Managing Challenging Behaviors

An Interprofessional Approach to Non-Pharmacological Behavior Management

Presenters

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Disclosure

Robbie Vendrely and Gabriel Ayala have the following financial conflicts of interest to report.

We are paid as part of our salary from Powerback Rehabilitation and Genesis Healthcare for time to develop and present this topic

Objectives

1) Identify common causes of challenging behaviors and best practice strategies for root cause analysis
2) Identify specific management strategies to address and modulate these behaviors
3) Determine strategies for behavior management that can be incorporated into an interdisciplinary care delivery mode

Audience Engagement

What are the challenging behaviors you experience?

Long Term Care Survey Process Updates

Long Term Care Surveyor Guidance Updates (June 29,2022) Effective Oct. 24:

Behavioral Health F949

Behavioral Health Training that is to include topics such as:

- **Person-centered care** and services that reflect the resident's goals for care;
- **Interpersonal communication** that promotes mental and psychosocial well-being;
- **Meaningful activities** which promote engagement and positive meaningful relationships;
- An **environment and atmosphere** that is conducive to mental and psychosocial well-being;
- **Individualized, non-pharmacological approaches to care**;
- Care specific to the individual needs of residents that are diagnosed with a mental, psychosocial, or substance use disorder, a history of trauma and/or post-traumatic stress disorder, or other behavioral health condition; and
- Care specific to the **individual needs of residents** that are diagnosed with dementia

Reference: SOM Appendix PP

LTCP Updates

Unnecessary Psychotropic/PRN use F578

- Inclusion of drugs that affect brain activities associated with mental processes and behavior
- Misdiagnosis of residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which excludes the resident from the long- stay antipsychotic quality measure.
- Investigate potential misdiagnosis under F-tag 641 (professional standards for diagnosis), including CMS audits
- F-tag 658 (Appropriate resident assessment that reflects resident status)
- AND.....

Reference: SOM Appendix PP , QSO 23-05-NH, Fact Sheet

LTCSP Updates

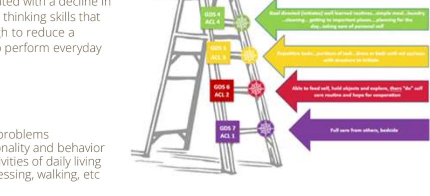
Pharmacy Services F758:

- Added language for surveyors to evaluate if the resident experience **psychosocial harm** related to side effects
- Side effects include sedation, lethargy, agitation, mental status changes, or behavior changes such that cause:
  - Affect resident's ability to perform ADL's and interact with others,
  - Cause withdrawal or decline in usual social patterns,
  - Decreased engagement in activities, and/or
  - Diminished ability to think or concentrate

Reference: SOM Appendix PP

Overview of Dementia

- What is Dementia?
  - It is ***not*** a specific disease
  - A term that describes a wide range of problems associated with a decline in memory or other thinking skills that are severe enough to reduce a person's ability to perform everyday activities
- Primary Symptoms
  - Loss of memory
  - Confusion
  - Communication problems
  - Changes in personality and behavior
  - Difficulty with activities of daily living
    - Bathing, dressing, walking, etc



Global Deterioration Scale (GDS)

- Overview of the stages of cognitive function
- Used to stage/level primary degenerative dementia such as Alzheimer's disease.
- 7 different stages
  - Stages 1-3 pre-dementia stages
  - Stages 4-7 are the dementia stages
- Establish a framework for global treatment goals and approaches that can then be individualized

