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% of people with dementia at some stage and these behaviours need individual management (Therapeutic Guidelines, 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).

Definitions
Responsive behaviour: a 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).

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).

Psychotropic medications: are 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, May 2013)

Antipsychotic medications: are used primarily to treat psychotic disorders. Risperidone is the only antipsychotic drug that is TGA approved for use in dementia (Therapeutic Guidelines Limited, 2018)

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

Clinical risk: is where action or inaction on the part of the organisation results in potential or actual adverse health outcome on consumers of health care (Department of Health, 2012, p5)

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

Acknowledgement
This SCP has been developed and reviewed by the Australian Centre for Evidence Based Care, La Trobe University for the Department of Health and Human Services based on the best available evidence in 2018.
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 the treatment of any new co-morbid 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
- All actions taken should be documented
- Establish a review plan to consider continuance or withdrawal of treatment.
- Commence antipsychotic deprescribing once the target behaviour is controlled or adverse effects are evident
- Instigate strategies for the prevention of responsive behaviours occurring in those at risk

Referral

- Health care professionals trained in the assessment and management of responsive behaviours.
- 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/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, as this supports recognition of a change. The 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 or harm. This will include identification of:
- 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
- the swift introduction of 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 (NPI) and Behave AD. Tools measuring targeted behaviours include: the Cohen Mansfield Agitation Inventory (CMAI); the Revised Algase Wandering Scale (RAWS) and; the Apathy Evaluation Scale (AES)

Identify or exclude physical, medical and psychological causes for the behaviour. These include but are not limited to:
- delirium, particularly if there is acute change from 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 Constipation SCP)
• dehydration (See Dehydration SCP)
• hunger or low blood sugar
• depression or anxiety
• hallucinations and/or delusions (psychosis)
• withdrawal associated with drug, alcohol and 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 individual staff and the team 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
• work place demands on staff
• effectiveness of clinical leadership

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

Review the indoor and outdoor environment including:
• stimulation and noise levels
• physical layout
• personalised and familiar bedroom surroundings
• lighting
• overcrowding and lack of privacy
• access to the garden
Document the assessment findings.

Analysis of the comprehensive assessment data
A skilled and experienced member of staff, in collaboration with the person with dementia, family and care team conducts a careful analysis of the underlying cause of the behaviour (or behaviours) 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 and concept mapping

**Interventions**

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

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

**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
- their 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/prefer red 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 the treatment of hallucinations or delusions, depression, anxiety or other underlying health conditions such as delirium
- when the risk of harm to the person with dementia and/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 a Residential Medication Management Review (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 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 2 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 as 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/nominated decision-maker. Risks associated with antipsychotic medication include:
  - hospitalisation
  - falls
  - worsening cognitive impairment
  - cerebrovascular events (stroke, transient ischaemic attack (TIA))
  - 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 commencing 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 1-2 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

**Prevention of 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 the 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**

• Health care professionals trained in the assessment and management of responsive behaviours. These include:
  – Dementia Support Australia (DSA) (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 Residential Medication Management Review (RMMR) when multiple psychotropic drugs are being used
• Hospital outreach services for treatment of medical illness and prevention of 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.
Ongoing observation of the person (use of 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 (e.g. 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 (DSA, old age psychiatry services)

**Resident involvement**

• Provide education and psychosocial support to the person with dementia and/or their family that align 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)
• the management of responsive behaviours
• the management and de-escalation of violence, aggression and severe agitation
• non-pharmacological interventions.
For nurses and medication endorsed workers, the correct use of benzodiazepines and antipsychotics for the pharmacological management of responsive behaviours.
Evidence base for this standardised care process


NSW Ministry of Health and the Royal Australian and New Zealand College of Psychiatrists 2013, Assessment and management of people with behavioural and psychological symptoms of dementia (BPSD), NSW MoH/RANZCP, Sydney.

O’Toole G 2017, CAUSEd: effective problem solving to support well-being, *Australian Journal of Dementia Care*, vol.6, no. 1, pp.15-16

Registered Nurses’ Association of Ontario (RNAO) 2016, Delirium, dementia, and depression in older adults: assessment and care, RNAO, Toronto.

Recognise the presence of changed behaviours

- Conduct a risk assessment
  - High risk or behaviour severity
    - Implement interventions to minimize 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

- Formulate an intervention plan informed by assessment outcomes and the person's background, preferences and ability
  - 1st line response - Non-pharmaceutical interventions
    - Monitor efficacy of the interventions and adjust as required
  - 2nd line response - Pharmacological interventions
    - Monitor pharmacological interventions for side effects
      - Review
        - Initiate antipsychotic withdrawal within 12 weeks of commencement
          - If target behaviour has resolved, initiate preventative strategies
          - If target behaviour has not improved, reassess