

## **QUALITY HEALTH STRATEGIES**

**Moderator: Jackie Hairston**  
**May 23, 2013**  
**9:30 am CT**

Operator: Ladies and gentlemen, thank you for standing by. Welcome to the Improving Care for People with Dementia Living in Nursing Homes Part 2 Conference Call.

During the presentation all participants will be in a listen-only mode. Afterwards we'll conduct a question-and-answer session. At that time, if you have a question, please press the 1 followed by the 4 on your telephone. If at any time during the conference you need to reach an operator please press star-0.

As a reminder, the conference is being recorded Thursday, May 23, 2013. I'd now like to turn the conference over to Jackie Hairston, Project Manager Delmarva Foundation. Please go ahead, ma'am.

Jackie Hairston: Good morning and thank you, Operator. Good morning to all of you and welcome to our webinar today. As you heard, my name is Jackie Hairston. I am one of the project managers here at the Delmarva Foundation, your QIO for Maryland and the District of Columbia.

I am pleased to be able to offer you this two-part series and this is part two of the two part series on improving care for people with - living with dementia in nursing homes.

Again, this is a series that was presented to QIOs across the nation as we were preparing for this second phase of work, looking at reducing antipsychotic use among our elderly population.

What you will be hearing today will be part two of a previously recorded session that will give you practice interventions that you can put into place immediately.

Part two will answer the question that I've been hearing from many of you in the field, if I remove the antipsychotics how can I control the behaviors? You will hear some of those interventions here today.

Part one and two recording and the PowerPoint presentations will be posted on Delmarva's website and those are [www.DCQIO.org](http://www.DCQIO.org) and [www.MDQIO.org](http://www.MDQIO.org).

So you can share with your staff at your convenience. The phone lines will be muted during the call. At the end of the presentation we will open up the lines to have some brief sharing time to discuss what we've heard and how you plan to be able to use some of the interventions that was shared today.

If you have a question that you would like our presenter to answer please submit the question via email to me or your quality improvement consultant and we'll send those questions forward to Dr. Wehry for a response.

Now we're very pleased to be able to share with you Dr. Susan Wehry, our presenter. She is a Board Certified Geriatric Psychiatrist and advocate for seniors and persons with disabilities. She has educated physicians, nurses, medical students, ombudsman, policy makers and direct care workers across the country.

She is currently serving as the Commissioner of the Department of Disabilities Aging and Independent Living for the State of Virginia - Vermont, sorry. So we will go ahead and begin our presentation with Dr. Susan Wehry.

Dr. Susan Wehry: Thanks very much for having me and welcome back for those who were in part one and welcome to people who weren't able to join us last week. I'm really looking forward to this session today which I hope will bring together both the concepts that we learned last week and also encourage you to share with nursing facilities some of the very practical tools and practical approaches that I will outline for you today.

There we go. My goals, are always, are somewhat immodest. I really do hope to not only inspire you to transform the work but also inspire you to take very practical steps with facilities, with the people with whom you work, to fundamentally change the way we approach dementia care for people living with dementia living in nursing homes.

The key points from last week and for this is that we live in a brave new - what I call, (unintelligible) world. And (unintelligible) and it is spelled there on your screen, should say S-Z-Y-G-Y - for those of you (unintelligible), simply speaks to the fact that we are at a time in the industry and in the quality improvement world in which I believe all the stars are aligned, by which I mean quality improvement efforts, new knowledge about dementia care, new knowledge about the science of quality improvement, new regulatory emphasis really brings us to an incredible opportunity where continuous quality improvement, person-centered care are aligned and dementia care is ready to move into its next evolution if you will, into its next area of improvement.

We have new knowledge and I think that that compels us to take more (unintelligible).

I summed this by saying it's a transformation from patient (unintelligible) to person (unintelligible) I think first point is (unintelligible) in Great Brittan (unintelligible) of the person in the disease as opposed to the centrality of the disease in shaping the way we approach dementia care.

Corollary to this is that (unintelligible) potential before has been really focused on as symptoms of a disease now (unintelligible) being appreciated as communication of unmet core human need. And it's that identification that is really driving a lot of the good work in dementia care.

And leads us to be able to develop more meaningful non-pharmacologic interventions that also lead us to be able to actually anticipate (unintelligible) prevent unwanted distracting bad behaviors.

We conclude with the notion that unnecessary antipsychotic use not only can but should be reduced and we now have the tools to do it.

In Part 1 we talked about this (unintelligible) initiative that I've already stressed. We talked also about the fact that dementia has high prevalence in nursing homes and that's part of the reason (unintelligible) by extension. We also presented some data showing that there's an overreliance on medication that has a negative impact on quality of life. They also have a (unintelligible) efficacy and high morbidity.

In today's Part 2, we're going to pick up that conversation and look at what we really mean by a person-center dementia care. We're going to look at this

from two frameworks, the patient (unintelligible) and then what (unintelligible) for moving from intervention to prevention with respect to the work that we do in dementia care.

