Section 11

Behavior CAP

Problem

The Behavior CAP focuses on reversing the daily display of troubling behaviors in the following areas:

- **Wandering** — moving with no rational purpose, seemingly oblivious to needs or safety.
- **Verbal abuse** — threatening, screaming at, or cursing others.
- **Physical abuse** — hitting, shoving, scratching, or sexually abusing others.
- **Socially inappropriate or disruptive behavior** — examples include making disruptive sounds or noises, screaming out, smearing or throwing food or feces, hoarding, or rummaging through other's belongings.
- **Inappropriate public sexual behavior or public disrobing**
- **Resisting care** — examples include verbal or physical resistance to taking medications, taking injections, completing a variety of activities of daily living (ADLs), or eating.

The daily occurrence of such behaviors is disruptive to both the person and others with whom the person comes in contact. Such behaviors may lead to restricting the person's mobility or interactions with others, and in worst cases to functional decline. The immediate goal of care is to reduce the frequency to less than daily occurrences and eventually to eliminate all occurrences.

For those exhibiting these behaviors less than daily, the immediate goal of care is to prevent the behaviors from increasing in frequency and secondarily to eliminate them.

These behavior symptoms are most often set in motion by a declining cognitive status or episodes of severe mental illness, although they can have other causes as well. Thus, understanding the nature of the problem and addressing the underlying causes have the potential to improve the quality of the person's life and the quality of the lives of those with whom the person interacts.

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Overall Goals of Care

- Eliminate underlying conditions or stressors that contribute to behavioral problems.
- Decrease the frequency or intensity of the behavior problems and prevent future escalation of the problems.
- Prevent secondary complications arising from the behaviors (for example, developing unsettled relationships with others, being abused by others, being physically restrained, or being admitted to a long-term care facility).
- Help staff and family caregivers cope with the existence of remaining behavior problems.

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Behavior CAP Trigger

TRIGGERED TO REDUCE THE OCCURRENCE OF DAILY BEHAVIORS

This group includes persons who display any of the following behaviors (or their equivalent) daily:

- Wandering
- Verbally abusing others
- Physically abusing others
- Socially inappropriate or disruptive behavior
- Inappropriate public sexual behavior or public disrobing
- Resisting care

This triggered group includes about 10% of persons in long-term care facilities, 3% of persons receiving home care, and less than 1% of older adults living independently in the community. Over a 90-day period, about one-third of these persons will improve so that none of these behaviors are exhibited daily.

TRIGGERED TO PREVENT BEHAVIORS FROM OCCURRING DAILY

This group includes persons who exhibit any of the previously mentioned behaviors on a less than daily basis (or when frequency was not present on the assessment, the behavior tended to be easily altered).

This triggered group includes about 8% of persons in long-term care facilities, 7% of persons receiving home care, and less than 1% of older adults living independently in the community.

NOT TRIGGERED

This group includes persons who have not exhibited any of the previously mentioned behaviors in the observation period during the last 3 days.

This group accounts for about 82% of persons in long-term care facilities, 90% of persons receiving home care, and 99% of older adults living independently in the community. Appropriate care for these persons is limited to monitoring for any unexpected new problematic behaviors.

Behavior CAP Guidelines

Initial considerations. For persons displaying behavioral symptoms, a three-step approach to care is recommended.

- Step 1: Characterize the specific nature of the behavioral symptoms. Assume that the behaviors displayed may be a means for the person to communicate the presence of existing or new health problems, discomfort, or fears. To ignore this possibility can further isolate someone who has limited cognitive skills or severe mental health problems.
- Step 2: As best as possible, identify the factors causing or exacerbating the behavior. Often disruptive behaviors are new, and as such, the person may have modifiable problems that can be addressed through good quality care. The review that follows focuses on the principal causal factors that must be considered. When a specific cause is

identified as the probable explanation, work with the physician, other care professionals, and when possible, the person, to establish a remedial plan of care.

- Step 3: Build on the person's strengths.

Step 1: Characterize the specific nature of the behavioral symptoms.

Active behaviors are often a form of communication, possibly about a mental or physical illness, an unmet need or fear, or the person's environment. Some are obvious, such as screaming or physical aggression. Other behaviors are less obvious, such as withdrawal from activities, isolation, or fear-induced agitation. In clarifying the nature of the behavior and related behavioral symptoms, consider the following:

- If the person is able to communicate, ask directly about his or her view of the situation. Does the person have an explanation for the behavior? Was he or she afraid? In pain? Excited or agitated? Hypervigilant? Was he or she aware of the consequences of the action?
- Describe the behavior in specific terms to facilitate understanding of its source or meaning, describing the behavior and what was happening when the behavior occurred.
  - Was aggressive behavior provoked (responsive) or unprovoked, especially when considered from the person's perspective?
  - Was it offensive (attacking someone else) or defensive (protecting oneself)?
  - Was it purposeful?
  - Was there an intent to harm in the behavior or was it a reflexive response?
  - Did it occur during specific activities (such as a bath)?
  - Was there any pattern, such as occurring at certain times of day?
  - Who was in the vicinity and involved?
- Did the environment influence the person's behavior (for example, lighting, noise, or setting)?
- Was it a reaction to a particular action, such as the person being physically moved?
- Is the person affected by sensory problems, particularly related to vision and hearing? If the person has problems with vision, is he or she often startled by others appearing in his or her field of vision unexpectedly? Does the person become confused by being unable to understand others because of hearing problems?

