Many difficult or challenging behaviours in older people with a dementia seen in acute care settings are indicators or cues to deeper needs being ignored. The behaviours are particularly challenging to nurses who do not have positive values about older people and dementia, and lack the necessary knowledge and learning in practice to deal with the older person constructively. In this situation, resorting to ignoring the person, or to restrictive management based on a limited number of approaches, can become the norm. Through the use of a vignette, this article offers an introductory framework to aid understanding of behaviours in people with dementia.

**Acute care and older people with dementia**

Older people sometimes need acute medical intervention, and some will also have a dementia or some form of cognitive impairment (Packer 1999). Sandberg et al (1998) estimate that up to 33 per cent of older people receiving acute care will have a dementia, 44 per cent will have an acute confusion, 40 per cent a depression in mood and, significantly, 50 per cent will have some form of psychomotor slowing. For example, it has been estimated that between 40 and 60 per cent of older people with hip fractures requiring surgical intervention have a dementia (Stromberg et al 1997). Even in patients with a mild-moderate impairment, Stromberg found there was an increased complication rate post-operatively, especially in terms of displacement of the fracture and wound infection (Stromberg et al 1997). Older people’s abilities to co-operate and follow prescriptions for treatment and care can influence their recovery, and the approach taken by the multidisciplinary team, ward environments and care routines are crucial.

The core issues in relation to care in acute hospital settings for older people have been set out by the Royal College of Nursing (RCN) and Help the Aged (2000), Help the Aged (1999) and HAS 2000 (1998). Older people with a dementia should be considered to be highly vulnerable to receiving inadequate care and treatment in a range of acute care settings. Little research has been carried out on older people’s experiences of acute care, or the outcomes for them on discharge. But, from the evidence of carers and families (for example RCN and Help the Aged (2000)) and from some research, such as Tolson et al (1999), McGillivary and Marland (1999) and Ekman et al (1991), it can be concluded that many people with a dementia leave hospital in a worse state than when they were admitted.

Medical conditions may have been appropriately addressed, but the overall health and wellbeing of the older person is often adversely effected by hospitalisation, to a degree that they and their carer experience difficulties resuming their usual routines at home.

Furthermore, the person with dementia often has a temporary or permanent increase in the level of both physical and psychological disability, with residual complications of poor care, such as weight loss, malnutrition, reduced oral hygiene, mobility or skin problems.

It makes no sense to treat one medical condition but to ignore the person’s overall health and wellbeing. This is not done with any deliberate intention but simply through benign ignorance and from pressure of work (Packer 1999). However, the situation must be challenged so that patients are not made more physically or mentally disabled, and staff are not left feeling that they do not want ‘them’ on the ward (Marshall 1999).

**A series of problems for staff**

To staff working in many acute care settings a person with a dementia can present as a series of problems which are disruptive to the ward (Bair et al 1999). Ekman et al (1991) found that nurses had negative reactions to people with dementia, especially where they were assessed by the nurses as having difficulty in communicating. The nurses consequently spent significantly less time assisting older people with a dementia than those without. Perhaps the dementia, and subsequently the people, were being ignored (Dewing 1999).

There can be a problem of establishing whether or not the person has a dementia and what kind and degree of dementia they have. Some older people may have a cognitive impairment but no diagnosis, or a hidden early dementia that only becomes obvious due to excessive cognitive challenge from a medical condition and from being in an acute hospital environment. It is very difficult to construct a picture of what is affecting a person with little knowledge about the dementia. Tolson et al (1999) found no evidence of formal assessment, and only 15 per cent of patients had any care planning for their cognitive impairment. This situation is then exacerbated by negative values about dementia and old age.

**Restrictive interventions**

The vignette in Box 1 relating to Tom and Alison reveals important factors about the values and knowledge of nurses and how it can lead to restrictive interventions.

