Aging Well in Harmony Toolkit: Personalised Care to Residents with Dementia in Rural Aged Care Facilities

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Welcome to the Aging Well in Harmony Toolkit

This toolkit is an outcome of a non-pharmacological intervention, 'Harmony in the Bush', conducted by Flinders University Rural Health SA in five rural aged care facilities over two years, funded by the Australian Department of Health under the National Aged Care Services Program. We aimed to demonstrate that a co-designed personalised care model, based on the *Progressively Lowered Stress Threshold* principles and *personalised and group music* activities, is effective in reducing behavioural and psychological symptoms of residents with dementia while also reducing caregiver stress.

Previous studies in Australian aged care centres have reported that more than half the residents have dementia and about 70–90% of these residents show behavioural or psychiatric symptoms. Research also revealed that these behavioural or psychiatric symptoms including agitation, aggression, mood dysregulation, wandering and anxiousness are associated with diminished quality of life for residents with dementia and increased caregiver stress . Best-practice evidence is important to address behavioural problems in residential aged care facilities, to improve patient outcomes and staff quality of life.

Our program 'Aging well in Harmony' is an innovative two-component intervention that integrates an established behavioural intervention, Progressively Lowered Stress Threshold (PLST), and personalised music activities. The focus was to reduce overall stress in the nursing home environment through staff education, personalised care plans and personalised music activities. We worked closely with personal caregivers, family members, nursing home managers, clinicians, diversional therapists, care workers and local musicians in the project implementation. We trialled the model in five nursing homes in Australia and 74 residents with advanced dementia participated in this two-component intervention. The intervention resulted in significant improvements in mood, sleep and function associated with a decline in dysfunctional behaviours. The staff reported less stress in the environment and were able to provide personalised care to the residents.

As such, this two-component personalised dementia care approach was an effective best-practice model of care for residents of aged care homes with dementia, and potentially could also be used in community settings.

The Ageing Well in Harmony Toolkit provides guidelines to design and implement a personalised dementia care plan to achieve a low-stress care environment in residential aged care homes.

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Introduction to the toolkit

Dementia is the second leading cause of death in Australia, and the single greatest cause of disability in older Australians aged 65 years and above. Currently, an estimated 459,00 Australians are living with dementia. The number of Australians living with dementia is predicted to increase to 590,000 by 2028, and 1,076,000 by 2058. In the year 2020, approximately 1.6 million Australians are estimated to be involved in the care of someone living with dementia. Thus, the health, social and economic impacts of dementia on Australians are immense and costly. The approximate cost of the disease to Australia was over $15 billion in 2018; and is predicted to cost more than $18.7 billion by 2025.

A total of 2,672 residential aged care facilities are in operation in this country and 14% of these facilities are in regional, rural and remote areas (Baldwin et al., 2013). Residents with dementia account for 52% of all residents, and about 73% of the total number of aged care staff are involved in providing care for residents with dementia directly (Dementia Australia National, 2019). In these facilities, many residents with dementia present challenging behavioural and psychological symptoms such as agitation, aggression, screaming, anxiousness, wandering, and distressed thoughts and perceptions. These symptoms are complex, stressful and costly aspects of care; they are associated with diminished quality of life and a high workload for aged care staff. These behaviours are even more complicated and demanding in rural and remote aged care settings, where it is more difficult to attract and retain a skilled workforce and to provide sufficient training resources than in metropolitan areas.

Non-pharmacological personalised dementia care interventions are attracting growing attention in caring for residents with dementia or managing their behaviours. This is because they are found to be more effective and less harmful than the side effects of psychotropic medications. Use of a co-designed personalised care approach (which involves the perspectives of staff, residents, family members and community members) can support persons with dementia, staff and organisations to reduce the overall stress level and improve quality of life for residents and staff.

We implemented the Harmony in the Bush study, a two-component personalised dementia care approach in five Australian rural aged care facilities (two in South Australia and three in Queensland). The findings of our study inform a potential way of caring for residents with dementia, staff and the environment across the rural facilities. These findings are summarised in this Ageing Well in Harmony Toolkit.

Meaning of Ageing Well in Harmony

Ageing Well in Harmony is the process of developing and maintaining a co-designed personalised care approach in aged care facilities that improves health and wellbeing of persons with dementia through a reduction of behavioural and psychological symptoms, with a comparable decline in staff's caregiving stress through organisational culture change.

This care approach exists at three levels:

- Residents with dementia – A harmonised care plan is created by a person-centred assessment of the residents' needs, values, preferences (activities & music), and their behavioural and psychosocial symptoms by an experienced clinical nurse in consultation with their family members and nursing and personal care staff.
- Staff – A skilled workforce is created by providing the staff opportunity to access training sessions on the personalised dementia care philosophy and strategies, and mentoring processes that enable them to respond to residents' needs.

Organisational environment – A positive organisational culture is created for adopting and implementing a personalised dementia care approach for the residents through building relationships among and between staff and residents.

Users of the toolkit

This toolkit can be used by the following persons because of its effectiveness in meeting clients' care needs through the identification and creation of a personalised care plan; training and mentoring the staff; and building a home environment in the facilities.

- aged care workers who are largely engaged in providing dementia care in aged care facilities and want to integrate person-centred care into their services;

- aged care facility managers and clinical leaders who are engaged in providing guidance to care workers in adopting and implementing person-centred care plans; and
- community nurses and home care workers who provide home care support for persons with dementia who are ageing in place in the community.

Why aged care facility managers/clinicians/workers/community nurses need this toolkit

Aged care workers may use this toolkit for:

- understanding the behavioural symptoms and psychosocial care needs of a resident with dementia;
- learning about the personalised dementia care philosophy and strategies;
- contributing to the development and implementation of personalised care plans;
- managing the challenging behaviours of residents with dementia in different situations through building relationships and using non-pharmacological treatment options; and
- understanding how to reduce workplace stress.

