Disruptive Behavior in Long Term Care

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Byrd Institute

Excellence in Geriatric Health Care Conference

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Goals

- Learn the appropriate & inappropriate use of psychoactive medications in NHs
- Learn about the models of disruptive behavior in residents with dementia
- Learn about person-centered approaches to PWDs

"I have no actual or potential conflict of interest in relation to this presentation"

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MH problems in NHs

- Most NH residents have some MH problems
- Depression (40%); Anxiety (3.5-20%); SMI (10%); Dementia (50%) with behavior problems (59%)
- 3 types of NH residents with MH problems:
  - SMI
  - Adjustment problems (anxiety/depression)
  - Dementia with behavior problems/agitation
- Need very different interventions – not one size fits all – require training & professionals

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OBRA – 87 Improve MH treatment of NH residents

1. MH screening for those with SMI (PASRR)
2. Guidelines for use of restraints & psychoactive med usage
3. Encouragement of non-pharmacotherapy

- OBRA intent not fully realized –
  - Lower # of inapp SMI admits; Less restraints
  - Anti-psychotic usage reduced – recent 'black box' warnings have helped
  - Anti-depressant use increased

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Side effects – Psychoactive meds

- Anti-depressants linked to falls in older adults
- Anti-psychotics (traditional & atypical) associated with greater mortality in AD residents – led to 'black box' warnings
- Sedative drug use related to mortality, cognitive impairment, and balance problems
- Total psychoactive drug load increases risk of hospitalization for NH residents

Need judicious use of psychoactive meds!

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Disruptive Behaviors

- Aggression
- Anxiety & Agitation
- Catastrophic reactions
- Crying, Screaming, Yelling
- Repetitive questions
- Suspiciousness, Paranoia

Only 5% of NHs use EBPs for non-pharmacological interventions

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ASCP Report - Psychopharmacology for PWDs

- 2% of older adults and 25% of NH residents receive anti-psychotic meds
- No meds have been approved by FDA for the management of behavior problems for PWDs
- Back box warnings for atypical and traditional anti-psychotic meds for those with dementia
- Meds should only be used in emergency situations
- Meds should only be used after non-pharmacological approaches have been tried first

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Treatment
DVA Meta-analysis of non-pharmacological interventions (2011)

Evidence to support behavioral interventions:

- Functional analysis of specific behaviors, CBT
- Token economies
- Habit training
- Progressive muscle relaxation
- Communication training

Not enough evidence for validation therapy, acupuncture, aromatherapy, music therapy, massage, exercise, pet therapy – may have promise

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Effective Treatment of Behavior Problems Include:

- Problem-solving approach: Antecedent-Behavior-Consequences – “training family or staff to carefully observe problem behaviors, identify antecedents, and modify physical environment, schedule or interpersonal interactions”
- Strategies to increase positive behaviors such as pleasant events and exercise
- Multicomponent programs that include environmental mods & staff education in ADL’s

Logsdon et al. Psychology & Aging 2007,22(1):28-36

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Treatment (cont.)
STAR-VA – Karlin & Teri

A trained MH provider consults with NH staff to implement interventions for difficult cases

- ABC approach - Identify & change antecedents and consequences of problem behaviors
- Increase pleasant events (meaningful activities)
- Promote effective communication
- Create realistic expectations for PWDs

Reduces disruptive behavior & depression & anxiety; improves staff knowledge & skills–but labor intensive

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Models of Disruptive Behavior – not mutually exclusive

- Kunik - Focus on mutative factors(depression/pain/UTI)
- Antecedent-Behav-Consequences CARES; DICE
- Volicer - understimulation-overstimulation
- Algase & Teri / Teepa Snow - Need-Driven Dementia-Compromised Behavior Model (NDB)
- Progressively lowered stress threshold
- Lawton – match between person & environment
- Validation approach e.g. Naomi Feil – change our behavior to accommodate residents' reality

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Kunik

- Many paths to disruptive behavior
- Disruptive behavior not a normal part of aging or even dementia
- Individualized approach
- Evaluate & treat for mutable causes such as pain, anxiety, delirium, over-medication, depression, personality problems or psychosis that could be causing disruptive behavior

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A-B-C Approach

- Evaluate the ANTECEDENTS of behavior – what triggered the event?
- Describe the BEHAVIOR – is it aggressive towards someone or is it confusion etc.?
- What are the CONSEQUENCES of the behavior – does the person get more attention or gets left alone like the person wants?

