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► Targeted Interdisciplinary Model for Evaluation and Treatment of neuropsychiatric symptoms

Manual, 2nd edition



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1. Preface to the 2nd edition

Behavioural and psychological symptoms of dementia, also labelled neuropsychiatric symptoms, are an integrated part of the dementia syndrome, and affect most people with dementia during the course of the disease (1, 2). These symptoms present challenges for the patients themselves, their relatives, and the staff caring for them. The first edition of the TIME-manual was published in 2012 as a support for the model, which aims to respond to these challenges in practice (3). Since then, the TIME-manual has been used in a variety of connections, equally for patients suffering from dementia in hospitals and in nursing homes, for community dwelling patients with dementia, and for patients without dementia, but with other psychiatric disorders. With regard to clinical practice, TIME has proved to be an assessment and a reflection model with a wide range of applications. There was, therefore, a need to revise the manual in order to be in accordance with the way that it is used in practice.

TIME is based on theories and principles both from person-centred care and from cognitive behavioural therapy. There is a general agreement that the causes of the behavioural and psychological symptoms in dementia and in most other serious psychiatric conditions are multifactorial. This means that these causes can be biological, psychological and social, and that they can interact with each other. In addition, it needs to be emphasised that particularly behavioural symptoms often occur and are maintained in situations in which patients are interacting with others (4, 5). This relationship perspective in connection with human behaviour is crucial to understand the behaviour. This again means that any assessments and interventions need to have a broad basis and embrace all these aspects. Only then can the measures that are taken have a chance of succeeding, and at the same time, ensure that these measures are tailor-made for each individual person (5). TIME is, therefore, characterised as a biopsychosocial intervention model that aims to integrate both pharmacological and milieu-therapeutic approaches, which are easily adapted to the field of practice. TIME represents a thorough assessment and analysis and is a roadmap for treatment

measures. TIME is interdisciplinary and comprise the entire group of staff members caring for the patient, as it is precisely the health worker and nurse out in practice who spend the most time together with the patients. They are the ones who provide milieu-therapy around the clock.

TIME consists of three phases that partly overlap. In this 2nd edition of the manual, the first phase is now labelled as the registration and assessment phase. The second phase, previously called the guiding phase, is now called the guided reflection phase, and the guiding meeting is now the guided reflection meeting (case conference). The third and last phase is now called the action and evaluation phase. The components of the phases are mainly the same as before, but the names are more in accordance with what happens in each phase and with the international terminology for comparable approaches to neuropsychiatric symptoms. The manual uses the term behavioural and psychological symptoms synonymously with neuropsychiatric symptoms. The registration and assessment phase is expanded in that we recommend that an assessment of symptoms of depression is executed. This is included because clinical experience and research show that depression can be difficult to detect (6). In addition, we now recommend a broader assessment of behavioural and psychological symptoms by using the unabridged NPI (The Neuropsychiatric Inventory, Nursing Home version) as a part of the assessment (7). A new form for the registration of the behaviour and the symptoms for use with community dwelling patients is also enclosed.

It is emphasised that the personal history of the patient should also include his or her present resources, and that gathering this information is an important angle of approach in order to closely cooperate with the relatives. In addition to the section on how to use principles from cognitive behavioural therapy in the model, a passage has been added explaining how to use the principles of person-centred care in practice. TIME is also discussed in relation to other milieu-therapeutic approaches. Two tables with overviews of the components in the registration and assessment phase and the guided reflection

meeting have been added so that the reader can follow these without having to read the entire section. The colour-codes used in the NPI 24-hour daily records forms have been changed to agree with current norms.

TIME was developed in the field of practice at Tjærahågen Nursing Home in the municipality of Rana. It is based on several years' work with residents who have dementia and additional symptoms that have created major challenges (6). The model was further developed at the Centre for Old Age Psychiatric Research and the Department of Old Age Psychiatry, Innlandet Hospital Trust. The model is easy to learn and easy to integrate in clinical practice. TIME provides a complete and unified approach both to the assessment and the measures taken. We have experienced that a systematic use of the model has helped our patients, and has also helped the staff to relate to the challenges appropriately. In cooperation with the Centre for Old Age Psychiatric Research, Innlandet Hospital Trust, we carried out an open non-controlled pilot study over a period of six months in 2010-2011 in nine nursing homes, in which we included 30 patients with severe degrees of agitation. The study, and focus group interviews of the staff involved, showed that TIME is a solid clinical and interdisciplinary model that can easily be implemented in nursing homes: the pilot study showed a significant improvement in patient agitation and a significant reduction in the strain on the staff. The study is published as an abstract in *International Psychogeriatrics*, volume 23, supplement 1, September 2011 (see enclosure) (8).

The TIME manual is a short and practical aid to carrying out TIME. It gives a step-by-step description of how to implement the intervention model. Since the previous edition of the manual, a teaching film has been produced to illustrate the features of the model and especially how to carry out the guided reflection meeting (the case conference) (9). You will find a link to the film in the back of the manual. Those who are going to use the TIME model should have thorough knowledge about dementia with special emphasis on the behavioural and psychological symptoms of dementia. The persons in the staff who are going to lead the work of carrying out the TIME model in nursing homes and chair the case conference meeting should have received special training in the principles of the model.

The project has received economic support from: The Norwegian Medical Association Fund for Quality and Patient Safety, the Municipality of Rana, the Centre of Old Age Psychiatric Research at the Innlandet Hospital Trust, Innlandet Hospital Trust, and the Norwegian Centre of Rural Medicine at The Arctic University of Norway, Tromsø (UiT).

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"There is nothing either good or bad, but thinking makes it so." *Hamlet, Shakespeare*

2. TIME – an intervention in three phases - overview

TIME is a systematic tool that the staff, working with the nursing home physician, use to assess and treat behavioural and psychological symptoms of people suffering from dementia or other complex disorders. These symptoms are also called neuropsychiatric symptoms or sometimes challenging behaviour. The intervention is based on principles and structures from cognitive behavioural therapy and from person-centred care (10, 11). The aim is to customize measures for the individual patient.

The execution out of this intervention consists of three phases that may overlap:

- The **Registration and Assessment Phase** includes an examination of the patient, which consists of obtaining her previous medical records, background information, and assessment of symptoms. Behaviour and symptoms are registered in detailed 24-hour daily records.
- The **Guided Reflection Phase**, in which one or more case conferences are conducted for the entire group of staff. Thorough systematic reflection based on cognitive therapeutic principles measures are customized for the individual patient. The situation is discussed using the cognitive problem-solving method, during which one problem at a time is analyzed (12). This is done systematically with the help of the five-column sheet technique in order to consider the following five aspects (12):
 - Assessed facts
 - Interpretation
 - Staff members' emotions (reactions)
 - Action to take
 - Evaluation
- The **Action and Evaluation Phase**, in which the measures agreed on in the case conference are implemented and evaluated.