Aged care facility managers/clinical leaders may want to use this toolkit for:

- learning more about dementia, the caring role, and personalised care service strategies;
- strengthening the availability of education and mentoring support for aged care workers;
- facilitating the implementation of co-designed personalised care plans by leading an organisational culture change; and
- increasing opportunities for staff, residents with dementia and their family caregivers.

Community nurses and home care workers may want to use this toolkit for:

- understanding dementia, care needs, the caring role, and availability of personalised dementia care services;
- providing support to persons with dementia and their family caregivers in the community;
- strengthening the availability of community support for persons with dementia; and

- enhancing the availability of information about dementia care support for family caregivers of persons with dementia and local community service organisations.

What this toolkit entails

This toolkit is an outcome of Harmony in the Bush project and includes the following sections:

- a background to the Harmony in the Bush project and its components;
- a description of the care needs of residents with dementia and a co-designed personalised care plan for this cohort;
- how staff can implement a personalised care plan through training and mentoring programs;
- a case example of harmonised culture in aged care facilities;
- workflow illustration for toolkit utilisation; and
- further information and resources.

Evidence-based Ageing Well in Harmony Toolkit

Harmony in the Bush – A Personalised Model of Dementia Care (2017–2019), a study funded by the Australian Department of Health, aimed to understand personalised care support for residents with dementia in Australian rural aged care facilities and to intervene with a two-component non-pharmacological care model including the Progressively Lowered Stress Threshold approach and music activities.

Dementia

Dementia is an age-related disease that is chronic and progressive in nature, characterised by a steady decrease in intellectual functioning. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. This cognitive impairment is progressed by deterioration in psychosocial behaviours and symptoms. Dementia results from a variety of diseases and injuries that often affect the brain, for example, Alzheimer's disease and stroke.

Key signs and symptoms

Dementia affects each person in a different way, depending on the impact of the disease and the person's personality. The signs and symptoms linked to dementia can be understood in three stages:

- **Early stage:** Early-stage dementia generally remains unnoticed because its onset is gradual. Common symptoms include forgetfulness, losing track of the time, and becoming lost in familiar places.
- **Middle stage:** Dementia progresses to the middle stage with clear behavioural signs and psychosocial symptoms. These include forgetting events and names, becoming lost at home, difficulty in communication, requiring assistance with daily activities, wandering, and repeated questioning.
- **Late stage:** Severe dementia means an overall dependency and immobility. Memory disorders are severe, and the physical signs and symptoms become apparent. Symptoms include lack of awareness of

time and place, difficulty recognising relatives and friends, need for assistance with health care, difficulty in walking, and aggression.

Forms of dementia

- Alzheimer's disease is the most common form and contributes to 60–70% of the total number of cases.
- Vascular dementia is caused by an abnormality in nerve cells (called Lewy bodies) because of protein aggregation inside the cells.
- Frontotemporal dementia indicates a deterioration of the anterior lobe of the brain.

Dementia treatment and care

Dementia treatment and care is mentally, emotionally and physically challenging and burdensome. Thus, it is dynamic and dependent on the environment in which the person with dementia lives. For those living with dementia in their homes, the care is informal and provided by loved ones or relatives. Dementia care in aged care facilities can be task-oriented, person-centred or both. It can also involve the use of prescription medications to manage challenging behaviours, despite the medications' limited efficacy and high risk of mortality.

Key facts about treatment and care

- No treatment is presently available to cure dementia or to prevent or alter its progress.

- The principal goals for dementia care are:
    i. early diagnosis to promote early and optimal management;
    ii. optimising physical health, cognition, activity and wellbeing;
    iii. identifying and treating accompanying physical illness;
    iv. detecting and treating challenging behavioural and psychological symptoms; and
    v. providing information and long-term support to carers.

Progressively Lowered Stress Threshold

The Progressively Lowered Stress Threshold approach involves the creation of individualised care plans and a low-stress organisational culture, based on the framework of non-pharmacological care in dementia (Hall et al, 1987). It recognises that behavioural and psychological symptoms are experienced by persons with dementia because of increased stress triggered by both internal factors (such as pain) and environmental factors (e.g. high noise level). If the stressful stimuli continue or increase, behaviour becomes increasingly dysfunctional, often proving challenging (e.g. aggression and agitation). As a result, reducing stress by modifying environmental or internal demands promotes functionally adaptive behaviour. The model has several principles, which in combination are aimed at lessening or eliminating stress triggers within the environment of the person with dementia whilst simultaneously introducing activities that enhance positive stimuli in the environment.

Principles of the Progressively Lowered Stress Threshold approach

- Introduce consistent individualised routines to compensate for conative losses.
- Organise small group activities to eliminate overwhelming stimuli.
- Allow residents to set their own sleep/wake cycle to prevent fatigue.
- Plan activities based on past experiences and practices considering present cognitive and functional abilities.
- Eliminate misleading stimuli that trigger illusions.

Music as a care tool

Personalised preferred music or group music activity programs can provide positive stimuli to persons with dementia and result in positive behavioural outcomes including reduced anxiety, depression and agitation, and improved cognitive functioning and quality of life. There is significant evidence that music use in rural

aged care facilities is a safe and low-cost intervention (Blackburn, R. et al. 2014; Thomas KS et al. 2017; Ray KD et al. 2017).

Key factors of music

- Music that people with dementia preferred in the past can be played for individualised listening.
- Group activities can include music and movement/dance, disability arts and creative aging program/s, visual arts mediums, storytelling, basketry/weaving, painting, drawing, screen-printing, knitting and sketching.

Harmony in the Bush – A clinical trial intervention

We hypothesised that the integration and application of the principles of the Progressively Lowered Stress Threshold model and music activities would result in a low-stress organisational environment and a positive workplace culture and promote better health and wellbeing outcomes for residents with dementia and their caregivers in rural aged care facilities. These outcomes could include reduced behavioural and psychological symptoms, and improved quality of sleep, wellbeing and contentment in residents with dementia and a parallel reduction in carers' stress and improvement in their wellbeing and job satisfaction. Therefore, the overall aim of our study was to develop a co-designed personalised model of dementia care, with the following specific objectives:

- training and mentoring of staff;
- identification of key drivers of personalised models of dementia care;
- co-designed and implemented individualised care plans incorporating the principles of the Progressively Lowered Stress Threshold model, and preferred music activities; and
- evaluation of the effectiveness of the Harmony in the Bush intervention.

