Hertfordshire and West Essex Integrated Care System

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REDUCING ANTIPSYCHOTIC PRESCRIBING FOR BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD)

Care Homes Good Practice Guidance

TABLE OF CONTENTS

AIM:

This guidance has been produced to provide GPs, pharmacists, and care practitioners with a practical approach in the treatment of behavioural and psychological symptoms of dementia (BPSD), including guidance on reviewing antipsychotics. This guideline aims to promote evidence based, cost effective prescribing and support adherence to up-to-date national guidelines (NICE guideline NG97, June 2018). Although BPSD can be treated with many different types of medications, this document only focuses on treatment with antipsychotics.

BACKGROUND:

BPSD includes a wide range of symptoms including agitation, aggression, wandering, hoarding, shouting, depression, anxiety, distress during care, sleep disturbance, hallucinations, apathy, delusions, and psychosis. More than 90% of people with dementia will experience these symptoms as part of their illness over the years and the number, type and severity of these symptoms varies between patients. Patients may also experience multiple symptoms at the same time, making it very difficult to target specific symptoms.

There are several rating scales to assess the severity and presence of BPSD symptoms. Two rating scales were recommended by a study which analysed 29 scales (Tible et al., 2017). Among these scales, the neuropsychiatry inventory (NPI) and the behavioural pathology in Alzheimer's Disease Rating Scale (BEHAVE-AD) were rated as the best measures for the assessment of BPSD symptoms. One of these two scales can be found in the following link: BEHAVE-AD-1.pdf (dementiaresearch.org.au).

Management of BPSD includes non-pharmacological and pharmacological interventions. Choice of treatment must always be patient, and caregiver centred with the aim of providing comfort for the patient and to help alleviate caregiver burden. Treating concomitant somatic diseases plays a crucial part in the treatment plan.

The NICE dementia guideline (NG-97), recommends non-pharmacological interventions as the first line approach and emphasises the importance of exploring possible clinical or environmental causes for symptoms as detailed in section 1, which often underpin the development of these symptoms of BPSD. It is important not to initiate pharmacological interventions until non-pharmacological options are explored.

SECTION 1 – GUIDANCE FOR PRESCRIBERS RESPONDING TO NON-COGNITIVE (BEHAVIOURAL AND PSYCHOLOGICAL) SYMPTOMS IN DEMENTIA WITHOUT ANTIPSYCHOTIC TREATMENT:

STEP 1: EXPLORE AND ADDRESS POTENTIAL BIOPSYCHOSOCIAL FACTORS:

BPSD patients with acute symptoms must at first be assessed to exclude alternative possible causes, such as physical health issues (e.g. pain or infection), environmental factors, psychosocial factors, and others. Two potential methods can be used to explore these underlying causes and one of them, called the PAIN approach, is described below. An alternative method called Antecedence, Behaviour and Consequence (ABC) chart is described in appendix 1.

- (P) Physical factors: ensure contributing physical health conditions including pain, acute infection, constipation, anxiety, depression, electrolyte imbalances, metabolic disorder, urinary retention, and others are managed appropriately.
- (A)Activity related: personal care activities, such as dressing and washing can cause agitation.
- (I)Iatrogenic/drug induced: drugs with high anticholinergic effects have the potential to cause symptoms, such as confusion, agitation, and delirium. They can increase the risk of cognitive impairment, constipation, urinary retention, dry mouth/eyes, sedation, insomnia, photophobia, and falls.
- (I)Intrinsic to Dementia: there are certain symptoms of BPSD which are intrinsic to dementia. These include wandering, agitation, delusion, and others.
- (N) Noise and other environmental causes: noise and other environmental factors, such as new admission to care home, light, unknown carer, and unfamiliar environment can cause BPSD symptoms.
- Expression of distress and unmet needs: make use of life history, direct observation of care and data collection e.g. sleep, pain, and ABC charts to understand what the unmet needs might be and to inform treatment changes (Brechin et al., 2013).

Non-pharmacological options must be the first line of treatment.

RESPONSE TO BPSD WITH ANTIPSYCHOTIC TREATMENT:

• Antipsychotics must not be used routinely to treat agitation and aggression in people with dementia. Long term treatment with antipsychotics carries cumulative risks of increased mortality, cognitive decline, falls and other adverse effects.

• If a decision is made to commence an antipsychotic drug, refer to step 2 onwards, for best practice guidelines on safe prescribing and review.

