Regional Geriatric Program of Eastern Ontario

INTRODUCING

Lisa White

GERIATRIC PSYCHIATRY OUTREACH NURSE

THE ROYAL

Lisa White is a Registered Nurse with a Bachelor's of Science in Nursing from Georgian College and York University's collaborative Nursing program and is Certified in Psychiatric and Mental Health Nursing CPMHN(C). She is currently a member of The Royal's Geriatric Psychiatry Outreach and Behaviour Supports Ontario (BSO) team. Prior to this, she worked on the Geriatric Psychiatry inpatient unit at The Royal. Her initial start in Geriatric Nursing began as a Unit Nurse at The Perley and Rideau Veterans' Health Centre. Lisa's passion for advancing care in the Geriatric population and continuing education was the inspiration for her to return to school as a mature student and enter the Nursing profession.

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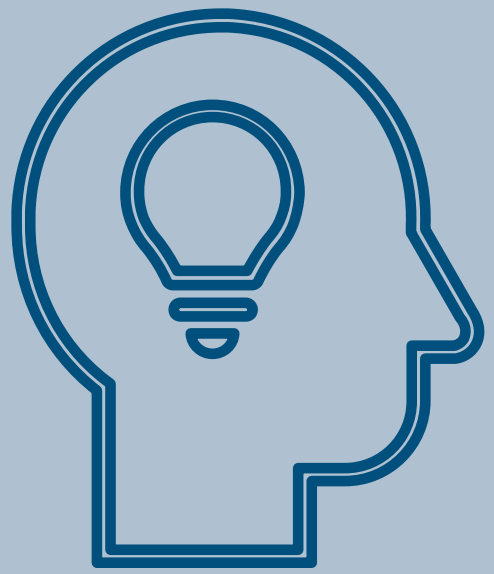

LEARNING OBJECTIVES

- BPSD and Responsive Behaviors
  - Types
  - Impact
  - Contributing Factors
  - Risk Assessment
  - Personhood
  - Management
- Support & Resources
- End of Life

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Dementia: BPSD/responsive behaviours, management, support, resources and end of life

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What are BPSD and responsive behaviours?

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What are BPSD and Responsive Behaviors?

- **BPSD** = Behavioural and Psychological Symptoms of Dementia that are the non-cognitive ***changes in mood and behaviour***
- Result of ***internal changes in the brain*** that may affect ***mood, judgment, perception*** **and** ***memory***; it can be affected by ***external changes in an Individual's environment***
- Referred to as ***'responsive behaviors'*** or ***'personal expressions'***
- They are a form of ***communication***
- They ***cue*** Healthcare Professionals and Care Givers to ***seek meaning behind the behavior***

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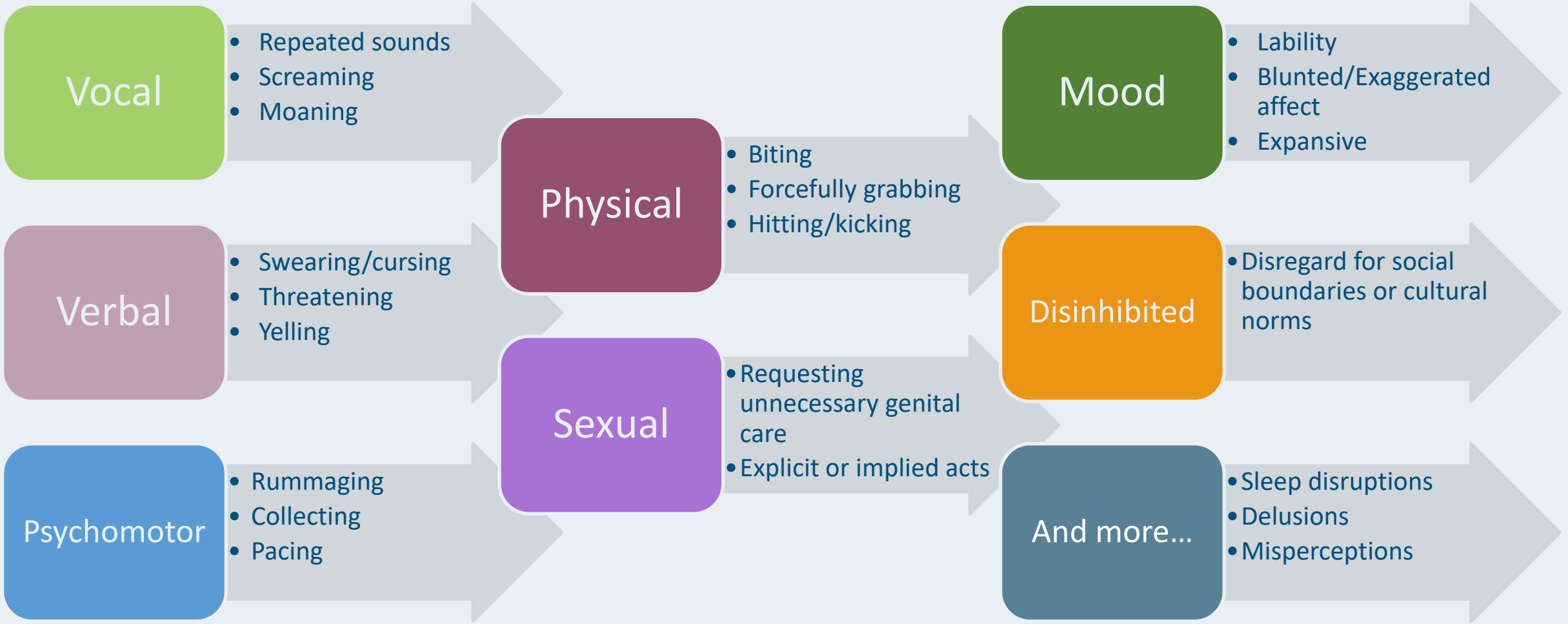
Types of BPSD and Responsive Behaviors



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POLL

Which of the following statements are true about bpsd:

A) They affect mood, judgement, perception and memory

B) They are a form of communication

C) They are a cue to seek meaning behind behavior

D) All of the above

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Understanding the meaning and finding strategies

Amnesia (loss of memory)	•Consistent routine •Repeat as needed •Use visual cues
Agnosia (loss of recognition)	•Introduce yourself •Offer one item at a time •Demonstrate how to use an object
Aphasia (loss of language)	•Use gestures and visuals •Simple one step instructions •Patience
Anosognosia (loss of self-awareness)	•Validate concerns and feelings •Try not to argue or force •Redirect with food or puzzle
Apraxia (loss of purposeful movement)	•Simplify task •Focus on one thing at a time •Demonstrate actions
Altered perception (misinterpretation of env't)	•Visible large print with contrast •keep lights on during day and off during night
Attention deficits (loss of attention)	•Reduce distraction and noise •One task at a time •Smaller visitor groups
Apathy (loss of initiation)	•Assist task initiation •Offer verbal cues •Utilize remaining strengths

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Potential Contributing Factors for BPSD

Medical Issues

Precipitating factors

Sensory Impairments

Environment

Unmet Physical Needs

Loss of Orientation

Lack of Meaningful Engagement

…putting together the data!

