AGGRESSION TIP SHEET

GENERAL PRINCIPLES

1. Context is important and will affect treatment planning. Specific information about exactly what happened, when it occurred, and how often it happens is essential to convey to the provider.

2. Aggression in the context of caregiving only, which ceases immediately when the interaction with staff members ends is least likely to respond to medication management.

3. More generalized, spontaneous aggression tends to be harder to treat and takes a great deal more effort to try and locate cues.

4. Focused aggression, especially when seeking out individuals, can be the most concerning and should be relayed to providers and decision-makers promptly.

5. Prepare yourself and your staff by reviewing educational materials about maintaining safety with physically aggressive patients. Links are provided on the web page.

FINDING A TRIGGER

1. Some aggression may stem from frustration with tasks they can no longer perform or information they can no longer process (such as directions). Keep track of these episodes and identify where and how help is needed (one-step directions as an example). Make sure this information is the chart for all caregivers to review.

2. Don’t put pressure or rush the resident through tasks or activities. This can provoke aggression due to anxiety or feeling angry or threatened.

3. Some residents are humiliated or embarrassed when others are involved with private care, such as bathing or toileting. This can lead to lashing out at staff members to get them to leave.

4. Losing one’s independence can lead to aggravation expressed as aggression. Allow decision-making, even if the decision seems trivial, as a way of giving the resident some control over their situation.

5. Does anxiety play a role or depression?

6. Does the resident appear suspicious of staff members or peers. Do they feel threatened?

7. Is the dining room or activity area too loud and uncomfortable for them.

8. Does the time of day play a role, such as becoming aggressive when they cannot go home at shift change? Is it easier to bathe in the afternoon rather than in the morning or evening? Knowing time-related changes in potential aggression is important.

9. Are they fatigued, or do they become aggressive when awakened by staff from overnight sleep or a nap?

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10. Does the aggression correspond to pain, indicate hunger or thirst, or is it a herald sign of an infection or illness?

IN THE MOMENT

1. Make sure you and the resident are safe. Remove other residents from a more public area to avoid any harm coming to them because of this aggression.

2. Step back, take a deep breath, count to ten, then try again. If needed, leave the room or area and re-approach after a few minutes to complete the task that provoked the aggression. If the task is not essential to complete then, postpone it for a longer period.

3. Be empathic and reassure the patient, in plain, concrete language that you are there to help.

4. Distraction may help some residents. Talking about their family or interests while performing a task may lead to a reduction in aggression.

5. Be as passive as possible emotionally. Becoming upset or irritated will only lead to further aggression by the resident and perpetuation of the situation. Ask another staff member to help at that point.

6. Make sure you employ enough people and safe techniques to keep the resident and others safe. Line-of-sight monitoring may be helpful to keep others safe. Again, references to help learn such techniques are on the web page.

7. Have a plan of approach for next time. With residents where a cue or need for the behavior is hard to identify scheduling cares with enough staff to carry out the activity as safely and rapidly as possible is paramount.

DISRUPTIVE VOCALIZATIONS: MANAGEMENT STRATEGIES

1. Use headphones (or speakers in an area not disturbing to others) to allow the patient to listen to either music or audio tapes suggested or provided by family, friends, or staff members they know speaking to them in a calm voice. The content of these tapes can be recollections of earlier events in their life, family stories, or a story from a book.

2. Move the patient to a quieter area if the cause of this behavior is primarily overstimulation. If possible, bring the patient to an area with staff present or near known objects (i.e. their room), which may also be calming.

3. Offer the patient food if hungry, and drink if thirsty.

4. Some patients respond to touch. Offer soft blankets, pillows or stuffed animals, or dolls that may calm the patient by providing tactile stimulation. Many patients held occupations or had hobbies in which they regularly worked with their hands. Sometimes repetitive tactile stimulation (fold towels, place beads in a container), can help calm patients.

5. Provide proscribed periods of one-to-one (lasting 10 minutes) every hour.

6. Check the lighting in the immediate area of the patient. Make sure it is well-lit. A patient's decreased vision in a poorly lit area can lead to confusion and anxiety, which may prompt vocalizations.

7. Assess and reassess pain. A pained expression increased BP or HR, and fidgeting can all mean the pt. is in pain. The longer the pain is untreated, the worse the vocalizations. Pain and physical distress often lead to vocalizations.

8. Always make sure to assess for hearing impairment as a cause for vocalizations.

IMPULSIVE BEHAVIORS TIP SHEET

Agitation, especially agitation that turns off and on like a light switch requires staff education. The impulsiveness stems from confusion, anxiety, and fear. That is why when the stimulus is over the agitation goes away immediately.
This is not personal. The resident has damage to the area of their brain that perceives that you are trying to help them. That is why impulsiveness comes on rapidly and goes away rapidly but is intense in presentation. Medications are often not helpful and can worsen the situation.

