EOLC [EPEC/G–ELNEC] Staff Education

[End-of-Life Nursing Education Consortium - Geriatrics]

Eliza Coffee Memorial Hospital

II. a) Principles of Assessment
b) Dementia

Robert J. Webb, MD Medical Director
Palliative Care Service & OASIS

June 10, 2015

Objectives

- Describe the 9 dimensions of patient and family assessments.
- Understand the concept of “Total Pain” and its application in assessing any symptom
- Understand dementias and their related behaviors.

a) The 9 dimensions of assessment

1. Illness / treatment summary
2. Physical
3. Psychological
4. Decision making
5. Communication
6. Social
7. Spiritual
8. Practical
9. Anticipatory planning for death

The physician & nurse role

- Listen
- Acknowledge
- Analyze
- Offer information, practical suggestions
- Introduce sources of support
- **DOCUMENTATION !!!!**

- **Cycle of “Ask – Inform – Ask” !**

1. Illness / treatment summary

- Primary diagnosis – what is it?
- Secondary concurrent illnesses
- Treatment summary
- Ask the patient what they understand to be the diagnosis, the treatment, etc.

2. Physical assessment

- Symptoms
- Physical function, impairments
- Physical examination
- Minimize tests (evidence-based use)

Common symptoms

- **Pain***
- Weakness / fatigue
- **Breathlessness***
- Insomnia
- Weight loss
- **Confusion/delirium***
- **Constipation***
- Anxiety
- **Nausea / vomiting** *
- Depression

* discussed later

Symptoms – causes

- Multiple causes
  - the primary illness
  - an effect of therapy
  - psychological, social, spiritual, practical issues
  - another medical condition

Pain* as a model for symptom assessment

- High prevalence
- Can be well controlled
- Often under-treated
- Adequate treatment requires adequate assessment
- Gateway to other assessments

** Will be discussed in more detail later*

Pain Assessment Overview

- Etiology
  - History
  - PE
  - Lab/diagnostic
- Location
- Intensity
- Character/ Quality
- Pattern
- What makes it better or worse
- Goals of Care
  - Function
  - Quality of Life
  - Comfort

Assessing Pain

- Can't measure "pain" easily [like BP]
- Pain scales often inconsistent
- Must evaluate its 'expression'
  - Assessing what contributes to pain/symptoms
    - Mood change
    - Chemical coping
    - Delirium
    - Opioid tolerance

Nonverbal Evidence of Pain *

- **Facial Expression**
- Immobilization of body part
- Purposeful motion
- Protective motion
- Rhythmic motion
- **Restlessness**
- **Agitation ***
- Tossing in bed
- Confusion

* More important in dementias [PAINAD tool]

Assessing Pain: Chronic TOTAL PAIN

(Applies equally to any symptom assessment)

- Treat all 4 components of ***Total*** Pain
  - **P** – physical
  - **A** – anxiety, anger, depression (emotional)
  - **I** – interpersonal (social) – financial/family
  - **N** – non-acceptance of EOL (spiritual)

How does Pain affect Functional Abilities

- Motor function
- Sensory function
- Effect on activities
- Effect on relationships
- Patient perspectives

3. Psychological assessment . . .

- Cognition (thinking)
  - delirium, dementia
- Affect (mood)
  - anxiety, depression
- Emotions prompted by the life-threatening illness

. . . Psychological assessment

- Coping responses - suicidal ideation?
- Emotional response to illness
  - Avoidance, denial
  - Fear, anger - loss of control, burden, abandonment, indignity
  - Lability, irritability
  - Intellectualization
  - Grief
  - Acceptance, spiritual peace

Unresolved issues

- Old feuds
- Last visits
- Lifetime project, piece of work
  - We aren’t going to ‘fix’ a problem that’s been there for 50 years!!

4. Decision-making assessment

- Capacity not same as competence
- Goals of care & Advance care planning
- Informed consent
- Decision-specific capacity
  - How functional is an older person in particular
  - How do they handle situations !

