

# Care Companion Programme

(Person-centred care)



BAY OF PLENTY  
DISTRICT HEALTH BOARD  
HAUORA A TOI

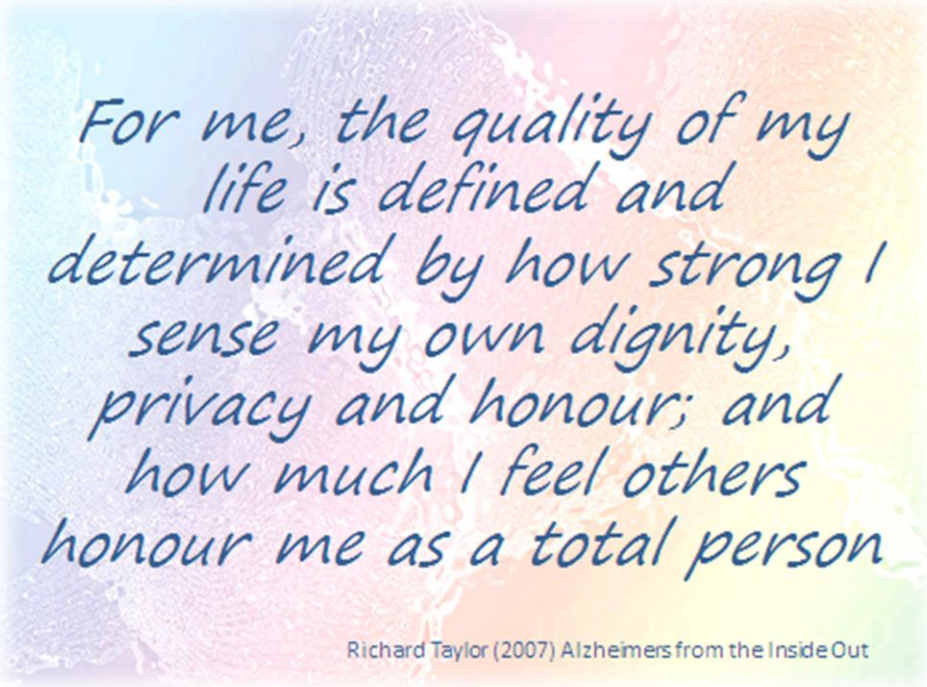


*This is your workbook to keep and use as your own resource and is designed to:*

- *introduce you to person-centred care and care companionship*
- *aid in your understanding of the person's needs and how to form a connection with them*
- *show you how to be a Care Companion*
- *give you practical tips to improve the physical and psychological well-being of the person you are caring for.*

## Introduction

Being admitted to hospital can be a frightening and disorientating experience, especially for people who have cognitive difficulties such as dementia or an intellectual disability. The effects of being acutely unwell for an older adult can result in delirium where people may experience disorientation, confusion and/or anxiety. There are also people who may need additional care to maintain their own safety due to mental illness such as self-harm, eating disorders or psychosis.



*For me, the quality of my life is defined and determined by how strong I sense my own dignity, privacy and honour; and how much I feel others honour me as a total person*

Richard Taylor (2007) *Alzheimers from the Inside Out*

## Person-centred care

Person-centred care focuses on identifying and responding to the individual person's physical and psychological safety, comfort and well-being in an environment which may be frightening or bewildering for the person.

The basic principle is recognition of the person as an equal partner in the planning of care – that knowing their opinions and experiences is important in how care is planned and delivered.

Person-centred does not mean “what the person says goes” but it does ask that we take into consideration and act on what the person expresses as a need where ever possible.

*Person-centred care means the person should experience feelings of:*

- *Security* – do I feel safe with the people looking after me?
- *Belonging* – do I feel like I am part of what is going on here or am I just told what to do?
- *Continuity* – is everyone approaching me in the same way or is it completely different depending on who is looking after me?
- *Purpose* – do I feel useful?
- *Achievement* – do I feel criticised or belittled when I get something wrong?
- *Significance* – do I feel that I matter, or do the ‘rules’?

Adapted from Nolan, Davies, Brown, Keady & Nolan, 2004

Undertaking care/nursing tasks in an individualised manner is a good first step in delivering person-centred care, but doing it in manner whereby the person feels safe with you, feels like they are important and that they do have a say in how and when things are done is true person-centredness.

## CARE values

Here at BOPDHB we are committed to providing care which is values-based. We can use our CARE values to demonstrate person-centred care.

