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Behavioral Management Related to Dementia in the Elderly in a Long Term Care Facility

by

Rose B. Bergquist, RN, BSN, PA-C

Bachelor of Science, Dickinson State University, 1991

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Abstract

Alzheimer's disease (AD) is the most common cause of dementia in adult life and recognized as the most common cause of late life dementia world wide. Care of an elderly individual with dementia requires a systematic approached to the management of behavioral disturbances. The purpose of this project was to provide education regarding management of an elderly individual with behavioral disturbance related to dementia to health care providers in long term care facilities. The project was conducted in three rural long term care facilities. Healthcare providers who receive education can become more competent in intervening with an individual who is exhibiting behavioral difficulties.

Behavioral Management Related to Dementia in the Elderly in a Long Term Care Facility

INTRODUCTION

Alzheimer's disease (AD) is the most common cause of dementia in adult life and recognized as the most common cause of late life dementia world wide. According to several reports, AD is considered the third most expensive illness in the United States with annual costs for caring for a single resident with AD to be $35,000 to $47,000. The total cost is more than $140 billion dollars per year in the United States assuming there are 4 million people with AD. Theses costs are even more ominous when considering that the prevalence of AD in the United States is projected to grow to nearly 15 million by the year 2050. (Geldmacher, 2003)

Approximately 1.5 million elderly individuals reside in long term care facilities. Individual with significant mental disorder is prevalent in 65% to 91% of the residents. The majority of elderly individual, with mental illness that requires institutional care, is approximately 89% of the nursing homes population along with another 11% in hospitals. The depression, behavioral, and psychiatric symptoms associated with dementia are the most common psychiatric problems in long term care facilities. It is estimated that 30% to 40% of individuals with dementia have significant behavioral and psychiatric symptoms. Approximately 22% of nursing home residents have depression. (American Geriatrics Society and American Association for Geriatric Psychiatry, 2003a)

Behavioral disturbances and dementia are closely linked together. Kovach, Noonan, Griffie, Muchka, & Weissman (2001) estimated that 70% to 90% of residents with AD develop behavioral symptoms. Problems such as depression, agitation, aggression, wandering, and sleep disturbance affect most if not all residents at some point in the disease process. Functional impairment in the resident and increased burden in the caregiver can seriously have an effect on care. These two components are often referred to as the most complex aspect of caregiving. As a result, behaviors impinge on the quality of life for the resident as well as the caregiver.

Teri, Logsdon, & McCurry (2002) states a common technique of assessing behavioral disturbances in the cognitively impaired elderly individual is a detailed clinical interview with the resident and caregiver about the resident's day to day functioning. The interview consists of questions about the occurrence, frequency, and severity of typical problems, including wandering, anxiety, depression, agitation, aggression, sleep disturbances, paranoia, suspiciousness, and verbal or physical threats or abuse. An assessment list is a valuable tool to ensure that the full identification of the problems is assessed in an effective and thorough manner.

According to Teri et al. (2002), a variety of mood and behavior assessment measurements with good psychometric properties have been developed. Some of the assessment tools are based on paper and pencil-informant-reports while other assessment tools require a structured interview with trained clinicians or direct behavioral observation. The tools vary in data format for example the Cornell Scale for Depression in Dementia provides information on the severity of symptoms. As well assessment tools, such as the Revised Memory and Behavioral Problem Checklist, rate behaviors on the

incidence of their occurrence and provide information about caregiver reactions to the behaviors. Various tools, such as Neuropsychiatric Inventory, summarize subscale information by computing from a combination of frequent and severity ratings of behavioral symptoms. According to Teri et al., a number of self-reporting instruments have shown to be valid when completed by caregivers of a resident with dementia.

Teri et al. (2002) reports there are no single assessment tool that is used universally in the clinical trials. Behaviors are often included as part of the comprehensive assessment with other cognitive, functional, and psychosocial measures. When researchers and health care providers are selecting a screening tool, one should consider the length of the measure, sensitivity to change, and specific behaviors of concern for one's clinical population. Researchers, who conduct research in populations of non–English speaking individuals from multicultural backgrounds and with limited education or reading skills, need to evaluate the validity of a selected tool for one's situation.

When a problem has been identified, a comprehensive assessment of the resident with dementia needs to be completed. Then the clinician needs to determine if the behaviors are related to medical, cognitive, dementia, environmental, or caregiver trigger. Common causes of behavior disturbances consist of medical illness, injury, side effect of medications, environmental changes, and interpersonal conflicts. Acute medical illness could include urinary tract infections, pneumonia, dehydration, constipation, injury, or pain.

PROBLEM AND PURPOSE

Cohen-Mansfield (1999) addresses the issue that nursing personnel are responsible for a multitude of assessments related to behavior disturbances which requires a course of actions. These decisions include three main areas: a) the placement of residents in the setting which provides the appropriate level of care, b) the implementation of prevention and management programs, and c) the selection, initiation, evaluation and determining of pharmacological, environment, and behavioral treatments. On the administrative level, nursing personnel decisions are related to the composition of care units, including admission and staffing criteria. Cohen-Mansfield reports nursing personnel need to know how to assess behavior disturbances that prove reliable and meaningful for one's clinical practice to effectively determine a plan for treatment.

The purpose of the project was to provide education for health care providers who are caregivers for residents with dementia in rural long term care facilities. The education material consisted: a) prevalence to dementia and behavioral disturbances associated with dementia; b) systematic approach to behavioral management; c) assessment of behavioral disturbances related to the problem, communication factors, environmental factors, and illnesses or conditions; d) appropriate interventions to implement for managing specific behavioral disturbances related to wandering, physically abusive behavioral symptoms, verbally abusive behavioral symptoms, sexual inappropriate behavioral symptoms, social inappropriate behavioral symptoms, and resists to basic cares; e) guidelines for documentation; and f) samples of behavioral management charting.

THEORETICAL FRAMEWORK

Benner's nursing model Novice to Expert is a foundation for differentiating clinical knowledge development in practice. Learning occurs at different stages. The

learning needs at the early stages of clinical knowledge development are different from those required at later stages. Through qualitative descriptive research, Benner applies the Dreyfus model of Skilled Acquisition to clinical nursing practice. (Tomey & Alligood, 2002)

Benner stated that theory is necessary to develop the right questions to ask in a clinical situation. Theory directs the practitioner in searching for problems and anticipating care needs. There is always more to any situation than theory predicts. (Benner, 2001)

According to Benner (2001), the nursing model consists of five stages based on learning and experience. The Dreyfus model makes it possible to describe the performance characteristics at each level of development and to identify the teaching or learning needs at each level.

Novice, the first stage of the Dreyfus model, is defined as where the beginner has no experience of the situations in which they are expected to perform. They are taught about the situations in terms of objective and context-free rules to guide actions in respect to different attributes. Novices enter into these situations which allow them to gain the experience so necessary for skill development. Any nurse entering a clinical setting where she or he has no experience with the resident population may be limited to the novice level of performance if the goals and tools of resident care are unfamiliar. This point illustrates the situational, experience-based premises of the Dreyfus model. This distinguishes between the level of skilled performance that can be achieved through principles and theory learned in a classroom and the context dependent judgments and skill that can be acquired only in real situations. (Benner, 2001)

Advanced Beginners, the second stage of the Dreyfus model, are those who can demonstrate acceptable performance. Advanced beginners have coped with enough real situations to note the recurring meaningful situational components that are termed 'aspects of the situation' in the Dreyfus model. Aspects require prior experience in actual situations for recognition and overall global characteristics that can be identified only through prior experience. The instructor provides guidelines for recognizing such aspects as a resident's readiness to learn. Experience is needed before the nurse can apply the guidelines to individual residents. The advanced beginner can now formulate guidelines that dictate actions in terms of both attributes and aspects. (Benner, 2001)

