GENTLE PERSUASIVE APPROACHES CURRICULUM

THE DEVELOPMENT AND PILOT EVALUATION OF AN EDUCATIONAL PROGRAM TO TRAIN LONG-TERM CARE FRONT-LINE STAFF IN THE MANAGEMENT OF RESPONSIVE BEHAVIOURS OF A MORE CATASTROPHIC NATURE ASSOCIATED WITH DEMENTIA

FINAL REPORT
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GENTLE PERSUASIVE APPROACHES CURRICULUM (GPA)

THE DEVELOPMENT AND PILOT EVALUATION OF AN EDUCATIONAL PROGRAM TO TRAIN LONG TERM CARE FRONT LINE STAFF IN THE MANAGEMENT OF RESPONSIVE BEHAVIOURS OF THE MORE CATASTROPHIC NATURE ASSOCIATED WITH DEMENTIA

BACKGROUND

Persons living with Alzheimer Disease and related dementias often respond to the environment in long term care institutions with fear and frustration. Respectful care of the resident who is experiencing a catastrophic emotional and physical response to a bewildering and overwhelming environment has become an issue of great importance for clinical and program support staff in long term care. The literature describing responsive behaviours of a physically aggressive nature supports that between 10% and 50% of older adults with cognitive impairments living in long term care facilities display some form of physical aggression (Beck, Rossby & Baldwin, 1991; Kaas & Richie, 1996; Colenda & Hamer, 1991; Ryden, Bossenmaier & McLachlan, 1991).

Staff consistently report feeling vulnerable and at high risk for injury if they have not been “formally” trained in respectful, non-violent, self-protective techniques. Staff also report that they are unsure of how to respond to physical expressions of anger in a manner that will not be injurious to vulnerable residents. In many instances, front-line, point-of-care staff, such as personal support workers, dietary aides and housekeeping staff, are not as likely to receive training in behaviour management as compared to registered nursing staff and senior managers despite being the personnel most likely to be working directly with residents (Dupuis, Wiersman & Loiselle, 2004). Without proper training, the inappropriate response techniques that staff select may have a pervasive and profound negative impact on residents with cognitive impairment leading to excess disability and a wounded spirit (Taft, 1995; Dawson, Wells & Kline, 1993; Rader, 1995). Further, these staff persons may also be at greater risk of injury themselves.

Existing training programs that focus on body containment techniques to control responsive behaviours of a more physically catastrophic nature are based on

a philosophy of care that focuses on pathologies and reinforces negative perceptions of persons with dementia as being assaultive, violent, dangerous and the passive recipients of care. In addition, these training programs are not specifically tailored for the learning needs and styles of front-line staff in long term care facilities. As such, they are in direct contrast to the shift in culture that has occurred in dementia care in the last decade that has seen a movement toward a milieu that is person-centred or relationship-centred. Central to this new context is the principle that an individual's life experience, unique personality, and network of relationships should be valued and taken into account by staff as having a direct application to the interpretation and response to behavioural episodes.

PURPOSE OF THE PROJECT

The purpose of the project was twofold: (1) to develop a standardized curriculum grounded in the principles of person-centred care to assist point-of-care staff and their front-line managers to respond effectively and with respect to the catastrophic verbal and physical expressions of needs demonstrated by persons with dementia in long term care settings; and (2) to conduct a preliminary evaluation of the curriculum.

OVERVIEW OF EDUCATIONAL INTERVENTION (GPA CURRICULUM)

The GPA project team developed and piloted a 7.5 hour, four module educational training program specific to the learning needs and styles of front-line workers in long term care, many of whom have expressed a desire to learn how to respectfully manage episodes of responsive behaviors of a more catastrophic nature expressed by residents with dementia. The educational curriculum was developed as an adjunct to the PIECES, U-First, and Enabler Programs, educational initiatives that were part of the Ontario Ministry of Health and Long-Term Care's Alzheimer Strategy (Initiative #1).

The GPA © curriculum was developed by a working committee appointed by the GPA Steering Committee, during the months of December 2003 through March 2004. The curriculum designers all had a rich and varied background in education, staff training and development, dementia care, and geriatric mental health. The deliverables of the educational curriculum subcommittee were an Instructor Manual and a Student Manual with explicit supportive text points illustrated by PowerPoint presentation slides. A copy of the Instructor Manual is located in the Appendix.

The curriculum was designed to be delivered during a single seven and one half hour program, a determination based on the experiential knowledge of the project team. The curriculum employs a number of different pedagogical techniques to enhance the learning environment for the participants. It is case-based, interactive, and helpful in the practical sense. It utilizes short-lecture format, experiential exercises, guided group discussion, dementia-specific videotapes, demonstration of appropriate techniques, and application by the participants through supervised role-play.

COURSE CONTENT

The GPA © Curriculum was developed as three sequential modules embedded with cumulative concepts related to person-centred care, the brain etiologies of disinhibited behavior, and communication strategies that serve to de-escalate, culminating in a final fourth module focusing on respectful body containment techniques. The body containment techniques taught in the program have been tailored to the older adult population.

The program was grounded in the principles of person-centered dementia care and understanding the impact of cognitive impairment on persons living with dementia. Key curriculum points emphasized reframing responsive behaviours of a more catastrophic nature, to be interpreted instead as self-protective, defensive, or communicative strategies in response to unmet needs (Cohen-Mansfield & Taylor, 1998; Talerico & Evans, 2000). In addition, the appropriate body containment strategies that can be used safely in response to episodes of high-end disinhibition

were taught. The educational objectives of the overall curriculum were to assist participants to:

1. Understand that the client with dementia is a unique human being who has an emotional response to stimuli;
2. From an holistic perspective explain the relationship between the disease process and the individual's behavioral response;
3. Describe emotional, environmental, and interpersonal aspects of communicating with persons with dementia;
4. Choose strategies that serve to diffuse challenging behaviors rather than escalating them; and
5. Demonstrate the suitable and respectful protective techniques to use in response to more catastrophic expressions of need.

Module 1 provides an overview of the principles of person-centred care, focusing on the meaning behind responsive, self-protective behaviours of persons with dementia. **Module 2** examines the impact of dementia on the brain with the discussion centering on the A's of dementia (i.e., anosagnosia, amnesia, aphasia, apraxia, agnosia, altered perception, attentional deficits, apathy), the relationship between characteristics of dementia and responsive behaviours in dementia, and care implications. **Module 3** focuses on the interpersonal, environmental and communication strategies that assist front-line staff to respond effectively to escalating expressions of unmet needs. Finally, **Module 4** provides an overview of body containment principles that, when respectfully used in the clinical setting, can assist staff to de-escalate responsive behaviours, particularly those of a more physically aggressive nature. More specifically, staff participants learn how to protect themselves, learn respectful escort techniques, and learn both individual and team techniques that can be used in response to behaviours of a more catastrophic nature. Staff participants have an opportunity to apply the techniques in role play situations.

PRE-TRAINING CURRICULUM REVISION

The curriculum was piloted during two day-long training sessions that involved participants in an Adult Day Services education workshops sponsored by the Ministry of Health and Long-Term Care. As a result of this pilot, revisions were made to specific PowerPoint slides and the accompanying explanatory text in order to enhance understanding of key curriculum concepts such as personhood, brain changes associated with dementia, and body containment techniques. For example, illustrative photographs were added to the manual. In addition, revisions were made to the evaluation measures, in order to make them more accessible and reader-friendly to front-line participants.

MASTER TRAINER PREPARATION

Ten Psychogeriatric Resource Consultants (PRCs) were trained as Master Instructors during the month of February 2004 to deliver the curriculum in a team teaching format (two PRCs per session). A standardized Instructor Manual that provided explicit explanatory text that supported each PowerPoint slide was given to each Master Instructor. The PRCs, all experts in adult education, first experienced the curriculum in its entirety and were then asked to review the Instructor Manual to reinforce key curriculum points. Follow-up meetings were held to coach the PRCs in curriculum delivery, in particular the body containment techniques that would be taught during the pilot.

EVALUATION OF THE GPA CURRICULUM

The Ruth Sherman Centre for Research and Education and The Murray Alzheimer Research and Education Program at the University of Waterloo collaborated in the development and conduction of the evaluation of the GPA curriculum. An evaluation proposal was submitted to the Research Ethics Board at McMaster University and the Office of Research Ethics at the University of Waterloo, and received full approval from both Ethics Boards.

EVALUATION SITES

Seven long term care facilities located in the Central South and Central West regions of Ontario were selected to participate in the implementation and evaluation of the GPA curriculum. Using the OLTCA and OANHSS databases of facilities in each region as the sampling frame, the study sites were randomly selected using a table of random numbers. The seven long term care sites included one facility from each of seven regions in Central South and Central West Ontario, including the Brant, Wellington-Dufferin, Waterloo, Haldimand-Norfolk, Halton, Hamilton, and Niagara regions. Upon selection of the sites, the administrative team of the facility was approached to determine interest in participation in the GPA project. Inclusion criteria after randomization included administrative commitment to release staff for training and willingness to host the event for the staff at their site. Of the seven pilot sites originally sampled, only one declined due to competing priorities. An alternative site that had been selected as a backup was approached and agreed to participate in the project.

CURRICULUM PARTICIPANTS

Each of the seven long term care facilities was asked to schedule three classes (for a total of 21 training sessions) of between eight to ten individuals whose typical case load included persons with dementia who displayed behavioural responses within the environment of the facility. The aim was to train 30 staff members at each site. The inclusion criteria as a participant in the training program was having a willingness to be scheduled into the educational sessions, and having awareness that it was part of a pilot evaluation of a new curriculum. The Psychogeriatric Resource Consultants assigned as Master Instructors for each site participated in a discussion with the senior management team regarding suitable individuals, ensuring that a high proportion of participants were front-line staff from all departments, for example, personal support workers, dietary aides, housekeeping staff and maintenance staff, the rationale being that these were the personnel most likely to interact with residents on a daily basis.

