3-195 Mental stimulation for blind ABI resident

TIPS Question:

A 37-year old resident at a nursing home in a small community is an acquired brain injury with coritcal blindness and ataxia. In the past he has been aggressive and resistive to care. In the past eight months his behaviour has improved greatly with the addition of medications such as Zydis 30 mg. This is given before his weekly bath routine. To date we have been keeping the staff consistent for the bathing and extended grooming routines. This resident is on an extensive waiting list for more appropriate placement. We are told that this may take months to years to achieve. My question is what are the best strategies as far as mental stimulation for this resident? Presently, he is assisted to the dining room for meals and then returns to his bed. He does attend one activity a month depending on his mood.
He also is given Nozinan 5 mg tid and Rivotril 0.5 mg tid. Do you have any other suggestions medication-wise as far as maximizing function and minimizing aggression are concerned?

Response:

1. **What is the behaviour/mental health cognitive need?**

   You have identified that your resident is responding to procedures that invade his personal space during personal care.

2. **Who is it affecting?**

   This affects the resident; he may be frightened, anxious. It affects how staff perceives him and interacts with him. It affects pharmacologic interventions, and possibly numbers of staff used to assist during care.

3. **What is the degree of risk?**

   Is there risk of injury as a result of altercations during care?

4. **How do we describe and record what we see?**

   Has there been behavioural charting such as ABC charting or the use of the Dementia Observation System (DOS) to track frequency of occurrence of the behaviour? Time of day? Has the DOS been used to track the response to the pharmacologic interventions? Is there a time of day that he would be more receptive to bathing?

5. **What are the possible causes?**

   Physical: This person has had a head injury and has cortical blindness and ataxia. Are staff Giving adequate explanations/preparation regarding care to compensate for deficits? Are the medications causing any untoward side effects?

   Intellectual: Does he comprehend what the staff are trying to accomplish? Is adequate time given to explanation? Has there been testing done regarding his cognitive functioning? Are the psychotropic medications causing any excessive sedation, confusion, loss of function?

   Emotional: Is he frightened during procedures? Does a calm approach with simple communication help? Does the type of bathing (shower, bath, bed bath) make a difference in response during personal care? Is there evidence of depression, psychosis? Has there been a depression scale such as the Cornell Scale used to screen for depression?

   Capability: Has this gentleman had abilities testing? What is he capable of doing for himself?

   Environment: Does the environment make a difference in responsive behaviour? Does he respond well to any of the staff? What are they doing differently than the others?

Social: Who is involved with this gentleman? Is there family? Pastoral Care? Recreation? Volunteers? CNIB?
Acquired Brain Injury Program? What activities did this resident enjoy prior to his brain injury? Is there anything that he can continue with in the facility? Does he enjoy music, horticulture, audio tapes, the outdoors, being read to, hand massages, pet therapy, stuffed animals, and olfactory stimulation?

6. What are the steps for providing the best care strategies?

1. Depending on the above assessment you can plan the strategies to make this resident's quality of life more meaningful. It would be important to know the abilities of this resident, and have him or substitute caregiver be involved in planning for his care.

   It will be important to pull in as many people to spend time with this gentleman as possible. Family, volunteer visitors, co- residents, recreation etc. could be scheduled in to provide 1:1 attention and stimulation. CNIB could be consulted to suggest activities appropriate to the client's level of cognition. Stimulation can occur in other senses with being read to, audio tapes, music, massage, and other sensory stimulation. Are there activities which would provide meaning, and give this individual a role?

   U-First Principles should be used to assist staff and family in caring for this resident. A Case Conference would be helpful to work with the staff and family to clarify *Understanding* the behaviour, *Flagging* observations, monitoring *Interactions, Reflection and Reporting*, using *Supportive* Care Strategies, and ensuring the *Team* is working together.

2. Regarding the psychotropics, the resident may benefit from a review and stream lining of the medications. It may be useful to involve a specialist such as a Geriatrician, Geriatric Psychiatrist, Internist or Neurologist to advise regarding the medications. With present medications he should be observed for sedation, confusion, decreased functional abilities, hypotension, falls, and Parkinsonian symptoms. As the care providers find strategies that work with this resident in communication, adjusting techniques for bathing, finding stimulation that would improve his quality of life, perhaps the medications could be tapered to lower doses, monitoring for response and re-emergence of behaviour.

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.*