



**Identification of
Risk & Prevention of Aggression
in Residential Care**

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This Manual has been developed so that each individual section can be taken and offered to staff in its entirety. It includes overheads and notes to assist the facilitator to give the presentation.


Developed by Jackie Baron, RN, MSN, GNC(C)

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SLIDE

Bio-medical model



- Problem -based
- Attempt to control dementia &/or behaviours with template "fixes" & medications
- Overlook what's happening physiologically, functionally & spiritually to person

Bio-Medical Model

1. Our current system of health care is based on a biomedical model that is very problem-based (focus is on disease and interventions to remove/reduce problems).

The system is driven from the top down; the organizational model is pyramid-shaped. The physician is at the top point of the pyramid, down through the Manager of Care, to the registered nurses, licensed practical nurses, care aides, dietary staff, housekeeping, etc., and finally to the resident and their family at the base.

2. We have tried to "control" resident's behaviours with template fixes or standardized care planning. Sometimes these are successful, but many times they are not, as residents are human beings with their own distinct ways of being & reacting. One resident may react well to 2 persons performing care; another may see this as hostile (especially if the person's background was a military one or one in a prisoner-of-war camp where force was used often to control).
3. The individual being cared for can become the disease, especially if negative behaviour results (e.g. alcoholic, schizophrenic).

People with cognitive problems, can include dementia; stroke; head injury, etc. They do not fit the model of normal aging. Their behaviours (when troublesome) are not looked at as "charming quirks", as in the cognitively alert.

With cognitive impairment, the brain doesn't wear a cast; it is often hard to see or remember that cell damage is occurring and challenging behaviours can be the result. This can lead to individuals being labeled problems, when their behaviour is a result of disease and damage to their brain.

Most care plans are behaviour driven, that is in response to the resident behaving in a certain way (rather than to functional implications of disease, as we'll see). Wandering

could mean someone's looking for a drink but cannot communicate this in the normal way; a person may be experiencing grief but cannot express it, except by aggressive responses to care. *Use any other examples from practice to illustrate this point.*

Resident-Centred Model

Before showing overhead, ask participants what they notice about residents who are admitted with challenging behaviours after several weeks and months in the facility? Ask if they notice that most behaviours do settle down and then ask why they think that is. *Hopefully they should reply with an answer that getting to know the resident and their likes and dislikes helps reduce the incidents of aggression.*

Exercise:

Have participants to take a scrap piece of paper and write:

- One thing that they would hate to have someone do to them if they were admitted into a care facility
- One thing that they would love care staff to do for them if admitted; something that could make their day.

Share these with the group. Discussion should evolve into being resident-centred and what are the limitations to putting this model into action; is it facility-driven or care staff driven-*usually a bit of both.*


Then put up overhead.

1. Stages of dementia will be discussed in more detail later in session. Can discuss how end stage COPD can affect behaviour as oxygen levels fall; diabetics and fluctuating blood sugars, etc.
- 2 & 3. Give examples from practice to illustrate these points.

SLIDE

Resident –Centred Model

- Understand the stage of a disease
- Understand why a person acts the way they do
- Understand who that person was, what they did, their interests, their dislikes, etc.



SLIDE

Definition of Aggression

- verbal or physical acting out of anger or hostile feelings.
- may be directed against self, other people or objects
- may include agitation, restlessness, threatened aggression, destruction of environment, self abuse, physical injury to others (Riverview Hospital, 1991)

What magnifies violent behaviour?

- Problem is externalized
- Misuse of medications
- Inappropriate language

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What Magnifies Violent Behaviour?

1. We are admitting residents at more acute levels; with multiple diagnoses. Many are cared for at home until later on into the disease. Families do not have the same expertise that we have; they try their very best but caring for someone with dementia and challenging behaviours is stressful 24 hours a day and 7 days a week. Many behaviours can become ingrained in the resident and are hard to reduce when they are first admitted. We need to get as much information from family as we can. Look for tools and strategies that will help us get to know the resident as quickly as we can; who they were; their likes and dislikes, etc. Biographies or posters with pictures are very helpful.
2. Medications are often used as the answer to challenging behaviours. However, in many situations it does not address the real reason for the agitation/aggression, such as hunger, thirst, need to go to the bathroom, etc. Residents can still be aggressive on medications, except now it is through a “fog” and can often be hard to see warning signs, until the resident strikes out. Medication also removes any vital remaining functional abilities. Can make resident more confused, frustrated & more vulnerable to stress leading to more aggression. Increases incontinence, postural hypotension; anxiety; slurred speech; stiffness and depression.
3. The language we use to describe behaviour is not neutral. Labels abound around challenging behaviour, nearly all are negative, except perhaps “pleasantly confused”. Labels pin

behaviour on people, regardless of where the behaviour occurs & the role of others in the behaviour (for example, *a purple dot).

For example, putting an aggressive label on a person suggests that the labeled individual is acting with malicious intent, premeditation and wants control over other people. This can be the case, in rare exceptions, but if someone is cognitively impaired, their brain is damaged and these intentions are impossible. Language shapes the way we think about approach, plan of care etc. It can be cruel, for example, name calling at school?

Note: Be careful with labeling and use appropriately, for example if someone is aggressive with pericare and nothing else, make sure that is communicated by placing that warning (i.e. purple dot) or other means of identification next to that entry on the resident's chart or Activity of Daily Living Sheet (ADL) only, not as a generalized warning.

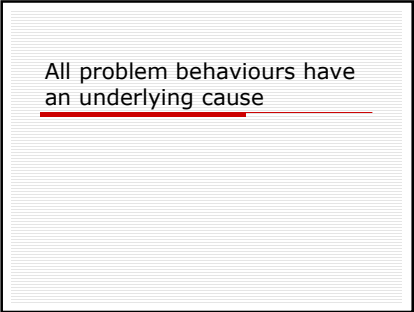
** identifying label depends on site.*

All Problem Behaviours Have An Underlying Cause

To say someone is aggressive or agitated only describes behaviour. It does not tell you why the individual is reacting in this way. Distress signals something is wrong, especially when communication &/or understanding of a situation is affected by a disease, such as in dementia.

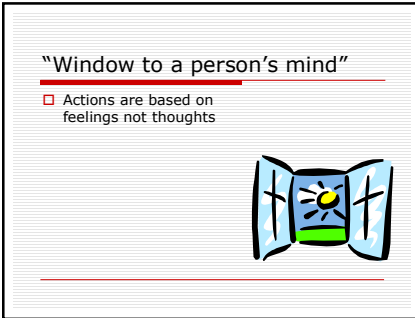
We need to look at specifics first, which is what we're going to do today in this session.

SLIDE



All problem behaviours have
an underlying cause

SLIDE



Window to a Person's Mind

When a person cannot communicate in the usual fashion, actions become the expression of feelings and thoughts for that individual.

When a resident is cognitively impaired behaviours tend to follow a course corresponding to a disease process, for example, someone who has Chronic Obstructive Pulmonary Disease (COPD) finds it harder to breathe as the disease progresses to its end stage. The resulting lack of oxygen can lead to confusion, agitation and aggression.

As we will see later, some disease processes, such as dementia, behaviour results from brain damage. In all cases, behaviour becomes worse if there is increased stress or a blocked need. Agitation & aggression is not a normal part of aging. As said before, in the majority of cases there is a reason .