<i>Person-centred CARE values</i>	<i>This means:</i>	<i>This does NOT mean:</i>
<i>Compassion</i>	Recognising the impact of the illness process and valuing the person's life and worth in the midst of their distress. Empathy along with actions of professional care. <i>Kindness.</i>	Feeling upset or distressed about the situation that the person is in.
<i>All-one-team</i>	Working in partnership with family/whanau and the person, knowing about the person's life prior to being in hospital. Multidisciplinary team members work together to provide holistic care.	The health care team is the expert and what we know is the most important goal for the person's care.
<i>Responsiveness</i>	Listening to understand what the person needs and wants (their goals – what is important to them and their family/whanau)	Seeing the person as being a victim or having no control of the situation – therefore we need to 'take care of them'
<i>Excellence</i>	Understanding and working with people to ensure their goals are met safely/ respectfully. Aiming for the best outcome but being flexible as to how to achieve this.	Treating everyone the same (the best care) – expecting that what we do and provide will meet the needs of all people who are in hospital.



*“I felt really listened to and then the information acted upon; I also feel that I have a good rapport with staff now and am able to voice any concerns without any problem.” (Family member)*

## Thinking about our care values.....



Please provide a short answer to demonstrate how you would show *compassion*

1. You are the care companion for a patient who begins shouting and declining care. How do you demonstrate compassion and what might be happening for the person?
2. The carer of the patient is distressed by this. What do you understand about their distress and what can you do to help?

## *Communication*

Communication is an essential part of being a person. This occurs through words and tone of voice – and also by the non-verbal cues we send, like how we approach a person, our body language and the expression on our face when we interact with the person.

There are many reasons why a person in hospital may not be able to communicate their needs or wants or ‘send a message’. It may be difficult for us to interpret or understand what they are trying to say. This is where taking the time to develop a relationship and learn more about them is important in helping us understand them.

Understanding what their ‘normal’ is, helps us understand how we might best interact and support them while they are in our world (the hospital). Families, whanau and friends may be able to help us understand how to best approach and care for their loved one.

People with cognitive impairment are often super-sensitive to non-verbal cues (body language) and communicate most reliably via their body language. When verbal language and body language don’t match, it is the person’s body language that is most likely to be a true reflection of what is being communicated – therefore we ‘listen with our eyes’ more than we listen with our ears.



What you hear the person saying



Yes dear, I'm ready for my shower.

What you see the person saying



Who are you???  
Get your hands off me or I'll scream

LISTEN  
With  
YOUR  
eyes

If the person feels rushed they may feel frustration, anger, and despair. This may occur when someone is struggling to express themselves or having difficulty in understanding the message you are trying to convey.

People with cognitive impairment can take up to 30 seconds to understand and comprehend what is said to them. This means you may need to wait 30 seconds before they will reply and/or to give another piece of information.

Using gestures (pointing, beckoning, etc.) are more easily understood than words. Also demonstrating/showing the person what you want them to do is very effective in communicating to someone who is confused.



### *Use the five S's*

*Slow down your rate of speech and wait... for a response*

*Simple ... one idea at a time*

*Specific ... use the names of objects and people*

*Show ... use gestures or point*

*Smile*

Ask yourself – “What is my body language actually saying?”



*Of course you're  
not taking too long,  
Mrs Smith*

*Is Mrs Smith likely to believe what you are saying? Why?*

## Safe care companion

*Providing safe care companionship to a person or a group of people promotes a therapeutic relationship and helps to increase physical and psychological safety.*

This is different from the traditional model of safety watch which implied that the carer was providing surveillance. The term “companion” has been chosen to recognise the therapeutic opportunity that an additional member of the healthcare team can have in caring for and interacting with the person.

A safe care companion may be required for many reasons; -

- Cognitive difficulties which may prevent the person from keeping themselves safe in the hospital environment, e.g. gets up without ringing the bell and falls.
- Mental illness and distress which may put them at risk of harming themselves or others.
- Eating disorders where the person may not be able to maintain their own food and fluid intake safely.

## Process

All people requiring safe companion care are assessed by the health care team each shift to identify:

- Why they require a safe care companion?
- Any possible changes to care which may reduce risks for them?
- The level and type of care that they require?

This assessment includes talking to the patient and their family/ whānau to understand how to support them during their hospital admission.

## *Observation and documentation requirements*

One of the key roles of the Safe Care Companion is to interact with the person at a level appropriate to their current health status.

There are tools that you can use that will provide you with valuable information and will enable you to participate in meeting the patient needs. This is an important part of the assessment and observation process in providing safe care.

### *“Getting to know me”*

This form is used to gather information about the person and their normal routine. This information can help us understand the person’s needs and form a connection with them. This is important when a person is confused or unable to tell us their likes/ dislikes or normal activities.

Getting to know the person helps us form an understanding of who they are and what distraction or activities may be beneficial for them and crucially how to do things in a manner that is normal for them. If we don’t know what is normal for them chances are we are going to do things in a manner that is confusing and frightening for them.



