Responsive Behaviours

BPSD: The term "behavioral and psychological symptoms of dementia" (BPSD) is used by the International Psychogeriatric Association to mean "the symptoms of disturbed perception, thought content, mood or behavior that frequently occur in patients with dementia"[i]. "Neuropsychiatric symptoms" is another term used to refer to these behaviours. Front-line staff providing care to those with dementia have used the terms "aggressive", "difficult" and "challenging" or more disconcerting, refer to the person as the ''aggressive resident.'' In an effort to move away from labelling individuals and to encourage staff to look for meaning behind the behaviour, the term "responsive behaviour" has been introduced in the dementia literature.

Responsive Behaviours: Refer to the sub-set of BPSD thought to be an expression of:

- Un-met needs (pain, hunger, thirst, elimination)
- Response to a stimulus in the environment (over/under stimulation, overcrowding, inconsistent routine, provocation by others, noise, light activity).
- Psychosocial needs (stress, apathy, loneliness, depression, lack of purpose)
- Responses to the approach of care team members or other residents

The term *responsive behaviour* is intended to focus attention on discovering the care approach that addresses the reason for the behaviour.

In the past, those providing care to people with dementia may have over-attributed *dementia* as the only reason for the behaviours without first exploring possible underlying causes. Though there are some behaviours that may be a manifestation of the disease process itself, caregivers are called upon to discover the cause of the responsive behaviours and find ways to minimize them. This reframing recognizes that the person with dementia has limited capacity to communicate their needs and experiences, or to control their responses.

Initial Assessment and Monitoring

The first step is to clearly describe the behaviour. Avoid labels and describe observations:

Non-specific labels	Specific Observations
Anxiety	Paces, appears upset, restless, appears fearful
Hoarding	Collects sugar, salt, apple sauce. Hides food in closet. Collects loose papers; collects utensils
Wandering	Becomes lost, looking for something (toilet, bed, food, looking for something familiar), trying to get home
Cursing	Calls nurses derogatory names when other residents call out, swears at staff during personal care
Shouting, calling out	Calls for nurse even when staff are standing beside him, calls for parents, child, husband or wife
Sleep disturbances	Difficulty falling asleep, difficulty staying asleep
Sun downing	Becomes agitated, anxious, fearful, and restless as daylight reduces, wants to go home, "The children will soon be home on the bus."
Delusions, hallucinations	Believes the lounge is their living room, believes another resident is their spouse, sees people or things that others can't see, needs to get to work, the cook is poisoning the food and serving snakes.

Aggression (verbal OR physical)	Strikes out during personal care, protective of territory (bed, certain room or place in dining room), threatens with a fist (e.g. during blood pressure checks, while being dressed / brushing teeth) Yells at other residents when they call out.
Inappropriate sexual behaviour	Grabs at staff during washing and feeding, reaches out to anyone walking by, and climbs into bed with other residents. (This may be because the resident doesn't know where their bed is, or thinks another resident is their spouse – it may not be sexually inappropriate when the reasons are understood.)
Inappropriate dressing/undressing	Wears bra on top of clothing, removes clothing in public, wears multiple layers of underwear, changes clothing frequently, refuses to change clothing / remove shoes or socks
Inappropriate voiding/ defecation	Voids in corner of utility room, voids in dining room, deposits feces in bath tub, removes incontinence product and voids on floor, smears feces on wall and bed.
Eats inedibles	Eats napkins, soap, feces, dirt from flower pots, artificial flowers, hand sanitizer, creams and lotions.
Interferes with other residents	Enters other rooms, pushes wheelchair-bound residents.

Consider the impact of the behaviour on all involved. Who is most bothered by this behaviour?

- The person with dementia
- Staff
- Family of the resident
- Other residents or their families

Not all responsive behaviours require a plan to intervene.

***Responsive behaviours that put the person or others at risk of harm require immediate intervention to address the safety of all involved*.** Staff will benefit from learning self-protection and de-escalation strategies such as are covered in Non Violent Crisis Intervention (NVCI).

