Management of BPSD in LTC

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This presentation is broadcasted from the traditional territories of the Kwikwetlem, Musqueam, Squamish, Stó:lō and TsleilWaututh First Nations.

Land acknowledgement

Conflict of Interest

- I have spoken at pharmaceutical companies sponsored dinners
- Remuneration for this activity is from the conference organizer only
- Medications will be discussed in generic names

Objectives

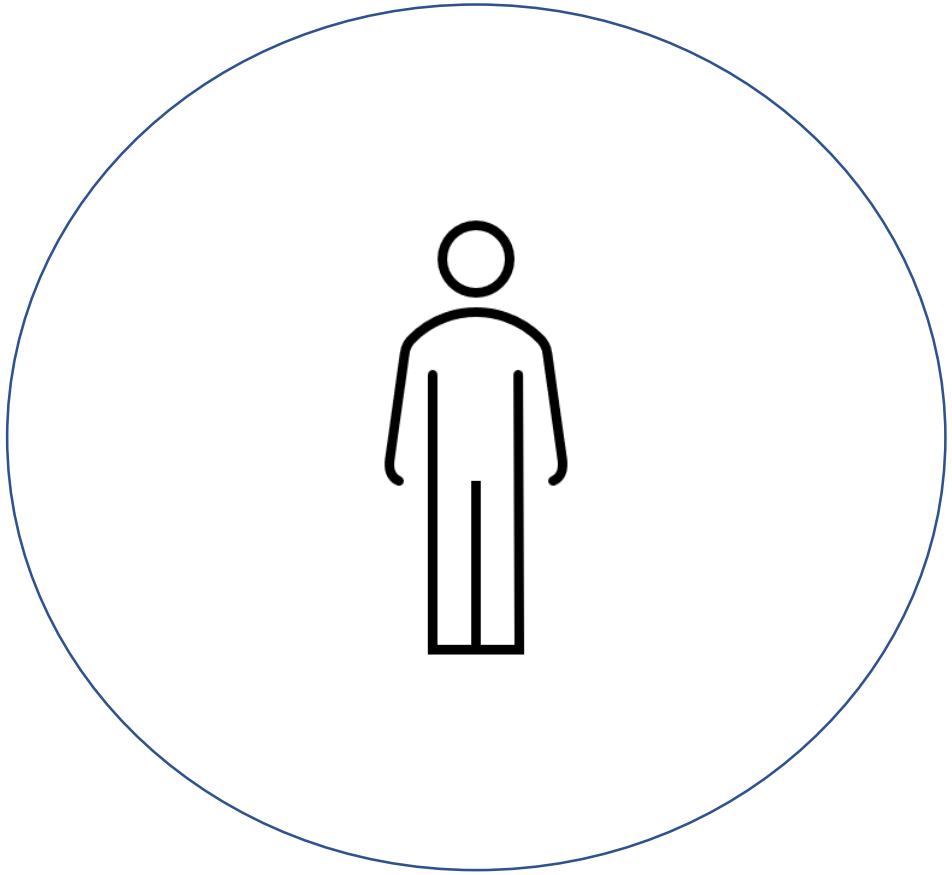
1. Brief review of behaviour associated with Dementia (BPSD)
2. Brief review of the structured assessment method
3. Learn about pharmacological Interventions for BPSD in LTC

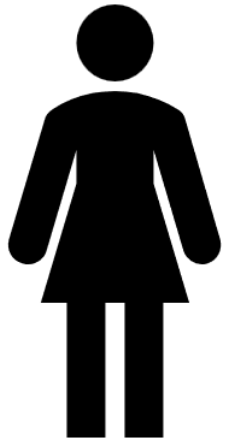
Overview

1. Define BPSD
2. Structured Assessment method
3. Approach to some common behaviours
4. Pharmacological interventions

What is BPSD?

Behaviour…





Behavioural and Psychological Symptoms of Dementia | BPSD

- Refers to the non-cognitive symptoms of disturbed perception, thought content, mood or behaviour that frequently occurs in patients with dementia
- Etiology is Multifactorial

IPA

BPSD – 2

Behavioral

- *Usually identified based on observation, these symptoms include:*
- physical aggression
- loud vocalisation
- restlessness
- agitation
- wandering

Psychological

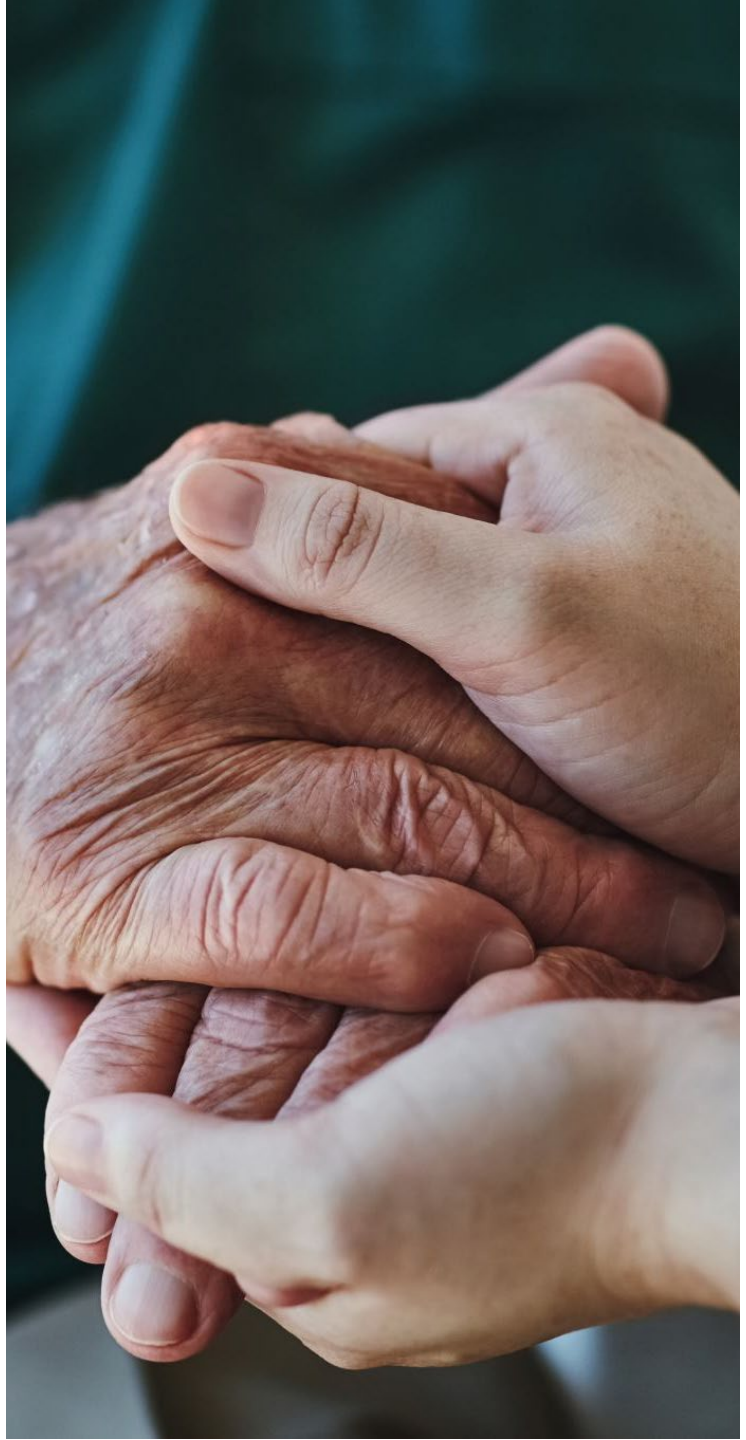
- *Usually assessed based on interviews with patients and relatives; these symptoms include:*
- anxiety
- depressive mood
- hallucinations
- delusions

Person with Dementia specific Impact

- Creates most caregiver distress
- Fluctuates
- Most last at least 6 months
- Early placement
- High Dementia care costs attributed to BPSD
- More severe symptoms associated with more rapid disease progression

Caregiver Impact

- Greater distress than caregivers of people with other chronic illnesses and caregivers of people living with dementia without BPSD
- Reduced Quality of Life (QoL)
- Depressive symptoms | Depression
- Physical illness
- Greater absenteeism rates from work



Factors contributing to behaviours

- Neurodegenerative changes increase vulnerability to stress
- Patient Factors
- Caregiver Factors
- Environmental Factors

Approach

- Assessment
- Nonpharmacological
- Pharmacological

Effective Interventions require:

Systematic Assessment Framework

Person-Centered Care

Individualized Care Planning

Systematic Assessment

Systematic Framework

- P.I.E.C.E.S.
- DICE
- Gentle Persuasive Approach (GPA)
- Baycrest Quick-Response Caregiver Tool – CARER
- ABC Dementia Scale

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

- A model for collaborative care and changing practice
- Provides a framework for understanding the behavior of a person with dementia
- A learning recourse on tools and methods used for a standardized approach to the assessment
- Uses the common language for communicating with the other members of the team.

PIECES Framework – 3 Questions (That's it)

What are the **priority** concerns; is it a **change** for the person?

What are the **RISKS** and possible **contributing factors**?

