Disclaimer

"Culture Change in Long Term Care" is an initiative of the Alzheimer Society designed to enhance the quality of life of people with dementia living in long term care homes in Canada and their families.

To enact this direction, the Alzheimer Society of Canada (ASC) funded an exploratory qualitative research in 6 long term care homes across Canada, which were selected by external subject matter experts on the belief that they are striving to provide elements of leading-practice, person-centred care to their residents with dementia.

ASC does not endorse or recommend any of the 6 homes which participated in this market research, nor the processes or services put into practice. The views and opinions included in the reports do not necessarily state or reflect those of ASC, and they may not be used for endorsement purposes.

Please note that the information contained in the following reports is not intended to serve as professional advice.

Northwood at the Harbour In Care Living
Leading Practices in Person-Centred Care
For their Residents with Dementia

Northwood at the Harbour, In Care Living, in north Halifax offers a range of accommodations and care alternatives in three connected buildings: Northwood Towers, Northwood Manor and Northwood Centre. The three buildings are linked through a shared commons that includes amenities such as a drugstore, beauty salon, fitness centre, on-site bank, medical centre, restaurant, community centre, greenhouse and a garden in an outdoor courtyard.

- Northwood Towers is an apartment building for seniors who want to live independently in their own home.
- Northwood Manor is home to seniors who live independently and to those requiring Residential Care (RCF) supervised care, Level I (limited help with personal care) and II Care.
- Northwood Centre offers 24-hour Level II Care (help with personal care and professional nursing care) and is home to residents living with dementia, acquired brain injury and other complex medical conditions.

Northwood Centre is a 9-storey building, made up of five neighbourhoods, with each floor home to 33 residents, including Special Care neighbourhoods for residents with advanced dementia.

A. Management Philosophy, Vision and Culture Change

- *"My approach was to figure out where I wanted to go…Determine a vision for resident care and how we needed to organize ourselves and work together to deliver this vision. Then, I needed to communicate the vision and behaviour expectations regarding that vision…I needed to develop a detailed understanding of where the organization and leadership team were against the vision and expectations, so I could determine the changes that needed to occur…I needed to make changes to the leadership team." (Corporate Director In Care Living)*

1. Articulating a vision for the future

- In response to an environmental scan and strategic review, the CEO of Northwoodcare Inc. announced in 2008 that the organization needed to change, that is:
  - "Move to a resident-directed model of care focusing on choice, participation and control for residents."
  - "Create a workplace where employees feel valued for their contribution through respect, communication and empowerment."
  - "Create a warm, welcoming and safe physical environment."

  (Rick Kelly, CEO of Northwood Care Inc., "Responding Today for the Sake of Tomorrow").

- Upon her appointment to the role, at about the same time as the CEO's announcement, the new Corporate Director In Care Living recognized that her first task needed to be the articulation of a clear vision for Northwood at the Harbour, the residential part of Northwoodcare. Northwood at the Harbour needed a vision of resident care *and* for how the organization needed to change to achieve and sustain it.

a) Objectives

- Create a vision for person-centred resident care and for how Northwood at the Harbour needed to change and organize itself to deliver this vision.

b) Approach

- Draft a vision for person-centred care at Northwood.
  - Include in the vision the rationale for change and the fundamental ways through which that change would be achieved.
- Share the draft vision with, and solicit input from, the leadership team at Northwood at the Harbour, and gain their support.
- Present the vision to the Executive and Board of Northwood Care for approval.

c) Processes

- The Corporate Director In Care Living drafted the following vision for person-centred care at Northwood.
  - *"An individualized, resident-directed approach that empowers residents to make choices about their own care and activities of daily living will give them a better chance to live full and abundant lives."* Excerpt from the Northwood at the Harbour vision document: <u>Creating a Living Model of Care</u>
  - She developed this vision guided by the following.
    - The corporation's strategic direction to move towards person-centred care.
    - Recent direction from the Nova Scotia Department of Health that identified resident-directed care as the preferred model of care in the province.
    - Feedback and input from the staff at the Home.
- The vision document included:

  (i) A vision of the future state of care at Northwood, written from the perspective of residents and staff, and vis-à-vis the culture of the Home.

  (ii) A rationale or "call to arms" for the change, including how shifts in the demographic profiles and needs of future residents will demand changes from the Nova Scotia Department of Health, the province's continuing care community and Northwood.

  (iii) A proposed model of care outlining the five fundamental means by which Northwood would evolve from its then-current institutional model to a person-centred model of care.

    1. *Shifting the way we work*, moving away from being a traditional skilled nursing facility to sustaining an environment focused on providing residents with more opportunity to choose and participate in more purposeful activities.

2. *Shifting our approach to staffing*, to restore flexibility and choice, setting aside fixed or prescribed routines, and following the lead of residents and families in how life unfolds each day.
3. *Shifting our approach to leading*, recognizing leadership is action, not a position, and how we treat each other is important.
4. *Shifting our use of physical space*, to create more "home-like" environments for residents.
5. *Shifting our culture*, from thinking of ourselves as delivering care to residents, to behaving as guests interacting with people in their own homes.

(Excerpts above from the vision document in Appendix A: Creating a Living Model of Care)

- The Corporate Director In Care Living presented the vision document to the leadership team, for discussion and input.
- With the assistance of an outside resource, the edits and additions of the leadership team were incorporated into a vision document, titled "Creating a Living Model of Care".

d) Results

- In early 2009, the vision document was presented to the corporate leadership team of Northwood Care Inc. and adopted by Northwood at the Harbour as their vision of care and guide for change.
  - The Corporate Director In Care Living is planning to condense the document to a single page, to more clearly and concisely articulate the vision to residents, staff and families to reinforce and further support culture change.
  - **(See Appendix A: Creating a Living Model of Care)**

2. Culture change

- As part of, and at the same time as, articulating a vision of care for Northwood at the Harbour, the Corporate Director In Care Living needed to look at the organization and identify what needed to change in order to achieve the vision.
- As her understanding of the organization grew, she realized that the then current culture did not support the collaborative, interdisciplinary, team-based approach necessary to support-person centred care.
- As well, she suspected that not all the members of her senior leadership team were fully aligned with, or personally prepared to change in order to achieve, the vision of care.

a) Objectives

- Understand the current organizational culture and structure, and the changes required to achieve the vision.
- Get the right leaders in place.
- Break down the functional silo mentality and barriers, and create an organizational structure to enable and support delivery of the vision.

b) Approach

- Meet informally with each member of the senior team, individually and collectively, to assess the nature and degree of communication, collaboration and teamwork – the operating culture.
  - *"When I took this job, I had informal meetings with each of my team members who were in leadership positions… No specific agenda… My objectives were to get to know each member and assess their fit with the vision and the changes I wanted to make." (Corporate Director In Care Living)*
- Talk to frontline staff and observe staff behaviour in the units to understand management and staff behaviour, relative to that necessary to fulfill the vision of care.
- Identify the gaps between the current organizational culture and structure and that necessary to fulfill the Northwood vision.
- Develop and act on plans to close the gaps, mobilizing the energy of the leadership team and using the vision as a guide.

c) Processes

- To understand the working dynamics between the directors, managers, and staff at Northwood at the Harbour, the Corporate Director organized informal morning coffee meetings with members of the interdisciplinary team, individually and collectively.
  - The coffee discussions had no formal agenda, other than getting together to talk, and no minutes were taken.
- It was through listening and observing during these meetings, supported by discussions with frontline staff members and observations of staff and manager behaviour, that the Corporate Director realized that the then current culture would not support the Northwood vision of care.
- Specifically, the Director made the following observations.
  - The model of care in place was largely institutional and medically driven in a hierarchical fashion, with nursing at the top.
  - Clinical processes and procedures took precedence over most other aspects of residents' activities of daily living and personal fulfilment. Often, task completion appeared to be more important than residents' non-clinical needs (i.e., needs for contact, recognition and interaction).
  - Nursing appeared to operate apart from the other disciplines, not sharing information with other members of the multi-disciplinary team or including them in decisions.
    - *"Nursing ruled the roost and was perceived to be very dismissive of the other roles." (Corporate Director In Care Living)*
  - Communication and collaboration between many of the functional areas was weak. The professional disciplines operated in distinct silos, and sometimes in competition.
    - *"The managers weren't talking with each other." (Corporate Director In Care Living)*

- Some functional areas felt excluded from the discussions and decisions impacting resident care and needs. Some staff did not feel valued for their roles or efforts, or part of a team.
  - *"Some of the other areas didn't feel valued, and felt excluded from decisions by the nursing department." (Corporate Director In Care Living)*
- The nursing managers were not visible on the floor and some residents felt isolated or apart from the clinical staff.
  - *"One of the residents pointed to the closed door of the staff lounge on the unit and said to me, 'Why are you calling this place my home when there's a room I can't go into?'"(Corporate Director In Care Living)*

d) Results

- The Corporate Director In Care Living realized that for culture change to occur, the nursing managers needed to share leadership and buy into the vision of collaborative decision-making and teamwork. The nursing managers needed to become part of the leadership team.
- The Director spoke with each member of the nursing leadership team, engaged in group processes to share the other disciplines' feelings of exclusion by nursing, and explored how this impacted the provision of care.
  - Some of the nursing leadership team either did not buy into the vision or were resistant to changing their behaviour and left the organization.
  - After a period of stressful nursing shortages and recruitment, the resulting nursing manager vacancies were filled.
- With a strong nursing leadership team in place, the Director In Care Living also started to change the structure of the organization, to break the silo mentality and structure at Northwood and build a more inclusive and shared style of leadership.
  - The former leadership team was composed of six individuals, in addition to the Director, with a bias to clinical care. The team, the Corporate Director In Care Living discovered, had rarely met together as a group.
    - Manager of Quality.
    - Director of Nursing.
    - Director of Client Services (Social Work, OT/PT, Hospice, Dieticians, Pastoral and others).
    - Director of Resident Programs and Services (Recreation Therapy, Northwood Bus, Assisted Living Residential Care).
    - Manager of Long-Term Care staffing.
  - The Corporate Director In Care Living created a new and broader leadership team made up of directors and managers representing each functional area of the Home. The leadership team meets every two weeks.
    - Corporate Director, In Care Living.
    - Manager, Staffing Resources.
    - Nursing Services Manager, 5 Neighbourhood Nursing Managers, Clinical Resource Manager and Quality Infection Control Manager.
    - Manager, Social Work (Social Work, Medical Records, Admissions).
    - Manager, Restorative Care (OT/PT).
    - Director, Resident Programs and Services (Recreation Therapy, Northwood Bus, Beauty Salon).

- Director, Environmental Services.
- Director, Food and Nutrition Services (Dieticians).
- Director, Physical Plant.
- Manager, Emergency Services and Protection.
- Manager, Material Management.
- Client Relations Coordinator.

- *"Now <u>all</u> departments are at the table." (Corporate Director In Care Living)*

- With a broader leadership team in place – a team more reflective and representative of everyone who supports the residents living at Northwood – the Corporate Director In Care Living communicated and discussed with team members her expectations of them, as leaders. These expectations are outlined in a document titled "In Care Living Expectations".
  - The expectations document begins with a definition of In Care Living, making reference to the person-centred care they are charged with delivering to both residents and fellow staff members:
    - *"An interdisciplinary team responsible to understand and uphold a person directed model of living which values choice, dignity, respect, self-determination, and purposeful living for all people who live and work at Northwood."* (Excerpt from the document, <u>In Care Living Expectations</u>.)
  - The expectations include those of:
    - The Corporate Director In Care Living.
    - Other team and staff members.
    - Northwoodcare Inc.
  - The document also outlines what members of the leadership team can expect from the Corporate Director.
  - **(See Appendix B: In Care Living Expectations)**
- To further help break down the silo mentality and build collaborative practice and teamwork, the new leadership team created an interdisciplinary "Pathways Team" with a mandate to improve resident care.
  - The role of the Pathways team was to explore and implement better processes and programs to improve resident quality of living and health, utilizing the experience and insight of all disciplines supporting residents at Northwood.
  - The Pathways team concept was replaced by a grassroots committee, the formation of which was spearheaded by a clinical staff member.
    - While completing a Masters of Nursing, this member of the team was very enthusiastic about building the kind of collaborative practice she'd experienced at school.
    - The leadership team supported her initiative and drive, empowering her to work with the Director of Resident Programs and Services to build what is today the successful Collaborative Practice Committee (described later in this document).
    - Among other things, the Collaborative Practice Committee has recently revised Northwood's Least Restraint policy and practices to build in safeguards to ensure that restraints are judiciously employed, and only as a last resort, and that ongoing assessments are undertaken to ensure the current use of restraints remains necessary.