• If reviewing a patient who has already been prescribed an antipsychotic, refer to step 4 onwards.

STEP 2: FACTORS TO CONSIDER BEFORE STARTING AN ANTIPSYCHOTIC:

●Antipsychotics must be only offered to people with dementia who are

a) at risk of harming themselves or others; b) experiencing agitation, hallucinations or delusions that are causing them severe distress (NICE, 2018).

● Ensure potential biopsychosocial factors are explored and non-pharmacological interventions have already been used for long enough (at least 4 weeks) where applicable.

● There should be clearly documented evidence in the care notes/ behavioural charts to demonstrate that there is a sufficient need for an antipsychotic to be prescribed.

● Consider risk factors for cerebrovascular disease e.g. Previous history of stroke or transient ischaemic attack (TIA), hypertension, diabetes, smoking and atrial fibrillation.

● Discuss the potential benefits and harms with the person/family members and care practitioners. The NICE decision aid can be used to support this discussion. NG97 Patient decision aid on antipsychotic medicines for treating agitation, aggression and distress in people living with dementia (nice.org.uk)

● Check for potential drug interactions and side effects (e.g. drowsiness and, confusion/ as per BNF/SPC/PIL) including cumulative side effects in combination with other medication.

● For people with dementia with Lewy bodies or Parkinson's Disease dementia, antipsychotics can worsen the motor features of the condition, and in some cases cause severe antipsychotic sensitivity reactions (NG,97). Seek specialist advice.

STEP 3: STARTING ANTIPSYCHOTIC TREATMENT:

● Start on a low dose.

● Monitor response to treatment, symptoms, and side effects.

● Non-pharmacological approaches must continue while the person is prescribed an antipsychotic.

● Use the lowest effective dose for the shortest possible time.

● Risperidone and haloperidol are the only antipsychotics licensed for non-cognitive symptoms in dementia. Although, some studies show that there are no significant differences across measures of effectiveness and safety among aripiprazole, olanzapine, quetiapine, and risperidone, licensed preparations should be preferred. Treatment plans should be individualised, and patient centred and may involve the use of off-label antipsychotics.

▪ Risperidone - Recommended starting dose is 0.25mg twice daily, increased in steps of 0.25mg twice daily on alternate days, adjusted according to response. The usual dose is 0.5mg twice daily. Maximum licensed dose is 1mg twice daily. Although haloperidol and risperidone both are licensed for BPSD, risperidone is the medication of choice due to more adverse drug reactions associated with haloperidol.

▪ Olanzapine - Usual dose range 2.5mg-10mg per day.

▪ Quetiapine – Usual dose range 12.5mg-300mg daily. Could be considered first choice for patients with Parkinson's Disease or Lewy Body Dementia due to lower risk of movement disorders.

▪ Aripiprazole- Usual dose range 5-15 mg daily. Could be considered as second choice for patients with Parkinson's Disease or Lewy Body Dementia where quetiapine is ineffective or contraindicated.

▪ Haloperidol – licensed for treatment of persistent aggression and psychotic symptoms in moderate to severe Alzheimer's disease and vascular dementia. Recommended dose 0.5 to 5mg/ day orally, as a single dose or in 2 divided doses, initial dose is 0.5mg daily; dose adjusted according to response at intervals of 1-3 days.

▪ Amisulpride – Usual dose range 25-50mg per day. This should be only considered where all other antipsychotic options have been ineffective or contraindicated.

● When antipsychotics are initiated in secondary care, baseline measurements should be taken in secondary care. Regular monitoring may subsequently be done in primary care on specialists' advice or depending on person's care plan. Both baseline and regular monitoring must be carried out by the primary care if antipsychotic is

initiated in primary care. This may include physical health monitoring mentioned in table 2.

STEP 4: REVIEWING ANTIPSYCHOTIC TREATMENT:

- If the patient is under regular review (every 6 weeks) by secondary care, responsibility for reviewing/reducing/stopping the antipsychotic would remain with secondary care.

- For patients who are not under review by secondary care (i.e. antipsychotic initiated in primary care; patients who have been discharged from secondary care):
  - Review every 6 weeks or as suggested by need.
  - Monitor response to treatment, symptoms, and side effects.

- Unless there is severe risk or extreme distress, the recommended default management is to reduce and stop the antipsychotic with monitoring, ongoing assessment of contributing factors and continuation of non-drug treatments, based around the person's needs, abilities, and interests. Decisions may be made to continue after 6 weeks and in these cases, it will be unlicensed use.

