EDGE

Electronic Dementia Guide for Excellence

EDGE Training Manual

Including Implementing EDGE DVD

THE JEWISH HOME & HOSPITAL LIFECARE SYSTEM
SARAH NEUMAN
CENTER FOR HEALTHCARE & REHABILITATION

WESTCHESTER

EDGE Training Manual

Acknowledgements

Disclaimer

This manual is an adaptation of the complete and original **EDGE** manual. This modified version was developed at The Sarah Neuman Center for Healthcare and Rehabilitation [The Westchester Division of The Jewish Home and Hospital] and it offers a practical "how-to" guide to implement an **EDGE** training program.

The overall goal of this manual is that it be used by any group of staff who wish to implement **EDGE** in their facility. It offers suggestions and guidelines about what worked for us. However, it is recommended that readers of this manual feel free to modify it for the needs of your residents and facility. The complete and original guide should always be referred to as the source material. That can be found at *dementiasolutions.com.*

Our training model included all three shifts of staff trained together in our classes. We found that this model worked very well because in some cases the residents behave very differently at different times of the day. Therefore staff was able to share knowledge about their residents based on a 24-hour period. This model also helped to bond the team together. It provided a means for staff who ordinarily do not work together to meet and learn together.

THE JEWISH HOME & HOSPITAL LIFECARE SYSTEM

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EDGE Training Manual—Table Of Contents

Introduction

The original purpose of implementing the **EDGE** model was in response to a New York State Department of Health grant to test the efficacy of the **BASICS/EDGE** model as a discrete intervention on two dementia units, as well as a catalyst for facility-wide culture change. Consistent with this model, the ongoing training focused on the Eight Keys to Implement **EDGE**. In its pilot testing, these were determined as the "building blocks" to create the most effective and comprehensive base from which to build a quality care dementia program.

In order to accomplish the training for **EDGE**, nine staff members underwent a five-day Train-the-Trainer session conducted by Judah Ronch, Ph.D., **EDGE** consultant. These trainers then developed a training program and facilitated the training of all staff on the dementia units. Each of the keys had a primary and a secondary trainer. Each of the "**EDGE** Trainers" met weekly to plan and organize the training program.

The **EDGE** trainers designed a training curriculum and training manual specific for Sarah Neuman.

What Is EDGE?

EDGE is an acronym for the Electronic Dementia Guide for Excellence.
It can be found online at *dementiasolutions.com*.
It was developed as an electronic or online system of information.

The purpose of **EDGE** was to be a quality improvement tool that:

1. Seeks to improve the process of caring for residents with dementia in long term care by teaching all persons who deal with the resident how to support the resident's attempts to obtain the highest quality of life possible.

2. Includes receiving input for the care plan from all persons who have an impact on the resident's life. For example, staff in all departments, family, volunteers, and frequent visitors.

3. Looks at a resident with dementia as a person with memory impairment who needs certain adaptive requirements to function at his/her highest level, just as any other person who is mentally or physically challenged.

4. Does not consider these adaptations "special care", but *necessary* care; as wheelchairs, walkers, and hearing aids are for persons who need them to cope with certain physical challenges.

5. Is meant to be a *starting point* to help *all* facility staff to learn how to *assess the ongoing needs of their residents with dementia* in a comprehensive way in order to plan interventions and services that meet their needs.

6. Is based on the **BASICS** *Hierarchy of Resident Needs* in long term care which outlines the needs of a resident with dementia on every level, from the most basic-biological (life-sustaining) to the highest level – creative and symbolic (life-defining), *the same needs we all have.*

7. Uses **BASICS** to look at a resident's problems *and* strengths to present a comprehensive picture of how well the resident's needs on every level are being met in the facility. **BASICS** gives staff a place to start in planning care for residents with multiple problems.

8. Provides in-services and worksheets to teach staff to evaluate each resident with dementia in order to determine his/her place on the **BASICS** Hierarchy and then to plan interventions to satisfy needs on that level. In this way, the resident is supported to reach for the next level of need satisfaction.

9. Illuminate the fact that, conversely, when a level of need is not satisfied (such as the need for self-dependence, sometimes not fostered because of institutional rituals), a resident can remain stuck on one level and as a result behave in a distressed or distressing way. The resident may even regress to a lower level of function when strengths are not recognized and supported.

10. Uses **EDGE** *Caregiver Goals* to direct quality care by focusing staff on what they can do to meet resident needs on every level of BASICS proposing that "problem behavior" is caused by unmet needs. Specific examples of how to meet each of the six Caregiver Goals during daily care are provided.

*The **EDGE** Program looks at a person with dementia as a whole person with multiple needs and many personal resources instead of as a one-dimensional confused person with a particular memory-based problem that needs to be addressed.*

The Eight KEYS

The **EDGE** Program is implemented through the application of eight (8) Keys. These keys provide the most effective and comprehensive method of building a quality dementia care program. Each Key is a resource to understand and more positively deal with a resident who has dementia.

First KEY	Meeting with Staff on All Levels
Second KEY	In-service: Building Staff-Resident Relationships, A Big Band Musical Program
Third KEY	**BASICS** In-service: Looking at the Quality of Life of Individual Residents with Dementia
Fourth KEY	In-service: Understanding Resident Needs When Coping with Physically Aggressive Behavior (PAB) and Other Disruptive Behavior
Fifth KEY	In-service: Tea Group – A Special Program for the "Difficult Resident"
Sixth KEY	Communication In-service: Breakfast (Lunch or Supper) Club
Seventh KEY	In-service: Putting Quality Dementia Care Principles into Practice
Eighth KEY	In-service: Strength-Based Care Planning using **BASICS**

KEY 1 – Meetings With Staff On All Levels

The purpose of Key 1 is to introduce **EDGE** *to all members of a facility. Since EDGE provides a means to help all staff in a facility understand the needs of a resident with dementia, it is important to include everyone in the training. The first meeting should be with the Administration of a facility.*

Step 1
Meeting with Administration

The purpose of this meeting is to:

a) Review the **EDGE** program
b) Decide to use **EDGE**
c) Select targeted units or resident groups to use **EDGE**
d) Appoint motivated **EDGE** trainers who are:
 • Informed and interested in quality dementia care
 • Staff motivators
 • Able to work well with all departments
e) Allocate time and resources needed to implement **EDGE**
f) Schedule the Department Head Meeting to introduce **EDGE** and the proposed training schedule

Step 2
Department Head Meeting

This Key suggests that at this meeting, Administration introduces the **EDGE** model. In our facility, after the introduction, each of the **EDGE** Trainers explained an aspect of **EDGE**. For example, What **EDGE** is; the **BASICS** model; Caregiver Questions; Caregiver Goals; Department Meetings; Training Schedule and the Timeline.

The Handouts that we distributed at this meeting follow:

• Proposed **EDGE** Training Timeline [SRN document]

• Functional Breakdown for Departmental Information Worksheet [web site]

• Departmental Information Worksheet [web site]

EDGE Training Timeline

October 2003

EDGE Train the Trainer sessions

November 2003

1. Administration Meeting 11/4
2. Department Head Meeting #1
3. Supplies/Budget

December 2003

1. Plan training dates for 2004 (by 12/15)
2. Assign all training modules (by 12/15)
3. Choose training cohorts (include Medicine and Rehab) (by 12/15)
4. Attend department based meetings (all/to be assigned)
5. Develop customized Key 7 for orientation, families, non-clinical departments (by 12/15)

January 2004

1. Department Head Meeting #2
2. Develop Evaluation Process and Tool (by 1/15)
3. Final Version of Training Manual (1/15)
4. Secure Location for training sessions (by 1/15)

February 2004

Start training sessions

May 2004

Initial training sessions completed

Next Steps

1. Monthly mentored practice meetings
2. Develop family training (by 6/04)

Step 3
Departmental Follow-up

After the Department Head meeting, each trainer worked with a department head using the Functional Breakdown Information Worksheet. By attending local staff meetings the trainers then assisted each Department Head to introduce the **EDGE** model to their staff. The information gathered served as baseline data about the level of care being delivered at that time.

Functional Breakdown for Departmental Information Worksheets

These descriptions are not meant to be diagnostic, but are an aid to help you think about our resident population and the kinds of approaches we can use to help them enjoy a higher quality of life.

Also, the progression of functional behavioral change is gradual and abilities are not lost overnight. Therefore, residents will gradually show signs more common to one phase than the other as dementia progresses, so no clear transition point will occur.

Higher Functioning Phase

Symptoms are mostly seen in deterioration of complex social/personal skills, requiring a gradual increase in the amount of assistance from others in dressing, bathing and toileting, in that order.

Examples:

- Has trouble interacting at social events; may become less outgoing
- Can't remember important aspects of personal life, names of grandchildren, high school or college attended
- Loses words, then thoughts and may make up stories to fill gaps of memory
- Trouble concentrating on 2 to 3 step tasks of daily living and leaves things poorly done like dressing incompletely, not completing personal hygiene tasks
- Loss of impulse control is possible, resulting in verbal outbursts, taking things which don't belong, sloppier table manners
- Some disorientation to date, day of the week, season, year
- Trouble following written signs, multi-step verbal directions (i.e. brush your teeth)
- May not remember having visitors or recent activities
- Becomes less able to find familiar places in the environment
- Becomes occasionally, then gradually incontinent of bladder, then bowel until full assistance with toileting may be required
- May repeatedly perform simple activities, like cleaning, folding things, emptying and filling purse, packing and unpacking bags
- Speaks with gradually fewer intelligible words
- May have moderate to severe anxiety, agitation and physically aggressive behavior
- Difficulty getting into chair, using utensils
- Loses willpower and is unable to put self in motion or initiate action, but may still respond to caregiver directions for simple tasks

Lower Functioning Phase

Symptoms are indicative of the severe cognitive and functional decline, which results in the loss of ability to perform basic bodily functions, necessitating total care.

