

# Curbside Consultation

*Peer to peer consultations facilitated by dementia care experts*



Alberta Health  
Services

Seniors Health  
Strategic Clinical Network

## Alternatives to Physical Restraints

### Case study

A 78 yr. old resident has a history of dementia (possibly Korsakoff's), chronic atrial fibrillation, CHF, COPD, frequent chest infections, obesity, heavy alcohol use with alcoholic liver changes, diabetes, osteoarthritis and GERD. He was a farmer for years and also worked in the oil patch. He has been a good dad and has a close relationship with his daughter. He likes dogs.

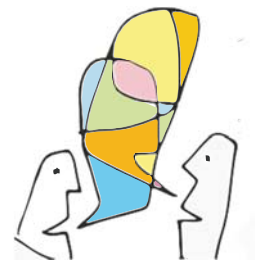
He was admitted to acute care when his wife could no longer manage him at home. He was eventually placed in LTC outside his home town and later transferred to his current care home in the same town as his wife and son. His wife comes in for short visits; she seems to struggle with the changes in her husband

On admission he was on an antipsychotic medication that was reduced and then discontinued. Following this he became more alert and more active but, after a couple of months, he began to wander into rooms, call out, and sometimes resist care. He self-propels in his wheelchair and will walk with staff. He is slowly losing weight as he is not able to focus on his meals.

In December 2015 he had a fall and hit his head, hip and shoulder. X-rays and CT were negative but from that time on his behaviours increased. Most nights he settles and sleeps for 6-7 hours and sometimes 12 hours at a time. His mornings are good, he is quiet and calm but later in the day he starts rolling into people with his wheelchair and calling out. He went to short stay at the hospital to address these behaviours but developed pneumonia and was sent back within a few days of his admission.

The care team is frustrated. Some of the residents are angry with him and bait him and there is a family member of another resident who has been witnessed to verbally provoke him.

## Alternatives to Physical Restraints ...



### Attempted strategies

#### *Person-centered interventions*

- Sit with him and talk while he eats and when getting nebulizers
- Brought him in to sit with staff who are charting
- Family members are called in but don't stay long
- He is now back on low dose of an antipsychotic
- Frequent consults to the short stay and Geriatric Mental Health teams.

#### *Site routines/environmental interventions*

As a last resort, the staff put him in a Broda chair to keep him from wheeling into other residents. Usually this happens over the lunch time so he is in the chair for less than an hour. After the other residents have eaten he is transferred back into his wheelchair and given his lunch.

Once he starts wheeling into other people and calling out, this behaviour carries on for the rest of the day and evening.

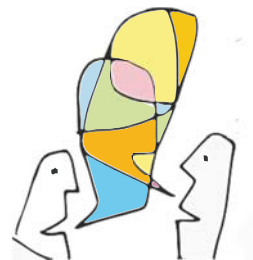
### What would the care team ask that the participants focus on?

“How can we support this resident and the care team to keep everyone safe and injury free without the use of restraints?”

### Medications

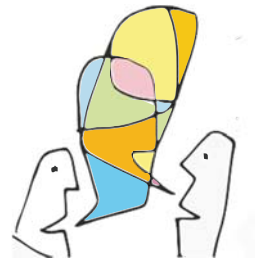
Medication	Class of medication and why prescribed	Possible side effects related to responsive behaviours	Anti-cholinergic
Spironolactone 100 mg once daily	Potassium sparing diuretic prescribed for CHF and fluid retention. Potentiates the effect of narcotics	Nausea, vomiting, diarrhea, breast swelling & tenderness, dizziness, headache, drowsiness, leg cramps	
Coumadin 1 mg every day except Friday 1.5 mg on Friday	Anticoagulant for atrial fibrillation	Nausea, stomach/abdominal pain, loss of appetite, unusual bruising, blood in the urine, feeling cold	yes

