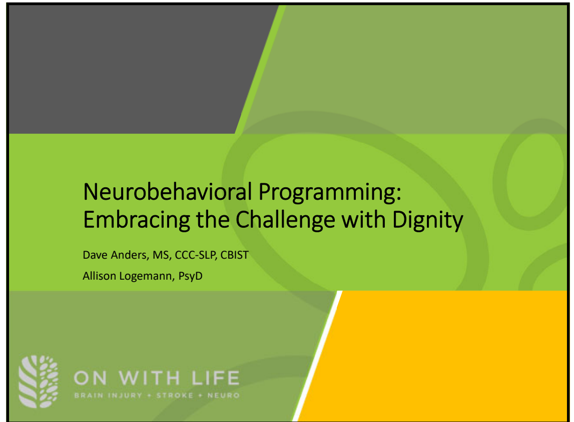

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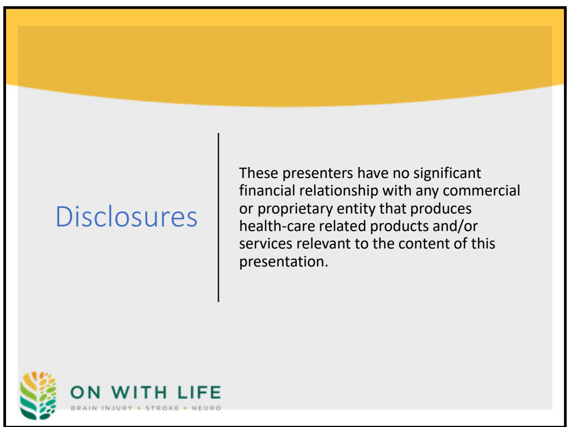

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What is behavior?

Observable action or inaction.

Behavior is a communication tool to:
- Access/obtain
- Attention (establish a connection)
- Avoidance
- Escape
- Automatic reinforcement (sensory-based)

What is this person trying to communicate?

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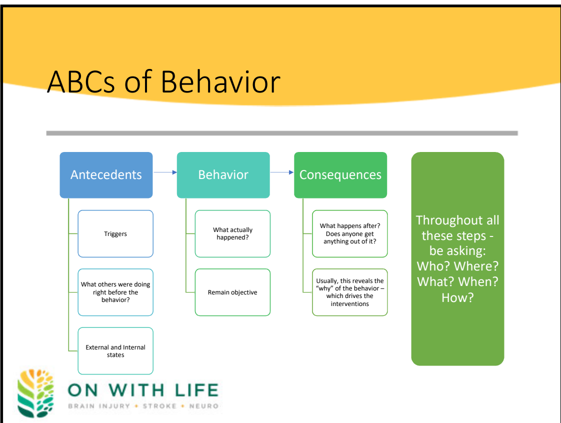

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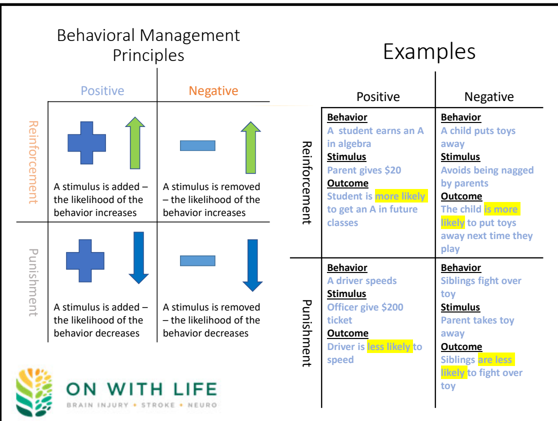

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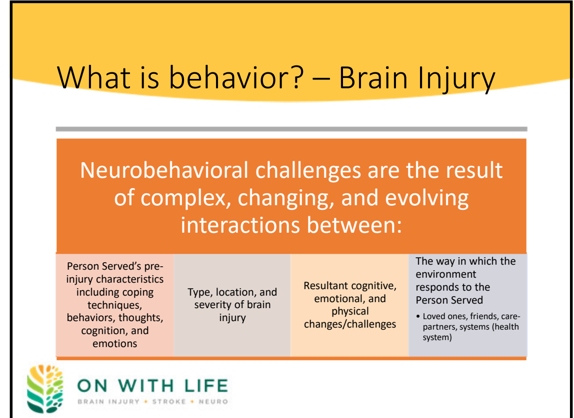

