PSYCHIATRIC SYNDROMES OF OLDER ADULTS

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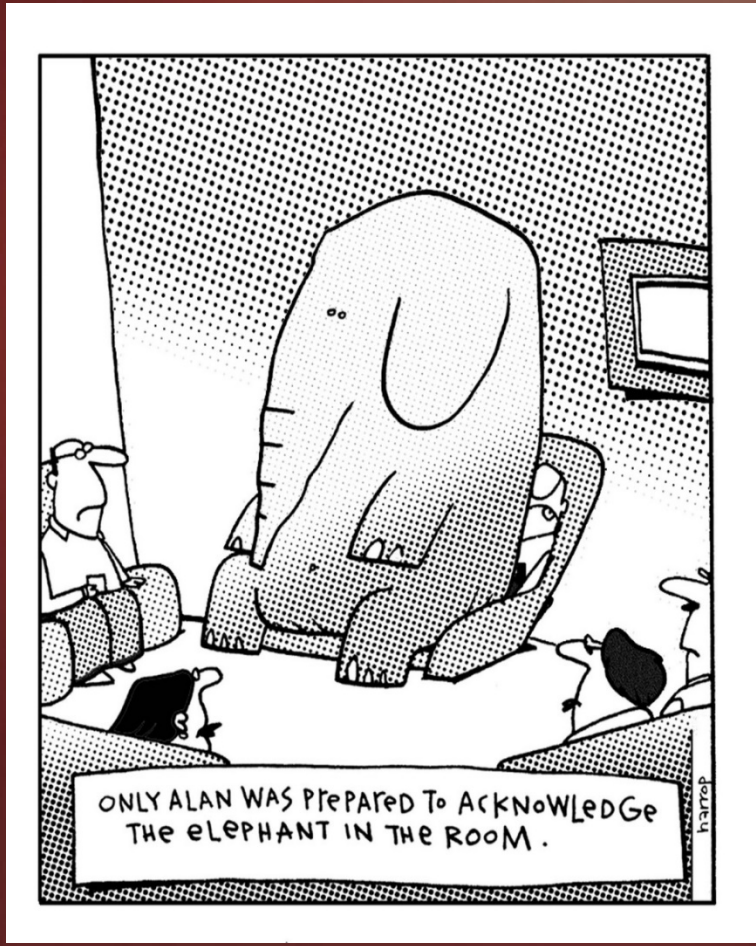
INTRODUCTION TO NEUROCOGNITIVE DISORDERS

POTENTIAL CONFLICTS OF INTEREST:

COGNITIVE CHANGE IS OFTEN THE "ELEPHANT IN THE ROOM" WHEN WORKING WITH SENIORS

- Often comes on slowly
- Usually NOT the presenting problem when someone sees their doctor.
- Can be brushed off or ignored for many years.
- Dementias have a spectrum of severity
- Significant issues of under diagnosis in the mild stage.



COGNITIVE IMPAIRMENT AND DEMENTIA ARE NOT A PART OF NORMAL AGING

IF WE CAN'T CURE IT WHY BOTHER GETTING A DIAGNOSIS?

- Cognitive change can effect every aspect of health and well being.
  - Ability to understand and follow-through with instructions
  - Judgment, Safety, Insight, Planning for the future.
- Early Diagnosis provides opportunity to plan and guides decision making.
- Not every dementia is the same: DIFFERENT DEFICITS
- AFFECTS MANAGEMENT OF BEHAVIORAL SYMPTOMS
- SIDE EFFECTS OF MEDS
- BRAIN RESERVE AND MEDICAL EMERGENCIES / DELIRIUM

REVERSIBLE CONDITIONS

- Depression or other mood disorders
- Low Vitamin B12
- Thyroid dysfunction
- Delirium
- Normal Pressure Hydrocephalus
- Pain
- Sleep Disorders
- Vision/ Hearing
- MEDS!!!!

DISORDERS CAUSING DEMENTIA

- Degenerative Diseases
  - Alzheimer's Dementia
  - Small vessel ischemia or Binswanger's disease
  - Lewy Body Disease
  - Parkinson's Disease
  - Pick's & Frontotemporal Degeneration disorders
  - Progressive Supranuclear palsy
  - Huntington's Disease
  - Multiple sclerosis
  - Primary Progressive Aphasia
  - Cortical Basal Degeneration
  - Creutzfeldt-Jakob Disease
- Large Vessel Stroke
  - Multi-infarct dementia (Vascular Dementia)
- Space occupying lesions
  - Brain tumor
  - Subdural hematoma
  - Normal Pressure Hydrocephalus
- Toxic Exposures
  - Alcoholic dementia
  - Metallic dementia
  - Organic poisons
- Infectious Disease
  - HIV/AIDS
  - Fungal or bacterial Meningitis or encephalitis
  - Brain abscess
- Traumatic Brain Injury
  - Head Injury
- Anoxia (no oxygen)
  - Cardiac arrest
  - Cardiac failure
  - Carbon Monoxide

"BIG PICTURE" POINTS

- AD NOW DEFINED BY ALZHEIMERS PATHOLOGY: SUBSYSNDROMAL, MCI , DEMENTIA
- DEMENTIA REQUIRES FUNCTIONAL IMPAIRMENT
- MCI MEASUREABLE IMPAIRMENT IN COGNITIVE DOMAINS (MEMORY EXECUTIV ETC) NO IMPAIRED FXN
- DECREASED BRAIN RESERVE SENSITIVE TO MEDS INFECTION METABOLIC CHANGES ETC

