Baycrest

MANAGING BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD)

NON-PHARMACOLOGICAL INTERVENTION STRATEGIES

This document was prepared by experts at Baycrest, which is the Toronto region lead for Behavioural Supports Ontario.

Behavioural Supports Ontario

Introduction

This document is a support tool for the management of Behavioural and Psychological Symptoms of Dementia (BPSD). It highlights a non-pharmacological approach towards behavioural interventions. Non-pharmacological strategies take various forms including sensory stimulation; psychosocial mediations; validation therapy; mental health and emotional supports; care-focused approaches, and more. These collective strategies are an important component in the care and management of BPSD and should make up a significant section of any individualized care plan.

Document Creation

This document is a collaborative effort compiling the experience and knowledge of the Baycrest Behaviour Support Outreach Teams (BSOTs) comprised of:

- the Community BSOTs: Cara Macanuel, MSc OT Reg. (Ont); Julia Rice, OT Reg. (Ont); Linus Chui Fan Ip, MSW, RSW; Peter Marczyk MSW, RSW; and Simonne Cumberbatch MSc. OT Reg. (ONT), and
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The document was compiled and edited by Simonne Cumberbatch MSc. OT Reg. (ONT).

Purpose

The key focus of this document is to provide a list of non-pharmacological recommendations which can be implemented by care staff across multiple silos. It focuses on eight common behaviour recorded within the BSOTs practice, and is presented in P.I.E.C.E.S. format, including possible triggers and causes for each behaviour. While this information is not exhaustive, these recommendations can be generalized to support care plan creation for more than the eight behaviours listed within the document. They are best utilized under the guidance of a multidisciplinary behaviour care team.

Implementation

Nonpharmacological interventions are often low to moderate cost, with minimal side effects and high potential for success when implemented in a client focused manner. The following approach to implementation is recommended:

- **Identify and prioritize specific behaviours of focus.**
    - We suggest no more than 3 priority behaviours to focus on at any one time.

- **Assess level of risk and/or need for medical attention.**
    - Consider use of screens such as; The P.I.E.C.E.S. RISK screen, geriatric depression screens (e.g. Cornell Scale for Depression in Dementia), screens for delirium (e.g. Confusion Assessment Method), and pain screens (e.g. FACES Pain Scale Revised, Pain Assessment in Advanced Dementia (PAINAD) scale)

- **Establish a baseline of frequency and patterns of behaviour via observation and assessment.**
    - Consider using the Dementia Observation System, A-B-C Charting or other such behavioural log to track changes.
    - The chosen tracking tool should be used again in follow up to assess the effectiveness of any given intervention.

- **Integrate the interventions**
    - Use the generalized intervention within this document to create person-centred care plans which are sensitive to the specific care context

Supporting Documents, Training and Education:

This document is a compilation of the experience and knowledge of the BSOT clinicians and consists of strategies used across community, LTCHs and acute care settings. It is highlighted that the following tools are commonly used in practice, and the following training/educations have been valuable adjusts to this combined knowledge.

Supporting Documents

Use of the following documents are free of charge, and permission for use is not needed, provided that the tool is not modified or altered in any way.

P.I.E.C.E.S RISK Assessment taken from the P.I.E.C.E.S. 3-Question Template http://pieceslearning.com/wpcontent/uploads/2016/02/PIECES_Laminate_Nov_09.pdf

DOS: https://brainxchange.ca/BSODOS

FACES Pain Scale Revised: https://www.iasp-pain.org/DownloadFPSR?navItemNumber=1119

Pain Assessment in Advanced Dementia (PAINAD) scale: http://dementiapathways.ie/_filecache/04a/ddd/98-painad.pdf

Cornell Scale for Depression in Dementia: https://cgatoolkit.ca/Uploads/ContentDocuments/cornell_scale_depression.pdf

Confusion Assessment Method: https://consultgeri.org/try-this/general-assessment/issue-13.pdf

Trainings and Educations:

To access these trainings and educations within Toronto please contact the Psychogeriatric Resource Clinicians or Alzheimer Society of Toronto. For program descriptions, please refer to the Behaviour Education and Training Support Inventory (BETSI) Provincial BSO Tool https://brainxchange.ca/Public/Files/BSO2/Behavioural-Education-and-Training-Support-Invento.aspx
P.I.E.C.E.S.: http://pieceslearning.com/

GPA: https://ageinc.ca/about-gpa-2/

UFIRST: http://u-first.ca/

Dementia Care Training Program (DCTP): https://alz.to/courses-learning-programs/dementia-certificate-program/

Behaviour Support Training Program (BSTP): https://alz.to/tag/bstp/

To learn more about the BSOTs and other BSO supported behavioural management teams within Ontario please go to: https://www.behaviouralsupportsontario.ca/

Table of Contents

Each of the behaviours referenced above is separated into P.I.E.C.E.S. sections to highlight the triggers and associated strategies of care.

Non-Pharmacological Strategies for Exit Seeking and Entering Co- Residents Rooms

PHYSICAL	
TRIGGERS/CAUSES	**INTERVENTION/ STRATEGIES**
1. Pain: chronic or acute	• Pain as possible cause for restlessness and treat as needed • Review all chronic conditions, e.g. OA, Fibromyalgia, back pain and assess for possibility of acute flare ups • Assess for acute medical causes of pain e.g. infection, trauma, rashes, constipation, falls or bumps etc.
2. Unmet basic needs	• Ensure all basic needs are met, inclusive of hunger, thirst, voiding, perceptive temperature e.g. hot/cold, uncomfortable clothes etc. 1) Offer client snacks or redirect to meals 2) Offer or re-direct to toileting - Assess for constipation. *Note:* Person with aphasia is often unable to verbalize their desires/needs. In cases such as this address care needs in a preventative manner e.g. set toileting schedule, set meal schedules in with increased snacks. Attempt to address needs prior to behavioural presentation.
3. Medical conditions: chronic or acute	• In cases of sudden behavioural changes or spikes in presentation complete a lab work to rule out acute infections or delirium • Assess the success of the management of chronic conditions e.g. diabetic persons still having significant spikes in glucose *Note:* Treatment of unmanaged medical conditions is a priority in behaviour management. Inclusive of acute psychological conditions. Non pharmacological approaches are limited in success if these elements are not first addressed.