  [older people want respect and independence…]

[will cover in more detail in “legal”]

5. Communication assessment . . .

- Is there someone to share fears with? talk to? plan with?
- Is the information understandable?
- ASK what the patient/family perceives as the problem – *what have they been told*
  - Ask – Tell – Ask cycle
  - "Any thoughts why this is happening?"
- What the patient wants to know

. . . Communication assessment

- Who else to talk to
- Limits of confidentiality
- Is language an issue?
- Words can be misinterpreted
  - Especially for aged


whatever happened to our sexual relations?
I don't know. I don't even think we got a Christmas card from them this year.
parodyville.com

6. Social assessment…

- Family & family dynamics
  - ‘Seagull’ & ‘Hummingbird’ children
- Community & culture
- Environment
- Financial – medical bills – family sacrifice

7. Spiritual assessment

- Meaning, value – personal, of the illness
  - burden, control, independence, dignity
  - [E.g. M&M choice in dementia !]
- Faith
- Religious life, spiritual life
- Pastor – not same as ‘chaplain’
- Rituals

Spiritual Status

Remember, friends, as you pass by
As you are now, so once was I.
As I am now, so you must be.
Prepare yourself, to follow me.

– Headstone, Asbly, Mass.

Spiritual crises

- Search for meaning or purpose in one's life
- Loss of a sense of connection
- Feelings of guilt or unworthiness
- Questioning of faith
- Desire for forgiveness
- Sense of abandonment by God
- Suffering !! (Distress which has no purpose or end in sight)

8. Practical assessment…

- Caregivers – who's available
- Domestic needs – day-to-day living
- Dependents – family needs & coping
  - **Multitasking** – woman's work never done !

9. Anticipatory planning for death

- Current losses
- Anticipated losses
- Advance care planning
- Advance planning for last hours
  - Do you want to die “on an IV”?
  - How many times do you want to die?
  - Do you want to live or be “kept alive”?

Case #2 - Mr. Charles Carcinoma

- 65 yom, adenocarcinoma L. lung stage IIIA
- Diagnosed 1 month ago
- COPD – smoker 1ppd
- Admitted with nausea/vomiting, chest pain

Case #2 –Assess't Practice

- In groups of three: one person be Mr. Carcinoma, one be the admitting nurse, and the third be a critical observer.
- In 5 min, the admitting nurse complete a brief screening assessment: which of the 9 dimensions might be more important at this **first** contact, and which could be done later?

Assessment Exercise …

- #1's: Mr./Ms. Carcinoma – put yourself in his/her shoes
- #2's: Admitting nurse – what do you focus on among the 9 dimensions?
- #3's: Observer - Report how well each of the other two role played – suggestions for improvement? (1min.)

Summary & Pearls

- 9 dimensions of assessment
- Prioritize initial assessment based on pt. need – symptoms needing attention ?
- Always include family dynamics in assessment
- “Ask – Inform – Ask” interactions
- Document response to tx symptoms !!!

b) Dementia

1) **Definition**:

- An acquired impairment in intellectual function, involving at least three of the following:
  - memory
  - emotion
  - language
  - eye-hand skills
  - executive function (planning or completing activities)

…Definition of Dementia

- i.e. **memory loss** causes **confusion**, which changes personality and **behavior**, which interferes with social and occupational functioning !
- Progressive, incurable, and fatal disease
- Prognosis: Lasts 3-20years, depending on type (4.5 yrs avg)

Types of Dementia

- Alzheimer's (A.D.) [~65%]
- Lewy-Body Type (LBD) [~15%]
- Vascular (stroke – VaD) [~5%]
- Mixed (Alz. + VaD/LBD) [~10%]
- Frontal-Temporal [< 5%]
- Dementia of Parkinson's [40% of PD]
- Others: Alcoholic, Creutzfeldt-Jacob

