Recognising and managing behaviours

Drs Karen Savery and Rebecca Moore

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Acknowledgement of Country

The RACGP acknowledges the Traditional Custodians of the land and waterways in which we work and live. We recognise their continuing connection to land, water and culture, and pay our respects to Elders past, present and future.

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Dr Karen Savery

Medical educator – Dementia Training Australia

Dr Savery is a Brisbane-based GP who works in clinical practice, residential aged care, and medical education. She is passionate about the education and mentoring of GPs, particularly in the area of aged care and dementia.

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Dr Rebecca Moore

Rebecca is a GP in Newcastle with a special interest in Geriatrics and Dementia. She is in the final stages of a Masters of Dementia through the Wicking Research and Education Centre at the University of Tasmania. Rebecca is a member of the Dementia Training Australia Medical Educator team.

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Learning Outcomes

By the end of this session, participants will be able to:

- Apply a patient centred approach to supporting individuals living with dementia who are experiencing changed behaviours
- Explain the role of non-pharmacological approaches to behaviour support
- Describe the role of medications in the support of a person living with dementia experiencing changed behaviour

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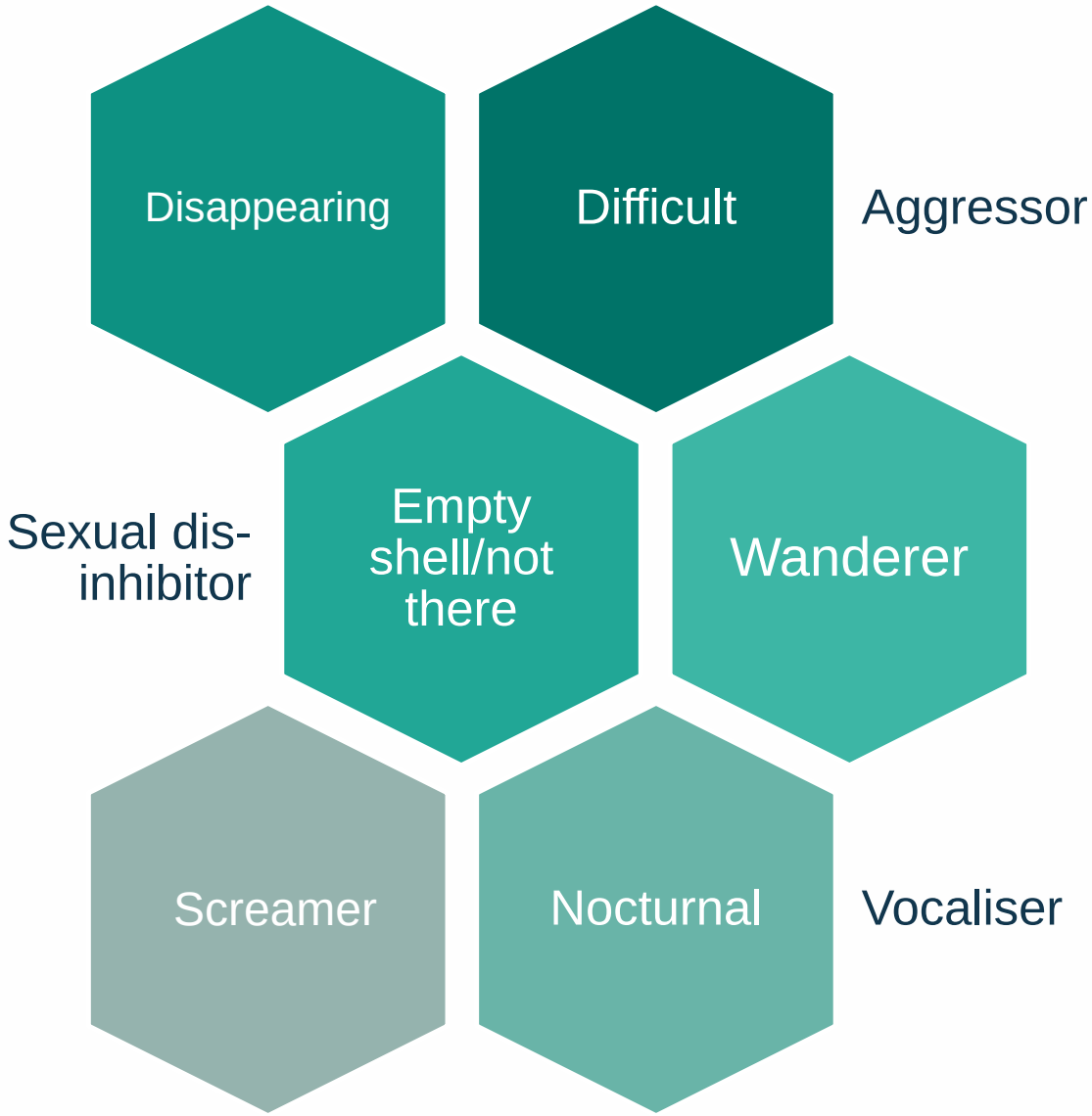
Stigmatising Language (do not use)



