    - the review process (eg, the algorithm on page 22)
    - how to taper (page 23)
    - how to cease (page 23).
- Provide examples of communication or other strategies to help manage changed behaviours (eg, elements in Appendix B). Only cover one element at a time.

You may want to go through this workbook, the online content for the program (at https://www.nps.org.au/professionals/antipsychotic-medicines) and the information outlined in Appendix B to identify further topics for microtraining.

When might you do microtraining?

From the HALT study, and in our conversations with facilities to design this activity, the common suggested time that microtraining could be used is during handover points (shift or patient handover).

This time was identified because there is a collection of staff gathered together focused on issues faced with residents that day. This provides the opportunity to microtrain multiple staff at once, and – if pertinent – you can select a real-life situation with a resident to illustrate the point of your microtraining lesson.

What is feedback?

Feedback is a process of providing information to a person about their performance of a task. This information should be objective, performance-based, and can be positive (reinforcing feedback) or helpful (corrective feedback).

Many people don't feel comfortable giving feedback. And that is reasonable, as we can all recall a time when we received feedback that was poorly delivered. It has the power to make people feel diminished. But well delivered feedback – particularly reinforcing feedback – has the power to help people feel good, in control of their job and able to improve.

How do you deliver good feedback?

A popular feedback model is PCAR-AR, sometimes also called CAR. This is a structure that helps you deliver feedback that is relevant, timely and objective. Below is an outline of PCAR-AR, what it stands for and an example[1] to show how you might deliver it.

[1] The example has been reproduced with permission from Archibald C. *People with dementia in acute hospitals: A practice guide for registered nurses.* Scotland: Stirling University, Dementia Services Development Centre, 2003.

P	**Permission**	No one likes having feedback foisted on them unwillingly. So make sure you ask permission to provide feedback. "Can I give you some feedback?" If the person doesn't want feedback, leave them be. They may be having an awful day.
C	**Context**	Talk about what you have just observed. Provide the context of the action to ensure that the person you are giving feedback to understands your perception of the situation. "Mrs Jones was in hospital last week, and she has been discharged back after her surgery. She was having a cup of tea in the lounge this morning, and she seemed to be shouting for her mum."
A	**Action**	Outline the specific behaviour you are giving feedback on. "When this happened, I noticed that you said to Mrs Jones, 'Be quiet, your breakfast is coming.'"
R	**Result**	Describe what happened as a result of the action. Remember this can be reinforcing (do more of) or corrective (do less of). "Because that happened, Mrs Jones was very upset."
—	**(check-in)**	Seek a response from the person that you are giving the feedback to. This is important, because you may only have part of the story. It also shows respect that you would like to hear their perspective. Sometimes you can simply pause, or perhaps say, "How do you feel about that?"
A	**Alternative**	Offer an alternative approach to the situation. Also, if at the check-in they rejected your feedback, you may wish to account for their comments. "Because Mrs Jones had surgery, she is a bit muddled from the anaesthetic. She is probably quite disoriented and frightened. Often when people with dementia call out for their parents like that it is a sign they would like to feel safe and secure. Perhaps you could have asked Mrs Jones a bit about her mum, or if you didn't have time perhaps offered some comfort through a touch and a recognition that she misses her mum."
R	**Result**	Describe what would happen as a result of the alternative action. "Often it doesn't take much to acknowledge what someone with dementia is going through. That will help them calm down"

When might you provide feedback?

Feedback can be provided at any time you observe staff providing care that could be improved (corrective feedback) or providing care that is of high quality (reinforcing feedback).

During the HALT study and from feedback provided by facilities when designing this activity, it was identified that structured and helpful feedback was a good tool to use opportunistically as you go about your day.

Remember to ask permission before you offer the feedback. This gives the other party an opportunity to opt out if they are not in a frame of mind to receive feedback.

Let's practise!

This is the opportunity to practise!

What did you find easy about applying the microtraining format?

What did you find difficult?

How do you think you will apply it in your facility?

Working as part of a team

In this section we're going to discuss the importance of working as part of a team and how the person with dementia, family members and carers are a central part of this team.

People with dementia who are experiencing changed behaviours may require the expertise of various health professionals.[2] The multidisciplinary team may include GPs, nurses, staff working in RACFs, carers, family members, specialists, pharmacists and other allied health professionals.[3]

Health professionals should also involve the person, their family and carers to respond to their needs and preferences.[5]

What good examples of teamwork can you think of at your facility?

What doesn't work?

Additional information about involving the person, their family and carers in the care being delivered can be found in the TOP5 resource.

Further information

- The TOP5 resource encourages health professionals to incorporate the knowledge of carers and individuals to promote person-centred care. There is an RACF toolkit that provides a range of ideas for how to implement in facilities.
  http://cec.health.nsw.gov.au/__data/assets/pdf_file/0012/295977/TOP-5-Residential-Aged-Care-Facilities-Toolkit.pdf
- The Older Persons Advocacy Network (OPAN) have developed a booklet entitled Medication: It's your choice and an accompanying video entitled Medication: It's your choice, It's your right.
  https://opan.com.au/yourchoice/

Goal setting

Revisiting champion nurse and pharmacist roles

Refer back to pages 8 and 9 where the roles of the champion nurse and pharmacist are outlined.

Now you have completed this training, how do you think your role can help to create change?

Creating change

Part of creating change is to identify the barriers and enablers in your setting, and how you might work with them to positively influence staff.

What are the enablers in your facility? What works really well (in relation to changed behaviours) that you might use to your advantage?

When answering this, think about staff, carers, programs, processes and other enablers.

How would you use these enablers to your advantage? How might you amplify them?

What are the barriers in your facility? What doesn't work well (in relation to changed behaviours) that you might encounter?

When answering this, think about staff, carers, programs, processes and other enablers.

How would you overcome, or lessen, the barriers? Or if they are beyond your control, how would you deal with them?

