Doc, can we medicate their agitation?

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Learning Objectives

1. How to describe dementia behaviors
2. How to recognize and evaluate delirium
3. How to manage a behavior crisis
4. Know when medication is appropriate
5. Be able to implement strategies to prevent dementia behaviors

Doc, my patient is “AGITATED”!

Repetitive Actions

Resistive to Bathing

irritable

Hitting

Accusing you of cheating

Wanting to go home

Aggressive

SCREAMING

Repetitive calling out

Abusive

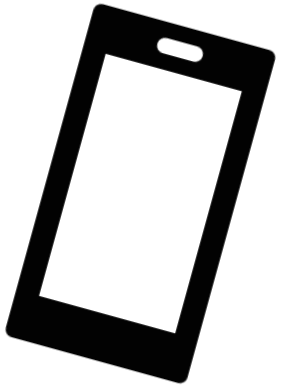
Restless

Accusing you of stealing

Doc, Can we medicate her agitation?

How dangerous is it?

Can you tell me more about her "agitation"?



Can you also tell me what you have tried to get her cooperation?

Case Scenario

Mrs S is an 80 year old woman who had a fall 3 weeks ago. She went to the hospital where they found no fracture, but just bruising on her left hip. The rest of her medical work-up was fine. She was started on an antidepressant 1 week ago because since her fall, because she was "not motivated" to do anything, staying in bed to rest. The last 2 days, was sleepier during the day, but also more restless at night. She is not following directions, but resisting personal care, kicking and hitting anyone who tries to change her wet garments or bedding.

STEP #1: ASSESS THE SITUATION

Are they a danger to **themselves** or to **others**?

Patients have an urgent need to feel safe. Oftentimes, an "agitated" behaviors is an attempt at self-protection.

If dangerous, remove persons or items to control the danger sufficiently, to allow for time of "watchful waiting" or cooling off.

Adapted from: https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4427.pdf

IF BEHAVIORS ARE STILL DANGEROUS

➡ CALL 911

GET HELP

If the patient is in danger of seriously hurting themselves or others, call 911. However, you should know that there are few/no geriatric psychiatry hospital beds available, and admission may only be for a medical workup only. Hospitalization or medications may not solve the problem- Ultimately, a change in approach is still the most effective intervention.

If NOT dangerous → TA -DA!

TOLERATE

If it is NOT Dangerous, allow patients to respond to their environment. Observe them. You might get clues about what is upsetting them.

ANTICIPATE

Behaviors are a way of communicating. If they cannot tell you, try to think ahead to meet their needs and avoid frustration or danger.

DON'T AGITATE

If they cannot reason or understand, don't try. Even re-orienting them can make them upset. Go with their flow. Try distracting or humoring the patient.

STEP #2: A SAFE APPROACH:

Connect in 3 ways

VISUAL

- Come from the FRONT
- Stop 6 feet out
- Give "HI" sign/wave
- Offer HANDSHAKE
- Go SLOW
- Get to the SIDE
- Get LOW (kneel/sit)

VERBAL

- Say "HI ___" (add preferred name)
- Wait-SLOW reaction time
- Say something nice/friendly
- Introduce yourself
- Wait for connection before moving towards them

TOUCH

- Touch is last
- Handshake then Hand-under-hand

- From Teepa Snow, Positive Approach to Care

A SAFE APPROACH

CREATE SAFETY

- They have an urgent need to feel safe.
- Be aware of body language.
- Speak slowly and calmly.
- Show Empathy, Respect.
- Address feelings.
- Apologize, Agree with them, Back off (Try again later)

SHOW CONCERN

- "I noticed that you did not eat breakfast this morning..."
- Can I do anything to help you feel more comfortable?
- Listen.
- Do not dismiss them

A SAFE APPROACH: PARTNERSHIP!

Intervention "to" a person reinforces helplessness.