MCI

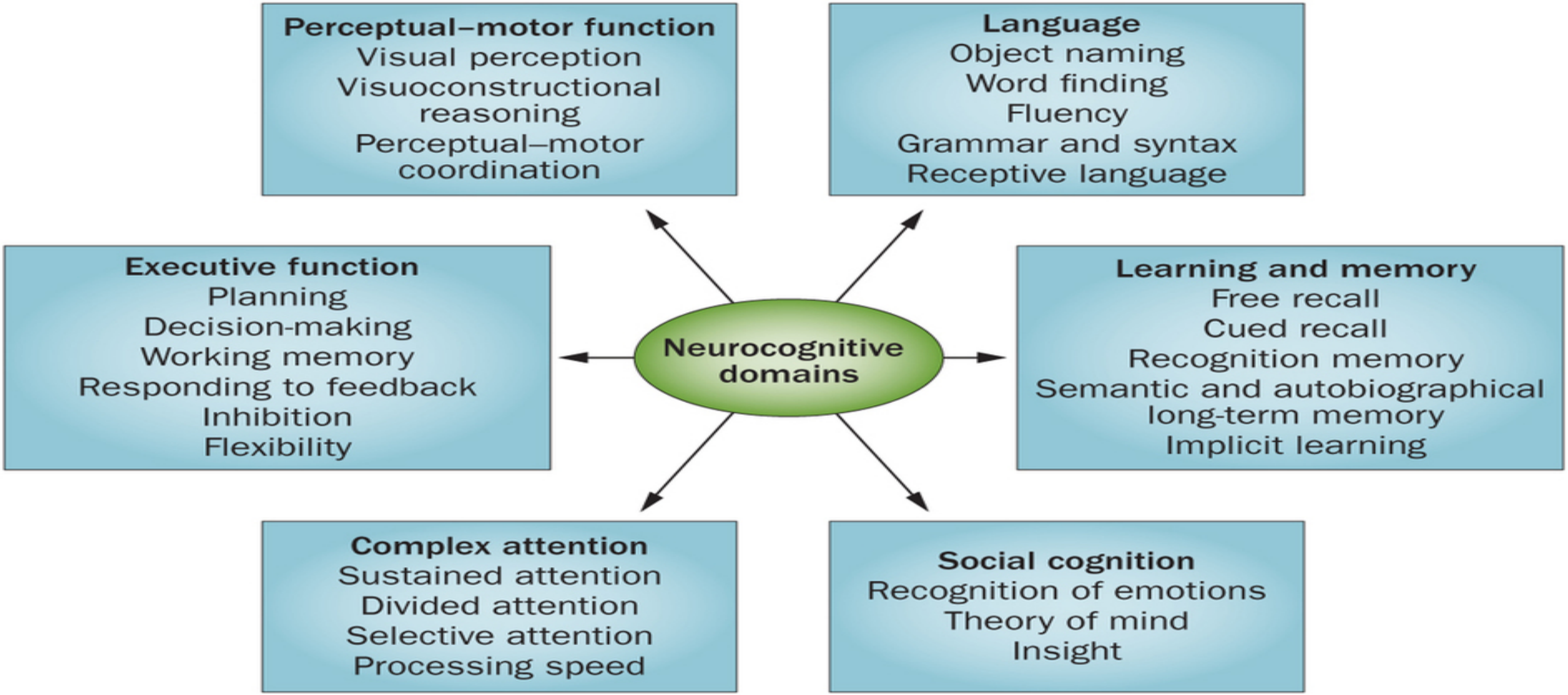
- MAY BE NOTICEABLE TO PT AND FAMILY/ FRIENDS
- 15 TO 20 PERCENT AGE 65 OR OLDER
- SOME REMIT SPONTANEOUSLY
- RETROSPECTIVE META ANALYSIS 32-38% DEVELOPED DEMENTIA 5YRS
- ACTIVE RESEARCH TO IDENTIFY THOSE AT RISK FOR PROGRESSION

DEMENTIA

- DECLINE IN FUNCTION (ADL /IADL)
- INTERFERES WITH WORK OR USUAL ACTIVITIES
- NOT EXPLAINED BY DELIRIUM OR OTHER NEUROPSYCHIATRIC D/O
- COGNITIVE IMPAIRMENT BY HX AND BY BEDSIDE OR NEUROPSYCHOLOGICAL TESTING

DEMENTIA

- COGNITIVE IMPAIRMENT IN TWO OF FOLLOWING DOMAINS:
- ACQUIRING AND REMEMBERING NEW INFO
- REASONING AND COMPLEX TASKS
- VISUOSPATIAL
- LANGUAGE
- CHANGES IN PERSONALITY LOSS EMPATHY APATHY IMPULSIVITY ETC



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EXECUTIVE FUNCTION

- Planning
- Attention,
- Problem Solving,
- Verbal Reasoning,
- Inhibition
- Mental Flexibility, Multi-tasking,
- Initiation
- Monitoring Of Actions
- Context (Green traffic light changing to yellow)

DYSEXECUTIVE SYNDROME

COGNITIVE

Impaired planning and reasoning affects the individual's ability to realistically assess and manage the problems of every day living.

