OANHSS

LTCHA Implementation
MEMBER SUPPORT PROJECT

Responsive Behaviours

Policy, Procedures and Training Package

Release Date: January 27, 2011

Ontario Association of Non-Profit Homes & Services for Seniors
7050 Weston Road, Suite 700, Woodbridge, Ontario L4L 8G7 (P) 905-851-8821 (F) 905-851-0744 www.oanhss.org

Disclaimer

The Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) Long-Term Care Homes Act (LTCHA) Implementation Member Support Project resources are confidential documents for OANHSS members only. Any review, retransmission, dissemination or other use of, or taking of any action in reliance upon this information, by persons or entities other than the intended recipients is prohibited without the approval of OANHSS.

The opinions expressed by the contributors to this work are their own and do not necessarily reflect the opinions or policies of OANHSS.

LTCHA Implementation Member Support Project resources are distributed for information purposes only. The Ontario Association of Non-Profit Homes and Services for Seniors is not engaged in rendering legal or other professional advice. If legal advice or other expert assistance is required, the services of a professional should be sought.

Table of Contents

ABOUT THIS DOCUMENT

The development and implementation of a policy and procedures for responsive behaviours is a requirement of Regulation 53 of the *Long-Term Care Homes Act, 2007* (LTCHA). This document contains a sample policy, procedures and staff training materials and tools that meet the minimum requirements of the LTCHA and regulation.

This package is intended to be used as a resource for OANHSS member homes to modify and customize, as appropriate. This material can also be used by homes to review their current policies and procedures and compare content. Please note: The project team have compiled these materials during the fall of 2010, and as a result, the information is based on the guidance available at this time. Members will need to regularly review the Ministry of Health and Long-Term Care (MOHLTC) Quality Inspection Program Mandatory and Triggered Protocols to ensure that internal policies and procedures align to these compliance expectations.

Acknowledgements

OANHSS gratefully acknowledges the contribution of written practices, resources and tools used in the development of this package from Maureen O'Connell, Psychogeriatric Resource Consultant, Simcoe County, City of Ottawa, Pam Hamilton, Psychogeriatric Resource Consultant Providence Centre in Kingston.

RESPONSIVE BEHAVIOURS

Philosophy

The fundamental principle of the Long-Term Care Homes Act (LTCHA), 2007, is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where residents may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met. LTCHA, 2007, c. 8, s. 1.

Policy

The home is committed to ensuring the needs of residents with responsive behaviours are met.

Preamble

The term "responsive" behaviours is used to describe a means by which persons with dementia or other conditions may communicate their discomfort with something related to, for example, the physical body (e.g., urinary tract or other infection), social environment (e.g., boredom, invasion of space) or the physical environment (e.g., lighting, noise, busyness). Responsive behaviours can also be 'protective behaviour'. In the past, these behaviours have often been termed "disruptive," "challenging" or "aggressive" and this previous terminology negatively labels residents.

Understanding the sources/underlying causes of responsive behaviours is key to providing the optimal care for a resident. Responsive behaviours often indicate an unmet need a person may have (cognitive, physical, emotional, social, environmental or other need). Or, sometimes behaviours are a response to circumstances within the social or physical environment that may be frustrating, frightening or confusing to a person.

When an individual's responsive behaviours escalate, this can lead to altercations among residents or staff and may be harmful or abusive. Therefore, a key aspect of resident care is to prevent or minimize the situations in which a resident exhibits responsive behaviours. The staff of the home can achieve this preventative approach by integrating the most effective strategies for individual residents into their plan of care, and implement these strategies through a coordinated, interdisciplinary approach.

Definitions

Responsive Behaviours: actions that may include a resident exhibiting one or more of:

- physically non-aggressive or protective behaviours such as pacing, undressing, handling objects
- physically aggressive or protective behaviours such as spitting, hitting, throwing objects, physical sexual advances
- physically hurting self or others
- verbally non-aggressive or protective behaviour such as verbal complaints, constant requests for attentions
- verbally aggressive or protective behaviour such as cursing, sexual comments
- verbal abuse
- resisting care
- socially inappropriate or disruptive actions

- difficulty with psychosocial adjustments or symptoms of depression (eg isolation, refusing to eat, withdrawal from usual activity pattern)
- delirium

Procedure

Prevention

1. Identify the causes and triggers (e.g. environmental such as lighting, social, food, medications, and specific activities) for responsive behaviours, altercations and harmful interactions. This assessment will include clinical assessments to ensure identification of causes of responsive behaviours such as, medication related, or chemically or physiologically based.