Alzheimer's Type Dementia

- Dr. Alois Alzheimer described a patient "Auguste D" in paper in 1906,

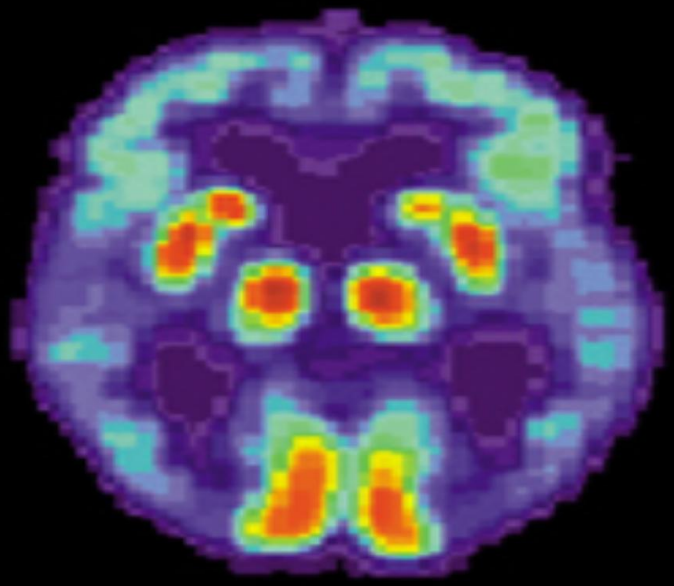
  w/ "pre-senile" dementia.