Examples:

- Needs total help with bathing, dressing and toileting

- Communicates using one or two words, at most, but still appears to understand when spoken to for some time

- Can respond to social stimuli by attending or showing pleasure, discomfort

- Loses weight, even if fed a proper diet

- Unable to walk

- Unable to sit up

- May scream or groan

- Unable to smile spontaneously, but may smile occasionally or laugh when hearing a familiar voice or music

- Unable to hold head up independently

- Eyes closed much of the time though awake and responsive in other ways to voices, music

- Sleeps much of the time, appears the brain no longer tells the body what to do

- May have seizures, cervical contractures

- Appears to be out of contact with the external environment, but may respond at times to positive touch, taste or temperature stimuli

Printable worksheets are available from www.dimentiasolutions.com.

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Step 4
Planning and Implementation

The **EDGE** trainers met on a weekly basis to adapt the **EDGE** curriculum to meet the needs of the facility. The trainers reviewed the five-day training we had experienced in the Train-the-Trainer session, including both the didactic and experiential components.

Based on the overall goal of our facility, to eventually train all staff, it was decided to develop a two-day curriculum for the staff on the dementia units. The plan was to train all community staff from all three shifts as a group. Additionally, the trainers believed that the experiential aspects of the training (the in-services), would be more beneficial if actual residents participated (rather than staff simulating residents).

The trainers then developed a training schedule and worked with Department Heads to schedule staff and backfill in order to ensure that the care of the residents on the units wouldn't be affected.

Cooperation from the Therapeutic Recreation staff was garnered in order to get their support for the experiential portion of the training, as well as not to conflict with previously scheduled activities for the residents who would be a part of the **EDGE** program.

Based on our experience, it is recommended to keep the number of participants in the training between 12 and 14.

Upon completion of the two-day training sessions for the dementia population; a decision was made to provide similar training to all the SRN staff. In order to accomplish this, the trainers developed the curriculum into a one-day training model. Subsequently when backfill money was not available, and staff could not be released for an entire day, the trainers developed the curriculum into four one-hour training modules.

EDGE Training Agenda—Day 1

Time	Activity
8:30 – 9:00 am	Welcome Introduction to **EDGE**
9:00 – 10:00 am	**BASICS** (KEY 3)
10:00 – 10:15 am	Break
10:15 – 11:30 am	Big Band (KEY 2)
11:30 am – 12:00 pm	Communication (KEY 6)
12:00 – 12:45 pm	Lunch
12:45 – 1:30 pm	Putting Dementia Care Principles Into Practice (KEY 7) Part 1
1:30 – 1:45 pm	Tea Group (KEY 5) Introduction
1:45 – 2:30 pm	Tea Group Experiential
2:30 – 2:45 pm	Tea Group Debrief
2:45 – 3:00 pm	Break
3:00 – 3:30 pm	Putting Dementia Care Principles Into Practice (KEY 7) Part 2
3:30 – 4:00 pm	Eliciting Feedback

EDGE Training Agenda—Day 2

Time	Activity
8:30 – 11:30 am	Physically Aggressive Behavior (PAB) KEY 4
11:30 am – 1:00 pm	Lunch Club KEY 6
1:00 – 1:45 pm	Lunch break
1:45 – 2:00 pm	Lunch Club KEY 6 Debrief
2:00 – 3:00 pm	Strength-based Care Planning KEY 8
3:00 – 4:00 pm	Highlights/Brainstorming/Implementation Next Steps
4:00 – 4:30 pm	Evaluations

NOTE: The trainers decided not to train the KEYS in sequential order. Partially, this was to accommodate the schedule of our residents and not interfere with their meal times, etc. The decision to begin the training with a didactic on BASICS was done to introduce the concepts of BASICS, which are the foundation of the EDGE model.

KEY 2 – Building Staff-Resident Relationships: A Big Band Musical Program

The purpose of the Big Band Musical Program is to use music from the past to assist residents with dementia to recall their personal history and increase opportunities for positive social interaction with staff. Those residents who would most benefit from such a program are those who do not generally initiate social interaction, but who do respond socially when engaged one to one. The goal for these residents is to improve mood, social interaction, and ability to share personal history, thereby enhancing quality of life.

Key 2 – Big Band

Learning Objectives:

As a result of this program, participants will be able to:

• Identify three residents that would benefit from this intervention;

• State three ways of supporting the resident to take part in this intervention;

• List three musical instruments that a resident with dementia might enjoy playing;

• Name three songs or pieces of music that residents in this facility might enjoy

Rationale

Music is an inexpensive, popular, practical and traditionally effective way of enhancing the quality of life of residents with dementia in nursing facilities.

The Big Band program can be looked at in the context of "person-centered care". Rather than seeing people with dementia as the ones having problems and those who are caring for them as having none, person centered care theory suggests that many of the problems in dementia care are interpersonal. They occur in communication. The relationships between the caregivers and those we are caring for are psychotherapeutic relationships. In person centered care, the relationships between all people in the care environment should be nurtured.

Person-centered care encompasses four major elements (**VIPS**, **V**aluing, **I**ndividuals, **P**erspective, **S**ocial) each of which are enhanced during this program. Let's talk about how each of these elements is reflected in big band (Brooker, 2004):

1. **V**aluing people with dementia and those who care for them

2. Treating people as **I**ndividuals

3. Looking at the world from the perspective of the **P**erson with dementia

4. A positive **S**ocial environment in which the person living with dementia can experience relative well being

Program Elements:

1. Familiar music provides sensory and memory stimulation and a friendly forum for social interaction for residents with dementia.

2. Music from the Big Bands, parade music, ethnic songs, and songs of the 20's 30's are part of the past youth for most of the residents with dementia in nursing facilities today.

3. Instruments that are easy for the resident to play or that residents have played in the past, and are still able to enjoy, are made available.

4. Residents are selected to participate in the activity by staff and interdisciplinary team members. Compatible residents can be grouped together into different groups.

5. The size of the group should be determined by the needs of the residents involved, and the number of staff available.

6. There should be enough staff and/or volunteer personnel that are familiar with the resident's abilities and personalities, to cue each resident to participate in whichever way the resident is able or wishes to take part in the program.

7. The facilitators and staff need to generate positive energy toward the activity and praise each resident's individual contribution to it.

8. Any staff volunteers or family members coming to the program should be invited to join the group's circle and participate as part of the group in whatever way they feel comfortable. *They should not be allowed to stand and watch as observers as this is very distracting to the group, it is not respectful of the goals of the program, and is intimidating to some participants.*

9. The room the activity is held in should be comfortable and cheerful and available for each session.

10. Social interaction should be encouraged and fostered.

11. Each facilitator or staff member present should be assigned to cue a certain number or residents, five or six works best.

Key 2 – Big Band

Guidelines:

Have the room prepared, with music playing as residents are brought in. As everyone gets settled, offer musical instruments
Sing along…one to one interaction…and have a blast!!!

All staff, including administration, all members of the interdisciplinary team, and primary care staff should take turns attending the music group in order to:

• Support the resident in the activity,

• Capture all outcomes for care planning, and,

• Increase the beneficial effects obtained from the program by reinforcing the use of social and memory skills in their daily interactions with the resident.

Program Facilitation Notes

30 minutes lecture
45 minutes program facilitation
30 minutes program debrief

Preparation:

Program facilitator should:

• Reserve space large enough for program (i.e. dining room, day room,)

• Develop list of five or six residents who would benefit from participating in this program. These are residents who are in the higher functioning phase of dementia (by our definition), but specifically require one to one engagement to participate in an activity.

• Communicate this list to unit staff the DAY BEFORE THE PROGRAM to have residents ready for program by on time.

• Have equipment ready for use:

• CD player

• CD ("Sound Choice Reminiscing Series volume 4 and 5)

• Instruments on cart

• Set up chairs in a circle, with room for wheelchairs as necessary. There should be enough chairs for each resident as well as each staff member attending.

Key 3 – BASICS In-Service

The purpose of Key 3 is to introduce the concepts of BASICS and how they relate to residents with dementia as well as caregivers.

Learning Objectives:

Upon completion of the program the participant will be able to:

- List three ways to learn about the self-concept and personal preferences of a resident with dementia
- Use the sample worksheet to gather information and formulate suggestions for improving quality of life for an individual resident with dementia

What is EDGE?

EDGE stands for Electronic Dementia Guide for Excellence. It is developed to be a quality improvement tool that seeks to improve the process of caring for residents with dementia in long term care by teaching all persons who deal with the resident how to support the resident's attempts to obtain the highest quality of life possible.

EDGE looks at a person with dementia as a whole person with multiple needs and many personal resources instead of a one-dimensional confused person with a particular memory-based problem that needs to be addressed.

EDGE is based on the **BASICS** Hierarchy of Residents needs in long term care which outlines the needs of a resident with dementia on every level, from the most basic-biological (life-sustaining) to the highest level-creative and symbolic (life-defining).

BASICS looks at a resident's problems and strengths to present a comprehensive picture of how well the resident's needs on every level are being met in the facility.

Review of BASICS

Each letter in the word **BASICS** represent a level in the hierarchy model of resident needs (refer to the handout for **BASICS**). [Suggestion is to have this enlarged and placed in the front of the room to be a visual cue to participants].

The **B** represents the resident's biological needs, for example the basic need for food, water, oxygen, safety and rest. Traditionally this need has been perceived as the responsibility of nursing. However, when you look at what this need really represents all departments are important in achieving this level. Nursing may assist the resident eating but dietary supplies the food. Engineering ensures that there is adequate heat or air conditioning. As with any of us, if this need is not met we will not go on to the next level.

The **A** represents the resident's Activities of Daily Living the personal needs that support life style such as eating, mobility, dressing and toileting

The **S** represents the resident's Societal needs, their need for a unique personal identity, and privacy. For example, how do they view themselves in society?

The **I** represents the resident's interpersonal needs, the need to feel a connection with others. The development of relationships with staff and other residents is at the heart of this.

The **C** represents the resident's need for creativity. This represents the resident's need for personal expression, problem solving opportunities and meaningful activity.

And finally the **S** represents symbolic needs the need for expression of beliefs, hopes, dreams, values and autonomy. At this level the resident will have a sense of peace in their universe.

Looking Inward

Discussion questions:
Ask participants to break into pairs and complete the questionnaire for **BASICS** in-service allow 10 minutes to complete and 5 minutes for discussion

Did you learn anything about your self-concept and needs while completing the questionnaire?

Did this help you to view your resident's differently?

Ask others in the group to share their answer to Question #10.

