What works in Challenging Behaviour? What care staff think is most helpful.

Lorna Mackenzie
Ian James
Newcastle Challenging Behaviour Service
76 homes (residential, nursing and Elderly Mentally Infirm).

Problematic behaviours include:
- Aggression (verbal and physical)
- Disruptive vocalisations (shouting)
- Sexual dis-inhibition
- Agitation
- ‘Attention seeking behaviour’
- Inappropriate urination/faecal smearing
• Such behaviours are common
• Historically most difficult treated with antipsychotic medication.
• Over 25% of people in care with dementia who present with challenging behaviours are prescribed such medications
• Limited efficacy of pharmacological approaches
• Risks
• UK Dementia Strategy. Time for Action. Always as a last Resort.
KEY FACTORS IMPACTING ON OUR CLIENT GROUP

- Sensory loss
- Mental health issues
- Physical decline
- Poor treatment regimes
- Loss
- Care staff related issues
- Lack of shared sense of reality
- Financial issues
- Intellectual decline
- Inadequate resources
- Loss of insight
- Polypharmacy
- Inappropriate environments
- Reduced communication abilities
- Complex life histories

CLIENT in care home
Aims of the Newcastle Challenging Behaviour Service

To treat challenging behaviour in a competent and staff-centred, person-focussed manner;
- To provide a biopsychosocial model of care in which pharmacological and non-pharmacological interventions were given as part of a rational treatment plan;
- To treat challenging behaviour in the setting in which it was being exhibited, as the settings are often linked to the behaviour;
• To work collaboratively with care facilities to improve the well-being of people in care;
• - To prevent unnecessary admissions to hospital;
• - To facilitate effective discharges from hospital to appropriate care settings;
• - To facilitate transfers of patients to appropriate care settings (from hospital to care facilities and between care facilities);
• - To develop links with statutory and regulatory organizations (eg. CQC).
• The NCBS use a formulation-based approach working with people with or without dementia, via their carers.

• Formulation involves developing an explanatory story which makes sense of an individual’s behaviour based on the information gathered at assessment.
Columbo Approach

- Being detectives – establish the facts
- Being inquisitive
- Putting the pieces together, generating a narrative
- Non-threatening way
Newcastle Model

- Physical health
- Mental status
- Medication
- Environment
- Cognitive status
- Behaviour

- Pre-morbid Personality
- Life story
- Need

- How John appeared at time of incident
- What John said at time of incident
JESSIE – AGED 77
Residing in a Nursing Home

- Jessie is noisy and disruptive when sitting with other residents.
- Jessie will slap her face and other parts of her body.
- Jessie is physically aggressive mostly towards staff but also towards other residents.
• Whilst checking notes in the home it was noted that, 3 months previously, Jessie had accused a member of staff of slapping her across the face; there was no evidence for this but it resulted in a member of staff being suspended when Jessie’s daughter called the police.

• Jessie had also accused staff members of stealing her watch. Staff could not understand why Jessie was being so “horrible”

• NPI-D
  Frequency and Severity 37
  Caregiver Distress 17
Returned one week later

• Advised by the nurse that, as a result of keeping the charts, staff had themselves discovered some of the reasons for the behaviours Jessie was displaying namely:
  1. Jessie was bored and
  2. Their lack of knowledge about dementia, in particular how to communicate effectively, might be contributing to poor approaches when they were attending to Jessie’s hygiene needs.
• Arranged a teaching session on Dementia one week prior to the Information Sharing session.
• At both sessions staff experienced, by use of exercises and role play, some of the emotions felt by Jessie e.g. emotions experienced during ‘hands-on’ care and frustration experienced by Jessie when staff were communicating with her.
Life Story

• Born and brought up in Newcastle


• Went to school in Benton. Has lived in Scotland. Brothers and sisters – Beattie, Sarah, John, Bill, Rebecca and Gordon (Gordon, 84, is the only one still alive, in Melrose) Went to school in Newcastle. Met husband Andre when she was 11. She married Andre when she was 19 and he was 40 – he was a French engineer. He died in 1995 at the age of 95.