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Management of BPSD

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Principles for Assessing and Managing BPSD and Responsive Behaviors

- ***Education*** and ***organizational support***
- Informed ***consent***
- Incorporating ***Personhood****
- ***Person-centred language***
- ***Identify BPSDs of concern***
- Review/assessment of diagnosis
- ***Assessment*** of psychosocial and environmental ***contributors***
- Utilization of psychosocial or ***non-pharmacological interventions***
- Routine ***reassessments*** of treatments/interventions
- ***Communication*** and ***care planning***

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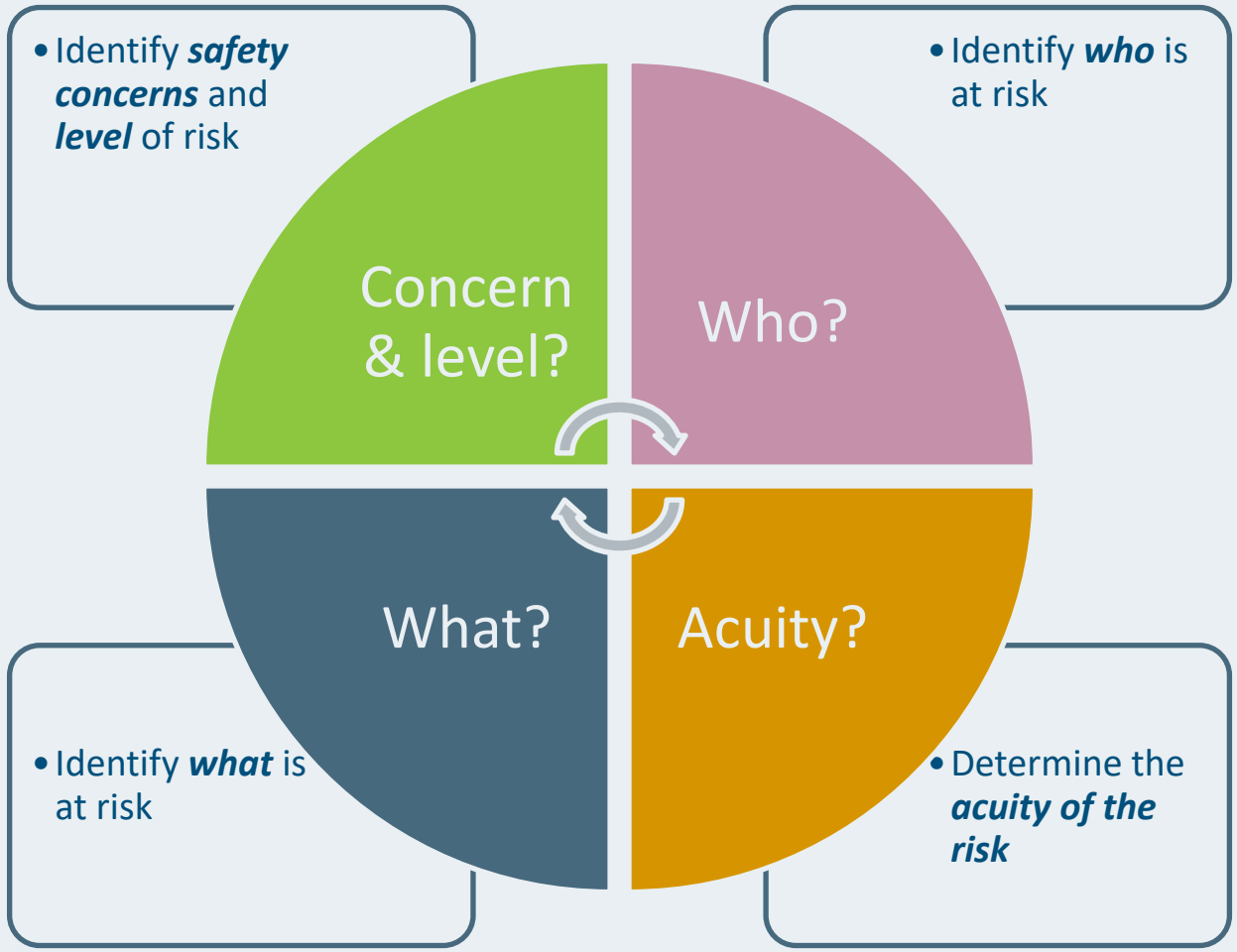
BPSD and Responsive Behaviors - Safety and Risk Considerations

Risk

Balancing



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WHEN TO TREAT

- ***Distressing***
- ***Damaging*** to social relationships
- ***Persistent*** and/or ***dangerous*** presenting risk
- Requiring ***emergency assessment/treatment*** to allow for investigation of underlying acute medical issues