If you were to go into a nursing facility, what would you like the staff to remember when caring for you?

Looking at Your Residents

Discussion Questions:
Use either small groups and complete a **BASICS** worksheet on a resident or choose a resident familiar to most of the participants and complete a **BASICS** worksheet on that resident.

Ask each group to give you information about the resident they discussed and/or wrote on the worksheets and write it on the flip chart for discussion

How do you see the resident?

How does the resident like to be seen?

1. What can the resident do? What does the resident like to do most, on his own or with limited assistance?

2. What makes the resident happy?

3. What suggestions do you have for improving the resident's quality of life?

In summary, discuss **BASICS** and putting the following words to a familiar song, sing the **BASICS** song with all the participants.

B	a need I have that is biological
A	an ADL I still can do
S	the name I call myself
I	the people I have fun with
C	a drawing I have done
S	I am all I can be

BASICS it's what **EDGE** is all about and that will bring us back to **BASICS**, **BASICS**!!

(1) Adapted for EDGE from Vickers, R. (1974). Originally modified with permission in J.L. Ronch, (July/August 1987). Specialized Alzheimer's unit in nursing homes: Pros and Cons. American Journal of Alzheimer's Care and Related Disorders & Research, 2, 10-19.

BASICS Hierarchy Model Of Residents' Needs In Long-Term Care

(**EDGE** looks at all levels of need for residents with dementia)

Need Satisfied

Fosters

1. Biological
Basic needs for food, water, oxygen, safety, rest, human stimulation.

self-preservation
Resident physically cared for and safe.

2. Activities of Daily Living
Personal needs that support life style (eating, mobility, dressing, toileting, personal hygiene).

self-dependence
Environment provides supplies and assistance to foster self-performance.

3. Societal
Need for unique personal identity, privacy (Resident's place in society).

self-identity
Environment provides for privacy affiliation with groups, culture, family customs, education, resident selection of associations with individuals and groups.

4. Inter-Personal
Need for connection with others (love and belonging).
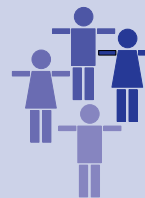
self-esteem
Environment fosters social role expression, supports interpersonal and social abilities, and promotes social confidence and an atmosphere of caring and being cared about.

5. Creative
Need for personal expression, problem solving opportunities, and meaningful activity.

Need for the activity in the resident's life that brings joy (face lights up-"the spark of life" is there, if even for a fleeting moment).

self-expression
Environment supports independent activity, humor, creativity, and encourages use of talents and skills. Environment identifies and fosters the activity that brings that "spark of life" to the resident. It also, supports the resident to continue to problem-solve and make decisions in his/her everyday life.

6. Symbolic
Need for expression of: beliefs, hopes, dreams, values and autonomy (ability to control important aspects of life). Sense of peace in the universe according to the individual resident's belief of the meaning of life.

self-actualization
Environment encourages hopefulness and self-fulfillment: ("Being all you can be") Environment respects and encourages expression of the spiritual dimension of the resident and supports spiritual ministry from outside sources as requested by the resident or family.

The purpose of Key 4 is to diminish physically aggressive behaviors (PAB) in residents with dementia by determining the purpose or meaning of the behavior to the resident and in this light, plan alternative interventions that will meet the resident's needs or goals and eliminate the need for PAB.

Learning Objectives

Participants will be able to:

1. Define physically aggressive behavior.

2. List two common background factors that can lead to PAB

3. Identify two variable factors that can lead to PAB

4. Use a worksheet to document a resident's PAB and the circumstances under which they occur

5. Work with the group to brainstorm ways to help a resident cope without using disruptive behavior

Handouts:
(These can be found on the internet at dementiasolutions.com)

1. **EDGE** Handout A: Factors Affecting PAB and other Disruptive Behavior

2. Worksheet A: Coping with PAB and other Disruptive Behaviors

3. Worksheet B: **EDGE** Worksheet for Describing Disruptive Behavior

4. Worksheet C: Solving Problem(s) by "Being a Detective" and looking for that "Spark of Life"

5. Figure 3.5 Physically non-aggressive behaviors

6. Figure 3.4 Approaches to management of verbal agitation

7. 3.6 Approaches to management of aggressive behaviors

8. 3.3 A model for explaining agitated behaviors

9. Sample ID Care Plan for coping with PAB & other disruptive behavior

Other Resources:

1. **EDGE** Environmental Considerations Checklist for coping with PAB & other disruptive behavior

2. **EDGE** interdisciplinary team effort coping with PAB & other disruptive behavior

3. Individual Resident Crisis Prevention Plan for coping with PAB

Please note that it is very helpful throughout this segment to use many examples and tell stories of residents the staff are familiar with.

Key 4

Time	Activity
8:30 - 10:00 am	Two-minute video
	Lecture
	Questions
	Review **EDGE** Handout A and **EDGE**
	Interdisciplinary Team Effort Coping with Physically Aggressive Behavior (PAB) & Other Disruptive Behavior
	Review STOP Strategy
10:00 - 10:15 am	Break
10:15 - 11:00 am	Case Study (role-play)
	Group discussion of role play using Worksheet B for Describing Disruptive Behavior (Doris)
	Worksheet C for Doris in Role play
	Divide into groups, group exercise using Worksheet C and resident they all work with
11:00 - 11:30 am	Group Report

Suggested Lecture

The purpose of this part of the program is to learn how to diminish physically aggressive behavior in our people with dementia by:

• Determining the purpose or meaning of the behavior to the resident

• Plan alternative interventions that will meet the residents needs or goals

• Eliminate the need for PAB

We need to look at physically aggressive behavior apart from other types of agitated behaviors because they present unique health and safety issues

A Definition of Physically Aggressive Behavior

Actions that are perceived as a threat to self and others

Examples:

Behavior targeted toward self: Head banging; throwing self off bed or chair; attempts to hurt self

Behavior targeted toward others: Hitting; biting; scratching; kicking; choking; spitting at; grabbing; sexual advances

While physically aggressive behaviors may be dangerous to others as well as the resident, and may interfere with and disrupt clinical care routines, they may actually express or symbolize the resident's goals or needs.

Residents who have dementia can't always tell us what they need but show us with their actions

If we look at them in this way, these behaviors become meaningful and assist us to plan successful interventions that will help the resident meet their perceived needs and goals without PAB.

We know dementia is a chronic, progressive disease. Although memory loss is the most widely recognized result of organic brain deterioration in dementia, behavior problems result as well, and are commonly referred to under the label of "agitation".

The disruption caused by agitated behaviors detracts from the quality of life of all people who live and work in the community. Other residents may be alarmed or frightened, it may interfere with their activities; their personal space may be invaded by being touched or harmed; their possessions may be touched, taken or damaged. Agitation diminishes the care of residents because time that might be spent addressing resident needs is spent in managing the agitation. Agitation (resident, not staff) increases staff member's stress. Stress is created when the person resists care, stress is created by the need to get the job done and there is the danger of injury to staff from PAB.

We know from research that specific types of agitated behavior tend to occur frequently in people who have dementia. Let's take a moment to look at some of these types of behavior that can frequently be observed in our residents.

Verbally Non-Aggressive Behaviors

Frequently requesting attention; bossiness or pushiness; complaints or whining; Negativism; stubbornness; unnecessary interruptions.

Ask for an example of a resident in the neighborhood or community of those being trained who exhibit this behavior.

Verbally Aggressive Behavior

Cursing; exhibiting temper outbursts; making strange or menacing noises; screaming.

Ask for an example of a resident in the neighborhood or community of those being trained who exhibit this behavior

Refer to Figure 3.4 "Approaches to Management of Verbal Agitation" and discuss.

Physically Non-Aggressive Behaviors

Performing repetitious mannerisms; pacing; inappropriate handling of objects; aimless wandering; inappropriate dressing or undressing.

Ask for an example again of familiar residents who exhibits this type of behavior.

Physically Aggressive Behavior

Hitting; pushing; scratching; kicking; grabbing objects; grabbing people.

Ask for an example of someone in community who exhibits this type of behavior.

Physically aggressive behaviors frequently take place in response to an intrusion into personal space by staff members or other residents. It may be a response to felt danger, hallucinations, impulses and misperceptions of environmental stimuli.

What Could be Some Causes?

Changes in the Brain

May not recognize you, not understand what you are saying, unable to start (initiate) an activity, visual and spatial changes

Lifelong Habits and Personality

Personality traits before the onset of dementia may influence behavior. An individual who was physically active may pace and wander.

Ask everyone what time they get up on a work day and then what time do you wake up on your day off or vacation?

- *Have a discussion about life-long habits which will follow us into the nursing home.*

- *Insert a story about a behavior which can be explained by a habit.*

Current Condition — Physical and Mental

Physical discomfort or pain; the need to urinate; hunger; tiredness; medication (too much or too little); depression; impaired hearing or vision; infection; constipation.

How do you react when you are hungry or in pain? Give an example or ask for one.

Do you notice changes in the behavior of residents you care for daily before they are sick? Ask for examples.

Environment—Physical and Psychosocial

Hallucinations– sensory experiences that cannot be verified by someone else. Delusions– beliefs that are contrary to fact which remain fixed.

Feel insecure; unable to recognize people; too hot or too cold; Sensory overload including too many activities happening; too much noise; time of day (sundowning); being involved in ADL (especially bathing and toileting); feeling uncertain and insecure; not recognizing people.

Can you think about what in the environment makes you feel upset or anxious vs. calm?

Excess Disability

Factors that make someone more impaired than they need to be by not wearing eyeglasses, hearing aide, by not allowing the person to use their remaining strengths and abilities we create feelings of dependence and loss.

Example: If your Supervisor tells you or shows you how to do something you do frequently, how do you feel?
Ask for other examples.

Summary

Agitation results from the imbalance in the interaction among lifelong habits and personality, current physical and mental status and less than optimal environmental conditions.

Most agitated behaviors arise because of dementia related impairments in both communication and the ability to use the environment appropriately. These impairments cause frustration because they prevent the individual from meeting personal needs and because of the presence of the impairments themselves. In the presence of both frustration and organic brain deterioration, especially of the frontal lobe, disinhibitions of the aggressive impulses that often are concomitant with frustration become more likely. What does this mean?