• They were together for over 50 years. Andre was born in Czechoslovakia. He was the youngest of 12.
Life Story (cont’d)

- Had 2 sons – Stephan and Andre and 2 daughters – Colette and Marie (daughters do not appear to get on).
- Worked as a domestic before she got married then worked in a shop.
- Had a good friend called Jilly – used to go to keep fit with her. Another good friend was Millie who she used to live beside.
- Used to go to church every Sunday – Church of England initially then Methodist Church – likes hymns.
Personality

- Good sense of humour. Friendly, bubbly, never stopped talking. Very caring. Even tempered
- She and Andre would lie in bed talking in the middle of the night. Loved pets – lots of pets buried in the garden.
- Likes being touched by women relatives.
- Easily embarrassed. Very private. Would refuse to be seen by a male GP in the past, it always had to be women.
• Used to have a cat called Fluffy, a big fluffy cat, who she was very fond of. Fluffy lived until she was 18½.
• Likes: cold milk. most foods but has to have a pureed diet because of her dysphagia.
• Loves children. Company of any kind. TV. Got Daily Mail every day. Shopping. Went to shops in town almost every day. Went to Jesmond Dene most weekends during the summer.
• Dislikes: hot drinks especially hot milk. Xmas cake. Spicy food. People being over familiar.
Personality (cont’d)

- Hobbies – Keep fit, cinema – old films. Used to go to Jesmond Cinema.
- Never wanted to be in care. Wanted Marie to look after her (Marie feels guilty about this)
Social Environment

Has been in Primrose House for 6 years. Prior to that she was in another home for 6 months. At that time walked with zimmer.
Medication

- Warfarin, Frusemide, Senna, Atenolol
- Temazepam 10mg nocte (had been on this for at least 5 years)

Mental Heath

- No past history

Neurological

MMSE April 2007 17/30
MMSE June 2008 10/30 - 0/3 Recall
Physical Health

- CVA x 5, Transient Ischaemic attacks
- # right ankle, #left tibia, dislocated jaw
- DVT
- Dysphagia (sometimes pockets food in her cheeks)
- Angina
- Can no longer mobilise. Uses a wheelchair.
Triggers
• Trying to change her
• Boredom

Behaviours
• Will try to kick people passing or will attempt to hit people with the strap from the hoist.
• Will also slap her thighs/head or legs which other residents find distressing.
• Will sit and blow ‘raspberries’ for long periods of time
What she said at the time of the incident

- “Pigs” Get off”. Liar, liar – I didn’t hit you. I never hit anyone
- Shouting, will also be verbally abusive

How she appeared at the time of the incident

- Angry
- Restless, frustrated, irritable and angry
Needs & Possible Thoughts

1. Jessie is trying to meet her need. She doesn’t want the carers attending to her. The need is for care interventions to be more acceptable to her. To understand that staff are trying to help her.

2. From the ABC charts completed by staff, it was identified that Jessie is most likely bored, so again she is trying to meet her need and in this instance it is occupation. Unfortunately, owing to her dementia, Jessie does not have the insight to know that how she was trying to keep herself occupied was inappropriate.
Attending to Jessie’s hygiene needs

Be aware of your non verbal communication.

• Don’t approach Jessie from behind – this could alarm or startle her and will not put her in the best frame of mind for interventions.

• Smile when approaching her so that she can see your intentions are friendly

• Try to get her attention before you begin to talk

• Make eye contact, get down to her level

• Minimise any background noise such as the radio, TV or other people’s conversation

• Give Jessie your full attention
• Prior to commencing the intervention try to gain Jessie’s trust. Talk to her for a few minutes before you begin the intervention. Look at the page above for ideas e.g. talk about her cat or all the pets she had.

• Marie will bring in a photo album – look through the album with her. She loves to talk about children – tell her about yours. Could you sing one of her favourite songs e.g. ‘Daisy, daisy’ with her?

• Jessie may be more amenable to care interventions if we try saying “Jessie, it looks as though somebody’s spilt something on your clothes, they’re all wet. Let me help get you more comfortable” or “Jessie, you’ve been sitting on something wet. Can I help you get changed into something comfortable”?
Care Interventions (cont’d)

• Give a running commentary as Jessie has a poor memory.
• Ask her permission to do something e.g. “Is it ok if I………etc
• Use humour. Jessie always had a good sense of humour. She liked to talk about her brother in law – he always made her laugh.
• Try and ‘do with’ Jessie rather than ‘do for’ i.e. can she wash her face or dry her hands. What could she still do for herself?
• Let Jessie see that you understand how she feels e.g. “I know that you don’t like us helping you, but I’ll do my best to protect your dignity”
Introduce a rummage box/bag. Fill it with objects that Jessie can feel, smell or taste (bearing in mind her dysphagia). You can be quite inventive about what you put in the box/bag e.g. pictures of old movie stars (she likes the old films), brightly coloured ribbons, lavender bag, something red (her favourite colour), something to cuddle (doll, cat, teddy) etc.

