Developing a Person-Centered Therapeutic Recreation Dementia Program

Village Nursing Home
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Village Nursing Home is part of Village Care of New York, a community-based, not-for-profit service organization serving the older adults, persons living with HIV/AIDS and individuals in need of medical and rehabilitation services.
DEVELOPING A
PERSON-CENTERED
THERAPEUTIC RECREATION
DEMENTIA PROGRAM

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Arthur Y. Webb, President and Chief Executive Officer
Herbert H. Fillmore, Executive Vice President SeniorChoices
Neil Pollack, Administrator, Village Nursing Home
Dear Colleague, May 26, 2008

It is with pleasure that I present to you “Pieces of the Puzzle,” Developing a Person Centered Therapeutic Recreation Dementia Program. Through a grant from the New York State Department of Health, Village Nursing Home combined the concepts of the American Therapeutic Recreation Association’s Dementia Practice Guidelines with those of Paraprofessional Healthcare Institute’s Coaching-Supervision techniques. Applied together, these practices create empowered staff who put the resident before the task, with a greater understanding of residents’ needs and behaviors, and a greater connection to them as individuals.

While our goals to increase socialization and decrease agitation in residents were met, we also found other notable results. They included: 1) a decrease in falls (a decline of more than 50% from baseline); 2) zero turnover in Certified Nursing Assistants over a period of 4 years; and 3) a continual decrease in those triggering for mood on the Minimum Data Set.

Enclosed please find a CD-ROM, consisting of the printable versions of the two training manuals, along with an introduction from each consultant, providing their thoughts on these materials and a video commentary from our team.

Please feel free to contact me regarding any questions about the training. If you experience any technical difficulties with the CD-ROM, please contact Rob Goldman at (212) 337-5668 or robertg@vcny.org.

Regards,

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Aimee Montgomery Wilson  
Director of Therapeutic Recreation, Volunteer Services and Pastoral Care  
607 Hudson Street  
New York, NY 10014  

October 9, 2007  

Dear Aimee,  

We have enjoyed working with you and the staff at Village Care Nursing Home and Chelsea Adult Day Center. It was a pleasure to collaborate with such energetic and passionate C.N.A.’s, recreation therapists, nurses and social workers.  

To assist Village Care in their NYS Department of Health Dementia Grant, PHI was asked to design a series of training to help prepare line staff (focusing on Certified Nursing Assistants (C.N.A.’s), supervisors and managers adopt a more person centered culture (Phase 1). The content of the training included a kick-off event on person-centered care; communication skills training for direct care staff and recreation therapists, and coaching supervision training for supervisors and managers. Later in the grant period (Phase II), PHI provided support in the form of full and ½ day booster sessions to the same participants in the first phase, to support the project through reinforcement of the skills through training.  

As promised, we are attaching our Introductory Coaching Supervision Curriculum for dissemination to NY State Nursing Homes. In addition, we are including two additional training workshops.  

- The Dementia Grant Kick Off! Training  
- Enhanced Communication and Problem Solving Training: Starring “The 3Ps”  

The second phase of the training included 2 booster sessions for supervisors and managers (a total of 2 ½ days) and one full day booster session for C.N.A.’s and Recreational Therapists. We have provided descriptions of this work for your project report below.  

Again, we truly enjoyed this work and hope that the residents, clients and staff at Village Care have felt a positive impact from the dementia grant project.
Sincerely,

Carin Tinney, MSW
Training and Curriculum Development Specialist
PHI
Dementia Grant Kick Off
Created for Village Care of New York
By PHI (www.PHInational.org)

Held on: March 27th, 2006
From: 9:00 am - 4:00 pm

It is important to note that this training was designed specifically for Village Care of New York as part of their Dementia Grant Project: Developing a Person-Centered Therapeutic Recreation Dementia Program. PHI, as the consulting organization, conducted site-based assessments of Village Care Nursing Home and Chelsea Adult Day Health Center to inform the design of this and subsequent trainings.

**Goals:**

Today’s training will help to build:

- Stronger connections between participants-- across organization levels, departments, programs and shifts;
- Excitement around the NY DOH Dementia Grant and working with each other in different ways;
- Understanding of the grant and various components of it;
- An awareness of and a common understanding of “person-centered care” and how it relates to people with dementia;
- A creative look at how activities can be carried out in the two settings;
- A different perspective on language and how it affects residents/clients.

**Preparatory steps for this workshop to happen successfully:**

- Place on each table: Name tents, markers, index cards/sticky notes, pens, paper, folders (for each participant)
- Write on a flip chart the following: Intro Questions, Goals for the Day, Words for language game, Sentence for language game (The latter two are found in Getting Started: A Pioneering Approach to Culture Change in Long Term Care Organizations.)
- Set up the Clothesline
- Prepare the “pairs” name tags for the first activity
9:00- 10:00  Opening Activity/Icebreaker/Introductions

1. Play energizing music in the background; facilitator to play a “DJ/MC” role that gets people’s energy up through dance and song (we suggest the tune: What’s your flava? By Craig David.) In addition to dance, have participants call out their favorite “flavor” – whatever that may be. The MC informs the group that as the other facilitator circulates, they will be given an index card with a word written on it.

2. The MC/DJ ends the song when the other facilitator has successfully distributed the index cards.

3. Welcome everyone and thank them for the energetic participation so far. Before reviewing the agenda, and doing formal introductions, explain that on their card is a word that is one-half of a well-known or logical pair, for example, “Peanut Butter” of “Peanut Butter and Jelly.”

4. Explain that this training, and the training they will be receiving throughout the course of the grant, will be interactive and at times surprising. The first surprise is that they are going to sit with new people, make new relationships, and the first step will be right now.

5. Ask everyone to look at their index cards, gather their belongings, and find their logical/well-known partner based on the word on the index card. This means they will have to stand and move to a different location. Once found they should find a new place to sit.

6. Turn to the pre-written flip chart page, and once everyone has settled again, tell participants that they will now interview their partners using the questions posted. They will have 3 minutes to interview their partner and they will be introducing their partner to the group using the information gained (total: 6 minutes for this part of the activity). Explain that they will only be asked to share a few points from the interview, not the whole thing. They don’t need to write information down, but they can if they wish.

**Flipchart:**
What do you like to be called here at the nursing home, and at home?
What motivated you to enter this work?

What gifts or talents do you have, that others may not know about you?

Describe a life-defining moment, a moment that illustrates who you intrinsically are. It could be personal or work related.

7. After the time has passed, ask participants to introduce their partner to the group and continue to do so until everyone has been introduced.

8. Trainers will follow the same format, introducing their co-trainers with the same kind of information.

10:00-10:15 Overview of the day
1. Thank everyone for participating in interviews and for being so welcoming.

2. Review the goals for the day and distribute the agenda.

Flipchart:
Our goals of the day:
Get to know each other better--the grant is based on a team effort!

Learn about the grant/project.

Define person-centered care.

Come to a common understanding about the word “activity.”

Develop understanding of how language creates a person-centered environment.

Have Fun!

3. Review timing, breaks, cell phones, beeper policies.

4. Engage the group to come up with the day’s “working agreements.” Working agreements set the tone that everyone is responsible for their own learning. To generate working agreements ask participants to share what they’d like from the group and from the facilitators that would help
them stay focused and help them learn best. For example, a participant might share, or you might start off with, “I learn best when people don’t have side conversations” or “I learn best when I can ask questions.” The facilitator in turn writes the agreement on a flip chart page as such: No side conversations; questions are welcomed. After the list is exhausted (no more that 10 minutes) ask the group to agree to try to adhere to the rules set forth. Set the tone of “trying” rather then “perfecting” because no one is perfect!

10:00-10:45 Logistics of the Dementia Grant, Q and A

1. In the front of the room, preferably on a stage, set up a “talk show” type atmosphere. One facilitator will be the “host” of the show, while the other will be “in the audience” fielding questions; this second facilitator will also be responsible for putting on flip chart questions that “need some research” at this time.

2. The host should play up the role, wear a wig, have a microphone, speak with an accent, if possible. The idea is to make it a light/inviting tone.

3. The host invites the project manager (the person in the Dementia Grant) that has the most amount of information on the grant to join him or her on stage.

4. The host makes some small talk chit-chat, and asks about her energy around the grant, what she’s looking forward to, etc.

5. Then the host turns to the audience and asks for questions about the project/grant. The dialogue continues in this fashion. Note: Beforehand, the host should have prepared a running list of questions, in case a shy audience comes to the ‘show!’ Some questions might be:

Interview questions:
- What is the dementia grant? Do you have the funding?
- What are our goals? What is the timeline? Who are the players?
- What should staff expect? What are the trainings about? Where will they be?
- How do you see this affecting residents and clients?
- How does this project fit into the bigger vision of the organization?
How will this affect nurse, C.N.A., and other jobs at the organization?

6. After these questions, the host and the facilitator in the audience turn the show around to ask the participants the following questions:

To the audience questions:
- What excites you about this grant/project?
- Knowing a little more about this project, what else do you think we should think about?
- What are your thoughts?
- What are you willing to share (talents, time, etc…) to help this succeed?

7. After about 40 minutes or until all questions have been answered, end the “talk show” and ask for a round of applause. Also provide participants with the correct place to go if they have additional thoughts/questions.

10:45-11:00 Break

11:00-12:00 Understanding Person-Centered Care

1. Distribute to or show participants the picture (Wheatfield with Crows by Vincent Van Gogh) but don’t give any identifying information about it. 
NOTE: This picture can easily be found online by googling: Wheatfield with Crows; Vincent Van Gogh. One source is:  
http://www.vggallery.com/painting/p_0779.htm

2. Ask participants for immediate reactions to it, what do they see, what do they think about it?

3. After a few minutes, if participants have been “assigning” meaning to the painting or to the painter who painted it… point out how easy it is to make assumptions and guesses about something so simple, in such a short period of time.

4. Reveal that the painting is one of Vincent Van Gogh’s last paintings prior to committing suicide. Ask participants to Look at the picture again:
   - What is happening for you?
   - Has anything changed when you look at it now?
   - Do you see anything that you didn’t before?
5. Connect responses to seeing the clients and residents
   - We often make an immediate diagnosis based on the way the person appears: what we see, smell, hear
   - We often treat the person based on their diagnosis or history;
   - We make meanings of their life
   - We make the assumption that because they are here, they want and need the help we know how to provide;
   - We assume that we have answers to their questions and processes to address their needs

6. Explain that sometimes in long-term care, we look at people and their needs based on what we can offer; and/or what we think we know from looking at them. Oftentimes organizations function on one set routine, protocol, model, care plan, and we try to fit people into categories. Explain that this organization is trying to change that by adopting “person-centered care.” Related to the picture: we are going to look beyond the picture to ask questions and be curious, to know the person not the image in front of you.

7. Explain that in a person-centered care model, you are trying to assume nothing and create care, activities and services based on the individual in front of you at the moment, not necessarily what you know about their condition.

8. Write on a flip chart the words: Person-Centered Care and ask the group to brainstorm: What does it mean to be person-centered?

**Personal Routine:**

9. Conduct the exercise: My Personal Routine; found in Module 4.8 of Getting Started: A Pioneering Approach to Culture Change in Long Term Care Organizations. This manual can be found online: pioneernetwork.org

**Person-Centered Care Scenarios**

10. Distribute the person-directed care continuum. Review the points on it.

11. Distribute the Person-Centered Care Scenarios. Assign each table (given about 4 people at a table) 2 practices to explore. Their job is to look at the practice and determine where on the continuum they would place it.
12. In the front of the room set up a clothesline between two points and put lots of clothes pins on it. Indicate which end of the clothesline is “Person-Directed” and which is “Staff-Directed.”

13. After 10-15 minutes, ask groups to report out by reading their scenario to the group and where they have determined the practice to be on the continuum. After they’ve explained their reasoning give the audience an opportunity to weigh in with additional thoughts. Have the group pin the practice on the clothesline.

14. Continue until all groups have reported out. End by explaining, that the first step is recognizing, being aware of where something may fall on the continuum, and that in every activity that the organization engages in, the goal should be to move more towards the right (person-centeredness). Also remind participants that moving right takes effort, time, commitment and energy. It is journey, not a sprint.

12:00-1:00 Lunch

12:45-1:00 Energizer/Team Builder
- After lunch is a perfect time to do a team building, energy building activity. There are many books on the subject. We suggest choosing an energizer, e.g. “Peculiarities” from a book like: 201 Icebreakers: Group Mixers, Warm Ups, Energizers, and Playful Activities. It was written by Edie West, and published by McGraw Hill in 1997.

1:00-2:30 Defining Activities, Getting creative
1. Ask: In the setting you work in, how would you define the term “activity”? Put the responses on a flip chart.

2. When it comes to your own home life, how would you answer the same question?

3. Look back at the Personal Routine. Could any of what you do be considered an activity?

4. Explain that when we are talking about “activities,” it is not necessarily talking about elaborate programs, art projects, games/bingo… we are
including things that people do everyday, bringing those things back into the nursing home/day center. (We believe these are enjoyable, meaningful activities; we are just enhancing what already exists by looking what people do every day.) Further present that people with dementia often have difficulty with newness and change. At times new activities that they have not done before cause undue anxiety, fear, and stress. They often can’t or don’t want to grasp new information. This is actually true for a lot of people, even without dementia!

5. Give each table, a myriad of different everyday household objects: napkins, washcloths, needle/thread/cloth, magazines, socks, potato peelers, CDs/cassettes, puzzles, kitchen utensils (masher/spatula), paper/pen/notebooks, books, letters/envelopes/cards, deck of cards, markers/supplies, rags, photos/albums, etc. An alternative to putting it on the table, would be to put the items in a large bag and have each team/table pick 3 objects.

6. Instruct the teams to come up with activities they can do with residents using what is in front of them. Remind the group to think of things they might do on an everyday basis.

7. After 10 minutes, have the groups share what they came up with.

8. Remind the group, this is just a taste of what is to come in the dementia grant program: making everyday activities, simple, easy, familiar and accessible.

2:30- 2:45     Break

2:45-3:30     The Words We Use

1. Explain that a major barrier to making a person-centered environment is keeping the language from the medical/institutional model of care.

2. Conduct the exercise: The Words We Use; found in Module 4.12 of Getting Started: A Pioneering Approach to Culture Change in Long Term Care Organizations. This manual can be found online: pioneernetwork.org
3:30  **Wrap Up**

1. Explain the next steps in the project
2. Turn the music back on and play something lively and fun. We suggest “Let’s get started” by the Black Eyed Peas.
3. Thank everyone for coming and invite comments and the opportunity for participants to share what they learned in a fun, upbeat way.
Village Care of New York and the Paraprofessional Healthcare Institute welcome:
The Chelsea Adult Day Health Center and the Third Floor of the Village Nursing Home
To the
Department of Health Funded
**Dementia Grant Kick Off!!**
Monday, March 27th, 2006

**Agenda for today’s events:**

9:00 a.m.
Opening Ceremony

10:00 a.m.
Overview of the initiative
Getting to know one another

11:00 a.m.
Jumpstart into Person-Centered Care

12:00 Noon
Lunch and Energizer

1:00 p.m.
Getting Creative about Activities

2:45 p.m.
The Language Game

3:30 p.m.
Wrap Up, Q &A, Next Steps
Your role as the leader of the group is to:
1. Find a Reporter for the group (ask someone or have someone volunteer)
2. Read (or have someone else read) each scenario aloud
3. Ensure that everyone’s voice is heard
4. Decide if practice is
   - Staff-directed
   - Individual is considered
   - Person-Centered
   - Person Directed
   Or somewhere in between two of the above; and tell us why you chose that option
5. If it is not Person-centered or Person-Directed, what would you do differently to make it thus?

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Person-Centered and Directed Practices
Varying Degrees of Choice and Autonomy

Person Centered and Directed Practices
(Begins somewhere between Consideration of the Person and Person’s Choice)

Staff Directed (agency scheduled routines/staffing dictate care provision)
Consideration of Individual (seek person’s input and tailor some aspects)
Person Centered (Offers choices of food, walking, bathing etc.)
Individual Control (have right of refusal and right to take risks)
Person Directed (individual has primacy -- determines own schedules, activities, meals, and caregivers)

Degree of Person-Centeredness and Directedness

Adapted from work done by the Lewin Group
Mrs. Green moved into room three bed B this morning. Upon her arrival, her nursing assistant introduced herself to her and asked her some questions in order to get to know her better. Amongst the questions she asked were her bathing preferences. Did she prefer a bath or a shower? Mrs. Jones stated that she preferred baths and further stated that she had brought her own moisturizing soap as her skin tends to be dry. The nursing assistant let Mrs. Jones know that she would receive her bath on Monday and Thursday mornings at 10:30 AM and that she would include her special soap as an intervention on the care plan.
Mrs. Brown moved into room three bed B this morning. Upon her arrival to the nursing home her nursing assistant spent time her with asking her about her interests, talents and usual daily routines. During this time, the nursing assistant learned that Mrs. Jones was in the habit of bathing one time per week in the bathtub, and has been going to the hairdresser every two weeks to have her hair washed and set. Mrs. Jones further stated that she always bathes before going to the hairdresser, and that she would like to continue that practice while living at the nursing home. The nursing assistant put all of this information into Mrs. Jone’s care plan in order to ensure her routine from the community could continue in the nursing home.
Dining

Caring Hearts Adult Day Health serves meals at 9 AM, noon, and gives clients a take-home snack at 3:00 PM. Clients that are independent eat in the dining room while clients requiring assistance eat in the activity room. Clients who do not prefer the main meal are offered a sandwich (tuna or cheese). The center uses plastic utensils and plates because one client has attempted suicide using a butter knife in another program, years ago.
Dining

Clients at Perfect Partners Day Center are able to bring their lunch from home or can eat the center’s main meal (or alternative). There is a refrigerator for client’s who prefer to bring their own food. The Center’s freshly cooked food is placed in large bowls with easy to grip serving spoons and then placed on the tables. Higher functioning clients and staff members bring the food to the tables which have tablecloths, salt and pepper shakers. All staff members (from all levels) have assigned tables and assist in serving the food to the clients. Staff members trained in assisting clients during mealtimes (c.n.a’s and nurses) are assigned to tables where their help is most needed. Staff members are encouraged to eat with the clients, and may arrange to eat the center’s delicious food at a nominal cost.
Dining

Clients at Sweet Home Adult Day Health Center order lunch from a menu each day. There are three options at each meal, with the menu changing daily. The meals are planned on a monthly basis by a volunteer group of clients and family members—during the nutrition group. There is also another group of clients who go with the ‘chef’ to the local market for fresh vegetables and specialty items on a weekly basis. Food is served on an eclectic mix of plates and silverware adorn the tables—as family members and clients are encouraged to donate used (but not valuable) dishes and utensils to make the atmosphere more ‘homey.’ Any broken plates are sent directly to the craft department for use in mosaic art projects.
Activities

The Merry Meeting Place Adult Day Care Center offers services from 8:00 AM to 6:30 PM at night. Activities run around the clock beginning at 10:00 AM, with new ones beginning on the hour, every hour until 4:00 PM. The ‘great hall’ is divided in half- with one side primarily reserved for dining. The dining area also has a television for clients who do not participate in the main activity being given at the time and during the times when clients are waiting to be picked up.
Activities
The In-Check Adult Medical Day Center offers scientifically tested, therapeutic interventions for clients needing care during the day. Interventions include finger painting class, puzzle hour, movie time, remembrance group, ballroom television, and imagination nation (guided meditation to different parts of the world.) The hour long groups are held in the main dining room. Professional staff members are trained in using techniques to persuade even the most stubborn clients to participate, so that clients leave with a sense of fulfillment and are able to sleep at night having spent some energy during the course of the day.
Activities

The Community Connection Adult Day Center offers a variety of activities for clients to engage in over the course of the day. There are at least 2 groups for clients to choose from; clients not wishing to attend group can use the ‘family room’ which is equipped with a television, books, puzzles, magazines, and a working aquarium. Other clients opt to assist in the daily life of the Center by setting up for lunch, sweeping, dusting, hanging pictures, and even some cooking. There is actually a ‘meal prep’ group for higher functioning clients 2 times a week. Each month staff members discuss the activities with family members and clients to see if the groups are enjoyable and meeting their needs.
Activities
The Gathering Place, is an ‘alternative’ adult day center where clients are encouraged to create their own activity routine each day. The center only accepts high-functioning elders looking to spend their day with people with similar interests. Each morning, staff members ‘survey’ the group to see what activities will be offered that day; staff members are also allowed to offer suggestions. Activities with the highest number of votes from the group of clients and staff members present are scheduled, and the day begins. This process takes about an hour each morning, but clients are served breakfast while it is happening. While the votes are tallied and schedule/staffing are arranged clients have about 20 minutes to socialize independently. An average of 3 groups run at one time, and clients not interested in the specific group may choose an individual activity to engage in.
Care Assignments

The nursing assistants at ABC nursing home punch in at the time clock and check the bulletin board next to the time clock for their scheduled unit. The scheduling coordinator posts this daily schedule each morning. Upon reporting to their posted units, the charge nurse gives each nursing assistant their assignment after giving report.
Care Assignments

The nursing assistants at JKL nursing home held a team meeting to begin self scheduling and consistent assignments concurrently. They learned from the residents on their unit what time they wanted to wake up, eat, etc. They created their schedules based upon their own availability and the times at which the residents needed their support. They created their assignments based upon their existing relationships with the residents.
Admissions

ABC nursing home has eliminated the word admission from their daily language as it is associated with illness and institutions. Instead, they met with their resident council and designed a process to help residents “move in” to their new home. With each planned move, the environmental services staff go to the resident’s home in the community and help pack personal items, furniture, photos etc. that the resident would like to decorate her new bedroom with. Upon arrival to the nursing home, staff and residents greet the new elder and begin establishing relationship. The first hours are spent unpacking, and getting settled into personalizing the elder’s room. After this is complete, the nurse assesses the resident and completes the required paperwork.
Death and Dying

GHI nursing home offers a memorial service each quarter. There is a memory board prominently posted in the home that identifies individuals who have passed away in the home during the quarter. At the time of the memorial service, family members of the residents who passed away are invited along with staff and friends. A single rose is placed at the front of the room in honor of each person who passed away.
Death and Dying

After getting to know the residents, the social worker at XYZ nursing home will meet with each person individually and ask them how they would like to be honored upon death. The social worker offers the option of a personal memorial service within one week of the individual’s death held at the nursing home in the chapel, offers to share an obituary in the home’s newsletter and bulletin board and asks for other suggestions from the resident. ABC nursing home also has a procedure to help the staff grieve the loss of a resident. Whenever an individual passes away, the staff hold a learning circle where each person speaks in turn sharing their feelings regarding the loss.
Welcome and Introductions (15 minutes)

1. Go around the room and ask participants to introduce themselves by sharing (Flipchart):
   - Name and where they work
   And choose one question to answer:
   - How they got their name/ interesting story behind it;
   - Something interesting or unusual about themselves;
   - Birthday
   - Favorite holiday and why
   - Favorite pass time

2. Facilitators introduce themselves (using same questions) and explain their role in this training; Talk briefly about Why this training, Why now? Connect this training to other organizational culture work being done.

3. Distribute OR FLIPCHART the agenda and have participants read the program goals aloud

   NOTE: At this point the Goals won’t bear much significance to the participants- we ask that you explain the 3P Goals after the first activity (Doing Our Best Work).

Doing Our Best Work (60 minutes)

Story Sharing (30 minutes)

1. Explain: That in the first activity today we are going to draw on what makes us unique and special in our work. To do this, everyone will have the opportunity to tell a story entitled: “When I made a difference in the life of another co-worker or consumer.”

2. Explain that the story should be about a time they knew they made a difference in the life of a resident or other co worker. Some helpful ways to help them tell the full story including sharing (Flipchart):
   - Tell the WHOLE story
   - Who else was involved?
   - How did you know you made a difference?
   - How did the experience felt then, afterwards, today?
3. Let participants know that as they are telling their stories, a facilitator will be listening for the unique skills and strengths that the storyteller brought to the situation- which will be shared in a larger group discussion later on.

**Teaching Tip:** As the participants are sharing, facilitators listen for and record each person's STRENGTHS. Note: you may notice that group members are encouraging/supporting others to share more- it's important to document that as well.

4. Divide the class into smaller groups- one facilitator for each group.

**Teaching Tip:** Ideally you do not want more than 6 people in a group. However, if 'extra' facilitation help is not available- and there are more than the ideal in each group- we suggest adding time to the activity- in lieu of cutting time from each participant’s story. It's an important activity that affords direct care worker's/other employees a rare opportunity to be proud of what they do, and gives you an opportunity to build on their stories and draw out their strengths throughout the training and your work with them. If the small groups end up being too large, you may choose to ask a volunteer to listen for and write down the strengths for each person. We recommend you prepare this person a day ahead of time or before the training begins.

5. In the small groups- give each person 5 minutes to share. After each person shares, you can paraphrase what you hear their strengths to be and ask if anyone heard other strengths to list out.

6. Bring the groups back together and in the large group have each facilitator report out on the strengths (not using names). FLIPCHART these for reference later on.

7. Affirm to the group: You make a difference for residents/clients/co-workers lives everyday. (Adapt this to be inclusive of your audience). Also affirm that as individuals and as a group they are rich with Strengths, Skills and Abilities.

8. Introduce the notion that everyone shapes the environment in which residents live and staff members work, everyone has and can influence peoples' each others' lives. Emphasize that your opinions and thoughts count. (Refer back to the strengths for proof of this). Explain that the skills learned in this seminar will help you to come closer to feeling like and being a full member of the team and community in which you work.

**When problems rise...** *(15 minutes)*

9. Relate that not every day is as cheery or productive as was shared just now- and tensions are high and problems come up.
10. Facilitate a discussion around: What happens to problems when they come up? Ask participants: What happens when a resident refuses to eat? Or is refusing to take his/her medication? What do you do?

11. Summarize and connect the discussion with this training (The 3P’s) and with Coaching Supervision. Connect back to the stories earlier in which they can/did make a difference. Share that their organizations are moving more towards relationship based and person centered problem solving where frontline staff are going to have the opportunity to resolve situations between themselves and the residents/clients. Provide the participants with the context for the training today- in that supervisors are learning/have learned Coaching Supervision in order to help them develop stronger problem solving skills and promote healthier communication.

Note: This training should be taught in conjunction with the Introductory Coaching Supervision Curriculum. We strongly recommend that this training be taught after the Coaching Supervision training is taught to all supervisors and managers; and those supervisors/managers should be made aware of the goals/content of this training to allow for the most effective communication between supervisors and those they supervise.

Barriers to Being Your Own Problem Solver  15 minutes

12. Affirm that there is probably some hesitation to immediately “signing on” to this training. Write “What gets in the way” on the top of a flipchart and facilitate a discussion around what will potentially get in the way of them being more actively involved in problem solving in their work.

Teaching Tips:
An example might be that participants are fearful of being disciplined for doing the ‘wrong thing’ if they take problems on themselves.

Some participants may name specific supervisors/managers- which is okay, your role will be to paraphrase each statement in a general way drawing out the qualities/characteristics of the person. Explain that it is likely that the characteristics they are describing in this one person are in others as well.

13. After the list is exhausted, let participants know you will be ‘revisiting’ this list later. Hang the list where all participants can see it.

Teaching Tip: Generating this list, surfacing resistance is important in demonstrating respect for the participants and acknowledging their current/past struggles with supervisors and the environment in which they work.
14. At this point, move to introducing the 3P’s: Paraphrase, Pull Back and explore Options and explain that the 3P’s will be taught in the context of active listening and problem solving.

Break (15 minutes)

P1: Pull Back (60 minutes)

Introduction to Pull Back (25 minutes)

1. Explain the first step to adopting stronger problem solving skills is “Pulling Back” emotionally from the situation.

2. Facilitators conduct a Role Play. Choose a scenario that will resonate with group. First play out: Not Pulling Back.

Sample Scenario
C.N.A. Wilma goes to her linen cart and finds no more wash cloths- she is just about to give a bed bath and really needs it- and the linen closet is a long walk down the hall. Gladys, another C.N.A. is walking down the hall with a wash cloth in her hand. Gladys is a floating C.N.A. and Wilma makes the immediate assumption that Gladys took the washcloth from her cart- and Wilma begins to explode- here’s an example of the dialogue- it increasingly gets heated.

Wilma: “Where did you get that cloth from? You took it from my cart didn’t you?”
Gladys: No I didn’t I got it from down the hall?
Wilma: There’s none left in the closet how did you get it?
Gladys: Are you accusing me of stealing?
Wilma: If the shoe fits…
Gladys: I ain’t no thief, like I said I got it elsewhere why would I steal your grubby old washcloth!

3. Debrief the role play using the following questions: What happened? what emotions came up for Wilma? What happened to the relationship between Wilma and Gladys?

4. Explain that there is a need for awareness of our own role in problem situation. What was Wilma’s role in this situation? What was Gladys’ role? Explain that we can’t change others, but we can change our response. In this, there is a pressing need for awareness of our own emotional responses (what we feel, opinions and judgments we hold) in order to put it aside. What was Wilma feeling when she left the room to find a wash cloth? (Walk through what might have been happening for Wilma in the room with her resident.)

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5. **Distribute the handouts on pull back and discuss the definition of Pull Back Define and go through the handout exploring Option A and B (handout)** (NOTE: It is helpful to have a personal time when you didn’t pull back to share when explaining Option A; and a time when you did pull back in explaining Option B.)

6. Ask: about difference in outcomes for both and the relationship between them.

**Developing Awareness and Pull Back Strategies (35 minutes)**

7. Divide participants into small groups (3-4 participants) or pairs. In groups have participants share times, behaviors, situations, people (without saying names), that are emotionally provocative; meaning they somehow stir you up with anger, sadness, hurt, hopelessness, etc…

**Flipchart:**
- Share a situation where you get emotionally triggered
- Share what happens to you in those moments
- Name the emotion

*Explain that the goal in sharing these stories is to help get in touch with what emotionally provokes them (person, time, behavior) and NAME the emotion. Remind them, that the emotions you need to pull back from can range from feeling angry to feeling embarrassed or ashamed. Some people need to pull back from sinking or swallowing their feelings altogether, while others must pull back in order to refrain from fighting with another person and reacting in a heated way.*

**Teaching Tip:**
If you haven’t shared a personal story of not pulling back earlier, it is helpful to do so here.

8. Give participants 10 minutes in the small group/pairs.

9. Rejoin the group- Ask participants to share some of the emotions that came up for them, and if they’d like, some of the situations that were provocative. Then begin to ask the question: If you were in this situation tomorrow, and you had to maintain emotional control and “stay in it” in a respectful way- what could you do? (Remind them of the example you played out earlier). Ask what can you do to freeze that emotion and set aside? (You are now generating a list of pull back strategies). Continue with the large group brainstorm and individual identification of on Pull Back strategies. Flipchart.
10. Tell the participants that you would like to leave them with at least one very concrete way to pull back emotionally.

11. Role Play the opening situation again, but this time, exaggeratedly pull back. Tell the group that you will exaggerate your pull back strategy so that it is visible. Do a short debrief.

Lunch (45 minutes)

Active Listening (95 minutes)

*Exercise: The importance of Listening* (5 minutes)

1. Segue from Pull Back: talk about the need to pull back from jumping immediately to solve the problem- there is a strong need to pause and listen to find out what the issue is. Ask participants: Why do we listen? Solicit responses and then review the handout: Real Listening *(handout)*

2. Facilitate a brief discussion about active listening and how the actual skill of paraphrasing plays a role in active listening *(handout)*

Non-Verbal Communication (Body Language) (40 minutes)

3. With another facilitator or participant you’ve prepped ahead of time, role play “poor non verbal body language” a.k.a. “not listening” for 2 minutes- emphasizing poor body language, inattentiveness, rudeness- without actually saying a word. (Choose a story that is personal and current so that there is some emotion/energy tied to your words.)

4. Debrief by asking: how do you know she wasn't listening? What did she do? What happened to the person telling the story? How do you think she was feeling?

5. Role play active non-verbal listening for 2 minutes- using body language and other non-verbal listening skills. Use the same story, but this time the facilitator should be listening intently.

6. Debrief: what happened for the person telling the story this time? How was she feeling? What did she do to tell you she was listening?

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7. Pair Participants and ask one person in the pair to think of a story that is current and important to them. For two minutes that person will try to tell the story, while the person does everything to not listen, similar to what you role played earlier.

8. Debrief with the questions above. Also ask, did that feel like two minutes?

9. Have them try role playing again using the same story; this time the non-listener will use active non-verbal listening skills.

10. Debrief with the questions above.

11. Reverse the pairs and give the new storytellers a minute to think about a current and important story to tell.

12. Repeat the not listening and listening exercises and debrief after each pair and at the end.

**Listening Actively to Mrs. Lee** (15 minutes)

1. Transition into the next activity. Ask what is the impact of taking the time to listen to a resident?

2. Emphasize that the foundation of person-centered care is Listening to what the resident/family wants and needs and delivering, to the best of your ability, what is needed. In the following role play, “Lunch time, Mrs. Lee!” we’ll see a scenario where the staff don’t really listen to Mrs. Lee and the staff and facility routine (delivering lunch and ensuring all residents eat) take the place of what the resident wants.

3. Introduce the role play “Lunch time, Mrs. Lee!” State that Mrs. Lee is resident at Industrial Care Nursing Home in Minnesota, a nursing home that needs ‘a little work’ in the area of delivering person-centered care.

4. Debrief the role play: Thinking about yourself: if you were Carrie:
   - How would you feel?
   - How about Brandi?
   - Ask the group, is getting her to eat a victory or a defeat?

5. Further debrief: Ask the group:
   - How would Mrs. Lee will feel/be for the rest of the day?
   - How would her day be?
   - What kind of mood would she be in?
   - How would she act around other caregivers that day?
   - What’s your experience of caring for someone who has had an uncomfortable morning?
P2: **Paraphrasing and Asking Open Ended Questions**  (45 minutes)

6. Let participants know there are different tools to help you listen better (one being non verbal communication). Flipchart and Review the definition of paraphrase

7. Distribute the Paraphrase handout

8. Distribute and review the Lead Ins

9. To practice paraphrase, you will now ‘redo’ parts of the role play with group using the following statements said by Mrs. Lee to practice paraphrasing and using open-ended, clarifying questions.

   “I’m not hungry. I wish I were a bird so I can fly this coup”

   “I don’t want to eat, and I’m really not hungry. I don’t want to do anything at all today- I feel miserable.”

   “Oh dear. I’m just not up to fighting you girls today…”

10. Distribute the clarifying questions handout, review and explain Open-Ended Clarifying Questions.

11. Go back to the paraphrases you created earlier and ask someone to follow the paraphrase with a clarifying questions (a question that would draw out a little more information). Repeat for all the paraphrases you completed.

12. Distribute the worksheet with the practice paraphrase/asking open questions. Ask participants to pair with someone next to them and ask each pair to do the worksheet together for 10 minutes to work on them. In lieu of reporting them out- while the participants are working- check in with each pair to ensure they are understanding the concept of paraphrase/asking open-ended questions.

13. If time allows, role play the scenario again with the two facilitators playing Mrs. Lee and Carrie. Using the paraphrases and questions just created.

14. Debrief using the same questions above (#10). And ask, what is the likely outcome for Mrs. Lee, for the C.N.A.’s and nurses, and for the organization?

15. Use that conversation to transition into Exploring Options.

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Break (15 minutes)

P3: exPloring Options (60 minutes)

1. Explain that in this next section, they will examine problem solving itself—taking a process they probably already do automatically (for example when a resident states she does not want to eat, yet you know that she needs to in order to maintain her health) and breaking it down into steps—with the goal of better understanding the steps and thus being better able to do it independently.

2. Post the prepared flip chart page with the case scenario for Nancy and Mr. Henry from Instructor’s Guide, “Exploring Options” (handout) and distribute the handout.

3. Explain that there are many approaches to problem solving and the one we are going to try in this training is called “Exploring Options.” This technique involves (FLIPCHART):

   - Analyzing the problem from different perspectives,
   - Identifying and exploring options for solving the problem,
   - Considering the likely outcomes or results, and then
   - Choosing the option with the best chance of satisfactorily solving the problem.

4. Distribute Handout, “The Exploring-Options Approach to Problem Solving” (handout) and Distribute (handout), “Important Factors.” Emphasize that it’s likely when you were solving the problem (From example above) you didn’t realized how much effort and work went into it. Explain that we are going to use the example to walk through and learn the “Exploring
Options Approach” to problem solving.

5. Read through the handout together, reviewing the important factors and pay special attention to the BALANCE of the 3 perspectives, particularly in person-centered care.

**Teaching Tip**

Sometimes one option creates a situation in which the interests of the consumer, the direct-care worker, and/or the organization are in conflict. For example, in the case of Mr. Henry, one option is to allow him to eat the sweets. This respects the consumer's right to choose what he wants but it places the consumer’s health in jeopardy and would put the organization’s reputation for promoting health in jeopardy if the direct-care worker simply responded to what the consumer wants.

Therefore, a more balanced solution for the direct-care worker would be a combination of options that address all three points of views—i.e., allow Mr. Henry to eat the candy, and also try to educate him about the dangers involved in this choice, and report to the nurse/organization that he is not following his diet.

6. Divide the group in 3. Have each group take a perspective to work on. Have participants explore: What is the problem in this situation from the points of view of the consumer, the direct-care worker, and the organization. Write the three problem statements generated by participants on the flip chart page.

**FLIP CHART**

*What is the problem?*

- For the Mr. Henry:
- For the Nancy:
- For the Nursing Home:

7. After 10 minutes, bring the group back together and have them report out. Ask for additional thoughts from the full group on each perspective.

8. Next, move into the important factors. Depending on the situation, some factors will be more important than others, and some may not even need to

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be addressed. Make two columns on a sheet of flip chart paper, and write the heading “Important Factors” over the left column. Considering all three points of view in the problem ask participants to identify which factors apply. Write their responses in the left column.

<table>
<thead>
<tr>
<th>FLIP CHART</th>
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</thead>
<tbody>
<tr>
<td>Important Factors</td>
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</tbody>
</table>

9. Write “Options” at the top of the right column on the flip chart page. Remind participants that options are possible solutions to the problem. Ask the group to brainstorm options that address each of the important factors they listed. The goal is to come up with as many options as possible, including at least one for each factor. Some options may address more than one factor. Encourage participants to be creative and think outside the box; sometimes thinking of ideas that are not realistic allows people to see possibilities that were not obvious. Write the ideas on the flip chart page.

<table>
<thead>
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⇒ **Teaching Tip**
If participants really think outside the box, they may come up with some silly and potentially dangerous options. Keep the tone light and note the options, but make sure there is a good selection of realistic ones. For example: an unthought of option might be to make S’mores or to tell him you had to throw it out because it fell on the floor.

**Discussion (20 minutes)**
10. After participants have suggested at least six options, explain that in order to select the best option for solving a problem, they will assess what is likely to happen as a result of each option. Then they will determine which option (or combination of options) best addresses the problem from all three points of view.

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11. Ask participants:
   *What would be the impact (both positive and negative) of each option on each of the important factors we listed?*

12. Ask participants which options have a positive impact on two or more of the important factors. Put a check mark next to those options (see the Instructor’s Guide).

13. Considering the checked options, determine which one (or which combination) comes closest to solving the problem from all three points of view—the consumer’s, the direct-care worker’s, and the organization’s. Write “Plan A” in the margin next to that option or options. Note that the solution that most fully addresses the important factors also most effectively addresses the problem from the perspectives of every party involved. Note that since participants have come up with more options than the ones they selected for Plan A, they could easily come back to their list to consider other options if Plan A does not work.

Small Group Work (if time allows)
14. Divide the participants into smaller (facilitated) groups. Have each group work on a different scenario. In 15 minutes, the most important part is to state the problem from all three perspectives, identify the important factors and come up with at least one solution that addresses each constituents problem.

15. After 15 minutes, have the groups report out by reading their scenarios and sharing their solutions – and why they came to that solution.

**Wrap Up and Evaluation**  
*(15 minutes)*

Take this time review the list of “Barriers” created at the beginning of training- ask if anything has changed for participants based on what was taught/discussed today. Follow up with any outstanding issues as you feel appropriate to your organization.

Distribute and collect the Evaluations.
Enhanced Communication and Problem Solving Skills Training
“Starring the 3P’s”

PROGRAM GOALS

We hope that by the end of the training, YOU WILL:

- **Know** how important **you** are and how you make a difference in the lives of the people you work for **and** the people you work with;

- **Understand** the impact of what you say and how you say it effects the people around you;

- **Strengthen** your existing and **learn new skills** to help you communicate more effectively;

- **Build on** your ability to solve problems by using a technique called, **Exploring Options**;

- **Be able to use** these communication and problem solving skills in real-life situations;

- **Feel that you have improved overall**- your ability to impact and shape the environment in which you work.
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“Starring the 3P’s”

Agenda

Welcome and Introductions

Morning Session
  o Doing Our Best Work
    o P1: Pulling Back in Stressful Situations

Lunch (45 minutes)

Afternoon Sessions
  o P2: Active Listening (Non verbal communication, Paraphrasing and Asking Open-Ended Questions)
    o P3: exPloring Options Approach to Problem Solving

Closing and Next Steps
Pulling Back

Oftentimes we are faced with situations and people who provoke an emotional response in us—be it anger, hurt, frustration, hopelessness, or sadness. When we are in an emotional state listening becomes difficult and communication often becomes charged. Whatever our reaction, we have a CHOICE in how we respond:

Defend our opinions

Prepare our response

Look for evidence to support our opinions

Discount evidence to the contrary

Suspend our opinions and put them on hold

Listen actively, without blocks or judgment

Look with curiosity for new information or insights

Stay open to being changed
**PULLING BACK**
...the ability to gain emotional control in stressful work settings.

- In healthcare settings, you may be faced with challenging supervisors or residents, angry family members, disappointed co-workers, and many unanticipated situations. Building on the skills that you already have, it is critical to learn effective ways for maintaining emotional control and evaluating a problem situation before responding.

- “Pulling Back” means being able to pause, to get your emotions under control, and to see the situation clearly.

- Good communication and problem solving can only come from clear and objective thinking.

- After pulling back for a moment, you can make sure you understand what’s going on and get additional information thru listening.

**Steps for Pulling Back**

1. Notice your internal reaction and judgments.
2. “Freeze-frame” your reaction - put it aside.
3. Put your attention back on the other person.
REAL *Listening is...*
Based on the intention to do one of four things:

- Understand a person better
- Enjoy the person you are with
- Learn something
- Give help, provide solace, show empathy or give sympathy
PARAPHRASE
The ability to state in your own words, from your own understanding, what you understood someone to have just said or expressed.

- Paraphrasing and Asking Open Ended Questions are tools of communication in the active listening. The goal of using these skills is to connect with the other person and get the best information possible before taking action.

- Paraphrasing is one part of a three-step listening process: non-verbal listening techniques; Paraphrasing; and asking open ended questions to gather additional information.

- Many people’s tendency is to move straight into problem solving without confirming the accuracy of information or gathering enough information. Active listening is essential before effective problem solving can take place.

Paraphrase

1. To paraphrase means to state in your own words what you understand someone to have just expressed or said.

2. Paraphrasing is absolutely necessary to effective listening. It keeps you engaged and helps you to better understand what the other person means. It also lets the speaker know that you are listening.

3. When paraphrasing, repeat the statement in a positive way, without blame or judgment.

Rewards of Paraphrasing:
- People LOVE feeling listened to! Don’t you?
- Paraphrasing can stop anger and cool down a crisis because the focus is on clarification of information rather than on reacting to the situation.
- Paraphrasing prevents miscommunication—false assumptions, errors and misinterpretations can be corrected on the spot.
- Paraphrasing helps you remember what was said.
- When you paraphrase you’ll find it much easier to stay focused on not lose your concentration. Your focus is on really understanding what is going on with the other person.
Lead-Ins for Paraphrasing...

I hear you saying that…

So, I think you said…

OK, So what I heard you say is…

I understand you said…

So you’re telling me that…

Am I hearing you correctly that…

Are you saying that…

I believe that you are saying…

So, you’re saying…

OK, Let me see if I got what you said…

So I understand the situation, let me summarize what you just said…

I want to be on the same page as you, so let me go over what you just said…
Asking Open Ended or Clarifying Questions

The five W’s also will help you get more information: Who, What, When, Where and how...

Questions (and sometimes Lead-in statements) that open up a conversation:

- Tell me a little more about…
- I’d like to hear about…
- Give me a little more detail, so I can get a clearer picture…
- I’m curious to know…
- What happened next (or before)?
- I’m really interested in knowing more about…
- How did that happen…
- What helped you…
- What are you thinking/feeling…
- How has your experience been so far?
- How are you managing…?
- Tell me what you’ve thought of so far about how to handle…

Any others you can think of?
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**Lunch Time, Mrs. Lee!!!**

**Narrator:** This is an interaction between the staff a resident, Mrs. Lee, at Industrial Care Nursing Home in Minnesota. The characters in the play are:

**Characters:**
Nurse: Hanna
First C.N.A.: Carrie
Resident: Mrs. Lee
Dietary Aide.: Brandi

**Hanna:** Lunch trays are here! Come on everyone, let’s get started.

**Narrator:** CNAs begin to deliver lunch trays to residents

**Carrie:** Good morning, Mrs. Lee. Isn’t it a beautiful day? I have your lunch for you. You need to eat because you ate like a bird for breakfast.

**Mrs. Lee** I’m not hungry. I wish I were a bird so I can fly this coup.

**Carrie** Oh but Mrs. Lee, you need to eat to keep up your strength. I’m sure you'll feel better once you start eating.

**Mrs. Lee** I don’t want to eat, and I’m really not hungry. I don’t want to do anything at all today- I feel miserable.

**Carrie:** I'll just wash your face with some nice, warm water. That will help you wake up and then put some nice music on to eat to.

**Mrs. Lee:** Please don’t wash my face. I feel too miserable to eat. You should give it to someone else.

**Carrie:** Well, all right, but you know that’s not what’s best for you.
**Narrator:** Carrie goes to the nurse and tells her Mrs. Lee would not eat her lunch.

**Carrie:** Hanna, Mrs. Lee is being noncompliant with her care plan. I tried as hard as I could to get her to eat her lunch and she asked me to leave and give her lunch to someone else.

**Hanna:** Thank you for trying. I'll ask the dietary aide to try; maybe she’ll eat for someone else.

**Narrator:** Hanna calls Brandi over, hoping that she’ll be able to convince Mrs. Lee to at least take the tray. Brandi agrees to try.

**Brandi:** Good morning Mrs. Lee! What’s this I hear about you not wanting your lunch today? You know you need to eat to keep your strength up.

**Mrs. Lee:** Oh dear. I’m just not up to fighting you girls today.

**Brandi:** Come on now Mrs. Lee, you’re not going to make trouble today are you?

**Mrs. Lee:** No, No…I don’t want any trouble.

**Brandi:** That’s my girl!

**Narrator:** Brandi sets up the tray and places the napkin on Mrs. Lee.

**Brandi:** I’ll be back for the tray in a little while. Enjoy your lunch!

**Narrator:** Mrs. Lee Just sits and stares at her plate with an absent look on her face.
THE EXPLORING OPTIONS APPROACH TO PROBLEM-SOLVING

**Definition:**
Exploring options, as an approach to problem-solving, is a step-by-step tool for identifying and considering possible solutions to a problem (options) that the direct-care worker can carry out.

**Three perspectives:**
In any problem encountered by the direct-care worker, there will be three perspectives – the consumer’s, the direct-care worker’s, and that of the health care organization providing the service. These perspectives are shaped by important factors—issues such as the health, safety, and rights of the consumer and the direct-care worker, and the legal and ethical responsibilities of the health care organization.

**Desired outcome:**
The desired outcome of this approach to problem-solving is to identify an option, or a combination of options, that takes into account all the important factors and thereby addresses the problem from all three perspectives.

**Steps:**
The main steps in the exploring options approach are:

- **Clearly state the problem:**
  Clearly state the problem from the perspective of the consumer, the direct-care worker, and the organization.

- **Identify important factors:**
  Identify all the important factors related to the problem, from each perspective.

- **Brainstorm options:**
  Brainstorm all the possible solutions to the problem (options) that are within the scope of the direct-care worker’s job.

- **Decide on Plan A:**
  Select the option, or combination of options, that address important factors from all three perspectives as the first choice (Plan A).

- **Decide on Plan B:**
  Select another option that addresses almost as many important factors as the “second choice” -- in case the first option is not effective (Plan B).
<table>
<thead>
<tr>
<th>Important Factor</th>
<th>Examples</th>
</tr>
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<tbody>
<tr>
<td>Client safety:</td>
<td>Client at risk of choking; client is being threatened</td>
</tr>
<tr>
<td>Caregiver safety:</td>
<td>Caregiver is being abused or threatened; Safe workplace; broken equipment</td>
</tr>
<tr>
<td>Infection control:</td>
<td>Universal precautions; sanitary living environment; infectious diseases</td>
</tr>
<tr>
<td>Client care:</td>
<td>Personal care and emotional needs are tended to</td>
</tr>
<tr>
<td>Role of the caregiver:</td>
<td>Staying within the job description</td>
</tr>
<tr>
<td>Cultural respect:</td>
<td>Respecting differences in cultures, values, religion, etc…</td>
</tr>
<tr>
<td>Client rights:</td>
<td>Confidentiality; privacy; choice; free speech</td>
</tr>
<tr>
<td>Following org. policy:</td>
<td>Dress code; absentee policies; following care plans</td>
</tr>
<tr>
<td>Personal situations:</td>
<td>Safety of family/self; needs of self/ family; government or school rules; cultural or religious beliefs; major disruption in schedule or routine; personal rights and preferences</td>
</tr>
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Exploring Options Worksheet

Nancy and Mr. Henry

Nancy has been working with Mr. Henry for a few weeks and enjoys working with him, although she says he can be very stubborn. He has diabetes, and yesterday Nancy found candy bars in his bedside stand, which goes against his care plan. She has tried before to tell him he shouldn’t eat candy, but he yelled, “I know that, but I don’t care!” Nancy doesn’t know what to do and has come to you.

1. State the problem from each perspective
   2. Important Factors: Check those factors that apply
   3. Options: List at least one possible solution for each perspective and for each checked factor.

For the consumer:
- Client safety
- Infection control
- Client care

For the direct-care worker:
- Client rights
- Cultural respect
- Role of the care-giver
- Following org. policy

For the organization:
- Care-giver safety
- Personal situations

Exploring Options Worksheet
Scenario:
Mrs. Looseleaf is 96 and very frail. This is your first day being assigned to her and you are responsible for giving her a bath, changing her sheets, and feeding her. When you enter her room, she is happy to see you, but she does not want you to give her a bath. You try to persuade her to have her bath, but this only upsets her further.

<table>
<thead>
<tr>
<th>1. State the problem from each perspective</th>
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<td>□ Client rights</td>
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<tr>
<td>For the direct-care worker:</td>
<td>□ Cultural respect</td>
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<td></td>
<td>□ Role of the care-giver</td>
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<tr>
<td>For the organization:</td>
<td>□ Following org. policy</td>
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**Exploring Options Worksheet**

*Scenario:*

---

Enhanced Communication and Problem Solving Skills Training
Starring the 3P’s
Presented by the Paraprofessional Healthcare Institute
Ms. Faithful has just been admitted to the nursing home. You enter her room at 8:00 am to deliver her breakfast tray and you find her on her knees in prayer. You interrupt her and explain that breakfast is here. Ms. Faithful tells you that she prays daily from 7:30 to 9:30 and advises you that she cannot eat breakfast at this time.

<table>
<thead>
<tr>
<th>1. State the problem from each perspective</th>
<th>2. Important Factors: Check those factors that apply</th>
<th>3. Options: List at least one possible solution for each perspective and for each checked factor.</th>
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</thead>
<tbody>
<tr>
<td>For the consumer:</td>
<td>□ Client safety</td>
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<td></td>
<td>□ Infection control</td>
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<td></td>
<td>□ Cultural respect</td>
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<td>□ Following org. policy</td>
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<td>□ Care-giver safety</td>
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<td>□ Personal situations</td>
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Enhanced Communication and Problem Solving Skills Training
Starring the 3P’s
Presented by the Paraprofessional Healthcare Institute
**Exploring Options Worksheet**

**Scenario:**
You have been assigned to Ms. Conway who is very weak and has severe osteoporosis. Her care plan says for two nursing assistants to transfer her from her bed to the chair. Ms. Conway has been asking to get out of bed for a while, but you have been unable to find another staff member to help you lift her. Ms. Conway asks you to please transfer her by yourself, telling you that others do it all the time.

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<tr>
<td><strong>For the direct-care worker:</strong></td>
<td>□ Cultural respect</td>
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<td>□ Role of the care-giver</td>
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<td><strong>For the organization:</strong></td>
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<td>□ Personal situations</td>
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</table>
Enhanced Communication and Problem Solving Skills Training
Starring the 3P’s

EVALUATION
What did you like most about today?

What will you do differently because of this training?

If you could, what would you change about this training?

Please use the rest of this space for any additional comments you would like to make about this training:

Enhanced Communication and Problem Solving Skills Training
Starring the 3P’s
Presented by the Paraprofessional Healthcare Institute
Coaching Supervision: Introductory Skills for Supervisors in Home and Residential Care

Funding for the development of this curriculum was provided by the U.S. Department of Labor through its High-Growth Initiative.

PHOTO: KEVIN MALONEY
The nonprofit Paraprofessional Healthcare Institute (PHI) works to strengthen the direct-care workforce within our nation’s long-term care system through developing innovative approaches to recruitment, training, and supervision; client-centered caregiving practices; and effective public policy. PHI’s work is guided by the belief that creating quality jobs for direct-care workers is essential to providing high-quality, cost-effective services to long-term care consumers.

PHI’s workplace practice and caregiving innovations have been developed in cooperation with a network of direct-care staffing agencies and training programs, including Cooperative Home Care Associates of the South Bronx and Home Care Associates of Philadelphia, and with Independence Care System, a nonprofit managed long-term care program for people living with physical disabilities in New York City. Through its consulting practice, PHI helps providers across the long-term care spectrum adapt these and other field-tested practices to fit their environments and needs.

A recognized leader in long-term care workforce policy, PHI also partners with federal agencies such as the Centers for Medicare and Medicaid Services and the U.S. Department of Labor to support research and demonstration programs to help create a more stable direct-care workforce. This work is supported by PHI’s National Clearinghouse on the Direct Care Workforce (www.directcareclearinghouse.org), a central “on-line library” of news, research, best practices, and other information for people working to solve the direct-care staffing crisis in long-term care. In addition, PHI staffs the Direct Care Alliance (www.directcarealliance.org), a national advocacy group representing long-term care consumers, workers, and providers whose goal is to create quality jobs and quality care.

PHI’s expertise in integrating industry practice and public policy has made the organization a valued partner to both industry stakeholders and national foundations. In affiliation with the Institute for the Future of Aging Services, PHI draws on this dual expertise in its role as designated national technical assistance provider for Better Jobs Better Care (www.bjbc.org), a three-year research and demonstration project funded by the Robert Wood Johnson Foundation and The Atlantic Philanthropies.

PHI’s team of state-based policy and practice experts work with providers, consumers, and worker organizations in New York, Pennsylvania, Massachusetts, Maine, Michigan, North Carolina, New Hampshire, Oregon, Iowa, and Vermont. For more information on PHI’s consulting services, please e-mail: consulting@paraprofessional.org.

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This publication is also available on the web at:
www.directcareclearinghouse.org
www.paraprofessional.org

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Additional Coaching Resources

Handouts
Acknowledgments

Coaching Supervision: Introductory Skills for Supervisors in Home and Residential Care was developed by the Paraprofessional Healthcare Institute (PHI) over several years with tremendous support from the supervisory staff in home and residential care settings, as well as instructors who participated in testing and evaluating the material. PHI thanks the U.S. Department of Labor for its support and vision, which made possible the final development and distribution of this curriculum.

Specifically, PHI would like to thank Director of Educational Programs Sara Joffe for developing the curriculum content and methodology. Ms. Joffe first introduced coaching supervision to PHI's affiliated home care agency, Home Care Associates of Philadelphia, where its effectiveness in reducing turnover of direct-care workers became readily apparent. She further refined the curriculum while teaching a course for home care supervisors at Lehman College in New York City and through a train-the-trainer program sponsored by the North Carolina Department of Health and Human Services.

PHI also wishes to thank Ellen Murphey for documentation of the curriculum; Mary Ann Wilner and Anne Wyatt for contributions during the early development stages; Sue Misiorski and Carin Tinney for additional teaching materials for residential care settings; Cathie Brady, Sue Misiorski, Aileen Moleski, Afeefa Murray, Peggy Powell, Carin Tinney and Peg Walsh for their efforts as instructors and evaluators; Judith Lorei for content review; and Jill Tabbutt-Henry, Carolann Barrett, and Karen Kahn for editorial assistance.

And, finally, PHI thanks Paxton Communications for their superb design work and their patience.

For more information about PHI and this curriculum, please contact:

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Introduction

This curriculum introduces the coaching approach to supervision as it is used in long-term care. It is designed to develop beginning coaching skills in supervisors of direct-care workers who assist people in home and residential care settings. These supervisors may include nurse supervisors, charge nurses, home care managers, and service coordinators, among others. All skills are taught in the context of the realities of work settings. With its focus on communication and problem solving, the curriculum may also be useful to other staff who work with direct-care workers but do not have direct supervisory roles.

Funded through the U.S. Department of Labor's High-Growth Initiative, this curriculum is recommended for training supervisors participating in DOL's certified apprenticeship programs for home health aides and certified nursing assistants. Designed to teach supervisors skills to build positive relationships with direct-care workers, the seminar provides a foundation upon which supervisors can strengthen their ability to mentor new workers and help workers develop personally and professionally.

The apprenticeship program is only one of many opportunities for using the curriculum, which could also be taught in community college nursing programs, advanced training institutes, or employer-based in-service programs. The modular format makes the program easily adaptable to fit the needs of many organizations.

Why Coaching Supervision?

Supervisors face challenging work situations every day. Their jobs require independent thinking and decision making along with the ability to juggle competing priorities and to respond to the urgent needs of both consumers and the workers who support them. These are demanding, often stressful, and sometimes overwhelming positions.

Supervisors’ jobs would, of course, be less stressful if direct-care workers were consistently reliable and responsible and possessed the ability to resolve problems effectively and independently.

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1 The term “direct-care workers” is used throughout the curriculum because such workers have varying titles in different settings. For example, certified nurse assistants or nurse aides provide services in residential care settings, whereas home health aides or personal care assistants work in home care settings. Instructors should use the term most appropriate for participants in their seminars.

2 The term “consumer” is used throughout the curriculum to refer to home care clients and residents of long-term care facilities. Instructors should use the term most appropriate for participants in their seminars—for example, “resident” or “client.”
Introduction

But this is not always the case. Supervisors in home and residential care settings spend a great deal of time attending to problems with frontline staff, including repeated lateness, call-outs, behavioral issues, and high turnover. Although it is tempting to blame direct-care workers for poor performance, supervisors must remember that such jobs are also stressful and that workers do not always have the resources to address the sometimes conflicting demands of work and family.

In response to questions about job satisfaction, many direct-care workers indicate that what keeps them motivated are their relationships with consumers. What pulls them away from their work are the complex demands of their home lives and not feeling valued or respected on the job.

The most influential factor in whether workers feel valued and respected at work is their relationship with their supervisors. When supervisors value supervisees as people—for example, by creating and maintaining positive relationships and modeling effective communication skills—workers feel increasingly capable and successful and are better able to solve problems independently. As a result, they are more likely to remain in their jobs when facing personal or work-related challenges.

Unfortunately, the relationship-building and communication skills that supervisors need to effectively manage direct-care workers have often not been formally included in supervisory training programs—if supervisors have had formal training at all. Most supervisors have learned a traditional, fairly punitive, approach to supervision that does not provide tools to successfully support and retain direct-care workers.

This curriculum introduces supervisors to coaching supervision, an innovative and highly effective approach to supervising and mentoring direct-care staff in long-term care. This approach to supervision centers on building relationships with supervisees, constructively presenting and addressing problems, and helping workers develop problem-solving skills. When implemented successfully, a coaching approach to supervision results in increased worker satisfaction and retention as well as improved quality of care.

