Practical Management of Challenging Behaviours in Dementia Care

Long-Term and Continuing Care Association of Manitoba
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Challenging Behaviours / Neuropsychiatric Symptoms are often referred to as

“RESPONSIVE” BEHAVIOURS

• Agitated, disturbing behaviours that challenge the skills, creativity and coping resources of the caregiver

• This view acknowledges that someone with dementia may be displaying agitation in response to some kind of noxious stimuli

• If the behaviour is in response to something bad, we must do our best to understand what that “something” might be
How Common are “Responsive Behaviours” Among People Suffering from Dementia?

Some research estimates:

57% of people with dementia display physical or verbal aggression (Hamel et al., The Gerontologist, 1990)

52% of people in non-institutional settings have a history of being verbally or physically assaultive (Eastley & Wilcock, Int’l Journal of Geriatric Psychiatry, 1997)

12% of persons with dementia in non-institutional settings displayed physical or verbal aggression (Chemerinski et al., Journal of Neuropsychiatry, 1997) – Argentinian study
MORE ESTIMATES

Prevalence of Responsive Behaviours Among People with Dementia

90% of patients with Alzheimer’s disease show behavioural changes including agitation, depression and aggression (Edwards, K., The Gerontologist, 2002)

21% and 22% of nursing home residents with Alzheimer’s disease showed physical and verbal aggression respectively (Voyer et al., Biomed Central, 2005) *

13% and 30% of Dutch nursing home residents with various kinds of dementia showed physical aggression and noxious verbalizations respectively (Zuidema et al., International Journal of Geriatric Psychiatry, 2007)

78% of long-term-care residents display neuropsychiatric symptoms (Seitz, International Psychogeriatrics, 2010)

Why is there such a variation?

*In Voyear’s literature review, prevalence ranged from 7 – 91% !!!!!!!!
What is Dementia?
Is it a disease?

• Dementia is a brain disorder that affects a person’s memory, his/her ability to think clearly and act purposefully
• Not a disease itself, but a word that describes a group of symptoms that accompanies certain disease processes, like Alzheimer’s disease for example
• Something that involves the entire central nervous system (CNS)
• The parts of the CNS affected define the different types of dementia
General Principles to Managing Neuropsychiatric Symptoms / Challenging Behaviours

• Non-pharmacological treatments should be used first
• Even when causes of challenging behaviours are deduced, medications should be used in conjunction with non-pharmacological interventions
• Non-pharmacological interventions work best when tailored to the individual
• Family and caregivers need to be key collaborators

International Psychogeriatric Association, BPSD Module 5, 2010
Day to day management of challenging behaviours starts by understanding the world of the individual living with dementia...

Appreciating Cognitive Losses or Thinking Problems

The 7 A’s + Executive Functioning
Why is it important to recognize cognitive losses?

Cognitive impairment is far more than just memory loss!

- Encountering stressors is a normal part of daily existence
- The cognitive losses of dementia greatly affect an individual’s interpretation of new stressors, influence the person’s internal response to stimuli and compromise previously successful coping mechanisms – thus resulting in challenging behaviours

Recognizing specific thinking problems helps caregivers to better understand challenging behaviours and respond more effectively.
What are the cognitive losses?
Trouble with Memory (Amnesia)

Examples of Behavioural Manifestations

• Repeating
• Misplacing things
• Insisting a recent event hasn’t occurred
• Disorientation
• “Living in the past”

Strategies to Compensate

• Provide cues and gentle reminders
• Treat all repetitions as if it were the first time
• Don’t assume a recent event can be recalled
• Reminisce about the distant past
Trouble Recognizing – People, Objects, Places (Agnosia)

Examples of Behavioural Manifestations

- Misidentifying loved ones including oneself
- Not recognizing professional caregivers
- Misusing common objects
- Eating usual things or mixing food

Strategies to Compensate

- Introduce yourself / don’t assume orientation to person
- Identify objects and places in the moment
- Prevent unfortunate mixtures by keeping items apart

Recognition of a kinship with others is often retained well into the illness.
 Trouble Using and Understanding Language (Aphasia)

**Examples of Behavioural Manifestations**
- Word finding difficulty
- Not using the right words
- Repetitive sounds/words
- Failure to reliably report distress (e.g. pain)
- Reverting back to one’s first language
- Needing more time to respond and/or not responding appropriately

**Strategies to Compensate**
- Speak slower and clearer than usual
- Accompany words with visual gestures
- Patience! Allow more time for a response
- Be mindful of facial expressions
- Use key words from the client’s first language
Trouble with Purposeful Movement (Apraxia)

Another thinking problem is the deterioration of someone’s ability to carry out a purposeful, previously learned movement. Because of this, the person may not be able to do many everyday tasks. Examples may include not being able to put on a pair of pants, butter a slice of bread or doing up buttons on a shirt.
Apraxia (Continued)

**Examples of Behavioural Manifestations**
- Deterioration of the ability to perform activities of daily living (e.g. dressing, grooming, toileting and eating) *despite* retained physical strength and range of motion
- Not getting the steps of a task right

**Strategies to Compensate**
- Provide short, simple instructions
- Assess capabilities regularly; refrain from assuming capability based on physical range
- Demonstrate an action in real time
Lack of awareness that someone *has* thinking problems (Anosognosia)

From the middle stage of an illness that causes dementia onwards, people lose the insight that they are having problems with their thinking or that they need help.
Lack of Awareness That Someone has Thinking Problems (Anosognosia)

Examples of Behavioural Manifestations

- Refusing assistance, care or aids
- Insisting that one “has already done it”
- Lack of insight and appreciation of risk
- Appearing stubborn
- NOT DENIAL!!!

