Dementia:

Understanding Risks and Preventing Violence

NOTE: Videos 5 and 6 in the *Working With Dementia* video series referenced on page 2 are no longer available, effective May 2022.

WORKSAFEBC

About WorkSafeBC

At WorkSafeBC, we're dedicated to promoting safe and healthy workplaces across B.C. We partner with workers and employers to save lives and prevent injury, disease, and disability. When work-related injuries or diseases occur, we provide compensation and support injured workers in their recovery, rehabilitation, and safe return to work. We also provide no-fault insurance and work diligently to sustain our workers' compensation system for today and future generations. We're honoured to serve the workers and employers in our province.

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We provide information and assistance with health and safety issues in the workplace.

Call the information line 24 hours a day, 7 days a week to report unsafe working conditions, a serious incident, or a major chemical release. Your call can be made anonymously. We can provide assistance in almost any language.

If you have questions about workplace health and safety or the Occupational Health and Safety Regulation, call during our office hours (8:05 a.m. to 4:30 p.m.) to speak to a WorkSafeBC officer.

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WORK SAFE BC

Health and safety resources

You can find our health and safety resources on worksafebc.com, and many of them can be ordered from the WorkSafeBC Store at worksafebcstore.com.

In addition to books, you'll find other types of resources at the WorkSafeBC Store, including DVDs, posters, and brochures. If you have any questions about placing an order online, please contact a customer service representative at 604.232.9704, or toll-free at 1.866.319.9704.

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Contents

About this book

The purpose of this book is to provide some understanding of how clinical care approaches and interventions can prevent or minimize the risk of injury to workers when caring for people with dementia. It also provides the framework for how to incorporate the Occupational Health and Safety Regulation (the Regulation) into clinical care to help eliminate or minimize the risk of worker exposure to violence.

Note

It is important to note that the Regulation definition of violence does not require the consideration of intent to harm. This means that any physical or verbal aggressive behaviour directed toward caregivers by people with dementia is considered to be an act of violence.

People with dementia eventually experience significant cognitive losses. They may not be able to verbally communicate their physical or emotional discomforts, so they express their needs and emotions through behaviours. These behaviours, often referred to as *response behaviours*, are defined as either physical or verbal non-aggression or physical or verbal aggression. Examples of physical or verbal aggressive response behaviours include hitting, grabbing, or swearing, and these behaviours present a risk of injury to caregivers.

In residential care, being struck or grabbed is the second most common cause of occupational injury after overexertion. In British Columbia, this accounts for more than 1,000 time-loss claims per year — many of which are related to caring for people with dementia.

How this book is organized

This book is organized in two parts.

Part 1: Clinical care approaches and interventions includes a brief overview of dementia, common causes of aggressive response behaviour, and suggested interventions to minimize or manage aggressive response behaviour.

Part 2: Incorporating the Occupational Health and Safety Regulation into clinical care defines the regulatory requirements for violence prevention measures and describes how these requirements can be integrated into clinical care.

This publication does not prescribe clinical practice.

The use of the word *violent* to describe behaviours of people with dementia is often extremely difficult for many caregivers to accept. These professionals understand that the response behaviours of people with dementia are expressions of unmet needs — not overt attempts to hurt others.

Note

Throughout this book, you will find excerpts from the Occupational Health and Safety Regulation that describe the specific requirements that relate to the information presented in this book. It's important to remember that this book does not replace the Regulation.

Yet, the Regulation specifically refers to violence, defining it as “the attempted or actual exercise by a person, other than a worker, of any physical force so as to cause injury to a worker, and includes any threatening statement or behaviour which gives a worker reasonable cause to believe that he or she is at risk of injury.”

Other terms, such as *excessive* or *threatening behaviour,* may also be used in clinical practice to describe actions by people with dementia that are considered violence under the Regulation.

No matter what term is used, employers are required to put in place measures to eliminate or minimize any risk to workers of physical or verbal aggression.

Related video

Working with Dementia:
Safe Work Practices for Caregivers

WorkSafeBC has produced a video called *Working With Dementia: Safe Work Practices for Caregivers*. The video’s six modules describe how to care for people with dementia.

The introductory module provides general information on dementia. The remaining modules use enactments to portray situations that caregivers may encounter when caring for a person with dementia. They show caregivers how to respond to similar situations in order to stay safe and support the person with dementia. The modules are available for streaming or downloading at no charge at worksafebc.com. The DVD may be purchased at worksafebcstore.com.

Who this book is for

This book is intended for employers, supervisors, and workers who care for people with dementia. Educators of future health care workers can also use it to prepare their students for some of the challenges they will face while working in health care. This book may also be helpful for people who are caring for a family member with dementia.

Part 1: Clinical care approaches and interventions

Understanding dementia

Dementia is a condition marked by declines in reasoning, memory, and other mental abilities. These declines eventually impair the ability to carry out everyday activities, including bathing, dressing, and eating.

Although dementia is most common in elderly people, it is not a normal part of aging. Dementia is caused by a number of underlying medical conditions that can occur in adults of any age. Alzheimer's disease is the most common cause of dementia, accounting for more than 50% of all cases. Vascular dementia is the second leading cause, accounting for 20–30% of all cases. Other diseases associated with dementia include Parkinson's disease and Huntington's disease.

About 10% of people older than 65 and 30% of people older than 85 develop dementia. Estimates by the Alzheimer Society of B.C. suggest that more than 70,000 people in B.C. live with some form of dementia. Based on current trends, this number is expected to exceed 175,000 by 2038.

People with dementia eventually experience declines in all areas of intellectual functioning. These declines include the loss of:

- Language and comprehension
- Awareness of what is going on around them
- The ability to reason, solve problems, and think abstractly

Because of these losses, people with dementia may not be able to verbally communicate their physical or emotional discomfort, so they may express their needs and emotions through behaviours.

As dementia progresses, lost abilities and mental and physical changes may lead to some behaviours that are described in this section. These behaviours may indicate an increased risk of aggression.

Alzheimer's disease

As mentioned earlier, Alzheimer's disease is the most common cause of dementia. Most people with Alzheimer's disease typically move through relatively predictable stages of cognitive and physical changes and losses that pose differing challenges to caregivers.

Early stage

In most instances, dementia is diagnosed in the early phase and may be called mild cognitive impairment. People with early-stage Alzheimer's disease typically have trouble remembering words or names, information from articles or stories read recently, and names of people met recently. They misplace or lose objects and have difficulty planning. Family, friends, and colleagues often notice a change in their performance at work and in social settings.

Limitations

People with early-stage dementia may have difficulty:

- Recalling recent incidents or current events, and finding correct words
- Following directions, and may become lost as a result
- Completing complex tasks such as organizing a party or planning a dinner
- Functioning in challenging situations, and may remain socially withdrawn

People at this stage of cognitive decline may be looked after by family in their homes or may reside in assisted-living facilities.

Middle stage

This stage is marked by significant losses in language ability and memory. While people generally retain essential knowledge (for example, they know their own name and that of their spouse or children) and have years of history and experience that they draw upon to try and make sense of their environment, they begin to decline in other ways. They may not recognize familiar objects and may have trouble recognizing some people. They may also have trouble finding words and may often repeat questions.

