

University of Nevada, Reno
Sanford Center for Aging/Nevada Geriatrics Education Center
Nevada Care Connection (a.k.a. SPE) Training Module
Lesson Plan

Unit: Managing Difficult Behaviors Associated with ADLs in Patients with Dementia

Introduction: The Managing Difficult Behaviors lesson is designed to familiarize service providers, both staff and volunteers, as well as informal caregivers such as family members, with strategies to manage difficult behaviors associated with activities of daily living (e.g. bathing, eating, toileting) while caring for individuals with dementia.

Learning Overview:

- (1) Trainees will participate in a session designed to teach and/or enhance knowledge of causes of difficult behaviors; strategies for interventions; causes of malnutrition; as well as compare and contrast “Old Model” of bathing to “Cultural Change Model”.
- (2) Trainees will engage in experiential exercises designed to simulate senior challenges related to difficult behavior.
- (3) Role-playing will allow trainees to practice applying newly learned skills.

Unit Objectives: The trainee will develop and refine knowledge of causes of difficult behaviors associated with activities of daily living (ADLs). Further interventions that can be implemented to re-direct, de-escalate or prevent the undesirable behavior will be explained along with strategies that can be implemented to improve quantity and quality of nutritional intake. The “Old Model” of bathing will be explained and compared to the “Cultural Change Model” with extensive discussion of how to improve the bathing experience for the patient.

Anticipated Outcomes for the Unit:

- Increase knowledge of causes of difficult behavior
- Increase knowledge of interventions that re-direct, de-escalate, or prevent the undesirable behavior
- Understand at least five potential causes of malnutrition
- Learn strategies that can be implemented to improve quantity and quality of nutritional intake.
- Compare the “Old Model” with the new “Cultural Change Model” of bathing
- Describe at least three strategies to improve the bathing experience for the patient

Materials:

Provided by the Facilitator:

- Lesson plan handouts (one for each trainee)
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Activities:

- Demonstrations involving role play and guided practice
- Utilization of key words and definitions

References:

Alzheimer's Association. Training for Dignity Manual. Available at <http://www.alz.org>.

American Medical Directors Assoc. Clinical Practice Guideline: Dementia. Available at <http://www.amda.com/info/cpg/dementia.htm>.

American Psychiatric Assoc. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Assoc, 1994. 133-156.

Chronic Care Networks for Alzheimer's Disease Initiative. Tools for early identification, assessment, and treatment for people with Alzheimer's disease and dementia.

Alzheimer's Assoc. and National Chronic Disease Consortium. Available at: <http://www.ncconline.org>.

Cummings, J.L. et al. Guidelines for managing Alzheimer's disease: Part I. Assessment. *Am Fam Physician*. 2002;65:2263-2272.

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Geldmacher, D. Long-term Cholinesterase inhibitor therapy for Alzheimer's disease: practical considerations for the primary care physician. *Primary Care Companion J Clin Psychiatry*. 2003;5:251-259.

Garavaglia, B. The pitfalls of diagnosing dementia: Looking beyond patient age. *Long Term Care Interface*. July/August 2007;8(4)46-48.

Hazzard, et al, *Principles of Geriatric Medicine and Gerontology*. 2nd ed.

LESSON:

Begin Lesson:

Behavior disturbances such as wandering, screaming, and aggression occur in over 50% of dementia patients. Areas where aggressions/agitations are most likely to occur are: toilet, dining room, and the bath/shower. Aggression is theorized to be correlated to cognitive impairment, function statuses (i.e., unable to complete or initiate a task), environmental stimuli-or social isolation, and emotional states such as anxiety- inability to express needs. Anxiety is believed to be related to general fearfulness, fear of specific object or event, restlessness, pacing, or worrying over insignificant matters. Inappropriate behaviors are frequently attention-seeking; therefore it is important to give attention regardless of behavior.

