INITIATION OF ANTIPSYCHOTICS IN PEIOPLE WITH DEMENTIA WHO ARE DISTRESSED CLINICAL SUPPORT TOOL DRAFT	UNIT NUMBER SURNAME FIRST NAMES(S) DATE OF BIRTH

INITIATION OF ANTIPSYCHOTICS IN DEMENTIA

For use by GP's or secondary care where a person with dementia appears to be distressed.

Step 1;- differential diagnosis Does the patient have a co-morbid psychotic illness?

(Schizophrenia, bipolar disorder or psychotic depression) Antipsychotic treatment is likely to be justified but note that the risks associated with these medicines apply irrespective of indication (embolic events, falls, pneumonia etc)

Is there reason to suspect the patient may have Lewy Body dementia?

If so, antipsychotics may cause life-threatening EPS. Quetiapine and clozapine are the antipsychotics of choice, but even these should be used with caution. Note that diagnostic accuracy is low and any suspicion of LBD warrants caution in the use of antipsychotics. Clozapine is only available via secondary care, but is also quite toxic in frail elderly people.

Step 2 symptoms and signs (which may help define the appropriate treatment)

What is wrong now that makes you consider starting an antipsychotic?

- ☐ Known or assumed psychotic symptoms (delusions/hallucinations/paranoia/suspiciousness)
- ☐ Agitation/Distress
- ☐ Fear/anxiety
- ☐ Depression/low mood
- ☐ Verbal or physical aggression
- ☐ Disinhibited behaviour (eg removing clothing)*
- ☐ Resisting care with ADL/help with eating/drinking*

*These symptoms/signs alone would not normally be indications for antipsychotic use

Step 3 Identifying the likely cause of this persons distress/behaviour?

Could the patient be experiencing:

- ☐ Medical illness/ Delirium (eg breathlessness from poorly controlled heart failure or a chest/ urine infection, constipation etc etc?)
- ☐ Physical pain from arthritis, pressure sores etc?
- ☐ Psychotic symptoms (hallucinations, delusions)?
- ☐ Depression?
- ☐ Fear/anxiety?
- ☐ Boredom from lack of activities or the wrong type of activities? (eg it being assumed that the patient enjoys endless daytime television)
- ☐ Living in a poor environment?
- ☐ Poor staff skills?
- ☐ Hunger/thirst?
- ☐ Is the behaviour specifically 'activity related' e.g. when about to have their hair combed or have a bath etc

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Step 4 alternatives to te use of antipsycotics.

Have you actively excluded or attempted to treat any of the above

- **With pharmacological approaches other than antipsychotics** (eg analgesics, antibiotics, diuretics etc)**?**

- **With non-pharmacological strategies** (activities, different staff approach etc)**?**

Step 5 Risk benefit analysis and identification of target symptoms

If an antipsychotic is to be prescribed, does the potential benefits of this medicine in ameliorating symptoms/improving the patients QOL outweigh the risks?

What are the target symptom(s) against which you will judge the benefits of treatment?(describe how they are quantified if possible)?

Step 6. discussion with family/carer/advocate

What risks of antipsychotic treatment,have been shared with the family etc

- ☐ **Stroke**
- ☐ **Falls/ poor mobility**
- ☐ **Confusion**
- ☐ **Etc**

Step 7 Antipsychotic Prescription Plan

1. Prescription given for _____

Choose an antipsychotic based on the anticipated side effect profile of the drug, the patient's physical health any other medicines that are prescribed

2. _____weeks supply given (we suggest a maximum of six weeks)

3. Arrangements for review _____.

Assess change in target symptoms (if any), and assess for side effects (sedation, EPS, constipation, postural drop etc). Document both.

Stop the antipsychotic

- If the target symptoms have not improved on treatment, review and reconsider likely cause of distress
- If the target symptoms have improved on treatment, and then get worse on stopping, consider re-starting the antipsychotic. Review at least every 6 months.

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REVIEW OF ONGOING PRESCRIPTIONS

Where possible anti-psychotics may be reduced and stooped, unless there are good reasons not to (eg a history of schizophrenia or evidence of ongoing psychosis in dementia da history of service distress before treatment. Where they are reduced a few may deteriorate but others masy improve.

List Current meds

What are current symptoms? (including target symptom) ?

How is the person overall?

Is the person distressed now?

Did treatment appear to modify the target symptom?

What might be the risks of discontinuation (eg resurgence of distress)?

What evidence of adverse reactions is there?

Is relative/advocate informed of the decision to stop/continue meds and have they been invited to comment (copy letter to relative may be adequate response for this)

What arrangements are there to review the effect of discontinuation?

Date for next review

Copy to
Gp/ cons psych
Care coordinator
Care home matron
Relative

CONTINUE OVERLEAF