EVALUATION DESIGN

To gain a comprehensive understanding of the impact of the curriculum on participants, the evaluation project team decided to incorporate a mixed-methods approach. The design employed both quantitative and qualitative data collection strategies. The evaluation protocol and its measures were piloted during the two day-long training sessions with adult day services staff in which the GPA curriculum was piloted. As a result of feedback during these sessions, revisions were made to the evaluation measures in order to make the tools more accessible and reader-friendly to front-line participants.

Quantitative Data Collection Strategies

Quantitative evaluation tools were administered at three points in the evaluation process: (1) before the curriculum began (i.e., pre-training measure), (2) immediately following the curriculum (i.e., post-training measure), and (3) six-weeks after the completion of the curriculum (e.g., six-week follow-up measure). These tools were designed to assess changes related to the curriculum in staff *self-perceived competency* when performing tasks as a direct-care staff person in the long-term care environment and staff *attitudes/values* related to management techniques and the use of behavioural controls in clinical practice. On the pre-training tool, the staff were also asked to provide information on their demographic characteristics, (i.e., gender, age, highest level of education, how long they had worked in long term care and for the present employer, job title, employment status, shift regularly worked) as well as whether or not they had had previous training focused on responsive behaviours. The participants' satisfaction with various aspects of the curriculum was obtained on the post-training measure.

A *Self-Perceived Competency Profile* was developed to assess staff members' perceptions of their competency with specific knowledge bases, experiences, and tasks associated with responsive behaviours taught in the curriculum. Staff were asked to indicate on a 5-point, Likert-type scale the degree of comfort they felt with 44 competencies such as knowledge about dementia and brain

changes, communication strategies, verbal and physical de-escalation techniques, and team work. Response categories ranged from 1="I find this difficult and I have to work consciously at it" to 5="This skill is so natural in my practice that I do it easily and automatically". Staff were asked to complete this profile immediately pre- and post-training, and again at six weeks post-training.

The *Perceived Attitude Profile* was developed to evaluate staff members' attitudes and values attached to responsive behaviours displayed by residents living in long term care settings. Staff were asked to indicate on a 5-point, Likert-type scale their level of agreement with each of 12 attitudes/values items (1="I mostly disagree" to 5="I mostly agree"). This profile was administered immediately pre- and post-training, and again at six weeks post-training.

The Satisfaction with the Curriculum Tool was implemented directly following the curriculum (post-training) to acquire feedback from participants regarding their satisfaction with various aspects of the program. Participants were asked to indicate on a 5-point Likert-type scale (1="I am very dissatisfied" to 5="I am very satisfied") the degree of satisfaction they had with aspects such as the course content, the length of the curriculum, the practical applicability of the material taught, the class size and location of the training, the quality of the facilitator of the training, and the accessibility of the course content.

Qualitative Data Collection Strategies

Four different qualitative data collection strategies were used in the evaluation of the GPA curriculum: focus groups with staff participating in the curriculum, semi-structured interviews with key informants, an open-ended tool completed by curriculum participants at the six-week follow-up, and an open-ended tool completed by the curriculum trainers.

Pre- and Post-Training Focus Groups

Focus groups were conducted with all staff who participated in the intervention immediately before the curriculum commenced and directly following the

curriculum. A total of 21 pre- and post-training focus groups were conducted. The focus groups were co-facilitated by the PRC conducting the GPA curriculum at the site and another member of the evaluation team with expertise in focus group facilitation. The evaluation team member also served as the recorder for the focus groups and documented the discussion

The pre-training focus groups were designed to illicit information on how staff members had typically responded to responsive behaviours in the past and how prepared they felt to handle responsive behaviours. More specifically, in the pre-training focus groups, staff were asked to: (1) describe a specific experience where they had to respond to a responsive behaviour, (2) describe what the experience was like, (3) explain how they had responded to the behaviour, (4) discuss how prepared they felt to respond to the behaviour; (5) describe how they would respond to a resident who became defensive, and (6) identify specific things they hoped to get out of the curriculum.

The post-training focus groups were used to examine how staff were feeling about their abilities to respond to responsive behaviours after participating in the curriculum. Staff were asked to: (1) discuss whether or not they felt better able to respond to responsive behaviours now that they had participated in the GPA curriculum, (2) describe how staff felt the training might impact upon their response to situations similar to those discussed in the curriculum, (3) identify things that they had learned during the day that they did not already know, and (4) describe how they might use the information they learned in their day-to-day practice.

Semi-Structured Interviews with Key Informants

Semi-structured interviews were conducted with key informants after the educational intervention to collect accounts of the perceptions of the impact of the curriculum on the organization. The original plan was to interview one member of the administrative team at each of the facilities involved in the curriculum, (for a total of seven management key informants) as well as the identified educator “champion” within each site who would be serving as a staff mentor after the curriculum (for a

total of seven “champion” key informants). However, one of the “champion” key informants in one of the project sites left for a position in another organization soon after the training had taken place, and only one key informant interview was able to be conducted at this site. Therefore, a total of thirteen key informants participated in the semi-structured interview.

An interview guide made up of two short sections was prepared for the interviews. The first section of the interview focused on the employment experience of the key informant and the second section explored the key informants’ perceptions of the curriculum and how he/she believed the curriculum impacted the organization. For example, key informants were asked to discuss what they thought the GPA program would do for their staff and for the organization overall, what they believed their staff learned at the GPA sessions, and specific instances where staff had had to use the information and skills taught during the curriculum. Most interviews lasted between 20 and 30 minutes, with a few lasting closer to 60 minutes in duration. All but one of the interviews were audiotaped and transcribed verbatim. One participant did not feel comfortable being audiotaped. In this instance, the interviewer documented in writing the responses to the questions outlined on the interview guide.

Open-Ended Tool Completed by Curriculum Participants at Six-Week Follow-Up

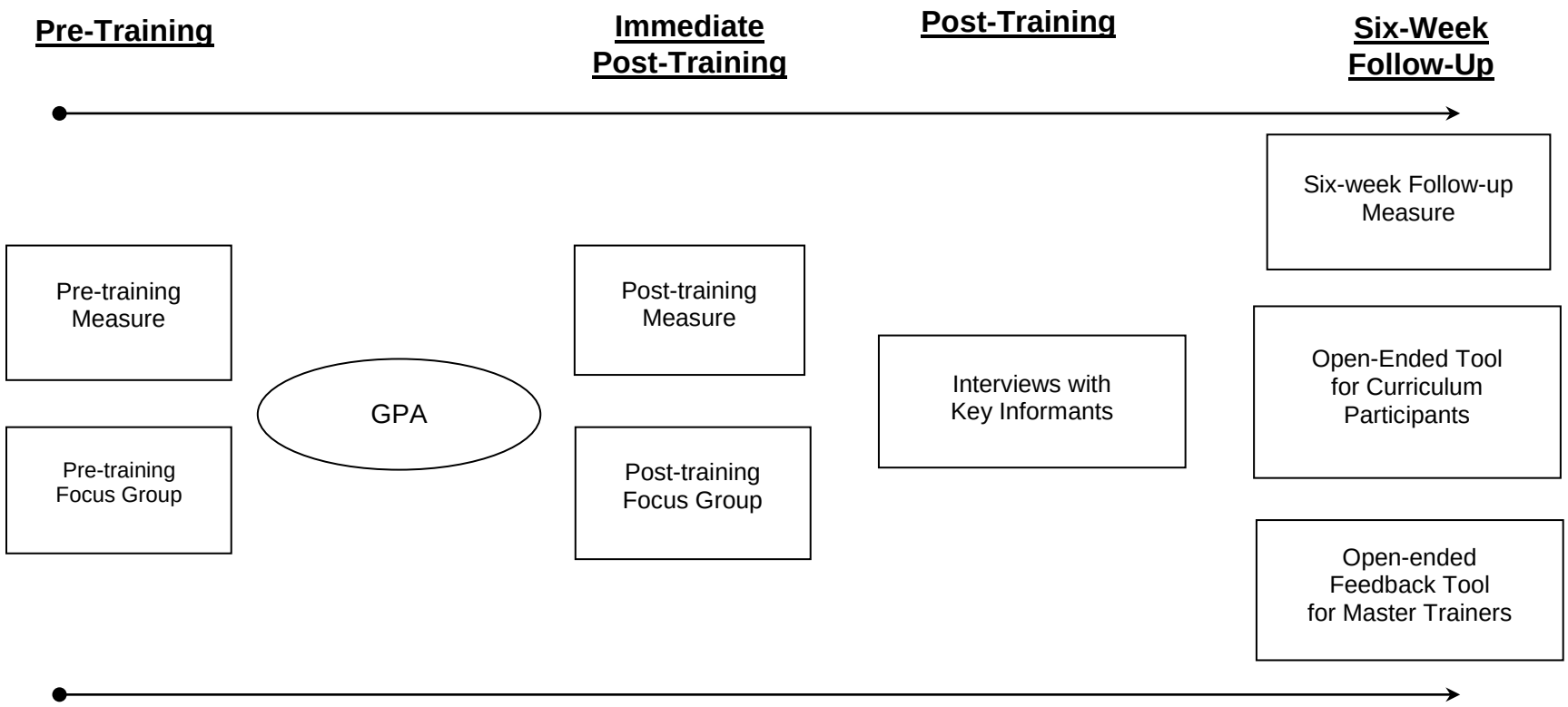
On the six-week follow-up measure, the classroom participants were asked to provide information about the skills they had had the opportunity to use in the six weeks following the curriculum and how effective these techniques had been in assisting the staff member to de-escalate the responsive behaviour. More specifically, in an open-ended format, staff were asked whether or not they had had the need to use the body containment holds or self-protective techniques taught in the curriculum during the previous six weeks, and if so to describe those experiences. They were also asked to explain whether or not they felt the holds and self-protective techniques they had used were effective.

Open-Ended Feedback Tool for Curriculum Master Trainers

One final data collection tool used in the evaluation of the GPA curriculum was developed to obtain important information about the curriculum by those who were teaching it. The eleven Master Instructors were each asked to reflect on their experiences conducting the GPA training and to complete an open-ended tool designed to elicit information from the trainers on various aspects related to their experiences. Trainers were asked to reflect and comment on their perceptions of the usefulness of the curriculum, the appropriateness of the resources used to facilitate the curriculum, how prepared they felt to teach this curriculum, and their experience facilitating the curriculum. They were also asked to comment on their overall impressions of specific aspects of the curriculum or the teaching environment (e.g., geared to different levels of ability, amount of information in the curriculum, difficulty of the curriculum, size of class), and how they felt their learners responded to the curriculum. Finally, the Master Instructors were asked for specific suggestions or recommendations to improve the curriculum or make it easier to teach.

