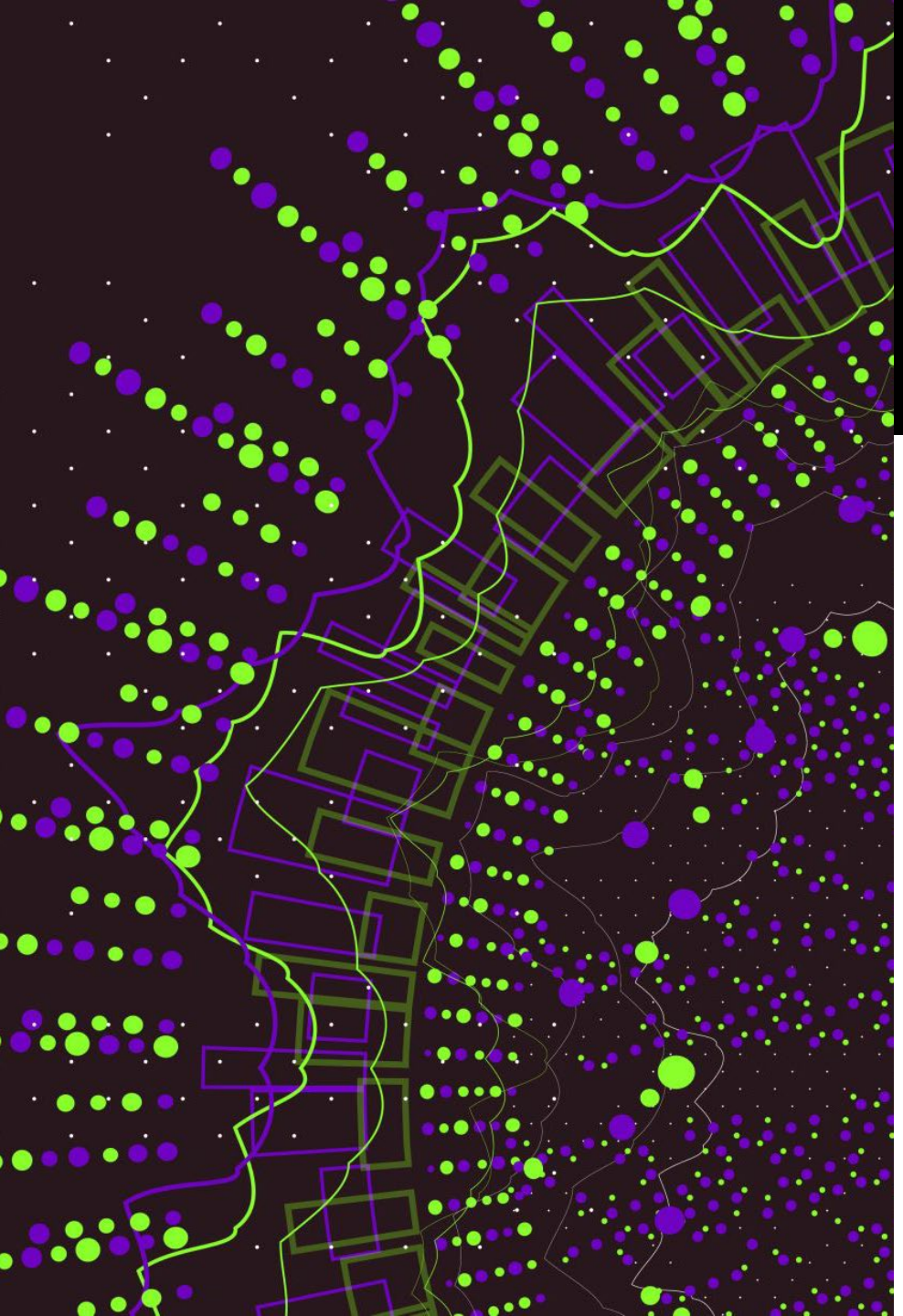


SIGNATURE HEALTH PARTNERS

ESSENTIALS OF PSYCHIATRY FOR THE NURSING HOME

Lea C. Watson MD, MPH, LLC
Geriatric Psychiatry
Consultation and Training

Things I get asked about the most

- Dementia, behaviors and medications
- Residents with severe personality disorders
- How to know when patients can make their own decisions