*What works one day for one person may not work the next day for the same person.*

## What may be useful to understand about the person?

- Who knows them best?
- What they prefer to be called?
- What their usual daily routines / activities are?
- What is important about their vision, hearing, or speech?
- Food and drink – what do they like and dislike, do they prefer to eat at a table?
- Where “home” is for them (this may be a term they are using to refer to a place that they feel safe and secure so we wouldn't argue with the factual accuracy of the 'address')?
- Who are their significant others, family members or pets if they are important to the person?
- What was /is their employment?
- What worries or upsets them?
- What makes them feel better if they are worried or upset?
- Is the person more agitated because their normal routine has been altered?

Make use of the 24-hour clock on the 'Getting to know me' form to record their normal daily routine.



*“It was wonderful to be asked to bring in photos and special items from home. Hospitals have changed so much. It really helped to comfort mum when she was so confused. She was a very pretty lady and even won the Carnival Queen in her young days. I noticed the nurses talking about the photos with her and she was able to tell them a bit about herself as a person. I noticed how she perked up when she was told how pretty she was.” (Daughter)*

8417 1017

Patient Label

**BAY OF PLENTY**  
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**GETTING TO KNOW ME**

I like to be called

The person who knows me best

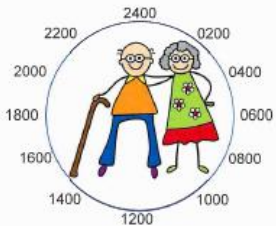
About my family, culture/spirituality

My life so far

My usual morning routine:

My usual evening/bedtime routine:

This is my day:



Getting to know me

8417 1017

Patient Label

**BAY OF PLENTY**  
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**GETTING TO KNOW ME**

Things I like/dislike and abilities

What will help us communicate with you

Preferences about my daily activities

**Guidance notes**

**I like to be called:** Your full name, or the name you would prefer to be called if this is different.

**The person who knows me best:** Who is most likely to know how you like things to be?

**About my family, culture/spirituality:** This may include details of your family members, good friends, pets, Pepeha, Iwi, Marae, or beliefs and practices important to you.

**My life so far:** What would you like us to know about your life? What did you do for a job?

**My usual morning routine:** What do you do and when? Do you shower? When do you have breakfast? What else do you do?

**My usual evening/bedtime routine:** What do you do after dinner and before bed? How do you relax and unwind? How do you sleep?

**Things I like/dislike and abilities:** Tell us about activities/ food; things that will help us get it right for you. Tell us things you do well.

**What will help you communicate with me?** Tell us what you would like us to know about your vision, hearing and speech. Does it help to write things down for you? Do you speak another language?

**Preferences about my daily activities:** Do you prefer to eat at a table, do you need your food cut up? Do you walk independently or do you use a walking aid? Do you need any help in the toilet?

**This is my day:** Mark on the 24 hour clock what you normally do in your day and when.



“Jack had been terribly confused in hospital, especially at night. I came in to visit him later in the afternoon one day and I was surprised to find one of the nurses chatting to him about the AIMS games. She had seen the logo on the shirt he was wearing and asked him about it. He was telling her how he was a scorer at the games. Even though he couldn’t remember the conversation afterward, he seemed more settled somehow.” (Wife)



*Please give 5 reasons for a care companion to be put in place.*

1.

2.

3.

4.

5.

*Describe three reasons why using the “getting to know me” form is helpful when you are care companion.*

1.

2.

3.



# ARE THEY DIFFERENT TODAY?

## Behaviour

Provide reassurance  
Be calm and patient  
Make instructions simple  
Do not challenge abnormal beliefs  
Are they over-stimulated?  
Do they have specific triggers for challenging behaviour e.g. noises, certain people?  
Do they have choices in care needs?  
Avoid making a person do something they don't want to do.  
Does the person have any unmet needs? E.g. thirsty, in pain?

## Physical Review

Check obs  
Change in medication or start medication?  
Hot swollen skin?  
Cough?  
Dark smelly urine?  
Are they constipated?  
Regular hygiene?  
Regular mobility?

## Environmental

Check lighting  
Check noise  
Do they know where they are?  
Too hot or cold?  
Is signage clear—e.g. toilet?  
Is there space to move around?  
Is there something to make the environment feel friendly / homely?  
Does the person know how to use the call bell?

## Mobility

Have they had a recent fall?  
Are they at risk of falls?  
Follow falls care plan  
Do they have activity and stimulation if appropriate?  
What footwear do they like to wear?  
Is their footwear well-fitting?

## Sensory

Does the person like to be touched or not?  
Do they wear glasses?  
Are they theirs, are they clean?  
Do they wear a hearing aid?  
Is it switched on?  
Is the battery working?  
Don't shout

## DETECT AND MANAGE DELIRIUM

## Family & Social

Do they have contact with family?  
Getting to know me form?  
Work with family to promote care.  
Family to bring in personal items

## Continence

Offer regular toileting  
Hygiene—provide assistance  
Orientate to toilet location

## Pain

Ask if they are in pain  
Provide appropriate pain relief  
Monitor facial gestures  
Monitor for body language

## Food & Drink


Encourage fluid intake  
Monitor fluid intake, not fluid given  
Encourage food intake  
What do they like and dislike?  
Check dentures if worn.  
—do they fit?  
Do they have problems swallowing?