Limitations

People with middle-stage dementia sometimes have difficulty:
- Recalling their current address or telephone number
- Recalling details of their personal history and identifying family and friends
- Identifying their current location, the time, day of the week, or season
- Initiating and following through on ideas
- Choosing appropriate clothing for a particular season or occasion without help
- Performing activities of daily living
- Focusing on and tracking moving objects
- Distinguishing between objects of similar colour
- Reading books or newspapers, especially long paragraphs

Throughout the middle stage, memory loss continues to worsen, substantial personality changes may occur, and the person requires considerable assistance with day-to-day activities. Alzheimer's disease also impacts physical abilities. People with later middle-stage dementia may experience:
- Problems starting and completing movements (for example, they may not be able to lift a fork to eat without seeing someone else demonstrate this first)
- Changes in appetite
- Changes in sleep/wake patterns

At this point, the person's care needs often exceed the resources and abilities of the family and community, and the person is usually moved into a residential care facility.

Late stage

At this stage, people lose the ability to respond overtly to their environment, communicate verbally, and control movements, and they appear withdrawn. They may not recognize loved ones and gradually lose the ability to walk without support, sit, use facial expressions, or hold their head up. Their muscles become rigid, their reflexes become abnormal, and their swallowing is impaired. People may be unaware of their surroundings and the presence of others. When verbal abilities are lost, people rely on more basic methods of communication, particularly touch. If pain is experienced, individuals may respond in an attempt to let the caregiver know they are acutely uncomfortable with what is being done. They will react to environmental stimuli such as hot versus cold, dry versus wet, and noisy versus quiet. They have irreversible weight loss. Death often results from secondary infections.

How abilities are lost as Alzheimer's disease progresses

Stage	Effects on person
Early Very mild to moderate cognitive decline	• Is forgetful and has word-finding difficulties • Has problems with orientation and following directions, and becomes lost as a result • Needs assistance with complex tasks (for example, shopping, cooking, or personal finances)
Middle Moderately severe to severe cognitive decline	• Needs assistance with dressing, bathing, personal grooming, and eating • Has difficulties remembering recent events and identifying family and friends • May become disorientated to time and place • Has difficulty making choices and concentrating
Late Very severe cognitive decline	• Speech is not recognizable, although person may occasionally utter words or phrases (non-verbal communication becomes increasingly important) • Needs assistance and support with walking, sitting, and holding up his or her head • Has difficulty swallowing • Has a loss of facial expression

Vascular dementia

Vascular dementia, the second most common cause of dementia, is caused by blockages in the blood supply to the brain. When this happens, the brain cells are deprived of oxygen and die. Strokes are the most common cause of vascular dementia. The strokes can be large or small, and more than one can occur over time, causing a cumulative effect. Cognitive and physical losses may vary (for example, language, memory, and the ability to walk) depending on the specific areas of the brain affected.

How can caregivers help

Caregivers can help people living with dementia by doing the following:

- Understand the progression of the illness.
- Understand how the illness can interfere with verbal communication, leading to communication through behaviour.
- Recognize that all behaviour has meaning and is a form of communication to express unmet needs. (See “Common causes of aggressive response behaviour,” pages 10–13.)
- Understand that other related psychiatric and medical conditions can contribute to aggressive behaviour.
- Use strategies to minimize anxiety and prevent aggressive behaviour. (See “Managing aggressive behaviour through care strategies,” pages 14–20.)
- Know each person’s life story, and incorporate that knowledge into care planning. (See “Appendix C,” page 37.)
- Develop a care plan designed to meet individual needs, thereby minimizing the risk of escalating behaviours.
- Recognize and report changes in behaviour such as sleep pattern and mood.
- Evaluate the effectiveness of the care plan on a regular basis.

Common causes of aggressive response behaviour

Unmet needs

People with dementia have the same basic needs as everyone else. They need to eat and drink, they need to use a toilet, they need to feel loved, they need to feel safe, and they need to experience meaning in their lives. When their needs are not met—for example, when they are thirsty and cannot get a drink on their own—they become frustrated. Since they have a lower threshold for stress because of their cognitive impairment, they are less able to control their reactions. So for some people with dementia, agitation may escalate to aggressive behaviour.

As abilities are lost and physical changes occur, people with dementia experience a decrease in their problem-solving abilities as well as changes in their ability to communicate. The common behaviours caused by losses of physical and cognitive abilities may be triggered or intensified when the person is stressed or has unfulfilled needs. Challenges with verbal communication often mean that people with dementia cannot ask for food when they are hungry, for medication when they are in pain, or for companionship when they are lonely.

People with dementia are easily overwhelmed by care that is provided too quickly or without emotional connection and explanation. When they are overwhelmed (for example, by overstimulation), they are often fearful and frustrated. Because their disease affects impulse control, they may express their frustration by grabbing a caregiver's arm or lashing out.

When a person with dementia behaves in a way that could hurt a caregiver, this is a distress signal. Whenever possible, caregivers need to attempt to figure out the cause of the behaviour and use interventions to stop the behaviour.

The following section describes some of the more common sources of stress for people with dementia that caregivers may consider when care planning and when sudden changes in behaviour are observed.

Physical, perceptual, and cognitive changes

When care planning, consider the following changes that people with dementia may be experiencing.

Memory impairment

People with dementia may ask the same question repeatedly because they do not remember the answer. Over time, they may become frustrated and agitated. The initial losses of memory involve recall of names, events, or placement of items. People with dementia may recognize a familiar item but forget how to use it (for example, a pencil or toothbrush). The most recent events are also the first to be lost, often leaving the person with memories of events that occurred many years ago or in their childhood.

Vision problems

There is some loss of peripheral vision and the ability to track fast-moving objects. People with dementia are easily distracted and can become quickly overwhelmed in a highly stimulating environment. This means that they may be startled when you move into view from the side.

Changes in sleep cycles

Sleep cycles are often disturbed for people with dementia because their internal clock that regulates sleep and awake periods is affected. They may wake up at night and require assistance.

Sensitivity to cold

Older adults may complain of feeling cold because their bodies lose the ability to regulate temperature. People with dementia may lose the ability to recognize hot and cold temperatures. They need to wear many layers of clothing and can become upset when they are undressed for bathing.

Changes in appetite

People with dementia may lose their senses of taste and smell. They lose the ability to recognize the sensations of hunger and thirst, or to know how to use a spoon or drink from a cup. For people with dementia, the inability to satisfy these needs can lead to distress.

Severe cognitive impairment

People with dementia may also lose the ability to control impulses and to have any insight into or understanding of the consequences of their behaviour. They may undress or masturbate in public, or they may verbalize thoughts that they would have normally kept to themselves.

Sundowning

Sundowning is the appearance or worsening of behaviour — such as agitation, pacing, or aggression — associated with the afternoon and evening hours. While the causes for this phenomenon vary, sundowning can be a symptom of delirium. For people with dementia who are affected by sundowning, care should be scheduled to accommodate these changes.

Medical conditions and other factors

When sudden changes in behaviour are observed, consider whether people with dementia may be experiencing any of the following conditions.