  – 51 year old woman

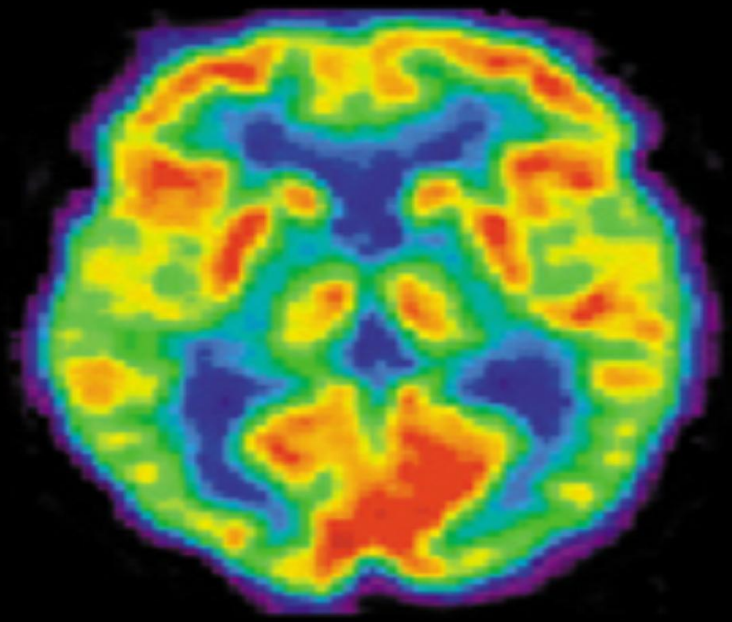
  – Died 5 years later

Alzheimer's PET Scans

Alzheimer's Brain

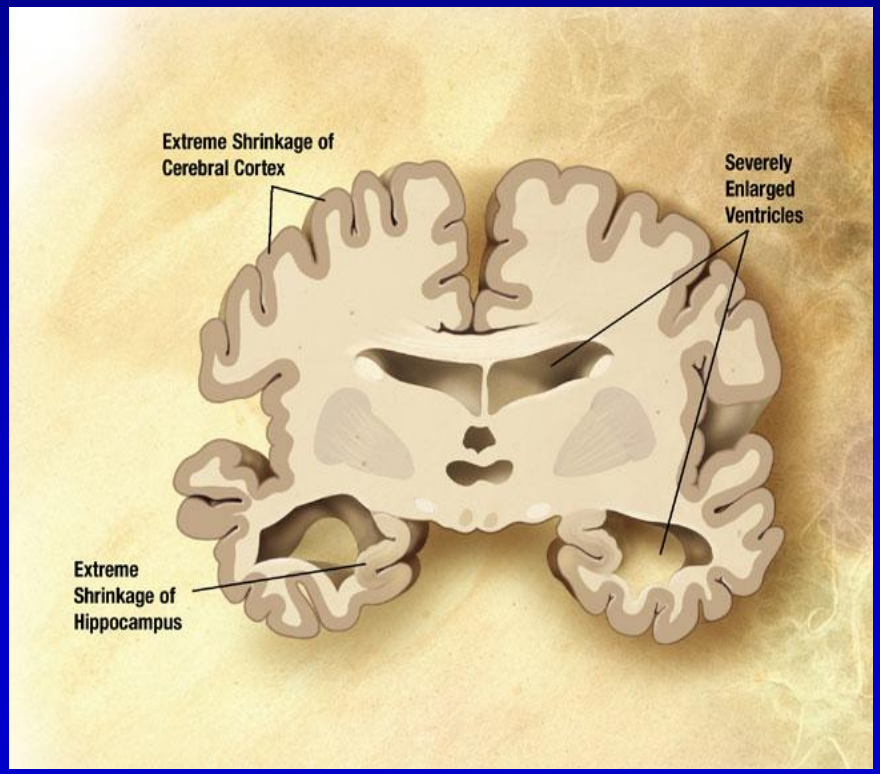


PET Scan of Normal Brain

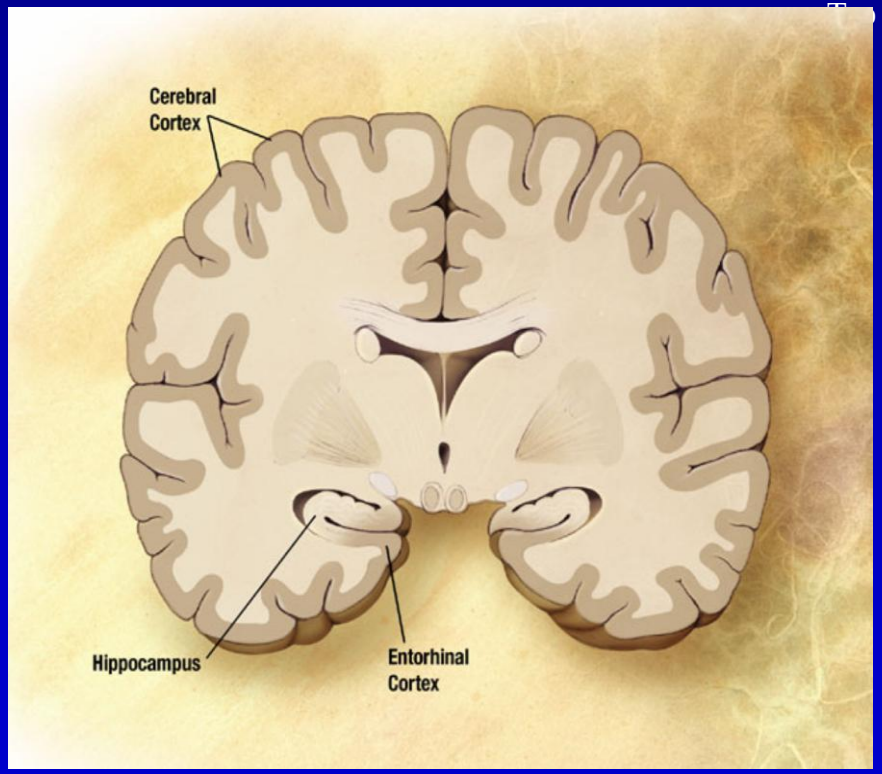


Alzheimer's v. Normal Brain

Alzheimer's



Normal Brain Cross-Section



2) Dementia Symptoms

Loss of memory affects perception which affects thinking, resulting in…

These problems:

- Memory loss
- Aphasia [speech]
- Agnosia [recognition]
- Loss of ‘executive’ planning

- disorientation
- apraxia [movement]
- abstract thinking

Affecting these skills:

- finances, driving, shopping, housekeeping, ADL’s (bathing, dressing, toileting, walking, eating)

…Symptoms of Dementia

…and triggering these behaviors:

- Easily distracted
- Hoarding/hiding
- Repetitive speech/actions
- Agitation, uncooperative, delusions/hallucinations
- Wandering/sundowning, Sleep problems
- Weight loss
- Sexual improprieties
- Rigidity & falling

Stages of Alzheimer's (A.D.)