For more assistance, consider activity trolley guide  
Kindly adapted from NHS Foundation Trust Publication 2018.

## Care companion shift plan – Handover

It is important that you receive handover information about the people in your care from the Registered Nurse (RN) who is responsible for the patient. This occurs as close to the start of each shift as possible and includes a review of the “Safe Care Companion Documentation of Shift Form” and a discussion around what the patient will require over the next period of time. The nurse will discuss the plan of care, e.g. taking the person for walks, the person’s hygiene needs, food and fluid delivery and toileting with you, what helps to calm the person when they’re anxious, etc.

This is important - as it is the time that you can plan together how to best meet the person’s needs over the shift and to learn how their needs have been successfully met on previous shifts.

8103 04/18	Patient Label	 <b>SAFE CARE COMPANION DOCUMENTATION OF SHIFT</b>
Date:    /    /		
<b>Supervision and delegation by registered nurse</b>		
The Care Companion: <ul style="list-style-type: none"> <li>• is accountable to the RN who has responsibility for the patient that shift and works under their direction at all times,</li> <li>• must have handover from this RN at the start of your shift, NOT just the previous Care Companion for the patient,</li> <li>• must notify the RN immediately of any change in condition or concerns</li> <li>• must not leave the patient without the permission of the RN supervising them and a relieving person being available to take over,</li> <li>• must remain alert at all times.</li> </ul> The RN will provide all clinical nursing care and seek assistance with routine support cares when required and will administer all the patient’s medications.		
<b>Level of Observation Required (tick one box) Refer to Policy 7.104.1 Protocol 3, Care Delivery – Patient Observation</b>		
<input type="checkbox"/> <b>Level 2 - 15/60: Frequent Observation</b>	<input type="checkbox"/> <b>Level 3 - same room and eyesight at all times</b>	<input type="checkbox"/> <b>Level 4 - Constant presence</b>
<b>RN to tick all boxes which apply</b>		
<input type="checkbox"/> Complete “Getting to know me” form to understand preferences, abilities and communication style		
<b>BEHAVIOURS</b> The person may:		
<input type="checkbox"/> like to walk about the ward	<input type="checkbox"/> be unintentionally intrusive	
<input type="checkbox"/> use unpleasant words	<input type="checkbox"/> be unable to follow instructions	
<input type="checkbox"/> respond by hitting out	<input type="checkbox"/> respond by shouting	
<input type="checkbox"/> call out with no obvious cause or expected response	<input type="checkbox"/> be at risk of self-harm	
<input type="checkbox"/> be a high falls risk	<input type="checkbox"/> other	
<b>COMMUNICATION AND REORIENTATION</b>		
<input type="checkbox"/> Help the patient remain orientated to time and place.	<input type="checkbox"/> Engage in gentle and calming conversation.	
<input type="checkbox"/> Gentle reminders throughout the day of day, date, time.	<input type="checkbox"/> Refer to patient’s “Getting to know me” form.	
<input type="checkbox"/> Night/day routines, e.g. curtains pulled / lights off at night, curtains open during the day, etc.		
<input type="checkbox"/> Remind about regular routines eg meal times, shower time, visiting, etc.		
<input type="checkbox"/> Encourage discussion about previous occupation, hobbies, childhood, etc., if appropriate.		
<input type="checkbox"/> Report the subject /quality of the patient’s conversation.		
<b>OBSERVATION</b>		
<input type="checkbox"/> Patient should be within sight at all times, including when in the toilet.		
<input type="checkbox"/> Care companion must be within arm’s length of patient at all times.		
<input type="checkbox"/> Patient may use toilet/ bathroom with door closed.		
<b>ENVIRONMENT</b>		
<input type="checkbox"/> Keep environment tidy and eliminate any risk		
<input type="checkbox"/> Keep environment calm and quiet		
<input type="checkbox"/> Do not over-stimulate the patient.		
<b>CARE TASKS</b>		
<input type="checkbox"/> Make/change bed	<input type="checkbox"/> Offer mouth hygiene	
<input type="checkbox"/> Ensure dentures are clean and in situ	<input type="checkbox"/> Assist to shower / sponge wash	
<input type="checkbox"/> Protect patient privacy	<input type="checkbox"/> Offer toileting every ____ hour(s)	
<input type="checkbox"/> Monitor bowels (utilise bowel chart)	<input type="checkbox"/> Hearing aid in situ and working	
<input type="checkbox"/> Ensure glasses are on and clean	<input type="checkbox"/> Report complaints of pain	
<input type="checkbox"/> Assist the patient with eating	<input type="checkbox"/> Offer and encourage fluids	
<input type="checkbox"/> Record intake on food chart	<input type="checkbox"/> Keep water fresh and available at bedside	
<input type="checkbox"/> Report level of assistance required to mobilise/toilet	<input type="checkbox"/> Ultra low bed	
	<input type="checkbox"/> Sensor mat bed/chair	

