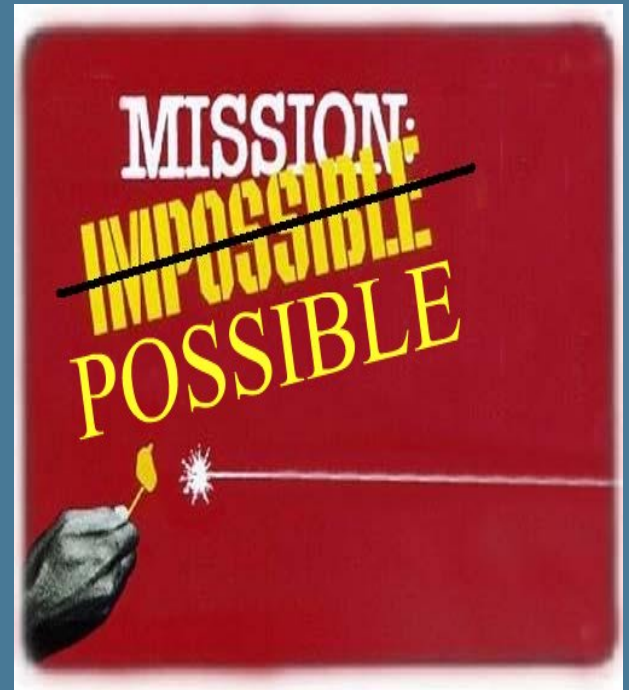




RESPONSIVE BEHAVIOURS: SUPPORTING PERSONS AND THEIR FAMILIES

JUNE 2015



OUR MISSION.....

**IF YOU DECIDE TO ACCEPT THE CHALLENGE
TOGETHER WE WILL:**

- Foster Communication
- Enhance Documentation
- Achieve better outcomes for the patients and their family.



OUR OBJECTIVES: TO

- Describe responsive behaviours associated with dementia
- Explain underlying causes for these responses
- Promote strategies to support individuals during transitions



WHAT ARE RESPONSIVE BEHAVIOURS?

- “Responsive behaviour” is a means of communication for those with difficulty expressing thoughts, feelings and needs.
- It is a reaction to stimuli that triggers the “fight or flight” response in a person with dementia

These reactions could be associated with:

- Real or Perceived Stimulus
- Unmet needs
- Social, emotional, or physical environment which may cause frustration, fear, confusion (MOHLTC, 2007)

IMPACT ON PATIENTS AND FAMILY

The onset of a responsive behaviour is often the triggering event for recognizing dementia.

Often this results in:

- Premature Institutionalization
- Delay in the person moving to the right type of care facility and receiving appropriate care
- Stigmatizing the person as “behavioural”
- Heightened stress, anxiety and uncertainty for persons and their caregivers
- Decline in quality of life and functional status
- Increased mortality
- Greater care costs

BEHAVIOURS THAT IMPACT CARE AND THE QUALITY OF LIFE OF PATIENTS AND THEIR FAMILIES

1. Pacing, wandering & exit-seeking
2. Restlessness & agitation
3. Grabbing people
4. Constant unwarranted requests for attention & help
5. Complaining or constant plaintive crying
6. Repetitive statements & questions
7. Cursing & verbal outbursts
8. Strange noises & screaming

WHAT IS THE NATURE OF DEMENTIA ?

