A Collaborative Approach to Managing Responsive Behaviours

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Baycrest
Oct 23, 2014
OBJECTIVES

• To understand the concept of responsive behaviours

• To review components of a behavioural assessment

• To examine the necessity of a team approach to assessment and on-going behaviour management strategies

• To learn how to create a team within the constraints and complexities of community/institutional practice

• Case Study Illustrations will be used throughout
More than 10,000 Canadians abused annually by fellow nursing home residents

Toronto’s Frank Piccolo was among the 10,000 Canadians abused by fellow residents in long-term care every year, a crime for which no one pays a penalty.
Resident on Resident Abuse

- Residents with dementia **do not** abuse each other
- Residents with dementia **can** be violent with each other
- Violence between residents with dementia **cannot** be considered abuse – it is a response to *something* with multiple possible causes
- When we do nothing to assess and manage the behaviours, we as health care professionals become guilty of abuse
Can we control our brain?

**HOW SMART IS YOUR RIGHT FOOT?**

1. While sitting in front of your computer, lift your right foot and make clockwise circles.

2. Now, while doing that, draw the number 6 in the air with your right hand. Your foot will change direction. And there's nothing you can do about it.
What is dementia?

- Alzheimer’s Disease
- Frontal Temporal Dementia
- Lewy Body Dementia
- Reversible Dementia
- Vascular Dementia

- Loss of memory
- Loss of judgment and reasoning
- Changes in mood and behaviour
What is a Responsive Behaviour?
What does it look like?

- Constant unwarranted requests for attention
- Pacing or wandering
- Trying to get to a different place
- Refusing to attend to personal hygiene
- Repetitive Sentences or questions
- General Restlessness or agitation
- Complaining or whining
- Cursing or verbal aggression
- Screaming
- Making strange noises
- Grabbing, Hitting, Spitting, Punching, Pulling Hair
Close your eyes...Imagine....
Why is it called responsive?

• All Behaviours have meaning

• Behaviours are a response to *something*

• Behaviours are an attempt by the cognitively impaired person to communicate an unmet need

• As caregivers, we aim to find out what that something is...to discover the unmet need.
What do we know about older adults with dementia?
We have been given a lot of tools...
Assessment Tools

- PIECES RISK tool
- CMAI – pre and post intervention – to determine which responsive behaviours to focus on and to determine efficacy of interventions
- Zarit Burden Interview (Caregiver burden)
- DOS – we modify according to caregivers ability and client needs (ie effectiveness of medications)
- PIECES – serves as assessment framework and basis for assessment report
- PainAD – Pain Assessment in Advanced Dementia
- Cornell (if depression is suspected)
- CAM – delirium screen
- MOCA or Mini Cog
- DAD – Disability Assessment for Dementia (Functional Ax) The DAD assesses ADLs and IADLs across three domains: Initiation, Planning & Organization and Effective Performance.
- Montessori Methods for Dementia Programming**
How does this impact us?
Keeping it simple

- PIECES is a framework we can use to organize information
- When information is organized, it becomes less overwhelming
- We don’t have to do the assessment alone
Introducing Mrs. Kay

- 87 year old widowed female living on assisted living floor of upscale retirement home

- PHx: Dementia Alzheimer’s; Valvular Disease; Osteoarthritis both knees with deformity; HTN; Parkinson’s tremor; Diverticular disease; Bilateral Hip Replacement, Breast Ca (remission from 2009)

- Propranolol 10 mg TID (9:00 17:00 22:00); Tylenol Arthritis 650 TID (9:00 17:00 22:00) – not to exceed 4000; Vitamin D3 1000 BU OD; Ranitidine 150 mg OD (9:00 am); Celexa 10 mg – ½ tablet HS; Furosemide 20 mg OD 9:00; Lactulose 15 mg HS; Mucillium 1 – 3 tsp OD 9:00; Trazodone 50 mg HS

- PRN meds – Tylenol Extra Strength 500 mg 1 to 2 tabs up to QID PRN note: from MAR w/o April 14 – no prn’s given
Reason for Referral