Discuss using examples.

Key 4 – PAB

All Behavior Has Meaning

Behavior, whether appropriate or disturbing, usually has some reason about why it occurs. There are many reasons why challenging or disruptive behaviors may be occurring. These behaviors should not be looked on as "problems" with no solutions. Rather one should consider these behaviors as "challenges" to caregivers because they may not be problematic to the person with dementia. It is our role to assess and intervene as soon as possible.

We learned previously that PAB might be related to changes taking place in the brain. PAB may result from the resident's inability to inhibit angry impulses because the parts of the brain needed to do so are not functional. In other instances we discussed, there may be events or factors in the environment triggering the behavior.

Examples:
If someone does not feel well, he or she may act out via disrupting behavior.

Reactions that occur when an individual's choice is threatened or curtailed in a restrictive environment often lead to the challenging behavior

Hearing orders like "sit down, don't touch that, don't go into that room may trigger PAB.

A key principle that should guide dementia practice is the importance of recognizing personal freedom and independence. The resident with dementia is always striving for old competencies to obtain a feeling of goodness about him/herself. When the environment allows residents to feel competent in the present or good about themselves, the need to search through the past for adaptation skills that might not work well in the present is reduced.

Use an example of behavior exhibited by a resident that is familiar to the class which highlights this.

For example, a resident who worked the night shift and always left his home at 11PM. If he now lives in a nursing home and wakes at 11PM, not remembering he is retired. He tries to leave the building to go to work which is viewed as a problem by the staff.

His sense of self is strong and his past as a good worker guided his behavior. If we view this behavior as a normal response to a pathological condition (dementia) not a pathological response to a normal situation it is easier to understand.

As caregivers we need to learn to respond to this type of communication from the resident by learning signs that signal escalation to PAB and intervene with methods that have been found to be successful to meet resident's needs prior to the PAB occurring. Although PAB may be disruptive, dysfunctional or ineffective from our viewpoint, it may the most integrated and meaningful response possible for the resident who is coping with dementia.

We know caring for a resident with PAB can be overwhelming and scary. The behavior may trigger fear, anger and other uncomfortable feelings in us. We have to acknowledge this and support each other. We see more residents with PAB in nursing homes because they have nowhere else to go when they cannot be cared for successfully at home. What are two important reasons for residential placement: incontinence and aggressive behavior?

What Can We Do?

PAB is successfully managed and/or reduced if we collaborate and support each other; use each other expertise and experience and your knowledge about the resident to search for a solution, which works for the resident and staff.

If we look at all PAB as expressing a need we then need to become detectives to determine what the need is so that we can meet it.

We need to look for clues as to why the person is distressed.

We need to know the life story—can we find clues to an identity, such as doctor or teacher, spouse or parent.

We need to look at what happened just before the behavior started, where, why

We need a plan to manage:

• Brainstorm

• All staff involved

• What worked in the past?

• What does not work?

• Realize we may need to change interventions

• Communicate among all caregivers

• Ask if there are any questions or comments.

*Lead a discussion using "**EDGE** Interdisciplinary Team Effort Coping With Physically Aggressive Behavior (PAB) & Other Disruptive Behavior" as a guide.*

Review STOP Strategy, To Handle Caregiver's Feelings When Tensions Build

Do role play that follows, and debrief with entire group using Worksheet C.

Divide into smaller groups and using **EDGE** Worksheet C and the **BASICS** Hierarchy.

Brainstorm about coping with a problem behavior of a resident the group works with and is having difficulty with.

*Note: this will be more successful if the trainer knows the residents the groups will select in advance. **EDGE** Worksheet A, a guide to summarize information obtained from the MDS and review of the medical record, can be completed before the group exercise and information used by the group during the exercise.*

End with each group reporting back to the entire class and ask for a commitment to try the interventions suggested.

Role Play - Key 4

Doris, John, Wife, Staff member, one group member, musical instrument

Scene: Doris was in the music group with three other residents sitting between a married couple. She is looking at the group leader with steady attention while holding an instrument and waiting for the music to begin.

Doris got up quickly and sat in John's lap and started to stoke his arm as soon as the music began.

Staff member and John's wife asked Doris to get off John's lap.

John seems upset by the incident.

Staff member takes Doris by the arm and tried to encourage her to take her own chair.

Doris rushes toward staff member and screams loudly "leave me alone; mind your own business" and tries to hit her with the musical instrument.

Wife tells Doris she is crazy and takes her husband's arm and leaves room

Group member yells at Doris to sit down and behave herself, she should be ashamed of herself.

Doris does not let go of John's arm as his wife is leading him away "No, stay with me, You don't want to go with her, you belong with me"

John and wife: leave

Doris hangs her head and looks sad and is quiet. She looks at the other resident watching her and shouts "what are you looking at, mind your own business".

Debrief using Worksheet C.

The Tea Group is a highly structured and formal program that:

- *Helps the very impaired and "difficult" resident reconnect with their old social skills*
- *Helps the caregiver to find a common ground to be able to communicate and help form a more positive relationship.*
- *Provides a social experience that promotes a sense of identity with the competent self rather than the sick self.*
- *Aims to establish a sense of community among a group of peers where they can exercise control and belonging.*

Learning Objectives

Upon completion of this module, participants will be able to:

1. List three benefits residents may derive from attending the Tea Group.
2. Describe the type of resident that the Tea Group was designed for.
3. List four important parts of the ritual of the Tea Group.
4. Demonstrate one communication technique used in the Tea Group.

Rationale

The ritual of the tea group is universal: we make the tea, serve the tea and drink the tea together. Even residents with moderate dementia can display competent social behavior.

Objectives of the Program

1. To provide an opportunity for these residents to share with others, experience control, reaffirm a positive identity, and have respite from failure and negative feedback.
2. To provide an opportunity for staff to see these residents in a positive light, as they once were: responsible, competent and affable people.
3. To help staff learn to facilitate old competencies in these residents in a unique setting "away from the job" that does not threaten their sense of job competence.
4. To promote the carry over of approaches and attitudes, witnessed by staff during group, into daily interactions with these residents on the unit.

Participants of the Program

Program is for very impaired "behavior problem" residents (usually with hostile defensive or withdrawn behavior, often referred to as "biters, scratches, screamers or kickers" by staff).

- Participation is limited to residents with similar levels of functioning in order to promote a consistent environment and to foster group ownership and cohesiveness. Higher functioning residents joining the group would most likely take over the program, and the targeted residents would, once again, be excluded.
- These residents do not typically participate in regular recreation programs
- Resident's dementia interferes with successful adaptation to facility routines or rules of social behavior.
- Resident is capable of some socially appropriate response, even if only when approached in a friendly, undemanding manner.

Physical Environment for the Program

1. Room with a door that can be closed, free of distractions, noise and interruptions if possible.
2. A table set with a tablecloth and flowers or a centerpiece.
3. A tea service, including the teapot, creamer and sugar bowl, cups and saucers, teaspoons, napkins, hot water in a carafe or coffee/tea machine or a kettle to boil water on the stove if available. A container of tea bags, and a tray of assorted cookies or snacks on a separate cart or counter. (All of these articles are important because their familiarity stimulates old patterns of behavior and social competency.)
4. The seating at the table is arranged according to residents' needs, and the likelihood of interacting positively or negatively with one another.

The Ritual is important. Regular, consistent and predictable cues help the resident with dementia become adapted to the program. It also promotes group connection and fosters a sense of control in residents.

Roles

Because the Tea Group is highly structured and meant to be a "formal" gathering, it is important for members to understand their roles and act accordingly.

The Facilitator

The facilitator creates a positive reality for the participants by promoting their sense of control, safety, identity, and membership. This is accomplished by encouraging, accepting and praising members' participation; directing their participation by encouraging the reticent, checking the talkative; and, listening to, following and using the ideas of others.

The facilitator is often the mediator and interpreter for the group. Humor, diplomacy, and quick thinking are used to deflect and defuse provocative or belligerent comments from a resident. The challenge for the facilitator is to enable independence while ensuring safety and freedom from failure or embarrassment. This takes faith, trust, vigilance and ingenuity. For example, instead of wiping a resident's chin, the facilitator would hand him a napkin with a telling gesture as might be done to a friend or family member. Most residents will respond appropriately to this familiar cue. The residents' self-esteem is protected by asking for opinions and advice instead of facts.

The key to the success of the program is that residents are never exposed to negative feedback of any kind. Mistakes are not corrected unless the resident asks for help to correct them. The facilitator is the model and sets the standard for impeccable good manners and considerate behavior that is appropriate to a formal tea party.

Key 5 – Tea Group

The Members

The members are the real hosts of the Tea Group, not the facilitator. This fact must be reflected to anyone participating in the group. The members, because of their dementia, cannot assume the role of host unassisted, but take their cues from the facilitator. Every effort is made to treat the residents as competent, respectable and independent adults capable of doing for others and receiving thanks for it.

The Invited Guests

Invited guests are there to observe and learn from the interaction between the facilitator and the members, and to notice the behavior triggered by the different techniques used. They are asked to act as guests and allow themselves to be served by the members of the Tea Group. They are also asked to refrain from making any helping gestures toward residents, and behave as they would when invited to a friend's home for tea.

What Non-Participating Staff on the Unit Are Told

Non-participating staff may be asked to help set the table, set up the room, distribute invitations, and escort the residents to the group. Once the Tea Group begins, they should observe the program quietly.

The Tea Group Ritual

(Approximately 45 minutes with a group of about 6–8 residents)

1. Invitations Are Given Out To The Residents

- Pre-made invitations are handed to pre-determined residents with their name imprinted on the invitation
- Residents are invited to the Tea Group and asked to come
- If a resident does not wish to come to the tea group they are not forced to come. Remember that attendance is voluntary.

1. The Meeting Is Opened

The meeting is opened with formal introductions if membership is relatively new or greetings if members know everyone. Everyone's name is mentioned several times, and they are encouraged to greet one another. Absent members are mentioned, and each resident's contribution to the last meeting is acknowledged. Whatever conversation or comments members initiate is given preference and the facilitator takes cues from them.