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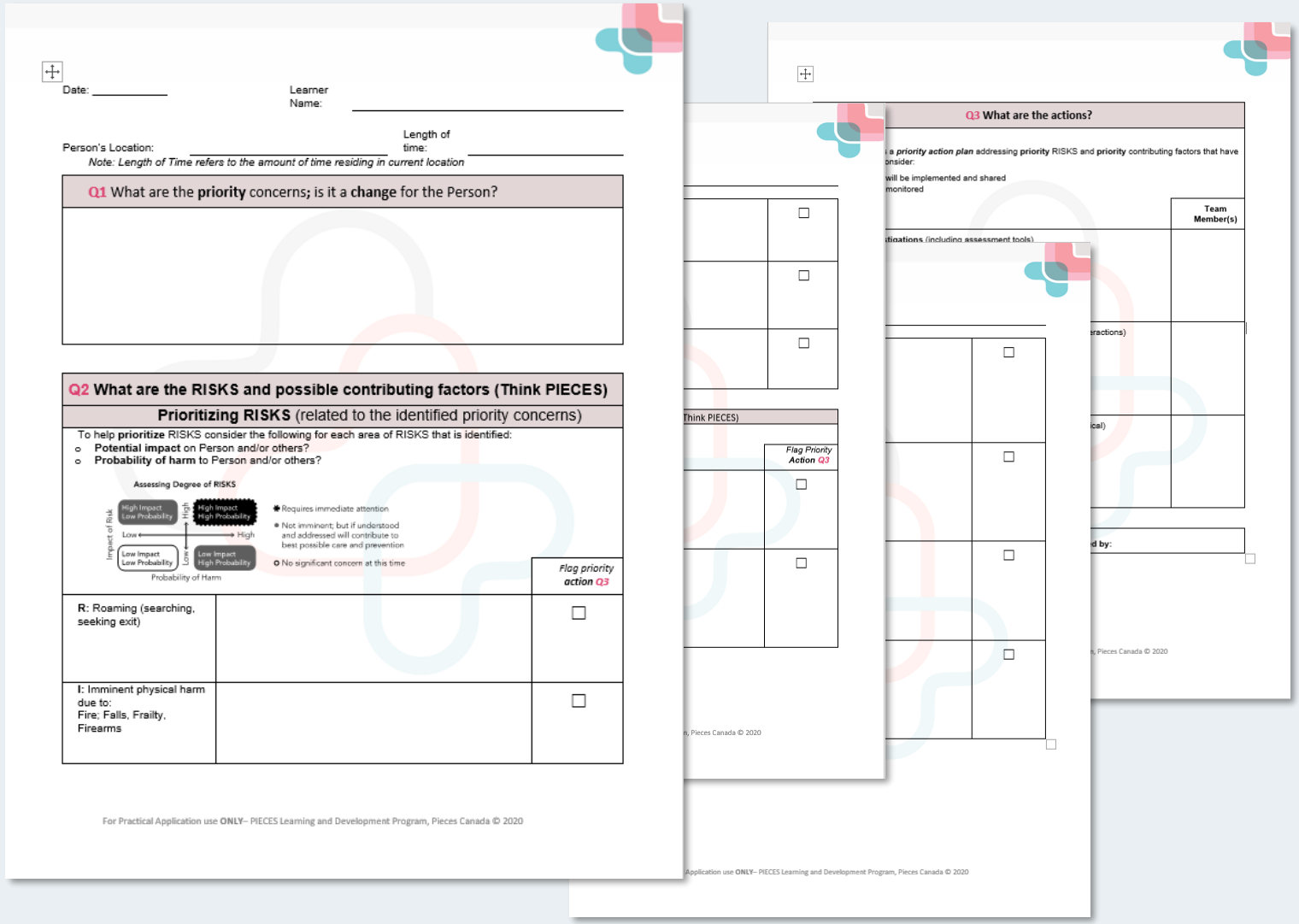
Assessment Tools

PIECES: Physical, Intellectual, Emotional, Capabilities, Environment, and Social

- 1. What has changed?
- 2. What are the RISKS (roaming, imminent physical harm, suicide ideation, kinship, and self-neglect) and possible causes (PIECES)?
- 3. What is the action?


Date: _____ Learner Name: _____

Person's Location: _____ Length of time: _____

Note: Length of Time refers to the amount of time residing in current location

Q1 What are the **priority** concerns; is it a **change** for the Person?

Q2 What are the RISKS and possible contributing factors (Think PIECES)

Prioritizing RISKS (related to the identified priority concerns)

To help **prioritize** RISKS consider the following for each area of RISKS that is identified:
- **Potential impact** on Person and/or others?
- **Probability of harm** to Person and/or others?

Assessing Degree of RISKS

Impact of Risk: Low / High; Probability of Harm: Low / High

High Impact Low Probability; High Impact High Probability; Low Impact Low Probability; Low Impact High Probability

- Requires immediate attention
- Not imminent; but if understood and addressed will contribute to best possible care and prevention
- No significant concern at this time

		Flag priority action Q3
R: Roaming (searching, seeking exit)		☐
I: Imminent physical harm due to: Fire; Falls, Frailty, Firearms		☐

For Practical Application use **ONLY**– PIECES Learning and Development Program, Pieces Canada © 2020

Q3 What are the actions?

a ***priority action plan*** addressing **priority** RISKS and **priority** contributing factors that have consider:

will be implemented and shared

monitored

	Team Member(s)
tigations (including assessment tools)	
eractions)	
ical)	

d by: _____

Think PIECES)

Flag Priority Action Q3

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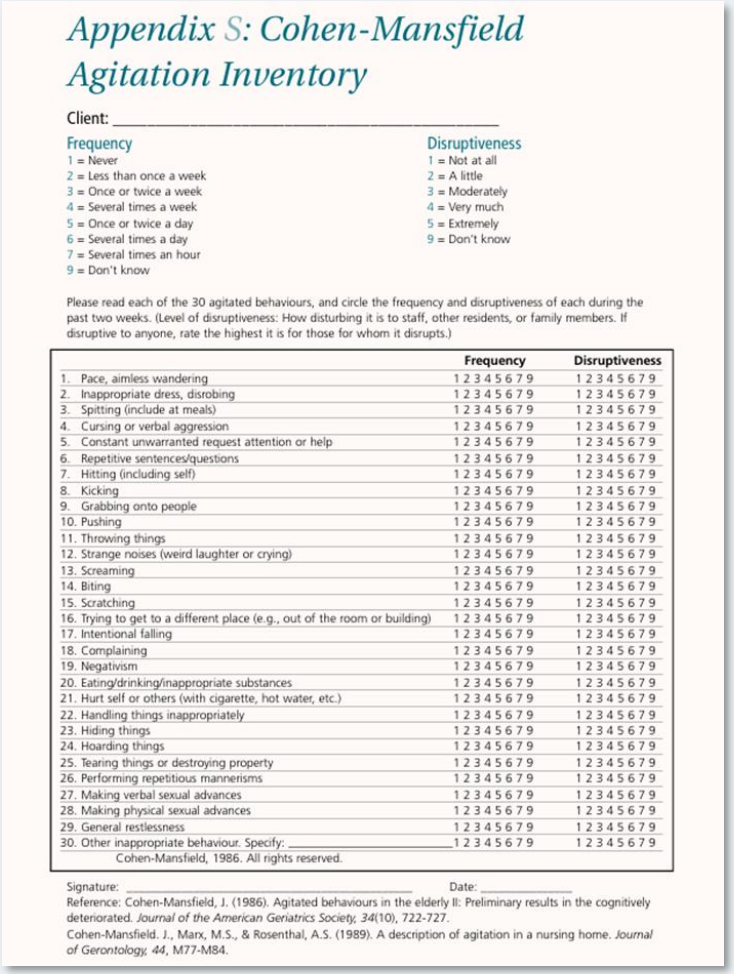
Assessment Tools

Cohen-Mansfield Agitation Inventory (CMAI)

- 29-item scale used to assess frequency and severity of agitation in older adults



Appendix S: Cohen-Mansfield Agitation Inventory

Client: _____

Frequency
1 = Never
2 = Less than once a week
3 = Once or twice a week
4 = Several times a week
5 = Once or twice a day
6 = Several times a day
7 = Several times an hour
9 = Don't know

Disruptiveness
1 = Not at all
2 = A little
3 = Moderately
4 = Very much
5 = Extremely
9 = Don't know

Please read each of the 30 agitated behaviours, and circle the frequency and disruptiveness of each during the past two weeks. (Level of disruptiveness: How disturbing it is to staff, other residents, or family members. If disruptive to anyone, rate the highest it is for those for whom it disrupts.)

