NHS Grampian

Guidance For The Management of Behavioural and Psychological Symptoms of Dementia for Patients in a Care Home Setting

Co-ordinators:	Consultation Group:	Approver:
Medicines Management Pharmacists	See consultation list	Grampian Primary Care Prescribing Group

Signature:		Signature:
		

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* Changes marked should detail the section(s) of the document that have been amended i.e. page number and section heading.

Consultation Group List
Original Antipsychotic Short Life Working Group
Dr Robert Caslake (Consultant Medicine for the Elderly)
Anuj Dawar (Care Home Manager)
Lyn Irvine (Alzheimer Scotland Dementia Nurse Consultant)
Angela Macmanus (Principal Pharmacist Royal Cornhill Hospital)
Primary Care Prescribing Group
Beverley Robertson (Staff Nurse)

Contents

Guidance for the Management of Behavioural and Psychological Symptoms of Dementia in a Care Home Setting

1. Introduction

This document is intended to highlight best practice in the management of behavioural and psychological symptoms of dementia (BPSD), particularly 'stress and distress' for patients within a care home setting.

1.1 Patient Groups To Which This Document Applies

Patients with dementia experiencing symptoms of BPSD; principles from this document could be used to support individuals with dementia living in both care home and community settings.

1.2 Patient Groups To Which This Document Does Not Apply

This document is not intended for use with patients who have a co-morbid illness for which they are prescribed an antipsychotic e.g. schizophrenia.

2. Evidence Base

Analysis of National Therapeutic Indicators highlights that NHS Grampian is an outlier with regard to the prescribing of antipsychotics in patients aged ≥75 years. NHS Grampian prescribed 0.47% more antipsychotics to patients aged ≥75 years compared to the average across Scotland (3.29% vs. 2.82%) (Data January 2020 – March 2020).

The data in Figures 1 and 2 signifies an opportunity for review of prescribing practice within NHS Grampian.

***Figure 1**: National Therapeutic Indicator: patients aged ≥75 years prescribed an antipsychotic as a percentage of all patients aged ≥75 years (overview of all Health Boards).*

