Altered Responses

Session 2

Host and Moderator: Barbara Tallman

Presenters: Deb Schick and Erin Yakiwchuk

Date: June 12, 2025

Territorial Honouring

The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

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The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Health Canada Santé Canada

Introductions

Host and Moderator

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Presenters

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Welcome and Reminders

- Please introduce yourself in the Chat!
- Your microphones are muted. There will be time during this session for questions and discussion.
- You are also welcome to use the Chat function to ask questions or if you have technical difficulties.
- This session is being recorded and will be emailed to registrants within the next week.
- Remember not to disclose any Personal Health Information (PHI) during the session.

Learning Objectives

By the end of the session, participants will be able to:

- Identify tools available to support individuals with altered responses
- Discuss limitations of medications
- Discuss the benefits of a team approach

Ms. K

Lived on a farm until she was 13. Father died suddenly.

Moved to the city and finished school

Became a school secretary and worked for many years at the school

Loved to socialize and loved children

Very faithful and regularly attended the local Lutheran Church

The Incident!

- Experienced increased depressive symptoms and trialed medication
- Experienced suicidal ideation following the death of her mother and was admitted to acute psychiatry
- Sister expressed concerns about frequency of middle of the night calls
- Had two car accidents
- Increased wayfinding issues
- Forgetting doctors' appointments
- Was committed.
- Trialed 3 personal care homes
- Testing showed dementia
- LTC waitlist

Assessment

- Using PIECES assessment
- BOS-DOS
- PACSLAC
- Confusion Assessment Method (CAM)
- Cornell Scale for Depression
- C-SSRS- SAFE-T Protocol

Ms K – Medications

- Aspirin 81 mg daily
- Rosuvastatin 10 mg daily
- Sertraline 50 mg daily
- Mirtazapine 15 mg daily
- Brexpiprazole 2 mg daily
- Quetiapine 50 mg at suppertime
- Levothyroxine 75 mcg daily
- Risedronate 35 mg once weekly
- Vitamin D 1000 units daily
- Senokot 1-2 tablets hs prn

Use of an Antipsychotic for Ms. K

Generally effective for:

- Hallucinations
- Delusions
- Major depression (adjunct treatment)

Potentially effective for:

- “Agitation”/”aggression”
  - Number needed to treat **5-7**

Ineffective for:

- Calling out
- Wandering, exit-seeking
- Hiding, hoarding items
- Sexual inhibition
- Insomnia
- Eating inedibles (e.g. soap)
- Fidgeting, tapping, clapping
- Inappropriate elimination

Centre for Effective Practice. Use of Antipsychotics in BPSD Discussion Guide. LTC 2nd ed, April 2011.
Maglione M et al. Comparative Effectiveness Review No.43: Rockville MD: Agency for Healthcare Research and Quality US, 2011.
Maher AR et al. JAMA 2011;306(12):1359-69

“Yellow Zone” Use of Antipsychotics

- Antipsychotic is being used as a chemical restraint to subdue or repress the response
- Should only be used when:
    - Severe, distressing, recurrent
    - Safety risk
    - Alternate measures unsuccessful
- Antipsychotic should be **one piece** of the care plan
    - Interprofessional care team (including family)
- Minimum effective dose, shortest possible duration
    - Attempt to reduce dose/deprescribe **every 3 months**

↑ Risk of serious side effects and mortality in dementia!