Self-reflection

Based on the training, what have you learned? Consider your knowledge, skills or other insights.

Setting goals

Setting goals as a result of this training may seem like a waste of time, but there is evidence to suggest that setting goals in the right way creates a significantly higher likelihood of being able to follow through on intended behaviour.

For this activity, we will ask you to identify one personal goal (eg, read further on how to taper) and three facility goals that you will work on after the training is over. With the facility goals, we will ask you to agree those with any other staff that you are training with.

Please refer to the goal setting handout. This can also be seen in Appendix D.

APPENDIX A. AGENDA FOR FACE-TO-FACE TRAINING

Learning outcomes

1. Demonstrate understanding of which conditions/presentations it is appropriate to use psychotropic medicines for in people with dementia with changed behaviours.
2. Identify that the use of antipsychotics or benzodiazepines has a specific and short-term role in the management of patients with dementia with changed behaviours.
3. Review and monitor patients who are taking psychotropic medicines to assess the risk of harm and potential benefits of deprescribing.
4. Illustrate how you would use a person-centred approach to the management of changed behaviours.
5. Develop a management plan for patients using a person-centred approach, involving the multidisciplinary team, regarding non-pharmacological strategies to assist in improving behaviours.
6. Review systems in your residential aged care facility for the management of patients with dementia to identify areas for improvement and reduce the risk of harm.
7. Identify opportunities for peer-to-peer opportunistic learning.

Pre-reading and activity

Before the face-to-face training today you should have:

- Completed P-CAT questionnaire – a self-report tool that helps to identify understanding of person-centred practices and application in practice
- Read ‘Basic rights of persons with dementia’ (Bradford University PCC manual 2.6)
- Read ‘Key principles of person-centred care’ (Alzheimer’s Australia NSW)
- Completed the person-centred care online tutorial as delivered by Prof Lynn Chenoweth
- Reviewed the handouts provided in Appendix B of the workbook.

Agenda

Time	No.	Item	Workbook page
10 min	1	**Welcome and housekeeping**	
10 min	2	**Agenda and introductions** Who are you and what do you want to get out of today?	Appendix A
15 min	3	**What is the changed behaviour activity?**	7–8
50 mins	4	**Medicines and their role in changed behaviour** Presentation and discussion on medicines and their limited role in the management of changed behaviour	13–18
30 min	5	**Reviewing medicines in people with changed behaviour** What does 'reviewing' actually mean in practice?	20–25
30 mins		**Break**	
60 mins	6	**Microtraining and feedback** What is it, and how will it help me share my knowledge with my peers?	26–30
10 mins	7	**Working as part of team** Teamwork for managing people with dementia is so important, but so hard. How might we make it work?	31
20 mins	8	**Goal setting and next steps**	32–33
5 mins		**Close**	

APPENDIX B. CHANGED BEHAVIOUR MANAGEMENT TECHNIQUES

The following section provides a range of practical information to inform day-to-day care for people with dementia. The information provided can be broken down into the following areas:

1. conceptualising and responding to challenging behaviours
2. communication techniques and responding to unmet needs
3. understanding spatial perception and reflexes
4. interactions.

These appendices are a guide only. Of course don't forget to check these against your facility's specific policies or operating procedures.

Contextual communication[2]

In contextual communication, emphasis is placed on six verbal communication strategies (illustrated in the table).

1. Use the person's name first and tell the person who you are.
2. Identify key words in a care activity and repeat these.
3. Identify key emotive words in the care activity and repeat these.
4. Use non-word sounds to convey ideas.
5. Constant use of appropriate tone, pitch, volume and rate of speech.
6. Use short sentences and keep instructions simple by discussing one step of the care activity at a time.

Verbal communication	Non-verbal communication	Contextual tasking third party props
(1) Use the person's name first. 'Molly, hello. I'm Rachael, your nurse.' Happy tone, normal pitch and volume.	Rachael starts communication by positioning herself just out of reach giving Molly her personal space. Rachael makes eye contact, smiles, then approaches and touches Molly's hand/arm making physical non-threatening contact.	Adjusted lighting and room temperature. Background noise reduced. Prepared clothes and other items needed for care activity.
(2) Identify key words in a care activity and repeat these. 'Molly, I have your blue *shirt*, it's time to put on your *shirt*.' Use normal conversational tone, normal pitch and volume and emphasise key words.	Rachael makes eye contact with Molly, then turns her head and looks at the shirt or touches Molly's upper garment to convey the idea of dressing.	Hold up blue shirt so Molly can see the shirt.
(3) Identify key emotive words and repeat these 'Molly, it's time to put on a *warm* shirt and keep *warm*.' 'Molly it's cold today so here is a *warm* shirt.' 'Molly this will make you feel *warm*.'	Rachael gently rubs Molly's upper arm to convey warmth.	Let Molly touch the shirt. Touch Molly with the shirt, on her hand, arm or cheek of her face, or give Molly an item to hold during the care activity.
(4) Use non-word sounds to convey ideas 'Molly, it's cold today, *bbbrrrrrrrrr*.' Use normal conversational tone, normal pitch and volume and emphasise key emotion).	Rachael pretends to shiver.	

[2] Reproduced with permission: Grealy J, McMullen H, Grealy J. *Dementia care. A practical photographic guide*. Oxford: Blackwell Publishing, 2005; p. 57.

Calling out for mother[c]

Mrs Jones is sitting having a cup of tea – every few minutes she lifts her head and shouts "Gran", "Mum".

Why do you think this person is calling out for her mother and grandmother?

What would your response to Mrs Jones be?

It is easy to dismiss such conversation as 'irrational' and respond as the nurse does below:

Think WHY?

In a busy ward, an older patient calling out for their mother can seem quite bizarre. After all, her mother would be about 110 and her grandmother 130 years or so! Nevertheless, comments such as "your mother is dead" would have been very damaging for Mrs Jones.

