Lecture Notes and Resource Kit

Poole's Algorithm

Nursing Management of Disturbed Behaviour in Aged Care Facilities

Aggressive, Confused or Inappropriate Behaviour

Is the person Aggressive?

Yes

AGGRESSION
Aim for safety - look for a stressor and remedy

Could there be medical problems?

Yes

No

Could the person have a Delirium?

Yes

DELIRIUM
Assess and treat cause

No

Could the person have Depression or a Mental Disorder?

Yes

DEPRESSION
or other mental disorder
Assess and treat problem

No

Could the person have Dementia?

Yes

DEMENTIA

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NSW HEALTH

Poole's Algorithm:

Nursing Management of Disturbed Behaviour in Aged Care Facilities

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Abstract

The management of disturbed behaviour in older people in residential care can present great problems for nursing staff and may result in poor outcomes both for the resident and the staff. A review of the literature shows a general consensus that early assessment of predisposing factors for delirium and depression, active treatment of those problems, the provision of a basic understanding of the cognitive deficits caused by dementia and the establishment of a supportive environment, can help to facilitate contented care for all involved. An Algorithm has been developed detailing, in order of priority, nursing assessment and management of aggression, delirium, depression/or other mental disorder and dementia, plus an outline of ways to develop a consistent care plan for supportive communication and care. The Algorithm is presented as a colour coded poster with an explanatory education workbook.

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Poole's Algorithm
Aged Care Facilities

Nursing Management of Disturbed Behaviour In Aged Care Facilities

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Poole's Algorithm:

Nursing Management Of Disturbed Behaviour In Aged Care Facilities

After taking part in this educational session, participants will be able to explain the use of Poole's Algorithm to prioritise assessment and management of disturbed behaviour in older people.

Learning Outcomes

1. Explain the principles of aggression management
2. Define the terms delirium, depression, mental disorder and dementia
3. Justify the order of assessment procedures
4. Outline nursing assessment and management procedures
5. Identify the major types of dementia
6. Describe the common cognitive deficits caused by dementia
7. Outline the requirements for providing care plans for older people with disturbed behaviour.

Figure 1: *Poole's Algorithm:* Nursing Management of Disturbed Behaviour in Older People

Aggressive, Confused or Inappropriate Behaviour

Instigate ❁ **Supportive Communication and Care Techniques**

Is the person Aggressive?
Yes → **AGGRESSION** Aim for safety - look for a stressor and remedy → Could there be medical problems? No → Instigate Supportive Communication and Care Techniques; Yes → Could the person have a Delirium?
No ↓

Could the person have a Delirium?
Yes → **DELIRIUM** Assess and treat cause → Could there be other medical problems? No → Instigate Supportive Communication and Care Techniques; Yes → Could the person have Depression or a Mental Disorder?
No ↓

Could the person have Depression or a Mental Disorder?
Yes → **DEPRESSION** or other mental disorder Assess and treat problem → Could there be other medical problems? No → Instigate Supportive Communication and Care Techniques; Yes → Could the person have Dementia?
No ↓

Could the person have Dementia?
Yes → **DEMENTIA** Assess and plan management → Plan ongoing care → Yes → Instigate Supportive Communication and Care Techniques

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AGGRESSIVE, CONFUSED OR INAPPROPRIATE BEHAVIOUR

Priorities for Management and Assessment

Is the person AGGRESSIVE?

If 'YES' ↓ If 'NO" go to next section page 6

AGGRESSION

Aim for SAFETY: Look for a stressor and remedy.
Overall approach: Non-Confrontation

1. Give person space (stand back)
   Calm, friendly, empathic approach,
   Meet the need or divert the attention
2. If Problem Persists - CALL for ASSISTANCE
   (Note the facility policy on use of restraint)
3. Don't hesitate to call 'Security' if any danger.
4. Afterwards evaluate (Behaviour Chart)
5. Debrief
6. Plan management
7. Follow the arrows >>>
8. ***Instigate ❁ Supportive Communication & Care Techniques***

An aggressive incident must be defused before assessment and treatment can take place.
Nurses have traditionally tended to approach their patients in a 'custodial manner' and psychosocial interventions receive little attention [1]. This can contribute to disturbed behaviour resulting in aggressive incidents especially by vulnerable people with sensory deficits or reduced neurological reserves.

The immediate approach should be to AIM for SAFETY and LOOK FOR A STRESSOR AND REMEDY, but be NON-CONFRONTATIONAL.

1. **GIVE the PERSON SPACE (Stand Back)** [2]. Those involved should stop doing whatever appears to be associated with the behaviour (e.g. changing a dressing), move out of range and remove any obvious stressors (e.g. people, equipment, noise, pain etc). However, it is particularly important to remember that if the situation is out of control and seems dangerous, then staff need to know how access the **SECURITY** arrangements of their particular establishment.

