

COMBATIVE BEHAVIOR

INTRODUCTION

Working in long-term care may bring you in contact with residents whose chronic confusion or cognitive impairment may cause them to exhibit combative behavior. It is essential to recognize that a resident's combativeness is a symptom of the need for care, not a sign of dislike or fear of you. Your ability to assess, understand and work to prevent or modify combative behavior will result in better care for residents and greater work satisfaction for you.

Philosophies, Purposes & Outcomes Intended:

1. Preserve human dignity.
2. Instill confidence.
3. Reduce injuries to staff and individuals.
4. To develop skills for assisting individuals to regain control of themselves.

DEFINITION

Combative behavior is any physically aggressive act that causes or intends to cause hurt or damage to a person or object. Some types of behavior you may encounter in long-term care include:

- Resisting care – for instance, aggressively hampering efforts at bathing or dressing.
- Verbal aggression – such as arguing, cursing, accusing, or threatening.
- Fighting – endangering residents or caregivers with punches, kicks and other hurtful acts.
- Catastrophic reaction – sudden mood changes with outbursts that indicate a resident is overwhelmed and unable to control feelings.
- Physiological Responses – heart rate increases, central blood flow decreases by constriction of blood vessels, peripheral blood flow increases by dilation, respiration increases and digestion ceases.

CAUSES

A healthy individual “mirrors reality” by objectively assessing what is going on in a particular environment and reacts appropriately, in socially interactive ways. Certain types of brain disorders, health conditions, psycho-social factors, environmental situations, and care-giving interactions can interfere with the ability of residents to mirror reality. In effect, behavior always occurs within a context of people, places, times, and events.

Dementia is a brain disorder in which both personality and thinking abilities deteriorate. It occurs in organic brain diseases, such as Alzheimer's, and in other disorders. It worsens over time. As Alzheimer's residents lose touch with reality, combative behavior may result from an inability to understand what is going on in the care setting.

Other health-related causes may include hearing or visual impairment, acute illness, multiple illnesses and disabilities, hormonal changes, loss of control over bodily functions, or disturbances in body image. Likewise, alcohol or drug-related conditions, changes in medication, and lack of sleep may induce episodes of combative behavior.

Psycho-social causes of combative behavior may stem from a resident's feeling threatened by life changes and frustrated by a perceived loss of control. Unable to communicate adequately, a resident may misinterpret your efforts to provide care. He or she may be unable to control feelings, or may withdraw from interaction.

Environmental causes of combative behavior can be varied. Very bright or dim lights, blaring radios and TV's, intrusive loud speaker messages, cluttered rooms, or the constant traffic of people coming and going can upset residents. A change of rooms, roommates or routines, as well as a disregard for the way a resident likes their belongings arranged, may also trigger combative behavior.

Unskilled care-giving acts that can contribute to combative behavior include being overly authoritarian, making gestures that startle or frighten, rough or hurried handling during care-giving, and impatient, loud or demeaning conversation.

MANAGING COMBATIVE BEHAVIOR

In dealing with disruptive or combative behavior, one must determine what the individual is trying to communicate through their behavior. If we don't act on the message it could lead to further escalation or if we try and suppress the behavior it may come out in some other way which may ultimately be more problematic. To manage the behavior, you need to assess and understand the reasons for it or the purpose it serves, develop a care plan based on realistic goals, use strategies to prevent it, and intervene safely when it occurs. Regardless of the circumstances, you must always treat residents with respect and preserve their dignity.

Assessing the Resident

A thorough assessment begins with a review of the patient's medical, social and work history, and a search for behavior patterns that may repeat. Visit with family members to better understand the resident's personality, former occupation, hobbies and life experiences. Keep the family informed and enlist their help in modifying the behavior. Talk with the resident to shape a closer, more understanding relationship. Maintain an ongoing, regularly updated assessment of the type of dementia, its severity and progression.

- If a resident resists care, assess and try to understand the cause. Refusing to be bathed, for instance, may mean an individual's sense of modesty is being offended by the need to undress in your presence. Refusing dinner or medication may mean a resident has fears of being poisoned. Or refusing to cooperate may be a way of exerting power and control, to avoid feeling helpless.
- If a resident becomes verbally aggressive, realize these are signs that they are losing impulse control. Anything that causes stress can bring on this behavior – from a change in routine to the notion that a caregiver is being overly familiar.
- If a resident starts a fight, realize that fighting is dangerous and act swiftly. Recognize that fighting happens most often when a resident feels his or her personal space or possessions are threatened. Personality conflicts can also lead to fighting.
- If a resident has a catastrophic reaction, the caregiver most trusted by the resident should intervene. Approach in a way to avoid startling the resident. Be gentle, but firm. A catastrophic reaction can't be predicted and thus can't be prevented. An outburst of crying, anger or fighting is a sudden response to feeling overwhelmed. It occurs most often in the morning, when daily care activity is at its peak.

