

# OVERVIEW OF CHALLENGING BEHAVIORS



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# PURPOSE & KEY TERMS

- The purpose of this section is to assist the learner in acquiring basic understanding of the type of behaviors associated with dementia, identifying who is affected by the behaviors and steps to solve or redirect the behaviors.
- Wandering
- Anxiety
- Agitation
- Pacing
- Physical Aggression
- Yelling

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# OBJECTIVES

- The learner will be able to:
  - ❑ Understand behavior is a form of communication.
  - ❑ Understand not all behaviors are a problem and may require an adjustment in your attitude and thinking.
  - ❑ List types of behavior symptoms encountered and types of interventions that redirect or minimize the behavior.
  - ❑ Discuss activities that may be meaningful to a resident.
  - ❑ Develop an individualized plan that addresses interventions for a behavior.

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# INTRODUCTION

- The problem may be that the resident becomes agitated when there is noise or confusion in the home:
  - The solution may be to be sure the resident is not in the room when the vacuum is being used; or
  - The resident is taken out for a walk when there are a lot of visitors.
- Challenging behaviors may have simple solutions such as the following example:

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# EXAMPLE

A nursing home resident was able to climb the tall fence surrounding a small courtyard off the Alzheimer's unit. Staff was continually following the resident out the door and bringing him back into the facility. A nursing assistant remembered the resident had worked in construction all his life so they hung a sign on the inside of the door that read **“CONSTRUCTION AREA — HARD HATS REQUIRED.”** The resident respected the sign and never went out the door again.

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# INTRODUCTION CONTINUED

- A qualified health professional (mental health professional or a RN experienced in mental health) can help you explore options to help the resident without using medications or physical restraints:
  - They may determine the behavior is due to a physical problem and recommend the resident see their primary health care practitioner;
  - They will assess the resident to determine if there is a medical reason for the behavioral symptoms (which may actually be delirium rather than dementia).

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# ALTERNATIVE MEASURES

- AFH rules require that you try all alternative measures before using psychoactive medications and physical restraints to solve behavior problems:
  - “Alternative measures” simply means using methods other than medications and physical restraints to reduce the behavior symptoms.
  - The qualified professional can help you determine other alternative measures you may not have considered.

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# ALTERNATIVE MEASURES CONTINUED

- It is important to consider physiologic (body function) reasons for behaviors, for example:
  - Illness;
  - Comfort;
  - Pain management;
  - Toileting;
  - Medication side effects;
  - Dehydration;
  - Constipation;
  - Hunger;
  - Change of medication;
  - Naps.

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# ALTERNATIVE MEASURES CONTINUED

- Psychosocial — psychological and social factor examples:
  - How the caregiver, resident or household members reacts to a situation;
  - Attention given to the resident's needs;
  - Companionship.

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# ALTERNATIVE MEASURES CONTINUED

- Activity examples:
  - ❑ Ambulation and other exercises;
  - ❑ Outings and recreation;
  - ❑ Social activities;
  - ❑ Doing something familiar to the resident based on the person's life experience.

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# ALTERNATIVE MEASURES CONTINUED

- Environmental examples:
  - Lower beds (if the resident does get up and fall, there is less distance to fall and the chance for injury is decreased);
  - Stop signs or Velcro tape across doorways;
  - Noise reduction;
  - Bedside commode or urinal;
  - Lighting.

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# ALTERNATIVE MEASURES CONTINUED

- You must initially identify the symptom or symptoms to determine whose problem it is:
  - It may be your problem, which will cause you to adjust your attitude and thinking;
  - Knowing your resident and practicing acceptance of the behavior may not be a problem at all.

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# ALTERNATIVE MEASURES CONTINUED

- If a behavior presents a challenge consider:
  - ❑ When does the behavior happen?
  - ❑ Who is present at the time?
  - ❑ What is going on at the time?
  - ❑ What is the resident trying to tell you?
  - ❑ Why is the behavior a concern?
  - ❑ Is this a new behavior or a repeat behavior?
  - ❑ What have you tried to do to stop or alter the behavior?
  - ❑ What has worked or not worked?