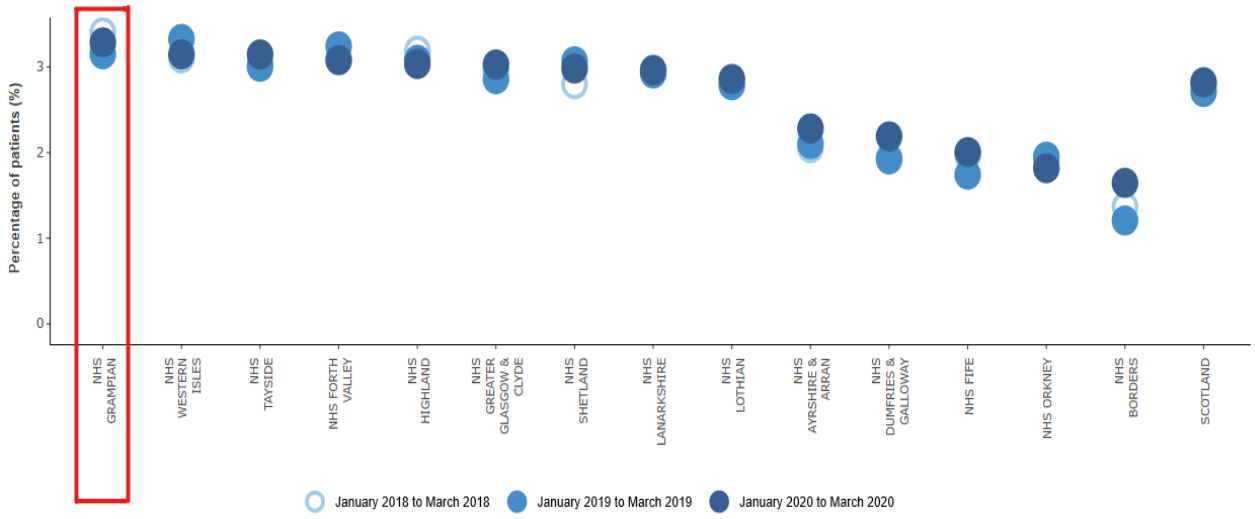
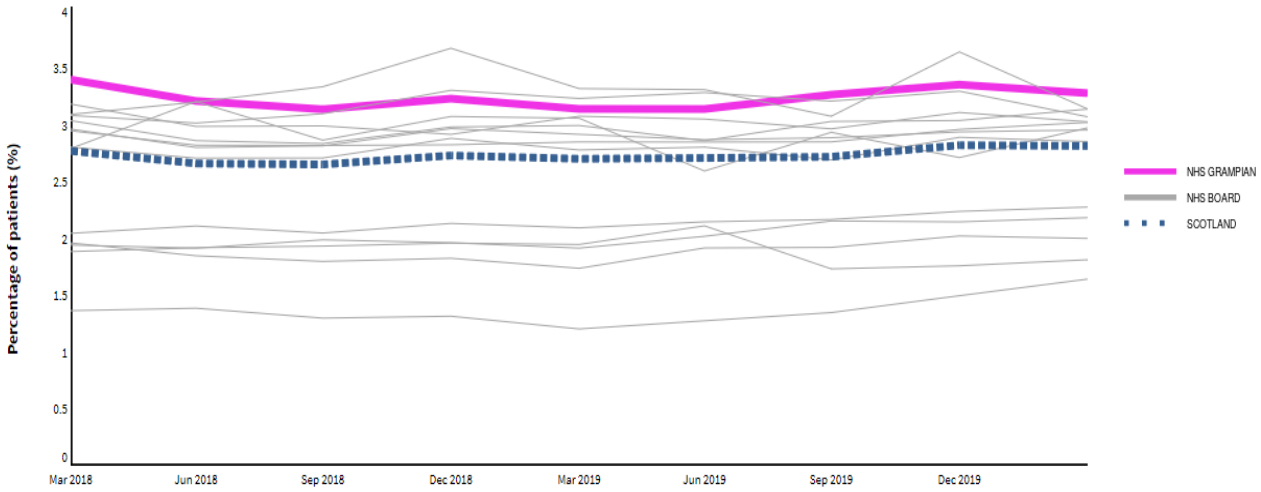


Figure 2: *National Therapeutic Indicator: comparison between NHS Grampian and Scotland; number of patients aged ≥75 years prescribed an antipsychotic as a percentage of all patients aged ≥75 years.*



Further analysis of NHS Grampian prescribing data highlighted that 28.88% of care home residents aged ≥65 years are prescribed an anti-psychotic. (Data January 2020 – March 2020).

Key facts:

- 90% of patients with dementia will experience BPSD as part of their illness. Often this 'challenging behaviour' is in an attempt to meet or express a physical or psychological need.[1]
- 'Challenging behaviour' associated with dementia should be managed in the first instance using *non-pharmacological measures*.[1, 2]
- Most BPSD can be improved within four weeks of making simple non-pharmacological changes and without the need for an antipsychotic e.g. treatment of pain, improved hydration, more social interaction etc.[3]
- Antipsychotic medicines have limited benefit in the treatment of BPSD and can potentially cause significant harm.
    - Antipsychotic use has been shown to be associated with a small increased risk of mortality and an increased risk of Transient Ischemic Attack (TIA) and stroke.[1,4]
    - Other significant risks include delirium, increased sedation and falls and all-cause mortality.[1]
    - In some patients, antipsychotics can worsen cognition and result in accelerated cognitive decline.[1]

3. Recommendations

3.1 Patient Centred Care of Dementia Patients

NICE suggests that a structured support tool can be used to document likes and dislikes, routines and personal history of a person living with dementia to enable person-centred care.[5] 'Getting to know me' is the nationally recognised document produced by Alzheimer's Scotland.

