INSTRUCTOR'S MANUAL
Understanding and Responding to Behavioral Symptoms of Dementia: A Guide for Direct Care Workers

Module 2
Common Behaviors and Behavioral Triggers Associated with Dementia: What You Need to Know

This teaching package was developed through a grant from the SCAN Foundation.

The content was developed by Linda Redford, R.N., Ph.D. in collaboration with Aging Services of California and the LeadingAge Center for Applied Research. The staff of four nursing homes in California graciously offered their time for focus groups to assist in shaping the content of these modules. Three of the nursing homes also participated in pilot tests of the curriculum and offered insights to make the curriculum most relevant to their needs.

MODULE 2

Common Behaviors and Behavioral Triggers Associated with Dementia: What You Need to Know

Learning Outcomes:

By the end of this activity, participants will be able to:

- Identify at least four behavioral symptoms that may be present with dementia.
- Describe currently accepted ways of talking about behaviors displayed by residents with dementia.
- Identify at least two needs of a resident with dementia that can trigger behavioral symptoms.
- Discuss at least three common environmental triggers for agitated or aggressive behaviors in residents with dementia.
- Describe and apply the components of a behavioral assessment.

Content Outline:

I) Current views on behavioral symptoms in dementia.
   a. Evolution in understanding of behaviors.
   b. How changes in our views of behaviors results in changes in our response.

II) Common behaviors displayed by persons with dementia.
   a. Wandering, Pacing, Fidgeting
   b. Rummaging/Hoarding
   c. Repetitive behaviors
   d. Verbal behaviors
   e. Sundowning
   f. Physically aggressive
   g. Inappropriate behavior

III) Conducting a behavioral assessment.
   a. General overview of behaviors
      i. Usual behavioral patterns
      ii. Characteristics of current behaviors
   b. Strategies for identifying causes and triggers of behaviors.

i. Noting resident characteristics
ii. Scanning and documenting environment and events
iii. Finding patterns

IV) Common triggers of behavioral symptoms in dementia.
   a. Needs or problems of the person
      i. Pain/discomfort
      ii. Illness
      iii. Medication
      iv. Fatigue
      v. Sensory problems
      vi. Fear/Anxiety
   b. Environmental Triggers
      i. New or unfamiliar setting
      ii. Noise
      iii. Large numbers of people
      iv. Lighting changes
      v. Staff changes

Materials Needed:

I. A computer
II. A projector to use with the computer
III. An Internet connection (if available)
IV. Flip chart
V. Markers
VI. Easily removable tape that will not damage walls (if flip chart pages are not self-adhering).

Instructor Guidance:

The time required to complete the content in this module will be approximately one hour, but may take more time if youelect to utilize all of the teaching strategies suggested. The Module is designed so that it can be divided into Sections offered at different times. It is desirable to cover the Sections on Common Behavioral Symptoms and Behavioral Assessment -and then have participants go to their unit/neighborhood and practice using the assessment guide provided in the handout. The latter section of the Module on “Triggers” can be covered in a separate session. This will allow participants to gather information about behaviors that can be applied in discussions of possible causes or “triggers”.

Activities:

I) **Welcome everyone and ask them to give their name and a brief statement about what they hope to learn from the session.** (10 minutes)

II) Strategies for assessing current knowledge and what is learned from the session.

a. Written Pre- and Post-Knowledge Assessments are a means of obtaining objective information about what participants know prior to an educational session and what they learned from the session. A Pre-Knowledge Assessment is included for use prior to Module 1 and the Post-Knowledge Assessment should be administered at the completion of all three modules.

b. It is also possible to assess overall knowledge of participants through structured questions, discussions, and exercises dispersed throughout the session. These exercises may allow you to identify any misconceptions held by participants and assess attitudes of the participants relating to dementia. Other activities will serve to reinforce the knowledge and skills being taught. Suggestions for these activities and their placement in the presentations are shown on the notes sections of each slide.

III) Further activities are provided in the slide notes.

Exercises:

Exercise 1

Instructor -

This exercise can be conducted at the point indicated on the Power Point slides and the remainder of the module completed in a second session. By doing this exercise first, participants can bring back their behavioral assessments and discuss them in the context of the possible triggering factors.If you choose to do this exercise at the end of the session, move the exercise slide to the end of the presentation.

> ***Break into teams of two to three people. Go to a unit/neighborhood where there are residents with dementia and observe the residents for the behaviors discussed. Choose a resident and one behavior of that resident. Collect information from the other staff, the charts, and your own observations to answer the questions on the Behavioral Assessment Tool provided in the HANDOUT Section of this Module.***

Case Studies:

These case studies can be used at the end of the session to reinforce some of the information provided.

1. Mrs. Morgan was admitted to your nursing home from another nursing home five days ago. Her family moved her because they felt she was not getting adequate care. Mrs. Morgan refuses to bathe and fights the staff when they try to dress her.
    a. What do you need to find out from Mrs. Morgan's family?
    b. What additional information do you need to assess Mrs. Morgan's behavior?
    c. Why might she be refusing to bathe or dress?
    d. What clues would you want to watch for in her behavior?

2. Mr. Jones has begun to yell and attempt to bite staff members when they dress and undress him. This behavior began three days ago. Previously staff had experienced no problems working with Mr. Jones.
    a. What additional information would you need to assess possible reasons for Mr. Jones's behavior?
    b. What could be some possible causes of the behavior?
    c. What would you want to observe about the behavior?

Resources:

ONLINE READING

Dementia Education and Training Program (2009). *Managing Behavioral Symptoms of Residents With Dementia in Long-Term Care Facilities.* http://www.alzbrain.org/pdf/handouts/2009.%20behavior%20book.pdf

International Psychogeriatric Association (IPA) (2002). *Behavioral and Psychological Symptoms of Dementia(BPSD) Educational Pack.* http://www.ipa-online.org/ipaonlinev3/ipaprograms/bpsdarchives/bpsdrev/toc.asp

VIDEOS

Video # 1- Purple Scarf is for an animated YouTube video. This short video illustrates a common type of interaction that occurs between people with memory loss and their loved ones. http://www.youtube.com/watch_popup?v=h_CTFx8aLGE&vq=medium

Video # 2- Choice and Challenge: Caring for Aggressive Older Adults Across Levels of Care is available through the American Psychiatric Nurses Association and portions can be found on YouTube at http://www.youtube.com/watch?v=egAWtMPj8HA

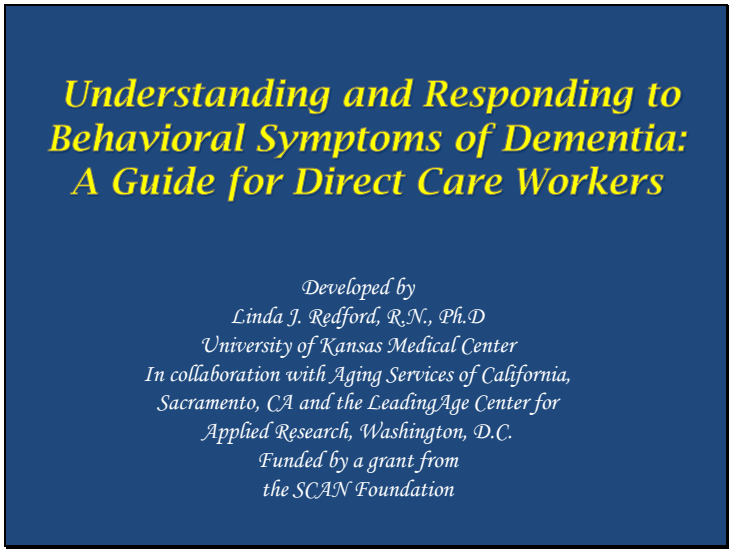
(1) Show short vignettes and stop the video.
(2) Ask participants –
    a. What behaviors might have been avoided?
    b. What could be done differently?

