Responding to Behaviours Due to Dementia

Achieving Best Life Experience

ABLE

Care Planning Guide

Sunnybrook
VETERANS CENTRE
when it matters MOST

Responding to Behaviours Due to Dementia: Achieving Best Life Experience (ABLE) Care Planning Guide

Veterans Centre

2010

Acknowledgments

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Based on the experience and wisdom of The Dorothy Macham Home Interprofessional Care Team

GREETINGS FROM THE VETERANS CENTRE'S DIRECTORS

We are very pleased to launch this exciting series of Achieving Best Life Experience (ABLE) Care Planning Guides to assist our interprofessional staff, our Veteran residents and their families in working together for the best possible quality of life for our residents.

While traditional care focuses on achieving the best clinical outcomes using accepted scientific evidence and traditional practice methods, our ABLE philosophy focuses on planning care with the resident and family to achieve what the resident considers to be his or her best life experience in the Veterans Centre. This involves integrating scientific evidence, the resident's current abilities and potential for improvement and the resident's desired life experience. This collaborative care planning welcomes and promotes creativity through understanding and sharing of perspectives and ideas.

The ABLE Care Planning Guides are intended for use beyond Sunnybrook's Veterans Centre. It is our hope that our ABLE guides will provide interprofessional staff working in complex continuing care facilities and nursing homes with an easily accessible resource to use with residents and families in planning and delivering care that is focused on what is important to each resident. We wish you a successful implementation!

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INTRODUCTION

At the Veterans Centre at Sunnybrook Health Sciences Centre, our goal is to help each Veteran live according to his or her preferences and to enjoy the best life experience possible. While traditional best practice and clinical guidelines focus on best clinical outcomes, in long term care, our focus is on quality of life and helping residents perform his/her desired activities. We encourage inter-professional collaboration and teamwork all focused on the resident's own desired outcomes. We work together to achieve our goals using the Achieving Best Life Experience (ABLE) Care Planning Guides.

The goal of this guide is to help staff recognize that residents' needs and changes in health status affect behaviours. Recognizing and addressing these underlying needs and health changes helps to ensure optimal quality of life for the resident.

This guide outlines a standard of care for responding to long term care residents who have challenging behaviours due to Alzheimer's disease or another dementias. This practice guideline is based on published research as well as input from experienced medical, nursing and allied health professionals working in the Dorothy Macham Home at Sunnybrook.

The Dorothy Macham Home (DMH) is an innovative care and research facility for 10 Veterans with challenging behaviours due to dementia. Veterans are admitted to the DMH if their behaviours put others at risk of injury or significantly disrupt the lives of others.

The model of care in the DMH is a radical shift from the traditional "assessment" model to a more progressive "living" model where residents stay in the DMH as long as required for their behaviours. Normal daily home activities are encouraged and there is considerable flexibility in activities, and care delivery. Creative care planning is individualized for each resident to maximize functioning and quality of life.

Almost all long term care residents with dementia exhibit behaviours that make their care more complex and can disrupt the lives of other residents and their families. More serious behaviours, such as physical aggression, occur in about 25 per cent of people with dementia. These behaviours usually increase as cognition declines and are most prevalent in the moderate to severe stages.

These behaviours can affect the resident with dementia and his or her family, other residents and their families, and staff. These effects range from no impact to risk of significant injury, increased caregiver burden, as well as reduced quality of life and increased excess disability for the resident because of physical or chemical restraints, reduced social interaction and reduced participation in activities. Effective assessment and management of these behaviours can improve quality of life for all residents.

Behavioural psychologist M. Powell Lawton[2] concluded that the less competent an individual is, the more the environment accounts for his or her behaviour. With declining cognitive function, the environment plays an increasingly therapeutic role in dementia care[3,4]. Therefore, an appropriate environment and knowledgeable staff who use individualized approaches to care can minimize catastrophic reactions and other disruptive behaviours.

ABLE CARE GOAL-SETTING FRAMEWORK

ASSESS RESIDENT'S ABILITIES & NEEDS

- Assess verbal & nonverbal communication skills
- Assess cognition
- Assess physical abilities (motor, sensory, pain, cormorbid health conditions)
- Assess psychological, emotional & spiritual needs

IDENTIFY POTENTIAL FOR IMPROVED FUNCTION & QOL*

- Identify current abilities & potential for improved/ enhanced abilities
- Assess potential for participation in meaningful leisure activities
- Identify limitations to function

LISTEN TO THE VOICE OF THE RESIDENT

- Share assessments with resident /family
  - Abilities
  - Potentials
- What would be the ideal life experience for this resident in the Veterans Centre?

ESTABLISH LIFE EXPERIENCE GOALS

- Establish realistic goals to achieve desired life experience
- How can we help to enable the resident to achieve goals?

CREATE & IMPLEMENT STRATEGIES TO ACHIEVE GOALS

- What is preventing the resident from achieving these goals?
- Identify interprofessional strategies to facilitate achieving life experience goals
- Communicate & implement strategies

MONITOR OUTCOMES

- Observe response to interventions
- Modify interventios based on response
- Periodic review of abilities and goals

*QOL = Quality of Life

COMPONENT 1

DOCUMENT BEHAVIOUR AND RISK

The first step in managing behaviours of residents with dementia is to document a resident's actions, the circumstances and the impact of these actions on the resident and others.

Describe Resident's Actions

Use descriptive, objective language, such as "walks constantly, raises voice when encountering obstacles, pushes others." See Table 1: Behaviours in Dementia for more examples. Avoid vague terms, such as "agitation." Also avoid making judgments of behaviour by labeling it "irritating" or an attempt to provoke staff or others.

Include the location, the time and the duration of the behaviour.

Include how this behaviour is different from the resident's usual pattern of behaviour.

Table 1: Behaviours in Dementia

- Wandering room to room
- Resisting assistance with care
- Physical aggression toward others - hits, kicks, pushes, bites, grabs, throws, pulls hair scratches, spits, destroys objects
- Verbal aggression – screams aggressively, threatens, swears, insults
- Physical aggression towards self – hurting self deliberately, intentional falls
- Repetitive vocalizations – repetitive phrases, calling out repeatedly, screaming
- Repetitive motor activities - pacing, moving furniture, hoarding, rummaging, disrobing
- Sexually inappropriate behaviour – either verbal or physical sexual advances
- Constantly watching room door for wanderers – guarding
- Seeking behaviour - exit, food, calling family
- Other – eating non-food items, unsafe eating behaviours (too fast, no chewing)

Describe the Events or Situation Leading up to Behaviour

Document events on the unit, other residents' behaviour, approaches by staff prior to the behaviour. You may need to look back at previous shifts as well as the hours and minutes prior to the onset of the behaviour.

Describe the Frequency of Behaviour.

Encourage staff on all shifts to monitor and document the behaviour, using the Daily Tracking Behaviour Frequency and Severity Form (Appendix 1), or for a more detailed account, the Resident Behaviour Observation Record (BOR), (Appendix 2) Summarize the findings and discuss with team.

Describe the Response of Other Residents and Staff to the Behaviour

Carefully reflect on and document your own response to the behaviour. Describe the response of other staff, the response of other residents and/or family members to the behaviour.

Describe the Effect of the Behaviour on the Resident and Others.

The behaviour may :

- have no effect
- have little effect on self/others
- be moderately disruptive or possible safety risk
- be significantly disruptive or putting others at risk
- be extremely disruptive or significant safety risk to self or others *

If disruptive, describe how the behaviour is adversely affecting other residents and what you have tried to reduce the effect on other residents.

If putting self or others at risk, describe how it is putting others at risk and what you have tried to reduce or eliminate this risk.

** See Component 5: Interventions to Reduce Adverse Outcomes*

COMPONENT 2

UNDERSTAND THE MEANING OF THE BEHAVIOUR

All behaviours have meaning. To understand behaviours in dementia requires an understanding of the meaning of the behaviours to the individual. Although serious behavioural symptoms can appear to be unpredictable, most are normal, exaggerated or catastrophic reactions to internal and/or external events or circumstances.

Internal events, such as acute illness, pain, adverse drug reactions, fatigue, anxiety, delusions and hallucinations, further impair cognitive function and perception.

External events or circumstances, such as the physical and social environment, caregiver approaches, and the behaviours of other residents, can either support or distract from functional tasks.

The ABLE Care Planning Guide uses the Unmet Needs Model for Understanding Behaviours[1]. See Table 2. This model identifies behaviours in dementia as complex and affected by the interaction of cognitive impairment, physical health, mental health, past habits and personality, as well as the environment. The behaviours and their meaning vary from person to person depending on all of the factors included in the model.

