Aged care assignment

Caring For People with Disruptive Behaviours Caring for older people can be very complex, due to the effects that aging has on the body, add to this complex situation, dementia, and it becomes even more complex. The behavioral disturbances that are common for this group of people are, hitting, screaming, biting, resisting care, wandering, self-harm, nocturnal wakefulness, refusal to eat, frequent and unnecessary toilet requests, and intrusion (Adams, 2008).

Acute care nurses are expected to deal with serious illnesses along with the behaviour issues of elderly people, which can be exacerbated by hospitalization. (Adams, 2008). This paper will examine the behaviours displayed by people with dementia in the acute setting, and strategies to provide appropriate care and manage these behaviours. In the acute setting and some residential aged care facilities, the nursing approach to these situations is to ignore the patient or to rely on the restrictive measures, for example, physical or chemical restraints (McCloskey, 2004).

Physical restraints are anything that prevents a person from free flow of moment. Chemical restraints are sedatives, antipsychotics etc (Wang&Moyle, 2004). These approaches are initiated to minimize or eliminate the particular behavior in question, thus reflecting ignorance to the needs of the older person with dementia (SullivanMarx, 2001: GP and Residential Aged Care Kit, 2006). Nurses can no longer take a reactive approach to these issues due to the scope and complexity of the issues.

Nursing staff should adopt a more proactive approach and carefully plan the care for patients who have dementia (Dewing, 2001: GP and Residential

Aged Care Kit, 2006). There are models of care that can be followed, which help to reduce the stress factors for these patients, thus in turn reducing the stress, frustration and aggravation for the nursing staff. These models of care have also been proven to enhance the level of care and improve the quality of life for the individual with dementia (Brooker, 2007). One such model of care is the Progressively Lowered

Stress Threshold Model (PLST), this was introduced in Canada in 2002, another model is the Person Centered Care Model, (Brooker, 2007: Edvardsson&Nay, 2009) Both models recognize that patients with dementia have difficulty in receiving, processing and responding to stimuli, especially environmental stimuli. These difficulties have resulted from the progressive decline in cognitive, effective and functional abilities (McCloskey, 2004). The PLST model also indicates that patients with dementia can exhibit behaviour that is baseline.

This behaviour can at any given time vary due to environmental factors or the stage of disease (Brooker, 2007: Edvardsson&Nay, 2009) Generally baseline behaviour is when a patient is in a calm state and able to function accordingly to the level of cognitive impairment they may have (Bartel, Dums, & Oxam, et al, 2004). If the patient is feeling stressed or experiencing feelings of loss of control, anxious behaviour, such as avoidance may occur (McCloskey, 2004). If this anxious behaviour continues, and there are excessive stimuli present, then aggression or verbal disruption may occur. GP and Residential Aged Care Kit, 2006). When these demands on the individual are removed or adjusted then functional behaviour will occur (Brooker, 2007). There are six main groups of stressors that affect the

patient with dementia, thus accelerating the behaviour from baseline to the anxious and dysfunctional level. The groups are changes in routine, fatigue, unfamiliar people, environment, caregiver, and demands that go beyond the functional capacity of the individual with dementia (Nordam, Sorlie, & Forde, 2003).

Also, excessive stimuli, perception of loss, anger, pain and medication could be included in this category. These stressors can cause the individual to become anxious, stressed and therefore trigger the dysfunctional behavior (Bakker, 2003: Edvardsson&Nay, 2009) As the disease progresses the person's ability to cope diminishes, as well as, their ability to adapt and cope with stimuli, thus increasing the dysfunctional behaviour. Interventions are needed that will reduce the stress, and environmental stimuli, thus promoting appropriate behaviour (Neville, 2002). Smith (2005, p. 5) state that " considerable observation is often required to understand the " problem" from the perspective of the person with dementia. " When a person with dementia is admitted to an acute care ward, they become exposed to many factors that they are not familiar with, they are busy and noisy (Willick & Willick, 2005). The patient with dementia will have problems coping with the constant ringing of the telephones, the noise of the nurse call system, the ever changing and movement of equipment, health professionals talking, staff they are not familiar with, and the layout of the ward (Willick, 2005: Edvardsson, 2009).

These alone are overwhelming to the patient, and then add the change of routine, and the fluctuating from overstimulation to sensory deprivation (Dewing, 2001). The patient with dementia will experience difficulty adapting

to the environment and will become stressed. This stress will be exhibited as disruptive or challenging to the acute care staff, given that they are unfamiliar with caring for the patient with dementia.