• Try reading the newspaper to her.
• Look through her photo album
• An activity apron
• Place a CD/Tape player beside her and put on some music that she likes e.g. hymns, popular classical music, Donald Peers or songs from musicals such as Oklahoma.
• **Outcome**
  Challenging behaviours all but disappeared

• NPI-D on discharge:
  Frequency and Severity  3 (Previously 37)
  Caregiver Distress  0 (Previously 17)
NPI-D Additions – quotes from staff

• Jessie still does the leg and head slapping but that’s the sign for the staff that they need to be changing her activity - the sign she’s bored with what she’s got.
• More accepting of care interventions now – the strategy “Somebody’s spilt something on you” works a treat.
• Much better when she is left on her own now that she is occupied, although she is getting more interaction with staff – seeing her in a different light.
Quotes on NPI-D additions (cont)

• The raggy doll and interactive dog worked so well that we asked the family to buy her a baby doll – she adores it.
• Now that she is active during the day she sleeps better at night.
• She’s just so much happier.
• We’ve really appreciated the input from your service – it has benefited all the residents, not just Jessie.
‘Is the approach successful?’

Neuropsychiatric Inventory with Caregiver Distress (NPI-D)

- Completed on initial visit to the home - provides a good overall description of which areas are problematic and distressing for the person and for the staff.

- On discharge - gives us a measure of the change in frequency/severity of behaviours and caregiver distress.

- CBS devised Qualitative section to be used with the NPI.
<table>
<thead>
<tr>
<th>What do you think has helped to make the situation more manageable</th>
<th>Yes/No</th>
<th>A little</th>
<th>A fair amount</th>
<th>A great deal</th>
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<tbody>
<tr>
<td>Formulation/Information sharing session</td>
<td>Yes/No</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Typed out formulation and interventions</td>
<td>Yes/No</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>A greater knowledge of the person’s life history, personality etc</td>
<td>Yes/No</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Increase in consistency of approaches or different approaches by staff</td>
<td>Yes/No</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Change in staff attitude towards the resident</td>
<td>Yes/No</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Engaging the resident in an activity or keeping him/her occupied</td>
<td>Yes/No</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Medication – Change, reduction or increase</td>
<td>Yes/No</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</table>
NPI-D Additions – 71 cases (2007 – May 2009)

- Demographics – 27% male
   33% Female
- Age range 62 – 104. Average age 83
- Diagnosis – 63 Dementia. Others included depression, bipolar disorder, schizophrenia, anxiety, Learning difficulties
<table>
<thead>
<tr>
<th>Presenting problem</th>
<th>Frequency in sample</th>
<th>Percentage of sample</th>
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<tbody>
<tr>
<td>Physical aggression</td>
<td>30</td>
<td>42</td>
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<tr>
<td>Verbal Aggression</td>
<td>27</td>
<td>38</td>
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<td>Irritability</td>
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<td>7</td>
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<tr>
<td>Disinhibition</td>
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<tr>
<td>Agitation</td>
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<td>6</td>
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<tr>
<td>Wandering</td>
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<tr>
<td>Non-compliance</td>
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<td>3</td>
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<tr>
<td>Pacing</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Qualitative feedback from staff

• Staff understand the client now.
• Staff phrasing requests and statements in a different way.
• Talking to client about his life.
• Recording behaviours in a systematic way – evidence of what is happening changed perceptions.
• Daughter of client attended formulation meeting, which increased her understanding of her mother’s behaviours.
• More tolerant now that we know about her background.
• Staff more understanding … now recognise that what they thought was verbal aggression was just her way of bantering with them – she’s very sarcastic, but that’s her nature
• Because staff have thought about it and documentation was presented positively, staff think about it in a different way
Given that previously staff in care homes may have attributed behaviour change to medication, it is of note that only 7% of the score was given to medication.

Staff who receive formulation-led individualised-case interventions attribute much of the change to increased understanding of the client’s personality and history, which leads to a new conceptualisation of the challenging behaviour.