Grŵp Strategaeth Meddyginiaethau Cymru Gyfan
All Wales Medicines Strategy Group

All Wales protocol for the appropriate prescribing of antipsychotics for people living with dementia

February 2024

This document has been prepared by the Antipsychotic Protocol Task and Finish group, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

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Contents

1.0 Introduction

People living with dementia can sometimes experience distress, or become fearful and/or frustrated, resulting in behavioural and psychological or non-cognitive symptoms such as walking with purpose, shouting and repeated questioning. These behaviours are sometimes representative of an attempt to communicate a need that has not been met, rather than as a progression of dementia.

Psychosocial and environmental interventions should be offered to reduce distress in people living with dementia[1], with antipsychotic prescribing reserved for people who are either at risk of harming themselves or others, or who are experiencing agitation, hallucinations or delusions that are causing them or their carer severe distress.

Antipsychotics may be prescribed to help manage non-cognitive symptoms of dementia that are severe and causing distress. However, the risk of adverse events associated with the use of antipsychotics in people with dementia may outweigh the benefits. Where antipsychotic prescribing is indicated, the aim is to reduce the risk of harm associated with the use of these drugs, and to improve outcomes for the person living with dementia.

This document has been developed by a multi-professional collaborative group following the request from Welsh Government's Pharmacy and Prescribing Branch to develop a protocol to support the appropriate prescribing and review of antipsychotics for people living with dementia in Wales, in response to the Banerjee Report[2] and the Dementia Action Plan for Wales[3].

It is recommended that health boards support change at an organisational level by establishing an interprofessional team within their Regional Partnership Board, which is responsible for psychotropic medication stewardship and delivery of the recommendations within this protocol.

1.1 Aim

The aim of this document is to guide best practice in the initiation; monitoring; review; tapering and stopping of antipsychotics where they are prescribed for people living with dementia who express distress. It also provides advice to generalists and specialists on management of long-term prescribing of antipsychotics where indicated.

This document is not intended to inform clinical management of patients prescribed an antipsychotic for a concurrent mental health issue, such as schizophrenia or psychotic depression. Any review of medication for these indications should be carried out in conjunction with specialist mental health services.

1.2 Scope

The document is intended for use across all care settings, and by all health and social care professionals involved in the care of people living with dementia. It is intended to support best practice by all healthcare professionals, both generalist and specialist, who care for people living with dementia.

2.0 Distressed behaviours associated with dementia

Non-cognitive symptoms of dementia can include a variety of symptoms and subsequent manifestations as outlined in Table 1. Several of these manifestations, if severe, may lead to expression of distress.

Table 1: Non-cognitive symptoms in people with dementia (adapted from Watt *et al* 2022[4])

Symptom	Examples of symptom manifestation
Agitation/aggression	Hitting, kicking, restlessness, screaming
Depression/dysphoria	Sadness, slowed movements or speech, early morning awakenings, mood congruent delusions
Delusions	False beliefs that someone is trying to harm them
Hallucinations	Hearing, feeling or seeing people that aren't real
Anxiety	Shortness of breath, separation anxiety, excessive worry, excessive fear
Elation/euphoria	Excessive happiness
Apathy/indifference	Less interest in participating in activities
Disinhibition	Impulsiveness, saying or doing inappropriate things
Irritability/lability	Impatience
Motor disturbances	Pacing, restlessness, repetition of activities
Night time behaviours	Frequent awakenings, early morning awakening, excessive daytime napping
Changes in appetite/eating	Weight loss/gain, changes in food preferences

Between 60-90% of people living with dementia may present with non-cognitive symptoms at some stage, which may cause expression of distress due to an unmet need for example shouting out because they are in pain, or feeling isolated.

Expression of distress in people with dementia is often a major stressor to carers, can be challenging to manage and frequently precipitate the move into long-term care or hospitals.

