# Management of Behavioural and Psychological Symptoms of Dementia

## Document Description

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Guideline</th>
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<tbody>
<tr>
<td>Service Application</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Version</td>
<td>1.0</td>
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</tbody>
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## Lead Author(s)

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
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<tbody>
<tr>
<td>Dr. Rizvi</td>
<td>Lead for Dementia</td>
</tr>
<tr>
<td>Grace Tsang</td>
<td>Deputy Director of Pharmacy</td>
</tr>
</tbody>
</table>

## Change History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>1.0</td>
<td>June 2011</td>
<td>New treatment guideline</td>
</tr>
</tbody>
</table>

## Links with External Standards

- CQC Essential Standard for Quality and Safety outcome 9
- Mental Capacity Act 2005
- Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
- NICE Clinical Guidance 42

## Key Dates

<table>
<thead>
<tr>
<th></th>
<th>DATE</th>
</tr>
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<tbody>
<tr>
<td>Ratification Date</td>
<td>July 2011 TMB 110/11</td>
</tr>
<tr>
<td>Review Date</td>
<td>July 2013</td>
</tr>
</tbody>
</table>
**Executive Summary Sheet**

<table>
<thead>
<tr>
<th>Document Title:</th>
<th>Management of Behavioural and Psychological Symptoms of Dementia</th>
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</thead>
</table>

**Please Tick (☑ ) as appropriate**

- This is a new document within the Trust  
- This is a revised Document within the Trust

**What is the purpose of this document?**

The aim of this guideline is to give clear and direct guidance to members of staff in management of behavioural and psychological symptom of dementia in patients with dementia within the trust and following discharge from hospital.

**What key Issues does this document explore?**

This guideline follow the specific recommendation of NICE Clinical Guidance 42 relating to pharmacological interventions for non-cognitive symptoms and behaviour that challenges

**Who is this document aimed at?**

Walsall Healthcare NHS Trust is committed to ensuring the medicines given are appropriate and person-centred to patients with dementia whilst in the hospital and following discharge from hospital. The use of pharmaceutical interventions for behavioural and psychological symptoms of dementia should be managed according to the relevant recommendations from NICE.

**What other policies, guidance and directives should this document be read in conjunction with?**

- Medicines Policy
- Safeguarding Adult Policy

**How and when will this document be reviewed?**

Every three years by the Deputy Director of Pharmacy or a suitably appointed individual by the Director of Pharmacy.
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1. Introduction

Walsall Healthcare NHS Trust is committed to ensuring the medicines given are appropriate and person-centred to patients with dementia whilst in the hospital and following discharge from hospital. Patients with a formal diagnosis of dementia who develop non-cognitive symptoms or behaviour that challenges should only be offered a pharmacological intervention according to relevant NICE recommendations in Clinical Guidance 42.

2. Scope

The aim of this guideline is to give clear and direct guidance to members of staff in management of behavioural and psychological symptoms of dementia in patients with dementia admitted to the Trust and following discharge from hospital.

This guideline applies only to patients who have a formal diagnosis of dementia.

This guideline does not include any diagnosis guidance for dementia.

3. Statement of Intent

To ensure the appropriate and safe prescribing of antipsychotic medication in management of behavioural and psychological symptoms of dementia. To ensure the appropriate and safe prescribing of antipsychotic medication in patients with a formal diagnosis of dementia following discharge from the hospital by effective communication to primary care or other secondary care providers.

4. Clinical Guideline(s)

This guideline applies only to patients who have a formal diagnosis of dementia. This guideline does not include any diagnosis guidance for dementia. Only specialists caring for patients with dementia can initiate treatment for Alzheimer’s disease. Exhibition of non-cognitive symptoms do not indicate diagnosis of dementia. Diagnosis of dementia must be carried out by trained specialists. Memory assessment services should be the single point of referral for all people with a possible diagnosis of dementia.

Delirium (sometimes called ‘acute confusional state’) is a common clinical syndrome and is different from BPSD. It is characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course. It usually develops over 1–2 days. It is a serious condition that is associated with poor outcomes. However, it can be prevented and treated if dealt with urgently. A person may already have delirium when they present to hospital or long-term care or it may develop during a hospital admission.1

People with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviour that challenges should be offered an assessment at an early opportunity to establish likely factors that may generate, aggravate or improve such behaviour. The assessment should be comprehensive and include:

- the person’s physical health
- other mental health problems such as depression
- possible undetected pain or discomfort
- side effects of medication
- individual biography, including religious beliefs and spiritual and cultural identity
- psychosocial factors
- physical environmental factors
- Behavioural and functional analysis conducted by professionals with specific skills, in conjunction with carers and care workers.
Behavioural and Psychological Symptoms of Dementia (BPSD)

Behavioural and psychological symptoms of dementia refer to the often distressing non-cognitive symptom of Dementia and include agitation and aggressive behaviour. BPSD have been defined as symptom of disturbed perception, thought content, mood or behaviour, frequently occurring in patients with Dementia. Other common terms in use for these symptoms include neuropsychiatric symptoms of Dementia, behaviour that challenges or non-cognitive symptoms of Dementia.