Use of these resources helps those caring for people with dementia to better understand each patient to enable the delivery of tailored care and can therefore help to reduce stress and distress and subsequent associated symptoms of BPSD for people with dementia.[6]

Prior to attempting to manage any perceived BPSD a complete and thorough assessment of the individual, 'problem', situation, environment and triggers must be undertaken and any subsequent mitigation of findings put in place.
Engagement and discussion with family members is imperative at each stage and throughout the care of patients with dementia.

3.2 Assessment of BPSD

Patients should be assessed and any possible reason(s) for BPSD established. This can include checking for and addressing any clinical or environmental causes (e.g. pain, delirium or inappropriate care).[5]

Some common causes which can be misdiagnosed as BPSD include:

- Pain or discomfort e.g. constipation, infection
- Hunger or thirst
- Lack of stimulation
- Environmental over stimulation e.g. noise, temperature, lighting
- Personal triggers e.g. personal care, sundowning, change in routine, change of caregiver
- Poor hearing/sight

An ABC chart (Appendix 1) is an observational tool used to collate information about a behaviour and can help to identify and understand what is trying to be communicated by the individual.

3.3 Non-pharmacological Management of BPSD

As initial and ongoing management, offer psychological and environmental interventions to reduce BPSD.[5]

Once BPSD have been confirmed and any reasons identified and mitigated for, any continuing / remaining BPSD should be managed in the first instance using non-pharmacological measures.[1, 2, 5] These should be tailored for each patient and will be unique depending on both the BPSD and the individual.

It is important that patients with dementia stay as active as they can – mentally, physically and socially. Activities encourage independence and promote confidence and self-esteem; helping to minimise boredom and frustration. The sense of purpose can help people with dementia feel less agitated and anxious.[7]

Activities may include:

- General day to day tasks
- Music therapy
- Art therapy
- Distraction techniques e.g. doll therapy and Twiddlemuffs (see NHS Grampian Twiddlemuff best practice guideline).

Further guidance on non-pharmacological management can be found on the Alzheimer's Scotland fact pages.

