Non Pharmacological management of BPSDs based on dementia specific models of care
‘BPSD is an umbrella term to classify a group of non cognitive symptoms and behaviours in people with dementia’
(Lawlor, 2002)

‘Rates of BPSDs have been estimated at 61-88% among people with dementia in a community setting, 29-90% in residents of Australian nursing homes and 95% among hospitalised patients in long term acute care’
(Brodarty, Draper, Low, 2003)
(Remington, Abdallah, Melillo, Flanagan, 2006) identified that BPSDs increase:

- caregiver burden
- need for earlier institutionalization
- increases the cost of care (direct and indirect)
- Chances of a poor prognosis
- increases progress of the illness
- the likelihood of exposure to physical or pharmacological restraint
Impact of BPSDs

- In a case of mild to moderate Alzheimer’s disease, it is possible to delay the deterioration of the clinical picture (on a cognitive psychopathological and behavioural level) for about 1 year, if the patient responds to the therapy.


- With a combination of non drug therapies, staff education on environmental management, communication techniques with the use of validation and reality orientation, Montessori based techniques, specific handover processes built in delirium and confusion assessment methods, formalised BPSD consults, lifestyle programs for sundowning and nocturnal delirium management has helped reduce and improve BPSD management up to 70% within dementia specific units.
Impact of BPSDs

(Remington et al, 2006) explains that when there are changes in the brain that impair memory, reasoning, language and other communication skills, behaviour becomes a primary method of nonverbal expression.

The loss of brain cells in dementia makes a person less able to tolerate stress.

Stressors such as fatigue, acute illness, pain, change in routine, or confusing stimuli can trigger the occurrence of problem behaviours or BPSDs.
### Most common referred BPSDs in a residential care setting

<table>
<thead>
<tr>
<th>Type of BPSDs referred for consult</th>
<th>Frequency in referrals v/s seven tiered model of management of BPSDs (Brodarty et al, 2003)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wandering, restlessness, intrusiveness, hoarding, shadowing, verbal disruption</td>
<td>30% (Tier 3 consult by primary care workers)</td>
</tr>
<tr>
<td>Verbal aggressiveness, refusal of cares</td>
<td>20% (Tier 3-4 consult by primary care workers or specialist primary care workers)</td>
</tr>
<tr>
<td>Sexual disinhibitions, social deregulation</td>
<td>5% Tier 3-4 consult by primary care workers or specialist primary care workers</td>
</tr>
<tr>
<td>Anxiety, depression (not recognised as such), nighttime disturbances, nocturnal behaviours</td>
<td>30% (Tier 4 consult by specialist primary care workers)</td>
</tr>
<tr>
<td>Agitation, psychosis, screaming</td>
<td>5% (Tier 5 consult in specialist team or DSU—challenged by aging in place)</td>
</tr>
<tr>
<td>Physical violence</td>
<td>8% BPSD Tier 7 (Intensive care specialist unit)</td>
</tr>
<tr>
<td>Sexual disinhibitions and violence, Suicidal tendencies</td>
<td>2% BPSD Tier 6 (admission to psychogeriatric or neuro behavioural units)</td>
</tr>
</tbody>
</table>

Apathy is not frequently recognised and reported as a concern
Depression is not reported as a mental health concern
Plan
Educating staff on the signs and symptoms of Depression and Apathy
Most common referred BPSDs in a residential care setting

These are the most common behaviours referred for BPSD consults:

- Verbal restlessness: 14%
- Apathy: 5%
- Attention seeking: 8%
- Resistive to care: 3%
- Anxiety: 10%
- Suspicious/Paranoia: 9%
- Physical aggressive: 5%
- Agitation: 5%
- Hoarding: 9%
- Wandering: 5%
- Disruptive: 5%
- Inappropriate: 5%
- Sexually Inapp: 5%
- Nocturnal disturbances: 4%
Environmental design
Meets best practice guidelines on environmental design (DTSC, 2010)

• Special care /dementia specific units Size (8-16)
• Layout (includes activity, quiet, high and low stimulus areas, kitchens, opportunity to engage in activity)
• visual cues, access
• safety (camouflaged doors, safe indoor areas)
• provision for wandering access to outside area
• Familiarity (decreasing sterility of surroundings)
• Privacy and community
• Community links (near shopping centres, arcades, medical access, coffee shops, community visitors schemes, lifestyle network supports)

➢ Regular environmental audits and reports are attended for resident case mix changes or when initiated by managers (increase in behaviours)
Creating Dementia Specific models of care to manage BPSDs

Clinical care

- Formalised BPSD consults and referrals internal and external
- Formalised BPSD case conferencing
- Formalised handover structure for dementia care
- Delirium assessment and screening tools
- CAM assessment processes
- Formalised structures for BPSD reports focus on non pharmacological interventions to manage BPSDs
- Dementia care competencies for care staff that work in DSUs focus on:
  - Communication
  - Person centred care
  - Delirium detection
  - Engaging resident in meaningful activity
  - Managing behaviours of concern (non pharmacological approaches)
  - Review of physical and psychotropic restraint policies to include non pharmacological strategies
  - Maybo training- safer health training
Creating Dementia Specific models of care to manage BPSDs