   The person may in fact be very frightened [2]. Despite any misgivings you may have, you should endeavour to settle a tense situation by modelling a CALM, **FRIENDLY, EMPATHIC APPROACH,** using the preferred name and by not arguing or disagreeing. Endeavour to empathise ("I can see you are upset. Can I help you?") and be particularly careful to listen to their reply and investigate any claims or accusations [3]. Bizarre things do happen. Always consider contacting the family and /or offer a phone call. The main aim is to **MEET THE IMMEDIATE NEED** as appropriately as possible, as sense will not prevail until that is satisfied. Think creatively and laterally about how you can meet the need safely.

   It may be helpful to attempt to **DIVERT THE ATTENTION**, particularly if there could be an element of dementia involved [4]. This might mean just walking away and returning with a different, smiling approach, or asking someone else to take over, or by changing the activity, or offering food or drink or a walk or company etc.

2. **IF the PROBLEM PERSISTS** it is important to seek help from senior staff and/or the medical officer and/or the family, quickly. If necessary, consider chemical or mechanical restraint in the least restrictive manner possible [3]. The last resort of mechanical restraint increases the need for supervision plus the facility's policy must be followed scrupulously - especially the need for a written medical order, the consent of relatives, frequent reassurance plus an observation and release time frame. The short term use of medications such as haloperidol (0.5-2mg) with small doses repeated often, is suggested [5,6,7,8]. Careful monitoring for signs of effectiveness or the development of Parkinsonian or extrapyramidal features is essential (e.g. facial spasms, restlessness, tremor, rigidity, stooped posture etc).

3. **Don't hesitate to call for help from the facility's designated SECURITY** staff if any real danger persists. A policy and protocol should be in place to support staff actions.

4. **Afterwards it is important to EVALUATE the event.** Review and discussion is important to ensure that this incident does not happen again. Documentation by way of a **Behaviour Chart** can be helpful in mapping and understanding events [2]. This should include: **A** - the ANTECEDENT - exactly what happened before the event; **B** - the BEHAVIOUR - exactly what behaviour occurred; **C** - the CONSEQUENCES - what response was there from others? (See Appendix A).

   The A or Antecedent is most important and is a description of the events immediately preceding the aggressive event, such as, 'I shook Mr X on the arm to wake him up' or 'Mrs Y sat down on Mrs Z's bed'. Look for the trigger or 'activating event' as well as patterns of activity that result from the behaviour, which could be implicated in the whole event.

5. Always remember to **SUPPORT the STAFF MEMBER and OTHER PEOPLE INVOLVED** and arrange a time to allow them to recount their part in the incident and ventilate their subsequent feelings. Incidents involving aggression are frightening for all involved. Staff motivation is positively enhanced when emotional needs are recognised and supported [9].

6. **With the 'ABC' in mind**, PLAN **the ongoing MANAGEMENT.** Always aim for a consistent approach with consideration of the possibility of personal misunderstandings, varied communication skills and prejudices both in the patient and the staff. Inform the medical officer and facilitate assessment for delirium and/or depression or other mental disorders. At all times **DOCUMENT** the events clearly, particularly in the management plan and in the ongoing **CARE PLAN**.

Could there be medical problems?

If 'yes' go to next section page 6, if 'NO' go to page 12.

Could the person have a DELIRIUM?

If 'YES' ↓ if 'NO' got to next section page 8

DELIRIUM

ASSESS AND TREAT CAUSE
Overall Approach: Support the person - define the acute disorder, instigate a remedy A.S.A.P

Definition: Delirium is an acute organic mental disorder characterised by confusion, restlessness, incoherence, anxiety or hallucinations which may be reversible with treatment.

1. Common clinical signs - acute, fluctuating, inattentive, disordered
2. Potentially reversible causes - medical, environmental
3. Nursing assessment: history, vital signs, environment.
4. Document, report (seek delirium screen), initiate appropriate treatment.
5. ***Instigate ❁ Supportive Communication & Care Techniques***

The immediate response to delirium must be to **ASSESS and TREAT the CAUSE** of the delirium. Therefore the **OVERALL APPROACH** must be to define the acute disorder and instigate a **REMEDY AS QUICKLY AS POSSIBLE**. A wide variety of diagnostic terms have been applied to delirium. These include confusion, acute confusion, pseudo-dementia, reversible dementia, transient cognitive impairment, acute brain failure, toxic psychosis, pseudosenility [8, 10, 64].

Definition: Delirium is defined as an acute organic mental disorder characterised by confusion, restlessness, incoherence, anxiety or hallucinations which may be reversible with treatment [5,11].

Delirium is a common 'precipitant of hospitalisation in the elderly' and affects up to 50% of patients in acute surgical and medical wards [12].

1. **COMMON CLINICAL SIGNS** are summarised as:
   - Acute onset – changed mental status over hours or days
   - Fluctuation – changing throughout the day
   - Inattentiveness – easily distracted, unable to sustain attention [14]
   - Disordered thinking &/or change in consciousness – hyperalert or drowsy.

   Older people may have nonspecific symptoms of illness and the first sign of illnesses such as pneumonia or a urinary tract infection may be delirium. The longer the delirium persists, the more the likelihood of poor outcomes with serious complications and even death [12, 13].