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# WHOSE PROBLEM IS IT?

Mary always loved to travel. She now has Alzheimer's disease and lives in an AFH. She happily spends her day quietly packing, unpacking and repacking her suitcase. She does not touch other people's things and does not try to leave the house. The provider is upset because Mary's room is always messy and cannot stand untidiness. The foster home provider is worried about what the family or the "state" will think if they see Mary's room this way.

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# WHOSE PROBLEM IS IT? CONTINUED

- When following a thoughtful process about a behavior and determining if the behavior is really a concern, it is important to look at how the behavior can be stopped or changed:
  - Sometimes just redirecting residents will change the behavior;
  - Understanding what the resident is trying to tell you will help you meet the person's needs;

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# WHOSE PROBLEM IS IT? CONTINUED

- ❑ The resident may just need to be taken for a walk, toileted, fed or laid down for a nap;
- ❑ Often the behaviors will increase after a family member has visited;
- ❑ Knowing this, plan ahead and have an activity ready to divert the resident after the family member has left.

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# WHOSE PROBLEM IS IT? CONTINUED

- It is important to know how to communicate with the confused resident. Be sure that your communication is:
  - ❑ Simple and direct using one statement, question or direction at a time;
  - ❑ Do not raise your voice or become angry;
  - ❑ The resident cannot control the behavior because of brain deterioration;
  - ❑ Scolding the resident may only make things worse.

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# BEHAVIORAL SYMPTOMS

- Behavioral symptoms you may encounter with your residents include:

- Wandering and/or pacing;
- Resisting personal care;
- Physically aggressive behavior;
- Yelling;
- Inability to walk safely resulting in falls;
- Anxiety and agitation;
- Up at night;
- Leaning or sliding in a chair;
- Getting into other residents' belongings/beds.

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# WANDERING/PACING

- Wandering behavior could be caused by:
  - Confusion;
  - Restlessness;
  - Boredom; or
  - Need for exercise.
- Pacing may be caused by:
  - Worrying;
  - Anxiety; or
  - Agitation.

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# WANDERING/PACING CONTINUED

- Provide activities that are meaningful:
  - Use information about their work history, volunteering and social interests;
  - Provide videotapes or photo albums of family members.
- Develop alternative outlets for energy:
  - Develop accessible indoor and outdoor areas where residents can pace and/or wander without leaving the premises or entering anyone else's private space;
  - Take the resident for walks or on errands with staff or household members.

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# WANDERING/PACING CONTINUED

- Develop plans:
  - ❑ Alarms and Med-Alert bracelets can be used;
  - ❑ You must develop a plan to prevent wandering from the premises and to know what to do if the resident should wander away;
  - ❑ Have a recent photo on hand;
  - ❑ Discuss and negotiate the plan with other care team members such as the family or the case manager;

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# WANDERING/PACING CONTINUED

- ❑ Place STOP or DO NOT ENTER signs on doors;
- ❑ Place a Velcro-fastened barrier strip at chest level over doorways the resident should not use;
- ❑ Develop a cozy place where the resident can feel comfortable and will be safe:
  - Provide safe things for the resident to touch.

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# WANDERING/PACING CONTINUED

Mr. Richey, a resident with dementia, always tried to wander away at 3:30 p.m. No one could talk him out of leaving and a caregiver had to accompany him for several blocks before he would return. On some days this presented a problem because there were not always two caregivers in the AFH. The other residents could not be left alone while the provider went out with Mr. Richey. The provider found out that Mr. Richey used to work the evening shift as a janitor. When there was no one to go out with Mr. Richey, the provider gave him a broom and he would “work” until he lost interest.

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# RESISTING PERSONAL CARE

- Resisting personal care may be caused by:
  - Resident feels attacked:
    - The resident with dementia may not remember a caregiver from one time to the next;
    - When helping the resident undress, the caregiver may seem like a stranger.
  - Even if the resident remembers the caregiver, there may be reluctance to allow such personal touching in private parts of the body.

