BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA: A PRACTICAL APPROACH

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Disclosure

- Dr. Sid Feldman
  - No conflicts of interest to report
Disclosure

• Dr. Andrea Moser
  • No conflicts of interest to report
By the end of this session, for patients with BPSD, you will be able to:

- Assess patients using the PIECES framework
- Utilize tools to assist in assessment and measure intervention success
- Develop behavioural approaches to management
- Be able to prescribe and de-prescribe antipsychotic medications appropriately
Challenges

What are the challenges you face with patients who have BPSD that you are hoping we can work on together today?
Prevalence of Responsive Behaviours/ BPSD

- 90% of patients affected by dementia will experience Behavioral and Psychological Symptoms of Dementia (BPSD) severe enough to be labeled as a problem during the course of their illness.

- These labeled as ‘responsive behaviours’

- Often associated with increased level of care such as LTC home
Case 1

- Case 1 focus on behavioural strategies
Overall Approach to BPSD/Responsive Behaviours

1. Evaluate & understand meaning

1. Manage
   a. Initiate non-drug therapy
   b. Consider drug therapy, when indicated (may include an antipsychotic trial as well as other options)
BPSD/Responsive Behaviour Symptoms Clusters

Psychosis
- Delusions
- Hallucinations
- Misidentification
- Suspicious

Aggression
- Defensive
- Resistance to care
- Verbal
- Physical

Agitation
- Dressing/undressing
- Pacing
- Repetitive actions
- Restless/anxious

Depression
- Anxious
- Guilty
- Hopeless
- Irritable/screaming
- Sad, tearful
- Suicidal

Apathy
- Amotivation
- Lacking interest
- Withdrawn

Mania
- Euphoria
- Irritable
- Pressured speech
Top Ten Behaviours not (usually) responsive to medication

- Aimless wandering
- Inappropriate urination /defecation
- Inappropriate dressing /undressing
- Annoying perseverative activities
- Vocally repetitious behaviour
- Hiding/hoarding
- Pushing wheelchair bound co-patient
- Eating in-edibles
- Inappropriate isolation
- Tugging at/ removal of restraints
Evaluating BPSD/Responsive Behaviours

Remember: Engage the family at every step

1. Assess & Document – behaviours or symptom clusters
   • Designate responsible care team member(s)
   • Use standardized clinical assessment tool

2. Identify Risks
   • Consider P.I.E.C.E.S. RISKS
     • Roaming
     • Imminent
     • Suicide
     • Kin
     • Self Neglect
Evaluating BPSD/Responsive Behaviours

3. Identify BPSD/Responsive Behaviour Causes
   • Consider P.I.E.C.E.S
     • 3-Questions Template:
       • What has changed?
       • What are the RISKS and possible causes?
       • What is the action?

     • Physical
     • Intellectual
     • Emotional
     • Capabilities
     • Environment
     • Social
Evaluating BPSD/Responsive Behaviours

4. Conduct a clinical evaluation\textsuperscript{10}
   - Check vitals
   - Conduct physical assessment
   - Consider common sources of pain
   - Optimize sensory functioning
   - Conduct mental health/status evaluation
   - Delirium workup with appropriate investigations
   - Identify recent changes (drugs, environment, routine, etc…)
   - Conduct imaging (if appropriate)
Initiating Non-Drug Therapy for BPSD/Responsive Behaviours

Remember: Individualize approach

- Identify behaviour and possible solution(s)
  - Consider using the Dementia Observation System (DOS)
- Manage with individualized non-drug therapy
  - Unless imminent risk of harm to resident, staff, or others
- Treat underlying causes with non-drug/drug therapy
  - (e.g. pain, constipation, delirium)

Remember: Leverage available system supports
Initiating Non-Drug Therapy for BPSD/Responsive Behaviours

• Environmental Considerations
  • Eliminate misleading stimuli
  • Reduce environmental stress
  • Adjust stimulation
  • Enhance function
  • Adapt physical setting to individual preference

• Safety considerations
  • Ensure your safety, the resident’s safety and other residents’ safety
  • Remove potentially dangerous objects, individuals and ongoing triggers
Initiating Non-Drug Therapy for BPSD/Responsive Behaviours

• Caregiver approach considerations:
  • Personal approach
    • Be calm and compassionate
    • Engage in individualized activities
    • Focus on resident’s wishes, interests, concerns
    • Approach slowly; look for signs of increased agitation and ask permission before entering
  • Daily routines
    • Maintain routines and reduce uncertainty
    • Use long-standing history and preferences as guidance
    • Individualize social and leisure activities
  • Communication style
    • Use positive non-verbal cues
    • Make eye contact (unless perceived as aggressive)
    • Use short simple words and phrases
    • Speak clearly and use a positive tone
    • Be patient
System approach

“Culture eats strategy for breakfast”

Critical to have a system approach to be successful.