Pain

Pain in the elderly is typically associated with:
- Infections (for example, bladder infections)
- Osteoarthritis
- History of hip fractures, other fractures, or back pain
- Cancer
- Constipation
- Dental decay
- Migraine or headache
- Pressure ulcers
- Poor circulation to the lower legs

Behaviours indicating pain

When people have cognitive limitations, it can be hard to identify pain as a problem. People with dementia who are pacing or demonstrating two or three of the following behaviours should have an in-depth pain assessment:
- Wincing, groaning, or striking out when touched or moved
- Tense body or resistance to movement or care
- Loud and repeated calling out (for example, asking for help)
- Irritability
- Rubbing of body parts, decreasing mobility, and increasing frequency of falls
- Increasing confusion and decreasing language ability
- Increased pulse, blood pressure, and sweating
- Refusing food and biting lips

When you observe restless pacing or clusters of behaviours that indicate pain, look for a cause before treating the behaviours with sedatives or similar medications. With proper pain management, the behaviours may disappear or be reduced. (See Appendix F, “Pain assessment tool for the cognitively impaired,” page 42.)

Mental health and addiction

People with mental health concerns and alcohol or drug addictions may also develop dementia and have co-occurring medical conditions. Additional assessments and more-detailed care plans may be required.

Delusions

People with dementia may have delusions. For example, they may think that caregivers are stealing things or poisoning them, or that spouses are having affairs. Understandably, experiencing such delusions may be very upsetting and frightening for people with dementia.

Personality changes

In some cases, people with dementia who were meek before their disease progressed may become disinhibited, swear, and be irritable. They may say what comes into their head before thinking about the impact their words will have on others. This behaviour usually results from damage in the frontal lobes. In rare cases, a difficult person may become more mild-mannered.

Delirium

Delirium is a sudden change in mental state that disturbs attention, thinking, and sleep patterns, causes confusion, and changes behaviour. People with dementia are at higher risk of delirium. If a person with dementia exhibits a sudden change in behaviour, this may be the result of delirium and not part of the dementia process. Delirium is a medical emergency.

Depression

About 50% of people with dementia will also experience symptoms of depression. People with dementia who are depressed become irritable, resistant to care, and verbally abusive. Depression is often missed as a cause of aggression because of the assumption that all depressed people are withdrawn and sad. (See Appendix G, “Cornell scale for depression in dementia,” page 43.)

Changes in environment

People with dementia may become anxious and stressed when there are changes in their environment, such as when moving into residential care or even changing rooms within a facility.

Managing aggressive response behaviour through care strategies

In the preceding sections, we reviewed some of the cognitive and physical changes that may occur as a result of dementia. We also reviewed the more common causes of stress and anxiety for people with dementia. And we discussed how these changes and sources of stress can lead to aggressive behaviour. When caring for people with dementia, it is important to recognize their cognitive and physical losses and to understand how care strategies can help minimize their stress and anxiety.

A key to providing good quality care for people with dementia is an individualized care plan that considers the person's strengths, limitations, preferences, and personal history. Particular attention should also be paid to behaviours and medical conditions, taking into account both current and future needs. This approach is commonly referred to as *person-centred care* (PCC).

This section describes some of the more common care strategies that may maximize the person's functioning and abilities, and reduce the risk of aggressive response behaviours.

Person-centred care

Person-centred care is an approach to caring for people with dementia that focuses on the whole person, not just the disease. Care is individualized, meaning that it is based on who the person is. PCC takes into account the person's life story and remaining cognitive and physical abilities, as well as preferences, gender, culture, values, and family. The goal of PCC is to enable people with dementia to feel supported, valued, and socially confident.

The PCC approach helps caregivers explore and understand the causes of challenging behaviours of people with dementia. Caregivers can then use this information to develop or adjust care plans to reduce the risk of aggressive response behaviours.

Know each person you care for

In the course of a busy workday, it may be hard to find the time to get to know a person with dementia. However, finding this time is important as a means of preventing situations that could lead to aggressive behaviour. Caregivers need to know what might trigger stress or anxiety in a person with dementia and should always be aware of possible reactions when providing care. (See Appendix C, "Getting to know me," page 37.)

Be consistent with verbal and non-verbal communication

People with dementia are extremely sensitive to body language, facial expressions, and tone of voice. Caregivers need to remember that their emotions are communicated, whether these feelings are verbalized or not. If you are upset or stressed, a person with dementia can become upset. Likewise, if your body language does not match what you are saying, your message may not be understood. So you need to be consistent with your verbal and non-verbal messages. When caring for a person with dementia, follow these guidelines:

- Keep your hands in an open and visible position.
- Smile.
- Match your words with your gestures.
- Avoid tense facial expressions.
- Avoid rolling your eyes.
- Maintain your focus on the person, not the task.

- Ask permission to touch the person, and do not use touch unless you have determined that it is safe to do so.
- If a co-worker is also present, avoid talking with the co-worker about things that don't concern the person with dementia. Keep the person with dementia engaged in the conversation.

Appropriate use of touch

Many people with dementia respond well to touch. Determine that using touch is permitted and safe to do so throughout the interaction. For example, "Can I lift your arm so that I can put this sweater on you?"

Outpacing a person with dementia

Outpacing means moving or speaking too quickly for the person with dementia to have a chance to process the information and respond. When caring for people with dementia, you need to slow down your approach, make one request at a time, and evaluate their understanding from one moment to the next.

Caregiver approach

When communicating with people with dementia, remember to consider:

- Your tone of voice
- How loudly you speak
- How fast you speak
- Their culture and native language
- Your body language
- Your facial expressions
- Active listening

Remember not to rush. Keep focused on the person, not the task.

Modify the care environment

Environmental modifications can help create a quiet and soothing atmosphere that reduces people's stress. For example, play music in the bathing room, and place pictures and signs where people with dementia can see them. If you need to have a conversation with someone or ask questions, move to a quiet environment where the person can concentrate on your requests.

Limit the number of caregivers

People with dementia may feel threatened or overwhelmed if more than one person enters their personal space at one time. When using a two-caregiver approach, one caregiver should enter the room first to connect with the person, using personal information to gain trust. The second caregiver should be introduced upon entry and can assist in getting the supplies ready. Conversation between the two caregivers should be kept to a minimum, with one caregiver talking with the person with dementia. Attempts should be made to reduce the number of new caregivers that a person with dementia has to deal with.

Delay or change the care approach

If a person with dementia requires care but is already agitated and frustrated, delay the task if it is not critical to the person's safety or health. Care can be provided when the person is calmer. If the task is especially stressful for the person, consider eliminating or changing it. For example, bathing may be a very stressful time for many people with dementia because they may feel cold or embarrassed, or they may not know who you are or what you are doing. Keep the bathing area warm, cover the person's body even during the bath, and promote comfort while ensuring privacy and dignity.

How am I feeling today?

Being stressed or distracted is not something that you can hide from people with dementia. If the answer to any of the following questions is "No," you may want to invest a couple of minutes to settle yourself, or get the help you need, before providing care:

- Have I emotionally prepared myself for my workday?
- Do I feel confident that I understand the care plan for this person?
- Do I feel supported by my team in providing the care?

Validate feelings

When people with dementia feel that their problems are acknowledged, understood, and accepted, their anxiety decreases. Caregivers should work to identify with the feelings that people with dementia are trying to express. You can agree with what a person wants to do (for example, drive to work or go home) and why they might want to do it, but then gently redirect them to do something else.

Avoid disagreeing with harmless delusions

Remember that often the disease is speaking, not the person. Do not disagree with people with dementia regarding what they perceive to be real. If their delusions are harmless, then no intervention is required. Try distracting the person with a favourite activity. For misplaced objects, remind people with dementia where their valuables are stored, or keep a spare set of items that are frequently missed close at hand (for example, a purse, keys, or glasses).