- Responsive behaviours – kicking, swearing, scratching
- Retirement Home Staff cannot manage – LTC
- LTC rejection d/t documented behaviours
Components of a Behavioural Assessment

Physical: Disease, Drugs, Discomfort, Disability, Delirium
(Client, Observation, MD, RN, Pharmacist, OT, PT)

Intellectual: Aphasia, Amnesia, Apathy, Agnosia, Apraxia, Anosognosia, Altered Perception
(Formal Neuropsych Ax, Observation, Dialog, Activities, OT, PT, PSW, RN, Family, Client)

Emotional: Anxiety, Depression; Delusions; Hallucinations;
(Client, Observation, Dialog, RSW, PSW, RN, Family)

Capabilities: ADLs & IADLs
(OT, Observation, PT, PSW, Client, Family)

Environment: Over/Understimulation; Change in Routine; Noise; Lighting; Colours; Temperature
(Observation, Dialog – nothing beats seeing it for yourself)

Social: Life Story, Cultural Heritage, Values, Beliefs
(Client, family, OT, SW, PSW, MD, Caseworker)
Questions to ask

- What is the behaviour? What does it look like?
- What is the RISK? For whom is it a problem?
- When does it happen?
- When does it NOT happen – exception to the rule?
- Who is part of the client’s team?
Mrs. Kay’s Team: Sources of Data

- The client herself, her daughter
- High End RH RPN’s and PSW staff, & CCAC contracted PSWs
- Toronto Central CCAC Care Coordinator, VHA Occupational Therapist, VHA Physiotherapist Assistant and VHA Physiotherapist.
- Review of the medical consultation notes that accompanied the referral as well as Mrs. Kay’s medical records at the High End Retirement Home.
- Direct observation of care
- Direct interaction with client & family
Highlights of Ax

• Responsive behaviours *limited* to personal care – look for exceptions to the rule

• Pain was the overriding cause of resistance to personal care…created ongoing negative associations

• All staff delivered care slightly differently leading to client anxiety and frustration

• Disability played a large role – inappropriate use of equipment…fear of falling.

• Personhood missing ingredient…
  - Client retained a strong sense of self and what was important to her - underutilized in approach
  - Client retained a sense of humour
  - Client would become angry if her requests were not acknowledged
Highlights of Interventions

• Pain Management – ½ before care
• Create pleasant ambiance while waiting for pain meds to take effect – use of music, gentle stretching and calm, adult tone of voice (eliminate negative association of pain/personal care)
• All staff to use same routine, equipment
• Acknowledge client’s emotional undertones when they are happening – validation
• Bedside coaching of PSW staff and allied health to assist with completion of assessment
• Telling the story of Mrs. Kay – humanize her to staff
• Elicit active participation of staff in coming up with solutions - ownership
Challenges with Mrs. Kay

Micro
- some staff unwilling to change approach;
- family approach
- Lack of communication between staff
- Documentation lacked consistency and detail

Mezzo
- Unit understaffed on three days
- PT lacked training – did not assess – limited interventions
- Unable to provide hands on education/bedside coaching to CCAC PSWs (inconsistent staffing)

Macro
- Simple behavioural issue – complicated by systemic issues
- Ax time consuming – had to observe many staff
- Key CCAC staff not educated in dementia care, but work on dementia floor
<table>
<thead>
<tr>
<th>Goals / Expected Outcomes</th>
<th>Progress Towards Outcomes / Discharge Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAREGIVERS KNOWLEDGEABLE RE: MAINTENANCE EXERCISE REGIMEN FOR PARKINSON'S D.</td>
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TREATMENT NEEDED TO BE SEEN IN 1 VISIT ONLY REQ'D

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**Goals of Discharge Planning:** Teaching Plan Developed: **Yes**

**Discharge Information (Complete only on D/C):**
- Teaching Materials Provided? **Yes**
- Ongoing Needs Discussed? **Yes**
- Equipment Plans:
  - CCAC to follow up
  - Client will Purchase
  - Other:

**Service Frequency Request:**
- Start W/O: **Y M D**
- Frequency: x per week for **1** week(s)
- PRD: **14/12/2016**

**Client Discharge to:**
- Self-care
- Family
- Hospital (Acute Care)
- LTC Home
- Other:

**Physician(s) Notified of discharge:**
- Yes
- No

If Yes, MD's Name:  
Phone:
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<th>Progress Towards Outcomes / Discharge Plans</th>
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<tbody>
<tr>
<td>Re. equipment is in home; ADP completed; Supporting document for insurance company provided &amp; wife has submitted - pending result</td>
<td></td>
</tr>
<tr>
<td>Client will have an opportunity to trial the recommended equipments</td>
<td>OT re: 1. Type 5 Dynamic Tilt w/ c; 2. Hospital bed - electrical; 3. Pressure relief mattress - OT to arrange equipment trial via SHHC</td>
</tr>
<tr>
<td>OT attempted CILT application - client does not qualify - unable to direct own care</td>
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<table>
<thead>
<tr>
<th># of Goals Set</th>
<th># of Goals Met</th>
<th>No Goals Set</th>
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<tbody>
<tr>
<td>1</td>
<td></td>
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Reason goals not met or set: 

Additional Comments: 

Date of Last Contact: Y M D

Goals of Discharge Planning: Teaching Plan Developed: Yes, No

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<td>2014 M 03 D 24</td>
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Teaching Plan Discussed With: Client, Caregiver, Other

Discharge Information (Complete only on D/C)

Teaching Materials Provided? Yes, No

Ongoing Needs Discussed? Yes, No

If Yes, Specify: 

Equipment Plans:

- CCAC to follow up
- Client will Purchase
- Other: 

Client Discharge to:

- Self-care
- Family
- Hospital (Acute Care)
- LTC Home

Clinic (Specify Type): 

Other: 

Physician(s) Notified of discharge: Yes, No

If Yes, MD's Name: 

Phone: 

Provider Information:

- Type Name: RN, RPN, OT, PT, SW, SLP, RDiet, Other: 

Provider Information:

- Type Name: XXX

Innovations in Aging
Common Challenges Behaviour Ax & Mgmt

• LTC, Acute Care, Community Care - transitions lack warm transfers and communication of essential information.

• Community Professionals work in isolation of each other – no team meetings or clinical rounds. CCAC CSR reports lack detail ---- > Lack of inter-professional collaboration.

• Behavioural Recommendations are not disseminated – lack of knowledge transfer

• Lack of front line staff who have PIECES/UFIRST training – or they have training but do not know how to apply theory to practice
Interdisciplinary & Collaborative Care
What does your team look like?

How do you collaborate?

What are some of the challenges you encounter?

What other teams do you collaborate with?
Challenges of Collaboration
Lack of time leads to...

- Bullet Rounds
- Huddles

We end up missing vital information
Possible Solutions

• Pay better attention to transitions – create time to invite community team to the institutional team on admission or discharge and discuss client – it will cost more time at the outset…but may be more effective in the long run

• When you have a new client, see who already is part of that team…talk to them. Be prepared to invest more staff resources getting to know who the new client is…behaviourally and personally…it will increase overall team capacity

• Increase your perception what team looks like – team could involved professionals in other institutions and/or agencies

• Provide didactic education to staff in behaviour management…but don’t forget they need help to apply the learning…it’s how adults learn best.
Case Vignettes – the importance of team
Meet Norman, age 59

Repeated ED visits
Dx Schizophrenia @ age 19
Intubated in past 6 months – Discharge 02 Sat: 69%
Lives in boarding home
Forgets to take meds
Episodes of incontinence
Client Goals:
To smoke and drink coffee
For people to be kind to me
Meet Bess

• 50 year old
• Lives with siblings
• Found barefoot on street
• Neighbour reports she sees Bess defecate on front lawn
• Crisis worker not sure if client has dementia
Take Away Message

- Personhood…know the person behind the illness/disease…tailor your interventions to the person

- Know that one person cannot complete an adequate assessment in isolation…use your team in the broadest sense of the word…including PSWs and housekeeping staff…family members and staff from other agencies…people who are important to your client.
Questions