Competent, the third stage of the Dreyfus model, is the nurse who has been on the job in the same or similar situations two or three years. Competence develops when the nurse begins to see his or her actions in terms of long range goals and is consciously aware of them. The plan consists of attributes and aspects of the current and contemplated future situation. They can determine which are to be considered most important and those which can be ignored. A plan establishes a perspective which is based on considerable, conscious, abstract, and analytic contemplation of the problem. The competent nurse lacks the speed and flexibility of the proficient nurse but does have a feeling of mastery and the ability to cope with and manage the many contingencies of clinical nursing. (Benner, 2001)

Proficient, the fourth stage of the Dreyfus, perceives situations as wholes rather than in terms of aspects, and performance is guided by maxims. The proficient nurse learns from experience what typical events to expect in a given situation. The proficient nurse understands the modifying of plans in response to these events. Maxims are used as

guides, but a deep understanding of the situation is required before a maxim is used. Maxims can mean one thing at one time and quite another thing later. When a nurse has a deep understanding of a given situation, the maxim provides a course as to which mechanism to take into consideration. Proficient nurses are best educated through the use of case studies reflecting the levels of complexity and ambiguity similar to real clinical situations. (Benner, 2001)

Expert, the fifth stage of the Dreyfus model, has an enormous background of experience and has an intuitive grasp of each situation. An expert operates from a deep understanding of the total situation. Skilled logical ability within the expert nurse is essential for those situations with which the nurse has had no previous experience. Expert nurses are not difficult to recognize because they frequently make clinical judgments or manage complex clinical situations in a truly remarkable way. (Benner, 2001)

Nurses make decisions regarding residents' care bases on assessments, knowledge, and experience. Nurse's decision making is reflected in determining the appropriate interventions related to the changes in the resident condition. Document of the assessment, interventions, and outcomes provide a means for communicating with other health care providers. Benner (2001) explains that changes can be documented by means of measurable vital signs and relatively clear observational data. The nurse's skills results in clear documentation and presentation of the case to the physician. Nurses must master the recognition components and the documentation to provide a convincing case presentation.

DEFINITIONS

Aggression is defined as "forceful physical, verbal, or symbolic action. It may be appropriate and self-protective, indicating healthy self-assertiveness, or it may be inappropriate. The behavior may be directed outward toward the environment or inward toward the self. Activity performed in a forceful manner" (Thomas, 1997, p. 51). Aggression can be physical, verbal, or sexual (Brodaty & Low, 2003).

Agitation is defined as "excessive restlessness, increased mental and physical activity. Severe motor restlessness, usually nonpurposeful, associated with anxiety" (Thomas, 1997, p. 51). Agitated behaviors consists of irritability, restlessness, physical and verbal aggression, resisting needed assistance, pacing, and wandering (Teri et al., 2002).

Behavior is defined as the "manner in which one acts; the actions or reactions of individuals under specific circumstance" (Thomas, 1997, p. 211). Behaviors are indicative of these reactions, including agitated night awakening, aimless, wandering, violent behavior, belligerence, and compulsive repetitive behavior (DeYoung, Just, & Harrison, 2002).

Behavioral Disturbances include wandering, verbally abusive behavioral symptoms, physically abusive behavioral symptoms, sexually inappropriate behavioral symptoms, socially inappropriate behavioral symptoms, and resists to care.

Dementia related to Alzheimer's disease is a common progressive dementia causing severe cognitive and behavioral dysfunction. Changes in cognitive and behavior occur as the illness progresses. In early stage, irritability, agitation, and restlessness are characteristic changes. As the illness proceeds to the middle stage, the individual may become anxious, hostile, emotionally labile, and prone to verbal and physical aggression.

In late stages, residents are often debilitated to exhibit hyperactive problem behaviors as previous. (DeYoung et al., 2002)

Elderly Individual is defined as an individual over the age of 65 years.

Health Care Provider is an individual who is trained to provide health care such as physicians, nurse practitioners, physicians assistants nurses, certified nurse assistants, pharmacists, and physical, recreational or occupational therapists. One is a part of the team to provide resident care in a long term care facility.

Minimum Data Set is a screening of the resident's functional status. Areas included are customary routines, cognitive patterns, communication patterns, hearing patterns, vision patterns, mood and behavior patterns, psychosocial well-being, physical functioning and structural problems, continence, disease diagnosis, health conditions, nutritional status, skin conditions, activity pursuit patterns, medications, special treatments and procedures, and therapies (Centers for Medicare & Medicaid Services, 2002).

Physical Abusive Behavioral Symptoms is defined as threatening gestures, pushing, shoving, throwing objects, damaging property, pinching, squeezing, hitting, punching, elbowing, slapping, kicking, brandishing a weapon, striking, an individual with an object, spitting, biting, scratching, tackling, or using a weapon (Cohen-Mansfield, 1999). "Other residents or staffs were hit, shoved, scratched, or sexually abused" (Centers for Medicare & Medicaid Services, 2002, p. 3-66).

Resident is defined as an elderly individual residing in a long term care facility.

Resists to Basic Care refers to "resistance with taking medications/injections, ADL assistance or help with eating. This category does not include instances where the

resident has made an informed choice not to follow a course of care. Signs of resistance may be verbal and/or physical. These behaviors are not necessarily positive or negative, but are intended to provide information about the resident's response to nursing interventions and to prompt further investigation for care planning purposes." (Centers for Medicare & Medicaid Services, 2002, p. 3-66 -3-67)

Rural Facility is defined as a facility located in southwest North Dakota and northeast South Dakota with population of less than 2000.

Sexually Inappropriate Behavioral Symptoms is defined as hugging, kissing, touching body parts, intercourse, or making obscene gestures inappropriately toward others (Cohen-Mansfield, 1999).

Socially Inappropriate Behavioral Symptoms "includes disruptive sounds, excessive noise, screams, self-abusive acts, or sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through other's belongings" (Centers for Medicare & Medicaid Services, 2002, p. 3-66).

Verbal Abusive Behavioral Symptoms is defined as hostile or accusatory language, cursing directed at an individual, verbal threat, or name calling (Cohen-Mansfield, 1999). "Other residents or staff were threatened, screamed at, or cursed at" (Centers for Medicare & Medicaid Services, 2002, 3-66).

Wandering is "locomotion with no discernible, rational purpose. A wandering resident may be oblivious to his or her physical or safety need. Wandering behavior should be differentiated from purposeful movement. Wandering may be manifested by walking or by wheelchair. Do not include pacing as wandering behavior." (Centers for Medicare & Medicaid Services, 2002, p. 3-66)

Literature Review

Behavioral disturbances are a primary reason for institutionalization of the elderly with dementia. Souder & O'Sullivan (1994) reports 90% of elderly with dementia will demonstrate behavioral disturbances. As stated in Souder & O'Sullivan, the presence of 3.6 behavioral disturbances per resident occurs in a 24-hour period in an institutional setting in an individual with dementia or psychiatric illness.

Behavioral disturbances affect staffing requirements, clinical milieu, and nursing burnout. The literature review provides evidence to support behavioral disturbances can lead to overuse of restraints, inappropriate use of psychotropic medications, and feelings of frustration and powerlessness among the nursing staff. Behavioral disturbances require additional nursing staff to resident time and increase the cost of institutionalization.