INTELLECTUAL	
TRIGGERS/CAUSES	**INTERVENTION/ STRATEGIES**
1. Anosognosia: Person does not understand why they cannot leave the site Person lacks insight into their limited ability to reach their goal destination safely and independently	• Do NOT use statements which suggest the person is trapped or locked on site e.g. "You are not allowed to leave" or "You can't go outside" - instead make use of distraction techniques • Provide a concrete reason for redirecting e.g. mealtime, recreational time, staff needing to clean the area or to speak with person etc. • Do not reply on use of logic or long explanations as this will likely confuse or agitate • Enter into persons reality when attempting to redirect, question: 1) Why the person desires to leave e.g. "What's at home?" 2) How they plan to get to the goal location e.g. car etc.? "Do you have

	enough gas in the car?" "Where is car parked?" 4) Who will go with them e.g. "Will someone come to pick you up?" "What time?" 3) Ask for a description of the location they are attempting to get to e.g. "What does your home look like? It sounds nice" Use these kinds of questions to guide the person away from their original focus and into discussion with you e.g. "It's not time for that pickup yet, what about a snack in the meantime? You can tell me about your house"
2. Amnesia: Person is unable to remember where they are, where their room is, or where public spaces are e.g. bathroom, TV Room etc.	• Allow for a period of adjustment to the new surrounding during initial transition- increased disorientation is expected for a period • Provide multiple reminders throughout the day – both verbal and non-verbal e.g. constant pointing to reinforce room location to client • Have staff walk with the person from public areas back to their room e.g. post meals and recreational activities etc. to reinforce and entrench the path • Place an identifying item or picture on their own room door- item/picture much be recognizable to client or draw their interest
3. Aphasia: Person is not able to express their reasons for wanting to leave and not understanding what is being said to them	• Use of simple, small and concrete terms when speaking • Only one staff member speaking at a time • More reliance on body language e.g. pointing to indicating where you would like the person to go • Providing visible and tangible distractions e.g. showing a snack vs attempting to describe it • Clear signage around public areas with large lettering and pictures e.g. bathrooms, exits, games room, dining rooms
4. Altered perception: Person does not recognize the location as someplace that is safe e.g. sees a LTCH building as a prison	• Provide emotional support and reassurance- address fear and anxiety • Allow the person as much free movement as is safe, do not have multiple staff crowd, or make them feel "trapped" or "cornered" • Alter the environment where possible to create a more "safe and welcoming" feel e.g. Place comforting and recognizable items within their room, and remove items which seem triggering • Identify and highlight which areas are most triggering and help the person to avoid them where possible
5. Delusion/hallucination: Internal irrational beliefs which are fixed and cannot be moved by logic e.g. beliefs that LTCH is unsafe Belief that there is a pressing need for them to leave e.g. someone is waiting for me, my room is on fire etc.	• Validate the person's feelings and allow them to express their distress • Do not attempt to convince the person that their beliefs are wrong instead address their *feelings* around the delusion e.g. focus therapeutic efforts on the person's fear or anxiety • Use the environment to provide them with concrete calming factors e.g. if the person reports that the room is on fire ask: can you smell smoke? See smoke? See flames or feel heat? etc. *Note*: If delusions and hallucinations are new it is important to seek medical/psychogeriatric assessment

EMOTIONAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Distress around family visiting and then leaving again – triggering feelings of abandonment	• Set up family visit around a similar time daily/weekly so person knows when to expect them • Place visual reminder of when visit will occur e.g. white board or calendar, so the person does not become focused on asking staff for these details • Have a distraction set up which coincides with family leaving e.g. meals, recreational activities, snacks or going for a walk • Coordinate family visit for when person is most calm and redirectable
2. Anger and agitation around feeling trapped	• Allow the person to wander freely on a locked unit if possible and safe by providing uncluttered paths with points of interest and a safe place to rest • Rely more on the locked door to stop exiting and limit staff physically attempting to stop/distract the person unless he/she has become disruptive • If safe to do so allow passive attempts to leave e.g. attempting to turn the doorknob. Uninterrupted failed attempts often result in self-redirection • Provide emotional support if person becomes distressed by feelings of being trapped • Use of the direction strategies with focus on the 4 steps (Validating, Join the world, Distract, Redirection) and use of GPA techniques
3. Increased agitation/restlessness related to sun-downing	• Identify individual behavioural patterns and habits to create preventative behaviour management plans • Use of DOS to highlight active times of exit seeking and attempt to engage client in activities prior to the initiation of behaviour • Time snacks around sun downing
4. Internal impulses and pressures	• Allow for safe independent or supported mobilization to release this urge as much as possible • If unit is not locked consider use of alarm on the person's clothing which will alert if they attempt to leaves premises • Use of disguised exist or unusual doorknobs/door handles implemented as per safety legislation • Create points of interests e.g. folding station, aquariums which pull path away from the exits • Enter into and validate the person's reality and engage them in discussion around why they wish to leave or how they plan to get to the location of their focus
CAPABILITY	

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Inability to way find	• Provide clear wayfinding cues with the environment e.g. signs, clearly marked areas • If the person can read, they can be provided with a reminder note which provides their room number/ floor number and is attached to their clothing. Staff can aid by drawing persons attention to it. • Staff aid with verbal and physical cues and reinforcement
2. Boredom/ under stimulation Over stimulation	• Prevent under stimulation 1) Review activities and rec. therapy available within the setting 2) Remind and encourage client to attend group activities 3) Complete Alzheimer's Society "All about me" book to gain greater insight into their personhood and interests 4) Provide safe Montessori based or repetitive engagement e.g. fidget apron, folding fabrics, stacking blocks, watering fake plants • Eliminating overstimulation 1) Remove person from residents with persistent vocalizations- if person is non mobile seat them in low trafficked zones 2) Provide access to quiet zones or sensory deprivation rooms 3) Remove client quickly post meals and group activities 4) Beware of when client is most prone to over stimulation 5) Provide noise quieting headphones/ music for client if a quiet zone is not possible 6) Identify times when person is most overstimulated and be proactive with the recommendations above

ENVIRONMENTAL

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1.New environment is confusing	• Use of large and easy to read signage/ or use of picture-based signage (e.g. picture of a toilet) to orient towards heavily used room • Use a cloth barrier or STOP sign on areas which should not be access • Staff verbal reinforcement and redirection to entrench routes and pathways
2. Doors and clear exits triggering a desire to leave or attempt to leave	• Disguising exit doors using murals, covering door handles, paint door same colour as wall etc. as safety codes permit. • Use of keypads instead of doorknobs, or use of doorknobs which are unusually shaped or have unusual locks • Encourage staff and visitors to use back exits or stairwells so persons aren't drawn to a heavy trafficked single point of access • Use of black mat in front the door or a Caution sign in front door to limit attempts to access

SOCIAL/CULTURAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Space feels unwelcoming or highly institutional	• Where possible ensure that the room or shared room has meaningful and person-centered unique identifiers e.g. pictures of family and friends, items from home etc. • During the initial transition encourage or allow person to take part in decorating their space if able • However ensure space is already set up to be warm and welcoming e.g. small touches such as open books, music, non-poisonous flowers etc.
2. Past routines e.g. walking dog at a certain time, leaving for work at certain time	• Identify any past routines via persons, family or friend interviews • Attempt to replicate routine as much as possible- e.g. if person is a late riser allow him/her to sleep in and make them last on the list for care. If the person never ate breakfast offer a snack later in the morning vs. waking them for breakfast • Identify past employment and use elements of this to engage him/her during the day e.g. if a secretary, provide with papers for writing/filing
3. Client feels lonely and does not feel like they belong	• Where possible ensure that the room or shared room has meaningful and person-centered unique identifiers e.g. pictures of family and friends, items from home etc. • During the initial transition encourage or allow person to take part in decorating their space if able • However ensure space is already set up to be warm and welcoming e.g. small touches such as open books, music, non-poisonous flowers etc.

