

# Behaviours that challenge: the 5-step approach



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Distressed behaviours among people with dementia can pose a serious challenge for staff. **Tina Kukstas** describes the “5 step approach”, which translates complex guidance on person-centred strategies into a more accessible format

**C**are home staff who support people with dementia are subject to ever increasing scrutiny and challenge by the Care Quality Commission (CQC), particularly if “hands on” physical intervention or some other form of restraint is deemed necessary. Antipsychotic medication has certainly been under scrutiny in this respect for many years.

Professor Sube Banerjee’s *Time for action* report, published in 2009, triggered the drive to reduce the use of antipsychotics for people with dementia and it has been strengthened by the newly revised guidance on the subject from the National Institute for Health and Care Excellence (NICE 2018). Both the report and the guidance recommend that antipsychotics are used only when all non-pharmacological approaches have been exhausted.

The effectiveness of non-pharmacological interventions has now been comprehensively evidenced. For example, a systematic review of randomised controlled trials (Livingston *et al* 2014) found that non-pharmacological approaches offer evidence-based strategies for care homes and said that future interventions should focus on consistent and long-term implementation through staff training.

Here in Gloucestershire, the challenge to care home staff of complex behaviours among people with dementia was recognised by 2gether NHS Trust specialist nurses from our Care Home Support Team, who were receiving regular referrals for support and advice. One issue that arose was that existing dementia practice guidance, such as that from NICE, is not always easy for frontline staff to apply.

Our “5 step approach” is intended to be a pragmatic and accessible solution to the problem, translating formal guidance into a useable format to assist the practice of all care and treatment staff, both registered and non-registered. Clinical and education staff in the trust formed a project group, which I led, and the Gloucestershire 5-step approach was formulated over a period of six months. We held a series of development workshops while individual practitioners worked on elements of the scheme.

Our objective was firstly to reduce the number of violent or aggressive incidents and minimise the use of antipsychotic medications, which, among

other things, have been linked to a heightened risk of parkinsonism, falls and increased cognitive decline (Banerjee 2009). And, secondly, it was to prevent the breakdown of care home placements, avoiding admission to hospital or a move to an alternative care home.

The 5 step approach can be summarised under the following headings: Gather, Look, Create, Share, Review (see diagram). It is about personalised care planning for behaviours that challenge in dementia and is based on the watchwords identity, comfort, occupation, inclusion and attachment.

## Step 1: Gather information

This step asks staff to gather information about the person focusing on three areas, namely physical health, life story and behaviours that are causing concern. First, the PINCH ME acronym is a way to remind staff what to focus on when considering physical health factors that might be impacting on someone’s wellbeing.

As a tool, PINCH ME invites them to look at Pain, Infection, Nutrition, Constipation, Hydration, Medication and Environment. Among other things, it prompts consideration of delirium as a possible cause of the person’s behaviour and seeking guidance and advice, if needed, to assess and treat a physical problem.

The second thing to focus on is any life story information known about the person, for example what they used to do as a job, what interests and hobbies they had or have currently, and who are or were the important people in their lives. Alzheimer Society’s “This is me” tool is helpful in capturing this information.

Finally, information should be gathered relating to the behaviours that are causing concern, as documented in antecedent-behaviour-consequence (ABC) charts or incident reports. An example of how to capture ABC information and a specimen template is included in the 5 step resource pack.

## Step 2: Look at the information

In this step, staff explore and consider the information gathered with colleagues and relatives or friends of the person with dementia. One way to pull together the information is to use

the “enriched care planning model” (May *et al* 2009), which again we incorporate in the 5 step resource pack.

The various domains in the enriched model provide an opportunity to highlight individual characteristics, including the type of dementia the person has. Conversations with the person’s relatives and friends may yield additional information previously unknown to staff.

It is suggested that different members of the care home team take responsibility for completing the various domains where they have a key worker role for particular residents, though it may be that there is a staff member who has a special interest in doing so for all residents, as happened in the service evaluation.

A significant discussion point within this step is to ask the question, “what is the person communicating/feeling?”

### Step 3: Create a plan

Staff identify behaviours and patterns to create a “traffic light” personalised plan or RAG plan: what to do or how to respond when the person is at “green” (when they are feeling okay), when they are at “amber” (showing signs of becoming distressed), and when they are at “red” (i.e. distressed).