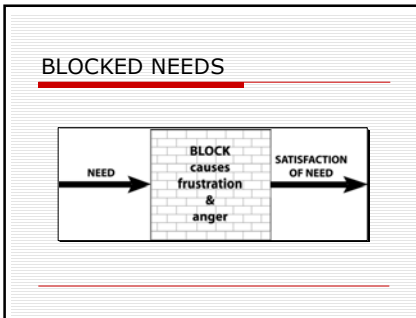
Blocked Needs

Ask:

How many of you become frustrated and angry?

What types of things make you feel this way?

Show: *Blocked Needs Slide*



The residents we care for also have needs. They're not necessarily the same as the ones we just talked about. They are often very basic, such as food, drink, needing to go to the bathroom, feeling safe. *(Can refer to Maslow's Hierarchy of Needs if familiar with this theory)*. When the resident's needs are blocked and, for example, they cannot eat or go to the bathroom independently, because they don't have the ability to do so, either physically or cognitively, they too become frustrated. However, because they have a lower threshold for stress (again due to their physical or cognitive status), they will be less able to control their reactions, and agitation becomes aggression very quickly.

This leads us into our next section: PAIN

Pain is an area that we have struggled with in the care of the elderly and even though we have made great strides, we are still not giving it all the attention it deserves.

Pain

Ask:

1. How many of you have never had pain before? How do you feel when you have pain? Do any of you get angry and mad?

Pain is not only a sensory experience, but it has an emotional impact as well, as this is often what we see expressed in behaviours by our residents in pain.

2. Pain is subjectively experienced & reported. McCaffrey & Beebe (1989) stated pain is “whatever the patient says it is and occurring whenever the patient says it does”.

In other words, if we all had the same injury, each one of us would experience the pain from that injury in a totally different way. Another individual cannot say that your experience of pain is not real for you; it is your lived experience that matters.

3. Have any of you, or do you have, persistent pain? i.e. continuing over a long time; may or may not be associated with disease process or tissue damage; modified by individual memory, emotions.


There are many types of pain, but just now think more about how pain affects your resident and what effect it has on their behaviours.

As with need blocks, if you cannot communicate normally or if communication is impaired, the only way the resident can show pain is through behaviour, for example, resisting when being dressed in the morning due to stiffness.

SLIDE

PAIN

- Unpleasant sensory & emotional experience
- Usually from tissue injury or disease
- Subjectively experienced & reported
- When acute, alerts person to something
- May become persistent



SLIDE

Why is Pain Under Recognized/Under Reported

- Failure to ask or to observe signs which indicate possible pain
- Communication impaired
- Alteration of pain experience d/t dementia
- Poor memory for pain
- Myths around pain
- Fear of addiction

Why is Pain Under Recognized/ Under Reported?

Ask:

Think about the residents you are caring for now. What are some of the disease processes they have that can lead them to have pain?

PAIN PROBLEMS TYPICALLY ASSOCIATED WITH :

Osteoarthritis and osteoporosis; history of hip & other fractures; history of back pain; presence of cancer; constipation; dental decay; infection; migraine or headaches; pressure ulcers; frequent falls with injuries.

If our residents have huge potential to experience pain, how is it that it is under recognized and under treated?

Show slide

Discuss each point.

MYTHS AROUND PAIN -

There are a lot of myths surrounding pain & elderly. To bear pain is a sign of strength; an inevitable part of aging; the cognitively impaired cannot be accurately assessed for pain; some residents are thought to complain of pain to get attention. *Ask group if there are any other myths.*

FEAR OF ADDICTION -

Many studies show that regular and correct dosing of analgesia for individuals in pain will not cause addiction. Medication will go to pain receptors and not pleasure receptors. As with any drugs in the elderly, we need to start low and go slow. There are many different combinations of medications that work well for pain management. We need to continue to educate both physicians and family members on good pain management, especially when we see adverse behaviours impacting adversely on the resident's quality of life.

Why Bother Treating Pain?

Pain in the elderly is under reported and under-treated. Pain in Care Homes in one study by Ferrell, 1996 showed 45-80% of residents had pain that was not being treated.

IMMUNE SYSTEM -

Various studies done on animals have shown that immune systems are suppressed by pain. We already know that the elderly have suppressed immune systems. Pain only decreases this more.

(Reference: Continuing Education session at GNABC conference)

DECREASED AIR VENTILATION -

If you are in pain, especially with fractured ribs or collapsed vertebrae from osteoporosis, you would find it hard to breathe. This can cause reduced oxygenation of the bloodstream and reduced oxygen to the brain and thereby confusion and agitation for the resident.

CARDIO VASCULAR EFFECTS -

May increase heart rate then blood vessels constrict, which causes Blood Pressure to change and oxygen usage to increase leading to hypoxia and ischemia to heart muscle. Again confusion and agitation result.

GASTRIC STASIS -

Many of us worry that if we treat pain by giving some of the codeine based medications we will cause more constipation for our residents. However, studies have shown that pain actually effects peristaltic action, causing gastric stasis and constipation. We are better to treat the pain and treat the possible constipation simultaneously.

MUSCULAR DECONDITIONING -

If you are in pain, you have a tendency not to want to move. This results in muscle tone loss, gait imbalances and falls; leading to more pain.

SLIDE


Why bother treating pain?

- Uncontrolled pain can kill
 - suppresses immune system
 - decreases air ventilation leading to pneumonia & low oxygen
 - affects cardiovascular activity
 - gastric stasis
 - muscular deconditioning

SLIDE

Behavioural indicators

- Agitation; fidgeting; restless pacing
- Tense body; resistance to movement &/or to care
- Increasing repetitive & loud calling out (asking for HELP!)
- Irritability; provoked or unprovoked aggression




Behavioural indicators (cont)

- Rubbing or favouring a body part(s); decreasing mobility & increasing falls
- Increasing confusion; decreasing language & inability to understand & react with environment
- Increased pulse, BP & sweating
- Refusing food; biting the lips

Pathophysiology of dementia

Stage 5 – Early dementia
"All dressed up & ready.....
With nowhere to go"



Behavioural Indicators

Walk through slide. Inform group that pain is usually indicated when there are 2 to 3 indicators happening together (e.g. agitation, calling out and resistant to care). If you see clusters of behaviours think pain first, before any other sedatives, neuroleptic medications, etc. are tried.

By treating these behavioural indicators with appropriate analgesic on a regular basis the incidence of these behaviours occurring can be reduced or removed completely.

Restless pacing (or agitation/fidgeting) and aggression together are key indicators for pain.

If family members or physicians are reluctant to treat pain aggressively, ask to do a trial on the medication and monitor the behaviours over a 6-8 week period. By demonstrating a change in the behaviour occurrence and improvement in the resident's quality of life, views on pain management can be altered.

Please refer to Appendix 1a, 1b, 1c

Examples of Pain flow sheets are found **Appendix 1**. They specifically focus on behavioural indicators to monitor when pain management strategies are working.

Pathophysiology of Dementia

Before putting up slide on Stage 5, inform group that the next few slides are going to look at Stages 5, 6 & 7 of dementia. Even though there are 7 stages in all, we rarely see the early stages in care as they are looked after in their homes or in assisted living facilities.

