Do You See What I See?
Parkinson’s Training
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Continuing Education
Nursing:
• This CNE activity has been jointly provided by Terri Goodman & Associates collaboratively with NADONA for one contact hour.
• Terri Goodman & Associates is an approved provider of continuing nursing education by the Texas Nurses Association - Approver, an accredited approver by the American Nurses Credentialing Center’s commission – Accreditation
• This activity is provided through an unrestricted educational grant from Acadia
• 1.0 Contact Hours Participants must complete entire activity. No partial credit will be awarded. Participants must submit a post event evaluation form

Disclosure
• Cindy Fronning has no actual or potentially relevant financial relationship to disclose and no conflict of interest in relation to this activity.
Objectives

- 1. Describe 2 types of hallucinations or delusions that a Resident with Parkinson's might experience.
- 2. List three things that need to be documented to prove a reduction in medication is not warranted.
- 3. Identify 3 interventions that should be included on the care plan.

Review of Parkinson’s Disease

“I feared Parkinson’s most when I least understood it — the early days, months, and years after I was first diagnosed. It seems strange to say it, but I had to learn to respect Parkinson’s disease.” — MICHAEL J. FOX
What is Parkinson’s Disease

• Parkinson’s disease is a progressive nervous system disorder that affects movement.
• Parkinson’s affects nearly 1 million people in the United States and more than 6 million people worldwide.
• Lifelong and progressive disease, symptoms slowly worsen over time.
• Symptoms and progression vary from person to person.
• Symptoms often begin on one side of your body and usually remain worse on that side, even after symptoms begin to affect both sides.

What is Parkinson’s Disease cont.

• 2 types of Parkinson’s symptoms:
   – It is called a “movement disorder.”
     • Tremors,
     • Slowness,
     • Stiffness/ Rigid
     • Walking and balance problems
     • Loss of automatic movements.
     • Speech changes
     • Writing changes

What is Parkinson’s Disease cont.

– Non-Motor Symptoms (Complications)
  • constipation, depression,
  • memory problems, loss of mental sharpness/ acuity,
  • insomnia, vivid dreams,
  • and daytime sleepiness,
  • impaired bladder control,
  • drooling, impaired taste, and swallowing.
  • sexual dysfunction,
  • vision problems/ dizziness,
  • sweating, body aches, and
  • generalized discomfort
  • Delusions, Hallucinations,
  • Anxiety, Pseudobulbar Affect (inappropriate laughing and crying)
What Causes Parkinson’s Disease?

• Occurs when brain cells that make dopamine, a chemical that coordinates movement, stop working or die

  Cause of Decreased Dopamine
  – a combination of environmental
    • pesticides and head injury.
    • in the early 1980s, a group of heroin users in California developed a form of Parkinson's after taking drugs contaminated with a toxin called MPTP
  – and genetic factors
    • Certain genetic mutations are linked to an increased risk of PD
    • researchers estimating that about 30 percent of Parkinson's risk is explained by genetics
  – Aging is the greatest risk factor for Parkinson’s, and the average age at diagnosis is 60. Still, some people get PD at 40 or younger.
    • researchers project the number of people with Parkinson’s will double by 2040
    • cells may be more susceptible to damage as they age
  – Men are diagnosed with Parkinson’s at a higher rate than women

7 Principles of Life With Parkinson’s Disease
(Adapted from MJ FOX Foundation)

Share these principles with your residents:
#1 – There is no average or common description of PD
#2 – Isolation can make PD worse
#3 – “Don’t Settle” – Make changes as the disease progresses
#4 – Keep up-to-date with credible resources
#5 – PD has ups and downs
#6 – Get involved
#7 – Make Plans

What is Parkinson’s Induced Psychosis?
Parkinson’s Disease (PD) Psychosis

- Approximately 50% of people living with Parkinson’s may experience hallucinations or delusions over the course of their disease.

- Causes of Hallucinations and Delusions
  - Side Effect of Dopamine therapy
  - Natural Progression of Disease

- What’s it like through the resident’s perception:
  - Seeing things that others don’t see
    - Like people either living or dead
    - Animals or other objects
  - Hearing noises that others don’t
    - Music
    - Voices
    - Conversations

Parkinson’s Psychosis cont.

- Resident Perception cont.
  - Paranoia (psychotic disorder characterized by delusions of persecution.)
  - Believing people want to
    - Hurt you
    - Talking about you
    - Take your money
    - Poison you
Parkinson’s Psychosis cont.

