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Compliance Monitoring

Compliance with this procedure will be against the Trust's agreed minimum requirement/standard as detailed within the Auditable Standards and Monitoring Arrangements

Guidance for the use of Antipsychotics for people with Dementia

1 INTRODUCTION

Many patients with a diagnosis of dementia will develop behavioural and psychological difficulties (BPSD) as the illness progresses. Symptoms include agitation, aggression, wandering, shouting and sleep disturbance. Non-drug strategies to manage these symptoms should be utilised first line, however it is acknowledged that in some cases antipsychotic drugs may need to be prescribed to reduce the suffering and distress of the patient.

The use of antipsychotic drugs in this patient group is associated with potentially serious adverse effects and an increased risk of cerebrovascular events and death (see Banerjee report), hence the need to have a clear rationale for prescribing, and regular review of the patient subsequently.

2 AIM

The aim of this guidance is to ensure North Essex Partnership University NHS Foundation Trust (NEP) staff are aware of the use of antipsychotics for people with dementia.

3 SCOPE

This guidance applies to all units/wards where a person with dementia is prescribed antipsychotics.

4 REFERENCES TO OTHER STANDARDS,POLICIES AND PROCEDURES

- NICE CG Dementia – supporting People with Dementia and their Carers in Health and Social Care 2006 amended March 2011
- The use of antipsychotic medication for people with dementia: Time for action Banerjee DH 12.11.2009

5 PROCEDURE

5.1 Assessment of the Patient before considering antipsychotic medication

5.1.1 The assessment should be within a multidisciplinary team, with a risk assessment and a care plan.

5.1.2 Consideration must be given to

- The patient's age
- The type of dementia (diagnostic assessment)
- Co-morbid psychiatric conditions
- Pre-existing physical health problems
- Current medication – review and rationalise
- Capacity and willingness to accept medication
- Drug and alcohol use
- Social circumstances
- Capacity to give consent to treatment- including best interest decisions taken in discussion with family and/or carers
- Other medications prescribed to the patient may influence their mental state and cognitive abilities. These should be considered, and appropriate adjustments made, before initiating treatment with an antipsychotic.

5.2 Indications for prescribing

5.2.1 If an antipsychotic drug is considered necessary to following should be followed:

- Antipsychotics should only be prescribed when:
  - Other causes of the symptoms (e.g. pain, delirium, agitated depression or anxiety) have been ruled out or treated but the symptoms persist
  - Behavioural symptoms are due to underlying mania or psychosis
  - Non-drug strategies and therapies have been tried and have not been effective
  - The symptoms are causing suffering or distress to the patient, or are causing danger to themselves or others.

- Antipsychotics should not be prescribed:
  - To routinely sedate the patient for ease of management
  - Because they were prescribed more than 3 months ago and have not been reviewed since.
  - Because they were prescribed by secondary care and the symptoms or circumstances in which they were prescribed no longer apply
  - Antipsychotics should only be prescribed with caution by a specialist for people with Lewy Body Dementia

5.3 Choice of antipsychotic

See Appendix 1

5.4 Prescribing for NEP inpatients (see also Appendix 2)

5.4.1 An assessment and a provisional diagnosis should be made as soon as possible after admission

5.4.2 All existing medication (both as prescribed and as actually taken) should be reviewed and rationalised where possible.

5.4.3 When other causes have been considered and treated and non-drug therapies have been tried, prescribe appropriate medication for BPSD at the lowest effective dose with a review date of not more than 2 weeks initially then 4-weekly intervals.

5.4.4 Care plans which include information about trigger factors, non-drug therapies and strategies, and plans for medication reduction or review should be revised regularly during the inpatient stay.

5.4.5 Discharge planning should include plans for reduction and/or discontinuation of antipsychotics (and benzodiazepines). This may not be at the time of discharge as the patient will need time to recover and to settle in their new environment or at home.

5.4.6 The carers or families of the patient should be involved in the discussion about treatment, and their comments taken into account.

5.4.7 Patients who leave inpatient care on antipsychotics (or benzodiazepines) but who do not have a long-term psychotic illness should have their medicines reviewed by the GP after discharge. The discharge letter should be clear about the discontinuation plan (Appendix 3). The care co-ordinator or the community team person assigned to the patient should follow up after 3 months to see whether the

discontinuation has happened, and contact the GP if not, and the consultant if necessary.

5.5 Prescribing for Community Patients

5.5.1 Carers or relatives should be invited to the appointment and involved in the medicines review if possible.

5.5.2 A clear record of medicines history including all medication that is actually taken and what is prescribed should be included in the outpatient letter to the GP.