Behavioural symptoms are often a resident's attempt to communicate these unmet needs. Identifying a resident's needs and understanding why a behaviour is occurring leads to appropriate management and may prevent the need for medications.

Table 2: Unmet Needs Model for Understanding Behaviours[1]

Cognitive Impairment

- Nature of cognitive deficits
- Type and severity of dementia
- Level of ability to communicate – receptive and expressive

Physical Health

- Acute illness → delirium
- Chronic illness symptoms
- Pain / discomfort
- Fatigue
- Adverse drug reaction
- Hunger

Environment

Physical environment:

- comfort level of furniture
- temperature
- design features that do not support independent function (e.g. bathroom difficult to locate)

Social environment

Behavioural symptoms of others

Caregiver approaches

Over or under stimulation

Mental Health

- Anxiety
- Depression
- Frustration
- Delusions / hallucinations

Lifelong Habits and Personality

- Preferences and dislikes
- Hobbies and interests
- Previous occupation and work
- Previous ways of responding to others

Look for Unmet Needs

Assess the resident for evidence of an unmet need, which could be a physical, medical, social, or environmental cause of his/her behaviours.

Consider whether the resident is experiencing:

- Hunger/thirst
- Pain/discomfort
- Fatigue
- Loneliness/fear
- Hearing/vision impairment
- Exacerbation of chronic illness
- Acute illness with delirium
- Urinary retention/constipation
- Medication side-effects
- Hallucinations/delusions
- Frustration related to mismatch between task and resident's abilities
- Frustration related to communication challenges

If resident is aggressive or resistant to care:

- identify the most appropriate timing and approach to care to enhance cooperation.
- assess a resident's remaining abilities and ensure that caregiving expectations are consistent with these abilities to reduce frustration.
- assess for possible pain during care (See ABLE CarePlanning Guide for Pain).

Assess the environment to ensure it is optimal for resident's cognitive and physical functioning, bearing in mind that one of the challenges of group living is creating an environment that can meet the various needs of the residents.

Consider:

- ***Televisions, radios, and other music sources*** — these can provide welcome stimulation to one resident but be a source of noise, frustration and even fear to another. (See Appendix 3, Optimal Use of Television/ Other Media in Dementia Care)
- ***Lighting*** — older people and people with dementia need increased lighting levels to see and negotiate their surroundings.
- ***Social interaction*** — providing the resident's preferred level of social interaction with others can reduce behaviours caused by sensory under- or over-stimulation.
- ***Environmental cues*** — helping residents locate their room and toilet can increase function and minimize frustration.

Assess the resident's program to ensure that it is appropriate for his or her abilities and preferences. In doing this, ask for input from the resident and his/her family about likes, dislikes, interests and lifestyle patterns. Within the team, discuss likes, dislikes, and usual daily routine as well as results of trial and error as documented on the resident's chart.

COMPONENT 3

LISTEN TO THE VOICE OF THE RESIDENT

Family members may be a valuable resource in understanding the meaning behind a resident's behaviour. Most families know and understand their resident's life story, likes and dislikes, and what is important to him or her.

However, families have varying knowledge and understanding about Alzheimer's disease and other dementias, and the impact of dementia on the resident's behaviour, and functional abilities. In addition, many families' lives are complex, with people struggling with their own health problems or trying to balance work and family responsibilities. Most families are grieving the loss of their resident's cognitive and functional abilities as the dementia progresses. Having an understanding of what our families are facing is crucial to communicating with them about the resident and to encourage their involvement.

Empathy, or being able to put yourself in someone else's shoes, is an important prerequisite to skilful communication. By empathizing with residents and their families, staff gain a greater appreciation of the resident's perceptions and understanding of his or her current reality.

Empathic listening is a skill, which can be practiced. It is an active process, of listening with intent to understand the other person. It is a way to discern what the person is really communicating and requires us to look beyond the actual words being spoken. Here are some suggestions to help in the development of this skill.

Do...	Don't...
✓ Give undivided attention.	× Ignore the emotion behind the message.
✓ Allow the person time to finish his or her thoughts.	× Allow your attention to wander.
✓ Ask open-ended questions.	× Finish sentences or "fill in the blanks."
✓ Go with the flow.	× Dismiss concerns before exploring them.
✓ Be aware of the person's body language – what is it telling you?	× Give false reassurances.
✓ Be aware of your own body language – what is it telling them?	× Jump to conclusions before you have heard the person out.
✓ Think before you speak.	× Make assumptions.
✓ Avoid being judgmental.	× Offer unwanted advice.
✓ Use restatement to clarify ("so what I hear you say is….").	× Change the subject.

One key component to showing someone you are really listening is to match the mood of the person. If the person is happy and cheerful, smile and act pleased; if someone is sad or distressed, show concern and have a sympathetic expression on your face. In other words, try to be in tune with his or her emotions and respond accordingly.

Understand the resident's past to inform current behaviours and assist with identifying unmet needs. Past areas to inquire about include:

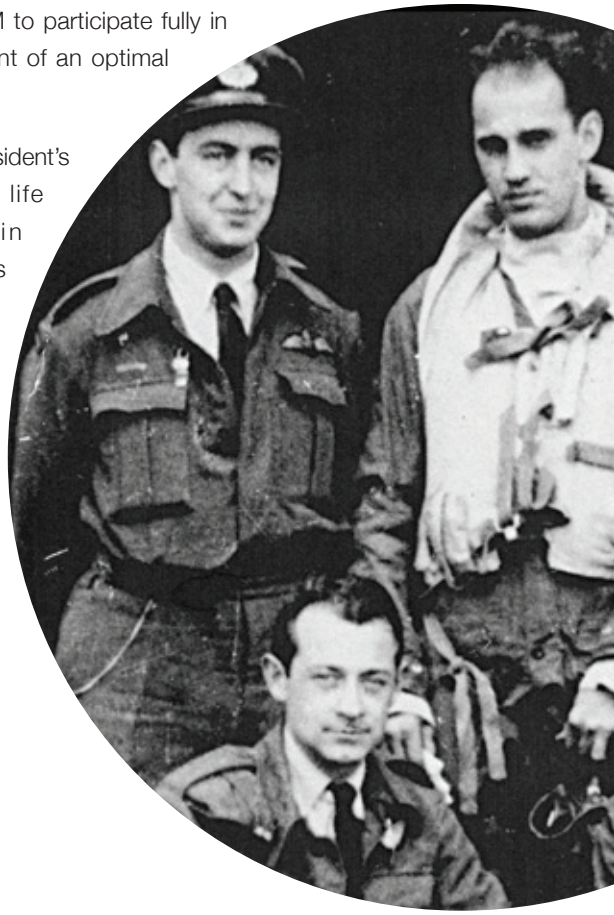
- Military service: significant events
- Occupation
- Hobbies and interests
- Social history
- Leisure
- Specific care preferences
- Family history and involvement
- Desired engagement with others
- Significant relationships

Understand the resident's current reality. This includes:

- Resident's current understanding of his/her life at the Veterans Centre
- Resident's current cognitive and physical abilities
- Resident's perceptions of staff, other residents, family members, and the environment
- Resident's desired activities

Share your assessment of behavioural symptoms with the resident's substitute decision maker (SDM) to validate the team's findings and to assist the SDM in understanding the behavioural symptoms, the risks resulting from these behaviours and the identified unmet needs underlying these behaviours. This validation and understanding allows the SDM to participate fully in the development of an optimal care plan.

Establish the resident's likely desired life experience in the Veterans Centre given their current abilities and potential.



COMPONENT 4

CARE PLANNING TO ACHIEVE RESIDENT'S DESIRED LIFE EXPERIENCE

Determining effective strategies requires a careful assessment of unmet needs and then trying different strategies and observing resident's responses to these strategies. This will result in a group of strategies that assist the resident in moving towards his or her desired life experience. Unless a resident is demonstrating behaviour that puts him or her or others at imminent risk of harm, non-pharmacological care strategies should be tried first. Non-pharmacological strategies are outlined in Table 3: Non-Pharmacological Interventions for Behaviours.

If a resident's behaviours put him/her or others at risk of harm or significantly disrupt the lives of other residents, discuss the situation with the team. You may consider a consultation to psychiatry or to the Dorothy Macham Home team, which is available to all Veteran Centre residents.

Medications may be required to ensure that residents with behavioural symptoms are not putting others at risk of harm or significantly disrupting the lives of others. See Appendix 5: Medications Used to Treat Behavioural Symptoms in Dementia, for a list of possible medications, doses and adverse effects.