Moving from intervention to prevention is about anticipating needs, addressing unmet needs, changing our behavior, not the behavior of the resident, and creating environments that work. I'm only talking about the environments that work and talk about creating environments that work for the people that live there and work for the people that work there.

To conclude (unintelligible) final half hour with looking at what our toolbox (unintelligible), what direct (unintelligible) for nurses and physicians can help us use non-pharmacologic interventions, what educational approaches are available, and then finally when if ever is it appropriate to use pharmacology. And the answer to that question is sometimes it is and we'll look at that as well.

The current model of dementia care is what I call looking at dementia from the outside in. We focus our understanding of dementia as a range of symptoms and it's (unintelligible) to kind of medical approach to symptom control.

Last time we talked about the brain behavior relationships and the five As; amnesia, apraxia, (unintelligible), and aphasia. And being (unintelligible) of impairment this profoundly impacts the life and quality of life and the ability to function independently of someone with dementia.

And in the shift from dementia from the outside in to looking at dementia from the inside out I want to stress again that it's not that we ignore the fact

that people live with a brain that is impacting or disease or disturbed or deteriorating.

It's that we shift our frame of reference and that informs our care. (Unintelligible) brain behavior relationships do apply but we shift away from that being the primary frame of reference.

With respect to behavior problems which are really the drivers of misuse of medication, the old model frames our understanding or frames the explanation about behavior problems and either coming from a direct impact (unintelligible) as you can see in this little graphic here, where the neurobiological (unintelligible) itself drives the behavior or by (unintelligible), the behavior arises because of the inability of the person to modify their behavior.

But it seems - I think the main message here is the current model looks at all behaviors as being the direct impact of the disease. When we shift to a new frame of reference when we are looking at dementia from the inside out we appreciate that who a person is is as important as what he or she has. Who a person is is as important as what brain dysfunction he or she has.

And we ask a very different question in this framework of dementia (care). In this framework of dementia care we ask the question, not what do we need to treat this person's symptoms of dementia but we ask the question what does the person living with dementia need to maintain (unintelligible)?

And when we ask the question that way we remind ourselves of our (unintelligible) and these are people who have dementia and they think about, what do we need, what does anyone need to maintain (unintelligible).

And by (unintelligible) and those who really study this (unintelligible) academically come up with these four components that everybody needs love, attachment, belonging, affection. And when we talk about love, belonging, attachment, and affection we talk about both in the giving and the getting of that. It's part of the (unintelligible).

We also have a need for comfort. We have a need for identity. We have a need to be and be seen. We have a need for dignity, respect, we have meaning in our lives. And it is true for most of us on this call and it is true for people living with dementia.

And when we look at care, even long term care facilities from the standpoint of a person (unintelligible) perspective, this is the question that we ask and it becomes part of our focus.

Another graphic way to look at this is to say, do we want to look at a person with dementia as our focus or a person (unintelligible) dementia? What a person's challenges is as important as what he can't do (as a corollary to this). And another corollary to this person-centered emphasis is that health is more than an absence of symptom.

Quality of life is more than good medical care. It's not instead of, it's not versus quality of life. Versus quality of care, it is that both are important or that all aspects of importance are aspects of person (unintelligible) are equally important in quality of life, that's really the message here.

To sum it up a different way, because I'm trying to find different ways to make sure the concept person (unintelligible) care is really the basis of our conversation. And I'd also put it like this, we look at the person rather than the (disease) as I said.

We look at abilities rather than inabilities. And when I say instead of it's more a shift in focus rather than either or. It's not one or the other. It's both and but how do you approach it is from the perspective of the person.

And the final implication for this for work in the long term care setting is that their job becomes about building the relationship more than just doing the task. The simplest example of this is in providing direct care in (unintelligible).

It is the difference in saying to staff, you have ten baths today and the person sees their job as making sure all those baths get done in a kind, gentle way and so forth.

Or your job is to make sure that Mary and Frank and Joe and Bob have a good day and part of having a good day might be getting cleaned. But their real job is about seeing what Mary needs that day (unintelligible) so forth rather than the task at hand.

Why the big push for this? One, it promotes the highest quality of life, prevents (unintelligible), leads to better outcomes, and if that weren't enough, it's required by regulations. So there are a lot of good reasons to practice person centered care.

Some of the research with respect to person centered care and one manifestation of person centered care is, of course, the use of individual routine instead of having people (unintelligible) institution routine and (unintelligible) the data around the (unintelligible) includes things like evidence for improved (unintelligible), evidence that there is less agitation and depression in those facilities where people have individualized



(unintelligible), and finally clear evidence that individualized routine lead to fewer falls and fewer (unintelligible).

A corollary or another (unintelligible) implication in which person centered care is that all behavior has meaning, all behavior is an attempt to communicate something, all behavior does communicate something.

