



Position Statement

‘Behavioural’ support frameworks

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About MCM

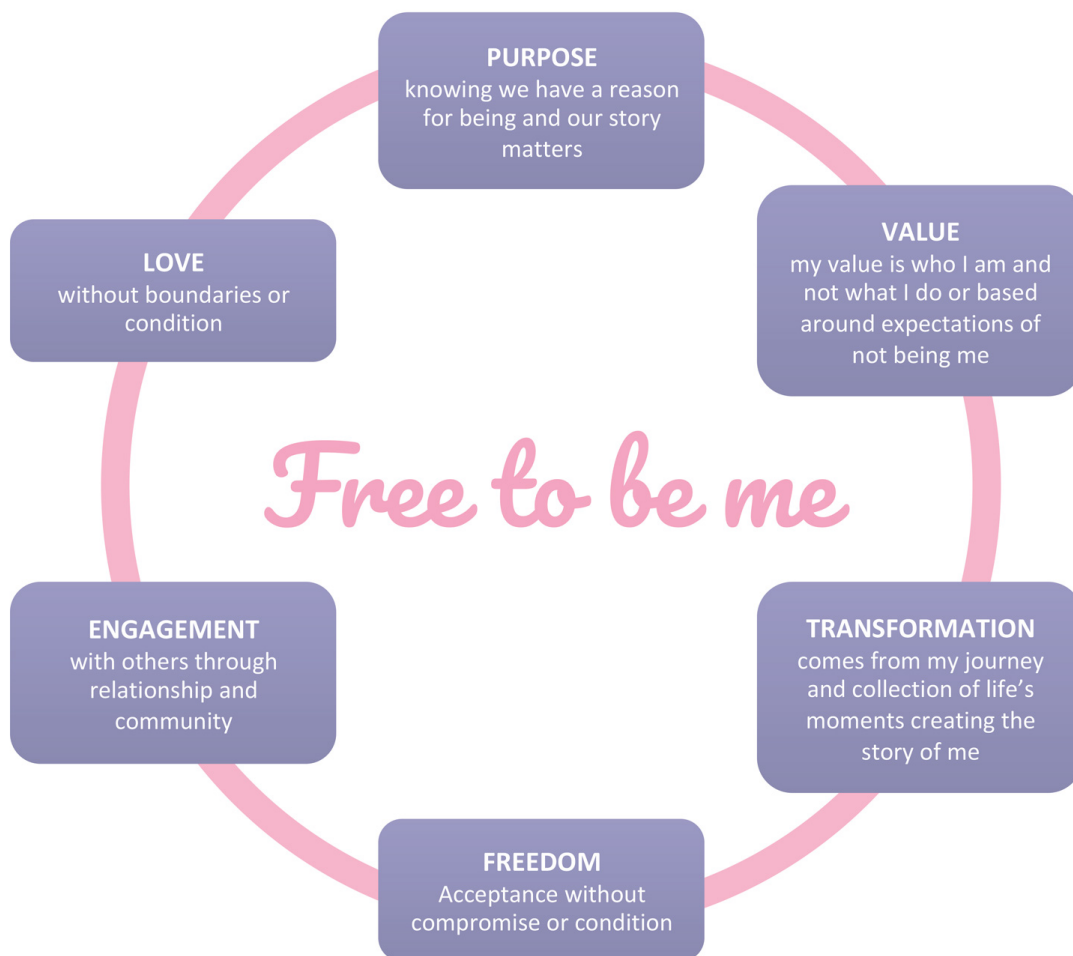
OUR MISSION

Creating meaningful care cultures where people are 'free to be me'. Why? Every Life Matters. Meaning Matters. Moments Matter. People Matter.

OUR VISION

To improve quality of life and lived experience for all people in health and social care services; bringing 'Meaning and Mattering' to the forefront of our interactions by connecting through our story, heart to heart and person to person. Offering a variety of services facilitating the effective and sustainable implementation of person-centred models of care for the health, social/aged and disability care settings.

OUR VALUES



Summary statement of position

Meaningful Care Matters (MCM) acknowledges behaviour is simply something that all humanity displays in the living of everyday life. Reflecting on our behaviour or someone else's is one of the primary means by which we develop self-awareness and emotional intelligence. The development of our own emotional intelligence is important in influencing well-being in others. Unfortunately, 'behaviour', displayed by some people who live in care homes, has been highly stigmatized and is often viewed with negative connotations. In many instances the negativity is reinforced by medical language which focusses instances of ill-being and distress as a side effect of a medical or mental health diagnosis classified as 'behaviours'.