Power Point

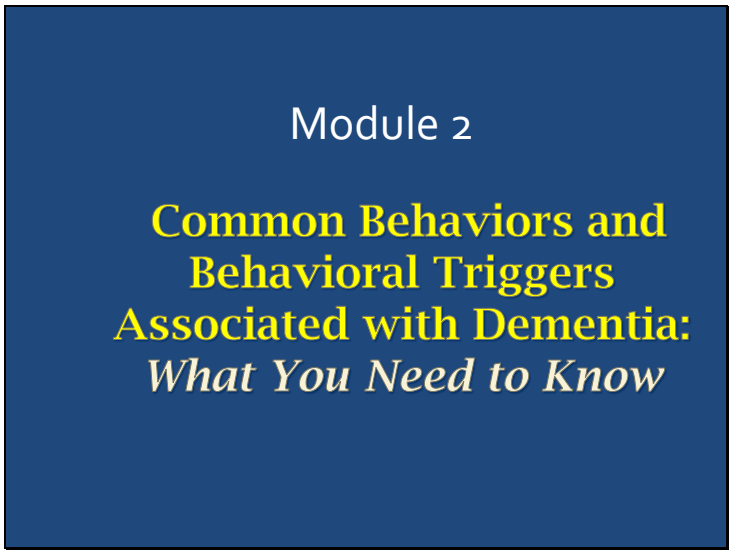
Common Behaviors and Behavioral Triggers Associated with Dementia:
What You Need to Know

Present the second set of Power Point slides "CommonBehaviors and Behavioral Triggers Associated with Dementia: What You Need to Know". Each slide has talking points and some have references that you can read if you want more information. In the talking points, you will find suggestions on when to ask questions of the participants, conduct an exercise, or play a video.

Slide 1

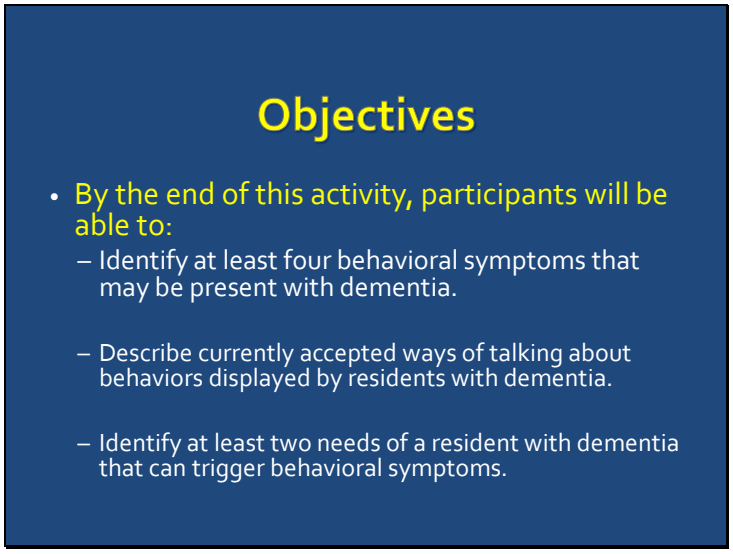


Slide 2



This module will help you identify behavioral symptoms that may be associated with dementia and the factors that can contribute to these behaviors. People with dementia often behave differently than normal in response to physical or psychological discomfort and/or stimuli in the environment. By recognizing these common behaviors associated with dementia and the factors that may trigger them, you will be better able to address them appropriately.

Slide 3



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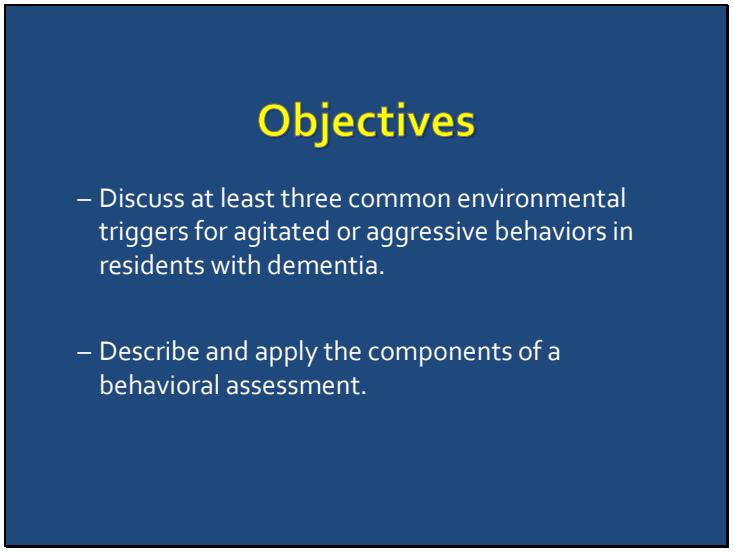

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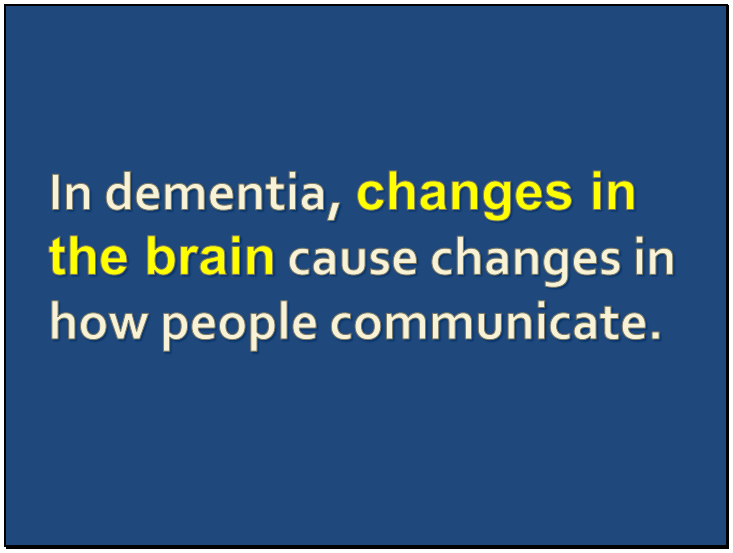
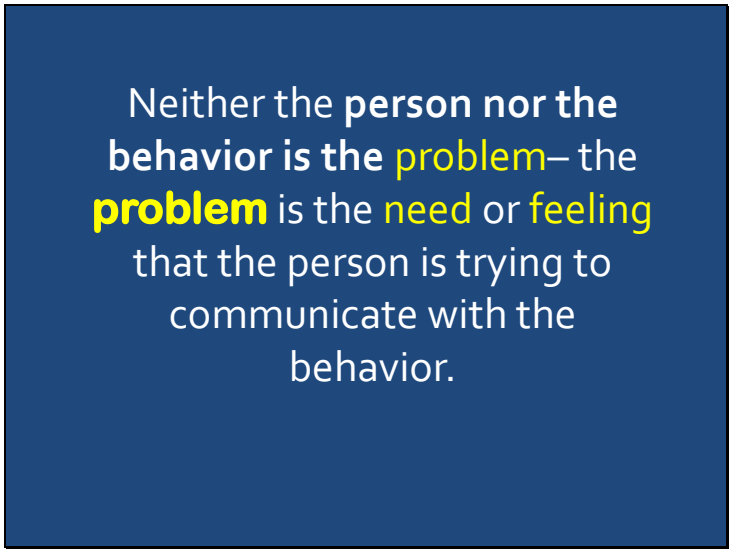


The behaviors associated with dementia are related to damage in the brain, but we now know these behaviors may be triggered and aggravated by other factors. It was once assumed that the damage to the brain caused the behavioral symptoms associated with dementia and nothing could be done other than medicating the person or using restraints. Now we know that there are often physical and emotional causes or “triggers” for behavioral symptoms of dementia that

