PART II OF THE SERIES:
DEMENTIA: It's Not Just Alzheimer's Disease

VCU Gerontology
School of Allied Health Professions

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

Agitation and Aggression

Strategies for Prevention and Intervention in ADCC Centers

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A PROGRAM FOR PROFESSIONAL CAREGIVERS WORKING IN ADULT DAY CARE SETTINGS

A FOUR-PART WEBINAR SERIES

1

Part I: DEMENTIA: It's Not Just Alzheimer's DISEASE (Impact for ADHC)

2

Part II: Working with Individuals with Agitation/Aggression

3

Part III: Working with Families

4

Part IV: Activities for the Cognitively Impaired

Learning objectives

1. Describe differences between **restless, agitated**, and **aggressive** behaviors.

2. List at least 4 **potential causes of aggressive behavior**.

3. Discuss ways to **minimize aggressive behavior** in the adult day center setting.

4. Identify possible **defusing strategies** for both cognitively intact and cognitively impaired residents.

For Review - Homework

- Case Studies – Decisions?
- SWOT Analysis
- Person Centered Care Approach
- Dementia (Many Types), Depression, Delirium, etc.

Case Study 1

Ms. Evans is an 82-year old African-American woman. She has shared a home with a woman, Ms. Jones, for nearly 40 years. Both women enjoyed good southern cooking, watching game shows and generally kept to themselves, but were certainly congenial during the infrequent times when they interacted with neighbors. They both worked in retail, shopped together, visited the same physician, attended the same house of worship and were rarely seen without the other.

Earlier this year, Ms. Jones died suddenly; the result of an apparent stroke. Ms. Evans remained in the home, but over time neighbors noticed that the house began to fall into ill repair. The once manicured yard became over-run with weeds, garbage piled high on the front porch and Ms. Evans would remain in her home for weeks at a time.

One morning, the city's street cleaning crew was coming through for annual maintenance. Signs had been posted for a week about car removal. Ms. Evans car had not been moved and was about to be towed. A concerned neighbor, hurried over to Ms. Evans' house, knocked on the door and was greeted by a rumpled, but congenial Ms. Evans who expressed her sincere thanks at the reminder to move her car, which she did immediately.

Later that evening, the neighbor returned when she noticed that Ms. Evans' car had not returned to its usual spot. She knocked, but this time there was no answer. The door was slightly ajar so the neighbor entered. She found Ms. Evans wandering between the kitchen and living room in an agitated state, in only a partial state of dress, talking to "Sissy." She was seemingly unaware of the neighbor at first and upon noticing her, became increasingly agitated and demanded to know where "Sissy" was. Not knowing what to do, the neighbor looked throughout the kitchen and home for some kind of contact information for a relative or friend. Without finding anything and with Ms. Evans continue to become increasingly agitated and disoriented, she called the paramedics.

The paramedics arrived and, upon a short assessment, commented about "another crazy old lady" and carried her off to the local hospital. She was never to return to her home.

Case Study 2

Mrs. Frank is a 92-year old widow. Her husband passed away some 20 years ago.

She has remained in her rural country home, active in her church and very engaged in volunteerism, maintaining an immaculate 3 acre yard and often in a very congenial mood.

Mrs. Frank had a cardiac episode about the time her husband became ill. She had been placed on Digoxin by her primary care physician, but other than this and eye drops for macular degeneration, Mrs. Frank is a healthy and vibrant woman.

One day, while on a ladder trimming her apple tree, Mrs. Frank falls and fractures her pelvis. She is admitted to the hospital, where she had surgery to repair the pelvis.

For the next two weeks she is completely "out of it." She hallucinates. She is agitated. Mrs. Frank is prescribed anti-anxiety medication as well a blood pressure medication, in addition to the Digoxin.

Mrs. Frank is admitted to a Rehabilitation facility where she improves slightly; enough to be admitted to a skilled nursing facility. She constantly asks to be taken home, continues to be forgetful and confused and is diagnosed with having progressive dementia.

Mrs. Frank is never to return home and passes away within 2 years during a slow decline in both physical and mental health.

Case study: Withdrawn executive

A 62-year-old female retired executive began having difficulty finding words.

She slowly began to lose her ability to express ideas.

She became quieter and somewhat socially withdrawn.

She also started to have trouble writing.

When talking, she took a long time to express her ideas. Others told her that she had trouble "spitting out her words."

Social graces remained preserved, although she expressed profound frustration regarding her speech, and she developed a major depression.

There was no family history of dementia.

Case Study: "It's NOT my fault!"

Mr. Ellis is an unmarried older adult living in government supported independent living.

As his social worker, you notice that over a series of months, he is becoming more isolated and speaking to you less and less.

He seems generally apathetic to most situations around him, aside from a daily trip to the store for groceries.

You notice challenges with his keys, balance and navigating the community's revolving front door.

When you initiate a general conversation, he seems to create stories of events that you do not recall.

He is also seemingly unaware of any decline in his health, but does continue to engage in the strange and confusing story-telling.

We're only human!

Aggression

Anxiety

Even ***violence***.

Anger

These are normal human emotions, responses and conditions.

It is one's ability to **control, change and manage** these responses and conditions that allows them to function in their particular culture.

Regardless of the diagnosis…

Whether you are assisting a person with any form of dementia, depression, delirium, or any other diagnosis, **it is important to know the signs and symptoms and progression of the disease** to better understand what **MAY** or **MAY NOT** be a behavior that causes concern.