	Frequency	Disruptiveness
1. Pace, aimless wandering	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
2. Inappropriate dress, disrobing	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
3. Spitting (include at meals)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
4. Cursing or verbal aggression	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
5. Constant unwarranted request attention or help	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
6. Repetitive sentences/questions	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
7. Hitting (including self)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
8. Kicking	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
9. Grabbing onto people	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
10. Pushing	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
11. Throwing things	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
12. Strange noises (weird laughter or crying)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
13. Screaming	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
14. Biting	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
15. Scratching	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
16. Trying to get to a different place (e.g., out of the room or building)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
17. Intentional falling	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
18. Complaining	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
19. Negativism	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
20. Eating/drinking/inappropriate substances	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
21. Hurt self or others (with cigarette, hot water, etc.)	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
22. Handling things inappropriately	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
23. Hiding things	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
24. Hoarding things	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
25. Tearing things or destroying property	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
26. Performing repetitious mannerisms	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
27. Making verbal sexual advances	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
28. Making physical sexual advances	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
29. General restlessness	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9
30. Other inappropriate behaviour. Specify: _____	1 2 3 4 5 6 7 9	1 2 3 4 5 6 7 9

Cohen-Mansfield, 1986. All rights reserved.

Signature: _____ Date: _____

Reference: Cohen-Mansfield, J. (1986). Agitated behaviours in the elderly II: Preliminary results in the cognitively deteriorated. *Journal of the American Geriatrics Society, 34*(10), 722-727.
Cohen-Mansfield. J., Marx, M.S., & Rosenthal, A.S. (1989). A description of agitation in a nursing home. *Journal of Gerontology, 44*, M77-M84.

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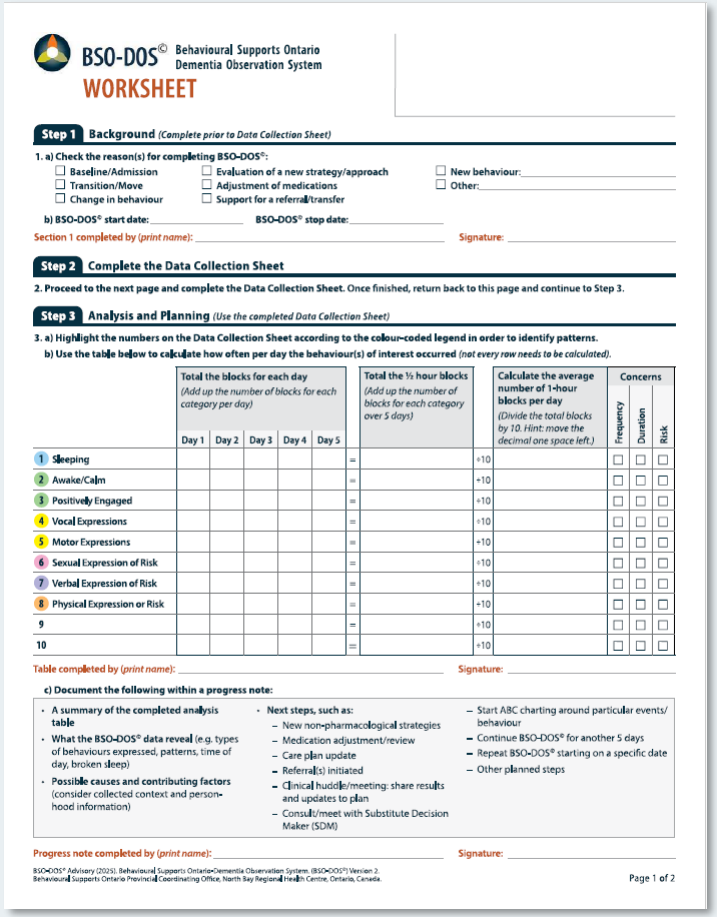
Assessment Tools

BSO-DOS Behavioral Supports Ontario: Dementia Observation System

- a standardized, direct observation tool used to collect measurable data on responsive behaviors in individuals with dementia



BSO-DOS© Behavioural Supports Ontario Dementia Observation System

WORKSHEET

Step 1 Background *(Complete prior to Data Collection Sheet)*

1. a) Check the reason(s) for completing BSO-DOS©:

☐ Baseline/Admission ☐ Evaluation of a new strategy/approach ☐ New behaviour:
☐ Transition/Move ☐ Adjustment of medications ☐ Other:
☐ Change in behaviour ☐ Support for a referral/transfer

b) BSO-DOS© start date: BSO-DOS© stop date:

Section 1 completed by (print name): Signature:

Step 2 Complete the Data Collection Sheet

2. Proceed to the next page and complete the Data Collection Sheet. Once finished, return back to this page and continue to Step 3.

Step 3 Analysis and Planning *(Use the completed Data Collection Sheet)*

3. a) Highlight the numbers on the Data Collection Sheet according to the colour-coded legend in order to identify patterns.
b) Use the table below to calculate how often per day the behaviour(s) of interest occurred *(not every row needs to be calculated)*.

	Total the blocks for each day (Add up the number of blocks for each category per day)						Total the ½ hour blocks (Add up the number of blocks for each category over 5 days)		Calculate the average number of 1-hour blocks per day (Divide the total blocks by 10. Hint: move the decimal one space left.)	Concerns		
	Day 1	Day 2	Day 3	Day 4	Day 5					Frequency	Duration	Risk
1 Sleeping						=		+10		☐	☐	☐
2 Awake/Calm						=		+10		☐	☐	☐
3 Positively Engaged						=		+10		☐	☐	☐
4 Vocal Expressions						=		+10		☐	☐	☐
5 Motor Expressions						=		+10		☐	☐	☐
6 Sexual Expression of Risk						=		+10		☐	☐	☐
7 Verbal Expression of Risk						=		+10		☐	☐	☐
8 Physical Expression or Risk						=		+10		☐	☐	☐
9						=		+10		☐	☐	☐
10						=		+10		☐	☐	☐

Table completed by (print name): Signature:

c) Document the following within a progress note:

- A summary of the completed analysis table
- What the BSO-DOS© data reveal (e.g. types of behaviours expressed, patterns, time of day, broken sleep)
- Possible causes and contributing factors (consider collected context and person-hood information)
- Next steps, such as:
  - New non-pharmacological strategies
  - Medication adjustment/review
  - Care plan update
  - Referral(s) initiated
  - Clinical huddle/meeting: share results and updates to plan
  - Consult/meet with Substitute Decision Maker (SDM)
  - Start ABC charting around particular events/behaviour
  - Continue BSO-DOS© for another 5 days
  - Repeat BSO-DOS© starting on a specific date
  - Other planned steps

Progress note completed by (print name): Signature:

BSO-DOS© Advisory (2025). Behavioural Supports Ontario-Dementia Observation System. (BSO-DOS©) Version 2. Behavioural Supports Ontario Provincial Coordinating Office, North Bay Regional Health Centre, Ontario, Canada.

