3-79 Calling out behaviour

TIPS Question:

An 80-year old resident with diagnoses of: dementia, # left hip, CVA, hypertension, CAD, NIDDM, skin cancer. We are having a great deal of difficulty with the resident calling out all day, evening and night. The P.I.E.C.E.S. approach has been applied to assist in this case. The Pro-Attention Plan has been in use x 4 weeks and the DOS x 4 weeks. The physician has the resident on the maximum dose of trazodone (100 mg @ HS, oxazepam 80 mg hs and risperadol 0.5 mg po. The resident's behaviour has not been reduced in frequency. Resident is involved in many activities throughout the day. A total pain assessment has been completed to rule that out.
Does anyone on the faculty have any suggestions on how we can better cope/manage with this resident?

What are the significant factors you have learned as a result of working through the six-question template?

- A more thorough way to appropriately assess & look into why my resident is exhibiting these behaviours. There are always reasons for exhibiting behaviours and P.I.E.C.E.S. now provides me with an excellent template to do so.

Response:

Congratulations on using the 6-Question template and finding best care strategies such as the Pro-Attention Plan to trial. You have taken the time to monitor the results using the DOS. You have sought many possible causes as there are a number of issues that may be contributing to this resident's behaviour of constant vocalizations. In your role as Psychogeratric Resource Person (PRP), you might want to think about the P.I.E.C.E.S. process as a continuous process, instead of a "one time event", where the 6-question template can be used again to evaluate the effectiveness of any strategies you developed with your first assessment using P.I.E.C.E.S.

The following is the 6-question template and it briefly outlines some areas to consider for further investigation.

1. **What is the behaviour-cognitive mental health need?**

   It sounds as though the verbally disruptive behaviour is 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.

2. **Who is it affecting?**

   This is very important. There are many Partners in Care involved: the client, family, the nursing staff, co-residents, family physician. Try to find out how staff truly feel about these behaviours. Often verbally disruptive behaviours leave staff's patience thin (even if it is singing). This has implications for whatever intervention you may attempt to implement.

3. **What is the degree of RISKS?**

   This framework will help prioritize the issues. Usually with this type of behaviours staff worry that the resident is at risk as frustrated co-residents may respond in an aggressive way.

4. **How do we describe and record what we see?**

   When a resident presents with these types of behaviours; there is usually a discrepancy in staff's perception regarding the type and frequency of behaviours. A Cohen-Mansfield Agitation Inventory (CMAI) would be very valuable. Have you been able to determine any patterns of behaviour using the Dementia Observation System (DOS)? For this type of resident it is very important to map out a pattern because you and your care team can start to implement interventions at the more vocal times. It this is not possible, and then at least staff know that a vocal period is approaching and can mentally prepare themselves. It is also great to see from the DOS that the vocal periods decrease at certain times of the day; in this way staff know there is relief.

To look at cause and effect with these behaviours, implement the ABC's of behaviour (P.I. E. C.E.S. manual), remember these three important points when assessing for antecedents (A) to behaviours:

i. there may be more than one antecedent or triggering factor for a specific behaviour

ii. they fluctuate

iii. It is not always possible to identify them.

When talking with staff remind them that a resident may display a certain behaviour for one reason and then display that same behaviour another time for a completely different reason. It is dangerous for a clinician to assume that certain behaviours have one antecedent and the antecedent always stays the same. Often behaviours are described as "episodic" and staff "never know when the behaviour is going to occur". This is usually the description if antecedents cannot be identified. What we have to remember is that there are always triggering factors, it may not be possible to identify them for some clients' behaviours.

5. 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 vocal due to undetected pain issues. You indicated that a pain assessment ruled out pain, but also listed a fractured hip as part of the diagnosis. You may want to trial round the clock analgesics to see if this helps in diminishing the vocalizations. It is often difficult to assess pain. Enlist the assistance of your physician to see if a different medication instead of Risperdone might be helpful. As the PRP you also have the option of seeking the assistance of the Specialty Geriatric Services team in your area. Could the resident have a delirium? There are a number of physical issues and multiple psychotropics that could contribute.

I: Intellectual:

Usually with vocally disruptive residents there is a significant degree of cognitive impairment and a complete cognitive assessment cannot be completed. When talking with your staff make sure they are attributing her behaviours to cognitive decline and not attention-seeking demands. The resident is "involved in many activities" – does this calling out decrease at those times of activity or does it continue?

E: Emotional:

A possible mood disorder should always be ruled out. Do not forget that the elderly do not present a depression with obvious symptoms. Again, you may not be able to complete an assessment of depression. It is important, then, to acknowledge to staff and family that this may be a factor contributing to her behaviours. Some behaviours have been lessened by use of SSRIs, but you report that the psychotropics the resident is on do not help reduce the behaviour. Perhaps it is time to review with the rest of the care team and determine if this is the best treatment plan.

C: Capabilities:

What are this resident's capabilities compared to the demand of her environment? Often behaviours are a result of the client's frustration. If no interaction or activity affects the noise-making then he disruptive vocalization may be organic in nature, i.e. the resident does not have control.

E: Environment:

Consider the staff/resident ratio, roommates, length of time at the facility, the noise level around the person, etc. You mentioned that this resident is involved in many activities throughout the day. Is it possible that she is over-stimulated?

S: Social:

It would be interesting to know some information about this person's past. Especially if the family say she is always singing. Does she like a certain type of music and would quiet down to listen to it, or sing along? This population often enjoys well known religious songs. As the PRP, you can seek out this information with family.

6. What are the steps for providing the best care strategies?

As the PRP you may want to meet with your care team, share your information and discuss the following, possibly using the U-First! wheel:

1. 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. Causes usually include over/under stimulation, pain, hunger, loneliness, cognitive impairment (does not know she is yelling). 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.

2. Think about potential interventions according to the above list. Structure a list of activities that target the above possible causes. Such interventions would include giving opportunities for quiet time, alternating with opportunities for stimulation. Loneliness may be helped with tapes of family members reading a book or culturally appropriate music. As you already know, the PRO-ATTENTION PLAN can be implemented to target loneliness and boredom, so continue with this to see if it helps while you trial other strategies. Usually there is a decrease in this behaviour during meals. If this resident is able to feed herself finger food, give her cut up grapes or something else easy to eat. Be creative in your interventions! It would be helpful to move the resident to each activity every half an hour. This activity list can be laminated and located close to the resident. In this way any staff member can check the activity list and move the person to the next activity based on the time on the clock.

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

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.*