Over a two-year period, this non-randomised mixed-methods study compared pre- and post-intervention measures with one- and three-month follow-up. A twelve-week intervention was implemented in each of the participating facilities. To reflect the diversity of the participant cohorts, two facilities were privately owned;

one was a publicly funded (state-run) centre; and another was a not-for-profit facility. The fifth facility was a not-for-profit, partly government funded community aged care. The study participants included eligible residents living with advanced dementia in the five facilities, their legal guardians, family members/relatives and aged care staff, and musicians/artists.

At pre- and/or post-intervention time points, each resident participant was assessed for cognitive function, agitation, activity of daily living, apathy, depression, pain, sleep pattern, and preferred past music. The residents were provided with a four-week intervention firstly based on a co-designed program based on the Progressively Lowered Stress Threshold and personalised preferred music playlists, followed by an additional four weeks of integrated small group music sessions.

In summary, dementia care is dynamic and challenging, and our Ageing Well in Harmony Toolkit is an evidence-based outcome of the Harmony in the Bush project. It is important to mention that the Progressively Lowered Stress Threshold principles including personalised activities and music components were applied as a whole in aged care facilities to ensure personalised care for residents with dementia. In this toolkit, we focus on sharing evidence from the Harmony in the Bush project regarding the identification of the residents' care needs, staff support components, and elements of organisational culture in light of the personalised care approach.

Aging Well in Harmony – Resident assessment


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The underlying philosophy of the Ageing Well in Harmony Toolkit is that the care components for a resident with dementia can be broadly categorised based on the assessment of physical, psychosocial and spiritual/cultural health.

Table 1 presents the assessment domains and their relevance to the implementation of the Aging Well in Harmony program

Table 1. Care needs of residents with dementia

	Definition	**Relevance**	**Measures**	**Outcomes**
Clinical diagnosis and clinical history	Physical signs and diseases	Behavioural and psychological symptoms	Lifestyle activities	Individual identity and cultural preferences
Behavioural problems	Addressing physical risk factors associated with behavioural and psychological symptoms of dementia	Identifying challenging behaviours that impact on physical and mental health	–Agitation inventory, especially social aspects, including factors associated with daily living	Understanding the cultural care needs
Major symptoms/problems Disability	Residents with dementia presenting symptoms such as physical weakness, falls, dental problems, poor eyesight and hearing loss	The behavioural and psychological symptoms include wandering, inappropriate dress, spitting, verbal aggression, screaming, repetitive sentences, grabbing onto people, throwing things, strange noises, scratching, trying to get to a different place, complaining, negativism, hurting self, handling things inappropriately, hiding, hoarding, performing repetitive mannerisms and restlessness	The social care needs presented by the residents are lack of social interaction, idle time passing, and isolation	Lack of connection to cultural activities
Current treatment process Pain	Residents with physical problems on medication	Psychotropic medications	Mostly arts and crafts activities	Celebration of some festivals, such as NAIDOC week, Christmas
Interventions Cognition	Pharmacological treatment, for example, medication use for physio-psychological conditions of residents with dementia	Encourage non-pharmacological treatment options, for example, personalised music therapy, personalised activities, patient active lifestyle, therapeutic touch for pain management, art and dance. In addition, cognitive therapy for challenging behavioural and psychological symptoms.	Personalised care plan implementation at group level, for example, group music sessions, personalised activities with access to community services to provide support along with meaningful care	Focus on grief, loss, suffering connection to land, family and community in providing care
Sleep	Abraham			

Depression	Vivian/Abraham			
Hobbies and preferred activities	Vivian/Abraham			
Music preferences	Music is a supplement to cognitive behavioural therapy and/or medication, to be an effective and safe compassionate intervention in behavioural change and meaningful interaction	Reducing depression, anxiety and improving well-being through connection to memory	Person-centred music and group music activities	Improved health and well-being and reduced used of antipsychotic medication

Aging Well in Harmony – Staff training program

The wellbeing of staff is one of the major factors that affects the wellbeing of residents. Training was provided in all five facilities and a total of 104 staff participated. Among the staff, 69.3% were personal carers, 18.2% were registered nurses, and 11.4% were enrolled nurses. More than one-third of the staff had a country of origin other than Australia. The level of improvement of knowledge was substantial between pre- and post-training, indicating an improvement for all staff attending training sessions. Training provided in the intervention included opportunities for staff to reflect on how to interact with residents who are living with dementia and better understand their responses and practices.

Aims of staff training

A common management response to improve care is staff training. We must say that the training sessions of the project alone were unlikely to change practice, but interactive workshops were an effective means of achieving long-term changes in knowledge and skills, and building relationships among staff.

Our project began with a two-hour training session for each staff member over the first three weeks, aiming to include all the staff caring for the residents with dementia. About 55% of the staff had, on average, more than 5 years' experience working in aged care facilities and almost 43% of them had Certificate III qualifications, so the training added to the knowledge base of inexperienced staff as well as relative newcomers.

The Ageing Well in Harmony Toolkit is a resource to assist staff to implement a person-centred care approach for residents with dementia. The major part of the intervention was training for staff on personalised dementia care that included:

i. workshops on the Progressively Lowered Stress Threshold principles and strategies
ii. on-the-floor mentoring

Our study found that the behaviours and symptoms of residents were cross-sectional and stayed for a long period. Opportunities to learn about dementia and personalised care and to work under mentorship with an experienced registered nurse were essential for staff to interact with the residents with dementia, to managing their challenging behaviours, and to build relationships between staff and residents, leading to less workplace stress.

