Stroke Education series
Putting Best Practices into Practice: Caring for residents with Stroke
Part 3 – Reducing and supporting behaviours in residents with Stroke.

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Putting Best Practices into Practice: Caring for residents with Stroke

A collaboration by RNAO LTC Best Practice program and Central South Regional Stroke Network.

This is part three of the four part stroke education series to support LTC staff to:

1. Identify risk factors to prevent responsive behaviours for residents with Stroke.

2. Understand the relationship between reducing and supporting behaviors, pain assessment and management, falls prevention and management and preventing pressure injuries in residents with Stroke.

3. Discuss the importance of an inter-professional team approach in Stroke Care.

4. Understand how to Integrate evidence-based resources in planning and improving care for residents with Stroke.
Stroke and Long Term Care

Of every 100 people who have had a stroke:

- 15 die
- 10 recover completely
- 21.3% of residents in LTC have had a stroke (CIHI 2014-15)
- Each year approximately 13,000 Ontarians are discharged from hospital following a stroke or TIA
- 1411 stroke persons were admitted to long term care homes within 6 months of an acute stroke in Ontario in 2014-15 (Ontario Stroke Evaluation: Report 2018: Stroke Quality of Care and Outcomes in LTC)
- Stroke is the third most common diagnosis in long term care (Price Waterhouse Cooper 2001)
Stroke and Long Term Care

Communication:
- 44.3% of stroke persons were understood (625/1411)
- 35.1% usually understood (495/1411)
  - Total: 79.4%
- 15.5% sometimes understood (218/1411)
- 5.2% rarely understood (73/1411)

Cognition:
- 20.3% of the stroke persons in long term care had severe cognitive impairment

(Ontario Stroke Evaluation Report 2018: Stroke Quality of Care and Outcomes in LTC)
Stroke in Long Term Care

Pain:
- 10.5% of stroke residents experience pain daily

Falls:
- 25.5% of stroke residents fall

Aggressive (Responsive) Behaviour:
- 29.8% (421/1411) are considered aggressive
- 4.9% (69/1411) are considered severely aggressive

Continence:
- 27.1% (383/1411) bladder continent  61.3% bladder incontinent
- 47.3% (667/1411) bowel continent  45.4% bowel incontinent

(Ontario Stroke Evaluation Report 2018: Stroke quality of Care and Outcomes in LTC)
Responsive Behavior

Definition:

- Is a term representing how persons with dementia or other conditions, actions, words and gestures are a response often to an unmet need, that express something important about their personal, social or physical environment

- May also be referred to as “protective behavior”
Top 10 Reasons for Responsive Behaviour

1.) Pain
2.) Other medical reasons (delirium, medications etc.)
3.) Boredom
4.) Loneliness
5.) Anxiety
6.) Frustration
7.) Confusion
8.) Wanting to go home
9.) Feeling threatened/fear
10.) Depression

Reference: Central East LHIN Behavioural Supports Ontario Intervention Tool Kit
The 8 A’s

1.) Amnesia – loss of memory
2.) Aphasia – loss of language
3.) Agnosia – loss of recognition
4.) Apraxia – loss of purposeful movement
5.) Altered Perception – loss of environmental perception; depth, visual, tactile, spatial, distance
6.) Apathy – loss of initiation
7.) Anosognosia – no knowledge of their illness/disease
8.) Attention Deficits – information processing/attention
Behavior changes

Stroke can decrease emotional control and change how residents behave and relate to others.

