Managing Challenging Behaviour Pack
For Care Home Settings

Susan Macpherson RMN
Care Home Liaison Nurse
OP BCaN CMHT
Definitions of challenging behaviour

Challenging behaviour can be defined into several different categories, these include:

- Physical aggression towards oneself or others
- Verbal aggression
- Hallucinations
- Delusions
- Depression
- Apathy
- Sexually inappropriate behaviour
- Removing clothing in communal areas
- Repetitive activities or questioning.

Staff and Challenging Behaviour

In each of the above categories there should be continuity in approach and staff should look at issues such as:-

- What can be done before the behaviour occurs?
- What can be done during the incident?
- What can be done after?

The above should take into consideration the needs of:

- The individual involved
- The staff involved
- Other residents within the care home

Dementia and challenging behaviour

Dementia compromises a person's ability to recognize and communicate their needs, so often challenging behavior is a sign that they are trying to communicate a feeling or a need. To understand challenging behaviour, it is important that you try to see things from the perspective of the person with dementia, who may be frustrated, fearful or stressed; feel lonely or suffering from pain and discomfort; misunderstand what is happening; feel ignored, overlooked and not in control of their life; or feel disorientated

The most common needs that should be considered are:

- Is the person in pain or discomfort
- Is there a lack of social contact
- Is there a need for stimulation i.e. boredom
- Could it be side effects of medication
- Delirium caused by infection or medication
What can staff do?

- Stay calm, don’t take challenging behaviour personally – it is rarely aimed at you.
- Show that you recognise and understand the person’s feelings.
- Speak in a calm and respectful manner and use reassuring words.
- Avoid making the situation worse, perhaps change the conversation or the activity you are engaging in whenever possible.
- If cares are being given and they are in the best interest of the resident then explain clearly what you are doing and the reason you are doing it. Don’t rush them this will lead to more frustration.
- Consider whether the individual has capacity to consent. If essential personal cares are being declined, do they need a Best Interests assessment to be completed?
- Ask yourself is whatever you are trying to do for that person really necessary at that moment. If you are able to give them a little space, come back in five or ten minutes and try again gently – you may be able to avoid a confrontation.
- Promote independence and offer encouragement wherever possible so that the person can complete their own care where appropriate.
- If the person is physically violent, give them plenty of space. Unless absolutely necessary, avoid crowding or trying to restrain someone as this can make matters worse.
- Observe for warning signs, such as anxious or agitated behaviour or restlessness. Take action immediately to help the person feel more calm and reassured.
- Try to work out what triggers any behaviour by discussing with colleagues and the resident. It may be something that can easily be addressed such as communicating more clearly so the person with dementia can understand your explanation that you are going to undress them for a wash or taking them to the toilet.
- Is the person hard of hearing and does their hearing aid battery need changing? It could be that simple.
- Speak with carers/relatives to establish any relevant history that may lead to any changes in behaviour such as significant anniversaries or routines that the individual used to follow.
- Speak with carers/relatives to establish any preferences that the individual may have had prior to their diagnosis of dementia.
- When the person is settled spend time with them to talk about what is upsetting them, be patient and reassuring.
- Keep a record of any aggressive and challenging behaviour. You may find there is a pattern and be able to change routines to suite the individual.

The following care plans should only be used as a guide.
Care plans should be written to reflect the needs of each individual.
Challenging Behaviour & Distress in Dementia

Is resident a risk to self or others?

yes – Self
Ensure Safety of Individual

see Care Plan 2

yes – Others
Ensure Safety of Others

Consider Safeguarding Alert

Look for Reason & Possible Solution(s)

Could it be Delirium?

yes
Assess & Treat

Could it be Depression?

no

no
Assess & Treat

Could it be Depression?

yes
Assess & Treat

see Care Plan 4

see Care Plan 3

Medication for agitation?

yes
see Care Plan 5

no

Is behaviour/distress still present?

yes
Refer to Mental Health Care Home Liaison Nurse

no
Continue with selected care plan(s)
<table>
<thead>
<tr>
<th>PRESENTING PROBLEM</th>
<th>PLAN</th>
<th>ACTION</th>
<th>EVALUATION</th>
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</table>
| Aggressive and challenging behaviour towards other residents and staff | To ensure the safety of individuals | Adopt a calm and relaxed posture  
Remain calm and encourage the individual to move to a less stimulating area.  
Attempt to identify triggers i.e. fear, pain, anxiety, physical ill health or personality.  
Spend time with the individual and offer reassurance  
Check for signs of pain or discomfort  
Offer prescribed PRN (as required) medication if prescribed. If medication isn't prescribed request review by GP  
In the case of an individual being injured a safeguarding alert should be implemented. |            |
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| Self-harm or destructive behaviour towards self. | To ensure the safety of the individual. | Adopt a calm and relaxed posture  
Remain calm and encourage the individual to move to a less stimulating area.  
Attempt to engage individual in meaningful activities  
Spend time with the individual and offer reassurance  
Check for signs of pain or discomfort  
Attempt to maintain a safe environment  
Offer prescribed PRN (as required) medication and observe for its effects.  
If medication isn’t prescribed request review by GP. | |
**CARE PLAN 3**