Perhaps 20 per cent of older people will show aggression in one form or another (as Tom might be starting to show), 25 per cent will ‘wander’ (as Tom was about to do). Up to 40 per cent will have some form of incontinence and 5 per cent will show sexual disinhibition (adapted from Burns et al 1990). Unfortunately, these behaviours and others are believed by many nurses to be directly caused by cognitive impairment, which may not always be the case. Behaviours in
feel uncertain about what to do next. Her only strategy had failed. In hospital. To her it seemed obvious. This would probably lead Alison to

Alison could not understand that Tom did not know that he was ill.

and preoccupied, he dismissed it, and the nurse, in no uncertain terms.

not make sense cognitively to Tom, so, consequently, feeling agitated

(because she cannot manage these situations well) she intervened

in negative terms. As she was anxious about patients who wander

under 'wandering'. From her limited knowledge of dementia she

she should build her interventions. She acted because she observed

Tom for that shift, wants to take his temperature, blood pressure

and respiratory rate.

Alison looks at her quizzically and responds, 'What do you mean you stupid girl – take my what? My breathing is

my own business so you can clear off.' Tom struggles to get past

Alison, who is standing directly in front of him.

Box 1 vignette

Tom is 93 and has severe dementia. He is recovering in hospital

from an acute chest infection and a fall. He is still poorly with a

temperature and rapid shallow breathing and has a lot of

mucous on his chest. Alison, the staff nurse assigned to care for

him for that shift, wants to take his temperature, blood pressure

and respiratory rate.

Alison walks up to Tom (who is standing shakily, looking

around and starting to try and walk away from his bed) and

says, 'Tom I need to take your temperature and blood pressure

and to see how your breathing is doing. Why don’t you come

and sit down.' Tom struggles to get past

Alison spoke to Tom in a friendly way and used his preferred form

of address. These are aspects of communication that can be

beneficial to the intervention, but they were not enough. This

vignette illustrates one of the classic errors in the way nurses

approach people with dementia. The nurse had decided to ‘divert’

Tom with what she considered important at a time when, clearly,

Tom needed to stand and walk around. Tom’s mind and eyes were

focused on this. Alison ignored his needs over her own because she

did not stop to interpret the behaviour or look for cues on which

she should build her interventions. She acted because she observed

Tom beginning to become restless and at risk of what she labelled

‘wandering’. From her limited knowledge of dementia she

understood the behaviour only from her perspective, and generally

in negative terms. As she was anxious about patients who wander

(because she cannot manage these situations well) she intervened

to try and stop him.

Then, her verbal communication was presented in a way that did

not make sense cognitively to Tom, so, consequently, feeling agitated

and preoccupied, he dismissed it, and the nurse, in no uncertain terms.

Alison could not understand that Tom did not know that he was ill.

She could not see that Tom did not appreciate that he was in a

hospital. To her it seemed obvious. This would probably lead Alison to

feel uncertain about what to do next. Her only strategy had failed. In

addition, her physical presence by standing directly in front of Tom

was perceived by him as being threatening, which only added to his

feeling of wanting to get away from her. As a result, Tom was left

feeling more restless and less safe, which only enhanced his desire to

leave. Alison did not achieve her agenda and was left with a new and

more risky situation to resolve or ignore.

framework to facilitate better interventions

Think about when you have approached a patient and reflect on your

own level of busyness, your motives and your agenda with that

person. Did you observe the person and his or her behaviour? The

greater the level of illbeing (in psychological and emotional terms)

then the harder it will be for you to get your agenda met. Timing is

important:

1. look for cues as to what the person’s behaviour may mean
2. interpret the possible meanings and identify what need is being

   communicated. The need may be physical, psychological, spiritual

   or social, or a mixture
3. start from where the person is, not from what you want to do

   (unless it is a medical emergency or the person or another person is

   in actual danger of harm)
4. think about what you will say and how to say it. Matching the

   complexity of your verbal communication to the person’s

   remaining cognitive abilities is crucial
5. make an approach using your presence and body sensitively. This

   means, for example, considering your level of calmness or anxiety

   and putting yourself in the right frame of mind to be with the

   person and thinking about your body position
6. begin by enabling the person to have their need acknowledged and

   responded to in some way
7. introduce your nursing need in a way that makes sense to the

   person after his or her needs have been acknowledged and

   responded to
8. enlist the person’s help to enable you to accomplish your task.