Non-Pharmacological Strategies for Food-Seeking Behaviour

PHYSICAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Oral health issues e.g. dental issues, swallowing issues, excess saliva	• Access dental services with specific assessments around identification of dental pain • Review fit of dentures – especially post weight changes • With excess saliva check with SLP or Dietitian re techniques to manage this e.g. crackers etc. • Provide sips of water to aid with dry mouth
2. Insatiable hunger- lack of inhibition around food intake or decreased feedback and sensation from GI	• Explore all possible physical or medical causes of hunger. E.g. unmanaged diabetes, hyperthyroidism, Graves' disease, medication side effects • GP consult to explore any other underlying cause: if source is identified educate care givers around why this is occurring • Consult dietician for calorie count, and direction over foods which lead to a longer last sensation of being full • Provide food items which can take longer to consume- e.g. small snack such as a bowl of cheerios, frozen apple sauce • Allow of multiple drinks across a day by use of smaller cups sizes
3. Seeking oral stimulation	• Look at solutions that meet oral need to chew by providing safe oral stimulation e.g. chewellery, chewing gum, etc. • Replace oral stimulation with other types of stimulation (e.g. bouncing a ball, rolling a ball, tactile games, etc.)

INTELLECTUAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Amnesia: Person is unable to remember the last time they had a meal	• Leave environmental cues visible to remind the person that they have already eaten e.g. leave the plate they ate off of on the table • Consider use of a schedule or signing sheet for the person to sign once they have received their meal. • Instead of refusing to provide food when it is requested, refer the person to the next time a snack or meal will be available. • Access dietician to identify diet appropriate small snacks which can be provided across the day
2. Aphasia: Person lacks the ability to communicate verbally, and they may resort to physical communication e.g. picking	• Avoid physical altercations or physically attempting to take the food from the person- unless it is an inedible or poisonous substance; this may trigger a physically defensive response from the person • Ensure areas which are frequently traveled by the person are clear of

up food from wherever it is found and eating it	food substance • If the behaviour is increased assume this means the person is hungry at that time and offer a snack vs. allowing them to continue to food seek independently
3. Altered perception: May cause challenges in differentiating between food items/non-food items.	• Consider use of a coloured place mat to bring attention to meals • Consider training the person to associate food being on the plate from non-food items off the plate • Avoid putting non-food items or inappropriate food items e.g. pack of pepper with the rest of the food on the tray • Objects with a changing shape e.g. napkin, rubber gloves may be more confusing, so limit the exposure to these during meals and when client is alone
4. Delusion/hallucination: Unusual believes around food- e.g. that food is being withheld or they are being starved	• Use of a food log and gain a signature post meals and snacks so this can be presented later to show a meal was provided • If permissions are given, consider videotaping client during meals with a time stamp to present afterwards • Validating client emotions and feelings • Address with Geri-Psych team if these hallucinations and delusions are new or sudden

EMOTIONAL

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Depression - Emotional eaters	• Establish if the increased eating is related to moods e.g. increased eating with depression, or increased eating with manic stages of bipolar disorder. • If the person seems happiest when access foods use their interest to encourage them to take part in other meaningful activities which can be used to substitute. • Establish if this behaviour is new or longstanding as long-standing behaviours need longer to extinguish

CAPABILITY

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Rely on client's strengths	If the person is physically able to feed themselves allow them to do so- even if this takes longer than staff feeding them.

ENVIRONMENTAL

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Person may seek food with greater frequency during mealtimes	• Consider timing of meals- is it in keeping with the persons most hungry times? • Consider allowing them to be the first one in and last out in dining

	room to ensure she/he has long enough to eat and reduce impatience to be fed.
	• If food stealing is in place:
	  ○ Person may have to be sat alone in dining room
	  ○ Person may have to be provided with second helpings to limit them from taking from others
	  ○ Person can be provided with small "in between" snacks while awaiting next course of the meal
	  ○ A staff member may be assigned to sit at the table to redirect

2. Environmental scan: Is there anything unsafe for them to eat	• Limit the persons accesses to items which would cause harm if ingested • Ensure that public spaces do not have inedible items which are easily accessible and easy to eat or swallow • When providing care check persons mouth to ensure they are not pocketing non-food items • If attempting to ingest inedible substances is a frequent behaviour set up scheduled safety check to ensure the mouth is free of items, and to limit risk of choking • Minimize any fake food as decoration especially in client accessible spaces

SOCIAL/CULTURAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. May seek food more when isolated, alone	• Consider activity engagement, social times throughout the day in line with previous social history
2. Review previous eating patterns	• Review the persons food related social history- it is possible they have always enjoyed food and meals, and this is their baseline • Check for history of eating disorders earlier in life

Non-Pharmacological Strategies for Hoarding

PHYSICAL	
TRIGGERS/CAUSES	**INTERVENTION/ STRATEGIES**
1. Hunger	• Rule out medical conditions which would create unusually high appetites causing client to hoard food – if this is highlighted as a cause please see section on Food Seeking Behaviour • Incorporate an exchange for snacks- all wrapping, utensils, uneaten snacks etc. much be given back to staff prior to getting a new snack
2. ABI or TBI – increased risk for hoarding	Link with ABI Network for ABI specific recommendations
3. Physically unable to clean own space	• Set up more regular intervals of room cleaning: including monthly episodes of full cleaning and removing items ○ If the person has an impaired memory complete full clean when they are not present ○ If memory is intact, engage them in setting up a cleaning schedule as part of the care plan and behavioural contract