New problems and situations may be especially poorly handled because of the inability to transfer previous knowledge to the new event

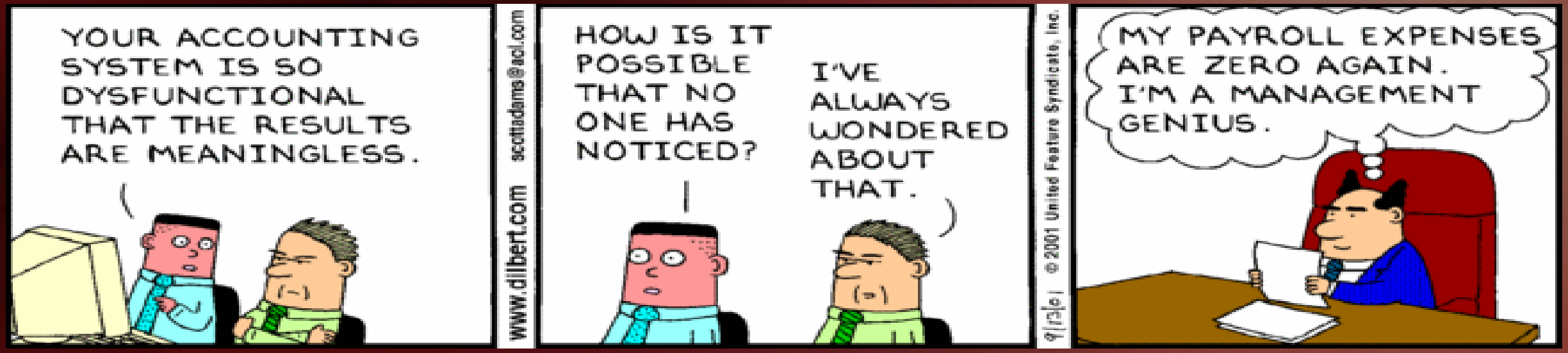
EMOTIONAL DYSREGULATION

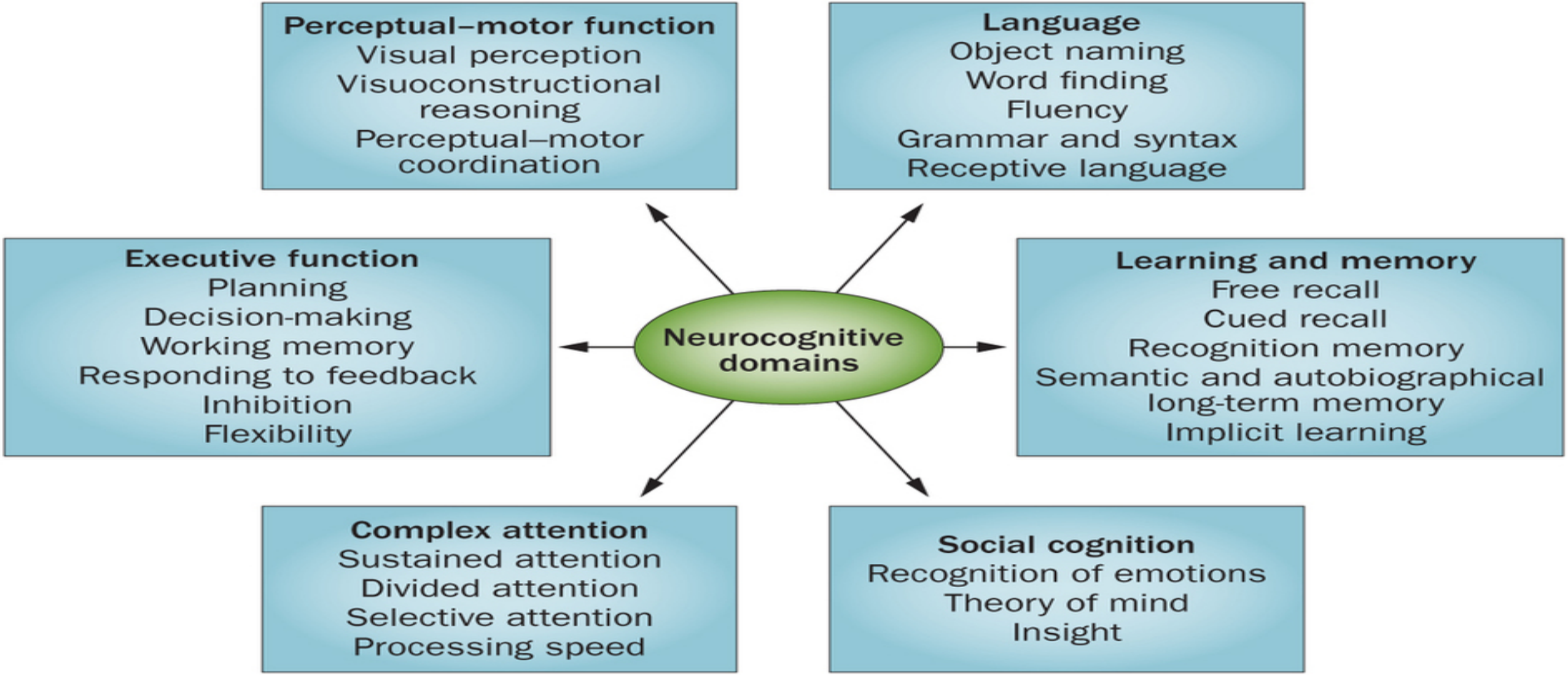
Difficulty inhibiting anger, sadness, frustration.

