**3-898 Best care strategies**

**TIPS Question:**

Resident is currently on Risperidone 0.5mg QAM and 1mg.QHS(reduced from 1mg.BID) and Trazodone HCL 100mg QHS. She sleeps well at night, but is also drowsy during the day, having to be awakened for meals etc. She has increased behaviours of layering clothes, increased apathy especially about her general appearance and decreased social behaviours. We are looking for our best care strategies. Is she showing signs of increased depression?

**What are the significant factors you have learned as a result of working through the six-question template?**

- A previous head CT (2001) showed chronic subdural hematomas or hygroma, microangiopathic disease and ventriculomegaly. New CT results are pending.
- She has hypothyroidism treated with 0.1 mg. Eltroxin OD, hypertension treated with Altace 5mg. OD and ECASA 325mg. OD.
- Recent blood work showed a B12 deficiency which treated with a loading dose of B12 and now on 100mcg. Monthly. She also has lymphopenia of unknown origin.
- She scored low 13/30 on the MMSE and has shown a recent decline in social behaviours (talking nasty to table-mates in DR) and sleeps upside down on her bed for much of the day.

**Response:**

It is great that you have flagged the change in this resident's condition and behaviour as a concern; i.e. increased drowsiness, lethargy, layering of clothing, decreased self-awareness and poor appreciation for how her social interactions affect others.

Before considering what are the best strategies for care, I always find it helpful to take a step back and reflect on where we are at in the assessment process. What do we know about the resident and what information do we still need to gather? At this point you will want to ask yourselves as a Team, have we answered the first five questions in the P.I.E.C.E.S. Template?

1. **Have we articulated the concerns and identified the changes in behaviours so that everyone on the team is working from the same start point?** Does everyone agree that it is a concern; who has observed what, when, etc? This is important as it will help to focus team observations, identify possible causes and allow for meaningful monitoring of change in response to whatever care strategies you implement. Are we missing anything? When did the changes emerge, and are they completely new or an exacerbation of existing problems? Perhaps at a care conference you would want to reflect as a team on what the issues are at present, what you know to this point and what questions are yet to be answered. Then hopefully you can move forward together with a step-by-step plan.
2. **Who is it affecting?** It is great that you have identified the concerns about the well being of the resident; are there other residents/staff or the family who are also being affected by the changes in this person's behaviour? This is a good opportunity to ask the question, who is currently involved in the process of assessing the resident's physical and cognitive/mental health, and in the care planning? Who has something to bring to the understanding of the resident's needs and possible interventions that is not involved? Remember to think about how the front line care providers are currently engaged in the dialogue and what information/strategies they have to offer and what opportunities exist for them to contribute. This is a good time to use the U-FIRST wheel to stimulate and focus discussion, and identify the questions that are unanswered. The goal of course is to problem solve together in an effort to understand what the changes in the resident might mean, and the possible cause
3. **Assessing the possible risk** (to the resident and others) associated with the changes in the resident's physical condition, cognitive status and behaviour is always important. Remember to use the RISK acronym e.g. you have not identified roaming/ wandering as an issue but it sounds as though the resident may have become at risk physically – how imminent is the risk, is she eating, is she at risk of falling due to drowsiness, etc? Again, the observations of all the team will be important.

**4. and 5**. What are the possible causes and what tools have been used to try and understand and describe/record concerns related to the resident's physical condition, cognitive status and behaviour? For example, have you used the DOS to capture the behaviour such as how much time the resident is asleep or drowsy, whether she is eating, if there are specific behavioural concerns, etc. This will help you to engage the front line care providers and capture their observations, and also allow you to monitor for change as you implement whatever care strategies, medication changes, etc, are considered appropriate.

Remember to think P.I.E.C.E.S. as you are trying to understand the possible causes and use the U-FIRST wheel with staff to engage their thoughts and focus their observations and the reporting of those observations to the team. For example, this resident has a number of **P**hysical issues - think about the 4 Ds; disease, drugs, delirium, discomfort. Has a delirium been ruled out; use the CAM to help identify those questions that assess for a possible delirium? e.g. fluctuation, acute onset, confusion, etc. Again, it will help to focus the observations of the team and the reporting back of those observations. Review the medications and why is she receiving them, when they were started, possible S/Es, etc.

I won't review all of the other parts of the P.I.E.C.E.S. but certainly you have considered a possible depression (**E**motional). You mention an increased depression; does she have a history of depression? No doubt you will be trying to ensure that you have ruled out all possible underlying physical causes since her drowsiness, etc could be related to physical illness, drugs, etc. If you are concerned about a mood disorder either as a primary or secondary problem, what about using SIGECAPS to help focus and gather observations from staff about her mood, energy, appetite, etc? Have you considered using the Cornell?

It is great that you have administered the MMSE to help understand her **I**ntellectual abilities. I am not clear from your description whether this resident has an identified dementia. Certainly she has significant cognitive difficulties and if she has not had a dementia work-up this needs to be undertaken. Is her apathy, decreased self- awareness, lack of concern about her personal appearance and how her behaviour affects others related to a depression, and/or a dementia; either existing (and possibly made worse by physical problems) or a dementia not yet diagnosed? Are her behaviours related to impairment in her executive functions due to frontal lobe damage? When considering whether her behaviours are due to a dementia and possibly specific problems related to her executive functions, remember to review the brain and behaviour section in your P.I.E.C.E.S. Resource Guide pages 53-65. This will help with identifying care strategies and also help you to engage the other staff in the understanding and problem solving.

Finally, the information you and your team collect by revisiting the above questions is what forms the basis for answering the last question; what are the best care strategies? Unfortunately, without knowing all of the information about the resident and what assessment has been undertaken to date, I cannot meaningfully advise as to what specific care strategies should be used. However, the answers to the above questions will help take you where you need to go in a step-by-step manner. Don't hesitate to ask your Psychogeriatric Resource Consultant and/or Psychiatry Outreach Team to share in the problem solving. If the problems are primarily related to a dementia then together you can develop the most supportive care strategies and decide on the most meaningfully way of interacting.

***Please note:*** *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*