Agitation in a hospitalized patient

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Clinical question

How do I assess and manage agitation in hospitalized older patients?

Bottom line

Older patients who present with agitation in acute care settings pose a complex clinical challenge. Each patient has a unique set of circumstances requiring a personalized care plan. It is imperative to develop an organized and systematic approach to identify predisposing, precipitating, and perpetuating factors (ie, 3 *P*s) for each patient. A framework is required to identify and describe target symptoms, and should include consideration of the presence of delirium, a structured assessment and documentation of symptoms and behaviour, and a determination of the use of nonpharmacologic strategies and appropriate use of medications when suitable. Clinicians should also provide support to the patient's family and to the clinical team.

An article[1] in the *Canadian Geriatrics Society Journal of CME* reviews a practical approach developed to manage agitation at The Ottawa Hospital in Ontario. This builds on a previous article describing the basics of behavioural management.[2]

Evidence

Agitation is common in older hospitalized people, but there is a paucity of good evidence to guide management. This is particularly true for medication use, especially for antipsychotic medications. *Agitation* is defined by the International Psychogeriatric Association as involving excessive motor activity or verbal or physical aggression causing emotional distress and excess disability for the affected person, and impairing relationships, social functioning, and activities of daily living.[3] The Confusion Assessment Method (CAM) and other screening tools such as 4AT have been shown to improve recognition of delirium and should be used when beginning to assess agitation, even in patients who have dementia.[4] A nonpharmacologic plan of care should be created and tailored to the patient's behavioural triggers. Staff should be trained in techniques such as gentle persuasive approaches.[5]

There is less clear evidence regarding the use of medications for agitation. Trazodone might help with sundowning, sleep, and nonaggressive agitation.[6] Research on antipsychotics for delirium and dementia has produced variable results, but a recent systematic review did not support routine use of antipsychotics for delirium.[7]

Approach

Agitation is often associated with delirium and use of a delirium assessment tool such as the CAM is recommended.[4] Agitation might also be superimposed on pre-existing symptoms of dementia. The presentation is frequently complicated by comorbidities, alcohol and substance misuse, pain, maladaptive personality characteristics, and social and family circumstances.

Whether CAM results are positive or negative, it is critical to explore, clarify, understand, and document the patient's personal behavioural triggers. Obtaining collateral information from multiple sources will help to establish the patient's baseline behavioural status (eg, information from family, friends, staff at long-term care or retirement home, and family physician). A nonpharmacologic plan of care tailored to the individual patient should be created. It must be simple, clear, and easy to understand to be implemented successfully. Nonaggressive forms of agitation might often be managed with nonpharmacologic interventions alone; if medication is required, antipsychotics should be avoided if possible.

Aggressive forms of agitation might require medication use. Three clinical scenarios justify consideration of an antipsychotic pharmacologic intervention: behaviour is not responsive to gentle persuasive approaches and verbal or physical aggression is severe enough to affect the patient's safety or the safety of others; behaviour is expressed as aggressive resistance impeding the provision of safe and essential patient care; or the patient is threatening or attempting to cause bodily harm, and behaving violently or posing a substantial potential and imminent threat or risk of harm to themselves or others.

The choice of agent (antipsychotic and other agents), dosage, route of administration, and timing must be tailored. The oral route is preferable. There are advantages and disadvantages to available agents, which include risperidone, quetiapine, haloperidol, and loxapine. Targeting the medication to specific symptoms, starting low and increasing based on response, limiting duration of use, and having good documentation are all principles of management. Rabheru[1] provides practical recommendations for pharmacologic management.

Implementation

A team approach is crucial, including educating family members and engaging them in management when possible. The Behavioural Vital Signs Tool (**http://www.cagp.ca/resources/Documents/Module%202%20-%20BVS%20Tool.pdf**) can be very useful to identify, document, and monitor behavioural symptoms.

Medications have limited benefit and consideration of their indications and monitoring strategies is important. If using antipsychotics, consent from the substitute decision

maker should be sought, given limited evidence of benefits and proven risks of adverse outcomes. The duration of treatment should be clarified as soon as possible.

Certain patient populations (eg, patients with Parkinson disease or Lewy body dementia) can be highly sensitive to antipsychotic medications. When they experience agitation, special attention must be paid to the choice of a safe antipsychotic to avoid adverse outcomes.

Figure 1 is an example of The Ottawa Hospital's behavioural care plan.

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Competing interests

None declared

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Figure 1. Example of a behavioural care plan from The Ottawa Hospital in Ontario

About the patient	Approach to anxiety and agitation
• A 78-year-old man with agitation from RH • Collateral history from RH: stroke 2 y ago with progressive decline in cognition and function. He confuses his daughter with his wife or mother. He is unaware of the year • He is verbally and physically aggressive with the residents and staff, and he is resistant to care. He is more confused in the evening and at night • Behaviour has been much worse in the past 48 h **Build trust: identify favourites** • Likes magazines, television, music, and talking about family	• Explain tasks before doing them, giving the patient time to process information before proceeding • Avoid asking too many questions • Use a calm approach. Reassure and redirect; socialize during rounds • Offer television with movies, snacks, and some magazines for distraction • Offer a quiet, calm environment; offer verbal reassurance and attempt reorientation • Keep the lights on and blinds open during daylight and evening hours • Limit daytime napping to 1-2 h • Ensure social engagement when rounding hourly; awaken if drowsy • Monitor for change in mood, tone and volume of voice, and increased restlessness and agitation such as fidgeting, difficulty redirecting, increased frustration, or change in tone of voice or facial expression • Intervene early to prevent escalation: consider use of as needed trazodone to prevent escalation and facilitate safety
Responsive behaviour	**Sleep hygiene**
• Pacing, wandering, irritability, restlessness • Sleep-wake cycle reversal • Punches and kicks personal caregivers • Triggers include sundowning, noise, poor sleep	• Increase daytime activities, particularly physical exercise • Provide a light snack before bedtime, avoiding too many liquids • If the patient does not settle after taking trazodone at 8:00 PM, offer an additional dose at 10:00 PM to help with sleep • Avoid waking the patient for care during the night • Avoid sedating medications after midnight to avoid increased sedation in the morning **Extrapyramidal symptoms** • Monitor closely for extrapyramidal symptoms: tremors, rigidity, drooling, leaning, shuffling, stooped posture, restlessness, difficulty swallowing, choking • Report these to the physician

RH—retirement home.