3-768 Meds sensitivity

TIPS Question:

What other options are available to residents who are sensitive to medications? Residents who demonstrate behaviours of sexual inhibitions, agitation, aggression etc.

Response:

I would like thank you for the additional information you sent regarding this resident and congratulate you and the team for having used the P.I.E.C.E.S. frameworks and assessment tools to help guide your care planning. It is also terrific that you have partnered closely with the Psychogeriatric Outreach Team; I am sure your thoughtful and comprehensive assessment was extremely helpful in identifying the problems, possible causes and intervention strategies. It is unfortunate that the challenges still exist and that the staff, perhaps the family as well if they are involved, and no doubt the resident himself remain under considerable stress. The challenges you describe i.e. unedited and impulsive behaviours including disinhibited sexual behaviour, constantly seeking out the attention of others, becoming easily frustrated when his needs are not immediately met, and showing little understanding or compassion for how his behaviours affect others are indeed characteristic of frontal lobe impairment. Changes in behaviour, insight, judgement, and impulse control related to frontal lobe damage are probably the most challenging for staff to understand and manage – especially in a LTC setting where there are often frail, cognitively impaired and vulnerable residents.

Unfortunately, although I am sure not surprisingly, there is no simple answer to your question; *what are the other options for best care strategies (apart from what you described in your addendum) and given that pharmacological interventions are so problematic for this gentleman?* However, I do have a number of comments that I hope you find helpful:

- Helping Team members to re-visit their expectations for care and the way they interact with the resident will be very important so that expectations are as realistic as possible. With this cluster of behaviours in particular it is often very difficult to "bond" with the resident – more likely, and not surprisingly, staff may express feelings of frustration, hopelessness, and sometimes anger and disgust as well because the behaviours are unpleasant and make them and other residents feel uncomfortable or even threatened. Unfortunately, this may lead to a way of interacting with the resident that exacerbates the problem rather than diminishes the behaviours.
- I find it helpful to remind myself that there are two ways of changing behaviour; a) Those strategies that change behaviour by changing the person him/herself i.e. his/her perception of the problem, appreciation of the consequences, risks, how their behaviour makes other people feel, etc. For this approach to be successful the person must have insight into their problem and the possible causes, and a willingness to change and work together with you to develop the best strategies. b) Alternatively, you change behaviour not by changing the person but by changing things external to the person i.e. environment, the way we interact with the person and respond to the behaviour, etc. ie. the A's (antecedents) and C's (consequences). This is almost always the more meaningful approach with persons with dementia. The focus then becomes on helping staff to understand the behaviour, identify the triggers and interact in a way that minimizes the extent to which the behaviours are distressing and disturbing for the resident and others – you certainly want to avoid making a difficult situation worse than it needs to be.
- To the extent that this resident's impulsive behaviours are secondary to his dementia and in particular the damage to his frontal lobe, it is not realistic to expect him to have control over them. It is possible that at times he may appear as though he can control himself and that he should know better. There is a particular risk of this erroneous assumption when there is a history of the behaviour but in the presence of frontal lobe damage the person has even less control (and in this case you mentioned a prior history of sexually inappropriate behaviour; it will be helpful to ensure you have as accurate and objective a history as possible). He may possess relative strength in certain areas of intellectual ability and there may even be some fluctuation so that at times he seems more aware. However when there is damage to the "executive" functions i.e. preservation, impulsive "in the moment" decision-making, distractibility, tendency to get "stuck" on a certain train of thought or action, impatience, and irritability, the person cannot "supervise" him/herself. If we believe that the person has control over his/her behaviour this takes us in a direction of interacting that can exacerbate the problem i.e. we might inadvertently try to instil remorse, rebuke, or

rationalize in an effort to help the person "appreciate" how the behaviour makes other people feel. Keep in mind the 7 A's – what do you know about this resident's memory and where he is in place and time; and to what extent he knows he doesn't know; and to whether he has insight into his impairment but more importantly insight regarding the consequences of his behaviour (anosognosia). Remember, this gentleman's reality is as real to him as our reality is to us – so it is important to know what his reality is because that gives you your starting point for interaction.

- Perhaps you could review the interaction strategies in light of this - I always like to take a step back and refocus (as often as necessary) because some gem is always identified. The task is then to find the most effective way of communicating those strategies among the Team. Clearly you have found some strategies that work – terrific! The fact that the resident's behaviour re-emerges does not mean that they are unsuccessful. If they are developed with the above information in mind they will likely be appropriate - a realistic expectation may not be to extinguish the behaviour but minimize the extent to which it is disturbing or unsafe.
- Without knowing the specific behaviours considered to be sexually inappropriate in this gentleman's case it is difficult for me to offer specific recommendations regarding interaction strategies. However, it will be important to find meaningful ways for staff to continue to engage with this resident. Due to his behaviours and the emotional reaction they evoke he may be at risk for receiving attention primarily when these behaviours occurs. This may inadvertently reinforce the very behaviours you are trying to diminish. If there is also concern about a possible mood disorder you will certainly want to explore ways to meaningfully respond to his need for attention - which is different than "attention seeking" behaviour, the latter implying a wilfulness and ability for planning that he may not be capable of. You want to avoid this resident having the perception he is being ignored or isolated – however unintentionally. Certainly ensuring that his mood is closely monitored (using SIGECAPS and possibly the Cornell) will be important.
- You mentioned that this resident has been moved to a secure unit due to concerns about his behaviour. If the move was more to address the safety concerns which is certainly understandable, you will want to explore how the environment fits with his capabilities and how he spends his time – what the opportunities are or meaningful activity and recreation. If he is under stimulated some of his behaviours may become aggravated. Use behavioural monitoring (DOS) to help determine the "rhythm" of his day on this new unit; this will help you to be proactive. Again, if there is concern about a possible depression as a complication then he may be feel like he is being punished by his move, so you will want to be able to compensate for this as much a possible.
- Review his ADL care plan and capabilities – do you know his strengths and deficits, what aspects of his care he can do for himself, where he needs assistance, etc. Where sexual expression is a problem e.g. touching staff breasts, making comments, etc., you want to ensure that you are helping him to be as independent as possible – and provide hands on assistance as required.
- There are a couple of resources you may want to consult to help you and your Team in the understanding and assessment of sexual expression for this or any other resident, and to guide your care planning, and assist in the understanding of how staff attitudes and beliefs may be positively or perhaps negatively influencing the behaviour:
    - An article published by Sloan (October, 1993) – Contemporary Long Term care
    - The *Intimacy, sexuality and sexual behaviour in dementia* guide for practice – you can download this from the P.I.E.CE.S. Website.
- Regarding his persistent seeking out of staff, if this is an issue you may want to consider the Pro Attention Plan as this can be very effective for residents who are cognitively impaired or showing anxiety and neediness on the basis of a depression.

***Please note:** TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*