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Concept Paper

The "PRIMING, TIMING, MIMING" Model of Individualized Behavioural Care Planning for Residents with Dementia

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Abstract

The current paper introduces the "Priming/Timing/Miming" Model of Behavioural Care Planning for persons with Dementia. This simple heuristic provides a quick, easy and systematic way to select from the vast number of behavioural strategies offered in the BPSD literature and to organize these in a way that can be incorporated into an individualized Behaviour Care Plan to deliver personal care to persons with dementia and also to develop a larger plan of care. An entire care plan is captured on one double-sided sheet of paper that can be updated by simply highlighting the relevant sections at team meetings. It has also been accommodated into electronic charting. An example using the "Priming/Timing/Miming" Care Plan document is provided. The model and document were developed with Multi-disciplinary input over more than a decade, on several inpatient dementia units. Training to use the model and care plan has been provided to numerous groups including Long-Term Care facilities, Retirement Homes, Dementia Units, Acute Care Hospital Units, Inpatient Acquired Brain Injury Staff and Outreach Teams. The model and care plan document are robust, successfully accommodating a wide range of behavioural presentations.

Keywords
Dementia; BPSD; behaviour; care planning

1. Introduction

There has been a growing literature on the Behavioural and Psychological Symptoms of Dementia", or BPSD over the last two decades [1-3]. Reviewing, critically evaluating, and integrating findings from the literature into day-to-day clinical practice can be daunting for clinicians working in typical dementia settings. The present paper introduces the "Priming, Timing, Miming" model and accompanying "Priming/Timing/Miming" Dementia Behaviour Care Plan Template. This model was developed over several years, with stakeholder input from a variety of disciplines in both a setting with specialized dementia units serving those with the most severe behavioural impairment as well as community Long-Term Care / Nursing Home facilities, to provide a framework by which staff from different care environments can quickly and easily incorporate behavioural approaches into structured, comprehensive and individualized behavioural care plans for persons with dementia.

Several models have emerged to address BPSD concerns in clinical environments, each with their roots in the philosophy of Person-centred Care, as first developed by Kitwood [4] in 1997. Some of these models include: the P.I.E.C.E.S. model [5] The Needs-Driven Dementia-Compromised Behaviour (NDB) Model [6], and the Butterfly Model [7]. Each of these models is briefly described below.

The P.I.E.C.E.S model identifies 6 spheres (Physical, Intellectual, Emotional, Capabilities, Environment and Social) to consider when identifying positive and negative contributors to specific behavioural presentations in dementia. It begins with the identified behavioural challenge and then explores the reasons for and resources available to ameliorate that specific behaviour. It can be used in the community or in LTC/Nursing Home settings.

The NDB model views disruptive behaviour in individuals with dementia as the expression of an unmet need or goal, addressing behavioural challenges, such as repetitive vocalizations, wandering and aggression, as in the Cohen-Mansfield Agitation Inventory [8]. The model identifies the role of what are termed "background factors" such as cognitive state, health status, neurological state and psychosocial contexts as well as "proximal factors" such as those of the person himself, the physical environment or the social environment in driving the expression of NDBs. This model views such behaviours as the most meaningful responses the person with compromised abilities can demonstrate in a given situation.

The Butterfly Household Model of Care is a model developed over 20 years ago by British Geriatrics Consultant David Sheard. This model focusses on enriching the physical environment of those with dementia and connecting these individuals to purpose and feeling. Facilities that have adopted this model are known for their brightly coloured rooms, rich artwork and objects which invite residents to connect both physically and emotionally to their environment, including staff.

The common strengths inherent in each of the aforementioned models includes their provision of meaning and understanding of behavioural expression in dementia and also in aiding staff/caregivers/family to utilize that understanding to develop ways to address those behavioural

concerns. Behaviour is not considered random, nor is the remedy for a particular behavioural challenge the same for any two people. However, these models focus on individual behavioural challenges, and do not articulate how a comprehensive behaviour care plan can be formulated that identifies the constellation of behavioural challenges a person with dementia may demonstrate and all the specific strategies to be employed. This poses a conundrum for staff who must try to determine what all the behavioural challenges are and then the various approaches for each of their charges, while acknowledging the individual as a whole and not simply a sum of targeted behaviours to be addressed.