## Questions to ask at handover

- Specific reason for safe companion care for this patient (their risks).
- What type of care do they require?
- How close you need to be to the person in close observation room?
- How do you request assistance from the RN or other team members?
- What things can you do to reduce the person's anxiety or fear?
- How do they indicate that they want to get up and move about?
- Do they try to get up without calling for help or ringing their bell?
- How mobile is the person and what assistance do they need to mobilise
- How does the person indicate that they need to use the toilet?
- Which family/ whānau members can participate in providing safe care companionship to the person and what support will they need?
- When will you get a break/relief and how often can you expect a break?
- What is the plan for checking in with each other?

*Provide 5 examples of what you need to know when receiving a handover at the beginning of your shift as a care companion.*

1.

2.

3.

4.

5.

## Documentation of shift

Write your full name and signature on the Safe Care Companion Form

- Document risks or behaviours you saw and what your actions were. For example:
  - **Wandering:** *Mrs. Jones tried to leave the cubicle stating she wanted to go home. I asked her if she would like a cup of tea, walked her back to her chair and got her a hot drink. I distracted her by talking with her. The main things we talked about were.....*
  - **Falls risk:** *Because she was confused, I reminded Mrs. Smith where she was and how to ring the bell if she needed to get up because it is not safe for her to walk alone.*
  
- Document how the person is reacting to the environment. For example:
  - **Confusion:** *Mrs. Smith didn't appear to know where she was, or Mrs. Smith knew where she was and who I was.*
  - **Anger:** *Mr Jones appeared angry about having to stay on the ward, stating that he wanted to go home and started packing his bags.*
  
- Document any other information agreed by the team for individual staff to report e.g. toileting, mobility, oral intake, what assessments were completed and multidisciplinary team input.
  
- If there are no concerns, you could write:
  - No risks observed, or 'rang the bell when wanted to get up', or 'remained in chair and participated in care'.*



*“I noticed Dad was very confused and unsafe in hospital and he had fallen over a lot. The nurses had a close eye on him in a special room. They asked me about Dad and his life and I was able to tell them about my Dad....about how he was the Kaumatua of our whanau, about how he had been strong for us all these years and the things that were important to him. Even though he was sick and old and tired, it didn't change his status in our whanau and the nurses respected that...they treated him with mana and aroha. He responded favourably to that respect; they maintained his dignity; he felt his Wairua was intact while he healed from his illness.” (Son)*

*The information written on the observation record is used by the nurse to reassess the person's safety. Every shift, review the management plan and the need for ongoing close observation.*

## **Important**

This form will be part of the person's health record and it can be read by other people, e.g. family/whanau or lawyers.

- Put the date and time on the sheet when writing anything on the form.
- It is important you only write what happened, or what you did – it is also useful to write some of what the person said that helped you decide how to interact with them.
- If you have any concerns about aspects of a person's care, discuss them with the RN.
- Report only on the direct interventions(s) you were involved in.
- Keep your notes short and to the point.
- Do not leave gaps in the writing you do.
- Don't write about your opinions or feelings.

## *Levels of observation and environment*

If you are a care companion for more than one person, this is called a “cohort” care companion; up to four patients may be cohorted in one room.

If you are a care companion for one person, this is called 1:1. This means you are only observing one person and you must remain within arm’s length of the person, unless otherwise directed.

*Low stimulus* means the person (often in a single room) requires very little noise/talking and low lighting. Sometimes the Occupational Therapist will create a day planner for the person to help them to manage stimulus.

*Familiarity* – Having items from home will often help comfort a person with confusion.

*Triggers* – you may notice a pattern or response from a person for which you can identify a definite trigger. This may be another person or an inanimate object. If you notice a trigger, communicate with your RN.



*What works one day for one person may not work the next day for the same person.*

## *Getting yourself ready for your day*

As the team member providing safe companion care you will be limited in your ability to leave the room for supplies. It is important to plan and prepare for your day. Ensure you have what you need including:

- Each person's "Care Companion Documentation Form"
- Linen, towels, bedding, bowls
- Contenance products, commode chairs
- Rubbish bags
- Clothing for the person
- Equipment required for clinical observation
- Any other activities which may be used with the people in your care.

### *Remember*

When you are working with 'cohorted' patients, all the patients are to remain in direct sight at all times. You may need to ask for assistance with toileting a patient unless the other patients are being safely observed by other people i.e. family, HCA, nurse.

Self-care is important – check when you will be relieved for a break and what support is available to you.

Check in with each other at regular intervals, particularly if a person is very agitated or requires close observation, think about more regular relief.

Ensure you know what needs to be observed and documented on the "Safe Care Companion Documentation Form".