When a patient shows symptoms or behaviour that are deemed challenging, the registration and assessment phase is initiated. This phase is described in detail in Section 5 in the manual. This phase can last from one day to three or four weeks, depending on how much time is available to observe the patient without making use of systematic measures.

The guided reflection meeting (case conference) is scheduled for a date when most of the staff can get together after the patient has been sufficiently assessed. In addition, certain information must be gathered about the patient prior to this meeting, including observations, registration, and the challenges involved in working with her. This meeting is described in Section 7.

The action and evaluation phase occurs after the case conference meeting, during which the suggested measures are tested out and evaluated. In the case conference meeting, there should be a set point of time for the evaluation and agreement as to how the evaluation should be executed. In practice, we continue using the same detailed 24-hour daily record as prior to the case conference, and repeat some of the assessment scales used during the registration and assessment phase. See Section 8 for a description of this phase.

3. When do we use TIME? Which patients is the model suited for?

In clinical practice, we use the model when we are working with patients who, because of behavioural or psychological symptoms, create major challenges for themselves, their relatives, other patients, or the staff. Normally, the model is used when a high level of agitation, aggression, or psychotic symptoms is experienced, or when the staff feel that their interventions are falling short in the daily tasks. If measures are taken that can easily solve the challenge, and the situation does not require a thorough assessment, we do not use the model systematically. If, for example, the patient is obviously suffering from depression and we find measures that seem to have an effect, it is not necessary to use the model fully.

If the staff are well trained in the model and this way to perceive and understand behavioural and psychological symptoms, elements of the model can be used on a smaller scale for daily routines, shorter meetings, physician's visits, and more informal discussions about the patient. The model can also be used for regular supervision of staff in dementia wards, hospital wards, and at-home visits.

4. Target symptoms: agreeing on what the challenges are – use of the NPI-NH

Before starting to register behavioural and psychological symptoms, it is vital that the staff agree on which behaviour or psychological symptoms create a challenge. This is done by the head nurse along with other staff members who best know the patient's symptoms and behaviour. They decide which symptoms and behaviour are to be observed and registered. We recommend using detailed categories as described in the NPI- NH (Neuropsychiatric Inventory, Nursing Home version), but for this purpose, only the sections that are relevant for this particular patient's behaviour or symptoms (7). This will give precise terms and descriptions of the symptoms one is treating, and ensures that everyone knows what needs to be registered at any given time.

If the behaviour and symptoms have many different characteristics, in order not to lose the overall picture, it is necessary to select a maximum of four that are needed for registration. In addition, we always register hours of sleep obtained in the 24-hour daily record, since this is important for the assessment and has important consequences for the rest of the ward.

5. The registration and assessment phase

Observation of the facts

– 24-hour observation form

When the staff and, possibly, the relatives have agreed on the symptoms to be focussed on, the registration and observation assessments can begin. This is performed daily with the help of a form using colour codes corresponding to particular symptoms or behaviour. An example of the 24-hour daily observation form and the colour coded form based on the NPI-NH (Neuropsychiatric Inventory Nursing Home version) is enclosed in this manual (7, 13). Regarding patients living at home, a separate form has been enclosed for use during home visits in order to register important behavioural and psychological symptoms.

Registration of other behavioural and psychological (neuropsychiatric) symptoms

In addition to the symptoms that are followed on the observation form, we recommend that a complete registration of other possible neuropsychiatric symptoms should be made using the NPI-NH, as a scale. Usually patients have several symptoms at the same time, and it may be useful in this phase to form a picture of the frequency and intensity of these symptoms. In this manner, we are less likely to overlook symptoms. If this process is carried out before treatment measures are started, the NPI-NH can also be used to evaluate the effects of the measures taken.

Registration of symptoms of depression

Depression can sometimes be an underlying cause of behavioural and psychological symptoms. It is, therefore, especially important to have a thorough registration of depressive symptoms. We recommend using The Cornell Scale for Depression in Dementia (CSDD) for patients with dementia and the Montgomery Aasberg Depression Rating Scale (MADRS) for patients who do not have dementia (6, 14).

Somatic examination

The assessment phase includes a report on the patient's somatic and mental health executed by the patient's physician. This should be done as soon as is practically possible, and involves an ordinary clinical examination of the patient focusing on possible causes of the behavioural and psychological symptoms.

Review of medication

The patient's physician should carry out a critical review of the patient's medication, with special emphasis on the side effects that can cause or contribute to the behavioural or target symptoms. When justifiable and feasible, the dosage in such cases should be reduced, or the medication completely stopped.

Assessment of pain

Pain is a common cause of neuropsychiatric symptoms. In connection with the patient's somatic assessment, there should also be a clinical appraisal of whether the patient has untreated pain, which can cause some of these symptoms. A thorough review and pain-relieving measures should be put into effect if this is suspected. For this assessment, it may be appropriate to use a clinical instrument such as the Mobilisation-Observation-Behaviour-Intensity-Dementia scale (MOBID-2) (15), as the pain assessment can be done in connection with bedside washing and dressing routines.

Degree of dementia

If there is a suspicion of dementia, then the degree of dementia should be assessed using, for example, the Mini Mental State Examination (MMSE), or the CDR (Clinical Dementia Rating scale) executed by a nurse in the ward (16, 17).

Activity of daily life (ADL) assessment

The patient's functional level in daily life is assessed with the help of, for example, the Barthel-ADL index or the Physical Self-Maintenance Scale (PSMS), carried out by staff who best know the patient (18, 19). By having a thorough review of the real functioning level, one can avoid both underestimating or overestimating the patient's ability to function. Both extremes can cause and perpetuate neuropsychiatric symptoms.

Personal background history – and the patient's resources

Recording the patient's background history, resources, and preferences is done by the primary contact person, who interviews the patient or her closest relatives. This interview is a good starting point for further cooperation with the relatives. They can often provide information about possible causes of the behavioural and psychological symptoms, and discuss which measures previously have had a positive effect. There are various forms which can be useful for this purpose. One example is "The History of My Life", which can be downloaded from www.aldringoghelse.no.

