Good Practice Guidance 11: Treatment of the behavioural and psychological symptoms of dementia (BPSD) including the use of anti-psychotics. Guidance for care homes.

Key points:

- **Between 68% to 98% of dementia patients may also have behavioural and psychological symptoms of dementia (BPSD)**
- **There are risks associated with the use of anti-psychotics in dementia**
- **Before initiating anti-psychotics GPs should consider excluding other factors that may influence behaviour such as pain, infection or depression**
- **There are simple non-drug alternatives to anti-psychotics that may be appropriate including a simple clinical care plan that considers how carers can help support the resident and changes to the physical environment that may make a difference to a resident's behaviour**
- **Care home staff have a responsibility to ensure that any changes in behaviour are reported promptly to GPs**
- **If an anti-psychotic is prescribed it should be clear what symptoms are being treated, how long it will be used for and how often it will be reviewed**

Reducing the prescribing of anti-psychotics in dementia patients

Dementia is characterised by the increasing impairment of cortical function and between 68% and 98% of patients may also have behavioural and psychological symptoms of dementia (BPSD)[1]. **These include agitation, aggression, wandering, shouting, repeated questioning, sleep disturbance, depression and psychosis.**

These symptoms can cause significant distress and harm to patients and their carers and they reduce overall quality of life. Antipsychotics, such as **haloperidol, risperidone, olanzepine, amisulpiride, aripiprazole** and **quetiapine** have been used for many years to manage these symptoms but there is evidence nationally that these drugs are started too freely, their use is not adequately reviewed and they are not withdrawn as early as they could be.

In 2009 an independent review commissioned by the Department of Health concluded that antipsychotics continue to be over-prescribed in dementia and the government has pledged to reduce this prescribing by two thirds by the end of 2011[2]. The Dementia Action Alliance has called for all prescriptions for anti-psychotic agents used in dementia patients to be reviewed by March 2012.

There are risks associated with the use of antipsychotics in dementia. These include:

1. **Risk of stroke**.
The Department of Health report[2] found that for every 1000 patients with the behavioural and psychological symptoms of dementia who had taken an antipsychotic for 12 weeks, an additional 18 may suffer a stroke or similar due to having taken the antipsychotic half of which will be severe.

2. **Increased risk of death**.
The Department of Health report found that for every 1000 patients with BPSD who take an antipsychotic for 12 weeks an additional 10 people may die due to having taken the antipsychotic. This number may increase to 167 over a 2 year treatment period[2].

3. **Effect on brain function**.
Antipsychotic use has been found to have a negative effect on mini mental state examination.

However, the use of antipsychotics to treat the behavioural and psychological symptoms of dementia (BPSD) may be appropriate.

BPSD can be disruptive and dangerous so antipsychotics may be considered if:

1. The patient is in severe distress[2].
2. There is an immediate risk of harm to the patient or others.
3. There are severe non-cognitive symptoms such as psychosis[3].

The only anti-psychotic medication which is licensed for BPSD is **risperidone** which is licensed for short term (≤ 6 weeks) treatment of persistent aggression in patients with moderate to severe Alzheimer's dementia.

The lowest effective dose should be used for the shortest possible time (ideally less than 12 weeks).

Treatment should be reviewed ideally monthly, but at least every 3 months.

In half of all cases of BPSD the symptoms may be self limiting, i.e. they may resolve without treatment so non-drug approaches should be considered first.

Watchful waiting is a process over four weeks involving ongoing assessment of contributing factors and simple non-drug treatments. The first approach for behavioural and psychological symptoms is to develop a **simple clinical care plan** for simple non-drug treatments based on person-centred care, designed around personal needs, abilities and interests. Soothing and creative therapies may be helpful.

Simple non-drug treatments care homes can try might include:

- developing a life story book,
- frequent, short conversations (as little as 30 seconds has proven effective),
- using personal care as an opportunity for positive social interaction**.**

Other things to consider within a clinical care plan include[4]:

- Do the carers understand how the resident is feeling? Are plans based on the resident's point of view?
- What are the resident's preferences and opinions? Consider their relationships with others.
- How are these supported?
- Do the carers help the resident to feel socially confident and not alone?
- How is the resident included in conversations and care?
- How are they shown respect, warmth and acceptance?
- Are the resident's fears recognised and addressed?
- What are their life history, culture and interests?
- Do they have any sensory problems (e.g. with hearing or sight)?
- Do they have communication problems?
- Do they have any physical needs or mobility issues?
- Have carers considered ways to help them with perceptual or memory problems?