Generally behavior communicates a need or a want and usually that need or want is for something to change, a need to have something start happening that isn't or stop happening that's distracting.

The real focus here is that all behavior has meaning and behaviors in dementia are not just symptoms of the disease. This is one area where my remarks are accompanied (unintelligible) with the focus on what's called BPSD, biological psychological symptoms of dementia.

But what's interesting about my emphasis versus, say, the emphasis of people who look at this from a symptoms standpoint, both of us recognize - we're pretty (unintelligible) interventions. So whether you call them symptoms or whether you call them communication, non-pharmacological approaches (unintelligible).

So you don't have to buy this (unintelligible) to be able to use the intervention but my own experience has lead me to believe that without the shift in focus the (unintelligible) medications is very strong if what we fundamentally think you're looking at is a symptom of a disease as opposed to looking at the communication of a need.

So the evidence for this notion that behavior expresses unmet core human need actually comes from a couple of places and is mentioned that unmet need

drives behavior comes from the work of the 1950s of (Abraham Maslow). I'm sure many of you are familiar with this, who tried to work out or tried to understand what drives human behavior.

He came up with a conceptual framework that had its flaws but I think for our purposes in long term care actually works very nicely. And he said about this hierarchy of need is that it is not the needs that are met that (unintelligible) behavior but rather the needs that are unmet.

So if you are cold, thirsty, hungry, tired, having some (unintelligible) needs to use the bathroom or whatever it might be, if you're attending a lecture or going to a movie, something that you might enjoy, that fundamental psychological need will get your attention more than anything else that is going on.

And this only - and this is where I think there's so little (unintelligible) but it's only when those needs are met that you sort of actually move up the hierarchy. (Unintelligible) but there does seem to be considerable merit in the notion that what really drives the behavior of all of us are unmet needs. We do something to get a need met that isn't currently being met.

(Maslow)'s conceptual framework has actually has a lot of resonance I think with the more recent work of (unintelligible). (Unintelligible) takes the old model that I spoke of earlier and extends it in a much more nuanced way and talks about behaviors, which you can see on the right hand side in three key ways.

Unmet need drives behavior as a way of actually fulfilling the need (unintelligible) directly. Unmet needs drive behavior and the means of communicating this to others what those needs are. Unmet needs can be drive

behavior and the outcomes of frustration or other negative aspects which then do (unintelligible) inhibition as we saw in the earlier slide.

You can appreciate how much more sophisticated, how much more nuanced this model is. And the simple model which says, bad brain, bad behavior, (unintelligible).

This model says, behavior's more complex and if you attend to learning about lifelong habits and personality you're really getting to know residents if we attend to the current conditions, both physical and mental if we attend to the environment, physical, psychosocial element, we will be in a better position to anticipate, address and meet needs.

And then there's not the distress kind of behavior that is (unintelligible) in the long-term care setting. So this I think is a lovely graphic and you can see that I have borrowed it and it is the model that actually informs - that really tells (unintelligible).

So to sum this up, person centered dementia care emphasizes that behaviors are linked to unmet core human needs.

Right, (unintelligible) suggest that that's true, that needs can be identified, anticipated and met. And there are two practices already in place in many homes that support this approach. And that (unintelligible) and individual (unintelligible).

This is a slide that basically says the same thing and the only point I want to draw out, however, from this slide (unintelligible) behaviors and compare (unintelligible) to what I'm now calling the old model to the emerging or new model, is Bullet Point 2.

One of the (unintelligible) outcomes I think should be in the way we think about this, has been - has led us to think and to speak with more precision about what behavioral problems are.

In the past when we think of something as symptoms we've attended to link (unintelligible) aggression, combativeness with care, wandering, which I'll redefine in a moment, wandering with (unintelligible) questions; all behaviors that we commonly associate with dementia (unintelligible) lump that together and just call them all symptoms.

And we haven't really appreciated the nuanced difference between aggression, verbal aggression, physical aggression, non-verbal agitation, simply walking about, getting exercise.

And one of the messages of the new way to think about dementia care is it really compels us to both define and think about behaviors with a lot more precision. Once you step away from, well, everybody with dementia does then you begin to appreciate what (unintelligible) why is John walking about?

Why is Mary calling us at night? And it makes for a very different treatment plan process to approach it from the standpoint of what is Mary trying to tell us from people with dementia do that. What tools do we have to stop it?

And this model, if (unintelligible) intervention to prevention, we ask the question what is this person trying to tell me instead of how do I get the symptom to go away? Prevention of unwanted or distress call behaviors in dementia is really a matter of creating a culture of treating a person with dignity and respect into basic core (unintelligible).

It is imperative to understand (unintelligible) lifestyle culture of the person that's being taken care of, their likes, their dislikes, their (unintelligible) and so forth. And importantly, prevention requires providing for conversations or opportunities for conversations and relationships.

