Gentle Persuasion Approach: A Nurse’s Experience

Caring for Persons with Responsive Behaviours in the Acute Care Setting

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Objectives

- To learn approaches for professional caregivers to enhance their compassionate and effective techniques to help persons with dementia when they are very upset and frustrated.

- To learn about an intervention to help professional caregivers intervene in an effective manner that is non-punitive, respectful and self protective.

- The approaches will be adapted and specific to the acute care setting.
Why do we not use the term “aggressive behaviours”?

- “Aggressive” or “challenging” behaviour is best understood as a **responsive** behaviour to **exert control** or to **protect** or **defend** oneself.¹

- It is possible to identify techniques that work with patients who protest.

- All behaviour has meaning.

¹Talerico & Evans (2000)
Gentle Persuasive Approaches
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Gentle Persuasive Approach

GPA was designed to help professional caregivers and health care workers intervene in an effective manner that is non-punitive, respectful and self-protective.
Background

This curriculum was developed so that professional caregivers could enhance their compassionate and effective techniques to help persons with dementia when they are very frustrated and upset.
Background (cont’d)

• 33% of older adults with dementia are hospitalized each year. This population has a four-fold risk of developing delirium.

• 30-60% of older patients develop delirium in the medical/surgical population.

• Dementia and delirium are associated with responsive behaviours – pacing, wandering, shouting, irritability, explosiveness and resistance to care
Components of GPA

- Unmet needs and behaviour
- Personhood
- Body Containment strategies
Unmet Needs and Behaviour

- There is a **meaning** behind each behavioural display.
- Most behaviours are **time limited** and **episodic**.
- Most behavioural displays are the result of an **unmet need**.
Food for Thought

When the feelings of a person with dementia are disregarded or unintentionally ignored, this can contribute to responsive behaviours.
What Kinds of Behaviours Do We See When Our Client’s Needs Are Not Met?

• Trying to get home
• Following/shadowing
• Reaching out
• Searching
• Collecting
• Pacing

• Calling out
• Pushing away
• Agitation
• Swearing
• Complaining
• Repetitive questions or requests
Understanding the Behaviour

To understand the behaviour, we must know the person behind the illness.

- Because the behaviour has meaning, the person will respond to our behaviour based on how he/she interprets it.

- To provide good care we need to know the person’s remaining abilities, as well as to understand the cause of his/her deficits.

Considerations of Care

- Learn what makes this person happy and provide it
- Concentrate on the person, not the task
Personhood

Personhood involves the support, respect, and trust given from one person to another in a caring relationship.

Personhood

The person with dementia has:

- A unique history
- The capacity for interpersonal relationships
- Significant others/family
- The need for a supportive environment
- Many remaining strengths and abilities

# Personhood-Promoting Interactions

<table>
<thead>
<tr>
<th><strong>Validate</strong></th>
<th>Supporting the emotions and feelings the person is experiencing</th>
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<tbody>
<tr>
<td><strong>Collaborate</strong></td>
<td>Working together with the person to enhance his/her abilities and encourage his/her choice</td>
</tr>
<tr>
<td><strong>Play and Celebrate</strong></td>
<td>Encouraging spontaneity, self-expression, joyfulness, and celebrate just for fun</td>
</tr>
<tr>
<td><strong>Facilitate</strong></td>
<td>Accommodating the persons disabilities to enable him/her to do a task or activity. Facilitating favoured activities or familiar occupations</td>
</tr>
<tr>
<td><strong>Relax</strong></td>
<td>Helping the person to relax and feel comfortable without making any intellectual demands.</td>
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Physical Restraints

Negative side effects can include:

- Injury
- Falls
- Decline in physical functioning
- Infection
- Constipation
- Incontinence
- Pressure ulcers
- Delirium
- Agitation
- Feelings of discomfort, fear, stress
Chemical Restraints

Risks include:

- Falls
- Injury
- Decreased mobility
- Delirium
- Restlessness

- Confusion
- Agitation
- Depression
- Death
Case Study: Alice Carroll
History

- Age 87
- Retired accountant
- Alzheimer’s Disease
- Lived with partner/caregiver Judy
- Had a dog called Emma and a cat named Trixie
- Liked to travel, newspapers, walking, Sudoku
Marked receptive aphasia, limited ability to follow verbal instructions

Nonsensical conversation

Required full assistance to dress, bathe

Incontinent of bowel and bladder

Ambulatory, independent mobility

Would exit condo; an alarm was put in place
Behaviours Prior to Admission

- Made verbal threats to Judy
- Raised a wine bottle over her head with verbal threat
- Judy felt worried about her safety
- Judy had attended the Reitman Centre CARERS program
Admission to Hospital

- Admitted to surgical unit with suspected bowel obstruction
- Resolved without surgical intervention, but Judy did not feel she could cope with her returning home due to Alice’s behaviours
- Currently staying on surgical unit, awaiting long term care space
- CCAC declined placement due to challenging behaviours not yet managed.
Responsive Behaviours in Hospital

- Attempted to hit/bite staff; Ativan administered IM
- Hit a patient in adjacent bed
- Searched through items on other patient’s table
- Made verbal threats, and grabbed and twisted RN’s arm, resulting in Code White and restraints on more than one occasion
- Wandered into NTICU, resulting in Code White and removal in handcuffs by security
- At times reluctant to cooperate with care
Medications to Address Behaviour and Cognition