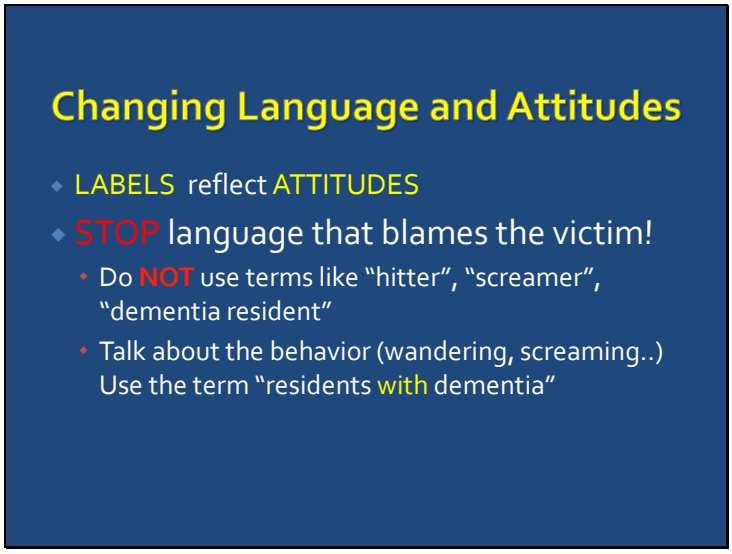
need to be addressed in much different ways. Medication is a last resort and restraints should be used only in very rare circumstances.

Slide 6



We now recognize that many behaviors displayed by people with dementia indicate that they are in some form of distress. The behavior is an indication of discomfort, pain, anger, fear and other physical and emotional conditions. The brain damage from dementia often makes it impossible for people to communicate their needs through language, so we must pay close attention to their verbal or physical behaviors to know how to help them.

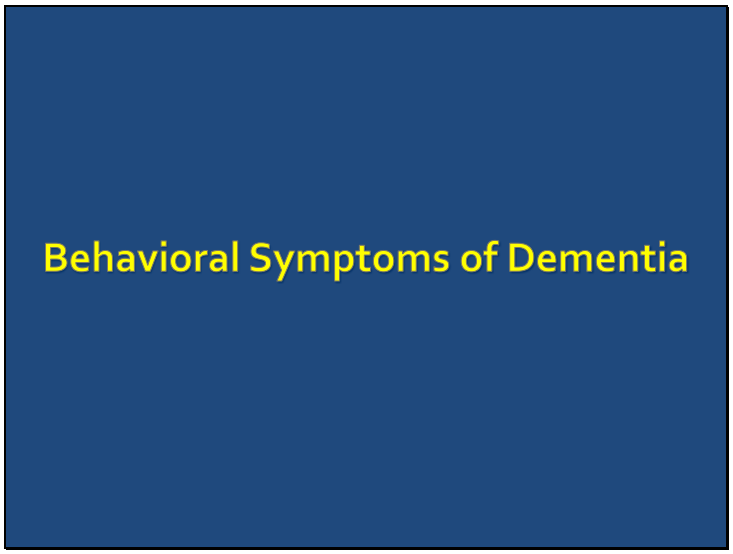
Slide 7



In order to change how we respond to behaviors associated with dementia, it is important to consider how we talk about these behaviors. We must be very careful not to label persons with dementia by the behaviors they display. Labels reflect attitudes and can shape how we respond to people. It is not unusual to hear a resident labeled as a "wanderer" or a "hitter". Labels can make people assume the behavior is just who the person is and fail to recognize that the person is experiencing pain, fear or some other emotional or physical problem that needs to be addressed. Labeling people with dementia by a negative behavior is blaming the victim.

Changing our language is not easy, but it is important that we do so. Never refer to a resident as a "dementia resident", rather the person is "a resident with dementia". Don't call a resident a "screamer", or a "hitter". Talk about what the resident is doing– "Mrs. Smith has been "wandering" and entering other resident's rooms this afternoon." "Mr. Thompson has been "screaming" more than usual today." The emphases and focus should not be on the behavior, but on searching for the underlying cause.

Slide 8



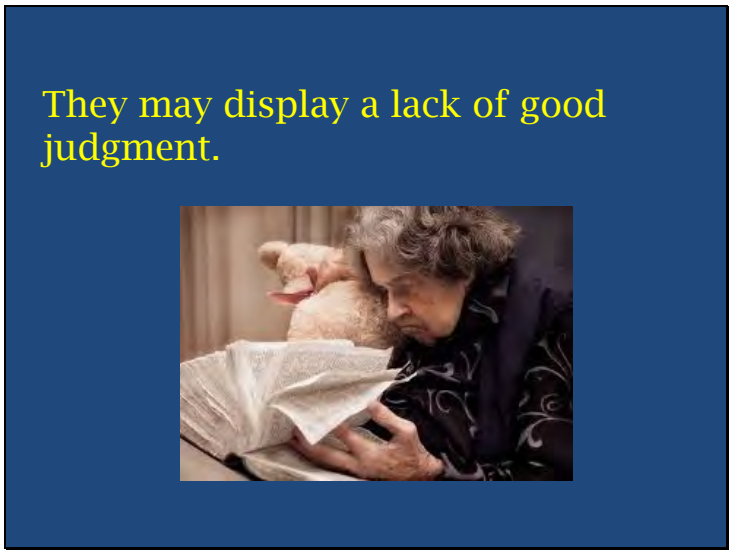
Have participants break into groups of three to four people.

Ask the following question- "What behaviors have you observed when working with residents who have dementia?"

Have each group talk among themselves for ten minutes with one person writing down the behaviors suggested. Ask one person from each group to report the behaviors they identified. Write the responses on a flip chart. Rather than repeat the same response, place a check mark (√) next to the behavior/characteristic that has already been recorded to indicate how frequently it is identified. After each group reports, attach the pages to a wall where they can be seen by everyone. You should refer back to these during the session to point out characteristics of dementia that have been identified. (This exercise should take approximately 20 minutes and will help you determine how familiar the participants are with behavioral symptoms of dementia.)

Let's talk about some of the behavioral symptoms that are commonly seen in residents with dementia. (Next Slide)

Slide 9

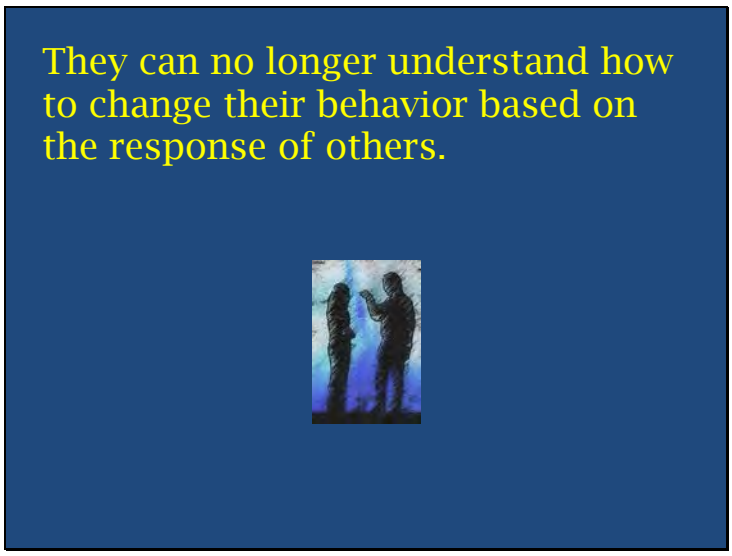


The ability to make good decisions is often affected by dementia. This can result in people saying and doing things that are out of character. It can also place them in danger, such as walking into traffic, going into extreme cold without a coat or protection, or becoming the victim of a scam artist.