Ensure family/whānau and visitors know they must notify you when leaving the person alone.

## *Health care assistant responsibilities*

- As a care companion you work under the direction and delegation of the RN; who will give you information and direction for the person(s) you are care companion for.
- Please ask the RN to explain if there is something you are unsure of.
- Keep the person in sight at all times as directed by your RN.
- During the day, engage the patients in conversation and if appropriate, in activities. During the night, make sure there is low lighting in the room and you can see the person(s) very clearly.
- Tell the RN straight away about any changes in the person(s) that you are worried about.
- For ideas on managing unpredictable actions or responses, please see the appendix section of this workbook.

Being a care companion may sometimes be demanding and stressful. Supporting each other is key. If you are finding it difficult, discuss with your RN or Clinical Nurse Manager (CNM) for ideas and support. Sometimes actions and responses from people can affect us as individuals. Recognising this, and asking for help and support is important. If you need a break from being a care companion for a while, speak with your RN or CNM.

*What are your main responsibilities when you are a care companion?*



## *The resource trolley*

Research has shown that when an individual's functional skills are equal to the challenges inherent in an activity, the individual is more likely to become fully engaged, lose track of time, and experience positive emotions. Activities that are personally interesting and designed to accommodate functional skills provide intrinsic motivation for participation.

The importance of the activity 'making sense' to the person cannot be understated. By utilising the 'getting to know me' tool and monitoring behaviour, a particular set of activities can be identified for the person to help with engagement, distraction, de-escalation and cognitive stimulus. This becomes more than a method to manage behaviour but also allows recovery and improvement in cognitive function.

*See Resource Trolley Preference Checklist in Appendix*



*“...I now understand how I react has a big impact on their day or even on their life.” (Staff member)*

## *Working with unexpected actions and responses*

There are many reasons why a person may demonstrate actions or responses which are not usual, are out of context to the setting or are difficult to understand while they are unwell or out of their normal environment and routines.

Please refer to the appendix for information on how to work with some of the more frequent responses and actions encountered in the care companion role.



*Sometimes, how we 'observe' a person may be threatening. Being with the person will help you gain what you are looking for.*

*Please provide a reflection of your experience of being a care companion.*

- *Include how long you spent being care companion.*
- *What challenges did you encounter?*
- *What worked well?*
- *What would you do differently next time?*
- *What items on the activities trolley have you been able to utilise and why?*

*Your experience of being a care companion....continued.*

# Appendix

Behaviours or actions which may be seen while providing safe companion care:

- Agitation, restlessness.....30
- Intrusive walking.....32
- Declining care.....33
- Sun downing.....34

Other useful resources:

- Delirium management protocol..... 36
- Resource trolley checklist.....37

## *Agitation, restlessness or the person indicating that they may respond in a threatening or hostile manner*

When we feel frightened and not in control of what is happening to us, a common response is to try and protect ourselves from the people around us.

For the confused person it is common for them to communicate their fear and need to protect themselves by yelling out, pushing others away or threatening the people around them including ourselves.

Consider the following

- Always approach the person from their front – if they can't see you coming you will make them jump
- Always introduce yourself EVERY TIME you approach the person. Use an open, calm and non-threatening manner (body language)
- Offer gentle reminders of where they are, that they are safe and that their family/whanau knows where they are using words and terms they can understand.
- Encourage the person to talk about what is causing them to feel anxious/scared and what might help them at this time
- Never argue with the person about the factual accuracy of what they are saying/their perception, instead focus on the emotions they are expressing and how you can reduce any fear that they have by saying something like "Mrs Smith, you look frightened/anxious/angry" helps to diffuse/deescalate the situation and helps the person to feel safe with you.
- If it is safe to do so, withdraw from the person and allow them to 'walk off' their anger/frustration. Provide the person with something else to focus on e.g. making their bed, folding linen, etc.
- Connect with the person verbally before touching them to deliver care – giving cues to what is going to happen next before approaching them. Pausing and seeking consent (non-verbal) and participation before

activity commences, e.g. I am going to wash your hands now, would you like a warm flannel to do this for yourself?

- Try to notice any patterns or common events that might lead to/trigger agitation or restlessness. Consider:
  - Does it occur at a similar time each day, how much noise and activity is there around the person,
  - Is it related to unmet physical needs (hunger, thirst, needing the toilet, too hot or too cold, in pain) that the person is unable to successfully communicate through more normal routes e.g. do they always start pacing about the room or remove their pants/skirt when they need to use the toilet.
  - Is it related to psychological need that they are unable to successfully communicate through normal routes (Loneliness, boredom, sadness, fear, etc.) e.g. does the person look sad/cry before they start to pace?
- Share any patterns or observations you make with the healthcare team. Plan and deliver care in a manner that avoids the triggers wherever possible e.g. if the person always becomes agitated during showering, offer an alternative way for them to maintain their personal hygiene e.g. the use of a bowl of water and a flannel to wash them.
- If you can provide the person with low stimulus activities or perhaps guide them away from the situation that is causing them distress.