The Spectrum of BPSD includes

- Aggression
- Agitation or restlessness; screaming
- Anxiety
- Depression
- Psychosis; delusions and hallucinations
- Repetitive vocalisation, cursing and swearing
- Sleep disturbance
- Shadowing (following the carer closely)
- Sun downing (behaviour worsens after 5 pm)
- Wandering
- Non specific behaviour disturbance e.g. hoarding

Table 1: Assessment of patient with non-cognitive symptoms

Assess patient early to identify factors that may influence behaviour. Include:-

<table>
<thead>
<tr>
<th>Physical Health</th>
<th>Suitable physical examination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any acute medical problems i.e. delirium</td>
</tr>
<tr>
<td></td>
<td>Exclude infection (especially UTI)</td>
</tr>
<tr>
<td></td>
<td>Exclude possible undetected pain or discomfort</td>
</tr>
<tr>
<td></td>
<td>Is patient dehydrated?</td>
</tr>
<tr>
<td></td>
<td>Any chronic disease that may have become unstable or relapsed?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Assess for anxiety and depression</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Side-effects of medication</th>
<th>What medication is the patient receiving?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assess for side-effects of medication (including acetylcholinesterase inhibitors).</td>
</tr>
<tr>
<td></td>
<td>Has any new medication recently been started?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychosocial factors</th>
<th>Individual biography</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Religious beliefs, spiritual and cultural identity</td>
</tr>
<tr>
<td></td>
<td>Against whom is the aggression directed? Is there a reason?</td>
</tr>
<tr>
<td></td>
<td>Physical environmental factors</td>
</tr>
<tr>
<td></td>
<td>Is the patient bored?</td>
</tr>
<tr>
<td></td>
<td>Behavioural and functional analysis in conjunction with carers and care workers</td>
</tr>
</tbody>
</table>

Management of BPSD –In General Hospital Setting

Prerequisite in management of Behavioural and Psychological Symptoms in patients with Dementia in General hospital is to identify the problem. Specialist Mental Health Services input is indicated particularly where clinical presentation can be Delirium in Dementia or in certain instances to differentiate between Dementia, Delirium and Depression.

Missed diagnosis rates for Delirium of 32-67 % (1) and for cognitive impairment of 55 % (2, 3) are typical examples. Follow flowchart 1 for the principle in management of BPSD.
Flow chart 1 - Principles in management of BPSD

Any acute change in behaviour in elderly
MUST RULE OUT DELIRIUM OR PHYSICAL HEALTH PROBLEMS

Risk Factors for Delirium
- Age 65 years or older
- History of dementia or delirium
- Current hip fracture
- Severe illness
- Polypharmacy

Symptoms of Delirium
- Sudden change in behaviour
- Increased confusion recently
- Fluctuant symptoms
- Disorders of thinking
- Altered attention span
- Altered level of consciousness

Rule out each of the common cause of delirium
- PAIN treat pain accordingly
- MEDICATION review medications
- INFECTION treat infection
- CONSTIPATION treat constipation
- DEHYDRATION treat dehydration
- ENVIRONMENT review environmental trigger factors

If delirium suspected, follow flowchart 2 for prevention and diagnosis of Delirium
If there is difficulty distinguishing between the diagnoses of delirium, dementia or delirium superimposed on dementia, treat for delirium first.

If delirium ruled out, use non-pharmacological interventions as first line intervention for BPSD

Only use pharmaceutical intervention as the last resort.
Warning: Avoid Antipsychotic medication in all patients with Dementia with Lewy Bodies (DLB) or Parkinson’s Disease Dementia.
Refer to Appendix 1 for antipsychotics in dementia checklist.
Print and record the assessment in medical notes

Treat delirium according to flowchart 3 treatment of Delirium
Use non-pharmacological interventions as first line and only use pharmaceutical intervention as last resort.

Consider referral to Mental Health team if experiencing difficulties in managing BPSD or delirium
Flowchart 2 - Preventing and Diagnosing Delirium

Person presents at hospital or long-term care

Has person any of the following risk factors?
- 65 years or older
- Cognitive impairment and/or dementia (1)
- Current hip fracture
- Severe illness (2)

Yes

At risk

No

Yes

Change in risk factors?

Not at risk

Has person any indicators of delirium? These are recent (within hours or days) changes in:
- Cognitive function
- Perception
- Physical function
- Social behaviour

These may be reported by the person at risk, or a carer or relative.
Be particularly vigilant for signs of hypoactive delirium

Daily observations for indicators of delirium

No

No

Assess for clinical factors contributing to delirium within 24 hours
Provide multicomponent intervention tailored to person’s needs and care setting delivered by a multidisciplinary team trained and competent in delirium prevention.
Ensure that people are cared for by a team of healthcare professionals familiar to them
Avoid moving people within and between wards or rooms unless necessary

(1) If cognitive impairment is suspected, confirm using a standardized and validated cognitive impairment measure. If dementia is suspected, refer to ‘Dementia: Supporting people with dementia and their carers in health and social care’ (NICE clinical guideline 42).
(2) For further information on recognising and responding to acute illness in adults in hospital see ‘Acutely ill patients in hospital’ (NICE clinical guideline 50).
(3) A healthcare professional trained and competent in the diagnosis of delirium should carry out this assessment.

