BEHAVIOURAL AND PSYCHOLOGIC SYMPTOMS OF DEMENTIA : WORKSHOP

Ontario Long Term Care Clinicians
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Andrea Moser, MD, MSc, CCFP, FCFP, COE, CMD

Adapted from : OCFP Alzheimers Strategy

Faculty/Presenter Disclosure

- **Faculty:** Andrea Moser

- **Relationships with financial sponsors:**
  - **Consulting Fees:** Think Research 2017
  - **Other: past** Employee of Centre for Effective Practice 2015-2017
  - **Other: current** Employee of Health Quality Ontario

Disclosure of Financial Support

- **This program has received no financial support.**
- **This program has received no in-kind support.**

- **<u>Potential for conflict(s) of interest</u>:**
  - None identified

Mitigating Potential Bias

- Not required
- antipsychotic guide developed from evidence,sector and expert input

Objectives

Be able to:

- Adopt a person centered approach to BPSD assessment and management
- Assess and interpret common BPSD in patients in LTC (and in community, hospital)
- Support the development, implementation and monitoring of non-pharmacological and pharmacological treatment.
- Be familiar with present risks, benefits and appropriate dose range of medications that are recommended for BPSD

Questions and challenges from your practice

- **Problems you were hoping we would specifically cover?**

Patient/Resident and Family Centered Care

- Empathy video https://health.clevelandclinic.org/2013/03/empathy-exploring-human-connection-video/

- Caregivers become patients https://health.clevelandclinic.org/2014/02/when-caregivers-become-patients-video/

Person Centered Care

- Donald Berwick, MD:

"The experience of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care."

- "Nothing About Me Without Me"

Core Concepts – Institute of Patient and Family Centered Care

Dignity and Respect

Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

Information Sharing

Health care practitioners communicate and *share complete and unbiased information with patients and families* in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.

Participation

Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.

Collaboration

Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation, and evaluation; in facility design; and in professional education, as well as in the delivery of care.

RFCC Outcomes

- Improved clinical outcomes
- Enhanced quality, safety and efficiency
- Increased resident, family and staff satisfaction
- Improved collaboration and communication
- Lower cost

Source: (Bertakis & Azari, 2011; Grumbach & Grundy, 2010; Oshima Lee & Emanuel, 2013)

Prevalence of BPSD

- **90% of patients affected by dementia will experience Behavioral and Psychological Symptoms of Dementia (BPSD) that are severe enough to be labeled as a problem during the course of their illness.**

Frequency of BPSD

- **Agitation:** **up to 75%**
- **Wandering:** **up to 60%**
- **Depression:** **up to 50%**
- **Psychosis:** **up to 30%**
- **Screaming:** **up to 25%**
- **Violence*:** **up to 20%**
- **Sexuality:** **up to 10%**

***more prevalent in severe dementia.**

Current Guidelines/Best Practice

- Quality Standards – Dementia with Aggressive Behaviours acute and LTC
- Canadian Coalition for Seniors Mental Health (CCSMH
- Canadian Consensus on Alzheimers Assessment and Treatment (CCDAT)
- Choosing Wisely
  - Canada LTC, Canadian Geriatrics Society
  - Choosing Wisely USA – American Medical Directors Association

CCSMH National Guidelines : www.ccsmh.ca

- Assessment and treatment of mental health issues in long term care homes
  - Evaluate for medical conditions and diagnostic tests as indicated
  - Detailed interdisciplinary assessment for antecedents/causes
  - If BPSD does NOT pose imminent risk to patient or others – non-pharmacologic Rx

CCCADT4: Canadian Conscensus on Alzheimers Diagnosis and Treatment

- for severe agitation, atypical antipsychotics are recommended
- but risks of therapy must carefully weighed against potential benefits

Choosing Wisely

- Canada
  - LTCMDAC and CGS: *Don't use antipsychotics as first choice to treat behavioural and psychological symptoms of dementia.*

- USA
  - AMDA: *Don't prescribe antipsychotic medications for BPSD in individuals with dementia without an assessment for the underlying cause of the behaviour*
  - AGS: *Don't use antipsychotics as the first choice to treat behavioral and psychological symptoms of dementia*