Curriculum Goal and Target Audience

The goal of this curriculum is to introduce seminar participants to a new model of supervision and to teach fundamental communication skills that lay the foundation for improving relationships with workers and developing their problem-solving skills. All skills are taught within the context of long-term care, making the seminar lively and practical for participants.

The target audience for this introductory workshop is supervisors of direct-care workers across all long-term care settings, including nurse supervisors, home care and community-based services managers, charge nurses, and service coordinators.

The four primary skills introduced in the curriculum are:

- **Active Listening:** Using skills such as body language, paraphrasing, and asking clarifying questions to listen attentively and ensure understanding.

- **Self-Management:** Setting aside emotional reactions and other listening blocks that can get in the way of hearing a worker’s perspective.
Self-Awareness: Being conscious of assumptions and biases that lead to prejudging workers and others.

Presenting the Problem: Using objective language to identify performance problems and hold workers accountable.

Most of these skills will not be entirely new to supervisors; instructors can draw on participants’ existing knowledge and skills to enhance the learning experience. In large part, the seminar is an opportunity to strengthen key supervisory skills in a supportive atmosphere so that participants can use them consistently and effectively on the job. For those who are new to supervision, the curriculum’s emphasis on learning through practice is particularly helpful.

Instructors

Ideally, a team of at least two instructors—experienced adult educators, social workers with group experience, or agency administrators with teaching experience—should present this curriculum. Instructors need to be skilled in interactive, participatory education techniques, and at least one needs to be comfortable with performing and conducting role plays (see “Course Approach and Teaching Methods,” p. I.6).

Before adopting this curriculum, it is important to assess the skills of the instructors as well as the particular needs and readiness of the seminar participants. Instructors with different experiences (nursing vs. social work, for example) will bring different strengths and perspectives to the training. Since the seminar relies heavily on sharing personal experience, the material will be shaped in part by those who teach it.

Instructors should be comfortable facilitating open and free-flowing dialogue and able to model honest, open communication throughout the seminar. Self-awareness is critical to becoming a skilled coach supervisor, and some of the activities will raise personal or emotional issues. Instructors must be prepared to help participants work through their feelings while managing their own, modeling self-management, another skill taught during the seminar.

Although this curriculum provides all materials and instructions to teach the seminar, it is highly recommended that instructors participate in a train-the-trainer program prior to conducting the course. Such training prepares instructors to use participatory activities to enhance self-awareness, reflection, and problem-solving and to guide participants through emotionally charged discussions.

3 PHI conducts train-the-trainer seminars for teaching coaching supervision. E-mail: consulting@paraprofessional.org or visit www.paraprofessional.org.
Curriculum Structure

The seven modules in this curriculum provide an introduction to coaching supervision and opportunities to develop four basic skills, as follows:

**Module 1: Introduction to Coaching Supervision**
- Coaching Supervision in Long-Term Care Settings
- What a Supervisor Does

**Module 2: Traditional and Coaching Approaches to Supervision**
- The Traditional Approach to Supervision
- The Coaching Approach to Supervision

**Module 3: Coaching Skill #1—Active Listening**
- Listening Exercise—Body Language
- Paraphrasing and Asking Open-Ended Questions
- Communication Game—Back to Back

**Module 4: Coaching Skill #2—Self-Management**
- Pulling Back
- Pull-Back and Paraphrase Role Plays
- Blocks to Listening

**Module 5: Coaching Skill #3—Self-Awareness**
- Role Play: Calling Out
- Personal Styles Inventory

**Module 6: Coaching Skill #4—Presenting the Problem**
- Accountability without Blame or Judgment
- Practice in Presenting the Problem

**Module 7: Making Coaching Work**
- Putting It All Together
- Coaching Skills Practice: Role Plays
- Requirements for Successful Coaching
Each module begins with a summary page describing:

- Goals of the module
- Teaching methods and time required for each activity within the module
- Supplies and handouts needed
- Advance preparations to help the seminar run smoothly.

Detailed guides for the activities follow the module summary page. Each activity guide includes:

**Learning outcomes.** Participants should have adopted or be able to demonstrate these concrete, measurable behaviors by the end of the activity. The focus of each activity, they provide a basis for instructors to measure the effectiveness of the curriculum.

**Key content.** This section contains the basic ideas and important points to be covered during the activity. *This information is not to be read to participants* but rather should be worked into discussions as the activity unfolds. If necessary, the instructors can summarize these points at the end of the activity, but again, they should not be simply read aloud.

**Activity steps.** These guides help instructors move logically through each activity. A time estimate is provided for each activity and its parts. However, instructors should be mindful of the needs and interests of participants and adapt both the steps and the time to meet those needs.

**Teaching tips.** Based on experiences with field-testing this curriculum, these are suggestions for optimizing particular activity steps.

**Teaching options.** These alternatives can replace suggested activities to accommodate time or other constraints.

Ideally, the entire curriculum will be taught from start to finish, as each module builds upon information learned in earlier ones, constantly reinforcing participants’ new knowledge and skills. With each successive module, the role plays also become more challenging and complex. The most favorable results will occur from teaching the curriculum step by step rather than expecting participants to leap quickly into complicated case scenarios and role plays.

Keeping in mind the overall structure of the curriculum, instructors should feel free to experiment, make changes, and take risks outside the recommended activities. Each group of participants will possess different needs and dynamics, and instructors should adapt the curriculum to best suit their individual groups. In particular, it is important to be aware of a group’s energy and to adjust activities accordingly; in some cases, teaching tips and options suggest possible alternatives.

**Timing**

The modules are designed for a two-day seminar (see “Two-Day Agenda,” p. I.10), but instructors may want to consider presenting them in alternate ways. This agenda is very dense, and participants are often tired after a full day. Other options include spreading the curriculum over three or four days. Although teaching the material on consecutive days is best for reinforcing learning, spreading out the modules over several weeks or integrating them into a full-semester course is also possible.

Supplementary activity guides—for closing Day 1, for opening Day 2, and for the evaluation
Introduction

Introduction, continued

and final closing—are provided in the Appendix. Instructors may integrate these activities as appropriate, depending on where they decide to end one session and begin the next.

If time is an issue, instructors should adapt the modules. These difficult choices must be made with great care because of the sequential nature of the activities. Enough time must be allotted for each lesson so that learners can assimilate new concepts and practice new skills. Rather than simply reducing the time spent on each skill, instructors may want to begin with a focus on the first two skills and teach the other two at a later date.

Course Approach and Teaching Methods

Course Approach: Focus on Relationships

At the core of coaching supervision is a supervisor’s ability to develop and maintain a relationship with each worker he or she supervises. It is through this relationship that problems are addressed. Throughout the curriculum, the emphasis is on nurturing the supervisor–worker relationship and on modeling in the classroom the importance of interpersonal connections. Given the focus on interpersonal relationships, the curriculum is designed to create an educational environment in which participants feel safe to share personal experiences, ideas, and viewpoints.

In teaching a curriculum in which relationships are viewed as central, how people teach is as important as what they teach. Instructors must model the skills they are teaching by showing respect for participants, valuing participants’ experiences and perspectives, and communicating clearly.

Teaching Methods: Focus on Participation

This curriculum is based on an adult learner-centered approach to education. At the core of a learner-centered educational program is problem-based learning, teaching strategies that actively engage learners in “figuring things out.” Rather than giving information to passive learners through lectures and demonstrations, instructors facilitate learning by building on what participants already know, engaging them in self-reflection and critical thinking and making problem situations come alive through role plays and other activities. Communication and problem-solving skills cannot be taught by merely lecturing about them; it is crucial that participants practice these skills over and over in a variety of real and simulated situations.

To encourage participatory learning, this curriculum uses a number of teaching methods, some focused on increasing self-awareness and others on building skills through practice. The primary modes of instruction include the following:

Case scenarios: Coaching skills are better learned in a reality-based context rather than as abstract concepts. Case scenarios are real-life examples used to illustrate a point or to challenge participants to devise effective solutions. These exercises present brief explanations of problem situations—usually ones that supervisors commonly experience—and ask participants to

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4 See PHI’s Guide to Implementing Learner-Centered Direct-Care Training (forthcoming, 2006). PHI also offers train-the-trainer workshops on creating learner-centered, participatory training programs.
propose appropriate responses. Case scenarios and accompanying role plays (see below) become increasingly complex over the course of the curriculum, challenging participants to stretch their coaching abilities.

**Role plays:** Role plays make case scenarios come alive as participants act out situations they are likely to encounter on the job. In this curriculum, two types of role plays are used: demonstration role plays and practice role plays. Demonstration role plays, by showing common supervisory situations and various types of responses, provide excellent material for analysis and discussion. These role plays may be previously scripted.

During practice role plays, participants draw on prior knowledge and experience while also developing coaching skills. Participants try out different responses to a given situation and then are given feedback about which responses were most effective. Role plays are also used to reinforce new skills—for example, by asking participants to pull back from an immediate emotional response when confronted by an angry worker.

Role-playing encourages participants to take risks in a safe environment, where they can learn from mistakes. Although not all participants will be comfortable performing in front of others, risk taking is an essential part of learning. One way to lower the risk level, especially early on in the seminar, is to conduct role plays in small groups rather than in front of the whole group. Instructors can also demonstrate a role play, sharing their own thoughts and feelings about role-playing in order to make them feel comfortable.

**Small-group work:** Small-group work helps ensure that all participants remain actively engaged in learning. It also facilitates cooperation and community building among participants. For small-group work, the instructor separates people into groups of four to six who sit together at a table or arrange their chairs in a small circle. Periodically changing the composition of the groups is recommended. Participants benefit from working with people with differing personalities, strengths, and weaknesses.

Small groups will work most effectively if given a clear task and roles (e.g., recorder, reporter, timekeeper) and a defined time limit. Instructors can help keep participants on task by walking around the room and checking in briefly with each group. The added benefit of small groups is that they teach about teamwork by embedding it in the learning process.

**Interactive presentations:** Rather than using a traditional lecture format, we recommend involving participants in interactive presentations, in which the instructor draws on participants' knowledge. This kind of participatory dialogue is much more engaging than a traditional lecture, wherein the lecturer provides all the information. The interactive presentation builds confidence and keeps participants interested, breaking down barriers between the teacher “expert” and the learner. One challenge is ensuring that the discussion stays focused on the topic at hand; instructors must continually guide participants back to the subject material and weave in participants’ comments to deepen learning.

In an interactive presentation, the instructor starts by asking participants what they already know about the topic, then draws out participants by asking them to contribute their own experiences and explain what the experiences taught them about the topic under discussion. Participants are also encouraged to ask questions, and instructors provide concrete examples of how the material being taught is relevant to particular situations supervisors encounter.
General Teaching Tips

Planning and Preparation

- Given the level of interaction and practice in this seminar, the ideal number of participants is twelve, with two instructors; activity steps and time are based on these numbers. Teaching options are offered in those activities that might require more time, additional instructors, or a different approach, if there are more than twelve participants.

- To keep participants engaged, interactive presentations should be limited to 15 minutes or less. Facial expressions, varied voice tones, and movement by instructors will keep activities dynamic.

- In the afternoon, groups often become lethargic. A brief, energizing activity in which people move their bodies a bit can shake off sleepiness and keep participants focused on learning. For example, participants can stand and shake out their arms and legs or stand in a circle and bounce a ball across the circle to one another. The idea is just to get the blood moving again, so energizers can be brief (2 minutes or less).

- Before teaching each module, instructors should review the activities and consider the arrangement of chairs that will work best for each. For example, activities involving role plays require a stage area that is easily viewed by the group. Check-ins and closings have a more intimate quality with chairs arranged in a circle. Participants can help rearrange chairs between activities.

- This curriculum is written with detailed instructions useful for new instructors. Experienced instructors will be able to draw from their own “toolbox” to vary some activities.

- Instructors unfamiliar with coaching may want to look at some additional resources. A reference list is included at the end of the manual.

Teaching Materials, Supplies, and Equipment

This curriculum requires a flip chart pad and easel, colored markers, masking tape, pens or pencils, paper for participants, nametags, and three-ring binders for participants. Instructors who want to use overhead projection—either transparencies or LCD computer—as a visual aid during presentations can easily adapt the recommended flip charts and handouts for overhead use.

In general, for all visual materials, it is important to:

- Write large: Printed words on flip chart pages should be large and clear. Using colored markers for different concepts can help to delineate and highlight specific points. Likewise, with typed overheads, it is important that words be legible and easily seen from the back of the room. The Arial font at a minimum size of 14 points is recommended.

- Provide handouts: Each module's advance preparation steps indicate which handouts to copy for participants. Some handouts are designed to review concepts, while others are worksheets to be completed during activities. These will become important reference sheets for participants when they apply their new skills in the workplace.
Introduction

Two versions of a handout are sometimes included: one for residential care settings, where direct-care workers are supervised on site, the other for home care settings, where direct-care workers have little, if any, on-site supervision. Instructors will only need the version appropriate for their setting and participants.

If new handouts are created, instructors should keep pages simple (lots of white space) and use large fonts.

- **Build a resource guide:** One desired outcome is to create a resource guide that participants can refer to after the seminar is completed. Every participant should be given a three-ring binder in which to keep handouts distributed for each activity. Passing out materials as they are used ensures that the information taught in each activity is fresh and provides participants with a sense of accomplishment as each activity or module is completed.

**Teaching Techniques**

- Throughout the seminar, it is important that instructors consciously model the material presented, using the four basic coaching skills in interactions with the participants.

- If two instructors are coteaching, it is often effective for one to facilitate discussion while the other writes key points on a flip chart page or overhead.

- Instructors should draw out the quieter people in the group so that everyone speaks during a discussion. More talkative participants should not be allowed to dominate discussions.

- There are several opportunities in the seminar for participants to share stories from personal experience. Because this is a rare pleasure for many, such conversations can take on a life of their own. The instructor should keep stories focused on the main point of the activity and watch the time so that all participants get a chance to share.

- Participants’ sharing may elicit questions or issues that cannot be tackled during the activity’s allotted time. In such situations, the instructor may want to track these issues in a visual way by creating a “parking lot”—an ongoing list on a flip chart page. As time and interest allow over the course of the seminar, these issues can be addressed.

- The role plays are critical to the effectiveness of this curriculum but may be new to many participants. Some may feel reluctant to participate. Instructors should explain that the role plays involve practice, not performance, and that participants will not be judged negatively for their efforts. Participants will learn the most from the role plays if they take their roles seriously and do their best.

- Role plays may also be new to instructors. Instructors who feel nervous about them will pass on their nervousness to participants. Therefore, it is essential that instructors practice the role plays prior to the seminar until they are comfortable with them and can support participants in taking risks to participate.

- Participants sometimes pose questions for which instructors don’t have answers. If this happens, instructors should acknowledge that the question is new to them and that they may be able to locate an answer before the next session. A willingness to research the question will demonstrate instructors’ investment in participants and in the seminar.
Introduction

Coaching Supervision: Sample Agenda for Two-Day Seminar

Day 1: 6 Teaching Hours (e.g., 9:00-4:00)

Module 1: Introduction to Coaching Supervision ........................................... total 1 hour
9:00–10:00
   Group Introductions ................................................................................. 10 minutes
   Coaching Supervision in Long-Term Care Settings ............................. 15 minutes
   What a Supervisor Does ....................................................................... 35 minutes

10:00–10:15 Break ...................................................................................... 15 minutes

Module 2: Traditional and Coaching Approaches to Supervision ........... total 50 minutes
10:15–11:05
   The Traditional Approach to Supervision ........................................... 20 minutes
   The Coaching Approach to Supervision .............................................. 30 minutes

Module 3: Coaching Skill #1—Active Listening ..................................... total 1 hour, 55 minutes
11:05–12:10
   Listening Exercise—Body Language .................................................... 35 minutes
   Paraphrasing and Asking Open-Ended Questions (set up) ................. 30 minutes

12:10–1:00 Lunch Break .............................................................................. 50 minutes

1:00–1:50
   Communication Game—Back to Back ................................................ 20 minutes
   Paraphrasing and Asking Open-Ended Questions (practice) ............ 30 minutes

Module 4, part 1: Coaching Skill #2—Self-Management ....................... total 1 hour, 45 minutes
1:50–2:35
   Pulling Back ......................................................................................... 45 minutes

2:35–2:50 Break ......................................................................................... 15 minutes

2:50–3:50
   Pull Back and Paraphrase Role Plays .................................................. 60 minutes

3:50–4:00
   Day 1 Closing ..................................................................................... 10 minutes
Day 2: 6 Teaching Hours (e.g., 9:00-4:00)

Day 2 Opening ................................................................. 25 minutes
9:00–9:25
Sharing thoughts and feelings and reviewing homework ......................... 25 minutes

Module 4, part 2: Coaching Skill #2—Self-Management .................... total 55 minutes
9:25–10:20
Blocks to Listening ....................................................... 55 minutes

10:20–10:30 Break ............................................................ 10 minutes

Module 5: Coaching Skill #3-Self-Awareness .................... total 1 hour, 30 minutes
10:30–12:00
Role Play: Calling Out .................................................. 20 minutes
Personal Styles Inventory ..................................................... 70 minutes

12:00–12:40 Lunch Break .................................................. 40 minutes

Module 6: Coaching Skill #4-Presenting the Problem .................... total 1 hour, 10 minutes
12:40–1:50
Accountability without Blame or Judgment .................................. 15 minutes
Practice in Presenting the Problem ........................................... 55 minutes

Module 7: Making Coaching Work .................... total 1 hour, 30 minutes
1:50–2:10
Putting It All Together: Skills Review .................................. 20 minutes

2:10–2:20 Break ............................................................. 10 minutes

2:20–3:30
Coaching Skills Practice: Role Plays ...................................... 55 minutes
Requirements for Successful Coaching ..................................... 15 minutes

3:30–4:00
Evaluation, Getting Support, and Final Closing ......................... 30 minutes
Goals
■ To provide an overview of the seminar agenda, goals, and objectives.
■ To set a welcoming tone during instructor and participant introductions.
■ To introduce the concept of coaching and its application in the context of supervising direct-care workers.
■ To have participants define the purpose of supervision and identify the barriers they encounter to achieving their goals as supervisors.

Time
1 hour

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<thead>
<tr>
<th>Training Activities</th>
<th>Methods</th>
<th>Time</th>
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<tbody>
<tr>
<td>1.1 Group Introductions</td>
<td>Large-group exercise</td>
<td>10 minutes</td>
</tr>
<tr>
<td>1.2 Coaching Supervision in Long-Term Care Settings</td>
<td>Interactive presentation</td>
<td>15 minutes</td>
</tr>
<tr>
<td>1.3 What a Supervisor Does</td>
<td>Individual work, small-group work, large-group discussion</td>
<td>35 minutes</td>
</tr>
</tbody>
</table>

Supplies
■ Flip chart, easel, and markers
■ Colored paper
■ Adhesive label sheets (Avery 5160 or equivalent)
■ Three-ring binders
Module 1: Introduction to Coaching Supervision

Handouts

- Handout 1: “Coaching Supervision—Sample Agenda for Two-Day Seminar”
- Handout 2: “Definition of Coaching Supervision”
- Handout 3: “Benefits of Coaching Supervision”
- Handout 4: “Roles of a Supervisor” (3 pages)

Advance Preparation

Set up the workshop space to allow for interactive sessions, keeping in mind the physical needs of participants.

Review the seminar materials for each activity.

Activity 1.2

Prepare an agenda for the seminar identifying sessions and times (sample included with handouts). Display as a flip chart, and include copies in binders to be distributed to participants.

Prepare flip charts for steps 1 and 3 as shown in text.

Copy Handouts 2 and 3, “Definition of Coaching Supervision” and “Benefits of Coaching Supervision.”

Activity 1.3

Make a copy of Handout 4, “Roles of a Supervisor,” on adhesive labels for each participant.
Activity 1.1: Group Introductions 10 minutes

Learning Outcome

By the end of this activity, participants will be able to:

Identify one another by name and give brief, pertinent information about each participant’s experience and professional role.

Key Content

- The participatory nature of this seminar makes it very important that participants feel safe and comfortable. Introductions help put participants at ease and begin to share experiences.
- Coaching supervision relies on building relationships. The seminar models this process by building relationships among participants and facilitators.

Activity Steps

Large-group exercise (10 minutes)

1. Introduce yourselves, giving a brief description of your background and experience in supervision, coaching, and/or coaching supervision.

2. Ask participants to go around the room and introduce themselves with their first name, the name of their organization, their role in the organization, how long they have worked there, and what they hope to get out of this seminar. If participants already know one another, ask them to share something about themselves that others in the group may not know. Continue until everyone has been introduced.

> Teaching Tips

- Keep the tone warm and welcoming.
- Keep your own introduction brief and focused.
- As this curriculum is about building relationships, it’s important for instructors to learn everyone’s name as soon as possible. Write them down if necessary.
- Time permitting, ask participants to answer the following question when introducing themselves: What keeps you coming to work each day?
- Listen carefully to each participant. Remember, you are modeling good coaching practices.
- If participants don’t know one another, adapt this as a partner activity. In step 2, have participants pair off and interview each other, gathering information about their names, organizations, roles in the organizations, how long they have worked there, and what they hope to get out of the seminar. Then ask partners to introduce each other to the large group.
Module 1: Introduction to Coaching Supervision

—Teaching Notes—
Activity 1.2: Coaching Supervision in Long-Term Care Setting

Learning Outcomes

By the end of this activity, participants will be able to:

Define coaching supervision; and

List the four major benefits of coaching supervision.

Key Content

“Coaching supervision” is a relational approach to managing and supporting direct-care workers that helps them to develop their own problem-solving skills—i.e., the ability to think critically, prioritize, and communicate effectively.

The first long-term care organization to adopt the coaching approach to supervision (which has been used extensively in the business world) was a home care agency in Philadelphia. Since 2000, the practice has spread to other long-term care organizations, including nursing facilities, because it has proved to be particularly effective in supporting and retaining direct-care workers.

Coaching has proven results, including these four major benefits:

- Enhances retention of employees;
- Defuses conflict;
- Improves problem solving; and
- Improves the likelihood that the needs of both the consumer and the worker will be met.

The coaching approach can be used in all interactions within an organization but has the most significant results when used in supervision.

The primary goals of the seminar are to introduce participants to coaching supervision and to begin to practice four coaching skills: Active Listening, Self-Management, Self-Awareness, and Presenting the Problem.
Module 1: Introduction to Coaching Supervision

Activity Steps

Interactive presentation (15 minutes)

1. Present the definition of coaching:

   Ask participants what comes to mind when they hear the word “coaching.” Allow several participants to share their thoughts.

   Display the prepared flip chart "Definition of Coaching Supervision," and read aloud or ask a participant to do so.

   
   ![Definition of Coaching Supervision]

   Connect what the participants were sharing above with the definition of coaching supervision. Emphasize the relational aspect—that creating a relationship is vital—and that one goal of coaching supervision is to help workers solve problems effectively.

   Ask if there are any questions and discuss until all participants understand the definition of coaching. Do not belabor the discussion—it will become clearer through the morning’s activities.

2. Explain that in recent years, long-term care organizations have begun to adopt coaching supervision because they have found it to be an effective way to support direct-care workers and help them perform their jobs better. It was first adapted by home care agencies and has since been used by nursing facilities.

   ✷ Teaching Tip

   If this seminar is sponsored by a long-term care organization for its own staff, management may want to make a short presentation at this point to explain why a decision has been made to adopt coaching supervision.
3. Briefly explain that coaching supervision has been found to reap significant benefits, and display the prepared flip chart “Benefits of Coaching Supervision.”

4. Read aloud the four major benefits, adding short explanations as necessary in order to make sure all participants understand. Be sure to recognize participants who named any of the four benefits in the above discussion, and place a check next to the benefit they mentioned. Ask participants if they have questions about the meaning of items on the list.

   ![Benefits of Coaching Supervision]

   - Enhances retention of employees
   - Defuses conflict
   - Improves problem solving
   - Improves the likelihood that the needs of both the consumer and the worker will be met.

   **Teaching Tip**
   Don’t spend a great deal of time now on the benefits. At the end of the seminar, instructors may add an optional activity that reviews these benefits as a means of summarizing some of the seminar’s key content.

5. Summarize by explaining that coaching is a system of communication that can be used by anyone in an organization. However, its most significant and immediate benefits occur when used in the context of supervision. For this reason, the primary goals of the seminar are to introduce participants to coaching supervision and to begin to practice the skills used in this approach: active listening, self-management, self-awareness, and presenting the problem.

6. Hand out the participants resource binders with the agenda and briefly go over time issues. Explain that participants can use the binders to collect the handouts over the course of the seminar, and that to start them off you have included handouts with “Definition of Coaching Supervision” and “Benefits of Coaching Supervision.”

   **Teaching Tip**
   Although a lot of material is presented in a short time, keep participants engaged by asking open-ended questions and eliciting their input. Make the presentation as interactive as possible.
Module 1: Introduction to Coaching Supervision

Activity 1.3: What a Supervisor Does 35 minutes

Learning Outcomes

By the end of this activity, participants will be able to:

- Identify the crucial functions of a supervisor;
- Describe what supervision, at its best, involves for both supervisor and supervisee; and
- Identify obstacles that keep participants from achieving their goals as supervisors.

Key Content

- The role of supervisor includes many functions. Some of these functions may feel more crucial to the job than others.
- Determining the most important supervisory functions helps frame the purpose of supervision and helps create an ideal vision of the job.
- Most supervisors cannot achieve their ideal vision on a daily basis because many obstacles arise.
- While some supervisory functions, such as disciplining staff, may feel negative, all are necessary parts of effective supervision.
- Coaching supervision approaches the “negative” aspects of supervision in a way that produces more positive results and brings supervisory interactions closer to our ideal.

Activity Steps

Individual work (5 minutes)

1. Distribute a piece of colored paper and Handout 4, “Roles of a Supervisor,” on adhesive labels to each participant. Ask participants to select the six to eight roles they consider most important and to paste them on the colored paper. Encourage participants to be creative in how they paste the words on their pages, creating a design and embellishing with markers if they choose.

   ► Teaching Tip
   Be clear that there are no right or wrong choices on the “Roles of a Supervisor” list.

Small-group work (10 minutes)

2. Divide the group into groups of four; ask participants to share with one another which roles they chose, why they chose them, and why they pasted the words the way they did on the paper.
Large-group discussion (20 minutes)

3. Ask for a volunteer to share three of his or her choices. Write the responses on a flip chart page entitled “Roles of a Supervisor.”

4. Ask the volunteer to explain the rationale behind his or her choices. For each choice, ask how many other participants made the same choice.

5. Ask for someone from another group to share different roles they selected. Repeat this process until someone from each group has spoken. Record all responses on the flip chart page.

6. Focusing on those roles that many people chose, ask participants why they consider those roles important to their jobs as supervisors and how those roles play out in their work.

7. Next, draw attention to the roles that were not chosen. Explore why no one chose those roles. Nevertheless, note that all the functions in the list are important to supervision, whether positive roles such as reinforcing success or negative ones such as correcting poor performance.

8. Explain that in doing this exercise, people often create a picture of what they consider the ideal supervisor. Ask the group if this vision of supervision feels possible in their workplaces. (You’re likely to hear a resounding “no!”)

9. Ask participants to describe the gaps in their work lives between what they consider the ideal and the actual. On a flip chart page entitled “Barriers to Being an Ideal Supervisor,” write down the obstacles to achieving the ideals that people name.
10. Affirm that the barriers they are talking about are real, not imagined. Explain that participants will revisit this list at the end of the seminar (Activity 7.3) to see if some of the barriers feel less difficult to overcome.

**Teaching Tips**

One purpose of the discussion on barriers is to uncover resistance to coaching supervision so that instructors can acknowledge the barriers and help participants put aside their skepticism, at least temporarily. Generally, if people are able to say, for example, “There is no time for it,” and an instructor pays attention, they are more willing to suspend disbelief and listen to the concepts being presented.

This discussion also informs instructors about what the group perceives as significant issues and what barriers will need to be addressed to enable participants to implement coaching supervision in their jobs.

11. Summarize by explaining that coaching supervision incorporates all the roles that have been discussed—both positive and negative—but when the coaching approach is used, supervision is able to come closer to an ideal vision. In particular, negative functions such as confronting, disciplining, and correcting result in more positive outcomes, with the number of disciplinary problems decreasing over time.

**Teaching Tip**

At the end of this activity, collect the colored papers with participants’ selections of key roles and post them on the wall.

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**Teaching Notes**
Goals

■ To illustrate, through demonstration role plays, the traditional supervisory approach that most participants are familiar with and to contrast that with the coaching approach to supervision.

■ To introduce the five steps used in coaching supervision.

■ To reinforce the important role that supervision plays in worker satisfaction and retention.

■ To introduce the four primary coaching skills taught in this seminar.

Time

50 minutes

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<tr>
<th>Training Activities</th>
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<tr>
<td>2.1 The Traditional Approach to Supervision</td>
<td>Demonstration role play, discussion</td>
<td>20 minutes</td>
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<tr>
<td>2.2 The Coaching Approach to Supervision</td>
<td>Demonstration role play, discussion, interactive presentation</td>
<td>30 minutes</td>
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Supplies

■ Flip chart, easel, and markers

Handouts

■ Handout 5: “Role Play—Traditional Supervision” (2 pages)
■ Handout 6: “Role Play—Coaching Supervision” (6 pages)
■ Handout 7: “What a Coach Supervisor Does”
■ Handout 8: “Comparison of Traditional and Coaching Supervision”
■ Handout 9. “Four Primary Coaching Skills”
Module 2: Traditional and Coaching Approaches to Supervision

**Advance Preparation**

Review the seminar materials for each activity.

**Activity 2.1**

Copy Handout 5, “Role Play—Traditional Supervision.”

Prepare flip charts as shown in steps 1 and 5.

**Activity 2.2**

Copy Handouts 6, 7, 8, and 9, “Role Play—Coaching Supervision,” “What a Coach Supervisor Does,” “Comparison of Traditional and Coaching Supervision,” and “Four Primary Coaching Skills.”
Activity 2.1: The Traditional Approach to Supervision

Learning Outcomes

By the end of this activity, participants will be able to:

- Explain the importance of supervision in worker satisfaction and retention;
- Describe the traditional approach to supervision, including the five basic steps;
- Explain the limited effectiveness of traditional supervision in motivating and training workers as well as developing their problem-solving skills; and
- Relate their own experiences with traditional supervision to the demonstration role play.

Key Content

- Supervisors have a powerful impact on workers’ lives. A worker’s relationship with his or her supervisor is often the most influential factor in whether the worker feels valued and respected at work. Not surprisingly, feeling valued and respected is one of the biggest factors affecting a worker’s decision to stay on the job or quit.

- Supervisors face challenging situations every day, especially in working with employees who have minimal work experience. Dealing with problems such as repeated lateness, no call/no shows, and negative or uncooperative attitudes can consume a significant portion of a supervisor’s time and energy.

- Although blaming workers for poor performance is tempting, it is helpful to remember that low-wage workers, particularly those new to the workforce, often have few resources or limited experience to fall back on when the complexities of caring for their families conflict with the needs of the workplace.

- There is a disturbingly high turnover rate among newly hired direct-care workers. Given the complexities of many workers’ personal and work lives, direct-care workers often need support in developing the communication and problem-solving skills required in a demanding workplace.

- Supervisors play major roles in helping workers to learn and grow personally and professionally and succeed on the job. The traditional model of supervision, however, does not provide supervisors with the tools needed to do this effectively.

- The five steps of the traditional approach to supervision, as illustrated in the role play, are:
  - Identify issues to be addressed;
  - Explain the rules clearly;
  - Explain the consequences of breaking the rules;
  - Offer possible solutions to the problem; and
  - Request or direct the worker to comply with work rules.
Module 2: Traditional and Coaching Approaches to Supervision

Activity Steps

Demonstration role play (10 minutes)

1. Reiterate the message from the discussion at the end of Activity 1.3, “What a Supervisor Does.” Supervisors’ jobs are demanding and stressful, and they frequently work in situations where they are understaffed and unsupported and have too few resources. In addition, people who are good at their jobs are often promoted to being supervisors but given little or no training for the job. All these factors make it difficult for supervisors to excel in their positions. This is problematic because supervisors play a critical role in the retention of direct-care workers.

2. Display the following flip chart:

3. Ask for a volunteer to read the statement aloud. Ask participants for their reactions to this quote, from their own experiences, particularly their experience being supervised.

   ► Teaching Tip
   When requesting reactions to the statement, ask participants to be brief. Explain that you only want to know whether the statement makes sense in their experience. They will be able to share more detailed stories later in this module.

4. Distribute Handout 5 “Role Play—Traditional Supervision”* and have two volunteers read it aloud, each taking a part. Ask the volunteers to use enthusiastic but realistic expression in their voices, not to read in a monotone and not to overplay.

   ► Teaching Tip
   The role play scenario is the core of this activity, so it is important that it be performed effectively. Before asking for two volunteers to read it aloud, explain that you are looking for people willing to play the role and have some fun.

* The role play scenario uses a residential care setting, but because the issues in a home care setting are so similar, it works well for those supervisors as well.
Module 2: Traditional and Coaching Approaches to Supervision

Demonstration role play (10 minutes)

5. Invite comments from participants on what happened in the interaction. Ask the group:

   What did the supervisor do?

   What strategies or techniques did the supervisor use to accomplish her goals?

   How did the worker react?

   What is the likely outcome of this interaction?

   **Teaching Tip**

   Participants’ reactions to the role play can range from “The supervisor did fine, the worker was clearly not committed to the job” to “The supervisor was cold and uncaring and didn’t give the worker a chance to explain herself.” Explore both extremes and help participants see that neither response is entirely true. The interaction is not supportive to the worker and is not likely to result in helping him or her become a better problem solver or more invested in her job. But since this supervisor has little time to address problems and a seemingly uncooperative employee, the approach is not unreasonable. Acknowledge that this is how most people were oriented to supervision and how most would have approached the worker.

6. Turn to the prepared flip chart page “Traditional Supervision: Five Steps,” and have a volunteer read the steps aloud.

   ![Flip Chart]

   **Traditional Supervision: Five Steps**
   - Identify issues to be addressed.
   - Explain the rules clearly.
   - Explain the consequences of breaking the rules.
   - Offer possible solutions to the problem.
   - Request or direct the worker to comply with work rules.

7. Ask:

   How was each step demonstrated in the role play scenario?

8. Invite participants to relate their experiences as supervisors or supervisees to the role play and to the list of steps used in the traditional approach. Ask:

   How do you usually approach supervisory interactions?

   How do you approach these interactions when you are stressed or have negative feelings about the worker?

   — Continued next page
Module 2: Traditional and Coaching Approaches to Supervision

Activity 2.1, continued

**Teaching Tip**
Keep the discussion focused on how participants’ experiences relate to the list of steps and to the role play. Don’t allow people to dwell on the specific issue of tardiness. Rather, focus on the relationship between the worker and the supervisor in the role play and the interactions between them.

9. Summarize by asking the group:

What chance do you think this supervisory intervention has of resolving the issue and retaining the worker?

---Teaching Notes---
Module 2: Traditional and Coaching Approaches to Supervision

Activity 2.2: The Coaching Approach to Supervision

30 minutes

Learning Outcomes

By the end of this activity, participants will be able to:

Relate their own experiences with supervision to the demonstration role play;

List the five basic steps of coaching supervision;

Compare how the traditional and coaching approaches to supervision differ with respect to the relationship between worker and supervisor and potential outcomes; and

Name the four primary coaching skills taught in this seminar.

Key Content

■ Workplace relationships are one of the most important contributors to how people feel about their jobs. In particular, relationships are at the heart of work with people who are elderly, chronically ill, or living with disabilities. A number of studies have shown that the opportunity for relationships with consumers draws workers to home health and long-term care—and the quality of relationships with coworkers and supervisors keeps them in their jobs.

■ Quality relationships underlie quality care. When an agency focuses on developing, in its staff, communication and problem-solving skills that support strong relationships, the entire organization benefits from increased efficiency, delivery of better quality care, and a more positive organizational culture.

■ Coaching supervision is an approach to working with direct-care workers that uses effective communication skills to build positive supervisor–worker relationships and stronger problem-solving skills. The coaching approach differs from the traditional approach that was modeled in the earlier role play in its emphasis on helping workers develop problem-solving skills and in the way coach supervisors behave toward workers.

■ The outcome of the scenario described in this activity’s role play is likely to be more positive than the outcome of the first role play. The worker is more likely to have more positive feelings about herself and her supervisor and to stay on the job as a result of the interaction.

■ The coaching approach takes more time in the early stages. In the long run, however, this investment pays off because coach supervisors retain more workers and spend less time dealing with problems.

■ The five basic steps of coaching supervision are:

  ■ Create a relationship with the worker;
  ■ Clearly present the problem;

—Continued next page
Module 2: Traditional and Coaching Approaches to Supervision

Activity 2.2, continued

- Gather information about the worker’s perspective;
- Engage in problem-solving with the worker; and
- Help the worker commit to action steps.

The four primary skills used in the coaching supervision model are:

- **Active Listening:** Using skills such as body language, paraphrasing, and asking clarifying questions to listen attentively and ensure understanding;
- **Self-Management:** Setting aside emotional reactions and other listening blocks that can get in the way of hearing a worker’s perspective;
- **Self-Awareness:** Being conscious of assumptions and biases that lead to prejudging workers and others; and
- **Presenting the Problem:** Using objective language to identify performance problems and hold workers accountable.

**Activity Steps**

**Demonstration role play (10 minutes)**

1. Pass out Handout 6, “Role Play—Coaching Supervision,” and ask two volunteers to read the parts aloud.

   **Teaching Tip**
   As before, choose volunteers who are strong readers and who can read with expression. You may wish to have the same volunteers read again, so that you can ask them later how they experienced the difference in the two approaches.

2. Invite comments from participants on what happened in the interaction. Ask the group:

   - *What did the supervisor do?*
   - *How did the worker react?*
   - *What is the likely outcome of this interaction?*
   - *What chance do you think this intervention has of succeeding in resolving the problem and retaining the worker?*

3. Ask participants to relate this role play to their experiences as supervisors or supervisees. Ask:

   - *Are there familiar aspects to the coaching approach?*
   - *Have you tried to take a similar approach with workers you supervise?*
   - *Have you ever had a supervisor who took an approach like this?*
Module 2: Traditional and Coaching Approaches to Supervision

Ask the volunteers who read the role play about their reactions:

*Did the interaction feel realistic to you?*

*Could you imagine approaching a worker in this way?*

4. Point out that in this role play the supervisor took a little more time with the worker than in the previous role play. Ask:

*How could the extra time initially spent with the coaching approach save time in the long run?*

**Interactive presentation (10 minutes)**

5. Distribute the Handout 7, “What a Coach Supervisor Does.” Review the five steps, by asking five participants to each read one aloud. Relate each step to specific actions taken by the coach in the role play.

**Teaching Tip**

There will not be enough time to relate all aspects of each step to the role play. Focus instead on how the five major steps came through in the role play (noting which ones were obviously demonstrated). Explain that other role plays in the seminar will demonstrate more clearly the fine points of these steps.

6. Distribute the Handout 8, “Comparison of Traditional and Coaching Supervision,” and review the similarities and differences. Explain that the rest of the seminar will focus on developing some key coaching skills to carry out the first three steps in the coaching approach. Note that these steps are fundamental and lay the groundwork for workers to become engaged in problem-solving with the supervisor and to become better problem solvers overtime. In more advanced coaching seminars, participants are introduced to a specific problem-solving model that can be used to build workers’ skills in this area.

7. Distribute Handout 9, “Four Primary Coaching Skills,” and review the four skills that are the seminar’s focus:

**Active Listening:** Using skills such as body language, paraphrasing, and asking clarifying questions to listen attentively and ensure understanding;

**Self-Management:** Setting aside emotional reactions and other listening blocks that can get in the way of hearing a worker’s perspective;

**Self-Awareness:** Being conscious of assumptions and biases that lead to prejudging workers and others; and

**Presenting the Problem:** Using objective language to identify performance problems and hold workers accountable.
Goals

■ To underscore the importance of active listening—i.e., listening with one's full attention—in supervisory interactions, even if it takes more time.

■ To have participants learn and practice active listening skills, including attentive body language, paraphrasing, and asking open-ended clarifying questions.

■ To reinforce the difficulty and importance of clear verbal communication and to identify strategies to improve verbal communication.

Time

1 hour, 55 minutes. A lunch break is suggested during Activity 3.2.

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<td>Demonstration and paired role plays; discussion</td>
<td>35 minutes</td>
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<tr>
<td>3.2 Paraphrasing and Asking Open-Ended Questions</td>
<td>Interactive presentation, large-group exercise, pairs work, demonstration role play, discussion</td>
<td>60 minutes</td>
</tr>
<tr>
<td>3.3 Communication Game—Back to Back</td>
<td>Pairs work, discussion</td>
<td>20 minutes</td>
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Supplies

■ Flip chart, easel, and markers
■ Blank paper and pencils

Handouts

■ Handout 10: “Active Listening”
■ Handout 11: “Lead-Ins for Paraphrasing”
Module 3: Coaching Skill #1—Active Listening

Coaching Skill #1—Active Listening, overview, continued

- Handout 12: “Lead-Ins for Open-Ended Clarifying Questions”
- Handout 13: “Paraphrase and Open-Ended Clarifying Questions Worksheet” (2 pages)
  (2 versions: residential and home care)
- Handout 14: “Back-to-Back” geometric designs (5 designs)

Advance Preparation

Review the seminar materials for each activity.

Activity 3.1

Copy Handout 10, “Active Listening,” for all participants.

Prepare the flip chart for step 2.

Think of a personal story for the role play in step 6.

Activity 3.2

Copy Handouts 11, 12, and 13, “Lead-Ins for Paraphrasing,” “Lead-Ins for Open-Ended Clarifying Questions,” and “Paraphrase and Open-Ended Clarifying Questions Worksheet” (2 versions: residential and home care).

Prepare flip charts for step 1.

Prepare for the demonstration role play in step 10.

Activity 3.3

Make enough copies of Handout 14, the five geometric designs, to provide one design for each pair of participants. If you have more than five pairs, copy each design on a different color paper so that you can easily give different designs to pairs sitting within hearing distance of each other.

Prepare flip chart for step 11.
Activity 3.1: Listening Exercise—Body Language

Learning Outcomes

By the end of this activity, participants will be able to:

- Explain the importance of active listening, especially in coaching supervision;
- Recognize that active listening takes conscious effort;
- Describe what body language is and its impact on communication; and
- Explain how poor listening undermines effective communication.

Key Content

- Good listening, or “active listening,” is essential to clear, effective communication and is of primary importance in coaching supervision.

- Active listening—i.e., listening with full attention to another person—is a skill that must be learned and practiced since it is rarely taught or experienced. It involves:
  - Using attentive body language,
  - Paraphrasing a speaker’s words, and
  - Asking clarifying questions to gather information and ensure mutual understanding.

- Active listening is the underlying skill in coaching supervision because:
  - When people listen with their full attention, they remember and understand more of what is being communicated. On the other hand, when they listen inattentively, they miss a great deal of what is being communicated.
  - Being listened to attentively feels caring and helpful to the speaker. Not being listened to, or being listened to in an inattentive manner, feels hurtful and unhelpful.

- Active listening requires constant, conscious effort.

- “Body language,” the focus of Activity 3.1, refers to the way people communicate nonverbally through postures, facial expressions, gestures, and movement. Body language can communicate more strongly than words, so people often respond to body language rather than to words. Because of the power of body language, it is necessary to become aware of one’s own body language and learn to use it effectively.

—Continued next page
Module 3: Coaching Skill #1—Active Listening

Activity Steps

Introduction (5 minutes)

1. Explain that this module introduces the primary tool used in coaching supervision—listening. Good listening is essential to any relationship and in effective communication. Although participants may feel they are already good listeners, coaching supervision requires a more conscious level of listening called active listening.

2. Display the prepared flip chart page “Real Listening Is...” and review the four objectives of listening attentively.

3. Distribute Handout 10, “Active Listening,” and review the definition and benefits of active listening. Point out that most people don’t use active listening because they have not been taught how to do it.

Demonstration role play and discussion (10 minutes)

4. Briefly explain the importance of body language in active listening, and note that real listening involves more than hearing what someone is saying. Ask participants for examples of body language.

5. Explain that you and your co-instructor will act out two role plays that will demonstrate poor and good body language. Before beginning, ask a volunteer timekeeper to announce when 2 minutes have passed.

6. To demonstrate poor nonverbal listening skills (or body language), one instructor tells a personal story to the other, who will do everything she can to act as if she is not listening. The story can be something positive or something he or she is struggling with. The listener demonstrates poor nonverbal listening skills by becoming increasingly distracted, looking at the clock, glancing away, fidgeting, yawning, slouching, re-crossing legs, etc. Use a full range of facial expressions and actions, and continue the role play for the full 2 minutes.
Module 3: Coaching Skill #1—Active Listening

**Teaching Tips**

If two instructors are not available, choose a participant to help with the role play and coach him or her during the morning break to act as the speaker.

This activity works best if the speaker shares something current and important. Choose a story you feel comfortable telling that does not compromise your role in the organization.

The listener must exaggerate poor body language for this exercise to work well.

7. Debrief with the following questions.

Ask participants:

*Do you think the listener was listening?*

*How could you tell?*

Write participants’ responses on a flip chart page entitled “Poor Listening.”

Ask the speaker:

*What did you notice about the listener’s behavior?*

*How did it feel not be listened to?*

Ask the listener:

*What do you remember about the speaker’s story?*

Emphasize here how little information the listener was taking in.

**Teaching Tip**

Remember that the focus is not simply on how good it feels to be listened to but also on the importance of listening in order to clearly understand the information being shared.

8. Repeat the role play about the same topic with the listener demonstrating good nonverbal listening skills through his or her body language—e.g., looking at the speaker, nodding, leaning forward, gesturing, ignoring outside noises, etc. Again, ask for a participant to keep time for 2 minutes.
Module 3: Coaching Skill #1—Active Listening

Activity 3.1, continued

9. Debrief with the following questions.

Ask participants:

*Do you think the listener was listening?*

*How could you tell?*

*What did you notice about her reactions to being listened to?*

Write participants’ responses on a flip chart page entitled “Active Listening.”

Ask the speaker:

*What did you notice about the listener’s behavior?*

*How did it feel to be listened to?*

Ask the listener:

*What do you remember about the speaker’s story?*

**Role plays in pairs, with large-group discussion (15 minutes)**

10. Explain that participants will now have a chance to experience for themselves the impact of poor vs. active listening and to practice using effective body language. Separate participants into pairs.

11. Give instructions for the role play. Ask the pairs to choose a speaker and a listener (let them know they will switch roles later). Tell the speakers to think of something personally important to them to share with their partner. Tell the listeners that they are encouraged to exaggerate their poor body language while listening (refer them to the “Poor Listening” flip chart).

12. Have participants role play for 2 minutes. (Instructor keeps time.)
Module 3: Coaching Skill #1—Active Listening

Teaching Tip
Some participants may become angry when they are blatantly not being listened to. Be prepared to acknowledge anger and other emotions and remind participants that this is an exercise—the listeners are simply doing what they were told. In the discussion, follow up on why participants might have become angry or upset when not being listened to.

13. Debrief with the whole group.

Ask the speakers:

*How did it make you feel to not be listened to?*

Ask the listeners:

*Do any of you remember what you were told?*

Teaching Tip
Create a flip chart page about the role-play results, writing the feelings and experiences of not being listened to in one column and the feelings and experiences of being listened to in another.

14. Repeat the exercise with listeners using positive body language. Ask the same debriefing questions, giving participants an opportunity to talk about how this role play felt and how it was different.

15. Ask the pairs to switch roles and repeat both the poor and active listening skills. Give the new speakers a minute to think about a story to tell. Debrief after each one, allowing people to share their experiences.

Teaching Tip
Switching roles and repeating the exercise is important so that everyone can experience and comprehend the frustration of not being listened to. As the role plays progress, the debriefing periods can be shorter as participants better understand the concept.
Module 3: Coaching Skill #1—Active Listening

Summary discussion (5 minutes)

16. End the session by reviewing the primary points participants have been making (i.e., negative feelings arise when not being listened to, and the importance of feeling listened to).

17. Ask participants:

What role do you think active listening, and specifically body language, plays in coaching supervision?

What might get in the way of supervisors using active listening when meeting with supervisees?

18. Emphasize that active listening is an essential skill that requires self-awareness and lots of practice. Encourage participants to strengthen their skills by consciously choosing to actively listen, both at home and at work. Explain that the next set of exercises will give them additional active listening tools.
Activity 3.2: Paraphrasing and Asking Open-Ended Questions

60 minutes

Learning Outcomes

By the end of this activity, participants will be able to:

- Define paraphrasing and open-ended questions;
- Explain the importance of these skills for effective communication and coaching supervision; and
- Demonstrate paraphrasing and asking open-ended questions.

Key Content

- When confronting a problem, many people, especially supervisors, tend to search immediately for a solution, without confirming the accuracy of the information they are given or gathering sufficient information.

- Paraphrasing and asking open-ended clarifying questions are essential techniques in coaching supervision. These communication tools are often used to gather additional (and more accurate) information from workers and to ascertain that you have correctly understood what they're saying. These steps are essential before effective problem solving can take place.

- Paraphrasing means stating in your own words what you think someone just said. Paraphrasing is important because:
  - People deeply appreciate feeling heard (recall Activity 3.1).
  - Paraphrasing can slow anger and cool down a crisis because the focus is on clarifying information rather than on reacting to the situation.
  - Paraphrasing prevents miscommunication and helps the listener remember what was said. False assumptions, errors, and misinterpretations can be corrected on the spot.
  - When paraphrasing, it's much harder to fall into the traps that block listening, such as the temptation to judge or interrupt (to be covered in Activity 4.3). The listener's focus is on really understanding what is going on with the speaker.

- Open-ended clarifying questions often begin with how, what, or why; they are used to clarify information and keep the conversation going by encouraging a person to share as much as he or she wishes. Closed questions result in a simple “yes” or “no” or in factual answers. Closed questions tend to bring the conversation to a stop, requiring more questions to obtain the full story.

- Used together, paraphrasing and asking open-ended clarifying questions greatly enhance communication. They are vital to successful coaching supervision because:
  - They allow for more complete understanding.
Module 3: Coaching Skill #1—Active Listening

Activity 3.2, continued

- They help establish and continue a positive relationship between the supervisor and worker.
- They set the stage for appropriate and effective problem solving by providing space for the worker to think about the problem, take ownership, and propose solutions.

Activity Steps

Interactive presentation (15 minutes)

1. Post the flip chart pages with the definitions of paraphrasing and open-ended clarifying questions.

![Paraphrasing, Open-Ended Clarifying Questions, and Closed Questions]

2. Read aloud and discuss with participants why these skills are essential in coaching supervision.

3. Distribute the Handouts 11, 12, and 13, “Lead-Ins for Paraphrasing,” “Lead-Ins for Open-Ended Clarifying Questions,” and “Paraphrase and Open-Ended Clarifying Questions Worksheet” (either the home or residential care version). Go over the “lead-ins” handouts with the group, explaining that these are suggestions to help make it easier to paraphrase and ask open-ended clarifying questions.

Large-group exercise (15 minutes)

4. Ask participants to turn to their worksheet. Explain that each of the statements on the worksheet is something a worker is saying to her or his supervisor at the beginning of a supervisory interaction. Some may sound familiar.

5. Read the first statement aloud. Ask the group to make suggestions about how to paraphrase this statement. Discuss which suggestions are effective paraphrasing and which may not be. Note that the tone of the paraphrase is as important as the words—i.e., statements back to workers should sound genuine.

Teaching Tips

Ineffective paraphrasing takes two forms: simply repeating without restating in different words or implying a negative judgment.
Module 3: Coaching Skill #1—Active Listening

Explain that paraphrasing means putting the statement in one’s own words. For example, if the original statement is, “You gave me a write-up for no good reason,” paraphrase by stating, “What I hear you saying is that you think my decision was unfair,” not merely, “I gave you a write-up for no good reason.”

If participants suggest paraphrases that are judgmental in tone or content, ask if they recognize the negative judgment in the words. A trick that can help with this—ask them to imagine a supervisor saying such a statement to them. Does it feel respectful and accurate, or does it feel hurtful? Get two to three workable suggestions from the group.

Judgmental statements are so common that it is sometimes difficult to recognize paraphrases or clarifying questions that carry negative judgments. Listen carefully to people’s suggestions for any trace of judgment or blame. Participants need to learn to recognize when their choice of words implies judgment or blame, what it means to remove the judgment from their words, why it is important, and how to do it.

Instructors need to model paraphrasing during the workshop. When doing so, tone is critical. It is important to sound natural and authentic.

6. Ask for suggestions for open-ended questions a supervisor might ask to better understand the worker’s situation. Remind the group to avoid negative judgments in phrasing questions and to refer to the handout for lead-ins. Discuss the suggestions offered by the group.

 ► Teaching Tips
To help participants create open-ended clarifying questions, the instructor can ask:

What do we need to know to better understand what might be behind this person’s story or where this person is coming from when he or she presents the story in this way?

You will probably get a number of questions that are not open-ended. Explain that these questions are okay, but a “yes” or “no” answer tends to bring the conversation to a stop and still requires more questions to understand what is going on. Encourage the group to devise at least two open-ended questions.

Note: If you are following the two-day schedule, consider taking a lunch break here. After lunch, you may want to insert an energizer or go directly to Activity 3.3, the back-to-back game, before returning to the pairs work and discussion for Activity 3.2 (steps 7-12).

Pairs work and discussion (20 minutes)

7. Ask participants to team up with someone they haven’t worked with yet. Assign each pair one or two statements and ask them to write down one or two paraphrases and two open-ended clarifying questions.

 ► Teaching Tip
Make sure pairs are spaced around the room so they can hear each other easily and not be distracted by others’ conversations. Give them about 10 minutes to work on their statements.
Module 3: Coaching Skill #1—Active Listening

Activity 3.2, continued

8. Read each statement and ask the assigned pair(s) to report to the group on how they paraphrased it. Then ask what open-ended clarifying questions they would ask. Summarize the responses on a flip chart page.

9. Ask the group whether the worksheet task felt difficult or awkward and which specific aspects of the task felt hard. Emphasize that these skills do not come naturally to most people, but with practice on the job and elsewhere, participants will become more skilled.

Demonstration role play and discussion (10 minutes)

10. Explain that the instructors will now role-play one of the scenarios on the worksheet. Note that the role play will not involve trying to solve the problem; the idea is to show how to use paraphrasing and clarifying questions to elicit information. This step is essential before any problem solving takes place.

11. Play out the scenario for 5 minutes or less, with the supervisor eliciting more and more information from the worker. Use some of the paraphrasing and clarifying questions suggested earlier by the reporting pairs.

Teaching Tip
The role play should be brief and focused entirely on eliciting information. It will feel unfinished because the problem won’t be solved. If you move into problem solving here, participants will lose sight of the importance of paraphrasing and asking clarifying questions.

12. Ask the group for responses to this role play. In particular:

What benefits of paraphrasing and asking open-ended clarifying questions did you see illustrated in the role play?
Activity 3.3: Communication Game—
Back to Back

20 minutes

Learning Outcomes
By the end of this activity, participants will be able to:

* Describe the challenges involved in strictly verbal communication;
* Explain the importance of verbal communication in supervision; and
* Name a number of verbal communication skills.

Key Content

- Verbal communication is as important as body language, or nonverbal communication, in coaching supervision. Focused, precise listening and speaking are essential, especially in phone conversations. However, few of us are trained in verbal communication skills, which are especially useful in effective supervision.

- Verbal communication skills include the following:
  - Paraphrasing
  - Encouraging
  - Asking clarifying questions
  - Checking progress
  - Framing (describing an overall picture)
  - Using images (“it looks like…”)

Activity Steps

Pairs work (10 minutes)

1. Tell participants that, while Activity 3.1 focused on nonverbal listening skills (body language), this activity focuses exclusively on verbal communication—an important part of active listening and a necessary skill for coaching supervision, particularly for supervisory interactions that take place on the phone.

2. Explain that participants will play a game that will allow them to experience both the importance of verbal communication and the skills required. Divide the group into new pairs and space them throughout the room. Have pair members sit back-to-back so that neither partner can see the other. Tell them to quickly decide who will be the “director,” and who will be the “implementer.” Ask the directors to raise their hands.

—Continued next page
Module 3: Coaching Skill #1—Active Listening

Activity 3.3, continued

Teaching Tip
Large rooms work best for this activity. Pairs need to be spread out so they can’t see each other’s drawings and partners can hear each other easily. In a small room, the noise level can become distracting.

3. Give instructions for the game:

Each director will be given a paper with a drawing on it. The directors are not to say anything about it nor show it to anyone, including their partner. Each implementer will be given a blank sheet of paper and pencil.

The task is for each pair to work together to recreate the director’s drawing on the implementer’s blank sheet of paper. The director will give instructions to the implementer and the implementer is to draw, without either person looking at the other’s paper.

The implementer is allowed to talk and ask questions to get information to duplicate the director’s drawing. Partners are encouraged to talk as much as they want to complete their task.

The rules of this activity are:

- Partners must remain seated in back-to-back position.
- Implementers may not peek at the directors’ drawings.
- Directors may not peek at the implementers’ drawings.
- No exceptions!

Pairs will have 5 minutes to complete their duplicate drawings.

If pairs finish the task before the time is up, they should not look at each other’s drawings. Instead, partners should continue talking with each other (still sitting back-to-back) to check the accuracy of the drawing. Directors should feel satisfied that they have given clear, effective instructions to their partners and that the implementers have understood and implemented the instructions. Implementers should feel satisfied that they have duplicated their directors’ drawings, according to the directions given.

4. Pass out a geometric design (Handout 14) to each director and blank paper and a pencil to each implementer, and have participants begin the exercise.

Teaching Tip
If possible, do not give the same design to more than one director. If you must use designs several times, make sure pairs using the same design are far away from each other. Printing different designs on different colored paper will make it easy to ensure that neighboring pairs don’t get the same design.

5. Circulate throughout the room once the activity begins to enforce the rules and review the instructions if necessary.
Module 3: Coaching Skill #1—Active Listening

► Teaching Tips
As you walk around the room, refrain from commenting on any of the drawings. Don’t give any clues. Defuse tension by reminding everyone it’s just a game.

Don’t allow implementers to begin new drawings if they think they’ve gotten things wrong. The point is for them to struggle through as best they can.

If the group is too large for each pair to report about their process (step 10), prepare to select a few to report to the group. As you circulate during the activity, notice pairs that are using different approaches to complete the task. Make sure their duplicate drawings reflect a full range of accuracy. It is better to choose a majority of pairs with inaccurate drawings than all the best ones.

6. Toward the end of the exercise, remind pairs to check in with each other about how satisfied they are with their work. They should not look at each other’s papers. If either partner is not satisfied, ask the pair to keep working until they are both satisfied with their efforts.

7. When all pairs have finished their drawings and check-ins, ask partners to turn around and show each other the two drawings. Allow a minute or two for partners to react and respond to each other.

► Teaching Tip
When the partners finally turn around and show each other their drawings, expect loud exclamations and laughter. Allow time for this informal debriefing.

Discussion (10 minutes)

8. Ask participants to rearrange their chairs in a large circle. Partners should be sitting next to each other.

9. Remind everyone that the game is not a contest with winners and losers but an exercise to learn verbal communication skills. Ask each pair, one at a time, to show the group their two drawings and to describe the processes they used to create the duplicate drawings—what worked well and what didn’t—whether or not the duplicates bear any resemblance to the originals.

► Teaching Tips
Keep a light tone in this activity, being clear that the game is meant to be a fun learning experience.

Make sure both partners get a chance to speak. If either partner starts blaming the other, gently interrupt and paraphrase the feelings that led the partner to blame the other (e.g., “So it was frustrating to you that you didn’t feel you were getting enough information.”). Do not collude in blaming anyone.