Ms. K's Family

Ms K's sister is the most important person in her life. Feeling overwhelmed

Ms K found strength in her faith

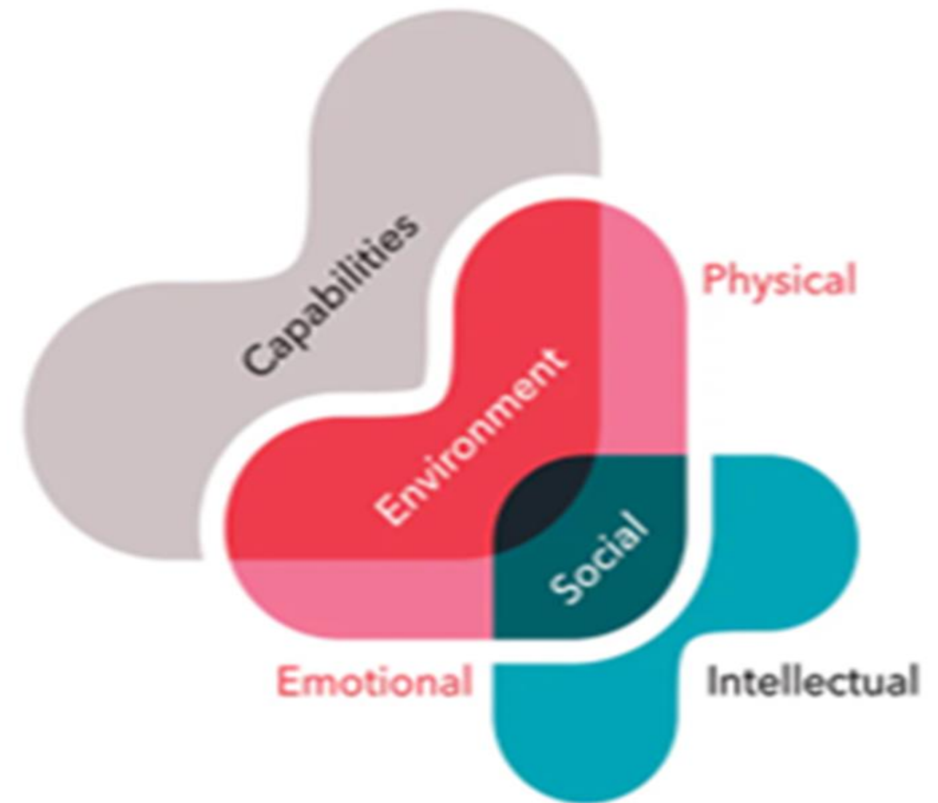
She enjoyed socializing but has become increasingly isolated following her mother's move to LTC and subsequent death

She loves BINGO

Question 1- What are the priority concerns?

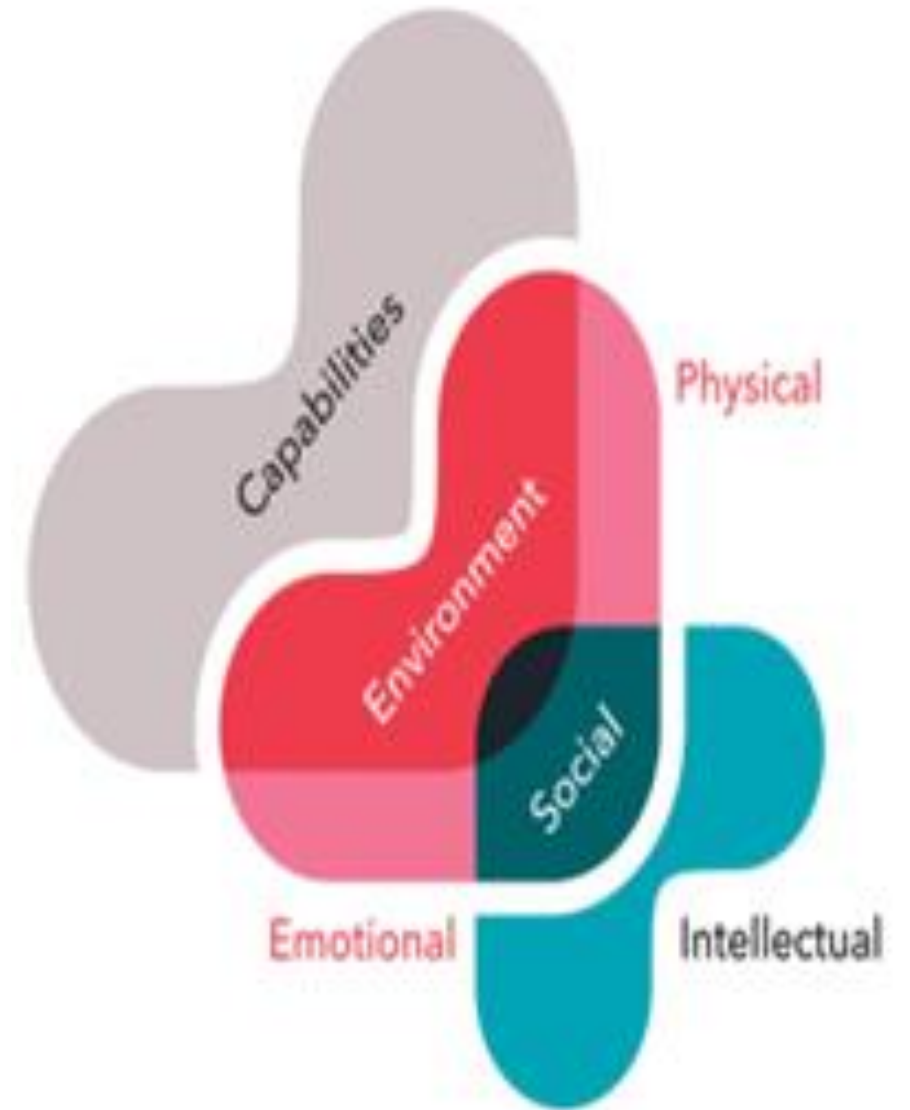
Everyone has a PIECE to play in finding the solutions