Daily observations for indicators of delirium

Carry out clinical assessment based on DSM-IV or short CAM to confirm the diagnosis. In critical care or in the recovery room after surgery, CAM-ICU should be used (3)

Delirium diagnosed? If difficulty distinguishing between delirium, dementia or delirium with dementia, treat for delirium first

Yes

Record diagnosis in the person’s hospital record and primary care health record

Treatment

No

No

(people at risk of delirium)

(Treatment)
Management of Delirium

In people diagnosed with delirium, identify and manage the possible underlying cause or combination of causes. Ensure effective communication and reorientation and provide reassurance for people diagnosed with delirium. Consider involving family, friends and carers to help with this. If patient with delirium is distressed or considered a risk to themselves or others and verbal and non-verbal de-escalation techniques are ineffective or inappropriate, consider giving short-term (usually for 1 week or less) haloperidol or olanzapine. Start at the lowest clinically appropriate dose and titrate cautiously according to symptoms.

Flowchart 3 – Treatment of Delirium

1. Identify and manage underlying cause or combination of causes
   - Ensure effective communication and reorientation, provide reassurance
   - Consider involving family, friends and carers to help with this

2. Ensure that people are cared for by a team of healthcare professionals familiar to them
   - Avoid moving people within and between wards or rooms unless

3. Delirium symptoms not resolved
   - Is person distressed or considered a risk to themselves or others?
     - Distress may be less evident in people with hypoactive delirium

4. No
   - Use verbal and non-verbal techniques (8) to de-escalate situation if appropriate

5. Delirium symptoms not resolved
   - Consider short-term (usually 1 week or less) Haloperidol(4) or Olanzapine(4)
   - In people with conditions such as Parkinson’s disease or dementia with Lewy bodies(10) use antipsychotics with caution or not at all

6. Delirium symptoms not resolved
   - Re-evaluate for underlying causes
   - Follow up and assess for possible dementia(5)

(4) Haloperidol and Olanzapine do not have UK marketing authorization for this indication
(5) For more information on dementia see ‘Dementia’ (NICE clinical guideline 42)
Pharmacological Management BPSD

For Patients with established Diagnosis of Dementia who are already on regular Antipsychotics when admitted to General Hospital
In this group of patients, the best practise approach would be:
1. Do not stop the prescribed regular antipsychotic suddenly unless there is any medical contraindication. Follow the continuation plan as advised by the specialist services.
2. At the point of admission, contact patients GP to clarify details of when, why and who initiated the regular antipsychotic.
3. If initiated by Secondary Specialist Older Adults Mental Health Services, inform the respective Older Adults Mental Health team to take advice on continuation of the prescribed antipsychotic on discharge.
4. If the regular antipsychotic was prescribed by GP, clarify why and when it was initiated as soon as possible. Recommend the GP to request Specialist Older Adult Mental Health Services to review its continuation following discharge.

For Patients with Diagnosis of Dementia where Regular Antipsychotic initiated in the General Hospital set up
In this group of patients it is advisable that regular antipsychotics are initiated only following assessment and advice of secondary specialist older adult mental health services or suitable trained care of elderly consultants. Follow the continuation plan as advised by the specialist services.

Antipsychotics if initiated for patients with Delirium
In this group of patients it is expected that low dose antipsychotic dose is only continued for the short period (7 days), as the Delirium aetiology is evaluated and addressed.

Target Symptom Group
While the physical health aspects are addressed behavioural problems remain unresolved, it’s important to identify the dominant target symptom group. Please refer to Appendix 2 for details of dominant target symptom group.

Non-Pharmacological Management of BPSD
Non-pharmacological treatment must be used as first line management of BPSD. Verbal reassurance and non-verbal de-escalation techniques should be tried first. Drug therapy should only be used if patient is considered a risk to themselves. For details of non-pharmaceutical management of BPSD, please refer to Appendix 3.

Risk of antipsychotics in patient with dementia
The use of either typical or atypical antipsychotics in patients with Dementia worsens cognitive function, increases the risk of cerebrovascular events (3 times) and increases mortality rate (2 times). They should only be used after full discussion with the patient (where the patient has capacity to understand) and carer(s) about the possible benefits and likely risks. Risk is likely to increase with increasing age and if other risk factors for cerebrovascular events are present e.g. diabetes, hypertension, cardiac arrhythmias, smoking and existing evidence of stroke or vascular Dementia.
**General guidelines if pharmacological treatment is indicated**

Non–pharmacological treatment must be trialled first before considering drug therapy. All major guidelines recommend psychosocial interventions should be the first line intervention. Prescribing of antipsychotics should only be the last resort and should be limited to short term treatment only. If antipsychotic treatment is considered necessary, print and record the antipsychotics in dementia checklist in medical notes.

Avoid prescribing of typical antipsychotics, e.g. haloperidol or promazine in patients with known dementia. Start atypical antipsychotics at low doses (usually 50% of normal elderly dose) and increase every 2-4 days if no response.

For other symptoms, drugs are used which have either been shown to improve these symptoms in subjects without Dementia or are licensed for Cognitive enhancement in patients with Dementia. In the event of continuing problems advice can be obtained from community mental health team.

