A Practical Approach to Dementia-Related Behaviours

Dementia Webinar
September 21, 2011

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Dr. Michael Wilkins-Ho
Disclosures

- Dr. Michael Wilkins-Ho – no disclosures
- Dr. Elisabeth Drance – no disclosures
Objectives

1. Assess factors that may contribute to dementia-related behaviours (DRB)

2. Describe key nonpharmacological approaches to coping with dementia-related behaviours

3. Use pharmacological approaches to dementia-related behaviours with more confidence
References and Resources

• VCH Atypical Antipsychotic Agents - Guideline for use as part of the management strategy of behavioural and psychological symptoms of dementia (BPSD)

• Evidence-Based Guidelines – Nonpharmacological management of Agitated Behaviours in Persons with AD and other Chronic Dementing Conditions (McGonigal-Kenney JGN 2006)

• Need-Driven Dementia-Compromised Behavior – an alternate view of disruptive behavior (Algase et al Am J AD 1996)
Factors that may contribute to DRB

**Background**

- 80-90% of people with dementia will experience behavioural symptoms at some point in their illness
- Many are at home, even more in residential care
- Behavioural symptoms are often the impetus for placement in a residential care setting
Factors that may contribute to DRB
CIHI RAI-residential data 2008 (Nova Scotia)

- Between 2003-2007 45% elders in residential care exhibited one of:
  - Verbal ‘abuse’ 16%
  - Physical ‘abuse’ 10%
  - ‘Resistiveness to care’ 30%
  - Social ‘inappropriateness’/’Disruptive’ behaviour 15%
  - Wandering
Factors that may contribute to DRB

Causes

People with dementia often have difficulty expressing their needs verbally, and instead use the most efficient means of communication available to them...

... their behaviour.
Factors that may contribute to DRB

Causes

• Behavioural symptoms are multifactorial
• They arise from a variety of *unmet needs* that are:
  – Biological
  – Psychological
  – Environmental (the people setting & the physical setting)
  – Created by the System of Care
• Need-Driven Dementia Compromised (NDDC) Behaviour Model (Algase et al 1996)
Factors that may contribute to DRB Causes

FUEL + MATCH = FIRE

RISK FACTOR + TRIGGER = BEHAVIORAL RESPONSE

Linda Bullock – Providence Health Care
### Background Needs Risk Factors

- Cognitive Abilities
- Psychiatric Needs
- Medical Needs
- Pain
- Medication Needs
- Psychosocial Needs
- Personality Needs
- Spiritual/Cultural Needs

### Immediate Triggers

- Emotional Needs
- Physiological Needs
- Physical Environment
- Social environment

### System Needs/Risk Factors

- Focus on Task
- “Doing to” rather than “helping with”
- We are the experts & know what you need.
- Care designed for the institution rather than the individual
- Staff education
- Staff empowerment
- Staffing levels

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**Red = Areas for Physician Focus**

**Black = Areas for Physician Awareness & Contribution to Interdisciplinary Care**
Key nonpharmacological approaches to coping with DRB

**Background**

- No cookie-cutter approaches

- *Individualized care planning* with *implementation* of that care plan helpful

- 1:1 intensive – explaining high placebo rates of response in medication studies

- Need more training & modeling of person-centered care, more appropriate staff: resident ratios, and better-designed environments for optimal implementation

Cohen-Mansfield J, 2007
Key nonpharmacological approaches to coping with DRB

What’s my role as a physician?

Physicians need to contribute to the solutions in the following ways:

• Assess and treat underlying illness (“background risk factors”)

• Support interdisciplinary staff to assess other background risk factors and immediate triggers

• To know when and how to use medications as part of the plan of care
Key nonpharmacological approaches to coping with DRB

Behaviours that respond poorly to drugs

• Wandering
• Pacing
• Entering rooms uninvited
• Attempting to leave
• Making disruptive vocalizations
• Voiding and masturbating in public places
• +/- Resistiveness to care
Key nonpharmacological approaches to coping with DRB

So What?