Why most of us work in this field

To provide comfort at the end of life

To promote safety and dignity for vulnerable humans

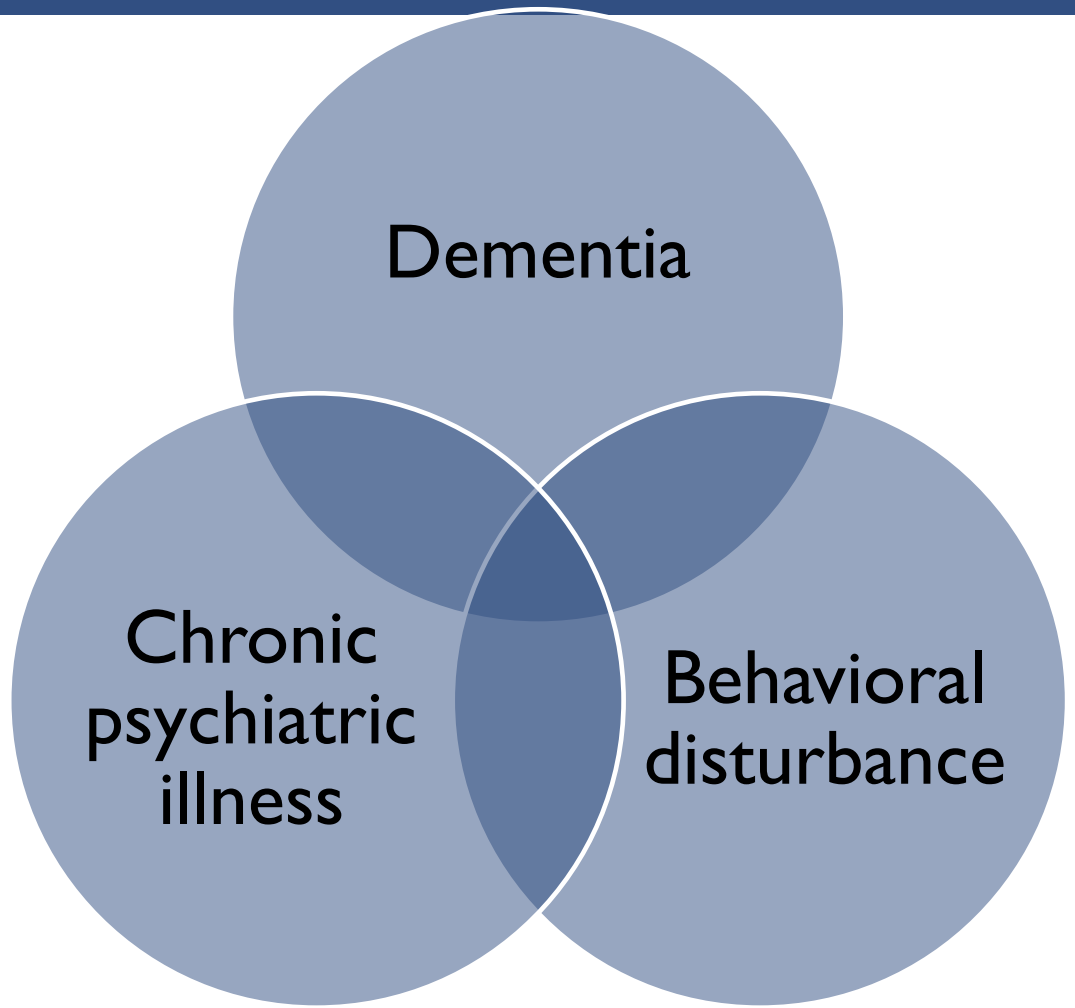
To be a force of good

Guiding principle: **do no harm**

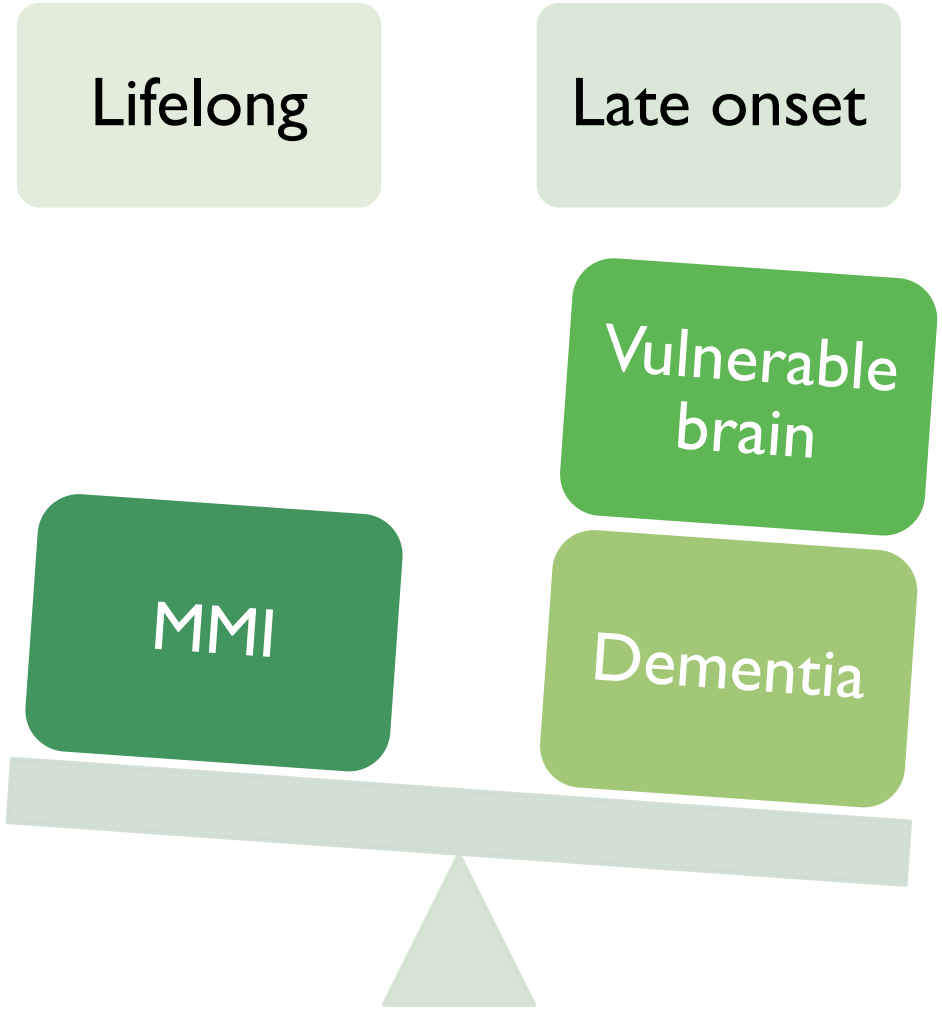
LTC at highest risk for AE's

- Multi-morbidity
- Polypharmacy
- High use of sedatives/hypnotics/muscle relaxants
- Age > 65, high rate of dementia
- Baseline risk for falls, confusions

Lots of overlap



Which is predominant?



IN DEMENTIA –

THE GOAL:
PREVENT DELIRIUM

How to prevent delirium?

- **Reduce med exposure**
- Reduce hospitalizations
- Avoid unnecessary procedures
- Avoid disruption to routine

What are "behaviors?" (BPSD)

- Observable activity = aggregate of responses to internal or external stimuli

Can extrapolate to "unmet need"

- Includes: aggression, agitation, confusion, depression, suspicion, hallucinations, sundowning, repetition, wandering

Unmet needs

- Boredom
- Comfort: pain, hunger, thirst, constipation, fatigue, touch
- Response to change in environment
- Acute medical illness (is the change sudden?)
- Medication side effects/interactions
- ***Is the patient declining in general? Is it time for a more structured environment? to revisit goals of care?***

Unmet needs

- D.B. is a 70 year old male with TBI and dementia residing in LTC facility
- Behaviors include yelling out inappropriate statements, throwing dishes, kicking bedside table over
- D.B. is often noted to appear anxious and restless prior to behaviors initiating
- Nursing staff now offers snacks to resident on a regular basis, specifically snacks with loud packaging as D.B.s noted behaviors reduce when he is distracted by crumpling up the bags to make the noise and then flatten the bag back out
- By targeting his unmet need of BOREDOM, with a simple, effective, and inexpensive intervention, his behaviors have been drastically reduced.

Brain safety = lowest possible CNS burden

- Anticholinergic load – Magellan score
- AED's
- Gabapentinoids
- Opioids
- Benzodiazepines
- Muscle relaxants

FDA warnings for increased risk of respiratory suppression

- OPIOIDS + BENZODIAZEPINES (BLACK BOX)
- GABAPENTANOIDS (GABAPENTIN, LYRICA) + OPIOIDS

What defines *overuse?