- Falls
- Suicidal Ideation
- Kinship- sister and staff
- Sleep
- Frailty



PIECES Assessment

Physical- Potential delirum, medication interactions, pain	Intellectual- anosognosia, amnesia, altered perception, apathy	Emotional- suicidal thoughts, not sleeping, loss of interest, paranoia, feeling abandoned
Capabilities- able to move herself in her wheelchair, likes to socialize	Environment- has experienced 5 moves in 18 months	Social- only support is sister, mother passed away in Jan 2024,



Question 2- What are the risks and possible contributing factors?

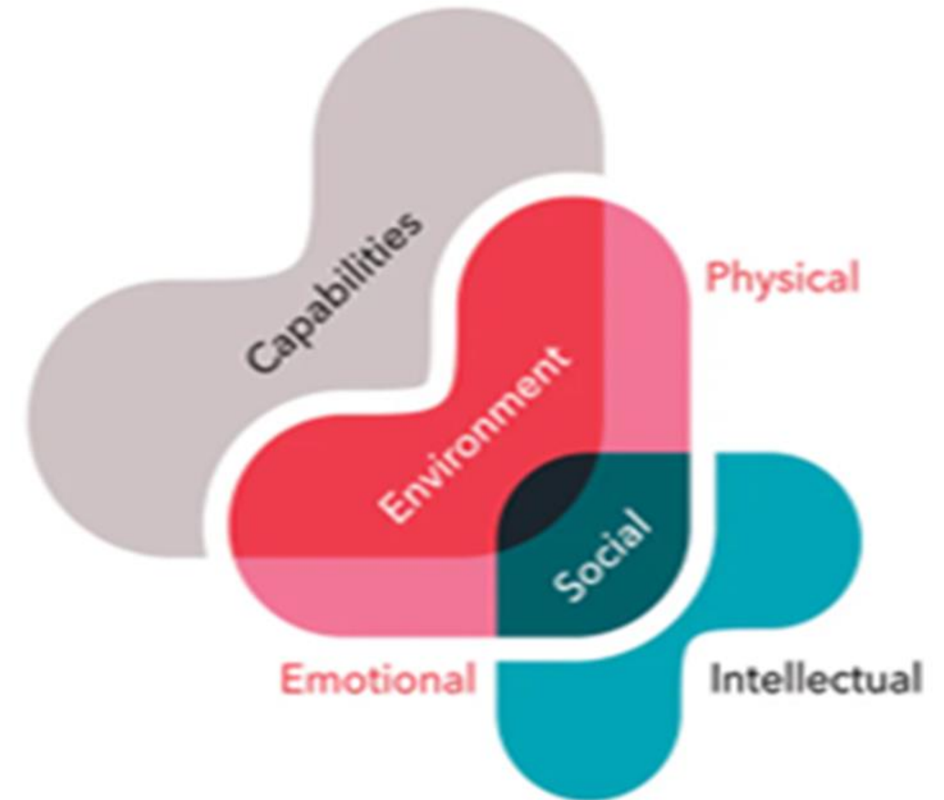
R- nothing indicated

I- falls related to delirium, increased fragility, not sleeping well, not eating well, pain

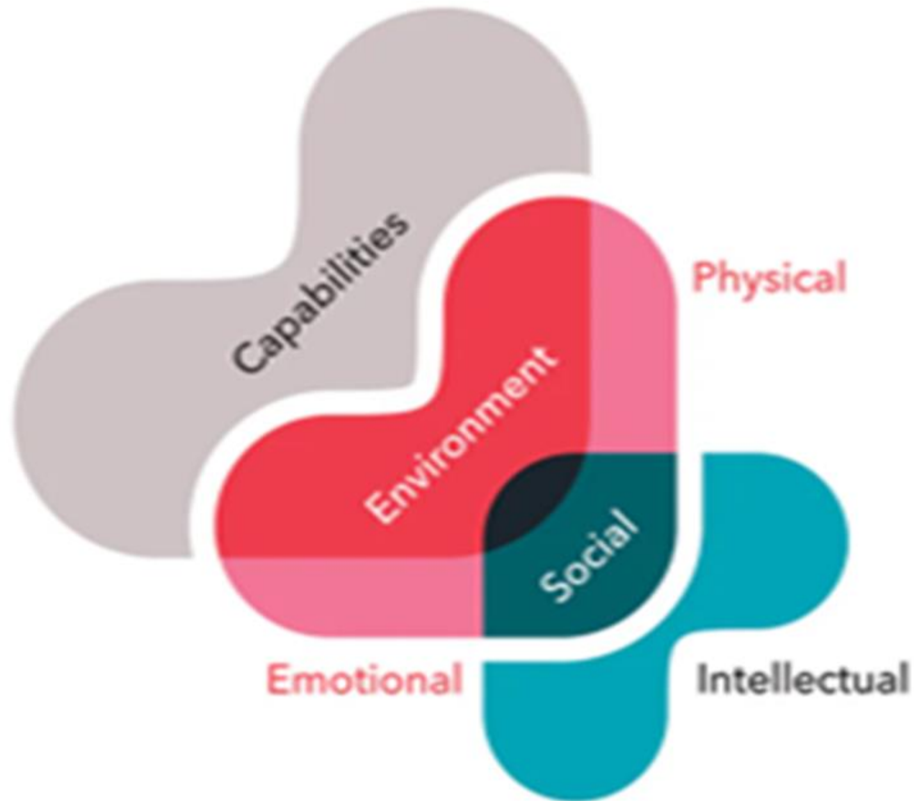
S: voicing suicidal thoughts, nail clippers, throwing self out of wheelchair

K: sister and staff

S: refusing her medications



Question 3- What are the Actions?



Priority Investigations:

Delirum workup, Depression Scale, BSO-DOS- charting was very good, Social History, Pain assessment and control, Geri Psych consult, C-SSCR and SAFE-T plans in place

Priority Interactions:

Offering choice, Listening, BINGO, spiritual care, allow time to de-escalate

Priority Interventions:

Review medications, walking program, spiritual care and interactions with people she is connected with, Make her room feel like home with her items, support for sister, sleeping, fall prevention, education for staff, dietitian consult