Refer to the following guidance to support with dose reduction:

- Table 1- Suggested tapering protocol for reducing and stopping antipsychotics.
- Recommended deprescribing protocol.

STEP 5: IF ANTIPSYCHOTIC IS CONTINUED, REPEAT STEP 4:

The prescriber should conduct health check at baseline, 3 months, and 6 months after prescribing a new antipsychotic. This health check should be repeated at least annually unless abnormality of physical health emerges. These physical health monitoring details are described in table 2.

STEP 6: IF ANTIPSYCHOTIC IS DISCONTINUED:

- Non-pharmacological treatments in managing behavioural symptoms, based on the person's needs, abilities and interests should continue after the antipsychotic has been stopped.
- It must be noted that antipsychotics can be withdrawn without significant detrimental effects on behaviour in around 50% - 70% of people living with dementia (NG 97).

TABLE 1: SUGGESTED TAPERING PROTOCOL FOR REDUCING AND STOPPING ANTIPSYCHOTICS USED FOR BPSD: THE FOLLOWING IS A TAPERING GUIDE FOR THE COMMONLY PRESCRIBED ANTIPSYCHOTICS FOR BPSD. INDIVIDUAL PATIENT CIRCUMSTANCES MAY NEED TO BE TAKEN INTO CONSIDERATION IN DOSE REDUCTION.

Antipsychotic	Usual dose range in dementia (oral)	Suggested regime for reduction/discontinuation (generally reduce the daily dose over 2-4 weeks and ideally 4 weeks)
Amisulpride	25-50mg/day	Reduce by 12.5-25mg every 1-2 weeks, then stop.
Aripiprazole	5-15mg/day	Reduce by 5mg every 1–2 weeks (depending on dose), then stop. (if patient is on 5mg daily, reduce to 2.5mg for 2 weeks; however, note that tablets are not scored, and liquid is expensive – contact local pharmacist for advice)
Haloperidol	0.5mg-5mg/day	Reduce by 0.25–0.5mg every 1–2 weeks (depending on dose) then stop.
Olanzapine	2.5mg-10mg/day	Reduce by 2.5mg every 1–2 weeks (depending on dose) then stop.
Quetiapine	12.5mg-300mg/day	For doses 12.5–100mg/day, reduce by 12.5–25mg every 1–2 weeks (depending on dose) then stop. For doses >100–300mg/day, reduce by 25–50mg every 1–2 weeks (depending on dose) then stop. If dose is 300mg/day, reduce to 150–200mg/day for 1 week then by 50mg per week.
Risperidone	0.25mg-2mg/day	Reduce by 0.25–0.5mg every 1–2 weeks (depending on dose) then stop.

(Adapted from the Maudsley Prescribing Guideline, 2021).

TABLE 2: SUGGESTED PHYSICAL HEALTH MONITORING IN ADULTS PRESCRIBED AN ANTIPSYCHOTIC FOR BPSD: A RISK BENIFIT ANALYSIS TO BE CARRIED OUT BY THE PRESCRIBER WHEN MONITORING IS NOT POSSIBLE DUE TO HIGH LEVEL OF PATIENT AGITATION, AND RESISTANCE OR URGENCY OF THE SITUATION.