FAST [Functional Assessment Stages] – correlate with ADL impairment

- 1 – normal
- 2 – mild cognitive impairment
- 3 & 4 – early A.D. [Mild – MMSE=25-14]
- 5 & 6 – middle stage of A.D. (most behavior problems) [Moderate – MMSE=13-1]
- 7 – end-stage A.D. [Severe – MMSE=0]

[*MMSE = Mini-Mental State Exam]

FAST Stage 6

- 6a – help dressing required
- 6b – help bathing
- 6c – help toileting
- 6d – urinary incontinence
- 6e – fecal incontinence

FAST Stage 7

- 7a – speaks < 6 intelligible words /day
- 7b – speaks only 1 word clearly/day
- 7c – bed-bound (2 person max. assist OOB)*
- 7d – cannot sit unsupported
- 7e – no longer smiles
- 7f – cannot hold head up

[* 7c = hospice eligible]

3) Dementia: cause & prevention?

- Inherited risk (Alzheimer's): 14% v 4%
  - If a parent has it, increased risk for child
  - Genes – APOEe4
- **Alzheimer's**: Protein plaques (amyloid) & neurofibrillary tau tangles, destroying brain cortex
  - Damage starts 10+ years before obvious symptoms

  [*Morley J. Alzh.Dis: Future Treatments. JAMDA 2010.*]
- **Vascular**: loss of sub-cortical brain tissue from strokes
- Others: loss of brain tissue/function from other disease

…Preventing Dementia ?

- Alzheimer's – exercise & learning !!
  - *Keep Your Brain Alive*. by Lawrence Katz, Manning Rubin. Workman 1999.
  - Brain Games [*Anderson. Brain games to slow cognitive decline in Alzheimer's disease. JAMDA 15 (2014)]*
  - Using non-dominant hand = new neurons
  - Exercise – walking/stretching/aerobics
- Vascular – control BP
- Pick your parents carefully !!!