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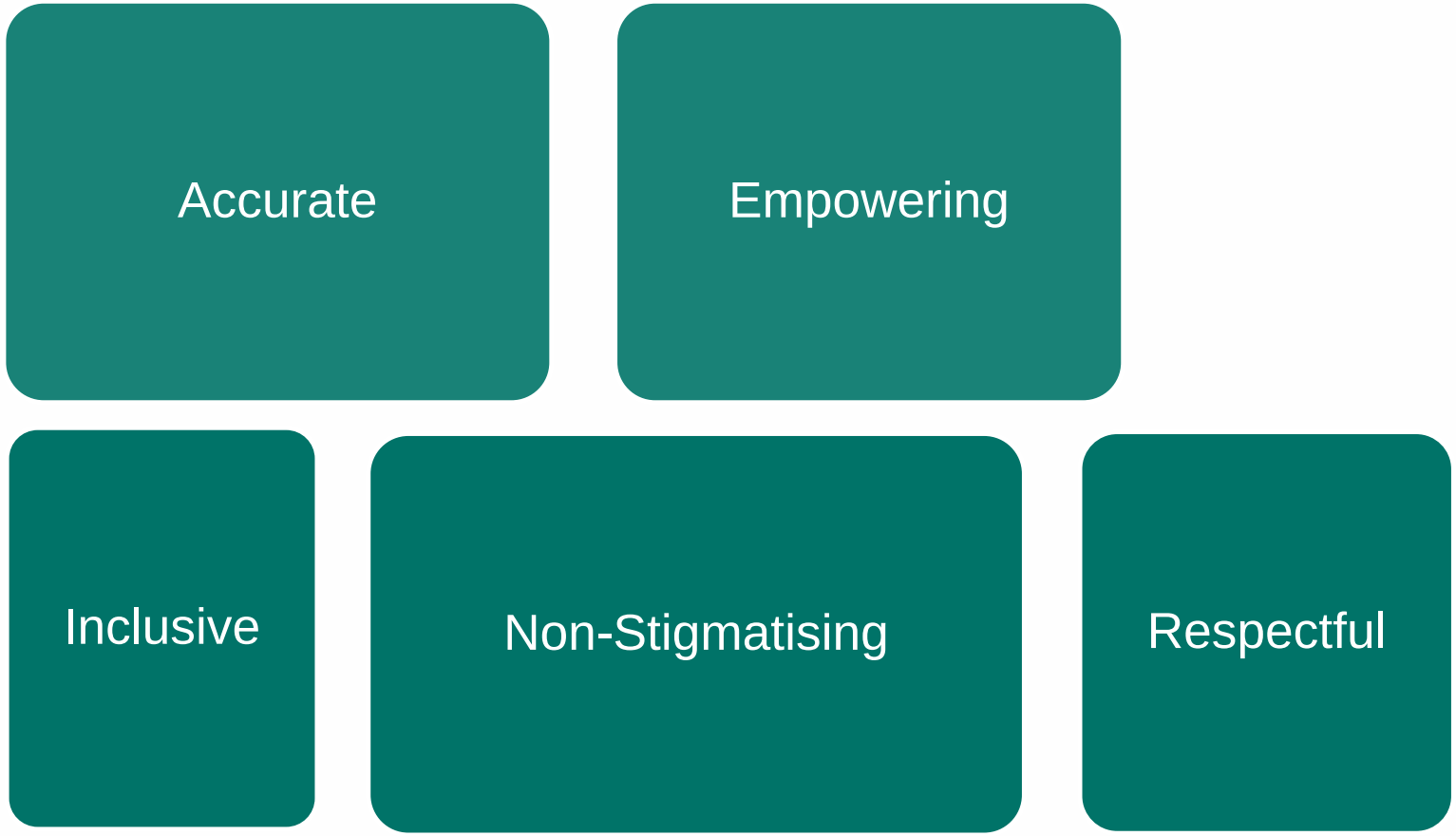
Instead use language which is:



