ADVICE FOR WARD STAFF DEALING WITH CONFUSED AND AGITATED PATIENTS

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BRAIN DAMAGE AND BEHAVIOUR

Points to remember -

- Sensory or physical handicaps, impairments or damage may affect cognitive and behavioural functioning - e.g. hearing, visual loss, loss of sense of smell. Cognitive functioning may also be affected by other, non-specific, factors - e.g. increased tiredness.
- In addition to physical limitations, a damaged brain can result in disturbances of cognitive function, mood, temperament and behaviour
- Be aware of the main cognitive, mood and behavioural deficits after damage to particular brain regions, and consider these as they apply to each particular patient.
- A damaged brain, together with the fact that the patient is in an unfamiliar environment, may result in further abnormalities of behaviour - e.g. poor memory, perseveration, confabulation, hallucinations, fear, anger, impaired comprehension, etc.
- The brain-injured patient may have more cognitive deficits than he or she is aware of.
- Many severe behavioural and cognitive problems in the early stages of recovery are temporary and will spontaneously resolve over a few days. In addition, they may be secondary to factors such as clinical/sub-clinical epileptic activity, drug toxicity, etc.

ASSESSMENT

- Patients who are severely cognitively impaired, or those with severe physical or communication handicaps can be assessed by using forced-choice recognition tests for reading and identifying pictures (i.e. patients are shown words and/or pictures and then later asked to pick the ones that they have seen before from a set containing those words and/or pictures that they have seen and some that they have not), and by the use of gestures to explain instructions. Scales such as the Wessex Head Injury Matrix may

be useful for those who have recovered from a comatose state but are not yet mobile or unable to communicate verbally.

- Inconsistencies in test performance, behaviour that is not usually associated with neurological conditions and the possibility of some secondary gain by the patient, can be indicative of psychogenic conditions such as hysteria or malingering. In suspected cases, provide a way out for patient to 'recover' so that he or she does not lose face.

- Remember, the patient is in a new and unfamiliar environment, surrounded by strangers. Furthermore, he or she may not know why they are there.

- Keep a well-organised environment with particular things in particular places.

- Provide marked routes to the toilet and bathroom, and labels or pictures on doors to specific rooms can help prevent the patient getting lost.

- Keep familiar stimuli, such as photographs of family or friends, near the bedside.

- Have a well-structured routine, with set things happening at set times.

- Avoid making unnecessary changes to the environment or routine.

- Keep noise to a minimum, particularly for patients who have suffered a head injury.

INTERACTIONS

- Give the patient plenty of reassurance.

- Ensure that the patient is allowed plenty of rest time.

- Keep a *Personal Profile Sheet* with the patient's details (names of family and friends, pets, interests, etc) at the end of the bed.

- As far as possible, try to maintain continuity of staff members who deal with the patient.

- Try to give your name to the patient when initiating conversation. Make sure your name-badge is clearly visible.
- Limit the number of visitors he or she has at one time.
- Avoid overloading the patient with information or asking questions that are too cognitively demanding.
- In general, try to follow three rules – avoid asking questions, generally agree with what the person is saying, and try not to interrupt the person during a conversation or while they are doing something.
- If the person is erroneously re-living a period in the past, or making up events that have happened or might happen ('confabulation') it is usually fine to go along with that rather than confront the person with the reality of the present. You need not feel guilty about doing this. Try to address any concerns that underlie the confabulation. Try to cover the topic indirectly from another angle. It may help to distract the person to other topics or activities they find interesting and enjoyable.
- Keep the patient's family informed about their condition, their treatment and any therapy programmes.

ACTIVITIES

- Concentrate on skills that the patient can do and things that he or she enjoys.
- Try to avoid situations where the patient makes lots of mistakes. Set realistic goals. Have initial goals fairly modest so that the patient may experience success and reinforcement from the beginning
- Break up large tasks into smaller parts and provide verbal or physical support. These cues and prompts can then be gradually reduced.
- Give the patient encouragement and/or reward as appropriate for successfully completed tasks.

HELPING MEMORY & ORIENTATION

- Especially in the early stages after severe brain injury, patients may have difficulty in retaining what has been told to them, and may also have problems in understanding speech. Repeating information several times, and using multiple modalities (speech, writing, pictures,) may help in this respect.

- Have the time, day, month, year, and place clearly displayed so that this information can be seen by the patient. Clocks and watches are available that have time and date information. It may help to have a magnetic white board on a nearby wall, with key reminders written on the board with a marker pen, or on Post-It tape in large print. If you think the person is interested in the news and can take in the information, then you could give them a daily newspaper of their choice, or have a TV news channel regularly on.

