Antipsychotic Alternatives

The following information suggests ideas for reducing antipsychotic drug use. A carefully monitored use of the alternatives with frequent reassessment is suggested. Always start by assessing the resident for pain*.

General Principles

- Start with a pain assessment.
- Provide for a sense of security.
- Apply the 5 Magic Tools (Knowing what the resident likes to See, Smell, Touch, Taste, Hear).
- Get to know the resident, including their history and family life, and what they previously enjoyed. Learn the resident's life story. Help the resident create a memory box.
- Play to the resident's strengths.
- Encourage independence.
- Use pets, children and volunteers.
- Involve the family by giving them a task to support the resident.
- Use a validated pain assessment tool to assure non-verbal pain is addressed.*
- Provide consistent caregivers.
- Screen for depression & possible interventions.
- Reduce noise (paging, alarms, TV's, etc.).
- Be calm and self-assured.
- Attempt to identify triggering events that stimulate behaviors.
- Employ distraction methods based upon their work and career.
- Offer choices.

Behaviors = Unmet Needs.

What to try when the resident resists care

Therapeutic Intervention

- Evaluate recent medication changes, especially if the behavior is new.
- Determine if the resident is in pain, and if so, why? Treat the pain.*
- Evaluate whether the care can be performed at a different time.
- Determine if the resident is trying to communicate a specific need.
- Evaluate the resident's sleep patterns.
- Place the resident in bed when he or she is fatigued.
- Evaluate if there has been a change in the resident's routine.
- Provide a positive distraction, or something the resident enjoys.
- Is the resident hungry? Offer the resident a snack prior to providing care.
- Provide a periodic exercise program throughout the day (e.g. A walk to dine program).
- Encourage wheelchair/chair pushups, or assist the resident to stand periodically.
- Provide activities to assess and provide entertainment.
- Encourage repositioning frequently.

Environmental & Equipment Intervention

- Use assistive devices (~~wedge cushion,~~ solid seat for wheelchair, side or trunk bolsters, ~~pommel cushion~~, Dycem, etc.).
- Evaluate the resident for an appropriate size chair and proper fit.
- Evaluate alternative seating to relieve routine seating pressure/pain.
- Use an overstuffed chair, reclining wheelchair, non-wheeled chairs, or wingback chair.
- Place a call bell in reach of the resident.
- Provide an over-bed table for to allow for diversional activities.
- Place a water pitcher in reach of the resident.
- Place the resident's favorite items in their room to provide them comfort.
- Allow access to personal items that remind the resident of their family, especially photos.
- Encourage routine family visits with pets.
- Provide consistent caregivers.
- Evaluate if the resident's environment can be modified to better meet their needs. (i.e. Determine if the resident's environment can be more personalized.)

* A pain assessment should include non-verbal signs of pain. If you do not have a pain assessment that includes non-verbal identifiers, go to: http://www.dads.state.tx.us/qualitymatters/qcp/pain/painad.pdf PAIN AD, WONG SCALE

Continued →

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Verbally Abusive/Physically Abusive

Therapeutic Intervention

- Begin with medical evaluation to rule out physical or medication problems.
- Evaluate the resident for acute medical conditions such as urinary tract infections, upper respiratory infections, ear infections or other infections.
- Evaluate the resident for pain, comfort and/or other physical needs such as hunger, thirst, position changes, bowel and bladder urges.
- Attempt to identify triggering events or issues that stimulate the behavior.
- Consider using a behavior tracking form to assist in identification of triggers and trending patterns.
- Consult with the resident's family regarding past coping mechanisms that proved effective during times of increased stress levels.
- Provide companionship.
- Validate feelings such as saying, You sound like you are angry.
- Redirect.
- Employ active listening skills and address potential issues identified.
- Set limits.
- Develop trust by assigning consistent caregivers whenever possible.
- Avoid confrontation. Decrease you voice level.
- Provide a sense of safety by approaching in a calm/quiet demeanor.
- Provide rest periods.
- Provide social services referral if needed.
- Provide a psychologist/psychiatrist referral if needed.
- Provide touch therapy and/or massage therapy on the hands or back.
- Reduce external stimuli (overhead paging, TV, radio noise, etc.).
- Evaluate staffing patterns and trends.
- Evaluate sleep/wake patterns.
- Maintain a regular schedule.
- Limit caffeine.
- Avoid sensory overload.