BEHAVIOURAL SYMPTOMS

Difficulty with social norms. Groups

"EGO SYNTONIC" DEFICITS





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ALZHEIMERS

- MOST COMMON DEMENTIA 60-80%
- A MAJOR CAUSE OF MORTALITY 5TH AGE 65 OR OLDER 6TH OVERALL
- ONLY ONE OFF TOP 10 CAUSES OF MORTALITY WHICH CANNOT BE CURED PREVENTED OR SLOWED
- EARLY ONSET HIGHLY HERITABLE <65 YO
- SMALL PERCENTAGE
- AMYLOID PRECURSOR PROTEIN, PRESENILIN 1 MUTATION ALMOST 100%
- PRESENILIN 2 95%
- BETA AMYLOID PLAQUES AND TAU TANGLES ACCUMULATION

RISK FACTORS FOR DAT

- AGE BY FAR IS GREATEST RISK FACTOR
- 65-74 3%
- 75-84 17%
- >85 32 %
- APOE4 HOMOZYOUS EIGHT TO TWELVE FOLD
- APOE4 HETEROZYGOUS 3x RISK OF APOE 3 HOMOZYOGOUS
- FH HAS OTHER UNKNOWN COMPONENT

ALZHEIMERS

- NATIONAL INSTITUTE AGING –ALZ ASSOCIATION
- CRITERIA FOR DEMENTIA AND:
- INSIDIOUS ONSET OVER MONTHS TO YEARS NOT HOURS OR DAYS
- HISTORY OF WORSENING OF COGNITION BY REPORT OR OBSERVATION
- INITIAL DEFICITS IN EITHER
- AMNESTIC AND ONE OF THE OTHER DEMENTIA DOMAINS (LANGUAGE PERSONALITY EXECUTIVE ETC)

TREATING COGNITIVE SYMPTOMS

- ALZHEIMER'S MEDICATIONS CANNOT ALTER DISEASE PROGRESSION
- TEMPORARILY SLOW THE WORSENING OF SYMPTOMS
- AND IMPROVE QUALITY OF LIFE FOR THOSE WITH ALZHEIMER'S AND THEIR CAREGIVERS.
- NOT INDICATED IN MCI
- NOT USED IN FTD

MEDS

Donepezil	Aricept	All stages	Nausea, vomiting, loss of appetite and increased frequency of bowel movements.
Galantamine	Razadyne	Mild to moderate	Nausea, vomiting, loss of appetite and increased frequency of bowel movements.
Memantine	Namenda	Moderate to severe	Headache, constipation, confusion and dizziness.
Rivastigmine	Exelon	Mild to moderate	Nausea, vomiting, loss of appetite increased frequency of bowel movements

CHOLINESTERASE INHIBITORS

- DONEZEPIL 5MG /DAY X 6 WEEKS THEN 10 MG. MAY USE 23 MG IN 12 WEEKS. USE WITH CARE CARDIAC CONDITIONS
- GALANTAMINE 8MG X 4 WEEKS THEN 16MGX 4 WEEKS THEN 24 MG RENAL MAX 16 MG(NON EXTENDED 4MG BID TITRATE UP TO 12 MG BID)
- RIVASTIGMINE PATCH 4.6 MG Q 24 HOURS X 4 WEEKS THEN 9.5 MG X 4WEEKS THEN 13.3 MG. ORAL BID WITH FOOD. 1.5 MG/3MG/4.5MG/6MG AT 2 WEEK INTERVALS

MEMANTINE

- NMDA ANTAGONIST
- 5MG BID X 7 D THEN 5MG AM 10MG PM X 7D THEN 10MG BID
- GFR 40-60 ML/MIN MAX 10 MG 5-30 MAX 5MG
- EXTENDED RELEASE: 7MG/DAY X 7 THEN 14 MG /DAY X 7 THEN 28MG /DAY
- SOME USE IN CATATONIA

VASCULAR DEMENTIA

- Second Most Common
- 10% of all Dementia
- Sudden or "Stairstep Progression"
- Neuropsych Matches MRI Imaging
- Lifestyle Modification Can Affect Course
- Mixed with Alz and others
- Genetic : CADASIL (Cerebral, Autosomal Dominant Arteriopathy, Subcortical Infarcts, Leukoencephalopathy)

LEWY BODY DEMENTIA

- Second most prevalent degenerative after AD.
- 3 to 26% of all Dementia
- 15 to 25% in Autopsy studies

TRIAD:

- Visual Hallucinations (Also tactile)
- Parkinsonian Features
- Fluctuating Course

LBD SX

- Changes in thinking and reasoning
- Confusion and alertness that varies significantly from one time of day to another or from one day to the next
- Parkinson's symptoms, such as a hunched posture, balance problems and rigid muscles
- Visual hallucinations
- Delusions
- Trouble interpreting visual information
- Acting out dreams, sometimes violently(REM) sleep disorder (Rx KLONOPIN)
- Autonomic Nervous System- Orthostasis

CTE (CHRONIC TRAUMATIC ENCEPHALOPATHY)

- Years After Trauma (Many Small Traumas More Likely
- Tauopathy?
- Memory loss
- Confusion
- Personality changes (including depression and suicidal thoughts)
- Erratic behavior (including aggression)
- Problems paying attention and organizing thoughts
- Difficulty with balance and motor skills

PDD

- Alpha Synuclein (Fxn not known) Lewy Bodies
- 2% Greater than 65 Have PD (1 Million)
- Of these 60- 80% Develop Dementia Sx
- At least one year after PD Motor sx
- Average is 10 years
- Continuum with LBD

GUIDELINES FOR DX PDD VS LBD

- **PDD:** Dx'd with PD based on movement symptoms and dementia symptoms don't appear until a year or more later
- **DLB**:
  - When dementia symptoms appear within one year after movement symptoms
  - When both dementia symptoms and movement symptoms are present at the time of diagnosis
  - When movement symptoms develop within a year of a dementia with DLB Dx
  - (Alz.org)

