

Positive Approaches to Care — 10 Ways to De-escalate a Crisis
Presented by Greater Oregon Behavioral Health, Inc.
Hosted by the Oregon Office of Rural Health Annual Forum on Aging
Presenters: Rod Harwood and Kris Boler
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Rose: Good afternoon everyone. Thank you so much for joining us today. It is 12:30, we're going to go ahead and get started. My name is Rose Locklear and I'm a Program Manager at the Oregon Office of Rural Health, and it is an honor to have Rod Harwood and Kris Boler join us to present Positive Approaches to Care — 10 Ways to De-escalate a Crisis. We can go ahead and move on to the next slide and I will introduce folks to the etiquette and orient you all with the webinar today.

So a bit about the platform. At the bottom of the screen there is the option for audio and video. We have those muted for you today as attendees. If you would like to enter a question, please use the Q&A feature. The chat button on the bottom will populate that to the right of your screen and chat feature, that's going to have, if you would like, the live streaming captioning service. The link to that is over in the chat feature. So can click on that and you will be able to follow along with text.

Our moderator is going to be Kris Boler. She will follow me today with a bit more housekeeping for those who may want information on continuing education. Finally, this will be posted under the Forum on Aging in Rural Oregon on our web site at the link there. This year we were unable to host a Forum. So, rather than a bunch of organizations doing the same presentation, I'm delighted that we're partnering with GOBHI to offer this session and help with the process. So Kris, you're on.

Kris: Thank you, Rose. Hello everybody. I'm Kris Boler, Older Adult Behavioral Health Manager with GOBHI, Greater Oregon Behavioral Health. I'm going to talk just briefly about the Older Adult Behavioral Health Initiative. This was formed and is run through the Oregon Health Authority in 2014 and it exists because older people and persons with disabilities face unique barriers to having their needs met.

So there are 24 specialists that work throughout the 36 counties in Oregon serving older adults in gaining better access to health services. And the things we do — we conduct community education, workforce development trainings. We offer complex case consultation to community partners when they need it, and we also work with communities to collaborate together to identify issues and gaps in services to this population and come up with creative ways to solve those.

We do offer NASW CEU's for this training, and it's worth one hour for CEU. We'll send you out information about that after the training, but you will receive an evaluation that you need to

send back to us in order to get on the roster that is submitted to NASW and to get your certificate.

Another piece of housekeeping is that the Older Adult Behavioral Health Initiative is evaluated by Portland State University. They send out online evaluation surveys to all participants for any trainings that we do, so you will receive that probably early next week and it will come from ioaevaluation@pdx.edu. Please do keep an eye out for it. It's really important because Portland State reports their findings back to the legislature and helps keep this program going and also pushes issues up at the state level. So it is super helpful and thank you in advance for doing that.

So today you're going to have Rod Harwood present the 10 Steps to De-escalation. Rod's an Older Adult Behavioral Health Specialist with GOBHI. He provides a lot of trainings in his service area. He is a certified Positive Approaches to Care Trainer. And he has 30 years of health care experience providing clinical support in hospital, mental health, and hospice settings, and I'm sure you are going to enjoy his presentation style and personality very much. Thank you for being here, and thank you, Rose and the Oregon Office of Rural Health for partnering with us on this presentation.

Rod: Good afternoon everyone. So glad you can join us on this beautiful spring/summer day here in Oregon. I'm glad you can join us. I think this is a very important topic. I know we have folks joining us from a wide band of care partners. Some of you are providing direct care for those that are living with dementia. Some of you have family members or someone you know that's living with dementia. And some of you in terms of the work that you do are supporting others that are doing the same.

So I hope that you find this presentation today helpful to you. The training that we're having here is 10 Ways to De-escalate a Crisis with Positive Approach to Care. This training enhances caregivers' understanding of the root cause of this behavior and offers strategies for preventing escalation and restoring a resident's sense of safety and control.

Now the objectives of this training include providing an overview of how the brain works in those living with dementia and how when feeling threatened, the primitive part of their brain becomes the boss of their behavior. We're also going to learn how the role of five senses impact our behaviors and what drives us and we'll provide an introduction to the positive approach to care in supporting those living with dementia.