NICE guideline NG97 (Dementia: assessment, management and support for people living with dementia and their carers)[1] recommends using psychosocial and environmental interventions as first-line management of distress in people living with dementia. The Alzheimer's Society provides comprehensive advice on how to manage these changes in behaviour[5].

When a person living with dementia presents with non-cognitive symptoms that cause distress, every effort should be made to find the underlying cause. Where an underlying cause is found, this should be treated in the first instance, using person centred care or appropriate medical management before considering commencement of an antipsychotic.

2.1 Person-centred care plan

Ward staff and carers are encouraged to complete a 'This is me / Dyma fi' or 'About me' tool as soon as possible in order to get to know the person, ahead of any formal medical assessment and as a preventative measure.

Care coordinators should ensure that people are aware of their rights to and the availability of local advocacy services, and if appropriate to the immediate situation an independent mental capacity advocate.

Information obtained by the team during the assessment should include discussion with family, friends, carer, and advocate, and be used to develop a care and treatment plan to address the person's needs, reduce distress and improve understanding of their needs and their quality of life.

Where people living with dementia communicate distress, the ABC (Antecedence, Behaviour, Consequence) chart (Appendix 1) is an appropriate measure to characterise events and resultant behaviours in order to develop a personal care plan at baseline. This will help the people around the person with dementia to know how best to manage situations that may occur. NICE guidelines (NG97) state that psychosocial interventions should always be tried first and should also be continued alongside any medical treatment[1].

2.2 Assessment of distress

In order to help determine the cause of, or unmet needs resulting in the expression of distress, an initial assessment should be undertaken by an appropriate team member in the care setting, or by the healthcare professional responsible for the patient's care.

The initial assessment should include the following:

- History taking with reference to premorbid state.
- Assessment of premorbid and current mental state, including any psychotic features, mood disorders or change in cognitive function.
- Documentation of description of onset, type, severity, pattern of behaviour and presentation.
- Assessment of potential underlying causes:
    - physical health issues (e.g. pain, infection, dehydration, constipation, delirium, visual impairment)
    - mental health conditions (e.g. anxiety and depression)
    - medication (e.g. anticholinergic burden, analgesics, side effects from other medication prescribed). Further information regarding polypharmacy can be found in the All Wales Medicines Strategy Group (AWMSG) Polypharmacy in older people: A guide for healthcare professionals[6]
    - recognised triggers
    - premorbid personality
    - response to social or physical environment

It is strongly suggested that validated tools such as the Cohen Mansfield agitation inventory[7], the Neuropsychiatric Inventory Questionnaire (NPI-Q) for nursing homes and caregivers[8-10] or the ABC chart (Appendix 1) are used to assess and monitor the severity, type and frequency of expression of distress at baseline (ABC chart) and during treatment. Table 2 lists factors to consider when assessing non-cognitive symptoms.

Table 2: Factors to consider when assessing non-cognitive symptoms of dementia (adapted from Watt *et al* 2022[4])

Factor	Examples
Protective	Presence of a familiar carer
	Being in a familiar environment
	Carer knowledge of dementia
	Availability of support for carers
	Use of glasses and hearing aids
	Creation of personalised care plan
	Carer knowledge of individual patients' preferences for non-medical interventions
Predisposing	Over/under stimulating environment
	Vision or hearing impairment
	Co-morbid psychiatric diagnoses
	Worsening dementia severity
	Carer burden or disease
Precipitating	Pain
	Hunger
	Thirst
	Medication changes
	Feeling too hot or cold
	Sleep disturbances
Perpetuating	Poor communication strategies between carers and patients
	Inadequate identification and treatment of precipitating factors
	Inadequate implementation of personalised care plan
	Lack of support for carers

3.0 Prescribing Antipsychotics

Not all people living with dementia who express distress respond to person centred, non-pharmacological approaches. Therefore in extreme situations, where there is considerable risk of harm to oneself or others, it may be appropriate to consider a **time limited** and **symptom targeted** approach using antipsychotic medication[1]. Antipsychotics have shown small but statistically significant efficacy in managing symptoms of[11]:

- psychosis
- delusions
- severe aggression
- severe agitation

Current research shows that some antipsychotics offer small therapeutic benefit for the symptoms of agitation and expression of distress in dementia yet pose a potential for significant risks and side effects and an increased risk of death or stroke[12].