2. The Making Of The Tea

All decisions, even the smallest, such as what type of tea to use, how many tea bags to use for the size of the carafe, whether the tea has steeped long enough, how to arrange the table, are reflected back to the group for consensus. The residents are so unused to having their opinion asked that in the beginning they take each question very seriously. By reflecting all decisions back to the group, the facilitator builds up their sense of control.

3. Residents Are Asked To Look Out For Each Others' Needs

As many of the tasks as possible are delegated to members of the group. In this way, the facilitator tries to identify possible roles for each resident, draw out competencies, and tries to promote interaction among the members of the group.

4. Conversation Develops

Conversation develops if the facilitator is patient, and lets things happen. If no one starts the conversation, the facilitator can start with a short conversation about what (s)he did over the weekend. Each resident is asked if they had a similar experience some time in their lives. For example, if the facilitator relates that she went skiing: "Has any one else enjoyed skiing with their families? Playing in the snow? Sleigh riding?" Each participant is asked about his or her experience with snow.

New conversations develop and the conversation takes new twists and turns. If a resident or guest begin to monopolize the conversation, the facilitator can say, "Let's ask Mary if she ever did that" to move the conversation along.

If the conversation lags, the facilitator can say, "it is certainly nice to get together and have this time to get to know each other better isn't it?"

Residents seem to respond positively to this. It seems to give them something positive that is easy to respond to and expresses their feeling when sometimes they cannot.

Silence is also acceptable. Sometimes, just being in a pleasant atmosphere away from the noise of the unit, may be what a resident enjoys. When residents feel comfortable and safe, they feel free to risk more ideas, and begin to interact more freely.

5. When The Meeting Comes To A Natural End

Usually in about 45 minutes, the conversation winds down and the Tea Group seems at its natural conclusion. Members help with as much of the clearing of the table as possible.

6. Debrief Tea Group

The group fills out the following chart separately and then discusses the tea group and then moves on to the next chart.

Questionnaire for Tea Group In-Service

Name _____ Date _____

1. Do you think the Tea Group will help you to see "difficult" residents in a different light? ☐ Yes ☐ No
Why?

2. How did you feel while participating in or watching the Tea Group?

3. Which residents do you think would benefit from this program?

4. What approaches have you tried in order to deal with the difficult behavior of these residents so far?
Resident: What worked: What didn't:

5. What can you do to encourage resident participation in the Tea Group?

6. How can you carry over approaches used in the Tea Group into the daily care of residents?

7. Other suggestions for making the program successful:

The chart below helps with any problem that may develop while doing the tea group.

Group Skills/Tea Group Problems/ Solutions: What Doesn't Work/What Works* (Lessons learned in facilitating a Tea Group)

Problems	Solutions
What doesn't work:	**What works:**
1. Having different people in the group each week.	Keeping the same people in the group each week - creates cohesiveness and familiarity.
2. Giving each person their own tea bag and cup of water *problem - some residents were attempting to eat the tea bags or didn't know what to do with them.	Having a carafe of hot water available.Asking residents: how many tea bags should be used; their preference for strength of tea, weak, medium or strong. Asking an appropriate resident to pour the tea, the others to pass the cups, cream, sugar and cookies.
3. Some residents go to the dining room for the group but leave before others arrive.	Having one of the facilitators in the dining room to greet the residents as they arrive. Asking the residents to help set the table, help make the tea, greet other residents as they come in etc.
4. Others not in the group wanting to join in and feeling left out.	Setting up a separate group that anyone can attend in another place for the same time as Tea Group, such as an informal coffee, tea or soda social.
5. Residents leaving the group early.	Thanking them for coming and welcoming them to come again the next time.
6. One person taking most of the cookies.	Treating the resident as an adult by politely saying: Mary, there are other people who haven't had cookies yet, could you leave some for them and pass them on? (The answer is usually "Oh, I didn't know. Sure I will.")
7. One person being mean to another in the group.	Asking for their help in helping everyone to feel good about coming to the group: "We all come here to have a good time and talk to each other. Can you help us to make Jerry feel glad he came?"
8. One person dominating the entire conversation.	Saying: e.g. "Thank you for sharing that John. Let's see if Mary has anything to add." Ask each resident that has not spoken about a similar subject: "John did you barbeque for your family?"
9. Someone is sleeping, drowsy, or not talking.	Asking if (s)he would like more tea or cookies. Then, politely asking for their input on the conversation: "John, was talking about cooking hot dogs over the open fire when he went camping. Did you ever go camping?"
10. Others wandering into the dining room.	Keeping the door shut during Tea Group to prevent distractions and unexpected guests from entering.
11. Staff referring to Tea Group as a tea party that everyone can attend and bringing a resident that does not belong to the group to join.	Telling the staff person that the resident is welcome to go to the tea social in the other room. Reminding staff that Tea Group works best when the same people, who have been carefully selected for the group, can attend and form a bond with each other. Inviting the staff member to come to the next group.

KEY 6 – Communication In-Service: Lunch Club (Breakfast Or Supper)

The purpose of Key 6 is to enhance communication skills and create opportunities for decision-making thereby promoting optimal use of residual cognitive abilities in residents with dementia who are trying to cope with language impairments.

Learning Objectives

Upon completion of this module, participants will be able to:

- Identify 2 communication strategies that encourage resident use of language

- Distinguish between a dining experience and eating

- Reinforce communication and emotional connection between residents despite language difficulties

Regardless of which meal is selected, the beauty of this program is that you really get to see how much skill and social interaction residents are still able to do, despite their dementia.

Communication, especially through language, fulfills a basic need in our lives. It enables us to connect with others and to share information. However, communication, even between people who do not have dementia, can be quite challenging.

People suffering from dementia lose the ability to communicate verbally. They forget the names of people and objects. It is like trying to speak to someone who does not speak your language. It is frustrating when you are not understood or cannot get an answer to a simple question. This is what it's like for residents with dementia, when they forget names of people and objects.

Most primary caregivers get to know their residents well enough that they can interpret gestures or words of their resident and know what they are asking.

Key 6 – Lunch Club

Because the residents may not be able to communicate with staff, families and peers, they may withdraw socially and become depressed. They experience the same feeling of frustration and isolation any of us would when we try to communicate with someone who does not speak our language.

The interesting thing is that people with dementia usually retain some long-term memories well into the late stages of their disease. Some of these memories are of familiar experiences. We can use these experiences to help our residents relate to past social roles, and perform tasks related to those roles.

By creating a familiar setting, these memories are awakened. The Breakfast or Lunch Club attempts to provide a familiar setting and a warm and accepting atmosphere where residents are helped to use their remaining abilities to assume past roles with competence.

The familiar tasks of preparing, serving and eating lunch and then cleaning up after it, helps residents to feel comfortable and competent once again. After all, these tasks were once a routine part of their everyday life experiences.

Residents with dementia, when placed in a social setting in which they feel comfortable, will feel encouraged to communicate. They will frequently retrieve language skills, which may have been unused for a long time.

The Lunch Club also gives residents the opportunity to step out of a dependent role and into a decision-making social role in which they interact with others to accomplish an important task. This further stimulates them to communicate with others and enhances their quality of life and sense of well being.

Selection of Residents for the Program

- Select 5-6 residents with similar language abilities. The program is kept small to monitor its effectiveness and permit maximum resident conversational opportunity.

- Residents in mid-stage dementia with moderate language ability are especially suitable

- Residents should be able to sit for the majority of the program (approximately 1 hour)

- Able to perform the majority of functional movements involved in the activity

Physical Environment for the Program

The guidelines recommend kitchen space if possible, with a home-like atmosphere to encourage customary behavioral response that will stimulate social interactions and communication. The area needs to be made free of distractions for the program.

The Menu

Grilled cheese and tomato sandwiches work well. It should be something that the residents can manage doing for themselves. This will vary depending on the level of the residents. Some higher functioning residents can use a knife and cut tomatoes and operate the electric griddle. Lower functioning residents can place their slice of cheese on the bread. The objective is always to have the resident do as much as possible for themselves.

The Process

Prepare the table surfaces with tablecloths, plates and place settings prior to the residents coming in. Once they come in to the room, ask them if they would like to make grilled cheese sandwiches.

Give each resident two slices of bread and butter. Ask them to spread the butter on their bread.

Hand each resident 1-2 slices of cheese and ask them to put it on the bread.

Select one resident to slice a large tomato. Ask which resident wants tomato.

Allow one resident to 'grill' the sandwiches on the electric griddle.

The Importance of Language

Each resident should be greeted by name and introduced to the other residents. Initial conversation should center on the breakfast, lunch, or supper theme. For example, "Do you like juice with your breakfast?"

Conversation is encouraged with reinforcement and positive feedback. The tone and content of the conversation is adult at all times. Residents will pick up on the emotional intent, even when not able to understand the words.

Errors in conversation are not corrected and no particular responses are expected from members of the group.

Each resident should be made to feel comfortable and an important part of the group.

Language Strategies

Repairing: repeating words offered to clarify the resident's meaning: For example, if the resident says "eggs, eggs, me." The response can be: "The eggs are good, yes?" or, "You like these eggs Mary?"

Acknowledging: responding in a way that indicates understanding of the meaning of a response. For example, "You like eating fried eggs, Mary."

Expanding: rephrasing the response in a more complete context that is more easily understood, For example, "Eggs are good when they are fried, aren't they?"

Extending: keeping the conversation going by responding to the subject: "What other kinds of eggs are good for breakfast?"

Mealtime conversation sometimes promotes understanding and insight among the members. The way the facilitator encourages language coupled with the comfortable and familiar environment allow participants to relax and interact with others. Structure is maintained throughout the session. At the conclusion of the club, the facilitator thanks each member for coming and comments on how each person helped to make it "such a nice time". The parting comment is usually about "looking forward to seeing you again."

Lunch Club Debrief

After the residents have returned to their communities, discuss your observations.

Consider the following points.

- Were there any surprises in terms of residents who spoke?
- Did residents exhibit any strength not previously seen by staff?
- Was the conversation and interaction between residents different?
- Did you see the residents in a new light?

The purpose of Key 7 is to provide the best possible quality of life for our residents and staff by looking at the care we give to residents with dementia determine where the successes are and looking at opportunities for improvement.