• A careful assessment can identify background factors & triggers that can be dealt with to address the unmet needs

• Without this, we are simply ‘medicating’ the problem

• Too many people are receiving psychotropic medications unnecessarily; medications that are certainly not benign...
Key nonpharmacological approaches to coping with DRB

Where to start

• Knowing the person “then” and now and using that understanding to plan care

• Ensuring care plan matches abilities and deficits

• Therapeutic communication
  – Therapeutic use of self
  – Being “there” with care

• Creating easy opportunities for meaningful activity
Key nonpharmacological approaches to coping with DRB

- **Sensory enhancement and relaxation**
  - Massage and therapeutic touch
  - Individualized music
  - White noise
  - Sensory stimulation
  - Aromatherapy

- **Structured Activity**
  - Physical Exercise
  - Outdoor Walks
  - Meaningful Activities (group & individual)
  - Recreational Activities

Adapted from McGonigal-Kenney et al 2006
Key nonpharmacological approaches to coping with DRB

- **Social Contact** – Real or Simulated
  - Individualized Social Contact
  - Animal Presence
  - Simulated interactions (video, audio)

- **Environmental Modifications**
  - Appropriate visual cuing
  - Wandering Areas
  - Appropriate Levels of Stimulation – avoid over/understimulation
  - Light Therapy – particularly for sleep disturbance

Adapted from McGonigal-Kenney et al 2006
Key nonpharmacological approaches to coping with DRB

- **Behaviour Therapy**
  - Utilization of Montessori Techniques
  - Differential reinforcement
  - Stimulus control

- **Staff Development**
  - Self Care
  - Ongoing education and skill development
  - Team Work

Adapted from McGonigal-Kenney et al 2006
Key nonpharmacological approaches to coping with DRB

Planning Care

- Who am I?
- Behavioural monitoring tool
- My daily care care planning tool
  - First person
  - Adaptable based on individual’s target behaviours
  - Focus is preventing/minimizing dementia related behaviours
GETTING TO KNOW ME

My Life Story

• I was born in (town/country)___
• I was ____ (the number) in the family.
• I speak the following languages:
• My education was (years, degrees, etc.)
• I am/have been a part of the _____________ faith.
• I married____________on ________________ at (location)
• In our life, we enjoyed the following together:____
• Our family includes (names and birthdays of children, grand-children or significant persons):
• Traumatic life experiences I have had are:
• My favourite movies are: _
• Important relationships in my life are/have been with
• Things I am most proud of are
• If I had to describe my personality throughout my life, I would say
• I manage stress/cope with difficult situations by
• As a child/adolescent, my hobbies were in (sports, music, art, etc.)
• As an adult, my hobbies/past times have been
Today I continue to enjoy __________________________
Were pets a large part of your life? Please elaborate. ______
If you enjoyed caring for plants, please indicate if you enjoy:
☐ Indoor gardening
☐ Outdoor gardening
☐ Both
I enjoy spending time with children. Yes No I don’t know

**Important Things About My Day**
I like to get up at ____________
I prefer to have a shower/bath and how often ________________
I eat breakfast at ___________ time.
My favourite breakfast foods are: _______
For lunch I like to eat: __________________________
I spend my afternoon doing ______________________
I nap/ do not nap during the day (please indicate time of day and duration) ____________________________
I eat supper/dinner at ______ time.
I spend my evenings ____________________________
I normally go to bed at _______time.
I have the following bedtime rituals: ______________
Other “little things” I would like you to know about me are: (special things about me that make my care day/care go well)________________________
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<tr>
<th>DATE</th>
<th>TIME</th>
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<thead>
<tr>
<th>TYPE OF NOISY OR DISRUPTIVE BEHAVIOUR</th>
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<td>Swearing</td>
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<td>Calling Out</td>
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<td>Crying</td>
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<td>Screaming</td>
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<td>Banging</td>
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<td>Verbal Abuse</td>
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<th>PERSON AFFECTED</th>
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<td>Staff</td>
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<td>Other Patient</td>
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<td>Visitors/Family</td>
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<th>LOCATION (See Key)</th>
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<tr>
<td>PR: Patient’s Room</td>
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<td>BR: Bathroom</td>
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<td>L: Lounge</td>
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<td>O: Other (state)</td>
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<table>
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<tr>
<th>RELATED FACTORS</th>
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<td>During Care</td>
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<td>During Activities</td>
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<td>With Others</td>
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<td>With Transfers</td>
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<th>STAFF INITIALS</th>
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<tr>
<td>Client Initials</td>
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### MY THINKING CHALLENGES AND ABILITIES

