Management strategies for wandering and restlessness in COVID-19 positive patients with dementia

Dr. Atul Nanda, MBBS, FRCPC | Lead Physician for Geriatric Psychiatry in Long-Term Care

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Background

- Wandering is not an uncommon symptom in patients with cognitive impairment
- Majority of these patients are usually redirectable and manageable
- It can be a major risk for spreading COVID-19 to other residents and care staff
- Treatment of these patients can be challenging for physicians and healthcare team
- There are multiple contributing factors to restlessness and wandering
- Currently there is limited evidence for symptomatic treatments in dementia
- Non pharmacological approaches should be considered the mainstay of therapy, complemented by psychotropic medications only when unavoidable
- Agitation is defined as ill-defined spectrum of abhorrent hyperactive motor behavior such as wandering
- It is accompanied by emotional distress and excess emotional disability
- Worse in evening hours - “sundowning”

Assessment

- Causes
  - Modifiable factors: unmet needs, acute medical problems, knowledge about the condition, caregiver distress, over/under stimulation, lack of routine, caregiving quality, caregiving quantity, caregiving knowledge, family dynamics
  - Unmodifiable factors: medical comorbidities, stage of dementia, type of dementia, brain changes, genetic makeup, personality, life history, infrastructure of care facility
- Describe and measure assessment of wandering and restlessness
  - When and how severe
  - Associated with depression
  - Emotional dysregulation and insomnia
  - Safety issues
  - Any triggers
  - Family dynamic
- Analyze - what do we know about the patient, and what could be contributing
  - Medical, psychological, or social factors

Ethical considerations

- Key ethical principles that constitute values to be considered
  - Harm principle - a society has the right to protect itself from harm (real or threatened) and government is justified in intervening and possibly infringing on rights of the individual to protect the community from harm
  - Autonomy - maintaining individual autonomy
  - Maintain patient privacy and confidentiality
  - Everyone matters equally but not everyone may be treated the same
  - Least resistive means to be used
  - Everyone working together

- Proportionality - measures that are implemented, especially restrictive ones, should be proportional to the level of threat and risk
- All decisions and procedures need to be fair and transparent in managing patients with COVID-19

Values in tension: Respect vs. The harm principle

- When possible, individual liberties and preferences should be respected
- In pandemic settings, individual rights including whether to practice physical distancing do not supersede public health safety concerns.

Risk/benefit analysis

- Public safety - minimize the net harm to public
- Care provider safety and wellbeing - minimize risk to the healthcare providers including moral distress
- Expose as few people to COVID-19 patients as possible
- Justifiable decision-making
- Established core value and practices for COVID-19 consistent with provincial, federal, and health authorities decisions

Non-pharmacological management

- Mainstay of the treatment
- Need creative and novel approach to avoid spreading transmission of COVID-19
- Patients who cannot register, or have lost the ability to comprehend, are not able to follow orders - they will need to be isolated
- Treatment approach depends on the stage of dementia
- Treatment approach also depends on addressing modifiable risk factors
- Non pharmacological approach is based on least restrictive approach, but mindful of risk of harm to others and caregivers
- Patients may react fearfully/increased anxiety as a result of countertransference from the care provider (if you are anxious, they become anxious, if you are fearful, they become fearful)
- Patient may become frightful/have increased anxiety when they don't understand why their caregivers are dressed oddly, with masks/gloves/gowns/faceshields etc.
- Environment of long term care (e.g. high tension, hyperalertness, increased anxiety will rub off on the patients)
- Reduced patience from the caregivers will trigger behavioral disturbance
- Sometimes, redirection and distraction, if not done patiently, can trigger more aggressive behaviour
- Become mindful of what is being displayed on TV, as it should not transfer increased fear and anxiety
- Caregivers to become extra vigilant of their own hygiene and sanitizing habits
- Avoid leaving contaminated PPE where patients can reach
- Encourage and monitor patient hand hygiene
- Monitor what patients may have touched, and immediately clean the surfaces
- Try sanitizing the patients hand as if providing a hand massage
- If patient allows, try putting a mask when he or she is in common areas

- When patient is in their room, close the doors and monitor through monitoring device or regular checkups
- Try and provide regular exercise
- Sensory stimulation and music therapy can be helpful
- Encourage virtual family visits via technology like FaceTime, Skype, Zoom, etc.
- Should continue even when pharmacological interventions are used

Pharmacological management

- Frequently provided but carries the risk of serious side effects
- Most of the medications are not approved
    - Antipsychotics are off label
    - Multiple morbidities and polypharmacy complicate the use of pharmacotherapy
    - Baseline ECGs should have been done (if feasible)
    - Carefully assess risk/benefit
    - Psychotropics should be for a limited time
    - Initiate low dose, titrate slowly to lowest effective dose
    - Continue to monitor target symptoms like wandering and restlessness
    - Use for shortest period of time
    - Evaluate side effects or the effectiveness
- Cholinesterase inhibitors/memantine
    - Some evidence it may be helpful
- Antidepressants
    - For affective symptoms and anxiety
    - Most commonly used
    - SSRI is reasonable choice, particularly citalopram (monitor QTc)
    - As effective as atypical neuroleptics
    - Tricyclic antidepressants not recommended because of anticholinergic side effects
- Antipsychotics
    - Atypical neuroleptics are first choice
    - Risperidone and aripiprazole are most commonly used
    - Effective in treating psychotic symptoms, agitation and aggressive behavior
    - Risperidone 0.125mg-2mg per day
    - Aripiprazole 1mg-10mg per day
    - Typical antipsychotics like haldol, loxapine etc. not recommended for this behavior
    - Side effects to be kept in mind - anticholinergic, orthostatic hypotension, seizures, EPS, sedation, QTc prolongation, increased risk of CVA, increased mortality
    - Evidence of quetiapine efficacy is mixed - has favorable side effect profile (sedation, lack of EPS), hence used often
        - Dosage can be 12.5mg-200mg per day
- Benzodiazepine
    - Lacks efficacy
    - Associated with sedation, dizziness, falls, worsening of cognition, paradoxical reaction, respiratory depression
- Other medications
    - Anticonvulsants - minimal effectiveness
    - Zopiclone/zolpidem - same as benzodiazepine

Conclusion

- An individualized treatment plan is needed
- A therapeutic decision tree should be established, taking into account a patient's individual and environmental risk
- Psychosocial treatment is pivotal, combining different non-pharmacological approaches is the first choice
- Pharmacological treatment can be added if required
- Regular assessment, close monitoring, discontinuing medications that become inappropriate
- Even with optimal management, sometimes the symptoms will not disappear completely and will remain challenging for all involved

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