TABLE 1: Checklist for the registration and assessment phase of TIME

Checklist for the registration and assessment phase of TIME		
ACTIVITY	Target symptoms: Agree upon the main challenges for the patient – use the Neuropsychiatric Inventory- Nursing Home Version (NPI-NH) to define precise target symptoms for the assessment.	
	Observation of the target symptoms – using a 24-hour observation form	Staff
	NPI-NH to assess other neuropsychiatric symptoms	Staff
	Cornell Scale of Depression in Dementia (CSDD) or another scale to assess possible symptoms of depression	Staff
	Physical assessment	Nursing home physician
	Review of medication	Nursing home physician
	Mobilisation-Observation-Behaviour-Intensity-Dementia scale (MOBID-2) to assess possible pain	Staff Nursing home physician
	The Clinical Dementia Rating scale (CDR) and/or the Mini Mental Status Examination (MMSE) to assess degree of dementia	Staff Nursing home physician
	The Physical Self-Maintenance Scale scale to assess activities in daily life	Staff
	The resident's life history, including preferences and resources using an appropriate questionnaire	Staff interview the resident, if possible, and/or the next of kin
Make an appointment for the date, time, and place for the case conference	Staff/TIME-administrator	
		RESPONSIBLE

6. Treatment during the registration and assessment phase

Sometimes it will be necessary to initiate treatment measures early in the registration and assessment phase out of consideration for the patient and the challenges faced by the staff. It is vital that these measures are registered and noted in the 24-hour observation form. However, we recommend that medication for challenging behaviour

should be postponed until after the registration phase has been completed. This is desirable both to get a full basis for decisions on medicinal treatment, and to ensure that non-pharmacological treatment is attempted first. The exception is pain-relieving treatment, as mentioned about assessment of pain in section 5 in this manual.

7. The case conference (guided reflection meeting)

The next phase in the intervention model consists of one or more case conferences. One or two hours should be set aside in order to get together as many of the staff members involved as possible. This means that the leading ward nurse should hire extra nurses to make up for the absences. Those who are free from their work timetable will also be asked to attend the case conference. This is the largest single expense in the model. It will be necessary to have a meeting room that is large enough for everybody, with a whiteboard and flip chart available. The meeting will, therefore, demand some preparation and must be announced in advance. It is possible to have a shorter meeting with fewer participants that still follows the main structure. This can be called when there is an urgent need to take action, have shorter morning meetings, conduct pure evaluation meetings, and so on.

For patients living at home, it will be necessary to have meetings with the staff members who are working at home care with the patient, and with the general practitioner, when possible. Sometimes, it may be desirable to have relatives present at these meetings, but not always. One

needs to have a pragmatic approach that takes consideration of everybody involved. Participation may vary from meeting to meeting, depending on upcoming goals and existing possibilities. Nevertheless, the main structure of the meeting can still be followed. Relatives can be given brief instructions at the beginning of the meeting in order to understand the column sheet technique.

The case conference follows a set structure inspired by consultations in cognitive behavioural therapy. You can find an overview of this meeting in Figure 2 at the end of this section. A more detailed description of the connection between TIME and principles of cognitive behavioural therapy can be found in section 9 in this manual. A fixed structure creates a feeling of security and ensures that the meeting is more than just an affirmation of how difficult and challenging the situation is. The aim is to reach a mutual and helpful understanding of the situation, agree on what measures should be taken in light of this understanding, and implement them in the next phase to relieve the burden for the patient and the staff.

Structure for the case conference:

(see table 2)

1. Status report – medical history – personal history are presented (maximum 10-15 minutes)
2. Make a list of problems (everybody contributes, maximum 10 minutes)
3. Prioritise problems from the list (maximum 10 minutes for point 2 and 3)
4. Make a five-column sheet: facts – interpretation – emotions – action to take – evaluation
5. Describe the facts – from the assessment phase: one problem at a time to be discussed in points 5-9
6. Suggest interpretations – use guided discovery – discuss/weigh up the interpretations
7. Describe possible emotions/reactions felt by staff and how they interpret these feelings
8. Suggest measures – based on interpretations, evaluation methods, and evaluation point of time for each measure
9. Sum up interpretations and measures – and the point of time for evaluation (5-10 minutes)

For points 4, 5, 6, 7, and 8, you need to set aside about 60 minutes. It is important to keep to the time frame in order to properly address all the points in the meeting and the challenges involved.

Ideally, two members of the staff should lead the meeting, as one person is needed to manage the meeting and another to take care of the whiteboard and flip chart. In addition, one member of the staff should write the minutes of the meeting. The leaders of the meeting should have received training in the model, but there is no requirement for them to have special education in cognitive behavioural therapy, since only the principles of this therapy form the basis for

the model. However, the leaders must comfortably distinguish between the cognitive concepts: situation (i.e. what are the measurable facts), thoughts (interpretations), behaviour and emotions, and the cognitive model's understanding of the relationship between them. See Section 9 in the manual for a more detailed description of this.

Status report

The meeting starts with a short summary of what we know about the patient. The personal history is presented with emphasis on the patient's preferences and resources. Then, there is a short presentation of the dementia disease and, if relevant, other serious disorders, functioning level, and somatic and psychic health. As this requires some preparation, the presenter needs to be determined prior to the meeting. The presenter needs to bring the patient's medical record and other documentation from the assessment phase to the meeting. No more than 10-15 minutes should be used for this status report.

List of problems - prioritising them

A list of problems is put up on the whiteboard or flip chart. Staff are free to suggest what they feel is important for them, but as a rule, the behaviour or symptoms listed in the registration and assessment phase will be most relevant. The leader of the meeting must try to concretise the problems together with the staff in order to represent measurable objective symptoms or behaviour, and not just interpretations or measures that concern the symptoms. For example, a problem with the patient refusing to be washed might be mentioned. This should be redefined as difficulties with the patient's personal hygiene. In this manner, the facts are described around the need for hygiene, which may lead to an open discussion about the seriousness of the issue for the patient. The leader then asks the staff themselves to prioritize the points on the problem list, and what is necessary to discuss during the course of the meeting. As a rule, a meeting manages to deal with one to two problems. As the challenges are connected to each other, this is often sufficient.

Column technique – guided discovery

From the problem list, one problem at a time is discussed

using the cognitive column technique. Five columns are drawn on the whiteboard/flip chart: 1. Situation/facts 2. Thoughts/interpretation 3. Emotions (of the staff) 4. Action to take 5. Evaluation. The staff discusses these aspects of the problem that has been chosen. The facts are usually what has been assessed earlier in the registration and assessment phase; otherwise, we must reconstruct them during the meeting.