Learning Objectives

Upon completion of this module participants will be able to:

- Illustrate how the Principles of Planning Quality Dementia Care are applied to everyday tasks in working with residents with dementia.
- State two ethical considerations used in planning care for residents with dementia.
- Explain how resident rights can be respected during two activities of resident care.
- Suggest how to meet a resident's needs on two levels of the **BASICS** Hierarchy.

This key is the theoretical and philosophical basis underlying EDGE. It describes some of the thoughts and beliefs that constitute quality dementia care. When we were ready to teach it, we condensed it by selecting only some of the principles and tried to deliver it in an experiential manner.

Quality Dementia Care

The following are examples from the **EDGE** literature that describe quality dementia care. It is helpful to think of it as:

Helping residents Be The Best They Can Be

There are many Principles of **EDGE**. The following are several key ones.

Work together in groups of 3 to answer the question assigned to your group. Try to identify residents with whom you are all familiar. Discuss the principles and how you can practice using them with these residents. Then be prepared to report out to the large group.

1. People, including those with dementia, have strong preferences with regard to how they see themselves, and how they would like to be seen by others. These ideas about self are called the person's "preferred view" and constitute the basic operating assumptions and frame of reference for interpreting events in one's life.

   Think of a couple of your residents. Describe the preferred view of each.

   If you can't think of the preferred view of the resident, how might you find out?

2. People with dementia actively attempt to use remaining cognitive, emotional, functional, and interpersonal skills, often creatively and appropriately, to cope with and solve problems on a continual basis each day. In this way, they try to preserve their preferred view of self and maintain self-esteem. Quality dementia care supports the resident's coping skills and incorporates interventions to achieve this into the care plan. It recognizes the value of the valiant coping processes the resident puts into use in daily routines.

   Think of examples of how you see your residents actively trying to use their remaining skills.

   How else might you encourage your residents to use the skills they still have?

3. Quality dementia care is built upon the principle that dementia is a disease that occurs in adulthood, and therefore, care is to be oriented toward preserving adult identity and dignity. This is particularly crucial in the area of daily activity (not only recreation, but ADL care, religious services, etc.) where the activity engaged in by the person with dementia and caregiver/family/friends should re-establish old roles, confirm dignity and worth, enable pleasure, reduce anxiety, create opportunities for success, and have meaning that is known to the resident.

   Describe what you do to maintain the dignity and worth of your residents. Think of how you create opportunities for your residents to succeed. What do you do to foster the 'adultness' of your residents?

   How can you support your residents' feelings of dignity and self-esteem in new ways?

4. Quality dementia care is created to allow the resident to be presented with attractive opportunities to become engaged in an experience, rather than an endless series of occasions for mandatory participation. It recognizes that individual differences in energy level, ability to concentrate, physical stamina, intrinsic or lifelong interest in an activity, perceived estimation of success and daily fluctuations in cognitive or physical ability and mood will all affect participatory preferences and abilities.

   How do you evaluate the resident's physical energy, mood and cognitive state on a daily basis? Give examples of how you help the resident make decisions about activities, on any given day.

5. People with dementia (or any illness) are functioning, thinking human beings and do not experience the illness passively. They react to it and attempt to restore, replace, compensate for, and preserve their identities, however strange the means might be". They remain active thinkers and problem-solvers.

   Describe examples of how you see your residents trying to preserve their identities.

   How do you see examples of your residents remaining active thinkers and problem-solvers?

6. Persons with dementia actively try to make sense of their experiences so that they might provide themselves with solace when upset, meaning when confused, and self-esteem when dignity is compromised. But faulty memory prompts them to rely on historically older information from their past not in tune with the present reality.

   Quality dementia care provides information to the resident in the here and now which fits with how the resident sees him/herself. It is presented so it can be understood by the resident given his/her cognitive abilities and preferred communication style.

   How do you provide information from the present to your residents that fits in with how they see themselves and makes sense to them?

7. Impaired memory for cognitive information (i.e. dates, names, or use of objects in the environment) does not necessarily mean that the person with dementia cannot accurately express valid emotional reactions to current or past experiences. Quality dementia care recognizes the validity of emotional expression and the therapeutic value of emotional communication, and does not assume that residents' emotional messages are all signs of confusion, or that emotional messages from persons in the environment will be inevitably misunderstood.

   How do you see your residents expressing appropriate and valid emotional responses to experiences?

   What can you do to encourage your residents to express their emotions?

8. Persons with dementia are infinitely varied despite similar diagnoses, socioeconomic background, culture or even heredity. Quality dementia care preserves individual identity by preserving aspects of each resident's knowledge about him/her self. It thereby provides therapeutic benefit without pressing persons with dementia to all act the same, enjoy the same experiences, or relate to others in a stereotypical way.

   What are examples of ways that you preserve the individuality of each resident?

   How can you do more to recognize the individual preferences of each resident?

9. Quality dementia care is based upon the principle that "blaming the victim" is not a therapeutic intervention. Persons with dementia are victims of conditions beyond their control. They are not going to respond to labels, shaming, guilt, anger, demands to explain themselves, or other such social pressures to conform. They are dependent to varying degrees, and rely on care that is enlightened, sympathetic, and creative, in response to their many needs and abilities.

   What examples have you seen of caretakers "blaming the resident"?

   What can you do if you see that occurring?

   How can you monitor yourself to make sure you don't resort to "blaming the resident?"

10. People with dementia (or any illness) are functioning, thinking human beings and do not experience the illness passively. They react to it and attempt to restore, replace, compensate for, and preserve their identities, however strange the means might be. They remain active thinkers and problem-solvers.

    Describe examples of how you see your residents try to preserve their identities?

    How do you see examples of how your residents remain active thinkers and problem-solvers?

11. Persons with dementia actively try to make sense of their experiences so that they might provide themselves with solace when upset, meaning when confused, and self-esteem when dignity is compromised. But faulty memory prompts them to rely on historically older information from their past not in tune with the present reality.

    Quality dementia care provides information to the resident in the here and now which fits with how the resident sees him/herself. It is presented so it can be understood by the resident given his/her cognitive abilities and preferred communication style.

    How do you provide information from the present to your residents that fits in with how they see themselves and makes sense to them?

12. Impaired memory for cognitive information (i.e. dates, names, or use of objects in the environment) does not necessarily mean that the person with dementia cannot accurately express valid emotional reactions to current or past experiences. Quality dementia care recognizes the validity of emotional expression and the therapeutic value of emotional communication, and does not assume that residents' emotional messages are all signs of confusion, or that emotional messages from persons in the environment will be inevitably misunderstood.

    How do you see your residents expressing appropriate and valid emotional responses to experiences?

    What can you do to encourage your residents to express their emotions?

Come fry with me

13. Persons with dementia are infinitely varied despite similar diagnoses, socioeconomic background, culture or even heredity. Quality dementia care preserves individual identity by preserving aspects of each resident's knowledge about him/her self. It thereby provides therapeutic benefit without pressing persons with dementia to all act the same, enjoy the same experiences, or relate to others in a stereotypical way.

    What are examples of ways that you preserve the individuality of each resident?

    How can you do more to recognize the individual preferences of each resident?

14. Quality dementia care is based upon the principle that "blaming the victim" is not a therapeutic intervention. Persons with dementia are victims of conditions beyond their control. They are not going to respond to labels, shaming, guilt, anger, demands to explain themselves, or other such social pressures to conform. They are dependent to varying degrees, and rely on care that is enlightened, sympathetic, and creative, in response to their many needs and abilities.

    What examples have you seen of caretakers "blaming the resident"?

Learning Objectives

Upon completion of this module participants will be able to:

• List three (3) ways strength based care planning benefits residents and staff.

• Explain a method for reviewing a resident's MDS to detect other changes in function caused by an identified problem.

• Identify resident strengths as well as problems on a resident's MDS.

• Use strength based care planning to develop effective approaches to care with measurable goals.

The resident retains far more abilities than are lost over the greater part of the course of progressive dementias like Alzheimer's and related disorders, and WHO HE IS (the PERSON) exerts more influence on his behavior than what he has (a Dementia). It is important, therefore, that the resident be encouraged to perform those actions and activities which rely on retained abilities, also called STRENGTHS, for as long as possible to optimize independence.

Without addressing ways to support and develop the resident's remaining strengths, the loss of ability to function due to factors other than those due to the dementia itself – ("excess disability") may occur, increasing the amount of care required and diminishing quality of life for the resident.

Unlike the traditional maintenance or "preventing deterioration" approaches to dementia care, building on retained cognitive and daily living skills is preferable because it:

• Improves life satisfaction for residents and staff

• Reduces burden for already busy caregivers

• Supports retained abilities leading to better adaptation to the environment

• Provides an atmosphere of care geared toward successful outcomes including improved functional status

The ID team should present an interdisciplinary picture of the resident's unique profile of abilities and disabilities to determine if some of his/her abilities are not being supported in daily care and then plan interventions to prevent "excess disability". For, if "excess disability" is allowed to occur, staff will:

• Increase the amount of time needed to care for the resident

• Send the message that the resident is not expected to do for him/herself, and to try to, is to go against normal procedure, perhaps provoking criticism from some staff

• Discourage any problem solving behavior or attempts to behave independently.

If we encourage residents with dementia to practice their retained skills in collaboration with us, we make them part of the "team" by giving them a voice in deciding how they will spend their time in ways that are meaningful for them. When resident preferences are included in the solution the resident joins with us to solve problems. This promotes feelings of self-esteem in them and in our selves.

Problems and Strengths

While the Resident Assessment Protocol (RAP) triggers from the Minimum Data Set (MDS) assessment are stated in "problem" mode, it is helpful to identify resident strengths in the MDS which the care plan may build upon to reduce the severity, frequency or intensity of an identified problem. In so doing, our aim is to improve functioning, rather than to prevent deterioration.

This type of assessment serves as the basis of attempts to reduce problems and achieve improved function, quality of life and resident satisfaction.

This strength-based approach makes it possible to collaborate with the resident's wish to retain independence by helping the resident use his/her natural repertoire of competent behaviors to achieve mastery of the environment. We will use the handouts to illustrate this.