2. **POTENTIALLY REVERSIBLE CAUSES OF DELIRIUM IN THE OLDER PERSON** are often misinterpreted and nurses can be the first to raise suspicions and avoid the trap of the inaccurate conclusions that the person only has problems related to dementia [13]. Information from an accurate history and assessment are essential to ascertain a baseline state. Some people are more likely (predisposed) to developing delirium (see Table 1)

Table 1: Potential causes (predisposing & precipitating) of delirium in the older person

Predisposing	**Precipitating**
Poor sight	Infections - UTI, pneumonia, cellulitis, etc
Severe illness (incl. depression)	Fluid & Electrolyte imbalance
Cognitive impairment	Hypoxia
Dehydration	Constipation/diarrhoea
	Urinary retention
	Uncontrolled pain
	Sleep deprivation
	Abnormal glucose levels
	Side effects/toxicity of medications
	Sensory deprivation/overload (incl. IDC , restraint & surgical procedures)
	WITHDRAWAL FROM ALCOHOL or DRUGS [7, 12]

3. Therefore the **NURSING ASSESSMENT** would need to include –

Table 2: Delirium assessment

- **Level of consciousness** - if clouded, this is a medical emergency - notify a medical officer.
- **Past documentation of previous cognitive /behavioural state** - case notes, GP, family, nursing home/hostel.
- **Cognitive mental status** - assess orientation. The Folstein Mini Mental Status Exam (MMSE) is often the preferred tool [5] but others include the Hodkinson Abbreviated Mental Test Score (AMTS) [15], the CLOCK [65], the MiniCog [66 and the SIS [67].
- The Confusion Assessment Method (CAM) [14] is available to enable non psychiatric clinicians to detect delirium symptoms.
- **Physical findings** - temperature, pulse, respirations, BP, U/A, BSL, SaO2, skin turgor and colour, urinary output, bowel status. Full body examination including mouth and ears. Tests ordered by the medical officer for a Delirium Screen might include: MSU, full blood count, differential and ESR, electrolytes, urea and creatinine, thyroid function tests, liver function tests, cardiac enzymes, calcium, cultures specific to the symptoms (e.g. wound swab). Second line investigations might include chest x-ray, ECG, CT head scan, ultrasound, EEG, B12 and folate levels. Lithium, Tegretol and Digoxin levels should be tested if on these drugs. Other useful tests include blood gases, blood cultures, drugs screen and C-reactive protein [7].
- **Medication history** - note the current medications, both prescription and 'over-the-counter' as well as compliance – does the person always take them as prescribed?
- **Pain level** - elderly people are known for their stoicism and the possible fear of nursing home placement, so do not always admit to severe pain [16].
- **Sensory status** - sight and/or hearing deficits. Always check whether hearing aids and glasses are needed, working or missing.
- **Environmental impact** – consider the impact of noise, light, unfamiliarity, isolation, boredom, immobility.
- **Social problems** - the stress caused by the increasing losses in old age can cause behavioural changes [17].

4. **DOCUMENT** findings, **REPORT** to a medical officer for Delirium Screen and medication review. **INITIATE APPROPRIATE TREATMENT** within nursing guidelines.

'Whilst accurate diagnosis may often depend on laboratory tests and the occasional use of high technology scans, the principle skill lies in sympathetic handling and an appropriate bedside manner from all involved' [7].

Could there be other medical problems?

If 'YES' go to next section page 8, if 'NO' go to page 12.

Could the person have DEPRESSION or other mental disorder?

If 'YES' ↓ If 'NO' go to next section page 10.

DEPRESSION/ Mental Disorder

ASSESS AND TREAT PROBLEM
Overall Approach: Support the person - define the acute disorder, instigate remedy a.s.a.p.

Definition: Depression is an abnormal emotional state characterised by exaggerated feelings of sadness, worthlessness and hopelessness which are out of proportion with reality.

A Mental Disorder is a disturbance of emotional equilibrium manifested by maladaptive behaviour & impaired functioning.

1. Nursing assessment - question and describe - use screening tools
2. Obtain history - previous and predisposing
3. Document & report to medical officer
4. Observe person for deterioration - support
5. ***Instigate ❁ Supportive Communication & Care Techniques***

The need is to **ASSESS AND TREAT the PROBLEM**. The **OVERALL APPROACH is to SUPPORT THE PERSON** whilst defining the acute disorder and instigating a remedy as quickly as possible.

Definition: Depression is an abnormal emotional state characterised by exaggerated feelings of sadness, worthlessness and hopelessness which are out of proportion with reality and are present for at least two weeks [18,5].

A Mental Disorder is a disturbance of emotional equilibrium manifested by maladaptive behaviour and impairment [5, 19].

Depression is often associated with self neglect and physical illness as well as being complicated by the side effects of anticholinergic tricyclic drug treatment. Depression usually presents as a gradual onset with mild cognitive impairment, worse in the morning with improvement towards the end of the day and is present over at least the last two weeks. It may be differentiated from delirium which presents as an acute onset with fluctuating symptoms that worsen towards the end of the day [20]. To aid accurate diagnosis, it is better to describe the actual signs and symptoms rather than just say that the person appears depressed.