Step 2: Identify the factors causing or exacerbating the behavior.

Does the person have a long-standing mental health problem possibly associated with the behavioral disturbances? Examples include schizophrenia, bipolar disorder, depression, anxiety disorder, and post-traumatic stress disorder. A detailed psychiatric evaluation and a physician-directed plan of care are required when these conditions stand behind the disruptive behavior.

- Common symptoms include delusions, hallucinations, motor excitation, grandiosity, hostility, irritability, hyperarousal state, sleeplessness, flashbacks, startled responses, and phobias (for example, fear of needles, or fear of leaving the room).
- Some of these conditions can be addressed with medical or drug treatment. [See Mood CAP.] Others that are less responsive to traditional therapies should still be identified, understood, and addressed in care planning. For example, the physician may recommend a combination of drug interventions and nondrug interventions.
- Persons exhibiting long-standing problem behaviors related to psychiatric conditions may lack the ability to develop strategies to bring trouble in their lives under their own control. These persons may place others in danger of physical assault, intimidation, or embarrassment. They also place themselves at increased risk of being stigmatized, isolated, abused, and neglected by loved ones and those who provide care.

Does the person have dementia or recent cognitive loss? Examples include Alzheimer's disease, a stroke, and a decline in the person's Cognitive Performance Scale (CSP) score. [See Cognitive Loss CAP.]

- Did the symptoms occur suddenly, following a recent decline in the person's cognitive performance? In this instance, assume that an acute state of confusion or delirium is present. For people with a recognized dementia and existing behavior problems, delirium is often best identified when there is a rather sudden increase in frequency of the existing behavioral symptoms or the onset of new behavioral symptoms. When delirium is present, every effort must be made to identify and treat the underlying causes of the delirium. [See Delirium CAP.] The possible direct causes to be addressed include the onset of a new/acute illness, the reoccurrence of a chronic illness, or changes in medication regimen.
- Behavioral problems in dementia sometimes can be relieved by medications designed for dementia. Consider consulting the physician about these medications.
- Could the person be trying to communicate an unmet need? Does the person have difficulty making him- or herself understood? The person may be unable to communicate stress such as the urge to urinate, have an inability to know where to go, or experience pain on urination. Similarly, a person may display a challenging behavior because he or she does not recognize a caregiver or finds the environment unfamiliar and frightening.
- Does the person have other types of discomfort or needs that he or she cannot verbalize?
  - For example, is the person disrobing in public because the clothing is too tight or uncomfortable?
  - Is fatigue leading to lessened impulse control by the person?
  - Is the person wandering because he or she feels the urge to urinate but is too disoriented to find a bathroom?

- A person partially paralyzed by a stroke may get frustrated, angry, and physically aggressive when caregivers do not understand his or her attempts to communicate.
- A person with impaired mobility may need to be repositioned if he or she has been in the same position for a prolonged period of time.

- Is the person misinterpreting the environment or actions of others?
  - A person with memory loss may forget that he or she is married or make inappropriate advances to a member of the opposite sex.
  - Similarly, a person with Alzheimer's disease, seeing a housekeeper straightening up the room and picking up clothing, may interpret the unfamiliar person as a thief.
  - In such cases, agitation, verbal abusiveness, resistance to care, or even physical aggression may occur.
- Can the behaviors of the cognitively impaired person be tolerated? For many persons with chronic progressive dementia, certain behaviors may continue despite remedial treatments or interventions. Occasionally, the behaviors will be distressing, yet often can be accommodated.
  - For example, many persons who wander can be accommodated without restraints in a hazard-free environment.
  - Similarly, if the needs and patterns of persons with repetitive behaviors or catastrophic reactions are anticipated, care plan strategies may be developed and followed to avoid escalation of the behavior. For example, if the person becomes agitated and is known to strike out at staff during ADL care, stopping the activity at the first sign of agitation, and trying later, may prevent the striking out.

Does the person have a new or acute physical health problem or a flare-up of a known chronic condition that may be causing or aggravating a behavior symptom?

