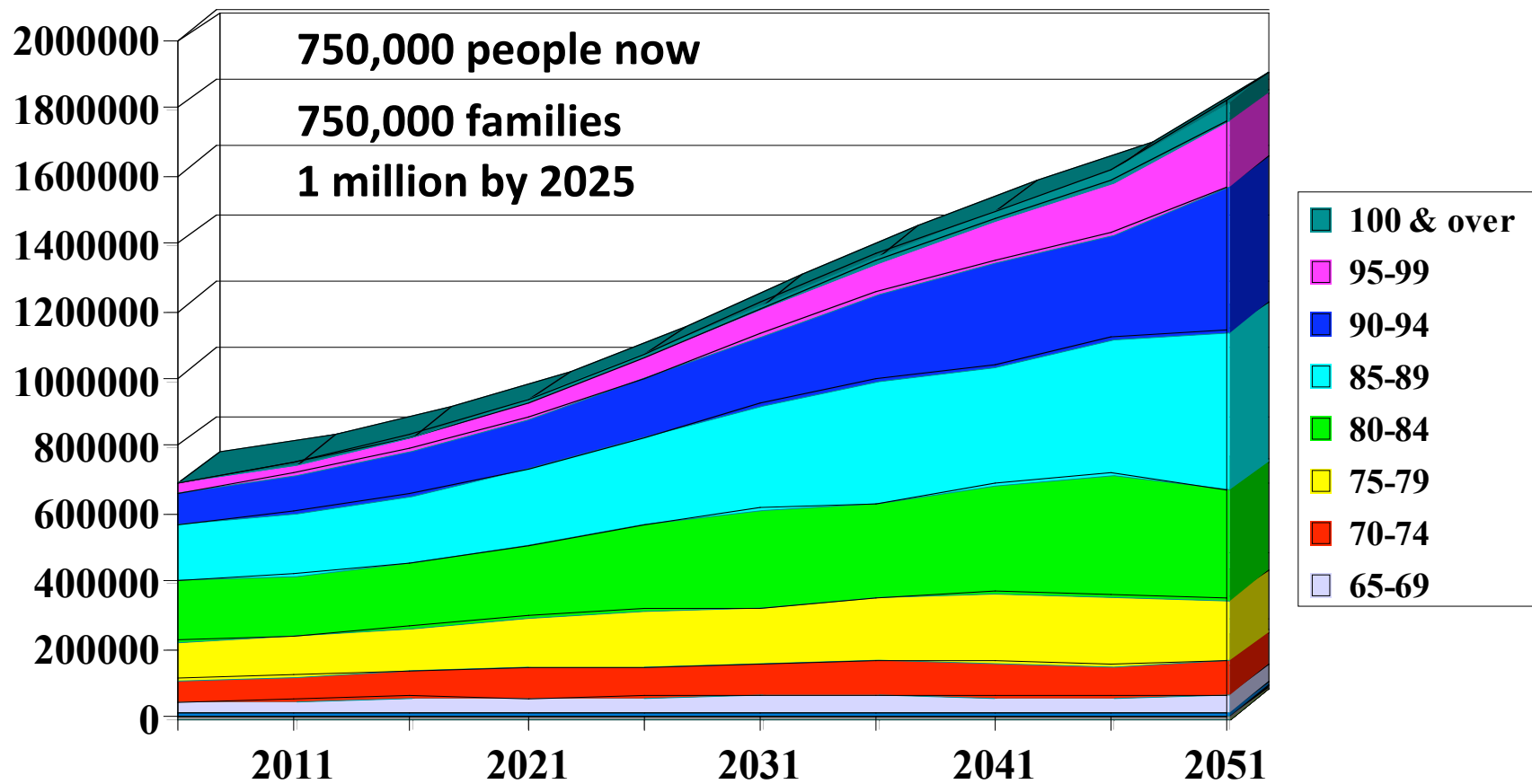


**Management of Behavioral and
Psychological Symptoms in People with
Dementia Living in Care Homes:
A UK Perspective**

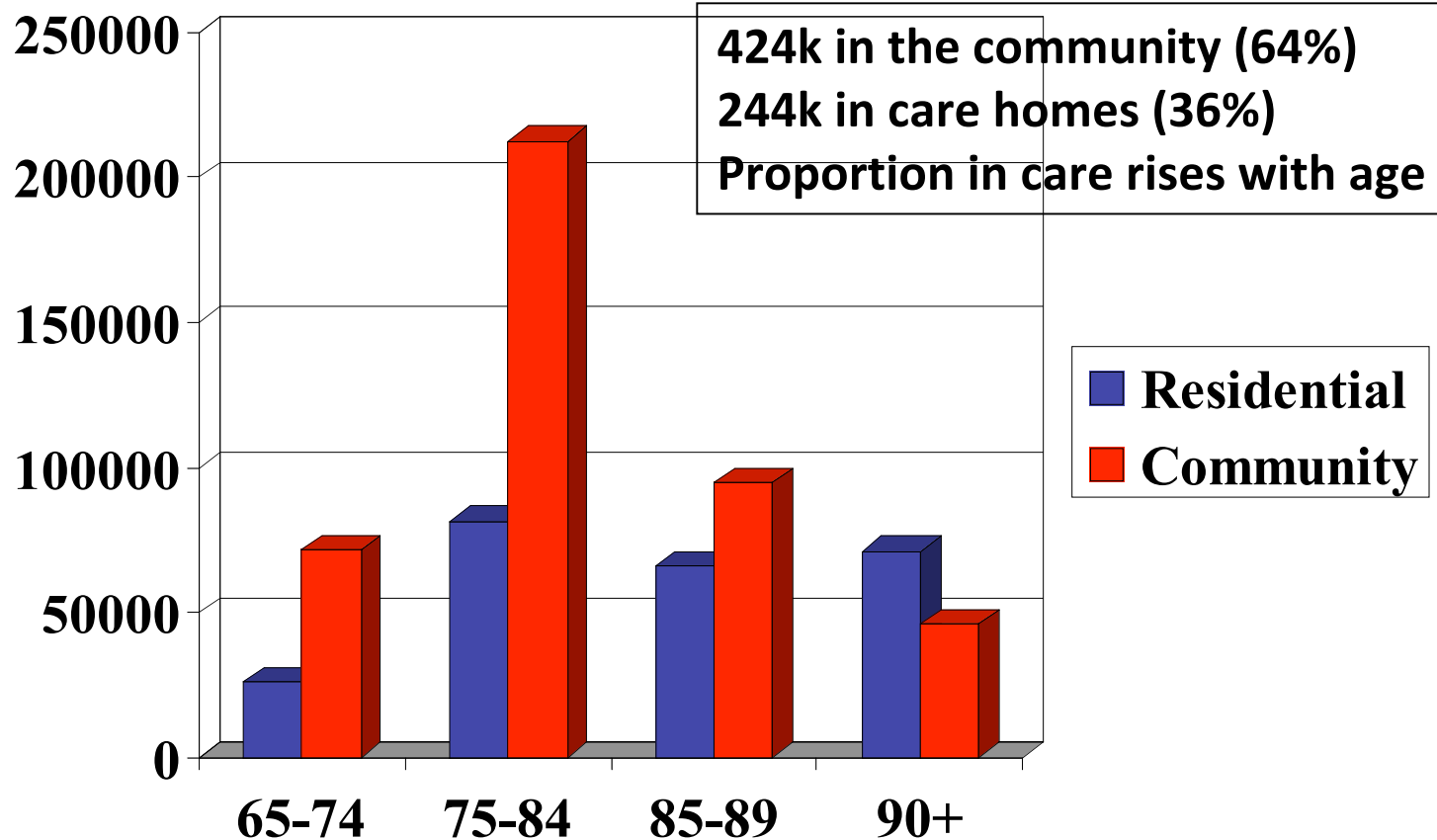
Clive Ballard
Professor of Age Related Diseases,
King's College London
And Director of Research, Alzheimer's Society (UK)

Exploring new directions



Dementia UK Results

Where are people with dementia?



