TRACS Community of Interdisciplinary Practice for People with Dementia

Assessment of BPSD

Questions that need to be asked to help understand possible etiology of the behaviour

(Weeks 7 and 8)

TRACS Community of Interdisciplinary Practice for People with Dementia

Learning Objectives

- To be able to describe important sources of information about the person and the BPSD
- To describe 3 types of information that need to be collected at the start of every assessment process
- To describe important steps that may need to be taken if risk of harm is imminent for the person with dementia, other residents or care staff
- To gain an understanding of important questions to ask during the assessment of BPSD

Learning Objectives (cont'd)

- To apply assessment information to theoretical models of BPSD
- To describe the core features of delirium
- To be able to differentiate delirium from dementia
- To describe basic underlying pathology leading to delirium
- To describe basic management for older persons with delirium

Assessment of BPSD

- Once you have identified that a BPSD is (or multiple BPSDs are) present, the next step is to determine how to help reduce the symptoms and improve the quality of life for the person with dementia
- This starts with a targeted assessment process
- A targeted assessment process means not working on assumptions (e.g., they must depressed… that's why the person is refusing to eat)

Assessment of BPSD

- Building on the person-centred theoretical frameworks from Module 3, it is important for staff and clinicians to not just assume that a given BPSD (e.g., agitation) arises in all patients for the same reason(s)
  - For example:
    - Not all people with dementia will vocalise due to underlying, and poorly managed, pain
    - Not all people who wander are doing that because they are feeling anxious

Assessment of BPSD

- The assessment process therefore relies on staff asking a broad range of questions to build an individualised formulation that helps explain why this particular individual is displaying this BPSD
- From the formulation, an individualised treatment plan can be developed that is based on the best available information about the person displaying the BPSD
- Therefore, a good understanding of the BPSD assessment process will help you to achieve a good outcome for the resident or patient concerned

Information to Consult

- Before you start you need to consider what sources of information are available to you to carry out the assessment process
- Such sources may include, but are certainly not limited to:
  - The person with dementia
  - Family carer
  - Family members or significant others
  - Occupational therapist
  - Diversional therapist
  - Physiotherapist
  - Kitchen & domestic staff
  - Chart entries
  - Care plan information

Assessment of BPSD – The Need for a Complete Picture

- Once the sources of information have been identified it is important to obtain a thorough understanding of the behaviour(s).
- Three types of information need to be collected at the start of the assessment process:
  1. What is the behaviour?
  2. Who is distressed by the behaviour?
  3. When does the behaviour occur?

Assessment of BPSD – The Need for a Complete Picture

1. What is the behaviour?
   - The behaviour needs to be described in as much detail as possible
   - Often you will hear people say – the person was aggressive or agitated – this unfortunately doesn't provide a useful description of the behaviour
   - Your ability to manage the BPSD will be all the better for having a clear understanding as to the actual behaviour being displayed

Assessment of BPSD – The Need for a Complete Picture

1. What is the behaviour? (cont'd)
   - Examples of what provides a meaningful description of the behaviour might include such detail as:
     - They have been entering other people's rooms and sitting on the bed
     - They have been refusing to eat or shower – they say "No! I don't want to!" every time the activity is attempted
     - They have become increasingly socially withdrawn and they no longer speak more than a few words to care staff

TRACS: Community of Interdisciplinary Practice for People with Dementia (CIP-D) Program

Assessment of BPSD – The Need for a Complete Picture

2. Who is distressed by this BPSD?
   - Is the person with dementia distressed? Are the care staff? And/or is it the family members who come and visit?
   - Why is the behaviour seen as distressing or upsetting? What is it about the behaviour that is distressing?
   - Do other residents become distressed by this BPSD – and does this impact on the problem?

Assessment of BPSD – The Need for a Complete Picture

3. When does the behaviour occur?
   - Onset – when did the BPSD start?
   - Time – what part of the day (be as specific as you can); during what daily tasks (e.g., showering); where does it occur; and does it only occur when particular residents and/or care staff are involved?
   - Frequency – how many times does it occur in a day? In an hour?
   - Duration – how long does each episode last?

TRACS: Community of Interdisciplinary Practice for People with Dementia (CIP-D) Program

Assessment of BPSD – The Need for a Complete Picture

3. When does the behaviour occur? (cont'd)
   - Severity – how distressing does the behaviour appear to be and what is the worst that could happen if this behaviour is expressed or continues to be expressed?
     - Is the person with dementia at risk of harm?
     - Are other residents at risk of harm?
     - Are staff members at risk of harm?
     - Are family members and visitors at risk of harm?