The current paper was conceived in response to a growing need for dementia care plans that are straightforward to complete, simple to follow for both regular and casual staff, and that can be regularly updated with little effort. It was specifically written for front-line clinicians and care teams working with individuals who have a dementia, in a variety of inpatient / Long Term Care settings. The applied focus of the model is on activities related to provision of personal care, as it is widely recognized that personal care activities constitute one of the most common triggers for resident distress, aggression and also for staff injury [9-13].

It is also important to note that dementia is a progressive disease; unfolding at different rates in different people. Behavioural care plans should take into account that each person has led a unique life with particular interests, experiences and preferences. Emerging studies, including the important CADRES trial conducted in Australia, underscore the value of individualized (person-centred) care approaches as a means to reduce aggressive behaviour [14-17].

2. The Rationale for Behaviourally-Based, Individualized Care Plans

If we begin with the premise that all behaviour has meaning, then we must acknowledge that the person with dementia is always trying to make sense of others' behaviours in their environment. When an individual fails to understand the intent of a behaviour it can often be interpreted as unwanted, or threatening. Indeed, it has been estimated that majority of "aggressive" behaviour is actually defensive behaviour, i.e., defending against something that is not understood and perceived as threatening [16, 17]. Therefore, anything that can be done to improve the individual's ability to understand, relate to the behaviour, or at least perceive it as non-threatening, is beneficial as it will decrease aggressive (responsive) behaviour.

Understanding is further improved when a consistent behavioural approach is utilized. Consistency minimizes confusion and maximizes efficiency, because a repeated pattern will more likely be remembered, anticipated and understood by the individual with a dementia [18]. An easy-to-understand care plan will promote consistency amongst staff.

3. Components of the "Priming/Timing/Miming" Model

The model explained in this paper is rooted in both the patient-centred care philosophy as well as a behavioural perspective. It has three components which are identified by a rhyming mnemonic i.e., "Priming, Timing, Miming" that provides a framework for rational consideration of what behavioural strategies to use and then quickly facilitates the ability to remember the chosen strategies by simply using the terms "Priming, Timing, Miming" as cues for identified strategies. Each of these components is described in detail, below.

3.1 Timing

This component of the Model encompasses two aspects, (1) Time of Day and (2) Pacing of Activities. Both are important considerations for providing care to individuals with dementia. ***Time of Day*** acknowledges that people have different (and preferential) diurnal rhythms – some individuals are at their best in the morning, while others peak later in the day. There is a vast literature demonstrating that people function most effectively when the level of task demands is synchronized with diurnal patterns [19, 20]. Increasingly, Long Term Care Facilities are recognizing the importance of incorporating their residents' normal rhythms into care plans [21, 22]. Thus, the time of day at which an individual is bathed, has meals, is awakened and goes to bed at night, should be determined with an individual's diurnal patterns in mind.

Pacing of activities, the second aspect of "Timing" reflects the "rhythm" or "dance" of care, where it is key to identify and match a pace of delivering care that the individual can keep up with comfortably. An individual with dementia will often have slowed or impaired information processing [23]. Thus, information that a staff member is approaching into an individual's personal space, making a request or initiating an activity should come at a slowed [24] pace that ebbs and flows with the rhythm that the resident dictates. As a care provider, you can lead the dance, but you cannot drag your partner along. It is important to watch for the resident's body language indicating that they are not understanding you, or are becoming confused by what they perceive as a deluge of words or actions. Failing to recognize an individual's increasing confusion (and frustration) can lead to defensive/responsive behaviours that put both the resident and staff at risk.

3.2 Priming

Sometimes even if activities are appropriately paced, an individual doesn't understand the request being made or has difficulties with initiation. Generally, in dementia, destruction of learning and memory occurs in the reverse order of which the information was laid down [25]. Therefore, any old, entrenched routines are more likely to be recognized and successful than are new routines that need to be learned. As such, old and familiar routines are more likely to result in cooperative behaviour.

