Nocturnal disruption in-service

Behaviour Management
A Guide to Good Practice

Working with people with dementia who present with nocturnal disruption

A presentation for residential aged care staff and community care staff prepared by the Dementia Collaborative Research Centres (DCRC-ABC) for the Dementia Behaviour Management Advisory Services (DBMAS)

Translating dementia research into practice ©UNSW as represented by the DCRC-ABC (2014)

Acknowledgment of Country
We acknowledge the traditional custodians of this land

We also pay respect to the elders past and present and extend that respect to other Aboriginal people present

Objectives
At the end of this presentation participants will have an increased understanding of:

• How nocturnal disruption presents in people with dementia
• Diagnostic criteria & potential causes of nocturnal disruption in dementia
• Strategies & considerations to assist in the care of people with nocturnal disruption in dementia

What is nocturnal disruption in dementia?
• Disturbance of sleep & circadian rhythm (body clock)
• Underlying dementia predominantly accounts for symptoms
• Associated with night & daytime behaviours

Nocturnal disruption may present as:
• ↑ early-morning awakenings
• ↓ total sleep time or sleep efficiency
• Loss of normal sleep patterns
• Fragmented night sleep
• Nocturnal confusion
• Reverse day-night patterns

Nocturnal disruption may also present as:
• Fatigue
• ↑ sleep onset latency
• ↑ daytime napping
• Excessive daytime sleepiness
• ↑ other BPSD at night e.g. restlessness, irritability, agitation, wandering
Causes of nocturnal disruption
- Physical factors - pain, discomfort, infection, illness
- Medication – adverse effects, withdrawal
- Inherent to dementia type (more common in DLB)
- ↓ environmental cues due to darkness
- Disturbances in the person’s environment
- Other BPSD exacerbated at night

Many potential areas may contribute to nocturnal disruption in dementia
- Fatigue
- Physical discomfort
- Loss of control
- Impaired vision or hearing
- Unmet needs
- Hallucinations
- Medication effects
- Need for attention
- Misunderstanding
- Fear

Diagnostic Considerations
Use a person-centred approach to gather ALL potentially important information
▼ Is the nocturnal disruption due to pain/discomfort, physical illness/injury or other physical causes?
▼ Is this a symptom of delirium, primary sleep disorder, psychosis or effects of medication?
If YES, respond & treat accordingly FIRST
If NO, consider management options
▼ Develop & trial individually tailored psychosocial/environmental strategies & interventions
▼ Only where necessary, use individually targeted medication
▼ Review!

Diagnosing nocturnal disruption in dementia
- Differentiate from other primary sleep disorders e.g. sleep apnoea, sleepwalking
- Eliminate delirium & comorbid medical conditions e.g. restless legs
- Consider psychiatric disorder or substance abuse

Measuring nocturnal disruption
Instruments to assist:
- Pittsburgh Sleep Quality Index (PSQI)
- Epworth Sleepiness Scale (ESS)
- Neuropsychiatric Inventory (NPI)
Prevalence of nocturnal disruption
Rates vary according to dementia severity, definition & assessment instruments used:
• 20% - 82% of those with dementia
• Higher prevalence in DLB & FTD compared to AD
• Lower in VaD

Nocturnal disruption causes stress &/or distress for:
• Care staff
• Other residents
• Family
• + the person with dementia!

Before you move on, have you:
• ensured that the person & all those in their environment are not at risk?
• conducted a full person-centred assessment of the behaviours presented?
• excluded &/or treated any potentially reversible factors?

Effects of nocturnal disruption
• Decline in cognition
• Risk of mortality
• Wandering, agitation & depression
• Quality of life
• Physical health
• + Premature placement in RACF

Your approach
Remember, nocturnal disruption is distressing! So be...
• Calm
• Gentle
• Thoughtful
• Work with the feeling
• Ensure comfort
• Take your time
• Look behind the behaviour
Caring approaches & interventions

First line response - psychosocial &/or environmental interventions

- Individually tailored
- Mixed evidence for multi-component interventions
- NITE-AD best evidence
- Don’t disregard traditional strategies e.g. gentle massage, warm milk

Principles of psychosocial responses

Safety
- Principles of psychosocial responses
  - Engagement
  - Reassurance
  - Clear communication
  - Safety
  - Simplify environment
  - Distract
  - Gentleness
  - Approach
  - Empathy
  - Individualisation
  - Acceptance
  - Simplify
  - Environment
  - Targeted & Individualised
  - Reduce fear

Caring approaches & interventions

2nd line approach - biological

- Quality evidence limited
- Consider pharma to manage underlying causes e.g. pain, anxiety
- Some evidence for ChEIs
- Some evidence for antipsychotics BUT not recommended
- No evidence for sedative-hypnotics although commonly prescribed

Pharmacological Approaches cont.

Where pharma is prescribed:
- Use in combination with psychosocial interventions
- Use with caution
- Monitor closely for adverse effects
- Review!
- Discontinue where indicated
- Be aware of significant risks with long term use of antipsychotics

Mr C – presentation

- Recent admission to RACF from hospital, following medical crisis
- Has lived a chaotic lifestyle at home, no routine or regular sleeping pattern
- Frequently awake at night
- Dishevelled & underweight on admission
- Staff report sleep/wake cycle irregular

A clinical scenario - Mr C
Mr C - presentation cont.

- Often awake late, wanders into other’s rooms → turns on lights &/or TV
- Doesn’t want to be disturbed in morning
- Resistant to encouragement to eat breakfast &/or shower
- Mr C can’t afford to lose weight
- Often falls back to sleep until 11am

Mr C

What are some of the factors potentially contributing to Mr C’s nocturnal disruption?

Mr C - potentially contributing factors

- Unreported pain/ discomfort/ acute illness/ infection
- Underlying depression
- Medication interactions, dosage, adverse effects, recently prescribed
- Disturbances occurring around Mr C
- Previous lifestyle
- Long-term lack of regular sleeping pattern

Potentially contributing factors cont.

- Lack of flexibility relative to previously living alone at home
- Particular RACF staff members
- Unfamiliar physical environment
- Reduced threshold to cope with stress due to dementia

Mr C - assessing the situation

- Encourage Mr C to express his concerns as best he can
- Observe for environmental triggers of nocturnal disruption
- Consult family to identify potential triggers
- Observe Mr C’s pattern across a 24 hour period – discourage napping
- Contact hospital for any additional information regarding Mr C’s history
Mr C – some outcomes

ND in dementia - conclusions

• Exclude &/or treat possible physical causes
• Individualised psychosocial interventions - first line approach
• Best evidence for multifaceted approach - targets several contributing factors
• Traditional interventions can contribute
• Where pharma necessary, some evidence for ChEIs & atypical antipsychotics
• Support carers!

‘Success’

• Typically not about eliminating BPSD
• Has BPSD ↓?
• Has person with dementia’s distress ↓?
• Has carers’ understanding of potential causes ↑?
• Has carers’ skills/coping ↑?
• Do carers feel supported?
• Be realistic about goals/outcomes
• BPSD are SYMPTOMS of dementia!

Reflection & review

How can you use this information to make a difference in the lives of people with dementia who present with nocturnal disruption in dementia?

Thank you for your attention

See DCRC website for further resources
http://www.dementiaresearch.org.au

Resources

Alzheimer’s Australia Help Sheets

Translating what we know about pain recognition & management in people with dementia

Supportive models of care
http://dementia.stir.ac.uk/design/virtual-environments/virtual-care-home

Dementia Outcomes Measurement Suite