3 Steps to Success

Step 1:
Awareness

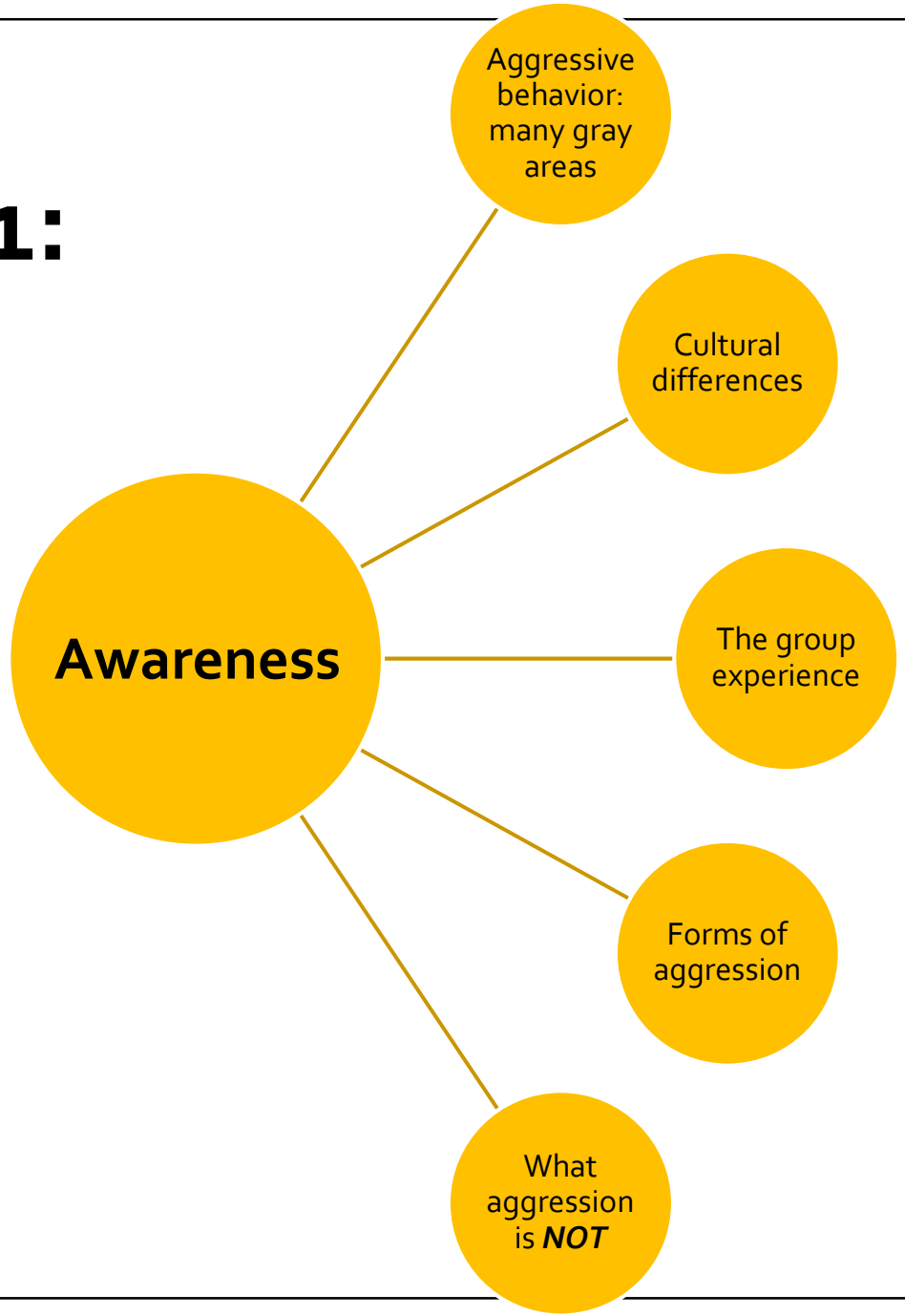
Step 2:
Empathy

Step 3:
Prevention & intervention strategies

STEP #1:

AWARENESS

Step #1:


Awareness
Aggressive behavior: many gray areas
Cultural differences
The group experience
Forms of aggression
What aggression is *NOT*

Family

Adult care centers

Sexual orientation

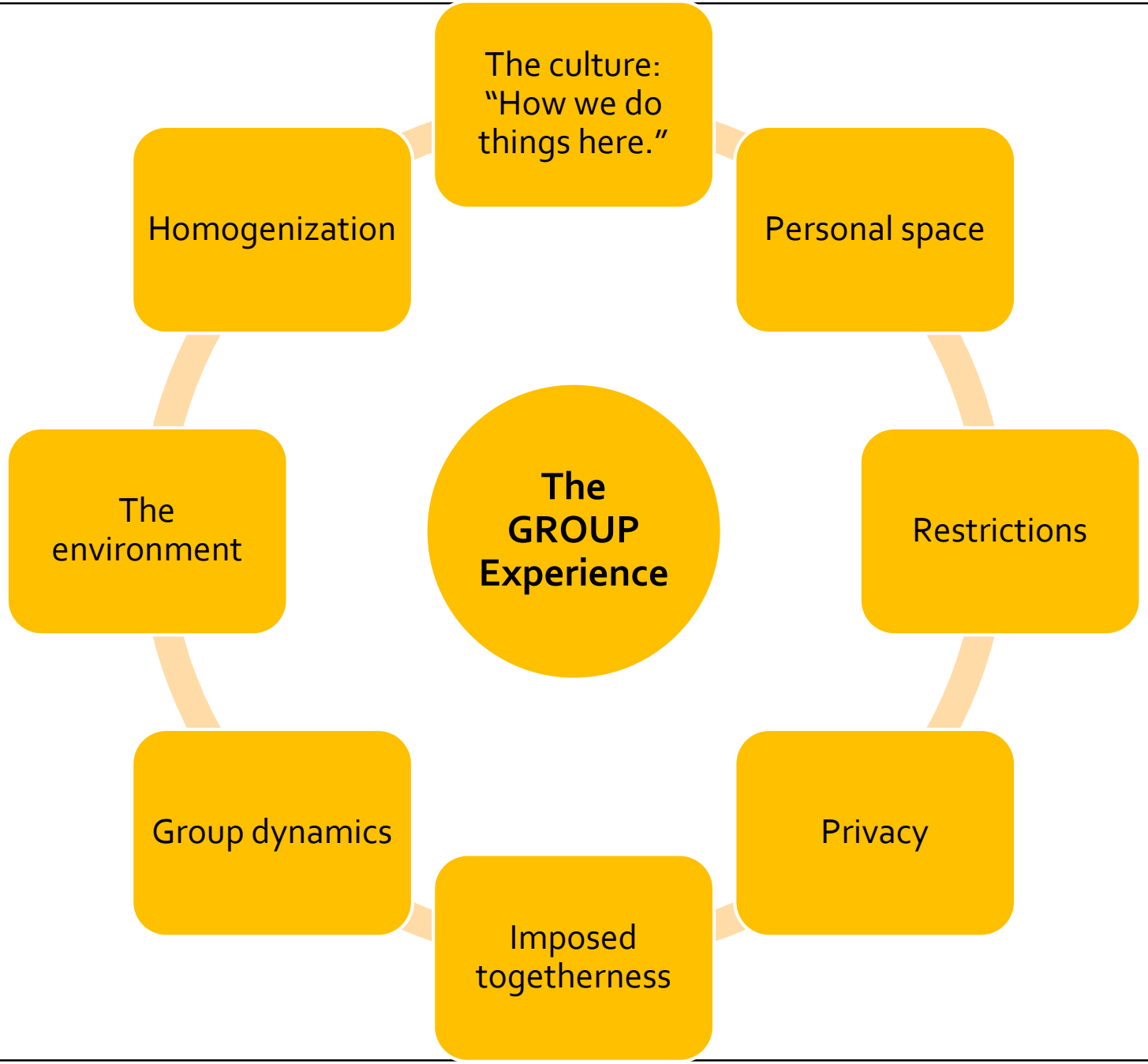
Gender identity

Age

Ethnicity

Religion

Cultural Differences

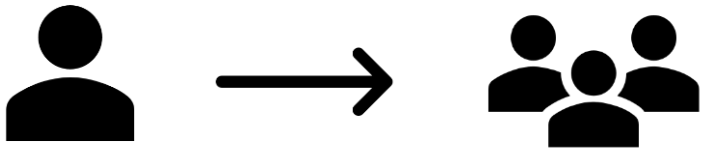

The culture: "How we do things here."
Personal space
Restrictions
Privacy
Imposed togetherness
Group dynamics
The environment
Homogenization
The GROUP Experience

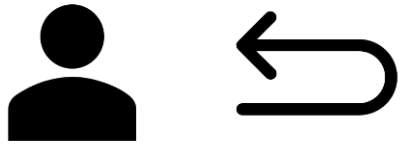
The Group Experience, cont'd

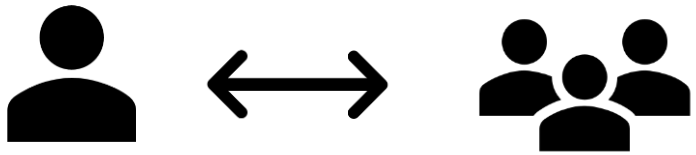
Have you ever been in a group situation?

- Was it your choice?
- How long did it last?
- What did you like best about it?
- What was the worst part?

Aggression's Directions







Aggression Lives in the Brain

- Biological factors
- Neurological and structural factors
- Psychological influences

Aggression ≠

- A description of mood
- A label for lack of cooperation
- Anger
- Disinhibition
- Intrusiveness
- “Doesn’t know his own strength”
- Catastrophic reaction

Behavior Changes of Dementia*

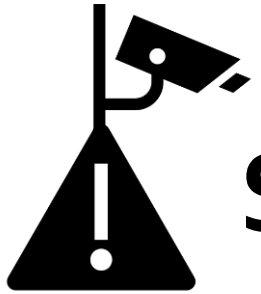
- Wandering & pacing
- Hoarding & 'shopping'
- Unfocused screams & cries
- Sundowning
- Inappropriate sexual touching or speech
- Personal insults
- Catastrophic reactions

**Often associated with agitation or aggression*

Delirium: Behavior Changes

<u>Sudden</u>, acute changes in behavior …

- Agitation or aggression
- Decreased attention
- Confusion
- Disorientation
- Irritability
- Switching from lethargy to agitation and back
- **… within hours or days.**



