Do You See What I See? Parkinson's Training

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1

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*

2

Disclosure

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

3

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.

 4

4

Review of Parkinson's Disease

 5

5

"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

6

6

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.

7

7

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**

 8

8

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)

 9

9

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

 10

10

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

 11

11

What is Parkinson's Induced Psychosis?

 12

12

13

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

14

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

15

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:

16

16

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 non-existent odors/scents
  - Somatic: Feeling as if a part of the body is changing or distorting

17

17

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

 18

18

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 care giver?

 19

19

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 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?

 20

20

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

 21

21

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

 22

22

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

 23

23

Common Interventions

 24

24

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,

 25

25

F757 and F758: Unnecessary Drugs and Psychotropic Drugs

How does CMS define unnecessary drugs?

Select Regulations	Intent of Regulations	CMS Guidance to Surveyors	For a Resident With Hallucinations and/or Delusions Related to Parkinson's Disease:
§483.45(d) Each resident's drug regimen must be free from **unnecessary drugs** §483.45(e)(1) Based on a comprehensive assessment of a resident, the facility must ensure that: Residents who have not used **psychotropic drugs** not receive these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record	To ensure each resident's medication regimen is managed and monitored to promote or maintain the resident's **highest practicable mental, physical, and psychosocial well-being** To limit the use of PRN psychotropic medications and ensure they are used only when medically necessary	The IDT is responsible for evaluating if a resident's symptoms are persistent or **clinically significant** enough to warrant initiation or continuation of a medication. The IDT must also understand whether a particular medication is clinically indicated to manage the symptom or condition. For psychiatric disorders, psychotropic medications may be effective when the underlying cause of a resident's distress has been determined, non-pharmacologic approaches to care have been ineffective, or expressions of distress have worsened. Psychotropic medications may be appropriate in specific enduring conditions such as chronic depression, PDP, or recurrent seizures. Other potential causes of symptoms must be ruled out and symptoms must be persistent and negatively affecting the resident's quality of life. The symptoms and goals of psychotropic therapy must be documented.	**When deciding if an antipsychotic medication is necessary for a resident with PDP, clinicians should ask themselves:** • Has PDP been documented in the medical record as the cause of the resident's hallucinations or delusions? • Are the resident's PDP symptoms clinically significant, causing functional decline or resident distress? • Have the goals of antipsychotic therapy for PDP been clearly identified and documented in the medical record? • Have non-pharmacologic approaches failed to manage the resident's PDP symptoms or are non-pharmacologic approaches clinically contraindicated or declined by the resident? • Is the prescribed medication clinically indicated to treat hallucinations and delusions associated with PDP? • Is the resident being monitored for any adverse consequences, specifically increased confusion or over-sedation? • Is the prescribed medication being used on a routine basis and not as needed?

 26

26

Behavior Interventions

Disease/ Symptoms	Interventions
Dementia	• Speak slowly and calmly • Simple and positive commands, Use gestures • Gentle touch • Approach patient from front • Concealed exits • Exercise, games, singing • Music, white noise, plants, animals, massage, aromatherapy
Paranoia / Hallucinations	• Avoid confrontation, validate their experiences • Re-assurance and distraction • Anticipate safety issues (conceal harmful objects)
Anxiety / Fear	• Place resident at a busy/high-traffic are • Scheduled events/individualized tasks/checks
Sleep Issues	• Wake up same time of the day • Keep occupied/awake in the day • Hallway/bathroom lights
Depression	• Provide Physical and mental activities • Increase socialization
PBA (Pseudobulbar Affect) Inappropriate uncontrollable laughing / crying/outbursts	• Calmly speak to the resident and ask if upset if experiencing uncontrollable crying or laughing • Encourage resident to take slow, deep breaths and try to relax until the episode passes. Have the resident change body position (standing when previously sitting down and vice versa) may also help them to cope with such attacks. • Ignore the uncontrolled outbursts of inappropriate behavior • Identify what the resident would like you to provide the resident when this happens – Remove from the situation, provide privacy, ignore it etc.