<table>
<thead>
<tr>
<th>Neuroleptic Drug</th>
<th>Starting Dose</th>
<th>Optimum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone</td>
<td>250 microgram twice a day</td>
<td>500 microgram twice a day</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>25mg at night</td>
<td>25-50mg at night</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>2.5mg at night</td>
<td>5-10 mg at night</td>
</tr>
</tbody>
</table>

Risperidone is licensed for the short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others. See Table 2 for baseline measurements required before initiating risperidone. If baseline measurements are not carried out before initiating risperidone and a side-effect develops it will be difficult to decide whether the effect was due to risperidone or if it was already there.

**Table 2: Baseline measurements before initiating risperidone**

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Baseline</th>
<th>After initiation of risperidone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body weight</td>
<td>Yes</td>
<td>at 3 months then yearly</td>
</tr>
<tr>
<td>Serum U+Es</td>
<td>Yes</td>
<td>yearly</td>
</tr>
<tr>
<td>FBC</td>
<td>Yes</td>
<td>yearly</td>
</tr>
<tr>
<td>Plasma glucose</td>
<td>Yes</td>
<td>at 4 – 6 months then yearly</td>
</tr>
<tr>
<td>LFTs</td>
<td>Yes</td>
<td>yearly</td>
</tr>
<tr>
<td>Prolactin</td>
<td>Yes</td>
<td>at 6 months then yearly</td>
</tr>
<tr>
<td>Blood pressure and pulse</td>
<td>Yes</td>
<td>monitor frequently during dose titration then monitor after dose changes and if there is evidence of other risk factors such as relevant personal/family history, co-prescription of drugs that prolong QT interval or lower potassium</td>
</tr>
<tr>
<td>ECG</td>
<td>Yes</td>
<td>measure again only if Neuroleptic Malignant Syndrome suspected</td>
</tr>
<tr>
<td>Creatinine phosphokinase</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

**Treatment Review and Duration**

For patients newly initiated with antipsychotics for BPSD and who respond to treatment, their antipsychotic should be cautiously withdrawn after 6 weeks. The dose of atypical antipsychotic should be reduced by 50% for one week and if there are no re-emerging symptoms then stop the drug. Review gain after one week. If symptoms re-emerge reintroduce the drug at starting dose. BPSD can persist and treatment with atypical
antipsychotics may be needed in the long term but must be reviewed and documented on a 3 monthly basis.

**Discharge Planning for Patients Newly Initiated with Antipsychotics**

For patients who are newly initiated with antipsychotics for BPSD, the prescribers in secondary care have a responsibility to ensure that antipsychotic prescriptions are reviewed within 6 weeks. The need for a review must be communicated to the patient’s GP in writing (electronic discharge summary or clinic letter) and to one other person as deemed appropriate (the patient themselves, or a primary carer, care home manager etc).

The following standard statement must be stated in the individual patient’s electronic discharge summary or clinical letter.

<table>
<thead>
<tr>
<th>Management Plan</th>
<th>Antipsychotic - newly initiated for BPSD. Dominant symptoms are ...................... GP please review the on-going need according to guideline within 12 weeks (or 6 weeks in case of risperidone) from initiation for dose reduction or discontinuation of antipsychotic.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information to Patient/Relative</td>
<td>(Insert drug name here) - newly initiated for managing your symptom. Your GP should review your antipsychotic within the 6 weeks after you started with this medicine. It is important that you attend this review.</td>
</tr>
</tbody>
</table>

**Discharge Plan for Patients Admitted with Antipsychotics**

For patients who are admitted with antipsychotics for BPSD, the prescribers in secondary care have a responsibility to remind GP that antipsychotic prescriptions should be reviewed within 12 weeks or according to patient’s management plan. The need for a review must be communicated to the patient’s GP in writing (electronic discharge summary or clinic letter) and to one other person as deemed appropriate (the patient themselves, or a primary carer, care home manager etc).

<table>
<thead>
<tr>
<th>Management Plan</th>
<th>Antipsychotics – continuation of treatment for BPSD before admission. GP please review the on-going need within 12 weeks or according to this patient’s management plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information to Patient/Relative</td>
<td>(Insert drug name here) - continuation treatment for managing your symptom. Your GP should review your antipsychotic medicine within the next 12 weeks or according to your management plan. It is important that you attend this review.</td>
</tr>
</tbody>
</table>
Prescribing Guidelines for Alzheimer’s Disease

<table>
<thead>
<tr>
<th>Key Symptom</th>
<th>First Line</th>
<th>Second Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Sertraline, Citalopram</td>
<td>Mirtazapine</td>
</tr>
<tr>
<td>Apathy</td>
<td>Sertraline, Citalopram</td>
<td>Refer to specialists caring for patients with dementia</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Risperidone</td>
<td>Olanzapine, Aripiprazole, Quetiapine, or Refer to specialists caring for patients with dementia</td>
</tr>
<tr>
<td>Aggression</td>
<td>Risperidone (Licensed indication)</td>
<td>Olanzapine, Aripiprazole, Quetiapine, or Refer to specialists caring for patients with dementia</td>
</tr>
<tr>
<td>Moderate Agitation or Anxiety</td>
<td>Citalopram</td>
<td>Trazodone, Mirtazapine, Refer to specialists caring for patients with dementia</td>
</tr>
<tr>
<td>Severe Agitation or Anxiety</td>
<td>Risperidone, Olanzapine</td>
<td>Aripiprazole, Quetiapine, or Refer to specialists caring for patients with dementia</td>
</tr>
<tr>
<td>Poor Sleep</td>
<td>Temazepam, Zopiclone</td>
<td>Zolpidem</td>
</tr>
</tbody>
</table>