Self-Defense

Usually an automatic, or gut, reaction

A response to perceived threatening behavior

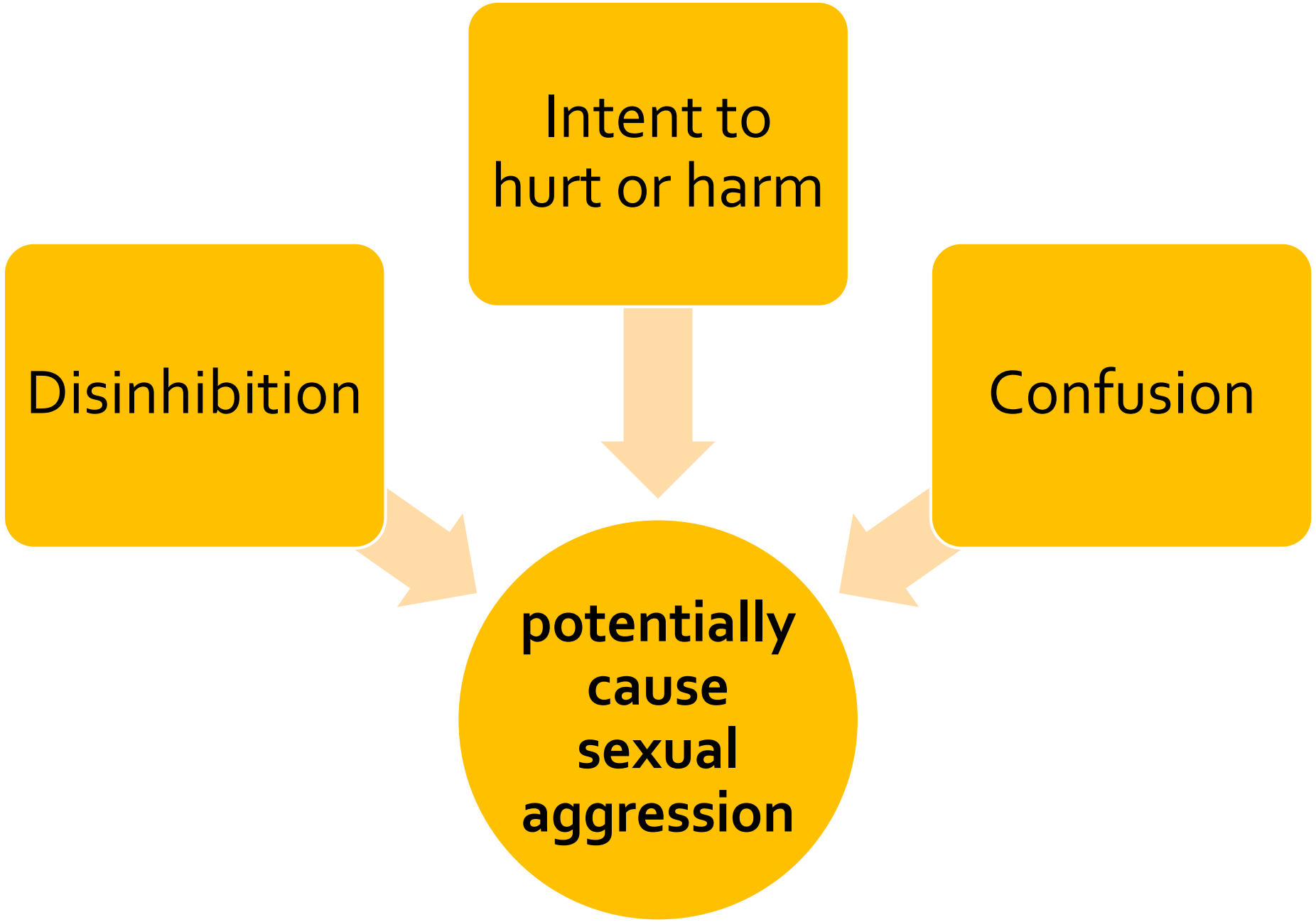
Fear or confusion about the intent of another's behavior

An attempt to stop threatening intrusions on personal space

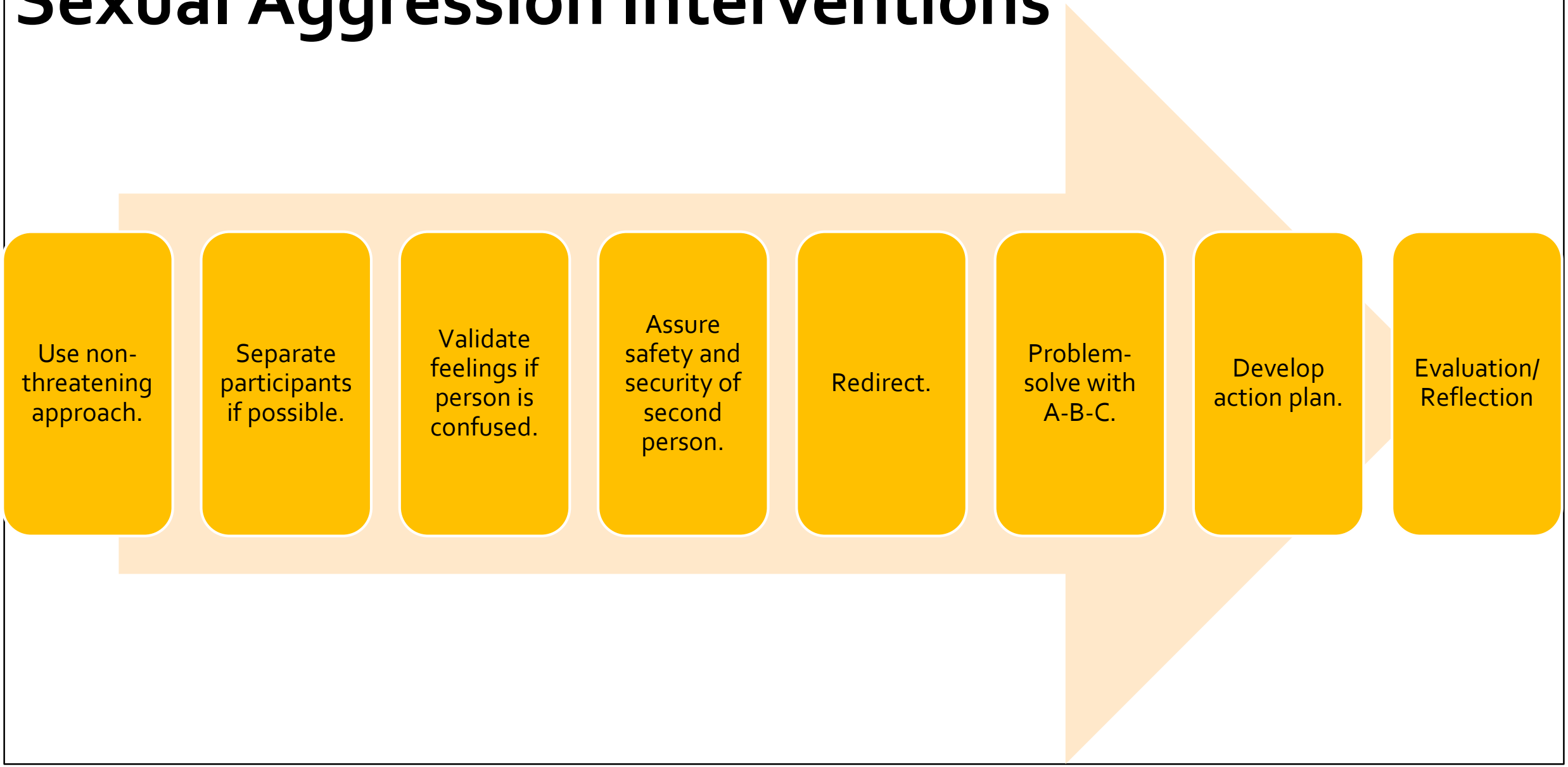
Protection of 'what is mine' from theft or injury

Participant-to-Participant Aggression

- Common, but often overlooked
- Rarely malicious – often due to confusion
- Often occurs between CI and CT
- Implications for managing the environment


Intent to hurt or harm
Disinhibition
Confusion
potentially cause sexual aggression