The health and wellbeing of staff is important as it influences the quality of life of residents with dementia. Our study 'Harmony in the Bush' focuses on reducing staff's caregiving stress. As such, training materials provided in the toolkit reflect on how to reduce the stress level of staff in aged care facilities, which are developed in accordance with the Progressively Lowered Stress Threshold principles developed by Hall (1987). Also, mentorship experience with an experienced and trained nurse/change champion enables them to understand and respond to the behaviours of residents with dementia.

Workshops on the Progressively Lowered Stress Threshold principles and strategies

Our project commenced with a two-hour training session for each staff member over the first three weeks prior to the intervention. An experienced registered nurse conducted staff training workshops focusing on the theory and delivery of the Progressively Lowered Stress Threshold. The workshops entailed an introduction to dementia and creating individualised dementia care plans based on the following principles:

- Introduce consistent individualised routines to compensate for conative losses.
- Organise small group activities to eliminate overwhelming stimuli.
- Allow residents to set their own sleep/wake cycle to prevent fatigue.
- Plan activities based on past experiences and practices considering present cognitive and functional abilities.
- Eliminate misleading stimuli that trigger illusions.

Training materials were provided to staff during the workshops to deliver a basic understanding of dementia, the complex behaviours of residents with dementia and personalised care. These included:

- PowerPoint presentation
- Staff notebook
- Reading materials.

The strategy-focused workshops consisted of the following content:

- introduction to the project and its aims;
- understanding of dementia and the importance of personalised care for residents with dementia;
- behavioural and psychological symptoms of residents with dementia;
- staff caregiver stress;
- Progressively Lowered Stress Threshold philosophy and principles;
- importance of individualised care plans and how to develop an individualised care plan;
- interaction with residents; and
- care environment and involving family members in care.

Four readings were provided to the aged care staff:

- Hall, G. R., Buckwalter, K. C., Stolley, J. M., Gerdner, L. A., Garand, L., Ridgeway, S., & Crump, S. (1995). Standardized care plan: Managing Alzheimer's patients at home. *Journal of Gerontological Nursing, 21*(1), 37-47. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6754179/pdf/nihms-1050149.pdf
- Warchol, K. (2018). The 'Progressively Lowered Stress Threshold' Model – Understanding and Minimizing Challenging Behavior. *Crisis Prevention Institute Blog.* https://www.crisisprevention.com/Blog/October-2010/The-Progressively-Lowered-Stress-Threshold-Model-U
- Hall, G., Kirschling, M., & Todd, S. (1986). Sheltered freedom: An Alzheimer's unit in an ICF. *Geriatric Nursing, 7*(3), 132-137. https://www.sciencedirect.com/science/article/pii/S0197457286800325
- Smith, M., Gerdner, L. A., Hall, G. R., & Buckwalter, K. C. (2004). History, development, and future of the progressively lowered stress threshold: a conceptual model for dementia care. *Journal of the American Geriatrics Society, 52*(10), 1755-1760. https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1532-5415.2004.52473.x

One additional reading was provided to the nurses:

- Hall, G. R. (1988). Alterations in thought process. *Journal of Gerontological Nursing, 14*(3), 30-37.

The training materials in the toolkit also included plenty of information about dementia, behaviours of concern, teamwork and useful communication strategies.

On-the-floor mentoring

At least two aged care staff and nurses in each facility were appointed as change champions by facility managers. These change champions received one hour of training from an experienced clinical nurse consultant on observation of residents' needs and provision of on-the-floor mentorship to staff to enable them to respond to the residents' needs.

The mentors' roles included the following:

- establishing a safe psychological environment for staff to explore their feelings about the care they provide and to discover new ways to approach people whose behaviours cause concern;
- showing sympathy for and understanding of the situation of residential staff and those they care for, and an understanding of dementia, including the multiple physical, medical, social and environmental reasons residents develop behaviours of concern;
- helping staff to develop the skills to understand the individual and collective causes of distress in each resident. This enabled the staff to better understand the nature and causes of their own response to the resident and to make adjustments or undertake interventions.

It was essential that mentors received peer support.

The responsibilities of mentors were:

- The delivery of a two-day training course (this required experience in delivery of adult training and education).
- Leadership of care planning meetings that focused on reducing the behaviours of concern of 6–8 residents. These meetings were reflective rather than prescriptive. The mentor provided emotional as well as clinical support to the staff and encouraged them to review their practice, feelings and perceptions of the

residents' feelings in the expectation that, in doing so, new and more effective methods of reducing the behaviours of concern could be found.

The mentorship support program provided:

- education to the care workers about common reasons for people's behaviours of concern;
- support for the care workers through an exploration of the reasons for the particular behaviours of their family members;
- support for the care workers to participate in the development of care plans for the person with behaviours of concern; and
- support for the care workers while the clinicians are trying to help the person with behaviours of concern.

The experience and qualifications that mentors required were:

- experience in personalised dementia care and managing behaviours of residents with dementia;
- leadership experience in care planning;
- attended the personalised dementia care training sessions;
- tertiary-level qualification in aged care.

The mentoring process

In the Harmony in the Bush project, mentor sessions were provided daily on the floor. Weekly meetings allowed a complete review of the residents' care plan and behaviours. Sessions generally occurred in handover time, when two overlapping shifts were on the premises. The mentors had the group together for 60 minutes. The mentors tried to establish rapport with staff as encouragement, and most of them were comfortable. The mentors tried to create a safe environment, where staff could be sure that disclosures would be treated confidentially and with respect.

Preparation for the sessions

- Explain the approach, and the evidence for it, to senior managers;
- obtain agreement to introduce it via the two-day training course;
- agree on frequency and timing of sessions with relevant managers; and
- provide training and introduce the mentoring strategies.

Key to mentoring sessions

- Support and encourage the staff member as she/he presents the information she/he has gained from research;
- encourage staff member to talk about how she/he feels when they are looking after the resident;
- encourage others to talk about their feelings;
- encourage staff to look at the situation from the point of view of the resident;
- encourage reflection on how the behaviours of concern are being responded to;
- encourage the exploration of new ways to respond;
- agree on a new approach; and
- ensure the new approach is entered into the care plan.