This position statement specifically addresses the negative stigma associated with behaviour acquired within institutions where it is either used pejoratively or pathologized.

MCM, through its work to help care services implement culture change, is driven to uphold the rights, advocate for and reduce discrimination against, people who live with dementia, learning disability or, are subject to such stigma which impacts wellbeing because of vulnerability.

The 'Behavioural Frameworks of Support' is the position statement of MCM in terms of supporting both formal and informal approaches which create well-being. We aim to de-stigmatize the perception of 'challenging behaviour' by encouraging a broader consideration of human responses to feelings.

Purpose of position statement

This position statement is designed to be a starting point to our (MCM) review of approaches in how we can meet the needs of the people we serve.

Our goal is in improving the lives of people, those who live and work in care and support services, adding purpose, value, engagement, love, freedom and transformation. We acknowledge the difficulties experienced by many care teams who, not for the want of trying to do their very best, experience difficulties in finding the right solution for some individual people. We also acknowledge a responsibility as human beings to contribute to a movement towards an improved society; one that demonstrates equality, fairness, and kindness to everyone. One that stops labelling and stigmatizing others.

Context

Both research and lived experience supports the fact a large proportion of people who develop dementia are older (Alzheimer's Society 2021) and the influence of the discrimination they experience often merges with agism.

People have for many years attached labels to explain Dementia's impact on behaviour. Words such as mad, challenging, aggressive, confused, demented. These and many other labels, some created through observance of daily activity and some through scientific study, are used to explain behaviour (Kitwood 1997).

Using these labels, to categorize what someone is doing, creates a stigma, (Baldwin and Capstick 2007). As well as the pervasive humiliation associated with dementia the person seeking care becomes further stigmatized by another label e.g. Ms. X has dementia, she is challenging, she is a shouter and a biter etc.

We see many examples of people being labelled as displaying challenging behaviour. It is difficult to change this mindset among care teams who quite realistically are challenged to find solutions to some exhibited behaviour. The view that behaviour should be viewed as an attempt communicate (Kitwood 1997), whilst adopted in theory, has not led to a significant change in direct care practice by care workers in care homes or indeed by family carers or, sadly, a number of care professionals.

Changes in personality have often been suggested as being caused by neurological changes in the brain. An alternative theory is explained that these changes may also be due to the changes in the social psychology of our environment – that it is the reaction of the people around us - to what we say and do that may influence personality changes. For example - memory loss associated with cerebral atrophy, experienced because of aging, is a reality. Each person's experience of how their memory lapse is perceived by others, is variable and dependent on their social network. Christine Bryden (Bryden 2005 p142) talks about the 'disease of society'. Tom Kitwood in *Dementia Reconsidered*, talked about a malignant social psychology. How we are accepted or stigmatized impacts our feelings and responses (Kitwood 1997).

Generalizations

Labels can lead to generalizations (someone with dementia becoming angry leads to the belief that all people with dementia become aggressive). This view then leads to assumptions about what someone is feeling and thinking. As with other aspects of life, age, gender, sexuality, race and ability, once someone is labelled as a member of a specific group there is often an assumption that behaviour of certain type will follow, e.g., old people can't make sensible decisions, their thought process is not current, they can't keep up. Many offensive, cruel and inaccurate generalizations have been made about we human beings based upon assumptions. If the standard paradigm of age and dementia influences views on ability, adopting life enhancing opportunities, and the prospect of purposeful living then inevitably any changes to alter that perception, both nationally and internationally, are likely to be negatively impacted.

Assumptions

Labelling the behaviour of someone else suggests, often inaccurately, an understanding of their feelings (sadness, happiness, anger). When, arguable, because behaviour is born of a personal feeling, (one doesn't just display behaviour without first feeling something) which can only be felt by oneself; we alone can subjectively identify our feelings at any given time. How we as individuals show that feeling is largely dictated by our personality, socialization process, health – physical and neurological, as well as how we perceive and interpret our current social environment. Understanding feelings therefore requires a biopsychosocial approach i.e., the biological, psychological, and social impact of a diagnosis of dementia (Downs and Bowers 2008). So, whilst one person may display his/her anger in an overtly aggressive manner (shouting or verbally offending or abusing someone else) another person may display their feelings differently.