Crosswalk - Common Cognition Tools

STAGE	Global Deterioration Scale	Adapted FAST Stage	Allen Levels	Mini Mental	BCAT Short Form	BCAT	BIMS
	1 Normal (No Cognitive Change)	1 or 2	Level 6 Planned Activities	28-30	19-21	44-50	13-15
	2 Very Mild Cognitive Decline (forgetfulness)	1 or 2	Level 5 Independent Learning	28-30	19-21	44-50	13-15
	3 Mild Cognitive Decline	3	Level 5 Independent Learning	24-27	16-18	34-43	13-15
Early Stage Dementia	4 Moderate Cognitive Decline (Late Confusional)	4 or 5	Level 4 Goal Directed Activities	19-23	11-15	25-33	0-12
	5 Moderately Severe Cognitive Decline	6 a,b,c,d, or e	Level 3 Manual Actions	0-18	0-10	0-24	0-7
Middle Stage Dementia	6 Severe Cognitive Decline	7 a or b	Level 2 Postural Actions	0-18	0-10	0-24	0-7
Late/End Stage Dementia	7 Very Severe Cognitive Decline	7 c, d, or e	Level 1 Automatic Actions	0-18	0-10	0-24	0-7

Adapted from: Adapted FAST scale; Worchal, 2004, 2010; Burns 2003, GRS Dementia Resource Guide, Brief Cognitive Assessment Tool Training Program

Dementia Stage Characteristics
GDS 4

Early-Stage Dementia

- Goal-directed actions
- Able to complete basic and simple IADLs early in this stage
- Able to learn new tasks, but requires repetition and structure
- Decreased memory of recent occasions or current events
- Difficulty performing complex tasks (e.g., planning a dinner, paying bills, managing finances)
- Optimal performance with structure and familiarity (e.g., memory books, schedules)
- Conversationally verbal, but may have word-finding difficulties
- Can become anxious easily

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Dementia Stage Characteristics GDS 5

Middle-Stage Dementia

- Manual action on objects
- Able to assist with basic ADLs and portions of a familiar task with set-up and cues
- Optimal performance with familiar, repetitive tasks
- Often requires physical, verbal and/or visual cuing to initiate, attend to, or complete a task
- Severely impaired memory of recent events
- Comprehends at word or phrase level
- Cognitive tunnel vision/visual agnosia

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Dementia Stage Characteristics GDS 6

Late-Stage Dementia

- Focused on postural actions – may rock, have a fear of falling, and/or posterior weight shift
- Typically able to feed self, but has difficulty with utensils
- Optimal performance utilizing hand under/over hand techniques
- Significant difficulty understanding/being understood
- Communicates best with simple one-step commands and 90-second response time often paired with non-verbal communication
- Grabs onto items/bars for support
- Behaviors are often a method of communicating an unmet need

Dementia Stage Characteristics GDS 7

End-Stage Dementia

- Responds to sensory stimulation
- May have automatic actions such as moving a body part
- Dependent for all mobility/ADL activities
- Loses ability to sit up independently and progresses to difficulty holding head up
- Communication is usually limited to facial expressions, phonation, and one-word utterances

Behavioral and Psychological Symptom of Dementia (BPSD)

- A spectrum of non-cognitive and non-neurological symptoms of dementia including:
  - Agitation
  - Aggression
  - Psychosis
  - Depression
  - Apathy, etc.
- Significantly impact prognosis and management of dementia
- **Affect up to 97% of community-dwelling patients with dementia**
- Caused by an interaction of biological changes, prior experiences, and current environment

