

Introduction to Assessment and Management of Behavioural and Psychological Symptoms of Dementia for Novice Clinicians

Online Educational Resource



This resource is a self directed learning program of nine modules with embedded film clips entitled “Expert Conversations”.

The resource was developed by Margaret Marshall, Dementia Training & Study Centre, QUT.

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Introduction to Assessment and Management of Behavioural and Psychological Symptoms of Dementia for Novice Clinicians - Online Educational Resource

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Recommendations for use of this resource



This program is designed primarily as a **self-directed learning program** aimed at assisting novice health professionals to better understand the care required for a person experiencing behavioural and psychological symptoms of dementia (BPSD).

For the purposes of this program, a “novice” clinician is defined as a clinician from nursing or allied health disciplines in the first few years post graduation. It is anticipated that this program of learning will assist a novice clinician newly appointed to a position, either in the community or a residential aged care facility, where they will care for people with BPSD perhaps for the first time.

Self-Directed Use

Novice clinicians wanting to use this eight module resource will require access to a computer connected to the internet. This arrangement is necessary so the video clips and on-line resources from various websites can be accessed and viewed.

Module for Workplace Leaders

While the program is designed for novice clinicians, more experienced and senior clinicians taking on a leadership role in an area caring for people with dementia may also find it helpful. This is particularly

so if they have not previously cared for people with BPSD. For workplace leaders in this position, a module has been included in the program to assist with some key issues related to managing the environment and staff providing care to people with BPSD.

Alternate option of Inservice Sessions

It is possible to use the modules as an ongoing in-service program as an alternative mode of delivery. First, the presenter needs to familiarise themselves with the content of the program. Sessions could be presented as eight individual in-service sessions under the guidance of an experienced clinician and worked through as a group activity. The presenter will guide the group through the content and various activities with the question and answer component used as a group activity.

The recommended approach for the in-service sessions will require the use of a data projector with the computer connected to the internet. The group will then work systematically through each module together.



The increasing prevalence of dementia means that both the novice and the experienced health professional will probably find themselves providing care to a person with dementia at some stage during their clinical life. This care may occur in a variety of locations, ranging from the residential aged care facility, to care in the community, such as a respite centre or a client's own home, or in a hospital ward or emergency department. Significant management challenges for the health care professional can be experienced in any context of care.

Increased knowledge and understanding of the behavioural and psychological symptoms of dementia (BPSD), how these behaviours are assessed, how they may be reduced or how the impact on the person with dementia or those around them may be minimised will assist you, the novice clinician, to make a positive difference for the person exhibiting these behaviours. The development of specific clinical skills in this area of practice will aid in both minimising the distress of persons with dementia and in increasing your sense of competence when working with people with a dementia profile.

Purpose of this Program

This program of learning aims to:

- introduce the concept of BPSD
- explore a number of models to assist with understanding the factors underlying the BPSD
- explore a number of individual BPSD, including the assessment processes, strategies and evaluation that clinicians can use to reduce the effects of the behaviours
- apply the various models and evidence based interventions to case study scenarios
- incorporate the input from experts via accompanying video clips
- offer some specific advice to work leaders on

- managing staff providing care to clients with BPSD
- outline advice on professional development and self care to novice clinicians working with people with BPSD.

As previously mentioned the program has been written primarily as a self directed study program for novice health professionals, from various health disciplines (nursing and allied health) working in various settings who have had limited exposure to people with dementia. Emphasis has been given to the residential situation in many of the scenarios. Some of the content may also be of use as a resource to assist care workers, carers and families of people with dementia.

The material assumes pre-requisite knowledge of the dementia syndrome including types and prevalence. To re-familiarize yourself with this knowledge, it is suggested that the following websites can be accessed:

- Dementia Training Centres www.dtsc.com.au
<http://dementia.uow.edu.au/eduonline/index.html>
- Alzheimer's Australia
<http://www.fightdementia.org.au/>
- Dementia Behaviour Management Advisory Service
<http://www.dementia.unsw.edu.au/info-module/dementia-you.html>



Overall outcomes for participants

After completing the eight modules of this program the novice clinician will be able to:

1. Explain the concept of BPSD and the models used to understand the potential underlying causes
2. Outline the assessment processes, tools and interventions used to manage
 - a. Vocally Disruptive behaviour,
 - b. Agitation,
 - c. Wandering,
 - d. Anxiety and Depression
 - e. Physical aggression.
3. Critically analyse given scenarios and select suitable evidenced-based interventions
4. Recognise the value of assessment and ongoing evaluation in the care of people with BPSD
5. Identify a variety of resources that can be readily accessed as reference materials.

Program Overview:

The broad content of the program is provided below. Each session includes objectives and questions both for reflection and for responses to be completed. Reference sites are included throughout the individual sessions.

Module 1 Unit 1	Introduction
	What are BPSD?
	Introduction to Experts
	Expert's Definitions
Module 1 Unit 2	Frameworks & Models for Understanding
	Value of using a framework
	Description of Models
	Introduction to Person- Centred care(PCC)

Module 2	Identifying and Collecting Information
	The assessment process
	Sourcing objective and subjective information in relation to behaviour
	Importance of individual preferences, history, cultural issues
	Assessment related to carer and care environment
	Description of Vocally Disruptive behaviours (VDB)
	Introduction Mrs A with VDB (case study 1)
	Assessment tools for VDB

Module 3	Planning & Implementing Strategies Commencement of planning process More about PPC and its application Types of Intervention strategies for BPSD Strategies for addressing VDB Continuation of case study - Mrs A with VDB Goal setting and realistic expectations of outcomes
Module 4	Evaluating effectiveness of strategies Process of evaluating effectiveness and comparison with goals Description of Agitation Strategies for addressing Agitation Introduction to Joyce (case study 2) experiencing agitation behaviour Evaluating level of success with interventions
Module 5	Sharon with Wandering Behaviour Description and assessment of wandering Behaviour Measurement tools for wandering Introduction to Sharon (case study 3) Strategies for addressing wandering behaviour
Module 6	John with Anxiety and Depression Description of Anxiety and Depression Cultural considerations for assisting Indigenous people with dementia Assessment tools for indigenous people with dementia Introduction to Mr B (case study 4) suffering with anxiety and depression Strategies for addressing Anxiety and Depression
Module 7	Jayita with Aggressive behaviour Description and assessment of Aggression Introduction to Jayita (case study 5) demonstrating aggressive behaviour Caring for people with CALD and dementia Strategies for addressing Aggression Role of multi-disciplinary team

Module 8	Advice for Workplace Leaders
	<ul style="list-style-type: none"> Establishing a culture promoting PCC The living environment & lifestyle of the person with dementia Valuable resources Staff issues

Module 9	Advice for Novice Clinicians
	<ul style="list-style-type: none"> Knowledge and skill development Useful resources Relationship Building Care for yourself

Reference articles provided at the end of each module

Glossary

In exploring what Behavioural and Psychological Symptoms of Dementia (BPSD) are all about, let's first meet Darren.

Darren is 61 years old, quite tall and physically fit. Darren has lived in a small rural community with his second wife of 10 years who is described as 'resilient'. His wife had been providing care and support for him for over four years, since he was forced to leave his part time work as a machine operator. Darren was also required to relinquish his driver's licence following his diagnosis with younger onset frontal lobe dementia. (In addition to his dementia, Darren had co-morbidities including neck pain, severe hearing loss, and long sightedness).

Darren deteriorated quickly within a relatively short space of time; he became incontinent, did not recognise his wife at times and lost the ability to communicate verbally. He did not like being helped to shower or dress and became agitated when receiving support with toilet tasks. He was exhibiting physically aggressive behaviour, for example, pushing his wife and wringing her arms or grabbing and bending her fingers making it difficult for his wife to manage him. Darren was admitted to a care facility.

This snapshot of Darren highlights some of the behaviours we will explore in this program. How will the staff best care for Darren and his wife?

Darren has a complex history which includes a number of co-morbidities which require input

into his care planning by all members of the multi-disciplinary team. Each team member will contribute their skill and knowledge of behavioural symptom assessment and management aimed at trying to ease Darren's discomfort.

1.1.1 Defining BPSD

In studying the behavioural and psychological symptoms exhibited in dementia, it is first worth considering the varying terms in use for dementia. Dementia is a term used to describe a number of specific diseases involving progressive cognitive decline primarily occurring in older adults. Here are two descriptions of dementia that identify the dimensions of the disease



Description of Dementia

Any organic condition where there is an irreversible loss of cognitive capacity and memory, such that there is a decline in a person's ability to function socially, physically and emotionally over time.

Dementia is a syndrome – usually of a chronic or progressive nature – in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal ageing. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not affected. The impairment in cognitive function is commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation.



This program will concentrate primarily on behavioural and psychological symptoms (BPSD) associated with dementia. BPSD pose a persistent clinical challenge as to how best to provide responsive care. Understanding more about BPSD will help you respond to, and provide therapy for, identified objective or subjective concerns of the person with dementia or their carer that can be sourced by observation or elicited through sensitive, systematic questioning.



Key Message

How a person with dementia behaves is a form of communication and may reflect emotions or unmet needs.

Behavioural and Psychological Symptoms of Dementia (BPSD) - A more descriptive term

The term encompasses all **behavioural and psychological symptoms of dementia**. Use of this term will assist health professionals to focus their responses and to speak a common language when working together to minimise the severity and impact of BPSD.

The International Psychogeriatric Association in 1999 came to a consensus agreement that

BPSD be defined as symptoms of disturbed perception, thought content, mood or behaviour that frequently occur in patients with dementia (Finkel & Burns 1999) (3)

Dementia is generally characterised by four stages:

- early difficulties (the pre-diagnostic phase)
- emergence of significant difficulties in daily living
- reduced capacity for independence
- incapacity and a high dependence on care.

Symptoms commonly linked with the progression of dementia impact on memory, orientation, judgement and problem solving, community participation, home and personal interests, and the level of personal care required.

1.1.2 BPSD – the scope

When we use the term behavioural symptoms, what might be observed?

Physical aggression, screaming, restlessness, agitation, wandering, culturally inappropriate behaviours, sexual dis-inhibition, hoarding and cursing.

What may be observed as psychological symptoms?

Depression, apathy, anxiety

What might be gained from discussing feelings or emotions with the person experiencing dementia or their carer?

Information may be obtained that reflects psychological symptoms of anxiety, depressive mood, hallucinations and delusions. You may also gain some greater insights into the experiences of the person with dementia, as well as the carer's perspective.



1.1.3 How often are these behaviours evident in clinical settings?

As an example, in Australia 92% of a sample of 11 Sydney nursing home residents were reported to have at least one type of BPSD as measured by the BEHAVE-AD *Scale (Brodaty et al.,2001).

In the table below the proportions of various behaviours seen are identified.



Table 1. Prevalence of BPSD in 11 Sydney Nursing Homes

BEHAVE-AD* BPSD items	Prevalence (%)
Behavioural disturbance (Activity disturbance + Aggression)	82
Aggression	77
Anxiety and phobias	69
Affective disturbance	60
Psychosis (Delusions + Hallucinations)	60
Delusions	54
Activity disturbance	53
Diurnal disturbance	47
Hallucinations	33
BEHAVE-AD total	92

* Behavioural Pathology in Alzheimer's Disease Scale (3) p.1.7

BPSD occur at different levels of severity across the progression of disease; they can be evident for a while and can seem to be resolved and can then reappear.

Research has indicated that with BPSD (3) p22

- the symptoms seem to **increase** as the disease progresses or
- symptoms may occur commonly during **specific periods** in the trajectory of the dementia disorder.

If treatment is not provided to reduce or resolve BPSD for the individual, there are significant impacts on everyone associated with the person with dementia, their family and carers and on society as a whole. (4)

1.1.4 Key messages

- BPSD is characterised by changes in behaviour and thinking expressed in many ways including agitation, depression and psychosis. These symptoms present as problems or unmet needs for the person with dementia. They contribute to carer and family stress and result in increased care costs which has an impact on society at large.
- BPSD are treatable and do respond to therapy that is focussed on reducing or resolving the behaviours within the context of the person's own situation.
- Treatment of BPSD offers the best chance to alleviate suffering and improve the quality of life of the person with dementia, reduce family burden and lower societal costs associated with caring for people with dementia.



Activity 1.1.1: Watch the “Expert Conversations” video clip entitled ‘Defining Symptoms of Dementia’ (3 mins duration)

The Experts are responding to the question “How do you define and/or conceptualise BPSD?”

Based on what you gained from the video, answer the following questions:

i) What do you anticipate would be the possible impact to all concerned with the care of people with dementia if symptoms remain untreated?

ii) Summarise the key elements of BPSD that have resonated with you and helped to define BPSD.

iii) Based on what you have explored in this module, how significant is the syndrome of dementia to health professionals? What is the value of learning about BPSD to you as a clinician?

1.1.5 Resources and References

1. Kitwood, T. (1998) *Dementia Reconsidered: The person comes first*, in Rethinking Ageing Series. Buckingham, Open University Press
2. World Health Organisation. Dementia, Fact sheet N°362. April 2012 can be found at <http://www.who.int/mediacentre/factsheets/fs362/en/index.html>
3. International Psychogeriatric Association Complete Guide to Behavioral and Psychological Symptoms of Dementia. (2010) www.ipa-online.org
4. Black W., Almeida O.P. (2004) A systematic review of the association between Behavioural and Psychological symptoms of Dementia and burden of care *Int Psychogeriatric*; 295-315

Additional Resources

5. Behaviour Management – A Guide to Good Practice (2012) available at http://www.dementia.unsw.edu.au/index.php?option=com_drcrc&view=drcrc&layout=project&Itemid=101&pid=154
6. Ornstein, K., Gaugler, J. E., Devanand, D.P., Scarmeas, N., Zhu, C. & Stern Y. (2012) The Differential Impact of Unique Behavioral and Psychological Symptoms for the Dementia Caregiver: How and Why Do Patients' Individual Symptom Clusters Impact Caregiver Depressive Symptoms? *The American Journal of Geriatric Psychiatry*, ISSN 1064-7481, 09/2012, p. 1

Objectives:

At the end of this module you will be able to:

1. Outline three models or frameworks for thinking about BPSD that will guide your understanding of how best to organise your approach to assessment and care delivery to individuals with BPSD
2. Using one of these models, describe how you might better appreciate behaviours demonstrated by a person with BPSD.
3. Identify the key concepts inherent in the philosophy of Person-Centred care

1.2.1 Why use a framework or model?

A number of frameworks and models are provided in the evidence based literature. These models provide guidance and structure to the clinician as an approach for use in assessing, planning and managing individualised care. The focus of care is aimed at resolving the discomfort associated with the experience of BPSD for a person with dementia.

The impact of BPSD on the immediate well being and quality of life of people with dementia and their carers can be overwhelming. The resulting carer burden and other negative health outcomes, cost of care, placement into care facilities and general disability are well documented. (1) To provide individualised interventions and improve prevention and management of BPSD, use of a framework or model is recommended. A model or framework will offer you, as the clinician, use of a structured approach to comprehensively collect and analyse information about the person, their environment, their behaviours and their potential triggers. It will also assist you to select the most appropriate treatment aimed at resolving or minimising the behaviour.

There is little consensus on which model is the most appropriate or effective to guide and inform management of care, but each model suggested below has been used extensively in both clinical research and practice. Exploring the evidence yourself by reading research reviews may provide you with an idea of what fits best with how you think and what will work best in your clinical environment and for the person for whom you are caring.

Several more commonly used models and frameworks are identified below for you to explore.

1.2.2 Examples of Models/ Frameworks for consideration

The following models provide a framework to assist in the analysis of assessment information.

i) Progressively Lowered Stress Threshold (PLST) - this model is built on stress theory. It posits that the person with dementia is increasingly less able to manage stress as dementia progresses.

This approach focuses on supporting those with dementia by facilitating the use of retained skills and abilities while reducing the environmental triggers for BPSD.

This is a useful model for analysing assessment information against stressors such as:

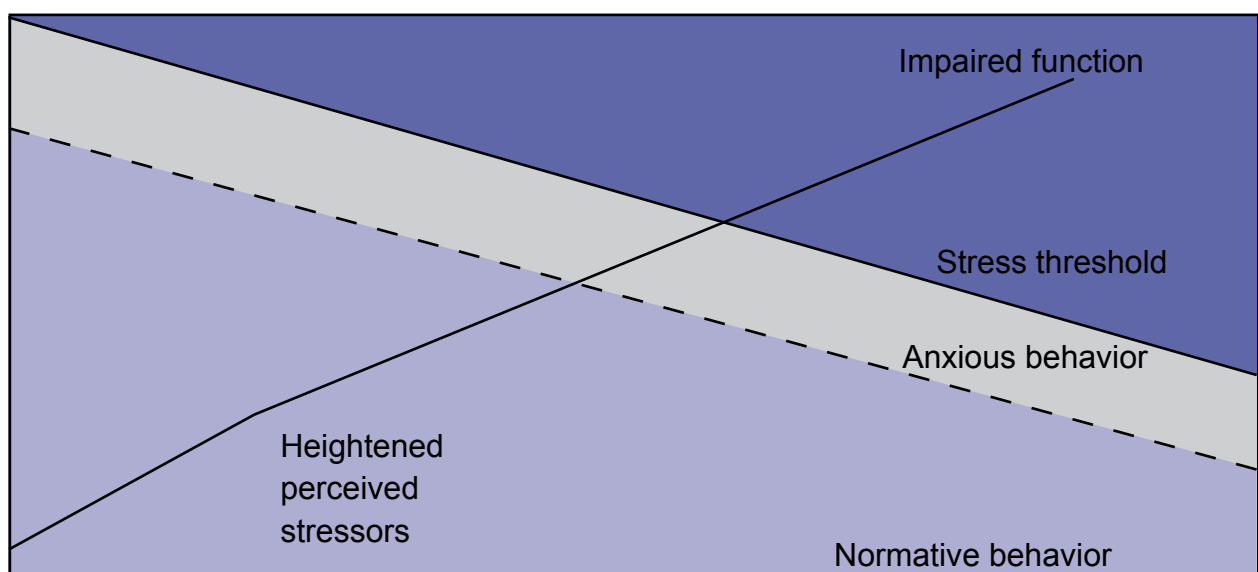
- Fatigue
- Change of routine
- Misleading environmental stimuli
- Physical stressors such as acute illness, adverse reactions to medication, infection, pain and discomfort.

This model suggests that, as dementia progresses, losses occur in cognitive, affective, and planning abilities. An array of behaviours

emerge when environmental demands, external or internal, exceed the person's ability to cope and adapt. These behaviours are hypothesized to be symptoms as a result of a progressively lowered stress threshold (PLST) and include agitation, night waking, late-day confusion and combative behaviours (2, 3, 4).

Hall and Buckworth (1987) suggest that as cognitive decline progresses there is a corresponding and progressive decline in the person's ability to tolerate stress of different types in a specific time period. (5)

Figure 1.1 Progressively Lowered Stress Threshold Model



Stress threshold in a patient with Alzheimer's disease and related dementia.

Source: Smith (2006) *Application of the Progressively Lowered Stress Threshold Model across the Continuum of Care*



Activity 1.2.1

Using the above model, suggest two examples of possible internal and external environmental stressors that a person with dementia may experience"

Internal:	i)
	ii)
External:	i)
	ii)

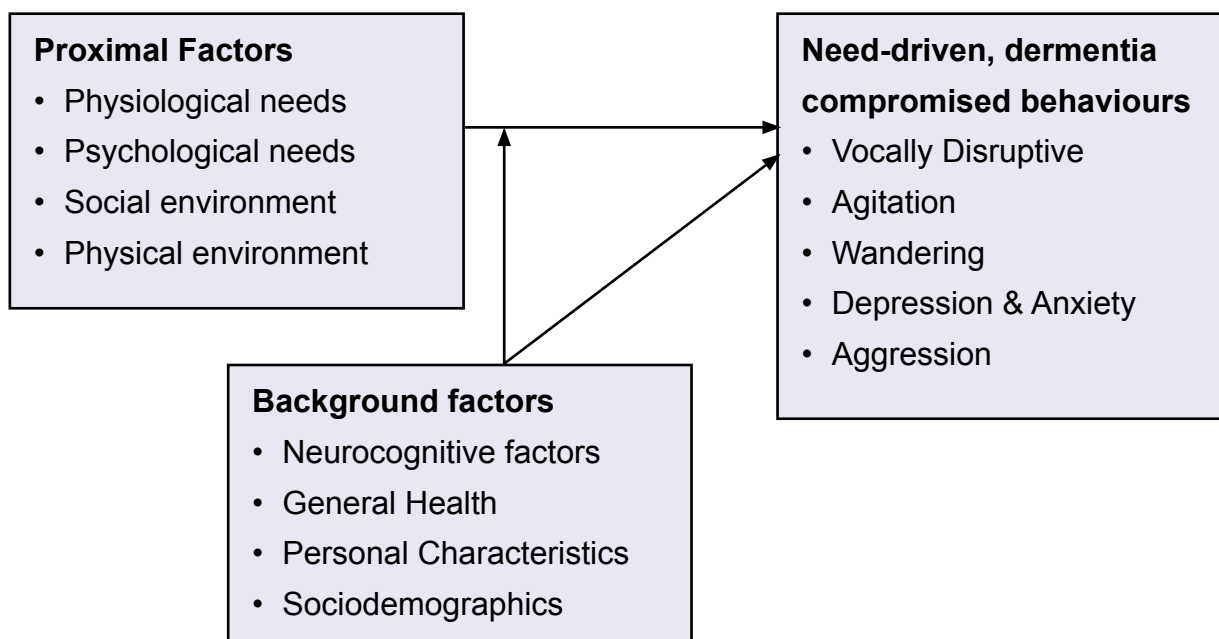
ii) The Need-Driven Behavioural Model –

this model is suitable for use independently or in combination with PLST. The Need-Driven Dementia Compromised Behaviour (NDB) model proposes that BPSD are an **indication of unmet needs**, as the person with dementia becomes progressively less able to meet their own needs.

The model takes into account the influence of:

- **background factors** these include neurological, cognitive, health and psychosocial characteristics and
- **proximal factors** such as needs of the person with dementia and the impact of social and physical environmental factors on behaviour. (6, 7,8)

Figure 1.2 Need Driven Dementia Compromised Behaviour (NDB) Model (Algase et al. 1996)



Activity 1.2.2

Identify from your own experience two background factors and two proximal factors, as given in the NDB model, that might contribute to a need becoming unmet.