1. **The NURSING ASSESSMENT needs to include:**

Table 3: Elements of a depression/mental disorder assessment

Is the person -

- Expressing any ideas of harm to self or others - 'life is not worth living', 'I wish I was dead', 'helpless', 'hopeless', 'worthless', OR aggressive statements? Ask specific questions regarding suicidal intent or plans (if present - maintain close observation and notify medical officer urgently). Consider using depression screening tools e.g. the Geriatric Depression Scale [29], Cornell Scale for Depression in Dementia [31], Non-verbal Depression Scale (30]. See Appendices B, C and D.
- Sad (facial expression, posture) – tearful, worse in the morning or evening?
- Anxious – changes in eating and sleeping patterns, lethargic/apathetic, agitated?
- Ruminating – going on and on about something?
- Hallucinating – visual, tactile, auditory or olfactory?
- Grandiose, delusional, paranoid – 'people are talking about me', suspicious of motives of other people or staff, poisoned food or drugs? [5,18]

2. **OBTAIN A HISTORY OF:**

- Previous mental state and any previous mental illness or psychiatric admissions
- Previous medication regime and compliance with treatment
- Any predisposing factors such as family or financial problems
- Any grief or loss situations.
  It is particularly important to liaise with the patient's family and also the staff of the retirement village or nursing home as well, who often have an in-depth knowledge of the patient's usual status and coping skills. However, the appropriate duty of care and the 'need to know' principle must be considered to avoid problems with confidentiality.

3. **DOCUMENT findings and report to a medical officer for referral for a mental health consultation and treatment.** Tricyclic antidepressant medications have been superseded by other classes of drugs (such as, the SSRIs – for example fluoxetine and sertraline etc) which have less side effects [18]. Consideration of a trial of medication for symptoms of depression that do not resolve spontaneously after two or three weeks, is recommended

4. **OBSERVE THE PERSON FOR SIGNS OF DETERIORATION.**
   Support, reassure and investigate any claims or accusations. Encourage the person to talk about their worries. One of the most important nursing skills is that of therapeutic conversation [21]. The ability to provide a non judgemental 'listening ear' with appropriate reflection is therapeutic.

Could there be other medical problems?
If 'YES" go to the next section page 10, if 'NO' go to page 12.

Could the person have DEMENTIA?

If 'YES' ↓ If 'NO' go to next section page 12.

DEMENTIA

ASSESS AND PLAN MANAGEMENT
Overall Approach: Empathic support, modification of communication and the environment.

Definition: Dementia is a clinical syndrome of organic origin, characterised by a slow onset of decline in multiple cognitive functions, particularly intellect and memory, which occur in clear consciousness and causes dysfunction in daily living;

1. Medical diagnosis - most common, less common, small group
2. Nursing Assessment - deficits affecting behaviour
3. ***Instigate ❁ Supportive Communication and Care Techniques***
4. Document and notify Med. Officer if ❁ Supportive Communication and Care Techniques are not successful.

DEMENTIA is the final consideration after delirium and depression or other mental disorders.

The need is to ASSESS and PLAN the MANAGEMENT. The Overall Approach is to provide EMPATHIC SUPPORT and MODIFICATION OF COMMUNICATION AND THE ENVIRONMENT.

Definition: Dementia is a clinical syndrome of organic origin, characterised by a slow onset of decline in multiple cognitive functions, particularly intellect and memory, which occur in clear consciousness and cause dysfunction in daily living [6, 22].

It has been thought that approximately 50% of people with dementia have Alzheimer's Disease (which can only be definitively diagnosed by brain biopsy in which neurofibrillary tangles and amyloid plaques are found); approx. 25% have vascular dementia; approx. 20% have a mixture of the two and approx. 5% have a rare diseases such as Pick's Disease, Huntington's Chorea or Creutzfeld Jacob Disease etc [23].

However, there has been increased recognition of the prevalence of Diffuse Lewy Body Dementia. The features overlap those of Alzheimer's Disease but include fluctuations of cognition or alertness, hallucinations, extrapyramidal features such as rigidity, as well as a pronounced sensitivity to neuroleptic medication [6, 57].

Although most types of dementia are chronic and progressive, there is a small group (including Vit B 12 and folate deficiencies, normal-pressure hydrocephalus and hypothyroidism etc.) which are theoretically 'reversible' if diagnosed and treated early enough [6].

Advances in recent research have included the development of medications which may slow the progression of symptoms of Alzheimer's Disease (for example Donepezil and Rivastigmine) [63].

Dementia is described as a 'loss of self' [24] or a condition in which the environment becomes increasingly foreign - rather like living in a bad dream - causing a progressively lowered stress threshold [25] . However, long term memories and behaviours remain the longest and can be utilised to facilitate adaptation for coping with the deficits. Considering the behaviour empathically or from the person's perspective, fosters greater understanding, patience and tolerance [26, 27].

Behavioural assessment is important to find specific deficits so that supportive care plans can be developed. These would endeavour to modify the environmental problems (signs, colours, pictures, light, room layout) and communication difficulties, by providing constant clues to reality (therapeutic conversation) as well as validation of thoughts and feelings. People with dementia need constant, sensitive direction and supervision, to compensate for their declining ability to plan, initiate and regulate [4, 28, 62].