Routines act as signals for behaviours, and in this way, the routine becomes a way of "priming" or signalling the resident that something is going to happen. Consider ***sleep*** hygiene as an example: Treatment for individuals with problems falling asleep often includes developing a regular, pre-bedtime set of activities, each signalling that sleep is coming - the relaxing bath, changing into pyjamas, turning down the bed, reading, and then going to sleep. Similarly, when residents have problems settling in at night, one might ask what the person's usual pre-bedtime routine was. This might include inquiring whether the individual always watched the news before bed, or had a favourite bedtime snack, or whether the resident prayed just before going to bed. Each of these steps is "Priming" the resident for sleep.

In addition to signals and cues, the "Priming" component also specifies the number of care-providers necessary to provide the needed level of support. i.e., the number of staff required to assist with a particular care activity such as dressing, or the number of staff required for bathing.

Bathing, a task that often is associated with challenges to care providers, is particularly well-suited to priming (i.e., routines and signals). One can identify what typical signals for bathing have been established previously: use of particular sensory items that are enjoyed or that were used at home (particular scented soaps, shampoos, aftershave), certain textures (thick vs. thin towels, plush robes); a new resident might also benefit from having the family member who assisted with bathing at home come in the first few days of bathing and assist staff so that the resident becomes familiar and feels safe with staff completing this task, thereby having the staff become the signal for a bath.

The priming component is also very important to ***dressing***: residents often wish to wear the same clothes over and over. Again, it is important to identify the signals (primes) at home that have indicated the need to change clothes: on laundry day; a particular activity such as going to church, having someone coming to visit, and then to incorporate these into the conversation during dressing.

3.3 Miming

This last component takes advantage of the idea that multi-sensory information processing is associated with increased understanding as compared to single-modality learning. This is the underlying premise of interventions such as Snoezelen [24]. In the "Priming/Timing/Miming" Model it underscores the need to present information both in verbal and visual modalities: saying simple phrases or instructions and simultaneously panto***miming*** or demonstrating the request, using slow and smooth movements. For example, one might present a resident's bathrobe while pantomiming washing/shaving, and also inviting the resident to come for morning care.

The principles of "Priming, Timing and Miming" are systematically applied to each of the regular ADL care areas into a standardized format resulting in a Behavioural Care Plan Template as described in the next section.

4. The Structure of the Priming, Timing, Miming Behaviour Care Plan Template

The "Priming, Timing, Miming" Behaviour Care Plan is presented as one, double-sided sheet, for an "at-a-glance" view of the care plan. Common behaviour strategies organized into the three elements of the model are presented for each ADL care area as well as some additional key areas of behavioural care planning on the template and those that are relevant for a particular individual are highlighted, in colour, while those that do not apply are not. This is a simple and straightforward way for the information to "pop off the page" to the attention of staff. It is particularly valuable for updates/reviews and also for casual/float staff who may not be familiar with a particular patient. There is also space for more unique triggers or strategies that have been found to be useful, as well as a space for "additional information" within each care area.

The "Priming, Timing, Miming" Behavioural Care Plan is typically constructed at a clinical meeting (Behaviour Rounds) with several staff who know the individual well. The meeting lasts approximately 45 minutes for the initial development of the plan and then is quickly reviewed (approximately 5-10 minutes) and updated at each patient review/conference. If significant changes in behavioural approaches are required, a subsequent Behaviour Rounds meeting is initiated. Approaches are decided upon after a careful assessment of the individual is completed and then brought together through discussion and consensus, keeping in mind what is realistically

"do-able" by a clinical team. The assessments are multi-disciplinary, with each team member presenting information on their particular area of involvement (e.g., OT/PT regarding walking/ Reminiscing group, Spiritual Health regarding participation in religious services, Hymn Sing, Nursing on provision of ADL abilities and support required. Psychology/Behavioural Technology provide information gathered from standardized assessment tools such as the Dementia Observation System (DOS) [26], the Kingston Standardized Behavioural Assessment (KSBA) [27] and the Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC-II) [28].