The extent of change depends on:
- Where the stroke was in the brain
- How severe the stroke was
- How long ago the stroke occurred
- Cognitive abilities, personality and behavior pre-stroke

- Behaviors may be inconsistent – good and bad days
- Some behaviors may be related to frustration – unable to communicate or function like they did before
- May be unaware of their changed behavior/personality
- Behavior may increase risk for falls and skin integrity concerns
Behavior Changes

- Anger and Aggression – can be caused by the brain area affected
  - may not be able to control these feelings
  - frustration, embarrassment, dependence, hopelessness, pain = anger

- Social Isolation – self image and self worth may be reduced, apathy can lead to depression

- Social Judgement – does not recognize when inappropriate in social situation
Behavior Changes

**Management:**

- Identify triggers – pain, situational, over stimulated, dysarthria, aphasia, fatigue
- Keep to routines and patient’s preferences – predictability key. Explain what you are doing, so resident is prepared
- Approach from the unaffected side so they are not alarmed and react angrily
- Offer support to reduce frustration
- Redirect and use a calm approach
- Reinforce and learn their interests and encourage gently but do not force participation/activity
- Recognize limits
- Give feedback/cues – reinforce appropriate behavior, offer alternatives
Agitated Behaviour

Presentation:
- State of restlessness, inability to relax, pacing
- Nagging, pleading, calling out
- Repetitiveness, unrealistic fears

Possible Causes/Triggers
- Physical
  - needing to go to BR
  - pain, constipation, discomfort
  - inability to communicate needs or understand what is being said – aphasia
  - lack of exercise and fresh air
- Environmental
  - new setting, care givers, room mate, treatment or care plan
  - temperature
  - sensitivity to light or noise
- Emotional
  - anxiety, fear and insecurity
  - boredom, over/under stimulation
  - looking for something comforting/familiar
Interventions

- Provide stimulating activities
- Calming strategies – reduce noise, clutter, distractions: dim lighting: relaxation opportunities
- Use verbal or non-verbal means to communicate – eye contact; short, simple sentences in a language the person understands; be aware of your body language; use of touch, smiling; any hearing or visual impairments
- Sundowning – quiet room well lit till bedtime; 1:1 activities
- Assess for pain – ask y/n questions using simple language to identify the problem; point to areas; be patient; PRN analgesics or new order; perform pain using appropriate tool; discuss with registered staff; educate team and resident/family on interventions to reduce pain; comfort measures
Verbally Aggressive/Angry Behaviour

Presentation
- Displays anger or is verbally abusive in predictable situation or with no apparent provocation

Possible Causes/Triggers
- Trouble controlling impulses, internal thoughts expressed without filtering
- Frustration often occurs when unable to make themselves understood, too much sensory stimulation, loss of independence/control
- Do not recognize others or their surroundings and feel scared- amnesia or agnosia
Interventions

- Step-by-step explanation using a calm voice of what is happening
- Be aware of own body language, tone of voice and facial expressions
- Stay calm, do not take it personally, remain warm, supportive and respectful
- If possible, give space and re-approach later
- Do not argue – it only aggravates the behavior
- Talk less- 2-3 words
- Assess the environment to identify possible triggers- noise level, temperature
- Attempt to redirect- utilize 1:1 social interaction or activities
- Group activity if preference for being around others and interest to participate in the specific activity
Physically Aggressive/Angry Behaviour

Presentation
- Displays anger, physically aggressive in predictive situations
- Angry or physically aggressive with no apparent provocation

Possible Causes/Triggers
- Trouble controlling impulses, internal thoughts expressed without filters
- Frustration when unable to make themselves understood, if too much sensory stimulation, loss of independence/control
- Do not recognize people or their environment/surroundings and feel scared – amnesia or agnosia
Interventions

- Similar to verbally aggressive/angry behavior
- Remove any people in the immediate area
- Assess the environment for possible triggers and potential threats to safety
- May need to set reasonable limits if applicable
Wandering

Presentation
- Aimless wandering, exit seeking, pacing

Possible Causes/Triggers
- Environmental triggers – doors, windows, shoes/coats, people coming and going out the door, noise
- Anosognosia – believe they are fine
- Behaviour has a purpose – ie, is hungry so seeking dining room/fridge or needs BR
- Attempt to return to familiar place or person
- Feeling anxious, restless, bored or confused
- Increased disorientation - med change, acute illness
- Change in schedule or routine
- New admission – new environment
Intervention