Consideration must be given to the risk and benefits of prescribing any antipsychotic. Treating 1,000 people for about 12 weeks would result in[2]:

Benefits:

- improvement in 91–200 out of 1,000 with behavioural disturbance
- improvement in 72 out of 1,000 with psychosis

Risks:

- an additional 10 deaths
- an additional 18 cardiovascular adverse events (CVAEs) (around half may be severe)
- an additional 58–94 patients with gait disturbance

Evidence suggests that longer term treatment may result in additional 167 per 1,000 deaths over a two year treatment period[2].

Pharmacological intervention should be viewed as a short-term intervention (up to six weeks) and requires careful ongoing monitoring (such as the Cohen Mansfield agitation inventory[7] or the NPI-Q for nursing homes and caregivers[10]) to ensure guidance is followed and inappropriate use is not continued[3]. It is not appropriate to prescribe antipsychotics without a clear rationale. They should not be used:

- to routinely sedate a patient for ease of management
- when the symptoms or circumstances for which they were prescribed no longer apply
- without a clear review date documented

Before prescribing antipsychotics consider:

- history of stroke or heart disease and potential for antipsychotic to increase risk of mortality
- the risk of severe sensitivity reactions (such as extra pyramidal side effects) in people with Parkinson's disease and those with Dementia with Lewy Bodies.
- comorbidities and other medication (including the potential for interactions)
- capacity assessment and best interest decision, including an Independent Mental Capacity Advocate (IMCA).
- using a patient aid (e.g. NG97 Patient decision aid on antipsychotic medicines for treating agitation, aggression and distress in people living with dementia (nice.org.uk) to discuss treatment options and risks with the patient and where relevant their families, carers or IMCA. Discussion regarding risks and benefits must be documented in the patient's notes.
- providing the patient and carer with a leaflet on the use of unlicensed or off label medicines (where appropriate)
- providing the patient / carer with a leaflet on antipsychotic use in dementia, such as that produced by the Alzheimer's Society: Antipsychotic drugs and other approaches in dementia

If prescribing medication, it is also recommended that non-pharmacological approaches should be used at the same time as any medication prescribed.

3.1 Baseline testing

Although guidance is available regarding baseline testing for people prescribed antipsychotics for psychosis and schizophrenia, there are few guidelines around

monitoring of antipsychotics for use in dementia, as they are used at low doses and not intended for long term use.

Where possible baseline testing should be undertaken as per the relevant Summary of Product Characteristics (SPC). However, it is acknowledged that it may not be possible to perform baseline tests prior to treatment in people who are extremely distressed. In these circumstances the most recent tests and clinical judgement should be used. If no recent results are available testing should be done at the earliest opportunity.

Appropriate physical monitoring and tests may be considered as part of the overall assessment of the patient's physical health, screening for delirium, infection or other causes of change in presentation, and to help guide choice of treatment. Suggested baseline tests and parameters include:

Parameter	Baseline	At each review
Mobility /Gait/Posture	✔	✔
Sleep	✔	✔
Communication	✔	✔
Bowels	✔	✔
Continence	✔	✔
Appetite/Fluids	✔	✔
Weight	✔	✔
Blood pressure/pulse	✔	Only if clinically indicated
Urea and electrolytes	✔	Only if clinically indicated
Full Blood Count*	✔	Only if clinically indicated
Prolactin**	✔	Only if clinically indicated
ECG if indicated	Check SmPC	Check SmPC

*To rule out physical cause of symptoms at baseline. Repeat only if clinically indicated
**Not required for aripiprazole, olanzapine or quetiapine. A raised prolactin level should not require change of treatment in older adults >65 years unless symptomatic.