- False beliefs (Delusions)
  - Delusions are fixed beliefs that do not change, even when a person is presented with conflicting evidence.
    - Erotomaniac:
    - Grandiose:
    - Jealous:
    - Persecutory:
    - Somatic:
    - Unspecified:

Assessing for PD Psychosis

- Identify all symptoms that the resident has been experiencing:
- Minor
  - Presence Hallucinations: Feeling that someone is present when nobody is actually there
  - Passage Hallucinations: Fleeting, vague images in the peripheral vision
  - Visual Illusions: Perceiving a real object as something different (e.g., seeing a tie and believing it is a snake)

- Hallucinations: Abnormal sensory perceptions when no real stimulus is present
  - Visual: Seeing people, animals, or objects
  - Auditory: Hearing sounds, such as music, people conversing
  - Tactile: Feeling something touching or moving on the skin
  - Olfactory: Smelling nonexistent odors/scents
  - Somatic: Feeling as if a part of the body is changing or distorting

Assessing for PD Psychosis cont.

- Delusions: Strong false beliefs despite evidence that the belief is not true
  - Persecutory:
    - Believing that someone is trying to harm, steal from, or deceive them
  - Jealousy:
    - Believing a spouse is being unfaithful
  - Reference:
    - Believing that something is directed toward them when it isn’t (e.g., television character speaking directly to them)

- History of
  - Dementia with Lewy bodies,
  - Schizophrenia,
  - Schizoaffective disorder,
  - Delusional disorder,
  - Mood disorder with psychotic features,
  - Delirium
Interviewing the Resident with Parkinson’s Disease

- Do you ever feel out of touch with reality?
- Do others ever tell you that what you are hearing, seeing or sensing (people, animals, or objects) are not actually there?
  - How often does this occur in a month? (Hallucinations)
- Do you believe or have any fear that a loved one is stealing from you or being unfaithful? (Delusions)
- Have you shared these experiences with your loved ones?
- Have these experiences had any impact on your family or caregiver?

Interviewing the Family Member or Caregiver

- Have you ever observed your loved one interacting with things, seeing things, or sensing things that are not there (hallucinations).
- Has your loved one had any false beliefs toward you or others, such as believing someone is stealing from them or being unfaithful (delusions).
- Does your loved one recognize that the experiences above are not real?
- Have these experiences affected your daily lives and/or your relationship?
- Does your loved one get visibly upset when these experiences happen?
- What does your loved one do?
- What has worked to calm your loved one or distract them from this thinking?

Diagnosing PD Psychosis

- Presence of at least one of the following symptoms:
  - Illusions – Hallucinations
  - False sense of presence – Delusions
- The above symptoms must be recurrent or continuous for at least 1 month and have occurred after the onset of PD.
- PD psychosis may occur with or without:
  - Insight
  - Dementia
  - Parkinson’s disease treatment
Diagnosing PD Psychosis cont.

- Other potential medical and psychological causes of psychosis must be excluded before a diagnosis of PD psychosis is made.
  - dementia with Lewy bodies,
  - schizophrenia,
  - schizoaffective disorder,
  - delusional disorder,
  - mood disorder with psychotic features,
  - delirium

Diagnosis Codes

- Diagnosis codes for PD Psychosis
  - F06.0 Psychotic disorder with hallucinations due to known physiological condition
  - F06.2 Psychotic disorder with delusions due to known physiologic condition
Interventions with Psychosis

- Recognizing the psychosis symptoms
- Communicating to the resident and family what it may be and mean
- Encouraging the resident and family to report any of these symptoms
- Doctors will first adjust medications, reducing or withdrawing those that are most likely to contribute to psychosis, such as dopamine agonists and anticholinergics.
- If motor (and other) symptoms worsen significantly as a result of these modifications, adding antipsychotic drugs may be necessary.
  - Pimavanserin
  - Quetiapine
  - Clozapine.