— Continued next page
Module 3: Coaching Skill #1—Active Listening

Activity 3.3, continued

10. As each pair reports, highlight the verbal communication skills that worked and those that didn't. Note the approaches that worked on a flip chart page. Remind participants of the difficulty of strictly verbal communication, and assure them they can become better through practice.

```
Verbal Communication That Worked
• Paraphrasing
• Encouraging
• Asking clarifying questions
• Checking progress
• Framing (describing an overall picture)
• Using images ("it looks like")
```

11. Display the prepared flip chart “Verbal Communication Skills.”

```
Verbal Communications Skills
• Paraphrasing
• Encouraging
• Asking clarifying questions
• Checking progress
• Framing (describing an overall picture)
• Using images ("it looks like")
```

12. Check off all the skills the group reported using to make their drawings. Ask the group if they used other skills not on the list, and add any that are suggested.

13. Ask participants:

   Based on your experience in the game, what do you think about the importance of being as clear as possible in what you say?

   In what aspects of your jobs is verbal communication especially important?

   What did you learn about communication during the game that you could apply to your job?
3.17

Module 3: Coaching Skill #1—Active Listening

14. Summarize the information in this module by reminding the group that both good verbal and nonverbal skills are required for active listening, and that active listening is the core of the coaching approach to supervision. Reinforce that active listening is challenging for most people because they have not been trained in those skills and may have ingrained habits that get in the way of paying full attention. Note that the next two modules in this seminar, self-management and self-awareness, focus on ways to move past habits that keep people from listening with full attention and provide more tools to improve active listening skills.

Note: If you did the back-to-back exercise before completing Activity 3.2, return now to step 7 of Activity 3.2.

—Teaching Notes—
Goals

- To help participants become more conscious of their emotional reactions to particular situations or people.
- To explore how emotional reactions can get in the way of real listening and to identify strategies for setting aside those reactions in order to listen more openly, improve communication, and solve problems.
- To describe and demonstrate how the skills of active listening and self-management—paraphrasing, asking open-ended clarifying questions, and pulling back—are applied in coaching supervision.
- To reinforce participants’ active listening and self-management skills by role-playing typical supervisory situations.

Time

2 hours, 40 minutes

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<td>Interactive presentation, demonstration role plays, brainstorm, discussion, small-group work</td>
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<td>4.2 Pull-Back and Paraphrase Role Plays</td>
<td>Practice role plays</td>
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<td>4.3 Blocks to Listening</td>
<td>Interactive presentation, individual and small-group work, discussion</td>
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Supplies

- Flip chart, easel, and markers
Module 4: Coaching Skill #2—Self Management

Handouts
- Handout 15: “Choosing to Pull Back” (2 pages)
- Handout 16: “Pulling Back: Overview”
- Handout 17: “Pulling Back: When Feelings Get in the Way of Listening”
- Handout 18: “Supervisory Role Plays for Pull Back and Paraphrase”
  (2 versions, residential and home care)
- Handout 19: “Blocks to Listening” (4 pages)

Advance Preparation
Review the seminar materials for each activity.

Activity 4.1
Prepare demonstration role plays for steps 4 and 6 that depict pull-back options A and B (see Handout 15, “Choosing to Pull Back”). The first role play should feature a situation in which a direct-care worker responds inappropriately and his or her supervisor reacts emotionally, thereby aggravating the situation. A sample scenario is provided in the Teaching Tip on p. 4.4, but instructors should tailor the role play to situations that are known problems for participants. Use the same situation for the second role play, but the instructor should respond by pulling back (see Teaching Tip, p. 4.4).


Activity 4.2
Make copies of Handout 18, “Supervisory Role Plays for Pull Back and Paraphrase” for all participants (choose residential or home care focus, as appropriate).

Activity 4.3
Make copies of the Handout 19, “Blocks to Listening” (4 pages) for all participants.

Think of examples of your own listening blocks to share as you review Handout 19.
Activity 4.1: Pulling Back 45 minutes

Learning Outcomes

By the end of this activity, participants will be able to:

- Identify situations that commonly cause them emotional stress, and recognize their internal reactions to these situations;
- Describe how emotional responses often get in the way of their ability to listen attentively;
- Identify two options for responding to stressful situations: reacting emotionally or pulling back from those emotions;
- Explain that pulling back from their emotional responses often leads to more effective communication; and
- Identify strategies for pulling back from their emotional responses.

Key Content

- People’s emotional responses to what others communicate, verbally or nonverbally, often get in the way of their ability to listen with full attention.
- While people rarely are able to control others’ words or behavior, each person can control his or her own emotional responses to a situation. Shifting personal internal responses makes it possible to listen more attentively. The resulting communication is more effective and more positive.
- The first step in shifting emotional responses to someone’s words, tone of voice, or behavior is to become consciously aware of those responses.
- When a person is listening attentively, he or she can make a conscious choice to pull back from negative judgments and stereotypes, to remain curious about the other person, and to stay open to possibly changing his or her opinion about the speaker. Pulling back is the ability to gain emotional control in stressful settings and generally leads to more effective communication and more positive supervisory outcomes. Practical pull-back strategies can help both in the moment and in the long run.
- Pulling back from an emotional response does not mean being soft or allowing dishonest workers to get away with something. In fact, observing one’s reactions makes it much less likely that a supervisor will be misled or manipulated. If a supervisor is listening attentively, paraphrasing, and asking clarifying questions whenever something seems confusing or odd, he or she will eventually uncover the truth.
Module 4: Coaching Skill #2—Self Management

Activity Steps

Interactive presentation (5 minutes)

1. Recall that, as demonstrated in the body language and paraphrasing exercises, people listen well when they bring their full attention to a conversation. But a listener's emotional responses to what a speaker is saying or how he or she is saying it often get in the way of listening with full attention. This module addresses such emotional responses and provides strategies for dealing with them. Identifying and controlling emotions are difficult skills to learn, and everyone will have a chance to practice.

2. Explain that in a supervisory situation, when listening to a worker talk about a problem, the supervisor often focuses on the worker as the problem—that is, on how the worker's behavior got him or her into the situation. In this session, participants will shift their focus from the worker to their own internal reactions, because that is something people can change. If a person changes his or her internal response in a difficult situation, that person can affect what happens in the interaction.

3. Pass out Handouts 15 and 16, “Choosing to Pull Back” (2 pages) and “Pulling Back: Overview.” Referring to Handout 15, briefly describe options A and B and the different outcomes that result from each strategy (see page 2 of handout). Next, referring to Handout 16, explain the meaning of “pull back,” discussing its particular importance in health care and asking for workplace examples of the need to pull back to gain emotional control. Review the three steps at the bottom of the handout for pulling back.

Demonstration role plays and discussion (10 minutes)

4. Explain that the instructors will now conduct a role play to demonstrate option A. (See instructions in Advance Preparation.)

Teaching Tip

Sample scenario: A charge nurse has paged a certified nurse assistant (CNA) to answer a call bell. The CNA storms up to the nurses’ station, where the nurse is completing charts. The CNA says, “What the hell were you doing, paging me? Don’t you think I have enough to do? I was up to my elbows in shit! You don’t seem to be doing anything—what’s wrong with your legs?”

In the option A role play, the nurse will explode at the CNA, shouting, “How dare you talk to me that way? Your behavior is completely unacceptable! It’s your job to answer call bells, and my job to see that you do so. Go do your job while you still have one!” etc.

5. Allow participants to react to the outrageousness of the worker’s behavior. Indicate that even in situations like this, where the behavior is clearly inappropriate, it is possible to use pull-back skills to shape a positive outcome. Ask participants:

What did you observe about the supervisor’s response to the worker?
What was the outcome?
Module 4: Coaching Skill #2—Self Management

How could the supervisor have responded differently, in order to obtain a better, more productive outcome?

6. Repeat the role play with the worker showing the same behavior and the supervisor demonstrating option B, using some of the suggestions from participants.

**Teaching Tips**

The situation and the worker's behavior in option B are the same as in option A. This time, however, the charge nurse stays focused on defusing the situation and getting the task at hand completed—i.e., responding to the call bell.

Examples of the nurse's response could be to take a deep breath, ask the CNA to sit down, paraphrase the CNA’s response, and then say quietly, “I understand that you are busy, and so am I. Your task here is to respond to the call bell. Please do that as soon as you can, and, later on, we will discuss better ways to respond to a page when you’re busy.” The nurse should exaggerate her pull-back response, so participants clearly see the behavior.

7. Ask participants:

*What did you observe this time about the supervisor’s response to the worker?*

*What was the outcome?*

*What strategies did the supervisor use to pull back from his or her emotions and get a more productive outcome?*

*How might these two interactions affect the relationship between the worker and the supervisor?*

**Teaching Tip**

Emphasize that choosing option B does not mean being soft. Paraphrasing and asking clarifying questions can cut through attempts to manipulate or mislead. This generally results in more fully finding out what is going on, as well as getting the necessary work done in the best way possible.

**Brainstorm and discussion (10 minutes)**

8. Explain that everyone uses one or more strategies to pull back in stressful situations. The goal of this activity is for participants to become aware of those strategies and strengthen them. Acknowledge the difficulty of staying calm and thinking clearly in stressful situations. To emphasize this point, instructors should give examples of pull-back strategies that work for them both in stressful situations and when preparing for potentially stressful situations.

9. Brainstorm with the group different strategies for pulling back. Ask:

*What do you do in emotionally stressful situations to keep yourselves together?*
Module 4: Coaching Skill #2—Self Management

Activity 4.1, continued

Write the strategies on a flip chart page entitled “Pull-Back Strategies.”

Teaching Tips

The list could include: take deep breaths, silently say a prayer, silently count to five, and silently say a personal affirmation such as “I have the strength to deal with whatever is happening here.”

Some strategies may not be appropriate responses to stressful situations (for example, walking away). Redirect or reframe such responses before writing them on the flip chart page. Remind participants to think about supervisory situations: “How would you feel if your supervisor walked away in a stressful situation?”

10. Explain to the group that there are two categories of pull-back strategies. The first are strategies that people use immediately or in the moment when they are having an emotional response. The second category’s strategies are ones people use when they know they are about to encounter a potentially stressful situation, such as a difficult meeting or phone conversation, but there is time to prepare.

11. Quickly review the list from step 9, and ask participants to identify which strategies are immediate or in the moment and which ones are preparatory. Label each strategy with an “I” or “P.”

Teaching Tip

Examples of preparatory strategies include: vent or talk to a coworker about the situation, listen to soothing music, or imagine yourself staying calm and collected during the situation. Some strategies may belong on both lists.

Small-group work (20 minutes)

12. Distribute Handout 17, “Pulling Back: When Feelings Get in the Way of Listening,” and read through it together. Explain that these are personal or workplace situations that may require a pull back. Use examples from your own life to help participants understand the concept and to model self-reflection and self-disclosure.
13. Have participants take a few minutes individually to check off those items on the list that resonate with them and add others they know are stressful for them.

14. Divide participants into small groups, and have them choose one person to take notes to report back to the group. Ask them to do two things in their small group:

   Briefly share the items they checked on the list: *What triggers your emotions?*

   As a group, help each individual identify pull-back strategies to use to avoid getting emotionally hooked. Each person should identify one *in-the-moment* and one *preparing strategy*.

15. Bring everyone back to the large group, and ask the reporters to briefly note which items were stressful for group members and which pull-back strategies were identified to counter those situations.

   **Teaching Tip**
   Reporters will not have time to tell all the group members’ individual stories. Help reporters stick to summarizing the stories and focusing on known pull-back strategies
Activity 4.2: Pull-Back and Paraphrase Role Plays

Learning Outcomes

By the end of this activity, participants will be able to:

- Demonstrate the skills they have been learning—paraphrasing, asking open-ended questions, and pulling back—in simulated supervisory interactions;
- Describe the challenge of mastering these skills as well as the benefits that result from using these skills in supervision; and
- Explain why it is important to listen to the worker’s perspective and gather as much information about a situation as possible prior to jumping into problem solving.

Key Content

- Learning new skills requires practice. Practicing in the relatively safe setting of the seminar environment will help participants solidify their understanding of skills they’ll soon be using in their jobs.

- The key task for this part of coaching supervision is to use the skills of active listening and self-management—including paraphrasing, asking open-ended clarifying questions, and pulling back—to find out more about the worker and what lies behind the situation being presented. When supervisors rush into problem solving, they may propose solutions based on false assumptions. Such solutions are rarely effective.

- By pulling back and listening, rather than immediately proposing solutions, supervisors provide opportunities for workers to examine the situation and propose their own solutions.

Activity Steps

Practice role plays (60 minutes)

1. Introduce this activity by presenting the following points:

   In this activity participants will be given a chance to practice the skills they have been learning through role plays. Role plays allow people to practice new skills in a safe environment—one in which there is support for learning and improving.

   The skills that participants have been learning are difficult; no one is expected to easily put them into practice. It’s important to be patient during the role plays, as everyone is simply trying to learn and improve their skills.

   Luckily, in role plays, mistakes are useful, because they provide helpful information to learn from. In order to learn, it is important to be able to give and receive constructive criticism, as well as point out what is done well.
Module 4: Coaching Skill #2—Self Management

2. Divide participants into two groups, each led by an instructor.

**Teaching Tips**

Keep the two halves well separated so as to decrease participants’ anxiety and reduce distracting noise. Ideally groups will meet in separate rooms.

Role plays can make participants nervous. This is the first time that all participants will be engaged in practice role plays. In order to decrease stage fright and save time, keep the atmosphere casual and conduct the role plays around a table or in a circle of chairs. Repeat at the outset that this is practice and not performance.

3. Distribute Handout 18, “Supervisory Role Plays for Pull-Back and Paraphrase,” to your group. Explain that everyone will get a turn to play the supervisor while the instructor will play a worker each time. Allow participants in your group time to read the scenarios.

4. Ask for a volunteer to start the role plays by choosing a scenario to enact. End each role play after the supervisor has successfully elicited clarifying information from the worker. *Do not go on to problem solving.* Explain that in coaching supervision, using communication skills to defuse a charged situation and gather more information is extremely important; all else depends on it, so this step must not be skipped over or hurried through.

**Teaching Tips**

Spend about five minutes on each role play, and five minutes on the follow-up discussion.

Remind your group members of the skills to be used—appropriate body language, paraphrasing, asking clarifying questions, and pulling back.

Before beginning each role play, ask the supervisor to state which pull-back strategies he or she plans to use.

Encourage participants to choose new scenarios for their own role play but allow people to repeat a scenario. If that happens, play the role of the worker a bit differently each time.

Keep the tone light and allow for laughter, but don’t allow any role play to become a comedy. Keep the group focused on the task.

Participants will be tempted during the role plays to move into problem solving. If participants start trying to brainstorm solutions to problems, gently interrupt and redirect them to asking clarifying questions or paraphrasing. Remind them that their task right now is to elicit more information only.

Some participants may feel awkward, anxious, or shy about performing in front of others. Acknowledge that this may be a new way of learning for some people and that it may feel awkward at first. Explain that role plays are highly effective tools for practicing and integrating new skills that involve interactions with others; role plays also simulate situations that people in their professional positions will encounter. Remind everyone that all participants are here to support one another in their learning, not to judge or ridicule. Use discretion, but in general it is not a good idea to allow anyone to opt out of participating in a role play.
5. Debrief after each role play by asking the following questions:

- What were this supervisor's pull-back strategies?
- Were they effective?
- Why?

If the group is unable to identify the strategies, ask the volunteer who did the role play to identify the strategies he or she used. Ask:

- What else did the supervisor do or say that seemed effective?
- Did the supervisor use paraphrasing and open-ended clarifying questions? How?
- Did you notice anything in particular about the supervisor's body language?
- What could be improved?

6. Continue until every participant has played the supervisor in a role play. Ask participants:

- What did you notice about the quality and flow of the interactions overall?

Look for participants to say that using the active listening and self-management skills helped, rather than hindered, the interaction, and that using the skills did not seem awkward.

Note: If following the two-day format, use the end-of-day closing activity here (see Supplementary Activity Guides, “Day 1 Closing”). Encourage participants to do the brief homework asked of them.
Module 4: Coaching Skill #2—Self Management

—Teaching Notes—
Activity 4.3: Blocks to Listening

Note: If this is the start of Day 2, begin with “Day 2 Opening Activity,” included in the Supplementary Activity Guides.

Learning Outcomes
By the end of this activity, participants will be able to:

- Describe common blocks to listening;
- Identify the three personal blocks that most often keep them from listening as effectively as they can; and
- Be more aware of these blocks in themselves as they arise in listening situations.

Key Content

- “Pseudo listening” is when people act like they are listening but actually are not. In many situations, such as when making light conversation at a party, this doesn’t matter much. However, pseudo listening can be problematic when good communication is needed, such as in supervisory interactions.

- Blocks to listening are distractions, usually unconscious, that keep people from listening with their full attention.

- Everyone experiences blocks to listening at some time. Becoming aware of their particular blocks helps people put them aside and bring full attention to listening.

Activity Steps

Interactive presentation (25 minutes)

1. Introduce the session by discussing the following points:

   People tend to think that listening well is easy. It is true that everyone has the ability to listen well, but various distractions get in the way.

   There are many blocks to good listening, and everyone experiences at least some of them. Usually people experience them without being conscious of them.

   This activity focuses on the most common blocks. Each participant will identify which particular blocks he or she experiences most frequently.

   When people identify their particular blocks to listening, they become aware of them and bring them to consciousness. Becoming aware of one's blocks is the first step in changing one's behavior.

   —Continued next page
Module 4: Coaching Skill #2—Self Management

The goal is to set aside these distracting blocks and make a conscious choice to listen.

**Teaching Tip**
If you have opened with a review of the homework exercise about listening, this next activity will be especially relevant. Use the stories participants shared about difficulties with the homework assignment to illustrate the concept of listening blocks.

2. Distribute Handout 19, “Blocks to Listening,” and ask a volunteer to read aloud the first three paragraphs. Explain the meaning of “pseudo,” if necessary. Explain that pseudo listening is very common and often doesn’t cause any problems. Ask how pseudo listening could be problematic in a supervisory interaction.

3. Read the description of the first listening block, “rehearsing.” Share a personal example of your experience with this listening block. Ask one or two participants to add personal examples of this listening block.

**Teaching Tip**
The more open and willing you are to disclose your struggles with listening blocks, the easier it will be for participants to acknowledge these blocks in themselves.

For example: “I tend to rehearse a lot. Once, at a training, I was annoyed by a participant who came in late several mornings. I finally took her aside to tell her that she could not continue in the program if she could not arrive on time. While she was trying to explain how important the training was to her and why she had been having difficulty arriving on time, I was rehearsing my speech. I never actually heard what was causing her tardiness, so I couldn’t work with her to resolve the problem.”

4. Continue to go through the handout, using the same format with each listening block: Read it aloud, talk about whether this block is one you (or your co-instructor) experience often, share a personal experience, and ask for personal examples from a few participants.

**Teaching Tip**
This concept is often new to participants, and they may have difficulty identifying their blocks. In addition, some in the group may be reticent to share examples of their listening blocks because they see them as personal flaws and may not want to reveal them in the large group. Be sure to emphasize that listening blocks are universal and very often unconscious.

**Individual work (5 minutes)**

5. After going through all ten listening blocks, ask participants to write down their three most common listening blocks on the last page of the handout.

**Small-group work (15 minutes)**

6. Explain that participants will now share their listening blocks in small groups, with each person giving examples of his or her blocks. The goal is to increase awareness of blocks that prevent people from listening fully and to devise strategies to avoid being caught in their particular listening blocks.
7. Divide participants into small groups. Ask one person in each group to act as recorder and jot down strategies as group members talk and another volunteer to report to the larger group. To guide the discussion, participants can refer to the questions at the bottom of the last page of the handout:

Think about how these blocks come up for you, especially in the context of supervision.

What will help you be aware that you are using these blocks?

What strategies might you use to return to actively listening when you recognize that your listening is blocked but you want to really listen?

**Teaching Tip**

Circulate around the room during the small-group discussions to ensure that conversations stay on track and everyone gets a chance to share.

**Discussion (10 minutes)**

8. Ask the reporter from each group to share the group’s strategies for becoming more aware of and overcoming members’ blocks to listening. Write participants ideas on a flip chart page entitled “What strategies can help you get back to really listening?”

**Teaching Tip**

If the following ideas are not suggested by the group, be sure to include them on the list:

*Mental check-ins:* Do a mental check-in every minute or so while listening.

*Practice with a partner:* Practice listening to someone who knows you well, and ask him or her to point out every time your attention seems to stray.

*Pause to find the cause:* If you notice that listening to someone is becoming more difficult, ask the person to pause for a moment. Ask yourself what blocks seem to be present.

Some groups may not come up with any workable strategies to return to active listening. Acknowledge how difficult it is in the moment to be aware of processes within oneself that are usually unconscious. Reassure participants that it is possible to become more aware. Point to the three strategies listed above as possible remedies, and ask if anyone has other ideas to add.
9. Remind the group that simply becoming aware of one's blocks is the most important step in choosing to set them aside and listen. Tell the group that the next module is designed to help them further extend their self-awareness.

**Teaching Option**

If time is limited, instructors can cover the 10 blocks to listening by assigning them to small groups as follows:

*Small-group work and discussion (15 min.)*

1. After discussing “rehearsing,” divide participants into three small groups, and assign three different listening blocks to each group. Ask each group to think of an example of how each listening block can occur in the supervisory relationship.

2. After 5 minutes, ask each group to describe their three listening blocks and share their examples. Ask other participants for additional examples of that particular listening block.

3. After everyone has finished reporting, ask participants if they recognize a particular block as one they might often use and to identify a strategy for getting past that block. Ask for further strategies as time allows.
Coaching Skill #3—Self-Awareness

Goals

■ To raise participants’ awareness of the judgments and assumptions they make about direct-care workers and how these assumptions may prevent them from (a) seeing the whole picture when a problem arises and (b) developing a positive relationship with the worker.

■ To explore personal styles, particularly as they relate to how individuals communicate and understand and react to situations.

■ To have participants identify their personal styles and recognize how differences in style may affect supervisory interactions.

Time

1 hour, 30 minutes

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<td>Role play, discussion</td>
<td>20 minutes</td>
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<tr>
<td>5.2 Personal Styles Inventory</td>
<td>Interactive presentation, large-group exercise</td>
<td>70 minutes</td>
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Supplies

■ Flip chart, easel, and markers
■ Masking tape, rope (optional; Activity 5.2)

Handouts

■ Handout 20: “Role Play—Calling Out” (7 pages) (2 versions: residential and home care)
■ Handout 21: “Personal Styles Inventory” (3 pages)

Advance Preparation

Review the seminar materials for each activity.
Module 5: Coaching Skill #3—Self-Awareness

Activity 5.1
Make three copies of Handout 20, “Role Play—Calling Out” (choose residential or home care focus, as appropriate).

Arrange chairs in a semicircle to create a stage area, with one chair at center stage.

Activity 5.2
Make copies of Handout 21, “Personal Styles Inventory” for all participants.
Module 5: Coaching Skill #3—Self-Awareness

Activity 5.1: Role Play—Calling Out 20 minutes

Learning Outcomes

By the end of this activity, participants will be able to:

- Explain that coaching supervision assumes that a more complete story always lies behind what a supervisor first hears and that, when he or she knows a worker’s full story, the supervisor is able to respond more effectively;
- Explain that effective listening requires an awareness of one's own judgments and assumptions; and
- Explain that, while a coach supervisor is empathetic, he or she still holds the worker accountable for providing quality care.

Key Content

- The personal lives of most direct-care workers are complex and challenging. The part of any work situation that supervisors see or hear about, upon which they often base their judgments and assumptions, is often a fraction of the whole story.
- The coaching perspective assumes that behind the incomplete description first heard by a supervisor always lies a more complete story. When a supervisor knows a worker’s situation more fully, he or she is able to respond more effectively.
- Learning fully about a person’s current situation through active listening does not mean getting emotionally caught in the story. While coach supervisors are empathetic, they still hold workers accountable to do their jobs according to expectations.
- To hear and appreciate a worker’s perspective and help the worker find an effective solution to a problem, a supervisor must be aware of his or her own judgments and assumptions about the worker and the situation.

Activity Steps

Role play (10 minutes)

1. Explain that the next activity is a scripted role play showing a slice of life for a worker.

   Ask for six volunteers to play parts in the play. Reassure them that they don’t need to memorize any lines but will merely read short parts from a script.

   Explain that one instructor will play Renee, a direct-care worker; the second instructor will play the narrator and will introduce new characters as each comes on stage. The volunteers each play a person Renee comes in contact with during the day.

   —Continued next page
Module 5: Coaching Skill #3—Self-Awareness

Activity 5.1, continued

There are three copies of the script (Handout 20): two for the instructors and the third to be divided among the other actors. Give each volunteer only the one page of the script for his or her scene. Each page is marked Scene One, Scene Two, etc., so actors will know when to play their parts. Tell them that the words they are to speak on stage are in italics. Give them a minute to look over their scripts and ask if they have questions about what they are to say. Ask them to try to get into character and read their parts with expression when on stage.

Ask the volunteers to stand at the side of the stage area with the narrator and to come in one at a time when announced. After each actor finishes their part in the play, they should join the audience. Remind the actors to keep quiet when they are off-stage so as not to distract from the ongoing play.

Teaching Tip
The instructor who is most comfortable with acting should play Renee. Play the role realistically—Renee is a decent human being who is having a very difficult day. Avoid playing for laughs. The audience should be able to see and identify with Renee’s gradually increasing tension and frustration.

2. Conduct the role play as follows:

Renee sits in a chair in the middle of the stage, eyes closed. The narrator announces Scene One and reads the introductory tag: “Pamela, Renee’s sister, calls at 5:55 a.m.”

Pamela enters and reads her lines. After Renee responds, Pamela leaves the stage and sits in the audience.

The narrator announces Scene Two, introducing the next actor with the line at the top of the second page of the script. Continue in this way until the end of Scene Six.

Renee breaks character, and she and the other instructor thank the volunteers and applaud them for their efforts.

Discussion (10 minutes)

3. Debrief the role play by asking the questions below and allowing a short discussion about each one:

What did you see or hear in the role play?

How might you have responded if you were Renee’s supervisor, not knowing the particulars of her life?

What assumptions or judgments would you have made about Renee after she called out for the second time?

How might you respond differently, knowing the story?
Module 5: Coaching Skill #3 — Self-Awareness

**Teaching Tip**
This scenario will likely generate concerns about probing into a worker’s personal life, e.g.:

- How much do you need to probe into someone’s personal affairs in order to supervise?
- Where do you draw the line between identifying problems and invading privacy?

It is helpful for a supervisor to have a broad idea of the complexities of a worker’s life; on the other hand, a supervisor doesn’t have to know all the details of a worker’s life to realize that personal problems may be getting in the way of doing the job.

4. Summarize by noting the following:

Coach supervisors assume that a more complete story always lies behind the fragments they initially hear. The first task is to listen actively to the worker’s perspective on the situation. Professional counseling skills are not required.

In striving to listen actively to workers, it is important not to become emotionally caught up in their situation and then fail to hold them accountable for their actions. Coaching supervision requires supervisors not only to be empathetic but also to expect workers to meet high standards and always provide quality care. Indicate that this aspect of coaching will be discussed later in the seminar.

When listening to someone’s story — especially when the situation feels familiar or repetitive — conscious or unconscious judgments and assumptions often emerge. As noted in the previous activity, judging is one of the ten common blocks to listening. People are more likely to judge others who think or act differently from themselves. Becoming aware of and working with such differences in personal style is the focus of the next activity.

Coaching supervisors also need to be clear about professional boundaries when speaking with direct-care workers about their lives. Being empathetic does not mean solving the worker’s problems. By themselves, listening and showing concern can often be helpful. A coach supervisor, however, should be prepared to refer the worker to other resources (e.g., transportation, social services) as needed.

**Teaching Tip**
At this point, instructors should assess participants’ energy level and decide which activity do next. If energy is still high, you may choose to move on to Module 6, “Present the Problem” and return to the “Personal Styles Inventory” later in the day. Presenting the problem is a somewhat difficult skill, so it is helpful to do this module’s activities when participants are still energetic and focused. The “Personal Styles Inventory” activity can be introduced in the afternoon to re-energize participants.
Module 5: Coaching Skill #3—Self-Awareness

—Teaching Notes—
Activity 5.2: Personal Styles Inventory  70 minutes

Learning Outcomes

By the end of this activity, participants will be able to:

Describe four basic dimensions of personal style and explain how these dimensions relate to communication and supervision;

Describe their own personal style on the continuum for each dimension;

Explain that differences in personal style are not right or wrong;

Explain how assumptions and judgments about others’ behavior can result from differences in personal style; and

Explain how being aware of differences in style and avoiding making judgments based on differences can have a positive impact on communication in general and coaching supervision in particular.

Key Content

■ Understanding another person’s reality is part of a coach supervisor’s job. As demonstrated in the calling-out role play, each worker has a story. This includes not only what is currently happening in his or her life but also how the worker interprets those circumstances. To help that person solve a problem or shift his or her way of thinking, a supervisor needs to understand how that person perceives and approaches the world and how he or she communicates.

■ Each person has a particular personal style that encompasses how that person perceives and approaches situations and communicates. Generally, people assume everyone sees and experiences the world as they do. However, understanding differences in style and refraining from judging differences are basic tenets underpinning coaching supervision.

■ Self-awareness is fundamental to effective communication and supervision. A supervisor’s first step in understanding others is to recognize that his or her personal style is unique, not universal or correct. Once aware of his or her personal style, a supervisor can communicate more effectively and make changes in approach, as necessary, to supervise people who possess different styles.

■ Four dimensions are presented in this model of personal styles, with a continuum of individual characteristics for each dimension:

  ■ Introvert/Extrovert
  ■ Big-Picture Oriented/Detail Oriented
  ■ Feeler/Thinker
  ■ Present Oriented/Future Oriented
**Module 5: Coaching Skill #3—Self-Awareness**

**Activity Steps**

**Interactive presentation (10 minutes)**

1. Give a brief presentation using the information in Key Content. In order to enhance communication within coaching supervision, explain that a supervisor must understand him- or herself and the other person as well as possible. Do not introduce the four dimensions yet.

2. Before introducing the “Personal Styles Inventory” (Handout 21), explain and illustrate the concept of the continuum as follows:

   Explain that this activity is designed to help each participant become more aware of aspects of his or her personal style. There are many aspects of personal style, but participants will be looking at four basic dimensions that play a big role in communication with others.

   Using introvert/extrovert as an example, note the two poles of this dimension. Explain that most people are not entirely extroverted or entirely introverted but have aspects of both. Usually, however, people *tend toward* one or the other pole to some extent. Participants can think of this dimension as a line (draw a line on a blank flip chart page) going from totally introverted on one end to completely extroverted on the other.

   Label each end of the line as in Handout 21, with “introverted” at the left and “extroverted” at the right. Explain that this line represents a “continuum,” a continuous progression from one end to the other. Write *continuum* under the line.

   ![Diagram of introverted-extroverted continuum]

   Briefly talk about the introvert/extrovert elements in yourself and place yourself along the continuum on the flip chart page by marking an X.

   **Teaching Tip**
   
   Modeling the thought process participants will need to engage in when asked to self-identify along each continuum, make sure everyone understands why you put the X where you did.
Large-group exercise (60 minutes)

3. Distribute Handout 21, “Personal Styles Inventory.” Explain that participants will now get a chance to place themselves along the introvert/extrovert continuum and three other continuums that reflect differences in personal style.

4. Read aloud the introduction to the handout. Emphasize the goal of participants identifying their own style in order to communicate more effectively with people with different styles.

5. Read aloud the introvert/extrovert descriptions on the handout and have participants think about where they would place themselves on the line. Remind them that they will probably respond to some items in each list but to pay attention to those that elicit the strongest responses.

6. After a few minutes, ask participants to consider a continuum line from one end of the room to the other and to place themselves on the line according to how far they see themselves from either pole. Show the location of the line by walking it from one end to the other; a wall at either end can denote an endpoint. It may be helpful to use masking tape to mark a line on the floor. Be clear about which end of the line represents the introvert point and which the extrovert. Invite participants to place themselves along the continuum.

Teaching Tips
Alternatively, use a rope as the continuum line, and have participants hold the rope as they place themselves along its length.

There may be spots along the line where two or more people feel they belong. That’s okay; tell them to just bunch up or try to determine gradations. Ask:

*Are the two of you really exactly the same degree of extroverted or introverted?*

Allow time for informal discussion as people place themselves. More time may be needed if participants already know one another, as they may have opinions about who belongs where. (Ultimately, of course, each participant should decide his or her position on the line.) This can be a valuable part of the exercise; it mirrors the judgments a supervisor might make to discern the personal style of a worker; in coaching supervision, such judgments may lead a supervisor to change approaches to more effectively communicate with a worker.

Teaching Option
If some participants are not able to move easily around the room, this exercise can also be done on a flip chart page. Draw a continuum line to represent the introvert/extrovert dimension, and mark each person’s position with his or her initials. Point to the center of the line, and ask each participant in turn to tell you where to write their initials by guiding you which way to move by saying, “More to the left [or right], more, more, …there.”

7. Once everyone has found a place along the line, ask:

*What about your experience or sense of yourself led you to place yourself where you did?*

Teaching Tip
Keep the tone light, allowing people to change their minds about where they place themselves and to say briefly how their personal style has played out in their lives. The stories will most likely be about interactions with family or colleagues.
Module 5: Coaching Skill #3—Self-Awareness

8. Have participants note where others are standing on the line. Ask:

*Are you surprised by where some people have placed themselves on the line?*

*What do you now understand differently about how those people think of themselves?*

Ask participants to think about people they supervise and where they might be located on this dimension. Give an example of how a difference in worker and supervisor styles could play out in a supervisory situation.

**Teaching Tips**

For example, if a worker is an introvert, he or she may not disclose a lot about a situation without the supervisor asking specific questions.

Make sure to relate each dimension to supervision—participants are unlikely to be able to make this connection themselves.

Remind participants that each person is unique and that the activity is designed to give them insight into their own and others’ ways of being in the world. No place on the continuum is right or wrong, better or worse. The goal is for participants to better understand themselves and others and to appreciate how they might have emotional responses to or make judgments about others whose style is different from theirs.

9. Repeat steps 5-8 for the three remaining dimensions, spending about 10 minutes on each.

10. Summarize by asking participants:

*How do you think knowing this information about yourself will help you be a more effective supervisor?*

*Knowing about personal styles, what will it be like to work with someone whose style is quite different from your own?*

**Note:** If you are following the two-day schedule, you may wish to break for lunch here.
Module 6

Coaching Skill #4—Presenting the Problem

Goals

- To reinforce the importance of balancing empathy and support with holding workers accountable for performing their jobs to specified standards.

- To introduce one aspect of the process of holding workers accountable: presenting the problem without blame or judgment.

- To have participants practice using the three rules for presenting the problem—be clear and direct, use objective language, and indicate belief in the worker.

Time

1 hour, 10 minutes

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<td>Large-group discussion</td>
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<tr>
<td>6.2 Practice in Presenting the Problem</td>
<td>Demonstration role plays, pairs work, discussion</td>
<td>55 minutes</td>
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Supplies

- Flip chart paper, easel, and markers

Handouts

- Handout 22: “Three Rules for Presenting the Problem”
- Handout 23: “Guidelines for Presenting the Problem”
- Handout 24: “Practice in Presenting the Problem” (2 pages) (2 versions: home and residential care)
Module 6: Coaching Skill #4—Presenting the Problem

**Advance Preparation**

Review the seminar materials for each activity.

**Activity 6.1**

Make copies of Handout 22, “Three Rules for Presenting the Problem.”

Prepare a flip chart as shown in Step 2.

**Activity 6.2**

Make copies of Handouts 23 and 24, “Guidelines for Presenting the Problem” and “Practice in Presenting the Problem” (choose residential or home care focus, as appropriate) for all participants.

Prepare demonstration role-plays as noted in the activity steps.
Activity 6.1: Accountability without Blame or Judgment 15 minutes

Learning Outcomes

By the end of this activity, participants will be able to:

- Explain that holding workers accountable is a central tenet of coaching supervision; and
- Explain that, in coaching supervision, the keys to achieving accountability from workers are to use clear, objective language free of blame or judgment and to express belief in workers’ abilities.

Key Content

- An important part of respecting and believing in workers is holding them accountable. In doing so, the coach supervisor communicates to the worker, “I believe in you, and I believe you can do this job well. Therefore, I’m going to hold you to it.”
- Before workers are hired, they should know what job they are expected to perform and how they are expected to do it. When a problem arises, the next step is to promptly present the problem to the worker and involve him or her in finding a solution.
- Coach supervisors can hold workers accountable without alienating them, by using clear, objective language free of blame or judgment and by expressing belief in the ability of workers to provide quality care.
- When a problem arises, this approach can be applied, by following the three rules for presenting the problem:
  - Be clear and direct about what the problem is.
  - Use objective language free from blame or judgment.
  - Indicate belief in the worker’s ability to resolve the problem.

Activity Steps

Large-group discussion (15 minutes)

1. Introduce the activity by explaining the following:

A common misconception about coaching supervision is that it is only about empathy and support for workers and that it allows workers to do their jobs poorly. However, a central aspect of this approach to supervision is holding people accountable for doing their jobs to the best of their ability.

— Continued next page
Module 6: Coaching Skill #4—Presenting the Problem

Activity 6.1, continued

Coaching supervision’s way of holding people accountable results in positive communication and more positive outcomes. A coach supervisor’s firm belief in a worker and in his or her ability to perform the job effectively is the beginning of holding a worker accountable. In doing so, the coach supervisor shows caring and respect, communicating to the worker, “I believe in you, and I believe you can do this job well. Therefore, I’m going to hold you to it.”

Coaching works best when used consistently in supervision. Fewer problems are likely to arise when communication is ongoing, clear, and positive. Of course, problems do arise, and this module focuses on what coach supervisors do when that happens.

2. Explain that, when a problem arises, coach supervisors rely on three basic rules to present the problem to the worker in such a way that it is more likely to be solved. Display the prepared flip chart “Three Rules for Presenting the Problem.”

3. For each of the rules, do the following steps:

   Read the rule aloud, and ask participants what they think it means.

   Give an example of not following that rule in supervision. Ask participants how a worker might feel in that situation.

   Ask participants to revise each example so the supervisor follows the rule. Ask what difference that would make to the worker.

Teaching Tips

Objective language

Objective language is language that expresses neither blame nor judgment. It is a statement of fact, not opinion. Objective language is the opposite of subjective language, which features opinion, blame, or judgment.

Most people use subjective language unconsciously. It requires conscious effort to use objective language.
Give two examples of not using objective language. Make the first example somewhat extreme, so that participants can easily recognize the blame or judgment involved. Then give a more subtle example, choosing subjective phrases that are commonly used by supervisors and that participants may not immediately recognize as subjective. For example:

Subjective: “You are always getting here late; you must not be committed to this job.”
Objective: “I’ve noticed that you’ve been between 10 and 20 minutes late several times this week. Is something making it difficult for you to arrive on time?”

Some participants may feel defensive about subjective language they commonly use and may have trouble coming up with alternatives that are truly objective. Remain patient and model speaking without blame or judgment, reminding participants that using objective language is a skill that requires practice.

Belief in the worker’s ability

Supervisors convey to workers that they believe in them through tone of voice and body language as well as actual words. The supervisor should be clear about the problem (without blaming), while demonstrating caring for the person and indicating, from observation or indirect reports, that the problem behavior is not the only thing the supervisor sees.

For example: “You’ve been on time every day for three weeks, and then this past week, you were more than 20 minutes late on Tuesday and Friday. You have been extremely reliable up till now, and that makes me wonder if something unusual is happening for you to cause this problem.”

Lastly, participants will likely ask what to do when they don’t have anything positive to say about a worker. Explain that there is almost always something positive one can say. By observing the worker carefully, the supervisor should be able to identify at least one positive quality he or she brings to the workplace. If the supervisor cannot find anything positive at all, the coaching approach will not work.


—Teaching Notes—
Module 6: Coaching Skill #4—Presenting the Problem

—Teaching Notes—
Activity 6.2: Practice in Presenting the Problem

Learning Outcomes

By the end of this activity, participants will be able to:

* Describe how the three rules for presenting the problem set the stage for discussing (and later solving) the problem; and
* Demonstrate their skill in applying the three rules for presenting the problem.

Key Content

- Being clear and direct about identifying a problem helps to keep the interaction focused on specific behaviors rather than on vague inadequacies of or judgments about the worker and will facilitate solving a specific problem.

- Using objective language creates a positive or neutral tone in a conversation and can reduce defensiveness in a worker, leading to constructive outcomes in supervisory interactions.

- Indicating belief in a worker’s ability to resolve a problem conveys the expectation of success, which can be a powerful motivator.

Activity Steps

Demonstration role plays (20 minutes)

1. Remind the group about the beleaguered direct-care worker, Renee, whom they met in the earlier role play (Activity 5.1). Explain that the two instructors will now role-play Renee’s afternoon meeting with her supervisor. In the role play, the supervisor will present the problem.

2. The instructor who played Renee previously should play her again, and the other instructor should play Renee’s supervisor. In the first scenario, the supervisor presents the problem using blaming and judgmental (subjective) language, berating Renee for calling out at the last minute.

3. Debrief the role play by asking:
   * What tone has the supervisor set for the interaction with Renee?
   * What effect do you think it is having on Renee?
   * What do you notice about Renee's response so far?
   * What do you think are the most likely outcomes of this interaction?

4. Ask the group for suggestions about how the supervisor might better present the problem to Renee, using the three rules: clearly and directly stating the problem, using objective language, and indicating belief in the worker.
Module 6: Coaching Skill #4—Presenting the Problem

5. Explain that the instructors will now redo the role play to show how a coach supervisor might begin this interaction with Renee. The instructor playing the supervisor should use some of the phrases just suggested by the group.

6. Debrief, using the same questions as above. Follow up by asking:

   * How was the supervisor clear and direct in describing the problem?
   * How did the supervisor use objective language?
   * How did the supervisor indicate her belief in Renee's ability to solve the problem?

   **Teaching Tips**
   Participants may focus on the rule about objective language because of its striking impact on the interaction. Be sure to balance the discussion by asking about the other two rules.

   * Remind the group that recognizing subjective language and replacing it with objective language is a skill that requires practice.

   **Pairs work and discussion (35 minutes)**

7. Explain that participants will now practice presenting the problem by working on a worksheet with another person. Distribute Handout 23, “Guidelines for Presenting the Problem.” Review this page with the group, making sure everyone understands each guideline.

   **Teaching Tip**
   Discussion of this handout can be fairly brief, just enough to quickly prepare participants for the worksheets. If participants seem comfortable with this topic (e.g., they quickly understood the difference between subjective and objective language), have them read through the page silently and then ask if they have questions.

8. Distribute Handout 24, “Practice in Presenting the Problem” (choose home or residential care focus, as appropriate). Divide the group into pairs. Assign each pair two statements from the handout, and for each statement, ask pairs to come up with a more effective way to present the problem. They can refer back to Handouts 22 and 23 for guidance.

9. When the group has completed the worksheet, ask to hear from the pairs who worked on problem A. Ask them to read aloud the original statement (with attitude) and follow it with their new version.

   **Teaching Tip**
   Remind participants that this worksheet will be part of their resource binders, so they may wish to write down not only the new versions of the statements they are working on but also the new versions of all other statements.

10. After hearing the reworded statements for problem 1, have the rest of the group imagine they are the worker in this situation, hearing these statements from their supervisor. Ask:

    * How does the original statement make you feel? The new version(s)?
    * How did the new version(s) follow the three rules for presenting the problem?
    * What was effective about the new version(s)? What could be improved?
Module 6: Coaching Skill #4—Presenting the Problem

11. If a new version is not as effective as it could be, ask the group for suggestions that would improve it or offer suggestions yourself.

12. Repeat this process for problems 2-6.

13. Congratulate participants on their work. Emphasize that presenting the problem with clarity and directness, objective language, and belief in a worker becomes easier with practice. If they are able to practice this process on the job, it will have a significant impact. The worker will more likely own the problem and be invested in finding solutions.
Goals

- To introduce the five-stage coaching-based performance model and demonstrate how the four skills learned in the seminar are used in the model.
- To have participants review and consolidate what was learned in the seminar by practicing coaching skills in on-the-job case scenarios.
- To review the requirements for successful coaching in the workplace.
- To reassess the benefits of using coaching supervision.

Time

1 hour, 30 minutes

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Supplies

- Flip chart paper, easel, and markers
- Pushpins or masking tape
- Flip chart page on “Barriers to Being the Ideal Supervisor” created in Activity 1.3
- Flip chart page on “Benefits of Coaching Supervision” from Activity 1.2
Module 7: Making Coaching Work

Handouts

- Handout 25: “Coaching–Based Performance Improvement Model” (2 pages)
- Handout 26: “Coaching Supervision Role Plays” (2 pages) (2 versions: home and residential care)
- Handout 27: “Requirements for Successful Coaching”

Advance Preparation

Review the seminar materials for each activity.

Activity 7.1

Prepare flip charts as shown in steps 2 and 3.

Make copies of Handout 25, “Coaching-Based Performance Improvement Model,” for all participants.

Activity 7.2

Make copies Handout 26, “Coaching Supervision Role Plays” (2 pages; 2 versions, choose residential or home care focus, as appropriate).

Prepare a flip chart page as shown in step 3.

Activity 7.3

Make copies of Handouts 27 and 28, “Requirements for Successful Coaching” and “How Coaching Saves Time,” for all participants.

Prepare a flip chart page as shown in step 5.

Have available the flip chart page, “Barriers to Being an Ideal Supervisor,” from Activity 1.3.

Prepare a flip chart page as shown in step 7.

Have available the flip chart page, “Benefits of Coaching Supervision,” from Activity 1.2.

If using the Teaching Option at the end of the activity, prepare a card for each of the four benefits of coaching supervision: enhances retention, defuses conflict, improves problem solving, and improves the likelihood of meeting needs of both workers and consumers.
Activity 7.1: Putting it all Together—Coaching-Based Performance Improvement Model

Learning Outcomes

By the end of this activity, participants will be able to:

Describe the four coaching skills they have learned and the particular ways each skill contributes to successful supervision; and

Identify the five steps of the coaching-based performance improvement model and how the skills learned in the seminar relate to this model.

Key Content

In coaching supervision, the focus is on building and maintaining relationships. Strong, positive relationships are the basis for successful, ongoing communication. The four skills presented in this seminar—active listening, self-awareness, self-management, and presenting the problem—are important tools for building and maintaining relationships, both on the job and in our personal lives.

Coaching is an ongoing process that is based on establishing good relationships with workers. When a problem arises, coach supervisors use a five-stage performance improvement model. This model closely parallels information presented in Activity 2.2 on what a coach supervisor does. The five stages of the performance improvement model are:

- Create a Relationship with the Worker
- Present the Problem
- Listen for the Worker’s Perspective
- Resolve the Problem with the Worker
- Obtain Commitment to Action Steps

Activity Steps

Large-group discussion (10 minutes)

1. Explain that this activity will review the four skills taught in the seminar—active listening, self-awareness, self-management, and presenting the problem—and put them in the context of a coaching-based performance improvement model. These skills are vital elements within coaching supervision and are used to foster a positive relationship and good communication with a worker and to set the stage for problem solving.
Module 7: Making Coaching Work

2. Review the skill of active listening by asking the following questions:

- What do you remember about this skill?
- What seems easy about this skill? What seems hard?
- Why is this skill important to coaching supervision?

Summarize and note participants’ responses on a flip chart page entitled “Active Listening.”

3. Review self-management, self-awareness, and presenting the problem in the same way. Explain that Activity 7.2 will offer more practice in these skills. Post the flip chart pages where they can be seen for the remainder of the workshop.

Teaching Tips

This review is helpful but may be shortened or omitted if there are time or energy constraints. If the seminar is conducted in two consecutive days, participants may be very tired at this point.

This part of the activity will go more quickly and smoothly if one instructor takes responses from the group while the other writes and posts the lists.
If participants are having a hard time remembering specifics about the skills, ask exploratory questions such as:

*How is active listening different from ordinary, passive listening?*

For self-management, add a follow-up question:

*Which block to listening is most familiar to you?*

**Interactive presentation (10 minutes)**

4. Explain that up to this point in the seminar, the focus has been the four basic skills of coaching supervision. These skills are *starting points* for coaching supervision. Remind participants that it is important for them to practice these skills in order to gain proficiency.

5. Explain that you will now put the four skills learned in the seminar into the context of the entire process of coaching supervision. Participants will see that these skills are the key steps in resolving problems with workers. Distribute Handout 25, “Coaching-Based Performance Improvement Model.” Explain that this model is specifically for problem situations with workers; coaching supervision, however, is an ongoing process and the skills learned in the seminar should be used in all interactions with workers. Go over the handout with the group; by this point, much of it will be familiar.

▶ **Teaching Tips**

Spend a little extra time on the two steps not discussed in the seminar (resolve the problem with the worker, and obtain commitment to action steps), and give concrete examples.

Make sure participants understand that resolving the problem is not a passive process for the worker in which the coach supervisor simply tells the person what to do. Emphasize that it is a collaborative process in which the worker is encouraged to take the primary problem-solving role. Another seminar will build on this foundation and introduce a specific model for helping workers develop problem-solving skills.

6. Explain that this process is not always to be followed step-by-step in this order. For example, it’s important to be actively listening during all supervisory sessions. However, in a session where you are addressing a problem, it is always important to present the problem up front, before going on to resolve it.

7. Answer questions participants may have about the five-stage process.
—Teaching Notes—
Activity 7.2: Coaching Skills
Practice: Role Plays

Learning Outcomes

By the end of this activity, participants will be able to:

Demonstrate their coaching supervision skills and identify areas for improvement; and
Explain the importance of exploring the worker's perspective in order to set the stage for effective problem solving.

Key Content

■ The four skills addressed in this workshop are challenging to learn and master. They require practice and support from one another through honest feedback and encouragement, both now, during role plays, and later when applying these skills on the job.

Activity Steps

Demonstration role play (15 minutes)

1. Explain that this activity will give participants more practice in using the four skills taught in the seminar. Participants will role-play situations typical of their workplaces, focusing on the first three stages of the coaching-based performance improvement model: creating a relationship with the worker, presenting the problem, and listening to gather information on the worker's perspective.

2. Distribute Handout 26, “Coaching Supervision Role Plays.” Read the two paragraphs of the first scenario aloud.

3. Display the prepared flip chart page, “Preparing to Address the Situation.”

Preparing to Address the Situation

• What do you see happening in this scenario?
• Do you notice an emotional response that you may need to pull back on?

Do you think, as the supervisor, that you might have blocks to listening in this scenario? If so, how might you prepare to address them?
• How can you present the problem clearly and objectively?
• What skills might you use to explore the worker's perspective?
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4. Explain that the two instructors will act out how a coach supervisor might handle the situation described in the first scenario. Ask participants to notice which skills the supervisor uses during the interactions (he or she should demonstrate all four skills from the seminar). The supervisor's goal is to engage the worker and elicit his or her perspective, not to fully resolve the problem.

5. Debrief by asking the group:

   *What did the coach supervisor do that was effective?*
   
   *How did he or she pull back? Present the problem? Actively listen? Elicit the worker's perspective?*
   
   *How could she or he have improved?*

Practice role plays (35 minutes)

6. Divide the class into three groups, and assign each a case scenario to work on. Using the flip chart questions as a starting point, share ideas in the group about how to address the situation. Choose one person to role-play the supervisor in front of the full group, using the ideas discussed. An instructor will play the worker.

7. Conduct the role plays one at a time, with the full group observing. Debrief each scenario with the questions in step 5 above.

► Teaching Tips

   If there are more than 12 participants, you will need additional groups and more time. Plan about 10 minutes for each role play and debriefing.

   During the scenarios, the instructors should play the workers realistically. Don’t act out the worst behavior imaginable.

   As long as participants are clearly trying to practice their skills, allow each one to have some degree of success as the supervisor. Demonstrate the actual benefits that result from using these skills. The worker’s attitude should visibly change over the course of the scenario. However, don’t dramatically exaggerate the benefits by having the worker hug and kiss her supervisor by the end of the encounter, calling her a saint, giving her gifts, etc.

   Try not to interrupt a role play. Let participants muddle their way through, even if they are having major difficulty—this is what it will be like for them on the job. They need to find out now which skills they need to practice more.

   During debriefing, emphasize that this is practice, not performance. Participants are here to help each other learn. Feedback should address what was done well and what can be improved and should be objective, not subjective. This is another opportunity for instructors to model skills participants will need for their own supervision situations.

Summary discussion (5 minutes)

8. Thank the volunteers who took the risk of role-playing the supervisor in front of the large group. Ask the volunteers to discuss what felt hardest about being the supervisor and what felt easy. Let participants know that if they keep practicing these coaching skills on the job, the skills will soon become natural and easier to use.
Activity 7.3: Requirements for Successful Coaching

Learning Outcomes

By the end of this activity, participants will be able to:

List the requirements for successful coaching; and

Address the challenges to achieving those requirements.

Key Content

■ Successful coaching requires:
  ■ Belief in a worker's capacity to succeed on the job;
  ■ Time to reflect and meet individually with workers; and
  ■ The four coaching skills presented in this seminar.

■ This seminar has so far provided participants with the third requirement: the skills. In addition to practicing the skills on the job, participants will need to consciously reinforce their belief in workers and ensure that their schedules allow adequate time for reflecting and meeting with workers.

■ The fundamental requirement is belief in a worker's capacity to succeed on the job. Everything else in coaching—every skill participants have learned in this seminar—springs from this belief.

■ Belief in and respect for workers requires a sincere attempt to understand their realities, which may be quite different from a supervisor's own reality or from what a supervisor assumes to be true. Belief in workers also entails holding them to high standards and holding them accountable for their actions.

■ While investing the time required for coaching may be challenging, especially in the beginning, the investment soon pays off in fewer problems and quicker, easier resolutions of problems.

■ Time savings can also be found in less supervisory time spent on disciplining workers, termination, turnover, and orientation of new workers.

Activity Steps

Large-group discussion (15 minutes)

1. Explain that this last activity covers the three basic requirements for successful coaching. Distribute Handout 27, “Requirements for Successful Coaching.” Explain that this seminar has so far provided participants with the third requirement—the skills. This activity focuses on the other two requirements: belief in the worker and devoting time to this type of supervision.
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2. Discuss the importance of belief in a worker:

Explain that the most fundamental requirement in coaching supervision is belief in a worker's capacity to succeed on the job. Everything else in coaching—every skill participants have learned in this seminar—springs from this belief.

Invite discussion about believing in workers’ abilities:

*Does it ring true for the group, in their experience?*

*What does it mean to have the capacity to succeed?*

*Do all workers have the capacity to succeed on the job? Most?*

**Teaching Tip**

It is often helpful to ask participants what they think motivates workers and to remind them that workers usually choose this work because they are caring people.

Engage participants in a discussion in which they imagine themselves as workers going in to meet with their supervisor. Ask:

*How would you feel if it was evident from your supervisor’s comments and attitude that she or he did not believe in your capacity to succeed and expected you to fail?*

*How would you feel about yourself? About the job?*

*How differently would you feel if your supervisor made it clear that she or he firmly believed in your capacity to succeed and expected you to succeed?*

Explore what is meant by the two items listed under belief in the worker’s capability: “an open mind about the person” and “interest in the person, in understanding his or her reality.” Ask why these characteristics would lead to believing in a worker. Discuss how belief in, and respect for, a worker requires a sincere attempt to understand that person's reality, which may be quite different from what the supervisor imagines. Understanding the worker's reality involves listening for and requesting more information about elements that are confusing or don't make sense, and asking clarifying questions until the story comes clear. Belief in a worker also entails holding him or her accountable for their actions.

3. Address time requirements, including having a private setting with no distractions in which to talk and choosing the right time to talk:

Explain that the time requirement for successful coaching often feels like the biggest challenge for beginning coach supervisors. Ask the group if this is true for them.

Explain that coaching does require a significant investment of time for the first few weeks, as coach supervisors begin to meet individually with workers.

**Teaching Tip**

Some participants may feel there will never be enough time to implement and practice coaching. Encourage them to take small steps. The first one is simply to start practicing their coaching skills in every interaction at work:

*Remind yourself to actively listen, pull back, and use objective language.*

This step alone can make a huge difference, and relationships will begin improving.
4. Ask the group if they can imagine how implementing coaching might save them time after some time has passed. Discuss the responses.

5. Post the prepared flip chart, “How Coaching Saves Time.”

6. Discuss each bullet in turn. Distribute Handout 28, “How Coaching Saves Time,” for resource binders. Summarize by noting that, while the time requirement for coaching may be challenging, especially in the beginning, the investment soon pays off in fewer problems and quicker, easier resolution of problems.

7. Discuss obstacles to investing time, especially initially, in coaching supervision, and brainstorm strategies to overcome them:

   Post the flip chart page “Barriers to Being an Ideal Supervisor” that participants created in Activity 1.3. Ask the group to revisit the obstacles they listed to making the initial time investment in coaching. Ask participants to brainstorm strategies to get around some of these obstacles in their organizations.

   Write their ideas on a flip chart page entitled, “Investing Time in Coaching Supervision: Overcoming Obstacles.”

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Module 7: Making Coaching Work

Activity 7.3, continued

Teaching Tip
If the group has trouble coming up with ideas, offer strategies that have worked for others [give 1-2 examples here]. Write them on the flip chart page. Encourage participants to take notes in their binders for future reference.

8. Summarize by displaying the flip chart from Activity 1.2, “Benefits of Coaching Supervision” and reiterating the four benefits: enhances retention, defuses conflict, improves problem solving, and improves the likelihood of meeting the needs of both workers and consumers. Ask participants to make links between the skills they’ve learned and the potential benefits they hope to see from using coaching supervision in their jobs.

9. Reinforce the message that participants can succeed by:

- Reassuring the group that making time in the first few weeks requires a strong commitment, but is possible.
- Telling the group that each of them has the capacity to succeed as a coach supervisor, as they’ve demonstrated during the seminar. Encourage them to report on their progress after they return to work and start putting coaching supervision into practice.

Teaching Option
The following additional activity can be used to reinforce the benefits of using coaching supervision.

Separate participants into four groups. Hand each group a card on which you’ve written one of the four benefits of coaching supervision initially introduced in Activity 1.2 as “Benefits of Coaching Supervision”: enhances retention; defuses conflict; improves problem solving; improves likelihood of meeting needs of both workers and consumers. Each group should choose a reporter who will summarize the small group’s discussion for the whole group.

Have each group identify how the skills taught in the seminar relate to the benefit written on the card. For example, active listening defuses conflict.

After about 5 minutes, bring everyone back to the larger group, and have reporters describe their groups’ discussions.

Note: A closing activity, including an evaluation for the whole seminar, is included in the Supplementary Activity Guides in the Appendix.
Appendix

Supplementary Activity Guides

Day 1 Closing  a.1
Day 2 Opening  a.3
Evaluation, Getting Support, and Final Closing  a.5
Additional Coaching Resources  a.9
Supplementary Activity 1:  
Day 1 Closing  
10 minutes

Goal
• To help participants reflect on what they have learned during the day and to give brief feedback to the instructors about their experiences in the seminar so far.

Learning Outcomes
By the end of this activity, participants will be able to:

- Identify and share what they have learned during the day;
- Describe the ideas and skills that other participants learned; and
- Explain what they're required to do as homework.

Time
10 minutes

Supplies
• Flip chart, easel, and markers

Advance Preparation
Review the seminar materials for this activity.

Have participants arrange the chairs in a large circle; this will help them transition from the previous activity.

Prepare a flip chart page with the homework assignment as shown in step 5.

Activity Steps

Large-group discussion (10 minutes)

1. The role-play activities just completed should have been fairly stimulating. Before moving into the closing session, a brief activity to calm and center people can help them focus for the last, very short, activity of the day.

2. Invite the group to stand and take a deep breath. With the out-breath, have them let go of muscle tension built up during the day by shaking their arms, hands, legs, and feet.

Teaching Option
Ask people to sit quietly with their eyes closed and take ten long breaths.
3. Praise participants for their hard work in today’s sessions. Without singling out individuals, you may want to refer to specific things you noticed occurring in the group that impressed you as an instructor—retaining a sense of humor under stress, supporting one another during role plays, or cooperating with one another to complete tasks.

4. Before the group finishes for the day, allow everyone a chance to speak briefly about what he or she has learned so far. Ask the group:

   *What new ideas or skills will you take with you when you leave this room?*

Ask a volunteer to address the question, and go around the circle until everyone has spoken.

**Teaching Tips**

Mention that it’s okay to say more or less the same thing that someone else has said, if it is true for them.

This is the end of a long, full day, so it’s important to keep this activity brief. Most participants will be tired, and, as a result, some may ramble on during the go-round. Gently redirect them to the highlights of what they have learned.

Remember to model good listening skills, especially in your body language. Let participants understand that you value their words.

Aside from asking a brief clarifying question, don’t engage in conversation with participants during the go-round. If someone says something that you feel needs a response, talk to that person privately after the session.

5. After each participant has spoken, tell them they have a 5-minute homework assignment. Direct attention to the prepared flip chart page, read the homework instructions, and answer any questions.

Wish participants luck and say farewell until the next meeting.
Supplementary Activity 2: Day 2 Opening

25 minutes

Goals

■ To help participants transition back into the seminar.
■ To give participants a chance to share thoughts, feelings, or questions that arose from the previous session’s experiences.
■ To review and learn from the homework assignment.

Learning Outcomes

By the end of this activity, participants will be able to:

Feel prepared to embark on another day of learning activities;
Consolidate and clarify their learning up to this point; and
Describe in depth what it means to actively listen and the challenges of doing this.

Time

25 minutes

Supplies

■ Flip chart paper, easel, and markers

Advance Preparation

Review the seminar materials for this activity.
Arrange chairs in large circle.
Prepare an agenda of the day’s activities and post for participants to see on arrival.
Prepare a flip chart as shown in Step 2 and post for participants to see on arrival.

Activity Steps

Large-group exercise (25 minutes)

1. Welcome the participants back to the seminar. Explain that the first activity is a check-in about the previous session—specifically, you would like to hear what thoughts, feelings, or questions have emerged as participants started to process the new ideas and skills. In addition, you want to hear from each person about his or her experience with the homework assignment.
2. Refer to the flip chart and read the questions aloud.

3. Go around the circle, letting each person speak without interruption from others. Participants can respond to these questions in either order; redirect them to the flip chart page as needed. Ask for a volunteer to go first.

▶ Teaching Tips
Briefly paraphrase each participant’s responses to let him or her know you listened and understood. Ask clarifying questions if something was confusing or incomplete.

Some participants may be so eager to talk about the homework that they skip over the first question on the flip chart page. Remind them to return to the first question after discussing the homework.

If participants respond with one-sentence responses such as “It was fine,” “I didn’t have any problem with it,” or “I hated it,” ask clarifying questions so that these participants examine and explain their experiences in more detail.

Sometimes everyone in a group finds the homework easy and thinks they listened well. Ask:

What made listening easy this time?

Which of the skills you learned and practiced in the previous sessions did you use?

How do these skills and strategies make it easier to listen well?

4. After everyone has spoken, sum up the most common responses to the homework.

▶ Teaching Tips
Common responses include that it was difficult to really listen for the entire 5 minutes.

Remind participants that active listening—listening with your full attention—is a challenging skill that requires practice and conscious self-management.

5. Review the day’s agenda, instructions, and answer any questions.
Supplementary Activity 3: Evaluation, Getting Support, and Final Closing

30 minutes

Goals
- To encourage participants to reflect on and share what the seminar has been like for them and what they have learned.
- To emphasize for participants the crucial importance of having support as they begin to implement coaching supervision in their jobs.
- To identify ways participants can support one another in implementing coaching supervision.

Learning Outcomes
By the end of this activity, participants will be able to:

- Provide feedback on their experience in the seminar by completing an evaluation form;
- Identify the aspects of the seminar that were the most meaningful for them, or from which they learned the most; and
- Suggest ways to support one another, keep themselves motivated, and keep learning once they leave the seminar and return to work.

Time
30 minutes

Supplies
- Flip chart paper, easel, and markers

Handout
- Handout 29: “Evaluation Form”

Advance Preparation
Review the seminar materials for this activity.
Make copies of the evaluation form for all participants.
Prepare a flip chart page as shown in step 4.
Activity Steps

Individual work (10 minutes)

1. Explain that the purpose of the evaluation is to help participants reflect on their experiences and to help the instructors in planning future seminars. Distribute Handout 29, “Evaluation Form,” and request that participants complete them during the next 10 minutes. When the time has finished, collect the completed evaluations and thank participants for their feedback.

Teaching Tip
To help participants focus, keep the room quiet. Resist the temptation to chat with the other instructor or participants who finish their evaluations early.

Large-group exercise (10 minutes)

2. Explain that, to share what everyone has experienced together, the group will do a “go-round,” in which each person will share the highlights of his or her learning in the last two days. Ask,

   What are the one or two most meaningful things that stand out for you from this seminar?

Start with a volunteer and go around the circle until everyone has shared.

Teaching Tip
This is only a 10-minute activity, so it’s important to keep participants focused on the question. Responses should take less than a minute.

Brainstorm (10 minutes)

3. Explain that implementing any substantial change requires support from others along with strategies for supporting yourself. Trying to go it alone with coaching has far less chance of success than when a person is supported by colleagues and friends and by his or her own conscious strategies.

4. Turn to the prepared flip chart page, and ask the group to brainstorm answers to the question. As participants call out ideas, write them on the page.
Teaching Tips

If the same few people are calling out all or most of the ideas, ask others for their ideas. Try to ensure that everyone contributes.

If you have a small group, use a go-round instead of a brainstorm, with each participant responding to the flip chart question. You may want to go around the group more than once.

Suggest that participants take notes so they can refer to these ideas later.

Once the group has run out of ideas, add your own if they haven’t been suggested. Some examples include:

- Regular check-ins with people who have participated in the seminar
- Soliciting help in pulling back and thinking through a difficult situation with a worker
- Placing visual pull-back reminders in visible places
- Developing “coaching buddy” relationships for regular or periodic support
- Finding time and mechanisms for stress reduction and self-care

5. Summarize by reiterating the importance of using these ideas to get support from others and from within themselves. Explain that when the going gets rough as they begin to implement coaching, they can turn to this list.

Teaching Tip

Remind the group that asking for support is a strength, not a weakness.

6. Thank the group for their participation and reiterate your confidence that they can implement coaching in their jobs. Both small steps and more substantial changes will make a difference.

Teaching Tip

If you are comfortable doing so, provide contact information for participants to call or email you in the weeks after the seminar to let you know about their progress in implementing coaching. Make it clear that while you probably cannot be a significant, ongoing support person for them, you are interested in their progress, and their feedback will help in planning future seminars.
Appendix: Supplementary Activity Guides

—Teaching Notes—
Appendix: Additional Coaching Resources

Additional Coaching Resources

A basic resource that includes many useful tips for managers and trainers.

Popular presentation of seven habits (in coaching language, “practices”) that are personally transformational.

An excellent and highly readable presentation of the stages and skills involved in transformational coaching.

A good resource for those interested in a more theoretical approach to the principles and foundations of coaching practice.

For theories of motivation, chapter 3 is very good.

Developing emotional intelligence is a significant aspect of coaching. While not about coaching per se, this book provides invaluable background material for the instructor.

A highly recommended, practical guide to developing leadership skills.

A useful guide to developing the communication skills required for effective coaching.

An interesting and provocative approach to learning about personal style differences and their impact upon communication. Chapter 10, “Communication and Team Learning,” and the foreword by Peter Senge are particularly good.

This highly readable book is especially useful in coaching for performance improvement.

Based on a collaborative coaching model, this is an excellent guide for creating coaching relationships and developing coaching skills.
Handouts

This section contains participant handouts, all of which are suitable for photocopying. Depending upon your personal preferences and training needs, many of these handouts might also be used as overheads.

The notation at the top of each page indicates the handout number and title, and the module and activity number with which the handout is associated.
Handout 1: Coaching Supervision—Sample Agenda for Two-Day Seminar

Handout 2: Definition of Coaching Supervision

Handout 3: Benefits of Coaching Supervision

Handout 4: Roles of a Supervisor
Coaching Supervision

Sample Agenda for Two-Day Seminar

Day One: 9 am – 4 pm

9:00-10:00   Introduction to Coaching Supervision
10:00-10:15  Break
10:15-11:05  Traditional and Coaching Approaches to Supervision
11:05-12:10  Coaching Skill #1—Active Listening
12:10-1:00   Lunch Break
1:00-1:50    Coaching Skill #1—Active Listening (continued)
1:50-2:35    Coaching Skill #2—Self-Management
2:35-2:50    Break
2:50-3:50    Coaching Skill #2—Self-Management (continued)
3:50-4:00    Closing
Coaching Supervision

Sample Agenda for Two-Day Seminar

Day Two: 9 am – 4 pm

9:00-9:25  Opening

9:25-10:20  Coaching Skill #2—Self-Management (continued)

10:20-10:30  Break

10:30-12:00  Coaching Skill #3—Self-Awareness

12:00-12:40  Lunch Break

12:40-1:50  Coaching Skill #4—Presenting the Problem

1:50-2:10  Making Coaching Work

2:10-2:20  Break

2:20-3:30  Making Coaching Work (continued)

3:30-4:00  Evaluation, Getting Support, and Closing
Definition of Coaching Supervision:

A relational approach to managing and supporting direct-care workers that helps them to develop problem-solving skills—i.e., the ability to think critically, prioritize, and communicate effectively.
Benefits of Coaching Supervision

- Enhances retention of employees.
- Defuses conflict.
- Improves problem solving.
- Improves likelihood that needs of both the consumer and the worker will be met.
Roles of a Supervisor

Use the following two template sheets as photocopy masters for creating enough labels for each participant.

The templates are designed to work with Avery Laser Labels 5160 (or equivalent).

There is room on both template sheets to incorporate additional "roles," if you wish.
<table>
<thead>
<tr>
<th>Develop</th>
<th>Provide Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivate</td>
<td>Reinforce</td>
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<tr>
<td>Empower</td>
<td>Support</td>
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<tr>
<td>Guide</td>
<td>Set Goals</td>
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<tr>
<td>Ensure Task Completion</td>
<td>Develop Problem-Solving Skills</td>
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<tr>
<td>Influence</td>
<td>Model Accountability</td>
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<tr>
<td>Hire/Fire</td>
<td>Help Think Through Personal Problems</td>
</tr>
<tr>
<td>Explain What to Do/Tell What Not to Do</td>
<td>Advise</td>
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</tbody>
</table>
Correct  Confront

Inspire  Listen

Direct  Create/Maintain Relationship

Discipline  Discuss

Maintain Clear Performance Standards  Mentor

Advocate for the Worker  Reflect

Provide Perspective  Discuss

Observe
Module 2

Handout 5: Role Play—Traditional Supervision

Handout 6: Role Play—Coaching Supervision

Handout 7: What a Coach Supervisor Does

Handout 8: Comparison of Traditional and Coaching Supervision

Handout 9: Four Primary Coaching Skills
Role Play—

*Traditional Supervision*

**Supervisor:** Okay, Helen, you know I’ve called you in here because we have a problem with your being late.

**Worker:** Yeah, well, the charge nurse—Lisa—said something to me about that.

**Supervisor:** So I have written down here that in the past two weeks since you started working, you came in at 3:20 on Tuesday, you came in at 3:50 on Thursday, and then just this past week, on Tuesday, you came in at 4:08. That’s when you clocked in. You know this is a problem, right, Helen?

**Worker:** Oh, yeah. Yeah, I guess.

**Supervisor:** When you were in orientation, we went over with you how important it is to be on time. You know that we have to cover shifts and that the aides who work the shift before you leave at 3:00. If you’re not here, there is no way the work that needs to be done can get done. You know that, right?

**Worker:** Mm-hmm.

**Supervisor:** So Helen, what’s the problem here?

**Worker:** (Sighing) The buses—at least three times a week—the buses are not coming on time. I’m there, most of the time—there for the right bus that should get me here on time—by 3:00. But a lot of times I’m waiting there 10 or 15 minutes, waiting for the bus to come. The bus is just killing me.

**Supervisor:** So the problem is the bus.

**Worker:** Yeah.
Role Play—Traditional Supervision—continued

Supervisor: Well, you know that it’s your responsibility to get here on time. And if your experience is that the bus is not getting you here on time, then Helen, you are going to have to do something about it. Which means that you are going to have to get a ride with somebody, go on another bus route, or take an earlier bus.

Worker: Well, I, ummm…

Supervisor: Are you willing to do that? Because your willingness to do that is an indicator of whether you’re willing to do what it takes to stay in this job.

Worker: I’ll try. I just…sometimes it might be hard for me to get an earlier bus. But I’ll try.

Supervisor: Helen, I need more from you than that you’ll try. I need to know that you’re willing to do this, because you need to be here at 3:00. You should consider this a verbal warning. If you’re late again, you’ll be written up for it.

Worker: I’ll take care of it. Don’t worry.

Supervisor: Okay.

Worker: You going to fire me or something?

Supervisor: I’m not going to fire you. I’m going to assume that you’ll keep to your word and that you’ll take care of it and be here regularly at 3:00.

Worker: It won’t be a problem anymore.
Role Play—

**Coaching Supervision**

**Supervisor:** Helen, you’ve been working for two weeks now. How’s it going?

**Worker:** Okay.

**Supervisor:** I asked you to come meet with me because I understand that you’ve had a problem with being late a few times over the past two weeks.

**Worker:** Oh, well, just a few times. Yeah.

**Supervisor:** What I have written here—from a conversation I understand you had with Lisa, the charge nurse—is that there were three times you were late, including Tuesday and Thursday from last week, and then again this past Tuesday. And each of those times you were 15 minutes or 45 minutes or even over an hour late on one occasion. So I imagine that something must be going on for you that is creating this problem, and I’d like to hear about it.

**Worker:** Mmm. I’ll try to correct it. It’s just that…the buses run late sometimes, and I’m standing there for sometimes 15 or 20 minutes. A lot of times it doesn’t come on time.

**Supervisor:** That must be very frustrating.

**Worker:** Yeah! It’s very frustrating! I don’t know how much those drivers get paid, but they should get docked for that.

**Supervisor:** Mm-hmm. It has really hard consequences for you. Something you don’t have much control over.

**Worker:** Right. Can’t get to work on time! I get so mad there’s smoke coming out my ears.

—continued, next page
Role Play—Coaching Supervision—continued

Supervisor: So, Helen, clearly you have a problem in terms of being able to rely on the bus. I don't have to ride the buses myself, so I haven't had to deal with that. That must be really difficult for you.

Worker: Yeah.

Supervisor: And I appreciate that it takes a lot to get here on the bus on a daily basis.

Worker: Sometimes. When it's running late, it's just...aggravating.

Supervisor: I assume that you don't have another option, other than the bus. Is that right? The bus is your only way to get here?

Worker: Right. I don't have a car. I don't drive.

Supervisor: Uh-huh. That's hard. So, we have a situation where the bus is not reliable, so you're not always able to get here on time. But on the other hand, I'm sure you appreciate how important it is that you are here on time.

Worker: Well, yes. I do. I got to take care of my residents. Somebody's got to be here for the residents.

Supervisor: Right. And as you know, we're often short staffed. So having you show up on time really makes a difference. Your presence makes a difference in terms of getting work done, but it also makes a difference to particular residents, as you know.

Worker: Uh-huh.

Supervisor: I heard that you've established really sweet relationships, particularly with Mrs. Smith and Miss Alice.

Worker: Oh yeah. They're great. We have a good time.

Supervisor: They really love you.

Worker: Really? Well that's...nice to hear that.
Role Play—Coaching Supervision—continued

Supervisor: Helen, I would like for this to work out. Very much. Because we really appreciate having you here, and we can't have this situation continue where you're coming in late. So I’m wondering if we can brainstorm together what might be possible options for you, in terms of how to deal with this. Is it possible for you to take an earlier bus, so that you can be sure to be here on time?

Worker: Well, uh... it's hard for me to take an earlier bus, actually. Because of what I'm coming from.

Supervisor: Are you willing to let me know what you're coming from? Because maybe I can work with you on this.

Worker: Well... I guess. I have another part-time job doing some private duty for a client.

Supervisor: A home health client?

Worker: That's right. I'm supposed to get off by 2:00, but she has so many needs. I hate to go when there's stuff that hasn't gotten done yet, and she really hates to see me leave. So sometimes it's hard to get away. But...

Supervisor: That doesn't surprise me, given what I've seen of you here and the attachment that you have to residents. I'm not surprised to hear you have a hard time leaving a client who really needs you.

Worker: Yeah. I guess I am a pretty caring person.

Supervisor: That's clear. We would never want to take that away from you. But it seems like the caring you have for your home health client is making it difficult for you to get out on time, and getting out on time is important to you, right?

Worker: Yes. It's really important. I promise it won't happen again. I'm going to make sure I get out on time. I promise.
Role Play—Coaching Supervision—continued

Supervisor: Helen, I trust that you believe that and really want to make a change.

Worker: I really do.

Supervisor: But I’m not convinced that in a couple weeks you might not get pulled back into the same thing with your home health client, because you’re so caring. So I think it would help us to think through strategies that you could use, to make sure that you get yourself out on time.

Worker: Right.

Supervisor: What worked for you on the days that you managed to get here on time?

Worker: Well, most of those days the 2:30 bus was on time. That’s the main thing. And a couple of days I managed to get out on time to catch the earlier bus, the 2:10 bus.

Supervisor: So if you get out on time, you can manage to get the earlier bus. And even if that bus is a little late, you’ll still get here on time. Is that right?

Worker: Yeah. So I just need to get out on time.

Supervisor: Mm-hmm. Your client loves you and needs you and likes having you there. But leaving on time isn’t a health or safety issue, right?

Worker: Right. She’s okay without me.

Supervisor: So clearly, Helen, you have no control over the bus. But you do have control over when you leave your client’s house, even though it might not seem that way.

Worker: Yeah, I guess that’s true.

Supervisor: What do you think might work for you, to remind you of that? And to remind you that there’s serious consequences to your not leaving on time?

—continued, next page
Role Play—Coaching Supervision—continued

**Worker:** Well... I could think about all the people here in the facility that need me, too. And that I have to go ’cause I might lose my job, and that would be terrible. If I tell my client about it, that could help. Because she cares about me, too. Maybe if she has a lot of things for me to do and I run out of time, we could make a list and I can make sure to do them next time.

**Supervisor:** Great! Seems like you’ve had some practice prioritizing and setting limits in other parts of your life.

**Worker:** Oh... with my kids, every day. They want so much out of me.

**Supervisor:** If kids don’t teach us to set limits, nothing will! So you have a number of different options. There’s reminding yourself about the people who need you here at the facility, there’s reminding yourself that your job here is at stake, and there’s letting your client know about the problem so that she can help support you in getting out on time. And you also had a great idea of making a list at the end of your time with her each day, of the things you’ll get to the next time. So you think all this will work?

**Worker:** Yeah, I think it will. I’m sure it will make a difference. I just never thought about it that way.

**Supervisor:** What strikes me is that you’re changing something with your client that’s been going on for a while—you’ve let her keep you longer than you’re supposed to stay, because you’re a kind and caring person. So she may put up a little battle at first.

**Worker:** Oh yeah, she’s a fighter!

**Supervisor:** You’ll have to be strong. But you also may need some support from the outside. And I’m willing to be that support for you.

**Worker:** Wonderful.

—continued, next page
Role Play — Coaching Supervision — continued

Supervisor: I’d like us to set up a kind of contract, where you’ll check in with me about how it’s going. Not in the sense that I’m checking up on you, but in the sense that I want to support you in doing this. It’s hard to change patterns that have been going on for a while.

Worker: Yeah.

Supervisor: So how about this, next week—Tuesday and Friday—I’ll find you on the floor and we’ll check in with each other about how it’s going.

Worker: Tuesday and Friday. I’ll look for you.

Supervisor: I’m writing it down here. Maybe you should write it down, too.

Worker: All right.

Supervisor: I’ll come and find you on the floor.

Worker: Come right at 3:00! You’ll see that I’m there.

Supervisor: Great. In terms of our policy, I’m going to see this conversation as a coaching for improvement session. I need to tell you, though, that if you are late again, it will be documented in your personnel file, and we’ll have to come up with a remedial plan.

Worker: That’s not going to happen.

Supervisor: I trust that it won’t. It’s been a pleasure talking with you, Helen.

Worker: For me, too.
What a Coach Supervisor Does

Create a Relationship with the Worker
- Demonstrate interest in the person
- Set tone: Establish a safe space
- Indicate belief in the person
- Manage personal emotions so they don’t get in the way of listening

Clearly Present the Problem
- State the problem in clear, objective, nonjudgmental terms
- Put within the context of other positive behaviors, attributes
- Move to a future orientation

Gather Information about the Worker’s Perspective
- Ask open-ended questions
- Listen actively
- Acknowledge worker’s perspective
- Reflect back (paraphrase)

Engage in Problem-Solving with the Worker
- Maintain focus on work-related behaviors
- Brainstorm options
- Ask for ideas, offer suggestions
- Offer information/ask questions about impact of choices
- Present new possibilities
- Request actions

Help the Worker Commit to Action Steps
- Come to mutual agreement on the nature of the problem
- Plan/set goals collaboratively
- Make mutual commitments for specific, measurable action steps
- Follow through on commitments
Comparison of Traditional and Coaching Supervision

<table>
<thead>
<tr>
<th>Traditional Supervision</th>
<th>Coaching Supervision</th>
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<tbody>
<tr>
<td>■ Identify issues to be addressed.</td>
<td>■ Create a relationship with the worker.</td>
</tr>
<tr>
<td>■ Explain the rules clearly.</td>
<td>■ Clearly present the problem.</td>
</tr>
<tr>
<td>■ Explain the consequences of breaking the rules.</td>
<td>■ Gather information about the worker's perspective</td>
</tr>
<tr>
<td>■ Request or direct the worker to comply with work rules.</td>
<td>■ Help the worker commit to action steps.</td>
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</table>
Four Primary Coaching Skills

- **Active Listening**: Using skills such as body language, paraphrasing, and asking clarifying questions to listen attentively and ensure understanding.

- **Self-Management**: Setting aside emotional reactions and other listening blocks that can get in the way of hearing a worker's perspective.

- **Self-Awareness**: Being conscious of assumptions and biases that lead to prejudging workers and others.

- **Presenting the Problem**: Using objective language to identify a performance problem and hold him or her accountable.
Handout 10: Active Listening

Handout 11: Lead-Ins for Paraphrasing

Handout 12: Lead-Ins for Open-Ended Clarifying Questions

Handout 13: Paraphrase and Open-Ended Clarifying Questions Worksheet

Handout 14: Back-to-Back Geometric Designs
Active Listening

Listening is essential to clear, effective communication. In coaching supervision, a very conscious level of listening is essential. We call this “active listening.”

Active listening—i.e., listening with full attention to the person speaking—involves:

- Using positive body language to communicate nonverbally. “Body language” refers to the way people communicate through facial expressions, postures, and gestures.

- Paraphrasing—i.e., repeating back in one’s own words what the speaker has said to ensure understanding.

- Asking open-ended questions to clarify or gather additional information. These questions usually begin with how, what, or why.

Active listening is the underlying skill in coaching supervision for the following reasons:

- When people listen with their full attention, they remember and understand more of what is being communicated. On the other hand, when they listen inattentively, they miss a great deal of what is being communicated.

- Being listened to attentively feels caring and helpful to the speaker. Not being listened to, or being listened to in an inattentive manner, feels hurtful and unhelpful.
Lead-Ins for Paraphrasing

Did I hear you say…

Did you say…

So, I think you said…

Okay, so what I heard you say is…

So I understand you said…

Am I hearing you correctly that…

Are you saying that…

Am I hearing you clearly that…

I believe that you are saying…

So, you’re saying…

Okay, let me see if I got what you said…
Lead-Ins for Open-Ended Clarifying Questions

What can you tell me about…?

What more can you tell me about…?

How did that happen?

What happened next / before…?

What led you to make this decision?

How do you feel about…?

What were you feeling/thinking when you…?
Paraphrase and Open-Ended Clarifying Questions Worksheet

1. “I am not coming in to volunteer for overtime. I just need to ask you about my schedule for next week.”
   Paraphrase:

   Open-Ended Clarifying Questions:

2. “I’m sorry I couldn't make it to the in-service yesterday. I was so tired. I just can't even keep my eyes open I'm so tired.”
   Paraphrase:

   Open-Ended Clarifying Questions:

3. “The nurse told me I had to come see you. She said you didn’t want me working on that unit. So here I am, where should I go now?”
   Paraphrase:

   Open-Ended Clarifying Questions:
4. “I’m not the one at fault, he is—he is a nightmare to work with! You don’t know because you don’t see. They must have been really desperate for CNAs to hire him!”

*Paraphrase:*

*Open-Ended Clarifying Questions:*

5. “I know I was late. It will never happen again—give me a chance, you have to believe me.”

*Paraphrase:*

*Open-Ended Clarifying Questions:*
Paraphrase and Open-Ended Clarifying Questions Worksheet

1. “I’m sorry I missed our meeting yesterday. I have been feeling very tired. I’m so tired I can hardly keep my eyes open.”

   Paraphrase:

   Open-Ended Clarifying Questions:

2. “The coordinator called to say I had to leave my case. She said to come right back to the office to pick up another case. So here I am.”

   Paraphrase:

   Open-Ended Clarifying Questions:

3. “I don’t care what you say, I won’t go back to this client again. And don’t be telling me I’ll be written up; there’s nothing you can say will make me go back.”

   Paraphrase:

   Open-Ended Clarifying Questions:
4. “I know I was late again. I swear if you give me a chance, this won't keep happening, you have to believe me.”

*Paraphrase:*

Open-Ended Clarifying Questions:

5. “I just ran in here because I am running out of gloves. But while I’m here, I thought I’d check again if there is any chance I can get more hours. I really need more hours.”

*Paraphrase:*

Open-Ended Clarifying Questions:
Back-to-Back Design 1
Back-to-Back Design 2
Back-to-Back Design 4
Back-to-Back Design 5
Handout 15: Choosing to Pull Back

Handout 16: Pulling Back—Overview

Handout 17: Pulling Back—When Feelings Get in the Way of Listening

Handout 18: Supervisory Role Plays for Pull Back and Paraphrase

Handout 19: Blocks to Listening
Choosing to Pull Back

Sometimes you are faced with situations and people who evoke an emotional response—be it anger, hurt, frustration, hopelessness, or sadness. When you are in an emotional state, listening becomes difficult and communication becomes “charged.” You always have a choice in how you respond.

When a person evokes your emotions, you have a choice.

Option A
Respond based on your emotions
- Defend your opinions.
- Prepare your response.

Option B
Pull back from your emotions
- Suspend your opinions, and put them on hold.
- Listen actively, without blocks or judgment.

Exchange becomes emotionally based for both
- Each looks for evidence to support opinions.
- Each discounts evidence to the contrary.

Engage in a “non-charged” dialogue
- Look with curiosity for new information or insights.
- Stay open to changing your opinion.

Result
- I feel heard!
### Option A
**generally leads to:**
- Difficulty thinking clearly
- Inability to listen
- Difficulty in being open to believing or trusting the other person
- Being judgmental
- Feeling justified or self-righteous
- Blaming the other person
- Holding onto anger, resentment, mistrust
- Self-fulfilling prophecy—in the future, the person will most likely act in the negative way we expect.

### Option B
**generally leads to:**
- Clear thinking
- More appropriate communication
- More empathy for those who think, see, and believe differently
- Nonjudgmental responses
- Having *more* information, and therefore a better understanding of the whole situation
- Defusing anger
- Building trust
- Problem-solving that involves both parties, resulting in mutual ownership of the solution
- Self-fulfilling prophecy—in the future, the person will most likely act in the positive way we expect.
Pulling Back—Overview

**Pulling Back:** The ability to gain emotional control in stressful situations.

- A supervisor’s ability to handle a situation well will be determined by his or her ability to stay calm and think clearly.

- To “pull back” is to be able to pause, get emotions under control, and clearly observe and assess the problem situation.

- After pulling back for a moment, a supervisor can make sure he or she understands what’s going on and ask for additional information, if necessary.

- Good communication and problem solving can only come from clear and objective thinking.

**Steps for Pulling Back**

1. Notice your emotional reactions and judgments.

2. "Freeze-frame" your reaction—put it aside.

3. Put your attention back on the other person.
Pulling Back—When Feelings Get in the Way of Listening

What behaviors, people, or situations trigger your emotions?

☐ I hear the same complaint over and over again.
☐ Someone refuses to take responsibility for a problem.
☐ I feel personally blamed or attacked and, therefore defensive.
☐ I get the sense that I am failing or have somehow messed up.
☐ The issue is too close to the bone for me.
☐ I’m blamed for something that isn’t my fault.
☐ I think the other person is lying.
☐ I know I’m right.
☐ I think one person is right and another is wrong.
☐ My idea is brilliant and the other person won’t accept it.
☐ I think this will go on forever and I don’t have the time for it.
☐ Someone’s behavior reminds me of my mother/spouse/ex…
☐ I’m tired, stressed, or just not in the mood.
☐ Others. ______________________________________________________

______________________________________________________________
______________________________________________________________

What do you usually do (what is your usual pull-back strategy) to calm yourself down? Identify one method to use in the moment and one to use to help you prepare for stressful situations. ______________________________________________________

______________________________________________________________
______________________________________________________________
Supervisory Role Plays for Pull Back and Paraphrase

The goal of these role plays is to practice pulling back and using paraphrasing to listen and gather information. Your challenge is to stay calm and gather information about what the real issue is, rather than becoming caught up in what a “difficult” person the worker is.

Read over the scenarios, and choose one to role-play with your group. Choose a scenario that resembles a situation you might encounter in your work environment. Here you will play the supervisor, and the instructor will play the worker.

1. The nurse supervisor says she asked the worker to come in because she is concerned that she has been getting to her assigned floor 5 to 15 minutes late all week. The worker says nothing is wrong and asks why is anyone complaining about a stupid 5 minutes.

2. The worker storms into the nursing office, demanding to know why she was pulled off her assignment. She claims the supervisor heard only the family member’s complaint and not her side of the story.

3. The worker comes to see the supervisor about needing to work part-time instead of full-time. She starts to cry and says she’s so stressed she can’t hold everything together but doesn’t know how she’s going to feed her kids if she cuts back.

4. The supervisor is explaining to the worker why she wrote her up, that a “no call / no show” always results in an automatic write-up. The worker says she knows other workers who have done worse things and never got written up. She says she knows the supervisor hates her and has always had it in for her.

5. The worker is a chronic complainer. She speaks in whiny tones about how exhausted she is, how she never gets a break, how nothing is going right in her life.

—continued, next page
6. You walk down the hall and see three call bells on. You stop a CNA and ask her why no one has attended to the call bells. She says, “Do I look like I have nothing to do? Why don’t you ask “do-nothing” Beatrice? Those are her residents, not mine.”

7. The worker says she has to quit. She looks upset but says she doesn’t want to talk about it; she just wants to know what paperwork she has to do.

8. The worker has a daughter who is homeless with a young child. The worker asks the supervisor for advice about how to help her daughter. When the supervisor says she feels badly for her and wishes she could help, the worker asks the supervisor to call shelters and rooming houses to find out their policies and decide which is the best place.
Supervisory Role Plays for Pull Back and Paraphrase

The goal of these role plays is to practice pulling back and using paraphrasing to listen and gather information. Your challenge is to stay calm and gather information about what the real issue is, rather than becoming caught up in what a “difficult” person the worker is.

Read over the scenarios, and choose one to role-play with your group. Choose a scenario that resembles a situation you might encounter in your work environment. Here you will play the supervisor, and the instructor will play the worker.

1. The supervisor says she asked the worker to come in because she is concerned that she has been arriving at her case 5 to 15 minutes late all week. The worker says nothing is wrong and asks why is anyone complaining about a stupid 5 minutes.

2. The worker storms into the supervisor's office, demanding to know why she was pulled off her case. She claims the supervisor heard only the family member's complaint and not her side of the story.

3. The worker comes to see the supervisor to ask for more hours. She starts to cry and says she can't feed her kids on what she's making.

4. The supervisor is explaining to the worker why she wrote her up, that a “no call / no show” always results in an automatic write-up. The worker says she knows other workers who have done worse things and never got written up. She says she knows the supervisor hates her and has always had it in for her.

5. The worker is a chronic complainer. She speaks in whiny tones about how exhausted she is, how she never gets a break, how nothing is going right in her life.

—continued, next page
6. You're doing a supervisory home visit, and the client seems particularly agitated and is complaining about her house being a mess. You go into the kitchen to ask the worker what has been going on and she says, “So you want me to be her maid, too? She doesn't want me to do anything on her care plan, and now you're asking me what the problem is? Are you the one who's going to give her a bed bath, big-time nurse?”

7. The worker says she has to quit. She looks upset but says she doesn't want to talk about it; she just wants to know what paperwork she has to do.

8. The worker has a daughter who is homeless with a young child. The worker asks the supervisor for advice about how to help her daughter. When the supervisor says she feels badly for her and wishes she could help, the worker asks the supervisor to call shelters and rooming houses to find out their policies and decide which is the best place.
Blocks to Listening

Listening is the most fundamental and important communication skill. A lot of the time, people look or act like they are listening, but they aren't really listening—they are pseudo listening.

Everyone does pseudo listening at times. Problems arise when good listening is important or when people do pseudo listening most of the time.

You can become more aware of your own pseudo listening if you notice the listening blocks you use. Being aware of listening blocks makes it possible not to use them or to use them less often.

Ten Common Listening Blocks*

1. Rehearsing—You can't really listen because you're practicing what you're going to say next. You may look like you're listening, but your mind is going a mile a minute because you've got a story to tell or a point to make.
   Examples:

2. Mind Reading—Rather than paying attention to what another person is actually saying, you're trying to figure out what he or she is really thinking or feeling. Mind readers make assumptions about what people mean and how people react to them, usually based on the peoples’ body language and other nonverbal cues.
   Examples:

*This material adapted from Matthew McKay, Martha Davis, and Patrick Fanning, Messages: The Communication Skills Book (Oakland, CA: New Harbinger, 1995).
Ten Common Listening Blocks—continued

3. **Comparing**—You have a hard time listening because you're trying to see who is smarter, more caring, more competent—you or the person speaking. You can't let in much because you're trying to see if you measure up.

   *Examples:*

4. **Filtering**—You listen to some things and not to others. You pay attention enough to hear only what you feel you need to hear, then your mind wanders. Or you may filter to avoid hearing things that are negative, critical, or unpleasant. It's as if some words were never said.

   *Examples:*

5. **Judging**—You dismiss others based on who they are or what they say. You aren't really listening but are having a knee-jerk reaction.

   *Examples:*

6. **Dreaming**—You are half listening, and suddenly the person's words trigger a chain of private thoughts. Your mind wanders, and you no longer hear what the person is saying. You can be prone to dreaming when you feel bored or anxious.

   *Examples:*

   —continued, next page
Ten Common Listening Blocks—continued

7. **Identifying**—A person's words remind you of something in your own experience, so now you're not listening to his or her words, you're thinking about what happened to you. Often you're just waiting for the person to finish so you can tell your own story.

*Examples:*

8. **Advising**—Before people get to what's really troubling them, you jump in with suggestions to solve the problem. Before they are finished talking, you are thinking about what to do.

*Examples:*

9. **Sparring**—You are quick to disagree—often listening only for points to argue with. This tends to happen when you have strong opinions on a subject. One type of sparring is the put-down, using sarcastic remarks to trivialize or dismiss another person's point of view. Another is discounting—running yourself down when you receive a compliment.

*Examples:*

10. **Placating**—You are nice, pleasant, and supportive but are not really listening. You will generally agree with what's being said, without really taking it in. In this mode, you may also be patronizing. This listening block is often used with children and older people.

*Examples:*
Identify your most common listening blocks.

1. ____________________________________________________________________________
2. ____________________________________________________________________________
3. ____________________________________________________________________________
4. ____________________________________________________________________________

Think about how these blocks come up for you, especially in the context of supervision.

What will help you be aware that you are using these blocks?

What strategies might you use to return to actively listening when you recognize that your listening is blocked but you want to really listen?
Handout 20: Role Play—Calling Out

Handout 21: Personal Styles Inventory
Role Play—Calling Out

The Actors
(in order of appearance):

Renee, a nursing assistant at Elmwood nursing home

Pamela, Renee's sister

Mrs. Brown, the day care provider

Johnny, Renee's boyfriend

Dr. Perry, the pediatrician

Vanetta, Renee's neighbor

Theresa Jones, 7-11 supervisor at Elmwood nursing home

Narrator

Activity Instructions

Renee and the narrator need copies of the entire script. Each of the other actors receives only the scene in which he or she appears.

The instructor playing Renee sits center stage. The narrator stands to one side with the other actors. When the narrator introduces each character, he or she joins Renee on stage. The actor reads his or her scene and then sits with the audience.
Scene One: Pamela

Narrator: Pamela, Renee’s sister, calls at 5:55 a.m.

Pamela: Renee, I am sick as a dog. I’ve been throwing up all night and I’m so weak I can hardly stand up. I’m sorry, girl, but there’s no way I can come over and watch the kids till the bus comes. You know I would if I could, right? I’ll talk to you later.

Renee: I’ll work something out. I’ll call the child care center.
Scene Two: Ms. Brown

Narrator: Ms. Brown, administrator at We Care Child Care Center answers the phone at 6:05 a.m.

Renee: Hi, Ms. Brown, it’s Renee Jenkins, Nicolle’s mom. I’m wondering if you would be willing to do me a big favor. When I drop Nicolle off this morning at 6:45, do you think you could also watch Gene and Marcella until school opens at 8? It’s just down the street and they can walk from there. I’d really appreciate the help, Ms. Brown. I need to be at work by 7, and my sister who usually comes to stay with the older kids can’t come today. Could you do that for me? I’ll pay you extra.

Ms. Brown: Ms. Jenkins, I’ll help you out this time, but you know you can’t make a habit of this. I can take only so many kids or I’ll lose my license. I already got a room full of kids sniveling and coughing who should by rights be home. But okay, bring them over this time. I’ll charge just $20 extra, but you’ll need to pay me in cash today. I got so much owing to me and all this damn welfare paperwork, sometimes I wonder why I stay in this business. But speaking of welfare, I was meaning to talk with you this evening, but seeing as I have you on the phone… According to the new regs, with what you’re making on both your jobs, you’re just over the limit for the child care subsidy. I need to tell you that from May 1st, your rate will go from $65 a week to $125 for Nicolle. I’m sorry to be the bearer of bad news, but I don’t make the rules. And it’s good you’re working, right? So, okay, I’ll see you and the kids at 6:45.
Scene Three: Johnny

Narrator: Johnny, Renee’s boyfriend, comes by at 6:15 a.m.

Johnny: Hey, girl, what’s up...you don’t look so good. Listen, I’m on my way to work and don’t have a lot of time, but I wanted you to know that I had my friend Bob, the mechanic, look at your car and he says if you take it to the shop it’ll probably cost close to $500, but he’s willing to work on it himself on his own time and it’ll only cost you half that—like $250, or at most $300. He says you can drive it the way it is, but you should have it taken care of soon, and he’s available the next two weekends. So give him a call. Good news, right? Hey, if you can get someone to watch the kids tonight, I heard there’ll be some good music at the club... Gotta run, see you later.
Scene Four: Dr. Perry

Narrator: The phone rings at 6:20 a.m., as Johnny is leaving. It is Dr. Perry, pediatrician at City Hospital.

Dr. Perry: Ms. Renee Jenkins? This is Dr. Perry over at City Hospital. We have the results back from the tests we ran on Nicolle when you brought her into the emergency room two nights ago. I would like you to bring her back in for additional tests. Her levels are high enough to cause concern, so we need to run more tests. No need for alarm, Ms. Jenkins, but given all her medical problems, we just need to be sure we know what’s happening with little Nicolle. So I need you to bring her in today, as soon as possible. Just stop at outpatient registration, and they’ll tell you where to go. Make sure you bring her in, Ms. Jenkins. Even if she isn't in pain right now, your child's health is important.
Scene Five: Vanetta

Narrator: The doorbell rings at 6:30 a.m.; it’s Renee’s neighbor, Vanetta.

Vanetta: Oh good, I caught you before you left. I wanted to give you the information about the job at the telemarketing company where I work. You know the deadline is this Friday. Look, I know you already have two jobs and you like them old people, but this job pays good and you just sit in an office. You don't need a car and all they're interested in is that you talk right. I know you'd get in. Okay, so I complain about the company all the time—they're evil and there are days if another person slams the phone down on me, I'll scream. But you get used to it, and after three months you get benefits and paid vacation and commissions on sales. The money is good, girl. And you look so tired and worn out all the time. Just read it, okay?
Scene Six: Theresa Jones

Narrator: At 6:40 a.m., Renee calls Theresa Jones, the 11-7 nursing supervisor at Elmwood Nursing Home, where Renee works as a CNA.

Renee: Hello, this is Renee Jenkins. I can’t come in today. I have some personal business I need to take care of. I’m sorry to call you just before my shift. I’m sorry, I gotta go.

Theresa Jones: Renee, do you have any idea how hard it is to find a replacement now for your shift? I just don’t understand you people. (Sigh) You know, Renee, this is the second time this week you’ve called out and that means you’re going to have to go into the office to see Margaret, the nursing supervisor on your shift. Make sure to get to the nursing office or call her later today. If she has to call you, that won’t be good, you know what I mean?
Role Play—Calling Out

The Actors
*(in order of appearance):*

Renee, a home health care aide for Compassionate Care

Pamela, Renee's sister

Mrs. Brown, the day care provider

Johnny, Renee's boyfriend

Dr. Perry, the pediatrician

Vanetta, Renee's neighbor

Theresa Jones, on-call coordinator at Compassionate Care

Narrator

Activity Instructions

Renee and the narrator need copies of the entire script. Each of the other actors receives only the scene in which he or she appears.

The instructor playing Renee sits center stage. The narrator stands to one side with the other actors. When the narrator introduces each character, he or she joins Renee on stage. The actor reads his or her scene and then sits with the audience.
Narrator: Pamela, Renee’s sister, calls at 5:55 a.m.

Pamela: Renee, I am sick as a dog. I been throwing up all night and I'm so weak I can hardly stand up. I'm sorry, girl, but there's no way I can come over and watch the kids till the bus comes. You know I would if I could, right? I'll talk to you later.

Renee: I'll work something out. I’ll call the child care center.
Scene Two: Ms. Brown

Narrator: Ms. Brown, administrator at We Care Child Care Center, answers the phone at 6:05 a.m.

Renee: Hi, Ms. Brown, it’s Renee Jenkins, Nicolle’s mom. I’m wondering if you would be willing to do me a big favor. When I drop Nicolle off this morning at 7, do you think you could also watch Gene and Marcella until school opens at 8? It’s just down the street, and they can walk from there. I’d really appreciate the help, Ms. Brown. I need to be at my case by 8, and my sister who usually comes to stay with the older kids can't come today. Could you do that for me? I’ll pay you extra.

Ms. Brown: Ms. Jenkins, I’ll help you out this time, but you know you can’t make a habit of this. I can take only so many kids or I’ll lose my license. I already got a room full of kids sniveling and coughing who should by rights be home. But okay, bring them over this time. I’ll charge just $20 extra, but you'll need to pay me in cash today. I got so much owing to me and all this damn welfare paperwork, sometimes I wonder why I stay in this business. But speaking of welfare, I was meaning to talk with you this evening, but seeing as I have you on the phone... According to the new regs, with what you're making on both your jobs, you're just over the limit for the child care subsidy. I need to tell you that from February 1st, your rate will go from $65 a week to $125 for Nicolle. I'm sorry to be the bearer of bad news, but I don't make the rules. And it's good you're working, right? So, okay, I’ll see you and the kids at 7.
Scene Three: Johnny

Narrator: Johnny, Renee's boyfriend, comes by at 6:15 a.m.

Johnny: Hey, girl, what's up? You don't look so good. Listen, I'm on my way to work and don't have a lot of time, but I wanted you to know that I had my friend Bob, the mechanic, look at your car, and he says if you take it to the shop, it'll probably cost close to $500, but he's willing to work on it himself on his own time and it'll only cost you half that—like $250, or at most $300. He says you can drive it the way it is, but you should have it taken care of soon, and he's available the next two weekends. So give him a call. Good news, right? Hey, if you can get someone to watch the kids tonight, I heard there'll be some good music at the club... Gotta run, see you later.
Scene Four: Dr. Perry

Narrator: The phone rings at 6:20 a.m. as Johnny is leaving. It is Dr. Perry, pediatrician at City Hospital.

Dr. Perry: Ms. Renee Jenkins? This is Dr. Perry over at City Hospital. We have the results back from the tests we ran on Nicolle when you brought her into the emergency room two nights ago. I would like you to bring her back in for additional tests. Her levels are high enough to cause concern, so we need to run more tests. No need for alarm, Ms. Jenkins, but given all her medical problems, we just need to be sure we know what’s happening with little Nicolle. So I need you to bring her in today, as soon as possible. Just stop at outpatient registration, and they’ll tell you where to go. Make sure you bring her in, Ms. Jenkins. Even if she isn't in pain right now, your child's health is important.
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Narrator: The doorbell rings at 6:30 a.m.; it’s Renee’s neighbor, Vanetta.

Vanetta: Oh good, I caught you before you left. I wanted to give you the information about the job at the telemarketing company where I work. You know the deadline is this Friday. Look, I know you already have two jobs and you like them old people, but this job pays good and you just sit in an office. You don’t need a car and all they’re interested in is that you talk right. I know you’d get in. Okay, so I complain about the company all the time—they’re evil and there are days if another person slams the phone down on me, I’ll scream. But you get used to it, and after three months, you get benefits and paid vacation and commissions on sales. The money is good, girl. And you look so tired and worn out all the time. Just read it, okay?
Scene Six: Theresa Jones

Narrator: At 6:40 a.m., Renee calls Theresa Jones, the on-call coordinator at Compassionate Care, where she works as a home care aide.

Renee: Hello, this is Renee Jenkins. I can't come in today. I have some personal business I need to take care of. You will need to find coverage for Mrs. Williams at 8, Mr. Henry at 11, and the new case, I think it's Ms. Aldridge, at 2. I'm sorry, I gotta go.

Theresa Jones: Renee, do you have any idea how hard it is to find a relief now for 8 a.m.? I just don't understand you people. (Sigh) You know, Renee, this is the second time this week you've called out, and that means you're going to have to go into the office to see Margaret, the home care manager. Make sure to get to the office or call her later today. If she has to call you, that won't be good, you know what I mean?
Personal Styles Inventory

Personal style encompasses the unique ways people perceive and approach situations, including how they communicate. Each of the four dimensions below can be represented by a line called a “continuum,” with the contrasting qualities (e.g., introvert and extrovert) lying at the ends. Most people place themselves along the continuum somewhere, rather than exactly at one end of the line, because they respond to some attributes of one quality and some of the other. Pay attention to the items below that elicit in you the strongest responses—chances are you are closer to that end of the continuum.

This exercise is designed to give you insight into your own way of being in the world. Each person is unique, and no position on the continuum is right or wrong, better or worse. The goal is to better understand yourself and your position on the continuum; you might also imagine where you’d place family members and friends on the line. In this way, you can come to appreciate differences in personal style and become aware of how you might be triggered by or judge others whose personal style is different from yours. Different styles are just that—different, not better or worse. Once you are aware of this, it becomes possible to change your approach and communicate more effectively with people who are different from you. This is especially important in coaching supervision.

Here are four dimensions of personal style. For each dimension, imagine a line with the poles on either end of the line. Based on the descriptions on the following pages, Where would you stand?

- **Introvert** ———————— **Extrovert**
- **Big-picture oriented** ———————— **Detail oriented**
- **Feeler** ———————— **Thinker**
- **Present oriented** ———————— **Future oriented**
### Introvert
- Prefer to think alone to solve a problem or deal with a situation.
- Am reserved or shy in social situations.
- Become easily absorbed in internal process (my own thoughts) and less tuned in to others.
- Am often quiet and focused on a task.
- Like working alone.
- May dislike being interrupted.

### Extrovert
- Prefer to work though a situation or problem by talking it out with others.
- Am outgoing and enjoy social situations.
- Am interested in pleasing others.
- Enjoy variety and choose relationships first, tasks second.
- Like working with people.
- May become impatient with long, slow tasks.
- Don't mind being interrupted.

### Big-Picture Oriented
- Need to know the overall picture before focusing on specific details.
- Like ideas, concepts, theories.
- Become bored with nitty-gritty details and facts.
- Am intuitive, making decisions based on gut feelings rather than facts.
- May leave out or neglect details or make errors of fact.

### Detail Oriented
- Need to know facts and specific details before focusing on the overall picture.
- Like the concrete, real, factual, tangible.
- Become impatient with theory, abstract ideas, or concepts.
- Think in careful, detail-by-detail accuracy, making decisions based on all the facts.
- May miss the big picture.
<table>
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<tr>
<th><strong>Feeler</strong></th>
<th><strong>Thinker</strong></th>
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| ■ Make decisions about people and life based on feelings—compassion, warmth, personal values.  
■ Get along well with people.  
■ Care about others’ feelings.  
■ Am swayed by feelings rather than rational argument.  
■ Like conciliation and harmony. | ■ Make decisions about people and life based on rational thinking—logic, factual evidence, not personal values or others’ feelings.  
■ May step on others’ feelings without realizing it.  
■ Am swayed by rational argument rather than feelings.  
■ Can tolerate interpersonal conflict. |

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<tr>
<th><strong>Present Oriented</strong></th>
<th><strong>Future Oriented</strong></th>
</tr>
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</table>
| ■ Prefer to be spontaneous, in the moment.  
■ Like to see all sides of an issue; am okay with changing my mind.  
■ Am comfortable changing goals based on new information.  
■ May become involved in many tasks or activities at the same time.  
■ Am uncomfortable with closure, definite endings. | ■ Like to plan, think about the future.  
■ Am firm, clear, sure. Prefer to make a decision and stick to it.  
■ Set goals and work toward them.  
■ Like to finish one task before moving on to the next. Don’t often look back.  
■ Like closure, clear endings. |
Handout 22: Three Rules for Presenting the Problem

Handout 23: Guidelines for Presenting the Problem

Handout 24: Practice in Presenting the Problem
Three Rules for Presenting the Problem

1. Be clear and direct about what the problem is.

2. Use objective language free from blame or judgment.

3. Indicate belief in the worker’s ability to resolve the problem.
Guidelines for Presenting the Problem

1. **Describe the behavior—don't pass judgment on it.** For instance, rather than saying, “You are too slow,” say, “I noticed that you spent an hour entering that data in the computer. If you spend that long, there won’t be time for your other tasks. What do you think you can do about that?”

2. **Be specific rather than vague.** For instance, rather than saying, “You seem like you have an attitude about doing this,” say, “When I asked you to do this, you frowned and rolled your eyes. Can you tell me what that was about?”

3. **Describe what you observed rather than what you assume to be the reason it happened.** Focus on what happened rather than why you think it happened. Offer an explanation only if you know for certain it is true.

4. **Focus on a behavior rather than the person.** For instance, rather than saying, “You are incompetent,” say, “You did not perform that task to the standard we require.”

5. **Don't avoid presenting the problem.** Don't say, “I just wanted to check in about how things are going” if you really want to address a problem behavior or situation.
Practice in Presenting the Problem

Provide another, more effective, way of presenting the following problems to a worker:

1. You know you should always check the schedule to see if there are any changes. Why the hell didn’t you?

2. You need to quit yelling at Mrs. Smith. You can't speak to a resident’s family members that way.

3. You are bossy and controlling and have a negative impact on everyone on your shift. Maybe no one else will say it; I’m just telling the truth.

4. You clearly don't care about your residents. You're just here for a job, and I’m sick of moving you from floor to floor because of resident complaints.

—continued, next page
5. You have called out at the last minute three times this month. I am beginning to think you have a problem with work ethics.

6. We’ve been over this before. You said you knew how to use a hoyer lift, but that doesn’t seem to be the case.

Notes:
Practice in Presenting the Problem

Provide another, more effective, way of presenting the following problems to a worker:

1. You know you should always check the schedule to see if there are any changes. Why the hell didn't you?

2. You need to quit yelling at Mrs. Smith. You can't speak to a patient's family members that way.

3. You are bossy and controlling and have a negative impact on the team. Maybe no one else will say it; I'm just telling the truth.

4. You clearly don't care about your clients. You're just here for a job, and I'm sick of covering for you.

— continued, next page
5. You have called out at the last minute three times this month. I am beginning to think you have a problem with work ethics.

6. We've been over this before. You said you knew how to use a hoyer lift, but that doesn't seem to be the case.

Notes:
Handout 25: Coaching-Based Performance Improvement Model

Handout 26: Coaching Supervision Role Plays

Handout 27: Requirements for Successful Coaching

Handout 28: How Coaching Saves You Time
Coaching-Based Performance Improvement Model

Create a Relationship with the Worker

- Identify any personal emotional triggers or listening blocks; use a pull-back strategy
- Find a good time to raise the issue
- Indicate interest and belief in the worker
- Use an inviting and encouraging tone of voice

Present the Problem

- Be clear and direct about what the problem is
- Limit the statement to a single problem (not a whole litany)
- Use objective language free of blame or judgment
- Emphasize the wish to resolve the problem positively
- Indicate belief in the worker's abilities, including his or her ability to resolve problems
- Reinforce the positive by pointing out the worker's specific accomplishments and successes
Listen for the Worker’s Perspective

- Put aside your own agenda while listening
- Listen actively to understand the worker’s perspective
- Acknowledge the worker’s perspective
- Paraphrase and use open-ended clarifying questions

Resolve the Problem with the Worker

- Maintain a focus on work-related behaviors
- Reach mutual agreement on the nature of the problem
- Develop strategies together to address the problem

Obtain Commitment to Action Steps

- Make mutual commitments for specific, measurable action steps
- Follow through on commitments
Coaching Supervision Role Plays

1. Ann has worked at the nursing home as a certified nurse assistant (CNA) for nine months. Up until now she has had no problems following policies and procedures. Ann approaches you in the morning and tells you that Mrs. Gray fell yesterday when she was transferring her from the toilet to her wheelchair. You question her about the delay in reporting and she states that she thought Mrs. Gray was going to tell you herself if she felt pain.

The home’s policy is that a worker be given a written warning for jeopardizing a client’s safety and not reporting a situation. You are curious about what happened for Ann in this situation, and you want to let her know the impact of not telling you immediately.

2. You’re working at the nurses’ station and are on the phone with a doctor getting an order when Brenda, a young CNA, stands in front of you, tapping her fingers and sighing loudly. When you look up, she says she needs to speak with you immediately. While you are still on the phone, she starts telling you how urgent it is that she speak with you. Brenda has had a pattern in the past of demanding immediate attention for things that feel critical to her but are relatively insignificant to you.

You finish your call and focus your attention on Brenda. You want to let her know it is not appropriate to interrupt you while you are on the phone, and you want to be able to listen to what she has to say.

3. It’s 2:45 on Friday, you have all the weekend shifts covered after working feverishly to get replacements for all the CNAs who called-out over the past three hours—and you can leave on time for once! You get a call from Cynthia who says she is sorry to be calling out so late but there’s no way she can work the 3-11 shift tonight. It’s her daughter’s First Communion on Sunday, and there is just too much to do.

Cynthia is a great CNA, very dependable, very caring with her residents. She is scheduled to work on the most challenging floor and no one else works there as well as she. You want to be able to empathize with her and see what’s underneath her last-minute call. At the same time, you want to let her know how difficult it will be to fill her shift at this point.

—continued, next page
4. You asked Lisa, a CNA, to come speak with you in the nursing office. She has been working at the home for about three months and up until now had no problems working with other aides. But in the past two weeks, three CNAs have complained to you about Lisa’s not pulling her weight, and this morning you heard her refuse to help another aide transfer a resident.

You want to hear what is going on for Lisa, and you want her to understand the impact of her negative behavior on the team.

5. Mary has been working at the facility just short of six months. Her job performance has been satisfactory with no major problems reported.

Mary’s schedule is to work every Saturday and have Sunday and Monday off. She had been doing this with no problems up until now. She is aware that she has to request Saturdays off in advance if she needs to do this, but yesterday (Saturday) she was a “no call/no show.” In your telephone conversation with her, she stated that according to the handbook, she is only required to work “every other weekend.”

You’ve asked her to meet with you first thing Tuesday morning—you must give her a written warning for the no call/no show. This is your first direct experience with Mary, and you’d like to help her avoid a similar situation in the future.

6. You are the nurse supervisor and are doing rounds on the dementia floor. You walk past a room with the door wide open. You can’t help but see Mrs. Beetle is in her underwear, wet, and asleep in the shower chair in the middle of her room. Looking down the hallways and in the bathroom, you fail to see an aide or nurse around. You wake up Mrs. Beetle and help her put a shirt on. As you are about to put on her sweatpants, Rhonda, a CNA, walks in and seems surprised and embarrassed at your presence. She offers no explanation but proceeds to put Mrs. Beetle’s sweatpants on her.

You want to let Rhonda know that this behavior is problematic, and you want to find out from her what was going on that Mrs. Beetle was left in that condition.
Coaching Supervision Role Plays

1. Ann, a home health aide (HHA), has been with the company for nine months. Up to now, she has had no problems following policies and procedures. You receive a call from Ann in which she states that her client fell two days earlier. When you question her about the delay in reporting, she states that she thought the client's daughter was going to call the agency.

You've scheduled a meeting with Ann. Company policy requires that a worker be given a written warning for jeopardizing a client's safety and not reporting the situation. You are curious about what happened for her in this situation, and you want to let her know about impact of not calling.

2. You're working at your desk, on the phone with a client, and HHA Brenda is standing in front of the desk, tapping her fingers and sighing loudly. When you look up, she says she needs to talk to you. While you are still on the phone, she starts telling you how urgent it is that she speak with you. Brenda has had a pattern in the past of demanding immediate attention for things that feel critical to her but are relatively insignificant to you.

You finish your call and focus your attention on Brenda. You want to let her know that it is not appropriate to interrupt you while you are on the phone, and you want to be able to listen to what she has to say.

3. It's 4 pm on Friday and everything is set for the weekend. You are scheduled to leave at 4:30 pm. You get a call from HHA Cynthia saying she is really sorry to be calling so late but there's no way she will be able to work this weekend. It's her daughter's First Communion, and there is just too much to do.

Cynthia's client, Mr. Smith, loves her and generally refuses to be cared for by aides he doesn't know. You want to be able to empathize with Cynthia and see what's underneath her last-minute call. At the same time, you want to let her know how difficult it will be to fill this case at this point.

—continued, next page
4. You have scheduled a meeting with HHA Lisa. She has been on the job for close to three months and, up until now, had no problem with attendance or call-outs. But in the past two weeks she has called out twice for “family emergencies,” and she has refused case assignments on two other occasions.

You want to hear what is getting in the way of Lisa’s ability to reliably show up on the job, and you want her to understand the impact on clients and the agency of her calling out and refusing cases.

5. HHA Mary has been working with the company just short of six months. Her job performance has been generally satisfactory.

Mary was assigned to a case that required her to work every Saturday and have Sunday off. She accepted the case with this understanding. She was also instructed that she was required to make a request in advance if she needed a Saturday off. The previous Saturday, Mary was a “no call/no show.” In your telephone conversation with her, she stated that according to the handbook, she is only required to work “every other weekend.”

You’ve scheduled a meeting that will result in a written warning for the “no call/no show.” This is your first direct experience with Mary, and you’d like to help her avoid a similar situation in the future.

6. You are the nurse supervisor, doing a supervisory home visit with HHA Rhonda. When you arrive at the house, the front door is wide open. The client is asleep in a chair in the living room. You check her vitals, and she seems okay, but you don’t see Rhonda anywhere. After 5 minutes or so, Rhonda comes running into the house and seems surprised and embarrassed to see you. She offers no explanation but proceeds to the kitchen to clean the lunch dishes.