Environmental & Equipment Intervention

- Use relaxation techniques (i.e. tapes, videos, music etc.).
- Help the resident create theme/memory/reminiscence boxes/books.
- Help the resident create a magnification box to create awareness of the resident's voice level and provide feedback.
- Use a lava lamp, soothe sounders, and active mobile.
- Play tapes and videos of family and/or familiar relatives or friends.
- Move to a quiet area, possibly a more familiar area, if needed. Decrease external stimuli.
- Use fish tanks.
- Encourage family visits, and visits from favorite pets.
- Identify if another resident is a trigger for this behavior.

Pacing/ Wandering At Risk for Elopement

Therapeutic Intervention

- Find ways to meet a resident's needs to be needed, loved and busy while being sensitive to their personal space.
- Provide diverse activities that correspond with past lifestyles/preferences.
- Consider how medications, diagnoses, Activites of Daily Living schedule, weather or how other residents affect wandering.
- Evaluate the need for a Day Treatment Program for targeted residents.
- Help resident create theme/memory/reminiscence boxes.
- Provide companionship.
- Provide opportunities for exercise particularly when waiting.
- Pre-meal activities.
- Singing, rhythmic movements, dancing, etc.
- Identify customary routines and allow for preferences.
- Help the resident create a photo collage or album of memorable events.
- Provide structured, high-energy activities and subsequent relaxation activities.
- Take the resident for a walk.
- Provide distraction and redirection.
- Provide written/verbal reassurance about where he/she is and why.
- Alleviate fears.
- Ask permission before you touch, hug etc.
- Assess/evaluate if there is a pattern in the pacing or wandering.
- Assess for resident' personal agenda and validate behaviors.
- Ask family to record reassuring messages on tape.
- Evaluate for a restorative program.
- Perform a physical workup.

Environmental & Equipment Intervention

- Remove objects that remind the patient/resident of going home (hats, coats, etc.).
- Individualize the environment. Make the environment like the resident's home. Place objects within the environment that are familiar to the resident.
- Place a large numerical clock at the resident's bedside to provide orientation to time of day as it relates to customary routines.
- Ensure the courtyard is safe for the resident.
- Decrease noise level (especially overhead paging).
- Evaluate floor patterns.
- Evaluate rest areas in halls.
- Evaluate camouflaging of doors.
- Evaluate visual cues to identify safe areas.
- Play a favorite movie or video.
- Put unbreakable or plastic mirrors at exits.
- Place Stop and Go signs.
- Evaluate the WanderGuard system.
- Use relaxation tapes.
- Evaluate and use, as necessary, visual barriers and murals.
- Evaluate wandering paths.
- Evaluate room identifiers.

What to consider when resident is disruptive in group functions

Therapeutic Intervention

- Evaluate new medications, antibiotics especially, and asses pain.
- Remove resident from group, evaluate for group stress
- Determine if resident requires toileting.
- Determine if resident is hungry, and if so, provide them with a small snack. If the resident is thirsty, provide the resident a beverage.
- If this is a new behavior in a group, evaluate what is different this time.
- Assure resident has had a rest period prior to group activity.
- Assure there are no medical complications (low/high blood sugar).
- Assure resident is not in pain.*
- Return resident to group function, if possible.

Environmental & Equipment Intervention

- Determine whether clothing is appropriate for a particular function.
- Evaluate is the resident has well-fitting shoes, and ensure they do not rub the resident's feet.
- Evaluate ambulation devices (wheelchair, walker) that are in good working condition.
- Ensure there is adequate lighting, especially at night.
- Ensure room/function is not overly crowded.
- Ensure room is not too warm or cold.
- Consider providing snacks and refreshments for all group functions.
- Ensure sound in group functions is loud enough so the resident can hear.
- Provide consistent caregivers.
- Evaluate if this program fits into the resident's area of interest.

What to consider with a sudden mood change, such as depression

Therapeutic Intervention

- Evaluate any new medications and assess pain*.
- Evaluate for orthostatic hypotension and change positions slowly.
- Reevaluate physical needs such as toileting, comfort, pain, thirst and timing of needs.
- Rule out medical problem (high/low blood sugar changes).
- Engage resident in conversation about their favorite activity, positive experiences, pets, etc.
- Touch if appropriate while recognizing personal body space.
- Anticipate customary schedules and accommodate personal preferences.
- Evaluate balance for sub-clinical disturbances such as inner ear infections.
- Validate feelings and mobilize the resident. For instance, if the resident states, I want to get up, reply, You want to get up? to confirm you heard them correctly. If so, act on the resident's request.
- Evaluate hearing and vision.
- Discern if talk therapy is possible.
- Assess sleep patterns.

Environmental & Equipment Intervention

- Assess for changes in the resident's environment.
- Assess for changes in the resident's equipment.
- Involve family members to assure them that there have been no changes within the family, without the facility's knowledge.
- Provide routines for consistency.
- Provide consistent caregivers.
- Provide nightlights for security.
- Employ the use of a memory box.
- Employ functional maintenance / 24-hour plan.
- Encourage the resident, if able, to verbalize his or her feelings.
- Eliminate noise and disruption.
- Employ the use of a sensory room or tranquility room.