Health Quality Ontario Quality Standard

Behavioural Symptoms of Dementia

- Care for Patients in Hospitals and Residents in Long-Term Care Homes

Behavioural symptoms of Dementia Quality Statements

- 1: Comprehensive Assessment
- 2: Individualized Care Plan
- 3: Individualized Nonpharmacological Interventions
- 4: Indications for Psychotropic Medications
- 5: Titrating and Monitoring Psychotropic Medications
- 6: Switching Psychotropic Medications
- 7: Medication Review for Dosage Reduction or Discontinuation
- 8: Mechanical Restraint
- 9: Informed Consent
- 10: Specialized Interprofessional Care Team
- 11: Provider Training and Education
- 12: Caregiver Training and Education
- 13: Appropriate Care Environment
- 14: Transitions in Care

Clinical Guides/Resources

- Centre for Effective Practice: Antipsychotic Guide
  - LTC edition
  - Primary Care Edition
  - Caregiver Edition
- Alberta Health Services
- BC health Services

Centre for Effective Practice (CEP)

Use of Antipsychotics in Behavioural and Psychological Symptoms of Dementia (BPSD) Discussion Guide

Long-Term Care (LTC) Edition

BPSD Symptoms Clusters
Ref Antipsychotic Guide (CEP)

1, 2

Psychosis	Aggression	Agitation	Depression	Apathy	Mania
					
Delusions Hallucinations Misidentification Suspicious	Defensive Resistance to care Verbal Physical	Dressing/undressing Pacing Repetitive actions Restless/anxious	Anxious Guilty Hopeless Irritable/screaming Sad, tearful Suicidal	Amotivation Lacking interest Withdrawn	Euphoria Irritable Pressured speech

Top Ten Behaviors not (usually) responsive to medication

- Aimless wandering
- Inappropriate urination /defecation
- Inappropriate dressing /undressing
- Annoying perseverative activities
- Vocally repetitious behavior
- Hiding/hoarding
- Pushing wheelchair bound co-patient
- Eating in-edibles
- Inappropriate isolation
- Tugging at/ removal of restraints

What is P.I.E.C.E.S.

- Taught to LTC registered staff since 1998, expanded with Behavioural Supports Ontario Funding
-
- Person-centered assessment approach
- Standardized Assessment Tools
- Guides development of non-pharmacologic strategies

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PIECES Risk Assessment Template

- The Three Question Template:
- 1. What has changed?
- 2. What are the RISKS and possible causes(using the PIECES framework)?
- 3. What is/are the action(s)?

PIECES Framework

Physical

Intellectual

Emotional

Capabilities

Environment

Social/Spiritual

P- Physical Problems

- **May be due to *P*hysical problems**
  - **Pain**
  - **Bowel**
  - **Bladder**
  - **Delirium**
  - **Diseases**
  - **Drugs**
  - **Hunger**
  - **Thirst**

I - Intellectual/cognitive changes

- **Memory loss, Amnesia:**
- **Agnosia (Recognition of people or things)**
- **Apraxia**
- **Aphasia (speech)**
- **Anosognosia (Not knowing you don’t know)**
- **Impaired executive functions (planning)**
- **Return to a place back in time**
- **Apathy**
- **Perceptual difficulties**
- **Primitive reflexes, perseveration**

E - Emotions

- **Depressive symptoms**
  - **Withdrawal, crying, repetitive**
- **Anxiety**
  - **Resistive behaviours**
- **Suspiciousness**
- **Delusions**
- **Psychosis**
- **PTSD**
- **Past psychiatric illness**

C – Capabilities / Functional ability

- **IADL and ADL**
  - **Personal care**
  - **Dressing**
  - **Toileting**
  - **Etc…**
- **too low to meet demands of environment (catastrophic reactions)**
- **not utilized enough: boredom**

E – Environment

- **May be due to *E*nvironment**
  - **Unfamiliar or Familiar**
  - **Noise – too quiet, too loud**
  - **Lighting**
  - **Temperature**
  - **Activity Level**
  - **Meaningful Activities**
  - **Confusing or Tense**

S- Social interactions

- **Social, Spiritual**
  - **Mountain Top Highs and Lows**
  - **Traumas**
  - **need to be useful**
  - **likes and dislikes of the person**
  - **cultural background**
  - **Lifelong coping strategies less effective**
  - **Meaningful activities**

Assessment of BPSD

- What assessment tools do you and the interdisciplinary team use in LTC/community?