INTELLECTUAL	
TRIGGERS/CAUSES	**INTERVENTION/ STRATEGIES**
1. Anosognosia: Person is unaware they are hoarding or unaware of the risks associated with hoarding	• All limits or expectations should be outlined in clear language and printed and provided to the person or placed on their wall, where the person, family, friends and staff can all easily access • Use uncomplicated language when limit setting ○ There should be limits on what type of items allowed in the room ○ How often new items are brought into the room? ○ How often items are cleaned out of the room? ○ How and where these items are stored?
2. Amnesia: Person forgets they placed the items there and brings more in	• Allow collection of items during the day and do not try to physically take an item from the person's hand • Wait until the item has been placed down to remove or retrieve it • Create a system of exchange re items entering the room (new items in = old items removed) • Check room periodically while client is not present for dangerous, molding or high-risk items • Provide reminders so the set decluttering day is not a "surprise" • Set up a schedule for when the room will be cleared and link the cleaning with a positive reinforcement • Place limitation on the food items which can be brought into the room-

	as these items may quickly spoil
3. Aphasia: There is an inability to ask for aid in removing items	• Set a cleaning/ decluttering schedule so there is no need to ask for the aid
4. Altered perception: Believes that collected items are something they are not e.g. the TV remote is a cell phone	• Demonstrate the true use of the items e.g. turn on TV with remote to explain that it's not a cell phone- offer aid in locating any item which the person feels is lost • Place items which are hoarded the most way from public spaces areas e.g. place remote in the nurses' office when it's not in use • Attach items down in public spaces if possible- e.g. attach remote to a table • Keep "lost and found" items in areas which are not accessible except to staff
5. Delusion: Collecting items because they believe they are leaving/going on a trip/returning home	• Provide the person with a bag if they do not have one - it is good to have similar "back up" bags • Allow client to pack this bag during the day • Empty back nightly or at frequent set intervals when client is asleep or distracted • Check the bag daily for high risk or spoiled items
EMOTIONAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Result of psychological trauma, loss or stressful life event	• Link client to GMHOT or other mental health services including counselling • CBT is recommended if capacity allows for this • Minimize use of reminiscent therapy • Ensure staff is aware of triggering history and educate the importance of a gentle and GPA based approach when attempting to clear hoarded items
2. Impulsivity- poor regulation of desires and actions	• Limit access to online/TV shopping • Have capacity for finances assessed and involve PGT if appropriate to limit spending • Check and clean out pockets of clothes while washing • Set up check ins with staff if he/she is community independent to review any new items being brought on site
3. Mental health disorders such as OCD, compulsive shopping, depression etc.	• Link client to GMHOT or other mental health services • Use same techniques as for "Impulsivity" *Note:* If having episodes of acute psychiatric distress there is often a need for pharmacological intervention to re-establish baseline prior to use of non-pharm strategies

CAPABILITY

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Physically unable to remove the items	• Staff, family and friends must take responsibility for reviewing and removing any items brought into the room
2. Visual impairment makes it challenging to see the stored items	• Providing cuing around where items are cluttered • If there is willing engagement allow the person to deciding power over which items will be removed • Staff should review the space to see if there are duplicates of hoarded items and advise the person of this as they may be unaware how many items they have

ENVIRONMENTAL

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Poor lighting limiting client's ability to see the items	• Provide lamps or replace older bulbs providing dim lighting. • After improving lighting, provide cuing around which areas need to be decluttered- provide aid as needed
2. Poor ability to pack/store/organize	• Aid by providing low cost organizational tools e.g. trays, cardboard boxes, Dollar store containers to help with room organization • Set up a schedule with staff to re-organize monthly – if there are social supports in place request that they also aid with this during visits
3. Space that is too small for all the items which they own	• Work with the person and family members to donate or discard unneeded items. • Aid in locating items/furniture which are more appropriate for the space. • Aid in planning for organizing the space prior to the person moving in • Request that family/friends do not bring new items/gifts unless they can be eaten/used once and discharged • Request that visitors alert staff when bringing in a new item

SOCIAL/CULTURAL

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1. Born during the depression or was raised in high levels of poverty	• Provide emotional support and reassurance that meals and items need will be provided daily • Where possible all meals should occur outside of the room • If unable to provide meals outside the room- then an exchange system should be created around meal provision • Provide emotional assurance that his/her needs will be met

2. History of homelessness/ transient living	• Provide emotional support and reassurance that their needs will be met by staff on site • Limit meals within the room • If the person is community independent implement a check in system: at the front desk, front of the home or at the nursing station on their unit. When the person returns from outside staff should review what they have brought in to determine if it is appropriate • Provide a small box which the person is allowed to fill with new items with the understanding that once the box is filled no new items can be brought in- unless it is again emptied.

Non-Pharmacological Strategies for Inappropriate Vocalization

PHYSICAL	
TRIGGERS/CAUSES	**INTERVENTION/ STRATEGIES**
1. Underlying medical condition	• Assess for pain and consult with pain specialist or physician for effective pain management plan • Rule out medical causes for pain such as unmanaged chronic illness e.g. low back pain or acute trauma e.g. falls • Assess for constipation
2. Unmet needs and discomfort	• Routine incontinence assessment to ensure there is no discomfort due to soiled briefs • Asses need to be toileted if still using bathroom • Assess for hunger or thirst • Assess for discomfort e.g. too hot/too cold, uncomfortable clothing • If the person has been seated or lying in the same position for hours, they may need to be re-positioned and transferred • If the person is aphasic staff should set up a list of common unmet needs (as listed above) and review these when vocalisations begin
3. Possible inadequate pharmacological pain management	• Consider medication review Note: Unless a result of pain or psychiatric/ psychological distress e.g. anxiety vocalisation does not often respond well to medication management
4. Poor hearing	• If hearing is impacted, he/she would be unable to gauge how loudly they are speaking
5. Mental disorders (anxiety, PTSD, OCD)	• Consider investigation and treatment of any acute mental health changes • Therapeutic engagement e.g. nonphysical care related conversations • Use of client specific distraction e.g. music, colouring, etc.
INTELLECTUAL	
TRIGGERS/CAUSES	**INTERVENTION/ STRATEGIES**
Anosognosia: The person is unaware that his/her actions maybe be disruptive to others	• Avoiding punitive language that attempt to instill remorse or belabor how their actions makes other's feel • Remind the person to be mindful of others • Use appropriate vocalization (calm voice, articulate, simple language) to model for resident
Amnesia: The person forgets certain information and	• Try to show family pictures to re-orient to reality

becomes unaware of the situation leading to anger/frustration	• Repeat information as needed without pointing out that the information has been provided already • Validate experiences of the past while redirecting the person to more pleasant activities grounded in the present
Aphasia: Not able to understand what is being told to him/her (receptive aphasia) or not able to express him/herself (expressive aphasia)	• Use simple and short sentences when communicating • More reliance on body language (e.g. facial expression and gestures) • Use visual cues to support verbal communication e.g. showing the person a soothing object vs describing it • Consider using communication cards or language cards • Engage speech language therapist – and provide client with language augmentation or alteration devices e.g. bell, word cards etc. • When appropriate consider the use of therapeutic touch
Delusion/hallucination: She/he is my husband/wife Speaking to people who aren't there	• Show photos of her/his family members • If the person is having audio hallucinations and is responding to these- once this is not loud or distressed allow them to do so • Use of reminiscent therapy- engage the person in conversation around pleasant memories of their family and past life