Then, finally, we are going to be looking at the 10 ways themselves to help a person deescalate when under stress. And I hope that you see as we're moving through this that much of what you are going to learn applies, I believe, to any person under distress. Many of these ways apply to that.

First off, we need to review the fact that, with dementia, there's four truths that we need to understand. First, at least two parts of the brain are dying. And it keeps changing and getting

worse. It is progressive. It is not curable or flexible, but chronic, and it results in death. It's terminal.

This umbrella — the reason I like to show this is because when we talk about dementia, it really is an umbrella term because there's many different diseases/conditions that have dementia as a part of it. As you can see underneath this umbrella, you do have one over there to the left. When most people think of dementia they think of Alzheimer's. That this is the big kid on the block. Most folks living with dementia have Alzheimer's, but we have frontal and temporal lobe dementias, Lewy body vascular dementias and a whole slew of others that are listed on the right.

There are lots of numbers that are thrown out there. Last I heard and read, there was at least 140 different conditions that have dementia as a part of that. And so a picture is worth a thousand words. And you look at this picture, as you can see on the left is a normal healthy brain, and the brain on the right is one that is dying. And it looks like it's dying. And in reality, as the dying process happens, obviously it shrinks. And you can see also, as the arrow points out, that the tissue of the brain itself actually shrinks where you see these gaps. Here and here.

And if you look here, the top of this picture this is actually the back of the brain we'll reference later. Another picture here is a PET scan. As you can see here, a normal brain on the left in terms of activity — of course the brighter the color the red tone is the more brain activity that is occurring — everything's firing. And as you move into early dementia, you're seeing more of the dark purple/blue tones where there's less activity. And then as you move to the right you see the late Alzheimer's, and you see very little activity and connection. And if you notice here how much it has in common with the child on the right.

Of course with a person living with dementia they are going the opposite direction in terms of development, where a small child in terms of interacting and receiving information is progressively developing. So how does dementia affect brain activity? We often think about yes, it affects learning. It affects memory. But also it affects thinking and planning and we see this oftentimes where a person gets to the point where they are unable to do their bills or complete activities throughout the day. Or, for instance, they become a danger to themselves in terms of driving or even cooking a meal. They are just unable to initiated sequence and terminate their activities. But also it affects their speaking. As dementia progresses, it affects that part of the brain in terms of their ability to both come up with the words that they are trying to say and also as it progresses it gets to the point where their language itself can become chit-chatty or garbled.

And finally, in terms of their understanding of what you are saying to them. I often refer to that as Charlie Brown teacher speech. They are hearing, "Wa, wa, wa, wa." Also, it affects in the later stages the sense of one's body location and relationship to the objects around it. They have less flexibility in terms of movement, and also less flexibility in terms of moving and having a greater fall risk.

And finally it affects sensory intake — the speed of processing. If you think about all of us looking at computers right now, and as those computers get older, the speed of processing slows. And in reality that's a normal part of aging for us. Starting at about age 25, our speed of processing slows about a half a second for every year as we get older. But obviously with a person living with dementia, middle stage dementia, lots of times as far them receiving information, it may take up to 30 seconds for them to receive that information that you are giving them — whatever way that you are communicating with them — for them to receive, to be able to cognitively understand or interpret what they are receiving and then respond back.

But that processing also affects your visual range. One of the things that you would learn, if you take more classes, we talk about early stages of dementia of individuals actually experiencing what we refer to as goggle vision. As you can see here looking at me if I hold my hands up in front of my eyes with my thumbs below my nose. And I encourage you to do that right now. Take your hands up and put them up in front of your eyes. Notice what your eyes can see and focus on. An object say eight, ten feet away from you. Then take your hands down and notice how much you're missing off to the left and right.

Early in disease our processors have slowed so much that we are not taking in that information to the left or right. I was working with one lady whose mother had recently had a car accident and after sharing with her about how dementia affects visual range, the light bulb for her went on. She said, "That's what my mother was experiencing. She's kept on saying she did not see those cars that were to her left or right." And it was at that point or stage of processing.

As the disease progresses, it moves into what we refer to as binocular vision in terms of the range of what they are receiving and then monocular end stages. So they're only receiving information through one eye. Now you can imagine how that can impact as a loved one, a caregiver as you are approaching them if they do not see you. We're going to get into that more later. Finally, it affects at the very primitive level: body regulation, blood pressure, body temperature and so on.