Whilst living with the personal restrictions associated with age and dementia many of us benefit from a supportive environment. For some people, those faced with constant criticism, humiliation, accusation, ridicule and infantilization, the difficulties of daily life are compounded with feelings of inadequacy. The impact is controlling and destructive by reducing confidence and subsequent ability to do things in our usual manner.

That is not to deny the reality that someone living with dementia has trouble in accomplishing everyday tasks or to suggest that the person should just be left to get on with everyday life without any help. Of course, receiving help is a vital part of living well with dementia. But it can be better provided in a manner that maintains dignity and promotes self-esteem. We all do better when we feel good about ourselves. When we feel bad, we react in a way that defends our sense of self; using learned behaviour as referred to above. **Our (MCM's) intention is to encourage care that focuses on positivity, empowerment, celebrates achievement, validates with genuine understanding, creating a feeling of high self-esteem thus reducing the likelihood of distress (Feil 2012).**

OUR CURRENT REALITY

For many reasons, the world of care and support services has largely focused on the end point of the experience of the feelings – the behaviour. Care and support services, despite all good intentions, is heavily focused on managing behaviour - behaviour identified by one of the labels that has been attached to people (all people) who live with dementia.

1. Feelings experienced = behaviour expressed
2. Managing Behaviour is a primary focus
3. Behaviour + Label = Identity

The reality of care home life is that a care worker does not have time to stop and counsel every person – if only it was that simple. Circumstances of daily care home life can often lead to care being rushed; and assumptions made too soon that a message, conveyed by the person with dementia, has been understood. That is too often the reality despite very good intentions otherwise. Yet, if we are to progress this demand to improve the lives of people living in care homes and make the work more achievable for care teams, we must find a solution. We know that short cutting a care experience for someone often leads to difficulty; incorrectly interpreting the message leaves the person who lives with dementia feeling misunderstood, unfulfilled, dissatisfied, ignored. This approach inevitably leads to consequences in one form or another.

OUR FUTURE REALITY

We cannot continue to treat people who have a diagnosis of dementia in a way that marginalizes them from other people. Labelling perpetuates the myth that there is a dementia type that causes all people to behave in a certain way.

As care providers we must learn to change our attitude. The person we are in the room with is the same as us and just as we expect to be treated fairly so does the person with dementia. We must learn to listen and hear what that person is saying, genuinely listen, hear, and empathize. Validate signs of distress with real and genuine listening and understanding (Feil 2012).

Examine and Evaluate.

Examine and evaluate our own attitudes and behaviours every day to consider how we did. Own any episodes that we get wrong – for example if we fail to understand someone. Try to adopt, non-defensively, the ‘it’s not you it’s me’ approach. ‘I misunderstood what you were telling me – I’m sorry. Can we please try again?’ Don’t beat ourselves up, rather seek and offer support to one another. It would be unusual for a single care worker to find all the answers on their own. Good team support is essential. Consider what we could have done differently. Try and retrace the dialogue; What did I say? What was the expression on my face? Did I turn away when X was talking to me? Did I show genuine warmth and understanding? Did I demonstrate that I was listening?

1. Behaviour Management begins with Attitude Adjustment beginning with self.
2. Adopt a collaborative approach
3. Undertake Reflective Practice to embed how to listen and understand vs label and manage

Policy and environmental context ¹

Internationally, there is a range of information, advice and policy directives provided in each country regarding the care and support of people living in care homes who have some form of cognitive disorder. It is important that each service follows the specific advice and directives to meet the requirements of their regulatory and governing bodies.

However, because this position statement is about how we improve the treatment and wellbeing of other human beings there is no contradiction associated with regulatory compliance and legislative controls. The framework of behavioural support within this positional statement will provide evidence of how providers of health and social care services meet the regulatory compliance and quality assurance needs of legislation in a person-centred approach without compromise to clinical care or medical support needs.

Additionally, each country and area will have its own support networks. Notwithstanding the good work and dedicated care provided in the majority of care homes and other services it can be observed that, mindsets toward people living with a dementia are, with very few exceptions, found to be lacking all that is needed. That being the case we, care providers, can become a source of education and hope for future improvement. Once enlightened with an improved position statement each organisation could become a source of influence within its own area. We ask all providers of care to be brave – seek to influence change within and outside of the care home in which you work.

Leadership

There are several challenges that impact application of this change for the care provider and not least among these is the recruitment and retention of good care teams. The development of dedicated and competent care teams can be addressed through leadership and strategic planning.

