Mnemonic techniques: how to CEASE stress and distress

Fionnuala Edgar describes how using different methods of teaching and learning – experiential learning and simplifying key concepts – had the potential to bring about practice change in a way that had not been achieved previously

It is estimated that around 90% of people with a diagnosis of dementia will present with psychological or behavioural difficulties, particularly in the more advanced stages of dementia (Thompson et al 2010). Anti-psychotic medication has often been seen as a first line response to these behavioural difficulties, but increasing evidence has emerged of the dangers of relying on it for the treatment of behavioural difficulties in dementia.

Anti-psychotic medication is now recognised as being ineffective in four out of five such cases, with significant associated side-effects including heightened risk of stroke and death (eg, Banerjee 2009). It is also known that the use of this medication merely addresses the symptoms rather than the cause of behavioural difficulties in dementia (Cohen-Mansfield 2001; James 2011).

In Scotland, there has been a change in the language used to describe such behavioural difficulties from traditional terms like "challenging behaviour" and "behavioural and psychological symptoms of dementia" to the term "stress and distress" in dementia. This alteration of terminology supports an understanding of behavioural difficulties in dementia as symptomatic of an unmet need (Cohen-Mansfield 2001; James 2011). In line with the shift of treatment focus, there has been a corresponding increase in the evidence base for non-pharmacological interventions for stress and distress in dementia (see Cohen-Mansfield 2016 for recent review).

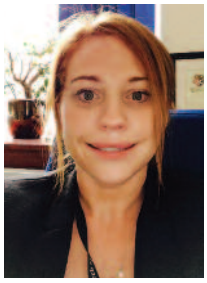
Stepped care model

Evidence published by the British Psychological Society (2013) for non-pharmacological approaches also promoted a "stepped care model" for the assessment and treatment of behavioural and psychological distress (see figure 1). In the Dumfries and Galloway region, where our service is based, training for care home staff in non-pharmacological approaches to assessment and treatment has been ongoing since 2010.

In this service, a clinical psychologist, advanced nurse practitioner, occupational therapist, social worker and speech and language therapist comprise a specialist, multidisciplinary team dedicated to providing education and support in dementia care. We are known as the IDEAS team (Interventions for Dementia: Education Assessment and Support) and our remit has extended beyond care home staff to include all facilities, agencies and individuals, whether public, private or voluntary sector, giving direct care to people with dementia and their families.

Although initial feedback from care home staff was encouraging (Warwick & Edgar 2011), problems were identified with turning the training into effective improvements in practice. These included high staff turnover, difficulties releasing staff to attend training, educational attainment and (less commonly) literacy difficulties among this group of staff. We saw that the solution lay in utilising different methods of teaching and learning: experiential learning and simplifying key concepts had the potential to bring about practice change in a way that had not been achieved previously. As the evidence base for assessing and treating stress and distress in dementia has evolved, so the IDEAS training has been continually adapted and updated.

Step 2 of the stepped care model (right) involves a "thorough assessment and general good practice in the care environment". It was clear to us that embedding the concept of "good practice" would be fundamental in increasing staff awareness of some of the underlying causes of low levels of stress and distress. Staff were therefore trained in the key aspects of good practice in dementia care, as outlined in the stepped care model. This included learning about (BPS 2013):



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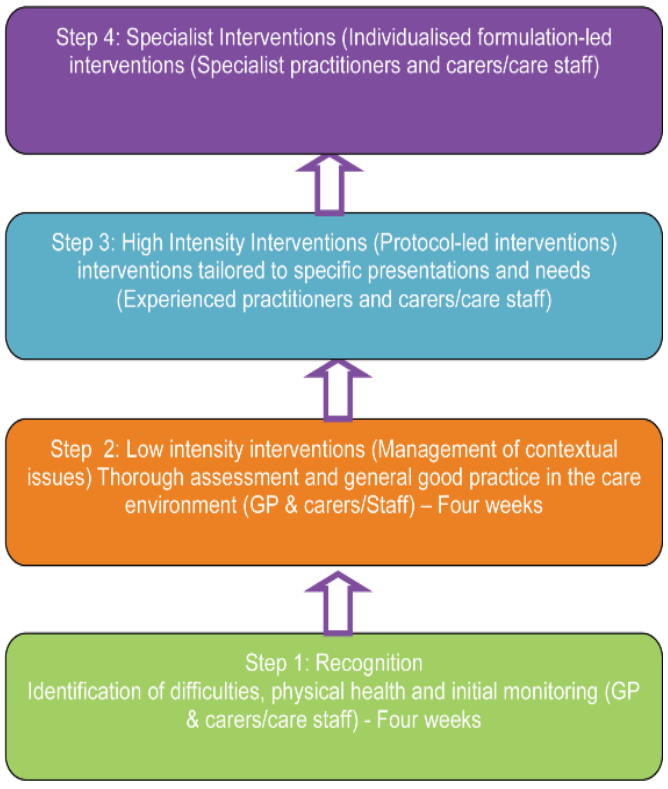