Care Homes in the UK



- Independent of the NHS: Vast majority are privately owned and run
- >70% of places funded by social services (means tested)
- 28,000 care homes: nursing homes and residential homes
- 25% places allocated for people with dementia
- Care Quality Commission acts as the regulator

Care Homes and Dementia

- 750,000 people with dementia in the UK. 250,000 of these individuals live in care homes (Dementia UK report)
- >70% of people in care homes in the UK have dementia, despite only 25% of places being specifically registered for dementia patients
- No mandatory dementia training for care staff
- Nursing homes have legal requirement for minimum of trained nurses, no requirements in residential homes
- Almost all hands on care provided by care assistants on minimum wage, with no or minimal formal training (small proportion have NVQs)
- Massive turnover of care home staff, substantial proportion of care home staff speak poor English and often do not have a good grasp of relevant cultural issues

Care Quality Commission



- Governance body, answerable to government, responsible for ensuring adequate quality of care home services
- Role
 - Inspect care homes, but criteria very centred around “hands-on” care needs not social needs
 - Investigate complaints, reports of abuse and neglect, safeguarding issues
 - Assess quality of care
 - Produce a publicly available report for each care home
 - No responsibility for prescribing/pharmacotherapy issues

Antipsychotics in Care Homes

- Estimated that 180,000 people with dementia on antipsychotics in the UK, the majority residing in care homes
- Research studies suggest >40% of care home residents with dementia prescribed antipsychotics
- Median duration of antipsychotic prescriptions to people with dementia in care homes are 1-2 years
- Reducing Antipsychotic prescribing has become a major clinical and political issue in the UK, but is a medical rather than a care home responsibility

Letter to Minister of State Professor Sube Bannerjee

- Some people benefit from these medications (eg where there is severe and complex risk) where trials have not been completed but there may be particular value in using these medications.
- I estimate that we are treating 180,000 people with dementia with antipsychotic medication across the country per year. Of these, up to 36,000 will derive some benefit.
- Negative effects that are directly attributable to the use of antipsychotic medication at this level equates to
 - 1,620 cerebrovascular adverse events, around half of which may be severe
 - an additional 1,800 deaths per year on top of those that would be expected in this frail population
- I estimate that we can reduce the rate of use of antipsychotic medication to a third of its current level over a 36 month period.



2010-11: Action on antipsychotics (UK)

- Minister Paul Burstow pledges to reduce antipsychotic use by 2/3
- Department of Health Stakeholder group set up
- National audit and ongoing audits of antipsychotic prescribing
- Ministerial Advisory Group for dementia research prioritizes research to improve the treatment of neuropsychiatric symptoms
- Best practice guide (draft launched 9th June) – Developed by the Alzheimer's Society with DH, with support of expert group and the Dementia Action Alliance

Department of Health Actions

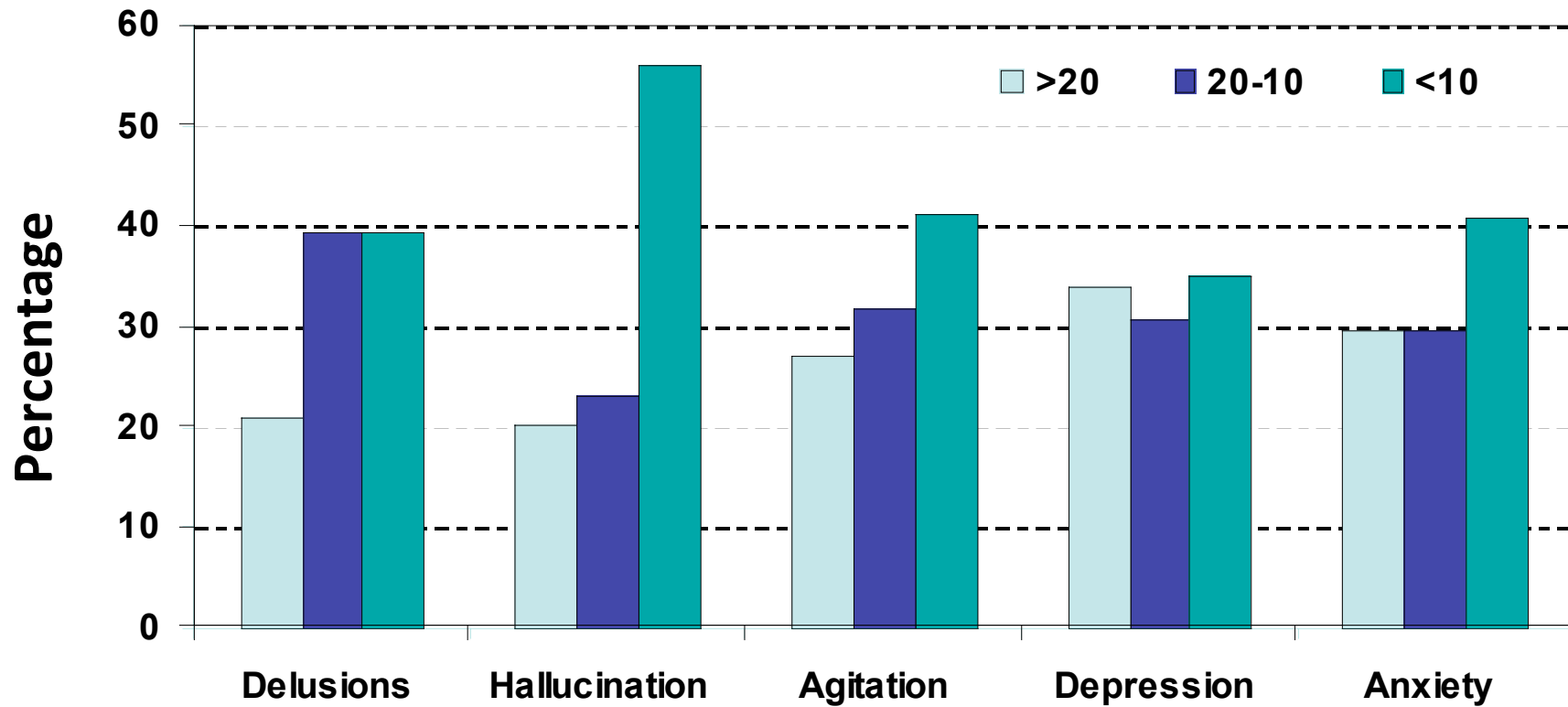


- Target: to reduce antipsychotic prescribing by two thirds
- Beginning to Implement audit of medical prescribers, with goal of making information publicly available
- Mandatory enforcement of 12 week reviews (advisory up to now)
- Best Practice Guide
- Modest support for training initiatives (eg FITS)
- So far in 1 year – estimated reduction of 21% achieved, but government very dissatisfied with slow progress

