NHS
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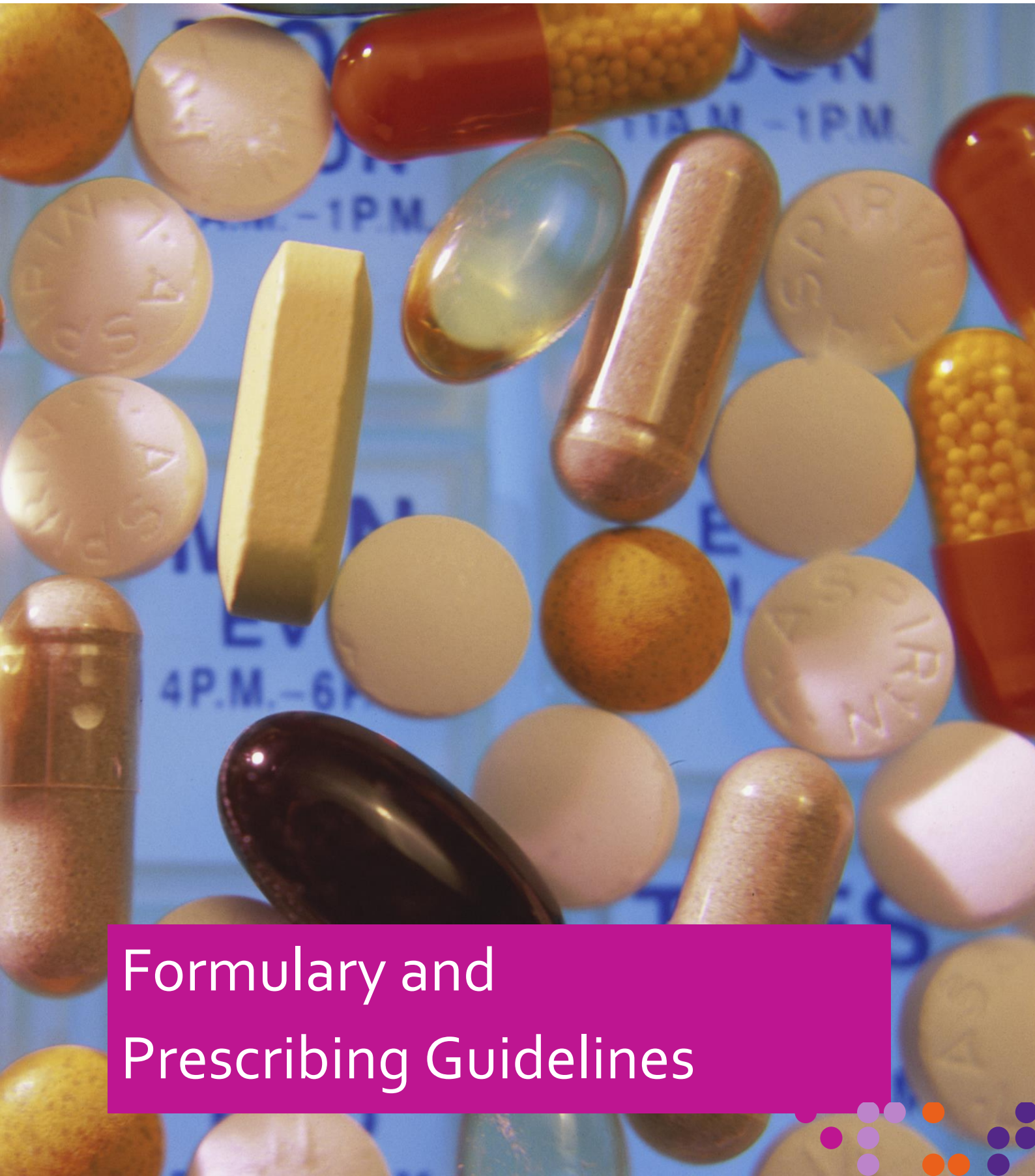
Section 7: Management of Dementia



