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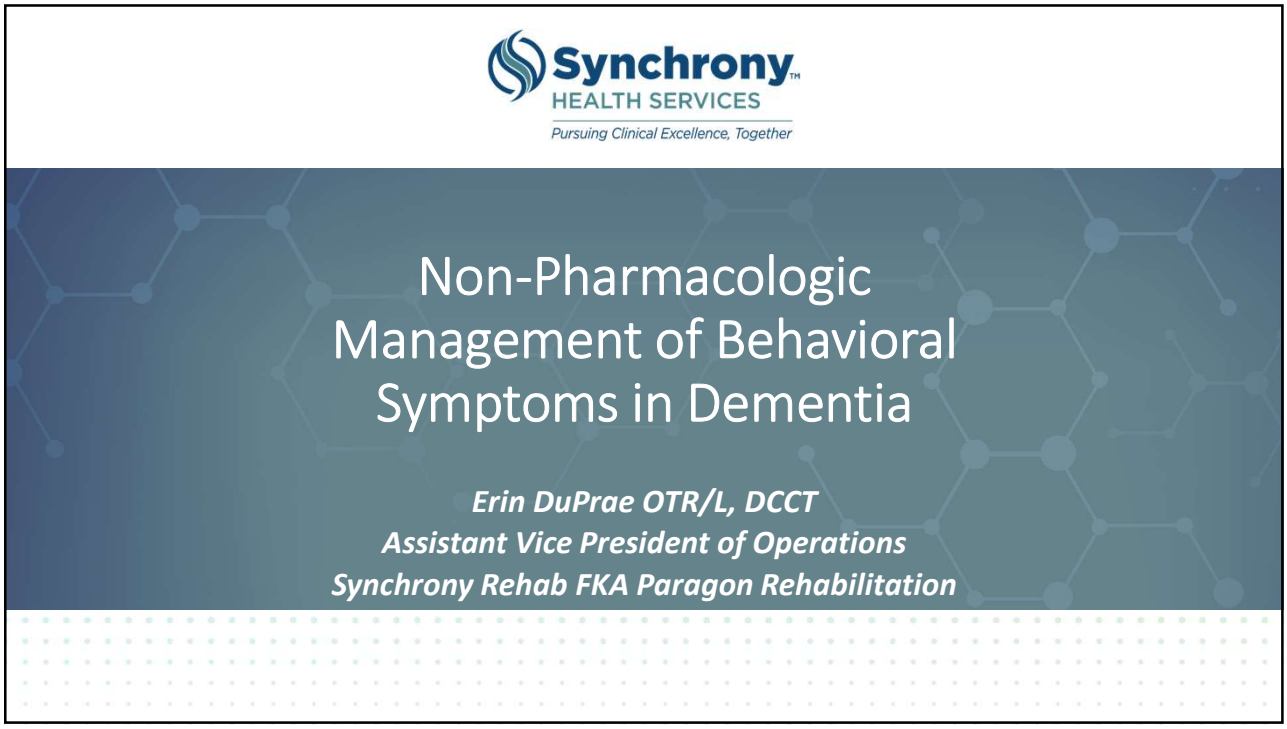
Synchrony
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Non-Pharmacologic Management of Behavioral Symptoms in Dementia
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Objectives:

- Participants will review and understand stages of dementia with remaining abilities.
- Participants will be aware of the direct and indirect interventions for behavioral and psychological symptoms of dementia.
- Participants will understand when and why specific interventions work.

Positive Approach

- Change focus from a negative perspective to a positive perspective.
- Provide patient centered care with an abilities based approach rather than an impairment based approach.

- Identify each person's strengths
- Develop care plans around strengths to maximize function
- Educate caregivers of strengths for positive interactions

Measurable Outcomes

Reduce behavior problems associated with dementia

- ❑ Increase individual, family, and surveyor satisfaction
- ❑ Increase staff satisfaction
- ❑ Decrease falls
- ❑ Increase nutrition, decrease weight loss
- ❑ Minimize health complications associated with dementia
- ❑ Increase activity participation
- ❑ Provide reimbursable therapy services

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Understanding Dementia

Cognition is the primary determinant of a person's maximum ability to function in every activity.

