3-575 Managing behaviours

TIPS Question:

A 63-year old resident is blind, wheelchair bound and has a history of alcohol abuse. He is divorced, has 3 brothers who do not have any contact with him and his cousin handles his financial affairs. He lived alone in an apartment with community support until he became abusive towards the workers. He is semi-independent with dressing, eating & toileting. He screams if he wants anything and continues until he gets what he wants. He shares a room and insists on having the TV very loud which annoys his roommate. He needs to be pushed to the dining room and refuses meds regularly.

Question 1: Could his blindness be caused by the alcoholism?
Question 2: How can his screaming be controlled without waiting on him?
Question 3: How can we lower his anxiety level without medication?
Question 4: Does CNIB go into facilities to train people?

Response:

Question 1: Could his blindness be caused by the alcoholism?

It would be very difficult to determine if the blindness was caused directly from alcoholism. There are so many reasons for eye -sight to fail. Common reasons for blindness could include: uncontrolled diabetes; macular degeneration; failing of eyesight throughout his life; familial reasons, untreated glaucoma. If he had a predisposition to vision problems and then did not look after himself, it is possible that the alcoholism *indirectly* made his eyesight worse.

Question 2: How can his screaming be controlled without waiting on him?

This is a very interesting question. It is important to look at the wording that you/the care team have used. The fact that there is a worry about 'waiting on him' tells me that staff have experienced a good deal of stress when it comes to this resident. First of all, his screaming can be *reduced* through a variety of interventions, but the chances of actually controlling the screaming are not as good. I feel you've provided a lot of valuable material and I would like to organize it with the 6-question template so that I can process the information more efficiently:

1. What is the behavior-cognitive mental health need?
   It sounds as though this gentleman may have a number of behaviours that may agitate those around him. Discuss with your care team what behaviours are the most disrupting and try to focus on one behaviour at first.

   - Screams when he wants something done
   - Insists on TV volume to be very loud
   - Needs to be pushed to dining room
   - Refuses meds regularly

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, community partners. This is a good opportunity to look for other Partners that may not be as actively involved as possible.

   It would be important to discuss with staff who they think each behaviour is affecting. If it is his roommate that is most affected, could he be given another roommate (perhaps hearing impaired)? If it is only staff that are affected, then staff can look at ways to lower their own stress levels (rewarding and supporting each other). There are some behaviours that are annoying, but actually don't affect anyone greatly. This discussion would help prioritize what behaviours staff hope to limit.

3. What is the degree of RISKS?

   This RISKS framework helps pinpoint the level of risk and to whom. Is there risk to this client due to potential aggression in response to his behaviour? Are others at risk due to his behaviours? If the actual degree of imminent risk is low, this would help staff relax, step back, and work through this issues in a systematic way.

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

   When a client 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. You would be able to get a clear understanding of exactly what behaviours are occurring. It is recommended to have each shift fill this out to determine if there are different behaviours for different shifts/staff. After it is determined exactly what the behaviours are, it would be beneficial to complete a DOS (Dementia Observation System) for approximately three days. This would show pattern in more detail. For this particular client this is very important because your team is probably feeling a lot of stress, frustration and particular feelings of "we tried that and it didn't work". For example, regarding his refusal of medications. It would be interesting to see how often he refuses and if it is at a certain time of day, from a certain staff member, or a certain medication. Step back and get objective data and help everyone re-focus.

5. What are the possible causes?

   P. Physical: We assume your team has ruled out possible physical causes. Sometimes physical issues do not cause the behaviours, but the behaviours are worsened. Check to see that this client is at his best physically and then target the behaviours. Do the staff know the implications of any of his physical complications?

   E. Emotional: Look for possible depression. Remember that older people may deny feeling depressed but are more irritable. A Cornell Depression Scale or SIGECAPS can lead the assessment. It would be interesting to know if this gentleman has had emotional difficulties in the past. The alcohol use may be indicative of a depression and subsequent self-medicating.

   I. Intellectual: This is a good opportunity to first ask staff what they think this client's cognitive status is and then present results from such assessments as the Folstein Mini Mental Status Examination and the Clock Drawing Test. Often staff over-estimate a client's abilities. Acknowledge that his cognitive status may fluctuate throughout the day as well. From your behaviour mapping (DOS) you would see his best/worst times of day.
   It would be important to ascertain the intellectual capabilities of this individual before determining a response to his behaviours. When I talk to staff about residents with difficult behaviours, I try to get a sense of the staff's interpretation of the behaviours. Often they will describe the behaviours in terms that sound like it is purposeful behaviour in that "he knows what he is doing". As most residents are probably cognitively impaired to some degree, it is important to acknowledge with staff that he may not always be aware of what he is doing. This helps lower staff's level of frustration. Also, watch for impulsive and frontal-lobe type of behaviours. If this is the type of dementia a person has then he/she may score high on the Folstein Mini Mental Status Examination. Individuals with this type of dementia generally score lower on questions requiring reasoning, abstraction, judgment and problem solving skills. Do not let a 'normal' Folstein score lead staff into thinking all behaviours are purposeful.