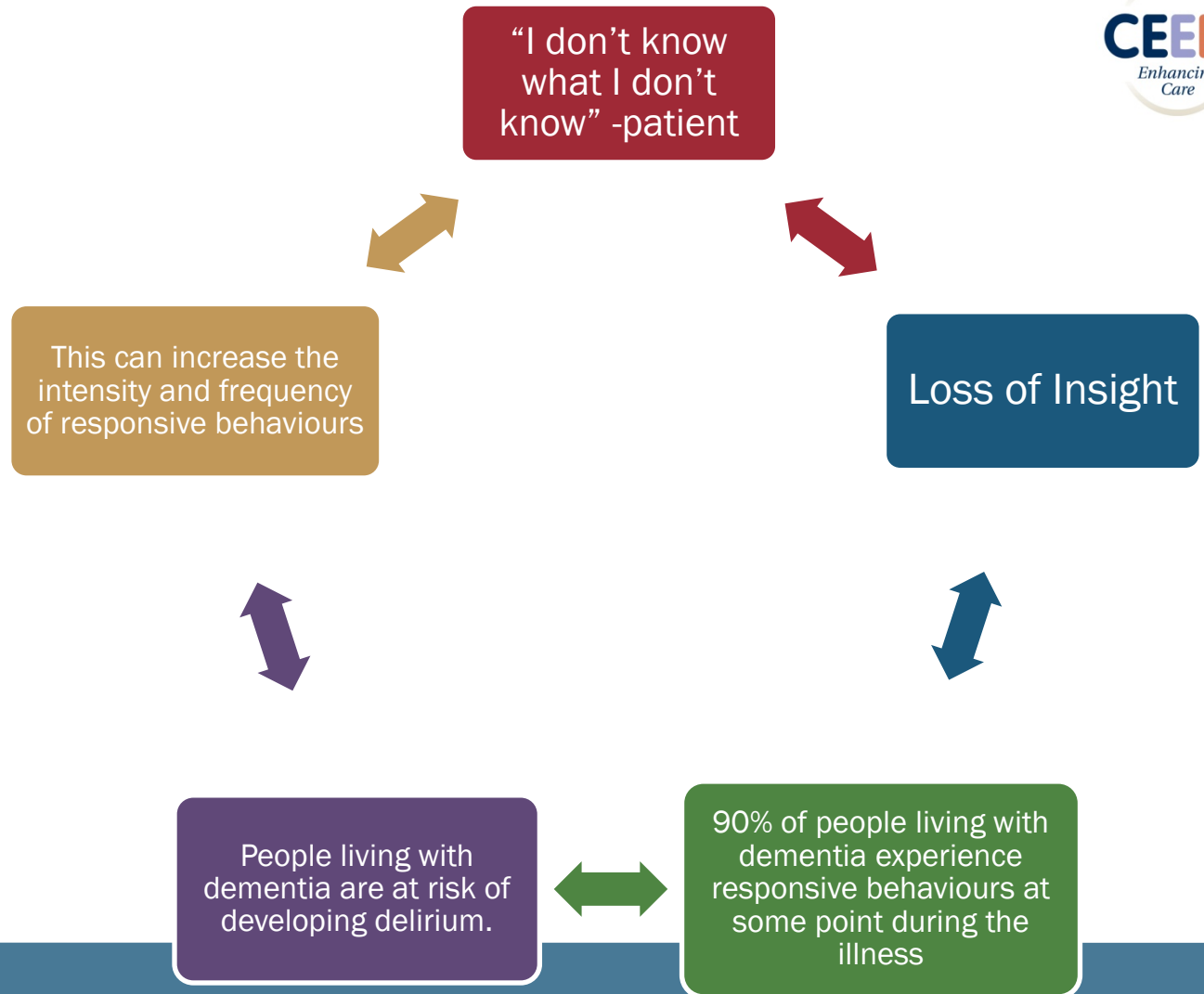
An acquired disorder affecting two or more cognitive domains. It affects function and is not due to depression or delirium.

- **Anosognosia:** The person does not know that he/she has a problem
- **Amnesia:** The person experiences a loss of memory
- **Apathy:** The person has no drive or initiative
- **Agnosia:** The person can no longer recognize things through their senses
- **Apraxia:** The person experiences a loss in purposeful movement
- **Aphasia:** The person loses the ability to use language (this includes the ability to speak, read, write and understand conversations)
- **Altered Perception:** The body misinterprets the information their senses are giving them

TYPICAL BEHAVIOURS SEEN WITH DEMENTIA

- Apathy
- Agitation/aggression
- Anxiety
- Euphoria/elation
- Disinhibition
- Depression/low mood
- Delusions
- Hallucinations
- Irritability/mood changes
- Aberrant motor behaviour

WHY DO SOME PEOPLE WITH DEMENTIA EXPERIENCE RESPONSIVE BEHAVIOURS?



HOW IS DEMENTIA LINKED TO DELIRIUM ?

- Pre-existing cognitive impairment greatly increases the risk of developing delirium.
- Delirium superimposed on dementia is frequently under-recognized.
- Symptoms of delirium are often attributed to the underlying dementia, age-related variations or environmental changes
- Some types of dementia look like delirium eg. Lewy Body Dementia (DLB)

TRIGGERS FOR RESPONSIVE BEHAVIOURS

Physical

Pain

Constipation

Urinary Retention

Dehydration/Hunger

Metabolic/Electrolyte

Infections

Organ Failure

Emotional

Depression

Anxiety

Psychosis

Medications

New or changed medications including OTCs/herbals

Anticholinergics, psychotropics, Anxiolytics, Analgesics

Alcohol/illicit substance use

Environment

Any recent changes to the environment i.e./ move, loss of a loved one etc.

