Dementia care 2: exploring how nursing staff manage challenging behaviour

The national dementia strategy calls for care homes to adopt a person centred approach to care planning. This study looks at whether this is being implemented.

INTRODUCTION
Dementia care and interventions initially centred on dementia being a “disease”, so medical interventions that were grounded in the “standard neurogenic disease paradigm” (Moniz-Cook et al, 2003) were the norm.

However, this model does not readily explain the range of individual differences between people with dementia, especially in terms of their different behavioural and emotional responses.

Kitwood (1990) forcefully dismissed the disease centred model of dementia as giving rise to “malignant social psychology” and gave 17 negative manifestations of how this dehumanises the individual, including:
- Disempowerment: inhibiting the remaining independence;
- Imposition: denying people choice;
- Labelling and disparagement: blanketing individuals as cognitively incompetent.

Kitwood (1990) argued that neurochemical and consequent structural changes in the brain cannot solely account for the manifestation of dementia. Rather, he favoured “biopsychosocial explanations” and advocated a person centred approach, based on meeting the physical and mental needs of people with dementia, by analysing the interaction between their neurological deficits, general physical health, personal history and care environment (Kitwood, 1994).

RESULTS
The study found evidence that both models of dementia care were in use. Three homes mainly used the medical approach, four the person centred approach and two were moving towards the latter.

CONCLUSION
Training in biopsychosocial approaches to managing challenging behaviours in dementia is needed for care home staff, family and other health professionals.

PRACTICE POINTS
- Care home staff should empower residents through assisted living that encourages independence, while offering assistance when necessary.
- They should also take a “team” approach, allowing members to contribute their own unique skills, be supportive of each other and communicate effectively together.
- Effective, good quality care and activity planning should be individualised and reflect each resident’s unique social history.
- Homes should provide a supportive and stimulating social environment, which could include themed corridors, mood lighting, complementary therapies and quiet rooms.

AUTHORS
Nicola L Wheeler, PGCert, BSc, is assistant clinical and research psychologist, mental health services for older people, Birmingham and Solihull Mental Health Foundation Trust; Jan R Oyebode, PhD, MPsychol (Clinical), BA, is director of the clinical psychology doctorate, University of Birmingham, and consultant clinical psychologist, mental health services for older people, Birmingham and Solihull Mental Health Foundation Trust.

ABSTRACT

Background
This second in a three part series on dementia care explores different approaches to care; part 1 examined communication issues. Dementia care traditionally uses a medical approach to management, which focuses on the standard neurogenic disease paradigm, but now many care home staff and health professionals are moving towards a person centred approach, based on biopsychosocial explanations.

Aim
This study sought to examine the extent to which care home staff have adopted a person centred approach.

Method
Focus groups were carried out with 36 direct care staff from nine care homes.

RESULTS
The study found evidence that both models of dementia care were in use. Three homes mainly used the medical approach, four the person centred approach and two were moving towards the latter.

CONCLUSION
Training in biopsychosocial approaches to managing challenging behaviours in dementia is needed for care home staff, family and other health professionals.

PRACTICE POINTS
- Care home staff should empower residents through assisted living that encourages independence, while offering assistance when necessary.
- They should also take a “team” approach, allowing members to contribute their own unique skills, be supportive of each other and communicate effectively together.
- Effective, good quality care and activity planning should be individualised and reflect each resident’s unique social history.
- Homes should provide a supportive and stimulating social environment, which could include themed corridors, mood lighting, complementary therapies and quiet rooms.

approaches. Our study sought to build on this by investigating the extent to which care home staff have adopted this approach.

METHOD
Nine nursing and residential care homes in the West Midlands specialising in caring for people with dementia participated. Three were drawn from each of the following social services categories: privately owned by individuals (P); owned by a chain (C); and run by a charity/voluntarily (C/V).

Each home manager provided data on resident numbers, staffing levels, staff training, policies and procedures, and specialist facilities and care provisions for residents with dementia. A one hour focus group discussion was then held with staff at each home. Thirty six participants (aged 18-57) took part (3-5 per group), including healthcare assistants (58%), nurses (14%), activity coordinators (6%) and managers (22%).

The discussions sought participants’ perceptions of caring for residents with dementia, and management approaches to behaviours considered to be challenging or problematic. The findings are presented with quotations from participants, identified by their home number (1-9), home type (P, C or C/V) and participant number (1-5).
RESULTS

Our findings revealed evidence of the use of both dementia care models.