2. Develop Strategies for Prevention which may include:
   - Environmental Adaptation Strategies such as noise reduction e.g. voice levels, radio, TV, scraping chairs, room temperatures, arrangements and design, lighting that accommodates vision changes, calming aromas, eliminate unpleasant odours
   - Orientation and Training programs for staff, families and volunteers especially on prevention, how to recognize the triggers and strategies to prevent escalation, how to communicate and how to manage a situation which has escalated (e.g. training to avoid particular places, events or circumstances)
   - Awareness, skills and knowledge related to responsive behaviours for staff and contractors
   - Awareness orientation and training for volunteers regarding how to recognize responsive behaviours, how to communicate with residents who exhibit responsive behaviours when involved directly with residents
   - Information for families, people of importance to residents and substitute decision makers related to the home practices related to residents with responsive behaviours
   - In practice, staff and volunteers proactively communicating with residents to prevent and respond to responsive behaviours and potentially harmful interactions
   - Developing interventions to minimize triggers or respond effectively for specific residents and to prevent the escalation of potentially harmful or abusive situations
   - Use of internal and external tools, experts and resources for screening, assessing and developing strategies for managing responsive behaviours.

3. Screening Protocols and Tools: Utilise Screening tools and protocols to assist caregivers to understand the cause(s) of a resident's responsive behaviour and to track the patterns of these behaviours. MDS RAI is an example of a screening tool that flags a problem or observation by staff, family and others of changes in a resident's behaviour and potential for altercations between/among residents or staff that may be harmful.

Purpose of Screening

Screening identifies level of risk associated with the behaviour (potential or imminent) – low, moderate, high; see Appendix E – Acute Responsive Behaviour Management – Screening Decision Tree and may identify behavioural triggers, patterns, contributing factors, environmental factors, type of behaviour, frequency of behaviour, potential for adverse drug reaction causing responsive behaviour, potential for altercations between residents.

Risks identified may include: e.g. elopement, or leaving the home without staff knowledge, roaming, imminent physical harm, (fire, falls, knives/sharp objects, firearms), suicidal ideation,

deteriorating relationship with staff/family, risk of fuelling another resident's behaviour, smoking, and substance misuse. High risk situations may require one to one staffing or transferring the resident to the hospital emergency department.

Refer to Appendix E - ACUTE RESPONSIVE BEHAVIOUR MANAGEMENT - SCREENING DECISION TREE

Screening Tools may include:

- Putting it All Together P.I.E.C.E.S.™/RAI-MDS Job Aid (see Appendix B)
- Dementia Observation System
- Cornell Scale for depression
- Cohen Mansfield Agitation Inventory
- P.I.E.C.E.S.™ "Three Question template" (see Appendix C)
- P.I.E.C.E.S.™"Psychotropic Template" (see Appendix D).

See www.**pieces**canada.com/pdf/Resources, for all P.I.E.C.E.S.™ tools + "putting it all together" user guidelines. All of these tools aid the interdisciplinary team to assess, communicate and co-ordinate the support the resident in the most effective manner possible.

Assessment

More in depth **interdisciplinary** assessments are carried out to integrate assessment findings and collaboratively problem solve for possible solutions)

- MDS RAI historical perspective
- P.I.E.C.E.S. ™ Information
- CCAC (MDS HC)
- Family/SDM
- Possible causes of behavior to be investigated further e.g. medications, urinary tract infection
- Is the resident hallucinating and acting on beliefs, tormented by beliefs?
- Is the behaviour disturbing to others?
- Is the responsive behavior manageable in the present setting?

Note: The home may establish a Responsive Behaviour Team which may include: P.I.E.C.E.S.™ internal resource staff, Personal Support Workers, Registered Nurses, Registered Practical Nurses, senior management, Pharmacist, Life Enrichment/Recreation/Therapies, Dietary, Housekeeping, RAI Coordinator. This team may also include other external specialty resources such as Psychogeriatric Resource Consultant and/or Specialized Outreach Teams.

Plan of Care

Establish resident focused, interdisciplinary goals and strategies to ensure resident well being and quality of life and resident/interdisciplinary team safety based on assessment findings.