Use caution when reorienting residents

Reality may shift for people with middle- or late-stage dementia. For example, a person may think it's 1972, or that it's morning when it's actually midnight. People with early-stage dementia and mild cognitive limitations can be oriented to the correct time and place. People with middle- or late-stage dementia have significant cognitive limitations and will become agitated and possibly angry if someone tries to convince them that they are wrong. If a person thinks it is time to go to work, then for that person, it is. Sometimes, orientation statements such as "It's lunch time" or "It's Tuesday" will work.

Take vision problems into account

To avoid confusing or startling people with dementia, approach them from the front, preferably angling your body off to one side, as this is a safer position. Caregivers also need to get down to the same level as people with dementia to speak face to face.

People with dementia may not see objects that are white or pastel until they are very close. Consider using bright colours on the doors to bathrooms and other areas you want residents to find easily. In some cases, you may wish to take advantage of the person's inability to differentiate between objects of similar colour. For instance, if you don't want people with dementia to open a certain door, the door can be painted the same colour as the wall, and they will be unlikely to see it.

Take hearing problems into account

Hearing loss is an invisible sensory deficit that has pronounced physical, mental, and psychological effects. People with dementia may not have their hearing loss identified to caregivers unless they use hearing aids or if someone, such as a family member, intervenes on their behalf. Whether they use hearing aids or not, people with dementia may be easily startled when you move into view. This stress may further interfere with their ability to hear and comprehend.

Approach people with dementia from the front to avoid startling them. Before speaking, lightly touch their forearm or hand if it is safe to do so, or establish eye contact. If they have hearing aids, ensure that they are wearing them, if possible. Face people with dementia directly, at their level and at a safe distance. Project your voice, but avoid yelling. Use a low pitch, speak slowly, and take your time. If they do not understand you, rephrase rather than repeat your questions. Make sure you are not standing in front of a window, as this puts your face in shadow and makes it more difficult for them to read your lips. Keep your hands away from your mouth and keep your mouth empty of food or gum when you speak. Avoid a setting with lots of sensory stimulation, especially background noise.

Take a flexible approach

Communicating with people with dementia who have a range of conditions and a decreased ability to communicate verbally can lead to a wide variety of outcomes. A good relationship and an effective technique used in the morning may be ineffective or even act as a trigger in the afternoon. Things can go badly even if a caregiver is doing everything correctly. A key to finding solutions is open communication between the person with dementia, the person's family, and the care team.

Distract with objects or activities

Use meaningful activities or items to distract. Encourage people with dementia to engage in activities they enjoy (for example, talk about their families or sing a song), or provide an object to hold or carry (for example, a face cloth). Distraction can also work when people with dementia exhibit obsessive or repetitive behaviours, such as making the same motion or asking the same question over and over. Caregivers can suggest the person engage in a favourite activity such as walking. Do not remind the person that you have already answered the question because this may be upsetting. Simply answer again in a calm voice.

Provide small snacks or beverages between meals

Before providing care, consider the time of day and when the person with dementia last ate. Blood sugars are often low late at night and early in the morning. Try giving people a light snack such as juice or toast before getting them out of bed or providing care.

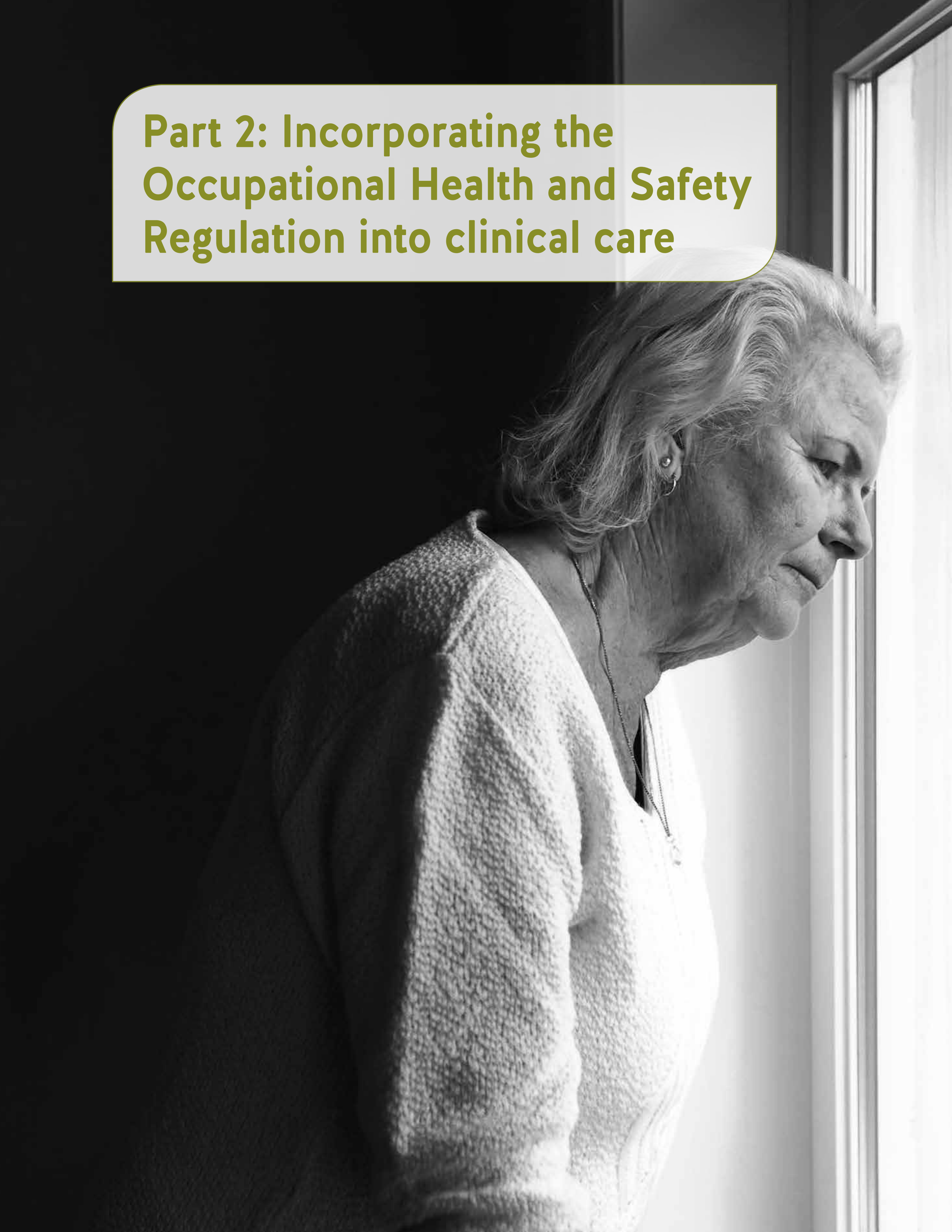
Allow people with dementia to wander and rummage safely

People with dementia may spend a lot of time walking around and rummaging or picking up various items. Provide areas where people can safely wander and collect items. For example, they should have access to indoor and outdoor areas where they can explore independently. Provide opportunities for physical activity, such as singing and rhythmic movements, particularly when people with dementia are waiting for a meal or activity to start.