Key to the plan is that it should be simple and accessible, using bullet points so that it is easy and quick to read for all staff. Care planning is intended to prescribe care and treatment, but in the real world staff may have insufficient time to find and read care plans in full so that little of what is in them is translated into care.

Traffic light plans are distinct from other care plans because they are visible and accessible, providing guidance and support to staff on the ground. A further difference is that traffic light plans focus on how the person is when they are well and how to maintain wellbeing. For example, the “green” section may recommend support to walk around the garden every day due to their lifelong interest in gardening and plants, a proactive rather than reactive style of care.

### Step 4: Share the plan

Staff make the plan visible to all workers and relatives or carers. Care homes can do this by placing the plan in the person’s room, perhaps by attaching it to the wardrobe door or keeping it in a folder. It is then accessible as personal care tasks are undertaken and acts as a reminder to use personalised approaches. Since it shows that the individual is “known” by staff, relatives are reassured too.

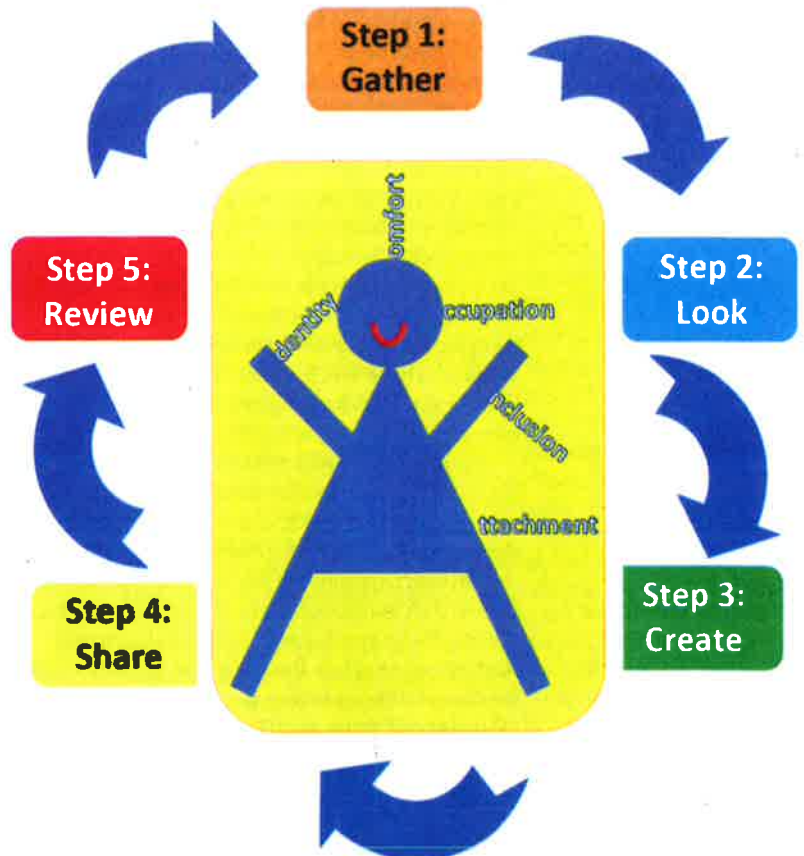
### Step 5: Review the plan

Staff review the plan to check that the information and personalised approaches in it are still working for the individual. It can be reviewed whenever appropriate and will ideally include conversations with relatives and friends.

### Implementation

We are disseminating the 5 step approach through the Gloucestershire Dementia Training and Education Strategy, which provides a range of

## The Gloucestershire 5 Step Approach: Personalised Care Planning for Behaviours that Challenge in Dementia



### The Dementia Training & Education Strategy for Gloucestershire

training opportunities for all organisations across the county including non-statutory services.

Mental health nurses on the trust’s Care Home Support Team have also produced their own pack for delivering the training to care homes, while the dementia ward at Charlton Lane Hospital has nominated lead clinicians who promote the 5 step approach from admission to discharge.

In consequence, the approach is now being used widely across Gloucestershire and has helped to establish a common language for staff in responding to complex behaviours. There is now an expectation that this non-pharmacological intervention will be considered prior to – or at least alongside – any medications being prescribed.