- Adapt strategies for the individual that respond to triggers and responsive behaviour. Consider the following strategies:
    - meaningful, purposeful, activity participation (e.g., photo albums, physical activity such as a walk, baking, sanding wood, dusting, delivering mail, activities that bring familiarity and enjoyment e.g. singing, dancing, attending church, etc.)
    - social interaction (e.g., sitting and talking with a person including active listening to the persons needs or struggles)

    - environmental intervention (e.g., removes noise/distraction, change lighting, prevent unpleasant odours, use suitable aromas or seating, etc.)
    - varying strategies for different times of day or night (e.g., late afternoon or evening)
- Integrate evidence–based strategies such as **GENTLECARE ™** approaches, Gentle Persuasive Approach techniques, to address specific behaviour as well as observing for triggers, method of communication, removing from certain situations, rest period, activity periods
- Procedures to minimize the risk of altercations (between residents or staff) or responsive behaviours for staff or residents who are at risk of harm or who may have been harmed
- Medications to prevent and manage responsive behaviours may be considered, after all other treatment alternatives have been tried and eliminated as a solution
- Strategies to address in depth assessment findings e.g. pain, infection, anxiety
    - Observe for escalation of responsive behavior from anxious ->verbal-> physical
    - Include techniques such as calming activity, redirection, diversion, reassurance, do nothing, do not argue with the person, etc.

Monitoring and Communication

Observe and document the resident's response to the care plan strategies, this can include:

- observation and documenting observations in charts and progress notes
- regular re-assessment using MDS-RAI 2.0
- medications dose, effectiveness and any negative reactions

All staff should be informed at the beginning of each shift when residents require heightened monitoring. Any new responsive behaviours and any behaviours that may cause risk to the resident or others should also be communicated to staff.

Referral Protocols

Methods of referral will vary according to residents' needs, referral practices and/or availability of specialized experts.
These referrals are appropriate when the resident's condition is very complex, when there is an imminent risk of harm, or when a psychiatric condition is suspected. Specialized service referrals can be directed to:

- services such as a Psychogeriatric Resource Consultant who can provide support, advice, staff or family education related to residents.
- services any time for assistance with care planning, difficulty finding solutions particularly when resident is at imminent risk of harm
- a Clinical Pharmacist regarding medications
- the Physician in an emergency situation for Form 1 (i.e. an application for a psychiatric assessment)
- Geriatricians or to Geriatric Psychiatrist
- other sources as required

Follow up and Evaluation

Individual Resident: follow up according to assessed needs and the care plan; reassess every 6 months at a minimum.

- MDS RAI outcome scales
- Staff recording resident's response to interventions – making changes if required.

Home Policy and Practices: evaluate and update at least annually in keeping with evidence based practices or if there are none, prevailing practices.

Possible Indicators

- Trends in the types, numbers and frequency of occurrences of responsive behaviours
- Use of tools/compare scores such as Putting it all Together or Cohen Mansfied, Inventory, behavior monitoring charts
- Trends in MDS RAI 2.0 data and outcome scores
- Quality Reporting Indicators e.g. Incident reports, Critical incident reports, use of chemical restraints, number of staff, contractors and volunteers receiving training.

Documentation

Individual Resident: assessment, interventions, resident's response to the interventions, reassessment, plan of care revisions, flow sheets. If resident's behaviour results in harm to others a Critical Incident Report to the Ministry of Health and Long-Term Care is required.

Home: a written record of the annual evaluation, who participated in this evaluation, and a summary of the types of changes made (and when) as a result of the evaluation.

Orientation and Training

All staff, contractors providing direct care and volunteers must be oriented prior to assuming their job responsibilities and retrained annually in caring for persons with responsive behaviours and behavior management.

1. Education Planning: suggested tool - The Dementia Education Needs Assessment (DENA) found at http://akeontario.editme.com/DENA with the following structure:
    1. What is this Home's educational 'need' with respect to dementia care?
        a. Critical issues?
        b. Staff development?
    2. What are the gaps that you would like to fill?
        a. Who have you consulted internally? (P.I.E.C.E.S. ™ trained staff, front-line staff, Health and Safety committee)
        b. Who have you consulted externally? (Psychogeriatric Resource Consultant, Best Practice resources, etc)
    3. Education Readiness of Staff
    4. Selecting the most appropriate educational program for the organization.