Prior to presenting a resident to the DMH team, complete the Veterans Centre Behaviour Assessment Form (See Appendix 6.) This form will guide the staff assessment of any resident with behavioural symptoms due to dementia. The advanced practice nurse from the DMH is available to assist staff with this assessment. Once a resident is presented to the DMH Team, recommendations for care planning or transfer to DMH are made by the DMH Team.

Table 3: Non-Pharmacological Interventions for Behaviours

General:

- Identify how resident shows discomfort.
- Assess and manage pain
- Assess and manage comfort – (Is resident cold or hot? In an uncomfortable position?)
- Offer food and fluids - flexible meal times and snacks if resident could be hungry.

- Provide one-to-one social interaction.
- Provide music (based on preferences and especially at meal and bath times if resident responds positively).
- Offer walking program.
- Offer gentle exercises.
- Offer a walk outside.
- Redirect from a potentially difficult situation (Guide by arm, smile, introduce new activity.)
- Play videotapes provided by family.
- Offer massage
- Introduce distracting stimuli such as music, conversation, touch.

Table 3: Non-Pharmacological Interventions for Behaviours *continued*

Environment Strategies:

- Assess and manage optimal level of stimulation for this resident, avoiding both over and under stimulation.
- Reduce unnecessary noise by turning off television, radio or closing door to hallway.
- Minimize barriers to movement/function.
- Ensure appropriate temperature/clothing.
- Ensure adequate lighting that is 30% more than normal.
- Camouflage exits to reduce exit-seeking behaviour.
- Provide access to outdoor therapeutic gardens.
- Ensure toilets are visible to improve continence.
- Ensure environment meets resident's functional needs.
- Minimize institutional appearance of environment by removing equipment, garbage, laundry when not in use.

Caregiving strategies:

- Encourage adequate rest periods.
- Provide care when resident is most likely to be cooperative.
- Determine if resident prefers a particular caregiver. If so, observe care by preferred caregiver to identify specific strategies that are effective.
- Assess pain during care. If observed, administer an analgesic before care.
- Offer choices around timing and pace of care: for dressing, showering or bathing.
- Give one-step instructions in simple language.
- Ensure resident is wearing hearing aid or glasses if needed.
- Cue resident with situation-appropriate objects.
- Provide quiet, warm rooms for bathing with warmed towels when possible.
- Enable resident to perform the ADLs that he/she can perform.
- Distract resident during care (e.g. music, conversation about topic of interest).
- Assess regularly for discomfort.
- Identify strategies to optimize toileting and offer regular toileting.

Programming strategies:

When planning activities, choose a time when the resident is most likely to be cooperative to minimize behaviours. Engage residents in:

- Snoezelen room/activities
- Recreation therapy assessment and planned activities
- Music/art/horticultural therapy
- Picture books, including family photograph or memory books
- Pet visits, walks, puzzles
- Assisting staff with cleaning or other unit activities.

Pharmacological Interventions for Behaviours

Situations where pharmacological interventions should be considered for managing behavioural symptoms include times when the resident's behaviour is putting him or her or others at imminent risk of harm or when the resident is distressed or disruptive and the behaviour is due to depression, anxiety or psychotic symptoms that include delusions or hallucinations.

Pharmacological interventions should not be used for behaviours that do not respond to medications (see Table 4)

Table 4: Behaviours that Do Not Respond to Medications

Wandering / pacing	Sexual disinhibition
Exit-seeking	Inappropriate dressing/disrobing
Sundowning	Inappropriate voiding/defecation
Hoarding	Swearing
Rummaging	Screaming/repetitive vocalizations
Resistance to care	Spitting

Start a medication for behavioural symptoms at a low dose to establish the resident's response. Increase dose gradually, if needed. It is important to monitor for side effects (including worsening cognitive functioning, sedation, increased agitation and extra-pyramidal side effects) after starting the medication and after increasing the dose. See Appendix 5: Side Effects of Meciations Used to Treat Behavioural Symptoms in Dementia. Some side effects can be delayed. A decline in a resident's physical or cognitive functioning requires a medication review to identify the need for a medication dose decrease or discontinuation. Medications that are not effective or no longer required should be discontinued.

Once a behaviour has resolved or is no longer disruptive or putting others at risk of injury, the need for the medication should be assessed and an attempt to discontinue the medication should be considered.

Managing Sexually Inappropriate Behaviour

Describe and document events or situations leading up to these behaviours e.g. viewing sexually explicit scenes on TV soap opera, or pictures in a magazine; resident flirting with staff/visitors or making inappropriate comments about their physical attributes; providing residents personal care.

Be aware of the context. On occasion, misunderstandings may occur during personal care when resident is unclothed and being touched intimately by staff.

In general:

- Do not visibly respond to behaviour.
- Avoid appearing shocked or flattered.
- Distract resident's attention immediately.
- Clearly state: "Please stop. This is not appropriate."
- Consider deferring care if resident's behaviour persists.

Prevention of this behaviour during personal care:

- Maintain professional attitude. Explain who you are and your role.
- Keep conversation to a minimum and directed at the task; avoid chit chat.
- Wear functional and professional clothing.
- Have two nursing staff assist with bathing if necessary.

Document successful strategies in care plan and share with the team.

Managing Territorial or Guarding Behaviour

Refer to the resident's past history to understand the meaning behind the behaviour (See Component 3).

Allow resident to have privacy and to lock up his belongings if he wishes.

Apply "Do not disturb" or "Stop" signs to door of resident's room.

Locate room away from residents who rummage or wander around the unit.

Redirect other residents away from resident's room.

Determine resident's preference for staff entering his/her room e.g. knocking or announcing that staff would like to enter room (unless urgent need to enter room).

Managing Repetitive Vocalizations

Assess for pain or other unmet needs and address needs (see Component 2). This needs to be done regularly to ensure that resident is safe and comfortable.

Pay frequent attention to resident when he is not calling out to reinforce positive behaviours.

Use Daily Tracking Behaviour Frequency and Severity Form or Resident Behaviour Observation Record to identify patterns of behaviour, including time of day to best determine timing of interventions (e.g. prior to usual periods of repetitive vocalizations).

Specific suggested interventions:

- Pain control
- One-to-one social interactions
- Music (based on preference)
- Family-generated videotapes
- Distracting stimuli (e.g. music, conversation, touch)
- Massage therapy
- Appropriate environmental stimulation

COMPONENT 5

INTERVENTIONS TO REDUCE ADVERSE OUTCOMES

Knowing how to effectively communicate with residents with dementia, their families and other team members is essential to assessment and management. Families of residents with aggressive or disruptive behaviours may be experiencing increased stress and/or guilt and will likely benefit from empathic, factual and solution-focused communication. The following is a guide to communicating appropriately with residents, their family members and with other team members on a day-to-day basis.

Communicate effectively with residents

Always introduce yourself.

How we communicate with residents often affects a resident's behaviour. If we approach a resident slowly with a smile, eye contact and a pleasant greeting, he or she is more likely to respond in a calm, pleasant manner.

However, if we approach a resident with little eye contact, no smile and a command— "It's time for your bath now"—he or she may resist staff's attempts to provide care and be labeled "aggressive." Many of our residents do not remember who a staff member is, even if she/he introduced herself/himself earlier that shift. Residents can become anxious when they do not remember who the staff member is and why they are trying to take them somewhere or take their clothes off. Therefore, re-introducing ourselves frequently in a patient, kind manner and re-stating what we would like to do and why helps many residents.

Keep communication simple.

Residents with dementia often lose the ability to understand verbal language. If English is not their first language, they may start using their first language more frequently as they lose their English language skills. As language abilities decline, non-verbal communication becomes more important and verbal communication must be made simpler.

When approaching residents, first ensure adequate lighting. To set the stage for effective communication, make eye contact, while facing resident with a calm facial expression and friendly gestures. Keep questions and requests very simple. Prompt residents to complete activities of daily living, such as dressing, by suggesting one simple task at a time. Combining tasks in one sentence can be very confusing.

Be a good listener and a good observer.

Although a resident's verbal communication can be quite impaired, careful listening and observing of facial expressions and gestures can often give staff clues as to what the resident is feeling or trying to communicate. Sometimes these changes in facial expression and tone of voice are very subtle and require thoughtful observation and interpretation followed by appropriate and timely response by staff. When residents are not heard or understood, their behaviour may escalate. See Table 5: Stages of Aggresive Behaviour.

