"How to" Guide:

Optimising the care of patients with dementia and BPSD

Purpose of this document

This document is designed to help secondary care clinical pharmacists to support the reduction of inappropriate prescribing of antipsychotic medicines for patients who have behavioural and psychological symptoms of dementia (BPSD). This will contribute to improving patient safety and outcomes in this cohort of patients and deliver continuous quality improvement in dementia services, aligning pharmacy contributions to the national 2012/13 ‘dementia’ CQUIN (standards for the quality of service which are related to payments received).

Note: Clinical team leaders will need to consider whether this guide can be used as a ‘stand alone’ resource for their Band 6 & Band 7 pharmacists, or whether some in-house training will be needed to support actions to be taken locally, if a potentially inappropriate prescription for an antipsychotic in a patient over 65 is identified. The recommendations below will also need to be read in the context of local policies. For example, many acute organisations have now set up specific pathways for this group of patients which may include referral to local mental health teams.

Background

In 2009 the Department of Health produced a report which raised public awareness of the estimated 1800 excess deaths and 1620 severe cardiovascular adverse events per year as a result of the use of antipsychotic medication in patients with BPSD. As a result, reducing morbidity and mortality in this patient cohort is, and continues to be, a national priority.

This document provides practical advice for pharmacists who work with patients on general wards. Preliminary work has suggested that the use of antipsychotics in patients over 65 years of age on general wards is unusual, occurring at a frequency of about 2 per week per pharmacist. In additions, these patients do not always suffer from dementia, so the strategies below should be achievable within current resources. As some hospitals have a policy to refer such patients directly to a mental health outreach team, you will need to find out what systems have been set in place in your organisation to address this issue. However, where no detailed arrangements are in place, this guide is designed to help you to contribute to improving care for this patient group.

Why pharmacists?

Pharmacists are highly regarded as clinical practitioners by other health and social care professionals, particularly in relation to medication use and therefore we can act as role models for good dementia care. Our unique ability to combine a general background of disease and therapy, with specialist knowledge of formulation, supply, and pharmacokinetics, complement the skills of other members of the health and social care team caring for patients with dementia.

In order to ensure that you have the background knowledge to implement the guidance, you may find it helpful to read the resource entitled “Reducing inappropriate use of antipsychotics for patients with Behavioural and Psychological Symptoms of Dementia (BPSD) in Primary and Secondary care”. You can find this in the dementia section on Link. This resource provides you with background information, support with improving your knowledge of the symptoms and management of BPSD, information for training others and for conducting audit in this key clinical area.

The following recommendations were developed from a Medicines Use and Safety workshop on reducing inappropriate use of antipsychotics in secondary care patients with dementia, held on 26th January 2012 in London.
What to do when you see a prescription for an antipsychotic in a patient over 65

1. Review the indication for the medication and write the indication on the drug chart. This will improve transfer of information relating to this therapy at discharge. Note whether there has been mental health team involvement and, if appropriate, highlight the need for referral to the team. You will need to ask your local mental health pharmacist how the process works in your locality.

2. If the indication is dementia (BPSD), find out whatever you can about
   a. When the medication was started, who initiated/recommended the treatment and details of any reviews
   b. When the latest review occurred and who was responsible (if known)
   c. Whether the medication is licensed for its current use. If licensed, confirm appropriateness of dose, form, route, frequency and ensure that the length of treatment is according to the summary of product characteristics. If unlicensed, follow local protocols for unlicensed medicines and ensure the clinical team is aware of the implications of unlicensed use.
   d. Whether the cognitive score (e.g. MMSE, AMTS, ACER) has changed since admission (if recorded). Do this for patients admitted on the therapy and also for those newly initiated in hospital.

3. Obtain as much background as you can about the reason for starting antipsychotics for this patient, which may require discussion with medical, mental health and social care teams, carers and family.

4. Decide on your recommendation, with the help of colleagues if required. Recommendations may include:
   a. stopping the medication and observing the patient,
   b. downward dose titration with the aim of withdrawal over weeks
   c. Initiation of alternative strategies for management, either to replace medication or to support dose reduction (may be drug and/or non drug).

   Recommendations and decisions should be discussed with the family/carers (usually the responsibility of the medical and/or nursing staff) and include a treatment plan and dates for review

5. Ensure recommendations are communicated to the prescriber and/or the responsible clinical team. Ideally this communication should be in writing, as well as verbally, to optimise continuity of care.

6. If patients are continued on an antipsychotic, annotate the discharge PRESCRIPTION with the indication for the medication and planned duration of antipsychotic. For unresolved use of antipsychotic medication, annotate the discharge prescription with a note highlighting the medication that requires review after discharge e.g. items prescribed with no indication information available in hospital

7. For patients continued on an antipsychotic, document on the discharge SUMMARY;
   - If it is to continue and for how long
   - Plan for dose reduction and dates for review

8. Working with the nursing team, ensure that contact is made with the GP surgery and the community mental health team (if involved) to alert them of
   a. the date of the patient’s discharge,
   b. recommendations
   c. details regarding review of these medicines

What to do if an antipsychotic is proposed to manage a patient with BPSD

1. Check whether the patient’s symptoms (e.g. agitation, restlessness) may be either caused or exacerbated by:
   a. Pain e.g. look at prn analgesia that may be unable to be taken, consider regular analgesia/formulation change.
   b. Constipation – check prescribing is appropriate
   c. Depression - has a mental health review been undertaken?

See also MUS dementia resource ‘case scenarios’ Link, ‘case answers’ Link and therapeutic update presentation Link and
2. Look at the ‘antecedent, behaviour, consequences’ chart, see http://www.specialconnections.ku.edu/?q=behavior_plans/functiona...chart to support identification of triggers for BPSD. Discuss reduction of these triggers with clinical team to prevent unnecessary use of antipsychotics.

3. Encourage the use of a non-drug approach before considering medication, see https://www.alzheimers.org.uk/site/scripts/documents.php?categoryID=200348&gclid=CJqIn9rqt8kCFQIQwwodN_YDmw

4. Don’t forget “simple” interventions such as ensuring access to a working hearing aid, reading glasses, playing the patient’s favourite music, offering tea and biscuits etc.

5. If an antipsychotic is required, ensure that U+E, ECG, LFT, FBC are completed before prescribing. Atypical agents are preferable, using risperidone first at the lowest dose for the shortest duration, with review times set. Encourage separate prescriptions for different routes as doses may not be equivalent. Note that the BNF maximum doses may be too high for vulnerable populations.

6. Liaise with nursing staff and/or discharge team to ensure that all staff and family caring for the patient are aware of monitoring parameters and the warning signs of deterioration or adverse effects.

Examples of how you can highlight these antipsychotic prescribing issues within your pharmacy team

- Discuss the rationale for reviewing antipsychotic prescribing in patients with BPSD at a clinical meeting.
- Through your clinical pharmacy manager, discuss opportunities for restricting prescribing of benzodiazepines and antipsychotics for patients over 65 years, perhaps in a similar way to restricted antibiotic prescribing, or think about how guidance on reducing inappropriate use of antipsychotics in patients with BPSD could be included in hospital policy and how that might be taken forward.
- Ask your dementia nurse (mental health team) for a teaching session on working with patients with BPSD.