P.I.E.C.E.S. tools

- Daily Observation Sheet (DOS)
  - Shows frequency, severity, patterns of behaviours, can be individualized
- A-B-C Charting
- Kingston Standardized Behavioural Assessment (KSBA)
  - Caregiver report of function and behavioural symptoms
- MMSE, MOCA, Clock
- Confusion Assessment Method (CAM)
- PainAD

Dementia Observation System (DOS)

ADDRESSOGRAP

e corresponding numbers to record in 1 hour intervals

Sleeping
Awake/Calm
Vocalizations
Restless, Pacing
5. Aggressive – verbal
6. Aggressive - verbal (with care)
7. Aggressive – physical
8. Aggressive – physical (with care)

Location: H. Hallway
B. Bedroom
T. TV room
Q: Quiet room
S: Shower room
D: Dining room
W: Washroom
O: Off unit

Month/Year: _
Dates: _____

IME/ DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
0700						
0800						
0900						
1000						
1100						
1200						
1300						
1400						
1500						

A-B-C charting

- Antecedent
  - Circumstances prior to the behaviour
  - Noise, activity
- Behaviour
  - Descriptive, avoid labelling
- Consequences
  - What was outcome of intervention

Kingston Standardized Behavioural Assessment - KSBA

- Caregiver questionnaire
-
- LTC, community versions

What form are the assessment tools in

- Paper
- Electronic

Additional Assessments in LTC

- Minimum Data Set – RAI – MDS
  - Cognitive Performance Scale – CPS 0-6
  - Aggressive Behaviour Scale – ABS
  - Depression Rating Scale – DRS

- Electronic Record?
  - DOS
  - ABC charting
  - PIECES assessment template
  - Others?

- Others?

Delirium

- Common, often superimposed on dementia
- Under recognized: (43% RN, 32-66% MD)
- Mortality (up to 30%) – higher if unrecognized
- Recovery: 1/3 complete, 1/3 partial, 1/3 die
- Following recovery - annual incidence of dementia is 20%
- Hyperactive / hypoactive / mixed

Delirium vs Dementia

CLINICAL FEATURES vs DEMENTIA		
CLINICAL	**DELIRIUM**	**DEMENTIA**
Onset	Sudden	Insidious
Course	Fluctuating	Stable
Consciousness	Reduced	Clear
Attention	Disordered	Normal
Hallucinations	Often Present	Often Absent until Late in Course
Psychomotor Activity	Increased, Reduced or Shifting unpredictably	Often normal may see agitation late in course

****WITH A NEW BEHAVIOUR PROBLEM, FIRST RULE OUT DELIRIUM****

Screening for Delirium

- Confusion Assessment Method / CAM
  - Based on clinical bedside assessment
  - Simple and quick to administer

Confusion Assessment Method - CAM

Acute Change in mental status

AND

Inattention/fluctuation

PLUS

Disorganized thinking

OR

Altered level of consciousness

- Sensitivity 94 - 100%
- Specificity 90 - 95%

Ann Intern Med 1990; 113:941
Arch Intern Med. 1995; 155:301

Non-Drug Therapy for BPSD

- Caregiver approach considerations:
  - Personal approach
    - Be calm and compassionate
    - Engage in individualized activities
    - Focus on resident's wishes, interests, concerns
    - Approach slowly; look for signs of increased agitation and ask permission before entering
  - Daily routines
    - Maintain routines and reduce uncertainty
    - Use long-standing history and preferences as guidance
    - Individualize social and leisure activities
  - Communication style
    - Use positive non-verbal cues
    - Make eye contact (unless perceived as aggressive)
    - Use short simple words and phrases
    - Speak clearly and use a positive tone
    - Be patient
- How are successes in care communicated?