1. **MEDICAL** diagnosis requires documentation of a decline in cognition from a previous level, examination of the process causing the decline and elimination of other causes.
2. **The NURSING ASSESSMENT** requires the identification of specific behavioural problems (remember that this person will always have a degree of transition stress when admitted for acute care).

Table 4: Behavioural deficits commonly observed in dementia.

The effect of cognitive deficits may be:

- Memory Loss - unable to remember words that are read, seen or heard; recent memories, people and events quickly forgotten - recent events simply do not exist.
- Language expression - unable to use language (speech, writing and reading) to communicate; difficulty saying precisely what they want to say or naming common objects or difficulty understanding what is said to them.
- Spatial awareness - unable to locate the position of the person or objects in space; difficulty knowing how to find their way.
- Apraxia – difficulties in carrying out planned or learned patterns of movement; difficulty in putting on clothes in the correct order or using appliances or making the bed.
- Agnosia - difficulties in recognising things and people, such as family members, objects (such as knife & fork), surroundings (such as their house).
- Insight - unable to plan or organise; may shop without money, be unaware of the state of untidiness of their house or dress inappropriately.
- Initiation - unable to start an action, such as eating a meal; may appear apathetic, unable to understand, unmotivated.
- Perseveration - unable to stop doing or saying something; repeats questions, statements, actions.
- Regulation - unable to keep on track or control social behaviour; easily distracted, wanders, talks over others.
- Connection - unable to connect behaviours, emotions and memories, angry responses, accusations of stealing [23].

3. **PLAN ONGOING CARE** by instigating Supportive Communication and Care Techniques. See page 12.
4. **DOCUMENT** findings and notify a medical officer if Supportive Communication and Care techniques are not restoring improved well being. Medications may be helpful (small doses - usually haloperidol 0.5mg - 2.0mg stat & prn or newer medications such as, risperidone or olanzapine). Whilst the use of medication is best avoided in the long term - the stresses imposed by illness or relocation which may cause agitated behaviour, may be minimised by small doses of a non sedating medication in the short term [6, 41].

Proceed to page 12.

❁ Supportive Communication & Care

How to develop a care plan for consistent care.

❁ Supportive Communication & Care

Overall Approach: Show RESPECT AND EMPATHY - to reinforce and reinstate the person's sense of DIGNITY and IDENTITY.

1. Gather information
2. Encourage family involvement
3. Brain storm ideas for care
4. Instigate consistent care plan
5. Use careful communication skills
6. Adapt the environment
7. Provide activity program
8. Consider medication
9. Encourage independence and mobility
10. Normalise sleep-wake cycle
11. Document, monitor and evaluate.

The fear of loss of dignity is reported to be the major reason for requests for euthanasia by people with a terminal illness - not necessarily fear of intractable pain as one might expect. In dementia and delirium, the first loss is one of dignity as the person endeavours to maintain their sense of reality, freedom and control, in an environment in which normality is slipping beyond reach. 'Where am I? Who are you? What are you doing? Why?' For elderly people with a lifetime of competence and achievement behind them, this can cause overwhelming anxiety, if not outright fear, and stimulate well developed defence mechanisms [27].

1. Gather information

- medical history – liaise with GP, what affects the person's life?
- social history – what important things have happened & what do they like to do?
- functional ability – what can they do?
- spiritual needs – what are their usual spiritual practices?
- Observe and describe the behaviour
- Record a Behaviour Chart (ABC)
- Look for Antecedents (triggers)and reinforcing events.[2,32]

2. Encourage family involvement

- Explain the facility routine to the family
- Ask for help in planning care
- Ask for details of usual routines, likes & dislikes
- Ask for personal mementoes & photos to display by bed
- Encourage contact as often as possible
- Support family in their acceptance of events. [33, 34, 51]

3. Brainstorm ideas for care

- Examine **Behaviour Chart** for patterns & triggers
- Discuss possible causes of behaviour in group staff meetings and with family
- Think about the effect of staff interactions, routines, environment
- Discuss overall aims – what is a reasonable change?
- Discuss possible methods of care and decide on the strategies. [34, 35]

4. Instigate consistent plan

- Make sure all staff members and family are aware of the plan
- Discuss plan at all handover meetings
- Monitor consistency of approach
- Plan regular evaluation and modification of care plan.[4,33]

5. Use effective communication skills

- Use the preferred name and make sure hearing aid and glasses are on & in working order
- Provide appropriate language and cultural practices with INTERPRETER help
- Introduce yourself each time you approach the person
- Use careful listening skills and PRAISE
- Consider appropriate voice tone, body language, touch
- Give appropriate clues to reality when using known social history
- Accept & validate the feelings and ideas expressed. [35,36,37, 50]

6. Adapt environment

- Adapt or modify **detrimental environment** (? homelike, light, noise, **BOREDOM** etc)
- **Consider SECURITY measures** if wandering is likely. [34,35, 37]

7. Provide activity programme

- Avoid boredom and loneliness
- Plan appropriate activity programme.
- Consider discussions, reminiscence, music, exercises, visitors. [37, 54]