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# RESISTING PERSONAL CARE CONTINUED

- ❑ Pain. If the resident has arthritis or another debilitating disease, it may hurt to have clothes removed;
- ❑ Does not recognize the equipment being used such as a handheld shower, bath seat or grab bars;
- ❑ Caregiver actions and attitude. Resident may react negatively if the caregiver is impatient or rushed.

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# RESISTING PERSONAL CARE CONTINUED

- Management of resistance to personal care:
  - ❑ Use a calm, gentle manner;
  - ❑ Consistently use the same caregiver who is successful with the resident;
  - ❑ Have the resident assessed for pain management needs by their primary healthcare practitioner or the RN consultant;
  - ❑ Distract the resident. Talk about something they enjoys;

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# RESISTING PERSONAL CARE CONTINUED

- ❑ Always dress the resident's painful or weaker arm or leg first;
- ❑ Give the resident a choice. "Do you want to use the blue towel or the yellow towel?";
- ❑ Give the resident a reason to go with you. "Let's go wash your hair. It is time for a shampoo." "It is time to get cleaned up for church";
- ❑ Come back later to see if the resident's mood has changed;
- ❑ Give positive feedback for cooperating. "That's great. You look so good now."

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# RESISTING PERSONAL CARE CONTINUED

Mrs. Perry had Alzheimer's disease. Her family cared for her before she entered an AFH. The provider noted that Mrs. Perry was uncooperative and fought with the caregivers when they tried to give her a bath. The provider spoke with the daughter about this concern. The daughter apologized for not telling the provider her mother's arthritis was getting more painful and that giving medication ordered for arthritic pain an hour before the bath helped ease the discomfort. This information was added to Mrs. Perry's care plan and the bath time went much smoother.

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# PHYSICAL AGGRESSION

- Physically aggressive behavior may be caused by:
  - Fear:
    - The resident may not understand what is happening and fights to protect himself.
  - Pain;
  - Illness/infections; or
  - Medication.

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# PHYSICAL AGGRESSION CONTINUED

- Management of physically aggressive behavior:
  - ❑ Remain calm and provide a quiet environment;
  - ❑ Identify and remove the cause of the distress;
  - ❑ Have the resident assessed for potential pain management;
  - ❑ Do not overwhelm the resident with more than one caregiver;
  - ❑ Explain slowly and clearly what you are going to do before you begin and as you go along;

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# PHYSICAL AGGRESSION CONTINUED

- ❑ Move slowly;
- ❑ Touch the resident gently;
- ❑ Do not argue with the resident;
- ❑ Provide a project to keep the resident busy.
- **Attempt to minimize the occurrences. Once the causes is determined and how best to handle, write the information in the care plan:**
  - ❑ This will alert all staff and caregivers to the problems and provide consistent care to the resident.

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# PHYSICAL AGGRESSION CONTINUED

Mrs. Jones, a person with Alzheimer's disease, had a lifelong habit of rising at 9 a.m. When she moved into an AFH, the provider served breakfast at 8 a.m. When the caregiver tried to get Mrs. Jones up for breakfast, she fought and kicked out at the provider. When they allowed her to sleep until 9 a.m., Mrs. Jones got up calmly and participated in her morning care without incident.

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# YELLING

- Yelling may be caused by:
  - ❑ Pain;
  - ❑ Hunger;
  - ❑ Thirst;
  - ❑ Need to toilet; or
  - ❑ Need for companionship.
- Management of yelling:
  - ❑ Offer food and/or drink.
  - ❑ Have the resident assessed for potential pain management. Refer to “Resisting personal care” in this chapter.
  - ❑ Toilet the resident.
  - ❑ Provide meaningful companionship or activities.

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# YELLING CONTINUED

Mrs. Moseley was frequently yelling out. It was determined after looking at her care needs and the environment that she was yelling because of pain from her arthritis. The provider gave her arthritis medication before caring for her, and the provider received instructions from an RN on how to handle Mrs. Moseley more gently.