Next session will focus on quality approaches that can help achieve success
Case 1: table discussion

Using Section A and B of the discussion guide:

- Suggest reasons for the behaviours seen under each category of the PIECES framework
- Develop a non-drug therapy approach to manage the behaviours seen based on these reasons
- Discuss how to support the interdisciplinary team in LTC
Case 1: Mrs R

- 85 year old female
- Retired secretary, loves music, art, cats
- Estranged from her 2 children
- Mixed dementia
- **PMHx:** Traumatic Brain Injury, long standing depression, psoriasis, osteoarthritis

**Behaviours**
- Physical and Verbal aggressive behaviours particularly during care
- Admitted to Behavioural Unit from community due to LTC refusals
- Medications: SSRI, trazodone
PIECES

PHYSICAL

INTELLECTUAL

EMOTIONAL

CAPACITY

ENVIRONMENTAL

SOCIAL/SPRITUAL
DICE Approach: Develop a Plan

- DESCRIBE
- INVESTIGATE
- CREATE
- EVALUATE
Review case 1

- General discussion
Case 1: Mrs R

- In LTC
- Physical aggression during care
- PIECES assessment to identify possible triggers
  - Pain – irritated rashes
  - Constipation
  - Marked hearing impairment
- Management
  - Consistent approach to care, slow, engage her in care
  - Trial of ‘pocket talker’ – able to hear, recognize staff, provide input on recent events, participate in activities, painting
  - Marked reduction in aggressive behaviours
Principles

- As per guidelines: Detailed interdisciplinary assessment for antecedents/causes

- Non pharmacologic strategies prior to pharmacologic intervention

- Sometimes a simple intervention can have a marked impact on behavioural symptoms and quality of life
Case 2

• Focus on pharmacologic approaches
Trends in use of antipsychotics

- CIHI Your Health System
- www.yourhealthsystem.ca

- Use of antipsychotics without a diagnosis of psychosis (MDS 2.0) in LTC

- Trending downwards in LTC
  - 2010 – 34%
  - 2014 – 27%
    - BC 31%, ONT 27%, ALTA 21%
Canadian National Guidelines

• Canadian Coalition for Seniors Mental Health: Assessment and treatment of mental health issues in long term care homes
  • Evaluate for medical conditions and diagnostic tests as indicated
  • Detailed interdisciplinary assessment for antecedents/causes
  • If BPSD does NOT pose imminent risk to patient or others – non-pharmacologic Rx

• Canadian Consensus Conference on Diagnosis and Treatment of Dementia (CCCDTD4), 2012
  • ‘for severe agitation, atypical antipsychotics are recommended but risks of therapy must carefully weighed against potential benefits
Managing BPSD/Responsive Behaviours

1. Initiate individualized non-drug therapy\textsuperscript{11, 12, 13}
2. Consider targeted drug therapy
   - Dependent on the behaviour
3. Monitor and document
   - Therapeutic goal for target symptom
   - Effectiveness and adverse effects
   - Consider dose reduction or discontinuation
4. Conduct follow-up
   - If antipsychotic used, reassess need every 3 months\textsuperscript{16}
   - Consider deprescribing when appropriate
5. Continue non-drug approaches to prevent further behaviours
BPSD/Responsive Behaviour Symptoms Clusters

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- Suspicious

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- Resistance to care
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Depression
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- Hopeless
- Irritable/screaming
- Sad, tearful
- Suicidal

Apathy
- Amotivation
- Lacking interest
- Withdrown

Mania
- Euphoria
- Irritable
- Pressured speech
Top Ten Behaviors responsive (perhaps!) to medication

- Physical aggression
- Verbal aggression
- Anxious, restless
- Sadness, crying, anorexia
- Withdrawn, apathetic
- Sleep disturbance
- Wandering with agitation/aggression
- Vocally repetitious behavior due to depression or pain
- Delusions and hallucinations
- Sexually inappropriate behavior with agitation
Decision framework for the use of medication in BPSD

- Is this medication indicated?
- Is it necessary and how will it be helpful to the patient?
- What are the risks?
- Will the benefits likely outweigh the risks?
- Who decides whether the benefits are worth taking the risks?
- When is it appropriate to consider stopping the medication and what will we use to monitor response?
Pharmacological treatment: Choosing best drug

- Correct underlying cause, deficiency:
  - Optimize treatment of dementia, CEIs, memantine
- Target appropriate symptom cluster:
  - Depression: Antidepressant
  - Anxiety (longer term): antidepressant
  - Difficulty falling asleep: Trazodone
  - Psychosis: antipsychotic
  - Aggression: antipsychotic
- Choose least likely to worsen dementia and medical problems
  - E.g. Least anticholinergic
- Choose drugs without problematic interaction
- Reduce overall drug burden as much as possible
Considerations for an Antipsychotic Trial for BPSD/Responsive Behaviours

- Consider whether an antipsychotic trial is needed – is there:
  - Imminent risk of harm?
  - Disturbing, distressing or dangerous symptoms?
  - Symptoms more likely to respond to antipsychotics?
Considerations for an Antipsychotic Trial for BPSD/Responsive Behaviours

- Initiate and conduct ongoing review
  - Weigh potential benefits and harms
  - Obtain and document informed consent
  - Select an antipsychotic; start low and go slow
  - Monitor behaviour change and side effects
  - Assess and document benefits/harms over 1-3 weeks (adjust therapy as needed)
  - Monitor and reassess on an ongoing basis for effectiveness and tolerability
  - Review for possible deprescribing after 3 months of behavioural stability
- Consider referral to a specialist if trial is unsuccessful
Considerations for an Antipsychotic Trial for BPSD/Responsive Behaviours

• Reassessing antipsychotics for possible deprescribing:
  • Stopping or tapering antipsychotics may decrease “all cause mortality” 27
  • Deprescribing may not be indicated for all residents
    • (e.g. residents whose symptoms are due to psychosis, or whose behaviour is especially dangerous/disruptive)
  • Evaluate reason for use and recent changes in targeted behaviour
  • Ensure suitable non-pharmacological measures are optimized
  • Antipsychotics can often be successfully tapered and/or discontinued28
  • Taper gradually, often by 25-50% every 2-4+ weeks and look for any resulting behaviour changes
    • Once stabilized on lowest dose, may discontinue in 2-4+ weeks
  • Continue to reassess for emergence of behaviours
### Comparing antipsychotics:

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<th>Drug Generic (Brand)</th>
<th>Efficacy or evidence in BPSD therapy</th>
<th>( \downarrow ) BP[^{[32]} )</th>
<th>Ach</th>
<th>Sedation</th>
<th>EPS</th>
<th>TD[^{[33]} )</th>
<th>Diabetes</th>
<th>Weight Gain[^{[27]} )</th>
<th>Usual Dose</th>
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</table>
| Risperidone* (Risperdal)\[^{[25, 26, 34]} \) | ✓ Indicated for severe dementia of the Alzheimer type\[^{[Health Canada]} \)  
• Evidence for efficacy in agitation, aggression & psychosis | ++ | ++ | ++ | ++ | + | ++ | ✓ ✓ ✓ ✓  (0.7lb/month) | 0.125mg – 2.0mg/d QHS (or divided BID) | $10-27 |
| Olanzapine* (Zyprexa)\[^{[25, 26, 34]} \) | • Off-label use in BPSD  
• Evidence for efficacy in agitation & aggression | + | +++ | +++ | ++ | + | +++ | ✓ ✓ ✓ ✓  (1.0lb/month) | 1.25mg – 7.5mg/d | $17-38 |
| Aripiprazole* (Abilify)\[^{[34]} \) | • Off-label use in agitation or aggression\[^{[18]} \)  
• Evidence for efficacy in agitation & aggression  
• Not eligible in ODB for dementia or BPSD in the elderly  
• Not for psychosis\[^{[same as placebo]} \) | + | + | ++ | + | + | – | ✓ ✓ | 2.0mg – 12.5mg QHS | $112-260 |
| Quetiapine (Seroquel)\[^{[25, 16, 34]} \) | • Off-label use in BPSD  
• Lacks evidence for efficacy in BPSD agitation, aggression, or psychosis  
• Consider in Lewy Body dementia, Parkinson’s (low EPS)  
• Note: although used, not indicated and lacking evidence for insomnia | ++ | +++ | +++ | + | + | +++ | ✓ ✓ ✓ | 12.5mg – 200mg/d (divided QHS-TID) | $10-59 |
| Haloperidol (Haldol) | • Useful short term in acute BPSD or delirium | + | + | + | +++ | +++ | ++ | ✓ ✓ | 0.25mg – 2mg/d | $14-25 |
| Loxapine (Loxapac, Xylac)\[^{[2]} \) | • Consider if other agents have failed and severe persistent dangerous behaviour continues  
• Severe, acute BPSD  
• Not to be used long-term due to adverse effects | ++ | ++ | +++ | +++ | +++ | + | – | 5mg – 10mg BID | $18-27 |
Case 2: table discussion

• Use Section C and D to decide if pharmacotherapy is indicated, and if so what agent would you choose?
• How would you obtain consent?
• How would you document?

• Comment on non pharmacologic approaches and whether they are relevant for this case?
Case 2 Mrs. S

- Former teacher, husband had died 2 years prior
- Alzheimer’s Disease x 5 years, significant dysphasia
- PMHx: GERD, HTN, OA
- Behaviours: Stayed in room, refused to come out, minimal food intake, screamed when anyone entered her room or came close to her, very resistive to care (3-4 staff), crying, asking “Is this the cemetery? Why are we here? I am dead?”. Seemed to be visualizing cemetery.
Review Case 2

• Consider DICE framework

• DESCRIBE

• INVESTIGATE

• CREATE

• EVALUATE
Mrs. S

- Non-pharmacologic strategies:
  - Staff would come in, sit down far from her and read a magazine—screaming would subside after a few minutes.
  - Enjoyed “Royal Family”—staff showed her pictures of Royalty and comment on their clothes. This would sometimes calm her enough to allow care (~15-25% of the time)
  - “Favourite foods” to start meals (only from familiar staff)
- Pharmacotherapy: No benefit from analgesics, SSRI x 2, SNRI x 1
- Antipsychotic: Risperidone 0.5 mg qAM and 0.75 mg qhs ->excellent response. After 6 weeks, no calling out about cemeteries or death. Much happier, weight gain, “chatty”.
Principles

- Sometimes psychosis needs an antipsychotic.
- Taper to lowest effective dose
- Eventually, as dementia progresses, likely will be able to discontinue completely
Case 2

- Case 2 summary to be available while groups discussing
Questions and cases

• What cases or questions do you want to discuss with colleagues today?
Review of challenges

What are the challenges you face with patients who have BPSD that you are hoping we can work on together today?
Additional cases
Mr. V

- Former TTC (maintenance)
- Alzheimer’s Disease x 7 years
- PMHx: osteoarthritis (knees), hypertension, headaches (migraine?)
- Behaviours:
  - Pushing co-residents, grabbing, pushing tables/chairs into others, agitated pacing, hitting himself in the head, resistive to care
  - Frequent “code whites” (IM haloperidol at times)
Mr. V

- Non-pharm approaches helped somewhat with frequency and intensity of symptoms: Enjoyed washing tables-put out salt or sugar for him to clean up, bolts to tighten, straightening magazines, objects to sand, family photo book
- Meds: Analgesics (including hydromorphone, steroid knee injections), cold pack for headaches
- … still very distressed and putting others at risk
- Risperidone titrated up to 1 mg daily and had excellent response
- Developed slowing and tremor
- Slow taper over 18 months down to zero
Principles

- Non-pharm before pharm (except in emergencies may need prn)
- Non-antipsychotics especially pain management
- Tapering cautiously can be successful even in highly agitated patients
Mrs. S