### MY TRANSFER & MOBILITY:

### HOW I LIKE TO COMMUNICATE:

### PERSONAL AIDE DEVICES I NEED:

### MY DRESSING HABITS/MY PERSONAL HYGIENE NEEDS (INCLUDING ORAL HEALTH):

### MY DINING/DIET ROUTINE:
<table>
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<th>MY DAILY CARE ROUTINE</th>
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<tr>
<th>Client Initials</th>
<th>Client PHN #</th>
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<th>MY BATHROOM ROUTINE:</th>
<th>MY REST &amp; SLEEP ROUTINE:</th>
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<tr>
<th>MY BATHING ROUTINES:</th>
<th>THINGS I LOVE TO DO:</th>
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<tr>
<th>WAYS TO HELP ME AVOID FEELING LONELY</th>
<th>THINGS THAT I FIND CALMING/THE WAY I LIKE TO BE APPROACHED:</th>
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VHCA
Vancouver Community Mental Health Service
HEART 21 C: 13/11/2008
# HEART PROGRAM
Helping Elders Adapt In Residential Transitions
Phone: 604-708-5344

## MY DAILY CARE ROUTINE

<table>
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<tr>
<th>Client Initials</th>
<th>Client PHN #</th>
<th>Client PID # (Internal Use Only)</th>
<th>Date Completed (dd/mm/yyyy)</th>
<th>Completed By Rachael Watson</th>
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## MY THINKING CHALLENGES AND ABILITIES:
- I have a Dementia from a fall I had in 2007. I have expressive and receptive aphasia. Some days I comprehend better than others. I have difficulty finding the right word sometimes and I find this frustrating.
- Please be patient with me while I attempt to express my needs and wants.
- I am sometimes afraid that I am being "watched" or "monitored" by others. I can't always control my behaviour and I get sad when I am blamed for bad things I may do.

## MY TRANSFER & MOBILITY:
- I can walk a few steps and really want to keep that or strengthen my walking.
- Please don't push me to walk when I am not ready though.
- I am at my best when the unit is quiet, usually in the evening or on weekends.
- Please allow me to propel my wheelchair around the unit at these times so I can satisfy my curious nature.

## HOW I LIKE TO COMMUNICATE:
- I am blind in my left eye, so please be certain to sit more to my right side.
- I like it when you sit down, it makes me feel less rushed and I like the eye contact.
- I am a curious person, and like to ask a lot of questions. I am not trying to be nosy, I just want to know a little bit about who is looking after me.
- "No" means no -- but I will come and find you when I am ready to do whatever it is.

## PERSONAL AIDE DEVICES I NEED:
- I wheel myself in a wheelchair. Please ensure the brakes are not left on as I may tip the chair over.
- Please help me with socks and slippers so I can have warm feet while propelling.
- If I must sit in the Broda chair, please make sure my bottom is well padded as I have lost about 30 lbs in the past year and my bottom gets sore quickly.

## MY DRESSING HABITS/MY PERSONAL HYGIENE NEEDS (INCLUDING ORAL HEALTH):
- My daughter has my dentures, but I can manage well without them.
- I don’t have any choking issues and eat a soft diet.

## MY DINING/DIET ROUTINE:
- I hate cold food.
- I have a sweet tooth. I LOVE chocolate.
- I can eat independently with set-up, but don’t forget to pull back the corners of the jam packets so I can get the foil off.
- I like a lot of jam!!!!
- I like apples, but please cut them up into bite size pieces for me. No need to remove the peel, I can do that myself.
- I take milk and 2 sugars in my tea or coffee.
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### MY PERSONAL CARE:
- Please leave my care until as late as you possibly can in the am.
- Please take my emotional temperature before giving care. If it is a bad time for me, please come back a little later.
- Before you start care, please chat for a few seconds. I really love to hear stories from your life.
- Talk about the things we need to do, just before and then again, as you do them.
- Give me information, but not too much at one time.
- Ask me to help...I love to help you.