27

28

Diseases and Behaviors

Disease	Behaviors	Items to document on
Parkinson's	Depression Anxiety (general anxiety, social phobia, obsessive-compulsive disorder (over conscientiousness, repetition, disturbing thoughts, and cleanliness obsessions) and panic disorder Medication related hallucinations (psychosis) Cognitive impairment (some dementia- slowed thinking and mild impairment of executive function (difficulties in planning and set-switching)) and motivational decline. Pseudobulbar Affect (PBA)	HALLUCINATIONS DELUSIONS DIFFICULTY FALLING ASLEEP DIFFICULTY STAYING ASLEEP VERBAL AGGRESSION WANDERING PACING LACK OF INTEREST EXIT SEEKING ABNORMAL APPETITE
CVA / Stroke	Feelings of irritability, Forgetfulness, Carelessness or Confusion. Anger, Anxiety Depression Pseudobulbar Affect (PBA)	
Multiple Sclerosis	Grief & sadness Worry Fear Moodiness Irritability Anxiety Depression PBA Euphoria Sexual Disinhibition	GROWLING OR NON-VERBAL SOUNDS REPETATIVE CHANTING ATTENTION SEEKING Inappropriate uncontrollable CRYING/TEARFULNESS and / or LAUGHING
Traumatic Brain Injury	Decreased self-awareness Poor cognition / memory Executive dysfunction Anxiety Depression Lack of Empathy Irritability Socially Inappropriate Language PBA Striking out	SEEING/HEARING THINGS NOT THERE HOARDING PARANOIA RUMMAGING HITTING/KICKING BITING RESISTIVE TO CARE SELF INJURIOUS DESTRUCTIVE BEHAVIORS RESTLESSNES

29

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 intrude on the privacy or activities of others
    - Did it disrupt the care or living environment?
    - Documentation that the physician and family were notified of new or worsening behaviors?
  - Daily documentation would also include the tracking sheet

30

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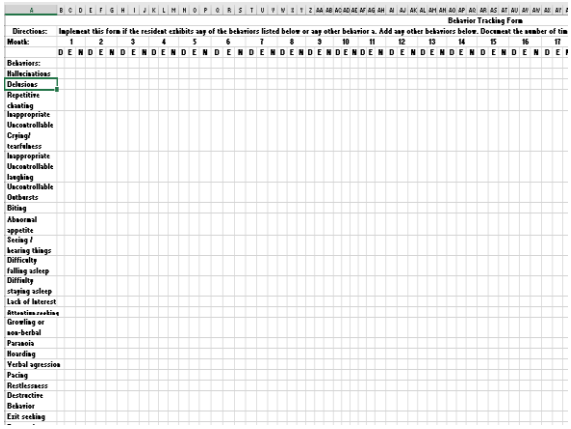

Behavior Tracking Form

Directions: Implement this form if the resident exhibits any of the behaviors listed below or any other behavior s. Add any other behaviors below. Document the number of tim

Month:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
	D E N	D E N	D E N	D E N	D E N	D E N	D E N	D E N	D E N	D E N	D E N	D E N	D E N	D E N	D E N	D E N	D E
Behaviors:																	
Hallucinations																	
Delusions																	
Repetitive cleaning																	
Inappropriate																	
Uncontrollable																	
Crying/ tearfulness																	
Inappropriate																	
Uncontrollable																	
laughing																	
Uncontrollable																	
Outbursts																	
Biting																	
Abnormal appetite																	
Seeing / hearing things																	
Difficulty																	
Falling asleep																	
Difficulty staying asleep																	
Lack of interest																	
Attention seeking																	
Growling or non-verbal																	
Paranoia																	
Hoarding																	
Verbal agression																	
Pacing																	
Restlessness																	
Destructive Behavior																	
Exit seeking																	

31

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.

 32

32

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

 33

33

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

 34

34

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 form my experiences
  - Anticipate safety issues (conceal harmful objects) if appropriate
  - Medication intervention

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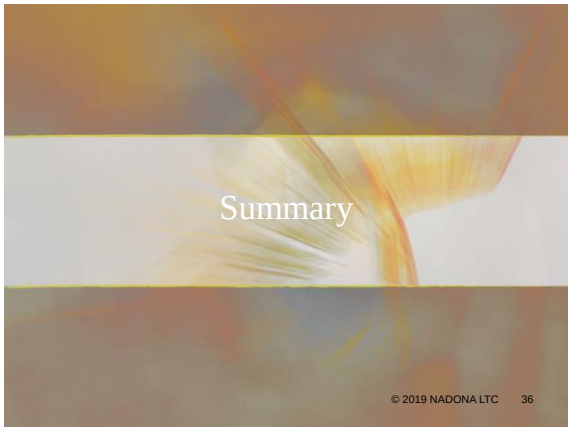
35



 36

36

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

 37

37

Resources

- https://www.michaeljfox.org/parkinsons-101?msclkid=d9c3b9792e36126b4ffae4ee579133d8
- https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/syc-20376055
- https://www.nuplazid.com/hallucinations-and-delusions?utm_source=bing&utm_medium=cpc&utm_campaign=Nuplazid%20DTP%20Unbranded%202019%20-%20Condition_BMM&utm_term=+Parkinsons%20+information&utm_content=Info%20Broad&gclid=CIDas_GzjeUCFQPYDQodwVoGtQ&gclsrc=ds
- https://movementdisorders.ufhealth.org/2011/09/29/parkinsons-treatment-tips-on-psychosis-and-hallucinations/

 38

38

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 39

39