2. Responsive Behaviours Orientation and Training by target audiences

    All staff: *Basic knowledge of dementia, common symptoms*

    - P.I.E.C.E.S.™ Enabler, Job Aid www.**pieces**canada.com/pdf/Resources
    - use of "Me & U-First" e-modules at www.u-first.ca (English and French)

    Front line staff: *Enhanced knowledge of dementia*

    - U-First "face to face" training at www.u-first.ca
    - Gentle Persuasive Approach (GPA) www.rgpc.ca

    Registered staff: *Enhanced knowledge of dementia, leading the team*

    - P.I.E.C.E.S.™ program, U-First or Gentle Persuasive Approach

    Management Staff: *Enhanced knowledge of dementia*

    - P.I.E.C.E.S.™ Enabler, other coaching programs.

3. M*y Guide for Living with Dementia* - www.dementianetworksc.org/myguide

4. Resource for educational materials
   Contact Information:
   Murray Alzheimer Research and Education Program
   Faculty of Applied Health Sciences
   University of Waterloo
   Waterloo, ON N2L 3G1
   Website: www.marep.uwaterloo.ca

5. **GENTLECARE ™**
   Website: www.gentlecare.com

APPENDIX A: RESPONSIVE BEHAVIOURS TRAINING PRESENTATION

For Appendix A: Responsive Behaviours Training Presentation see attached Microsoft PowerPoint presentation included in this package.

APPENDIX B: "PUTTING IT ALL TOGETHER" RAI-MDS© AND P.I.E.C.E.S.™ INTEGRATION JOB AID

The information captured in the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) and the (P.I.E.C.E.S.) (Physical, Intellectual, Emotional, Capabilities, Environment, Social) Framework can be integrated to enhance the person's and his/her TEAM care planning process and eliminate unnecessary assessment duplication.

RAI-MDS® and P.I.E.C.E.S.™ Integration

The RAI-MDS and the P.I.E.C.E.S. Framework both:

- ✓ Foster an interdisciplinary, person-centered approach to care;
- ✓ Are grounded in the principles of seeking effective intervention and evaluation for care planning; and
- ✓ Facilitate appropriate referrals such as:
  - Referral to the P.I.E.C.E.S. Resource Staff team members;
  - Referral to the PRC;
  - Referral to other interdisciplinary partners such as Psychogeriatric Outreach; Palliative Care, Pain Consultant; Stroke Strategy team, rehabilitation partners, Alzheimer Society

The RAI-MDS and P.I.E.C.E.S. Framework – How Do They Connect?

1. The most recent RAI-MDS assessment, the CAPs[1], and Outcome Measures provide evidence-based information to inform the P.I.E.C.E.S. 3-Question Assessment Framework for those "IN the MOMENT" situations that occur when a person is experiencing an acute change between RAI-MDS assessments.
   i) "What has changed?" – What was the person's status on the most recent assessment? What's different now?
   ii) "What are the RISKS and possible causes?" - What were the risks identified on the most recent assessment? What are they now?
   iii) "What is the action?" - What interventions were in place to address a triggered CAP for the most recent assessment? Is there a need for changes in the intervention(s) now?

[1] Clinical Assessment Protocols were released by CIHI May 2008. Jurisdictions that have not implemented CAPs may continue to use Resident Assessment Protocols (RAPs) for the RAI 2.0 and Client Assessment Protocols (CAPs) for the RAI-HC

2. If a person is experiencing an acute change situation, the P.I.E.C.E.S. Assessment Framework may assist in addressing the care needs "IN the MOMENT" and in determining the need for a full RAI-MDS "Significant Change" assessment.