5. Areas Covered in the Priming/Timing/Miming Behavioural Care Plan Template

5.1 Behavioural Goals

These address the challenges that may limit any of: the individual's quality of life, provision of successful care, or a move to a different setting, etc., as well as the status achieved (at each review). They appear at the beginning of the document, but often are easier to identify after the rest of the behavioural care plan is completed.

5.2 Basic Information

This section includes those diagnostic or modifying factors that have been identified during the team's assessment of the patient that need to be considered in the care plan, including: diagnoses, expressive/receptive language status, sensory deficits, issues related to pain.

5.3 Care Areas

These are the areas to which the "Priming/Timing/Miming" model is key and constitutes the bulk of the behavioural care plan. The sample care plan below provides examples of how the model is applied to each area. The Care areas addressed are:

Bathing	Oral Hygiene
Grooming	Toileting
Dressing	Eating
Mobility	Transfers

A number of additional important areas are also covered within the "Priming/Timing/Miming" Behavioural Care Plan Template. These are:

5.4 Agitation/Aggression Triggers

This area is given particular emphasis to help staff readily identify triggers for agitation/aggression, and the early warning signs that a patient may display (both verbal and non-verbal). An initial KSBA and DOS are completed and utilized to identify behavioural challenges and triggers. The KSBA was selected as the primary behavioural measure as it represents a wider breadth of behaviour than that typically seen in measures of BPSD, such as the Neuropsychiatric Inventory (NPI) [29].

5.5 Additional Strategies

These are the "little gems" that individual staff may have found to be very helpful with a particular individual but that might not be readily known by all staff or automatically considered when reviewing individual care areas.

5.6 Pleasurable Activities

These are important to include, not only to optimize Quality of Life for the resident, but also as activities that can be used as distractors.

5.7 Family Supports

This model recognizes family as an important part of the care team. Knowing who are the primary supports, what the nature of their support is (visits, outings, phone calls) and any arising issues (e.g., may bring in foods that increase choking risk) helps to address education needs for families and also to identify successful strategies family utilize that can also be incorporated by staff.

5.8 Plan

What is overarching the plan for the individual? This speaks to items such as placement plans, stabilization of behaviour and optimization of the individual's Quality of Life. It differs from the lower-level Behavioural Goals that are necessary in order for the "Plan" to be executed. For instance, the person's overall plan of achieving behavioural stability will be defined by the successful completion of the behavioural goals identified at the beginning of the Care Plan Document.

6. Measuring Change and Effectiveness of the PTM Care Plan

As stated above, an initial PTM behavioural care plan is developed by the team and this plan is then updated periodically, at regular conference reviews or when a change has occurred. The regular review and updating of the plan offers a method by which to evaluate whether the strategies employed are effective. This evaluation of the care plan's success is measured by: (i) articulating the changing status of each of the behavioural goals (achieved, improved, ongoing, discontinued) where sequential behavioural measurements using the DOS and KSBA are made to provide information on range, frequency and timing of behaviours as appropriate, to provide objective data to be used in determining goal status'; (ii) by indicating a change in the level of support that is required in the Care Areas (including both the number of staff required to provide assistance as well as the level of assistance that is needed); (iii) by an improved number and type of activities in which the patient is involved as well as the duration of time the individual is able to spend engaged in these activities).