Know when to walk away

Sometimes, people with dementia will become stressed and agitated no matter what you do. Even if you have done everything right, their anxiety may increase, and they may become aggressive. Trying to continue with the care activity will often make it worse and put you, the person with dementia, or your co-workers at greater risk of injury. Temporarily walking away from a person with dementia who poses a risk to a caregiver is not a sign of professional failure or abandonment of one's duty to care. If the person is not in imminent danger, leave to stay safe, and give the person time to calm down. Make sure other people are also clear of danger. Rather than trying to de-escalate a situation, it may be better to reassess, seek guidance or assistance, find another approach in a calmer setting, or develop a planned intervention.

Part 2: Incorporating the Occupational Health and Safety Regulation into clinical care



How to develop a successful violence prevention program

In the Regulation

The Regulation defines violence as "the attempted or actual exercise by a person, other than a worker, of any physical force so as to cause injury to a worker, and includes any threatening statement or behaviour which gives a worker reasonable cause to believe that he or she is at risk of injury."

Employers are required to implement measures to eliminate or minimize any risk to workers from violence. Incorporating a violence prevention program into care planning can be an effective way to keep workers safe.

A violence prevention program includes actions or interventions taken to eliminate or minimize the risk of worker exposure to violence. Properly executed, a good violence prevention program will benefit both workers and residents. (Note: In the following sections the term *resident* is used to describe a person with dementia who is receiving care in any setting.)

Violence prevention program elements

According to the Regulation, a violence prevention program must include:
- Risk assessment (section 4.28)
- Procedures and policies (section 4.29)
- Instruction of workers (section 4.30)
  - Informing workers of any risk of violence
  - Educating and training
  - Developing responses to violent incidents
  - Follow-up after incidents

Assessing the risk of violence

To assess activities and conditions that may expose workers to violent behaviour, look at the resident, the work being done, the work environment, and the caregiver. Risk assessments help determine appropriate interventions and set priorities when allocating resources to minimize the risk to workers. Assessing risk starts when a person begins receiving care.

The resident

Consider whether the resident with dementia has:
- A history of aggressive behaviour
- Delirium or other medical conditions that, if unrecognized or left unattended, may lead to violence (see "Common causes of aggressive response behaviour," pages 10–13)
- Difficulty expressing needs and typically shows signs and symptoms of frustration before becoming aggressive

The work being done

Consider whether care activities such as the following may agitate the resident:
- Toileting and pericare
- Bathing
- Getting dressed
- Taking medications

The care schedule itself may agitate residents with dementia if a task is being done at a time that doesn't work for them or if the care is being rushed. Care that focuses on individual residents' needs — not the need to complete a certain number of tasks — will put caregivers at reduced risk of injury.

The work environment

Ask yourself the following:
- Does the person's room have too much stimulation (for example, noisy or bright)?
- Is the temperature too cold?

The caregiver

Ask yourself the following:
- Does the caregiver have the necessary advanced skills to provide care to residents with dementia?
- Is the worker emotionally prepared?

In the Regulation

Section 4.29, Procedures and policies

If a risk of injury to workers from violence is identified by an assessment performed under section 4.28 the employer must

(a) establish procedures, policies and work environment arrangements to eliminate the risk to workers from violence, and

(b) if elimination of the risk to workers is not possible, establish procedures, policies and work environment arrangements to minimize the risk to workers.

Developing procedures and policies to control the risk of violence

Procedures are the care strategies that are implemented to eliminate or minimize aggressive response behaviour. *Policies* are written documents that state the organization's commitment to violence prevention and outline the roles and responsibilities of the employer, supervisor, and worker in violence prevention.

Most often, the interventions or controls identified to minimize aggressive behaviour in residents with dementia involve adapting or implementing new care strategies (see "Managing aggressive behaviour through care strategies," pages 14–20). It is essential that care plans are updated with the new or modified strategies, and care staff are notified of the changes.

In the Regulation

Section 4.28, Risk assessment

(1) A risk assessment must be performed in any workplace in which a risk of injury to workers from violence arising out of their employment may be present.

(2) The risk assessment must include the consideration of
  (a) previous experience in that workplace,
  (b) occupational experience in similar workplaces, and
  (c) the location and circumstances in which work will take place.

Informing workers

Employers are required to inform their workers about risks of violence and to instruct workers about the processes in place to minimize the risk of injury.

Communicating information

There are a number of ways to communicate information about risks of violence. Find methods that work for your facility. Common examples include using a purple dot (for example, stuck to a client's chart or nameplate) as a means of conveying that staff need to refer to the nursing notes or care plan, or to ask a clinical person for more information.

The presence of a purple dot does not indicate anything other than that there is a risk of violence when caring for this person, and that staff need to check the care plan to learn the specific ways to provide care. Some facilities with electronic record keeping have developed formal electronic alerts that notify staff of any risks whenever a resident's record is opened.

Whatever means of communication are used, staff must always know relevant, objective information about the risks they face, along with interventions to follow, for all of the people who may put them at risk.

Medical information: Confidentiality vs. disclosure

Care professionals are expected to maintain the confidentiality of residents' medical information. There are, however, some legal and ethical situations in which there is an obligation to divulge parts of this information in a timely manner. One such situation is when there is reason to believe that a resident poses a risk to the health and safety of another person.

The relevant information must be shared within the organization in a way that allows other workers to know about the risk, the level and triggers of the risk, and interventions to minimize the risk. This information must also be disclosed to other employers and workers who work with the resident (for example, housekeepers, dietary workers, and ambulance paramedics).

Educating and training workers

Employers are responsible for educating and training workers in the violence-prevention measures — the care strategies — and informing workers of what they need to do if a resident becomes violent.

Workers who have received adequate instruction will:

- Understand dementia — the cognitive losses and related conditions, and how people may express themselves in an attempt to have their needs met
- Know how to determine which residents may become violent and what might trigger that behaviour
- Know their roles and responsibilities in ensuring a safe work environment
- Understand how information about risks of violence is shared within the facility
- Know what care strategies have been put in place to eliminate or reduce the risk of violence
- Know how and when to report unsafe conditions
- Know how to respond to an escalating situation, including understanding their personal limitations

Note that under section 3.23 of the Regulation, employers must include violence prevention in their orientation of new and young workers before they begin work.

In the Regulation

Section 4.30, Instruction of workers

(1) An employer must inform workers who may be exposed to the risk of violence of the nature and extent of the risk.

(2) The duty to inform workers in subsection (1) includes a duty to provide information related to the risk of violence from persons who have a history of violent behaviour and whom workers are likely to encounter in the course of their work.

(3) The employer must instruct workers who may be exposed to the risk of violence in

  (a) the means for recognition of the potential for violence,

  (b) the procedures, policies and work environment arrangements which have been developed to minimize or effectively control the risk to workers from violence,

  (c) the appropriate response to incidents of violence, including how to obtain assistance, and

  (d) procedures for reporting, investigating and documenting incidents of violence.

What to do if a violent incident occurs

The Regulation requires facilities to plan how they will respond to violent incidents. Most residential care facilities rely on a response by co-workers in a show of presence, which by itself may defuse the incident by supporting the affected worker. Teams that are formed to intervene in violent incidents (for example, Code White responders) require specialized training.