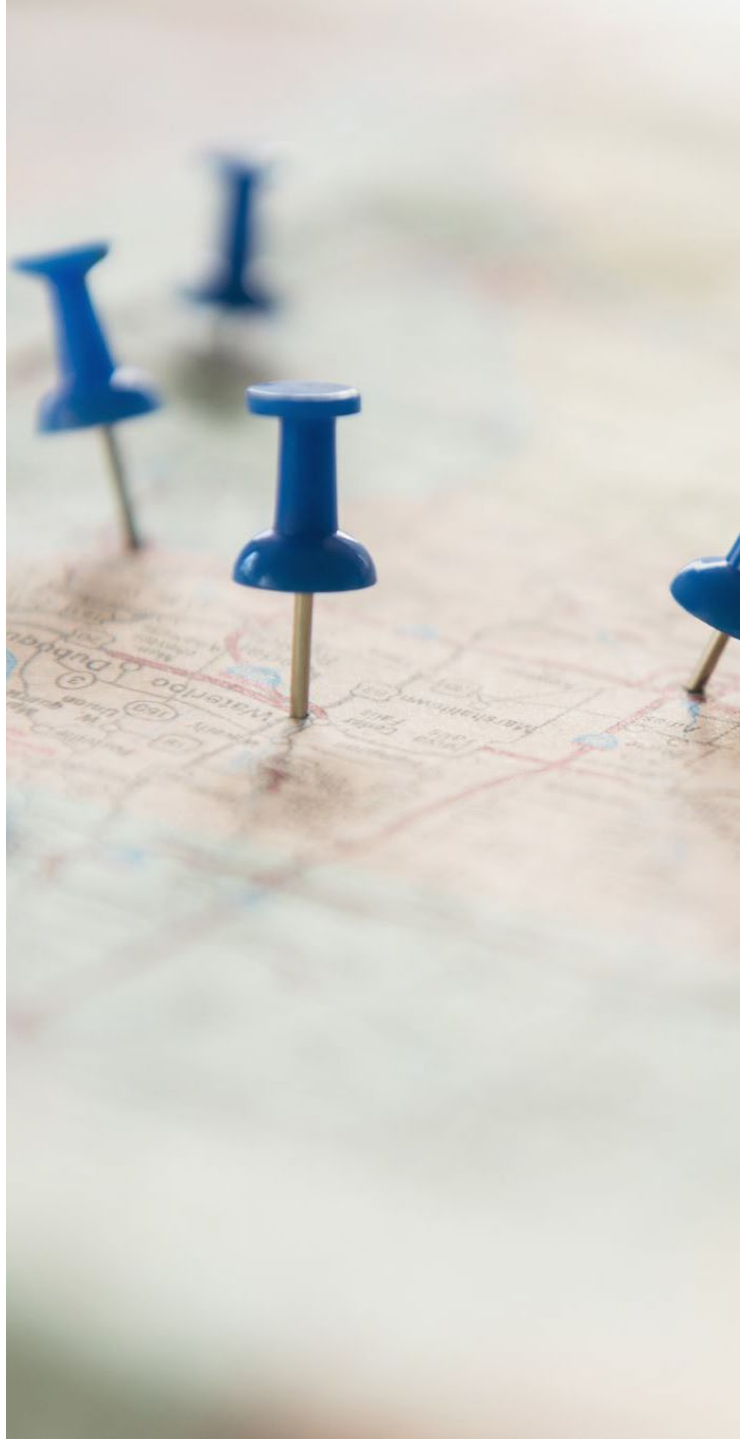
- Think **PIECES**
- Avoid Assumptions! Think Atypical!

What are the **actions**?

- Investigations
- Interactions
- Interventions

Behaviours

- Describe
- Change – New or existing
- Risks – Imminent or remote



BC BPSD Algorithm

- www.bcbpsd.ca

P.I.E.C.E.S. – ABC Tool

Behaviour that is misunderstood and mismanaged may escalate

Think **ABC**

A = Antecedent [what was the trigger?]

B = Behavior [what behaviour resulted?]

C = Consequences [what was the consequence?]

ABC Tool

A | Antecedent

- What was happening before the behavior began?

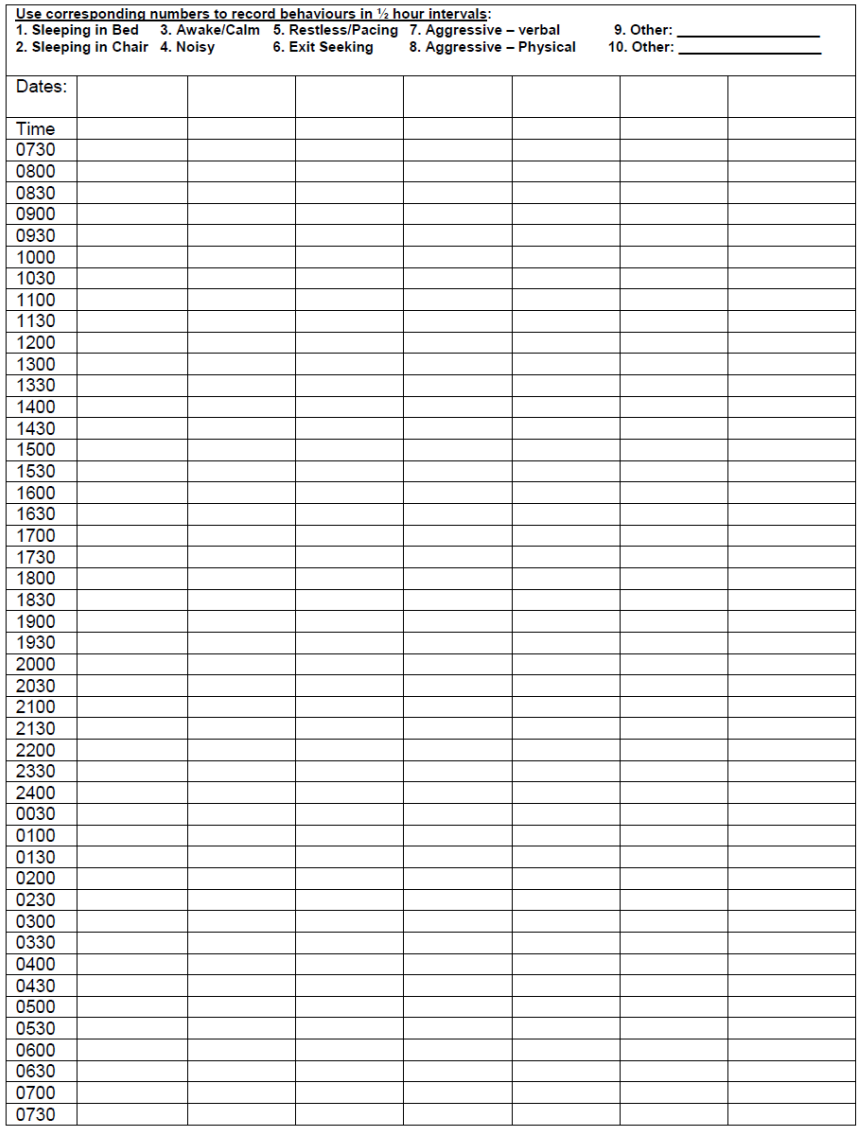
B | Behavior

- Describe the behavior.
- Use clear & neutral terms.
- Focus on one behavioral event at a time.

C | Consequences

- What happened next?
- What did the staff do?
- How did the patient respond?
- Who was affected by the behavior? (coresident/staff/caregiver)

Dementia Observation System (DOS) Tool

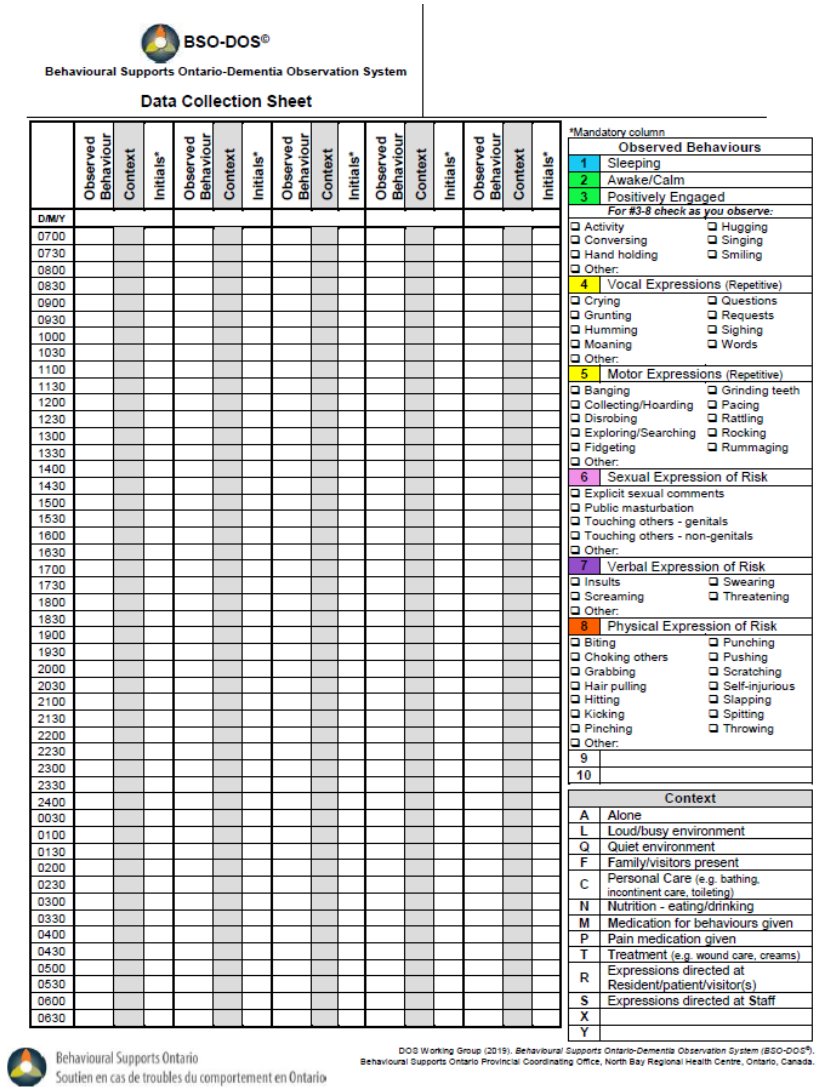


Use corresponding numbers to record behaviours in ½ hour intervals:
1. Sleeping in Bed 3. Awake/Calm 5. Restless/Pacing 7. Aggressive – verbal 9. Other: _____
2. Sleeping in Chair 4. Noisy 6. Exit Seeking 8. Aggressive – Physical 10. Other: _____

Dates:							
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0700							
0730							

- To assess a person's behaviour over a 24-hour cycle for up to 7 days to determine the occurrence, frequency, and duration of behaviours of concern.
- On admission, change, or effectiveness
- Record behaviour in 30-minute intervals for the duration of 7-days
- Record behaviours of concerns in the progress notes: What, Where, Why, How, and the Outcome?
- Use colour codes to interpret the results

Behavioural Supports Ontario-Dementia Observation System (BSO-DOS) Tool



BSO-DOS©

Behavioural Supports Ontario-Dementia Observation System

Data Collection Sheet

	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*	Observed Behaviour	Context	Initials*
D/M/Y															
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0600															
0630															

*Mandatory column

Observed Behaviours

1 Sleeping
2 Awake/Calm
3 Positively Engaged

For #3-8 check as you observe:

- ❑ Activity
- ❑ Conversing
- ❑ Hand holding
- ❑ Hugging
- ❑ Singing
- ❑ Smiling
- ❑ Other:

4 Vocal Expressions (Repetitive)

- ❑ Crying
- ❑ Grunting
- ❑ Humming
- ❑ Moaning
- ❑ Questions
- ❑ Requests
- ❑ Sighing
- ❑ Words
- ❑ Other:

5 Motor Expressions (Repetitive)

- ❑ Banging
- ❑ Collecting/Hoarding
- ❑ Disrobing
- ❑ Exploring/Searching
- ❑ Fidgeting
- ❑ Grinding teeth
- ❑ Pacing
- ❑ Rattling
- ❑ Rocking
- ❑ Rummaging
- ❑ Other:

6 Sexual Expression of Risk

- ❑ Explicit sexual comments
- ❑ Public masturbation
- ❑ Touching others - genitals
- ❑ Touching others - non-genitals
- ❑ Other:

7 Verbal Expression of Risk

- ❑ Insults
- ❑ Screaming
- ❑ Swearing
- ❑ Threatening
- ❑ Other:

8 Physical Expression of Risk

- ❑ Biting
- ❑ Choking others
- ❑ Grabbing
- ❑ Hair pulling
- ❑ Hitting
- ❑ Kicking
- ❑ Pinching
- ❑ Punching
- ❑ Pushing
- ❑ Scratching
- ❑ Self-injurious
- ❑ Slapping
- ❑ Spitting
- ❑ Throwing
- ❑ Other:

9
10

Context

A	Alone
L	Loud/busy environment
Q	Quiet environment
F	Family/visitors present
C	Personal Care (e.g. bathing, incontinent care, toileting)
N	Nutrition - eating/drinking
M	Medication for behaviours given
P	Pain medication given
T	Treatment (e.g. wound care, creams)
R	Expressions directed at Resident/patient/visitor(s)
S	Expressions directed at Staff
X	
Y	

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

DOS Working Group (2019). *Behavioural Supports Ontario-Dementia Observation System (BSO-DOS©)*. Behavioural Supports Ontario Provincial Coordinating Office, North Bay Regional Health Centre, Ontario, Canada.

- 3-steps
- Baseline or admission behaviour or any new or change in behaviour.
- Data collection over a 24-hour cycle for 5 days using colour-coded legend
- Analysis and planning by determining the occurrence, frequency, duration and risk.
- Provide a summary, possible causes and contributing factors
- Care plan

Agitation – 1

- Inappropriate verbal, vocal, or motor activity that is not judged by an outside observer to result directly from the needs or confusion of the agitated individual
- Not a diagnostic term
- A cluster of symptoms

Cohen-Mansfield

Agitation – 2



A. The patient meets the criteria for a neurocognitive disorder.



B. The patient exhibits at least one of the following behaviours associated with observed or inferred evidence of emotional distress (e.g., rapid changes in mood, irritability, outbursts). The behaviour has been persistent or frequently recurrent for a minimum of two weeks and represents a change from the patient's usual behavior.

Agitation – 3

Excessive Motor Activity

- Pacing
- Rocking
- Gesturing
- Pointing fingers
- Restlessness
- Performing repetitious mannerisms

Excessive Verbal Activity

- Yelling
- Speaking in an excessively loud voice
- Using profanity
- Screaming
- Shouting

Agitation – 4

Physical Aggression

- Grabbing
- Shoving
- Pushing
- Resisting
- Hitting others
- Kicking objects or people
- Scratching

- Biting
- Throwing objects
- Hitting self
- Slamming doors
- Tearing things
- Destroying property

Cohen-Mansfield Agitation Inventory (CMAI) – 1

Cohen-Mansfield Agitation Inventory (CMAI)[1] - Short

Instructions: For each of the behaviours below, check the rating that indicates the average frequency of occurrence over the last 2 weeks.

Never	Less than once a week	Once or Twice a week	Several Times a week	Once or Twice a day	Several Times a day	Several Times an hour
1	2	3	4	5	6	7

Physical/Aggressive							
1. Hitting (including self)	1	2	3	4	5	6	7
2. Kicking	1	2	3	4	5	6	7
3. Grabbing onto people	1	2	3	4	5	6	7
4. Pushing	1	2	3	4	5	6	7
5. Throwing things	1	2	3	4	5	6	7
6. Biting	1	2	3	4	5	6	7
7. Scratching	1	2	3	4	5	6	7
8. Spitting	1	2	3	4	5	6	7
9. Hurting Self or others	1	2	3	4	5	6	7
10. Tearing things or destroying property	1	2	3	4	5	6	7
11. Making physical sexual advances	1	2	3	4	5	6	7

Physical/Non-Aggressive							
12. Pace, aimless wandering	1	2	3	4	5	6	7
13. Inappropriate dress or disrobing	1	2	3	4	5	6	7
14. Trying to get to a different place	1	2	3	4	5	6	7
15. Intentional falling	1	2	3	4	5	6	7
16. Eating/drinking inappropriate substance	1	2	3	4	5	6	7
17. Handling things inappropriately	1	2	3	4	5	6	7
18. Hiding things	1	2	3	4	5	6	7
19. Hoarding things	1	2	3	4	5	6	7
20. Performing rep. mannerisms	1	2	3	4	5	6	7
21. General restlessness	1	2	3	4	5	6	7

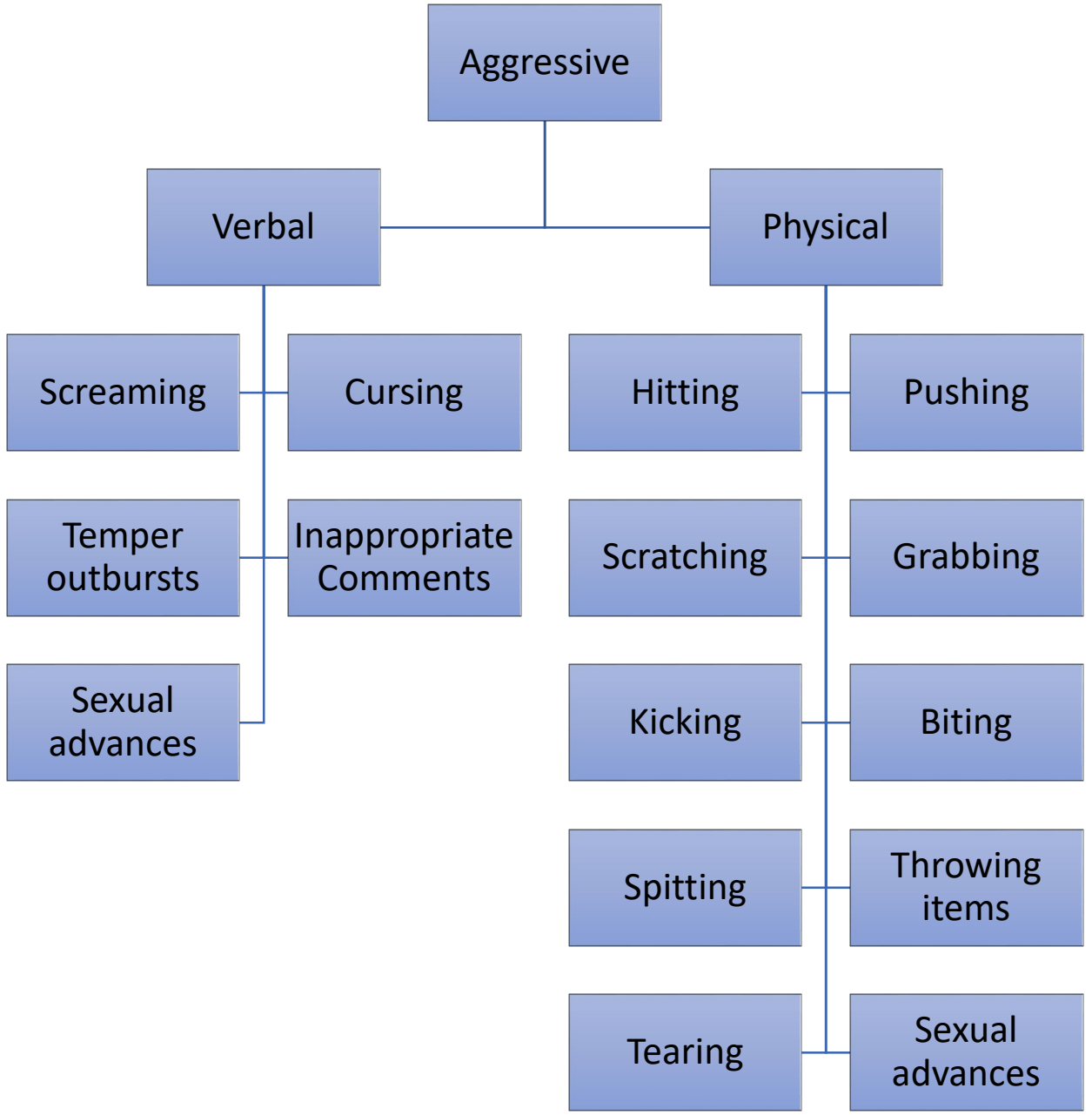
Verbal/Aggressive:							
22. Screaming	1	2	3	4	5	6	7
23. Making verbal sexual advances	1	2	3	4	5	6	7
24. Cursing or verbal aggression	1	2	3	4	5	6	7

Verbal/Non-aggressive:							
25. Rep sentences or questions	1	2	3	4	5	6	7
26. Strange noises (weird laughter or crying)	1	2	3	4	5	6	7
27. Complaining	1	2	3	4	5	6	7
28. Negativism	1	2	3	4	5	6	7
29. Constant unwarranted request for attention or help	1	2	3	4	5	6	7