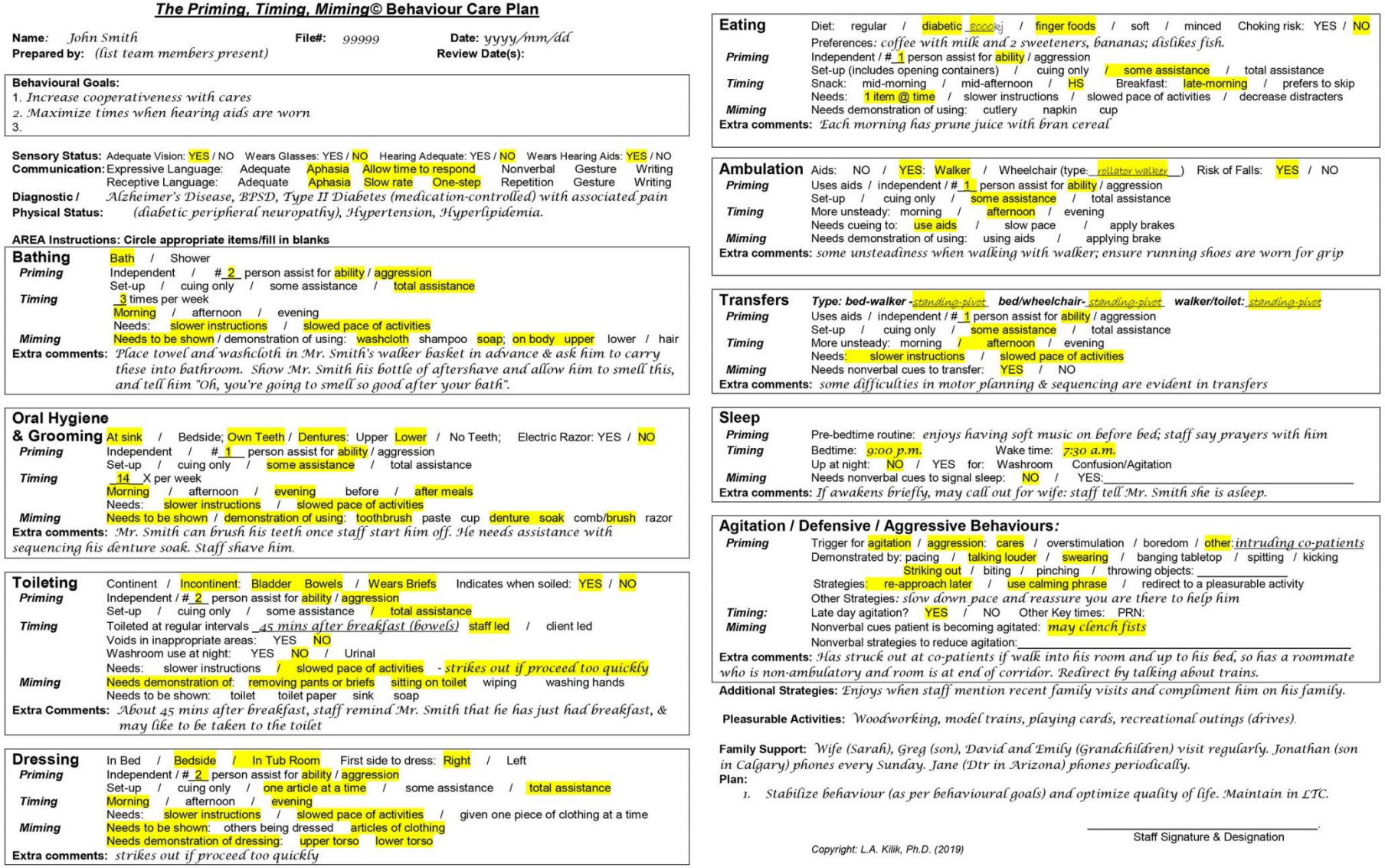
7. Case Example

Below is a case example demonstrating how a behavioural care plan can be developed using the "Priming, Timing, Miming" Care Plan. The narrative information is provided below, then the example shows how this information can be communicated in the Behavioural Care Plan, with relevant areas highlighted on the care plan document (See Figure 1), and extra comments inserted, where appropriate, to capture the background information a team would collect at admission. An explanation of how the document would be constructed for this case is also provided.