8. Medication

- Consider medication TRIAL if depression, PAIN or psychosis is likely
- If person remains distressed, SHORT TERM traditional or atypical psychotropic medication MAY be helpful in small doses repeated often, but must be closely monitored for Parkinsonian side-effects which are particularly likely in Lewy Body Disease.
- Seek expert advice.[16,39,40, 41]

9. Independence and mobility

- Encourage person to do as much as possible for themselves
- Encourage participation in exercise programme
- Maintain dignity and promote self confidence
- Prevent loss of strength. [42]

10. Normalise sleep-wake cycles

- SHORT rest period only in the afternoon
- Exercise, stimulation & sunshine during the day
- Use bedroom for sleep only
- Avoid caffeine but provide light snack in evening
- Provide help and reassurance with toileting and orientation at night
- Accept that a person may be wakeful at night and provide reassurance and gentle activities such as favourite music [43].

11. Document, monitor and evaluate

- All care and changes MUST be documented
- Confused people cannot tell you what is wrong with them & cannot ask for help, particularly with PAIN management
- Older people have changed symptom presentation
- Monitor for new delirium &/or depression
- Review Care Plan daily and modify when necessary
- Consult with local Aged Care team.

SPECIFIC PROBLEMS – FOLLOW THE ALGORITHM – then consider adding the following strategies:

Specific Issues

Specific Interventions

- Falls
- Inappropriate Sexual Behaviour
- Incontinence
- Resistance To Care
- Screaming / Calling Out
- Wandering

FALLS

- Assess risk and reassess if change in health status
- Review/reduce medication
- Provide safe footwear and clothing
- Test eyesight and glasses
- Provide safe uncluttered environment
- Arrange Physiotherapist assessment – balance, gait etc
- Provide exercise programme
- Maintain walking aids
- Consider Hip Protectors, wrist guards, helmet, knee & shoulder pads
- See - **Wandering**
- If absolutely necessary – use restraints in the least restrictive way and adhere scrupulously to facility policy
- See – Shanley 'Putting Your Best Foot Forward – Preventing and Managing Falls in Aged Care Facilities'. [34, 55]

Inappropriate SEXUAL BEHAVIOURS

- Consider lifetime habits, clothing, urinary tract dysfunction
- Examine staff & resident's reactions & debrief
- Provide privacy
- Provide activity programme
- Provide exercise programme
- Reinforce appropriate behaviour
- Keep verbal response to negative behaviour to a minimum
- Assess touch response – if appropriate provide stuffed animals, doll, massage, pets, etc
- Increase staff interactions with the person. [47, 48, 49, 58]

INCONTINENCE

- Assess over several days – when, how often, where, toileting pattern, fluid intake, infections, medications, past history
- Provide easily manageable clothing
- Provide consistent, appropriate toilet schedule
- Provide signs &/or bright colours on toilet doors
- Provide protective garments and aids
- Maintain good hygiene
- Provide privacy and time
- If faecal incontinence – assess for & relieve impaction.
- Address fibre & fluid intake, increase exercise, schedule to respond to gastro-colic reflex after meals
- **National Continence Helpline 1800 33 00 66** [4, 52, 53]

RESISTANCE TO CARE

- Review when, what, who & social history
- Consider how it is being done, privacy, rush
- ASK questions & listen to what the person is saying
- Change time it is done
- Change how it is done (bathe/sponge instead of shower)
- Change carer
- Provide distraction – music, singing, chat
- Provide gentle encouragement, reward
- Compromise, simplify – change expectations
- Think creatively and laterally. [34, 35, 36]

SCREAMING/CALLING OUT

- Address PAIN, toilet, loneliness or fear needs
- Is there too little or too much stimulation?
- Provide meaningful activity programme
- Consider 'Simulated Presence Therapy' – audio or video recording of familiar people
- Assess touch response– if appropriate provide stuffed animals, doll, massage, pets
- Consider 'white noise'- gentle ocean, bird sounds, soft music
- Surround with familiar possessions
- Increase staff interactions with the person at regular time intervals, not only in response to calls
- Validate, distract, acknowledge. [45, 46]

WANDERING

- Provide, safe, secure, **interesting** wandering area (in & out)
- Set up toileting schedule
- Provide meaningful activity programme – particularly late afternoon
- Consider 'Simulated Presence Therapy' – audio or video of familiar people
- Assess touch response– if appropriate provide stuffed animals, doll, massage, pets
- See - **Falls** - risk protection
- Surround with familiar possessions
- Label own room, toilet, etc
- Provide exercise programme
- Camouflage exits etc
- Increase staff interactions with the person
- Validate, distract, acknowledge. [37, 44]

Remember:
Behaviour is a means of communication.

The person is not the problem
The problem is the problem

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Appendix A

BEHAVIOUR CHART

(**A**nticedent. **B**ehaviour. **C**onsequence.)

Surname: .... MRN: ....

Given Names: ....

Date of Birth: .... Sex: ....

(Affix patient label here)

DATE	TIME	BEHAVIOUR B - Behaviour	WHAT HAPPENED BEFORE A - Anticedent	WHAT HAPPENED NEXT C - Consequence	LOCATION	PERSONS PRESENT	SIGN.

