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

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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 tubing
- 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:

- dehydration
- electrolyte imbalance
- end of pain
- infection/sepsis/inflammation
- respiratory failure (hypoxia/hypoxemia)
- miosis of faeces
- fine retention
- medication toxicity (especially anticholinergics e.g. teicoplanin, ceftriaxone, digoxin, aminoglycosides, antiarrhythmics, antiarrhythmics, antiemetics).

If withdrawal is suspected:

- Use diazepam and/or haloperidol
- Do not use antipsychotics
- Euthanaise the patient if required
- Refer to ACHES guidelines

Step 2. Assess Risk

- Consider potential for violence, pulling out tubes, obscuring, interference with other patients, falls, accidents etc.

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. rush away, offer interventions or offer food and drink to diffuse tension
- Encourage family to stay and wait
- Consider 1:1 companion / advice from Dementia Champion

Pharmacological Management of Agitation in Older Patients

Antipsychotic medications are not 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 (twin tablets) – 25mg (tablet) 4 hourly p.r.n. 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 5.0mg (tablet, liquid, IM) 4 hourly p.r.n. Max 2mg in 24 hours N.B. 30-60 minute onset
- On
- Resperidone 0.25 to 8.0mg (tablet or liquid) 4 hourly p.r.n. Max 2mg in 24 hours (These agents are calming with much sedation)

If the response is inadequate, escalate to senior staff

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

- Quetiapine 12.5mg (twin tablets) – 25mg (tablet) 4 hourly p.r.n. Max 100mg in 24 hours
- Olanzapine 5.0mg (tablet or once-dispersible tablet) 4 hourly p.r.n. Max 10mg in 24 hours.

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

If the response is inadequate, escalate to senior staff

Upon adverse effect, proceed to Step 5.
Behavourual Observation Form

- Assists with monitoring for cognitive deterioration

**Intervention Letter (IL):** enter below (see instructions over page)

<table>
<thead>
<tr>
<th>Time</th>
<th>Examples</th>
<th>Action/Intervention</th>
<th>Score</th>
<th>Examples</th>
<th>Action/Intervention</th>
</tr>
</thead>
</table>
| 4    | Violent, unable to be de-escalated, poses a risk to staff or other patients. Absconding and at imminent risk to staff members | Code Black | -1 | Reduced emotional reactivity (decreased mood/cognitive function) | Non-pharmaceutical 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, screaming, threatening) | Urgent clinical review  
Non-pharmacological management (e.g., blood tests, trust case)  
Adjust regular/short term Medications  
Consider sedation  
Consider physical restraints | -2 | Drowsy but easilyroused | Routine team review  
Observations |
| 2    | Wandering, packing clothes, distressing, walking out but settles with reassurance, pulling at intravenous lines/dressings, trying to get out of bed | Routine team review  
Non-pharmacological management  
Review regular medications | -3 | Drowsy, difficult to arouse, 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/irritable/irritable | Non-pharmacological management  
Delirium - non-catecholamine, e.g., UAI, 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-pharmacological 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 arousability score, and perform/document observations 10 minutes. For a minimum of 30 mins from when IV sedation was last administered.  
Refer to Procedural Sedation NPS. |
Delirium and Dementia

The Royal Perth Bentley Group is committed 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.

Policies and Guidelines
Cognitive Screening Policy for the Older Person (PDF 805.15KB)
Delirium Management Clinical Practice Standard (PDF 1.07MB)

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
Alzheimer's Australia (External Link)
Alzheimer's Society UK (External Link)
Partnering with Consumers

Delirium
Patient Information

‘TOP 5’
Partnering with Consumers

Pet Therapy

Our wonderful Pet Therapy dogs “Imshi” and/or “Yallah” are visiting wards 4 and 5. Please inform staff if you would like a visit.
Other Work: