3-671 Family refusing antipsychotic meds

TIPS Question:

A 72-year old resident with Alzheimer Disease had been transferred to our unit over a month ago. Resident very resistive to care, striking out at staff, confused, disoriented, restless, pacing and agitated. Behaviour recorded using D.O.S. and CMAI. Behaviour log presented to MD and family members for possible use of antipsychotics. However, family members refused use of new medications stating that resident didn't have problem behaviour when staying with family members. Besides educating family re: Alzheimer Disease process, are there any other recommendations you can suggest to help family members understand the situation better?

Response:

This sounds like a common, yet difficult situation. It is very difficult for staff to watch families make, what we feel is, a wrong decision concerning their loved ones, in this case not 'allowing' antipsychotic medication to lower her agitation and anxiety. It was situations such as this that prompted us to collaborate with other Partners in Care and put together a resource section on family interactions and tips for effective family meetings (P.I.E.C.E.S. resource manual). Family members have their own values, beliefs, attitudes, communication and interaction patterns that affect care of the resident. Sometimes, unpopular decisions are made by a family member. Members of the care team must help each other and others demonstrate sensitivity and respect for the individuality of the resident and families. This can be done by working through the four question Partners in Care template. If you consider this family member's situation through the use of this template, it helps staff understand families' behaviours and uncover potential interventions.

1. **Expectations**: What are the expectations of this family in relation to the needs of the resident?

    a) It would be interesting to know the families' interpretations of this resident's behaviours. You have already identified that there is a need to help the family better understand the behaviours and Alzheimer Disease. This family appears to truly believe that the resident's behaviours do not need to be this challenging, since these behaviours were not present at home. Work with this belief, don't challenge it. Agree that the resident did not have these behaviours at home. The rest of this template needs to be completed to give ideas on *how* to offer education and support.

    b) What do you know about the family? The P.I.E.C.E.S. model can be used from the perspective of the family member and is a useful guide when getting to know the family.

        P: **physical** health of the caregiver – substance abuse, diseases (Poor sleep? Health worries? Fatigued from demands from rest of family members?)

        I: intellectual capacity and behaviour of the caregiver- cognitive impairment and ability to understand and appreciate issues (what education and experience does the family have regarding this resident's situation?)

        E: **emotional** health of the caregiver-longstanding unresolved relationship issues which tend to worsen in times of stress, history of abuse in family, feelings of depression, anger, guilt about the placement process, mental illness (Family members may have their own mental health concerns e.g. "emotional baggage" from previous experiences. Are they dealing with grief?)

        C: functional **capability** of the caregiver (do they feel capable of helping with care? Are they feeling overwhelmed?)

        E: **environmental** factors affecting the caregiver (what is the physical environment like where the family visits? Is it noisy? Chaotic? Odour-free?)

        S: **social support**, within, and outside of, the family, communication about their roles and expectations (Does this family member feel supported by the rest of the family or staff? Is he/she clear about their role and expectation in the facility during visits? Are there conflicts at home between children/spouse/siblings/parent?)

    Some of these questions may be too personal to ask, but it is important to consider these factors when regarding the families' behaviours and looking for methods to support them.

c) The family has a right to act differently than what the team considers "normal" and still be respected; this includes inaction or unpopular decisions.

2. **Strengths, Contributions & Opportunities:** What are the strengths, contributions, and opportunities for collaboration as a result of bringing people together to plan care?

   a) Learn about the strengths and opportunities of the family members. Identify opportunities that exist for collaboration and maximizing their involvement. Develop strategies to reinforce positive interactions, e.g. verbal feedback, updated notes, and regularly scheduled brief 'update' phone calls.

   b) Family members have their own problem-solving methods. When problem-solving methods do not work, people often try harder by doing more of the same thing. Families under stress tend to use the same approach even if it creates conflict, often because they do not know how to respond differently. Think about this family in this context.
   c) Staff understanding and tolerance is necessary for problem solving around issues such as this because their own strategies may be different from other staff members, as well as the families'.