Sexual Aggression Interventions



STEP #2:

EMPATHY

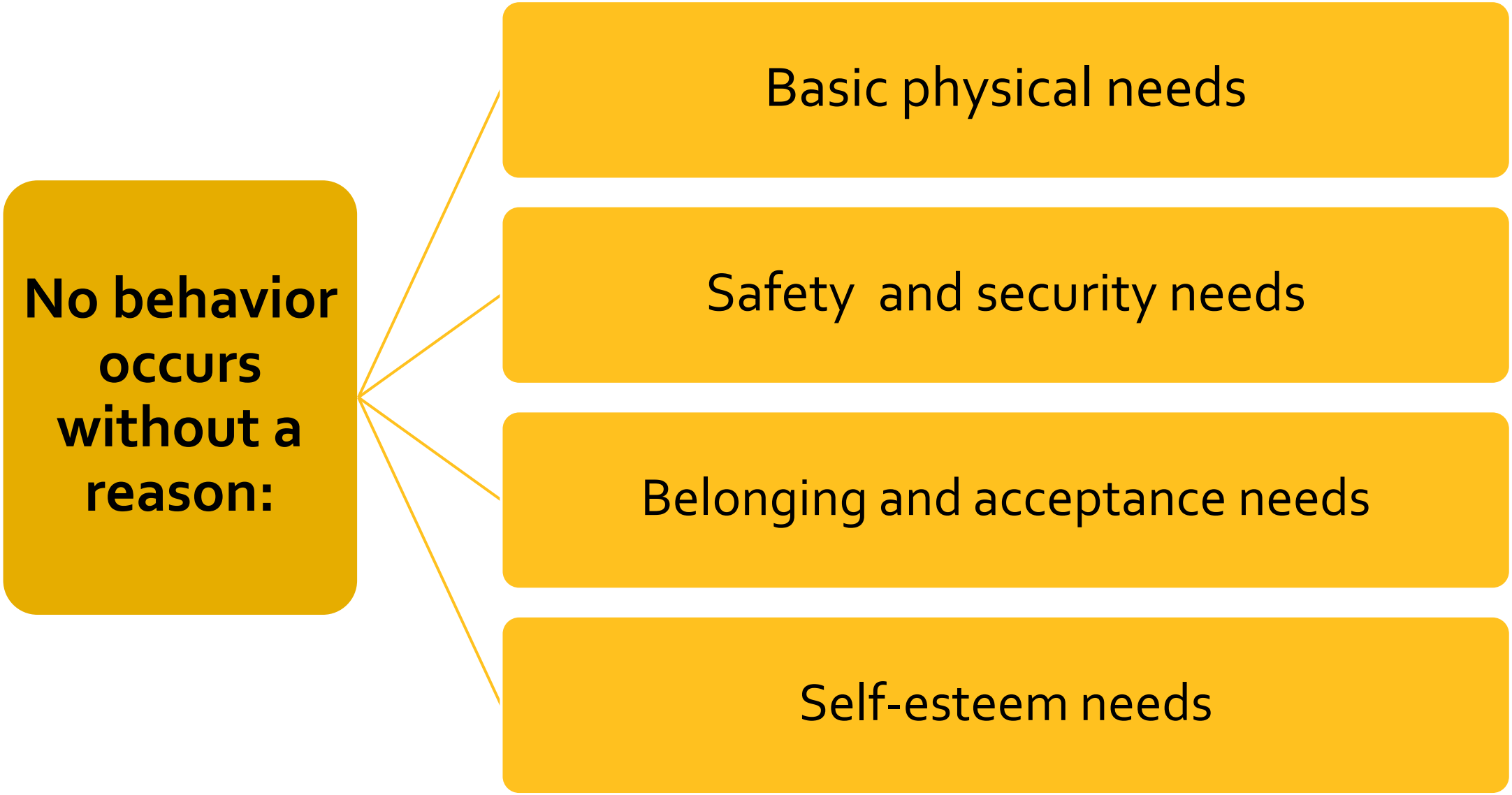
Empathy

- the ability to recognize and understand the meaning and significance of another person's emotions and behavior

Sympathy

- the act of expressing interest or concern about the problems or emotions of someone else; pity/paternalism.

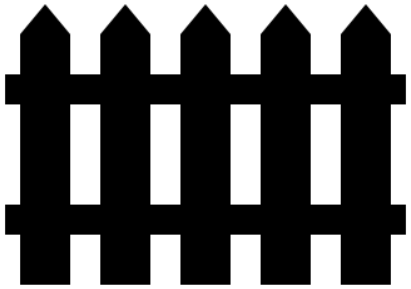
Unmet Needs


No behavior occurs without a reason:
Basic physical needs
Safety and security needs
Belonging and acceptance needs
Self-esteem needs

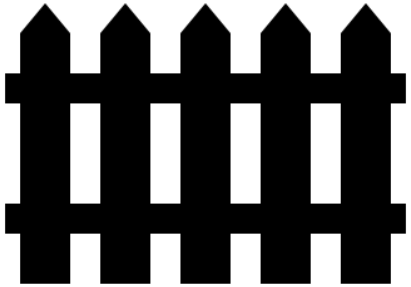
3 Big Barriers

These barriers can prevent people from independently meeting their own needs.