Why do we need to know what's happening in the brain during dementia? We will see that there are specific physical appearances and behaviours associated with each stage. If you

know what these are, you can anticipate what might trigger behaviours when you are caring for these residents. You can adapt your approach, use distraction, etc.

It also helps to know when someone is moving from one stage to the next, as this can be very stressful for the resident as more losses are occurring and there is often more agitation and more aggressive during these transitions.

Family or other caregivers at Stage 5 are often very stressed as there are so many challenging behaviours to contend with. Remember they do not have the knowledge and expertise that we do. Stage 5 is often when admissions to care occur, especially if there are physical limitations too.

The work of Mary Lucero is used in the descriptions used for these Stages. Mary is a gerontological nurse consultant living in Florida and she illustrates these dementia stages so well.

So Stage 5 is early dementia and as Mary says they are “All dressed up and ready.....with nowhere to go”.

Stage 5 - Early Dementia

By Stage 5, losses have already occurred for the individual with dementia. Concentration, memory and emotions are being affected. Often people cannot recognize familiar objects and have trouble recognizing some people. Speech is starting to be affected too. There is trouble finding words and often repeated questions are asked to illicit the information that has been forgotten.

One of the great difficulties with any disease that affects the brain, is there are no outward signs, except in the resident’s behaviours. There is no bandage, no scar, no cast. So while we are looking at these stages, I want you to visualize the different parts of the brain that are being attacked by this disease and use bandaids as a visual aid to illustrate the “wounds” being left behind.

SLIDE

Stage 5

- Occipital lobe and visual cortex affected
- Lose peripheral vision
- Lose ability to look up
- Lose ability to focus & track moving objects
- Becomes very obsessive & repetitive
- Delusional

SLIDE

Stage 5 (cont)

- Agitation increases
- Love to rummage & wander
- Disoriented to time, place & person
- May be personality changes
- Cannot follow through on ideas
- Lose ability to read

PERIPHERAL VISION LOST -

Persons with dementia can only see straight ahead. They are not aware of objects to the side of them, including people, objects, etc. That's why it is usually better to approach people from the front.

ABILITY TO LOOK UP LOST -

Persons with dementia miss signs, pictures, objects that are placed too high. If they are seated in chair or wheelchair and you are standing in front talking to them, they will only see your body, not your face. This can be extremely frightening and can elicit an aggressive response. Caregivers need to get down to the same level as the person with dementia.

OBSESSIVE AND REPETITIVE -

Persons with dementia ask the same question over and over again and can become agitated over time.

DELUSIONAL -

Persons with dementia start to believe staff are stealing things, poisoning them, husbands/wives are having affairs with other people, etc.

RUMMAGE & WANDER -

Persons with dementia cannot prevent this. They have a need to keep busy and believe they have responsibilities still to complete. Also we inform them that this is their "home" so why shouldn't they be able to wander where they please and take whatever is there? One recommendation is to make area for them to rummage in. For example, an old dresser filled with clothes or a box with scarves/material in.

PERSONALITY CHANGES -

Can lead to violent behaviour under stress or a new environment (e.g. admission into care). Often family will say that resident used to be meek and mild and now has had personality change to the other extreme. In rare cases, individuals will go from being a "difficult" person to one who is "much nicer to be around".

In this stage we need to reduce stresses such as noise, glare of lights. Put signs/pictures in places where they can be seen. Slow down and don't give too much information at any one time.

Look at Reisberg's reverse development chart. Explain how residents with dementia lose their abilities in the opposite way to which we gained our abilities. In Stage 5 residents are functioning at a 5-7 yr old level. However, it is important to remember that we never treat our elders as children. It is just that their ability to respond to us and be responsible for their own care is now at that level.

Refer to Reisberg's chart-Appendix 2

Look at chart with percentages of behaviours in Stage 5 and Mary's Lucero's descriptors regarding this stage to correlate. After Stage 6 refer to 4b & 5b; Stage 7 refer to 4c & 5c.

Stage 6 – Middle Dementia

MOTOR CORTEX AFFECTED -

Ask participants to imagine bandaids on top of skull to illustrate where the damage is occurring.

STARTING MOVEMENT AFFECTED -

Persons with dementia often cannot start a process, such as eating. They need cueing many times to maintain abilities.

GAIT/POSTURE -

Person with dementia lean to one side (often left) or lean forward or pull back. They often shuffle with knees bent and have problems lifting their feet. Refer back to pain that this kind of posture would cause.

TROUBLE GETTING UP & DOWN -


Persons with dementia lose the ability to organize their body movements due to the damage in the motor cortex (messages from brain no longer getting to muscles to coordinate them).

SLIDE

Stage 6 – Middle dementia

"I want to go with you"

- Motor cortex affected
- Problems starting movement & following through
- May have swallowing problems
- Gait, posture affected
- Trouble getting up & down
- Balance compromised



SLIDE

Stage 6 (cont)

- Feeling of restlessness and needing to move
- May have muscle cramping
- Fascination with small objects
- More damage occipitally -only sees contrasts
- Mind blindness

Stage 6 (cont)

- Unaware of recent events & surroundings
- More personality/emotional changes
- Feel cold to their bones
- Extreme thirst & enormous appetite
- Unable to make body do what it should or what we want it to
- Cannot follow directions
- Visual field neglect

FASCINATION WITH SMALL OBJECTS -

Persons with dementia often worry & pick away at something, such as design on upholstery. They may eat small objects.

*Ask what age they are developmentally with this kind of behaviour?
Answer should be "toddler" stage.*

CONTRASTS ONLY -

Imagine more bandaids on back of head. White & pastels poorly seen until very close. Persons with dementia may not see a white toilet seat on light coloured floor and refuse to use toilet. One suggestion would be to use a darker toilet seat. This can work to our advantage. If we don't want a person with dementia to open a door, another suggestion would be to paint it the same colour as the surrounding wall and they will not see it as an exit.

MIND BLINDNESS -

Persons with dementia are unable to distinguish night from day. They are often awake at night and in need of support. Think of it like entering a room after being out in the sunshine. Glaring floors may also scare a person with dementia as to them as it looks like water.

PERSONALITY/EMOTIONAL CHANGES -

Persons with dementia may have these, especially when stressed.

COLD TO THEIR BONES -

Persons with dementia often feel cold to their bones because the hypothalamus in brain is affected (temperature regulator). That is why they layer their clothes and often do not want to be undressed for bathing.

THIRST & APPETITE -

Persons with dementia will eat anything if able, even noxious substances. Sense of taste and smell is destroyed. They often get dehydrated and lose weight if unable to start eating or drinking and if they have no one to assist them.

UNABLE TO GET BODY TO WORK -

Persons with dementia are often unable to get their bodies to work due to some prefrontal lobe damage. They cannot work out how to get their body to move the way we are asking them to.

VISUAL FIELD NEGLECT –

Persons with dementia cannot see totally out of one field of vision (often the left). They often will take food from resident to the right of them as that is what they easily see. This can cause aggression between residents, especially if one is more cognitively alert.

We need to kick start their movement for them. Give directions slowly and clearly. Use mime and pictures when helpful. Turn plate around so resident can be aware of food where there is visual field neglect.

Resident is now functioning at level of 3 – 4 yrs.

End of Stage 6

Persons at this stage of dementia lose virtually all cognitive functioning such as forming thoughts, reasoning, judgment, personality and abstract thinking.