• Former teacher, husband had died 2 years prior
• Alzheimer’s Disease x 5 years, significant dysphasia
• PMHx: GERD, HTN, OA
• Behaviours: Stayed in room, refused to come out, minimal food intake, screamed when anyone entered her room or came close to her, very resistive to care (3-4 staff), crying, asking “Is this the cemetery? Why are we here? I am dead?”. Seemed to be visualizing cemetery.
Mrs. S

- Non-pharmacologic strategies:
  - Staff would come in, sit down far from her and read a magazine—screaming would subside after a few minutes.
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Principles

- Sometimes psychosis needs an antipsychotic.
- Taper to lowest effective dose
- Eventually, as dementia progresses, likely will be able to discontinue completely
Mr C

- 79 year old construction worker
- Mixed dementia
- PMHx: peripheral vascular disease, vascular leg ulcer, alcohol use
- **Behaviours:** Resistive behaviours at home
- Fall at home, admitted to acute care
- Delirium in acute care with physical aggression, sleep disruption
- Risperidone 1mg bid with good effect

- Transferred to LTC in crisis after discharge home
Mr C

- In LTC
- Lethargic
- Gait instability and multiple falls, essentially bed bound
- Decreased oral intake and weight loss

- Decision to trial gradual dose reduction
- Decrease by 0.25mg every 1-2 weeks monitoring for recurrence of behaviours

- Successful taper, no aggression, no psychosis
- Gait remains unsteady more alert and able to express basic needs
Principles

• Antipsychotic may be required for short duration with delirium

• Try to taper dose of antipsychotic once delirium clears

• Usually able to discontinue successfully
Mrs R

- 85 year old female
- Retired secretary, loves music, art, cats
- Estranged from her 2 children
- Mixed dementia
- **PMHx:** Traumatic Brain Injury, long standing depression

**Behaviours**
- Physical and Verbal aggressive behaviours particularly during care
- Admitted to Behavioural Unit from community due to LTC refusals
- Medications: SSRI, trazodone
Mrs R

- In LTC
- Physical aggression during care
- PIECES assessment to identify possible triggers
  - Pain – irritated rashes
  - Constipation
  - Marked hearing impairment
- Management
  - Consistent approach to care, slow, engage her in care
  - Trial of ‘pocket talker’ – able to hear, recognize staff, provide input on recent events, participate in activities, painting
  - Marked reduction in aggressive behaviours
Principles

- As per guidelines: Detailed interdisciplinary assessment for antecedents/causes

- Non pharmacologic strategies prior to pharmacologic intervention

- Sometimes a simple intervention can have a marked impact on behavioural symptoms and quality of life
Mrs L

• 80 year old female with advanced dementia
• Housewife of Italian descent, prided herself on family and cooking
• PMHx: Osteoarthritis, hypertension
• Behaviours: Unprovoked physical aggression to staff and co-residents, episodes of psychosis, resistive to care
• Form 1 to ED on 3 occasions in past 2 years
• Admitted to psychiatry inpatient unit once

• Meds: loxapine, trazodone, citalopram, galantamine
• Previous trials: risperidone, olanzepine, quetiapine, haloperidol, multiple antidepressant agents, BDZ
Mrs L

- Admission to Behavioural Unit
- Family concerned she is over-medicated
- Lethargic, Gait unstable, Parkinsonism/EPS, Rigidity, Tremor, shuffling gait
- Postural hypotension and Falls
- Consultation with psychiatry: attempt dose reduction
- Loxapine 25 mg daily divided dose, decreased to 20mg x 2 weeks, then 15mg
- Physical aggressive recurs towards co-residents, staff
- Increase to 20mg – behaviours improve
- Family pleased as less lethargy and more interactive on visits
Principles

• If on complex psychotropic medication regime obtain past medical records prior to attempting dose reduction

• Consider dose reduction with close monitoring

• Involve geriatric psychiatry for complex cases

• Sometimes dose reduction or change to medication with safer side effect profile not possible
Resources

- Centre for Effective Practice
  - effectivepractice.org

- Canadian Coalition of Seniors Mental Health
  - www.cccsmh.ca
  - Delirium, depression, suicide, BPSD

- Geriatric interorganizational interprofessional Collaboration (GiiC)
  - http://giic.rgps.on.ca/toolkit-libraries

- Behavioural Supports Ontario (BSO)
  - http://www.akeresourcecentre.org/BSOAbout

- 4th Canadian Consensus Guideline on the Diagnosis and Treatment of Dementia
  - http://www.alzheimer.ca/~media/Files/national/For-HCP/for_hcp_recos_CCCDTD4_en.ashx
Questions

Andrea Moser (amoser@baycrest.org)

Sid Feldman (sfeldman@baycrest.org)
Dementia Observation System (DOS)

Use corresponding numbers to record in 1 hour intervals
1. Sleeping 5. Aggressive – verbal Location: H. Hallway S: Shower room
2. Awake/Calm 6. Aggressive - verbal (with care) B. Bedroom D: Dining room

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Comments:
# ABC Behaviour Observation Table

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<td><strong>Date/Time of Day</strong></td>
<td><strong>Before</strong> the behaviour</td>
<td>The <strong>specific</strong> behaviour observed</td>
<td><strong>After</strong> the behaviour</td>
<td>Any thoughts on the possible function of the behaviour?</td>
</tr>
<tr>
<td>Signature</td>
<td>Where was it? Who was there?</td>
<td>What happened as a result of the behaviour?</td>
<td>Noise? People? Smell?</td>
<td>Avoidance, attention, tangible (i.e. food), sensory, medical</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Antecedent</th>
<th>Behaviour</th>
<th>Consequence</th>
<th>Notes</th>
</tr>
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<tr>
<td>Observer</td>
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# Pain Assessment IN Advanced Dementia- PAINAD (Warden, Hurley, Volicer, 2003)