- Adhere to routine – create personalized schedule/calendar
- Assist if seem confused or lost – provide wayfinding signs; personalize door entry of their room
- Lock doors/secure – signage, wandering bracelets/system; camouflage exits
- Ensure environment is safe for wanderer – remove clutter and objects that may be a risk, accompany when walking
- Create rest stations – engaging in activity ie. magazines, pictures/wall art, puzzles
- Schedule outdoor/off unit activities – garden walks, exercise program to expend energy, a drive
- Engage in purposeful activities – towel folding, setting/wiping tables, golf putting, memory book, watering plants,
- Work with family to develop a safety plan and keep communication open and timely
Depression

- It is normal to feel sadness and loss post stroke
- 33 – 50% of stroke persons develop clinical depression during the first year post stroke
- Most often begins 3-4 months post but can occur at any time, even years later

**Definition**

- A chronic, overwhelming sense of sadness, loss of interest and despair that interferes with a person's functional ability. May feel a significant lack of energy. It can slow physical and mental recovery and they may lose interest in participating or in self care.
Depression

Presentation

- **Physical** – sleep pattern and eating habit changes; reduced energy and easily fatigued; tearful

- **Attitudinal** – not caring; loss of interest; negativity; self focus and self loathing; withdrawing

- **Emotional** - hopelessness, worthlessness and guilt; sadness and despair; anxiety/nervousness; irritability/angry

- **Mental Functioning** – difficulty concentrating and with decision making; confusion short term memory loss
Interventions

- Observe and share findings with team

- Some of these symptoms may be caused by stroke – conversely team members may not recognize when a stroke person is depressed because they relate the symptoms to the stroke or to aging. Difficult to assess when communication or cognitive deficits present

- Establish a connection with the stroke person – when know them better we are able to identify patterns/changes
  - Ask how they are feeling and actively listen to response. This builds rapport and helps identify any other causes for low mood such as pain
  - Communicate with care and empathy and be accepting not judgmental

- Offer support
  - Share resources with person and family
  - Routine helps- create day planning and structure
Interventions

- Encourage stroke person to stay active and involved
  - Determine what activities they enjoy and help them to access them
  - Encourage family and friends to spend time with stroke person

- Encourage stroke person to talk about their emotions
  - Help them feel comfortable expressing their grief and sadness about the stroke and what they feel they have lost
  - Provide realistic hope for the future – improvement can continue for weeks and months post
  - Communicate with team while respecting privacy
Best Practice Recommendation: Behavior

- Stroke residents with cognitive impairment and evidence of changes in mood (depression, anxiety, apathy) or other behavioral changes on screening should be referred to and managed by an appropriate mental healthcare professional.

- All stroke residents should be considered at high risk for post-stroke depression, which can occur at any stage of recovery. Residents and families should be given information and education about the potential impact of stroke on their mood/behavior. Residents and their families should have their psychosocial and support needs assessed as part of their ongoing stroke management.

  (Canadian Stroke Best Practice Recommendations)
Vascular Dementia

Definition:

- Dementia is a syndrome that includes loss of memory, judgement and reasoning and changes in mood, behavior and communication abilities

- **Vascular dementia** is related to stroke and can cause a loss in memory, reasoning, thinking, attention span and independence with adl’s
  - Vascular dementia results when a critical part of the brain does not receive enough oxygen
Vascular Dementia

Presentation

- Affects stroke persons in different ways and the rate of progression varies between persons.
  - Problems concentrating and communicating
  - Depression – decreased mood and affect
  - Stroke symptoms displayed such as physical weakness or paralysis
  - Seizures
  - Memory problems – especially recent
  - A “stepped progression” – stable and then demonstrate a sudden and noticeable decline in function
  - Acute confusion
  - Hallucinations – seeing things that don’t exist
  - Delusions – believing things that are not true
  - Wandering – getting lost
  - Physical or verbal aggression
  - Restlessness
  - Incontinence
Intervention