They are unconcerned about others and are often unaware of them (banging into other residents seemingly unaware).

With frontal lobe damage, their “policeman” who tells them right from wrong is seriously ill. They do not anticipate consequences of their behaviour. Will undress in public, masturbate in public, verbalize thoughts that they would have normally kept to themselves for example, racial slurs.

They are now functioning now at level of child 24-36 mnths old.

SLIDE


End of Stage 6

- Frontal lobe begins to cease functioning
- Person becomes totally focused on their own needs
- Demand instant gratification
- Uninhibited in actions
- Last stages may curl into fetal position

SLIDE

Stage 7 – Late Dementia
"In His Own World"

- Subcortical damage occurs & body shuts down
- Failure to thrive, no matter what
- Often residents will die of secondary infections
- Processing of things done sensory



Exercise:

Review behaviour percentage table Stage 6 and Mary Lucero’s descriptors. Remember to remind group that residents in Stage 6 revert to their mother tongue, but still cannot understand and read in this language. Interpreters will say that the resident in Stage 6 is talking “garbage”, muddled speech in that language. They are no different in their losses comparative to English speaking residents in Stage 6.

Refer to Appendix 3

Stage 7 – Late Dementia

Person with dementia will have irreversible weight loss. Their body is shutting down preparing for death. This is very difficult for families who think the resident is starving to death. Weight is not gained even with tube feeding. Again education is key.

Resident now processes everything on a sensory level. They may look like they will not react (vegetative state), but can still scratch and pinch if something feels uncomfortable. They will react to hot versus cold, dry versus wet, pleasant versus frightening.

The person with dementia is now functioning between 4 weeks and 15 months. They cannot smile and can no longer move themselves or lift up their heads.

Review Mary’s descriptors and last section of behaviour percentage table.

The Brief Cognitive Rating Scale (BCRS) tool is a good way to track residents through the stages of dementia and can inform caregivers and their families when residents are making a transition from one stage to another. These transitional stages can be even more stressful for residents as they experience more losses. Knowing that a resident is in a particular stage, or transitioning through stages should make a caregiver more aware that a resident can experience a catastrophic reaction and take more precautions during care.

Refer Appendices 4,5 & 6

Vascular Dementias

Vascular dementias are caused by a clot or bleed that disrupts the blood supply to the brain.

More sudden onset of cognitive/memory problems. Persons with vascular dementia follows a step-wise progression in terms of losses that the person suffers, rather than a gradual decline as in Alzheimer's type dementia.

There are differences between someone who suffers damage to the right side of the brain, compared to the left. The right side is what we are concentrating on here as there is more potential for excessive behaviours in these individuals.

Depression, delusions and night time confusion are common. Emotional lability, as well as vision problems (often complete vision loss on the left side).

Persons with vascular dementia show an indifferent reaction to things. They often act as if nothing is wrong.

Also, remember that head injuries (especially frontal lobe) leads to challenges with disinhibition, not knowing right from wrong and often violent outbursts.

Delirium, Depression & Loss

Delirium, as many of you are aware, leads to a dramatic change in a person's cognition and behaviour. If a middle to late stage dementia resident exhibits a dramatic change from their "usual" behaviour typical of the stage they are in, this is also as a result of a delirium and not part of the dementia. These dramatic changes need to be assessed and treated.

Question:

What are the 2 most common causes of dramatic behaviour changes for our residents with dementia?

SLIDE

Vascular Dementias

Right Side of Brain

- Lose ability to use or understand gestures & facial expressions
- May still be able to respond to voice tone or touch
- May be disinhibited
- Unable to control emotions & very unpredictable
- Apathetic, poorly motivated.
- Significant depression

Delirium, Depression & Loss

- Drugs &/or alcohol
- Malignancies
- Infections
- Metabolic
- Endocrine
- Neurological
- Vitamin deficiencies
- Genetic
- Chronic illness
- Psychosocial



SLIDE

Answer:

Constipation & urinary tract infections.

Please refer to Appendix 7: “Reflective Experience of Loss”

Apart from delirium, depression can be another cause of excessive behaviours. Many people believe depression just makes a person withdrawn and sad, but depression can lead to anger, aggression, resistiveness to care and verbal abuse. It is often missed especially when associated with dementia.

Exercise: *Appendix 7*

Other potential causes of excessive behaviours are as follows:

DRUGS -

especially cardiac & hypertensive medications; anti-Parkinson's and sedatives.

TUMOURS -

especially pancreatic and gastro-intestinal

METABOLIC IMPAIRMENTS -

diabetes, low oxygen, electrolytes, uremia

ENDOCRINE SYSTEM -

hypo and hyper thyroid

NEUROLOGICAL FACTORS -

dementias, tumours, strokes

VITAMIN DEFICIENCIES -

especially B12, niacin & iron

PSYCHOSOCIAL FACTORS -

loss of family, independence, coping skills, isolation.

Context of Excessive Behaviors (Aggression or Violence)

Let's review some of the areas we have covered.

DISEASE -

We have seen how this affects behaviour as an individual loses abilities and function

DYSFUNCTION -

Ask how much can the resident really do themselves? Often we see an elder person and because there is no outward sign of the damage occurring in the brain, we assume they have more abilities than they do. This places enormous stress on the person.

STRESS -

How does stress affect you? When do you find your coping skills reduced?

UNDERSTANDING -

If a person is having trouble comprehending, stress will result and resistance & aggression quickly follows. Even mild, little old ladies will fight like tigers if they feel cornered & threatened. If a person feels repeatedly threatened then aggression becomes the normal response.

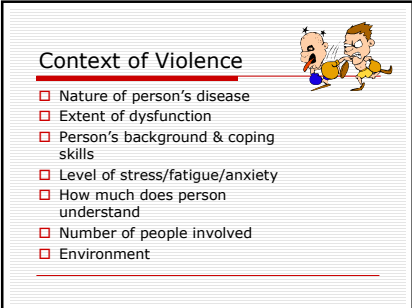
NUMBER OF PEOPLE -

If more than one person is needed to give care, ensure that not everyone enters the resident's room at the same time. Can be threatening & scary. One person enter first and start connecting with the resident & setting up and then the next person can enter casually to help.

ENVIRONMENT -

Hard to change, but we can make some modifications (e.g. music playing in bathroom)

SLIDE



Context of Violence

- Nature of person's disease
- Extent of dysfunction
- Person's background & coping skills
- Level of stress/fatigue/anxiety
- How much does person understand
- Number of people involved
- Environment

The slide includes a cartoon illustration of two people, one appearing to be in a state of distress or aggression, and another person nearby.

SLIDE

Other Issues to Consider

- Is the resident in pain?
- Is procedure/care really needed?
- Can we do it differently?
- Did resident receive "energy boost" before task?
- Did they have a rest before task?
- What does this person like to do?

Other Issues to Consider

PAIN

Look at this first, especially if there are clusters of behaviours

Ask Is the PROCEDURE/TASK NEEDED? –

It is always best to back away & leave someone if they are already agitated or frustrated. We need to do a lot of education around this issues not only with staff, but family members. They need to know that we are not being neglectful in our care when someone is not shaved, for example. But that the resident is having a “bad day” and we are allowing him to have a more stress-free time. We will return to do care when he feels more calm.

