- Single-side print
- Fold page in half and crease along fold line
- Cut along outline
- Be sure to round the corners

FOLD LINE

Dementia Training Australia

Responsive Behaviours

Quick Reference Cards

Quick tips

What if...?

Responsive Behaviours

What next?

Which tool?

www.dta.com.au

This set of Quick Reference Cards is designed to provide an on-the-spot point of reference for health professionals and care staff working with people with dementia to help in the management of responsive behaviours.

The cards are intended to be used in conjunction with a person-centred approach to care; being mindful that knowing the individual, is fundamental to the provision of all high quality care.

These cards and the lanyard checklist cards are provided as a guide only. It is recommended that the resources on which they are based, listed on the **Reference** card, be referred to for more comprehensive and detailed information.

This resource was devised by the TRACS CIP-D community team led by Professor Elizabeth Beattie, and the Queensland Dementia Training Study Centre led by Sandra Jeavons and Elizabeth Miles with expert advice from Mr Fred Graham (Metro South Health QLD), Dr Margaret McAndrew (QUT), Professor Nancy Pachana (University of QLD), Jennifer Marshall (Anglicare SQ), Denise Edwards (Blue Care), Dr Judy McCrow (Churches of Christ Care) and Dr Leander Mitchell (UQ).

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Dementia Training Australia is supported by funding from the Australian Government under the Dementia and Aged Care Services Fund.

Download the free app version of this resource and DTA's Medication Management app.

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ASSESSMENT TOOLS

Recommended tools for measuring responsive behaviours appear on each specific behaviour card. While they are considered the most appropriate scales for assessing behaviours, clinicians must also determine:

- when to administer an assessment tool
- who is qualified to administer it
- who is qualified to interpret the score
- what to do with the results

Does your health service or facility have guidelines on the use and interpretation of particular assessments and recommended actions to take based on the outcomes?

Notes on scoring, interpretation and actions are typically included with the scale (See the Dementia KT Hub - dementiakt.com.au/doms/).

Each individual situation requires consideration of the many factors contributing to the current status of the person being assessed. The use of a framework will help ensure a comprehensive approach. See the **Frameworks & Models** card.

Screen for delirium when there is a sudden, new or fluctuating change in behaviour, physical function or cognition. See the **Delirium** card.

ASSESSMENT TOOLS

ASSESSMENT TOOLS

The following recommended measures are freely available online. Most* are available from: www.dementiakt.com.au/doms/

AES	Apathy Evaluation Scale*
AI	Apathy Inventory
BEHAV-AD	Behavioural Pathology in Alzheimer's Disease *
CMAI	Cohen Mansfield Agitation Inventory – specific subscales*
CSDD	Cornell Scale for Depression*
EAT	EHE Environmental Assessment Tool
GDS	Geriatric Depression Scale*
IQAD	Informant Scale for Anxiety in Dementia
NPI/ NPI-C	Neuropsychiatric Inventory/-Clinician - specific subscales*
OVERT	Overt Aggression Scale
PAS	Pittsburgh Agitation Scale*
RAGE	Rating Scale for Aggressive Behaviour in the Elderly*
RAID	Rating Anxiety in Dementia Scale*
RAWS	Revised Algase Wandering Scale
SBMI	Screaming Behavioural Mapping Instrument
VBS	Verbal Behaviour Scale

Delirium Assessment:

CAM Confusion Assessment Method – and variants*

4AT Rapid assessment test for delirium

DRS Delirium Rating Scale*

Pain Assessment:

Abbey / PAINAD / PACSLAC II / DOLOPLUS-2

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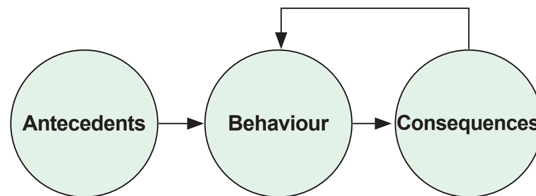
FRAMEWORKS & MODELS

The following models and frameworks offer approaches that may be used individually or in combination. Each of these frameworks is underpinned by a **person-centred approach.**

The **ABC Behavioural Assessment tool** (Cohen-Mansfield. 2000) focuses on: **A**ntecedents (triggering event or circumstance), **B**ehaviour (the actual behaviour) and **C**onsequences (what happens after the behaviour)