Antipsychotic examples	Amisulpride, Aripiprazole, Haloperidol, Olanzapine, Quetiapine and Risperidone
Blood & Lipid profiles	Baseline and 12 weeks. Annually only if patient is on statin or patient's BMI ≥ 30. if fasting samples for lipid profile are impractical then non-fasting samples are satisfactory for most measurements except low-density lipoprotein (LDL) and triglycerides (TG). Consider tool of Older Persons Prescriptions in Frail adults with limited life expectancy (STOPPFrail) criteria in decision making and for patients who the STOPPFrail criteria applies to, this may not be necessary. Follow NICE NG238 Overview | Cardiovascular disease: risk assessment and reduction, including lipid modification | Guidance | NICE (updated December 2023).
Blood Pressure (BP)/Pulse	Baseline, 12 weeks and then annually. BP target <140/90 mmHg in adults with hypertension aged under 80, <150/90 mmHg in adults with hypertension aged 80 and over (NICE NG136 Overview | Hypertension in adults: diagnosis and management | Guidance | NICE , 2019). Refer to appropriate clinician for investigation/management if patient shows symptoms of hypertension or hypotension. Consider age, frailty, risk of falls and take a patient centred approach setting BP target.
ECG	Baseline for haloperidol and Perform an ECG for other antipsychotics to monitor for QTc prolongation if there are cardiovascular risk factors, including a strong family history of CVD or if new medicines or changes to physical health have increased the risk of QTc prolongation.
Fasting blood glucose & Hba1c	Baseline and 12 weeks for all antipsychotics, then annually for olanzapine and only high-risk patients for other antipsychotics (BMI≥30 or family history of DM) - If fasting blood glucose (FBG) is impractical then random blood glucose (RBG) can be measured and interpreted accordingly. Consider tool of Older Persons Prescriptions in Frail adults with limited life expectancy (STOPPFrail) criteria in decision making and strict hba1c level targets may not be appropriate. Managing diabetes risk is tailored to the patient's overall health status and life expectancy. Follow Public Health Guideline PH38: Overview | Type 2 diabetes: prevention in people at high risk | Guidance | NICE , Updated 2017))
Full Blood Count (FBC)	Baseline and annually - Stop suspect drug if neutrophils <1.5 x 109 and refer to medical specialist if <0.5 x 109. Note: high frequency of benign ethnic neutropenia in some ethnic groups.
Liver Function Tests (LFT)	Baseline and annually; Check the level of aminotransferases (ALT/AST). The antipsychotic should be stopped if there is an asymptomatic increase in aminotransferases higher than 3 times the maximum level of normal (aminotransferases are sensitive marker of liver injury).
Prolactin	A prolactin level is useful at baseline. Drugs reported to cause raised prolactin: amisulpride, sulpiride, risperidone, and first-generation antipsychotics. Aripiprazole, olanzapine, and quetiapine usually have minimal effect on prolactin levels. Refer to a psychiatrist for advice if antipsychotic induced hyperprolactinaemia after assessing for symptoms. Normal ranges are: Men 0–424 mIU/L (0 -20 ng/ml) and Women 0–530 mIU/L (0 – 25ng/ml). Note that a chronically raised prolactin can increase the risk of osteoporosis and some studies suggest an increased risk in breast cancer. If prolocatin level is >2500mIU/L, then refer for tests to rule out prolactinoma.
Renal Function (U&E & eGFR)	Baseline and annually– Presence of chronic kidney disease increases risk of CVD. Monitor Urea and Electrolytes (U&Es) and eGFR.
Weight (BMI/ Waist circumference)	Baseline and annually - Target BMI is 18.5-24.9 kg/m2 (18.5-22.9 kg/m2 in South Asian or Chinese). If the antipsychotic is used for short term, then weight management through lifestyle is encouraged apart from those patients who are predispose to diabetes.

Adapted from guidance-on-choice-and-selection-of-antipsychotics-in-the-management-of-psychosis-and-schizophrenia-in-adults-v21-internet-version.pdf (hpft.nhs.uk) & HPFT physical health policy V 6.1. Reproduced from the GP Guide for Physical Health Monitoring in Adults Prescribed an Antipsychotic for Serious Mental Health Illness (SMI), October 2020, Herts Valley CCG.

RECOMMENDED DEPRESCRIBING PROTOCOL:

- Deprescribing is recommended if a patient with BPSD has been taking antipsychotic treatment for more than 6 weeks and either symptoms are controlled or there is no response to current treatment.
- Review at every stage of dose reduction to evaluate patient response. Expected benefits may include improved alertness, reduction of weight lossor weight gain (e.g. with olanzapine), reduced number of falls and extrapyramidal side effects.
- Abrupt discontinuation of antipsychotics can result in adverse withdrawal effects (especially after prolonged use). Withdrawal effects can include psychosis, hallucinations, delusions, aggression, agitation, nausea, vomiting, sweating, insomnia, headache, restlessness, and anxiety.
- If doses higher than the recommended range (see table 1 and electronic medicines compendium/EMC) was prescribed by a specialist, seek their advice before making any changes.
- In some cases, it may be necessary to withdraw the drug more gradually, particularly if symptoms reappear or withdrawal symptoms occur.
    - Implement small decreases in dose (ensure dose reduction is possible with strengths available), one step down at a time.
    - Where the antipsychotic is given more than once daily, decrease only one dose to start with, choosing the dose where the patient is likely to be least affected. For example, if symptoms are more present in the morning, start by reducing evening doses.
    - Allow sufficient time for the patient to adapt to the new dose (usually 1-2 weeks) before considering the next small reduction in dose.
    - When the lowest daily dose has been achieved, then consider administering on alternate days before stopping completely.
- For those with worsening of symptoms, the first four weeks are the most challenging. Monitoring, ongoing assessment of contributing factors and non-pharmacological treatments may prevent the need to restart antipsychotics.
- The risk of recurrence of symptoms after discontinuation may be more likely if previous discontinuation has caused symptoms to return, or the person currently has severe symptoms.