The acute care staff, being familiar with the hospital, and the ward, may not be aware, that the patient is experiencing stress from excessive stimuli (Agahi, 2004: Willick& Willick, 2005). For appropriate care to be given to a person who has dementia and disruptive behaviour, an assessment of the patient's environment must be done, as well as a care plan, identifying all factors that may contribute to the stress and behaviour, these will need to be adjusted accordingly for future care (Bergmark, Parker, &Thorslund, 2000: GP and Residential Aged Care Kit, 2006: Edvardsson&Nay, 2009).

The lack of understanding of the behavioral outbursts of the patient with dementia may lead to the patient receiving inappropriate care, thus leading to frustration for the nursing staff and the patient (Willick & Willick, 2005: Edvardsson&Nay, 2009). Take for example the use of restraints, which still continue to be used in the acute setting as well as residential aged care facilities, despite the evidence that these are inappropriate for managing dysfunctional behaviour Wang&Moyle, 2004). They have been also been proven to have negative outcomes, which include the increased workload for nurses, and increased patient mortality (McCloskey, 2004: GP and Residential Aged Care Kit, 2006). All too often restraints are used while the patient is still kept in an environment that is highly stimulating, therefore increasing the patient's stress levels elevating the patient at risk of injury (Sullivan-Marx, 2001).

There are many alternatives to physical restraints, some of them are, electronic devices which include alarming door mats, bedside mats, bed mats, chair mats, wandering monitor alarms, family/ volunteers and hospice workers to visit and distract the patient, medication changes, placing the patient in a compatible position or location, exercise programs, diversional therapy, beds at the lowest position, falls prevention management, reclining or regency chairs, and routine toileting, if the patient cannot communicate the need to go to the toilet, they can become agitated and stressed (Sullivan-Marx, 2001).

The most important issue is the ongoing education of staff in the area of physical restraints, and the dangers of using them (Wang, 2004). Due to the fact that patients with dementia have difficulty expressing themselves, before intervention takes place, the nurse must first and foremost assess the cause of the behaviour. This may be discomfort, and they cannot communicate this to the staff (Miller, 1999).

An array of underlying health conditions such as pain, urinary tract infections, constipation, hypoxia, renal and liver disease, and drug toxicity, can be contributing factors to dysfunctional behaviours, such as agitation (Willick & WIllick, 2005). A complete assessment of all of the following, medication reviews, and laboratory tests such a blood tests, can rule out the possibility of a physical cause of the behaviour(GP and Residential Aged Care Kit, 2006: Edvardsson, 2009). The nurse could commence a behaviour log to determine the triggers for the behavior, is it the time of the day? A particular person or activity? (Neurgroschi, 2002).

On completion of the behaviour log, and the identification of triggers, this information can be entered into the care plan. The care plan is a tool, which all staff have access to, and is a guideline for the care of the patient who owns the care plan (Jeste, 2003: Edvardsson, 2009) Patients with dementia can become agitated when their personal space becomes invaded; personal space is the distance between them and others (Targum, 2001). The patient with dementia, who is experiencing aggression, has a personal space area that is four times larger than that of the person who is not experiencing aggression (McCloskey, 2004).

Studies in this area have demonstrated that assaults can occur when staff or caregivers are in a close situation with the patient; this can be when attending to personal hygiene cares, feeding, repositioning or attempting to move patient from one area to another (Targum, 2001). Due to the fact that they may not understand what is happening, the patients are likely to lash to at the staff/ carer, in an attempt to protect their belongings or space from in their belief, an intruder. Any attempt to stop or reduce this behaviour could create further stress and the escalation of the agitation (GP and Residential Aged Care Kit, 2006).

This is problematic for acute care staffs who are attempting to provide basic care needs for these patients, and invasive procedures, these procedures may include the removal of drains, tubes, and changing of dressings (Uden, Lindseth, 1992). The nurse should at all times ask the patient’s permission first and explain exactly what she is wanting to do for the patient and give the patient time to respond is important. To manage these behaviours the

nurse could, where possible and trying not to invade the patient's personal space, prompt the patient to complete the task independently.

The use of single instructions during repositioning, feeding, and bathing can be beneficial for the nurse and the patient, thus reducing the behaviour (Torjuul, , 2006). To complete the more complicated or complex procedures the nurse could give the patient something to hold on to, for example, a towel, or a magazine, the nurse may ask the family to provide a familiar object for the patient, this again being beneficial in distracting the patient from task at hand therefore reducing the behavior(Edvardsson, 2009).

