

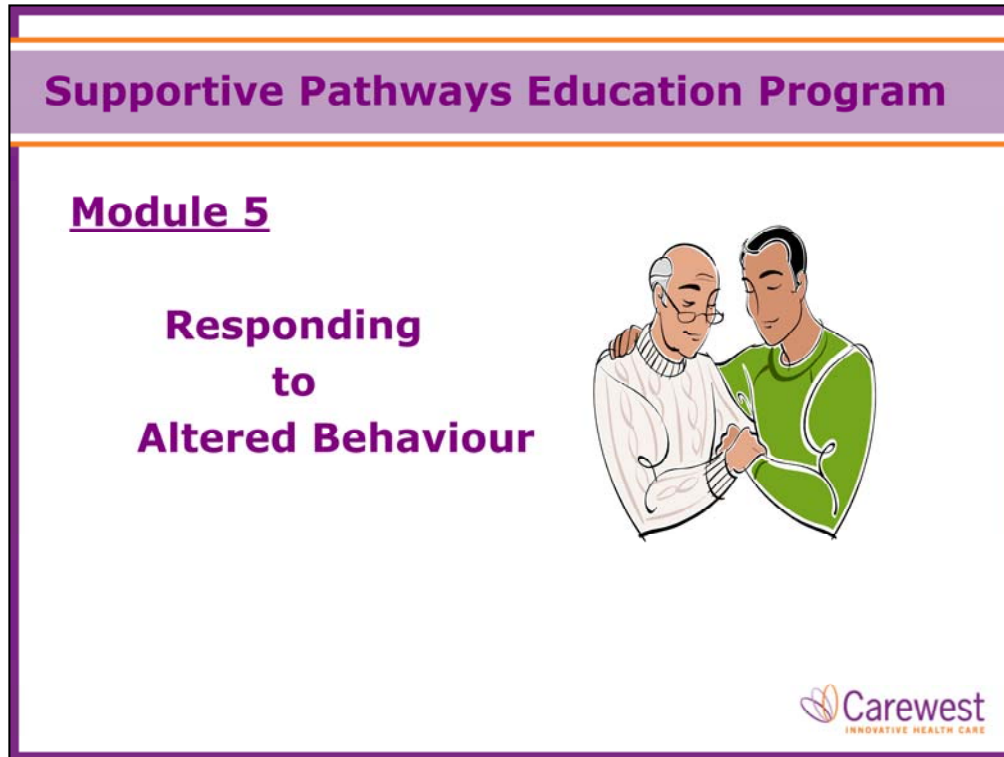


Suggestion:

If this is a start of a new day ask each participant to tell you one thing they remember from each previous module (ah-ha moments).

If they miss any key messages add them to the discussion.

This helps remind participants of what has already been covered and to refocus



TIME REQUIRED:

To complete this module plan 2 hours 45 min

SUPPLIES NEEDED:

LCD / Laptop

Screen

Flipchart / markers

Case Study Sheets

VIDEO Clip:

Choice and Challenge

- Dealing with the Aggressive Older Adults Across Levels of Care




BEST PRACTICE – These are some practices to incorporate into teaching or review at the end as a summary of content.

- Staff will know the **person's usual patterns** of behaviors
- Staff will understand that every **behavior has a meaning** and the importance of assessments to rule out physical causes (look for meaning)
- Staff will **recognize potential triggers** to behaviors
- Staff will **stay calm**, monitor their own level of fear and anxiety, and establish a relaxed mood
- Staff will **respect a client's personal space**
- Staff will leave a client where they are **unless it is an unsafe situation or they are interfering with the rights of others**
- Staff will **provide reassurance** to the client that they will not be harmed and encourage the person to talk rather than act out their anger
- Staff will **listen** to concerns, be flexible and accepting, ask what is troubling them.
- Staff will **provide alternatives** to the behavior, distract or divert the person's attention – state the action you want (e.g. avoid saying: "Don't go there", "Don't do that")
- Staff may **use appropriate humor** and laughter to stimulate a sense of relief and provide comfort through a sense of belonging
- Staff may **use touch and/or hugs** as a form of communication whenever appropriate or possible
- Staff will **not argue**, but will "let things be" if the situation is not harmful
- Staff will **accept behaviors** which are normal for a person with a dementing illness
- Staff will **pre-plan** their intervention especially when more than one caregiver is required
- Staff will know **that approach is important**

STAFF WILL USE THE FOLLOWING WAYS TO INTERVENE

- **Redirect** whenever possible.
- **Minimize** or eliminate triggers.
- **Validate** feelings.
- Invite the client to a quiet / peaceful place
- Recognize need for pain management
- Use “Path of least resistance”
- **Support and partner with families**
- Minimize moves/changes
- Make environment familiar
- **Re-approach at a later time**
- Try a different caregiver
- Go with the client rather than pull away
- **Quiet tone**
- Provide care with **least number of staff** possible
- Only one staff talk at a time

Objectives
To understand that behaviours may occur when interacting with persons who have dementia
To discuss strategies to prevent and intervene when behaviours including aggression occur
To learn a problem solving approach to support persons with dementia who are distressed
To consider delirium as a cause if there is a change in behaviour



Discuss that they will hear the terms altered, challenging, responsive or other terms related to behaviour. They all mean the same thing.

Read objective aloud and share:

- behaviors may occur as a reaction to their perception of their environment and the people they encounter
- today we will discuss common behaviours seen in persons with dementia
- we can't forget that many of these behaviours may be related to a basic human need
- we need to consider these basic needs FIRST before we assume they are 'just part of the disease.'



All behaviour has meaning – it's our job to try to figure out the meaning!

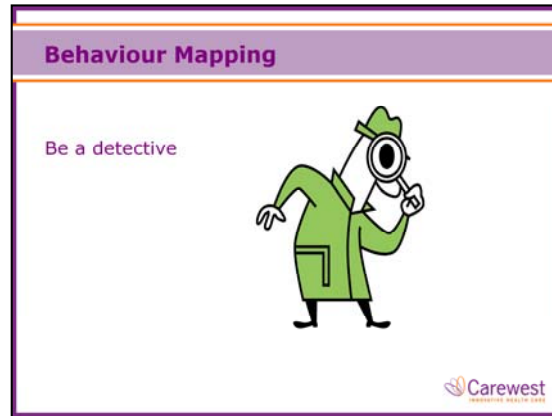
These behaviours are often referred to as...

Responsive Behaviours or David Sheard refers to them as **Expressive Behaviors** (they are trying to tell us something)

This is helpful because it causes us all ..

- **to focus on the person**
 - **to look for the meaning behind the behaviour**
 - **to consider, 'what might they be responding to?'**
- Persons with dementia sometimes lose their ability to express themselves through the spoken word
 - Non-verbal behavior becomes an important communication mechanism for the person with dementia
 - Sometimes physical illness is the message being conveyed (delirium).
 - It is very important that all caregivers report behavioral changes to someone who can help look for the cause and possible interventions.

Think about who this would be in your situation – Care Team Members? RN? Case Manager? Team Leader? Mental Health Team?

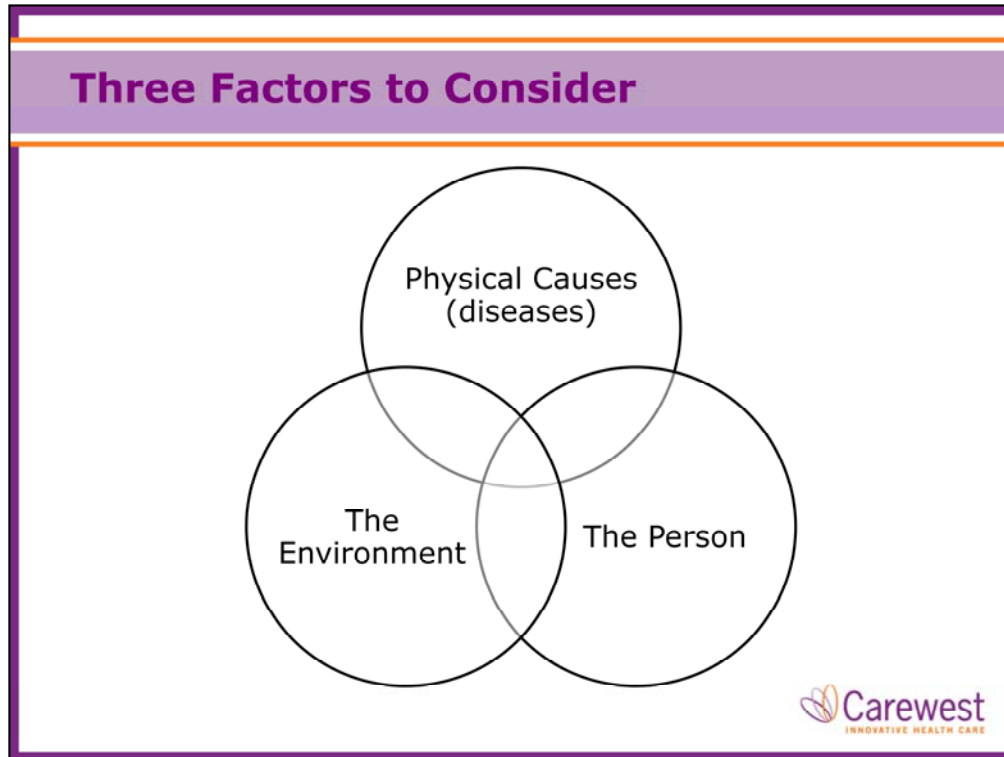


Behaviour maps are usually kept for several days to help **identify patterns in the behaviour and it's meaning.**

- What was happening before the behaviour occurred?
- Who was involved?
- What was the behaviour - describe exactly what happened (be specific)
- When did it occur?
- What happened after?

Behaviour mapping following an intervention **can help determine if the intervention is helping.**

It is very important to include the front line caregivers when doing behavior mapping



To discover the meaning of behaviour the situation needs to be assessed from four different perspectives.

Read the first three:


- physical causes (diseases)
- the person
- the environment

Trainer: these are described on the next slides

Physical Causes

Is the behavior related to:

- medical history, chronic pain, psychiatric illness?
- depression or delirium?
- UTI, pneumonia, constipation, dehydration, acute pain?
- medications such as antipsychotics?
- changes related to the type of dementia they have?
- what the disease has taken away?