Anticipatory Set:

Today we will explore the different types of interventions or strategies for managing difficult behavior during activities of daily living such as toilet, bathing, and eating/nutritional needs. These topics are important when working with individuals with dementia because they greatly influence the quantity and quality of life.

1. The “ABCs” of behavior included Antecedent event (triggering event; what happens before the behavior); the Behavior itself; and the Consequences of the behavior.
2. Six steps of Behavior Management include:
 - 1) Define: Observe the problem (what, when, how, where, who)-describe the action.
 - 2) Analyze the ABC’s (e.g., Did anyone or anything trigger the event? How did others react?)
 - 3) What happened after the behavior? How did others react?
 - 4) Plan for intervention.
 - 5) Implement.
 - 6) Evaluate and modify.
3. Difficult behaviors can be a cry for attention as well as an effort to communicate various feelings such as anxiety and fear. Thoroughly evaluating the situation surrounding the difficult behavior can greatly assist in deciphering the appropriate intervention.

Share the Objective:

During this meeting we will be discussing the following:

- a) **THEORIES REGARDING AGGRESSION**
- b) **ABC's OF BEHAVIOR**
- c) **SIX STEPS OF BEHAVIOR
MANAGEMENT**
- d) **TREATMENT OPTIONS**
- e) **STRENGTHENING APPROPRIATE
BEHAVIOR**
- f) **4 R's (REPEATING, REDIRECTION,
REINFORCEMENT, & REASSURING)**
- g) **FIVE BASIC GOALS OF CARE**
- h) **ENHANCING FUNCTIONAL ABILITIES**
- i) **DE-ESCALATION STRATEGIES**
- j) **NURSING/CAREGIVER BAIS
STRATEGIES/INTERVENTIONS**
- k) **IMPACT OF AGGRESSIVE/DIFFICULT
BEHAVIOR ON PATIENT**
- l) **POSSIBLE ETIOLOGIES FOR
WANDERING**
- m) **NUTRITIONAL
CONCERNS/MALNUTRITION**
- n) **INTERVENTIONS TO IMPROVE
MEALTIME EXPERIENCE IN
LTC/ASSISTED LIVING**
- o) **ETHICAL ISSUES**
- p) **BARRIERS TO IMPROVED FEEDING IN
COMMUNITY NURSING HOME**
- q) **THE CULTURAL CHANGE EXPERIENCE
GOALS: RESIDENT DIRECTED vs.
FACILITY DIRECTED**
- r) **THE BATHING EXPERIENCE: OLD
MODEL vs. CULTURAL CHANGE
MODEL**
- s) **IMPORTANT CONSIDERATIONS FOR
RESIDENT CENTERED CARE**
- t) **PERSON CENTERED CARE PLANS**

Each unit will include:

- * **Input**
- * **Modeling and guided practice**
- * **Discussion & debriefing**

Share the Handout:

- The Global Deterioration Scale will be used to assess memory loss in older adults.
 - The Mini-Mental Status Exam will be used to assess cognitive ability in older adults.
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Input:

a) THEORIES REGARDING AGGRESSION

1. Cognitive impairment: cannot understand/process information
2. Functional Status: unable to complete or initiate a task
3. Environmental Stimuli: too much or too little
4. Emotional Status (e.g., anxiety/fear): arising from inability to express needs.

b) ABC's OF BEHAVIOR

- A-** Triggering event (**antecedent**- what happens before the behavior)
- B-** The **behavior** itself.
- C-** The **consequence** of the behavior.

c) SIX STEPS OF BEHAVIOR MANAGEMENT

1. Define: Observe the problem (what, when, how, where, who)- describe the action.
2. Analyze the ABC's: Did anyone or anything trigger the event? Look for clues.
3. What happened after the behavior? How did others react?
4. Plan for intervention.
5. Implement.
6. Evaluate and modify.

d) TREATMENT OPTIONS

1. Change the antecedent.
2. Change the consequence.
3. Change both.

First, rule out other causes of inappropriate behavior (i.e. pain, medication side effects or interactions, sensory deficits).

