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Faculty Disclosures:

Dr. Baker has disclosed that he has no relevant financial relationship(s).

Ms. Wheeler has disclosed that she has no relevant financial relationship(s).

Mr. Vozella has disclosed that he has no relevant financial relationship(s).

Webinar structure

- This introduction
- “IDT” approach
  - Ms. Wheeler: evaluating behaviors – concepts for staff
  - Mr. Vozella: the role of life-engaging activities in dementia care – the why and how
  - Dr. Baker: discussion of Medical Director and physician/NPP roles
- The IDT at work: case presentations
Carrie Wheeler, CRNP, GNP-C

“Good evening. Tonight I want to discuss a little bit how best to teach your team how to work on problem behavior, and I’d just like to preface this by saying problem behaviors mean problems for the residents along with the staff; and sometimes you need to separate how much of the problem really impacts on the staff and how much versus how much of it impact the residents themselves.
So, first of all, many of the problem behaviors can be traced back to the four A’s, which are

- **Amnesia**, which goes along with the dementia – these are the problems such as, I have “I haven’t seen my husband in weeks,” or “I haven’t eaten,” or “I don’t need to eat; I just had my breakfast”;
- **Aphasia**, where folk can’t find words or understand words that are spoken to them – this is equated to being in a foreign country;
- **Apraxias**, which are large motor movements, which are dressing or eating – folks tend to lose that ability further along in the dementia process; and
- **Agnosias**, the ability to identify objects and people, a system by not being able to recognize a bathroom is, what toilet or a sink are utilized for; and edible versus inedible foods – what are the non-edible foods.
To evaluate problem behavior, what we use is the 5D process:

- Describe
- Decode
- Design intervention(s)
- Do it
- Determine if plan is successful

First is, describe what the behavior is; this included the “what”, which means what is being exhibited by the resident; what place does this occur; where does this occur; and who is usually involved when the resident is exhibiting this behavior. The reason we look at this is to see if they are trending, number one, is also helps us decode, perhaps, what it is that’s contributing to these behaviors.
The decoding process I equate to being both a Sherlock Holmes and also working through these (realizations) as a translator, because basically you need to go in there and speak dementia in order to decode why the resident may be exhibiting this behavior. Does this have to do perhaps with their “pre-morbid” personality? What type of job did they hold? We know that night-workers have a great deal of difficulty, once they develop dementia, with sleeping during normal sleeping hours. What was their lifestyle like? And also their pre-morbid habits?

We also need to look at that point about delirium – possible med-to-med interactions, or if there are co-existing medical conditions that may be contributing to this behavior.

We design interventions - which is the “what”, usually this is the team approach of about between social work, activities, nursing staff, doctors, and non-physician practitioners. We develop that plan, and then we do it. You need to have the entire team on-board with what the approach will be. And finally, you need to determine if your plan is successful; you need to re-evaluate whether your behaviors have gotten better, gotten worse, or stayed the same. Many times, the first time around we need to modify what our interventions are in order to reach a final conclusion.
Some of the types of behaviors that may be exhibited are verbal – these are the repetitive phases or requests such as “help me, help me”; they may call out a caregiver’s name repeatedly; there may actually be some threatening or obscene language; or screaming. We need to remember that loud does not always mean that they are angry; this may be fear or need for reassurance.

**Verbal**

- Repetitive Phrases or requests
- HELP ME, HELP ME
- Calling out caregivers name repeatedly
- Threatening or obscene
- Screaming
- Loud does not always mean angry- may be fear or need for reassurance
Some of the causes of verbal repetitive phrases are: difficulty with communicating what you need (again resident speaks, dementia speaks—and if you can’t interpret what they are saying, it is very difficult to assist them with that); also difficulty with understanding what I am asking you to do (if a staff member comes up to a resident and uses long phrases and asks for more than one task at a time, many residents become overwhelmed and they react verbally; they may be afraid and have some fear (again, if you consider the fact that you have been ripped out of your home and placed in a foreign environment, and you have people talking to you that you don’t understand, you may react that way); there may be some physical needs—hunger, thirst, the fact that they may need to be toileted or that they may already be dirty. They may be having pain, and that really should be the first thing that we look at. Also we tend to place
residents in chairs with alarms and not allow them to move freely – maybe they just need to get up and stretch their legs, or perhaps you can take them for a walk. They may be too hot, they may be too cold – many of our residents are wearing briefs, and a pair of hipsters, and a pair of sweatpants on top of that, which can be extremely uncomfortable for them. They may have emotional needs, where they just need a kind word; or again, the environmental needs, which is - are they sitting comfortably, have they been allowed to stretch their legs recently? Is it too bright? Is it too noisy? And what is the physical layout of the area that they are sitting in?
### Interventions - verbal