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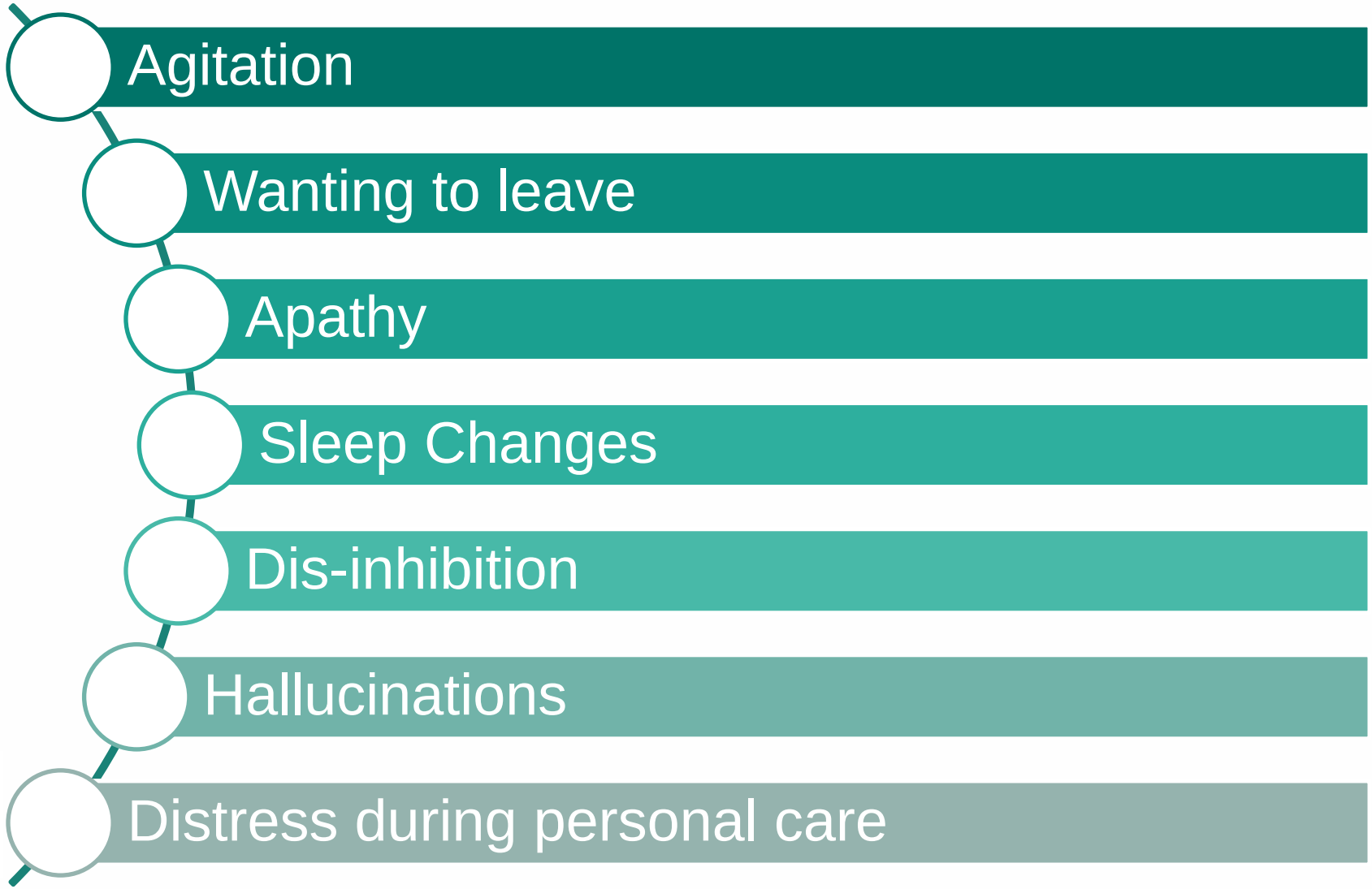
What do we mean by changed behaviours