<table>
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<tr>
<th>ITEMS</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>SCORE</th>
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</thead>
<tbody>
<tr>
<td>Independent of vocalization</td>
<td>None</td>
<td>Occasional moan or groan. Low- level of speech with a negative or disapproving quality</td>
<td>Repeated troubled calling out. Loud moaning or groaning. Crying</td>
<td></td>
</tr>
<tr>
<td>Negative vocalization</td>
<td>Smiling or inexpressive</td>
<td>Sad, frightened, frown</td>
<td>Facial grimacing</td>
<td></td>
</tr>
<tr>
<td>Body language</td>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch</td>
<td>Unable to console, distract or reassure</td>
<td></td>
</tr>
<tr>
<td>Consolability</td>
<td></td>
<td></td>
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</tbody>
</table>

*Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items*
Kingston Standardized Behavioural Assessment

COMMUNITY FORM* - KSBA(comm)

Patient Name ____________________________ [Case # ______________]  
Sex M__ F__ Age_________ Education_________ Years of Illness_________
Date ______________________ Your Relationship to Patient ______________
Lives in Community___________ or Lives in Care Facility _____________

Please check all of the following behaviours that have occurred in the last month or are presently occurring, and that are a change from your spouse/relative/client's earlier behaviour (prior to illness). Indicate whether they apply by marking the box beside the appropriate statement. The Total Score equals number of boxes checked.

1 Daily Activities
1. No longer takes part in favourite pastimes (or greatly reduced).
2. Reduced personal hygiene. (e.g. Would not take a bath unless told to do so, or wears the same clothes for days unless made to change).
3. If left on his/her own, doesn't eat properly.
4. Unsafe in daily activities, if left unsupervised.
5. No longer uses some common objects properly (e.g. telephone).
6. Unable to handle personal finances.
7. Is unable to perform usual household tasks.
8. Gets confused in places other than home.
9. Overly dependent, wants more guidance than usual.
10. Trouble appreciating subtleties in conversations (e.g. recognizing humor).
11. Difficulty judging the passing of time.
12. Wanders aimlessly.
15. Fails to recognize family or friends.
17. Voids in non-toilet areas.
< Total Daily Activities

2 Attention/Concentration/Memory
18. Can't concentrate, pay attention for long.
19. Misplaces things more than usual.
20. Has difficulty organizing his/her time or daily activities.

< Total Attention/Concentration/Memory

3 Emotional Behaviour
21. Forgets activities, conversations of only a short time before.
22. Forgets important everyday information.
< Total Emotional Behaviour

4 Aggressive Behaviour
23. Shows little or no emotion.
24. Mood changes for no apparent reason.
25. Expresses inappropriate emotions, either type or intensity.
< Total Aggressive Behaviour

5 Misperceptions/Misidentifications
27. Claims an object/possession looks similar to, but is not the real one.
28. Claims a family member looks similar but is not the true one.
29. Thinks present dwelling is not their place of living.
30. Thinks people are present who aren't.
< Total Misperception Behaviour
<table>
<thead>
<tr>
<th></th>
<th>Paranoid Behaviour</th>
<th>Sleep/Activity/Sundowning</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>34 Suspicious of family and friends.</td>
<td>52 Falls asleep at uncharacteristic times.</td>
</tr>
<tr>
<td></td>
<td>35 Suspicious about money issues.</td>
<td>53 Gets up and wanders or awakens frequently</td>
</tr>
<tr>
<td></td>
<td>36 Accuses others of stealing his or her things.</td>
<td>at night, more than usual.</td>
</tr>
<tr>
<td></td>
<td>37 Accuses spouse of infidelity.</td>
<td>54 Sleeps more.</td>
</tr>
<tr>
<td></td>
<td>38 Expresses suspicion around taking medication.</td>
<td>55 Behaviour more agitated or impaired in late</td>
</tr>
<tr>
<td></td>
<td>&lt; Total Paranoid Behaviour</td>
<td>afternoon.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt; Total Sleep/Activity/Sundowning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Judgement/Insight</th>
<th>Motor/Spatial Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>39 Shows poor judgement in social situations.</td>
<td>56 Poor coordination seen in limb/finger</td>
</tr>
<tr>
<td></td>
<td>40 Shows poor judgement about driving.</td>
<td>movements.</td>
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<tr>
<td></td>
<td>41 Shows uncharacteristic change in his or her concern</td>
<td>57 Slowness of movement.</td>
</tr>
<tr>
<td></td>
<td>42 Poor choices in dressing. (e.g. wears clothes that</td>
<td>58 Unsteadiness when walking.</td>
</tr>
<tr>
<td></td>
<td>are inappropriate for season or temperature, wears the</td>
<td>59 Has trouble dressing, especially with buttons</td>
</tr>
<tr>
<td></td>
<td>same clothes for days).</td>
<td>or shoelaces.</td>
</tr>
<tr>
<td></td>
<td>43 Makes inappropriate sexual advances.</td>
<td>60 Difficulty judging object sizes or how near</td>
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<tr>
<td></td>
<td>44 Shows less self control than usual.</td>
<td>an object is from themselves.</td>
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<td></td>
<td>45 Unable to identify personal safety risks.</td>
<td>&lt; Total Motor Spatial Problems</td>
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<tr>
<td></td>
<td>&lt; Total Judgement/Insight</td>
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<table>
<thead>
<tr>
<th></th>
<th>Perseveration</th>
<th>Language Difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>46 Repeats same actions over and over.</td>
<td>61 Reads far less frequently than previously.</td>
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<tr>
<td></td>
<td>47 Repeats same words or phrases.</td>
<td>62 Substitutes some words for others.</td>
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<td></td>
<td>48 Repeatedly shouts or calls out.</td>
<td>63 Does not watch or follow television.</td>
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<td>&lt; Total Perseveration</td>
<td>64 Does not speak unless spoken to. (e.g. Does</td>
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<tr>
<td></td>
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<td>not participate in conversations.)</td>
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<td>65 Often cannot find the right word.</td>
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<td>66 Trouble pronouncing words.</td>
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<td>67 Does not understand simple commands,</td>
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<td></td>
<td>explanations.</td>
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<td></td>
<td></td>
<td>68 Does not produce meaningful speech.</td>
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<td></td>
<td>&lt; Total Motor Restlessness</td>
<td>&lt; Total Language Difficulties</td>
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<table>
<thead>
<tr>
<th></th>
<th>Motor Restlessness</th>
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<tbody>
<tr>
<td>9</td>
<td>49 Desire to pace or walk almost constantly.</td>
<td>NPL Total (1,2, 10 - 12)**</td>
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<tr>
<td></td>
<td>50 Can't sit still, restless, fidgety.</td>
<td>NPT Total (3 - 9)**</td>
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<td>51 Tries doors, windows.</td>
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<td>&lt; Total Motor Restlessness</td>
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</table>