Table 5: Stages of Aggressive Behaviour

Stage of Aggressive Behaviour	*Caregiver Responses*
1. Fear/Anxiety	***Offer Support***
• Subtle change in affect/ behaviour • Fidgeting/ Pacing/Wandering • Repetitive behaviour • Limiting eye contact	• Use a calm, friendly approach • Acknowledge and validate concerns • Identify and address triggers • Refocus attention
2. Verbally or Physically Resistant	***Provide Guidance***
• Losing rationality • Argumentative • Unable to hear or follow simple directions • Hostile responses/verbal threats	• Remain calm but firm • Give clear, simple, directions • Set simple, reasonable, limits • Remove spectators
3. Physical Aggression	***Activate Safety Protocol †***
• Danger to self or others • Complete loss of control • Injury to person or property	• Alert team members • Observe from a safe distance, remove unnecessary staff and ensure the other residents and visitors are away from the area • Remain alert to personal threat
4. Tension Reduction	***Re-establish Communication***
• Physically and emotionally drained • Self-conscious • Humiliated	• Provide emotional support for all involved (resident, staff, witnesses) • Be non judgmental • Request or lead, team/resident/family debriefing of the incident • Develop and initiate interprofessional care plan based on debriefing findings

† Call code WHITE (See Component 5 on Page 22 for Code White Violent Person Response Plan Flow Chart.) Notify MD on Call. Notify Substitute Decision Maker (SDM)

Respond immediately to high risk aggressive behaviours

When a resident exhibits aggressive behaviour that puts others at risk of harm, first reduce immediate risks by:

- moving other residents and visitors away from aggressive resident.
- removing potentially dangerous objects from the area, if possible.
- identifying nearest exit from room and keeping exit clear of obstacles.
- calling security for assistance if risk persists.

Call **Code White**. Notify MD on call. Notify SDM.

Code White "Violent Person" response plan flow chart

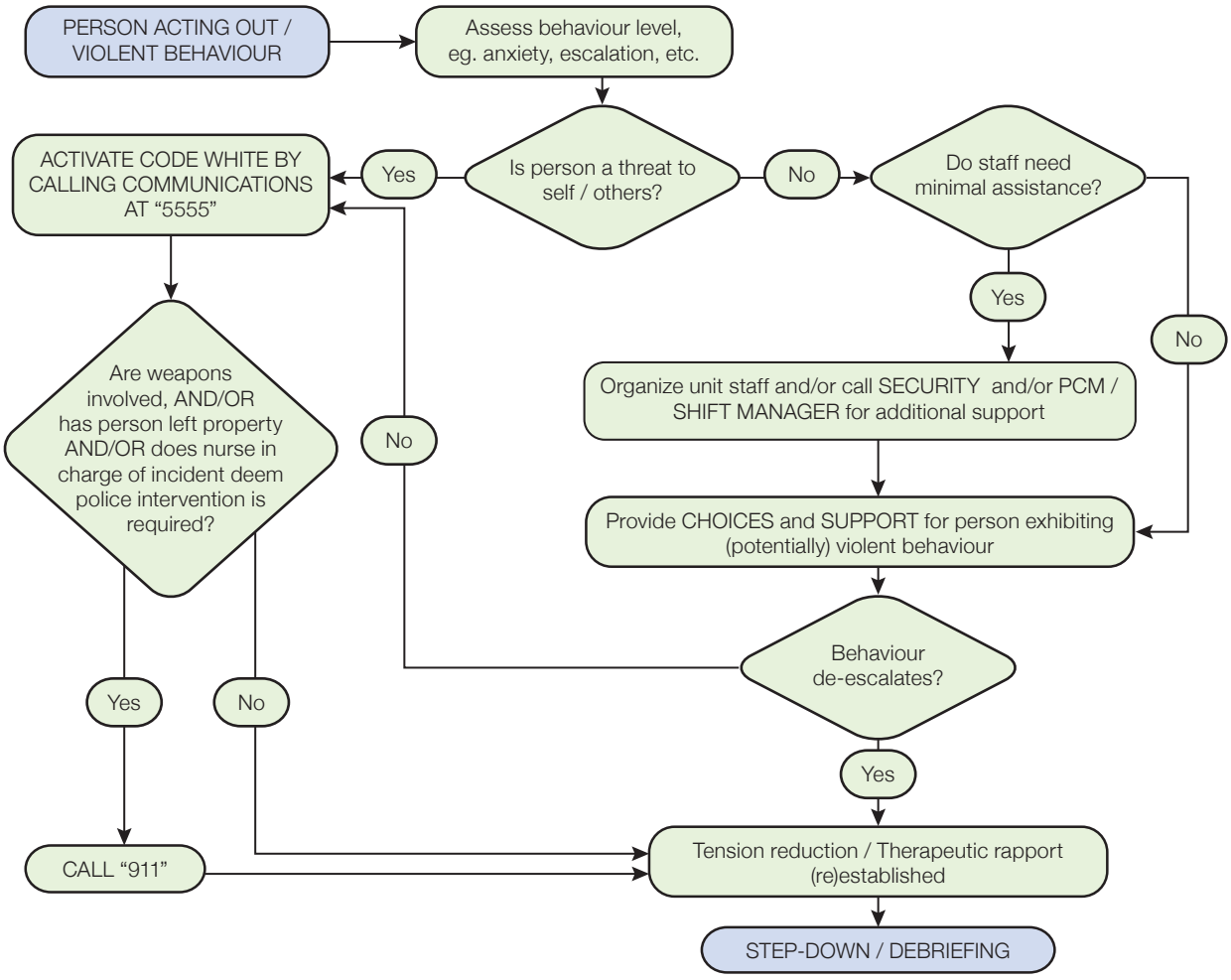
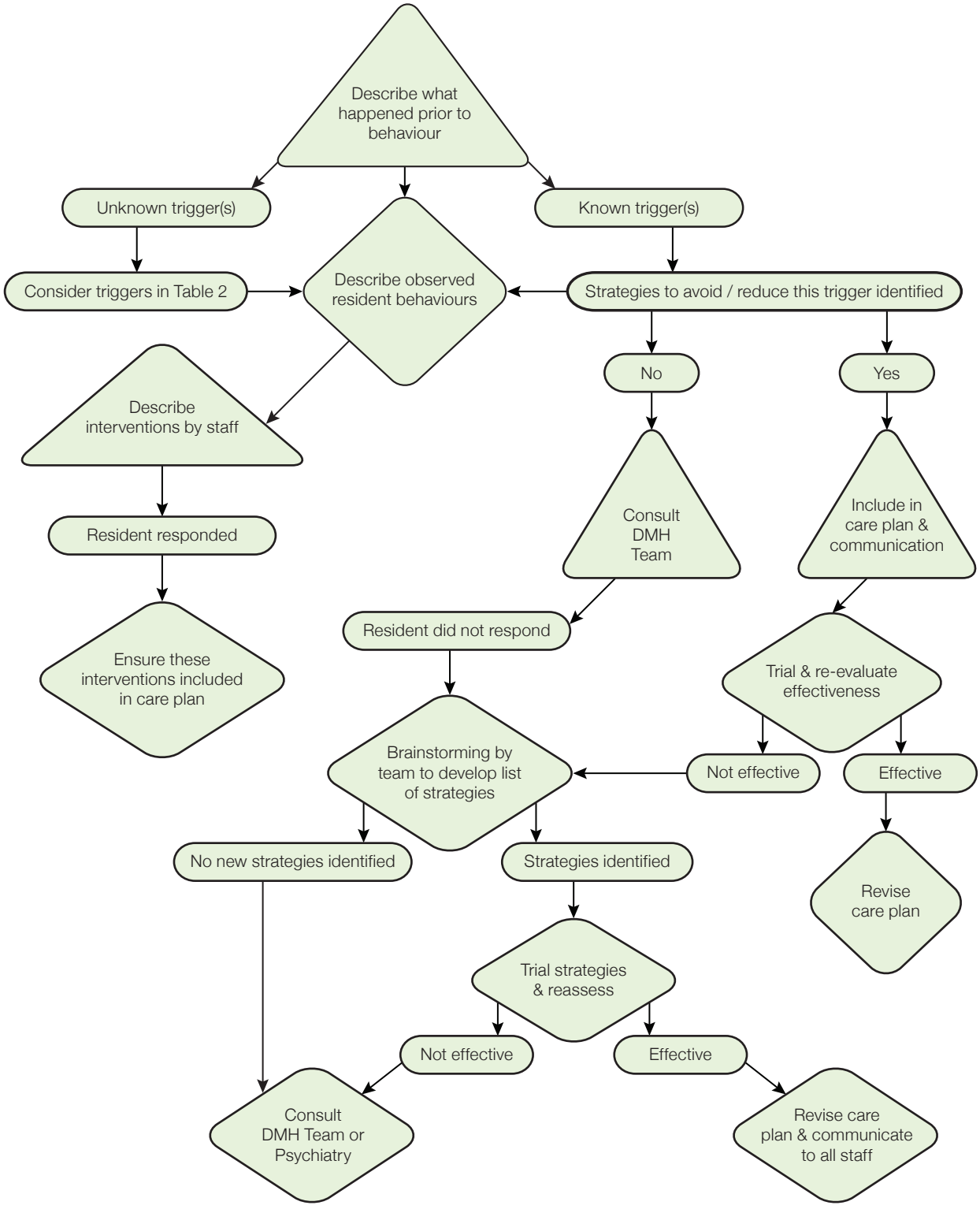