Figure 1 provides a visual representation of the timeline for all data collection strategies used in the evaluation design.

Figure 1
Timeline of Evaluation Design



EVALUATION RESULTS

SUMMARY OF QUANTITATIVE ANALYSES

A total of 205 participants participated in the GPA curriculum and completed at least one of the quantitative evaluation tools (i.e., the pre-training measure, the post-training measure, or the six-week follow-up measure). Of these, 188 completed both the pre-training measure and the post-training measure and 75 completed all three tools.

Characteristics of Curriculum Attendees

The characteristics of the entire sample (n=205) and the smaller sample of participants who completed all three quantitative evaluation tools (n=75) are presented in Tables 1, 2, 3, and 4. The majority of both sample groups were female, forty years of age or older, and had at least college-level education. In terms of characteristics of their employment status, most of the curriculum participants in both samples worked either full- or part-time, with the majority regularly working the day shift. Over 50% of both sample groups had worked in long term care for 10 years or longer, although there was a range of participants involved in the curriculum from those with very little experience (i.e., less than 2 year) to those with over 20 years experience in long term care. Also, although the majority of the two sample groups had worked for their present employers for 10 years or more, there was a range of years worked for the present employer from those who had been with the current facility a relatively short period of time (i.e., less than two years) to those who had worked at the same facility for over 20 years. The majority of the participants were health care aides or personal support workers, followed by nursing staff, helping staff, support staff, and administration/management. Interestingly, both samples were split between those who had had previous training in responsive behaviours (a little over 50% of each sample) and those who had no previous training.

Satisfaction with GPA Curriculum

Participants in both sample groups were overwhelmingly satisfied with the GPA curriculum. Respondents indicated that the training program was a good length, was well organized, used a variety of interesting educational approaches, was facilitated by well-prepared trainers, and provided new learning that would be useful in direct clinical practice. Tables 5 and 6 provide a summary of levels of satisfaction of various aspects of the GPA curriculum for both sample groups.

Participants provided suggestions for improving the curriculum. Some respondents recommended that the program provide opportunity for case study application and that there be opportunity for some type of follow-up to reinforce the new motor competencies associated with the training. Respondents also indicated that they continued to have learning needs in regard to managing difficult communication predicaments such as repetitive vocalizations, and responding to episodes of sexual disinhibition. Some participants indicated that they would like to learn more about specific brain pathologies and their relationship to behaviour. In addition, respondents recommended that the GPA Curriculum be disseminated to their colleagues.

Table 1
Characteristics of Respondents in Full Sample (n=205)

Characteristic	n	Pct.
Sex		
Female	185	94.4
Male	11	5.6
Age		
Less than 20 years	1	.5
20 to 29 years	29	14.9
30 to 39 years	47	24.2
40 to 49 years	59	30.4
50 to 59 years	49	25.3
60 years or older	9	4.6
Education		
Elementary	5	2.6
High School	50	26.2
College	87	45.5
Professional Certificate	38	19.9
Undergraduate Degree	10	5.2
Master's Degree	1	.5
Staff Status		
Full-time staff	116	59.8
Part-time staff	70	36.1
Casual staff	8	4.1
Shift Regularly Worked		
Day shift	109	56.8
Evening shift	43	22.4
Night shift	12	6.3
No regular shift	28	14.6

Table 2
Characteristics of Respondents in Full Sample Continued (n=205)

Characteristic	n	Pct.
Years Worked in LTC		
Less than 1 year	2	1.0
1 to 2 years	28	14.4
2 to 5 years	30	15.5
5 to 8 years	17	8.8
8 to 10 years	12	6.2
10 to 20 years	72	37.1
20 years and over	33	17.0
Years Worked for Present Employer		
Less than 1 year	3	1.5
1 to 2 years	41	21.0
2 to 5 years	38	19.5
5 to 8 years	20	10.3
8 to 10 years	13	6.7
10 to 20 years	80	41.0
Staff Position		
Administration/management	15	7.7
Nursing	40	20.6
Health Care Aide/PSW	99	51.0
Support Staff	20	10.3
Helping Staff	21	10.3
Previous Training		
No	98	51.3
Yes	93	48.7

Table 3
Characteristics of Respondents Who Completed all Three Surveys (n=75)

Characteristic	n	Pct.
Sex		
Female	73	97.3
Male	2	2.7
Age		
20 to 29 years	7	9.5
30 to 39 years	21	28.4
40 to 49 years	22	29.7
50 to 59 years	21	28.4
60 years or older	3	4.0
Education		
Elementary	3	4.2
High School	17	23.6
College	31	43.1
Professional Certificate	16	22.2
Undergraduate Degree	5	6.9
Staff Status		
Full-time staff	43	57.3
Part-time staff	30	40.0
Casual staff	2	2.7
Shift Regularly Worked		
Day shift	41	55.4
Evening shift	15	20.3
Night shift	6	8.1
No regular shift	12	16.2

Table 4
Characteristics of Respondents Who Completed all Three Surveys Cond't (n=75)

Characteristic	n	Pct.
Years Worked in LTC		
1 to 2 years	10	13.3
2 to 5 years	11	14.7
5 to 8 years	5	6.7
8 to 10 years	6	8.0
10 to 20 years	28	37.3
20 years and over	15	20.0
Years Worked for Present Employer		
1 to 2 years	17	22.7
2 to 5 years	15	20.0
5 to 8 years	9	12.0
8 to 10 years	5	6.7
10 to 20 years	29	38.7
Staff Position		
Administration/management	5	6.7
Nursing	18	24.0
Health Care Aide/PSW	37	49.3
Support Staff	6	8.0
Helping Staff	9	12.0
Previous Training		
No	39	53.4
Yes	34	46.6

Table 5
Satisfaction with Various Aspects of Curriculum for Full Sample (n=205)

	Degree of Satisfaction		
Satisfaction Items	n[a]	Mean[b]	Std.dev.
Overall course content	189	4.57	.89
Length of curriculum	187	4.24	1.03
Amount of material presented	188	4.52	.96
Difficulty level of content	187	4.41	1.01
Material had practical application	188	4.60	.92
Appropriate exercises and activities used	187	4.61	.91
Overall organisation of training	190	4.64	.87
Class size	189	4.67	.91
Method of instruction	188	4.64	.92
Location of training	189	4.53	1.00
Facilitator overall	187	4.64	.86
Facilitator's knowledge of subject area	189	4.66	.90
Facilitator's preparation for class	187	4.65	.91
Facilitator as a source of motivation	187	4.61	.91
Appropriate examples used by facilitator	189	4.65	.90
Class materials overall	188	4.62	.90
Materials were clear and well organised	187	4.67	.88
Materials were easy to understand	188	4.63	.91

[a] Number of participants responding to questions
[b] Average level of satisfaction (1="I am very dissatisfied" to 5="I am very satisfied")

Table 6
Satisfaction with Various Aspects of Curriculum for Those Who Completed All Surveys (n=75)

	Degree of Satisfaction		
Satisfaction Items	n[a]	Mean[b]	Std.dev.
Overall course content	75	4.67	.74
Length of curriculum	74	4.46	.89
Amount of material presented	75	4.67	.76
Difficulty level of content	75	4.56	.84
Material had practical application	75	4.73	.72
Appropriate exercises and activities used	74	4.73	.73
Overall organisation of training	75	4.72	.75
Class size	75	4.77	.71
Method of instruction	75	4.73	.72
Location of training	75	4.63	.91
Facilitator overall	75	4.75	.72
Facilitator's knowledge of subject area	75	4.76	.71
Facilitator's preparation for class	75	4.77	.73
Facilitator as a source of motivation	75	4.73	.72
Appropriate examples used by facilitator	75	4.75	.72
Class materials overall	75	4.69	.74
Materials were clear and well organised	74	4.72	.73
Materials were easy to understand	74	4.72	.73

[a] Number of participants responding to questions
[b] Average level of satisfaction (1="I am very dissatisfied" to 5="I am very satisfied")

Immediate Impact of GPA Curriculum

To determine whether or not there were changes in staff self-perceived competency and staff attitudes/values after staff had participated in the curriculum, we conducted paired t-tests comparing staff scores on the self-perceived competency items and attitude/values items before the curriculum (pre-training measure) with the same scores from the tool that was completed immediately following the curriculum (post-training measure).

Impact on Self-Perceived Competency

In all but one instance, staff reported statistically significant increases in self-perceived competency immediately following the curriculum. Staff felt significantly more competent in their abilities to identify the triggers of responsive behaviours, to communicate more effectively with residents, to identify appropriate and respectful responses when experiencing responsive behaviours, and to know how to de-escalate a situation and respond appropriately after a situation. The only item that did not show a significant change between pre-training and post-training was the communication item "Reorient person to present reality, time, and place." In fact, staff showed very little change in their beliefs about their abilities to use this strategy. Use of reorientation techniques are very much dependent on the person and the situation. In some instances, reorientation may be appropriate, but in many others it may just serve to upset the resident further and escalate the situation even more. Upon reflection, this item likely was difficult for staff to respond to given the importance of the context to the use of reorientation techniques. Table 7 summarizes the changes in staff self-perceived competency from before the curriculum to immediately following the curriculum.

Impact on Staff Attitudes/Values

When we examined changes in staff attitudes/values towards responsive behaviours from before the curriculum began to immediately following the curriculum, seven of the twelve items showed statistically significant differences from

pre-training to post-training. In all of these instances, staff demonstrated a significantly more positive attitude towards responsive behaviours that reflected the person-centred philosophy and need-based nature of behaviours that guided the curriculum. Interestingly, the items that did not appear to change significantly from pre-training to post-training were those that reflected a more negative perception of behaviours such as "People with dementia have the right to express their emotions but only under certain circumstances," "When people with dementia throw objects or swear it is going too far," "Physical dis-inhibition in dementia is a significant problem in LTC," and "The expression of negative emotion in persons with dementia should be strictly controlled." These results would suggest that curriculums such as the GPA may be effective in validating and increasing attitudes and values about responsive behaviours that are already fairly positive. However, one curriculum may not be enough to effectively change more negative attitudes and values. Table 8 summarizes the changes in staff scores on the attitude/value items from pre-training to post-training.