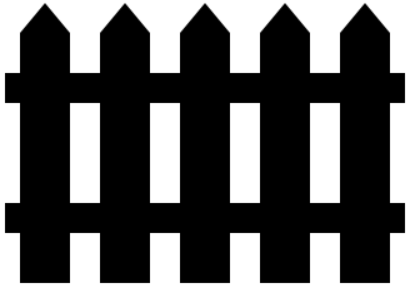
Limited ability to communicate



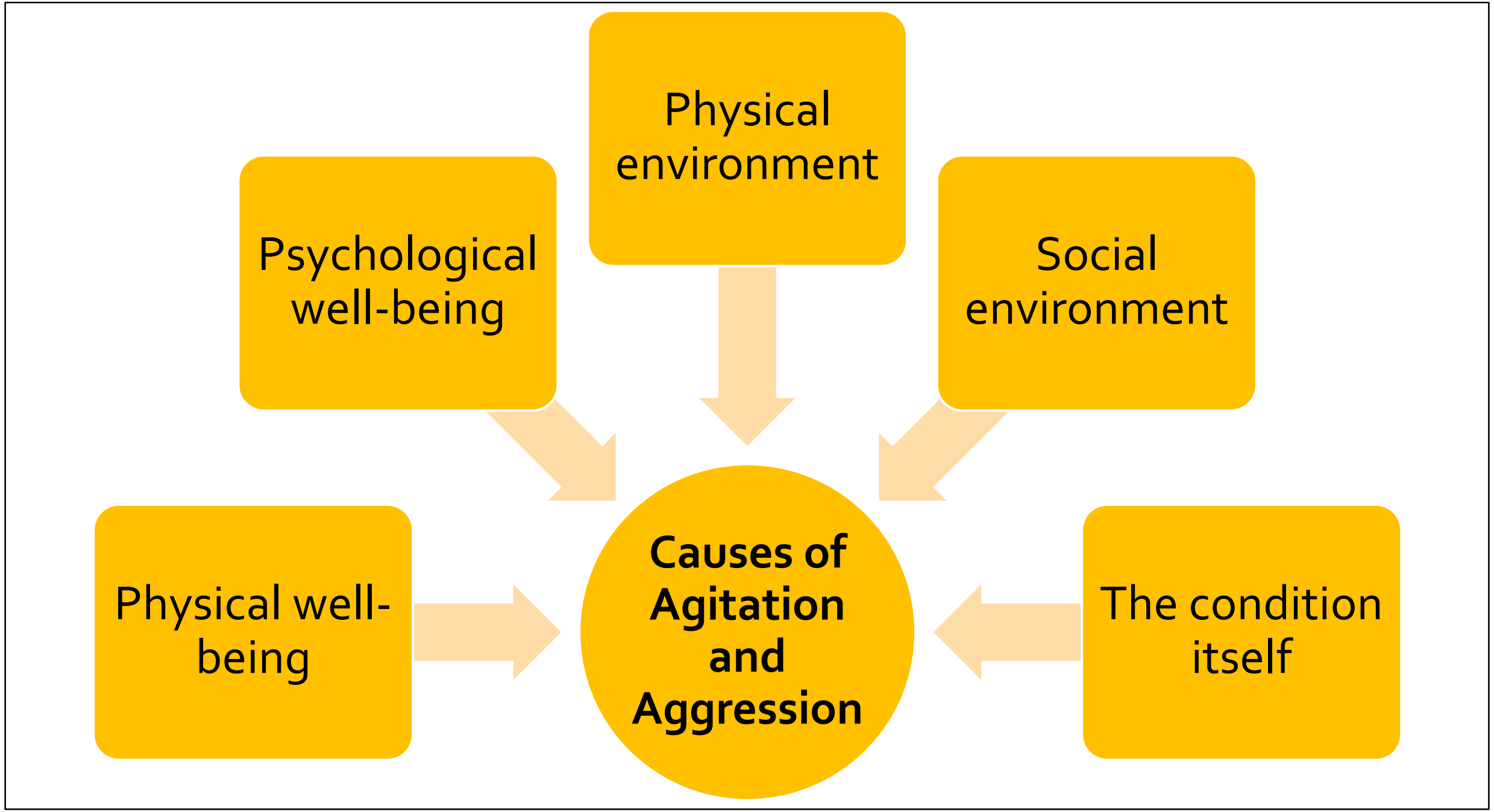
Dependence on others



Confusion and disorientation



These 3 barriers are common themes when discussing causes of disturbing behavior.


Physical environment
Psychological well-being
Social environment
Physical well-being
Causes of Agitation and Aggression
The condition itself

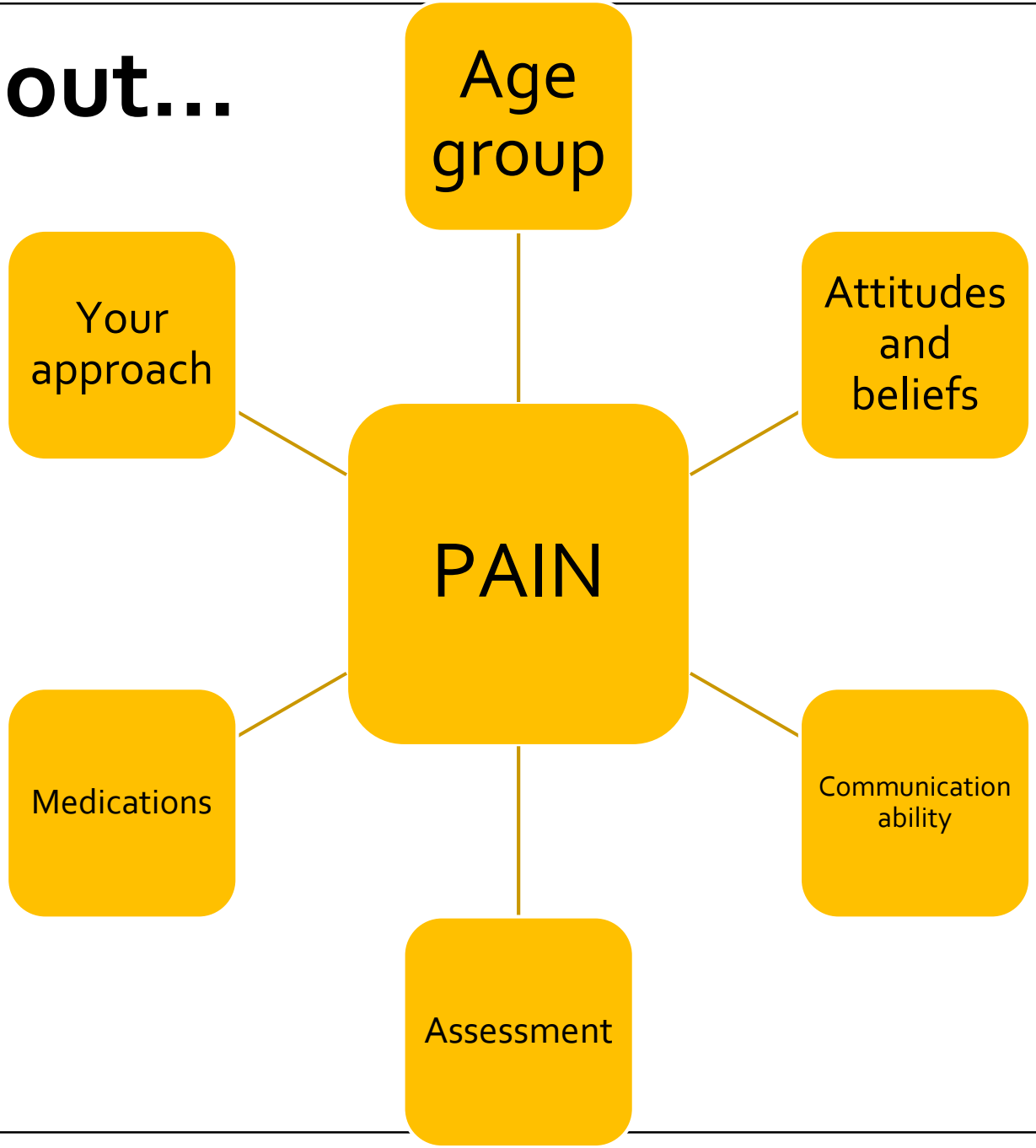
The Condition Itself

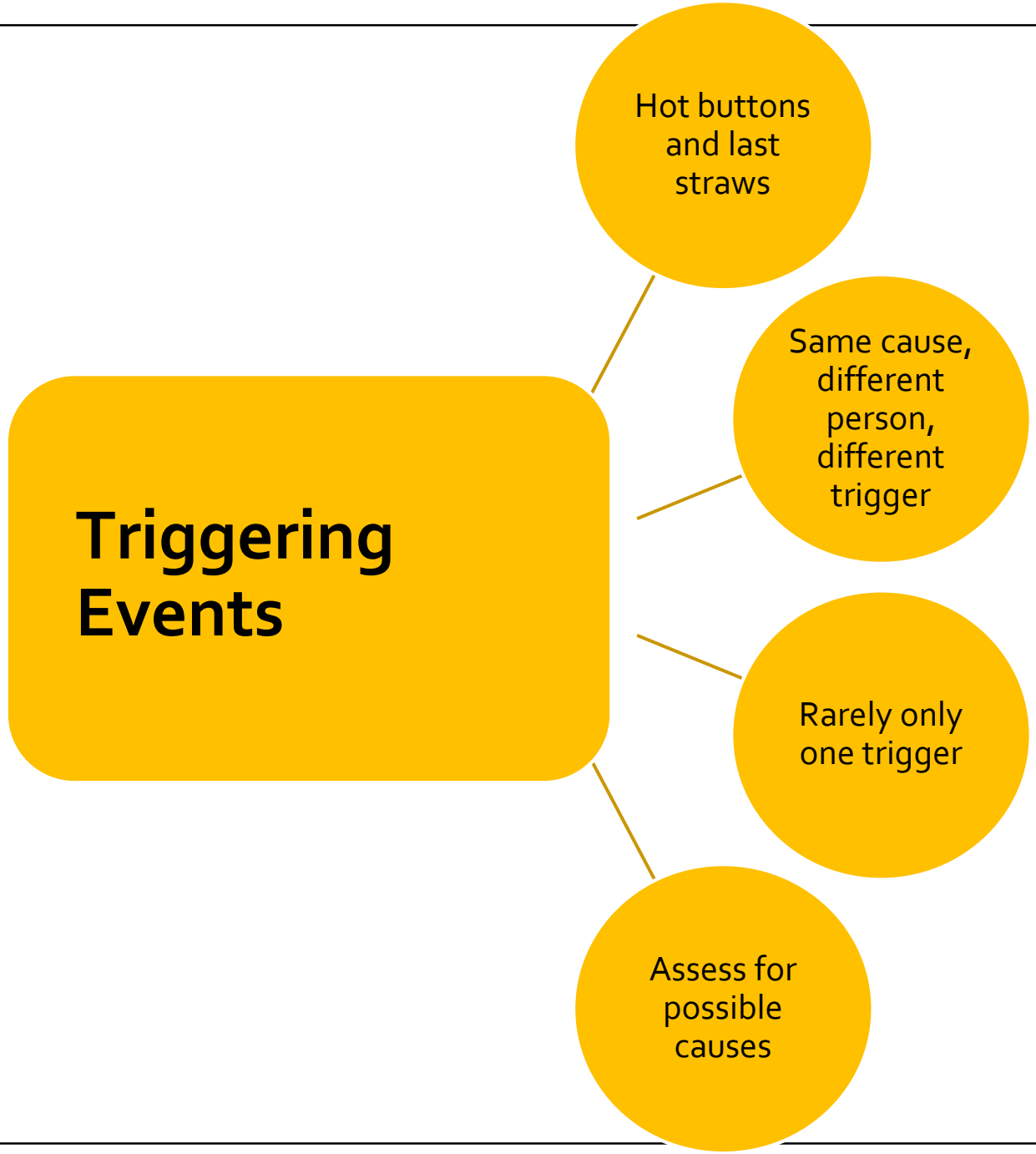
- Hallucinations
- Rage ‘storms’
- Impulsivity
- Extreme mood fluctuations
- Disinhibition
- Immature impulse control

