Long-Term Care Survey Alert

RESIDENT ASSESSMENT: Root Out F Tags: Determine The Root Cause Of Behavioral Sx

Make this survey and quality issue a care plan priority.

If you believe behavior has meaning, then you're on the right track to figuring out what a resident with dementia is trying to communicate when he lashes out, withdraws or repeatedly tries to leave the facility.

Care planning these behavioral symptoms puts you ahead of the new survey and quality-of-life curve for ensuring facilities ease cognitively impaired residents' psychosocial distress.

Case in point: Alois Alzheimer Center takes a comprehensive approach to determine the cause of residents' behavioral communication, according to **Susan Gilster, RN, PhD,** executive director of the facility in Cincinnati, OH. If a resident has a sudden change in behavior, for example, the Alois care team looks at the usual suspects, including urinary tract infection or other infection. And they look to see if the person is "tired or hungry" or not sleeping well, says Gilster.

Clinical gem: If the initial urinalysis is negative for infection -- and the team can't figure out what's causing a resident's behavioral change -- they repeat the urinalysis, says Gilster. The facility staff has found in some cases the resident's behavior changes before the urinalysis shows infection.

Home in on Pain

Pain ranks at the top of the list of known causes of agitation and even aggressive behavior in people with dementia. Gilster recounts how one cognitively impaired woman admitted to the facility with "seriously aggressive behaviors" turned out to be in severe pain due to undetected metastatic breast cancer. The Alois care team investigated her history and found that she had been diagnosed with the cancer in the previous care setting but declined treatment.

By the time she entered the Alois center, "she was in severe pain but couldn't tell anyone," says Gilster. "When we treated the pain, the behaviors stopped."

Key strategy: Use a behavioral pain assessment scale for people with dementia. While there are many different tools, they all agree on the common elements of what can signify pain, including "agitation, increased restlessness, movement, facial grimacing, being combative and moaning," advises **Betty Ferrell, RN, PhD, FAAN.** Ferrell is a nurse researcher and pain expert with the **City of Hope Medical Center** in Duarte, CA.

If the resident who has been acting out suddenly grows still, that may not be a good sign. If the person's pain "comes on suddenly," you will generally see behavioral symptoms of the pain, says Ferrell. "But if that pain goes on for days or weeks or months, the person no longer has the energy to keep having those behaviors -- particularly older people with other chronic illnesses," she adds.

Medication strategy: If you've assessed the person with behavioral symptoms or a behavioral change for likely causes of the behaviors and can't find the problem, then you can try round-the-clock Tylenol to see if that helps the person's behavioral symptoms, suggests Ferrell.

Free resources: Check out the pain assessment scales for people with dementia at www.cityofhope.org/prc/elderly.asp.

Take a Look at Depression

As a cause of behavioral symptoms, the team looks at depression second to pain. People with dementia often express depression through behavior or sometimes "unusual physical manifestations," says Gilster. Her facility cared for one person whose head got lower and lower until his chin continuously rested on his chest.

The team worked him up for neuromuscular problems but couldn't find any. Then with input from the CNAs who knew the resident well, the physician ordered antidepressant therapy, she relays. "After a few weeks, the person's head returned to its normal position," says Gilster, who's seen that same head-dropping phenomenon in other depressed patients with dementia.

Medication strategy: If the Alois care team suspects depression is behind a person's behavioral symptoms, the physician puts the resident on an antidepressant for four to six weeks, relays Gilster. "If that doesn't work, we will try a different antidepressant for another trial of treatment," she adds.

Identify Social, Environmental Stressors

The team assesses whether the person displaying behavioral symptoms can manage the amount of stimulation on a particular unit. They monitor whether he may feel bombarded by too many activities. Gilster says experience has taught the center staff that "older people need time to just sit and regroup. They don't need constant activities."

In evaluating a resident's behavioral distress, the Alois team also assesses whether the person still fits in the group she's in -- or whether the person has "moved further along in the disease process so that the group is now stressful for the person," says Gilster.

They also look to see if the programs are too hard now so the person can't understand them and cannot converse with people any longer. If the resident has deteriorated cognitively so that her peers in the group are too high functioning to keep up with, she may become agitated or "move within and become depressed," cautions Gilster.

While Alois is set up with four different, self-contained units geared to meet residents' varying functional levels, traditional facilities without that capability can work out a program to individualize an environment for residents with dementia, says Gilster. For example, the "facility needs to help the person with dementia belong in a group where he or she fits in cognitively," she emphasizes.

Protect higher-functioning residents: "When you put higher functioning people in with those who are much lower functioning, the most intact people end up nurturing" those who are less capable, says Gilster. That can be beneficial for all the residents involved, she adds. "But if you don't watch that carefully, you find that the effort exhausts the more intact people."