Temperature, Noise, Lighting

A FRAMEWORK TO ASSESS PATIENTS: P.I.E.C.E.S.

There are many factors which help to understand why the behaviour is occurring and to identify unmet needs.

Physical

Intellectual

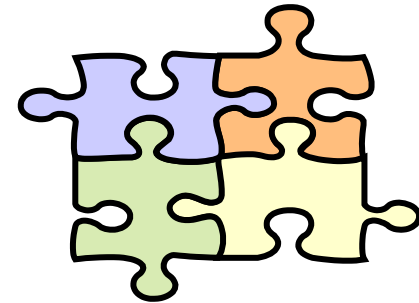
Emotional

Capabilities

Environment

Social and Cultural Factors

P.I.E.C.E.S.



WHAT DO YOU THINK IS CAUSING THE BEHAVIOUR?

- Describe the person's behavior
- What happens just before/after the behavior occurs?
- How often does this occur?
- What interventions comfort the patient?
- What types of leisure activities decrease/increase the responsive behaviors
- Does time of day, rest, noise, pain or eating affect the behaviour?
- How did the patient cope with experiences earlier in life?
- How does the person's behavior interact with other patients & staff?

HOW TO DEAL WITH THESE CHALLENGES?

1. Identify **TRIGGERS** for the behaviours
2. Address/Resolve **TRIGGERS**
3. Initiate Non Pharmacological approaches
4. Role model strategies for staff and family



NON –PHARMACOLOGICAL APPROACHES

- **Patient –centered Intervention:**
 - Timely, structured, systematic, consistently applied, time limited
- **Music therapy**
 - Preferred music choices
 - Refer to: Alive Inside (youtube)

More studies needed to demonstrate the efficacy of:

- Aroma therapy
Multisensory
Stimulation (Snoezelan)
- Massage
- Bright Light/ white noise

BEHAVIOURS NOT AMENABLE TO PHARMACOLOGICAL MANAGEMENT

- Wandering / Pacing/ Exit Seeking
- Resistance to care
- Sundowning/ late afternoon restless
- Inappropriate voiding
- Hiding and hoarding / rummaging
- Inappropriate dressing /disrobing
- Eating inedible objects
- Spitting
- Repetitive activity
- Tugging at seatbelts
- Pushing/ touching
- Repetitive / vocally disruptive
- Swearing/Screaming
- Sexually disinhibited actions

PERILS OF MEDICATIONS: RISKS VS. BENEFITS

Antipsychotic (neuroleptics) use:

- Associated with a slight increased risk of mortality in older patients with dementia
- Associated with a slightly higher risk of CVAs
- May decrease cognitive function

- **Potential benefit (e.g. resolution of delusions, improvement in sleep) must be balanced against potential risks (e.g. falls, increased risk of strokes and mortality)**

SUGGESTED MEDICATIONS

- Despite modest efficacy, small but significant increase in adverse events mandates that neuroleptics should *not* be used routinely to treat patients with aggression or psychosis unless there is marked risk or severe distress.
- Citalopram and sertraline may be helpful in controlling irritable behaviour in Alzheimer's Disease (AD)
- Risperidone is the only atypical antipsychotic medication approved for the short-term treatment of aggression or psychosis in patients with severe dementia. Not to be used if vascular dementia is present
- Quetiapine is a less potent neuroleptic which is more sedating than others
- Haloperidol is likely still the best for aggressive behaviour
- Trazodone may be used for sedation especially at night



RISKS TO BE DISCUSSED WITH PATIENTS OR SUBSTITUTE DECISION MAKERS WHEN STARTING MEDICATIONS

- Over sedation
- Postural hypotension
- Falls
- Metabolic syndrome
- Extra pyramidal symptoms
- Tardive dyskinesia
- Stroke
- Increased mortality



MEDICATION USE: KEY CONSIDERATIONS

- Start Low and go slow with any dosing
- Engage the patient /family/substitute decision-maker in the health care planning and decision-making process.
- Obtain consent for health care treatment from the appropriate decision-maker before administering antipsychotic medication.
- Regularly review the need (or not) for ongoing antipsychotic therapy for behavioural psychological symptoms of dementia and trial withdrawal.
- Continue non-pharmacological approaches

PRACTICE TIP: CONSIDER THE FOLLOWING PARAMETERS WHEN ASSESSING EFFECTIVENESS OF INTERVENTIONS:

- frequency of symptoms
- severity of symptoms
- functional status
- quality of life for resident
- input from individual when possible, physician, health care provider, caregiver, family and substitute decision maker.

