Government of Western Australia
East Metropolitan Health Service

Royal Perth Bentley Group

Delivering ‘A Better Way to Care’ for patients with Cognitive Impairment

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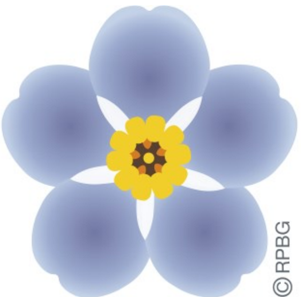
Royal Perth Bentley Group

2018



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Management of agitation in older patients

This guide refers to patients with PERSISTENT behavioural problems such as:

- Restlessness
- Pulling at lines and tubes
- Continually trying to get out of bed
- Talking to self
- Pacing
- Trying to leave ward or hospital
- Shouting, swearing, arguing, insulting staff
- Threatening or trying to hit, kick, bite or scratch

Behaviour like this is usually due to DELIRIUM or DEMENTIA. Remember…

- Delirium may indicate a serious underlying medical problem or medication side effect
- Agitated patients with delirium or dementia sometimes injure themselves or staff
- Benzodiazepines usually make agitation worse: increasing the risk of falls, pressure injuries, aspiration, etc.

This guide is not about patients with:

- Simple insomnia
- Simple threats to leave hospital against medical advice or conflict about a specific issue
- Behavioural problems due to a psychiatric disorder such as mania or psychosis.

Step 1. Review diagnosis and screen for new problems, such as:

- **D ehydration**
- **E lectrolyte imbalance**
- **L evel of pain**
- **I nfection/sepsis/inflammation**
- **R espitory failure** (hypoxia/hypercapnia)
- **I mpaction of faeces**
- **U rine retention**
- **M edication toxicity** Especially anticholinergics (e.g. tricyclics, oxybutynin, tiotropium), digoxin, sedatives, opiods, corticosteroids, anticonvulsants, antiparkinsons.

Consider alcohol or benzodiazepine withdrawal

If withdrawal is suspected:

- Use diazepam and thiamine
- Do not use antipsychotics
- Commence Alcohol Withdrawal Scale (AWS) and refer to AWS guidelines

Step 2. Assess Risk

Consider potential for violence, pulling out tubes, absconding, interference with other patients, falls, accidents etc

If high risk:

- A single room
- Companion
- Discuss with Senior
- Proceed with Medication

Step 3. Non-Pharmacological Interventions: FIRSTLINE Management

- **Maintain low level sensory stimulation: soft lighting and sound**
- **Single room if possible**
- **Staff to calmly engage, distract and supervise the patient**
- **Avoid confrontation** e.g. walk away, defer interventions or offer food and drink to diffuse tension
- **Encourage family to stay and assist**
- **Consider 1:1 companion / advice from Dementia Champion**

Pharmacological Management of Agitation in Older Patients

Antipsychotic medications are not a first line treatment and should be used with caution because of the association with strokes and adverse cardiac events.

If the patient has Parkinsonism, use only Quetiapine 12.5mg (frail patients) – 25mg (tablet) 4 hourly prn. Max 100mg in 24 hours. Do not move onto Step 4 or 5.

Step 4. Use only one of these high potency antipsychotics:

Haloperidol – 0.25 to 0.5mg (tab, liquid, IM)
4 hourly prn : Max 2mg in 24 hours
N.B. 30-60 minute onset

OR

Risperidone – 0.25 to 0.5mg (tablet or liquid)
4 hourly prn. Max 2mg in 24 hours

(These agents are calming without much sedation)

If the response is inadequate escalate to senior staff

Upon senior review, proceed to Step 5.

Step 5. Use only one of these more sedating antipsychotics:

Quetiapine 12.5mg (frail patients) - 25mg (tablet)
4 hourly prn. Max 100mg in 24 hours

OR

Olanzapine 2.5mg (tablet or oro-dispersible wafer)
4 hourly prn. Max 10mg in 24hours.

- Aim to use one drug and optimise first line treatment
- Keep doses to a minimum: giving higher doses on the first night is unlikely to help
- If the situation is escalating get advice from a senior colleague
- Review prescription daily

Version 3 Next review date: February 2020 Developed by: Cognitive Impairment Reference Group and Psychiatry Department 2010
Title: Management of Agitation in Older Patients Flowchart Endorsed by Drugs and Therapeutics Committee: 21st February 2017

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Royal Perth Hospital

Behavioural Observation Form

- Assists with monitoring for cognitive deterioration

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add Ward/Clinic info here

Agitation Scale
add patient ID label here

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Intervention Letter (IL) - enter below (see instructions over page)

Date: ____________ **Form number:** __________

Time																								
4																								
3																								
2																								
1																								
0																								
-1																								
-2																								
-3																								
-4																								
IL																								
RN initial																								
Companion initial																								