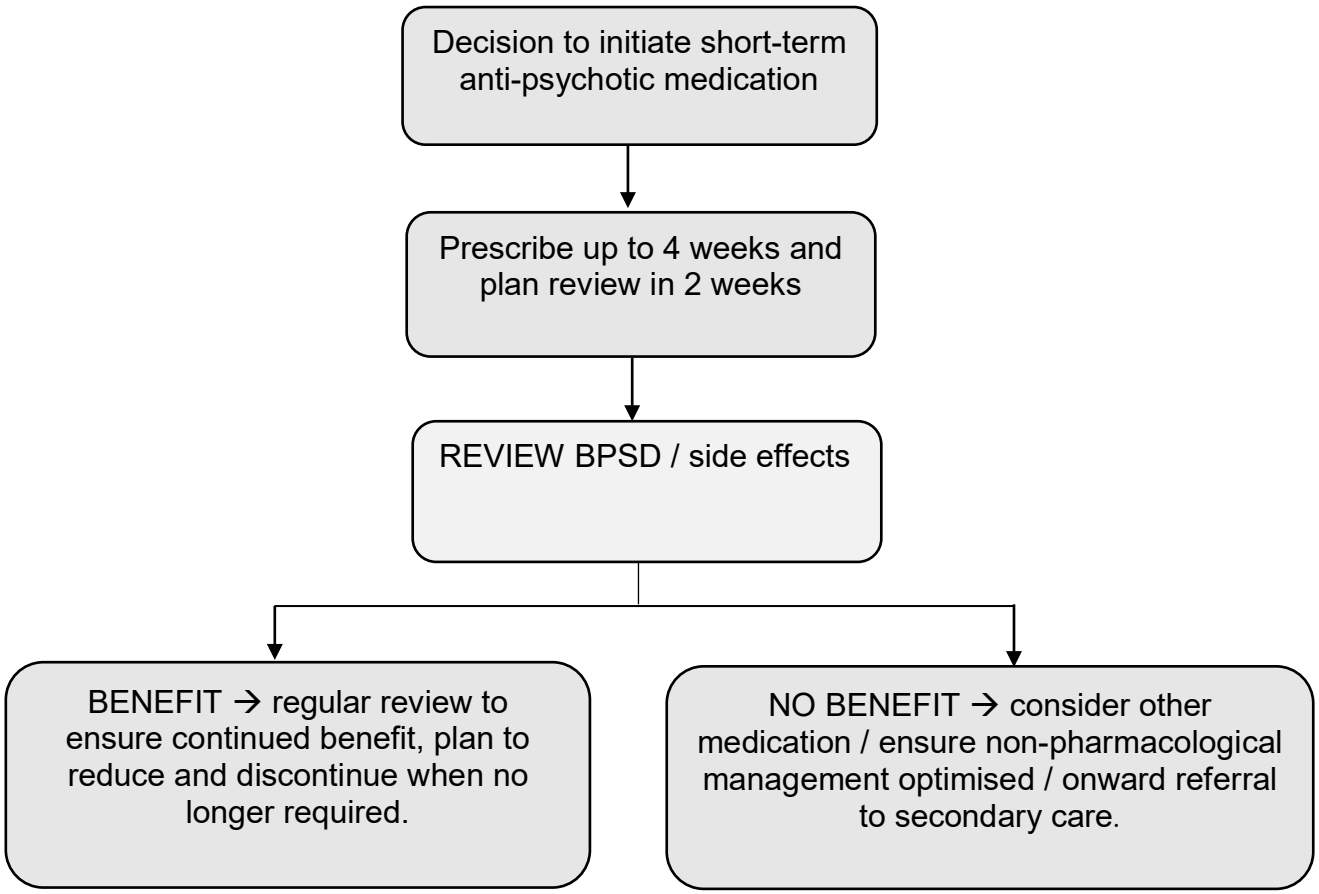
3.4 Pharmacological Management

When a patient's behaviour is severe, they present a risk to themselves/others or when non-pharmacological management has failed to achieve sufficient improvement in BPSD the initiation of pharmacological treatment could be considered.[1, 2, 5]

Risperidone is the only antipsychotic licensed for use in BPSD and is licensed for "short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia which has been unresponsive to non-pharmacological interventions and where there is a risk of harm to self or others".[8]

In practice, quetiapine is commonly prescribed off-label to treat BPSD.

For some patients, it may be appropriate to seek advice from secondary care mental health services prior to initiating treatment and/or if pharmacological measures prove ineffective.



Risperidone dosage information[8]

Starting dose of 250 micrograms twice daily is recommended. Dose can be increased in steps of 250 micrograms twice a day on alternate days if required; usual dose 500 micrograms twice daily.

Appendix 2 and 3 contain an "assessment and initiation" checklist and a "review" checklist to support the management of BPSD.

Patients who continue on long term antipsychotics for BPSD should be reviewed at least every 3 months.