Using an observation chart, document the impact the intervention is having on mitigating the behaviours as intended.

DOCUMENTATION :

- Assess frequency of responsive behaviours:
 - “DOS tool” AND narrative notes
- Describe all consistent approaches taken to minimize the response
 - narrative
- Describe interventions and outcomes to your intervention
- The CCAC uses this information to help with transitions



(Cohen-Mansfield and RAI)

TAKE HOME MESSAGE

- Describe EACH behaviour in **neutral** clear language
 - (avoid words like “whining” and “aggressive”)
- Care plan should identify each behaviour, trigger and related intervention
- Ongoing monitoring for any changes i.e. decreased intensity, frequency, duration
- Imprecise charting has consequences for the patient and family

WHAT SUPPORTS ARE OUT THERE TO HELP ?

- Behavioral Supports of Ontario (BSO)
- Psychogeriatric Resource Consultant (PRC)
- Gentle Persuasive Approach (GPA)
- Coast (Community Outreach Assessment Team)
- Alzheimer Society, First Link, Caregiver support/education
- CCAC, Direct patient services, Respite, Day Programs, Caregiver Connect, Long range planning,
- Geriatric Outreach/Specialized Geriatric Services (at St. Joe's and HHSC)

REFERENCES

- Azermai, M., Petrovic, M., E Iseviens, M., Bourgeois, J., VanBortel, L., VanderStrchele, R. (2011) Systematic Appraisal of Dementia guidelines for the management of behavioral and psychological symptoms. *Aging Research Review* .in press. 10.1016, 07.002
- Canadian Coalition for Seniors Mental Health, (2010). *A Person-Centered Interdisciplinary Approach, Pocket Guide Tool on the Assessment & Treatment of Behavioural Symptoms of Older Adults Living in Long Term Care Facilities.*
- Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care . October 25
- Gillies, L. Coker , E. Montemuro, M. Pizzacalla, A. (2015) Sustainability of an innovation to Support and Respond to Persons with Behaviours related to Dementia and Delirium . *JONA* 45(20) 70-73
- Holttä, E., Laakkonen, M.L., Laurila, J., Strandberg, T., Tilvis, R., Kautiainen, H., Pitkälä, K. (2011) The Overlap of Delirium with Neuropsychiatric symptoms among Patients with Dementia. *Am J Geriatric Psychiatry* 19(12):1034-1041
- Ontario Association of Non-profit Homes and Services for Seniors in (2011) *Responsive behaviours Training* . Toronto , On.
- Okura, T., Plassman, B., Steffens, D., Llewellyn, D., Potter, G., Langa, K. (2011) Neuropsychiatric Symptoms and Risk of Institutionalization and death: The Aging, Demographics and Memory Study. *J. American Geriatrics Society* .59(30):473-481
- Rader, J., Tornquist, E. M. Ed. (1995) *Individualized Dementia Care* . Springer Publishing Co. New York .
- Rosy, D. (2015) *Caring for Patients with Dementia and Responsive Behaviors across the Continuum* . Panel Presentation . Annual RGPs of Ontario Education Day . April . Toronto , Ontario.
- [Sunnybrook Veterans Centre , \(2010\) Responsive Behaviours due to Dementia , ABLE . Toronto , Ont.](#)
- Voyer , P., Verreault, R., Mengue, P., Laurin, D., Rochette, L., Shindle –Martin, L. (2005) Managing Disruptive Behaviours with Neuroleptics . *Journal of Gerontological Nursing* 31(11):49-59.
- Voyer, P., McCusker, J., Cole, M., Monette, J., Champoux, N., Ciampi, A., Belzile, E., Richard, H. (2015) Behavioral and Psychological Symptoms of Dementia. *Journal of Gerontological Nursing*.41(1):22-37.

ADDITIONAL LEARNING RESOURCES

- *The Dementia Education Needs Assessment (DENA)* found at:<http://akeontario.editme.com/DENA> *Basic knowledge of dementia, common symptoms*
- P.I.E.C.E.S.[™] enabler, Job Aid www.piecescanada.com/pdf/Resources
- “Me & U-First” e-modules at www.u-first.ca (English and French)
- *Enhanced knowledge of dementia :Enhanced knowledge of dementia, leading the team.*
- U-First face to face training, www.u-first.ca/e-learning/me-and-ufirst/me-and-ufirst.htm
- Gentle Persuasive Approach (GPA) www.rgpc.ca
- Gentle Persuasive Approach
- www.marep.uwaterloo.ca
- www.akeresourcecentre.org
- www.shrtn.on.ca

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