Table 6: Aggressive Incident – Debriefing Flow Chart



Review and Revise Behaviour Care Plan

Table 7: Tools for Monitoring Behavioural Symptoms in Dementia

Tool	Purpose of Tool	Frequency of Documentation	Duration	Recommended Use
Daily Tracking Behaviour Frequency and Severity Form (Appendix 1)	Track the shift to shift frequency & severity of one identified behaviour and adverse effects of a medication	Once per shift	1 week	Before and after implementing an intervention for an identified behaviour
Resident Behaviour Observation Record (Appendix 2)	To identify a more detailed pattern of a behaviour in terms the frequency and duration of multiple levels of severity of a behaviour or small group of behaviours.	q ½ hour	7 days	1. To identify more complex patterns of behaviour: levels of severity, time of day, duration, fluctuation from day to day to determine if intervention is needed, prior to starting an intervention and monitoring response to interventions 2. To identify specific triggers of behaviours (e.g. what behaviours precede severe behaviours) 3. To quantify time spent sleeping/awake
Cohen-Mansfield Agitation Inventory[5] (Appendix 4)	To identify the frequency of 29 different behaviours over time	Once with collaboration from team	Retro-spective over a 2-week period	To capture a summary of all behavioural symptoms before and after an intervention, or to monitor the ongoing effectiveness of a behaviour.

Prevent excess disability

Assess medications

All medications used to manage behaviours have the potential to cause excess physical and cognitive disability. Other medications can also impair cognitive and physical functioning. See Appendix 5: Side Effects of Mediations Used to Treat Behavioural Symptoms in Dementia. Review all medications regularly to assess ongoing need and benefit as well as possible detrimental effects on function.

Assess abilities

On a daily basis, assess residents' abilities to initiate, sequence, and follow through on ADL tasks, as well as their ability to safely use tools such as toothbrushes and razors. Abilities can fluctuate throughout the day due to factors such as fatigue and environment. Using simple one-step directions if necessary, give cues and encouragement to help residents carry out as many of their own ADLs as possible. Consult with Occupational Therapy for options and aids to enhance retained abilities.

Identify unrecognized or sub-optimally treated medical conditions

Medical illness can cause delirium, which may be misinterpreted as worsening dementia. Any rapid decline in cognitive and/or physical functioning requires a full medical assessment.

Identify environment-function mismatch

The environment should support and enhance a resident's ability to function. Ensure needed environmental cues are available whenever possible. This may require re-arrangement of furniture to maximize visibility and function, or simple signs for curing. Ensure environment provides an optimal level of stimulation.

COMPONENT 6

MONITORING THE RESIDENT'S RESPONSE TO INTERVENTIONS

Dementia results in a progressive decline in physical and cognitive abilities. Therefore effectiveness of all non-pharmacological and pharmacological interventions for behavioural symptoms needs to be monitored over time. All interventions have the potential to result in worsening of behavioural symptoms and medications also have the potential of other adverse effects, including functional decline. See Appendix 5: Side Effects of Medications Used to Treat Behavioural Symptoms in Dementia.

There are different tools for tracking behavioural symptoms. These include the Behaviour Tracking Form, the Behaviour Observation Record and the Cohen-Mansfield Agitation Inventory[5] (See Appendices 1, 2, & 4 for copies of tools). The tools with their respective purposes, frequency, duration and recommended uses are shown in Table 4.

SUMMARY

Behavioural symptoms are very common in long term care residents with dementia. All behaviours have meaning. All Assessments of behaviours in dementia require an understanding of the meaning of the behaviours to the individual. Although serious behavioural symptoms can appear to be unpredictable, most are normal, exaggerated or catastrophic reactions to internal and/or external events or circumstances.

Cohen-Mansfield[1] has described the unmet needs model which identifies behaviours as complex and affected by the interaction of cognitive impairment, physical health, mental health, past habits and personality, as well as the environment. Behavioural symptoms are often a resident's attempt to communicate these unmet needs.

Identifying a resident's needs in order to understand why a behaviour is occurring is essential to determining appropriate management and may prevent the need for medications. Non-pharmacological interventions should always be tried first unless the resident's aggressive behaviour poses an immediate risk of harm to him or herself or others. A creative approach to care strategies is essential and recognizes the uniqueness of each resident's perceptions and preferences.

With declining cognitive function, the environment plays an increasingly therapeutic role in dementia care. Therefore, providing an appropriate environment and having knowledgeable staff who use individualized approaches to care, are essential to minimize catastrophic reactions and other disruptive behaviours.

Ongoing, clear, and respectful communication with residents, families and other staff is essential to determining and meeting the needs of our residents.

Resources for assistance and a flow chart, Stepwise Approach to Assessing and Managing Behaviours in Dementia, (Appendix 7) are included in the Appendix. Other resources include the Dorothy Macham Home team, consulting geriatric psychiatrist and psychologist.

DEFINITIONS

ADL function:	Ability to perform basic activities of daily living including mobility, washing, dressing, grooming, toileting, feeding.
Behaviour:	The physical or verbal actions, or mannerisms exhibited by an individual.
Communication:	Verbal and non-verbal means of conveying a message to others. Non-verbal includes tone of voice, facial expression, gestures, posture and level of attentiveness.
Delusions:	Fixed false beliefs.
Environmental context:	The physical environment in which behaviour occurs, including location, noise level, lighting, temperature.
Exit-seeking:	Repetitive attempts to leave the unit, looking for the exit, asking staff to assist in exiting the unit.
Guarding/territorial:	Heightened level of alertness and watching of an area with the view to preventing or responding to access by others.
Hallucinations:	Hearing (auditory), seeing (visual), or smelling (olfactory) stimuli that are not present.
Hoarding:	Collecting objects and refusing to part with them.
Physical aggression:	Hitting, kicking, pushing, biting or grabbing other people or objects; throwing objects; destroying property.
Repetitive vocalizations:	Repeated noise-making by screaming, yelling, calling out, repeating phrases.
Rummaging:	Touching and handling objects with no obvious purpose.
Sexual inappropriateness:	Unwanted verbal or physical sexual advances towards others.
Social context:	The social environment in which a behaviour occurs, including number of people, type of interactions between people, expectations of behaviour by others, other activities.
Verbal aggression:	Screaming, yelling, swearing, or uttering verbal threats or insults.
Wandering:	Not recognizing being lost. Unable or unwilling to ask for help, to express destination or to follow directions.

REFERENCES

1. Cohen-Mansfield, J., Marx, M.S., Rosenthal, A.S. (1989). A description of agitation in a nursing home. Journal of Gerontology: Medical Sciences, 44(3), M77-M84.

2. Lawton, M., & Nahemow, L. (1973). Ecology and adaptation in the aging process. In C. Eisdorer & M. Lawton (Eds.), Psychology of the Aging Process, American Psychological Association.

3. Lawton, M. (1977). An ecological theory of aging applied to elderly housing. Journal of Architecture and Education, 31(1), 8-10.

4. Lawton, M. (1981). Sensory deprivation and the effect of the environment on the management of the patient with senile dementia. In N. Mille & G. Cohen (Eds.), Clinical Aspects of Alzheimer's Disease and Senile Dementia. New York: Raven Press.

5. Cohen-Mansfield, J., & Werner, P. (1997). Management of verbally disruptive behaviors in nursing home residents. Journal of Gerontology, 52(6), M369-M377

6. Cohen-Mansfield, J. (2001). Instruction Manual for the Cohen-Mansfield Agitation Inventory (CMAI). www.dementia-assessment.com.au/symptoms/CMAI_Manual.pdf.