Environmental structure *is the first line of prevention.*

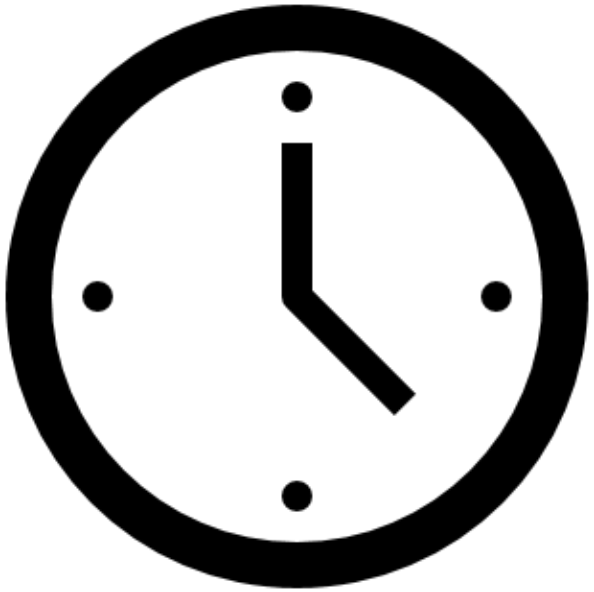
Medication management *is also indicated for some types of neurological disorders but hopefully the last line of defense.*

A Word About…


Age group
Your approach
Attitudes and beliefs
PAIN
Medications
Communication ability
Assessment


Triggering Events
Hot buttons and last straws
Same cause, different person, different trigger
Rarely only one trigger
Assess for possible causes

Difficult Times



- Mornings
- Transitions
- Personal care (toileting), Bathing (if provided at center)
- “Sundown” – End of day routines

Fight-or-Flight

- Automatic reaction to a threat
- Brain ⇨ Hormones ⇨ Organs
- Negative effects if chronic
- Primitive vs modern
- Implications for care

Show-down: lion versus zebra …

Rosie

- Rosie's is a tale of unmet needs.
- She is a participant in your center. She typically engages in most activities but one day around 11:00 am she began to be a little restless. She sighs. She begins to squirm in her seat. She's does not say that anything is wrong but clearly something has changed. She then mentions that she must go to the bathroom. Staff is busy doing an activity and let her know that they will assist her in a few minutes. She rocks back and forth. She calls out for assistance again. Staff again assure her that it will be a minute. She calls out in an even more urgent voice that she must go NOW! She cannot get to the bathroom on her own, much less in time.
- She feels a warm trickle and begins to cry. The other participants will make fun of her. Her daughter will be disappointed. Rosie throws her cane on the floor. Staff comes to her side and starts to comfort her in a soft voice.
- Rosie screams, "No!" and smacks the staff's hand.

Think about the scenario…

- Describe Rosie's agitated behavior. Did she display any aggression?
- What were Rosie's needs? *(Think Maslow)*
- What might have happened next?
- Has an incident similar to Rosie's happened in your center?
- What can you do within your center's daily operations to prevent a similar situation from occurring?

Agitation

Reminder….

- Increased intensity or frequency of behaviors.
- This state indicates intense physical or emotional discomfort, high arousal and tension levels, and irritability.

STEP #3:

STRATEGIES

Regulations

- Minimum standards
- Best practices

Refer to your current Department of Social Services Regulations.

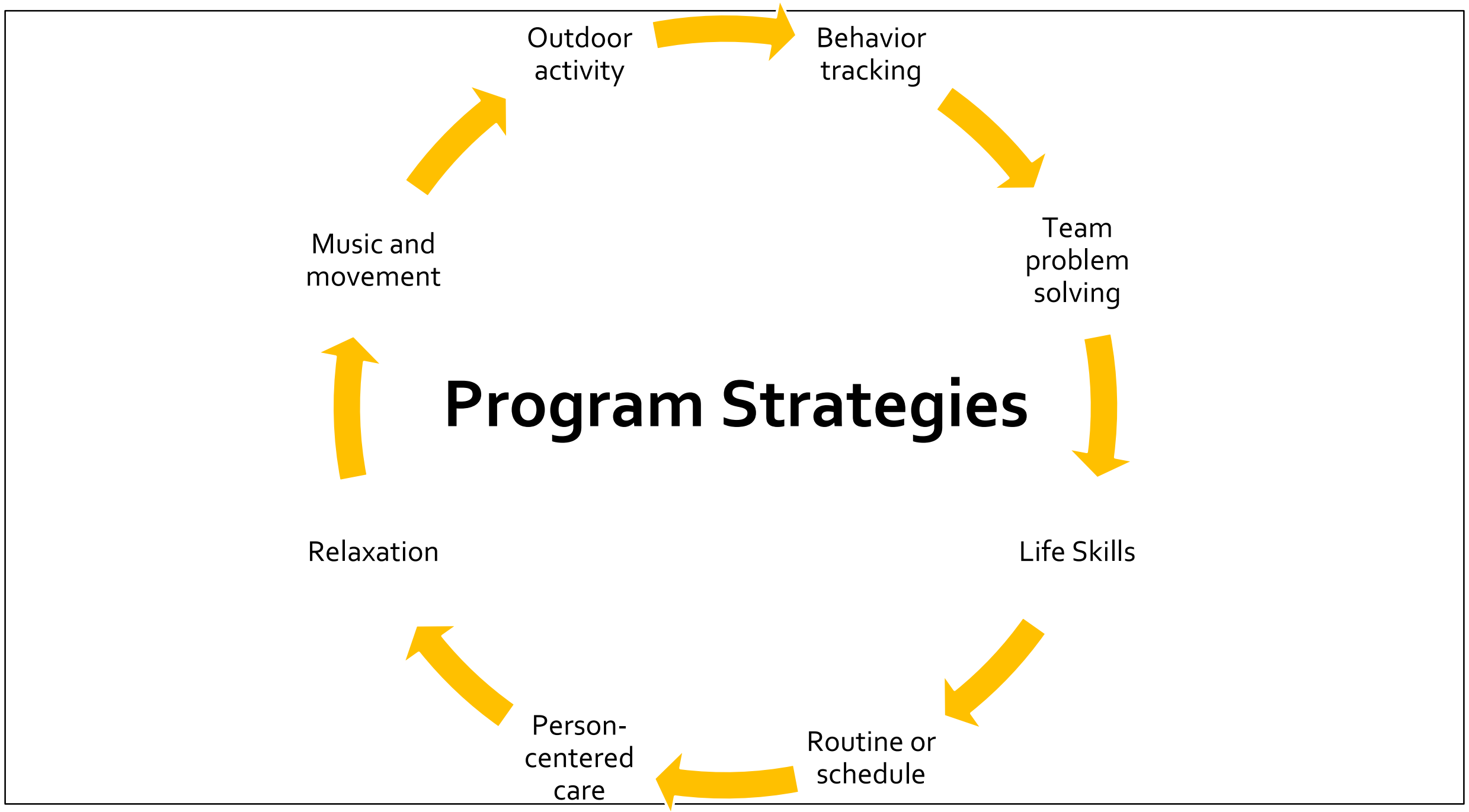
When To Intervene

Use a management strategy to stop agitated or aggressive behavior <u>if</u>:	The behavior significantly interferes with the personal **rights** of others;
	If the behavior significantly threatens the **well-being** of anyone;
	If the behavior chronically interferes with necessary **personal care** (ADLs).