Formulating a Plan

Work closely with the entire care-giving team to develop a plan for successful management, containment and, where possible, prevention of combative incidents. Make your goals realistic. Begin with the understanding that you'll probably be unable to stop all behavior problems, and cannot halt the progression of conditions such as dementia. Some realistic goals:

- **Attend to safety** of the combative resident, other residents, staff, visitors and the environment.
- **Provide Support** by having all caregivers stay alert to give aid in combative behavior situations.

- **Increase Awareness** of behavior that may give clues to the onset of an aggressive act.
- **Strive For Containment** with efforts to decrease the frequency, intensity, duration, and disruptiveness of combative behavior.

Prevention

Our actions should be motivated by the need to protect and teach, not by a desire to punish. Despite a resident's confusion or cognitive impairment, always try to validate his or her reality and honor the human dignity to which each of us is entitled. Give each resident your respect, shown by words of praise and gestures of support. Encourage a resident's self-care and functional independence to the full extent of their present capabilities. Use the following preventive strategies:

- Validate the reality of the confused residents. When you enter the resident's rooms, prepare to "jump into their reality" rather than insisting on yours. If they are convinced it is the 1940's, let it be so. If they think their morning involves getting ready for work, avoid the urge to make them "get real." Chronically confused residents will be unable to join you in your reality. So, even if it makes you uncomfortable, join them in their reality, whatever it may be.
- Watch for clues that combative behavior may erupt, such as agitation, nervousness, frustration, fear, panic, despair, guilt, suspiciousness, hostility, confusion, annoyance, and resentment. Personal responses with physical and behavioral responses to look for:

Emotional Responses

- Anxiety - Muscles tension
- Fear - Tingling in hands or limbs
- Anger - Stomach ache
- Frustration - Chest pain
- Irritability - Cold sweat
- Panic - Racing heart
- Despair - Feeling faint
- Guilt - "Freezing"

Cognitive Responses

- Can't concentrate - Desire to run away
- "I am a failure" - Drinking/Drug use
- "It's my fault" - Taking anger out on someone else
- End result will be a catastrophe - Sleeplessness
- Can't make decisions - Hiding or isolating
- "Others" are to blame - Quitting
- Things will never get better - Avoiding
- "I bear sole responsibility for what happens"
- "I am not allowed to make a mistake because someone will criticize me."

Historical

- What has happened the last several times the person was in this environment?
- What are the historical consequences of the behavior from long ago?

Social Environment

- Territorial
- Lack of interactions with family/friends
- Lack of privacy
- Someone else exhibits maladaptive behavior

- Certain people the individual dislikes
- Someone looking or acting threatening, annoyed or angry
- Imitation of staff behavior
- Presence of family members, old friends, etc.
- Attention being given to someone else, or another getting to do something that they like
- Lack of attention

Physiological Issues

- Accidents/falls
- Physical ailments
- Improper positioning
- Premenstrual discomfort
- Eating certain foods (especially disliked or “allergic foods”)
- Not enough to eat
- Too long since last food/drink
- Being awakened too early
- Not enough sleep
- Seizures
- Behavior associated with sexual arousal
- Signs of discomfort – pained facial expression, holding part of one’s body, etc.
- Constipation

Medication

- Taking certain medications
 - How recently was medication taken?
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- With your words and actions, “mirror” such qualities as kindness, patience, good humor, respect, and friendship. Often, a resident may draw reassurance from you, and “mirror” your good will in their responses.
 - Approach slowly from the front to avoid startling the resident. Don’t appear afraid or unsure of yourself even though you maybe shaking on the inside.
 - Allow the resident more space when they are angry. Be aware of your position. Watch so that you don’t do something intentionally or unintentionally to intimidate the individual.
 - Keep at arms length and one small step away from the individual whether standing or sitting.
 - Get yourself at eye level.
 - Move with the individual, not ahead or after the individual.
 - Speak deliberately and respectfully, with short words and sentences.
 - Identify yourself and the care you’re planning to provide.
 - Don’t argue.
 - Don’t demand.
 - Don’t promise anything that you can’t deliver.
 - Listen carefully and respond to the problem and not the words (or observe carefully in the case of a nonverbal individual).
 - Accept and acknowledge the individual’s statements as expressions of their feeling.
 - Often, a resident won’t be able to remember or carry out a series of tasks, so break the tasks into single acts:
 - Out of bed
 - Into the bathroom
 - Use the toilet
 - Brush teeth

What if you and the resident “don’t click?” It can hurt to see someone refuse to be fed or bathed by you, yet be quite happy with the care of a colleague. Recognize that it just happens sometimes and don’t take it personally. Wherever possible, an alternate caregiver should be assigned to avoid an interaction that causes problems.