Positive care cannot flourish without competent, dedicated, and compassionate management and leadership. The level of energy required to implement change in a care service is too great for a laissez-faire approach. Recruitment and retention of a team of people

England = [Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk) [GOV.UK \(www.gov.uk\)](http://www.gov.uk)

Wales = [Home | Care Inspectorate Wales](#)

Ireland = [The Health Information and Quality Authority \(HIQA\)](#) - [Regulation of residential care for older people \(citizensinformation.ie\)](#)

Canada = [A Guide to the Long-Term Care Homes Act, 2007 and Regulation 79/10 \(gov.on.ca\)](#)
[Dementia in long-term care | CIHI](#)

Australia = ACQSC. [Quality Standards | Aged Care Quality and Safety Commission](#)

working within care services demands constant nurturing and support, to and by, all levels of management.

Processes

MCM challenges the traditional model of care services for people living with dementia. A model filled with outdated systems and programs which have been designed to manage people in the most cost-efficient manner. Underlying the development of a care service is the standard paradigm of older people living with dementia mentioned previously. That view impacts every aspect of a provision; the economy of scale – number of places, size, and design of buildings, cost per capita, fixtures and fittings, staffing numbers and categories of care, as well as the actual framework of care. Despite the huge expense, and attention to detail, applied to the building and running of a care home the actual lived experience is often still based on institutionalism.

1. People Matter

This position statement suggests that the starting point for someone, who we are caring for, should begin with an opportunity to sit and talk, to speak and be heard how he/she is feeling. Turning the system on its head and framing the compliance with regulations around the person rather than the other way around. Someone who is being supported through a health or social care service may well be at their lowest ebb and vulnerable due to feelings of loss related to independence. Person centred support frameworks should protect those whom we are caring for from having to face the institutional process created not for them, but for the benefit of systems and regulation. 'Knowing people' is fundamental to the foundation of a support framework which reduces the stigma and pathologizing of 'behaviour' (as discussed in this document), which is ultimately the expression of an unmet need being presented in a state of ill-being.

2. Words Matter

Language has a powerful influence on feelings and attitudes. The wrong word or phrase can cause a range of emotions which are both positive and ones which can evoke ill-being. Furthermore, the way in which we speak, tone, choice of words and use of language can be different to the way the person we are caring for is familiar with. All these factors influence the way someone feels and comprehends what is being said. Words Matter. There is no simple way of changing language without first changing our thinking. As human beings we are fallible creatures and wrongly chosen words can hurt and offend others.

For example, using the words 'daft or silly' may be words we have always said to identify an action wrongly done. In many relationships they are harmless and friendly terms used to identify misdoing something. But said in the wrong context, to someone who doesn't know us, even though we may have some knowledge of him/her, can be hurtful and provoke a negative reaction.

Once we know the person, we have a better understanding of how we can communicate in a way that is meaningful to him or her, remembering that conversational nuances are different for each of us.

3. Attitudes Matter

Much has been said about the wrongly framed approach and we know change in attitudes takes a long time. Ultimately, we are talking about care home culture change. There are many things which cannot be controlled, but as individuals we can control our attitudes towards other people despite some cultures of care which may not necessarily be as adaptive to personhood as we would choose them to be. The whole point is that we as individuals have a choice and can influence change if we so choose.

For the health and social care sector, learning anti oppressive approaches is an essential element of culture change which is needed to nurture an environment free from oppression, agism, and all other forms of discrimination (Dalrymple and Burke 1995). The starting point for this is equality and diversity training. Thereafter we must name and empower accountability to establish a behavioural pattern in ourselves and our teams which promotes wellbeing for others. This not only benefits those we care for but also respects our fellow colleagues. The beginning of culture change is to set a new normal which may include, but is not limited to, banning offensive jokes, language, pictures, and anything that marginalizes anyone. Political correctness is much criticized but before we heard the term many people faced significant levels of stigma.

This is the beginning of applying a truly person-centered approach. But understanding equality and diversity is not enough in its own right to produce culture change. Attitudes need to be more than a philosophical approach. They must be a tangible reality in the everyday experience of life, not just work life, but life in general.

Feelings Matter

The language of feelings is important when we communicate and interact with people living with a dementia. When we use this language, it is imperative we encourage thinking that frames the interactions. We must do so without blaming the person with dementia who exhibited some form of behaviour that offends, frightens, annoys etc. Any expression such as this is about the person trying to communicate something to us which we have not yet understood.