## Alternatives to Physical Restraints ...



Nozinan 2.5 mg in the morning and 5 mg at bedtime	Antipsychotic used for psychosis, schizophrenia, manic/depressive syndrome. Prescribed for behaviour management (pharmacologic restraint).	Dry mouth, urinary retention, constipation, weight gain, No recommended in patients with liver disorders. Have strong analgesic, antihistamine and antispasmodic properties.	yes
Tecta (pantoprazole) 40 mg twice daily	Proton Pump inhibitor prescribed for GERD	Abdominal pain, nausea, headache, dizziness, itching, deficiencies in B12 potassium, calcium, magnesium and other vitamins and minerals	
Lactulose 30 ml twice daily	Used for liver disease not constipation	Diarrhea, cramping, nausea	
Lantus 10 units at bedtime	Insulin to treat high blood sugar	Irritation of daily injections, potential hypoglycemia	
Furosemide 40 mg in the morning and 20 mg at 1400hrs	Diuretic to reduce symptoms of swelling and shortness of breath	Frequency, dehydration - confusion; Thiamine (B1) deficiency (worsens CHF); B6 deficiency - necessary for serotonin & melatonin synthesis (insomnia, anxiety, depression)	yes
Pulmicort 1 neb twice daily	Bronchodilator to treat COPD	Dry throat, nausea, bad taste in mouth, runny nose, not wanting to leave the mask in place	
Combivent 1 neb 4 times daily	Bronchodilator to treat COPD	Headache, dizziness, nausea, dry mouth, shaking, tremors, constipation, not wanting to leave the mask in place	yes
Fentanyl patch 25 mcg/hr., change every 3 days	Narcotic analgesic	Urinary retention, hallucinations, respiratory depression, confusion, sweating, dry mouth, nausea, nervousness, weakness, headache, skin irritation at site, itchiness	yes
Zyprexa 2.5 to 5 mg PO/SL @ bedtime PRN	Antipsychotic	Drowsiness, lightheadedness, nausea, dry mouth, constipation, weight gain, tremor, difficulty swallowing, confusion, restlessness, urine retention	yes

# Alternatives to Physical Restraints ...



## Ideas suggested by Alberta LTC teams

### *Resident assessment/evaluation*

- Pain assessment - Is his pain well controlled? Reassess the Fentanyl dose and perhaps add routine Tylenol and use warm blankets for comfort.
- Full medication review with the pharmacist. Nozinan can cause agitation. Antipsychotics are not recommended with liver disorders, no evidence of benefit with wandering.
- Is he still using his inhalers correctly? If not then perhaps they could be stopped.
- Assess for urinary retention.
- Assess for visual acuity, can he see where he is going?
- Assess for reasons for his weight loss e.g. cancer, pain, anxiety, nutrition, digestive issues, and high blood sugar. Does the dietician regularly monitor his intake?
- Could he be experiencing depression?
- Documentation of the subtle signs that staff note as triggers for his behaviours

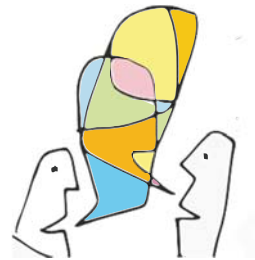
### *Person centered strategies*

- Try a short rest in the afternoon
- When he wanders, is he looking for something or someone?
- Music therapy/individual music playlist
- Try a rocking Broda chair instead of a stationary one (self-soothing)
- Provide activities such as fidget/busy boards, tactile resources, Snoezelen, an old engine he can touch and smell the oil, pet therapy, reminiscing
- Explore the option of a companion hired by the family for the lunch hour and to take him outside
- Try a regular toileting schedule and toilet him right before lunch before his behaviour starts
- Offer finger foods throughout the day, perhaps he is hungry
- What is going on when he is not having these behaviours? Could there be more of that?

### *Site specific strategies*

- Offer education to the family members of the residents on his floor
- Education resources for staff and family
- Offer to speak at resident/family council meetings
- Involve staff in a care planning meeting about this resident

# Alternatives to Physical Restraints ...



## Staff education and resources

- [AUA toolkit](#) Meaningful Activities
- [Finding Joy: Strategies for Meaningful Activity](#)
- Geriatric Pain Assessment: <http://www.geriatricpain.org>
  - [Pain Assessment Checklist for Seniors with Limited Ability to Communicate \(PACSLAC\)](#)
  - [Comprehensive Pain Assessment Tool](#)
- University of Alberta <http://www.painanddementia.ualberta.ca>
  - Online workshop: [Observing and talking about pain behaviors](#)
- [RxFiles](#): <http://www.rxfiles.ca>
  - [Dementia Overview: Cognitive & Behaviour Tx](#)
  - [Behaviour Management in Dementia: Where do Antipsychotics Fit?](#)

## Curbside Consultation info

The Appropriate Use of Antipsychotics (AUA) team hosts monthly peer to peer call-in meetings to discuss specific challenges related to care of persons with dementia. A case study is prepared in advance and sent out to care teams on our contact list. During a call on the third Wednesday of each month, care teams share their expertise. The case study and suggested strategies are summarized and shared or later used for staff education.

*If you have a topic or resident case study you'd like help with, or would like to be on our e-mail list, contact:*  
[AUA@ahs.ca](mailto:AUA@ahs.ca)