- The Corporate Director In Care Living believes that Northwood is now well on the way on its person-centred care journey, with a strong leadership team in place and collaborative practice and shared leadership growing across the home.
  - *"We have the leadership team we need and I'd say we are about 70% there with collaborative practice and shared leadership." (Corporate Director)*
  - *"There's a vision and it's being actualized." (Staff Educator)*
- Even though members of the senior leadership team will make beds alongside the CCAs and PCWs in the neighbourhoods, to help out during staff shortages, the Corporate Director In Care Living believes she and her senior team need to be even more visible to staff.
  - The next steps for the senior leadership team are to focus on bringing the message of person-centred care more directly to staff, to reinforce and coach for the behaviours aligned with the new vision of care of Northwood, and to personally be visible champions of change.
    - *"There's still a lot of work to do. We need to help our frontline staff truly see and live the vision. I need to be more visible to the staff, on the floor. " (Corporate Director In Care Living)*
    - *"The nursing management team is all on call. I've come in to give meds to residents on the weekend. We all feel the pain. It's good for the staff and residents to see us sharing the workload on the neighbourhoods. It promotes teamwork and it helps break down the silos." (Corporate Director of In Care Living)*

3. Empowerment

a) Objectives

- Build a culture of empowerment across Northwood that is consistent with management's philosophy of shared leadership and which gives employees the autonomy and accountability to do what is right for each resident, in terms of person-centred care.
  - *"We don't look for reasons why we can't take a resident with complex needs. We ask ourselves: what would it take for us to accommodate them?" (Manager Social Work)*

b) Approach

- Empowerment, and the accountability and autonomy necessary to practice it, are part of Northwood's expectations of managers and staff.
- There is a clear expectation that the senior leadership team members encourage and empower the members of their teams to do what's right for the resident – to abandon the routine in favour of residents' needs.
  - *"I believe in allowing people to use the skills, ability and common sense they have in doing their job… each of you possesses that capability. You show it daily. And you must move it out to your staff."* (Expectations of the Corporate Director In Care Living, excerpted from In Care Living Expectations)
  - *"(In my former role) As the Infection Control Coordinator, the only way I could do my job was to empower everyone else to do the right thing. I couldn't do it all myself." (Corporate Director In Care Living)*

- *"At the end of every day, I try to focus on someone. I'll just sit down with a resident and hold their hand and talk. Sometimes [staff members] are so focussed on the task. But you take the time. This is what I love to do. It feels good to do. I feel like I'm making a difference."(Continuing Care Aide)*

c) Processes/Examples

- Having staff members feeling accountable for, and empowered and supported in, making on-the-spot decisions about residents' quality of living and health is integral to person-centred care. Rigid protocols and routines often get in the way of meeting residents' unique needs.
  - *"If I read the communications book and see that Mr. Smith was up all night, I'll go over to the Aide and say, 'Why get Mr. Smith up at 7 a.m. when he was up and awake all night? He's just going to sleep in his wheelchair and be uncomfortable. Maybe we should let him get his sleep.'" (Continuing Care Aide)*
  - *"We can change our agenda. The work will still get done." (Staff Educator)*
- Management involves and seeks the input of staff on any changes that are made, especially those that impact resident care.
  - *"Management involves us in changes that are made…They get our input…We're the ones that are going to be doing it…We know the residents best…So, we need to be involved or at least understand the rationale for the change." (Continuing Care Aide)*
- The Least Restraint pilot project contains a good example of empowerment and its impact on person-centred care ***(Discussed in Section E: Environment of the Home)***.
  - When asked which residents living in the Special Care unit (for residents living with dementia) should be first in the restraint-free trial, the staff chose those residents most agitated by restraints; not the easiest sample for a test.
  - The staff felt that while these residents might be more behaviourally challenging, especially in the context of the pilot project, they would benefit the most from being freed from restraints.
- Another example is the variations between how each neighbourhood at Northwood Centre operates, which is distinctive to the manager and team that work there. Hiring, scheduling and staffing are unique to each neighbourhood, based on residents' and staff needs.
- In celebration of their 50th Anniversary in North Halifax, Northwood had a day-long Block Party for residents and neighbours. The management and organization of the party were co-led by one of the Area Support Clerks, who felt empowered to pursue her interest in event planning and had it integrated into her role at the Home.
  - The party was a massive undertaking that required city permits, fund-raising and sponsorships, marketing and the logistics of organizing food, entertainment and activities for the neighbourhood.
  - The Block Party brought residents, their families, staff and people from the neighbourhood together, creating a positive and "normalizing" experience for residents.

- Treating staff members in a person-centred fashion is important at Northwood, and the Home has contracted with an outside supplier for an EAP program, available to all staff members. The cost of the Employee Assistance Program at Northwood at the Harbour is totally funded by fundraising efforts led by one of the home's administrative assistants. She was encouraged to volunteer for the role by a manager who perceived she had the talent for it, and has embraced it with a passion that has produced results beyond expectation.
    - The fundraising efforts, including selling Northwood t-shirts, have been so successful that they cover the circa $40,000 annual costs of the EAP contract and leave a surplus at the end of the year.

B. Management Processes

1. Strategic plan 2011 – 2014

- Northwood at the Harbour is part of a larger organization called Northwoodcare group of companies, which offers a wide range of services to support seniors and others both in the community and through Northwood's homes. Building on past efforts and drawing on input from stakeholders, Northwood identified four strategic directions for its businesses.

    i) *Responsiveness to people we serve*: Programs/services are designed to address the needs of our changing demographic.

    ii) *Resident, client and community focus*: Collaborate with communities and government in the delivery of services that support individual choice no matter where people live.

    iii) *Health and safe workplace*: Northwood's leadershift (i.e., shared collaborative leadership) promotes participation in decision making and the development of a safe and supportive work environment.

    iv) *System competency*: Commit to innovative solutions that maximize our resources to provide programs/services across the lifespan.

a) Objectives of Northwood at the Harbour's 2011 through 2014 strategic plan

- In line with the four strategic directions of the Northwood Corporation, develop a strategic plan to guide the Home's person-centred and resident- and staff-supporting activities over the next 4 years.

b) Approach

- Create a strategic plan for Northwood at the Harbour that outlines the following, under each of the four corporate strategic directions.
    - A translation or specific application of the corporate strategic direction for Northwood at the Harbour.
        - For example: "Responsive to the people we serve" was related to the Northwood value "People come first".

- The global behaviours and actions required from the leadership team and staff to act on the strategic direction.
    - For example, “Acknowledge the importance of input and the significant voice of the resident” is one of the global actions listed to help put people first.
- The outcomes or results that will be visible if the global behaviours and actions are successful.
    - For example, one of the visible outcomes will be that “Care routines will evolve to activities of daily living and will focus on knowing the social, spiritual, physical and emotional needs of individuals.”
- The specific tools that will be used to measure the success of Northwood’s initiatives.
    - Resident and family surveys, compliments and complaints, care audits and quality indicators are some of the measures listed.

• In addition to the broad behaviours and actions identified above, the strategic plan also includes specific initiatives and projects targeted to each of the four strategic directions, along with project goals, leaders, actions, timeframe and outcomes.

c) Processes and Results

• Over a series of meetings, as a group and within their own areas, the leadership team representing each of the functional areas of Northwood at the Harbour discussed and agreed upon specific actions to be undertaken – collaboratively, collectively and independently – in pursuit of each corporate strategic direction.

• Progress against each activity is revisited and discussed quarterly, by the leadership team, and additions and updates are made.

• **(See Appendix C: Northwood at the Harbour In Care Living 2011/2014)**

2. “Collaborative Practice Committee “

a) Objectives

• To improve the quality of living and safety of residents, and to develop and foster inter-professional collaborative practice in so doing.

• Break down the competitive and silo mentality between the functional groups at Northwood and create a team and organization that works collaboratively to improve the quality of life of residents.

b) Approach

• Build an inter-disciplinary collaborative committee to explore, test, refine and implement ways to improve residents’ quality of living and safety.

c) Processes

• Spearheaded by one of the clinical care staff, with support of the leader team, the Collaborative Practice Committee was formed.
    - **The terms of reference for this committee are in Appendix D.**

- The Collaborative Practice Committee is comprised of representatives from across Northwood, including:
  - Occupational Therapy
  - Physiotherapy
  - Spiritual Care
  - Manager of Occupational Health and Safety
  - Social Work
  - Manager Food Services
  - Hospice Nurse
  - Nurse Practitioner
  - Dietician
  - Environmental Supervisor
  - Nursing Clinical Leaders (3)
  - Nurse Manager
  - Infection Control Nurse
  - Client Relations Coordinator
  - Pharmacist
  - Recreation Therapy
  - Staff Education
- The committee currently does not include representatives from the CCA or Housekeeping groups. The Corporate Director believes this will change in the near future.

- Broadly, the committee's mandate is to improve residents' lives and safety. This is accomplished through identifying opportunities to do so, designing and undertaking interventions or initiatives to realize these opportunities, evaluating the outcomes, and fine-tuning and implementing the new processes, procedures or activities.
- Evidence-based decisions regarding care and clinical practice are critical so data collection and analysis are built into the committee's processes.
- The committee has a process and tool for helping decide whether and how an opportunity or issue should be brought forward.
  - **(See Appendix E: Collaborative Practice Implementation Tool)**
- The committee also accepts and assesses projects from staff at Northwood related to improving the quality of living and safety of residents. Examples include:
  - Neglected and poor oral health in residents often results in local infections and/or systemic diseases. In one of the projects, nursing staff were trained to examine and assess residents' oral health, bringing attention to and helping tackle the issue. Now, residents' oral health and the nursing assessments are discussed at residents' annual Care Conferences.
  - Another initiative, currently being piloted on a couple of the Northwood units, is related to improving communications between shifts and team members through a revised communications sheet.
    - **(See Appendix F: Collaborative Practice Project Submission Form)**

3. Client relations coordinator

a) Objectives

- Ensure that the voices and needs of residents are always being heard and addressed by both management and staff at Northwood.

b) Approach

- Create a full time position called a Client Relations Coordinator to represent residents' needs and perspectives in decision-making.
  - We are told that this is currently the only funded position of this type in Canada although there is nothing stopping other Homes from doing the same.

c) Processes

- The Client Relations Coordinator meets with the resident and family members within the first 3 weeks of their arrival at Northwood, does rounds every day to build relationships with both residents and staff, and has an open door policy for residents and their families.
  - At the introductory meeting, the Client Relations Coordinator lets residents and family members know who she is, what she does, the services she provides, and that she is available to them whenever they need her.
  - *"I try to have a real relationship with residents and their families…Let them know I am here to advocate on their behalf and support them through the resident's stay at Northwood." (Client Relations Coordinator)*
- The Client Relations Coordinator attends meetings at all different levels within the organization and across all the different functional areas in her role as the advocate for residents and their families.
  - *"I go to staff meetings across all functions including Housekeeping and Food Services. My role in these meetings is to act on behalf of residents and families. My message is everyone has the capacity to engage residents while they do their job… singing while working… giving residents a cloth to help clean. Person-centred care is the job of everyone who comes in contact with residents." (Client Relations Coordinator)*
- The Client Relations Coordinator coaches every new staff member on how to interact with residents with dementia in a person-centred, sensitive and compassionate way.
  - (**See Appendix G: Sensitivity and Compassion**. This is the point-form template the Client Relations Coordinator uses for these coaching sessions)
  - The objective of this coaching is to help change the focus from processes and tasks to relationship building.
  - *"I include all the key learning from my experience with residents with dementia and their families. Care is not the task you are doing, but the conversation you are having with the resident while doing it." (Client Relations Coordinator)*
- The Client Relations Coordinator also does on-the-job coaching and mentoring of staff at the request of the team leads in each neighbourhood.

4. Spiritual care

a) Objectives

- Provide for the spiritual needs of residents of Northwood and their families.

b) Approach

- Northwood has a full-time spiritual care chaplain, a role important to residents, staff and families in the Northwood community.
- In addition to providing one-on-one spiritual comfort to residents and staff, and assisting with hospice care, the chaplain also conducts funerals and memorials on site and small-group Spiritual Circles with residents living with dementia.

c) Processes

- Funerals and memorials on-site.
  - For some of the families of recently deceased residents, Northwood has become so closely associated with being their loved one's home that they want to have the funeral or memorial service on the site.
  - Family members, friends, residents and staff are invited to attend the funeral or memorial in the penthouse/boardroom at Northwood.
  - The chaplain, and residents and staff who would like to speak, share thoughts and memories of the deceased.
  - *"They'll say things like, 'Mom lived here for 20 years. This was her home.'" (Chaplain)*

- Small group Spiritual Circles for residents with dementia.
  - Residents bring their religious faith with them when they move into Northwood, and residents with dementia are no exception.
  - Yet, for some residents with dementia, participating in or attending large-group religious or spiritual activities can be overwhelming and uncomfortable.
  - Working with the Recreation Therapy team, the chaplain invites residents with dementia to attend a smaller-group Spiritual Circle.
  - Residents form a small circle and participate in a variety of engaging activities that spark and connect with their memories, and religious/spiritual history and needs.
  - Activities include singing hymns, listening to stories from the bible, touching and smelling a freshly baked loaf of bread (in the context of religious allegory), and passing around Christmas ornaments.

5. "Activities of Daily Living" form

a) Objectives

- Communicate clearly and concisely the important practical information staff members need to know about each resident related to their activities of daily living.

b) Approach

- A review of the current resident profile tool was undertaken and feedback gathered from residents and interdisciplinary team members on how communicating practical information pertaining to residents' activities of daily living could be improved. For residents with dementia, the team relied on the feedback from family members and interdisciplinary team members.

c) Processes

- A multi-disciplinary team reviewed the current profile form and suggested revisions, including changing the form to use more positive terminology. A new draft of the form was created.
- Focus groups with interdisciplinary team members and residents were conducted to gather feedback about the new draft form. For residents with dementia, the team relied on the feedback from family members and interdisciplinary team members.

d) Results

- After incorporating the feedback from the focus groups, the new form has been rolled out and is currently being evaluated. It is written in the first-person perspective of the resident. For example:
  - "This is what keeps me safe and comfortable…" is the heading for the section describing mobility and other needs.
  - "This is how I like to be approached for the day…" is the heading for the section dealing with residents' morning wakening, bathing, dressing and other preferences.
  - **(See Appendix H: Resident Activities of Daily Living form)**

C. Care Planning

1. Care plan and case conferences

- Northwood is currently implementing a new care planning process.

a) Objectives

- To build stronger relationships between the resident, their family and the Northwood team.
- To encourage and facilitate the family members of residents to become more engaged and involved with their resident and their care.
- Make the initial and annual case conference meetings more resident- and family-centred and inter-disciplinary.

b) Approach

- Gather data about how case conference meetings are currently conducted at Northwood, and then explore and act on ways to improve them to increase resident and family engagement.

c) Processes

- Conduct research.
  - Representatives from Recreational Therapy and Nursing Management audited case conferences for two months, acting as quiet observers of the proceedings.
  - Focus groups were conducted with residents, family members and members of the interdisciplinary team. For residents with dementia, the team relied on the feedback from family members and interdisciplinary team members.
  - The findings from the research indicated that case conferences were focussed more on process than on the resident or family.
    - The meetings were very clinical, with the focus on reporting to the family, but with very little engagement of family members.
    - The conferences were driven by nursing staff and constituted a detailed recapitulation of the resident's medical, dietary, social-behavioural and other data.
    - *"It was a report card and a data dump for the families." (Corporate Director In Care Living)*

d) Results

- The case conference meetings are in the process of redesign.
  - Facilitation of the care conference will begin with engaging the resident and family to ensure their input and concerns are seen as most important and are addressed. For residents with dementia, this may simply be in the form of a friendly greeting, depending on their cognitive ability.
  - The role of the facilitator is to help ensure:
    - Resident and family participation and engagement.
    - The voices of all those in the multi-disciplinary staff team are heard, especially those who know the resident best.
- The care plans have also been redesigned to help see the resident as a person first, not a patient. They are:
  - Written on a narrative, first-person (resident) basis; and
  - Based on a resident's abilities, not deficits – putting the person first instead of their diagnosis.
  - *"The care plans are better than before…More in layman's terms…Written from the resident's point of view; for example, "What I need to keep me safe"." (Occupational Therapist)*

D. Environment of the Home

1. Restraint free program

- In 2010, the Restorative Care team noticed that the use of restraints at Northwood at the Harbour was increasing.
  - The team was first alerted to the issue by the wheelchair technician, who brought to their attention that requests for seatbelts for wheelchairs were being submitted without the prior assessment of residents.