Turning then to the column for interpretations, the leaders invite the staff, in an open and encouraging way, to give their interpretations by using open questions and a non-judgemental attitude. This is called guided discovery (20). The reasons for the different interpretations are discussed, including the likelihood that a given interpretation is appropriate and will help the patient. If at this stage, someone suggests an action to take, this idea should be recorded in the appropriate column to be discussed when the interpretations are complete.

In the column for emotions, the emotional reactions of the staff caused by challenging behaviour are described. This helps the staff to realize that feelings such as sadness, helplessness, fear, anger, and irritability are normal, and that these emotions can affect their interactions with the patient. By accepting this, one can discuss how to manage such feelings and help the staff to understand them as a result of a way of thinking. The understanding and interpretation of what lies behind these feelings is also noted in the column for interpretations (thoughts). The discussion at the guided reflection meeting has the aim of reducing strong and unpleasant feelings once a more realistic understanding and interpretation of the situation has been reached.

The column for action to take will be, to a large extent, based on the understanding reached during the meeting. Open questions should be asked and as many ideas as possible should be brought up (brainstorming). Then, the participants should select action(s) to take that seem the most promising and feasible to implement. It is vital that the staff themselves understand that they are the ones responsible to propose interpretations and measures, and that the leaders of the meeting are only to guide them by using guided discovery.

Describing the actions as SMART:

The actions to take should be describable as SMART, in accordance with terms traditionally used in cognitive therapy (21).

As an example, when increased physical activity of a patient is to be tested, the actions to take should be described beforehand using the following terms:

SPECIFIC: A detailed statement on how the activity is to be established. Who is responsible for carrying out the activity?

MEASURABLE: The activity must be able to be registered and executed.

ACTUAL: The activity should be implemented now, not in a few weeks. When will the activity start??

REALISTIC: Clarify whether it is possible to achieve this with current resources.

TIME FRAMED: It must be decided how long the measure should be attempted. .

Consequently, actions must be planned in detail as to when and how they are to be carried out, how long they should be attempted, and who is responsible for doing this. In addition, there must be a discussion of possible hindrances that need to be overcome.

There are no special limits to the possible actions to take. These activities will vary from patient to patient. The list of actions is endless: music therapy, reminiscence therapy, increased physical activity, baking and other daily activities, aromatherapy, shielding (protecting), setting boundaries, validation therapy, reality orientation, initiatives to increase the involvement of the patient's relatives, detailed procedures for communication during care routines, division of responsibilities among the staff, etc.

Actions to take can range from changes that affect the whole ward to ones that are targeted for a specific

patient. Medication actions may also be deemed necessary, but non-pharmacological options should be tried out first whenever possible. The actions should then be registered in the system the ward uses for planning the work with the patient, such as the daily/weekly plan, nursing plan, treatment plan, etc. (22).

Describing the evaluation

For every problem, it must be stipulated how and when the actions are to be evaluated. This is constantly noted in the column for evaluation. As a rule, this will be done by continuing the 24-hour observation form, repeating

the clinical assessment instruments used in the registration and assessment phase. For example, a date can be chosen for evaluation during a physician's regular visit, or during a new case conference, when needed.

Summary

The leader should start summing up the meeting about 5-10 minutes before it ends. For every problem, there should be a short summary of mutual interpretations and actions to be attempted going forward. There will also be an opportunity for participants to give their feedback and opinions about the meeting itself.

TABLE 2: Plan for the guided reflection meeting (case conference)

Plan for the case conference (the guided reflection meeting) (1.5 hours)				
ACTIVITY	Preparation: convene meeting and prepare a meeting room with blackboard or similar facilities (projector, if available). Check that a flip chart and markers are available	TIME – administrators: Chairman for the meeting Note taker (whiteboard) Minute recorder		RESPONSIBLE
	1. Status Report: personal history and main points from the patient medical record is presented	10-15 min.	Decide in advance who should prepare and present the patient personal history and the main points from the medical record	
	2. Create a problem list	10 min.	Staff (as many as possible should attend the conference) Leading registered nurse and the nursing home physician should attend the conference, if possible	
	3. Prioritise problems from the list			
	4. Draw a 5-column sheet on the whiteboard: facts – interpretations (thoughts) – emotions – actions – evaluation	60 min.		
	5. Describe facts – from the registration and assessment phase: one problem at a time			
	6. Suggest interpretations – guided discovery – discuss and reflect			
	7. Describe any emotions experienced by the staff – include interpretations by the staff			
	8. Suggest SMART actions – based on the interpretations – decide upon how and when to do an evaluation of the actions			
9. Summarize interpretations and actions – close the meeting	5-10 min.	TIME – administrator Chairman		

TABLE 3: An example of a five-column sheet from a case conference:

Registration Facts	Interpretation, Thinking Understanding	Feelings and Reactions (From Staff)	What to do -- Actions and Treatments	Evaluation – How and When
<p>Aggression</p> <p>At bedtime, hits and kicks the staff when receiving care</p> <p>anger and swearing when staff change over.</p> <p>Every day</p>	<p>“He does it deliberately”</p> <p>He has frontal lobe affect, has reduced control and options</p> <p>Dementia is advanced, he doesn’t understand.</p> <p>We are insecure, can be injured: no one has been injured so far, he is not strong, little danger.</p> <p>We have too few people on shift. We have tried utilizing more, it didn’t help.</p> <p>Side effects of haloperidol and oxazepam: weakened cognition.</p> <p>At-shift changeover – busy and little contact with staff: Sundowning; overburdening during the day, increased confusion</p>	<p>Irritation and anger</p> <p>Anxiety</p>	<p>Acceptance of the behaviour as a part of his disease, leaving him no choice.</p> <p>Training, techniques to avoid blows.</p> <p>Share day between staff – see list</p> <p>Avoid leaving him alone at shift changeover</p> <p>Reality orientation before confusion builds up</p> <p>Shield in own room if possible after dinner, rest, use music he likes</p> <p>Preventive, go for walk just before dinner</p> <p>Check music preferences – obtain CD – speak with relatives</p> <p>Stop haloperidol first, then stop oxazepam. After one week, consider giving donepezil 5 mg increasing to 10 mg after 4 weeks.</p>	<p>Continue behaviour registration, brief review at physician’s visit: 2 weeks</p>

Some aids for use during the guided reflection meeting

In Table 2, you will find a schematic overview of the meeting. In Table 3, there is an example of a five-column sheet with the results from a conceivable consultation meeting in which we illustrate how an aggression problem can be approached for a patient. Moreover, you will find instructions in order to use Socratic dialogue in the case conference. Socratic dialogue is a method for questioning and reflecting that gives rise to a more explorative way of thinking. In addition, we have

enclosed four TIME tips that can help you reflect about common problems that often occur in the meeting. And finally, there is an exercise that can help you learn to distinguish between the facts, i.e. what you observe and measure, your interpretations (thoughts), and your emotions. Being able to distinguish between these three concepts makes it easier to solve problems both for oneself and in the interaction with patients. This makes it easier to use the cognitive column technique in the case conference.

