

MANAGING AGITATION AND AGGRESSION IN DEMENTIA

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THE CONCEPT OF SUFFERING

DEFINITIONS:


- The state of undergoing pain, distress, or hardship (Oxford dictionary)
- An experience of unpleasantness and aversion associated with the perception of harm or threat of harm in an individual (Wikipedia)

REVIEW OF KEY POINTS FROM CASE STUDY

- **76 y/o Filipino woman**
 - Residing in assisted living facility x 2 years
 - Diagnosed with Alzheimer's Dementia since 2009
 - Had high profile job;
 - Preferred to stay at home prior to illness
- **History**
 - Hx of refusing caregivers in her home; aricept(donepezil) seemed to decrease anger
 - Was arguing more when placed; started on ativan(lorazepam)
 - Hx of sleep problems; started on Ambien (zolpidem)
 - Sleeps a lot during the day
- **Current problems**
 - Recently started hitting, kicking, yelling at staff and others; roommate upset
 - Behavior worsens with attempts to bathe, when taken to dining room or to activities
 - Post starting on seroquel (quetiapine) has fallen, eating less and quieter
 - Staff want her to stay on seroquel,
 - Family concerned about too much daytime sleep

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GENERAL TREATMENT PRINCIPLES

- Identify and treat comorbid physical illnesses
 - e.g., diabetes, hypertension
 - Promote brain health by exercise, balanced diet, stress reduction
 - Avoid anticholinergic medications
 - e.g., diphenhydramine
 - Set realistic goals
 - Limit prn (as needed) psychotropic medication use
 - Specify and quantify target behaviors
 - Maximize and maintain functioning
 - Establish and maintain alliance with patient and family
 - Consider referral to hospice (when appropriate)
 - Identify and examine context of behavior (is it harmful to patient or others) and environmental triggers (e.g. overstimulation)
 - exclude underlying physical discomfort
 - consider nonpharmacological strategies
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NONPHARMACOLOGIC APPROACHES FOR PROBLEM BEHAVIORS


To improve function:

Behavior modification, scheduled toileting, graded assistance, positive reinforcement to increase independence


For problem behaviors:

Music during meals, bathing; walking or light exercise; simulate family presence with video or audio tapes, pet therapy, speak at patient's comprehension level, bright light, "white" noise (i.e., low-level, background noise)

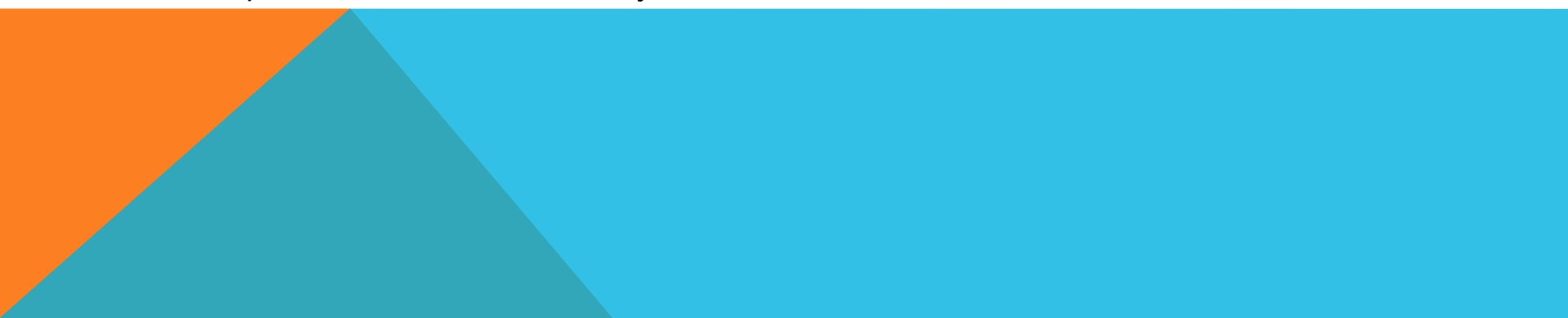
WHAT STEPS WOULD YOU ADVISE THE ASSISTED LIVING TEAM TO TAKE IN THE INITIAL APPROACH WITH THIS RESIDENT?

