NHS
Sussex Partnership
NHS Foundation Trust

Rapid Tranquillisation in Older age and frailty including dementia

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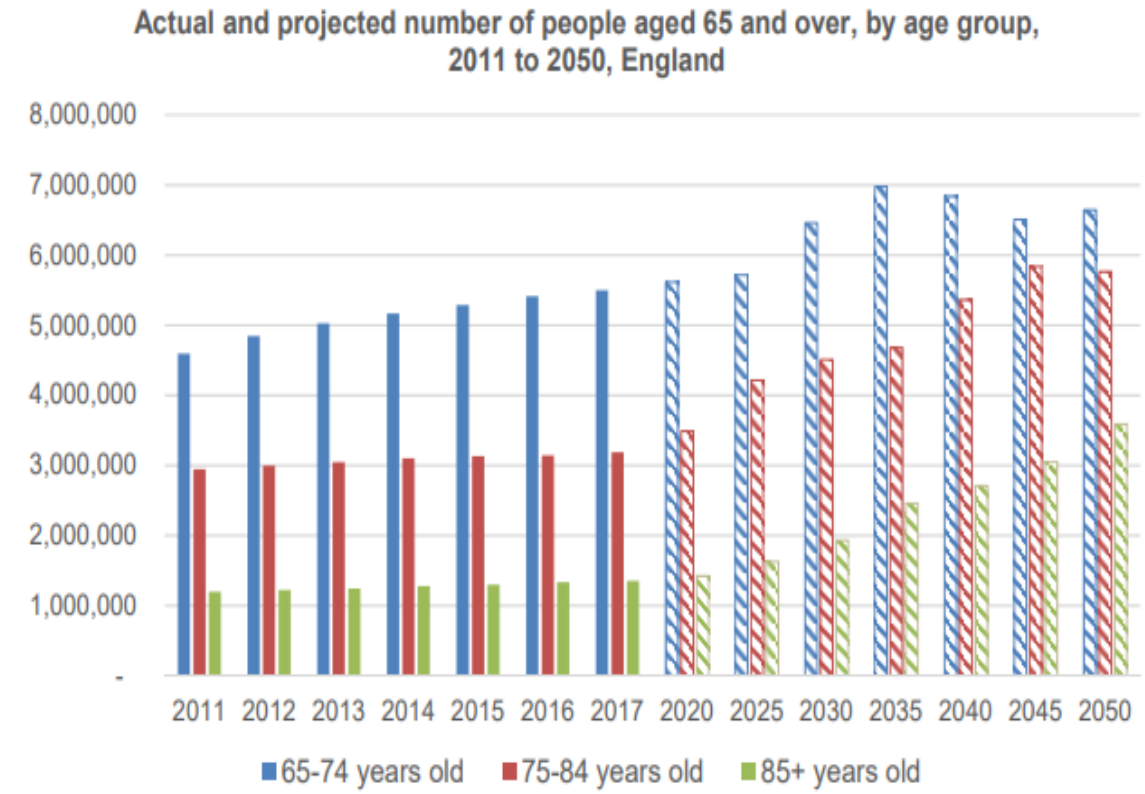
Background

- How old is an older adult?
- Over 80% >65y live with a long term condition
- Frailty affects > 6.5%
- Increased risk of mental illness and admission into hospital
- Acute disturbance and agitation in this population common
- Most common cause: Delirium



Source: ONS, Analysis of population estimates tool; Mid-Year Estimates 2011-2017 among those 65+

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Causes of acute disturbance/aggression in older adults

Multiple causes, but most commonly:

Primary psychiatric disorder

Delirium

Symptoms of dementia

Substance use

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Prescribing in older adults- why does age matter?