Read More

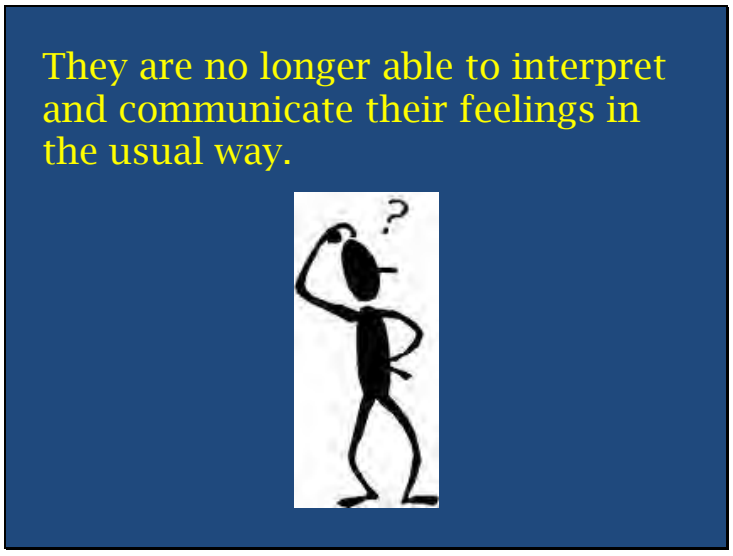
DementiaGuide (2006). *What to Look For.*
http://www.dementiaguide.com/symptomlibrary/thinkingjudgement/comprehension

Slide 10



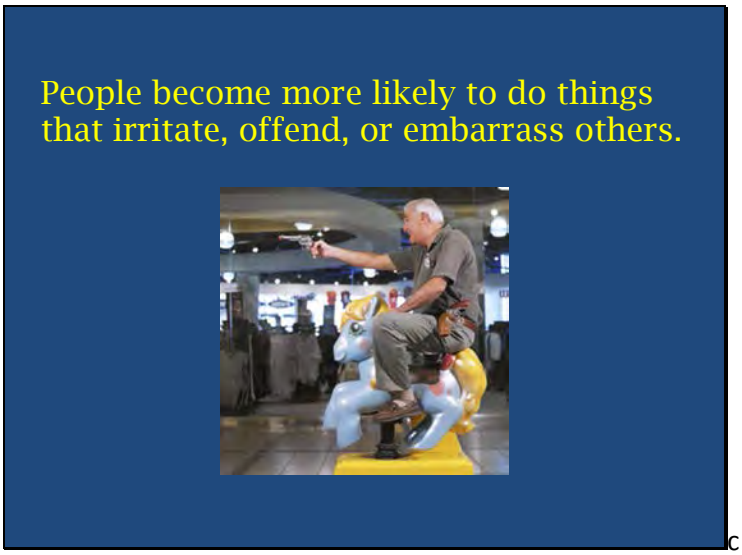
Generally if someone does something that irritates others or that is unacceptable, people will respond verbally or show looks or behavior indicating disapproval. Normally people can “read” the responses of others, such as a frown or look of anger, and are able to modify their behavior if they chose. Dementia causes people to no longer be able to understand the reactions of others or to respond by changing their behavior. Scolding or showing disapproval of the behavior of an individual with dementia will generally not change the behavior. In fact, confronting or challenging them may lead to an escalation of the unwanted behavior.

Slide 11



Normally we can understand and respond when our body tells us we are hungry, thirsty, need to urinate, are cold or are experiencing fatigue. Dementia damages the part of the brain that helps us understand the signals we are receiving from our body. The person with dementia will be uncomfortable, but may not be able to understand the cause of the discomfort and respond appropriately. Staff must use good observational skills to interpret the non-verbal communication attempts of residents with dementia.

Slide 12



As the part of the brain that controls behavior becomes damaged by dementia, it is not uncommon for people with dementia to say and do things that are considered socially inappropriate. They lose the ability to understand the difference between behaviors that are socially OK and those that aren't. They have lost the ability for their brain to tell them what ***not*** to do.

Persons with dementia have a general loss of mental abilities that impacts their life and that of caregivers in many ways. Next, we will talk about some of the specific behavioral symptoms of dementia that you as a caregiver see daily.

Slide 13

There are a number of behaviors that are common among individuals with dementia. Memory problems and subtle behavior changes are evident in early dementia, while many of the more overt behaviors occur in persons with moderate to severe cognitive impairment.

Ask participants- "How would you describe the behaviors on this? If you can, give an example of a resident that displays the particular behavior."

Wandering-

- Orbiting – this is when an individual starts at one point (such as the nurse's station) and returns to the same area.
- Visiting – some persons, when wandering, will tend to enter other people's rooms.
- Shadowing – as the name indicates, this is when an individual follows closely behind another individual.

Rummaging & Hoarding- Some individuals with dementia have a tendency to rummage through drawers and closets as if looking for something. Others tend to gather up all sorts of items as if they were collectors. These behaviors are particularly a problem if they are rummaging through or hoarding other resident's possessions. Hoarding is also a problem when perishable food or medications are hoarded.

Slide 14

Repetitive behaviors are very common in moderate and advanced dementia. These behaviors can be annoying and frustrating to caregivers. Sometimes the individual with dementia will repeat the same behavior over and over, such as continually washing the same dish, tapping their fingers, saying the same phrase. Continual pacing is seen with the person walking aimlessly back and forth. Fidgeting is also common, with individuals being in seemingly perpetual movement– twisting a piece of clothing, constantly moving in their chairs, moving their feet and so forth.

Some repetitive behaviors appear to be attempts at "self soothing". This type of behavior is seen in other conditions with brain involvement, such as autism, developmental disabilities, and brain injury. If the individual does not appear distressed, other residents are not adversely affected by the behavior, and it does not jeopardize anyone's safety, it may be best at times to tolerate the behavior.

Read More

Alzheimer's Society (2010). *Unusual Behaviors.* http://alzheimers.org.uk/site/scripts/documents_info.php?documentID=159

Slide 15

Verbal Behaviors - The verbal behaviors can take many forms. Those listed are among the common non-aggressive verbal expressions.

Repeating questions and comments often occurs because the individual does not remember what they just said. It can become annoying for caregivers when they are asked "What time is it?" several times within a minute, but it does no good to become impatient or scold the person. It will not help them to remember better.

Constant repetition of the same word or phrase tends to occur in later stages of dementia. They literally "get stuck" on a word or phrase and can't seem to move to a different phrase or activity.

If you have an Internet connection, go to Video #1,"Purple Scarf", in the Instructors Manual for this module. This video provides an animated portrayal of an interaction between a woman with **dementia and her daughter.**

Slide 16

These are some of the more aggressive forms of verbal behavior. These can be quite distressing for family, particularly if the person was typically reserved and never spoke harshly to or about others. They can also be difficult for staff when the names or slurs are directed at them. It is important to remember that the behavior is not intentional, but a result of damage to the brain of the individual.

Slide 17

Physical Aggression **-** It is estimated that physical aggression occurs with about 45% to 50% of people with dementia at some point. It is most likely to occur when the individual is frustrated, pressured to do things they can no longer accomplish, or tired. Physical aggression needs to be managed for the safety of the individual, other residents and staff. In the next module, we will talk about strategies for preventing and/or diffusing aggression, as well as staying safe and keeping the resident and others safe.