- A review of monthly nursing reports of the numbers of restraints in use confirmed the increase.
- *"We needed to break the cycle." (Occupational Therapist)*

a) Objectives

- Reduce the use of restraints at Northwood at the Harbour by one-third by December 2011.

b) Approach

- Focus on reducing the current percentage of restraints in use (34%) before tackling new restraint use.
- Experiment success into place in one of the neighbourhoods and expand the learning and processes across Northwood at the Harbour.
- Apply the learning to the process for deciding why and when a resident needs a new restraint.

c) Processes

- A multidisciplinary Least Restraint Committee team was formed. It was led by an Occupational Therapist, and was composed of Nursing Services Managers, Nursing Clinical Leaders, Licensed Practical Nurses, Continuing Care Assistants and representatives from Physical Therapy, Social Work, and Recreation Therapy.
  - Interest in participating in the committee grew over time and no one was excluded from joining.
- The Committee engaged one of Northwood's Special Care neighbourhoods for residents with dementia to pilot reducing the use of restraints.
  - This neighbourhood had a particularly high percentage of restraint use, about 67%, compared to about 34% for all of Northwood.
- Borrowing from the literature and existing tools, Occupational Therapy led the Committee in developing an assessment tool for helping decide whether the continued use of restraints for a particular resident was appropriate.
  - The tool focuses on understanding the current rationale for the use of restraints, including the physiological, psychological, treatment-related and environment factors contributing to the perceived risk-related behaviours of the resident that the restraint is intended to mitigate.
  - The tool also lists potential alternative tactics to provoke problem-solving to replace restraints with something more appropriate to the situation.
  - **(See Appendix I: Least Restraint Assessment Tool – Part I)**
- The staff working in the pilot-project neighbourhood decided to start by assessing those residents who were most agitated by restraints. Staff felt that while these residents were behaviourally challenging, they would benefit most from being restraint free.
  - The pilot focussed on one resident per week.

- Following an assessment of the resident's care plan, strategies were developed with staff for removing the restraints and replacing them with alternative tactics.
- For each resident, a detailed care plan was created to help mitigate the agitation or other risk behaviours that prompted restraint use.

  (i) On the Monday, the restraint was removed and strategies put in place.

  (ii) Over the next four days, the effectiveness of the strategy was monitored and assessed.

  (iii) If, by Friday, the strategy was effective, the restraint was removed. If not, the strategy was fine-tuned and again monitored for a further week, at the end of which the effectiveness was again assessed and a decision made about the continued use of restraints

d) Results

- After the pilot, the restraint program was rolled out to the next Special Care neighbourhood and eventually to every resident using a physical restraint.
- Staff and family education programs were developed and included in the rollout. The purpose of these programs was to help family and staff members understand the risks of using and not using restraints, appropriate and improper use of restraints, and the definition of what is a restraint.
  - *"If a seat-belt is promoting function for a resident in a wheelchair, it's an enabler. But it's still considered a restraint." (Occupational Therapist)*
- In addition to the education programs, one-on-one meetings were held with family members who still perceived a higher risk to their loved one from having no restraints. The focus of discussions in these meetings was on why restraints were not appropriate and to talk about the alternative strategies that could be employed.
  - **(See Appendix J: Is this device a physical restraint?)**
- Using the learning from the pilot, Occupational Therapy created an assessment, problem-solving tool to use for deciding if restraints are appropriate to employ with a resident, who is currently not using any.
  - This assessment tool helps the staff team explore the contributing factors to the resident behaviours that suggested the use of restraints.
  - The tool also helps staff explore alternative tactics, in lieu of restraints.
  - **(See Appendix K: Least Restraint Assessment Tool – Part II)**
- The decision to use or not use restraints is now made at a meeting attended by the resident and family as well as:
  - Nursing staff, and the Continuing Care Assistant if they are the primary formal caregiver.
  - Occupational Therapy.
  - Social Work.
  - Recreation Therapy.
  - Physiotherapy, the Client Relations Coordinator and Pastoral Care may attend or be invited.

- The decision to use or not use a restraint is reviewed at the meeting. If a restraint is not deemed necessary, the plan for alternative measures is discussed. If a restraint is deemed necessary, the family are asked to sign a consent for physical restraint form, on behalf of the resident (if the resident is incapable of participating and making an informed decision).
  - **(See Appendix L: Consent for Physical Restraint)**
- The use of restraints is now reviewed annually as part of each resident's Care Conference and each month the neighbourhoods review their restraint use.
- As of July 2012, the percentage of physical restraints at Northwood had been reduced from 34% to 17%.

2. Turning Northwood Centre into a home-like setting

- Northwood Centre was built in 1976 and the design of its interior space and residents' rooms reflected the thinking about long-term care at the time.
  - A very institutional and hospital-like environment with approximately 33 beds per floor.
- In 2011, Northwood embarked on a very ambitious and major renovation project on its nine care floors to make them more home-like for residents.

a) Objectives

- Create a more home-like environment for residents and staff, within the constraints imposed by the current physical plant and funding.

b) Approach

- Engage residents and staff:
  - In the design of the renovations.
  - To work together as a team in moving residents and their belongings from the un-renovated floors to the newly renovated floors.

c) Processes

- The design of the renovations was approached by trying to make the common and private spaces as home-like as possible.

  For the common areas, this meant the following.
  - Removing the "bumpers" on the hallway walls that were intended to prevent the walls from being scuffed by wheelchairs or meds carts.
  - Making the nursing station more open and approachable – more informal and less institutional – instead of being surrounded by a barrier-like counter.
  - Changing the staff lounge into an open area, visible and accessible to residents.
  - Making the dining area more casual and friendly, with some smaller isolated eating areas for those who like privacy.
  - Making the kitchen areas look more contemporary and cafeteria-style.
  - Making the entrances to residents' rooms more like the front door of a home than of a hospital room.
  - Changing the lighting to be more natural than artificial-looking.

- Changing the colours of the walls and materials on the floors to be “warmer” and “friendlier”.

For the private spaces.

- Residents’ rooms were painted in softer less institutional colours.
- Fixtures and bathrooms were updated to look more like hotel rooms.

- Input from residents, families and staff was sought through the design process, especially for choices of a colour palette for the common area walls.
- Initiation of the renovation project waited until one of the care floors was vacant, through a combination of natural bed vacancies and social work, nursing and environmental services moving residents to other units.
- Once a floor had been renovated, the team had four hours to completely move all 33 residents and their belongings from the old onto the new floor.
  - This effort required a multidisciplinary team of clinical and non-clinical staff including:
    - Nurses, continuing care assistants/personal care workers, housekeepers, environmental services and members of the leadership team.
- To celebrate the move, the entire team shared lunch on the new unit, with the residents.
- The renovations are almost completed with 7 of 9 floors done to date.

E. Recreational Therapy – Programs & Activities

1. Special care luncheon

a) Objectives

- Create a “going out for dinner” experience for residents with dementia and their families to:
  - Provide residents with a meaningful, family-centred social “outing”.
  - Help educate family members on ways they can positively interact with their loved ones, in a safe and supportive environment.

b) Approach

- Small groups of residents with dementia and their family members participate in a luncheon outside of their neighbourhood, in the Penthouse/boardroom of Northwood.

c) Processes

- Small groups of no more than 16 residents with dementia, and their family members, are invited to participate in a luncheon organized by the recreation therapy team. About 30 residents and family members typically attend.
- The luncheon is held on the top floor of the Northwood Centre building, in the boardroom. The boardroom is set up to look like a restaurant. For residents with dementia who are unable or are uncomfortable going outside Northwood to a restaurant for dinner with their families, this is the next best thing.

- The dietary team caters the luncheon, with special requests handled in advance.
- The recreation therapy team participates in the luncheon. Special Care staff members also attend if there are residents at the luncheon who are at risk of choking while eating.
- Staff model and coach family members on how to interact and relate to their loved ones with dementia.
- The luncheon lasts approximately 1½ hours. Soft music plays during the event, often Frank Sinatra.
- *"Some people don't know how to engage with their family member. Some are uncomfortable and don't understand what's happened to their parent. They see you interacting with their mother in ways they don't." (Recreation therapist)*
- *"The families love it." (Recreation therapist)*

2. Montessori methods for residents with dementia

- The recreation therapy team recently participated in a 2-day workshop describing the Montessori methods for dementia and how to integrate them into recreation programming and activities at Northwood.
- According to the Recreation Therapists, the workshop stimulated new ideas and reaffirmed that what they have been doing is on the right track.

a) Objectives

- Deliver Montessori programming to the residents of Northwood with dementia, through the Clinical Care Aides and Personal Support Workers.

b) Approach

- Demonstrate to frontline staff the effectiveness and value of Montessori methods to engage and stimulate residents with dementia.
- Gain the support and buy in of frontline staff to use Montessori methods with their residents, alone or in small groups.
- Train, actively coach and supervise staff in using simple Montessori programs.

c) Processes

- The recreation team is in the early stages of planning their approach to implementing the Montessori methods across Northwood, but it will involve the following steps.
    - Demonstrate to the frontline staff that spend the most time with residents (the Continuing Care Assistants and Personal Care Workers) the effectiveness and value of Montessori methods to engage and stimulate residents with productive and fulfilling activities.
        - This will likely involve inviting CCAs and PCWs to observe and participate in Montessori activities conducted by members of the RT team with a resident or residents.

- Gain the support and buy in from frontline staff, through their participation in the demonstrations with the RT team and debriefing discussion, to use Montessori activities with their residents – one-on-one or in small groups.
- Train, actively coach and supervise frontline staff in using simple Montessori activities that the RT staff have designed, tailored to the individual needs of residents.
- Track progress, including resident participation in Montessori activities.

• *"There is a lot of buy in from the staff on my unit (for the Montessori methods)." (Recreation Therapist)*

• *"If they see that it works, if families notice change, it'll all come together." (Recreation Therapist)*

3. TGIF – "Thank God I'm Female"

• For female residents of Northwood, including those living with dementia, the recreation therapy team has created a unique women's group named Thank God I'm Female.

a) Objectives

• Provide support for female residents of Northwood in recognition of their unique needs.

b) Approach

• The "Thank God I'm Female" group is a forum for discussion, sharing, and women-centred activities facilitated by the recreation therapy team.

c) Processes

• The group meets weekly and all female residents of Northwood are invited to come.
  - For residents living with early stage dementia or mild cognitive impairment, the TGIF meetings are a "normalizing" experience, as they permit them to spend time outside their neighbourhoods with residents with higher cognitive functioning.
• Activities include topical discussions, such as:
  - "What is it like to be a woman?"
  - "What is it like to be a woman living at Northwood?"
• Sometimes the activities involve simply going to see a movie, such as the recent excursion to see the movie about male strippers, "Magic Mike".

F. Diet and Nutrition

• The Northwood team believes that meals are an important part of providing person-centre care for their residents with dementia to help maximize their quality of life and happiness.

a) Objectives

- Develop customized nutrition care plans that meet the particular dietary needs and preferences of each resident.
  - The need may be the result of a diagnosis (such as dementia), therapeutic diet, allergy or cultural belief.
- Provide a quality dining experience for the residents.
- Provide consistency of dietary team staffing on each unit to help engender a family-type atmosphere at mealtime, with the dietary staff becoming very familiar with the residents and the residents with the staff members.
  - This is especially beneficial to residents with dementia who respond better to routines and familiar faces.

b) Approach and Processes

(i) ***Individual preferences***

- The Food Service Supervisor interviews the resident and/or family within the first 6 weeks of admission and then annually afterwards.
  - **(See Appendix M: "In Care Living Initial Nutrition Interview" and "In Care Living Follow Up/Annual Nutrition Interview").**
- If the Food Service Supervisor is not able to obtain all the information from the resident due to an illness such as dementia, they will interview other members of the team in the dining room at mealtime.
- The Dietary Aide and Food Service Supervisor report daily any additional likes and dislikes obtained during mealtime, either from the resident, family or staff member.
- The menu is designed to provide choice at each mealtime.
  - The Dietary Aide offers choice both verbally and visually.
  - Many residents with dementia have difficulty answering a question, but are visually able to respond to the meal they prefer.
- Northwood has computerized programs, which enable all the information gathered to be stored and updated so that each resident can be provided with an appropriate choice at each meal. These programs provide daily updates for the Dietary Aide regarding resident preferences.
  - Daily "Distribution Sheets" are used to identify these choices for each resident to the Dietary Aides and Nursing staff.
- The interviews, visits on the floor by the Food Service Supervisor, care plan meetings, and nutritional assessments continue to identify changing preferences.
  - The Dietician is a core member of the care planning team. Each resident's care plan is reviewed twice a year. This gives the Dietician the opportunity to present, discuss and get input on the nutrition part of the resident's life care plan.
  - Daily, the Food Service Supervisors are in each dining room for which they are responsible.

- The dietary team at Northwood believes they must respect choice at the moment.
    - It becomes more challenging when a resident can no longer identify food.
    - The caregiver has to rely totally on observations of behaviour and food intake.
    - Creativity, trying different foods and feeding techniques may be required.