	Behaviour	Possible Solutions
DOS Colours*[4]	**Noisy** (Yellow)	• Distract, engage • Individualized music, nature sounds, presence therapy (tapes of family)
	Restless (Orange)	• Distract, engage • "Rest stations" in pacing path, adapt environment to reduce exit-seeking, physical exercise, outdoor activities
	Exit-seeking (Brown)	• Distract, engage • Adapt environment to reduce exit-seeking, physical exercise, outdoor activities • Register the individual with MedicAlert and Alzheimer's Society Safety Home program (contact information will be on bracelet or necklace) • Hide exits with curtains, or paint a black circle on the floor (the individual will think it is a hole and will not exit)
	Verbal aggression (Pink)	• Distract, engage • Individualized music, nature sounds, presence therapy (tapes of family)
	Physical aggression (Red)	• Distract, keep calm, remain warm and supportive • If possible, give the person some space and try to approach later
Other	**Delusion/ hallucination**	• Understand this is the reality and do not confront the false belief • Focus on how the resident feels, not the content; offer distraction, avoid clutter, ...
	Agitated/ irritated	• Calm, soothe, distract • Individualized music, aromatherapy, pet therapy, physical exercise, outdoor activities
	Resistant to care	• Identify source of threat (e.g. pain); change routines and approaches
	Repetitive questions/ mannerisms	• Reassure, address underlying issue, distract • Put the answer to the same repetitive question on a piece of paper or card and ask the resident to read the card instead
	Hoarding	• Remove items gradually, reorganize and clear paths in the case of emergency; be compassionate
	Inappropriate behaviour (e.g. disrobing, masturbation in public, verbally inappropriate, hyper sexuality)	• Distract, re-direct • Keep an active and regular schedule to avoid boredom • Try increasing the level of appropriate physical attention • Provide personal space if possible and come back when the resident is calmer • Allow the individual to masturbate in a private area

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*DOS = Dementia Observation System (Colours used in table are taken from the DOS system, though you may use different colours in your practice)

Application of P.I.E.C.E.S. through cases

Cases part 1 – non pharmacologic approach.

- **Using the PIECES framework hypothesize what could be contributing to this behavior?**
- **Pretend you are working with the interdisciplinary team and develop strategies that could be used to care for this person & minimize impact of the behavior.**

PIECES framework to understand BPSD and tailor non-pharmacological treatment

- **P - Physical**
- **I - Intellectual**
- **E - Emotional**
- **C - Capabilities**
- **E - Environment**
- **S - Social, spiritual, background history**

Case A

Case B

BPSD PHARMACOLOGIC MANAGEMENT

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Decision framework for the use of medication in BPSD

- **Is this medication indicated?**
- **Is it necessary and how will it be helpful to the patient?**
- **What are the risks?**
- **Will the benefits likely outweigh the risks?**
- **Who decides whether the benefits are worth taking the risks?**
- **When is it appropriate to consider stopping the medication and what will we use to monitor response?**

Pharmacologic Principles for Prescribing in the elderly

- Protein binding
  - Often decreased protein levels particularly in dementia – increases ‘free’ drug levels.
- Renal clearance
  - Decreased GFR with aging, atherosclerosis, hydration issues
  - Calculated eGFR with consideration of age, weight, sex. (Cockroft-Gault)
- Awareness of Drug – Drug interactions
- Serum Drug Levels – valproic acid, Li, TCAs
- Cautious of Drug Cascade

Prescribing principles cont'd

- Correct/optimize treatment for underlying medical problem.
  - Example: cholinesterase inhibitor
- Remove possibly offending drugs.
  - E.g. Benzodiazepines, anticholinergics
- Identify target symptom or cluster.
- Use one drug at a time, monitoring effect on target symptoms.
- Obtain consent to treatment

Top Ten Behaviors responsive (perhaps!) to medication

- Physical aggression
- Verbal aggression
- Anxious, restless
- Sadness, crying, anorexia
- Withdrawn, apathetic
- Sleep disturbance
- Wandering with agitation/aggression
- Vocally repetitious behavior
- Delusions and hallucinations
- Sexually inappropriate behavior with agitation

BPSD Symptoms Clusters

1, 2

Psychosis	Aggression	Agitation	Depression	Apathy	Mania
					
Delusions Hallucinations Misidentification Suspicious	Defensive Resistance to care Verbal Physical	Dressing/undressing Pacing Repetitive actions Restless/anxious	Anxious Guilty Hopeless Irritable/screaming Sad, tearful Suicidal	Amotivation Lacking interest Withdrawn	Euphoria Irritable Pressured speech

