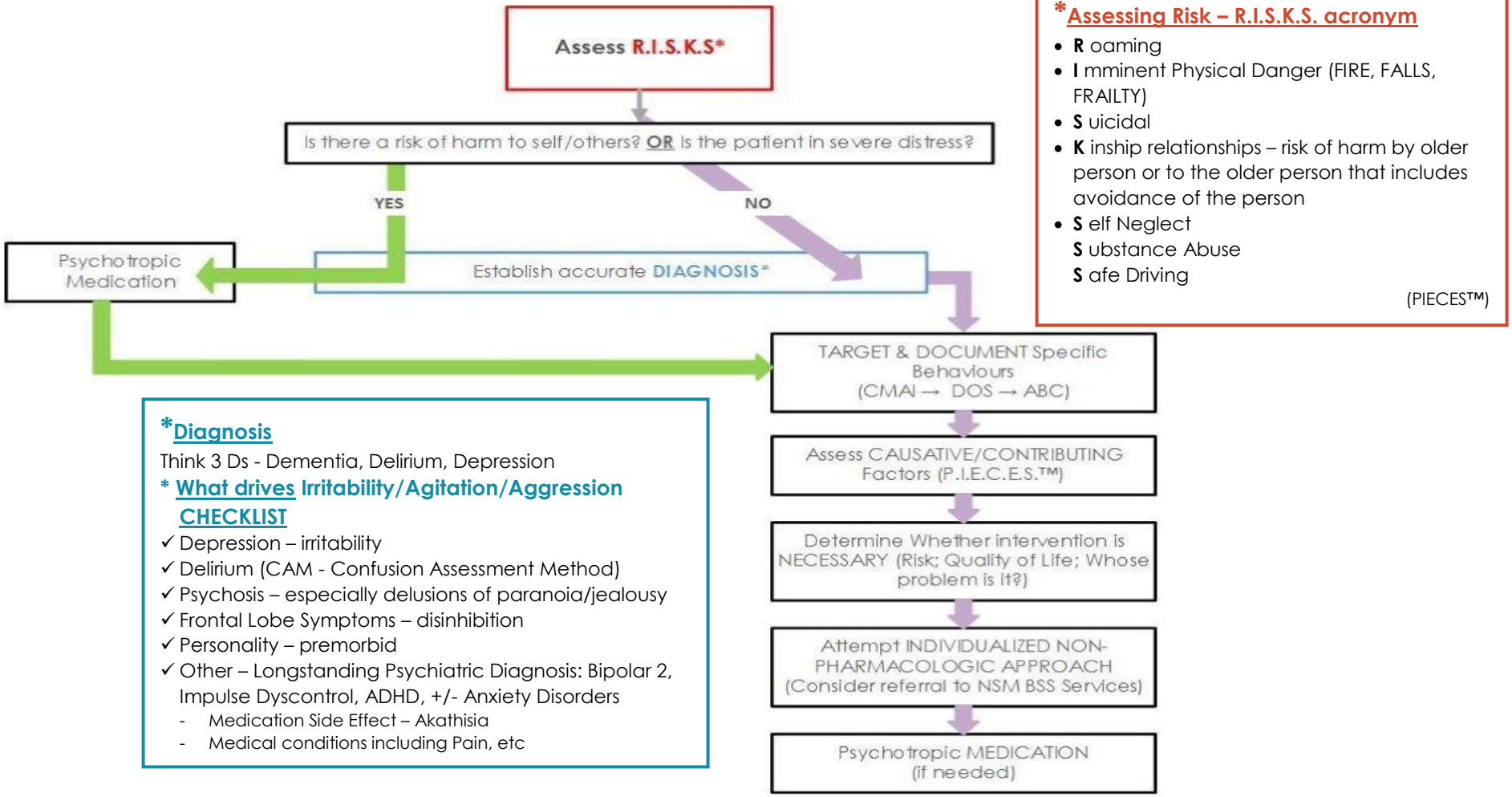
North Simcoe Muskoka Specialized Geriatric Services

Quick Reference Card A

Promoting the Appropriate Use of Atipsychotics: A Toolkit for NSM LTCH Providers, May 2017

General Principles for Prescribing Psychotropics for BPSD



***Assessing Risk – R.I.S.K.S. acronym**

- **R** oaming
- **I** mminent Physical Danger (FIRE, FALLS, FRAILTY)
- **S** uicidal
- **K** inship relationships – risk of harm by older person or to the older person that includes avoidance of the person
- **S** elf Neglect
  S ubstance Abuse
  S afe Driving

(PIECES™)