(ii) ***Texture modifications***

- Northwood's goal is to offer the same meal or main entrée to everyone and to offer a texture as close to "normal" as possible.
- If necessary, the dietary team provides a variety of textures for each menu entrée. For example, if the main entrée is a turkey dinner, they provide:
    - Finger Food Diet – The potatoes are boiled instead of mashed, and the turkey and vegetables are cut into bite size pieces,
    - Minced: The turkey is minced or shaved.
    - Cut Meat: The turkey is cut in small pieces about the size of a thumb-nail
    - Finely Cut: The turkey is cut in pieces the size of the nail on the baby finger, and vegetables may have to be cut or mashed.
    - Modified: The turkey is ground twice with gravy and the vegetables are mashed. The meal is served in a small individual casserole dish with piped in stripes of turkey, dressing, mashed potato and mashed vegetable.
    - Puree: The turkey and other items are pureed to be smoother than the modified meal (described above).
- Everyone is offered a varied menu based on the master menu, which provides choices.
- The team also provides a variety of thickened liquids as required.
- The Dietician individualizes the texture required for each resident for each meal.
    - The resident may receive a regular breakfast, minced at lunch and modified at supper.
    - The diet order is based on each resident's ability at the time of meal service.
- The Dietician and Occupational Therapist work together to assess the proper texture for residents having difficulty at meal time.
    - The assessment tools may include a standardized bedside swallowing assessment or meal observation in the dining room.
- Swallowing ability is not always consistent.
    - The diet order has to be flexible to accommodate the resident on good and challenging days.
    - A Supervisor is able to authorize a lower texture if required and the Dietician is notified immediately.
- The resident has to be set up for success.
    - Proper position and mouth care are most important.
    - Residents with dementia are not rushed. Education helps to reinforce this.
    - Individual instructions can also be written on the Nursing daily care plan and the Nutrition Tray Card.

- The Nutrition Tray Card is used as a communication tool.
    - The Dietician enters the diet (both the texture and therapeutic components) in the computer system along with any other information that is important, like preferences/individual requests, special equipment, etc.
    - The Food Service Supervisor completes the dining room/seating information, prints one copy and places that copy in the "Tray Card Binder", kept in the unit kitchenette.
    - The Dietary Aides refer to this information prior to and during meal service. The tray cards are updated if any of the information changes.

(iii) ***Quality dining experience***

- Northwood encourages residents to feed themselves by providing special feeding aides as required.
    - This could include lip plates, straws, dycem placemats, sip cups, nosey cups, covered mugs, bamboo spoons, built-up handled utensils, etc.
- The dietary team is aware of the impact the dining room atmosphere has on the residents' intake and enjoyment of food.
    - Attention is paid to noise level (no medication crushing in Dining Room), room temperature (avoid drafts), familiar place settings, and enjoyable tablemates.
- Staff members are encouraged to not rush meal service.
- Meal times have been increased to accommodate a relaxed approach.
- A new process has been initiated to allow families and friend to purchase a meal voucher to enjoy a meal with a resident in the resident's home.

(iv) ***Consistency of staffing***

- The Dietary Aides and Dieticians are assigned to particular units.
    - The Dietary Aide is responsible for the same 28 – 33 residents daily.
- Management supported the establishment of this continuity by changing the Dietary Aide schedules.
    - This involved meeting with the union to agree on 12 hour shifts, without incurring overtime.
    - These 12-hour shifts allow Northwood to have 2 Dietary Aides assigned to each unit, so when one is not working, the other is on duty. When one of these Dietary Aides has a day off, every effort is made to assign the same floats to one neighbourhood.

G. Staff Education and Training

1. Continuing Care Assistant and Personal Care Worker orientation

a) Objectives

- Facilitate and support all new frontline hires to provide the Northwood version of person-centred care to all residents as quickly as possible.

b) Approach

- Provide extensive orientation and supervision to all new frontline hires.

c) Processes

- A 7-day orientation to Northwood that includes the basic Human Resource on-boarding, as well as overviews of abuse prevention, lifts and transfers, and other procedures and policies (e.g., Least Restraint policy).
- 2 days working with a CCA preceptor on one of the units.
  - The focus of the two days is on-the-job training, with a skilled and experienced care practitioner and mentor, to introduce the new hire to the Northwood philosophy of person-centred care.
- 3 days on the floor.
  - For these three days, the new hire begins to work alone on the floor.
  - If the new hire has any questions or feels challenged, their mentor (with the support of the LPN education liaison) is close at hand to provide advice or assist.

2. "Virtual Dementia Tour"

a) Objectives

- Provide all staff with the opportunity to personally experience what it is like to live with dementia.
- Build staff:
  - Empathy for residents living with dementia.
  - Understanding of, and patience with, the effects of the disease.
- Translate their personal experience of simulated dementia into lessons about how to provide person-centred care to residents with dementia.
  - *"Putting yourselves in the shoes of someone with dementia…Opens your eyes to dementia and asks the question, "Do you think you give good care to someone with dementia."" (Client Relations Coordinator)*
  - *"Insight on what a person with dementia goes through." (Continuing Care Aide)*
  - *"Walking in the shoes of someone with dementia." (Dietician)*

b) Approach

- Northwood has trained "Virtual Dementia Tour" facilitators from the multidisciplinary team that:
  - Help orient staff to the experience.
  - Conduct the Tour.
  - Debrief with staff afterwards.
- The Tour takes place in an apartment at the Northwood at the Harbour complex that is set up for this purpose.
- Staff members are asked to complete a survey pre-test, followed by a post-test at the conclusion of their "tour".

- After completing the pre-test, the tour participant is:
  - Outfitted in gear that helps simulate the effects of age and dementia (e.g., vision-limiting goggles, popcorn kernels in shoes, fingers taped together, and a cacophony of noise through headphones).
  - Then asked to complete a series of five simple tasks.
  - The instructions for this part of the test are read at the same volume as the taped cacophony of noise, making it difficult for the staff member to decipher what there are being asked to do.
- The post-experience survey is conducted and a debriefing available.
- Staff members are given a takeaway sheet after this training, which gives them many recommendations for appropriate and positive interactions with dementia residents.
  - **(See Appendix N: Recommendations for Interactions with Dementia Residents)**

c) Processes

- Northwood is currently putting all staff through this training.

3. "Alzheimer's Disease and Other Dementias" caregiver course

a) Objectives

- The focus of this course is to improve the care for residents with dementia by:
  - Providing participants with a better understanding of dementia, how it works, and its impact on behaviours.
  - Helping participants to know how to separate the person from the disease.
  - Teaching approaches to care.
- *"Teaches you it's not the person it's the disease…and how best to deal with/respond to certain behaviours." (Continuing Care Aide).*

b) Approach

- The Alzheimer Society developed this course.
- It is mandatory to take for CCAs and PCWs working in Northwood neighbourhoods with residents with dementia, and all other staff members working in these neighbourhoods are encouraged to take it as well.
- The dietary team contributes to this course.
  - **See Appendix O** for the education materials the dietary team uses as a basis for discussion during this course. These materials also serve as handouts to allow participants to review the content again, after the session.

H. Staff Scheduling

a) Objectives

- Provide continuity and consistency of care to residents.

- Maintain stability in the residents' environment by minimizing the introduction of new people and maintaining familiar faces.
- Foster relationship-building between residents and staff.
- Maximize the opportunity for staff members to learn about residents, and vice versa.
  - The more that staff know about each resident, the more person-centred the care they provide can be.
- Have staff members become informal advocates for each resident, making sure their needs are met.

b) Approach

- As much as possible, CCAs and PCWs are dedicated to neighbourhoods to preserve consistency and continuity of care to residents.
- Depending on the neighbourhood – the manager and needs of residents – CCAs and PCWs can volunteer to be the primary caregivers for up to 4 residents, while sharing responsibility of other residents.
  - *"It is important to know and interact with residents and their families. The more information I know, the better the care. Residents should have a choice if they're able to make a choice or you know what their preferences would be." (Continuing Care Assistant)*
  - *"The more you learn about the resident the better you can provide care. These residents are under my care all the time. Makes providing care a lot better. Get to know the resident's likes and dislikes… How best to approach them. Gives you the experience to learn what works and doesn't work with each resident. Helps make their day better. I also pass this information on to other staff. It's not what you do, it's how you do it. I become an advocate for these residents, especially those who can't speak for themselves…Almost like a family advocate…Making sure their needs are met."(Continuing Care Aide)*

I. Hospice Care

a) Objectives

- Northwood has two RNs who both work part-time in a hospice function. The focus of their work with residents with dementia is to determine, and then provide the necessary care, which the resident and their family want in the later and end-of-life stages of the disease.
  - *"We are there to walk the journey with them…To support and comfort them on this journey…To help them make informed and compassionate decisions on treatments and interventions." (Hospice RN)*
  - *"We ensure that the resident's and families' desires are identified and respected." (Hospice RN)*

b) Approach

- As part of the admissions process, one of the hospice nurses meets with the resident (when possible) and family to determine their goals of care throughout the later stages of dementia. This includes identifying what is in the resident's best interests and how to keep them as active and engaged as possible for as long as possible.
  - Components of this discussion include things like pain and symptom management, food toleration, and spiritual care.
  - Directives are written as a result of this meeting.
  - *"We work with the resident and family to establish the right goals of care throughout the later stages of the disease." (Hospice RN)*
- The hospice nurses are part of the care conferences. They are also on call as the need arises for both residents and their family, and to support staff in the care of residents.
  - *"We see it (Northwood) as their (the residents') home. We go to them, their bedside." (Hospice RN)*
- Part of these RNs' role, where required, is to be the resident advocate to the family to ensure the resident's wishes are respected.
  - *"It's mostly about the resident's wishes, not the families' or the doctor's." (Hospice RN)*

J. Family Engagement

- The leadership team at Northwood is acting in a number of ways to increase participation and engagement among the family members of residents.

1. Neighbourhood gatherings

a) Objectives

- Get family members more active and engaged in their resident's care.

b) Approach

- Northwood had a long-standing Family Council; however, its members mostly consisted of families whose loved one at Northwood had passed away.
  - At one point, only two of the members had a relative at the home, whereas the remaining members did not.
  - On the whole, Council members' perspectives were more informed by memory and history, than the current reality.
- The Northwood team transitioned the Family Council members providing an opportunity for them to join a newly formed Northwood Auxiliary. The previous council members are a very active group in organizing events at Northwood.
  - The outgoing members of the Family Council were recognized for their contribution to Northwood at the Harbour at a special event.

- Instead of a Family Council, residents and families were invited to join Neighbourhood Gatherings to represent each of Northwood at the Harbour's five neighbourhoods.
    - New Terms of Reference were drafted for the Neighbourhood Gatherings, including conditions of membership to ensure the membership continues to reflect current residents of, and issues related to, the specific neighbourhoods.

2. Family survey

a) Objectives

- Measure family involvement and identify opportunities to increase their involvement and engagement.

b) Approach

- In their pursuit of increasing the participation and engagement of family members at Northwood, the leadership team realized that they had no benchmark or reliable data on family involvement.
    - To act on this, a survey is being conducted in October of this year to measure the frequency and nature of family/friends visits to residents of Northwood at the Harbour.
    - Nursing staff will be asked to document how often each resident receives visits from their loved ones.
    - Attendance at care conferences will also be measured, as well as at other resident-focussed meetings, celebratory and social events such as the Garden Party and Block Party, and educational seminars and meetings.
    - Armed with this information, the leadership team plans to experiment with ways of increasing family involvement.

3. Dementia education for family members

a) Objectives

- Help family members understand and cope with what happens throughout the continuum of dementia.
- Give families the education and tools they need to have a productive visit with their resident.
- Help family to deal with the fear and embarrassment of this unknown person they are visiting.
    - *"To help family cope with, understand and enjoy their loved one without expecting them to be who they were, but appreciating they are still the same person." (Client Relations Coordinator)*

b) Approach

- Northwood has just started this program, which is provided by the Alzheimer Society.
- It is a 7-week course that is offered by Northwood to all family members of residents, free of charge.

- Five Northwood staff members have been trained to conduct this course. Each of the five teaches a component.
- The results thus far have been very encouraging.
  - *"This course has changed the frequency and quality of visits for those family members who have taken this course." (Client Relations Coordinator)*
  - *"We have participated in this program. We have been able to explain the different textures and liquids visible in the dining room and have been available for questions and suggestions. Family are encouraged to assist in the Dining Room." (Dietician)*

4. Family Training

a) Objectives

- Encourage family to be part of the care team.

b) Approach

- Teaching family how to help care for their resident with dementia.
  - *"We help family learn how to help care for their resident with dementia…feeding, range of motion, walking, use of mobility equipment. We bring them in and show them how to do these different things with their resident. We encourage and help family members to be part of the care team." (Occupational Therapist)*

Appendix A: Creating a Living Model of Care

(Two left mouse clicks to open document below. Requires Adobe Reader™.)

NORTHWOOD

Creating a Living Model of Care

In Care Living

April 2009

Appendix B: In Care Living Expectations

(Two left mouse clicks to open document below. Requires Adobe Reader™.)

In Care Living

In Care Living: an interdisciplinary team responsible to understand and uphold a person directed model of living which values choice, dignity, respect, self-determination, and purposeful living for all people who live and work at Northwood.

We work within a team concept where the individual needs of each person comes before the tasks to be completed.

Departmental Expectations:

What I expect:

- If there are concerns that I am notified first, if I don't respond you have my blessing to go to Rick.
- When you take time off that I am made aware the day before either by telephone, voice mail, or e-mail. If you do have to take time off and have commitments you arrange to postpone, cancel, and/or re-book them. You ensure your area is covered. If you are ill and cannot make these arrangements, I would expect that you call to inform me so I can make arrangements so as not to cause hardship to our clients. (Of course there are times when emergencies will make this impossible.)
- That you will take ownership of your responsibilities and assume accountability for your role within your department.
- That you take risks and working towards for the common goals/priorities of the department.
- That you communicate, keeping me informed of the impacts both positive and negative your decisions have especially on other departments.

What everyone expects:

That you:

- Be respectful in your approach and in working together.
- Be a part of the team and provide input. We cannot work in isolation.
- Be creative, no idea is a bad idea.
- Be supportive, assist in each others initiatives.
- Be open to involvement and feedback from all departments.
- Be open to and constructively address issues with each other.