Intervention "**WITH**" someone, promotes <u>partnership</u>

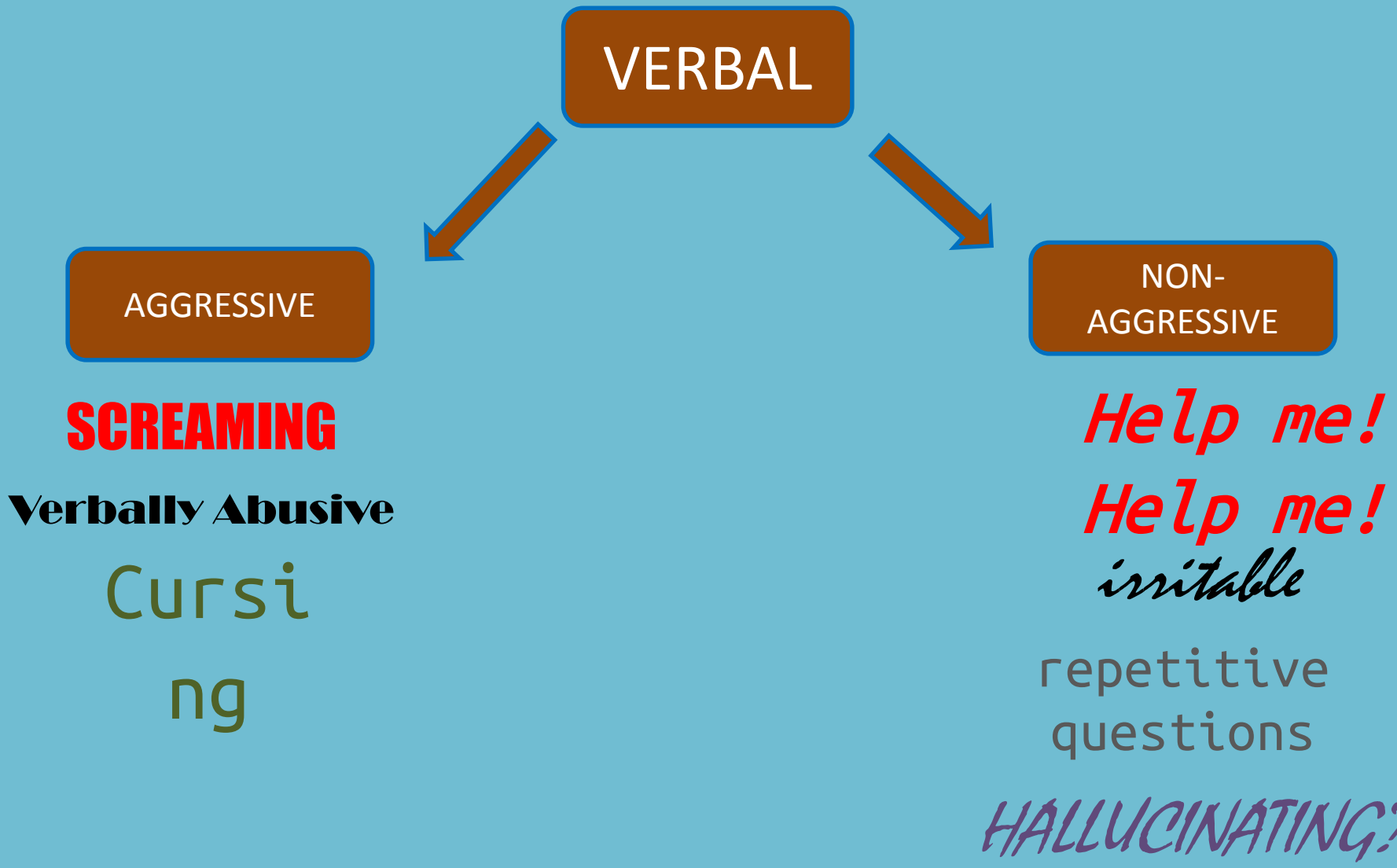
- Ask for permission, ask them to HELP. Give them choices.
- Redirect (consider favorite food/drink, person, music, etc.)
- Show and do things together.