Exercise–Part I

Worksheet A illustrates a common care planning method used in many facilities:

• A problem or RAP trigger is identified through MDS assessment

• The ID team sets a goal they would like to see achieved

• Strategies are then planned by the ID team and/or nursing staff many times without consulting the resident, or

• Primary caregivers on every shift, the family, or significant others who could provide valuable information into what the problem behavior indicates about the resident's attempts to cope, and the corresponding strengths that could be used to outline the resident's preferred approaches using **BASICS**.

Worksheet B demonstrates Strength Based Care Planning using **BASICS** for Gerald which lists information staff acquired from the MDS, the resident record, talking to the resident and all who know him, and by observing the resident in his daily life.

1. What other approaches might be used for each problem considering Gerald's identified strengths?

2. Do you think this method of care planning can develop more resident centered approaches to care than the care planning methods discussed with Worksheet A?

Part II
More Comprehensive Care Planning Using BASICS

If we look at Gerald's problems listed on Worksheet A, we see that the most life threatening problem, is a biological problem, is a weight loss of 4 lbs. in one month. If Gerald continues to lose weight at this rate, there is risk of death.

Let us look at the Resident Need Index in **BASICS** to help us see how we might plan more effective care for Gerald by identifying how this one problem affects Gerald's function on every level of **BASICS**.

The text explains how to review an MDS to find resident problems and strengths.

Each group has one of the **BASICS** Problem/Strength menus listing problems and strengths identified on Gerald's MDS.

Each group will read the problems and strengths to the group in order to find out something about who Gerald is as a person.

Using Each Level of BASICS, Consider:

1. What type of a person is Gerald? Can we find out from his MDS? Ask someone from each group to read their part of Gerald's MDS information in the Problem/Strength menus under every level of BASICS.

2. What does this tell us about Gerald?

3. Why do you think Gerald has lost 4lbs. in a month?

4. Ask each group to discuss how the problem affects the level of BASICS they have, starting with Biological up to Symbolic.

5. Do we need more information?

6. Where will we find more information to help us plan effective approaches to help Gerald meet the identified goal that he gain weight, and more importantly that will support Gerald to have a quality of life he can enjoy?

7. Is the weight loss Gerald's biggest problem?

It is, because as a Biological need it is the most fundamental, and could be life threatening. That is why we start with the lowest level of **BASICS** when we assess a resident's needs. This biological need must be met before we look at the next level of need. As you can see this one problem of weight loss affects Gerald on every level:

- On the Biological level he is at risk of a life-threatening decline.
  He went from eating to not eating
  .(Self-preservation not supported)

- On the ADL level he has had a loss of function because he is not allowed to feed himself in his preferred manner. He went from feeding himself (independence) to not feeding himself (dependence).
  (Self-dependence not supported)

- On the Societal level he expresses feeling a loss of self worth because his view of himself has been diminished. He went from doing something that helped retain his identity as a capable older adult to doing something that he feels means that he is a childish, dependent person. (People food vs. baby food).
  (Self-identity not supported)

- On the Interpersonal level he has lost valuable contact with good friends who satisfy his need to be thought highly of by others, causing a loss of self-esteem. He went from socializing with significant friends to no socializing at meals.
  (Self-esteem not supported)

- On the Creative level he lost the opportunity to make choices and solve his own problems about how he would eat, skills he always prided himself on. He went from solving his own eating problems (couldn't use utensils, used his hands effectively) to not being given the opportunity to exercise autonomy. (from meals being best time of day to worst time of day) He lost that "spark of life" (eyes went from being alive with purpose to dull with defeat).
  (Self-expression not supported)

- On the Symbolic level he lost his life-long feeling of hopefulness and that he was able to lead a worthwhile life. He went from feeling like "somebody" in a hopeful world to feeling like a "nobody" in a world that encouraged hopelessness.
  (Self-actualization not supported)

Instead of supporting Gerald to reach for the next level of **BASICS** need, Gerald's caregivers unknowingly allowed him to slip to a lower level of function on the **BASICS** Hierarchy.

Has Gerald changed his basic philosophy of life since he entered the facility? Or did this crisis precipitate a change in the way he sees himself in the community and as a person, causing him to try to cope in the best way he could which resulted in a change in his usual behavior.

1. Don't we all do this when we are in crisis?

2. Is Gerald's reaction uncalled for by the circumstances?

3. Would some care planning methods label Gerald as disruptive and try to treat the symptoms instead of the man?

4. Can we find out the real cause of the problem and what it means to

Gerald without looking at who he is as a person and what his strengths are as indicated on the MDS as well as from all the other sources we considered in this exercise?

5. Do you think strength based care planning will work for Gerald?

Suggest approaches that might be used to solve the identified problems under each level of **BASICS**.

The strengths listed on the right side of each of the sample problem/strength menus for each level of **BASICS** target categories of resident functions that can be used to plan the interventions the team may use to address each problem. Goals can be stated as quantitative (a number of times in a day or week) or qualitative (with less anger) once a problem has been identified and described in the problem column, or can be written as a strength to be maintained or improved through use of the approaches chosen by the team.

Worksheet C

Select a resident you know and discuss a problem the resident has. How might you use information you know from the MDS, the resident record and information they have gathered from those who know the resident well, to plan strategies that take the resident's needs into consideration. Relate the identified problems and strengths on each level of **BASICS**.

Discussion Questions About Team Care Planning for a Resident

1. What is your resident's problem?

2. What does it mean to the resident and how does it affect the way the resident functions under each level of BASICS?

3. Which strengths does the resident have under each level of BASICS?

4. Which goals have you set?

5. Which approaches do you suggest to meet those goals?

6. Did you learn more about the resident than you knew before?

7. How was this process helpful in helping you to look at care planning in a broader sense?

8. How do you think this method would be helpful in planning more comprehensive care for your residents?

9. How could it be incorporated into the present care planning process?

Key 8 – Strength Based Care Planning

Additional Training Formats

After the completion of training for the dementia units, the trainers adapted the **EDGE** program into two separate curriculums. Using the concepts of **BASICS** and customer service the trainers developed a one day training program geared for the staff caring for the higher functioning residents.

Due to the facility's commitment to the **EDGE** model, the trainers believed the concepts of **BASICS** were central to the training.

The training then turned toward communication skills both between staff and residents.

Finally, the participants interviewed residents and then developed a care plan based on the interviews.

One-Hour Training Sessions

The final sessions were developed as one hour training sessions covering the topics of **EDGE** that pertained to all residents within the facility.

BASICS – The same material was presented as the previous sessions

Creating Connections

A new session focuses on building relationships between residents and staff.

Be a Detective: All Behavior Has Meaning

A similar session as previously presented with the focus on all resident behavior not just residents with dementia

Strength Based Care Planning

Using the concepts of building on a resident's abilities not disabilities.

EDGE Training One-Day Agenda

Time	Topic
	Welcome from Administration
8:30 – 10:00 am	Culture Change Overview
	a) Brief lecture on culture change history
	b) Video & debrief
	c) What 1 thing would you want people to know?
	d) What is your am routine
	e) Change
	f) Jewish Home process
10:00 – 10:15 am	Break
10:15 – 11:15 am	Person-centered Care
	a) **BASICS**
	b) All behavior has meaning
	c) Strength-based care planning
	d) (think about questions)
11:15 am – 12:00 pm	Relationships/Communication/Respect/ Role Plays
12:00 – 1:00 pm	Lunch
1:00 – 2:00 pm	Resident Interviews
2:00 – 3:00 pm	Strength-based Care Planning
3:00 – 3:15 pm	Break
3:15 – 4:30 pm	Teambuilding
	Tying it all together
	Wrap Up
	Evaluations

Creating Connections

Introduction:

"This module is about creating a connection with each of our residents. What do you think we mean by creating a connection with a resident? Can anyone give us an example of a resident with whom you feel you have a connection?

In order to demonstrate what we mean, we are going to look at a short, 5-minute video. We are giving you a printout of the script, but the video is very short and goes very quickly, so please don't look at the script until after you watch it and please pay close attention."

Show the video "Look At Me."

After the video, ask the following:

"What were your general reactions to the video?"

Typical answers will be: sad, depressing, moving, powerful.
(acknowledge the validity of all responses)

Ask:
Before you heard the narration, just looking at the man, would you also have thought that he's a crabby old man?

Say:
"There was one constant theme that the man kept referring to as he narrated his life. Who remembers what it was?"

If someone says family and loved ones, that's great. If not, acknowledge every comment and then say, do you recall how much he talked about his loved ones?

"That seemed to be the most important thing in his life."

Ask:
If you knew just that one thing about this man, how could you use it to establish a meaningful connection with him?

"Acknowledge any comments and say something like, yes, everyone who comes into contact with this gentleman could say something about his family – based on a photo, or a memory, etc. in order to relate to him in a meaningful way."

Ask:
Think about the image we saw in the video, of the man trying to get up out of the wheelchair onto the bed. If you didn't have the benefit of the narration, how might you react to that action? What might you say to him?

Say:
Since you've heard the narration, what do you think is behind his action?

Typical comments will be "Sit down, Mr. Smith". "What are you doing, Mr. Jones?" "Don't do that Mr. Brown."

Ask:
Now that you know about the man's independence, how would your reaction to him getting out of the wheelchair be different?

Say:
We're going to do an exercise that will help us develop a connection with our residents.

Exercise

Set up the participants so that they will be working in pairs or small groups (depending on the number of people). Distribute several photos of the elderly people to each group. Ask each group to select one photo.

Their assignment is to create a story about the people in the photo they have selected, using all the levels of **BASICS**.

Give them about 15 minutes to work on this.

When 15 minutes has passed, ask each group to show the picture and tell the story they have created. Then go on to the next group.

Debrief

Ask:
"What did you learn from this exercise?"

Acknowledge whatever answers you get. Build on whatever has been said to say something like:

"It's very important that we find at least one piece of information about a resident that we can use to create a meaningful connection."

Ask:
"If the resident can't tell us something about himself, or doesn't have a relative to tell us, how might we find a clue to understand something about him so we can create a connection?"

Acknowledge all answers. Include possibilities of looking for clues by watching the resident's actions; or even by making up a story that will help us relate in a more meaningful way.

Ending the Session

Ask for any volunteers to share one thing that they are taking away from this module.

