Management of agitation in older patients

This guide refers to patients with PERSISTENT behavioural problems such as:

- Restlessness
- Pulling at lines and tubes
- Continually trying to get out of bed
- Talking to self
- Pacing
- Trying to leave ward or hospital
- Shouting, swearing, arguing, insulting staff
- Threatening or trying to hit, kick, bite or scratch

Behaviour like this is usually due to DELIRIUM or DEMENTIA. Remember...

- Delirium may indicate a serious underlying medical problem or medication side effect
- Agitated patients with delirium or dementia sometimes injure themselves or staff
- Benzodiazepines usually make agitation worse: increasing the risk of falls, pressure injuries, aspiration, etc.

This guide is not about patients with:

- Simple insomnia
- Simple threats to leave hospital against medical advice or conflict about a specific issue
- Behavioural problems due to a psychiatric disorder such as mania or psychosis.

Pharmacological Management of Agitation in Older Patients

Antipsychotic medications are not a first line treatment and should be used with caution because of the association with strokes and adverse cardiac events.

**Step 1. Review diagnosis and screen for new problems, such as:**

- Dehydration
- Electrolyte imbalance
- Level of pain
- Infection/sepsis/inflammation
- Respiratory failure (hypoxia/hypercapnia)
- Impaction of faeces
- Urine retention
- Medication toxicity: Especially anticholinergics (e.g. tricyclics, oxybutynin, tiotropium), digoxin, sedatives, opioids, corticosteroids, anticonvulsants, antiparkinsons.

**If withdrawal is suspected:**

- Consider alcohol or benzodiazepine withdrawal
- Use diazepam and thiamine
- Do not use antipsychotics
- Commence Alcohol Withdrawal Scale (AWS) and refer to AWS guidelines

**Step 2. Assess Risk**

Consider potential for violence, pulling out tubes, absconding, interference with other patients, falls, accidents etc

**Step 3. Non-Pharmacological Interventions: FIRSTLINE Management**

- Maintain low level sensory stimulation: soft lighting and sound
- Single room if possible
- Staff to calmly engage, distract and supervise the patient
- Avoid confrontation e.g. walk away, defer interventions or offer food and drink to diffuse tension
- Encourage family to stay and assist
- Consider 1:1 companion / advice from Dementia Champion

**Step 4. Use only one of these high potency antipsychotics:**

- Haloperidol – 0.25 to 0.5mg (tab, liquid, IM)
  - 4 hourly prn: Max 2mg in 24 hours
  - N.B. 30-60 minute onset
  - OR
- Risperidone – 0.25 to 0.5mg (tablet or liquid)
  - 4 hourly prn. Max 2mg in 24 hours

(These agents are calming without much sedation)

**Step 5. Use only one of these more sedating antipsychotics:**

- Quetiapine 12.5mg (frail patients) – 25mg (tablet)
  - 4 hourly prn. Max 100mg in 24 hours
  - OR
- Olanzapine 2.5mg (tablet or oro-dispersible wafer)
  - 4 hourly prn. Max 10mg in 24 hours

- Aim to use one drug and optimise first line treatment
- Keep doses to a minimum: giving higher doses on the first night is unlikely to help
- If the situation is escalating get advice from a senior colleague
- Review prescription daily