Ms K – Medication Review

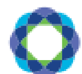
- ~~Aspirin 81 mg daily~~
- ~~Rosuvastatin 10 mg daily~~
- ~~Sertraline 50 mg daily~~
- Mirtazapine 15 mg daily
- Brexpiprazole 2 mg daily
- ~~Quetiapine 50 mg at suppertime~~
- Levothyroxine 75 mcg daily
- ~~Risedronate 35 mg once weekly~~
- Vitamin D 1000 units daily
- ~~Senokot 1-2 tablets hs prn~~

Additions:

- **Scheduled** Tylenol Arthritis 1300 mg BID
- Start duloxetine (30 mg -> 60 mg daily)

Changes:

- ↓ brexpiprazole 1 mg daily
- Polyethylene glycol (PEG) 17 g daily in orange juice



deprescribing.org | Antipsychotic (AP) Deprescribing Algorithm

August 2018

Why is patient taking an antipsychotic?

- Psychosis, aggression, agitation (behavioural and psychological symptoms of dementia - BPSD) treated ≥ 3 months (symptoms controlled, or no response to therapy).

- Primary insomnia treated for any duration or secondary insomnia where underlying comorbidities are managed

Recommend Deprescribing

Strong Recommendation (from Systematic Review and GRADE approach)

Taper and stop AP (slowly in collaboration with patient and/or caregiver; e.g. 25%-50% dose reduction every 1–2 weeks)

Stop AP
Good practice recommendation

Monitor every 1-2 weeks for duration of tapering

Expected benefits:

- May improve alertness, gait, reduce falls, or extrapyramidal symptoms

Adverse drug withdrawal events (closer monitoring for those with more severe baseline symptoms):

- Psychosis, aggression, agitation, delusions, hallucinations

If BPSD relapses:

Consider:

- Non-drug approaches (e.g. music therapy, behavioural management strategies)

Restart AP drug:

- Restart AP at lowest dose possible if resurgence of BPSD with re-trial of deprescribing in 3 months
- At least 2 attempts to stop should be made

Alternate drugs:

- Consider change to risperidone, olanzapine, or aripiprazole

If insomnia relapses:

Consider

- Minimize use of substances that worsen insomnia (e.g. caffeine, alcohol)
- Non-drug behavioural approaches (see reverse)

Alternate drugs

- Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this deprescribing algorithm. See AP deprescribing guideline for details.

- Schizophrenia
- Schizo-affective disorder
- Bipolar disorder
- Acute delirium
- Tourette's syndrome
- Tic disorders
- Autism
- Less than 3 months duration of psychosis in dementia
- Intellectual disability
- Developmental delay
- Obsessive-compulsive disorder
- Alcoholism
- Cocaine abuse
- Parkinson's disease psychosis
- Adjunct for treatment of Major Depressive Disorder

Continue AP
or consult psychiatrist if considering deprescribing

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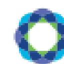
Contact deprescribing@bruyere.org or visit deprescribing.org for more information.

Bjerre LM, Farrell B, Hogel M, Graham L, Lemay G, McCarthy L, et al. Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia: Evidence-based clinical practice guideline. Can Fam Physician 2018;64:17-27 (Eng), e1-e12 (Fr).

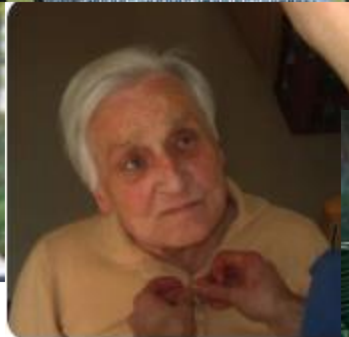

deprescribing.org

Project ECHO Palliative Care - Canada BY Pallium Canada CGNA Canadian Gerontological Nursing Association

Ms. K: Where is she now?

- Engaged with the community
- BINGO!
- Attending church
- Better relationship with her sister and staff
- KiKi the cat
- Pain

If you've seen one person living with dementia, you've seen **ONE** person living with dementia.



Session Wrap Up

- Please fill out our feedback survey, a link has been added into the chat.
- A recording of this session will be emailed to registrants within the next week.
- Thank you for your participation!

Thank You

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