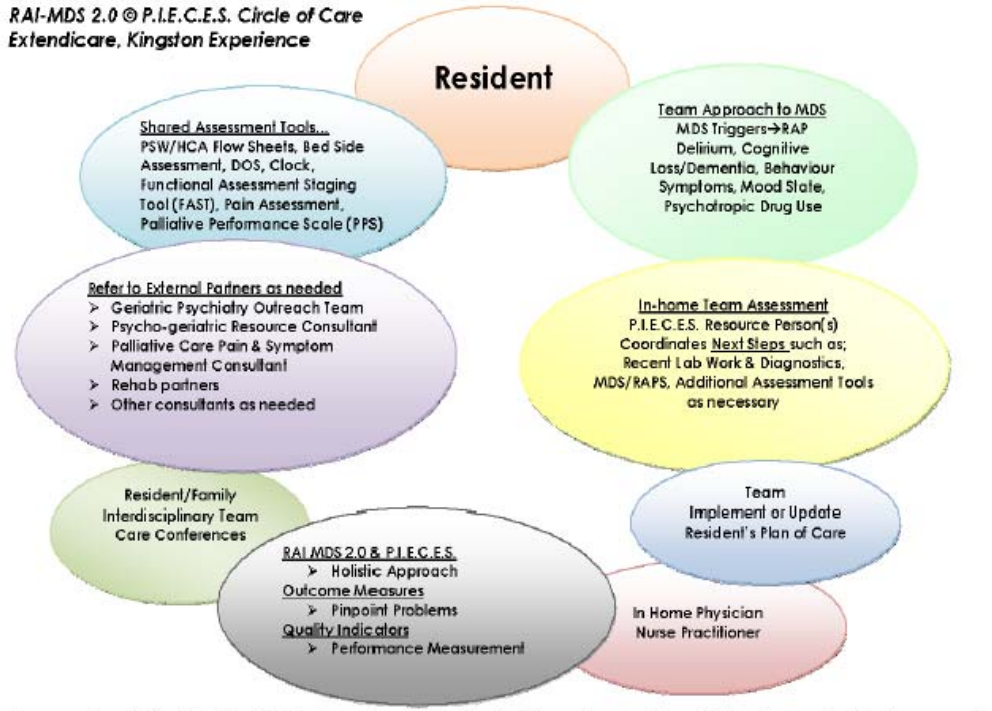
3. The P.I.E.C.E.S. Assessment Framework can be used to assist with care planning when CAPs are triggered (e.g., Delirium, Cognitive Loss, Behaviour, Mood, and Pain) during routine assessments.

4. The completion of a RAI-MDS assessment may prompt the need for more specialized assessment using the P.I.E.C.E.S. Assessment Framework and/or referral to PRC or other interdisciplinary partners.

5. Intervention(s) initiated as part of a P.I.E.C.E.S. assessment and team discussions can be evaluated by comparing the RAI-MDS Outcome Measures from the "before and after intervention".

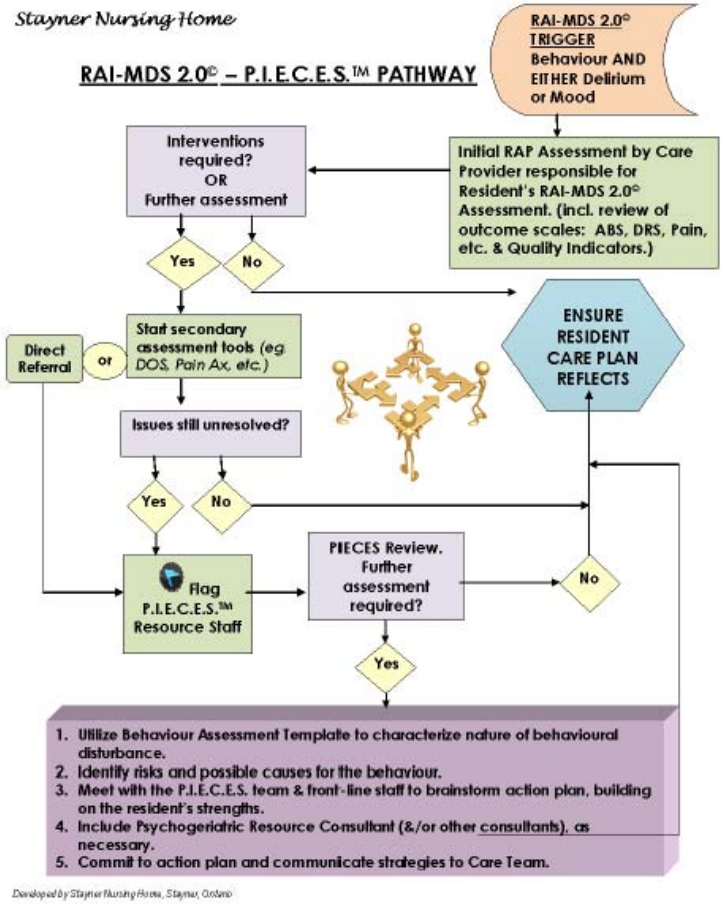
Two models that provide examples of P.I.E.C.E.S. and RAI integration are shown on the flip side of this page. They may be adopted or customized to an organization's standards and policies for practice.