Mrs Jones is in hospital and has had major surgery. Old memories and the concept of time were muddled – the past seemed like the present. Problems with new memories and ideas and her move to a strange and alien environment meant that she did not know where she was and why she was there. She felt lost, disoriented, alone, frightened and confused. She may have been suffering constant pain.

When people living with dementia call out for their parents it is often because of the association between parenting and being nurtured – feeling safe and secure. This tells us something very significant about how she was feeling at that time. It would have been worthwhile to ask Mrs Jones to tell you about her mum. Sometimes, the simple 'telling of the story' helps people to feel better and reassures them that somebody is interested in how they feel and how important their mother was to them. This would have been one way of clarifying her feelings and comforting her.

CONSULT WITH THE FAMILY – Mrs Jones's daughter may have been able to shed considerable light on the problem

Demanding to see the doctor[d]

Most staff in acute care would probably have witnessed this scenario. A patient asks repeatedly to see the doctor. What would you do?

The response below is not helping the patient. Nor would responses such as "he is on his rounds" "he will be here this afternoon" etc.

Think WHY?

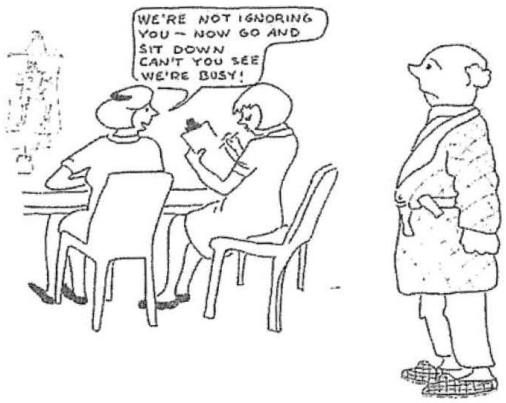
What are some of the reasons that this patient may wish to see his doctor? Problems with new memories and ideas mean that he may not know where he is or why he is there. Problems with new memories mean that he may be forgetting that he is asking the same question repeatedly. He may be sensing that all is not well. He may think a doctor will allow him to go home. It would be worthwhile to also inquire if the patient is in pain. As you can see by the drawing below, avoiding confrontation, trying to work out what is wrong and clarifying his feelings and comforting him hold the potential for meaningful communication and a calming effect on this gentleman.

[d] Reproduced with permission Archibald C. *People with dementia in acute hospitals: A practice guide for registered nurses.* Scotland: Stirling University, Dementia Services Development Centre, 2003.

Calling for staff's attention[e]

Two nurses are sitting in the office undertaking handover between shifts. A patient continually tries to get their attention but is ignored. The patient is becoming more and more angry and distressed. Why do you think this is happening and what would you do to defuse the situation?

The unhelpful response below will usually simply serve to put more fuel on the fire.



Think WHY?

Problems with mind images, reasoning and thinking things through make it hard for the person to interpret situations and see things from another point of view. This can make the person with dementia seem self-centred. The patient does not understand that you are busy or that your work is important. All he understands at that point in time is that you are ignoring him. He may be in pain. The situation could have been avoided if the staff had of responded sooner

[e] Reproduced with permission: Archibald C. *People with dementia in acute hospitals: A practice guide for registered nurses.* Scotland: Stirling University, Dem Services Development Centre, 2003.

Interfering with the environment[f]

A patient goes into the office and begins to empty the waste bins on the floor.

A scenario as that detailed above is not uncommon. Some patients with dementia will strip the beds, attempt to move furniture and other activities that can be particularly time consuming for staff trying to put a stop to such behaviour.

Why do you think this patient may be behaving in this manner?

What would your response be?

The unhelpful response will not achieve much in the scheme of things. The patient more than likely has no wish to stop what he is doing and after all, who are you to tell him what to do?

[f] Reproduced with permission: Archibald C. *People with dementia in acute hospitals: A practice guide for registered nurses.* Scotland: Stirling University, Dementia Services Development Centre, 2003.

Think WHY?

He may be extremely bored and searching for something to do to help the staff who seem very busy. He senses that he should be doing something but appropriate images of things he could be doing do not form in his head or he does not recognise which of the images that do form are appropriate. Images that do form in his head are strong old memories from the past – from his notes you ascertain that he worked as a refuse collector so perhaps you can gently guide him to another activity or location (or if possible let him help empty certain bins). The point is that he needs to be given something meaningful to do.

Spatial awareness at meals[c]

Molly is unable to distinguish her personal space and so takes food from both plates on the table.

Placing a contrasting coloured placemat under Molly's plate helps define what is hers. Molly will then only eat from her plate.

✓ **Key Learning:** Once the plated food is further defined by contrasting coloured placemats Molly confines herself to her own food.

[c] Reproduced with permission: Grealy J, McMullen H, Grealy J. *Dementia care. A practical photographic guide*. Oxford: Blackwell Publishing, 2005; p. 24.

Releasing the grasp[d]

The hand: stimulating grasp reflex (part A)

Description
The grasp reflex is where the hand curls into a fist.
This usually happens spontaneously when an object is placed in a person's hand.

Aim
To elicit a grasping reflex around a utensil, e.g. spoon.

Procedure
Stimulate the palm of the hand.
The person then grasps the object and it is often difficult to remove the object from the person's hand.

(1) Stimulation of the palm with the spoon.

(2) Further assistance with the grasping reflex by gently closing the hand around the spoon.

(3) Full grasp of spoon.

✓ **Key Learning:** Support the procedure by using key words, verbal prompts and, if required, some physical assistance.

[d] Reproduced with permission: Grealy J, McMullen H, Grealy J. *Dementia care. A practical photographic guide*. Oxford: Blackwell Publishing, 2005; p. 28-9.