*Be aware of what you may be communicating. The belief is that 55% of communication is body language, 38% is the tone of voice, and 7% is the actual words spoken.*

## *Intrusive walking*

Walking about/wandering should be viewed objectively and placed where it belongs: as an enabling activity that gives the confused person choice, independence, a sense of control, a sense of purpose and also reduces boredom. Walking has the added benefits of being helpful for constipation, maintaining bone density, maintaining balance skills and reducing falls.

Some helpful ideas for those that want to walk and for those whose walking has become concerning are:

- Find safe areas and opportunities for the person to walk e.g. a quiet lounge, a safe corridor.
- Common reasons for walking include trying to find the toilet and/or something to eat or drink, trying to cope with having pain, being bored, being frightened, trying to find a loved one, trying to find somewhere where they feel safe, etc.
- Offer other individualised distractions, e.g. folding linen, playing card games, having a chat, making their bed with them.
- Close the ward thorough-fare doors where possible to provide a safe confined area that the person can mobilise around.
- Have an agreed plan within the ward team as to what to do if the person is unsafe to leave the ward but at high risk of leaving unaccompanied or does leave unaccompanied. This plan might include: using the nurse call bell system to request immediate assistance, trying to persuade the person to stay by talking to them (you will need to know what types of things to say to the person) or it might be that you do not try and peruse them to leave but simply alert the nurses immediately if they do.
- Wherever possible involve the person's family/ whānau/main carer in the care planning process and agree in advance the likely involvement they will have should the person try to leave unaccompanied. Also have them identify distractions which may be brought in from home to help the person feel more settled in the ward.



## Declining “refusing” care interventions

When people in hospital are confused they often simply cannot understand that they need assistance to do things, and will therefore decline your help. From their point of view this is very understandable i.e. few of us would accept someone wanting to remove our clothes to give us a shower if we genuinely believed that we didn't need help to do this. Our interventions are therefore about reducing fear, embarrassment and finding alternative ways to undertake the task that is more acceptable to the person.

Before and during assisting someone who is/is likely to decline care interventions, some useful ideas are:

- Use tips/ideas from the 'communication' section of this workbook.
- Consider – do I have to get this task done now and in this manner or is there another way I could get the task done?
- Before you start to undertake the care task, explain what you would like to do. Keep communication simple and clear. Multiple instructions can be overwhelming. Be aware the person may find a relatively simple task difficult.
- Use a gentle tone and keep the area calm.
- Talk to the person about pleasant and happy things relevant to them while you are helping them.
- Explain how you are keeping them safe (e.g. "if you sit on this seat you won't be worried about falling").
- Look for signs the person may need to go to the toilet.
- Make sure the person has had pain relief from the nurse, if needed, before you move them.
- Make sure the person has their hearing aids, glasses and dentures on.
- If they have their ways of doing things, let them do it their way as long as you keep them safe.
- Give them plenty of time to do things for themselves, don't hurry them.
- Encourage and engage families/carers and support them to be involved in the person's care if they choose.

## *Sun Downing Syndrome: What is 'sun downing'?*

In the late afternoon or early evening, people with delirium or dementia may become more confused, disoriented, restless or insecure. They may see, hear or believe things that aren't real, especially at night. Attention span and concentration may also become more limited. Some people may become more impulsive, responding to their own ideas of reality that may place them at risk. Being unfamiliar with the environment and out of normal 'routine' as well as the onset of evening may mean the person is more tired, restless and unsettled.

*Sun downing can be worse after a move or a change in routine.*

There are a lot of other reasons the person can be more restless at this time, and the health care team will be trying to find out what these might be, like:

- poor sleeping habits
- hunger
- infection
- anxiety and fear
- pain
- bowel or bladder problems
- boredom
- knowledge of previous routines is helpful. Consider what the person's habits were at this time of day while at home, e.g. dinner preparation.



*The patient's reality is very real to them. In order to work with them, you may need to enter their reality. For example, they think someone has stolen their toilet bag. Respond and acknowledge their distress by saying something like "that must be very annoying...one of my specialities is finding missing toilet bags".*

### *What to try...*

- Early afternoon rest - if fatigue is making the sun downing worse, an early afternoon rest might help. Keep the person active in the morning and encourage a rest after lunch.
- Familiar activities in the evening - Early evening activities that are familiar from an earlier time in the person's life may be helpful. Closing the curtains, a pre-dinner drink or assisting with preparing dinner or setting the table may be helpful.
- Avoid physical restraint - Don't physically restrain the person. Let them pace where they are safe. A walk outdoors can help reduce restlessness.
- Encourage comforting pastimes - Some people are comforted by soft toy animals, pets, hearing familiar tunes, or an opportunity to follow a favourite pastime.
- Minimise noise and lights - Consider the effect of bright lights and noise from television and radios.
- Avoid upsetting activities - Try not to arrange baths or showers for the late afternoon if these are upsetting activities.