Figure 1: Stepped care model

• emotional status of the client (assessing emotions, moods, worries, beliefs)
• physical environment (eg, overcrowding, privacy, noise levels)
• carer communication skills and style of interacting
• communication (can the person with dementia communicate what they want and can others communicate with them)
• design and layout of environment
• social contact (opportunities to spend time with others)
• occupation (eg, how the person with dementia is spending their time).

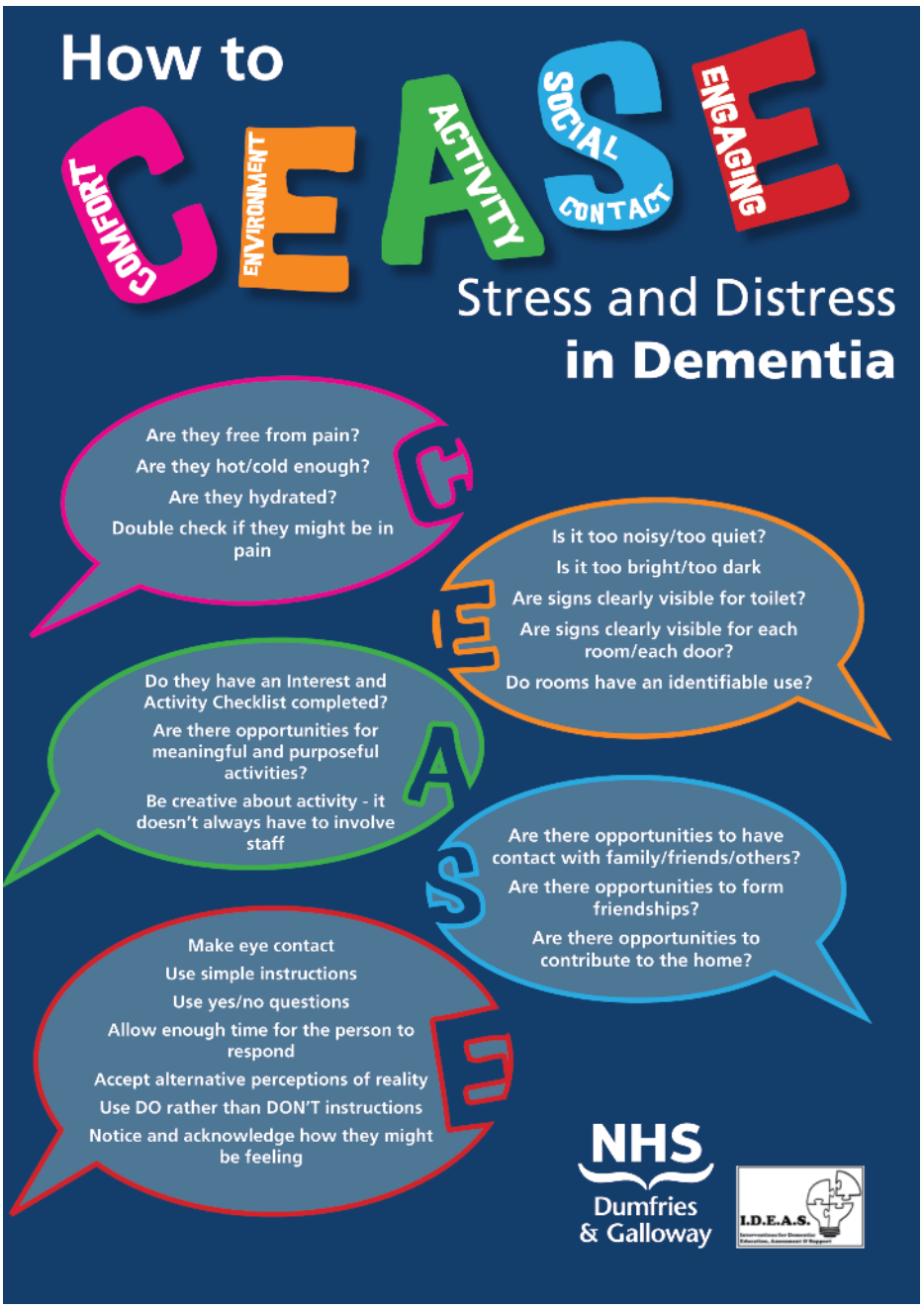
When developing the training, feedback and experience from previous training as well as an understanding of barriers to effective practice change were taken into consideration. It was noted that staff had a significant amount of new information to digest during the training and that different formats for learning should therefore be considered.