Prescribing Guidelines Dementia with Lewy Bodies or Parkinson’s Disease

Patients with Dementia with Lewy Bodies (DLB) or Parkinson’s Disease Dementia are particularly vulnerable to neuroleptic sensitivity reactions and also have marked extrapyramidal side effects. Treatment doses should follow the guideline as below. The starting dose should follow guidance from the BNF and the lowest effective dose should be used. The management of antidepressants and hypnotics in patients with Dementia has little evidence base and should follow existing guideline for the management of these drugs in elderly patients without Dementia. Treatment doses should follow BNF guidelines.

<table>
<thead>
<tr>
<th>Key Symptom</th>
<th>First Line</th>
<th>Second Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Citalopram</td>
<td>Sertraline</td>
</tr>
<tr>
<td>Apathy</td>
<td>Sertraline, Citalopram</td>
<td>Refer to specialists caring for patients with dementia</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Quetiapine</td>
<td>Refer to specialists caring for patients with dementia</td>
</tr>
<tr>
<td>Aggression</td>
<td>Quetiapine</td>
<td>Refer to specialists caring for patients with dementia</td>
</tr>
<tr>
<td>Moderate Agitation or Anxiety</td>
<td>Citalopram</td>
<td>Refer to specialists caring for patients with dementia</td>
</tr>
<tr>
<td>Severe Agitation or Anxiety</td>
<td>Quetiapine</td>
<td>Refer to specialists caring for patients with dementia</td>
</tr>
<tr>
<td>Poor Sleep</td>
<td>Temazepam, Zopiclone</td>
<td>Zolpidem</td>
</tr>
<tr>
<td>REM Sleep Behaviour (Nightmares, Hyperactivity)</td>
<td>Clonazepam 500-1000 microgram at night</td>
<td>Refer to specialists caring for patients with dementia</td>
</tr>
</tbody>
</table>
Prescribing Guidelines for Vascular Dementia or Stroke related Dementia
There is little evidence base for the treatment of BPSD in Vascular dementia or Stroke related dementia. The cholinesterase inhibitors (Donepezil, Rivastigmine, Galantamine) and Memantine are not licensed for the treatment of Vascular Dementia and should not be used. Prescribers are advised to follow the prescribing guidance for Alzheimer’s disease but to use with extreme caution due to an established increased cerebrovascular risk (i.e antipsychotics)

Other BPSD and Other Dementia (e.g Fronto-Temporal lobe Dementia)
There is little evidence base for the treatment of other BPSD or for the treatment of common BPSD in other dementias. Specialist advice should be sought.

5. Audit / Monitoring arrangements

<table>
<thead>
<tr>
<th>Monitoring Process</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who</td>
<td>Trust’s clinical lead for Dementia and Pharmacy Department</td>
</tr>
<tr>
<td>Standards Monitored</td>
<td>Audit Standard as set in agreement with NHS Walsall for CQUIN 2011-12 and NHS contract.</td>
</tr>
<tr>
<td>When</td>
<td>Audit will be carried annually or more frequent according to agreement with NHS Walsall for CQUIN 2011-12 and NHS contract.</td>
</tr>
<tr>
<td>How</td>
<td>Audit of prescribing and medical documentations</td>
</tr>
<tr>
<td>Presented to</td>
<td>The audit results will be presented to the Medicines Management Quality Board and all Divisional Quality Boards</td>
</tr>
<tr>
<td>Monitored by</td>
<td>The Medicines Management Quality Board will monitor the action plan.</td>
</tr>
<tr>
<td>Completion/Exception reported to</td>
<td>The Medicines Management Quality Board will receive notification of completed actions or breaches.</td>
</tr>
</tbody>
</table>

6. Standards/Key Performance Indicators
This prescribing guideline is auditable according to standards set by NHS operating framework for 2011-2012. The compliance is being monitored according to CQUIN Medicines Management Target 2d for 2011-2012.

7. Training

Staff development requirements in relation to service develop and quality will be assessed at appraisal using the KSF framework and development needs will become part of the PDP feeding into the ward/departmental/divisional training needs analysis.

Staff will be informed of their responsibilities for service development and quality through training programmes. Training will be given to staff identified as requiring it to perform their role, with the appropriate regularity as defined within the Training Needs Analysis (TNA). The TNA is available from the Learning & Development Centre and via the Trust intranet.

8. Definitions

BNF defines as British National Formulary
BPSD defines as Behavioural and Psychological Symptoms of Dementia.