Background factors:	i)
	ii)
Proximal factors:	i)
	ii)

iii) **The Behavioural Assessment tool uses the A B C approach** – this mnemonic helps to recall the three important foci for assessing and evaluating behaviour.

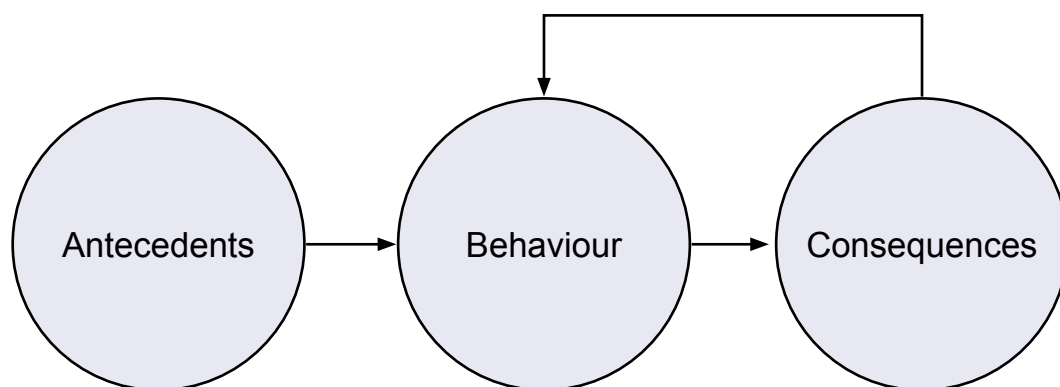
- “**A**” refers to the antecedent or triggering event that precedes the behaviour, that is, what happens before the behaviour, where did it occur and what else was going on in that situation. Identifying the antecedent is necessary for effective management

- “**B**” is the behaviour, how long did it last and what exactly was said and done
- “**C**” is the consequence of that behaviour, that is, what happens after the behaviour. What was done, what interaction occurred and what else happened

Note - sometimes this consequence then becomes an antecedent itself.

The approach is to reinforce appropriate behaviours while discouraging those that are dysfunctional.

Figure 1.3 Behavioural Model



Source: Cohen-Mansfield J (1998) (7)

1.2.3 Useful memory aid for thinking about BPSD

The following framework is a mnemonic providing an easy way to remember a consistent approach to assessment and care

iv) **PIECES mnemonic** – each letter of this word refers to an area requiring assessment and management.

- “**P**” – physical cause e.g. pain, urinary discomfort
- “**I**” – intellectual capacity e.g. memory, confusion, cognition

- “**E**” - emotional health e.g. depression, anxiety
- “**C**” – capability e.g. maintaining level of independence
- “**E**” – environment e.g. keeping surroundings unambiguous
- “**S**” – social self e.g. who is this person, what is their life history?



In this context there is also a need to take account of social and cultural factors causing issues for the person with dementia in the current setting. A comprehensive history needs to be taken from the person and or family, including usual routines, familiar practices, language and preferences of the person.

1.2.4 Introduction to Person-Centred Care (PCC)

A person-centred approach to care provides a holistic framework for understanding the person with dementia as well as their behaviours causing concern.

Essential to this approach is that the person is placed at the centre of their own care provision and that the needs of their carers are also recognised. This is individualised care with a strong focus on the relationship and the quality of interactions. The following summarises the dimensions of PCC.

PCC requires:

- recognition of, and connection with, the person,
- a focus on their strengths and goals
- an interdisciplinary approach and
- recognition of the centrality of relationships

The PCC approach requires the clinician to take into account all aspects of care - psychosocial needs, spiritual and cultural needs, social interactions and relationships, as well as physical wellbeing.

There are four key elements - VIPS:

- (V) **V**aluing the person with dementia
- (I) **T**reating the person as an **I**ndividual
- (P) **L**ooking at the work from the perspective of the **P**erson with dementia



- (S) A positive **S**ocial environment in which the person with dementia can experience relative wellbeing



1.2.5 Key Message

Whichever models or frameworks are used to guide or manage care the following broad principles need to be applied

- The **dignity and rights** of persons with dementia and BPSD are recognised and respected.
- Treatment and management has a goal of **maximising quality of life and safety** within the least restrictive environment for each individual.
- The behaviour of persons with dementia is recognised as a **form of communication**.
- The **impact** of BPSD on the person with dementia, families and staff who provide care is recognised
- **Collaboration** with all people affected is the preferred approach to managing BPSD.



Activity 1.2.3: Watch the video clip “Expert Conversations - Frameworks & Models for Understanding” (14 mins duration)

The Experts are responding to the question

“What principles, frameworks and/or models of care guide your understanding of and approach to addressing BPSD?”

Questions and Reflection

1. After listening to the expert conversations, which one or two of these models might best suit your care of a person with dementia in your setting. Explain why you think this?

2. Select one of the models and outline how the behaviour of a person with dementia, for whom you have cared, might be explained.

3. Which of the models outlined may be best suited for use in your setting, when caring for people with dementia from a culturally or linguistically diverse background?

1.2.6 Resources and References

1. Black W. & Almedia O.P. (2004) A systematic review of the association between the Behavioral and Psychological Symptoms of Dementia and burden of care. *Int Psychogeriatr* 16:295-315
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Additional Resources

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Objectives:

At the end of this module you will be able to:

1. Outline the key areas and questions needed for the comprehensive behaviour assessment that will assist an understanding of the areas of concern for people with BPSD
2. Explain the use and value of preferred assessment tools
3. Outline the assessment process and questions you could use for the person in the provided case study focusing particularly on her disruptive vocalisation behaviour.

Before exploring the dimensions of assessment for a specific BPSD we will first consider information applicable generally across any presenting behaviour.

2.1 Risk assessment

On initial meeting with the person with dementia, and at the beginning of the activity of assessment, first ask yourself the question –

“What has brought this person into my care?”

Most often the answer to this question will provide a focus and highlight the symptoms the person is experiencing.

Immediately determine whether the person with dementia is subject to either an immediate or potential risk that will place either the person themselves, their family or care staff in any danger or harm.

Assess the type of risk as immediate or potential:

- **Immediate risks** may include self destructive behaviours, lack of awareness of exposure

to danger, or danger to others by physical aggression or psychosis (e.g. delusions, hallucinations)

- **Potential risks** may include increased risk of falls, safety hazards in the care environment or during transfer from current accommodation to a new setting.

Where there is immediate risk urgent attention will be needed to put interventions in place to prevent harm, such as placing the person in a safe location.

Interventions would also include:

- increased frequency of observations,
- communication to staff and
- possible allocation of additional staff to the area where the person is located.

Risks determined as potential risks will require noting and be incorporated into the eventual plan of interventions.

2.2 The assessment process

Comprehensive assessment requires the gathering of information to assist in the description and investigation of the BPSD. Collecting information from a variety of sources will assist in developing a picture of the person and their behaviour.

While an initial assessment is undertaken on first contact with a person with dementia, this is of course **an ongoing process** that continues throughout the period of care for that person.

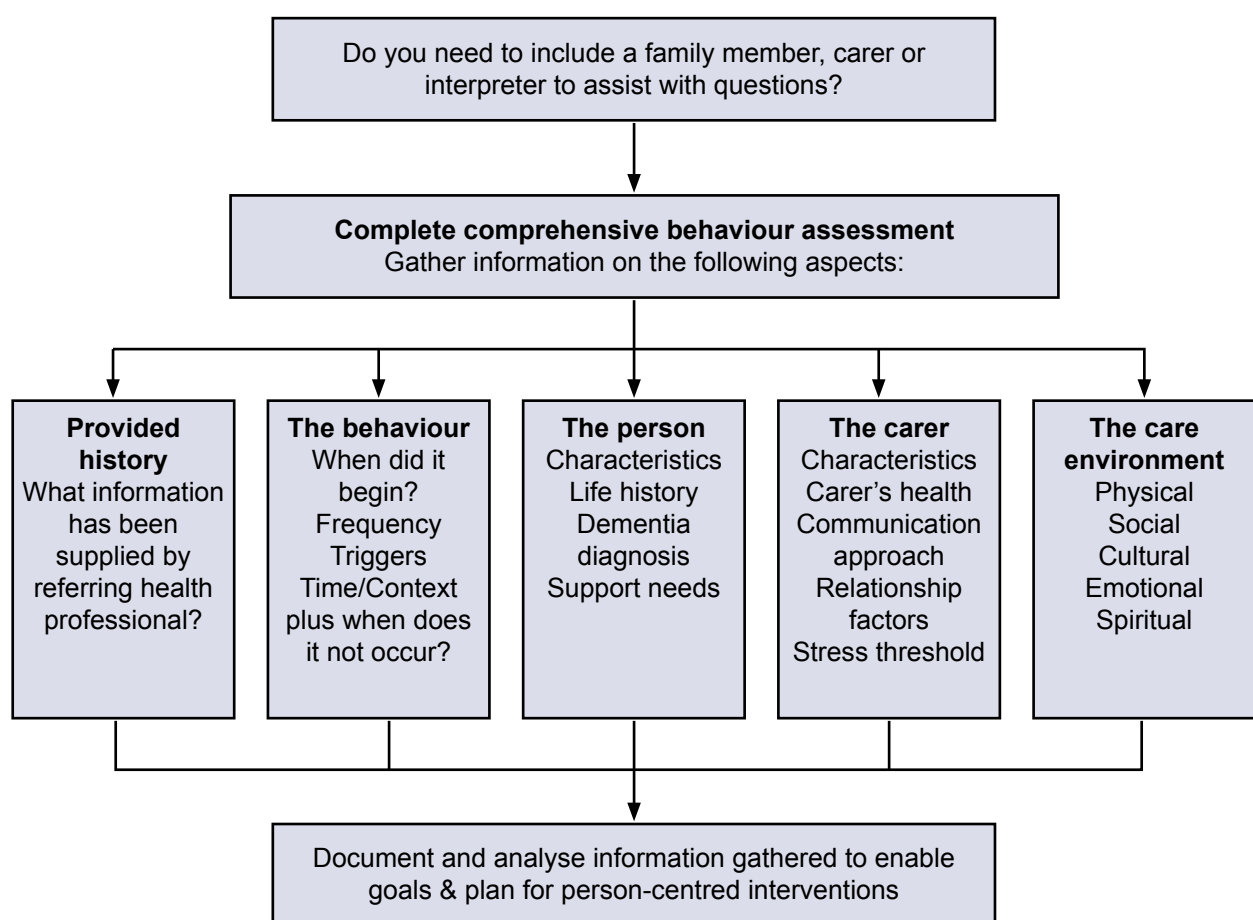
At commencement of the assessment, it will be important to read any information supplied by the referring health professional e.g. referring doctor or case worker, including medical history, current medications and pre-existing conditions and established care to date.

In addition, it is important to arrange to have the primary carer or family member available to assist with questions, especially if the person with dementia has compromised verbal communication ability and is unable to provide answers to questions themselves. If the person with dementia and/or their primary carer or support

person do not speak English it may be necessary to arrange for a bilingual interpreter.

The following diagram provides an outline of the areas to explore in relation to the person with dementia and the behaviour being exhibited.

Figure 2.1 Guide for the Assessment Process



Modified from Flow diagram of behaviour management process DBMAS : Guide to Good Practice 2012 P20 (1)

Each area in the above diagram will now be outlined more fully, apart from the client's history. This history is usually supplied by the referring health professional and will provide a necessary background to your assessment.

i) The person's behaviour

In interviewing the family member or carer it is possible that they may not understand that dementia interferes with the person's ability to control their behaviour. This can result in the belief that the behaviour is deliberate.

Explaining this misunderstanding can improve their appreciation of the situation and reduce the tendency for them to criticise, assign blame or become irritated with the person.

Apart from observing and recording the behaviour it will be necessary to explore the characteristics of the behaviour, to describe these in detail and establish a 'behaviour baseline'- that is, what was occurring at the time of the initial assessment.

Details related to the characteristics of the behaviour need to be collected by observing and asking questions related to:

- **frequency** (how often & when), **duration** (extent of time for each episode) and intensity of the behaviour
- **extent of discomfort** that the behaviour causes the person with dementia
- clarification of **events which lead** to the behaviour occurring (the triggers)

- locations where the behaviour occurs, as described by people (carers or staff) present with the person when the behaviour occurs
- **consequences** of the behaviour for the person with dementia and for other people and responses to the behaviour by other people
- circumstances that prevail when the behaviour is **not occurring**
- **extent of concern** for the person with dementia and others in the environment, including the emotional effect on those exposed.

In the following example varying indicators are described that might be observed in a person with dementia who is experiencing pain – **note how extensive this assessment is, with seven indicators explored to represent the symptom of pain.** This is the level of observation required to gain a comprehensive profile of the 'communication' (non verbal) being provided by the individual.

Indicators reflecting the presence of pain

- Facial expressions: Slight frown, sad, frightened face, grimacing, wrinkled forehead, closed or tightened eyes, any distorted expressions, rapid blinking
- Verbalizations, vocalizations: Sighing, moaning, groaning, grunting, chanting, calling out, noisy breathing, asking for help
- Body movements: Rigid, tense body posture, guarding, fidgeting, increased pacing, rocking, restricted movement, gait or mobility changes
- Changes in interpersonal interactions: Aggressive, combative, resisting care, decreased social interactions, socially inappropriate, disruptive, withdrawn, verbally abusive
- Changes in activity patterns or routines: Refusing food, appetite change, an increase in rest periods or sleep, changes in rest patterns, sudden cessation of common routines, increased wandering
- Mental status changes: Crying or tears, increased confusion, irritability, or distress
- Medication use: Especially psychoactive drugs that can interfere or interact with analgesics and elicit "unusual" pain behaviours as noted by family caregivers

The IPA Complete Guides to BPSD – Nurses Guide 2012 p8

Triggers which may contribute to the behaviour

Trying to identify what might contribute to the behaviour of a person with dementia is a key element of the assessment process – these may be discussed as **triggers** for the behaviour which once identified provides the focus for interventions to reduce the behaviour itself and the impact of the behaviour on those involved.



Activity 2.1: Refer to BPSD Guide 2012 (p32) Table 1.2 Factors which may contribute to BPSD

Under the headings of “the person with dementia” “communication” “activities of living” and “the care environment”, this table provides an overview of possible sources of triggers that may exist and which need to be documented in relation to the behaviour.

a) Why is it important to explore possible triggers for behaviours? How might you do this?

b) Reflecting on a person with dementia you have provided care for – what might have been the triggers for the behaviour they exhibited?

ii) The Person

Collecting information about **who** the person is will enable you to build a picture of the person and their individuality. Recording information about their preferences, interests, routines, likes and dislikes, life history, social networks, spiritual and cultural background, work life and special or traumatic events that have occurred will help to provide a picture of the person with whom you are building a relationship.



Reflection

Thinking about what you would consider is important for others to know about you as a person if they were providing care to you, may help you in thinking about the person with dementia.

Information is also required in relation to the ability of the person with dementia to independently meet his/her activities of daily living (ADLs) and any support needed to provide for these activities. Katz has developed an index tool useful for assessing a person's level of independence with ADLs (3)

iii) The Carer

The impact of caring for a person with dementia is a demanding role and can result in significant stress and sense of burden as well as the positive experiences. Therefore, assessing the well being of the carer is also important.

Asking questions related to how much the carer knows about dementia, how well they are coping with their role, other demands they may be experiencing, their health and the opportunities that exist for time out will allow you to gain details and an insight as to their state of wellbeing. Observation of the carer's interactions and

communication style with the person with dementia will also help to identify any issues that may have relevance to the behaviour of the person with dementia.

iv) The Care Environment

Assessment of the care environment is important, as it can have significant impact on the person with dementia. (4) The dimensions to be considered include:

- **Physical factors** – light levels, heat, humidity, noise, physical layout, access to outdoors, safety, furnishings. Try to identify factors that may be disorienting, limiting, over stimulating and/or under stimulating.
- **Social/Cultural factors** – these include the people who come into contact and interact with the person with dementia, quality and types of activity they share, flexibility of routine, opportunities for meaningful social interaction and engagement.
- **Time and resources** available for support
- **Cultural appropriateness** – information in relation to customs, language and food, religious and spiritual practices and degree of adjustment to Australian life e.g. length of time in Australia.

Assessment tools and design principles for the care environment entitled "Enhancing the Healing Environment" are available from the Kings Fund website. (4) These assessment tools identify five components that aim to create the desired outcomes of:

- easing decision making
- reducing agitation and distress
- encouraging independence and social interaction
- promoting safety and
- enabling activities of daily living.



Activity 2.2: Watch the “ Expert Conversations” video clip entitled Collecting information (36 minutes duration)

The Experts are responding to the question

“What types of information are important to collect when assessing BPSD and how do you access this information?”

Based on the experts suggested approach and the information provided in the table 1.2 in the BPSD Guide, p.32 answer the following questions:

a) The experts suggest that you seek information about the top 5 items of importance to the person you are assessing. What will be the value in seeking this information?

b) In obtaining information from relatives or carers, divergent views may be provided in describing behaviour. How might you overcome this dilemma in order to obtain the most accurate picture of the situation?

c) Where possible, it was suggested that the person with dementia is asked “what might be one or two ways we could improve things for you”. How might this information assist?

Our first case study concerns Mrs A, a person with dementia who is exhibiting Vocally Disruptive Behaviour (VDB). Before we meet Mrs A we will explore more about VDB.

2.3 What is Vocally Disruptive Behaviour?

Vocally disruptive behaviour (VDB) refers to screaming and verbal agitation which causes

stress within the person’s environment. It can be intermittent or incessant and could be singing, screaming, abusive or verbally aggressive comments, repetitive questioning, groaning and sighing.

The term “disruptive” is based on the perception of others.

Causes

Theories propose that the cause of VDB include:

- physical or psychological discomfort or social isolation, combined with operant learning (i.e. behaviour inadvertently reinforced from increased attention)
- reduced stress thresholds due to cognitive impairment
- a possible response to psychotic symptoms such as visual and/or auditory hallucinations.

Effects

VDB causes significant stress and/or distress whether in a care facility or in a home environment. This behaviour has been shown to evoke concern, frustration, anxiety, anger and complaints from care staff, visitors, other residents and neighbours. Nursing staff may express a desire to distance themselves from people with dementia exhibiting VDB. In addition, in a care facility the person with VDB may become victim to verbal and/or physical aggression from other residents who have reduced tolerance of the behaviour, sometimes as a result of their own cognitive impairment.



Activity 2.3: Read Part 1 of the case study related to Mrs A who demonstrates Vocally Disruptive behaviour.

(In the story there is a reference to DBMAS, this is an acronym for the Dementia Behaviour Management Advisory Service which offers clinical advice on dementia on a 24 hour basis, available in all states)

Mrs A's Case Study – Part 1

Client Demographic Profile

Mrs A, is an 80 year old widow of 13 years following what her three children describe as a “good marriage”. Her children, one daughter and two sons, and grandchildren are in ongoing contact with her. Mrs A had been a teacher of English as a second language and then later on taught stress management and meditation until her retirement. Her physical health was quite good apart from having broken her femur twice as a result of a fall. She lived with her daughter for a number of years before moving into a care facility.



Key Referral Information

Mrs A came to the attention of DBMAS clinicians when she had exhibited aggressive verbal behaviour on several occasions during personal care activities of washing and dressing. It was reported that she was making very loud and continuous vocalisations, screaming and yelling out and this was causing distress to staff and other residents to the point that complaints were received from their families.

While residing in a previous facility, about two years ago, Mrs A had fractured her femur in a fall. This had happened again resulting in Mrs A being hospitalised for several weeks, just prior to moving into the current facility.

Description of Behaviour

When the DBMAS clinician visited her, Mrs A was restrained in a chair with a belt across her midriff to prevent further falls. She was sitting quietly in the chair in her own single room but during the visit she begins to scream loudly and also make several guttural noises repeatedly.

The facility staff have also observed from outside her room that she appeared to be seeing things and conversing with a person who was not present, but her speech was unintelligible. They queried with the doctor whether Mrs A was possibly having psychotic episodes, specifically visual hallucinations. The vocalization behaviour and apparent hallucinations had led to Mrs A being isolated and largely left in her room alone for long periods which presented an additional threat of her experiencing rejection, isolation, loneliness and boredom.

Approach Used to Assess Behavioural and Psychological Symptoms of Dementia

The ABC (Antecedent; Behaviour; Consequences) approach was used to underpin Mrs A's assessment by the DBMAS clinicians. The DBMAS clinicians considered that the pain Mrs A had was as a result of the fractures that she had suffered which may not have been adequately managed and was possibly contributing to the loud vocalisations. Pain and depression were both measured using the Abbey Pain Scale and Cornell Scale for Depression in Dementia and level of agitation was measured using the Cohen-Mansfield Agitation Inventory. These assessments did not indicate any significant factors that may have been contributing to Mrs A's loud vocalisations. Observational charts over a 24 hour period were used to try to determine a pattern to the vocalisations and this did not reveal any pattern that could be targeted. Mrs A was taking a range of medications including antipsychotics and depression medications and these were evaluated and trialled in different doses and combinations, however it was concluded that these did not contribute to her behaviour.



Activity 2.4: From Mrs A's situation and keeping in mind the A-B-C model respond to the following:

a) Formulate the three questions you would pose to Mrs A's daughter in seeking information about Mrs A's vocalisation behaviour.

i)

ii)

iii)

c) State what you consider might be the possible antecedents (explanations) for her behaviour, using information provided in Mrs A's case study:

i)

ii)

b) List the observations you will make to better understand Mrs A's behaviour.

2.4 Assessment tools

Mrs A's assessment included the application of a range of tools to assist with diagnosing a number of elements of her cognitive and functional state and with the aim of identifying unmet needs.

These included:

- **Abbey Pain Scale** - to assess Mrs A's level of pain management (5)
- **Cornell Scale for Depression in Dementia (CSDD)** - to assess Mrs A's level of depression and apathy (6)
- **Cohen-Mansfield Agitation Inventory** - to assess level of agitation (7)

To view samples of these tools, if you are unfamiliar with them, go to websites listed in Resources section.

Be aware that there are well prepared guidelines that accompany the use of these tools which you can consult.