- Dementia Symposium
- Research & Projects (Blue Plate study, End of life care, CBT, SMILE, SDS programs)
- Staff education (new therapies Montessori, Time slips, managing behaviours of concern etc)
- Experiencing dementia - Alz Australia

Education PIE

- PCC
- Model change
- BPSD
- CBT
- Communication
- Lifestyle education
- Families
- Lifestyle engage
- Environmental
Creating Dementia Specific models of care to manage BPSDs

Family support and Education

- Information sessions on dementia and coping strategies
- Dementia grief and loss, engaging with a person with dementia
- Memory Van visits
- Carers support groups
- Information brochures and help sheets
- Newsletters and Information
Creating Dementia Specific models of care to manage BPSDs

- Increase awareness and tolerance
- Decrease stigma by providing information sessions for residents
- Preventative and promotional initiatives Healthy brain gym
- Active lifestyle choices
Non Pharmacological

Effective BPSD Interventions

- CALD communication aides: 1.90%
- PERAT: 3.80%
- Solitaire activities: 4.56%
- Sensory based therapy: 3.80%
- Pain relief: 7.60%
- Trans generational programs: 2.60%
- Exercise programs: 6.46%
- Visitors schemes: 3.80%
- Montessori roles: 7.22%
- CBT: 2.60%
- Reminescing: 3.80%
- Pastoral support: 1.90%
- RMMRs: 4.18%
- Gardening: 2.28%
- Music: 6.08%
- PCC activities: 6.48%
- Reestablish patterns: 1.90%
- Male orientated: 1.90%
- Relaxation techniques: 2.28%
- Massage/gentle touch: 3.42%
- Cooking: 1.14%
- Visual orientation: 4.94%
- Environmental: 4.94%
- Art: 1.90%
- Simulated doll therapy: 1.14%
- Validation: 1.90%
- Pet therapy: 6.60%
- Computers: 0.30%
- Choir: 0.30%

- Visual orientation: 4.94%
MONTESSORI TECHNIQUES

Memory cueing strategies
Clear enabling signage
(orientation, independence)
Roles and responsibilities

Bed time 9pm
Time to rise 6am
Breakfast 9am
Lunch 12md
Dinner 5.30pm
Supper with Janet Monday, Wednesday Thursday 7pm
Shower 8.30pm
Night time 9pm
Programmed daily person centred roles to reduce resident anxiety associated with compulsive behaviours

**Mrs Qs Montessori roles and routines**

- **1400hrs**  Provide required gardening tools for gardening tasks, sweeping leaves, watering, plant clipping
- **Provide access to specially designed cleaning kits for different activities for her to use**
- **1700hrs** Preparing table for dinner (and control sun downing environment)
- **sweep the floor, assisting with folding clothing and cleaning tables, washing dishes**
- **1800hrs** Prepare her room for night time routine, play her favourite music or the provide the daily newspaper (replicate night time routines attended at home)
- **2000hrs** Provide pm shower in anticipation and explanation to settle for the night
Sun downing programs

- Identify peak periods for behaviours
- Attend population analysis of person centered interests
- Identify periods of high activity - program high stimulus activities
- Program low stimulus activities for before dinner (trained aroma/massage therapist)
- Night time settling routines for after dinner
Older adults with Alzheimer disease who have been involved in a religious tradition, well-rehearsed rituals and emotionally salient behaviours can still be employed well into the later stages of this disease.

An approach called procedural and emotional religious activity therapy, or PERAT, can provide enjoyable and meaningful activities that may reduce agitation and increase quality of life for patients as well as for caregivers (Vance, 2010).

Liaise with Pastoral support or Catholic church support to provide a box with ‘PERAT’ supportive therapy items.

This box can be used when resident is distressed or anxious.

Providing key items that the resident can resonate with can provide reassurance, encourage use of box to calm resident concerns and behaviour.

The box above can be provided to hold PERAT specific therapy items. Images in the frame adjacent can be placed in the box with prayers, hymns and rosary beads etc.
Time slips: Creative storytelling

- Time slips was originally designed for people with cognitive disabilities such as dementia.
- Creativity is an ideal way for people with cognitive challenges to communicate.
- Time slips encourages creative storytelling, links community with the home and residents.
Non pharmacological strategies to manage BPSDs

Works best

- with individual BPSD consults case reviews and care mapping techniques, delirium screening methods
- Staff education on dementia, communication, use of environment to control behaviors, understanding person centered needs
- Educating, supporting staff
- Combination use of milieu therapy, SDS programming and basically using person centered approaches to managing each BPSD
References

14. www.googleimages.com