The patient with dementia may become agitated and stressed during dressing changes, the nurse can minimize the stressors and agitation by modifying or controlling the factors that have contributed to the disruptive behaviour displayed (Sorlie, Kihlgren). The nurse can critically question the procedure that she is performing. Is it painful? Are there too many people present during the procedure? Is the time appropriate or is the procedure being done at a time of high activity in the unit? Does she require the presence of a family member, to help minimize the behavior? What is the patient's normal routine at that time of the day? GP and Residential Aged Care Kit, 2006) Identifying these factors will be helpful to staff and will assist in them in being aware of excessive stimuli and this in turn can be transferred to the care plan and assist in the direction of the nursing care, and the management of the disruptive behaviour(Lindsbeth, Marhaug, Norberg&Uden, 2008: Edvardsson&Nay, 2009). The nurse, when attending to the patient who has complex care, needs to reduce the distractions and the agitation, this can be achieved by closing the door to the patient's room and

have a least amount of people present as possible, while completing the procedure(Lindsbeth, et al 2008).

The nurse should remain calm and efficient, speak in a soft manner and explain the process of the procedure in simple language. To discover a strategy that would work to make the patient feel safe while these procedures are taking place, may take some flexibility and creativity. It has been found that music therapy is helpful and beneficial in reducing behaviours, by creating a soothing, relaxing environment (Madan, 2005). In Madan, (2005) it is stated, " It appears that music is a promising alternative to restraint use in the management of disruptive behaviours. As discussed previously, the use of restraints to prevent the patient from disrupting a procedure, or to control disruptive behaviour, is common practice in some acute areas (GP and Residential Aged Care Kit, 2006). There is no evidence in existence that can prove their effectiveness in reducing or preventing disruption of a procedure nor is there evidence in existence that proves their effectiveness in maintaining the safety of the patient with disruptive behaviours (SullivanMarx, 2001).

Due to the dangers associated with the use of restraints, they should not be considered as an option. With careful care planning, incorporating knowing the patient, their right to refuse care, and to make their own choices, being able to recognize what the stressors and agitators are for the patient, establishment of relationships with the family, health care professionals, being creative, flexible, and patient, will achieve restraint free care(Wang&Moyle, 2004: Edvardsson&Nay, 2009). The physical environment of people with dementia is often controlled by other people.

A thorough assessment of the patient’s environment must be done to provide the appropriate care needed (Brooker, 2007: Edvardsson&Nay, 2009). The acute ward can be very stressful for dementia patients due to the multiple and competing stimuli (Willick & Willick, 2005). People who have dementia have limited ability to cope with and understand what is happening in their environment (GP and Residential Aged Care Kit, 2006: Smith&Buckwalter, 2005). To manage the disruptive behaviour due to environmental factors the nurse must assess if the temperature in the room is right is there excessive noise?

Can the patient see out of the windows? Or are the sills above eye level? Is the environment clutter free? Are the areas easily accessible for the patient? Unless the micro-environment is managed in a way that the patient is comfortable, then any endeavor to reduce the disruptive behaviour is worthless (Smith&Buckwalter, 2005: GP and Residential Aged Care Kit, 2006). Staff must use empathy and be actively aware of the comfort needs of the patient with dementia, they may not be able to convey to the nursing staff that he/she are in discomfort, or cannot manage for themselves how to lleviate the discomfort, so will become agitated and distressed(Brooker, 2007: Edvardsson&Nay, 2009). The patient may begin to pace, in an effort to reduce the discomfort, the cumulative effect of noise, cold/heat, not being able to see out of a window, being thirsty, hungry, can be devastating, and leading to disruptive behaviours, (Willick& Willick, 2006). Modifications may be needed for the immediate environment, these can be simple and creative, and this in turn, maybe all that is needed to manage the disruptive behaviour (Brooker, 2007).

The positioning of calendars, clocks, photos and pictures around the patient's room can help with orientation. Keeping the room closed during periods of high activity (Brooker, 2007). Lighting must be given careful consideration as dim lights create shadows and this can confuse and frighten the patient, again contributing to disruptive behaviour (GP and Residential Aged Care Kit, 2006). Bright lights may be helpful to the nursing staff, but are problematic for the patient with dementia, due to the fact that their eyes are light sensitive, and can become irritated by the bright lighting.