Personal Reflections

- Care Quality Commission Need to monitor and report upon prolonged antipsychotic prescribing
- Substantial safe reductions in antipsychotic use and improved practice can only be achieved with a more consistent commitment to evidence based staff training to provide alternatives
- Without increased training, substantial risk that antipsychotics will be replaced by “non-evidence based” alternatives which may be equally or even more harmful
- Pharmacological and non-pharmacological management of Behavioural and Psychological Symptoms in people with dementia needs to be supported as a research priority

Agitation and other BPSD are common



>20: N=119
20-10: N=125
<10: N=162

Non AD dementias

- Vascular dementia (VaD) – Some VaD patients in 2 risperidone studies, but no separate analysis and no specific trials of VaD. Cochrane review of memantine in VaD indicates modest but significant benefit on NPI.
- DLB/PDD – only 1 RCT (with quetiapine), showing no significant benefit. Serious potential concerns re neuroleptic sensitivity. Several trials suggesting some benefit in DLB/PDD with rivastigmine. One poster of RCT indicating benefit of Pimavanserin in PD psychosis
- Marked need for treatment studies examining treatment of neuropsychiatric symptoms in non-AD dementias

Risperidone Efficacy: BEHAVE-AD

Ballard & Howard 2006 Nature Neuroscience Reviews

	Target symptom	Mean Difference from placebo	p value	95% CI
Risperidone 1mg	Psychosis	-0.79	p=0.03	-1.31 to -0.27
Risperidone 1mg	Aggression	-0.84	p=0.0002	-1.28 to -0.40
Risperidone 2mg	Aggression	-1.50	p<0.0001	-2.05 to -0.95

STAR TRIAL: Zhong et al 2007

	Quetiapine 200mg (N=114)	Quetiapine 100mg (N=120)	Placebo (N=92)	Evaluation
PANSS-EC	-5.7 (0.9)	-4.9 (0.8)	-3.9 (0.9)	NS
NPI (total)	-9.7 (2.2)	-8.9 (2.1)	-8.2 (2.4)	NS
NPI (agitation)	-1.1 (0.5)	-0.9 (0.5)	-1.2 (0.5)	NS
NPI (psychosis)	-2.5 (0.9)	-1.8 (0.8)	-2.5 (0.9)	NS
CGIC	3.0 (0.2)	3.2 (0.2)	3.6 (0.2)	NS

Adverse events with Risperidone

Ballard & Howard 2006, Nature Neuroscience Reviews

Adverse events	Dose / day	Risperidone	Placebo	Odds Ratio	95% CI	P Value
Extra pyramidal symptoms	1mg	32 / 500	20 / 571	1.78	1.00 to 3.17	p<0.05
	2mg	35 / 165	12 / 163	3.39	1.69 to 6.80	p=0.0006
Gait	1mg	21 / 402	1 / 408	7.47	2.21 to 25.28	p=0.001
Somnolence	1mg	138 / 665	72 / 685	2.36	1.71 to 3.24	p<0.00001
	2mg	46 / 165	13 / 163	2.36	2.30 to 8.64	p<0.00001
Respiratory tract infection	1mg	15 / 149	6 / 163	2.93	1.11 to 7.76	p=0.03
fever	2mg	24 / 165	12 / 163	2.14	1.03 to 4.44	p=0.04
Peripheral oedema	0.5mg	24 / 149	9 / 163	3.29	1.47 to 7.32	p=0.004
	1mg	32 / 315	15 / 333	2.43	1.29 to 4.59	p=0.006
	2mg	30 / 165	9 / 163	3.80	1.74 to 8.29	p=0.0008

Major Adverse Outcomes with antipsychotics over 6-12 weeks (Schneider et al 2005, Ballard et al 2009)

- Parkinsomism
- Sedation
- Gait disturbance
- Increased respiratory infections
- Oedema
- Accelerated cognitive decline
- Stroke (>3 fold)
- Other thrombo-embolic events
- Mortality (1.5-1.7 fold)

No Benefit and Accelerated Cognitive Decline with Quetiapine

	rivastigmine	quetiapine	placebo	ChI v plac	Nlp v plac
Week 6	N=24 (15 completed SIB)	N=26 (14 completed SIB)	N=29 (17 completed SIB)		
Diff CMAI	-8.3±18.4	-4.7±17.3	-6.2±17.2	T=0.4 P=0.67	T=0.3 P=0.74
Diff SIB	+4.2±15.4	-10.5±14.8	+2.8±15.5	T=0.3 P=0.80	T=2.4 P=0.02*
Week 26	N=24 (16 completed SIB)	N=26 (15 completed SIB)	N=29 (17 completed SIB)		
Diff SIB	-1.1±21.1	-11.6±15.6	+2.3±18.1	T=0.5 P=0.61	T=2.3 P=0.03*
Diff CMAI	-10.5±20.4	-4.4±15.7	-7.9±16.6	T=0.5 P=0.62	T=0.1 P=0.87