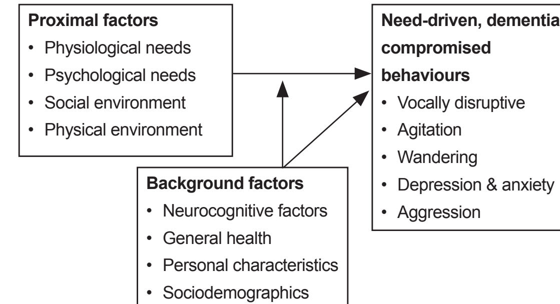
The **PIECES™ mnemonic** provides a way to recall a consistent approach to assessment and care:

- **P hysical cause** e.g. pain, discomfort
- **I ntellectual capacity** e.g. memory, cognition, confusion
- **E motional health** e.g. depression, anxiety
- **C apability** e.g. maintaining level of independence
- **E nvironment** e.g. keeping surroundings unambiguous
- **S ocial Self** e.g. who is this person, what is their life history

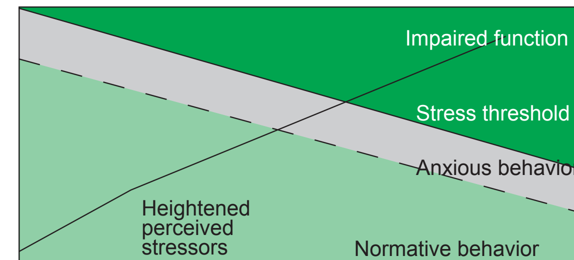
FRAMEWORKS & MODELS

FRAMEWORKS & MODELS

NDB Need Driven Dementia Compromised Behaviour Model (Algase et al 1996) characterises responsive behaviour, or BPSD as an expression of need.



PLST Progressively Lowered Stress Threshold Model (Smith, Hall, et al. 2006) is based on the premise that as dementia progresses, the person is less able to manage stress. Focus is on remaining abilities and reducing internal and external stressors.



Stress threshold in a patient with Alzheimer's disease and related dementia.

Source: Smith (2006) Application of the Progressively Lowered Stress Threshold Model across the Continuum of Care

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FOLD LINE

Has there been a sudden change or exacerbation?

Are you responding calmly?

Have you identified triggers?

Restrain Physically or Chemically

Ignore

Who is unsafe and why?

AGGRESSION

Please refer to *Behaviour Management; A Guide to Good Practice (2012)* page 73 for a definition of this behaviour

Expert consensus guidelines recommend appropriate use of atypical anti-psychotics may be necessary for safety

Behaviour Management; A Guide to Good Practice (2012) page 70

AGGRESSION

AGGRESSION

AGGRESSION

- **Keep Calm**
  Maintain composure; allow time for, and time to, control emotions
- **Who is unsafe and why?**
  Determine any immediate risk of harm; move people as necessary to regain a safe environment, alleviate or remove triggers and consider medical review
- **Exclude delirium**, pain, discomfort, infection (see **Delirium** card)
- Is there a history of depression, anxiety or psychotic symptoms?
- **Triggers**
  Does the person feel threatened during personal care? Is this more likely with staff of a particular gender, ethnicity or manner?
- **Is there a history** of trauma or abuse, e.g. domestic violence, war trauma, stolen generation, previous institutionalised care?
- **Psychosocial and environmental interventions**
  Introduce individualised interventions particularly sensory, touch, music
- **Assess, using for example:**
  RAGE **CMAI** subscale
  OVERT **NPI-C** aggression subscale
  PAS Pittsburgh Agitation Scale

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FOLD LINE

Over or under stimulated?

Has there been a change in routine?

Is there discomfort, fatigue or pain?

AGITATION

Ignore

Trial tailored music as a preventative strategy

How did the person historically deal with stress?

Please refer to *Behaviour Management; A Guide to Good Practice (2012)* page 85 for a definition of this behaviour

AGITATION

AGITATION

AGITATION

- **Is there underlying pain or discomfort?** Constipation, infection, uncomfortable clothing, too hot or too cold
- **Exclude delirium** (see **Delirium** card)
- **Is the person over or under stimulated?** environment too noisy, too quiet? sufficiently engaged or bored?
- **Understand who the person is** How did they historically respond to stress? e.g. withdrawal, burst of anger, anxiety. What were the main activities in their daily working lives?
- **Has a change of routine or environment precipitated the behaviour?** Change in staff, change in family or visitors, different room
- **Provide sensory or touch activities** Music therapy, touch therapy, meaningful activity, exercise, time outdoors, pets
- **Assess using, for example:** **CMAI** Cohen Mansfield Agitation Inventory **PAS** Pittsburgh Agitation Scale **NPI** – Agitation/Aggression and Aberrant Motor Behaviour subscales
- **Review medication** - dosage, interactions, akathisia

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FOLD LINE

Mental health history?