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Volicer

- Agitation (e.g., yelling, crying etc.,) is often due to under-stimulation – treatment is to provide more stimulation
- Aggression (e.g., fighting, hitting, yelling at someone) often caused by poor caregiver technique – treatment is to train the caregiver

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Need-driven Behavior

- All behavior reflects communication
- Person is trying to communicate a need
- Treatment is to identify and satisfy the need
- For example, those with narcissistic personality disorders may be trying to gain attention
- Those who are anxious & dependent may be clinging and sending out signals that they can't manage on their own

Lowered Stress Threshold & Person-Environment Fit

- Frail older adults, particularly those with dementia, may have less internal resources to manage stressful situations
- We need to plan for an environment that is low stress so that the demands (e.g. paying bills, buying groceries) don't overwhelm the person
- However, the environment should be stimulating enough to provide meaningful challenges congruent with the PWD's cognitive level

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Validation Therapy – Person Centered Care

- For PWDs, we need to 'enter their world' and not expect them to enter ours
- We need to try to put ourselves in their shoes
- Confronting PWDs with reality can be frightening and does not work to calm people down and behave normally
- If the person believes that they need to go to work – don't tell them that they are retired but discuss the importance of work in their lives

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Needs of All People With Dementia

- Have Physical Needs Met: Hunger, Thirst, Restroom, Pain/Discomfort, Rest
- Feel Safe and Secure
- Positive Human Contact
- Meaningful Activity
- Feel That They Are Contributing
- Have Success Experiences

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How to Frustrate a Person with Dementia

- Tire Them Out
- Bore Them
  - Low Frustration Tolerance
  - Need to Alternate Periods of Rest & Periods of MEANINGFUL ENGAGEMENT
- Make Them Feel Like a Failure
  - Talk Too Fast; Correct Them All The Time; Are they Always Getting Help? Never Getting to Help?

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How to Help a Person with Dementia

- **Give Them Success Experiences!**
- **Find Ways for them to Contribute**
- **Can They Keep Up??? If not -** *Slow It Down*
- **Can They Hear??? If not,** *Speak Loudly, Clearly, Slowly*
- **Can They See??? If not,** *Use High Contrast, No Glare*
- **Be Enjoyable to Be Around!**
  - Implicit Learning & Emotional Memory are Preserved Skills: People with dementia remember people they Like so be Rewarding to be around and Deliver Person-centered Care

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CARES: Person Centered + Behavioral Approach Basic Online Training for all NH staff

- **C**onnect with the Person
- **A**ssess Behavior
- **R**espond Appropriately
- **E**valuate What Works
- **S**hare with Others

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CARES (cont.)

- Person-centered approach
- Show that one cares
- Help residents in a sensitive, thoughtful, and respectful way, like one would do for a good friend or family member
- Focus on what residents *can* do rather than what they can't
- Add meaning to residents' lives & celebrate moments of success

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C = Connect

- The “C” step is about making a connection with people each time you interact with NH residents
- It’s about taking time to greet them and doing so in a respectful, friendly, and nonthreatening way
- It’s about noticing their individualities
- Making a connection and being perceived as safe is especially important for NH residents
- <u>If NH residents feel connected to you, they are more likely to listen to you</u>

A = Assess

- Figure out what might be causing this person to respond in a certain way or become upset
- If you have had a chance to get to know the person, it will be easier to figure out why he or she is behaving in a certain way
- When a person becomes upset, there is something or someone that has triggered the reaction. What is the trigger?
- Was it the TV or a harsh roommate?

Assessment Questions

- 1. Does the behavior need a response? Some irritating behaviors are harmless.
- 2. Is this person's behavior dangerous to himself or herself or other people?
- 3. Is this behavior a change for the person?
- 4. What do you think might have caused this person to behave in this way? Is it because of something in the environment? Is it because of someone? Is there a physical or medical reason?

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R = Respond Appropriately

- After you have assessed a person's behavior, you will need to decide on the best way to respond
- The key is to make your response fit the person and the situation e.g., reduce stimulation while eating; bathe person at another time
- If the person is fearful, think about the best way to make him/her feel safe

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Respond Appropriately (cont.)

- It's important to understand that the ways you respond—the tone of your voice, your body posture, the words you choose—are as important as the response itself
- No matter what kind of response a situation requires, put the dignity of the person first
- Think about who the resident is & what she needs

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E = Evaluate What Works

- Did the person you are caring for become calmer or happier based on what you said and did? Or, did he or she become more upset?
- Keeping track of what works will help the next time you are in a similar situation with that person.
- What worked one time may not work every time.
- The more time you spend with a person and note what's working, the more effective you will become.

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S = Share with Others

- Sharing information helps everyone to do their job better. Sharing successes is a simple way to create a more positive environment.
- If the information you need to share is not about a success, the simple act of sharing can foster concern and encourage everyone to work together to reach a goal.
- Discussing with family, staff, or even with the person how well a certain response worked promotes consistency.

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Resources

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