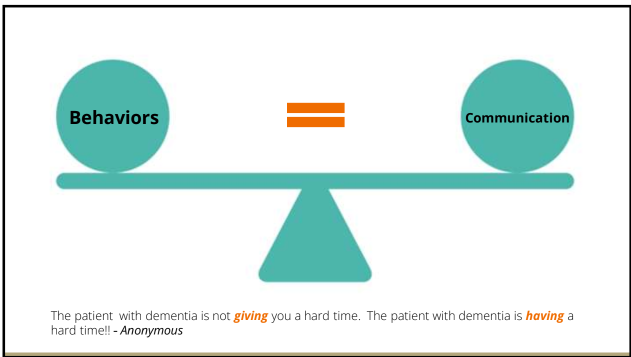
Definition of Behavior

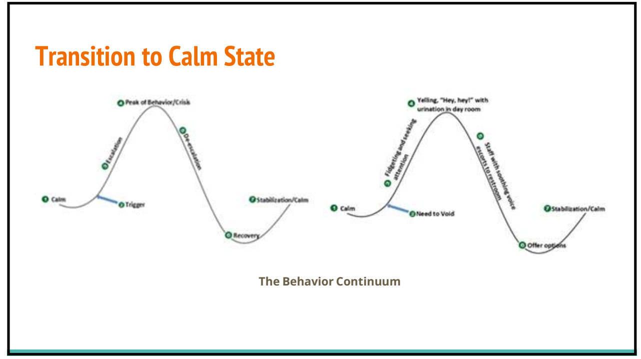
- The manner of conducting oneself involving an action and response to stimulation
- Response of an individual to the environment
  - Environment may include people in the area

Photo credit: Pixabay from Pexels

Challenging Behaviors

- Challenging is ***not*** a synonym for bad behavior, rather, it is behavior that is inadequate, inappropriate or excessive
  - Remember: It is a client's best ability to communicate an unmet need
- Examples of Common Challenging Behaviors
  - Avoidance
  - Withdrawal
  - Hitting/Swinging
  - Pacing
  - Self harm
  - Screaming





Common Internal and External Triggers

Internal triggers:

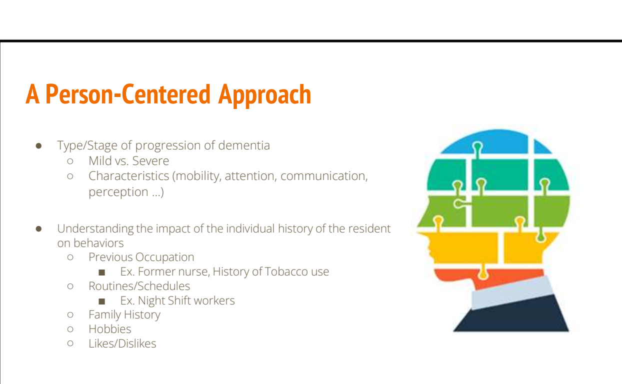
- Emotion (despair, anxiety, fear)
- Medication
- Illness
- Confusion
- Pain/discomfort
- Toileting urge
- Stress

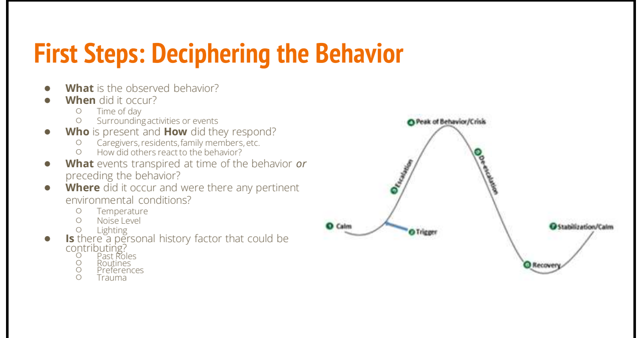
Photo credit: Pixabay from Pexels

External triggers:

- Lack of meaningful activity
- Unpleasant events
- Actions of others
- Demands of others
- Lighting (too bright, dim)
- Noise (loud, quiet)
- Overstimulation

Has medication been considered as a possible cause of the BPSD?





Deciphering the Behavior: Case Study

- **What?** John is disrobing in the dayroom
- **When?** 9:30 AM
- **Who?** 5 other residents and Sally, a CNA
- **Where?** Dayroom
- **History?** Was a night shift worker and always went to bed after breakfast
- **Stage?** Late GDS Stage 5

Next Steps: Management Strategies

General Communication Considerations

- Non-Verbal Behavior
  - Body Language
  - Eye Contact
  - Stance
  - Position
- Announce when and why need to enter personal space
- Respect personal space needs and your position

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Use of Self

Behavior can be impacted by others, both positively and negatively.

