Whittington Health NHS

ANTIPSYCHOTIC PRESCRIBING IN PATIENTS WITH BOTH DELIRIUM AND DEMENTIA

Subject:	Antipsychotic prescribing
Guideline Number	N/A
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Guideline Executive Owner:	Clinical Director, Medicine, Frailty and Networked Service ICSU
Designation of Author:	Dr Gurcharan Rai/ Dr Celia Bielawski/ Dr Susan Hay
Name of Assurance Committee:	As above
Date Issued:	December 2015
Review Date:	3 years hence
Target Audience:	All staff dealing with acutely unwell elderly patients in hospital
Key Words:	Anti-psychotic medication, dementia, delirium

Version Control Sheet

Version	Date	Author	Status	Comment
1.0	Feb 2012	Dr G Rai, Dr C Bielawski	Off line	New guideline approved at CGC
2.0	Dec 2015	Dr G Rai, Dr C Bielawski Dr S Hay	Live	Updated using Maudsley Prescribing Guidelines in Psychiatry 2015 and in line with ILAT practice / policy

➢ Criteria for use

This guideline is designed to help guide clinicians on the appropriate use of anti-psychotic medication in patients with dementia, with or without delirium.

➢ Background/ introduction

Antipsychotics are drugs designed to treat conditions like schizophrenia, however they are often also prescribed to people with dementia and/or delirium for management of behavioural and psychiatric symptoms causing distress or agitation.

Main reason for reducing the prescribing is that antipsychotics can increase the risk of cerebrovascular events and mortality in people with dementia. The risk is higher with higher doses. The 2009 report for the Minister of State for Care Services made 11 recommendations, which included the need to reduce the use of antipsychotic drugs for people with dementia and suggestion that the Care Quality Commission should consider using rates of prescription of antipsychotic medication for people with dementia as a quality measure.

The Whittington hospital has a guideline on delirium, which includes a section on pharmacological and non-pharmacological management of psychotic symptoms and behavioural symptoms in patients with delirium. This guideline extends this by including advice on patients who may have dementia.

➢ Inclusion/ exclusion criteria

Inclusion: Any patient in hospital with diagnosis of dementia with or without delirium.

Exclusion:

Patients with delirium and no underlying dementia (see delirium guidelines).

Patients receiving end of life care, patients who are intoxicated or withdrawing from alcohol and /or drugs.

➢ Clinical management

DELIRIUM:

Delirium, otherwise known as Acute Confusional State, is a common medical emergency with many possible medical causes so assessment and investigation for the underlying cause is the first principle of management. It is important to remember that delirium often occurs in patients who have dementia (acute on chronic confusional states) and investigation and

management of delirium in these patients is the same as for those with pure delirium.

	Please see Whittington Health Guideline: **See Delirium guidelines for pharmacological and non pharmacological management of behavioural and psychiatric symptoms in patients with delirium.**

DEMEMTIA:

Non-pharmacological measures.

1. Factors such as pain, hunger, thirst, boredom, fear/anxiety or depression and environmental factors such as lack of activities, inadequate staff attention or poor communication between the patient and staff can cause distress and behavioural change. It is important to identify and treat the cause (s) and often these patients do NOT require anti-psychotic drugs.

2. Activities, behavioural approaches/modifications, multisensory stimulation, reminiscence therapy, therapeutic use of music etc have been shown to improve non-cognitive symptoms and behaviour and reduce the need for anti-psychotics and therefore should be tried first.

2. Drug Treatment.

Anti-psychotics may be considered ONLY if symptoms are causing distress to the patient or if the symptoms are considered to pose danger to the patient (himself/herself) or others – these include;

- agitated behaviour which has not responded to non-pharmacological behaviour.
- distressing psychotic symptoms, including delusions, hallucinations,, paranoia and suspiciousness.

Principles of drug treatment:

While considering medication for psychotic and behavioural symptoms in patients with dementia, use NICE 3 Ts (target, titration and time)-

TARGET: drug treatment should have a specific target symptom

TITRATION: the starting dose should be low and then titrated upwards

TIME: drug treatment should be time limited

While both typical and atypical antipsychotics can be used their choice should be informed by side effect profile and individual circumstances. Specifically:

1. Prescribe as per NICE guidelines – do not use antipsychotics for mild to moderate non-cognitive symptoms in dementia with Lewy Bodies

because of increased risk of adverse reactions such as postural hypotension, parkinsonism and falls.

2. When prescribing discuss risk and benefit, assessing for cerebrovascular risk factors and discuss increased risk of stroke/TIA and adverse effects on cognition

3. The ILAT (Islington Liaison and Assessment Team) can provide advice on indications and choice of medication to treat neuopsychiatric symptoms in dementia. There are Old Age Psychiatry specialist nurses and a consultant Old Age Psychiatrist in the team.