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Let’s meet Anna

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Anna has come to the RACF for respite after recent hospitalisation for a chest infection.

The RACF has contacted you to ask you to come and see Anna as she is confused and keeps calling out.

How do you assess Anna?

Possible causes?

- Could it be delirium or a biological cause?
- Could it be an environmental trigger?
- Could it be depression or a psychiatric cause?

- Or could it be a combination of the above?

Could it be delirium?

- Delirium is serious
- Hypoactive / hyperactive / mixed

- Acute
- Fluctuating alertness / altered level of consciousness
- Fluctuating cognition
- Inattention
- Disorganised thinking
- Hallucinations

Drug related

Alcohol

Anticholinergic load

New medication

Physical

Constipation

Dehydration

Poor Sleep

Disorientation

Pain

Urinary retention

Organic

Infection urine/viral/cellulitis

Stroke

Endocrine

Electrolyte

Hospital Elder Life Program (HELP) Trial

Inouye & colleagues, 1999

LANDMARK

Cognitive interventions
Visual aids
Hearing aids
Address Immobility
Hydration
Good Sleep hygiene

Reduced delirium by 40%

Adapted from cgatoolkit.com

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Case: Anna

Anna’s confusion improves with adequate fluids and time to settle into the RACF.

Staff say that she is still agitated at times, and tends to call out or walk into other resident’s rooms.

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Possible causes?

- Could it be delirium or a biological cause?
- Could it be an environmental trigger?
- Could it be depression or a psychiatric cause?

- Or could it be a combination of the above?

Could there be an Environmental Trigger?

- Overstimulation or understimulation
- When does the changed behaviour occur?
- Any preceding events?
  - noise, particular carers
- Could there be unmet needs?
  - hungry, bored, lonely
- Change in environment?
- Sleep disturbance?
- Abuse/neglect?

Non-Pharmacological support

- Identify and minimise triggers
- Calm approach, speaking slowly
- Don’t argue
- Distract and divert attention
- Non-threatening postures

Non-Pharmacological Interventions

- Individualised
- Optimise quality of life
- Safety for self and others
- Regular exercise
- Orientation devices (clock/calendar/signage)
- Routine
- Adjust the environment

Non-Pharmacological Interventions

Activities the person enjoys

- Familiar activities (folding/shopping/gardening)
- Music or animal therapy
- Aromatherapy or massage
- Exercise
- Reminiscence therapy
- Montessori-type activities, dolls

Non-pharmacological Interventions

Who to call when it is not effective:

- Geriatrician
- Older person’s Mental Health team
- Dementia Support Australia
  - 24 hours help ph: 1800 699 799
  - DSA and Severe Behavioural Response Team (SBRT)

Case: Anna is now living permanently in the RACF

6 months later…

Anna’s calling out and agitation has increased. She believes all car accidents on the news are about her son. She is upset that he has died (he hasn’t). She calls her daughter at 2am.

Staff think she might need something to calm her down

How do you assess Anna?

Possible causes?

- Could it be delirium or a biological cause?
- Could it be an environmental trigger?
- Could it be depression or a psychiatric cause?

- Or could it be a combination of the above?

- Or could it be a progression of dementia?

Could there be a Psychiatric trigger?