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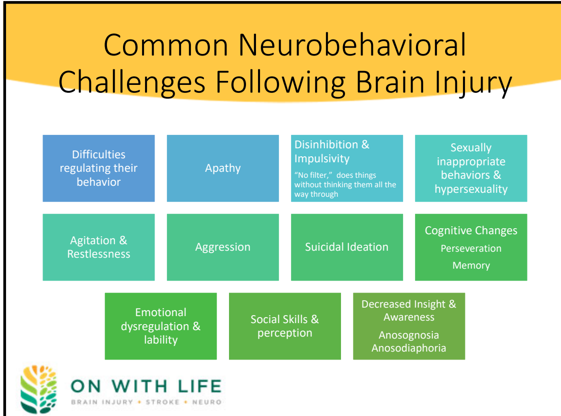

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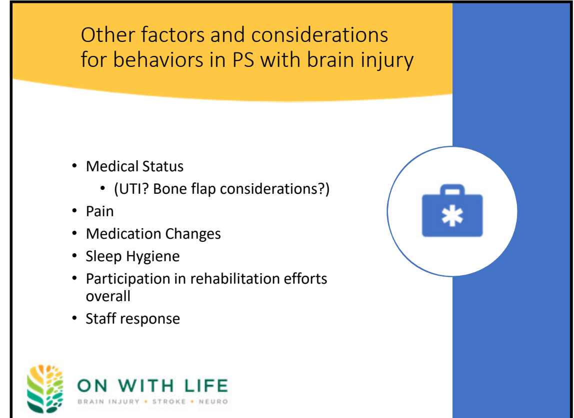

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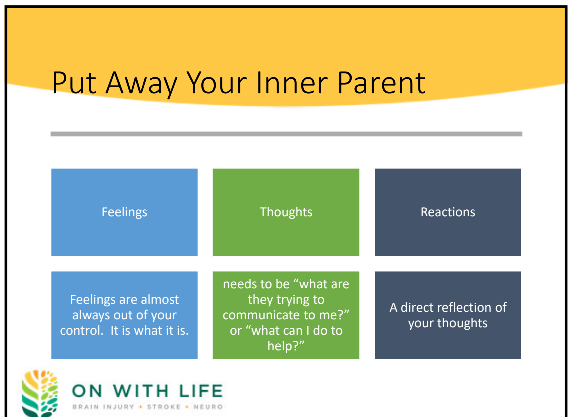

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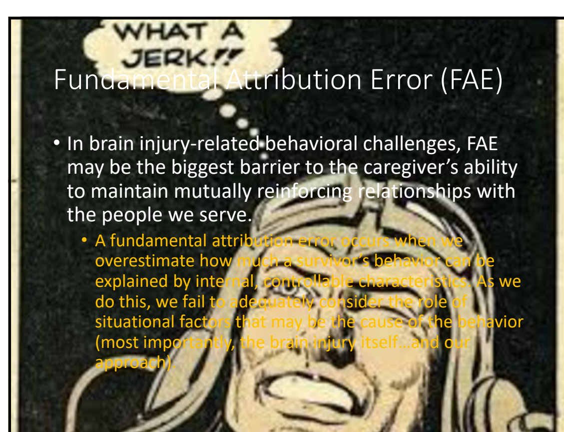

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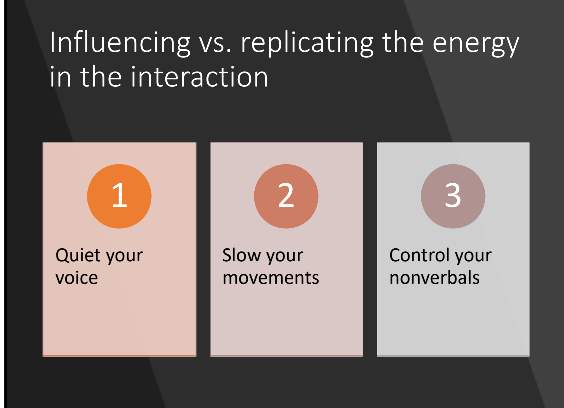