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A medication review should be considered. Side effects? Appropriate dose?
Interactions?

A physical assessment is required

The Person

Is the behavior related to:

- fears (e.g. post traumatic stress)?
- hunger, thirst, other unmet needs such as intimacy?
- things that upset them (triggers)?
- boredom – nothing to do?
- their personality, family relationships, culture or religion?
- abilities/disabilities to understand, communicate or function?
- past routines/ lifestyle (e.g. went for a daily walk outside)?



Trainer: This was discussed in detail in previous modules so do just a quick review.

If you have examples from your practice add them in.

Trigger - Something that causes a **person to react** in a certain way.

ASK the participants :

WHAT WOULD Cause you to react?

e.g. fear of water, fear of heights (lift) being told what to do, noise,
someone looks like someone you disliked

Another e.g. - the person may recall something they don't like about 'dark haired people' and react to staff who have dark hair.

Are they bored?

Remember – if the person has nothing to do – you may not like what they find to do. (Quote by Marlene Collins)

The Environment

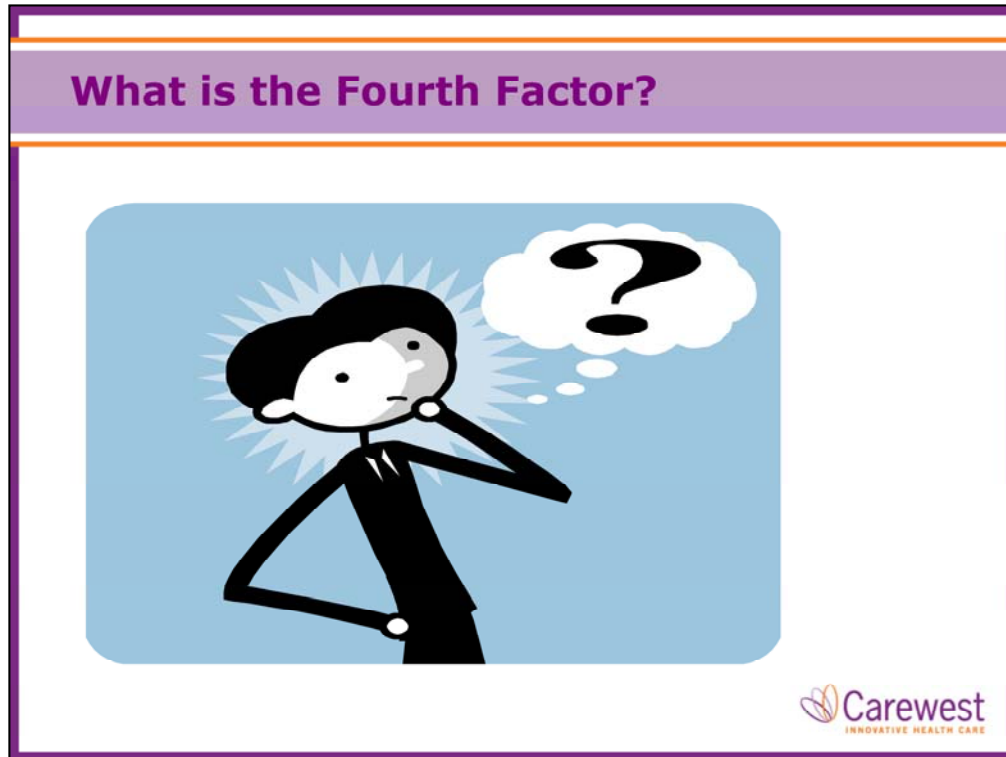
Is the behavior related to:

- a rushed, noisy, hospital-like environment?
- unfamiliar caregivers/surroundings?
- no opportunity for choices or to do something?
- task focused versus resident focused care culture?
- minimal social interaction with staff?



Trainer: this will be discussed in a later module

Share: when their surroundings are too unfamiliar, it won't trigger the memories required to recognize the new situation as safe and acceptable.



ASK: What is the fourth factor to consider?

Answer on next slide



Trainer: discuss briefly here but it will be discussed again as we go through each behaviour.

Trainer: may provide a few brief examples from experiences.

Do we have a need to be 'in control' ?

Do we 'force' the person to do things that lead to behaviours?

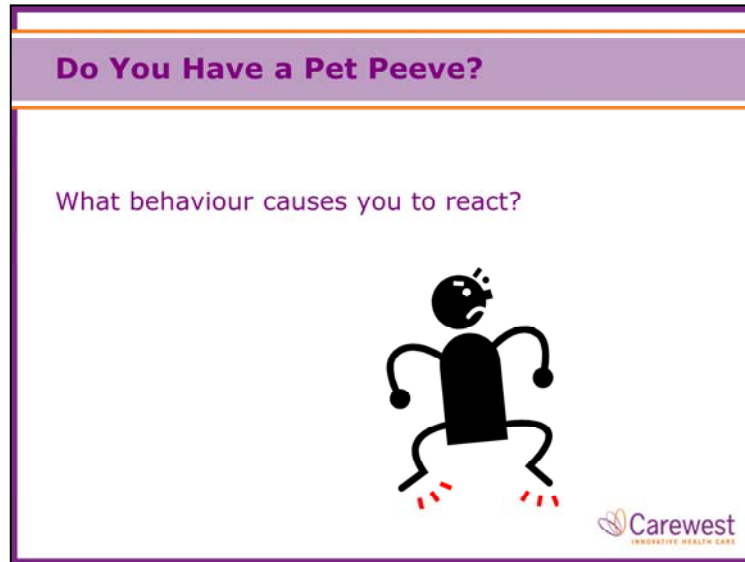
Do we anticipate needs?

- thirst
- hunger
- tired
- constipation
- pain relief
- something to do
- loneliness
- need for toileting
- need for reassurance
- need for touch

Are we reinforcing the behaviour?

E.g. Does the person only have human contact when they yell or call out?

ASK: Are we willing to share and try our creative ideas?



Ask: Are there some behaviours that you are less tolerant of - while other staff aren't so bothered?

Ask the group if anyone has any pet peeves – e.g. spitting, messing things up, noise? **These are our triggers.**

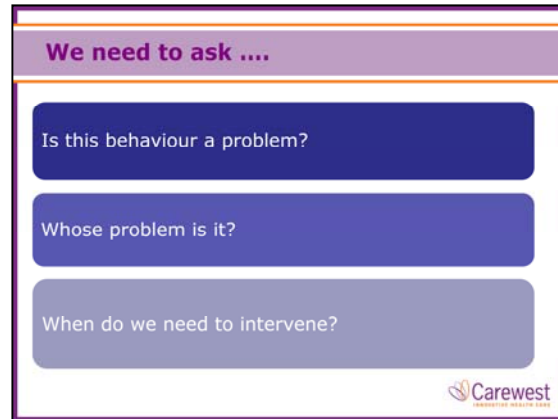
If working with **Caregivers including Family**

- Encourage them to consider why some behaviours bother them more than others
- Help them to realize the person is not knowingly acting that way
- Encourage them to schedule breaks from caregiving

How Can We Support The Client with Dementia?

Behavior can be an indication
that the person with dementia
is **distressed** and needs our support.





When we are considering altered behaviors, we must ask ourselves the above questions.

Sometimes we do not need to intervene.

e.g. Rummaging in their closet may not be a problem but going through another residents things may put them at risk

In an adapted environment, some of the behaviors may be tolerated:

- the client is safe
- their dignity is being preserved
- there is not the potential for injury to themselves or others

We must not assume that altered behavior is unacceptable.

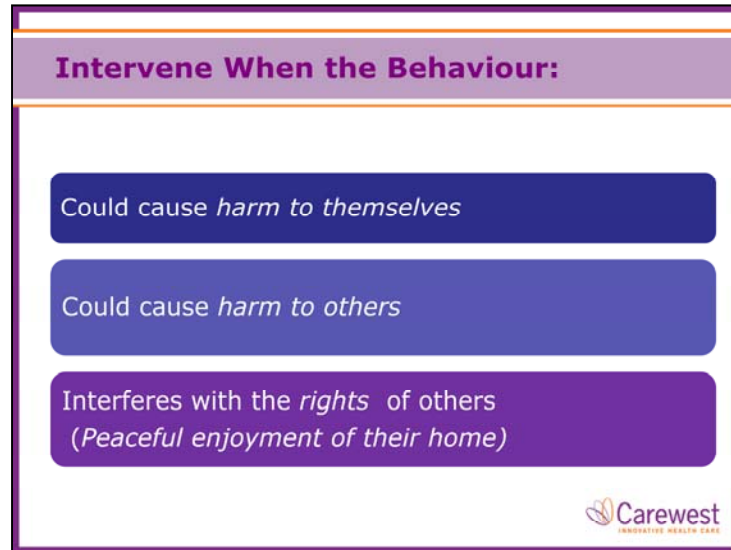
e.g. Think about someone pacing.....**Is this a problem?**

When does it become a problem?

e.g. if they are so exhausted that they may fall or if they are pushing their way through a group of clients. **Do we need to intervene?**

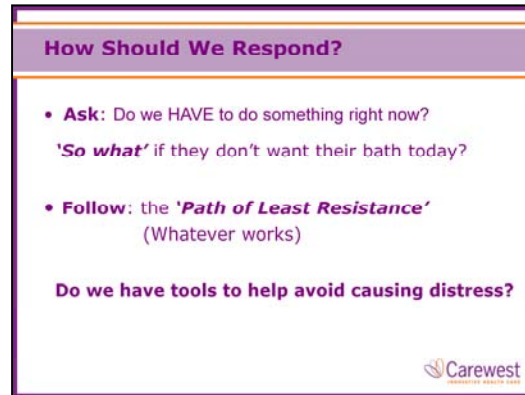
– we need to problem solve

Trainer: Move to the next slide to discuss when we need to intervene



Discuss the rights of others. i.e. *Peaceful enjoyment of their home*

Example: not having someone interrupt your meal or sleep



'SO WHAT' – meaning - **Will there be a negative consequences if we don't do something?**

What are the consequences of NOT doing something? e.g. changing an incontinent product

- How likely is their skin to breakdown if they are moving around?
- Is it bothering anyone?
- Can we try again later or with a different person?

