Person-Centered Care Decreases Agitation

Promoting choice, self-determination helps dementia patients without resorting to drugs.

BY MICHELE G. SULLIVAN

Holistic, person-centered care can reduce symptoms of agitation in dementia patients, compared with the effects of standard long-term care, a randomized controlled trial by Australian researchers indicates.

Focusing on the patient as a whole and seeking to make the most of his or her remaining abilities is also economical and easy to implement, the researchers recently reported (Lancet Neurol. 2009;8:317-25).

"Care that addresses residents' total human needs can mitigate cognitive and functional deterioration," asserted the team led by Lynn Chenoweth, Ph.D., of the University of New South Wales, Sydney.

The Caring for Aged Dementia Care Residents Study (CADRES) was composed of 289 residents living in 15 Australian long-term care facilities. All of the residents had progressive dementia with persistent behaviors that made it difficult for staff to care for them.

The facilities were randomized to three interventions: usual care, person-centered care, and dementia-care mapping, which includes person-centered care.

The researchers provided staff training in the facilities randomized to one of the experimental plans. The person-centered care training consisted of a 2-day session for two staff members of each facility, who then developed and implemented practices in their respective facilities. Training stressed that behavior is a form of communication and that feelings persist in individuals despite cognitive decline.

Trainees were encouraged to focus on "the unique way those residents express feelings and needs" and how staff actions could address individuals' preferences and needs.

Dementia-mapping care training also consisted of a 2-day session for two staff members per facility, and they, too, then helped their colleagues implement the approach.

This system of care entails observation of which care factors most affect resident behavior, either negatively or positively. Daily observations are then integrated into a person-centered care plan.

Care continued as usual at the control sites, characterized by custodial tasks, physical restraint, and "a tendency to neglect residents' psychosocial needs when meeting activities of daily living," according to the researchers. Staff at these facilities paid little attention to promoting choice and encouraging self-determination by residents with dementia, according to Dr. Chenoweth and her colleagues.

Outcome measures included the 29-item Cohen-Mansfield Agitation Inventory (CMAI), the Neuropsychiatric Inventory for the Nursing Home, and the Quality of Life in Late-Stage Dementia (QUALID) scale. Outcomes were measured at baseline, after 4 months of intervention that included telephone support by the researchers, and again 4 months after that (8 months after the start of the study).

The patients' average age at baseline was 84 years. Their average dementia score was 5.2 on the Global Deterioration Scale, indicating moderate dementia, according to the researchers.

At 4 and 8 months, agitation had increased in the control group but decreased in residents under the experimental care approaches.

The standard-care residents' CMAI scores went up 9 points on average at 4 months and 8 points at 8 months. In contrast, the agitation scores went down 6 points by the study's end (8 months) in the person-centered care recipients and by 2 points in the dementia-care mapping group.

The neuropsychiatric inventory score decreased significantly only in the person-centered care group, where it dropped a mean of almost 7 points at 4 months and another 2 points at 8 months.

There was no significant change in the quality of life scores for any group. Nor was there any indication that either experimental care approach decreased accidents, hospital admissions, drug costs, or the need for psychotropic medications.

However, the investigators noted, the dementia-care mapping group did experience a significant decrease in the number of falls, while the person-centered care and usual care groups saw increases in falls.

The costs of implementing the care programs differed significantly. The additional cost per site for dementia-mapping care was $6,654, compared with $1,492 for person-centered care. The researchers also estimated the cost per average point drop in agitation on the CMAI scale. Again, person-centered care was more economical than dementia-mapping care ($5.30 vs. $32.46, respectively).

The study affirmed previous findings that person-centered care is a valuable way to decrease agitation in dementia patients without resorting to drugs, Dr. Clive Ballard and Dr. Dag Aarsland, both of King's College, London, wrote in an editorial accompanying the report.

They added that the study also provided valuable information about the usefulness of dementia-mapping care, which had not been fully investigated.

The commenters offered a few caveats about the CADRES study, saying that any intervention can result in nonspecific benefits when compared with standard care.