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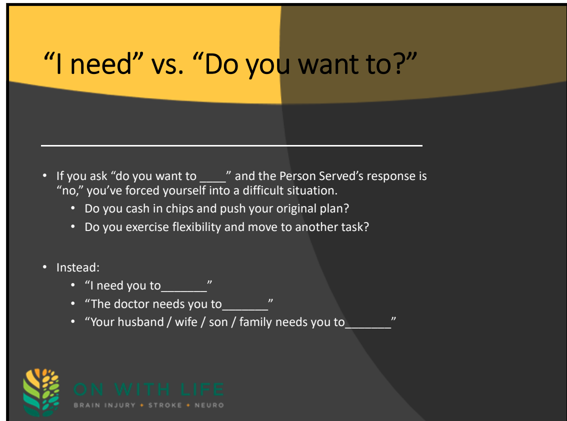

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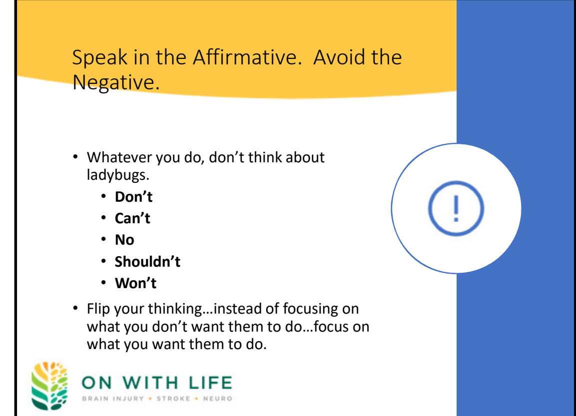

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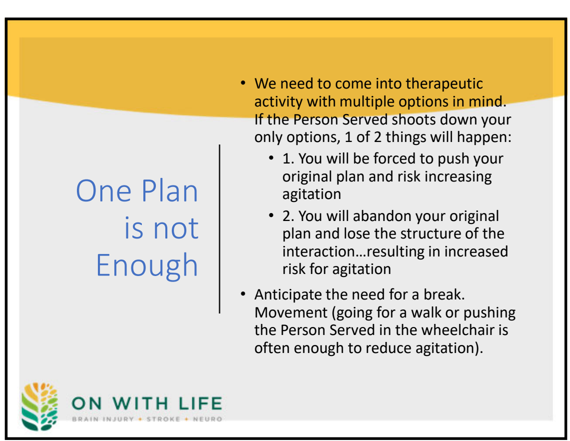

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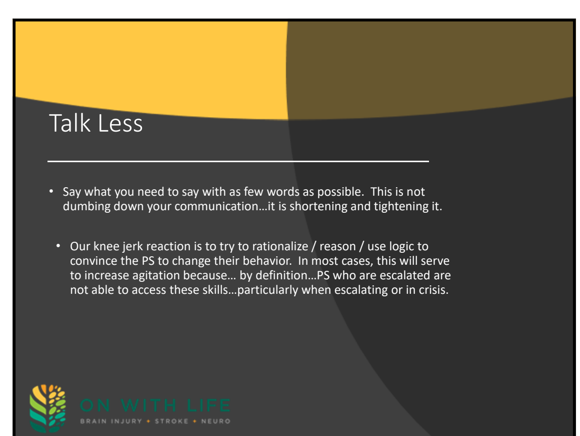

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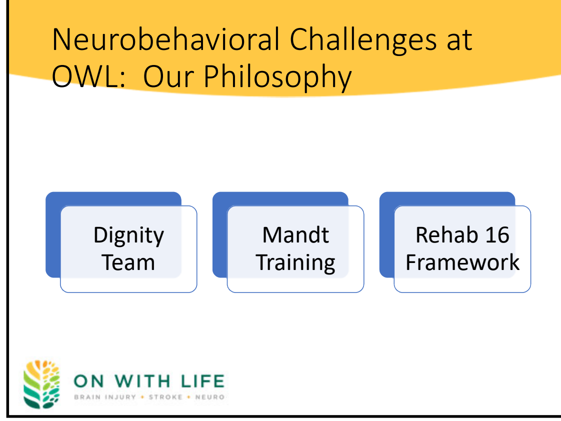

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Neurobehavioral Challenges at OWL: The Dignity Team

Members:

- CNAs
- Clinical Counselor
- Clinical Director
- Neuropsychologist
- Person Served Care Coordinator
- Physician's Assistant
- Social Worker
- Therapists (OT/PT/SLP)
- Others as warranted