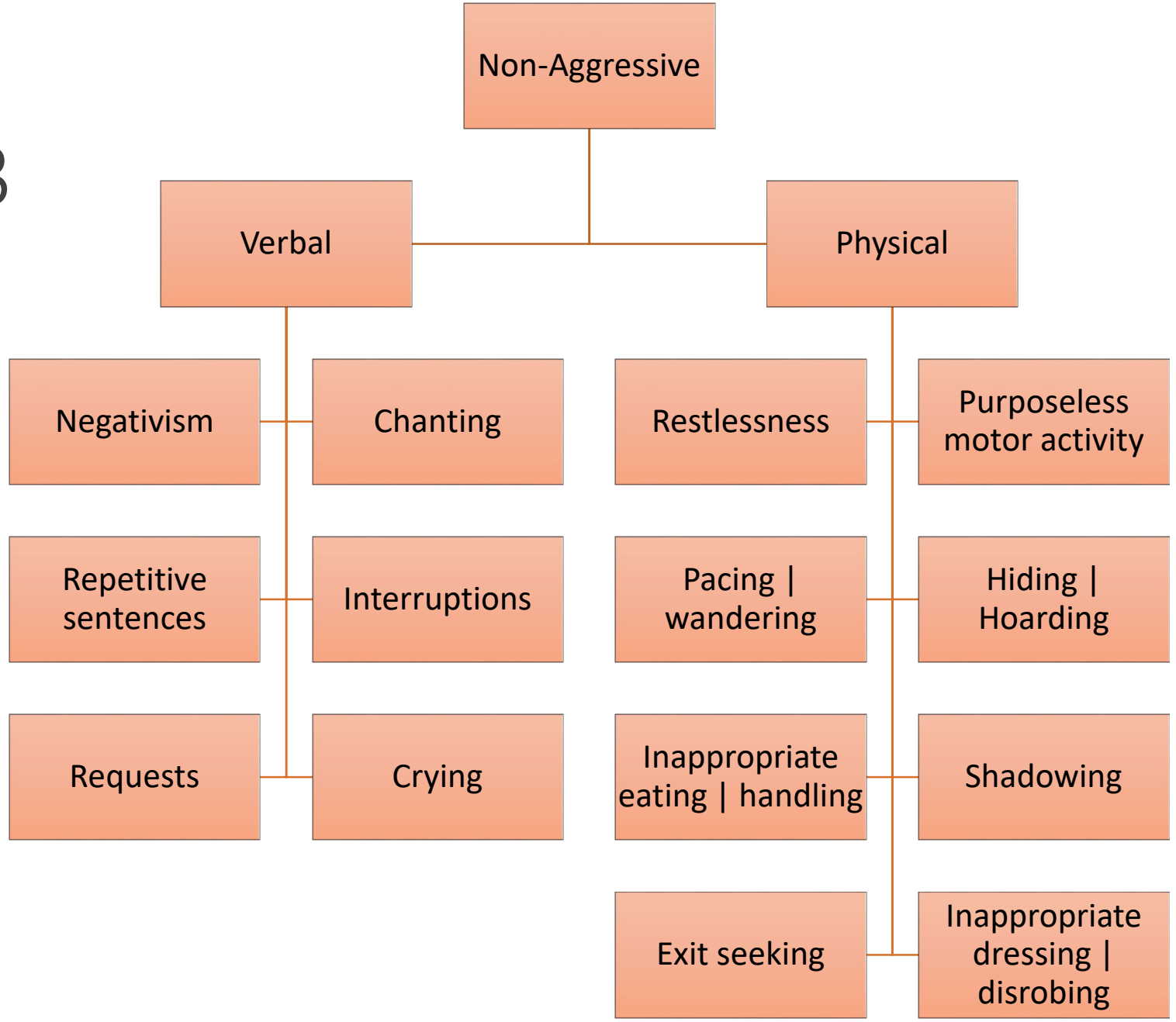
Signature: _____ **Date:** _____

- 29-item scale
- Assess Agitation over the past two weeks
- 4 domains - physically aggressive, physically non-aggressive and verbally agitated behaviours
- 7-point scale ranging from “never” to “several times per hour”

CMAI – 2


Aggressive
Verbal
Physical
Screaming
Cursing
Temper outbursts
Inappropriate Comments
Sexual advances
Hitting
Pushing
Scratching
Grabbing
Kicking
Biting
Spitting
Throwing items
Tearing
Sexual advances

CMAI – 3


Non-Aggressive
Verbal
Physical
Negativism
Chanting
Repetitive sentences
Interruptions
Requests
Crying
Restlessness
Purposeless motor activity
Pacing | wandering
Hiding | Hoarding
Inappropriate eating | handling
Shadowing
Exit seeking
Inappropriate dressing | disrobing

Neuropsychiatric Inventory (NPI)

NPI-Q SUMMARY

	No	Severity	Caregiver Distress
Delusions	0	1 2 3	0 1 2 3 4 5
Hallucinations	0	1 2 3	0 1 2 3 4 5
Agitation/Aggression	0	1 2 3	0 1 2 3 4 5
Dysphoria/Depression	0	1 2 3	0 1 2 3 4 5
Anxiety	0	1 2 3	0 1 2 3 4 5
Euphoria/Elation	0	1 2 3	0 1 2 3 4 5
Apathy/Indifference	0	1 2 3	0 1 2 3 4 5
Disinhibition	0	1 2 3	0 1 2 3 4 5
Irritability/Lability	0	1 2 3	0 1 2 3 4 5
Aberrant Motor	0	1 2 3	0 1 2 3 4 5
Nighttime Behavior	0	1 2 3	0 1 2 3 4 5
Appetite/Eating	0	1 2 3	0 1 2 3 4 5
TOTAL			

- NPI Questionnaire
- Brief 5-minute tool
- Informant based
- 12-domains
- Records presence of a symptom, severity (3) and caregiver distress (5)

P.I.E.C.E.S. Problem Solving



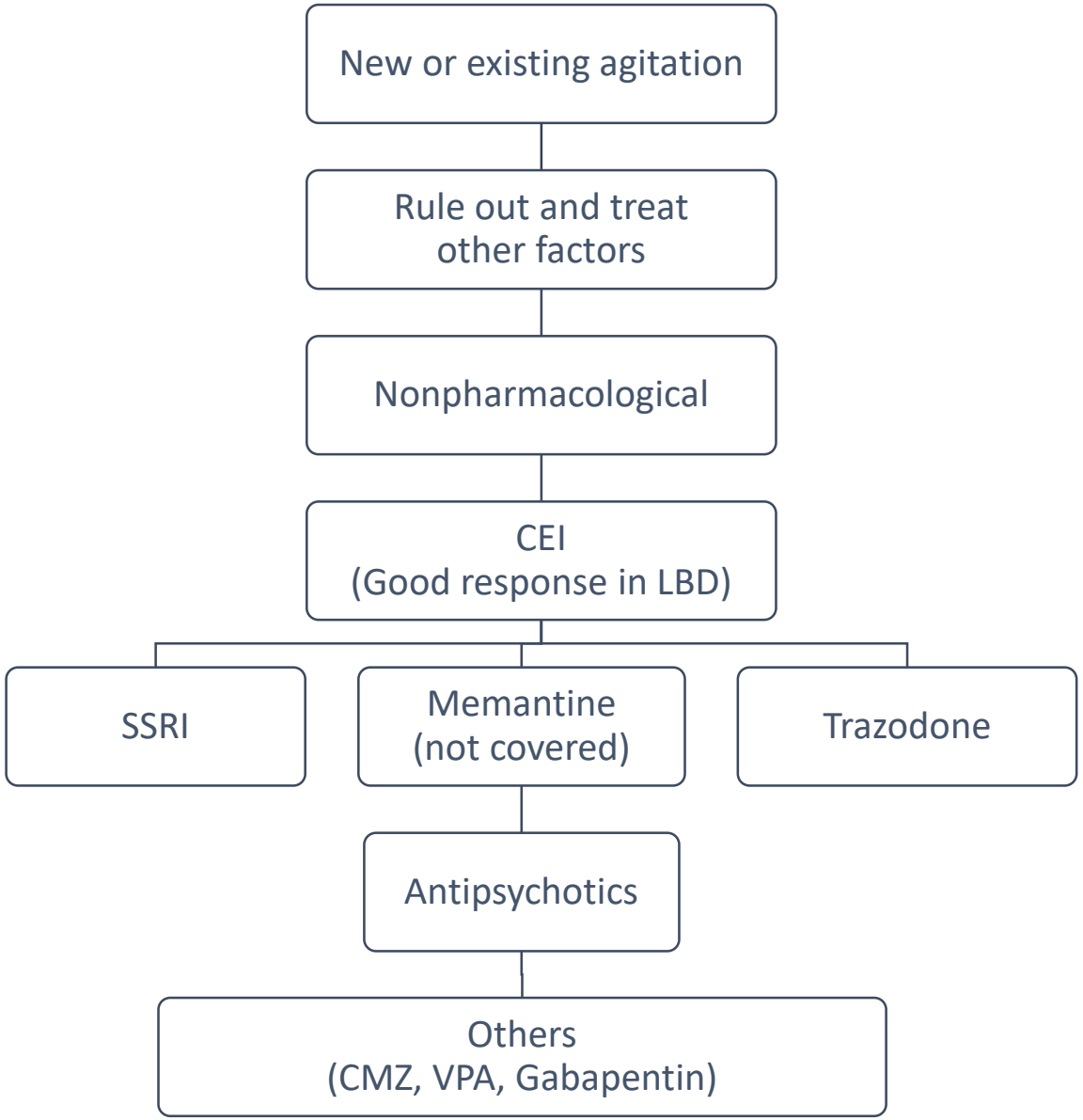
When to consider Pharmacological Interventions

- Behaviors becoming dangerous, distressing, disturbing, or damaging to social relationships
- Has not sufficiently responded to non-pharmacological interventions
- Significant risk to self or others

Approach to BPSD

Agitation

- New or existing?
- Type of agitated behaviour
- Any aggression or risks?
- Ruled out other factors
- Nonpharmacological measures first
- Meds