SECTION 2– INFORMATION FOR CARE PRACTITIONERS ANTIPSYCHOTIC MEDICINES FOR TREATING NON-COGNITIVE (BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS) IN DEMENTIA:

Antipsychotic medicines are sometimes used to treat behavioural and psychological symptoms in dementia. Only risperidone and haloperidol have a licence to treat these sorts of problems in people living with dementia. Other antipsychotics, including olanzapine, aripiprazole, and quetiapine, are often prescribed to treat these behavioural symptoms but are not licensed for this use.

The most common side effects of antipsychotics are:

- Feeling sleepy or less alert (although some people have difficulty falling or staying asleep)
- Headache
- Changes in appetite and weight gain
- Symptoms like those of Parkinson's disease. These may include slowness or difficulty in moving, a sensation of stiffness or tightness of the muscles (making the person's movements jerky), and sometimes even a sensation of movement 'freezing up' and then restarting. The person may develop a slow shuffling walk, a tremor, increased saliva or drooling, and a loss of expression on the face.

Not everyone will get these, but many people will. The higher the dose of antipsychotic and the longer the person takes it, the more likely they are to get these side effects (NG 97). There are also other less common side effects (refer to the medicine's patient information leaflet for a full list of side effects). The most serious side effects include an increased risk of stroke.

Because of these side effects, it is important that non-pharmacological treatments (e.g., music, aromatherapy, activities that are person-centred) are used as a first line option. It may be necessary in some cases for a person to be prescribed an antipsychotic, for example when a person is at risk of harming themselves or others, or if they are severely distressed. In these cases, non-drug measures must continue alongside the antipsychotic. Where antipsychotics are prescribed for behavioural symptoms in dementia, these medicines must be reviewed regularly, with the prescriber, to see if the dose can be reduced or if the medication can be stopped. Refer to section 3 and 4 for further guidance.

SECTION 3 - GUIDANCE FOR CARE PRACTITIONERS RESPONDING TO NON-COGNITIVE (BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS) IN DEMENTIA:

Initial presentation of symptoms: **use non-pharmacological measures.**

1) Identify what the behavioural symptom is.

2) Identify and address cause of behaviour(s).

- **The reason for the behaviour could be due to an unmet need.** Sleep charts, pain charts, bowel charts may help to identify what the unmet need might be and could help to guide treatment.
- Pain, infection, constipation, and other physical factors can cause aggression/outbursts, if the patient is unable to communicate. If the potential cause of the behaviour is due to a physical factor,
    - Liaise with the GP to treat accordingly.
- If the cause of the behaviour is due to other factors e.g. environmental, lack of understanding about the person:
    - Use person-centred, non-drug measures (see section 4 for ideas). Care should be more personalised to the individual at the end of their life. Record this in the care plan.
    - It is important to recognise that behaviours such as walking about or sundowning could be a sign that the person has an unmet need. The person may be trying to communicate a need.
- Simple adjustments to social interactions and the environment can make a difference.
- Set up a system for monitoring and documenting behaviour and outcomes of non-pharmacological measures (e.g. using ABC charts). Record the trigger, description of the behaviour, what actions were taken to support the person and the outcome. You may need to try several different things over the course of a few weeks before you see improvement. Clear documentation will help to identify what is working and what is not working.
- Be patient. Remember, behavioural symptoms of dementia often disappear over 4-6 weeks without the need for medication.
- If the above options have not worked, liaise with the GP for further advice.