Change from Baseline to 6 months DART AD

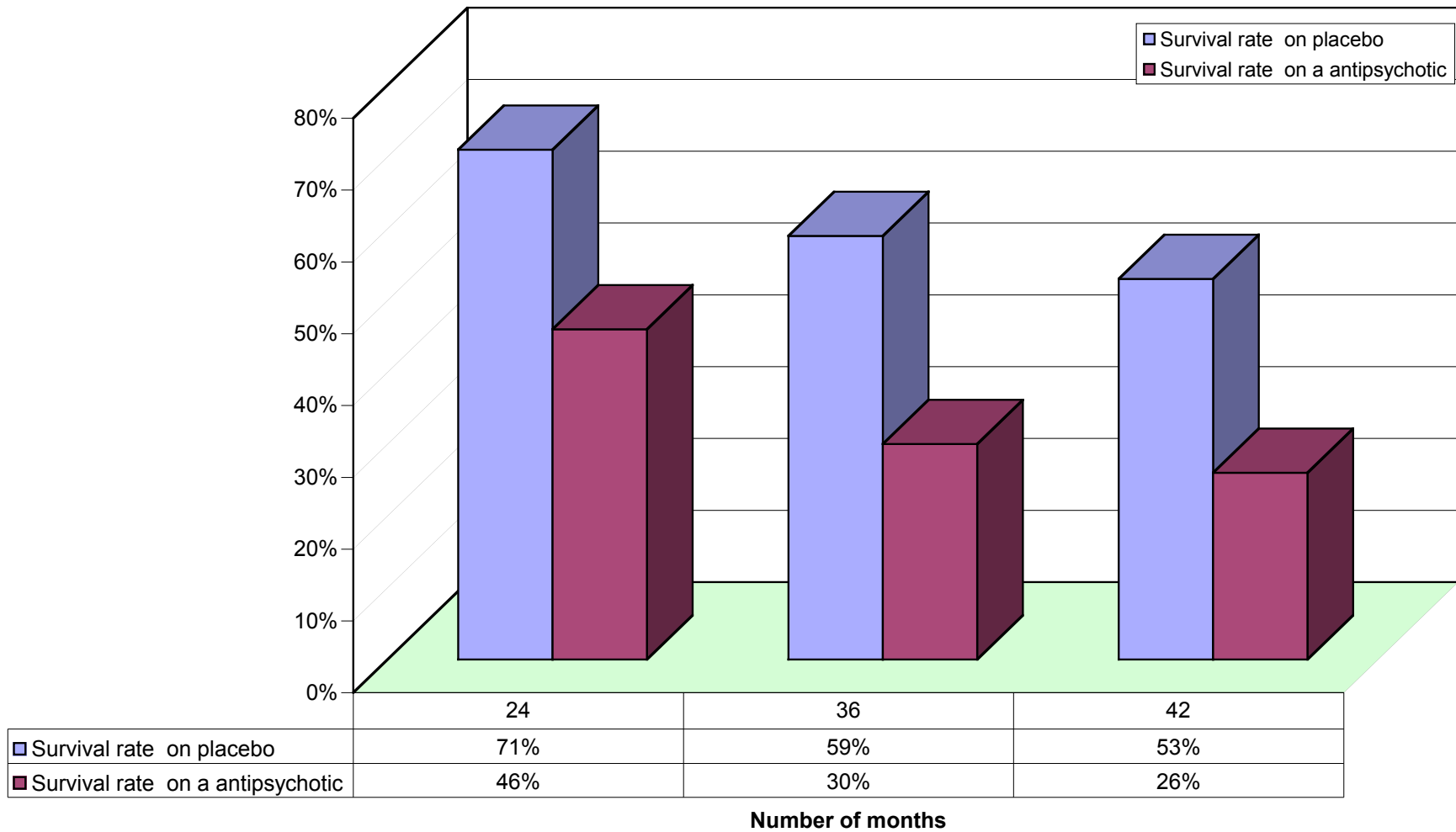
Ballard et al PLOS Medicine 2008

Total NPI	(n=56) 1.3 (15.5)	(n=53) 4.5 (17.6)	-2.4 (-8.2 to 3.5) ³	0.4
MUPDRS	(n=41) 0.8 (4.1)	(n=43) -0.4 (3.2)	1.3 (-0.4 to 3.0) ⁴	0.1
Bristol ADL	(n=54) 1.8 (8.9)	(n=52) 0.2 (7.2)	1.7 (-1.2 to 4.6) ³	0.2
Change in FAST⁵	(n=53)	(n=53)		0.9
-2	0	1		
-1	3	4		
0	34	32		
1	12	8		
2	4	8		
CGIC⁵	(n=48)	(n=48)		0.9
Very much improved	1 (2%)	0		
Much improved	3 (6%)	0		
Minimally improved	7 (15%)	14 (29%)		
No change	18 (37%)	14 (29%)		
Minimally worse	9 (19%)	10 (21%)		
Much worse	7 (15%)	10 (21%)		
Very much worse	3 (6%)	0		

DART AD: Differential Survival

Ballard et al Lancet Neurology 2009

Differences in the survival rates in the DART-AD trial



The dementia antipsychotic withdrawal trial (DART-AD): long-term follow-up of a randomised placebo-controlled trial. www.thelancet.com/neurology.09 Jan 2009

Why do people die?



- Causes of death (Ballard et al 2010)
 - Pneumonia
 - Stroke
 - Pulmonary embolism
 - Sudden cardiac arrhythmias
- Likely Mediating Factors
 - Dehydration
 - Chest infection
 - Over sedation
 - Q-T prolongation

FITS: Stopping Neuroleptics: Impact on Quality of Life

n=42	Baseline (sd)	Follow-up		Evaluation (Baseline v Follow-up)
		FITS (sd)	Control (sd)	
Social Withdrawal	6.64 (8.96)	-5.24 (13.56)	-1.29 (5.42)	T 2.1 p=0.04
Daytime sleep	-20.69 (23.24)	-6.20 (24.58)	-1.29 (24.38)	T 1.1 p=0.27
Type 1 Behaviours	+34.74 (19.53)	+13.44 (23.73)	+1.47 (24.29)	T 2.3 p=0.03
Wellbeing	0.65 (0.69)	+0.34 (0.59)	+0.15 (0.98)	T 2.2 p=0.03
CMAI	42.88 (14.57)	+0.75 (22.35)	+5.29 (12.74)	T 0.83 p=0.41

Standardized tailored psychological Interventions

- Care Homes:
 - Cohen-Mansfield 2007 (n=167) Placebo controlled trial of personalized non-pharmacological interventions for 4 hours over days resulted in significant reduction in agitation ($p=0.002$)
 - Cohen-Mansfield 1997 (n=58) Placebo controlled trial of “social interaction”, music or simulated presence resulted in significant 25% reduction in abnormal vocalizations over 6 weeks
- Teri and Colleagues (Seattle protocols), Gitlin and others have shown similar benefits with structured intervention programmes for people living in their own homes

Efficacy improves with severity of agitation

BPST “tool Box” intervention from CALM-AD STUDY

(Ballard et al Am J Ger Psychiatry 2009)

N= 200	CMAI baseline	CMAI week 4	Evaluation (paired sample t test)
Overall	62.2±14.3	55.6±17.2	T=5.6 P<0.0001
Baseline CMAI <53	47.1±3.8	48.6±15.9	T=-0.7 P=0.46
Baseline CMAI 53-70	61.2±4.8	54.7±16.2	T=4.1 P<0.0001
Baseline CMAI >70	82.4±12.7	67.1±18.9	T=5.3 P<0.0001

Pleasant Activities (including music)

Buettner L & Fitzsimmons 2002	RCT	12	70	Significant results on depression
Choi AN et.al. 2008	Pilot-controlled trial	5	20	Sig. effect on agitation
Cooke ML et.al. 2009	Randomised cross-over design	8	47	NS
Ledger AJ & Baker FA 2007	Longitudinal repeated measure design	42	45 13NH	NS
Lin Y et.al. 2010	Pretest-posttest control group design	6	100	Sig. decrease in agitation, total and 4 subfactors
Raglio A et.al. 2008	RCT	16	59	Sig. Decrease NPI in intervention group Sig. Diff. Between groups
Sung HC et.al.	Quasi-experiment	6	57	Sig. lower agitation
Sung HC et al 2010	Quasi-experiment pretest-posttes	6	29	Sig lower anxiety in intervention group p=0.001