Anxiety, depression or apathy?

Avoid over-stimulation and change

Are needs being met?

Ignore

Are there specific triggers?

ANXIETY

Please refer to *Behaviour Management; A Guide to Good Practice (2012)* page 97 for a definition of this behaviour

ANXIETY

ANXIETY

ANXIETY

- **Understand who the person is**
  Do they have a history of anxiety, depression or other mental health issues?
  What do they like / dislike, biography
  Avoid the need for too many decisions
- **Triggers**
  Does the person become anxious at particular times of the day, when alone, when a particular person is with them?
  Is there underlying pain or discomfort?
- **Routine**
  Maintain structure and preferred routine. e.g. Do they like to shower in the evening or morning?
- **Avoid overstimulation**
  Keep the environment familiar, safe and uncomplicated
- **Psychosocial and environmental interventions**
  Trial individualised activities that are meaningful for the person such as music, exercise, time outdoors, meals or outings with family or friends
- **Differentiate** depression, anxiety, apathy
- **Assess using, for example:**
  RAID Rating Anxiety in Dementia Scale
  IQAD Informant Scale for Anxiety in Dementia

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FOLD LINE

Understand who the person is

Engage with the person 1:1 for 10 mins each shift

Monitor the person's level of engagement

Tailor activities meaningful to the person

Ignore

Ensure depression assessed

APATHY

Please refer to *Behaviour Management; A Guide to Good Practice (2012)* page 109 for a definition of this behaviour

APATHY

APATHY

APATHY

- **Understand who the person is**
  Previous and current interests, likes / dislikes, abilities, introvert / extrovert
- **Tailor specific engaging activities**
  Small / large group, individualised activities that are meaningful for the person and may include multi-sensory, music, exercise, time outdoors or with pets
- **Engage one to one** for 10 minutes each shift
- **Monitor the person's level of engagement**
  eye contact, initiation, facial expressions
- **Assess using, for example:**
  AES Apathy Evaluation Scale
  AI Apathy Inventory
  NPI Neuropsychiatric Inventory
  NPI-C Neuropsychiatric Inventory-Clinician-apathy subscale

  Depression scales (see **Depression** Card)
- Exclude hypoactive delirium (see **Delirium** card)
- **Review medication**
  dosage, interactions

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FOLD LINE

Mental health history?

Is there sleep disturbance?

Trial walks, dance, or other exercise to lift mood

Refocus/ distract with reminiscence therapy

Ignore

Is the person at risk?

DEPRESSION

Please refer to *Behaviour Management; A Guide to Good Practice (2012)* page 121 for a definition of this behaviour

DEPRESSION

DEPRESSION

DEPRESSION

- **Assess**
  Assess and respond to risk of self-harm or suicidality

  Essential to differentiate clinical depression from delirium, apathy, sleep disturbance, loss of pleasure or impaired concentration

  Use scales such as:
  CSDD Cornell Scale
  GDS Geriatric Depression Scale
- **Psychiatric and psychosocial history**
  Does the person have a history of major depressive disorder?

  Is the person grieving? Are they adjusting to leaving their home / spouse / pets?
- **Exercise**
  Trial exercise that is enjoyed by the person such as walks, dance or physical activity sessions, swimming / hydrotherapy.
- **Psychosocial and environmental interventions**
  Introduce reminiscence / life story work, music that is mood enhancing, pet therapy
- **Review medication**
  Dosage, interactions
  Psychiatric and/or psychology consult

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FOLD LINE

Identify social cues and early indicators

Are your responses consistent, neutral & simple

Provide privacy for sexual expression

Restrain Physically or Chemically

Ignore

Distract/ redirect the person

DISINHIBITION

Please refer to *Behaviour Management; A Guide to Good Practice (2012)* page 133 for a definition of this behaviour

DISINHIBITION

DISINHIBITION

DISINHIBITION - SOCIAL / SEXUAL

- **Triggers, cues and early indicators**
  Observe what precipitates the behaviour e.g. particular staff or residents and intervene to redirect, distract or screen.
- **Is the behaviour distressing or harming others?** Is it triggering agitation, anxiety, aggression, wandering in other residents/ patients?
- Does the person need privacy for sexual expression?
- Is urinating in public or in an inappropriate place because the person cannot find or distinguish the toilet? In their early life did they routinely urinate outside? e.g. farmer or no indoor toilet.
- **Assess using, for example:**
  NPI-C Disinhibition scale
  Have sexual needs been assessed?
- **Psychosocial and environmental interventions**
  Introduce modified clothing, activity aprons and other sensory activities; pet therapy; encourage more physically and emotionally affectionate contact with family and friends
- Avoid being reactive and shaming the person; keep responses consistent, neutral and simple.