Picture

Aging Well in Harmony – Two-component program

Picture

Development of a personalised care plan – A living document

In aged care facilities, care plans are often formalised documents that do not accurately represent the reality of care provision. They are viewed by staff as useful only for accrediting and funding purposes, rather than as a document that tells the story of their care and one which celebrates their thinking and expertise. A co-designed personalised care plan provides not only an opportunity to explore and reflect on the feelings and experiences of residents with dementia, but also to encourage staff to collectively evaluate and update the care plans. In this way, care plans become truly representative in personalised dementia care. The residents and their family members usually have little or no control over care plan content and consequently feel excluded. This in turn discourages them from communicating with staff about the plans. Inclusion of families and communities in the identification of the residents' care needs was a positive step in this project. Family members' feelings, experiences and perspectives are valuable for staff to hear and act on accordingly. The Harmony in the Bush study used a set of intervention strategies as part of the personalised care plan, which were implemented collectively in each of the aged care facilities.

Key intervention strategies

- co-designed individualised care plan
- reduced ambient noise
- no waking of residents in the morning until 10:00 am
- provision of individualised breakfasts
- provision of food and drink station for residents
- provision of morning drinks, for example, milkshakes
- serving one plate at a time during mealtimes
- provision of evening wind down, for example sing-along
- lights off at night; use only torches when checking on the resident/s
- if residents wake up at night, give them a warm drink to settle or Weet Bix
- provision of afternoon rest: 2:30–3:00 pm every day
- playing preferred individualised music list 30 minutes per day minimum, mostly during rest periods (2:30–3:00 pm)

- Provision of individualised activities, for example knitting, gardening; residents can use the kitchen.

Table 2. Person-centred care strategies for residents with dementia

Care components		Strategies	Way of implementation	Outcome examples
Behavioural and psychological change	Reduction of noise level	Switch off TV No dragging of devices on the floor Reduce outside noise	Encourage staff to reduce noise level inside and outside the facility to facilitate a peaceful home environment	*Um, they are less aggressive, so they ar resident …*
	No wake-up policy	No push for wake up in the morning until 10.00 am	Encourage staff to wait for residents to wake up in the morning to start general care activities, such as showering, breakfast, etc.	*We do not push them for waking up in th calm in the breakfast table.*
	Lights off at night	No indoor or outdoor lights during night-time	Staff use only torches when checking on the residents	*They are sleeping well at night, so they rest so at night they are not, like, wande well now.*
	Afternoon nap	Provision of afternoon rest at 2:30–3:00 pm everyday	Staff encourage residents with dementia to have an afternoon nap	*… they have a sleep in the afternoon, wh so stressed out and their behaviour, and um, before dinner …* *Um, (the calmness in the facility, the cal Oh, yeah. So, starting from, you know, v huge improvement, so it's really more to*
	Active lifestyle	Preferred personalised activities	Take the residents for a walk in the morning or afternoon	*Yeah. Well they're mostly out all walkin out with the DTs for walks and that too, around.*
Physical health change	Individual breakfast	Develop person-centred breakfast menu	Do not push residents to eat breakfast and provide breakfast at each resident's preferred time	*We do not push them for waking up in th calm in the breakfast table.*
	Morning drinks	Keep them hydrated	Integrate a morning drink in breakfast menu	*… when we follow the program, we wou Their nutrition and hydration are better and they're less distracted.*
	Food and drink station	Better fed during night with sandwiches/biscuits and keep them hydrated during the day and night-time	Nutrition & hydration	
	Serving one plate at a time	Prepare an individualised meal menu	Weight stabilisation	*by a certain time to fit with the meals an they might have for breakfast, but they' know, they're – so they're focused, and weight …*
Quality of life improvement	Provision of individualised activities	Personalised activities	Engage them in preferred activities, such as drawing, painting or singing	*One of the beautiful things that came ou there was a lady who had been playing because she could do it, that's why she about when her baby died. So, whatever memory of when her baby died, and how So, it was a beautiful story that she actu*
	Provision of individualised music	Preferred playlist of music	20–30 minutes, twice a day (morning and afternoon) Personalised song selection and play in an	*The music intervention makes them calm their faces. And of course, the sing-alon Well, the particular person I'm talking a see she lights up and her mood level is q*

			individualised session, mostly when they were in room or outside garden	
	Group music session	Guitar or drum sessions	45–50 minutes twice a week (in TV room or a big room) – doors were open so that residents can join the session at any time. Providing different instruments to the residents for playing along with the live performances	*Well I suppose, you know, one lady in pa other ones, she doesn't really talk much she has, but when, when we're close enc singing loud enough, that she gets at wh like you can almost see the memories; it husband and they used to sing those son face, and there's another one that goes, smile, it's just, it, it makes them happy. can't say the words, they're humming it*
	Social interactions	Family member visits	Inviting family members to different social and cultural events	*Um, like when they sit down and have th there's, ah, a gap of time that they then they're ready for bed, it's more an orga*
		Attend group music sessions	Encourage family members to attend group music sessions and sing-alongs	*Um, sitting down and having a sing alon sleep, um, they go out into the garden to*

In summary, we found that the co-designed personalised model of care used in the Harmony in the Bush project was effective in improving the health and wellbeing of residents with dementia, with a comparable reduction of staff work stress.

Music intervention

Harmony in the Bush Study – Key findings

Residents' health and wellbeing outcomes

Table 3 illustrates the changes in behaviours and psychosocial symptoms in residents with dementia, pre- and post-intervention, showing an improvement in sleep patterns, nutrition and weight stabilisation. The common symptoms among the residents before the intervention were pacing; aimless wandering; general restlessness; trying to get to a different place; repetitive sentences; and cursing and verbal aggression. Longitudinal analyses between baseline and post-intervention observed a significant decline in behavioural and psychological symptoms of dementia across domains. Analyses of the data indicated the decline in scores was significant after controlling for age and gender. During interviews and focus groups, facility managers, clinicians, care workers, diversional therapists and musicians also reported a great improvement in the residents' wellbeing and a reduction in behavioural symptoms (Table 3).