The assessments undertaken with Mrs A did not indicate any significant factors contributing to her vocalisation behaviour.

Other assessment tools specific to VDB include:

- **The Screaming Behavioural Mapping Instrument (SBMI)** – records nine types of VDB and if vocalisations manifest five times in a 3 minute observation period a rating of 'constant' or 'extreme' is recorded
 - **The Typology of Vocalisations (TOV)** scale measures verbal or non-verbal, meaning reason, content, timing and level of disruptiveness on a 5 point Likert scale.
- (1) p170

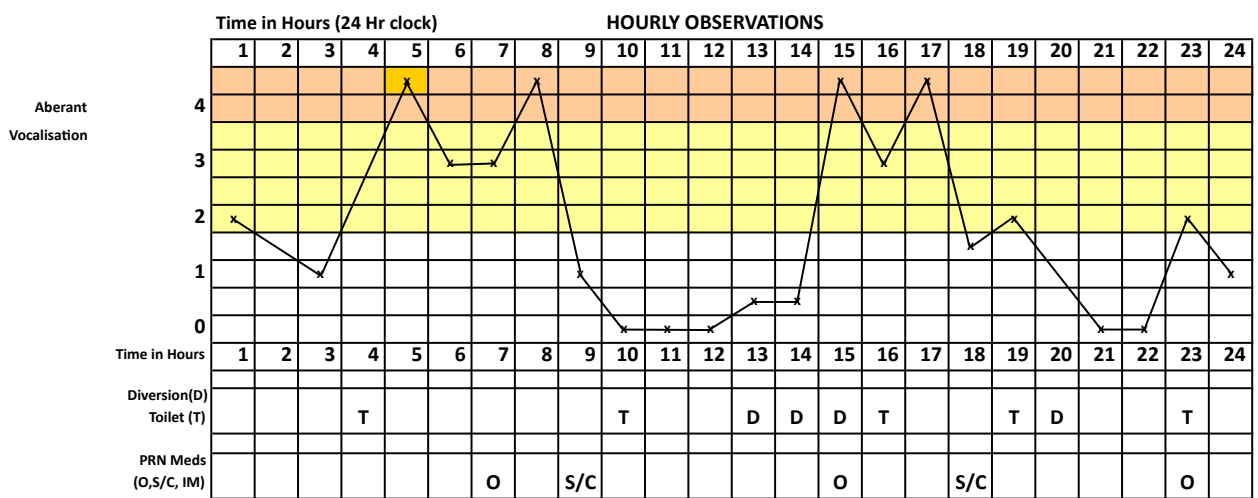
By establishing an observation chart to monitor Mrs A's on-going behaviour, including non verbal cues, further information about her responses and demeanour can be sourced.



Activity 2.5

In the hourly observation chart (shown below), the recordings reflect the level of aberrant vocalisation behaviour for each hour. The grading of the yellow from light to dark indicates the level of intensity of the behaviour with dark being the greatest intensity.

In the lower portion of the chart, the provided interventions are recorded – Diversions and Toileting and the PRN medications.



(modified from a section of an observation chart developed by PA Hospital)

Broadly, what inferences can you make from the above scenario in relation to the clients progress over this 24 hour period?



2.5 Key Message

- Detailed assessment that provides information about the history, the physical and psychosocial aspects and behaviour of the person with dementia is necessary for the comprehensive planning of interventions and care.
- Thorough assessment that explores for potential stressors or unmet needs will assist in identifying possible triggers contributing to the behaviour of concern
- Involving family and carers in the information gathering process can help in gaining greater insights into the client's history and preferences
- Vocally Disruptive Behaviour can be an indicator of an unmet need or reduced stress thresholds.

2.6 Resources and References

1. Behaviour Management – A Guide to Good Practice 2012 available at http://www.dementia.unsw.edu.au/index.php?option=com_drcrc&view=drcrc&layout=project&Itemid=101&pid=154
2. The IPA Complete Guides to BPSD (2012) – Nurses Guide p8
3. Index of Independence in Activities of Daily Living tool can be found at <http://www.healthcare.uiowa.edu/igec/tools/categorymenu.asp?categoryID=5>
4. Kings Fund tools for Enhancing the Healing Environment can be found at <http://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia>
5. Abbey Pain Scale can be found at <http://www.dementiacareaustralia.com/images/stories/abbey%20pain%20scale.pdf>
6. The Cornell Depression Scale can be found at http://geropsychiatriceducation.vch.ca/docs/edu-downloads/depression/cornell_scale_depression.pdf
<http://img.medscape.com/pi/emed/ckb/psychiatry/285911-1335300-1356106-1392041.pdf>
7. Cohen-Mansfield Agitation Scale can be found at http://www.dementia-assessment.com.au/symptoms/CMAI_Scale.pdf

Additional Resources

8. Cohen-Mansfield J. (1999) Measurement of Inappropriate Behavior Associated with Dementia Journal of Gerontological Nursing 25,2 45-51
9. Beck C. & Vogelpohl T.S. (1999) Problematic Vocalisations in Institutionalized Individuals with Dementia. Journal of Gerontological Nursing; Sep; 25, 9;
10. Lai C.K.Y. (1990) Vocally disruptive behaviours in people with cognitive impairment: Current knowledge and future research directions. American Journal of Alzheimer's Disease, 14, 172-180.
11. Teri L., Logsdon R. G., & McCurry, S.M. (2002) Nonpharmacologic treatment of behavioural disturbance in dementia. Med Clin N Am 86 641–656
12. Summary of the NDB Model with assessment <http://www.healthcare.uiowa.edu/igec/publications/info-connect/assets/ndb.pdf>

Objectives:

At the end of this module you will be able to:

1. Outline some key factors to take into account in the development of an intervention plan for a person with BPSD, once your initial assessment is complete
2. Use the assessment data provided in Mrs A's case study to guide the development of goals for selected interventions
3. Differentiate ways to demonstrate the promotion of person-centred care
4. Identify possible interventions and rationale that might be tried for Mrs A which focus on reducing her vocalisation behaviour.



3.1 Factors for consideration when planning care

The process of preparing the goals of care and a plan of interventions will be based on the information that has been collected and documented following a comprehensive assessment.

Before interventions are devised, some important factors need to be taken into account.



Activity 3.1: Watch the “Expert Conversations” video clip entitled ‘Factors to consider’ (19 minutes duration)

The Experts are responding to the question

“Based on the information collected when assessing BPSD, how do you decide: (a) when to intervene; and (b) when not to intervene?”

a) Summarise two key messages that resonated with you from the comments made by the experts.

i)

ii)

Early intervention, where possible, is vital in the planning process. This will often involve anticipating actions that may escalate a person's behaviour, leading to increased agitation or aggression. The planning process involves anticipating and being proactive by putting interventions in place that aim to diminish stressors or resolve unmet needs.

As mentioned previously in Module 1.2, delivery of quality care involves planning interventions that take account of, and apply, person-centred care (PCC), a philosophy to guide staff in their approach to care of a person with dementia. The concept of PCC underpins the care for a person with dementia.

Kitwood (1993) emphasised the importance of quality interactions between the healthcare professional and the person with dementia and indicated that these interactions influence the sense of personhood of that person, giving that person recognition, respect and trust (1). These interactions create a social relationship within which the person with dementia can retain their sense of self. Excluding a person with dementia from a relationship because of their cognitive impairment is to deny them an aspect of their existence.



Activity 3.2: Access the website

<http://www.health.vic.gov.au/dementia/strategies/person-centred-care.htm>

and consider the actions provided under the link entitled “Communication strategies” (2)

Provide, in the columns below, four examples of **positive person-centred interactions** which offer positive experiences for the person with dementia and suggest four less helpful **interactions** that may contribute to negative experiences.

<i>Positive Person-centre interactions</i>	<i>Less helpful interactions</i>
1.	
2.	
3.	
4.	

3.2 The Planning Process (Development of a Plan)

The development of an Intervention Plan for a person with dementia will:

- utilise the findings of the assessment process
- include realistic goals to be achieved
- identify strategies aimed at resolving, reducing or managing BPSD
- where possible, select research based interventions for which the evidence is strong
- assist and educate carers/family to understand

the behaviour, the goals of care and to contribute to care

- incorporate effective strategies already used by carers
- enable evaluation to take place

In formulating the plan consideration needs to be given to input from other stakeholders (multi-disciplinary team, family and carers) as well as seeking validation for proposed approaches.



Activity 3.3: Watch the “Expert Conversations” video clip entitled ‘Planning and Implementing strategies’ (36 minutes duration)

The Experts are responding to the question:

If an intervention is required to address a BPSD, what approach do you take in planning and implementing the intervention and why?

As you watch this session **note key points** suggested by the Experts concerning the planning of interventions and list these beside the given topics below.

Topic	Key points
Overall approach	
Goals	
Intervention selection	
Team approach	
Family involvement	
Medications	

When planning care give priority to non-pharmacological interventions where ever possible. A multi-faceted approach will often be necessary in which biological (pharmacological) treatment is indicated in combination with psychosocial and environmental interventions.

Using the Need-Driven Behaviour model as an example, the following diagram outlines the process of intervention planning for BPSDs, from assessment of contributing factors through to the ongoing management.

Figure 3.1 Need-driven Intervention Plan model Algase 1996 (11)

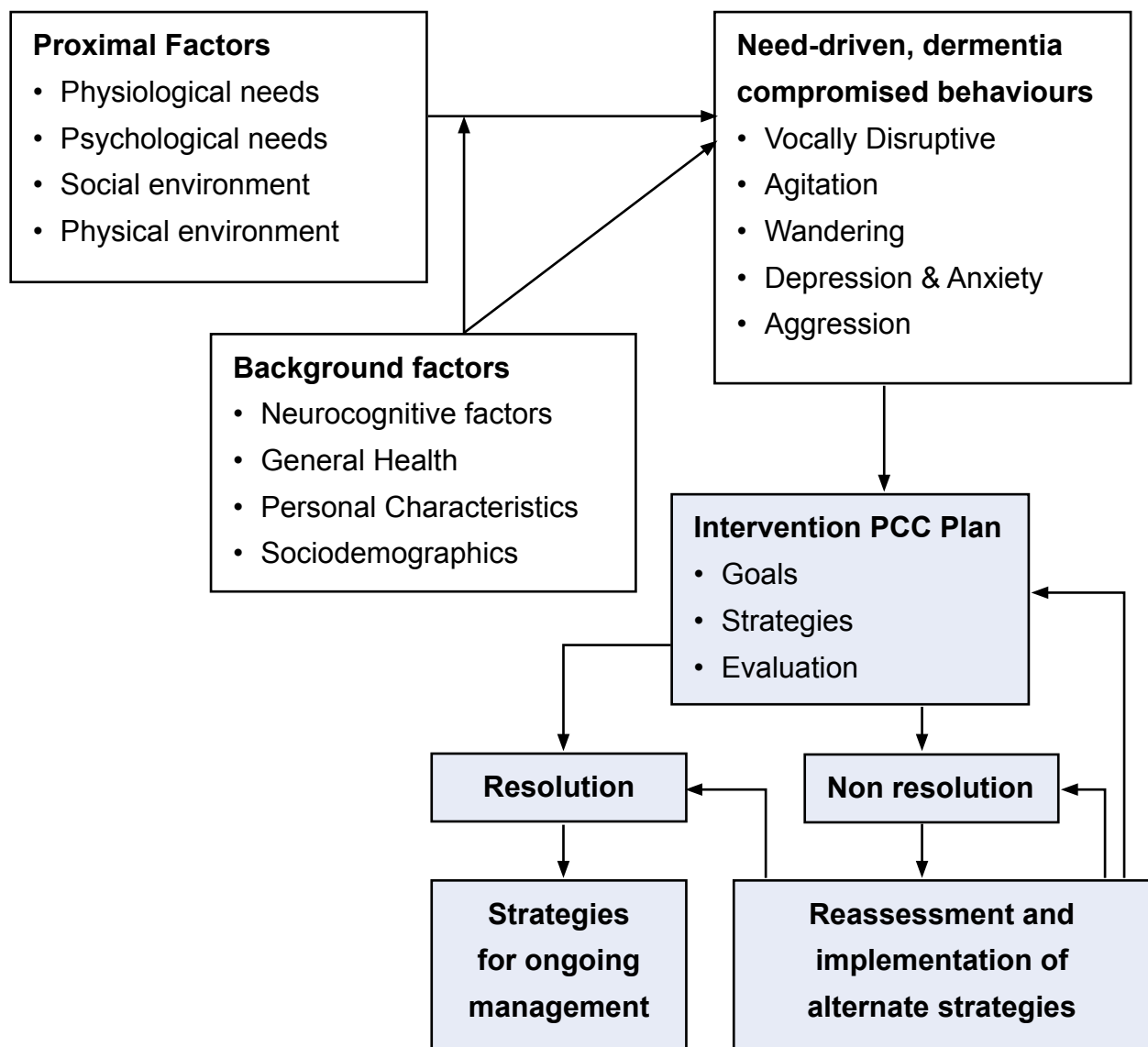


Figure 3.1 above aims to illustrate use of the NDB model showing that once factors contributing to the need-driven compromised behaviour have

been identified then an intervention plan (goals and strategies) is developed and implemented, regularly reviewed and evaluated.

The intervention strategies for BPSD can be summarised as:

1. Non-pharmacological approaches

Assess and address environmental, physical, and psychological precipitants, predisposing factors, perpetuating factors. Multifactorial behavioural interventions may be required.

Examples of evidence-based interventions under this category include: Therapeutic recreation, reminiscence, exercise, music, sensory, touch therapies, use of animals, environmental modifications and education/training of carers. (3) p62

These interventions are designed to occupy the person with dementia in meaningful, engaging activities that build relationship, enhance recall, maintain functional capacity and stimulate creativity. They may also calm, soothe and relax the person.

2. Pharmacological treatment

McKeith et al (2005) summarises the main drug groups recommended for use in the management of BPSD as:

- **Atypical antipsychotics**

Advantages: Can reduce agitation and psychosis

Can be associated with increased risk of stroke in Alzheimer's disease

Disadvantages: Can provoke severe neuroleptic sensitivity reactions in DLB

Not recommended for use in dementia (by the UK Committee on Safety of Medicines)

- **Other (described as anti dementia)**

Cognitive enhancers - Cholinesterase inhibitors may improve apathy and mood symptoms

Memantine may reduce agitation

- **Antidepressants**

Can reduce depression and emotional ability

- **Benzodiazepines** - not advised in people with dementia (4) p738

3.3 Strategies shown to have assisted Vocally Disruptive Behaviours

As has been stated earlier, the interventions to be selected will:

- relate to the documented assessment information
- be trialled one at a time in a systematic way for a nominated time period
- ideally be based on evidence from sound research

Most of the research related to persons with VDB have been case studies and no randomised controlled trials of the most promising interventions are reported (3) (4). Consequently, the most efficacious interventions are still not clear.

The type of interventions can be categorised into:

- psychosocial or environmental, sometimes referred to as non-pharmacological - grouped into the broad categories of music, multisensory, therapeutic activities and miscellaneous
- biological/pharmacological – which include cholinesterase inhibitors, antipsychotics - typical and atypical, antidepressants and other medications.

Preparing realistic goals**Activity 3.4**

Using the given aims of care, develop specific goals that will guide what is to be achieved with the selected intervention thereby providing a way to evaluate the success or not of that intervention.

<i>Aim of Care</i>	<i>Goal</i>	<i>Interventions</i>
Eliminate pain		Provide regular analgesia especially prior to ADL and exercise and maintain regular observation for signs of discomfort
Enhance comfort during routine care, such as bathing, feeding, toileting		Use a calm approach Use gentle slow movements Ensure environmental temperature and noise levels are suitable Use actions that minimise indications of discomfort
Increase opportunities for engagement		Offer opportunities for involvement in engaging 1:1 or in group activities Encourage volunteer or family visits Place in a location where others can interact naturally and without effort Attend for short interaction on half hourly basis
Reduce boredom		Provide sensory or touch therapy session in morning Offer music or an exercise activity of preference as a distraction in the afternoon



Activity 3.5

We will now follow up with Part 2 of Mrs A's story and explore some planning activities based on her assessment data provided in Module 2

a) Read Mrs A' case study – Part 2

Mrs A's Case Study – Part 2

Strategies Used to Address Behaviour and Support Care

Mrs A's family conveyed that they wished to avoid excessive medication being given to her. Strategies to support Mrs A and address the behaviour were considered and these included non-pharmacological interventions, which were trialled first to try to avoid use of medications. A 24 hour chart was used to record the incidence of the loud vocalisations over a five day period and the charts showed the vocalisations occurred for an average of 6.5 hours per day, mostly during morning and evening hours



DBMAS clinicians were asked to assist and they worked to empower staff by involving them in developing strategies to address the behaviour. Approximately 18 strategies were trialled which included fiddle maps (large cloth with buttons, zips etc.), fiddle muffs (muffs with buttons etc. inside), whole body massage focussing on different body parts over time, a cuddly bear toy, garden walks, one to one communications, music and Mrs A's own stress relief tapes, and an afternoon nap. Participation in communal activities was found to be overstimulating and this exacerbated the vocalisations.

The staff developed a chart to record the interventions and as the interventions were applied, they were documented in her chart. Information recorded included the time of the intervention, the level of success that had been achieved and the duration of Mrs A's response. Some strategies were effective, however, in all cases the effectiveness was only short term, inconsistent and unpredictable when repeated. The afternoon nap appeared to have a more lasting effect in reducing the vocalisations over other strategies.

Efforts were made to involve Mrs A's family with requests to bring in music that she particularly enjoyed and suggestions about other pastimes. The DBMAS clinicians educated staff to consider Mrs A's individuality and needs and to be mindful of possible brief strategies that would not be time consuming and might improve her situation.

These included closely observing her body language and non-verbal communication which reflected her emotional state. In addition, having brief interactions with her when passing acknowledged her isolation. Placing Mrs A to face the garden which she loved was a simple strategy that did not require extended staff involvement and was preferential to facing into a room.

Following the challenge to develop consistent and ongoing strategies to support Mrs A and address the loud vocalisations, it was decided, in collaboration with other health professionals including a geriatrician, that a pharmacological management plan should be included. The priority was to find a balance “between quality of life where she is not sedated by the medication and where she is not unduly disturbed by the psychotic elements of her illness.

b) From Mrs A's case study list the interventions systematically introduced with the aim of reducing Mrs A's VDB. Provide a possible reason why each intervention was selected for trial (not the effectiveness).

Remember to give consideration to the assessment information and the unmet-needs model

Intervention	Possible Reason/s (rationale) for using this intervention

Biological (Pharmacological) interventions

Evidence for pharmacological treatments for VDB is limited. The use of Risperidone (Ozidal, Risdone) was found to reduce VDB in a number of random controlled trials. (3) p173

Pharmacological interventions are used when indications suggest there is a need to:

- treat depressed mood/agitation
- treat psychotic symptoms e.g. delusions and hallucinations
- review adverse drug effects

As suggested in the previous module, the carer/family will also be assessed for their emotional responses, in particular, evidence of reduced coping such as anxiety, frustration or anger. The planning process will need to take account of the needs of the carer and family and include interventions that offer:

- education about VDB and its causes
- assistance with providing comfort measures to offer the person with VDB
- support with communication strategies
- involvement in a consistent approach to the person with dementia devised by the staff and in collaboration with the carer.

3.4 Clinical Reflections

Remain focussed on individuality and person-centeredness in your approach to care. Certain strategies and interventions that work very well for some people will not be successful with others and it is important to keep trying all possible

strategies until options are exhausted. Be aware of the changes that may occur as the disease progresses and the impact that this has on behaviour and modify strategies accordingly. It is important to accept a point at which it is clear that further efforts are unlikely to produce effective outcomes. At this point other approaches need to be considered with the involvement of a multi-disciplinary team in discussions, support and supervision.



3.5 Key Message

- Use of a person-centred approach to care promotes the development of a helping relationship and recognises the individuality of the person
- The selection of interventions that are aimed at the cause of the behaviour rather than the behaviour itself are more likely to be effective but the cause may not be clear
- Planning to include a variety of interventions that can be systematically trialled is likely to find the most effective solutions to reducing or eliminating the behaviour
- Recognising the carer or family as members of the team and acknowledging their skills, experience and references in the planning process is a key consideration
- Evidence suggests that therapeutic recreation may be the most effective intervention for management of VDB

3.6 Resources and References

1. Kitwood, T. (1997) The experience of dementia. *Aging & Mental Health* 1(1):13-22
2. Victorian Government Health Information: Dementia-Friendly Environments. Person-centred Care
<http://www.health.vic.gov.au/dementia/strategies/person-centred-care.htm>
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11. Lai C.K.Y. (1990) Vocally disruptive behaviours in people with cognitive impairment: Current knowledge and future research directions. *American Journal of Alzheimer's Disease*, 14, 172-180.
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13. Algase D. L. (1996) Need-driven dementia-compromised behaviour. An alternative view of disruptive behaviour. *American Journal of Alzheimer's Disease* November/December
14. Summary of the NDB Model with assessment
<http://www.healthcare.uiowa.edu/igec/publications/info-connect/assets/ndb.pdf>

Additional Resources

Objectives:

At the end of this module you will be able to:

1. Explain the important features of evaluating interventions to determine the level of effectiveness
2. Outline some key elements related to the assessment of a person with dementia experiencing agitation
3. Develop goals for given interventions, provided in the case study for agitation, that can be used to evaluate the planned interventions
4. Suggest indicators of effectiveness, in relation to agitation, that could be used to determine the success of interventions.