Socratic dialogue – as an aid in the case conference

“Socratic dialogue is a guide with the help of questions which are exploratory and promote logical thinking” (20).

- ▶ **Always discuss one theme at a time.** This means that other themes that pop up should be noted down and returned to at a later stage. For example: “That was interesting. I’ll make a note of it, and we can come back to it when we finish what we are dealing with right now.”
- ▶ **Be empathetic.** Don’t be judgemental and condescending. Make a note of all reflections, but ask for clarification and reasons if anything is unclear.
- ▶ **Ask open questions to encourage reflection** – avoid questions which can be answered with “yes” or “no”.
- ▶ **Avoid direct leading questions.** The group members themselves are responsible for trying to find answers and, through reflection, arrive at one or more mutual interpretations/understandings of the theme.
- ▶ **Dig deeper,** ask further questions to get concrete and precise understanding if something is superficial. For example, “If we understand you right, what does this mean for us and for the patient?”
- ▶ **Ask for justifications** and reasons about interpretations. “What is in favour of – what is against your understanding?” This opens up opportunities for reflection, especially when there is negative thinking.
- ▶ **“Are there other ways to understand the whole picture? And, in which case, what would that mean?”**
- ▶ **Invite the participants to look at things from the patient’s perspective:** “If you were the patient in this situation in the ward, what do you think you would have thought and felt.” “Seen from the patient’s side – how can we understand what she does?”

▶ **Present a suggestion if the group get stuck.** Formulate a suggestion that you believe in, but pose it as a question: For example, “Is it the case that the patient really wants to be alone more?” “Are there any clues in the personal history or behaviour that support this?” This type of question is a leading question, which is sometimes necessary in order to further develop interpretations and actions to take.

▶ **Always sum up** what has been said before moving on, and check to see if a mutual understanding has been reached: “If I understand you right, then it is like this...etc. Have I understood you correctly?”

Four TIME - tips for the case conference

Advice about problems and concerns that often pop up at meetings:

“The actions or treatment only works from time to time.” About not expecting it to work every time.

▶ The method doesn’t have to work every time for you to use it. This is most acceptable when the treatment does not demand too much time, energy, or money to implement. Perhaps it only works every third or fourth time. This might be good enough for a treatment or an action to be used. It’s better than no effect at all.

“She uses physical and verbal abuse. It seems as if she does it wilfully.” About reduced control of impulses.

▶ Sometimes it seems that people with dementia or other serious psychiatric disorders do hurtful or troublesome things consciously or wilfully. It is wise to distinguish between being able to plan what one does, and actually doing it. Many patients with dementia have reduced control of impulses and cannot suppress the urge to hit, shout, scold, and so on. In other words, they have no choice to behave in another way due to their condition. The ability to control their behaviour and understand its consequences is often reduced.

“We think she could manage much more than she actually does. She wants to have as much help as possible.” About executive function inability to take action.

▶ Patients with dementia and other brain diseases can sometimes appear to be passive and unwilling to do simple tasks that they are physically and mentally capable of executing. We expect them to be able to do more than they actually do. This is often caused by executive failure. The brain disease often makes them unable to start and finish certain tasks. It is not that they do not want to do anything, or that they want to have as much help as possible, but rather they cannot manage. They often need more help than we think in order to undertake various tasks.

“We feel powerless. Nothing we do helps. He is just as ill, regardless of what we do.” About reducing the feelings of being powerless.

▶ Patients with agitation and aggression caused by brain disease will often have long-lasting symptoms, no matter what we do. This can also be the case for patients suffering from serious depression and anxiety. This is often due, at least to some degree, to the brain disease itself. They may need to be consoled, sung to, cared for, fed, etc., even though nothing seems to alleviate their distress. In such cases, we should lower our expectations that they will get better simply because of our efforts. At the same time, we should know that taking good care of them and consoling them reduces their inner pain, even though it may not show on the outside. Safety, consolation, and warmth are priceless for people who are suffering, even though they may not get better. Feeling powerless and that you cannot manage can be caused by wanting to “manage” more than is possible to achieve and by underestimating the good that you actually do.

An exercise in distinguishing between facts, thoughts, and feelings

Distinguishing between the facts (what actually happens), our thoughts/interpretations about what happens, and our emotions created by our thoughts, can be difficult. However, in order to resolve difficult challenges in a group, this is very important. Study the statements below and write whether you think each one describes a fact, a thought or an emotion.

:	Fact	Thought	Emotion
Magny is ill			
She lies in bed all day long			
She’s not present enough.....			
She has a fever			
I’ll never manage this			
I’m sad.....			
The people in this ward are hopeless.....			
He drinks about 500 ml every day			
Nothing in this ward works			
He hits the staff every time they are trying to wash him			
Guilt			
I’m angry and irritated			
He does it wilfully			
I am scared			
I can’t take any more of this.....			
She can’t do anything because she’s just a stand-in.....			
She’s an assistant nurse.....			
Joy.....			
She doesn’t get out enough.....			
The behaviour is caused by a brain disease.....			
He is at an advanced stage of dementia.....			

8. Action and evaluation phase

During the case conference, decisions are made as to how and when certain actions should be attempted and evaluated in the following weeks. As a rule, this means that the agreed-upon 24-hour observation form is continued. After a while, the same clinical instruments used in the registration and assessment phase are utilised.

A date for the evaluation should be agreed on, for example, at a physician's appointment or during another meeting. If necessary, a new case conference is proposed. The action and evaluation phase should take place over a period of a few weeks to allow time to determine that the measures have had the desired effects. It is important not to give up the action and treatment too quickly, as it can take several weeks before effects can be seen.