CHANGING PROCESS -

Perhaps we don't need to shower or bathe someone. Maybe a bed bath is all they can tolerate. Using baby dolls for someone who has a need to bath their own child (past responsibilities Stage 5).

ENERGY BOOST -


Look at meal times for residents. Often blood sugars are low, especially last thing at night and early morning. Don't have to be diabetics to have low blood sugars. Try giving toast or Ensure before getting them up.

PERSON'S LIKES -

Drawing, playing with coloured material, eating (can use cookies, etc to help with giving pericare).

Communication

Communication



- Loss of abilities to express &/or understand
- Reversion to "home" language
- Changes sensory areas
- Reality vs validation
- Not what you say, but how you say it

REALITY ORIENTATION -

Only works well to reorient someone to reality if there is mild cognitive deficits, but not for someone in Stages 5, 6 or 7 of dementia. Today is not their “real” world. They will get agitated and angry if you try and convince them otherwise. Reality orientation still works for things like “it's lunchtime” or it's Sunday. If they think it's time to go to work, then for them it is!

EMOTIONS -

Also different. Reasoning is gone and the ability to think something through is also gone. Feelings are easily picked up.

Non-Verbal Communication

Words are not necessarily more important than actions. We talk so much in this society that we forget that a touch or a picture may say more.

Humans need touch. It helps us survive. Touch helps elicit listening and hold attention. A study by De Wever in 1977 showed residents preferred a touch on the arm or face rather than around their shoulders. Make sure touch is appropriate. A big bear hug may be misinterpreted by some residents with dementia as being an intimate connection (especially with frontal lobe damage).

Residents pick up on “leaked” facial expressions (that is our tone & expressions don’t match).

Open versus closed postures the best and make eye contact.

Validation Therapy

Validation therapy was originated by Naomi Feil.


It helps the resident to feel that the problem they have is understood and acknowledged.

Enter the resident’s world by trying to identify the feelings being expressed. When a resident feels accepted, it does not matter what he/she is trying to say. Feeling and anxiety tend to decrease. Agree with what they want, but in the conversation, distract them or “steer” them to something else.

SLIDE


Non-verbal communication

- “A picture is worth a thousand words”.
- Touch
- Facial expressions
- Posture
- Gestures



Validation Therapy

- There is a reason behind behaviour
- All people are unique & valuable
- Behaviour is often the reliving of past issues
- When painful feelings are validated they diminish
- Be empathetic



SLIDE

Example of Validation:

Ben: “I have to find my car keys”

Nurse: “Your car keys?” (does not tell him he doesn’t have a car & hasn’t driven for years).

Ben: “Yes, I need to get to work – lot’s to do, you know!”

Nurse: “You are busy today” (don’t say he’s in a care home now)

Ben: “Hell, yes. I’m busy everyday, girlie”

Nurse: “You like being busy” (trying to distract)

Ben: “ What planet do you live on? I didn’t say I LIKED it, just have to work” (getting a little frustrated, but seems to have forgotten the keys)

Nurse: “I know about work. In fact, I have to do some now. I’m getting ready to fix some lunch. Can you help?”

Ben: “Lunch, huh? I’m kind of hungry myself”.

Insert train journey story to wrap up session.

The Experience of Dementia as a Journey

I am going on a long journey by train. As I begin, the city skyscrapers and country landscape look familiar. As I continue my journey, the view reminds me of times gone by and I feel relaxed and comfortable. The other passengers on the train appear to be feeling the same way and I engage in pleasant conversation with them.

As the journey progresses, things begin to look different. The buildings have odd shapes and the trees don’t look quite the way I remember them. I know that they are buildings and trees, but something about them is not quite right. Maybe I’m in a

different country with different architecture and plant life. It feels a bit strange, even unnerving.

I decide to ask the other passengers about the strangeness I feel, but I notice that they seem unperturbed. They are barely taking notice of the passing scenery. Maybe they have been here before. I ask some questions but nothing seems different to them. I wonder if my mind is playing tricks on me. I decide to act as if everything looks alright, but because it does not, I have to be on my guard. This places some tension on me, but I believe I can tolerate it for the remainder of the trip. I do, however, find myself becoming so preoccupied with appearing all right that my attention is diverted from the passing scenery.

After some time, I look out the window again and this time I know that something is wrong. Everything looks strange and unfamiliar! There is no similarity to anything I can recall from the past. I must do something. I talk to the other passengers about the strangeness I feel. They look dumbfounded and when they answer, they talk in a new language. Why won't they talk in English I wonder? They look at me knowingly and with sympathy. I've got to get to the bottom of this so I keep after them to tell me where the train is and where it is going. The only answers I get are in this strange language, and even when I talk, my words sound strange to me. Now I am truly frightened.

At this point, I figure that I have to get off this train and find my way home. I had not bargained for this when I started. I get up to leave and bid a pleasant goodbye. I don't get very far, though, as the other passengers stop me and take me back to my seat. It seems they want me to stay on the train whether I want to, or not. I try to explain but they just talk in that strange language.

Outside the window, the scenery is getting even more frightening. Strange, inhuman-looking beings peer into the window at me. I decide to make a run for it. The other passengers are not paying much attention to me, so I slip out of my seat and quietly walk toward the back of the car. There's a door! It is difficult to push, but I must! It begins to open and I push harder. Maybe now I will get away. Even though it looks

SLIDE

SLIDE

pretty strange out there, I know I will never find my way home if I don't get off the train. I am just ready to jump when hands suddenly appear from nowhere, and grab me from behind. I try to get away. I try to fight them off, but I can feel them pulling me back onto the train. I hear the door shut. They take me back to my seat. I realize now that I will never get off the train; I will never get home.

How sad I feel. I did not say goodbye to my friends or children. As far as I know, they do not know where I am. The passengers look sympathetic, but they do not know how sad I feel. Maybe if they knew they would let me get off the train. I stop smiling, stop eating, stop trying to talk, and avoid looking out of the window. The passengers look worried. They force me to eat. It is difficult because I am too sad to be hungry.

I have no choice now. I have to go along with the passengers because they seem to know where the journey will end. Maybe they will get me there safely. I fervently wish that I had never started out on this journey, but I know I cannot go back.

Dawson, P., Wells, D.L. & Kline, K. (1993). *Enhancing the Abilities of Persons with Alzheimer's and Related Dementias*. New York: Springer Publishing Co. pp xiv-xv



APPENDICES

CHRONIC PAIN ASSESSMENT TOOL

INSTRUCTIONS: Check off pain indicators observed in the resident.

1. Identify the resident's physical signs, behavioural symptoms or verbal reports, which could indicate pain.
2. **Circle the boxes of the frequent signs & symptoms** (more than 3 times/shift)
3. Record **the most frequent signs and symptoms** on the Pain Flow Sheet.
4. Document pharmacological interventions and resident responses to them.
5. Evaluate effectiveness of interventions and alter treatments as necessary.
6. Continue monitoring until pain is controlled or alleviated.