EMOTIONAL

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Personality: The person may use inappropriate vocalization as means of coping with strong emotions	• Attempt to identify and address the emotion causing the person's distress vs focusing on the behaviour it causes • Try to introduce other ways to cope such as getting involved with activities, squeezing stress ball etc. • Use of therapeutic engagement and play therapy • Model the behaviour you wish from the person e.g. lower your voice and speak gently when addressing her/him
Loneliness or perceived isolation	• Implementation of a proactive attention plan so that client is given positive human interaction prior to starting to call out • Consider use of stimulated presence with a voice client is comforted by • Use of TV or Radio programming which client finds soothing • Therapeutic engagement e.g. engaging in non-care related conversations once daily • Set up friendly visitors or volunteers if family and friends are unable to visit • Trial use of baby doll or toy cat/dog to see if client gains comfort from these items • If not too disruptive encourage taking part in activities and groups within the setting

Anger/frustration	• Explore the reasons for these feelings of anger or frustrated • Offer to problem solve with resident to meet their emotional needs vs telling them what to do • Assign a staff with good rapport a set time weekly to discuss this person's frustrations
CAPABILITY	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Language barrier	• Try to use interpreter to make sure there is clear communication • Try to assign healthcare providers which speak the same language
Pre-existing norms and beliefs	• Attempt to provide re-educate around social norms using simple concrete terms • Try to explore intentions behind each behaviour
ENVIRONMENTAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Misunderstanding social expectations	• Re-orient the person to the environment and explain social expectations e.g. "if you need my attention you can call my name"
Lack of privacy	• Provide privacy when it is needed • Knock the door and wait for response before entering
Under stimulating or unfamiliar environment	• Try to involve in meaningful and engaging activities to distract • See list of recommendations in sections above
Overstimulating	• Minimize exposure to overstimulating television or radio programs • See list of recommendations in sections above
SOCIAL/CULTURAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Pre-existing norms and believes	• Try to re-educate around the social norms and expectations of the site • Try to explore intentions behind each behaviour
Pre-existing norms and believes (staff, family)	• Avoid labeling the behaviours- Is the person singing loudly? Did they sing or hum to themselves within their home before? If signing is the behaviour perhaps engage in singing groups or music with them • Educate staff and family members about being mindful for BPSD and how this can present without allowing the behaviour to become "normalized" and ignored

Non-Pharmacological Strategies for Paranoia, Suspiciousness, Delusions

PHYSICAL	
TRIGGERS/CAUSES	**INTERVENTION/ STRATEGIES**
Brain damages e.g. tumor, acquired brain injuries and type of dementia which affect judgement and orientation to reality	• Provide emotional reassurance e.g. if the person is constantly worried about not having money to pay for meals etc. reassure the person that the bill is already paid- provide them with a receipt if needed • Assure the person that they are safe • If they are experiencing distress and at risk of harming themselves or others, refer to psychiatrist or medical team for treatment
Sudden physical changes e.g. infection, delirium	• Seek medical assessment and treatment as soon as possible as the following can cause delusions and confusion: ○ Delirium ○ Infection ○ Certain disease which reduce the amount of oxygen delivered to the brain e.g. Anemia, Asthma, Stroke ○ Over dosage and side effects of some medications ○ Taking hormones in combination with antidepressants.
Mental illness and substance use e.g. alcohol, cocaine, cannabis, LSD	• Consultation with psychiatrist
Sensory deficits, e.g. low vision and diminished hearing	• Use hearing aid or pocket talker • Use communication board, pictures, pen and paper
INTELLECTUAL	
TRIGGERS/CAUSES	**INTERVENTION/ STRATEGIES**
Amnesia – loss of memory E.g. Misplacing objects and believing that someone is stealing from them.	• Prepare duplicates of the same item that can be provided when the original is lost • Provide reassurance that their belongings are safe • Provide secured storage for the specific items e.g. a locker, adding a lock to cabinet, etc. and allow the person to have a key and staff to have back up keys
Altered perception – misinterpretation of sensory stimulation	• Identify and then remove triggers which cause distress • Validate the person's feelings and emotions: do not cause them to feel that their fear is not valid • Assess for changes or decline in vision
Agnosia – loss of recognition of sensory information	• Provide emotional support and validate vocalised concerns

Misinterprets benign objects as being harmful E.g. seeing a black coat hanging on the door as a bear; seeing his own image in the mirror as a suspicious stranger in his home	• Put the blinds down if reflection is an issue • Improve lighting within the home • Remove clutter within the home • Put clothes away versus leaving them hanging *Note*: It is important to differentiate delusions from altered perception or agnosia
Hallucinations and delusion The person may have paranoid persecutory delusions e.g. someone is trying to kill or harm them; their food/medications are poisonous.	• Staff should make a focused attempt to build up trust and rapport with the person. • Opening the medication package in front of the person can provide reassurance that no one tampered with the medication • Under medical guidance medication can be put into food/drinks which have strong flavours or are cold/hot- be aware if the person is able to notice the change in flavour this may make them more suspicious of their meals • Seek medical treatment if delusions are severe or greatly limit care

EMOTIONAL

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Feeling fearful, anxious, depressed	• Provide emotional reassurance • Provide gentle physical touch if helpful, e.g. gentle hugs, holding hands, etc. with staff who have established rapport and trust • Encourage the person to verbalize their feelings. Offer protection and support during this process • Consult with doctor for possible treatment of depression if it is identified as the major contributing force behind the behaviour
Missing spouse and loved ones, loneliness or delusions around spouse's actions E.g. believes her spouse is having an affair with someone else	• Provide evidence that spouse still loves him/her e.g. love letters and voice notes, videos • Encourage spouse and family to visit • Consider simulated presence with loving messages • Provide support for the person who the delusion maybe fixed on at that time
Past traumatic experience E.g. a history of sexual abuse leading to feelings of being threatened when personal care is provided	• Provide lots of reassurance and positive distraction during the process e.g. use of gentle therapeutic touch, music, aromatherapy • Break down care process into small steps. Providing cues and next steps through the process • Requesting the persons aid and permission at each step • Using the gender which the client is most comfortable with • Minimize nudity as much as possible- provide a robe or towel during the process • Only use one staff if possible and identify which staff has best rapport-

	where possible using the same staff every time • Ensure staff is aware of this history of abuse
Feeling fearful, anxious, depressed	• Provide emotional reassurance • Provide gentle physical touch if helpful, e.g. gentle hugs, holding hands, etc. with staff who have established rapport and trust • Encourage verbalization of their feelings. Offer protection and support. • Consult with psychiatry for possible treatment if depression is identified as the major contributing force behind the behaviour

