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RGP of Toronto Network Webinar

The Evolution of Person-Centred Language with Responsive Behaviours in the TAHSN Community

February 22 2018

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Trillium Health Partners
Objectives:

• Describe the impact of language on patient care

• Introduce the Toronto Academic Health Sciences Network Community of Practice (TAHSN CoP), Person-Centred Language for Responsive Behaviour Document

• Identify how the document can be used and the potential impact on patient care

• Discuss possible alignments with quality improvement initiatives across care facilities
The Power of Words

- Words cannot change reality, but they can change how people perceive reality. Words create filters through which people view the world around them.

(Schafer, John R. 2010)
Think about this........

• Have you ever had a friend describe a person you are about to meet for the first time as... “untrustworthy” and you became predisposed to view that person as “untrustworthy” regardless of the person's actual level of trustworthiness?

• The single word "untrustworthy" creates a filter, or primacy effect, that predisposes you to view the person you are about to meet as untrustworthy.

  John R. “Jack” Schafer, Ph.Dhttps://www.psychologytoday.com/experts/jack-schafer-phd
This happens in care situations as well!

Thoughts

Words

Perceptions

Actions
Think about what may be happening in this scenario. What “word” has often been used to describe this situation?
How would you describe what this woman is doing?
How would you describe this?
In our care environments:

• Care providers often use the terms “aggressive”, “difficult”, and “challenging” when they encounter a person presenting with the symptoms of disturbed perception, thought content, mood or psychomotor behaviour.
The language we use...

- Language such as this contributes to a culture of labelling and blame, often impeding the development of a supportive and caring relationship between the person and his/her caregiver.
The Consequences ....

- Once this kind of language is used to describe a patient’s behaviour it tends to label the patient and perpetuate a trajectory of negative consequences during hospitalization and discharge.
The Consequences ….

Care providers talk and think about “things” to be “managed” instead of people to be understood.
What do we mean by that?

- Let’s consider the case of Ms. Sharp
Ms. Sharp

- 84 year old female, living alone in a bungalow
- Neighbours called 911 because they saw her wandering around the streets, without a coat or hat, in the middle of January
- Her home was unclean, there was spoiled food in the refrigerator, and there were piles of garbage in the kitchen
- She was confused and agitated
- EMS were concerned and took her to hospital
Mrs. Sharp..... continued

• EMS notes read that she was “aggressive and combative” when they assessed her

• She resisted getting into the ambulance and kicked the EMS crew

• On arrival to ED, she was screaming, kicking and attempting to bite one of the EMS crew and triage nurse

• She was given Haldol 2mg and put in restraints
Ms. Sharp.....continued

• Past medical history: hypertension, TIA x2, atrial fibrillation, osteoarthritis, and mild dementia

• Unclear if she has been taking her medications as ordered

• Examination and work-up in ED reveals rapid atrial fibrillation (HR 152), hypertension (BP 160/90), fever (38.2). Diffuse joint pain.

• She was confused, agitated, resistant to examination
Ms. Sharp.....continued

• Admitted with rapid atrial fibrillation and delirium.

• Inpatient unit: “confused” and “uncooperative with care”
Ms. Sharp.....continued

• On in-patient unit, she was refusing to take medications (thought she was being poisoned)

• Would not let staff perform personal care; 4 staff needed to perform personal care successfully

• Swung her cane at staff, kicked and hit nurses, shouted profanities
Course in hospital

- Described as “aggressive” and “combative”
- Scheduled Haldol ordered; PRN Haldol ordered
- Geriatric medicine and psychiatry consults ordered
- By day 14, medically stable: atrial fibrillation controlled, OA pain controlled, delirium resolving
But...

- Significant deconditioning: as result of time spent in restraints and inconsistent participation with PT
- Team felt she would benefit with admission to Slow Stream Rehab, to regain function and hopefully be able to return home some day
Declined........