We periodically review the approach to keep it fresh. We did so in 2017, for instance, by simplifying the model by using key words rather than sentences to describe each stage and inserting a capacity assessment for the personalised care plan. A further review is planned for later this year.

## References

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## Evaluation

We undertook a service evaluation at a care home in Cheltenham with the aim of assessing the impact of the 5 step approach there. We recorded the amount of violent or aggressive incidents before doing the training and distributing the resources, then followed up post-training with two more visits to get qualitative feedback. Six months after the training, we reviewed the number of incidents and referrals to the trust Care Home Support Team.

What we found was that reported incidents of violence and aggression in the home fell from eight during the six months before introducing the resources to four in the six months afterwards. Referrals to the Support Team dropped from six to zero over the same period. While these outcome measures are not conclusive, given the small sample, they do give us grounds for confidence, particularly as NICE (2018) links a reduction in behaviour that challenges with the availability of non-pharmacological interventions.

Gloucestershire Clinical Commissioning Group (CCG) has agreed to fund hard copies of the resources for a further year so that they can be distributed through our dementia training initiatives. Our scheme has significantly driven forward dementia care practice in the county, among the many benefits being a structured framework that has the potential to reduce anxiety for care staff supporting people with dementia (Kukstas & Furniaux 2015).

An electronic version of the resource is available on the Gloucestershire dementia training strategy website [www.gloucestershire.gov/dementiatraining](http://www.gloucestershire.gov/dementiatraining).

For further information on the 5 step approach, contact [tina.kukstas@nhs.net](mailto:tina.kukstas@nhs.net). ■

## Case study:

### Personalised care plan

Bob is a 74 year old man who has been in the army all his life. He has not married but has strong relationships with his army colleagues, one of whom (John) still visits him in the care home where he lives.

Other information about Bob drawn from ABC charts and personal history:

- At times he paces around the unit in an agitated way
- He tends to hoard items such as cutlery in his room
- He occasionally will not come out of his room or barricades himself in the lounge
- He likes sport: archery and swimming
- He likes country music, especially Don Williams
- He appears worse when there is more than one person talking to him
- He sometimes refers to the staff as "those blinking Germans."

### Traffic lights

#### Green

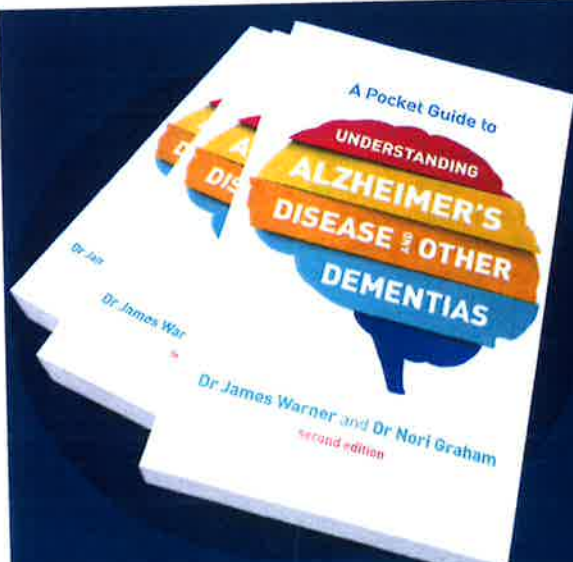
- Provide Bob with a programme for him to see when he is due to water the plants and exercise, e.g. timetable: 10am as plant watering time / 2pm as exercise time
- Provide calendar where John's visits can be put down and referred to.

#### Amber

- Approach Bob with respect and calm tone offering a walk or a chat about his interests in archery and swimming, using his life story book.
- Encourage him to move to a safe personal space, such as the hallway or his room, saying "we need to go this way Bob". Speak clearly and with authority
- Encourage him to listen to Don Williams. He will often sing along to the track "You're my best friend".

#### Red

- Staff to remain calm and be aware of their body language when approaching Bob.
- Use calming sentences, such as "I'm on your side Bob".
- Provide reassurance, such as by saying "this is hard but it's being sorted".
- Distract Bob with offers to walk out to the garden to "check on things there" or "do some exercises".



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