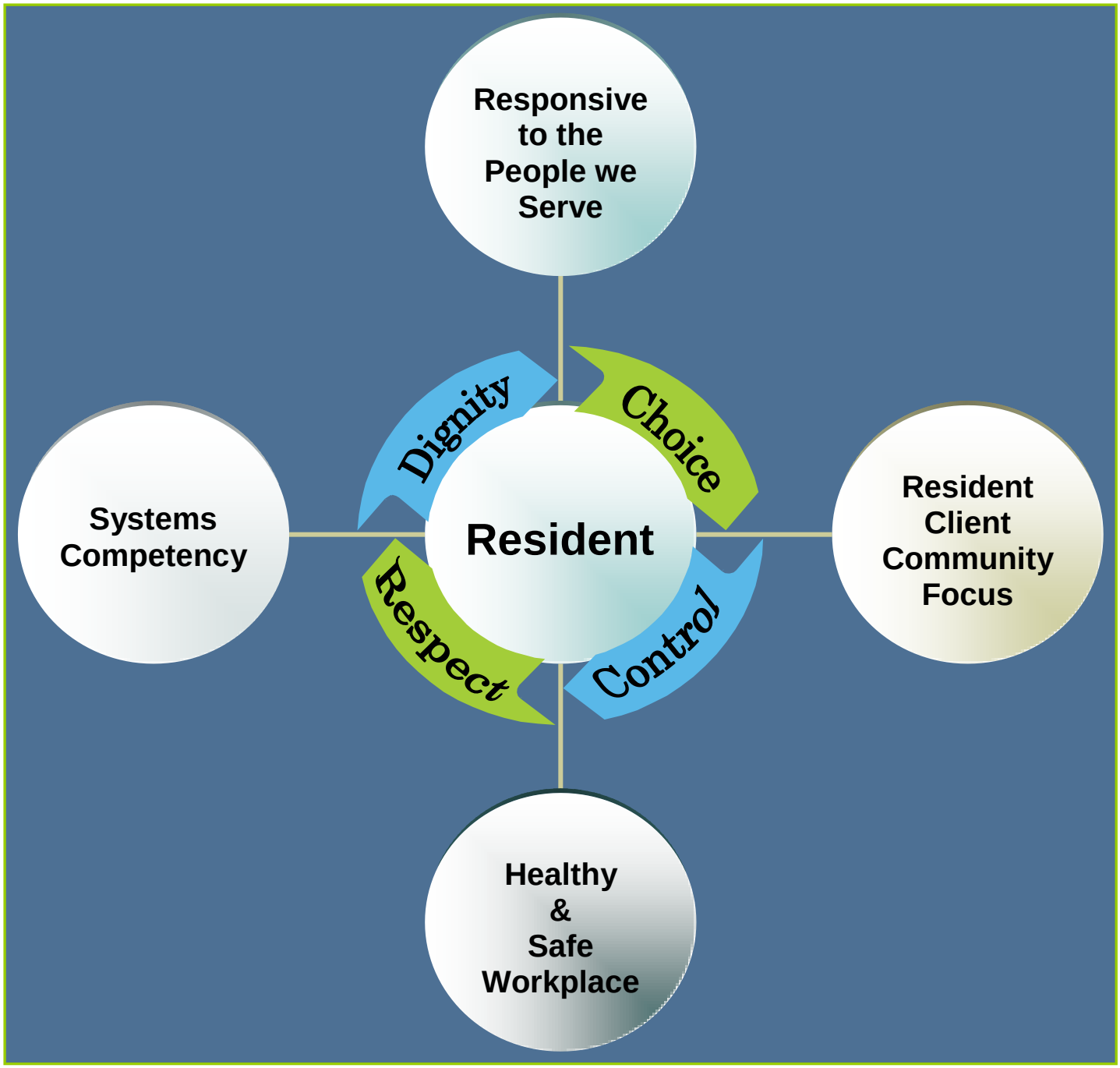
What the company expects:

- That we do our jobs.
- That we have regular attendance within the average(there are times when this is not possible)
- That we represent the company in a positive manner at all times.
- That we are accountable for our decisions.
- That we will make mistakes but we will take responsibility for them and move on.

What you can expect:

- That I will back your decisions if I have been kept me informed (and mostly even if I haven't).
- That I will ensure you get the credit when you initiate something.
- That you share in the credit for the overall departmental successes.
- That you will be given a chance to give input, whenever possible.
- That you will be held accountable to take ownership of your responsibilities.

Appendix C: Strategic Plan



Northwood at the Harbour
In Care Living 2011/2014

Responsiveness to the People We Serve

Programs/services are designed to address the needs of our changing demographics.

People Come First

We believe we are a voice for our community, enlightening others to the importance of those entrusted to our care and we acknowledging our first responsibility is to listen and to understand. We recognize we are privileged to have the opportunity to share in each resident's life and transition to death.

What do we need to do?

- Take time to actively listen to people recognizing the diversity and value each offers.
- Assume the responsibility to acknowledge the importance of input and the significant voice of the resident.
- Recognizing the significance of residents/family feedback: through Resident Care Conferences, Resident Council, Family Council, Family Nights and surveys.
- Seek out staff and community feedback through regular interdisciplinary meetings
- Develop, monitor and analyze key indicators as measures to service excellence.
- Be aware of external environmental scans that affect resident living e.g. HANS, Senior Secretariat, Department of Health and Wellness.
- Remain or become active in external committees, associations, working group

What translated behaviours and/or actions will we see?

- Care Routines will evolve to Activities of Daily Living and will focus on knowing the social, spiritual, physical and emotional needs of individuals.
- Staff know residents as individuals
- Residents and family input is sought in making decisions.
- Information from direct care/services providers closest to the residents is sought, utilized and valued
- All staff are voices for In Care Living – honoring and promoting what we do
- Resident and Family are satisfied with the care and services provided.
- Our community recognizes and promotes Northwood as an excellent place to live.
- Indicators are monitors and acted upon.

How will we measure our success?

- Resident/Family Survey
- Complements and Complaints
- External Committee Membership
- Internal and External participation and committee membership
- External reviews, annual Licensing, Accreditation Surveys
- Care Audits and Quality Indicators

How do we know when we are there?

We enact the Model of Living where residents are at the centre of all decisions. Residents are honored in life and in death and we support each other to accept the responsibility, to acknowledge emotions and to cope with the sense of loss. We accept diversity and acknowledge its strength.

Resident, Client & Community Focus

Collaborate with communities and government in the delivery of services that support individual choice no matter where people live.

People Come First & We are not alone

We believe in strength in numbers and that our community supports our success and succession. We believe inclusion is vital to maintain our vibrant and active community and exclusion leads to a sense of isolation and loneliness.

What do we need to do?

- Learn about and revive the Social Movement that created and shaped Northwood.
- Create opportunities for involvement through conversations, meetings, shared programs.
- Create awareness and become knowledgeable on current trends and issues affecting our community.
- Work as a true interdisciplinary teams valuing and inviting others into our departments in efforts to build community.
- Collaborate within the Communal Living POD on issues that globally affect the services we provide.
- Be active on internal and external committees and agencies that impact our services.
- Participate and collaborate in committees and working groups that the move the integration of continuing care services with the Capital Health District.

What translated behaviours and/or actions will we see?

- When we refer to our community it in inherent that it includes residents, family, staff, volunteers, tenants and community centre members.
- Leaders participate in external committees.
- Departments create opportunities for interaction between other departments.
- The physical environment is non territorial and space firstly belongs to the people who live here.
- Everyone feels a part of creating the vitality and relationships that we are known for.
- The external community seeks opportunities for partnership with us as we are sought out for our expertise in Long Term Care.
- Relationships are built with Department of Health and Wellness and Capital Health District and are valued and collaborative.

How will we measure our success?

- Outcomes of working groups and committees
- Internal committee meeting minutes

- Minutes from Resident and Family councils
- External committee involvement
- Active Partnerships

How do we know when we are there?

Building relationships, socializing and sharing keep us active and involved. We are known for our openness and the diversity and strength of our community.

Healthy and Safe Workplace

Northwood's Leadershift promotes participation in decision making and the development of a safe and supportive environment.

Everyone Plays a Part & Growth Is Built on Trust

We believe that everyone in our community adds valve. We are responsible to acknowledge and celebrate the diversity of our community: those who we serve and those who serve. Enriching lives includes not only how we enrich the lives of residents' and their families, but in doing so, how we enrich our own lives.

What do we need to do?

- Communicate and hold each other to expectations based on the mission, vision and values as outlined in Our Path, Employee Hand Book, and Resident Care Standards.
- Connect with staff e.g. provide individual time to converse with staff, have regular staff meetings (monthly at minimum).
- Provide the tools and support for people to live, work, volunteer in a safe environment.
- Recognize the value that each staff member brings to the residents, focusing on their unique talents and contribution to team.
- Complete staff performance reviews and include development plans
- Create education delivery methods that meet the varied learning styles and skill development.
- Create opportunities for input and involvement in decision making in creating a safe environment.
- Increase preceptor/mentorship programs to enable staff to share their knowledge and skills.
- Recognize the strengths achieved in creating cultural competency

What translated behaviours and/or actions will we see?

- People are not afraid to provide feedback or take initiative to create a safe workplace.
- People see value in attending educations sessions and share their knowledge with others
- Performance reviews are a positive experience
- Managers are enablers and support staff to lead
- Residents, families, staff, volunteers share in decisions.
- The resident is at the centre of all we do and is the core of our decisions.
- Staff express confidence in decision making in providing service and interactions with residents
- People report hazards without fear of repercussions.
- Staff have access to current policies, procedures safe work practices

How will we measure our success?

- Annual Performance Review Completed
- Mandatory Education Attendance
- Staff Survey/ Results – Worklife Pulse
- Quality Worklife Statistics: Recruitment and Retention, Attendance, WCB, Exit Interviews

How do we know when we are there?

We have fostered the power of our leaders through engagement and opportunity; recognition that leaders are found throughout our community: residents, families, staff, and volunteers. Diversity is respected and enabled.

System Competency

Commit to innovative solutions that maximize our resources to provide programs/service across the lifespan.

We can Always do Better & The Future is in Our Hands

We believing in using our human and financial resources to "do good" and commit to allocating them to improve resident living. We believe we cannot remain stagnant, that we learn from others and we have the ability to teach.

What do we need to do?

- Watch and learn from our community and external sources.
- Be visible and attentive to the evolving needs of our community.
- Develop budgets financial and monitor and resources to ensure allocation is able to sustain necessary programs and services.
- Support an environment where people ask questions
- Be active in research initiatives: Research Advisory, Champions for Research.
- Inform and educate our community on the benefits of research and knowledge transfer.
- Be open to the need to continuously review and revise policies, procedures and practices to achieve best practices.
- Create and support an education model that will provide the core competencies required by staff to meet the needs of the residents and families.
- Review the current indicator tracking in place and that data are accurate and reliable.
- Acknowledge, value and support the contributions of the Northwood Foundation

What translated behaviours and/or actions will we see?

- Communal and Enablement pods work collaboratively to respond the current issues.
- Education is available for all community members.
- Staff have access to information that enables resource monitoring and accountability.
- Our community actively supports the foundation and its goals.
- Educational opportunities are available to staff and families to assist them in supporting and meeting the needs of the residents.
- Human and financial resources are allocated, monitored and utilized to best meet the needs of the resident.

How will we measure our success?

- Resident/Staff Satisfaction Survey
- Safety Survey
- Staff Survey – Worklife Pulse
- Staff Recruitment and Retention: Statistic, Exit Interviews
- Financial Reports
- Quality Indicators for each department
- Workplace Injury and WCB statistics

How do we know when we are there?

Residents live active and meaningful lives. Programs and services are interdisciplinary and evidence based and we continually search for ways to improve. Resources are available to meet needs.

Northwood at the Harbour – 2011-2012 In Care Living Goals

Responsiveness to the People We Serve

Programs/services are designed to address the needs of our changing demographics.

GOALS	LEADERSHIP	ACTIONS	DATE	OUTCOMES
Residents are able to afford basic needs to maintain their quality of life. **Corporate Impact**	Nursing Services Social Work Financial Services Foundation	Monitor the impact of Care Initiative on residents' ability to maintain unfunded services and equipment that is required to maintain their quality of life. Determine the socioeconomic status of residents most affected. Investigate broader impact of Cost of Care throughout sector via external committees e.g. CDCCC	April 2011 and ongoing	• Hardship needs are identified through nursing and social work. • Data Collection on use of fund will be completed through Social Work services. • Requests to Dignified Living fund and funding will be process and monitored by financial services and the foundation.

GOALS	LEADERSHIP	ACTIONS	DATE	OUTCOMES
		Work with the foundation to establish a dignity fund to provide assist to residents who are financial unable to meet critical needs.	April 2011 June 2011	• Meeting held between foundation, client services, resident programs and services, finance and representative from Ivany and Northwood at the Harbour representatives to review hardship fund reviewed with financial services and Foundation. • Dignified Living fund created. Process developed including procedure and criteria for application of funding. • Potential Funding Source identified through foundation.
Implement interdisciplinary resident focused care planning to enable relationship building between the resident, their family and the interdisciplinary team enhancing the quality of care, safety and wellbeing for residents.	Director Resident Programs and Services Nursing Service Manager 7/8/9 Manor Clinical Resource Manager Corporate Director	Develop resident profiles that are based on the resident's activities of daily living rather than routines.		• Social History template developed. • Involvement of NSCC Recreation Therapy students • Development of draft interdisciplinary care plans based on best practice resources. • Develop Draft Care Journals • Focus Groups held with interdisciplinary team including residents to garner feedback. • Revisions complete to Daily Activities template.
The other projects and initiatives being undertaken by Northwood — too many to list — were not included in this report.				

Appendix D: Collaborative Practice Committee Terms of Reference

NORTHWOOD
live more.

Northwood at the Harbour

Policy No.

Manual: Organization Wide			
Section: Terms of Reference			
Policy Title: Collaborative Practice Committee – Terms of Reference			
Original date procedure issued:			**Originator of the Procedure**
Month	Day	Year	
October	19	2011	
Last date procedure revised:			**Approving Authority**
Month	Day	Year	

Accountability: Corporate Director In-Care Living

Goals

Primary Goal:

To improve the quality of living and safety of the resident by identifying the needs, reviewing the best safe evidence informed practices, implementing changes in procedures and developing the mechanisms to evaluate and monitor the progress and effectiveness of new procedures while adhering to our strategic direction.

