MANAGEMENT OF AGITATION IN OLDER PEOPLEWITH DELIRIUM AND/OR DEMENTIA

WHAT IS THE TRIGGER FOR AGITATION?

Treating the underlying cause is the best way to manage agitation. If the cause for agitation is not clear, it is essential to carry out a proper assessment:

PINCH ME

P Pain: Is the person in any pain? Has urinary retention been excluded?

IN Infection: Chest/ urine/ CNS/ skin/ joint. Refer to sepsis pathway as appropriate.
Intracranial: Is there a focal neurological deficit? Head injury?

C Constipation: When was the last bowel movement? Could there be faecal impaction? (Consider DRE and disimpaction).

H Hydration & Nutrition: Does the patient seem dehydrated? Is there any major electrolyte imbalance or metabolic disturbance? Consider hypoxia, hypotension, hypoglycaemia.

M Medication: Omission of regular medication (esp benzodiazepines/ alcohol), addition of new medication (steroid, anticholinergic, opioid).

E Environment: Overstimulation (noise/ activity), understimulation (boredom, reduced social contact and activity), break in established routine, fear/ uncertainty associated with change in care setting, restrictions on movement.

NON-PHARMACOLOGICAL APPROACH

Sedating drugs can prolong delirium and result in adverse effects (e.g. falls, aspiration, prolonged QT interval).
Non-pharmacological approaches should always be considered first line management.

- Calmly reassure and re-orientate the person.
- Acknowledge the person's distress (I can see you are worried, I understand you want to go home).
- Avoid arguing and negative language (can't, don't, not allowed).
- Ensure adequate analgesia (regular paracetamol is a reasonable step even if the patient does not report significant pain).
- Encourage regular oral hydration.
- Ensure the person is wearing personal adaptive equipment (glasses, hearing aids, dentures).
- Minimize sleep interruptions.
- Enable regular safe mobilisation (with a healthcare attendant or family or friends if required).
- Allow family or friends/ significant others to visit and stay with patient (this is often the best way to help settle an agitated patient)
  - One-to-one special attendant if the person is a risk to themselves or others.

PHARMACOLOGICAL APPROACH

- Sedating medications may result in serious side-effects for older people:
  - Antipsychotics are associated with increased risk of falls, aspiration pneumonia, dystonias, extrapyramidal side effects, stroke, cardiac arrhythmias and death.
  - Benzodiazepines are associated with increased risk of falls, respiratory depression and prolonged delirium.
- Can the symptoms be better managed by prescribing a family or friend visit and/or arranging a one-to-one special attendant? –If yes, this should be undertaken.
- **A sedating medication should only be prescribed if the patient is severely distressed, a risk to themselves or others and non-pharmacological approaches have failed. Patients wandering should not be controlled with sedating or antipsychotic drugs.**
  - Always prescribe as a STAT dose. The decision to prescribe a regular or PRN sedating medication should ONLY be made by a senior member of the patient's primary team.

Document:

- **What, precisely, was the observed behaviour? (i.e. describe the agitated behavior or, ideally, review Behavior Chart).**
- **What assessment was carried out (PINCH-ME)?**
- **What non-pharmacological approaches were taken?**
- **Was the protocol below followed? If not, please document reasons.**

Medication for patients not requiring rapid sedation (with behavioural problems not managed by non-pharmacological methods OR with disturbing hallucinations or delusions).

- **Quetiapine is the preferred first line agent.**
- **AVOID COMBINING ANTIPSYCHOTIC DRUGS.**
- **If a patient is already prescribed an antipsychotic drug (e.g. olanzapine, risperidone), give an extra stat dose of this medication (see below).**
- **Liquid (risperidone, haloperidol) and orodispersible (olanzapine) formulations available**

If not on any anti-psychotics: Quetiapine PO 12.5mg-25mg stat.
Repeat dose after 60 minutes if required (max 50mg/24h).

If already taking regular antipsychotic:

Quetiapine:	**Prescribe 12.5mg-25mg PO stat. Repeat dose after 60 minutes if required. Max 50mg (Lowest tablet available 25mg, can be halved)**
Risperidone:	**Prescribe 0.25-0.5mg PO stat. Repeat dose after 60 minutes if required. Max 2mg. (Lowest tablet available 0.5mg, can be halved, liquid available)**
Olanzapine	**Prescribe 1.25-2.5mg PO stat. Repeat dose after 60 minutes if required. Max 5mg. (Lowest tablet available 2.5mg, Orodispersible tabs 5mg can be halved)**
Haloperidol	**Prescribe 0.25-1mg PO stat. Repeat dose after 60 minutes if required. Max 3mg. (Lowest capsule available 0.5mg, liquid 2mg/ml available)**

Medication for patients requiring rapid sedation. (SEVERELY AGITATED AND A RISK TO THEMSELVES OR OTHERS). This decision should be made by a senior clinician.

In combative or violent behaviour; Lorazepam PO	**Start with a low dose: 0.5mg po stat. May repeat as stat doses after 30-60 minutes up to max of 2mg/24h.**
In florid psychosis or extremely combative or violent behaviour; Haloperidol PO or IM ***NEVER give Haloperidol IV (risk of PROLONGED QT interval, torsade de pointes, sudden death)**	**Start with low dose: 0.25 -0.5mg PO stat or 0.5mg IM stat. May repeat as stat doses after 30-60 minutes up to max of 3mg/24h.** **Haloperidol should be avoided in patients with Parkinson's disease, dementia with Lewy bodies and those with prolonged QT interval (QTc>440ms).**

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