   C. Capabilities. You noted that this gentleman is semi-independent with dressing, eating and toileting. That is great that he has had strengths identified. Are there other strengths that can be brought forward? It is important to list the strengths as well as the deficits when describing an individual. I assume his lack of mobility and blindness result in little independence. In the P.I.E.C.E.S. training you may remember that 'environmental press' was discussed. Briefly: when an individual feels they have too little demand on their abilities or too much demand for what they are capable of, then they get frustrated. Individuals would display

their frustration according to a variety of factors, such as, past coping skills, present cognitive abilities, perceived support and control. When you think of this gentleman in that context you may not be surprised at his screaming behaviour. He must feel very little personal control and independence.

You mentioned that he needs to be pushed to the dining room. Do staff feel he is capable of pushing himself to the dining room, but refuses? This is an important distinction because if he can, in fact, do it himself, but wishes staff to do it, then he must feel he needs the attention/support/control. If so, then staff can look at giving him what he needs in other ways. If it is not inconvenient to push him to the dining room, discuss with staff the possibility of doing it as a favour to him and to help the quality of his care. On the other hand, he may not be able to push himself and does require assistance. Usually individuals that suffer from Parkinson's Disease have the 'on/off' phenomenon where they can push themselves sometimes and other times they cannot (due to medication profiles).

E. Environment. What is his environment like, especially when he appears more agitated? His blindness and lack of mobility would limit his ability to interpret his surroundings Is this why he has to have the TV so loud? Do staff feel he needs the TV this loud or do they think it is only to annoy his roommate? If they feel he does not need the TV loud, then talk about why, then, would he insist on the loud volume. If it is attention seeking or control seeking, that is OK. Then at least staff would have an idea of what they could do for him to lower his agitation. (Note PRO-ATTENTION PLAN and PERCEIVED CONTROL from P.I.E.C.E.S. training).

S. Social. Is there any staff that feel they have better interactions with this gentleman? If this is the case, try to see if the facility can assign the client's care to these staff members.

Personalizing this gentleman is probably the most important part of your involvement. How often have you heard someone refer to another person's odd behaviours by saying "oh, that's just ___, he's always been like that". It is amazing how patient people become when they understand more about the person and where the behaviours are 'coming from'.

Also, it sounds like this gentleman came with a 'history' of being abusive with the community support workers. It is difficult for all of us not to judge someone, and this gentleman's history implies that he has had difficulty with relationships most of his life. This can tell the staff two important things: not to take his present behaviours personally and they are not going to be able to significantly change this person. Caution staff to not judge him according to his past, as there are always two sides to every story.

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

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

a) The possible causes for these behaviours. Do not forget that there are multiple reasons for behaviors. Brainstorm with the group and see what you come up with as possible causes. Usually these type of behaviours are due to cognitive impairment. When individuals have difficulties putting their world together they become more agitated. Also, check this client's daily activities and see if he ever has opportunity for control.

b) Institute potential interventions according to the above discussion. Is there anyway that he can be given PERCEIVED CONTROL (as noted in training manual). Give him some minor choices during care, meds and meals. Giving him some control and compromising with him is more likely to decrease the inappropriate behaviours. Talk with your team and see what is feasible in your environment. Try to alter the environment to decrease the behaviours, rather than trying to change the client's thoughts. Staff will feel less stress about a client if they feel they are actually doing something about the behaviour. Instituting the Perceived Control will give the staff something to do with this person that is positive.

c) Ask staff to think objectively about their responses to the behaviours. Include all involved

staff in this discussion, even if you have to leave notes for staff on alternate shifts. Note YOUR RESPONSE summary. The most common reason behaviour plans do not work is inconsistency.

d) Talk to staff about their perception of the behaviours. These behaviours are exhausting for staff. Validate their feelings on this topic. Some facilities have granted an extra break to the staff who deal with the exceptionally difficult behaviours. This makes staff feel supported and increases their reserve to deal with complex situations.

In summary, if staff attempt to increase this gentleman's quality of life by giving him extra attention or meeting his needs as fast as they can (encourage the staff not to regard this as 'waiting on him'); then his frequency of screaming will decrease.

Question 3: How can we lower his anxiety level without medication?

I really like this question as it shows that you are concerned about his anxiety, but do not wish to over-sedate him. Don't forget that behaviour plans are not independent from medication. If this gentleman is assessed and it is felt he does have an anxiety disorder, which necessitates medications, do not hesitate to have him treated.
If you follow the steps outlined in question #2, his anxiety level should decrease, as he would feel more supported and less 'out of control'.

Question 4: Does CNIB go into institutions to train people?

I had varied responses to this question. It seems it is district-specific. I think it is a great idea to call and ask if they would help support this gentleman. I don't know what kind of adaptation this person had developed to his blindness before he arrived at your facility. Also, the CNIB could talk to staff and increase their awareness/understanding of what it must be like to lose your vision.

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.*