Formulary and Prescribing Guidelines

7.1 Approved drugs for use in cognitive impairment of Alzheimer's disease

Drug[3]	Formulation[3]	Dose[3]	Licensed[4]
Donepezil	Tablets 5 mg, 10 mg Orodispersible Tab 5mg, 10mg	Initially 5 mg once daily at bedtime, increased if necessary after 28 days max. 10 mg daily	Mild to moderate dementia in Alzheimer's disease.
Rivastigmine	Capsules 1.5mg, 3mg, 4.5mg, 6mg Oral solution 2 mg/mL.	Initially 1.5 mg twice daily, increased in steps of 1.5 mg twice daily at intervals of at least 14 days according to response & tolerance; usual range 3–6 mg twice daily; max. 6 mg twice daily	Mild to moderate dementia in Alzheimer's disease
	Patches, 4.6 mg/24 hours; 9.5 mg/24 hours	Initially apply 4.6 mg/24 hours patch daily, removing after 24 hours; if well tolerated, increase to 9.5 mg/24 hours patch daily after no less than 28 days; if patch not applied for more than several days, treatment should be restarted with 4.6 mg/24 hours patch. To be used in patients experiencing excessive gastro-intestinal side-effects and dizziness with oral preparation.	
Galantamine	Tablets 8mg, 12mg Oral solution 4mg/mL.	Initially 4 mg twice daily for 28 days increased to 8 mg twice daily for 28 days; maintenance 8–12 mg twice daily	Mild to moderate dementia in Alzheimer's disease.
	M/R Capsules 8mg, 16mg, 24mg XL)	Initially 8 mg once daily for 28 days increased to 16 mg once daily for 28 days; maintenance 16–24 mg daily	
Memantine	Tablets 5mg, 10mg, 20mg	Initially 5mg once daily, increased in steps of 5mg at weekly intervals; max 20mg daily	Moderate (see below) to severe dementia in Alzheimer's disease
	Oral solution 5mg/actuation (10mg/ml)		
	Soluble Tablet 10mg, 20mg		

7.2 NICE Technology Appraisal

NICE TA217, March 2011 (updated June 2018). Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease.[2]

1.1 The three acetylcholinesterase (AChE) inhibitors donepezil, galantamine and rivastigmine as monotherapies are recommended as options for managing mild to moderate Alzheimer's disease under all of the conditions specified in 1.4 and in recommendation 1.5.5 of the NICE guideline on dementia.

1.2 Memantine monotherapy is recommended as an option for managing Alzheimer's disease for people with:

• moderate Alzheimer's disease who are intolerant of or have a contraindication to AChE inhibitors or

• severe Alzheimer's disease.

Treatment should be under the conditions specified in recommendation 1.5.5 in the NICE guideline on dementia.

1.3 This recommendation has been updated and replaced by recommendation 1.5.5 in the NICE guideline on dementia.

1.4 If prescribing an AChE inhibitor (donepezil, galantamine or rivastigmine), treatment should normally be started with the drug with the lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started). However, an alternative AChE inhibitor could be prescribed if it is considered appropriate when taking into account adverse event profile, expectations about adherence, medical comorbidity, possibility of drug interactions and dosing profiles.

1.5 When using assessment scales to determine the severity of Alzheimer's disease, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the results and make any adjustments they consider appropriate. Healthcare professionals should also be mindful of the need to secure equality of access to treatment for patients from different ethnic groups, in particular those from different cultural backgrounds.

1.6 When assessing the severity of Alzheimer's disease and the need for treatment, healthcare professionals should not rely solely on cognition scores in circumstances in which it would be inappropriate to do so. These include:

- if the cognition score is not, or is not by itself, a clinically appropriate tool for assessing the severity of that patient's dementia because of the patient's learning difficulties or other disabilities (for example, sensory impairments), linguistic or other communication difficulties or level of education or

- if it is not possible to apply the tool in a language in which the patient is sufficiently fluent for it to be appropriate for assessing the severity of dementia or

- if there are other similar reasons why using a cognition score, or the score alone, would be inappropriate for assessing the severity of dementia.

In such cases healthcare professionals should determine the need for initiation or continuation of treatment by using another appropriate method of assessment.

7.3 NICE NG97: Dementia: assessment, management and support for people living with dementia and their carers

NICE NG97 [1], updates and replaces NICE CG42 Dementia: supporting people with dementia and their carers in health and social care (CG42) published in 2006.

This NICE guideline has been completely re-written and is one of the first guidelines to integrate health and social care. From a medicines perspective, the addition of memantine to ACHEs is now recommended. Prescribing of medicines for dementia in primary care is covered in the Shared Care Protocol for Dementia.

There are recommendations on the use of 'off-label' treatments for Dementia with Lewy Bodies. There is also information on anticholinergic burden reviews and treatment of agitation, aggression, distress and psychosis. Patient decision aids are available on use of antipsychotic medicines and enteral tube feeding.[5]

Below are the recommendations from NG97 that relate to treatment with medicines. (The bullet point numbers are retained from the original NG97, as they are referred to in other documents, such as the TA217).
These recommendations will be followed, unless the recommendations are covered by a separate protocol (e.g. Shared Care Protocol).

