5-5-25 Weekly Clinical Update

Last week, documentation of behaviors was the focus of the update. This week, the documentation of interventions, specifically non-pharmacological interventions will be the focus of the update.

While medications play a role in some behavioral symptom management, nonpharmacological interventions such as diversional activities and environmental adjustments are equally essential for improving quality of life. Proper documentation of these interventions not only supports resident well-being but also enhances care team collaboration, regulatory compliance, and continuity of care. Included in documentation are: the interventions determined by the Interdisciplinary Team, documentation of the implementation of those interventions AND (perhaps most importantly), the effectiveness of those interventions.

Nonpharmacological interventions play a vital role in the holistic care of nursing home residents, promoting comfort, engagement, and dignity. Accurate documentation ensures these interventions are effective and integrated into residents' care plans. By prioritizing structured, detailed records, nursing homes can elevate the standard of resident care and foster collaboration among caregivers.

So, how do you figure out appropriate non-pharmacological interventions for behaviors or for pain management?

- Conduct a comprehensive assessment
    - Observe AND DOCUMENT behavioral patterns by identifying triggers, frequency, and intensity of behaviors or pain episodes.
    - Assess cognitive status to determine if the resident has dementia, delirium or other cognitive impairments influencing the residents' responses and reactions or the specific assessment of pain
    - Evaluate physical conditions that could possibly necessitate specific pain management strategies
    - Consider emotional factors such as anxiety, depression and/or social isolation that can contribute to behavioral issues or physical discomfort
- Identify personalized approaches AND DOCUMENT in resident's Care Plan
    - By using a structured approach and tailoring interventions to the individual, nursing homes can significantly enhance residents' comfort, engagement, and overall well-being.

    - Engage AND DOCUMENT conversations with the resident, if possible, or consult family members to determine preferences, prior routines, past hobbies and individualized characteristics that could assist the resident
        - Some examples of assessment questions might include:
            - ❖ What is the most important thing in the resident's life?
            - ❖ What are the resident's non-negotiables?
            - ❖ What are the resident's greatest fears? Does the resident feel "safe"?
            - ❖ What brings the resident joy?
            - ❖ Does the resident have a history of any trauma that must be intentionally avoided?
            - ❖ What is the resident's comfort food(s)?
    - Consider AND DOCUMENT cultural background when selecting interventions
    - Customize interventions based on the resident's level of cognition, mobility and sensory abilities
- Select evidence-based interventions (These are only examples of potential interventions…not a complete list)
    - For pain:
        - Massage
        - Repositioning techniques
        - Heat/cold
        - Guided breathing
        - Music
        - Family diversion
    - For agitation/anxiety
        - Sensory stimulation
            - ❖ (Sight, hearing, smell (aroma therapy), taste, touch)
        - Pet therapy
        - Meaningful diversions…meaningful to the resident
        - Soothing, quiet environment
    - For sleep disturbances
        - Light therapy
        - Bedtime routine to match previous routines
        - Calming sounds
        - Aroma therapy
        - Mindfulness techniques
    - For social withdrawal

        - Encourage social interaction at the resident's comfort level (i.e., small group, large group, 1:1 interactions)…remember not all residents are comfortable in every setting
        - Story telling
        - Reminiscence therapy, keeping in mind, not all memories are positive memories…staff must avoid identified triggers
- Monitor and adjust interventions as needed AND DOCUMENT those revisions in the resident's Care Plan
    - In order to adjust the plan, there must be documentation of the resident's response using whatever documentation system used by the facility
        - REMEMBER, Direct Care Partners must have input into the resident's plan and interventions
        - Use standardized formats in the Electronic Medical Record or structured documentation templates to ensure consistency and documentation by all disciplines
        - Teach staff to avoid subjective descriptions…a primary rule to documentation is that staff should only document facts…no opinions
        - Update the documentation routinely…not just with exceptions
    - Collaborate with the entire Interdisciplinary Team to refine/revise strategies
    - Modify interventions based on effectiveness, frequency, duration or type as necessary