MEDICAL PHARMACIES TABLET

Drug information and news for health care providers

March 2015

UTILIZING THE UNMET NEEDS MODEL FOR MANAGING BEHAVIOURS

BACKGROUND

All behaviours of individuals have meaning.[1] The challenges related to behaviour issues in residents affected by dementia can best be addressed if the cause of the specific behaviour is understood. The "Unmet Needs Model" developed by Cohen-Mansfield and Taylor provides a basis for assessing and understanding potential causes of agitated behaviour.[2] The Unmet Needs Model proposes that problem behaviours are a complex phenomenon affected by an interaction of cognitive impairment, physical health, mental health, past habits and personality, and environmental factors.[2] Therefore, since the triggers of problem behaviours vary greatly among individuals, strategies for addressing behaviour issues should be individualized and targeted at resolving the unmet needs of the resident.

For a figure that illustrates circumstances that may lead to agitated behaviours through unmet needs of residents with dementia, please refer to this month's QI.

IDENTIFYING THE UNMET NEEDS OF RESIDENTS

A resident attempts to communicate his/her needs through behaviour.[1] The figure in the QI provides a general framework for understanding the unmet needs of residents. A listing of more specific examples within each category follows:[1]

- **Lifelong habits and personality. Consider the resident's:**
  - Preferences and dislikes
  - Hobbies and interests
  - Previous occupation and work
  - Previous ways of responding to others
- **Current condition. Consider the resident's:**
  - Physical health: acute illness (potential delirium), chronic illness, pain/discomfort, fatigue, medication side effects, hunger/thirst, hearing/vision impairment, urinary retention/constipation
  - Mental health: anxiety, depression, frustration related to mismatch between task and resident's abilities, delusions/hallucinations
- **Environment:**
  - Physical environment: comfort level of furniture, temperature, design features that do not support independent function (e.g., bathroom difficult to locate)
  - Social environment
  - Behavioural symptoms of others
  - Caregiver approaches
  - Overstimulation or understimulation

THE UNMET NEEDS MODEL AND APPROACH TO CARE

Utilization of the Unmet Needs Model allows for non-drug approaches to care that address residents' issues:[3]

1. Assess the problem
2. Hypothesize the cause
3. Analyze the treatment options
4. Treat
5. Assess

The most common unmet needs of residents include the following:[3]

1. If vocal/verbal behaviours:
   a. Pain/discomfort
   b. Loneliness/fear
   c. Depression
   d. Boredom
2. If physically non-aggressive behaviours:
   a. Need of activity and stimulation
3. If aggressive behaviours:
   a. Evasion of discomfort
   b. Attempt to communicate needs
   c. Personal space

IDENTIFYING THE BEHAVIOUR AND ASSOCIATED RISK

The first step to addressing behaviours in residents with dementia is the documentation of the actual behaviour, as well as the location, time, frequency, and duration of the behaviour.[1] It is also important to document any issues that may have triggered the behaviour (e.g., other residents' behaviour, approaches by staff) and situations or actions that have been found to reduce the behaviour. The response of staff, other residents, and/or family members to the behaviour is also an important observation.

It is important to view the resident with dementia as more than a collection of symptoms and behaviours. Above all, each resident must be viewed as a person with a unique set of qualities. Get to know the resident, not just the condition. This is the essence of person-centred care.[4]

ADDRESSING UNMET NEEDS

Pharmacological intervention is considered for managing behavioural symptoms that put the resident or others at imminent risk of harm. It should also be considered when behaviour is due to depression, anxiety, or psychotic symptoms that include delusions or hallucinations or when pain or other pharmacologically responsive symptoms are present.[2] Non-pharmacological approaches for behaviours should always be considered, and they include the following:[1]

- Assess and manage comfort (e.g., temperature, resident's position)
- Offer food and fluids
- Provide one-to-one social interactions
- Provide music based on preferences
- Offer walk outside
- Offer walking program and gentle exercises
- Play videotapes provided by family
- Introduce distracting stimuli such as music, conversation, touch

RESOURCES

Many other non-pharmacological interventions are available and should be individualized for the needs of each resident as assessed. Resources include the following:

- Sunnybrook Veterans Centre. Responding to Behaviours Due to Dementia. Available at http://sunnybrook.ca/uploads/ABLE_CarePlanningGuide.pdf.
- Cohen-Mansfield J. Non-Pharmacologic Treatments in Alzheimer Disease. Available at http://catalogue.iugm.qc.ca/GEIDEFile/27651.pdf?Archive=104995792217&File=27651_pdf.

In addition, there are a number of educational programs available that are designed to help caregivers better understand and manage the challenges associated with care of individuals who have dementia. Programs include the following:

- Gentle Persuasive Approaches (GPA). Information available at https://www.geriatriccp.ca/courses/Gentle-Persuasive-Approach.html
- PAC (Positive Approach to Brain Change™) Training (Teepa Snow). Information available at http://teepasnow.com/events/pac-training
- Putting the P.I.E.C.E.S.™ (Physical, Intellectual, Emotional, Capabilities, Environment, Social) Together. More information available at http://www.piecescanada.com/. **MPT**

References:

1. Sunnybrook Veterans Centre. Responding to Behaviours Due to Dementia. Available at http://sunnybrook.ca/uploads/ABLE_CarePlanningGuide.pdf. Accessed Feb. 15, 2015.
2. Cohen-Mansfield J. Theoretical framework for behavioral Problems in Dementia. Alzheimer's Care Quarterly 2000; 1:8-21.
3. Cohen-Mansfield J. Non-Pharmacologic Treatments in Alzheimer Disease. Available at http://catalogue.iugm.qc.ca/GEIDEFile/27651.pdf?Archive=104995792217&File=27651_pdf. Accessed Feb. 15, 2015.
4. The Use of Antipsychotics in Residential Aged Care. The Royal Australian and New Zealand College of Psychiatrists. Available at http://www.bpac.org.nz/a4d/resources/docs/RANZCP_Clinical_recommendations.pdf. Accessed Mar. 6, 2015.