Minimize high risk behavior in four ways:
Build a proactive program
Establish a flexible, adaptable environment
Prevention
Evaluate your program's resources
Promote positive interaction strategies

Thought for the Day:

Be proactive, Not reactive.


Program Strategies
Outdoor activity
Behavior tracking
Team problem solving
Life Skills
Routine or schedule
Person-centered care
Relaxation
Music and movement

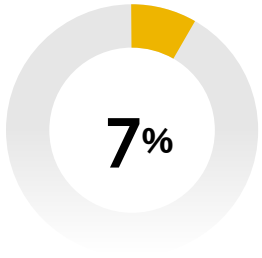
Relaxation Activities

Relaxation Activities Benefits

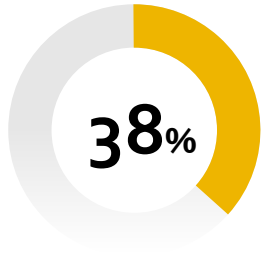
- **Deep abdominal breathing**
  - helps oxygen to reach lower parts of lungs
- **Release of tension**
  - gives an external means of managing agitation
  - provides sense of control over one's body
- **Focus of attention**
  - provides cognitive activity
  - -- can serve as a distraction
  - -- anchors confused and disoriented people in their body and in the environment

Communication …

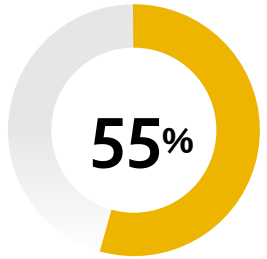
… your most important behavior management tool:



from words



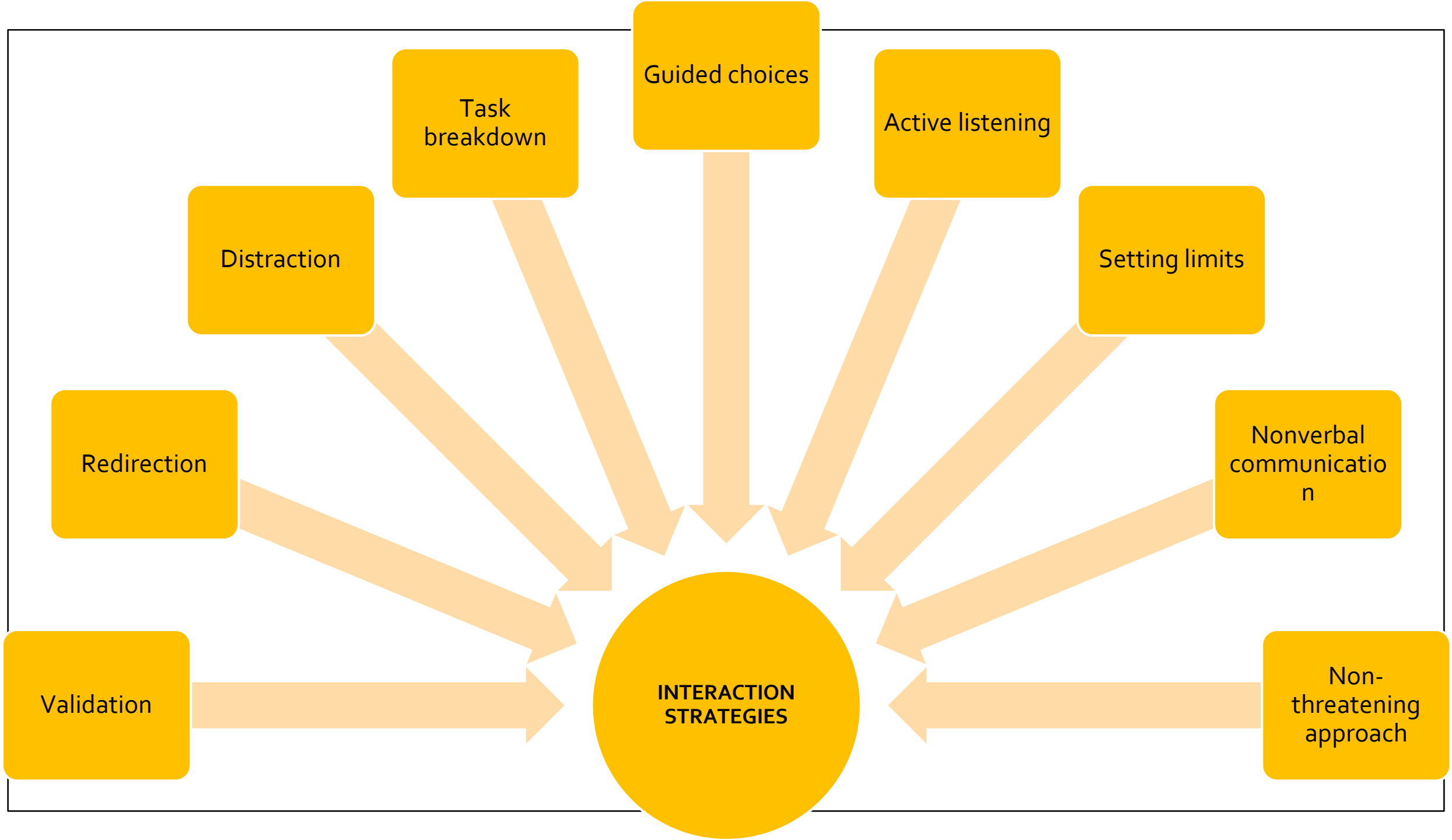
from paraverbals



from body movements

Your words are a very small part of communication.

Remember, the burden of communication is on YOU!