And often times in (unintelligible) facility there will be - the development of some (unintelligible) at this point as the facilities say, I wish we had time for one to one, I wish we had time for more conversation, I wish we had time for relationships.

The take home message for you and for facilities is really the notion that having a relationship focused in your work doesn't take more time.

There's actually some evidence to show that comes to us from the fall prevention world that a single ten-minute conversation, just a one-to-one social interaction per day for a resident with dementia can actually decrease the risk of falling because one of the things we know, for example, about people with dementia is when they fall it is when they're unattended, don't have attention, or when they're walking about.

So when I say something like provide (unintelligible) conversations I don't mean that it has to be a lengthy or an ongoing one-to-one. It's really in the way the work is done as well as the knowledge about what small interventions are doing for a person.

And then of course, ensuring opportunities to try new things, having opportunities for pleasurable things, having - that the resident likes to enjoy, are critical components of preventing the distress that leads to the unwanted behavior.

And again, because I think it's so important the way we frame this, I would encourage you to appreciate that - to think about the difference between saying we're creating opportunities for pleasure but we know (unintelligible) things they like to do that creating an opportunity for pleasure is a (unintelligible) different sounding activity than saying, we'll find ways to distract them.

And old dementia care is about distraction. It's about moving the person away from the object of their desire and moving it towards something less distracting. And to some extent, distractions or redirection as it's also called does sometimes work for a short period of time.

But one of the reasons people say redirection doesn't work is because the need remains unmet. And in the new way or the way we continue to expand our knowledge about dementia, what we appreciate is redirection and distraction don't work because they have fundamental (unintelligible) underlying (unintelligible).

So I - again, encourage you to play with this idea because it - I do think there's a fundamental shift in the way that we think about it.

The notion of watchful (unintelligible) is beginning to get some (unintelligible) and a very nice description of this can be found at the (unintelligible) website in (unintelligible) United Kingdom. And so I mentioned this to you last time and that was a resource site that I would, again, encourage you to go to.

The notion of watchful (unintelligible) is really just what it sounds like. When you are getting to know a new resident it is a matter of making frequent and ongoing observations and making frequent and ongoing interventions and

(unintelligible) and paying attention to what things to increase the stress and what things to alleviate the stress.

Two tools coming to us from culture change that help (unintelligible) relationship based care helps (unintelligible) watchful waiting as an intervention is creating the organizational practices and policies that actually make it inevitable that staff comes to know residents and that's (unintelligible).

Another resolution in our thinking about dementia care has to do with this notion of (unintelligible) be present. And in this notion of being present in the relationship based care we're learning a lot of looking at (unintelligible) stages of dementia from a whole area of work known as (unintelligible) end of life late stage dementia care.

One of the features of that model of care is this notion of being present - psychological presence meaning available and attuned to the person who is completely (unintelligible).

And in this notion of relationship based care we're really emphasizing the idea of going from doing (unintelligible) to simply being with another person. The psychological and physical availability is present (unintelligible) seems to be very helpful.

The final notion about relationship based care is that folks in long term care (unintelligible) directly or indirectly in that industry are not alone in this. And we have - I think for too long tried to do it all ourselves and then frustrated (unintelligible).

One of the things that relationship based care also reminds us is that we are not the only people in resident's lives. And one of the ways I think that (unintelligible) partners can be helpful to facilities is in (unintelligible) slightly larger way and to encourage partnerships (unintelligible), family and friends.

I sum this up by saying the perspective that we need, dementia from the inside out, is simply a matter of standing in the shoes of people who have dementia.

Behaviors have multiple contributors. There are many different (unintelligible) for looking at this, for people (unintelligible) or their family's been (unintelligible), what the environment looks like, what our practices are and so forth, and then the behaviors of caregivers, ourselves.

Important to understand about behavior is that it is a lot easier to change ours than somebody else's.

Moreover, in studies that have been shown with folks with dementia - again, coming from the folks in the area of (unintelligible) prevention, one of the observations that's been made with respect to (unintelligible) and people with dementia is that some of the interventions, the multi-factorial assessment, the multi-disciplinary interventions, are not always that successful.

And that what's probably true about that is that the reason for that probably has to do with the fact that people (unintelligible) impairment cannot in fact (unintelligible) adhere to (unintelligible) program strength training, (unintelligible). Nor do they have the same ability to change that behavior.



What's clearly (unintelligible) in terms of transforming dementia care is that we further extend our emphasis on changing us and changing the environment (unintelligible).

We hit on this very briefly last week. I'm just going to reinforce this here. If relationships matter in relation to people with dementia they absolutely matter in relationship to staff.

Administrators, outside regulators need to (unintelligible) perspective from the sampling of staff. And when we are interacting at any level we have to model appreciation and respect. We have to model that we care about the (unintelligible) and if we respect and (unintelligible) the staff they will give better care. Facilities also must (unintelligible) fact finding, not on faultfinding.