   For more complicated tasks and interventions you may need to work

   in partnership with the person’s carer or another person who is

   known and trusted
9. establishing consent is a key component. Ensuring consent is

   ongoing is also vital, this can be done by observing and valuing

   verbal and non verbal communication. A person with dementia can

   mean no, but not be able to say it clearly or directly.

If Alison had applied this framework to Tom then the intervention

might have looked more like that described in Box 2 overleaf.

summary

If nurses plan and approach older people with dementia with positive

values, and learn from the person’s communication through their

behaviour, the outcomes for all parties can be improved. The vignette

has offered one example, but also demonstrates that there are no

failure-proof ways of communicating, and sometimes nurses need to

learn through trial and error. Only in this way can they become more

skilled in their interventions to facilitate rather than manage

challenging behaviours. Avoidance and ignorance do not help in either

the short term or the long term. The good news is that single
interventions are successful 45 per cent of the time and multiple interventions, as shown in Box 2, are more successful (Bair et al. 1999).

**Box 2 intervention**

- Alison is aware that Tom is becoming restless and starting to fidget in his seat – **initial observation of his behaviour**
- She is conscious that she has not spent any time with him on this shift and feels that now would be a good time for her to spend some time with Tom. She is aware of her anxiety about Tom possibly starting to wander and reminds herself that she must not approach Tom in a way that is seen by him to be controlling or limiting his freedom – reflecting on her own level of busyness and her motives
- Alison observes that Tom is looking around and attempting to stand up – **observing behaviour and looking for cues**
- Alison then identifies several possible needs Tom may have: he is disorientated, has a physical need such as to use the toilet or relieve his pressure areas, or he wants to leave and go home – interpreting the meaning of his behaviour and identifying what need is being communicated
- Alison walks up to Tom. She approaches him slowly so as not to startle him and is smiling and seeking definite eye contact. Tom is standing shakily, looking around and starting to try and walk away from his bed. Alison says, ‘Hello Tom. Nice to see you again. Now, I wonder if I can be of any assistance to you’ – verbally acknowledging he may have a need
- As she says this, Alison bends down to be at a slightly lower level than Tom – **sensitive use of body and presence**
- Tom sits down, looks at her and responds, ‘Hello, do I know you? Anyway, I want to get out of here. Please show me where to go’. Having got off to a good start and acknowledged that Tom’s need is one that Alison most fears, she has to quickly make a decision about how to respond verbally and non verbally without becoming threatening, or Tom perceiving any sense of power imbalance between them.
- Alison, like many nurses in this situation, will not know for certain whether what she says or does will be right. ‘Is there something you have in mind to do?’ – **sticking with identifying Tom’s need**
- Tom says he wants to know where his wife is. He can hear voices behind him and thinks she might be there and he wants to make sure she is not lost. Alison assists Tom to stand up and walk to where he can see the ward more clearly – this is not her priority but accepts that it helps to reorientate him, as well as helping him to feel he is safe, and is enabling him to improve his mobility
- She asks him if he is feeling warm or cold today as sometimes it can get warm indoors – Alison is pursuing one of her tasks now but does it in a way that Tom accepts as part of their conversation
- They both look to see if Tom’s wife is there and agree that she is not. Alison suggests that his wife will be coming to see him, as she usually does, in less than two hours. Alison then asks Tom if he needs to use the toilet, which he does not. Then, as they get back to his bed, Alison points out the photograph and name card by his bed. Tom accepts that this is his place and takes a seat again looking relaxed and humming to himself
- Alison feels this is a good moment to ask about her tasks: ‘Tom I wonder if you would mind me taking your blood pressure with this machine? – **shows the machine to act as a memory cue for Tom**
- Tom says this will be fine but he is not sure what it means. Alison shows Tom the cuff and stethoscope and Tom begins to open his pyjama jacket – **to him this means Alison wants to listen to his heart**
- Alison responds by saying she doesn’t need to bother him that much and she can take the blood pressure on just his arm – **evidence that Tom is consenting to the procedure**

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**References**