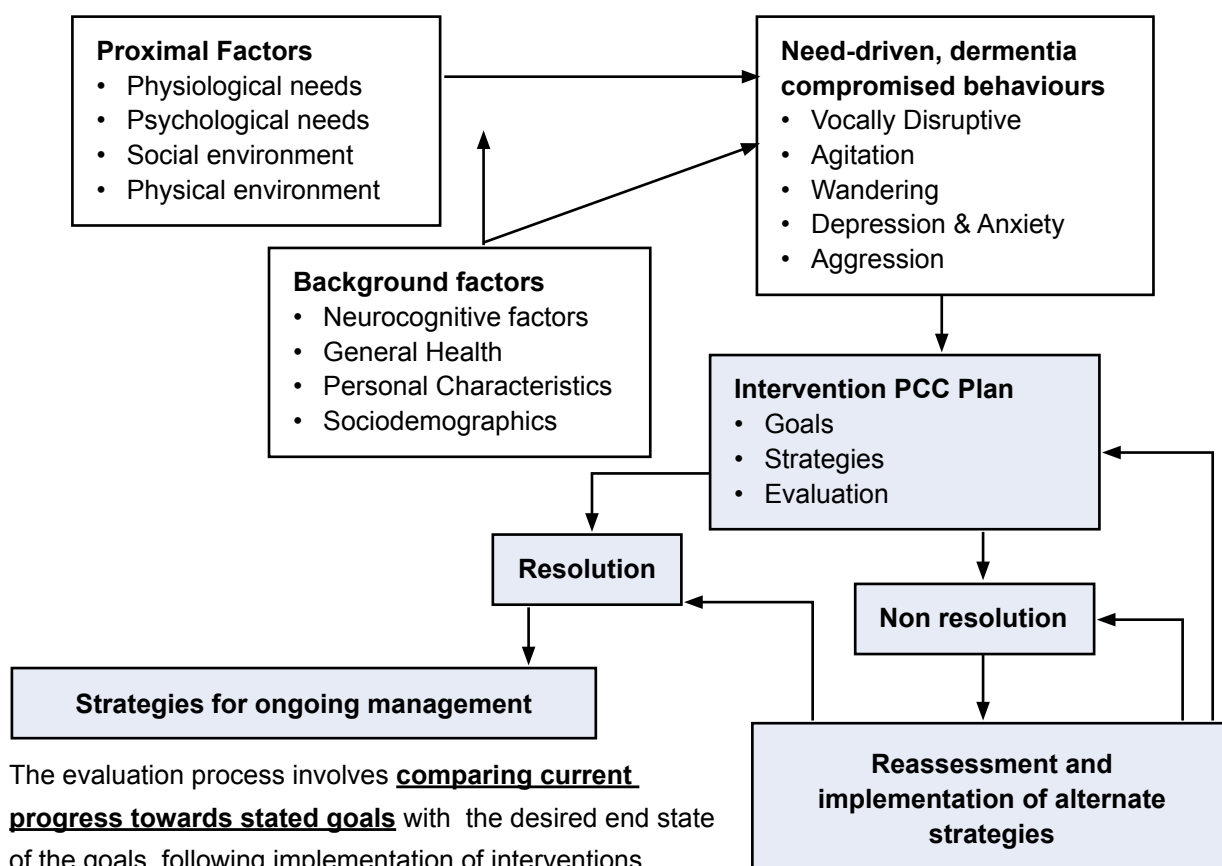
4.1 The process of evaluation

Once goals have been developed and interventions planned and implemented, the third component of an intervention plan for a person with dementia involves the evaluation process. This part of the intervention process involves questions such as:

- Has the intervention made any difference?
- Have there been any changes in behaviour no matter how small?
- To what degree has the change occurred?
- Is the change an incremental improvement or do the changes come and go?
- How is the change demonstrated?

Figure 4.1 Need-driven Intervention Planning model

How will you obtain the answers to these questions for the selected intervention?





Activity 4.1: Watch the “Expert Conversations” video clip entitled ‘Evaluating the effectiveness of Strategies’ (22 minutes duration)

The Experts are responding to the question

- **How do you know when an intervention to address BPSD has been successful?**
- **What do you do when an intervention to address a BPSD has been unsuccessful?**

For the following goals and interventions, develop indicators that will provide a measure of the effectiveness of the given intervention.

Goal	Intervention	Indicators of effectiveness
Reduced frequency of VDB over next 2 days	Frequent brief periods of interaction by assigned carer at times when VDB not exhibited	
Responds to a calming environment for up to 30 mins between 2-4pm for one week	Offer brief (15-30 mins) music therapy with personal choices of music from 2pm	

When there is no indication of improvement evident or the behaviour worsens after a short period of time, maybe over a couple of days (and up to a week), the situation will need reassessment. When this situation exists then an alternate strategy can be introduced and trialed for another short period. Ongoing monitoring of progress over a further period is important to gauge if the success is maintained. If an intervention is likely to be successful for the person with dementia, a change will usually be seen within a week.

Our case study for this module introduces **Joyce**, a 64 year old lady with younger onset dementia secondary to Huntington’s disease diagnosed 12 years earlier. Joyce is now exhibiting agitation behaviours.

First we will look at the behaviour described as **agitation**.

Agitation

4.2 What is agitation?

The 2012 BPSD Guide, Module 4 p82 (1) provides an overview of agitation behaviour and describes it as a commonly occurring BPSD, with observable, non-specific, restless behaviours that are excessive, inappropriate and repetitive, such as:

- Irritability
- Restlessness and/or pacing
- Aberrant motor activities such as excessive fidgeting or hand wringing and/or
- Disruptive vocalisations

It is often associated with poor health and quality of life outcomes. (1)



Activity 4.2

Go to the BPSD Guide p 82 and read the summary and key messages about agitation.

4.3 Assessment and measurement of agitation

The focus of assessment for agitation will include observing and recording the frequency, duration and intensity of the behaviour and any possible triggers for the behaviour e.g. what contributes to an increase in agitation levels.

Referral notes and questions posed to a carer or a family member can be used to provide further information to aid identification of factors that may be contributing to the behaviour (see the example shown in the Assessment box on p87 BPSD Guide)

Several instruments can be used to assist in measuring agitation, these include -

- The Cohen-Mansfield Agitation Inventory (CMAI), (6)
- the Pittsburgh Agitation Scale (PAS) (5), and
- the Neuropsychiatric Inventory (NPI) & NPI-Clinician (NPI-C).

The first instrument will be familiar to you from Module 2 in this program. Now we introduce you to the Pittsburgh Agitation Scale (PAS) and a third instrument, the Neuropsychiatric Inventory (NPI). This is available in two formats, the NPI and the NPI-Clinician, the latter being an expanded version of the NPI, allocating agitation to a discrete subscale (1) p86. Each of these instruments uses a scale and progressive comparison of scores over time, all of which contribute to the evaluation process. Trends showing either reduction or increase in behaviour indicators can be monitored as an indication of improvement or deterioration in the behaviour of the person with dementia.

4.4 Management of agitation

Guidelines recommend the use of multidisciplinary, individualised person-centred care with goals and interventions trialled in the following sequence:

- First-line approach - Psychosocial & environmental interventions
- Second line of approach - Biological (pharmacological) interventions

a) Psychosocial & environmental (Non-Pharmacological) Interventions

Choice of interventions will depend on assessment data and any identified or suggested triggers. Where the intervention addresses the cause it is likely the behaviour will be reduced.



Activity 4.3: Go to the BPSD Guide p 88-89 under 'Management of Agitation' or Appendix 3 where a variety of psychosocial interventions are provided.

In the columns below, provide **four** suggested interventions shown to have beneficial effects and **three** interventions which are not supported by evidence.

<i>Psychosocial Interventions</i>	<i>Level of Evidence as identified in Appendix 3</i>
1.	
2.	
3.	
4.	
5.	
6.	
7.	

b) Biological (pharmacological) Interventions

Treatment of agitation with medication is used particularly when non-pharmacological interventions are not showing success. There is strong evidence for use of Olanzapine (Aprolan, Lanez) and Risperidone (Ozidel, Resdone) although the side effects of atypical antipsychotics do pose safety concerns and sometimes cause deterioration in condition.

Some positive effects have been shown with Memantine (Ebixa, Memesol) use.

Use of analgesics for underlying pain treatment and antidepressants such as Mirtazapine (Avenza, Axit) and Citalopram (Abbapram, Celapram) have shown efficacy. (1) p89-90.

4.5 Evaluation of interventions

If the focus of evaluation activities is assessing whether some indication of change exists, then it makes sense that we compare the current situation with what existed before, that is, our baseline data. The concept of 'baseline' is important because it provides a clear, common point from which we can move forward.

Behaviour change may be small and incremental and it may also fluctuate across a time frame.

Regular observation and recording of the characteristics of the behaviour is a key element in demonstrating that change has occurred.

As an example, when comparing observations first recorded before the trial of an intervention for psychomotor agitation with the indicators of restlessness following the intervention, the questions you might ask are:

- Is pacing (wandering in small back and forth motion), repetitive tapping, wringing of hands or fidgeting **now less frequent?**
- Has calling out or pathological crying **diminished?**



Activity 4.4

a) We will now meet Joyce, read her profile given below

Joyce's Case Study - Part 1

Joyce is a 64 year old woman with younger onset dementia secondary to Huntington's disease diagnosed 12 years ago. Joyce lives with her husband, Doug, who reports having been her carer for the past 13 years.

Joyce was a highly accomplished and respected person with a promising career in the Public Service a source of great personal pride prior to her being diagnosed with Huntington's disease. An incident at work in which Joyce made a significant mistake, most likely the product of the undetected dementia, resulted in the termination of her position. Joyce found this to be a humiliating experience which Doug reported had left her emotionally and psychologically traumatised.

Over time Joyce's husband repeatedly contacted Alzheimer's Australia and other agencies requesting help with her behaviour which was escalating in severity. It was evident Doug had reached a crisis point where he felt desperate and unable to cope and DBMAS clinicians were asked to assess the situation.



Description of Behaviour

The behaviour that Doug reported, in addition to verbal outbursts, was yelling and screaming that escalated to physical aggression at times, with threats to pull things off the wall and to walk out. Doug reported that these episodes of behaviour could continue for more than a day, increasing in intensity and severity.

An accumulation of traumatic past experiences and the termination of Joyce's position at work with resultant loss of control and self esteem appeared to occupy Joyce's thoughts. Clinicians described paranoia and a loss of control, insight and the ability to interpret situations, as contributing to the irrational nature of the dementia related behaviour.

Joyce believed that someone was trying to poison her (paranoid delusion) and demanded that her fingernails, that had been cut, be put back on her fingers. She refused to take medications, which included analgesics to manage her arthritis-related pain, with the consequence that she remained in uncontrolled pain that contributed to her distress.

Doug, being overwhelmed and having little understanding of her condition, inadvertently exacerbated Joyce's behaviour with inappropriate responses and directive communication. In addition, their disorganised home environment contributed to surroundings that were not conducive to caring for and managing irrational behaviour. Clinicians reported that Joyce functioned better with a consistent routine and was also more responsive to community care workers for whom she had an affinity. However, unexpected or unplanned changes to carers or routines caused significant distress to Joyce who, according to Doug, became "inconsolable" leaving him at a loss and desperate as to how to respond. Her inconsolable distress escalated into agitation and then aggression which resulted in Doug seeking help

b) From the above case study about Joyce

i) Identify the behaviours demonstrated by Joyce that indicate agitation

ii) What triggers for her behaviour are suggested?

Assessing Joyce's symptoms

Approach Used to Assess Behavioural and Psychological Symptoms of Dementia

The *PIECES framework* was used to assess Joyce's situation and to identify possible unmet needs. The PIECES mnemonic prompts the following considerations Physical, Intellectual, Emotional health; Capability; Environment and Social Self. This framework enabled clinicians to identify and explore both the environmental factors and factors intrinsic to both Doug and Joyce, and to identify elements that they might otherwise have missed. In addition, they felt that a home assessment and face to face interviews were an essential component to enable them to elicit relevant, comprehensive, information to be able to develop a constructive response.

An interdisciplinary team, including a geropsychiatrist and a neuropsychologist, visited Joyce to undertake assessment, including her paranoid delusions, in the home environment. Joyce then had a short period in respite care and expressed pleasure and satisfaction with the care, for example, good physical care, nutrition and the opportunity to socialise. She was also able to engage in some hobbies in the same way as she did at home with the Community carers. The clinicians observed that in a less reactive environment (respite care), where the carers were focused on providing pleasant events, she expressed happiness. They noted that the obsessive behaviour and perseveration (preoccupation with her fingernails) displayed by Joyce due to the dementia was possibly more readily managed in the care environment.



Activity 4.5

- a) From Joyce's assessment information and using the PIECES framework, suggest the unmet needs which may exist.

Framework	Possible Unmet Need
Physical	
Intellectual	
Emotional	
Capability	
Environment	
Social Self	

b) It is also clear that Doug is not coping - what actions may be helpful for Doug?

Planning Interventions for Joyce - Part 2

Strategies Used to Address Behaviour and Support Care

Following assessment of the physical environment and personal factors for Doug and Joyce, the clinicians developed a plan using a “multi-pronged”, interdisciplinary team approach. Central to this plan was a response pathway for Doug to streamline the services provided. Doug had regularly contacted multiple sources for help, resulting in duplication of effort and frustration for the providers. This pathway meant that each source he approached was fully briefed on his status and could provide appropriate and constructive advice, assistance and emotional support.

In addition, education and support of the Community carers and Doug, the main people who interacted with Joyce was an important strategy. Doug was offered counselling which he refused. However, he was informed and educated about effective communication with Joyce aimed at ameliorating the frequency and severity of the behavioural episodes. Techniques included, remaining calm and being gentle, not challenging or confronting her and sitting down beside her instead of standing over her. The same strategies were presented to Community carers.

Close examination of Joyce’s behavioural episodes showed a pattern of escalation from initial distress at an event or situation. This was pointed out to Doug and Community carers so that they were able, by identifying the early signs in the pattern, to respond early and appropriately in such a way that would avoid escalation. This included focusing on activities that would give her pleasure and empower Joyce to make choices where possible, as well as involving her in tasks that raised her self-esteem. The importance of monitoring her responses at all times and being alert for indications of distress was stressed.

Development of the plan and implementation of the strategies led to an improvement in the situation for Joyce and Doug. Evidence of this is demonstrated in fewer calls for help from Doug, falling from multiple weekly calls to less than monthly - and then intermittent and occasional only. Training and up-skilling the Community carers who had regular contact with Joyce and Doug was a key strategy in the effective management of the situation. The Community carers are now able to respond to day to day needs and provide ongoing emotional and physical support for both Doug and Joyce.



Activity 4.6: From the above description of the planned strategies for Joyce and Doug, answer the following questions related to evaluation

a) Indicate the ways in which clinicians or carers can regularly monitor Joyce's response to planned interventions?

b) For how long is it helpful for interventions to be continued?

c) In the table below, suggest observations that may indicate the interventions being used with Joyce are having a positive effect.

Goal	Intervention	Observations showing a positive response by Joyce to these interventions
Analgesics accepted without concern within one week	Individual music therapy each day combined with hand massage prior to offering analgesic	
Agitation following interaction with Doug less evident over the next month	Provide communication techniques such as, remaining calm and being gentle, not challenging or confronting Joyce and sitting beside her instead of standing over her	
Engages in positive decision-making and makes choices over the next two weeks	Encourage Doug/carers to: <ul style="list-style-type: none"> • offer alternate activities for Joyce to decide • request Joyce's preference when offering food or drinks 	
Verbal outbursts less frequent over next month	Reduce harsh noise and promote a calm, low stimulation environment	

4.6 Clinical Reflections on Joyce's case study

There are a number of points to highlight in this case that assisted behaviour management. Initially, using a model (in this instance PIECES) to guide assessment and the development of care strategies ensures objectivity and assists a focussed intervention.

The importance of a multidisciplinary team approach supported and enhanced by input from a number of sources is vital and demonstrated the value of interdisciplinary contributions to care giving.

In addition, regular documentation with contributions from everybody involved in the case was central to successful outcomes. Making this documentation available and ensuring ease of access by everyone involved in the care is very important. This ensures that actions are based on current circumstances and apply within the context of a wider support network.



4.7 Key Message

- Agitation is a commonly occurring BPSD with both behavioural and psychosocial dimensions
- Management with non-pharmacological interventions is the first line of approach
- Comparing observations prior to and following interventions provides an indication of a positive or negative trend
- Regular review of the outcome of interventions provides an indication of the value of the intervention in managing a behaviour
- Current evidence suggests that music is an effective intervention for agitation management.

4.8 Resources and References

1. Behaviour Management – A Guide to Good Practice 2012 available at http://www.dementia.unsw.edu.au/index.php?option=com_drcrc&view=drcrc&layout=project&Itemid=101&pid=154
2. Cohen-Mansfield J., Werner P. & Marx M.A. (1989) An Observational Study of Agitation in Agitated Nursing Home Resident *International Psychogeriatrics*, Vol. 1, No. 2,
3. Ballard C., Corbett A., Chitramohanc R. & Das Aarsland D. (2009) Management of agitation and aggression associated with Alzheimer's disease: controversies and possible solutions. *Current Opinion in Psychiatry*, 22:532–540
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5. Forester B.P. & Oxman T. E. (2003) Measures to Assess the Noncognitive Symptoms of Dementia in the Primary Care Setting, *Prim Care Companion J Clin Psychiatry* 5(4): 158–163. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC419385/>
6. Cohen-Mansfield, J (1999) Management of Inappropriate Behavior associated with Dementia, *Journal of Gerontological Nursing* Feb 25,2 ProQuest Health and Medical Complete p 42

Objectives:

At the end of this module you will be able to:

1. Outline the key elements to include in the assessment for a person with wandering behaviour
2. Using the NDB model, suggest from the given case study the probable consequences of wandering behaviour
3. Select possible interventions which evidence suggests may be useful to trial in managing wandering behaviour
4. Identify any successful interventions used in Sharon's case study and indicate how effectiveness could be determined.

5.1 Wandering behaviour

Wandering behaviour can be one of the most challenging BPSDs to manage, as clients may unwittingly place themselves in danger and expose themselves to injury or death, although wandering within safe areas may have positive effects, for example exercise.

Definition of wandering

In dementia, wandering may reflect diminished 'way finding' ability in pursuit of a need or goal. A cognitive change, such as an attention deficit, might interfere with one's ability to keep a goal or destination in mind. (1).

Algase et al (1996) suggest information about the relationship between these goals, needs, environmental conditions and particular rhythms and patterns of wandering will provide the foundation for designing and targeting effective interventions.

What is wandering?

Wandering is a syndrome of dementia-related

locomotion behaviour having a frequent, repetitive, temporally-disordered, and/or spatially-disorientated nature that is manifested in lapping, random, and/or pacing patterns, some of which are associated with eloping, eloping attempts, or getting lost unless accompanied. (2)

One aspect of wandering, the geographic pattern of it, can be described as one of the following patterns below:

- Lapping – circular locomotion in larger spaces e.g. around the perimeter of a room, up and down a long corridor.
- Pacing – short locomotion back and forth between two points
- Random – locomotion without a direct path and multiple changes of direction

Direct locomotion from point A to B is not considered wandering

Wandering can also be described in terms of a rhythm involving locomoting (walking) and non-locomoting (sitting, standing still, lying down) phases. People with dementia who wander tend to get lost easily, try to find their way by investigating their environment and often find it very difficult to rest, sit down to eat a meal or enjoy activities and stand or sit still during care interactions with staff. It is clear that people may wander for different reasons, in different ways and with differing outcomes and often the person with dementia cannot tell us why they are walking so much.

Peatfield (3) identifies a number of researchers that have suggested wandering may be a physiological coping mechanism that the individual uses to reduce stress and it may be beneficial to the person with dementia to meet the need to be alone, or to reduce their boredom. (4,5,6,)



Activity 5.1

Read the summary for Wandering behaviour in 2012 BPSD Guide p179, noting the **causes** of wandering and the measurement tests used to gauge the dimensions of the wandering. (7)

In terms of observations during the assessment process the dimensions of the behaviour that will be of value to record are **pattern, frequency, duration and peak period of occurrence**.

It is also important to determine the effects this behaviour is having on the carer or family, as often there is significant anxiety about the **adverse outcomes** for the person with wandering behaviour for their safety and concern they may get lost or come to harm.

The assessment process will involve taking a history of the behaviour from the resident's carer or family members and from observing the person's behaviour. This assessment, with a focus on identifying proximal or background factors, will potentially enable you to gain an understanding of underlying triggers or unmet needs that might be contributing to the resident's wandering.

This information will assist in the preparation of a plan to address these triggers and unmet needs.



5.2 Measurement tools for Wandering

The Revised Algase Wandering Scale is specifically designed to evaluate wandering behaviour. Versions are available for both long-term care and a community version. (3) P183 The NPI and CMAI tools include some items related to wandering but are not strong measures for evaluating a person whose primary issue is wandering.

An observation sheet, used while trialling interventions, needs to plot:

- frequency and duration of wandering across a given day,
- length of time the person sits, rests, remains at the table during meals or stays sitting during activities and
- any reduction in aspects of wandering such as entering the private spaces of others without invitation, trying door knobs or windows and trailing and shadowing staff and other residents.

All of these observations may assist staff to determine whether interventions being trialled are having a degree of effect.