Act only if the consequences would put them or others at risk if the intervention did not occur at that time

- Communicate with the staff/family why you didn't do something e.g. change dirty clothing (chart your actions and rationale).
- If the intervention is REALLY necessary, you might need to involve other staff (e.g. bowel movement might need to be cleaned up as it impacts others) – but there are some ways to approach even this in a way that helps reduce the client's stress – and we'll talk about some of these ideas in the module).

ASK: How can this be done?

- Try to take the "**path of least resistance**" (**pick your battles**). This is an important concept for staff and the family member caring for someone at home. This can decrease their stress and battles with the person.

See next slide for tools

What is in the Caregiver's Toolbox?

- Knowledge
- Personal Strengths
- Caring/Patience
- Sense of humor
- Communication skills
- Supportive environment
- Creativity
- Team support



Trainer Note:

Also the ability not to take it personally.



This slide and the next two give examples of common support strategies.

Give examples of when these strategies were effective from your experience

Support Strategies



Marlene Collins 2009

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Trainer's note:



Suggest that these slides on support strategies could be posted in staff rooms

The Art of Positive Redirection

Don't tell them "they can't". Don't say "no".



Offer a positive alternative to what they want to do.
"Come with me ..."

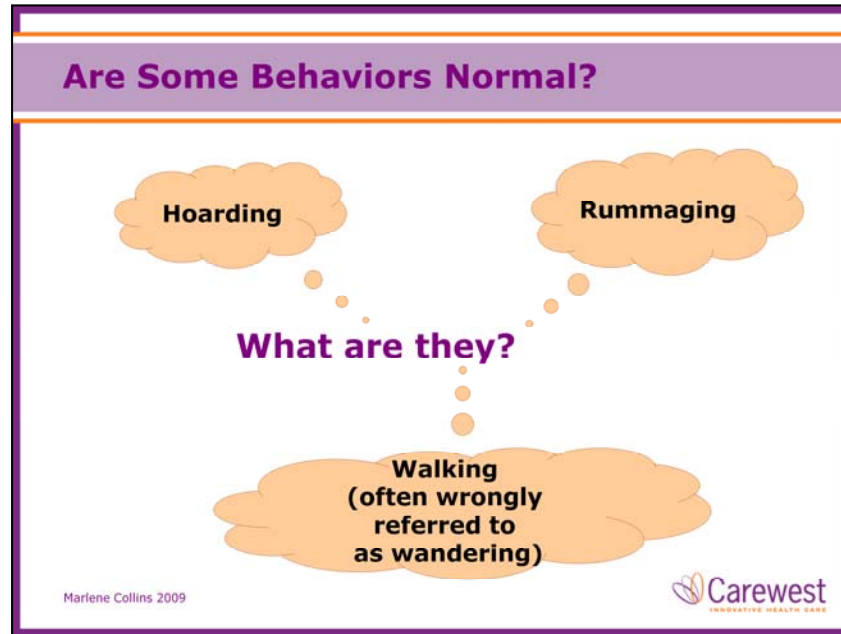


Explain: that distraction is a very effective tool providing it is done in a positive way.

This includes recognizing and acknowledging the person's feelings and **their topic of concern and then suggesting something else.**

E.G. a person upset about a locked door:

"I don't like that door either – let's go look for a different one",
and then try find something to do or see on the way that could be
a good distraction.



What do these labels mean?

'Hoarding' can be 'collecting'

'Rummaging' can be 'sorting', 'organizing', 'packing' or 'looking for something familiar'

'Walking' or 'wandering' can be 'exercising', 'going somewhere', 'looking for something'

Behaviors are often 'labeled' and we need to avoid this when we can – because then we could miss the meaning behind the behavior

These behaviors can become a 'problem' though if they start to:



- interfere with the rights of others, or
- cause potential harm to themselves and others

Examples:

- if they were to 'hoard' items that were potentially dangerous
- if they 'rummage' in other people's belongings with the potential that that person may harm them
- if they pace till they are exhausted and start to fall

Support Strategies


You cannot medicate for these, nor should you want to!



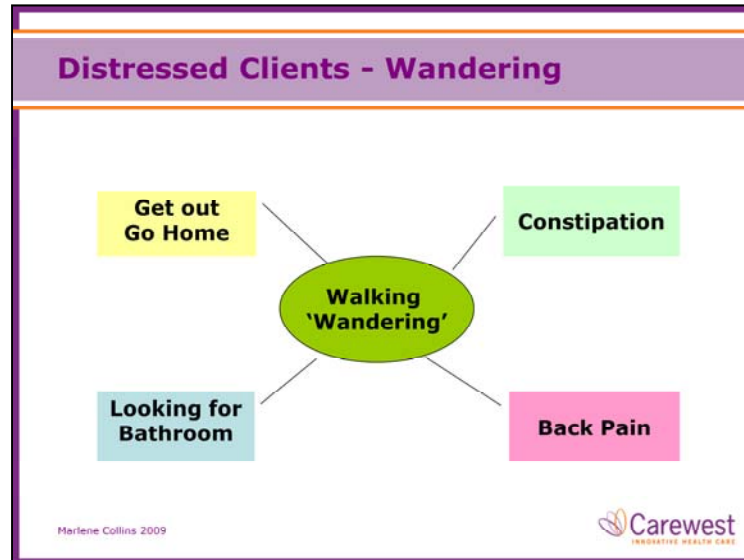
Instead ...

we need to find ways to support their needs

Marlene Collins 2009



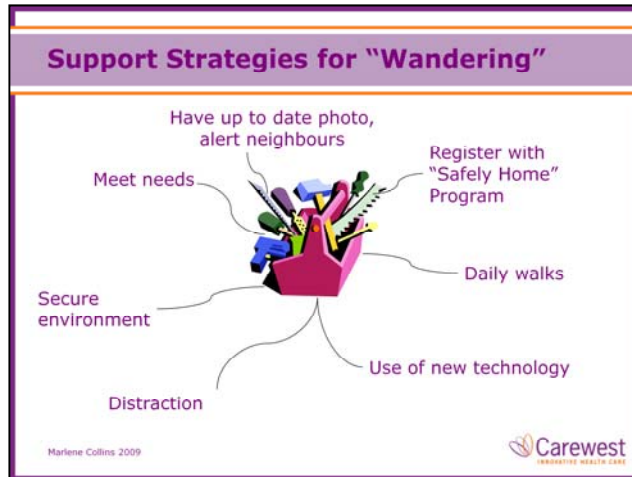
Examples include – having things that they can ‘rummage’ through
- ensuring there is opportunity to walk



They wander. We... walk, browse, exercise, are lost, look for something

WANDERING - WHY?

- Inability to express hunger, thirst
- Physical discomfort (walking might ease the pain in their legs)
- Need to use the bathroom
- Desire to exercise - Continuation of life pattern - very active people before the disease more prone to wander
- Stress (walking might be their way of coping)
- May be a longtime habit (daily walk)
- Searching for something familiar – home/people (family, staff)
- Boredom/ sensory deprivation
- May be a direct result of physical changes to the brain
- Unable to way find due to temporal lobe damage - Being lost
- Reaction to medication (antipsychotic) - may develop a need to pace around even more; medications can have the side effect of restlessness



Trainer: Respond to participant interventions. Show slide for other suggestions. Information below is extra content you can use.

INTERVENTIONS

- Ensure needs are met- hunger, thirst, toileting, need for exercise, relief of boredom
- Environment should be secure in an unobtrusive way to allow safe wandering
- Medications usually don't work for this behaviour
- GPS Tracking devices e.g. Real Time Location Monitor

FOR CLIENTS LIVING IN THE COMMUNITY

- Register the person with Alzheimer Society "Safely Home Project"
- Ensure they have identification. Some caregivers sew name tags onto the person's clothing or have the person wear an ID bracelet.
- Keep an up-to-date photo of the person
- Tell the caregiver to alert the neighbours and stores in their neighbourhood where the person may wander. Ask them if they see the person to invite them in and call the caregiver.
- If in a small town alert the local police force
- They may need to install alarms or alerts to let them know if a door has been opened
- Try to establish a safe place for them to wander - secure the yard. Try to get them out regularly for a walk - volunteers, neighbors, family



RETURN HOME

Remember that "home" might not be the new condo that the couple moved into two (2) years ago, but the house where they lived most of their lives - or even the house they grew up in as a child.

PLACES IN THEIR PAST

As many are more orientated to the past-they tend to go to places they frequented in the past.

Did they always walk to a favorite coffee shop, pick up the mail, go to a friend's house ?

Many of your clients with alcoholism may head for the bar.

FLORIDA FACTOR

Robert Koester of Virginia Search and Rescue found there was a tendency to travel south.

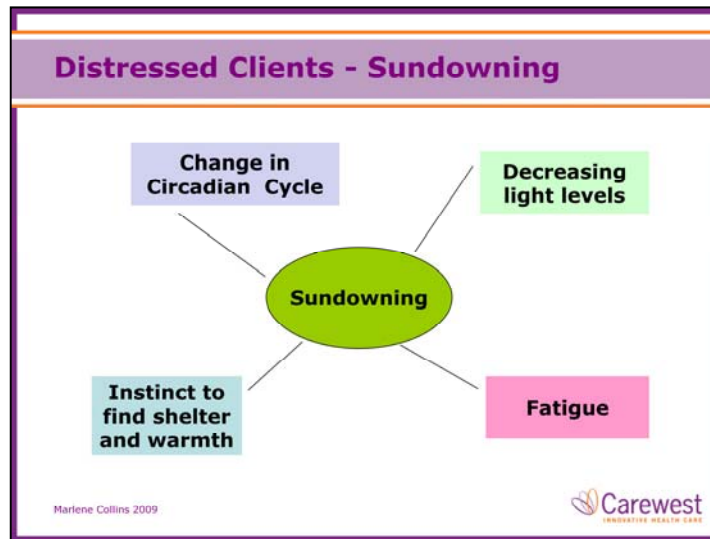
PATH OF LEAST RESISTANCE

Most clients with dementia will choose sidewalks, roads, follow creeks or drainage ditches. Close to 25% were found along a travel aid (road/sidewalk) and 50% found a travel aid. More than 95% were found 2.4 km radius from the place last seen with 50% of those found within a 1KM distance.