- Address physical needs
- Calming environment - lights and sound
- Distraction
- Redirection
- Reassurance

*Best interventions present communications and simple words or actions, or to demonstrate or to use what we call ‘charades’ in order to make a point across. You should always address physical needs, a calming environment such as light and sound (overhead paging – which most facilities no longer use, can be a big problem), television is too loud, multiple radios, even staff can become very loud at times. You can attempt to use some distraction with them – basically changing the subject or taking them along to do something else, or re-directional reassurance.*
Some physical exhibits of behaviors are restlessness or pacing, they may hit, bite or scratch, they may pinch or spit, they may exhibit wake reversal, inappropriate undressing, inappropriate exposing, or the Sundown phenomena.
Restlessness can usually be linked to again, pain, hunger, thirst, or the need to be toileted, or already being incontinent. You need to check the environment for sensory overload – again, noise or excessive lighting. You should re-direct into meaningful physical activities – many of our residents who were housekeepers, they enjoy folding, or a lot of physical activities such as simply taking them for a walk showing them the outside of their window. Keep them engaged in their favorite activity or change the activity type if they are still not wanting to sit for a period of time. And most important, attempt a rest period, that should be in their routine. Many of our residents are waking very early in the morning and really don’t get their down-time during the day – sometimes just putting them into a recliner for fifteen or twenty minutes for a power-nap helps greatly with the afternoon.
When we have residents who undress or expose themselves, we know that it’s normally not sexual in nature, and we can gently re-direct them. Many times it is a sign that they need to be toileted (again, I can’t tell you that I need to go to the bathroom, I can just start stripping my pants off. I may also already wet or soiled.) If they are sitting at a very warm area, they may be taking their clothing off to cool themselves. We need to dress our residents in comfortable clothing that is non-constricting – once again, if you have somebody in a brief and a set of hipsters and a pair of jeans or pants that are uncomfortable for them, that is three layers that can make them extremely uncomfortable and they may feel the need to take that clothing off. A lot time, if residents are bored, that’s the first thing that they will do is attempt to take their clothing off.
Some of the interventions that have been very successful here at Copper Ridge are the use of ‘onesies’ – which zip up the back (it discourage the resident to undress because the top and bottoms are connected), or reversing a belt and putting toward the back, especially for the gentleman, makes it more difficult for them to get their pants off.
We also have a lot of residents that have a traditional ‘Sun-downing’ – this is a diurnal variation in their behaviors; it may be secondary to visual miscues - as the darkness starts in the corners they tend to resemble items that may be fearful for them; they may be tired (again, that may be the “witching” hour”). It is a primitive reflex; we know that our ancestors, as the sun went down, had to be hyper-vigilant because there was a lot of danger out there. So some of our residents exhibit that primitive reflex once again and become extremely hyper-vigilant, and this may be shown by agitation.

To draw the shades before sundown, and provide artificial light with gradual dimming; we found that adjusting the environment significantly reduces the amount of ‘Sun-downing’ in our residents.
If folks have sleep/wake cycle reversal, most importantly it’s to find out what their pre-morbid sleep and wake was; it’s very difficult to change someone’s underlining sleep disorder. Night-workers, folks that perhaps slept in recliners most of their adult lives, or slept on the couch watching TV to fall asleep – it’s very hard, once they develop dementia to redirect them away from that. Their environment should be comfortable temperature and lighting; most importantly keep them awake and engaged during the day; if allowed to nap too much, by bedtime they don’t really have that much of a need for sleep. Exercise in always wonderful – it could something as simple as throwing a ball around or going for a simple walk. Toileting and a snack before bedtime sometimes help tremendously because they don’t have that urge to climb out of bed, and normally their stomach is at least comfortably full. There should be some winding down before bed and no stimulation;
they should not be engaging in physical activities or watching any television that may add to that; soothing music, diminished light helps quite a bit, and routine is extremely important. They should be allowed to go to bed on their time but it should be a consistent time every evening.