In the next section we see how elements of the Need-Driven Behaviour model (previously introduced in Module 1) along with a stress process model has been used to develop a more specific model highlighting the adverse outcomes of the behaviour, called the Risky Wandering and Adverse Outcomes (RWAO) model. We will then use this model to assess the subject of our case study, Sharon, in terms of possible triggers for her challenging behaviour

Figure 5.1 The Need-driven compromised behaviour (NDB) model

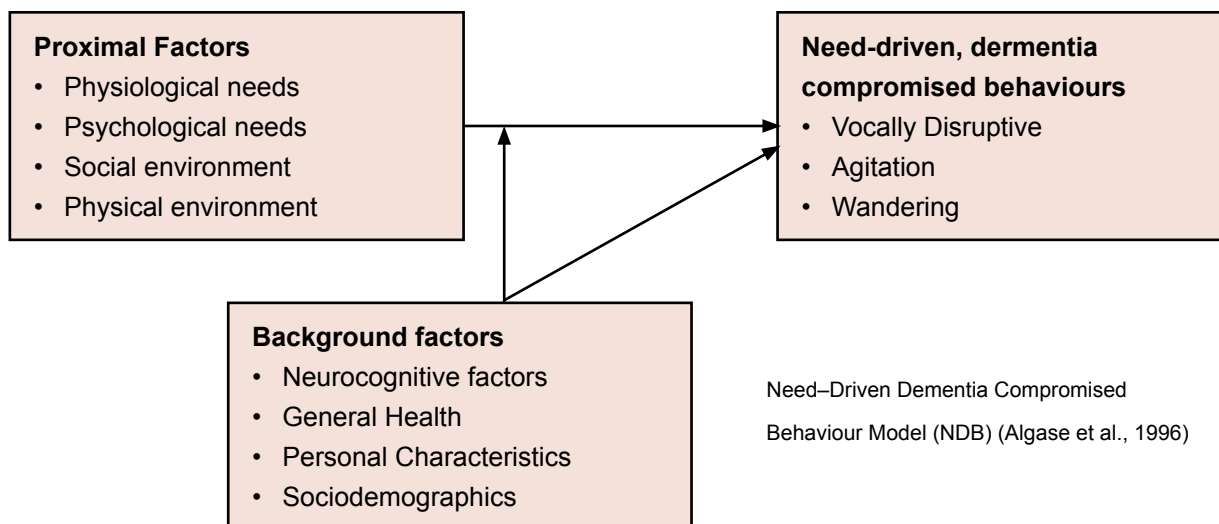
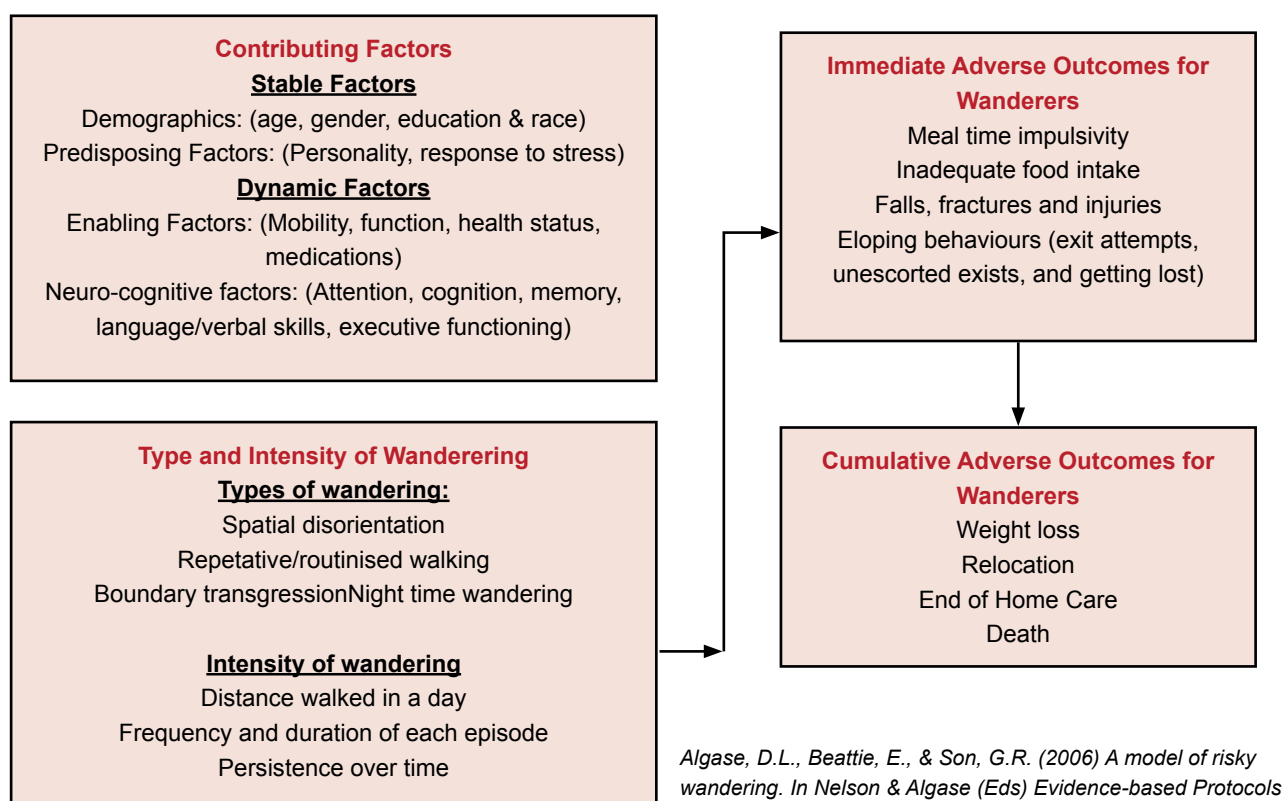


Figure 5.2 below introduces the Risky Wandering and Adverse Outcomes (RWAO) model which identifies that the type and intensity of wandering can lead to immediate adverse outcomes that

if unchecked can have a cumulative effect with severe results on the wanderer, adding to the concern of and burden on their caregiver.

Figure 5.2 Risky Wandering and Adverse Outcomes model (RWAO)





Activity 5.2: Sharon's Story

a) Our case study in this module is about Sharon. Read her profile below.

Sharon is a 71 year old woman diagnosed with early onset Alzheimer's disease at 63 years and currently living in a residential care facility. Sharon's husband Ron is her only family contact since the death of their only child, a son in his thirties, in a car accident. She has a history of being a keen golfer, accomplished gardener and was involved in several voluntary activities including meals on wheels throughout her fifties. After her son's death she became depressed but was successfully treated with antidepressants. Several years after this Ron became aware of her memory loss issues. Her entry to permanent residential care was precipitated by several events that involved getting lost and being unable to return home, the last one involving a broken arm from a fall in a park 4 kms from home after 3 hours missing and a police search. She was also waking up repeatedly at night, roaming the house, walking away from Ron while he was trying to help her bathe, dress or go to the toilet and becoming agitated and responding by hitting and swearing at Ron. He felt unable to take her out to the shops or other outings and was exhausted.



Sharon's relationship with her husband is difficult and complex. When he arrives to see her she becomes stressed, agitated and aggressive towards him. Ron has been depressed himself and drinking to excess, related to the death of their child and to his wife's situation, and this has contributed to Sharon's distress.

Key Referral Information

Sharon was a school principal in their small rural community and some of the current staff were former pupils, who reported that Sharon had been harsh, strict and unpopular. However, others recall her as cheerful and outgoing and very involved with families and showing kindness.

Sharon was referred to DBMAS clinicians for behaviour that included frequent intrusive wandering (boundary transgression) into other peoples' rooms and staff work areas, disturbed night time activity and close shadowing of staff. She also walked constantly throughout the building, was often seen trying door handles on locked doors and on multiple occasions she became lost within the facility and unable to locate her own room.

Description of Behaviour

The staff reported that they had been able to engage Sharon in what she perceived to be 'higher level' activities of filling out reports and accompanying the nurse with the medication trolley. However, with the progression of her dementia and increasing time spent wandering, this strategy of engagement was no longer possible particularly after an incident when staff were busy administering medications she had entered into another resident's room and rummaged through their personal items. Sharon was irritable and distressed and she had hit out at the staff member who tried to coax her to leave the room. She was also found in another resident's room attempting to feed her. The situation was exacerbated when; as a result of wandering into another resident's room when staff were carrying out ADLs on the occupant, Sharon climbed into the resident's bed and lay down to rest.

The staff had taken to offering Sharon snacks and drinks while she was moving about the RACF because it was increasingly hard to get her to sit down for long enough to eat. Her husband spent most of his time visiting walking with her around the facility.

b) Using the RWAO model for assessment of Sharon's wandering behaviour, identify **three behavioural instances** from the above history and indicate the possible unmet need and likely consequences, in the table below.

<i>Contributing proximal factor/s</i>	<i>Description of Wandering</i>	<i>Adverse outcome</i>
1.		
2.		
3.		

5.3 Interventions for Wandering Behaviour

a) Non Pharmacological Interventions

A comprehensive review by Hodkinson of a large number of studies undertaken to test the efficacy of interventions for the management of wandering behaviour categorises them as:

1. Environmental modifications – these would include visual manipulation of environment such as grid patterns on the floor, camouflage or concealment of exits and use of mirrors.

2. Technology and safety interventions – these might include devices to disguise exits and tracking or alert devices to enable the individual to be located once they go beyond their area of safety.

3. Physical/psychosocial interventions – which include any type of barrier that assists the person to remain with others within a designated area. Examples of psychosocial interventions include exercise, massage and touch, music therapy and social interaction during accompanied walking.

4. Offering carer support and education to explain aspects of the behaviour that are beyond the control of the person with dementia

Hodgkinson also highlights *“Additional humanitarian issues need to be considered in the management of the wandering patient. Use of restraints, surveillance and some medications may de-humanise the patient and have a negative impact on other aspects of their lives. This also impacts on the families of the patient who would see such interventions as excessive and potentially unnecessary. A balance between the needs of carers and the humanity, dignity and ethical rights of their patients needs to be struck in the management of wandering behaviour.”* (8)

This statement emphasises the dilemma often faced by health professionals when wandering behaviour poses a significant risk to the individual of injury or even death especially when the family is resistant to use of medication or technologically mediated devices. Limiting access or restraining the person in any way can cause severe distress for the person with dementia.

The autonomy of the individual also needs to be taken into consideration and the risks associated with wandering weighed carefully. The negative physical consequences of prolonged wandering that is unresponsive to intervention can be severe fatigue, sleep disruption and weight loss in excess of that caused by the dementia process alone.

b) Biological (Pharmacological) Interventions

There has been limited research on medications effective for wandering behaviour. Risperidone (Ozidal) has been shown to have greater effect on wandering than Haloperidol (Serenace), although antipsychotics are not generally recommended (7) p187.

Where pain relief is an underlying need, analgesics may assist. However, sedation is not recommended in those whose walking is persistent and frequent because it may increase the risk of falling.



Activity 5.3: Continue with Sharon's case study and note the various interventions that were trialled for her and answer the following question

Sharon's case study - continued

Approach Used to Assess Behavioural and Psychological Symptoms of Dementia

The multiple medications that Sharon had been prescribed appeared to exacerbate her behaviour and presented a challenge when assessing the underlying causes. The DBMAS clinician discussed with the pharmacist and geriatrician a trial of reductions and different combinations of the medications to try to identify contributing factors. Sharon had previously suffered urinary tract infections, which had resolved, although she was still receiving treatment that would have aggravated her restlessness and wandering both of which were not responding to other medications.



Strategies Used to Address Behaviour and Support Care

A meeting with all staff involved with Sharon's care was held and everyone had input into the development of strategies to support Sharon. STOP DO NOT ENTER signs were put on staff work area doors which were initially effective in redirecting Sharon from other resident's rooms, staff private spaces and spaces where, in the staff's opinion, she was at risk of harm to herself or others. However, their effect quickly wore off and Sharon resumed her intrusion into most areas. To address the problem of excessive responses to ADL care proceeding with other residents a strategy of distracting Sharon while staff carried out care on others was considered. This was effective but time consuming for staff and therefore not feasible.

Staff then tried a full door panel that looked like an outdoor scene on the doors of rooms that Sharon was most attracted to and kept their doors closed. This worked well for all but one room where the resident was in bed a lot and wanted the door kept open to enjoy passing traffic.

Sharon looked at the doors but did not try to open them and it continued to work most of the time. Staff were encouraged to determine when the peak period of Sharon's wandering activity was each day using a simple pedometer count averaged hourly over 3 consecutive days. During that peak period, which was 9am-1pm, a staff member spent a minimum of 3 periods of 10 minutes each walking with her outdoors, talking and engaging her. Staff evaluated her mood and found that, during the period she was walking outdoors she expressed relaxation and enjoyment, which lasted for about 30 minutes once back indoors.

Additionally, the DBMAS clinician allocated time to employ one person to engage with Sharon for 20 minutes a day at another time for one week. This proved very successful and this reduced Sharon's agitation and stress and therefore that of the staff. However, it did not have any real effect on the time she spent walking alone. This was not sustainable financially, but the carer who had been employed suggested strategies to engage Sharon that she had found helpful and meaningful, they included music, massage and accompanied walking in the gardens. However, despite the efforts of the staff, any activities that engaged Sharon were only effective when somebody stayed with her and was able to accompany her walking and engage with her.

From **Appendix 3** in Behaviour Management – A Guide to Good Practice 2012 provide responses for a) and b) in the following table.

- a) Identify six interventions trialled for Sharon and indicate which interventions are supported by some level of evidence using Appendix 3.
- b) Suggest how staff might monitor each intervention to be able to gauge effectiveness

(One example is provided to demonstrate the type of responses required)

<i>Interventions trialled</i>	<i>Some level of Evidence supports intervention</i>	<i>Mechanism to determine Effectiveness</i>	<i>Effectiveness shown by:</i>
1. Stop signs on doors	moderate	Record no of times sign deterred exit – over a 2 day period	Reducing no of exits over 2 days
2.			
3.			
4.			
5.			
6.			
7.			

c) What other specific assessment might have helped the staff understand the expression of Sharon's wandering behaviour?

d) Suggest two further interventions that might be trialled with Sharon. (Use Appendix 3 BPSD Guide)

i)

ii)

e) What support might be offered to Sharon's husband to help him understand Sharon's behaviour?

f) What specific care policies need to be put in place to protect the resident who wanders?



5.4 Key Message

- Wandering is a commonly occurring BPSD and presents as excessive locomotion, the inability to sit and rest, getting lost, entering private spaces uninvited, trying to leave unaccompanied.
- The type and intensity of wandering behaviour can result in adverse outcomes that compromise the person's safety and general health, such as injury and weight loss.
- Evidence suggests that therapeutic touch offers the most effective intervention for management of wandering.

5.5 Clinical Reflections

As a member of a team of health professionals involved in the care of a person with dementia the novice clinician needs to consciously and regularly observe for the effectiveness of both non pharmacological and pharmacological interventions including comfort and pain and ensure a safe supportive social or physical environment. For a person with wandering behaviour creating a safe environment requires particular attention and use of creative barriers may help to minimise access to inappropriate or restricted areas. In support of the team approach developing a detailed knowledge of the background and life story of the person with dementia is essential.

5.6 Resources and References

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Objectives:

At the end of this module you will be able to:

1. Outline the key elements to include in the assessment of a person with mood and/or behaviour suggesting an underlying depression, or possibly the presence of co-morbid anxiety
2. Suggest from the given case study, using the NDB model, the probable consequences of depressed or anxious mood
3. Select possible interventions, focusing on depressed or anxious mood, which evidence would indicate may be useful to trial in managing behavioural changes related to mood
4. Outline the key approaches to be considered when caring for an individual from a Aboriginal or Torres Strait Islander background

6.1 What is Depression?

Depressive symptoms are the most commonly occurring psychosocial behaviour in clients with dementia. The person with dementia experiencing depression may present as sad, unhappy, withdrawn, inactive, tired, tearful and without interest. In addition, there may be:

- Weight loss
- Sleep disturbance
- Criticism, envy
- Loss of pleasure
- Constipation
- Self-deprecatory statements, pessimism, expressed wishes to die
- Guilt feelings, loss of self-esteem, decreased sense of lifelong accomplishments

- Feelings of helplessness, hostility, agitation, aggression, and anxiety
- In severe cases, psychotic symptoms, e.g. delusions
- Suicidal ideation

Depression occurs from changes in brain chemistry and there may be a family history of major depressive disorder. (1) P119 Depression is also highly associated with dementia. (1) P123

While apathy may be a symptom of depression, generally apathy is characterised by a lack of emotion rather than the emotional sadness associated with depression and is considered as a separate symptom.

Evidence suggests that apathy is an independent syndrome, although no structured definition is available. (1) P109

The pervasive depressive mood, lack of appreciation of anything positive in life and sometimes rapid decline in cognition creates a heavy burden on carers, who at times suffer depression themselves as a result of the impact of their role. Depression often results in early admission to a care facility and reduced quality of life.

6.2 What is Anxiety?

Symptoms of anxiety are often difficult to separate from physical illnesses or medication side effects in older adults. For example, shortness of breath, rapid heart rate and sweating palms may each be a sign of anxiety, or may be the result of a medication or the symptoms of an illness affecting the older person.

The person with dementia experiencing anxiety may present as agitated, restless, withdrawn, frightened, or tense. Physical signs of anxiety

include shortness of breath, rapid heart rate and sweating palms.

Similar to depression, anxiety occurs from changes in brain chemistry and there may be a family history of anxiety or depressive disorder (2)

Anxiety can result in early admission to a care facility and reduced quality of life, and can also worsen the prognosis of other illnesses. (3) (4)

The assessment process for a need-driven compromised behaviour requires you to observe and pose questions in relation to each of the **proximal and background factors**. This will help

you to determine the status and severity of the symptoms.

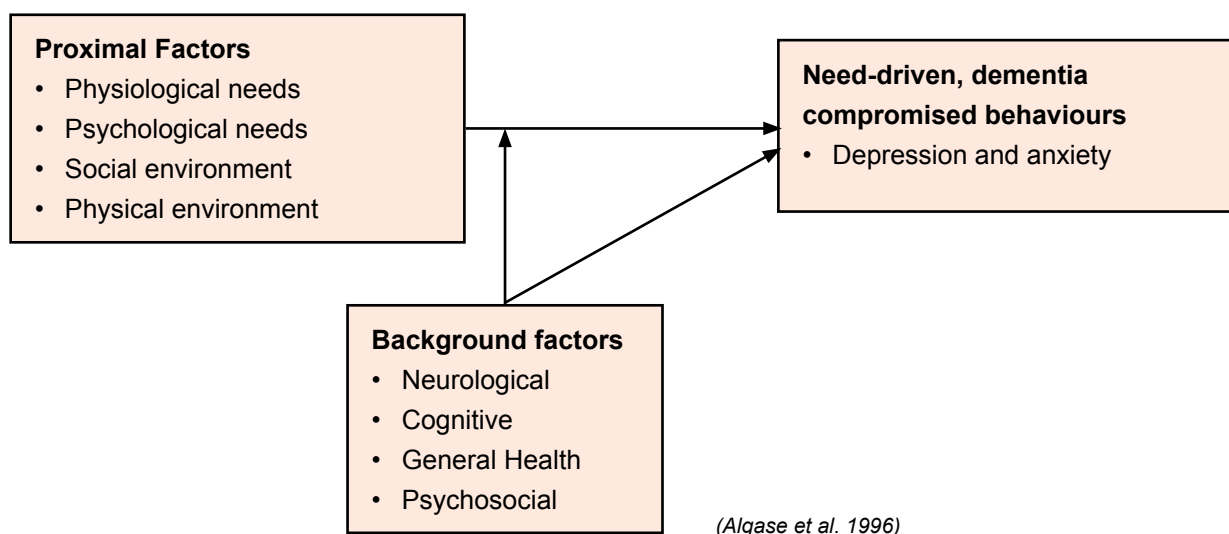
Families, who have intuition about their family member with dementia, may suspect a depressive state that may not be initially evident to their clinician. As dementia progresses, seeking information from the person with depression and anxiety about how they feel may become more difficult because of the increasing language and communication difficulties and apathy. This highlights the importance of sourcing detailed information from the carers and family members.



Activity 6.1

Read the Depression summary in The Guide to BPSD p 118-120 (1) and the Anxiety summary (1) p95-96

Figure 6.1 The Need-driven compromised behaviour model



Mr B is an Indigenous Australian man and prior to exploring the assessment process for him, we will

look at the cultural considerations associated with caring for an Indigenous Australian with dementia.

6.3 Cultural Considerations when caring for people with dementia from an ATSI background

Person-centred care involves treating each person as an individual, recognising their value as a human being and attempting to understand their perceptions, customs and life experiences

While there are many differences in language and cultural norms across the diverse community groups that make up the Aboriginal and Torres Strait Islander population, it is still possible to recognise some key cultural norms that apply across most communities.

Whenever possible, it is important firstly, to seek an understanding at a local level of the unique needs of the community to which the client belongs.

Perceptions of dementia in indigenous communities may include the idea of “payback” or “bad spirits”, although there is an awareness of memory loss in more urban communities. As story telling (yarning) is a key communication tool for conveying the history of a community, it can be used as a meaningful activity by health professions when working with communities. (5) As many Indigenous Australians are reluctant to seek assistance from mainstream health care

services, making a request for the help of an Aboriginal and Torres Strait Islander health worker may assist in obtaining important assessment information and conveying messages about the planned care.

Where possible, you need to attempt to gain an understanding of the historical traditions and cultural norms of the person in your care to ensure the service delivery provided is culturally appropriate.

Try to be aware of customs such as, preferred ways of addressing Elders, body language, eye contact and other cultural cues, especially when speaking with members of the community who will assist you in understanding the history of the person with dementia.

Providers of care to Indigenous Australians with dementia in the Northern Territory have developed a culturally sensitive assessment tool known as the Kimberley Indigenous Cognitive Assessment (KICA), used for global cognitive screening for those living in rural and remote areas. (6) The KICA tool comprises a number of sections and assesses the person and their primary carer.

The research undertaken to develop this tool identified that dementia is substantially higher in Indigenous Australians than in that of the general population of developed and developing countries across all age groups (over the age of 45 years).

6.4 Assessment tools for Indigenous Australians with dementia



Activity 6.2

Access the website <http://www.wacha.org.au/kica.html> to view a culturally orientated assessment tool and read other KICA information.



Activity 6.3

Read Mr B's profile and information about his behaviour below and then answer the following questions.

Mr B's Case Study

Mr B is a 71 year old Indigenous man who had been a stockman and lived an itinerant life in remote and rural areas. When first assessed by the DBMAS clinicians Mr B was 67 years old and living on the veranda at the home of a 'niece' in the traditional kinship sense of the word, in a small rural Indigenous community. A contributing factor to Mr B's ongoing residence at this location was his great attachment to the dogs that lived there. Mr B had been married and had two daughters and a son, who did not live in his community and were not willing to remain involved in his ongoing care. In an attempt to engage their participation DBMAS clinicians had offered to fly them in for family consultation, although this did not occur.



Mr B had multiple co-morbidities, which included chronic kidney failure, diabetes, hypertension, osteoarthritis, cardio vascular disease, cataracts and alcohol abuse. Many of Mr B's conditions had remained untreated because of limited care in his remote location and had become serious and chronic.

Key Referral Information

DBMAS clinicians referred Mr B to a geriatrician who diagnosed his dementia by using the Kimberly Indigenous Cognitive Assessment tool (KICA) along with a clinical interview and other investigations. He was referred to DBMAS most recently by the Aged and Disability Remote Service after concern was raised by members of the local community who had noted changes in his memory and behaviour demonstrating a lack of awareness of his surroundings. They were concerned about his habit of crossing the main road between his residence and the pub and shops, as well as the fact that Mr B was not taking his medications as required. At this time Mr B's cognition had deteriorated and his niece indicated she was no longer able to take care of him.