American Geriatrics Society and American Association for Geriatric Psychiatry Expert Panel on quality mental health care in nursing homes has developed a consensus statement on the management of behavioral symptoms associated with dementia. The consensus statement provides guidelines to health care providers, but clinical judgment and the consideration of unique aspects of individual residents will be necessary for assessment of symptoms and optimal treatment. (American Geriatrics Society and American Association for Geriatric Psychiatry, 2003b)

American Geriatrics Society and American Association for Geriatric Psychiatry (2003b) states the experts panel's recommendations of primary clinical importance related to the potential improvement in the management of behavioral disturbances related to dementia consists of:

- Education and training of mental health professionals working in nursing homes and of nursing home staff in the recognition, assessment, treatment, and monitoring of behavioral symptoms in nursing home residents is essential.
- The Minimum Data Set cannot adequately identify all residents with behavioral symptoms therefore verbal, nonverbal, and behavioral symptoms should be described and quantifies.
- Residents with new onset of or changes in behavioral symptoms should be assessed for disorders such as psychosis, depression, anxiety, sleep disorders, other neurological conditions, adverse drug reactions and interactions, and substance abuse or medication abuse or withdrawal. Assessment should also include environmental, situational, social, and psychological factors.
- Residents with new onset of or changes in behavioral symptoms should have vital signs taken and be evaluated for adverse medication effects, infections, dehydration, pain or discomfort, delirium, fecal impaction, and injury.
- The assessment and treatment of behavioral symptoms should be interdisciplinary; development of individualized care plans should involve families and include information about residents obtained from staff and family members.
- After associated medical conditions are assessed and treated, the initial treatment of behavioral symptoms should be

nonpharmacological when there are no psychotic features and when there is no immediate danger to the resident or others.

- Trained professionals or trained nursing home staff should administer appropriate nonpharmacological interventions which include sensory therapy, activities therapy, modification of activities of daily living care to meet individuals' needs, environmental modifications, behavioral therapy treatments, and social contact interventions.

Brodaty & Low (2003) report behavioral management training for caregivers can successfully reduce agitation. Staff training programs on implementation of behavioral management approaches reduces aggressive behavior during personal care, administration of medications with bathing, and staff injuries. Brodaty & Low provide evidence that psychological techniques can be effective in reducing aggression.

Buettner & Kolanowski (2003) introduces the Need Driven Dementia Compromised Behavior Model which challenges the view on dementia related behaviors as part of the disease process. Need Driven Dementia Compromised Behavior Model addresses behavior disturbances as an unmet need. The elderly individual who wanders, screams, or strikes out is pursuing a goal or expressing a need. Behaviors are viewed as integrated and meaningful response that an elderly individual with dementia can make at that time. Assessment of background factors includes neuropathologic changes in the brain; cognitive factors such as attention, memory, aphasia, apraxia, and agnosia; and health status. Psychosocial factors include gender, education, past occupation, personality type, and history of stress response. Background factors are important in the selection of

recreational activities. Promoxial factors induce a need state and precipitate dementia-related behaviors. Promoxial factors consist of physiological and psychological need states and qualities of the immediate physical and social environment such as noise level, lighting, temperature, crowding, and staff mix. The key is to identify unmet needs or environment constraints, working with the individual's strengths, and guiding the resident with an intervention plan based on the Neurodevelopmental Sequencing Program.

Buettner & Kolanowski (2003) explains Neurodevelopmental Sequencing Program is based on observation that behavior, movement, and functional losses in people with dementia occur in approximately the reverse order of their development. The concept of using appropriate recreational interventions comes from the fact that human beings are active, living organisms who derive satisfaction from using their inborn abilities. Residents with dementia are placed in a program level based on assessment of their level of function. The Neurodevelopmental Sequencing Program has been shown to overall improve grip strength, flexibility, and agitation reduction. Selected interventions are based on functional skills of the resident with dementia to promote movement and provide success experiences.

Buettner & Kolanowski (2003) reports the American Therapeutic Recreation Association held a consensus meeting to discuss the issue of elderly individuals with dementia who have a low rate of activity participation. American Therapeutic Recreation Association developed practice guidelines for recreation therapy in the care of individuals with dementia. The intervention therapy was based on the Need Driven Dementia Compromised Behavior Model and Neurodevelopmental Sequencing Program. Need Driven Dementia Compromised Behavior Model is a middle range theory that describes

behavioral disturbances related to dementia and illustrates the processes that produce them. Driven Dementia Compromised Behavior Model identifies and describes the causal processes through which interventions are expected to produce desired outcomes. Need Driven Dementia Compromised Behavior Model can be used as the guideline framework for understanding the dementia-related behaviors. Neurodevelopmental Sequencing Program is a practice theory that describes the design of an intervention, the resource needed to deliver, and the implementation of the interventions.

The American Therapeutic Recreation Association's dementia practice guidelines provide recreational and other health care providers with a consistent framework to follow for assessment, prescription, treatment, and outcome measurement for elderly individuals with behavior disturbances. The guidelines consist of 10 valid and reliable assessment tools, 82 recreation therapy protocols, and the most current evidence supporting the interventions. The conclusion of the project was that the American Therapeutic Recreation Association's guidelines are an excellent example of an interdisciplinary approach that is effective in clinical practice. Positive outcomes can be achieved by combining assessment of needs, environmental supports, and a neurodevelopmental program that meets those needs. In view of nonpharmacological interventions for aggression and current federal regulations, psychosocial interventions are as important as medications in the treatment of behavioral disturbances. (Buettner & Kolanowski, 2003)

Buffum, Miaskowski, Brod, & Sands (2001) report individuals with dementia may be unable to provide self reports of pain because of memory loss, concentration difficulties and confusion. Agency for Health Care Policy Research's pain guidelines

supports a need to develop pain assessment methods for residents with dementia. Clinicians need to know the resident's baseline level of behaviors, compare changes in behavior over time, initiate interventions, and evaluate the effectiveness of the interventions using the same assessment tool.

Assessment of Discomfort in Dementia protocol explained by Kovach et al. (2001) was developed based on the assumptions that behaviors associated with dementia are symptoms of unmet physiological or nonphysiological needs. Assessment of Discomfort in Dementia protocol provides a systematic approach for completing an assessment and treatment plan for both physical and affective discomfort. Assessment of Discomfort in Dementia protocol consists of a stepped approached that attempts to relieve behavioral symptoms. Physical and affective assessments are components of the protocol along with pharmacological and nonpharmacological interventions. Analgesics should be used before psychotropic medications. Psychotropic medications are often necessary, if the resident's problem is manifested as behavioral symptoms. Treatment with a psychotropic medication may cease behavioral symptoms but does not provide pain relief.

Dementia and behavioral disturbances are linked as evident in the literature analysis. Behavioral disturbances can and should be assessed for unmet needs such as environmental stresses or physical needs of a resident with dementia. Health care providers routinely receive little training in the direct care management of behavioral disturbances in residents with dementia. Sparse, empiric data from clinical trials are accumulating to indicate that behavioral problems can be effectively managed with nonpharmacological interventions. The American Geriatrics Society and American

Associations for Geriatrics Psychiatry (2003b) indicated that nursing home staff should be educated to observe and report ongoing changes in resident's behaviors. The residents with new onset of or changes in behavioral symptoms but without immediately dangerous behaviors may be appropriately observed and evaluated without implementation of specialized treatments. Behavioral interventions could be implemented.

The American Geriatrics Society and American Associations for Geriatric Psychiatry (2003b) state behavioral symptoms should be described in terms that identify and quantify observable verbal, nonverbal, and physical behaviors through documentation. The Minimum Data Set is routinely used, but is inadequate to identify all residents with behavioral symptoms. Various mood and behavior assessment tools have been use in conducting studies as evident in the literature review. The assessment tools are chosen based on the desired outcomes of the clinical trial. There is no single tool that is used universal in clinical trials that are comprehensive.

IMPLICATIONS FOR NURSING PRACTICE

Dementia is a serious public health problem with increasing prevalence because of the aging of the population according to Lyketsos et al (2002). Dementia is characterized by global cognitive decline sufficient to affect functioning. It is a chronic illness with seriously disabling effects for residents, their families and, society.