It is also important to consider the person's environment and how it might affect them. Key questions to ask are[4]:

- If the resident is being cared for in a bed or chair, are they comfortable and free of pressure sores?
- Is the TV or radio playing something that the resident can relate to and enjoy?
- If the resident is mobile, can they move around freely and have access to outside space?
- Does the resident recognise the environment as home? Does it contain things to help them feel at home?
- Could assistive technology be used to improve freedom or safety?
- Does the resident have the correct eye glasses, and are they clean?
- Is their hearing aid turned on and working correctly?
- Is it too hot or too cold?
- Is the resident hungry? People may forget to eat.

It is important that all staff who are caring for these residents receive comprehensive training on supporting with dementia. This should include:

- General dementia awareness
- How to communicate with people with dementia
- Supporting residents with challenging behaviour

There are many examples of good practice in managing people with dementia and often simple skills make a significant difference to patient care. For example, if carers carrying out basic tasks can introduce themselves to the resident and explain clearly what they are going to do before they do it; this may reduce anxiety and agitation.

Getting to know your residents and understanding why they may be behaving in certain ways will often give clues as to how to manage their behaviour. There have been examples of residents who were used to shift patterns wandering early in the morning and understanding this behaviour and putting strategies in place to manage it may reduce the likelihood of anti-psychotics being prescribed.

There are a wide range of resources available to care homes around interventions to reduce the behavioural symptoms associated with dementia. More information is available from http://www.alzheimers.org.uk/bpsdguide

What can care homes expect from a GP, with the support of care home staff, who is caring for a resident with BPSD?

A GP is asked to consider the following points, with care home staff before prescribing antipsychotics for residents with dementia:

- They should initially consider other factors which may influence behaviour such as medical problems e.g. pain or infection, psychosocial factors, side effects of medication, alcohol withdrawal or changes in environment.
- They should treat any causative problems such as depression, anxiety, infection, insomnia then consider non-drug approaches which could include changes to environment, activities, music or aromatherapy.
- They should avoid using antipsychotics for mild to moderate symptoms.
- They are reminded to consider other drug options such as anti-depressants, and short term use of lorazepam.
- There should be a full discussion with the person with dementia and/or family and carers about the possible benefits and risks of treatment. In particular cerebrovascular (stroke) risk factors should be assessed and the possible increased risk of stroke/transient ischaemic attack and possible adverse effects

on cognition discussed. The National Prescribing Centre (NPC) produce a decision aid which may help in discussions.

- The choice of antipsychotic should be made after considering the risks and benefits of treatment for an individual patient with **risperidone** being the first line choice.
- The dose should be low initially and then reviewed upwards if necessary.
- Treatment should be for a certain length of time and should be regularly reviewed (at least every 3 months).
- Target symptoms should be identified, quantified and documented and changes in these symptoms should be assessed and recorded at regular intervals. Care home staff should be able to assist with this by documenting changes in a resident's care plan and communicating these with the GP.

Things to consider for your residents with dementia who display signs of BPSD or are taking an anti-psychotic:

- Have other causes of distress been considered, such as pain/discomfort, infection or constipation?
- Would the resident benefit from any of the many non-drug interventions that are available such as those listed above?
- Have you considered implementing a clinical care plan including the questions listed above?
- Have you considered the resident's physical environment – refer to the questions listed above?
- What symptoms are the anti-psychotic being used to treat? Have any changes in the frequency or severity of these symptoms been reported to the relevant healthcare professional?
- Has there been a change in circumstances for a resident? For example are they now more settled in the home and if any symptoms have lessened would a trial without anti-psychotics now be appropriate?
- Have they had a recent review of their anti-psychotic medication by the GP?
- Good practice may include keeping a register of all residents with dementia who are prescribed an anti-psychotic and recording the date of any reviews. This could also include flagging to GPs when a three monthly review is due.
- It is important if a resident with dementia is transferred to another care setting that a comprehensive description of any behaviour management strategies goes with them (this may include admission into hospital or transfer to another home).

References:

1. Regional drugs and therapeutics centre safer medication use: Antipsychotic use in the elderly with dementia September 2010

2. The Department of Health. The use of antipsychotic medication for people with dementia: Time for action. A report for the Minister of State for Care Services by Professor Sube Banerjee. November 2009
3. NICE CG 24 Dementia 2006
4. Alzheimer's Society. Optimising treatment and care for behavioural and psychological symptoms of dementia. A best practice guide for health and social care professionals. July 2011.

Further Information

- Further information on managing medicines in care homes is available in Outcome 9 of the CQC Essential Standards of Quality and Safety.

- Further information on The handling of medicines in Social Care' can also be found on the Royal Pharmaceutical Society website: www.rpharms.com

- The Nursing and Midwifery Council (NMC) provides guidance and advice on a number of topics which is available on their website; www.nmc-uk.org including;
  - The code: Standards of conduct, performance and ethics for nurses and midwives
  - Standards for medicines management

The above links are made available solely to indicate their potential usefulness to users. The user must use their own judgment to determine the accuracy and relevance of the information they contain.

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