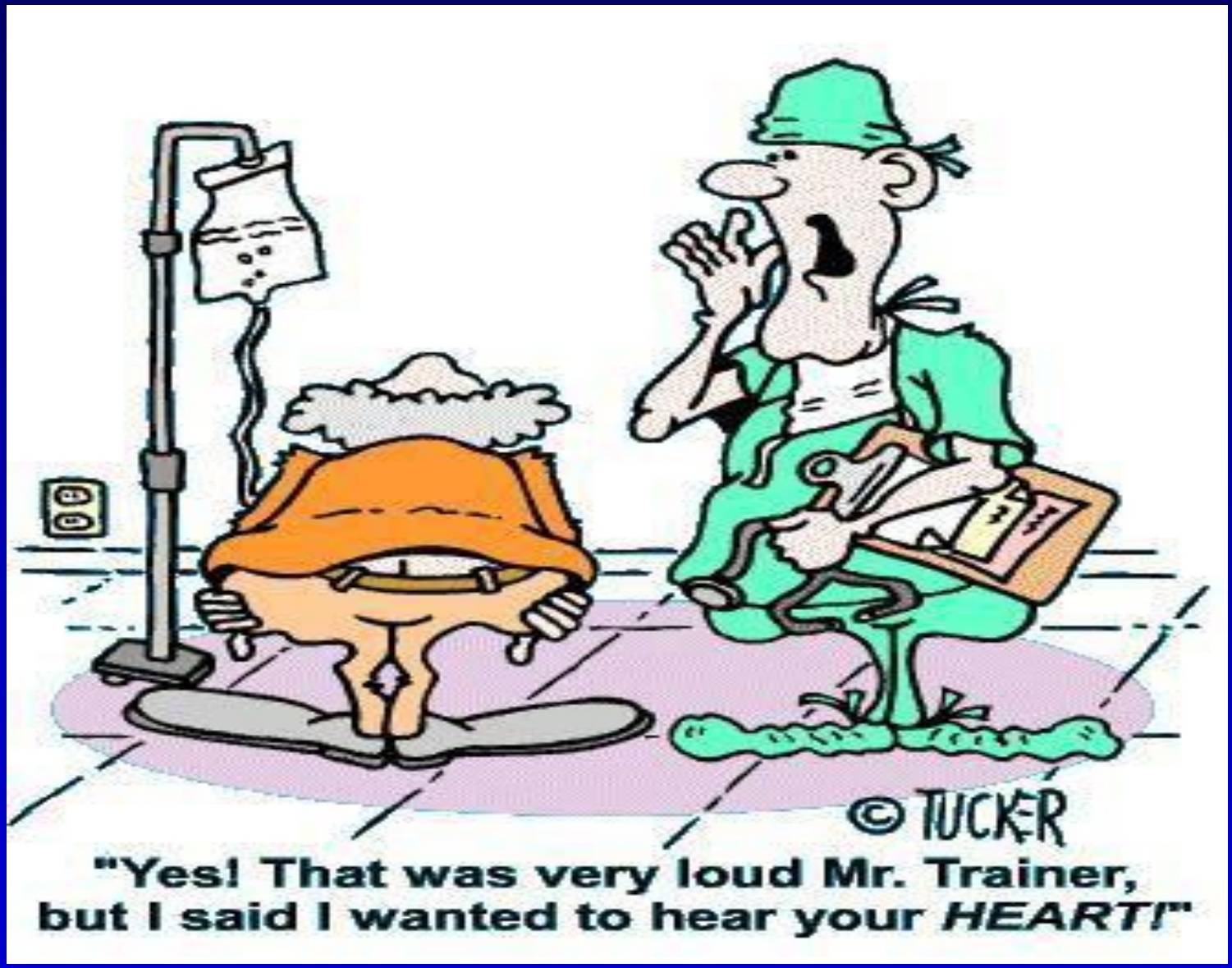
2. Treatment for Problem Behaviors

1) Rule out treatable disease
2) Making the diagnosis
   - Why make it early?
3) Non-pharmaceutical treatment
4) Drug/pharmaceutical treatment
5) Drug *Do's & Don'ts* Reinforced

1) Rule out Other Treatable Disease

- Depression (Pseudo-dementia)
- Delirium [drugs, infections]
- Age-associated Memory Impairment [AAMI]
- Hypothyroidism
- Vit. B12 deficiency
- Alcoholism
- Drugs & polypharmacy
- *Hard of hearing* !

Hard of Hearing v. Alzheimer's



2) Making the Diagnosis

- Rule out other treatable causes
  - Lab tests, examination
- Clock drawing test [CLOX]
  - Ask to draw a clock and show time 2:45
- MMSE – Mini-Mental State Examination

  < 26/30 = dementia

  Short Term Memory recall: 4+ /5

  SLUMS – St. Louis University Mental Status

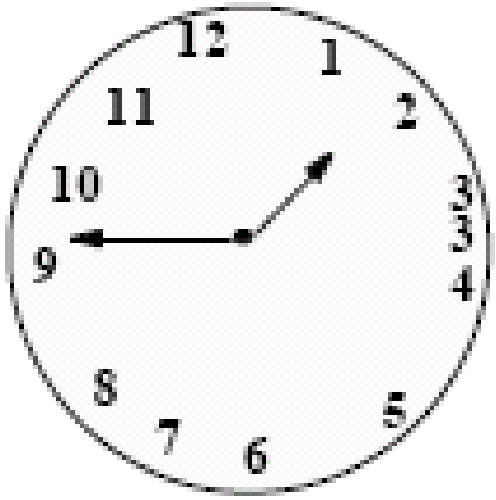
  [<20/30 = dementia]