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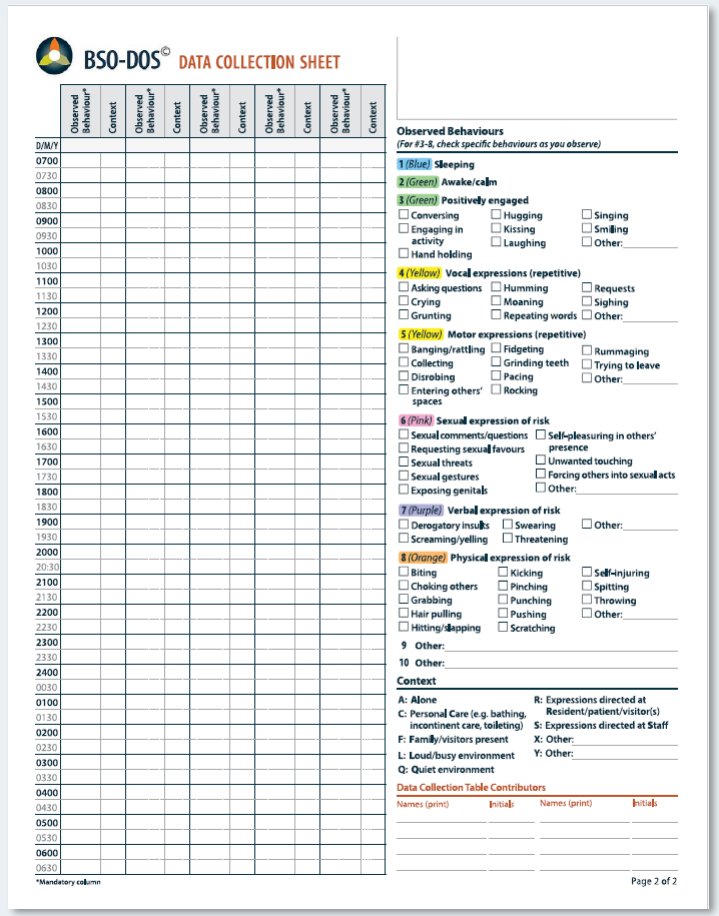

BSO-DOS© DATA COLLECTION SHEET

D/M/Y	Observed Behaviour*	Context	Observed Behaviour*	Context	Observed Behaviour*	Context	Observed Behaviour*	Context	Observed Behaviour*	Context
0700										
0730										
0800										
0830										
0900										
0930										
1000										
1030										
1100										
1130										
1200										
1230										
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0430										
0500										
0530										
0600										
0630										

*Mandatory column

Observed Behaviours
(For #3–8, check specific behaviours as you observe)

1 *(Blue)* Sleeping

2 *(Green)* Awake/calm

3 *(Green)* Positively engaged
☐ Conversing ☐ Hugging ☐ Singing
☐ Engaging in activity ☐ Kissing ☐ Smiling
☐ Laughing ☐ Other:
☐ Hand holding

4 *(Yellow)* Vocal expressions (repetitive)
☐ Asking questions ☐ Humming ☐ Requests
☐ Crying ☐ Moaning ☐ Sighing
☐ Grunting ☐ Repeating words ☐ Other:

5 *(Yellow)* Motor expressions (repetitive)
☐ Banging/rattling ☐ Fidgeting ☐ Rummaging
☐ Collecting ☐ Grinding teeth ☐ Trying to leave
☐ Disrobing ☐ Pacing ☐ Other:
☐ Entering others' spaces ☐ Rocking

6 *(Pink)* Sexual expression of risk
☐ Sexual comments/questions ☐ Self-pleasuring in others' presence
☐ Requesting sexual favours
☐ Sexual threats ☐ Unwanted touching
☐ Sexual gestures ☐ Forcing others into sexual acts
☐ Exposing genitals ☐ Other:

7 *(Purple)* Verbal expression of risk
☐ Derogatory insults ☐ Swearing ☐ Other:
☐ Screaming/yelling ☐ Threatening

8 *(Orange)* Physical expression of risk
☐ Biting ☐ Kicking ☐ Self-injuring
☐ Choking others ☐ Pinching ☐ Spitting
☐ Grabbing ☐ Punching ☐ Throwing
☐ Hair pulling ☐ Pushing ☐ Other:
☐ Hitting/slapping ☐ Scratching

9 Other:

10 Other:

Context

A: Alone
C: Personal Care (e.g. bathing, incontinent care, toileting)
F: Family/visitors present
L: Loud/busy environment
Q: Quiet environment
R: Expressions directed at Resident/patient/visitor(s)
S: Expressions directed at Staff
X: Other:
Y: Other:

Data Collection Table Contributors

Names (print)	Initials	Names (print)	Initials

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Personhood

Definition: the support, respect and trust given from one Individual to another in a caring relationship (Kitwood, 1997)

- ***Person-centred dementia*** care aims to enhance the wellbeing of Individuals living with dementia by ***meeting their psychological needs***:
  - To be valued
  - Recognized by their histories, routines, personal preferences, needs
  - Acknowledge they experience the world in a unique way
  - See social relationships as important for their wellbeing