Secondary Goal:

To develop and foster interprofessional collaborative practice for better communication, consistency and quality of care for residents.

Objectives:

- Identify resident needs, problem-solve, and make synergistic collaborative health care decisions.
- Provide a forum for evidence informed decision making with criteria based on resident needs, values, and choices.
- Review of current practices and procedures in the clinical area to be revised based on a sound body of evidence.
- Use evidence from research, clinical experience, and resident preferences comparatively with present practices and industry standards.
- Utilize Interprofessional collaborative practice.
- Support and apply a resident centered approach in all decision making
- Adherence to set ground rules of every meeting, as agreed upon by the members
- Participate in research as a way to find answers to questions generated by clinical issues and as a collaborative practice initiative with other disciplines.
- Refer issues to other Committees when appropriate.
- Identify and analyze trends (internally or externally) that may impact clinical practice.
- Implement practice changes when appropriate to assist with future planning for the organization
- Evaluate effectiveness of any interventions or practice changes made within a reasonable time frame.
- Evaluate effectiveness of committee based on pre-determined measureable outcomes on yearly bases, and implementing identified improvements.

Committee Decision-Making:

The committee will strive to make collaborative decisions based on membership consensus. Consensus represents a negotiation process that results in a set of decisions that everyone can "live with", because it reflects the interests of everyone at the table giving everyone a say in the outcome. If a consensus is not achieved a vote will be held with the wishes of the majority ruling.

Quorum:

A quorum is achieved at least 12 committee members are present. Decision making is of high importance in a collaborative model. In the event that a quorum does not exist, decisions will be deferred until a quorum can be achieved. Members meeting without a quorum can meet and discuss issues or practices currently being examined.

Frequency of Meetings:

Meetings to be held once every two weeks until a time decided upon by the committee deemed appropriate to change the meetings to once monthly.

Communication:

- A recorder will be present to document meeting and generate minutes of the meeting
- Minutes will be disseminated and an agenda forwarded to all members the week prior to a scheduled meeting.
- Applicable research articles will be made available to all members via email or ICAN the week prior to a scheduled meeting.

Membership:

Standing:

OT

PT

Spiritual Care

Manager OH&S

Social Work

Manager Food Services

Hospice Nurse

Nurse Practitioner

Dietitian

Environmental Supervisor

3 RNCL's

Nurse Manager

Infection Control Nurse

Client Relations Coordinator

Pharmacist

Recreation Therapy

Staff Education

Invitees:

As issues are discussed the committee may invite guest representatives as needed to attain the best expert input required e.g. MD, Resident, direct care givers, legal.

Facilitator:

A facilitator will assist the members to remain focused on task at hand. The current facilitator will remain until Committee members determine the committee is established and ready to move to a chair and co-chair format. Other responsibilities include ensuring meeting minutes, agendas, and any relevant information is forwarded to all members.

Terms of Membership:

Each member will commit to a minimal 2 year term. There will be no alternatives for attendance. A maximum of 30 percent of the membership can change in one year.

Responsibility of Members:

- To act as a role model for interprofessional collaboration as a part of regular work.
- To attend all meetings, and to forward regrets to the facilitator when attendance is not possible.
- To be prepared for all meetings, having read any pre-circulated information and materials.
- To respond to emails in a timely fashion.
- To have a clear understanding of their own role and expertise, be confident in their own abilities and be committed to the Values & Resident Care Standards of Northwoodcare Inc.
- Each member understands the roles of the other members
- See conflict as a positive and growing experience
- Accountability to share their own perspective of any issues brought forward at the meeting with a commitment to support the consensus decision following the meeting (even if it does not reflect the perspective of that individual).
- Share responsibility for outcomes.
- Demonstrate mutual trust and respect with other members.
- Work together within the National Interprofessional Competency Framework (February 2010).

Appendix E: Collaborative Practice Implementation Tool

(Two left mouse clicks to open document below. Requires Adobe Reader™.)

Collaborative Practice Implementation Tool

Steps	Guidelines
Potential issue brought forward: • Determine if it is actually an issue *After you have reviewed all of the questions in the corresponding guideline and determine it is still an issue that requires action, please advance to the following steps:*	• Before taking on a task and working through the various stages of implementation, it is important to fully examine if this is needed or does is required some modifications/additions to what is currently in existence • Why did the issue come forward? Conflict between Recreation and Unit Staff. It originally was brought to my attention by Kathy and then Jennifer, as follow up to a unit meeting where it was also raised there • Is it a matter of lack of awareness/education? While this is certainly a component, there are other issues as well • Check procedures None in existence relative to this situation • Talk to all involved for their interpretation of the issue, who sees it as an issue? Met with recreation, unit team,(both rotations) and Dietary,(one rotation) • Identify the real root cause of the issue, sometimes need to ask many questions to get to real issue. The unit staff are not working in a collaborative interdisciplinary fashion: 1. Unit team does not have a clear understanding of one another's roles 2. Specific to recreation: discipline's educational background, clinical standards, expectations & limitations; program design, etc. 3. Unit team has not been informed of Kathy's overall unit recreation plan. Types of programs, target participants for each program, frequency, etc. 4. Unit team has not had any opportunity to have input into the above 5. Unit staff support of these programs is inconsistent at best due to lack of awareness, understanding, etc 6. Kathy is not in the loop re: daily changes to resident medical status, unit "hot spots" 7. Unit team acknowledged difficulty in broadening their group to include other disciplines – Kathy does not feel like part of this team 8. Kathy is of little support to team when not aware of these day to day changes/issues 9. Communication is poor between disciplines 10. No formal opportunity for interprofessional problem solving or planning of initiatives • Identify the purpose for the change and who it should benefit. The purpose for the change is to have all disciplines learn to work together vs. in silos as it the current practice. Everyone needs to share a common goal, share resources, support one another. This will benefit the residents, staff, family and volunteers on many different levels

Appendix F: Collaborative Practice Project Submission Form

(Two left mouse clicks to open document below. Requires Adobe Reader™.)

Collaborative Practice
Project Submission Form

Project Title: Oral Health –Brushing up on Mouth Care Submitted By: Karla Sonnichsen Date: June 26th/2012.

Who is this project important to?

This would be an important initiative for all of our residents within Halifax Northwood and potentially corporately. It would be important to all front line staff educationally.

Who will it impact and how broadly?

It will affect each resident and their physical health related to disease prevention; not only their oral health but prevention of systemic disease also. Their quality of life would be improved based on overall well being and comfort. Their families would have the added benefit of knowing this aspect of care was included in overall care.
I anticipate this would be seen as leading practise nationally in terms of LTC.

How it is resident centred? Each individual's oral health is independently and regularly assessed with unique interventions planned based on who they 'are' and how they respond. A huge aspect of this project's success will depend on staff's comprehension and implementation of resident centered care.

How is it interprofessionally based? Involved in this initiative will be the Health Center and both the dentist and the dental hygienist. They will provide both care and education. The nurse practitioner will teach RN's oral assessments and this information will be presented at the Care conference. All staff on the team (PT, OT, Leisure Rec. dietary, and environment etc.) can be involved in noting oral health in terms of ability to eat and whether they notice signs of discomfort. It is believed once oral health is maintained then there might be less responsive behaviours based on discomfort and that each professional will note this change when providing care. This initiative, because the premise is resident centered, will affect everyone's care of the resident. All levels of nursing are directly involved in assessment and care. Pharmacy is involved in terms of med review and those medications that can affect oral 'dryness'.

Does it have any ethical issues associated with it? Our current care of LTC resident's oral health is an ethical issue as we are currently not providing adequate care.
This has been researched in terms of LTC studies and the Dalhousie oral health project but also in terms of enquiring directly on our units with our staff.

Appendix G: Sensitivity and Compassion

We are all advocates for the residents at Northwood. Everyone deserves to be treated with dignity and respect, including our co-workers, families and volunteers.

Imagine being a resident suffering from Dementia, and arriving here with your meager belongings to live the rest of your life, often with a roommate you've never seen before.

Who is the resident/client?

- Frail, vulnerable, trusting, frightened, apprehensive
- Younger, more challenges with disabilities
- Increase in dementia
- Someone's mom, sister, aunt, wife, friend.

What does their journey into care look like?

- Losses – dignity, finances, belongings, home, independence, friends, health, identity…their ability to see their future
- Box analogy: what would you save from the culmination of your life?
- Caregiver burnout – families, spouses, self.
- Often have been admitted to acute care, and transferred over to long term care without an opportunity to go home and take care of things.

Question: Are you now reduced, as a human, to your present circumstance? (Who were you – I *was* an engineer – still are, only not active.)

What do they deserve their experience in Long Term Care to be?

- Sacred trust is given from the resident and their families
- Trust and respect is earned by staff
- Everyone needs purpose in life – think about what the elderly does at home.
- Residents need opportunities to make as many decisions as possible around their daily schedules and personal care (ie. Clothing etc.)
- Wish to retain activities of daily living – hair brushing, dressing, personal care, oral care, eating.
- Residents need safe venues to voice their opinions. (Resident council, family council, advocate)
- Respectful, dignified life being provided by all – nursing, dietary, administration, client services, housekeeping, environmental.

Dignity issues:

- How we address a resident – never "honey, sweetie, etc."
- Toileting (signage in rooms, doors open etc)
- Access to their personal space (room)

- Bathing/personal care (commode chair beside the bed…an acute care scene, only putting pads on instead of mesh panties)
- Clothing – personal items
- Belongings
- Confidentiality
- Staff actions on the floor -
- Empowerment – encouraging residents to do for themselves; calling maintenance for any work to be done in their space.
- Use appropriate language: not "diapers", "bibs" or baby talk

What can we do to be part of the solution:

- Ask resident how they want to be addressed
- Ask permission to enter their space – EVERY time
- Stop inappropriate conversations in public areas, such as nursing station, hallways, other resident's rooms.
- Follow the care plan
- Try not to clean floors around the dining rooms at meal times.
- Do not use the pill crusher around the dining rooms.
- Speak with the resident before touching their personal items – ie. "Your flowers are looking a little wilted…are you ready to part with them?"
- NEVER take another resident's belongings, such as razors, extra socks, etc for another resident.
- Acknowledge residents when they are in common areas. Take the time to stop and say hello. It only takes 3 seconds.
- Remember, families have many dynamic issues…do not take things they say personally, and be as helpful as possible. They are often hurting. (decreased family visits, etc)
- Give the resident opportunities to give back…if they offer you a candy, accept with pleasure and thank them.
- Work out problems with other staff – unhappy, non-communicating staff makes for unhappy residents.
- Never discuss work displeasures with residents…it is not their problem (we're always short staffed)
- Stop the paternalistic care – you look tired, you need to go to bed, etc.
- Give the resident autonomy. Ask them what they'd want, how they'd want it and when. Do not assume we know best.
- Tone of voice – how we say things, not what we say.
- Remember the dignity issues – wash their hands and face after each meal, immediately remove the protective clothes covering, brush their hair in the mornings, or after they've had a rest.

- Remember there are generational differences – the terms that they use are geared to that era.
- As caregivers, identify areas of concern around lack of access for residents (soap dispensers on the walls beside the sink is not accessible to the resident in a wheelchair.)
- Give the resident opportunity to be self sufficient…have them call for their appointments, etc.
- Ask about their lives…everyone has a story.

What does the resident expect and deserve to receive?

- Consistent care. Residents identify their care is conditional on who is on that shift.
- Non-paternalistic attitude
- A social model of care, not a medical one – this is not an acute care site. This is their home. Pretend you work in homecare and that you are entering someone's private space.
- A sense of purpose
- Caring, happy staff
- A concise, up-to-date care plan that is used on a daily basis
- Acknowledgement
- If you are working nights, remember that residents will be tired and sleeping during this time. Act accordingly
- Everyone should help them have a drink of water. Hydration is important.
- Polite, respectful, sincere attitudes (old fashioned manners)

We need resident focused care, not process focused care

Number one statement heard from residents: I don't want to complain or report anything, or it will affect the quality of my care. (abuse)

You don't have to hit a person to hurt a person. Abuse takes on different guises…neglect, intimidation, emotional abuse, physical abuse.

Justifications are excuses for non-performance (eg. I can't, I couldn't, not enough time, not enough staff)

The best way to evaluate people is to watch them work.

Appendix H: Resident Activities of Daily Living form

Reviewed By _____Date _____

RESIDENT ACTIVITIES OF DAILY LIVING

NAME: _____ LIKES TO BE CALLED: _____ ROOM: _____ ALLERGIES:_____AHCDS:_____

BATH (DAY/TIME):_____ REVIEWED WITH RESIDENT/FAMILY ON: _____ STAFF SIGNATURE:_____

This is what keeps me safe and comfortable...

Mobility: Risk for Falls ☐Heightened

☐ Weight Bearing Transfer Method

☐Side ☐ Elbow ☐Pivot ☐ x1 ☐x2

Assistive Device ☐Cane ☐Walker (2 w/w or 4 w/w) ☐Scooter

☐Wheelchair w/c Cushion Type: _____ ☐Foot Pedals

☐Geri Chair ☐Qfoam ☐Other: _____ ☐Bed mobility slider sheet

☐ **Mechanical Lift** ☐ Stand-up Lift (must weight bear)

☐ Ceiling or Medi-Man lift

☐ **Sling** _____

Walks ☐Independent ☐Stand By ☐Assist ☐ x1 ☐x2

Elimination: ☐**Toileting Routine** Frequency:_____

☐Grab Bar ☐Assist ☐ x1 ☐x2

Bladder: ☐Continent ☐Incontinent ☐Urostomy

☐Catheter Change Date:

☐ Suprapubic Catheter ☐ Condom Catheter

Bowel: ☐Continent ☐Incontinent

☐Ileostomy ☐ 1 Piece ☐ 2 piece

☐Colostomy ☐ 1 Piece ☐ 2 piece

Incontinent Product: ☐Day/Evening _____

☐Night _____

Safety: ☐Call bell within reach

☐Alarmed bed ☐Posey alarm

☐Chair pressure alarm ☐Seat belt alarm

☐Lap Belt * ☐Lap Tray* ☐Restraint*

Side rails*: _____

*See restraint checklist

Vision: ☐Blind ☐R ☐L ☐Glasses

Hearing: Adequate ☐R ☐L

Impaired/Deaf: ☐R ☐L

Hearing Aid(s) ☐R ☐L

Teeth: ☐Own ☐None

Dentures: ☐ Upper ☐Lower

Diet: _____

☐Supplements: _____

☐**Difficulty Chewing**

☐**Choking Risk**

☐Feeds Self ☐Assist

☐Total Assist

☐Adaptive eating aids

Food Allergies:

Pain:

☐Occasional

☐Frequent

Where:

*** Report pain to charge staff ***

Comments:

This is how I like to be approached for the day...