An evaluation involves discussing these five points for every action or group of actions:

1. Have the actions been carried out as planned?
2. If the actions have not been carried out as planned, why? Do they need to be adjusted, or can hindrances be removed?
3. Have they had the desired effects on the target symptoms?
4. Have they had undesirable effects, or side effects that require a change or discontinuation of the program?
5. Should the measures be continued? In which case, for how long? When and how should the next evaluation be executed?

9. Cognitive behavioural therapy - useful principles

TIME has taken part of its theoretical basis from principles in cognitive behavioural therapy concerning the understanding of human behaviour and the usefulness of structure in problem solving. The model provides a tool for self-help the next time a challenge arises.

Understanding of behaviour

Human behaviour is understood as being subject to biological, psychological, and social factors. This demands a broad approach and assessment of challenging behaviour, as seen in the registration and assessment phase of TIME. Our behaviour is often relational, and mutually influenced by interacting with others. That is why we often see challenging behaviour in our

patients when they are interacting with other patients or staff, for example, at mealtimes or during personal care. The way we interpret the patient's behaviour influences and shapes our own behaviour towards the patient; in this way, we can maintain, reinforce, or change the behaviour of the patient.

A central point in cognitive psychology is that our feelings and behaviour in a given scenario are often determined by our interpretation of the situation. By reassessing our own unhelpful thoughts and interpretations, our emotions and behaviour in a given situation can be changed (20). Cognitive behavioural therapy recognises that we are, to a large extent, influenced by

our surroundings. We, ourselves, can contribute to the way we feel by changing unhelpful interpretations and behaviour, even though the surroundings cannot be changed. Sometimes, for example, in cases of advanced dementia, we cannot change the patient's behaviour, no matter what measures we try; however, we can change our own interpretation and experience of the behaviour. If we are successful in changing our mindset, it may be easier to endure the period of time we are caring for the patient.

Structure – a tool to self-help

In a chaotic situation in a ward where challenging behaviour is common, we experienced that the structure in problem-solving from cognitive therapy was helpful. The cognitive principle of always systematically approaching one concrete problem at a time, assessing and summing up the facts, exploring different interpretations as a team, and suggesting possible actions, released a wave of creativity among the staff.

A well-known structuring approach technique in cognitive therapy is the four-column form, through which every situation or problem area is described in detail with columns for situation (facts), thoughts (interpretations), emotions, and behaviour (12). We have changed the column for behaviour to a column for actions or treatments, based on the interpretations we agreed upon as being probable or helpful, and we added a fifth column for evaluation.

There is no need for intensive training in cognitive behaviour therapy in order to conduct and carry out a guided reflection meeting (case conference) based on this method. A simple introduction to the principles for cognitive behavioural therapy is sufficient, since the method is simple, structured, and based on common sense. It is not a matter of “treating” the staff or the patient with cognitive therapy, but of using the cognitive model to structure the approach to behavioural and psychological symptoms, and finding beneficial, appropriate actions to be executed. This method is ideal for reaching individually-tailored treatment that is central. Sometimes, it is simply a matter of accepting the behaviour for a while as a

natural part of the patient's disorder, and thereby, freeing oneself from one's own expectations that the behaviour must be changed because it is unacceptable, which often leads to feelings of inadequacy. Medication can also be given as a part of the measures.

The model is simple, easy to learn, and largely based on common sense, similar to cognitive behavioural therapy. An important point is that the model is used as a tool that can be repeated time after time. In this way, the staff are given the possibility of trying to methodically relate to neuropsychiatric symptoms every time they arise. The way forward to the action is the same in every case, but the action and treatment that are finally adopted are individual, based on flexibility and customized for the individual patient. This gives the staff a feeling of security and has a beneficial effect on the environment in the ward for all patients.

«If we can reorient our thoughts and emotions, and reorder our behavior, not only can we learn to cope with suffering more easily, but we can prevent a great deal of it from starting in the first place.”

Dalai Lama, Ethics for the New Millennium, 1999.

10. Person-centred care – useful principles

TIME has taken some of its theoretical basis from the principles of person-centred care. There are many concurrent theoretical ways of understanding behavioural and psychological symptoms between cognitive behavioural therapy and person-centred care. Both emphasise the relational aspect in the understanding of behaviour, and recognise that an approach should combine biological, social, and psychological factors. It is mainly the interaction between these factors that reveals the symptom complexity of the individual patient.

Both emphasise that treatment actions must be customized for the individual patient if they are to have any effect.

In recent years, person-centred care has been defined in practice through the VIPS framework (23). The VIPS framework means that a person has an independent Value irrespective of disease and level of functioning. Treatment and actions around the person must be based on the person's Individual life story, preferences, resources, and abilities. In order to understand the individual's symptoms and behaviour, one must always strive to see the situation

from her Perspective. In addition, there must be an emphasis on the Social environment in which the person lives. The challenges of person-centred care have been to transfer the theoretical stock of ideas to the field of practice. This has largely succeeded by using the VIPS framework and Dementia Care Mapping (DCM) (23, 24)

In TIME, we stress that all three phases make use of principles from person-centred care. In the registration and assessment phase, the patient's personal history, resources, and preferences are central when gathering information from the patients themselves and from their families. In the case conference, one of the main questions the participants are to reflect upon is precisely what we think are the patient's own thoughts behind her behaviour and symptoms, i.e. the patient's perspective. The actions we agree upon in the meeting to be tested out in the action and evaluation phase are to be suited for the individual patient. Thus, the treatment actions must be customized for the patient based on a rigorous assessment of social, psychological, and biological factors.

11. The relationship between TIME and other milieu-therapeutic methods

The TIME model has been developed to give an interdisciplinary manual-based tool for use in cases of neuropsychiatric symptoms caused by suffering of both a somatic and psychiatric nature. One of the main strengths of TIME is its comprehensive bio-psychosocial approach to these types of challenges. Our experience is that a systematic use of the model leads to a fuller appraisal of the patient, better person-centred care, and cognitive milieu therapy. The effective use of the model increases if the staff are familiar with the various milieu-therapeutic methods, and can use them flexibly when one of the methods has been agreed upon in the guided reflection meeting in TIME. In addition, it is

a definite advantage if, beforehand, the ward staff use, for example, structured milieu-therapy (22) and have integrated principles of person-centred care in their ward. Then, it is easier to apply the tailor-made action plan that comes out of TIME. We have also seen the advantages of using the Marte Meo method as a part of TIME, both in the registration and assessment phase and the guided reflection meeting (25). The same thing might be possible with DCM when TIME is used with people suffering from dementia. Therefore, these methods are not in opposition to each other; rather, they complement each other with somewhat different aims and demands based on training and education.

