Responsive behaviour

Standardised care process

Objective

To promote evidence-based practice in responses to behaviours expressed by people with dementia who live in residential aged care settings.

Why the response to behaviour is important

Responsive behaviours affect up to 90 per cent of people with dementia at some stage, and these behaviours need individual management (Therapeutic Guidelines Ltd 2018). The recognition, assessment, management and evaluation of responsive behaviours expressed by people with dementia should be undertaken by an interdisciplinary team in collaboration with the person, their family and nominated decision-maker (Registered Nurses' Association of Ontario 2016).

Any form of physical or pharmacological restraint is to be used as a last resort on a temporary basis following comprehensive assessment of a person's behaviour and exhausting all reasonable alternative options (Aged Care Quality and Safety Commission 2019). This SCP should be read/used in conjunction with the *Physical restraint* SCP.

Definitions

Antipsychotic medications: Medications used primarily to treat psychotic disorders. Risperidone is the only antipsychotic drug that is approved the Therapeutic Goods Administration for use in dementia (Therapeutic Guidelines Ltd 2018). The use in a residential aged care setting could be considered as chemical restraint.

Behavioural and Psychological Symptoms of Dementia (BPSD): 'Symptoms of disturbed perception, thought content, mood, or behaviour that frequently occur in patients with dementia' (Finkel & Burns 1999).

Clinical risk: Where action or inaction on the part of the organisation results in a potential or actual adverse health outcome on consumers of health care (Department of Health 2012, p. 5).

Psychotropic medications: Drugs that have specific effects on the central nervous system and the potential to change mood, perception or behaviour (NSW Ministry of Health and the Royal Australian and New Zealand College of Psychiatrists 2013). The use in a residential aged care setting could be considered as chemical restraint.

Responsive behaviour: The term originating from, and preferred by, people with dementia that represents how their actions, words and gestures are a response to something important to them. People with dementia may use words, gestures or actions to express something important about their personal, social or physical environment (Murray Alzheimer Research and Education 2018).

Restraint: Any practice, device or action that interferes with a person's ability to make a decision, or restricts their free movement. Where physical or chemical restraint are used, residential aged care services must meet a number of conditions (ACQSC 2019).

Standardised care process (SCP): This has been developed for the department's Strengthening Care Outcomes for Residents with Evidence (SCORE) initiative through a comprehensive review of the evidence and consultation with public sector residential aged care stakeholders and experts to mitigate significant clinical risk in residential aged care services.

Team

Manager, registered nurses, enrolled nurses, personal care attendants, leisure and lifestyle, general practitioner (GP), allied health professionals (such as a physiotherapist, occupational therapist and exercise physiologist), residents and/or family/carers.

Acknowledgement

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Brief standardised care process

Recognition and assessment

- Know the person's usual or baseline behaviour.
- When a different behaviour emerges, undertake a risk assessment. If risks or behaviour severity are high initiate interventions to prevent harm.
- If risks are moderate to low commence a comprehensive assessment – this includes: a detailed description of the behaviour; exclusion of physical, medical and psychological causes for the behaviour; information about the person, the staff and the team involved in the person's care and support; a review of the social and cultural environment; and the indoor/outdoor environment.
- Document the assessment findings and undertake an analysis of the underlying cause of the behaviour.
- Formulate an intervention plan, monitor ongoing behaviour and set a review date.

Interventions

- Interventions should aim to reduce, or resolve, the underlying cause of the behaviour.
- Introduce individualised non-pharmacological interventions as a first-line strategy.
- Introduce pharmacological interventions for treating any new comorbid conditions identified through the assessment, or where there is risk of harm, serious distress or there has been no response to non-pharmacological interventions.
- Follow the general principles of prescribing psychotropic medications for behaviour management.
- Obtain consent for treatment with psychotropic medication from the person with dementia or their nominated decision-maker.
- Document all actions taken.
- Establish a review plan to consider continuance or withdrawal of treatment.
- Begin antipsychotic deprescribing once the target behaviour is controlled or adverse effects are evident.
- Instigate strategies for preventing responsive behaviours occurring in those at risk.

Referral

- Healthcare professionals trained in the assessment and management of responsive behaviours
- Dementia Support Australia
- Occupational therapy
- Physiotherapy
- Environmental design services
- Review by a specialist or Residential Medication Management Review (RMMR)
- Hospital outreach services
- Dementia Australia
- Dementia Training Australia

Evaluation and reassessment

- Establish a formal monitoring plan for the effectiveness of interventions and any changes in the behaviour.
- When medication is commenced, regularly review and monitor for response to treatment, emergence of adverse effects and/or side effects and the ongoing need for psychotropic medications.
- Adjust interventions as required. If there is no improvement, or the behaviour worsens, reassess or seek advice from specialist services.