**Recognize the difference between the Individual and their diagnosis!*

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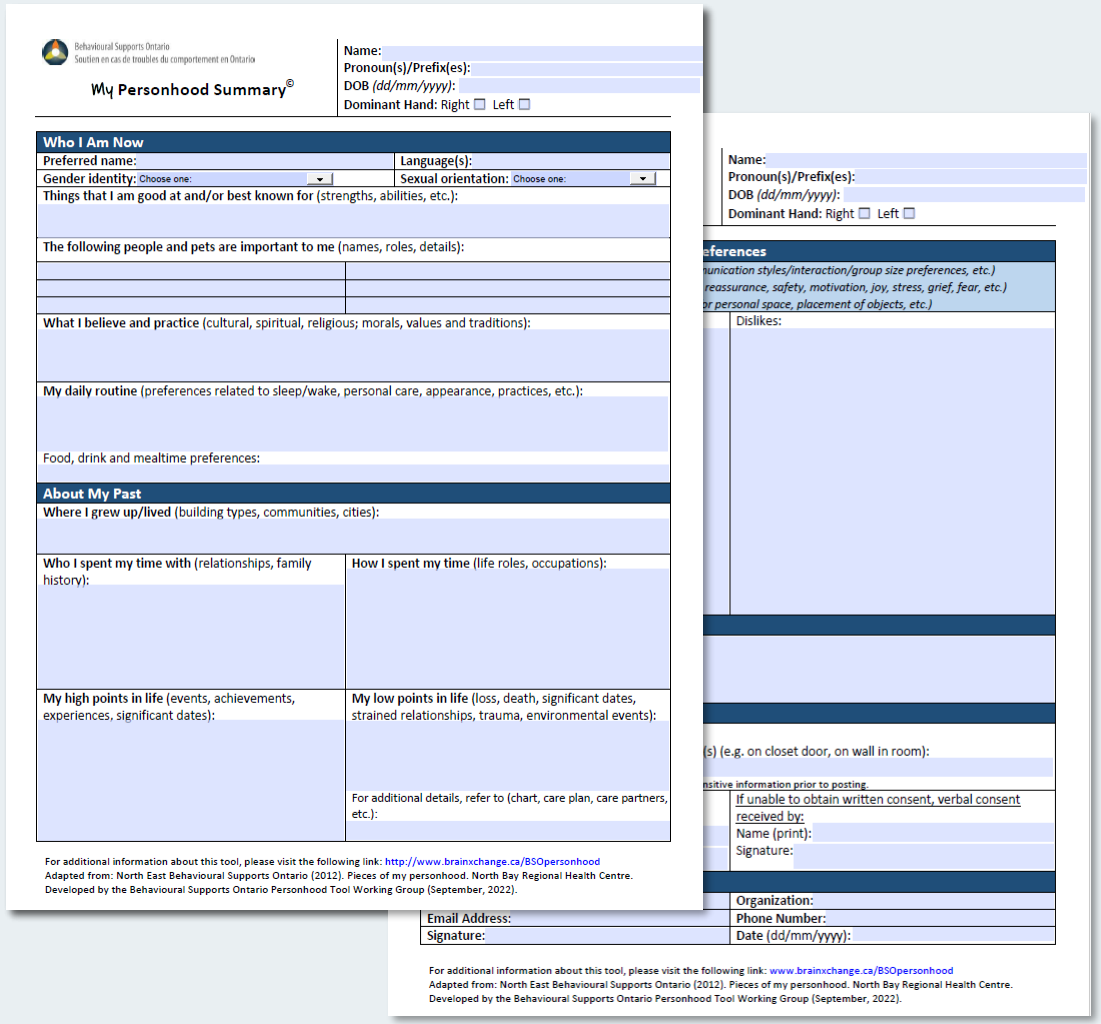
Personhood Sources

- The Individual
- Care Givers
- Family
- Friends
- Community members
- Chart
- Other care team members



Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

My Personhood Summary©

Name:
Pronoun(s)/Prefix(es):
DOB *(dd/mm/yyyy)*:
Dominant Hand: Right ☐ Left ☐

Who I Am Now

Preferred name: | **Language(s):**
Gender identity: Choose one: | **Sexual orientation:** Choose one:
Things that I am good at and/or best known for (strengths, abilities, etc.):
The following people and pets are important to me (names, roles, details):
What I believe and practice (cultural, spiritual, religious; morals, values and traditions):
My daily routine (preferences related to sleep/wake, personal care, appearance, practices, etc.):
Food, drink and mealtime preferences:

About My Past

Where I grew up/lived (building types, communities, cities):
Who I spent my time with (relationships, family history):
How I spent my time (life roles, occupations):
My high points in life (events, achievements, experiences, significant dates):
My low points in life (loss, death, significant dates, strained relationships, trauma, environmental events):
For additional details, refer to (chart, care plan, care partners, etc.):

For additional information about this tool, please visit the following link: http://www.brainxchange.ca/BSOpersonhood
Adapted from: North East Behavioural Supports Ontario (2012). Pieces of my personhood. North Bay Regional Health Centre.
Developed by the Behavioural Supports Ontario Personhood Tool Working Group (September, 2022).

Name:
Pronoun(s)/Prefix(es):
DOB *(dd/mm/yyyy)*:
Dominant Hand: Right ☐ Left ☐

eferences
unication styles/interaction/group size preferences, etc.)
reassurance, safety, motivation, joy, stress, grief, fear, etc.)
or personal space, placement of objects, etc.)

Dislikes:

(s) (e.g. on closet door, on wall in room):

nsitive information prior to posting.

If unable to obtain written consent, verbal consent received by:
Name (print):
Signature:

Organization:
Email Address: | **Phone Number:**
Signature: | **Date** (dd/mm/yyyy):

For additional information about this tool, please visit the following link: www.brainxchange.ca/BSOpersonhood
Adapted from: North East Behavioural Supports Ontario (2012). Pieces of my personhood. North Bay Regional Health Centre.
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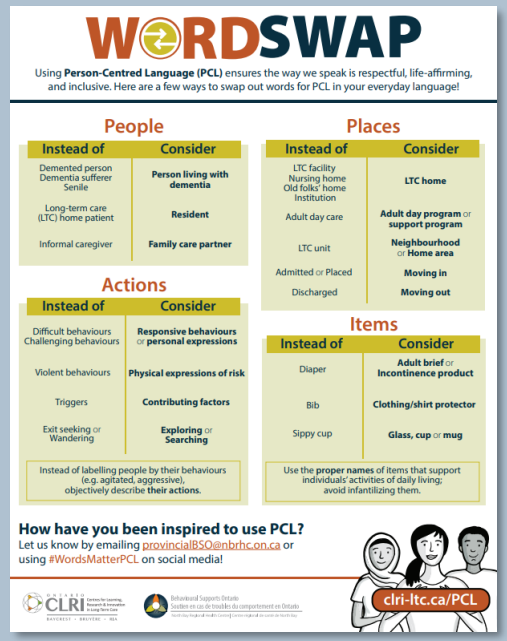
PERSON CENTRED LANGUAGE



WORDSWAP

Using **Person-Centred Language (PCL)** ensures the way we speak is respectful, life-affirming, and inclusive. Here are a few ways to swap out words for PCL in your everyday language!

People

Instead of	Consider
Demented person Dementia sufferer Senile	**Person living with dementia**
Long-term care (LTC) home patient	**Resident**
Informal caregiver	**Family care partner**

Places

Instead of	Consider
LTC facility Nursing home Old folks' home Institution	**LTC home**
Adult day care	**Adult day program** or **support program**
LTC unit	**Neighbourhood** or **Home area**
Admitted or Placed	**Moving in**
Discharged	**Moving out**

Actions

Instead of	Consider
Difficult behaviours Challenging behaviours	**Responsive behaviours** or **personal expressions**
Violent behaviours	**Physical expressions of risk**
Triggers	**Contributing factors**
Exit seeking or Wandering	**Exploring** or **Searching**

Instead of labelling people by their behaviours (e.g. agitated, aggressive), objectively describe **their actions**.