Risk of Harm?

- Points to consider with the assessment of risk of harm
  - If immediate risk of harm is identified then you need to consider immediate action
  - This may include the need to identify potential triggers for the behaviour and to put measures in place to prevent that trigger occurring (e.g., if they are hitting people with their golf clubs then remove their golf clubs)
  - The cessation of contact between the person with dementia and the "at risk" staff member or resident

Risk of Harm?

- Points to consider with the assessment of risk of harm (cont'd)
  - Consider contacting the resident's G.P., Psychiatrist, or Geriatrician for a consultation
  - If safety cannot be guaranteed consider a review for inpatient hospital admission
  - If risk of harm is not immediately indicated then the assessment can continue…

Data Gathering – Implications for Chart Entries

- In addition to behaviour charts, review chart entries for information regarding onset, time, frequency, duration, and severity of BPSD.
- The reality, however, is that chart entries often do not contain enough information.
- Therefore, as you are increasing your understanding of the assessment of BPSD, you will become increasingly aware of your own chart entries and how important they might be in the data gathering stage of treating BPSD

Data Gathering – Implications for Chart Entries

- Therefore, when you notice a BPSD, consider commenting on onset, time, frequency, duration, and severity at the time
- Also, be specific about which other staff members or residents were involved
- AND provide a detailed description of the behaviour – again avoid using one or two words to describe the behaviour

Assessment of BPSD

- Now that you have assessed risk and have obtained a baseline measure of the behaviour (e.g., onset, frequency, duration, and severity), gathering of broader history information is the next important step
- An older adult presents with a large amount of personal history. It can therefore be difficult, and often overwhelming, to determine what information is most important in the context of BPSD

Assessment of BPSD

- Some general information is important initially…
  - Where was the person born? – helps to screen for cultural or religious values
  - Did they grow up in the country or the city? – helps gain understanding of lifestyle
  - What was their main lifetime occupation and hobby? – helps gain information regarding interests
  - Did they marry? – helps screen for important anniversaries and lifetime social roles

Assessment of BPSD

- Now that you have a very basic understanding of the person, you need to find out other salient information to help you gain better insight into the person – remember all assessment and treatment needs to occur within a person-centred approach to care
- The following slides highlight some ways in which to gain good information quickly – particularly when speaking to family or friends of the person with dementia

Questions to Help you Start

- What things did the person really like (food, people, activities)?
- What things did the person really dislike? Were there any ways of speaking with the person that would make them angry? Were there any ways of talking about things that would make them anxious?
- Throughout their life, what things did the person do to bring themselves comfort when they were upset?

Questions to Help you Start

- What activities occupied a lot of their time?
- How did this person usually respond in stressful situations (i.e. did they withdraw and think things over or did they get angry and swear)?
- Do they have any cultural beliefs that they expressed frequently?

TRACS: Community of Interdisciplinary Practice for People with Dementia (CIP-D) Program

Questions to Help you Start

- Do they have any religious or spiritual beliefs that are important to them?
- Were they equally comfortable around males and females?
- Specifically for the person with dementia – ask in what ways could I change things to help you? – this however is dependent on the stage of dementia and cognitive status of the resident.

Questions to Facilitate Learning

Before we continue, here are some tasks to help you think about the assessment process in BPSD

1. Think about what would be the important questions to have answered regarding the cognitive status of the person with dementia?
2. What are some important questions to ask regarding personal history of the person with dementia?
3. What are some important questions to ask about physical health of the person with dementia?
4. What are some important questions to ask regarding mental health of the person with dementia?

Questions to Facilitate Learning

Before we continue here are some tasks to help you think about the assessment process in BPSD (cont'd)

5. What are some important aspects to consider regarding the communication by care staff to the person with dementia?
6. What are some important questions to ask regarding the way that care is provided to the person with dementia?
7. List important aspects to consider regarding the environment of the person with dementia

The following slides provide examples of questions for each of these areas. See how many of the questions you considered are inline with these slides…

Q1. Cognitive Status of the Person with Dementia

- What type of dementia does the person have? How does this inform the BPSD or triggers relating to the BPSD?
- Has there been a rapid decline in cognition? – this may indicate a process other than dementia impacting the BPSD (e.g., delirium)
- What cognitive difficulties does the person experience and how does this impact the person's BPSD or responses by staff to the BPSD
  - Are there memory problems that result in the person failing to remember how to complete personal care tasks?
  - Are there executive functioning problems impacting the person's ability to initiate pleasant activities?