The hand: stimulating grasp reflex (part B)

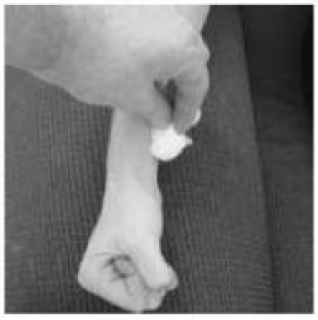
Description
The grasp reflex is where the hand curls into a fist.
This is usually seen when an object is placed in a person's hand.

Aim
To elicit a grasping reflex.

Procedure
The grasp reflex is achieved by stimulating the interior aspect of the forearm with cotton wool, tissue or similar soft material.

(1) Stimulation of the inside of the arm with tissue or cotton wool.

(2) Gently stroke the inside of the arm.



(3) The stimulation leads to the closing of the hand curling into a fist.

✓ **Key Learning:** Stroking should be very light, like butterfly wings touching the skin.

Withdrawal action: kick reflex[e]

Description
Tactile stimulation of the underside of the foot can elicit a kicking action, that is, moving the foot away from the irritating stimuli. This reflex is based on a protective, safety response to potential harm of the foot.

Aim
To stimulate the kicking reflex to get Molly to uncross her legs.

Procedure
Molly cannot understand that Rachael wants Molly's legs uncrossed, so rather than pulling the legs apart Rachael uses the withdrawal reflex. Preferably perform in a quiet environment. Stand on one side:

- With one hand: gently tickle the underside of Molly's foot (plantar aspect) with a finger. If this does not elicit a response replace with firm strokes.
- With the other hand: hold the ankle or calf of the upper foot to guide it away from you.

Molly has crossed her legs and her body and legs are rigid.

Rachael gently tickles the underside of Molly's foot.

Molly responds to the tickle or stroke by eliciting the withdrawal reflex. Her legs are now uncrossed.

✓ **Key Learning:** This technique should be performed from the opposite side of which the uppermost leg is crossed. If the left leg is crossed over the right leg then squat to the right side. In this position you are less likely to be kicked. This technique should not be performed on a person who has existing spasticity of the leg.

[e] Reproduced with permission: Grealy J, McMullen H, Grealy J. *Dementia care. A practical photographic guide*. Oxford: Blackwell Publishing, 2005; p. 35.

Decreasing arousal and agitation[f]

Description
Tactile input over the sensory distribution of the back (posterior rami) leads to a calming effect through an inhibitory effect on the sympathetic chain of the autonomic nervous system.

Aim
To induce relaxation.

Procedure
Preferably perform in a quiet environment.
Place the person in a prone or sidelying (coma) position, although it can be performed in a sitting position as illustrated.
The care staff's hand firmly strokes the person's back alongside the spine, from the base of neck to below the hips in a slow rhythmic manner.

Stroke up and down in rhythmic movement from just below the hips to the nape of the neck.

Most effective in a quieter environment.

Relaxation will be shown by slowed breathing, less muscle tension and less talking.

[f] Reproduced with permission: Grealy J, McMullen H, Grealy J. *Dementia care. A practical photographic guide*. Oxford: Blackwell Publishing, 2005; p. 32.

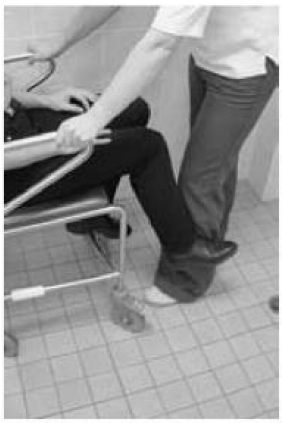
Toileting using a shower chair[g]

ADL = activities of daily living
RTC = resistance to care

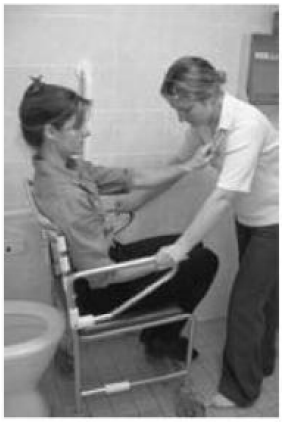
RTC:	**Back arching** **Grabbing** **Hitting** **Stiffening limbs**
Technique:	**Body rigidity**
Number of care staff:	**1–2**

Possible triggers of RTC:

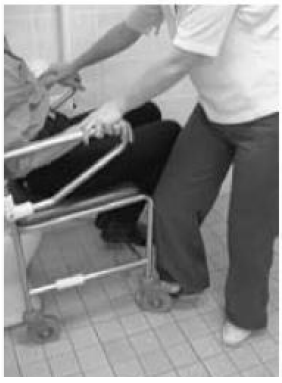
- Sense of falling.
- Cool, uncomfortable room temperature.
- Misunderstands the care activity.
- Nothing to hold onto for security.
- Feeling vulnerable undressed.



In this position Rachael can be kicked by Angela.



In this position Rachael's shirt or body can be grabbed, hit or pinched by Angela.

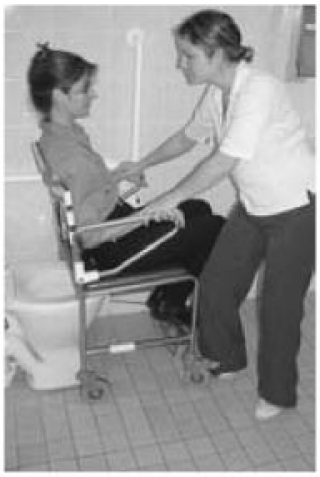


Rachael positions the shower chair castors so that they are aligned to roll directly backwards.

Rather than standing in front of the chair Rachael positions herself to one side so she can't be kicked.

Rachael uses her right knee to help position the shower chair, that is, to increase the forward thrust over the toilet.

[g] Reproduced with permission: Grealy J, McMullen H, Grealy J. *Dementia care. A practical photographic guide*. Oxford: Blackwell Publishing, 2005; p. 124-5.