YOUR RESPONSE TO THIS AGITATION IS THE MOST IMPORTANT ELEMENT

If you become upset, anxious, or angry the patient perceives the emotion, and the agitation will worsen. Make sure your staff recognizes their own strengths and weaknesses in this regard.

1. Always evaluate to determine whether the behavior is based on an UNMET NEED:

Hunger
Thirst
Mobility
Companionship
Pain relief

2. Use a calm approach. Slowly explain to the resident what you are going to do. Explain and perform any action, such as dressing or using the toilet,

ONE STEP AT A TIME.

3. If a calm approach has been tried and is repeatedly unsuccessful then SCHEDULE DAILY CARES:

Toileting
Dressing
Peri care/bathing
Putting to bed

This allows enough staff to be present to rapidly and safely complete the task with a minimum of stress on the resident and staff.

4. Use an AREA THAT IS SAFE for the resident and staff members, away from other residents and will limit the effect of any noise on others. This may require using the bathing area for daily care.

5. If some staff are consistently better able to care for the resident ask the DPOA or guardian if a VIDEO RECORDING of the staff working with the resident can be made

for educational purposes. The CD or videotape can then be given to the DPOA or guardian when no longer needed. A formal release form should be made to assure that the video recording is done properly to protect the privacy of the resident.

6. Employing COUNTER STIMULUS when caregiving can be effective in some residents. Using white noise with loud, vocally disruptive residents such as radio, fan, and hair dryer. Tactile stimulation can be effective in calming residents when care is completed. Warm blanket. stuffed animal, plush pillow.

7. Assess the LEVEL OF STIMULATION when caregiving. For some residents a more The stimulating environment will agitate them, such as a dining room, whereas other residents appear calmer when they are in a more active setting.
8. Always make sure that the patient has been evaluated for SENSORY DEFICITS, especially hearing and vision and if present is treated as effectively as possible.

HELP WITH BATHING

1. Make sure you are aware of the resident's bath practices earlier in life.
    - Time of day-morning, later in the day, before going to bed
    - Types of bathing-tub, shower, bed bath

2. Common issues which cause bathing problems:

    - Pain
        - Employ analgesics and hot packs prior to the bath
        - Move and wash limbs, sore areas carefully
        - Do not rush the resident, allow them to soak in the warm water
    - Fatigue, weakness from frail health status
        - Assess the resident's ability to bathe in a tub or shower
        - Bed bathing may be preferable
        - Determine the time when the resident is most energetic
    - Fear, misunderstanding
        - Move and speak slowly
        - Allow them to participate in the process
        - Encourage family to help initiate the process
    - Anxiety, apprehension
        - Create a calming environment to bathe in
        - Have same sex aides bathe the resident
        - Bath towels, bathrobes to reduce embarrassment
        - Supportive touch while on the lift
    - Discomfort
        - Reduce the discomfort from cold drafts and harsh sprays
        - Comfortable lift seat or shower chair

3. Remember that bathing should be a pleasurable experience.

4. Trusted staff members should be employed on a consistent basis as the bath aide.

5. Washing hair can be the most difficult part of the bath. Many women will allow the hairdresser to wash their hair.

MANAGEMENT OF DISROBING

1. Patients may disrobe due to irritation with skin lesions or rashes. Make sure that a comprehensive evaluation of the resident's skin is completed if they begin to develop disrobing as a behavior.

2. Residents may need to use the toilet but are unable to remove the appropriate clothing in a socially acceptable manner. Make sure that a toileting schedule is in place to limit this need to disrobe.

3. Constipation may cause abdominal discomfort which may be relieved by removing pants or a belt. Evaluation and treatment for constipation may relieve the disrobing.

4. Clothing may be discarded due to weight gain, where the clothing feels tight and uncomfortable, or with weight loss, due to loose or baggy clothing. Experiment with the right fit for the individual.

5. Residents may disrobe if the clothing does not reflect their previous attire. Knowing their clothing preferences or if they dressed in a certain way for work may explain their efforts to disrobe.

6. Pain may lead to disrobing. Always make sure the resident is evaluated for undertreated pain.

7. Hypersexual behavior can lead to a resident disrobing, though this is actually a rare cause for the behavior.

8. Patients who disrobe frequently may be responding to the cue of other clothing in their room or in a bath or shower area. Removal of the clothing may limit the disrobing. If a resident disrobes due to such cues it may be necessary to change the clothing of a roommate with the resident out of the room.

9. Delusional thoughts may influence the resident to disrobe. Make sure the resident is evaluated for any potential psychosis.

10.Residents may disrobe due to fatigue and a desire to go to bed. Lacking the ability to properly dress themselves for bed after disrobing may explain this behavior.