The Process:

- Meet at least weekly to collaborate regarding neurobehavioral challenges
- Mixture of what is seen on nursing end, in therapy, and reported in individual sessions
- Create / modify a dignity plan that is then disseminated to all therapists and nursing staff

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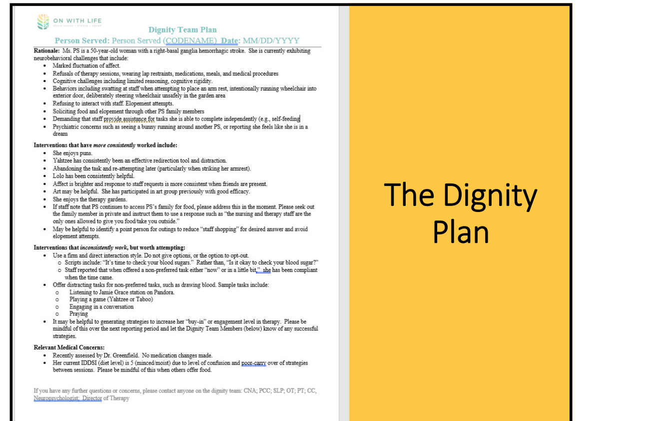

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Dignity Team Plan

Person Served: Person Served (CODENAME) **Date:** MM/DD/YYYY

Rationale: Ms. PS is a 50-year-old woman with a right-basal ganglia hemorrhagic stroke. She is currently exhibiting neurobehavioral challenges that include:

- Marked fluctuation of affect.
- Refusals of therapy sessions, wearing lap restraints, medications, meals, and medical procedures
- Cognitive challenges including limited reasoning, cognitive rigidity.
- Behaviors including swatting at staff when attempting to place an arm rest, intentionally running wheelchair into exterior door, deliberately steering wheelchair unsafely in the garden area
- Refusing to interact with staff. Elopement attempts.
- Soliciting food and elopement through other PS family members
- Demanding that staff provide assistance for tasks she is able to complete independently (e.g., self-feeding
- Psychiatric concerns such as seeing a bunny running around another PS, or reporting she feels like she is in a dream

Interventions that have *more consistently* worked include:

- She enjoys puns.
- Yahtzee has consistently been an effective redirection tool and distraction.
- Abandoning the task and re-attempting later (particularly when striking her armrest).
- Lolo has been consistently helpful.
- Affect is brighter and response to staff requests is more consistent when friends are present.
- Art may be helpful. She has participated in art group previously with good efficacy.
- She enjoys the therapy gardens.
- If staff note that PS continues to access PS's family for food, please address this in the moment. Please seek out the family member in private and instruct them to use a response such as "the nursing and therapy staff are the only ones allowed to give you food/take you outside."
- May be helpful to identify a point person for outings to reduce "staff shopping" for desired answer and avoid elopement attempts.

Interventions that *inconsistently work*, but worth attempting:

- Use a firm and direct interaction style. Do not give options, or the option to opt-out.
  - Scripts include: "It's time to check your blood sugars." Rather than, "Is it okay to check your blood sugar?"
  - Staff reported that when offered a non-preferred task either "now" or in a little bit," she has been compliant when the time came.
- Offer distracting tasks for non-preferred tasks, such as drawing blood. Sample tasks include:
  - Listening to Jamie Grace station on Pandora.
  - Playing a game (Yahtzee or Taboo)
  - Engaging in a conversation
  - Praying
- It may be helpful to generating strategies to increase her "buy-in" or engagement level in therapy. Please be mindful of this over the next reporting period and let the Dignity Team Members (below) know of any successful strategies.

Relevant Medical Concerns:

- Recently assessed by Dr. Greenfield. No medication changes made.
- Her current IDDSI (diet level) is 5 (minced/moist) due to level of confusion and poor-carry over of strategies between sessions. Please be mindful of this when others offer food.