NICE defines as National Institute of Clinical Excellent

UTI defines as urinary tract infection

GP defines as General Practitioners

DLB defines as Dementia with Lewy Bodies

9. Legal and professional Issues
   Information in this guideline is based on the following documents.
   • NICE clinical Guidance 42 March 2011
   • Walsall Multi Agency Adult safeguarding procedures
   • Safeguarding Adults
   • Mental Capacity Act
   • Deprivation of liberty safeguards

10. References
   1. NICE CG 103 July 2010 Delirium: diagnosis, prevention and management
   2. International Psychogeriatric association .BPSD; Introduction to Behavioural and Psychological symptoms of Dementia,2002. [www.ipa-online.org](http://www.ipa-online.org)
   5. Lawlor 2004 Behavioural and Psychological symptoms in Dementia, the role of Atypical antipsychotics .J Clin Psychiatry ,65 Suppl(1) 5-10
   7. Opie J, Rosewarne R, O’Connor DW The efficacy of psychosocial approaches to behaviour disorders in Dementia, A systematic Literature review. Aust NZJ Psychiatry 1999;33;789-99
   9. Resource Pack. Caring for People with Dementia in Acute Care Settings, The Dementia Services Development Centre ,University of Stirling 2010
   10. Elizabeth Hersch ,Sharon Falzgraf. Clinical Interventions in Aging 2007;2(4);611-621
   12. NICE,SCIE Dementia Supporting People with Dementia and their carers in health and Social care Nov 2006
11. **Related Guidelines:**

- Medicines Policy
- Walsall Multi Agency Adult Safeguarding Policy-
- Incident policy for reporting and investigating adverse incidences and near misses
- Dignity Policy
- Mental Capacity Policy
- Deprivation of Liberty Safeguards (DOL's) operational policy
Appendix 1

Antipsychotics in dementia – Checklist  (Page 1 of 2)

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Assessed by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

**Initial assessment**

<table>
<thead>
<tr>
<th>Has the patient had an assessment to identify potential physical or psychosocial/environmental reasons for non-cognitive symptoms? (see table 1 overleaf)</th>
<th>YES / NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have an individual care plan?</td>
<td>YES / NO</td>
</tr>
</tbody>
</table>

**Before initiating antipsychotic treatment**

<table>
<thead>
<tr>
<th>Is antipsychotic treatment indicated? (*)</th>
<th>YES / NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have cerebrovascular risk factors been assessed?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>Has there been a baseline assessment of cognitive function?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>Have the benefits/risks of treatment been discussed with the patient and/or carer and documented in the notes?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>Have the target symptoms (that the medication should be improving) been identified, quantified and documented?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>Have baseline measurements been carried out? (see table 2)</td>
<td>YES / NO</td>
</tr>
<tr>
<td>Has a date for review of treatment been set?</td>
<td>YES / NO</td>
</tr>
</tbody>
</table>

* Antipsychotics should not be used for mild to moderate non-cognitive symptoms. Medication for non-cognitive symptoms or behaviour that challenges should only be considered as a first-line option if there is severe distress or an immediate risk of harm to the person with dementia or others. For patients with dementia with Lewy bodies seek specialist advice before initiating an antipsychotic.

<table>
<thead>
<tr>
<th>Antipsychotic initiated</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose</td>
<td></td>
</tr>
<tr>
<td>Date antipsychotic initiated</td>
<td></td>
</tr>
<tr>
<td>Date of next review</td>
<td></td>
</tr>
</tbody>
</table>

**Review of treatment**

| Date | |
| Current antipsychotic and dose | |
| Have target symptoms been assessed (for improvement) and documented? | YES / NO |
| Has cognitive function been assessed (for decline)? | YES / NO |
| Has the patient been assessed for antipsychotic side-effects? (e.g. sedation, extrapyramidal symptoms, BP and pulse, blood glucose, anticholinergic S/Es, weight and central obesity. In patients with DLB monitor for severe untoward reactions particularly neuroleptic sensitivity reactions). | YES / NO |
| Antipsychotic to be continued? | YES / NO |

* If YES, document reason why in the notes and discuss with patient and/or carers. Set another date for review.
### Antipsychotics in dementia – Checklist

**Table 1: Assessment of patient with non-cognitive symptoms**

Assess patient early to identify factors that may influence behaviour.

| Physical Health | Suitable physical examination  
| Exclude infection (especially UTI)  
| Exclude possible undetected pain or discomfort  
| Is patient dehydrated?  
| Any chronic disease that may have become unstable or relapsed? |

| Mental Health | Assess for anxiety and depression |

| Side-effects of medication | What medication is the patient on?  
| Assess for side-effects of medication (including acetylcholinesterase inhibitors).  
| Has any new medication recently been started? |

| Psychosocial factors | Individual biography  
| Religious beliefs, spiritual and cultural identity  
| Against whom is the aggression directed? Is there a reason?  
| Physical environmental factors  
| Is the patient bored?  
| Behavioural and functional analysis in conjunction with carers and care workers |

**Table 2: Baseline measurements before initiating risperidone**

Risperidone is licensed for the short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer’s dementia unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others.

If baseline measurements are not carried out before initiating risperidone and a side-effect develops it will be difficult to decide whether the effect was due to risperidone or if it was already there.