*No Benzodiazepines

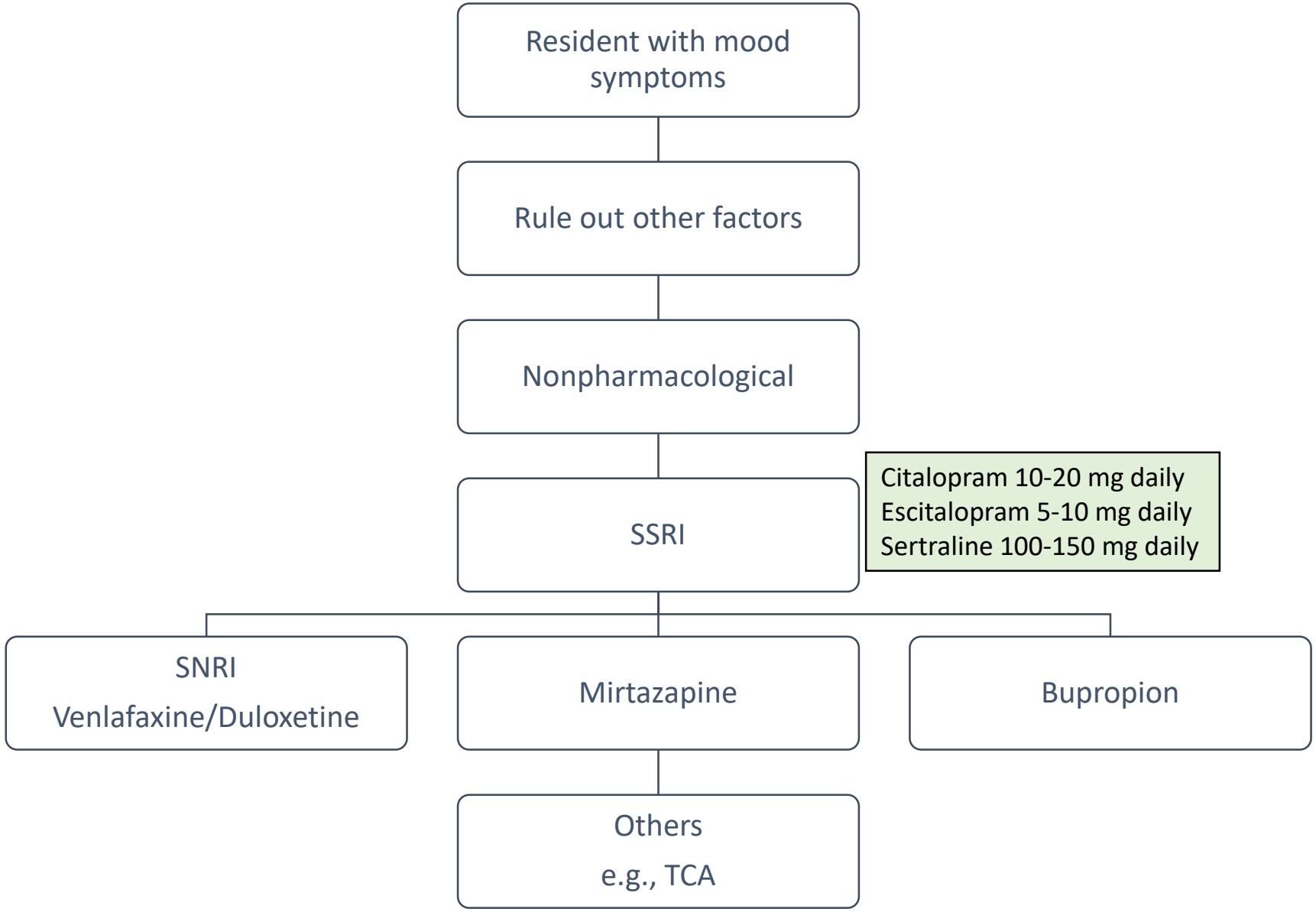
Mood

- Agitation or aggression may be the primary manifestation of depression
- Unable to describe
- Vascular dementia – a challenge
- If in doubt – try a therapeutic trial with an antidepressant
- Depression may show signs of cognitive changes – pseudodementia
- Depression is a risk factor for future decline
- Challenging when – agitation, aggression, apathy, sleep-wake disturbance or social isolation

Mood – 2

- No clear diagnostic criteria
- SSRIs preferred – Citalopram or Sertraline
- Venlafaxine, Bupropion or Mirtazapine – not enough evidence
- TCAs – if you must choose, then Nortriptyline is preferred

- Temporary or chronic?

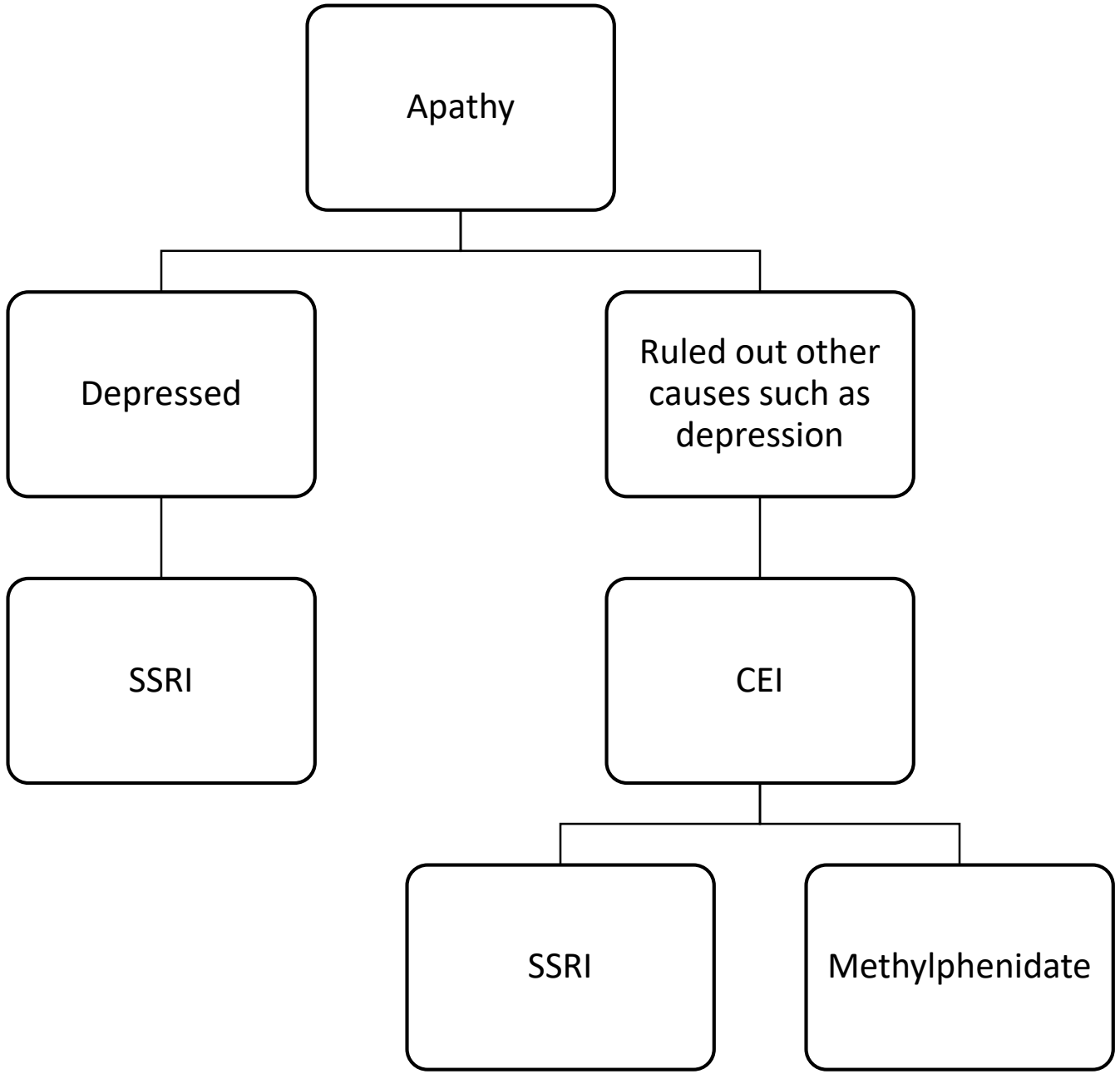

Resident with mood symptoms
Rule out other factors
Nonpharmacological
SSRI
Citalopram 10-20 mg daily
Escitalopram 5-10 mg daily
Sertraline 100-150 mg daily
SNRI
Venlafaxine/Duloxetine
Mirtazapine
Bupropion
Others
e.g., TCA

Anxiety

- Acute vs chronic vs recurring
- Can be part of the mood disorder spectrum
- Rule out other factors such as medication Aes
- Nonpharmacological first
- Meds – SSRIs (Sertraline 100-150 mg daily, Escitalopram 5-10 mg daily), SNRIs and Mirtazapine (15-30 mg daily)
- Short-term use of Benzodiazepines?
- Some may need to remain on benzodiazepines for longer periods due to chronic use – aim to taper off by switching to long-acting agent (Clonazepam)

Apathy

- Challenging to differentiate from depression
- Causes significant impairment

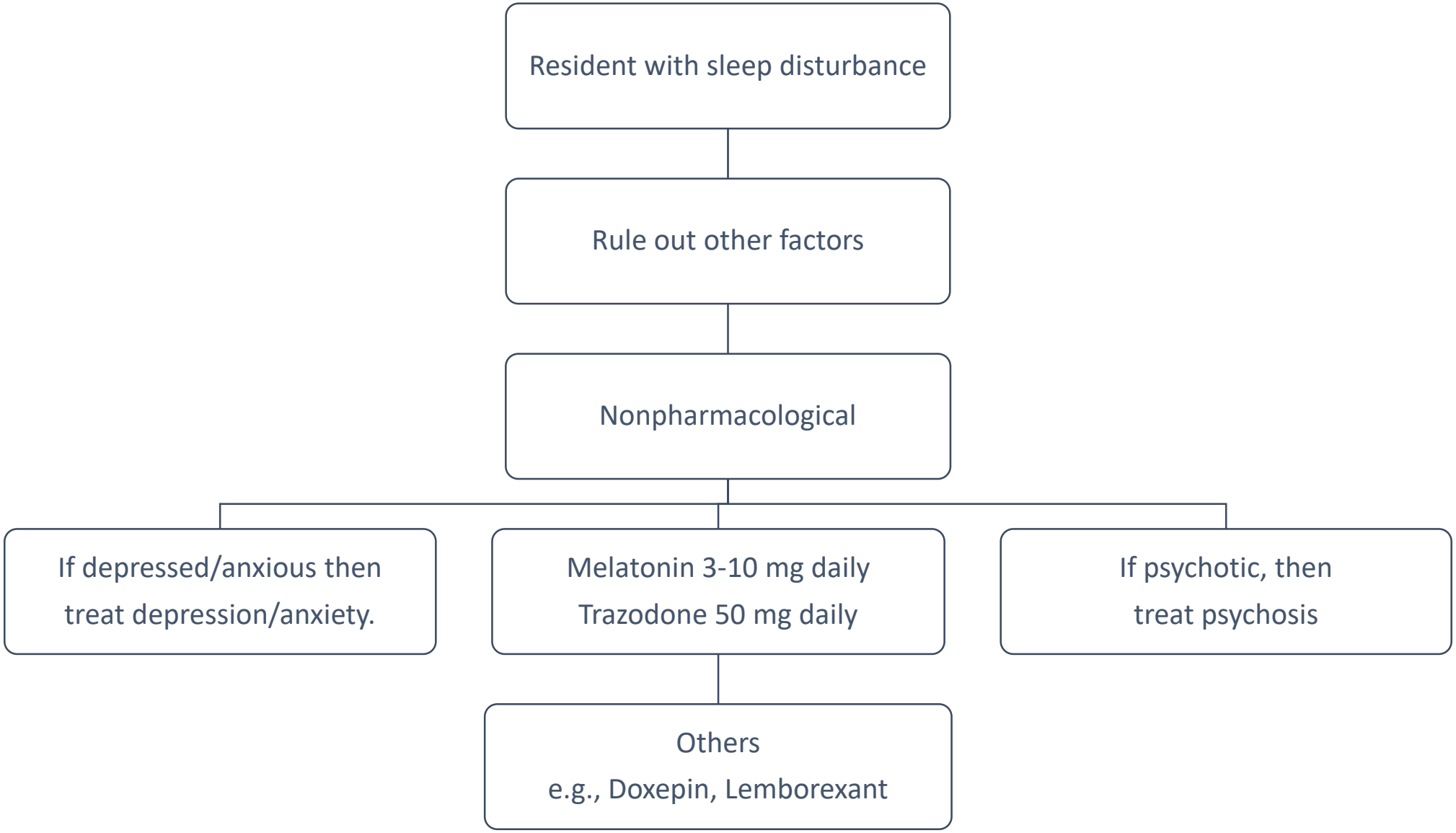

Apathy
Depressed
Ruled out other causes such as depression
SSRI
CEI
SSRI
Methylphenidate

Sleep Disturbance – 1

- Ageing process
- MNCD specific – RLS, REM
- Prominent sleep disturbances may lead to daytime agitation which is unlikely to improve until sleep has been optimised.