Validation and Reminiscence

Study	Study design	Length	Sample	Impact
<i>Validation therapy</i> Deponete A & Missan R 2006	Pre-test-post-test Randomly assigned	12	30	Within-group effects. SR , VT
<i>Reminiscence therapy</i> Chiang, KJ., et.al. 2010	Experimental design	8	130	Significant positive short-term effect on dpression, psychological well-being and lonliness p<0.0001
Haslam, C. et.al. 2010	RCT	6	115	Cognitive performance improved significantly in GR condition. p=0.04 Well-being in control group condition improved p=0.07
Jones ED 2003	RCT	3	30	Reduction GDS in intervention group Significant diff between groups, p=0.002
Karimi, K., et.al. 2010	Three-group pre-post-test design randomised allocation	6	39	Sig diff betweenintegrative RT and control condition
Lai, CKY., 2004	Single-blinded parallel-groups RCT	6	101	NS T1 and T0 p=0.014 on WIB
Wang, J-J., et.al. 2003	Quasi experimental random assignment	16	94	Sig diff pretest-posttest on depression, p=0.041
Wang, J-J., et.al. 2004	Longitudinal experimental	16	48	Depression, p=0.05 Mood, p=0.05
Wang, J-J., et.al. 2007	RCT	8	102	MMSE, p=0.015 CSDD, p=0.026
Wang, J-J., et.al. 2008	Longitudinal experimental	8	77	NS (sig., p=0.011 on social disturbance subscale of CAPE-BRS

Intervention by a Clinical Psychologist –

- Bird et al 2009: 44 consecutive referrals for challenging behaviour (2/3 in residential care). Assessment and interventions were undertaken in collaboration with family carers and care staff. Outcomes Measures taken pre-intervention and up to 5-month follow-up. Psychotropic medication was used with a minority of participants but, overall, antipsychotic use was reduced. Psychosocial methods predominated, with 77% of cases judged as mainly or entirely psychosocial by expert panel. There were significant improvements in behaviour and carer distress. Using conservative criteria there was a 65.9% clinical success rate.
- Bird et al 2007: 33 residential care clients with BPSD referred to a community psychogeriatric service (intervention group) received treatment with focus on causes of behavior (ABC). Cases were managed primarily by psychosocial means with psychopharmacology as an adjunct. A control group was made up of 22 referrals to an adjacent service, which used primarily psychopharmacology with psychosocial methods as an occasional adjunct. Measures of behavior showed significant improvement in both groups at two- and five-months' follow-up. Antipsychotic use in the intervention group decreased over time while in the control group it increased. Five control group participants spent extended periods as inpatients in a psychogeriatric unit.