- Declined by 3 slow stream rehab facilities due to documented behaviours:
  - “aggressive”
  - “combative”

- Remained in acute care hospital for six more weeks

- Discharged to a Nursing Care home
How could this have been different?

What role did language play?

What needs to change?
Toronto Academic Health Science Network
Senior Friendly Community of Practice

• Consortium of the University of Toronto and its affiliated academic hospitals

• Develop collaborative initiatives that optimize, advance, and sustain a shared academic mission of high quality patient care delivery, education, knowledge transfer, and research innovation

• As a community we had a common need to enhance practice with responsive behaviours across sites>Language became a natural place to start

• Development of a working group
Responsive Behaviours are Common

• Between 35% to 90% of people with dementia will experience a responsive behaviour at some point

• Common in delirium, for both cognitively intact and cognitively impaired persons

• Delirium can exaggerate responsive behaviours of dementia

• May have more than one responsive behaviour at a time

• More common, and often more severe, among those in long term care or in hospital

(Devshi, Shaw & Elliot-King, 2015
Cerejeira, Lagarto, Mukaetova-Ladinska, 2012
Hasegawa, et al., 2013
Marcantonio, 2017)
Person Centred Language

- Responsive Behaviours working group created Person Centred Language for Responsive Behaviours document
• Describes person-centred language for physical and/or verbal responsive behaviours

• Applicable to diagnoses beyond dementia across the healthcare continuum

• Case examples demonstrate person centered documentation and guide practical application of the key principles
Key Concepts: Responsive Behaviour

• Actions, words and gestures are a response to something important to the person

• All personal expressions (words, gestures, actions) have meaning

• Behaviours are a means of communicating needs and concerns
Responsive Behaviour:

• Look past pathology and look for the root cause of the behaviour

• Try to create a comprehensive understanding of the person and his/her expressions

• Language must be specific and objective in order to facilitate understanding and appropriate care planning
How we talk about responsive behaviours matters!!

- Impact of our language (written and spoken) when describing responsive behaviours is widely felt
  - For the person with dementia, it can be demoralizing and dehumanizing, creating a negative label
  - For the family of the person with dementia, it can also be insulting and upsetting
  - For the care team, it colours our expectations and interpretations of that person and their behaviour
## Person Centred Language: Physically responsive behaviours

<table>
<thead>
<tr>
<th>Language to avoid</th>
<th>Definition or context</th>
<th>Examples of Preferred Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restless</td>
<td>Tendency of body/parts of the body to be continuously moving (e.g. fidgeting, blinking, tapping, rocking back and forth, pacing)</td>
<td>“person walking around room, does not sit down”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“person does not appear calm when sitting in chair”</td>
</tr>
<tr>
<td>Inappropriate Behaviour (when used to describe disrobing)</td>
<td>The person may take off some/all of their clothes in public view Possible reasons may include: uncomfortable clothing; elimination needs; preparing for a nap</td>
<td>“person unbuttons blouse in dining room”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“person unzips pants when walking by hallway bathroom”</td>
</tr>
<tr>
<td>Exit Seeker Flight Risk</td>
<td>Person expresses verbally or demonstrates through actions that they want/need to be elsewhere</td>
<td>“person trying to leave floor - needs to go home to walk the dog or has an appointment to get to”</td>
</tr>
</tbody>
</table>
Person Centred Language: Verbally Responsive Behaviours

<table>
<thead>
<tr>
<th>Language to Avoid</th>
<th>Definition or context</th>
<th>Examples of Preferred Language</th>
</tr>
</thead>
</table>
| Screamer Disruptive | Frequent calling out in a loud tone  
Rpetitive requests for help  
Non-verbal: repetitive vocalizations that may be loud or escalating in tone | “person repeatedly calling out spouse’s name loudly during morning care”  
“person repeating sounds loudly while sitting in chair” |
Potential Applications in the TAHSN Community

Communication

• Guide for verbal and written communication at transitions of care (i.e. Inpatient to rehab)
• Encourage appropriate language in face-to-face discussions
• Provide language for documentation practices and processes

