

Use of Antipsychotics and Other Medications for Urgent Treatment of Severe Agitation, Psychosis or Aggression in Older Adults with Dementia in Long-Term Care Settings

INTRODUCTION AND DISCLAIMER

For severe behavioral disturbances posing a risk to the patient, staff or co-residents, the best supported evidence is for the atypical antipsychotics, in particular **RISPERIDONE**, **OLANZAPINE**, and **ARIPIPRAZOLE**. **Informed consent should be obtained from the patient or substitute decision maker as soon as possible given the urgency of the situation.** All atypical antipsychotics are associated with approximately a 1% increased risk of stroke and death over a short-term treatment period of 6-12 weeks. **THIS TOOL, PREPARED IN APRIL, 2012, IS A CONCEPTUAL AID FOR HEALTH CARE PROVIDERS. IT IS NOT A SUBSTITUTE FOR A PHYSICIAN'S DIAGNOSIS AND TREATMENT AND IS NOT MEDICAL ADVICE. USE AT YOUR OWN RISK.**

ASSESSMENT

Does the behavior require urgent treatment?

- **Physical aggression** (e.g. hitting, pushing, kicking) towards co-resident which are not limited to specific situations (i.e. not in response to another resident threatening patient)
- **Physical aggression** (e.g. hitting, pushing, kicking) towards staff that is not limited to specific situations (i.e. not during care)
- **Psychotic symptoms** (e.g. hallucinations or delusions) which are severe and distressing to patient or co-residents, or staff

DO NOT initiate antipsychotics for non-aggressive physical agitated behavior such as wandering, pacing, or general restlessness. Instead use non-pharmacological approaches or initiate treatment with other medications as appropriate.

Investigate treatable causes:

- Rule out **DELIRIUM** or initiate investigation for delirium
- Rule out **PAIN** or initiate investigations for pain or discomfort
- Recent **MEDICATION** addition or change

Evaluate for Potential Contraindications:

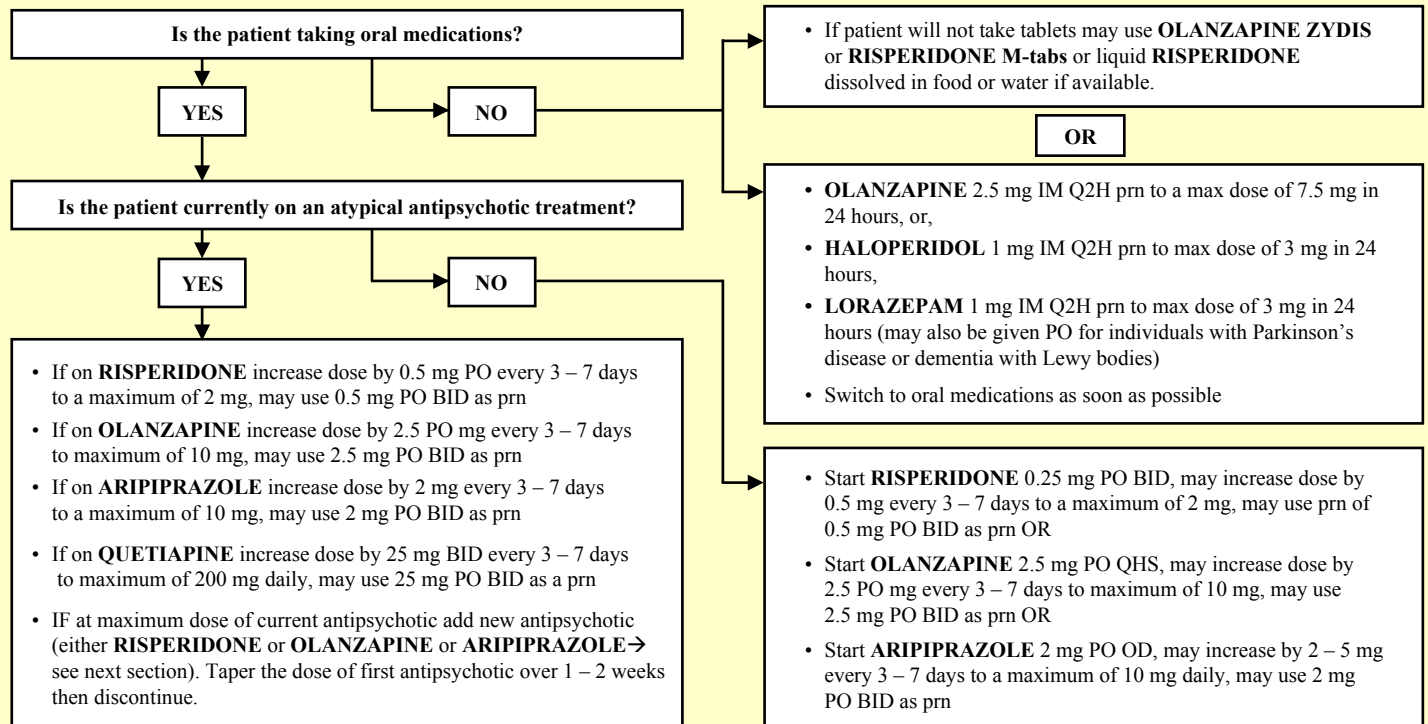
Does the patient have a known relative contraindication to antipsychotic treatment?

- Known allergy or previous sensitivity to a given antipsychotic
- Parkinson's disease
- Dementia with Lewy bodies

If YES: may use **LORAZEPAM PO/IM** (see below)

PHARMACOLOGICAL MANAGEMENT

For all individuals use the lowest dose that is effective in treating the symptoms, only increase dose to maximum suggested dose if behaviors do not respond to lower doses. A duration of **TWO WEEKS** may be required full response to medications are observed following initiation of treatment.



MONITORING

Use medications for as short a time period as possible. Attempts should be made to decrease and discontinue medications after 6-12 weeks if symptoms have remained stable. After initiating treatment monitor for:

- Sedation
- Unsteady gait
- Parkinsonism (tremor, rigidity):
NOTE: DO NOT use anticholinergics (e.g. BENZTROPINE) for EPS
- Increasing confusion, cognitive or functional decline
- Worsening restlessness or akathisia

Managing Side-Effects:

If side-effects occur during treatment do not increase dose and continue to monitor for 7 days unless side-effects are serious. If side-effects persist reduce antipsychotic dose by one increment (e.g. reduce RISPERIDONE by 0.5 mg or OLANZAPINE by 2.5 mg) and observe. If side-effects persist at lowest dose then discontinue and start new antipsychotic.

Treatment Non-Response:

If symptoms persist despite trials of two antipsychotics, or if person does not tolerate antipsychotics, consider referral to geriatric psychiatry outreach services for further assessment and treatment options.