We want to make sure that their environment is adjusted to make it comfortable for them. A bedroom should look like a bedroom. And they should be encouraged to only be in their bedroom at nap-time or at night for sleep. It should be safe for them, free from obstructions; the lighting should be appropriate so that if they do wake up during the night there are not a lot of shadows in the corners. It should be fairly quiet, unless they are used to sleeping with the television or a radio on. Bed alarms are very, very difficult because every time they sometimes they roll in bed, that goes off and can disrupt sleep. Visual cues such as having either a nightlight on or a bathroom door open sometimes helps.
Some of the ADL interventions that we’ve tried for problem behavior have been: for bathing - using some previous preferences - if the time of day – a lot of people preferred to bath in the evening as opposed to the morning. What type of products did they use - soap, shampoo, or did they use some type of shower gel? Did they enjoy a tub bath or a shower? Also, some of the older folks tend to take a bath only once or twice a week, or at the very most, twice a week; it may be difficult to get them to change old habits. The room should be at the proper temperature.

Plan for success; have the supplies ready – there’s nothing worse than getting a resident into the bathroom for a shower or a bath, and them having to stop, leaving them without their dignity, while you run out to get towels and washcloths. Privacy is important – a bath blanket sometimes

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<td>- Use previous preferences - time of day, products, tub vs. shower</td>
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<td>- Proper temperature of room and water</td>
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<td>- Plan for success - have supplies ready</td>
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helps for those who are a little shy. Clothing should be removed and be out of sight, out of mind – in other words, once they are undressed for a bath or a shower, their clothing should be stashed somewhere where they can no longer see it. Lavender or vanilla scents sometimes helps with relaxing, and keep their hands busy and let them help – washcloths in their hands, or soap, or bottle of shampoo that’s not opened – they tend not to scratch or pinch if their hands are occupied. A lot of people develop a fear getting into a tub or a shower because they are afraid of falling. Sometimes having a contrasting mat available, a shower chair that might be brightly decorated with some towels does help.

We also tend to not to use the word bath, or tub, or shower, if the patient is afraid; we may say “let’s go freshen up” or “let’s just go for a walk” and gently guide them down the hallway in that direction.
If we have residents who have difficulty with getting clothing or getting dressed due to their apraxia, we offer them one or two choices only, “would you like to wear your red outfit or your blue outfit?” Many residents develop what they call their uniform of the day, who only wear black pants and a red shirt every single day, so we encourage the family to bring in five or six sets of the identical outfit so that we can safely remove the dirty clothes and offer them a fresh outfit every day, and they are very content to do that.

Hanging clothing up the following morning tends to help with getting them dressed. Avoid zippers and buttons; it’s very difficult to sequence, sometimes you need to lay out the one item at a time in cue, give them some patience, sometimes if you start the process for them then they are
able to assist with getting dressed and you don’t have to have as much of a fight with them.

Maintain, again, privacy, if possible. Also it’s OK to wash and dress them the night before if it’s a challenge in the morning. Because of the diurnal variation, some residents are much easier to handle at bedtime to get their tub-bath or their shower, and you can dress them in clean clothes in the morning. There is absolutely nothing to say that someone can’t sleep in clean clothes.
For toileting, if they don’t have the ability to understand that they need to go to the bathroom, can they understand the sense of urgency? Can they find the bathroom? Can they locate the toilet in the room? Some of the interventions for people who tend to use object that are not toilets, like a sink or a trashcan, is to make toilets in a contrasting color, or use fluorescent on it. Also, for gentlemen, we can try to put a target in the bottom of the toilet for them to aim at, that helps significantly. Can they remember what to do once they are in the bathroom, or locate the toilet? Some folks can find the bathroom but then have a lot of difficulty getting their clothing off, and completing the process of actually wiping themselves, cleaning their hands, and re-dressing themselves.
And constipation and urinary tract infections – if this is an issue for them, makes it much more difficult and does bring the behaviors out. These are the first things that we look at if someone has now had a change in their behaviors from their baseline.
Further along in dementia, patients tend to not eat as well; they develop anorexia; sweet and salty are the last to go. There’s no shame to adding some additional salt and sugar to meals for people in the end stages of dementia to encourage them to eat. They may have some apraxia to utensils; they should be given finger foods or mugs with handles to make it easier to get their food into their mouths; this is for residents who will not allow you to feed them. They should be given one food at a time; preferably on a small plate with a contrasting color (blue plates work very well for a contrast). They may need to have a plate guard or a buffalo plate with separate sections in it in order for them to complete their meal.