APPENDIX B: "PUTTING IT ALL TOGETHER" RAI-MDS© AND P.I.E.C.E.S.™ INTEGRATION JOB AID…cont'd



Assessments and Care Planning include observations by all interdisciplinary team members. This continuous step-by-step approach recognizes changes in a Resident's behaviour which triggers further team dialogue and evaluation.

Developed by Extendicare, Kingston, Ontario



Developed by Stayner Nursing Home, Stayner, Ontario

APPENDIX C: P.I.E.C.E.S.™ "THREE QUESTION TEMPLATE"

For Appendix C: P.I.E.C.E.S.™ "Three Question Template", see attached PDF included in this package.

APPENDIX D: P.I.E.C.E.S.™ "PSYCHOTROPIC TEMPLATE"

Three-Question Framework for Selection and the Detection, Monitoring the Use, Risk, and Benefits of Psychotropics

1. When should a psychotropic be used or considered?
2. How do I select the right medication?
3. How do I monitor the response and side effects (with person, family, providers)?

Are the benefits outweighing the risks and side effects (to this treatment vs. other treatments)?
- ☑ How long is the medication to be used, and when is it to be reviewed?
- ☑ What are the indicators for increasing or decreasing the medication?

Important Note:

- Withdrawal symptoms are associated with many psychoactives, including SSRIs (flu-like symptoms). The dose must be *reduced slowly* and the status monitored closely.

If no response, consider non-adherence, wrong diagnosis, wrong dose, or not enough time.

CLASS	Preferred choices, starting doses	Side Effects	Notes & max. recomm. doses
SSRI	Citalopram (10 mg), Escitalopram (5-10 mg), Setraline (25 mg): preferred Paroxetine, fluoxetine, fluvoxamine: more common or severe drug interactions; prolonged side effects with fluoxetine	**H**eadache, **A**gitation, **N**ausea, **D**iarrhea **S**weating, **S**omnolence ***HANDS*** Monitor for hyponatremia. Anticholinergic effects: paroxetine	
SNRI	Venlafaxine (37.5 mg)	Headache, nausea, elevated BP in higher doses.	Watch for suicidal risk when "energy" increased but still despondent. Max. recommended dose: 300 mg daily
	Duloxetine (Start dose 30 to 60 mg)	**D**ry mouth, **A**ppetite loss, **N**ausea, **C**onstipation **E**quilibrium (dizziness), **S**omnolence or sleep disturbance ***DANCES***	Not for use with persons with liver disease and/ or severe kidney problems, uncontrolled glaucoma. Watch for drug-drug interaction (i.e. not with fluvoxamine, MAOI some antibiotics i.e. Cipro etc)
NASA	Mirtazapine (15 mg)	Dry mouth, drowsiness, weight gain, dizziness: mild anticholinergic activity	Weight gain can be substantial. Maximum recomm. Dose: 45 mg
NDRI	Bupropion (100 mg)	**S**eizures, **H**eadache, **A**gitation, **R**ash, **E**mesis, **S**leep disturbance ***SHARES***	Maximum recommended dose: 150 mg BID
SARI	Trazodone (25-50 mg)	Drowsiness and orthostatic hypotension	Used more for sedation than for antidepressant effect. Effects last approx. 4 hours
RIMA	Moclobemide (150 mg)	Monitor for hypotension. When combined with MAO-B (Eldepryl), MAOI diet/full precautions needed	In doses up to 600 mg per day, no dietary precautions required. Given BID from 300 mg to 600 mg daily
STIMULANT	Methylphenidate (5 mg in morning)	Cardiovascular risks: high BP, agitation, sleeplessness	Usually not a first line treatment
TRICYCLIC	Avoid most TCAs, Nortriptyline or Deipramine may be considered in treatment resistant depression	(C)ardiovascular: Orthostatic hypotension (dizziness), falls, ↑ pulse rate Anti(C)holinergic: Urinary retention constipation, dry mouth, blurred vision ***3 C's*** (C)onfusion: Monitor with the C.A.M.	Usually not a first line treatment