Resident involvement

- The assessment and care plan should be developed in collaboration with the person with dementia and their family or nominated decision-maker.
- Support the person's ability to be involved in decisions about their care.
- Provide education and psychosocial support to the person with dementia and their family.

Staff knowledge and education

Residential aged care staff should be educated and trained in: dementia care; communication skills; person-centred care; the management of responsive behaviours; the management and de-escalation of violence, aggression and severe agitation; non-pharmacological interventions; and the correct use of psychotropic medication for the pharmacological management of responsive behaviours.

Full standardised care process

Recognition

It is important to know the person's usual or baseline behaviour – this helps in recognising change. Change may include:

- a new behavioural presentation with acute or chronic onset
- an existing behaviour that has altered or worsened in a short or extended period of time
- the changed ability of those supporting the person with dementia to respond effectively to existing behaviours.

Assessment

Risk assessment

When the behaviour emerges, establish whether there is an immediate or potential risk that will place the person with dementia, or others, in any danger. This will include identifying:

- the type, degree and immediacy of risk
- the nature, frequency and severity of the behaviour and the context in which it is occurring
- the severity of distress to the person with dementia or to others.

Immediate action is required if risks or behaviour severity are high (occurring frequently, causing serious distress or harm). Interventions to prevent harm include:

- maintaining a safe environment and increasing staff presence
- referral to specialist services or acute services
- swiftly introducing non-pharmacological and pharmacological approaches.

Where risks or behaviour severity are lower (mild or moderate, not causing serious distress or harm), the comprehensive assessment should be carried out and non-pharmacological approaches considered as a first-line intervention.

Comprehensive assessment

- Promptly carry out an assessment when responsive behaviours emerge to establish the underlying causes and triggers of the behaviour.
- The assessment should be comprehensive and occur in collaboration with the person with dementia, those who know them well, and the interdisciplinary team.
- Interpreter services should be used where English is not the primary language for the person with dementia or those who know them well.
- Establish the person's ability to understand and appreciate information relevant to making decisions and their legal representative identified.

Establish a detailed description of the responsive behaviour by:

- identifying when the behaviour began
- maintaining a behaviour observation chart over a minimum of three days
- measuring the frequency, duration, severity and consequences of the behaviour
- recording the factors that trigger, aggravate or improve the behaviour. This may include events that lead to the behaviour, where the behaviour occurs and who was present using standardised assessment tools. Global tools include Neuro Psychiatric Inventory and Behave AD. Tools measuring targeted behaviours include the Cohen Mansfield Agitation Inventory; the Revised Algase Wandering Scale and the Apathy Evaluation Scale.

Identify or exclude physical, medical and psychological causes for the behaviour. These include but are not limited to:

- delirium, particularly if there is an acute change from the baseline behaviour (if delirium is suspected investigate underlying causes such as infection, prescribed drugs, alcohol withdrawal, metabolic disturbances and carry out a delirium screen (pathology) – see the delirium SCP)
- pain or discomfort (see the pain SCP)
- medicines – recent changes, side effects and interactions
- constipation (see the constipation SCP)
- dehydration (see the dehydration SCP)
- hunger or low blood sugar
- depression or anxiety
- hallucinations or delusions (psychosis)
- withdrawal associated with drug, alcohol or smoking history
- terminal restlessness
- a review of the person's medical and psychiatric history, including vascular risk factors
- sensory impairment
- unmet psychological and emotional needs.

Gather information about the person including:

- dementia diagnosis
- personal/life history, including work history, special and traumatic events
- religious beliefs, spiritual and cultural identity
- premorbid personality and coping strategies
- roles and responsibilities
- hobbies and interests
- routines and rituals
- preferences (likes and dislikes)
- social factors
- support needs during activities of daily living (meals, personal care delivery).

Gather information about the staff involved in the person with dementia's care and support including:

- relationships between staff and the person with dementia
- interaction and communication style
- conflicts between staff and family
- knowledge and understanding of dementia and of the person with dementia
- skills, experience and level of training in caring for people with dementia
- attitudes and empathy
- stress threshold
- workplace demands on staff
- effectiveness of clinical leadership.

Review the indoor and outdoor environment including:

- stimulation and noise levels
- physical layout
- personalised and familiar bedroom surroundings
- lighting, consider contrasting colours for toilet seats and doors
- overcrowding and lack of privacy
- access to the garden.

Review the social and cultural environment including:

- opportunities for meaningful engagement
- quality of activities
- flexibility of routines
- adequacy of staff time or attention
- the person's communication needs and abilities
- acknowledgement, respect and support for the person's cultural background, spirituality and diversity
- the effect of other people on the person with dementia.