The environment the sound and smell – it should be a social environment for them. If they are suffering from constipation, GERD, dehydration, or
pain, these need to be addressed in order to encourage them to eat. Also, we have trouble with folks again who don’t understand what’s edible and what no longer is edible -and this really is just a need to monitor them more closely.

We have a lot of residents who pace, or are very restless; we do what’s called ‘eat on the go’ – every time they pass a staff member we hand them a cup with a few bites of food in it that they can eat as they are running along – Cheerios, fruits such as grapes cut in half – are very effective for that.
Verbal

- Supply word if struggling - allow to complete thought - Don’t put words in mouth - repeat back statement to assure your understanding
- If repetitive - respond once and then change subject - Don’t become repetitive yourself
- WORDS MAY NOT HAVE INTENDED MEANING - listen for the “flavor” not the substance of the words
- Focus on what is retained - not what is lost

If a resident is becoming very frustrated with their verbal skills, you can help supply the word if they are struggling, you should allow them to complete their thought – don’t put words in their mouth, but mirror back to them their statement to them to that you can be sure of what they are saying to you. If they are extremely repetitive, we advise our staff to respond once and then change the subject, don’t become repetitive yourself. Words may not have the intended meaning – you need to listen for the ‘flavor’, not the substance of the word. And focus on what is retained, not what is lost. Pictures work extremely well. Miming works extremely well.
Some non-verbal interventions are the consideration that the elbow to the wrist is considered a “safe zone”. If you need to guide somebody because they are becoming agitated, this is an area that is safe for both the resident and for yourself; it’s very difficult for them to swing at you if you hold them in that area. It’s also a non-threatening area for a resident.

You should always try to get to their eye level and make eye contact with them so that they can see your face and interpret what’s going on in there. Your body language is extremely important – just as what they are saying to you may not have any type of meaning, what you’re saying back to them they may have difficulty interpreting. But a smile - a relaxed affect, reflect a relaxed habitus - really goes a long way with a very demented resident. Your facial expression, again, should show that you are relaxed, that you
are not angry or hurried. Tone of voice – kind of self-explanatory, not loud, it’s not necessary to yell in their ears; even the hard-of-hearing residents tend to hear fairly well if you get at their level. And use pictures or charades. When you do want to communicate, it should be short and to the point – one to two words – “go to the bathroom”, “use the toilet” – very succinct. Too many words are very confusing.
Some of the ‘pearls’ you should keep in mind: firstly, assess for unmet physical needs – again, this could be pain, hunger, thirst, temperature, or the fact that they may need to be toileted. Provide for some rest periods – a tired resident tends to act out more than someone who is well-rested. Glasses and Hearing Aids – I can’t emphasize enough how important it is that the residents wear their glasses if they need them, and are able to hear you. It really helps a great deal with the communication with them. Use very short and simple sentence with cues, and these are usually physical cues such as showing by example or charades. Be concrete – we’ve had some residents that we’ve redirected from using crayons, for example on the wall in their rooms, and they go back and use a pencil, because you didn’t say “don’t draw on the wall”, you basically said “don’t
use the crayon on the wall.” So you need to be very concrete and not use any type of a distraction, they really don’t understand that.

The environment should always be adjusted for their comfort. Many times we will see our staff walking around in short-sleeved scrubs, but we have our resident in sweat suits and sweaters and jackets some times. Look for glare and shadows which can be misinterpreted. Monitor for noise – television, staff. Clutter that might be around – it’s very confusing. Distract and redirect.

And most importantly, you should get on the bus. But that means re-orientation does not work in this group. If they are having a day that they are just riding around somewhere on the bus or they’re on the train, or they’re out on a cruise ship – you just get right on there with them.”

- Carrie Wheeler, CRNP, GNP-C

(AMDA Webinar - “The True Meaning of Non-Pharmacologic Management of Behavior Symptoms in Older Adults with Cognitive Impairment” - presented December 13, 2011.)