Throughout this we'll be watching some videos with Teepa Snow. As I mentioned I'm a certified trainer with Positive Approach to Care. This is a program that was started by Teepa Snow. Teepa has well over 30 years' experience in working with those that are living with dementia. She has a background of occupational therapy. She developed this with a team in a hospital back in North Carolina and eventually has expanded and developed the whole program much further since then. Now we're going to have Teepa share with us.

Teepa (video): Take your fingers fold them over and go down. These are the two halves of your brain and they both go down to the center. So this is the brain sitting like this and you have two halves — they're called hemispheres. You have a map of your body: do this.

Two halves on each side of your brain. This is — this side. Put your right hand up and move it over here. On the left side of your brain. The map for the right side of your body is on the left side of your brain. It's split right down the middle. The map for the right side of your body is on

the left side of your brain. I know. Do this. It is crossed over. There's a crossover and it has a fancy name, it's called corpus callosum. The wiring, all the wiring that goes from your brain to your body crosses over in your brain. It is a really powerful crossover. It's also a very dangerous crossover.

It means that only this side of the brain controls this side and this side of the brain this side. And then there are other special functions. It's specialized. This side can't do what this side does. They're all unique and special. The front of your brain can't do what the back of your brain does. The surface of your brain is the new part, called the neocortex. It is also called the thinking brain. It is the thinking brain. It is the brain you use when you want to think, do things, talk. This is the active thinking part of your brain.

Rod: So we look at that. Excuse me. As we look at this picture here again, as you notice here that front part of the brain, the frontal lobe regulates behavior and impulse. And the far back the red part of the brain which is the back side, which in that earlier picture was at the very top, is the occipital lobe and that's where as our eyes take in information, it is then — I would say projected on the back part of our brain and we process it there. Keeping that in mind. And of course on the left and right you'll have the temporal lobes of speech and language and then the parietal lobe which is processing sensory up there on the top, which affects our ability to move and be aware of our surroundings.

Teepa (video): Take your index fingers do like this with the thumbs and the sides of your index fingers.

Rod: I'll pause here for just a second. If you are ever in training with Teepa, one of the things that she wants you to do is take in information and learn in multiple ways. As you can see, she is a very kinetically focused learner and encourages the participants to participate with her, so would I would actually encourage you, wherever you are, to take your hands out and follow Teepa. You will remember it much easier.

Teepa (video): This is the primitive part of your brain. This is the part that develops first, the part that is functional first. Look it's the engine. It's the core part, if this part isn't working the outside part doesn't get to do anything. So it's really important that this part work. It has three core components. Let me give you the words that go with it. Hippocampus. Say it, Hippocampus. Thrive to survive.

Now the thrive to survive has multiple complex structures and wiring in it including your thalamus, your hypothalamus, your wiring, your adrenal glands. It's all the hormonal mechanisms, but it's also the feeding in system and feeding out system — blood pressure. That's the first system and that's a critical system. And back here, thumbs up. Amygdala. Say: Amygdala. Amygdala, is a fancy word it's hard to spell. It's the most primitive part of the brain. Its goal is to keep you alive. Keep you alive.

So we know some things now, and if we know this about the brain, what are we going to know about what people do? They can only do what their brain allows them to do. Because who's in charge? The brain! And when the brain's making mistakes, guess what I'm going to be doing? Making the same mistakes! It's not about what I want and what I used to do. It is now what I'm stuck with because I can only do what my brain allows me to do, and I can only do what I still have left.

This Amygdala is the boss of life when it sees a threat. When it thinks there is a threat it takes over your brain. And when it turns on, it turns off the thinking part of your brain — the language part of your brain — and the skills part of your brain. It narrows your visual field down to a simple tunnel. Because what it's looking for is how to get rid of the threat or how to get away from the threat. So what happens when the Amygdala turns on? We have fright, flight or fight. Because I want to kill the thing, get away from it, or, ah I don't know what to do — you panic.