Table 3. Prevalence of behavioural and psychological symptoms in residents with dementia

Domain	Symptoms	Baseline n (%)	4 weeks n (%)
Aggressive behaviour	Hitting	12 (16.2)	16 (21.6)
	Kicking	6 (8.1)	10 (13.5)
	Grabbing onto people	25 (33.8)	22 (29.7)
	Pushing	20 (27.0)	16 (21.6)
	Throwing things	7 (9.5)	13 (17.6)
	Biting	3 (4.1)	8 (10.8)
	Scratching	6 (8.1)	10 (13.5)
	Spitting	12 (16.2)	12 (16.2)
	Hurting self or others	8 (10.8)	9 (12.2)
	Tearing things or destroying property	13 (17.6)	11 (14.9)
	Screaming	17 (23.0)	17 (23.0)
	Cursing and verbal aggression	41 (55.4)	28 (37.8)
Physically non-aggressive behaviour	Pacing, aimless wandering	64 (86.5)	49 (66.2)
	Inappropriate dress or disrobing	33 (44.6)	23 (31.1)
	Trying to get to a different place	47 (63.5)	21 (28.4)
	Handling things inappropriately	36 (48.6)	16 (21.6)
	Performing repetitious mannerisms	32 (43.2)	23 (31.1)
	General restlessness	55 (74.3)	40 (54.1)
Verbally agitated behaviour	Repetitive sentences	45 (60.8)	20 (27.0)
	Complaining	30 (40.5)	15 (20.3)
	Negativism	33 (44.6)	18 (24.3)
	Constant unwarranted requests for attention or help	31 (41.9)	15 (20.3)
Hiding and hoarding	Hiding	20 (27.0)	11 (14.9)
	Hoarding	23 (31.1)	13 (17.6)

Impact on staff workplace stress

Table 4 shows the factors associated with Caregiver Stress Inventory scores including aggressive behaviours, inappropriate behaviours, resident safety and resource deficiency. Female staff reported a higher mean score than males regarding stress related to inappropriate behaviour. The other significant difference was that staff whose country of birth was not Australia reported high stress scores in the domains of aggressive behaviours and resource deficiency. The total scores on the Caregiver Stress Inventory reduced between the two time points. Analyses also showed consistent decline in staff stress in all subscales.

Table 4. Effectiveness of intervention on stress associated with caregiving

	Baseline	**Follow-up**
Aggressive behaviour	4.3 (1.1)	3.5 (1.4)
Inappropriate behaviour	3.2 (0.9)	2.7 (1.1)
Resident safety	4.2 (1.0)	3.5 (1.2)
Resource deficiency	3.6 (1.2)	3.0 (1.1)
Total CSI	3.6 (0.9)	3.1 (1.1)

Table 5 presents the qualitative evidence of staff stress reduction. The intervention improved knowledge and understanding about personalised dementia care and how to develop care plans, built capacity in managing behaviours and improved work–life balance, all of which contributed to the reduction of carers' stress in the workplace.

Table 5. Project outcomes on staff stress reduction

Care components	Implementation strategies	Outcomes
Improved knowledge on personalised dementia care	Knowledge about dementia	*Yeah, we need more education for our staff as well for dementia. … We have totally fresh staff who don't know nothing about dementia. Just need education to everybody to keep it up. … Yeah, the training does help implement everything and it reinforces everything that you guys have said and taught.* *Yeah, I think there's less, um, medical intervention, like medications. I think there's still obviously some residents* [with dementia] *that we try everything and it doesn't sort of work for them; we, sort of, use that as a last resort, but I feel like we use less medications to deal with difficult behaviours or residents being unsettled, um, which is better for them.*
	Understanding of personalised care	*There is one resident in there that, like I can understand her better from when I first engaged with her, I can now understand what she wants, like, you know, come on, we'll go for a walk, and yeah, she's talking and then, yeah, I can. I think.* *And I think knowing that we've got all these strategies from what we've learnt that when we have a difficult resident or when they're unsettled, we know we can sort of go back to that and try the – and 9 times out of 10 it will work …*
Changed care approach and plan	Personalised approach	*Just personalise more to each individual …* *So, if we keep up with our routine, I think that will make them happier. Before the program they're usually up during the night, they couldn't sleep, so the next day they would get more agitated. After the program, next day they are happier.*
	Care plan change	*And we don't wake them up in the morning, we let them sleep and rest. Staff are less stressed. Very satisfying working in that wing; I love it. Very rewarding.*

		Um, where some of the residents are up for breakfast and some of them might not get up until a bit later, 9:30, 10 o'clock, so we know they're a bit of a late, later riser, um, a lot of them are more happy to join in the activities now, more cooperative.
	Lowering stimulation	*Um, there was a lot to take on board to start with, because we had to really change our mindset … initially we were trying to provide stimulation, so we had to really learn about, about lowering the stimulation* [as part of the program].
	Reduce confusion	*Ah, I think mealtimes are better with the one thing at a time. We used to, you know, the table was set, drinks would arrive, and the meal arrives and there was just so much confusion, but now it's, it's one step at a time. They're a lot more able to help themselves, they're, that's, that's improving.*
Capacity building in behaviour management	Critical reflection on work	*So we do start* [to struggle with] *dementia behaviour and challenging behaviours and we just recently had a staff can't cope and had to go on stress leave because of this, so, yeah, I think the more education than we're doing, intervention when we're doing like projects like this. That basically we don't push the residents that – that they find their own, um, how do I put that? Um, they do their own thing in their own time…*
	Person-focused action	*… now because they're doing it in their own time … and we've, sort of, said it doesn't matter if they miss a shower on a day.* *For example, yeah, one of the residents, he did not want to go in a group activity, so when he did indicate, you know, one of the staff member go sit with him and liked to do, you know believe in God, so they read the Bible for him and they calm him down so that's a one-on-one activity.* *… one when we started The Harmony in the Bush, she would just spell, just spell the same word over and over and over and she'd come up to you and spell the same word. We went through a stage where she would then, she started*

		talking just in sentences, she would tell you what she wanted, if you initiated conversation with her. She would answer appropriately or whatever. She'd had a little bit of a back step the last few days, when, yeah, but in general …
	Easy to manage	*… they will have a laugh. Um, they're not just seated in one spot and trying to look at, you know, the television which I would say they wouldn't even remember or understand what's on TV. So yeah, and it's good. Like, you know, um, less behaviours and they're more, like, um, happier, I'd say. Ah, easier to manage.*
Work–life balance		*And it's not so stressful or overwhelming working there anymore.* *… because it's not rushed anymore and trying to keep to task you feel better when you go home because at the end of the day that they've had a great time and they've gone to bed, I am happy and contented.*