MODIFYING BEHAVIOR

With time and effort, it is possible to modify combative behavior to the extent that it poses less of a threat to safety and security, and less of a problem to effective care management. However, such an effort calls for modifying behavior on both the resident’s and the caregiver’s side.

A resident’s combative behavior may improve with:

- A well-formulated plan of assessment and treatment
- Positive feedback to encourage acceptable behavior
- Counseling for residents who can benefit from it.

A caregiver can contribute these skills by:

- Making efforts to build a therapeutic relationship
- Remembering to speak clearly and face the resident
- Using reassuring body language
- “Mirroring” acceptable behavior by example

COMMUNICATING WITH ALZHEIMER’S PATIENTS

As a result of physiologic changes caused by Alzheimer’s disease, affected people may not communicate well with others. They are not creating these obstacles on purpose, and are probably as frustrated as their friends and family about the communication problems. People with Alzheimer’s disease may:

- Use certain words repeatedly
- Invent new words to describe familiar objects
- Have difficulty finding the appropriate words
- Revert to speaking a native language
- Use offensive words
- Frequently lose their train of thought
- Speak less often
- Use gestures to communicate instead of words.

You can help the person with Alzheimer’s disease by being a good listener. Let the person with Alzheimer’s know that you are listening and that you are trying to understand them. Maintain eye contact to show them that you care about what they are saying. Encourage them to continue trying to express their thoughts, even though they may have difficulty doing so. Don’t interrupt them, no matter how long it takes them to think about and describe what they want. Avoid criticizing or correcting their speech or actions. Don’t argue with them.

Follow these tips for improving communication with a person affected by Alzheimer’s disease:

- Respond calmly and express support
- Use a gentle, relaxed tone of voice
- Use positive and friendly facial expressions
- Don’t approach the resident from behind – always from the front

- When beginning a conversation, identify yourself and address the person by name
- Speak slowly and clearly
- Use short, simple, familiar words
- Break tasks and instructions into clear simple steps
- Ask one question at a time and allow enough time for a response
- Avoid using pronouns (“he” or “she”); instead, identify people by name.
- Avoid negative statements and questions (“You know who that is, don’t you?”)
- Use nonverbal communication such as pointing and touching
- Don’t talk about the resident as if they weren’t there
- Be patient, flexible, and understanding.

DOCUMENTATION OF RESIDENT ABUSIVE BEHAVIOR

- On any shift, when a new challenging behavior develops, the staff involved will complete an incident report, notifying the nurse and case-manager.
- Incidents of resident abusive/combatative behavior will be documented in the resident’s medical record.
- Appropriate interventions for prevention and protection of staff and other residents will be carefully planned and communicated to staff immediately by the interdisciplinary team.
- Appropriate family member/legal representative will be notified and included in plan of care.
- Further incidents will be recorded and reported to the nurse to determine effectiveness of interventions. Success of interventions will be recorded in the progress notes.
- Revisions to interventions will be made as necessary by the resident’s interdisciplinary team.
- Communicate plan of care/interventions to appropriate staff. Notify the doctor and family as appropriate.
- Tracking tools including the Daily Behavior Log and behavior description sheet as well as 15 – 30 minute tracking forms may be used when a detailed objective measurement of behavior is needed.
- The nurse is responsible at the end of each shift to chart in the progress notes, a summary of behaviors occurring for that shift specifically addressing the resident’s response to the interventions tried forth incident using the FOCUS charting format. If there is a psychotropic medication ordered specifically as an intervention for a challenging behavior, the nurse must also chart the number of times the target behavior occurred on the “Psychotropic” Medication Behavior monitoring record.
- The case manger is responsible for completing the behavior assessment form and assures the care plan is accurate and interventions are effective.

CONCLUSION

As caregivers, we need to strive to see reality mirrored as the residents see it, by entering their world and reflecting the realities they experience. Even more important, we can serve as a mirror to residents. Our positive actions and attitudes reflect the reality that the world has a place for them in which to feel at home, in comfort and dignity, supported by the best care we can provide.

Date