3-759 Interventions for unpredictable behaviour

TIPS Question:

What tools could we use to determine if unpredictable aggressive episodes relate to his time during the war? What other interventions could we implement in dealing with unpredictable aggressive behaviour?

Response:

First of all I must say how pleased I am that you have called these behaviours 'unpredictable" aggressive episodes. Sometimes staff will say that aggressive behaviours are occurring without any reason or provocation. There are always reasons, we may just not know what the reasons are and therefore the behaviours are unpredictable. We, as care providers, often cannot find out exactly why residents are exhibiting certain behaviours. Do you remember the example used by the facilitators in your P.I.E.C.E.S. education that there are multiple reasons for all our behaviours (sometimes the example is used that one individual may do a simple behaviour like put on a certain sweater, for five different reasons). It is equally as important to remember that not only are there multiple reasons for behaviours, but the reasons fluctuate (if the person wears the same sweater next week it may be for a completely different reason). It appears you and the care team have not fallen into the two common traps: 1) determining one reason for behaviour and failing to note that there are many reasons for the same behaviours that occur at different times, and 2) *determining that there are no reasons for behaviours because staff cannot find a consistent pattern*.

You asked what tools could be used to determine if these unpredictable aggressive episodes do relate to his time during the war. As stated above, you may never actually be able to unequivocally make that determination. Having said this, it would help staff if an effort were made to look for frequency and types of behaviours, patterns of these behaviours, staff response to behaviours and possible causes of these behaviours. When I ask staff to fill out any charts or complete any tools, I always tell them why. This may seem like a simple step that doesn't need to be noted, but, in fact, people forget this step a lot. We may have told *some* staff this information, but not *all.* We may think the reason for completing the tools/charts is very obvious and does not need to be stated. It is so important to get proper information and encourage completion of these tools that one should always state *why* they need to be completed. Your issue would lead into this well: you would suggest staff complete the Cohen-Mansfield Agitated Inventory (CMAI) first as an aid in narrowing down the target behaviours. You could then tell the staff that they are completing the CMAI in an effort to narrow down significant behaviours, which will then be monitored with the Dementia Observation System (DOS). The CMAI would serve as an excellent baseline before any behavioural interventions are started. When staff complete another CMAI in the future, it would be easy to see change. The CMAI is also very useful when there are incongruencies in the behavioural reports from different staff/shifts. Please use the Disruptiveness Form (found in the P.I.E.C.E.S. resource guide) as this elicits the very important information "how disruptive do the caregivers/providers find this behaviour". The client may have multiple agitated behaviours, but only one or two are truly disruptive. You could then take these behaviours and chart them on the DOS. It is important to note that the eight behaviours listed on the DOS sample (found in the P.I.E.C.E.S. resource guide) are in a particular order i.e. sleeping…. to…. physical aggression. Some Care Teams have found it useful to add examples beside each behaviour on the DOS key. These examples could be from the completion of the CMAI. Be careful not too add too many behaviours onto the DOS, especially if they overlap with each other and do not follow the continuum of: no agitation …to ....most agitated the client can become. It is not mandatory to do the CMAI first, but if the Care Team feel it would be helpful to determine the frequency and disruptiveness of each behaviour *before* they complete the DOS, then this would be perfectly appropriate.
There are a number of issues that may be contributing to these residents' behaviour of unpredictable aggressive episodes. I'm glad to see you applied the 6-question template to structure/organize the information. I like your acknowledgment of the potential effects of loud voices and sounds and that it is possible that the environment reminds this person of the war and results in distrust and fear for this individual. I'll just briefly re-cap the six question template:

What is the behaviour-cognitive mental health need?
It sounds as though it is primarily aggressive behaviours that are the main issue. Are there any other behaviours with this person that causes you and the care team concern? Sometimes, a variety of difficult behaviours stem from the same cause. It would be good to have actual examples of the aggressive behaviours. Sometimes we think there are more behaviours, than there actually are.

Who is it affecting?
This is very important. There are many Partners in Care involved: the client, family, nursing staff, co-residents, and family physician. Depending on the type of aggressive behaviours, it would be interesting to know which group is the most sensitive to these behaviours. The co-residents…the staff? Try to find out how staff truly feel about these behaviours. This has implications for whatever intervention you may attempt to implement and how fast. Sometimes co-residents are not aware of the disruption as much as care providers would assume. How about visiting family members?