3.2 Choice of antipsychotic

Risperidone is licensed for short-term (up to six weeks) treatment of persistent aggression in people with moderate to severe Alzheimer's disease when there is risk of harm to the person or others, and is generally considered the first-line choice. However, this antipsychotic may not always be the most appropriate (for example in Dementia with Lewy Bodies) or may require dose adjustment (for example in renal impairment). There are other antipsychotics with similar evidence of benefit and that may be used off label; each antipsychotic has a slightly different profile with its own potential risks and side effects (Table 3 and Table 4).

When selecting the most appropriate antipsychotic, the clinical profile of the antipsychotic should be considered along with the type of dementia, presenting symptoms, concomitant prescribed medication and comorbidities. If, after consideration of these factors, more than one antipsychotic is suitable, the antipsychotic with the lowest acquisition cost should be selected. Prescribers are

advised that the difference in cost between different drugs and drug formulations can be significant, and can vary over time.

Medicinal form and availability should be considered prior to treatment initiation when managing patients with swallowing difficulties. Antipsychotics are often available in different formulations (for example, risperidone for oral administration is available as a tablet, oral solution and orodispersible tablet, see BNF). The Care home medicines optimisation toolkit, endorsed by AWMSG, includes guidance on managing swallowing difficulties[13], advice is also available from NEWT guidelines[14].

Antipsychotic medication should be initiated at the lowest dose and slowly titrated up to an effective dose according to response (the “start low and go slow” approach).

Expression of distress in dementia is often relatively short-lived, and a short course of an antipsychotic (e.g. up to six weeks) should always be the intended duration[1,3,15] where non-pharmacological methods have not worked or are inappropriate.

Table 3 – Antipsychotic choice, adapted from The Maudsley prescribing guidelines in psychiatry 14th edition[15]

Antipsychotic	Initial daily 'low' dose	Usual dose range in dementia	Clinical profile	Licensed indication in dementia
Amisulpride*	25 mg*	Up to 50 mg/day	Emerging evidence of efficacy and may be used where other antipsychotics are ineffective or not suitable.	Not licensed for the treatment of aggression in patients with dementia.
Aripiprazole*	5 mg*	Up to 15 mg/day	Less effect on QT interval. Less EPSE, could be considered for patients with Parkinson's disease or Lewy body dementia as lower risk of movement disorders.	Not licensed for the treatment of aggression in patients with dementia.
Haloperidol	250 microgram	Up to 2 mg/day	Not recommended except in delirium – only consider where all other choices are ineffective or contraindicated. High risk of EPSE and QT prolongation therefore not recommended for use in dementia (except in delirium for short term use).	Treatment of persistent aggression and psychotic symptoms in patients with moderate to severe Alzheimer's dementia and vascular dementia when non-pharmacological approaches and when there is a risk of harm to self or others[16].
Olanzapine	2.5 mg	Up to 10 mg/day	Alternative where risperidone not suitable but can have more sedative effects and can increase appetite.	Not licensed for the treatment of aggression in patients with dementia.
Quetiapine	12.5 mg	Up to 300 mg/day in divided doses	May be associated with sedation and hypotension. Less evidence of efficacy in this patient group. Less EPSE, may be considered where antipsychotic required in Parkinson's disease or Lewy body dementia.	Not licensed for the treatment of aggression in patients with dementia.
Risperidone*	250 microgram*	Up to 2 mg/day	Generally, first line choice as licensed for up to six weeks. Caution with dosing if renal function is impaired.	Licensed for short-term treatment (up to six 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[17].

*caution with dose and titration in renal impairment – see eBNF. EPSE - extrapyramidal side effects.