Continued →

Resident Information Summary

How does resident prefer to be addressed by staff? ______________________________

Resident-preferred activities before admission:

____

Favorite foods: ____

Any food allergies or special diet?____

Dislikes in foods:____

Favorite beverages:____

Dislikes in beverages:____

Former occupations:____

Where was resident born?

____

Native language, 2nd language____

What is resident faith, if any:

____

Shower time preference: ____

Important health condition history:____

____

Important medications/side effects:

1.____

2.____

3.____

Who are the family members? What are their names and who comes to visit?

1. ____
2. ____
3. ____
4. ____

- To be filled out by staff, resident or family/friends/significant others

Resident Information Summary

How does resident prepare for bed? ____
What are the resident sleep patterns and moods? ___________________________________
____

Is resident using any incontinence items? Name of product/s: ______________________
____

Any visual, hearing or ambulatory devices used before admission?
____

Any skin breakdown in last year? ____

Any falls in the last year? Any injury? ____________________________________

Does resident have pain history (acute or chronic?) __________________________
____

What helps their pain? ____

How does resident prefer to take their medication? __________________________

Does resident receive any Hospice services? _______________________________

History of oxygen use (how often, how many liters, name of current 02 company?)
____

Does resident need assistance with ambulation? ____________________________

When irritated, what calms the resident? _________________________________

What triggers resident behaviors? _____________________________________
____

Please give the staff two suggestions that would make the resident happy during their stay:

1. ____

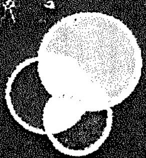
2. ____

- To be filled out by staff, resident or family/friends/significant others

Resident Information Summary

Additional/changes:

- To be filled out by staff, resident or family/friends/significant others



Trauma Informed Care
Person Centered Care Plan Example #1

Problem/Strengths	Goal	Intervention	Who/Date
• I recently lost my husband of 45 years and had to move into Salem Manor. I am having problems with my memory. • "I feel a bit lost." • I have great family support and a good sense of humor. • Admission date: October 20, 2018 • Own decision maker	My goals are to: • Adjust to living at Salem Manor the "best I can" as indicated by statements of not feeling lonely, no weight loss, attending two activities per week, no crying. • Attend church services at Salem United Church of Christ twice per month. • Participate in two activities every week (music, card games and Bingo are my favorites). • Participate in my Women's Circle monthly meeting at Salem United Church of Christ. • I would like my Pastor to visit monthly. • I want my family to take me to visit my husband's grave once a month.	• My daughter will bring in some important things from home that remind me of my home, my husband and our children (photo album, my husband's favorite reclining chair, a plant and the quilt I made.) • My niece will help get me to church services on Sunday at my church at least twice a month. I need your help to be dressed and ready to go by 9:00 am. • I would like my minister or someone from my church to visit me at least once a month.	Daughter/Social Services October 22, 2018 CNA's Resident's family to determine schedule and communicate to facility (November 1, 2018) (Ongoing) Nursing determine any medication schedule changes and provide medications to family to administer if needed. SS to contact church and make requests (November 1, 2018)

		• One of my "Circle" friends will come and pick me up every month. I need to be ready to go and have my medicine. We meet every third Thursday at 3:00 pm. • Assist me to the activities of my choice twice a week and introduce me to women I might enjoy meeting and who like the things I do. • I need you to help me remember where the dining room, my room and activities are and help me get there if I need it. • Monitor and track symptoms of grief/adjustment (crying, social isolation, loss of appetite, weight loss, statements of loneliness)	CNA's/Nursing (November 15, 2018 and Ongoing) Activity and CNA staff to make introductions (November 15, 2018 and Ongoing) Activities Staff/CNAs (October 21, 2018 and Ongoing) SS/Nursing/CNA

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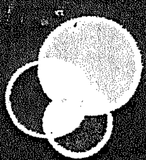

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Trauma Informed Care
Person Centered Care Plan Example #2