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Stages of Dementia

Allen Cognitive Level: 1- Automatic Actions, End stage

- Developmental age comparison = 0-12 months
- Likely bedbound, mute, and requires total care
- Can feel and express love and experience relationships with others

Primary remaining abilities:

1. Sensory stimulation
2. Swallow
3. Vocalize
4. Partial range of motion

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Stages of Dementia

Allen Cognitive Level: 2- Postural Actions, Late Stage

- Developmental age comparison = 12-18 months
- Sits, stands, or walks with assistance
- Communicates needs through gestures, behaviors, words in short phrases

Primary remaining abilities:

1. Gross motor movement
2. Simple communication
3. Possible self-feeding
4. May sit, stand, or walk

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Stages of Dementia

Allen Cognitive Level:
3- Manual Actions, Middle Stage

- Developmental age comparison = 18 months – 3 years
- Moves self and objects in ways that can cause safety risk.
- Communicates in a basic level
- Abilities vary from low to high

Primary remaining abilities:

1. Grasp objects
2. Eye-hand coordination
3. Follows one step directions with cues
4. Notices effects of actions on objects

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Stages of Dementia

Allen Cognitive Level:
4 – Goal-Directed Activity, Early Stage

- Developmental age comparison = 4 – 10-12 years old
- Benefits from routine and structure; has trouble with change
- Poor judgement
- Needs more cognitive assistance with new or complex tasks
- Abilities vary from low to high

Primary remaining abilities:

1. Simple problem-solving
2. Some new learning
3. Follows routines
4. Goal-directed in familiar activities

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Stages of Dementia

Allen Cognitive Level: 5 – Independent Learning Activities, Mild Cognitive Impairment

- Developmental age comparison = teens to early 20's
- Independent to supervision depending on familiarity or complexity of the task

Primary remaining abilities:

1. Follows simple written instructions
2. Trial and error problem-solving
3. Usually notes only primary effects of actions
4. Possibility of employment
5. Driving and childcare are possible

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Stages of Dementia

Allen Cognitive Level: 6 – Planned Activities

- Developmental age comparison = 25 years old or more
- Best ability to function is Independent

Primary remaining abilities:

1. Executive function
2. Abstract thinking

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What is Negative Behavior?

You are traveling alone and staying in an unfamiliar hotel. The first evening you are there, you hear unusual noises outside your door. A few minutes later, a stranger walks in and instructs you to get up and go with him to the bathroom to take a shower.

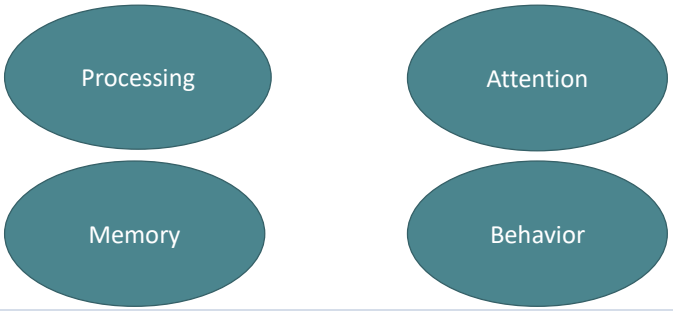
How would you respond; with resistance, screaming or maybe trying to run away? How would the response be perceived? Would your behavior indicate prescribing medication?

Direct and Indirect Interventions

Communication: interchange of information

- Expressive
- Receptive

Potential challenges



Direct and Indirect Interventions

Communication Approaches

- ❑ Gain attention and trust
- ❑ Make direct eye contact
- ❑ Address by name
- ❑ Eliminate distractions
- ❑ Be aware of body language, facial expression, and tone of voice
- ❑ Speak slowly
- ❑ Speak in short sentences
- ❑ Wait for a response
- ❑ Use closed-ended questions
- ❑ Help develop relationships with you and others
- ❑ Use visual demonstration and tactile cues
- ❑ Use nouns (shirt, toothbrush, chair) and avoid pronouns (he, she, they, it)
- ❑ Use consistent cues/instruction
- ❑ Use the visual field
- ❑ Anticipate needs

Understanding Behaviors

Behavior is a form of communication

Behaviors often arises due to:	Common behavior problems
❑ Pain	❑ Resists care
❑ Fear	❑ Aggression – verbal/physical
❑ Loss of sense of self	❑ Anxiety
❑ Unable to express an unmet need	❑ Restlessness
❑ Inappropriate expectation of a caregiver	❑ Wandering
	❑ Sad or depressed mood
	❑ Screaming
	❑ Irritability

Approaches to minimize behaviors

- ❑ If able, come back later.
- ❑ Listen, validate, and provide support.
- ❑ Incorporate interests and engage in activities.
- ❑ Follow routines.
- ❑ Gain trust and agreement.
- ❑ Allow to make choices.
- ❑ Check for pain.
- ❑ Help the individual develop relationships with you or others.
- ❑ Minimize time left alone.
- ❑ Anticipate and meet needs.
- ❑ Reduce stressors.