3. **Communication**: How should people communicate care needs, strategies, and care plan improvements/adjustments?
   a) We all think we communicate well. However, when things break down, it's usually due to poor communication. Assumptions are often made that people know and understand information when, in fact, they do not. Therefore, communication requires constant monitoring and procedures to ensure that assumptions are corrected. Think about what assumptions this family may be working under. It is great that you already filled out the DOS and CMAI. These tools would help considerably because they are objective, clear 'proof' of challenging behaviours. Think of these forms as just *part* of your communication. Don't put too much value on them and then not understand why families can't believe the tools. Families are not used to reading and using tools. They may not understand how truly objective the DOS can be. Look for other ways that you can communicate to family that there is an issue with behaviours.

   b) Ask the family to suggest other methods for sharing information; sometimes conferences may not be possible to attend. Also, families sometimes feel out-numbered and cornered in a conference. They may feel they are trying to protect their loved one and they feel staff are trying to 'drug' them to make their jobs easier.

   c) When interacting with the family, always ask yourself, "What if it were me and my family here?" How many times have you and your staff joked with each other and said that if your parent were in a facility you would be an awful daughter/son to deal with? How about telling co-workers that they 'better watch out' when you're in a facility. We do recognize that it is very difficult to be family members. I've often heard health care professionals state that they 'had no idea' what it was like to be a family member of a resident until their parent was admitted to a facility. We, as staff, have to acknowledge what a difficult position the family is in. They want to protect their family member, but yet they don't have enough knowledge of the best interventions, and they don't yet trust the system.

   d) Family and peer group or caregiver support groups have been identified as beneficial strategies to help families cope with issues of institutionalization of their relatives. Not all family members feel comfortable with this forum; perhaps 1:1 discussion would be more appropriate.

4. **Outcome**: Are people satisfied with the outcomes of resident care?
   Sample questions for family:
   a) How has your relationship or interaction with care team made a difference to the care of the resident?
   b) Do you feel that you are a valued member of the care team?
   c) How have you/are you involved in family meetings with the team?

d) What improvement suggestion to care do you have?

Sample questions for the team:

a) How much more confident do you feel working with the family as a member of your care team?
b) How are you able to be involved with the resident and family to improve a situation?
c) Has your involvement with the family helped you to develop care strategies that will preserve the resident's care?
d) What have you learned about the family that could improve care of the resident?

When you and your care team work through this Partners In Care template, there will be a better understanding by staff of how they can help the family help the resident. Whatever messages the care team wants to give the family, do it slowly and by a trusted/familiar staff member. If the family feels part of the team and is respected, then they will *slowly* hear the education and feel the support staff have to offer. If the family does not feel respected and staff are 'ganging up' on them, then they will continue to interact in only the way they know how.

Look at your goals with this resident. What you hope to do is decrease anxiety level and therefore, the challenging behaviours. You know this resident is quite confused and does not understand the environment. When talking with family, identify this as your main goal- your main goal is not to drug the resident. Talk with the family and staff on all the other ways that the anxiety level could be decreased and how you are going to implement them. This may include less frequent care, at a different time of day; cut down on the number of different staff that do care, try to keep the resident from over-stimulation. He/She needs time to settle into the facility, as only a month has passed. Tell family you are happy to not use medications right now, while you try other things. Involve the family in deciding what interventions could be realistic to calm this resident down. Gently suggest that medication may be required in the future if the resident still requires it. If you put the medication request on hold for a bit, this will allow the family to feel more relaxed and build more of a trust with the staff. If your care team still feel that antipsychotics are needed, then make a contract with the family. Note a small dose; draw up a side-effect sheet for staff to check off each shift, this may make the family feel better about the medication being monitored. Make sure there is a time limit to this trial of medication and a date for review, this way the family can trust that the medication can be discontinued if is not helping, or is not worth the side-effects. Giving the family some perceived control on the intervention decisions will help them trust and support the care team.

Consider using a Pro-Attention plan (P.I.E.C.E.S. manual) for the family member and increase friendly interactions with them. This will help him/her feel more valued and not all interactions will feel negative and problem-related.

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.*