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FOLD LINE

Past history of psychosis?

Exclude delirium

Who is being distressed by this?

Individualised psychosocial care

Ignore

Review and refer to gero-psychiatrist

PSYCHOTIC SYMPTOMS

Please refer to *Behaviour Management; A Guide to Good Practice (2012)* page 155 for a definition of this behaviour

PSYCHOTIC SYMPTOMS

PSYCHOTIC SYMPTOMS

PSYCHOTIC SYMPTOMS

(Delusions and hallucinations)

- Does the person have a history of schizophrenia or other major mental disorder?
- Is there any immediate risk of harm or active suicidal ideation?
- Exclude delirium, pain, discomfort, infection (see **Delirium** card)
- Ensure claims such as theft are not actually based in fact
- Ensure lack of suitable hearing aids or glasses is not contributing to misinterpretation of the environment.
- **Assess, using for example:**
  NPI Delusions and hallucinations subscale
  BEHAV-AD - suitable for acute, community and residential aged care settings
- **Psychosocial and environmental interventions**
  Trial individualised, meaningful activities such as music, exercise, pets or robotic animals, outings
- **Review**
  Medication - dosage, interactions
  Psychiatric consult

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FOLD LINE

What was the person's usual sleep pattern?

Trial daily walking and outside activities

Ensure a routine before bed

Does the person get lost going to the toilet?

Ignore

Ensure underlying conditions are treated

SLEEP DISTURBANCE

Please refer to *Behaviour Management; A Guide to Good Practice (2012)* page 145 for a definition of this behaviour

SLEEP DISTURBANCE

SLEEP DISTURBANCE

SLEEP DISTURBANCE

- **Treat underlying causes**
  Ensure pain, depression, anxiety, agitation and other conditions (e.g. sleep apnoea) are treated. Exclude delirium. (see **Delirium** card).
- **Review medication**
  dosage, interactions, treatment of underlying conditions
- **Exercise and daylight exposure**
  Trial daily walking or other exercise, outside activities such as gardening, increased exposure to daylight.
- **Sleep hygiene**
  Implement sleep hygiene routines compatible with the person's history and preferences. These may include quiet time, warm drink, shower, lavender oil hand massage before bedtime, a favourite pillow, relaxing music.
- Minimise evening and night time noise and light disturbance. Is it possible to move the person to a quieter location?
- Does the person need help toileting at night?
- **Assess using, for example:**
  A sleep-log to accurately record sleep patterns
  NPI / NPI-C – Sleep disorders subscale

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FOLD LINE

Is the person experiencing feelings of isolation?

Is there delirium discomfort or pain?

Trial tailored sensory activities

Restrain Physically or Chemically

Ignore

Reinforce non VDB with positive touch

VOCALLY DISRUPTIVE BEHAVIOUR

Please refer to *Behaviour Management; A Guide to Good Practice (2012)* page 169 for a definition of this behaviour

VOCALLY DISRUPTIVE BEHAVIOUR (VDB)

VOCALLY DISRUPTIVE BEHAVIOUR (VDB)

VOCALLY DISRUPTIVE BEHAVIOUR (VDB)

- **What are the triggers or unmet needs?**
  Does the person with this behaviour have a reduced stress threshold?
  Are they experiencing feelings of isolation (social or psychological) or boredom?
  Is the VDB associated with visual or auditory hallucinations?
- **Exclude delirium**, pain, discomfort, infection (see **Delirium** card)
- **Operant Conditioning** - Has the person become conditioned to this behaviour? Use touch to positively reinforce non-VDB.
- **Psycho-social and environmental interventions**
  Introduce individualised interventions particularly sensory activities such as touch therapies, aromatherapy, music therapy, also outdoor activities.
- Activities to promote relaxation may also help other residents distressed by the behaviour.
- **Assess using, for example:**
  CMAI Cohen Mansfield Agitation Inventory – specific subscales
  NPI-C – subscale
  PAS Pittsburgh Agitation Scale
  SBMI Screaming Behavioural Mapping Instrument
  VBS Verbal Behaviour Scale

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FOLD LINE

Is the environment too busy / noisy or too dull?