Source: Statistics from Virginia Search and Rescue Website

GET STUCK

They cannot think to turn around or back up and usually stop when they get stuck.



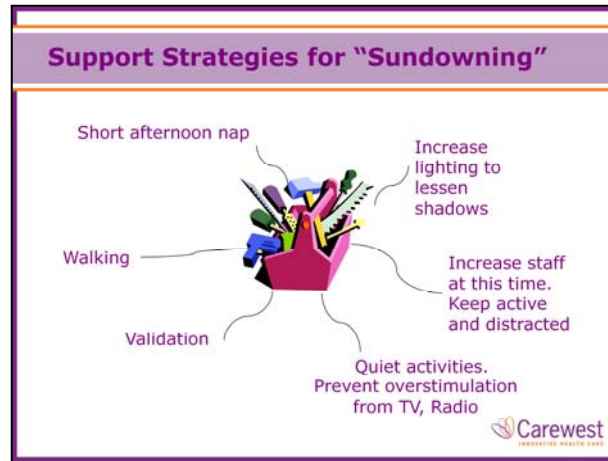
Sundowning Definition - When someone becomes confused, anxious, aggressive, agitated, or restless consistently later in the day (usually late afternoon or early evening).

- can be a problem for as many as 66% of people with Alzheimer's disease or other dementias
- can occur at any stage of the disease but it tends to peak in the middle stages of dementia and lessens as the disease progresses.
- cause unknown

MAY BE RELATED TO:

- Decreasing light levels
- Inability to cope with stress
- Fatigue (trying to cope with this 'unknown' environment since the morning)
- Instinct to find shelter and warmth for the night (Marlene Collins)
- **Disruption of the Circadian cycle (sleep/wake pattern) because of the dementia (the person cannot distinguish day from night)
- **Not as much or no activity in the afternoon compared to the morning (can lead to restlessness later in the day)

**Source: Alzheimer Canada



Trainer Tip: Respond to participant interventions.

Below is extra content you can use.

INTERVENTIONS

- Short late afternoon naps (limit to 30 min.)
- Increased lights to decrease shadows
- Increase staff levels at this time - activities, quiet music
- At home the caregiver may try quiet activities or a walk
- Validation
- See if the behaviour is being caused by discomfort (hunger, need to use the toilet, pain).
- Avoid making appointments, bathing, or other potentially stressful activities in the late afternoon or evening. **
- A rocking chair can provide stimulation while having a calming effect. **
- Brisk walks or other forms of physical activity throughout the day may reduce restlessness or the need to wander later. **
- Keep him active and distracted when sundowning may occur (for example, preparing dinner, setting the table). **
- Allow quiet time if this helps decrease agitation.
- Restrict the amount of caffeine and sugar he has in the morning. **
- Maintain a regular eating and sleep schedule as much as possible. **
- Familiar routines may help him feel more secure. They can include readying the home for evening (closing curtains, turning on lights) or bedtime routines that include warm milk and soft music. **

** Source Alzheimer Canada



SCREAMING, MOANING - WHY?

- Pain-moaning
- Illness, e.g. UTI, Flu
- Over stimulation
- Depression, anxiety, loneliness
- Need for attention - sensory deprivation, social isolation. In a young child, crying out to communicate hunger, pain or fear is not considered a behaviour problem (Carlson, Flemming, Smith, & Evans, 1995).
- Damage to the brain late stage dementia - lack of communication ability, lowered inhibitions, misinterpretation of caregiver behaviour
- Perseverative e.g. same sound na, na, na over and over again

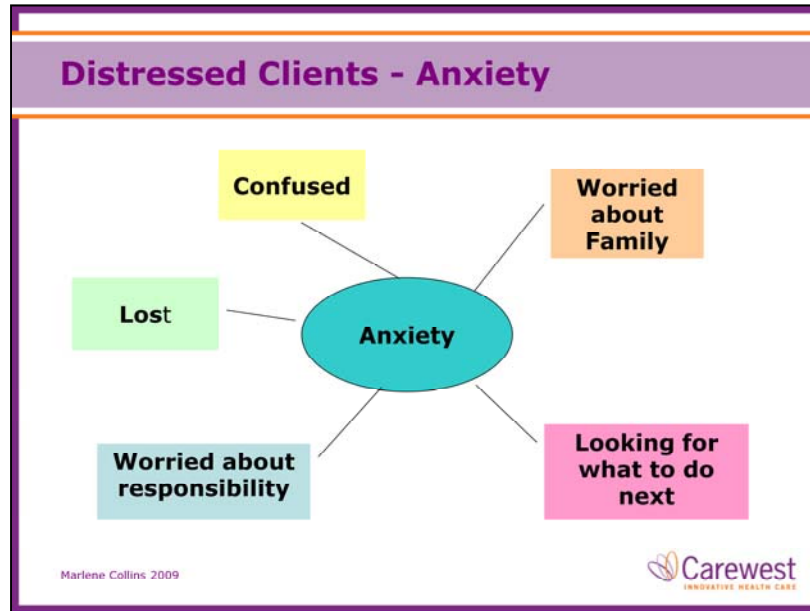


Trainer Tip: Respond to participant interventions.

Information below is extra content you can use.

INTERVENTIONS

- Behaviour mapping is very important to look for triggers and consequences. If the only time the person gets attention is when they yell, we may be reinforcing the behaviour.
- If moaning, try giving pain medication regularly. Frequent position changes. Look at seating to ensure comfort.
- If person seems to be over stimulated take the person to a quiet place. Reduce glare to reduce visual over stimulation.
- If under stimulated, try to increase contact with the person. Use volunteers, tactile stimulation, one on one staff contact and sensory interventions like music.



We....anxious, afraid, nervous, restless, bored, angry, lonely

ANXIETY- WHY?

Affects up to 40% of people with dementia. (Carlson, Flemming, Smith,& Evans, 1995)

Memory loss-people and environment are not familiar. Can't retain person's image if they are gone. May feel abandoned.

- Loss of control - functional decline
- Decreased reasoning ability
- Depression, other illness

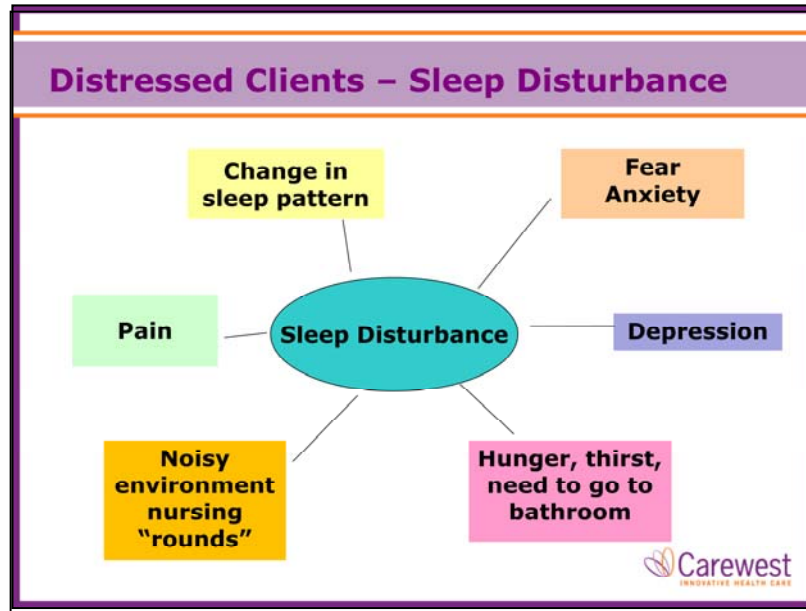


Trainer Tip: Respond to participant interventions

Information below is extra content you can use.

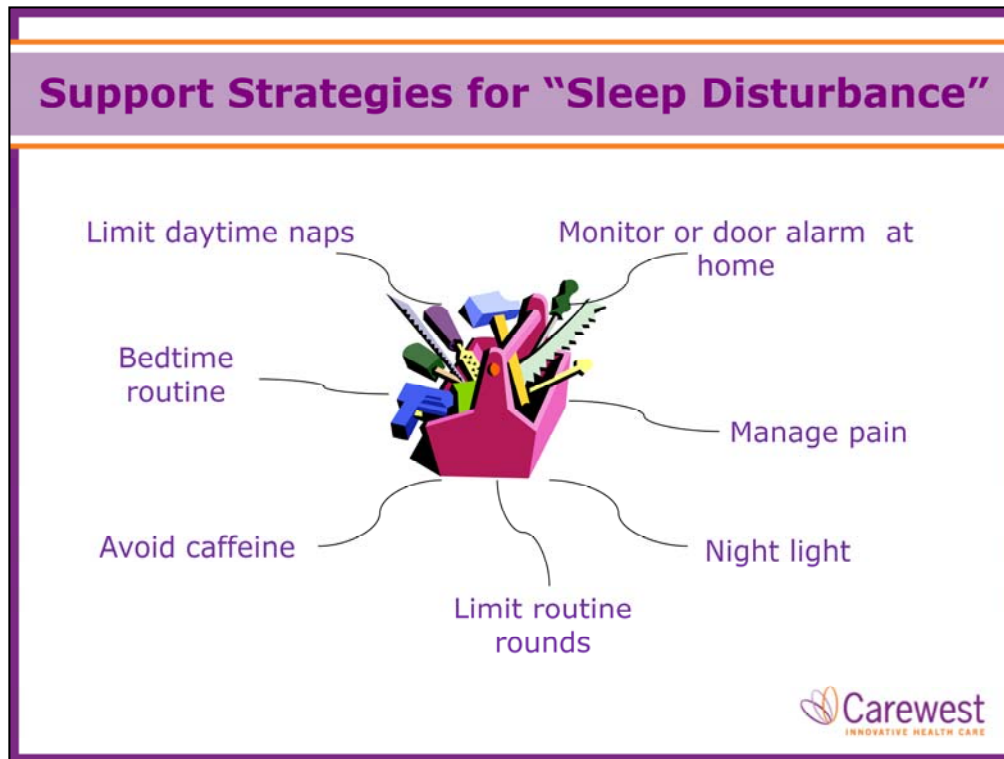
INTERVENTIONS

- Try to incorporate them into your activities so they can be with you
- Give them a job to do
- Reassurance
- Environment that feels familiar
- Phone call to family (if person calls frequently at night the family member can leave a reassuring message on their machine at bedtime and turn off ringer)
- Family video with reassurance