4. All patients prescribed antipsychotics should have baseline ECG, weight, pulse, BP, fasting glucose and blood lipid profile

5. CONTRAINDICATIONS: Parkinson's Disease, Lewy Body Dememtia, epilepsy, long QT on ECG

3. Antipsychotic drugs:

3.1. Oral Risperidone 0.5mg up to 1mg bd. Available as 500mcg, 1mg and 2 mg tablets, including dispersible tablets, or liquid (1mg/ml)-

Risperidone is the only drug licenced in the UK for the management of non-cognitive symptoms associated with dementia. It is specifically indicated for **SHORT TERM TREATMENT (UP TO SIX WEEKS)** of persistent aggression in moderate –severe Alzheimer's disease unresponsive to non-pharmacological approaches and where there is risk to self or others.

3.2. Oal Olanzepine 2.5mg up to BD tablet or orodisprsible (velotab).

3.3. Haloperidol - If the patient is unwilling to take oral medications and there is significant risk to either self or others from non-cognitive symptoms in dementia that have not responded to de-escalation techniques then Haloperidol IM 0.5 mg can be used for rapid tranqullisation. Give 05mg stat and assess for effect in 1 hour before prescribing higher doses. Maximum 4mg in 24 hours. Check temperature, pulse, blood pressure and respiratory rate every 10 minutes for 1 hour, then half hourly until patient is ambulatory. Ensure IM procyclidine is available due to risk of acute dystonia.

3.4. Other drugs sometimes used under ILAT guidance are:-

3.4.1. Sulpiride 50-200mg bd- available as 200mg tablets only or solution (200mg/5ml)

3.4.2. Amisylpride – 50-200mg bd – available as 50mg,100mg or 200mg tablets or solution (100mg/ml)

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4. Other drugs for agitation or behavioural symptoms in dementia:.

4.1. Avoid benzodiazepines – they are associated with cognitive decline and increase risk of falls. In the event that antipsychotics are contraindicated and there is need for sedation **loazepam** 0.5mg – 1mg PO or sublingual or IM- maximum 2mg in 24 hours.

NB When used IM this medication has a rapid onset.

Midazolam IM can be used - when parenteral Lorazepam is not available. Recommended dose for **adults** is 2.5mg (**2.5ml**) or 5mg (**5ml**) and in **elderly patients** or those with significant renal, hepatic, respiratory or cardiac impairment the initial dose should be **1 to 2mg (1 to 2ml).**

4.2. Acetylcholinestrase inhibitors may be an option for people with dementia who clearly are not suffering from an acute confusional state/ delirium. Memantine may also have benefit on non-cognitive symptoms in dementia. **Please refer to the Integrated Liaison & Assessment Team for advice regarding these medications (bleep 1106)**

5. Medication Review.

ALL ANTI-PSYCHOTIC DRUGS PRESCRIBED IN HOSPITAL SHOULD BE REVIEWED DAILY AND BEFORE PATIENT IS DISCHARGED FROM HOSPITAL.

IF A PATIENT IS DISCHARGED ON A NEWLY PRESCRIBED ANTI-PSYCHOTIC PLEASE INDICATE IN THE DISCHARGE SUMMARY THE SPECIFIC INDICATION FOR THE DRUG AND WHEN THIS MEDICATION SHOULD BE REVIEWED OR STOPPED.

➢ Contacts (inside and outside the Trust including out-of-hours contacts)

Care of Older People Department – Dr C Bielawski or Dr G S Rai on 0207 288 5462/5310

ILAT – Islington Liaison and Assessment Team – Bleeep 1106 or Dr Susan Hay Telephone number 0207 561 4136 (liaison Office)

➢ References (evidence upon which the guideline is based)

Delirium in the Elderly – Assessment and management – Whittington Hospital NHS Trust Guideline – April 2011

Department of Health: The use of antipsychotic medication for people with dementia: Time for action. A report for the Minister of State for Care Services by Professor Sube Bannejee, October 2009

Maudsley Prescribing Guidelines in Psychiatry 12 Edition, David Taylor, Carol Paton, Shitij Kapur, 2015.

National Institute for Health and Clinical Excellence and Social Care Institute for excellence – Dementia – supporting people with dementia and their carers in health and social care. NICE clinical guideline 42, March 2011

- **Compliance with this guideline (how and when the guideline will be monitored e.g. audit and which committee the results will be reported to) Please use the tool provided at the end of this template**

Via clinical audit

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

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1.	**Does the procedural document affect one group less or more favourably than another on the basis of:**		
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	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
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If you have identified a potential discriminatory impact of this procedural document, please refer it to the Director of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Human Resources.

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To be completed and attached to any procedural document when submitted to the relevant committee for consideration and approval.

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is it clear that the relevant people/groups have been involved in the development of the document?	Yes	
	Are people involved in the development?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
5.	**Evidence Base**		
	Are key references cited in full?	N/A	
	Are supporting documents referenced?	N/A	
6.	**Approval**		
	Does the document identify which committee/ group will approve it?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
8.	**Document Control**		
	Does the document identify where it will be	Yes	

	Title of document being reviewed:	Yes/No	Comments
	held?		
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	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
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10.	**Review Date**		
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	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Executive Sponsor Approval			
If you approve the document, please sign and date it and forward to the author. Procedural documents will not be forwarded for ratification without Executive Sponsor Approval			
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The Director of Nursing and Patient Experience's signature below confirms that this procedural document was ratified by the appropriate Governance Committee.			
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