Document the assessment findings.

Analysis of the comprehensive assessment data

A skilled and experienced member of staff, in collaboration with the person with dementia, their family and care team, conducts a careful analysis of the underlying cause of the behaviour(s) by:

- identifying the target behaviours or psychological symptoms
- formulating an intervention plan, establishing ongoing behaviour monitoring and setting a review date.

A behaviour model or framework may support the systematic approach to assessing and understanding the underlying causes of the behaviour, as well as developing individualised interventions and responses to minimise or resolve the behaviour. Behaviour models include:

- ABC model
- need-driven dementia compromised behaviour
- progressively lowered stress threshold
- CAUSEd (Communication, Activity, Unwell/unmet needs, Story, Environment, Dementia) and concept mapping.

Interventions

Select interventions that aim to reduce or resolve the underlying trigger or cause of the behaviour rather than modifying the behaviour itself. Interventions should consider:

- the characteristics and severity of the target behaviour
- the person's unmet needs
- treatment of any underlying physical/medical or psychological causative factors
- the person's current skills and functional ability
- the stage of dementia
- the person's needs during personal care and bathing
- the goals of care.

Non-pharmacological interventions

Where the behaviour has minimal impact on safety, wellbeing and quality of life, use non-pharmacological interventions as the first line of management of responsive behaviours before a pharmacological intervention is considered. Interventions should be individually tailored to the person to ensure they are meaningful and appropriate. Interventions should consider:

- the person's background (biography and life experiences)
- social and vocational history
- the person's personal, cultural, religious and spiritual preferences
- the skills and resources available at the residential care facility.

Examples of non-pharmacological interventions include (but are not limited to):

- life review / life story work
- modifications to the physical environment
- social inclusion
  - one-to-one interaction
  - meaningful occupation and roles
  - meaningful hobbies and past times
- validation therapy
- sensory therapies
  - aromatherapy
  - sensory stimulation
  - music therapy / preferred music
  - massage (and therapeutic touch)
  - animal-assisted therapy (pet therapy)
- reminiscence therapy
- simulated presence therapy
- physical exercise and dancing
- assistive technology
- psychological therapies.

Document interventions and outcome goals.

Pharmacological interventions

Pharmacological management may be considered in the following circumstances:

- for treating hallucinations or delusions, depression, anxiety or other underlying health conditions such as delirium
- when the risk of harm to the person with dementia or others has been assessed as imminent and serious
- if the level of distress to the person with dementia significantly interferes with their quality of life, or
- if there is no response to non-pharmacological interventions on their own.

General principles of prescribing to manage responsive behaviours include:

- ensuring target symptoms are identified, quantified and documented
- targeting the action of the drug to the symptom
- using the lowest effective dose for the shortest period of time
- introducing one drug at a time, starting with a low dose, and increasing slowly as necessary
- undertaking an RMMR or review by a specialist where multiple psychotropic drugs are indicated
- initiating non-pharmacological approaches alongside pharmacological interventions
- ceasing pharmacological interventions that have proven to be ineffective.

The use of psychotropic medications in people with responsive behaviours are associated with possible harms.

- Risperidone is the only antipsychotic drug that is TGA approved for use in dementia. Its only indication is for the treatment (up to 12 weeks) of psychotic symptoms, or persistent agitation or aggression that is unresponsive to non-pharmacological approaches in people with moderate to severe dementia of the Alzheimer type.
- Benzodiazepines should not be used regularly for longer than two weeks without review and evaluation.

Where pharmacological therapy is indicated:

- Identify vascular risk factors (history of stroke, poorly controlled atrial fibrillation, hypertension, diabetes).
- Proceed with caution in people with dementia with Lewy bodies or Parkinson's dementia because most antipsychotics are associated with increased risk of adverse effects.
- Identify the target symptoms to be treated pharmacologically.
- Explain the benefits and potential risks of treatment to the person with dementia and/or their nominated decision-maker. Risks associated with antipsychotic medication include:
  - hospitalisation
  - falls
  - worsening cognitive impairment
  - cerebrovascular events (stroke, transient ischaemic attack)
  - death.
- Risks associated with benzodiazepine medication include:
  - worsening cognitive impairment
  - increased sedation
  - postural hypotension
  - falls.
- Obtain consent for treatment from the person with dementia or their nominated decision-maker before starting psychotropic medication.

- Document all actions in the person with dementia's chart.
- Establish a review plan to consider continuance or withdrawal of treatment.