Who is it a problem for? Level of risk?

Are basic needs being met: hungry, need to void, bored?

Does this person feel lost, tired, frightened, frustrated, engaged?

Ignore

Restrain physically or chemically

WANDERING

Please refer to *Behaviour Management; A Guide to Good Practice (2012)* page 179 for a definition of this behaviour

WANDERING

WANDERING

WANDERING

- **Level of Risk**
  Assess and respond to risk of getting lost, going missing, falls, weight loss, sleep deprivation, entering private spaces of staff or other residents/patients.
- **Under or over stimulating environment**
  Can the surroundings be adjusted (e.g. lighting) or the person repositioned to a quieter spot or brought closer to the action?
- **Engage the person in a tailored activity**
  Small / large group, individualised activities that are meaningful to the person such as - multi-sensory, music, exercise, time outdoors, pets
- **Therapeutic touch** such as relaxing, hand massage may reduce restlessness and need to walk
- **Environmental interventions** – do an EAT assessment; disguise or conceal exits, place Stop signs on doors / boundaries; determine if the person can find the toilet / their room / the dining area?
- Ensure the person is wearing ID with up to date contact information.
- **Assess**
  Use the Revised Algase Wandering Scale (**RAWS**) Long term Care / Community versions available

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FOLD LINE

Maintain hydration oxygenation elimination nutrition

Optimise environment – consider orientation lighting noise

Reduce or remove psychoactive drugs

Normalise sleep-wake cycle without drugs

Maintain safe mobility with regular exercise

Address acute medical issues

DELIRIUM

DELIRIUM

DELIRIUM

DELIRIUM

Assess for delirium if any of the following present:

- Is there evidence of an acute change in cognition, physical function or behaviour?
- Is there evidence that cognition, physical function or behaviour are fluctuating during the course of a day?
- Is the person having difficulty focusing attention or concentrating?
- Is the person's speech disorganised or incoherent, such as rambling or irrelevant conversation?
- Are there changes to the person's level of consciousness (either hyper-alert to hypo-alert)?
- Have perceptual disturbances such as hallucinations or delusions recently appeared?
- Are there changes in psychomotor activity (either hyperactive or hypoactive)?

Screen for delirium using:

CAM Confusion Assessment Method (variants where applicable such as the CAM-ICU)

4AT Rapid assessment test for delirium

DRS Delirium Rating Scale

Alert medical staff to a positive screen of delirium

Physiological contributors

Monitor vital observations, constipation, pain, fluid balance, urine dipstick, sleep patterns, nutrition and weight

Psychosocial and environmental interventions

Try socialisation, interaction, exercise, low stimulus and lighting appropriate to the time of day

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FOLD LINE

REFERENCES

These cards are based on the following resources:

Behaviour Management; A Guide to Good Practice - Managing Behavioural and Psychological Symptoms of Dementia (2012) Dementia Collaborative Research Centre - Assessment and Better Care (DCRC-ABC),UNSW. Available at: www.dementiaresearch.org.au/bpsdguide.html

Introduction to Assessment and Management of Behavioural and Psychological Symptoms of Dementia for Novice Clinicians Guide (2013) Dementia Training Study Centres Available at: www.dementiaresearch.org.au/bpsdguide.html

Frameworks and Models references:

Cohen-Mansfield J. (2000) Theoretical frameworks for Behavioural Problems in Dementia. *Alzheimer's Care Quarterly*, Fall

Algase D., Beck C., Kolanowski A., Whall A., Berent S., Richards K. & Beattie E. (1996) Need-driven dementia compromised behavior: An alternative view of disruptive behavior. *American Journal of Alzheimer's Disease*, 11(6), 10-19.

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Smith M., Hall G. R., Gerdner L. & Buckwalter K. C. (2006) Application of the Progressively Lowered Stress Threshold Model across the Continuum of care. Nursing Clinics of North America, 41,57-81

ASSESSMENT TOOLS
FRAMEWORKS AND MODELS
AGGRESSION
AGITATION
ANXIETY
APATHY
DEPRESSION
DISINHIBITION
PSYCHOTIC SYMPTOMS
SLEEP DISTURBANCE
VOCALLY DISRUPTIVE BEHAVIOUR
WANDERING
DELIRIUM
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