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# VIOLATING OTHERS SPACE

- Getting into other residents' things and beds possible causes:
  - ❑ Seeking companionship;
  - ❑ Lacks meaningful activity;
  - ❑ Needs toileting; or
  - ❑ Doesn't recognize own room.
- Management:
  - ❑ Provide activity and/or companionship:
    - Ask the family for photos of the resident's family or favorite places and create a scrapbook of things that interest the resident.

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# VIOLATING OTHERS SPACE CONTINUED

- ❑ Provide a Velcro barrier. See “Wandering and pacing”;
- ❑ Put up stop signs;
- ❑ Be alert to the resident’s need to toilet;
- ❑ Put a picture and the name of the resident on her or his bedroom door:
  - Put familiar items in the resident’s room. Use a favorite blanket or bedspread for the bed.

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# VIOLATING OTHERS SPACE CONTINUED

A man was going into other residents' rooms and taking their belongings. The AFH provider noted this happened in the evening when the man was in the living room alone and the provider was in with residents helping them get ready for bed. It seemed the man was more restless when left alone without anything to do. The provider knew the man had been a letter carrier. She put all of the "junk" mail in a box and gave it to the man in the evening when she was with the other residents. The man sorted the mail over and over. He was satisfied with the activity and the other residents were relieved he stopped going into their rooms.

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# UNSAFE WALKING AND FALLING

- Walking unsafely and falls can be caused by:
  - ❑ Medications including drug side effects, drug interactions or a change in medications;
  - ❑ Illness/infections;
  - ❑ Poor lighting, especially if the resident has poor vision;
  - ❑ Frailty and weakness due to disease; or
  - ❑ Fatigue.

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# UNSAFE WALKING AND FALLING CONTINUED

- Management of unsafe walking:
  - ❑ Request the physician order an evaluation by a physical therapist or an occupational therapist;
  - ❑ Provide non-slip shoes and surfaces. Slippery walkways, tubs and showers cause falls;
  - ❑ Remove obstacles;
  - ❑ Be sure the lighting is adequate. Lighting that is too dim or too bright can cause shadows where the resident cannot see clearly;

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# UNSAFE WALKING AND FALLING CONTINUED

- ❑ Be sure the edges of steps are clearly visible:
  - If steps are all the same color without a clear marking on the edge, it is more difficult to see when and where to step up or down.
- ❑ Discourage the use of shoes with thick soles or ones that are too big or badly worn:
  - These can cause the resident to trip and fall more easily.
- ❑ Be sure walking surfaces are smooth and even;

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# UNSAFE WALKING AND FALLING CONTINUED

- ❑ Keep equipment in good working order:
  - For example, inspect hand rails, bath benches, walker and wheelchairs regularly to be sure they are safe and do not need repair. Have weakened or broken equipment repaired immediately.
- ❑ Be sure furniture is solid and not too soft or too low:
  - The furniture must be solid so it does not tip over easily.
  - Furniture that is low and soft is harder to rise from when a resident is physically weak.

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# UNSAFE WALKING AND FALLING CONTINUED

- Try to anticipate the resident's needs by learning about normal patterns of behavior and habit:
  - Use these naturally occurring opportunities to help the resident with ambulation. For example, the resident uses the bathroom an hour after a meal;
  - Offer assistance to the resident at that time to avoid having her go alone and fall;
  - If the resident normally gets restless and tries to get up and walk after being seated for an hour, plan to be on hand to assist at those times.

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# UNSAFE WALKING AND FALLING CONTINUED

- Use a position change alarm. These alarms attach to the resident and to the chair or bed and when the resident rises an alarm goes off to alert you:
  - These devices cannot ensure safety and can be seen as restrictive so they should be used only after careful consideration and discussion with the resident and/or the resident's family.