LBD/PDD PSYCHOSIS RX

- AVOID High Potency Aps (Haldol, Risperdal etc)
- SERIOUS SIDE EFFECTS
- Sudden changes in consciousness
- Impaired swallowing,
- Acute confusion,
- Episodes of delusions or hallucinations,
- Appearance or worsening of Parkinson's symptoms
- No Rx if no distress, danger loss of function
- Charles Bonnet Syndrome

LBD / PDD PSYCHOSIS

- Sinemet/ DA can cause or worsen. Consider reduction
- SEROQUEL 6.25 MG TO 50 MG (Cognitive, Orthostatisis, Urinary Retention, Constipation)
- CLOZARIL As above. Also Neutropenia
- PIMAVANSERIN (Nuplazid) Inverse Agonist 5HT2A (Binds and decrease receptor activity) Antagonist (Blocks) Ki 0.087 (Dissociation Constant) Ki > 300 for D2
- ECT!!!

NUPLAZID

- 34 Mg Per Day (Usually No Titration
- QT Prolongation
- Nausea.
- Constipation.
- Swelling Of The Extremities.
- Walking Abnormally (Gait Disturbance)
- Hallucinations.
- Confusion
- Expensive Pt Assistance Available

PSEUDOBULBAR AFFECT

- 1) Emotional response inappropriate to the situation (Laughing / Crying)
- 2) Incongruence of emotions and affective response;
- 3) Inability to control the duration and severity of the episode; and
- 4) Emotional expression does not lead to a feeling of relief for the patient.

PBA

- Exaggerated Involuntary Emotional Expression (Laughing / Crying)
- Incongruent with subjective emotion
- Independent or in Excess of Stimulus
- Distress or Interference with function
- Neurological Cause (Alz, Vascular, MS, PD)
- Nuedexta

NUEDEXTA

- Dextromethorphan Hydrobromide / Quinidine Sulfate
- 20mg/10mg X 7 Days Then q 12 hours
- Quinidine blocks CYP 2D6 metabolism of Dextromethophan
- Some use Dementia / Behavioral Disturbance

FRONTO TEMPORAL DEMENTIA

- 1:1 AD 45 to 64
- More common than AD < 60 yo
- Behavioral and Language Variant ST
- Behavioral (Drive, Social Inhibition, Exec. Fxn)
- Dysexecutive syndrome can come on later
- Often misdiagnosed as affective disorder (especially in early onset)

SUBTYPES OF FTD

- Behavioral Variant (Frontal)
- Semantic Variant
- PNFA

FTD SX“ (“HOMER SIMPSON SYNDROME”)

- Hyperorality: (mmm… Donuts)
- Lack of Empathy “Doik”
- Rude Comments
- “Disgusting” Behaviors

BEHAVIORAL VARIANT FTD

- FRONTAL VARIANT FTD (FVFTD) OR "PICK'S DISEASE."
- APPROXIMATELY 60% OF PEOPLE WITH ANY FORM OF FTD HAVE BVFTD.
- SOCIAL SKILLS, EMOTIONS, PERSONAL CONDUCT, AND SELF-AWARENESS.
- STUBBORNNESS, EMOTIONAL COLDNESS OR DISTANCE, APATHY AND SELFISHNESS.
- UNLIKE ALZHEIMER'S DISEASE, DON'T SHOW ANY CONFUSION OR FORGETFULNESS ABOUT WHERE THEY ARE OR WHAT DAY IT IS, AT LEAST AT FIRST.

SEMANTIC VARIANT

- 20% of FTD cases. Language difficulty, the predominant complaint of people with SD, is due to the disease damaging the left temporal lobe, an area critical for assigning meaning to words.
- Loss of the meaning, or semantics, of words.
- For example, early in the illness a patient might lose the word for a falcon, later-on forget the word for a chicken, then call all winged creatures "bird" and eventually call all animals "things
- Names of people, even good friends, can become quite difficult
- When SD starts in the right temporal lobe, people in the early stages have more trouble remembering the faces of friends and familiar people. Additionally, these people show profound deficits in understanding the emotions of others.

LANGUAGE DEFICITS

PROGRESSIVE NON FLUENT APHASIA

- PNFA 20% of all people with FTD
- PNFA have difficulty producing language fluently even though they still know the meaning of the words they are trying to say.
- The person may talk slowly, having trouble saying the words, and have great trouble with the telephone, talking within groups of people or understanding complex sentences.

BEHAVIORAL SYMPTOMS OF DEMENTIA

- Agitation
- Verbal and physical aggression
- Increased nighttime wakefulness
- Paranoia
- Hallucinations
- Anxiety
- Depression
- Mania • Disinhibition
- Apathy
- Repetitive vocalizations •
- Wandering • Aberrant motor behaviors
- Helen H. Kyomen, MD, MS March 18, 2012 American Association for Geriatric Psychiatry 2012 Annual Meeting

RECOGNIZING AND RESPONDING TO BEHAVIOR CHANGE

WHAT KIND OF BEHAVIOR CHANGES MIGHT BE TREATED WITH ANTI-PSYCHOTIC MEDICATIONS?