Person Centred Care – Kitwood 1995

Person's
Experience

= B + P + H + NI + SP

Background
and
Lifestyle

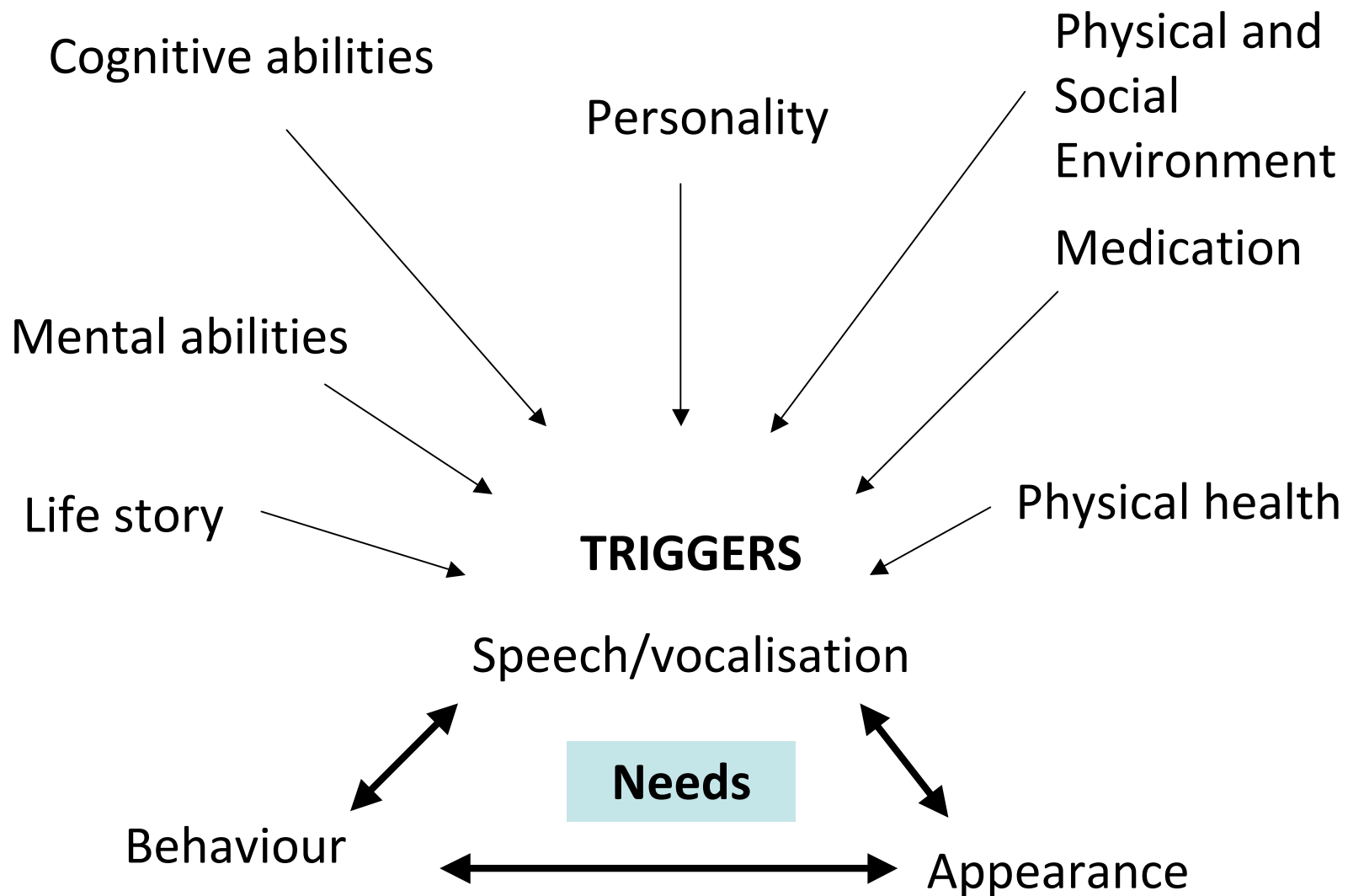
Personality

Health
Illness

Cognitive
Support Needs

Life at the
Moment

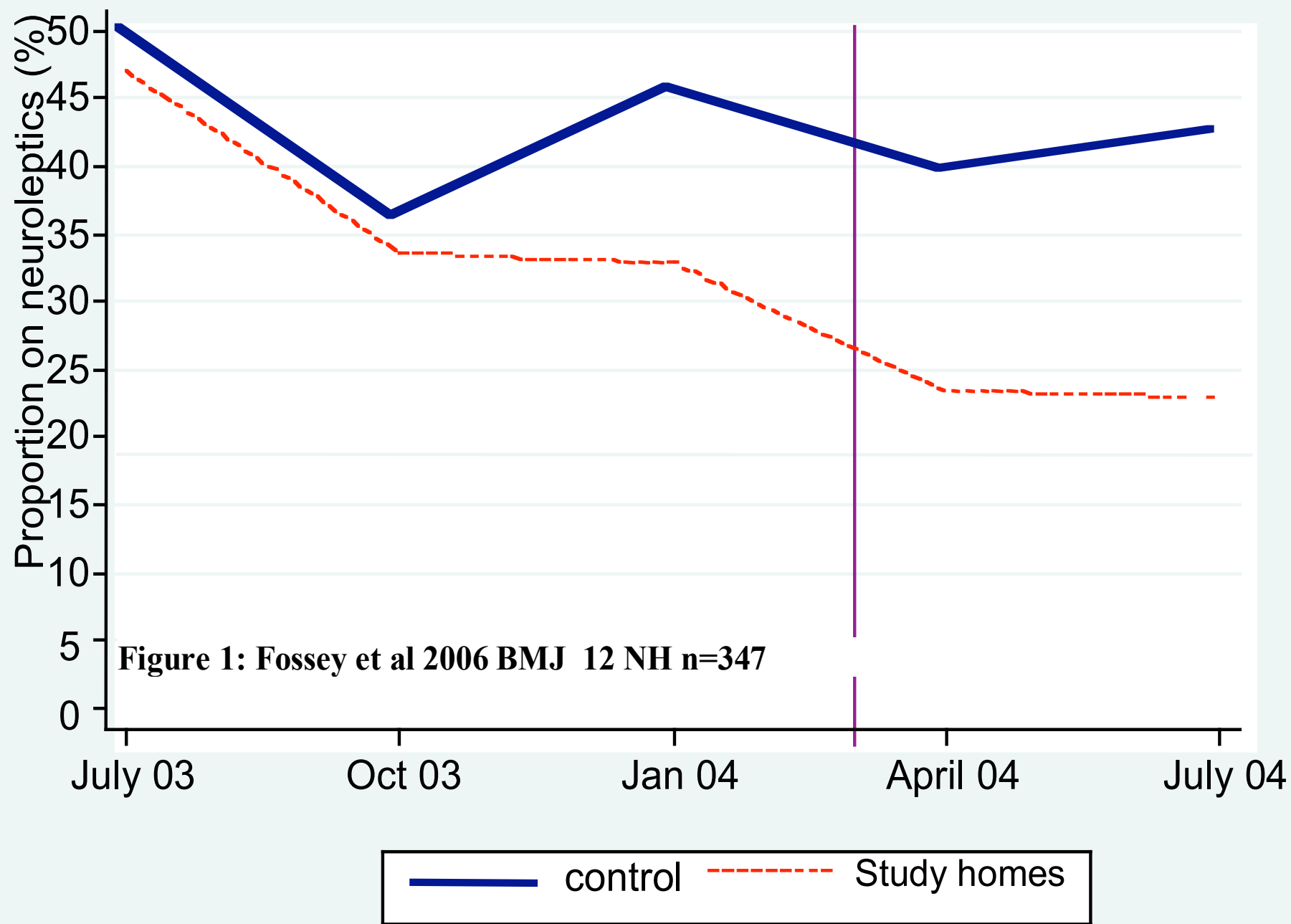
Example – shared formulations using PCC and CBT ideas. (See Fossey and James 2008)



Chenoweth et al 2009 Lancet Neurology

Person Centred Care: CADRES Study

- Two interventions: Person Centred Care Training and Dementia Care Mapping (DCM)
- 4 month cluster trial , 15 care homes, 289 residents with dementia
- Significant mean difference of 10.9 on CMAI (95% CI 0.7-21.1; $p=0.04$) was achieved with DCM and a difference of 13.6 on the CMAI (95% CI 3.3-23.9; $p=0.01$) with Person Centred Care Training
- Standardized Effect size of 0.55
- Neither intervention reduced antipsychotic use



WHELD Pilot Study

Main aim:

- To find out the most effective combination of psychosocial treatments for residents to improve quality of life, reduce prescribing and reduce falls

Pilot Interventions:

- Person Centred Care
- Social Intervention and
- Pleasant activities
- Antipsychotic Review
- Exercise



RESEARCH

Efficacy of treating pain to reduce behavioural disturbances in residents of nursing homes with dementia: cluster randomised clinical trial

Bettina S Husebo *postdoctoral fellow*¹, Clive Ballard *professor*², Reidun Sandvik *registered nurse*¹, Odd Bjarte Nilsen *statistician*³, Dag Aarsland *professor*⁴

¹Department of Public Health and Primary Health Care, University of Bergen, 5020 Bergen, Norway; ²Wolfson Centre for Age-Related Diseases, Wolfson Wing and Hodgkin Building, Guy's Campus, Kings College, London SE1 1UL, UK; ³Department of Psychiatry, Stavanger University Hospital, 4011 Stavanger, Norway; ⁴Karolinska Institute, Department of Neurobiology, Care Sciences and Society, Karolinska Institute-Alzheimer Disease Research Center, Novum, Stockholm, Stavanger University Hospital, Department of Psychiatry, Stavanger, Norway, and University of Oslo, Oslo, Norway

RESEARCH

Table 3| Comparison of Cohen-Mansfield agitation inventory (CMAI) total score between control and intervention (stepwise protocol for treatment of pain) groups using repeated measures analysis of covariance (ANCOVA)*

Week	Mean (SD) CMAI total score		Effect of intervention on CMAI total†		Intraclass correlation coefficient‡
	Control group	Intervention group	Estimate (95% CI)	P value	
0	56.2 (16.1), n=177	56.5 (15.2), n=175	—	—	0.162
2	53.9 (17.0), n=161	52.0 (19.5), n=158	−3.6 (−0.5 to −6.7)	0.022	0.261
4	52.5 (16.3), n=160	49.4 (19.0), n=148	−4.1 (−0.9 to −7.4)	0.012	0.231
8	52.8 (16.8), n=157	46.9 (18.7), n=147	−7.0 (−3.7 to −10.3)	<0.001	0.226
12	52.5 (16.0), n=152	50.3 (20.3), n=142	−3.2 (0.1 to −6.4)	0.058	0.253

*Baseline score as covariate and least squares weighted by number of patients within cluster; P value from multivariate test of intervention was 0.002, and cross effect between week and intervention was <0.001.

†Variable estimate by week of effect of intervention on CMAI score from estimated model.

‡Proportion of total variance between clusters, and measured within framework of ANCOVA.

RESEARCH

Table 5| Comparison of mobilisation-observation-behaviour-intensity-dementia-2 (MOBID-2) pain scale total score between control and intervention (stepwise protocol for treatment of pain) groups using repeated measures analysis of covariance (ANCOVA)*