Multiple co-morbidity = multiple medicines = risks of cumulative effects, side effects and interactions

Adverse drug reactions= risk of increased hospital stay, falls, dependence

Increased sensitivity to medication due to pharmacokinetic and pharmacodynamic changes

Limited evidence base for prescribing- frail and/or older adults not recruited into drug trials

Patient centred approach is to consider co-morbidities, observations, any pathology results and available evidence

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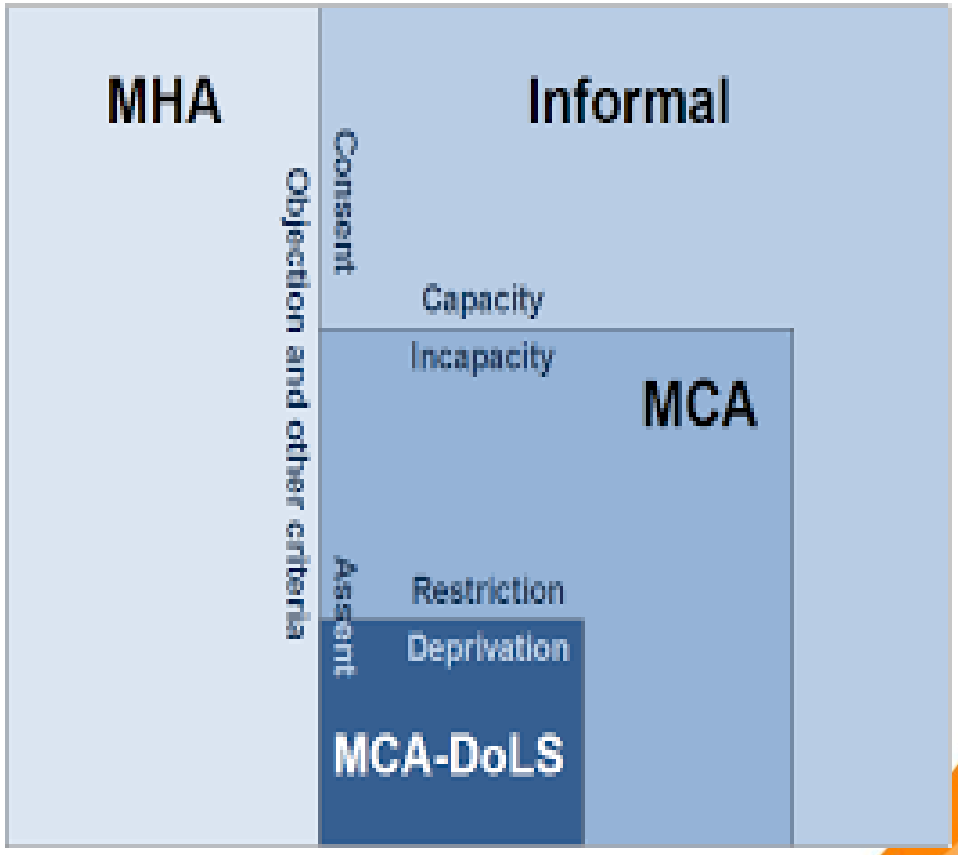
Consent/MCA

- Important consideration
- Document in care plan for easy reference

Mental Capacity Act 2005 – 5 principles

1. A presumption of capacity
2. Individuals supported to make their own decision
3. Unwise decisions
4. Best interests
5. Less restrictive option



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Recommendations

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Pharmacological management- notes

Depending on the individual patient:

- The best evidence for benefit over risk of harm is for IM lorazepam used alone and the combination of IM haloperidol plus an IM promethazine
- In dementia, haloperidol is licensed for the treatment of persistent aggression and psychotic symptoms in patients with moderate to severe Alzheimer's dementia and vascular dementia when non-pharmacological treatments have failed and when there is a risk of harm to self or others
- Risperidone is indicated for the short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to nonpharmacological approaches and when there is a risk of harm to self or others.
- Anti-psychotics should be avoided in older adults known to be living with Lewy Body Dementia
- Lorazepam and promethazine can both worsen confusion, and doses should be kept to a minimum
- Promethazine and procyclidine have anticholinergic side affects: use with care in the elderly, particularly those with dementia as they can cause confusion. Discuss with a Consultant before prescribing.
- Risk of falls from other physical meds concomitantly prescribed should be considered
- Consider total anticholinergic burden of medicines prescribed