CAPABILITY

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Unable to distinguish between reality and delusion/paranoia	• Validation of feelings • Empathize and try to understand the function of the delusion and the main feeling caused by it • Beware that logic does not shift delusions so do not attempt to explain away the delusion • Try to re-direct to more positive experiences • Do not reason, argue or challenge the paranoia or delusion as it is real to him/her • Avoid confirming or feeding into the delusion or reinforcing the false belief

ENVIRONMENTAL

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Unfamiliar/unrecognized environment and caregivers	• Place familiar and emotionally significant objects from home in the living environment • Staff try to build trusting relationships with client- building rapport increases the chance that the person will trust what staff say
Disruption to routines	• Try to establish and stick to set routines • When having to change routines do so slowly and in a graded manner and allow for a small time of adjustment after each change • Staff should complete a log to monitor the frequency of the delusions to ensure changes are implemented only after delusions have settled.
Inadequate lighting	• Provide adequate lighting • Provide a night light but first check that this does not cause elongation of shadows and distort shapes which may cause greater delusions
Other people/other residents getting inside the person's room	• Put a stop sign or alarm on the door to prevent other residents from entering the person's room • Review recommendations for Exit Seeking and Entering Co-Residents Rooms for other strategies

SOCIAL/CULTURAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Social isolation	• Encourage families and friends to visit at set times so this can be incorporated into a routine • Arrange friendly visitors who are made aware of client's delusions • Engage in meaningful social activities and provide reminders and encouragements to aid with this

Non-Pharmacological Strategies for Resistance to Care

PHYSICAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1.Pain: Joint/back/leg pain aggravated during care and transfer	• Create a pain management plan based on in-depth pain assessment and tracking or pain complaints • Consult pain specialist • Always screen for pain prior to initiating care • Provide gentle rubbing or heat pad or pain cream to the affected area as per directive • Use soaker pad or transfer blanket to turn the person over instead of directly pull over the affected area. • Avoid direct contact with affected area as much as possible- wash around painful area first. • Re-assess chronic diseases for acute flares e.g. OA
2.Sudden physical changes, such as UTI, URI, delirium	• Treat the conditions and symptoms as soon as possible- use lab work to test for specific illness
3.Hearing loss	• Use hearing aid or pocket talker to ensure client can hear caregivers' directions • Focus on pronunciation, tone, rate and clarity of speech while providing care • Establish the level of tone the person requires to hear clearly • One staff member to speak at a time during care • Ensuring staff speak into the ear which is most functional • Use communication board, pictures, pen and paper • Increased use of body language and nonverbal cues during communication
4.Vision impairment	• Guide the person step by step through the care process with clear and simple instructions • Apply proper eyeglasses if possible. • Ensure the person is aware of your presence - introduce self and purpose of the visit every time care is initiated • Use high contract visual cues in bathroom so the person can better see sink, tub and toilet • Ensure area of care is well lit
5.Discomfort e.g. Constipation	• Provide prune juice, high fiber diet, laxative if needed • Provide routine toileting

INTELLECTUAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1.Agosognosia: Person is not aware of their own limitation e.g. "I can do it myself", "I do not need any help," "I wash/shower myself all the time" .	• Validate the persons belief by using phrases such as "I know you can do this yourself- I am just here to set you up" • Distract with singing, nice chatting, joking and dancing • Allow the person to participate in care while providing cueing and assistance- Avoid giving directions in strong tones • Encourage independence in aspects where possible- only stepping in when they struggle and offering "Why don't I give you a hand" • Offer choices during care and allow the person to lead care where possible – ask questions such as "What would you like me to do next?" • Allow the person to take part in deciding where and when care will take place e.g. bedside vs bathroom • Start from washing the feet; slowly move up when the person feels comfortable • Leave areas which are not being cleaned covered with a towel, so the person is not fully naked when they do not need to be • Provide a washcloth to allow for the person to attempt to clean the areas of themselves that they can
2.Amnesia: Person forgets when they last received care: e.g. I just washed yesterday, I'm clean already, today is not the day for my car	• Help the person to realize the need for care e.g. let them feel or see the soiled brief/pants. • Use of a gentle but firm approach if effective. • Use of "accidents": E.g. spilled water over the persons clothes to validate the need for changing clothes • Lay fresh clothes out on the bed to cue need to change • Providing a set time and date for care giving and provide multiple reminders on the day before and the day of • Allow for some flexibility on the day of personal care so it can be moved later if client requires more encouragement during the day • Provide numerus clothing options which are similar to each other
3.Aphasia: Not able to understand and express or follow care instruction	• Use simple and clear instructions • Incorporate more use body language • Model the behaviour e.g. Staff can pretend to wash themselves to show which areas they would like the person to clean

4. Altered perception: E.g. Challenges with depth perceptions	• Use of adaptive equipment:
	  ○ Raised toilet seat
	  ○ Grab bar or toilet seat with
	  ○ Put color tape on toilet seat or use bright colored seat
	  ○ Bright mats in bathtub
	  ○ Coloured towels for cleaning

	• Being aware of common triggers within the bathroom
	  ○ Tubs can look like deep dark holes
	  ○ Garbage baskets can look like toilets
	  ○ Shiny tiles can appear wet and slippery
	• Provide calm emotion reassurance during care
	• Cover mirrors if the person believes their reflection to be another person in the room

5. Dressing Apraxia	• Mirror and demonstrate actions of dressing with client • Initiate the task and set up all items needed for dressing prior to starting • Give step by step verbal and physical cues • Provide hand on hand physical aid as needed
5.Delusion/hallucination: She/he will hurt me Page 25, Delusion 3. Privacy- add intervention: - Allow the resident to wash her private area if she/he is able to	• Validate the person's feelings and provide reassurance • Seek psychogeriatric assessment and treatment if the delusion/hallucination is causing severe distress • If delusions or hallucination are new keep note of their focus and frequency to establish triggers and patterns