- Conditions such as delirium, an infection, dehydration, constipation, and congestive heart failure are physical health problems that can cause behavior disturbances. [A review of the Delirium, Dehydration, and Undernutrition CAPs is warranted.]
- Determine if anything interferes with the person's ability to get enough sleep (for example, light, noise, frequent vital sign checks during the night, or a roommate with different sleep patterns).
- Is the person in pain? This can result in depression, reduced mobility, social isolation, sleep disruption, and behavioral outbursts. The person may be startled if touched or moved in a way that aggravates the pain. If the person is receiving a pain medication or another pain management therapy, review it to find out whether it is being administered regularly and whether the dosage or intervention is enough to manage the pain without breakthrough pain. [See Pain CAP.]

Could the onset or aggravation of problem behaviors be associated with medication side effects?

- Is the person receiving a new medication or has there been a change in dosage? Review the length of time from the change to the onset or worsening of behavioral symptoms.
- Is the person receiving any medication known to contribute to or aggravate behaviors? Common medications causing side effects leading to behavior problems include:
  - Antiparkinsonian drugs can cause hypersexuality and socially inappropriate behavior, such as public masturbation or unsought sexual advances.
  - Some medications, such as sedatives, centrally active antihypertensives, some cardiac drugs, and anticholinergic agents can cause paranoid delusions, induce delirium symptoms, or cause reversible cognitive damage.
  - Bronchodilators or other drugs used to treat respiratory problems, such as chronic obstructive pulmonary disease (COPD) or asthma, can increase agitation and cause difficulty sleeping. Too much caffeine and nicotine can also have a similar adverse side effect.
  - Many medications and substances can impair impulse control. Examples include benzodiazepines, sedatives, alcohol, or any product containing alcohol (for example, some cough medicines).

Do family members and caregivers interact appropriately with the person? The actions and responses of family members and caregivers can aggravate or even cause behavioral outbursts.

- Do caregivers or family members have unrealistic expectations for what the person can do, considering the person's physical and cognitive function?
  - If appropriate, are caregivers dividing larger tasks (such as dressing) into a string of smaller activities the person can perform?
  - Are family members and formal caregivers aware of the person's cognitive patterns and physical functioning?
  - Do family members or caregivers express frustration with the person?
- Do family members and caregivers provide cues, reminders, and reassurance to help the person make sense of things?
- Are family members and caregivers asking too many questions or making too many statements at once? A person with communication problems—either physical or cognitive—could become frustrated coping with the information provided.
- Are there major unresolved sources of interpersonal conflict between the person and family members, other care recipients, or staff? Previous life events or dysfunctional patterns in social relationships may be an underlying cause of current behavior problems.

Is a behavior management program in place? What are the key elements of the program? Review how the person has previously responded to attempts to change or alter the behavior. What was tried? How well did it work?

- Is there a scheduled, at least monthly, drug regime review program involving nurses, physicians, and the pharmacist? Evaluate whether

there is congruence between psychiatric diagnoses and the prescription of psychotropic drugs. Assess whether there is a need to increase the use of a drug or whether it can be tapered off.

- Is there a documented behavior management program in place? Does it reference how others can best approach the person so that he or she reacts appropriately? Is there a strategy for increasing staff interactions with the person? Have staff received specific instructions on how to carry out such exchanges? Are they encouraged to enter into such exchanges, and is there a process for documenting the results? Does the program include specific behavioral therapy sessions led by a trained leader? Does it include structural activities? Has there been an environmental review, and have steps been taken to alter problematic stimuli?
- Has the program set specific improvement targets, either by changes in type of behavior, frequency of behavior, or date of expected change? Have specific changes been documented?
- Does the program serving the person have access to mental health specialists for evaluations? Has the person had a mental health evaluation, if needed?
- Evaluate the benefits for continuing interventions by determining whether or not the person's behavior improved over the last 90 days.
- Consider what other less restrictive approaches might be used if the current intervention is stopped.
- Track the person's response to a decrease or change in existing interventions, particularly changes in the use of psychotropic medications or restraints. Use of physical restraints should be considered a last resort option, if used at all.

Step 3: Build on the person's strengths.

The care plan should include strategies for improving the person's quality of life by enhancing his or her personal, social, and environmental strengths. Consider areas of strength that have been evident over the person's life in addition to those that are present today. Increase the opportunities for the person to draw on his or her strengths in daily life.

- When is the person comfortable and relaxed (for example, time of day, location, type of activity, social environment)? Are there factors present in these circumstances that can be used to reduce instances of problem behaviors?
- Which family members or caregivers are able to engage in calm, composed interactions with the person? Speak with these individuals to learn what they find to be effective in engaging the person in activities without agitation.
- What is important to the person now? What was important to the person previously? Does the person have opportunities to engage in activities that he or she values? Are there objects of sentimental value to the person, and does he or she have access to those objects (for example, photographs of family members, cards)?

- Be aware of cultural factors that may be a central part of the person's identity. Are there events that have been important for the person to celebrate? What can be done to support interactions with the person's cultural community?

- Where is the person most relaxed? What features of the physical and social environment are associated with positive behavior patterns? Does the person demonstrate less agitated behavior in quiet settings, less crowded environments, or environments with reduced visual stimuli?

Additional Resources

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