Vocalizations:

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> spontaneous pain complaints; comments, exclamations | <input type="checkbox"/> moaning |
| <input type="checkbox"/> anxious pain complaints: requests for help, exclamations | <input type="checkbox"/> whimpering |
| <input type="checkbox"/> angry outbursts/yelling triggered by sensory stimulation
(e.g. touching to give care; noise) | <input type="checkbox"/> groaning |
| | <input type="checkbox"/> crying |

Facial Expressions/Body Movements:

- | | | |
|---|--|---|
| <input type="checkbox"/> frowning | <input type="checkbox"/> rigid posture | <input type="checkbox"/> rocking |
| <input type="checkbox"/> tightly closed eyes | <input type="checkbox"/> clutching/rubbing body parts | <input type="checkbox"/> fidgeting/restlessness |
| <input type="checkbox"/> widely opened eyes | <input type="checkbox"/> guarding body part | <input type="checkbox"/> shaking/shuddering |
| <input type="checkbox"/> tightly closed mouth | <input type="checkbox"/> hand tension (fingers curled) | <input type="checkbox"/> pacing |
| <input type="checkbox"/> widely opened mouth | <input type="checkbox"/> grimacing (facial strain) | |

Physiological/Automatic Responses:

- | | | |
|--|---|--|
| <input type="checkbox"/> rapid shallow breathing | <input type="checkbox"/> local tenderness | <input type="checkbox"/> chronic regurgitation/belching |
| <input type="checkbox"/> pallor/blanching | <input type="checkbox"/> swollen joints | <input type="checkbox"/> abdominal bloating |
| <input type="checkbox"/> perspiration | <input type="checkbox"/> weakness | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> increased heart rate | <input type="checkbox"/> weight loss | <input type="checkbox"/> hypersensitivity (heat cold,
pressure, weather change) |
| <input type="checkbox"/> nausea & vomiting | <input type="checkbox"/> weight gain | |
| <input type="checkbox"/> impaired chewing/speech | | |

Activities & Behaviours:

- | | |
|--|--|
| <input type="checkbox"/> insomnia | <input type="checkbox"/> intolerance to touch |
| <input type="checkbox"/> nocturnal waking | <input type="checkbox"/> resistance to joint movements |
| <input type="checkbox"/> decreased appetite | <input type="checkbox"/> stiffness in the morning |
| <input type="checkbox"/> withdrawn | <input type="checkbox"/> stiffness after activity |
| <input type="checkbox"/> decreased activity levels | <input type="checkbox"/> avoids noise |
| <input type="checkbox"/> increased distractibility | <input type="checkbox"/> avoids light |
| <input type="checkbox"/> low frustration tolerance | <input type="checkbox"/> avoids movement |
| <input type="checkbox"/> agitation | <input type="checkbox"/> avoids standing |
| <input type="checkbox"/> frantic | <input type="checkbox"/> avoids walking |
| <input type="checkbox"/> aggressive behaviour | <input type="checkbox"/> avoids gentle exercise |

Standard:

Residents who are unable to express verbal symptoms of pain, but show behavioural indicators, will be assessed for pain.

Adapted from Margaret Gibson, PhD. C. Psych, Psychologist: Veteran Care Program, Parkwood Hospital, London, ON, 1998

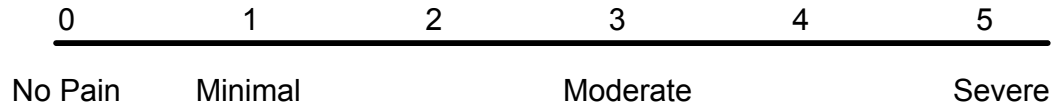
PAIN FLOW SHEET

Use with **Chronic Pain Assessment Tool** for most frequently observed pain indicators x 14 days.

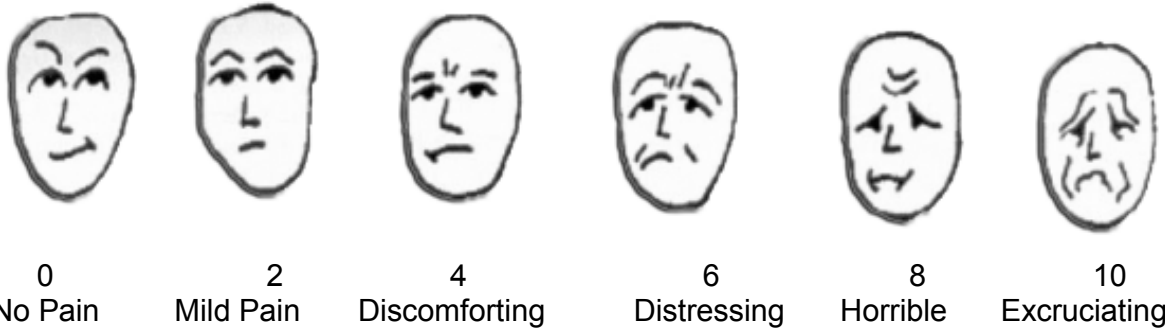
LOCATION: Indicate based on verbal statements &/or observed physical gestures

1 _____	2 _____	3 _____
4 _____	5 _____	6 _____

Pain Rating/Resident Report (Numeric Scale)



Facial Rating Scale



PAIN FLOW SHEET

24 HOUR DAY IN 2 HR. INCREMENTS

DATE:

	0700	0900	1100	1300	1500	1700	1900	2100	2300	0100	0200	0300	0500
Location of Pain (Indicate Number)													
Current Activity (Indicate Number)													
Pain Behaviours													
1													
2													
3													
4													
5													
6													
Pain Intensity													
Numeric (1 – 10)													
Sedation Scale													
(0-3 or S)													
Med Given (MAR)													
Outcome													
Effective; Ineffective													
RN/LPN Initials:													

Legend:

? = behaviour present &/or analgesia given; Ø = behaviour absent &/or no medication given;

PN = see Progress Notes; **NA** = not applicable

Correspondence of Functional Assessment Stages to Normal Development

Approx. Age Function Acquired	Stage of Disease	Characteristics
Adult	Borderline	Normal adult
8 – 12 yrs	Early (Stage 2)	Deficit in word finding; handles simple finances
5 – 7 yrs	Moderate (Stage 3 & 4)	Problems selecting clothes; requires assistance in complex tasks
3 – 5 yrs	Moderate (Stage 5)	Difficulties putting on clothes and with personal grooming. Can still control urine and bowels and go to toilet unaided.
2 – 3 yrs	Early & Middle Stage 6	Requires assistance dressing & bathing. Needs assistance with mechanisms of toileting (e.g. flushing)
24 months – 2 yrs	Late Stage 6	Urinary & fecal incontinence
4 weeks – 15 months	Stage 7	Speech very limited; ambulation lost; cannot sit-up smile or hold head up.

Source: Reisberg et al: “ Incidence of Behavioral Symptoms in Aging and Alzheimer’s”, Bulletin of Clinical Neurosciences, 1990.