APPENDICES

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VETERANS CENTRE

APPENDIX 1

BEHAVIOUR FREQUENCY & SEVERITY DAILY TRACKING FORM: GUIDELINES FOR COMPLETION

Behaviours Requiring Medication: (Circle all that apply)
Physically Aggressive: hits/kicks/pushes/bites/grabs/throws
Verbally Aggressive: screams/threatens/swears
Sexually Inappropriate: verbal or physical sexual advances
Other: _____
(Note: wandering, pacing, exit-seeking, rummaging, disrobing, repetitive questioning,& repetitive vocalizations generally do not respond to medications)

PATIENT IDENTIFICATION

Severity:

No effect on self/others 0
Little effect on self/others..... 1
Moderately disruptive/possible safety risk to self/others..... 2
Significantly disruptive/self or others are at risk..... 3
Extremely disruptive/significant safety risk to self or others 4

Date: (Y/M/D)																								
# Above Behaviours	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N
Per Shift >6																								
6																								
5																								
4																								
3																								
2																								
1																								
0																								
Behaviour Severity	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N
4																								
3																								
2																								
1																								
0																								
Staff Initials																								

D=day shift E=evening shift N=night shift

The purpose of this form is to track the frequency and severity of behaviours that are affecting the resident's safety and/or quality of life or the safety and/or quality of life of other residents. In order to recognize patterns of behaviour and possible contributing causes, accurate tracking from shift to shift and day to day is essential.

Behaviours Requiring Medication:

Circle all behaviours that are being considered for medication. Do not circle behaviours that are not affecting the resident or others and therefore do not require medication.

Severity:

The severity of a behaviour is rated by its impact on the resident and/or other residents. Behaviours may put the safety of the resident and/or others at risk or significantly disrupt the quality of life of others. Severity is coded on a 0-4 scale as outlined on the tracking form.

Tracking each shift:

The staff on day shift enters the date prior to completing the shift and severity tracking.

The number (#) of times a behaviour is observed on each shift is indicated by an "X" in the box on the same line as the appropriate number (from 0 to >6 times).

The severity code (outlined in the top right hand corner of the page) is indicated by an "X" in the box on the same line as the appropriate number (from 0-4).

The staff completing the tracking form on that shift then puts his/her initials at the bottom of the appropriate shift.

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APPENDIX 2

RESIDENT BEHAVIOUR OBSERVATION RECORD

Resident Behaviour Rating/Color Code

1. Sleeping in bed
2. Sleeping in chair
3. Awake/calm
4. Least challenging behaviour
5. } Increasing severity of behaviours
6. }
7. }
8. Most challenging Behaviour

PATIENT IDENTIFICATION

Time	Indicate Most Challenging Behaviour Observed for each ½ hour - Year/Month/Dates (for a 7 day period)						
0730							
0800							
0830							
0900							
0930							
1000							
1030							
1100							
1130							
1200							
1230							
1300							
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2130							
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2230							
2300							
2330							
2400							
0030							
0100							
0130							
0200							
0230							
0300							
0330							
0400							
0430							
0500							
0530							
0600							
0630							
0700							

Indicate number corresponding to behaviour and when completed, color each number with a different color as indicated. (RED for the most severe behaviour and then lighter colors for less severe behaviours)

*Adapted with permission from Resident Observation Record – Shalom Village Nursing Home

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APPENDIX 3

A GUIDE TO OPTIMAL USE OF TELEVISION/RADIOS/ MUSIC LISTENING EQUIPMENT

Rationale:

Television, radio programs and /or recorded music can provide meaningful stimulation and enhance quality of life for residents with dementia. However, these media can also create excess noise, increased confusion, and frustration when residents are unable to follow, are disturbed by, or are not interested in a particular program or musical selection. Televisions, radios and recorded music can also create excess background noise, which makes it difficult for residents with hearing impairments to communicate and difficult for residents with cognitive impairments to manage their environment

Guidelines:

Individual Rooms

1. On admission, televisions should only be brought in for residents who can benefit from television programming. All televisions brought into the Veterans Centre should be equipped with wireless headsets, either Infra-red or DECT 6.0 (Other wireless headsets interfere with the phone system).

2. For residents who are not able to indicate their television/radio program and/or musical preferences, use of televisions/radios/music listening equipment in individual resident rooms should be planned and monitored by the team periodically throughout the day and evening shifts to ensure that the resident is engaged and enjoying the programming. A list of appropriate program types and/or channels and/or music preferences is to be posted on the television or radio or music listening equipment for these residents. Programs or musical selections that increase aggression, inappropriate sexual behaviour or anxiety for the resident (or his/her roommate if applicable) or create excess noise for other residents should be avoided.

3. Staff will turn off television sets /radios/music listening equipment that are not being used for programming that meets the above criteria or if these media are not being watched/listened to by one or more residents.

4. Televisions should be turned off with resident's consent during staff-resident interactions and during care.

5. Music may be used during care to enhance/facilitate the resident's experience. Otherwise, radios/recorded music should be turned off with resident's consent during care.

Common Areas

6. The use of television/radio/ music listening equipment in common areas should be restricted to specific planned programs that meet the following criteria:

    a. Scheduled start time and finish time with maximum duration of 2 hours. A schedule for appropriate programs including channel is to be posted with scheduled OFF times clearly indicated.

    b. Appropriate content for residents given their age and interests and their ability to follow, comprehend, and enjoy. (See Content Recommendations below) Television programs such as CP24, CNN, MuchMusic, soap operas, young children's programs or programs with violent or disturbing content are prohibited in common areas.

    c. Radio programs /recorded music used in common areas would include classical music, jazz/big band and easy listening popular music from the 1950s-1970s. More recent popular music genres are generally not familiar to our residents and can be distracting/annoying.

A GUIDE TO OPTIMAL USE OF TELEVISION/RADIOS/ MUSIC LISTENING EQUIPMENT

d. Programs/music that increase or have the potential to increase verbal/physical aggression, inappropriate sexual behaviour or anxiety should be avoided.

e. Radio or recorded music in the dining room requires agreement by all residents present. This could mean that radio/music may only be played during specified times. Residents who do not wish to listen to radio/ music during their meal will have the option of dining in their rooms during these specified times.

f. Sound quality and speaker placement will be assessed by audiology or other appropriate health professionals such as music therapy.

7. Staff will turn off television sets radios and music listening equipment that are not being used for programming that meets the above criteria or if these media are not being watched/listened to by one or more residents.

8. Televisions in common areas that are not used for appropriate programming for residents on a regular basis will not be connected to cable service.

Content Recommendations:

Appropriate content for residents needs to be specifically assessed taking into consideration their age, interests and musical preferences as well as their ability to follow, comprehend and enjoy television and/or radio programs.

Residents with cognitive impairments or dementia may have a limited attention span and a decreased ability to sequence and problem solve. Residents with limited mobility may not be able to remove themselves or turn the television/radio/music listening equipment off when they have had enough. Residents may also have difficulty discerning environmental sounds from television/radio sounds.

Steps to determining appropriate television program content:

1. Determine each resident's past television viewing and/or radio listening habits (consult with resident/family member). Understand if the resident had the television or radio on for "company" at home.

2. Establish current viewing interest and evaluate this experience for the resident. Monitor the experience for the resident noting attention span and ability to follow the program. The team will evaluate and document the resident's experience in terms of enjoyment, initiating involvement and finding meaning in viewing the program. The team will note and document if the resident is comfortable, able to follow and discuss events, able to focus and track the television program.

3. If the experience is positive, post the programs and channels with optimum viewing times on the television of the resident. (i.e. Mystery, Favourite sports, The Price is Right, etc). Note the channels and viewing times. Document this information in the Care Guide.

4. Monitor the response of the resident to the sounds of the television. Does he jump, look anxious or startled. Review his/her comfort levels following television viewing.

5. Utilize videotapes, DVD's or television stations of interest to residents with dementia such as: musicals, comedy, travel, nature i.e. Planet Earth or home-made family movies.

6. Monitor optimal viewing time for individual residents. There should be a beginning and an end to all viewing. The television should be on for short periods of time with a specific program for viewing.

A GUIDE TO OPTIMAL USE OF TELEVISION/RADIOS/ MUSIC LISTENING EQUIPMENT

Steps to determining appropriate use of recorded music:

1. Inclusion of music in the environment must be a conscious choice. The situation needs to be regularly assessed by staff and altered if not appropriate.
2. Whenever possible, residents should be given the opportunity to choose the music to which they are listening.
3. For optimal benefit, music listening periods should be time limited and purposeful.

Consultation with a music therapist is recommended when providing recorded music in the following situations:

1. Help is needed to determine a resident's music listening preferences
2. A resident asks to use music for relaxation
3. Staff would like to provide recorded music for a resident/patient who is palliative/unconscious/sedated
4. A resident has a negative reaction to music.
5. Any situation where there is uncertainty about the use or application of music

Evaluation:

Compliance with these guidelines will be audited as part of the Veterans Centre "Senior-Friendly" environment audits.

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APPENDIX 4

COHEN-MANSFIELD AGITATION INVENTORY (CMAI)

Resident Name.....

Date.....Unit…….....