The most important adverse effects of antipsychotic medication include:

- reduced mobility
- change in posture or change in gait
- increased sedation
- increased falls risk (dizziness, sedation, postural hypotension)
- Parkinsonism (tremor, impaired posture/gait, muscle rigidity)
- worsening cognition
- peripheral oedema
- risk of thromboembolism (increased by reduced mobility and reduced fluid intake)
- risk of cardiac arrhythmia, myocardial infarction and stroke.

Patients should be kept well hydrated and as mobile as possible particularly in the initial four to six weeks of treatment. Any adverse effects should be recorded in the patient notes or care plan.

Table 4: Relative side effects of antipsychotics (most side effects are dose-related)[15]

Antipsychotic	Anticholinergic	Sedation	Hypotension	Parkinsonism	QTc
Amisulpride	0	0	0	+	++
Aripiprazole	0	0	0	0	+
Haloperidol	+	+	+	+++	++
Olanzapine	+	++	+	0	+
Quetiapine	+	++	++	0	+
Risperidone	+	+	++	+	+

Key: 0 little or none, + mild, ++ moderate, +++ marked

3.3 Antipsychotic initiation

On initiating an antipsychotic a review date must be set by the prescriber, and the healthcare professional responsible for the review must be clearly documented. The review should take place within the first week of treatment. It is recommended that any patients starting an antipsychotic for non-cognitive symptoms should have the All Wales Antipsychotic Monitoring Record (AWAM) (Appendix 2) completed in order to document details of initiation and ongoing monitoring and review. It is recommended that this be uploaded to the Welsh Clinical Portal to enable other healthcare professionals involved in the patient's care to access the information.

Where an antipsychotic is prescribed in an inpatient setting, the reason for prescribing, and treatment response should be clearly communicated in the discharge or transfer of care letter, along with the ongoing treatment and review plan (including relevant dates). In many cases, the review will be completed by the GP and care home staff. Send a copy of the completed AWAM record with any documents on transfer of care or discharge to clarify how and when the next review will take place.

Upon initiation, carers should be advised that particular attention must be paid to encourage / advise adequate fluid intake and mobilisation to reduce the risk of adverse events due to dehydration and immobility. The Public Health Wales website

has resources relating to hydration[18]. It should also be highlighted that the risk of such adverse events may be highest in the first few weeks.

Adverse effects should be minimised by starting at the lowest dose and titrating gradually to an effective dose.

3.4 Antipsychotic monitoring and review

3.4.1 Initial review

An initial review must take place within the first week of treatment and be documented in AWAM Record. The initial review should ideally have a multidisciplinary team approach and the responsibility and accountability of the review lies with the team. The review should consider and inform management of the following:

- response to the target symptom(s) for which the antipsychotic was prescribed
- the effect of treatment on the overall quality of life and function of the person
- any notable changes in cognition
- any adverse effects (this is not an exhaustive list, see SPC for individual medicines)
    - hypotension
    - falls
    - over-sedation
    - dehydration / change in fluid intake
    - constipation / change in bowel habit
    - posture and gait changes
    - rigidity, tremor, hypersalivation, peripheral oedema or parkinsonism i.e. extrapyramidal side effects (EPSE)

Where adverse effects occur, consider reducing the dose or stopping treatment and switching to an alternative antipsychotic if needed.

If treatment is swapped to another antipsychotic due to inefficacy or side effects, the new antipsychotic should be started at the lowest dose with monitoring whilst the former antipsychotic is tapered.

NICE guidelines recommend review of the antipsychotic every six weeks[1], however reviews could take place more pragmatically once every four weeks. Once symptoms are controlled and stable, antipsychotic tapering and discontinuation should be considered.

3.4.2 Ongoing monitoring and review

The initial prescriber is responsible for ongoing monitoring and review, unless there is agreement from someone more appropriate, for example a GP or staff within the older people's mental health service to continue the review. Where responsibility for review is delegated by the initial prescriber, a clear action plan including intended duration of treatment should be provided.