Determining whether or not a particular behavioral disturbance is a problem involves determining the nature and severity of the behaviors in question and the effects of those behaviors. A comprehensive behavior management plan is necessary for behaviors that occur frequently. According to Kaplan and Hoffman (1998), health care provides caring for a resident with behavioral disturbances can benefit by utilizing a

systematic approach. Kaplan & Hoffman explains the five P's to a behavioral management plan as follows (p. 229-230):

1. Define the **problem** by describing the behavior
2. Learn about the **person** through medical evaluation and family interviews
3. Brainstorm **possible** causes and triggers
4. Develop a management **plan**
5. **Pass** it on

Step one is defining the problem by describing the behaviors. The goal of behavior management plan is to reduce the incidence of problematic behaviors. The resident with dementia who has behavioral disturbances cannot change. Health care providers observe behavioral disturbances carefully and identify specific problems. Documentation of behaviors is reviewed to determine the intensity, duration, and frequency of the behavioral disturbances. Factors regarding what takes place before and after the behavior problems occurs and what interventions seem to be successful in claming the resident should be documented. Review process indicates whether the changes develop over time and whether there is a pattern to the behaviors disturbances. (Kaplan & Hoffman, 1998)

Step two involves learning more about the person (resident) through medical evaluation and family interviews. Behavioral disturbances represent attempts to communicate needs or to express distress. Health care providers should inquire into triggers related to the resident's anxiety or distressed along with what provides relief. (Kaplan & Hoffman, 1998)

Step three is to brainstorm for possible causes. Brainstorming is conducted during the case management conference. Case management conference consists of family members and health care providers involved in the resident's care. Discussions are related to identifying behavioral disturbances, precipitating triggers, and relevant characteristics of the resident. Precipitating triggers may include physical environment, pain, delusions, and health care provider's behaviors. (Kaplan & Hoffman, 1998)

Step four involves developing a plan. The comprehensive behavioral management plan addresses all of the precipitating triggers identified related to the behavioral disturbances. Interventions are based on characteristics knowledge of the resident and successes of the present caregivers and family members. All health care providers are informed of the behavioral management plan. Current health care provider staffing and resource can accommodate the implementation of the interventions. Behavioral management plan is implemented, evaluated, and modified according to the responses of all involved in the case. (Kaplan & Hoffman, 1998)

Step five ensures passing information on. Health care providers need to communicate interventions and techniques that effectively work during bathing, dressing, and other activities. Communication is the key to success between nursing assistant and nurses. Interventions should become part of the resident's care plan. (Kaplan & Hoffman, 1998)

IMPLICATIONS FOR EDUCATION

Introduction

This project was designed to provide education for health care providers who are involved in the care of elderly individuals with behavioral disturbances related to

dementia in rural long term care facilities. Health care providers can obtain a better understanding of the prevalence of behavioral disturbances related to dementia through education. Education sessions introduced a systematic approach to evaluate and implement appropriate interventions for managing specific behavioral disturbances related to wandering, physically abusive behavioral symptoms, verbally abusive behavioral symptoms, sexual inappropriate behavioral symptoms, social inappropriate behavioral symptoms, and resists to basic care. Through education and experience, health care providers can become more confident and competent in dealing with behavioral disturbances.

Health care providers were presented with information regarding assessment and interventions related to behavioral management for an elderly individual with dementia. The following is a sample of some of the material taught in two separate sessions.

Assessment of Behavioral Problems

Identifying patterns of behaviors over time may clarify the underlying causes of problem behaviors. Factors to consider are time of day, nature of the environment, and what the resident and others were doing at the time as stated by the Center for Medicare & Medicaid Services (2002).

Communication with a resident with dementia can be a difficult task. Robinson, Spencer, & White (1998) reports often in early stages of dementia, residents have trouble finding the words to express their thoughts, or are unable to remember the meaning of simple words or phrases. In the later stages of dementia, it can become more difficult to understand the resident if speech is more garbled and nonsensical. When a resident

cannot comprehend what is being said, or find the words to express his own thoughts, it can be frustrating for the resident and the health care providers.

Environmental conditions can have a profound effect on residents' behaviors. Kaplan & Hoffman (1998) report environments that support people as they age promote wellness and eliminating environment elements that could cause accidents are preventive interventions. Achieving such a setting of an environment must be given priority by all nursing facilities.

The onset of acute illness and/or the worsening of a chronic illness can cause a change in behaviors. Often identification and treatment of the illness can resolve disruptive behaviors. Sensory impairment of vision or hearing can lead to disruptive behaviors.

Behavioral Management Interventions

A comprehensive behavioral management plan should be developed as soon as possible after completion of the assessment of the resident's behaviors. Health care providers should determine a plan that incorporates the values and preferences of the resident and family along with the consideration given to comorbid conditions.

The Minimum Data Set classifies behaviors into five types: wandering, physically abusive behavioral symptoms, verbally abusive behavioral symptoms, sexual inappropriate behavioral symptoms, social inappropriate behavioral symptoms, and resists to basic cares wandering behavioral. Specific coping interventions were discussed regarding management for each type of behavioral disturbances.

Documentation

Monitoring of resident's behavior and response to interventions must be documented. Elements of a documentation for monitoring behaviors consists of the following: a) the date the behavior occurred; b) the time the behavior occurred; c) the intensity of the behavior; d) the location of the behavior; e) the duration of the behavior; f) the activity the resident was engaged in when the behavior occurred; g) the approach used by staff to handle the situation; h) the result of using this approach; i) the behavioral goal accomplished; and j) the initials of the staff member reporting (Graham, no date, p.16). Documentation of this information provides the interdisciplinary team with the information necessary to evaluate what interventions are working and what interventions need to be modified in the care plan based upon patterns of behavior identified and potential triggers.

IMPLICATIONS FOR NURSING RESEARCH

Procedure Section

Population and Sample

Data was collected from a health care provider in a rural long term care facility located in southwestern North Dakota and northwestern South Dakota. A random sampling of employed health care providers, who provide care for a resident with behavioral disturbances related to dementia, had equal opportunity to participate in the project.

Health care providers gave permission by participating in the project. Participation consisted of attending the education classes and agreeing to take a pretest and posttest. The education classes were held as part of the long term care facility's educational in-services.

Project Design

The project design was qualitative in nature. As stated in Polit & Hungler (1999), qualitative research is a flexible approach to the collection and analysis of data, because it is impracticable to define the flow of activities precisely. The general topic was narrowed and clarified on the basis of self-reflection and discussion with colleagues. Project design evolved as the course of data collection occurred. The project design allowed for a full range of beliefs, feelings, and behaviors to be expressed through discussions and observations. Polit & Hungler explain qualitative research assists in shaping nurses' perceptions of a problem or situation and their conceptualizations of potential solutions.

Data Collection Methods and Procedures

In preparation for the educational sessions, the researcher presented a power point presentation regarding the prevalence behavioral disturbances related to dementia along with systematic approach to evaluate and implement appropriate interventions for managing specific behavioral disturbances to the rural health education consortium. Rural health education consortium consisted of administrators, director of nurses, and educator from the long term care facilities. For the administrators that were not present, an individual meeting was held. Permission to conduct the project was obtained from the long term care facilities administrators.

A power point presentation regarding the prevalence behavioral disturbances related to dementia along with systematic approach to evaluate and implement appropriate interventions for managing specific behavioral disturbances was presented to the physicians providing care in the involved long term care facilities. The support of the

physicians was obtained to present the management of behavioral disturbance in the long term care facilities.

Education session notifications were posted in the long term care facilities two weeks prior to the actual session date. These education sessions were conducted as part of the monthly education in-services. Health care providers were paid by the long term care facility employer. Health care providers gave their permission to participate in the project by attending the in-service and agreeing to take a pretest and posttest. Each of the two sessions was held at three different rural long term care facilities on different dates.

The first session for the power point presentation addressed the prevalence and diagnosis criteria for dementia; defining behavioral disturbances; prevalence of behavioral disturbances; systematic approach to behavioral management; assessment of behaviors; goals pertaining to interventions; and documentation. Refer to Appendix A. Discussion, comments, and questions were addressed at the session.