TOTAL SCORE (1 - 12)

** see Manual page 8
# KSBA (comm) - Analysis Form

## Behavioural Profile

<table>
<thead>
<tr>
<th>COMPARISON SCALE</th>
<th>Daily Activities</th>
<th>Attention/Concentration/Memory</th>
<th>Aggressive Behaviour</th>
<th>Misperceptions</th>
<th>Paranoid Behaviour</th>
<th>Judgement/Insight</th>
<th>Perseveration</th>
<th>Motor Restlessness</th>
<th>Sleep/Activity/Sedation</th>
<th>Motor/Spatial Problems</th>
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## Total Score Analysis

### Comm

<table>
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<tr>
<th>Total Score Descriptions</th>
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<th>Total Score Descriptions</th>
<th>Total Score</th>
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### Inst

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</table>

To produce a behaviour profile, count the number of items checked for each behavioural group and circle that number on the above chart in the appropriate column. To the right of the profile chart are columns for total score analysis. Select the appropriate column and circle the number matching the total score. (COM = community living; INST = institutional living).
KSBA\textsubscript{(comm)} Behavioural Analysis Procedures

**For long term care residents, use the KSBA\textsubscript{(ltc)} form.**

**For explanations and samples as to how to use this form see KSBA Administration and Interpretation Manual, which can be downloaded free of charge from www.kingstonscales.ca**

or e-mail: kscales@queensu.ca

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# Kingston Standardized Behavioural Assessment

**LONG TERM CARE FORM - KSBA(LTC)**

**Patient Name: ____________________**

**Case: ____________________**

**Sex:** M F **Age:** ______ **Education:** ______ **Years of Illness:** ______

**Date:** ________________ **Rater/Informant:** ____________________

**Lives in:** Facility Type ____________________

Please check all of the following behaviours that have occurred in the last month or are presently occurring, and that are a change from your client/patient's earlier behaviour (prior to illness). Indicate whether they apply by marking the box beside the appropriate statement. The Total Score equals number of boxes checked.

## 1 Daily Activities

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>No longer takes part in favourite pastimes (or greatly reduced).</td>
</tr>
<tr>
<td>2</td>
<td>Resistant to bathing.</td>
</tr>
<tr>
<td>3</td>
<td>Refuses to leave own room.</td>
</tr>
<tr>
<td>4</td>
<td>No longer uses some common objects properly (e.g. silverware).</td>
</tr>
<tr>
<td>5</td>
<td>Does not like being touched.</td>
</tr>
<tr>
<td>6</td>
<td>Combines foods not usually eaten together.</td>
</tr>
<tr>
<td>7</td>
<td>Refuses to eat.</td>
</tr>
<tr>
<td>8</td>
<td>Drools on self, clothing.</td>
</tr>
<tr>
<td>9</td>
<td>Overly dependent, wants more guidance than usual.</td>
</tr>
<tr>
<td>10</td>
<td>Eats other's food at meal time.</td>
</tr>
<tr>
<td>11</td>
<td>Difficulty judging the passing of time.</td>
</tr>
<tr>
<td>12</td>
<td>Wanders aimlessly.</td>
</tr>
<tr>
<td>13</td>
<td>Hides things.</td>
</tr>
<tr>
<td>14</td>
<td>Hoards objects.</td>
</tr>
<tr>
<td>15</td>
<td>Fails to recognize family or friends.</td>
</tr>
<tr>
<td>16</td>
<td>Incontinence of urine/faeces in clothes in daytime.</td>
</tr>
<tr>
<td>17</td>
<td>Voids in non-toilet areas.</td>
</tr>
<tr>
<td>18</td>
<td>Smears faeces.</td>
</tr>
</tbody>
</table>

< Total Daily Activities

## 2 Attention/Concentration/Memory

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>19</td>
<td>Can't concentrate, pay attention for long.</td>
</tr>
<tr>
<td>20</td>
<td>Misplaces things more than usual.</td>
</tr>
</tbody>
</table>

## 3 Emotional Behaviour

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>21</td>
<td>Easily distracted by surrounding noises.</td>
</tr>
<tr>
<td>22</td>
<td>Places things in inappropriate places.</td>
</tr>
</tbody>
</table>