After the initial review, subsequent reviews should take place at least every six weeks until symptoms are stable, and include the following:

- any non-pharmacological interventions tried, and the response
- current medication prescribed
- current antipsychotic prescribed including treatment duration
- the effect on the target symptom(s) for which the antipsychotic was prescribed
- the effect of the treatment on the overall quality of life and function of the patient
- any evidence of adverse effects, including sedation, changes in mobility or posture, weight gain, cognitive decline, and extrapyramidal side-effects (EPSE)
- consideration must be given to the discontinuation of antipsychotic treatment, or reduction to the lowest effective dose
- any consultation with patient, family, carers to establish whether the continued use of antipsychotics is appropriate
- any change in medication should be made following discussion with the person and their family or carers, or where applicable an advocate
- the outcome of the review, date of next planned review, and person responsible

If attempts at tapering or stopping treatment are unsuccessful and it is recognised that the antipsychotic is appropriate for longer term use, this decision should be clearly documented in the AWAM Record. Where this is the case it may be considered appropriate, in conjunction with the patient and their family and/or carers, for reviews to take place less frequently (biannually for example). Details of this, including frequency of ongoing review, should be clearly documented in the AWAM Record.

Antipsychotics are not licensed for long term use in dementia, and there is little guidance to suggest what physical health monitoring should be undertaken and how frequently for this patient group. However, if these medications are continued in the longer term (> three months), the approach to physical monitoring should be individualised and clinical judgement utilised based on risks, comorbidities and physical health.

Monitoring should only be undertaken if the results will change clinical practice or increase patient safety. Monitoring should be used in conjunction with reviewing the need for the medication and for consideration of de-prescribing[19].

3.5 Antipsychotic discontinuation and reduction

Most people will not experience re-emergence of their non-cognitive symptoms when antipsychotics are gradually reduced or discontinued[15,20]. In addition, presenting behaviours change over time due to the progressive nature of dementia, therefore it is important to consider the ongoing need for continued treatment regularly.

NICE advise that antipsychotics should be used at the lowest effective dose for the shortest possible time, and that the person should be reassessed at least every six weeks to determine whether the antipsychotic is still required. Treatment should be discontinued if the person is not seeing clear ongoing benefit, and after discussion with the person taking them, and family and carers.

When people living with dementia are transferred between settings, for example into a care home, it is recognised that there will be a "settling in" period. The healthcare professional responsible for the patient's care may choose to delay the discontinuation or reduction of an antipsychotic until the person is settled in their new home environment. Care plans should include documentation of current duration of antipsychotic treatment and a suggested management plan.

A Cochrane review[21] of withdrawal versus continuation of low dose antipsychotics concluded that there is low-quality evidence that antipsychotics may be successfully discontinued in older people with dementia for non-cognitive symptoms who have been taking antipsychotics for at least three months, and that discontinuation may have little or no important effect on expression of distress and psychological symptoms. This is consistent with the observation that most expressions of distress associated with dementia are intermittent and often do not persist for longer than three months[21].

People with psychosis, aggression or agitation who responded well to long-term antipsychotic drug use, or those with more severe non-cognitive symptoms at baseline, may benefit from the continuation of antipsychotics where attempts to reduce or stop the medication has been unsuccessful[22].

3.6 Tapering Guidance

Antipsychotic treatment should be tapered and discontinued if[6]:

- there is no evidence of clear benefit at a stabilised treatment dose
- there is emerging evidence of side-effects that outweigh the intended benefits of treatment (best interest principles to be followed)
- after three months the patient's symptoms are stable and no previous attempts to taper have been made

If the person is still under the care of the mental health team, or they have a comorbid mental health condition, the mental health team should be contacted for advice before tapering or stopping the antipsychotic.

Tapering or stopping regimens should be individualised to each person and their response to change. Individuals prescribed a 'low dose' of antipsychotic, may have the medication stopped without tapering. Examples of a 'low dose' of antipsychotic can be found in Table 5. It is important to closely monitor the patient for re-emergence of target symptoms.