Now this amygdala turning on: when it turns on you will not be logical, reasonable and rational. You will not be able to control your emotions. You will not be able to think things though. You will not be able to make good choices. You will not be able to initiate sequence, terminate, and move onto something different. You can't let it go, it's got to be dealt with in this moment, right now. And there's only one step: fight or flight.

Rod: So on the primitive part of the brain, I want you to realize that with a person who is under stress, what did she say? She said that it becomes the boss. It determines what's going to take place. I want you to look at here again this image that we have here and see the blue line that comes across? That PET scan that I showed you earlier, in terms of where it scans across the bottom PET scan, this is where the slice occurs. So looking at this, notice where the arrows are, where the firing is occurring. Right there is where the Amygdala is at. So as you can see in the late stages of Alzheimer's that's still going fairly strong, still somewhat weaker, but that's determining a lot of what is taking place.

Down here, that's the frontal lobe. That's that executive part of the brain that determines what should I do, what should I not do? It is a whole lot weaker now. If you were to take your hand out and you were to say that the one hand being the amygdala and then the other hand being like a helmet over the top and that is the frontal lobe, that is really controlling, lots of times, our reactions.

Now does that mean that for all of us the amygdala doesn't sometimes still become the boss? Certainly it does. When we get frightened or we get angry and we want something sometimes that overrides any cognitive decision making. But imagine again for a person, as the disease progresses, that ability of the executive part of the brain to able to decide for itself, is this a good thing — that is taken away. So it is the boss of life when it sees a threat. And it turns off our thinking, our language, and our skills.

I remember when I was a kid a swarm of bees actually landed on my shoulder. Was I thinking very well? Could I articulate what was going on? No. I just took off. And whether that was the right thing to do or not, it didn't matter. I was gone, because I felt threatened, and that's what I did. My focus became very narrow and tunnel focused because the goal was to keep me alive, to get rid of the threat, to get away from it.

And when we're working with those living with dementia that are limited in terms of their visual range, in terms of what they're understanding of what is being said. If what they are hearing is, "Wa, wa, wa," and what they are seeing they don't understand. You can imagine how that can impact what's going on with them. So with that in mind let's see what Teepa has to say about this.

Teepa (video): What everybody needs to learn how to do is to de-escalate people. Guess what that requires you to be able to do? Communicate effectively. Because now I have somebody in acute distress. Unless you know how to take them down verbally and nonverbally all you are going to do is increase their distress, which is typically what happens. Which is why they end up with the EMS people strapping them down to the gurney and have to "drug them up." Because they've reached maximum crisis.

I walked in on a Saturday into a building one time. I was there to train staff but nobody was in the place I was supposed to do training and I heard down the hall, "NO! NO! You get away! I'm going to kill all of you." I thought, well now I know where everybody is. And I went down the hall. Because of course, when there's a racket everybody wants to check it out. So everybody was down there checking out the racket. Basically everybody who was supposed to be in my class, I suspect. And there was a woman backed into a corner, and there were four EMS folks who were trying to move in on her. And the staff said, "This is what we're talking about. She gets totally out of control." They were all saying, calm down. Now turn to your partner. I want you to do this one, this one's really popular. Do this: calm down. I need you to calm down. Calm down.

And I said, "Gentleman, gentleman! Stop! Come here. I will handle this. I'm an expert." Now I'm going, oh crap, I hope I can do this. But what did I know if I chose not to do it? She was already flinging arms around; she had a cut on her arm from where she'd flung against edge of the wall and it sliced her skin. She's was 89 years old; she's terrified; she was fighting them off, but she missed them and hit the wall, because she didn't have depth perception. She was crouching down, she was trying to find things to throw. It was just going to get worse and worse. I said enough — time. And I pulled everybody back and I said you guys back off. Quit watching, it's not a show. They were all like -- and then they hid so they could watch. I know what they did. Fortunately, I just got enough out of her range and I didn't really care.

And I said, what's her name? And they said, Milly. I said, Milly, who are these people? All these people?! Every one of them is coming at you. Now notice what I did. That's Milly and I turned this way. Who is on Milly's side? I am and I did what she was trying to do only I was her champion. None of it! You get out of here! All you people you leave her alone!

