By Alicia Ault
Associate Editor, Practice Trends

New Orleans — Educating staff to spot triggers for disruptive behavior in long-term care facilities and residents to identify changes caused by aging from those caused by disease may help to decrease agitation and the management of mental illnesses, said Dr. Patel, of the department of psychiatry at Wright State University, Dayton, Ohio. Given that staff members are “overburdened and underpaid,” said she, they often do not have the ability to manage these residents.

Agitated residents who have reached the crisis point are at a greater risk of falls and of injuring themselves and others. Such residents will also tend to be noncompliant, increasing the caregiver’s burden, Dr. Patel said. There is already a 50%-70% turnover rate for licensed practical nurses and registered nurses; if they feel more burdened, turnover is likely to increase, she said.

In addition, unmanaged psychiatric emergencies expose clinicians and facilities to potentially higher malpractice and workers’ compensation premiums.

After she taught staffs at facilities in Ohio about ways to better manage resident turnover and reduce agitation, the group was generally well educated, and 219 deceased participants are included in the analysis.

Amita Patel said at the annual meeting of the American Geriatrics Society that the Baltimore Longitudinal Study of Aging (BLSA) indicates that Alzheimer’s pathology pushes you over the edge into becoming demented.

Having cerebrovascular disease on top of just a little AD pathology you have no potential conflicts of interest. The chance of being demented with just a little stroke significantly increased your risk of being demented. The researchers found that only the strokes that occurred in the cortex increase the risk of becoming demented.

The left image shows plaques and tangles (CERAD 2). The right image shows a middle cerebral artery stroke on an autopsy specimen.

When it comes to the association between strokes and Alzheimer’s pathology, it takes about three cortical strokes to induce dementia. When there is moderate AD pathology (CERAD 2), dementia is apparent after two strokes on average. It was possible for patients with moderate AD pathology to never progress to dementia, as long as they remained free of strokes, said Dr. O’Brien, a professor of neurology at Johns Hopkins University, Baltimore.

One stroke was about 50%, the chance with two strokes was about 80%, and the chance with three strokes was 100%. Strokes in the subcortical part of the brain were not significantly related to dementia.

Stroke size was not a factor in dementia risk. Large strokes tend to be symptomatic. However, in this group the presence of asymptomatic (and presumably small) strokes still conferred a greater risk of dementia. In addition, microstrokes—those occurring in the cortex and requiring a microscope to see—were as likely to increase the risk of becoming demented as a large very large stroke in the subcortical part of the brain.

If an older person is cognitively normal before a stroke, the chance of becoming demented is the same as for the age-matched stroke-free population. However, for those who have some cognitive decline before the stroke, the chance of becoming demented after a stroke is extraordinarily high—a 40-fold increased risk, said Dr. O’Brien disclosed that he has no potential conflicts of interest.

The first step to heading off emergencies in long-term care facilities is to prevent stress. The environment should be made as soothing as possible.

At this point, the resident should be given empathic support, encouraged to breathe, and asked to go to a quiet area. There, an assessment can be made, and—depending on the situation—oral medications might be offered.

An assessment should include an evaluation of what might have caused the episode—environment, a peer interaction, or a drug interaction. A complete blood count, toxicology screen, cardiac screen, and vital signs assessment can all help to get to the root cause. Substance abuse should be suspected if the patient has recently returned from a leave outside the facility, Dr. Patel said.

Once the etiology has been identified, treatment can begin. If the resident calms late,” she said. If the resident calms away and return at another time.

Staff members sometimes have a hard time coping with residents who may be stressed because they are grieving a loss of control or lack of attention from family. The staff can be trained in ways to help residents identify early signs of their distress and also to accept death as a reasonable outcome. If residents become agitated—exhibiting a change in voice; glaring; perspiring; or becoming restless, irritable and suspicious—“this is the state where you know they eventually are going to escalate.”

The left image shows plaques and tangles (CERAD 2). The right image shows a middle cerebral artery stroke on an autopsy specimen.

The first step to heading off emergencies in long-term care facilities is to prevent stress. The environment should be made as soothing as possible.

At this point, the resident should be given empathic support, encouraged to breathe, and asked to go to a quiet area. There, an assessment can be made, and—depending on the situation—oral medications might be offered.

An assessment should include an evaluation of what might have caused the episode—environment, a peer interaction, or a drug interaction. A complete blood count, toxicology screen, cardiac screen, and vital signs assessment can all help to get to the root cause. Substance abuse should be suspected if the patient has recently returned from a leave outside the facility, Dr. Patel said.

Once the etiology has been identified, treatment can begin. If the resident calms late,” she said. If the resident calms away and return at another time.

Staff members sometimes have a hard time coping with residents who may be stressed because they are grieving a loss of control or lack of attention from family. The staff can be trained in ways to help residents identify early signs of their distress and also to accept death as a reasonable outcome. If residents become agitated—exhibiting a change in voice; glaring; perspiring; or becoming restless, irritable and suspicious—“this is the state where you know they eventually are going to escalate.”

The left image shows plaques and tangles (CERAD 2). The right image shows a middle cerebral artery stroke on an autopsy specimen.