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Drug Therapy

- Used when non-drug approaches fail or there is imminent risk
- Match drug to behaviour
  - Depression … antidepressant
  - Anxiety, chronic… antidepressant
  - Anxiety, episodic… short acting benzodiazepine (Eg. Lorazepam)
    - E.g prior to event that triggers agitation/aggression such as bathing
  - Antipsychotic… see next slide
- Avoid drugs that may make targeted behaviour **worse**
  - E.g. benzodiazepine in resident with sexual disinhibition
    - a benzodiazepine will often worsen the disinhibition

Behaviour	Drug Therapy
Psychosis, Aggression, Agitation (severe)	• Atypical antipsychotics (such as risperidone, aripiprazole, olanzapine, quetiapine as discussed in detail on page 6)[10, 14]
Agitation (severe)	• SSRIs or trazodone but evidence is lacking[15, 16]
Agitation (severe) in Lewy Body Dementia or Parkinson's	• Possible cholinesterase inhibitors • Very low dose quetiapine[15, 16]
Anxiety (short term/ intermittent)	• A short acting benzodiazepine such as lorazepam prior to anxiety provoking events such as bathing[17]
Anxiety (chronic)	• Antidepressants (such as SSRIs, SNRIs) • Buspirone[10]
Depression (severe)	• Antidepressants such as SSRIs (e.g. citalopram, sertaline), SNRIs (e.g. venlafaxine, duloxetine), other antidepressants (bupropion, mirtazapine, nefazodone) • Secondary TCAs (nortriptyline or desipramine) may be suitable if coexisting indication such as neuropathic pain, etc., but caution regarding anticholinergic load, etc.[10, 16, 18]
Apathy	• Limited role for drug therapy but occasionally cholinesterase inhibitors may be helpful • Methylphenidate also sometimes used, but limited by concerns such as stimulant effect on behaviour and risk of diversion[15, 18]
Mania	• Addressing any possible drug causes is of primary importance • Evidence for specific recommendations lacking • Mood stabilizers an are option, but take caution regarding tolerability and drug interactions

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Cognitive enhancers

- **Indications for donepezil, rivastigmine, galantamine**
  - Alzheimer disease
  - Vascular dementia or mixed vascular-AD
  - Lewy Body dementia

- **Not proven helpful in:**
  - Fronto-temporal dementia(Picks disease),
  - Alcohol-related dementia
  - Mild cognitive impairment

Cognitive enhancers

- **Possible benefits**
  - Improving cognitive function
  - Maintaining functional abilities
  - Improving socialization
  - Prevent decline in ADLs, decreasing amount of care needed
  - Postponing institutional care
  - Reducing behavioral and psychological symptoms (esp. in Lewy Body dementia)

Cognitive enhancers

- **Side effects of Acetylcholinesterase:**
  - Worsening of heart block leading to syncope, falls and fractures
  - Asthma, COPD
  - Peptic ulcers (esp. if taking other drugs)
  - Seizures
  - Drug interactions with Paroxetine, Fluoxetine, Fluvoxamine
- **Risks to monitor with use:**
  - Muscle cramps
  - Insomnia and agitation
  - Nausea and vomiting
  - Diarrhea and
  - Weight loss.

Glutaminergic agent for moderate dementia

- **Memantine (Ebixa)**
- **Indications:** moderate to severe AD and vascular (or mixed) dementia
- **Benefits:** cognition, socialization, ADLs and BPSD
- **Risks:** confusion, headaches, agitation, insomnia, dizziness, urinary incontinence and UTIs. Hallucinations if dose too high.
- Do not use if severe renal impairment.
- Not covered on ODB

Anxiety symptoms

- “Anxiety is NOT a benzodiazepine deficiency”
  Dr. Bill Dalziel, geriatrician
- Cholinesterase inhibitor
  - particularly for anxiety of early dementia.
- SSRIs
  - first line treatment for anxiety disorders
  - will take a few weeks to work
  - check drug interactions.
- Consider trazodone (watch for hypotension)

Antidepressants: indications

- Depression pre-existing or complicating dementia: Sig: E Caps, Cornell depression scale for depression in Dementia
- Depressive and anxiety symptoms of frontal-temporal lobe dementia
- Persistent anxiety symptoms leading to catastrophic reactions (e.g. vascular dementia)
- Prevention of recurrent depressive episodes and anxiety disorders
- Trazodone used for short-term sedation

Depressive symptoms

- **S** - sleep disturbance
- **I** – loss of interest
- **G** – guilt
- **E** – energy
- **C** - concentration
- **A** – appetite
- **P** – psychomotor retardation or agitation
- **S** – suicide