STAGE SPECIFIC BEHAVIORS
STAGES 5-7

<u>BEHAVIORAL SYMPTOM</u>	Stage 5	Stage 6	Stage 7
Purposeless Activity (fidgeting or pacing)	61%	68%	18%
General Suspiciousness & Paranoia	57%	36%	0%
Anxiety, impatience per upcoming events	46%	32%	0%
“People Are Stealing Things” Delusion	43%	18%	0%
Agitation (nonverbal anger, negativism)	43%	64%	38%
Tearfulness	43%	59%	18%
Fear of being left alone	43%	46%	0%
Day/Night Sleep Disturbances	43%	27%	18%
Depressive Mood/Statements	39%	18%	0%
Inappropriate activities (rummaging, etc)	39%	59%	18%
Anxieties (General)	37%	18%	0%
Wandering away from home or caregiver	36%	50%	18%
Verbal outbursts	32%	46%	18%
General delusions	32%	36%	0%
“Not My House” Delusion	29%	23%	0%
“Not My Loved One” Delusion	25%	23%	0%
Feeling Abandoned Delusion	18%	14%	6%
Physical threats and/or violence	14%	27%	18%
Visual Hallucinations	11%	18%	6%
Auditory Hallucinations	7%	14%	0%
Spouse Infidelity Delusion	7%	9%	0%

* Percentage of Subjects Manifesting Symptoms

Source: Reisberg, et al: “Incidence of Behavioral Symptoms in Aging and Alzheimer’s”, Bulletin of Clinical Neurosciences, 1990.

Stage 5

Early dementia

"All dressed and ready.... With no where to go"

Physical Appearance: Looks normal

- ◆ Wears clothing appropriately
- ◆ Wears "trappings"
- ◆ Wears supportive appliances, such as hearing aids, glasses
- ◆ Relatively good speech/language
- ◆ Good social skills
- ◆ Immediate memory relatively intact
- ◆ No noticeable changes in posture and/or gait

Awareness: "Lost in Time" – knowledge of past, present and future

- ◆ Believes still has responsibilities
- ◆ Doesn't believe needs assistance
- ◆ Perception of reality based on MISPERCEPTIONS
- ◆ Retains ability to form a thought; plan an action; and follow-through

Behaviours: "Normal"

- ◆ Wandering pattern – exit-seeking
- ◆ May get started going somewhere and lost train of thought (perceived as purposeless wandering)
- ◆ Delusions, suspiciousness, anxiety related to loss of short term memory causing misperceptions
- ◆ Tearfulness, depression and catastrophic outbursts
- ◆ Environmental stimuli prompts behaviour
- ◆ Resistant to caregiving: ADL's relatively intact
- ◆ Primarily needs supervision in eating, toileting, bathing, dressing, grooming
- ◆ Sleep disturbances
- ◆ Socially interacts best with alert individuals, mothers Stage 6; doesn't do well with Stage 7
- ◆ May fear being left alone
- ◆ May have sexual drives/desires
- ◆ Experiences relocation trauma

Lucero, Mary . Geriatric Resources. *Stage specific behaviours*. Taken from presentation 2000 in South Fraser Health Region, BC.

Stage 6

Middle dementia

"I want to go with you"

Physical Appearance: Looks "unfinished"

- ◆ Doesn't want to change clothes-layer clothes, because of they're cold
- ◆ Beginning to remove "trappings" soon after putting them on
- ◆ Beginning to remove supportive appliances soon after putting on
- ◆ Ambivalent about social graces (rummaging)
- ◆ Noticeable speech/language comprehension deficits (make up words, revert to mother tongue)
- ◆ Difficulty retaining thoughts
- ◆ Noticeable changes in posture and/or gait and/or balance
- ◆ Onset of loss of peripheral vision; may neglect one side of body

Awareness: knowledge of past and immediate present

- ◆ Gives up previous responsibilities
- ◆ Unconcerned re whereabouts
- ◆ Perception of reality based on MISSING INFORMATION
- ◆ No longer able to think abstractly

Behaviours: "Normal"

- ◆ Wandering pattern; Self-Stimulation; akathisia (searching for things/people; involved in repetitive tasks)
- ◆ Delusions, suspiciousness, anxiety related to loss of recognition of loved ones/familiar persons
- ◆ Tearfulness, depression and catastrophic outbursts; related to comprehension and communication difficulties; unable to communicate needs
- ◆ Environmental stimuli prompts behaviour
- ◆ Much resistance to caregiving with unfamiliar persons: ADL's require simplification and time
- ◆ Primarily needs supervision in eating, toileting, bathing, dressing, grooming
- ◆ Social butterfly; searches for social contact; may develop a buddy and spend day with him/her
- ◆ Nurtures Stage 7 and listens to Stage 5
- ◆ May fear being left alone
- ◆ May go along with sex, but doesn't have real sex drive

Lucero, Mary . Geriatric Resources. *Stage specific behaviours*. Taken from presentation 2000 in South Fraser Health Region, BC.

Stage 7

Late dementia

"In his own world"

Physical Appearance: Looks "abnormal"

- ◆ Wears clothing inappropriately; fiddles with them; takes off shoes and socks
- ◆ Doesn't wear "trappings"
- ◆ Doesn't wear supportive appliances
- ◆ Doesn't have social graces (takes food off others)
- ◆ Severe speech/language comprehension difficulties
- ◆ Much difficulty recognizing and/or using common objects
- ◆ Looks "lost in thought"; hard to get and keep attention
- ◆ Significant posture, gait and balance deficits (will lose ability to ambulate, sit-up, hold-up head and swallow)
- ◆ Onset of weight loss
- ◆ Onset of downward restricted gaze; loss of 3-D vision

Awareness: Limited to what is in field of vision

- ◆ Senses heightened significantly; seeks immediate sensory gratification; reacts negatively to "noxious stimuli"
- ◆ Retains some overlearned skills from past

Behaviours: "Normal" for this stage

- ◆ Wandering pattern: Self-stimulation; Modeling
- ◆ Very sensory oriented; fluctuating periods of hyper-hypo-activity; hyperorality
- ◆ Doesn't recognize loved ones/familiar persons
- ◆ Catastrophic outbursts related to severe comprehension and communication deficits
- ◆ Can't communicate needs, pain, discomfort
- ◆ Much resistance to ADL's. Almost total care and gross simplification
- ◆ Hypersensitive skin – doesn't like bathing; disrobes often
- ◆ Will accept but not initiate interaction
- ◆ Sexual behaviour-may engage in masturbation

Lucero, Mary . Geriatric Resources. *Stage specific behaviours*. Taken from presentation 2000 in South Fraser Health Region, BC.

Brief Cognitive Rating scale (BCRS)

Circle the highest rating for the resident under the appropriate date column.

