CHANGED BEHAVIORS in Dementia

Dementia changes the brain and can affect how people see, remember and experience the world. Sometimes behaviour is unintentional and happens because of changes in the brain. Other times, it is an expression of unmet need or something that they are experiencing that they cannot communicate. Both need to be understood and respected.

Alert

Report

- Are these new behaviours?
- **OR** have these behaviours got worse in their intensity?
- **IF YES** — see the *Acute Deterioration* and *Delirium* care guides.

Alert/respond now

- Is the health and welfare of this resident, other residents or staff at risk?
- **IF YES** — call the registered nurse, clinical manager or an ambulance immediately.

Assessment

- **Check vital signs** – heart rate, blood pressure, respiratory rate, oxygen saturations and temperature.
- Identify potential triggers.
- **Remember:** the resident has behaviour changes due to disease. They cannot help their behaviour. Don't judge the resident.

OBSERVE

Signs and symptoms

- Fidgeting
- Apathy
- Anxiety
- Repetitive/obsessive behaviours
- Leaving the facility unsafely
- Excessive walking and pacing
- Resistance in allowing others to help with personal care
- Sleeping patterns change, day–night reversal
- Intruding into another resident's space
- Physical and verbal aggression
- Paranoid/delusional thoughts. Eg, common delusions in people with dementia are theft and infidelity
- Hallucinations: seeing or hearing people, animals or objects that are not there
- Misidentification of staff and/or family and whānau members is also common
- Inappropriate undressing
- Inappropriate sexual behaviour
- Screaming, calling out, crying

IDENTIFY

CAUSES OF CHANGED BEHAVIOURS IN DEMENTIA

Physical causes

- Acute illness – delirium due to illness, urinary tract infection, chest infection, stroke, heart attack
- Side effects of medication
- Impaired vision or hearing
- Dehydration
- Hunger
- Constipation
- Fatigue
- Pain/discomfort

Environmental causes

- Too large an environment
- Too much clutter
- Excessive stimulation – too much noise, too many people
- No orientation information or cues
- Lack of meaningful activity, stimulation and structured routines
- Unstructured environment
- Unfamiliar environment

Psychosocial causes

- Inability to communicate an unmet need
- Previous life experiences and trauma - violence, war, colonisation, abuse, institutionalisation

Behaviours related to tasks

- The task is unfamiliar, too complicated or too many steps are involved in the task for the resident to manage

ACTION

ACTION PLAN

De-escalate the situation

- Use a quiet approach, good communication, reassure, comfort and listen.
- Walk away if you think your presence is escalating things. Ask another person for help.

Take action

- Look for and identify a potential unmet need; is the resident hungry, thirsty, in pain, wanting to go to the toilet or lost and disoriented?

Be mindful of your own body language, voice and tone. Quiet, non-threatening interaction is required

Know your resident

Who are they? Family and whānau, previous occupation, hobbies, interests, likes and dislikes.
Know their health history.

Consider

- What is the resident trying to communicate?
- How does this behaviour connect to their biography, relationships and context?
- What does this moment feel like for them?

Immediate steps in changed behaviour management

For a few moments, observe resident from a distance because they may settle on their own accord without intervention

- Acknowledge distress and reassure the resident
- Do not argue or correct
- Remove resident to a quiet environment
- Distraction – exercise eg, walk, music, food, snack, touch, massage
- Search for belongings if resident considers them lost or stolen
- Consider potential fear of people or noise
- Consider individual gender and cultural views influencing behaviour
- Consider physical distance and your safety

Cultural variations should be included when observing what may be considered hallucinations. For Māori and other Indigenous peoples, seeing elders, spirits, or people who have passed on is considered part of spirituality and may not be a sign of unwellness

REPORT

Is the health and welfare of this resident, other residents or staff at risk?
IF YES — call the registered nurse, clinical manager or an ambulance immediately

RECORD

- **Communication needs to be concise** – give simple instructions, make eye contact, face the resident, smile and maintain a calm manner
- **Make sure the resident is wearing glasses and hearing aids, if required**
- **Understand your resident's previous fears and triggers**
- **Environment** – quiet; reduce noise and personalise your resident's bedroom
- **Food and fluid charts** – know resident's likes and dislikes
- **Bowel management** – monitor for signs of constipation
- **Socialisation** – involve your resident in regular activities; music, exercise, crafts. Involve your activity coordinator/ diversional therapist when planning care
- **Personal care** – showering, dressing and grooming. Don't rush the resident. If they are able, let them choose when, what clothes to wear, if appropriate
- **Review medications with registered nurse, nurse practitioner, general practitioner**
- **Involve family and whānau** who can help in understanding behaviour and support with finding solutions
- **Review by general practitioner**
- **Behaviour monitoring chart –** was there a trigger for behaviour? What was the resident trying to communicate?

Behaviour charts

- What time the incident occurred
- What happened before the event
- Who else was involved
- Who was affected
- Staff response
- What worked and what did not work in managing the resident's behaviour

Documentation

- Be complete and accurate in what you write
- Describe what actually happened or what you observed
- Record your successes or failures
- Avoid making assumptions
- Update resident care plan

Take care of yourself

After stressful episodes, take time to debrief and speak with someone you trust