Depression vs Dementia

Features that Distinguish Depression from Dementia	
Primary Depression	**Primary Dementia**
Onset more acute and dated.	Insidious onset, vaguely dated.
Patient complains of cognitive deficits and seeks help.	Unaware or no complaints of cognitive deficits.
Patient complains in detail of memory.	Vague complaints.
Deficits are emphasized.	Deficits are concealed.
Patient makes little effort at task.	Patient struggles with tasks.
Attention is preserved.	Faulty attention and concentration.
“I don’t know” answers are typical.	Frequent “near miss” answers.
Variable performance.	Consistently poor performance.

Depression is often superimposed on dementia.

Antidepressants: Choices

- Citalopram and escitalopram
- Sertraline
- Duloxetine*
- Venlafaxine
- Mirtazapine
- Trazodone used for short-term sedation

- * MOHLTC medication management program, LTC

Best choices: antidepressants

- **SSRI for depression or anxiety**
  - Citalopram and Escitalopram
  - Sertraline
- **When noradrenergic properties may be wanted (pain, activation)**
  - Venlafaxine *not if unstable BP
  - Duloxetine
- **When sedation may be a benefit**
  - Trazodone *watch for hypotension
  - Mirtazapine * some anticholinergic properties
- **Weight loss**
  - Mirtazapine

Antidepressants: risks

- Agitation and suicidal risk
- Headaches
- GI upset, diarrhea and bleeding ulcers
- Hyponatremia
- Over-sedation or insomnia
- QT prolongation
- Falls

Antipsychotics: indications

- **Severe and persistent behavioral and psychological symptoms which are distressing to the patient or put the patient at risk and do not respond to non-pharmacological intervention and**
- a. Psychosis
- b. An imminent risk of harm to other residents or staff
- c. Severe and disruptive agitation or aggression

- **Acute management of symptomatic delirium**

- **Continuation of treatment of psychotic disorders that preceded the dementia**

Considerations for an Antipsychotic Trial for BPSD

- Consider whether an antipsychotic trial is needed
  - Imminent risk of harm?
  - Disturbing, distressing or dangerous symptoms?
  - Symptoms more likely to respond to antipsychotics?

Best choices: anti-psychotics

- **For acute delirium– very short term (days)**
  - **Haloperidol (0.5 mg that may be repeated)**
- **For persistent psychosis/agitation**
  - Risperidone *:
    - start with 0.25-0.5 mg daily and increase slowly as needed/tolerated over weeks to max. 2 mg per day
  - Olanzapine *:
    - start with 2.5 mg daily and increase slowly as needed/tolerated over weeks, to max 10 mg daily
  - Aripiprazole*
    - 2.5mg daily – target 10-15mg daily
  - Quetiapine:
    - start with 12.5 mg daily or BID and increase slowly over weeks to max 200 mg daily

*Recommended in the 4th Canadian Consensus Conference on the Diagnosis and Treatment of Dementia

Antipsychotic medications

- **Risks and side effects:**
  - Hypotension can lead to falls and fractures
  - Over-sedation
  - Anticholinergic side effects that can worsen cognition
  - Weight gain and increased vascular risk factors may increase risk of CVA or worsen vascular or mixed dementia
  - Parkinsonism (extra-pyramidal side effects affecting gait and posture, tremors, rigidity, excessive drooling) and tardive dyskinesia
  - Akithisia, Neuroleptic malignant syndrome
  - **Increased mortality with all anti-psychotics (X2)**
- **NO ideal anti-psychotic available at this time**

Antipsychotic medications

- **Strategies that minimize the risk to the patient**
  - Use only if absolutely needed and only for as long as needed (e.g. days in delirium, months in severe BPSD)
  - Chose drug that will be least likely to worsen medical problems of the patient
  - Monitor closely for side effects
  - Give it time to work before increasing the dose to toxic range…
  - As soon as the symptoms appear to be under control, decrease the dose to avoid accumulation
  - Review every 3 - 6 months if used for BPSD

Antipsychotic medications

- **Strategies that minimize the risks:**
  - Discuss risk/benefit ratio with capable patient or substitute decision maker (SDM)
  - Review benefits and side effects you are watching for with family or SDM
  - Document that you are reviewing regularly to try to decrease or discontinue.
  - Document non-pharmacological interventions used to reduce use of anti-psychotic medications