The second session for the power point presentation included specific interventions to implement for managing behavioral disturbances related to wandering, physically abusive behavioral symptoms, verbally abusive behavioral symptoms, sexual inappropriate behavioral symptoms, social inappropriate behavioral symptoms, and resists to basic cares; guidelines for documentation; and samples of behavioral management charting. Refer to Appendix B. Discussion, comments, and questions were addressed at the end of each session.

A pretest was administered during this project to explore the participant's knowledge of the prevalence of behavioral disturbances related to dementia along with systematic approach to evaluate and implement appropriate interventions for managing

specific behavioral disturbances prior to the educational session. The pretest was developed based on the material presented at that session. A multiple choice questionnaire design was used in the first session. Refer to Appendix C. An open ended questionnaire design was used in session two. Refer to Appendix D.

An identical posttest was conducted to evaluate the participant's knowledge of the prevalence of behavioral disturbances related to dementia along with systematic approach to evaluate and implement appropriate interventions for managing specific behavioral disturbances at the end of the educational session. The posttest results were compared with the pretest results. The posttest included a comment section.

Results

Total participates in the pretest of the first session included 18 license nurses and 15 other health care providers. Of these participates 16 license nurses and 15 other health care providers completed the posttest. The pretest scores for the license nurses were 73% compared to a posttest score of 90%. The pretest scores for the other health care providers were 73% compared to posttest score of 87%.

Total participates in the pretest of the second session included 10 licensed nurses and 22 other health care providers. Of these participates 8 license nurses and 13 other health care providers completed the posttest. One facility received the in-service but did not participate in taking the pretest and posttest as requested. The pretest scores for the license nurses were 74% compared to a posttest score of 88%. The pretest scores for the other health care providers were 76% compared to a posttest of 95%.

The results of project did reflect an increase percentage pertaining to the scores on the posttest compared to the pretest. General discussions following each of sessions

indicated a better understanding regarding dementia and interventions for behavioral management.

SUMMARY AND RECOMMENDATIONS FOR FURTHER STUDIES

An identified limitation to the project includes the small sample size regardless of the sessions being held in three different locations. At one of the location, health care providers during the second session did not follow the instructions to the pretest or posttest. The pretest and posttest from this session was not reported in the results. According to Polit & Hungler (1999), data collection and analytic procedures that rely on subjective judgment could suffer in terms of reliability and generalizability if the sample size is small.

Another identified limitation to the project was the environment that the sessions were conducted in. The conditions were not conducive for an ideal learning environment. Some of the health care providers were on duty which lead to coming in later or leaving early. Disruptive noise from overhead paging or call lights ringing were presented in two of the long term care facilities. Learning would be enhanced if the sessions were conducted outside the long term facility to decrease the number of disruptions.

Health care providers' perception of test taking can affect their anxiety level. At one long term care facility the health care providers started discussing the format of the second session test. Several of the health care providers became apprehensive in the test taking process. The project researcher recognized the apprehensive of health care providers related to the test taking process. The health care providers were less apprehensive with taking a test that was in a multiple question format compared to the

open end question format. The open end question format did generate more discussion among the health care provider.

The project researcher recommends conducting comprehensive education in-service as a half or full day instead of two sessions a month apart. The sessions were conducted as separate sessions on the request of the employers of the long term care facilities to reduce cost. Education in-service provided in one longer session would reduce disruptions and enhance the learning environment. The one longer session would provide opportunity for adequate test taking time, in depth case discussion, and questions.

Care of an elderly individual with dementia requires a systematic approached to the management of behavioral disturbances. Health care provider's assessment includes physiological and non physiological factors that may be causing the behavioral disturbances and vocalizations. A comprehensive management plan for an elderly individual with behavioral disturbances related to dementia needs to address all of the identified triggers by health care providers and family members. Comprehensive management plans should be implemented, evaluated, and modified according to the effect of the interventions and health care providers' observations.

Health care providers who attend educational in-services can develop a better understanding of the disease process as well as appropriate interventions to implement for specific behavior disturbances. Health care providers can become more confident and competent in providing care to residents with behavioral disturbances through education and experience. Therefore, health care providers can make a difference in the quality of life of a resident in a long term care facility through the application of a comprehensive behavioral management plan.

Appendix A:

Session One

Power Point Presentation

Behavior Management in Residents with Dementia

By
Rose Bergquist

Introduction

- AD most common dementia in adult life
- Annual cost for caring for a resident is $35,000 to $47,000
- Currently between 1.3 to 1.6 million residents living in our nations nursing homes
- Projections are the numbers will double by 2030 and triple by 2050
- 90% of residents with dementia display disruptive behaviors – *"Behavioral Problems"*

What Is Dementia of Alzheimer's Type According to the DSM IV?

- The development of multiple cognitive deficits manifested by both:
  - Memory impairment (impaired ability to learn new information or to recall previously learned information)

What Is Dementia of Alzheimer's Type According to the DSM IV?

- One (or more) of the following cognitive disturbances:
  - Aphasia (language disturbance)
  - Apraxia (impaired ability to carry out motor activities despite intact motor function)
  - Agnosia (failure to recognize or identify objects despite intact sensory function)
  - Disturbance in executive functioning

What Is Dementia of Alzheimer's Type According to the DSM IV?

- Significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.
- Gradual onset and continuing cognitive decline.
- Not due to any other central nervous system conditions, delirium, major depressive disorder or schizophrenia.

What Is Dementia of Alzheimer's Type According to the DSM IV?

- With early onset: If onset is at age 65 years or below
- With late onset: If onset is after the age 65 years

What Is Dementia of Alzheimer's Type According to the DSM IV?

- Without Behavioral Disturbance: If the cognitive disturbance is not accompanied by any clinically significant behavioral disturbance.
- With Behavioral Disturbance: If the cognitive disturbance is accompanied by a clinically significant behavioral disturbance (wandering, agitation)

Centers of Medicare & Medicaid Services Define Behaviors

Wandering:

* Locomotion with no discernible, rational purpose (Do not include pacing).
* Oblivious to his or her physical or safety needs.

Centers of Medicare & Medicaid Services Define Behaviors

Verbally Abusive Behavioral Symptoms:

* Other residents or staff were threaten, screamed at or cursed at.

Centers of Medicare & Medicaid Services Define Behaviors

Physically Abusive Behavioral Symptoms:

* Other residents or staff were hit, shoved, scratched, or sexually abused.

Centers of Medicare & Medicaid Services Define Behaviors

Socially Inappropriate/Disruptive Behavioral Symptoms: Includes disruptive sounds, excessive noise, screams, self-abusive acts, or sexual behavior or disrobing in public, smearing of food of feces, hoarding, rummaging through other's belongings.

Centers of Medicare & Medicaid Services Define Behaviors

Resists Care: Resists taking mediations, ADL assistance such as help with eating, dressing or bathing.

Center for Medicare & Medicaid Services (January 2004)

Residents in long term care facility

- 60% will experience agitation
- 42% will experience irritability
- 38% will experience motor restlessness
- 36% will experience disinhibitions
- 23% will experience depression

Nursing Facility Survey Program for ND Department of Health

- Since the implementation omnibus budget reconciliation act
- Decrease in restraint usage- 0.9% compared to 7.8%
- Behavioral symptoms affecting others- 26.6% compared to 19.7%
- Symptoms of depression- 29.4% compared to 12.4%

Nursing Facility Survey Program for ND Department of Health

- Prevalence of antipsychotic drug use in the absence of psychotic or related conditions is reported to be 28.3% compared to 21.4%

Effects of Disruptive Behaviors

- Effects on other residents
- Stress experienced by other residents and staff
- Increased falls and injuries
- Economic costs- property damage and staff burn out, absenteeism, and turnover

Effects of Disruptive Behaviors

- Emotional deprivation such as isolation of the resident
- Use of physical or pharmacological restraints

Systematic Approach to Behavioral Management

Step 1 Define the ***problem*** by describing the behavior. Goal is to reduce the number of incidence.