APPENDIX D: P.I.E.C.E.S.™ "PSYCHOTROPIC TEMPLATE"…Cont'd

Atypical Antipsychotics		Newer Antipsychotics – Side Effects to Monitor	Clinical Response
Common Olanzapine Risperidone Quetiapine **Advantages of New Antipsychotics** • Less EPS • Less risk of developing tardive dyskinesia • Less cognitive effects • May stabilize mood		Dizziness, Agitation (early), Somnolence, Hypotension May cause weight gain May cause tachycardia, with higher doses – EPS Watch for sedation **Cautions:** • Lipid increases • Insulin resistance (glucose changes) • Weight gain • Potential cardiovascular events **DASH**	The clinical factors to monitor include the 7 parameters of delusion: 1. Dangerous, threatening 2. Distressing to self — Initial 3. Disturbing to others 4. Direct Action, if acting on them 5. JeoparDizing independence 6. Distant or present — Later 7. Definite (fixed) vs insight Tranquilizing effect usually occurs early; however, resolution of psychosis may take 1-2 months
Traditional antipsychotics or neuroloeptics		**Traditional Antipsychotics - Side Effects to Monitor**	**Mainly used if delirium**
High potency	Haloperidol	• Constriction: EPS: rigidity, tremors, showed movements, drooling, leaning to one side, parkinsonian gait and falls • Less EPS but more anti-cholinergic than haloperidol **4C's**	
Mid potency	Loxapine, Perphenazine		
Low potency	Chlorpromazine	• Anti-Cholinergic side effects, Confusion, Cardiovascular side effects	In general, should be avoided
If it is an anxiolytic, what class is it?		**Side Effects to Monitor**	**Response**
Benzodiazepine	Lorazepam, Oxazepam, Alprazolam, Temazepam, Clonazepam	Confusion and memory problems, ataxia (poor balance) and falls, disinhibition leading to inappropriate or aggressive behaviour	• decreased agitation and anxiety • Rapid response within 1-2 hours • Best in panic attacks or catastrophic reactions
Mood stabilizers		**Side Effects to Monitor**	**Response**
	Lithium Carbonate	Ataxia and falls, confusion, weakness, diarrhea usually when serum level is greater than 0.8 mmol/L some GI upset in early treatment. Polyuria, tremor may occur at therapeutic doses. Maintain serum levels between 0.4 to 0.7 mMol/L	• stabilization of mood and behaviour within 2-4 weeks at therapeutic dose/level • Mostly used when previous recurrent mood disorder, particularly bipolar illness
Antiepileptic	Na Valproate, Carbamazepine, Lamotrigine	Sedation, ataxia, nausea; if there is bruising or bleeding of any type, call physician. Check if drug levels and blood work done regularly (liver, hematology). Watch for rashes particularly with Lamotrigine.	• May be considered in lability of mood and behavioural problems in dementia
Drugs to treat Dementia		**Side Effects to Monitor**	**Response**
Cholinesterase inhibitors	Donepezil, Rivastigmine, Galantamine	Muscle cramp, Insomnia, Nausea, Diarrhea and weight loss Slow pulse, heart block, peptic **MIND**	• Improve or prevent decline in ADLs, Behaviour, Cognition, and Decrease caregiver time (ABCD)

Cognitive Enhancers (Potential Problems)

Pam Hamilton BA Curriculum and Clinical and Education Consultant.
Joanne Collins. RSW. Curriculum and Education Consultant> Nova Socita Coordinator.
Diane Harris R.N. MSc CHRD, CPT. Performance & Learning Consultant, Project Coordinator
J. Kenneth LeClair MD, FRCP(C). Clinical Advisor, Curriculum & Education Consultant
Marie France Rivard MD, FRCPC(C). Chair, Steering Committee for P.I.E.C.E.S. for Family Physicians

Glutaminergic agent	Side Effects to Monitor	Response
Memantine • Indicated for moderate to severe dementia	Confusion, Headache, Equilibrium, Constipation, Kidney function **CHECK**	• Cognition - improved • Socialization – improvements • Household tasks • ADLs - improved function • Persecutory thoughts decreased • Excessive activity/irritability decreased • Caregiver time saved **C-SHAPES**

APPENDIX E: ACUTE RESPONSIVE BEHAVIOUR MANAGEMENT - SCREENING DECISION TREE