Approaches to Resident Behaviours

Victoria-South Island LTCI Community of Practice Working Group

SOURCE

In 2022, meetings of the South Island Long-term Care (LTC) providers resulted in this list of suggestions for providers treating residents with Behavioural and Psychological Symptoms of Dementia (BPSD)*.

BACKGROUND

BPSD refers to the altered perception, thought content, mood or behaviour that residents with dementia frequently experience. Physiologically these behaviors are attributed to dysfunction in the parts of the brain that mediate emotional regulation, self-awareness and perception. Benign stimuli, combined with personality, traits and lived experiences can produce strong feelings and unintended reactions. BPSD should be viewed as the person's best attempt to manage in a situation they find challenging, even threatening.

All behaviour has meaning.

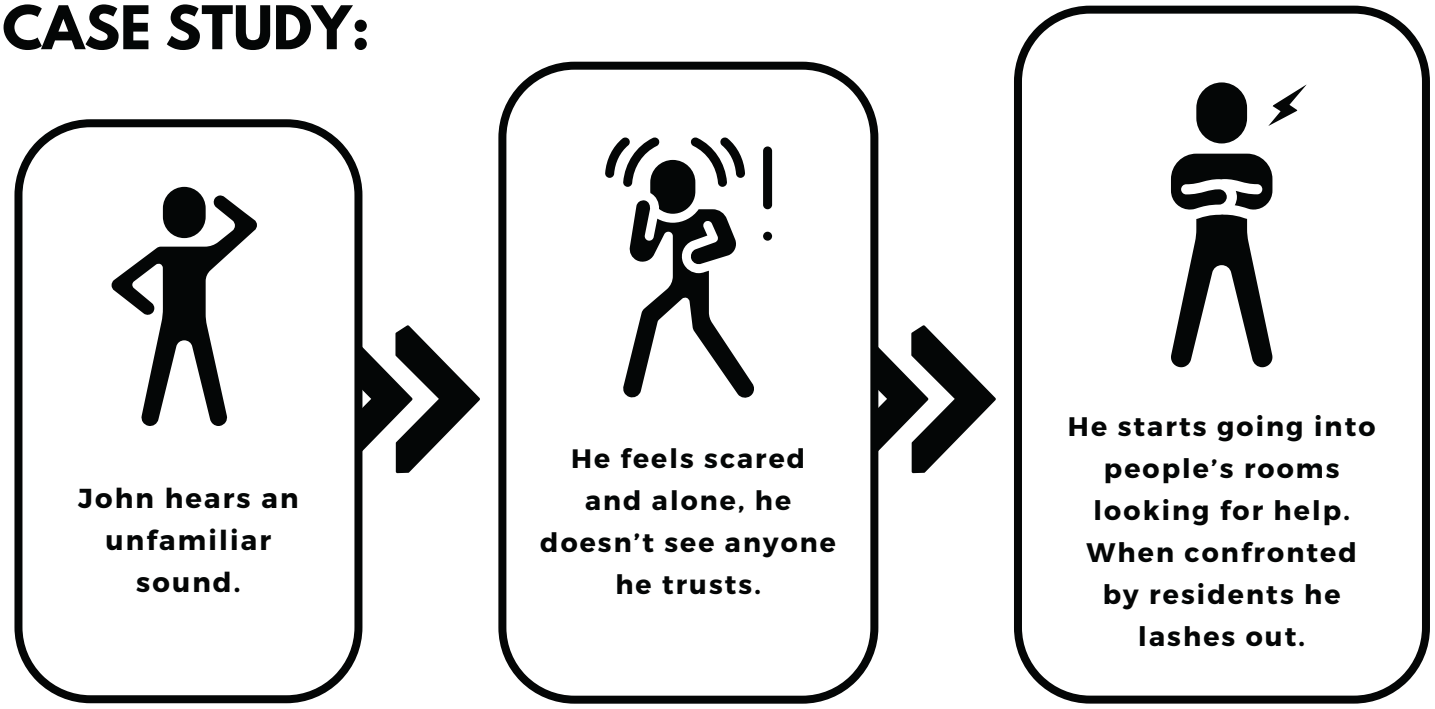
**Also known as Responsive Behaviors or Neuropsychiatric Symptoms.*

LTCI
Vic-SI Long-term Care Initiative

THE MRP'S ROLE

Changing a behaviour requires altering its stimulus so it no longer generates strong feelings. The MRP's role is to support the team in choosing which stimulus to reduce and then to evaluate the trial. They also look for medical causes and decide when medication is necessary.

CASE STUDY:



STIMULUS	STRONG FEELING	RESPONSE BEHAVIOUR
Other examples: pain, hunger, obstruction, needs to use the bathroom etc.	*Misinterpretations: anxious, lost, defensive, frustrated, pleasure seeking.*	*Urges: calling, crying, yelling, hitting, repetitive questions, sexual acts.*

TRY ASKING THESE QUESTIONS:

- *What was the physical and emotional environment before their behaviour?*
- *Do they need more socializing or more quiet?*
- *What are their needs that are not being met?*
- *What was their emotion before and during the behaviour?*
- *What is the resident's reality? Where/when are they?*
- *What are they experiencing physically?*

APPROACH

Many disruptive behaviours are a result of fear (modesty concerns, abuse history, discomfort, anxiousness) or pain. The Dementia Observation System can identify what time of day the behaviours are occurring, giving clues to the cause of the fear.