If we are to adopt this element of the framework, where feelings are considered to be an expression of need and remove the label of 'challenging behaviour' we must alter our position. We must consider how our position, which includes a judgement about behaviour in relation to Dementia, impacts the loss of self (Sabat 2001). We must harness and nurture the framing whereby we examine the cause using the principles in this support model.

What precipitated the display of anger?

How did we respond?

What can we do differently?

Behaviour charts that perpetuate and reinforce adverse expressions of ill-being, without an honest reflection on causal factors or a record of the feeling or unmet need being communicated, are unhelpful. A behaviour chart which records only an episode of 'challenging behaviour', without due consideration to the individual needs and circumstances, is a wholly inadequate record of someone's distress. Such documents become powerful pieces of evidence which can influence the persons future care support.

Yes, record the expression but where possible talk about it calmly together as a team, not defensively, not blaming, but being truly honest about what may have caused the outburst of anger. If this is unable to be reviewed in a team context, discuss with the family in an attempt to know the person better. Know and understand the individual needs of the person so that future expressions of similar nature can be supported in a way which is meaningful.

If one of us, and we have all done it, makes a mistake with an approach we must have the confidence of being able to say it out loud. Mistakes in care are only wrong if done deliberately – then of course it becomes a matter for Safeguarding someone from abuse. Sharing and learning together will help the team to grow.

Developing your own Behaviour Support Model

- Make Frameworks of Support a reality by including it in your strategic plan.
- Plan how to disseminate the messages throughout the whole team.
- Consider your staff support structure – individual and group support sessions for the whole team
- A manager should plan his/her own support network - arrange some ongoing coaching for some personal one to one time
- Diarize meetings and coaching sessions for the team – make them happen
- Establish groups of team members to review systems and processes. Devolve, don't abdicate, responsibility. The managers role is to stick with it not simply let someone else get on with it without support. Set realistic time frames to allow thinking time
- Plan and book training – approaches to understanding feelings needs considerable support
- Arrange for someone to come and look at your service every now and again; someone from the social work team, one of the homes relatives, a manager of another care home. A fresh pair of eyes visiting and taking a barometer to your service is valuable. We miss what we see every day.

Remember to REFLECT, RESPECT and RESPOND vs REACT

Statement of position being taken

The position statement reflects the MCM values regarding our frameworks of support to 'understanding behaviour' and we commend these values to all; companies, individual people living, working and visiting care services.

True person-centered care is about enabling people to live a life of their own choosing. This is where we truly see the ability of being 'Free to be Me', enabling the display of self, not stifling it. Behaviour is normal – we all have it. Every human being has some form of behaviour that irritates, offends, disrupts the wellbeing of another person. Behaviour is not always considered a negative event and it is unfortunate that this has become engrained in our cultures. We have the opportunity to redefine a new norm and re-calibrate the feelings one associates with 'behaviour' to simply reflect our individuality and approach to life. How we react and respond to behaviour is key to enabling our people to enjoy a life of freedom from oppression.

How we create our own framework of support for our people is essential. In essence lets come back to the art and heart of personhood which is summarized as follows:

Purpose:	knowing we have a reason for <i>being</i> and our story
Value:	my value is who I am and not what I do or based around expectations of not being me
Transformation:	comes from my journey and collection of life's moments creating the story of me
Freedom:	acceptance without compromise or condition
Engagement:	with others through relationship and community
Love:	without boundaries or condition

Appendix One - Background Information and Literature Review

Both research and lived experience supports the fact a large proportion of people who develop dementia are older (Alzheimer's Society 2021) and the influence of the discrimination they experience often merges with agism. Old age is often associated with senility, weakness and feebleness, with references to 'incompetent, ugly and burdensome', (Kitwood 1997. p12) (Bytheway 1995) and a diagnosis of dementia reinforces the myth that incapacity affects every older person (Brooker 2007). The influence of other people's opinions on our behaviour is powerful and the concept of self-fulfilling prophecy is accurate (Gross 1989). Positioned thus, it is small wonder that someone, living with diagnosis of dementia and attempting to integrate into a care home community, an environment which may be unfamiliar to them, may well display their opinion defensively. The stage having already been set by the diagnosis of their dementia (Sabat 2006).