Sustainability of Impacts of GPA Curriculum

To determine whether or not the observed changes in self-perceived competency and attitudes/values were sustainable after the staff had returned to practice, we conducted Repeated-Measures Anova using the sample of staff that had completed all three measures (pre-training, post-training, and six-week follow-up). If the impacts were sustainable, there should not be any significant differences in scores between the post-training and the six-week follow-up.

Sustainability of Impacts on Self-Perceived Competency

The results of the Repeated-Measures Anova suggest that the increases in self-perceived competency observed immediately following the GPA curriculum were sustainable six-weeks following the curriculum. That is, staff continued to have increased perceptions of their abilities to understand responsive behaviours and respond in appropriate and respectful ways to these behaviours after they had been

back in the workplace for six weeks. The only competency item that did not appear to be sustainable was related to staffs' perceptions of their abilities to "identify signs and symptoms of impending challenging behaviours." Although staff continued to feel competent in their ability to identify what triggered a behaviour once it occurred six weeks following the curriculum, they did not feel as confident at this time in their ability to identify potential signs and symptoms of behaviours before they occurred. Table 9 shows the changes/sustainability in self-perceived competency scores across the three measurement time periods.

Sustainability of Impacts on Staff Attitudes/Values

When we examined the sustainability of changes to staff attitudes/values observed from pre-training to post-training, we found that changes in attitudes on some items did not appear to be as sustainable several weeks after the curriculum as changes in self-perceived competency. Three of the seven attitude/values items that had shown increases in positive attitudes from pre-training to post-training showed significant decreases in scores at six-week follow-up. Although the GPA curriculum was able to significantly increase staff attitudes that were fairly positive to begin with from pre-training to immediately following the training, these increases in attitudes were not sustainable once staff returned to the workplace. In fact, in two of the three cases, the scores at six-week follow-up were lower than they were before the training began. That is, despite still being fairly high scores at the six-week follow-up, the level of agreement on these two items (i.e., "if people with dementia are given an appropriate avenue for expression of their negative emotions it will reduce irritability, depression and agitation" and "challenging behaviours in a person with dementia means that there is something wrong: An unmet need of some kind should be addressed") was significantly lower at the six-week follow-up than they were before the training began. As mentioned earlier, one staff training program may not be sufficient to change attitudes and ensure the sustainability of changes in attitudes/values. Other researchers have emphasized the need for more regular training opportunities to ensure staff are kept current on the most effective strategies

and are able to maintain information and skills related to responsive behaviours over the long term (Moniz-Cook et al., 1998).

A third attitude item also showed a significantly lower level of agreement at six-week follow-up compared to pre-training but this change may actually reflect a positive change in staff attitudes. At six-week follow-up, staff appeared to have a stronger belief in their fellow staff members' approaches to responsive behaviours than they reported pre-training. At six-week follow-up they were more likely disagree with the statement; "staff in my organization/facility need to change their approach to the management of physical agitated behaviour in dementia," than they were both immediately following the training and before the training began. Perhaps because a number of colleagues had participated in the curriculum and staff generally were feeling more competent in their abilities to respond to responsive behaviours, this served to strengthen the team and staffs' perceptions of their colleagues abilities.

Although some changes in attitude/values did not appear to be sustainable once staff returned to their jobs, two of the attitude items did appear to be sustainable from post-training to six-week follow-up. Staff members' level of agreement with the item; "What is wrong is not the emotional expression, only its public display," was significantly higher at post-training compared to pre-training and, although the score lowered a little at the six-week follow-up, the difference was not statistically significant. Staff scores on the item; "If a resident is physically out of control I should try to stop that behaviour by touching the resident in some way," decreased significantly from pre-training to post-training and then remained fairly stable at six-week follow-up. Generally though, the pattern of the results from both sets of analyses (i.e., paired t-test and repeated measures Anova) suggest that the GPA curriculum may not be as effective in changing staff attitudes/values and sustaining those changes over time as it is in increasing and sustaining self-perceived competency. Table 10 summarizes the changes in staff attitudes/values from pre-training, to post-training, to the six-week follow-up.

Table 7
Differences in Self-Perceived Competency Items From Pre-Training to Immediate Post-Training

	Pre- Training			Post- Training				
Competency Items	**n**	**Mean[a]**	**Std. Dev.**	**n**	**Mean[a]**	**Std. Dev.**	*t*	*p*
Have a clear understanding of how changes in the brain result in challenging behaviours	168	***3.43***	1.05	168	***4.40***	.71	-12.018	<.001
Generally able to interpret residents' behaviours	179	***3.42***	.99	179	***4.18***	.77	-10.663	<.001
Able to identify triggers of challenging behaviours	173	***3.28***	1.01	173	***4.12***	.82	-10.449	<.001
Able to identify signs and symptoms of impending challenging behaviours	176	***3.27***	1.04	176	***4.19***	.75	-13.065	<.001
Understand that the way I communicate with residents impacts on how the resident receives and responds to the message	177	***4.37***	.85	177	***4.60***	.64	-3.204	.002
Use the "Stop and Go" approach when my work requires me to enter the residents' personal space	128	***3.82***	1.15	128	***4.49***	.72	-6.024	<.001
In communication with a person with dementia:								
Minimize distractions and noise	174	***3.96***	1.01	174	***4.44***	.78	-6.435	<.001
Speak slowly and clearly in a soft and calm tone	178	***4.30***	.93	178	***4.57***	.68	-4.809	<.001
Use simple language with familiar words	176	***4.38***	.88	176	***4.56***	.62	-3.157	.002
Visually demonstrate what I am saying	168	***4.07***	1.00	168	***4.46***	.75	-5.722	<.001
Avoid arguing and confrontations	172	***4.35***	.92	172	***4.62***	.62	-4.779	<.001
Repeat what I am saying	174	***4.28***	.92	174	***4.52***	.70	-3.398	.001
Validate and respect the residents feelings	176	***4.33***	.92	176	***4.55***	.67	-3.545	<.001
Reorient person to present reality, time, place	138	3.99	1.08	138	3.93	1.15	.609	.544

[a] Average perceived competence (1="I find this difficult and I have to work consciously at it" to 5="This skill is so natural in my practice that I do it easily and automatically"

Bold italics indicate means that are significantly different*; Italics* indicate means that are reaching statistical significance

Table 7 Continued

	Pre- Training			Post- Training				
Competency Items	**n**	**Mean[a]**	**Std. Dev.**	**n**	**Mean[a]**	**Std. Dev.**	*t*	*p*
I use the following behaviours:								
Acquire resident's attention with eye contact	179	***4.07***	1.03	179	***4.45***	.72	-4.769	<.001
Don't stand or kneel directly in front of resident	166	***3.62***	1.13	166	***4.30***	.91	-7.356	<.001
Remove the audience	159	***3.65***	1.04	159	***4.26***	.82	-7.546	<.001
Know when it is necessary to ask for help	178	***4.48***	.86	178	***4.66***	.60	-3.096	.002
Decrease stimuli in the environment	162	***3.86***	.95	162	***4.33***	.78	-6.938	<.001
Find someone familiar with the resident	176	***4.20***	.95	176	***4.48***	.73	-3.589	<.001
Know when I've been dismissed	131	***4.05***	1.04	131	***4.53***	.71	-5.254	<.001
Remember that verbally defensive behaviour will not hurt and don't overreact	166	***4.16***	.93	166	***4.60***	.69	-6.046	<.001
Ask for an assignment switch or work in pairs	131	***4.04***	1.04	131	***4.37***	.87	-3.496	.001
Use physical interventions only as a last resort	126	***4.21***	1.00	126	***4.63***	.60	-4.450	<.001
Doing nothing	108	***3.44***	1.37	108	***4.25***	1.04	-6.049	<.001
Able to demonstrate the suitable and respectful self-protective techniques in response to a reflex grab	133	***3.23***	1.16	133	***4.39***	.71	-11.972	<.001
Able to demonstrate the suitable and respectful self-protective techniques in response to defensive grab	129	***3.17***	1.20	129	***4.40***	.71	-11.006	<.001
Able to demonstrate the suitable and respectful self-protective techniques in response to defensive stroke	125	***3.14***	1.21	125	***4.40***	.71	-10.904	<.001
Using gentle redirection, able to help bring resident away from an unsafe situation/altercation	166	***3.99***	1.02	166	***4.51***	.69	-6.922	<.001
As a team, we are able to bring a resident away from an unsafe situation using a team re-direction technique	133	***4.03***	1.00	133	***4.58***	.59	-6.126	<.001

[a] Average perceived competence (1="I find this difficult and I have to work consciously at it" to 5="This skill is so natural in my practice that I do it easily and automatically"

Bold italics indicate means that are significantly different*; Italics* indicate means that are reaching statistical significance

Table 7 Continued

	Pre- Training			Post- Training				
Competency Items	**n**	**Mean[a]**	**Std. Dev.**	**n**	**Mean[a]**	**Std. Dev.**	*t*	*p*
In de-escalating a situation:								
Offer continued support to the resident	175	***4.02***	.90	175	***4.50***	.62	-6.988	<.001
Help them express their feelings	173	***3.95***	.94	173	***4.50***	.68	-7.662	<.001
Help them give voice to their emotions	175	***3.90***	1.00	175	***4.48***	.64	-8.097	<.001
Acknowledge their feelings and emotions	177	***4.14***	.92	177	***4.59***	.58	-7.349	<.001
Ensure a calm environment	176	***3.95***	1.02	176	***4.47***	.66	-7.175	<.001
Divert with food, drink, pictures, conversation	175	***4.20***	.95	175	***4.59***	.61	-5.544	<.001
After a situation:								
Ensure that no one has been injured	167	***4.47***	.77	167	***4.62***	.61	-2.646	.009
Inform supervisors/colleagues	168	***4.57***	.77	168	***4.72***	.56	-2.796	.006
Discuss ways to inform the family	126	***3.68***	1.14	126	***4.35***	.73	-6.972	<.001
Look for treatable causes (infection, pain, etc.)	142	***3.88***	1.10	142	***4.47***	.78	-6.738	<.001
Evaluate how TEAM responded to an episode	125	***3.54***	1.17	125	***4.34***	.76	-8.437	<.001
Offer support to TEAM members	148	***3.91***	1.09	148	***4.47***	.73	-7.223	<.001
Talk to a trusted colleague	160	***4.09***	1.12	160	***4.58***	.60	-6.526	<.001
Look after oneself	150	***3.86***	1.19	150	***4.51***	.76	-7.628	<.001