Lighting in the room should be glare and shadow free (Brooker, 2007). The environment should be made clutter free if the patient begins to wander, any attempt to restrict the movement of the patient with dementia will only lead to frustration and agitation (GP and Residential Aged Care Kit, 2006: Edvardsson&Nay, 2009). Family/ friends can be asked to accompany the patient on walks; diversional therapists can be consulted to create a diversional therapy care plan outlining activities to reduce the disruptive behaviour (Lucero, 2002).

Willick & Willick, (2005), point out " that the environment of an acute care hospital can be constructed in such a way to provide support to a person with dementia and their carer. " Wandering in the evening or at night can be problematic, this is called " sundowning", this generally happens at times when the patient has been busy in earlier times (Lucero, 2002). They become confused, agitated and aggressive because they no longer know what it is they were doing. The nurse can obtain information from family/carers about the patient's earlier life nd career, and plan strategies around this to manage disruptive behaviours that are displayed in the

evening. It may be just a simple task, but, this will give the patient a purpose (Lucero, 2002). Sensory deprivation may contribute to confusion and agitation in the patient with dementia; staff should ensure that if the patient has sensory aids such as hearing aids and glasses that these are clean, working, and fitted properly(Bakker, 2003: GP and Residential Aged Care Kit, 2006).

Lack of taste is another sensory deprivation that can be experienced by the patient with dementia, ill fitting dentures, ulcers in the mouth, dental caries can contribute to lack of taste, and this in turn can contribute to disruptive behaviours at mealtimes (GP and Residential Aged Care Kit, 2006). Oral hygiene is very important for older people especially those with dementia. When all aspects of taste deprivation are eliminated and the behaviour still continues, nursing staff may then need to evaluate other factors happening at mealtimes that may be contributing to the behaviour (Bakker, 2003).

Interaction with other people and staff is important, all too often patients with dementia are left alone, especially those who exhibit disruptive behaviours (Glister, Acconrinti&Dalessandro, 2002). There is research evidence that the patient with dementia when left alone or unoccupied, will exhibit disruptive behaviour (GP and Residential Aged Care Kit, 2006). Patients with dementia should not be assigned to single rooms; this will only lead to isolation, and loneliness, which in turn will exacerbate the disruptive behaviour.

Hospital wards may over stimulate the patient due to the fact of multiple people in the room, in turn contributing to disruptive behaviour (Glister, et al

2002). Semi-private accommodation, with one other person would be more suitable to the patient with dementia, this would provide social interaction. Caution must be taken when selecting appropriate persons, as they must be sensitive to the patient's level of cognition. Many people with dementia are cared for by either family or familiar staff in a long-term residential care facility, and then upon admission to an acute are ward, the person with dementia is faced with unfamiliar staff, which in turn can be stressful, thus contributing to disruptive behaviour (Willick & Willick, 2005: Edvardsson&Nay, 2009). Involving family/carers with the care planning for the patient will help facilitate appropriate care, and maintain a consistent routine, maximize strengths and abilities, and identify any potential needs that may arise in the hospital (Dyer, Hyer, Feldt, Lindeman, Busby-Whitehead, Greenberg, and Kennedy&Flaherty2003). Family/carers may be asked to remain with the patient until the behaviour subsides or the patient is settled.

If the patient with dementia is experiencing behaviours that cannot be settled with interventions that have been implemented, the nursing staff could ask the family member/ carer to remain for the entire shift or if it is at night the hospital could make arrangements for the family member/carer to stay the night. Maintaining familiar home routines and rituals are very important to the person who has dementia (Targum, 2001). The patient may display agitation and disruption at medication times; this may be due to the fact that the medications are being given to him/her at a time that differs to their normal routine(Brooker, 2007).

Modification of medication rounds, making them similar to the times the patient has the medication at home, the nurse in turn may ask the family member/carer to assist with the medication giving (GP and Residential Aged Care Kit, 2006). The nurse could consult with the family member/carer the best approach to administer the medications (Lindsbeth, et al, 2008). Patients with dementia respond better to routines and familiar staff, where possible one health care professional should perform procedures and care.

