

Staff Key to Heading Off Psychiatric Emergencies

BY ALICIA AULT

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NEW ORLEANS — Educating staff to spot triggers for disruptive behavior in long-term care facility residents and to effectively prevent escalation is key to helping head off psychiatric emergencies, Dr. Amita Patel said at the annual meeting of the American Association for Geriatric Psychiatry.

In general, LTC staff—nurse's aides, in particular—are undereducated about dementia and the management of mental illnesses, said Dr. Patel, of the department of psychiatry at Wright State University, Dayton, Ohio. Given that staff members are "overburdened and underpaid," she said, they often do not have the ability to manage these residents.

Agitated residents who have reached the crisis point are at a higher risk of falls and of injuring themselves and others. Such residents will also tend to be noncompliant, increasing the caregiver's burden, Dr. Patel said. There is already a 50%-70% turnover rate for licensed practical nurses and registered nurses; if they feel more burdened, turnover is likely to increase, she said. In addition, unmanaged psychiatric emergencies expose clinicians and facilities to potentially higher malpractice and workers' compensation premiums.

After she taught staffs at facilities in Ohio about ways to better manage residents, the workers' compensation premiums there went down, Dr. Patel said.

The first step is to prevent stress. The facility's environment is often an issue: Hallways are overcrowded; loud noises em-

anate from televisions or alarms; lighting is harsh; bathwater is too cold; exit signs act as a beacon for wandering residents seeking a way out. Instead, the environment should be made as soothing as possible, Dr. Patel said.

Alleviating boredom also can help. Activities and exercise are important, especially in the early evenings, when there are often no staff members available to provide activities. Residents may go to bed too early and wake up agitated, she said. Fenced areas can be maintained to allow higher-functioning residents to walk or get outside.

The staff also can make an environment more—or less—hospitable. Administrators should allow time for education on dementia and psychiatric illnesses, so that staff members know what to expect, Dr. Patel said. Staff members can also be taught to become less task oriented. For instance, if a resident is distressed and will not eat, the nurse should not continue shoveling food in just to complete that task, she said. The staff member can walk away and return at another time.

Residents also should be given eye contact, especially if they are hearing or vision impaired. Standing behind an impaired resident and barking out directions can be distressing, Dr. Patel noted.

Validation therapy is useful, particularly in paranoid or delusional residents. If residents are paranoid, don't try to tell

them [their fears are] not true, she said. Instead, tell them that the situation will be investigated.

Staff members sometimes have a hard time coping with residents who may be stressed because they are grieving a loss of control or lack of attention from family. The staff can be trained in ways to help residents tolerate some of their distress and also to accept death as a reasonable outcome of living.

If residents do become agitated—exhibiting a change in voice; glaring; perspiring; or becoming restless, irritable and suspicious—"this is the state when you know they eventually are going to esca-

late," she said.

At this point, the resident should be given empathetic support, encouraged to breathe, and asked to go to a quiet area. There, an assessment can be made, and—depending on the situation—oral medications might be offered.

An assessment should include an evaluation of what might have caused the episode—environment, a peer interaction, or a drug interaction. A complete blood count, toxicology screen, cognitive screen, and vital signs assessment can all help to get at the root cause. Substance abuse should be suspected if the patient has recently returned from a leave outside the facility, Dr. Patel said.

Once the etiology has been identified, treatment can begin. If the resident calms

down, ongoing behavioral interventions and modifications of the environment should be considered. Continued agitation may require sedation or use of a gerichair. Restraints should be used only as a last resort.

There are no medications approved by the Food and Drug Administration for the management of acute psychiatric emergencies in elderly people, Dr. Patel said. Most often, benzodiazepines are used.

Federal regulations require institutions to document that patients are being given medications for an adequate indication, and that they are given the appropriate dosage for the appropriate duration, Dr. Patel said. Documentation that therapeutic goals are being met must be provided.

The benefits of short-term medication use need to be weighed against the risks of chronic dosing. The benzodiazepines are not well studied in dementia or for long-term use, but are preferred for short-term episodes, despite side effects such as excessive sedation, ataxia, respiratory suppression, and the potential for abuse.

Newer antipsychotics may be useful, especially because several are available as orally disintegrating tablets, including risperidone (Risperdal) and olanzapine (Zyprexa). Residents cannot "cheek" those medications, she noted. Intramuscular olanzapine has been studied in agitated patients with schizophrenia. A 5-mg per injection dose has been recommended for geriatric patients. It should not be used in conjunction with benzodiazepines.

Dr. Patel is a speaker for Eli Lilly & Co., Wyeth Pharmaceuticals, Forest Pharmaceuticals Inc., and Sanofi Aventis. ■

The first step to heading off emergencies in long-term care facilities is to prevent stress. The environment should be made as soothing as possible.

