Medicines Optimisation and BPSD

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Medicines optimisation

- Patient focused
- Collaborative working
- Stakeholders
- Current drivers influencing change
  - Clinical commissioning group outcome indicator set
  - Part of NHS England’s systematic approach to quality improvement
Example of CCGOIS

- Mental Health
- Enhancing the quality of life for people with dementia prescribed antipsychotic medication
Sube Banerjee’s Report

- 2009 - Professor Sube Banerjee’s report\(^2\) “Time for Action” highlighted problem of overprescribing of antipsychotics in order to manage BPSD

- Ministerial Mandate to reduce this prescribing – TWO THIRDS reduction by late 2011; renewed in NHS Operating Framework 2012/13

- CCGO I set 2013/14 – Dementia included as an area requiring particular attention
Why is antipsychotic prescribing a problem? – The clinical evidence

“...examine the use of antipsychotic medication for people with dementia in the NHS in England...concerns over the past years about the use of these drugs...there are indeed significant issues in terms of quality of care and patient safety...”

- 180,000 people with dementia treated with antipsychotics per year
- Up to 36,000 (about one third) may derive some benefit from treatment
- Results in additional **1,800 deaths** and **1,620 cerebrovascular events** per year
- Side-effects are common and can be severe sedation, extrapyramidal symptoms, worsening cognition, gait disturbance leading to falls/fractures and increased risk of stroke
Behavioural and Psychological Symptoms of Dementia (BPSD)

- Describes the group of non-cognitive symptoms experienced in dementia
- Affects 50–80% of patients with up to 90% of dementia sufferers experiencing BPSD at some point
- The appropriate initial management approach depends on the symptom, its type, severity, frequency and impact, and the situation in which it occurs
- Treatment is still not well informed by properly conducted studies and many available agents have been linked to serious adverse effects
Symptoms

The symptoms of dementia occur in three groups:

1. **Cognitive dysfunction**, resulting in problems with memory, language, attention, thinking, orientation, calculation, and problem-solving.

2. **Psychiatric and behavioural problems (affect 50-80%)**, such as changes in personality, sexual disinhibition, depression, aggression, disruptive vocal activity such as shouting and sun downing (behaviour worsens after 5pm), hallucinations and delusions.

3. **Difficulties with activities of daily living**, such as driving, shopping, eating, and dressing.
Assessing the BPSD – prior to treatment

NICE Guidance for dementia\(^1\) recommends:

“People with dementia who develop non-cognitive symptoms or behaviour that challenges should be offered a pharmacological intervention in the first instance only if they are severely distressed or there is an immediate risk of harm to the person or others.”

- The assessment for *behaviour that challenges* should be comprehensive and include:
  - the person's physical health
  - 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.

- The frequency of the review should be agreed by the carers and staff involved and written in the notes.
Treatment Options - Non-pharmacological

- Aromatherapy
- Reflexology
- Massage
- Psychological strategies
- Snoezelen
- Exercise
- Art & music therapy

Non-pharmacological/non-drug measures
The four guiding principles of medicines optimisation

Principle 1: Aim to understand the patient’s experience
- To ensure the best possible outcomes from medicines, there is an ongoing, open dialogue with the patient and/or their carer about the patient’s choice and experience of using medicines to manage their condition; recognising that the patient’s experience may change over time even if the medicines do not.

Principle 2: Evidence based choice of medicines
- Ensure that the most appropriate choice of clinically and cost effective medicines (informed by the best available evidence base) are made that can best meet the needs of the patient.

Principle 3: Ensure medicines use is as safe as possible
- The safe use of medicines is the responsibility of all professionals, healthcare organisations and patients, and should be discussed with patients and/or their carers. Safety covers all aspects of medicines usage, including unwanted effects, interactions, safe processes and systems, and effective communication between professionals.