Impact on organisational culture and environment change

Key aspects of the organisational culture and physical environment improved considerably, even in those facilities where the budget was limited, and changes were small (Table 6). While it is difficult to quantify the effects of these improvements, the staff suggested that these improvements will reduce overstimulation, confusion and feelings of insecurity. In addition, changes will increase helpful prompting, opportunities for socialisation, and time spent outdoors or in meaningful activity.

Table 6: Change in culture and physical environment of aged care facilities

Care components	Strategies	Outcome examples
Leadership to change	Socialise with residents	*Sit down and be just part of it, like, sort of be a bit where they're at, and chat and socialise with them and, because they want to feel comfortable as well, but if you're racing around doing this and that all day …*
	Role change of leaders and staff	*Ah, not – more so the, um, management do that here. A leader can change them and we're working with them all the time …* *But there's also been a massive shift in staffing, the way people [carers] take on the role now too, which has been good. The attitude, yeah. And that's a good shift, because it's in the right direction.*
Improved relationships among staff	Teamwork	*Oh, we're all chilled* [as a team]. *Staff are, look, some days, it works really well and obviously depends on what, um, ah, team mix you have … I think the [key staff], yeah, are, sort of, quite positive, most of them. Um, I think, you know, some more support would probably be beneficial for them just, you know, so that they – just so they – so they – they are still doing the right thing. Um, and more education, probably, on – for staff as well, especially staff on the floor.*
	Following the decisions of coordinator	*As I said … I used the walkie-talkie in the afternoon, ah, to the coordinator. If the coordinator is not here I use the walkie-talkie to the staff and the staff are always obliging and bring the people down here so that we can get them settled before the music therapist starts her program, and they're settled.*
Physical environment	Provide more time to the residents	*The staff are less stressed so we have more patience with the residents, and we can give them more time.* *It's good to be able to spend that extra time with the resident and give them something that brings them enjoyment, um, …*
	Lowering stimulation	*Um, there was a lot to take on board to start with, because we had to really change our mindset … initially we were trying to provide stimulation, so we had to really learn about lowering the stimulation* [as part of the program].
	Reduced noise level	*There's not a loud noise like the TV on or the music loud or anything like that; everything's kept very calm* [after the intervention].
	Freedom of choice	*So, it doesn't matter if instead of having – when they wake up, instead of having toast and Weet Bix, they may just have toast or just Weet Bix.*

	Home environment	*For me, I have seen more of a home approach in a sense that there are some residents that if can relate the facility to be what their home environment was in a sense of dining room, for example, tablecloths. It was an individualised approach to keep that person occupied. This brings a home-like environment for residents as well as staff.*

Using the toolkit

Picture

The Ageing Well in Harmony Toolkit promotes personalised dementia care, which is part of the improvement of health and wellbeing of residents and staff, and a change in organisational culture. This toolkit contains a number of person-centred care strategies, which are used for a person with dementia living in aged care facilities. Table 7 provides a guide to using this toolkit.

Table 7. Use of Ageing Well in Harmony Toolkit

Preparation	
Insert picture	Open discussion with facility managers and clinicians about the challenges experienced by staff in providing care to residents with dementia
Insert picture	Care plan assessment for residents + Participant observation by an experienced clinical nurse to record the needs and preferences of each resident with dementia
Insert picture	Organise education and training sessions for all staff

Insert picture	Establish mentoring process and train the mentor
Organisational culture and physical environment	
Insert picture	Improve interactions among and between staff and residents
Insert picture	Create home environment
Insert picture	Reduce unnecessary inside and outside noise level
Insert picture	Shared decision making and implementation
Insert picture	Organisational safety

Implementation of personalised dementia care	
Insert picture	Record care needs and preferences and co-design individualised care plan
Insert picture	No waking up residents in the morning until 10:00 am
Insert picture	Provision of individualised breakfast
Insert picture	Provision of food and drink station for residents
Insert picture	Provision of morning drinks, for example, milkshakes
Insert picture	Serving one plate at a time during mealtimes

Insert picture	Provision of evening wind down, for example sing-along
Insert picture	Lights off at night; use only torches when checking on the resident/s
Insert picture	If residents wake up at night, give them a warm drink to settle or Weet Bix
Insert picture	Provision of afternoon rest: 2:30–3:00 pm every day
Insert picture	Play preferred individual music list 30 minutes per day minimum; mostly during rest periods (2:30–3:00 pm)
Insert picture	Provision of individual activities, for example knitting, gardening; residents can use the kitchen

Sustainability of person-centred care	
Insert picture	Ensure that a care plan has been implemented for each resident
Insert picture	Regularly check that residents' and their family caregivers' perspectives are included in the care plan
Insert picture	Ensure sustainability of personalised care plan and training and mentoring for staff

Resources

Dementia assessment and person-centred care practice

Delirium Clinical Care Standard: https://www.safetyandquality.gov.au/our-work/clinical-care-standards/delirium-clinical-care-standard

Clinical Handover Policy Directive: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/communicating+for+safety/isbar+-+identify+situation+background+assessment+and+recommendation

Person-centred dementia care

Australian Safety and Quality Framework for Health Care: https://www.safetyandquality.gov.au/