Factors that could affect sleep include:

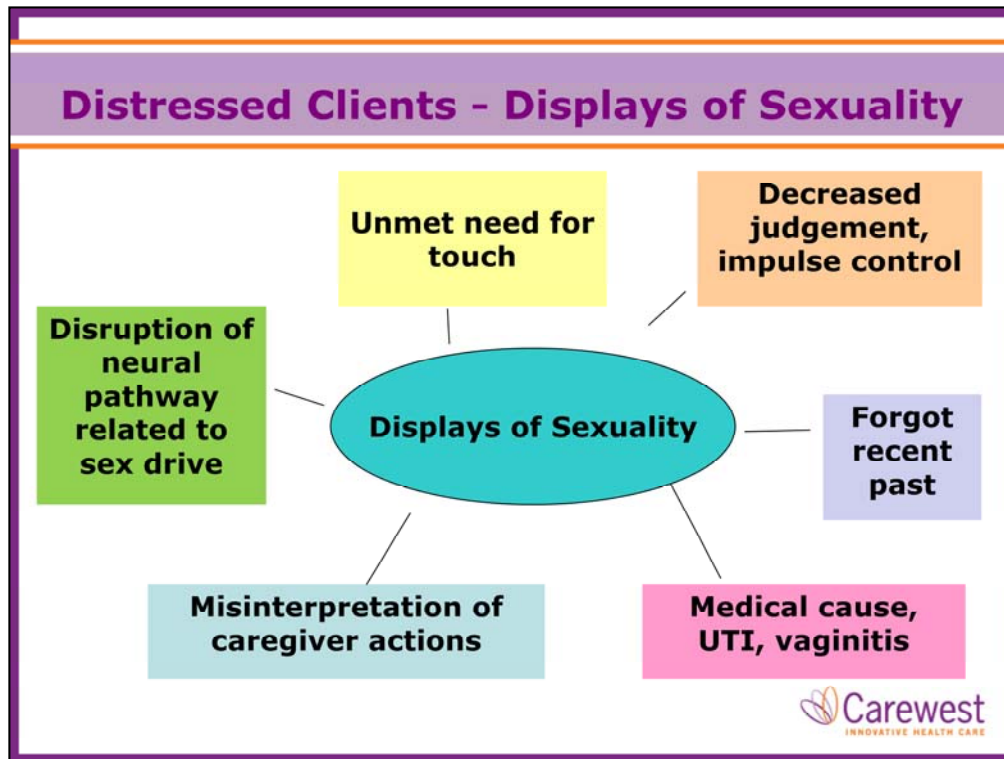
- Pain
- Depression
- Medication side-effect
- Restless legs /periodic limb disorder
- Sleep apnea
- Anoxia
- Environment- too noisy, too much light, nursing "rounds"
- Fear/anxiety
- Decrease in REM (Rapid Eye Movement- deep sleep)
- Increase in daytime sleepiness, waking up at night, increased time to fall asleep.
- People with later stages of dementia have a "polyphasic" sleep pattern (similar to newborn) (Northwood, 2002).
- We need to adapt our routines to their pattern - Would you wake an infant to change them or would you wait for them to wake on their own?



Trainer Tip: Respond to participant interventions
. Information below is extra content you can use.

INTERVENTIONS

- Limit day time naps to 30 minutes
- Avoid caffeine
- Have a predictable bedtime routine
- Use a nightlight if they are fearful of the dark.
- Don't insist that they sleep only in a bed
- Assess any medications that may interfere with sleep
- If the person awakes offer reassurance, orientation, toileting, fluid or food
- Try to keep active during the day
- Home caregivers may need to have bells or a monitor to alert them the person is up. Expect sleep disturbance and ensure the person's safety at night.
- Limit routine rounds – individualize them



Displays of sexuality could mean:

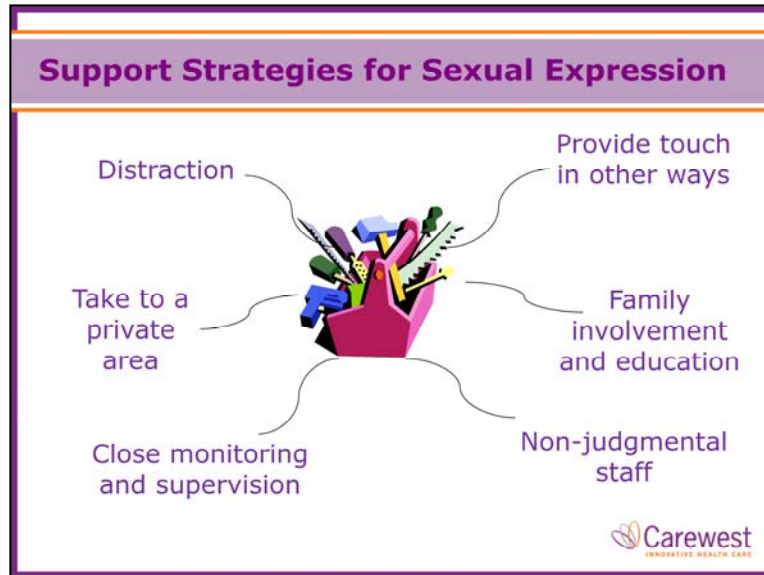
- Unmet need for touch, affection, attention, intimacy
- Uncomfortable - too hot, clothing too tight
- Medical cause - UTI, skin rash, uterine prolapse, vaginitis
- Misinterpretation of caregiver actions
- Disruption in the neural pathways related to sex drive or hormonal changes occurring due to dementia
- Decreased judgment, impulse control, social awareness and disinhibition- damage to frontal/temporal lobe
- Misidentification of people due to disease process
- Forgetfulness of the recent past- sexual intercourse may be initiated repeatedly.
- The person is unaware of the demanding nature of this behaviour.

What does the research say?

- Inappropriate sexual behaviour is not particularly common in people with dementia (Higgins et al, 2004).
- It is more likely to occur in the moderate to severe stages of most forms of dementia, though it is sometimes evident in residents with mild cognitive impairment (Alagiakrishnan, 2004).
- The reasons for sexual disinhibition or inappropriate behaviour in people with dementia remain unclear, but may include disease-related factors, social factors, psychological factors and certain drugs and alcohol (Series 2005).
- Research suggests that staff, residents and family often disagree on what is meant by appropriate or inappropriate behaviour (Gibson et al, 1999).
- Large variation in reported levels of sexual disinhibition both in the community and residential care ranging from 2 to 17 per cent (Series et al, 2005).
- Some studies have suggested there is equal frequency in inappropriate behaviour in men (8%) and women (7%) (Burns et al, 1990). Several other studies suggest much higher frequency in men, but this may be linked to subjective definitions and over-reporting of men to women.

Source:

http://www.ilcuk.org.uk/images/uploads/publication-pdfs/pdf_pdf_184.pdf



Trainer Tip: Respond to participant interventions.

Information below is extra content you can use.

INTERVENTIONS

- Assess like any other behaviour. Describe in objective terms (Nonjudgmental)
- Whose problem is it?
- Attempt to meet need for intimacy and to be connected to others in other ways- hugs, touch, dancing, massage.
- Distraction may be effective by substituting other activities such as exercise
- Include families in problem solving. Educate families.
- Hormone medications may be tried if the problem is severe and a danger to others
- If unable to easily move a client masturbating in public place cover lap with blanket

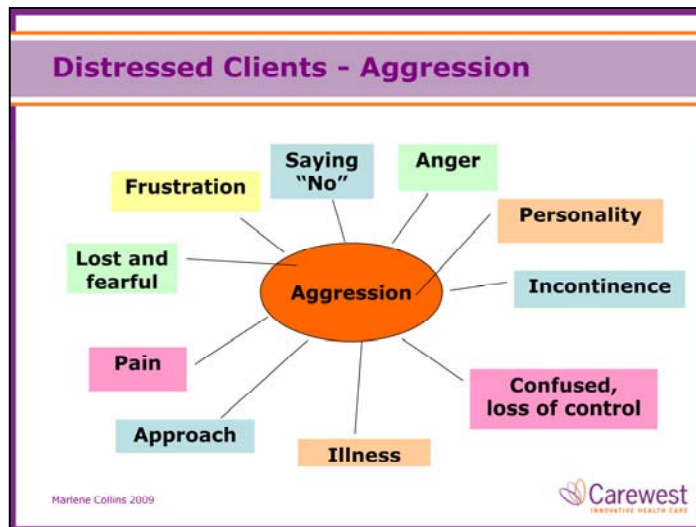
Inappropriate Clothing Could be a Trigger



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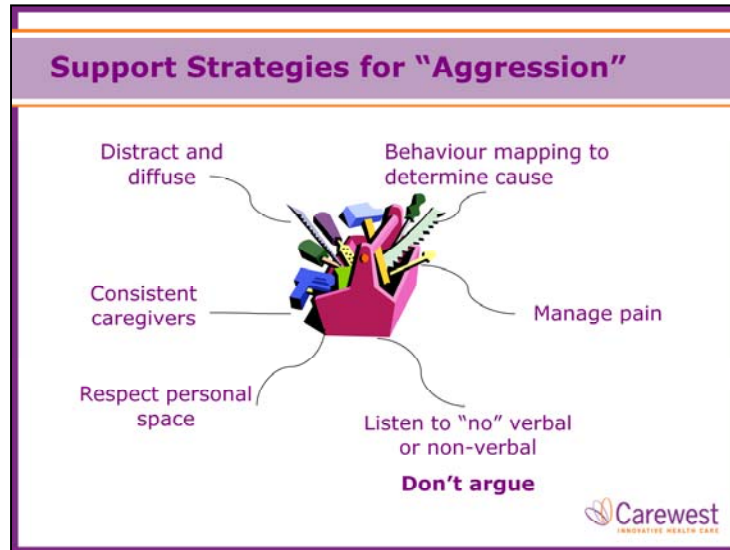
Triggers could include :

- The clothing we wear
- Where we position our bodies during care
- Reminding them of someone they were intimate with



Aggressive (physical or verbal) or resistive behavior could mean:

- They are struggling to retain the last measure of power they believe they still have by saying **"NO"** with words or actions.
- They have a decreased ability to communicate
- They are feeling frustrated, under pressure or humiliated
- May have pain
- A defensive response to unwanted touch (e.g. pulling down pants)
- They perceive threat, invasion of personal space (fear)
- They may have decreased judgment and self control due to frontal lobe damage (the little man that sits on your shoulder and tells you not to hit that annoying person has left them!)
- May have a life long history of aggression (domestic abuse, boxer)



Trainer Tip: Respond to participant interventions
Information below is extra content you can use.