5.5.3 Psychotropic medicines should be reviewed. A plan should be made for reduction in the community by the GP if appropriate

5.5.4 Recommendation should be made to the GP to review if non-psychotropic medicines are likely to be causing adverse effects (particularly increase in dementia and confusion, depression or pain, delirium, or psychotic symptoms or BPSD)

5.6 On-going Care of Patients Prescribed Antipsychotic Medication

5.6.1 Review:

- Every patient prescribed antipsychotic medication in this setting should have the treatment regularly reviewed. Consideration should be given to reducing or discontinuing the treatment, and the outcome of the review should be documented.

5.6.2 Reducing doses:

- The lowest effective dose should be prescribed. Reductions can be made in a stepwise manner depending on the drug and dose prescribed

5.6.3 Discontinuing treatment:

- If the antipsychotic has been prescribed for less than a month it can be stopped without tapering off.
- If the drug has been prescribed for between 1 and 3 months it can be tapered off over a period of 4 weeks. Smaller doses can be stopped in a shorter time.

- Patients who have been prescribed antipsychotics for longer than 3 months should have them withdrawn more slowly (for example 4-weekly). The dose can be halved for each step down to the lowest dose recommended before stopping. If withdrawal effects are observed the dose should stay the same for another month before review for further reduction.

- Sudden withdrawal can cause increased behaviour problems, nausea, sweating, acute anxiety, nightmares, and poor sleep.
- The patient should be regularly monitored for signs and symptoms of relapse or withdrawal effects.
- Ensure the plan is communicated to the service who will follow up the patient- i.e. the GP or community mental health service.

6 SUMMARY OF CHANGES

Date	Page Number(s)	Summary of Changes
December 2015	Entire Document	Re-formatted. Length of document shortened to focus on remit of antipsychotics in dementia
	3	Introduction and background information shortened
	5	Choice of antipsychotic moved to Appendices
		Removal of advice regarding non-antipsychotic medication in dementia
		Removal of prescribing in acute trusts and primary care sections- these organisations will follow their own guidelines
	9	Prescribing information reformatted into a flow chart
	8-11	Appendices rationalised and reduced in number