Q2. Life History

- Who are important family members and friends?
- Do they have any current or past pets?
- What is their sexuality?
- Do they have any salient migrant experiences?
- What was their main life time occupation?
- Is there any history of trauma (sexual abuse, abusive parents or spouse, war trauma, stolen generation)?
- Are there any significant anniversaries (marriage, death of spouse, friends, children)?
- What activities did they used to enjoy?
- Where did they live for most of their life?
- What was their general communication style through their life (abrupt, passive, humorous)?
- Do they have any significant past psychiatric history (e.g. lifetime history of anxiety, depression, psychosis)?

Q3. Physical Health

- Are they experiencing:
  - Delirium*
  - Fever
  - Oral pain
  - Constipation
  - Urinary tract infection
  - Chest infection
  - Other illness
  - Adverse effects of medication
  - Poor sleep
  - Headache
  - Fatigue
  - Impaired vision (without easy access to glasses)
  - Impaired hearing (without easy use of hearing aid)
  - Itchiness
  - Dehydration
  - Too cold/hot

*(*Note that delirium will be covered in greater detail in later slides)*

Q4. Current Mental Health

- Do they have:
  - Symptoms of depression
    - Does the person express sad mood?
    - Do they show any positive emotions?
  - Symptoms of anxiety
    - Does the person report fear or worries?
    - Does the person show physiological signs of anxiety (e.g. tremor that exists only within the context of anxiety vs. Parkinson's symptoms)? Do any facial expressions represent anxiety?

Q4. Current Mental Health

- Do they have:
  - Post-traumatic stress disorder
    - Does the person report distressing dreams or are they experiencing phenomena associated with the traumatic event?
    - Is there any lifetime history of trauma?
  - Psychosis
    - Is there some form of perceptual disturbance present? (more common in certain subtypes of dementia – refer module 1)
- Note: mental health symptoms can overlap with symptoms of dementia. If concerned seek psychology/psychiatry consultation

Q5. Aspects of Communication by Care Staff

- Are staff:
  - Speaking too quickly
  - Being condescending
  - Not making eye contact
  - Not using person's name
  - Not using person's title (e.g., some may prefer Mrs Jones rather than Beverly)
  - Engaging in arguments with the person with dementia
  - Correcting mistakes – indicating failure
  - Reasoning with the person with dementia
  - Not using preferred language
  - Not being sensitive to cultural factors or ways of communicating given the person's culture

Q6. Care of Person with Dementia

- Are table settings for meals too cluttered
- More than one course at a time
- Inflexible meal times
- Poor interpersonal functioning with other members at their table
- Oral pain impacting eating
- Person's eating space not defined
- Insufficient contrast between table cloth and crockery
- Food not liked or culturally inappropriate
- Care plan not maintained
- Care delivery rushed
- Lack of gentle approach
- Too many staff involved
- Resident's not involved in their own personal care
- Bathroom – cold, claustrophobic
- No choices offered
- Poor choice of hygiene method used – shower instead of bed bath
- Poor assessment of resident's abilities to complete task
- Cultural or spiritual needs not integrated into care

Q7. The Environment Inside the Care Facility

- Overwhelming size
- No orienting cues (signs)
- Glare from light – on the floor or walls
- Noisy environment
- Too many people in a group
- Nil personalisation of personal space
- Room difficult to find
- Culturally or spiritually insensitive objects
- Lack of space to pray
- Lack of privacy

Q8. The Environment Outside the Care Facility

- Lack of points of interest
- Lack of colour
- Insufficient shade
- Does not encourage sitting
- Does not encourage walking
- Not easily visible from indoors
- Does not encourage engagement
- Physically unsafe paths leading to dead ends

TRACS
Community of Interdisciplinary Practice for People with Dementia

Stimulation

- Is there a lack of structured physical activity?
- Is the person bored?
- Can the person initiate activities or does the person need help starting the activity? (linked with changes in frontal lobe function)
- Are activities in line with the person's current abilities. For example, what type of dementia do they have, what neurological changes most frequently occur with this, and what cognitive functions are likely compromised? (all activity engagement needs to compensate for these variables)
- Is the person being given the opportunity to engage in activities that are preferred and personally meaningful?
- Are activities provided in an inflexible manner such that all resident's need to engage in the same sort of task?
- Are large group based activities appropriate (consider the PLST model)?
- Are smaller group activities better tolerated?
- Can the person remember or understand what steps are needed for successful completion of the task. If not, are alternatives available?