Table 5. Examples of low doses of antipsychotics that may be discontinued without tapering[6]

Antipsychotic	Daily "low dose"
Amisulpride	25 mg daily
Aripiprazole	2.5 mg daily
Haloperidol	250 micrograms daily
Olanzapine	2.5 mg daily
Quetiapine	25 mg daily
Risperidone	250 micrograms daily

Higher doses of antipsychotics require gradual tapering before being discontinued; the patient should be reviewed after each dose change to evaluate response.

Where the person has been prescribed an antipsychotic for a period up to three months:

- reduce dose by 25–50% and monitor closely over at least two weeks
- the person should be monitored for any changes in expression of distress using a validated tool or chart such as the Cohen-Mansfield Agitation Inventory[7]
- if no re-emergence of previous target symptoms occurs, review in at least two weeks to reduce by a further 25–50%, to be followed by stepwise reduction every two weeks dependent on response

Where a person has been prescribed an antipsychotic for a longer period of time (over three months) they may benefit from a slower tapering regime. In such cases it is advised to seek specialist advice from the mental health service[6].

3.7 Audit Tools

Each organisation should ensure that prescribing practice is regularly audited to establish practice against NICE NG97 standards[1]. The AWMSG CEPP National Audit – Antipsychotics in Dementia can be used for this purpose within GP practices.

The Prescribing Observatory for Mental Health (POMH) is a subscription-based project open to all healthcare organisations in the UK that provide specialist mental health services. POMH has developed audit standards for use in specialist mental health services, which are noted below:

1. The clinical indications (target symptoms) for antipsychotic treatment should be clearly documented in the clinical records.
2. Before prescribing antipsychotic medication for non-cognitive symptoms, likely factors that may generate, aggravate or improve such expressions of distress should be considered.
3. The potential risks and benefits of antipsychotic medication should be considered and documented by the clinical team, prior to initiation.
4. The potential risks and benefits of antipsychotic medication should be discussed with the patient and/or carer(s), prior to initiation.
5. Medication should be regularly reviewed, and the outcome of the review should be documented in the clinical records. The medication review should take account of: a) therapeutic response b) possible adverse effects.

4.0 Resources related to antipsychotic prescribing

Resources for health care professionals:

- Health Education and Improvement Wales (HEIW) has developed a training module to increase the knowledge of healthcare professionals on the safety issues associated with antipsychotic use in dementia: Safe Use of Antipsychotics in Dementia Care (registration required)

- NHS Safe Prescriber: Dementia friendly prescribing module (free registration required)

The following resources provide additional background and information:

- NHS England Antipsychotic-Prescribing-Toolkit-for-Dementia
- T7: Reducing antipsychotic prescribing in dementia | PrescQIPP C.I.C

Resources for carers:

- Antipsychotics and other drug approaches in dementia care | Alzheimer's Society (alzheimers.org.uk)

- Mental Health and Medication Wales Home (choiceandmedication.org)

Resources in Welsh:

- The Alzheimer's Society website includes a number of publications and factsheets in Welsh including Y canllaw dementia (The dementia guide).

5.0 Antipsychotic subgroup membership

The task and finish group membership and draft protocol were approved by the Members of the Antipsychotic subgroup:

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Appendix 1: Antecedence, Behaviour, Consequence (ABC) Chart

Adapted from James (2011)[23]

1. Distressed Behaviour: .....

2. Date and Time	3. Where was the distress observed?	4. Who was there at the time?
5. What was going on for the person prior to the incident? (A – antecedent)		
6. What did you observe the person do? (B – actual behaviour)		
7. Record what the person said during the incident.		
8. What made the situation better? (C - consequences)		

9. What emotion were they expressing before the incident?				10. What emotion were they expressing during the incident?			
Angry	□	Frustrated	□	Angry	□	Frustrated	□
Anxious	□	Happy	□	Anxious	□	Happy	□
Bored	□	Irritable	□	Bored	□	Irritable	□
Content	□	Physically Unwell	□	Content	□	Physically Unwell	□
Depressed	□	Restless	□	Depressed	□	Restless	□
Despairing	□	Sad	□	Despairing	□	Sad	□
Frightened	□	Worried	□	Frightened	□	Worried	□

Appendix 2: All Wales Antipsychotic Monitoring (AWAM) Record

This monitoring record is intended to be used across all care settings. It is recommended that the completed record is added to the Welsh Clinical Portal.