Thirdly, with respect to organizational practices and how they influence person centered care, we need to make sure that there's better training available for staff and evidenced based practices for dealing with dementia. The quality of the workplace is critical to the quality of care.

One of the tools that we often use and it (unintelligible) describe briefly in a moment is a tool that was created to actually take (Maslow)'s hierarchy of needs and apply it to the environment and to just see how are we doing.

In this particular worksheet, which is a tool that can be made available to facilities, facilities are invited to look at the ways they currently meet all of those hierarchy of needs (unintelligible) person in need, and (unintelligible) practices that might meet those needs in a more person centered way.

And I think, again, trying to anticipate where the pushback is or the hesitation is in facilities. I appreciate that when we start talking about creating environments that work administrators in particular (unintelligible) understandably see dollar signs and think about what they can't do, think about what they would like to do. And they say, we don't have the money for it.

And I appreciate that. I particularly appreciate it in my current role as Commissioner of the Department. What needs to be emphasized is that we're always on (unintelligible), trying to get more resources but then looking at (unintelligible) that actually improve the physical environment.

And if there's one area of (unintelligible) that we can look at is this (unintelligible) area of reducing noise. It doesn't cost anything to remove overhead pages. It doesn't cost anything to have staff have their conversations in the staff room or away from the hallways.

It doesn't cost anything to turn down radios and televisions. I suppose it might cost something there if you want to supply everyone with their own headsets. But basically changing the environment is not always the (unintelligible) money.

As always, when you get facilities to look at on creating different environments we'll eliminate or prevent some behaviors. The bigger target that's involved, measure - I mean (unintelligible) something, measure, test it, see how they do.

Engaging physicians is quite critical in any endeavor we want to (unintelligible) reducing antipsychotics. There's a very nice article in the Journal of the American Medical Directors Association, the reference is cited

for you there, that actually speaks to the fact that physicians actually have a very positive attitude for non-pharmacological intervention but very few physicians actually know what any of them are or know much about the evidence based behind them.

And this particular look at physician attitude, physicians (unintelligible) for medications as the number one barrier to actually trying other things first. What I think that study speaks to is in fact the need for better education and for better communication between staff and physicians.

So to recap the prevention model, it's really a matter of anticipating and meeting unmet needs. And you see some person centered care of our ways to approach that at the organizational level, the environmental level, that behavior level.

That said, not all needs can be anticipated or met successfully. And so that is as important to have a toolbox that includes some ways to intervene when we haven't successfully anticipated or met the need.

And so what I want us to do now for the remaining time is to talk about non-pharmacological practices, medications, and training tools that are out there to help staff do this.

As always, intervention or prevention, we start with the question, I'm curious, what is this person trying to tell me in the case of any behavior. And we don't ask that alone or just in our own heads or just (unintelligible) member of the team or (unintelligible) but together.

And we say, what just happened? What do we think it means? What do we know about this person?

In the case of something like aggression which is often fear driven we might ask the question how can we create a greater sense of safety? How can we create a greater sense of security so that this behavior doesn't happen again?

And the (unintelligible) always ask, what did we bring to the table after we changed our behavior? So (unintelligible) intervention like (unintelligible) starts with what just happened, what do we know.

And we know about some common behaviors, what they commonly communicate. I prefer the term walking about to wandering, I think wandering is (unintelligible) or at least it's become (unintelligible), and it really reinforces walking as a symptom.

People walk for a lot of reasons. They walk because they have energy and they're bored. They walk because they have energy and they like to walk. They walk because they're curious. They walk because maybe it's reflected of a (unintelligible).

They walk sometimes because they want out of the long-term care facility. (Unintelligible) divide this into purposeful and non-purposeful walking to describe these but I think that what may be more helpful is to try to simply understand what walking means for and what walking contributes to in the individual resident (unintelligible).

We also know that common behaviors associated with dementia include (unintelligible) combativeness and it appears that the two primary drivers of the communication behind care combativeness has to do with fear or has to do with discomfort.

There is a tool available, it's been around for a lot of years, a second edition has just come out, and that is (John Raider)'s (unintelligible) battle. And this will give an evidence based practice.

It was seen as so valuable when it first came out that (unintelligible) bought both the book and maybe the video at the time to really have this (unintelligible) or the base for dealing with combativeness of care issues in individuals who have dementia.

And it can't be said often enough to always pull this off, dust it off - pull it out and dust it off when dealing with combativeness with care because of (unintelligible). It's a common place - it's a common situation (unintelligible).

Now let me just describe very quickly the way I encourage us to use more precision in the language that we use to describe behaviors. When I talk about agitation I talk about agitation as (unintelligible) behaviors that can - that are self (unintelligible).

So somebody (unintelligible) yelling or screaming out. Communication is pretty straightforward. Look at me, listen to me, do something.