Approach to the Acutely Agitated Patient

- **Safety** - of the patient, other residents and staff is number one concern
- **Assess competency** - Except in an emergency the patient (if capable) or Substitute Decision Maker must be involved in treatment plan.
- **Treatment** – of choice in urgent situations is oral atypical antipsychotics
  - M tab and Zydis are more quickly dissolved but **do not** have a more rapid onset of action

Urgent Situations – Atypical Antipsychotics

Atypical Antipsychotic	Dose	Frequency	Max dose/24 hrs
Risperidone	0.25-1 mg po tabs/liquid	Q2-4 hr prn	2 mg *more EPS over 1mg*
Olanzapine	2.5-5 mg po tabs	Q2-4 hr prn	10 mg
Quetiapine	12.5-25 po tabs	Q2-4 hr prn	200 mg

Urgent Situations – Second Line

Medication	Dose	Frequency	Max dose/24 hrs
Haloperidol	0.5-1 mg po/liq/im	Q2-4 hr prn	2 mg *Watch re EPS
Loxapine	2.5-5 po tabs/liq/im	Q2-4 hr prn	25 mg *Anticholinergic
Lorazepam	0.5-1 mg po tabs/sl/sc/im	Q2-4 hr prn	2 mg *Disinhibition, depressant, falls

Cannabinoids

- Evidence free zone
- Trials pending – Sunnybrook, CAMH

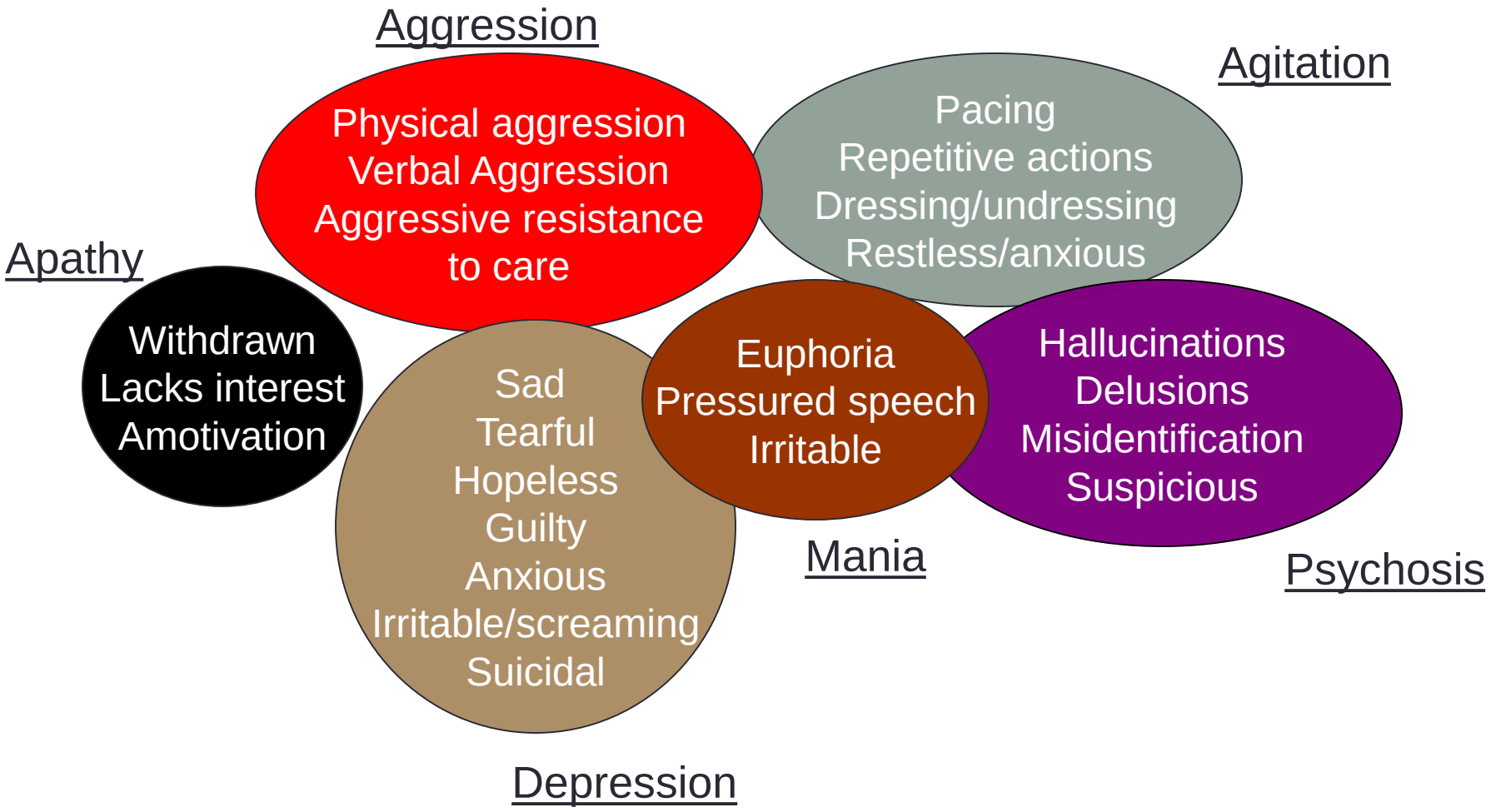
Application of P.I.E.C.E.S. through cases