1

Acknowledge and address the staff and resident stress.

- *Enquire about staff/residents feelings and provide suggestions to improve safety. Identify what staff feel is at risk with the behaviour, such as loss of an orderly care environment or risk of injury to resident or staff. Staff should feel safe before trialing non-pharmacological solutions.*

2

Speak with the residents to understand the circumstances to determine possible stimuli that could cause the behaviour.

- *Speak with the resident and staff to answer the questions in the interpretation framework. Look beyond any misinterpretations or exaggerated responses by other residents or staff to find the original stimulus. All behaviour has meaning.*

3

Work with staff to manage the responsive behaviour immediately and trial ways to modify the stimulus.

- *Address the emotion in the response. Modifying different stimuli will likely be necessary until you find the right one modified in the right way. Creating a more positive emotional state throughout the day or week can reduce a stimulus's effect. Use 'Possible Solutions' on last page for ideas to change stimulus.*

4

Treat any medical or physical issues:

- *Look for causes of pain especially in not obvious places like mouth, armpits, ears, groin (or start a pain tracking scale)*
- *Treat any signs of elimination problems, systemic illnesses, metabolic abnormalities, or psychosis*
- *Consider reversing any medication changes*

5

Talk to the family for ideas that will provide the resident joy, distraction, or purpose.

6

Consult a reference guide or other BPSD resources for new ideas (see chart below & attached resources).

ANTIPSYCHOTICS

Dementia is a changing disease; behaviours may only show up in the middle stage. This means that every resident stops needing antipsychotics at some point - their disease has progressed, and the medication may only be giving them side effects (i.e. there is no behaviour left to treat). Frequent 'tests of tapering' are required to find this point in the disease progression. CMAJ recommends testing every three months.

Criteria for Use:

The Alzheimer Society of Canada's criteria for using antipsychotics[1] for residents with dementia note that the following conditions must be met:

1. ***The resident's behaviour is not improved with non-drug approaches, and;***
2. ***The resident is at risk of harming themselves or others, and;***
3. ***Antipsychotic drugs are not used more than 3 months.***

Effective when used for:

- Distressing hallucinations
- Delusional Disorder
- Schizophrenia
- Behaviour that places self/others at risk for harm
- Traumatic Brain Injury
- Major Depression

NOT effective to treat and may worsen:

- Pacing
- Fear
- Restlessness
- Wandering
- Sleep disturbances
- Sun-downing
- Shouting
- Cursing
- Repetitive questions
- Social or sexual disinhibition eg spitting or masturbation
- Protectiveness/territorial behaviour
- Hoarding

Side Effects:

- sedation
- confusion
- weight gain
- high blood sugar/high cholesterol
- falling
- QT prolongation
- postural hypotension
- EPS (rigidity, stiffness, akinesia)
- constipation
- problems urinating
- stroke
- edema
- ***Black Box warning***

Family needs to consent & be aware of 1% mortality

[1] https://alzheimer.ca/sites/default/files/documents/ASC-statement_use-of-antipsychotic-medications.pdf

	Behaviour	Possible Solutions
DOS Colours[4]	**Noisy** (Yellow)	• Distract, engage • Individualized music, nature sounds, presence therapy (tapes of family)
	Restless (Orange)	• Distract, engage • "Rest stations" in pacing path, adapt environment to reduce exit-seeking, physical exercise, outdoor activities
	Exit-seeking (Brown)	• Distract, engage • Adapt environment to reduce exit-seeking, physical exercise, outdoor activities • Register the individual with MedicAlert and Alzheimer's Society Safety Home program (contact information will be on bracelet or necklace) • Hide exits with curtains, or paint a black circle on the floor (the individual will think it is a hole and will not exit)
	Verbal aggression (Pink)	• Distract, engage • Individualized music, nature sounds, presence therapy (tapes of family)
	Physical aggression (Red)	• Distract, keep calm, remain warm and supportive • If possible, give the person some space and try to approach later
Other	**Delusion/ hallucination**	• Understand this is their reality and do not confront the false belief • Focus efforts on how the resident feels, not the content; offer distraction, avoid clutter, TV, radio
	Agitated/ irritated	• Calm, soothe, distract • Individualized music, aromatherapy, pet therapy, physical exercise, outdoor activities
	Resistant to care	• Identify source of threat (e.g. pain); change routines and approaches
	Repetitive questions/ mannerisms	• Reassure, address underlying issue, distract • Put the answer to the same repetitive question on a piece of paper or card and ask the resident to read the card instead
	Hoarding	• Remove items gradually, re-organize and clear paths in the case of emergency; be compassionate
	Inappropriate behaviour (e.g. disrobing, masturbation, verbally inappropriate,)	• Distract, re-direct • Keep an active and regular schedule to avoid boredom • Try increasing the level of appropriate physical attention • Provide personal space if possible and come back when the resident is calmer • Allow the individual privacy for intimate/personal activities

BPSD RESOURCES

Dementia Training Australia's BPSD Quick Reference Cards

A complete, but easy to read, 6 page guide to addressing BPSD

PIECES as an interactive algorithm

PIECES as a two page chart

The BC Guide for Managing BPSD

Physician Resources from BC Patient Safety and Quality Council

Three page review of antipsychotics by Shared Care

CFPC article on deprescribing antipsychotics

Alzheimer's Society Position statement