Behaviors like (unintelligible), slapping, yelling, screaming, intend to call attention to the person and they want you to come. Generally these people who are agitated want something. They need something. And they are trying to get our attention. And I think the (unintelligible) as well.

Generally triggers for agitation might be something in the environment, too hot, too cold, too noisy, too quiet. It might infection. It might be pain, constipation, and so forth. From a human being standpoint, what

(unintelligible) has pointed out is that verbal agitation is often triggered by loneliness, detachment, and (unintelligible) or some other unmet need.

So when I use the word agitation I use it to collectively refer to those behaviors that are self (unintelligible) that appear to wish to communicate something is wrong, do something.

And if I (unintelligible) on a person centered level as to what they unmet need is for that person, because they can't tell me, then I go back to the usual suspects, the environment, infection, pain, constipation, and so forth that you see on the slide.

And I begin to address each of those systematically. And when that doesn't work I then continue to identify (unintelligible) preventions that might address one of the four unmet human needs for attachment, for (unintelligible), belonging, or loneliness.

It will always help to make sense of the communication and address the underlying problems, any of those medical or environmental or core human that I've mentioned. Rarely if ever will medication help in the instant of (unintelligible) behavior except in (unintelligible) for infection. But medications rarely help with agitation.

An exception to this rule is if the agitation (unintelligible) something is wrong behavior is driven by a significant depression. Teasing out depression in the face of dementia is difficult but not impossible. And an antidepressant in the face of an untreated depression and complicating the dementia may sometimes be indicated.

Aggression on the other hand is very clearly a (unintelligible) behavior. When somebody is hitting, kicking, pinching, biting, threatening, swearing, (unintelligible), pulling someone's hair they are not saying come closer. When someone's being aggressive they are saying quite clearly go away, stop, leave me alone. Something is wrong but it's not with me, it's with you.

The common triggers for aggressive, which is another directive communication, tend to be fear, anxiety, frustration, (unintelligible) loss, medication, crowded, noisy environment, or a (unintelligible) or impatient staff.

Much of aggression can be prevented by a concerted effort to work with staff around their impatience and their tension when dealing with somebody who is afraid and escalating.

So much training now is in the direction of trying to help staff acquire skills for de-escalation because you can have the (unintelligible) of a situation where the person is beginning to express the stop, go away message, (unintelligible) at you or another resident.

And the approach to that resident to help decrease their fear is critical in both preventing injury and preventing reaching for the PRN.

To do this requires (unintelligible), take a deep breath, learning how to stay calm, learning how to be willing to stop what you are doing and back away, and if you have a headset that says this is about the relationship, not about getting the bath done - this is about the relationship, this is about the resident's quality of life, this is about the resident's point of view something's wrong here rather than I have to get (unintelligible) it makes it much easier to stop,

back away, take a deep breath, give yourself time to make sense of the communication and to address the underlying problem.

Now with respect to aggression, this may be the one area where medication may play a role.

There's an excellent slide deck from (Clyde) (unintelligible), again, from the UK on (unintelligible) website which talks about - a publication in the new study, looking once again about appropriate treatment of pain being a good intervention in both agitation and (unintelligible) loosely and in aggression. This is another area where analgesia might be an appropriate medication.

I'll talk in just a moment about the use of antipsychotics for treating severe aggression that is either driven by psychosis or fear. But before I do that let me first speak to what we do when the meaning is not clear and what the non-pharmacologic interventions are that we might want to try first.

If it's not clear what a person's behavior means, they're new, we don't know them very well, or (unintelligible), the approach is pretty straightforward. We stop, we ask what is this person trying to tell me, you huddle, and you ask is there a history? Is there a pattern? Have we seen this before? Is it happening the same time day? Is it the same caregivers? When family visits, when family doesn't visit? And you begin to get to know them.

Asking if there's a history of the behavior, however, is not a green light for dismissing it. I've seen too many times when a behavior that has become familiar is expressed - when patient's express (unintelligible) staff say, that's John, he always does that.



And no, (unintelligible) tell us something. If the behavior is problematic it becomes critical to ask the - what is he trying to say if he's doing this all the time as opposed to saying this is what people with dementia do, which is why it's so critical to look at it from that point of standing in the person's shoes.

And then when the meaning is not clear you ask what has worked and what hasn't worked in terms of altering that behavior. You identify the unmet needs. You address that need, having (unintelligible) flexibility and anticipate the need to prevent the behavior.

Absent that, the strategies that have been employed with some success include these. And for the best summation I call your attention to the (unintelligible) Association's recent publication in this regard, which can be found at their website because they have summed up all the data on non-pharmacological interventions and I think laid it out very nicely.

As I said where we (unintelligible) just a little in whether we think of these as communications or behavioral psychological symptoms of a disease but the summation is quite (unintelligible).