### MY BATHING/BATHROOM ROUTINES:
- I do best if you refer to my baths as my visit to the “spa” rather than just telling me I have to have a bath.
- Being very thin, I really appreciate a warm room
- I can do most of my own washing if you get me started.
- I wear Attends, and am incontinent of urine.
- I need you to make sure my bowel movements are every 1-2 days or else I get uncomfortable, and when I’m uncomfortable, I’m not much fun to be around.
- Like everything, I do well in the bathroom when I don’t feel rushed

### MY REST & SLEEP ROUTINE:
- I am not a morning person in general.
- Please try to arrange tests and investigations in the afternoon
- Please minimize the care I need for the mornings

### THINGS I LOVE TO DO:
- Before I get sick I read the newspaper daily. Please offer me a newspaper to flip through as it was an important part of my day.
- I love animals. If you or a visitor have a pet that you bring to work, please let me visit with it as it gives me a lot of joy.
- I like to learn about people around me. I am inquisitive and ask a lot of questions. I may not always remember what you have told me, but it makes me feel better to be able to engage with others.

### THINGS THAT I FIND CALMING/ THE WAY I LIKE TO BE APPROACHED:
- Please knock when entering my room. I startle easily as my vision is poor.
- Try to approach me from the right as I am legally blind in my left eye. A gentle hand on my shoulder or arm is comforting to me.
- Please explain what you are going to do before you do it. Use short sentences and be sure I understand before you start.

WAYS TO HELP ME AVOID FEELING LONELY:
- I am a social person, so if I approach you, please acknowledge me. Chat with me when you can, even if it's just a few minutes. I will usually wheel myself away when I am finished chatting.
- Please include me in all social activities. I get bored easily and this can result in me getting short/ upset with others easily.
- Take me outside whenever possible. I find the trees, flowers, and animals comforting and calming.
Pharmacological approaches to DRB

Questions to ask before starting a drug

• what is the target problem being treated?
• by what criteria, and at what time, will the effects of therapy be assessed?
• are nonpharmacologic therapies available?
• is this the best environment/staff for starting the medication
• is behaviour due to any reversible medical condition?
• is this the lowest practical dose?
• could discontinuing other medication help to reduce symptoms?
• does this drug have adverse effects that are more likely to occur in older patients?
Pharmacological approaches to DRB

Antipsychotics

- only risperidone is currently approved in Canada for management of behavioural disturbances

- open-label studies have shown quetiapine to be well tolerated by patients with Parkinson disease and by those sensitive to neuroleptics

- there was no evidence that risk of stroke associated with use of risperidone or olanzapine increased over risk associated with typical antipsychotics for the elderly
Pharmacological approaches to DRB

Effects Sizes

“Effect sizes for most atypical antipsychotic drugs on the outcome measures that assess global behavioural disturbance are in the range of 0.1 to 0.2, which is very low.”

Pharmacological approaches to DRB
The use of antipsychotic medication for people with dementia: Time for action

“15 randomised placebo-controlled trials of atypical antipsychotics provides robust evidence for an increased risk of CVAEs, with a pooled relative risk of 2.57 (95% CI 1.41-4.66)”
Pharmacological approaches to DRB
Atypical Antipsychotics and Mortality Risk
(Black Box Warning)

Mortality risk
• Odds Ratio = 1.7 times (FDA April 2005)
  • 17 studies: 5106 pts, 4.5% vs 2.6% placebo
• Odds Ratio = 1.54 times (Schneider JAMA 2005;294:15)
  • 15 studies: 3353 pts, 3.5% vs 2.3% placebo
Pharmacological approaches to DRB
Weighing Risk vs. Benefits of Atypicals

• NNT for benefit: 5 - 14 patients
• NNH for mortality: 100 patients
• 1 patient death for every 9 – 25 who benefit
Pharmacological approaches to DRB
VCH Atypical Antipsychotics Guideline
Guideline for use as part of the management strategy of behavioural and psychological symptoms of dementia (BPSD)