Clock Drawing Test

Brief Screening Exams

Clock Drawing Test

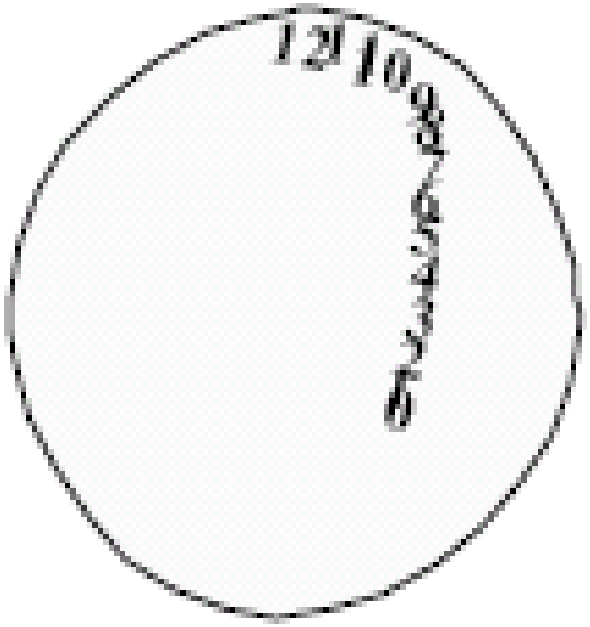
Mildly Impaired Sample



Brief Screening Exams

Clock Drawing Test

Moderate / Severely Impaired Sample



Why make an early Diagnosis

- Because there is no cure, important to decide how to live and be taken care of!
- Helps patient & family focus on their goals
- Improves care planning [family example]
  - Advance Directives [e.g. no antibiotics]
- Improves behavior management
- Organize support for caregivers
- Helps avoid non-beneficial care
- Consider clinical trials [research]

3) Non-pharmaceutical Treatments

- Never say “no” – use re-direction & distraction
- Tone of voice and body language !!!
- No diet restrictions [except caffeine]; snacks help
- Exercise/activity/aromas/ **soothing music** **[musictherapyformemory.com]**
- Toilet every 2 hr if incontinent
- Sundowning – keep active in day; avoid caffeine, reduce diuretics
- AVOID MAJOR SURGERY **& Meds** if possible [case examples – CA pancreas]

4) Drug (pharmaceutical) Treatment

A. Try to slow down the disease
   - Four drugs regulate brain neurotransmitters

B. Control the symptoms
   - Insomnia, wandering, anger, depression, agitation

Drug (pharmaceutical) Treatment

A. Try to slow down the disease

- *Cholinesterase Inhibitors*: Aricept (donepezil), Exelon (rivastigmine), Razadyne (galantamine)
- *NMDA receptor antagonist*: Namenda (memantine)

  - Might slow the decline rate – 3-4% over 6 mo.
  - Trial prescription for few months for effect
  - Side-effects & expensive

…Drug/pharmaceutical Treatment

But, little difference in avoiding NH care: *

- 44/100 not on drug go into LTC
- 42/100 on drug go into LTC

Costs (ARP):

Aricept: $235/mo [5mg-10mg/day]

Exelon patch: $230/mo [4.6mg or 9.5mg/day]

Namenda: $190/mo [5-10mg bid]

References

1. *Trinh N. Efficacy of cholinesterase inhibitors in the treatment of neuropsychiatric symptoms and functional impairment in Alzheimer disease. A meta-analysis. JAMA 2003;289.*
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…Drug/pharmaceutical Treatment

B. Controlling the symptoms

Can't treat the cognitive problem; only the behavior problem

- 20-60% experience agitation *[Sachs/Shega]*

Match the drug to the behavior:

- Hyperactivity = irritable, restless, dis-inhibition
- Mood & apathy = anxiety, depressed, no appetite
- Psychosis = delusions, hallucinations, anxiety

…Drug/pharmaceutical Treatment

Hyperactivity Rx: beta-blockers [no RCT], analgesics, anticonvulsants?

Mood / apathy Rx: anxiolytics, antidepressants

Psychosis Rx: antipsychotics (e.g. haloperidol, risperidone) – Black Box Warning: not approved by FDA; usually no help

- 'Aricept' & Namenda can help control aggression sometimes
- **Morphine, Methadone,** Tylenol - often work best ! (pain = underlying problem)

Treating Agitation: what's best?

- Opioids * – morphine or methadone
  - Morphine – 3mg po/subQ, Q1h prn till calm; then bid and titrate
  - Methadone – 2.5mg po/subQ, q3h prn till calm; then qday and titrate

* *see references list*

- Controlling Agitation in Dementia
  - opioid v atypical antipscyh.