Monitoring

- Consider level of frailty
- Higher risk of benzodiazepine dose accumulation in older adults:
- Staff must be responsive to any changes particularly a fall in oxygen saturation
- After oral prn, recommended to monitor hourly for minimum one hour and document appropriately
- Further monitoring as clinically appropriate
- Review all ‘prn’ medication
- Undertake post RT review, within 72 hours, and document

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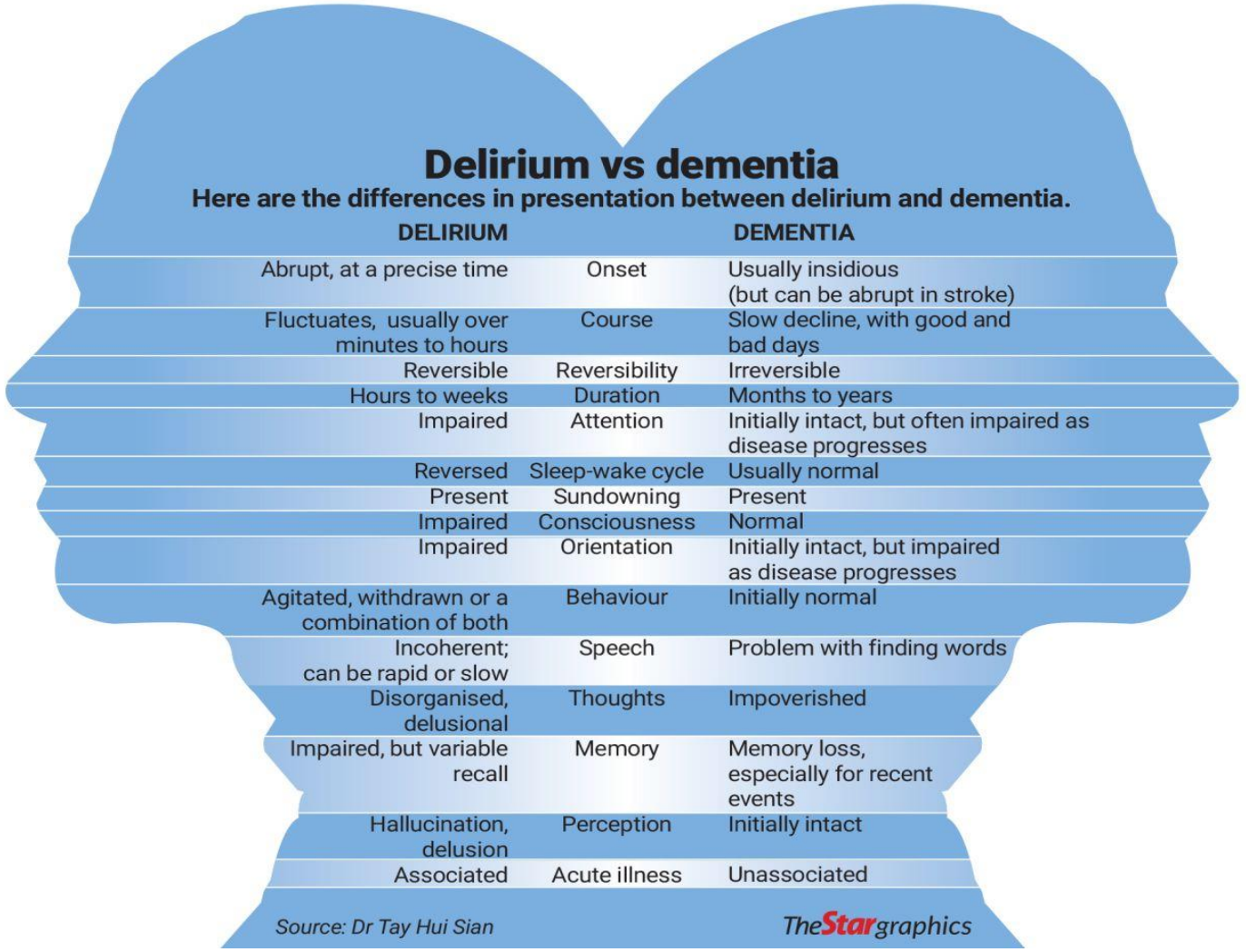
Special consideration: Dementia vs Delirium



Delirium vs dementia

Here are the differences in presentation between delirium and dementia.