Staff and family caregivers usually find physical aggression one of the most frightening for them to deal with – is this true for you?

Triggers for aggressive behaviour- We have discussed triggers to any behaviour earlier – but let's look at some that seem to be particularly important in aggression_ e.g. **control** and **personal space**.

Trainer tip: DEMOS are optional

#1 - Walk up to a participant wearing a sweater and start taking the sweater off and telling her she is going to have a bath. **Afterward ask: Did she feel in control? Did she feel like hitting you or yelling at you? Did she feel that you had invaded her space? Ask if she felt she needed a bath?**

#2 - Ask them to pair up. Have them put a distance between themselves and the other person. One person slowly walks toward partner- partner holds up their hand when they have come close enough. Switch. **Discuss –There may be variations in the amount of personal space preferred. May depend on how well you know the person, cultural variations, male coming toward female.**

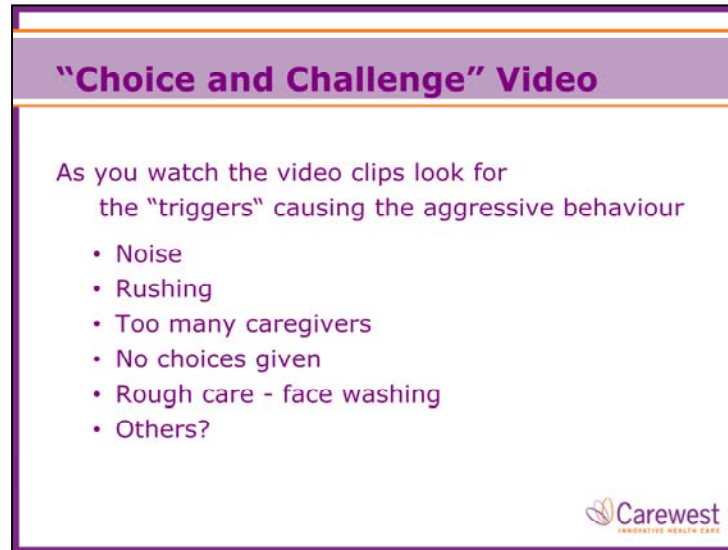
(See next page)

Keep in mind:

- *older persons with aggression need four times more personal space*
- *we need to ask for permission to enter personal space*
- *sensory deficits, decreased peripheral vision that may not allow person to track you as you approach*
- *frontal lobe damage - lack of inhibition if the person feels threatened*
- *our approach - palms up approach, smiling, not rushing, not forcing, using*
- *eye contact, using their name*
- *allow them choice and a feeling of control*
- *touch (pay attention to how they react to your touch or coming into their space)*
- *approach slightly from the side (front on can be too 'trapping')*
- *get their attention before you start to do something with them*
- *we need to be alert (always) to the signs the clients give us that we have invaded their space. **If they tell you to get out - get out or back up!***
- *if two person care is planned staff must agree on an approach before going in.*

Signs of agitation – intervene or 'back off'?

- *refer to the 'so what' discussion from earlier*
- Don't argue – the client is always right! Ask them to repeat after you..."They are right, I am wrong". Remember the "path of least resistance".
- Distract and defuse – one staff person talks to the client and distracts them with conversation - while the other staff does the 'clean up' (or other care intervention). Make your plan before you go into the room and staff do NOT talk to each other during the care. The person talking is standing in close, holding her arm (and the staff person can't let go) – more control and safety.



Show video "*Choice and Challenge - Caring for Aggressive Older Adults*"
Ask staff to watch for triggers to the client's behaviours.

Trainer Note : leave the bottom items off the slide till after the video – will come in on the second click

Ask: What triggers did you see in the video?

- Once you have feedback click to get the answers:
- Discuss pain as a trigger in the case of Rose.



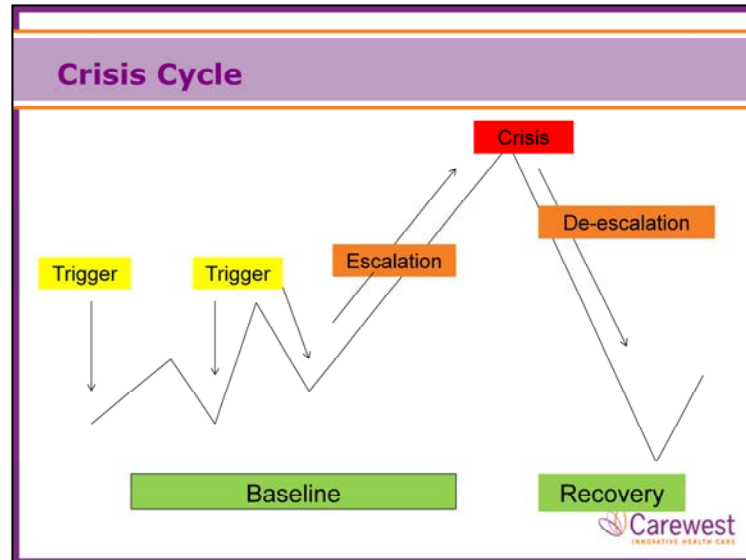
Ask: What are some signs that a person is getting very agitated – and might be leading up to a crisis?

Use flip chart to record their answers (optional)

Stress the importance of early intervention to prevent the behaviour from becoming a crisis situation. Deal with it now or it may take twice the amount of time to deal with the crisis later.

ASK: What are some interventions we can do at this stage?

- *recognize and deal with what is happening*
- *take to quieter area – (not a punishment, but a way to help the client feel calmer– you might ask if you might sit with them)*
- *validate their feelings (You look really upset, can I help you?)*
- *reassure*
- *consider the need for pain medication, food, water*
- *distract with food or activity (calm activity)*
- *there is LOTS we can do without giving medication*
- *remove other clients from the area if you are unable to move the agitated person*



The **CRISIS CYCLE** helps to explain what happens when beginning behaviors are not "checked" by interventions and a crisis ensues. Stress the importance of knowing your client and their baseline data (normal pattern of behaviour).

TRIGGER

This is the precipitating factor(s) – what are the things that build up to lead to the crisis (catastrophic reactions)? Communicate the triggers to others to help everyone avoid the crisis.

- It is a situation or event that creates/causes stress
- this is what makes someone change their behavior i.e. deviate from their baseline behaviour

ESCALATION

This is when the behaviors start increasing in severity and become more challenging. The client is trying to communicate to us. What is the message?

CRISIS: ALSO KNOWN AS CATASTROPHIC REACTION

- an over-reaction to situation
- often unpredictable (usually lasts less than 2 minutes e.g. client may be crying hysterically)
- our goal at this stage is to prevent injury to client or others

WHAT BEHAVIORS DO WE SEE IN A CRISIS SITUATION?

PHYSICAL ABUSE: kicking, choking, punching, hair pulling, grabbing, biting, spitting, pushing other clients, wrecking things

VERBAL ABUSE: *swearing, yelling*

EMOTIONAL OUTBURSTS: *crying*

INTERVENTION

If the caregiver is at home alone they may need to remove themselves from the situation to prevent injury.

Remove other clients from the area. Only intervene physically if danger to themselves or others.

DE-ESCALATION STAGE

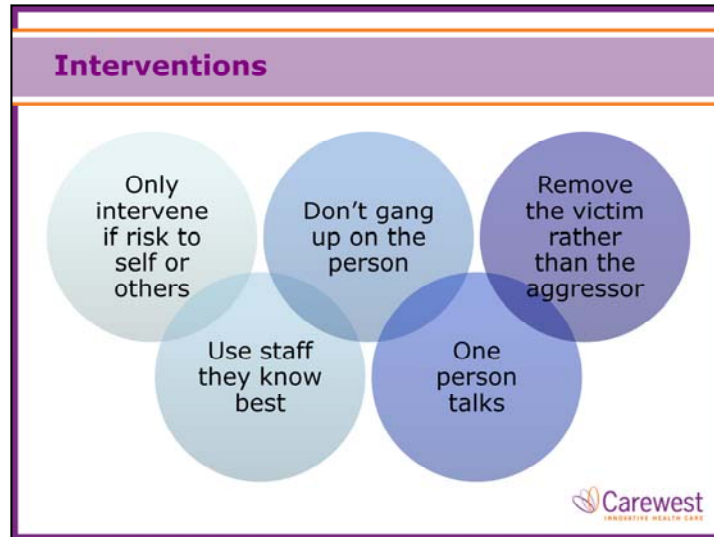
Decreased emotion, exhaustion, collapse, slowing down

INTERVENTIONS

Reassure, rest, quiet, decreased stimuli, comfort: food, water, sweater, analgesic

RECOVERY PHASE

Back to baseline behavior. It will depend on degree of catastrophe. In earlier dementias, you may see increased depression following a crisis. This will be very individual.



If client is out of control and at risk to injure self or others - respond quickly and calmly. Have staff who know the client well or have a good relationship intervene.

If the client being aggressive with other clients try and remove the victim not the aggressor as they will be more willing to go.

No more than 2 staff are needed to approach client – remember only one talks. The team leader, e.g. RN or LPN, should always be present and one of the key players in the situation – an opportunity to role model.

Try to diffuse the situation first. Speak in gentle, matter of fact manner, one person does the communication. Staff should offer a hand and ask “Can I hold your arm?” Only if necessary, gently take hold of an arm. There is no need for any other physical contact. Disengage them from the victim and gently lead the person away. If escorting them, put your arm through theirs and then hold their hand. Ensure that the client does not lose his balance.

If you ‘must’ move someone to another location, and they are very agitated, you might ask another staff to bring a wheelchair to put behind them, lower them into the chair to move them.