The discrimination is largely unintentional, institutional, and international. People living with a dementia, learning disability or other medical/mental health illness resulting in cognitive impairment are frequently 'controlled' by the assumptions of other well-meaning people. As such, the discrimination is even more difficult to change because those assumptions flow beneath the surface of a genuine caring attitude. Nevertheless, because it perpetuates a generalized myth about capability, it is destructive (Sabat 2001). 'A landscape of meaningless has developed around dementia, and this urgently needs to be tackled' (Killick and Allan 2001 p120).

Social policy, strategies and action plans can drive change - examples of these are in references. Although there is a plethora of evidence to support the proposal for change, we have yet to see movement which accepts that someone who is in a minority, in this case aged and living with dementia, should live with the same rights as those in the majority. Policy alone will not change mindsets. Real transformation requires widespread culture change involving everyone; a full consideration of our individual and personal position, examining our own language, our behaviour and thoughts, and our willingness to challenge anything and everything that may, albeit inadvertently, lead to prejudice being applied to the treatment of another person.

People have for many years attached labels to explain Dementia's impact on behaviour. Words such as mad, challenging, aggressive, confused, demented. These and many other labels, some created through observance of daily activity and some through scientific study, are used to explain behaviour (Kitwood 1997).

Using these labels, to categorize what someone is doing, creates a stigma, (Baldwin and Capstick 2007) and we now understand, that each new label creates an additional dilemma for the progress and application of meaningful care and support. As well as the pervasive humiliation associated with dementia the person seeking care becomes further stigmatized by another label e.g. Ms. X has dementia, she is challenging, she is a shouter and a biter etc.

We see many examples of people being labelled as displaying challenging behaviour. It is difficult to change this mindset among care teams who quite realistically are challenged to find solutions to some exhibited behaviour. The view that behaviour should be viewed as an attempt to communicate (Kitwood 1997), whilst adopted in theory, has not led to a significant change in direct care practice by care workers in care homes or indeed by family carers or, sadly, a number of care professionals.

Changes in personality have often been suggested as being caused by neurological changes in the brain. An alternative theory is explained that these changes may also be due to the changes in the social psychology of our environment – that it is the reaction of the people around us - to what we say and do that may influence personality changes. For example - memory loss associated with cerebral atrophy, experienced because of aging, is a reality. Each person's experience of how their memory lapse is perceived by others, is variable and dependent on their social network. Christine Bryden (Bryden 2005 p142) talks about the 'disease of society'. Tom Kitwood in *Dementia Reconsidered*, talked about a malignant social psychology. How we are accepted or stigmatized impacts our feelings and responses (Kitwood 1997).

Generalizations

Labels can lead to generalizations (someone with dementia becoming angry leads to the belief that all people with dementia become aggressive). This view then leads to assumptions about what someone is feeling and thinking. As with other aspects of life, age, gender, sexuality, race and ability, once someone is labelled as a member of a specific group there is often an assumption that behaviour of certain type will follow, e.g., old people can't make sensible decisions, their thought process is not current, they can't keep up. Many offensive, cruel and inaccurate generalizations have been made about we human beings based upon assumptions. If the standard paradigm of age and dementia influences views on ability, adopting life enhancing opportunities, and the prospect of purposeful living then inevitably any changes to alter that perception, both nationally and internationally, are likely to be negatively impacted.

Assumptions

Labelling the behaviour of someone else suggests, often inaccurately, an understanding of their feelings (sadness, happiness, anger). When, arguable, because behaviour is born of a personal feeling, (one doesn't just display behaviour without first feeling something) which can only be felt by oneself; we alone can subjectively identify our feelings at any given time. How we as individuals show that feeling is largely dictated by our personality, socialization process, health – physical and neurological, as well as how we perceive and interpret our current social environment. Understanding feelings therefore requires a biopsychosocial approach i.e., the biological, psychological, and social impact of a diagnosis of dementia (Downs and Bowers 2008). So, whilst one person may display his/her anger in an overtly aggressive manner (shouting or verbally offending or abusing someone else) another person may display their feelings differently.