Intervention in a "person-centered" and "strength based" way- **HONORS** the individual

Take care of the "whole person"- there may be multiple needs

Adapted from: https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4427.pdf

STEP #3: GET A GOOD DESCRIPTION:



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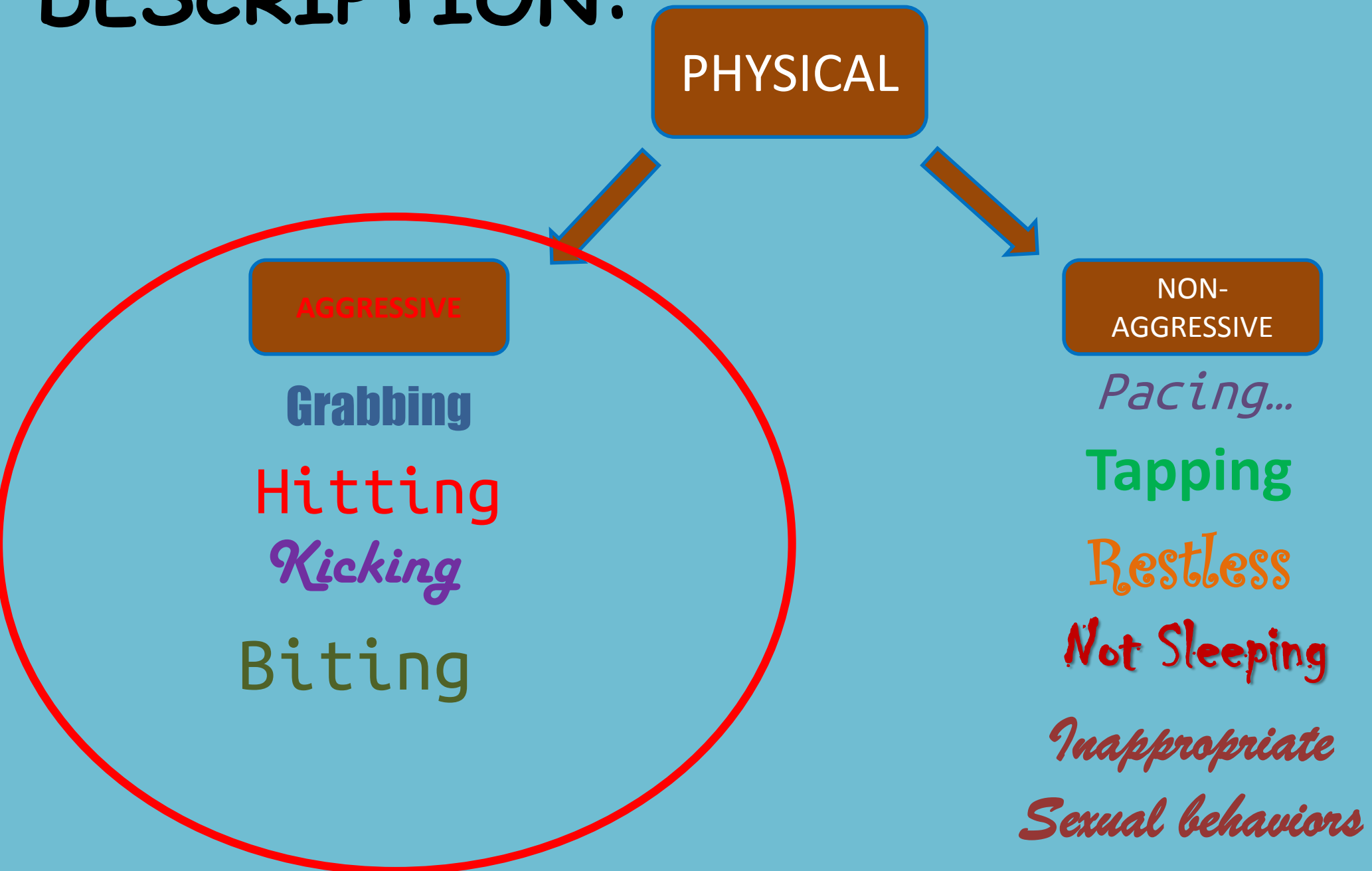


DESCRIPTION:

WHEN

NEW

REVIEW "STOP AND WATCH"

RULE OUT DELIRIUM

ACUTE ONSET
Within last 24-48 hours

+

INATTENTION
Can't follow directions

PSYCHOSIS
Hallucinations (seeing things...
Delusions (paranoid beliefs)

OR

SLEEP-WAKE
Daytime sleepiness
Nighttime restlessness

IF YES, GET MEDICAL ATTENTION!