<table>
<thead>
<tr>
<th>PRESENTING PROBLEM</th>
<th>PLAN</th>
<th>ACTION</th>
<th>EVALUATION</th>
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</thead>
<tbody>
<tr>
<td>The individual is exhibiting symptoms of delirium.</td>
<td>To assess and carry out interventions to prevent, detect or manage delirium.</td>
<td>Spend time with resident to assess for &amp; complete Delirium Checklist.</td>
<td>Use Daily Changes Chart to record signs of increased confusion, agitation, disorientation or drowsiness.</td>
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<tr>
<td>i.e recent &amp; fluctuating disorientation and/or confusion over the last few hours or days, possibly as a result of:</td>
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<td>Is this a rapid onset? (Check with relatives)</td>
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<tr>
<td>Pain (e.g. from falls)</td>
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<td>Carry out physical obs (temperature, blood pressure, pulse) and urine analysis. Check for constipation.</td>
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<tr>
<td>Infection or Illness (e.g. UTI, pneumonia, pressure sore)</td>
<td></td>
<td></td>
<td>Avoid moving to different bedroom unless absolutely necessary</td>
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<tr>
<td>Constipation</td>
<td></td>
<td></td>
<td>Is resident hallucinating (seeing or hearing things) or has delusions (irrational beliefs)?</td>
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<tr>
<td>Dehydration</td>
<td></td>
<td></td>
<td>Encourage fluid intake using fluid balance chart to record.</td>
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<tr>
<td>Recent changes in medication</td>
<td></td>
<td></td>
<td>Ask for review of treatment by GP, District Nurses, Community Matron or Case Manager</td>
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<tr>
<td>Poor nutrition</td>
<td></td>
<td></td>
<td>If infection is present treat with prescribed medication.</td>
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<tr>
<td>New Sensory Impairment</td>
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<td>Sleep Disturbance</td>
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**CARE PLAN 4**

**RESIDENTS NAME:** ________________________

**DATE PLAN STARTED:** __________________

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| The individual is exhibiting signs of depression. i.e:  
- Poor concentration  
- Poor sleep  
- Poor appetite  
- Negative thinking  
- Slowed down  
- Expressing hopelessness | To assess for and treat possible depression. | Spend time with individual and assess for low mood  
Spend time with individual in order to allow them to talk about how they are feeling in order to validate their feelings  
Offer emotional support and reassurance  
Check for signs of pain, discomfort or ill health  
Attempt to engage in meaningful activity e.g. reminiscence or craft groups.  
Ensure adequate diet and fluid intake  
Attempt to ensure a restful night’s sleep.  
Offer medication if prescribed observing for side effects and effectiveness |
**RESIDENTS NAME:** ______________________

**DATE PLAN STARTED:** __________________

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<tr>
<td>Resident at risk of serious side-effects as is being treated with antipsychotic medication and has dementia.</td>
<td>To minimise risk of side-effects &amp; avoid potential consequences of over-sedation i.e:</td>
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<tr>
<td>Side effects include:</td>
<td>Care staff to monitor for any observed side effects, in particular symptoms of over-sedation i.e:</td>
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<tr>
<td>- Over-sedation</td>
<td>- dehydration</td>
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<tr>
<td>- Weight gain</td>
<td>- risk of water infection</td>
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<tr>
<td>- Risk of Diabetes</td>
<td>- weight loss</td>
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<tr>
<td>- Low blood pressure causing dizziness</td>
<td>- confusion</td>
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<td>- Tremors</td>
<td>- disorientation</td>
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<td>- Stiffness of the limbs</td>
<td>- resistance to care due to confusion</td>
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<tr>
<td>- Risk of stroke</td>
<td>- agitation</td>
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<tr>
<td>- Risk of blood clots</td>
<td>- poor concentration</td>
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<td>- Reduced sex drive</td>
<td>- loss of interest &amp; poor motivation</td>
</tr>
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<td>- Constipation</td>
<td>- risk of pressure sores</td>
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<td>Care staff to report concerns to &amp; liaise with GP or Care Home Liaison Nurse to ensure 12-weekly review of prescribed anti-psychotic meds so as to reduce and / or stop treatment as soon as possible.</td>
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Care staff to monitor for any observed side effects, in particular symptoms of over-sedation i.e:
- drowsiness
- sleepiness
- difficulty waking
- reduced ability to eat/chew and drink,
- unsteadiness or loss of mobility
- incontinence or increased incontinence
- slurred speech
- muscle weakness
- slowed reflexes
- reduced facial expression
- reduced emotional expression