1. Learn more about
 - How ALF works,
 - Staff on duty and level of staff education related to dementia
 - Is there continuity of caregivers? New caregivers?
 2. How well does the geriatrics team know the patient and the family and goals of care, patient/family preferences?
 3. Try to find out why this patient has started hitting, kicking, yelling more recently?
 - Consider pain, urine infection, constipation, poor management of other health issues, new roommate, changes in staffing, weight loss, teeth problems, new medications, boredom, lack of privacy, sensory impairment, etc.
 4. Importance of one quarterback!.....avoid confusion
 5. All contact with staff is via fax or phone:
 - Important to establish a relationship with key staff members;
 - Important to always speak with staff member who works with patient and NOT to rely only on faxed reports
 6. Responding to staff and family in a timely manner is key (develops trust)
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WHAT IS A GERIATRICS INTERDISCIPLINARY TEAM?

- Geriatrician, advanced practice nurse, social worker, and psychologist
(sometimes a pharmacist, physical or occupational therapist)
 - Complex patient and Family = unit of care
 - Geriatrician manages medications and health issues along with advance practice nurse
 - Social worker manages family support for caregiver stress/burden, guidance for resources, behavior management, and long term planning
 - Psychologist provides assessment of cognitive status, depression, anxiety and therapy if needed
 - There is often a crossover of the roles of the team members
 - A well-functioning team is not static
 - They need to grow and learn from each other
 - Work out issues
 - Focus of teams is to provide a high level of quality care in accordance with the patient's and family preferences
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HOW WOULD YOU WORK WITH THE CLINICAL TEAM AND FAMILY TO MANAGE THIS RESIDENT'S CARE?

- Mrs. X was seen at the geriatric clinic with her daughter two months ago and she seemed to be fairly stable. Was not hitting/yelling at that time, but cognitive status had declined and was now often incontinent of urine
 - MOCA score 12/30 from previous score one year ago of 15/30
 - daughter did report that Mrs. X sometimes grimaces and moans a little when they got her up from her bed or a chair but she denied pain when asked
 - in the past month (since the clinic visit):
 - faxes started to come to the clinical team reporting increased agitation with kicking, yelling, hitting
 - daughter called CNS telling her that the family was told Mrs. X would have to move out of the facility if her behaviors were not managed
 - daughter tearful and doesn't know what to do
 - Geriatrics CNS had several discussions with staff via phone and tried to get more information about triggers for behavior (antecedent, behavior, and consequence).
 - Staff asked about non-verbal and verbal signs of pain, s/s urine infection, cough, sleep habits, activities at facility.
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TEAM DISCUSSION