If you have any further questions or concerns, please contact anyone on the dignity team: CNA; PCC; SLP; OT; PT; CC, Neuropsychologist; Director of Therapy

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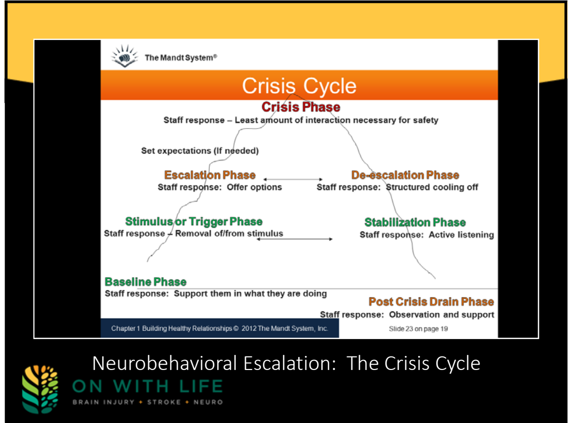

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Common Behavioral Challenges Following Brain Injury (Case Examples)

- Apathy or low activation
- Disinhibition/Impulsivity ("No filter," does things without thinking them all the way through)
- Sexually inappropriate behaviors/hypersexuality
- Agitation/Restlessness
- Aggression
- Suicidal Ideation
- Cognitive Changes
  - Perseveration
  - Memory
- Emotional dysregulation or lability
- Social Skills and perception
- Lack of awareness of challenges, or doesn't fully understand the extent of their challenges (anosognosia and anosodiaphoria)

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Case Example: Suicidal Ideation

32-year-old gentleman with a medical history significant for cerebral palsy and resultant physical limitations.

Has a significant psychiatric history that includes severe depression, anxiety, and trauma.

Presents with pervasive suicidal ideation that includes voicing these thoughts to staff, family, and calling suicidal hotline

Reduced behavioral activation and inconsistent activity refusal.

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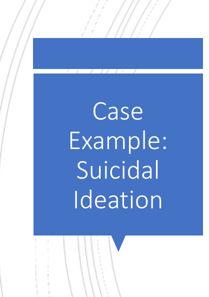

The conceptualization:

Due to the chronicity of these thoughts and through repeated evaluation, Mr. YYY does not currently appear to be an imminent risk to himself. He has voiced a plan to end his life which includes refusal of CPAP and self-removal of his enteral feeding tube. However, this plan does not place him at immediate risk of death, nor does he have the physical means to follow through on it. Mr. YYY has not acted on these thoughts in the past, and at times they appear to be incongruent with his affective and behavioral presentation. We recognize that Mr. YYY has a history of depression and anxiety that may exacerbate suicidal ideation; however, it is conceptualized through discussion and consultation with the dignity team that his suicidal thoughts are not reflective of true desires of self-harm. Given the nature of his specific presentation, it is felt that asking follow-up questions or giving increased attention to Mr. YYY after he voices these thoughts is directly reinforcing these thoughts and results in their increased prevalence. Rather, attention and reinforcement should be given to more adaptive behaviors such as activity engagement and positive thoughts about the future.

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Case Example: Suicidal Ideation

The interaction guidelines:

- Redirection
  - Alternative Behaviors (use open-ended questions and choices)
  - Remind him of the progress he has made, and continued work with his counselor
- Continue to schedule unique and personalized goals
- Conversations and interactions should remain focused on the positive including fun and engagement with others.

Interactions that are *not* currently useful:

- Refrain from using open-ended questions.
- If he is endorsing suicidal thoughts, sitting and giving it attention is not helpful. Asking follow-up questions or spending extra time with him as a result of these thoughts likely increase the prevalence.

Continue to assess for severe depression (changes in sleep, appetite, activity refusal, time in bed, voicing a specific plan).

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Case Example: Apathy & Decreased Behavioral Activation

- 50 year-old gentleman with a left MCA stroke, diabetes mellitus (uncontrolled)
- Participated in our inpatient stroke program, then moved to our RNR house for continued intervention
- While on inpatient, neuropsychological testing revealed weaknesses in processing speed (slowed), variable attention, and novel problem-solving.
- Additionally endorsed depression and anxiety
  - "I am concerned for vegetative symptoms related to depression including reduced motivation and initiation.
- No neurobehavioral challenges while an inpatient person served….. However
- Once admitted to RNR, significant apathy, lack of motivation, poor participation in anything.