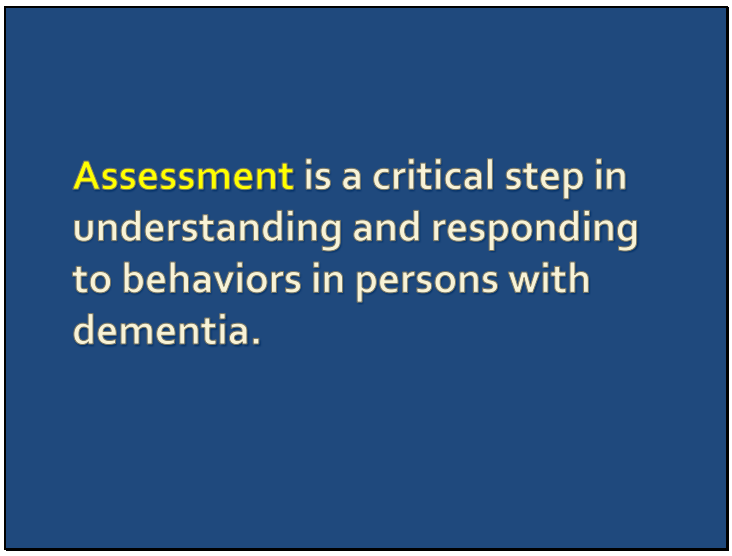
Slide 18

Inappropriate Behaviors - Inappropriate behaviors are those behaviors that tend to make others uncomfortable. They include such behaviors as disrobing or urinating in public, touching another person or oneself in an inappropriate area of the body, getting in bed with another person without mutual consent, and masturbating in public.

Some of these behaviors occur due to the area of the brain affected by dementia. Many, though appearing on the surface to be sexual in nature, are not. Others are the result of biological needs that the individual can no longer control. Ways to respond to such behaviors will be discussed in Module 3.

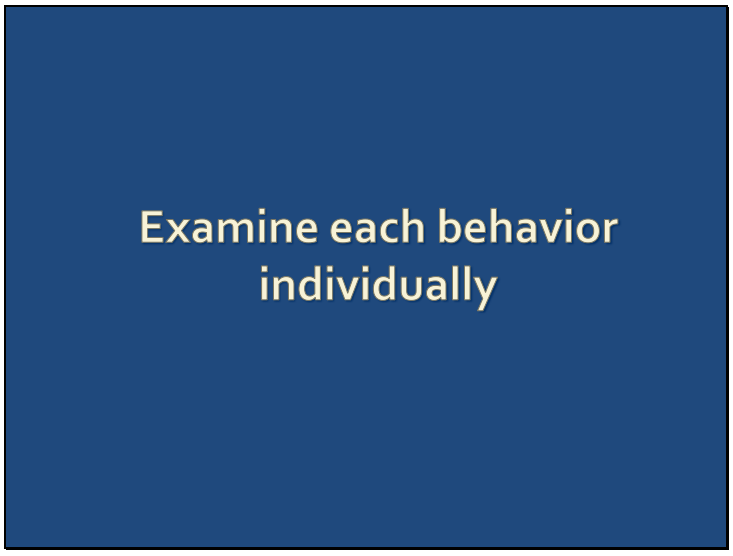
Next we will talk about the importance of assessing each behavior.

Slide 19



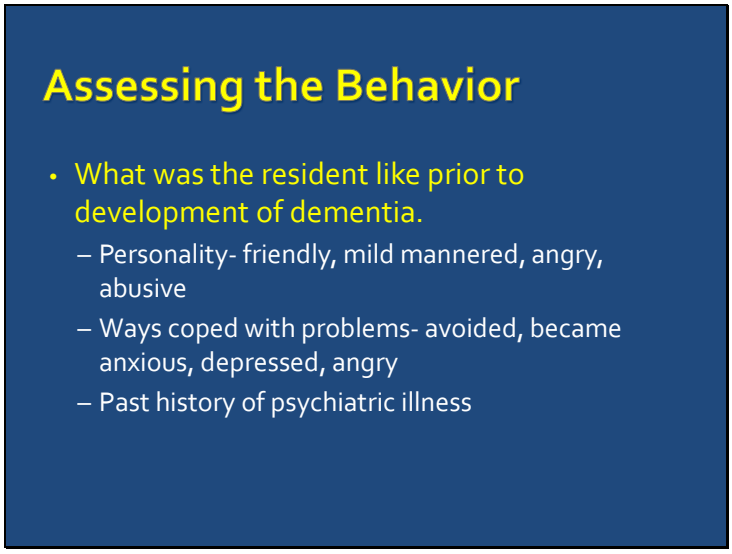
Before you can effectively respond to a behavior, it is important to determine what may be causing the behavior. A thorough assessment is often needed to determine the cause of a given behavior. REMEMBER- each individual behavior should be assessed and your findings documented. ***Refer to the Behavior Assessment tool in the Handouts Section.***

Slide 20



Each behavior may have a different cause or be the result of different needs. Make certain to assess and respond to each behavior separately.

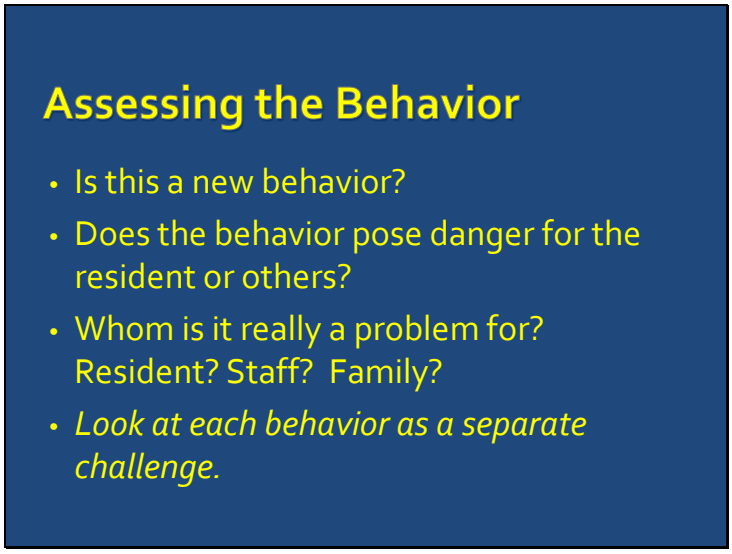
Slide 21



Knowing the person's previous behavior and how they coped may help you better understand the current behavior. However, dementia may result in someone who was once very friendly, warm, and kind becoming belligerent, angry, and/or aggressive. Knowing the person's past personality can help caregivers know whether this is a manifestation of past coping mechanisms or a new response.

For example, persons who typically became angry and aggressive when frustrated may show that response to events or demands in the environment that they cannot understand or control. People who have typically avoided frustrating circumstances or conflict, may become withdrawn and isolated.

Slide 22



First we need to DESCRIBE THE PROBLEM BEHAVIOR. What is the real concern? Look at it carefully! It's not enough to say, "He's agitated" or "He's confused". The behavior must be evaluated in terms of possible causes, potential for danger to self or others, and for whom the behavior is a problem.

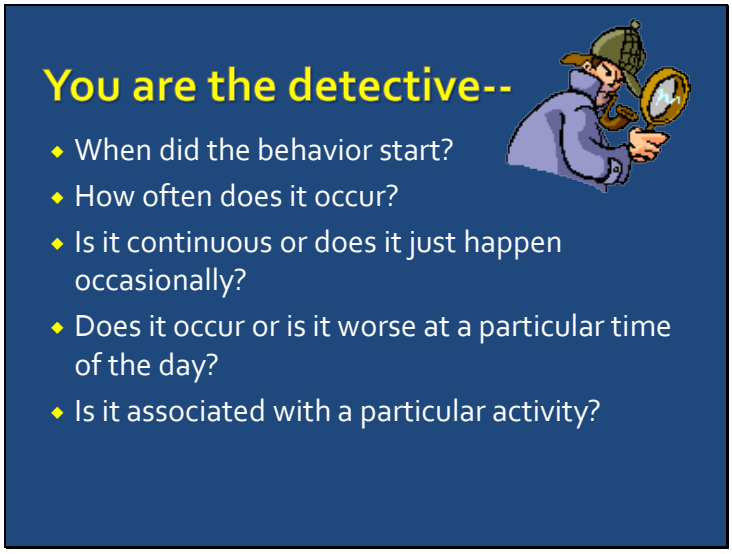
If the person has recently moved to the facility or changed rooms, it may take a couple weeks before behavior can be adequately assessed. Changes such as moves can either result in past behaviors stopping for a time or new behaviors surfacing. Eventually, typical behavioral patterns will emerge and can be assessed. It is the direct care workers who are usually in the best position to recognize changing patterns of behavior.