Stroke and Alzheimer's Pathology Raise Risk of Dementia

BY KERRI WACHTER

Senior Writer

BALTIMORE — The interaction of cerebrovascular disease and Alzheimer's disease pathology appears to significantly increase the risk of dementia, Dr. Richard O'Brien said at a meeting on Alzheimer's disease and related disorders sponsored by Johns Hopkins University.

"Having cerebrovascular disease on top of just a little Alzheimer's pathology pushes you over the edge into being demented," said Dr. O'Brien, reporting on data from the Baltimore Longitudinal Study of Aging (BLSA).

The BLSA was initiated in 1958 with the aim of helping researchers learn what happens as people age and sort out changes caused by aging from those caused by disease or other causes. Current enrollment is 2,135 volunteers, and 219 deceased participants are included in the autopsy component. Participants are evaluated yearly.

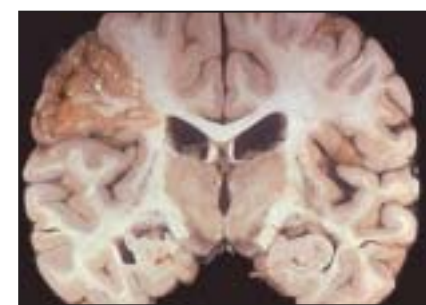
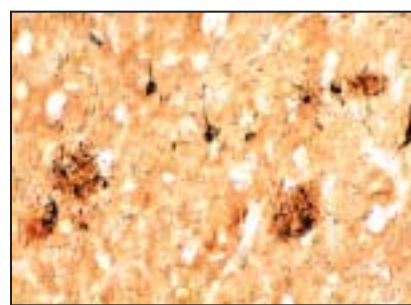
As of the last analysis in December 2006, 175 brains with normal, stroke, and/or Alzheimer's disease (AD) pathology had been autopsied. The average age at death was 87 years (range 57-102 years), and the group was predominantly male (69%). The group was generally well educated with an average of 18 years of schooling. Overall, 104 had a Consortium to Establish a Registry for Alzheimer's Disease (CERAD) pathology score of 2 or greater, indicating AD pathology. A total of 77 had had at least one stroke.

In those with no stroke, AD pathology could be relatively severe (up to a CERAD score of 2) and still have a relatively low risk of dementia. However, when at least one stroke has occurred, the risk of dementia jumps sub-

stantially with only a small amount of AD pathology (CERAD 1). In the absence of AD pathology, it takes about three cortical strokes to induce dementia. When there is moderate AD pathology (CERAD 2), dementia is apparent after two strokes on average. It was possible for patients with moderate AD pathology to never progress to dementia, as long as they remained free of strokes, said Dr. O'Brien, a professor of neurology at Johns Hopkins University, Baltimore.

Stroke alone increased the risk of dementia in this cohort as well. Of those with evidence of stroke on autopsy, 37 had symptomatic strokes. These patients had a fourfold greater risk of dementia than did those with no evidence of stroke. The remaining 40 participants with evidence of stroke at autopsy were asymptomatic. These individuals also had an increased risk of dementia (odds ratio 3.2). "Having a stroke significantly increased your risk of being demented, whether or not that stroke was clinically symptomatic," said Dr. O'Brien, who is also chair of neurology at Johns Hopkins Bayview Medical Center in Baltimore.

When it comes to the association between strokes and dementia risk, numbers and location matter. "The more strokes you have, the more likely you are to be demented." The researchers found that only the strokes that occur in the cortex increase the risk of becoming demented," Dr. O'Brien said. The chance of being demented with



The left image shows plaques and tangles (CERAD 2). The right image shows a middle cerebral artery stroke on an autopsy specimen.

one stroke was about 50%, the chance with two strokes was about 80%, and the chance with three strokes was 100%. Strokes in the subcortical part of the brain were not significantly related to dementia.

Stroke size was not a factor in dementia risk. Large strokes tend to be symptomatic. However, in this group the presence of asymptomatic (and presumably small) strokes still conferred a greater risk of dementia. In addition, microstrokes—those occurring in the cortex and requiring a microscope to see—were as likely to increase the risk of becoming demented as a very large stroke in this cohort.

If an older person is cognitively normal before a stroke, the chance of becoming demented is the same as for the age-matched stroke-free population. However, for those who have some cognition problems prior to a stroke, the chance of becoming demented after a stroke is extraordinarily high—a 40-fold increased risk, he said. Dr. O'Brien disclosed that he has no potential conflicts of interest. ■

PHOTOS COURTESY DR. RICHARD O'BRIEN