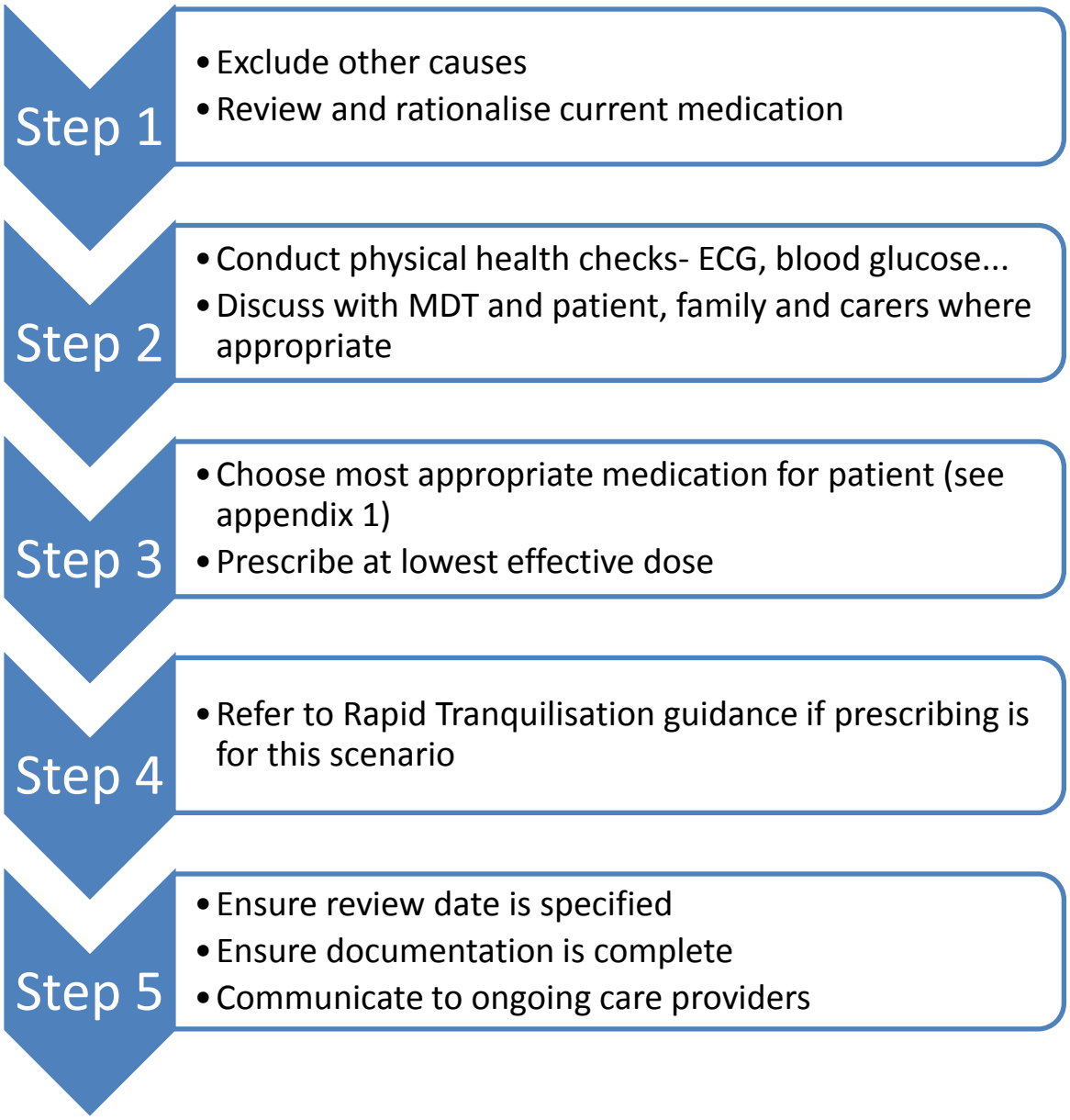
Appendix 1 –

Choice of antipsychotic for BPSD

Drug	Dose range	Comment
Risperidone	250 microgram – 1mg up to twice a day	Is licensed for use for people with dementia for up to 6 weeks. It has fewer side effects than the older antipsychotics. It does have significant anticholinergic effects at higher doses and should not be used for people with Parkinson's or Lewy body dementia. It affects blood sugars (caution with diabetes) and raised prolactin levels may cause osteoporosis.
Olanzapine	2.5-5mg daily in one or two doses	Unlicensed use. Less anticholinergic side effects, but may cause weight gain and blood sugar dyscrasias. Sedative. In older adults select a lower initial dose and gradual dose increase especially if female and/or a non-smoker.
Quetiapine	12.5-100mg daily in one or two doses	Unlicensed use, although considered the preferred drug in practice. Less anticholinergic side effects. May be used cautiously with parkinson's or Lewy body dementia. Less effect on weight, blood sugars and prolactin levels.
Aripiprazole	2.5-10mg daily in the morning	Unlicensed use. As for Quetiapine but less likely to cause drowsiness. Negligible effect on the QT interval, use a lower initial dose in older adults. May cause agitation in first 2 weeks.
Haloperidol	250 microgram – 1mg up to BD	Unlicensed use. Check ECG before using. Anticholinergic side effects (akathisia and stiffness). Do not use if patient has Parkinson's disease or Lewy body dementia. Note- only use this drug with extreme caution and in discussion with a specialist in dementia

Appendix 2 -

Flow chart for prescribing antipsychotics



Appendix 3 –

Sample GP letter for discharge from caseload

Dear Doctor,

I am writing to inform you that I am discharging patient *name* from my caseload. This patient is currently prescribed *antipsychotic name(s)* at dosage *dose and frequency* which was commenced on *date* for

Choose one of the following

1. Dementia with psychotic features
2. Dementia with aggressive behaviour which was unresponsive to other interventions

I would recommend discontinuation of *antipsychotic name(s)*

As *name of patient* had Dementia with *Choose one of the following:*

"psychotic features" or "aggressive behaviour" we would recommend that he/she is reviewed at the practice in 3 months. At that point it is recommended that a "best interests" assessment is made with regards to discontinuing the medication. Once it has been decided to discontinue the medication we would recommend a tapered withdrawal of the medication, requesting carers to contact your surgery if there is any acute deterioration associated with this. We would also recommend a patient review once the medication has been withdrawn. If in this particular case you have concerns then please do not hesitate to re-refer to us for supervision of the withdrawal.

Add other diagnosis details and care plan

Current medication for mental health

All other current medication

Changes that have been made during inpatient stay or at outpatient clinic.

Yours sincerely

Appendix 4 Managing behaviour problems in people with dementia - 24-hour sleep and activity chart

A record of when and how often behaviour problems occur may be helpful to all who support the patient in planning their care.
Please complete this chart and bring it to your next appointment or discuss it with

……..on (*date)*……..

Name of patient …….. Person completing ……

Key:

Active involvement in tasks/interests E

Restlessness, agitated A

Day & Date	8 am	9 am	10 am	11 am	12 am	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 pm	1 am	2 am	3 am	4 am	5 am	6 am	7 am

Please write any other comments overleaf