< Total Attention/Concentration/Memory

## 4 Aggressive Behaviour

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>23</td>
<td>Shows little or no emotion.</td>
</tr>
<tr>
<td>24</td>
<td>Mood changes for no apparent reason.</td>
</tr>
<tr>
<td>25</td>
<td>Expresses inappropriate emotions, either type or intensity.</td>
</tr>
<tr>
<td>26</td>
<td>Makes uncharacteristically pessimistic statements.</td>
</tr>
<tr>
<td>27</td>
<td>Expresses suicidal feelings, threatens to hurt him/herself.</td>
</tr>
</tbody>
</table>

< Total Emotional Behaviour

## 5 Misperceptions/Misidentifications

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>28</td>
<td>Verbally abusive at times.</td>
</tr>
<tr>
<td>29</td>
<td>Uncharacteristically excitable, easy to upset; reacts catastrophically.</td>
</tr>
<tr>
<td>30</td>
<td>Throws things at, or pinches others.</td>
</tr>
<tr>
<td>31</td>
<td>Attempts to hit/strike out at others.</td>
</tr>
</tbody>
</table>

< Total Aggressive Behaviour

## 6 Total Misperception Behaviour
6 Paranoid Behaviour
38 Suspicious of family and staff.
39 Suspicious about money issues.
40 Accuses others of stealing his or her things.
41 Accuses spouse of infidelity.
42 Expresses suspicion around taking medication.
< Total Paranoid Behaviour

7 Judgement/Insight
43 Seeks constant attention.
44 Eats non-food items.
45 Grabs others nearby.
46 Shows increased sexual drive, interest.
47 Makes inappropriate sexual advances.
48 Accident prone, gets hurt a lot.
49 Unconcerned about personal safety.
50 Invades personal space.
< Total Judgement/Insight

8 Perseveration
51 Repeats same actions over and over.
52 Repeats same words or phrases.
53 Talks about same topic over and over again.
54 Repeatedly shouts or calls out.
55 Clapping/noise making.
< Total Perseveration

9 Motor Restlessness
56 Desire to pace or walk almost constantly.
57 Can't sit still, restless, fidgety.
58 Tries doors, windows.
59 Repeatedly rearranges furniture.
60 Bangs head deliberately.
< Total Motor Restlessness

10 Sleep/Activity/Sundowning
61 Falls asleep at uncharacteristic times.
62 Gets up and wanders or awakens frequently at night, more than usual.
63 Sleeps more.
64 Behaviour more agitated or impaired in late afternoon.
< Total Sleep/Activity/Sundowning

11 Motor/Spatial Problems
65 Poor coordination seen in limb/finger movements.
66 Slowness of movement.
67 Unsteadiness when walking.
68 Difficulty judging object sizes or how near an object is from themselves.
< Total Motor Spatial Problems

12 Language Difficulties
69 Substitutes some words for others.
70 Does not speak unless spoken to. (e.g. Does not participate in conversations.)
71 Often cannot find the right word.
72 Trouble pronouncing words.
73 Does not understand simple commands, explanations.
74 Speaks in meaningless phrases, or unintelligible language.
< Total Language Difficulties

<table>
<thead>
<tr>
<th>NPL Total (1,2,10-12) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPT Total (3-9) *</td>
</tr>
</tbody>
</table>

TOTAL SCORE

* see Manual page 8
To produce a behaviour profile, count the number of items checked for each behavioural group and circle that number on the above chart in the appropriate column. To the right of the profile chart are columns for total score analysis. Select the appropriate column and circle the number matching the total score.
**KSBALTC** Behavioural Analysis

**PROCEDURES**

**STEP 1**
Circle the sum of total items scored (See arrow).

**STEP 2**
Read total score performance classification in column to right (See arrow).

**STEP 3**
Create behavioural profile by circling sum of items scored for each behavioural group (See arrows). Connect circles, if desired.

---

For explanations and samples as to how to use this form see

KSBALTC Administration and Interpretation Manual, which can be freely downloaded from: [www.kingstonscales.org](http://www.kingstonscales.org)

or email: kscales@queensu.ca

Practical Quality Improvement Tools for Long Term Care

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Speaker Disclosures

Dr. Auger has disclosed that she has no relevant financial relationship(s).

Dr. Williams has disclosed that she has no relevant financial relationship(s).

Slide deck developed by Dr. Williams and Dr. Andrea Moser
WELCOME AND INTRODUCTION
Learning Objectives

By the end of the session, participants will be able to:

• Understand and apply Quality Improvement tools to improve practice in Long Term Care
• Engage in exchange of ideas with colleagues on possible Quality Improvement initiatives in Long Term Care
What is Quality Improvement?

A formal process that:

- looks at the way we do things and helps us identify new ways, that will be even more effective
- focuses on systems, not people
- helps to create reliable processes to improve your work
Why Quality Improvement?

“Keep doing what you've always done and you'll keep getting what you've always got.”

Buckminster Fuller

"If you're not part of the solution, you're part of the problem."

Charles Rosner
Using Quality Improvement in LTC

• Address quality measures reported the CIHI national reporting system (antipsychotics, pressure ulcers, falls)
• Increase efficiencies to deliver quality outcomes with shrinking resources
• Reduce polypharmacy
• Decrease non-value added work
In Quality Improvement work, we use many QI tools. The QI framework provides a structure for the path forward.

Resources:
Institute for Healthcare Improvement
www.ihi.org
The Quality Improvement Framework

Model for Improvement

AIM
What are we trying to accomplish?

MEASURE
How will we know that a change is an improvement?

CHANGE
What change can we make that will result in an improvement?