An anti-psychotic medication is being prescribed to this individual for distressed symptoms associated with a dementia.

This medication should be reviewed on a 6-weekly basis (or at regular intervals, as documented in the individual's care plan).

Consider use of Cohen Mansfield Agitation Inventory (CMAI-short)[7] to monitor progress against target symptoms.

At each review, **consideration should be given** to a reduction in or discontinuation of the drug.

Antipsychotics have shown modest efficacy in managing symptoms of:

- psychosis
- delusions
- severe aggression

Antipsychotic medication should **not** be prescribed:

- to routinely sedate a patient for ease of management
- when the symptoms or circumstances for which they were prescribed no longer apply
- without a clear review date

Antipsychotic initiation

NHS No: _____ Surname: _____ First Name: _____ Address: _____ _____ Date of birth: _____	Date of assessment: _____ **Location of patient when medication commenced** Hospital ☐ Own home ☐ Ward ☐ Care home ☐ Other_____

Reason for prescribing an antipsychotic	
Target symptoms, severity & risk of harm to self/others (Cohen-Mansfield / NPIQ score)	Other approaches tried (include non-drug interventions and medications)

Risks considered
Cardiovascular assessment
Co-morbidities / other medication
Physical health review.
Has treatment for pain / infection / depression been optimised?

Baseline physical health	Mobility/Gait/Posture	
	Sleep	
	Cognition	
	Bowels	
	Appetite/Fluids	
	Other notable (please state)	

Current psychotropic medication		
Drug name	Dose	Frequency

Patient capacity	(Yes / No)	Initials
Capacity to consent to medication Discussion with person (if appropriate) Best Interest decision made (discussion with family/carer and staff) Patient/carer information leaflet given		

Antipsychotic prescribed (including dose)		
Drug name	Starting dose	Frequency & timings

Antipsychotic review	
Date of next planned review	
Clinician responsible for next planned review	Signature (and designation)

ANTIPSYCHOTIC MONITORING RECORD

Antipsychotic Monitoring and Review

NHS No: _____ First name: _____ Surname: _____ Date of birth: _____	Date of review: _____
Patient seen? Yes / No	**Location of patient when reviewed** Hospital ☐ Own home ☐ Ward ☐ Primary care ☐ Other_____

Current psychotropic medication (especially benzodiazepines)		
Drug name	Dose	Frequency

Changes from baseline physical health or any new side effects?	
Sleep / Sedation (Sleeping more during the day)	
Parkinsonian (Drooling, tremor, rigidity)	
Physical (Poor posture, less mobile, higher falls risk)	
Cognition (Confusion, communication skills)	
Appetite / Fluid intake	
Bowels (Bristol stool chart)	
Other notable (please state):	

For how long has the antipsychotic been prescribed? (in weeks or months)

Has discontinuation been previously attempted?	

Any changes in or benefit to target symptoms?
Description of current presentation. Use objective measures (Cohen-Mansfield / NPIQ)

Antipsychotic review					
Outcome of review for (name and dose of drug):					
Continue	☐	Stop	☐	Trial off	☐
Restart	☐	Change dose	☐	Change drug	☐
With whom has the outcome been discussed?					
Next planned review (in weeks or months)					
Clinician responsible for next planned review		Signature and designation			

ANTIPSYCHOTIC MONITORING RECORD

Appendix 3: Antipsychotic Prescription Flow Chart