Positive impact through use of self is when someone enters the situation with the client and assists them through the situation by

- Staying present through the stressor with emphasis on self awareness
- Mirror
  - Tone of voice
  - Acknowledge distress
  - Control environment as much as possible
  - Stay focused on situation

Photo credit: Wallace Chuck

General Approaches: Response to Behavior

Do…

- Remain calm
- Isolate the situation from past situations
- Set limits
- Be aware of client's body language
- Be clear and consistent
- Listen empathetically, validate
- Provide choices
- Provide quiet time

Don't…

- Threaten
- Overreact
- Challenge the situation
- Make false promises
- Allow anxiety to "freeze" you
- Don't dismiss the person's perception/emotions

Considerations in Determining an Individualized Plan

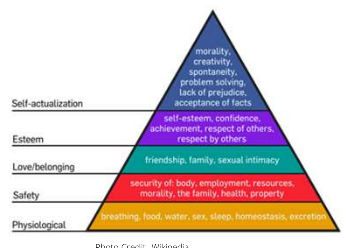


Photo Credit: Wikipedia

Self-Actualization: Does the person have meaningful engagement opportunities

Esteem: Does the person need validation?

Love/Belonging: Are they lonely? Need human contact?

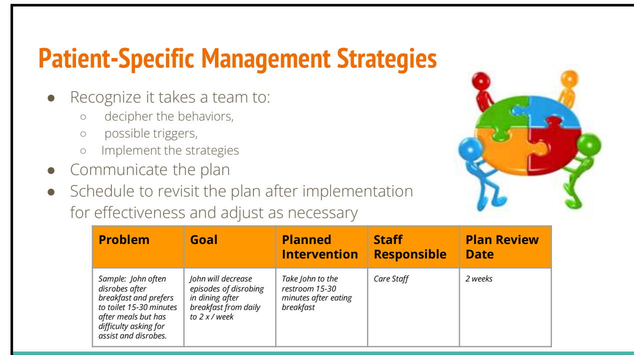
Safety: Does the person perceive a threat?

Physiological: Is the person hungry? In Pain? Ill? Uncomfortable?

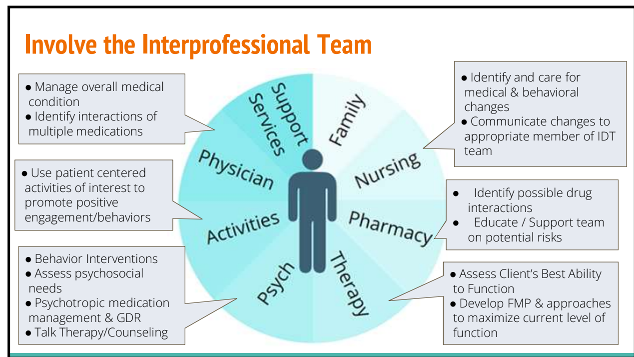
Individualized, Non-Pharmacological Interventions Examples

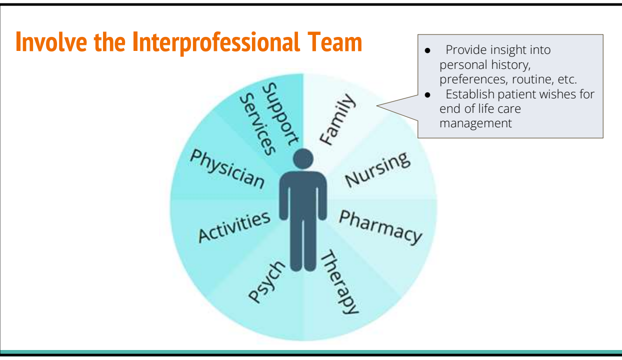
- Sensory Considerations
- Exercise and/or Pain Relief
- Individualized Schedules/Routines
- Meaningful Activities
- Environmental Modifications
- Pets/Animals
- Music, Massage, Aromatherapy
- Activities meeting spiritual needs