DELIRIUM		DEMENTIA
Abrupt, at a precise time	Onset	Usually insidious (but can be abrupt in stroke)
Fluctuates, usually over minutes to hours	Course	Slow decline, with good and bad days
Reversible	Reversibility	Irreversible
Hours to weeks	Duration	Months to years
Impaired	Attention	Initially intact, but often impaired as disease progresses
Reversed	Sleep-wake cycle	Usually normal
Present	Sundowning	Present
Impaired	Consciousness	Normal
Impaired	Orientation	Initially intact, but impaired as disease progresses
Agitated, withdrawn or a combination of both	Behaviour	Initially normal
Incoherent; can be rapid or slow	Speech	Problem with finding words
Disorganised, delusional	Thoughts	Impoverished
Impaired, but variable recall	Memory	Memory loss, especially for recent events
Hallucination, delusion	Perception	Initially intact
Associated	Acute illness	Unassociated

Source: Dr Tay Hui Sian

TheStargraphics

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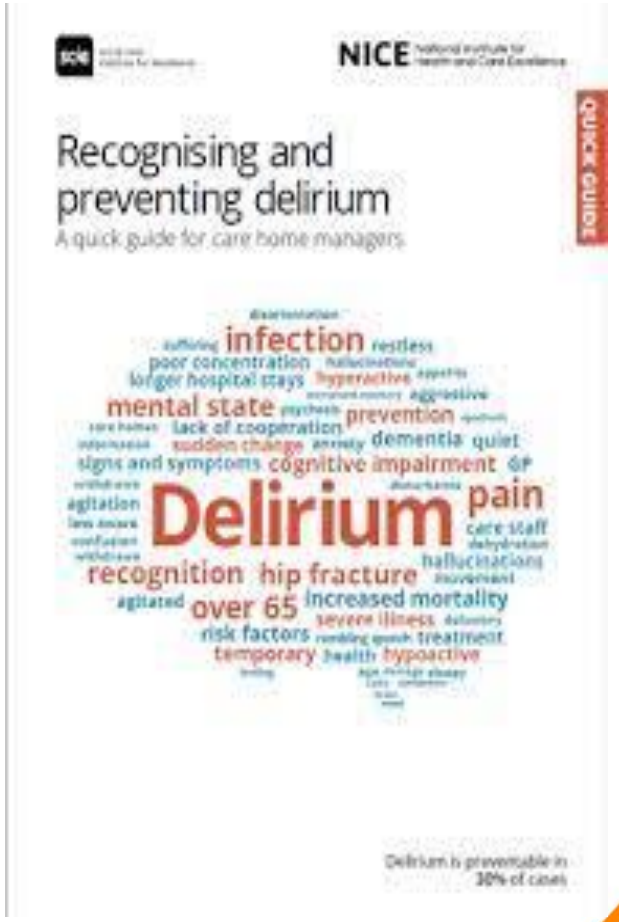
Special consideration: Delirium

- Known to occur more frequently in older adults
- Difficult to diagnose in this cohort
- NICE guidance CG103 (last updated Jan 2023):

-.Evaluation and management of underlying causes

- Effective communication and reorientation
- Where individual is distressed and de-escalation unsuccessful- short term haloperidol
- Lowest effective dose, caution advised in the elderly
- MHRA advice on using haloperidol for delirium in the elderly

- Some studies have also demonstrated that using quetiapine twice-daily dosing decreases the duration of delirium
- The efficacy of using second-generation antipsychotic versus first-generation medications remains debatable.



