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Barriers to managing behavioural and psychological symptoms of dementia: Staff perceptions☆

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Summary
Background: Residential aged care facilities are increasingly using pharmacological methods of managing BPSD such as antipsychotics, despite little evidence of effectiveness and high rates of adverse effects. Nonpharmacological approaches to management of behavioural and psychological symptoms of dementia (BPSD) have not been widely implemented in residential aged care, despite reported effectiveness of these strategies.

Residential aged care staff opinions on the effectiveness of non-pharmacological approaches to dementia care and any limitations to their use are not well documented.
Methodology: This is the qualitative arm of a broader research project.

A 43-point questionnaire was distributed to 6 rural aged care facilities to explore nurses' perceptions of the limitations of five commonly employed non pharmacological and pharmacological interventions in managing BPSD.
Findings: Staff reported that some non-pharmacological methods of managing BPSD were not the role of nursing staff. This suggests that other interventions such as increased staffing levels would not be effective in facilitating non pharmacological approaches to managing BPSD.

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Dementia is an umbrella term that refers to symptoms caused by changes in cognitive function. These can include alterations in memory, personality and behaviour. It is estimated that around 250,000 people in Australia have dementia. As Australia's population ages, more people will be affected by dementia (Access Economics, 2009). Sixty to eighty percent of all residents in aged care facilities in Australia have a diagnosis of dementia, and this figure is predicted to increase (Crotty, Whitehead, & Lange, 2004).

Behavioural and psychological symptoms of dementia (BPSD) such as aggression, agitation, wandering and sleep disturbance occur in as many as 80% of people with dementia (Margallo-Lana et al., 2001; Zimmer, Watson, & Treat, 1984) and are associated with increased care giver burden, decreased quality of life for the resident, and increased healthcare costs (O'Neil et al., 2011). The unmet, and frequently unknown, needs of residents with dementia provide challenges for care in the residential aged care setting.

It is recommended that a non-pharmacological approach to BPSD should be considered before resorting to any type of pharmacological interventions. However, pharmacological approaches are often used as first-line treatment (Byrne, 2011). Antipsychotic medications are commonly used to reduce the frequency and severity of BPSD despite little evidence that such interventions are effective, and potential side effects are frequent and hazardous (O'Neil et al., 2011). Of increasing concern is the prescription of these medications without attempting other treatment options.

A number of non-pharmacological therapies are available for people with dementia exhibiting BPSD. These management strategies include: behavioural, cognitive, stimulation and emotion oriented strategies (National Prescribing Service, 2008). It has also been suggested that caregiver and residential care staff education and training, may have a positive impact on the management of BPSD in the aged care setting (Fossey et al., 2006; Selwood, Johnston, Katona, Lyketsos, & Livingston, 2007).

For many years, behavioural therapy has been based on the principles of conditioning and learning theory using strategies aimed at suppressing or eliminating challenging behaviours. A shift in strategy has become prominent recently with the use of non-aversive methods in helping to develop more functional behaviours. Moniz-Cook et al. (1998) suggest that behavioural analysis is often the starting point of most other forms of therapeutic intervention in this area. Furthermore, it is suggested that modern behavioural approaches can be wholly consistent with person-centred care. The effectiveness of behavioural therapy has been established for dementia in only a small number of studies. However, many have presented case studies testifying to the efficacy of behavioural therapy, and stress that any behavioural therapy should be personalised to the individual (Fossey et al., 2006; O'Connor & Ames, 2008).

Person-centred care is a holistic alternative to conventional care practices, which incorporates all or some of the non-pharmacological strategies listed above. Central to the approach is the philosophy that the client has human needs, and the acknowledgement of these needs can alleviate cognitive and functional deterioration (Kitwood, 1997). Consequently, the nature of the caregiver/client relationship will impact on care and subsequent BPSD depending on whether the person is being respected or depersonalised in care. Use of person-centred care, is becoming more common in residential care, because it can reduce need-driven dementia-compromised behaviours and help maintain personhood (Fossey et al., 2006; Kitwood, 1997; Vernooij-Dassen, Vasse, Zuidema, Cohen-Mansfield, & Moyle, 2010). A number of studies report a reduction in agitation in residents, when an individuals' care is personalised on the basis of an individuals' preferences and needs (Edvardsson, Winblad, & Sandman, 2008; Fossey et al., 2006).

One of the criticisms of person centred care practices is the time required to plan and implement the care. Time constraints to good resident care in residential aged care (RAC) settings are well recognised (Boldy & Grenade, 2001, chap. 3; Manthorpe & Watson, 2003) and a constant source of stress. Demands on staff include the provision of assistance for residents with cognitive impairment and other limiting physical conditions. These demands are compounded when staff encounter BPSD especially resistive behaviours, non compliance and outright aggression. The literature reports (Nishtala, McLachlan, Bell, & Chen, 2008a, 2008b) that time is the dominant factor in limiting behavioural interventions. Authors argue that the resources required to implement many of the strategies far exceed that are which available in most RAC facilities (Hersch & Falzgraf, 2007; Turner, 2005). The limitations, including time, which impact on the management of BPSD in residential care are poorly researched and reported. Effective behaviour management techniques are shown to impact on all areas of care (Hickson, Worrall, Wilson, Tilse, & Setterlund, 2005; Pearson & Chalmers, 2004) and are therefore an essential staff skill in RAC settings.

In this paper we report the findings of the descriptive analysis of the short answer responses to a survey that was designed to determine RAC staff knowledge and appropriate implementation of behaviour management for residents with dementia. There were limitations to the use of common methods of managing BPSD identified by staff in this qualitative arm of the study that were not reported in the findings from the survey, nor are they reported as a barrier in contemporary literature.

The survey used in this study explored dementia care regarding the use of pharmacological, behavioural, stimulation, emotional and cognitive oriented strategies. Pharmacological strategies, as the name suggests involve the use of drugs, most notably antipsychotic drugs in the management of BPSD. Behavioural strategies to manage BPSD involve redirecting residents, providing distraction from negative behaviour and increased signage in the facility. Stimulation oriented activities involve engaging the resident in exercise, cooking and gardening. Emotional oriented strategies are largely focussed on reminiscing with the resident, looking at photographs of people familiar to them and discussing past interests and family. Finally, cognitive oriented strategies engage residents by the use of clocks, calendars and games. The quantitative arm of the study is reported in full in Collegian 2012 (Ervin, Finlayson, & Cross, 2012).

Aim

The aim of the qualitative data collection was to further explore RAC staff perceptions of the limitations to five