Cases part 2 –pharmacologic approach.

- **Using the PIECES framework hypothesize what could be contributing to this behavior?**
- **Pretend you are working with the interdisciplinary team and develop strategies that could be used to care for this person & minimize impact of the behavior.**
- What is leading you to consider pharmacologic management
- What pharmacologic management might you recommend

Adapted from McShane R. Int Psychogeriatr 2000;12(suppl 1): 147

BPSD Symptom Clusters



PIECES framework to understand BPSD and tailor non-pharmacological treatment

- **P - Physical**
- **I - Intellectual**
- **E - Emotional**
- **C - Capabilities**
- **E - Environment**
- **S - Social, spiritual, background history**

Family physicians are at the core of the treatment team, working with:

- **Patients and substitute decision makers**
- **Other caregivers (home care, LTC staff)**
- **Community resources (Alzheimer Society, First Link programs)**
- **Consultants such as PRCs, Outreach teams, Specialized geriatric medicine and mental health services, mobile Support teams (BSO)**

Resources

- Canadian Coalition of Seniors Mental Health
  - www.ccsmh.ca
  - Delirium, depression, suicide, BPSD

- Health Quality Ontario Quality Standard
  - http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards/Behavioural-Symptoms-of-Dementia/

- CEP antipsychotic guide
  - https://thewellhealth.ca/dementia

- 4th Canadian Consensus Guideline on the Diagnosis and Treatment of Dementia
  - http://www.alzheimer.ca/~/media/Files/national/For-HCP/for_hcp_recos_CCCDTD4_en.ashx

Antipsychotic Guide Discussion

- Is it useful
- What sections are of most benefit
- What sections are less useful

Discussion and feedback

- **Other materials that would be helpful to develop or reference?**

  - **Contact:**

Andrea Moser (amoser@baycrest.org)

Mr. Rose

- **Every day Mr. Rose remains in the same chair all morning until someone comes to get him for lunch. After lunch, he lingers in the dining area even after everyone has left.**
- **His wife is annoyed that “he just sits there like a log” and never does anything!**

Mrs. Easy

- **Mrs. Easy was admitted to your ward 5 days ago. She looks upset and tells you that she finds that “the service is terrible”.**
- **She wants to leave immediately.**
- **She continues to pace, fidget and becomes tearful when she is redirected to her room.**

Mr. Klein

- **Mr. Klein comes out of his room inappropriately dressed. He has no shirt or undershirt. He has put his sweater on rather than a shirt and put his pajama top over his sweater. You can also see his pajama bottom sticking out of the bottom of his pants. He has just walked past one of other residents who shouted that he looked stupid and an altercation followed.**

Mr. Borden

- **Mr. Borden was admitted to hospital because he physically assaulted another resident of the Long Term Care home, where he resides. The dispute was over a toothbrush.**
- **This morning, he is very upset because his glasses and wallet have been stolen and he demands that you call the police.**

Mr. Noisy

- **Mr. Noisy has yet again got into trouble because he makes inappropriate comments to other residents and staff. He is insulting and provocative. This leads to verbal shouting matches and sometimes physical aggressive behavior.**