Description of Behaviour

DBMAS clinicians noted that Mr B was demonstrating a lack of motivation and this contributed to his deteriorating living conditions. He was not engaging in adequate self care and was unhappy to have assistance with ADL's particularly from female staff. The behaviours that were evident included tearfulness, obvious sadness from his expression and body language, withdrawal, apparent reluctance to receive care and expressed wishes to die. The reported behaviour included limitations in being able to express himself verbally, restlessness and occasional wringing of his hands and finger tapping. He also expressed frustration, agitation and hostility when he resorted to banging

hard on specific doors in the facility that led to the outside area. The DBMAS clinicians were conscious of the ongoing need to balance clinical considerations with Mr B's values and standards and to remain mindful of the need for cultural appropriateness of any intervention.

The initial goal was to maintain Mr B in the community familiar to him along with his companion dogs. A community care package was arranged to support Mr B in the community, with involvement of the local HACC coordinator as the care package provider was 100km away.

Approach Used to Assess Behavioural and Psychological Symptoms of Dementia

In addition to reports by the local community, detailed notes on Mr B's previous health history from all agencies with whom he had contact were examined by the DBMAS clinicians. The niece on whose veranda Mr B had lived had been made his joint guardian with the Public Guardian and was able to be interviewed.








The PEACE framework (Physical, Emotional, Activity, Communication and Environment) was used in the assessment and development of support for Mr B. The perception was that this framework was consistent with an unmet needs model and would help to underpin holistic care of Mr B.

a) From the information provided above, identify the possible **unmet needs** that could be contributing to Mr B's behaviour and which would become the focus of any intervention

<i>Unmet Need</i>	<i>Behaviour</i>

Mr B's assessment included the use of the PEACE model shown below, which allowed the clinicians to ask questions in each of the areas to Mr B, his niece and probably members of his community as well. These questions would help provide an indication of any unmet needs and to determine any intention of self harm.

Figure 6.2 Assessment tool for people with Dementia

People with dementia acting differently		How to help someone with Behavioural and Psychological Symptoms of Dementia (BPSD)	
Things to check		Things to do	
P hysical	• Are they sick?	• Go to clinic • Tell them what is happening	
E motional	• Are they angry or upset more?	• Don't argue • Reassure - treat with respect	
A ctivity	• Are they not doing what they used to do?	• Help them do what they used to do • Distract	
C ommunication	• Are they talking wrong way?	• Take time to listen • Take time to yarn	
E nvironment	• Are they getting lost?	• Keep things their way • Keep them safe	
  Helping Australians with dementia, and their carers 1800 699 799  NT Dementia Behaviour Management Advisory Service			

Source: http://www.frontierservices.org/images/DL_brochure_new.pdf (7)

b) Compose a question for each of the elements of the PEACE model that you might ask Mr B's niece in seeking additional information and details about his behaviour

Element	Question for Mr B's niece
"P"	
"E"	
"A"	
"C"	
"E"	

6.5 Measurement tools for Depression and Anxiety

As indicated in the BPSD Guide (1) p122 – the assessment instrument recommended by experts for measuring depression is The Cornell Scale for Depression in Dementia (CSDD)

The Geriatric Depression Scale (GDS) is also recommended for use in less severe cases.

The subscales of NPI and the Hamilton Depression Rating Scale (HAM-D) are also widely used.

Measuring the level of depression at the original assessment will provide a baseline from which further measurement can be compared. Tracking these measurements over reasonable time intervals (e.g. every 3 months) will provide an indication of any changes that may occur following interventions particularly in relation to indications of planned self harm.

The RAID – Rating Anxiety in Dementia Scale – is the most widely used anxiety scale for persons with dementia. It is a brief and easy to score scale. It is available on-line at: <http://www.anxietydementia.co.uk/> (8)

6.6 Planning interventions to manage depression and anxiety

Effective interventions to manage depression and anxiety include both psychosocial and environmental (non pharmacological) and biological (pharmacological)

a) *Psychosocial and environmental interventions* are grouped into four categories and include

- therapeutic activities
- exercise
- music
- special care planning

Non pharmacological Interventions encouraging pleasurable events are supported by strong evidence. Teri (1997) suggests identifying activities that the person has enjoyed in the past and modifying them for the person's current level of functioning. This may include being outside, listening to music, having meals with family or friends, helping around the house, exercising, and going for a ride in the car. (9)

Activities aimed at reducing depressing or anxiety-provoking thoughts may include refocussing and distracting the person with memory books with pictures of happier times, reminiscing pleasant experiences or engaging in cheerful conversations.

b) *Biological (pharmacological)* interventions are grouped as antidepressants and cholinesterase inhibitors (ChEIs). The evidence for items in each of these categories is variable.

In selecting interventions, the goal is to attempt elimination of sources of conflict and frustration, coming from those proximal and/or background factors that may be triggering the behaviour and to be alert for signs of self harm and attempt to protect him from self injury.



Activity 6.4

Read the Management of Depression in A Guide to Good Practice: Managing BPSD
p 124-126

Concern for the caregiver's own emotional state will be important as they too can develop depressive moods particularly when providing care in the home environment. Discussions on

ways to improve caregiver mood are likely to have a positive outcome on the client's behavioural problems.

Mr B's story continues.



Activity 6.5

Read about the strategies used to address his behaviour and ongoing care

Mr Bs case study – continues

Strategies Used to Address Behaviour and Support Care

As Mr B's health and cognition deteriorated he became more sad and withdrawn. It was determined that he required ongoing professional care and support so, as an initial step, he was placed in a transitional care unit. It was explained to him that it was important for him to stay a while to treat his various medical conditions. Encouraging him to remain in the facility for respite care was made easier by the fact that the dogs he had been attached to had died. However, he did leave the facility without telling staff and spent a period being cared for in the community with a safe return bracelet and involvement of the police in tracking him down. The local carers were provided with education and information about his dementia in an attempt to support him in the community but eventually he was unable to continue living safely there and was moved into a Residential Care Facility.



Initially he was sad and tearful and reluctant to accept care, so several strategies were put into place. He enjoyed John Wayne movies so these were made available. His apparent resistance to care was addressed by primarily assigning male staff to assist with his ADL's. DBMAS clinicians put together a history for facility staff and supported them in managing his care.

Due to the fact that he had been a heavy drinker it was necessary to manage withdrawal with Valium, however he was allowed access to small amounts of alcohol on a daily basis. He began to climb over the facility fences, however when signs warning about snakes were placed on the fence he stopped doing this. After a little while Mr B was encouraged to walk in the grounds and to potter in the facility garden and he helped with watering and caring for some native plants. Regular visual observations of Mr B to ensure his safety and wellbeing were instituted as part of his planned care. Attempts to involve the family in supporting him in the facility were unsuccessful and to retain his good faith the staff kept a calendar of times that attempts had been made to contact his family and also times that he was able to try to contact his family himself.

The DBMAS clinicians maintained contact with Mr B and continued advising staff about his care. They documented strategies to help Mr B overcome issues and emphasised the importance of acknowledging the Indigenous culture and how to respect this.

The clinicians provided various interventions to deal with Mr B's mood behaviour.

a) Identify the behaviours he exhibited and summarise the interventions used in the table below

<i>Demonstrated Behaviour</i>	<i>Interventions</i>

b) Source the following website and from the suggestions provided identify three other culturally appropriate interventions that could be trialled with Mr B that might engage him

<http://www.frontierservices.org/images/DBMASActivityIdeasforCarers.pdf> (5)

i)
ii)
iii)

Other websites with useful information on assisting indigenous clients with dementia can be found at:

<http://www.fightdementia.org.au/understanding-dementia/dementia-learning-resource-for-aboriginal-and-torres-strait-islander-communities.aspx> (10)

<http://dtsc.com.au/wp-content/uploads/Dementia-Yarning-Presentation-310712.pdf> (11)

http://dbmas.org.au/Want_to_know_more_/Resources1.aspx (12)



6.7 Key Message

- Depression is a commonly occurring BPSD and presents as sadness, negativity, and withdrawal
- Anxiety, while often as common as depression in older persons, is often unnoticed and thus untreated; this may be particularly true for persons with dementia, as anxiety symptoms can mimic those of many other disorders including dementia itself
- Evidence suggests that exercise offers the most effective intervention for management of depression and anxiety
- Establishing a close observation regime and ensuring a safe environment is essential for a person with depressive mood who expresses a desire to end their life
- Sourcing information about the local indigenous community and its traditions, values and practices assists in providing culturally appropriate interventions and care for indigenous clients
- Recognising and incorporating the role of the community in the care of an indigenous person with dementia may assist in meeting the person-centred care needs.
- Knowledge of the key elements and attitudes to dementia of a particular ethnic community will assist carers to modify an approach to management of BPSD that is acceptable to the client and their family.
- Knowledge of, and sensitivity to, taboos and customs of a particular culture may prevent the creation of triggers that lead to behavioral and psychosocial symptoms of dementia

6.8 Clinical Reflections

This was a very complex case and it is important to involve anybody who is able to contribute to resolving the range of issues. The multi-disciplinary team approach is crucial in contributing to the development of strategies for care.

In small remote communities it is especially important to develop the networks and relationships that allow clinicians to work with the community, care agencies and other local organisations to support clients and not to take over. An important factor, especially in Indigenous communities is respect and consideration for cultural traditions and values.

6.9 Resources and References

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7. Brochure for Carers of Indigenous people acting differently http://www.frontierservices.org/images/DL_brochure_new.pdf
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10. Dementia Learning Resource for Aboriginal and Torres Strait Islander Communities available at: <http://www.fightdementia.org.au/understanding-dementia/dementia-learning-resource-for-aboriginal-and-torres-strait-islander-communities.aspx>
11. Yarning – a culturally safe method of Indigenous Conversation available at <http://dtsc.com.au/wp-content/uploads/Dementia-Yarning-Presentation-310712.pdf>
12. Activity Guidelines for Indigenous Australians - Dementia Behaviour (2012) http://dbmas.org.au/Want_to_know_more_/Resources1.aspx

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Objectives:

At the end of this module you will be able to:

1. Outline the key elements to include in the assessment of a person responding with aggressive behaviours
2. Identify, from the given case, the probable factors contributing to aggressive behaviour, using the Progressively Lowered Stress Threshold model
3. Select possible interventions, focusing on aggressive behaviour, which evidence would indicate may be useful to trial in managing this behaviour.
4. Identify any successful interventions used in Jayita's case study and indicate how the effectiveness of these could be determined
5. Outline the key approaches to be considered when caring for an individual from a culturally and linguistically diverse (CALD) background.

7.1 What is aggression?

Aggressive behaviour associated with dementia is characterised by physical or verbal threats aimed at people or objects. This may involve abusive language, insults, actual assaults such as hitting or punching and/or throwing of objects.

The aggressive behaviour may be due to frustration, anger or fear. It is often a reaction to feelings of threat arising from invasion of personal space particularly when being helped with activities of daily living (ADLs) and will usually relate to an unmet need or stressor.

It is a behaviour which causes significant distress to the person with dementia, their family and the staff caring for them. Risk of harm or injury to

staff, other clients in an aged care environment or carers and family at home is a major concern.

This risk of harm particularly contributes to a reduction in social interaction and can lead to isolation and reduced quality of life. While others may be less inclined to engage with the person showing aggression, often the behaviour is readily forgotten by the person with dementia and the withdrawal of close and warm interactions can create a stressor for further behaviour.

It is worth noting that the overall frequency of BPSD, and in particular agitation and aggression, **increases** with the severity of dementia.

7.2 Assessment related to aggressive behaviour

As it is important for the clinician to understand the underlying causes of the aggression and it is useful to have a model in mind, such as the Progressively Lowered Stress Threshold (PLST) model, to help uncover possible triggers for the behaviour.

PLST is a conceptual model that helps to explain antecedents to the aggressive behaviour.

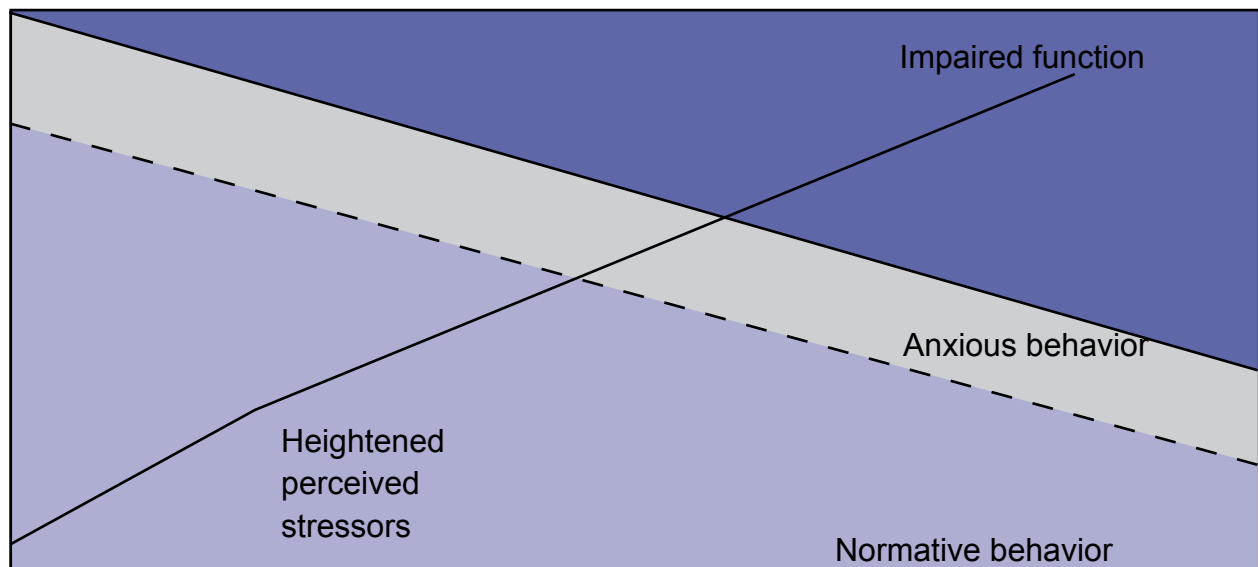
The PLST model suggests that there are four clusters observed in dementia -

1. Impairment of cognition
2. Emotional impairment
3. Reduced planning ability

Each of these three clusters represents **the losses** that occur as dementia progresses.

The 4th cluster is the behaviours that emerge when environmental demands, external or internal, exceed the person's ability to cope and adapt.

Figure 7.1 Progressively Lowered Stress Threshold Model



Stress threshold in a patient with Alzheimer's disease and related dementia.

Source: Smith Application of the Progressively Lowered Stress Threshold Model Across the Continuum of Care

Seeking information about the demands that may exist both within the person or in the external environment that are creating a stressful state for

the person, will provide the clinician with a focus on which to target interventions and attempt to reduce the stressors that exist. (1)



Activity 7.1

Read the Aggression summary and notes in Guide to BPSD p71-75 (2)

7.3 Measuring Aggression

Well established specific scales for evaluating aggression include:

- The Rating Scale for Aggressive Behaviour in the Elderly (RAGE) which enables the quantification of type, frequency and pattern of physical and verbal aggression as well as antisocial behaviour
- The Overt Aggression Scale (OVERT)

Aggression measures are also included in other more general tools such as CMAI, NPI and NPI-C introduced earlier in Module 2

Our next case study is about Jayita an Indian widow, but before we consider the cultural issues associated with this case study, we will first look at assessing the heightened stressors in Jayita's situation.



Activity 7.2

- a) Read the short profile about Jayita below and then respond to the activity

Jayita's case study

Jayita, is an 88 year old widow of Indian nationality, with two adult sons who remain in regular contact with her. Jayita has been diagnosed with moderate dementia of the Alzheimer's type and she currently resides in a residential care facility. Jayita has osteoarthritis in her knees and a recently fractured hip. Her osteoarthritis and record of falls place her at ongoing risk of falls which the use of a walking frame has not prevented. Jayita has impaired hearing and double incontinence and has been become agitated and aggressive.



Key Referral Information

Jayita was referred to the DBMAS clinicians by a senior nursing advisor at her facility. Factors leading to the referral were resistiveness to care, agitation, verbal aggression occasionally escalating to physical aggression. Jayita exhibited these behaviours and was most highly resistive when staff attempted to engage her in aspects of personal care.

Description of Behaviour

When the DBMAS clinicians first met Jayita they noted that she appeared somewhat isolated. Detailed discussions with Jayita's family revealed that Jayita's routine prior to moving to the facility included a shower in the evening. It transpired that Jayita's showers at the facility were scheduled for the morning – outside of her normal routine of many years. In addition, cultural practices and age meant that personal care by a male was taboo for her and attempts by male carers to support her personal care resulted in escalated behaviour.

Approach used to assess the Behavioural and Psychological Symptoms of Dementia (BPSD)
The DBMAS clinicians used the PLST model to underpin Jayita's assessment and to identify possible stressors contributing to her behaviour. Considering the change that Jayita had experienced from her normal routine by being asked to shower in the morning was the first point of consideration. The cultural and age issue of having personal care needs attended to by a male was also noted. Both of these possibly contributed to Jayita's resistiveness to care, agitation and aggression. The impact on Jayita's behaviour of possible unmanaged pain caused by her osteoarthritis and multiple falls was considered. Her pain was assessed using the Abbey pain scale and results indicated that use of analgesia was warranted. Her level of aggression was assessed using the Rating scale for Aggressive behaviour in the Elderly (RAGE) Scale.

b) Using the PLST model , and from the information provided **above in Jayita's case study**, identify possible **increasing stressors** that could be contributing to her behaviour and which would then become the focus of any intervention.

<i>Possible Stressor</i>	<i>Behaviour</i>

Another factor to be taken into account during assessment and in providing care for Jayita is the need to determine how well she understands and speaks English if it is not her first language. In addition whether there are any key elements from her cultural background that are important to her which may impact on the quality of care provided. Sensitivity to her cultural needs will be an important facet in the planning of her care and in targeting identified stressors. These elements will be highlighted in the briefing provided to staff caring for Jayita.

Prior to exploring a plan of care for Jayita, we will look at the cultural considerations associated with caring for a person from culturally and linguistically diverse backgrounds (CALD).

7.4 Caring for clients with dementia from a CALD background

There are invaluable resources available on the Alzheimer Australia website at <http://www.fightdementia.org.au/understanding-dementia/cultural-diversity.aspx>

This site offers information about culturally appropriate assessment tools as well as providing an outline of the perceptions of dementia held by members of twelve different ethnic communities. An overview is provided of some of the relevant key issues raised by these communities. This is a useful reference site, if you are unfamiliar with a particular ethnic group.

The following are some suggested helpful ways to act when caring for residents from any ethnic group – these tips have been taken from the above website. (3)



Tips and strategies for working with people with dementia from CALD backgrounds

1. Consider each person as an individual – they are influenced by the culture and experiences of their country of birth, migration experiences, religion, ethnic background, language and family system.
2. Understand barriers to access – linguistic, economic and social barriers that individuals from different cultures face, preventing access to healthcare and social services. Try to provide services in a person's preferred language.
3. Understand that families may use alternative models of care and use alternatives to western philosophy and practice.
4. Do not place everyone in a particular ethnic group into the same category, assuming that there is one approach for every person in that group.
5. Respect cultural differences regarding physical contact, appropriate eye contact and voice volume.
6. Cultivate relationships with families over time, not expecting immediate trust in and understanding of dementia services.
7. Consider the family's background and experience in determining what services are appropriate.
8. Consider the culture's common perceptions of ageing, caring for elderly family members and memory impairment.
9. Understand that the family's culture impacts on choices regarding ethical issues such as artificial nutrition, life support and autopsies.
10. Regard the religious community for various cultures as a critical support system. (3)

Awareness of these above tips and strategies related to caring for a person with dementia from a CALD background provide clinicians with clear guidance for a person-centred approach to care.

As you will remember the approach has four elements – VIPS, that is, Valuing the person, treating them as an Individual, taking account of their Perceptions and creating a Social environment that enhances the person's well being. An attempt to understand the customs and taboos of a particular culture is about recognizing their individuality and the social environment that makes them comfortable.

In relation to communication for a client who does not speak English, the use of an interpreter is useful. As the nature of the information required can sometimes be clinically difficult, seeking a bilingual clinician should be your first preference and a bilingual health worker would be your second choice. If neither is available, then the use of an interpreter service may be an available alternative.

As there are some ethical considerations related to the use of any interpreter it will be useful to be aware of some guidelines in relation to working with an interpreter. The family may also need to be consulted about this choice of action.



Activity 7.3

- a) Read BPSD Guide to Good Practice p 26-29 (2)
- b) Read Quality Dementia Care: Practice in Residential Aged Care Facilities for all staff, Alzheimers Australia, p30 (4)

7.5 Planning interventions to manage aggression

The process of planning care to modify aggression will commence with ensuring safety, as far as possible, for the person with dementia, the staff, along with other residents, if residing in a residential care facility or if at home, the family carer.

An understanding of the factors that may be contributing to the person's behaviour will enable you to select and trial interventions that target the triggers or possible stressors. Selection of interventions will also take into account the individuality of the person and their identified everyday preferences.

The following interventions, evaluated by systematic reviews as having a level of

effectiveness, are suggested as possible alternatives for trialling:

1. Psychosocial and environmental interventions include therapeutic activities such as: touch, acupressure, music, structured activities
2. Biological (pharmacological) intervention
 - a) use of an atypical antipsychotics (Risperidone (Ozidal), Quetiapine (Delucon) and Olanzapine (Aprolan) to assist when an issue of safety exists. The general use of antipsychotics is not well supported as they are associated with significant side effects.
 - b) use of cholinesterase inhibitors (ChEIs) and Memantine show potential benefits.



Activity 7.4

Read the continuation of Jayita's story and answer the following question

Jayita's case study - continues

Strategies used to address Jayita's behaviour and support care

The change to usual routine and the cultural and age issue was addressed when she was **showered in the evening with only female staff** attending to her personal care needs.



In addition, it was recommended that staff provide Jayita with **analgesia** 30 minutes prior to engaging her in personal care activities and to then assess the effectiveness of this in relation to reducing her agitated and aggressive behaviour. In addition, **aromatherapy** was introduced as a component of her personal care regime.