NOT NEW

DESCRIBE FREQUENCY

- Less than once a week
- Twice or several times per week
- Once or twice a day
- Several times a day
- Several times an hour

DETECTIVE WORK

LOOK FOR UNMET NEEDS

LOOK FOR SITUATIONAL TRIGGERS

Case Scenario, continued

- Vital Signs: all normal, no constipation
- Exam: Answers with short phrases, responds slowly, no opening eyes. You notice some skin breakdown on buttocks due to moisture from her refusing to be changed. She does not let you touch her left hip.
- Because you suspect Delirium, Labs are ordered:
  - Lab results: Low sodium 130 (normal 135-145), Dehydrated (elevated BUN/Cr), Urine- some WBCs and some bacteria, but not a lot.

CONCLUSION: Delirium due to low sodium, dehydration, possibly from new antidepressant side effect.

Step #4: Treat Underlying Cause

The underlying medical problem must be treated

TREATMENT for Mrs. S: replace sodium, push fluids, stop antidepressant, try acetaminophen.

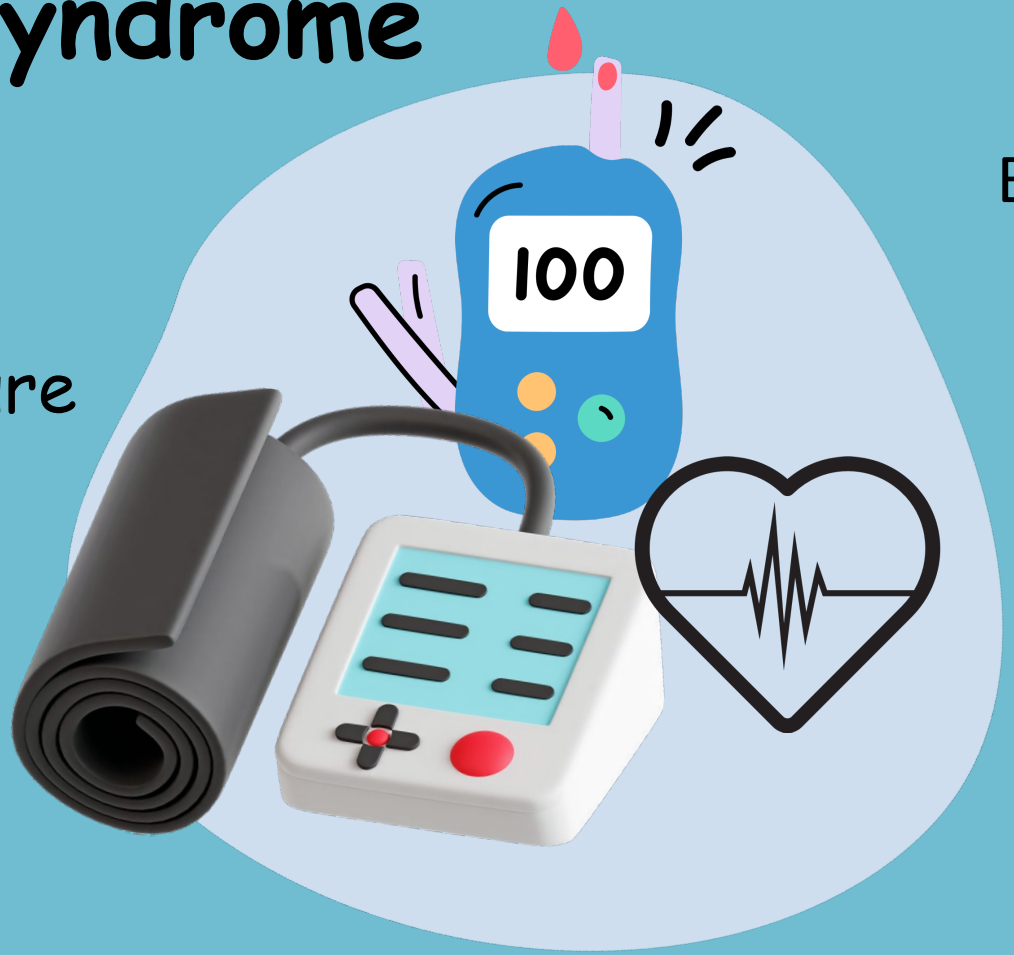
But Doc, Can we medicate her agitation?