Debriefing

- Help to realize that the situation was not personally directed
- Empathize
- Should be about learning and problem solving not blaming



DEBRIEFING FOR STAFF AND FAMILY CAREGIVERS

- Staff and family must be supported and be able to realize that the situation was not personally directed at themselves.
- Empathize that the experience may have been very scary for them.
- Debriefing should be a learning experience not blaming.
- Discuss at an appropriate time what happened and encourage problem solving towards solution.
- Aggression in the community may be more difficult to deal with as the caregiver may not be able to get help.
- Caregivers may need to leave the house for their own safety.
- This is a common reason for institutionalization.

Medications as a Last Resort

Did you notice that ...
medication was not listed as a strategy for
altered behaviors in our tool kits?

Why would that be?

Medication has to be used appropriately
– right reason/right dose



ASK participants to comment on the question

Answers should include:

- other strategies should always be tried first
- all medications have side effects and often interact with other medications that our residents are on
- older adults, especially those with dementia, do not do well on medications
- usually they can't tell us how the medication is effecting them and it could result in 'altered behaviors' that are medication induced
- new research has shown that lots of these medications, especially antipsychotics cause individuals to be at risk

Move on to next slides about the appropriate use of antipsychotics

Appropriate Use of Antipsychotics

What is all the fuss?



- In the past antipsychotics have been used to help manage behaviours for persons with dementia but with more evidence and research this is now being reconsidered



Are Antipsychotics Effective For...?

- Interfering with other residents - NO
- Inappropriate dressing/undressing - NO
- Perseveration, doing something over/over - NO
- Repetitive screaming/calling out - NO
- Eating items unsafe to eat - NO
- Trouble sleeping - NO
- Voiding, etc. in inappropriate places - NO
- Elopement (trying to leave) - NO
- Poor social skills - NO

That's why we need other strategies



Trainer's Note:

This slide is animated so that each behavior will appear and on the next click they will disappear because they are not effective. The bottom line will appear and stay at the end.

Antipsychotics - Possible Hazards

- Decrease in cognitive function and the ability to engage
- Mobility impaired - increase in falls
- Metabolic implications - diabetes
- Strokes/Aspiration Pneumonia/Cardiac problems
- Mortality (death)

Therefore....

**Health Canada issued Warnings
about the use of Antipsychotics**



The Appropriate Use of Antipsychotics

Antipsychotics should only be considered when:

- the person has a mental illness or a psychosis (e.g. delirium)
- the person is at risk of harming themselves/others
(and everything else has been tried)

Antipsychotics

- must be reviewed frequently
- used at the lowest dose possible
- used for the shortest time possible
then gradually reduced and discontinued



Notes to stress:

Long term use of antipsychotics are appropriate for many mental illnesses such as schizophrenia

Antipsychotics should not be substituted with benzoids e.g. Ativan, sedatives or physical restraints



Always think safety first. Prevention of aggression is our best strategy

Keep your hands visible - if your hands are behind your back, the client may think you have a weapon.

Avoid approaching from the back to prevent a startle reflex.

If your client is reacting in an unacceptable way, can you ignore them? If not, can you remove others and leave them.

Think about where you are standing.

Have you left yourself an opportunity to exit?

Should you be in front of them? If you are directly in front, the client may think you are trying to block his exit and push you aside to get out.

Know the position of your body. Would you appear threatening to them? How are you positioned when you are performing pericare? Is your back turned?

Try not to lead the client down the hall by being several steps ahead of them. They could easily twist your arm behind your back.

Safety in Caregiving

Attending to a client in a wheelchair

From the side is safer



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Avoid standing still, or kneeling in front of the client; stand slightly to the side when giving care

- This is the safe positioning of the caregiver
- You can see the client; and can escape if she tries to harm you



For hair pulling

Ask them to let go. Place your hands on top of their hand and **gently push down**, when you feel them release, move away. If they don't release call for help.

For biting

Press into the bite rather than trying to pull away. Biting usually occurs in clients that are more severely demented.

Pinching

Slightly **press into the pinch** to decrease pressure of the pinch

Lean into the pinch to cause the clients fingers to spread out, thus releasing the pinch then move out to safety

Safety in Caregiving

Releasing yourself from a grab

Frail Elder
- effective to distract or wait

Strong aggressive grab
- use element of surprise to get out of grip.



For wrist/hand finger/arm grabbing

Frail Elder

- Go with the client rather than trying to pull away if they are grabbing you.
- **DO NOT** grab or hit the client.
- Can you give them a hug or a back rub?
- Attempt to distract, try going limp with your arm and wait for the person to release.

Strong Aggressive Individual - Use element of surprise to break free

Safety in Caregiving

Moving away from a punch

- Block the punch with two hands
- Move away from the person
- Do not grab the person's hand



Safety in Caregiving

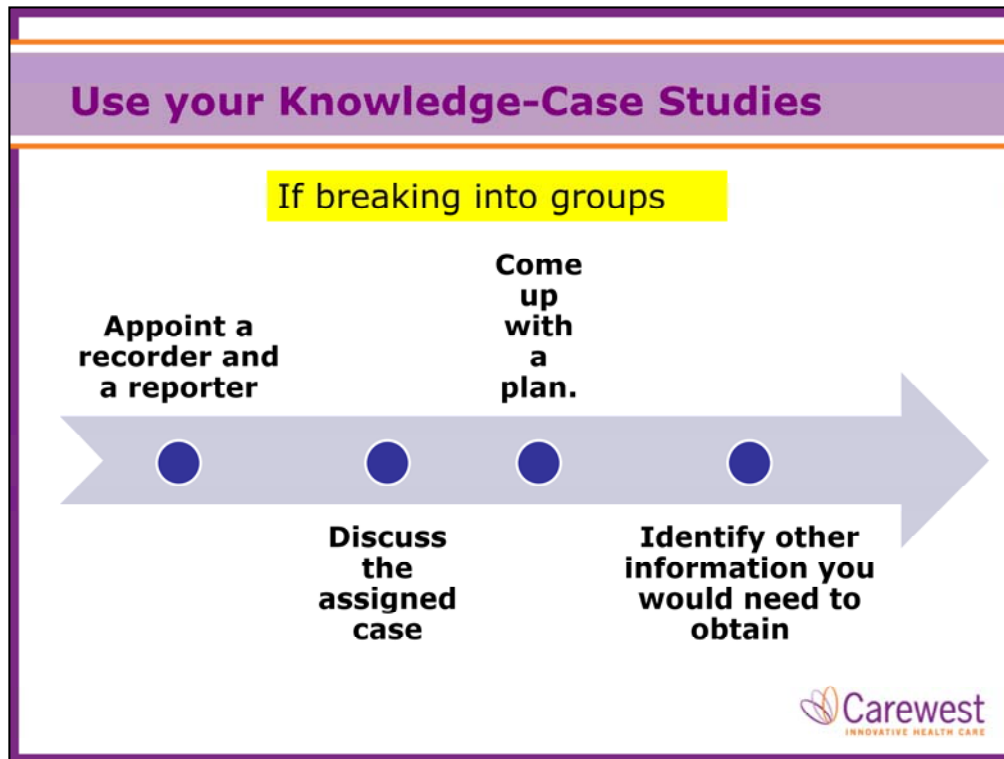
Releasing from a choke

- Quickly raise both of your arms
- Rotate away to safety



Chokes

- If the person is choking you, lift your arms up and place your hands on top of your head.
- Take a short step away and twist your body in the same direction as you step (i.e. if you step back with your right foot, twist to the right).
- N.B. chokes can be life threatening and need to be countered quickly without hesitation.



Trainer Tip: Pick **one** of the case studies to do as a group or you can break them into groups as below and have them report back. Depends on how much time you have. Evaluations show that the participants find value in doing the case studies.

OPTIONAL CASE STUDIES (see next pages)

Break them into 4 groups and assign each group to a case study (in their handouts). Give them about 5-10 min. to discuss. and then report back to the large group. When they come back together, have them read their case out loud and report on their suggestions. Have the rest of the group add to the discussion if they feel strategies were missed.

After the case studies discuss how much they accomplished in 10 minutes.

Ask : Could you get together with your team for 10 minutes to do similar problem solving?

FACILITY CLIENT CASE STUDY #1

Mrs. L. is an 80 year old client with multi-infarct dementia. She was admitted 8 months ago. She is Vietnamese and has lived in Canada for 5 years. She speaks only a few words of English. Staff report that she is more confused and she has been voiding and defecating on the floor of various room on the unit. How would you deal with this problem?

INSTRUCTOR NOTES

Is it a problem? Whose problem is it?

THE PERSON - Find out her toileting habits in her youth prior to coming to Canada? Squatting is common in Asia. She may not know what a toilet is. Has there been a change in medication? Does she have visual problems? She has communication barriers - is she fearful or unable to communicate her need to staff.

DISEASE - Has she had another infarct causing increased confusion? Delirium? Urgency to void?

THE ENVIRONMENT - Are toilets visible? Observe where she is going. Is it a place that might look like a bathroom - e.g. utility room?

STAFF - Are they anticipating her need and taking her to the toilet?

CONSIDER - Behaviour mapping to determine her pattern, location of inappropriate elimination. Ask family to determine if she can still read. Sign on BR in her language. Use a picture if unable to read (the type that would be used in her country). Leave door open to the BR and a light on at night. Anticipate her need to go. If there is one consistent place you may consider use of a commode there or if squatting is her norm a pot or pad on the floor. If in another person's room, you may consider some barrier to her entering that room.

FACILITY CLIENT CASE STUDY # 2

Alice is an 85 year old woman with Alzheimer disease. Her husband Al has been her caregiver for the past five years. He is no longer able to care for her at home due to urinary and fecal incontinence and night time wandering. She has a history of congestive heart failure and is hard of hearing. Alice has just been admitted and is wandering at night. She climbs into other client's beds and has been hit by Mr. J. twice. The team has come together to discuss her care. Her husband is very upset that Mr. J. has hit his wife. What are we going to do?

INSTRUCTOR NOTES

Is it a problem? Whose problem is it? Yes, it is a problem as she is getting injured by Mr. J. and her husband is upset.

PERSON - Ask the husband if she was up at night at home. Did she work night shifts? What did he do at home if she was up? Bedtime routines? Does she not hear Mr. J. tell her to get out? Is she cold at night sleeping alone? Hungry?

