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HSAG HEALTH SERVICES ADVISORY GROUP

ADVERSE EFFECTS WITH ANTIPSYCHOTIC MEDICATIONS

Warnings and Precautions | All antipsychotics have a warning for use in elderly patients with Dementia-Related Psychosis: Increased incidence of death (may be related to cerebrovascular adverse events, such as stroke or transient ischemic attack)

Follow facility procedures for reporting adverse effects of medications

Adverse effect	aripiprazole* (Abilify, Aristada)	asenapine* (Saphris)	brexpiprazole* (Rexulti)	cariprazine* (Vraylar)	chlorpromazine (Thorazine)	clozapine* (Clozaril, Fazaclo, Versacloz)	fluphenazine (Prolixin [Decanoate])	haloperidol (Haldol [Decanoate])	iloperidone* (Fanapt)	lurasidone* (Latuda)	olanzapine* (Zyprexa [Zydis/Relprevv])	paliperidone* (Invega [Sustenna])	perphenazine* (Trilafon)	pimavanserin** (Nuplazid)	quetiapine* (Seroquel [XR])	risperidone* (Risperdal [Consta])	thioridazine (Mellaril)	thiothixene (Navane)	trifluoperazine (Stelazine)	ziprasidone* (Geodon)
Cardiovascular																				
Orthostatic Hypotension: Use with caution in patients with known cardiovascular or cerebrovascular disease	Low	Medium	Low	Minimal	High	High	Low	Low	Medium	Low	Low	Low	Low	Minimal	Medium	Medium	High	Low	Low	Low
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	Minimal	Minimal	Minimal	Minimal	Medium	Low	Low	Low	Low	Minimal	Low	Low	Minimal	Medium	Low	Low	High	Low	Low	Medium
Endocrine/Metabolic																				
Dyslipidemia: Undesirable alterations in lipid levels, including HDL, LDL, or triglycerides	Minimal	Low	Low	Minimal	Medium	High	Low	Low	Minimal	Minimal	High	Minimal	Minimal	Minimal	Medium	Low	Medium	Low	Low	Minimal
Hyperglycemia/Diabetes: Monitor glucose regularly in patients with and at risk for diabetes	Low	Low	Low	Low	Low	Medium	Low	Low	Minimal	Minimal	Medium	Medium	Low	Minimal	Low	Low	Low	Low	Low	Low
Hyperprolactinemia: May cause breast enlargement (gynecomastia) and sexual dysfunction	Minimal	Low	Minimal	Minimal	Medium	Minimal	High	High	Low	Low	Low	High	High	Minimal	Minimal	High	Medium	High	High	Low
Weight Gain: Monitor weight at least quarterly	Minimal	Low	Minimal	Low	Medium	High	Low	Low	Medium	Low	High	Medium	Low	Minimal	Medium	Medium	Medium	Low	Low	Low
Risk of Falls and Fractures																				
Fracture risk: Increases with duration of use, generally longer with atypical medications	Medium	Medium	Medium	Low	Low	Medium	Low	Low	Medium	Low	Medium	Medium	Medium	Low	Medium	Medium	Low	Low	Low	Medium
Neurologic																				
Extrapyramidal Symptoms (EPS): Movement disorders such as acute, sustained muscle contractions causing twisting, repetitive movements or abnormal postures: dystonia, pseudoparkinsonism, inability to initiate movement (akinesia), and/or feelings of restlessness (akathisia)	Medium	Medium	Medium	Medium	Low	Low	High	High	Minimal	Low	Low	High	High	Minimal	Low	High	Low	High	High	Low
Sedation: Monitor for signs and symptoms of sedation	Low	Low	Low	Low	High	High	Low	Low	Low	Low	Medium	Low	Medium	Low	Medium	Low	High	Low	Low	Medium
Seizures/Convulsions: Use cautiously in patients with a history of seizures or with conditions that lower the seizure threshold	Low	Low	Low	Low	Low	High	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low	Low
Tardive Dyskinesia: Involuntary, repetitive body movements such as lip smacking, tongue protrusion, and grimacing. Discontinue if clinically appropriate	Low	Minimal	Low	Low	High	Minimal	High	High	Low	Low	Low	Low	High	Minimal	Minimal	Low	High	High	Low	Low
Other Systemic Effects																				
Anticholinergic Effects: Dry mouth, dry eyes, difficulty urinating, constipation, blurred vision, confusion, memory impairment, drowsiness, nervousness, agitation, rapid heart rate, weakness	Minimal	Minimal	Minimal	Minimal	High	High	Low	Low	Medium	Minimal	Medium	Low	Medium	Minimal	Low	Minimal	High	Low	Low	Low

*Second generation "atypical" antipsychotic medications
**Novel antipsychotic only for Parkinson's disease psychosis

Risk: Minimal (white) | Low (yellow) | Medium (orange) | High (red)

Table adapted from medication prescribing information and:
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 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 likely to engage them positively.

Adapted from: "Oasis" Mass Senior Care Foundation Antipsychotic Initiative 2011–12

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