1.4 Interventions to promote cognition, independence and wellbeing
1.4.5 Do not offer acupuncture to treat dementia.
1.4.6 Do not offer ginseng, vitamin E supplements, or herbal formulations to treat dementia.

1.4.9 Do not offer non-invasive brain stimulation (including transcranial magnetic stimulation) to treat mild to moderate Alzheimer's disease, except as part of a randomised controlled trial.

1.5 Pharmacological interventions for dementia

Managing medicines for all dementia subtypes

1.5.1 For guidance on managing medicines (including covert administration), see the NICE guidelines on managing medicines for adults receiving social care in the community and managing medicines in care homes.

Pharmacological management of Alzheimer's disease

1.5.2 The three acetylcholinesterase (AChE) inhibitors donepezil, galantamine and rivastigmine as monotherapies are recommended as options for managing mild to moderate Alzheimer's disease under all of the conditions specified in 1.5.5 and 1.5.6. This recommendation is from NICE technology appraisal guidance on donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease.

1.5.3 Memantine monotherapy is recommended as an option for managing Alzheimer's disease for people with:

- moderate Alzheimer's disease who are intolerant of or have a contraindication to AChE inhibitors or
- severe Alzheimer's disease.

Treatment should be under the conditions specified in 1.5.5. This recommendation is from NICE technology appraisal guidance on donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease.

1.5.4 For people with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor:

- consider memantine in addition to an AChE inhibitor if they have moderate disease
- offer memantine in addition to an AChE inhibitor if they have severe disease.

1.5.5 Treatment should be under the following conditions:

- For people who are not taking an AChE inhibitor or memantine, prescribers should only start treatment with these on the advice of a clinician who has the necessary knowledge and skills. This could include:
    - secondary care medical specialists such as psychiatrists, geriatricians and neurologists

- other healthcare professionals (such as GPs, nurse consultants and advanced nurse practitioners), if they have specialist expertise in diagnosing and treating Alzheimer's disease.

- Once a decision has been made to start an AChE inhibitor or memantine, the first prescription may be made in primary care.
- For people with an established diagnosis of Alzheimer's disease who are already taking an AChE inhibitor, primary care prescribers may start treatment with memantine (see recommendation 1.5.4) without taking advice from a specialist clinician.
- Ensure that local arrangements for prescribing, supply and treatment review follow the NICE guideline on medicines optimisation.
- Do not stop AChE inhibitors in people with Alzheimer's disease because of disease severity alone.

Note: Prescribing of medicines for dementia in primary care is covered in the EPUT Shared Care Protocol for Dementia. The recommendations in 1.5.5 above are from NICE, and they do not represent the arrangements in place.

1.5.6 If prescribing an AChE inhibitor (donepezil, galantamine or rivastigmine), treatment should normally be started with the drug with the lowest acquisition cost (taking into account required daily dose and the price per dose once shared care has started). However, an alternative AChE inhibitor could be prescribed if it is considered appropriate when taking into account adverse event profile, expectations about adherence, medical comorbidity, possibility of drug interactions and dosing profiles.

This recommendation is from NICE technology appraisal guidance on donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease.

1.5.7 When using assessment scales to determine the severity of Alzheimer's disease, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the results and make any adjustments they consider appropriate. Healthcare professionals should also be mindful of the need to secure equality of access to treatment for patients from different ethnic groups, in particular those from different cultural backgrounds.

This recommendation is from NICE technology appraisal guidance on donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease.

1.5.8 When assessing the severity of Alzheimer's disease and the need for treatment, healthcare professionals should not rely solely on cognition scores in circumstances in which it would be inappropriate to do so. These include:

- if the cognition score is not, or is not by itself, a clinically appropriate tool for assessing the severity of that patient's dementia because of the patient's learning difficulties or other disabilities (for example, sensory impairments), linguistic or other communication difficulties or level of education or
- if it is not possible to apply the tool in a language in which the patient is sufficiently fluent for it to be appropriate for assessing the severity of dementia or
- if there are other similar reasons why using a cognition score, or the score alone, would be inappropriate for assessing the severity of dementia.

In such cases healthcare professionals should determine the need for initiation or continuation of treatment by using another appropriate method of assessment.

This recommendation is from NICE technology appraisal guidance on donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease.

1.5.9 Do not offer the following specifically to slow the progress of Alzheimer's disease, except as part of a randomised controlled trial:

- diabetes medicines
- hypertension medicines
- statins
- non-steroidal anti-inflammatory drugs (NSAIDs), including aspirin.