- You could make up a wristband for the patient. This should have their name on, very brief details of what has happened to them and/or what is wrong with them, how long they have been in hospital and answers to any other frequently asked questions. When the patient asks what is wrong with them or where they are, encourage them to look at their wristband.

- Have a paper and pencil handy at the patient's bedside so that the patient can write things down rather than rely on their memory.

- Keep a communication notebook so that staff and visitors can record the day and time of their interactions with the patient.

- 'Confused' patients may also have lost many of their past memories and may even be unable to recognize close family members. While such amnesia is usually temporary, having reminders available (e.g. family photographs) may help such memories to return. Some patients may respond to favourite music from the past – this may not only bring back past memories, but also be a useful distraction when the person is upset or agitated for some reason.

MANAGEMENT OF PROBLEM BEHAVIOUR

- An accurate assessment of the problem behaviour or problem mood-state will help successful management. Understanding why a behaviour is occurring (cause) needs to precede attempts at treatment (cure).

- Cognitive and behavioural deficits may influence each other. Cognitive deficits may lead to frustration and depression. Comprehension problems may result in the patient getting confused about interventions or treatments. Memory problems may lead to conflict about what was said or not said. Expressive difficulties may result in frustration and the patient being misunderstood by staff. Behavioural problems, anxiety or depression may result in poor concentration and then other impairments such as memory deficits

- A logical approach to problem behaviours can help, though this may require the involvement of a psychologist. Try to determine the 'A-B-C' of the problem behaviour. What preceded the behaviour (**A** - 'Antecedents') for example, the state of patient, events in the environment, etc., what are the features of the behaviour itself and how often does it occur (**B** - 'Behaviour') and (iii) what follows the behaviour (**C** - 'Consequences'). This will help to determine the nature of the problem behaviour.

- If possible, quantify behaviour in order to have an objective baseline with which to monitor improvement/deterioration. Essentially, determine how often the behavioural disturbance occurs (you may wish to break down the behaviour into different parts).

- Find out what incentives or rewards the patient has responded to in the past. These may be verbal (praise), leisure-related (watching TV, having a cigarette), food or drink related, or money-related. Reward good behaviour, provide appropriate feedback to inappropriate behaviour. This may involve provision or removal of privileges or tangible rewards. Remember to show the patient examples of appropriate behaviour if this does not spontaneously occur.

- *Anger Outbursts* – Carry out an accurate assessment of when and why anger outbursts occur. Try to identify and to avoid situations that lead to these in first place, thus preventing their occurrence. Try not to make any direct 'knee-jerk' response - distract the patient's attention to another activity, remove the patient from the situation or remove yourself from the situation. Be calm and firm, giving appropriate feedback as to adverse consequences of behaviour and encourage and support more positive ways that the patient can use to deal with similar situations. Do not take anger personally.

- *Socially Inappropriate Behaviour/Speech* – Use a procedure similar to that detailed above in response to anger outbursts. On the first few occasions give feedback and suggest alternative ways of behaving. Subsequently ignore inappropriate behaviour.

- Try to maintain consistency in the management of a patient's problem behaviour between staff (day/night, nurses and others), and between family members.

WANDERING

- Ensure that the patient has at least two nametags attached to them that give details of the ward they are on and a contact phone number.

- Make sure that other ward staff are aware of the possibility that patients may wander off so that they can keep an eye out for them.

- Sometimes patients wander because they feel uncertain and disorientated in a new and unfamiliar environment. Giving them extra help in finding their way around and plenty of reassurance may be all that is needed in this type of situation.

- Some wandering may occur due to the loss of short-term memory that occurs following brain injury. The patient may go off somewhere, for example, to the bathroom, and simply forget where it was they were going.

- Patients sometimes wander off searching for someone or something related to their past. The best way to deal with this type of wandering is not to reason, but to gently distract their attention and bring them back to the ward.

- Another, often overlooked, reason for wandering is that the patient is in some sort of physical discomfort or pain which is eased by walking. It is important therefore, to try and find out if there is any physical problem/source of pain and to alleviate it if possible.

- It is usually wise not to confront a patient who is determined to leave the ward, as they may become very upset. Instead, try accompanying them a little way and then diverting their attention so that you can return to the ward together.

- If a patient does wander off, try not to show anger or anxiety when you do find them. Reassure them and try to get them back into familiar surroundings and a familiar routine as quickly as possible.

- Electronic alarm systems are available that will trigger when a door is opened - this may help if the patient has their own room and is told to remain there. There are also more sophisticated alarm systems that will sound if the patient passes a certain location in the ward.

AND FINALLY …

To help YOU cope with the stress of dealing with brain injured patients and their families -

- Stay calm
- Take a break
- Talk to others with knowledge and experience of similar problems
- Find out more information from relevant sources (patient organizations, library, the Internet, etc.)
- Refer to this booklet from time to time