Jane Saunders 2022

Dementia Behavioral Complications in Long-Term Care

Faculty/Presenter Disclosure

- **Faculty: Jane Saunders**
- **Relationships with financial sponsors:**
  - **None**

Disclosure of Financial Support

- **None**
- **No Potential for conflict(s) of interest:**

Clinical Scenario

- Mrs M, 88
- RN calls:
  - Hitting and biting during care
  - Care impossible
  - Staff getting hurt
  - “Hostile and rude”
- Need a prn and med change

What do you do first?

- 1. Prescribe trazadone 12.5mg-25mg po pre care
- 2. Prescribe risperidone 0.25mg po BID and prn
- 3. Ask for more information
- 4. Suggest the use of posey mitts during care
- 5. Plan to see Mrs. M the next day?

First steps

? Ask more information:

1. Establish safety and provide support

2. Duration of symptoms?

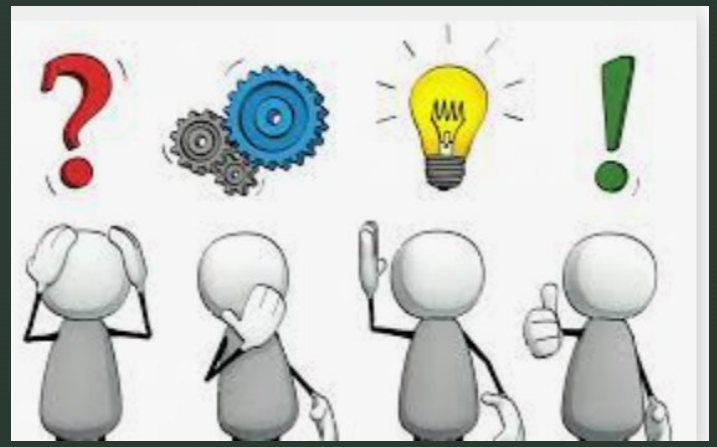
3. Any changes: physical/ social/Covid?

4. Neuropsychiatric “vitals”- ABC, DOS, nursing notes

DOS and ABC Charting

- Aggression during care for the last month
- Gradual increase in “hostility” and negative behaviours over the last 9 months.

DOS and ABC Charting



BSO-DOS®

Behavioural Supports Ontario-Dementia Observation System

Data Collection Sheet

	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*
D/M/Y															
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*Mandatory column

Observed Behaviours

1 Sleeping

2 Awake/Calm

3 Positively Engaged

For #3-8 check as you observe:

- ☐ Activity
- ☐ Conversing
- ☐ Hand holding
- ☐ Hugging
- ☐ Singing
- ☐ Smiling
- ☐ Other:

4 Vocal Expressions (Repetitive)

- ☐ Crying
- ☐ Grunting
- ☐ Humming
- ☐ Moaning
- ☐ Questions
- ☐ Requests
- ☐ Sighing
- ☐ Words
- ☐ Other:

5 Motor Expressions (Repetitive)

- ☐ Banging
- ☐ Collecting/Hoarding
- ☐ Disrobing
- ☐ Exploring/Searching
- ☐ Fidgeting
- ☐ Grinding teeth
- ☐ Pacing
- ☐ Rattling
- ☐ Rocking
- ☐ Rummaging
- ☐ Other:

6 Sexual Expression of Risk

- ☐ Explicit sexual comments
- ☐ Public masturbation
- ☐ Touching others - genitals
- ☐ Touching others - non-genitals
- ☐ Other:

7 Verbal Expression of Risk

- ☐ Insults
- ☐ Screaming
- ☐ Swearing
- ☐ Threatening
- ☐ Other:

8 Physical Expression of Risk

- ☐ Biting
- ☐ Choking others
- ☐ Grabbing
- ☐ Hair pulling
- ☐ Hitting
- ☐ Kicking
- ☐ Pinching
- ☐ Punching
- ☐ Pushing
- ☐ Scratching
- ☐ Self-injurious
- ☐ Slapping
- ☐ Spitting
- ☐ Throwing
- ☐ Other:

9

10

Context

A	Alone
L	Loud/busy environment
Q	Quiet environment
F	Family/visitors present
C	Personal Care (e.g. bathing, incontinent care, toileting)
N	Nutrition - eating/drinking
M	Medication for behaviours given
P	Pain medication given
T	Treatment (e.g. wound care, creams)
R	Expressions directed at Resident/patient/visitor(s)
S	Expressions directed at Staff
X	
Y	

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

DOS Working Group (2019). *Behavioural Supports Ontario-Dementia Observation System (BSO-DOS®).* Behavioural Supports Ontario Provincial Coordinating Office, North Bay Regional Health Centre, Ontario, Canada.