The intervention that I have (unintelligible) is the intervention of personalized individualized (unintelligible). And if you haven't (unintelligible) website I really, really direct your attention to it because (unintelligible) has done extraordinary work out of New York in terms of taking advantage of new technology like iPod shuffles to create for residents 500 of their favorite songs as a way of "reducing agitation, reducing depression, awaking the memory, and creating more opportunities for social interaction and engagement."

And the notion of using music is not new in caring for people with dementia. What I (unintelligible) about the work of (unintelligible) and his colleagues is that it is - comes from a person centered perspective. It is individualized.

And it's working. And he is expanding that to -looking at it in a variety of populations and now (unintelligible) some of those - the expansion of the research to really make this an evidence based practice. But music has been an intervention that does work as an intervention.

It does however work before the person is ramped up all the way - it works better before a person becomes very agitated, that is calling out and so forth, than it does after a person is completely escalated.

Massage has mixed reviewed. Like with everything it's worth trying on an individual basis. It can be a foot rub or a hand rub or it could be a body massage or rubbing shoulders. And the data I think (unintelligible) evidence based is really (unintelligible).

Recreational (unintelligible) like this but not being bored, feeling engaged (unintelligible) pleasurably helps.

One of the therapies (unintelligible). One of the problems with aromatherapy or frankly any non-pharmacologic interventions is not used in a person centered way are pretty much doomed to fail.

I was recently talking with a group of physicians and directors (unintelligible) these issues and one of the administrators said that I heard that lavender was really good for helping people so I went out and I bought some lavender spray and put it on the (unintelligible) and it didn't seem to help a bit.

And that doesn't surprise me because lavender might not help for everybody but it's always worth asking on an individualized basis, using the evidence (unintelligible) things that might work, asking a resident (unintelligible) families that would like to try it.

Try it, see if it works for that person, and if it doesn't, (unintelligible) continue. That doesn't mean aromatherapy might not help the next person. Much of person centered care is a continuous process of trying things for which there's a little bit of evidence that they might work, seeing if they work for that person, and (unintelligible) if they do, and discontinuing if they don't.

So let's now look at medications. If these other interventions which we always go to first don't work what do we reach for? (Unintelligible) reached for just about any psychotropic that was available.

We've looked at using (unintelligible) antidepressant, antipsychotics, (unintelligible) to try to find something that we knew modified the brain because we don't have an anti-agitation or anti-aggression drug. There simply isn't one that exists.

The focus of our attention currently is on antipsychotics but frankly it could as easily be on any of these other off label drugs.

Antipsychotics for those of you who aren't as familiar with the names of some of them are listed here for reference for you. The problem with medication is that when we use any of these, but particularly the (unintelligible) antipsychotics, we're always using them in an off label way and that means that the risk benefit equation becomes very, very critical in terms of deciding whether or not to (unintelligible).

My additional problem with medication is that it reinforces - reaching for the medication reinforces the notion that behaviors are symptoms and doesn't always lend itself as (unintelligible) to thinking about behaviors as communications.

To put it differently, why would you medicate something if it were just a message. So I think the emphasis on medication can disserve residents in a couple of ways.

Finally, the risk of using these drugs are real and the benefits are quite (unintelligible) as we really emphasized last week. Those risk include (unintelligible), increased risk of pressure ulcers, diminished quality of life, and increased risk of death.

Significant adverse events associated with antipsychotic use specifically in people with dementia include (unintelligible) disturbance, respiratory infections. You can see the list.

Specifically with (unintelligible), one of the most successful pharmaceutical campaigned drugs, (unintelligible), actually has been associated with accelerated cognitive decline. So that (unintelligible) which you can access at the (unintelligible) website.

Threefold increase risk of stroke and increased risk of death. So even though antipsychotics may have some benefit it is (unintelligible) from the risks are generally greater.

Nonetheless, it is important for us to appreciate that in some situations such as severe aggression that may threaten the (unintelligible) of a person resident,

that may threaten the loss of relationships that's important to a person, it may be appropriate to have a short term trial of an antipsychotic.

The antipsychotic I think that is probably - I think the evidence of this is pretty (unintelligible). The medication (unintelligible) that is preferred is (unintelligible). So in the face of severe aggression it may be appropriate. In the face of severe psychosis antipsychotics are good for psychosis.

Psychotic (unintelligible) are things like delusions, hallucinations, (unintelligible) symptoms. However, delusions that don't interfere with the quality of life, however closely they're held, don't need treatment. We should only try the treatment for symptoms that are disruptive to the quality of life or threaten the health (unintelligible) security of the resident.

The evidence is pretty clear, (unintelligible), but if medications are to be used (unintelligible) after 12 weeks. (Unintelligible) these medications is always a matter of starting with what is the person trying to tell me, figuring out what to do, trying non-pharmacological strategies first, then if you're going to use medication choose according to specific syndromes.

If it looks more like depression you don't reach for antipsychotics. Just (unintelligible). Reach for a drug with specific symptoms, in the case of depression you might reach for an antidepressant. We identify the target, having identified the target we communicate that target to the family, to the residents, to the team. Complete the medical assessments.