Rod: As you can see here the first thing that Teepa did, is that she removed the threat. Now did Teepa come in and say all these EMTs are doing their job; they're not a threat? No. She took number three on here. She quickly got on Milly's side. She began to look at it through Milly's perspective. She took on the same energy level. Did you notice that? Did you notice that? She immediately began reacting to Milly's perceived threat at the same level showing Milly that she understood that this was a threat and that she was going to help her.

And she then created space in doing so. Part of the reason for creating space is not only helping Milly feel like the threat is being removed. Why do you think why else she's creating space? Milly is taking in a lot of information. Her focus is narrowly focused and in order for Teepa to help her, she needs to remove the other stimulus in the room. She creates a space and she does it in such a way that Milly doesn't see Teepa as part of that threat. But again Teepa is on her side.

Teepa (video): Oh, Milly. Oh man I can't believe they did this. Oh, god are you okay? What do you want to do right now? What are you planning on doing right now? Absolutely taking my hand. Oh, my god I cannot believe this happened. Are you okay? Oh, god, Milly.

Rod: Notice here. She gets at her eye level and notice how the energy level also drops. She is getting at her eye level and she is empathetic in her voice and she is still again acknowledging that this certainly is a threat. But she's getting her eye level and lowering the energy level in the room. And then she's using what we refer to as hand-under-hand. Right here is the symbol. Two hands coming together. But I'm going to let Teepa show us herself what hand-under-hand is.

Teepa (video): If I need a little bit more what I might do is called hand-under-hand assistance. What you're going to do is offer your hand to the person, like a regular handshake. Slide your hand up and around so you have a clasp thumb to thumb. What this actually allows me to do is control the wrist, the forearm, the elbow, the shoulder. And I can also cue her to do big movements as well as small movements. What also happens, is if she's not able to use a utensil or use an object, I can help her with manipulation so that she can move through the activity and I'm the one with the skill. Okay? It is the most extensive kind of help you're going to give, rather than doing for the person.

Rod: So what hand-under-hand does is, again, it uses established nerve pathways. What is that? Of course it's shaking hands. I know we're in the age of COVID right now, so we have to be very careful about this. If you're in a care facility you need to treat it as a family environment, taking all the precautions that you can take to keep the person safe. But using the handshake, even though that person's brain — that person that's living with dementia — their brain is gradually dying. The strong neural pathways are still there and established. It also, it is used in terms of eating, in terms of combing the hair, in terms of bushing the teeth. So those are early established neural pathways that you can use the hand-under-hand.

It also helps to connect you to that person. By physically they obviously they have to reach out their hand and we'll look at that a little bit. They have to reach out their hand to invite you in, but it automatically becomes a connection between the two of you. And also gives you advance notice of possible problems. As you're reaching out to do hand-under-hand, don't be quick to grab their hand.

Pay attention to their own body language, pay attention to whether they're receiving your invitation or not. That's letting you know if something's up. If there are other problems. And it helps you assess what's going on with them. Also hand-under-hand allows that person to feel in control. With the hand-under-hand, again, using what we refer as the bird or butterfly approach, allows you as the caregiver to still have some control, but allows that person to feel in control as you do hand-under-hand with them because they're able to do things themselves.

It is important here for you to know the person you're working with, though. As you approach them and you reach out that the hand you use and you come alongside their dominant side. That gives that person, again, a greater sense of control of what's going on when so much is being taken away from them.

And then connect with them their eye-hand skills as we talked about earlier. It allows you to do with and not to them. And one other thing that you can do. When you have that hand-under-hand and your hand is under their hand, as the brain condition changes where they're having more and more difficult time focusing, anything that's going on in the room can draw their attention. By simply pumping their hand with your hand that's underneath them, it draws attention back to you and whatever it is you're wanting them to do.

And finally, this approach matters in using hand-under-hand. The process, you start out in their public space. It's interesting. We're talking that's six feet away in this age of COVID. Really that is the public space. You're starting out that far away. Why do you start out that far away? It's important that you, again, give them opportunity that, for them to see. And then, you're able to gesture and greet them by name. You offer your hand and make eye contact with them.

And this is just a picture here. This is not a video that we're watching here. You can see people here to the left. Her hand is under the other person's hand. Approach them slowly within their visual range. Then you shake hands and maintain hand-under-hand and move to what is referred to as a supportive stance. Where Teepa is at right here, is in supportive stance. She is slightly off to the side.