Step 2 Learn about the ***person*** through medical evaluation and family interviews;

Systematic Approach to Behavioral Management

Step 3 Brainstorm *possible* causes and triggers (Case management conferences)

Step 4 Develop a management *plan* (Comprehensive)

Step 5 ***Pass*** it on. (Communication and sharing of interventions)

On to Assessment

- Social history on admission to the long term care facility.
- Interview spouse, caregiver, family members, and close friends.

Shall We RAP

- Total of 18 RAPs
- Problem-orientated framework for evaluation of potential problems
- Important to think of why the RAP was triggered
- Keep asking Why? What? When? How?

Continue to Assess and RAP

A person reacts because there is something awry in the physiology, safety, love, belonging, or self-actualization

Assessment of Behavioral Problems

- How did behaviors develop over time? Were problems signs evident in the resident's stay or even earlier in the resident's life?
- Does the behavior endanger the resident or others? If so, how does it endanger the resident and others?

Assessment of Behavioral Problems

- Has a resident experienced change such as movement to a new unit, assignment of new non-licensed direct care staff to the unit, changes in medications, withdrawal from a treatment program, and decline in cognitive status?

Assessment of Behavioral Problems

- Are behaviors problems related to daily variations in functional performance and how?
- Does it lead to difficulties dealing with people and coping in the facility?
- What is the level of dementia? Does the resident have difficulty with impulse control, judgment, or misunderstanding? Is the resident able to tell staff what is wrong?

Assessment of Behavioral Problems

- How do caregiver's procedures affect the resident? Is the care giving procedure too complex and confusing, unfamiliar, or too fast for the resident? Are there too many caregivers?
- Does the presence or absence of other persons precipitate an event?

Assessment of Behavioral Problems

- Was a combative act prompted by paranoid delusions about another's motives or actions?
- Did recent loss of loved one, change in staff, an intra-facility move, or placement with a roommate with whom the resident cannot communicate lead to disruptive behavioral symptoms?

Assessment of Behavioral Problems

- Does the resident have an unresolved mood state or relationship problem that may lead to behavioral symptoms?
- Does the resident experience frustration because of rejections by family?

Assessment of Communication

- Do caregivers speak too fast and/or use complex sentences?
- What are the communication abilities of the individual?

Assessment of Communication

- Is a friendly, calm approach with good eye contact used in providing activities of daily living for the resident?
- Is each step explained?

Assessment of Environment

- Is staff sufficiently responsive?
- Does staff recognize stressors for the resident and early warning signs of problem behavior?
- Does staff follow the resident's familiar routing?

Assessment of Environment

- Does noise, crowding or dimly lit areas affect resident's behavior?
- Are other residents physically aggressive?
- Is the physical space in which the resident living to large?
- Is there consistency in the daily structure?

Assessment of Environment

- Is there too much stimulation going on in the environment such as music playing during a conversation, too many people around, or too much noise?
- Is there too much clutter in the environment for the resident to absorb?

Assessment of Illnesses/Conditions

- Can physical health factor such as pain or discomfort from physical conditions related to arthritis, constipation, or headache be identified?

Assessment of Illnesses/Conditions

- Can an acute illness such as urinary tract infection, pneumonia, other infections, fever, hallucination, delusions, sleep deprivation, fall with physical trauma, nutritional deficiencies, weight loss, dehydration, electrolyte disorder acute hypertension, or thyroid disorder be identified?

Assessment of Illnesses/Conditions

- Can any changes in vision, hearing, and ability to communicate or understand others be identified?
- Can worsening of a chronic disorder such as congestion heart failure, diabetes, psychosis, Alzheimer's disease or other dementia, cerebral vascular accident, or hypoglycemia for a diabetic be identified?

Assessment of Illnesses/Conditions

- Can symptoms of depression such as impaired concentration, memory loss, apathy, or sleep disturbances be identified?
- Are there any recent changes or additions of medications involved?

Behavioral Management Intervention Goals

- Promote security in a predictable, supportive but non-demanding environment.
- Built self-esteem by paying special attention to 'failure-free environments' that ensure success without being demeaning or condescending.

Behavioral Management Intervention Goals

- Build the resident's self-respect; the resident should not be made to feel less valued because of diminished skills and abilities. Residents with Alzheimer's disease may express their frustration with statements such as "I am just a big dummy", or "I can't do anything right".

Behavioral Management Intervention Goals

- Plan activities and structure the environment to help the resident develop interpersonal relationships that increase their sense of community and act as a buffer against loneliness and isolation.

Behavioral Management Intervention Goals

- Accept unique personality characteristics and behaviors that define the resident.
- Build a caring atmosphere in which the resident learns to trust staff.
- Support remaining skills and find ways of providing opportunities for success.

Behavioral Management Intervention Goals

- Maximize functional abilities by allowing residents to continue to do as many self-care tasks as they can manage without regard to how long it takes or how well it is done

Behavioral Management Intervention Goals

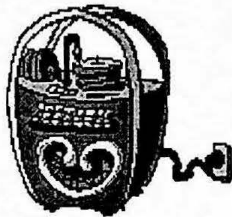
- Support remaining skills and find ways of providing opportunities for success.
- Provide residents with the opportunity to be useful to contribute to the nursing facility community.

Behavioral Management Intervention Goals

- Support family involvement with the resident; provide specific guidelines, education, and resources to increase the family members' knowledge of ways to support the resident in the facility

Why should we do Documentation?

- Monitoring of the implementations of behavioral management plan is necessary to be able to evaluate what is working for the resident and what is not



Documentation should include:

- Date behavior occurred.
- Time the behavior occurred.
- Intensity of the behavior.
- Location of the behavior.
- Duration of the behavior.
- Activity the resident was engaged in when the behavior occurred.

Documentation should include:

- Approach used by staff to handle the situation.
- Result of using this approach.
- Behavioral goal accomplished.
- Initials of the staff member reporting.

Documentation Forms

- Review of several different types of documentation forms
- Narrative charting

Caregivers

- Caregivers can make a difference in the quality of life of residents in a long term care facilities through application of behavioral management techniques.

Conclusion

- Comments
- Questions

APPENDIX B:

Session Two

Power Point Presentation

Behavioral Management in Residents with Dementia

By
Rose Bergquist

Caregiver's Philosophy

- Very little is known about the experience of a dementia person. Some seem fully aware, some are partially aware, some are aware in moments, and some are not aware at all.

Caregiver's Philosophy

- The dementia person needs ANOTHER to have personhood continue. The dementia person requires an environment for being a person. The further the dementia process, the more the need for person-work.

Caregiver's Philosophy

Problems are the direct result of feeling lost; problems exist because others cannot enter into their world. People they do not know call them names, expect things from them, and otherwise exceed their capacities.

Caregiver's Philosophy

- There may be ways of rediscovering identity and even enjoying the decline. The later position may be an act of faith; the idea that the person can be sustained only by having an "us" makes a difference.

Caregiver's Philosophy

- Communication with a dementia patient can be considered like a tennis match where the goal is to keep the ball going. What is the person actually saying at any given time? Fostering empowerment involves being a good observer, waiting for the right path to open up, and for the right response.

Caregiver's Philosophy

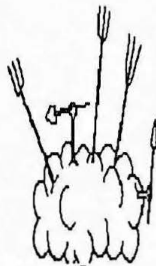
- "Violence is the voice of the unheard." Behavior problems are adaptive attempts of the person to avoid a confrontation with the reality of the condition and its limits. What does the behavior mean? It may be a valid response to the phenomenological world. It comes from fear or frustration.

Caregiver's Philosophy

- Values of the life story – The photo album of the person. This is the narrative, the who-they-are of the person. The process alone is important; so is the information. Do not be concerned about the narrative truth .