The strategies relating to changing Jayita's personal care regime were shown to be effective and reduced the agitated and aggressive behaviour associated with personal care. DBMAS clinicians were consulted on strategies to try to engage Jayita in order to reduce her isolation and to address her agitation and aggression. The clinicians offered **education to staff** and recommended that they acquire as much information as possible about Jayita's life history, key events and experiences. This would be beneficial both in engaging Jayita and in identifying possible background factors that might be contributing to her agitation. Jayita's sons were asked to put together **a life story book** that would be a means for the staff to engage Jayita in discussion and reminiscence about her life's experiences.

The implications of the environment in relation to Jayita's cultural background and the possibility that this was contributing to her aggression was considered. Jayita's room **was personalised** with special items, colour was used to lighten the room and highlight important locations especially the toilet and bathroom. **Cue cards** were developed with symbols or pictures of certain items and the associated word in Hindi, her native language, to help Jayita make better sense of her environment and encourage engagement.

As a result of this multi-strategy approach to care for Jayita and after identifying and addressing factors that contributed to her aggressive state, the staff and family reported a marked improvement in Jayita's general demeanour and engagement within the facility and activities that were organised.

From Jayita's story the interventions used by staff to manage Jayita's behaviour included:

- changing the time of her shower
- bathing provided only by female staff
- education to staff about collecting Jayita's history and preferences
- pain relief
- aromatherapy
- reminiscing – life story book (moderate)
- personalising her environment
- cue cards in her language

Identify four suitable alternate interventions (showing strong to moderate quality rating for the research) that could be further trialled for Jayita should the above strategies not have been successful. Use the Guide to Good Practice: Managing BPSD" Appendix 3: Psychosocial and environmental interventions table to source this information.

<i>Alternate Interventions</i>	<i>Quality rating of Evidence for this intervention</i>	<i>Author</i>



7.6 Key Message

- Aggressive behaviour is characterised by physical and verbal behaviour that threatens possible harm. It may escalate to actual harm and can have a significant impact on family, carer and health care staff
- Evidence suggests that, where safety is an issue, antipsychotics offer the most effective intervention for the management of repeated aggression
- Sourcing information about cultural preferences and rituals assists in providing culturally competent interventions and care
- If English is not the preferred language for the person with dementia accessing bilingual interpreters especially during history taking is most advantageous.

7.8 Resources and References

1. Smith M., Hall G. R., Gerdner L. & Buckwalter K. C. (2006) Application of the Progressively Lowered Stress Threshold Model across the Continuum of care. Nurs Clin North Am; 41:57-81
2. Behaviour Management – A Guide to Good Practice 2012 available at http://www.dementia.unsw.edu.au/index.php?option=com_drcrc&view=drcrc&layout=project&Itemid=101&pid=154
3. Dementia within Culturally and Linguistically Diverse (CALD) Communities can be found at <http://dementia.uow.edu.au/understandingdementiacare/module6/index.html>
4. Alzheimers Australia: Quality Dementia Care1: Practice in Residential Aged Care Facilities for all staff can be found at <http://www.fightdementia.org.au/research-publications/quality-dementia-care-papers.aspx>

Additional Resource

5. Perceptions in ethnic communities: Project Report October 2008 p15 available from <http://www.fightdementia.org.au/understanding-dementia/cultural-diversity.aspx>

7.7 Clinical Reflections

Novice clinicians need to work within the structure of a validated model or framework to guide development of supportive strategies. It is very important to place the person with dementia **at the centre of their interventions**, remaining mindful of the multiple and complex interactions of culture and life experiences that have made up their lives and may continue to exert an influence over time.

Objectives:

At the end of this module you will be able to:

- Outline the value of establishing a workplace culture that respects personhood, independence, self-worth & dignity as means of supporting a holistic approach to people with BPSD
- Explain the value of promoting the use of creative and novel approaches to resolving issues related to care for people with BPSD
- Identify the pivotal role of communication approaches that achieve a person-centred focus and create a calming environment
- Outline ways to overcome the challenges associated with caring for people with BPSD
- Describe ways to support staff, their life style issues and challenges
- Outline the environmental factors that support the management of BPSD
- Identify the staff issues associated with caring for clients from various cultural backgrounds
- Explain the importance of multidisciplinary care provision for people diagnosed with dementia.

8.1 Leadership that promotes quality care for the person with BPSD

As a leader within the health care team concerned with provision of care services to people living with dementia, whether in an aged care facility or in the community, it is important to reflect on the key elements that contribute to and facilitate effective leadership and management.

There are a number of strategies that can be instituted that will enable quality care to be provided to clients with BPSD. In any health care

team evidence of good leadership and effective management are key attributes for provision of quality care that will enable quality standards to be met.



Activity 8.1: Watch the “Expert Conversations” video clip entitled ‘Advice for Workplace Leaders’ (11 minutes duration)

The Experts are responding to the question: What advice would you give to workplace leaders about effective responses to BPSD?

In this video clip the experts highlight some of the factors that would contribute to a quality service for clients with BPSD. We will explore these topics and provide suggested articles that support these approaches to care provision:

- Culture of person-centred care
- Quality care
- Client environment
- Awareness of available resources
- Selection and education of suitable staff
- Workload and time issues
- Multi-disciplinary team

8.2 Establishing a Culture promoting personhood

Chenoweth et al (2009) state that “practices of physical restraint or neglect of psychosocial needs can exacerbate need-driven dementia-compromised behaviours, leading to loss of self-care, decision making, and social engagement and increased social alienation” (1) p317

Creating a suitable environment where the person is treated as an individual and offered choices within his or her ability to choose, can be achieved by promoting person-centred care (PCC). This approach encompasses respect for the individual,

their culture, needs, preferences and personal history. In addition, their life experiences are elicited, recorded and incorporated into the care provided. As many behaviours can be reduced or averted by appropriate interventions, it is through **knowledge and awareness of the person's individuality** that strategies can be introduced that reduce the triggers to BPSD and with this approach dignity is promoted and quality of life maintained.

The mission and values of an organisation responsible for the care of persons with BPSD needs to clearly convey the commitment to holistic care encompassed in person-centred care. Promoting a person-centred culture begins at the management level. **Leaders can model this behaviour** by treating staff with the same respect afforded residents and their families and acknowledging their individuality.

An induction program offered at commencement of employment that provides **orientation to concepts of PCC** will convey the desired approach. This needs to be followed up with ongoing in-service sessions to reinforce the philosophy and values underpinning the holistic care approach. **Mentoring new staff** and modelling the approach and communication with clients helps the new staff member learn and adopt the skills.

Regular feedback to staff through **performance appraisal and provision of positive reinforcement** when PCC is well demonstrated helps to embed the culture. Opportunities for further development need to be made available and this is particularly important when a person's performance indicates there is a need for improvement.

Providing person-centred care takes time and requires staff members to make an effort to get to know the person for whom they are assigned. This often means that **meeting the person's needs will take priority over task completion**. Staff should be made aware that this is an organisational value supported by senior staff and management, so they can feel comfortable taking time with the client using strategies to minimise BPSD. In the longer term, time is saved when clients respond to the strategies used and are able to feel calm and comfortable.

It may be possible to nominate certain members of staff as **"behavioural champions"** who will take a special interest in a specific type of BPSD, keeping up to date on the current research and developments about that behaviour. This information can be regularly shared with other staff members caring for a resident who poses a particularly difficult scenario.



Activity 8.2

a) Identify the key elements of a person-centered culture in your workplace.

b) Apply the assessment tool for Person-centered Care found at the following website within your setting

<http://www.dementia.unsw.edu.au/images/dcrc/pdf/pcat.pdf> (3)

c) From your assessment using this tool identify the areas which require further action and improvement?

8.3 The client's living environment

As a workplace leader the creation of the physical environment, whether in a care facility or at home, needs to be designed and modified, as required, with the safety of the client and carer/staff in mind.

The ideal environment for a person with dementia should be quiet and well lit, with the area properly heated or cooled as appropriate to the climate(4). Maintenance of a calm well lit environment is helpful to reduce overstimulation, a factor that might trigger an escalation of BPSD. Calmness is created where noise, general movement and traffic are kept to a minimum. Where wandering behaviour is present the client needs to have a safe area to walk.

Providing cues, symbols, labels and signage to assist with orientation in moving around their environment offers a level of independence and dignity. Where intrusion into certain areas is undesirable then creative ways of disguising these entrances can be used. For a client from a non English speaking background these signs can be provided in the client's own language.

Flexibility is needed in order that the environment can be adjusted in support of creative interventions being used to reduce escalation of BPSD. This may include decoration of bedrooms, sitting or dining areas with pictures, photos, messages and images meaningful to the resident.

The environment ideally needs to promote meaningful activity and social engagement while encouraging independence and preserving privacy and safety(4). This can be accomplished when the care planning for each resident is designed to meet individual needs; where the staff know their residents well and have an understanding of their history, lifestyle, accomplishments and preferences.

Some helpful suggestions may be found in the following documents:

- i) Adapting the ward for people with dementia
http://www.health.nsw.gov.au/pubs/2003/pdf/adapting_the_ward.pdf (5)

- i) Enhancing the Healing Environment which can be found at <http://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-in-dementia-care> (6)

8.4 The resident's lifestyle

Traditionally medications, physical and verbal restraint were used to manage BPSD. Today, leaders within the clinical setting can influence the quality of care provision for individuals with BPSD by emphasizing that care planning will give

- priority to non-pharmacological interventions over biological interventions and
- interventions (both pharmacological and non-pharmacological) are evaluated and evidence of benefit or detriment documented clearly and accurately.

The quality of life for a person with BPSD is a responsibility that senior clinicians will oversee to ensure that staff or carers carry out the planned care and that each client's care provision will aim to:

- provide routines associated with ADL's that are in accordance with the resident's preferences
- offer opportunities for leisure and social interaction especially with their family and friends
- create activities that are meaningful and suit their skills, preferences and experiences;
- enable their involvement in decision making and promote independence
- involve and respect relatives as partners in care, where this is possible
- maintain a level of comfort by reducing physical and sensory limitations and treating pain and
- recognise and accommodate cultural and spiritual practices and customs

Keeping the allocation of staff members consistent so that they care for the same clients/residents regularly helps the person with BPSD to sense a familiarity with the person caring for them. This can be a calming element and facilitates a build up of knowledge about individual preferences which can be taken into account during care giving.

Where the person with BPSD has family members that visit, the senior clinician has a significant role in involving the family and keeping them informed. At times there may be concerns expressed and interactions with members of the family may become challenging. It is important that care staff are not made vulnerable or left to cope alone with upset family members. Staff need to feel assured that the senior clinician will take on the role of listening to the issues and where possible, will endeavour to minimise an escalation of the situation.

8.5 Valuable Resources

Management is ultimately responsible for effective use of resources and the efficient operation of a service whatever the setting, in a facility or in the community or person's home.

While often the major component of care may be delivered by carers or nursing staff there are a number of other members in the health care team that bring a range of different skill sets to the care provision of a person with BPSD.

The concept of the multidisciplinary team is an important one in the management of individuals with BPSD. Team meetings and case conferences can be most helpful in offering new insights and creative options for interventions that could be trialled for a specific behaviour, especially when this behaviour is not responding to current strategies. Using the diverse input of clinicians from other disciplines, as well as family members,

is invaluable in managing BPSD. Inevitably the professionals who spend a relatively limited time with the client do rely on input and meaningful documentation from those caring for the person on a 24 hour basis.

Many services now use an interdisciplinary care planning approach with written care plans that each member of the team contributes to progressively. This strategy ensures every team member is kept up to date on evolving situations and made aware of current interventions in use.

In a situation where a particularly difficult scenario exists or the care team is unsure of the best way to deal with a person's BPSD, access is available on a 24 hour basis from experts in dementia management at the Dementia Behaviour Management Advisory Service (DBMAS). (7)

The range of services offered by DBMAS clinicians is extensive as the following description conveys. The role of DBMAS clinicians requires that they:

“provide information and advice on dementia and related behaviour, assessment and diagnosis support, clinical supervision and mentoring of carers and care staff, support with care planning, short term case management, including guidance related to dementia and other care issues such as environment, safety etc/, access to brokerage funds to provide short term interventions and direct services, tailored information and education workshops, liaison and referral to other related services and clinical support and advice related to dementia and related behaviours.”

Behaviour Management – A Guide to Good Practice P8 (7)

The educational services include workshops as well as many free online resources all of which can be found at the DBMAS website <http://dbmas.org.au/> (8) and the Dementia Training Study Centres site http://dbmas.org.au/Want_to_know_more_/Useful_links.aspx (9)

This site also provides a link to Fight Alzheimers Save Australia site for resources that are useful to assist with the education of carers and family members.

8.6 Staff issues

Pearson A. et al in their final report in 2002 to Commonwealth Department of Health and Ageing on *Recruitment and Retention of Nurses in Residential Aged Care* identified that:

“a supportive work environment has been identified as a key retention strategy for aged care, one in which there is adequate staff supervision, professional and emotional support, positive feedback systems, such as regular staff appraisal and strong professional leadership”. (10)

Careful selection of staff is a critical element in ensuring that clinicians caring for people with dementia have the skills or aptitude and opportunities for further development essential to PPC. Jeon et al (2010) suggest that “the essential strategies linking recruitment with retention are: careful selection of student nurse clinical placements and their ongoing supervision and education, training for skills, leadership and teamwork for new and existing nurses, increased staffing levels and family friendly policies”. (11)

The importance of staff development specific to direct care management of BPSD cannot be overstated. This education needs to include reflections on current research outcomes and an emphasis on the importance of using

evidence based interventions aimed at reducing or eliminating the identified causes of various behaviours. Providing resources to allow time for staff to undertake educational sessions builds workforce capacity and increases expertise.

Establishment of a mentoring process provides skilled clinicians with opportunities to model approaches for dealing with BPSD and then allows for the less experienced team member to be supervised as they practice the approach previously demonstrated. Offering feedback on performance and providing encouragement on improvement reinforces skill development.

Development of specific communication skills is invaluable to development of carer-client relationship and is an important component of PCC. The skill set required by staff caring for people with BPSD requires emphasis in ongoing inservice programs available to team members.

Staff may also be offered the opportunity to take on specific roles that contribute to the culture and atmosphere of a particular setting. The role of Laughter Boss is an example of this responsibility where a certain number of staff are trained in the techniques of bringing humour and fun into the care environment.

8.7 Resources and References

1. Chenoweth L. (2009), Caring for Aged Dementia Care Resident Study (CADRES) of person-centred care, dementia-care mapping, and usual care in dementia: a cluster-randomised trial. www.thelancet.com/neurology Vol 8 April 2009
2. Nolan et al (2004), Beyond 'person-centred' care: a new vision for gerontological nursing International Journal of Older People Nursing in association with Journal of Clinical Nursing, 13, 3a, 45-53
3. The Person-centred Care Assessment Tool An Australian Government Initiative La Trobe University, the J.O and J.R. Wicking Trust – Medical and Scientific Research Grants (ANZ Trustees), and Umeå University can be found at <http://www.dementia.unsw.edu.au/images/dcrc/pdf/pcat.pdf>
4. Dewing J. (2009) Caring for people with dementia: noise and light: sensory stimulation can have a significant effect on the wellbeing of people with dementia. Nursing Older People 21.5 June 2009 p34
5. Fleming R., Forbes I. & Bennett K. (2003) Adapting the Ward for people with Dementia can be found at: http://www0.health.nsw.gov.au/pubs/2003/pdf/adapting_the_ward.pdf
6. Kings Fund tools for Enhancing the Healing Environment can be found at <http://www.kingsfund.org.uk/projects/enhancing-healing-environment/ehe-design-dementia>
7. Behaviour Management – A Guide to Good Practice (2012) available at http://www.dementia.unsw.edu.au/index.php?option=com_dcrc&view=dcrc&layout=project&Itemid=101&pid=154
8. Dementia Behaviour Management Advisory Service can be found at <http://dbmas.org.au/>
9. Dementia Training Study Centres can be found at http://dbmas.org.au/Want_to_know_more/Useful_links.aspx
10. Pearson A et al (2002) Final report in 2002 to Commonwealth Department of Health and Ageing on *Recruitment and Retention of Nurses in Residential Aged Care*
11. Jeon Y., Teri M. & Chenoweth L. (2010) Review Article: Leadership and management in the aged care sector: A narrative synthesis Australasian Journal on Ageing, Vol 29 No 2 June, 54–60

Additional Resource

12. Alzheimers Australia: Quality Dementia Care2: Practice for Managers in Residential Aged Care Facilities can be found at <http://www.fightdementia.org.au/research-publications/quality-dementia-care-papers.aspx>

Objectives:

At the end of this module you will be able to:

1. Identify the resources available to you to further develop your knowledge and skill base in dementia care and BPSD
2. Describe how you can continue to improve the care you provide and gain a sense of achievement
3. Outline what relationship building means to you when caring for a person with BPSD
4. Outline the value of appropriate communication when caring for clients with BPSD
5. Describe how you can protect yourself as a health professional in relation to challenges that arise in giving care and in maintaining a healthy life style.



Activity 9.1: Watch the “Expert Conversations” video clip entitled ‘Advice for Novice Clinicians’ (28.30 minutes duration)

The Experts are responding to the question:

- What advice would you give to novice clinicians involved in assessing and/or addressing BPSD? That is, with respect to their clinical practice and personal wellbeing.

9.1 Knowledge & Skill development

Dementia care is a complex activity requiring some significant skills which can be developed overtime with ongoing learning and practice. Clinicians new to the care of people with BPSD will find that as they increase their knowledge of dementia and explore the research literature for effective interventions their interest and commitment to quality care is heightened. The

challenges of finding the triggers for BPSD through a process of discovering and meeting a person’s needs or by reducing probable stressors can be most rewarding, although also at times, frustrating. Persistence, tenacity and creativity are key factors in finding solutions for people who are unable to communicate their frustrations or needs except through the behaviour they exhibit.

It may take time to build your knowledge base and expertise, particularly about the causes of dementia, the various assessment tools and diagnostic tests, as well as the uses and side effects of medications prescribed for your clients and the management of BPSD. It may be possible to approach a more senior member of staff who would be willing to mentor you in this respect and provide guidance for specific care planning necessary for more complex situations.

9.2 Useful Resources

You are part of a health team made up of professionals from various disciplines – members of the multi-disciplinary team are a major resource to you in your care of the person with BPSD. Take every opportunity to learn from them, ask questions and seek their assistance with problem issues - two heads are often better than one when problem solving.

In addition, expert advice is available to you on a 24 hour basis from the Dementia Behaviour Management Advisory Service (DBMAS). This is a free service and the BPSD guide you have accessed throughout this program is a resource that has been developed by this service. (1) A number of useful websites exist that can readily be accessed to update you on aspects of care provision, some you have used while working through the modules of this package. Often these sites can be used to provide additional information to carers and family members and it is worth

making yourself familiar with the content that exists so that you are in a position to refer to them when talking with carers and family members. In relation to your own knowledge and skills, although a formal review process may be in place, it is certainly valuable to seek regular feedback on your performance and to request opportunities to attend educational sessions and further skills development. At times you might request access to debriefing sessions; particularly when the care environment has been extra stressful or a particular client interaction has been distressing. This may also provide you with an opportunity to explore what could have been done differently in the circumstance you encountered.

9.3 Relationship building

Following some encounters you have faced you may feel you have not been particularly successful. This experience may emphasise for you the importance of refining your communications skills aimed at enhancing your interactions in the arena of dementia. The art of listening is particularly important and vital for gaining an appreciation of what the person with BPSD is trying to convey, this also includes keen observation of non verbal cues and body language.



As you have learnt earlier in this program person-centred care is the approach that research indicates is helpful for people with dementia. In building a relationship with your clients remember to consider your own approach to them in terms of your body language, gestures and facial expressions. Your aim is to convey a willingness to listen, empathy and respect for the person's individuality. If your communication reflects judgement, irritation, frustration or impatience this may further trigger the behaviour that you are trying to diminish.

To gain an appreciation of how a person with early dementia feels about how they wish to be treated the following articles may be helpful.



Activity 9.3: Other helpful and instructive articles can be sourced from the websites below.

Come Talk With Me: Strategies for enhancing communications in dementia care presentation by

- **Jade Cartwright**

<http://echo.ilecture.curtin.edu.au:8080/ess/echo/presentation/2cc47ab3-9970-46ee-a864-c682e41599df> (4)

- **Good practice principles for assessing and caring for people with challenging behaviours in Residential Aged Care Facilities**

http://www0.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_014.pdf (5)

In the end, why do you want to do this work? Hear what the experts say



Activity 9.4: Watch the “ Expert Conversations” video clip entitled ‘Final note from the Experts’ (8 minutes duration)

The Experts are responding to the question:

- Why did you decide to specialise in the area of BPSD?

Listen to their responses and reflect on your own reasons for working with people with BPSD.

9.5 Resources and References

1. Behaviour Management – A Guide to Good Practice (2012) available at http://www.dementia.unsw.edu.au/index.php?option=com_drcrc&view=drcrc&layout=project&Itemid=101&pid=154
2. Enhancing Communication: An inspirational guide for people like us with early stage memory loss. A “By us For Us” Guide
http://marep.uwaterloo.ca/products/BUFU/88483_enhancing.communication.pdf
<http://www.marep.uwaterloo.ca/products/bufu.html>
3. Communication module
<http://dementia.uow.edu.au/understandingdementiacare/module3/index.html>
4. Come Talk With Me: Strategies for enhancing communications in dementia care presentation by Jade Cartwright <http://echo.lecture.curtin.edu.au:8080/ess/echo/presentation/2cc47ab3-9970-46ee-a864-c682e41599df>

5. Good practice principles for assessing and caring for people with challenging behaviours in Residential Aged Care Facilities
http://www0.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_014.pdf

Additional Resources

6. Guide for healthy Lifestyles for Professionals can be found at <http://www.dementia.unsw.edu.au/info-module/info-service.html>
7. Transitions in care of people with Dementia can be found at <http://www.dementia.unsw.edu.au/images/drcrc/pdf/transitions.pdf>

Abbreviation	Term	Definition/Comment
ADLs	Activities of Daily Living	
BPSD	Biological and psychological symptoms of dementia	
CALD	Culturally and Linguistically Diverse	
CMAI	Cohen-Mansfield Agitation Scale	
CSDD	Cornell Scale for Depression in Dementia	
DBMAS	Dementia Behaviour Management Advisory Service	
IPA	International Psychogeriatric Association	
NDB	Needs-Driven Behaviour	
NPI	Neuropsychiatric Inventory	
NPI-C	Neuropsychiatric Inventory-Clinician	
OVERT	Overt Aggression Scale	
P.E.A.C.E.	Mnemonic representing Physical, Emotional, Activity, Communication, Environment	Used as an assessment tool
P.I.E.C.E.S	Mnemonic representing Physical cause, Intellectual capacity, Emotional health, Capability environment and Social self	Used as an assessment tool
RAGE	Rating Scale for Aggressive Behaviour in the Elderly	Used as an assessment tool
RAID	Rating for Anxiety in Dementia	Used as an assessment tool
VDB	Vocally Disruptive Behaviour	

Possible responses to the activities of each module

This answer guide will provide you with responses to the activities presented in each module of the self-directed learning package. A summary of the question is provided and is shown in **black, bold italic print**. The suggested responses are in black print.