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>After initiation of risperidone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body weight</strong></td>
<td>✔</td>
<td>at 3 months then yearly</td>
</tr>
<tr>
<td><strong>Serum U+E's</strong></td>
<td>✔</td>
<td>yearly</td>
</tr>
<tr>
<td><strong>FBC</strong></td>
<td>✔</td>
<td>yearly</td>
</tr>
<tr>
<td><strong>Plasma glucose</strong></td>
<td>✔</td>
<td>at 4 – 6 months then yearly</td>
</tr>
<tr>
<td><strong>Blood pressure and pulse</strong></td>
<td>✔</td>
<td>monitor frequently during dose titration</td>
</tr>
<tr>
<td><strong>ECG</strong></td>
<td>✔</td>
<td>then monitor after dose changes and if there is evidence of other risk factors such as relevant personal/family history, co-prescription of drugs that prolong QT interval or lower potassium</td>
</tr>
<tr>
<td><strong>Prolactin</strong></td>
<td>✔</td>
<td>at 6 months then yearly</td>
</tr>
<tr>
<td><strong>LFTs</strong></td>
<td>✔</td>
<td>yearly</td>
</tr>
<tr>
<td><strong>Creatinine phosphokinase</strong></td>
<td>✔</td>
<td>measure again only if Neuroleptic Malignant Syndrome suspected</td>
</tr>
</tbody>
</table>

### References

Appendix 2

Target Symptom Group
Different behaviours are best approached using different non-pharmacological or pharmacological methods. Recognition of BPSD is the first step in developing a management plan, and care must be taken to establish its presence.

The goal of treatment should be to detect and manage BPSD before caregiver burnout and irreversible damage to the support environment occurs. The plan should consider the severity and intrusiveness of the behaviour and whether non pharmacological intervention is sufficient or the behaviour is significant enough to require both pharmacologic and psychological interventions (4) Identifying target behaviour also allows the response to treatment to be monitored. Rating Scales may be employed to identify and quantify behaviours and the response to treatment. A number of instruments have been developed to assess the range and severity of BPSD.

The most useful in terms of outcome assessment because of its specificity reliability and validity are
- Cohen –Mansfield Agitation Inventory (CMAI)
- Neuropsychiatry Inventory (NPI)
- Behavioural pathology in Alzheimer's disease (BEHAVE-AD)
(Appendix 3)

Identifying the Dominant Target Symptom Group
- Psychosis; delusion and hallucination
- Depression; Depressed mood and /or loss of ability to enjoy previously pleasurable activities. May or may not include apathy.
- Apathy; diminished motivation, listlessness; loss of drive to engage in activities. These may be perceived as laziness.
- Aggression
- Agitation/anxiety
- Sleep disturbance
- Other symptoms; e.g. vocalisations, sexual disinhibition, stereotypical movements etc.

Formulating the Target problem
It's important to try to understand why a particular symptom or behaviour is being experienced by a particular person at that particular time. This is called “Formulating the problem”. It is useful to consider the problem as an expression of unmet need-a communication that challenges others to understand. For example, is their call for attention an expression of pain, boredom, sadness, anxiety or loneliness.
Appendix 3 - Non-Pharmacological Management of BPSD

Non pharmacological interventions should be tailored to the individual and the impact carefully monitored. Care of patients with BPSD involves a broad range of non-pharmacological interventions for both patients and carer/family. Caregiver education, support and behaviour training are integral parts of intervention for these patients (4,5). A systematic literature review has provided evidence to support the effectiveness of activity programme music, behaviour therapy and changes to physical environment (6).

Changes in environment can have a positive impact on symptoms of BPSD
People with dementia have memory and cognitive impairment and problems in design and configuration of facilities they are in can cause or exacerbate restlessness, frustration, anxiety and disorientation.
Simple changes in the environment can be beneficial. (3) These include
- Moderating noise and other levels of stimulation
- Increasing signage and access to toilets
- Ensuring surroundings are well lit
- Improving time orientation (prominent calendar/clock)
- Making the environment as homelike and reassuring as possible.
- Separating non-cognitively impaired residents from people with dementia.
- Small scale group living
- Any measure to reduce stress levels
- If possible consistency of staff and caregivers

Recreational activities may enhance quality of life and well being
Some useful activities for the management of BPSD
- Exercise
- Gardening
- Music
- Art
- Pet therapy
- Walking
- Group activity e.g. Singing or craft
- Maintaining routine

Behaviour Management
Behaviour management is defined as a structured intervention usually carried out by caregivers under supervision of a professional with expertise in this area (3). This might involve removing rewards for attention seeking behaviour or giving rewards for increased social activity. Behaviour management, involving pleasant events or problem solving, has been shown to improve symptoms of depression in people with Dementia (7).
Key point in Behaviour Management (8)
It can be all too easy to focus on the behaviour as a problem with the fault lying squarely with the individual. In order to respond to behaviours that challenge us we need to;

- consider personal responses to an individual's behaviour
- identify some techniques for responding to individuals
- understand the reasons for behaviours
- adopt more positive and person centred approaches

People with dementia are often labelled by the descriptions that we apply to their behaviour, for example as ‘aggressive’ or as a ‘wanderer’. This is unhelpful in the context of person centred care and can be counterproductive to finding solutions to the problems that the behaviour causes.