TRACS
Community of Interdisciplinary Practice for People with Dementia

Further Reading

- Have a read through the list of questions included in the document titled "Appendix 1_Questions to facilitate assessment" to give you an idea of the broad range of questions that might be appropriate depending on the BPSD being displayed.
- Use the Forum on the website to discuss what you like (and maybe also what you don't like, or would like more information on) in terms of the questions and more broadly the BPSD assessment process

Theoretical Frameworks and Assessment Questions

- If the preceding questions were to be asked during the assessment of BPSD this would still represent a lot of information.
- The job now is to take this information and to group the data into an evidence based-model of BPSD.
- As discussed in Modules 5 & 6, theoretical frameworks help to structure and make sense of this information. Recall that the models included the Needs-Driven Dementia-Compromised Behaviour model, the PIECES framework, the Progressively Lowered Stress Threshold Model, and the A-B-C analysis

Theoretical Frameworks and Assessment Questions

- How can understanding theoretical models guide questions you need to ask?
- Describe a theoretical model of BPSD and what types of questions you would need to ask to help understand a BPSD from this framework.

Develop Your Own Case Study

- Construct a case study of a person with dementia. Provide information about the BPSD in the example. Remember the important features related to detailing BPSD. Then provide information about the person's history.
- Using the case study you've developed, structure the information to fit a formulation based on a:
  - Needs-Driven Dementia-Compromised Behaviour Model
  - Readjust to form a PIECES framework
  - Use the information to fit in with a PLST model
  - Provide an A-B-C analysis of the BPSD

Delirium

- The following represents a very brief look at delirium as it is an important diagnosis to consider in the context of dementia
- Delirium refers to:
  - An abrupt change of consciousness or behaviour that is accompanied by a change in cognition (e.g., attention) that cannot be better accounted for by a dementia.
  - Delirium develops over the course of hours to days (compared with dementia which develops over months/years)
  - The symptoms of delirium can fluctuate throughout a 24 hour period

Delirium

- Delirium can occur with or without dementia – for the purposes of this course we will be discussing delirium within the context of it being superimposed on dementia
- Diagnosing delirium in a person with dementia is difficult. It is however very important to rule in/out, as delirium is linked to increased morbidity and mortality
- Also, when assessing BPSD it is important to consider if agitation is the result of a BPSD or if it may represent a symptom of delirium – a good assessment is therefore particularly important, helping you to gain information related to time of onset, whether the symptoms represent a gradual or abrupt change, and whether there is any variation in the symptoms

Delirium

- The change in consciousness may reflect:
  - A general deterioration in the persons awareness of their environment
  - Difficulty focusing or sustaining attention on tasks
  - Changes in sleep-wake cycles – e.g., an abrupt change in time spent sleeping during the day or increased frequency/severity of night time agitation. The day/night cycle may reverse.
  - Difficulty orienting to time, place and person

Delirium

- The change in cognition may reflect:
  - Changes in memory – an abrupt deterioration in recall of recent (or even remote) events
  - Changes in language – deterioration in expressive and receptive language skills. The person with dementia who is experiencing superimposed delirium may become aphasic or may have a new and abrupt onset of difficulty naming common objects (e.g., cup or pencil)

Delirium

- The change in cognition may reflect: (cont'd)
  - Disorganised thinking
  - Changes in perception – hallucinations or misinterpretations
  - Delusions - paranoia

Delirium

- Changes in behaviour
  - Increased restlessness
  - Agitation – increased vocalising (e.g., calling out, screaming or moaning)
  - Aggression – may physically hit someone due to perceived fear due to hallucination or thought disorder (paranoid delusion)
  - Hypoactivity – lethargic, withdrawn behaviour, quiet or increased drowsiness

Delirium

- Change in mood:
  - Increased anxiety
  - Increased irritability
  - Increased depressed mood
  - Labile mood (note: mood may not fluctuate for some persons with dementia who are experiencing a superimposed delirium)

Delirium

- Copy and paste this link into your browser for further information on guidelines for the management delirium produced by the department of health…

http://docs.health.vic.gov.au/docs/doc/Deliriu m-Care-Pathways-2010

Case Study - Delirium

- Now that you have an understanding of delirium, develop a case study that would represent a prototypical presentation of delirium in an older adult who also has a diagnosis of dementia.
- In your case study, be sure to describe the core diagnostic features of delirium and how the current presentation differs from the baseline presentation of the person with dementia.
- Provide information that may aid a clinician to understand the pathology that may be contributing to the state of delirium
- Then describe management strategies you would implement