Behaviour Assessment and Tracking

The P.I.E.C.E.S. framework provides a systematic review of key areas that may contribute to responsive behaviours:

- Physical
- Intellectual
- Emotional
- Capability
- Environment
- Social/spiritual

The ABCC model from P.I.E.C.E.S. – Alberta guides staff through a discussion of what happens before, during and after the responsive behaviour to reveal patterns or underlying causes.

Other useful tools include:

1. Cohen-Mansfield Agitation Inventory (CMAI);
2. Behaviour tracking tool from P.I.E.C.E.S. Alberta based on Dementia Observation system
3. ABCC Behaviour Log

Use of these tools may require additional staff competence which can be obtained by attending P.I.E.C.E.S. education.

Sleep and Dementia

Research shows 40-70% of people with dementia will have a sleep disorder. Sleep disorders interfere with problem solving, memory and daily functioning overall. Sleep problems can contribute to depression, aggression, increased risk of falls and fractures. Pain can interfere with sleep. A focus on sleep in people with dementia can improve quality of life and reduce responsive behaviours.

Consider Possible Underlying Medical Conditions

Exacerbations of chronic conditions: Consider if the change in behaviours may be related to exacerbations in other chronic medical conditions such as Parkinson's, arthritis and diabetes. Avoid tight glycemic control, as this can produce higher rates of hypoglycemia. The Canadian Diabetes Association recommends fasting blood sugars of 5.0 to 12.0 mmol/L in the frail elderly and recommends that in elderly people with cognitive impairment, strategies should be used to strictly prevent hypoglycemia, which includes the choice of antihyperglycemic therapy and less stringent A1C target.[ii]

Treatment of underlying medical conditions is an important step in addressing new or worsening behaviours. Blood work and other investigations may be required, and are described in the P.I.E.C.E.S. lab work recommendations.

Delirium: If the behaviour occurs suddenly or an existing behaviour escalates suddenly (within hours to days) consider the possibility of delirium. Older adults with cognitive impairments such as dementia are at greater risk of developing delirium, referred to as "delirium on dementia." Those with no underlying dementia may also develop delirium. A diagnostic tool for delirium is the Confusion Assessment Method (CAM).

There are a number of medical conditions that may result in delirium such as: excessive medications, dehydration, malnutrition, infection and stress. Assessment and reduction of delirium risk factors is essential to prevent delirium. Resources for delirium education and risk assessment are available on the AUA Toolkit.

Hallucinations may be present in delirium. If they are disturbing to the resident, a short course (One dose or a few days) of antipsychotics may be required while the underlying delirium is treated – if non-pharmacologic strategies are unsuccessful. Consider that antipsychotics and many common medications with anticholinergic burden may *cause* delirium. Hallucinations may also occur as part of the dementia disease process. If the person is disturbed by the hallucinations, medications such as antipsychotics may be helpful but should be reassessed regularly as the need for these medications may change over the course of the disease.

Pain: Assessment of pain in those with dementia relies heavily on observing body language and responsive behaviours. A variety of pain assessment resources are available for use with seniors.

Depression: Consider other mental health conditions such as agitated depression. Features of depression, delirium and dementia can overlap. Consider if a trial of antidepressants might be of benefit. Monitor carefully for antidepressant side effects such as headache, agitation, nausea, diarrhea, sweating and somnolence.

Medication Adverse Effects: Medical management of chronic conditions may contribute to the development of delirium and responsive behaviours. Consider the risk/benefit of continued use of medications such as: benzodiazepines, medications for urinary incontinence, antipsychotics, narcotics, cholinesterase inhibitors, statins and long term use of proton pump inhibitors and any medications with anticholinergic properties.

Apathy: Individuals with dementia often lose the ability to initiate conversations or activities but may be willing to participate if others engage them. This common apathy associated with dementia may be mis-labelled as a symptom of depression..

[i] FINKEL, S.I. (1996a). New focus on behavioural and psychological signs and symptoms of dementia. International Psychogeriatrics, 8(Suppl. 3), 215-216.
[ii] Graydon S. Meneilly MD, FRCPC, FACP Aileen Knip RN, MN, CDE Daniel Tessier MD, MSc, FRCPC. Can J Diabetes 2013;37(suppl 1):S1-S212.