

## **Addressing Psychomotor Agitation Protocol**

### ***Purpose***

The purpose of this protocol is to offer health care providers an understanding of the kinds of behaviours which can be associated with delirium, including an emphasis on psychomotor agitation. The protocol will provide an approach to caring for delirious patients with psychomotor agitation, with interventions aimed at reducing the agitation and addressing the safety factors involved with caring for these patients.

### ***Introduction and Definition of Associated Terms***

Delirium is often accompanied by a disturbance in psychomotor activity. The literature describes three subtypes of delirium based on psychomotor activity and arousal (Lipowski, 1990). However, it is important to remember that each patient will have his/her own way of demonstrating their experience with this disorder.

1. **Hyperactive delirium:** The hyperactive form of delirium is often characterized by agitation, a hyperalert state, hallucinations, delusions and disorientation which can be very upsetting to the patient, family and caregivers (Ross, Peyser & Shapiro, 1991). Agitation can be manifested in a variety of ways e.g. attempting to get out of bed and climbing over bedrails; verbal aggression; resistance to care; physical aggression; rocking motion and wringing of hands. The patient's emotional reaction to symptoms of delirium can itself be a significant aggravating factor. The patient may find comfort in knowing that the symptoms are often temporary, unless the delirium is due to a major stroke or to another event that may cause permanent brain injury (American Psychiatric Association, 1999)
2. **Hypoactive form:** The hypoactive form of delirium is often characterized lethargy, a hypoalert state, confusion and sedation. Hallucinations, delusions or illusions less often accompany it. It is important to note, this is the most common form of delirium in elderly hospitalized patients. The state of hypoactivity, is thought to contribute to the under recognition of delirium.
3. **Mixed delirium:** The mixed form of delirium can present with alternating features of both hyperactive and hypoactive subtypes. (Rapp & The IOWA Veterans Affairs Nursing Research Consortium, 1998)

The delirious patient may also exhibit emotional disturbances such as anxiety, fear, depression, irritability, anger, euphoria and apathy. Patients may present

with a labile mood and rapid and unpredictable shifts from one emotional state to another.

### ***Individuals at risk***

Virtually all patients who have delirium are at risk for developing behaviours which can be distressing for them, their family and caregivers.

### ***Who would most benefit from the use of this protocol?***

Patients who have delirium  
Patients who have cognitive impairment

### ***Initial Assessment***

In order to understand the influences of agitated behaviour with delirium, an assessment should include a specific description of the behaviour, including the time it occurred, its severity, frequency and any precipitating events. Broad descriptions such as "aggressive" or "attention seeking" are not informative and can lead to "labeling" the patient. Specific and descriptive documentation e.g. "Mrs. B. hits out at nursing staff with a cane, usually in the morning during am care," helps in the development of treatment strategies.

It is also important to consider who has the problem with the behaviour. Is it the person with delirium, the family, the staff or other patients in the setting? Such a question may indicate where to target any intervention, or indeed whether any intervention is required. If the behaviour is not distressing to the patient or to others then no intervention is necessary.

### **Assessment Techniques**

Assessment methods include direct observations, reports from family and sitters and rating scales. Care must be taken to ensure the information provided regarding the behaviour is not biased and is in sufficient detail to understand the circumstances surrounding the behaviour.

After the assessment, meet with family as soon as possible to discuss delirium and the behavioural issues of concern, answer questions and share insights. It is important to inquire if they have observed any interventions which help to decrease agitation in the patient.

### **Care Plans**

A careplan should be formulated as soon as possible and shared with the patient/family. **One member of the health care team, should be**

**responsible for ensuring the plan is reviewed regularly with the multidisciplinary team.**

The care plan may involve many trial and error attempts with various interventions but it is crucial to document which interventions were tried and the results which occurred, under specific circumstances. When targeting behavioural issues the desired outcome should be specified in terms of reducing the undesirable behaviour and being careful not to replace one behavioural challenge with another. For example: An acceptable outcome may be: "Mrs. B. will feel more secure and not have the need to hit out." Unacceptable: "Mrs. B. will not physically participate in her am care when caregivers are present". The latter outcome could promote apathy or withdrawal.

***Interventions for Addressing Psychomotor Agitation***

Some interventions for managing challenging behaviors associated with delirium have been suggested by research in this area, whereas other interventions are simply based on "good nursing care". Many interventions suggested by authors are interventions that have been investigated for use in chronic confusion, which caregivers have applied when working with delirious patients. The interventions provided herein include those supported by research as well as those that were commonly cited by authors, despite a lack of research support. (Rapp & Iowa Veterans Affairs Nursing Research Consortium, 1998)

*A. Patient care interventions:*

1. Sit and be present with the patient, acknowledging and gently exploring his/her feelings or fears.
2. Address basic needs: pain, hunger, thirst, need to reposition, bowel and bladder elimination, need for company
3. Reassurance and clear explanation to the patient of any procedures or treatment to be carried out. (See protocol on Cognitive/Perceptual Enhancement for communication techniques)
4. Continuity of care from nursing staff is desirable
5. Maintain or restore patient's normal sleep pattern.(See Sleep Enhancement Protocol)
6. Encourage visits from family and friends who have a calming effect on the patient. However, briefing the family on the situation is necessary, along with communicating any calming interventions that have been successful so they may continue with these.
7. Sensitively, encourage family to reduce the number of visitors and/or the length of visits if this is observed to be a predictor of agitation.
8. Diversion can be used to distract the patient from the disruptive behaviour