You want to let Rhonda know that this behavior is problematic, and you want to find out from her what is going on.
Requirements for Successful Coaching

Belief in a worker's capacity to succeed on the job.

- An open mind about the person
- Interest in the person, in understanding his or her reality

Time to reflect and meet individually with workers.

- Private setting
- Careful timing
- Distractions minimized

Skills to use in coaching supervision.

- Active Listening
- Self-Management—Pulling Back Emotionally
- Self-Awareness
- Presenting the Problem
How Coaching Saves You Time

- Relationships with workers will become stronger and more positive and rewarding. As a result, most interactions will go more smoothly and quickly.
- Small problems will be caught earlier, before they develop into big ones.
- Fewer problems will arise.
- Problems that do arise will be resolved more quickly and effectively. (The worker is less likely to return the next week with the same problem.)
- More workers will remain in their jobs; you will be supervising more experienced workers who understand the rules and are comfortable with them.
- Coaching is a mentoring process that encourages workers to think more critically and solve problems on their own. After several months of coaching, workers take more responsibility for their actions and require less supervisory time.

Less supervisory time spent on discipline, termination, turnover, and orientation of new aides.
Handout 29: Evaluation Form
Coaching Supervision: Introductory Skills for Supervisors in Home and Residential Care

Evaluation Form

1. What were the highlights of the seminar for you?

2. What would you recommend that we change if we offer this seminar again?

3. What did you learn that feels new or significant to you about the role of a supervisor of direct-care workers?

4. What did you learn about the coaching approach to supervision that feels new or significant to you?

5. What did you learn about yourself?
6. Did you feel comfortable with your own level of participation?

7. Did you feel time was used effectively? Was there enough time for the activities?

8. Please comment on the leadership of the presenters.

9. What plans do you have to use the material presented at this seminar? Please provide as much detail as you can.

10. What problems or barriers do you think you might encounter in using a coaching approach to supervision?

11. What support do you think you might need to effectively implement a coaching approach to supervision?

Optional Information

Name_________________________________ Job Title _______________________________
Organization __________________________________________________________________
Length of time in current job____________________________________________________
Dementia Grant Kick Off
Created for Village Care of New York
By PHI (www.PHInational.org)

Held on: March 27th, 2006
From: 9:00 am - 4:00 pm

It is important to note that this training was designed specifically for Village Care of New York as part of their Dementia Grant Project: Developing a Person-Centered Therapeutic Recreation Dementia Program. PHI, as the consulting organization, conducted site-based assessments of Village Care Nursing Home and Chelsea Adult Day Health Center to inform the design of this and subsequent trainings.

Goals:
Today’s training will help to build:

- Stronger connections between participants-- across organization levels, departments, programs and shifts;
- Excitement around the NY DOH Dementia Grant and working with each other in different ways;
- Understanding of the grant and various components of it;
- An awareness of and a common understanding of “person-centered care” and how it relates to people with dementia;
- A creative look at how activities can be carried out in the two settings;
- A different perspective on language and how it affects residents/clients.

Preparatory steps for this workshop to happen successfully:

- Place on each table: Name tents, markers, index cards/sticky notes, pens, paper, folders (for each participant)
- Write on a flip chart the following: Intro Questions, Goals for the Day, Words for language game, Sentence for language game (The latter two are found in Getting Started: A Pioneering Approach to Culture Change in Long Term Care Organizations.)
- Set up the Clothesline
- Prepare the “pairs” name tags for the first activity
9:00- 10:00 Opening Activity/Icebreaker/Introductions

1. Play energizing music in the background; facilitator to play a “DJ/MC” role that gets people’s energy up through dance and song (we suggest the tune: What’s your flava? By Craig David.) In addition to dance, have participants call out their favorite “flavor” – whatever that may be. The MC informs the group that as the other facilitator circulates, they will be given an index card with a word written on it.

2. The MC/DJ ends the song when the other facilitator has successfully distributed the index cards.

3. Welcome everyone and thank them for the energetic participation so far. Before reviewing the agenda, and doing formal introductions, explain that on their card is a word that is one-half of a well-known or logical pair, for example, “Peanut Butter” of “Peanut Butter and Jelly.”

4. Explain that this training, and the training they will be receiving throughout the course of the grant, will be interactive and at times surprising. The first surprise is that they are going to sit with new people, make new relationships, and the first step will be right now.

5. Ask everyone to look at their index cards, gather their belongings, and find their logical/well-known partner based on the word on the index card. This means they will have to stand and move to a different location. Once found they should find a new place to sit.

6. Turn to the pre-written flip chart page, and once everyone has settled again, tell participants that they will now interview their partners using the questions posted. They will have 3 minutes to interview their partner and they will be introducing their partner to the group using the information gained (total: 6 minutes for this part of the activity). Explain that they will only be asked to share a few points from the interview, not the whole thing. They don’t need to write information down, but they can if they wish.

Flipchart:
What do you like to be called here at the nursing home, and at home?
What motivated you to enter this work?

What gifts or talents do you have, that others may not know about you?

Describe a life-defining moment, a moment that illustrates who you intrinsically are. It could be personal or work related.

7. After the time has passed, ask participants to introduce their partner to the group and continue to do so until everyone has been introduced.

8. Trainers will follow the same format, introducing their co-trainers with the same kind of information.

10:00-10:15       Overview of the day
  1. Thank everyone for participating in interviews and for being so welcoming.

  2. Review the goals for the day and distribute the agenda.

Flipchart:
Our goals of the day:
Get to know each other better—the grant is based on a team effort!

Learn about the grant/project.

Define person-centered care.

Come to a common understanding about the word “activity.”

Develop understanding of how language creates a person-centered environment.

Have Fun!

3. Review timing, breaks, cell phones, beeper policies.

4. Engage the group to come up with the day’s “working agreements.” Working agreements set the tone that everyone is responsible for their own learning. To generate working agreements ask participants to share what they’d like from the group and from the facilitators that would help
them stay focused and help them learn best. For example, a participant might share, or you might start off with, “I learn best when people don’t have side conversations” or “I learn best when I can ask questions.” The facilitator in turn writes the agreement on a flip chart page as such: No side conversations; questions are welcomed. After the list is exhausted (no more that 10 minutes) ask the group to agree to try to adhere to the rules set forth. Set the tone of “trying” rather then “perfecting” because no one is perfect!

10:00-10:45 Logistics of the Dementia Grant, Q and A

1. In the front of the room, preferably on a stage, set up a “talk show” type atmosphere. One facilitator will be the “host” of the show, while the other will be “in the audience” fielding questions; this second facilitator will also be responsible for putting on flip chart questions that “need some research” at this time.

2. The host should play up the role, wear a wig, have a microphone, speak with an accent, if possible. The idea is to make it a light/inviting tone.

3. The host invites the project manager (the person in the Dementia Grant) that has the most amount of information on the grant to join him or her on stage.

4. The host makes some small talk chit-chat, and asks about her energy around the grant, what she’s looking forward to, etc.

5. Then the host turns to the audience and asks for questions about the project/grant. The dialogue continues in this fashion. Note: Beforehand, the host should have prepared a running list of questions, in case a shy audience comes to the ‘show!’ Some questions might be:

   Interview questions:
   - What is the dementia grant? Do you have the funding?
   - What are our goals? What is the timeline? Who are the players?
   - What should staff expect? What are the trainings about? Where will they be?
   - How do you see this affecting residents and clients?
   - How does this project fit into the bigger vision of the organization?
• How will this affect nurse, C.N.A., and other jobs at the organization?

6. After these questions, the host and the facilitator in the audience turn the show around to ask the participants the following questions:

To the audience questions:
• What excites you about this grant/project?
• Knowing a little more about this project, what else do you think we should think about?
• What are your thoughts?
• What are you willing to share (talents, time, etc…) to help this succeed?

7. After about 40 minutes or until all questions have been answered, end the “talk show” and ask for a round of applause. Also provide participants with the correct place to go if they have additional thoughts/questions.

10:45-11:00 Break

11:00-12:00 Understanding Person-Centered Care

1. Distribute to or show participants the picture (Wheatfield with Crows by Vincent Van Gogh) but don’t give any identifying information about it. 

   NOTE: This picture can easily be found online by googling: Wheatfield with Crows; Vincent Van Gogh. One source is: http://www.vggallery.com/painting/p_0779.htm

2. Ask participants for immediate reactions to it, what do they see, what do they think about it?

3. After a few minutes, if participants have been “assigning” meaning to the painting or to the painter who painted it… point out how easy it is to make assumptions and guesses about something so simple, in such a short period of time.

4. Reveal that the painting is one of Vincent Van Gogh’s last paintings prior to committing suicide. Ask participants to Look at the picture again:
   • What is happening for you?
   • Has anything changed when you look at it now?
   • Do you see anything that you didn’t before?
5. Connect responses to seeing the clients and residents
   - We often make an immediate diagnosis based on the way the person appears: what we see, smell, hear
   - We often treat the person based on their diagnosis or history;
   - We make meanings of their life
   - We make the assumption that because they are here, they want and need the help we know how to provide;
   - We assume that we have answers to their questions and processes to address their needs

6. Explain that sometimes in long-term care, we look at people and their needs based on what we can offer; and/or what we think we know from looking at them. Oftentimes organizations function on one set routine, protocol, model, care plan, and we try to fit people into categories. Explain that this organization is trying to change that by adopting “person-centered care.” Related to the picture: we are going to look beyond the picture to ask questions and be curious, to know the person not the image in front of you.

7. Explain that in a person-centered care model, you are trying to assume nothing and create care, activities and services based on the individual in front of you at the moment, not necessarily what you know about their condition.

8. Write on a flip chart the words: Person-Centered Care and ask the group to brainstorm: What does it mean to be person-centered?

**Personal Routine:**

9. Conduct the exercise: My Personal Routine; found in Module 4.8 of *Getting Started: A Pioneering Approach to Culture Change in Long Term Care Organizations*. This manual can be found online: pioneernetwork.org

**Person-Centered Care Scenarios**

10. Distribute the person-directed care continuum. Review the points on it.

11. Distribute the Person-Centered Care Scenarios. Assign each table (given about 4 people at a table) 2 practices to explore. Their job is to look at the practice and determine where on the continuum they would place it.
12. In the front of the room set up a clothesline between two points and put lots of clothes pins on it. Indicate which end of the clothesline is “Person-Directed” and which is “Staff-Directed.”

13. After 10-15 minutes, ask groups to report out by reading their scenario to the group and where they have determined the practice to be on the continuum. After they’ve explained their reasoning give the audience an opportunity to weigh in with additional thoughts. Have the group pin the practice on the clothesline.

14. Continue until all groups have reported out. End by explaining, that the first step is recognizing, being aware of where something may fall on the continuum, and that in every activity that the organization engages in, the goal should be to move more towards the right (person-centeredness). Also remind participants that moving right takes effort, time, commitment and energy. It is journey, not a sprint.

12:00-1:00 Lunch

12:45-1:00 Energizer/ Team Builder
- After lunch is a perfect time to do a team building, energy building activity. There are many books on the subject. We suggest choosing an energizer, e.g. “Peculiarities” from a book like: 201 Icebreakers: Group Mixers, Warm Ups, Energizers, and Playful Activities. It was written by Edie West, and published by McGraw Hill in 1997.

1:00-2:30 Defining Activities, Getting creative
1. Ask: In the setting you work in, how would you define the term “activity”? Put the responses on a flip chart.

2. When it comes to your own home life, how would you answer the same question?

3. Look back at the Personal Routine. Could any of what you do be considered an activity?

4. Explain that when we are talking about “activities,” it is not necessarily talking about elaborate programs, art projects, games/bingo… we are
including things that people do everyday, bringing those things back into the nursing home/day center. (We believe these are enjoyable, meaningful activities; we are just enhancing what already exists by looking what people do every day.) Further present that people with dementia often have difficulty with newness and change. At times new activities that they have not done before cause undue anxiety, fear, and stress. They often can’t or don’t want to grasp new information. This is actually true for a lot of people, even without dementia!

5. Give each table, a myriad of different everyday household objects: napkins, washcloths, needle/thread/cloth, magazines, socks, potato peelers, CDs/cassettes, puzzles, kitchen utensils (masher/spatula), paper/pen/notebooks, books, letters/envelopes/cards, deck of cards, markers/supplies, rags, photos/albums, etc. An alternative to putting it on the table, would be to put the items in a large bag and have each team/table pick 3 objects.

6. Instruct the teams to come up with activities they can do with residents using what is in front of them. Remind the group to think of things they might do on an everyday basis.

7. After 10 minutes, have the groups share what they came up with.

8. Remind the group, this is just a taste of what is to come in the dementia grant program: making everyday activities, simple, easy, familiar and accessible.

2:30- 2:45       Break

2:45-3:30       The Words We Use

1. Explain that a major barrier to making a person-centered environment is keeping the language from the medical/institutional model of care.

2. Conduct the exercise: The Words We Use; found in Module 4.12 of Getting Started: A Pioneering Approach to Culture Change in Long Term Care Organizations. This manual can be found online: pioneernetwork.org
3:30  **Wrap Up**

1. Explain the next steps in the project
2. Turn the music back on and play something lively and fun. We suggest “Let’s get started” by the Black Eyed Peas.
3. Thank everyone for coming and invite comments and the opportunity for participants to share what they learned in a fun, upbeat way.
Village Care of New York and the Paraprofessional Healthcare Institute welcome:
The Chelsea Adult Day Health Center and the Third Floor of the Village Nursing Home
To the Department of Health Funded
Dementia Grant Kick Off!!!
Monday, March 27th, 2006

Agenda for today’s events:

9:00 a.m.
Opening Ceremony

10:00 a.m.
Overview of the initiative
Getting to know one another

11:00 a.m.
Jumpstart into Person-Centered Care

12:00 Noon
Lunch and Energizer

1:00 p.m.
Getting Creative about Activities

2:45 p.m.
The Language Game

3:30 p.m.
Wrap Up, Q &A, Next Steps
Your role as the leader of the group is to:
1. Find a Reporter for the group (ask someone or have someone volunteer)
2. Read (or have someone else read) each scenario aloud
3. Ensure that everyone’s voice is heard
4. Decide if practice is
   - Staff-directed
   - Individual is considered
   - Person-Centered
   - Person Directed
   Or somewhere in between two of the above; and tell us why you chose that option
5. If it is not Person-centered or Person-Directed, what would you do differently to make it thus?
Person-Centered and Directed Practices
Varying Degrees of Choice and Autonomy

Person Centered and Directed Practices
(Begins somewhere between Consideration of the Person and Person’s Choice)

Staff Directed
(agency scheduled routines/staffing dictate care provision)

Consideration of Individual
(seek person’s input and tailor some aspects)

Person Centered
(Offers choices of food, walking, bathing etc.)

Individual Control
(have right of refusal and right to take risks)

Person Directed
(Individual has primacy -- determines own schedules, activities, meals, and caregivers)

Degree of Person-Centeredness and Directedness

Adapted from work done by the Lewin Group
BATHING

Mrs. Green moved into room three bed B this morning. Upon her arrival, her nursing assistant introduced herself to her and asked her some questions in order to get to know her better. Amongst the questions she asked were her bathing preferences. Did she prefer a bath or a shower? Mrs. Jones stated that she preferred baths and further stated that she had brought her own moisturizing soap as her skin tends to be dry. The nursing assistant let Mrs. Jones know that she would receive her bath on Monday and Thursday mornings at 10:30 AM and that she would include her special soap as an intervention on the care plan.
Mrs. Brown moved into room three bed B this morning. Upon her arrival to the nursing home her nursing assistant spent time with her by asking her about her interests, talents and usual daily routines. During this time, the nursing assistant learned that Mrs. Jones was in the habit of bathing one time per week in the bathtub, and has been going to the hairdresser every two weeks to have her hair washed and set. Mrs. Jones further stated that she always bathes before going to the hairdresser, and that she would like to continue that practice while living at the nursing home. The nursing assistant put all of this information into Mrs. Jone’s care plan in order to ensure her routine from the community could continue in the nursing home.
Dining

Caring Hearts Adult Day Health serves meals at 9 AM, noon, and gives clients a take-home snack at 3:00 PM. Clients that are independent eat in the dining room while clients requiring assistance eat in the activity room. Clients who do not prefer the main meal are offered a sandwich (tuna or cheese). The center uses plastic utensils and plates because one client has attempted suicide using a butter knife in another program, years ago.
Dining

Clients at Perfect Partners Day Center are able to bring their lunch from home or can eat the center’s main meal (or alternative). There is a refrigerator for client’s who prefer to bring their own food. The Center’s freshly cooked food is placed in large bowls with easy to grip serving spoons and then placed on the tables. Higher functioning clients and staff members bring the food to the tables which have tablecloths, salt and pepper shakers. All staff members (from all levels) have assigned tables and assist in serving the food to the clients. Staff members trained in assisting clients during mealtimes (c.n.a’s and nurses) are assigned to tables where their help is most needed. Staff members are encouraged to eat with the clients, and may arrange to eat the center’s delicious food at a nominal cost.
Dining

Clients at Sweet Home Adult Day Health Center order lunch from a menu each day. There are three options at each meal, with the menu changing daily. The meals are planned on a monthly basis by a volunteer group of clients and family members- during the nutrition group. There is also another group of clients who go with the ‘chef’ to the local market for fresh vegetables and specialty items on a weekly basis. Food is served on an eclectic mix of plates and silverware adorn the tables- as family members and clients are encouraged to donate used (but not valuable) dishes and utensils to make the atmosphere more ‘homey.’ Any broken plates are sent directly to the craft department for use in mosaic art projects.
Activities

The Merry Meeting Place Adult Day Care Center offers services from 8:00 AM to 6:30 PM at night. Activities run around the clock beginning at 10:00 AM, with new ones beginning on the hour, every hour until 4:00 PM. The ‘great hall’ is divided in half- with one side primarily reserved for dining. The dining area also has a television for clients who do not participate in the main activity being given at the time and during the times when clients are waiting to be picked up.
Activities
The In-Check Adult Medical Day Center offers scientifically tested, therapeutic interventions for clients needing care during the day. Interventions include finger painting class, puzzle hour, movie time, remembrance group, ballroom television, and imagination nation (guided meditation to different parts of the world.) The hour long groups are held in the main dining room. Professional staff members are trained in using techniques to persuade even the most stubborn clients to participate, so that clients leave with a sense of fulfillment and are able to sleep at night having spent some energy during the course of the day.
Activities

The Community Connection Adult Day Center offers a variety of activities for clients to engage in over the course of the day. There are at least 2 groups for clients to choose from; clients not wishing to attend group can use the ‘family room’ which is equipped with a television, books, puzzles, magazines, and a working aquarium. Other clients opt to assist in the daily life of the Center by setting up for lunch, sweeping, dusting, hanging pictures, and even some cooking. There is actually a ‘meal prep’ group for higher functioning clients 2 times a week. Each month staff members discuss the activities with family members and clients to see if the groups are enjoyable and meeting their needs.
Activities
The Gathering Place, is an ‘alternative’ adult day center where clients are encouraged to create their own activity routine each day. The center only accepts high-functioning elders looking to spend their day with people with similar interests. Each morning, staff members ‘survey’ the group to see what activities will be offered that day; staff members are also allowed to offer suggestions. Activities with the highest number of votes from the group of clients and staff members present are scheduled, and the day begins. This process takes about an hour each morning, but clients are served breakfast while it is happening. While the votes are tallied and schedule/staffing are arranged clients have about 20 minutes to socialize independently. An average of 3 groups run at one time, and clients not interested in the specific group may choose an individual activity to engage in.
Care Assignments

The nursing assistants at ABC nursing home punch in at the time clock and check the bulletin board next to the time clock for their scheduled unit. The scheduling coordinator posts this daily schedule each morning. Upon reporting to their posted units, the charge nurse gives each nursing assistant their assignment after giving report.
Care Assignments

The nursing assistants at JKL nursing home held a team meeting to begin self scheduling and consistent assignments concurrently. They learned from the residents on their unit what time they wanted to wake up, eat, etc. They created their schedules based upon their own availability and the times at which the residents needed their support. They created their assignments based upon their existing relationships with the residents.
Admissions

ABC nursing home has eliminated the word admission from their daily language as it is associated with illness and institutions. Instead, they met with their resident council and designed a process to help residents “move in” to their new home. With each planned move, the environmental services staff go to the resident’s home in the community and help pack personal items, furniture, photos etc. that the resident would like to decorate her new bedroom with. Upon arrival to the nursing home, staff and residents greet the new elder and begin establishing relationship. The first hours are spent unpacking, and getting settled into personalizing the elder’s room. After this is complete, the nurse assesses the resident and completes the required paperwork.
Death and Dying

GHI nursing home offers a memorial service each quarter. There is a memory board prominently posted in the home that identifies individuals who have passed away in the home during the quarter. At the time of the memorial service, family members of the residents who passed away are invited along with staff and friends. A single rose is placed at the front of the room in honor of each person who passed away.
Death and Dying

After getting to know the residents, the social worker at XYZ nursing home will meet with each person individually and ask them how they would like to be honored upon death. The social worker offers the option of a personal memorial service within one week of the individual’s death held at the nursing home in the chapel, offers to share an obituary in the home’s newsletter and bulletin board and asks for other suggestions from the resident. ABC nursing home also has a procedure to help the staff grieve the loss of a resident. Whenever an individual passes away, the staff hold a learning circle where each person speaks in turn sharing their feelings regarding the loss.
Enhanced Communication and Problem Solving Training  
Starring “The 3Ps” 

Facilitator Guide and Handouts

Welcome and Introductions (15 minutes)
1. Go around the room and ask participants to introduce themselves by sharing (Flipchart):
   - Name and where they work
   And choose one question to answer:
   - How they got their name/ interesting story behind it;
   - Something interesting or unusual about themselves;
   - Birthday
   - Favorite holiday and why
   - Favorite pass time

2. Facilitators introduce themselves (using same questions) and explain their role in this training; Talk briefly about Why this training, Why now? Connect this training to other organizational culture work being done.

3. Distribute OR FLIPCHART the agenda and have participants read the program goals aloud

   NOTE: At this point the Goals won’t bear much significance to the participants- we ask that you explain the 3P Goals after the first activity (Doing Our Best Work).

Doing Our Best Work (60 minutes)

Story Sharing (30 minutes)
1. Explain: That in the first activity today we are going to draw on what makes us unique and special in our work. To do this, everyone will have the opportunity to tell a story entitled: “When I made a difference in the life of another co-worker or consumer.”

2. Explain that the story should be about a time they knew they made a difference in the life of a resident or other co worker. Some helpful ways to help them tell the full story including sharing (Flipchart):
   - Tell the WHOLE story
   - Who else was involved?
   - How did you know you made a difference?
   - How did the experience felt then, afterwards, today?

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1 This is an unpublished PHI facilitator guide. It is not yet “curriculum.” We are more than pleased in your interest in it and encourage you adopt it to your own organization as you see fit.

Enhanced Communication and Problem Solving Skills Training  
Starring the 3P’s  
Presented by the Paraprofessional Healthcare Institute
3. Let participants know that as they are telling their stories, a facilitator will be listening for the unique skills and strengths that the storyteller brought to the situation— which will be shared in a larger group discussion later on.

**Teaching Tip:** As the participants are sharing— facilitators listen for and record each person's STRENGTHS. Note: you may notice that group members are encouraging/supporting others to share more— it’s important to document that as well.

4. Divide the class into smaller groups— one facilitator for each group.

**Teaching Tip:** Ideally you do not want more than 6 people in a group. However, if ‘extra’ facilitation help is not available— and there are more than the ideal in each group— we suggest adding time to the activity— in lieu of cutting time from each participant’s story. It’s an important activity that affords direct care worker’s/other employees a rare opportunity to be proud of what they do, and gives you an opportunity to build on their stories and draw out their strengths throughout the training and your work with them. If the small groups end up being too large, you may choose to ask a volunteer to listen for and write down the strengths for each person. We recommend you prepare this person a day ahead of time or before the training begins.

5. In the small groups— give each person 5 minutes to share. After each person shares, you can paraphrase what you hear their strengths to be and ask if anyone heard other strengths to list out.

6. Bring the groups back together and in the large group have each facilitator report out on the strengths (not using names). FLIPCHART these for reference later on.

7. Affirm to the group: You make a difference for residents/clients/co-workers lives everyday. (Adapt this to be inclusive of your audience). Also affirm that as individuals and as a group they are rich with Strengths, Skills and Abilities.

8. Introduce the notion that everyone shapes the environment in which residents live and staff members work, everyone has and can influence peoples’ each others’ lives. Emphasize that your opinions and thoughts count. (Refer back to the strengths for proof of this). Explain that the skills learned in this seminar will help you to come closer to feeling like and being a full member of the team and community in which you work.

*When problems rise... (15 minutes)*

9. Relate that not every day is as cheery or productive as was shared just now— and tensions are high and problems come up.
10. Facilitate a discussion around: What happens to problems when they come up? Ask participants: What happens when a resident refuses to eat? Or is refusing to take his/her medication? What do you do?

11. Summarize and connect the discussion with this training (The 3P’s) and with Coaching Supervision. Connect back to the stories earlier in which they can/did make a difference. Share that their organizations are moving more towards relationship based and person centered problem solving where frontline staff are going to have the opportunity to resolve situations between themselves and the residents/clients. Provide the participants with the context for the training today- in that supervisors are learning/have learned Coaching Supervision in order to help them develop stronger problem solving skills and promote healthier communication.

Note: This training should be taught in conjunction with the Introductory Coaching Supervision Curriculum. We strongly recommend that this training be taught after the Coaching Supervision training is taught to all supervisors and managers; and those supervisors/managers should be made aware of the goals/content of this training to allow for the most effective communication between supervisors and those they supervise.

Barriers to Being Your Own Problem Solver 15 minutes

12. Affirm that there is probably some hesitation to immediately “signing on” to this training. Write “What gets in the way” on the top of a flipchart and facilitate a discussion around what will potentially get in the way of them being more actively involved in problem solving in their work.

Teaching Tips:
An example might be that participants are fearful of being disciplined for doing the ‘wrong thing’ if they take problems on themselves.

Some participants may name specific supervisors/managers- which is okay, your role will be to paraphrase each statement in a general way drawing out the qualities/characteristics of the person. Explain that it is likely that the characteristics they are describing in this one person are in others as well.

13. After the list is exhausted, let participants know you will be ‘revisiting’ this list later. Hang the list where all participants can see it.

Teaching Tip: Generating this list, surfacing resistance is important in demonstrating respect for the participants and acknowledging their current/past struggles with supervisors and the environment in which they work.
14. At this point, move to introducing the 3P’s: Paraphrase, Pull Back and expLore Options and explain that the 3P’s will be taught in the context of active listening and problem solving.

Break (15 minutes)

P1: Pull Back (60 minutes)

*Introduction to Pull Back* (25 minutes)
1. Explain the first step to adopting stronger problem solving skills is “Pulling Back” emotionally from the situation.

2. Facilitators conduct a Role Play. Choose a scenario that will resonate with group. First play out: Not Pulling Back.

**Sample Scenario**
C.N.A. Wilma goes to her linen cart and finds no more wash cloths—she is just about to give a bed bath and really needs it—and the linen closet is a long walk down the hall. Gladys, another C.N.A. is walking down the hall with a wash cloth in her hand. Gladys is a floating C.N.A. and Wilma makes the immediate assumption that Gladys took the washcloth from her cart—and Wilma begins to explode—here’s an example of the dialogue— it increasingly gets heated.

**Wilma:** “Where did you get that cloth from? You took it from my cart didn’t you?”
**Gladys:** No I didn’t I got it from down the hall?
**Wilma:** There’s none left in the closet how did you get it?
**Gladys:** Are you accusing me of stealing?
**Wilma:** If the shoe fits…
**Gladys:** I ain’t no thief, like I said I got it elsewhere why would I steal your grubby old washcloth!

3. Debrief the role play using the following questions: What happened? what emotions came up for Wilma? What happened to the relationship between Wilma and Gladys?

4. Explain that there is a need for awareness of our own role in problem situation. What was Wilma’s role in this situation? What was Gladys’ role? Explain that we can’t change others, but we can change our response. In this, there is a pressing need for awareness of our own emotional responses (what we feel, opinions and judgments we hold) in order to put it aside. What was Wilma feeling when she left the room to find a wash cloth? (Walk through what might have been happening for Wilma in the room with her resident.)

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5. **Distribute the handouts on pull back and discuss the definition of Pull Back Define and go through the handout exploring Option A and B (handout)** (NOTE: It is helpful to have a personal time when you didn’t pull back to share when explaining Option A; and a time when you did pull back in explaining Option B.)

6. Ask: about difference in outcomes for both and the relationship between them.

**Developing Awareness and Pull Back Strategies** (35 minutes)

7. Divide participants into small groups (3-4 participants) or pairs. In groups have participants share times, behaviors, situations, people (without saying names), that are emotionally provocative; meaning they somehow stir you up with anger, sadness, hurt, hopelessness, etc…

**Flipchart:**
- Share a situation where you get emotionally triggered
- Share what happens to you in those moments
- Name the emotion

*Explain that the goal in sharing these stories is to help get in touch with what emotionally provokes them (person, time, behavior) and NAME the emotion. Remind them, that the emotions you need to pull back from can range from feeling angry to feeling embarrassed or ashamed. Some people need to pull back from sinking or swallowing their feelings altogether, while others must pull back in order to refrain from fighting with another person and reacting in a heated way.*

**Teaching Tip:**
If you haven’t shared a personal story of not pulling back earlier, it is helpful to do so here.

8. Give participants 10 minutes in the small group/pairs.

9. Rejoin the group- Ask participants to share some of the emotions that came up for them, and if they’d like, some of the situations that were provocative. Then begin to ask the question: If you were in this situation tomorrow, and you had to maintain emotional control and “stay in it” in a respectful way- what could you do? (Remind them of the example you played out earlier). Ask what can you do to freeze that emotion and set aside? (You are now generating a list of pull back strategies). Continue with the large group brainstorm and individual identification of on Pull Back strategies. Flipchart.

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10. Tell the participants that you would like to leave them with at least one very concrete way to pull back emotionally.

11. Role Play the opening situation again, but this time, exaggeratedly pull back. Tell the group that you will exaggerate your pull back strategy so that it is visible. Do a short debrief.

Lunch (45 minutes)

Active Listening (95 minutes)

**Exercise: The importance of Listening** (5 minutes)

1. Segue from Pull Back: talk about the need to pull back from jumping immediately to solve the problem- there is a strong need to pause and listen to find out what the issue is. Ask participants: Why do we listen? Solicit responses and then review the handout: Real Listening (handout)

2. Facilitate a brief discussion about active listening and how the actual skill of paraphrasing plays a role in active listening (handout)

Non-Verbal Communication (Body Language) (40 minutes)

3. With another facilitator or participant you’ve prepped ahead of time, role play “poor non verbal body language” a.k.a. “not listening” for 2 minutes-emphasizing poor body language, inattentiveness, rudeness- without actually saying a word. (Choose a story that is personal and current so that there is some emotion/energy tied to your words.)

4. Debrief by asking: how do you know she wasn't listening? What did she do? What happened to the person telling the story? How do you think she was feeling?

5. Role play active non-verbal listening for 2 minutes- using body language and other non-verbal listening skills. Use the same story, but this time the facilitator should be listening intently.

6. Debrief: what happened for the person telling the story this time? How was she feeling? What did she do to tell you she was listening?

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7. Pair Participants and ask one person in the pair to think of a story that is current and important to them. For two minutes that person will try to tell the story, while the person does everything to not listen, similar to what you role played earlier.

8. Debrief with the questions above. Also ask, did that feel like two minutes?

9. Have them try role playing again using the same story; this time the non-listener will use active non-verbal listening skills.

10. Debrief with the questions above.

11. Reverse the pairs and give the new storytellers a minute to think about a current and important story to tell.

12. Repeat the not listening and listening exercises and debrief after each pair and at the end.

**Listening Actively to Mrs. Lee (15 minutes)**

1. Transition into the next activity. Ask what is the impact of taking the time to listen to a resident?

2. Emphasize that the foundation of person-centered care is Listening to what the resident/family wants and needs and delivering, to the best of your ability, what is needed. In the following role play, “Lunch time, Mrs. Lee!” we’ll see a scenario where the staff don’t really listen to Mrs. Lee and the staff and facility routine (delivering lunch and ensuring all residents eat) take the place of what the resident wants.

3. Introduce the role play “Lunch time, Mrs. Lee!” State that Mrs. Lee is resident at Industrial Care Nursing Home in Minnesota, a nursing home that needs ‘a little work’ in the area of delivering person-centered care.

4. Debrief the role play: Thinking about yourself: if you were Carrie:
   - How would you feel?
   - How about Brandi?
   - Ask the group, is getting her to eat a victory or a defeat?

5. Further debrief: Ask the group:
   - How would Mrs. Lee feel/be for the rest of the day?
   - How would her day be?
   - What kind of mood would she be in?
   - How would she act around other caregivers that day?
   - What’s your experience of caring for someone who has had an uncomfortable morning?
**P2: Paraphrasing and Asking Open Ended Questions (45 minutes)**

6. Let participants know there are different tools to help you listen better (one being non verbal communication). Flipchart and Review the definition of paraphrase

7. Distribute the Paraphrase handout

8. Distribute and review the Lead Ins

9. To practice paraphrase, you will now ‘redo’ parts of the role play with group using the following statements said by Mrs. Lee to practice paraphrasing and using open-ended, clarifying questions.

   “I’m not hungry. I wish I were a bird so I can fly this coup”

   “I don’t want to eat, and I’m really not hungry. I don’t want to do anything at all today- I feel miserable.”

   “Oh dear. I’m just not up to fighting you girls today…”

10. Distribute the clarifying questions handout, review and explain Open-Ended Clarifying Questions.

11. Go back to the paraphrases you created earlier and ask someone to follow the paraphrase with a clarifying questions (a question that would draw out a little more information). Repeat for all the paraphrases you completed.

12. Distribute the worksheet with the practice paraphrase/asking open questions. Ask participants to pair with someone next to them and ask each pair to do the worksheet together for 10 minutes to work on them. In lieu of reporting them out- while the participants are working- check in with each pair to ensure they are understanding the concept of paraphrase/asking open-ended questions.

13. If time allows, role play the scenario again with the two facilitators playing Mrs. Lee and Carrie. Using the paraphrases and questions just created.

14. Debrief using the same questions above (#10). And ask, what is the likely outcome for Mrs. Lee, for the C.N.A.’s and nurses, and for the organization?

15. Use that conversation to transition into Exploring Options.

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Break (15 minutes)

P3: exPloring Options (60 minutes)

1. Explain that in this next section, they will examine problem solving itself—taking a process they probably already do automatically (for example when a resident states she does not want to eat, yet you know that she needs to in order to maintain her health) and breaking it down into steps—with the goal of better understanding the steps and thus being better able to do it independently.

2. Post the prepared flip chart page with the case scenario for Nancy and Mr. Henry from Instructor's Guide, “Exploring Options” (handout) and distribute the handout.

   **FLIP CHART**
   **Nancy and Mr. Henry**

   Nancy has been working with Mr. Henry for a few weeks and enjoys working with him, although she says he can be very stubborn. He has diabetes, and yesterday Nancy found candy bars in his bedside stand, which goes against his care plan. She has tried before to tell him he shouldn’t eat candy, but he yelled, “I know that, but I don’t care!” Nancy doesn’t know what to do and has come to you for advice.

3. Explain that there are many approaches to problem solving and the one we are going to try in this training is called “Exploring Options.” This technique involves (FLIPCHART):
   - Analyzing the problem from different perspectives,
   - Identifying and exploring options for solving the problem,
   - Considering the likely outcomes or results, and then
   - Choosing the option with the best chance of satisfactorily solving the problem.

4. Distribute Handout, “The Exploring-Options Approach to Problem Solving” (handout) and Distribute (handout), “Important Factors.” Emphasize that it’s likely when you were solving the problem (From example above) you didn’t realize how much effort and work went into it. Explain that we are going to use the example to walk through and learn the “Exploring

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Options Approach” to problem solving.

5. Read through the handout together, reviewing the important factors and pay special attention to the BALANCE of the 3 perspectives, particularly in person-centered care.

**Teaching Tip**

Sometimes one option creates a situation in which the interests of the consumer, the direct-care worker, and/or the organization are in conflict. For example, in the case of Mr. Henry, one option is to allow him to eat the sweets. This respects the consumer's right to choose what he wants *but* it places the consumer’s health in jeopardy *and* would put the organization’s reputation for promoting health in jeopardy if the direct-care worker simply responded to what the consumer wants.

Therefore, a more balanced solution for the direct-care worker would be a combination of options that address all three points of views—i.e., allow Mr. Henry to eat the candy, *and also* try to educate him about the dangers involved in this choice, *and report to the nurse/organization that he is not following his diet.*

6. Divide the group in 3. Have each group take a perspective to work on. Have participants explore: What is the problem in this situation from the points of view of the consumer, the direct-care worker, and the organization. Write the three problem statements generated by participants on the flip chart page.

**FLIP CHART**

*What is the problem?*

- For the Mr. Henry:
- For the Nancy:
- For the Nursing Home:

7. After 10 minutes, bring the group back together and have them report out. Ask for additional thoughts from the full group on each perspective.

8. Next, move into the important factors. Depending on the situation, some factors will be more important than others, and some may not even need to

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be addressed. Make two columns on a sheet of flip chart paper, and write the heading “Important Factors” over the left column. Considering all three points of view in the problem ask participants to identify which factors apply. Write their responses in the left column.

<table>
<thead>
<tr>
<th>FLIP CHART</th>
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<tbody>
<tr>
<td>Important Factors</td>
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9. Write “Options” at the top of the right column on the flip chart page. Remind participants that options are possible solutions to the problem. Ask the group to brainstorm options that address each of the important factors they listed. The goal is to come up with as many options as possible, including at least one for each factor. Some options may address more than one factor. Encourage participants to be creative and think outside the box; sometimes thinking of ideas that are not realistic allows people to see possibilities that were not obvious. Write the ideas on the flip chart page.

<table>
<thead>
<tr>
<th>FLIP CHART</th>
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<tbody>
<tr>
<td>Important Factors</td>
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⇒ Teaching Tip
If participants really think outside the box, they may come up with some silly and potentially dangerous options. Keep the tone light and note the options, but make sure there is a good selection of realistic ones. For example: an unthought of option might be to make S’mores or to tell him you had to throw it out because it fell on the floor.

Discussion (20 minutes)
10. After participants have suggested at least six options, explain that in order to select the best option for solving a problem, they will assess what is likely to happen as a result of each option. Then they will determine which option (or combination of options) best addresses the problem from all three points of view.

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11. Ask participants:
   *What would be the impact (both positive and negative) of each option on each of the important factors we listed?*

12. Ask participants which options have a positive impact on two or more of the important factors. Put a check mark next to those options (see the Instructor’s Guide).

13. Considering the checked options, determine which one (or which combination) comes closest to solving the problem from all three points of view—the consumer’s, the direct-care worker’s, and the organization’s. Write “Plan A” in the margin next to that option or options. Note that the solution that most fully addresses the important factors also most effectively addresses the problem from the perspectives of every party involved. Note that since participants have come up with more options than the ones they selected for Plan A, they could easily come back to their list to consider other options if Plan A does not work.

Small Group Work (if time allows)

14. Divide the participants into smaller (facilitated) groups. Have each group work on a different scenario. In 15 minutes, the most important part is to state the problem from all three perspectives, identify the important factors and come up with at least one solution that addresses each constituents problem.

15. After 15 minutes, have the groups report out by reading their scenarios and sharing their solutions – and why they came to that solution.

**Wrap Up and Evaluation (15 minutes)**

Take this time review the list of “Barriers” created at the beginning of training- ask if anything has changed for participants based on what was taught/discussed today. Follow up with any outstanding issues as you feel appropriate to your organization.

Distribute and collect the Evaluations.
PROGRAM GOALS

We hope that by the end of the training, **YOU WILL**:

- **Know** how important **you** are and how you make a difference in the lives of the people you work for **and** the people you work with;

- **Understand** the impact of what you say and how you say it effects the people around you;

- **Strengthen** your existing and **learn new skills** to help you communicate more effectively;

- **Build on** your ability to solve problems by using a technique called, **Exploring Options**;

- **Be able to use** these communication and problem solving skills in real-life situations;

- **Feel that you have improved overall**- your ability to impact and shape the environment in which you work.
Enhanced Communication and Problem Solving Skills Training
“Starring the 3P’s”

Agenda

Welcome and Introductions

Morning Session
  o Doing Our Best Work
  o P1: Pulling Back in Stressful Situations

Lunch (45 minutes)

Afternoon Sessions
  o P2: Active Listening (Non verbal communication, Paraphrasing and Asking Open-Ended Questions)
    o P3: exPloring Options Approach to Problem Solving

Closing and Next Steps
Pulling Back

Oftentimes we are faced with situations and people who provoke an emotional response in us—be it anger, hurt, frustration, hopelessness, or sadness. When we are in an emotional state, listening becomes difficult and communication often becomes charged. Whatever our reaction, we have a CHOICE in how we respond:

**Choice Point**

**Option A**
- Defend our opinions
- Prepare our response
- Look for evidence to support our opinions
- Discount evidence to the contrary

**Option B**
- Suspend our opinions and put them on hold
- Listen actively, without blocks or judgment
- Look with curiosity for new information or insights
- Stay open to being changed
**PULLING BACK**
...the ability to gain emotional control in stressful work settings.

- In healthcare settings, you may be faced with challenging supervisors or residents, angry family members, disappointed co-workers, and many unanticipated situations. Building on the skills that you already have, it is critical to learn effective ways for maintaining emotional control and evaluating a problem situation before responding.

- “Pulling Back” means being able to pause, to get your emotions under control, and to see the situation clearly.

- Good communication and problem solving can only come from clear and objective thinking.

- After pulling back for a moment, you can make sure you understand what’s going on and get additional information thru listening.

**Steps for Pulling Back**

1. Notice your internal reaction and judgments.

2. “Freeze-frame” your reaction – put it aside.

3. Put your attention back on the other person.
REAL *Listening is...*
Based on the intention to do one of four things:

- Understand a person better
- Enjoy the person you are with
- Learn something
- Give help, provide solace, show empathy or give sympathy
**PARAPHRASE**
The ability to state in *your own words*, from your own understanding, what you understood someone to have just said or expressed.

- Paraphrasing and Asking Open Ended Questions are tools of communication in the active listening. The goal of using these skills is to **connect with the other person and get the best information possible before taking action.**

- **Paraphrasing is one part of a three-step listening process:** non-verbal listening techniques; Paraphrasing; and asking open ended questions to gather additional information.

- Many people's tendency is to move straight into problem solving without confirming the accuracy of information or gathering enough information. Active listening is essential **before** effective problem solving can take place.

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**Paraphrase**

1. **To paraphrase** means to state in your own words what you understand someone to have just expressed or said.

2. Paraphrasing is absolutely necessary to effective listening. It keeps you engaged and helps you to better understand what the other person means. It also lets the speaker know that you are listening.

3. When paraphrasing, repeat the statement in a positive way, without blame or judgment.

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**Rewards of Paraphrasing:**
- People LOVE feeling listened to! Don’t you?
- Paraphrasing can **stop anger** and cool down a crisis because the focus is on clarification of information rather than on reacting to the situation.
- Paraphrasing prevents miscommunication—false assumptions, errors and misinterpretations can be corrected on the spot.
- Paraphrasing helps you remember what was said.
- When you paraphrase you’ll find it **much easier to stay focused** on not lose your concentration. Your focus is on really understanding what is going on with the other person.
Lead-Ins for Paraphrasing...

I hear you saying that…

So, I think you said…

OK, So what I heard you say is…

I understand you said…

So you’re telling me that…

Am I hearing you correctly that…

Are you saying that…

I believe that you are saying…

So, you’re saying…

OK, Let me see if I got what you said…

So I understand the situation, let me summarize what you just said…

I want to be on the same page as you, so let me go over what you just said…
Asking Open Ended or Clarifying Questions

The five W’s also will help you get more information: Who, What, When, Where and how...

Questions (and sometimes Lead-in statements) that open up a conversation:

- Tell me a little more about...
- I’d like to hear about...
- Give me a little more detail, so I can get a clearer picture...
- I’m curious to know...
- What happened next (or before)?
- I’m really interested in knowing more about...
- How did that happen...
- What helped you...
- What are you thinking/feeling...
- How has your experience been so far?
- How are you managing...
- Tell me what you’ve thought of so far about how to handle...

Any others you can think of?
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**Lunch Time, Mrs. Lee!!!**

**Narrator:** This is an interaction between the staff a resident, Mrs. Lee, at Industrial Care Nursing Home in Minnesota. The characters in the play are:

**Characters:**
Nurse: Hanna  
First C.N.A.: Carrie  
Resident: Mrs. Lee  
Dietary Aide.: Brandi

**Hanna:** Lunch trays are here! Come on everyone, let’s get started.

**Narrator:** CNAs begin to deliver lunch trays to residents

**Carrie:** Good morning, Mrs. Lee. Isn’t it a beautiful day? I have your lunch for you. You need to eat because you ate like a bird for breakfast.

**Mrs. Lee** I’m not hungry. I wish I were a bird so I can fly this coup.

**Carrie** Oh but Mrs. Lee, you need to eat to keep up your strength. I’m sure you’ll feel better once you start eating.

**Mrs. Lee** I don’t want to eat, and I’m really not hungry. I don’t want to do anything at all today- I feel miserable.

**Carrie** I’ll just wash your face with some nice, warm water. That will help you wake up and then put some nice music on to eat to.

**Mrs. Lee** Please don’t wash my face. I feel too miserable to eat. You should give it to someone else.

**Carrie** Well, all right, but you know that’s not what’s best for you.
**Narrator:** Carrie goes to the nurse and tells her Mrs. Lee would not eat her lunch.

**Carrie:** Hanna, Mrs. Lee is being noncompliant with her care plan. I tried as hard as I could to get her to eat her lunch and she asked me to leave and give her lunch to someone else.

**Hanna:** Thank you for trying. I'll ask the dietary aide to try; maybe she'll eat for someone else.

**Narrator:** Hanna calls Brandi over, hoping that she'll be able to convince Mrs. Lee to at least take the tray. Brandi agrees to try.

**Brandi:** Good morning Mrs. Lee! What’s this I hear about you not wanting your lunch today? You know you need to eat to keep your strength up.

**Mrs. Lee:** Oh dear. I’m just not up to fighting you girls today.

**Brandi:** Come on now Mrs. Lee, you’re not going to make trouble today are you?

**Mrs. Lee:** No, No…I don’t want any trouble.

**Brandi:** That’s my girl!

**Narrator:** Brandi sets up the tray and places the napkin on Mrs. Lee.

**Brandi:** I'll be back for the tray in a little while. Enjoy your lunch!

**Narrator:** Mrs. Lee just sits and stares at her plate with an absent look on her face.
THE EXPLORING OPTIONS APPROACH TO PROBLEM-SOLVING

**Definition:**
Exploring options, as an approach to problem-solving, is a step-by-step tool for identifying and considering possible solutions to a problem (options) that the direct-care worker can carry out.

**Three perspectives:**
In any problem encountered by the direct-care worker, there will be three perspectives – the consumer’s, the direct-care worker’s, and that of the health care organization providing the service. These perspectives are shaped by important factors—issues such as the health, safety, and rights of the consumer and the direct-care worker, and the legal and ethical responsibilities of the health care organization.

**Desired outcome:**
The desired outcome of this approach to problem-solving is to identify an option, or a combination of options, that takes into account all the important factors and thereby addresses the problem from *all three perspectives*.

**Steps:**
The main steps in the exploring options approach are:

- **Clearly state the problem:**
  Clearly state the problem from the perspective of the consumer, the direct-care worker, and the organization.

- **Identify important factors:**
  Identify all the important factors related to the problem, from each perspective.

- **Brainstorm options:**
  Brainstorm all the possible solutions to the problem (options) that are within the scope of the direct-care worker’s job.

- **Decide on Plan A:**
  Select the option, or combination of options, that address important factors from all three perspectives as the first choice (Plan A).

- **Decide on Plan B:**
  Select another option that addresses almost as many important factors as the “second choice” -- in case the first option is not effective (Plan B).
<table>
<thead>
<tr>
<th>Important Factor</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Client safety:</td>
<td>Client at risk of choking; client is being threatened</td>
</tr>
<tr>
<td>Caregiver safety:</td>
<td>Caregiver is being abused or threatened; Safe workplace; broken equipment</td>
</tr>
<tr>
<td>Infection control:</td>
<td>Universal precautions; sanitary living environment; infectious diseases</td>
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<tr>
<td>Client care:</td>
<td>Personal care and emotional needs are attended to</td>
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<tr>
<td>Role of the caregiver:</td>
<td>Staying within the job description</td>
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<tr>
<td>Cultural respect:</td>
<td>Respecting differences in cultures, values, religion, etc…</td>
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<tr>
<td>Client rights:</td>
<td>Confidentiality; privacy; choice; free speech</td>
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<tr>
<td>Following org. policy:</td>
<td>Dress code; absentee policies; following care plans</td>
</tr>
<tr>
<td>Personal situations:</td>
<td>Safety of family/self; needs of self/family; government or school rules; cultural or religious beliefs; major disruption in schedule or routine; personal rights and preferences</td>
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</table>
Exploring Options Worksheet

Nancy and Mr. Henry

Nancy has been working with Mr. Henry for a few weeks and enjoys working with him, although she says he can be very stubborn. He has diabetes, and yesterday Nancy found candy bars in his bedside stand, which goes against his care plan. She has tried before to tell him he shouldn’t eat candy, but he yelled, “I know that, but I don’t care!” Nancy doesn’t know what to do and has come to you.

1. State the problem from each perspective

2. Important Factors:
   Check those factors that apply

3. Options:
   List at least one possible solution for each perspective and for each checked factor.

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<th>For the organization:</th>
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Enhanced Communication and Problem Solving Skills Training
Starring the 3P’s
Presented by the Paraprofessional Healthcare Institute
Mrs. Looseleaf is 96 and very frail. This is your first day being assigned to her and you are responsible for giving her a bath, changing her sheets, and feeding her. When you enter her room, she is happy to see you, but she does not want you to give her a bath. You try to persuade her to have her bath, but this only upsets her further.

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**Exploring Options Worksheet**

*Scenario:*
Ms. Faithful has just been admitted to the nursing home. You enter her room at 8:00 am to deliver her breakfast tray and you find her on her knees in prayer. You interrupt her and explain that breakfast is here. Ms. Faithful tells you that she prays daily from 7:30 to 9:30 and advises you that she cannot eat breakfast at this time.

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### Exploring Options Worksheet

**Scenario:**
You have been assigned to Ms. Conway who is very weak and has severe osteoporosis. Her care plan says for two nursing assistants to transfer her from her bed to the chair. Ms. Conway has been asking to get out of bed for a while, but you have been unable to find another staff member to help you lift her. Ms. Conway asks you to please transfer her by yourself, telling you that others do it all the time.

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EVALUATION
What did you like most about today?

What will you do differently because of this training?

If you could, what would you change about this training?

Please use the rest of this space for any additional comments you would like to make about this training:
Booster Session Descriptions

½ Day Booster Session for Supervisors and Managers
Approximately 4 months after the initial Introduction to Coaching Supervision training, PHI conducted two ½ day booster sessions for supervisors and managers (including social workers and recreation therapists) to reinforce and enhance skills learned. Each session was conducted by one PHI trainer with a group of 6-8 supervisors/managers. We have laid out the goals, objectives and methodology used below:

Goal
To provide an opportunity for participants to refresh and enhance the four fundamental skills of coaching supervision: Active Listening, Self Awareness, Self Management and Present the Problem.

Objectives
By then end of this session, participants will:
- Be able to state the four skills of coaching supervision;
- Be able to paraphrase and use clarifying open ended questions to gain a better understanding of a situation;
- Be able to effectively ‘Present the Problem.’

Methodology
- Engaging opening activity to review the 4 skills of coaching
- Large Group sharing about using the skills
- Review of and practice using the skill of Active Listening
- Review of and practice using the skill of Presenting the Problem
- Case scenario work and role plays
2-day Booster Session for Supervisors and Managers

Approximately one year after conducting the initial Introduction to Coaching Supervision Training (about 6 months after the first booster session), PHI conducted a two day intensive booster training to reinforce skills learned and provide additional coaching based skills pertinent to the work of supervisors, managers, recreation therapists and social workers.

Goals

- To reinforce the skills of coaching supervision learned during the original 2 day training;
- To introduce advanced coaching skills based on the organizations current needs in the project.

Objectives

By the end of this two day seminar, coaches will have:

- Developed a deeper understanding of coaching supervision and enhanced their abilities to apply the skills in real life situations at work;
- Develop skills to more effectively support C.N.A.’s in developing problem solving skills and ultimately, solving their own problems;
- Identified ways to more effectively hold workers accountable to performance standards and commitments;
- Learned ways to provide feedback to CNAs, peers and managers without blame or judgment;
- Enhanced their awareness and understanding around power dynamics inherent in supervision;
- Understand how coaching skills can be used to work effectively with work teams.

Areas covered:

- The Three Levels of Listening
- Problem Solving and Coaching Supervision
- Paraphrasing for Fact and Feeling
- Asking Effective Questions
- Coaching Practice (Pairs and Group work)
- Holding someone accountable in a supportive environment
- Giving Constructive Feedback
- Working with Resistance
- Coaching Teams: Using Intermediary Skills
One Day Booster Session for C.N.A.’s and Recreation Therapists
Approximately one year after the initial communication skills training, PHI conducted a one-day training for C.N.A.’s and Recreation Therapists from Chelsea Adult Day Health Center and the third floor of the Village Care Nursing Home. This training was designed to respond to the current needs of the organization related to the work done in the Dementia Grant initiative.

Rationale: In designing this booster training, several areas for training/improvement were brought forward: working with float staff and agency staff to communicate the uniqueness of the dementia floor and Day Center; managing stressful situations and taking care of one’s self in those situations; and working with families to promote person-centered care.

A common theme emerged in thinking these through: the C.N.A.’s and staff at the Day Center and on the dementia floor have a new language/culture (after being engaged in this grant) and are having some difficulty translating it to other staff and to families. This booster session was designed with the following goals in mind.

Goals
To help participants understand and appreciate their new language and culture fluently (in terms of their work on the dementia floor and Day Center); knowing the personal benefits of the culture/language; understanding the other parties language (perspective); and finding ways to ‘translate’ will serve to decrease the stress and anxiety experienced by C.N.A.’s on an everyday basis.

Objectives
By the end of this one day booster session, participants will have:
- Defined person centered care (from their own perspective);
- Explored the current challenges- personally and professionally- of using a person-centered approach;
- Explored what’s currently happening with float staff, agency staff and families when they come to the floor/center ‘speaking a different language’ and having different expectations;
- Explore barriers to developing healthy relations with float/agency staff and families;
- Learn and strengthen existing tools that make “translation” and working together easier.

Topic areas covered:
- Person-centered care
- Working with Resistance
- Creating a welcoming environment
- Giving Feedback
Caring for People with Alzheimer’s Disease and Related Disorders

This training material was written and developed by Linda Buettner, CTRS, PhD, a professor of University of North Carolina, Greensboro and Suzanne Fitzsimmons, MS, GNP the Director of the Center for Positive Aging of Florida Gulf Coast University in Florida. Much of this material was derived from the Dementia Practice Guidelines also authored by Buettner and Fitzsimmons.

The training consists of 5 parts plus a booster training. The five parts may be taught in a full day training or used separately depending upon the educational needs of your staff. The training is geared towards CNAs, nurses, therapists, social workers and other professionals. The booster training is a summary of the other 5 parts and should be done six months to a year after staff has received the initial 5 parts. It should take 2 or more hours to complete the booster training.

The files are in folders named Part 1, Part 2, Part 3, Part 4, Part 5, and Booster. Within each folder are handouts for the attendees and a PowerPoint presentation for the facilitator. The handouts follow the slides and in some cases includes additional information to be used as a resource. In addition the first 4 parts have pre and post tests, along with an answer key if you wish to use this. It is suggested that you print the PowerPoint as a guideline for the facilitator.

Some training parts have worksheets, case studies and other interactive materials. Instructions are included for all activities and these are used at the discretion of the facilitator. Encourage discussion and the use of actual facility cases.

For further information or questions please contact Sue Fitzsimmons at suzfitz@usa.net or call 941-628-6823.
Contents of Training Materials

Part 1 The Basics
Handouts - a worksheet at the end. *(This is completed by the attendees at the end of this section)*
Pre-Test
Post Test
Test Answer Key
The Basics Powerpoint

Part 2 Communication
Handouts
Pre-Test
Post Test
Test Answer Key
Describing and drawing project *(This is prompted at slide 13 of the PowerPoint)*
  Directions for implementing
  Drawing
Communication PowerPoint *(The last slide also has a simple communication assessment that the attendees can try on residents)*

Part 3 Behaviors
Handouts
Pre-Test
Post Test
Test Answer Key
Behavior Risk Worksheet *(This is completed at the end of the presentation)*
  Directions for implementing
  Behavior risk sheet
Routine Worksheet *(This is also optional at the end of the Power point)*
  Sample: Marjorie Routine
  Self and resident routine worksheet
Behavior PowerPoint
Part 4  Activities
Handouts (*Included are the optional activities*)
Optional Activities for end of Power point
  Homemade Butter
  Sound Identification Activity
  Poetry Cognitive Activity
    Instructions
    Poetry worksheet
  Relaxation Protocols
    Guided Imagery
    Progressive Muscle
Case Studies
Pre-Test
Post Test
Test Answer Key
Behavior PowerPoint

Part 5  Team Process
Handouts (*With optional case study*)
NEST checklist (This is a list of different things that could be contributing to behaviors)
Team Process PowerPoint

Booster Training
  Booster Handouts
  Booster PowerPoint
Caring for People with Alzheimer’s Disease and Related Disorders

One hour training by:
Linda L. Buettner & Suzanne Fitzsimmons
Four part training program

1. Basic information about dementia
2. Communication skills needed by the Dementia Specialist
3. Behavior management skills needed by the Dementia Specialist
4. Using activities to help.
Part 1
The Basics
Objectives

Upon completion of this session the participants will be able to:

1. Define ADRD and the term dementia.
2. Describe how ADRD affects the brain.
3. Explain how Alzheimer’s disease differs from the cognitive changes of normal aging.
4. List the stages of ADRD and the symptoms, behaviors and challenges of each stage.
DEMENTIA

Loss of intellectual abilities such as memory capacity, severe enough to interfere with social or occupational functioning.
What is dementia?

- Syndrome; a group of signs and symptoms that cluster together without one specific cause

- Loss of mental function in 2 or more areas such as language, memory, visual and spatial abilities, or judgment severe enough to interfere with daily life

- There are over 70 different conditions that cause dementia
What is Alzheimer’s disease?

- Most common cause of dementia (50%)
- Progressive brain disorder that gradually destroys a person’s memory
- Changes in personality and behavior
Alzheimer’s

- Affects as many as 5 million Americans.
- Attacks the brain, begins gradually, and progresses at a variable rate.
- Can last from 3 to 20 years from the time of onset of symptoms.
- Warning signs: Problems with memory, finding the right words, familiar tasks, learning, changes in personality
Alzheimer’s Disease recap

- Progressive, neurological illness in which brain cells are destroyed
- The destruction results in structural and chemical changes in the brain
- There is no single cause
- There is no cure
- Treatments are limited
Other Common Dementias

- Multi-infarct dementia, Stroke, Parkinson’s disease, Huntington’s disease, Creutzfeldt-Jakob disease, Pick’s disease, AIDS, syphilis, and Lewy body dementia

- Other physical conditions may cause or mimic dementia: depression, isolation, sensory deprivation, brain tumors, head injuries, nutritional deficiencies, hydrocephalus, infections, drug reactions, and alcohol and thyroid problems
How the brain works

- The cerebrum fills up most of your skull. It is involved in remembering, problem solving, thinking, feeling and it controls movement.
- The cerebellum sits at the back of your head, it controls coordination and balance.
- The brain stem sits beneath your cerebrum and connects the brain to the spinal cord and controls automatic functions such as breathing, digestion, heart rate and blood pressure.
How the brain works

- The real work of your brain goes on in individual cells called neurons.
- An adult brain contains about 100 billion nerve cells, or neurons, with branches that connect at more than 100 trillion points. Scientists call this dense, branching network a "neuron forest."
- Signals traveling through the neuron forest form the basis of memories, thoughts, and feelings.
Dementia or Normal Aging???