Be a Detective: All Behavior Has Meaning

Leaders Guide

The purpose of this session is to learn how to diminish agitated behavior in our residents by: determining the purpose or meaning of the behavior to the resident and to plan alternative interventions that will meet the resident's needs or goals and eliminate the need for agitated behavior.

We know that the disruption caused by agitated behaviors detracts from the quality of life of all people who live and work in the community. Other residents may be upset or frightened, it may interfere with their activities; their personal space may be invaded by being touched or harmed.

Agitation diminishes the care of all residents because time that might be spent meeting resident needs is spent in managing the agitation. Resident agitation increases staff member's stress. Stress can be created when the person resists care, stress is created by the need to get the job done and there is danger of injury to staff from aggressive behavior.

Ask:
How do you feel when you need to approach someone who is verbally or physically aggressive?

We know from research that specific types of agitated behavior tend to occur frequently in people who have dementia but can be exhibited by residents who do not have dementia as well.

Ask the group to take out the chart #1 Origins of Behavior in Dementia, point out that it can explain behavior in residents without dementia as well

Lifelong Habits and Personality

Ask:
How do you think this can effect behavior?

Can anyone give me an example? What time do you get up on a workday?

What time do you get up on your day off? Is this a lifelong pattern for most of us?

What other lifelong habits and personality influence our behavior?

Current Condition Physical and Mental

Ask:
How do you react when you are hungry or in pain?

What other factors cause physical and mental discomfort? physical discomfort or pain the need to urinate, hunger, tiredness, medication (too much or too little), depression, constipation, infection impaired hearing, vision.

Ask:
Do you notice changes in the residents you care for before they are sick? (or children or family member if they do not provide direct care)
Can you give an example?

Environment—Physical, Psychological and Social

Hallucinations – sensory experiences that cannot be verified by someone else

Delusions – beliefs that are contrary to fact which remains fixed.

The resident may feel insecure, unable to recognize people, too hot, too cold Sensory overload including too many activities happening, too much noise Being involved in ADL especially bathing and toileting

Ask:
What in the environment makes you feel upset or anxious?
What in the environment makes you feel calm?

In summary agitation results from the imbalance in the interaction among life-long habits and personality, current physical and mental status and less than optimal environmental conditions.

Agitation can also be caused by the inability of the individual to meet their own personal needs and because of the presence of the impairments themselves.

Ask:
Have you ever needed to be dependent upon someone to meet your needs i.e. to be toileted, to be fed? What was it like?

Also making someone more impaired than they need to be which is called excess disability creates feelings of loss and dependence.

Not wearing eyeglasses, hearing aide, not allowing the person to use remaining strengths and abilities can cause agitated behavior.

Ask:
Were you ever in a situation when a supervisor explains how to do something that you do every day? How did you feel?

Behavior can be changed. Behavior whether appropriate or disturbing, usually has some reason about why it occurs.

If we consider these aggressive behaviors as "challenges: to caregivers

because we have not yet figured out what the cause of the behavior is and work together as a team we can be successful detectives.

If behavior expresses a need than we need to become detectives to determine what the need is so that we can meet it.

Remember the **BASICS** hierarchy of needs. We cannot satisfy a higher level until those needs, which come before it, are met.

Look for clues as to why the person is distressed.

Know the life story can we find clues there

Look at what happened just before the behavior started, where, why

Create a plan to manage

Brainstorm together

All staff needs to be involved

Ask ourselves what has worked in the past, what does not work

Communicate among all caregivers

Exercise

If the group is small go around the room or if the group is large break into groups.

Say:
Most of us have a nighttime routine before we go to bed

Ask:
What is one thing you would like the staff to know so that you could sleep comfortably if you were to come to live at Sarah Neuman?

What level of **BASICS** does this habit meet?

How could the staff find that out about you?

As stated at the beginning of this manual, the **EDGE** model developed at the Sarah Neuman Center is unique to the facility's staff and resources. The development of ongoing programs and clubs as a result of the **EDGE** training was one of the positive outcomes of this endeavor. The clubs that developed as a result of the **EDGE** training were essentially hybrid programs based on the available resources within the facility.

"The Let's Do Lunch Club"–
This group which was the precursor of our restaurant-style dining was our first club. Department Heads and a group of developmentally disabled young adults as well as staff volunteers ran this lunch club three days a week where residents were able to enjoy a quiet place to dine with their friends that was based on Key 6.

"Come Fry with Me"–
A program developed by the manager of the food service department based on Key 6. Residents are involved with the preparation of a meal in which they then partake. This meets the ADL level of **BASICS**.

"The Rhythm Band"–
A program based on Key 2. The original Big Band is very labor intensive involving one staff member for each resident participating. The rhythm band draws on the common bond of music in a small group using rhythm instruments. This program involves one to two staff members

"The Rosary Circle"–
A program developed based on the highest level of **BASICS**, meeting a resident's symbolic needs. This club meets weekly and was originally conceived by a Department Head who continues to run the program. When the residents see the Department Head come to the floor each week with the box of Rosary Beads, they are stimulated to remember how to say the rosary.

"Talking Trash"–
A favorite of the residents that meets the creative level of **BASICS**. The

Rosary Club

social worker from the special needs community brings one of the supermarket tabloids and the group is able to reminisces about times past while they discuss the marriages of Liz Taylor or an Elvis sighting.

"The Poetry Club"–
The poetry club meets weekly and the leader who is another department head reads poetry to the residents and they then discuss the poem. This meets the creative and interpersonal levels for our residents. For one of our residents who is a former elementary school teacher, this group brought back memories of happy times past when the group read some of the poems that this resident had read to her class.

"Memory Book Club"–
This club meets weekly and meets the creative level of **BASICS**. The club was originally started by a social work intern but is now continued by a staff member. Each page in a memory book has pictures and words that are created together with a resident no matter what the stage of dementia and contain the memories of the resident in the moment. The pages may contain words, pictures and or photographs created together.

"Wine and Cheese"–
The Wine and Cheese Club happens every Sunday and was begun by a CNA who decided that she wanted to

do something to make the residents' Sunday a more enjoyable day. It meets the societal level of **BASICS** and is really an extension of Key 5 – The Tea Group, as it has many of the same components as the tea group.

"The Mailroom Club"–
The Mailroom Club meets the interpersonal as well as the symbolic levels of **BASICS**. This club meets whenever there is a mailing to go out in the community. The residents find meaningful work to do in folding, stuffing, sorting and stamping envelopes and helping to get the work done in the community. There is camaraderie among the group participants and support for each other.

As you can see, you can make a club out of any idea.

Closing Remarks

The success of the **EDGE** training at Sarah Neuman Center can be attributed to the commitment of Administration. The Administrator was involved in choosing the original **EDGE** trainers. These **EDGE** trainers were given the charge to develop the curriculum and organize the training. Always mindful of the NYS DOH grant, the trainers developed the timeline and completed the training within the allotted time frame.

References

Bradley, A., Ronch., & Pohlmann, E. (1999). The **EDGE** Project. Available at www.dementiasolutions.com.

Ronch, J., Bradley, A., Pohlmann, E., Cummings, N., Howells, D., O' Brien, M. & Beria J. The Electronic Dementia Guide for Excellence (**EDGE**): An Internet-based Education Program for Care of Residents With Dementia in Nursing Homes. Alzheimer's Care Quarterly. 2004: 5 (3): 230-240.

Ronch, J., Goldfield, J. (2003). Mental Wellness In Aging: Strengths-Based Approaches. Baltimore: Health Professionals Press, Inc.

Weiner, A., & Ronch, J. (Eds.). (2002). Culture Change in Long-Term Care. Journal of Social Work in Long-Term Care.

Zgola, J., Bordillon. (2001). Bon Appetit! The Joy of Dining in Long-Term Care. Baltimore: Health Professionals Press, Inc.

Brooker, D. What is Person Centered Care for People With Dementia? Reviews in Clinical Gerontology 13(3). 215-222; 2004.

Additional Resources

Alzheimer's Association Publications
Understanding early-onset Alzheimer's disease: a guide for health care professionals.
Chicago, IL: The Alzheimer's Association, 1999.
http://www.alz.org/resources/FactSheets/Fsonset.pdf

Understanding early-stage Alzheimer's disease: a guide for health care professionals.
Chicago, IL: The Alzheimer's Association, 1999.
http://www.alz.org/Resources/FactSheets/FSEarlystageguidecare.pdf
(Single copies of above 2 items can be requested by calling (800) 272-3900.)

Ethical issues in Alzheimer's disease.
Chicago, IL: The Alzheimer's Association, 2001. (Can be ordered by calling (800) 223-4405 at a cost of $15.00)

Alternative treatments for Alzheimer's.
http://www.alz.org/AboutAD/Treatment/Alternative.asp

Alternative treatments: Buy? Or Beware?
Advances. (Association Newsletter) Winter 2000; vol. 19(4), pp. 6-7, 11. Available online:
http://www.alz.org/Resources/Advances/Winter2000.pdf

Facts about health claims for drugs and dietary supplements. (factsheet)
Available online:
http://www.alz.org/Resources/FactSheets/FSTherapy_claims.pdf

Music, art and other therapies.
http://www.alz.org/Care/DaytoDay/Music.asp
Music therapy in Alzheimer's disease. (Resource List)
http://www.alz.org/Resources/Resources/rtrlmusictherapy.asp

Web Sites

www.alzhudsonvalley.org
1-800-872-0994 24-hour toll-free
Helpline: 1-800-272-3900
info@alzhudsonvalley.org

Guidelines for Alzheimer's Disease Management.
Available at www.alzla.org under Medical Guidelines.

National Guideline Clearinghouse is a publicly available electronic repository for clinical practice guidelines and related materials that provides online access to guidelines. It is available at www.guideline.gov.

Alzheimer's: dealing with uncooperativeness.
Building Better Health, AdvancePCS.
http://www.buildingbetterhealth.com/topic/alzuncoop

Communicating with someone who has Alzheimer's.
Building Better Health, Advance PCS.
http://www.buildingbetterhealth.com/topic/alzcomm

EDGE

Electronic Dementia Guide for Excellence

Implementing EDGE DVD

EDGE

E l e c t r o n i c   D e m e n t i a   G u i d e   f o r   E x c e l l e n c e

EDGE Training Manual

Including Implementing EDGE DVD

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SARAH NEUMAN
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