Personal Care: Hygiene: ☐Total ☐Assist ☐Self ☐Bed

Bathing: ☐Tub ☐Shower ☐Bed bath

Dressing: ☐Total ☐Assist ☐Self

Laundry: ☐Facility ☐ Family

☐**Smokes** # / Day _____ ☐Smoking Apron

☐**Alcohol** Limit

Comments: *Please introduce yourself to me when you begin your shift ☺*

This is how I like to spend my time... **Rec**

Reviewed_____**By**_____

Rest: ☐N ☐Y Time:_____

Side Rails: ☐N ☐Y: ☐½ ☐¾ ☐1 full ☐2 full

☐Positioning Device Specify:

Checks/ frequency:

☐Incontinence _____
☐Breathing _____

☐Reposition _____

Recreation/ Spiritual

☐Participates in Activities ☐On unit ☐Off unit

Specify:

Comments:

Personal Care: Hygiene: ☐Total ☐Assist ☐Self ☐Bed

Bathing: ☐Tub ☐Shower ☐Bed bath

Dressing: ☐Total ☐Assist ☐Self

Laundry: ☐Facility ☐ Family

☐**Smokes** # / Day _____ ☐Smoking Apron

☐**Alcohol** Limit

This is how I like to be approached for the evening...

Comments: *Please introduce yourself to me when you begin your shift ☺*

This is what I need during the night...

Elimination:

Bladder: ☐Continent ☐Incontinent

Bowel: ☐Continent ☐Incontinent

☐Night incontinent product _____

Checks/ frequency:

☐Incontinence _____
☐Breathing _____

Safety:

☐Call bell within reach

☐Bed alarm

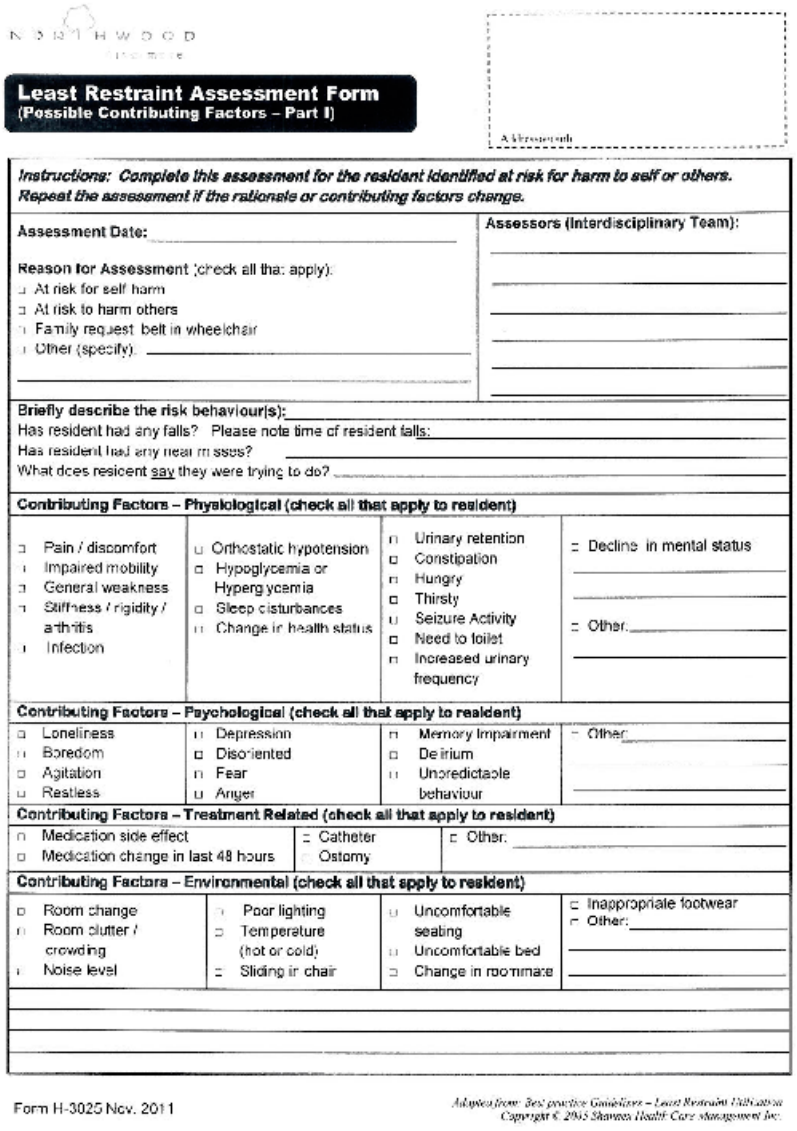
☐Posey alarm

☐Empty Catheter ☐Bed pan ☐Bathroom / Commode	☐Reposition _____ ☐ Use Slider Sheet * Activate Alarms *	☐ Other: _____ Side rails: _____

Comments:

Appendix I: Least Restraint Tool – Part 1

(Two left mouse clicks to open document below. Requires Adobe Reader™.)



NORTHWOOD

Least Restraint Assessment Form
(Possible Contributing Factors – Part I)

A Wesgroup

Instructions: Complete this assessment for the resident identified at risk for harm to self or others. Repeat the assessment if the rationale or contributing factors change.

Assessment Date: _____

Assessors (Interdisciplinary Team):

Reason for Assessment (check all that apply):
- ☐ At risk for self harm
- ☐ At risk to harm others
- ☐ Family request belt in wheelchair
- ☐ Other (specify): _____

Briefly describe the risk behaviour(s): _____
Has resident had any falls? Please note time of resident falls: _____
Has resident had any near misses? _____
What does resident say they were trying to do? _____

Contributing Factors – Physiological (check all that apply to resident)

☐ Pain / discomfort	☐ Orthostatic hypotension	☐ Urinary retention	☐ Decline in mental status
☐ Impaired mobility	☐ Hypoglycemia or Hyperglycemia	☐ Constipation	_____
☐ General weakness	☐ Sleep disturbances	☐ Hungry	_____
☐ Stiffness / rigidity / arthritis	☐ Change in health status	☐ Thirsty	☐ Other: _____
☐ Infection		☐ Seizure Activity	_____
		☐ Need to toilet	
		☐ Increased urinary frequency	

Contributing Factors – Psychological (check all that apply to resident)

☐ Loneliness	☐ Depression	☐ Memory Impairment	☐ Other: _____
☐ Boredom	☐ Disoriented	☐ Delirium	_____
☐ Agitation	☐ Fear	☐ Unpredictable behaviour	_____
☐ Restless	☐ Anger		

Contributing Factors – Treatment Related (check all that apply to resident)

☐ Medication side effect	☐ Catheter	☐ Other: _____
☐ Medication change in last 48 hours	☐ Ostomy	

Contributing Factors – Environmental (check all that apply to resident)

☐ Room change	☐ Poor lighting	☐ Uncomfortable seating	☐ Inappropriate footwear
☐ Room clutter / crowding	☐ Temperature (hot or cold)	☐ Uncomfortable bed	☐ Other: _____
☐ Noise level	☐ Sliding in chair	☐ Change in roommate	_____

Form H-3025 Nov. 2011

Adapted from: Best practice Guidelines – Least Restraint Utilization
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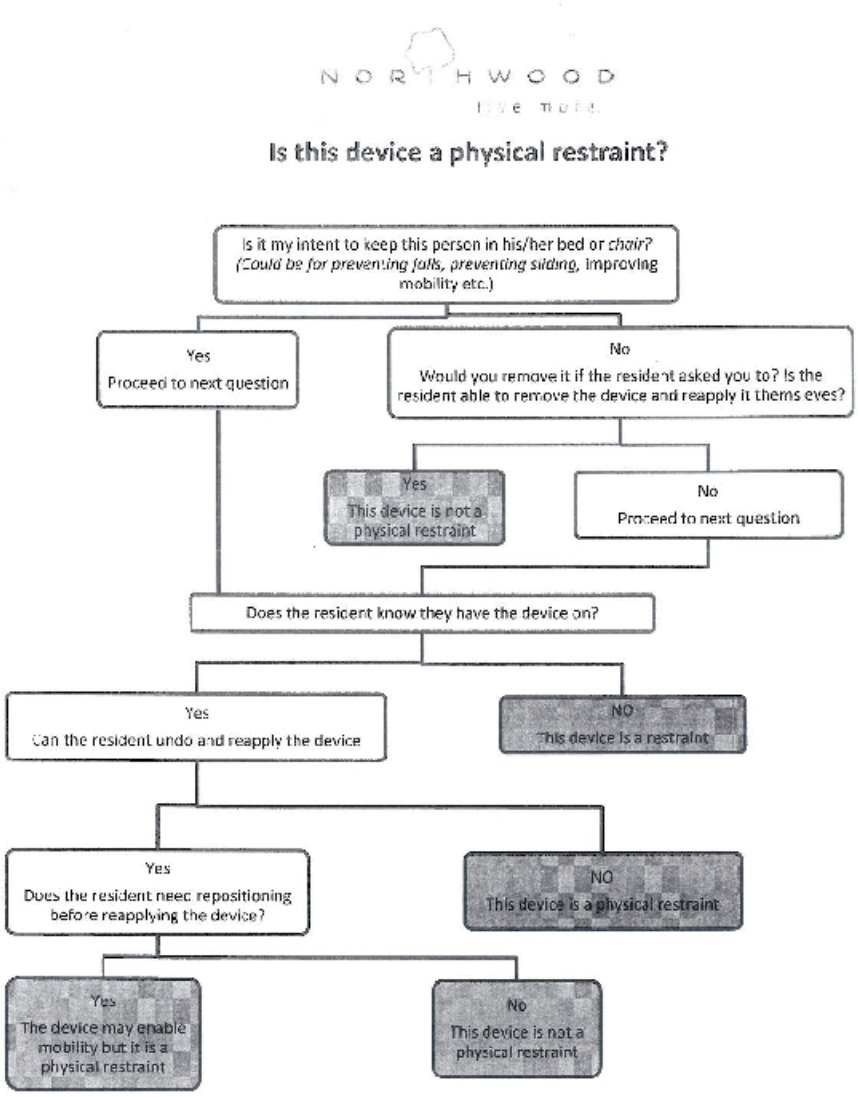
Appendix J: Is this a physical restraint?

(Two left mouse clicks to open document below. Requires Adobe Reader™.)



Appendix K: Least Restraint Tool – Part 2

(Two left mouse clicks to open document below. Requires Adobe Reader™.)

NORTHWOOD

Least Restraint Assessment Form
(Alternative Interventions – Part II)

Addressograph

Resident Name: _____

Alternative Interventions for Restraints (Check all that apply to resident: E = Exists, T= Tried, W=Will try)

	E	T	W	Comments		E	T	W	Comments
ENVIRONMENTAL CHANGES:					**DIRECT CARE:**				
Improved / alternate lighting					Hip protectors				
Personalize environment					Mobility aid within reach				
Cloth barrier across doorway attached with Velcro					Have mobility aids out of sight				
Comfortable room temperature					Provide appropriate cues (e.g. step-by-step instructions)				
SEATING AND POSITION SUPPORT:					Call bell in reach				
High back or support chair									
Individualized seating					Maximize independent call bell use				
Power lift chair					Relocate resident closer to nursing station				
Tilt wheelchair					Appropriate / alternate footwear				
Alarm on chair					Limit time spent in bed				
Glider / rocker					Facilitate rest periods				
SAFETY IN BED:					**NUTRITIONAL CARE:**				
Bed in low position					Provide additional fluid and nutritional intake				
Brakes on wheelchair next to bed					Adapt provision of nutrition to resident's condition (e.g., finger food, frequent small meals, etc.)				
Side rails – 1/2 / 3/4									
Bed alarm					**PHYSIOLOGICAL INTERVENTION:**				
Lipped Mattress					Treat the underlying pathology and contributing factors (e.g. infection)				
TOILETING AND CONTINENCE:					Pain Management				
Continence evaluation									
Individualized toileting program					Medication review				
Identify bathroom									

Page 1 of 1

Form H-3026

Adapted from, Best practice Guidelines – Least Restraint Utilization
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Appendix L: Consent for Physical Restraint

(Two left mouse clicks to open document below. Requires Adobe Reader™.)

NORTHWOOD

In Care Living, Nursing Services

Consent for Physical Restraint

addressograph

I hereby give consent for the application of a physical restraint for: _____
(Resident)

I have been informed that the physical restraint to be used is one that is approved for use by Northwoodcare Incorporated. I am aware that the least restrictive form of physical restraint will be utilized and the use of the physical restraint will be kept to a minimum for the shortest period of time possible.

I understand there are risks and benefits of restraint use. The following are some of the potential risks and benefits. The primary risks and benefits are noted but the list is not all inclusive.

Potential Risks	Potential Benefits
Accidental injury: falls, entrapment, strangulation Decreased mobility: loss of muscle mass, muscle tone and strength; joint stiffness, contractures Pressure sores/ skin abrasions Incontinence, constipation, urinary tract infections Decreased appetite, dehydration Loss of dignity, feelings of being punished, withdrawal Increased agitation , anxiety	Protection from accidents or injuries Protection of other residents or staff from physical harm Resident may experience and enhanced feeling of safety

I have considered the risks and benefits of restraint use in making my decision. Alternatives to restraint have been attempted without success and they include

_____
_____
_____
_____
_____

Appendix M: In Care Living Initial Nutrition Interview

Northwood

Resident Name

Room

In Care Living Initial

Nutrition Interview

Food Service at Northwood

Introduction

Hello , my name is _____.