- We all lose things or forget things.
- Memory loss not part of aging.
- Physical, psychological, and environmental factors can cause changes to occur.
What are the early warning signs:

- Recent memory loss that affects job performance
- Difficulty performing familiar tasks
- Problems with language
- Disorientation to time and place
- Poor judgment
- Problems with abstract thinking
- Misplacing things
- Changes in mood or behavior
- Personality changes
- Loss of initiative
Some of the normal age-related memory changes

- Slower thinking
- Difficulty paying attention
- More memory cues required
Normal vs. Problem

1. **Normal**: Forgetting the name of someone you were just introduced to.
2. **Normal**: Going into the living room and forgetting what you were going there for.
3. **Normal**: Forgetting where you left your car keys.
4. **Normal**: Taking longer to learn a new job task.
5. **Normal**: Forgetting the name of the movie you saw last week.

1. **Problem**: Forgetting the name of your neighbor who you lived next to for the past 10 years.
2. **Problem**: Forgetting or becoming confused over how to get to the living room.
3. **Problem**: Finding that you put your keys in the freezer.
4. **Problem**: Forgetting how to tie your shoe.
5. **Problem**: Forgetting that you went to the movies last week.
Normal vs. Alzheimer’s Brain
Characteristics of Alzheimer’s Disease Symptoms: two distinct types

Cognitive symptoms
- Amnesia
- Aphasia
- Agnosia
- Apraxia

Psychiatric/behavioral
- Depression (mood)
- Psychosis (delusions and hallucinations)
- Major personality and behavioral changes
- Restlessness and agitation
- Apathy
AD does not come on suddenly!

- Insidious onset
- Gradual decline
- Recent memory impaired first
- Often 1-2 years before seeking medical attention
Stages of Alzheimer’s

**Stage 1:** No impairment (normal function)

**Stage 2:** Very mild cognitive decline (may be normal age-related changes or earliest signs of Alzheimer's disease)

- **Symptoms/Behaviors:** memory lapses, especially in forgetting familiar words or names or the location of keys, eyeglasses or other everyday objects.

- **Challenges:** These problems are not evident during a medical examination or apparent to friends, family or co-workers.
Stage 3 Mild cognitive decline

Early-stage Alzheimer's can be diagnosed in some, but not all, individuals with these symptoms.

- **Symptoms/Behaviors**: Word- or name-finding problems, decreased ability to remember names when introduced to new people, performance issues in social or work settings, reading and retaining little material, losing or misplacing a valuable object, decline in ability to plan or organize.

- **Challenges**: Resident may be depressed, anxious or upset over changes that are occurring. Or may deny there is a problem and refuse to see a doctor. May have apathy, not wanting to do anything.
Stage 4: Moderate cognitive decline

**Symptoms/Behaviors** Decreased knowledge of recent occasions or current events, difficulty with mental math, decreased ability to perform complex tasks, such as marketing, planning dinner for guests or paying bills and managing finances, reduced memory of personal history, repeating questions or statements.

**Challenges:** Providing assistance, such as reminders, without upsetting the resident. Tolerance of repetition of statements or questions. May place items in unusual places, horde items
Stage 5 Moderately severe cognitive decline

- **Symptoms/Behaviors**: Major gaps in memory and deficits in cognitive function emerge. Some assistance with day-to-day activities becomes essential. May be unable to recall such important details as their current address, their telephone number, become confused about where they are or about the date, day of the week, or season, may need help choosing clothing.

- **Challenges**: Makes accusations of infidelity or stealing. Threats and cursing, inappropriate behavior, such as kicking, hitting, biting, screaming or grabbing. Because they lack of judgment and tend to wander, people with moderate Alzheimer's disease aren't safe on their own. They may exhibit restless, repetitive movements in late afternoon, or continually repeat certain stories, words or motions, such as tearing tissues.
Stage 6 Severe cognitive decline

- **Symptoms/Behaviors** Memory continues to worsen, significant personality changes; extensive help needed with customary daily activities. May forget the name of spouse or primary caregiver but generally can distinguish familiar from unfamiliar faces, help needed with dressing and toileting.

- **Challenges**
  - Experience disruption of their normal sleep/waking cycle
  - Have increasing episodes of urinary or fecal incontinence
  - Experience significant personality changes and behavioral symptoms
  - Wandering
Stage 7 Very severe cognitive decline

- **Symptoms/Characteristics**: This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak and, ultimately, the ability to control movement including swallowing.

- **Challenges**: Communication of needs severely impaired, physiological decline is severe.
How big is the problem?

- Five million Americans
- 1:8 over 65
- 1:2 over 85
- 1:3 families
- 60-70% nursing home residents
- Cost to families is enormous
How is it diagnosed?

- Memory Clinics - diagnostic centers
- Physical exam
- Routine lab tests and EKG
- Brain imaging studies
- Personal and family history
- History of medication use and alcohol use
- Neurological exam
- Assessment for depression and cognitive functioning (Scales: Geriatric depression scale - MMSE)
- Sort out type of dementia, depression, delirium and establish baseline.
Treatments

- Medications
- Education
- Support groups
- Cognitive activities
- Physical activities
- Social Activities
- Control diabetes, BP, Cholesterol
- Treat depression
- Nutritional diet
How can you help your residents?

- Activity to stimulate the use of the brain and the body.
- Activity to encourage movement.
- Activity for social connections.
- Activity to provide joy.
- Allow to do as much as possible for self
Questions???

Answer the questions to Part 1 worksheet.

Note: You may help each other, use the manual/handouts or anything else that might assist you.
Part 1: The Basics
Pre-Test

Date: ____________________                Occupation: _________________________
Facility: ___________________________   Name: _____________________________

How long working in this position: ___________________________

1. Alzheimer’s disease:
   a. is a type of dementia
   b. is caused by a stroke
   c. comes on all of a sudden
   d. only affects memory

2. When people get older it is normal to:
   a. forget the names of family members
   b. have trouble with word finding
   c. take longer to learn new things
   d. repeat themselves many times

3. Persons in the late stages of Alzheimer’s disease usually are:
   a. usually able to feed themselves
   b. usually able to communicate their needs
   c. usually incontinent
   d. usually capable of walking with assist

4. The major working part of the brain is
   a. glands
   b. neurons
   c. hormones
   d. hard tissue

5. The early stages of Alzheimer’s disease may cause
   a. cardiac changes
   b. breathing problems
   c. personality changes
   d. digestion problems
Caring for People with Alzheimer’s Disease and Related Disorders

Part 1: The Basics

By

Linda Buettner, Ph.D. CTRS
Suzanne Fitzsimmons, MS, ARNP
Slide 4: Overview
This session will provide a brief overview of Alzheimer’s disease and related disorders (ADRD), compare the differences in cognitive changes in normal aging versus ADRD, and provide a listing of the common stages along with symptoms, behaviors and challenges for each stage.

OBJECTIVES:
Upon completion of this session the participants will be able to:
1. Define ADRD and the term dementia.
2. Describe how ADRD affects the brain.
3. Explain how Alzheimer’s disease differs from the cognitive changes of normal aging.
4. List the stages of ADRD and the symptoms, behaviors and challenges of each stage.

Slide 5/6: Dementia: What is it?

What is dementia?
- Dementia is a loss of mental function in two or more areas such as language, memory, visual and spatial abilities, or judgment severe enough to interfere with daily life.

- Dementia itself is not a disease but a broader set of symptoms that accompanies certain diseases or physical conditions.

- Dementia is a syndrome: a group of signs and symptoms that cluster together without a specific identified cause. It is an umbrella term that encompasses many diseases. There are more than 70 different conditions leading to dementia.

Slide 7: What is Alzheimer’s disease?

Alzheimer’s disease is the most common cause of dementia. Approximately 50% of cases of dementia is caused by Alzheimer’s disease.

AD is a progressive brain disorder that gradually destroys a person’s memory and ability to learn, reason, make judgments, communicate and carry out daily activities.

As Alzheimer’s progresses, individuals may also lose the ability to recognize familiar objects and lose the ability to carry our motor function tasks including the ability to speak and swallow.

Changes in personality and behavior, such as anxiety, suspiciousness or agitation, as well as delusions or hallucinations may also occur.
Slide 8: Alzheimer’s disease (Continued)

- Affecting as many as 5 million Americans.
- Attacks the brain, begins gradually, and progresses at a variable rate.
- Can last from 3 to 20 years from the time of onset of symptoms.
- Warning signs of AD: memory loss that affects job/home skills, difficulty performing familiar tasks, problems finding the right words, disorientation as to time and place, poor or decreased judgment, difficulty with learning and abstract thinking, placing things in inappropriate places, changes in mood and personality, and marked loss of initiative.
- Physicians can now diagnose AD with an accuracy of 85-90%, however, a definitive diagnosis is possible only through the examination of brain tissue at autopsy.

Slide 9: Alzheimer’s disease recap

- Progressive, neurological illness in which brain cells are destroyed
- The destruction results in structural and chemical changes in the brain
- There is no single cause
- There is no cure
- Treatments are limited

Slide 10: Other common dementias

- Other physical conditions may cause or mimic dementia: depression, isolation, sensory deprivation, brain tumors, head injuries, nutritional deficiencies, hydrocephalus, infections, drug reactions, alcohol abuse and thyroid problems.

Slide 11: How the brain works and how ADRD affects the brain

- Your brain is your most powerful organ, yet weighs only about three pounds. It has a texture similar to firm jelly.
- It has three main parts:
  1. The **cerebrum** fills up most of your skull. It is involved in remembering, problem solving, thinking, feeling and it controls movement.
  2. The **cerebellum** sits at the back of your head, it controls coordination and balance.
  3. The **brain stem** sits beneath your cerebrum and connects the brain to the spinal cord and controls automatic functions such as breathing, digestion, heart rate and blood pressure.
Slide 12: How the brain works

- The real work of your brain goes on in individual cells called neurons.
- An adult brain contains about 100 billion nerve cells, or neurons, with branches that connect at more than 100 trillion points. Scientists call this dense, branching network a "neuron forest."
- Signals traveling through the neuron forest form the basis of memories, thoughts, and feelings.

Neurons are the chief type of cell destroyed by Alzheimer's disease. Eventually the cell loss is massive.

Slide 13: Dementia vs. normal aging

- From time to time, everyone experiences memory losses over seemingly simple tasks like finding a set of keys or remembering names or important appointments. The fact is that people of all ages occasionally have trouble remembering things.

- As people age, they may assume their memories will fail. Although researchers have identified some memory changes that are associated with normal aging, the large majority of older people will not face severe memory loss.

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Slide 14: Early warning signs of a problem

- Recent memory loss that affects job performance
- Difficulty performing familiar tasks
- Problems with language
- Disorientation to time and place
- Poor judgment
- Problems with abstract thinking
- Misplacing things
- Changes in mood or behavior
- Personality changes
- Loss of initiative

---

Slide 15: Some of the normal age-related memory changes:

- Slower thinking.
  All body systems become less efficient with age, including thinking and problem solving abilities. The speed of learning and recall decreases. More time to learn new things and/or
retrieve information may be needed. Short-term memory doesn't necessarily fade with age; it just takes longer to function.

- **Difficulty in paying attention.**
  Many memory changes are due to problems of attention, not retention. Reduction in the ability to concentrate as a person ages makes it harder to remember. Distractions are more difficult to ignore and interruptions may cause forgetfulness.

- **More memory cues required for recall.**
  As people age, more memory aids or cues are needed, and more often, to retrieve information from memory. A cue can be a word, picture, smell, rhyme, or anything associated with information or events to be remembered.

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**Slide 16: Normal vs. abnormal**

**Normal**: Forgetting the name of someone you were just introduced to  
**Problem**: Forgetting the name of your neighbor who you lived next to for the past 10 years.  
**Normal**: Going into the living room and forgetting what you were going there for.  
**Problem**: Forgetting or becoming confused over how to get to the living room.  
**Normal**: Forgetting where you left your car keys.  
**Problem**: Finding that you put your keys in the freezer.  
**Normal**: Taking longer to learn a new job task.  
**Problem**: Forgetting how to tie your shoe.  
**Normal**: Forgetting the name of the movie you saw last week.  
**Problem**: Forgetting that you went to the movies last week.

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**Slide 17 Slide of normal vs. abnormal brain**

The abnormal brain is shrunken and has deep grooves
**Slide 18: Characteristics of Alzheimer's Disease**

**Cognitive symptoms**
- Amnesia: Inability/Difficulty in remembering
- Aphasia: Inability/ Difficulty understanding or expressing verbal or written words
- Agnosia: Inability/ Difficulty recognizing familiar objects or faces
- Apraxia: Inability/ Difficulty with motor tasks

**Psychiatric/behavioral**
- Depression (mood)
- Psychosis (delusions and hallucinations)
- Major personality and behavioral changes: suspicious, paranoid, complaining, cursing
- Restlessness and agitation: Motor or verbal
- Apathy: Lack of motivation

---

**Slide 19: Alzheimer’s Disease does not come on suddenly**

- Insidious onset: Cannot pinpoint when it started
- Gradual decline: Slow and progressive changes
- Recent memory impaired first: Can remember things from long ago
- Often 1-2 years before seeking medical attention

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**Slide 20: Stages/Characteristics of Alzheimer’s Disease**

**Stage 1: No impairment (normal function)**

**Stage 2: Very mild cognitive decline** (may be normal age-related changes or earliest signs of Alzheimer's disease)

**Symptoms/Behaviors:** memory lapses, especially in forgetting familiar words or names or the location of keys, eyeglasses or other everyday objects.

**Challenges:** These problems are not evident during a medical examination or apparent to friends, family or co-workers.
Slide 21: Stage 3 Mild cognitive decline
(Stage 3 Mild cognitive decline with Early-stage Alzheimer's can be diagnosed in some, but not all, individuals with these symptoms)

**Symptoms/Behaviors:** Word- or name-finding problems, decreased ability to remember names when introduced to new people, performance issues in social or work settings, reading and retaining little material, losing or misplacing a valuable object, decline in ability to plan or organize.

**Challenges:** Resident may be depressed, anxious or upset over changes that are occurring. Or may deny there is a problem and refuse to see a doctor. May have apathy, not wanting to do anything.

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Slide 22: Stage 4 - Moderate cognitive decline - (Mild or early-stage Alzheimer's disease)

**Symptoms/Behaviors** Decreased knowledge of recent occasions or current events, difficulty with mental math, decreased ability to perform complex tasks, such as marketing, planning dinner for guests or paying bills and managing finances, reduced memory of personal history, repeating questions or statements.

**Challenges:** Providing assistance, such as reminders, without upsetting the resident. Tolerance of repetition of statements or questions. May place items in unusual places, horde items.

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Slide 23: Stage 5 Moderately severe cognitive decline - (Moderate or mid-stage Alzheimer's disease)

**Symptoms/Behaviors** Major gaps in memory and deficits in cognitive function emerge. Some assistance with day-to-day activities becomes essential. May be unable to recall such important details as their current address, their telephone number, become confused about where they are or about the date, day of the week, or season, may need help choosing clothing.

**Challenges:** Accusations of infidelity or stealing, Threats and cursing, inappropriate behavior, such as kicking, hitting, biting, screaming or grabbing. Because they lack of judgment and tend to wander, people with moderate Alzheimer's disease aren't safe on their own. They may exhibit restless, repetitive movements in late afternoon, or continually repeat certain stories, words or motions, such as tearing tissues.
Slide 24: Stage 6 Severe cognitive decline - (Moderately severe or mid-stage Alzheimer's disease)

**Symptoms/Behaviors** Memory continue to worsen, significant personality changes; extensive help needed with customary daily activities. May forget the name of their spouse or primary caregiver but generally can distinguish familiar from unfamiliar faces, help needed with dressing and toileting

**Challenges**
- Experience disruption of their normal sleep/wake cycle
- Have increasing episodes of urinary or fecal incontinence
- Experience significant personality changes and behavioral symptoms, including suspiciousness and delusions (for example, believing that their caregiver is an impostor); hallucinations (seeing or hearing things that are not really there); or compulsive, repetitive behaviors such as hand-wringing or tissue shredding
- Tend to wander and become lost

Slide 25: Stage 7 Very severe cognitive decline (Severe or late-stage Alzheimer's disease)

**Symptoms/Characteristics:** This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak and, ultimately, the ability to control movement including swallowing

**Challenges:** Communication of needs severely impaired: Frequently individuals lose their capacity for recognizable speech, although words or phrases may occasionally be uttered. Extensive ADL assistance needed: eating and toileting and there is general incontinence of urine. Individuals lose the ability to walk without assistance, then the ability to sit without support, the ability to smile, and the ability to hold their head up. Reflexes become abnormal and muscles grow rigid. Swallowing is impaired.

Slide 26: How big is the problem?

Five million Americans
1:8 over 65
1:2 over 85
1:3 families
60-70% nursing home residents
Costly to families
Slide 27: How is it diagnosed?

- **Memory Clinics** - diagnostic centers: A memory clinic is one of the best choices to determine a correct diagnosis.
- **Physical exam** – there are many treatable conditions that have similar symptoms. The doctor is looking for any of these.
- **Routine lab tests and EKG**: Looking again for other, perhaps treatable conditions that may look like dementia such as thyroid problems, vitamin deficiencies and others
- **Brain imaging studies**: This can show if there is a vascular problem such as a stroke, mini strokes, and other structural problems
- **Personal and family history**: Asking about the symptoms and when they started, determining if there is a family history, determining risk factors such as a past head injury, diabetes, high blood pressure.
- **History of medication use and alcohol use**: The side effects of some medications can cause memory problems and confusion. Also medication combinations or toxicity can cause cognitive problems as can alcohol usage.
- **Neurological exam**: Examining for signs of a stroke, Parkinson’s disease and other neurological disorders with dementia symptoms.
- **Assessment for depression and cognitive functioning**: Using written tests to screen for depression. If the test result is positive then a more thorough depression examination would be needed. A cognitive functioning test would use a basic, standard test (MMSE) as a guideline for overall functioning of the brain.
- The results of all of this are examined and a diagnosis is made.

Slide 28: Treatment

**Medications**: May be helpful in some patients

**Education**: Persons in early stages often desire to learn about their condition. Although they might have memory problems they can learn.

**Support groups**: This assists clients with the emotional aspect of the diagnosis

**Cognitive activities**: Activities that stimulate various parts of the brain such as word puzzles, thinking activities, learning, computers, board games, etc

**Physical activities**: Exercise, dance, sports

**Social Activities**: Programs that promote socialization with others: tea party, reminiscing, etc

**Control diabetes, BP, Cholesterol**: Good control over chronic illnesses

**Treat depression**: Persons with depression often do not care enough to remember

**Nutritional diet**: Heart healthy diet
Part 1 Worksheet

Name: _________________________________________   Date: _______________

With my residents what I could do to stimulate movement:

__________________________________________________________________________

__________________________________________________________________________

With my residents what I could do to stimulate social connections:

__________________________________________________________________________

__________________________________________________________________________

With my residents what I could do to stimulate the brain:

__________________________________________________________________________

__________________________________________________________________________

With my residents what I could do to allow them to do more for themselves

__________________________________________________________________________

__________________________________________________________________________
Part 1: The Basics
Post-Test

Date: ____________________                Occupation: ____________________________

Facility: ___________________________   Name: _________________________________

How long working in this position: ______________________

1. Alzheimer’s disease:
   a. is contagious
   b. is a progressive disease
   c. comes on all of a sudden
   d. only affects memory

2. When people get older it is normal to:
   a. forget the names of their friends
   b. have trouble with word finding
   c. take longer to learn new things
   d. get lost in their neighborhood

3. Persons in the early stages of Alzheimer’s disease usually are:
   a. usually unable to feed themselves
   b. usually unable to communicate their needs
   c. usually incontinent
   d. usually capable of walking with assist

4. The major working part of the brain is
   a. glands
   b. neurons
   c. blood vessels
   d. hard tissue

5. Communication with non-responsive persons with Alzheimer’s disease
   a. is not worth doing
   b. may cause them stress
   c. should only be done by nurses
   d. may be done by touch
Part 1  The Basics

Answer Key

Pre-test

1. a
2. c
3. c
4. b
5. c

Post-test

1. b
2. c
3. c
4. b
5. d
The Art of Caring for People with Alzheimer’s Disease and Related Disorders

by:
Linda L. Buettner & Suzanne Fitzsimmons
Part 2

Communication and the four A’s
Objectives

Upon completion of this session the participants will be able to:

1. Discuss how ADRD affects communication.
2. Describe how the 4 A’s affects the ability to communicate.
3. List strategies for verbal and non-verbal communication.
Communication:

A process by which information is exchanged between individuals through a common system of symbols, signs, or behaviors.

The areas of the brain used for communication are often affected early in the disease process of Alzheimer’s.
Verbal communication

- Organizing the message
- Sending the message
- Receiving the information
- Processing the information
- Organizing a response
- Responding
Non-Verbal Communication

- Body language
- Show the person – take 2-3 minutes
- Facial expression
- Gestures
- Touch
- Tone of voice (you are on a schedule but you have to take your time)
Understanding what is heard
Why problems occur:

Early

Amnesia

May not remember the name of someone or something

Aphasia

Can’t understand what people say or how to express self

Agnosia

Can’t recognize objects/faces, therefore can’t name them

Apraxia

Can’t do familiar gestures

Late
Amnesia

❖ Memory
  ■ Recent
  ■ Short term
  ■ Remote
Aphasia

Understanding words & language

- Receptive
- Expressive
Agnosia

Recognizing objects & faces
Apraxia

- Familiar motor skills
- Writing a note to someone
Project

Describing and Drawing Activity
Memories
Talking: using words

[Image of brain tissues]
Temper and emotions...
Because of these symptoms the person cannot always:

- Express needs
- Cooperate with your wishes
- Recognize familiar objects or people
- Understand what an object is used for
- Respond to reason
- Learn new things
- Make complex decisions
The individual can:

- Feel pain and not always be able to express it
- Experience emotions (sadness, fear, loneliness)
- Enjoy hobbies, recreational interests, favorite foods, and music (you might need to adapt)
- Respond to voice and eye contact
- Understand human kindness and compassion.
Changes in communication that may occur

- Difficulty finding the right words
- Using familiar words or phrases repeatedly
- Inventing new words to describe familiar objects
- Easily lose their train of thought
- Difficulty organizing words logically
- Reverting to speaking in a native language
- Using curse words
- Speaking less often
- More often relying on gestures instead of speaking
- Not understand what is said
Strategies you can use for better communication

- Remove background noise (turn off radio, TV)
- Do a three second assessment
- Approach the person from the front and get eye contact.
- Call the person by name and state your name.
- If the person uses the wrong word or cannot find a word, try guessing the right one.
- Use short, simple words and sentences. Talk slowly and clearly.
- Ask one question at a time.
- Patiently wait for a response. A person may need extra time to process your request.
- Repeat information and questions. If the person doesn't respond, wait a moment. Then ask again.
- Speak clearly, avoid slang and expressions.
- Avoid quizzing such as "Do you remember when...?"
- Give simple explanations.
Three second assessment
Strategies for non-verbal communication

As verbal communication becomes increasingly difficult, you might find that you rely more on non-verbal communication, i.e. tone and pitch of voice, eye contact, facial expression, posture, sign language and physical contact.

- Soft and caring tone of voice.
- Maintain eye contact.
- Soft, calm, warm facial expression.
- Gesture to emphasize words and feelings.
- Use touch such as a hand on the shoulder if the resident allows this.
- Use a communication board to determine unmet needs.
- Put up signs
- If you don't understand what is being said, ask the person to point or gesture.
- Focus on the feelings, not the facts. Sometimes the emotions being expressed are more important than what is being said. Look for the feelings behind the words.
Strategies for resident who are non-responsive or do not communicate

- Can respond well to soft, familiar voices and touch.

- Can still take hold of their hand or put your arm around them. This can communicate a great deal and provide reassurance.
How do you know how much the individual understands?

- Do the 6 Point Communication Assessment
  - tell her to raise her arm (1 pt.)
  - ask what day it is (1 pt.)
  - ask what year it is (1 pt.)
  - ask her to identify a pen and a watch (1 pt.)
  - tell her to pick up the spoon (1 pt.)
  - repeat “today is a pretty day” (1 pt.)

- Less than 3 points use a hand mirror to see if the individual recognizes herself.
Questions???
Part 2: Communication
Pre-Test

Date: ____________________ Occupation: ____________________________

Facility: ___________________________ Name: _____________________________

How long working in this position: ___________________________

1. A client with agnosia may not be able to:
   a. tie his shoe
   b. understand what you are saying
   c. recognize his spouse
   d. remember his childhood home

2. A strategy for better communication with people with Alzheimer’s Disease is:
   a. provide background stimulation such as a television or radio
   b. get and maintain eye contact
   c. speak as loud as you can
   d. ask many questions until they respond

3. Non-verbal communication can be useful with:
   a. clients with amnesia
   b. clients with depression
   c. clients with apraxia
   d. all clients

4. A good method of communicating with a non-responsive clients is to:
   a. turn on the television
   b. hold the clients hand
   c. ask staff to be quiet when in their room
   d. take them to activities
Caring for People with Alzheimer’s Disease and Related Disorders

Part 2: Communication and the 4 A’s

By
Linda Buettner, Ph. D., CTRS
Suzanne Fitzsimmons, MS, ARNP
Slide 2:

OBJECTIVES:
Upon completion of this session the participants will be able to:
1. Discuss how ADRD affects communication.
2. Describe how the 4 A’s affects the ability to communicate.
3. List strategies for verbal and non-verbal communication.

Slide 3: Part 2: Communication and the 4 A’s

Slide 4: Communication

Communication is a process by which information is exchanged between individuals through a common system of symbols, signs, or behaviors.

The areas of the brain used for communication are often affected early in the disease process of Alzheimer’s. Difficulty in communicating can be a very frustrating problem for the client, family and caregivers.
Slide 5: Verbal communication

- **Organizing the message:** Cognitively determining what one wants to communicate
- **Sending the message:** Getting the message to the receiver
- **Receiving the information:** Physically hearing or seeing a message
- **Processing the information:** Understanding what was communicated
- **Organizing a response:** Determining and formulating a response
- **Responding:** Getting the response to the receiver

Slide 6: Non-Verbal Communication

- **Body language:** Using the body rather than a verbal comment or response
- **Show the person** – take time to demonstrate
- **Facial expression** - smile, frown, sticking out your tongue
- **Gestures** - Signals with hands, feet and other parts of the body. Body language may mean different things to different people.
- **Touch** - Pat on the back, rubbing a sore body part
- **Tone of voice** - Voice tone should equal what is being said

Slide 7: Understanding what is heard ….

This is the part of the brain that is used to understand what is said. The one on the left is from a person who had a healthy brain, the other from someone who had Alzheimer’s. You can see the atrophy that has occurred in the Alzheimer’s brain.
Slide 8: Why communication problems occur:

**Amnesia:** May not remember the name of someone or something

**Aphasia:** May not be able to understand what people say or how to express self

**Agnosia:** Unable to recognize familiar objects or faces, therefore has difficulty talking about these objects or people

**Apraxia:** May be unable to do hand gestures or demonstrate what is needed.

---

Slide 9: Amnesia: Memory

- **Recent:** What happens in the past minute. Some people with dementia have intact recent memories.
- **Short term:** Occurring within the past 24 hours. This is generally impaired in people with dementia.
- **Remote:** Occurring 24 hours ago to the distant past. Persons with dementia generally lose recent remote memory, then ones that occurred in the past 5 years, then past 20 years and so on. Many people just have memories that occurred in the ages of 18-24, for some even younger.

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Slide 10: Aphasia: language

Understanding words & language. A person can have one or both of the following problems:

- **Expressive aphasia:** Difficulty expressing self verbally or in writing. This is more common than expressive aphasia
- **Receptive aphasia:** Difficulty understanding words that are said or read. Many people with dementia can understand what, or most, of what is being said to them.

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Slide 11: Agnosia: Recognition

The inability to recognize familiar objects and faces.
Example: A client is not brushing his teeth; perhaps he does not recognize the toothbrush.
Example: Not recognizing a spouse, thinking the spouse is a parent.
Slide 12: Apraxia: Familiar motor tasks

The inability to do motor tasks that one was once capable of doing. Examples are tying shoes or buttoning, zipping a jacket or writing a note.

Slide 14: Brain Section: Memories
This is one of the areas of the brain where memories are stored. The brain section on top was from a healthy brain while the bottom one was from someone who had Alzheimer’s Disease. You can see how it is shrunken and shriveled.

Slide 15: Brain Section: Using words
This is one of the areas of the brain where language is formed and understood. The brain section on top was from a healthy brain while the bottom one was from someone who had Alzheimer’s disease. Once again, you can see how it is shrunken and shriveled, and has large openings.
Slide 16: Brain Section: Temper and Emotions

This is one of the areas of the brain where temper and emotions are formed and understood. The brain section on top was from a healthy brain while the bottom one was from someone who had Alzheimer’s Disease. You can see the dramatic differences. When a person with dementia has an unmet need and cannot express it, they may get frustrated easily and be unable to cope, resulting in crying, anger and other emotions out of proportion to the need.

Slide 17: Because of these symptoms the person cannot always:

- Express needs (resulting in an unmet need)
- Cooperate with your wishes (as they may not understand what you want)
- Recognize familiar objects or people (making them wonder who is with them and where their loved ones went, or wear other persons clothing)
- Understand what an object is used for (as they no longer recognize it)
- Respond to reason (Unable to comprehend rationalizations)
- Learn new things (May not be able to remember the steps or tasks)
- Make complex decisions (Unable to ask questions, opinions, get advice or understand answers and options)
Slide 18: The individual can:

- Feel pain and not always be able to express it. Look for subtle signs such as moaning, rubbing, clutching, rocking, crying, increased vital signs, irritability, loss of appetite, decreased mobility or function, or agitation.
- Experience emotions (sadness, fear, loneliness, anxiety) and not be able to express it
- Enjoy hobbies, recreational interests, favorite foods, and music (you might need to adapt)
- Respond to voice, eye contact and touch.
- Understand human kindness and compassion.

Slide 19: Changes in communication that may occur

- Difficulty finding the right words. May actually state that they can’t remember the word.
- Using familiar words or phrases repeatedly. This is a coping mechanism to maintain their ego and integrity.
- Inventing new words to describe familiar objects. Often they do not realize they are doing this. Others may substitute words like “thing-a-ma-jing” for an object generic names such as “buddy” for a person
- Easily lose their train of thought. Forgetting the point of the what one is trying to say while speaking.
- Difficulty organizing words logically. This often sounds like a “word salad” such as “There, this, a hall, in bathroom?” (Is there a bathroom in this hall?)
- Reverting to speaking in a native language. Memory from long ago is stronger so the first language often returns.
- Using curse words. In persons who normally never used them.
- Speaking less often. Not initiating conversion, speaking only when spoken to.
- More often relying on gestures instead of speaking. Pointing to what one wants rather than asking.
- Not understand what is said. (Family members often call this being stubborn, often times the person just does not understand what is being said)
Slide 20: Strategies you can use for better communication

- Remove background noise (turn off radio, TV)
- Do a three second assessment: When approaching someone. Stop within 10 or so feet from them. Look at their face, look at their hands, about 3 seconds. What does the face tell you? Sad, upset, angry, bored, asleep, reading, engaged in something? What do the hands say? Are they relaxed? Restless, tapping, rubbing. Adjust your approach toward what you observe.
- Approach the person from the front and get eye contact.
- Call the person by name and state your name. Never say “remember me?” What’s my name? Do you remember your name?
- If the person uses the wrong word or cannot find a word, try guessing the right one.
- Use short, simple words and sentences. Talk slowly and clearly. Avoid jargon and slang.
- Ask one question at a time.
- Patiently wait for a response. A person may need extra time to process your request.
- Repeat information and questions. If the person doesn't respond, wait a moment. Then ask again.
- Avoid quizzesing such as "Do you remember when...?"
- Give simple explanations.
**Slide 22: Strategies for non-verbal communication**

- As verbal communication becomes increasingly difficult, you might find that you rely more on non-verbal communication, i.e. tone and pitch of voice, eye contact, facial expression, posture, sign language and physical contact.
- Soft and caring tone of voice. Talk “gently and in a soft, non-rushed manner.”
- Maintain eye contact when possible.
- Use the persons name often.
- Soft, calm, warm facial expression.
- Gesture to emphasize words and feelings.
- Use touch such as a hand on the shoulder if the resident allows this.
- Use a communication board to determine unmet needs.
- Put up signs
  - If you don't understand what is being said, ask the person to point or gesture.
  - Focus on the feelings, not the facts. Sometimes the emotions being expressed are more important than what is being said. Look for the feelings behind the words.

**Slide 23: Strategies for resident who are non-responsive or do not communicate**

- May respond well to soft, familiar voices and touch.
- Soft humming and very quiet singing may also be soothing.
- Can still take hold of their hand or put your arm around them. This can communicate a great deal and provide reassurance.
Slide 24: How do you know how much the individual understands?

- Do the 6 Point Communication Assessment
  - tell her to raise her arm (1 pt.)
  - ask what day it is (1 pt.)
  - ask what year it is (1 pt.)
  - ask her to identify a pen and a watch (1 pt.)
  - tell her to pick up the spoon (1 pt.)
  - repeat “today is a pretty day” (1 pt.)

Less than 3 points is significant impairment and the individual will need different methods of communication from staff.
Part Two: Communications

Directions for Implementing the Describing and drawing project

1. Ask for a volunteer from the audience, stating you need someone with excellent communication skills. Have that person come to the front of the room.

2. Provide each person in the audience with a blank sheet of paper.

3. Instruct the group that the volunteer in the front will describe what is on a piece of paper and the audience will make a copy of it on their paper.

4. The audience may NOT ask any questions.

5. Ask the volunteer in the front to turn around with his/her back towards the group.

6. Provide the volunteer with a copy of the following page and make certain that others in the room can not see the paper.

7. The volunteer will verbally (No body language or gestures) describe what the audience must draw.

When finished, have the volunteer up front show the original piece of paper.

Determine how many in the audience got the drawing correct.

Have the audience describe the frustrations, problems they had in completing the drawing.
Part 2: Communications
Post-Test

Date: ____________________                Occupation: _________________________

Facility: ___________________________   Name: ___________________________

How long working in this position: ______________________

1. A client with expressive aphasia may not be able to:
   a. recognize his children
   b. understand what is said to him or her
   c. ask for something to eat
   d. feed him or herself

2. A strategy for better communication with people with Alzheimer’s Disease is:
   a. provide detailed information
   b. ask them if they remember your name
   c. avoid slang and expressions
   d. call them honey as they probably don’t remember their own name

3. Non-verbal communication can be useful with:
   a. clients with anxiety
   b. clients who are non-verbal
   c. all clients
   d. clients in end-stage dementia

4. A good method of communicating with a non-responsive client is:
   a. talk softly to the client while providing care
   b. be silent when providing care
   c. chat with other staff members while providing care
   d. leave a radio on in the clients room
Part 2  Communications

Answer Key

Pre-test

1. c
2. b
3. d
4. b

Post-test

1. c
2. c
3. c
4. a
Part 3

Behavioral Issues
Objectives

Upon completion of this session the participants will be able to:

1. Discuss the different types of behaviors.
2. Describe how unmet needs lead to behaviors.
3. List strategies for responding to behaviors.
What are disturbing behaviors: Things to consider

- Is it a disturbing behavior, or a lifelong personality trait?
- Is it a disturbing behavior or merely annoying but harmless?
- Is the behavior harmful to the resident or to others?
Agitated Behaviors

- We want to prevent these from occurring
- If they do we want to calm those who are agitated

DOES THIS PHOTO TELL YOU ENOUGH?
Apathy or Passivity

Lack of interest
Lack of motivation,
Withdrawal
Social isolation

Depression
Loss of function

WHAT DOES THIS TELL YOU?
Passive Behaviors

- To prevent passive behaviors
- To alert those who are passive
Psychiatric

Depression
Anxiety
Psychosis
Paranoia
Delusions
Hallucinations
Physically non-aggressive

Motor-restlessness
Repetitive movements
Wandering
Rummaging, hoarding
Hiding things
Intrusive
Spitting
Pacing
Picking, scrubbing, and rubbing
Physically aggressive

- Hitting
- Biting
- Kicking
- Pushing
- Spitting
- Destroying things
- Throwing objects
- Self-injurious

Space, pain, perceived threat, frustration
Verbally Non-aggressive

Vocalizing
Repetitive questioning
Complaining
Screaming
Weepy, crying
Moaning

Pain, depression, fear, loneliness
Verbally aggressive

Arguing
Yelling
Threatening
Irritability
Cursing
Angry outburst

Past personality, chronic mental health issues
## Other behaviors

<table>
<thead>
<tr>
<th>Behavior</th>
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Now that you described the behavior.....
Look for a reason

1. Undressing
2. Suspicious
3. Climbing into bed with other resident

1. Skin irritation, history of home nudity
2. Hiding medications in foods
3. Unable to find own bed, “wife seeking” behavior
Look for an unmet need

- Afraid
- In Pain
- Tired
- Thirsty or hungry
- Lonely
- Cold, hot
- Craving activity or stimulation
- Need to go to the bathroom
- Need to change position
- Need to get away from......
Needs related to health

- Acute illness (can’t tell you)
- Chronic illness (arthritis)
- Effects of medicines (more confused)
- Changes in hearing or vision
- Dehydration (dry lips)
- Constipation (abdominal symptoms)
- Pain (rubbing)
- Depression (crying or screaming)
Needs related to the environment

- Too much noise or clutter
- Excessive stimulation
- Poor sensory environment
- No orientation or cues
- Environment too large or unfamiliar
- Unstructured environment
- Too cold, too hot
Needs related to the task

Task is too complicated
Too many steps at a time
Not modified for increasing impairment
Task unfamiliar
Too boring, childlike, or useless
Needs related to communication

- No communication
- Failed to get attention
- Too much verbal information
- Too fast, too loud, too soft, mumbled
- No cues or gestures or demonstration used
- Complicated language
Do some problem solving

- When did the problem occur?
- What triggered it?
- Look at time of day?
- Did you make an error in your approach? (Caregiver technique)
- Develop a list of alternative strategies to try
Behavior Basics

1. If you know one person with dementia, you know one person with dementia. What works with one may not work on another.

2. Persons with dementia almost always have short term memory loss. Do not “challenge” their short term memory by asking questions that rely on memory. Ask if they enjoyed breakfast, not what they had for breakfast.

3. If they ask you a question 50 times, just answer it the same way 50 times. It may be annoying to you but imagine how frustrating it is for the person who can’t remember.
4. Persons with dementia almost always remember what happened years ago:
   - This adds to their confusion.
   - They may be looking for their mother, their childhood home.
   - Avoid arguing or rationalizing that this person is no longer alive.
   - This serves little purpose as they will forget what you told them or get angry and argue.
   - It is easier to enter their world rather than to try to get them orientated to today’s world.

Example: Oh, your father is at work, we will call him later.
5. Tell what to do rather than what not to do

*Resident is heading towards the exit door, attempting to leave.*

- You say to him “do not to go out.”
- He stops, but then does not know what to do and may try to go out again.
- Instead of telling him not to go out ask him to come and help you, see something etc…….
- This gives an action to do to replace the desire to leave.
6. Sudden change in behavior comes from sudden problems. Example: Resident is usually agreeable and easy to deal with. One day he seems annoyed and agitated. He yells at you and refuses to eat. Behavior like this requires a doctor’s visit to find out what is physically wrong with him. A medication to calm him down does not help if he has a tooth abscess or urinary tract infection.

Also may be the resident who is normally agitated; is now calm and passive.
Basics cont.

7. Don’t talk about them in front of them

8. Realize that they would rather dress themselves, bathe themselves, drive, etc. These losses cause loss of self esteem and self-identity. Try to preserve dignity.

Basics cont.

10. Remember they have a brain disease.
   - They can not help the way they act.
   - Think that they are doing things intentionally or that they could stop their behavior if they really tried hard?
   - That is like telling someone with a heart condition that they could make their heart better if they tried real hard.
Re-set the schedule
Time of Day of the Problem

- Morning
- Afternoon
- Evening
- Night

Most residents have MIXED Behaviors: Times of passivity/times of agitation
Simple methods to manage the daily routine:

- Use a large clock, calendar, and schedule
- Find out the residents' prior routines & interests
- Stick with the same routine each day
- Simplify activities and encourage self-care
- Supervise with dignity-use system of least restrictive prompts (more details later)
- Structure activities - use planned lists for ideas
- **Do NOT** make the mistake of sterilizing the environment - stimulation & activity are vital!
- Individualize (see handout about Marjorie)
Use the 6 R’s for responding...

- Review unmet needs
- Reassess
- Reconsider your approach & plan
- Redirect if possible
- Routine and structure
- Reassure the confused individual
Balance the day

- Things for survival
- Interesting activities
- Rest
- Choices

Time to socialize
Family
Helping others

Kovach, 2003
Questions???

You will now fill out the Part 3 worksheet
This one you will do by yourself
Part 3: Behaviors
Pre-Test

Date: ____________________                Occupation: ____________________________
Facility: ___________________________ Name: ____________________________
How long working in this position: ____________________________

1. Your male resident has asked you “what’s for dessert?” ten times in the past 3 minutes. Which of the following methods of responding would best maintain the resident's dignity?
   a. Inform the resident you have already told him and will not tell him again.
   b. Answer the question the same way each time he asks.
   c. Tell him he will not get anything if he keeps asking.
   d. Inform the resident he needs his memory checked.

2. Your female resident has been refusing to take a shower. Which of the following would you do first?
   a. Ask another staff member to help you get her in the shower.
   b. Ask the resident why she does not want to shower.
   c. Tell the resident she has no choice.
   d. Tell the next shift to do the shower.

3. You have a new resident on your unit. She yells “Help me” “Help me” for hours the first evening. What is the first thing you should do?
   a. Ask to have the resident transferred off the unit.
   b. Request a psychiatric evaluation.
   c. Request earplugs for the staff.
   d. Assess the resident for basic unmet needs.

4. Your resident is asking for his father, who died many years ago. The best response to this is to tell him:
   a. Your Father is dead.
   b. Your Father would be 125 if he were alive today.
   c. He is busy, we will try and contact him later.
   d. He is in the cemetery.

5. You find a male resident climbing into the bed of a female resident. The first thing you do is:
   a. Assume he is being sexually inappropriate.
   b. Request a psychiatric evaluation.
   c. Assess if he has trouble locating his own room.
   d. Request placement in a special unit.
Caring for People with Alzheimer’s Disease and Related Disorders

Part 3: Behaviors

By

Linda Buettner, Ph.D. CTRS
Suzanne Fitzsimmons, MS, ARNP
Slide 3: Objectives

Upon completion of this session the participants will be able to:

1. Discuss the different types of behaviors.
2. Describe how unmet needs lead to behaviors.
3. List strategies for responding to behaviors

Slide 4: What are disturbing Behaviors: Things to consider

- Is it a disturbing behavior, or a lifelong personality trait?
  Some people always complain, are restless, yell and curse

- Is it a disturbing behavior or merely annoying but harmless?
  It may be annoying that a person taps, hums or whistle constantly, however it may be easier for you to tolerate this behavior than it is for the person to stop doing it.

- Is the behavior harmful to the resident or to others?
  Annoying behaviors are repetitive questions, wandering, attempting to leave, asking to go home. Harmful behaviors are physical or psychologically damaging to other residents. Name calling to a staff member may be ignored; name calling to other residents is harmful.

Slide 5: Agitated Behaviors

- We want to prevent these from occurring. Setting up the environment, modifying your approach, determining needs all helps to prevent agitation.

- If these behaviors do occur we want to calm the person who is agitated. Behaviors can escalate out of control and spread to other residents.

- Simply knowing a person is agitated does not tell you the full story.
Slide 6: Apathy or Passivity

- Is a lack of interest or motivation
- Leads to a withdrawal from life and social isolation
- Leads to depression and loss of function
- Simply knowing a person is passive does not tell you the full story.

Slide 7: Passive Behaviors

- Many people do not feel passive behaviors are a problem. Passivity, doing nothing, or apathy, having no motivation, leads to functional and cognitive decline. If you don’t use it you lose it.
- Passive behaviors means less self-care and more staff interventions for ADL’s. It may also mean moving less and lead to skin breakdown and incontinence. Decline in food intake leads, weight loss and other physical declines are some of the consequences of apathy.
- The objective is to prevent these passive behaviors
- To alert and engage those who are passive.

Slide 8: Psychiatric Conditions that may cause behaviors

This group of behaviors is often referred to as psychiatric symptoms. These are the symptoms that can lead to increased medications and a whole cascade of negative events. These need psychiatric evaluation. Often initially responds best to 1 on 1 intervention.

**Depression:** May cause weepiness, crying, moaning, sleep and appetite changes, and a decline in function.

**Anxiety:** May cause motor or verbal restlessness, excessive questioning, fear, pacing, rubbing. This too often causes sleep and appetite changes, and a decline in function.

**Psychosis:** Unfounded beliefs, argumentative, may become combative if misinterprets environmental cues and staff or other residents actions.

**Paranoia:** Suspicious behavior, excessive anxiety and fear, often fearful of others actions, accusing, difficult to reassure.

**Delusions:** Having false beliefs. This may cause anger, arguing and depression.

**Hallucination:** is a sensory perception experienced in the absence of an external stimulus. Hallucinations may occur in any sensory modality—visual, auditory (hearing), olfactory (smell), gustatory (taste), tactile (touch), or proprioceptive (sense of balance and position in space).
**Slide 9 Physically non-aggressive**

Expert researchers like Dr. Cohen-Mansfield have categorized behaviors to help us better describe the problem. More specifically, an area that we might work on after the client is assessed is the area of physical non-aggressive behaviors. This list includes examples of physically non-aggressive behaviors that we might be called on to treat.

**Motor-restlessness:** Constant or repetitive, non-productive body movements.

**Wandering:** May be seeking an exit seeking, may be recreational, craving tactile stimulation, environmentally cued, reminiscent, and agitated-purposeful (exit seeking)

**Rummaging, hoarding:** Packing and repacking clothing or items. Taking and hiding or hording large amounts of items. Taking things from other residents’ rooms, from staff, storage rooms etc.

**Hiding things:** Usually in combination with rummaging, paranoia and suspicious.

**Intrusive:** Getting into other persons personal space, no sense of privacy.

**Spitting:** Not directed towards others

**Pacing:** Different than wandering. Usually associated with anxiety and other psychiatric behavior.

**Picking, scrubbing, and rubbing:** More specific motor-restlessness actions.

**Slide 10: Physically Aggressive**

This probably has something to do with the individual’s past personality, past psychiatric disorder, environmental change, and style of coping with stress. It also may be specific to a care routine like bathing. Again it revolves around an unmet need and is probably the most appropriate response the individual can make. For these individuals you want to build a trusting relationship with them. You want them to trust you and feel safe with you and visa-versa. Once the individual trusts you, you can become their advocate in care or quality of life.

Often these behaviors are an attempt to get control of a situation they are not comfortable with. It may mean they feel frustrated, threatened or anger towards a specific person or the environment in general. You may see: Hitting, Biting, Kicking, Pushing, Spitting, Destroying things, Throwing objects, Self-injurious
Slide 11: Verbal Non-Aggression

This is another prevalent problem. The client who is constantly talking, making noise, complaining, asking for help, moaning, crying or screaming is troubling to others. This is a tough category. First of all if this behavior is not harmful to the individual, he or she might simply be bored or lonely. More structure in the individual’s day should help. For screaming or moaning the individual probably needs a pain assessment and your first recommendation should be for that. Determine unmet needs and try to establish a trusting relationship.

**Vocalizing:** Verbally aggressive
**Repetitive questioning:** Asking the same thing over and over
**Complaining:** Generally the complaining is repetitive
**Screaming:** Without any seeming cause such as pain
**Weepy, crying:** May be a method of communication when the resident can not pinpoint what he/she is unhappy over.
**Moaning:** When pain, discomfort is ruled out, may be a habit or a form of restlessness. Best to intervene immediately before it becomes a habit.

**Pain, depression, fear, and loneliness:** These are often the causes of verbal non-aggressive behaviors

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Slide 12: Verbal Aggression

This might be a specific reaction to one staff member or resident, pain, past personality, or simple frustration. These behavior are generally directed to other people

- Arguing
- Yelling
- Threatening
- Irritability
- Cursing
- Angry outburst

Past personality and chronic mental health issues are often factors in these behaviors.
Slide 13: Other Behaviors

**Refusing care:** May wish to do this themselves, may not feel comfortable with particular caregiver

**Refusing medications:** May not like the taste, may have too many medications ordered

**Refusing foods or liquids:** Medication toxicity, oral problems such as tooth decay or abscess

**Socially inappropriate:** Determine their culturally acceptable behavior

**Disrobing:** Can’t find their room, skin irritation, UTI, hot environment, normal behavior

**Urinating in public or somewhere other than a toilet**

**Suspicious, paranoid**

**Elopement:** What is the unmet need?

**Gluttony:** Often seen with those with Pick’s Disease.

**Pica (eating non-edibles)**

**Sleep-wake disturbance:** Bright light therapy/outdoor waking may help.

**Late day restlessness:** Try exercise and a nap.

**Sexually inappropriate/Disinhibited** Sexually inappropriate behavior are often not what they seem and staff and family often over react.

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Slide 14: Look For a Cause for behaviors

**Undressing** - May have a history of going nude at home, may have skin irritation, may have clothing on incorrectly

**Suspicious** - May correctly suspect that staff is hiding medication in food. Trying to “poison” them.

**Getting into bed with another resident** - May be unable to find own bed, may think it is their spouse

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Slide 15: Look For an unmet need

**Afraid:** Look for pacing, trembling, picking

**In Pain:** Rocking, rubbing, moaning

**Thirsty or hungry:** Wandering, seeking behavior

**Tired:** Need to rest or sleep

**Lonely:** Apathy

**Cold, hot:** Sweating, flush or pale skin, body language

**Craving activity or stimulation:** Attention seeking

**Need to go to the bathroom:** Pacing, irritable

**Need to change position:** Restless

**Need to get away from…...** Irritable
Slide 16: Needs related to health

**Acute illness** (can’t tell you)
**Chronic illness** (arthritis)
**Effects of medicines** (more confused)
**Changes in hearing or vision** (Increase in confusion)
**Dehydration** (dry lips and furrowed tongue)
**Constipation** (abdominal symptoms)
**Pain** (rubbing)
**Depression** (crying or screaming)

Slide 17: Needs Related to the Environment

**Too much noise or clutter:** Irritable
**Excessive stimulation** Irritable
**Poor sensory environment:** Apathy
**No orientation or cues:** Increased confusion
**Environment too large or unfamiliar:** Irritable
**Unstructured environment:** Confusion
**Too cold, too hot:** Irritable

Slide 18: Needs Related to the Task

Task is too complicated
Too many steps at a time
Not modified for increasing impairment
Task unfamiliar
Too boring, childlike, or useless
Slide 19: Needs Related to Communication

No communication: Unable to communicate at all
Failed to get attention: Unable to get someone’s attention
Too much verbal information: Unable to interpret the message
Too fast, loud, too soft, mumbled: Unable to hear the message clearly
No cues or gestures or demonstration used: Unable to interpret the message
Complicated language: Unable to interpret message

Slide 20: Do some Problem Solving

When does the problem occur? Morning? Bath time? With a particular staff person? During or after family visits? Everyday?
What triggered it? Similar to above but more specific
Look at time of day? Is it in the morning, evening, night?
Did you make an error in your approach? (Caregiver technique) Did someone else set the resident off such as another resident, a family member, or something else
Develop a list of alternative strategies to try: Such as bathing in the evening

Slide 21: Behavior Basics

- If you know one person with dementia, you know one person with dementia. Everyone is different, with different needs. What works with one may not work on another.

- This is a common error that families make. Testing their loved ones to see how much better or worse they are on a given day. There are many, many physical and other reasons for having a better or worse memory at a given time such as blood sugar, oxygenation, cardiac function, medication usage are a few examples.

Persons with dementia almost always have short-term memory loss. They may not remember what occurred yesterday, an hour ago, or a moment ago. Do not “test” their short term memory by asking questions that rely on memory. Ask if they enjoyed breakfast, not what they had for breakfast. You would hate it if someone did that to you on a daily basis. It makes them feel bad about themselves and serves no purpose. If you want their memory tested ask the head nurse, the doctor or someone with testing knowledge to do this.

- If they ask you a question 50 times, just answer it the same way 50 times. It may be annoying to you to be asked that many times but imagine how frustrating it is for the person who can’t remember.
Slide 22: Behavior Basics cont

- Give a hint!! You are walking with a resident when you see his wife coming down the hall. Don’t ask “Do you know who that is?” Say” Hey look, its your wife Betty.”

- Persons with dementia almost always remember what happened years ago. This is one factor that adds to their confusion. They may be looking for their mother, their childhood home. Avoid arguing or rationalizing that this person is no longer alive. This serves no purpose, as the person with dementia will forget what you told them within the hour. It is easier to enter their world rather than to try to get them orientated to today’s world. Example: Oh, your fathers at work, we will call him later.

Slide 23: Behavior Basics cont.

- Make the facility available. Lock away poisons, breakable, the important papers. Have many areas that they can rummage through without being told “no”.

Tell what to do rather than what not to do:

Resident is heading towards the exit door, attempting to leave.

- You say to him not to go out.
- He stops, but then does not know what to do and may try to go out again.
- Instead of telling him not to go out ask him to come and help you, see something etc……..
- This gives an action to do to replace the desire to leave.

Slide 24: Behavior Basics cont

- Provide choices, simple choices. Poor Example: What flavor ice cream do you want? Good Example: Do you want chocolate or vanilla ice cream?

- Sudden change in behavior comes from sudden problems.

Example: Resident is usually agreeable and easy to deal with. One day he seems annoyed and agitated. He yells at you and refuses to eat. Behavior like this requires a doctor’s visit to find out what is physically wrong with him. A medication to calm him down does not help if he has a tooth abscess or urinary tract infection. Also may be the resident who is normally agitated; is now calm and passive. May indicated an acute undetected illness.
Slide 25-26: Behavior Basics cont

- The best way of preventing problem in the future is to have routines in place now. Bathing, dressing, meals.

- Don’t talk about them in front of them.

- Ignore behaviors that are irritating but harmless.

- It is easier for you to change than to change a person with dementia.

- Persons with Alzheimer’s disease often lose their sense of taste. The taste of sweet things is the last to go therefore they may have developed a severe “sweet tooth.” Provide ice cream or Ensure if they are refusing to eat regular meals.

- If word finding is a problem create a communication board, a hint book, or respond to the emotion.

- As we age it is difficult to understand when there are distractions in the environment. Turn off the TV or radio; get away from the crowd if communication becomes frustrating.

- Realize that they would rather drive, shop, do the bills, dress and bathe themselves.

- Remember they have a brain disease and can not help the way they act. Thinking that they are doing things intentionally or that they could stop their behavior if they really tried hard is like telling someone with a heart condition that they could make their heart better if they tried real hard.

- Avoid “hiding” medications in foods. This leads to paranoia and refusing to eat, for a good reason.

- Not all of these will work all of the time or with every resident.

- Choose your battles. Save the arguments for what really matters: safety issues.
Slide 28-29: Schedules

We often hear that someone has agitated behavior or that they are passive. Research shows that the most common behavior is mixed behaviors. That is during a 24-hour period a resident will show periods of both agitation and periods of passivity. Some people feel that passivity leads to boredom and ultimately agitation. As behavior fluctuates throughout the day, programs and techniques of care providers should take this into account. Other finding from research:

Passive behaviors: provide programs in the morning when most alert and in the late afternoons to alert the resident prior to mealtime.

Agitated behaviors: Provide programs ½ hour prior to the residents known time of agitated behaviors, also provide quiet programs in the late afternoon and early evenings.

Slide 30: Managing a Routine

Routine is a major part of behavior prevention. Here are some tips:

- Use a large clock, calendar, and schedule
- Find out the residents prior routines & interests
- Stick with the same routine each day
- Simplify activities and encourage self-care
- Supervise with dignity-use system of least restrictive prompts (more details later)
- Structure activities - use planned lists for ideas
- Do NOT make the mistake of sterilizing the environment - stimulation & activity are vital!
- Individualize (see handout about Marjorie)

Slide 31: Use the six R’s to respond to a Behavior

- Review unmet needs
- Reassess
- Reconsider your approach & plan
- Redirect if possible
- Routine and structure
- Reassure the confused individual
Don’t leave people sitting in one place, doing one thing, without stimulation too long. Balance the day with activity, rest, food, toileting, and fun with others.
ADDITIONAL INFORMATION

Risks for behaviors

- Impaired communication (language difficulties)
- Female
- Fatigued
- Recently experienced a change of environment, housemate, or routine
- Individuals who are experiencing pain or infection
- Individuals who are experiencing an overwhelming influx of external stimuli
- Individuals who are deprived of environmental stimuli or activity
- Individuals receiving health care
- Individual with impaired physical function
- Individuals with depression

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Responding to Behaviors

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Verbal Behaviors

Repetitive Questioning: Due to loss of short-term memory. Give consistent answers, distract, provide activities. Write answer on pad for patient to keep.

Complaining: Generally caused by unmet need that can’t be verbalized. Listen for feelings in addition to content. Observe body language for clue as to pain, fatigue etc.

Asking for the impossible: (such as a deceased relative): Long-term memory intact, short-term impaired. First talk to them about person they are asking for, look at photos of the person, they miss them, do not tell them the person is deceased, then attempt to distract.

Screaming: Over/under stimulated, unmet need, underlying untreated physical/emotional condition. Depression is a frequent cause of screaming. Provide comfort items.

Manipulative: Frustration, confusion. Provide simple tasks, focus on feelings not facts.

Anxiety: Confusion, fatigue, over stimulated. Assess needs, reassure, provide comfort and outlets.

Paranoid/Suspicious: Common in middle stages, often caused by forgetting where items are located. Do not argue or try to reason. Investigate the suspicion; it may be based on fact. Offer simple answers. If forgetting whereabouts of belongings have multiples of items if possible, learn hiding places. Do not take personally.

Withdrawn/Isolated/Weepy/Apathy: Get assessed for depression.

Cranky: Check for unmet need, pain, fatigue. Remove from over stimulating environment.
Slide Identify and manage behaviors common to patients or participants with ADRD.

Psychiatric Or Other Inappropriate Behaviors

Hallucinations/Delusions: Hearing or seeing something that is not there or unfound beliefs. Investigate if it is in fact a hallucination. Check for visual or hearing impairment, increase lighting, remove clutter. Check for sensory depravation. Check medication side effects.
**Socially Inappropriate Behavior**/ No longer remembers social graces. Avoid situations that precipitate inappropriateness. Don’t scold, distract by giving simple tasks.

**Impulsive Sexual Behavior:** Remain calm and reply consistently. If self-stimulating, provide privacy. Increase opportunity for touch and warmth. Offer soothing objects. Don’t argue or reason, change subject. Ignore that which is harmless.

**Undressing:** Provide comfortable clothes, praise appearance, check for skin irritation, urinary tract infections and bathroom needs. If persistent, provide clothing with fasteners in back, provide activity to keep hands busy.

**Urinating in public/inappropriate places:** Place signs on bathroom door. Provide bedside commode. Toilet before leaving home and check for need every half hour. Establish toileting schedule. If persistent get assessment for urinary tract infection or prostate problem.

**Spitting:** Check for swallowing difficulties, dental exam for oral pain, provide tissues or cup.

**Aggressiveness**

**Verbal:** Under or over stimulating environment, frustration, pain, constipation, fatigue. Only one person should address the patient, having many people talking at once will add to the aggression and confusion. Use soft voice, don’t argue or attempt to reason, try distracting by changing the subject or engage in an activity. When all else fails ignore the outburst and give time for both of you to cool down. Quiet the environment. Check basic needs especially pain or fatigue.