During an incident

If workers encounter an increasingly violent situation, they should follow these guidelines:

- Maintain or increase the personal space of the resident.
- Do not argue or disagree with the resident.
- Try to defuse the situation by distracting or calming the resident if it is safe to do so.
- Remove others (residents and visitors) from the immediate environment as quickly and quietly as possible if it is safe to do so.
- Safely remove yourself from the situation as soon as possible.
- Call for help (for example, “Code White”).
- Contain the resident in a safe space. Remove environmental hazards only if it is safe to do so.

Refusing unsafe work

Under section 3.12 of the Regulation, workers have the right to refuse unsafe work if they have reasonable cause to believe it may pose an undue risk of injury to any person. The list below is a summary of the process that workers and employers must follow:

(1) The worker must immediately report the situation to a supervisor.

(2) The supervisor must immediately investigate and either remedy the situation or advise the worker why action has not been taken.

(3) If the worker is unsatisfied with the decision, the employer and supervisor must carry out another investigation in the presence of the worker who made the report and a worker safety representative.

(4) If that investigation produces results that are still unsatisfactory and the worker continues to refuse work that the worker believes is unsafe, then WorkSafeBC must be contacted immediately to initiate an investigation by an officer.

Under section 3.13 of the Regulation, workers who follow this process must not be subject to disciplinary action.

Follow up with witnesses

It can be extremely upsetting for anyone to witness a violent incident. Once a violent incident has ended, you should follow up with all witnesses — including other residents, family members, and visitors — to determine how they are and to provide assistance if they are experiencing difficulty.

After an incident

Workers involved in a violent incident must report the incident and seek first aid or medical treatment if needed.

Following a violent incident, employers:

- Must investigate the incident to determine why the resident with dementia became aggressive
- Must define corrective actions (revised or new care strategies) to prevent recurrence of the aggressive behaviour
- Should ensure the resident's care plan is updated, alerts are activated, and changes are monitored

Prompt and effective post-incident procedures will provide support for those affected by workplace violence and help reduce psychological trauma.

Critical incident response program

Anyone who is exposed to violent behaviour or who witnesses a traumatic event may develop post-traumatic stress disorder (PTSD). Caregivers who are experiencing emotional or psychological trauma (for example, feeling intense fear or helplessness, or persistently re-experiencing an incident) should seek help through their employer's critical incident response (CIR) program. CIR and critical incident stress debriefing may reduce the risk of developing PTSD if provided in a timely manner, ideally within 24 to 72 hours of the incident.

For employers who do not have a CIR program, WorkSafeBC offers one at no cost. If you have questions or wish to arrange an intervention, please page the critical response specialist at 1.888.922.3700. Your call will be answered immediately between 9:00 a.m. and 11:00 p.m., seven days a week.

Reporting and documenting violent incidents and updating care plans

Much of the activity within health care involves one-on-one interactions with residents. These interactions produce valuable information or experiences that could lead to changes that can improve care for residents and reduce risks for workers. Such information and experiences will have no value if they are not shared. That's why it is important to report and document violent incidents.

Care plans and activities of daily living (ADL) forms should include documentation of behaviours. Update care plans and ADLs regularly, and make them accessible to all workers. Caregivers should describe as accurately as possible any acts of violence and any known triggers for the behaviours. For example, if a resident bites when being dressed, the care plan or ADL should accurately note the behaviour and trigger: "If I become overwhelmed when you are dressing me, I may try to bite you to let you know."

Benefits of documentation

Accurate documentation provides numerous benefits, including the following:

- Helps find ways in which care plans can be altered to reduce risks for caregivers
- Provides information that can be shared with supervisors, other caregivers, and families
- Supports requests for additional resources to care for the resident
- Helps communicate successes and lessons learned about the most effective care approaches

In the Regulation

Section 4.31, Advice to consult physician

The employer must ensure that a worker reporting an injury or adverse symptom as a result of an incident of violence is advised to consult a physician of the worker's choice for treatment or referral.

Chart violent incidents

Healthcare professionals who do medical charting have a responsibility to document changes in a resident's behaviour, potential triggers for violence, and aggressive incidents. Follow these charting guidelines:

- Stick to factual information, and use neutral language to record behaviours you have observed and remarks you have heard.
- Use precise terms, including actual language used, even if it is offensive (for example, "Get out of here, you stupid bitch!"). Avoid subjective terms such as "Aggressive+++."
- Note responses or changes in behaviour that are made as a result of these observations.

Program review

Employers must evaluate violence prevention interventions to determine if they are reducing the risk of injury from violence. Evaluations can be done by the violence-prevention working group or the joint health and safety committee (or worker health and safety representative, if applicable). You can evaluate the effectiveness of interventions by comparing the risk level of the work activities or conditions before and after implementation. (See "Assessing the risk of violence," page 24.) This review is in addition to the incident investigation that should occur after each report of a violent incident.

Keys to a successful violence prevention program

A successful violence prevention program needs to be designed specifically for the unique nature and varied needs of your organization and its residents. It requires the commitment of the employer, the workers, and the joint health and safety committee (or worker health and safety representative, where applicable) to violence prevention and the interventions that have been adopted. Maintaining open lines of communication and ensuring that every member of your organization clearly understands the scope of violence prevention is crucial to a program's success.

A well-designed violence prevention program will:

- Minimize the potential for physical and psychological injuries to workers
- Provide clear roles and responsibilities for the employer, supervisors, and workers
- Improve resident care and safety
- Improve the quality of the work environment

Appendices

Note: The assessment tools and resources presented in the appendices are examples of the many resources that have been developed to assist with providing care to people with dementia. Your organization may already use these or similar tools. Other tools and resources can be found through the websites listed in Appendix H.

Appendix A: Four steps toward better communication with persons with dementia

1. **Start the interaction in a conversational manner.**
    - Approach from the front, calmly and slowly.
    - Make eye contact.
    - Call the person by preferred name.
    - State who you are and why you are there.
    - Allow time for a response.
    - Begin in a conversational, not task-focused, manner.
2. **Simplify what you say.**
    - Use questions that can be answered “yes” or “no.”
    - Use simple, short sentences.
    - Provide choices if possible, and show options.
    - Rephrase your sentences.
3. **Check your approach.**
    - Consider your verbal message, including tone of voice, rate of speech, and volume.
    - Suggest or invite, don’t tell, as an approach to begin a task.
    - Consider your non-verbal message, including body language, facial expression, and use of touch.
    - Ask permission.
4. **Be supportive.**
    - Provide the words the person is looking for.
    - Listen for their emotional message. Pay attention to:
        - Tone of voice.
        - Body language.
        - Facial expression.
    - Validate the emotional message with empathy, sincerity, and acceptance.