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13. Appendix

Abstract from TIME pilot study

Published in *International Psychogeriatrics*, Volume 23, Issue S1, September 2011, pp S92-S138 (supplement published by the IPA Congress Den Haag 2011 when the study was presented orally). After this publication, the acronym MIND was changed to TIME to be more consistent with the Norwegian acronym TID for the intervention model.

Multidisciplinary Intervention for challenging behavior in Nursing home patients with Dementia (MIND)

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Context

Nearly all nursing-home patients with dementia experience behavioral and psychological symptoms (BPSD). Psychotropic drugs are extensively used to treat BPSD in spite of the fact that the evidence for effect is weak and the risk of severe adverse events is considerable. There is a lack of large, rigorous studies investigating the effect of holistic approaches which are based on both biological, social and psychological factors. We have conducted a pilot study of an intervention which includes both a rigorous assessment and the treatment of BPSD. This model, Multidisciplinary Intervention for challenging behavior (agitation) in Nursing home patients with Dementia (MIND), is based on the theoretical framework of cognitive behavioral therapy (CBT), and tailor a treatment plan that takes into account the unique characteristics of each individual.

The main aims of the pilot study were to evaluate the utility of the research plan for a future RCT, and the ability of the intervention to induce clinically meaningful change in outcome measures.

Methods

The pilot study includes 30 patients from 9 nursing homes in Norway. Inclusion criteria were a stay in the nursing home of more than 4 weeks, score on the Clinical Dementia Rating scale (CDR) of one or higher and a score of six or more on the agitation item of the Neuro-psychiatric Inventory (NPI).

The first part of the intervention consisted of a three hours lecture for the staff about dementia, BPSD, quality of care and MIND. MIND was successively implemented for each patient in three stages: a registration-observation stage which includes medical examination of the patient, background history and a detailed registration on a daily basis of the behaviours or symptoms at stake. A staff guiding stage consisting of a structured guiding meeting then followed. Specially trained nurses from the nursing home set a meeting for 1-1,5 hours for the nursing home health workers. After this meeting a detailed plan for the patient is put into action, and the evaluation stage begins.

In this presentation we account for measurements at baseline and after 6 weeks. These were done by research assistants who interviewed the staff members who knew the patient best. We will repeat these measures after 4 and 8 months. Outcome measures were agitation measured by Cohen Mansfield Agitation Inventory (CMAI), neuro-psychiatric symptoms measured by the Neuropsychiatric Inventory (NPI), depression by Cornell Scale for Depression in Dementia (CSDD) and quality of life by the Quality of Life in Late-stage Dementia scale (QUALID). Change at 6-week was explored by the Wilcoxon Signed Rank Test.

Results

Of the 30 patients included at baseline, 28 patients (one deceased, one hospitalized) were assessed after 6 weeks of intervention. At baseline the mean age was 81,9 years (SD 9,1), 57 per cent were women. CDR scores at baseline showed that 3 per cent had mild dementia (CDR 1), 43 per cent had moderate dementia (CDR 2), and 53 per cent had severe dementia (CDR 3). Table 1 shows the scores on outcome measures at baseline and at 6-week follow-up. There was a significant improvement on subscales of the NPI for agitation, affective and psychotic symptoms and of depressive symptoms measured by the CSDD. The NPI 10 staff distress measurements showed a significant decline. A non-significant trend of reduction was observed for agitation measure by the CMAI and there was a non-significant improvement in patients' quality of life measured by QUALID. The utility of the research plan was established with needs of only minor changes.

TABLE 1: Outcome measures at baseline and 6-week follow-up

	Baseline Mean (SD)	Follow-up Mean (SD)	p¹
CMAI	60,2 (19,6)	56,7 (14)	0,3
NPI 10 sum	34,4 (20,7)	27,0 (16,9)	0,008
NPI agitation (sum of agitation, disinhibition, irrita- bility, aberrant motor behavior)	18,0 (7,9)	13,2 (7,5)	0,001
NPI affective (sum of depression and anxiety)	6,2 (7,2)	4,0 (5,5)	0,02
NPI psychosis (sum of delusions and hallucinations)	5,0 (6,6)	3,4 (5,5)	0,04
NPI 10 staff distress	13,6 (7,2)	11,4 (5,8)	0,04
CSDD	7,0 (5,6)	6,0 (4,3)	0,04
QUALID	25,7 (8,9)	23,0 (8,1)	0,09

¹Wilcoxon signed-rank test

Conclusion

The pilot study shows that the intervention by MIND might be a systematic and simple tool for nursing home health workers to treat agitation, and to tailor a treatment plan that considers the unique characteristics of each individual. There was a significant reduction, measured after about 6 weeks of intervention, in agitation, affective symptoms, and psychotic symptoms in the patients, as well as reduced caregiver burden. Though this is an open study without a control group, these results are suggestive of a possible effect of the intervention. The results need to be replicated in a randomized controlled trial, and we are planning for such a trial based on our experience from this pilot study.

Colour codes for use in the 24-hour observation form

Neuropsychiatric symptoms

These colour codes are based on Neuropsychiatric Inventory Nursing Home version (NPI-NH) (7). It is not meant to be used as a scale. In which case, we recommend using the original NPI-NH. This version combining the NPI-NH questions with the use of colour codes has not been validated. We combined these questions from the NPI-NH with the colour codes in TIME only to be more precise in our descriptions in the registration-assessment phase and for using with the 24-hour observation form.

COLOUR	BEHAVIOR	DESCRIPTION
	SATISFIED/NORMAL BEHAVIOUR	To be described in detail at the beginning of registration for each item.
	SLEEP – NIGHTTIME BEHAVIOUR	
	AGITATION -AGGRESSION	
	ANXIETY	
	DISINHIBITION	
	HALLUCINATIONS	
	DELUSIONS	
	APATHY	
	DEPRESSION	
	EUPHORIA	
	ABERRANT MOTOR BEHAVIOUR	
	IRRITABILITY/LABILITY	

SLEEP		
1.	Does the resident have difficulty falling asleep?	
2.	Does the resident get up during the night? (Do not count if the resident gets up once or twice per night only to go to the bathroom and falls back asleep immediately)	
3.	Does the patient wander, pace, or get involved in inappropriate activities at night?	
4.	Does the patient wake up at night, dress, and plan to go out, thinking that it is morning and time to start the day?	
5.	Does the patient wake up too early in the morning (before other residents)?	
6.	Does the resident have any other nighttime behaviours that we haven't talked about?	

