Vocally disruptive behaviours in-service

Behaviour Management
A Guide to Good Practice

Working with people with dementia who present with vocally disruptive behaviours (VDB)

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

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 vocally disruptive behaviours (VDB) present in people with dementia
• Diagnostic criteria & potential causes of VDB in people with dementia
• Strategies & considerations to assist in the care of people with VDB in dementia

What are vocally disruptive behaviours (VDB) in dementia?
• Any vocalisation that causes stress within the person’s environment
• Can be intermittent or incessant
• Potential peak periods in afternoons

VDB in dementia may present as:
• Verbal agitation
• Screaming
• Groaning
• Abusive comments
• Singing
• Sighing
• Aggressive comments
• Perseveration
• Repetitive questioning

Potential causes of VDB
• Physical &/or psychological discomfort – the person with dementia may be in PAIN!
• Social / emotional isolation – the person may feel disregarded, ignored
• Reduced threshold to cope with stress secondary to cognitive impairment – dementia continues to damage the person’s brain
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VDB is associated with:

- Communication abilities, cognition, social interaction, mobility, performance in activities of daily living
- Visual &/or auditory hallucinations
- Depression

Diagnostic Considerations
Using a person centred approach, gather ALL potentially important information:

▼ Could this be a delirium from pain/ discomfort, physical illness/ injury or other physical/ medical causes?
▼ Does the person have a psychiatric history?
▼ Do they have a history of hallucinations?
If YES, respond & treat accordingly FIRST

If NO, consider management options

▼ Develop & trial psychosocial strategies & interventions
▼ Only where necessary - individually targeted medication in combination with psychosocial interventions
▼ Review!

Differential diagnosis for VDB in dementia

- Differentiate between various factors contributing to the VDB
- Eliminate reversible causes of delirium
- Scales measuring VDB largely include it as subset of BPSD or agitation

Measuring VDB in dementia

Instruments to assist:
- Cohen Mansfield Agitation Inventory (CMAI) - 6 items
- Pittsburgh Agitation Scale (PAS) - aberrant vocalisation
- Revised Neuropsychiatric Inventory Clinician (NPI-C) - aberrant vocalisation

Prevalence of VDB in dementia

Rates vary according to definition used & setting e.g. RACF vs at home

- Verbal aggression 10 - 48%
- Repetitious noises 3% - 31%
- Screaming 10 - 15%
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**VDB causes stress &/or distress for:**
- Care Staff
- Other residents
- Family
- Visitors
- Neighbours
- the person with dementia!

**NB:** the term *disruptive* is based on the perception of others

**Effects of VDB**
- Complaints from other residents, visitors, neighbours, staff
- Others avoid the person with dementia - can ↑ unmet needs & isolation
- ↑ burden on family & RACF carers
- ↓ quality of life for those cohabiting
- Risk of aggressive response from others
- VDB is *distressing* for the person with dementia

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

**Your approach**
VDB is distressing! So be...
- Calm
- Gentle
- Thoughtful
  + Work with the feeling
- Ensure comfort
- Take time
- Look behind the behaviour

**Caring approaches & interventions**
**First line response:**
- Psychosocial &/or environmental e.g.
  - ↑ opportunities for social interaction, attention &/or stimulation
- Music interventions
- Touch
- Aromatherapy

**Principles of psychosocial responses**
- Engagement
- Reassurance
- Safety
- Clear communication
- Simplify environment
- Targeted & Individualised
- Distraction
- Gentle approach
- Empathy
- Reduce fear
- Acceptance
Caring approaches & interventions
2nd line approach - biological
• Evidence for ↓ VDB with risperidone
• But NOT recommended due to safety concerns
• Very limited evidence for antidepressants & ChEIs

2nd line approach – biological cont.
Where pharma is prescribed:
• Use with caution - short term only
• Use in combination with psychosocial interventions
• Be aware of risks
• Reduce, discontinue when indicated
• Monitor closely & REVIEW!

A clinical scenario - Miss T

Miss T - presentation
• Has lived in RACF for some years
• Now largely unable to communicate
• Calling out for no obvious reason ↑
• Screams loudly during personal care
• Chronic VDB causes significant distress to other residents, visitors & staff
• Staff concerned for Miss T but frustrated & try to avoid her room

Miss T - presentation cont.
• Families & visitors frequently complain
• Neighbours complained to police of possible maltreatment
  • Miss T’s sister & nieces embarrassed & distressed by reactions of others → now visit infrequently

Miss T
What are some of the potentially contributing factors for Miss T’s VDB?
Miss T - potentially contributing factors

- Unreported pain/discomfort/acute illness/infection
- Medication interactions, dosage, adverse effects
- Under- or overstimulation (noise, people, activities)
- Unidentified, potentially unmet needs
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- Medication interactions, dosage, adverse effects
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Potentially contributing factors cont.

- Unfamiliar/ altered/deprived physical environment
- Altered routines, new staff, particular staff and/or family members
- Reduced threshold to cope with stress due to dementia

Miss T - assessing the situation

- Encourage Miss T to express her needs as far as she is able
- Directly observe what may trigger the behaviour
- Involve staff who know Miss T quite well in identifying her unmet needs or possible reasons for her VDB
- Consult her personal history

Miss T - assessing the situation cont.

- Assess the immediate environment for possible triggers
- Consult close family members to identify possible triggers
- These may be unknown to staff &/or undocumented

Miss T – some outcomes
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VDB in dementia - conclusions

• Multidisciplinary, individualised, multifaceted approach ALWAYS!
• Reduce &/or treat possible causes e.g. pain, depression, environmental stressors
• Transfer to area where they may be less disruptive*
• Some evidence for hand massage, music interventions & **operant conditioning
• Medication trials disappointing
• 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 VDB?

Resources

Alzheimer’s Australia Help Sheets
Translating what we know about pain recognition & management in people with dementia
Dementia Outcomes Measurement Suite

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