GERIATRIC DEPRESSION SCALE

Appendix B

(Short Form)

Name: .... D.O.B. .... Age: .... Sex: .... Date: ....

(Circle the applicable answer)

1	Are you basically satisfied with your life?	Yes / No
2	Have you dropped many of your activities or interests?	Yes / No
3	Do you feel that your life is empty?	Yes / No
4	Do you often get bored?	Yes / No
5	Are you in good spirits most of the time?	Yes / No
6	Are you afraid that something bad is going to happen to you?	Yes / No
7	Do you feel happy most of the time?	Yes / No
8	Do you feel helpless?	Yes / No
9	Do you prefer to stay at home, rather than do out and do things?	Yes / No
10	Do you feel that you have more problems with your memory than most?	Yes / No
11	Do you think it is wonderful to be alive now?	Yes / No
12	Do you feel pretty worthless the way you are now?	Yes / No
13	Do you feel full of energy?	Yes / No
14	Do you feel that your situation is hopeless?	Yes / No
15	Do you think that most people are better off than you?	Yes / No

Scoring

Each time a question is answered in the following way a point is scored.

1	No	6	Yes	11	No
2	Yes	7	No	12	Yes
3	Yes	8	Yes	13	No
4	Yes	9	Yes	14	Yes
5	No	10	Yes	15	Yes

Each answer counts for one point

Scores greater than 5 indicate probable depression.
Where a score of more than 5 is indicated, a more thorough clinical investigation should be undertaken.

Signature of Assessor: ....

Yesavage, J. A. (1988) Geriatric Depression Scale. *Psychopharmacology Bulletin. 24(4):709-711.*

CORNELL SCALE FOR DEPRESSION IN DEMENTIA

Name: .... D.O.B. .... Age: .... Sex: .... Date: ....

Rating: Score rates are based on information obtained by clinician interviews with a member of the nursing staff (or a carer) and the patient.

Time taken: 20 minutes with nurse or carer, 10 minutes with patient.

SCORING SYSTEM

a = unable to evaluate
1 = absent
1 = mild or intermittent
2 = severe

Ratings should be based on symptoms and signs occurring during the week prior to the interview. No score should be given if symptoms result from physical disability or illness.

A.	**Mood Related Signs**				
1.	Anxiety – anxious expression, ruminations, worrying	a	0	1	2
2.	Sadness – sad expression, sad voice, tearfulness	a	0	1	2
3.	Lack of reactivity to pleasant events	a	0	1	2
4.	Irritability – easily annoyed, short tempered	a	0	1	2
B.	**Behavioural Disturbance**				
5.	Agitation – restlessness, handwringing, hairpulling	a	0	1	2
6.	Retardation – slow movements, slow speech, slow reactions	a	0	1	2
7.	Multiple physical complaints (score 0 if GI symptoms)	a	0	1	2
8.	Loss of interest – less involved in usual activities (score only if change occurred acutely, i.e. in less than 1 month)	a	0	1	2
C.	**Physical Signs**				
9.	Appetite loss – eating less than usual	a	0	1	2
10.	Weight loss (score 2 if greater than 5lb or 2.5 kgm in a month)	a	0	1	2
11.	Lack of energy – fatigues easily, unable to sustain activities (score only if change occurs acutely i.e. in less than I month)	a	0	1	2
D.	**Cyclic Functions**				
12.	Diurnal variation of mood - symptoms worse in the morning	a	0	1	2
13.	Difficulty falling asleep – later than usual for this individual	a	0	1	2
14.	Multiple awakenings during sleep	a	0	1	2
15.	Early morning awakening earlier than usual for this individual	a	0	1	2
E.	**Ideational Disturbance**				
16.	Suicide – feels life is not worth living, has suicidal wishes, or makes suicide attempts	a	0	1	2
17.	Poor self esteem - self-blame, self depreciation, feelings of failure	a	0	1	2
18.	Pessimism – anticipation of the worst	a	0	1	2
19.	Mood-congruent delusions – delusions of poverty, illness, or loss	a	0	1	2

SCALE

No depression:	**Depression:**	**Major depression:**
up to 7	7 or more	12/13 and up

Signature of Assessor: ....

Reprinted with the permission of G. Alexopouloa.

Reference: Alexopoulos, G. Abrams, R. Young, R. Shamoian, C.(1988)'Cornell Scale for Depression in Dementia. *Biological Psychiatry.* 23: 271-284.

Hayes and Lohse NON-VERBAL DEPRESSION SCALE

Appendix D

Name: .... D.O.B. .... Age: .... Sex: .... Date: ....