IF AN ANTIPSYCHOTIC IS STARTED, CONTINUE NON-DRUG MEASURES:

If an antipsychotic is started, for example, if non-drug measures have not worked, or if the antipsychotic has been prescribed for a person who is at risk of harming themselves or others, or severely distressed:

- Continue to monitor behaviour e.g. using behavioural charts.
- Monitor and document side effects. Liaise with GP if side effects occur (see section 2 for a list of common side effects. Note this list is not exhaustive. Further information can be found in the medication patient information leaflet (PIL)).
- Continue person-centred, non-drug measures (see section 4 for ideas).
- Set up a system within the home to ensure that antipsychotics being used to treat these behavioural symptoms are reviewed with the GP every 6 weeks or sooner if required.

IF AN ANTIPSYCHOTIC DOSE IS BEING REDUCED/ STOPPED, CONTINUE NON-PHARMACOLOGICAL MEASURES:

- Continue person-centred, non-drug measures (see section 4 for ideas).
- Monitor behaviour at every stage of dose reduction and after the antipsychotic has been stopped e.g. using behavioural charts.
- Monitor for withdrawal symptoms. This is more likely to occur if the person has been on the drug for a long time and the dose is reduced too quickly. Common withdrawal symptoms include nausea, vomiting, sweating, insomnia, headache, restlessness and anxiety. Liaise with the GP if withdrawal symptoms occur or if behavioural symptoms reappear during dose reduction as it may be necessary to review the withdrawal regimen.
- For those with worsening of symptoms, the first four weeks are the most challenging. Continuing person-centred non-drug treatments may prevent the need to restart antipsychotics.
- It is important to note that antipsychotics can be withdrawn without significant detrimental effects on behaviour in around 50-70% of people living with dementia (NG 97).
- Liaise with the GP if behavioural symptoms reappear after the antipsychotic drug has been stopped.

SECTION 4 – IDEAS FOR CARE PRACTITIONERS NON-DRUG MEASURES FOR MANAGING NON-COGNITIVE (BEHAVIOURAL AND PSYCHOLOGICAL) SYMPTOMS IN DEMENTIA:

- Clear records will help to identify and address patterns or triggers for behaviour and will help to identify how well a person with behavioural problems is responding to different situations and different approaches.
- Use a behavioural chart, for example an ABC chart, to record:

  - Antecedent: what triggered the behaviour (e.g. activities, settings, objects, individuals, thoughts, feelings)

  - Behaviour: what did the behaviour look like (give a clear description of the behaviour that occurred)

  - Consequence: what actions were taken to support the person and what was the outcome (include what approaches were taken to support the resident and how the person responded to these approaches. It is important to include what did not work as well as what did work).

- You may need to try several different things over a few weeks before you see improvement. If distress or behaviours do not resolve with the advice given in the following table, consult with the GP.

NB: ABC chart is added in Appendix 1

POSSIBLE CAUSE: PHYSICAL HEALTH	
Challenging behaviour may result from:	**Ideas for staff**
Pain People with dementia are often not able to identify or may deny pain due to cognitive impairment. Pain can be a major trigger for agitation and aggression and is one of the most common causes of behavioural. symptoms in dementia.1	Think about potential **cause** of the pain. **Ask** the person – keep questions simple. ▪ Check for any **pressure sores/ ulcers.** If the person is unable to verbalise pain ▪ Use pain assessment tool – this can guide you to the cause of the pain, severity, when it occurs and what helps to make the pain better or worse. ▪ Look for **signs** e.g., facial expressions, body language. ▪ **Observe pain response** during personal care, tasks, and transfers. **Factors that could help to alleviate pain:** distraction, relieving boredom, a calm, comfortable environment, social contact, treating anxiety and/ or depression. If prescribed 'When required (PRN)' pain relief, ensure there is a PRN protocol which is person-centred. This will help to identify what signs and symptoms to look out for that might suggest a resident is in pain. If requiring 'PRN' medicines regularly, liaise with the GP to decide whether the medicine should be prescribed regularly.
Infection	Refer to GP. For assessment of UTI, refer to 'To Dip or Not to Dip? (agedcarequality.gov.au) (refer to the section on UTIs and hydration on the webpage)
Hunger, thirst, dehydration.	Is pain affecting ability to eat or drink e.g. dentures, painful teeth? Check access to food and fluids. Visual aids, such as pictorial menus or showing plates of the food on offer may help people to make choices. Refer to Hertfordshire and West Essex Integrated Care board (HWEICB) Malnutrition pathway download (hweclinicalguidance.nhs.uk) and other fortifying food guideline download (hweclinicalguidance.nhs.uk).
Constipation	Monitor bowels (using bowel chart).