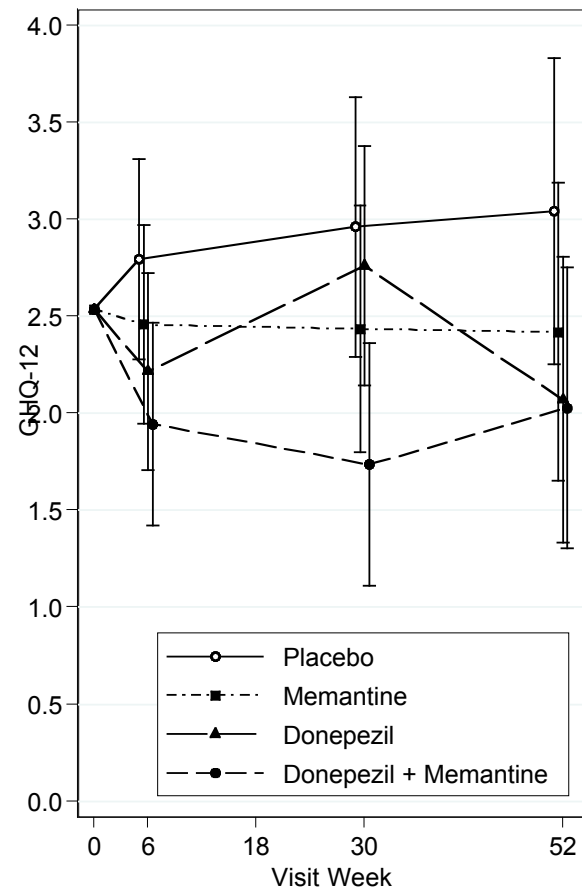
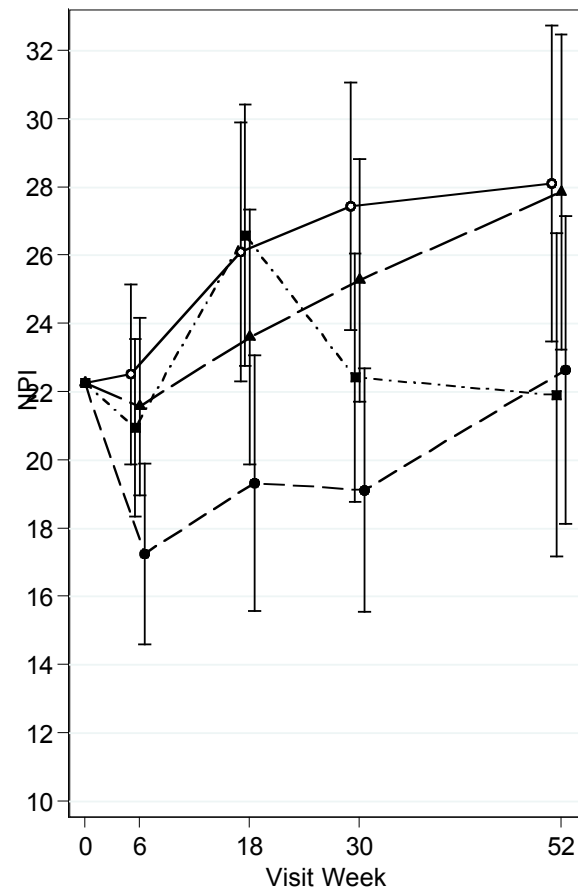
Week	Mean (SD) MOBID-2 total		Effect of intervention on MOBID-2 total†		Intraclass correlation coefficient‡
	Control group	Intervention group	Estimate (95% CI)	P value	
0	3.7 (2.5), n=163	3.8 (2.7), n=164			0.094
2	3.5 (2.4), n=159	2.9 (2.5), n=152	-0.7 (-0.4 to -1.1)	<0.001	0.070
4	3.3 (2.4), n=155	2.7 (2.2), n=146	-0.8 (-0.4 to -1.2)	<0.001	0.059
8	3.5 (2.6), n=154	2.3 (2.1), n=145	-1.3 (-0.8 to -1.7)	<0.001	0.082
12	3.5 (2.5), n=151	2.9 (2.6), n=140	-0.8 (-0.3 to -1.2)	0.001	0.139

*Baseline score as covariate and least squares weighted by number of patients within cluster; P value from multivariate test of intervention was <0.001, and cross effect between week and intervention was 0.009.

†Variable estimate by week of effect of intervention on MOBID-2 from estimated model.

‡Proportion of total variance between clusters, and measured within framework of ANCOVA.

DOMINO. Estimates of mean NPI and GHQ-12 by visit and treatment arm Howard et al NEJM 2012





Best Practice Guide: Treatment and care for behavioural and psychological symptoms



Optimising treatment and care
for people with behavioural and
psychological symptoms of dementia

A best practice guide for health
and social care professionals



- Developed in partnership with Department of Health
- Led by
 - Clive Ballard
 - Alistair Burns
 - Anne Corbett
- Advisory group: Sube Banerjee; Nina Barnett; Donald Brechin; Peter Connelly; Jane Fossey; Clive Holmes; Julian Hughes; Gill Livingston; Deborah Sturdy; Simon Wright
- Focus on preventing and managing BPSD
- Now available as consultation document

MANAGEMENT OF ALZHEIMER'S DEMENTIA
NEW GUIDANCE AND THE CHANGING NHS

2011



Best Practice Guide: Treatment and care for behavioural and psychological symptoms

	Green – No symptoms. Simple preventative measures	Prevention
	Amber – Mild or moderate symptoms. Low intensity, general interventions	Watchful waiting
	Red – Severe symptoms. Specific interventions and guidance for antipsychotic use	Specific interventions Antipsychotic prescription

MANAGEMENT OF ALZHEIMER'S DEMENTIA
NEW GUIDANCE AND THE CHANGING NHS

2011



Best Practice Guide: Prevention

1

Prevention Clinical checklist

This checklist should be completed for each person with dementia.
Keep this chart with the person's correspondence.

Name: _____

General symptoms

Include known symptoms and information based on

A recommended rating scale is the Clinical Giot
(Appendix 1). If completed, enter score here: _____

Other symptoms

Note any other significant symptoms in the relevant
for information.

Pain (Scale: Pain Rating Chart)

Depression (Scale: Cornell Scale)

Neuropsychiatric symptoms (Scale: Neuropsychiatric)

Delirium and confusion (Scale: Confusion Assessment)

Other relevant health problems

Signed: _____

2

Prevention Guidance

People with dementia often experience behavioural and psychological symptoms (BPSD). Many people are prescribed dangerous antipsychotic drugs. However, there are a number of simple approaches that may prevent these symptoms from developing before medication needs to be prescribed.

This guidance outlines the key steps to take to actively prevent symptoms.

Medical review

A thorough medical review is essential to detect any general health problems that could impact on the person's quality of life, well-being or other symptoms. In particular, pain can be a major trigger for agitation and aggression. Infections (eg urinary tract infection) can increase agitation and hallucinations. Other key triggers include dehydration, constipation and malnourishment. A record should also be kept of any clinically significant behavioural symptoms.

For each person with dementia complete:

- a medical review (including medication review)
- the checklist for specific clinically significant symptoms (see 1: Prevention – Clinical checklist).

Understanding of dementia

It is important that all care staff are aware and understand the needs of a person with dementia, including aspects of person-centred care (see overleaf). Dementia affects people in different ways, causing a broad range of symptoms. This means that there is not a 'one-size-fits-all' care strategy.

Different types of dementia may also require different approaches to treatment depending on the symptoms and types of drugs that are suitable for that type of dementia.

It is also important to recognise that behavioural and psychological symptoms are not 'bad behaviour' on the part of the person. These symptoms are caused by chemical changes in the brain which are out of their control. Nevertheless simple adjustments to social interactions and environment can make a difference.

Recognition of triggers and early signs

Recognition of triggers and early signs that may precede behavioural and psychological symptoms is crucial. In most cases developing simple approaches to address these early signs can help prevent symptoms from developing at all. Key signs to look out for are:

- pain, malnourishment, dehydration and physical illness
- stress, irritability, mood disturbance and suspiciousness
- increased levels of distress
- early signs may be noticed at certain times of the day, particularly during personal care
- although not the most common trigger, it is important to be aware of any signs of abuse or neglect.