DISEASE - Is her CHF controlled? She may be needing to void more at night or need the head of the bed raised. Wandering could be related to need for toileting. She is in Stage 6 Alzheimer disease- wandering and sleep disruption is common.

ENVIRONMENT -The environment is new to her. She may be unable to find her way. Is she looking for her husband? Try a body pillow. Is Mr. J's room at the end of the hallway? Is it cold?

THINGS TO CONSIDER - Behaviour map to get more information. Identification of her room and bathroom. Commode at bedside if looking for BR. She may be seeking warmth or her husband when climbing in bed with others. Provide warmth and comfort. Look at occupying her with something to do on night shift if unable to sleep. Can you use barriers or locks to keep her out of Mr. J's room? Is Mr. J's room in her path of travel - end of hallway? Would changing her room location help? With time she may settle into the new environment. If finances allow, a companion may help while she settles in.

FACILITY CLIENT CASE STUDY #3

Ed is a 76 year old client with Alzheimer Disease. He speaks only one or two words, is totally incontinent and requires total assist. Other problems noted on his chart are macular degeneration and arthritis. Ed screams loudly when staff are giving him a tub bath and strikes out and bites staff. Two staff have been injured and Julie has a large bruise from having been bitten on the arm. How can we deal with this situation?

ASSESS - Are there any staff that can bathe him without violence? What do they do? Are there times he is worse- certain staff, time of day? When does he start to get agitated- taking off clothes, lift, going into water, hair washing, touching privates? Cold?

THE PERSON - Was he very modest in the past? Fear of water/ heights? Violence, sexual abuse? Liked showers? Need for control? His vision may be limited due to macular degeneration.

DISEASE - Does he have pain from Arthritis? Try pain medication prior to next bath and assess. He is Stage 7 Alzheimer Disease. Limited ability to communicate- fighting may be communicating that he can no longer tolerate this method of bathing. Look at bed bathing as an option.

ENVIRONMENT - Try distraction in the tub - sponge to hold, music, food

STAFF PROTECTION - Don't put in his teeth prior to the bath. Wear padded jacket.

FACILITY CLIENT CASE STUDY #4

Mr. P. is a 60 year old male with Pick's Disease. He has been divorced for five years. His daughter lives in Halifax and visits once a year. He has one male friend who visits weekly and seems concerned about him. His communication is decreased to single words. The NA Mary was upset to observe him masturbating in the dining room when she was bringing other clients in for lunch. Jeff also reported observing him rubbing the front of his pants in the hallway yesterday. Staff also reports that he grabs their breasts when they are giving care. Some staff are upset with this behaviour and feel something has to be done. "It is not fair that staff and other clients have to put up with this sexually inappropriate behaviour. What questions would you ask? What plan would you put in place?"

ASSESS - Describe exactly what was observed. It is an itch, UTI, clothing too tight

PERSON - He has little family contact and few friends. Poor communication ability to express his needs? Boredom.

DISEASE - Picks disease can cause sexual disinhibition. Misinterpretation of care. Increase attention outside the intimate care situation- Hand on shoulder, hand massage, activities to relieve boredom. Compliment him to increase self esteem. Two staff when giving personal care.

If masturbating move him to a private area. Don't leave him alone in dining room for long periods.

Male volunteer for increased social contact.

HOME CARE CASE STUDIES

CASE STUDY #1

Mrs. J. is an **80 year old woman with Alzheimer Disease**. She is cared for by her daughter who works part-time. Mom has been staying home alone up to this point but last week her daughter came home and her mother was not home. A search of the neighbourhood found her sitting in a nearby park. Her daughter is now worried re: what to do. What would you suggest?

ASSESS: Is this a problem? How often has this occurred? Does she find her way home?

PERSON: Did she always like to go to the park?

ENVIRONMENT: Is it a small community where neighbours look out for everyone?

CONSIDER: - Arranging for daily walks to the park
- Purchasing an emergency alert bracelet
- Arranging for a Home Care Assessment

CASE STUDY #2

Mr. P has **been diagnosed with Lewy Body dementia**. He is cared for by his frail wife. Lately he has had some falls and his wife had to call a neighbour to pick him up. Mrs. P. says she can't turn around because he will be up out of the chair alone. "He just won't listen". She thinks she should tie him in the chair when she has to run down to the store or get her work done. How would you deal with this situation?

ASSESS: Is this a problem?

PERSON: Wants to be mobile/independent?

DISEASE: Falls are common in Lewy Body Dementia

RRESTRAINTS: Research indicates restraints are not safe and could put the person at more risk

CONSIDER: - Arranging for a Home Care Assessment
- Suggesting that the wife get someone to be with Mr P when she needs to go out

HOME CARE CASE STUDY #3

Mr. D has been violent with his wife last week and she has a black eye. She has told her family that she fell. You have come into the house to provide respite care while she goes to get groceries. You are feeling a little concerned as to whether it is safe. Mr. D. has accused you in the past of taking his money. What would you do in this situation? What questions would you ask?

ASSESS: Ask the case manager to visit/assess

DISEASE: Aggressive behavior is common

CONSIDER: - Asking the wife if she feels safe? Explain that there is help and support available and encourage her to ask for help.
- Sharing information about Support Groups with her.
- Discussing with Mrs D some of the strategies that she may want try to see if it would reduce the incidents of aggression

CASE STUDY #4

Mabel is a delightful **lady who cares for her husband AL who has vascular dementia**. She confides in you that Al is always after her to have sex. He can be quite persistent. She finds that their relationship has changed so much she doesn't want to have sex with him anymore.

ASSESS: Ask the case manager to visit/assess

PERSON: Disinhibition can occur and sexual needs/desires are real

CONSIDER: - Asking the wife if she has someone she can talk to about this?
- Encouraging her to seek out support.

Goals for Care

To help clients feel content and secure.

Reduction or elimination of "triggers" that lead to distressed behaviours.

To interact effectively with the person when behaviors occur.

Aim for a win/win solution.



End the session by reviewing the goals for care for a person with altered behaviours.

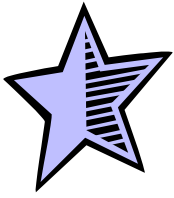
Learning

- What is one thing you learned that will change how you support a person with distressed behaviour?



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Ask each person to state one thing they have learned that will change how they approach a person behavior related to their dementia occurs.



BEST PRACTICE – These are some practices to review at the end as a summary of content.

- Staff will **know the clients** usual patterns of behaviors
- Staff will **understand that every behavior has a meaning** and the importance of assessing to rule out physical causes (look for meaning)
- Staff will **recognize potential triggers** to behaviors
- Staff will **stay calm**, monitor their own level of fear and anxiety, and establish a relaxed mood
- Staff will **respect a client's** personal space
- Staff will allow a client to remain where they are unless it is an unsafe situation.
- Staff will **provide reassurance** to the client that they will not be harmed and encourage client to talk rather than act out his anger
- Staff will **listen to concerns**, be flexible and accepting, ask what is troubling them.
- Staff will **provide alternatives** to the behavior, distract or divert the person's attention – state the action you want (e.g. avoid saying: “don't go there”)
- Staff **may use humor** and laughter to stimulate a sense of relief and provide comfort through a sense of belonging
- Staff **may use touch** and hugs as a form of communication whenever appropriate or possible
- Staff **will not argue**, but will “let things be” or ignore behaviors if the situation is not harmful
- Staff **will accept behaviors** which are normal for a person with a dementing illness
- Staff **will pre-plan their intervention** especially when more than one caregiver is required
- Staff will **know that approach is important**

Questions?



Please refer to your handouts – includes references



Why Do They Do That? Interventions?

- Difficulty bathing
- Difficulty dressing
- Difficulty toileting



TRAINER NOTE This material can be used when discussing the video and in solving the case study. Time will probably not allow a detailed discussion unless you are splitting the module up.

Resistance and verbal and physical aggression often occur around personal care activities.

DIFFICULTIES WITH BATHING

- Modesty
- Memory problems - think they just had a bath. Don't feel they need a bath.
- Life history of fear of water. Fear of water being too hot. Association with a 'bad experience' in their past.
- Lack of control. Involve them in the process-give some limited choices-now or after breakfast.
- Inability to understand what is expected. Inability to communicate discomfort.
- Pain
- Depression - loss of interest in personal hygiene
- Can no longer tolerate that method of bathing.
- Fear of the sound of running water
- Noise - don't use jets on tub
- May have changed perception of hot or cold

Interventions related to bathing difficulties:

Assess:

- At what step of the procedure they refuse.
i.e. Taking off clothing, when water is involved?
- Are some caregivers able to be successful?
- Is there one time of day that is better?

Suggestions:

- Look for evidence of pain.
- Have the bath run prior to taking them into the tub room. Allow them to feel the water temperature. Keep them warm.
- Use reassurance and explanations of what is happening.
- Give them a reason to bathe.
- Homelike appearance for the tub room. Some recommend soft music and bird song recording. Good smells.
- Look for alternate method if person is resisting- leave underwear on or leave towel wrapped around, shower, wash at sink or bed bath.
- Water temperature. This may be due to damage to hypothalamus region of the brain.
- Altered sensations of water due to brain damage.

DIFFICULTY WITH INAPPROPRIATE TOILETING

- They may not be able to recognize or find the toilet
- May revert to childhood memories of outhouse or for other countries squatting
- May not remember what a toilet is for
- They may not respond to the body's signal due to damage to the brain

INTERVENTIONS

- Take them to the toilet regularly
- Watch for signs they might need to go
- Use pictures as well as words to identify the bathroom. Leave the door open to make it visible.
- Remove plants, wastebaskets, etc. that the person may mistake for a toilet
- Ensure clothing is easy to remove and pull up
- Provide privacy
- Don't scold or embarrass

DIFFICULTIES WITH DRESSING

- Damage to frontal lobe- unable to sequence
- Apraxia (inability to perform purposeful movement) due to brain damage
- Forget how due to memory loss

INTERVENTIONS

- Clean out the closets to limit choices
- Match outfits on hangers
- Lay out clothes in the order to be put on. Underwear on top.
- Ensure privacy
- If they want to wear the same outfit all the time have duplicates to permit washing. Some items may signify security for the person.
- Don't argue about getting undressed for bed. They can sleep in their clothes.