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**Lake Superior Quality Innovation Network**  
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## Behavior Management in Dementia

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## Objectives

- Recognize common behaviors in dementia
- Identify appropriate indications for antipsychotics
- Identify “target behaviors”
- Understand non drug management of behaviors
- Understand drug management of behaviors

## My First Experiences

- Case of Mr. Jones
- Case of Bill

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## Indications for Antipsychotics

- Schizophrenia
- Delusional disorder
- Mood disorder such as bipolar
- Tourette's Disorder
- Huntington's disease
- Hiccups
- Nausea and vomiting associated with chemotherapy
- Delirium

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## Indications for Antipsychotics in Dementia

- Hallucinations (not Bonnet's syndrome)
- Delusions (not misperceptions)
- Aggressive behaviors?
- Severe distress
  - Inconsolable
  - Target behavior presents danger to person or others

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## Behavioral and Psychological Symptoms of Dementia (BPSD)

- Wandering
- Unsociability
- Poor self care
- Inattention or indifference to surroundings
- Fidgeting/Nervousness/Restlessness
- Mild anxiety
- Impaired memory
- Uncooperativeness
- Verbal expressions

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## Behavioral Symptoms of Dementia

- Thought of as a medical problem
- Need to think differently... the doc in the office cannot fix
- Similar to daily behaviors of children in day cares and preschools

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## Investigation of Behaviors

- Unmet physical needs
- Unmet psychological needs
- Environmental causes
- Psychiatric causes

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## Unmet Physical Needs

- Pain
- Infection/illness
- Dehydration/nutrition
- Sleep disturbance
- Sensory deficits
- Constipation
- Incontinence/retention
- **MEDICATIONS!!!!**

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## Unmet Psychological Needs

- Loneliness
- Boredom
- Apprehension/worry/fear
- Emotional discomfort
- Lack of enjoyable activities
- Lack of socialization
- Loss of intimacy

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## Environmental Causes

- Level/type of stimulation as noise or lighting
- Institutional routines
- Lack of cues and prompts to function
- CAREGIVER APPROACHES

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## Psychiatric Causes

- Depression
- Anxiety
- Psychosis
- Other mental illness
- DELIRIUM

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## Delirium

- Acute cognitive impairment caused by a medical problem
- Disturbance of consciousness
- Disturbance develops over a short period of time usually over hours or days and can fluctuate
- Subtypes are hyperactive, hypoactive, and mixed
- Is the person more confused than usual?

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## Symptoms of Delirium

- Agitation/Restlessness
- Confusion
- Delusion/Hallucinations/Psychosis
- Disinhibition
- Inattention/Irritable
- Disorganized thinking
- Altered level of consciousness/fluctuating
- Labile affect

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## Management of Delirium

- Treat underlying cause
- Provide safety
- Non-pharmacologic and pharmacologic symptom management
- Pharmacologic interventions

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## Psychotropic Rounds

- What is the target behavior?
- Describe the target behavior accurately
- Is the target behavior really a problem?
- What was the antecedent?
- Is there a reversible condition?
- Is the medication effective for the target behavior?

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## Poor Examples of Target Behaviors!

- Agitation
- Resistance to Cares
- Wandering
- Yelling
- Uncooperativeness
- Physically Aggressive
- Paranoia
- Hallucinations

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## Good Examples of Target Behaviors

- Need to describe behavior accurately and provide an example instead of just saying “agitation”, “resistant to cares”, etc.
- Need details, frequency, interventions, and medication management
- Who is the behavior affecting?
- Instead of describing a behavior in general terms be very specific. Example: “He yells when he is left alone in the dining room” or “He grabs at the NAR’s clothing during morning cares”

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## Document What is Working and What is Not Working

- Document interventions and results
  - Is the behavior improving?
  - Necessary to provide to physician for further recommendations
  - May be necessary if facility determines this resident's behaviors are a threat to the safety of individuals in your facility, and resident will need to be discharged to a more appropriate setting

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## What You Should Document

- Behaviors and staff assessments
- Include details
  - Does the behavior occur every day/every shift?
  - What exactly is the resident doing or saying?
    - ✦ Example: "Resident is acting up" is non-specific. "Resident is throwing books at nurse" is more specific.
- Use actual "resident quotes" in progress notes
- Contacts with physician, psychologist, or psychiatrist for evaluations
- Interventions and effectiveness
- Training of staff