**Physical:** Under or over stimulating environment, frustration, pain: Stay calm, protect yourself, remove dangerous items from environment, give personal space, do not confront or accuse, offer reassurance that you will keep them safe. If holding onto you tight, stay relaxed; attempting to pull away will cause increased grabbing. Calmly state that this hurts. Bring the resident to quiet controlled environment. Determine what triggered reaction and prevent situation from reoccurring.

**RESTLESS**

**Pacing Picking:** Substitute an activity for the behavior. Allow freedom to move safely, find outlets for energy. Walk, exercise, dancing, craft activity.

**Rummaging/Hoarding:** Provide dresser or space for rummaging and provide activities. Ignore behavior that causes no harm.

**Refusing**
**Medications:** Inability to understand the need, difficulty with swallowing. Give only essential medications. Tell that the MD, or other influential person wants them to have it. Make simple medication chart and post to give control to the patient.

**Foods:** Give one food at a time, give small servings, provide many small meals throughout the day, provide calm environment, eat with others, allow to feed self even if messy, provide finger foods, oral assessment. Check medication side effects.

**Fluids:** Offer fluids on a regular basis. Check for oral pain. Give high fluid content foods such as Popsicles, pudding, fruit.

**Others**

**Overeating:** Forgotten that they have eaten. Provide low cal snacks such as crackers, involve in cooking and other activities, allow her to plan menus and post them.

**Pica behavior:** Inability to recognize an item as being inedible, eating non-edible items: Remove harmful items such as plants, Styrofoam, paper products. Provide finger foods, gum, and crackers. Involve in activities to keep hands busy.

**Providing Personal Care and ADL’s**

**Basics**
- Communicate who you are and what you are going to do
- Provide privacy
- Provide comfortable environment (room temp)
- Focus on them not the TV or another staff member
- Consider individual preferences and needs
- Allow them to do as much as possible for themselves
- Provide simple instructions
- Provide simple choices
- Routine
- Be patient
- If you have a “difficult” resident, provide care to him/her first in the morning, rather than leaving till last.

**TIPS for DRESSING**

1. Limit choices of clothing in closets and dressers. Too many choices may be overwhelming.
2. Lay out clothing in the order they would be put on for self-dressing.
3. Use layering.
4. Replace buttons, zippers, and fasteners with Velcro. Velcro often enables the older adult with dementia to continue to dress independently.
5. Allow time and encourage the individual to do as much as possible. Avoid delays or interruptions in the routine.
6. Make sure the room is warm enough, especially if it takes the person with the impairment some time to get clothing on and off.
7. Provide privacy for dressing.
8. If the individual insists on wearing the same clothes everyday, try to launder them often and get duplicates of favorite clothing.
9. Break down all dressing techniques into manageable steps. Assess whether the person with the impairment needs sequencing (putting in order), prompting (verbally reminding what to do), or hand over hand assistance (physically helping). Don’t over do your helper role!
10. Be gentle: avoid rushing, forcing limbs, pushing, grabbing.
11. Keep your voice calm and pleasant even if you are feeling impatient and frustrated.
12. Get help if you are having trouble.

Considerations:
A generation ago people did not change their clothing everyday. Being reminder to do so can be humiliating. Being able to dress independently promotes self-esteem. Allow the person time. If someone is removing clothing inappropriately consider the reason. Are they too warm? Do they need to go to the bathroom? Are they ready for bed?

Toileting

Individuals affected by dementia often become incontinent – unable to control urination or bowel movements – as the disease progresses– but many people find ways to manage this problem.

1) Make sure she/he can get to the bathroom: Leaving the bathroom door open may be helpful at times or a simple sign with a Toilet symbol will help.

2) Reminding: Once residents lose sense of the location of the bathroom they may need redirection towards the bathroom and possible cuing as to the chain of events. Watch body language and behaviors that signal a need to find the bathroom.

3) Observing their normal bathroom habits: Make mental or physical notes of when your resident normally uses the bathroom and when they have bowel movements can be of great assistance later when you have to ensure they make it to the bathroom.

4) Conditioning: As the disease progresses and daily structure becomes more important, you may have to develop a toileting schedule. Take the resident to the restroom when she/he is most likely to go, even if she was already wet. This helps in stages when residents were no longer aware of their needs.

5) Protective products: Avoid using these for persons who are generally continent. Doing so will increase the likelihood of them become incontinent permanently. Check
and change soiled incontinent products every 2 hours. **If left unchanged they tend** to be bulky and heavy, especially between the legs. The plastic outer covering can be irritating and cause heat build up within the product itself.

6) **Getting a resistant person to sit on the toilet:** Often the resident does not understand what you are doing, being pulled and tugged on and can become very anxious over the whole procedure, sometimes resulting in fight.

Resistance is often caused by confusion over what is happening.
Is there a favorite staff member?
Only one person should provide verbal instructions to avoid confusion and fear.
Use calm voice
Tell the resident that you are here to help

Stand on the same side of the resident when she/he was standing in front of the toilet.
Back her/him up till the toilet seat touches the back of her legs.
It might be helpful to place a foot at the place where you wanted the client to start sitting down. Then when the heels hit your foot or the back of her legs touches the seat edge, the client will stop. Then place one hand on her back by her shoulders and one hand on her waist to start the sitting motion. You can also give simple verbal directions at the same time. Give any verbal direction as one step at a time until that step is completed and the next step is ready.

7) **Cleaning up after using the bathroom:** Make sure your resident/client is cleaned up properly after having a bowel movement to avoid infection, skin damage and unpleasant odors. The ease of this will likely depend on your loved one’s state of mind. It is best to clean from the front to the back to avoid infection from the fecal matter that may be there.

8) **Setting up a regular routine:** Setting up a regular bathroom routine is essential as the disease progresses. This does not mean taking your resident/client to the bathroom at an exact time but at regular intervals that you know will work for your loved one. For instance at a certain length of time after eating, a certain time before bed or even during the night after going to bed. This not only helps to get to the bathroom before they have an accident but also allows you a regular time to help keep them clean.

9) **Identifying environmental problems in the bathroom:** Here are some items that can also cause problems for person using the bathroom:

   **Privacy, privacy, privacy**

   **Simplify:** Keeping the bathroom as free from clutter is better.

   **Recognizing:** Keep the lid up on the toilet and keep the bathroom as open as possible helps to reduce anxiety and confusion. Avoid using the bathroom as a storage closet for wheelchairs etc, it looks confusing and not like a bathroom. Make certain it smells good.
Bathing And Grooming:

Basics

- Encourage self-care as long as possible.
- Personal preferences and past practices
- Provide time, privacy and simple one step instructions
- Sequence of appropriate prompts:
  - Verbal: Mary brush your teeth
  - Demonstrate if needed (You pantomime brushing your teeth)
  - Hand over hand start the motion Place your hand on Mary’s hand and guide it up to her mouth

Bathing Tips:

- Bath time is frightening for many individuals and is the most frequent time for catastrophic reactions (angry out of control outbursts) to happen. The person may become confused and cannot manage independently, because he/she is embarrassed because they need help in a very personal way.
- Be very patient with the individual.
- Tell the person about the bath just before it is time.
- Have everything prepared ahead of time (soap, towels, shampoo, clean clothes, etc.).
- Water temperature should be monitored closely so that it is not too hot or too cold.
- If possible baths (only a few inches of water) are preferable to showers for many older adults. If a shower is inevitable, use a shower chair and a hand held showerhead.
- Have grab bars installed in the bathtub and bathroom to ensure the person's safety.
- Eliminate other safety hazards in the bathroom such as throw rugs or extra containers of shampoo, etc.
- It is often helpful to give the individual a bath mitt or a washcloth to hold. It may prevent the caregiver from being grabbed or hit.
- A warm bathrobe and cozy slippers are often helpful in the transition after the bath.
- Do not overdress, comfortable clothing is best and is more practicable.

Shaving

It is much easier (and safer) to shave another person with an electric razor. Individuals who are diabetic or on anti-coagulants (such as Coumadin or other medications to thin the blood), should use an electric razor to reduce the risk of cuts and infection. If the care receiver wears dentures, have them put them in their mouth before shaving him. Also,
have him in a sitting position if possible. If your care receiver can't shave on his/her own because of an unsteady hand, let him/her apply the lather and wash off with a cloth after he/she is shaved.

**MEAL TIME:**

- Do not stand over the residents. Sit to interact.
- Talk to the residents rather than to other staff member, or include the residents in your conversation
- Do not watch TV during mealtime.

1. Keep the dining area quiet and free from distractions. Soft relaxing music may be good. Avoid glaring lights.
2. When serving a meal, eliminate complex choices by placing one or two types of food out at a time.
3. Set simple place settings with only the dishes and utensils the person will need for the meal. Avoid designs on the plates. A plain color is best.
4. Contrast the colors of the tablecloth, napkins, and plates so that the person with the disability can distinguish between items easily.
5. Get rid of artificial fruit and vegetables or other items that might be eaten by mistake.
6. Allow the individual plenty of time to eat and encourage the person to feed himself or herself.
7. Maintain a regular mealtime schedule and provide social interaction and conversation.
8. Sit at the same place and at the same table for all meals.

**If there are problems consider:**

1. Assess what is causing the problem. Is it the use of silverware, other distractions, too much food on the plate, caregiver impatience or position? Try finger foods like sandwiches, cheese cubes, fish sticks, and cubed fruit pieces. Eliminate noise and confusion in the dining room. Serve one bowl of food at a time. Allow 45-60 minutes for the person to eat.
2. Keep in mind the dietary history of the person. Did they have a sweet tooth, small appetite, never ate breakfast? Don’t force them now.
3. Consider temperature of food. Persons with cognitive impairments cannot always judge the temperature of the food when it is too hot. Test the food for the person it there is any doubt.
4. Having the person assist in food preparation can increase appetite. Peeling oranges, stirring batter, making a salad are sensory tasks that stimulate appetite.
5. Loss of desire of forgetting to drink can lead to dehydration and other medical problems. Offer fluids on a regular schedule.
6. If plates are sliding around the table use a wet washcloth or piece of rubberized material to stabilize the setting. Suction plates and weighted spoons are available at medical supply companies.
7. Medical problems like depression or constipation can cause a loss of appetite.
INTERACTION TIPS

**Tip one: approaching the person with dementia**
1. Approach slowly and calmly; speak slowly, clearly, and distinctly. Introduce yourself each time and state what you are doing.
2. Use a friendly tone and facial expression that is pleasant.
3. Make eye contact and call the person’s name.
4. Do not touch the person from behind or the side, or without his or her permission.

**Tip two: instructing the person with dementia to complete tasks**
1. Use one step instructions.
2. Use gestures and demonstrations to supplement words.
3. Be patient and repeat instructions the same way.
4. When possible tell the patient what to do, not what not to do.

**Tip three: getting dressed**
1. Allow the person to do as much as possible for himself or herself.
2. Make a pile of clothing to put on in the order in which one would dress.
3. Get easy to put on clothes and limit the choices.
4. Use a consistent method each day.
5. Simplify closets and dressers and add written cues.

**Tip four: bathing**
1. Try to set up a bath time routine. Bathe the same time of day.
2. Set up the bath area with everything within reach before you start, make sure area is warm.
3. Talk reassuringly during the bath.
4. Provide privacy and the opportunity to do as much as possible for self.
5. Use soothing music, laminated photos, and snacks as distractions.
6. Bath mitts are often useful to keep the individual involved in self-care.

**Tip five: eating** - food preparation is a great activity for the person with dementia.
1. Make sure the person is sitting upright, and is comfortable at mealtime.
2. Simplify the table and the environment. (e.g. turn off TV, radio, etc.) Avoid crowding.
3. Serve small amount of food at a time, do not clutter the area with distractions.
4. Assess ability to use silverware, and provide finger foods as needed.
5. Assess ability to sit for required amount of time, provide mobile foods & fluids.
6. Give preferred foods. Continue to reassure the individual about safety of foods.
7. Observe and assess for swallowing problems.

**Tip six: wandering and mobility**
1. Allow the individual to have as much freedom as possible. “Use it or lose it” philosophy.
2. Safe proof dangerous areas, put up stop signs, make sure the bathroom is marked with a visible sign or a different colored door.
3. Provide lots of activities and things to do throughout the home.
4. No medication will stop the individual from wandering, sensorimotor activity is a basic need.
Tip seven: aggressive or hostile behavior
1. First make sure the person is safe and will not cause harm to others. A quiet homelike area may prove useful. Try a calming diversion, a rocking chair, and a relaxation program.
2. There is a reason for every behavior. Ask yourself the following:
   • Is there a basic need such as thirst, tired, hunger, pain, toilet need, lonely, or bored.
   • Is this a new behavior? Does it occur with a specific other person, time or place?
   • Is the person medically ill?
   • Is there something new in the environment? Too much stimulus? Not enough?
   • Has there been any change in medication?
   • What triggered the behavior? How could this be prevented in the future?

Tip eight: rummaging and hoarding and repeated verbalization
1. Try redirecting the individual by giving something to do such as a game, magazines or books, puzzles, a newspaper to read, music to listen to.
2. Create a rummaging dresser in an area the individual frequents.
3. Provide walking and exercise on a daily basis.
4. Provide with sensory activities in a variety of locations.
5. Provide with structured daily activities and programs to meet needs for stimulation.
6. Who is a problem for? Is the behavior harmless but irritating to staff or family? Can the behavior be ignored? Answer repeated questions calmly each time.

Tip nine: the environment
1. People with dementia need a quiet, orderly environment.
2. For safety, maintain uncluttered rooms and hallways.
3. Doors of different colors may help the individual find the bathroom. Signs are helpful.
4. Avoid high gloss, slick floors and tabletops.
5. Avoid using scatter rugs, especially dark colored rugs.
6. Create activity areas throughout the home with interesting things to do.

Tip ten: take care of yourself
1. Remember the person you care for has a serious brain disease. Do not take the behaviors personally; they are part of the illness.
2. Eat right, exercise and get regular check-ups.
   Ask for help when you need it, don't wait till you can no longer cope.
Part 3 Worksheet Directions:

1. Provide each staff member with a copy of the sheet on the following page. Inform them that they will be filling it out on themselves.

2. The first section lists what research has found to be risks for disturbing behaviors. Although the research looked at persons with cognitive impairments, it is interesting for staff to see any of the risks they might have. Have the staff check any of the risk factors they have. Then ask for a raise of hands to show who has one or more risk, 2 or more and so on.

3. Part 2 is simply the descriptions of disturbing behaviors that are common in persons with cognitive impairments. Have your staff check any of the behaviors they might have had in the past 2 weeks. Then ask for a raise of hands to show who had one or more behavior.

4. Next, of the staff who raised their hands for having, ask for a show of hands for how many felt that their behavior was due to an unmet need.

This exercise shows that even without cognitive impairments, that humans often have behaviors.
Part 3: Behaviors

Part 1: Check any of these risks that you have:

- Impaired communication (language difficulties)
- Female
- Fatigued
- Recently experienced a change of environment, housemate, or routine
- Individuals who are experiencing pain or infection
- Individuals who are experiencing an overwhelming influx of external stimuli
- Individuals who are deprived of environmental stimuli or activity
- Individuals receiving health care
- Individual with impaired physical function
- Individuals with depression

Part 2: Check off any of these behaviors you have done in the past week

- Apathy: passive, lack of interest, lack of motivation, withdrawal, and social isolation.
- Psychiatric: depression, anxiety, psychosis: paranoia, delusions, and hallucinations.
- Physical non-aggressive: motor-restlessness, repetitive movements, wandering, rummaging, hording, hiding things, intrusive, spitting, pacing, picking, and rubbing.
- Physical aggressive: spitting, hitting, biting, kicking, pushing, destroying things, and self-injurious.
- Verbal: non-aggressive: vocalizing, repetitive questioning, complaining, screaming, weepy, crying, and moaning.
- Verbal: aggressive: arguing, yelling, threatening, irritability, cursing, and angry outburst.
- Other: refusing care, medications, foods or liquids, socially inappropriate (disrobing, urinating), gluttony, pica, sleep-wake disturbance, sun-downing, sexually inappropriate, and disinhibition.

Buettner & Fitzsimmons 2007
Marjorie - My Routine -

❤ Have a good stretch and get out of bed
❤ Take my morning pills the nurse brings me
❤ Wash and dress: I shower and shampoo my hair twice a week (Monday and Friday).
❤ Have a cup of coffee with my breakfast.
❤ Straighten things up in my room.
❤ Go to morning exercise class
❤ Ask the nurse if I can read to any of the residents who are blind.
❤ Lunch
❤ Nap
❤ Afternoon craft program
❤ Watch Oprah
❤ Have dinner
❤ Chat with family on the phone
❤ Get ready for bed
❤ Take evening meds
❤ Get a good nights sleep

Other Things To Keep Me Busy When I Am Bored:
Attend music programs, pet or children visits
Now fill this out on yourself, describing a typical day. Next select one of your residents and fill out what their routine is. Add to it things you think would make their life more meaningful.

Now list your Weekday Routine:

Other Things To Keep Me Busy When I Am Bored:
Part 3: Behaviors
Post-Test

Date: ____________________                Occupation: _________________________
Facility: ___________________________   Name: ___________________________
How long working in this position: __________________

1. Your male resident has asked you “when is lunch?” ten times in the past 3 minutes. Which of the following methods of responding would best maintain the resident's dignity?
   a. Inform the resident you have already told him and will not tell him again.
   b. Tell him he will not get anything if he keeps asking.
   c. Tell him when lunch is.
   d. Inform the resident he needs his memory checked.

2. Your female resident has been refusing to take a shower. Which of the following would you do first?
   a. Ask another staff member to help you get her in the shower.
   b. Ask the resident why she does not want to shower.
   c. Tell the resident she has no choice.
   d. Tell the next shift to do the shower.

3. A resident named Joe is saying he wants to go home. He starts walking towards the exit door. Your best response is:
   a. “Joe, come here, I want to show you something”
   b. “Joe, don’t go out that door”.
   c. “Joe, you don’t want to go now, it is dark out”
   d. “Joe, get back here or you will not get supper”.

4. Your resident is asking for his father, who died many years ago. The best response to this is to tell him:
   a. Your Father is dead.
   b. Your Father would be 125 if he were alive today.
   c. He is busy; we will try and contact him later
   d. He is in the cemetery

5. Your client, Norma, is normally agitated on bath day. Today Norma allows you to provide care without the usual cursing and yelling. After the shower you:
   a. Tell Norma what a good girl she was
   b. Tell the nurse you think Norma might not be feeling well.
   c. Brag to others that you have the magic touch
   d. Tell the family that Norma’s behaviors are improving
Part 3  Behaviors

Answer Key

Pre-test

1. b
2. b
3. d
4. c
5. c

Post-test

1. c
2. b
3. a
4. c
5. b
Caring for People with Alzheimer’s Disease and Related Disorders

by:

Linda L. Buettner & Suzanne Fitzsimmons
Part 4

Providing Activities
Objectives

Upon completion of this session the participants will be able to:

1. Describe the benefits of activities for residents.
2. Describe how to select activities based on personality.
3. List basic principals for running small groups.
4. Explain how various staff members can assist in providing activities.
5. List what type of activity is beneficial to what behavior type.
Part 3
Providing Activity
Benefits of remaining active

1. Provides sensory stimulation
2. uses physical skills - prevents disuse or atrophy from occurring
3. Provides an opportunity for socialization
4. May lead to better mood and less apathy
5. Improves cognitive function
6. Improves sleep
7. Allows for self expression
8. Fitness - cardiovascular, strength, flexibility
9. Allows opportunity to test self
Dr. Cohen-Mansfield found that 60% of day nursing home residents have NOTHING to do.

This is the time when most disturbing behaviors occur.
What to do based on who

- Plan the activities; consider what the person enjoyed in the past.
- The more impaired the person, the simpler the activity needs to be.
- APPROACH and COMMUNICATION are critical. Demonstrate what to do and provide encouragement.
Immediate Family

Spiritual life

People you care about

Your dreams for the future

What you love to do for fun

Hobbies
Personality

- Personality is our pattern of thinking, feeling and acting
- Style of Interest defined by two personality traits
  - Extraverted versus Introverted
  - Open versus closed
<table>
<thead>
<tr>
<th>Trait</th>
<th>High Score</th>
<th>Low Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extraverted</td>
<td>Outgoing, sociable, active, assertive, talkative</td>
<td>Reserved, loner, even-paced</td>
</tr>
<tr>
<td>Openness</td>
<td>Curious, like novelty, experience emotions, aesthetic</td>
<td>prefer the familiar, muted emotional responses, conservative</td>
</tr>
</tbody>
</table>
Steps in running a small group

1. Get your stuff together for the activity
2. Bring your residents to area for the activity
3. Think about their personalities
4. Alert each person
5. Show and Tell
6. Demonstrate
7. Each person gets to touch, talk, move
8. Keep it short – leave them wanting more.
9. Bring the group to closure – say goodbye and help them on to something else.
Design of Activity

Something the resident does not the staff
Can be anything (normal):

- Club
- Writing/reading/poetry
- Sing or Dance
- Walk together
- Card group
- Fashion club
- Cooking club
- Reading group
- Nature lovers
- Dog Fanciers
Never leave a resident with nothing to do....

- After care or activity session provide resident with a something to hold or interact with.
- Think about style of interest
- Magazine, familiar game, video of family, Simple Pleasures item, towels to fold.
PET Scans show why
Sensory activity can take place in many ways

- Before care
- During care
- After care
  - When alone
  - When in a small group

- EVERYTHING on a special care unit should become an activity to help the resident

- Transitions are very important
Animal Assisted Activities

- Goals:
  - Practice ADLs
  - Mobility
  - Social skills
  - Communication
  - Provide emotional outlet
  - Cognitive stimulation
Exercise for function

- Basic assessment and physician approval
- At least 3x per week on the unit
- RT plus exercise videos
- Exercise to music is best.
Cognitive Activities

- Nancy-MMSE=0
- Client we treated in community
- Considered a “problem” in nursing home
- Designed a plan with cognitive activity in a.m. and adapted music in p.m.
Use students and volunteers

- Teach them about dementia
- How to do an activity with people with memory loss
- Have them assist a few times then take over.
Basic Principles

- Object is to actively engage
- Resident does more than the staff does
- Staff instructs, then prompts, resident speaks
- Adapt activity to lower functioning
- Lower functioning needs shorter programs with fewer participants
- Minimal use of large programs
Helping your resident attend various types of activities

- Know which ones they wish to attend (preferences)
- Have resident ready for the activity
- Transport them if on unit, arrange transport if off-unit
- Ask activity department to include your resident in activities
- Ask family members to participate in facility activities with resident
Help your resident with self-initiating activities

- Seat near radio
- Provide magazines
- Provide Simple Pleasures item or other recreational items
- Seat near other friendly residents to chat
Before care while waiting

- Look inside purse to organize
- Sort some socks and roll into balls
- Listen to music with a headset
- Magazine or book to read
- Sort a deck of cards
- Draw on sidewalk
- Price is Right before a meal
During care

- Wave machine while receiving medications
- Muff while getting a wound treatment
- Stuffed fish in the bath
- Squeezies during dentist visit
After care

- Leave with a Home Decorator book
- Message magnets
- Set up with picture dominoes and a friend
- Small group tether ball game
- Sewing cards
- Jewelry to sort and organize
Beyond personality
What about mood?
And the situation?

Need to be flexible
Ask yourself does my resident seem:

- Under-stimulated or Over-stimulated
- Immobile or Passive
- Restless
- Anxious or Stressed
- Depressed
- In pain or with recent illness
- Different because of medication changes
Under-stimulated

- Sensory based activities
- Seated near action on unit
- Provide with activities within reach
- Lots of opportunities for movement
- Always leave with something to do after care is provided
Over-stimulated

- Small groups or quiet area
- Calming activities
- Provide with soft tactile “Simple Pleasures” items
- Outdoor activities
Immobile or Passive

- Use sensory-motor therapy programs
- Provide vibratory stimulation (massage)
- Re-position for programs
- Assist to change positions every 20 minutes
- Provide relaxation or rest programs with active programs
- Always alert the individual before a task
Motor Restlessness

- Morning walking program every day
- Opportunities for appropriate repeated movements (washing tables, sorting, exercises, stirring, shaking, painting or sketching)
- Unit jobs like delivering mail and messages or setting tables
- Adequate stimulation - diversional activities
Anxious or Stressed

- Provide programs of comfort
- Reassure frequently
- Allow time for self-expression
- Reduce stimulation
- Use warming “Simple Pleasures” items
- Telephone family or friends
- Memory books of familiar photos
Depressed

- One-to-one programs
- Exercise and walking
- Comforting activities (rocking chair or bean bag chair with headphones)
- Videos of family children or pets
- Feelings groups
- Frequent reassurance
In pain or recently ill

- Short programs
- Comforting and warming activities
- Re-position frequently
- Gradually increase endurance
- Hand and foot massage
- Relaxation
- Watch for symptoms of pain or weakness
Work with strengths-->Success!
Simple Pleasures

Handmade recreational items for nursing home residents
Making items available:
Agitated Wandering

- Wanderers cart
- Table ball game
- Latch box
- Two by two sensory wall hangings
- Look inside purses and fishing boxes
- Walk with the person and divert attention
Wanderers Cart & Latch Box
Sensory Wall Hangings
Wall hangings
Table ball game
Look Inside Purses and Fishing Boxes
Vocalizing (Verbally non-aggressive)

- Wave machine
- Hand muff
- Polar fleece hot water bottle (screaming)
- Sensory vest
- Sensory table cloth
- Stuffed fish and butterflies
- Promote social interactions
Stuffed Fish, Butterflies, Message Magnets
Polar fleece hot water bottle
Wave machine
Hand Restlessness

- Wave machine
- Hand muff
- Home decorator books
- Sensory vest
- Sensory table cloth
- Look inside purse and fishing box
- Sewing cards Squeezies
Home Decorator Books & Activity Tablecloth
Sewing Cards & Polar Fleece Muff
Passivity

- Electronic Stim box
- Squeezies
- Tether ball game
- Sensory table cloth
- Picture dominoes
Picture dominoes & tether ball
Squeezies & Stim box
Process of starting activity

- Get supplies
- Alert each resident in small group
- Talk to each resident to welcome them
- Show the activity
- Give just enough help to start
- Keep it short (15 minutes)
Keeping a group together

- Set up in circle or semi-circle
- Move resident to resident to engage
- Give positive encouragement
- Pay attention to body language
- Build trust and have fun.
Adapting

He can’t….

Adapt it so he can!

1. Change equipment
2. Change rules
3. Simplify
How could these be adapted?

- Brushing hair
- Having snacks
- Reading together
- Dancing
- Watching old time TV and discussion
- Going for a walk
- Cleaning up
- Playing cards
- Delivering mail
- Decorating the bulletin board
- Sewing buttons on
Questions???

Read and discuss the three case studies
1. A resident who is down-to-earth, practical, traditional and pretty much set in their ways would be said to have which of the following personality types?
   a. Extrovert
   b. Introvert
   c. Openness
   d. Closed

2. You can help your resident do self-initiating tasks by
   a. Seating them near other residents.
   b. Providing magazine within reach
   c. Turning on a favorite radio station.
   d. All of the above.

3. Residents with low cognitive functioning need programs that
   a. Provide maximum sensory bombardment.
   b. Are shorter than those for higher functioning residents
   c. Provide aerobic exercise
   d. Do not require the client to do anything.

4. Your resident is anxious, fearful and repeatedly asking questions. You should offer which of the following types of programs:
   a. A music event with 70+ people attending.
   b. Chair volleyball
   c. Musical instruments group
   d. Calm classical music program with 2 other residents

5. In order for residents to use Simple Pleasures or other recreational items you should:
   a. Keep them behind the nursing station to hand out when asked for
   b. Store them in the locked cupboard and bring them out when the activity personnel are around
   c. Place them in open carts in various locations around the unit
   d. Keep them in the activity storage room where they won’t get lost
Caring for People with Alzheimer’s Disease and Related Disorders

Part 4: Providing Activities

Linda Buettner, Ph.D. CTRS
Suzanne Fitzsimmons, MS, ARNP
Slide 3: Objectives
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5. Improves cognitive function
6. Improves sleep
7. Allows for self expression
8. Fitness - cardiovascular, strength, flexibility
9. Allows opportunity to test self
11. Providing Activity

Slide 6: Nothing to do…
Behavioral Symptoms of Dementia: These occur when the resident has nothing to do. When children or people are bored they often find their own activity to do. These may not always be acceptable behaviors or activities.

Slide 7: What to Do Based on Who
1. Plan the activities; consider what the person enjoyed in the past. Develop a list with the family of activities such as, playing cards, going for walks, caring for pets, household chores, games and crafts that the resident did at home.

2. The more impaired the person, the simpler the activity needs to be. A very impaired person requires close supervision, frequent assurance, and step-by-step instructions. Demonstrate what needs to be done.

3. APPROACH and COMMUNICATION are critical. Demonstrate what to do and provide encouragement.
Slide 8: Draw the sun picture on the piece of paper. Then write the roles that you play for each ray.

Imagine losing one or more of these roles. How would you feel with a diagnosis of Alzheimer’s? Imagine being told you could not drive to see your grandchildren or to shop when you need to.

Slide 9: Personality

- Personality is our pattern of thinking, feeling and acting

- **Style of Interest Defined by two Personality traits:**

  **Introverted:** Those who prefer *Introversion* draw their primary energy from the inner world of information, thoughts, ideas, and other reflections. When circumstances require an excessive amount of attention spent in the "outside" world, those preferring Introversion find the need to retreat to a more private setting as if to recharge their drained batteries.

  **Extroverted:** In contrast, those who prefer *Extraversion* are drawn to the outside world as their elemental source of energy. Rarely, if ever, do extraverted preference people feel their energy batteries are "drained" by excessive amounts of interaction with the outside world. They must engage the things, people, places and activities going on in the outside world for their life force.

**Openness:** Open to new experiences with broad interests and a strong imagination.

**Closed:** Down-to-earth, practical, traditional and pretty much set in their ways.

Slide 10

**Personality traits**

<table>
<thead>
<tr>
<th>Trait</th>
<th>High Score</th>
<th>Low Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extraverted</td>
<td>Outgoing, sociableactive, assertive, talkative</td>
<td>Reserved, loner, even-paced</td>
</tr>
<tr>
<td>Openness</td>
<td>Curious, like novelty, experience emotions, aesthetic</td>
<td>prefer the familiar, muted emotional responses, conservative</td>
</tr>
</tbody>
</table>
Slide 11: Steps for Leading an Activity

- Get your stuff together for the activity
- Bring your residents to area for the activity and make certain they have no unmet needs
- Think about their personalities
- Alert each person
- Show and Tell what the activity will be
- Use cuing to engage each person if needed
- Demonstrate each action again and assist to start movement if needed
- Each person should touch, talk, move
- Keep it short – leave them wanting more.
- Bring the group to closure – say goodbye and help them on to something else.

Slide 12: Design of Activity

Something the resident does, not the staff

Can be anything (normal):
- Biking club
- Write a story
- Sing or Dance
- Walk together
- Card group
- Fashion club
- Cooking club
- Reading group
- Nature lovers
- Dog Fanciers

Activities

Daily housekeeping routines - Tasks such as folding laundry, raking, sweeping, dusting, clearing and setting tables, and making beds are good for people with Alzheimer's disease because no new learning is required. These tasks can make the person feel useful and productive.
Some activities include a chair looking out a window at a birdfeeder, or a circle of chairs to encourage interaction between residents and their surroundings. Some things can be ready as a diversion from restlessness, worry or harmful behavior.

Gardening either indoors or out to provide sensory stimulation and exercise. Cherry tomatoes and herbs are fast growing and useful. Window boxes may work well, or using
some other way to raise plants up so person doesn't have to bend over. Simply allowing them to water the plants can help them to contribute to the home and feel useful.

**Cooking** also provides lots of stimulation in the form of smells, tastes, and textures. Ex. Boil potatoes with the skin on and have individual peel the potatoes when cool. Blender cooking is easy, safe and a fun way to prepare healthy snacks. Having the individual help prepare meals and snacks will help improve appetite. They can also help set the table and clear away the dishes, and wash or rinse the dishes when through with the meal.

**Dominoes** and **simplified card games** are good to fill time before/after meals. Matching skills are often retained until later in the disease. The person does not necessarily have to play a game, but can simply sort or build with them. Individuals can make dominoes from cut 2"x 4" pieces of wood. Cards can be made with pictures mounted on 3x5 card stock.

Go for **walks** and bring back flowers, leaves and plants to press for later projects. Use clear contact paper to make window hangings with the pressed plants. This will give you something to talk about; it might bring up memories from the past.

**Photography** is another great activity. Get an auto focus camera and let the patient shoot whatever appeals to him/her. Taking film to be developed, sorting and mounting pictures, and putting together a scrapbook are all part of the ongoing photography project. This will give you something to talk about; it might bring up memories from the past.

**Music** is another easy to structure activity that the person with AD can enjoy. The library is a great source of familiar music and can provide for a pleasant outing. To make the experience a chance for self-expression, put on some music and provide paints or a ball of clay to work with. Remember it is the process **not** the product that is important. You might want to type or write out the words to the music in large print (so they can follow along.

**Exercise and movement** are possibly the most important of all the activities you can do with the AD patients. Exercise can ward off illness, decrease agitation, and improve sleep patterns. Exercise does not necessarily mean lifting weights, doing chair workouts or jogging. Think of the active things the person enjoyed such as walking the dog, putting away groceries, making the beds, or hanging out laundry. These are great opportunities to lift, stretch and move in a familiar way. You may also be able to find exercises that can be done from a sitting position that are fun and easier for older people.

A **small piece of luggage, an old brief case, a purse or even a tackle box** can be filled with interesting things to explore and look through. For a lady, old cards, letters, junk mail, magazines, photographs, a pair of dressy gloves, trinkets or jewelry, an old set of keys and other things to tinker with. Be sure that the things are not small enough to be swallowed or mistaken as edible.

For a man who liked to fish a tackle box with lures (with the hooks removed) and different types of worms or other fishing things, a picture of a fishing trip, or a magazine
with fishing and hunting. A briefcase with and old pocket watch, and old papers that could look work related might also be interesting to a retired business person, male or female.

Fill an old suitcase with a scarf, suit coat or jacket, (tie, belt or suspenders), book (nursery rhymes, Bible), Photographs (children, family, etc), camera, a variety of other everyday things that could bring back memories. (Hat, toys, dolls, model airplane, car or boat) be colorful. Take out one item at a time and talk to about it. Engage the resident in a conversation (even if it you don't understand act as if you do). Show enthusiasm, also show respect for the objects, and tell them they will be put back into the attic. The things in the suitcase can change to add diversity.

Make an Alzheimer's apron with lots of pockets. Using elastic or Velcro and string attach a variety of interesting objects to each pocket. Some suggestions include: a small music box, garden gloves, a ball of socks with an item hid inside, small photo album, old jewelry items, a calculator, a watch, a wooden spoon. Be sure the items are removable for washing, elastic and Velcro work well.

For individuals that like to sew, make simple cardboard sewing cards. Use any size cardboard, punch holes around the edges, and glue an attractive picture in the center. Take a ball of yarn and tape the end up to make it stiff like a needle. The individual can sew and re-sew these cards. Make seasonal ones to decorate the home or give as gifts.

Scrapbooks and photo albums are interesting and stimulate functioning in individuals with cognitive impairments. It may be a good idea to label the pictures for the individual who can read.

Take an old dresser and fill the drawers with interesting clothing items to rummage through. The individual may enjoy finding items, sorting or folding them. Towels and sweaters are especially good. The next drawer can be filled with toys or objects to manipulate. Old food boxes from pop tarts; cereal etc. can be cleaned and placed in another drawer. Watches, jewelry and personal items should also be included.

Develop a "place" for the individual's leisure time stuff. The idea is that the individual should learn where to look for stimulation or activity. Use familiar things owned from the past. For example, fishing gear. Don't move or change the stuff or the place it is located. Safe proof the hooks and other things available for leisure time. The individual can have a radio or tape player available in this leisure area to listen to ad lib. Music can set a relaxing or stimulating mood and serve as an important outlet.

Art Therapy: For improving self esteem, reducing depression & anxiety, affirming a person's existence, increasing concentration, orientation, fine motor skills and spatial planning. Allows non-verbal expression of emotions. (Extra cueing, prompting and encouragement are important). The process is what is most important not the product. Can use pen, pencil, crayons, and paintbrush. (Non-toxic materials)
Expressive arts are valuable for the individual with Alzheimer's Disease. Some suggestions include; homemade clay (nontoxic), chalk and black paper, colored pencils and pens. Make your own holiday cards using stencils or stamps. Using items from nature walks (dried flowers, pine cones, leaves) often leads to a meaningful and successful activity.

Many individuals enjoy helping out. Structure simple chores and include cues. Tasks like washing down a table, folding towels, sorting socks or silverware can be useful and help fill time before or after meals.

If you are handy with a video camera, it might be fun to make a film of loved ones, pets, babies, or other meaningful things for the individual with dementia to watch. Have the person in the video actually speak to the individual with dementia using his or her name frequently. This short video needs to have a simple background to reduce confusion. This video can provide a few minutes of respite for the caregiver.

The book called "Simple Pleasures: A multi-level sensorimotor intervention for nursing home residents with dementia" by Linda L. Buettner and Doreen B. Greenstein has 23 items that have been tested for usefulness for people with dementia or Alzheimer's Disease. Several of the items are things that you could help a person with dementia to make (they will require assistance). Other items are fairly simple and inexpensive to make and will help with some of the common disruptive behaviors you may be dealing with.

Slide 13: Never leave a resident with nothing to do….

- After care or an activity session provide resident with a something to hold or to interact with.
- Think about style of interest, past roles, and hobbies.
- Consider a photo filled magazine, familiar game, video of family, Simple Pleasures item, towels to fold.
**Slide 14: PET Scans**
PET scans show the sensorimotor area of the brain is intact and in need even in severe dementia. (Bright white areas)

**Slide 15: Sensory activity can take place in many ways**
- Before care
- During care
- After care
  - When alone
  - When in a small group
- EVERYTHING on a special care unit should become an activity to help the resident
- Transitions are very important
Slide 16: Animal Assisted Activities
- Goals:
  - Practice ADLs
  - Mobility
  - Social skills
  - Communication
  - Provide emotional outlet
  - Cognitive stimulation

Slide 17: Exercise for function
- Basic assessment and physician approval
- At least 3x per week on the unit
- RT plus exercise videos
- Exercise to music is best.

Slide 18 Cognitive Activities
- Variety of activities that use:
  Motor skills
  Language
  Visual spatial
  Memory
  Executive functioning

Slide 19: Use students and volunteers
- Teach volunteers about dementia
- How to do an activity with people with memory loss
- Have volunteers assist a few times then take over.

Slide 20: Basic Principles
- Object is to actively engage
- Resident does more than the staff does
- Staff instructs, then prompts, resident speaks
- Adapt activity to lower functioning
- Lower functioning individuals need shorter programs with fewer participants
- Minimal use of large group programs
Slide 21: Helping your resident attend various types of activities

- Know which ones they wish to attend (preferences)
- Have resident ready for the activity
- Transport the resident if on unit, arrange transport if off-unit
- Ask activity department to include your resident in activities
- Ask family members to participate in facility activities with resident

Slide 22: Help your resident with self-initiating activities

- Seat near radio
- Provide magazines
- Provide Simple Pleasure or other recreational items on a cart
- Seat near other residents he or she enjoys to chat

Slide 24: Before care while waiting

- Look inside purse to organize
- Sort some socks and roll into balls
- Listen to music with a headset
- Magazine or book to read
- Sort a deck of cards
- Draw on sidewalk (black paper hung on wall or table and chalk)
- Price is Right activity before a meal

Slide 25: During care

- Wave machine while receiving medications
- Muff while getting a wound treatment
- Stuffed fish in the bath
- Squeezies during dentist visit

Slide 26: After care

- Leave resident with a Home Decorator book or Message magnets
- Set up with picture dominoes and a friend
- Small group tether ball game
- Sewing cards
- Jewelry to sort and organize
Slide 28: Ask yourself does my resident seem-
- Under stimulated or Over stimulated
- Immobile or Passive
- Restless, Anxious or Stressed
- Depressed
- In pain or with recent illness
- Different because of medication changes

Slide 29: Under stimulated
- Sensory based activities
- Seated near action on unit
- Provide with activities within reach
- Lots of opportunities for movement
- Always leave with something to do after care is provided

Slide 30: Over stimulated
- Small groups or quiet area
- Calming activities
- Provide with soft tactile “Simple Pleasures” items
- Outdoor activities

Slide 31: Immobile or Passive
- Use sensory-motor therapy programs
- Provide vibratory stimulation (massage)
- Re-position for programs
- Assist to change positions every 20 minutes
- Provide relaxation or rest programs with active programs
- Always alert the individual before a task

Slide 32: Motor Restlessness
- Morning walking program every day
- Opportunities for appropriate repeated movements (washing tables, sorting, exercises, stirring, shaking, painting or sketching)
- Unit jobs like delivering mail and messages or setting tables
- Adequate stimulation - diversional activities

Slide 33: Anxious or Stressed
- Provide programs of comfort
- Reassure frequently
- Allow time for self-expression
- Reduce stimulation
- Use warming “Simple Pleasures” items
- Telephone family or friends
• Memory books of familiar photos

**Slide 34: Depressed**
• One-to-one programs
• Exercise and walking
• Comforting activities (rocking chair or bean bag chair with headphones)
• Videos of family children or pets
• Feelings groups
• Frequent reassurance

**Slide 35: In pain or recently ill**
• Short programs
• Comforting and warming activities
• Re-position frequently
• Gradually increase endurance
• Hand and foot massage
• Relaxation
• Watch for symptoms of pain or weakness

**Slide 36: Work with strengths to offer successful activities**

**Slide 37: Resident showing pleasure over simple outdoors activity. This is the goal of your programs.**

**Slide 38: Simple Pleasures:**
Handmade recreational items for nursing home residents

**Slide 39:** Too often nursing homes look like this, a line of residents sitting, doing nothing. Simple Pleasures attempts to alleviate this scene.

**Slide 40: Making items available**
Have items available throughout the unit, especially where resident gather

**Slide 41: Simple Pleasure items to use for Agitated Wandering**
• Wanderers cart
• Table ball game
• Latch box
• Two by two sensory wall hangings
• Look inside purses and fishing boxes
• Walk with the person and divert attention

Slide 47: Simple Pleasure items to use for Vocalizing (Verbally non-aggressive)

• Wave machine
• Hand muff
• Polar fleece hot water bottle (screaming)
• Sensory vest
• Sensory table cloth
• Stuffed fish and butterflies
• Promote social interactions

Slide 51: Simple Pleasure items to use for Hand Restlessness

• Wave machine
• Hand muff
• Home decorator books
• Sensory vest
• Sensory table cloth
• Look inside purse and fishing box
• Sewing cards Squeezies

Slide 54: Simple Pleasure items to use for Passivity

• Squeezies
• Tether ball game
• Sensory table cloth
• Picture dominoes

Slide 57: Process of starting activity

• Get supplies
• Alert each resident in small group
• Talk to each resident to welcome them
• Show the activity
• Give just enough help to start
• Keep it short (15 minutes)

Slide 58: Keeping a group together

• Set up in circle or semi-circle
• Move resident to resident to engage
• Give positive encouragement
• Pay attention to body language
• Build trust and have fun.

Slide 59: Adapting

1. Change equipment
2. Change rules
3. Simplify

Slide 60: How could they be adapted?

• Brushing hair
• Having snacks
• Reading together
• Dancing
• Watching old time TV and discussion
• Going for a walk
• Cleaning up
• Playing cards
• Delivering mail
• Decorating the bulletin board
• Sewing buttons on

Slide 62: Questions
Optional activities

Program participants will form small groups and practice leading one of the following activities. Be prepared to demonstrate interactions for the entire group in 20 minutes.

Homemade butter

Place cup of heavy cream into a tightly sealed container. Shake until the fat separates from the buttermilk. Pour off buttermilk. Have resident spread the butter onto a cracker or piece of bread. To make it easier, add a couple of marbles to the cream.

Sound identification activity

Using a sound effect CD, play various sound effects to be identified. Preview the sounds to determine which ones are easy enough to use.

Poetry cognitive activity Reprinted by permission of Fitzsimmons

Follow the following protocol

Exercise: Poetry I

Exercise Type: Communication and language

Cognitive Functioning: Moderate

Materials Needed: Pens, pieces of scrap paper and a copy of the following page for each participant.

Method:

1. Pass out the scrap paper but not the love poem.
2. Have participants write the numbers 1 through 5 down the side of the scrap paper.
3. Next they are to write down five foods they really like.
4. Now hand out the poem.
5. Have them transfer the words they wrote on the scrap paper to the corresponding blank on the poem sheet.
6. In turn have each participant read his or her poem.
I Love You More Than…

I love you more than 1_________________

And 2___________________, and

3___________________ too!

I love you more than 4___________________,

And 5___________________, it's true!

So, if I love you more than all

These foods that I adore,

You must understand these words ~

I love you, that's for sure!
**Guided Imagery for relaxation**

To provide an opportunity for relaxation for clients with disturbing behaviors.

**Staff Requirements:** 1 therapist, nurse, or other health care professional.

**Entrance Criteria:** Displays physically aggressive behavior, such as hitting, punching, pinching, pushing, kicking, and/or slapping. These clients may need 1:1s vs. group involvement. Displays physically non-aggressive behavior, such as wandering, restlessness or repetitive movement. Demonstrates vocalizing behavior, such as demanding, repeating or screaming. These clients may need to be 1:1 depending on intensity of behaviors. Displays depressive or passive behaviors such as withdrawal, apathy, isolated or unable to express emotions.

**Exit Criteria:** Client showed no signs of improvement after four weeks. Client continues to display disturbing behaviors. Clients' behavior negatively impacts involvement of others.

**Group Size:** 1 to 8 clients.
**Duration:** 20 to 30 minutes.

**Safety Considerations**
- **Environmental Risks:** No specific risks.
- **Client Risks:** No specific risks.

**Facility & Equipment Required**
- **Facility:** Room that can be closed off from pedestrian traffic and noise.
- **Equipment:** One chair for each client.

**Methods**

- **Part I: Preparation**
  Clients are seated in a circle.
  Ask them to remove anything that is in their hands such as a purse, cane, or walker.
  Turn the lights down if possible.
  Instruct them to close their eyes.

- **Part II:** Guided Imagery script: Read the following slowly, pausing between sentences, with a calm, soft voice.
  We are going to do an exercise that will help you to relax............
  It is called guided imagery..................
  I will read you a story and while I do I want you to imagine in your mind the place I am describing..................
  I will turn down the lights.....................
Everyone get comfortable in their seat and let go of anything in your hands.
Close your eyes.
You are riding in the front seat of a car.
You are on your way to a house on a lake.
You have been riding for several hours.
The road bends and turns close to the lake.
Finally you arrive and the car stops.
You climb out of the car.
smell a wonder smell... Pine....
You can see the lake through the trees by the shore.
You walk down the dirt path to the lake.
Small sticks and leaves crunch under your feet.
The air is warm and slightly humid...
The sun is shining through the branches....
Such a warm wonderful feeling....
so peaceful.......
so content.....
You get to the waters edge and sit on a rock warmed by the sun.
The sun shining on the lake looks likes diamonds.
Your arms, legs and face feel the warm sun.
The slight gentle breezes feels like a soft touch....
You hear the lake..
Gently lapping on the shore....
You see a few small fishes... swimming slowly through the water....
The lake is so clear...you can see to the bottom....
Smooth sand and small stones of every color....
You put your hand in...and pick up a handful of sand....
Within the sand....are shiny beautiful smooth stones....
You drop them back in the water....
Removing your shoes...you place your feet in the water....
It is warm here...where the water is shallow....
The water feel silky....
Smooth.......
and thick like syrup....
You hear a bird overhead calling....
Then another from a distance replies....
You spread out a blanket...and lie down....
Soon the warm sun...is beating on your back....
Feeling soothing....
and wonderful....
Like a touch-less back rub…………
You hear the lake gently lapping……
You smell the water…………
You smell the pine trees........
Your body is feel very light........
Very relaxed...........
You drift.............
Into a light pleasant sleep..................................................

- **Part III: Follow-up**

  When finished, remain seated and do not speak for a minute or two.
  Then say “I hope you have found this to be relaxing”………………
  “I will turn the lights on now”
  Ask clients how it made them feel

  Reprint with permission of Buettner & Fitzsimmons
**Progressive Muscle Relaxation**

To provide a guided method of relaxation for clients with disturbing behaviors.

**Staff Requirements:** 1 therapist, nurse, or other health care professional  
**Entrance Criteria:** Clients who exhibit behaviors of distress such as wandering, restlessness, anxiety, agitation, abusiveness and depression.  
**Exit Criteria:** Client shows a decrease in target behaviors or client no longer wishes to participate.  
**Group Size:** 4-6 clients.  
**Duration:** 15-20 minutes to one hour.  

**Safety Considerations**  
**Environmental Risks:** No specific risks.  
**Client Risks:** No specific risks.  

**Facility & Equipment Required**  
**Facility:** Quiet room with no foot traffic.  
**Equipment:** One chair for each client.

**Methods:** There are three components to this relaxation group.

- **Part I: Preparation**  
  Clients are seated in a circle.  
  If possible have clients remove their shoes.  
  Ask them to remove anything that is in their hands such as a purse, cane, walker.  
  Turn lights down if possible.  
  Instruct clients to follow your directions

- **Part II: Muscle relaxation**  
  Read the following slowly and model the action.

1. “First we will do your right hand. Make a fist with your right hand, hold, 2, 3, 4, 5, 6, 7, relax.”  
2. “Next we will do your right hand. Tighten your right upper arm by showing off your muscle, hold, 2, 3, 4, 5, 6, 7, relax.”  
3. “Now your left hand. Make a fist with your left hand, hold, 2, 3, 4, 5, 6, 7, relax.”  
4. “Next your left arm. Tighten your left upper arm by showing off your muscle, hold, 2, 3, 4, 5, 6, 7, relax.”  
5. Well we do the muscles of your face next. “First raise your eyebrows, hold, 2, 3, 4, 5, 6, 7, relax.”  
6. “Now squeeze your eyes shut, hold, 2, 3, 4, 5, 6, 7, relax.”  
7. “Next clench your teeth and pull back the corners of the mouth hold, 2, 3, 4, 5, 6, 7, relax.”
8. “Next we will do your shoulders and neck. Raise your shoulders and press head against their resistance hold, 2, 3, 4, 5, 6, 7, relax.”
9. “On to the chest and back. Breathe in, hold the breath and press shoulders back hold, 2, 3, 4, 5, 6, 7, relax.”
10. “Now tighten or draw in your belly, hold, 2, 3, 4, 5, 6, 7, relax.”
11. “Well will finish with the legs and feet”
12. “First your right thigh, shovel it forward, hold, 2, 3, 4, 5, 6, 7, relax.”
13. “Next your right shank. Lift your right heel off the ground, hold, 2, 3, 4, 5, 6, 7, relax.”
14. “Next your right foot. Curl the toes on your right foot, hold, 2, 3, 4, 5, 6, 7, relax.”
15. “Now your right thigh, shovel it forward, hold, 2, 3, 4, 5, 6, 7, relax.”
16. “Next your right shank. Lift your right heel off the ground, hold, 2, 3, 4, 5, 6, 7, relax.”
17. “Next your right foot. Curl the toes on your right foot, hold, 2, 3, 4, 5, 6, 7, relax.”

- **Part III**: Follow-up
  - When finished, remain seated and do not speak for a minute or two.
  - Ask clients how it made them feel.
  - Turn up lights.
  - Assist clients in putting shoes back on.

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Discussion Cases

Case Study One

Mrs. Jones is an 85-year-old woman with significant cognitive impairment. Mrs. Jones has no family members in the area. She requires total care including needing to be fed, bathed and dressed by staff. She does not resist care, has her meals pureed and eats everything offered. Mrs. Jones is a life-long vegetarian who does not eat red or white meat, nor fish. For dinner on Sunday the kitchen, by mistake, sends Mrs. Jones ground turkey on her tray. What do you do?

Case Study Two

Mr. Smith is a friendly man who wanders around the nursing home unit for most of his waking hours, frequently going in and out of other residents’ rooms. Although none of the residents seem to mind Mr. Smith’s activities, a family member of a female resident has expressed concern. What do you do?

Case Study Three

Mrs. Doubtful has mild cognitive impairment with paranoia and is suspicious of staffs’ behaviors and intentions. She feels that the nursing staff is trying to steal from her and that they are hiding “poison” and medications in her food. For that reason, she is refusing to eat anything that is not individually wrapped and unopened. You happen to know that the evening nurse does indeed hide medication in Mrs. Doubtful food. What are the problems, issues and possible solutions in this case?
Part 4: Activities
Post-Test

Date: ____________________                Occupation: _________________________
Facility: ___________________________   Name: ___________________________

How long working in this position: __________________________

1. A resident who is enjoys engaging in things, people, places and activities going on in the outside world for their life force would be said to have which of the following personality types?
   a. Extrovert
   b. Introvert
   c. Openness
   d. Closed

2. After your client is finished with an activity program which of the following would be a good thing for you to do?
   a. Leave him or her for the nursing staff to get.
   b. Tell him or her to take a catnap.
   c. Tell him when lunch is.
   d. Provide him or her with a magazine of choice.

3. Clients with low cognitive functioning need programs that
   a. Provide maximum physical exertion
   b. Have less than 6 participants
   c. Provide aerobic exercise
   d. Do not require the client to do anything.

4. Your resident is passive and falls to sleep on and off during the day. You should offer which of the following types of programs:
   a. Tether ball
   b. Current events
   c. Poetry reading
   d. Classical music program

5. In order for residents to use Simple Pleasures or other recreational items you should:
   a. Keep them behind the nursing station to hand out when asked for
   b. Store them in the locked cupboard and bring them out when the activity personnel are around
   c. Place them in open carts in various locations around the unit
   d. Keep them in the activity storage room where they won’t get lost
Part 4 Activities

Answer Key

Pre-test

1. d
2. d
3. b
4. d
5. c

Post-test

1. a
2. d
3. b
4. a
5. c
Caring for People with Alzheimer’s Disease and Related Disorders

Linda L. Buettner & Suzanne Fitzsimmons
A Team Process for Treating Behaviors
Objectives

Upon completion of this session the participants will be able to:

1. Describe what a behavior team is.
2. Detail the steps for treating behaviors.
3. List some methods of evaluating behaviors.
Steps for the treatment of disturbing behaviors
Build a Behavior Team

1. Select staff members for the team
2. Include as many disciplines as possible
3. Determine how often you will meet
4. Select a team leader
5. Determine the specific process based on your facility
6. Determine meeting times
7. Get the word out to the rest of the facility
Provide a Referral Form

You may wish to have a referral form for other disciplines and families to request the services of the behavior team.
When Team meets

Team to review new referrals
Determine team members responsibilities

Team reviews ongoing resident cases
  ➢ Determine follow-up
  ➢ Discharge from team services
For new cases - Step One
Define The Behavior

- What is the behavior?
- Is it a behavior or merely an annoyance?
- Who is involved?
- When does it occur?
- How often does it happen?
- How long does it last?
- Where does it occur?
- What precedes the behaviors?
- What has been tried in the past?

- What are the consequences of the behavior?
- Use a behavior monitor
- Use a staff Communication Book
- Talk to hands-on care staff
- Know the behavior you are targeting!
Step Two: Review the following

- Underlying medical condition? Delirium? Infection, constipation, medications, pain
- A basic unmet need causing behavior?
  - Tired, hunger, pain, toilet, bored, lonely, under or over stimulated
- Depressed? Use depression scales.
- Environmental factors?
- Staff approach triggering behavior?
- Use the NEST checklist
Did anything from step 2 resolve the problem

- Yes……
- Inform others to prevent reoccurrence.

- No, continue to step 3
Step Three
Evaluate the Resident

- Select baseline behavioral tool depending upon targeted behavior

- Possible tools
  - Cohen-Mansfield
  - Overt Aggression
  - Algase Wandering
  - Apathy Scale
Step Four: Come back and Brainstorm

- Review findings
- Brainstorm possible causes/solutions with family & other staff
- Use/review a Staff Communication book
- Use/review a behavior monitor
Did this resolve the problem?

- Yes- inform others to prevent reoccurrence.

- No-continue to next step
Step Five

Can this be treated with therapeutic activity & staff techniques?

- Define a consistent staff approach and a response
- Modify the environment
- Set realistic goals
- Inform all staff
Step Five Cont.

Therapeutic Intervention

Assess to develop an activity plan for the resident

- Level of cognitive and physical functioning
- Barriers to participation
- Strengths/weaknesses
- Assess leisure interests
  - Farrington Leisure Interest
  - Input from client family or friends
- Select one or more evidence-based intervention
- Implement for 2 weeks
Step Six: Treat & Evaluate

- After treatment determine if the intervention should:
  - Continuation
  - Discharge
  - Change in treatment

Continuation:

Treatment has been effective but need more time for full effectiveness to take place.
Step Six cont: Re-evaluate

Discharge

Treatment was effective. Provide follow-up plan to prevent re-occurrence and to integrate into routine activities and care.
Step Six cont: **Re-evaluate**

**Change Treatment**

- Reassess and modify your plan if the treatment has not been successful.
Step Eight: Documentation

Resident’s behavior and responses.
Step Nine: **Integrate**

- Get the resident involved in facility’s routines and programs to maintain positive changes.
- Inform all staff of outcome of problem.
Step Ten

Re-evaluate as needed for any follow-up.
Case Study
Caring for People with Alzheimer’s Disease and Related Disorders

A Team Process for Treating Behaviors

By

Linda L. Buettner Ph.D., CTRS
Suzanne Fitzsimmons, MS, ARNP
**Slide 3: Objectives**

Upon completion of this session the participants will be able to:

- Describe what a behavior team is.
- Detail the steps for treating behaviors.
- List some methods of evaluating behaviors.

**Slide 4: Steps for the treatment of disturbing behaviors**

**Slide 5: Build a Behavior Team**

Base this on existing teams you might have such as falls preventions, skin team and others. Determine when and where your team will meet and do written policy and procedure, following your facilities guidelines.

1. Select staff members for the team
2. Include as many disciplines as possible
3. Determine how often you will meet
4. Select a team leader
5. Determine the specific process based on your facility
6. Determine meeting times
7. Get the word out to the rest of the facility

**Slide 6: Provide a Referral Form**

You may wish to have a referral form for other disciplines and families to request the services of the behavior team. Having a referral provides a method for all staff members to have the problems they are facing, examined and dealt with by the facility. This supports the people who provide hands-on care and gives them a voice both in identifying problems and coming up with solutions.

**Slide 7: When Team meets**

Team to review new referrals
- Determine team members responsibilities
- This is the assigning of the investigation portion of the problem.

Team reviews ongoing resident cases and determines what step is next
- Determine further investigation
- Determine follow-up
- Discharge from team services
Slide 8: For New cases - Step One - Define The Behavior

- **What is the behavior?** Saying a person is agitated is not enough
- **Is it a behavior or merely an annoyance?** Is this something that should be ignored? Will it lead to larger problems? Does it bother other residents? It is reasonable to expect it to stop.
- **Who is involved?** In addition to the resident, who is involved? Staff, family, other residents? Some one else? Be specific in defining this.
- **When does it occur?** Exact time and day of the week or during a specific activity. Is it during personal care, breakfast, change of shift?
- **How often does it happen? How long does it last? Once a day, one an hour?** A behavior monitoring form is useful to gather this information, which should be quantitative.
- **Where does it occur?** Pinpoint the location. Is it in the shower room only? When off the unit? When out of the facility?
- **What precedes the behaviors?** What happened prior to the occurrence?
- **What has been tried in the past?** If this happened in the past, how was it addressed?
- **What are the consequences of the behavior?** A PRN medication, tears, not eating, sleeping, upset.
- **Use a behavior monitor.** Your pharmacy can provide this.
- **Use a staff Communication Book** This can be a simple notebook placed in the staff or break room of the unit. Make certain staff checks this daily, adding questions or solutions. Put a simple note about the problem that is occurring. If a staff member has a solution, he or she responds to the question with the solution for all to see. Example: Question: How do you get Mrs. Brown to accept oral care? Answer: I put on the Sound of Music CD in her room during care and she will brush to the music.
- **Talk to hands-on care staff.** These are the staff that generally can provide the most information about the resident.
- **Know the behavior you are targeting!** The more clues you have, the better the chance of solving the case.