EMOTIONAL

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1.Lack of rapport or trust with the care giver: "I do not like her/him"	• Take time to establish rapport prior to care: E.g. Talking, joking, therapeutic touch, singing, dancing and/or playing music to help the person feels more comfortable. • Creation of a reward system associated with personal care may also aid with rapport building • Consider stimulated presence with a recording of a family member encouraging person to accept care giving • Visiting with the person outside of care giving times
2. Fearful: Fear to fall, fear of harm e.g. when having to use the mechanical lift for transfers	• Provide reassurance. • Provide a hand or arm for support or direct to the grab bar • Allow person to use or hold on to their mobility device for as long as possible during transfer • Request PT mobility assessment and OT bathroom safety assessment to decrease risk of falls with transfer and bathroom care • Review the above assessment when there are noted changes to mobility, strength and balance
3. Concerns over privacy: does not feel comfortable to be exposed, especially the	• Cover client with a towel especially private areas or provide a robe • Expose only the area being washed

private area	• Speak softly to the person as not to embarrass them by announcing need to toilet/shower- do not shout out directions around care • Review recommendations from Non-Pharmacological Strategies for Resistance to Care for other care based approaches
4.Frustration and anger due to loss of functions and lack of control	• Approach client gently and give genuine sympathy • Provide options and elements of autonomy e.g. choice regarding clothing, time for care etc. • Encourage the person to participate in care as much as they can • Allow the person to guide pace of care if they are able to do so
5. Bad/low/labile mood/depression: "Go away! Get out!" swearing	• Allow space to calm down. Re-approach later • Use of humor to improve person's mood • Link caregiving to positive reinforcement e.g. family visit
6. Past traumatic experience	• Provide lots of reassurance and distraction use gentle therapeutic touch. • Be aware of gender specific trauma and provide care with this in mind e.g. the person may need only female staff • Break down care process into smaller parts • Use of care limiting items e.g. dry shampoo, bed baths • Review recommendations listed within the Emotional section of Inappropriate Vocalisations
7. Being rushed during care/shower	• Be patient. Try not to rush. Set aside enough to complete care without rushing the person • Complete care during low pressure periods for staff so they are able to spend longer with care • Be mindful of your own facial expression and tone of voice- tone has been shown to have a great effect on behavioural presentation

CAPABILITY

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1.Language barrier	• Use of body language, communication cards or interpreter if available • Learn a few words from the person's first language to facilitate care
2. Unable to weight bear or tolerate long duration of care procedure	• Provide care efficiently by having all staff and items needed for care in place- and being aware which step each staff member would take • Use of bathroom assistive devices e.g. bath bench • Consider providing bed bath • Request OT and PT assessment to identify the safest way to provide client with personal care • Use of clothes which are easy for client or staff to remove

ENVIRONMENTAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1.Too many people approach the person and/or talk at the same time, too much noise	• Avoid having too many staffs present during care. • Only one staff member speaks at a time- identify this staff member prior to entering the persons room • Be aware of how quickly a small space such as a bathroom can feel filled with people • Keep the environment quiet and calming
2. Lack of privacy: E.g. shower curtain or door are not closed	• Put on a shower curtain, close the door • Wash the private area at the very end of care • Minimize amount of staff present during care
3.Water is too cold or too hot	• Let the person test the water. • Adjust the water temperature as requested by client • Do not put the water on to the persons skin prior to warning them first- be very careful when putting water onto their face
4. Room temperature is too cold especially during shower in cold weather	• Provide a heater to keep the bathroom warm • Let the water warm • Allow client to wear robe until ready for care to keep warm
5. Dislike of the bathroom setting: E.g. Too cluttered, bathroom does not feel like a home bathroom	• Remove clutters from bathroom as much as possible • Accommodate the person's preference to make the care process inviting e.g. pleasant aromatic smell, music • Consider providing a plastic tub to the persons care can be completed within the bedroom at the bedside • Allow the person to have bed bath if bathroom is too triggering – consider no water clean products such as dry shampoo
6. Care atmosphere: E.g. Caregiver's approach, attitude, tone of voice	• Use of gentle approach and friendly tone of voice. • Avoid interference by other persons during care
7. Lack of proper lighting and equipment: E.g. grab bar, raised toilet seat, dark bathroom	• Install proper equipment as needed- see recommendations in the Altered Perception section of Resistance to Care • Make sure bathroom is well-lighted.
SOCIAL/CULTURAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
1.Lack of social interaction with the person	• Take time to establish rapport prior to initiating care: E.g. Talking, joking, therapeutic touching, singing, dancing and/or playing music to help the person feels more comfortable

2.Personal Preferences e.g. Sensitive to certain genders or certain caregivers e.g. Being aware of client's past history of routines and prefaces e.g. Social and cultural norms for bathing e.g. person is used to wash from a basin with a towel	• Find a better match and adjust staff assignment as needed • Provide care based on the person preferences e.g. what time of day are they most open to care - morning care or afternoon etc. • Some cultures do not shower/bathe fully but use a basin or shower- be aware of client's culture specific needs • Get to know client's socio-cultural history – To Holocaust survivor a shower may look like a gas chamber • There may be a history of only allowing a hairdresser to wash and style their hair – but not be open to staff doing this

Non-Pharmacological Strategies for Sexually Inappropriate Behaviour

PHYSICAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Underlying medical condition	• Urology and/or gynecology consultation to rule out any medical condition that can contribute to inappropriate sexual behavior
Possible side effect of medication (levodopa, benzodiazepines)	• Consider medication review
Hormonal imbalance	• Review age related hormone changes • Consider investigation and treatment
Alcohol use/ Drug use	• Monitor closely if resident is using alcohol or other drugs as this can lower inhibitions
Possible disease related symptoms- Mental health with fixations on sexual topic, thyroid issues etc.	• Assess and treat as indicated by mental health care team

INTELLECTUAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Anosognosia: The person believes that she/he is young and healthy and in sexual prime	• Ensure that staff feel empowered to develop boundaries clear boundaries which they remind the person of at the start of interactions e.g. "I am only here for …" • Use firm language – be careful as friendly tones can be misinterpreted during care giving • Try to use mirror to remind resident his/her age
Amnesia: The person forgets that he/she is married	• Try to show family pictures to re-orient to reality
Aphasia: Not able to understand long explanations as to why the behaviour is inappropriate Client may also have difficulty understanding staff and residents verbal and nonverbal signals of disinterest	• Use of simple and short sentences • Use of a firm and strong "No" • Pause care and step back when behaviour presents • Consider using communication cards • Match body language, tone and nonverbal and verbal language of non-interest- all to demonstrate lack of interests e.g. Say no firmly and strongly, cross arms and step back away from resident • Do not take part in longer conversation- provide short firm responses
Altered perception:	• Show photos of her/his family members

misidentify others as spouse Delusion/hallucination: She/he is my husband/wife	• Provide reality re-orientation- "This is not your wife…" or "I am not your wife…" • Provide redirection and guide the person away • If the person is focused on a co-resident attempt to keep these two separated • Help both the person and the co-resident to appreciate the consequences of this sexual action- being aware that the co-resident's feelings and safety are of equal importance • If the person or the co-resident that is involved is incapable the POA should be advised as to the behaviours • If the behaviour is unwanted or causes distress to a co-resident it is directed towards staff should schedule safety checks
EMOTIONAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Loneliness	• Try to introduce to residents with similar interests and cognitive capacities or try to arrange volunteer's visits • Involve in group activities • Speak to POA, friends or family to advise them re clients need for human contact
Missing family	• Schedule time for phone calls to the family • Engage client in reminiscent therapy
Lack of intimacy	• Consider providing private space for consensual partner visits • Provide appropriate therapeutic touch and tactile stimulation
CAPABILITY	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Language barrier	• Try to use interpreter to make sure that the person understands staff and other residents • Learn key phrases in the primary language such as "Stop", "No" or "I am only here to provide care"
ENVIRONMENTAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Misunderstanding social cues	• Provide care by 2 staffs for safety • Avoid assigning male/female care providers • Wear uniform- and use this to aid in identification of role • When providing care keep facial expression neutral and maintain a professional demeanor • Wear a protective disposal apron which is covering of chest area during