Score:	Examples:	Action/Intervention:	Score:	Examples:	Action/Intervention:
4	Violent, unable to be de-escalated, poses a risk to staff or other patients. Absconding and at imminent risk to staff/others	**Code Black**	-1	Reduced emotional reactivity (decreased mood/cognitive function)	Non-pharmalogical management Consider triggers (e.g. lack of sleep/single room, lack of activity). **Routine team review.**
3	Agitated, pacing, not able to be redirected, appears very distressed, resistant to care, refuses medication, attempting to get out of restraints or to leave ward/hospital, verbally aggressive (yelling/swearing/threatening)	**Urgent clinical review** Non-pharmalogical management (e.g. blood tests/root cause) Adjust regular/prn medications Consider prn sedation	-2	Drowsy but easily rousable	**Routine team review** Observations
2	Wandering, plucking at clothes, distressed/crying out but settles with reassurance, pulling at lines/tubes/ dressings, trying to get out of bed	**Routine team review** Non-pharmalogical management Review regular/prn medications	-3	Drowsy, difficult to rouse, difficulty staying awake. Avoiding eye contact/interaction	**Urgent clinical review** Omit sedative medications + medical review needed Observations/blood glucose
1	Mildly agitated or distressed, settles with reassurance. Restless/fidgety/jumpy	**Non-pharmalogical management** If delirium - root cause, e.g. U/A, MSU, pain score. Refer to	-4	Unconscious, unable to wake patient	**Medical Emergency Team (MET)**
0	Alert, calm, may be mildly confused and needs orientation OR asleep. Compliant with care	**Non-pharmalogical management** As appropriate	**Sedated**	Patient sedated as per MO instructions	**Nurse must be experienced in patient assessment.** Maintain airway/breathing. Assess and document depth of sedation using rousability score, and perform/document observations 10 minutely for a minimum of 30 mins from when IV sedation was last administered. **Refer to Procedural Sedation NPS.**

1. Patients need to be scored **at a minimum** every hour. Document the exact time of observation.
2. Place a "•" in the row the patient is scoring, OR an "X" if asleep / an "S" if sedated (in the zero row)
3. Document interventions by letter at the appropriate time and record actual intervention on page 2 .
4. Patients do not have to exhibit all the behaviours applicable to a particular score.
5. Initial for each action/intervention (both RN and companion - see over page)

Rousability Score
0 = none (awake, alert)
1 = mild, occasionally drowsy
2 = moderate = frequently drowsy (rousable to voice)
3 = difficult to rouse (rousable to pain/stimulus)
4 = unconscious/unrousable

BEHAVIOUR OBSERVATIONS

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Royal Perth Bentley Group

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MY INFORMATION HUB: **Royal Perth Bentley Group**

Delirium and Dementia

Delirium and Dementia

The Royal Perth Bentley Group is commited to caring for people with Cognitive Impairment.

Delirium and Dementia are forms of cognitive impairment.

'Forget Me Not'

Where you see this symbol, staff will be able to assist you with any questions related to Delirium and Dementia - or can direct you to someone that can.

Contacts

Elaine Newman
Co-ordinator for Cognitive Impairment

For any enquiries please send Elaine an email.

Policies and Guidelines

- Cognitive Screening Policy for the Older Person (PDF 805.15KB)
- Delirium Management Clinical Practice Standard (PDF 1.87MB)

Resources

- A Better Way to Care: Actions for Clinicians (External Link)
- Delirium Clinical Care Standard (External Link)
- Clinical Practice Guidelines and Principles of Care for People with Dementia (External Link)
- Caring for Cognitive Impairment Campaign (External Link)
- Delirium E Learning for the Group - WACHA (External Link)

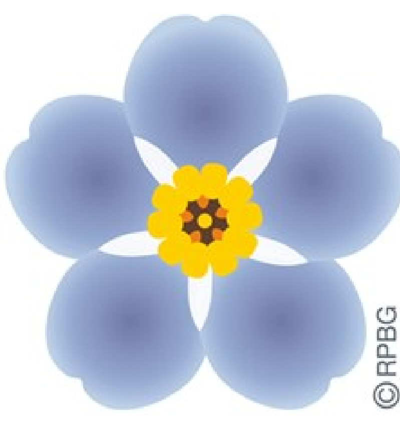
Useful Links

- Alzheimers Australia (External Link)
- Alzheimers Society UK (External Link)

Take 5

Delirium and Dementia HUB Page

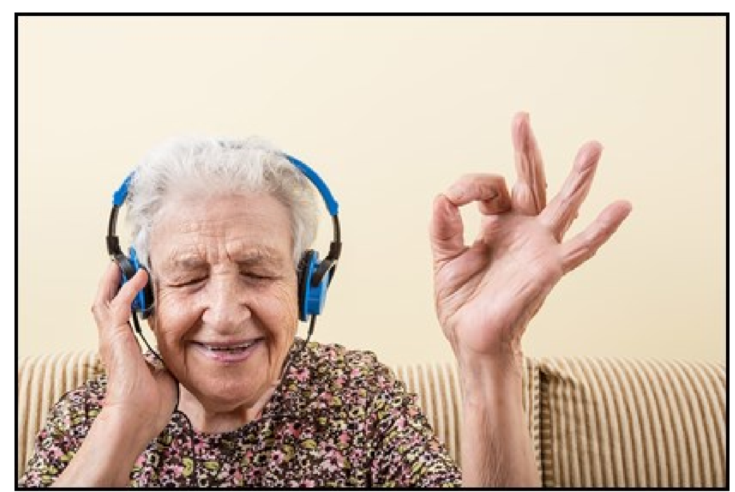
Partnering with Consumers



Partnering with Consumers

Other Work:

FOR HOME AND COUNTRY
CWA
W.A.



BENTLEY
HEALTH SERVICE

SERVIO
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Hospital