Slide 9:  Step Two: Review the following

**Underlying medical condition?** Delirium? Infection, constipation, medications, or pain. There are many, many medical problems that cause behavior problems. A UTI, oral pain, and pneumonia are common culprits. Another “problem” is the resident who is normally grumpy or just plain aggressive. All of a sudden this resident is passive. Chances are the resident has a medical problem.

**A basic unmet need causing behavior?** It can be difficult determining unmet needs. Often it means offering a variety of things to the resident. Determine if the problem occurs at the same time and if feasible, speak with the resident a half hour before the behavior starts. Often when agitated a resident can’t express themselves but talking to the ahead of time might help find out what the problem is. Tired, hunger, pain, afraid, toilet,
bored, lonely, under or over stimulated. Use the N.E.S.T. checklist at the end of this section.

**Depressed? Use depression scales.** Depression is common among nursing home residents, especially those who have dementia. Along with depression may come irritability, weepiness, anxiety and verbal or physical aggression.

**Environmental factors?** There are not many of use that desire to get old, retire and move into a nursing home. Not being able to control the temperature, the activities, the sounds, who is around you, the smells, the light levels, can be very frustrating.

**Staff approach triggering behavior??** Some believe if you set the environment and your approach, you can prevent most behaviors from occurring. This requires skill and ability, having an in-dept understanding of the resident, and the ability to predict actions and reactions. It may be as simple as who sits next to who in the dinning room.

**Slide 10: Did anything from step 2 resolve the problem**

- Yes…… Inform others to prevent reoccurrence
- No, continue to step 3

**Slide 11: Step Three-Evaluate the Resident**

- Select baseline behavioral tool depending upon targeted behavior
- Possible tools
  - Cohen-Mansfield (agitation)
  - Overt Aggression (aggression)
  - Algase Wandering (Wandering)
  - Apathy Scale (Apathy)
This helps define and quantify the behavior.

**Slide 12: Step Four-Come back together and brainstorm**

- Review findings
- Brainstorm possible causes/solutions with family & other staff
- Use/review a Staff Communication book. This is a simple notebook left in the staff break room or other area of the unit where only staff would see it. Request staff members to look at the book each shift. If staff is having a problem, staff is to write the problem in the book. If a staff member has a solution or possible
solution they write it under the problem. Often times a staff member on another shift may hold the key to a behavior.

- **Example Entry**
  - June 20, 2007  First shift

Mrs. J in room 123 starts yelling and spitting when teeth are brushed.
Cindy CNA

Try putting on the Sound of Music CD when providing personal care, talking to her about the tape while giving care, encouraging her to finish brushing her teeth so she can sing along with the tape. Works every time for me and puts a smile on her face.
Kathy CNA 2nd shift

- Use/review a behavior monitor. This can show behavior patterns and interventions that are tried.

**Slide 13:** Did this resolve the problem?

- Yes……. Inform others to prevent reoccurrence
- No, continue on

**Slide 14: Step 5 - Can this be treated with therapeutic activity & staff techniques?**

- **Define staff approach and response**
  - Determine a consistent approach and response to the behavior.
- **Modify the environment**
  - Prevent triggers and excessive stimulation
- **Set realistic goals**
- **Inform all staff**

**Slide 15: Step 5 cont.**

Assess to develop an activity plan for the resident

1. **Level of cognitive and physical functioning.** You will want something that is geared towards their cognitive and physical ability
2. **Barriers to participation.** Some examples include: Intolerance to heat or cold? Family approval, nursing or therapy schedule
3. **Strengths/weaknesses.** Hearing, strength, friendly, vision, communication, etc
4. **Assess leisure interests.** What they enjoyed in the past. Adapt or modify based on strengths and weaknesses

**Farrington Leisure Interest:** This assessment helps define past interests

**Input from client family or friends.** Ask them what the resident enjoyed in the past

Select one or more evidence-based intervention
Implement for 2 weeks

**Example of adapting:**

**Mrs. F** loved making quilts but no longer see well enough nor has the dexterity not the cognition to continue making quilts.

**Modify:** Have volunteers make crochets squares. Provide a large plastic needle and yarn and have the resident make a quilt by sewing together the squares.

**Mr. Joseph** was an illustrator of textbooks. He enjoys looking through his books of his past illustrations but by mid afternoon he is agitated as he feels he needs to start working but is unable to start.

**Modify:** Make copies of his past illustrations or even of family photographs. Place on a clipboard. On top of it place a piece of tracing paper. Provide the clipboard and pencil for Mr. Joseph.

**Mrs. Green** was an avid artist in the past but is frustrated as she no longer can “get started” when given paper and supplies.

**Modify:** Take a large piece of cardstock or foam board. With a fat black marker draw lines, circle and other shapes on the board (not small). Provide Mrs. Green with acrylic paints and brushed. Instruct her to paint inside each shape a different color. The result will be an abstract.

Mrs. Green declines further. She can no longer do the modified painting but still enjoys colors. Provide her with large paint chips, wallpaper samples and various pieces of fabric. She may look through these, selecting those she feel would go good together. Another method is to put together a jewelry box with costume jewelry and various colored scarves or pieces of fabric. The resident determines which jewelry goes well with which fabric.

**Slide 16 Step Six: Treat & Evaluate**

**After treatment determine if the intervention should:**

- Continuation
- Discharge
- Change in treatment

**Continuation:**
Treatment has been effective but need more time for full effectiveness to take place.
Slide 17: Step Six (cont) Re-evaluate

Discharge
Treatment was effective. Provide follow-up plan to prevent re-occurrence and to integrate into routine activities and care.

Slide 18: Step Six cont: Re-evaluate

Change Treatment
•Reassess and modify your plan if the treatment has not been successful.

Slide 19: Step 8-Documentation

Document residents’ behavior and response to interventions.
Do not just say resident agitated. Describe the behavior. Agitation means different things to different people.

Slide 20: Step 9-Integrate

Get the resident involved in facility’s routines and programs to maintain positive changes.
Make certain all staff is aware of the outcome of the problem.

Slide 21 Step 10- Re-evaluate as needed for follow-up

Slide 22 Case study

Gert was verbally repetitive saying, “the baby’s sick, the baby’s sick” in the dining room and other residents became upset with her. Residents would yell, “why don’t you shut up”. The care staff tried to remove Gert but she then got louder and abusive toward the staff. When they tried to provide her meal in the hallway she refused to eat. This problem began to cause poor nutrition for Gert and significant weight loss.

What is the process that should be followed?

What plan would your team suggest?
**N.E.S.T. Checklist**

Ask yourself: Who is the behavior a problem for? Often times the behavior is simply annoying but harmless, or simply a long-standing personality trait. Make certain you are working towards increasing the client's quality of life. Then use the N.E.S.T. approach.

**N (Needs)**

**Background factors:**
- Neurological: Parkinson’s, stroke, MS,
- Cognition: attention, memory, aphasia, apraxia, and agnosia
- General Health: Past and current diagnoses: High blood pressure, cardiac disease, arthritis, diabetes
- History of response to stress
- Gender, education, past occupation
- Personality

**Proximal Factors:**
- Physiological Needs: hunger or thirst, elimination, pain, discomfort, or sleep disturbances.
- Physical environment: light level, noise, temperature, or persons
- Social Environment: staff mix, staff stability and skill, program/unit ambiance, presence of others.
- Psychological Needs: loneliness, fear, apathy, depression.
- Functional Impairments: Ability to self feed, bathe, toilet, ambulate and transfer.
- Acute medical condition (infection, high blood sugar…)

**E (Environment)**
- Bright light or glare
- Too cold or too warm
- Too much noise or clutter or chaotic, too many people around
- People leaving area causes client to want to leave
- Near people the client doesn’t enjoy
- Happens at one particular time, with a particular staff or family or other person.

**S (Stimulation)**
- Nothing to interact with
- Large group without individualized interactions
- Left in front of (TV, Nursing Station, etc.) for more than 90 minutes
- Too much noise (over head paging, TV, music overhead, work men, people coming & going)
- No opportunity: to talk with friends or others, to move about, go outdoors, touch, explore, create
- No opportunity for recreation or leisure interests

**T (Techniques)**
- Physically forcing care: ADL’s, feeding, medications, others
- Tasks: Rushing client. Not allowing client to do self-care
- Communication: Poor techniques, language barrier, other
- Does not allow privacy, choices, dignity

Reprint by permission Buettner & Fitzsimmons
Caring for People with Alzheimer’s Disease and Related Disorders

Linda L. Buettner CTRS, Ph.D.
& Suzanne Fitzsimmons, MS, GNP
Booster Training
Objectives

Upon completion of this session the participants will be able to:

1. Describe what dementia is.
2. List methods of communicating with people with dementia.
3. Explain types of behavior common in dementia.
4. Detail benefits of activities for people with dementia.
What is dementia?

- Syndrome; a group of signs and symptoms
- Loss of mental function in 2 or more areas severe enough to interfere with daily life
  - Memory
  - Orientation Perception
  - Attention
  - Ability to perform tasks in sequence
  - Language
  - Judgment
  - Motor Function

There are over 70 different conditions that cause dementia
Two types of dementias

Reversible

- Intoxications
- Infections
- Metabolic disorders
- Major depression
- Brain tumors
- Head injuries
- Normal pressure hydrocephalus

Non-Reversible

- Alzheimer’s disease
- Multi-infarct or vascular dementia
- Parkinson’s disease
- Lewy Body disease
- Creutzfeldt-Jakob disease
- Pick’s disease
- Huntington’s disease
- AIDS dementia complex
## Characteristics of Alzheimer’s Disease Symptoms: two distinct types

<table>
<thead>
<tr>
<th>Cognitive symptoms</th>
<th>Psychiatric/behavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amnesia</td>
<td>Depression (mood)</td>
</tr>
<tr>
<td>Aphasia</td>
<td>Psychosis (delusions and hallucinations)</td>
</tr>
<tr>
<td>Agnosia</td>
<td>Major personality and behavioral changes</td>
</tr>
<tr>
<td>Apraxia</td>
<td>Restlessness and agitation</td>
</tr>
<tr>
<td></td>
<td>Apathy</td>
</tr>
</tbody>
</table>
Normal vs. Alzheimer’s Brain
# Stages of Alzheimer’s disease

<table>
<thead>
<tr>
<th>Function</th>
<th>Early Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory</td>
<td>Routine loss of recent memory</td>
</tr>
<tr>
<td>Language</td>
<td>Mild aphasia (word finding difficulty)</td>
</tr>
<tr>
<td>Orientation</td>
<td>Seeks familiar and avoids unfamiliar</td>
</tr>
<tr>
<td>Motor</td>
<td>Some difficulty writing and using objects</td>
</tr>
<tr>
<td>Mood and behavior</td>
<td>Apathy &amp; depression</td>
</tr>
<tr>
<td>Activities of daily living (ADL)</td>
<td>Needs reminders with some ADL’s</td>
</tr>
</tbody>
</table>
## Stages of Alzheimer’s disease

<table>
<thead>
<tr>
<th>Function</th>
<th>Middle Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory</td>
<td>Chronic, recent memory loss</td>
</tr>
<tr>
<td>Language</td>
<td>Moderate aphasia</td>
</tr>
<tr>
<td>Orientation</td>
<td>May get lost at times, even inside the home</td>
</tr>
<tr>
<td>Motor</td>
<td>Repetitive actions, apraxia</td>
</tr>
<tr>
<td>Mood and behavior</td>
<td>Possible mood and behavioral disturbances</td>
</tr>
<tr>
<td>Activities of daily living (ADL)</td>
<td>Needs reminders and help with most ADL’s</td>
</tr>
</tbody>
</table>
## Stages of Alzheimer’s disease

<table>
<thead>
<tr>
<th>Function</th>
<th>Late Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory</td>
<td>Mixes up past and present</td>
</tr>
<tr>
<td>Language</td>
<td>Expressive and receptive aphasia</td>
</tr>
<tr>
<td>Orientation</td>
<td>Misidentifies familiar persons and places</td>
</tr>
<tr>
<td>Motor</td>
<td>Bradykinesia, at risk for falls</td>
</tr>
<tr>
<td>Mood and behavior</td>
<td>Greater incidence of mood and behavioral disturbances</td>
</tr>
<tr>
<td>Activities of daily living (ADL)</td>
<td>Needs reminders with all ADL’s</td>
</tr>
</tbody>
</table>
## Stages of Alzheimer’s disease

<table>
<thead>
<tr>
<th>Function</th>
<th>Terminal Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory</td>
<td>No apparent link to past or present</td>
</tr>
<tr>
<td>Language</td>
<td>Mute or few incoherent words</td>
</tr>
<tr>
<td>Orientation</td>
<td>Oblivious to surroundings</td>
</tr>
<tr>
<td>Motor</td>
<td>Little spontaneous movement, dysphagia, myoclonus, seizures</td>
</tr>
<tr>
<td>Mood and behavior</td>
<td>Completely passive</td>
</tr>
<tr>
<td>Activities of daily living (ADL)</td>
<td>Requires total care</td>
</tr>
</tbody>
</table>
Strategies for Treatment of Alzheimer’s Disease

- Prevention of disease
- Delay onset
- Slow rate of progression
- Treat primary symptoms (cognitive)
- Treat secondary symptoms (behavioral)
Treatments

- Medications
- Education
- Support groups
- Cognitive activities
- Physical activities
- Social Activities
- Control diabetes, BP, Cholesterol
- Treat depression
- Nutritional diet
Care of Persons with Dementia

- Create a supportive atmosphere
- Structure appropriate activities & routine
- Design “dementia friendly” environments
- Facilitate peer groups (for emotional support & shared activities)
- Provide cues and stimulation
- Self determination
Communication with people with memory loss

- Meet them where they are
- Accept and Adapt
What’s the Fuss Over Autonomy?

- Power or right to make one’s own decisions & choose personal preferences
- Recognition of one’s values, history, personhood
- Loss of autonomy threatens well-being
Communication Changes over the Course of the Disease

- **Early stage**: Difficulty finding the right word, repetitiveness & keeping pace with others

- **Middle stage**: Increased difficulty with speaking correctly & comprehending language of others

- **Late stage**: Vocabulary reduced to a few words or phrases; increased need for nonverbal cues

- **Terminal stage**: Mute or occasional word/phrase
Things to Think About When You Speak

- Make the setting free of distractions
- Gain attention, make eye contact, be aware of body language
- Provide orienting information
- Use short, simple sentences
- Use familiar and concrete words
- Break down tasks into steps
- Avoid open-ended questions
- Help reduce choices
Identify yourself and address the person by name in an adult manner.

Maintain eye contact, standing or sitting at his or her level.
Speak slowly and clearly but not loud.

Ask one question at a time. Ask yes/no questions rather than open-ended. Provide simple choices.
Allow plenty of time to respond.

Don’t interrupt
Use the same words when repeating a statement

Would you like to……..
Early Stage

- Reminders and cues
- Demonstrations
- Assist to start
- Hand over hand

Late Stage

- Amnesia
- Aphasia
- Agnosia
- Apraxia
When You Are Having Trouble Understanding

- Active listening
- Focus on word or phrase that may have meaning
- Respond to the emotional tone
- Try to stay calm and be patient
- Ask others for clues
Things to Avoid

- Arguing
- Giving strict orders
- Condescending
- Asking questions requiring detailed responses
- Talking about people in front of them
- Asking, “Do you remember?”
- Saying “No, no, no, no, no.”
Changes in communication that may occur

- Difficulty finding the right words
- Using familiar words or phrases repeatedly
- Inventing new words to describe familiar objects
- Easily lose their train of thought
- Difficulty organizing words logically
- Reverting to speaking in a native language
- Using curse words
- Speaking less often
- More often relying on gestures instead of speaking
- Not understand what is said
Strategies for non-verbal communication

As verbal communication becomes increasingly difficult, you might find that you rely more on non-verbal communication, i.e. tone and pitch of voice, eye contact, facial expression, posture, sign language and physical contact.

- Soft and caring tone of voice.
- Maintain eye contact.
- Soft, calm, warm facial expression.
- Gesture to emphasize words and feelings.
- Use touch such as a hand on the shoulder if the resident allows this.
- Use a communication board to determine unmet needs.
- Put up signs
- If you don't understand what is being said, ask the person to point or gesture.
- Focus on the feelings, not the facts. Sometimes the emotions being expressed are more important than what is being said. Look for the feelings behind the words.
Strategies for resident who are non-responsive or do not communicate

- Can respond well to soft, familiar voices and touch.

- Can still take hold of their hand or put your arm around them. This can communicate a great deal and provide reassurance.
This ends the Communication section......

Now on to behaviors............
Behavioral Symptoms

More disturbing to both family and professional caregivers than the memory loss and other cognitive problems
Psychiatric symptoms that you might see

- Depression
- Anxiety
- Agitation
- Apathy
- Psychosis
- Paranoia
- Delusions
- Hallucinations
Agitated Behaviors: goal of treatment

- To prevent these from occurring
- To calm those who are already agitated
Verbally: aggressive

Arguing
Yelling
Threatening
Irritability
Cursing
Angry outburst.
Verbally Non-aggressive

Vocalizing
Repetitive questioning
Complaining
Screaming
Weepy, crying
Moaning
Physically aggressive

- Hitting
- Biting
- Kicking
- Pushing
- Destroying things
- Self-injurious.
Physically non-aggressive

Motor-restlessness
Repetitive movements
Wandering
Rummaging, hording
hiding things
Intrusive
Spitting
Pacing
Picking, and rubbing
Boredom = Agitation

- 1.5 hours or more in the same pursuit = Significantly higher levels of agitation

- Examples:
  Sitting at nursing station, parked in the hall, watching television
Passive Behaviors: goal of treatment

- To prevent passive behaviors
- To alert those who are passive
Apathy

Passive
Lack of interest
Lack of motivation
Withdrawal
Social isolation
Depression

Loss of function

Boredom = Apathy
Other Behaviors

- Refusing care
- Refusing medications
- Refusing foods or liquids
- Socially inappropriate
- Disrobing
- Urinating in public
- Gluttony
- Pica
- Sleep-wake disturbance
- Sundowning
- Sexually inappropriate
- Disinhibition
In the nursing home these behaviors lead to:

- Removal from traditional facility programs
- Social isolation & Boredom
  - Increased Behaviors
    - Increased Medication
      - Increased Sedation
      - Passivity
      - Loss of Function
Ultimate goal for both categories is active engagement in meaningful activity
Look for an unmet need

- Afraid
- In Pain
- Tired
- Thirsty or hungry
- Lonely
- Cold, hot
- Craving activity or stimulation
- Need to go to the bathroom
- Need to change position
- Need to get away from.....
Needs related to health

- Acute illness (can’t tell you)
- Chronic illness (arthritis)
- Effects of medicines (more confused)
- Changes in hearing or vision
- Dehydration (dry lips)
- Constipation (abdominal symptoms)
- Pain (rubbing)
- Depression (crying or screaming)
Needs related to the environment

- Too much noise or clutter
- Excessive stimulation
- Poor sensory environment
- No orientation or cues
- Environment too large or unfamiliar
- Unstructured environment
- Too cold, too hot
Needs related to the task

Task is too complicated
Too many steps at a time
Not modified for increasing impairment
Task unfamiliar
Too boring, childlike, or useless
Needs related to communication

- No communication
- Failed to get attention
- Too much verbal information
- Too fast, too loud, too soft, mumbled
- No cues or gestures or demonstration used
- Complicated language
Do some problem solving

- When did the problem occur?
- What triggered it?
- Look at time of day?
- Did you make an error in your approach? (Caregiver technique)
- Develop a list of alternative strategies to try
Behavior Basics

1. If you know one person with dementia, you know one person with dementia. What works with one may not work on another.

2. Do not “challenge” short term memory by asking questions that rely on memory. Ask if they enjoyed breakfast, not what they had for breakfast.

3. If they ask you a question 50 times, just answer it the same way 50 times. It may be annoying to you but imagine how frustrating it is for the person who can’t remember.

4. Persons with dementia almost always remember what happened years ago:
   - This adds to their confusion.
   - They may be looking for their mother, their childhood home.
   - Avoid arguing or rationalizing that this person is no longer alive, it serves little purpose as they will forget what you told them or get angry and argue.
   - It is easier to enter their world rather than to try to get them orientated to today’s world. Example: Oh, your father at work, we will call him later.
Basics cont.

5. Tell what to do rather than what not to do

*Resident is heading towards the exit door, attempting to leave.*

- You say to him not to go out, he stops, but then does not know what to do and may try to go out again.
- Instead ask him to come and help you, see something etc………
- This gives an action to do to replace the desire to leave.

6. Sudden change in behavior comes from sudden problems. Resident is usually agreeable and easy. Today he seems agitated, yelling and refuses to eat. New behavior, for better or worse usually mean there is something physically wrong. A medication to calm him down does not help if he has a tooth abscess or urinary tract infection.
Basics cont.

7. Don’t talk about them in front of them

8. Realize that they would rather do things for themselves. These losses causes loss of self esteem and self-identity. Try to preserve dignity.


10. They have a brain disease.
    - They can not help the way they act.
    - Think that they are doing things intentionally or that they could stop their behavior if they really tried hard?
    - That is like telling someone with diabetes that they could control their blood sugar by trying really hard to make their pancreas work.
How can you help your residents?

- Activity to stimulate the use of the brain and the body.
- Activity to encourage movement.
- Activity for social connections.
- Activity to provide joy.
- Allow to do as much as possible for self.
Benefits of remaining active

1. Provides sensory stimulation
2. Uses physical skills - prevents disuse or atrophy from occurring
3. Provides an opportunity for socialization
4. May lead to better mood and less apathy
5. Improves cognitive function
6. Improves sleep
7. Allows for self expression
8. Fitness - cardiovascular, strength, flexibility
9. Allows opportunity to test self
What to do based on who

- Plan the activities; consider what the person enjoyed in the past.
- The more impaired the person, the simpler the activity needs to be.
- APPROACH and COMMUNICATION are critical. Demonstrate what to do and provide encouragement.
Steps in running a small group

1. Get your stuff together for the activity
2. Bring your residents to area for the activity
3. Think about their personalities
4. Alert each person
5. Show and Tell
6. Demonstrate
7. Each person gets to touch, talk, move
8. Keep it short – leave them wanting more.
9. Bring the group to closure – say goodbye and help them on to something else.
Design of Activity

Something the resident does not the staff
Can be anything (normal):

- Club
- Writing/reading/poetry
- Sing or Dance
- Walk together
- Card group
- Fashion club
- Cooking club
- Reading group
- Nature lovers
- Dog Fanciers
Basic Principles

- Object is to actively engage
- Resident does more than the staff does
- Staff instructs, then prompts, resident speaks
- Adapt activity to lower functioning
- Lower functioning needs shorter programs with fewer participants
- Minimal use of large programs
Helping your resident attend various types of activities

- Know which ones they wish to attend (preferences)
- Have resident ready for the activity
- Transport them there if on unit, arrange transport if off-unit
- Ask activity department to include your resident in activities
- Ask family members to participate in facility activities with resident
Help your resident with self-initiating activities

- Seat near radio
- Provide magazines
- Provide Simple Pleasure or other recreational items
- Seat near other residents to chat
Under-stimulated

- Sensory based activities
- Seated near action on unit
- Provide with activities within reach
- Lots of opportunities for movement
- Always leave with something to do after care is provided
Over-stimulated

- Small groups or quiet area
- Calming activities
- Provide with soft tactile “Simple Pleasures” items
- Outdoor activities
Immobile or Passive

- Use sensory-motor therapy programs
- Provide vibratory stimulation (massage)
- Re-position for programs
- Assist to change positions every 20 minutes
- Provide relaxation or rest programs with active programs
- Always alert the individual before a task
Motor Restlessness

- Morning walking program every day
- Opportunities for appropriate repeated movements (washing tables, sorting, exercises, stirring, shaking, painting or sketching)
- Unit jobs like delivering mail and messages or setting tables
- Adequate stimulation - diversional activities
Anxious or Stressed

- Provide programs of comfort
- Reassure frequently
- Allow time for self-expression
- Reduce stimulation
- Use warming “Simple Pleasures” items
- Telephone family or friends
- Memory books of familiar photos
Depressed

- One-to-one programs
- Exercise and walking
- Comforting activities (rocking chair or bean bag chair with headphones)
- Videos of family children or pets
- Feelings groups
- Frequent reassurance
In pain or recently ill

- Short programs
- Comforting and warming activities
- Re-position frequently
- Gradually increase endurance
- Hand and foot massage
- Relaxation
- Watch for symptoms of pain or weakness
Process of starting activity

- Get supplies
- Alert each resident in small group
- Talk to each resident to welcome them
- Show the activity
- Give just enough help to start
- Keep it short 15-30 minutes
Keeping a group together

- Set up in circle or semi-circle
- Move resident to resident to engage
- Give positive encouragement
- Pay attention to body language
- Build trust and have fun.
Adapting

He can’t…. Adapt it so he can!

1. Change equipment
2. Change rules
3. Simplify
Questions???
Caring for People with Alzheimer’s Disease and Related Disorders

Booster Training

Linda Buettner, Ph.D. CTRS
& Suzanne Fitzsimmons, MS, ARNP
Slide 3: Objectives

Upon completion of this session the participants will be able to:

- Describe what dementia is.
- List methods of communicating with people with dementia.
- Explain types of behavior common in dementia.
- Detail benefits of activities for people with dementia.

Slide 4: What is dementia?

- Syndrome; a group of signs and symptoms
- Loss of mental function in 2 or more areas severe enough to interfere with daily life

Affects:
- Memory
- Orientation Perception
- Attention
- Ability to perform tasks in sequence
- Language
- Judgment
- Motor Function

There are over 70 different conditions that cause dementia

Slide 5: Two types of dementias

Reversible

Medications - Older adults are often on complex medication regimens. Dementia can be related to toxic effects of these medications or drug-food interactions. Moreover, many classes of drugs are known to affect mental status such as psychotropic, anticonvulsants, antibiotics, and antihypertensives.

Infections - An infection in one’s blood or central nervous system can cause dementia. Laboratory tests usually reveal such infections causing dementia.

Metabolic disorders - There are numerous metabolic disturbances associated with dementia. These include vitamin deficiencies, chronic kidney failure, thyroid, liver and pancreatic disorders.

Depression - Depression is a psychiatric disorder with the principal symptoms of sadness, difficulty in thinking and concentration, decreased activity, feelings of helplessness and hopelessness, and sometimes suicidal ideation. Many severely depressed people will have some cognitive deficits, like poor concentration and attention, which can mimic a dementia. This condition is sometimes called pseudo dementia. These people may not receive treatment for their depression unless it is differentiated from the
symptoms of dementia. Depression is treatable but requires prompt evaluation and
treatment. Another challenge is the presence of both dementia and depression. In this
situation, the intellectual presentation may be more extreme for the stage of the dementia.
A skilled diagnosis by a psychiatrist, neurologist, or geriatrician is important to sort out
this complex clinical picture. Depression is treatable, whether alone or in combination
with dementia.

**Brain tumor and subdural hematoma** - The presence of a brain tumor or traumatic
brain injury can result in dementia depending on the location of the mass or injury in the
brain. These problems are diagnosed using brain-imaging techniques such as a CT scan
or MRI.

**Normal pressure hydrocephalus** - Normal pressure hydrocephalus (NPH) is a relatively
uncommon brain disorder that involves an obstruction in the normal flow of cerebral
spinal fluid. This blockage causes a buildup of cerebral spinal fluid in the ventricle
(space) in the brain. The clinical symptoms of NPH are urinary incontinence, poor
balance and gait, and dementia. NPH is sometimes treatable with a neurosurgical
procedure in which a shunt is inserted to divert the cerebral spinal fluid away from the
brain.

**Some Non-Reversible forms of dementia**

- Alzheimer’s disease
- Multi-infarct or vascular dementia
- Parkinson’s disease
- Lewy Body disease
- Creutzfeldt-Jakob disease
- Pick’s disease
- Huntington’s disease
- AIDS dementia complex

**Slide 6: Characteristics of Alzheimer’s Disease Symptoms: two distinct types**

**Cognitive symptoms**
- Amnesia: Inability/Difficulty in remembering
- Aphasia: Inability/ Difficulty understanding or expressing verbal or written words
- Agnosia: Inability/ Difficulty recognizing familiar objects or faces
- Apraxia: Inability/ Difficulty with motor tasks

**Psychiatric/behavioral**
- Depression (mood)
- Psychosis (delusions and hallucinations)
- Major personality and behavioral changes: suspicious, paranoid, complaining, cursing
- Restlessness and agitation: Motor or verbal
- Apathy: Lack of motivation
Slide 8: Stages of Alzheimer’s disease - Early

<table>
<thead>
<tr>
<th>Function</th>
<th>Early Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory</td>
<td>Routine loss of recent memory</td>
</tr>
<tr>
<td>Language</td>
<td>Mild aphasia (word finding difficulties)</td>
</tr>
<tr>
<td>Orientation</td>
<td>Seeks familiar and avoids unfamiliar</td>
</tr>
<tr>
<td>Motor</td>
<td>Some difficulty writing and using objects</td>
</tr>
<tr>
<td>Mood and behavior</td>
<td>Apathy &amp; depression</td>
</tr>
<tr>
<td>ADL’s</td>
<td>Needs reminders with some ADL’s</td>
</tr>
</tbody>
</table>

AD is slowly progressive and may last three to 20 years. The rate of progression varies from person to person. The disease tends to advance according to stages of severity. It unfolds in subtle ways, not unlike normal absent-mindedness, except with regularity. Early stage symptoms may be imperceptible until the patient or family notices that a pattern has developed or a stressor such as acute illness make symptoms more apparent. Forgetting appointments, misplacing things, difficulty managing a checkbook, word finding problems, and loss of initiative are typical changes at this stage. Symptoms may be inconsistent, with “good days” and “bad days” making life unpredictable for all concerned. One’s ability to manage self-care tasks is usually not compromised at this point but reminders and supervision are needed with certain activities of daily living (ADLs) such as cooking, shopping, and paying bills.

Slide 9: Stages of Alzheimer’s disease - Middle

<table>
<thead>
<tr>
<th>Function</th>
<th>Middle Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory</td>
<td>Chronic, recent memory loss</td>
</tr>
<tr>
<td>Language</td>
<td>Moderate aphasia</td>
</tr>
<tr>
<td>Orientation</td>
<td>May get lost at times, even inside the home</td>
</tr>
<tr>
<td>Motor</td>
<td>Repetitive actions, apraxia</td>
</tr>
<tr>
<td>Mood/ behavior</td>
<td>Possible mood and behavioral disturbances</td>
</tr>
<tr>
<td>ADL</td>
<td>Needs reminders and help with</td>
</tr>
</tbody>
</table>

As AD progresses to the middle stage, the symptoms are more obvious. Memory loss and disorientation worsen, expressive and receptive language difficulties increase, and independence with activities of daily living is compromised. The patient’s ability to make autonomous health care and financial decisions is questionable and others must assume the role of surrogate decision-makers. At this point, difficulty with self-care tasks usually arises.
Slide 10: Stages of Alzheimer’s disease - Late

<table>
<thead>
<tr>
<th>Function</th>
<th>Late Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory</td>
<td>Mixes up past and present</td>
</tr>
<tr>
<td>Language</td>
<td>Expressive and receptive aphasia</td>
</tr>
<tr>
<td>Orientation</td>
<td>Misidentifies familiar persons and places</td>
</tr>
<tr>
<td>Motor</td>
<td>Bradykinesia; falls</td>
</tr>
<tr>
<td>Mood/ Behavior</td>
<td>Greater incidence of mood and behavioral disturbances</td>
</tr>
<tr>
<td>ADLs</td>
<td>Needs help with all ADLs</td>
</tr>
</tbody>
</table>

Late in AD, all cognitive functions are severely impaired and the person is completely dependent on others for most or all ADLs. Even long-term memory is significantly compromised at this point. Individuals may misidentify familiar people, places and objects. Constant supervision is required for the sake of safety and care.

Slide 11: Stages of Alzheimer’s disease - Terminal

<table>
<thead>
<tr>
<th>Function</th>
<th>Terminal Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>Mute or few incoherent words</td>
</tr>
<tr>
<td>Orientation</td>
<td>Mostly oblivious to surroundings</td>
</tr>
<tr>
<td>Motor</td>
<td>Little spontaneous movement, dysphagia, myoclonus, and seizures</td>
</tr>
<tr>
<td>Mood/Behavior</td>
<td>Generally passive</td>
</tr>
<tr>
<td>ADLs</td>
<td>Needs total care</td>
</tr>
</tbody>
</table>

In the final stage of AD, there is little or no language, little purposeful movement, and total dependence on others. Death usually results from sepsis or pneumonia at this stage. At any point in the disease, co-existing medical problems can exacerbate symptoms and hasten decline if not properly treated.

Slide 12: Strategies for Treatment of Alzheimer’s Disease

—**Prevention** - The ideal approach to deal with any disease is to prevent it altogether, for example, with a vaccine. Since the causes of AD are not known at this time, it is difficult to arrive at such a simple solution. However, as understanding of risk factors grows, there may be ways of reducing personal risk for the disease that ultimately prevent the onset of the AD.

—**Delay the onset** - If the disease cannot be prevented, the next best approach is to delay its symptoms for 5 or 10 years. Since most people with AD are elderly, delaying the disease might result in their death from other common causes. It has been estimated that if AD could be postponed, in effect, for just 5 years, then the incidence could be cut by one-third.

—**Slow down progression** - After early symptoms of the disease develop, the goal then is to maintain individuals at their highest possible level of functioning. Stopping or
slowing down the usual advance of the disease could theoretically enable individuals to remain independent and living in their own homes with minimal supports. Drugs currently approved and in testing phases aim to accomplish this goal but have thus far fallen short of expectations.

— **Treat primary symptoms** - If none of the above steps can be accomplished, the next best approach is to improve memory and other brain functions impaired by AD. By treating these symptoms, there is a hope of slowing down progression too. Again, current drugs and experimental drugs are directed toward this goal but have thus far fallen short of expectations for dramatic benefits.

— **Treat secondary symptoms** - If the cognitive symptoms of AD cannot be successfully treated, the next best approach is to treat behavioral symptoms often associated with the disease: insomnia, agitation, hallucinations, delusions, etc.. A variety of behavioral and pharmacological approaches aim to alleviate these symptoms.

### Slide 13: Treatments

**Medications**: May be helpful in some patients

**Education**: Persons in early stages often desire to learn about their condition. Although they might have memory problems they can learn.

**Support groups**: This assists clients with the emotional aspect of the diagnosis

**Cognitive activities**: Activities that stimulate various parts of the brain such as word puzzles, thin king activities, learning, computers, board games, etc

**Physical activities**: Exercise, dance, sports

**Social Activities**: Programs that promote socialization with others: tea party, reminiscing

**Control diabetes, BP, Cholesterol**: Good control over chronic illnesses

**Treat depression**: Persons with depression often do not care enough to remember

### Slide 14: Care of Persons with Dementia

In the absence of completely effective medical treatments of AD right now, much attention must be given to psychosocial approaches to caring for affected individuals. The rest of the training program will focus on meeting their needs as well as helping families in their traditional role as caregivers. Major areas of concern for persons with the disease include:

**Creating a supportive atmosphere** by understanding how the person with AD perceives his or her world,

**Developing programs of structured activities** that promote remaining abilities and minimize the effects of compromised abilities,

**Designing “dementia friendly” environments** that offer cues to simplify surroundings,

**Enabling persons with AD to talk about their challenges together in peer groups** and giving them a voice in their own care.
Slide 15: Communication with people with memory loss

- Meet them where they are
- Accept and Adapt

Slide 16: What’s the Fuss Over Autonomy?

Power or right to make one’s own decisions and choose personal preferences - Autonomy is something that every adult is expected to exercise but AD changes one’s ability to make sound decisions independently.

Recognition of one’s values, history, personhood - Autonomy means making personal choices based on preferences made over the course of one’s life experience.

Loss of autonomy threatens well-being - To take away autonomy or have it taken away is an assault on one’s self-esteem.

Slide 17: Communication Changes over the Course of the Disease

As AD worsens and the affected person suffers more brain damage, ability to communicate becomes increasingly impaired. Engaging in conversation, which might have been a simple task before the onset of the disease, now requires more effort. AD affects one's ability to understand and use words (aphasia). As the disease progresses, one’s vocabulary becomes more limited. The ability to process what is said also takes longer periods of time.

- Early stage: Difficulty finding the right word, repetitiveness & keeping pace with others
- Middle stage: Increased difficulty with speaking correctly & comprehending language of others
- Late stage: Vocabulary reduced to a few words or phrases; increased need for nonverbal cues
- Terminal stage: Mute or occasional word/phrase

The following is an overview of some communication challenges across the early, middle, late, and terminal stages of AD:
**Early Stage** Even in the early stages of the illness, a person with AD begins to have problems with communication. Expressive aphasia is exhibited at this stage as seen in difficulty finding a specific word, often a noun. An item may be described instead of actually using a specific word. For example, when trying to think of the word “chair,” the person might say, "I sit there, I eat my meal there, or I read there." Because of the decreased ability to think of nouns, the person might use generic words that do not carry much meaning. Words like “things” or “stuff” might be used more frequently instead of words specifying an exact idea.

The person may also begin to have difficulty with receptive aphasia. Though concrete thinking and understanding are still often intact, one might have difficulty with abstract thought. For example, the ability to understand proverbs or figures of speech might be impaired. A phrase such as "An apple a day keeps the doctor away" might prove terribly confusing. The literal meaning of words and phrases may make more sense than their figurative meaning.

Also, the memory problem may cause the person to unknowingly repeat statements or questions. Losing track of conversations may also be noticeable. Robert Davis (1989), a minister with AD writes about his communication problems early in the course of his AD:

“In my present condition (just seven months since diagnosis) there are times when I feel normal. At other times I cannot follow what is going on around me; as the conversation whips too fast from person to person and before I have processed one comment, the thread has moved to another person or another topic, and I am lost isolated from the action—alone in a crowd. If I press myself with greatest concentration to try to keep up, I feel as though something short circuits in my brain. At this point I become disoriented, have difficulty with my balance if I am standing, my speech becomes slow, or I cannot find the right words to express myself.”

(pp. 85-86).

**Middle Stage** By the middle stage of the disease, one's inability to communicate effectively becomes more obvious. The person might forget what he or she was talking about in the middle of a conversation. Repetitious questions and statements tend to become more frequent. On the other hand, the person may refrain from talking much out of worry or embarrassment. Initiating a conversation may be too taxing but responding to specific questions might also be limited. At this stage, the person is not always able to process strands of conversation. The person might wish to express a thought but choose the wrong words. At this stage, a person might avoid social situations. Mixing up words and thoughts is common. This "word salad" occurs as aphasia worsens. It becomes more difficult to understand what the person with AD is trying to say.

**Late Stage** In the late stage of the disease, vocabulary is often reduced to a few words or phrases. Repetition may be evident but just a few words or phrases may be repeated. A person might also repeat back what is said or echo another’s words. Comprehension decreases significantly. Nonverbal communication becomes more important, even a necessity at this point.
Terminal Stage
In the terminal stage, the person is often mute or utters a few incomprehensible sounds. The ability to follow a simple, two-step command may be lost. When communication skills are severely impaired, it should be assumed that the person with AD can still experience emotion. Nonverbal means are perhaps the only means to connect with someone at this final stage.

Slide 18: Things to Think About When You Speak

**Make the setting free of distractions** - First, try to pick a setting that is free of environmental distractions. Background noise like music, a television, or loud conversations can inhibit the person with AD from focusing on what you are saying. Individuals with AD typically have difficulty sorting out competing stimuli, so decreasing distractions will facilitate communication.

**Gain attention, make eye contact and consider body position** - First, set the stage for good communication. Before starting a conversation, make sure that the person with AD knows you are in the room and that you can be easily seen and heard. Use your body posture and language in intentional ways. Establish and maintain eye contact. Establishing eye contact before beginning to speak will set the mood for the conversation and will help the person to focus on the conversation. Nonverbal communication becomes more important than spoken language as AD progresses. A person with AD receives cues from the tone of your voice and body language. If you appear stressed or hurried, the person with AD will pick up on these feelings and the essence of the conversation may be lost.

**Provide orienting information** - If you do not have a very close relationship with someone with AD, you probably need to re-introduce yourself at each encounter. A good introduction involves stating your name and the purpose of your encounter. This orienting information provides a context for and prepares the way for a successful interaction. It is also important to address the person by a preferred name or title. Whether to use just first name, both first and last name, or a surname will be an individual decision. If the person had a title used in earlier years (e.g., Doctor or Officer), it might be wise to use that official name. Simply ask the person about his or her preference.

People with AD often respond to the mood of situation more than actual spoken words. For example, if you use precise words but sound hurried or disinterested, your mood will be communicated rather than the intended message. Since it is very important to set a proper tone, you need to first convey calmness. It takes practice to sound relaxed when other things may be on your mind, but this is a necessary skill. It is also important to use humor. Smiling at and laughing with a person can set a relaxed tone. Humor that is abstract, such as sarcasm, should not be used since it may not be understood.
- Make the setting free of distractions
- Gain attention, make eye contact, be aware of body language
- Provide orienting information
- Use short, simple sentences
- Use familiar and concrete words
- Break down tasks into steps
- Avoid open-ended questions
- Help reduce choices

**Slide 19:**
Identify yourself and address the person by name in an adult manner.
Maintain eye contact, standing or sitting at his or her level

**Slide 20:**
Speak slowly and clearly but not loud
Ask one question at a time.
Ask yes/no questions rather than open-ended.
Provide simple choices

**Slide 21:**
Allow plenty of time to respond.
Don’t interrupt

**Slide 22:**
Use the same words when repeating a statement

**Slide 23:** Early stage to late stage
Amnesia - Provide reminders and cures
Aphasia - Demonstrate
Agnosia - Assist to start
Apraxia - Hand over hand
Slide 24: When You Are Having Trouble Understanding

- Active listening
- Focus on word or phrase that may have meaning
- Respond to the emotional tone
- Try to stay calm and be patient
- Ask others for clues

Communication difficulties may arise when the person with AD struggles to communicate a thought or idea but the words are not easily understood by others. First, take a deep breath and give the individual your full attention. In this way, you assume the role of an active listener. Focus on a specific word or phrase that seems to have particular meaning. You may be able to best understand the person with AD by being open to hearing the emotional tone of the communication. This may prove to be a better means of communication than the actual words being spoken.

Slide 25: Things to Avoid

Don't argue - Arguing only makes a situation worse. Someone with AD no longer has the ability to be rational or logical to the same extent as in the past. Arguing is bound to lead to frustration for both parties. Do not allow yourself to get caught in an argument.

Don't give strict orders - Few of us like to be bossed around, and the person with AD is no exception. Gentle persuasion and limiting choices are much better ways of getting something done. State directions positively. Instead of saying "You can't go outside now," try an alternative such as, "Let's sit down here, I really could use your help right now."

Don't be condescending - It is a challenge to speaking slowly and in short sentences without using a condescending tone of voice. Also, an adult tone of voice and respectful words are needed. There is the risk of triggering anger if the person with AD feels that he or she is being treated like a child.

Don't ask questions requiring detailed responses - Answers to direct questions often require a good memory. Someone with AD may feel embarrassed or humiliated if asked questions that cannot be answered correctly. Try rephrasing questions to be more concrete and specific. For example, instead of saying "Who are the people in this photo?" say, "This must be your family." This approach allows the person to reply gracefully and without undue pressure.

Don't talk about people in front of them - It is easy to fall into the habit of talking about people in front of them when they can no longer communicate well. It is difficult to know how much someone with AD understands, so it is best to assume that everything can be understood.

Don't bother asking, “Do you remember?” - Although it certainly is useful to tap into the preserved, long-term memory of someone with AD through reminiscence, it is not
worthwhile to ask questions about recent events that cannot be recalled. What is the point of testing a person’s faulty recent memory?

Don’t say “No, no, no, no, no.”

Slide 26: Changes in communication that may occur

- Difficulty finding the right words. May actually state that they can’t remember the word.
- Using familiar words or phrases repeatedly. This is a coping mechanism to maintain their ego and integrity.
- Inventing new words to describe familiar objects. Often they do not realize they are doing this. Others may substitute words like “thing-a-ma-jing” for an object generic names such as “buddy” for a person.
- Easily lose their train of thought. Forgetting the point of the what one is trying to say while speaking.
- Difficulty organizing words logically. This often sounds like a “word salad” such as “There, this, a hall, in bathroom?” (Is there a bathroom in this hall?)
- Reverting to speaking in a native language. Memory from long ago is stronger so the first language often returns.
- Using curse words. In persons who normally never used them.
- Speaking less often. Not initiating conversion, speaking only when spoken to.
- More often relying on gestures instead of speaking. Pointing to what one wants rather than asking.
- Not understand what is said. (Family members often call this being stubborn)

Slide 27: Strategies for non-verbal communication

- As verbal communication becomes increasingly difficult, you might find that you rely more on non-verbal communication, i.e. tone and pitch of voice, eye contact, facial expression, posture, sign language and physical contact.
- Soft and caring tone of voice.
- Maintain eye contact.
- Soft, calm, warm facial expression.
• Gesture to emphasize words and feelings.
• Use touch such as a hand on the shoulder if the resident allows this.
• Use a communication board to determine unmet needs.
• Put up signs
• If you don't understand what is being said, ask the person to point or gesture.
• Focus on the feelings, not the facts. Sometimes the emotions being expressed are more important than what is being said. Look for the feelings behind the words.

Slide 28: Strategies for resident who are non-responsive or do not communicate

➤ Can respond well to soft, familiar voices and touch.

➤ Can still take hold of their hand or put your arm around them. This can communicate a great deal and provide reassurance.

This ends the Communication section……..

Slide 30: Behavioral Symptoms

More disturbing to both family and professional caregivers than the memory loss and other cognitive problems

Slide 31: Psychiatric symptoms that you might see
This group of behaviors is often referred to as psychiatric symptoms. These are the symptoms that can lead to increased medications and a whole cascade of negative events. These are areas that we can treat very well. We all have expertise in psychiatric treatment in our backgrounds and we need to apply those skills to people with dementia.

Depression: May cause weepiness, crying, moaning, sleep and appetite changes, and a decline in function.

Anxiety: May cause motor or verbal restlessness, excessive questioning, fear, pacing, rubbing. This too often causes sleep and appetite changes, and a decline in function.

Psychosis: Unfounded beliefs, argumentative, may become combative if misinterprets environmental cues and staff or other residents actions.
**Paranoia:** Suspicious behavior, excessive anxiety and fear, often fearful of others actions, accusing, difficult to reassure.

**Delusions:** Having false beliefs. This may cause anger, arguing and depression.

**Hallucination:** is a sensory perception experienced in the absence of an external stimulus. Hallucinations may occur in any sensory modality—visual, auditory (hearing), olfactory (smell), gustatory (taste), tactile (touch), or proprioceptive (sense of balance and position in space).

**Slide 32: Agitated Behaviors: goal of treatment**

- To prevent these from occurring
- To calm those who are already agitated

**Slide 33: Verbally aggressive**

These behaviors are generally directed to other people. Another area that you might be called upon to address is the area of verbal aggression. This might be specific to a reaction to one staff member or resident, pain, past personality, or simple frustration. You will need to thoroughly assess the situation to make sense of it and to come up with a plan.

- Arguing
- Yelling
- Threatening
- Irritability
- Cursing
- Angry outburst.

**Slide 34: Verbally Non-aggressive**

Another category, this is the most prevalent problem, is verbally non-aggressive behaviors. The client who is constantly talking, making noise, complaining, asking for help, moaning, crying or screaming. This is a tough category and first of all if this behavior is not harmful to the individual, he or she might simply be bored or lonely. More structure in the individual’s day should help. For screaming or moaning the individual probably needs a pain assessment and your first recommendation should be for that. One of our interventions that can help with screaming is the Simple Pleasures hot water bottle. You must have an physician’s order to try it because it uses heat

- Vocalizing
- Repetitive questioning
- Complaining
Slide 35: Physically aggressive

Another category that you might be called upon to treat is physical aggression. This probably has something to do with the individual’s past personality, past psychiatric disorder, environmental change, and style of coping with stress. It also may be specific to a care routine like bathing. Again it revolves around an unmet need and is probably the most appropriate response the individual can make. So within our scope of practice what can we do? First build a rapport, a level of trust with the individual. The case study in the Appendix shows one example of this. Then once the individual trusts you, you can become the liaison in care or quality of life. You need to advocate for the individual and make sure others are educated and included in your approaches.

Hitting
Biting
Kicking
Pushing
Destroying things
Self-injurious.

Slide 36: Physically non-aggressive

More specifically, an area that we might work on after the client is assessed is the area of physical non-aggressive behaviors. This list includes examples of physically non-aggressive behaviors that we might be called on to treat. Think of these as an UNMET NEED. Try to figure out in your prescription how you will address the unmet need. Be creative.

Motor-restlessness
Repetitive movements
Wandering
Rummaging, hording
Hiding things
Intrusive
Spitting
Pacing
Picking, and rubbing

Slide 37: Boredom = Agitation

- 1.5 hours or more in the same pursuit =
  Significantly higher levels of agitation
Examples:
Sitting at nursing station, parked in the hall, watching television

In fact, Kovach and Schlidt (2001) found that in one long-term care setting agitation was significantly higher in the evening and when clients were occupied in the same pursuit for 1.5 hours or longer. The authors suggest a need to a balance between sensory stimulating and sensory calming activities to avoid agitation.

**Slide 38: Passive Behaviors: goal of treatment**

- To prevent passive behaviors
- To alert those who are passive

Another goal: persons who are passive are not always viewed as a problem. Passivity does bring other problems such as weight loss, physical function loss, decreased ADL function, increased independence on staff.

**Slide 39: Apathy**

Passive
Lack of interest
Lack of motivation
Withdrawal
Social isolation
Depression all these lead to Loss of function
Boredom also leads to apathy

Behavioral symptoms that have been identified as disturbing may first show up as apathy. This is manifested as passive behavior, lack of interest and motivation, withdrawal, social isolation.

Research shows passivity is a separate symptom from depression but many persons with dementia also are depressed. We believe, as do many other researchers, that if untreated this leads to a more rapid loss of function.

**Slide 40: Other Behaviors**

**Refusing care:** May wish to do this themselves, may not feel comfortable with particular caregiver
**Refusing medications:** May not like the taste, may have too many medications ordered
**Refusing foods or liquids:** Medication toxicity, oral problems such as tooth decay or abscess
**Disrobing:** Can’t find their room, skin irritation, UTI, hot environment, normal behavior

**Urinating in public or somewhere other than a toilet**

**Suspicious, paranoid**

**Gluttony:** Often seen with those with Pick’s Disease

**Pica (eating non-edibles)**

**Sleep-wake disturbance:** Bright light therapy/outdoor waking may help

**Late day restlessness**

**Sexually inappropriate/Disinhibited** Sexually inappropriate behavior are often not what they seem and staff and family often over react.

There are a host of other problems you may be called on to assess and care plan for such as refusing care, food, or medications. Disrobing is an area in which you need to assess the environment.

Urinating publicly can occur if a trigger is seen or if the person can’t find a bathroom. Gluttony is often seen with patients who have Pick’s disease. They need an environment strictly structured with limited access.

Sleep wake problems may be helped with bright light therapy or outdoor walking programs, gardening.

Sexually inappropriate behavior are often not what they seem and staff and family often over react. Persons with dementia have basic human rights and nursing homes and assisted living centers must provide for that.

**Slide 41: In the nursing home these behaviors lead to**

Removal from traditional facility programs

Social isolation & Boredom

- Increased Behaviors
- Increased Medication
- Increased Sedation

Passivity → Loss of function

**Slide 42: Ultimate goal for both categories**

is active engagement in meaningful activity

**Slide 43: Look for an unmet need**

**Afraid:** Look for pacing, trembling, picking
In Pain: Rocking, rubbing, moaning
Thirsty or hungry: Wandering, seeking behavior
Tired: Need to rest or sleep
Lonely: Apathy
Cold, hot: Sweating, flush or pale skin, body language
Craving activity or stimulation: Attention seeking
Need to go to the bathroom: Pacing, irritable
Need to change position: Restless
Need to get away from...... Irritable

Slide 44: Needs related to health
Acute illness (can’t tell you)
Chronic illness (arthritis)
Effects of medicines (more confused)
Changes in hearing or vision (Increase in confusion)
Dehydration (dry lips)
Constipation (abdominal symptoms)
Pain (rubbing)
Depression (crying or screaming)

Slide 45: Needs related to the environment
Too much noise or clutter: Irritable
Excessive stimulation Irritable
Poor sensory environment: Apathy
No orientation or cues: Increased confusion
Environment too large or unfamiliar: Irritable
Unstructured environment: Confusion
Too cold, too hot: Irritable

Slide 46: Needs related to the task
Task is too complicated
Too many steps at a time
Not modified for increasing impairment
Task unfamiliar
Too boring, childlike, or useless

**Slide 47: Needs related to communication**

**Failed to get attention:** Unable to get someone’s attention  
**Too much verbal information:** Unable to interpret the message  
**Too fast, loud, too soft, mumbled:** Unable to hear the message clearly  
**No cues or gestures or demonstration used:** Unable to interpret the message  
**Complicated language:** Unable to interpret message

**Slide 48: Do some problem solving**

**When does the problem occur?** Morning? Bath time? With a particular staff person? During or after family visits? Everyday?  
**What triggered it?** Similar to above but more specific  
**Look at time of day?** Is it in the morning, evening, night?  
**Did you make an error in your approach?** (Caregiver technique) Did someone else set the resident off such as another resident, a family member, or something else  
**Develop a list of alternative strategies to try:** Such as bathing in the evening

**Slide 49: Behavior Basics**

1. If you know one person with dementia, you know one person with dementia. What works with one may not work on another.  
2. Do not “challenge” short-term memory by asking questions that rely on memory. Ask if they enjoyed breakfast, not what they had for breakfast.  
3. If they ask you a question 50 times, just answer it the same way 50 times. It may be annoying to you but imagine how frustrating it is for the person who can’t remember.  
4. Persons with dementia almost always remember what happened years ago:  
   - This adds to their confusion.  
   - They may be looking for their mother, their childhood home.  
   - Avoid arguing or rationalizing that this person is no longer alive, it serves little purpose, as they will forget what you told them or get angry and argue.  
   - It is easier to enter their world rather than to try to get them orientated to today’s world. Example: Oh, your fathers at work, we will call him later.

**Slide 50: Basics cont.**

5. Tell what to do rather than what not to do

Buettner & Fitzsimmons 2007
- Resident is heading towards the exit door, attempting to leave.
- You say to him not to go out, he stops, but then does not know what to do and may try to go out again.
- Instead ask him to come and help you, see something etc……
- This gives an action to do to replace the desire to leave.

6. Sudden change in behavior comes from sudden problems. Resident is usually agreeable and easy. Today he seems agitated, yelling and refuses to eat. New behavior, for better or worse usually mean there is something physically wrong. A medication to calm him down does not help if he has a tooth abscess or urinary tract infection.

Slide 51: Basics cont.
7. Don’t talk about them in front of them

8. Realize that they would rather do things for themselves. These losses causes loss of self esteem and self-identity. Try to preserve dignity.


10. They have a brain disease.
- They cannot help the way they act.
- Think that they are doing things intentionally or that they could stop their behavior if they really tried hard?

➢ That is like telling someone with diabetes that they could control their blood sugar by trying really hard to make their pancreas work.

Slide 52: How can you help your residents?
- Activity to stimulate the use of the brain and the body.
- Activity to encourage movement.
- Activity for social connections.
- Activity to provide joy.
- Allow to do as much as possible for self

Slide 53: Benefits of remaining active
1. Provides sensory stimulation
2. Use physical skills - prevents disuse or atrophy from occurring
3. Provides an opportunity for socialization
4. May lead to better mood and less apathy
5. Improves cognitive function
6. Improves sleep
7. Allows for self expression  
8. Fitness - cardiovascular, strength, flexibility  
9. Allows opportunity to test self  

**Slide 54: What to do based on who**

Know the resident, past work, past hobbies, special talents, family and friends and other meaningful parts of his or her life. Who they are helps you provide activities.

- The more impaired the person, the simpler the activity needs to be.  
- APPROACH and COMMUNICATION are critical. Demonstrate what to do and provide encouragement.

**Slide 55: Steps in running a small group**

1. Get your stuff together for the activity  
2. Bring your residents to area for the activity  
3. Think about their personalities  
4. Alert each person  
5. Show and Tell  
6. Demonstrate  
7. Each person gets to touch, talk, move  
8. Keep it short – leave them wanting more.  
9. Bring the group to closure – say goodbye and help them on to something else.

**Slide 56: Design of Activity**

Can be anything (normal):
- Club  
- Writing/reading/poetry  
- Sing or Dance  
- Walk together  
- Card group  
- Fashion club  
- Cooking club  
- Reading group  
- Nature lovers  
- Dog Fanciers

**Slide 57 Basic Principals**

- Object is to actively engage  
- Resident does more than the staff does
• Staff instructs, then prompts, resident speaks
• Adapt activity to lower functioning
• Lower functioning needs shorter programs with fewer participants
• Minimal use of large programs

**Slide 58: Helping your resident attend various types of activities**

• Know which ones they wish to attend (preferences)
• Have resident ready for the activity
• Transport them there if on unit, arrange transport if off-unit
• Ask activity department to include your resident in activities
• Ask family members to participate in facility activities with resident

**Slide 59: Help your resident with self-initiating activities**

• Seat near radio
• Provide magazines
• Provide Simple Pleasure or other recreational items
• Seat near other residents to chat

**Slide 60: Under-stimulated**

• Sensory based activities
• Seated near action on unit
• Provide with activities within reach
• Lots of opportunities for movement
• Always leave with something to do after care is provided

**Slide 61: Over-stimulated**

• Small groups or quiet area
• Calming activities
• Provide with soft tactile “Simple Pleasures” items
• Outdoor activities

**Slide 62: Immobile or Passive**

• Use sensory-motor therapy programs
• Provide vibratory stimulation (massage)
• Re-position for programs
• Assist to change positions every 20 minutes
• Provide relaxation or rest programs with active programs
• Always alert the individual before a task

**Slide 63: Motor Restlessness**
• Morning walking program every day
• Opportunities for appropriate repeated movements (washing tables, sorting, exercises, stirring, shaking, painting or sketching)
• Unit jobs like delivering mail and messages or setting tables
• Adequate stimulation - diversional activities

**Slide 64: Anxious or Stressed**
• Provide programs of comfort
• Reassure frequently
• Allow time for self-expression
• Reduce stimulation
• Use warming “Simple Pleasures” items
• Telephone family or friends
• Memory books of familiar photos

**Slide 65: Depressed**
• One-to-one programs
• Exercise and walking
• Comforting activities (rocking chair or bean bag chair with headphones)
• Videos of family children or pets
• Feelings groups
• Frequent reassurance

**Slide 66: In pain or recently ill**
• Short programs
• Comforting and warming activities
• Re-position frequently
• Gradually increase endurance
• Hand and foot massage
• Relaxation
• Watch for symptoms of pain or weakness

**Slide 67: Process of starting activity**
• Get supplies
• Alert each resident in small group
• Talk to each resident to welcome them
• Show the activity
• Give just enough help to start
• Keep it short 15-30 minutes

**Slide 68: Keeping a group together**
- Set up in circle or semi-circle
- Move resident to resident to engage
- Give positive encouragement
➤ Pay attention to body language
➤ Build trust and have fun.

Slide 69: Adapting

1. Change equipment: Make larger, less pieces, less complex

2. Change rules

3. Simplify