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.

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

D ehydration
E lectrolyte imbalance
L evel of pain
I nfection/sepsis/inflammation
R espiratory failure (hypoxia/hypercapnia)
I mpaction of faeces
U rine retention
M edication toxicity Especially anticholinergics (e.g. tricyclics, oxybutynin, tiotropium), digoxin, sedatives, opiods, corticosteroids, anticonvulsants, antiparkinsons.

1 **Consider alcohol or benzodiazepine withdrawal**

If withdrawal is suspected:

- 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

2

If high risk:

- A single room
- Companion
- Discuss with Senior
- Proceed with Medication

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**

3

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.

**If the patient has Parkinsonism, use only Quetiapine 12.5mg (frail patients) – 25mg (tablet) 4 hourly prn.
Max 100mg in 24 hours. Do not move onto Step 4 or 5.**

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)

4

If the response is inadequate escalate to senior staff

Upon senior review, proceed to Step 5.

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 24hours.

5

- 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

Version 3 Next review date: February 2020 Developed by: Cognitive Impairment Reference Group and Psychiatry Department 2010
Title: Management of Agitation in Older Patients Flowchart Endorsed by Drugs and Therapeutics Committee: 21st February 2017