*Look for the meaning behind the actions and you will find an unmet need.*

## DELIRIUM PREVENTION/MANAGEMENT PROTOCOL



### DAYTIME

- Encourage patients to use their visual and hearing aids during the daytime.
- Encourage communication with patients and reorientate frequently e.g. day, date, time (“its lunch time”).
- Provide reassurance and explanation to the patient and carers using short simple sentences.
- Ensure adequate lighting; blinds and curtains open during the day.
- Encourage normal daily routine, i.e. get out of bed for meals.
- Encourage early mobility to prevent deconditioning.
- Introduce oneself with each encounter, explaining any procedures and giving the patients choices regarding their care whenever possible.
- Identify language or communication barriers and provide resources as appropriate.
- Involve the family/whānau in care planning
- Ask family bring in a few familiar objects, usual interests, familiar clothing.
- Discuss with family/whānau cues for distraction – i.e. grandchildren, pets, photographs may assist.
- Minimise the use of restraints, this includes bed rails, catheters and lines.
- Ensure your patient receives adequate opportunities for rest.
- Try to limit inter and intra-ward transfers.
- Try to ensure continuity of staff.
- **THINK GERIATRIC GIANTS; Bowels, bladder, fluid balance, pain etc.**



### NIGHT TIME

- Prepare.
- Hygiene needs, oral hygiene, medications.
- Turn down lighting, shut curtains.
- Encourage communication with patients and reorientate frequently e.g. “it’s bed time”.
- Consider toileting needs.
- Minimise noise inside and outside the room.
- Remove hearing aids and glasses.
- Consider earplugs.
- Speak to family about normal sleeping habits – i.e. does the patient usually have a radio or light on?
- Avoid physical restraints.
- Try to maintain or restore normal sleep pattern.
- Gentle approach and handling.
- Ensure call bell within reach, bed in low position, environment tidy and clutter free.
- Consider potential for darkened environment to heighten arousal/contribute to hallucinations/altered perception.
- Consider the need for family to stay overnight if distressed.
- Try to minimise sleep interruptions to sleep overnight.
- **THINK GERIATRIC GIANTS; Bowels, bladder, fluid balance, pain, sleep deprivation etc.**

From Waitemata DHB Delirium workbook (2015) with kind permission of authors.

# Resource Trolley

## Preference Checklist

Preferences can change day-to-day and morning-to-afternoon. Please trial different resources to build a personalised plan.

Personalised Resource Plan	
Morning	Afternoon

### Doing

- Reading
- Colouring in
- Aqua paints
- Walking/ been taken for a walk
- Doing puzzles/code breakers
- Cleaning/folding /home projects
- Knitting
- Deep breathing
- Shower
- Phone/ talk to family or friends
- Journal
- Take part in religious or spiritual activities
- Swaying
- Memory card game
- Dominoes
- Cards
- Bingo
- Conversation cards
- Other.

### Fidget items...

- Sensory bottle
- Textured ball
- 'World' stress ball
- Smiley face ball
- Rubber string ball
- Bubble wrap
- Fidget apron
- Mix and match balloon game
- Gel mat
- Other:

### Taste/oral motor ...

- Brushing teeth
- Lip balm
- Green mouth stick
- Hot drink/ Cold drinks
- Blowing bubbles
- Other:

**Touch**

- Doing hair/makeup
- Shower: cold/cool/warm/hot /powered
- Tucked or untucked
- Having an arm/hand massage
- Washing hands
- Patting a pet/animal
- Warm or cold face/head cloth
- Being hugged or held
- Using powders or lotions
- Being wrapped in a blanket
- Other:

**Sounds**

- Listening to music: classical, folk, rock n roll, hard rock, dance/pop, country, reggae, R&B, cultural, worship, live, instrumentals
- Radio
- Quietness
- White noise
- Nature noises: sea, animals, waves, birds, rain, wind chimes
- Busy environments
- Singing or talking
- The hum of others/noisy room
- Earplugs/earmuffs
- Other:

**Visual**

- Dim lighting
- Photos or videos
- City: vehicles, people, buildings
- Nature: bush, sea, rivers, clouds, stars, sunset and sunrise, animals, the sea, snow falling, rain, fish, waterfalls
- Home videos/photos
- Coffee table/ adult picture books
- Artwork
- Sport
- Movies
- A TV program
- Other:

**Comfort items...**

- Wrap around body lycra
- Blanket
- Round cushion
- Own blanket or pillow
- Weighted cat
- Doll
- Other:

**Smell**

- Perfume/aftershave
- Scented lotions
- Shower gel/soap
- Coffee/tea
- Essential oils
- Flowers/plants
- Other:

**Notes:**


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CHOOSE  
kindness

Manaakitanga