Two thirds of people
in care homes have
dementia

- Emphasis on person-centred care
 - Care plan
 - Involvement of carers
 - Consider physical environment
- Importance of medical review
- Understanding of dementia
- Recognition of triggers
- Involvement of family and / or carers

2011
MANAGEMENT OF ALZHEIMER'S DEMENTIA
NEW GUIDANCE AND THE CHANGING NHS



Best Practice Guide: Watchful Waiting

3 Watchful waiting Clinical checklist

Watchful waiting is a proactive process over four weeks: involves ongoing assessment of contributing factors and simple non-drug mean 'doing nothing'. A high proportion of people with behavioural and psychological symptoms experience si four weeks with no specific treatment. Watchful waitin effective therapeutic approach unless there is severe ri checklist will give you some ideas for assessment and n further improve the likelihood of a favourable outcome

Name: Current diag:

General symptoms

Include known symptoms and information based on person-centred (see 4: Watchful waiting guidance)

A recommended rating scale is the Clinical Global Impression o (Appendix 1). If completed, enter score here:

Other Symptoms

Note any other significant symptoms in the relevant box. Optional rat for information.

Pain (Scale: Pain Rating Chart)

Depression (Scale: Cornell Scale)

Neuropsychiatric symptoms (Scale: Neuropsychiatric Inventory)

Delirium and confusion (Scale: Confusion Assessment Method)

Other relevant health problems

Signed: Date:

5 Watchful waiting Clinical care plan (Week 0)

This chart should be completed when mild to moderate behavioural and psychological symptoms appear. This should be accompanied by a medical review and used alongside 4: Watchful waiting guidance.

Name: Current diagnosis:

Week 0

What are the symptoms?

How severe are they? Mild ☐ Moderate ☐ Severe ☐

What are the risks:

to the person

to others

How distressed is the person?

How would the person benefit if these risks were addressed?

What watchful waiting tools are in place for the care plan?

Watchful waiting assessment completed ☐ (give brief summary of outcome of assessment)

Brief summary of watchful waiting care plan (based on 4: Watchful waiting guidance)

What would be a sign of improvement for this person (to be used as an outcome measure)?

What is the plan for further review and support?

Signed: Date:

- Ongoing assessment and non-drug treatments
- Person-centred care
 - Positive social interaction
 - Life story book
 - Short, frequent conversations
- Clinical care plan
- Suggested for four weeks when symptoms emerge
 - BPSD usually improve after four weeks with no treatment



Best Practice Guide: Specific Interventions

7 Specific interventions Guidance

If symptoms persist after watchful waiting it is appropriate to attempt specific interventions. Psychosocial interventions and pharmacological treatment is recommended

Psychosocial interventions

Psychosocial interventions are more tailored, systematic approaches to person-centred care (than those outlined earlier in watchful waiting).

The following steps should be taken to develop a Specific intervention care plan (8):

- Complete medical and mental health review including 6: Clinical checklist
- Consider all aspects of person-centred care (see 4: Watchful waiting guidance)
- Consult with family or carers on the best approach
- Design specific interventions (the brief and simple approaches below have been shown to be effective and can be administered by care staff with support from any clinician)
- Consider whether care staff require specific dementia training (person-centred care training for staff can reduce antipsychotic use and improve agitation).

Improving social interactions

Brief psychosocial therapies help to engage people in ways that they find interesting and enjoyable. These should generally include 10–30 minutes of daily one-to-one conversation or activity based on the person's interests, hobbies, history and ability, and feedback from their carer and/or family.

Pain is one of the most common causes of BPSD

8 Specific interventions Clinical care plan (Week 0)

Name:	Current diagnosis:
<p>Week 0</p> <p>What are the symptoms?</p> <p>What are the risks: to the person to others</p> <p>How distressed is the person?</p> <p>Why does this level of risk and distress require a specific treatment?</p> <p>How would the person benefit if these risks were addressed?</p> <p>Medical review completed <input type="checkbox"/></p> <p>Clinical checklist completed <input type="checkbox"/></p> <p>Person-centred care assessed <input type="checkbox"/></p> <p>Summarise outcome of person-centred care assessment:</p>	

- For severe BPSD
- Tailored psychosocial interventions
 - Improving social interactions
 - Promoting positive activities and exercise
 - Brief Psycho-social therapies
 - Specialist referral (e.g. ABC)
- Pharmacological options
 - Depression – sertraline, Citalopram
 - Sleep disturbance
 - Analgesic
- Antipsychotic
 - Risperidone for 6 weeks



Best Practice Guide: Monitoring and Review

9 Antipsychotics prescription Safety monitoring guidance and Monitoring plan

Antipsychotic drugs are known to be harmful. It is vital that any person prescribed these drugs and progression of symptoms. This plan should be completed when a prescription of antipsychotics is given.

Adverse effects of antipsychotic drugs
The most important adverse effects associated with antipsychotics are parkinsonism, falls, dehydration, chest infections, ankle oedema, deep vein thrombosis/pulmonary embolism, cardiac arrhythmia and stroke (highest risk in first four weeks of treatment).

Antipsychotics are also associated with increased mortality in the long term (often related to pneumonia and thrombo-embolic events) which can be caused by over-sedation and dehydration.

Name:

Current prescription:

Monitoring by GP / practice nurse:

Daily monitoring by care staff:

Overall plan for monitoring and review:

Signed:

11 Antipsychotics prescription Review chart

This chart should be completed for any patient prior to discontinuation or continued prescription of an antipsychotic. All prescriptions should be reviewed at six weeks (recommended) or 12 weeks.

Name: Current diagnosis:

Current prescription:

What are the symptoms?

How severe are they? Mild ☐ Moderate ☐ Severe ☐

What are the risks:

to the person

to others

How distressed is the person?

How would the person benefit if these risks were addressed?

Clinical treatment decision:

Discontinue ☐ Continue prescription ☐ details:

What would be a sign of ongoing improvement or stabilisation for this person?

What is the plan for further review?

If antipsychotics are discontinued, what additional support is needed for the first four weeks of discontinuation?

Signed: Date:

- Side effects more severe in long term use
- Side effects improved through simple monitoring
 - Sedation
 - Fluid intake
 - Chest infection
- All antipsychotic prescriptions reviewed at 12 weeks
 - Discontinuation is default
 - Discontinue by tapering for high doses
- Return to non-drug interventions

Optimising treatment and care for people with behavioural and psychological symptoms of dementia

A best practice guide for health
and social care professionals

- For access to the guide and to download, go to:

<http://www.alzheimers.org.uk/bpsdguide>

- To access the reference list that supports the recommendations, go to:

http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1675

Conclusions – the Evidence Base

- Antipsychotics have a focussed but limited role in the short term management of severe aggression and psychosis. The best evidence base for pharmacological treatment is for short term treatment with risperidone as a treatment for aggression, but we are currently overprescribing, the longer term efficacy is limited and the serious adverse risks are considerable
- The evidence base supports the value of simple non drug interventions and intensive staff training in care homes
- Recent evidence re-inforces the potential value of analgesia