As the participant in this learning process, we hope you will attempt to formulate your own responses to the questions after studying the text, the provided case studies and any recommended references.

It is suggested that you:

- have a notebook handy before you start
- test your learning by composing your responses and writing them in the note book
- use this guide to confirm the accuracy of your answer and to gauge whether you have an understanding of the content
- where you have not been accurate or clear, use the given responses to help clarify the situation and reinforce your knowledge.

While some activities have some definitive responses others rely on you, as the participant, to contribute from your own experiences. Where this is the situation no formal response will be outlined. In general, the responses offered are examples only and may not totally cover all possibilities. You may be able to seek advice from a more experienced clinician to confirm the suitability of your response.

In extending your knowledge about BPSD, extensive reading and exploration of available research articles will provide you with more comprehensive options to manage people with dementia exhibiting challenging behaviours.

Good luck with your study of BPSD.

Module 1 – Unit 1 Introduction to BPSD



Activity 1.1.1

After watching the first video clip 'Defining Symptoms of Dementia'

i) What do you anticipate would be the possible impact to all concerned with the care of people with dementia, if symptoms remain untreated?

The quality of the person's life quickly deteriorates, as they become more disabled. They may cause disruption and may harm themselves or others. Their distress and confusion increases. Premature institutionalization may be necessary.

For the family and carer the burden of care increases as meeting their activities of daily living (ADL's) becomes increasingly difficult. The impact on some family members and particularly children can be most distressing. School age children, particularly adolescents, can feel quite lost when a parent suffers with dementia. This can lead to stress, increased financial costs, loss of income and time to meet their own physical, social and psychological needs.

i) Summarise the key elements of BPSD that have resonated with you and helped to define BPSD.

Participant's own responses

iii) Based on what you have explored in this module, how significant is the syndrome of dementia to health professionals? What is the value of learning about BPSD to you as a clinician?

The significance of this syndrome is that the incidence of dementia is increasing so rapidly that it has become a major issue for all health professionals working in a variety of settings.

The value in understanding BPSD enables you to recognise that this is a form of communication indicating a person's discomfort or distress and so enabling you as a health professional to assist the person by selecting interventions aimed at reducing the behaviour.

Module 1 – Unit 2 Frameworks & Model for Understanding



Activity 1.2.1

Using the above model, suggest two examples of possible internal and external environmental stressors that a person with dementia may experience

Internal:	i) fatigue, illness, hunger, awareness of having dementia or their losses
	ii) discomfort or pain, full bladder, adverse reactions to medications
External:	i) changes to routine, excessive noise
	ii) excessive movement, alterations in temperature (hot or cold)



Activity 1.2.2

Identify from your own experience two background factors and two proximal factors, as given in the NDB model, that might contribute to a need becoming unmet.

Background factors:	i) Loss of language skills, loss of memory, difficulty in concentrating
	ii) Inability to sleep, immobility, reduced motor skills
Proximal factors:	i) Feelings of sadness, tearfulness, immobility, loneliness, fearfulness
	ii) Bright light, high noise level, temperature variations, environment with too much or too little stimulation



Activity 1.2.3

From the video clip “Frameworks & Models” by the Experts

i) Which one or two of these models best suit your care of a person with dementia in your setting. Explain why you think this?

Participant's own responses

ii) Select one of the models and outline how the behaviour of a person with dementia, for whom you have cared, might be explained.

Participant's own responses

iii) Which of the models outlined may be best suited for use in your setting, when caring for people with dementia from a culturally or linguistically diverse background?

Probably NDB model - the unmet needs model may be best suited for a person from a CALD background

Module 2 Identifying and collecting information



Activity 2.1

Using the BPSD Guide 2012 (p32) Table 1.2 Factors which may contribute to BPSD identifying possible sources of triggers

a) Why is it important to explore possible triggers for behaviours? How might you do this?

It is important to identify possible triggers so they can be targeted for reduction or elimination. This can be accomplished by reading their referral notes and history, by undertaking a comprehensive assessment from the individual and carer & family members and by ongoing observation of the person.

b) Reflecting on a person with dementia you have provided care for – what might have been the triggers for the behaviour they exhibited?

Participant's own responses



Activity 2.2

Using the video clip “Collecting information” and the table 1.2 on p32 BPSD Guide 2012

a) The experts suggest that you seek information about the top 5 items of importance to the person you are assessing. What will be the value of this seeking this information?

This allows for the identification of the items important to the person or their special likes or dislikes. Knowing this information may provide ways to calm the person if their likes can be provided and dislikes avoided. Can promotes development of a person-centred relationship by referring to topics important to the person.

b) In obtaining information from relatives or carers, divergent views may be provided in describing behaviour. How might you overcome this dilemma in order to obtain the most accurate picture of the situation?

If possible bring relevant people together and seek objective information from them, explore possible factors that might influence interpretation of behaviour such as, time of day, environment or even hearsay. Ensure objective data is current data.

c) Where possible, it was suggested that the person with dementia is asked “what might be one or two ways we could improve things for you”. How might this information assist?

May identify an unmet need and focus interventions on making the person more comfortable and hopefully by doing this can reduce the challenging behaviour. Provides for a greater understanding of the person and how they wish to be cared for.



Activity 2.4

From the Mrs A's situation and keeping in mind the A-B-C model respond to the following:

a) Formulate the three questions you would pose to Mr's A's daughter in seeking information about Mrs A's vocalisation behaviour

Please describe Mrs A's verbal behaviour in terms of how often and for how long is each outburst, describe also the loudness, content, time of day and impact of her surroundings?

What have you observed that seems to cause her to vocalise and what seems to make this behaviour worse?

Are you aware of any actions that seem to soothe her or reduce the frequency and intensity of the vocalisation

b) State what you consider might be the possible antecedents (explanations) for her behaviour , using information provided in Mrs A's case study:

i) pain while ADL's performed

ii) lack of social interaction from being consistently alone, presence of restraint (belted in chair)

c) List the observations you will make to better understand Mrs A's behaviour.

Record how often the behaviour occurs, time of day, the intensity, the level of disruptiveness to others, duration, any strategies that reduce the behaviour and when the behaviour is not present.



Activity 2.5

Using the given hourly observation chart:

Broadly, what inference can you make from the above scenario in relation to the clients progress over this 24 hour period?

The diversional activity provided between 13.00 -15.00hrs did not prevent a reoccurrence of the behaviour.
The diversional therapy at 20.00 hrs appears to have had a reducing/calming effect.

Module 3 Planning and Implementing Strategies



Activity 3.1

From the Expert's session “ Factors to consider” about (a) when to intervene; and (b) when not to intervene? How will you decide?

Summarise two key messages that resonated with you from the comments made by the experts.

Plan ahead when anticipating that behaviour may escalate; consider a multi-faceted approach as behaviours not necessarily discreet entities; be aware that negative behavioural responses over time may lead to staff withdrawal; sometimes direct intervention not required but adjustment of environment; consider whether behaviour is actually causing problem such as risk of harm or can just be allowed to continue.



Activity 3.2: Access the website

<http://www.health.vic.gov.au/dementia/strategies/person-centred-care.htm> and consider actions under the link entitled “Communication strategies”

Provide, four examples of *positive person-centred interactions* and suggest four less helpful interactions

Positive Person-centre interactions	Less helpful interactions
1. Show respect for the person by explaining what you are doing for them	Speak about the person as if they are not present
2. Use their name & refer to unique aspects of their life	Use statements that dehumanise, intimidate or threaten the person
3. Acknowledge their individual preferences and dislikes	Ignore their attempts to contribute or act for them rather than allowing independent action
4. Seek their involvement and encourage independence	Make fun or mock the person or their behaviour or show irritation or annoyance with their behaviour.
5. Slowing down activities and conversation and allowing for calm unrushed interaction	Being hurried and impatient , not taking time to understand and interpret behaviour.



Activity 3.3

List the key points suggested by the Experts concerning the planning of interventions and list these beside the given topics below

Topic	Key points
Overall approach	Systematic, deal with one issue at a time, PCC rather than task centred*,
Goals	Target symptoms rather than overall goals ... one problem at a time, give time limit Make clear what is the end goal – to reduce, reorient, eliminate, shift
Intervention selection	Needs driven - hunger, pain Continuum of easy things to do progressing to multifaceted Segmenting the work, one piece at a time unless dangerous to self or others Chart completion – observation chart
Team approach	select leader of care, choose person as close support person, involve family member, regular case conference, use of specialists and DBMAS
Family involvement	Inclusive, especially if risky meds -may need to establish guardianship
Medications	Review each, reduce to bare minimum Consider positive or negative consequence Monitor for undesirable effects



Activity 3.4

From the given aims of care, develop more specific **goals** that will guide what is to be achieved with the selected interventions thereby providing a way to evaluate the success or not of that intervention.

Aim of Care	Goal	Interventions
<i>Eliminate pain</i>	No discomfort or reduced evidence of pain for next 48 hrs then review	<i>Provide regular analgesia especially prior to ADL and exercise and maintain regular observation for signs of discomfort</i>
<i>Enhance comfort during routine care, such as bathing, feeding, toileting</i>	Positive state of comfort indicated or conveyed during ADL's over next three days	<i>Use a calm approach Use gentle slow movements Ensure environmental temperature and noise levels are suitable Use actions that minimise indications of discomfort</i>
<i>Increase opportunities for engagement</i>	Engages to some degree in activities and interacts with others over next 48 hrs then review	<i>Offer opportunities for involvement in engaging 1:1 or in group activities Encourage volunteer or family visits Place in a location where others can interact naturally and without effort Attend for short interaction on half hourly basis</i>
<i>Reduce boredom</i>	Engages in activities at least twice a day for next two days and review	<i>Provide sensory or touch therapy session in morning Offer music or an exercise activity of preference as a distraction in the afternoon</i>

b) From Mrs A's case study list the interventions systematically introduced with the aim of reducing Mrs A's VDB. Provide a possible reason why each intervention was selected for trial (not the effectiveness).

<i>Intervention</i>	<i>Possible Reason/s (rationale) for using this intervention</i>
Use of fiddle maps& muffs	Provides touch, relaxation and distraction
Whole body massage	Using touch to provide calmness and relaxation
Doll & cuddly bear therapy	Provides touch and relaxation plus sense of belonging
Garden walks	Provide gentle physical activity and distraction
One to one communication	Reduce sense of isolation, provide a distraction and reinforce person-centredness
Music	Use of sound to induce a calmer state and create reminiscence
Stress relief tapes	To bring calmness – she previously taught stress Management and meditation (see Mrs A's case study Part 1)
Afternoon nap	Induce rest and relaxation
Participation in communal activities	To reduce isolation & boredom as she occupies a single room
Placed to face the garden	To reduce stimuli and provide a calming image

Module 4 Evaluating Effectiveness of Strategies



Activity 4.1

From the Expert's session "Evaluating the effectiveness of Strategies" for the following goals and interventions, develop indicators that will provide a measure of the effectiveness of the given intervention.

Goal	Intervention	Indicators of effectiveness
Reduced frequency of VDB over next 2 days	Frequent brief periods of interaction by assigned carer at times when VDB not exhibited	No of times calling out reduced by 30%
Responds to a calming environment for up to 30 mins between 2-4pm for one week	Offer brief (15-30 mins) music therapy with personal choices of music from 2pm	Engages with music therapy for over 20 mins. Reduced frequency of VDB between 2-4pm



Activity 4.3

Using the BPSD Guide p 88-89 under 'Management of Agitation' or Appendix 3, provide four suggested interventions shown to have beneficial effects and three interventions which are not supported by evidence.

Psychosocial Interventions	Level of Evidence as <u>identified in Appendix 3</u>
Music concerts, music with hand massage , individualised	Moderate to strong
Indoor gardening	Moderate to strong
Acupressure,	Moderate to strong
Aromatherapy	Moderate to strong
Bright light therapy	Not supported
Group music	Not supported
Therapeutic touch	Not supported



Activity 4.4

b) From Joyce's case study

i) Identify the behaviours demonstrated by Joyce that indicate agitation

Verbal outbursts of yelling and screaming, at times leading to aggression, pulling things from the wall, threats to walk out, inability to interpret situations

ii) What triggers for her behaviour are suggested?

Loss of control and self esteem from her job termination, Arthritic pain, Paranoia, chaotic home environment, inappropriate communication by husband(Doug)



Activity 4.5

a) From Joyce's assessment information and using the PIECES framework, suggest the unmet needs which may exist

Framework	Possible Unmet Need
Physical	Relief of pain, good nutrition
Intellectual	Usual Routine
Emotional	Supportive gentle interaction
Capability	Opportunity to choose actions
Environment	Calm less reactive environment; orderly environment
Social Self	PCC - individualised attention

b) It is also clear that Doug is not coping - what actions may be helpful for Doug?

Time out, counselling, education about Joyce's condition, support and examples as to how to interact with her.



Activity 4.6

From the planned strategies for Joyce and Doug:

a) What are the ways in which clinicians or carers can regularly monitor Joyce's response to planned interventions?

Streamlining the pathways of reporting for Doug allows clinicians to be updated on any escalation of behaviour early. Teaching Doug & carers about the need to monitor responses at all times and to be alert to signs of distress provides an indication of Joyce's progress.

b) For how long is it helpful for interventions to be continued?"

For as long as they are being effective and reducing behaviours that cause distress

c) In the table below, suggest observations that may indicate the interventions being used with Joyce are having a positive effect.

Goal	Intervention	Observations showing a positive response by Joyce to these interventions
<i>Analgesics accepted without concern within one week</i>	<i>Individual music therapy each day combined with hand massage prior to offering analgesic</i>	Joyce receives and agrees to swallow analgesic without verbal outbursts before the end of the one week period
<i>Agitation following interaction with Doug less evident over the next month</i>	<i>Provide communication techniques such as, remaining calm and being gentle, not challenging or confronting Joyce and sitting beside her instead of standing over her</i>	Joyce listens to and responds to Doug's interactions. Agrees to suggestions offered by Doug without verbal outbursts or irritation by the end of the one month period
<i>Engages in positive decision-making and makes choices over the next two weeks</i>	<i>Encourage Doug/carers to:</i> <ul style="list-style-type: none"><i>• offer alternate activities for Joyce to decide</i><i>• request Joyce's preference when offering food or drinks</i>	Joyce selects an option when offered more than one alternative both with refreshments and activities without verbal outbursts within the two week period
<i>Verbal outbursts less frequent over next month</i>	<i>Reduce harsh noise and promote a calm, low stimulation environment</i>	Records of verbal outbursts show a ongoing decrease in occurrence of verbal outbursts over the one month period

Module 5 Case Study focusing on Wandering Behaviour



Activity 5.2

b) Using the RWAO model for assessment of Sharon's wandering behaviour, identify three behavioural instances and indicate the possible unmet need and likely consequences in the table below:

<i>Contributing proximal factor/s</i>	<i>Description of Wandering</i>	<i>Adverse outcome</i>
Need to find familiar places e.g. her room, and know where she belongs	Walking frequently around the RACF and going into the rooms of other residents (boundary transgression)	Disruptive annoyance to other residents Privacy infringement
Need for companionship and recognition; need for help with way finding	Close shadowing of staff and other residents (repetitive and routinised walking)	Annoying other people by getting too close to them and following them about
Need to return to a familiar place, need for greater freedom and control over her environment	Often lost within the facility (spatial disorientation)	May decrease personal safety and increase her agitation.



Activity 5.3

From **Appendix 3** in Behaviour Management – A Guide to Good Practice 2012.

a) Identify six interventions trialled for Sharon and indicate which interventions are supported by some level of evidence.

b) Suggest how staff might monitor each intervention to be able to gauge effectiveness

(One example is provided to demonstrate the type of responses required)

<i>Interventions trialled</i>	<i>Some level of Evidence supports intervention</i>	<i>Mechanism to determine Effectiveness</i>	<i>Effectiveness shown by:</i>
1. Stop signs on doors	moderate	Record no of times sign deterred exit – over a 2 day period	Reducing no of exits over 2 days
Distracting Sharon while ADL care given to other residents	limited	Record Sharon's period of non locomotion while distraction occurring	Reduced wandering into others rooms

<i>Interventions trialled</i>	<i>Some level of Evidence supports intervention</i>	<i>Mechanism to determine Effectiveness</i>	<i>Effectiveness shown by:</i>
Individualised attention (PCC) of 20 minutes	limited	Record Sharon's period of non locomotion during one to one interaction	Reducing episodes of wandering – less evidence of agitation - calmer state
Brief 10 minute interactions		Record Sharon's frequency of invasive wandering between interactions	Reducing episodes of wandering – less evidence of agitation - calmer state
Music therapy	moderate	Record Sharon's period of non locomotion following therapy	Sharon calm during music session, reducing level of wandering
Massage/therapeutic touch	Moderate - strong	Record Sharon's period of non locomotion following therapy	Sharon calm during massage session, reducing level of wandering
Door concealment	modest	Record no of times an attempt to open/exit door occurred – over a 2 day period	Doors that previously attracted Sharon remain closed

c) What other specific assessment might have helped the staff understand the expression of Sharon's wandering behaviour?

The Revised Algase Wandering Scale for Long Term Care(RAWS-LTC)

d) Suggest two further interventions that might be trialled with Sharon.

i) Cease providing the treatment for urinary tract infection, no longer required

ii) Melissa oil combined with base lotion applied to face and arms twice daily (strong evidence)

e) What support might be offered to Sharon's husband to help him understand Sharon's behaviour?

Explaining why Sharon's behaviour occurs and aims of the strategies being trialled.

Providing suggestions as to how he can best contribute in support of the strategies.

Offering opportunities for support/counselling for his own feelings and distress

f) What specific care policies need to be put in place to protect the resident who wanders?

Provide safe and secure areas for person to wander. Employ alert devices that will inform staff should a person leave the security of the area/facility. Monitor intensity of wandering to be aware of degrees of exhaustion. Employ devices to disguise exits

Module 6 Case Study focusing on Depression & Anxiety



Activity 6.3

From Mr B's profile and given information"

a) Identify the possible unmet needs contributing to Mr B's behaviour and which would become the focus of any intervention"

<i>Unmet Need</i>	<i>Behaviour</i>
Companionship (apart from dogs)	Sadness, tearfulness
Awareness of surroundings	Reluctance to self care
Safety in relation to crossing road and self medication	Lack of awareness of surroundings Unsafe road crossing
Ability to communicate his needs	Hostility, banging on door
Positive interactions	Withdrawal, wishing to die
Self care	Dislikes being assisted by female staff

b) Compose a question for each of the elements of the PEACE model, that you might ask to Mr B's niece in seeking additional information and details about his behaviour

<i>Element</i>	<i>Question for Mr B's niece</i>
"P"	What are you most concerned about in relation to your uncle's physical health?
"E"	How do you think your uncle feels about his situation?
"A"	What can your uncle no longer do that he did before?
"C"	How well does your uncle answer you and tell you about himself?
"E"	How safe do you think your uncle is at present in the community?



Activity 6.5

a) The clinicians provided various strategies, to deal with Mr B's mood behaviour. Identify the behaviours exhibited, summarise the interventions used in the table below

<i>Demonstrated Behaviour</i>	<i>Interventions</i>
Sad and tearful	John Wayne movies Planting bush plants, watering
Reluctance to accept care	Identify male carers where possible
Inability to live safely in community	Managed care environment and special care plan
Absconding	Safety bracelet and police tracking
Exiting ventures	Cards warning of snakes
Sadness over loss of family/dogs/community	Contact activities documented and regular efforts made to engage with family
Alcohol withdrawal symptoms	Use of Valium & some alcohol
Expressed wish to die	Establish close observation regime and safe environment

b) Source from the given website and from the suggestions provided identify three other culturally appropriate interventions that could be trialled with Mr B that might engage him

i) Offer a selection of arts & crafts
ii) Prepare some sensory items to sort e.g. leaves, sticks
iii) Visits from community members for story telling and yarnning

Module 7 Case Study focusing on Aggression



Activity 7.2

Using the PLST model , and information provided *in Jayita's case study*, identify possible increasing stressors that could be contributing to her behaviour and which would then become the focus of any intervention.

Possible Stressor	Behaviour
Pain from osteoarthritis	Agitation & aggression
Limitations with mobility	Agitation & aggression
Incontinence & personal care provided by a male	Physical aggression
Change shower routine from evening to morning	Physical aggression
Feelings of isolation from impaired hearing	Verbal aggression
Unmet cultural needs in relation routines, language and customs	Agitation & aggression



Activity 7.3

Suggest four suitable alternate interventions (showing strong to moderate quality rating for research) Using “A Guide to Good Practice: Managing BPSD” [Appendix 3: Psychosocial and environmental interventions table](#), that could be further trialled for Jayita should the above strategies not have been successful.

Alternate Interventions	Quality rating of Evidence for this intervention	Author
Multi-sensory stimulation	strong	Ward-Smith 2009
Individualised psychosocial intervention based on behavioural therapy	moderate	Davison et al 2007
Music therapy	moderate	Savansdottir 2010
Light therapy	moderate	Dowling 2007
Acupressure	moderate	Lin et al 2009
Tactile massage	moderate	Suzuki et al 2010

Module 8 Advice for Workplace Leaders



Activity 8.2

a) Identify the key elements of a person-centered culture in your workplace.

Participants own response

b) Apply the assessment tool for Person-centered Care found at the given website

Participants own response

c) From your assessment using this tool identify areas which require further action and improvement?

Participants own response

Module 9 Advice for Novice Clinicians



Activity 9.4

Listen to their responses and reflect on your own reasons for working with people with BPSD.

Participants own response



DEMENTIA
TRAINING
STUDY CENTRES