Source: Geropsychiatric Education Program, 2008, Vancouver Coastal Health

Appendix B: Behavioural escalation continuum model — Responding to persons with dementia

Behaviour level	Caregiver approach
When you see anxiety Defined as a change or increase in behaviour: • Restless, pacing, rocking, withdrawal • Caregiver seeking	**Be supportive** • Acknowledge the change. • Validate the feelings. • Display understanding and support. • Respond in a calm and gentle voice. • Offer reassurance and assistance. • Check for underlying needs.
When you see agitation Resident becomes increasingly irrational and includes the following behaviour: • Belligerent • Challenging • Refusing	**Be responsive** • Acknowledge the change. • Validate the feelings. • Be flexible. • Offer choices and redirect. • Respond in a calm tone. • Ignore the challenge, but don't ignore the behaviour. • Check for triggers, including: – Unmet needs – Your approach and the environment
When you see verbal or physical aggression Resident experiences a total loss of control — an emotional and physical response: • Verbally threatening and abusive language • Physical aggression such as hitting, biting, or kicking	**Be directive** Immediately do the following: • Stop the task and check your approach. • Increase the resident's personal space. • Be aware of your surrounding environment. Regain control of situation by doing the following: • Respond calmly, using non-threatening body posture. • Don't react, argue, give a defensive response, or rationalize. • Validate by acknowledging their feelings. • Give direction or instructions. • Keep it short and simple. • Recognize the difference between venting and abusive language. After the resident has de-escalated, do the following: • Seek clarification for the behaviour. • Allow time and try another approach. • Redirect. • Check for triggers, including: – Unmet needs – Your approach and the environment

Source: Geropsychiatric Education Program, Vancouver Coastal Health

Appendix C: Getting to know me

The “Getting to know me” questionnaire is for the resident, family members, and care providers. Information gathered through these questions will help develop the care plan.

Getting to know me

My life story

I was born in (town/country) ____

I was __________ (the number) in the family.

I speak the following languages: ____

My education was (years, degrees, etc.) ____

My occupation was ____

I am/have been a part of the ______________________________ faith.

I married ____________________ on __________ at (location) ______________________________

In our life, we enjoyed the following together: ______________________________

____

____

Our family includes (names and birthdays of children, grandchildren, or other significant persons)

____

____

____

____

____

____

____

____

____

____

____

Life roles/occupations

Traumatic life experiences I have had are ____

____

I really don't like it when ____

____

My favourite movies are ____

____

Important relationships in my life are/have been with __________________________________

____

Things I am most proud of are ____

____

If I had to describe my personality throughout my life, I would say _______________________

____

I manage stress and cope with difficult situations by ____________________________________

____

As a child/adolescent, my hobbies were in (sports, music, art, etc.) ______________________

____

As an adult, my hobbies/pastimes have been ____

____

Today, I continue to enjoy ____

____

Were pets a large part of your life? Please elaborate. __________________________________

____

If you enjoyed caring for plants, please indicate if you enjoy:

Indoor gardening _______ Outdoor gardening ________ Both _________

I enjoy spending time with children. Yes _______ No ________ I don't know ________

Important things about my day

I like to get up at _________ (time)

I prefer to have a shower/bath and how often ____

I eat breakfast at _________ (time)

My favourite breakfast foods are ____

For lunch I like to eat ____

I spend my afternoon doing ____

I nap/do not nap during the day (please indicate time of day and duration) __________________

I eat supper/dinner at ________ (time)

I spend my evenings ____

____

I normally go to bed at ___________ (time). I have the following bedtime rituals: _______________

____

Other "little things" I would like you to know about me (special things about me that make my care go well) are:

____

____

____

____

____

____

____

____

____

____

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____

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Source: Geropsychiatric Education Program, 2010, Vancouver Coastal Health

Appendix D: Behaviour pattern record

The behaviour pattern record is used to help define causes of new behaviours that residents develop. Often, causes of behaviour are not apparent, so it is helpful to track when and where behaviours occur and what activities happen before, during, and just after the resident exhibits the behaviour.

When	**What** What behaviour was observed?	**Where** Where did the behaviour occur?	**Why** What was happening just before the behaviour occurred? Who else was present? Unusual noises?	**How** What interventions were used? How were interventions implemented?	**Outcome and suggestions for future care planning** How did the client respond?
Date: Time: Initials:					
Date: Time: Initials:					
Date: Time: Initials:					
Date: Time: Initials:					
Date: Time: Initials:					

Source: Geropsychiatric Education Program, Vancouver Coastal Health

Appendix E: Client 7-day observation record

The client 7-day observation record is a tool to help define causes of new behaviours that residents develop. Often, causes of behaviour are not apparent, so it is helpful to track when and where behaviours occur and what activities happen before, during, and just after the resident exhibits the behaviour.

Examples of excessive verbal behaviour

1. Repetitive
2. Making noise
3. Constant groaning
4. Swearing

Examples of excessive physical behaviour

5. Pacing
6. Striking out
7. Restlessness
8. Resists care

Other

9.
10.
11.
12.

Analyze the coded entries to determine if there is a pattern with identified triggers.

Y/M/D							
Time							
0730							
0800							
0830							
0900							
0930							
1000							
1030							
1100							
1130							
1200							
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0630							
0700							

Source: Geropsychiatric Education Program, Vancouver Coastal Health

Appendix F: Pain assessment tool for the cognitively impaired

The pain assessment tool for the cognitively impaired is a quick assessment guide to help determine whether a resident's change in activity pattern or behaviour is related to pain. If the resident recently developed any of the behaviours listed in the tool, pain may be the cause of the behaviour, and the resident needs to be assessed further to determine the source of the pain.

How to use the tool

Assess for changes in the resident's activity patterns using these new behaviours as possible indicators of pain. Please check the box next to each behaviour you observe in the resident.

Verbal expression

☐ Cries out with touch
☐ Yells/screams/shouts
☐ Moans with turning
☐ Volume of voice increases or becomes shrill
☐ Becomes very quiet
☐ Swears or calls people names
☐ Talks without making sense
☐ Grunts

Facial expression

☐ Facial grimaces such as wincing or painful look
☐ Closes eyes
☐ Winces with touch
☐ Worried expression/frowning

Physical behaviours

☐ Resists care
☐ Shields or protects a certain part of body
☐ Rocks back and forth
☐ Isolates self from others
☐ Becomes physically aggressive, striking out
☐ Stiff or rigid body

Physiological behaviours

☐ Vital sign changes such as increased BP, pulse, breathing (acute pain only)
☐ Becomes pale
☐ Becomes cold
☐ Has red or swollen body part

Psychological changes

☐ Crying/tears
☐ Increased confusion
☐ Irritability/agitation

Source: Vancouver Residential Palliative Care (2007)

Appendix G: Cornell scale for depression in dementia

The Cornell scale for depression in dementia is designed as a screening tool and is not diagnostic. It is for use with moderately to severely impaired residents with dementia. The tool is valuable to demonstrate effectiveness of interventions, especially antidepressant treatment, when it is completed before the intervention and several weeks after.

How to use the screening tool

The clinician interviews the resident's caregiver on each of the 19 items of the scale. The caregiver (or "informant," as noted on the scale) is instructed to base his or her report on observations of the resident's behaviour during the week prior to the interview. The clinician then briefly interviews the resident.

Total time of administration is approximately 30 minutes.

Scoring

1. Each question is scored on a two-point scale:
   0 = absent; 1 = mild or intermittent; 2 = severe; 9999 = unable to evaluate
2. The caregiver is asked to describe the resident's behaviour observed during the week prior to the interview. Two of the items, "loss of interest" and "lack of energy," require both a disturbance occurring during the week prior to the interview and relatively acute changes in these areas occurring within one month. For these two items, the caregiver is instructed to report on the resident's behaviour during the week prior to interview, then give the history of the onset of changes in these two areas that may have taken place within the past month.
3. The item "suicide" is rated with a score of "1" if the resident has passive suicidal ideation (for example, feels life is not worth living). A score of "2" is given to subjects who have active suicidal wishes or have made a recent suicide attempt. History of a suicide attempt in a subject with no passive or active suicidal ideation does not in itself justify a score.
4. If there is a disagreement between the clinician's impression and the caregiver's report, the caregiver is interviewed again in order to clarify the source of discrepancy.
5. Older persons often have disabilities or medical illnesses with symptoms and signs similar to those of depression. Scoring of the Cornell scale on items such as "multiple physical complaints," "appetite loss," "weight loss," "lack of energy," and possibly others may be confounded by disability or physical disorder.