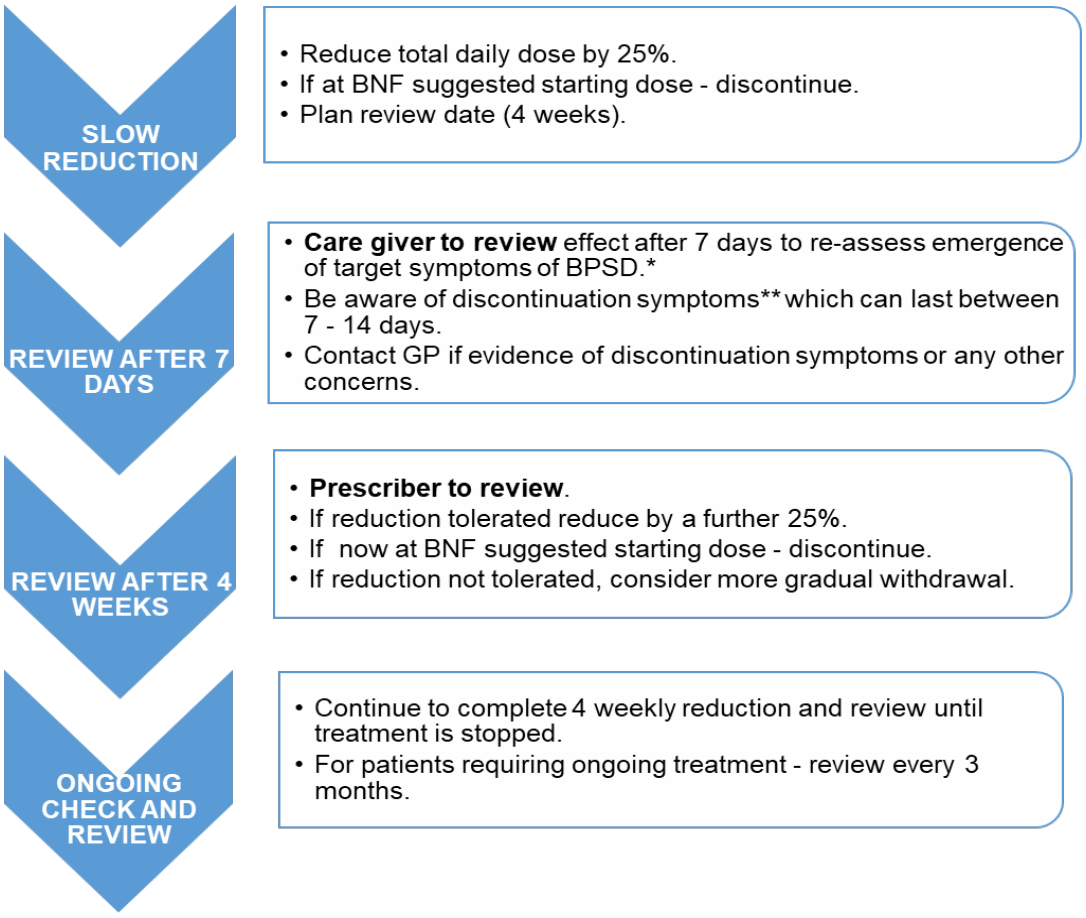
3.5 Stopping (de-prescribing) / Reducing Antipsychotics in Patients with Dementia

(Adapted from NHS Scotland Polypharmacy Guidance)

Reducing/stopping antipsychotic medicines must be carefully considered and planned to minimise any potential negative outcome(s) for patients, their families and carers.

Practical points

- Involve care home staff and family members from the outset and throughout. Utilise their knowledge of patient routine in order to formalise an initial and ongoing plan for the patient.
- Carefully plan the first dose reduction to align with the time of day when the patient is most settled e.g. if the most agitated time is the evening and more calm in the morning, then change the morning dose first.



*Where there is a re-emergence of BPSD refer to non-pharmacological management guidance to determine alternative measures that can be taken to support patients.

**Discontinuation symptoms include nausea, vomiting, anorexia, diarrhoea, rhinorrhoea, sweating, myalgia, paraesthesia, insomnia, restlessness, anxiety and agitation.

4 Additional resources

There are many resources available on the Grampian Guidance pages which may also help to support the assessment and care of patients with dementia.