AGITATION/AGGRESSION		
1.	Does the resident get upset when people are trying to care for him/her, or resist activities such as bathing and changing clothes?	
2.	Does the resident always want things his/her own way?	
3.	Is the patient uncooperative, resistive to help from others?	
4.	Does the resident have other behaviours that make him/her hard to handle?	
5.	Does the resident shout, make loud noises, or swear angrily?	
6.	Does the resident slam doors, kick the furniture, or throw things?	
7.	Does the resident attempt to hurt or hit others?	
8.	Does the resident have any other aggressive or agitated behaviours?	

ANXIETY		
1.	Does the resident say that he/she is worried about planned events, such as appointments or family visits?	
2.	Does the resident have periods of feeling shaky, unable to relax, or feeling very tense?	
3.	Does the resident have periods of (or complain of) shortness of breath, gasping, or sighing for no apparent reason, other than being nervous?	
4.	Does the resident complain of butterflies in his/her stomach, or of racing or pounding of the heart because of being nervous? (Symptoms not explained by ill health)	
5.	Does the resident avoid certain places or situations that make him/her more nervous, such as meeting with friends or participating in ward activities?	
6.	Does the resident become nervous and upset when separated from you or from others he/she trusts ? (Does he/she cling to you to keep from being separated?)	
7.	Does the resident show any other signs of anxiety?	

DISINHIBITIONS		
1.	Does the resident act impulsively without thinking about the consequences?	
2.	Does the resident talk to total strangers as if he/she knew them?	
3.	Does the resident say things to people that are insensitive or hurt their feelings?	
4.	Does the resident say crude things or make inappropriate sexual remarks?	
5.	Does the resident talk openly about very personal or private matters not usually discussed in public?	
6.	Does the resident fondle, touch, or hug others in a way that is not appropriate?	
7.	Does the patient show other signs of a loss of control over his/her impulses?	

HALLUCINATIONS		
1.	Does the resident act as she/he hears voices or describing hearing voices?	
2.	Does the resident talk to people who are not there?	
3.	Does the resident see things that are not present or act like she/he sees things that are not present (people, animals, lights, etc.)	
4.	Does the resident smell things that others cannot smell?	
5.	Does the resident describe feelings things on his/her skin or act like he/she feels things crawling or touching him/her?	
6.	Does the resident say or act like he/she tastes things that are not present?	
7.	Does the resident describe any other unusual sensory experiences?	

DELUSIONS		
1.	Does the resident believe he/her is in danger – that others plan to hurt him/her or have being hurting him/her?	
2.	Does the resident believe that others are stealing from him/her?	
3.	Does the resident believe that his/her spouse is having an affair?	
4.	Does the resident believe that his/her family, staff members, or others are not who they say they are?	
5.	Does he/she believe that family members plan to leave him/her?	
6.	Does the patient believe that television or magazine figures are actually present in the room? (Does he or she try to talk or interact with them?)	
7.	Does he/she believe any other unusual things that I haven't asked about?	

APATHY / INDIFFERENCE		
1.	Has the resident lost interest in the world around him/her?	
2.	Does the resident fail to start conversation? (score only if conversation is possible)	
3.	Does the resident fail to show emotional reactions that would be expected (happiness over a visit from a friend or family member, interest in the new sports, etc.)?	
4.	Has the resident lost interest in friends and family members?	
5.	Is the resident less enthusiastic about his/her usual interests?	
6.	Does the resident sit quietly without paying attention to things going on around him/her?	
7.	Does the resident show any other signs that she/he doesn't care about doing new things?	

DEPRESSION		
1.	Does the resident cry at times?	
2.	Does the resident say, or act like he/she is depressed?	
3.	Does the resident put him/herself down or say that she/he feels like a failure?	
4.	Does the resident say that he/she is a bad person or deserves to be punished?	
5.	Does the resident seem very discouraged or say that he/she has no future?	
6.	Does the resident say that he/she is a burden to the family, or that the family would be better off without him/her?	
7.	Does the resident talk about wanting to die or about killing himself/herself?	
8.	Does the resident show any other signs of depression or sadness?	

EUPHORIA		
1.	Does the resident appear to feel too good or to be too happy?	
2.	Does the resident find humour and laugh about things that others do not find funny?	
3.	Does the resident seem to have a childish sense of humour, with a tendency to giggle or laugh inappropriately (such as when something unfortunate happens to others)?	
4.	Does the resident tell jokes or say things that are not funny to others, but seem funny to him/her?	
5.	Does the resident show any other signs of feeling too good or being too happy?	

	ABERRANT MOTOR BEHAVIOR	
1.	Does the resident pace or wheel around the facility with no reason?	
2.	Does the resident open or unpack drawers or closets over and over?	
3.	Does the resident repeatedly put on and take off clothing?	
4.	Does the resident engage in repetitive activities, such as handling buttons, picking, wrapping string, moving bed sheets, etc.?	
5.	Does the resident have repetitive activities or "habits" that he/she performs over and over? Is the resident excessively fidgety ?	

	IRRITABILITY – LABILITY	
1.	Does the resident have a bad temper, flying "off the handle" easily over little things?	
2.	Does the resident rapidly change moods from one to another, being fine one minute and angry the next?	
3.	Does the resident have sudden flashes of anger?	
4.	Is the resident impatient, having trouble coping with delays or waiting for planned activities or other things?	
5.	Is the resident easily irritated?	
6.	Is the resident argue or is he/she difficult to get along with?	
7.	Does the resident show any other signs of irritability?	

24-Hour Observation Form for use in institutions

Insert appropriate colour codes with the description of the behavior or symptoms to be registered

..... Name:
 Birth:

Date	07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	00:00	01:00	02:00	03:00	04:00	05:00	06:00	
Insert colour																									

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Behaviour and symptom registration form for persons living at home

Insert the colour codes of behavior and symptoms that are to be observed and recorded

<input type="text"/>	<input type="text"/>	<input type="text"/>	Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>	Birth:

When starting a visit, set up time. Each box is five minutes. Register the behavior you observe by using the appropriate colour code. More observations on the same day are registered in the same line.

Date																														
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5-column sheet for problem analysis in the guided reflection meeting (the case conference)

Date:

Patient:

Problems

Facts	Interpretation	Emotions (Staff)	Action to take (SMART)	Evaluation

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Link to the TIME manual and the teaching film about TIME: <http://tidmodell.no/>