The item scores are added. Scores above 10 indicate a probable major depression. Scores above 18 indicate a definite major depression. Scores below 6, as a rule, are associated with absence of significant depressive symptoms.

To minimize assignment of falsely high Cornell scale scores in disabled or medically ill residents, raters are instructed to assign a score of "0" for symptoms and signs associated with these conditions. In many cases, the relationship between symptomatology and physical disability or illness is obvious. In some residents, this determination cannot be made reliably.

Cornell scale for depression in dementia

Patient status: ☐ Nursing home resident ☐ Outpatient ☐ Inpatient

Informant used: ☐ Yes ☐ No

Scores: 0 = absent 1 = mild or intermittent 2 = severe 9999 = unable to evaluate

Ratings should be based on symptoms and signs occurring during the week prior to interview. If severe and intermittent, score as severe. No score should be given if symptoms result from physical disability or illness.

	Informant				**Patient**				**Rater's opinion**			
A. Mood related signs												
1. **Anxiety** Anxious expression, ruminations, worrying	0	1	2	9999	0	1	2	9999	0	1	2	9999
2. **Sadness** Sad expression, sad voice, tearfulness	0	1	2	9999	0	1	2	9999	0	1	2	9999
3. **Lack of reactivity to pleasant events**	0	1	2	9999	0	1	2	9999	0	1	2	9999
4. **Irritability** Easily annoyed, short tempered	0	1	2	9999	0	1	2	9999	0	1	2	9999
B. Behavioral disturbance												
5. **Agitation** Restlessness, handwringing, hairpulling	0	1	2	9999	0	1	2	9999	0	1	2	9999
6. **Retardation** Slow movements, slow speech, slow reactions	0	1	2	9999	0	1	2	9999	0	1	2	9999
7. **Multiple physical complaints** (score 0 if GI symptoms only)	0	1	2	9999	0	1	2	9999	0	1	2	9999
8. **Loss of interest** Less involved in usual activities (score only if change occurred acutely i.e.: in less than 1 month)	0	1	2	9999	0	1	2	9999	0	1	2	9999
C. Physical signs												
9. **Appetite loss** Eating less than usual	0	1	2	9999	0	1	2	9999	0	1	2	9999
10. **Weight loss** (score 2 if greater than 5 lbs. in 1 month)	0	1	2	9999	0	1	2	9999	0	1	2	9999
11. **Lack of energy** Fatigues easily, unable to sustain activities (score only if change occurred acutely i.e.: in less than 1 month)	0	1	2	9999	0	1	2	9999	0	1	2	9999
D. Cyclic functions												
12. **Diurnal variation of mood** Symptoms worse in the morning	0	1	2	9999	0	1	2	9999	0	1	2	9999
13. **Difficulty falling asleep** Later than usual for this individual	0	1	2	9999	0	1	2	9999	0	1	2	9999
14. **Multiple awakenings during sleep**	0	1	2	9999	0	1	2	9999	0	1	2	9999
15. **Early morning awakenings** Earlier than usual for this individual	0	1	2	9999	0	1	2	9999	0	1	2	9999
E. Ideational disturbance												
16. **Suicide** Feels life is not worth living, has suicidal wishes, or make suicide attempt	0	1	2	9999	0	1	2	9999	0	1	2	9999
17. **Self-depreciation** Self-blame, poor self esteem, feelings of failure	0	1	2	9999	0	1	2	9999	0	1	2	9999
18. **Pessimism** Anticipation of the worst	0	1	2	9999	0	1	2	9999	0	1	2	9999
19. **Mood congruent delusions** Delusions of poverty, illness, or loss	0	1	2	9999	0	1	2	9999	0	1	2	9999

Source: Dr. George S. Alexopoulos, Director, Weill Cornell Institute of Geriatric Psychiatry. Revised Dec. 15, 1998. Reprinted with permission.

Appendix H: Website resources

Alzheimer Society of B.C.

The Alzheimer Society of B.C. website gives up-to-date information on Alzheimer's disease and dementia, and provides resources for people who have dementia and for those caring for people with dementia.
alzheimerbc.org

Vancouver Coastal Health Geropsychiatric Education Program

The website for Vancouver Coastal Health's Geropsychiatric Program provides educational information and resources on caring for people with dementia, including risk assessment tools that can be downloaded for free.
geropsychiatriceducation.vch.ca

worksafebc.com — Health care & social services

WorkSafeBC's web portal for the health care and social services sectors provides online workplace injury prevention resources intended for employers and workers. The resources target the primary causes of workplace injury, including violence, patient handling, and exposure to infectious disease.
worksafebc.com/healthcare

Glossary

Alzheimer’s disease
A form of degenerative brain disease that is the most common cause of dementia.

care plan
A document that outlines how a resident is to be cared for. It describes the tasks and responsibilities of all those involved in caring for the resident.

cognitive decline
The loss in the ability of the brain to perform regular functions such as judgment, reasoning, memory, learning, understanding, and insight into self.

delirium
A sudden state of severe confusion, sometimes associated with hallucinations, lasting several hours to several weeks.

delusion
An unshakable belief that something is true when it is not. May be accompanied by hallucinations.

dementia
A decline in memory and an inability to make decisions and carry out activities of daily living due to a disease process in the brain. Dementia may be caused by a number of different diseases, most of which are progressive and result in death.

Huntington’s disease
A form of degenerative brain disease.

incident
An accident or other occurrence that resulted in or had the potential for causing a death, injury, occupational disease, or damage to equipment or property.

The terms *incident* and *accident* are often used interchangeably, but the preferred term is incident because it includes near misses as well as accidents.

intervention
An action taken to improve or enhance positive behaviours in residents with dementia.

Parkinson’s disease
A progressive, degenerative nerve disorder that affects movement, speech, and brain function.

perception
How people interpret their surroundings.

resident
For the purposes of this book, a person with dementia who is receiving care in any setting.

residential care
Care that includes 24-hour supervision, personal nursing care, and treatment by skilled caregivers. Also referred to as complex care, extended care, intermediate care, or long-term care.

sedative
A drug that has a soothing, calming, or tranquilizing effect.

sensory deficit
Loss of function in one of more of the senses, including sight, hearing, smell, taste, or feel.

secondary infection
A bacterial, viral, or fungal infection that develops following an infection by another kind of bacteria, virus, or fungus. For example, elderly people often develop pneumonia following a severe respiratory infection.

vascular dementia
Loss of brain function because of a lack of oxygen to the brain cells. Vascular dementia is often caused by a stroke and, therefore, has a sudden onset.

violence
The attempted or actual exercise by a person, other than a worker, of any physical force so as to cause injury to a worker. It includes any threatening statement or behaviour that gives a worker reasonable cause to believe that he or she is at risk of injury.

Notes

Notes

Notes