Problem/Strengths	Goal	Intervention	Who/Date
• I saw combat in Vietnam and have bad dreams and sometimes I have flashbacks. I tend to rely on alcohol daily to cope. It helps me deal with those things! • I do not like to be told what to do and I do not like crowds of people or loud noises. • I have some VA friends I am close too. We support each other and get together weekly to play cards. I want to keep doing that while I am here. • Admission Date October 20, 2018	My goals are to: • I want to work hard to get out of here and go back to my apartment as soon as I can by participating in Physical Therapy/Occupational Therapy (PT/OT) as scheduled. • I agree to try and develop three coping strategies per month to help deal with my flashbacks. • I want to drink three beers every day while I am here. • I want to stay in touch with my VA friends – we like to drink beer and play cards at least once a week.	• Resident has agreed to PT/OT to build strength and endurance. PT/OT will work with him to set up daily appointments. • Resident has agreed to allow us to connect with the VA about possible equipment options for him and his apartment to assist with discharge home. • Discuss alcohol use with provider and secure order for beer. Resident agrees that nursing can keep the beer in the med room and he can ask for up to three daily. • Track alcohol intake daily.	PT/OT to set up schedule with by October 21, 2018 Social Services (SS) by no later than October 219, 2018 SS/Nursing to complete initial assessment by October 24, 2018 Nursing by October 22, 2018. Nursing will monitor daily and ongoing. Nursing/SS/Ongoing SS/Nursing/Ongoing

		• Risk/benefit for alcohol use will be reviewed quarterly and as needed with changes to requests for alcoholic beverages. • Review alcohol intake monthly with resident. • The IDT will track for any unsafe behavior, such as (accidents, including falls, reports from residents/staff/visitors such as inappropriate remarks, verbal/physical aggression), discuss with resident, and report to the provider if it occurs. • Activities will establish a time, and place for the weekly card games. • Resident agrees that is ok to share with any staff that he has occasional flashbacks triggered by loud noises, bright lights. It is best to leave him alone during these times. He has never hurt anyone.	SS/Nursing/Ongoing SS/IDT/Nursing/CNA/ Administration/Ongoing Activities by October 23, 2018. Nursing/SS/Activities will monitor ongoing. SS will communicate this to nursing staff/other staff as appropriate by October 23, 2018 and monitor ongoing.

Trauma Informed Care
Person Centered Care Plan Example #3

Problem/Strengths	Goal	Intervention	Who/Date
• I have bipolar disease. I have been very depressed and have been living in a bad situation for a long time. My spouse has a bad temper! "He blames me for everything!" "I can't do anything right!" • My strength is my willingness to make changes to improve my life, even though it is scary! • Admission date November 1, 2018 • Own decision maker	My goals are to: • I want to get my bipolar disorder under better control so I can enjoy life as indicated by taking medications, following my plan of care, not socially isolating myself, sleeping six hours per night, avoiding statements of worthlessness and finding alternative coping strategies. • I have two grandchildren I really want to be able to enjoy them. I would like them to visit once a month. • I want to work with Social Services to identify two coping strategies per month to help with my depression, feelings of worthlessness and feeling afraid.	• Review medications with resident and get input on medication history – what worked, what has not, side effects • Review medications with provider and pharmacy for interactions • Monitor and track targeted symptoms (crying, social isolation, insomnia, statements of worthlessness, feelings of being afraid) • Discuss opportunities for non-pharmacological approaches that would assist her to feel safe and lesson depressive symptoms (hobbies, music, visits from grandchildren, meditation, counseling, etc.)	Nursing by November 5, 2018. Nursing November 22, 2018 and then ongoing Social Services/Nursing/ CNA/ongoing Social Services/Nursing/ Activities/Ongoing

	• I need a break from my husband until I can figure things out. I really do not want him to visit or call me! • I want to make as many of my own choices here as I can. I do not want to be told what to do! • I just want live in a nice place without being afraid.	• Identify other friends/family that she feels safe/comfortable with. Assist as needed in making contact for visitation • Social Services has informed husband that resident prefers he not visit her or have any other contact with her at this time. • Social Services communicate to IDT that she does not want her husband to visit, attend CP meetings or have any information about her while she is here. Document and share plan with appropriate staff. • Track the husband's attempts to contact daily (telephone, visits, written) • If the husband visits do the following: o Notify Charge Nurse o Notify Social Services o Social Services will meet with the resident and review the visitation request	November 1, 2018 November 1, 2018 SS/IDT communicate to appropriate staff November 1, 2018 SS/Nursing/CNA/ongoing SS/IDT/Nursing/CNA November 1, 2018 Ongoing

		◦ Social Services will contact the husband to discuss the resident's wishes and update him regarding her wishes. ◦ Social Services will update IDT and document current plan • Follow a consistent plan for all cares and provide her with copy so she knows what to expect. If changes need to occur, provide an explanation and allow as much opportunity for choice as possible • Determine if resident is safe to return home and opportunities for community referrals/resources. (See Discharge Care Plan)	Ongoing SS/IDT November 2, 2018/Ongoing SS/Nursing Referrals as requested

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