- Example: Staff reports a 99 yr old male is delirious and suddenly confused. I ask the patient what he had for breakfast and he states he does not want to go to bed. I observe that Mr. P. does not have his eye glasses on nor his hearing aids in place. After his glasses and hearing aids are on, Mr. P. responds appropriately to all questions.

e) STRENGTHENING APPROPRIATE BEHAVIOR

1. Provide positive reinforcement/interaction whenever/wherever possible.
2. Maximize reinforcers rather than wait until patient is obviously distressed.
3. Escape motivated behavior- change aversion quality of the situation
 - a. Example: Mr. B & Mr. S. did not get along and fought at mealtime each day. Mr. B. tried to hit Mr. S. with his cane. The nursing staff requested medication to calm the 2 patients or wanted them to take their meals in their rooms. I suggested the 2 men be placed at different tables at opposite ends of the dining room. There was no further problem.
4. Terminate the situation they perceive as threatening
 - a. i.e. Bed bath instead of tub bath.
5. Use embedding technique by introducing a pleasant stimuli (handholding, photograph, song) into the perceived threatening situation.

f) 4 R's (REPEATING, REDIRECTION, REINFORCEMENT, and REASSURING)

g) FIVE BASIC GOALS OF CARE

1. Patient to feel safe – feel protected, observe body language, facial expressions.
 - a. Example: Mr. W. imagines that there is a miniature sumo wrestler on his shoulder. He has an ongoing pleasant conversation with this imagined person. He seems to be happy to have his friend with him at all times. The

nursing staff is concerned about this hallucination and requests antipsychotic medication for the patient. Since the hallucination is non-threatening, the patient is not fearful or upset, but rather soothed by his little imaginary friend, no medication should be administered.

2. Patient to feel physically comfortable.
3. Minimize stress / environmental distractions.
4. Experience pleasure – sexual expression.
5. Experience a sense of control – dignity, freedom, enhance functional abilities.
 - a. Example: Mr. J. liked to put his clothes on inside out over his PJ's for breakfast each morning. The nursing staff argued with him each AM and tried to persuade him to remove his PJ's and put his clothes on correctly. Pt became agitated and would yell and try to hit the staff. Nursing requested an antipsychotic med or mood stabilizer so Mr. J. would be more cooperative. I suggested they permit him to dress as he liked and there were no further outbursts or unmanageable behaviors.

h) ENHANCING FUNCTIONAL ABILITIES

1. Build up handles on utensils.
2. Non-breakable, no-slip dishes, no-spill cups, straws.
3. Velcro and snaps.
4. Handrails.
5. Non-skid floors.
6. Hearing aids/glasses.
7. Walker/physical therapy.

i) DESCALATION STRATEGIES

1. Accepting instead of contradicting a confused elderly person's reality- search for clue words.
 - a. Example: Mr. H. states that his wife is coming to visit tomorrow. You know that his wife has been deceased for 5 years. How do you handle this? It is best to validate his feelings of joy by saying "I'll bet you're looking forward to her visit." Telling the patient that his wife is dead serves no

purpose. He will not remember this later and he will have to grieve her loss all over again in the present.