Sensory impairment e.g., eyesight	Check that there is enough light. If the person wears glasses, make sure they are clean.
Poor eyesight/ hearing can lead to misunderstandings and misperceptions (the person can mistake what they see or hear for something else)	Be aware that reflections in mirrors could be misinterpreted as another person. Remember that many people with sight loss will not pick up on visual communication e.g. facial expressions might be lost to them. Improve ways of verbal communication e.g. ask the person where you are most likely to be seen and heard, given their condition. Three key principles: 1. Make things bigger (such as using clocks and watches with large numbers). 2. Make things brighter (by using good lighting). 3. Make things bolder (use contrasting backgrounds).
Restlessness	Consider body language, facial expressions, gestures, general demeanour. ▪ If the person is pacing around, do they want to go for a walk? ▪ Are they fidgeting because they need to use the toilet?
Medication side effects	Liaise with GP.

POSSIBLE CAUSE: ENVIRONMENTAL FACTORS	
Challenging behaviour may result from:	Ideas for staff
Over-stimulation	Noise that is acceptable to care staff may be particularly distressing and disorientating, especially busy times of the day such as shift change-over and mealtimes. ▪ Consider quiet time. ▪ Consider change of scenery e.g. garden, another room. ▪ Tailor music/songs to what the individual prefers. ▪ Be alert to noise from other devices such as alarms, doorbells, telephones. Try to minimise these types of noises, which can be intrusive, especially at nighttime.
Under-stimulation	Use meaningful activities that are relevant to the person based on interests, hobbies, or previous work. Frequent, short conversations (as little as 30 seconds has proven effective). ▪ Use social areas to encourage interactions. ▪ Some people relate better to pictures than words. ▪ Consider music (tailored to what the individual likes). Music from the past can bring back good memories. ▪ Just 60 minutes of pleasant activities each week improves behaviour and other symptoms.
Getting used to a new place. May take up to 6 weeks for people to feel settled.	Use information from family and/ or previous care facility of what has helped in the past. Familiar items e.g., personal belongings in room. Consistency with people involved in the person's care, particularly in the first few weeks. Support the person to continue their preferred routine. (Routines help the person with dementia know what to expect). When they wake up, for example, do they normally have the radio/TV on?

Confusion linked to physical design of the home	Ensure there is good lighting. Use of pictures and colours to find the way around (some people relate better to pictures than words). Clear signage to toilets.
Reactions to uncomfortable temperatures	▪ Check that the temperature is not too hot or too cold.
Challenging behaviour may result from:	Ideas for staff
Lack of knowledge about the person and their beliefs and preferences	The more you know about the person with dementia, the more likely it will be to understand what they may be trying to communicate. Consider the following: ▪ Life story. ▪ Personal likes and dislikes. ▪ Important relationships. ▪ Culture – promote respect for religious or cultural rules and customs. ▪ Beliefs. Consider whether the person thinks they have work or care responsibilities. e.g. that they need to go to work. Offer alternative meaningful activity which will be valued by the person. Acknowledge where the person is at - don't argue or attempt to change their viewpoint. Promote work with family members to inform care and better understand the resident.

POSSIBLE CAUSE: LACK OF UNDERSTANDING OF HOW THE PERSON SEES AND INTERPRETS THEIR WORLD	
Challenging behaviour may result from:	Ideas for staff
Person unable to communicate their needs or requests are being ignored	Be proactive with checking person's needs at frequent intervals. Use short, simple sentences or statements or non-verbal gestures to indicate walking to the toilet etc.
Hearing and visual difficulties	Check for sensory impairment. Find a suitable place to talk, with good lighting, away from noise and distraction. If they have visual impairment on one side then approach from the other. Ensure verbal communication is clear, loud enough (but not shouting as this might look aggressive), speaking slowly enough, talking into the good ear.
Difficulty in recognising everyday objects	Use alternative means to aid recognition e.g. holding object, by demonstrating use of object, for example, flushing a toilet.
Repetitive behaviour **e.g. repeating actions, words, gestures**	If a person is repeating the same question or phrase, try to help by offering an answer to break the cycle e.g. if asked the time, tell them the time, and also show them the time on a watch or clock. When an action is repeated, e.g. packing a bag or folding clothes, this may be linked to a previous job or hobby. Try turning this into an activity.
Lack of inhibition **(disinhibition)** **Behaving in a way that others might find embarrassing (for example, saying things that aren't appropriate)**	Use distraction techniques and alternative means of meeting needs. Observe for time of day and notice triggers.
Experiencing delusions and visual hallucination symptoms	Take personal care tasks slowly and give repeated reassurance about intentions. Acknowledge the delusion/ hallucination - don't ignore it or try to prove to the person they are wrong. If they are not concerned or anxious about it, then don't dwell on it. Ensure plenty of reassurance if the person is worried and ensure there are alternative activities to be involved in. Liaise with GP.