- Severely aggressive behavior
  - Especially physical aggression
  - Danger to the person or others
- Hallucinations and Delusions
  - If distressing or of potential harm to the individual
  - Sometimes these are more distressing to caregivers.
  - Note: memory problems are often mistaken for delusions
    - e.g., thinks people are stealing items
  - Also consider vision& hearing problems
- Schizophrenia
- Severe mood disorders
- Not responding to non pharmaceutical therapies
- Significant decline in function
- Substantial difficulty receiving needed care
- Possibly other distressing agitations

TYPES OF ANTIPSYCHOTIC COMMONLY USED IN OLDER ADULTS

- Haldol (1st Generation) 0.25 - 2 mg po qday
- Risperdal (2nd Generation) 0.25 - 2 mg po qday
- Abilify (2nd Generation) 2-10 mg po qday
- Zyprexa (2nd Generation) 2.5 -7.5 mg po qday
- Seroquel (2nd Generation) 12.5-150 mg po qday

ANTIPSYCHOTIC SIDE EFFECTS

- Sedation
- Confusion, delirium, cognitive worsening
- Worsening psychotic symptom
- Orthostatic hypotension:
- Parkinsonian side effects
- Weight gain/glucose /diabetes
- Triglyceride
- Urinary retention/ constipation

INCREASED FALL RISKS AND ANTIPSYCHOTICS

- Worsening of Parkinson's motor symptoms (rigidity, slowness etc)
  - Haldol, Abilify, Geodon, Zyprexa
  - Seroquel and Clozaril less of a problem with this
- Orthostatic hypotension (blood pressure drops when standing up from lying or sitting position)
  - Seroquel and Clozaril
- Combination of above especially problematic in individuals with Parkinson's

BEHAVIORAL SIDE EFFECTS MADE SIMPLE:

- Decreased control from "above" (disinhibition): BZD, anticholinergic medications, sedating antipsychotics. (Seroquel etc.) Mood stabilizers.
- Paradoxical rxn: "not all that paradoxical"
- Increased irritation from below: ssri, less sedating antipsychotics (risperdal, geodon, haldol)
- Example: akathisia

PARADOXICAL REACTIONS: "NOT ALL THAT PARADOXICAL"

- Opposite of what is expected
- Doesn't make sense
- Medicine meant to calm makes patient more agitated

PREFERRED MEDICATIONS

- BUSPIRONE 2.5 MG PO TID – 5 MG PO TID MAXIMUM OF 60 MG/DAY
- TRAZODONE 25-50 MG PO TID
- DEPAKOTE 125 MG PO TID
- NUEDEXTA
- ANTIPSYCHOTICS AND BENZODIAZAPINES AS LAST RESORT "LOW AND SLOW" WATCH FOR DISINHIBITION AND SIDE EFFECTS

DEMENTIA ANTIPSYCHOTIC PRESCRIBING

1. Rule out reversible causes prior to using a drug.
2. Try non-drug management strategies first.
3. Clearly document treatment targets (symptoms) before and after a treatment strategy is tried.
4. *Justify the use of an antipsychotic.
5. Consider the impact of side effects on comorbidities when choosing a drug and start with a low dose.
6. If the drug doesn't help, stop it (use appropriate tapering).

WHAT KIND OF BEHAVIORS ARE NOT TREATED WITH ANTI-PSYCHOTIC MEDICATIONS?

- Wandering
- Nervousness
- Insomnia
- Fidgeting
- Restlessness
- Impaired memory
- Poor self care
- Mild anxiety
- Inattention or indifference to surroundings
- Uncooperativeness without aggressive behavior
- Sadness or crying alone that is not related to depression or another psychiatric disorder

FOR QUESTIONS AND/OR REFERRALS

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- martin.freimer@hsc.utah.edu
- u1084369@utah.edu

WHAT KIND OF MEDICATIONS TREAT BEHAVIOR CHANGE?

WHAT IS A BEHAVIOR CHANGE

- You know the person best!
- What is his or her baseline?
- What has changed?

ASSESS BEFORE YOU IMPLEMENT

- In addition to the behavioral change, consider environmental/family or other factors that could contribute to the change.
- Are you aware of:
  - changes to the person's physical environment or schedule
  - family news or changes in family dynamics
  - other news the person received, such as deaths of acquaintances
  - changes in the person's ability to interact with others, such as mobility, hearing, or visual changes
- Being aware of these changes can help providers make more informed decisions about how to treat the behavioral change.

CHANGES THAT YOU SHOULD NOTIFY A HEALTH CARE PROVIDER ABOUT IMMEDIATELY

- NEW SYMPTOMS
- Not eating
- Not wanting to get up
- Not talking
- Markedly increased or decreased activity
- Changes in types of movement (psychomotor activity)
- New changes in mood
- Suddenly making less sense
- New hallucinations or delusions
- You know the patient best! What is their baseline?
- Not showing pleasure in interactions, activities, etc. (Anhedonia)
- Changes in speech
- Changes in ability to understand