Also, the study period was too short to fully determine the possible benefit of each intervention, wrote Dr. Ballard and Dr. Aarsland.

"Despite the caveats, CADRES is of major importance in showing the value of dementia-care mapping as an effective approach to reducing agitation in care-home residents with dementia," they said.

"Further research should build on this finding to develop an intervention that can improve other neuropsychiatric symptoms, reduce inappropriate prescribing of psychotropic drugs, and hopefully lead to direct improvement in the quality of life of care-home residents." ■

Oldest in LTC Less Likely to Have Serious Mental Illness

BY MIRIAM E. TUCKER

NATIONAL HARBOR, MD. — Long-term care residents aged 85 and older are less likely than younger residents to have a serious mental illness, more likely to have dementia, and equally likely to have depression or anxiety.

Up to 80% of long-term care (LTC) residents have diagnosable neuropsychiatric disorders, including dementia, according to an analysis of data from the 2004 National Nursing Home Survey.

The new findings are among the first detailing the rates of these disorders among the "oldest old" population now making up the fastest-growing segment of the over-65 age group and disproportionately represented in nursing homes.

"As a rapidly growing subpopulation, the oldest old in LTC have what appear to be distinct characteristics relative to other age groups, and these no doubt affect their care," Catherine A. Yeager, Ph.D., and her associates said in a poster presented at the annual meeting of the Gerontological Society of America.

The 2004 National Nursing Home Survey, conducted between August and December 2004, is one in a series of nationally representative sample surveys of U.S. nursing homes conducted by the Centers for Disease Control and Prevention. A total of 1,174 nursing home facilities participated, producing data for 1,317,300 residents.

The population included 674,500 persons aged 85 and older. The survey data show "a few notable exceptions" to expected patterns of frailty and disability with age, said Dr. Yeager, of Robert Wood Johnson Medical School, Piscataway, N.J., and her associates.

The 85-plus group was more female (82%), more white (90%), and more likely to be widowed (72%) than were either the aged 75-84 or 65-74 groups.

Of the 674,500 oldest old population, 17,300 had lived 100 years or more.

Only small proportions of all residents had neuropsychiatric diagnoses at the time they were admitted to LTC: 10% with dementia, 2% with schizophrenia spectrum, 0.3% with bipolar disorder, 0.2% with depressive disorder, and 0.2% with anxiety.

However, neuropsychiatric diagnoses increased in all groups. At the time of the survey, depressive disorders were present in 35% of the oldest old, not significantly different from the 36% among the 75- to 84-year-old group and 32% of the 65- to 74-year-old individuals.

Neither did rates of anxiety disorders differ by age, occurring in 12% of both the 85-plus and aged 75-84 groups, and 11% of the aged 65-74-group, according to the survey.

However, the oldest old were less likely than the two younger groups to have been diagnosed with a serious mental illness, including schizophrenia spectrum disorder (8.5% in 85-plus group, 13% in 75-84 group, and 17% in 65-74 group) and bipolar spectrum (1.2%, 2.3%, and 3.2%, respectively).

In the 85-plus age group, 8.5% had been diagnosed with a serious mental illness, compared with 13% and 17% in the two younger age groups.

Conversely, both the 85-plus and 75-84 groups were more likely than the 65- to 74-year-olds to have dementia (22% in the older groups vs. 13% in the youngest group).

In all three age groups—and especially among the oldest old—the survey found more clinical indicators of dementia and depression than formal diagnoses had indicated.

The researchers reported moderate to severe impairment in decision making, an indicator of dementia, in 55% of the oldest old, 34% of the 75- to 84-year-olds, and 11% of the youngest group. Likewise, the proportions with "low mood not easily altered," a proxy for depressive disorder, were 49%, 37.5%, and 14%, respectively.

Once in the LTC, all groups show an increased prevalence of formal neuropsychiatric conditions," reported the group led by Dr. Yeager, who also works in the Essex County Hospital Medical Center, Cedar Grove, N.J. ■