- RISK > BENEFIT
- NO/ negative evidence
- Known harms
- Often dosed inappropriately
- COMMON SIDE EFFECTS ARE DEPRESSION, FALLS, CONFUSION

Most *overused psychotropics in PALTC

Valproic Acid (Depakote, Depakene) for behaviors

no efficacy, can *cause* depression, cognitive impairment, movement problems, blood and liver toxicity; often leads to add-on cascade: hyperammonemia > lactulose > anti-diarrheal

Quetiapine (Seroquel) for behaviors, sleep

No indication, antihistaminic but not antipsychotic at usual doses, often dosed incorrectly – t1/2 = 6 hours; all classic antipsychotic risk

Gabapentin (Neurontin) for generalized pain, anxiety

No indication! side effects include depression, dizziness, apraxia, edema; often used with other CNS's, FDA warning for respiratory suppression

Most *overused meds continued

- Benzodiazepines for behaviors, sleep

  Increases risk for falls, stroke, depression, pneumonia, *disinhibition*; black box with opioids

- Oxybutynin (Ditropan) for incontinence

  Rarely helpful for dementia related incontinence; extremely anticholinergic

- Baclofen for muscle "whatever"

  Centrally acting muscle relaxant; causes CNS depression, dizziness, weakness; often used with other CNS's

≈

For example

- S.L. is an 85 year old male with end stage dementia who resides at LTC facility. He is on the following regimen:
  - Lisinopril 5mg qd
  - Oxybutynin 5mg BID
  - Divalproex 500mg TID "for behaviors"
  - APAP 650mg po q 6 hr prn
  - Donepezil 10mg qhs
  - Carbidopa/levodopa 25/100 po QID
  - Baclofen 5mg TID
  - Simvastatin 20 mg qhs
  - Cranberry capsule daily

1. Strategize- highest risk combos?
2. *overused list?
3. BEERS?
4. Unnecessary meds?
5. Supplements?

For example

- S.L. is an 85 year old male with end stage dementia who resides at LTC facility. He is on the following regimen:
  - Lisinopril 5mg qd
  - ~~Oxybutynin 5mg BID~~
  - ~~Divalproex 500mg TID "for behaviors"~~
  - APAP 650mg po q 6 hr prn – SCHEDULE?
  - ~~Donepezil 10mg qhs~~
  - Carbidopa/levodopa 25/100 po QID
  - ~~Baclofen 5mg TID~~
  - ~~Simvastatin 20 mg qhs~~
  - ~~Cranberry capsule daily~~

One more…..

- R.G. is a 68 year old female with chronic pain who resides in a LTC facility. She is on the following regimen:

- Oxycontin ER 20mg q 12 hr
- Gabapentin 600mg qhs
- APAP 650mg TID
- Lorazepam 0.5mg q 6 hr prn
- Oxycodone 5-10mg q 4 hr prn
- Atorvastatin 40mg qhs
- Vitamin C 250mg qd
- Loratadine 10mg qd

1. Strategize- highest risk combos?
2. *overused list?
3. BEERS?
4. Unnecessary meds?
5. Supplements?

One more…..

- R.G. is a 68 year old female with chronic pain who resides in a LTC facility. She is on the following regimen:

- Oxycontin ER 20mg q 12 hr
- ~~Gabapentin 600mg qhs~~
- APAP 650mg TID – MAXIMIZE DOSE
- ~~Lorazepam 0.5mg q 6 hr prn~~
- Oxycodone 5-10mg q 4 hr prn – SCHEDULE
- Atorvastatin 40mg qhs
- ~~Vitamin C 250mg qd~~
- Loratadine 10mg qd – LIMIT TO SEASON

Become a PRN-free zone…

- PRN drugs require residents to "earn" them and feed a loop of positive reinforcement
- PRN drugs often prevent staff from exploring more appropriate non-pharmacologic interventions
- Success requires CULTURE change for all stakeholders
  - Consider rewards for non-pharm, innovations, share best practices
  - Set expectations upon admission

PRN- free Zone

- LTC facility in Denver who, over the course of one year, reduced the number of PRN prescriptions to nearly ZERO (hospice and epilepsy use excepted)
  - Culture change for front line care staff
    - Initial push back came from nursing staff- offered opportunity to educate on non-pharm interventions and to expand treatments offered (aroma therapy, massage, acupuncture)
  - Change in learned behaviors with residents
    - With residents, we saw a large reduction in learned behaviors to obtain the medication of choice (reduction in reported pain score values in attempts to "earn" the prn)

Resources

- Website quick tips: http://www.leawatsonmd.com/index.php/quick-tips/

- Magellan risk scale:

http://www.leawatsonmd.com/wp-content/uploads/2018/05/Magellan-Anticholinergic-Risk-Scale.pdf