Care homes were categorised into three groups according to their predominant approach to care, as perceived by focus group participants:

- Those describing elements of malignant social psychology, where the standard neurogenic disease paradigm tended to underlie the care culture (n=3);
- Those using a biopsychosocial approach (four homes) (n=4);
- Those moving towards the latter (n=2).

Consensus between participants in each focus group was evident in their perceptions of their home’s approach. This consensus was both verbal, such as seeking affirmation from colleagues, and non-verbal, such as head nods, and confirmed in responses given by their care home manager.

Three of the nine homes (1C, 5C/V and 8P) showed a reliance on the standard neurogenic disease paradigm, characterised by their frontline use of drug therapy for managing challenging/problematic behaviours: “We tend to use quetiapine” (home 8P, participant 4). The remaining homes showed the culture shift towards person centred care. For example, staff in home 3C described using medication as (Stokes, 2000) “true last resort”:

“If it’s appropriate, if they are extremely agitated and anxious, for them, we may use a small sedative” (participant 3).

Three homes (4C/V, 7P and 9P) echoed this view, reporting that drug therapy for behavioural management was “unnecessary medications. They just complicate things and aren’t needed” (home 4C/V, participant 3). Four homes (2C, 4C/V, 6C/V and 9P) showed strong evidence of a person centred approach, relying on psychosocial and behavioural management strategies. Social history, for example, was used to develop individualised care and activity plans:

“Another group of ladies like to sit in the middle lounge and do some knitting or sewing as they used to make clothes for their families, so we use information from the families… to get to know the residents and things they enjoy doing and then we cater for their specific needs” (home 9P, participant 2).

Social history was also used to maintain daily routines:

“We’ve had some residents who didn’t want to go [to] bed at night and then we found out that was because they used to work night shifts, so we just adapt to it. If they want to walk the corridors at night, then we will walk with them, and if they want breakfast in the middle of the night… they will have breakfast in the middle of the night” (home 6C/V, participant 3).

The standard neurogenic disease paradigm

Kitwood (1997; 1990) described how malignant social psychology arises as a result of seeing dementia as an organic mental disorder for which nothing can be done (Stokes, 2000). This characterised the care environment of homes following the standard neurogenic disease paradigm. All participants acknowledged their work was mentally tiring (“It’s hard and it does wear you out,” home 4C/V, participant 1), but, in homes using medical behavioural management, staff had low morale:

“They [residents with dementia] can’t communicate with you, so you end up finding it frustrating” (home 5C/V, participant 1).

In such homes, staff also showed evidence of disempowering residents:

“They are quite severe like, dementia patients are. They won’t be aware of what’s happening. They haven’t got a clue really” (home 7P, participant 1).

The work of these staff was described as task orientated, mainly towards caring for physical needs: “You have the washing, cleaning and cooking to do” (home 8P, participant 1). In these homes, the roles of carers (healthcare assistants), nurses and management were clearly demarcated:

“Even when there is only three of you [carers] on, the nurses still don’t come out and help you… They aren’t on the floor as often as they should be. We shouldn’t say that about nursing staff and management really, but they don’t help us carers” (home 5C/V, participant 4).

Such high levels of stress and frustration seem symptomatic of burnout (Kitwood, 1997; Maslach, 1982). They may lead to staff sickness and lack of job satisfaction, perhaps resulting from residents’ non-compliance:

“If you have someone who is constantly wandering, you have your other residents to look after which makes them agitated… so you end up finding it frustrating” (home 5C/V, participant 1).

This may also result from residents’ physical or verbal aggression:

“If you have someone on the odd day who is high that day… they might be more physically or verbally aggressive… towards us” (home 1C, participant 1).

While acknowledging that staff undergo mandatory training including that on health and safety and on manual handling, staff in these homes talked of a lack of career opportunities to improve qualifications and pursue professional development interests:

“Companies won’t pay out for training when it’s like £100 per person, and they have a large number of staff and a high turnover” (home 5C/V, participant 4).

Staff seemed to lack motivation to do a good job, often describing their work negatively and referring to residents as “them” or “they” or colloquially as “the razzies” (home 8P, participant 1). Such attitudes may hinder staff in forming valuablerelationships with residents through interaction and reminiscence.

Person centred care and moving towards it

Homes where care was described as being more person centred relied on “a good working team” (home 9P, participant 2) whose members communicated well with each other, using the unique skills of each to provide optimum dementia care. There was also evidence of colleagues supporting each other at difficult times in these homes:

“You need your team mates there with you, just like to take some of it away from you… if you’re stuck in the middle and you have three or four [residents] that are bombarding you, if a colleague comes one or two can toddle off with her or summat” (home 4C/V, participant 1).