[a] Average perceived competence (1="I find this difficult and I have to work consciously at it" to 5="This skill is so natural in my practice that I do it easily and automatically"

Bold italics indicate means that are significantly different*; Italics* indicate means that are reaching statistical significance

Table 8
Differences in Attitudes/Values Items From Pre-Training to Immediate Post-Training

	Pre-Training			Post-Training				
Value Items	**n**	**Mean[a]**	**Std. Dev.**	**n**	**Mean[a]**	**Std. Dev.**	*t*	*p*
People with dementia have the right to express their emotions but only under certain circumstances.	184	2.65	1.65	184	2.80	1.69	-1.082	.281
When people with dementia throw objects or swear it is going too far.	181	2.67	1.38	181	2.59	1.55	.844	.469
Physical dis-inhibition in dementia is a significant problem in LTC.	162	3.54	1.09	162	3.64	1.20	-.897	.371
The expression of negative emotion in persons with dementia should be strictly controlled.	178	2.26	1.21	178	2.12	1.29	1.506	.134
If people with dementia are given an appropriate avenue for expression of their negative emotions it will reduce irritability, depression, and agitation.	183	***4.05***	1.06	183	***4.42***	.95	-4.216	<.001
Challenging behaviours in a person with dementia means that there is something wrong: An unmet need of some kind should be addressed.	181	***3.62***	1.29	181	***4.39***	1.00	-7.281	<.001
What is wrong is not the emotional expression, only its public display.	173	***2.62***	1.27	173	***2.90***	1.58	-2.280	.024
If a resident is physically out of control I should try to stop that behaviour by touching the resident in some way.	182	***2.35***	1.22	182	***1.95***	1.40	3.279	.001
All human beings react negatively or inappropriately to threatening things from time to time, and people with dementia are not different.	183	***4.23***	1.15	183	***4.53***	.93	-3.186	.002
Physically aggressive behaviour should be interpreted as an attempt by persons with dementia to self-protect or defend themselves.	182	***3.79***	1.16	182	***4.51***	.89	-7.584	<.001
Staff in my organisation/facility use a thoughtful, open-minded and flexible approach to cases of agitated physical behaviour in dementia.	180	3.81	1.13	180	3.96	1.00	-1.601	.111
Staff in my organisation/facility need to change their approach to the management of physically agitated behaviour in dementia.	181	***3.33***	1.23	181	***3.61***	1.23	-2.642	.009

[a] Average degree of agreement with each item (1=mostly disagree to 5=mostly agree)
Bold italics indicate means that are significantly different*; Italics* indicate means that are reaching statistical significance

Table 9
Sustainability of Impacts: Differences in Self-Perceived Competency Items from Pre-Training to Six-Week Follow-up (n=75)

	Pre-Training		**Post-Training**		**Six-Week Follow-up**			
Competency Items	Mean[a]	Std. Dev.	Mean[a]	Std. Dev.	Mean[a]	Std. Dev.	F	*p*
Have a clear understanding of how changes in the brain result in challenging behaviours	***3.54***	1.10	***4.32***	.74	4.16	.87	25.842	<.001
Generally able to interpret residents' behaviours	***3.44***	1.04	***4.19***	.81	4.07	.77	33.344	<.001
Able to identify triggers of challenging behaviours	***3.24***	1.11	***4.16***	.77	4.13	.76	45.391	<.001
Able to identify signs and symptoms of impending challenging behaviours	***3.21***	1.11	***4.26***	.69	***4.07***	.81	53.876	<.001
Understand that the way I communicate with residents impacts on how the resident receives and responds to the message	***4.32***	.91	***4.66***	.53	4.56	.73	5.146	.007
Use the "Stop and Go" approach when my work requires me to enter the residents' personal space	***3.61***	1.25	***4.48***	.61	4.46	.69	25.907	<.001
In communication with a person with dementia:								
Minimize distractions and noise	***4.03***	1.12	***4.43***	.81	4.44	.79	7.533	.001
Speak slowly and clearly in a soft and calm tone	***4.29***	.94	***4.57***	.69	4.54	.73	3.947	.021
Use simple language with familiar words	***4.39***	.84	***4.59***	.62	4.62	.68	3.008	.049
Visually demonstrate what I am saying	***4.09***	1.05	***4.49***	.78	4.46	.82	8.651	<.001
Avoid arguing and confrontations	***4.20***	1.04	***4.56***	.67	4.63	.69	7.722	.001
Repeat what I am saying	4.36	.87	4.54	.67	4.60	.73	2.898	.059
Validate and respect the residents feelings	4.36	.89	4.50	.61	4.50	.76	1.304	.275
Reorient person to present reality, time, place	4.02	1.06	4.04	.97	4.10	.91	.129	.879

[a] Average perceived competence (1="I find this difficult and I have to work consciously at it" to 5="This skill is so natural in my practice that I do it easily and automatically"

Bold italics indicate means that are significantly different*; Italics* indicate means that are reaching statistical significance

Table 9 Continued

	Pre-Training		Post-Training		Six-Week Follow-up			
Competency Items	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	F	*p*
I use the following behaviours:								
Acquire resident's attention with eye contact	***4.03***	1.03	***4.49***	.65	4.44	.81	9.860	<.001
Don't stand or kneel directly in front of resident	***3.62***	1.06	***4.38***	.79	4.22	.95	18.297	<.001
Remove the audience	***3.74***	.94	***4.32***	.79	4.34	.85	19.683	<.001
Know when it is necessary to ask for help	4.54	.86	4.68	.60	4.71	.66	1.740	.179
Decrease stimuli in the environment	***3.91***	.88	***4.42***	.68	4.33	.84	14.471	<.001
Find someone familiar with the resident	***4.24***	.87	***4.54***	.74	4.40	.85	3.102	.048
Know when I've been dismissed	***3.84***	1.22	***4.50***	.79	4.46	.81	12.532	<.001
Remember that verbally defensive behaviour will not hurt and don't overreact	***4.04***	.89	***4.66***	.61	4.57	.74	18.107	<.001
Ask for an assignment switch or work in pairs	***4.15***	.95	***4.50***	.83	4.56	.77	4.513	.013
Use physical interventions only as a last resort	***4.13***	1.08	***4.64***	.53	4.53	.83	5.757	.004
Doing nothing	***3.26***	1.41	***4.26***	1.04	*3.82*	1.25	10.485	<.001
Able to demonstrate the suitable and respectful self-protective techniques in response to a reflex grab	***3.28***	1.25	***4.49***	.62	4.32	.81	31.343	<.001
Able to demonstrate the suitable and respectful self-protective techniques in response to defensive grab	***3.16***	1.13	***4.51***	.59	*4.29*	.82	37.990	<.001
Able to demonstrate the suitable and respectful self-protective techniques in response to defensive stroke	***3.30***	1.07	***4.50***	.59	***4.27***	.82	32.777	<.001
Using gentle redirection, able to help bring resident away from an unsafe situation/altercation	***3.91***	1.09	***4.56***	.58	4.46	.78	15.539	<.001
As a team, we are able to bring a resident away from an unsafe situation using a team re-direction technique	***4.04***	.93	***4.53***	.66	4.31	.93	5.319	.007

[a] Average perceived competence (1="I find this difficult and I have to work consciously at it" to 5="This skill is so natural in my practice that I do it easily and automatically"

Bold italics indicate means that are significantly different*; Italics* indicate means that are reaching statistical significance

Table 9 Continued

	Pre-Training		**Post-Training**		**Six-Week Follow-up**			
Competency Items	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.	F	*p*
In de-escalating a situation:								
Offer continued support to the resident	***3.93***	.91	***4.37***	.69	4.41	.79	10.936	<.001
Help them express their feelings	***3.83***	1.03	***4.42***	.67	4.38	.77	15.246	<.001
Help them give voice to their emotions	***3.75***	1.08	***4.42***	.60	4.37	.76	21.402	<.001
Acknowledge their feelings and emotions	***3.97***	1.03	***4.56***	.55	4.55	.75	16.775	<.001
Ensure a calm environment	***4.00***	1.00	***4.51***	.58	4.38	.82	11.514	<.001
Divert with food, drink, pictures, conversation	***4.31***	.83	***4.59***	.63	4.56	.72	3.915	.002
After a situation:								
Ensure that no one has been injured	4.54	.66	4.66	.51	4.71	.63	2.247	.110
Inform supervisors/colleagues	4.67	.66	4.77	.43	4.75	.60	.977	.379
Discuss ways to inform the family	***3.82***	1.21	***4.51***	.59	4.44	.69	13.502	<.001
Look for treatable causes (infection, pain, etc.)	***4.05***	1.18	***4.53***	.57	4.62	.56	9.552	<.001
Evaluate how TEAM responded to an episode	***3.60***	1.21	***4.40***	.61	4.34	.82	15.883	<.001
Offer support to TEAM members	***3.87***	1.22	***4.52***	.60	4.52	.77	16.783	<.001
Talk to a trusted colleague	***4.02***	1.11	***4.48***	.64	4.48	.78	9.777	<.001
Look after myself	***4.00***	1.15	***4.57***	.68	4.45	.94	11.972	<.001

[a] Average perceived competence (1="I find this difficult and I have to work consciously at it" to 5="This skill is so natural in my practice that I do it easily and automatically"

Bold italics indicate means that are significantly different*; Italics* indicate means that are reaching statistical significance

Table 10
Sustainability of Impacts: Differences in Attitudes/Values Items from Pre-Training to Six-Week Follow-up (n=75)