Dealing with behaviour that challenges

- How behaviour is described can lead to an assumption that the problem lies with the person
- Behaviour needs to be placed within an interpersonal and environmental context
- the behaviour of people with dementia is not an inevitable consequence of the condition

Strategies for managing behaviours that challenge

- Adopt a relaxed but a friendly approach
- Be calm but confident
- Don’t rush in and try to avoid sudden actions or movements that can be misconstrued as threatening
- Introduce yourself and let the person see you
- Don’t approach from behind –this can be threatening and may provoke angry or impulsive reaction
- Try to avoid standing over people –this can be intimidating and can also display a lack of respect for the person
- Get down to the persons level and try to adopt a relaxed posture
- Use eye contact (non threatening) or touch to gain trust/confidence
- Reassure the person that you are there to help them, and not to harm them
- Show respect. Always speak to the person with dementia as a unique individual, even if they do not understand what you are saying. Always use their preferred mode of address and avoid speaking over them (to relatives, for example)
- Always explain what you are going to do—that you are not going to hurt them or harm them in any way. This may be portrayed by verbal or non-verbal means (our body language, gestures or responses)
- Put yourself in their shoes and ask
  - How would I feel or respond in this situation
  - Would I like this?
  - Would I like my mother or father to be treated like this?
- Allow room for choice—does the person respond better to a male or female, or a particular member of staff? Do they respond better to being washed in the bathroom or in their room? Or someone doesn’t want to go to the toilet or to bed at a certain time, respect this—you can always try later. Respect Privacy and dignity
- Allow the person time to respond. Do not try to rush or push them. If your first approach does not succeed—give them a few minutes. At the very least the person may acknowledge that a member of staff is trying to respect and understand their rights to refuse treatment or care. This can go a long way towards instilling trust and confidence in a caring relationship
• Adapt your approach. If one approach is unsuccessful do not be afraid to try another. If the person does not take to a member of staff don’t be offended –try another
• Be consistent and keep the number of staff involved with the person to a minimum. This will improve continuity and consistency of care. Staff will also get a better opportunity to get to know the person as an individual –their likes and dislikes, personality traits and how they respond to care
• Document what works. If the person responds to or appears to be more comfortable with a particular approach or person ,document this and share this information with others
• Never place yourself at risk of harm

Behavioural Interventions –ABC Approach

Use the ABC approach to identify triggers, describe behaviours and outline the consequences of the behaviour should it continue. This helps to identify the need for intervention, to plan interventions and to identify patterns of behaviours.

**ABC Template (A –Antecedent  B –Behaviour C- Consequence)**

This approach looks at what the antecedents (A) or triggers were that give rise to the behaviour

- When and where did the behaviour start
- What was happening prior to the incident and who was present
- Where did the behaviour occur
- What was happening

Staff are then asked to be specific say precisely what the behaviour (B) was ‘Mrs Jones kicked john’ as opposed to ‘Mrs Jones was aggressive’. By being explicit, staffs then know what behaviour they need to address.

- What is the behaviour(Be Specific)
- Was the onset of behaviour sudden or gradual
- Who or what was it directed at
- How long did the behaviour last

They then need to assess the consequences (C)

- Which interventions or approaches were tried and which worked
- Which medication/sedation was used
- Was any form of restraint used(caution avoid physical restrain)
- Did the person have to be isolated
- Did they calm down of their own accord
- Was anyone hurt or distressed by the behaviour
- Did the person gain anything as a result of the behaviour

ABC Recording sheet is helpful in this approach (Appendix5)
**Behaviour Management - Specific Interventions (9)**

<table>
<thead>
<tr>
<th>Activity associated with potential BPSD</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bathing</strong></td>
<td>Make a safe bathroom. Be Prepared, don’t rush. Ensure room and water temperature are comfortable. Wash hair last. A recent study found benefit of person centred bathing and towel bath in decreasing agitation and discomfort. (10)</td>
</tr>
<tr>
<td><strong>Eating</strong></td>
<td>Maintain a regular mealtime. Avoid distraction at meals. Check the food temperature. Honour preferences when possible and offer finger foods.</td>
</tr>
<tr>
<td><strong>wandering</strong></td>
<td>Provide adequate daily physical activity. Create a safe environment and safe wandering paths. Remove reminders of leaving (coats, umbrella). Have alarms or bells at exit doors. Access. Assistive Technology.</td>
</tr>
<tr>
<td><strong>Incontinence</strong></td>
<td>Scheduled voiding. Be attentive to non verbal cues (such as pacing). Simplify clothing and clear obstacles. Put signs (including pictures) at the bathroom door. Give positive reinforcement.</td>
</tr>
</tbody>
</table>

**Non Pharmacological Interventions as recommended per NICE Clinical Guideline (2006) (11)**

- Aromatherapy
- Multisensory Stimulation
- Therapeutic use of music and/or Dancing
- Animal Assisted Therapy
- Massage

There is additional support for Validation Therapy and Reminiscence. Evidence also supports range of effective psychological intervention in long term care setting including social interaction and music and use of staff training /education in reducing Agitation.