5 References

(1) Howson, C, PrescQIPP NHS Programme. *Reducing Antipsychotic Prescribing in Dementia Toolkit.* London: PrescQIPP NHS Programme; 2014.
(2) Alzheimer's Society. *Drugs for behavioural and psychological symptoms in dementia. Factsheet 408LP.* London: Alzheimer's Society; 2017.
(3) Alzheimer's Society. *Changes in behaviour. Factsheet 525LP.* London: Alzheimer's Society; 2017.
(4) Scottish Government Polypharmacy Model of Care Group. *Polypharmacy Guidance, Realistic Prescribing.* 3rd edition. Edinburgh: Scottish Government; 2018.
(5) National Institute for Health and Care Excellence. *Dementia: assessment, management and support for people living with dementia and their carers.* London: NICE; 2018.
(6) Alzheimer's Scotland. *Understanding stress and distress in dementia: the importance of a person-centred preventative approach.* Edinburgh: Alzheimer's Scotland; 2018.
(7) Alzheimer's Scotland. *Activities a guide for carers of people with dementia.* Edinburgh: Alzheimer's Scotland; 2012.
(8) Joint Formulary Committee. *British National Formulary.* 79. London: BMJ Group and Pharmaceutical Press; 2020.

6 Distribution List

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Appendices

Appendix 1 - ABC chart

The ABC chart can be used to record behavioural concerns.

'A' stands for antecedents, that is, what occurs immediately before the behaviour you observe and can include any triggers, signs of distress or environmental information.

'B' refers to the behaviour itself and is a description of what actually happened or what the behaviour 'looked' like.

'C' refers to the consequences of the behaviour, or what happened immediately after the behaviour and can include information regarding other people's responses to the behaviour and the eventual outcome for the individual. It can also be a good idea to keep track of where and when the behaviour occurred to assist in identifying any patterns.

Example

Date	Time	Antecedents	Behaviour	Consequences	Other information
Friday 6th December 2013	*7.30am*	*Whilst giving her personal care*	*Mrs E started to shout and wave her hands at the carer*	*She stopped shouting and waving her arms when her regular carer came into the room and started to attend to her*	

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Date	Time	Antecedents	Behaviour	Consequences	Other information

Appendix 2 - Assessment and initiation checklist

Patient name	
Patient DOB	
GP name	
Date	
Reason(s) for need to complete assessment	*Include details of patients symptoms and behaviour*

Medication should not be issued without prior investigation into underlying causes and non-pharmacological interventions.

Underlying cause identification and mitigation

Has there been a full and thorough investigation of any underlying causes of BPSD? Complete details below. If "no" – do not proceed and refer to page 3 and Appendix 1 and/or Alzheimer's Society guidance	Yes / No
○ Pain ○ Environment (temperature, lighting) ○ Hunger/thirst ○ Change of carer ○ Time of day ○ Other……	Details:

Non pharmacological management

Have non pharmacological measures been put in place in an attempt to support/manage the BPSD? Complete details below. If "no" – do not proceed and refer to page 3 or Alzheimer's Scotland guidance	Yes / No
○ Day to day tasks ○ Art or music therapy ○ Twiddle muff/doll therapy ○ Reminiscence/life story work ○ Any other measures	Details:

Initiate antipsychotic medication? Yes / No

Drug	
Dose	
Review date	

When initiating an antipsychotic please consult and consider local and national guidelines in addition to licencing of medications.

Appendix 3 - Review checklist

Patient name	
Patient DOB	
GP name	
Date	

Review of BPSD

Has there been any change in BPSD since initiation of medication? Improvement or deterioration of BPSD? Emergence of other BPSD?	Yes / No
Details:	

Tolerability of medication

Has the patient experienced any side effects of medication?	Yes / No
Details: *Parkinsonism, falls, dehydration, LRTI*	

Ongoing non-pharmacological interventions

Has there been continued support for patient with non-pharmacological interventions?	Yes / No
Details:	

Ongoing management of medication

Medication should only be continued where there is marked clinical improvement in BPSD and with full considerations or risks vs benefits of ongoing treatment.

Stop medication Y / N	Reduce Y / N	Continue Y / N
Details:		
Review date (2-4 weeks)		

Note: antipsychotic medication used in BPSD should be used at the lowest dose possible for the shortest duration as possible.

A review date should always be set even if the decision is made to continue with medication.