**Scheduled**
- Memantine 10 mg BID
- Risperidone 0.125 mg BID
- Sertraline 50 mg HS

**PRN**
- Ativan 0.5-1mg QID
- Risperidone 0.25 mg q 4 h for agitation
Geriatric Consult Team Observations

- Alice was in four point soft restraints, in a high observation room.
- The room was very stimulating with other agitated patients, machinery, multiple staff and visitors.
- Alice was found to be very agitated, struggling to free herself, in briefs, and was incontinent.
- Staff reported challenges in maintaining the safety of this patient and other patients while she was ambulatory.
## The 8 “A”s of Dementia

<table>
<thead>
<tr>
<th>A</th>
<th>Description</th>
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<tbody>
<tr>
<td>Anosognosia</td>
<td>Loss of self awareness</td>
</tr>
<tr>
<td>Amnesia</td>
<td>Loss of memory</td>
</tr>
<tr>
<td>Aphasia</td>
<td>Loss of expressive or receptive language</td>
</tr>
<tr>
<td>Agnosia</td>
<td>Loss of recognition</td>
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<tr>
<td>Apraxia</td>
<td>Loss of purposeful movement</td>
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<tr>
<td>Altered perception</td>
<td>Hallucinations and/or delusions</td>
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<tr>
<td>Attention deficits</td>
<td>Easily distracted</td>
</tr>
<tr>
<td>Apathy</td>
<td>Not same as depression</td>
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Paradox of Dementia

“They don’t know that they don’t know;
They forget that they forget.”
The Neurogenic Reflex Grab

- Interpreted by staff as aggressive behaviour
- The result of a neurological reflex response
- Person with dementia will often instinctively grab on when something comes in close contact
- Pulling away reinforces the reflex and the person will simply tighten his/her hold
Care Conference
(Family, OT, Rec therapy, DP, CA, RN, CNS, SW, Geriatrician, Geri Psych.)

• 1:1 in a semi or private room to decrease stimuli

• Remove restraints; allow Alice freedom to walk accompanied by CA

• Scheduled toileting
  - Take to bathroom in the AM, after meals, and before bed
  - Remove briefs
  - Allow time and privacy for elimination
Care Conference (cont’d)

- Provide colourful magazines and newspapers. Likes to sit and look and read.
- Pictures of Alice’s favourite pets, her dog Emma, cat Trixie. Recall stories of her pets.
- Engage in conversation. Speech may be nonsensical but Alice understands the tone and expression, and enjoys the social engagement.
Let her walk and walk and walk.

Provide exposure to natural light, a room by the window

Consistency of staff

Provide scheduled rests, as she may not recognize fatigue.

“Know the Person” Learn about Alice, relate effectively.
Care Conference (cont’d)

- Provide nutrition and hydration. Alice is unable to express her thirst or hunger.
- Redirect with gestures, facial expression.
- Engagement of staff in order to understand Alice as a person, understand her unmet needs.
- Apply to specialty bed prior to LTCH.
Outcome for Alice

- Responsive behaviour very significantly reduced for remainder of stay on unit
- Continent of bowel and bladder
- Admitted to specialty bed at Toronto Rehabilitation Institute. No further responsive behavior!!!
- Accepted into Judy’s choice of LTCH
Tips
“Sometimes, doing nothing is the best thing.”

- Create supportive, safe environment
- Allow personal space
- Reduce the number of people present
- Have one calm person interacting with the patient
- Remember that many behaviours are time limited

Understand

- “Search for the Meaning:” Identify triggers and unmet needs
- Understand underlying causes
- Know the person, find out what is important to them, and relate effectively
- Use GPA and 8 A’s of dementia to create and understand the plan

Plan

- Encourage family and ask what they find effective. Family are experts.
- Care conference With OT, PT, Recreational therapy, RN, CA, geriatric CNS, all front line care providers
- Make a plan and follow up
- Share plan with all care providers
Manipulate the Environment

- Remove potential hazards, *e.g.*, objects that can be thrown or used for hitting
- Reduce stimuli
- Provide natural light
- Provide diversion, *e.g.*, magazines, photos, pictures, familiar objects
Consider Physical Needs

• Order exercise:
  ➢ Up in chair 3 x per day for meals
  ➢ Up for walks

• Give the person as much control as possible:
  ➢ Reinforce retained abilities
  ➢ Scheduled toileting

• Avoid constipation
“Stop and Go”

- When Alice is resistive to care, stop, pause, and reapproach.
- If she continues to resist stop and return latter
- Pay attention to her cues
Limit Restraints & Psychotropics

- Remove lines, saline lock IV, and D/C catheter
- Use positive verbal and physical language
- Use a sitter instead of restraints
- Leave restraints on for as short a period as possible
- Be mindful of risks and negative effects of restraints and psychotropics
- Remember that psychotropics do not target wanting to leave and calling out.
Use Resources

- Specialty beds (TRI, Baycrest, CAMH, Ontario Shores)
- Internal consult team, CNS, Geriatric psychiatry
- Hold care conference to make a plan, and then share it
- AD Society First Link (for families)
- Reitman Centre CARERS Program (MSH)
Contact Information

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References


Kitwood, T.  *Dementia Reconsidered: The Person Comes First* (Open Univ. Press 1997).