• conduct patient assessment before initiating drug therapy
• non-drug interventions considered first line
• recognize the evidence for drug therapy is modest
• discuss the risks and monitor drug therapy
• team huddle prior to initiating drug therapy
• unknown which atypical antipsychotic optimizes safety and efficacy
• start with appropriately low dose
• make a decision regarding effectiveness by 8 weeks
• review for drug taper after a 3 to 6 month period of behavioural stability
Pharmacological approaches to DRB

Alternatives to Antipsychotics: Antidepressants

• trazodone has beneficial effects on disruptive behaviour
• citalopram more effective than perphenazine or placebo in a 17-day study of hospitalized inpatients with behavioural disturbances
• SSRIs can cause transient, but occasionally persisting, hyponatremia, serum sodium levels; should be checked at one month and periodically, especially in those with low-normal sodium levels at baseline
• greatly increased risk of gastrointestinal bleeding among those taking SSRIs and concurrent anticoagulant therapy
Pharmacological approaches to DRB
Alternatives to Antipsychotics: Hormones

• one randomized double-blind trial, comparing cyproterone with haloperidol (n = 27) - cyproterone was more effective controlling aggressivity without hypersexuality and had lower incidence of side effects. In the one uncontrolled naturalistic observational study identified (n = 19), cyproterone was associated with significant reductions in aggressivity without major side effects (Bolea-Alamanac BM, et al, J Psychopharmacol. 2011 Jan;25(1):141-5. Epub 2009 Nov 26)

• when staff or other residents are at risk from a patient’s sexual aggression, a treatment approach including SSRIs, antipsychotic medication, and hormonal agents (cyproterone, leuprolide, medroxyprogesterone) has been suggested
Pharmacological approaches to DRB

Alternatives to Antipsychotics: AchEIs

• AChEIs have a modest benefit
• A prospective placebo-controlled study showed galantamine prevented emergence of behavioural disturbances
• AChEIs might have an increasing role in the future for BPSD in LBD where antipsychotics are less helpful
• evidence of efficacy of rivastigmine in LBD for treatment of delusions, hallucinations, and behavioural problems
• for frontotemporal dementia, results with AChEIs mixed, but SSRIs have been recommended for this condition (in one study, however, paroxetine was not shown to be of benefit)
Pharmacological approaches to DRB
Alternatives to Antipsychotics: Memantine

• pooled analysis conducted in people with agitation/aggression or psychosis from 3 large 6-month, randomized studies in moderately severe to severe Alzheimer's disease
• effect of memantine and placebo on these specific symptoms was evaluated
• significant treatment advantage at both 12 and 24/28 weeks for memantine over placebo
• well-tolerated
• may be a safe and effective treatment in Alzheimer's disease patients with agitation/aggression or psychosis, who are otherwise prone to rapid progression

Pharmacological approaches to DRB

Alternatives to Antipsychotics: Mood Stabilizers, CBZ and Oxcarbazepine


Pinheiro D.

- modulation of glutamate-mediated excitatory synaptic transmission and GABA-mediated inhibitory synaptic transmission might reduce behavioral symptoms

- only carbamazepine demonstrated efficacy BPSD in controlled studies, but with significant adverse events (sedation, hyponatremia, cardiac toxicity), particularly in the elderly and is a strong enzymatic inducer increasing likelihood of drug-drug interactions

- oxcarbazepine, theoretically, could be an alternative to carbamazepine, but no clinical study published to support this -better tolerated than carbamazepine, but induces severe and more frequent hyponatremia
Pharmacological approaches to DRB

Alternatives to Antipsychotics:
Mood Stabilizers, Gabapentin


• limited data on the efficacy of gabapentin for BPSD (11 case reports, 3 case series and 1 retrospective chart review)

• no controlled studies

• in most of the reviewed cases, gabapentin was reported to be a well tolerated and effective treatment for BPSD

• dearth of available data limits support for the off-label use of gabapentin for the treatment of BPSD
Pharmacological approaches to DRB

Alternatives to Antipsychotics: Mood Stabilizers, Valproic Acid


- valproic acid showed some interesting results in BPSD within a large number of open label studies and case reports