Education

• Influence education at orientation for physicians, staff, students and volunteers
• Facilitate the use of person-centred language in educational modalities
• In academic institutions as resource for verbal and written communication when training healthcare professionals
Potential Applications in the TAHSN Community

Care

• Create targeted care plans for clients
• Facilitate clear evaluation of care strategies

Organizational Capacity

• Assist human resources personnel with assessment of sensitivity to senior friendly strategies and approaches amongst potential applicants
• Influence policy development (i.e. Constant Care)
• Influence development of documentation tools, templates
Impact of Person Centred Language

↑ Patient and family satisfaction

↑ in staff perceptions of personhood

↑ in targeted care planning

↓ use of pharmacological interventions for responsive behaviours

↓ in violent incidents with staff and patients

Change in discharge destination

↓ in violent incidents with staff and patients

Patient and family satisfaction

↑ in staff perceptions of personhood

↑ in targeted care planning

↓ use of pharmacological interventions for responsive behaviours

↓ in violent incidents with staff and patients

Change in discharge destination

↑ in staff perceptions of personhood

↑ in targeted care planning

↓ use of pharmacological interventions for responsive behaviours

↓ in violent incidents with staff and patients

Change in discharge destination
Imagine........

- How we might describe delirium...
- How we might describe behaviours of dementia...
- How we might monitor patient progress with behavioural interventions...
- How we might describe patient progress with de-escalation after a Code White or use of restraints...
Ms. Sharp revisited......

• EMS reports that on arrival “she was attempting to strike out at the paramedics when they tried to restrain her in the ambulance”

• ED documentation revealed she was “not able to lie still in bed” and “tried to push staff away when they attempted to take vital signs”

• ED physician on call felt that physical restraints were not indicated as there were no acute safety concerns and upon assessment Ms. Sharpe was verbally re-directable.
Ms. Sharp revisited....

Documentation on in-patient unit states:

• “not oriented to person, place or time”

• “had difficulty following one step cues when there was a lot of noise in the room”

• “tried to push the caregiver away intermittently with attempts to administer medications or provide peri-care”
As a consequence how did the team manage Ms. Sharp’s behaviours?

• Turned off the TV when providing instructions
• Closed the curtain to↓ distractions
• Explained what they were wanting to do prior to initiating the task and ensured she understood
• Involved her with her care
• Kept the conversation positive “Told her what she could do to help and not what she couldn’t do”
• Used music for relaxation and distraction when needed
• When required returned at another time to provide care
Ms. Sharpe revisited.....

- Medically stable by Day 4
- Intermittently participated with Physiotherapy and Occupational therapy
- Close to her functional baseline
- Transferred to an inpatient rehabilitation facility
- Discharged home with increased community supports 3 weeks later
Implementation in our TAHSN community

• Developing an implementation and evaluation plan along with teaching resources that can be shared across sites.

• Collaborating with other community partners who share our passion for person centered approaches in understanding and describing responsive behaviours.
BSO Non-Stigmatizing Language: Dementia Focus

• Project stemming from the BSO Knowledge Translation and Communications Advisory

• Co-leads are Kate Ducak (Research Institute for Aging) and Gagan Gill (Alzheimer Society of Ontario) with Tina Kalviainen as the BSO Provincial Coordinating Office’s lead collaborator.

• There are over 25 members on the expert panel, including those with lived experience.
• Currently in the process of shaping Guiding Principles.

• Consideration is also being given to various knowledge to practice strategies that will support putting into practice the use of non-stigmatizing language.

• Should you wish to be kept informed of the release of a final document, please consider subscribing to the BSO Provincial Pulse eNewsletter.

• Please visit: http://brainxchange.ca/bsopnewsletter.aspx and provide your contact information and click “Subscribe Now”.
How have we operationalized person centered language at Trillium Health Partners?