POSSIBLE CAUSE: UNDERLYING EMOTIONAL OR MENTAL HEALTH PROBLEMS	
Challenging behaviour may result from:	Ideas for staff
Undiagnosed depression and anxiety	Ensure resident has access to activities and actively encourage participation. Promote active involvement of relatives in care. Be aware of triggers for anxiety e.g. confined places.
Person may be searching for a loved one	Try to provide the person with a sense of control and safety and ask them about their loved ones. Try to avoid correcting what they say as it is much more important to focus on the person's feelings rather than whether what they are saying is true. Try using life story information and photos to reinforce sense of identity and enhance memories.
Experience of bereavement or effects **of traumatic events in their life**	Enable safe expression of emotions. It might be more positive to enter and accept their reality rather than bring the person back to our reality. Acknowledge and empathise with their feelings. Check with family what works. Enable usual coping behaviours, e.g. safe walking. Consider using dolls and pets.
Disorientation and memory problems	Try to make the most of the person's strengths and remaining abilities.

Acknowledgement to Sussex Partnership NHS Foundation Trust- the above table is based on version 4 of the document 'Reducing antipsychotics in people living with Dementia' .Other references used: Social Care Institute for Excellence (SCIE) https://www.scie.org.uk/dementia/ Alzheimer's Society https://www.alzheimers.org.uk/about-dementia

Useful Resource : Alternative therapies for dementia | Alzheimer's Society (alzheimers.org.uk)

APPENDIX 1:

ABC stands for Antecedence, Behaviour and Consequence, and is an important way of reviewing how well a person with behavioural problems is responding to different situations. Completed ABC charts and / or diaries must be reviewed along with the person-centred care plan at regular intervals, including at medication review, to help decide what plan of actions to continue with.

Antecedence

Record the situation in which the problem behaviour occurred, for example.

- Time of day, activities that were happening or about to happen.
- Was anything different to usual?
- Any other clues to set the scene.

Behaviour

Record the actual behaviour.

- What happened? How long did it last for? How severe was it?
- Did anyone present do anything to try and manage it? If so, what?

Consequence

- How did the behaviour settle? How did the person respond to attempts to manage the behaviour?
- Important to include things that didn't work. What worked well?
- Were there any significant consequences, eg family member now refusing to visit, care staff injured, patient fell or hurt themselves?
- Did anything else happen after the episode of behaviour?

Date and Time	Antecedent (What triggered or came before the behaviour?)	Describe the behaviour (include location and other aspects of the environment (eg, lighting, noise)	Consequence (What did you do, or what happened to the behaviour? How severe was it?)	Outcome (What did the observed person do after the incident was over?)

Acknowledgement to Hertfordshire Partnership Foundation NHS Foundation Trust (HPFT)- the above information in appendix 1 and table is based on version 1 of the document 'Guidelines for the pharmacological Management of Dementia' (Butterworth,2020).

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Version	2.1
Developed by	SM Badrul Hyder, Senior Pharmaceutical Advisor, Social care and Integration, Hertfordshire and West Essex Integrated Care Board (HWEICB)
Date Ratified	October, 2024
Review Date	October, 2025

Version 1.1: Developed by Pragna Patel, Care Home Improvement Team Pharmacist, Herts Valleys CCG, Date ratified October 2020 (Medicines Optimisation Clinical Leads Group, HVCCG);

Version 2: Developed by SM Badrul Hyder, Pharmaceutical Advisor, Social Care & Integration, Hertfordshire and West Essex ICB, Date ratified: May 2024 (Medicines optimisation & Prescribing delivery & implementation group, HWEICB).

Version 2.1: Developed by SM Badrul Hyder, Pharmaceutical Advisor, Social Care & Integration, Hertfordshire and West Essex ICB, Date Ratified: October 2024 (Medicines optimisation & Prescribing delivery & implementation group, HWEICB)

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EPUT DTC, August 2024