7.1 Narrative Information Gathered by the Team

Mr. Smith is an 82-year-old married gentleman, diagnosed with BPSD secondary to Alzheimer's Disease. He is a retired high school teacher whose hobbies included woodworking, model trains and playing cards. He has 3 children and 7 grandchildren. He was transferred to a LTC facility from home, because of resistiveness to care, becoming verbally abusive and striking out at his wife and homecare staff. Community resources had been maximized and his spouse was no longer able to manage his care at home. Since his admission, he has also struck out at a co-resident on one occasion, when the person entered his room and approached him while he was in bed. He is also combative with staff during provision of care. Mr. Smith is diabetic and suffers from peripheral neuropathy, hypertension and, hyperlipidaemia. His expressive and receptive language are impaired (but he can follow simple one-step commands) and he has decreased hearing (but repeatedly has lost his hearing aids). He uses a walker but often forgets to do so and is unsteady when walking.

The behavioural care plan for Mr. Smith is presented below, in Figure 1. Explanations for each section follow.



***The Priming, Timing, Miming*© Behaviour Care Plan**

Name: *John Smith* **File#:** *99999* **Date:** *yyyy/mm/dd*
Prepared by: *(list team members present)* **Review Date(s):**

Behavioural Goals:
1. *Increase cooperativeness with cares*
2. *Maximize times when hearing aids are worn*
3.

Sensory Status: Adequate Vision: YES / NO Wears Glasses: YES / NO Hearing Adequate: YES / NO Wears Hearing Aids: YES / NO
Communication: Expressive Language: Adequate Aphasia Allow time to respond Nonverbal Gesture Writing
Receptive Language: Adequate Aphasia Slow rate One-step Repetition Gesture Writing
Diagnostic / Physical Status: *Alzheimer's Disease, BPSD, Type II Diabetes (medication-controlled) with associated pain (diabetic peripheral neuropathy), Hypertension, Hyperlipidemia.*

AREA Instructions: Circle appropriate items/fill in blanks

Bathing Bath / Shower
Priming Independent / #_2_ person assist for ability / aggression
Set-up / cuing only / some assistance / total assistance
Timing _3_ times per week
Morning / afternoon / evening
Needs: slower instructions / slowed pace of activities
Miming Needs to be shown / demonstration of using: washcloth shampoo soap; on body upper lower / hair
Extra comments: *Place towel and washcloth in Mr. Smith's walker basket in advance & ask him to carry these into bathroom. Show Mr. Smith his bottle of aftershave and allow him to smell this, and tell him "Oh, you're going to smell so good after your bath".*

Oral Hygiene & Grooming At sink / Bedside; Own Teeth / Dentures: Upper Lower / No Teeth; Electric Razor: YES / NO
Priming Independent / #_1_ person assist for ability / aggression
Set-up / cuing only / some assistance / total assistance
Timing _14_ X per week
Morning / afternoon / evening before / after meals
Needs: slower instructions / slowed pace of activities
Miming Needs to be shown / demonstration of using: toothbrush paste cup denture soak comb/brush razor
Extra comments: *Mr. Smith can brush his teeth once staff start him off. He needs assistance with sequencing his denture soak. Staff shave him.*

Toileting Continent / Incontinent: Bladder Bowels / Wears Briefs Indicates when soiled: YES / NO
Priming Independent / #_2_ person assist for ability / aggression
Set-up / cuing only / some assistance / total assistance
Timing Toileted at regular intervals *_45 mins after breakfast (bowels)* staff led / client led
Voids in inappropriate areas: YES NO
Washroom use at night: YES NO / Urinal
Needs: slower instructions / slowed pace of activities - *strikes out if proceed too quickly*
Miming Needs demonstration of: removing pants or briefs sitting on toilet wiping washing hands
Needs to be shown: toilet toilet paper sink soap
Extra Comments: *About 45 mins after breakfast, staff remind Mr. Smith that he has just had breakfast, & may like to be taken to the toilet*

Dressing In Bed / Bedside / In Tub Room First side to dress: Right / Left
Priming Independent / #_2_ person assist for ability / aggression
Set-up / cuing only / one article at a time / some assistance / total assistance
Timing Morning / afternoon / evening
Needs: slower instructions / slowed pace of activities / given one piece of clothing at a time
Miming Needs to be shown: others being dressed articles of clothing
Needs demonstration of dressing: upper torso lower torso
Extra comments: *strikes out if proceed too quickly*