Monitoring Chart: ABC (Antecedent \ Behaviour \ Consequence)

Surrey Place Developmental Disabilities Primary Care Program

Patient Name		Date of Birth	Results to be reviewed and analyzed with:
First	Last		

Use this observational tool to record information on behaviours that challenge. The aim of using this chart is to better understand what the behaviour is communicating. Be as objective as possible when describing behaviour. Describe what you see and hear. Check for occasions or triggers where the behavior is most likely to occur. Look at what consequences might be maintaining the behavior. Based on the observation, develop a plan.

Pre-existing conditions
Factors that increase vulnerability or sensitivity to triggers. Think HELP factors: Health or medical problems (H), Environmental stressors (E), Life events or trauma (L), Psychiatric disorder (P)

Antecedent
What happened just before the behaviour occurred and might have triggered it? Include setting and activities.

Behaviour
Describe the behaviour as accurately and specifically as possible. Include frequency, duration, and intensity on a scale of 1 to 5 (5 is most severe).

Consequence
Things that happened immediately after the behaviour occurs, and make it more or less likely to happen again

Occasion	Pre-existing conditions	Antecedent	Behaviour	Consequence
Example Date Feb 6/10 Time 6:30-7:10pm Observer Rene – evening staff member	H: John had a toothache. L: John's mother was in hospital with broken hip and could not visit. L: John's usual primary staff member was on holidays.	E: John was eating supper in kitchen when another resident bumped into him when passing food.	John started to yell and threw his plate across the table. He ran out of room, screamed for 10 minutes and threw cushions around living room. The intensity was 4/5.	- Staff made a change to the environment, removing other residents, to create a calming space, to help reduce sensory overload. - Staff noted and acknowledged the life stressors for John and that he is likely feeling overwhelmed and distressed, missing his mother and primary worker. - Staff said sorry for having been bumped into during supper. Staff showed empathy for John's difficulty. - Staff offered John a soft sandwich, which was easier for him to eat, recognizing that the current meal was hard to chew and likely painful for him. A dental appointment has been booked.
Date Time Observer				
Date Time Observer				

Causes of Resistance to Care?

- 1. Poor vision/hearing?
- 2. Fear?
- 3. Pain?
- 4. Shame?
- 5. Constipation?
- 6. Poor vision/hearing and constipation
- 7. All of the above

Aggression/Resistance during Care

Fear

Pain

Shame

Fear

- Poor information processing
- Sensory impairment- visual and auditory
- Poor visuospatial abilities
- Dizzy, postural hypotension
- Negative association: previous trauma, pain

Pain/Discomfort

- OA
- GERD
- Cancer
- Dyspnoea
- Constipation- bowel care- painful stool- care
- Atrophic vaginitis, yeast , UTI

Shame

- Nudity. modesty
- Previous trauma
- Ashamed re loss of function, feels humiliated

Management

1. Gather Information

2. Neuropsychiatric “Vitals”

3. Identify and address potential causes

Which one do you address first?

- 1. Constipation
- 2. Severe pain: OA and spinal stenosis
- 3. modesty
- 4. Fear
- 5. 1,2
- 6. All of the above

The order of things

One step at a time with medication

Beware being up a creek without a paddle

Exceptions

Emergency: meds

Non-pharm interventions

Which one first?