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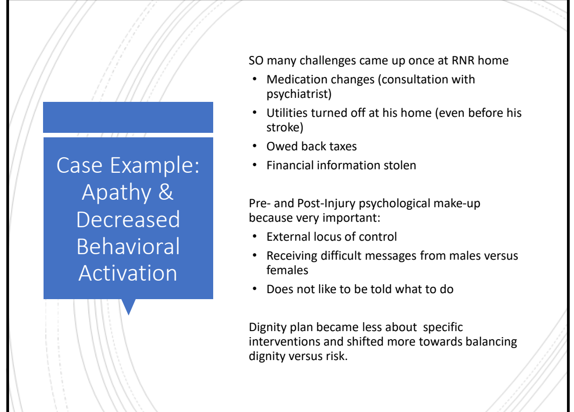

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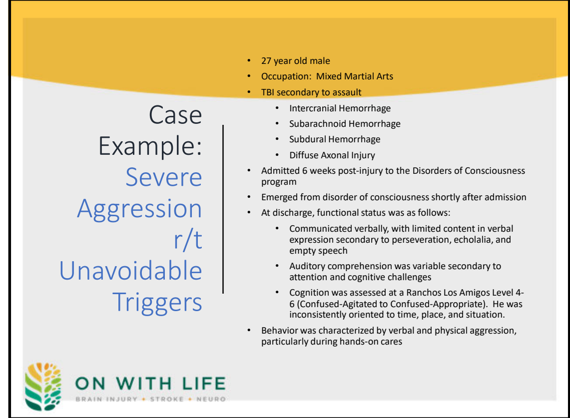

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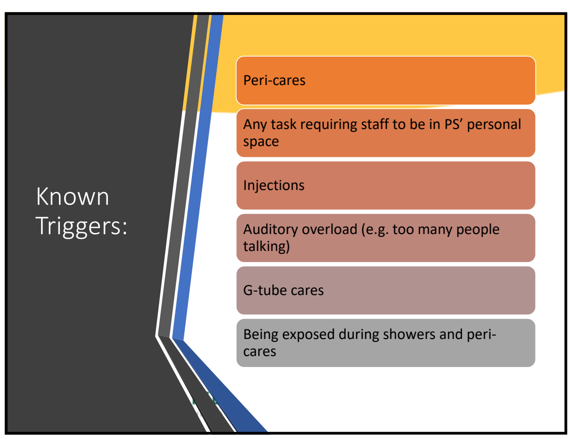

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Dignity Plan: Transfers

Transfer Instructions:

1. Make eye contact with John
2. Tell him the ultimate goal: “We are going to stand up and transfer to your ______”
3. “I’m going to tip your chair forward.” –helps to place a hand on his shoulder during tipping forward or reclining back.
4. “I’m going to remove your right leg rest, help me lift up your leg”
5. “I’m going to remove your left leg rest, help me lift up your leg”
6. Make eye contact again and show him the gait belt
7. “John, I need to put this belt around you, can you help me? Lean forward.”
8. If he doesn’t help, don’t force it. Give him the cue again to lean forward. May help to use gestures or tactile cues to show him what you want.
9. Put the gait belt on.
10. “I’m going to unbuckle your seat belt”
11. Make eye contact
12. “John I’m going to come in close to help you transfer. I want you to give me a hug”
13. Make sure both arms are wrapped around you.
14. “we are going to turn to the (right/left) and sit on your _______. Help me stand, John”
15. If he doesn’t help, don’t force it. It may take several attempts for him to kick in his legs to help (has taken up to 7 or 8 in therapy)
16. During the transfer tell him “We are turning to the (right/left) to sit on your ______”
17. Once you get to the goal area, give him a minute before starting the next step.

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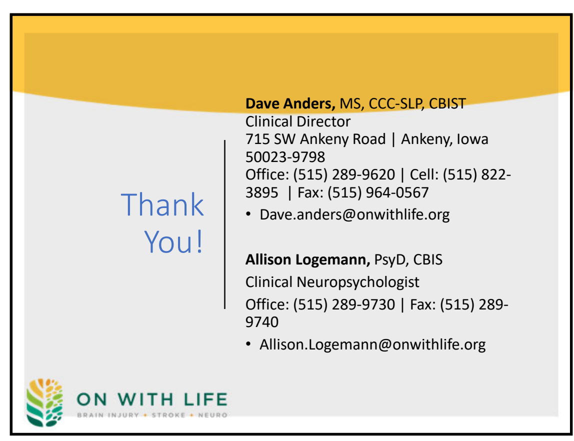

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