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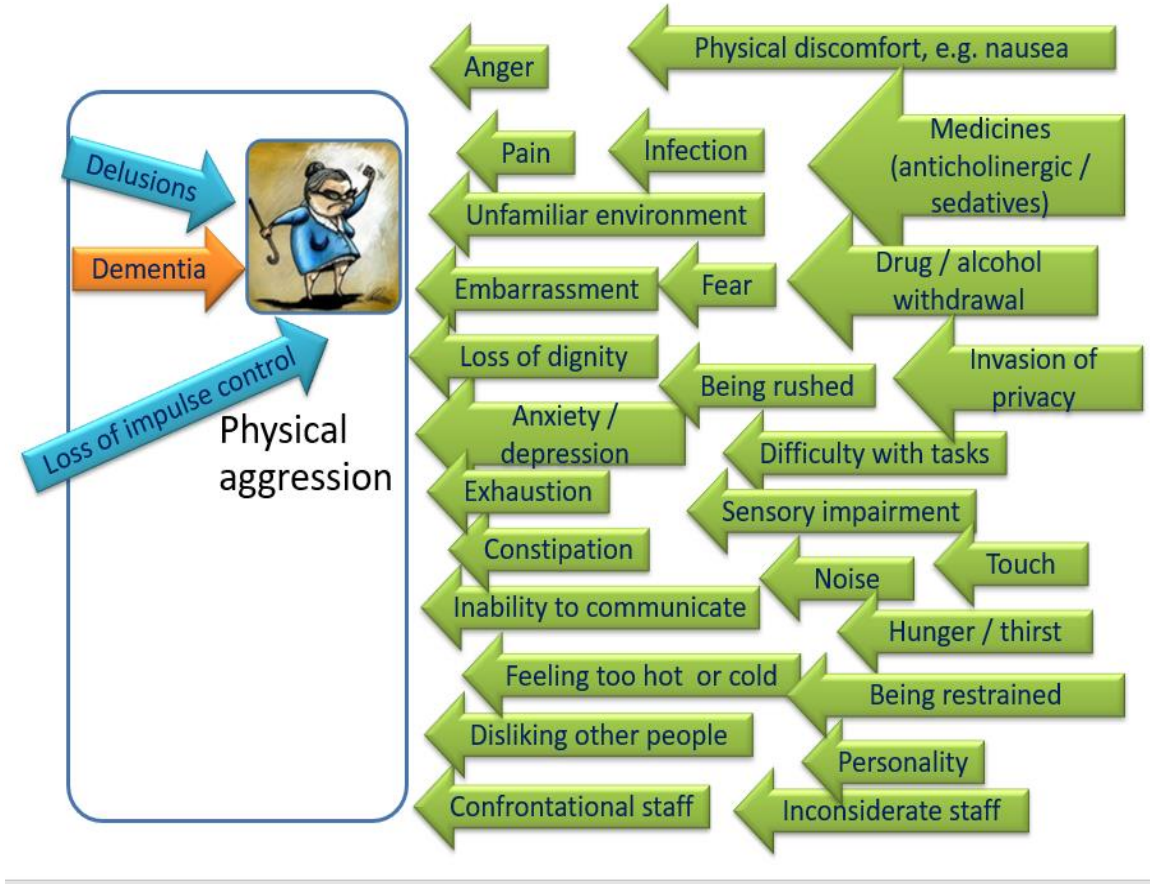
Special considerations- BPSD

Behavioural and psychological symptoms of dementia- can result in agitation and aggression in older adults with dementia

- Clarify nature of the problem
- Keep track of what is going on by documentation (behaviour charts, pain scales)
- Check if there are any triggers
- Identify which behaviours are most challenging
- Exclude non-dementia causes
- Treat underlying medical disorders (impairment of vision, hearing, movement)



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Any Questions?

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