Caregiver's Philosophy

- There is always a battle between the desire to keep safe and to let the resident go on his or her own



Care-Giver Consideration/ Interventions

- Consistent staffing assist in establishing a rapport and sense of trust with the resident.
- Implement consistent routines for activities, such as bathing, meals, and getting ready for bed.
- Identify staff members who work well with the resident.

Care-Giver Considerations/ Interventions

- Be aware that shift changes are often stressful times and provoke anxiety because of increased noise and activity level.
- Plan time to socialize with the resident.

Care-Giver Considerations/ Interventions

- Implement R.E.S.P.E.C.T. model- Recognize, Empathize, Support, Prevent, Enhance, Care, and Take time.

Care-Giver Considerations/ Interventions

- Recognize that angry or agitated behaviors are often symptoms of dementia and are not deliberate responses.
- Be careful not to reinforce unwanted or inappropriate behaviors by overreacting or by gesture, behaviors, or manner of communicating with residents.

Communication Interventions

- Speak in a clam, normal tone of voice.
- Approach the resident from the front and slowly.
- Conduct task into short steps briefly explaining each one.
- Use repetition.

Communication Interventions

- Reassure resident frequently about where he or she is and why.
- Try written reassurance for mildly impaired resident.
- Try not to confront or argue with the person.

Communication Interventions

- Check if hearing aids and eyeglasses are in place and functional.
- Limit the number of staff to redirect the resident.
- Increase the resident trust by humoring and joking.

Communication Interventions

- Approach the resident in a casual non-threatening manner.
- Call the resident by his or her name.
- Identify yourself. Approach the resident from the front and slowly.
- Avoid asking questions that relay on memory.

Communication Interventions

- Explain and prepare the resident regarding what is to done using simple, clear, short sentences. Use repetition.
- Implement ways for the resident to communicate with you such as using a bell or using the quite symbol and having the resident come to you, if capable, instead of yelling across the room.

Communication Interventions

- Reasoning with residents frequently leads to frustration and anger.
- Try not to express your anger or impatience verbally or with physical movements such as shaking of head or pointing fingers.

Communication Interventions

- Give praise and encouragement as the resident completes each task.
- Do not talk down to the resident or treat them as children.

Environmental Interventions

- Create a warm and familiar environment that resembles a person's home, with spaces for the living room and kitchen.
- Provide consistency within the environment, maintain routines and don't change the furniture arrangement.

Environmental Interventions

- Limiting the physical space. Encourage small groups for dining and activities for example four to six residents.
- Avoid excessive stimulation such as playing music during conversation. Keep the noise level down.

Environmental Interventions

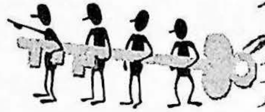
- Utilize orientation materials or cues such as signs for their bedroom and bathroom.
- Use calendars, clocks, labels and newspapers for orientation to time.

Environmental Interventions

- Be alert to sensory environment such as colors, patterns of the tiles, and visual contrast between the floors and the walls.
- Provide adequate lighting and avoid glare.
- Equip doors and gates with safety locks.

Environmental Interventions

- Equip doors and gates with safety locks.
- Avoid long distances for the resident to ambulate from the bedroom to the dining room.



Environmental Interventions

- Prevent falls by avoiding uneven walking surfaces, proper handrails available, furniture that is not too soft, low, too deep or unstable, and proper fitting shoes/slippers and clothing.

Therapeutic Interventions

- Aroma Therapy to assist in claming the resident.
- Install essential oils diffusers in hallway and common rooms.
- Use behavior management, weight loss, insomnia, pain, sensory stimulation and memory stimulation.

Aroma Therapy

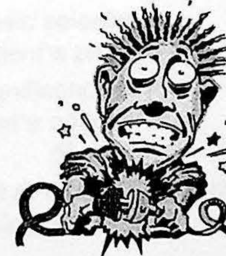
- Relax
  - Eucalyptus Spearmint
  - Cedar wood Sage
  - Blue Lavender Palma Rosa

Aroma Therapy

- Sleep
  - Lavender Vanilla
  - Chamomile
  - Sweet Bay Rose

Aroma Therapy

- Awake
  - Bergamot Coriander
  - Orange Ginger
  - Grapefruit Peppermint



Therapeutic Interventions

- *Adapted recreation.*
  - Gardening/adapted gardening.
  - Open recreation in leisure lounge or activities areas.
  - Special recreational events.
  - Folding Laundry such as towels.
  - Computer games/table games such as puzzles.

Therapeutic Interventions

- Free time kitchen activities such as doing dishes, setting/clearing the table, and preparing snacks.
- Community recreational outing such as shopping, lunch or community events.

Therapeutic Interventions

- Leisure Education
  - Leisure education for staff and families.
  - Re-education of residents on how to use recreational items.
  - Leisurely Look Newsletter Program to raise awareness of recreational opportunities and self-expression.

Therapeutic Interventions

- Recreational
  - Exercise to music
  - Stimuli of hands and feet
  - Cognitive stimuli
  - Feelings group
  - Fall prevention
  - Social skills group
  - Walking groups
  - Balance and strength group
  - Therapeutic cooking group
  - Finger food group
  - Bakers

Therapeutic Interventions

- Exercise to music therapy.
- Morning walking group.
- Cooking group.
- Massage therapy to hands and feet.
- Tapes.
- Folding towels.

Music Therapy

- Individualized music selection according to resident's preferences.
- Determine the significance of music before the resident's onset of behaviors.
- Interview resident or a family member to determine music preference.

Music Therapy

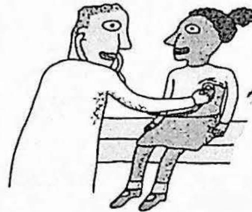
- Try to obtain a favorite album from the resident's personal collection that can be transferred to audiotape and returned to their collection.
- Optimal effectiveness is achieved by implementing the music 30 minutes before the onset of behaviors.

Music Therapy

- Ongoing evaluation should be conducted to determine the resident's response.
- Music that is pleasing to one resident may be annoying to another. Therefore, other residents in the areas should be assessed for their response to the music.

Wandering Interventions

- Recent medical evaluation, particularly if wandering begins suddenly. Consider possible physical causes such as illness, fever, hunger, pain, and swelling.



Wandering Interventions

- Allow the resident to wander in a safe and secure environment.
- Remove or camouflage environment stimuli. Remove items that may trigger desire to go out such as shoes, coat, or purse. Hide doorknobs behind cloth panels.
- Clearly label the resident's room.

Wandering Interventions

- Place familiar objects, furniture, and pictures in surrounding.
- Decrease noise levels and number of people interacting with resident at one time.
- Place lines on the floor.
- Take for a drive.

Wandering Interventions

- Clearly label resident's room.
- Install monitors and alarms.
- Provide a wanderer's cart to push.
- Distract with conversation, food, drink, or activities.
- Take for walks.
- Place lines on the floor.

Wandering Interventions

- Put up stop signs or police tape across the door.
- Create a structured activity schedule such as folding laundry, baking, or other activities that the resident enjoys. Consider past skills and interests
- Implement a bowel and bladder program,

Wandering Interventions

- Limit activities to 20-30 minutes or less, depending on level of impairment.
- Try placing a large, digital clock by the bed to orient person to time

Verbally Abusive Behavior Interventions

- Minimize hunger by providing snacks.
- Schedule rest periods to avoid fatigue.
- Play soft, calming, relaxing music or sound such as rainfall or waves.
- Read to resident.
- Activity plan to reduce boredom and frustration.

Verbally Abusive Behavior Interventions

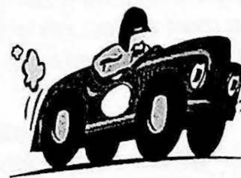
- Implement bowel and bladder schedule to minimize incontinence.
- Repositioning every two hours if person is bedridden.
- Provide massage therapy.
- Provide animal assisted therapy.