2. Validating feelings of confusion, anger, etc.
 - a. Example: Mr. N. was very agitated and angry. He stated he waited 1 hour for the nurse to help him off the toilet. He said she was lazy and irresponsible. I validated Mr. N.'s feeling of anger, frustration, and abandonment. I promised him we would try to do better and apologized for the lack of care and attention. His agitation and anger abated quickly.
3. Use a cooling off period.
4. Distraction to diffuse catastrophic reactions.
 - a. Example: Mr. D. and Mr. B. were in the hallway shouting, swearing, and arguing with each other. I stood between them and in a calm voice, reminded them that we must treat each other with kindness and respect. Knowing that Mr. B. liked music and liked to sing, I suggested that we sing a song. I started singing, Mr. B. joined right in and in a few moments, so did Mr. D. Both seemed very mellow and happy after we sang a few songs.
5. Do one task at a time.
6. Realistic expectations.
 - a. Example: Mrs. K's daughter, Rose, is her caregiver at home. Rose expresses stress and frustration regarding her mother's eating habits. I asked if she had to feed her mother and she replied "no." I asked if she had to sit and keep her mother company while she eats, and she replied "no, I do my housework." I asked if her mother made a mess and spilled food on her clothes, the table, and floor and she replied "no." I then asked what caused her to be so stressed about the mealtime. She stated that her mother took 60-90 minutes to eat her meal. I pointed out that her mother was independent, tidy, and entertained herself at mealtime and this was remarkable for a 90 yr old with dementia. Rose had unrealistic expectations regarding her mother and

seemed satisfied with her mother's mealtime habits after our discussion.

7. Humor/diversion.
8. Avoid blocks to communication.

j) NURSING/CAREGIVER BASIC STRATEGIES/INTERVENTIONS

1. Regular routine/ keep it simple/ avoid change.
2. Opportunity to participate / make choices – ask close ended questions.
3. Focus on assets – use remaining abilities – use short statements .
4. Be flexible / alter situations.
5. Don't reason with patient – can no longer think logically.
 - a. Example: Mr. C. was a retired Army officer who had been in the war. When he was fearful or stressed, he would crawl under his bed, which he thought was a foxhole. Nursing staff tried to cajole him out and pull him out to no avail. I crawled under the bed with him and talked about the war. He also thought I was a General. I enlisted his help to crawl out of the foxhole and help me with the troops. He very willingly obliged. We used this technique successfully each time we found him under the bed.
6. Approach slowly from the front in a friendly relaxed manner.
7. Rest between stimulating activities.
8. Sensory stimulation such as:
 - a. Aromatherapy
 - b. Massage
 - c. Pet therapy
 - d. Music therapy
 - e. Audio/visual tapes of family
9. Recreational interventions
 - a. Exercise movement program
 - b. Walking program
 - c. Sorting games
 - d. Music/singing

k) IMPACT OF AGGRESSIVE/DIFFICULT BEHAVIOR ON PATIENT

1. Alienation from staff/family.
2. Stress.
3. Decreased quality of care.
4. Social isolation.
5. Unmet needs.

l) WANDERING BEHAVIOR

1. Possible etiologies for wandering:
 - a. Acting out prior life experiences.
 - b. Stress reduction.
 - c. Fear.
 - d. Explore new environment.
 - e. Satisfy urges/needs (hunger, thirst, toileting).
 - f. Boredom, restlessness.
2. Interventions for wandering:
 - a. Daily exercise.
 - b. Attempt to pinpoint cause.
 - c. Is wandering a problem? For whom?
 - d. Safety for wandering person
 - i. Photo/ID
 - ii. Fence/hedge
 - iii. Locks/bells on door, nightlights
 - e. Reassurance.

m) NUTRITIONAL CONCERNS/MALNUTRITION

1. Eating patterns in stages of Alzheimer's
 - a. Early Stage:
 - i. Changes in preferences.
 - ii. Forgot to shop.
 - b. Middle Stage:
 - i. Agnosia, dyspraxia, food hoarding in mouth, failure to chew sufficiently with risk of choking, not finish meal, food gorging, forget he/she is hungry, distractibility, reduced attention and concentration
 - c. End Stage:
 - i. Eating slower, food remains in mouth longer, refuse to open mouth, impaired, delayed pharyngeal stage,

swallow function, turning head away, refusing to swallow, leaving mouth open.