I'm going to share my video here, if you can see me. Hopefully you can. Now as I'm looking in the screen, right in your face, for a person that's living with dementia this would not feel supportive. But, in fact, it could be seen as confrontational. Supportive stance moves slightly to the side like what I am here and it allows that person to see past the other person and if they feel trapped they see a way to get by. Remember we talked about earlier the goggle binocular and monocular perspective? If you would put your hands and do that and have that person

stand in front of you, that's all you see. But if the person's slightly to the side it allows them to see a way past.

Finally, get at their eye level and respect their intimate space. Pay attention again to body language. Make sure they invite you in. One of the other things about intimate space is — especially as the disease progresses — anything they touch is their intimate space. There's no sense of boundaries. That's the advantage again of being in supportive stance. You are only allowing them to see what you want them to see. And then of course wait for their acknowledgment, connection. And wait for response.

Now as I shared this, one of the trainings that we offer is called, Positive Physical Approach and it is a two-hour virtual training now. It goes much more extensively into using the physical positive approach. Again, this is a two-hour training. If this something that you'd be interested in, we can certainly provide this and I can provide this later.

Teepa (video): [Breathing deeply] There we go there we go. There you go. You're okay. It's okay. I'll deal with them. Come on. Let's go sit down a minute, come on, it'll be ok.

Rod: Now two things here. Breathing in sync and in a calm voice. Notice how a calm voice and again the level of energy, how dramatically different that was from when Teepa first engaged Milly. The energy level has gradually gone down. At first, Teepa matches that energy level and gradually helps Milly calm down.

The other thing here is the breathing in sync. Teepa seems to over exaggerate with her body. Why does she do that? Because it is visual. That's how Milly's receiving information first. But Teepa is helping her do something that's really important and that's helping her breathe. Milly has gotten upset. Lots of times when you get upset, your breathing becomes shallow, maybe even stop breathing. And what happens, too, is her cortisol levels have risen. And through breathing you are able to lower those cortisol levels which helps Milly retake control of her ability to cognitively think and assess what's going on around her.

Another thing that is occurring here through this breathing, it's helping again Teepa and Milly to connect. As mentioned at the beginning of the training today, part of my background was hospice and lots of times when I get called in to be with hospice patients and my background was as a chaplain being with a person towards the end of life. One of the things that I did, particularly towards the later stages when there wasn't a lot of verbal interaction occurring, I would sit in a supportive position with that person and I would hold their hand, and then I would match their breathing. I would get in sync with them in breathing and that was actually something I had been taught earlier on to do. And I noticed how often that helped me and that person connect and be there with each other during that time that we were visiting.

And for a person who is living with dementia, who is feeling scared, feeling afraid, feeling like they're all alone, again this is one of the things that you can do. Finally, of course having a relaxed body and visually for them to see that. If they see you as all tense that's the message

that they are receiving, that the environment is not safe for them. So it is important for our bodies to be relaxed.

So, even when we are walking in the room, it is important for us to check ourselves maybe even take a breath ourselves so that we can be relaxed and be present with them. This is why it is important for us to look at how the five senses impact how we take in information.

First off, our primary way of taking in information is through what we see. If you would see my hand right now, I would be holding it up and I would be holding my thumb up first in front of you. By holding my thumb up, it is like the artist. You hold your thumb out in front of you and whatever it is you are looking at that's what you focus on. How we take in information primarily, first of all, is visual. That's how we receive information before anything else. We take it in visually. Even when we take in what we hear, which is secondary. Off to the left and to the right what do we hear and what do we do?

We turn right away and look as to where that's coming from. Again because our vision is primary. Third, is auditory. But so often times what we do wrong is as caregivers is we like to talk. But the person living with dementia is focused on what we look like, how we look visually, and not processing that content. So again, our first way of communicating needs to be always visual first. So looking at this and we talked about public space. What we see visually, again how we take in data, also relates to the zones in which we connect with people. That public space is six feet away or more. It is where we first connect, again, as I shared earlier, it can take up to 30 seconds sometimes for a person to process and recognize what's in front of them so we need to be in a space further out for them to first see us.