	care • Give person something to hold during care
Lack of privacy	• Provide privacy when needed • Knock the door and wait for response before entering
Under stimulating or unfamiliar environment	• Try to involve in meaningful and engaging activities to distract client prior to care
Overstimulating	• Minimize exposure to overstimulating television or radio programs
SOCIAL/CULTURAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Pre-existing norms and beliefs (resident or client)	• Try to re-educate the person about social norms e.g. "It's not nice when you…" • Try to explore the true intentions behind each behavior e.g. Disrobing due to discomfort vs sexual intent • Certain cultures are male dominated and expect submissions from females – address these expectations with the person and their family/friends
Pre-existing norms and believes (staff, family)	• Avoid negative or subjective labeling of the person's behaviors • Educate staff and family members about sexuality, aging and Dementia • Ensure that the site has clear policies around dementia and sexuality e.g. conducting sexuality specific capacity assessment, allowance for private masturbation • Consider education to staff around safe sex practices within the context of dementia • If staff is aware that the person is engaging in sex, sexual health screening and testing should become a part of their standard medical check ups • Use of PRCs to aid in education of staff

Non-Pharmacological Strategies for Sleep Disturbances

PHYSICAL	
TRIGGERS/CAUSES	**INTERVENTION/ STRATEGIES**
Underlying medical condition (i.e. thyroid condition, delirium, B12 deficiency, iron deficiency, sleep apnea, insomnia)	• Urology and blood work to rule out possible medical concerns • Consider vitamins or supplements as needed (i.e. B12, melatonin) • If diabetic, monitor blood sugar levels during the day • Consider a referral to a sleep clinic, assessing the need for a CPAP machine, snore strips etc. if client has sleep apnea or difficulty breathing overnight • Sleep study assessment- use of a sleep journal
Possible side effect of medications (e.g. antipsychotics)	• Consider medication review
Alcohol use	• Monitor and suggest decreasing use if a concern
Caffeine use	• Limit caffeine intake during the day • Avoid caffeine in the evening • Avoid chocolate in the evening
Physical decline	• Encourage more physical exercise or activity during the day • Encourage more exposure to natural light during the day which incorporates exercise e.g. going for a walk outside
Pain	• Effective pain management /pain specialist consultation • Consider a hot shower before bed • Consider a massage or gentle physical touch before bed • Consider using pillows to help with body positioning for comfort
Digestive concerns (i.e. constipation, acid reflux)	• Have concerns assessed and treated by a doctor/gastro specialist • Consultation with a dietician • Avoid spicy food and heavy meals before bed • Small snacks before bed which have no effect on the persons alertness • Avoid laying down right after a meal or use positioning post

INTELLECTUAL	
TRIGGERS/CAUSES	**INTERVENTION/ STRATEGIES**
Anosognosia: lack of awareness of their sleep reversal	• Avoid arguing the beliefs around the lack of sleep: instead look at implementing other strategies to help resolve sleep concerns

Amnesia: forgets where the bathroom is in the middle of the night	• Night light or hallway light to help guide and illuminate overnight • Use of movement activated lights so light does not keep the person up overnight • Wayfinding cues e.g. pictures of the toilet with an arrow pointing in the direction of the bathroom • Removing distractors in environment e.g. shutting all other doors except bathroom, which has a nightlight in it to guide towards itself
Sun downing: brain changes and cognitive decline	• Encourage more physical activity during the day and meaningful activities when sun downing occurs • Avoid lighting which causes shadows at night • Consider impact of lighting and use of lamps and light • Explore whether activity level is too demanding or not stimulating enough at this time; consider appropriate sensory opportunities.
Aphasia: Not able to communicate when they are tired	• Look for non-verbal cues that the person may be tired (i.e. yawning, rubbing eyes, dozing in their chair) vs waiting on them to request to go to bed • Use simple and short sentences • Use body language to communicate e.g. pointing to the bedroom • Use visual cues to support verbal communication • Consider using communication cards e.g. a card with a bed on it
Altered perception: May misinterpret items in their living environment when it gets darker	• Ensure that there are no shadows at night that make the client see things that could be considered frightening
Delusion/hallucination: May think something bad is going to happen at night	• Validate emotions and reassure them that they are safe • Remain with the person until they fall asleep
EMOTIONAL	
TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Depression	• Have depression professionally assessed and treated by a specialist as depression can present with insomnia e.g. geriatric psychiatrist, geriatrician, etc. • Provide caregiver education about the symptoms of depression
Social isolation	• Consider a day program during the day to increased engagement in meaningful occupation • Try to get the person outside for natural light during the day or consider bright light therapy
CAPABILITY	

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Toileting difficulty	• Try to use the bathroom before bed • Avoid fluid intake three hours before bed • Look at getting assistive technology to help encourage independence with toileting e.g. raised toilet seat or commode within the bedroom etc.

ENVIRONMENTAL

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Noise	• Limit the noise on site overnight. • Consider white noise as an option or calming music before bed
Room temperature	• Aim for the room temperature between 60-67F degrees
Under stimulating or unfamiliar environment	• Try to involve in meaningful and engaging activities during the day • Use family and spouse to gain better knowledge around the person's specific interests
Overstimulating	• Minimize exposure to overstimulating television or radio programs in the evening • Use the bedroom for sleep and intimacy only • Provide a quiet space which can be accessed just before bed to decrease stimulation prior to bed
Light	• Try to minimize light in the bedroom, consider black out curtains • During the daytime have blinds open and at night close the curtain • Consider bright light therapy • Limit use of TV or other lit devices 2 hours before bed

SOCIAL/CULTURAL

TRIGGERS/CAUSES	INTERVENTION/ STRATEGIES
Previous employment schedule (i.e. shift work)	• Validation therapy e.g. if the person believes they need to go to work, tell them that they have the day off • Slowly wake the person earlier each morning to help readjust sleep schedule. Use of music, light exposure, a "good morning" 10 minutes prior to waking may help them gradually wake up • Engage the client in Montessori Based activities during the daytime
Previous sleep habits	• Gather information about past bedtime routines and implement past habits e.g. did they previously shower before bed then read for ½ hour • Avoid excessive napping during the daytime. Try to have the person nap in the morning vs. in the afternoon • Create a clear sleep schedule which the team follows nightly to create a routine as this increased reflex to sleep

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