Antipsychotic deprescribing

Maximum treatment duration of antipsychotic medication is 12 weeks. Once the target behaviour is controlled or adverse effects are evident:

- Initiate a clinical review in collaboration with the person with dementia and/or nominated decision-maker.
- Slowly taper and stop the antipsychotic drug.
- Monitor every one to two weeks during the deprescribing period for adverse drug withdrawal events and expected benefits.
- If the target behaviour relapses consider non-pharmacological interventions, restart the antipsychotic drug at the lowest possible dose or consider alternate drugs.

Preventing responsive behaviours

Identify people with dementia who may be at risk of experiencing responsive behaviours by:

- establishing the person's functional and cognitive abilities
- getting to know the person (beliefs, preferences, usual routines and rituals) and their personal history (major life events and experiences, work history, recreation)
- establishing the person's communication ability and interaction patterns
- obtaining a history of behaviours (type, triggers and strategies that minimise or eliminate the target behaviour)
- identifying delirium risk factors.

Document effective prevention strategies and communicate prevention strategies to staff.

Create a dementia-friendly environment.

Establish a team of skilled and knowledgeable staff who:

- understand the impact dementia has on the person
- validate the person's reality and emotions
- are respectful in their interactions with the person with dementia and support their dignity
- use effective verbal and non-verbal communication techniques.

Referral

- Healthcare professionals trained in the assessment and management of responsive behaviours. These include:
  - Dementia Support Australia (1800 699 799)
  - geriatrician
  - old age psychiatry services
  - psychology services
- Occupational therapy for assessment and advice on functional capacity or environmental modifications
- Physiotherapy for exercise prescription
- Environmental design services for environmental modifications
- Review by a specialist or RMMR when multiple psychotropic drugs are being used
- Hospital outreach services for treating medical illness and preventing hospitalisation
- Dementia Australia for family support, counselling and advice
- Dementia Training Australia for training

Evaluation and reassessment

Ongoing monitoring is essential to identify:

- the effectiveness of each intervention
- any changes in the behaviour
- to what extent the behaviour changes
- how the change is demonstrated.

Establish a formal monitoring plan that involves input from the interdisciplinary team, person with dementia and family members.

Initiate ongoing observation of the person (a behaviour chart is a useful tool for monitoring change).

Adjust interventions as required.

When medication is commenced, regularly review and monitor for:

- response to treatment (impact on target behaviour or symptoms)
- emergence of adverse or side effects including changes in cognition, extrapyramidal symptoms and anticholinergic effects (for example, dry mouth, constipation, urinary hesitancy and delirium) when using an antipsychotic
- the ongoing need for antipsychotic therapy.

If there is no improvement, or the behaviour worsens:

- return to the assessment and identify alternative interventions and continue monitoring
- seek advice from specialist services (Dementia Support Australia, old age psychiatry services).

Resident involvement

- Provide education and psychosocial support to the person with dementia and/or their family that aligns with the person's individual needs and the stage of dementia.
- Provide an explanation of the underlying causes of responsive behaviours to the person with dementia and/or their family.
- Develop the assessment and care plan in collaboration with the person with dementia (where feasible), their family and the interdisciplinary team.
- Support the person with dementia's ability to be involved in decisions about their care.

Staff knowledge and education

Residential aged care staff should be educated and trained in:

- dementia care (consistent with their role and responsibility)
- communication skills
- person-centred care (rather than task-focused care)
- managing responsive behaviours
- managing and de-escalating violence, aggression and severe agitation
- non-pharmacological interventions.

Nurses and medication-endorsed workers must be trained in the correct use of benzodiazepines and antipsychotics for the pharmacological management of responsive behaviours.

Evidence base for this standardised care process

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Recognise the presence of changed behaviour

Conduct a risk assessment

High risk or behaviour severity

Implement interventions to minimise harm and distress

Low or moderate risk or behaviour severity

Commence a comprehensive assessment

Exclude or identify and treat reversible causes

Commence a behaviour chart to identify patterns triggers

If behaviour has not resolved

Gather information about the person

Review the built environment

Review the social and cultural environment

Review staff factors

Careful analysis of the assessment results

Formulate an intervention plan informed by assessment outcomes and the persons background, preferences and ability

1st line response non-pharmacological interventions

2nd line response pharmacological interventions

Monitor efficacy of the interventions and adjust as required

Monitor pharmacological interventions for side effects

Review

Initiate antipsychotic withdrawal within 12 weeks of commencement

If target behaviour has resolved, initate preventative strategies

If target behaviour has not improved, reassess

Important note: This SCP is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. It is just one element of good clinical care decision making, which also takes into account resident/patient preferences and values. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. To the extent allowed by law, the Department of Health and Human Services and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

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