Make sure that a person centered plan incorporates all the non-pharmacologic strategies. All of those alternatives, including analgesics go first before you go to antipsychotics. Families and residents must be involved (unintelligible).

Once all that's done you go for (unintelligible) dose, monitor the side effects, review that benefit risk equation after six weeks, and discontinue at 12 weeks. That will be an appropriate way to pursue or to use medications for the persons with severe aggression threatens the (unintelligible).

And I'm delighted to see that just today from CNS sent out the much awaited Hand in Hand curriculum as a tool. It's making available to nursing homes to really teach person centered care in dementia.

I still haven't seen the Hand to Hand curriculum yet. I'm eager to take a look at it but I've heard very good things about it. (Unintelligible) patients will have a look this afternoon if you wish.

The curriculum that I was involved with - creating a curriculum known as Oasis I hope to make available to all after the first of the year. Oasis curriculum training is currently being rolled out in 100 homes in Massachusetts after a successful pilot last year in ten home sin Massachusetts.

Clearly looking at how to implement person centered dementia care and getting staff the tools, the knowledge - from my point of view, the attitudes that they need to do this work.

There are probably others out there. I don't know about all of them. My suggestion is that you take a look at Hand in Hand and when I can make Oasis available to a larger audience I'd be happy to do that. We're rolling it out in 100% (unintelligible) over the next year and have started that process already. So we hope to have Oasis competent staff trained in a very short period of time.

This is a slide that summarizes Dr. (Ballard)'s work. I won't read it all to you but it's basically captures what I just told you. (Unintelligible) I hope will be pursuing some strategies with the (unintelligible) that you work in.

I would recommend that (unintelligible) the summary slides (unintelligible) physicians really capturing physician's perspectives and those that prescribe the (unintelligible) just kind of captures best I think what we know about antipsychotic use. Limited use, (unintelligible) high risk, sometimes okay, never before we try (unintelligible) first.

So in closing, now that we know better we have to do better. (Unintelligible) person centered dementia care helps us achieve many aims, not just in (unintelligible) quality of life but an improvement in many of the healthcare outcomes that we've been working hard on for many years.

Finally, I hope you agree that antipsychotics can and should be reduced. I thank you for being here, for staying for the conversation, and you'll see that what follows on the rest of your slide deck are references that I've (unintelligible) slides, and then a series of resources that are available to you as well. So resources, references at the end of the slide deck. And I...

Jackie Hairston: And we're going to now open up the lines so that we can just take a minute to talk about what you heard today. Now on the - those of you that are on the WebEx I put on the chat features some questions to be thinking about as you were listening to Dr. Wehry.

So Operator, I'm going to ask that you open up the lines and just for a couple of minutes, not so long. If some of you on the line would like to share what you heard and what resonate with you. Are you able to see the connection that

these non-pharmacological interventions can have on reducing - on the use of antipsychotics?

So Operator, can you tell folks how they can comment?

Operator: Thank you. Ladies and gentlemen, if you'd like to register a question please press the 1 followed by the 4 on your telephone. You'll hear a three toned prompt to acknowledge your request.

If your question has been answered and you'd like to withdraw your registration please press the 1 followed by the 3. If you're using a speakerphone please lift your handset before entering your request. One moment please for the first question or comment.

Ladies and gentlemen, as a reminder, to register for a question or comment pres the 1-4.

Jackie Hairston: And we're a small group this morning so if you could just share - say one thing you heard that maybe you're already doing at your facility that you would like to share with the rest of us that's working as you - as all of you probably have - are working with dementia residents in your facility that have dementia. Don't be shy guys, I know you're not shy.

Operator, can you remind folks again how to get into the queue?

Operator: Absolutely, ladies and gentlemen, as a reminder, to register for a question or comment press the 1-4 on your telephone.

Jackie Hairston: Thank you. While we're waiting for folks to get their thoughts together I know as I've been going out to facilities and talking to folks everybody's



dealing with residents that have some kind of cognitive loss and are struggling and are challenged in controlling the behaviors.

And a lot of folks are really nervous about removing the antipsychotics but I think what we heard here today from Dr. Wehry is that there really is a way that it can be done. And again, she wasn't advocating that we don't ever use antipsychotics again. They have their place and they're appropriate. And really gave us a lot of food for thought.

Do we have anyone that would like to share what they're doing with their dementia residents?

Operator: As a reminder, to register for a question press the 1-4.

Jackie Hairston: Okay. Well, since we have a quiet group today I'm going to go ahead and not belabor the call. Those of you that are on the WebEx, there is a polling question, if you would please take a few minutes to answer those polling questions we do value your comments and your thoughts and so that we can make these presentations more valuable to you.

And again, I want to thank all of you for joining the call. And so Operator, you can officially - I'll turn it back over to you.

Operator: Ladies and gentlemen, that does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your line.

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