Slide 23

Direct Care Workers--

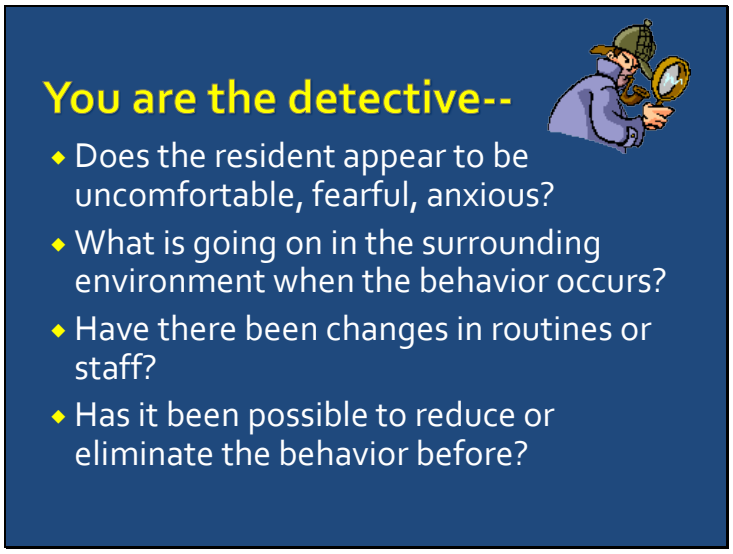
- You are with the residents every day and know them well.
- You are in the best position to figure out what is triggering behavioral symptoms.
- You are the eyes and ears of the unit and the advocate for the resident.
- You are the detective.

Slide 24



- ***When did the behavior start?***
  - Is it a new behavior or has it been going on for some time?
  - Is it known when the behavior began and what may have triggered it?
  - If the resident is new to the facility, it may be necessary to ask family members if the behavior occurred previously.
- **How often does it occur?**
  - Is the behavior an everyday occurrence, several times a week, or less frequently?
- **Is it continuous or intermittent?**
  - Does it go on for hours?
  - Does it come and go--- how often, how long does it last?
- **Does it occur or is worse at a particular time of the day?**
- **Is it associated with a particular activity?**
  - Activities, particularly those that invade a person's privacy or are threatening or uncomfortable may trigger behaviors.
    - Bathing
    - Activity time
    - Mealtime

Slide 25

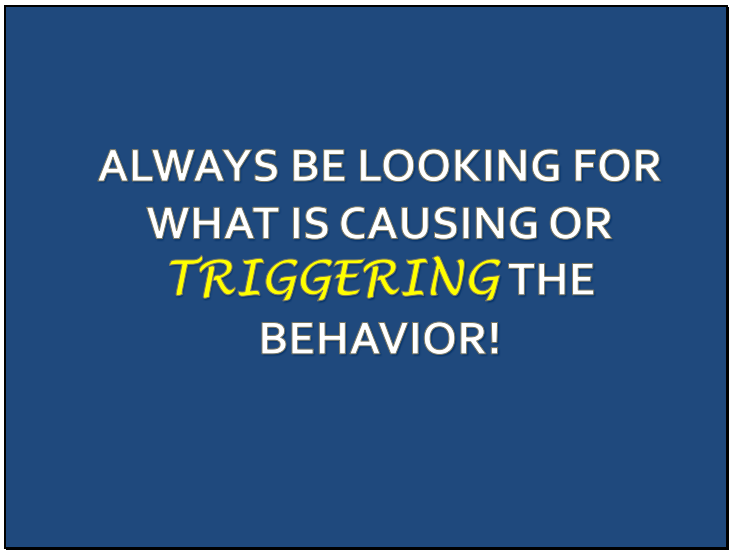


- ***Environment*** – Behaviors are often triggered by things going on in the environment.
  - Too few activities can lead to boredom, while too many activities or activities that are too stimulating can result in adverse behaviors.
  - Low lighting causes difficulty seeing and creates shadows that can be misinterpreted and cause fear or anxiety.
  - Large numbers of people can be anxiety provoking for persons with dementia and sometimes a particular person may trigger behavioral symptoms.

- **Staff changes**–New staff or frequent changes in staff can be distressing to individuals with dementia and may result in behavioral symptoms.

- ***What works***–If an individual displays the same behavior repeatedly, it is important to know what works to prevent, reduce or alleviate the behavior. Whenever a strategy is tried to address a behavior, it is important to communicate in writing whether it worked so that all others working with the individual will know what has and has not been successful.

Slide 26



CONDUCT EXERCISE #1 IN THE INSTRUCTOR'S MANUAL (Optional)

SAY THIS IF CONTINUING WITHOUT DOING THE EXERCISE

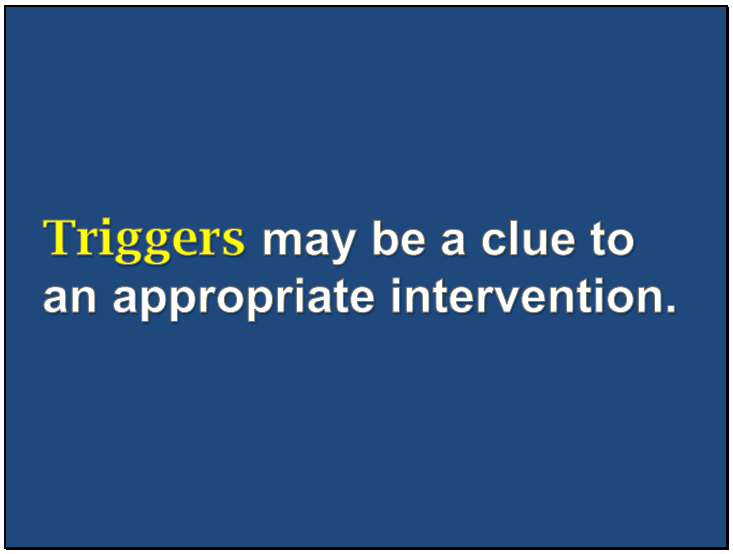
Behaviors are often triggered by physical needs of the individual – e.g., hunger, need to urinate – or environmental events– e.g., noise, diminished light, staff changes. We will talk about typical triggers as we move through this module.

USE THIS IF PARTICIPANTS HAVE CONDUCTED THE EXERCISE

?

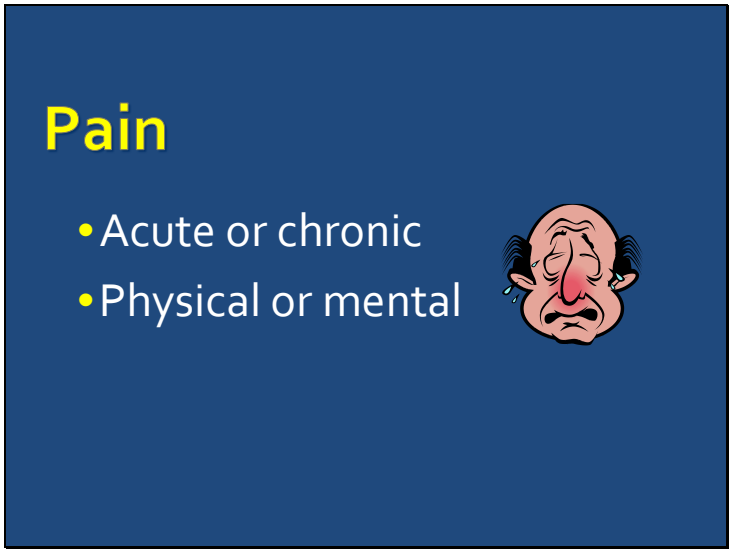
Ask participants–
"What behavior did you choose to assess?"
"What was happening in the environment around the resident prior to the behavior?"
"Describe the resident's behavior."
"What do you think are the possible causes or triggers of the behavior you observed?"
"How did you come to this conclusion based on your observations?"