***Diagnosis**

Think 3 Ds - Dementia, Delirium, Depression

*** What drives Irritability/Agitation/Aggression CHECKLIST**

- ✓ Depression – irritability
- ✓ Delirium (CAM - Confusion Assessment Method)
- ✓ Psychosis – especially delusions of paranoia/jealousy
- ✓ Frontal Lobe Symptoms – disinhibition
- ✓ Personality – premorbid
- ✓ Other – Longstanding Psychiatric Diagnosis: Bipolar 2, Impulse Dyscontrol, ADHD, +/- Anxiety Disorders
  - Medication Side Effect – Akathisia
  - Medical conditions including Pain, etc

Indications for Use of Antipsychotic Medications

***PSYCHOSIS*:** if delusions of persecution/paranoia or of jealousy AND/OR any psychosis causing risk to self/others AND/OR any psychosis causing severe distress	***OTHER PSYCHIATRIC CONDITIONS*** with Psychotic Symptoms whether premorbid (Schizophrenia) or late onset (Major Depressive Episode-MDE with Psychosis) OR Psychiatric Conditions that are premorbid & severe and well controlled (Bipolar 1 Disorder with psychosis) or are premorbid and well controlled but worsen off antipsychotic (Bipolar 1 without psychosis, severe OCD, Adjunctive strategy for MDE without psychosis)
SEVERE AGGRESSION (PHYSICAL OR VERBAL), SEVERE AGITATION, OR OTHER BPSD without psychosis: that causes risk to self/others AND/OR causes severe distress	

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Antipsychotic Medication MONITORING PLAN

Obtain a thorough history, including all baseline labs, if available.

☐ **Electrolytes, CBC*, serum creatinine, liver function tests (AST, ALT, etc.), thyroid function** at baseline and Q3months** OR as clinically indicated

*Agranulocytosis/leukopenia/neutropenia may not be time dependent. If neutrophil count is low, monitor closely for fever and signs/symptoms of infection. Discontinue and reassess antipsychotic if ANC less than 1.5x10^9.

** Q3month review should include a pharmacist.

METABOLIC DISORDER

Typically comes on late in the course of therapy but some factors (particularly weight gain) can appear earlier in treatment. Prevention is easier to manage than treatment, making early monitoring important.

☐ **Weight** at initiation/dose change, then monthly x3 months, then Q3months while stable

☐ **HbA1C** at baseline, then 3 months after initiation/dose change, then annually*

*May increase to Q3-6months in patients with obesity, family history of DM, weight gain greater than 5% body weight

☐ **+/- Fasting/random blood glucose** at baseline, then 3 months after initiation/dose change, then annually OR as clinically indicated

EXTRAPYRAMIDAL SYMPTOMS & TARDIVE DYSKINESIA

EPS typically have early onset (within the first few days), but akathisia and pseudoparkinsonism can occur within the first 6 weeks (more common with first generation antipsychotics vs. second and third generation antipsychotics, but can occur in SGA/TGAs, particularly risperidone and aripiprazole). TD is thought to be related to the duration of treatment and total dose. Prophylaxis not usually indicated in this population.

☐ Evaluate **motor signs/symptoms** (motor restlessness, rigidity, shuffling gait, cog wheeling, tremor, difficulty swallowing, etc.) at baseline AND Q3months AND as clinically indicated

CARDIOVASCULAR RISK

☐ **Orthostatic vitals*** at initiation and with dose titrations AND Q3months in patients with CV risk factors**, particularly when using asenapine, clozapine, risperidone, quetiapine, chlorpromazine and ziprasidone

☐ **ECG** to assess QT interval at baseline in patients with CV risk factors* AND as part of differential diagnosis in the setting of dizziness, fainting spells, palpitations, nausea/vomiting

From most to least QT prolonging: ziprasidone > quetiapine = risperidone = olanzapine = haloperidol > clozapine(ref: 2009 schizophrenia PORT treatment recommendation)

☐ Serum **potassium and magnesium** at baseline and as clinically indicated in patients with CV risk factors

☐ **Lipids** 3months after initiation/dose change and annually thereafter

*To accurately assess for orthostatic change, take vitals at least 1-minute post position change.

** Heart failure, recent myocardial infarction, preexisting conduction abnormalities, syncope, family history of sudden cardiac death (before age 40), long QT syndrome

ANTICHOLINERGIC EFFECTS

Typically early onset

☐ Monitor patient for dry mouth, dry eyes, blurry vision (usually transient and only near vision affected), constipation, urinary retention, confusion and delirium

NEUROLEPTIC MALIGNANT SYNDROME (NMS)

⇨ In the setting of fever, rigidity, diaphoresis/autonomic instability, test CBC for WBC and CPK level.

If suspicion of NMS, immediately discontinue the antipsychotic(s) and ensure patient avoids dehydration

PROLACTIN LEVELS

⇨ In the setting of decreased libido, erectile or ejaculatory dysfunction, menstrual changes, galactorrhea, monitor prolactin Q1month x 3 months, then annually