- 1. Constipation: PEG
- 2. Severe pain: OA and spinal stenosis:
  - under-diagnosed and under-treated.
  - Renal function and NSAIDs, Tylenol, Bupronorphine patchh
- 3. modesty
  - Hand them the cloth
  - Modesty apron
  - normalise

Fear

- Associate care with negative experience, pain
- Anticipates harm
- Fight or flight- defending themselves
- Need to facilitate positive associations
- Non care contact

Understanding Aggression

- Theory of mind
- Retrogenesis can be helpful to conceptualize
- Fight/flight/ freeze exercise
- Non-pharmacological strategies first

If time to continue the story

- ? Questions

Improvement

- Constipation: was day 8!
- Pain: addition of bupronorphine patch very helpful
- Care much improved
- Still ”hostile” , won’t sit to eat
- Intrusive, especially after about 4 in the afternoon
- Psychotic symptoms: she has no clothes and part of her body is rotting.

Current Medication

- Tylenol 1 g po tid
- Bupronorphine patch 5 micrograms every 7 days
- Amlodipine 5mg po daily
- Advair and prn Ventolin
- Trazodone 25mg po HS

What do you think is going on?

- 1. Delirium
- 2. Sundowning
- 3. Depression
- 4. Akathisia

Collateral

- DOS charting
- The better we know our patients the better the care
- Who were they in their prime?
- Likes/dislikes
- Introvert/extrovert
- My story

Further Collateral

- Retired librarian, introvert
- Diagnosed AD 8 years ago
- Very gentle and kind
- Funny, family “her life”
- Episode of depression with diagnosis of AD: had insight
- No visitors for a year because of Covid. Family lives in US.

Depression

- Very common in the elderly , particularly in LTC
- Covid related isolation profound impact
- Non- pharmacological options : technology (FaceTime, Zoom), meaningful activities, transitional objects, treats
- Needs pharmacological treatment
- SSRI

What investigations need to be done before prescribing an SSRI?

- 1. ECG
- 2. Renal function
- 3. Na
- 4. Nothing
- 5. ECG and renal function
- 6. ECG, Na and Renal Function

Before Prescribing an SSRI

- ECG: QT/QTC
- Na- SIADH common problem
- Renal Function : dose adjustment
- Escitalopram. Citalopram
- Sertraline

Prognosis

- Good for quality of life
- Mrs. M improves
- Staff identify that her room is very close to the nursing station and is too busy for her. They move her to a quieter area
- Once volunteers are allowed back into the unit, a companion visits her 3x per week reading to her and reminiscing quietly in her room
- Virtual resolution of symptoms

What do antipsychotics help for

- Delirium: agitation, aggression and psychosis
- Psychotic symptoms, including pre-existing disorders
- Aggression and psychomotor agitation
- Beware side -effects

Conclusions

- The person matters
- Be a detective
- Can make a big difference

- Questions / Comments?

Additional Information

The Evidence

- 5 main clusters:
  - Apathy
  - Depression
  - Psychosis (delusions and hallucinations)
  - Sleep disturbance
  - Agitation and aggression
    - (restlessness, repetitive statements, vocalizations, aggressive language, aggressive physical actions, sexual disinhibition)

Symptom Frequency

- Apathy most common then agitation
- Changes with disease progression
- Prevalence in LTC:
  - 60% dementia
  - Median prevalence of NPS: 78%
  - Depression ~40%
  - Aggression ~ 10-20%
  - Psychosis ~ 15-30%
  - Agitation ~ 30%

Behaviors that do not respond to medication

- wandering
- exit seeking
- hiding and hoarding
- repetitive activity eg clapping/counting
- restlessness/pacing
- some sexualized behaviour
- inappropriate dressing /undressing
- tugging at seatbelts
- resistance to care
- sundowning
- swearing
- unsociable behaviour
- indifference to the surroundings
- inappropriate voiding
- eating inedible objects
- Spitting
- pushing wheel chair bound residents
- poor self care
- poor memory
- personality style

So……

- Familiar mantra
  - Start low, go slow
  - Consult geriatric dosing guideline
  - Adjust dose for renal, hepatic function, other concomitant drug use
  - Use for a specific indication/ diagnosis
  - Enquire about all medication- otc, friends, families, naturopathic and prescribed
  - What meds are still at home in the cupboard “just in case”
  - Regular medication review