Sleep Disturbance – 2

- Sleep disturbances can be caused by a variety of factors
  - Depression
  - Anxiety
  - Pain
  - Reduced activity
  - Medications AEs
  - Nocturia
  - OSA


Resident with sleep disturbance
Rule out other factors
Nonpharmacological
If depressed/anxious then
treat depression/anxiety.
Melatonin 3-10 mg daily
Trazodone 50 mg daily
If psychotic, then
treat psychosis
Others
e.g., Doxepin, Lemborexant

Wandering

- Leads to early placement
- Aimless walking, exit seeking or pacing
- May be associated with anxiety, limited activity, poor navigational ability (visuospatial)
- Exit Door strategy, motion sensor alarms, scheduled activity, trackers, identification markers
- Unlikely to respond to pharmacological agent – unless agitation

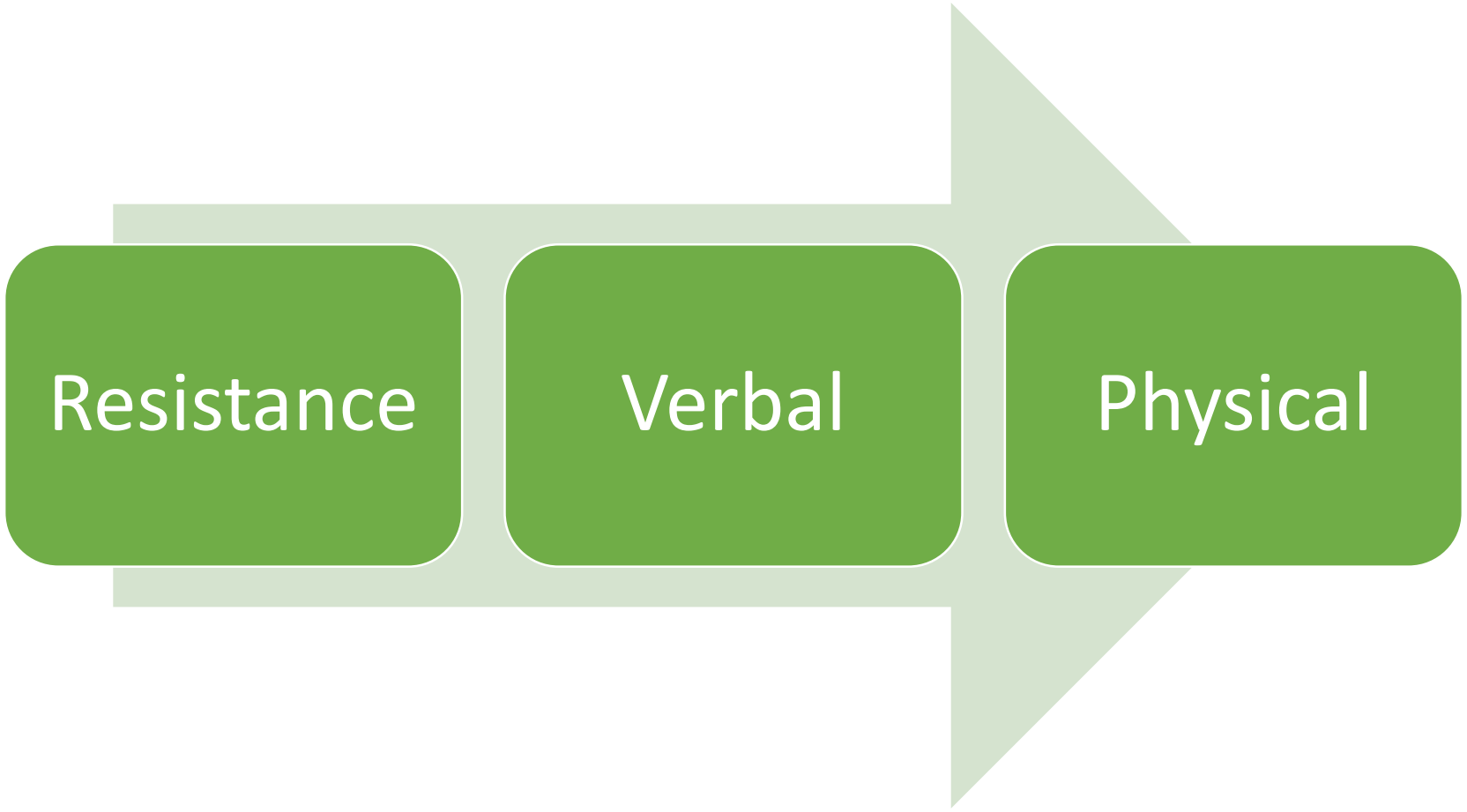
Behaviour in response to care

- Resistance to taking medication, record vitals, eating, investigations or ADLs
- Poor understanding –cognitive or language error
- Consider past trauma
- Pain
- Afraid or uncomfortable due to personality traits, preferences, cultural or religious leading to protecting themselves
- Invading personal space
- Not properly explained

Look at possible causes

- Pain
- Poorly understood
- Afraid or uncomfortable due to personality traits, preferences, cultural or religious leading to protecting themselves
- Invading personal space
- Not properly explained

Range of behaviours in response to care…



RESISTANCE

- Assess for Pain
- Trial of analgesics
- Non-threatening posture
- Effective communication
- Person-centred care – individualised care plan
- STOP – Stop, Think, Observe, Plan
- Maintain capabilities
- Environmental cues
- Anything New?

SHAVING/DRESSING/BRUSHING

- Declutter
- Simple arrangements
- Assist with electronic items
- Use bright color labels
- Slow the process
- Breakdown tasks into multiple steps and provide an Instruction sheet if capable
- One instruction at a time
- Pick what needs to be worn
- Use phrases – getting ready for a visit, dinner, etc.
- Allowing mimicking the actions
- Try Hand over hand

TOILETING

- Put up signs
- Scheduling
- Look for signs – restless, fidgety
- Respect privacy
- Comfortable clothing
- Use distraction – towel, doll, music
- Use phrases as reminiscence – laundry day, freshen up, getting ready

BATHING/SHOWER

- Maintain privacy and dignity – cover private parts
- Environment – test water/room temperature
- Bathing techniques – bed bath, under-the-clothes bath, toilet bath, 6 or 7-day bath, sitting bath
- Use a bathmat to make the depth easier to see
- Use bubble bath
- Use scented items such as lavender
- Use bath as a ‘SPA’ – candles, plastic cups with juice
- Use hand over hand
- Use music, a towel, and encouraging words

When to consider Pharmacological Interventions

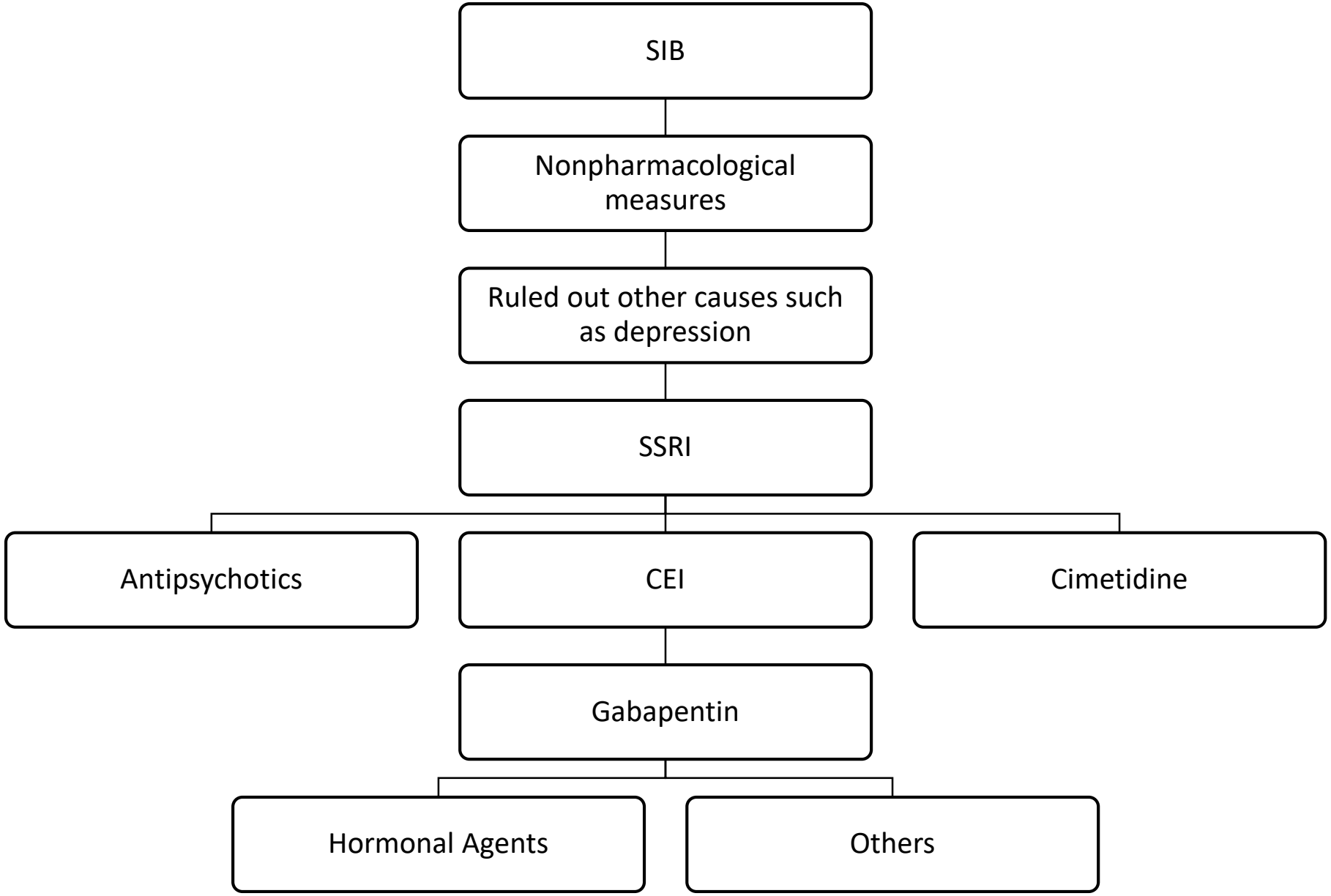
- Behaviors becoming dangerous, distressing, disturbing, or damaging to social relationships
- Has not sufficiently responded to non-pharmacological interventions
- Significant risk to self or others
- Options