	Pre-Training		Post-Training		Six-Week Follow-up			
Value Items	Mean[a]	Std. Dev.	Mean[a]	Std. Dev.	Mean[a]	Std. Dev.	F	*p*
People with dementia have the right to express their emotions but only under certain circumstances.	2.91	1.57	2.74	1.63	2.55	1.60	1.380	.255
When people with dementia throw objects or swear it is going too far.	2.68	1.40	2.65	1.65	2.64	1.49	.032	.969
Physical dis-inhibition in dementia is a significant problem in LTC.	3.59	1.02	3.73	1.23	3.44	1.15	1.468	.234
The expression of negative emotion in persons with dementia should be strictly controlled.	2.39	1.81	2.17	1.29	2.14	1.25	1.190	.307
If people with dementia are given an appropriate avenue for expression of their negative emotions it will reduce irritability, depression, and agitation.	***4.09***	1.04	***4.49***	.86	***4.07***	1.23	4.927	.008
Challenging behaviours in a person with dementia means that there is something wrong: An unmet need of some kind should be addressed.	***3.91***	1.17	***4.46***	.97	***3.85***	1.29	8.585	<.001
What is wrong is not the emotional expression, only its public display.	***2.65***	1.24	***3.14***	1.53	2.81	1.51	3.476	.034
If a resident is physically out of control I should try to stop that behaviour by touching the resident in some way.	*2.30*	1.22	*1.95*	1.40	2.01	1.29	1.882	.156
All human beings react negatively or inappropriately to threatening things from time to time, and people with dementia are not different.	4.39	1.02	4.54	1.00	4.41	1.02	.572	.566
Physically aggressive behaviour should be interpreted as an attempt by persons with dementia to self-protect or defend themselves.	***3.95***	1.15	***4.53***	.88	***4.15***	1.18	7.316	.001
Staff in my organisation/facility use a thoughtful, open-minded and flexible approach to cases of agitated physical behaviour in dementia.	3.72	1.15	3.97	1.01	3.87	1.22	1.816	.166
Staff in my organisation/facility need to change their approach to the management of physically agitated behaviour in dementia.	3.32	1.22	***3.58***	1.26	***2.93***	1.48	5.886	.003

[a] Average degree of agreement with each item (1=mostly disagree to 5=mostly agree)
Bold italics indicate means that are significantly different*; Italics* indicate means that are reaching statistical significance

SUMMARY OF QUALITATIVE DATA ANALYSIS

The data from both the pre- and post-training focus groups documented on the flip-charts were compiled and subjected to thematic content analysis.

Summary of Findings from Pre-Training Focus Groups

Five general themes were identified from the recorded data and were common across all seven of the curriculum sites. The common themes across sites related to: Types of Incidents (A Risky Business), Handling Behaviour (Retreat, Regroup, Then Advance), Feelings in Response to Episodes (Not a Pleasant Space), Perceived Preparedness (Defenseless and Exposed) and Learning Goals (The Whole Nine Yards).

Types of Incidents (A Risky Business)

Review of the focus group transcriptions do not reveal a strong sense that episodes of a very high-end physical nature were occurring on a frequent basis for this sample. Many instances were shared where participants reported that they were the objects of hissing, swearing and cursing. Participants also described instances where they had to deal with residents who were exit-seeking, as well as those who were fretful and engaging in repetitive vocalizations. For the most part, the behavioural displays most likely to occur that were a cause of concern to participants included outright refusal to cooperate, grabbing, pushing, pinching, biting, spitting and hitting within the context of interpersonal interactions. These included attempts to deliver personal care, medications, or food.

In addition, there were examples shared when staff experienced threats uttered by residents. These involved residents threatening staff by making a fist and shaking it. There was one anecdote reported whereby a resident raised a cane and threatened to hit staff with it. Participants also stated that residents had threatened to throw things during an episode. For example, there were episodes described that involved residents attempting to throw a walker at co-residents or through the window in order to effect leaving a secure unit. In one instance a resident threw water in a staff member's face. In another, a resident threw a television remote

control in the direction of a participant. Further, there were reports of some residents chasing staff during an episode.

In some instances participants reported that they had experienced situations where co-residents became embroiled in an altercation when personal space had been intruded upon. For example, it was reported that one resident wandered into a co-resident's space and was punched by the room occupant. In other instances participants had to intervene in order to prevent residents from kicking out at each other when in heavily congested public areas such as lounges or dining rooms.

Staff reported that for the most part they sustained only scratches or bruises from finger marks as a result of having been grabbed. One participant stated that she had sustained a sprained hand when an angry resident fell on it during an episode. There were no reports of incidents that involved injury such as fracture. Participants of two sites (Site 02, 04) made specific reference to sexual disinhibition of both a verbal and physical nature.

Handling Behaviour (Retreat, Regroup, Then Advance)

For the most part, participants outlined techniques used in response to high-end behavioural episodes that were limited to interpersonal verbal strategies and use of personal space. Their examples did not indicate any strategies that were specific to "body containment skills". Common reports of interventions focused in the area of interpersonal space (e.g., back-off, leave and return), and communication strategies (e.g., reassurance, explanation, or reasoning with the resident). If these did not work, then participants would call for assistance, although there were no specific inferences made by participants that would suggest that when help arrived those team members who responded would be any more successful in de-escalation (i.e., more on the scene, strength in numbers, not necessarily more effective by virtue of no explicit planned intervention).

Participant comments suggested there was little sense of team discussion or planning when faced with episodes of high-end responsive behaviours of a catastrophic nature. Rather, responses are suggestive of the sense that staff

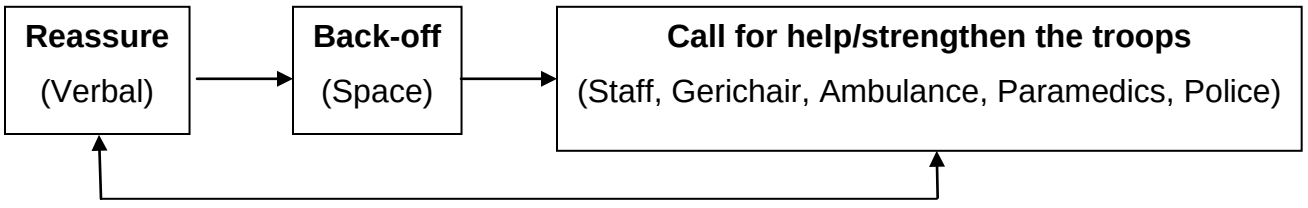
reacted based on their own skill set and knowledge base, resulting in a high potential for practice inconsistencies. There was no evidence of a common language or minimum standard approach supported by policies and procedures at any of the sites.

There was a recurrent theme evident in the responses of participants from three pilot sites highly suggestive that a favoured response was the use of physical restraint to manage behaviour. Participants of these sites (Site 03, 05, 07) made multiple references to the use of Gerichairs to manage residents who were out of control. This is suggestive of an organizational culture that is risk-aversive and intolerant of negative emotional expressions.

Participants frequently mentioned the use of inappropriate behavioural techniques that they used in response to episodes during which a resident might grab a wrist. For example, one participant mentioned that one approach was to pry the resident's fingers back if they were to grab, an action that is contraindicated in the frail elderly population, particularly those with dementia who may experience primitive reflexes and rigidity.

Participants of two facilities made reference to calling an ambulance and using paramedics to transport an out-of-control resident for emergency psychiatric triage. It is noteworthy that several participants stated that upon arrival the paramedics did not appear to "know what to do", increasing their discomfort and the uncertainty of the situation. Staff at one facility also made reference to the use of the police in the context of behavioural management responses.

Overall the typical response patterns described by curriculum site participants can be represented in the following linear decision-making feedback loop.



Of significance is that none of the participants mentioned having a debriefing session after a catastrophic event had reached its conclusion in order to evaluate approaches or revise the care plan.

Feelings in Response to Episodes (Not a Pleasant Space)

Despite low reports of high-end responsive behaviours of a catastrophic physical nature, participants used strong emotional language to describe their reactions to incidents. The suggestion is that the staff had an emotional over-reaction to episodes because they had no theoretical or formal skills base from which to react with confidence. Many participants reported feeling fearful, helpless and violated, an unpleasant position from which to practice. The language used by participants to describe their experiences suggested vulnerability and a position of uncertainty. For example, many participants stated that they felt that their hearts were racing, that they were preoccupied with worry about what to do and how to manage the situation. Participants also stated that they were embarrassed by behavioural outbursts of a physical nature because they thought they might be perceived by others as incompetent. Several participants stated that they were not confident that they would be supported by administration if they were to touch the resident to control the body in some way during the episode. If they decided to touch the resident in some way, they were not sure if this was “allowed” and would worry thereafter if they would be disciplined. Consequently, they felt unsupported and alone with the burden of residents they experienced as challenging. Participants also identified that they felt frustrated, and on occasion, angry about being in a position where they were not sure how to proceed and even less certain about the success of any of their attempts to respond to the resident of concern.

Perceived Preparedness (Defenseless and Exposed)

Although some participants stated that they felt well-prepared to handle difficult situations that involved responding to physical behaviours, in general, participants reported not feeling well-prepared to manage such behaviours. Participants shared concerns about the safety and security of the residents in their case load as well as the welfare of their colleagues. In addition, participants stated that while eventually they might begin to develop an intuitive approach to a resident's responsive behaviours as they got to know the resident over time, this was often difficult in the case where a resident was newly admitted and was not yet "understood". Consequently, they felt ill-equipped to handle outbursts involving residents not well known to them given that they would not yet have determined the triggers to behavioural episodes that could be modified, or the interpersonal strategies that might serve to de-escalate the resident. As a result they felt vulnerable in such circumstances.

Goals (The Whole Nine Yards)

Project participants listed similar learning goals across all seven pilot sites. Of significance is that participants intuitively understood that they would need to learn an assessment and interpretation approach, rather than body containment techniques in isolation. None of the participants stated that they wanted to learn body containment strategies in isolation of a more consolidated and holistic training program. A summary of pre-workshop learning goals included the following:

- Communication strategies
- Team approaches
- Recognition and modification of triggers
- Redirection techniques
- Appropriate body containment techniques

In addition participants listed several learning needs that were not explicit parts of the GPA curriculum, for example, understanding the meaning behind sexual behaviour, interpretation and response strategies to repetitive vocalizations, and strategies for bathing and managing personal care.

Summary of Post-Training Focus Groups

Participants were able to identify and articulate the immediate learning outcomes as a result of participating in the GPA training program. Four general themes were identified from the recorded data related to the post-training focus groups, and were common to each of the seven curriculum sites. These were: Knowledge Acquisition (Building from Ground Zero), Interpersonal Strategies (Dialogue is the Key), Physical Techniques (In the Context of the Person), and Hopefulness.

Knowledge Acquisition (Building from Ground Zero)

Participants stated that they had little prior knowledge of the impact of specific areas of brain damage common in dementias that can impact on human behaviour prior to participating in the GPA Curriculum. Participants identified that this new understanding helped them interpret behaviours within the human context and regard their residents' behavioural expressions with greater tolerance. In particular, participants stated that they had new understanding of concepts such as agnosia, apraxia, and perceptual deficits and how these might contribute to behavioural episodes. Participants also stated that they felt better prepared to recognize, identify and correspondingly modify those environmental and interpersonal triggers that might result in a catastrophic reaction on the part of the resident. In addition, participants stated that they acquired an expanded knowledge of concepts related to personhood and person-centred care, and seeking out the meaning behind behavioural expressions within the context of the life history and past relationships. It is alarming, but not surprising that the front-line staff had such little prior

knowledge about the brain etiologies and triggers behind responsive behaviour, particularly of a more catastrophic nature.

Interpersonal Strategies (Dialogue is the Key)

Participants stated that they appreciated expanding their skill set with regard to communication strategies that could prove useful in de-escalating behaviours. They stated that they had not known about interpersonal acknowledgement strategies such as validation therapy that might contribute to the resident being more deeply understood.

Participants also stated that they had expanded their capacity to use verbal strategies that involved redirection, distraction, matching the desired pace of the resident, slowing the pace of an interaction, and strategically stopping an intervention to allow the resident to regain self-control. In particular, participants mentioned their new understanding of concepts such as interpersonal space, making multiple references to a key curriculum concept referred to as “Stop and Go”.

In addition, participants mentioned that they had new confidence in the use of team members to assist with managing a catastrophic episode. In the context of the training, participants learned that each team member involved in an episode should be assigned a specific supportive and well-defined role to play, a new concept for most participants. Participants stated that they anticipated they would feel more comfortable asking for help once back in the workplace, whereas in the past they had often felt that asking for help was admitting failure or might be perceived by colleagues as an indication of incompetence. Participants also gained a new appreciation for team debriefing after an episode to review the success of the intervention and discuss alternative plans to be implemented in the case of a recurrent behavioural episode.

Physical Techniques (In the Context of the Person)

Participants who commented during post-training focus groups all indicated that they had an increased body of technical knowledge upon which to draw in the event of a physically catastrophic episode involving a single resident or a group of residents. Participants mentioned several of the body containment strategies taught during the program, expressing satisfaction that these were practical, reasonable and respectful. Participants indicated that they believed these would be effective back in the workplace. In particular, participants expressed interest in the ways the techniques could be applied to such situations as residents seated in wheelchairs who were expressing a catastrophic reaction, those who were brandishing canes or walkers, and those persons who were actively engaged in exit-seeking behaviours such as using a walker to push against a closed door. Of greatest significance, however, was that participants stressed a key curriculum concept related to the positive power of engaging the resident in a supportive relationship and learning about the resident's past life history so that these could be drawn upon to help de-escalate the resident during high-end responsive episodes of a catastrophic nature. Clearly they understood that the body containment techniques would not be useful in isolation of the interpersonal approach.

Hopefulness

Overall, participants expressed hope that the knowledge gained from this program would enhance their capacity to perform their jobs. Participants were hopeful that the body containment techniques would prove effective back in the workplace.

Open-Ended Tool for Curriculum Participants at Six-Week Follow-up

Participants were asked to respond to questions related to their utilization of the body containment techniques taught during the GPA program at a six-week interval post-training. Respondents indicated that they had had occasion to use

some of the techniques taught during training with positive effect. In particular the respondents indicated that they had used the "strolling escort" technique to bring residents away from a point of altercation or during an episode of agitated exit-seeking. Some participants indicated that they were very pleased with how effective this technique could be in other clinical applications. As one participant wrote,

> ***I use the technique every time I walk a resident. It gives support and control when you are transferring them from chair to bed, etc. But in a behavioural way I have not had to use the techniques yet. But I have the techniques if I need them.***

Participants also reported using the reflex release technique appropriate during situations where a resident had grabbed onto either a body part or bedrails when agitated during personal care. As one of the participants indicated,

> ***I have a resident, a big man who is so protective of his private parts that when you start to do personal care for him he becomes so upset. There were instances when I was doing personal care, he quickly grabbed my hand and held it tight. At that point I just let my arm go limp and tell him please let go…then I gently tap the back of his hand. Sometimes that works, but sometimes he won't listen and holds tighter, so I do the reflex grab by gently handling the resident's thumb just between my thumb and forefinger and gently opening it back off my hand or sometimes my wrist.***

None of the respondents at the six week period indicated that they had used the team techniques in response to episodes of resident behaviour. Those individual techniques that were applied were reported to be successful and effective for the most part. As one respondent indicated, ***"[The techniques] were so effective that I feel confident now dealing with aggressive residents."*** Another respondent wrote, ***"[The techniques] were extremely useful, gives you a sense***

of self control as well as protecting yourself and the resident." Another respondent indicated that there are positive outcomes for both residents and staff with the use of these techniques. ***"Yes, with the techniques it was quicker to get the resident to release their hand-rail and also release the clothing. And less stress for both of us."***

Findings from Semi-Structured Interviews with Key Informants

Overall key informants were very pleased with the GPA curriculum, stating that they supported the day-long workshop format, multi-media approach, team teaching support and class size. Key informants also stated that they were pleased with the quality of the workshop handout materials.

Transcribed interviews were subjected to thematic content analysis to identify recurring themes. Themes that emerged in relation to perceived benefits of participating in the program were: Knowledge Building, Confidence Building, Team Building, Skill Building, Relationship Building and Philosophical Reinforcement. Identified issues related to the curriculum included: Systems Barriers (time, staffing), and Wish List (more classes, f/u from PRC).

Knowledge building

One participant stated that some of the knowledge pieces acquired as a result of staff training were actually an affirmation of prior intuitive practice. For example, staff would often "back off" from a resident, but would have no theoretical knowledge behind why this might be an effective strategy. The participant explained,

> ***A lot of staff had mentioned the "Stop and Go" approach. It's something that they already did do. Some did. Some did more than others. Some did more effectively than others. At least now they understand why it works. Why the way you stand, the way***

> ***you talk, the tone of your voice, your posture, your approach and everything.***

Confidence building

Key informants were pleased with the manner in which GPA Curriculum training assisted staff participants to develop confidence in situations involving residents who were difficult for staff to manage. It also enhanced staff capacity to act because they had confidence that they would be using techniques supported by management. One stated,

> ***It just gave everybody a sense of security. That we're dealing with…That we have the knowledge to deal with the situations and the staff have the security in knowing that they're doing the appropriate thing.***

Skill building

One key informant expressed support for the way the GPA Curriculum helped staff in the organization respond positively and effectively to those residents who are agitated in their exit-seeking. She stated,

> ***One thing I know that they use often is the door. You know, when somebody's at the door – how to move them away from the door without causing too much commotion and just bringing them along and walking with them down the hallways. I think that's the most thing that they've used.***

Another key informant reported that participation in the GPA curriculum brought immediate results in relation to enhanced skills. She stated,

The participants learned good techniques on how to handle a resident who is aggressive. I had a couple of staff who probably within twenty-four hours of their session actually used it. They were successful with it, and the word spread very quickly.

Team building

A key informant stated that as a result of the training program staff were participating actively in post-episode debriefing sessions to review approaches and make suggestions for improvements to the plan of care. She explained,

And if anything does happen on the floor, that they need to use any of these approaches, we do sort of have a debriefing sort of session. Cause it could be stressful and it could be…you know, they might just need to sort of discuss what they did wrong or what they could have done better. So that's in place as well.

Another key informant gave evidence that suggested that participants of the curriculum were more likely to engage in group problem-solving and share information about successful strategies. For example,

The other support too is their communication. Instead of saying: "We need to get the resident to do this", they're actually now saying: "How did we do it last time".

One of the key informants emphasized how pleased she was with the trans-disciplinary approach to the curriculum. She stated,

Again a team work thing, because we did have people from all departments attend…Housekeeping, laundry, managers, office staff, health care aides, and RNs attended. And I think it was just

> ***a team work approach that getting people to understand that they could all learn more and that they were all part of the process together.***

Strengthening the team meant that staff felt more conformable asking for help, particularly when they had reached their personal limit. One key informant explained this as follows:

> ***I think staff learned to work better with each other in something like that as a team. You know, not being afraid to ask: "Can you help me here?" Or: "Can you just take over? I can't take anymore of this." You know: "I can't handle it." That type of thing.***

Another key informant reinforced this idea,

> ***Actually they're coming to me to talk about if they're having a particularly tough time with a resident. And we talk about alternatives. You know, how we can get around that, that'll work both for the resident and for the staff members. They're sharing information amongst themselves. I've seen specific examples of, you know, when a staff person is saying: "I can't get Mrs X to let us give her a bath". Another staff person will share: "If you do it in this order…." So I've just seen sharing information more.***

Relationship Building

Key informants felt that offering their staff participation in the GPA program went a long way to build positive relationships between front-line workers and management. They stated that the discussion and dialogue opportunities embedded in the training helped staff perceive that "somebody's actually listening to them."

