Date: September 10, 2019

PLEASE NOTE that Project ECHO® Care of the Elderly case recommendations do not create or otherwise establish a provider-patient relationship between any ECHO Care of the Elderly Hub team member/presenters and any patient whose case is being presented in a Project ECHO® setting.

All resources are posted in the COP website, under "September 10 – Dementia". You must be logged in to view the resources.

Case Synopsis:
77 y.o. female with atrial fibrillation and dementia in LTC for two months. Recently diagnosed with colon cancer and had a bowel resection done. Easily agitated and restless. Sleep has been poor. On multiple antipsychotics (Trazodone, Haloperidol, sertraline) with poor response. On multiple medications.

1. Other than antipsychotics, what approaches can be used to manage the agitation?
2. Regarding end of life care and/or palliative care, when would be a good time to start these discussions? How may her dementia affect the process? How can I best manage family dynamics where there is disagreement?
3. What are some approaches for managing her polypharmacy?

<u>Summary of Recommendations:</u>
Further workup/investigations:

- Exploration of her personhood using P.I.E.C.E.S (**P**hysical, **I**ntellectual, **E**motional, **C**apabilities, **E**nvironment, **S**ocial) framework to yield person-directed approach to care and responsive behavior management e.g., "understanding the meaning behind the behavior"
- Further assessment of depression as potentially contributing to agitation
- Assessment of pain as a possible component of responsive behaviours using a validated tool e.g., Pain Assessment in Advanced Dementia (PAIN-AD)

Non-Pharmacological interventions:

- Engaging in early palliative care discussions by framing it as part of goals of care with the resident's values at the core
- Engaging the resident in meaningful activities during the day to keep her active by using the information from the P.I.E.C.E.S assessment

Pharmacological interventions:

- Consider optimizing Sertraline dosing if clear signs of depression. If insomnia is also a problem, may consider switching to Mirtazapine or optimizing Trazodone dose if not already taking the maximum dose
- Consider reassessing Haloperidol given adverse effects particularly akathisia which may further exacerbate agitation. If an antipsychotic is indicated, consider an atypical antipsychotic such as Quetiapine or Risperidone
- Consider optimizing Tylenol dose and schedule for pain control
- Consider reassessing Ferrous Gluconate and discontinuing if appropriate to minimize constipation, pain
- When considering when to start/stop cholinesterase inhibitors some approaches include: Dr. William Dalziel's approach of engaged vs unengaged with the external environment as a measure; Gold Standards Framework's Surprise Question, "would you be surprised if this

resident were to die in the next year?”; functional ability as a measure by looking at ADLs; determining when the cholinesterase inhibitor was started and if an improvement was observed; and considering if adverse effects are present

- If indicated, cholinesterase inhibitors should be given in the morning as they can be activating and affect sleep