Acute Stress

- Catastrophic reaction
- May range from appearing anxious, verbal aggression, threatening or physical aggression
- Brief and self-limiting
- Identify triggers and manage risks
- May not need change or do anything

Sexually Inappropriate Behaviour (SIB)

- Impulse control and inhibitions involve the frontal lobe, hypothalamus, limbic system, and striatum. Damage can lead to SIB.
- Differentiate between natural sexual expression vs behavioural change of an altered sexual drive interfering with normal activities of living or is pursued at inconvenient times and with unwilling partners.
- It can impact existing relationships and expressions of sexuality.
- Acts – touching, fondling, disrobing and touching themselves in public.
- Verbal – inappropriate language inconsistent with the person's personality.
- Rule out other factors
- Nonpharmacological first


SIB
Nonpharmacological measures
Ruled out other causes such as depression
SSRI
Antipsychotics
CEI
Cimetidine
Gabapentin
Hormonal Agents
Others

Psychosis – 1

- Chronic or new-onset
- More cognitively impaired
- Rapid decline

Psychosis – 2

- Sx of delusions or hallucinations or both
- Diagnosis of MNCD
- Sx not present before MNCD
- At least 1 month and cause disruption
- Exclude schizophrenia and related disorders
- Exclude delirium
- Exclude general medical condition or direct physiological effects of a substance

Psychosis – 3

	Psychosis in MNCD	Psychosis in Psychotic Disorders
Past Hx	Rare	Frequent
Bizarre delusions	Rare	Frequent
Misidentification	Frequent	Rare
Visual Hallucinations	Frequent	Rare
Auditory Hallucinations	Rare	Frequent
SI	Rare	Frequent
Remission	Frequent	Rare
Need for long term treatment	Rare	Frequent
Mean Dose	1/4th of an adult dose	½ to 2/3rd of an adult dose

Delusions

- Fixed and false beliefs
- Short-lived or chronic
  - **Suspicious or paranoid** – most common
  - House is not one's home – exit-seeking, wander
  - Imposter (Capgras) syndrome
  - Morbid Jealousy/infidelity
  - Phantom boarder syndrome
  - **Abandonment**
- If persistent, not responded to other measures or poses a significant then pharmacologic treatment may be helpful or necessary
- Chronic are challenging to treat as delusions are hard to shift

Hallucinations

- Error of perception in the absence of an external stimuli
- Visual more common
- Some have auditory
- Others are rare
- Some do not need to be treated, such as phantom boarder
- Visual/auditory impairment or misperception may cause or worsen hallucinations

Misidentification

- Error with perception in the presence of a stimuli
- Multifactorial
- Perceptual and cognitive errors such as poor vision, poor hearing, language, or memory deficits
- Misperception – may have an associated belief
  - Presence of people (most common)
  - Misidentify person
  - Misidentify own self
  - Misidentify events on TV
- Some do not need to be treated

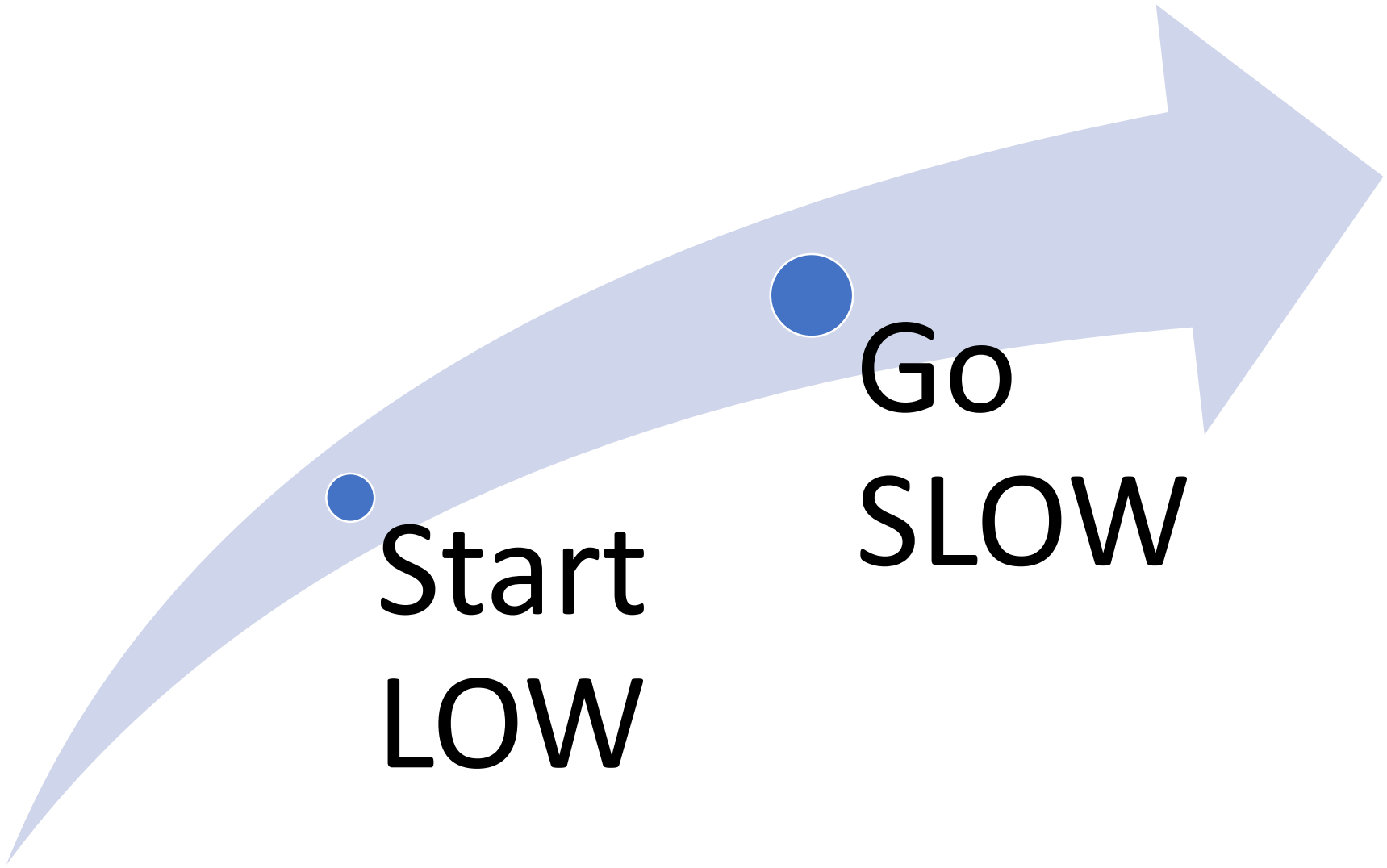
Vocalization

- “vocal sounds or inappropriate use of words that are repetitive and persistent and upsetting to persons exhibiting them or to others in the same environment, including other residents, care providers, and family members.”
- Distressing
- Multifactorial – vary from person to person, sensory deficits, boredom, unmet needs, pain, executive dysfunction (frontal lobe) or external
- Unable to identify needs
- Inconclusive treatment options

Pharmacology

Prescribing – general principles

- Nonpharmacological first
- Consider meds when mod-severe symptoms, impact on functioning, caregiver distress, not responded to other measures and/or risks
- Obtain consent
- Atypical > typical – may be used for psychosis, agitation and aggression
- SSRIs > others – may be used for depression and agitation
- CEI and Memantine – may be used for BPSD
- Anticonvulsants – CMZ has some role in resistant agitation
- Individualized Care plan – decide on target behaviour and regularly review


Start
LOW
Go
SLOW

How to reduce AEs

- Decide on the necessity of prescribing medications
- Avoid, if possible, drugs
  - Affecting receptors such as anticholinergic, alpha-blockers
  - Marked sedative effects
  - Long half-life
  - Potent inhibitors
  - Treating AEs with another drug

Antidepressants – 1

- No one antidepressant superior to the other
- Avoid TCAs
- SSRIs are generally well tolerated
- SNRIs, Mirtazapine and Bupropion are alternatives
- Therapies: exercise, problem-solving therapy, behavioural therapy, behavioural activation, reminiscence

Antidepressants – 2

- Citalopram 10-20 mg daily
- Escitalopram 5-10 mg daily
- Sertraline 100-150 mg daily
- Venlafaxine 150 mg daily
- Mirtazapine 15-30 mg daily

Antidepressants – 3

- Anticholinergics AEs: TCAs, Paroxetine
- Postural hypotension: TCAs, Trazodone
- Falls risks: SSRIs, TCAs
- High blood pressure: SNRI
- Sedation: variable with TCAs, Paroxetine, Fluvoxamine, Mirtazapine, Trazodone
- Weight gain: TCAs, Paroxetine, Citalopram, Mirtazapine
- Weight loss: Duloxetine
- OD: SSRIs & SNRIs are relatively safer
- Bleeding: SSRIs (+NSAIDs +Aspirin)
- Interstitial Lung Disease: SSRIs, SNRIs
- Nausea: More with SNRIs
- Hyponatremia: All antidepressants
- Prolong QTc interval

Antipsychotics – 1

- Acute vs chronic symptoms
- Non-responders: Clarify diagnosis, ensure adherence, comorbidities, AEs and drug Interactions
- Multidisciplinary input
- Frist choice: SGA. Some may need more than one or on a LAI
- Adjunct: psychoeducation, follow-up

Antipsychotics – 2

- Risperidone 1 – 1.5 mg daily
- Olanzapine 5 – 10 mg daily
- Quetiapine 100 – 200 mg daily
- Aripiprazole 5 – 10 mg daily