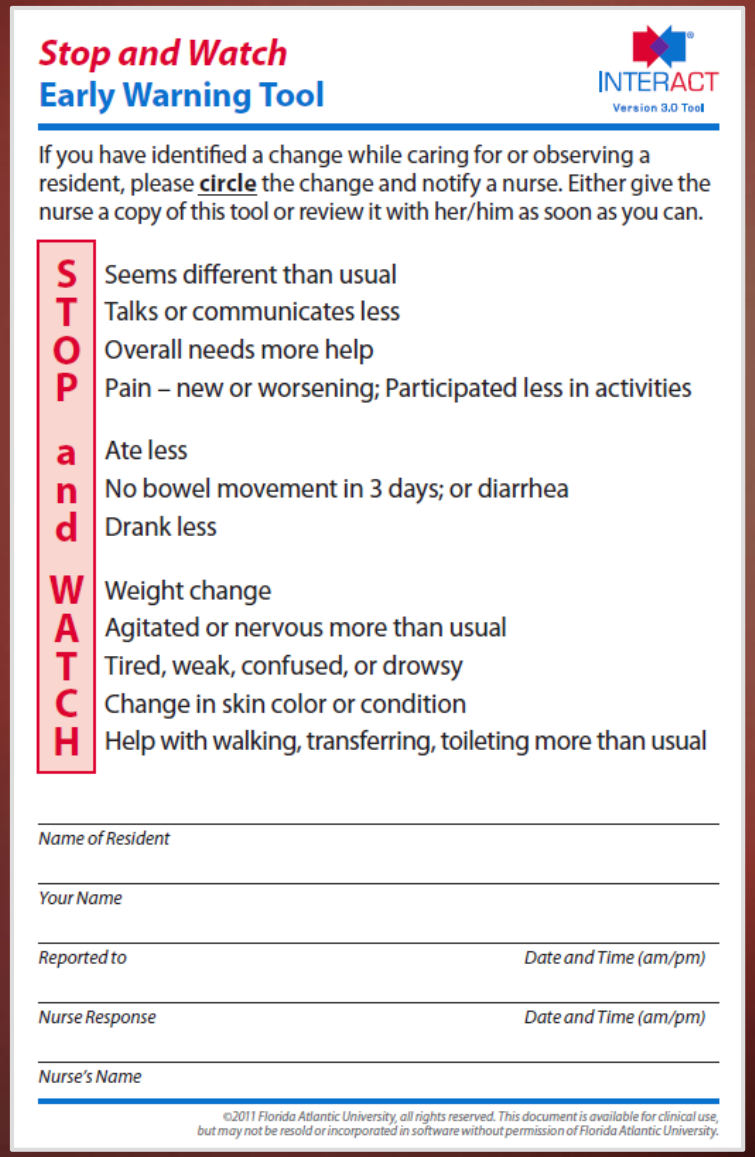
FOLLOWING UP ON THE BEHAVIOR CHANGE

- Stop and Watch and SBAR are tools to help everyone recognize a behavior change and communicate the change to a licensed nurse who then assesses and reports the change to a health care provider.
- The decision the health care provider makes regarding how to treat the behavior change is communicated back to the licensed nurse and then to other care providers and the family.
- And the process begins all over.

WHAT YOU SHOULD DO WHEN YOU NOTICE A BEHAVIOR CHANGE

Stop and Watch

- Useable by all facility staff and family members regardless of department or title
- Prompts reporting to licensed nurses
- Documentation and feedback loop
- Trust yourself!



Stop and Watch
Early Warning Tool

INTERACT
Version 3.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to *Date and Time (am/pm)*