- however, among the five controlled studies that have been published, none confirmed its efficacy on these symptoms

- no notable major side effect reported (haematologic and hepatic effects are not more frequent than in the general population), except possible excessive sedation
Pharmacological approaches to DRB

Alternatives to Antipsychotics: Mood Stabilizers, Lamotrigine and Topiramate

- Lamotrigine, which may potentially induce severe cutaneous side effects when administered with valproic acid, has two case reports to indicate some interest in BPSD.
- Although topiramate has shown interesting results in one open study in BPSD, its use in demented patients cannot be recommended because of its deleterious effect on cognitive functions.
Summary and Practice Points

• conduct comprehensive assessment of unmet needs before initiating drug therapy
• non-drug interventions are considered first line before drug therapy
• consider first other pharmacological interventions depending on nature and severity of symptoms.
• recognize that the evidence base for antipsychotic drug therapy is modest
• know the risks of side effects and monitor throughout drug therapy
• document consent discussions
Summary and Practice Points

• antipsychotics are indicated when:
  • there is a significant risk of harm to the patient or others
  • when agitation or aggressive symptoms are
    • persistent,
    • recurrent, or
    • severe enough to cause significant suffering and distress, or significant interference with care

Salzman et al 2008; CCMHS 2006; GPAC 2008; Lyketsos et al 2006
Summary and Practice Points

- unknown which atypical antipsychotic optimizes safety and efficacy
- regular use of typical antipsychotics are not the answer
- start with appropriately low dose
- monitor using efficient tools
- make a decision regarding effectiveness by 8 weeks
- review for drug taper after a 3-6 month period of behavioural stability
First Patient Scenario
A Common Story
First Patient Scenario
A common story

• You are caring for a 79 year old woman who has been living in a care home for 1 year.

• You receive a call asking for some “pre-bath” sedation because this lady is becoming aggressive around bath time.

• She is also reported to be increasingly “resistive to care” – often swearing and yelling at staff to “get out” or pushing them away when they want to help her with personal care.

What do you do next?
First Patient Scenario
Follow the dementia-compromised needs driven (DCND) pathway

• Determine the exact nature of the issue –
  – Behaviour Tracking Log x 7 days
  – Severity – ie safety concerns
  – Other symptoms
• Assess biological issues
  – Other physical symptoms
  – Pain
  – Medications
  – Constipation
• Assess for delirium, depression, psychosis
First Patient Scenario
Follow the DCND Behaviour Model

• What kind of discussions have the staff had around her care, and her needs? How has her care plan been adapted as the result of her behavioural symptoms?
• Interpersonal communication
  • Is she feeling rushed, outpaced when staff deliver care?
  • Are they connecting with her socially before completing the tasks of care?
  • How well does she understand what staff are trying to do?
First Patient Scenario
Follow the DCND Behaviour Model

• Other psychiatric symptoms
  – Delusional ideation
  – Misinterpretation of environment
  – Changes in sleep/appetite
  – Acute Changes in cognition – Delirium???
• Where is she in her dementia trajectory?
  – Is the environment demanding too much from her?
• What do you and the staff know about her as a person?
  – Previous traumas
  – Activities & people she finds calming
First Patient Scenario
Follow the DCND Behaviour Model

• Physical environment
  – Bathroom too cold?
  – Bathroom & Bathtub frightening?

• System factors
  – Who says she has to have a bath? Are there other ways to deliver the care?
  – Are we pushing her care too quickly because staff feel they have too much work to do to take the time that is needed?
First Patient Scenario
Outcome of Assessment

• Behaviour Tracking Log revealed behaviour occurring mostly with morning care, but only when care delivered before 10:00am – no injuries of staff
• Recent staffing model change has meant people who don’t know Ellen are now giving her a bath. Time of bath has recently changed to am from pm because of staff changes.
• Staff have noticed a gradual withdrawal from activities she previously enjoyed and an increase in irritability with other residents – although mild.
• Mood appears more dysphoric than in past
• Sleeping less and up intermittently throughout the night; more disoriented to people.
• Appetite has dropped off and has lost 3 kilos over the past 2 months.
First Patient Scenario
You see her to assess…. 