To prevent being grabbed Rachael supports Angela's grip of the armrests of the shower chair by placing her own hands over Angela's hands.

Notice that the heel/butt of Rachael's hand is resting against the shower chair armrest and is not pushing onto Angela's hand.

✓ **Key Learning:** Toileting		
Contextual communication		**Contextual tasking**
Verbal communication	**Non-verbal communication**	**Third party props**
Explain the care activity and purpose and give the person time to adjust to this.	Physically prompt the person's hands to the correct position	Well lit bathroom. Warm bathroom temperature. Place a towel over the person's lap for privacy.

Showering[h]

ADL = activities of daily living
RTC = resistance to care

ADL:	**Showering**
RTC:	**Grabbing soft items**
	Grabbing fixtures and fittings
	Grabbing care staff
	Yelling
Technique:	**Facing the person toward the care staff member**
Number of care staff:	**1–2**

Possible triggers of RTC:

- Bathroom temperature is cooler than bedroom.
- Noise from the fan may cause fright/panic, or interfere with hearing.
- Voice echo may cause confusion.
- Feel vulnerable undressed.
- Misunderstands the care interaction.

This photograph shows the view a person sees if faced toward the shower wall.

A shower rose suddenly appearing squirting water will probably frighten or confuse the person.

A common RTC behaviour in this situation is the person grabbing the shower rose from the care staff member.

[h] Reproduced with permission: Grealy J, McMullen H, Grealy J. *Dementia care. A practical photographic guide*. Oxford: Blackwell Publishing, 2005; p. 126-8.

Approaching the person's face with an open face flannel can partially or fully obscure the person's visual field, which can also frighten and confuse.

Angela demonstrates the natural reaction for the person whose visual field is suddenly blocked – she grabs the face flannel.

The next five photographs illustrate specific techniques designed to engage the person in the shower.

It is preferable that the person being showered faces out toward the care staff rather than to the wall (if safe to do so). Angela can now see Rachael, the shower rose, and the face flannel. Rachael explains the interaction to Angela, using repetitive key words like 'shower', 'water' and 'wash' to help Angela understand the care interaction being carried out.

Rachael offers Angela the shower rose to hold to promote independence and participation, if it is safe to do so.

Rachael offers Angela a face flannel and assists Angela by guiding her hand to bring the face flannel to her own body.

Angela demonstrates how, even when she can't wash herself, she still prefers to hold a face flannel.

Rachael demonstrates the approach to washing Angela's face in which she has wrapped the face flannel over three of her fingers so Angela's visual field is not obscured by the face flannel.

✓ **Key Learning:** Showering

Contextual communication		**Contextual tasking**
Verbal communication	**Non-verbal communication**	**Third party props**
Explain the care activity and purpose and give the person time to adjust to this. Reinforce purpose using key words such as, 'Angela, it is time for your shower. The water will be warm. You enjoy having a warm shower.'	Face the person outwardly, from recess if possible. Once undressed wrap towels around shoulders and torso and across the person's lap for privacy and warmth. Check water temperature is warm and wet person's feet first, working up the body. Do not spray water directly onto the person's face.	Warm temperature. If the person walks in the bathroom place bath mat(s) or towels on the floor so it is not cold and wet under foot. Place items on shelf next to the person, e.g. soap, shampoo, face washer, to help orientate them to the purpose of the activity. Dress warmly prior to leaving the bathroom to accommodate for the cooler bedroom.

Assisting to eat[i]

ADL = activities of daily living
RTC = resistance to care

ADL:	**Assisting to eat**
RTC:	**Turning away**
	Refusing to open mouth
Technique:	**Rooting and suck reflexes**
Number of care staff:	**1**

Possible triggers of RTC:

- The person is not being assisted to eat in a way that makes sense to them.
- The person is not aware that it is mealtime.
- Lack of appetite.
- The food looks or smells unfamiliar.
- Misunderstands the care interaction.
- Does not know what kind of food it is.

In this photograph Molly is being offered food on a spoon. The care staff member, spoon and bowl of food are clearly visible to Molly.

However, Molly keeps closing her eyes and mouth and turning her face away when Rachael brings a spoon of food to Molly's mouth.

Rachael attempts to stimulate the suck reflex by placing a small amount of food on Molly's top lip.

However, Molly keeps her eyes and mouth closed.

[i] Reproduced with permission: Grealy J, McMullen H, Grealy J. *Dementia care. A practical photographic guide*. Oxford: Blackwell Publishing, 2005; p. 133-34.

Rachael then stimulates the rooting reflex by stimulating Molly's left cheek, but Molly continues to keep her eyes and mouth closed.

Rachael uses verbal prompts by describing the food, its taste and smell, and stimulates both the rooting and suck reflexes. Molly opens her eyes and mouth and tastes the food.

✓ **Key Learning:** Assisting to eat

Contextual communication		**Contextual tasking**
Verbal communication	**Non-verbal communication**	**Third party props**
Explain the care activity and purpose and give the person time to adjust to this. Use key words to reinforce the purpose of the activity and to stimulate appetite. 'Molly, the chicken soup is warm and tasty. It smells great. You like chicken soup.'	Sit where the person can see you and the spoon and bowl of food. Assist the person at their pace.	Serviette or napkin on their lap. Eating utensils and plate or bowl on placemat on table in front of them. Aroma of food.

Sundowning[j]

ADL = activities of daily living
RTC = resistance to care

RTC:	**Sundowning**
Technique:	**Validate and distract**
Number of care staff:	**1**

Sundowning is when the person with dementia experiences an acute increase in disorientation or deterioration in cognition, with a sudden onset of restlessness and confusion, in the late afternoon into the early evening.

Possible triggers of RTC:

- Lack of sensory stimulation, e.g. lower lighting in the evening.
- Tiredness.
- Background noise.
- Frustration with activities of daily living and social and recreational activities.
- Increased misinterpretation of events.
- Seeking security and emotional warmth.
- Hunger.