So we present ourselves in that visual range. Again, remember the goggle, the binocular and the monocular vision. We need to be in front of them and then give them an opportunity to become aware of our presence. Then we engage them verbally. We introduce ourselves. And one of the things you would learn through learn through the Positive Physical Approach, we would bring our hand up next to our face simply to draw the attention of them to our face which hopefully, then, is with a smile and a warm approach.

Then, of course, then we offer our hand and wait for a response, and we wait. And if they choose not to reach out their hand, what we do is six feet away or more we actually turn to the side slightly, continue to engage them, and then we can offer, again, our hand out. And then if they then reach out their hand they are letting us know they are ready for us to connect hand-under-hand. And be in a supportive versus confrontational stance.

Make note: no touching until you've done your visual and verbal. And don't do to somebody, but do it with. Make sure that you are there to support them in what they want to do. Remember dementia robs skill before robbing strength. So as we do the hand-under-hand, we are offering them the skill, while they still have the strength maybe to eat and do other things. Or to, if they will, move to a space where they feel more comfortable and using the hand-under-hand for support.

And fourth, how we receive information is through our smell. And fifth, through our taste. Remember, it takes two to tango rather than tangle. When Teepa walked into that room there was a lot of tangling going on and no partnering and accomplishing anything.

Teepa (video): So she got up. I had her walk over to the gurney, sit down on the gurney. I helped her lie down on the gurney. I said I'm going to put this strap here to hold you on. Okay? Okay? She said yeah, yeah put it on, put it on. I said, now I'm going to put one on down here because I don't want your legs to come up. Okay. And I'm going to put a blanket up real high because you're cold. Why was she cold? Her anxiety was so high, she was freezing because she's had been through this horrible incident. So what happened was, I said here I'm going to hug you. I'm going to hold your hand. And I walked out with her. She got in the emergency vehicle, no problem whatsoever. They were like, how did you do that? Were you watching?

I was willing to go where she was. She was a terrified, trapped person and what they didn't realize was they were making it worse in their effort to help because they are trained to do what they are trained to do, which is transport people emergently. And some of them go further and they've got more skill but that's not what their job is until we make it their job. Their job is to help people who have dementia.

Rod: Finally, it is important for us to be there for them, tend to their needs. As Teepa pointed out, a person under stress, there's a lot of things going on and for us to communicate with them that we recognize maybe she's shaking, whatever is taking place, that we are there to support her. Now all those steps a ways beforehand lead to the point where Milly began to trust Teepa. And finally, again, be willing to go where she is, not where we see things are, but where she is.

So the basis for success is to be a detective, not a judge. Oh they're doing it wrong. Oh they're having bad behavior. Look, listen, offer. If it is not working, think, back up, pause. Look, listen, and offer again. Use your approach as a screening tool. Are they receptive to you? Where are their eyes going to? How are they acting?

Always use the sequence for cues: your visual, your verbal and your physical. Use what you're wanting first from them. Use visual cues first. Visually show them what you want them to do. Then match that with telling and then prompting with touch. Again, but also then match your help to the remaining abilities. And that's where here on this slide then is actually some additional one-hour trainings. There are four on the left that we have available now and four on the right that are coming soon. Part way down on the left, you see Introduction to GEMS.

In terms of matching to their abilities, we know that the disease is progressing. Teepa developed a way to recognize where people are at in terms of matching what we can offer and how we approach them to their abilities and she calls it the GEMS. She sees each person as a gem at each level of progression, so that we recognize they are precious and we are there to

provide support so we can help them shine where they are. So we can help maybe avoid having to de-escalate situations.

And again, three other two-hour trainings that we have available are: Workshop A. Normal versus Not Normal Aging; Workshop B. Positive Physical Approach, which I mentioned earlier; and Workshop C. Living GEMS.

Any questions?

Kris: Thank you, Rod. We do have questions. And I'll go through them. I did want to point out the other trainings that are available just in case you are wondering. You can reach out to us and there's no cost for those.

So the first question is: What do you do if there are family members present during a crisis who are making things worse with their well-intentioned but unhelpful activities and moves?

Rod: Good question. And you know if I was doing this one live, I would lots of times punt it right back. What's been your experience? It really depends upon each family dynamic, the history that they have with them. Part of what you need to be able to do is to help that family member know that you're there to support. You may have to take them out of the room.