• You rule out delirium as trigger for behaviour change
• You suggest that care plan be reviewed and revised to be sure it matches Ellen’s needs
• Assess mood status more closely
• Track pain for a defined period
• Talk to family members for their take on Ellen’s mood
• If behaviour does not resolve or escalates despite change in care plan, consider trial of Citalopram given wt loss and sleep changes and increased irritability.
• Keep your eye on the situation…..!
Second Patient Scenario
Old Man Yells at Cloud

• You are oncall covering a residential care facility

• at 10:00 pm, you receive a call from the nursing station that a resident you have never met, Mr. A, has just hit another resident with whom he shares a four-bed room

• Mr. A. is 68 and has a vascular dementia requiring placement on the secure ECU last month.
Second Patient Scenario

- for the last 3 days, he has been more resistive to care, and often refusing his antihypertensives.

- in the past 2 days, he has become more physically resistive to personal care and direction, and making statements that people were stealing his money.

- he is not on any psychotropic medications except zopiclone 7.5 mg HS for sleep, which he refused tonight.

- the staff want you to certify him to hospital.

WHAT WOULD YOU DO NEXT?
Second Patient Scenario
On-the-Phone Clinical Considerations

• How is he now? What is his level of agitation? Escalating? Calming down?
• Can you get vitals? Does he accept medications now? Is he in pain or discomfort? Does he have urinary symptoms? Does he have constipation?
Second Patient Scenario
Consider your Pharmacologic Options

- antipsychotics can be crushed and given with food (except anything that is labeled “long-acting” or “extended release” or “controlled release” or “LA, XR, ER, CR”, etc.)
- long-acting antipsychotics can be given whole with ice cream, as long as the tab/cap isn’t crushed
- liquid forms can also be given with ice cream as long as there is no “Give on empty stomach” labeling on the supply
- liquid risperidone and loxapine can be given in tea; liquid haldol cannot
- haloperidol, loxapine, and methotrimeprazine can all be given subcutaneously (short-term)
- lorazepam can be given SQ (Diazepam CANNOT and you wouldn’t use in geriatrics anyway)
Second Patient Scenario

• You decide with the staff that you will try giving him a dose of quetiapine 50 mg now if he accepts it by mouth while you get dressed and go down there…
• Once there, you make an active decision to coach the staff through this
• The staff report that the quetiapine has helped settle the resident
• You decide not to certify to hospital tonight but what do you do now?
Second Patient Scenario
Clinical Considerations for the Next Day

- Medical workup (esp. for infection), review medications (especially recent changes or omissions due to transfer); EKG also for baseline QTC

- Speak to SDM about the situation and there view of the clinical and ethical issues; family notes sundowning

- Speak to SDM about medications, rationale, route and whether we need to hide them

- Ensure staff safety and ability to do implement care plan, including medication dispensation medical workup
Second Patient Scenario
Clinical Considerations for the Next 24 Hours

• Consider use of regular antipsychotic in the short-term

• Behavioural charting started- ascertain frequency, pattern, severity, nature and effectiveness of staff interventions

• Increase vitals frequency and include sit/stand for orthostasis

• Single room possible? Other environmental interventions (remove projectile objects)
Second Patient Scenario
The Next 24 Hours

• he accepts quetiapine crushed into ice cream

• discussion with the family for consent and staff with the management plan leads to quetiapine being ordered 25 mg PO BID, ensuring a 16:00 dose to attenuate sundowning behaviours

• this partially settles him and no orthostasis, or falls is observed

• family understand the severity of aggression and are agreeable to loxapine SQ if quetiapine is refused by the resident; the staff however, are not so confident in SQ administration due to safety
Second Patient Scenario
What’s next? You could consider...

• you refer to mental health - rule out comorbid psychiatric issues

• you ask for a family meeting for the next day to plan ahead and review “Level of Intervention”
Second Patient Scenario

However...

- In the next 24 hours, the team notices increasing aggression, medication refusal, and accusations of theft against the same co-resident.

- ....you should probably certify to hospital now.
Questions?

• Q&A period – 20 minutes