2. Who is at risk for malnutrition?
 - a. 40-60% of hospitalized older adults
 - b. 40-85% of nursing home residents.
 - c. 20-60% of home care patients.
3. Triggers for malnutrition.
 - a. Serum Albumin less than 3.4
 - b. Serum Cholesterol less than 160
 - c. Hemoglobin less than 12
4. Scales for evaluating malnutrition risk in the elderly.

Item Eval	Criterion 1 point	2 point
Sadness (GDS)	10-14	>15
Cholesterol	<160	
Albumin	3.5-4.0	<3.5
Loss of Weight	1 kg in 6 mo.	3 kg in 1 mo
Eating problem	Pt needs assist	
Shop and food	Pt needs assist	

Total scores > 3 indicate patient at risk

Morley J. AM Geriatric Soc, 1991; 39 (1139-1140)

5. Treatable causes of malnutrition. (Meals On Wheels)
 - a. Medication.
 - b. Emotional problems (depression).
 - c. Anorexia; alcoholism.
 - d. Late-life paranoia.
 - e. Swallowing.
 - f. Oral factors.
 - g. No money.
 - h. Wandering (other dementia related behavior).
 - i. Hyperthyroidism, hypoparathyroid, hypoadrenal.
 - j. Enteric problems (malabsorption).
 - k. Eating problems (inability to feed oneself).
 - l. Low-salt, low cholesterol diets.
 - m. Stones.

From Anorexia in the elderly: Annals of LTC 2004
6. Poor nutrition may result in:
 - a. Decreased muscle strength.
 - b. Poor wound healing.
 - c. Increased pressure ulcers.
 - d. Increased risk of infection.

- e. Increased post-operative complications
- 7. Physiological changes that contribute to weight loss:
 - a. AD results in changes in the brain which result in loss of appetite and sense of smell.
 - b. Feeling of fullness may occur due to lack of relaxation of the stomach.
 - c. Liquid caloric supplement may improve nutrition without causing a feeling of fullness.
- 8. Fluids
 - a. AD patients cannot regulate fluid intake based on thirst. Therefore, they are at increased risk for dehydration.
 - b. If refuse fluids, give foods high with H₂O concentration.
 - i. Applesauce
 - ii. Jello
 - iii. Popsicle
 - iv. Ice cream
 - v. Soups
 - c. Oral liquid supplements between meals to boost caloric requirements do not alter # of calories consumed at a meal if given 60 min before the meal.
- 9. Hurdles to promoting optimal nutrition
 - a. Distraction and wandering.
 - b. Difficulty swallowing/chewing.
 - c. Restrictive diet.
 - d. Medications.
 - e. Food recognition.
 - f. Spatial orientation.
 - g. Individual biorhythm.
 - h. Lack of staff.
 - i. Loss of hunger.
 - j. Co-morbidities.
 - k. Educational needs.
 - l. External factors.
- 10. To produce improved eating in demented patients, one must make changes in the environment, caregiving, or patient.
 - a. Environmental changes:
 - i. Prepare food close to serving area.
 - ii. Therapeutic dinnerware.
 - iii. Good lighting/diffuse lighting.
 - iv. Avoid clutter/distractions.

- v. Music.
- vi. Colorful dishes/glasses- red/blue.
- b. Caregiving changes:
 - i. Small frequent meals/1 course at a time.
 - ii. Finger foods, recognizable foods.
 - iii. Sit up/feet on floor/chin tuck position.
 - iv. Remain upright for 30-60 min after meal.
 - v. Sit and feed at patient's eye-level/make eye contact.
 - vi. Stroke throat to encourage swallowing.
 - vii. Larger meal breakfast/lunch.
 - viii. Frequent verbal cueing of desired behavior.
 - ix. Vitamin/mineral supplement.
 - x. Off the clock.
 - xi. Observe ritual-hand washing/blessing.
- c. Changes in the patient:
 - i. Relearn eating behavior- hand over hand guide.
 - ii. Dentures in place, mouth care.
 - iii. Dental soft diet.
 - iv. Wear glasses/hearing aids.
 - v. Exercise.