Strategies to Compensate

- Step into the individual’s reality and recognize strengths
- Normalize assistance (i.e. “I do this for everybody”)
- Avoid arguing
- Offer help as if it were temporary (i.e. “I help you just this once”)
Trouble Perceiving the World Accurately (Altered Perception)

Someone with cognitive impairment may experience things differently. He/She may have **delusions** (false beliefs), experience **hallucinations** (experiencing something that isn’t there at all) or **illusions** (mistaking something for something else), or **poor depth perception**.

**Strategies to Compensate**
- Avoid arguing or trying to impose reality
- Step into the person’s world; respond to his/her feelings rather than the facts being expressed
- Validation therapy
- Alter the environment to minimize misinterpretation
Lack of Motivation / Initiation (Apathy)

Examples of Behavioural Manifestations

- Appearing not to care / withdrawn
- Failure to initiate activities (e.g. conversation, eating)
- Appearing “stuck”
- Sitting in the same place for long periods of time

Strategies to Compensate

- Help the person initiate or get something started
- Connect with the individual on a regular basis
- Gently persuade the individual to join activities he/she formerly enjoyed
Executive Functioning: Necessary for activities of daily living

- Planning
- Organizing
- Sequencing (doing things in proper order)
- Initiating (knowing when to start something)
- Ceasing (knowing when to stop)
- Judgment
- Abstraction
Peril of Only Using Antipsychotic Medication to Manage Behaviours

- Atypical antipsychotic use associated with an increased risk of mortality (Schneider, JAMA, 2005)
- Antipsychotic use associated with a higher risk of CVAs (Herrmann, CNS Drugs, 2005)
- Overall decrease in cognitive function (Vigen, American Journal of Psychiatry, 2011)
It is important to remember that...

Behaviour has meaning...

What we experience as disturbing, agitated or challenging behaviour might be an individual’s way of showing that he/she is in distress. Cognitive losses prevent the individual from coping with the distress. **We must always do our best to address the root cause of the behaviour!**

Left unchecked or we don’t bother, agitation can **escalate!**
RESPONSIVE BEHAVIOURS
Looking for Possible Causes

One systematic, provincially recognized, simple to use framework is:

Putting the **P.I.E.C.E.S.™** together
What does P.I.E.C.E.S.™ stand for?

P – Physical
I – Intellectual
E – Emotional
C – Capabilities
E – Environment
S – Social / Cultural

It is a framework that reminds us to consider many factors when trying to understand an individual and why his/her behaviour is occurring.
P.I.E.C.E.S. in Manitoba

Between 2008 and 2011

• 1012 Allied health professionals received full PIECES training. 625 were nurses.
• 452 senior leaders received Senior Leaders training to support PIECES-trained personnel.

Source: Alzheimer’s Society of Manitoba
Best Practices involve properly using the 3-Question P.I.E.C.E.S. Template

1. What has changed?
   • Avoid assumptions; think atypical; What is of concern to the team now?
2. What are the RISKS and possible causes?
   • Think P.I.E.C.E.S.
3. What is the action?
   • Investigations / Interventions
   • Interactions
   • Information
In 2011, Toronto, Ontario psychogeriatric resource consultants surveyed 46 PIECES-trained allied health professionals who had received training between 2009 and 2011.

- 95% of respondents reported using “parts” of their PIECES training in their everyday practice
- 26% of respondents reported using the 3-Question template regularly to work through challenging behaviours
- Of those professionals not using the template consistently, 94% reported a desired to use the template if barriers were removed
Reported Barriers

- Lack of common language with co-workers
- Perceived lack of management support
- Not enough time allotted to apply the template properly
Question 1: What has changed? – Avoid assumptions; think atypical

Efficiency tip: Document the behaviour using specific language, avoiding vague terms such as aggression, agitation or confusion.

Result: The care team understands unambiguously the challenging behaviours that need to be addressed – thus saving time!
Using the P.I.E.C.E.S.™ Template Efficiently
Continued

Question 2: What are the RISKS and possible causes? – Think P.I.E.C.E.S.

**Efficiency tip:** Flag risks quickly. Explore *only* those elements of PIECES that *directly* explain the behavioural displays described in Question 1.

**Result:** Significant amount of time saved gathering superfluous information that may not contribute to behavioural understanding.
Using the P.I.E.C.E.S. ™ Template Efficiently Continued


Efficiency tip: Address the previously identified risks. Avoid vague terms (e.g. “offer reassurance”, “distract”, “redirect”) when describing actions and delegate tasks to specific team members.

Result: Team members will have a clear understanding on what actions to take; reduced diffusion of responsibility.
Person with DEMENTIA

Vs.

PERSON with Dementia

T. Kitwood
What is your definition for Person-Centred Care?

Some general principles include:

• Each client has a unique history and preferences that must be taken into account in order to understand him/her better
• Care must incorporate the client’s priorities, not just what we think is “obviously” best
• Remaining client strengths are supported and utilized during care
• Feedback from the client is regularly obtained in order to properly evaluate our progress
Creative Solutions
Connecting with Resident Personhood