• Integration into:
  – Policies: restraint minimization, constant care policy, delirium
  – Education: Person Centred Language workshop, Delirium Day, Orientation, presentation during Seniors Month
  – Forms: Behaviour Observation log
  – Corporate initiatives: Senior Strategy, Medical Psychiatry Alliance

• Shared with our local LHIN
# Behaviour Observation Log

Encourages assessment of patterns, triggers, successful strategies

<table>
<thead>
<tr>
<th>Patient Behaviour (PB)</th>
<th>Code</th>
<th>Action Taken (AT)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping in Bed</td>
<td>1</td>
<td>Comfort</td>
<td>A</td>
</tr>
<tr>
<td>Sleeping in Chair</td>
<td>2</td>
<td>Interpreter</td>
<td>B</td>
</tr>
<tr>
<td>Awake/Calm</td>
<td>3</td>
<td>Re-orientation</td>
<td>C</td>
</tr>
<tr>
<td>Climbing</td>
<td>4</td>
<td>Snack/hydration</td>
<td>D</td>
</tr>
<tr>
<td>Restless</td>
<td>5</td>
<td>PRN Meds for Restlessness</td>
<td>E</td>
</tr>
<tr>
<td>Wandering/pacing</td>
<td>6</td>
<td>PRN Meds for Pain</td>
<td>F</td>
</tr>
<tr>
<td>Physically Responsive Behaviour</td>
<td>7</td>
<td>Distraction (TV/magazine)</td>
<td>G</td>
</tr>
<tr>
<td>Verbally Responsive Behaviour</td>
<td>8</td>
<td>Up for Walk</td>
<td>H</td>
</tr>
<tr>
<td>Trying to Leave the Unit</td>
<td>9</td>
<td>Repositioned</td>
<td>I</td>
</tr>
<tr>
<td>Pulling at Lines/Tubes</td>
<td>10</td>
<td>Family Visiting</td>
<td>J</td>
</tr>
<tr>
<td>Other (document in progress note)</td>
<td>11</td>
<td>Toileting</td>
<td>K</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other (document in progress note)</td>
<td>L</td>
</tr>
</tbody>
</table>
Senior Friendly

E-Learning Modules

Delirium

Responsive Behaviours

Dementia
Dialogue

• How would you put this into practice at your institution to generate improvement in care and service?

• How could you measure it’s effectiveness?
# Working Group Members and Acknowledgements

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<td>St. Michael’s Hospital</td>
</tr>
<tr>
<td>Katherine Reece</td>
<td>Occupational Therapist</td>
<td>University Health Network</td>
</tr>
<tr>
<td>Christopher Uranis</td>
<td>Advanced Practice Nurse</td>
<td>Centre for Addiction and Mental Health</td>
</tr>
<tr>
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</tr>
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<td>Nicole Spira</td>
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<td>Micheal Garron Hospital</td>
</tr>
<tr>
<td>Leanne Ginty</td>
<td>Clinical Nurse Specialist</td>
<td>Sinai Health System</td>
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</table>
References


• Schafer, John R. (2010, November 2). Words Have Power [blog post]. https://www.psychologytoday.com/blog/let-their-words-do-the-talking/201011/words-have-power
Questions and Discussion......
Thank you for attending this webinar!

You will receive a quick evaluation survey by email – please share your suggestions and topics for future sessions. A link to presentation slides and a recording will be provided.

Please mark your calendars to join our next webinar presentations:

**February 27 2018, 12-1pm**

*Geriatric Care at the Intersection of Medicine and Architecture*

Dr. Diana Anderson, MD, MArch
Healthcare Architect

**March 13 2018, 12-1pm**

*World Delirium Awareness Day – Update on Delirium Screening and Detection*

Dr. Niamh O’Regan, MB BCh BAO, BMed Sci, MRCPI, PhD
Assistant Professor, Geriatric Medicine, Schulich School of Medicine and Dentistry, Western University

If you have additional questions, contact ken.wong@sunnybrook.ca

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