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Understanding Behaviors

Developing interventions

Document the behavior

- who, what, where, when, why, and how

Consider triggers

- include chart review

Identify non-pharmacologic interventions

Monitor and observe interventions

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Case Study

Last night during his shower, Mr. Miller struck Ashley, a young CNA in the SNF. Unharmed but shaken, Ashley called on Emily, another young CNA, to help with the rest of the shower. Together, the two aides were able to complete the shower, but Mr. Miller's behavior situation got progressively worse. Both aides were eventually struck, and Mr. Miller used profanity throughout the entire ordeal. After the shower, Mr. Miller continued to curse. He also began to throw things and appeared to put others in harm's way.

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As an intervention, Mr. Miller was given lorazepam to control his verbal and physical agitation, as well as to promote compliance during future showers.

This is just the latest in a long series of adverse outcomes related to Mr. Miller's showers. It is not the first occurrence to result in the filing of an incident report. The interdisciplinary team is looking for a new way to approach the situation.

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Locating relevant background information: Based on care notes and discussions with employees, it is noted that Mr. Miller is currently functioning in the low early stage of dementia due to his Alzheimer's disease. In terms of personal history, he is a retired Army colonel who never married, and his siblings call him a "very private, reserved man." Upon admission, the family told the intake nurse, "He is a sweet man who would never hurt a fly." Intake notes also indicate that he has always preferred showers in the morning to "start his day fresh."

Reviewing the facility's response: Sandy, one of Mr. Miller's regular nurses, has confided to the DON that, "Mr. Miller has Alzheimer's/dementia, and this type of behavior is common. We have no other choice than to give add a new medication. He can't be allowed to hurt someone, and he certainly can't go without a shower." According to Sandy, nursing took no further steps beyond asking Mr. Miller's physician for a medication script to reduce this behavior.

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What is the behavior? Mr. Miller refuses to take a shower. If pushed against his will, his negative behaviors escalate. He becomes verbally and then physically aggressive, often striking one or more care partners and screaming some variation of "Leave me alone" that's often laced with expletives.

When does the behavior occur? Showers have been offered to Mr. Miller late in the afternoon or at night since his arrival nearly two weeks ago, and each time the activity is posed, his negative behavior has occurred.

Where does the behavior occur? Mr. Miller is typically approached about taking a shower when he's in the day room, where many residents gather to socialize. His refusals begin when he is first asked to go to the shower room and continue to escalate as he is led there, during the shower, and in the immediate aftermath.

Who is or isn't present when the behavior occurs? The CNAs who have been on the receiving end of Mr. Miller's shower refusals have all been young females. Ashley, a 20-year-old CNA, has been the most involved in Mr. Miller's shower care, and has often recruited Emily, another young female caregiver, to assist her when Mr. Miller shows resistance.

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Identify logical reasons and/or triggers for Mr. Miller's response:

- Mr. Miller perceives the nursing home's young, female CNAs are threatening his autonomy and invading his privacy
- Mr. Miller is embarrassed by the fact that his loss of control is made evident to his peers
- Nursing home staff have failed to gain Mr. Miller's agreement to shower and to establish his trust
- Nursing home staff have failed to accommodate Mr. Miller's typical routine

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Match non-pharmacologic interventions to potential reasons and triggers:

Potential Trigger	Drug Free Intervention
Perceives female CNAs as invading his privacy.	Assign male caregiver to assist with bathing.
Embarrassed his loss of control is exposed to his peers.	Educate caregivers to invite Mr. Miller for a shower in a more private setting.
SNF staff failed to gain his agreement and trust prior to the shower.	Gain attention and trust with agreement to participate in self care tasks.
Staff failed to accommodate Mr. Miller's typical routine.	Change shower time to accommodate Mr. Miller's routine prior to admission with morning preference.

Monitor and observe interventions.

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When and Why interventions work

The goal must be to recognize the message behind their behavior, understand their feeling, validate that feeling, meet their needs, and prevent further occurrences.

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