Teepa in beginning obviously was shoeing the EMTs out right away. As I'm talking here, this is what we refer to as a team approach. You would have one member engaging those family members and helping maybe in some ways using these same skills and de-escalating them because they're upset. Acknowledging that they are upset, not denying it. But as you progress, slowly lowering it and removing what they see as a threat or concern in their eyes.

Kris: That's a really good idea. Reminder to folks, you are welcome to use the Q&A feature to type in your question. Everybody is/was muted when they entered so if trying to say something and can't, that's why. But please do use the Q&A section. Next question: What do you recommend if nothing is working to calm the person down?

Rod: First off, so often times in the past, our tendency is go right to the medications and drugs. I would suggest again what we need to do is to go back and find ways to remove the threat.

Sometimes when people are particularly towards later stage of dementia, what we refer to as the amber state and ruby state. How much information they're able to process at one time becomes very limited. For most of us, we can process at any one time five to eight pieces of information. As the disease progresses, that goes down below here.

So can you imagine if you're a person and you are only able to process two or three and in the environment you're in. And that's one of the things you can do is look at the environment you're in. Is that person being overloaded with too much information? Too much sensory input? What do you need to do to lower the amount of sensory input so that they can process

what it is? We talk about kids having a time out. But from their perspective, look through their eyes. How much information is being brought in? Is there any way that you can lower that sensory input so that they can catch up with what's going on? And then you can engage them.

Kris: Great. Another question: Rod, can you please review the basics of success again?

Rod: Okay. Let's do that. Basics for success: be a detective not a judge. In our brains, when we deal with situations, we quickly want to come up with decisions, assess what's going on. And so we quickly use all of our past experience and we make our judgments. One of the things that as we're working with a person living with dementia, the person that we're working with today isn't necessarily the person that we were working with yesterday.

Also as they're engaging, they may be, because their processor is not working very well, they may take a hair brush and see it as a brush and start brushing their teeth with it. We quickly come in and we see that and we make a judgment. That's not right. In the GEMS, we refer that you become a diamond right then. Instead be a detective. What's going on with them? How did they get there? Look, listen, offer.

We teach this in terms of the positive physical approach — how you offer without showing your agenda. And if what you're offering and how you're approaching is not working stop, literally stop. Back up. Think: Ok, what am I missing here? How do I approach them here. Using your approach as a screening tool. And always use the cues, visual cues for instance if I was wanting to walk with a person, take them to the dining hall, and I'm doing hand-under-hand, my other hand I would cue them visually out front and say let's go this way.

That visual cue along with the verbal. And then the physical as we walk together. And matching your help with their abilities. A ruby towards the end can only handle a couple of pieces of information. If you start walking with them and you carry on a conversation, "how is your day?" What did you just do? You threw in bunch of information that stops them from the task at hand. They might stop dead in their tracks right now. Again, you have to match your help to their abilities. Does that help?

Kris: I believe it does and we are at time. So thank you everybody who came to join our presentation today. Thank you Oregon Office of Rural Health for partnering with us and letting us use your very lovely Webex platform. I hope everyone has a really delightful day. Rod and Rose, if you have parting words, please do share them. Otherwise, thank you everybody.

Rod: I want to thank you for letting me share on this very important topic. Every time I share this I pick up something new. My email is on here. If you want to receive the CE, you are going to fill out an evaluation form. So you'll need to let me know and I can send that to you.

Otherwise, Portland State University will be emailing you an evaluation form. If you are in assisted living or a care facility and need these hours to meet your dementia care training, again, fill out the eval that Portland State University has. You will get a certificate that you

participated. If you are in a care facility now setting with several members of your team participating in this, I'm going to ask your administrator to take a roll call there, a roster, and send that to me.

That way we can make sure that Portland State University sends you the eval as well. And thank you. I apologize, in using this platform, it is always a challenge for us in this day and age. But thank you. Thank you for participating.

Rose: Thank you so much Rod and Kris. And as I mentioned in the beginning, the slides will be available on our website. So, if you do have some challenges with the video being transmitted over this platform, the videos will be in the PowerPoint and you can access them that way as well. So thank you so much and have a great weekend everybody.

End of meeting.