Curbside Consultation

Peer to peer consultations facilitated by dementia care experts

Seniors Health
Strategic Clinical Network

Managing Aggression on a Specialized Dementia Unit

Case study

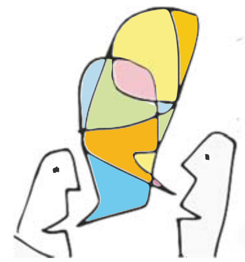
An 81 year old retired engineer has a 10 year history of Alzheimer's Dementia (previously discussed July 2016, The Over-Protective Resident). The Long Term Care (LTC) reported he was unable to speak, fearful and paranoid, territorial, frequently rummaged through other people's belongings and wandered with a high risk of elopement (even removing screens from windows to climb out).

He was seen by Geriatric Mental Health prior to being sent to the MDE unit (Managing Dementia with Expertise). Medications trialed included citalopram, trazadone (PRN), risperidone and galantamine.

Once on the MDE unit, he was only aggressive during personal care but was tall and strong.

Attempted strategies

- Supportive Pathways and person-centred approaches guide all care on the MDE unit, e.g. distraction, reassurance, "No" means no. If he refuses care, we re-approach later.
- One person talks at a time using short, simple instructions. Allow him time to absorb information.
- Family involvement: ask them to observe if he's more drowsy or agitated, ask what worked in the past.
- Take the "path of least resistance" – e.g. shower when his wife is present.
- Care given consistently by those HCAs with whom he has developed a rapport.
- When he is agitated during personal care, one person stands in front giving directions, one person on each side gently holds his hands and one person behind washes and changes. Sometimes people have to hold his legs (gently but firmly). The goal is always to provide care without him being scared.
- With the above approaches he sometimes requires assistance of one person with personal care; there are still times when he requires 4 or 5 people.



Pharmacologic strategies

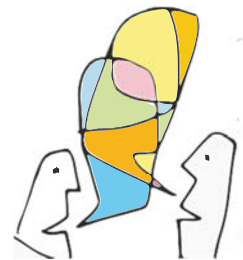
The MDE program is a unique program with unique resources (e.g. there is one Health Care Aide HCA for every three residents). There are weekly interdisciplinary clinical rounds which include the physician, pharmacist and interdisciplinary team. They don't start a meeting until the HCA is in the room. They discuss client responses to medications and person-centred approaches.

Over the course of this resident's admission, many medication changes were made: several antipsychotics and a benzodiazepine were tried and were not effective; unnecessary medications were discontinued (e.g. Galantamine). He is currently on Stelazine (a typical antipsychotic) and Trazadone (SSRI antidepressant). His medications will continue to be adjusted to avoid side-effects, sedation and falls, and to support gentle, person-centred approaches. The goal is that he will be calm, alert and mobile.

Medications

Medication	Rationale	Action
Galantamine	For beginning mild to moderate stage Alzheimer's	Discontinued
Citalopram	Paradoxical effect – can cause increased agitation	Discontinued
Luvox	Fewer side-effects/excitation than other antidepressants. Can help at bed time with sleep & depression	Trialed and discontinued – resident had an allergic reaction
Trazadone	Increased dose to 400 mg daily in divided doses. Dose must be personalized – tolerance is very unique person to person	Continued – resident is calmer, and is awake and mobile
Risperidone	Behaviours remained during care	Discontinued
Olanzapine	Tried in place of risperidone, but behaviours remained during care	Discontinued
Haldol	Attempted, but behaviours remained during care	Discontinued
Ativan	PRN before care – behaviours remained during care	Discontinued
Stelazine	This medication occasionally works when other antipsychotics have not. This medication has had some effect	Continue for now but watch for side effects – not a question of if but when
Clopixal	Depot injection typical antipsychotic, lasts 72 hours	This is considered a last resort and they are trying not to use it

Managing Aggression ... *continued*



Staff education and resources

- Non Violent Crisis Intervention: https://www.crisisprevention.com/
- Vancouver Coastal Health Geropsychiatric Education: http://geropsychiatriceducation.vch.ca
    - Behavioural Escalation Continuum Model
- Terra Nova Films: YouTube Dealing with Physical Aggression in Caregiving video (2:46)
- Teepa Snow YouTube video (2:53) Communicating with patients with dementia/Alzheimer's

About the MDE Unit at Bethany Calgary

MDE is a unique program, servicing the southern half of Alberta. A primary diagnosis of dementia is required to be eligible; the resident must have unpredictable aggression and require 3 or more staff to provide care. Residents are admitted by referral only. It is a transition program – the average stay is 18 months; residents are transferred to a LTC dementia unit once stable and one person at a time is able to provide care.

The enriched interdisciplinary team includes Geriatric Psychiatry, Pharmacist, Recreational Therapy, Social Work, Occupational Therapy, Dietary, Clinical Educator, RNs, LPNs, Health Care Aides and Spiritual Care. There is a ratio of 1 HCA to 3 residents. There are no security guards.

Once on MDE, all residents progress through 3 phases:

1) Assessment: Admission to 6 weeks. During assessment there are not many medication changes as the goal is to find the person's baseline.
2) Stabilization: The goal is to wean off antipsychotics and put on something else – less is best, lowest dose possible. The desire is to allow the person to be alert enough to be mobile and calm. Non-pharmacological interventions are emphasized (e.g. Supportive Pathways, Non-Violent Crisis Intervention)
3) Graduation: Transition to a LTC dementia unit. Historically, only one resident has required a readmission to MDE after transition to LTC.

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*