Molly has sat herself in a chair and has been crying, calling for her mother.

Angela responds by comforting Molly and uses the validate and distract technique to calm her.

Molly:	'I want my mum she's not home.' (upset)
Care staff member:	'Its okay Molly . . . you miss your mum?' (reassuring tone and touch)
Molly:	'Yes, I want my mum.' (upset)
Care staff member:	'She's a good mum.' (reassuring tone and touch)
Molly:	'Yes, she should be here.' (worried)
Care staff member:	'It's almost tea time . . . Is your mum a good cook?' (distract)
Molly:	'Yes.'
Care staff member:	'Does she cook roasts?' (distract)
Molly:	'Yes, roasts.'
Care staff member:	'And her gravy, does she make nice gravy?'
Molly:	'Yes, good gravy.'
Care staff member:	'And dessert, what about apple pie?' (distract)
Molly:	'Mmmm.'

[j] Reproduced with permission: Grealy J, McMullen H, Grealy J. *Dementia care. A practical photographic guide*. Oxford: Blackwell Publishing, 2005; p. 137-8.

✓ **Key Learning:** Sundowning		
Contextual communication		**Contextual tasking**
Verbal communication	**Non-verbal communication**	**Third party props**
Speak calmly and reinforce the person's positive feelings. Encourage the person to speak. Use verbal positive distraction. This means moving the person's thoughts away from feelings of loss or grief to happier memories. Avoid telling lies, such as assuring Molly that her mother is coming soon and avoid reality orientation, such as telling Molly that her mother is dead.	Eye contact. Gentle touch. Listening.	Items that reinforce the positive distraction, in the example given, would be taking her to the kitchen, offering her food and looking at the menu.

Wandering[k]

ADL = activities of daily living
RTC = resistance to care

RTC:	**Walking away** **Pulling away**
Technique:	**Diagonal approach**
Number of care staff:	**1**

Possible triggers of RTC:

- Uncertain about their own needs.
- Pre-illness habitual behaviours, such as the person who always took a walk before breakfast.
- Long-term memory driven behaviours.
- The person is going somewhere or looking for something, even if we do not know what it is.
- Delusion driven walking, such as the person who feels they are in a concentration camp or gaol.
- Other causes, such as medical issues, e.g. pain, cerebral irritation, continence issues.

This photograph shows Molly wandering and she has become tired and irritable.

The correct approach is for Rachael to approach Molly using a diagonal approach so as not to frighten Molly, and then move to her side.

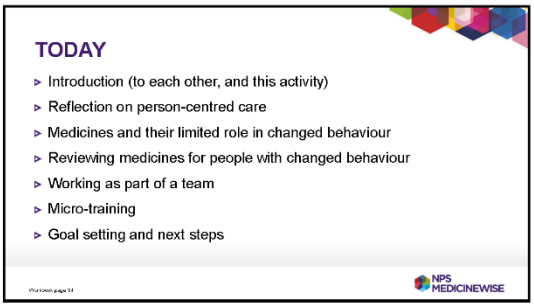
Notice how Rachael and Molly now have direct eye contact and Rachael holds Molly's forearm gently using the forearm placement technique. Rachael is now able to validate Molly's emotion and find out what she needs.

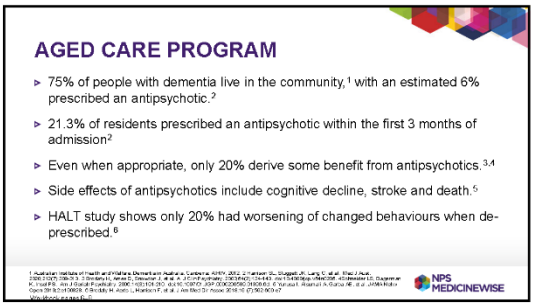
[k] Reproduced with permission: Grealy J, McMullen H, Grealy J. *Dementia care. A practical photographic guide*. Oxford: Blackwell Publishing, 2005; p. 140.

✓ **Key Learning:** Wandering		
Contextual communication		**Contextual tasking**
Verbal communication	**Non-verbal communication**	**Third party props**
Speak calmly and reinforce the person's positive feelings. Encourage the person to speak. User positive verbal distraction. This means moving the person's thoughts away from wandering to another activity.	Calmly and slowly approach the wandering person diagonally from the front. The approach is less intimidating to the person. Establish eye contact. Gently touch using forearm placement technique. Listening.	Items that reinforce the positive distraction, such as offering food and drink. Involve Molly in an activity that she likes, e.g. folding napkins, watching a video of the family.

APPENDIX C. SLIDES FROM TRAINING

3/12/2020





1

CHANGED BEHAVIOUR ACTIVITY

Education sessions

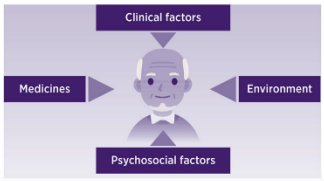
- Deprescribing protocols
- Microtraining
- Support catch-ups and regional peer-sharing meeting

NPS MEDICINEWISE

WHAT IS QUALITY USE OF MEDICINES?

1. Use a medicine only when necessary.
2. If it is necessary, use the right medicine at the right dose.
3. Use medicines in a way that ensures a safe an effective outcome.

WHAT IS THE UNDERLYING CAUSE?