Mnemonics are seen as an effective way of retrieving new information, particularly when used alongside other learning strategies (such as traditional teaching) (Putnam 2015). It was postulated that providing staff groups with a simple mnemonic to remember the key principles of basic good practice in the care environment would be a straightforward way to enhance learning.

We came up with the mnemonic CEASE to encapsulate the main concepts of basic good practice in dementia care as highlighted in the stepped care model. It was seen as helping staff to understand how their actions and behaviours could influence whether some stress and distress behaviours occurred in the first place. The mnemonic stands for:

C – Comfort (assessing the person's comfort levels, eg, are they in pain? Are they hydrated? Is the temperature of the room comfortable?).
E – Environment (promoting dementia-friendly design principles, including noise levels/lighting/signposting).
A – Activity (promoting engagement in meaningful and purposeful activity).
S – Social contact (facilitating contact with others, including family/friends/visitors/staff, both directly and indirectly).
E – Engagement (promoting effective communication between staff and dementia patients and considering the importance of emotions, how the person with dementia may be feeling).

To promote the acronym in care homes locally, the graphics team at Dumfries and Galloway council produced some colourful posters (see above) as well as pens and mugs emblazoned with the CEASE logo. These were distributed to everyone attending IDEAS training sessions and were also sent to every care facility providing dementia care in the region. Older adult community mental health nursing teams were provided with pens and posters to promote the use of CEASE in any contact with local care homes.



The role of the IDEAS team was expanded beyond training last year when it received permanent funding which enables it to accept requests for direct assistance relating to stress and distress behaviour in dementia. The CEASE mnemonic has become an important part of the local stress and distress care pathway as a result.

So the use of the acronym CEASE – in line with the recommendations of the stepped care model - could help prevent stress and distress behaviours from occurring. It has the potential to be a useful tool to facilitate early identification of underlying causes of any stress and distress behaviours, which could in turn reduce demand on specialist services.

Local outcomes

Anti-psychotic drug use in the locality was monitored and audited to establish whether any differences were notable during the pilot phase of the IDEAS project and the concurrent national drive to reduce reliance on anti-psychotic prescribing. Results were encouraging with a 76% reduction in expenditure in anti-psychotic medications between March 2012 and March 2014. It is difficult to know which variables were responsible for the reduction and to what extent, but➤

➤ the figures are encouraging given our focus on training during this period.

During 2012 - 14 there were additional significant outcomes in relation to the IDEAS project, including:

- reduction in A&E presentations from care homes
- reduction in emergency admissions to acute general hospitals from care homes
- reduction in number of adverse incidents in four out of six care homes assessed
- reduction in staff sickness and use of agency staff, and improvements in staff morale
- one in three care homes reported a reduction in incidents of verbal and physical aggression during the test phase
- one in three care homes reported a reduction in staff concern about undertaking personal care tasks
- individual case studies indicated a reduction in stress and distress behaviours due to input from the IDEAS team.