I am a Food Service Supervisor with the Food Service Department of Northwood.

I would like to tell you about our menu and find out more about your likes and dislikes so we can create a menu that works for you.

Information for Resident

I want you to be aware that :

- We have a four week cycle menu.
- The menu is posted on the bulletin board near the Dining Room
- The Dietary Aide will pass along any requests or dislikes.
- There is a Food Service Supervisor available at each meal.
- You can request a visit from the Dietitian at any time.

DIET
Current Diet
Are you on a special Diet? Do you have any allergies? Do you restrict any foods? Why?

WEIGHT	
Current Weight	
Has there been any changes in your weight?	Yes No

CHEWING/SWALLOWING	
Current Texture	
Do you have your own teeth, partial plate or dentures?	Yes No
If you have a partial plate or dentures, do you wear them at meals?	Yes No
Do you have any problems chewing food especially meat?	Yes No
Do you have any problems swallowing food or liquids?	Yes No
Do you cough, choke or have pain when swallowing food or liquids?	Yes No
Do you ever have mouth pain, mouth sores or poor dental status?	Yes No
Do you have any problems cutting your food?	Yes No
Do you prefer to have your food cut up?	Yes No

HEALTH	
Do you ever have Nausea, Vomiting ?	Yes No
Do you ever have diarrhea or constipation?	Yes No

INTAKE			
How would you describe your appetite?	Good	Fair	Poor
Do you take supplements? (Boost, Ensure)			Yes No
What are your favorite foods?			

Please complete electronic copy and submit in Care Trak.

Completed by_____ Date_____

Reviewed by Dietitian_____ Date_____

Northwood

Resident Name

Room

In Care Living Follow Up/Annual Nutrition Interview

Food Service at Northwood
Introduction
Hello , my name is _____. I am a Food Service Supervisor with the Food Service Department of Northwood. I wanted to follow up on the meal service at Northwood.

Checklist : Circle all items resident likes. Note any dislikes.

Breakfast
How is Breakfast ? Excellent Good Poor
Eggs – Fried, Scrambled , Boiled, Omelet, Poached
Toast – White Wholewheat
Cereal – Oatmeal Cold Cereal
Fruit - Prunes Mandarin Oranges
Juice - Apple Orange Cranberry Prune
Beverage - Milk Tea Coffee Water
Comments:

Lunch
How is Lunch ? Excellent Good Poor
Soup Chowder
Casserole
Sandwiches
Salad Salad Plate Fruit Salad Plate
Comments:

Supper
How is Supper ? Excellent Good Poor
Ham Chicken Turkey Roast Beef Fish Corn Beef
Potato – Mashed Boiled Baked Rice
Vegetables Carrot Peas Broccoli Turnip Cabbage Beans Corn
Pasta Spaghetti Lasagne Beef a roni Mac and Cheese
Comments:

Record any dislikes and requested alternate. Use menu as guide

Dislike	Next Option	Menu Item	No Alternate	Completed Clerk's Initials	Refer to Dietitian

Are you satisfied with the quality of the meals?	Yes No
How is the service in the Dining Room?	Excellent Good Poor
Is there ever a time that you had nothing to eat at a meal?	Yes No
Are you getting enough to eat?	Yes No
Are your meals hot?	Yes No
Do you check the menu on the Bulletin Board?	Yes No
Other Comments	

Visit required by the Dietitian? Yes No

Please complete electronic copy and submit in Care Trak.

Completed by_____ Date_____

Reviewed by Dietitian_____ Date_____

Appendix N: Recommendations for Interactions with Dementia Residents

- Keep things visual. The tasks that were easily seen were the most likely to be completed and ever repeated.
- Reinforce, encourage, reassure and come to their rescue. Often a simple verbal reinforcement will assist.
- Caregivers should make a special effort to make things as positive as possible by creating successes with the resident with dementia. This would mean a shift to a positive, success oriented style of caregiving.
- Be calm. Cut down on noise. Because a resident has difficulty discriminating relevant vs. irrelevant stimuli, any additional noise or visual distraction causes the resident to be unable to concentrate on the tasks at hand making them appear more confused than they really are, and will increase agitation.
- Allow shadowing to occur. It is a sense of comfort for the resident and not an attempt by the resident to create problems for the caregiver. This should be viewed as a positive thing and one that can help manage behaviors in a productive way.
- Give ample time. For caregivers this information is invaluable. Caregivers need to carefully give dementia residents commands and be more realistic about what has been understood.
- Allow hoarding as this seems to help create a sense of security in some. Try not to remove a hoarded object from a resident without replacing it with something else.
- It seems to go against the resident's natural instinct to interact with others. However, the importance of socialization is proving to be vital in the care of people with dementia. Caregivers can "create" social settings and situations for the resident in order to meet the socialization need.
- Repetition is a common behavior and one that seems to give a sense of comfort. Even if the resident continues to do the same thing over and over, caregivers should allow this to happen, as long as it does not create a danger to resident or others. This can be considered a behavioral problem if the family or staff try to intervene when the elder is actively doing something. The result could be defiant or disruptive behavior. It is necessary to wait until the resident is asking for help or aimlessly wandering before introducing something new.
- ***Treat behavior problems as coping strategies.*** This is the biggest hurdle we can jump in healthcare. Too much time is spent trying to "fix" the resident through medications when studies show that many medications given for behavior problems are harmful to people with Alzheimer's disease. More time needs to be spent trying to understand behavior and, better yet, unless the behavior causes a danger to the resident or someone else, ***let them be.***
- Your actions and reactions will set the stage for how the resident will act/react.
- Always remain calm, with a non threatening stance, and approach the resident from the side rather than standing in front of them. You will appear to be a barrier.

Appendix O: Dietary education materials

Meal times provide us with an opportunity to spend time with our family and friends, as well as share food together. When caring for someone with dementia, mealtimes can sometimes become stressful.

Loss of memory and problems with judgment can cause difficulties with eating and nutrition for many people with dementia. However, there are ways to help the person with dementia and their care givers.

Loss of appetite

A person with dementia may forget how to chew and swallow. Other reasons for an apparent loss of appetite may include ill-fitting dentures, insufficient physical activity and being embarrassed by difficulties in eating.

Things you can try:

- Check with the doctor to make sure that there are no treatable causes for loss of appetite, such as acute illness or depression.
- Offer meals at regular times each day.
- Allow the person to eat when hungry.
- Encourage physical activity.
- Provide balanced meals to avoid constipation.
- Try a small glass of juice, wine or sherry – if medications permit – before the meal to whet appetite.
- Offer ice cream or milkshakes.
- Try to prepare familiar foods in familiar ways, especially foods that are favorites.
- Encourage eating all or most of one food before moving on to the next – some people can become confused when tastes and textures change.
- Try to make mealtimes simple, relaxed and calm. Be sure to allow enough time for a meal. Assisting an impaired person can take up to an hour.
- Consult a doctor if the person with dementia experiences significant weight loss (such as 2.5kg in six weeks).
- Check with the doctor about vitamin supplements.
- Caregivers should also make sure their own diet is varied, nutritious and enjoyable.

Overeating

Some people with dementia may overeat or even develop an insatiable appetite.

Things you can try:

- Try five to six small meals per day.
- Have low calorie snacks available, such as apples and carrots.
- Consider whether other activities – such as walks or increased socialization – may help.
- Lock some foods away, if necessary.
- Leave healthy snack foods on the table – this may be enough to satisfy some people.

Sweet cravings
People with dementia may crave sweet foods.

Things you can try:

- Check medications for side effects. Some antidepressant medications cause a craving for sweets.
- Try satisfying the sweet cravings with foods that have some nutritional value such as milkshakes, eggnogs or low calorie ice cream.

Mouth, chewing and swallowing problems
Some problems with eating may relate to the mouth. A dry mouth, or mouth discomfort from gum disease or ill-fitting dentures, are common problems.

Things you can try:

- Arrange a dental check-up of gums, teeth and dentures.
- Moisten food with gravies and sauces if a dry mouth is causing problems.
- For chewing problems, try light pressure on the lips or under the chin, tell the person when to chew, demonstrate chewing, moisten foods or offer small bites one at a time.
- For swallowing problems, remind the person to swallow with each bite, stroke the throat gently, check mouth to see if food has been swallowed, do not give foods which are hard to swallow, offer smaller bites and moisten food.
- Consult the doctor if choking problems develop.

At the table
Pouring a glass of juice into a bowl of soup or eating dessert with a knife indicate a person with dementia is having difficulty at the dinner table.

Things you can try:

- Serve one course at a time and remove other distracting items from the table such as cutlery, glasses or table decorations.
- Ensure the crockery is plain and is a contrasting colour to a plain tablecloth.
- Allow plenty of time to eat.
- Keep noise or activity in the environment to a minimum.
- Ensure there is adequate lighting.
- Serve food that is familiar to the person.
- Eat with the person with dementia so that they can follow your lead.
- Serve familiar food.

Other considerations

- **Keep eating simple** – not all food has to be eaten with cutlery if this is becoming difficult. Finger foods can be a nutritious and easy alternative.

- **Keep in mind a person's past history with food –** they may have always had a small appetite, been a voracious eater or had a craving for sweets.
- **Watch food temperatures** – while warm food is more appetizing, some people with dementia have lost the ability to judge when food or drink is too hot. Beware of using styrofoam cups – they hold the heat for a long time and tip over easily.
- **Offer support** – spoiled food in the refrigerator, hiding food or not eating regularly may all be signs that someone living alone needs more support.
- **Offer fluids** – regular drinks of water, juice or other fluids are essential to avoid dehydration. Many people with dementia do not get enough fluids because they may forget to drink or may no longer recognize the sensation of thirst.
- **Be prepared for changes** – many eating problems of dementia are temporary and will change as the person's abilities deteriorate.

Where to get help

- Your doctor
- Your local community health service

Things to remember

A person with dementia may forget how to chew and swallow.

- Check with the doctor for other causes for loss of appetite, such as acute illness or depression.
- Caregivers should also make sure their own diet is varied, nutritious and enjoyable.

http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Dementia_how_to_encourage_healthy_eating?open

Dementia and Dysphagia: Cognitive Deficits and Eating Challenges

From the earlier stages of forgetfulness and confusion to the end stage of impending death, provisions must be made by the caregivers and professionals to encourage adequate nutrition for people with dementia. The changes that occur during the progression of Alzheimer's disease affect people cognitively, physically, and emotionally and present environmental challenges. Strategies for managing some of these changes are summarized in the following table as found in original article: 10/9/2006

Dysphagia and Nutrition Management In Patients With Dementia: The Role of the SLP by *Sue Curfman, M.A., CCC*

http://www.speechpathology.com/articles/article_detail.asp?article_id=262

CHALLENGE	INTERVENTION
Forgetfulness and Disorientation	
Misinterprets the bodily needs of hunger and food	Offer liquids and water constantly. Residents do not usually ask for a drink. Dehydration may increase combativeness.
Plays with food/Forgets how to eat/ does not recognize food as food.	Often residents cannot move on from the before meal activity to the meal itself. Consequently they play with the food because there are no cueing devises to inform them of the change. As an intervention, alter the appearance of the table to signal that the activity is now eating by using a tablecloth, flowers , baskets for napkins and placemats.
Eats with fingers instead of utensils.	Increase the number of finger foods being offered; positively affirm resident's eating abilities; simply the eating task so they can exceed using one step directions as needed.
Does not use utensils correctly	Limit the number of utensils. Often residents with dementia eat with a knife because they pick it up with their dominant hand to cut their food(whether it needs it or not) and then forget to put it down to select a fork and spoon
Unable to make choices if too much food or too many containers are present at one time.	Serve one course at a time so the necessity of making choices is limited and there are fewer distractions available; when appropriate, allow menu selection and choice between 2-3 main choices. If dining at a restaurant, offer the menu and the give the cueing needed to help with choices. For example, "Would you prefer chicken or beef today?" If residents cannot make choices at all and you know their likes/dislikes , you might say , "this restaurant is noted for their excellent roast beef. Would you like some?"
Demonstrates an inability to understand what is expected of them at mealtime.	If residents feel that there is too much food on their plate, use two plates, serving half a meal at a time.

CHALLENGE	INTERVENTION
Limited Attention Span	
Inability to attend to the task of eating limits the meal being consumed entirely.	Use simple words. Touch and redirect the resident to the task of eating. Five to six meals per day be needed for residents who are unable to eat much at any one time especially if they become agitated when caregivers attempt to refocus them.
Leaves the table during the meal.	The meal may be a combination of sitting and eating, followed by a walk and eating finger foods from a bowl.
Judgment and Safety	
Eats food pieces that are too big to swallow safety.	Cut food to the appropriate size.
Eats non-editables.	Avoid decorations on food, extra packaging, and disposable dishes.
Pours liquids onto foods	Offer either food or liquid at one time.
Takes another resident's food.	Use placemats or trays to provide a visible boundary.
Perceptual Dysfunction	
Difficulty distinguishing color contrasts	Be conscious of color contrasts between placemat, plate and food. (Example white placemat, white plate with fish and mashed potatoes, will not be able to distinguish the food).
Communication: Understanding and being understood	Develop a list of likes and dislikes available for staff to use. Use multi-sensory cueing with frequent pointing. Move the food away from the table to regain attention. Use verbal encouragement, such as "This is a new recipe I want to cook for my daughter. Would you please try it for me and tell me what you think?" When asking questions about food choices , use "either/or" questions rather than "yes or no", which could lead to no's and no eating.

CHALLENGE	INTERVENTION
Weight Gain/Loss	Doubling up on Breakfast may help weight to be maintained. Snacks between meals and before bedtime. Alternate hot and cold foods to help trigger a swallow. Implement high-protein and increased calorie foods.
Anxiety Someone seated “in their place.”	Some residents prefer or demand the same seat every time and will become aggressive if someone else is sits “in their seat.” Consider using name cards.
Sits too close to others or someone they dislike	Important to arrange table with appropriate tablemates

http://www.speechpathology.com/articles/article_ detail.asp?article_id=262