Items

Instead of	Consider
Diaper	**Adult brief** or **Incontinence product**
Bib	**Clothing/shirt protector**
Sippy cup	**Glass, cup** or **mug**

Use the **proper names** of items that support individuals' activities of daily living; avoid infantilizing them.

How have you been inspired to use PCL?
Let us know by emailing provincialBSO@nbrhc.on.ca or using #WordsMatterPCL on social media!

clri-ltc.ca/PCL

- Person-Centred Language refers to using language that puts the ***Individual first*** rather than the disease

- It is demonstrates respect, dignity, thoughtfulness by ***focusing on strengths and abilities*** in a respectful, life-affirming, and inclusive manner

Specific → **Objective** → **Respectful**

Non-Pharmacological Interventions

Non-pharmacological interventions are ***non-drug related strategies*** for managing BPSD

Goal: to improve or maintain an Individual's cognitive function, allow individuals to perform usual activities of daily living (to the extent they can safely and effectively), and address behavioral symptoms

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Non-Pharmacological Intervention Strategies

- ***All behavior has meaning!***
- Consider the PIECES realms (Physical, Intellectual, Emotional, Capabilities, Environment, and Social)
- Demonstrate unconditional positive regard
- Avoid conflict
- Emphasize non-verbal communication (smile)
- STOP and Go (Stop > Think > Observe > Plan)
- Give undivided attention-catch the clues
- Connect don't correct, validate instead of orientating-meet them where they are
- Doing nothing is having a plan!
- Validate-support emotions/feelings – 'you look upset'
- Collaborate-work with the Individual and the team
- Facilitate-set them up for success
- Have fun-encourage spontaneity
- Relax-avoid making intellectual demands
- Focus on de-escalation-remain calm
- Provide consistency/routine
- Don't rush
- Maintain meaning and purpose
- Simplify choice, offer 2 options and use visual clues where possible
- Help start activities that they can then take over and continue

Consider hands-on interventions only as a last resort to address significant imminent risk!

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General Approach Tips

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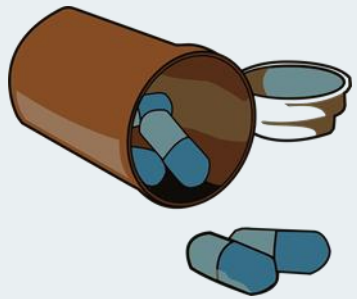
Pharmacological Interventions

- Pharmacological interventions for (BPSD) involve the use of meditations, drug classes may include:

  - *Antidepressants*
  - *Cholinesterase inhibitors* and N-methyl-D-aspartate *(NMDA) receptor antagonists*
  - *Analgesics*
  - *Antipsychotics**



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Pharmacological Considerations

- **Atypical Antipsychotics:**
  - *severe agitation or psychosis*
  - *associated with an increased risk of death and stroke*
  - *monitored carefully for adverse events*

There is little or no evidence to support the use of benzodiazepines or other hypnotics in the treatment of bpsd!

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Extrapyramidal Side Effects (EPSE)

Side Effect	Onset
Acute dystonia: Involuntary muscular contraction which results in abnormal posture or movement. Typically involve muscles of the head and neck. Painful, needs treatment.	Hours to 5 days
Parkinsonism: Slow movements (shuffling gait, soft/weak voice), mask-like expression, tremor, rigidity, drooling, constipation	Few days but may emerge slowly over several weeks.
Akathisia: sensation of inner restlessness, a compulsion to keep moving, irritability, agitation	5-60 days
Tardive Dyskinesia: Involuntary movements such as lip smacking, tongue protrusion or pushing and other facial muscle movements	Months to years

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Pharmacological Intervention Guidelines

- Document ***informed consent***
- Review ***risks verses benefits***
- Consider ***consequences*** of treating verses not treating
- Consider ***kidney and liver function***
- Start with ***one medication at a time***
- ***Start low, go slow***
- ***Monitor*** for adverse side effects and drug-drug interactions
- ***Optimize*** dose, frequency, and target administration times
- Regularly ***reassess need for continued use***

***PRNs to Address Acuity:**

1st line: Trazodone (mood, anxiety, and insomnia)

2nd line: Risperidone, Olanzapine, Quetiapine (oral antipsychotics)

3rd line: Loxapine (injectable antipsychotics)

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BPSD and Responsive Behaviors that May Respond to Pharmacological Interventions

- Anxiety
- Depressive symptoms
- Withdrawal
- Mood dysregulation
- Delusions
- Hallucinations

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Behaviors that are Unlikely to Respond to Pharmacological Interventions

- Purposeless/repetitive motor and verbal behaviors
- Resistance to care
- Sexually disinhibited behaviours with agitation
- Socially inappropriate dressing/undressing
- Home seeking, wandering, unintentional intrusiveness
- Inappropriate urination/defecation
- Hiding/collecting
- Eating inedible items
- Pushing others in wheelchairs

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Support and resources

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Support – Self compassion (for all!)

- Encourage self-compassion! Acknowledge it's ok to feel concern, pity, or even sorrow for one's suffering but, it is important to remain motivated to act in ways to alleviate suffering. We are often tasked with not only supporting the Individual living with dementia but, also their Care Givers, other Healthcare Professionals and ourselves!

Supportive Techniques:

- Practicing Mindfulness
- Identifying positive coping methods through self care
- Acknowledging gratitude
- Reaching out for help

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Care Giver Support – Respite

- **Respite:**
  - ***Ontario Health at Home*** provides home care and facilitates access to community support services as well as long-term care home placement services and information about, and referrals to, other providers of health and social services
  - ***South-East Ottawa Community Health Centre (SEOCHC)*** is a non-profit, community-governed organization that provides comprehensive healthcare services including: primary care, health promotion, social services, community and resource development, home support and advocacy
  - ***Adult day programs (ADP)*** provide part-day supervised activities in a group setting for dependent adults, such as the frail elderly, or Individuals with Alzheimer's disease
  - ***Short stay accommodations*** that may include substitute living arrangements in a supported environment
  - ***Retirement home accommodation*** (early stages) for Individuals and their Care Givers
  - ***Private Healthcare support services*** for at home or long term care facilities

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Care Giver Support – Community Resources

- ***Community Resources:***
  - The ***Dementia Society*** of Ottawa and Renfrew County
  - ***Alzheimer Society*** of Ontario
  - ***Community Support Services (CSS)*** - supports older adults, seniors and adults with disabilities with the goal of supporting individuals to remain safe, independent and healthy at home
  - ***Meals on Wheels***/La Popote roulante
  - -***Heart to Home Meals***
  - ***Community Centres*** (ie. Somerset West Community Health Centre, Centretown Community Health Centre) for and social groups, fitness and exercise programs

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Support – Educational Opportunities & Online Resources

- **Resources:**
  - Behavioral Supports Ontario (BSO)*
  - brainXchange
  - DementiAbility
  - Gentle Persuasive Approaches (GPA®)
  - iGeriCare
  - Pieces Canada
  - Teepa Snow's Positive Approach to Care
  - U-First!