NPS MEDICINEWISE

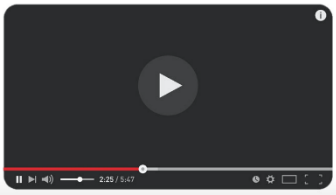
EVEN WHEN IT IS DEMENTIA…

Behaviours and their likely response to antipsychotic medicines

Behaviours that may respond	Behaviours that respond poorly
Hallucinations	Apathy
Delusions	Low mood
Persistent angry, anxious or aggressive states	Inappropriate toileting
	Inappropriate sexualised behaviour
	Wandering
	Calling out

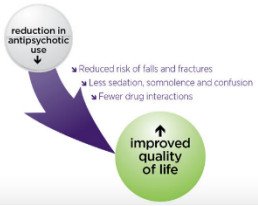
NPS MEDICINEWISE

LIVED EXPERIENCE



NPS MEDICINEWISE

IMPROVED QUALITY OF LIFE, IMPROVED SAFETY



NPS MEDICINEWISE

CHOOSING WISELY RECOMMENDATION

Choosing Wisely recommendation from the Australian and New Zealand Society for Geriatric Medicine[15]

Do not use antipsychotics as the first choice to treat behavioural and psychological symptoms of dementia.

Choosing Wisely Australia

NPS MEDICINEWISE

ANTIPSYCHOTICS

	Medicine Dosing and Titration	Considerations for older people	Monitoring
TGA approved PBS listed	**Risperidone**[2] Start with a dose of 0.25 mg twice daily, increase by 0.25 mg every 1–2 days as needed, to a maximum of 1 mg daily.[2]	While risperidone has the strongest evidence for its effectiveness,[1] there is mixed evidence for the use of risperidone 0.5–1 mg daily for treating aggression.[4] There is only limited evidence of benefit for other agitated behaviours.[1]	Review if there are any adverse effects seen[1] in the early treatment phase. Adverse effects to monitor include sedation, postural hypotension, extrapyramidal symptoms and tardive dyskinesia.[2]
No TGA approval No PBS listing	**Olanzapine** 2.5 mg daily. Increase by 2.5 mg every 1–2 days as needed, usual maximum of 10 mg daily in 1 or 2 divided doses.[3]	Olanzapine and quetiapine are more sedating than risperidone, which may be more suitable than antipsychotic.[1]	Discontinue antipsychotic if no improvement seen within a relatively short timeframe (usually 1–2 weeks).[2] Review the need for ongoing antipsychotic use every 4–12 weeks.[2]
	Quetiapine[3] For dosing, seek specialist advice.[3]	Both olanzapine and quetiapine cause weight gain, and it may be significant with olanzapine.[1]	
	Aripiprazole[3] For dosing, seek specialist advice.[3]	In Lewy body dementia, antipsychotics (even risperidone) can cause deterioration in cognition and motor function and increase agitation. However, low dose quetiapine is sometimes prescribed as it has a lower potential for extrapyramidal side effects.[1] Aripiprazole may be less likely to increase the QT interval compared to other antipsychotics.[1]	

[2]Risperidone is TGA-listed for aggression and psychotic symptoms. See the PBS website for more information.

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NPS MEDICINEWISE

4

BENZODIAZEPINES

Medicine dosing and titration	TGA-approved indication	Considerations for older people
Oxazepam 7.5 mg 1–3 times daily[2] Half-life of 6–12 hours[4]	Short-term relief of severe anxiety and agitation[2]	Limit use to 2 weeks.[3] Benzodiazepines may cause: • Worsening cognition in dementia[5] • Rebound insomnia[5] • Increase in the risk of falls and associated injury.[3]
Temazepam 5–10 mg at night[4] Half-life of 9–12 hours[4]	Short-term treatment of insomnia[4]	
Lorazepam 0.5–1 mg daily[4] Half-life of 12–24 hours[4]	Short-term management of agitation[5]	

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NPS MEDICINEWISE

CONSENT

- Gaining consent to prescribe psychotropics is important.
- Steps involved in obtaining consent include:
  - determining if person has capacity to provide consent
  - if not, seeking out substitute decision-maker
  - providing information on risk vs benefits of medicines
  - checking understanding
  - documenting consent (or refusal of consent)

NPS MEDICINEWISE

5 questions to ask

1. Do I really need this medicine?
2. What are the risks?
3. Are there safer options?
4. What if I do nothing?
5. What are the costs?

NPS MEDICINEWISE

Choosing Wisely Australia

5

PROVIDER RESPONSIBILITIES

- If a chemical restraint is used:
  - Inform resident's representative as soon as practicable
  - Ensure care and services plan is documented in accordance with Aged Care Quality Standards Standard 2 that identify:
    - behaviours relevant for the need for the restraint
    - alternatives to restraint that have been used
    - reasons for the restraint
    - information provided to the prescriber that informed prescribing of the medicine.
  - Monitor (regularly) for signs of distress of harm while person is subject to restraint.

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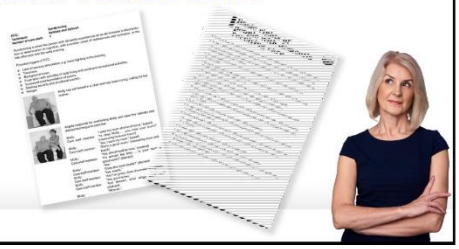
BUT… WHAT ELSE IS THERE?



REGULARLY REVIEW AND TAPER

- Antipsychotics and benzodiazepines are not 'set and forget' medicines. They should have a goal that informs their use.
- They are usually prescribed for a short time to help with changed behaviours, then removed when the behaviours are manageable.
- Medicines should be continually reviewed and monitored to determine whether they are achieving the goals of therapy.
- If they are not achieving goals of therapy, they should be ceased.
- HALT study showed only 20% of patients had increase in changed behaviours after ceasing their antipsychotic.