Physically Abusive Behavior Interventions

- Alternate quiet time with more active time.
- Make sure resident is comfortable.
- Plan outing, activities when person is rested.
- Keep daily routine if possible. No surprises.

Physically Abusive Behavior Interventions

- Prevent or reduce aggression by avoiding known triggers, and environmental stressors such as invasion of personal space, fatigue, fear, discomfort, and loss of control.



Physically Abusive Behavior Interventions

- Remove resident from stressful situations, person(s), or place.
- Try music, massage, and quiet reading as way to clam resident.
- Use gentle physical touch to clam resident.

Yells "get me out of here" Over stimulated

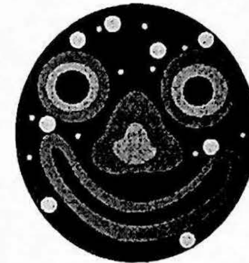
- Use calming music or relaxation.
- One staff communicates.
- Relocate in quieter area but do not isolate.
- Arrange phone calls from family or friends.
- Provide nature type activities.

Repetitive, Picking or Tapping-Under Stimuli

- Involve in small group social activity.
- Locate near activity areas.
- Use headphones to listen to music or story.
- Pet therapy.
- Provide simple, pleasures and tactile items.

Sexually Inappropriate Behavior Interventions

- Modified clothing.
- Try music or white noise therapy.
- Avoid triggers such television, music or contact with certain other residents or staff members.



Sexually Inappropriate Behavior Interventions

- Attempts to distract and redirect behavior with conversation, food, drink, or other activities.
- No standard pharmacologic treatment for hypersexuality (Provera, Lupron).
- Good communication among staff to provide consistency in dealing with the behaviors.

Sexually Inappropriate Behavior Interventions

- Proper assessment and detective work regarding the resident's history from a reliable informant to determine the root of the problem.
- Remember even the most impaired, dependent residents with dementia retain adult feelings and should be treated as adults.

Bathing Interventions

- Determine the best time of day to bath the resident. What time of day did the resident bathe prior to entering into the nursing home? Did the resident take baths or showers?

Bathing Interventions

- Have the bathroom warm, low lit, and inviting.
- Have the bathroom warm, low lit, and inviting.
- Approach techniques set the tune. Try "Lets get freshened up for the day" instead of "Do you want a bath now?"

Bathing Interventions

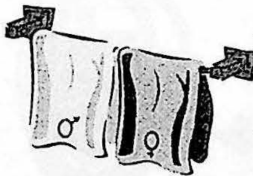
- Start bathing in the least sensitive area first. Start with the legs and feet, then the arms and trunk, and peri-care and lastly the face.
- Wash the hair last or at a different time. Women like to go the beauty salon. Try a no rinse shampoo applied to a washcloth and gently massage into the hair.

Bathing Interventions

- Distract the resident by singing, playing music, talking, or holding onto a favorite stuff animal.
- Wrap a towel around the shoulder to provide warmth, reassurance, privacy, respect and dignity.

Bathing Interventions

- Consider a towel bath if the above interventions do not work.



Dressing Interventions

- Keep the dressing routine consistent and use simple task techniques to avoid overwhelming the resident.
- Support independence in dressing.
- Have the room warm while dressing.
- Privacy should be provide.

Dressing Interventions

- Show the resident the clothing while introducing the idea of getting dress. If able have the resident assists into choosing the clothing from limited items.
- Avoid interruptions in the morning routines and provide adequate time to dress and get ready for the day.

Eating Interventions

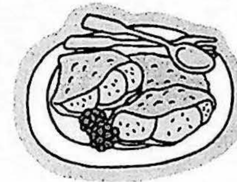
- Simplify and modify foods and dining apparatus.
- Try finger foods.
- Provide soft playing music during meal.
- Use aprons instead of towels.
- Cue by using touch, mirroring and verbal methods.

Eating Interventions

- Have a good dental evaluations regarding fitting of the dentures, gums, and teeth.
- Alter the appearance of the table to signal that the activity is eating by using tablecloth, flowers, place mats, and a basket of napkins.

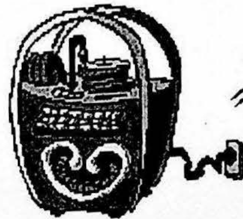
Eating Interventions

- Serve appetizing foods that the resident can tolerate.
- Reduce noise and distractions in the dining area during the meal time. Consider small groups dining according to eating abilities.



Why should we do Documentation?

- Monitoring of the implementations of behavioral management plan is necessary to be able to evaluate what is working for the resident and what is not



Documentation should include:

- Date behavior occurred.
- Time the behavior occurred.
- Intensity of the behavior.
- Location of the behavior.
- Duration of the behavior.
- Activity the resident was engaged in when the behavior occurred.

Documentation should include:

- Approach used by staff to handle the situation.
- Result of using this approach.
- Behavioral goal accomplished.
- Initials of the staff member reporting.

Conclusions

- Comments
- Questions

APPENDIX C:

Session One

Test

Session One Test

Date: ______________________

Position: ____________________

1. What is the percentage of resident with dementia that will experience disruptive behaviors?

   a. 45%.
   b. 70%.
   c. 85%.
   d. 90%.

2. Annual cost for a single resident with Alzheimer's Disease are reported to be:

   a. $35,000 to $45,000.
   b. $50,000 to $55,000.
   c. $55,000 to $60,000.
   d. $70,000 to $75,000.

3. Alzheimer 's disease is diagnosed in about ______ of new cases of dementia in people over 65 years of age

   a. One-fourth.
   b. One-half.
   c. Two-thirds.
   d. Three-fourth.

4. A comprehensive behavioral management plan consists of:

   a. Restraints usages.
   b. Medications administrations and restraint usages.
   c. Utilizing a systematic approach for identifying problems and possible triggers.
   d. Placements in a lock ward in a long term care facility.

5. The worsening of a chronic illness can cause a change in the resident's behaviors.

   a. True.
   b. False.

6. Residents with early onset of dementia may have trouble with:

a. With short-term memory only.
b. With long-term memory only.
c. Finding the words to express their thoughts.
d. Unable to remember the meaning of simple words or phrases.
e. Both C and D.

7. Assessment of behavioral problems includes:

   a. Patterns of behaviors over time.
   b. Time of day.
   c. Nature of the environment.
   d. All of the above.

8. Documentation process is:

   a. Provides a method for on-going monitoring and evaluation of interventions.
   b. Complicated and time consuming for staff.
   c. Should be done by licensed nursing staff.
   d. All of the above.

9. Assessment in the developmental of a behavioral management plan for a resident with a new onset of disruptive behaviors should include:

   a. Social history and onset of acute/chronic illness.
   b. Communication, environment, and behavioral problem.
   c. Environment, communication, behavioral problem and onset of acute/chronic illness.
   d. Behavioral problem, communication, social history, onset of acute/chronic illness, and environment.

10. The health care team in the management of a resident with disruptive behaviors consists of:

   a. Physician, licensed nursing staff, and social workers.
   b. Physician, licensed nursing staff, social workers, and family.
   c. Physician, licensed nursing staff, social workers, family and certified nurse's aides.
   d. Physician, licensed nursing staff, social workers, family, certified nurse's aides, restorative aides, physical therapists, speech therapists, dietary personnel and others that are involved in the care of the resident.

APPENDIX D:

Session Two

Test

Session Two Test

Date: ____________________

Position: __________________

1. List three coping interventions for communication skills:

   a. ____

   b. ____

   c. ____

2. List three interventions related to environmental approaches:

   a. ____

   b. ____

   c. ____

3. List three interventions related to music therapy:

   a. ____

   b. ____

   c. ____

4. List three coping interventions for wandering behavioral symptoms:

   a. ____

   b. ____

   c. ____

5. List three coping interventions for verbally abusive behavioral symptoms:

   a. ____

   b. ____

   c. ____

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