Patients with dementia will become agitated and stressed when they are confronted with a person they are not familiar with. The assignment of unfamiliar staff will only create more stress and perpetuate the disruptive behavior (Brooker, 2007). Nurses can better respond to agitation and disruptive behaviors in this population, when they have adequate knowledge regarding dementia, they should remain open to new strategies to manage these behaviours, and these strategies should be shared (Lawlor, 2002). Nurses need emotional support as ell, because caring for people with dementia, can be emotionally exhausting and stressful, then with added to this disruptive behaviour it will escalate (Willick & Willick, 2005). Nurses who are caring for this population should have access to research and educational recourses on how to manage disruptive behaviour as well as the availability of a gerontology nurse specialist(Lawlor, 2002: Edvardsson&Nay, 2009). The attitude and manner of the nursing staff can have an impact on the behaviour of the patient with dementia (Adams, 2008).

Given the fact that people with dementia are sensitive to nonverbal cues, they will be able to sense when a nurse is apprehensive and mirror their affective behaviour and respond negatively (Adams, 2008). Likewise if a

nurse approaches the patient with dementia, in a calm, relaxed and patient gentle way, the patient will remain calm and relaxed. Appropriate communication strategies are important in the management of disruptive behaviours in the patient with dementia (Miller, 1999).

The nurse, as mentioned previously, should approach the patient in a calm relaxed manner, speaking directly to them, remembering not to move or walk around when conversing with the patient. If the patient is approached inexpertly, or in an abrupt manner, they can become agitated and stressed (Miller, 1999). Smith & Buckwalter, (2005, p. 47) argue that “ a number of reasonably simple nursing interventions may reduce the risk of inadvertently precipitating behavioral symptoms. ” Removing the patient to a quite room or removing the excessive stimuli during conversation can help to reduce disruptive behaviours.

If the patient is not responding or understanding what is being related to them, the nurse should use short simple sentences and repeat the sentence using the same phrases (Smith&Buckwalter, 2005). Patients with dementia have delayed thought processes, so the nurse must give ample time for the patient to respond, before repeating what she has requested (GP and Residential Aged Care Kit, 2006). McCloskey, (2004) states, “ People with dementia can be overwhelmed by such phrases as, “ How are you today”, or “ Can you tell me what is upsetting you”.

The rephrasing of these questions to “ You appear to be having a good day”, or “ You are upset, I can help you”. If the patient does not respond to this strategy, then the nurse may implement the use of memory cards, pictures

or cue cards, these can be a valuable resource in the explanation of procedures (Brooker, 2007: Smith , 2005). There are medications available to mange dementia and disruptive behaviours. Bassiony (2003, p. 396), state that “ good clinical care dictates that nonpharmacologic interventions for the treatment of psychiatric and behavioral symptoms of dementia be considered and implemented first”.

The medications that are available for the management of dementia are anticholinesterase, anti-psychotics, and anti-depressants (Cohen-Mansfield, 2004). These treatments may be necessary when non-pharmacological interventions have not alleviated the disruptive behaviours (GP and Residential aged Care Kit, 2006). Low doses of psychotropic drugs may be helpful in the management of disruptive behaviours (Cohen-Mansfield, 2004). The medication that is to be prescribed will depend on the type of symptoms the patient is displaying.

The patient’s general practitioner or specialist will determine the suitability of medication for the patient (Fergusson&Howard, 2000). The use of antipsychotics and anti-depressants can be interpreted as chemical restraints if they are not used appropriately (Wang&Moyle, 2004). Patients who are taking these medications need to be monitored closely for extra-pyramidal side effects; these can be any of the following, tremors, rigidity, and bradykinesia (Bergman&Lerner, 2002). The nurse will need to monitor the patient closely, as they are at risk of falls, when taking these types of medications.

Overshott, Byrne&Burns (2004), state that “ The safe and effective management of behavioral and psychiatric symptoms of Alzheimer’s disease is one of the greatest challenges clinicians face. Traditionally, pharmacological interventions have been the mainstay of treatment but there is growing evidence for the effectiveness of a wide range of nonpharmacological measures”. Caring for the patient with dementia who is displaying disruptive behaviours is a combination of many factors as shown in this essay. It reaches from the patient, family/carers, doctors, nursing staff and other patients.

Nurses need to be aware and understand that behavioral disturbances are common in patients with dementia and should be anticipated. Interventions may not be required if the patient is not displaying behaviour that is a risk to themselves, or others around them. The nurse where possible can attempt to accommodate the behaviour, while maintaining the safety of all involved. REFERENCES Adams, T. (2008). Dementia Care Nursing: Promoting Well-Being In People with Dementia and their Families. Hampshire: Palgrave MacMillan. Agahi, N. (2004).

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