Slide 27



When you figure out what caused a behavior, you have a better chance of finding an effective approach to addressing the behavior and preventing future episodes.

Slide 28



Pain and discomfort are common causes of residents withdrawing, becoming agitated, and/or striking out at caregivers. Remember that pain can be physical (such as pain or discomfort from arthritis, poor circulation, or cancer) or it can be mental (such as grieving for a loved one, anguish over moving from ones home, etc.).

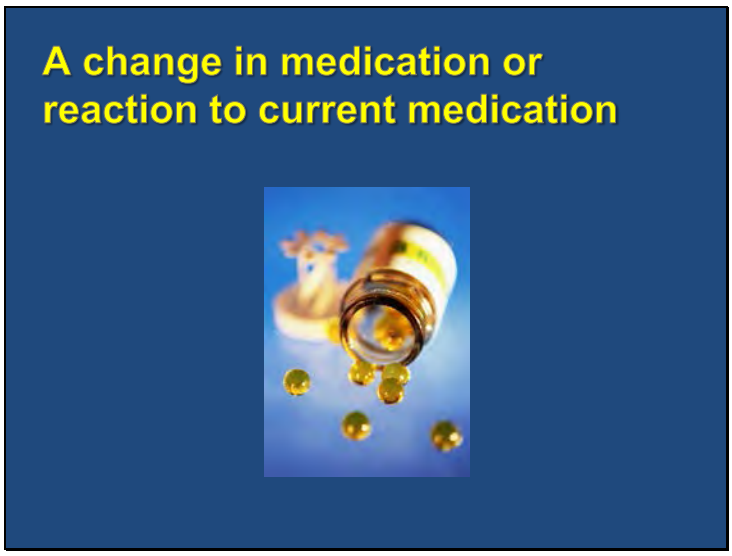
Ask participants-"Think about a time when you experienced pain (like a bad headache, back pain, grief over loss of a loved one) and how you acted? Would someone share how they act when in pain?"

Slide 29

Changes in behavior can be the first sign of illness or injury in frail older persons. These changes may be the symptoms of “delirium”. Typical behaviors associated with delirium include fluctuations in levels of consciousness ranging from being hyper-alert to hardly responsive. The resident may see or hear things that are not there or misinterpret environmental sights and sounds. The resident may become agitated and strike out at caregivers or be withdrawn.

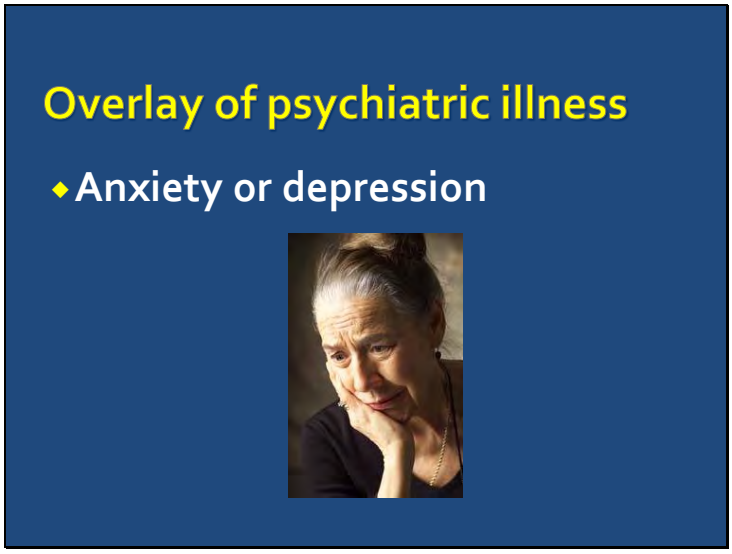
A rapid change (within hours or a few days) in behavior of any resident should trigger an examination for possible infections, injuries or other causes. As discussed on the previous slide, pain may also be a cause of changes in behavior. Look for signs of pain or discomfort.

Slide 30



Changes in medication or a reaction to one or more medications can cause behavioral disturbances. Anytime a new behavior appears, check for recent additions to or changes in medications or dosage levels. Occasionally medications can build up in the individual's system and cause problems, so even longtime medications can be a problem. Some medications likely to cause behavioral changes are anticholinergics (i.e., benedryl, bladder pills for frequent urination, some medications for neuropathy, drugs for diarrhea, etc.) and steroids.

Slide 31



People may have a long standing history of psychiatric conditions, such as depression or anxiety, before they develop a dementia. It is often difficult to determine whether behaviors are due to the dementia or the underlying psychiatric illness. Information on the resident's record or family members should alert you to a previous history of mental illness or problems coping with daily life.

Slide 32

Behaviors are often triggered by physical needs of the individual – e.g., hunger, need to urinate, and fatigue.

Slide 33

Unmet Needs

- Need for human interaction/touch
- Need for stimulation
- Need for socialization

Human touch has been shown to be necessary for healthy development and for life itself. It has a powerful affect in calming and reassuring people. Often nursing home residents receive little in the way of caring touch. Touching is all too often limited to caregiving tasks.

There are some people who, because of their past experiences or cultural beliefs, are not comfortable being touched. This can be particularly true if the person is of the opposite sex or of a different race or cultural background. Always be aware of individual preferences.

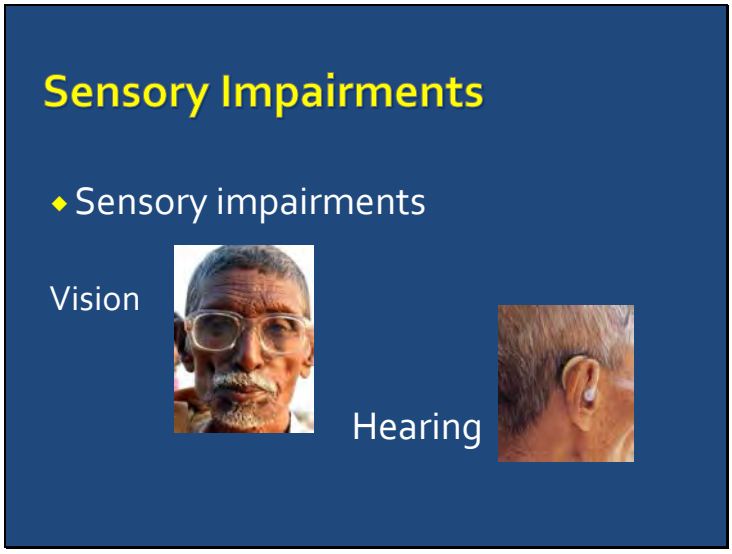
Slide 34

Fear and Confusion

- Hallucinations/delusions.
- Unable to understand what is happening around them.
- Medication reaction.

Changes in the brain due to dementia cause confusion, which can be frightening and anxiety provoking for the individual. These brain changes can sometimes be helped or made worse by medications. Whatever the cause, these changes may result in individuals misinterpreting their environment and seeing or hearing things that are not there. People with dementia are not able to understand what is happening to them or around them and are likely to show their fear and anxiety through a variety of physical or verbal behaviors.

Slide 35



The inability to see or hear further aggravates the problems associated with dementia. Misinterpretations of what is in the environment are more likely and the risk for hallucinations or delusions increases.

Slide 36

Ask participants- "What activities or things in the environment have you seen trigger behavioral changes (e.g., angry outbursts, screaming, hitting) in individuals with dementia?"

Slide 37

Many personal care activities are invasive and sometimes painful.