Before training any exploration questions offered by management to assess an episode were seen as criticisms by front-line staff, leading to antagonist relationships between front-line staff and management. As one participant indicated,

> ***See, a long time ago there used to be, management used to say: What was your approach? And staff used to take offence to that, because they would say: I didn't do anything. So they didn't realize what they meant by: What was your approach. They took it saying: I did something wrong. No, you didn't. So now they understand what we meant by approach.***

Another key informant who was a member of senior management identified that participation in the GPA program had facilitated stronger and more positive relationships between front-line staff and management. She stated,

> ***I think that the staff just know that knowing that each other have attended, are supporting each other out there on the floor with ideas, and they come to me and present things to me and ask me if I think that they're on the right track.***

Philosophical Reinforcement

One participant expressed satisfaction that the GPA curriculum reinforced the general philosophical principles behind the facility's care delivery model. She stated,

> ***And management is supportive of this. Do it another day. Find a different way. Decrease agitation, increase activities, and hopefully decrease medication. And quality of life will be increased…Make them aware of this is how we plan on doing things. That they are people and we must remember that – that they be treated as such.***

Systems Barriers

Despite seeing the GPA curriculum as being positive for both staff and management, the key informants also identified two systemic barriers to adopting the approach outlined in the curriculum.

Leadership and Enrollment in the Vision Issues

In some instances key informants made statements suggestive of a pervasive sense of powerlessness, particularly those who were middle managers. As one conflicted participant indicated,

> ***And there's basically a conflict on the floor between the client and between staff…So what I was hoping for this whole thing to come out would be that…that conflict would be resolved…And that's the only way to go about it. I can't tell them what to do anymore…They're not children. They're grown adults. I can't tell them. They have to see it. They have to believe it. And that's it.***

This anecdote has implications for leadership structure and vision-building within the organization.

Support Structure Issues

In addition, participants identified some of the structural barriers faced in trying to use some of the techniques taught during the curriculum. Some facilities, for example, had few, if any, activities in which to redirect residents who were becoming agitated.

> ***[There's] nothing that's going to keep their interest for a long period of time, or enough time so that they forget what they were…had to be redirected from. So to redirect you need tools, you need something to redirect to. You can't just grab 'em and***

> ***turn 'em around the opposite way. "Won't you walk this way for a while?" Because that's exactly what they're doing for the last three hours --- walking around in a circle. They've got themselves stuck in a corner or somebody else's room, sits down in a chair because they're tired. There's no other chairs around other than what's in front of the nurses' station, which is three or four of them, which is crowded with wheelchairs, or the dining room, which is being washed and they can't go in. So residents walking around have no place to sit down. There's no sitting lounge. There's no community centre. There's no social area.***

Wish List

Key informants mentioned that they would anticipate the greatest impact of the program when all members of the interdisciplinary team were trained at the same knowledge and skill level. In addition, participants mentioned the perpetual challenge of replacing staff so that they could participate in a full-day session. All participants stated that the full-day curriculum was essential and that breaking the modules up into smaller educational sessions would not be as effective. In addition, key informants stated that they would like to see opportunities for the PRC Master Instructors to work with the in-house champion to strengthen direct application of the learned skills in clinical situations. Some key informants suggested that under the guidance of the PRC Master Instructor, the in-house champion could hold "booster" sessions that would assist front-line workers in maintaining competencies. As one key informant stated,

> ***I think the physical things were very informative, but I also think that if you don't practice them they're lost. And it's almost like you have to have a process in place where, you know, you would be saying to people, "Let's practice. Let's practice." And in long***

term care it just seems like everybody is so busy. So that maybe that component of it falls away.

Findings from Open-Ended Feed-Back Tool for Master Trainers

Master trainers indicated that they felt well-prepared to deliver the content. Some respondents requested that a video that would refresh them on the specific motor competencies taught in Module 4 be made available. Feedback indicated that the content of the curriculum was easy to deliver and was well organized. Overall, feedback indicated that the Facilitator Manual was a useful document that provided structure to the classroom delivery. Several trainers made specific suggestions for improvements to the format of the manual so that it would be more user-friendly. For example, they recommended the use of icons to indicate use of supportive videotape materials, and they identified places in the Modules where material could be condensed because it was repetitious. In addition, several trainers commented that the key curriculum concepts embedded in the first three Modules was familiar to the degree that they felt comfortable with making slight adjustments to accommodate more discussion from classroom participants.

Respondents all reported that the motor skills in the Fourth Module were practical, tangible techniques that were relatively easy for classroom participants to master at an introductory level of competency. Respondents reported that they would provide follow-up to the curriculum sites after the evaluation of the program was complete. Trainers also recommended that the classroom participants be provided with an opportunity to review and practice the motor competencies taught in the Fourth Module on a regular basis.

Trainers indicated that they enjoyed delivering the program and looked forward to disseminating it to other long term care facilities. Respondents reported that the facial expressions, body language, questions, and level of engagement of classroom participants suggested that it was a well-received program. The trainers also indicated that the curriculum reinforced the concepts of team work and collaborative practice.

Feedback received also supports the team teaching approach used for this project. Respondents indicated that it was helpful and supportive to have a co-facilitator present, particularly during the floor exercises in Modules 3 and 4. The majority of trainers indicated that the class size should remain at a maximum of ten to twelve participants in order to maintain control over the proceedings and provide a high coaching level during the Fourth Module. Overall, feedback on the videotapes currently used to support key curriculum points was positive. However, several respondents made suggestions for improvements to the video materials; for example, they recommended the creation of a compilation video that would streamline use of this medium in the classroom.

CONCLUSION

In the Ontario Dementia Caregiver Needs Project, conducted to address Initiative #6 of the Ontario Alzheimer Strategy, caregivers of persons with dementia emphasized their concerns regarding the lack of dementia specific knowledge and training that staff working with persons with dementia appeared to have(Dupuis & Smale, 2004). The caregivers identified a number of specific care provider groups who needed specialized training and education in dementia and dementia care and especially highlighted the need for training targeted at front-line staff working in both acute care and long-term care settings (Dupuis & Smale, 2004). The Gentle Persuasive Approach Curriculum addresses the concerns expressed by dementia caregivers and provides a much needed program to ensure that staff have the knowledge base and skills necessary to respond appropriately and respectfully to responsive behaviours.

Those attending the workshop demonstrated enhanced competencies related to the specific skills taught in the course. The results of this evaluation project support that a curriculum designed to teach response techniques within a person-centred context assist staff participants to transfer this knowledge to direct care episodes back in the workplace as evidenced by self-reported utilization.

IMPLICATIONS FOR EDUCATION, RESEARCH, BEST PRACTICE GUIDELINES

The results of this GPA project suggest that this curriculum may be an effective training program, increasing staff members' understanding of person-centred care and the need-based nature of responsive behaviours as well as increasing staff's self-perceived competency to respond to specific behaviours. Nonetheless, several suggestions were made throughout the project to strengthen or support the curriculum even more. These include:

- developing a stronger linkage between the PRCs and in-house champions,
- providing "booster" sessions for staff to assist front-line workers in maintaining competencies learned during the curriculum,
- incorporating curriculum components into core training for personal support workers, and
- developing strong teaching partnerships between Mental Health Outreach case managers, psychogeriatric resource consultants, the Alzheimer Society Chapter public education coordinators, and others involved in teaching on dementia and dementia care (e.g., MAREP).

This curriculum was initially piloted within Central South and Central West Ontario and was designed primarily for staff working in long term care settings. The success of the curriculum suggests that many more staff groups and settings could benefit from the program. The curriculum has implications for:

- Psychogeriatric Resource Consultants across the province who may be able to use this curriculum in their smaller communities.
- A number of health care sectors where services are offered to the frail older adults, particularly those with cognitive impairment. For example, with

modifications, the GPA curriculum has clinical application in Adult Day Programs, Inpatient Geriatric Assessment Units, Inpatient acute care medical units and Inpatient Psychogeriatric Assessment Units.

- Volunteers working with persons living with dementia.

- Partners in care (family members of persons living with dementia).

Areas for curriculum expansion were also identified by the participants in the GPA program such as:

- responding to episodes of sexual disinhibition,

- creative activities strategies.

- responding to repetitive vocalizations, and

- training in leadership, coaching and mentoring.

PLANS FOR DISSEMINATION

Provincial Training

A subgroup of the GPA Steering Committee has been developing a process for implementation of the evidence-based training program throughout the province of Ontario. The original trainers involved in the pilot evaluation were certified as Coaches in June 2005. They have now begun to teach additional classes in their designated long term care facilities. The first certification classes for Psychogeriatric Resource Consultants, Public Education Coordinators, Outreach Team Case Managers and Long term Care Facility based educators will begin in the Fall of 2005. At the completion of the two-day training program, the participants will be able to teach the curriculum to front-line staff in their own region. At the time of this report, the classes that have been scheduled are full. The GPA Implementation

team plan to roll-out the training classes four times a year. It is the intent to market the certification classes to all areas of the province and beyond. The GPA curriculum is copyrighted, and a trademark is pending. The Hamilton Continuing Gerontological Education Cooperative hold the copyright and trademark. A cost for registration for the certification classes has been based on cost recovery. In the near future, the GPA Steering Committee will look at adapting the cost in order to provide some additional operational budget to the CGEC, however, the intent is to make the program affordable.

Sustainability

The goal of the GPA Steering Committee is to ensure that the GPA training is a sustainable program that is transferred to practice at the bedside. Toward that end, a partnership has been struck between the GPA project team and the Health Care Health and Safety Association of Ontario, in order to begin lobbying efforts to the Ministry of Health and Long-term Care so that the costs of staff release time might be subsidized in some way. A document describing the GPA program and its potential benefits has been released to the MOHLTC, OLTCA, and OANHHS.

Conferences

The GPA program and the results of the project have been presented at the Annual OPGA spring workshop, May 2005, and the OLTCA annual spring retreat, June 2005. The participants at these events were very interested in the program and are intent on pursuing this for their own organizations. In addition, the results from this project have been submitted and accepted for presentation at two peer-reviewed conferences. These are the 34th Annual Scientific and Educational Meeting of the Canadian Association on Gerontology, October 21, 2005, Halifax, Nova Scotia; and the 12th Annual Nursing Research Day, McMaster University School of Nursing, October 13, 2005, Hamilton, Ontario. An abstract will also be submitted to the Alzheimer Society of Canada's annual conference in 2006. A publishable paper will also be prepared and submitted to a peer-reviewed journal by December 2005.

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