- Depression
  - Increase in apathy?
  - Minimal oral intake?
  - Suicidal ideation?
- Anxiety
- Psychosis
  - Secondary to dementia
  - Due to another psychiatric condition

Depression/Anxiety in Dementia

- Antidepressants e.g., citalopram, sertraline, or mirtazapine
- Cholinesterase inhibitors e.g. rivastigmine, donepezil (possible benefit for psychosis, hallucinations, apathy, anxiety).
- Memantine – moderate evidence for aggression
- Benzodiazepines, e.g., oxazepam 7.5mg-15mg or lorazepam 0.5 mg (maximum 2 to 4 mg every 24 hours)

Pharmacological treatment for changed behaviours

Informed consent essential as considered a **chemical restraint**

- Consider if considerable distress or risk of harm to self/others
- Consider if unresponsive to psychosocial interventions
- Aim for least harmful medication for the shortest period of time
- Review regularly

Anti-psychotics – as per Therapeutic Guidelines

Risperidone 0.25 mg orally, twice daily. If needed, increase the dose by 0.25 mg twice daily every 2 or more days. (Maximum of 2 mg daily in 1 or 2 doses)

OR

Olanzapine 2.5 mg orally, daily. If needed, increase the dose by 2.5 mg daily every 2 or more days. Maximum of 10 mg daily in 1 or 2 doses.

Seek specialist advice in Parkinson's and Dementia with Lewy Bodies

- *Potentially severe sensitivity reactions to antipsychotics*
- *May consider Rivastigmine/donepezil or Quetiapine*

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Anti-Psychotics continued…

- Start low and gradually increase
- If no response within a month cease treatment
- Changed behaviours usually transient so continue to reassess need
- Watch for side-effects
- Once stable, cease gradually over 2 to 4 weeks

Risperidone is the only PBS listed antipsychotic for BPSD and *only* for Alzheimer type

Initial authority

- no more than 12 weeks, non-responsive to non-pharmacological methods

Continuing authority

- must have responded to an initial course
- Is for dose tapering purposes OR has trialled a period of reduction/cessation and experienced worsening or re-emergence of symptoms
- must be discussed formally with psychiatrist or geriatrician or in a documented clinical review process involving at least one other medical practitioner.

Adverse effects

- Extra-pyramidal effects
- Sedation
- Exacerbation of confusion and cognitive decline
- Postural hypotension -fractures and falls
- QT prolongation
- Increased risks of hospitalisation and death
- Increased risk of strokes *(more than twice as likely compared to placebo although dependent on dementia subtype)*

Insufficient evidence

- Anticonvulsants – No evidence for Sodium Valproate
- Opioids
- Melatonin
- ECT for aggression

Back to Anna – agitation and calling out

Agitation

- Individualised psychosocial intervention
- Moderate evidence for music therapy and aromatherapy
- Best evidence is atypical antipsychotics but not recommended first line due to safety concerns
- Some evidence for ChEIs, memantine, anti-depressants and analgesia when indicated

Vocally disruptive behaviour

- Exclude discomfort, delirium
- Individualised behavioural strategies e.g music therapy, aromatherapy
- Therapeutic recreation best evidence for psychosocial management
- Risperidone has the best evidence if medication indicated but is not routinely recommended
- Evidence for ChEI and anti-depressants limited

Framework for changed behaviours

- Could it be delirium or a biological cause?
- Could it be an environmental trigger?
- Could it be depression or a psychiatric cause?
- Could it be a progression of dementia?

- Or could it be a combination of the above?

Resources

Dementia Australia®

Home Information Support Ed

Nightingale Program

DS Dementia Support Australia

Who we help Where we go Understanding changed behaviours Resources

Home ▸ Who We Help ▸ For Health Care Professionals ▸ Services ▸ GP Advice Service

Listen

GP Advice Service

Forward with dementia

A guide to living with dementia

dta Dementia Training Australia

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Further learning

Looking at Residential Aged Care: Living the best life possible S2, EP-5

The team meet with dementia consultant Jason Burton to discuss what can be done to support the person with dementia live their best life possible. SHOW NOTES: Dementia Australia Providing support, information and services for people living with dementia, carers, family and health profession...

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Questions

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Next webinar

31 July 7pm

New horizons and research into dementia

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