GETTING STARTED
DEFINING THE PROBLEM
UNDERSTANDING YOUR SYSTEM
DESIGNING AND TESTING SOLUTIONS
IMPLEMENTING AND SUSTAINING CHANGES
SPREADING CHANGE

Act
Plan
Study
Do
The Iterative Process

- Getting started
- Defining the problem
  *the problem statement*
- Understanding your system
  *the fishbone diagram*
The Iterative Process

- Designing and Testing Solutions
  *the PDSA cycle*
- Implementing and Sustaining Changes
- Spreading Change
Problem Statement

In order for us to better understand the current situation of our system it is helpful to involve staff in determining what is the problem.
Problem Statement Examples

• Aggressive behaviours are being reported by staff but supporting documentation is difficult to locate.

• There has been a recent increase in workplace injuries from resident on staff violence

• Psychotropic drug use in our facility is above the average for the province

• MDS report shows increase in worsening resident pain scores
Problem Statement

• What is the problem?
• Who does this affect?
• When is it a problem?
• Why should I care?
• How does it affect the resident?
• How does this problem make you feel?
• Look for the problem, not the solution
Small Group Activity

What is the problem you would like to work on?

Write a problem statement

Topic ideas
Emerg transfers
Antipsychotic use
Pain mgt
Falls
Why Learn about Fishbone Diagrams?

Fishbone Diagrams:

• gather many perspectives around causes of a specific problem
• get us out of tunnel thinking
• involve all staff in problem solving
• help us understand systems issues
Fishbone/Ishikawa/Cause and Effect Diagram

Provider (Staff)

Policies

Person (Resident)

Place (Equipment)

Procedures

EFFECT / PROBLEM
Why are there so many challenges documenting responsive behaviours?

**Category: Policies**
- The policy is not clear on who should document
- The policy is not clear on who should document
- Policy does not include Residents with RB

**Category: Provider/Staff**
- Not my resident
- No policy for documenting RB
- Not enough time
- Do not know what to document
- Don’t know where to document
- New Resident to home

**Category: Person/Resident**
- Not a new behavior for Resident
- Every resident has a behavioural issue
- New Resident to home
- Don’t know where to document
- Not enough time

**Category: Place/Equipment**
- We do not have enough space to do our documentation
- Our electronic documentation tool does not allow for the different types of behaviours

**Category: Procedures**
- Duplication of documentation
- Not sure where to document the behaviour in the notes
- Not sure where to document
- Not sure when to document
- Multiple assessment tools, unsure which to use
Small Group Activity

Creating a Fishbone Diagram

Emerg transfers
Antipsychotics
Falls or?
Fishbone Activity Instructions

1. Brainstorm causes as to why your identified problem exists.

2. Write each possible cause on a sticky note. One idea for each sticky note.

3. Each team member should contribute at least 5 sticky notes.

4. Delegate one member of your team to share their experience and reflect on the process.
Why Learn about PDSA Cycles?

PDSA cycles are an effective way to develop, test and refine changes to your system based on the wisdom and experience of those doing the work.

Also known as “rapid cycle improvement”
PDSA Cycles
Can be used to:

• **Develop a change:**
  • don’t have an idea (theory) to test yet
  • learning about the system, looking for ideas to test

• **Test a change:**
  • trying and adapting existing knowledge on small scale
  • learning what works in your system

• **Implement an improvement:**
  • making this change a part of the day-to-day operation of the system in your pilot population

• **Spread an improvement:**
  • adapting the change to areas or populations other than your pilot populations
PDSA

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Act  Plan
Study  Do

Focus is here
Aim Statement

What are we trying to accomplish?

i.e. if the problem was solved, what would be achieved?

“Reduce the number of physically aggressive responsive behaviors by 50% from 36 to 18 per month in the Maple unit at Spring Woods Manor by May 31, 2017.”
AIM Statement

• Clear
  • What
  • By How Much - measurable
• Time Specific
  • By When
• Stretchable
• Provides Real Value
PDSA Cycle

**Act**
- What changes are to be made?
  - Next cycle

**Plan**
- Objective
- Questions and predictions (Why?)
- Plan to carry out the cycle (Who, What, Where, When)
- Plan for data collection

**Study**
- Complete the analysis of the data
- Compare data to predictions
- Summarize what was learned

**Do**
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data

(Langley et al., 2009)
PDSA: Guidance for Testing a Change

- Answer a **specific** question
- Make a **prediction**
- Collect **data over time**
- Test in a wide range of conditions
- Build knowledge **sequentially** using multiple PDSA cycles
PDSA Measures

• Collect useful data, not perfect data
• Consider qualitative data as well as quantitative data
• Need enough data to make decisions
• Use paper and pencil data
• Use sampling
• Record what went wrong during the test
Sequence of Improvement

- Theory and Prediction
  - Developing a change

- Testing a change
  - Test under a variety of conditions

- Implementing a change
  - Make part of routine operations

- Sustaining improvements and spreading changes to other locations

(ACT-DO-PLAN-STUDY)

(Scoville & Lloyd, 2010)
All Washed Up!
All Washed Up!
Small Group Activity

Creating a PDSA Cycle.
First PDSA Cycle Activity Instructions

1. Craft an AIM statement

2. Develop change idea
   • Test a hypoglycemia rapid response kit for residents, or
   • Your own improvement idea that you would like to test

3. Clarify objective and what is going to be measured

4. Fill out the Plan part of your first PDSA Cycle.
Craft your aim statement

• The aim of the __________________ quality improvement team is to increase/reduce ____________ by ___%, from _____ (baseline number) to ______ (target number) persons/percent by ________________ by _________ (date/timeline)
Questions?