NOT SO FAST!!!

Antipsychotics & Sedatives are ONLY to be used as a last resort. If the patient is very distressed, or in danger of hurting themselves or others, THEN consider medications for the short term...

Common Antipsychotic Side Effects: Metabolic Syndrome

Diabetes
High Blood Pressure
High Cholesterol
Weight Gain



BLACK BOX WARNING

Heart Attacks
Stroke
Death

Common Antipsychotic Side Effects: Movement Disorders

Extrapyramidal symptoms (EPS)

Parkinsonian symptoms (tremors, shuffling gait, slow movements)

Akathisia (restlessness)

Dystonia (involuntary painful muscle contraction- ex: neck twisted)

Tardive Dyskinesia (involuntary tongue thrusting, blinking, squirming, twisting, arm/leg movement)

Medicines to Manage Delirium and Psychosis

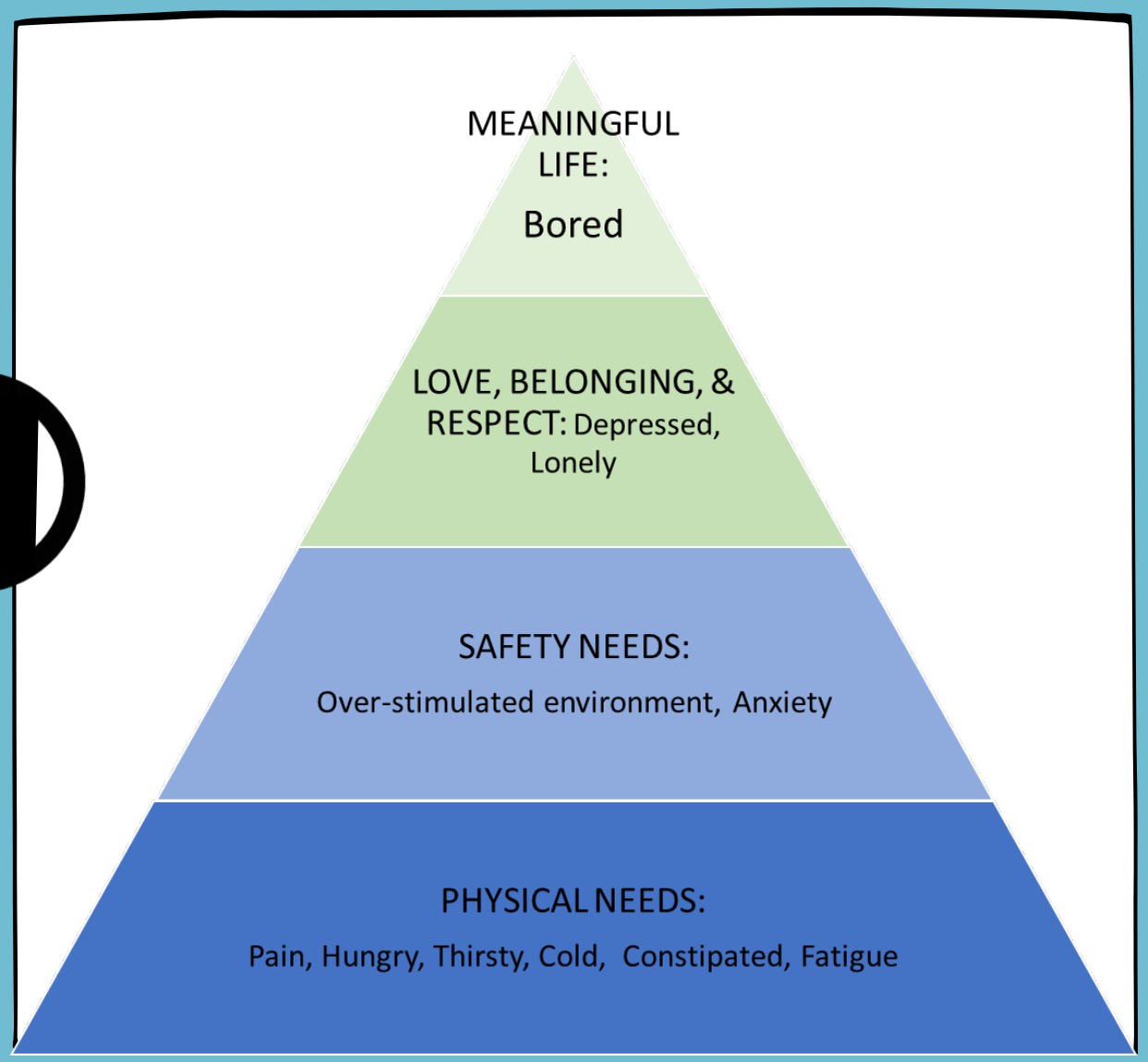
Benzodiazepines	Lorazepam (Ativan)	zzzz... Basically, a Tranquilizer, also addictive
Antipsychotics	Haloperidol (Haldol) Quetiapine (Seroquel) Risperidone (Risperdal) Olanzapine (Zyprexa) Aripripazole (Abilify) Pimavanserin (Neuplazid)-NEW	Blocks Dopamine
Serotonin reuptake Inhibitors	Citalopram (Celexa) Escitalopram (Lexapro)	**Antidepressants**
Mood stabilizers:	Lithium Anticonvulsants (gabapentin)	**Anti-Seizure**