Teamwork seemed to help empower both residents with dementia and staff, improving quality of life for both parties and leading to a celebration of achievements:

“It [dementia care] is very, very rewarding, and I think that side of it is frequently missed out, because… when you do make a breakthrough, it just gives you the feeling of, ‘Oh gosh, I’ve really...
Focus group participants emphasized the need to talk and empathize with residents:

"Coz talking to them does really help you connect with them a bit better, if you understand them as a person" (home 4C/V, participant 2).

Homes also made physical changes to their care environments. One had a "reminiscence floor" where residents with dementia lived:

"On the reminiscence floor, we all know what their needs and wants are and we are better able to deal with them" (home 2C, participant 2).

Others had themed corridors ("We have a movie corridor and it's the old film stars," home 3C, participant 3), quiet rooms, soft lighting and therapy lights. Some staff spoke of paying attention to seating and eating arrangements:

"We have a separate lounge and dining room. As a result, mobility is improving, eating is improving, residents are enjoying their food more and they are getting some social stimulation as well when walking down the corridors together or with carers" (home 6C/V, participant 4).

Participant 3 in home 6C/V talked about using complementary therapies to enhance the holistic approach to managing dementia care, allowing residents to feel secure in a friendly, relaxed and stimulating setting:

"I am doing reflexology… which helps them relax better and sleep better… and aromatherapy baths."

Here, behaviours were phrased in terms of needs to be satisfied, rather than problems to be dealt with. Staff talked about dementia as a neurological impairment affected by the social environment, so they looked for reasons for residents' challenging behaviours:

"He was always playing with the doors, opening and closing them, and testing the handles… and you think 'why is he doing that?' But then we looked in the care plan, through his social history, and found out he used to be a carpenter. He's checking all the doors to make sure they are hanging properly and ensure he has done a good job" (home 6C/V, participant 4).

When asked to recall memories of residents with dementia for whom they had cared, participants from homes that had embraced the person-centred approach typically spoke affectionately about all of them, even challenging ones:

"They are all so individual. They have all got a special place in your heart. There are very few that I can't remember and I have been doing this job for 22 years…. You remember them all for different things, different reasons, whether it be for good or bad.…." (home 3C, participant 3).

However, in homes where malignant social psychology was evident, participants almost always recalled residents who were aggressive and had challenging behaviours, and talked of managing them by using medication:

"For me it was 'Matron'.…. When she first came, she was dreadful…. Nasty, violent, aggressive, and she would kick you and everything…. Later she was lovely…. It was the drugs in the end that they gave her. That one little tablet just changed her entirely…." (home 8P, participant 1).

**DISCUSSION**

Focus group members in two thirds of the homes found a biopsychosocial approach enabled some residents to function at their optimum level, reducing the need for medication as a first line management approach. However, other homes still used medical management as a primary strategy. This reliance on medical behavioural management may stem from lack of knowledge/experience of biopsychosocial interventions and their potential benefits.

Our results, although representative of our sample, may not be representative of care homes generally. These homes may have had their own agendas for participating. Some participants saw their homes as providing optimum dementia care and were keen to share good practice -- for example, those in homes 3C, 6C/V and 9P. For others, participation may have been a means of addressing problems they were experiencing.

Our research supports the Alzheimer’s Society’s (2007b) report, which emphasized the need for dementia-awareness training for care home staff. Training in biopsychosocial approaches to dementia is needed for care home staff, family and other healthcare professionals. However, such provision is seen as costly, leading a healthcare assistant (participant 4) in home 5C/V to suggest:

"Perhaps the lottery fund could give money to care homes for this kind of training, like for staff and relatives, like a grant."

**CONCLUSION**

Our findings suggest optimum dementia care relies on staff having confidence, competence and special qualities, such as "a lot of patience" (home 4C/V, participant 2) and "understanding" (home 3C, participant 2), which enable them to interact positively with residents. This ensures they are seen as "people with dementia" (Stokes, 2000) and that their individual needs are met by empowering both carers and residents:

"… it always helps to have higher [staff] numbers, but [is] not always necessary. As long as the staff that you have really do understand what dementia is… it’s not just a disease… the person is still there. As long as you treat the residents with respect and dignity. It’s all about understanding how to cope/deal with the residents, not the number of staff that you’ve got. As long as they’ve got the training, I think that’s the main point" (home 3C, participant 3).

Part 3 of this series, to be published in next week’s issue, examines resident wellbeing reviews.

**REFERENCES**