Date	Date	Date	Date	
Rating	Rating	Rating	Rating	Axis I: Concentration
1	1	1	1	1. No objective or subjective evidence of deficit in concentration
2	2	2	2	2. Subjective decrease in concentration ability
3	3	3	3	3. Minor objective signs of poor concentration (e.g. subtraction of serial 7's from 100)
4	4	4	4	4. Definite concentration decline (e.g. marked deficits on serial 7's; frequent deficits of serial 4's from 40's)
5	5	5	5	5. Marked concentration decline (e.g. cant' give months backwards or serial 2's from 20)
6	6	6	6	6. Forgets the concentration task. Will count forward when asked to count backwards for e.g.
7	7	7	7	7. Marked difficulty counting forward to 10 by 1's
				Axis II: Recent Memory
1	1	1	1	1. No objective or subjective evidence of deficit in recent memory
2	2	2	2	2. Subjective impairment only (e.g. forgetting names more than before)
3	3	3	3	3. Problems with recall of specific events evident on detailed questioning. No deficit in recall of major recent events
4	4	4	4	4. Cannot recall major events of previous weekend/week. Poor knowledge of current events, favorite TV shows
5	5	5	5	5. Unsure of weather; may not know their current address or who is current Prime Minister
6	6	6	6	6. Occasional knowledge of some events. Little or no idea of current address, weather etc.
7	7	7	7	7. No knowledge of any recent events
				Axis III: Past Memory
1	1	1	1	1. No subjective or objective impairment to past memory
2	2	2	2	2. Subjective impairment only. Can recall 2 or more primary school teachers
3	3	3	3	3. Some gaps in past memory upon questioning. Able to recall at least 1 childhood teacher &/or 1 childhood friend
4	4	4	4	4. Clear deficit. Spouse recalls more of resident's past than resident. Cannot recall childhood friends/teachers. Knows names of most schools attended. Confuses timeline in talking about personal history
5	5	5	5	5. Major past events sometimes not recalled (e.g. names of schools)
6	6	6	6	6. Some residual memory of past (e.g. may recall country of birth or former occupation)
7	7	7	7	7. No memory of past
				Axis IV: Orientation
1	1	1	1	1. No deficit in memory for time, place identity of self or others
2	2	2	2	2. Subjective impairment only. Knows time to nearest hour and location
3	3	3	3	3. Any mistakes in time are out more than 2 hrs.; day of week out by more than 1 day; date out by more than 3 days
4	4	4	4	4. Mistakes in month out by 10 days; in year out by 1 month
5	5	5	5	5. Unsure of month and/or year and/or season; unsure of where they are
6	6	6	6	6. No idea of date. Identifies spouse but may not recall their name. Knows own name
7	7	7	7	7. Cannot identify spouse. May be unsure of personal identity
				Axis V: Functioning & Self Care
1	1	1	1	1. No difficulty, either subjectively or objectively
2	2	2	2	2. Complains of forgetting where objects are. Subjective work difficulties
3	3	3	3	3. Decreased job functioning evident to co-workers. Difficulty travelling to new locations
4	4	4	4	4. Decreased ability to perform complex tasks (e.g. planning dinner for guests, handling finances, shopping, etc)
5	5	5	5	5. Requires assistance in choosing proper clothing
6	6	6	6	6. Requires assistance with feeding, and/or toileting, and/or bathing, and/or ambulating
7	7	7	7	7. Requires constant assistance in all activities of daily life
				TOTAL SCORE
+ 5	+ 5	+ 5	+ 5	
				= Stage of Dementia

Adapted from Reisberg (1983)

GUIDELINES FOR SCORING BCRS

Ratings: Need to take into account the resident's level of education, cultural background etc. Rate each axis on the BCRS on a scale of 1-7. The scale defines the degree of impairment on each axis as follows:

- 1** **normal, no cognitive decline present. Average or better performance**
- 2** **very mild, subjective impairment in comparison with 5-10 years ago**
- 3** **mild, minimal impairment which is clinically seen with detailed questioning**
- 4** **moderate, marked impairment, which is easily seen on clinical observation**
- 5** **moderately severe on assessment**
- 6** **severe impairment, with some residual abilities in some areas**
- 7** **very severe impairment with few abilities seen on assessment**

Axis I: Concentration

Assesses concentration and attentiveness. Taking into account the educational level of resident, ask "How far did you go to school? How are you at subtraction? What is 7 from 100? 7 from 93? 7 from 86? (if they can't do these ask serial 4's; if can't do serial 4's ask serial 2's)"

Axis II: Impairment of Recent Memory

Ask "What did you do last weekend? What did you have for breakfast? What is the weather like today? Who is the Prime Minister of Canada?"

Axis III: Impairment of Past Memory

Ask "What primary schools did you attend? Where was it located? Who were your primary teachers? Where were you born? Who were childhood friends? What kinds of things did you do with your friends?"

Axis IV: Orientation

Ask hour, day, week, date, place and identify self

Axis V: Functioning and Self Care

TABLE 1 COMPARISONS OF DELIRIUM AND DEMENTIA ⁸		
	Delirium	Dementia
Onset	Usually rapid	Usually slow, insidious
Course of symptoms	Fluctuates within hours	Relatively stable
Duration	Days, weeks	Months, years
Memory	Impaired recall of recent events	Recall of recent events, and new learning are impaired (permanent)
Hallucinations	Visual / auditory	Less common, usually auditory
Sleep / wake cycle	Alert at night, drowsy by day	Fragmented sleep
Orientation	Disoriented and confused	Disoriented and confused
Level of Consciousness	Altered, fluctuates	Alert, stable
Behaviour	Agitated, restless	Agitated or apathetic, may wander
Thought content	Incoherent, confused	Disorganized
Insight	May be present in lucid moments	Absent

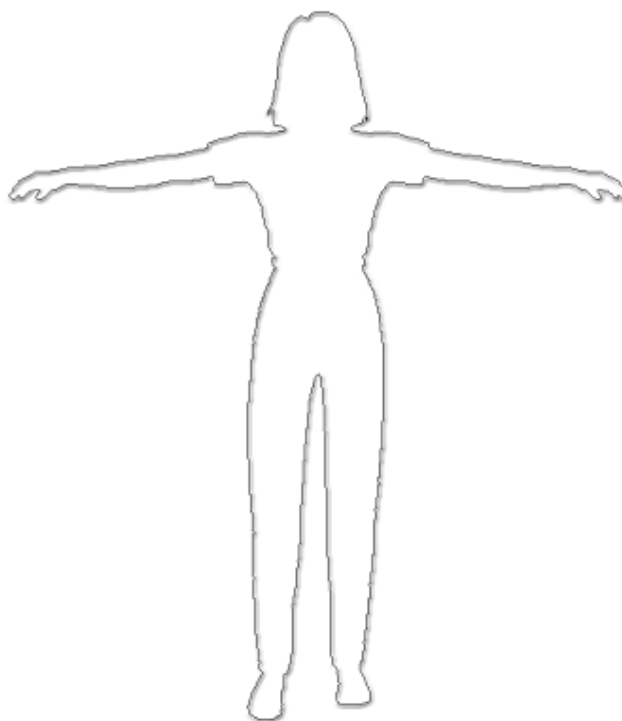
Geriatric Psychiatry Resource Manual for Nurses, 1997.

Depression and loss

Ask each participant to take a piece of scrap paper and draw a stick figure on it, big enough to fill the page. Then ask them to write a value or something that is important to them in 5 spots on the figure (head, left & right arms, left & right legs). These values can include family, health, honesty, etc. Once they have written the words in along each of the 5 body parts, tell the following story:

“You are in your senior years. Unfortunately you have just suffered a stroke affecting the right side of your body. Rip off your right leg (participants rip off that body part from their drawing). You recover partially, and manage to return home with your daughter’s care. However, after a few months, your care is getting heavier and your daughter has a new job, so you are placed in an assisted living facility. This means you have to sell some of your belongings and leave the house you have lived in for 30 yrs. Rip off one of your arms. You have been lucky that you could take your pet with you. But one day, the pet is run over by a car. Rip off your left leg. Then you hear your best friend has died. Rip off your remaining arm. After a few years, you are showing signs of dementia; wandering away and some personality changes. You also fell when you were out wandering and fractured your hip. You cannot be cared for any longer at the assisted living facility, so you are placed in a multi-level care placement. Take the remaining body part, your head, and roll it into a ball. Pass it to the person on your left. You have now handed everything over to the care staff in the facility. How do you feel?”

Explore feelings with participants and then show the Delirium, Depression & Loss overhead.



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