F757 and F758: Unnecessary Drugs and Psychotropic Drugs

<table>
<thead>
<tr>
<th>Select Regulator</th>
<th>Intent of Regulation</th>
<th>CMR Guidance to Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>M Audiovisual Pain</td>
<td>To ensure each resident's medication regimen is adjusted to maintain the resident's highest level of function and comfort</td>
<td>The CMR is responsible for ensuring that the F757 and F758 fails can be documented in the clinical record</td>
</tr>
<tr>
<td>F757 and F758 Fail</td>
<td>To list possible interventions for the resident's quality of life</td>
<td>The CMR is responsible for ensuring that the F757 and F758 fail can be documented in the clinical record</td>
</tr>
</tbody>
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Behavior Interventions

- Simple and positive comments, use gestures
- Simple words
- Pronouns, present tense of the action
- Exercise, garden, sing
- Meals, undercrain, praise, reinforce

F757 and F758 Fail

- Avoid confrontation, validate their explanations
- Reassurance and distraction
- Account for subtle emotional harm

Affective / Mood

- Fears, resident at risk, high-risk
- Scheduled events, individualized

Sleep Issues

- Wake up later times of the day
- Keep resident awake in the day
- Medication/Behavior

Depression

- Provide reassurance and mental activities
- F757 and F758 Fail

PSA (Patient Selected Affect) Inappropriate فuncomprehensible language/lying/verbalizing

- Calmly speak to the resident and ask if words or phrases are comprehensible
- Encourage resident to take steps, deep-breathing, to ask about the resident's past experiences in the healthcare setting, to cope with such emotions
- Ignore any uncomprehensible statements of inappropriate behavior

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Your Subtopics Go Here

Documenting PD Psychosis Events

• First point of documentation is your assessment.
  • Then the daily documentation of the behaviors that the resident exhibits.
    – Include in the nurses notes:
      • Trigger of the behavior?
      • What occurred?
      • What intervention was done?
      • How did the resident respond to the intervention?
      • If the intervention didn't work what else was initiated?
      • Did it put the resident at risk for illness or injury?
      • Did it interfere with the resident’s care?
      • Did it interfere with the resident’s participation in activities or socialization?
      • Did it put others at risk for illness or injury?
      • Did it infringe on the privacy or activities of others?
      • Documentation that the physician and family were notified of new or worsening behaviors?
    – Daily documentation would also include the tracking sheet
Case Scenario

- Joe is a 76 year old gentleman who is residing in your facility due to a recent fractured hip. He also has Parkinson’s, Congestive Heart Failure (CHF) and High Blood Pressure. He has been in your facility for 2 weeks and his fracture is healing nicely. He is participating in therapies. Yesterday he refused to go to therapy because he thought they were trying to hurt him when they exercised his legs. He thought there were snakes on the walls in the therapy gym. (Pulley ropes).

- He is now refusing to go to therapy. He also has made comments about his wife having an affair since he was admitted. He refuses to see her or talk to her on the phone.

Case Scenario  Documentation & Intervention

- Issues: Hallucinations and Delusions causing potential self-harm due to rejection of therapy services and isolation from wife.
- Documentation would be done for both hallucinations and delusion
- It would reflect the frequency of the behaviors.
- Interventions and outcome would be documented.
  - Some interventions may include
    - Having conversations with Joe & family
    - Asking how he would like to have you intervene
    - Write the care plan with Joe & Family and have them agree with the plan
Care Plans

- **Focus:**
  - Resident focused
  - Include the behavior exhibited

- **Goal:**
  - Measurable – Ability to show if met or progress made

- **Interventions:**
  - What the resident wants done
  - Resident’s expectations
  - Specific to the focus
  - Directed to meet the goal
  - Contact the physician (supply with newest info of episodes)

  - **Type**
  - **Frequency**
  - **Severity**
  - Outcome of non-pharmacological interventions

Joe’s Care Plan

- **Focus:** I experience episodes of hallucinations and delusions such as seeing things that are not there and believing things that are not true.

- **Goal:** To lessen the severity of my reaction to the episodes

- **Interventions:**
  - Avoid confrontation, validate my experiences
  - Re-assure and distract me from my experiences
  - Anticipate safety issues (conceal harmful objects) if appropriate
  - Medication intervention

Summary

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Summary

• Educate your staff to recognize potential symptoms of PD Psychosis
• Initiate an assessment for new admissions or newly diagnosed residents with Parkinson’s Disease
• Create a Policy and Procedure for documentation and care planning
• Train your staff in handling the behavior episodes as directed by the resident and family

Resources

• https://www.michaeljfox.org/parkinsons-101?mclid=0c3b9792e3612d64ffae4ce579133e8
• https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/tc-20376055