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That is not to deny the reality that someone living with dementia has trouble in accomplishing everyday tasks or to suggest that the person should just be left to get on with everyday life without any help. Of course, receiving help is a vital part of living well with dementia. But it can be better provided in a manner that maintains dignity and promotes self-esteem. We all do better when we feel good about ourselves. When we feel bad, we react in a way that defends our sense of self; using learned behaviour as referred to above. **Our (MCM's) intention is to encourage care that focuses on positivity, empowerment, celebrates achievement, validates with genuine understanding, creating a feeling of high self-esteem thus reducing the likelihood of distress (Feil 2012).**

OUR CURRENT REALITY

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4. Feelings experienced = behaviour expressed
5. Managing Behaviour is a primary focus
6. Behaviour + Label = Identity

The reality of care home life is that a care worker does not have time to stop and counsel every person – if only it was that simple. Circumstances of daily care home life can often lead to care being rushed; and assumptions made too soon that a message, conveyed by the person with dementia, has been understood. That is too often the reality despite very good intentions otherwise. Yet, if we are to progress this demand to improve the lives of people living in care homes and make the work more achievable for care teams, we must find a solution. We know that short cutting a care experience for someone often leads to difficulty; incorrectly interpreting the message leaves the person who lives with dementia feeling misunderstood, unfulfilled, dissatisfied, ignored. This approach inevitably leads to consequences in one form or another.

OUR FUTURE REALITY

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As care providers we must learn to change our attitude. The person we are in the room with is the same as us and just as we expect to be treated fairly so does the person with dementia. We must learn to listen and hear what that person is saying, genuinely listen, hear, and empathize. Validate signs of distress with real and genuine listening and understanding (Feil 2012).

Examine and Evaluate.

Examine and evaluate our own attitudes and behaviours every day to consider how we did. Own any episodes that we get wrong – for example if we fail to understand someone. Try to adopt, non-defensively, the ‘it’s not you it’s me’ approach. ‘I misunderstood what you were telling me – I’m sorry. Can we please try again?’ Don’t beat ourselves up, rather seek and offer support to one another. It would be unusual for a single care worker to find all the answers on their own. Good team support is essential. Consider what we could have done differently. Try and retrace the dialogue; What did I say? What was the expression on my face? Did I turn away when X was talking to me? Did I show genuine warmth and understanding? Did I demonstrate that I was listening?

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5. Adopt a collaborative approach
6. Undertake Reflective Practice to embed how to listen and understand vs label and manage

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Online

Alzheimer's Society - [Who https://www.alzheimers.org.uk/get-involved/make-donation?gclid=CjwKCAiAouD_BRBIEiwALhJH6Cn3pjWbL-6TuzPhpz1ZSYCBtVferykzzb7kvL5kc8TIJwnan6uFmxoC3s0QAvD_BwE&gclid=aw.dsgets+dementia?](https://www.alzheimers.org.uk/get-involved/make-donation?gclid=CjwKCAiAouD_BRBIEiwALhJH6Cn3pjWbL-6TuzPhpz1ZSYCBtVferykzzb7kvL5kc8TIJwnan6uFmxoC3s0QAvD_BwE&gclid=aw.dsgets+dementia?)

England

Care Quality Commission standards UK [Care Quality Commission \(cqc.org.uk\)](http://www.cqc.org.uk)

Care Act - [Care Act 2014 \(legislation.gov.uk\)](http://www.legislation.gov.uk)

Mental Capacity Act 2005. - [Mental Capacity Act 2005 \(legislation.gov.uk\)](http://www.legislation.gov.uk)

Wales

[Home | Care Inspectorate Wales](#)

Ireland

[The Health Information and Quality Authority \(HIQA\) - Regulation of residential care for older people \(citizensinformation.ie\)](#)

Canada

Regulation is by Province.

[A Dementia Strategy for Canada - Rural Dementia Action Research \(RaDAR\) - University of Saskatchewan \(usask.ca\)](#)

[A Dementia Strategy for Canada: Together We Aspire - Canada.ca](#)

[Alberta Dementia Strategy and Action Plan - TREC \(trecresearch.ca\)](#)

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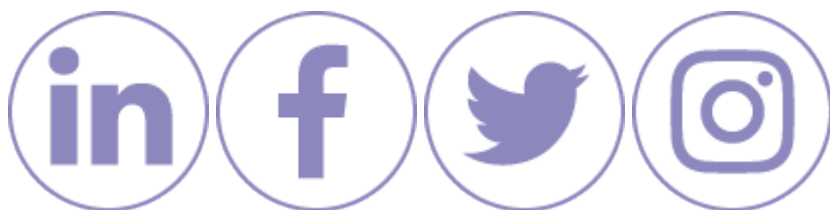
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For further information regarding Meaningful Care Matters Services, please contact us on:

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meaningful care matters
Free to be me