Australian Commission on Safety and Quality in Health Care, Patient-centred care: https://www.safetyandquality.gov.au/

Advance care planning: https://advancecaredirectives.sa.gov.au/

Health and Community Services Charter of Healthcare Rights: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/safety+and+quality/partnering+with+consumers+and++the+community/hcscc+charter+of+healthcare+rights

Online dementia care support

Dementia Support Australia: https://dementia.com.au/

Dementia Behaviour Management Advisory Services (SA): https://www.agedcareguide.com.au/

Hospital Dementia Services: https://www.aihw.gov.au/reports/aged-care/the-hospital-dementia-services-project-a-study-de/contents/table-of-contents

Interaction with a person with dementia: http://nursing.flinders.edu.au/comeintomyworld/

Mobility and self-care

Fall and injury prevention:

https://www.sahealth.sa.gov.au/wps/wcm/connect/8acea4004654c05ab1a9fb2e504170d4/Directive_Fall+%26+Fall+Injury+Prevention+%26+Management+PD+%26+Toolkit_Dec2015.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-8acea4004654c05ab1a9fb2e504170d4-mMz0WJ6

Nutrition

Nutrition – things to consider: https://daa.asn.au/smart-eating-for-you/smart-eating-fast-facts/medical/malnutrition-who-is-at-risk-and-things-to-consider/

References

Appendix

Organisational culture and the physical environment have a direct influence on residents with dementia and aged care workers. Several areas of the culture and physical environment of aged care facilities were identified by the investigators of the Harmony in the Bush study and in the literature that require improvement (Table 8). This intervention is dementia-care specific, and required changes are listed under five areas that underpin the health and wellbeing of residents with dementia and their carers.

Table 8. Key areas of organisational culture and physical environment

Care components	**Problematisation of culture and physical environment**
Leadership	The confusion associated with dementia means a variety of safety features need to be built into the environment. They include a secure perimeter, hot water temperature control and safety switches in the kitchen. Safety features must not be obvious as this leads to people feeling trapped.
Relationships among staff	To provide opportunity for residents to continue to be part of their community after moving into aged care, access to shopping, their church, parks and social clubs should be facilitated. If getting outside is difficult, consider what the resident sees from her window, and whether this provides an opportunity for interaction with everyday life. Create private spaces for visits.
Reduce stimulation	People living with dementia experience difficulties in coping with large amounts or competing sources of stimulation (for example having the television on while eating a meal). The facility must be designed to reduce the impact of unnecessary stimulation, especially noise. For example, entry and exit doors used for deliveries and staff movements should not be visible to the residents, nor should there be audible staff paging systems.

Home environment	The facility is the residents' home; therefore the environment should be as homelike as possible. In the absence of a cure for dementia, the goal of care is to maintain the person's abilities for as long as possible. This requires opportunities and encouragement to use those abilities in normal everyday tasks. All the features found in a domestic home should be provided, including a kitchen, laundry, garden and social spaces.
Highlight important features	Features that are important to the residents should be highlighted. These include toilet doors, exits to safe outside areas, and orientation aids such as signs, pictures or objects to help them recognise their room.

Harmony in the Bush project's evidence

The Harmony in the Bush research team argues that a cultural shift and physical environmental modification in rural aged care facilities can improve the care services for resident with dementia and staff relationships that occur in the context of good leadership. A number of strategies were suggested to improve the organisational culture and physical environment:

Key strategies

- Encourage facility leaders to discuss more with staff and familiarise themselves with the care need and preferences of each of the residents with dementia;
- improve collaboration among staff;
- improve vertical relationships in implementing care decisions;

- lower unwanted stimulation;
- reduce inside and outside noise; and
- develop a home environment for the residents.

Table 9. Staff care support components

	Physical	**Behavioural/psychological**	**Social**	**Cultural**
Nature of care	Treatment based – understanding of symptoms and diseases	Treatment based – understanding of behavioural and psychological symptoms	Lifestyle based – review of daily lifestyle activities	Values based – acknowledgement of cultural values
Aim of treatment	Reduction or delaying the physical risk factors	Emotional care for residents with dementia	Social aspects, including factors associated with behaviours, for example, isolation, hiding, hoarding or wandering	Integrate cultural and spiritual care into general care for residents
Care needs specification	Clinical diagnosis and medical treatment options for specific type of dementia	Cognitive stimulation for the maintenance of reasoning skills and memory connection	Personalised activities and respite care to improve social interaction among the residents	Emphasis on each individual's dignity and cultural preferences
Interventions	Pharmacological treatment, for example, medication use for physio-psychological conditions of residents with dementia	Encourage non-pharmacological treatment options, for example, personalised music therapy, personalised activities, patient active lifestyle, therapeutic touch for pain management, art and dance. In addition, cognitive therapy for challenging behavioural and psychological symptoms.	Personalised care plan implementation at group level, for example, group music sessions, personalised activities with access to community services to provide support along with meaningful care	Focus on griefs, loss, suffering and connection to land, family and community in providing care
Care management	Physical symptom management, such as frailty, BMI, dysphagia, pain and constipation	Behavioural and psychological symptom management, such as wandering, verbal aggression, hitting, screaming, negativism, eating disorder, handling things inappropriately, hiding, hoarding and restlessness	Social interaction management through organising dementia-friendly events, such as group bus trips, dementia café choices and community events	Cultural care management, such as support in prayers, greetings and cultural festival celebrations
Maintenance of care	Frailty reduction and maintenance of mobility Dietary support, including nutrition plan, availability of food, hydration and spoon feeding	Encourage positive relationships between staff and residents Person-centred interaction to individualise care needs and expectations of persons with dementia Day-to-day care strategies Lowering stress through pleasurable and meaningful activities	Develop dementia-friendly home environment and accommodation Use of assistive technology to maintain communication Provide family caregivers access to information and encourage them to visit the resident	Cultural therapeutic touch & protection of cultural identity and dignity Value cultural healing beliefs and practices

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