Pharmacological management of non-Alzheimer's dementia

1.5.10 Offer donepezil or rivastigmine to people with mild to moderate dementia with Lewy bodies.[1]

1.5.11 Only consider galantamine[2] for people with mild to moderate dementia with Lewy bodies if donepezil and rivastigmine[1] are not tolerated.

1.5.12 Consider donepezil or rivastigmine for people with severe dementia with Lewy bodies[1].

1.5.13 Consider memantine[3] for people with dementia with Lewy bodies if AChE inhibitors[4] are not tolerated or are contraindicated.

1.5.14 Only consider AChE inhibitors[4] or memantine[3] for people with vascular dementia if they have suspected comorbid Alzheimer's disease, Parkinson's disease dementia or dementia with Lewy bodies.

1.5.15 Do not offer AChE inhibitors or memantine to people with frontotemporal dementia[5].

1.5.16 Do not offer AChE inhibitors or memantine to people with cognitive impairment caused by multiple sclerosis.

1.5.17 For guidance on pharmacological management of Parkinson's disease dementia, see Parkinson's disease dementia in the NICE guideline on Parkinson's disease.

1.6 Medicines that may cause cognitive impairment

1.6.1 Be aware that some commonly prescribed medicines are associated with increased anticholinergic burden, and therefore cognitive impairment.

1.6.2 Consider minimising the use of medicines associated with increased anticholinergic burden, and if possible look for alternatives:

- when assessing whether to refer a person with suspected dementia for diagnosis
- during medication reviews with people living with dementia.

1.6.3 Be aware that there are validated tools for assessing anticholinergic burden (for example, the Anticholinergic Cognitive Burden Scale), but there is insufficient evidence to recommend one over the others.

1.6.4 For guidance on carrying out medication reviews, see medication review in the NICE guideline on medicines optimisation.

1.7 Managing non-cognitive symptoms

Agitation, aggression, distress and psychosis

1.7.1 Before starting non-pharmacological or pharmacological treatment for distress in people living with dementia, conduct a structured assessment to:

- explore possible reasons for their distress and
- check for and address clinical or environmental causes (for example pain, delirium or inappropriate care).

1.7.2 As initial and ongoing management, offer psychosocial and environmental interventions to reduce distress in people living with dementia.

1.7.3 Only offer antipsychotics[6],[7] for people living with dementia who are either:

- at risk of harming themselves or others or
- experiencing agitation, hallucinations or delusions that are causing them severe distress.

1.7.4 Be aware that for people with dementia with Lewy bodies or Parkinson's disease dementia, antipsychotics can worsen the motor features of the condition, and in some cases cause severe antipsychotic sensitivity reactions. For more guidance, see the advice on managing delusions and hallucinations in the NICE guideline on Parkinson's disease. Be aware that interventions may need to be modified for people living with dementia.

1.7.5 Before starting antipsychotics, discuss the benefits and harms with the person and their family members or carers (as appropriate). Consider using a decision aid to support this discussion. See https://www.nice.org.uk/guidance/ng97/resources

See Appendices 1 and 2 of this document for tools to assess BPSD (Behavioural & Psychological Symptoms of Dementia) before prescribing antipsychotics. Complete Appendix 2 if starting an antipsychotic.

See Appendix 3 of this document for a guide to selecting the most appropriate antipsychotic. See Appendix 4 of this document for a flowchart for prescribing antipsychotics in Behavioural & Psychological Symptoms of Dementia.

1.7.6 When using antipsychotics:

- use the lowest effective dose and use them for the shortest possible time
- reassess the person at least every 6 weeks, to check whether they still need medication.

1.7.7 Stop treatment with antipsychotics:

- if the person is not getting a clear ongoing benefit from taking them and
- after discussion with the person taking them and their family members or carers (as appropriate).

1.7.8 Ensure that people living with dementia can continue to access psychosocial and environmental interventions for distress while they are taking antipsychotics and after they have stopped taking them.
1.7.9 For people living with dementia who experience agitation or aggression, offer personalised activities to promote engagement, pleasure and interest.
1.7.10 Do not offer valproate to manage agitation or aggression in people living with dementia, unless it is indicated for another condition.[8]

Depression and anxiety
1.7.11 For people living with mild to moderate dementia who have mild to moderate depression and/or anxiety, consider psychological treatments.
1.7.12 Do not routinely offer antidepressants to manage mild to moderate depression in people living with mild to moderate dementia, unless they are indicated for a pre-existing severe mental health problem.

Sleep problems
1.7.13 Do not offer melatonin to manage insomnia in people living with Alzheimer's disease.