…Treating Agitation: Anti-psychotics

All have s/e, Black Box Warning for CV events and death. *[based on meta-analysis ARI = 1.2% ; OR=1.5; Irwin/Sachs/Shega]*

All are used ‘off-label’ !

CMS red-flagging use in dementia in LTC !

Modest effect [NNT 5-14] c/t placebo, but “adverse effects offset advantages”
[Schneider. NEJM 2006]

…Treating Agitation: Anti-psychotics*

‘Atypicals’ [2nd generation; better for non-dementia psychosis; $$$ 136+/mo]

risperidone [Risperdal] – 0.25mg qhs po [max 2mg]

olanzapine [Zyprexa] – 2.5mg qhs po/subQ [15mg]

quetiapine [Seroquel] – 25mg qhs po

aripiprazole [Abilify] – 5mg qhs po [best if long QT]

ziprasidone [Geodon] – 20mg IM/po bid

[Sachs/Shega/Irwin review at 2011 AAHPM]*

…Treating Agitation: Anti-psychotics

‘Typicals’ [1st generation; more s/e; ‘cheap’ - $0.20/tab]

haloperidol [Haldol]; chlorpromazine [Thorazine]

- acute agitation = 1mg subQ, Q1h till calm/asleep, then q6h x 24hr
- chronic – not recommended for more than few days, unless other drugs fail; use lowest dose - 0.5mg qhs up to 2mg qid
- avoid IV/subQ if hx QTc >440ms [risk of torsades]

…Treating Agitation: what helps?

Antidepressants: worth trying 1 mo. min. & reassess ???

Serotonergic deficits contribute to verbal aggression, insomnia, depression, psychosis

- TCA's – nortriptyline 25mg to 100mg hs
  - Not amitriptyline
- SSRI's – no help *[Beck S, et al. J Fam Prac. 2013.]*
  - Tolerated ok = escitalopram [Lexapro], citalopram[Celexa]
  - Avoid - paroxetine [Paxil], fluoxetine [Prozac]
- Trazodone [tetracyclic, serotonin modulator]
  - Sedating – good for hs

…Treating Agitation: what's best?

- Other Drugs
  - Lorazepam [Ativan] – anxiety, anti-seizure
  - Memantine [Namenda] – can help [ARR 16%]
  - Divalproex sodium [valproic acid] – anti-convulsant, bipolar *[no benefit per Cochrane]*
  - Chlorpromazine [Thorazine] – anti-psychotic; good in terminal delirium; orthostasis!; caution if subQ [potential necrosis; IV best; or IM]

Treatment References…

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Treatment References [why use opioids]

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5) Dementia Drug Pearls

- Always R/O treatable cause of a problem
- Consider 3mo trial of cholinesterase inhibitor
- Give meds for limited times; continue based on measurable observations if possible
- Try opiate for agitation [morphine or methadone]
- If delusions/hallucinations, only treat if a threat to self/others, or interfere w/ care
- AVOID POLYPHARMACY:
  - *the more pills, the worse they feel and behave*
  - *Stop all "unnecessary" [non-comfort] drugs*

…Pearls !!!

- Avoid the ***we have to prescribe something to help*** **!**
- Everything we do has Placebo Effect – many improve regardless (39% - *Cochrane Review*)
- Focus on ***TLC*** ! *Why do anything which could prolong the suffering of dementia!!!*
  - *i.e. option to stop everything not solely for comfort !*
- If Rx, document dx & rationale for the drug!

Help for Caregivers

- Alzheimer's Society – www.alz.org
- Dementia 'day club' – WICP *[friendship club]*
- ADEAR – Alzheimer's Disease Education & Referral Center – National Institute on Aging
  - ***Caring for a Person with Alzheimer's Disease***
  - Go to nia.nih.gov/Alzheimers/Caregiveing
- Comfortcarechoices.com

Laugh – or go crazy !

As you slide down the banister of life, may the splinters all point down.

- Maxine

THANK YOU !