3-67 Behaviour and Psychotropics

TIPS Question:

A 69-year old male resident has resided in our long-term care facility for 7 years, with a history of Rt. CVA with Lt. Hemiparesis, alcohol and substance abuse, Type II diabetes. Most ADLs' are provided with staff assistance i.e bathing, toileting, dressing etc. The resident is verbally and physically abusive to staff, making regular racial and rude remarks to staff concerning their skin colours, kicking, slapping and throwing any object in sight at staff and sometimes to other residents present at the time he is upset.

The 6-question P.I.E.C.E.S template has been addressed but resident continues to be more agitated and aggressive such that some of the staff in the facility are reluctant to care for him. Some of his medications: antipsychotic and antidepressant includes: Loxapine 5mg @ am, 15mg @ hs. Paxil 20mg OD, Epival 250mg BID, Risperdal 1mg @ 0800, 1200 & 3mg @ 1700.

Staff are concerned re: amount of medication the resident is on. How can we better cope and manage his aggressive behaviour with respect to his medication?

Response:

This situation is certainly a major challenge. Often there are, as you are aware, multiple reasons for the behaviour.

Physical causes: Possibly in this case where diabetes control is a problem, careful monitoring including regular morning, afternoon and targeted glucose levels when he is belligerent may reveal "hypoglycemic" aggression.

Intellectual: It appears he has both a vascular and an alcohol related dementia; therefore, assessing the "A's" will be important.

Emotional: Ruling out a psychosis will be important. Alcohol related dementia may have an associated psychosis that is not readily apparent.

Capability and Environment are their triggers in the environment; match of demands with capability.

Social: This one appears particularly important. These derogatory remarks are extremely difficult not to take personally. Even through we may know they are due to his brain disorder, it is still hard to reconcile at times. Working and allowing the staff to identify their feelings as well as find mutually supportive sharing strategies will be critical.

In terms of medication, it is often a trial and error process using the most effective combination that maximizes benefit, minimizes side effects. I would suggest in this case specialized referral and shared care.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*