**Communication Strategies**

- Eliminate distractions – tv, radio
- Approach person slowly and from the front – establish and maintain eye contact
- Use short, simple sentences and speak slowly
- Give one instruction at a time
- Ask yes/no questions versus open ended
- Repeat message using the same wording
- Avoid interrupting the person and allow plenty of time to respond
- Encourage them to talk “around” the word they are seeking
Intervention

ADL Strategies

- **Eating:** offer 1 food at a time; use contrasting colors for food, plate, mat; lighter utensils; check for dental issues, poor fitting dentures, mouth dryness or swallowing deficits
- **Bathing:** ensure privacy and respect; have bath water ready beforehand and ensure appropriate temperature; let person touch water so knows it’s safe; shampoo last and avoid face; cover mirrors; use colored decals to indicate bottom of tub; use GPA training
- **Dressing:** lay clothing out in sequence with underwear on top; choose clothes that fit easily/liked; keep consistent dressing routine; purchase duplicate clothing for items worn often
- **Toileting:** ensure toilet is visible; clearly mark BR door to cue resident this is where the BR is; use a timed toileting routine to avoid incontinence; provide adequate lighting to BR; UTI’s are common so if fever persists over 24 hours, contact physician
- **Mobility for Wanderers and Exit Seekers** – increase daily exercise and activity level; provide safe outdoor access; adjust person’s stimulation; add familiar items to their doorways and rooms to enable identification; address wandering cause to ensure not because of need to be toileted or for pain relief; review meds to ensure not creating agitation
The Interprofessional Team

RNAO Recommendation:

- Initiate and maintain collaborative processes within the team, especially in situations of increasing resident complexity, to improve resident outcomes

- Interdisciplinary collaboration is critical to the best possible outcomes for the stroke resident

Why?
- Communication
- Treatment specificity and specialization
- Scope of Practice
- Resident complexity
- Best evidenced-practice
- Shared decision making
- Quality of Work Environment
- Safety

RNAO Best Practice Guidelines
Intra-professional Collaborative Practice among Nurses 2nd ed., 2016
Developing and Sustaining Interprofessional Health Care:
Optimizing patient, organizational and system outcomes 2013
The 12 Stroke Specific Care Plans:

1.) ADL Care Plans – Final - June 2016

2.) Behaviour Change - Final – June 2016

3.) Bowel Bladder Continence Final – June 2016

4.) Cognition Care Plans – Final – June 2016

5.) Communication – Final – June 2016

6.) Depression – Final - June 2016

7.) Leisure – Final – June 2016

8.) Mobility Positioning Transfers – Final –June 2016

9.) Nutrition Hydration Swallowing – Final- June 2016

10.) Pain – Final – June 2016

11.) Perception – Final – June 2016

12.) Skin Care – Final –June 2016

Best Practice Guideline: Behaviour

RNAO Best Practice Guideline
Delirium, Dementia and Depression in Older Adults:
Stroke Resources

- Ontario Stroke Network: www.ontariostrokenetwork.ca
- Canadian Stroke Best Practice Guidelines: www.strokebestpractices.ca
- RNAO Best Practice Guidelines: https://rnao.ca/bpg
- Stroke Care Plans: www.swostroke.ca
- Taking Action for Optimal Community and Long Term Care (TACLS): www.strokebestpractices.ca
References


References continued


- Ontario Stroke Evaluation Report 2018: Stroke Quality of Care and Outcomes in Long Term Care ICES and CorHealth


References continued


- Registered Nurses’ Association of Ontario (2016). Intra-professional Collaborative Practice among Nurses. Toronto, ON: Registered Nurses’ Association of Ontario


Questions ?

Thank you !