9. Encourage patients to be involved in and control as much of their care as possible. Be sure to allow them to set their own limits and do not force patients to do things they do not want to do.
10. Involve the patient in recreational programming (Consult to RT if available)
11. Daily mobilization (See Mobility Enhancement Protocol)

*B. Environmental /Supportive Interventions:*

1. Avoidance of inter-intra ward transfers
2. Sensory aids should be available and working (See Addressing Cognitive & Perceptual Disturbances Protocol)
3. Removal of patient from the situation which may be contributing to the agitation
4. Eliminate irritating noise (e.g. pump alarms)
5. Use music, which has an individual significance to the confused and agitated patient, to promote the reduction of agitated behaviours. Music with water or nature sounds has been shown to have a relaxing effect with some patients.
6. Keep the environment calm and quiet with adequate but soft indirect light and limit noise levels
7. Consider the use of nightlights to combat nighttime confusion
8. Fall prevention measures (see Mobility Enhancement Protocol-Appendix A)

**Other Interventions:**

After a number of non-pharmacological interventions have been tried and have proven unsuccessful, it may be necessary to consider the need for the following interventions:

*A. Pharmacological Interventions*

All sedatives may cause delirium, especially those with anticholinergic side effects (British Geriatric Society, 1995). Any drug used for the treatment of delirium will have psychoactive effects, and may further cloud mental status which may obscure efforts to follow the patient's progress (Inouye, 2000).

In general:

- The use of sedatives and anti-psychotics should be kept to a minimum.
- Limit the use of medications in patients with delirium and if possible, use one medication at a time to evaluate its effectiveness and occurrence of side effects.
- Use the lowest dose for the shortest duration possible.

- Psychotropic medications should be directed at treating specific target behaviours/symptoms which should be monitored for resolution.
- Medication treatment needs to be reviewed regularly with the multidisciplinary team.

Pharmacological interventions may be necessary in the following circumstances:

- to prevent patients endangering themselves or others
- to relieve distress in a highly agitated or hallucinating patient
- in order to carry out essential medical treatment or investigations

Medication selection in part, will depend upon the etiology of the delirium and should be discussed with the physician. It is important to communicate the interventions which were tried unsuccessfully and a specific description of the behaviour(s) in question e.g. timing, frequency, precipitators.

The following medication options have been reported in the literature (Rapp & Iowa Veterans Affairs Nursing Research Consortium, 1998; Marcantonio, 1995; American Psychiatric Association, 1999; Jacobson & Schreiber, 1997):

Haloperidol (Haldol) 0.5 – 5 mg bid to q6h po/IM /IV dose  
 Risperidone (Risperdal) 0.25mg – 1.5mg po bid (maximum 3 mg /day in the elderly)  
 Olanzapine (Zyprexa) 2.5mg – 5mg po od  
 Lorazepam (Ativan) 0.5 -1 mg bid to q6h po/IM

### *B. Restraints*

Use of restraints in treating patients with delirium should be avoided if at all possible and should be a "last resort" intervention. If restraints are considered refer to the Least Restraint Policy # 1-1-3000 with special attention to the Decision-Making Process and Procedure for Applying a Restraint

### **Evaluation**

Outcome measures may include:

Patient feeling more in control and secure  
 Reduction in the incidence or severity of the targeted behaviour or symptom  
 Less sedation  
 Decreased incidence of the agitated behaviour  
 Improved functional ability  
 Avoidance of complications of delirium e.g.  
 a. falls  
 b. pressure Sores

c. functional Impairment

d. incontinence

e. medication requirements\*

Note: Medication requirements can change dramatically once initial symptoms are controlled. Monitor target symptoms carefully and adjust medication doses accordingly to achieve desired drug effects without intolerable side effects.

## ***References***

American Psychiatric Association(1999). Practice guideline for the treatment of patients with delirium. American Journal of Psychiatry, 156(5), 1-20.

Inouye, S. K, (2000). Assessment and management of delirium in hospitalized Older patients. Annals of Long-term Care, 8(12),53-59.

Jacobson, S. & Schreibman, B. (1997) Behavioural and pharmacologic treatment of delirium. American Family Physician, 56(8), 1-10.

Lipowski, Z. J. ( 1990). Acute confusionl states. New York: Oxford University Press.

Marcantonio, E. (1995) Delirium. In M.H. Beers & R. Berkow (Eds.),The merck manual of geriatrics New Jersey: Merck & Co. Inc.

Rapp, C.G. & The IOWA Veterans Affairs Nursing Research Consortium (1998) Research-Based Protocol: Acute Confusion/Delirium, The University of IOWA Gerontological Nursing Interventions Research Centre, Research Development and Dissemination Core.

Ross, C. A. & Peyser, C. E. & Shapiro, I. (1991). Delirium: Phenomenologic and etiologic subtypes. International Psychogeriatrics, 3, 325-332.