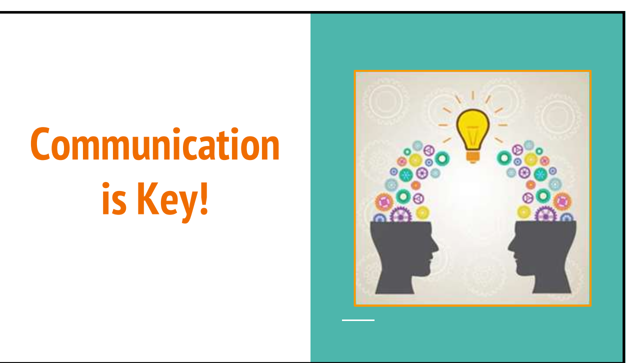
Reference: SOM Appendix PP



Problem	Goal	Planned Intervention	Staff Responsible	Plan Review Date
Sample: John often disrobes after breakfast and prefers to toilet 15-30 minutes after meals but has difficulty asking for assist and disrobes.	*John will decrease episodes of disrobing in dining after breakfast from daily to 2 x / week*	*Take John to the restroom 15-30 minutes after eating breakfast*	*Care Staff*	*2 weeks*







Sharing Strategies

Sample Functional Maintenance Program

Share what works with:

- Interdisciplinary Team
- Family
- Visitors

This is my functional maintenance program. My care team has determined that I am here in my journey through dementia. Use this plan for tips and strategies to interact with me while we work together. If my illness is causing a barrier to care, help me find a better way to complete a task so we can both be successful. Thank you again for all your help and hard work.

communication

- Use concrete words and gestures when communicating with me so I can understand the message.
- Ask me questions with choices. For example: "Do you want to wear your green or your blue sweater today?"
- I can name familiar objects, but I am not able to speak in full, detailed sentences.
- I may often be misunderstood while talking, and I repeat statements.
- I know my spouse and children's names even though I can't recall certain aspects of my life.

activities of daily living (ADL)

- I can feed myself, but please put my food in sight and within reach.
- I am still able to perform parts of my bathing and dressing independently.
- I need help with attention to detail with my self-care.
- Keep my toiletries to a minimum number of items, and place them where I can see them.
- I need cues to begin, continue and stop tasks.

mobility

- I can walk and will do so with a purpose.
- I may not be able to use an assistive device if I haven't used one in the past.
- Because I have tunnel vision, approach me from the front and make sure the path I walk is free of hazards.

swallowing

- I am on the following diet:

activities

- Give me the opportunity to participate in the following:

behavioral

- I live in the immediate situation. Help me reduce feeling impatient, paranoid, and suspicious by:

the following individualized approaches/cues should be used with me:

Case Study: Meet Ruth

- Ruth is a 85 year old female resident of a long-term care facility.
- Recent increase in agitated behaviors
  - Exit seeking in the late afternoon & frequently shaking/banging the front doors
  - Resisting bathing attempts from caregivers

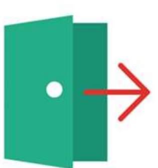
Case Study: Deciphering Behaviors

- **What?** Resists going to shower and hits/resists staff when in shower
- **When?** After Supper
- **Who?** Evening shift nursing and aides
- **Where?** Shower Room (Large Open Area)
- **History?** Former school teacher, mother of two daughters
- **Social?** She was married to a preacher, very involved in her church
- **Interests?** Knitting, Gardening, Listening to Church Hymns, Reading
- **Stage?** Early GDS Stage 5

Case Study: Possible Interventions

Exit Seeking

- Engage Ruth in meaningful activities at this time of day
  - Ex. Knitting, grading papers, gardening, reminiscing book, etc.
- Train staff in validation & redirection approach
- Involve family members with phone calls or recorded messages at certain times of the day
- Provide a safe wandering environment
- Assess environment level: Is it overstimulating? Understimulating?
- Referrals to Rehab to assist with analyzing triggers, communication strategies, task modifications
- Family/Caregiver Education