n) INTERVENTIONS TO IMPROVE MEALTIME EXPERIENCE IN LTC/ ASSISTED LIVING

1. Staff consistency.
2. Staff to walk around and observe who needs help.
3. Schedule staff breaks and staff meals before/after patient meals.
4. Encourage families to visit at mealtime.
5. Encourage families to bring the patient's favorite foods.
6. Administer analgesics and antiemetics before meals.
7. Focus on quality vs. quantity – caregiver impatience.
8. Offer choices.
9. Increase accessibility to food.

o) ETHICAL ISSUES

1. Right to refuse food if dislikes and right to insist on food they do like even if it presents choking risks.
2. Quality of life vs. preservation of life- Patient's preference must be considered (i.e. as outlined in informed consent or Advanced Directives).
3. PEG (stomach feeding) tube- Risks, lack of benefits, no decrease in aspiration, pressure ulcers, enhanced survival.
4. Quality of life decreases as nutritional risk increases with resulting risk for decreased body weight, pressure ulcers, and infection.
5. Promote self feeding or enhanced assisted feeding.
6. No food restrictions- any food better than no food.
7. Add butter and cream.
8. Suitable consistency.
9. Nutritional drinks to augment diet NOT replace.

p) BARRIERS TO IMPROVED FEEDING IN COMMUNITY NURSING HOME

1. Lack of time.
2. Too many residents require assistance.
3. Short staffed.
4. Nurse-CNA communication problem.
5. Food service concern- Inadequate variety / quantity.
6. Educational needs.

**q) THE CULTURAL CHANGE EXPERIENCE
GOALS: RESIDENT DIRECTED VS. FACILITY DIRECTED**

1. Goals of care must always be directed towards providing/increasing quality of life.

r) THE BATHING EXPERIENCE- OLD MODEL vs. CULTURAL CHANGE MODEL

1. Old model.
 - a. Shower room.
 - i. Cold, unfamiliar, large, institutional in appearance, noisy, equipment, uncomfortable bath/shower chair
 - b. Bathing/shower experience.

- i. Strip in room, chair/ARJO to tub, breeze on behind, cold, feet dangling, hosed down, submersed in tub.
 - 2. Cultural change model.
 - a. Shower room.
 - i. Pictures on wall, curtains, wallpaper/borders, curtain around tub, colorful paint, music.
 - b. Bathing/shower experience.
 - i. Pre-organized equipment, pre-fill tub, undress patient in shower room, uncover limited area using towel or clothes around shoulders/lap/legs, padded shower chair/ food rest.
 - ii. Takes 1.6 min. longer for new in-shower experience .
 - iii. Win/win outcome for staff/resident.
 - 3. In bed bathing experience.
 - a. No-rinse bath, improves skin condition.
 - b. If good AM/PM incontinence care, once weekly bathing is adequate.
 - c. Alter/adjust “must bathe twice weekly” attitude. Nothing in current regulations to prevent change.
 - d. Takes 3.3 minutes longer for no rinse bed bathing.
 - e. Win/win outcome for staff/resident

s) IMPORTANT CONSIDERATIONS FOR RESIDENT CENTERED CARE

- 1. Consistent staff assignments.
 - a. Encourage the development of meaningful relationships.
 - b. Promote continuity of care.
 - c. Facilitates ownership for improved care and outcomes.
 - d. Prevents staff from feeling like an interchangeable part.
- 2. Relationship-centered care avoids making staff feel like “just an aide”.
 - a. Validate staff and patients.

t) PERSON-CENTERED CARE PLANS

1. Presents problem, goal, and intervention from patient's perspective.
2. Decreases risk of prejudicing patient or making mistaken inferences.

Activities:

- Discuss experiences you have had with persons with dementia who exhibited difficult behaviors while involved in daily activities.