Principle 4: Make medicines optimisation part of routine practice
- Health professionals routinely discuss with each other and with patients and/or their carers how to get the best outcomes from medicines throughout the patient’s care.
At Initiation

- Define target symptom(s), including history, severity and frequency
- Exclude possible underlying cause(s), e.g. pain, infection, drug-induced
- Consider aggravating or alleviating factors
- Consider non-pharmacological approaches, if appropriate
- Document reason(s) for pharmacological management, e.g. severe distress
- Consider cardiovascular risk factors, when initiating antipsychotics
- Ensure baseline physical health monitoring, including relevant blood tests
- Discuss with service user/carers, i.e. risks versus benefits, & if “off-label” use
- Document details of treatment, i.e. medicine name, dose and frequency
- Confirm next review, ideally within two weeks

At Review (every 3-6 months)

- Assess changes in target symptom(s), including severity and frequency
- Assess for any side-effects, including any necessary management
- Ensure physical health monitoring completed, including obs & blood tests
- Consider medication cessation or reduction, if appropriate and rationale
Antipsychotics- General Principles

- An atypical antipsychotic is to be preferred over a typical one lowest possible effective dose, for the shortest possible time, ideally less than 12 weeks. Where symptoms respond to treatment, the antipsychotic may be continued for up to 3-6 months then a trial discontinuation should be attempted.

- Continuation should be reviewed regularly (2 weekly); at review, reduction or cessation of the medication should be actively considered.

- Ensure baseline and follow-up physical health e.g. blood tests and ECG

Varying side-effect profile – guide choice?

**Risperidone** 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.”

No other antipsychotics licensed for use in Alzheimer’s dementia therefore “off-label use”
Alternative options

Benzodiazepines
- Widely used but poorly supported
- They have been associated with cognitive decline and increased frequency of falls and hip fracture in the elderly population

AChEIs (donepezil, rivastigmine and galagamine)
- Their effect apparent only after several weeks of treatment
- Rivastigmine has shown positive results for neuropsychiatric symptoms in LBD and VD
- A systematic review of RCTs concluded that AChEIs have a modest impact on BPSD

Antidepressants- Trazodone TCA with sedative effects and may be considered for the management of anxiety, agitation and aggression,
Mood stabilisers/anticonvulsants - Carbamazepine

- Carbamazepine: LIMITED evidence - agitation and aggression in BPSD

- CNWL approved carbamazepine for the management of agitation and aggression as a behavioural and psychological disturbance in dementia--- but remains “off-label” use---

- Ensure physical health monitoring i.e. baseline and follow-up bloods tests
Medicines Optimisation-Key Consideration in BPSD

- Patient’s/Carers education—Understand what your medication is for
- Watch out for side effects—let healthcare professionals know so they can help
- Formulation: Once daily = preferable, Modified release preps—don’t chew/break
- Physical help in taking medicines? Blister packs with days printed, alarms, telephone services etc..
- Pharmacist can help arrange repeat prescription from GP
- Home delivery of medicines
More information for service users and carers

1. Patient Information Leaflets
2. Choice and Medication Website http://www.choiceandmedication.org/cnwl/
3. Medicines Information Helpline
4. My Medication Passport

Medicines Helpline

Service Users and Carers can call the helpline and speak to one of our pharmacists about their medication.

Examples of questions could include:

- What is my medicine for?
- How long will it take for my medicine to work?
- Will my medicine cause side effects?
- Is it safe to take with the other medicines I take?

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Summary: Medicines Optimisation in BPSD

- Assessment and identification of target symptoms-exclude physical illness such as constipation, pain and infection
- Individualise treatment and assess risk factors
- Informed decision-making with individual and carers (discuss and clearly document treatment options and explain the risks to patient/family/carers)
- Frequent monitoring for adverse events and review treatment with consideration of discontinuation
References


9. The Royal College of Psychiatrists Faculty for the Psychiatry of Old Age. Atypical antipsychotics and behavioural and psychiatric symptoms of dementia PRESCRIBING UPDATE FOR OLD AGE PSYCHIATRISTS . Accessible via; www.rcpsych.ac.uk/pdf/BPSD.pdf