What is the degree of RISKS?
This framework will help prioritize the issues. Again, when you outline exactly what the behaviours are, how frequent they are, what the responses are and who the behaviours are affecting, then you will get a good idea about the element of risk. When I hear the words “unpredictable aggressive episodes” I immediately picture a resident pushing and hitting other vulnerable co-residents, without any warning what so ever. This makes me feel like there is a huge risk and we have to act immediately. The situation may not actually be as imminent as one may think; therefore looking at the degree of risk may actually make me, as a staff person, feel better about the situation and enable me to prioritize interventions appropriately.

How do we describe and record what we see?
As stated earlier, a Cohen-Mansfield Agitation Inventory (CMAI) would be very valuable. It would also be beneficial to complete a Dementia Observation System (DOS). This would show pattern in more detail. It is very important to map out a pattern because you and the care team can start to implement interventions at the more aggressive times. If this is not possible, then at least staff know that a difficult period is approaching and can mentally prepare themselves. It is also great to see from the DOS that the difficult behaviours decrease at certain times of the day, in this way staff know there is relief.
Also, you may not see any patterns in his behaviours, as you already suspect. This would be invaluable information as it would validate what people already think.

When looking at staff response to the behaviours there are a few things to keep in mind. When charting difficult behaviours, staff tend to stop charting after a while because these behaviours are ‘the norm’ for the resident. When staff do chart on these behaviours, they tend to write down the same information each time. Remember the section on ‘Your Response’ in the P.I.E.C.E.S. education? It was noted that individuals are often not objectively aware of their own responses and therefore do not chart the real responses they are actually giving to residents. Caution staff to look objectively at their own behaviours and responses when completing this type of charting.

What are the possible causes?

P: Physical: It is assumed that possible physical causes were ruled out. When in doubt, some facilities have asked the family physician for regular pain management in case the resident is acting out due to undetected pain issues. There may be other physical causes for these behaviour, brainstorm with staff on what these might specifically be.

I: Intellectual: I assume you have been able to gather some information on this person’s cognitive status. Some of his behaviours may be the result of cognitive impairment and his trouble with putting his own world together in his mind. Remember in your P.I.E.C.E.S. education that the facilitators talked about individuals *living in the moment* and they often combine past memories with present happenings. This brings in your good point about his aggressive episodes being related to an altered state of mind. When talking with the staff make sure they are attributing these behaviours to cognitive decline and not attention-seeking demands.

E: Emotional: A possible mood disorder should always be ruled out. The elderly do not present a depression with obvious symptoms. Again, you may not be able to complete a full assessment of depression. You have noted that there may be an emotional cause to the behaviours; specifically that the person may relive incidents from the war and is therefore distrustful and fearful of his present situation. It is important, then, to acknowledge to staff and family that this may be a factor contributing to these behaviours.

C: Capabilities: What are this resident's capabilities compared to the demand of the environment? Often behaviours are a result of the client's frustration. This is especially true when staff find, through DOS charting, that most of the aggressive behaviours occur during and after care.

E: Environment: You have pointed out the loud voices and sounds may bring back memories of this individual's time during the war. As a result of the environment, this person may feel more distrust and act out from fear. It is common to gloss over the environmental issues when completing the six-question template, but it can be seen in this case how important the impact of the environment is on behaviours. Consider the staff/resident ratio, roommates, length of time at the facility, the noise level, sights and smells around the person, etc.

S: Social: You already know the significance the war played on this individual. It would be interesting to know some more information about this person's past. What was his role in the war, where and when?

What are the steps for providing the best care strategies?

Meet with the care team, share your information and discuss the following:

The possible causes for these behaviours. Do not forget that there are multiple reasons for behaviours. Brainstorm with the group and see what you come up with as possible causes. In these types of cases it is often difficult to identify definite causes of the behaviour. Err on the side of caution and assume all these reasons may be at play at one time or another.

Think about potential interventions according to the above list. Structure a list of activities that target the above possible causes

Perception of the behaviours. These behaviours are exhausting for staff. Validate their feelings on this topic. Staff will feel less stress about a client if they understand the person's background more and if they feel they are actually doing something about the behaviour.

You asked what other *interventions could be implemented in dealing with unpredictable aggressive behaviours*. Specific interventions would result from your discussions above. You and the care team will end up re-framing this person's behaviours, rather than actually changing them. You can alter the environment to decrease the frequency and impact of the behaviours and you can have a better understanding of the behaviours and support those that are affected by his behaviours, but to actually 'stop' the behaviours is unlikely. Already you have accomplished a great deal by identifying that this person's past affects his present behaviours and the staff do not seem to have labelled them as 'attention seeking, negative behaviours".

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*