INSTRUCTIONS

Please read each of the agitated behaviours below, and circle the number that corresponds to the frequency and disruptiveness of each during the past two weeks.
(Definition of Disruptiveness: How disturbing it is to staff, other residents or family members. If disruptive to anyone, rate the highest it is for those for whom it disrupts.)

FREQUENCY
1 = Never
2 = Less than once a week
3 = Once or twice a week
4 = Several times a week
5 = Once or twice a day
6 = Several times a day
7 = Several times an hour
9 = Don't know

DISRUPTIVENESS
1 = Not at all
2 = A little
3 = Moderately
4 = Very much
5 = Extremely
9 = Don't know

Circle the number that represents the Frequency and Disruptiveness of each of the behaviours below.

		FREQUENCY	DISRUPTIVENESS
1	Pace, aimless wandering	1 2 3 4 5 6 7 9	1 2 3 4 5 9
2	Inappropriate dress disrobing	1 2 3 4 5 6 7 9	1 2 3 4 5 9
3	Spitting (include at meals)	1 2 3 4 5 6 7 9	1 2 3 4 5 9
4	Cursing or verbal aggression	1 2 3 4 5 6 7 9	1 2 3 4 5 9
5	Constant unwarranted requests for attention or help	1 2 3 4 5 6 7 9	1 2 3 4 5 9
6	Repetitive sentences or questions	1 2 3 4 5 6 7 9	1 2 3 4 5 9
7	Hitting (including self)	1 2 3 4 5 6 7 9	1 2 3 4 5 9
8	Kicking	1 2 3 4 5 6 7 9	1 2 3 4 5 9
9	Grabbing onto people	1 2 3 4 5 6 7 9	1 2 3 4 5 9
10	Pushing	1 2 3 4 5 6 7 9	1 2 3 4 5 9
11	Throwing things	1 2 3 4 5 6 7 9	1 2 3 4 5 9
	Circle the number that represents the Frequency and Disruptiveness of the behaviours below	FREQUENCY 1=Never	DISRUPTIVENESS 1=Not at all

COHEN-MANSFIELD AGITATION INVENTORY (CMAI)

		2=Less than once a week 3=Once or twice a week 4=Several times a week 5=Once or twice a day 6=Several times a day 7=Several times an hour 9=Don't know	2=A little 3=Moderately 4=Very much 5=Extremely 9=Don't know
12	Strange noises (weird laughter or crying)	1 2 3 4 5 6 7 9	1 2 3 4 5 9
13	Screaming	1 2 3 4 5 6 7 9	1 2 3 4 5 9
14	Biting	1 2 3 4 5 6 7 9	1 2 3 4 5 9
15	Scratching	1 2 3 4 5 6 7 9	1 2 3 4 5 9
16	Trying to get to another place (eg. out of the building	1 2 3 4 5 6 7 9	1 2 3 4 5 9
17	Intentional falling	1 2 3 4 5 6 7 9	1 2 3 4 5 9
18	Complaining	1 2 3 4 5 6 7 9	1 2 3 4 5 9
19	Negativism	1 2 3 4 5 6 7 9	1 2 3 4 5 9
20	Eating/drinking inappropriate substances	1 2 3 4 5 6 7 9	1 2 3 4 5 9
21	Hurt self or other (cigarette, hot water, etc.)	1 2 3 4 5 6 7 9	1 2 3 4 5 9
22	Handling things inappropriately	1 2 3 4 5 6 7 9	1 2 3 4 5 9
23	Hiding things	1 2 3 4 5 6 7 9	1 2 3 4 5 9
24	Hoarding things	1 2 3 4 5 6 7 9	1 2 3 4 5 9
25	Tearing things or destroying property	1 2 3 4 5 6 7 9	1 2 3 4 5 9
26	Performing repetitious mannerisms	1 2 3 4 5 6 7 9	1 2 3 4 5 9
27	Making verbal sexual advances	1 2 3 4 5 6 7 9	1 2 3 4 5 9
28	Making physical sexual advances	1 2 3 4 5 6 7 9	1 2 3 4 5 9
29	General restlessness	1 2 3 4 5 6 7 9	1 2 3 4 5 9
30	Other inappropriate behaviour. Specify:	1 2 3 4 5 6 7 9	1 2 3 4 5 9

COHEN-MANSFIELD AGITATION INVENTORY (CMAI)

DEFINITION OF CMAI BEHAVIOURS

1. **Pacing and aimless wandering** - constantly walking back and forth, does not indicate normal purposeful walk, include wandering when done in wheelchair.
2. **Inappropriate dressing or disrobing** - putting on too many clothes, putting on clothing in a strange manner (e.g. putting pants on head), taking off clothing in public or when it is inappropriate (if only genitals are exposed, do not rate; see item 28). Do not rate a person's ability to dress/undress as in ADLs.
3. **Spitting(including while feeding**) - spitting onto floor, other people, etc.; do not include salivating over which the person has not control, or spitting into a tissue, or onto ground outside.
4. **Cursing or verbal aggression** - only when using words; swearing, use of obscenity, profanity, unkind speech or criticism, verbal anger, verbal combativeness. Nonverbal will be marked under screaming.
5. **Constant unwarranted requests for attention or help** - verbal or nonverbal unreasonable nagging, pleading, demanding (indicate also for disoriented people).
6. **Repetitive sentences or questions** - repeating the same sentence or question one right after the other (do not include complaining - see item 18; even if oriented and even if possibly warranted).
7. **Hitting (including self)** - physical abuse, striking others, pinching others, banging self/furniture.
8. **Kicking** - strike forcefully with feet at people or objects.
9. **Grabbing onto people or things inappropriately** - snatching, seizing roughly, taking firmly, or yanking.
10. **Pushing** - forcefully thrusting, shoving moving, putting pressure against.
11. **Throwing things** - hurl, violently tossing up in the air, tipping off surfaces, flinging, spilling food.
12. **Making strange noises** - including crying, weeping, moaning, weird laughter, grinding teeth.
13. **Screaming** - loud shrill, shouting, piercing howl.
14. **Biting** - chomp, gnash, gnaw (people or self).
15. **Scratching** - clawing, scraping with fingernails (people or self).
16. **Trying to get to a different place** - trying to get out of the building, off the property, - sneaking out of room, leaving inappropriately, trying to get into locked areas, trespassing within the unit, into offices, other residents' rooms or closet.
17. **Intentional falling** - purposeful falling onto floor, include from wheelchair, chair, or bed.
18. **Complaining** - whining, complaining about self, somatic complaints, personal gripes or complaining about external things or other people.
19. **Negativism** -bad attitude, doesn't like anything, nothing is right.
20. **Eating or drinking inappropriate substances** - putting into mouth and trying to swallow items that are inappropriate.
21. **Hurting self or others** - burning, cutting touching self or other with harmful objects.
22. **Handling things inappropriately** - picking up things that don't belong to them, rummaging through drawers, moving furniture, playing with food, faecal smearing.
23. **Hiding things** - putting objects under or behind something.
24. **Hoarding things** - putting many or inappropriate objects in purse or pockets, keeping too many of an item.
25. **Tearing things or destroying property** - shredding, ripping, breaking, stomping, on something.
26. **Performing repetitious mannerisms** - stereotypic movement, such as patting, tapping, rocking self, fiddling with something, twiddling with something, rubbing self or object, sucking fingers, taking shoes on and off, picking at self, clothing or objects, picking imaginary things out of air or off floor, manipulation of nearby objects in a repetitious manner.
27. **Making verbal sexual advances** - sexual propositions, sexual innuendo, or "dirty talk".
28. **Making physical sexual advances or exposing genitals** - touching a person in an inappropriate sexual way, rubbing genital area, inappropriate masturbation, when not alone in own room or bathroom, unwanted fondling or kissing.
29. **General restlessness** - fidgeting, always moving around in seat, getting up and sitting down, inability to sit still.