NPS MEDICINEWISE

FACILITY LEVEL PROCESS

Who	When	How
▶Use data to review ▶Select appropriate residents	▶Prioritise order ▶Consider a staggered start	▶Ascertain history ▶Ensure safety

NPS MEDICINEWISE

USING DATA WHEN REVIEWING

QUM REPORT - MINIMISING ANTIPSYCHOTIC USE FOR BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA

[redacted]

NPS MEDICINEWISE

7

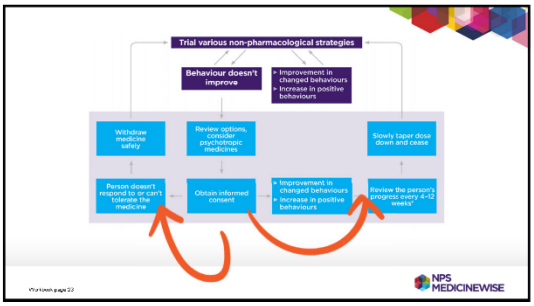
EXAMPLES OF DATA REPORTS

Provider	Psychotropic specific reports	Features
WebsterCare	Yes	• Regular reporting cycles • Incorporates evidence-based recommendations on prescribing of medicines for residents • Includes information on residents using antipsychotics for all conditions

MPS	Yes	• Regular reporting cycles
		• Counts of residents being prescribed antipsychotics
		  • As required vs continuous antipsychotics
		  • Atypical vs typical vs other antipsychotics

Best Health Solutions	Yes	Regular reporting cycles
Other tools that can be used to help review medicines		
Self-assessment tool for recording consumers receiving psychotropic medicines developed by the Aged Care Commission		

NPS MEDICINEWISE



NPS MEDICINEWISE

TAPERING

- Gradually decrease daily dose by 25% every 1–4 weeks
- Monitor for:
  - withdrawal symptoms
  - recurrence of changed behaviours or appearance of new changed behaviours
  - expected benefits from tapering
- Use non-medicine alternatives matched to behaviour when tapering
- Continue to taper and cease if no symptoms

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8

CESSATION

- Slower tapering (12.5%) when reducing to final lowest dose
- Finish treatment 2 weeks after lowest dose
- Consider alternate day dosing
- If symptoms, return to previous lowest tolerated dose
- Begin tapering again after 6–12 weeks at a lower tapering rate (5–12.5% of daily dose)

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NPS MEDICINEWISE

HOW DO YOU REVIEW?

- Do you use data to help monitor and review people in your facility on medicines?
- What data source do you use? How do you get your data?
- How often do you review within your facility?
- How can you work together to ensure a positive and continuous review process?

NPS MEDICINEWISE

WHAT IS MICROTRAINING?

- Microtraining (or microlearning) is the breaking down of information into bite-sized chunks.
- By only focusing on highly-targeted chunks, lessons become much easier to digest and the likelihood of knowledge retention is increased.
- It has the added bonus of being easier to work into your everyday.
- Previous programs have shown this to be effective in Australian RACFs both opportunistically during the shift and/or at shift handover.

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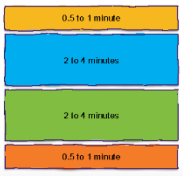
NPS MEDICINEWISE

MICROTRAINING FORMAT



Active start

Demonstration

Discussion

Conclusion

NPS MEDICINEWISE

WHAT IS FEEDBACK?

- Feedback is information on performance.
- Effective feedback is timely, i.e. when there is still the opportunity to act on it.
- Effective feedback is specific. General comments about performance can't be enacted.
- Feedback can be corrective… but also reinforcing (i.e. do more of, do less of).

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FEEDBACK FORMAT

P permission: ask the other party for permission.

C context: describe the situation.

A action: outline the specific behaviour.

R result: outline the result.

– (seek input, you may have misunderstood the situation)

A alternative action: outline an alternative action.

R result: results of new action.

NPS MEDICINEWISE

WHAT THINGS DO I FOCUS ON?

- Microtraining:
  - Range of topics
  - Short and sharp; don't take on too much
  - Consider preparing 4-5 at once
- Feedback:
  - opportunistic

(Put it back on page 10)

NPS MEDICINEWISE

FEATURES AND BENEFITS

Microtraining	Feedback
Can be done with more than 1 staff member	Can be ad hoc
General in nature to allow people to understand how it may apply to a range of situations	Addresses issues in a timely manner
Limitations	
Requires preparation time	May not allow the person receiving the training to think about how this can be applied more broadly
	Usually done one-on-one

NPS MEDICINEWISE

LET'S PRACTICE...

- Role play microtraining.
- You will be given a topic and resource.
- 5 minutes to prepare.
- 5 minutes to microtrain.
- 5 minutes to talk about what worked or didn't.

NPS MEDICINEWISE

THE CARE TEAM

- Nurses and other staff in RACFs
- General practitioners
- Pharmacists (dispensing, QUM, accredited)
- Specialists (geriatrician, neurologist, psychiatrist)
- Allied health professionals (physiotherapist, podiatrist)
- People with dementia, their families and carers are also important members of team

NPS MEDICINEWISE

MANAGEMENT AS A TEAM INCLUDES

- Daily living activities
- Brain function
- Risk factors
- Mental health and wellbeing
- Behaviour
- Comorbidities
- Nutrition
- Safety
- Medicines
- Support
- Planning for the future

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BARRIERS TO TEAMWORK

- Communication barriers
- Medical staff not co-located
- Recommendations not always enacted
- Staffing levels
- Funding
- Lack of coordination

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YOUR FACILITY

- How do you communicate as part of a team within your facility?
- How do you document changes in behaviour or medicines?
- How might you work together over the next six months?
- Who would be responsible for what?
- How might you bring the GP into your conversations?

NPS MEDICINEWISE

CREATING CHANGE

- Look at the champion nurse and pharmacist role on pages 8 and 9.
- How do you think your role can help create change?
- What are the enablers that you might use?
- How would you use them?
- What are the barriers that you might face?
- How might you overcome them, or otherwise manage them?

14

SETTING GOALS

	Goal	Notes	When
Personal			
Facility			

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NPS MEDICINEWISE

NPS MEDICINEWISE

CHANGED BEHAVIOUR ACTIVITY GOALS

	Goal	Notes	When
Personal			
Facility			

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