Case Study: Possible Interventions

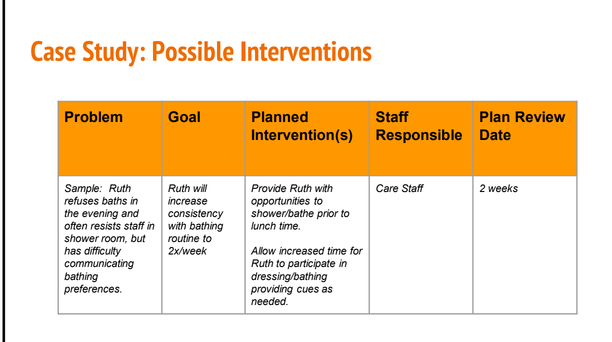
Problem	Goal	Planned Intervention	Staff Responsible	Plan Review Date
Sample: Ruth often exhibits exit-seeking behavior in the afternoon and is disoriented to time and place.	*Ruth will decrease episodes of exit-seeking in evening from daily to 2 x / week*	*Provide Ruth with meaningful engagement activities 1 hour prior to dinner (such as setting the tables, watering plants)*	*Care Staff Activities*	*2 weeks*

Case Study: Possible Interventions

Bathing Refusal

- Discover Ruth's former bathing routine and try to mimic
- Be mindful of any modesty concerns or considerations
- Increase home-like environment (smaller shower room, softer lights, aromas)
- Take note of temperature preferences (ex. Warming towels, bathroom, etc.)
- Consult with OT to maximize Ruth's independence during bathing

Case Study: Possible Interventions



Problem	Goal	Planned Intervention(s)	Staff Responsible	Plan Review Date
Sample: Ruth refuses baths in the evening and often resists staff in shower room, but has difficulty communicating bathing preferences.	*Ruth will increase consistency with bathing routine to 2x/week*	*Provide Ruth with opportunities to shower/bathe prior to lunch time.* *Allow increased time for Ruth to participate in dressing/bathing providing cues as needed.*	*Care Staff*	*2 weeks*

Summary

- Behaviors are a means to communicate an unmet need
- Proactively reduce behaviors by fostering a culture of person-centered care through increased awareness and understanding of dementia
- Decipher the Behavior as part of an Interprofessional Team
- Develop an individualized plan
- Communicate the plan with everyone
- Review the plan and revise as needed.
  - Be patient as your first attempt may not be successful

References

Alzheimer's Disease & Dementia Care | Texas Health and Human Services

Antipsychotic Alternatives

Non-Pharmacological Approaches to Address Behaviors

Bourgeois M. S. (2019). Caregiving for Persons with Dementia: Evidence-based resources for SLPs. Topics in language disorders, 39(1), 89–103. https://doi.org/10.1097/TLD.0000000000000166

Cloak N, Al Khalili Y. Behavioral And Psychological Symptoms In Dementia. [Updated 2022 Jan 20]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK551552/

Gitlin, L. N., Hodgson, N., Jutkowitz, E., & Pizzi, L. (2010). The cost-effectiveness of a nonpharmacologic intervention for individuals with dementia and family caregivers: The tailored activity program. The American Journal of Geriatric Psychiatry : Official Journal of the American Association for Geriatric Psychiatry, 18(6), 510-519. doi:https://doi.org/10.1097/JGP.0b013e3181c37d13

Laver, K., Clemson, L., Bennett, S., Lannin, N. A., & Brodaty, H. (2014). Unpacking the evidence: Interventions for reducing behavioral and psychological symptoms in people with dementia. Physical & Occupational Therapy in Geriatrics, 32(4), 294–309. https://doi.org/10.3109/02703181.2014.934944

Piersol, C. V., & Jensen, L. (2017). Occupational therapy practice guidelines for adults with Alzheimer's disease and related major neurocognitive disorders. AOTA Press, The American Occupational Therapy Association, Incorporated.Retrieved from https://www.proquest.com/other-sources/occupational-therapy-practice-guidelines-adults/docview/2041847672/se-2?accountid=143111

Roberts, G., Morley, C., Walters, W., Malta, S., & Doyle, C. (2015). Caring for people with dementia in residential aged care: Successes with a composite person-centered care model featuring Montessori-based activities. Geriatric Nursing, 36(2), 106–110.

Thank You!