Video

If you have an Internet connection, go to Video #2, "*Choice and Challenge: Caring forAggressive Older Adults Across Levels of Care",* in the Instructor's Manual for this module. This video shows several vignettes that can be used for discussion.

OR

Read the following scenario to the participants —
What if tomorrow you were in an accident and could no longer care for yourself? You are brought to (Name of your organization). You can't eat, bathe, dress or go to the bathroom without help from someone. You can't communicate and tell them it hurts when someone lifts your arm to put on a shirt. No one talks to you while caring for you.
(Give participants several seconds to consider their feelings and how they might behave. Encourage them to share their feelings with the others.)

Slide 38

Any move or change in environment can increase confusion and anxiety in a resident with dementia. All residents who have just moved to a new nursing home or even a new room in the same nursing home will require time to adjust. Placing familiar items in the room– family pictures, a quilt from their bed at home, familiar furniture– may facilitate the adjustment process. Careful planning prior to and during the move may also reduce confusion and anxiety on the part of the resident.

Slide 39

Many people with dementia have difficulty in situations where there are a large number of people or a lot of noise. These factors can be distracting to residents and create anxiety that results in unpleasant behaviors.

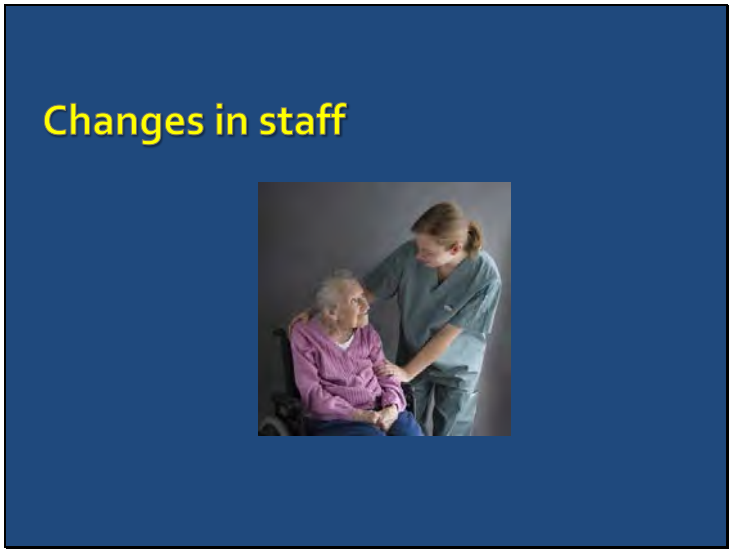
Slide 40

The lack of structured activities, as evident in this picture, can result in unwanted behaviors, as well as a decline in the physical well-being of the residents. Structured activities are important, but new activities should be introduced slowly with an attempt to avoid sudden changes in routines. Consistent structured routines are important to feelings of security of persons with dementia.

Slide 41

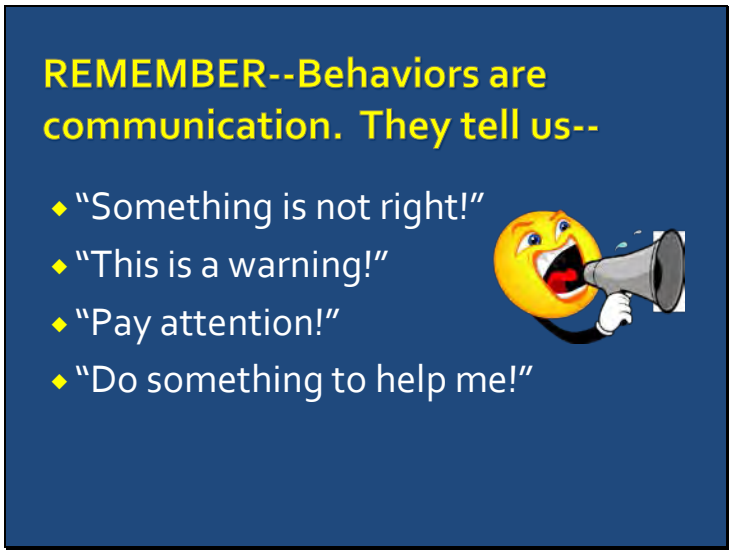
At the end of the day, the lower light makes it more difficult to see and to make out objects. Shadows appear and can be misinterpreted by someone who is already confused and may have vision problems. It is in the evening and at night that confusion often increases and people with dementia get more anxious and agitated. Increased agitation at the end of the day is referred as “sundowning”. The causes and management of sundowning will be discussed in Module 3.

Slide 42



Staff changes, whether because of shift changes or changes in assignment, can result in behavioral symptoms among residents. Shift changes should be conducted with a minimum of activity and provide a smooth transition. Having consistent assignments of staff allows residents to become familiar and comfortable with their caregivers.

Slide 43



Slide 44

Wrap Up:

Thank the participants for attending the session and remind them of the Resource Section in the front of their manuals if they wish to learn more about behaviors associated with Dementia.

HANDOUTS

Module 2

BEHAVIOR ASSESSMENT GUIDE

Complete this form whenever a behavioral symptom of dementia is observed. Use a different form for each behavior. This information will help you to understand the pattern and possible trigger(s) of a particular behavior and develop an effective plan of action. (Copy this form front and back so it is on one sheet)

Resident Name_____ Room/Bed_____ Date_____ Time_____

1) Describe the behavior: _____

2) Is this a new behavior (within the last week)? Yes No Don't Know

3) Is this resident new (within the last 2 weeks) to this facility/unit? Yes No

4) Does the behavior pose a danger for the resident or others? Yes No Don't Know

5) When did this particular behavioral episode begin?
   a) Within the last hour
   b) 2 to 4 hours ago
   c) Longer than 4 hours ago
   d) Do not know

(Answer questions 6 & 8 if this behavior has been observed before. If not, skip to question 9).

6) Did the resident display this behavior prior to coming to this unit? Yes No Don't Know

7) How long has this behavior been observed in this resident (on this unit)?
   a) Less than a week
   b) 1 to 2 weeks
   c) More than 2 weeks, but less than a month
   d) More than a month
   e) Do not know

8) How long does this behavior generally last?
   a) Less than an hour
   b) 1 to 2 hours
   c) 2 to 4 hours
   d) Longer than 4 hours
   e) Do not know

9) Where was the resident when the behavior began?
   a) Own room
   b) Common room
   c) Dining room
   d) Bathing area
   d) Other (please describe) _____

BEHAVIOR ASSESSMENT GUIDE- Page 2

Resident Name_____

10) Does the resident appear to be (circle all that apply)-
    a) Uncomfortable
    b) Fearful
    c) Anxious
    d) Angry
    e) Other (please explain) _____
    f) None of the above

11) What activity(ies) were occurring with or around the resident when the behavior began (i.e., bathing, dressing, television on, many people moving around, etc.)? _____

    _____

12) Was there loud noise or a lot of activity present? Yes No

13) Are there any new staff members caring for the resident? Yes No

14) Was there a staff change around the time the behavior began? Yes No

15) Is the behavior stopped or reduced by (circle all the work)-
    a) Talking with and reassuring the resident?
    b) Giving the resident a simple task/activity to do?
    c) Giving the resident an object? (describe object) _____
    d) Bringing a dog, cat or other animal for the resident to pet?
    e) Giving the resident something to drink?
    f) Taking the resident to the bathroom?
    g) Moving the resident to a quieter location?
    h) Playing music?
    i) Slowly explaining and demonstrating what you are going to do before touching the resident?
    j) Moving very slowly and gently when moving resident's arms, legs, etc.?
    k) Providing pain medication?
    l) Other? (please describe) _____

16) Please describe any additional things that make the behavior worse? _____

    _____

17) Please describe any additional activities/situations that improve the behavior? _____

    _____

18) Other comments _____

    _____