SIDE EFFECTS OF MEDICATIONS USED TO TREAT BEHAVIOURAL SYMPTOMS IN DEMENTIA

Antipsychotic Medications	Side Effects
Older, typical anti-psychotic (avoid if possible) Haloperidol (Haldol) Chlorpromazine Methotrimeprazine (Nozinan) Loxapine	Extra-pyramidal symptoms (EPS) Sedation Orthostatic hypotension Tachycardia Urinary retention Dry mouth Blurred vision Constipation Tardive dyskinesia ↑ Prolactin (breast tenderness) ↓ Seizure threshold
Newer, atypical anti-psychotic Olanzapine (Zyprexa)	Extra-pyramidal symptoms (less) Sedation Weight gain Orthostatic Hypotension ↓ Seizure threshold Tardive dyskinesia Anticholinergic effects
Risperidone (Risperdal)	EPS (dose-dependent) Insomnia Hypotension ↑ Prolactin (breast tenderness) Tardive dyskinesia
Quetiapine (Seroquel)	Cataract formation Minimal EPS Orthostatic Hypotension (less) Tardive dyskinesia

SIDE EFFECTS OF MEDICATIONS USED TO TREAT BEHAVIOURAL SYMPTOMS IN DEMENTIA

Extra-Pyramidal Side Effects

Type	Definition	Frequency	Onset
Tremor	Resting, pill-rolling tremor as seen in Parkinson's Disease	15-20%	1st few months
Gait	Shuffling, small stepped-gait with stooped posture and ↓arm swing	15-20%	1st few months
Rigidity	Increased muscle tone	15-20%	1st few months
Dystonia	Disordered muscle tone resulting in spastic contractions of muscles (Can be life-threatening)	10-20%	1st few days
Akathisia	Feeling of restlessness, often with the inability to remain still	20-25%	1st few weeks or months
Tardive Dyskinesia	An abnormal, involuntary movement disorder (usually orofacial, may involve hands and feet)	20% 52% 60%	after 1 year after 2 years after 3 years

SIDE EFFECTS OF MEDICATIONS USED TO TREAT BEHAVIOURAL SYMPTOMS IN DEMENTIA

Antidepressants	**Side Effects**
SSRIs	Anorexia/weight loss Nausea Diarrhea/constipation Hyponatremia Extra-pyramidal symptoms (Paxil) ↓platelets Sedation/insomnia Serotonin syndrome† Discontinuation syndrome††
Trazadone	Sedation Dry mouth Orthostatic hypotension Arrhythmias Priapism
Bupropion	Dose-related seizures Hypersensitivity reaction Insomnia
Venlafaxine	Same as for SSRIs Dose related ↑blood pressure ↑ Glaucoma Seizures in pre-disposed patients
Tri-cyclic antidepressants (nortriptyline, amitriptyline)	Sedation Arrhythmias Dry mouth Anticholinergic effects ↑ Glaucoma Lower seizure threshold Photosensitivity Hyponatremia Orthostatic hypotension
† Serotonin syndrome: tremor, agitation, delirium, rigidity, myoclonus, hyperthermia, and obtundation ††Discontinuation syndrome: Sudden withdrawal of antidepressants can cause GI disturbances, delirium, vivid dreams, insomnia, flu like symptoms, hyperactivity and sensory disturbances. ***(All antidepressants have been associated with increased falls in the elderly)***	

SIDE EFFECTS OF MEDICATIONS USED TO TREAT BEHAVIOURAL SYMPTOMS IN DEMENTIA

Sedative / Hypnotics	**Side-Effects**
Benzodiazepines (e.g. lorazepam, clonzepam)	Sedation ↑ Confusion Ataxia Weakness Dizziness Increased risk of falls Agitation Hallucinations Paranoid ideation Disinhibition
Buspirone	Dizziness Nervousness Headache Nausea
Chloral hydrate (not recommended)	Early tolerance Sedation GI irritation Dizziness Excitation
Anticonvulsants	**Side-Effects**
Carbamazepine	Dizziness Confusion Hyponatremia Blood cells abnormalities
Cognitive Enhancers **Cholinesterase Inhibitors:**	**Side Effects**
Donepezil Galantamine Rivastigmine	Nausea, vomiting, diarrhea Bradycardia Stomach irritation, ulceration Excess salivation Anorexia, Weight Loss Dizziness Headache Sleep disturbance Bronchospasm (if asthma, COPD)
Others	**Side Effects**
Memantine (Ebixa)	Hypertension, dizziness, headache Constipation Confusion, Hallucinations

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APPENDIX 6

BEHAVIOUR ASSESSMENT FORM

PATIENT IDENTIFICATION

Current Care Team:
Primary Nurse: _____
Associate Nurse: _____
Attending MD: _____

Dementia History:
Diagnosis: _____
Onset: _____
Current severity: _____

Medications: _____

_____

Other Medical Problems:

_____

_____

_____

_____

Primary Challenging Behaviour	
Description	
Frequency	
Severity of Disruption/ Risk to Self or Others	
Antecedants	
Consequences	
Strategies Tried	
Consistency of Approach	
Successful Strategies	
Unsuccessful Strategies	

BEHAVIOUR ASSESSMENT FORM PAGE 2

Behaviour History	
Pre-Dementia Personality	
Previous Challenging Behaviours:	Description
	Management Strategies Tried:
	Successful Strategies:
Current Challenging Behaviours (other than primary behaviour)	Description:
	Management Strategies Tried:
	Successful Strategies:

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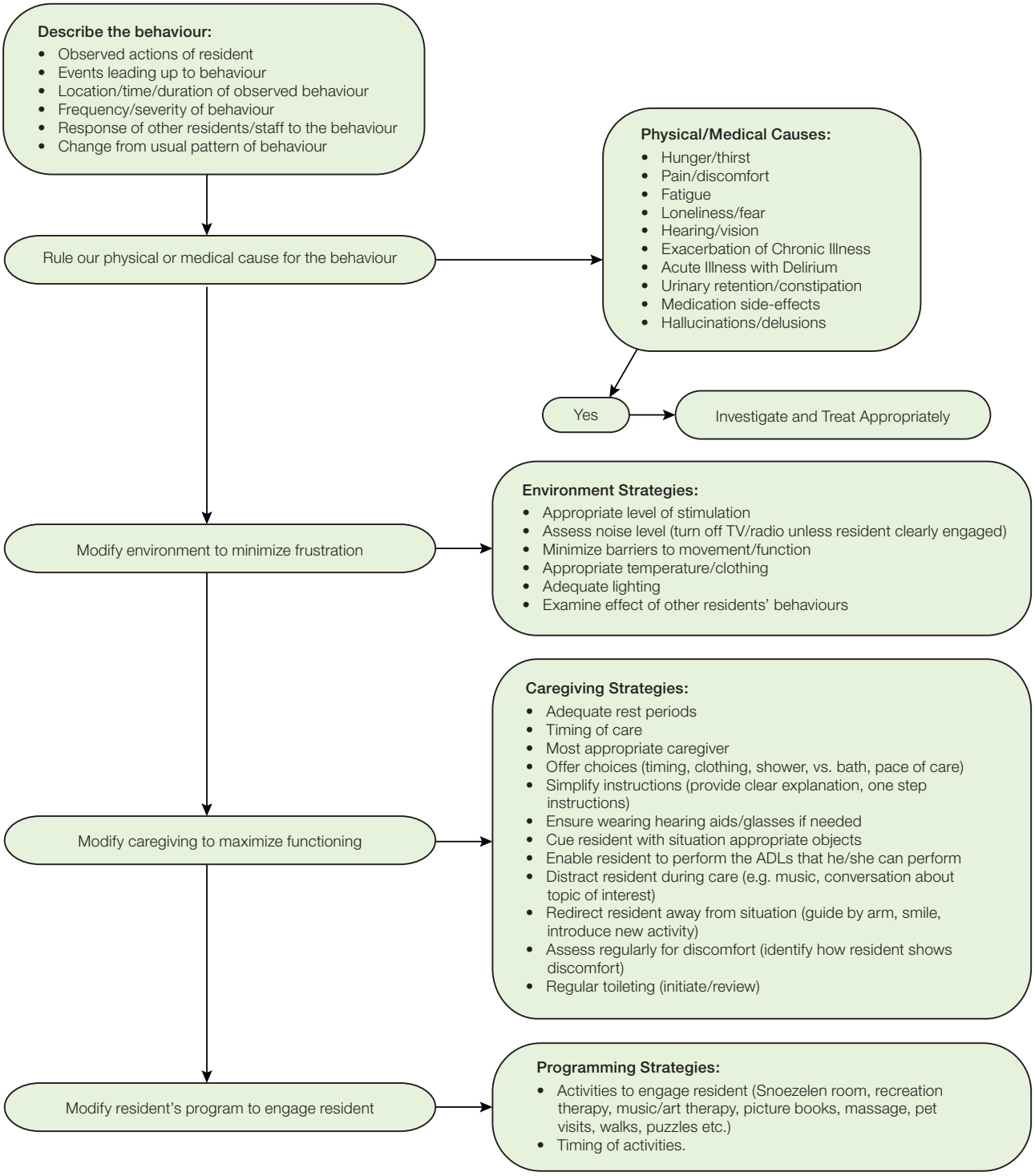
APPENDIX 7

A STEPWISE APPROACH TO ASSESSING AND MANAGING BEHAVIOURS IN DEMENTIA



Responding to Behaviours Due to Dementia using Achieving Best Life Experience (ABLE) Care Planning Guide

2010

PR 15040 (2010/09)