AGE

Capabilities, Physical, Environment, Social, Emotional, Intellectual

Positive Approach to Care®

iGeriCare

www.DEMENTIABILITY.com DEMENTIABILITY Changing the face of dementia...one step at a time.

U-First!®

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario
Provincial Website / Site-Web Provincial

brainXchange

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Care Giver Support – Healthcare Professionals

- **Multi-disciplinary Supports:**
  - Primary Care Providers (PCPs) – Physician or Nurse Practitioner
  - Geriatric Consult teams (Geriatricians, Nurses)
  - Geriatric Psychiatry teams (Psychiatrists, Geriatric Psychiatry Nurses, Behavioral Therapists)
  - Behavioral Supports Ontario Champions (PSWs, Registered Nurses)
  - Occupational Therapists
  - Physiotherapists
  - Dieticians
  - Recreational Therapists
  - Social Workers
  - Spiritual Supports
  - Personal Support Workers
  - Clinical Directors

-Gerontologists
-Pharmacists
-Nurse Educators
Care Coordinators
Community Health Organizations
Dementia Care Coaches
Rehabilitation Assistants
Community Health Workers
Program Managers
-Speech Language Pathologists

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Care Giver Support – Acute Care

- ***Geriatric Psychiatry and Community Services of Ottawa (GPCSO)*** - a fully bilingual geriatric psychiatry program (Psychiatric Consultations, Case Management and Supervised Groups) working with older adults to optimize their mental health and/or dementias with challenging behaviours

- ***Regional Geriatric Program of Eastern Ontario (RGPEO)*** - Geriatric Emergency Management (GEM) program Nurses have special training in working with older adults over 65 years of age who go to the Emergency Department if they have been identified with special concerns; they can make recommendations for support at home, follow-up with specialists or to the Geriatric Assessment Outreach Team as needed

- ***Royal Ottawa Health Care Group (ROH) Geriatric Psychiatry*** – provides a range of services to meet the mental health needs of adults 65 years of age and over including Day Hospital, Outreach & behavioral support to LTC, Outpatient, Inpatient; working with families, primary care physicians, community psychiatrists and community agencies, staff help individuals improve their quality of life and achieve optimal level of functioning

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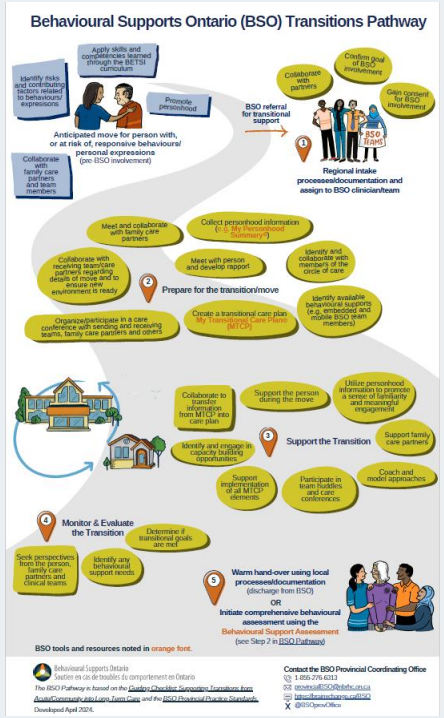
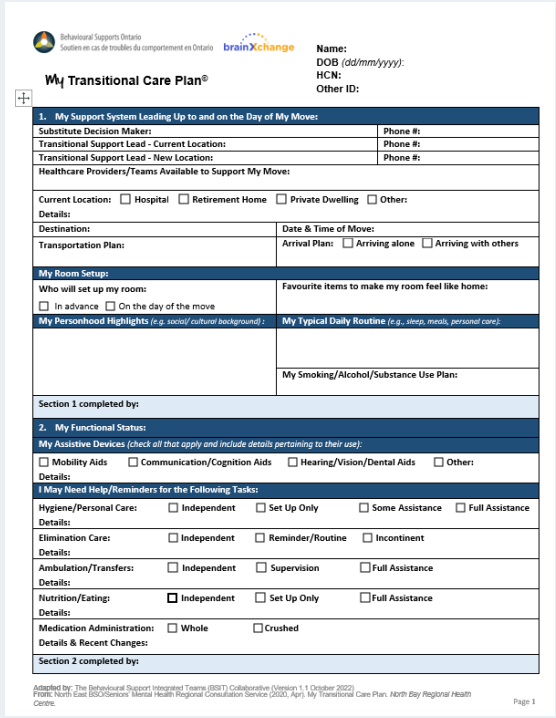
Care Giver Support – Acute Care

- ***Montfort Hospital*** - A bilingual multidisciplinary Specialized Geriatrics Clinic is held once a week (Individuals attend 1 – 3 sessions for a full Geriatric workup by a Geriatrician and other multidisciplinary staff as appropriate)



- ***Behavioral Supports Ontario Nursing support teams*** in **acute** and **long-term care** - members with enhanced experience, education and training who provide behavioural health care services for older adults in Ontario with, or at risk of, responsive behaviours/personal expressions associated with dementia, complex mental health, substance use and/or other neurological conditions who also facilitate transitions through healthcare pathways



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End of life

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End of Life - Timelines

- Dementia is ***progressive*** and ***life limiting*** due to the effects of the disease process

- ***Individual lifespans vary*** depending on a number of factors including: length of illness, care supports in place, acute/chronic medical issues, safety/risk reduction strategies, stage of dementia

- Common ***late stage dementia signs may include***: limited speech to totally non-verbal, limited cognition/understanding, total dependence for activities of daily living (ADLs), decreased oral intake/swallowing difficulties, bowel/bladder incontinence, limited or loss of weight bearing/ambulation abilities

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End of Life – The Healthcare Professional's Role

As Healthcare Professionals how can we help prepare Individuals and their Care Givers for end of life?

- Continuing professional education
- Helping educate and support Individuals' and Care Givers
- Focusing on enhancing comfort and reducing pain
- Addressing potential unmet needs
- Advocating for individuals
- Supporting Care Givers

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End of Life – When Do We Talk About it?

- **Opportunities to discuss end of life care planning:**
  - With initial diagnosis (Primary Care Providers)
  - Acute care visits-Emergency department or medical admissions to hospital
  - Admission to communal living facilities (retirement homes)
  - Admission to assisted living facilities (long-term care homes)

- **With whom to discuss end of life care planning?**
  - Individual (person centred care approach)
  - Others identified by Individuals as Care Givers
  - SDMs/POAs for health

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