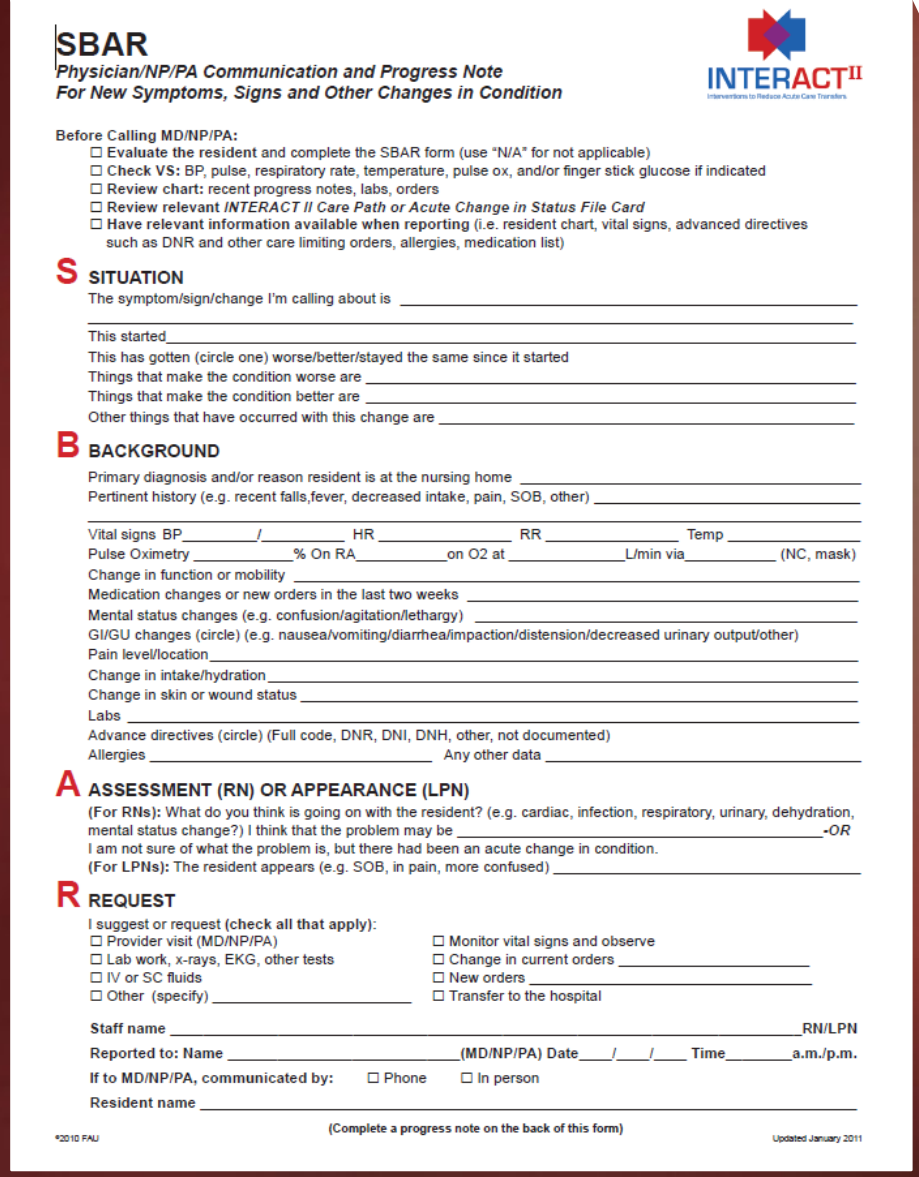
Nurse Response *Date and Time (am/pm)*

Nurse's Name

WHAT YOU SHOULD DO WHEN YOU NOTICE A BEHAVIOR CHANGE

SBAR Communication

- The licensed nurse will report the behavior change to the health care provider using SBAR
  - Situation – what is the change?
  - Background – details about the change and other circumstances that might be impacting the change
  - Assessment – the licensed nurse's assessment of the resident (physical, mental, environment)
  - Request – what will be done next
- The information you report to the licensed nurse helps him/her provide the appropriate information about the behavior change



SBAR

Physician/NP/PA Communication and Progress Note
For New Symptoms, Signs and Other Changes in Condition

INTERACT II

Before Calling MD/NP/PA:
- ☐ **Evaluate the resident** and complete the SBAR form (use "N/A" for not applicable)
- ☐ **Check VS:** BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- ☐ **Review chart:** recent progress notes, labs, orders
- ☐ **Review relevant *INTERACT II Care Path or Acute Change in Status File Card***
- ☐ **Have relevant information available when reporting** (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

S SITUATION

The symptom/sign/change I'm calling about is _____
_____
This started_____
This has gotten (circle one) worse/better/stayed the same since it started
Things that make the condition worse are _____
Things that make the condition better are _____
Other things that have occurred with this change are _____

B BACKGROUND

Primary diagnosis and/or reason resident is at the nursing home _____
Pertinent history (e.g. recent falls,fever, decreased intake, pain, SOB, other) _____
_____
Vital signs BP_____/_____ HR _____ RR _____ Temp _____
Pulse Oximetry _____% On RA_____on O2 at _____L/min via_____ (NC, mask)
Change in function or mobility _____
Medication changes or new orders in the last two weeks _____
Mental status changes (e.g. confusion/agitation/lethargy) _____
GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other)
Pain level/location_____
Change in intake/hydration_____
Change in skin or wound status _____
Labs _____
Advance directives (circle) (Full code, DNR, DNI, DNH, other, not documented)
Allergies _____ Any other data _____

A ASSESSMENT (RN) OR APPEARANCE (LPN)

(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be _____ *-OR*
I am not sure of what the problem is, but there had been an acute change in condition.
(For LPNs): The resident appears (e.g. SOB, in pain, more confused) _____

R REQUEST

I suggest or request **(check all that apply)**:
- ☐ Provider visit (MD/NP/PA)
- ☐ Lab work, x-rays, EKG, other tests
- ☐ IV or SC fluids
- ☐ Other (specify) _____
- ☐ Monitor vital signs and observe
- ☐ Change in current orders _____
- ☐ New orders _____
- ☐ Transfer to the hospital

Staff name _____ **RN/LPN**
Reported to: Name _____ **(MD/NP/PA) Date**____/____/____ **Time**_____**a.m./p.m.**
If to MD/NP/PA, communicated by: ☐ Phone ☐ In person
Resident name _____

(Complete a progress note on the back of this form)

Updated January 2011

FOR LICENSED NURSES: WORKING WITH THE PROVIDER

- Could the new symptom be associated with a side effect or illness?
- What was the time course?
  - e.g. the time between a medication given and onset of symptoms ed given/ symptoms
- What is the risk vs benefit of more medications?
- Are there non-pharmacologic means?
  - Use whenever possible
- Always give the health care provider feedback regarding any treatment changes.

WHAT THE PROVIDER WILL DO WHEN S/HE HEARS ABOUT A CHANGE

- Ask the licensed nurse for more information
- Determine whether a medication change or other treatment is needed
- Determine if other information is needed (e.g. lab tests)
- Instruct the licensed nurse to administer the medication change

KEEP IN MIND

- Did the resident experience something upsetting?
- Was a new medicine started prior to the behavior? Within hours? Days?
  - A medication doesn't have to be for "behavior" or "psychiatric" to contribute to behavior change
  - "if it can get in the brain it can affect the brain"
- What happens when more of the same medicine is given?
  - Does the behavior intensify?
  - Is it more frequent?
- Maybe the solution is "less medicine" not a new medicine or "more of the same"
- Your observation may be key to the solution!!

OTHER TYPES OF PSYCHOTROPICS

- Benzodiazapines
  - Ativan, Xanax, Valium, Klonopin
- Selective serotonin reuptake linhibitors (SSRI)
  - Zoloft, Prozac, Paxil, Celexa, Lexapro
- Seratonin-norephinepherine reuptake inhibitors (SNRI)
  - Cymbalta, Effexor, Pristiq
- Mood stabilizers
  - Lithium, Depakote, Tegretol
- Buspar

FOR FAMILIES: QUESTIONS TO ASK YOUR PROVIDER

1. Indication/Target Symptoms
2. Effective?
3. Dosage?
4. Directions?
5. Drug-drug interactions?
6. Drug-disease interactions?