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# UNSAFE WALKING AND FALLING CONTINUED

Torrance had recently had a stroke. He wanted to keep going independently to the bathroom even though he had fallen a few times. The caregiver expressed her concern about his unsteadiness and tried to make him accept her help walking. The caregiver did not realize she was putting her own fears above that of the resident. Mr. Torrance knew the chances he was taking and accepted responsibility for his actions. He did not want to use a commode. The provider made sure there was good lighting and no obstructions in his path to the bathroom and allowed the independence and dignity of going to the toilet alone.

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# ANXIETY AND AGITATION

- Possible causes:
  - Worry or fear; or
  - Pain.
- Management:
  - Provide calm, quiet and stable surroundings. Changes in caregivers, surroundings or residents can cause distress for a resident with dementia.
  - Try to maintain a structured schedule.
  - Respond with reassurance and affection.
  - Provide an outlet for nervous energy.
  - Avoid serving caffeinated beverages.

# ANXIETY AND AGITATION CONTINUED

Mrs. Handley was a 90-year-old woman who had dementia due to multiple strokes. Every evening at 5 p.m. she became agitated and aggressive. She would stand in one place, shifting her weight from one foot to the other demanding to see her father. At first, the provider had tried to reason with her and told her that her father was dead. Mrs. Handley became even more upset and started crying. Instead, the provider put her hand around Mrs. Handley's shoulders and said, "You are very worried aren't you?" After reassuring Mrs. Handley, the provider would walk with her to the living room and give her a photo album filled with pictures of Mrs. Handley's family and friends. Within a few moments, Mrs. Handley would be absorbed in her album and be calm and relaxed. The provider noted in the care plan what increased her anxiety and what helped alleviate her stress.

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# UP AT NIGHT

- Inappropriate night rising may be caused by:
  - ❑ Inactivity during the day;
  - ❑ Need to toilet;
  - ❑ Too much or too little lighting;
  - ❑ Fear;
  - ❑ Confusion;
  - ❑ Hunger or thirst; or
  - ❑ Pain.

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# UP AT NIGHT CONTINUED

- Management of inappropriate night rising:
  - Provide meaningful activity during the day;
  - Place a commode at the bedside;
  - Use a night light:
    - The resident may be unable to recognize his surroundings when awakening at night;
    - The night light may help the person recognize the surroundings, relax and go back to sleep;
  - Be sure bright lights from the street or hall are not shining into the resident's room;

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# UP AT NIGHT CONTINUED

- ❑ Use an alerting device or intercom to alert you:
  - Be sure the devices do not invade the resident's privacy; and
  - The person's movement is not overly restricted.
- ❑ Play soft music;
- ❑ Be sure other household members are not playing their radios or TVs too loud;
- ❑ Get the resident up to toilet;
- ❑ Medicate the resident for pain, if appropriate;
- ❑ Bring the resident a drink and a snack.

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# UP AT NIGHT CONTINUED

One provider told of a resident who was having difficulty sleeping and would not stay in bed all night. The provider lay down on the resident's bed to see what the resident saw. What she found was that the hall light shone directly into her eyes. By moving the bed slightly the problem was solved.

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# LEANING OR SLIDING IN CHAIR

- Leaning or sliding in a chair may be caused by:
  - Poor upper body strength;
  - Weakness on one side of the body due to stroke;  
or
  - Attempting to reach for something too far away.

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# LEANING OR SLIDING IN CHAIR CONTINUED

- Management of leaning or sliding in a chair:
  - ❑ Ask the physician for an assessment by a physical therapist or occupational therapist;
  - ❑ Adjust the seat of the chair so it tips slightly to the back;
  - ❑ Place a wedge cushion in the seat with the narrow end to the back;
  - ❑ Create a non-slip surface by using Scotch-guard®, non-slip rug backing or a rubber bath mat;

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# LEANING OR SLIDING IN CHAIR CONTINUED

- ❑ Try having the resident use different types of chairs throughout the day;
- ❑ Use recliners;
- ❑ Use a position change alarm. See “Unsafe walking” in this chapter;
- ❑ Place interesting items and activities well within the resident’s reach.

# DISCUSSION/QUESTIONS

