

**ADVERSE EFFECTS WITH ANTI-PSYCHOTIC MEDICATIONS**

Warnings and Precautions • Elderly Patients with Dementia-Related Psychosis: Increased incidence of cerebrovascular adverse events (e.g., stroke, transient ischemic attack, including fatalities)

Follow facility procedures for reporting adverse effects of medications

	Abilify	Saphris	Thorazine	Clozaril, FazaClo ODT	Prolixin	Haldol	Fanapt	Zyprexa (Zydis, Relprevv)	Invega	Trilafon	Seroquel (XR)	Risperdal	Mellaril	Navane	Stalazine	Geodon
	aripiprazole *	asenapine *	chlorpromazine	clozapine *	fluphenazine	haloperidol	iloperidone *	olanzapine *	paliperidone *	perphenazine *	quetiapine *	risperidone *	thioridazine	thiothixene	trifluoperazine	ziprasidone *
<b>Cardiovascular</b>																
Orthostatic Hypotension: Use with caution in patients with known cardiovascular or cerebrovascular disease.	Yellow	Orange	Red	Red	Yellow	Yellow	Orange	Yellow	Yellow	Yellow	Orange	Orange	Red	Yellow	Yellow	Yellow
QT Prolongation: Avoid use with drugs that also increase the QT interval and in patients with risk factors for prolonged QT interval. A prolonged QT interval may cause fatal arrhythmias.			Orange	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	White	Yellow	Yellow	Red	Yellow	Orange	Yellow
<b>Endocrine/Metabolic</b>																
Dyslipidemia: Undesirable alterations in lipid levels.		Yellow	Orange	Red	Yellow	Yellow	White	Red	White	White	Orange	Yellow	Orange	Yellow	Yellow	Yellow
Hyperglycemia/Diabetes: Monitor glucose regularly in patients with and at risk for diabetes	Yellow	Yellow	Yellow	Orange	Yellow	Yellow	Yellow	Orange	Orange	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Hyperprolactinemia: May cause breast enlargement (gynecomastia) and sexual dysfunction.		Yellow	Orange	White	Red	Red	Yellow	Yellow	Red	Red	White	Red	Orange	Red	Red	Yellow
Weight Gain: Monitor weight at least quarterly		Yellow	Orange	Red	Yellow	Yellow	Orange	Red	Orange	Yellow	Orange	Orange	Orange	Yellow	Yellow	Yellow
<b>Risk of Falls and Fractures</b>																
Fracture risk: Increases with duration of use which is generally longer with atypical medications.	Orange	Orange	Yellow	Orange	Yellow	Yellow	Orange	Orange	Orange	Orange	Orange	Orange	Orange	Yellow	Yellow	Orange
<b>Neurologic</b>																
Extrapyramidal Symptoms (EPS): Movement disorders such as acute, sustained muscle contractions causing twisting, repetitive movements or abnormal postures (dystonic reactions); pseudoparkinsonism; and inability to initiate movement (akinesia) and/or inability to remain motionless (akathisia).	Orange	Orange	Yellow	Yellow	Red	Red	White	Yellow	Red	Red	Yellow	Red	Red	Red	Red	Red
Sedation: Monitor for signs and symptoms of sedation.	Yellow	Yellow	Red	Red	Yellow	Yellow	Yellow	Orange	Orange	Orange	Yellow	Yellow	Red	Yellow	Yellow	Orange
Seizures/Convulsions: Use cautiously in patients with a history of seizures or with conditions that lower the seizure threshold.	Yellow	White	Yellow	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
<b>Systemic</b>																
Anticholinergic Effects: Dry mouth, dry eyes, difficulty urinating, constipation, blurred vision, confusion, memory impairment, drowsiness, nervousness, agitation, rapid heart rate, weakness.			Red	Red	Yellow	Yellow	Orange	Orange	Yellow	Orange	Yellow	White	Red	Yellow	Yellow	Yellow
Tardive Dyskinesia (with high doses): Involuntary, repetitive body movements such as lip smacking, tongue protrusion, and grimacing. Discontinue if clinically appropriate.	Yellow		Red	White	Red	Red	Yellow	Yellow	Yellow	Red	White	Yellow	Red	Red	Yellow	White

\*Second generation "atypical" anti-psychotic medications

Risk:	Minimal	Low	Medium	High
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Table adapted from:

A Guide to the Management of Psychotic Disorders and Neuropsychiatric Symptoms of Dementia in Older Adults: The American Geriatrics Society. April 2011.  
Mehta S, Chen H, Johnson M, Aparasu R. Risk of falls and fractures in older adults using antipsychotic agents: a propensity-matched retrospective cohort study. *Drugs & Aging* [serial online]. October 1, 2010;27(10):815-829.  
Muench J, Hamer A. Adverse effects of antipsychotic medications. *American Family Physician* [serial online]. March 1, 2010;81(5):617-622.

## BEHAVIOR MODIFICATION INTERVENTIONS

Recognize non-verbal communication of unmet need(s), e.g., “Agitation” - Clapping, yelling, slapping thighs, and screaming. Address the individual’s needs. Consider common causes:

- Noisy environment
- Pain
- Constipation
- Discomfort
- Infection
- Drugs
- Hearing loss
- Boredom
- Loneliness
- Abrupt, tense, or impatient staff
- Frustration

Aggression (hitting, swearing, biting, etc.), in contrast to agitation, is a fear based behavior. Communication is pretty clear. The resident most likely feels threatened.

Try an alternative approach.

Utilize de-escalation techniques, as appropriate. Neither you nor the resident should be or feel backed into a corner.

- Signal breath - If you are upset when approaching the resident, it will only make the situation worse. Stop. “Take a step back.” Slowly count to three (3) as you inhale, count to three (3) as you exhale. Repeat. You are now ready to approach the resident.
- Body language and tone of voice - Your body language and voice should communicate that the resident is safe and that you are not going to hurt him/her. Use a soft, neutral, calming tone of voice. Speaking almost in a whisper is sometimes helpful. Relax your shoulders; place your hands by your side. If assault is likely, the thinking stance is preferred: one hand cupping your elbow and the other hand touching your chin. This positions your hands to block punches or kicks without looking threatening.
- Monitor your proximity to the resident - Maintain a socially comfortable distance (generally 3-5 feet). Approach from the side and to the front of the resident remain in the resident’s visual field of view. Stay close enough to be heard, but not close enough to be struck.
- Ask, don’t tell, the resident to walk with you to a comfortable location where you can both sit. Walk slowly. As with whispering, walking slowly is incompatible with agitation and aggression. Ask, don’t tell, the resident to sit down with you to talk about what is bothering him or her.
- Identify with the resident; identify solutions to address the unmet need that triggered the behavioral communication. If possible, offer the solution immediately. Consider an intermediate solution if necessary.
- Listen actively. When a solution is not clear or available, simply listen, write it down and make a plan with the resident to address the concern.
- Diversion and distraction. There may be occasions in which it is not possible to identify the unmet need. In those circumstances, it may be possible to turn the resident’s attention toward something pleasurable. The better you know your residents’ strengths and interests, the better able you will be to select a distraction that is actually likely to engage them positively.

Adapted from: “Oasis” Mass Senior Care Foundation Antipsychotic Initiative 2011-12