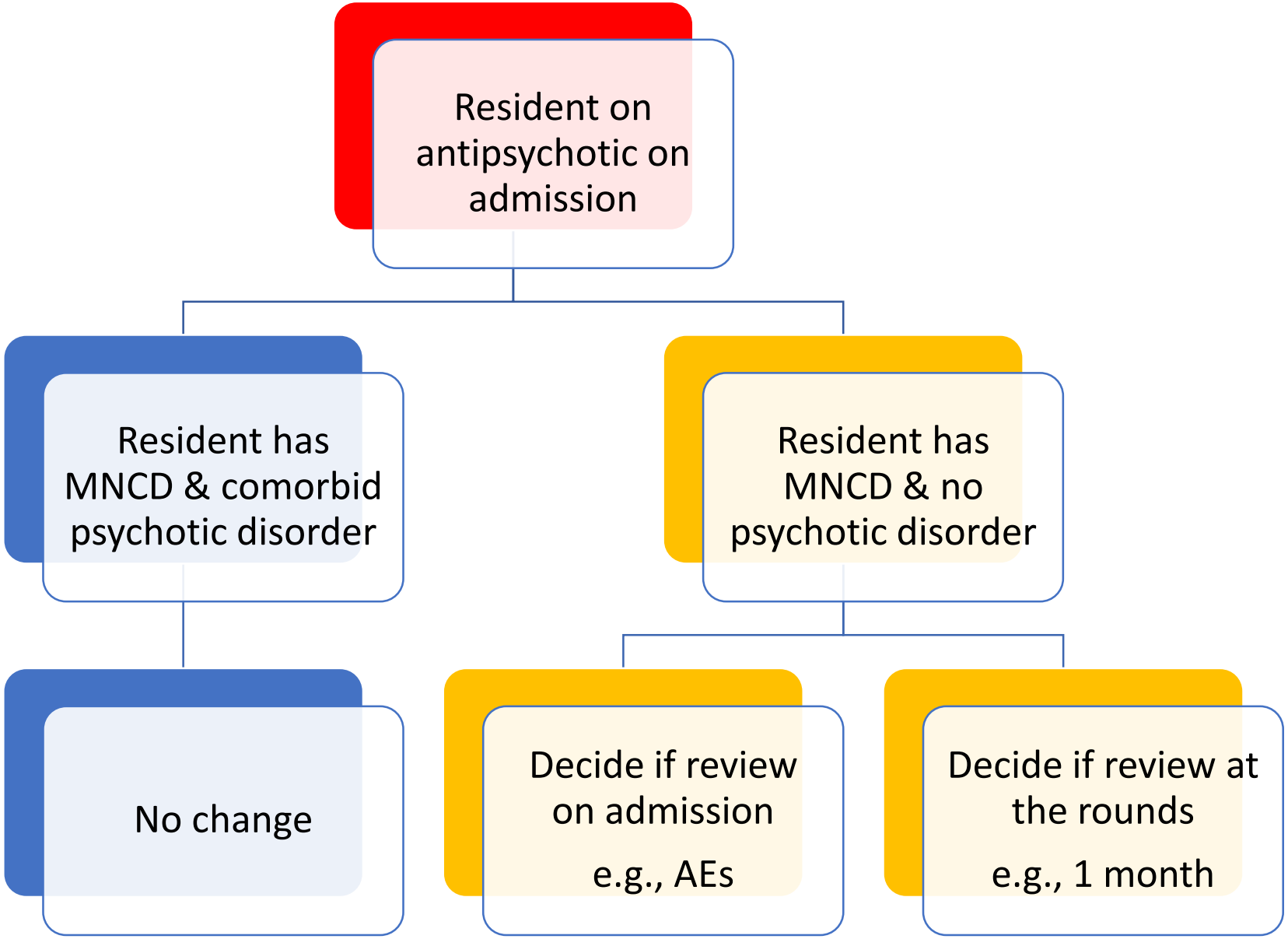
- Haloperidol 1 mg daily
- Loxapine 2.5 – 10 mg daily

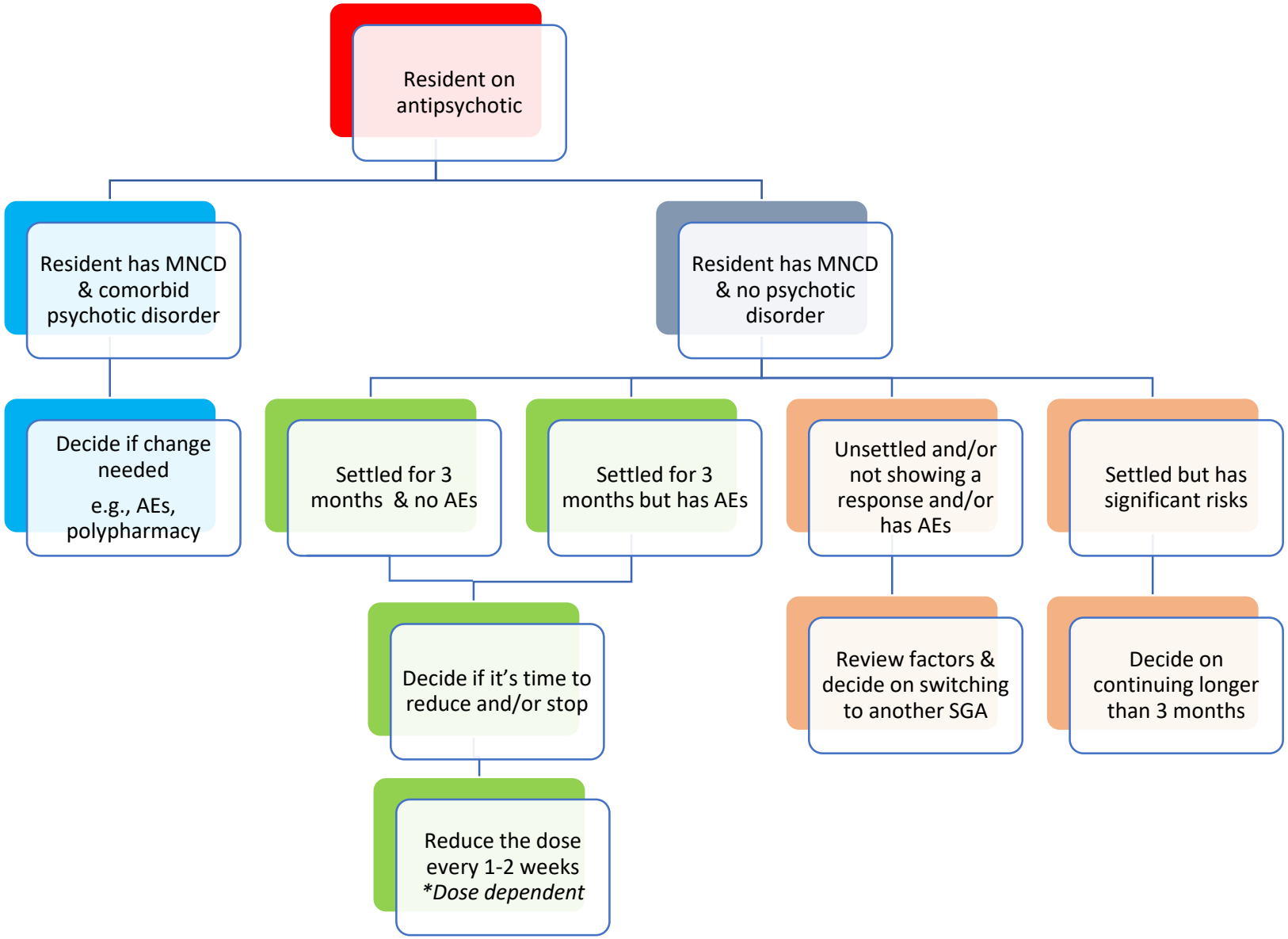
Antipsychotics – 3

- Metabolic – weight gain, hyperlipidemia, hyperglycemia, and hypertension
- Cardiac – Orthostatic hypotension with Inc HR, prolonged QTc, Myocarditis, Cardiomyopathy
- Sexual – Galactorrhea
- Hematological – Abnormal WCC
- Seizures
- Anticholinergic – Inc HR, dry mouth, urinary retention, constipation, blurred vision and confusion
- Sedation
- Neuroleptic Malignant Syndrome

Extrapyramidal Side Effects (EPSEs)

- Akathisia is a sensation of restlessness, frequent pacing, a compelling urge to move, or an inability to sit still.
- Parkinsonism
- Dystonia is a tonic contraction of a muscle or muscle group.
- Tardive Dyskinesia
  - Sucking, smacking of lips
  - Choreoathetoid movements of the tongue
  - Facial grimacing
  - Lateral jaw movements
  - Choreiform or athetoid movements of the extremities and/or truncal areas


Resident on antipsychotic on admission
Resident has MNCD & comorbid psychotic disorder
Resident has MNCD & no psychotic disorder
No change
Decide if review on admission
e.g., AEs
Decide if review at the rounds
e.g., 1 month



*Decision making tool based on the nursing report, AEs, family concerns, DOS, and NPI-Q

Decision making Tool

Date	Resident		Care Plan
Med	Indication	Decision-making pathway	Decision
	• Diagnosis: • Delusions • Hallucinations • Aggression • Others:	• DOS • NPI-Q • Risks: • Concerns (e.g. family/AEs): Effective/Needed: Not Effective/Needed:	• D/C • Reduce frequency • Reduce dosage • Reassess • No change

Anticonvulsants

- Limited evidence for valproic acid
- Carbamazepine has a role in resistant agitation
- Gabapentin may be used in pain-related concerns and sexually inappropriate behaviour

Trazodone

- Older antidepressant
- Has a sedative effect
- Average daily dose is 50-150 mg daily
- AEs – sedation, bradycardia, postural hypotension, constipation, dry mouth, priapism

Benzodiazepines

- Limited evidence
- Lorazepam 1-2 mg dose for acute aggression and preintervention
- Temazepam and Oxazepam are occasionally used as sedatives
- Clonazepam 1-2 mg daily for REM sleep behaviour disorder or when switching from lorazepam

Melatonin

- Mixed results
- Circadian rhythm phase advancement in older adults and with dementia
- Average dose: 3-10 mg daily

Zopiclone

- Used as a sedative
- Average dose is 5 mg daily

Nabilone

- Synthetic cannabinoid
- Some evidence in agitation
- Used to address behaviour in response to care
- Average dose is 0.5 mg two to three times daily (max 6 mg daily)

BPSD Not Amenable To Pharmacologic Management

- Undressing
- Repetitive Activity
- Vocalization
- Eating inedible objects
- Tugging at restraints
- Exit-seeking
- Spitting
- Pushing wheelchair
- Hiding
- Hoarding
- Inappropriate Voiding
- Poor Social Skills
- Wandering
- Resistiveness to Care

Questions?

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