Eating Diet: regular / diabetic _2000kj_ / finger foods / soft / minced Choking risk: YES / NO
Preferences: *coffee with milk and 2 sweeteners, bananas; dislikes fish.*
Priming Independent / #_1_ person assist for ability / aggression
Set-up (includes opening containers) / cuing only / some assistance / total assistance
Timing Snack: mid-morning / mid-afternoon / HS Breakfast: late-morning / prefers to skip
Needs: 1 item @ time / slower instructions / slowed pace of activities / decrease distracters
Miming Needs demonstration of using: cutlery napkin cup
Extra comments: *Each morning has prune juice with bran cereal*

Ambulation Aids: NO / YES: Walker / Wheelchair (type: _rollator walker_) Risk of Falls: YES / NO
Priming Uses aids / independent / #_1_ person assist for ability / aggression
Set-up / cuing only / some assistance / total assistance
Timing More unsteady: morning / afternoon / evening
Needs cueing to: use aids / slow pace / apply brakes
Miming Needs demonstration of using: using aids / applying brake
Extra comments: *some unsteadiness when walking with walker; ensure running shoes are worn for grip*

Transfers ***Type: bed-walker -*** _standing-pivot_ ***bed/wheelchair-*** _standing-pivot_ ***walker/toilet:*** _standing-pivot_
Priming Uses aids / independent / #_1_ person assist for ability / aggression
Set-up / cuing only / some assistance / total assistance
Timing More unsteady: morning / afternoon / evening
Needs: slower instructions / slowed pace of activities
Miming Needs nonverbal cues to transfer: YES / NO
Extra comments: *some difficulties in motor planning & sequencing are evident in transfers*

Sleep
Priming Pre-bedtime routine: *enjoys having soft music on before bed; staff say prayers with him*
Timing Bedtime: *9:00 p.m.* Wake time: *7:30 a.m.*
Up at night: NO / YES for: Washroom Confusion/Agitation
Miming Needs nonverbal cues to signal sleep: NO / YES:_____
Extra comments: *If awakens briefly, may call out for wife: staff tell Mr. Smith she is asleep.*

Agitation / Defensive / Aggressive Behaviours:
Priming Trigger for agitation / aggression: cares / overstimulation / boredom / other: *intruding co-patients*
Demonstrated by: pacing / talking louder / swearing / banging tabletop / spitting / kicking
Striking out / biting / pinching / throwing objects: _____
Strategies: re-approach later / use calming phrase / redirect to a pleasurable activity
Other Strategies: *slow down pace and reassure you are there to help him*
Timing: Late day agitation? YES / NO Other Key times: PRN:
Miming Nonverbal cues patient is becoming agitated: *may clench fists*
Nonverbal strategies to reduce agitation:_____
Extra comments: *Has struck out at co-patients if walk into his room and up to his bed, so has a roommate who is non-ambulatory and room is at end of corridor. Redirect by talking about trains.*

Additional Strategies: *Enjoys when staff mention recent family visits and compliment him on his family.*

Pleasurable Activities: *Woodworking, model trains, playing cards, recreational outings (drives).*

Family Support: *Wife (Sarah), Greg (son), David and Emily (Grandchildren) visit regularly. Jonathan (son in Calgary) phones every Sunday. Jane (Dtr in Arizona) phones periodically.*
Plan:
1. *Stabilize behaviour (as per behavioural goals) and optimize quality of life. Maintain in LTC.*

_____.
Staff Signature & Designation

Figure 1 Sample "Priming/Timing/ Miming" behavioural care plan document.

7.2 Incorporating the Information into the Priming/Timing/Miming Behaviour Care Plan

In the sections labelled ***Diagnostic / Physical status,*** Mr. Smith's pain symptoms and associated reduction strategies are identified on the care plan document, as well as the fact that Mr. Smith's Diabetes is managed with oral medications.

In the section on ***Eating***, Mr. Smith's diabetic diet is specified as well as his food preferences and that he does best with finger foods. The level of Priming required is 1 person, providing 1 item at-a-time. Regarding Timing, he prefers a late breakfast.

Bathing and Dressing are areas where the level of Priming requires 2 persons. Mr. Smith responds to the Prime of being given his towel and washcloth, and being asked to put these in his walker basket and take them to the tub room. Mr. Smith's wife has brought in his favourite aftershave which staff ask him to smell with the comment "Oh, you're going to smell so good after your bath!" He recognizes the scent and then can appreciate what is going to happen next.

In the area of ***toileting***, this gentleman wears briefs and is incontinent (bowels and bladder) but will occasionally indicate he needs to use the toilet. His home bowel routine was to have prune juice each morning with some bran cereal and then have a bowel movement about 45 minutes later. This dietary information is captured in the section on Eating. Staff reminds Mr. Smith that he just had his breakfast and mention that he probably would like to be taken to the toilet. He responds to this favourably. It is noted that if staff proceeds too quickly during toileting, then Mr. Smith will strike out. They are mindful of using a slowed pace and demonstrate (mime) each step before making any hands-on contact.

With respect to ***agitation/aggression*** Mr. Smith cannot reliably state he is in pain, so staff monitors for any nonverbal signs. Mr. Smith can also become confused when co-residents come into his room or into his personal space and may strike out in these situations. Strategies used to minimize these issues include having a roommate who is not ambulatory and a room that is at the end of a corridor, away from the areas where most residents walk about.

Additional strategies used by staff include using conversation about, and showing pictures of trains as distractors, if Mr. Smith appears to be getting agitated.

8. Conclusions

This paper introduced the "Priming, Timing, Miming" model for developing individualized behavioural care plans for individuals with a dementia. This model represents a quick and straightforward method of capturing the specific behavioural approaches that optimize personal care and quality of life for residential patients with a dementia. By simply rehearsing the words "Priming, Timing, Miming", staff can easily cue themselves about key elements to consider when working with individuals who have a dementia. The author has used this model for more than 10 years on specialized inpatient dementia units within a Geriatric Psychiatry Program and it has been shown to have the capacity to capture the care plans for highly diverse and complex individuals. The care plan template is used to incorporate multidisciplinary input, including data from commonly-used standardized behavioural assessment tools, is regularly updated with ease and is provided in the transfer package when individuals are moving to a Long Term Facility. Evaluation of effectiveness of individual care plans is demonstrated by change in Behaviour Goal Status, Change in the number of staff and level of assistance required for ADLs as well as level of

engagement in pleasurable individual/group activities. In a study conducted with LTC/Retirement Home facilities [30], Feedback examining the usefulness of the PTM Behaviour Care Plan in facilitating transfer to LTC has consistently been positive; at least 75% of the respondents identified the following benefits: (i) Facilitated the process of getting to know new residents, (ii) Provided tips for successful initial contact with resident, (iii) Was helpful in planning for agitated/aggressive behaviour, (iv) Was helpful to assist is planning for delivery of personal care, (v) Was helpful in managing sleep.

While the findings from inpatient and LTC uses of the PTM Behavioural Care Plan have been encouraging, some limitations of the model are also identified: One such limitation refers to the transferability of strategies from one level of care to the next - LTC facilities may not have access to the same strategies available in a specialized, locked dementia unit, such as use of restraints. Therefore the need to revise goals to match a receiving facility's resources and capacities has become a process that is now regularly undertaken with our inpatients. For example, we now routinely ask what restraints are acceptable in the receiving facility (e.g., seatbelt, belted tray) and seek to reduce the range that would be used well before transfer to bolster successful transition. A second potential limitation was the paper version of the plan when facilities are increasingly moving to electronic patient records. Our feedback from LTC facilities has been that they have easily incorporated the template into their electronic charting, as we have at the inpatient setting.

The "Priming/Timing/Priming" Behavioural Care Template is available from the author free of charge by emailing to kilikl@queensu.ca. Training is available upon request and has been provided to numerous LTC facilities, Retirement Homes, Acute Care Hospital teams, Inpatient Rehabilitation Programs and Community Care Teams.

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