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## Staff Approaches Are the Most Frequent Causes of Behaviors

- Staff takes behavior personally and reacts by scolding or getting angry
- Staff does not view behavior as a symptom of a bigger problem
- Staff tends to focus on the results of the behavior instead of the cause
- Staff corrects, argues, or tries to reorient residents with dementia

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## Result of Our Own Behavior

- Residents feel rushed and pressured
- Residents are not given choices
- Resident frustration level increases
- Residents may become fearful or angry
- New behavioral symptoms develop
- Existing behaviors worsen
- Catastrophic reactions may occur

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## Behavior Has Meaning

- All behavior has meaning and the resident is trying to communicate something, i.e., fear, frustration, anger, etc.
- Agitation is actually the resident communicating distress
- Behaviors are a form of communication that something is not right in the resident's world
- We need to change how we think about a resident's behavior and realize that we have control over the situation

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## Suggestions to Change Our Behavior

- Accept the patient's reality
- Use social graces and communicate as if the resident was not confused
- Remove time constraints and task oriented goals
- Provide opportunities for the resident to succeed
- Find the path of least resistance

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## Changing Our Behavior

- Redirect with a positive approach
- Distract and divert
- Back off, come back later, and try again
- Do not correct or shame
- Watch your attitude
- Monitor your body language and tone of voice
- Don't use all your energy trying to change what you can't change
- Go with the flow!!!

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## Modifiable Factors Related to Abusive Behaviors in Dementia

- Lack of understanding leads to resistance to cares
- Use behavioral interventions to prevent escalation of behaviors
- Treat depression (serotonergic deficit may be the mechanism by which depression increases abusive behavior)

Volicer et al, Journal American Medical Director Association 2009; 10: 617-622

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## Antipsychotics and Mortality in Dementia

- Several studies show modest effect of risperidone in treatment of agitation, aggression, and psychosis in dementia. **HOWEVER...**:
  - Antipsychotics are associated with increased sedation, gait disturbance, falls, anticholinergic effects, and increased QTc prolongation
  - Antipsychotics have a **BLACK BOX** warning of increased deaths to thrombo-embolic events, sudden cardiac arrhythmias, and bronchopneumonia

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## Summary of Antipsychotics in Dementia

- Harmful
- Used off label to treat BPSD
- Ineffective in treating behavior
- Usage varies from facility to facility based on facility culture, not patient characteristics
- Based on a fundamental misunderstanding of behavior in dementia
- Belief that a medication will simply make a person stop doing something undesirable, and quickly

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## So Why Do We Use Antipsychotic Meds?

IF ALL WE HAVE IS A HAMMER,  
EVERYTHING LOOKS LIKE A NAIL!

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## Suggestions for Managing Behaviors

- Identify target behavior
- Look for reversible causes
- Treat depression and pain
- Change the culture by being open minded and not defensive
- Drugs are not always the answer, concept of “Doctor Fix It Calls”
- Use drugs only for appropriate reasons
- Monitor for effectiveness and dose reduction

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## Other Thoughts

- Get your medical director/MDs involved
- Psychiatrists tend to prescribe meds
- Mentally ill patients dose reductions should be managed by a psychiatrist
- Develop a facility “CHAMPION” who manages your psychotropic rounds
- Provide caregiver education and support
- Train staff in problem solving of specific behaviors
- Just say NO to antipsychotics!!!!

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## References

- University of Iowa web site, various documents all free, [igec.uiowa.edu](http://igec.uiowa.edu)
- Antipsychotics and Mortality in Dementia, *Am. J. Psychiatry* 2012;169;7-9
- The Ethics of Antipsychotics in Alzheimer’s, *Caring for the Ages* 05/01/11
- Modifiable Factors Related to Abusive Behaviors in Nursing home Residents with dementia, *JAMDA* 2009; 10: 617-622
- Clarifying Delirium Management: Practical, Evidenced-Based Expert recommendations for Clinical practice, *J of Palliative Medicine* vol 16, no 4 pp 423-431 2013
- Omicare regulatory update on F329 Unnecessary drugs July 2013
- Changing Your Behavior to Prevent Behavioral Symptoms a ppt presentation by Jan B. Garard RN Quality Improvement Coordinator DHS MN
- Nonpharmacologic Management of Behavioral Symptoms in Dementia, *JAMA* vol. 308, no. 19 pp 2020-2029, Nov. 2012

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