Review of CEASE

Over the past five years, approximately 2,000 staff from health, social care, private and voluntary care organisations have attended our training. Feedback from delegates has been consistently positive about the use of the CEASE acronym.

To further evaluate the utility of CEASE, a brief survey was sent to all care home facilities, community mental health teams, inpatient wards and other staff groups who had attended the training. The substantive questions were:

1. Are you aware of the CEASE stress and distress resource as developed by the IDEAS team?
2. What does the acronym CEASE stand for?
3. How often do you feel you refer to CEASE in your day-to-day work (either directly or indirectly)?
4. How useful have you found this resource in terms of addressing any stress and distress behaviours in your day-to-day work?
5. Would you recommend this resource as a useful tool to colleagues who have not undertaken training in dementia care?
6. Have you any additional comments regarding CEASE?

Survey results

A total of 54 of respondents completed the survey, 45 of whom said they had attended IDEAS training in the preceding three years. They were mainly junior and senior care home staff and care home managers, but other respondents included nurses, health care support workers, speech therapists and an occupational therapist, among others.

Points for practice

- The diversity of skills and abilities of those working in dementia care must be considered in the development of any training
- Using a range of teaching methods, including mnemonics, can enhance the embedding of new knowledge and skills
- Simplifying key concepts to meet the abilities of trainees is essential in any training role
- These teaching methods can help to reduce stress and distress behaviours by facilitating early identification of underlying causes
- More effective teaching may be partly responsible for reducing reliance on anti-psychotic medication.

An analysis of the data indicated that 83% of respondents had heard of the CEASE resource, while 58% knew what the letters stood for when presented with a multiple choice selection. The majority reported referring to CEASE very often (23%) or often (41%) in their daily work.

Figure 2 (below) shows that 26% found CEASE very useful and 57% useful.

Examples of additional comments from the survey are:

It is a great way to easily explain or to remind other care staff what to be looking out for and possible triggers of certain behaviours (care home manager).

This was a very helpful training tool - we use it more than we realise… with some steps becoming more of a habit (senior carer).

Great resource and training programme - thank you (care home manager).

Summary and recommendations

The stepped care model has been found to be a useful tool in training staff working in dementia care and the majority of those aware of it appreciated the utility of the CEASE mnemonic. It seems likely that other staff groups may find it helpful in promoting best practice.

Training in dementia care should always consider a wide range of learning tools for consolidating new information and enhancing the learning experience. Further research is required to fully understand the gap between knowledge and effective practice change, particularly when working across the diverse range of dementia services in health, social care, private and third sector organisations. ■

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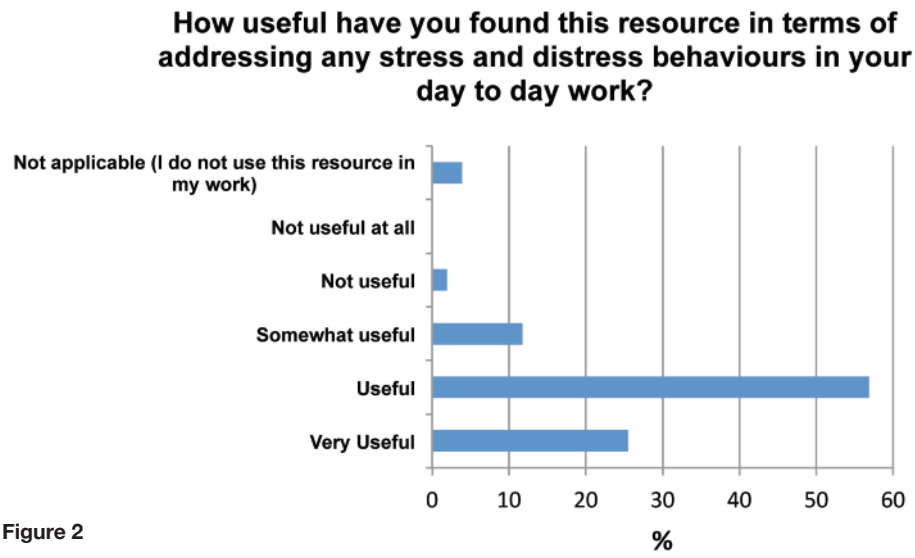

Figure 2