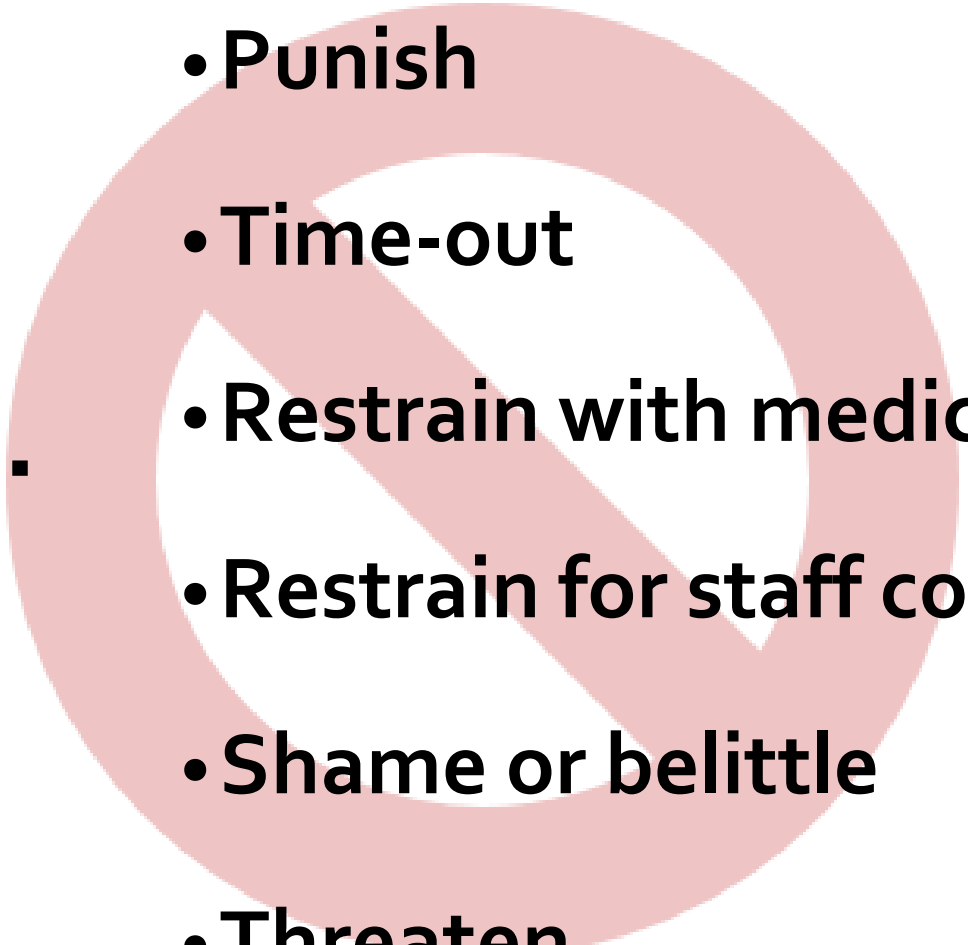

Guided choices
Task breakdown
Active listening
Distraction
Setting limits
Redirection
Nonverbal communication
Validation
INTERACTION STRATEGIES
Non-threatening approach

Valuable Words

“Please let go.”	“I’m sorry.”	“Could you help me with __?”	“Can you hold this for me?”
“Tell me about __.”	“Tell me more.”	“You’re safe here with me.”	“What can I do to help right now?”

Don’t ever, EVER …

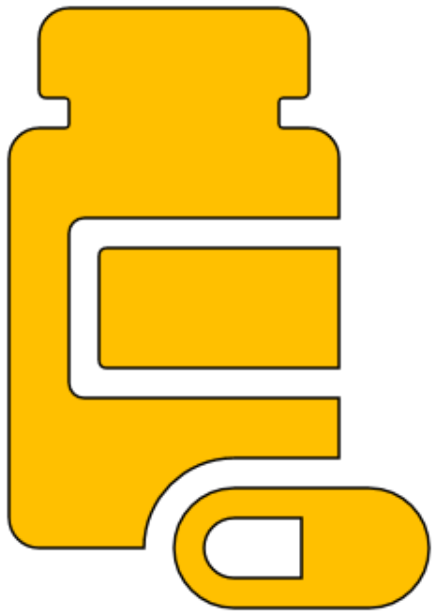
- Punish
- Time-out
- Restrain with medications
- Restrain for staff convenience
- Shame or belittle
- Threaten



Your A-B-Cs

- **A**ntecedent (what happened before the behavior)
- **B**ehavior (the undesirable action)
- **C**onsequence (the result of the behavior)

Medications



Targeted medications

Antidepressants

Dementia medications

Antipsychotics

Pain medications

Tranquilizers

Remember, the best treatment for high risk behavior is YOU!!

Immediate Intervention

1

Defuse

- Ensure safety of all
- Ask for help (if needed)
- Non-threatening approach
- Be directive (if appropriate)

2

Reduce the tension

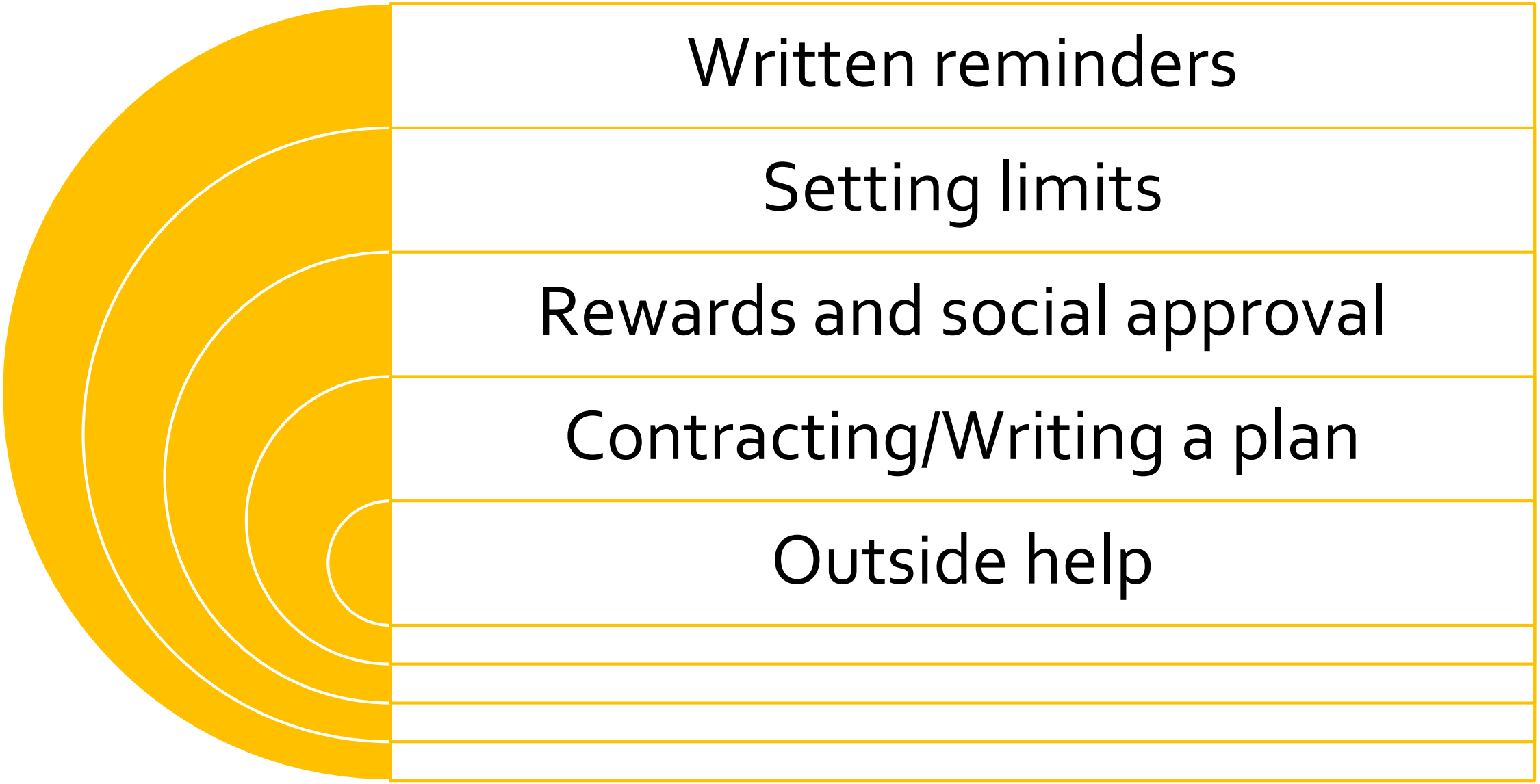
- Lower intensity
- Provide time
- Quiet, safe place
- Redirection

3

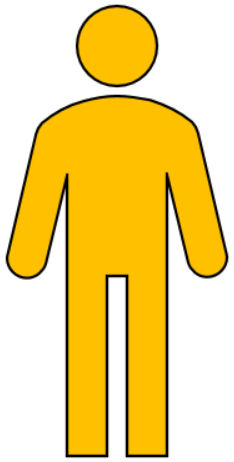
Debrief

- Validation
- Discussion of limits or rules
- A-B-C Problem-solving
- Reassurance of others

Behavior Management



Practice Personal Safety



- Your person
- Your approach
- The environment

If All Else Fails …

- Back off.
- Step out of range.
- “Please stop.”
- Block strikes.
- Break grabs.
- Press into bites and pulls.

Prevention:

- We recognize triggers.
- We understand sources.
- We meet the need.

+

Intervention:

- We ensure safety.
- We analyze behavior.
- We search for triggers.
- We make changes.
- We evaluate.

→

Then we start again.

Homework

Continue to work on your SWOT analysis.

Join us for Working with Families Webinar

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