PROBLEM

1. Behaviors



2. Not many activities at facility



3. Unable to stop Mrs. X from daytime sleeping at first



4. Mrs. X enjoyed looking at photos



5. Meal times seemed to set off behavior (ABC)



6. Family support



7. Communication with the residence facility




8. Future

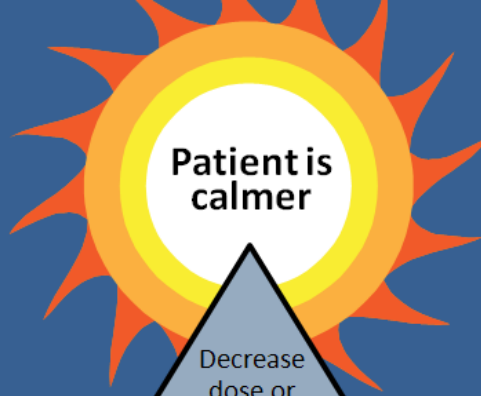


SOLUTION

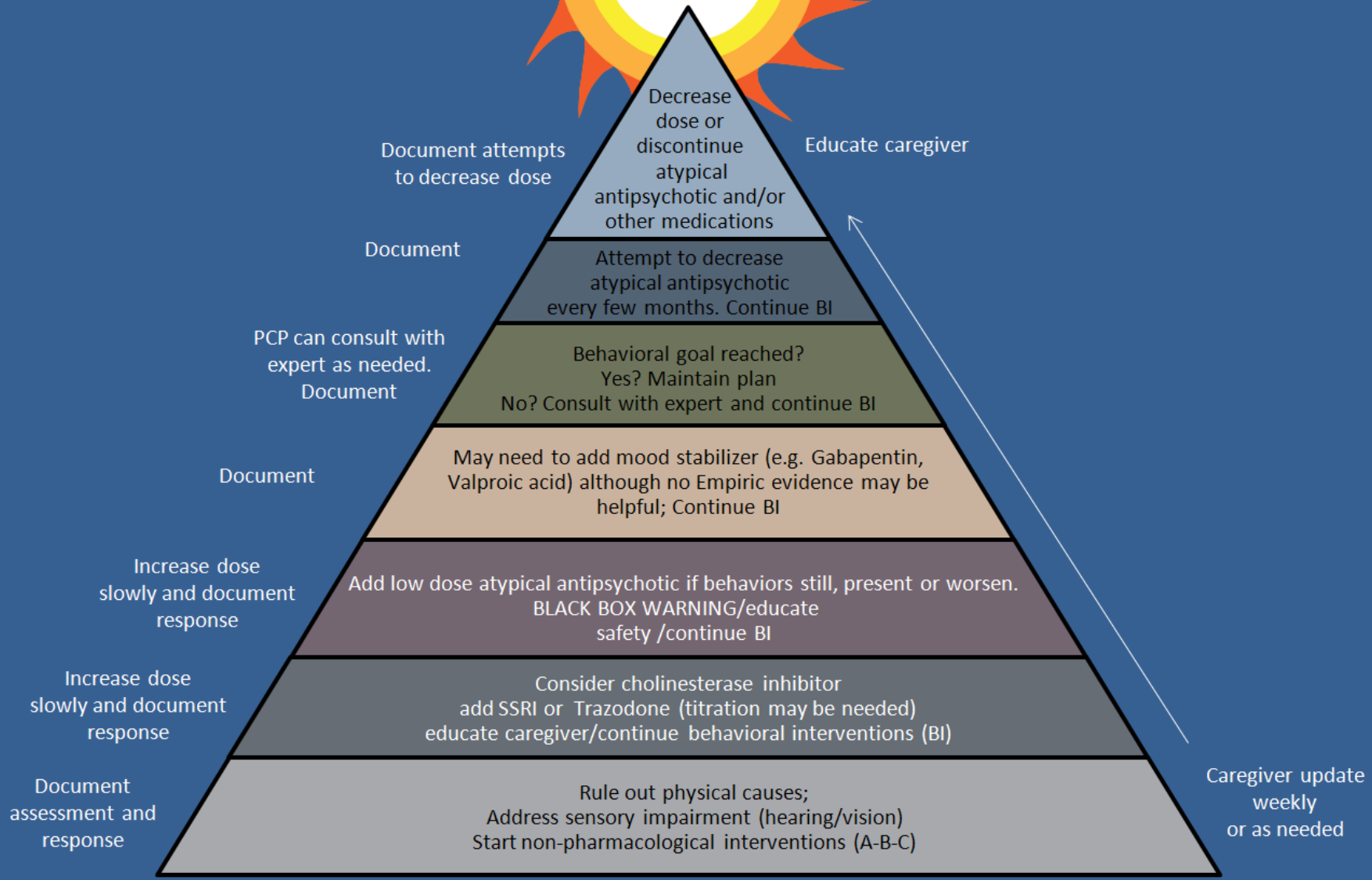
- Give acetaminophen 500 milligrams three times a day for ? pain. Start trazodone at bedtime (stop Ambien) or could start SSRI (e.g., citalopram, sertraline). Did not d/c seroquel
- Daughter to take Mrs. X to visit an adult day health care program; take her out during the day if possible
- Encouraged staff to limit naps to < one hour; add short daytime walks outside
- Daughter brought in box of old photos she could sift through
- Mrs. X was placed at smaller table with only one other resident and reviewed distraction techniques/rewards with staff
- Social work encouraged daughter to attend her caregiver support group. Provided long term planning information
- Requested feedback from facility staff and responded in timely fashion
- Over time needed to increase dose of trazodone, but did need to remain on atypical antipsychotic for awhile

THE REAL AND THE IDEAL

- Many people with dementia do have behavioral challenges which require an atypical antipsychotic for awhile despite best attempts to avoid these
 - Key issue is not randomly prescribing antipsychotics without first getting a complete history from staff and/or family who know patient
 - Lorazepam (on Beers list) not recommended for older people, but sometimes useful for anxiety (e.g. Hx of agoraphobia and ++anxious when bathing)
 - Behavioral modifications for behavior should be tried first and always continue but don't always work alone if agitation, aggression, or psychosis present
 - All responses to behavioral techniques and to medications need to be monitored and documented as to whether they are meeting the objective
 - e.g., will agree to bathe three times a week (measurable goals)
 - No two people are alike
 - There are different types of dementia
 - Try to avoid PRN(as needed) medications
 - Patient may be over sedated and many facilities do not have staff to determine the need
 - Address medication side affects: EPS and metabolic syndromes with antipsychotics
 - **Communication is the key!!! Managing challenging behaviors in dementia is both an art and a science**
 - **Document all attempts to alleviate the patient's "suffering" and outcomes of interventions**
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Patient is calmer



Increased agitation or aggression