STEP #5: Use Non-drug Strategies

So, How can we get her to cooperate?

DETECTIVE WORK:

Find the unmet need…



Maslov's Hierarchy of Needs

DETECTIVE WORK: Use the ABC's to find the Triggers

Antecedent

- Who is around?
- What were they doing?
- Where are they?
- What time of day?
- Why- possible trigger

Behavior

- Specific Behaviors exhibited
  - Physical
  - Verbal

Consequence

- What was the result?
- Did they get hurt?
- What will you do if it happens again- to get a different result?

- From STAR-VA ABC card

DETECTIVE WORK: Plan with 3P's

PREPARE

- Ex: Have a favorite snack available for distraction if needed.

PREVENT

- Ex: Don't have the resident in the common area around this time of day

BE PRESENT

- Ex: Walk with them, acknowledge their frustration. Lead them to a quiet area with activity.

Case Scenario 1

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Is there an unmet need?

Case Scenario 1: DETECTIVE WORK
Find the Triggers

Antecedent

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Case Scenario 1: DETECTIVE WORK

Plan with 3P's

PREPARE	PREVENT	BE PRESENT

Case Scenario 2

Mark is a very "active" 78 year old man with dementia who wheels up and down the hall, goes into other rooms, "rummaging", reaches across the table and "takes" things from everyone, including food, "hoards". This behavior worsens in mid-morning and the late afternoon. This has caused a lot of "yelling and fighting" in the house.

Is there an unmet need?

Case Scenario 3

Ron moved in 1 week ago, and has been restless every afternoon and evening, trying to leave the house. When you tell him this is his new home, his wife has died, and the house was sold. He gets mad at you and screams, "you know nothing!", He is refusing food, drink, and meds. Says "I am NOT a prisoner! I don't belong here! I am calling the police!" He has pulled the door so hard that he broke the doorknob.

Is there an unmet need?

PREPARE

PREVENT

BE PRESENT

Case Scenario 4

Do you have any challenging scenarios you would like to share?

Is there an unmet need?

PREPARE

PREVENT

BE PRESENT