For each item check one of the 5 columns, which best describes how frequently you observed these behaviours during the last month, when they were not caused by a medical condition or pain (refer to descriptor of frequency below)

		Always	Almost always	Usually	Occas-ionally	Almost never	
	Points	4	3	2	1	0	Total
1.	Cries (aloud, silently with or without tears)						
2.	Sobs uncontrollably (weeps aloud, uncontrollably)						
3.	Looks sad, gloomy						
4.	Avoids eye contact (looks away)						
5.	Mouth turned down						
6.	Looks angry, grimaces						
7.	Head held down						
8.	Covers face with hand, arm, hair						
9.	Refuses food, liquids, medications						
10.	Wakes early (4-5am) & unable to go back to sleep						
11.	Frowns, scowls						
12.	Withdraws by sleep, feigns sleep, keeps eyes closed						
13.	Chooses to be socially isolated (refuses contact with others, does not associate with others, sits by self, does not interact)						
14.	Does not participate in usual activities (ADL, social, recreations)						
15.	Agitated (screams, wrings hands, moves incessantly, excited)						
16.	Tense, irritable						
17.	Makes little effort to perform simple tasks						
18.	Short attention span (looks away and fidgets)						
19.	Unwilling to perform ADL (hygiene, dressing, transfers)						
20.	Cannot concentrate (poor focussing or fixing one's gaze)						
					Total Score:		

Frequency scale:

Frequency	**Descriptor**	**Range of scores**	**Meaning**
Always	= Daily	71-80	Probable major depression
Almost always	= Every couple of days	51-70	Probable depression
Usually	= Weekly	31-50	Professional review needed
Occasionally	= Second weekly	11-30	Monitoring needed
Almost never	= Once a month or less	0-10	Monitoring needed

Signature of assessor ....

Reprinted with the permission of P. Hayes and D. Lohse

Reference: Hayes, P. Lohse, D. and Bernstein, I. (1991) 'The Development and Testing of the Hayes and Lohse Non-Verbal Depression Scale', Clinical Gerontologist 10(3), 3-13.

Overhead Hard Copies

- to be enlarged and copied onto transparencies for lecture presentations and handouts.

AGGRESSION

Aim for SAFETY - look for a stressor and remedies
Overall Approach: NON-CONFRONTATION

1. GIVE PERSON SPACE (stand back)
   calm, friendly, empathic approach,
   meet the need or divert the attention
2. If Problem Persists - CALL for ASSISTANCE
   (Note the facility policy on use of restraints)
3. DON'T HESITATE to call 'SECURITY' if any danger.
4. EVALUATE afterwards (Behaviour Chart)
5. DEBRIEF
6. PLAN management
7. FOLLOW THE ARROWS →
8. ***Instigate ❆Supportive Communication & Care Techniques***

DELIRIUM

ASSESS AND TREAT CAUSE
Overall Approach: support the person - define the acute disorder, instigate a remedy a.s.a.p

Definition: Delirium is an acute organic mental disorder characterised by confusion, restlessness, incoherence, anxiety or hallucinations which may be reversible with treatment.

1. COMMON CLINICAL SIGNS - acute, fluctuating, inattentive, disordered
2. POTENTIALLY REVERSIBLE CAUSES: medical, environmental
3. NURSING ASSESSMENT: history, vital signs and environment.
4. DOCUMENT, REPORT, (delirium screen) INITIATE APPROPRIATE TREATMENT.
5. ***Instigate ❆Supportive Communication & Care Techniques***

DEPRESSION/ Mental Disorder

ASSESS AND TREAT PROBLEM
Overall Approach: SUPPORT THE PERSON – define the acute disorder - instigate remedy a.s.a.p.

Definition: *Depression is an abnormal emotional state characterised by exaggerated feelings of sadness, worthlessness and hopelessness which are out of proportion with reality.*

A Mental Disorder is a disturbance of emotional equilibrium manifested by maladaptive behaviour & impaired functioning.

1. NURSING ASSESSMENT - question and describe - screening tools
2. OBTAIN HISTORY - previous, predisposing
3. DOCUMENT & REPORT TO MEDICAL OFFICER
4. OBSERVE PERSON FOR DETERIORATION - SUPPORT
5. ***Instigate ❁Supportive Communication & Care Techniques***

DEMENTIA

ASSESS AND PLAN MANAGEMENT
Overall Approach: empathic support, modification of communication and the environment.

Definition: *Dementia is a clinical syndrome of organic origin, characterised by a slow onset of decline in multiple cognitive functions, particularly intellect and memory, which occur in clear consciousness and causes dysfunction in daily living.*

1. MEDICAL diagnosis - most common, less common, small group
2. NURSING ASSESSMENT - deficits affecting behaviour
3. ***Instigate ❁Supportive Communication & Care Techniques***
4. DOCUMENT and notify Med. Officer if ‘supportive communication and care techniques’ are not successful

How to develop a care plan for consistent care
Supportive Communication and Care Techniques

Overall Approach: Show RESPECT AND EMPATHY - to reinforce and reinstate the person's sense of DIGNITY and IDENTITY.

1. Gather information
2. Encourage family involvement
3. Brainstorm ideas for care
4. Instigate consistent care plan
5. Use careful communication skills
6. Adapt environment
7. Provide activity programme
8. Consider medication
9. Encourage independence & mobility
10. Normalise sleep-wake cycle
11. Document, monitor & evaluate

Specific Issues

Specific Interventions

- Falls
- Inappropriate Sexual Behaviour
- Incontinence
- Resistance To Care
- Screaming / Calling Out
- Wandering

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