1.7.14 For people living with dementia who have sleep problems, consider a personalised multicomponent sleep management approach that includes sleep hygiene education, exposure to daylight, exercise and personalised activities.

Parkinson's disease

1.7.15 For guidance on managing Parkinson's disease symptoms in people with Parkinson's disease dementia or dementia with Lewy bodies, see the NICE guideline on Parkinson's disease. Be aware that interventions may need to be modified for people living with dementia.

1.8 Assessing and managing other long-term conditions in people living with dementia

1.8.1 Ensure that people living with dementia have equivalent access to diagnosis, treatment and care services for comorbidities to people who do not have dementia. For more guidance on assessing and managing multimorbidity, see the NICE guidelines on multimorbidity and older people with social care needs and multiple long-term conditions.

1.8.2 For more guidance on providing support for older adults with learning disabilities, see the NICE guideline on care and support of people growing older with learning disabilities.

Pain

1.8.3 Consider using a structured observational pain assessment tool:

- alongside self-reported pain and standard clinical assessment for people living with moderate to severe dementia
- alongside standard clinical assessment for people living with dementia who are unable to self-report pain.

1.8.4 For people living with dementia who are in pain, consider using a stepwise treatment protocol that balances pain management and potential adverse events.

1.8.5 Repeat pain assessments for people living with dementia:

- who seem to be in pain
- who show signs of behavioural changes that may be caused by pain
- after any pain management intervention.

Falls

1.8.6 For guidance on managing the risk of falling for people living with dementia (in community and inpatient settings), see the NICE guideline on falls in older people. When using this guideline:

- take account of the additional support people living with dementia may need to participate effectively
- be aware that multifactorial falls interventions may not be suitable for a person living with severe dementia.

Diabetes

1.8.7 For guidance on setting HbA1c targets for people living with severe dementia who have type 2 diabetes, see recommendation 1.6.9 in the NICE guideline on type 2 diabetes in adults.

Incontinence

1.8.8 For guidance on pharmacological treatment of overactive bladder, see the NICE technology appraisal on mirabegron for treating symptoms of overactive bladder.
1.8.9 For guidance on treating faecal incontinence, see recommendations 1.7.2 and 1.7.8 in the NICE guideline on faecal incontinence.

1.10 Palliative care

1.10.1 From diagnosis, offer people living with dementia flexible, needs-based palliative care that takes into account how unpredictable dementia progression can be.
1.10.2 For people living with dementia who are approaching the end of life, use an anticipatory healthcare planning process (see recommendation 1.1.12 on advance care planning). Involve the person and their family members or carers (as appropriate) as far as possible, and use the principles of best-interest decision-making if the person does not have capacity to make decisions about their care.
1.10.3 For standards and measures on palliative care, see the NICE quality standard on end of life care for adults.
1.10.4 For guidance on care for people in the last days of life, see the NICE guideline on care of dying adults.
1.10.5 For guidance on best interests decision-making, see the NICE guideline on decision-making and mental capacity.
1.10.6 Encourage and support people living with dementia to eat and drink, taking into account their nutritional needs.
1.10.7 Consider involving a speech and language therapist if there are concerns about a person's safety when eating and drinking.
1.10.8 Do not routinely use enteral feeding in people living with severe dementia, unless indicated for a potentially reversible comorbidity.

References cited in text above:

[1] At the time of publication (June 2018), donepezil and rivastigmine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent

should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

[2] At the time of publication (June 2018), galantamine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

[3] At the time of publication (June 2018), memantine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

[4] At the time of publication (June 2018), the AChE inhibitors donepezil, rivastigmine and galantamine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

[5] Note that logopenic aphasia, which has previously been included in some diagnostic guidelines for frontotemporal dementia, has now been shown to most commonly be caused by Alzheimer's disease.

[6] The MHRA (2012) has given advice for health and social care professionals on prescribing antipsychotics to people living with dementia to treat the behavioural and psychological symptoms of dementia.

[7] At the time of publication (June 2018), the only antipsychotics with a UK marketing authorisation for this indication were risperidone and haloperidol. The marketing authorisation for risperidone only covers short-term treatment (up to 6 weeks) of persistent aggression in people with moderate to severe Alzheimer's disease unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others. The marketing authorisation for haloperidol only covers treatment of persistent aggression and psychotic symptoms in people with moderate to severe Alzheimer's dementia and vascular dementia when non-pharmacological

treatments have failed and when there is a risk of harm to self or others. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

[8] If relevant, follow MHRA advice that valproate medicines are contraindicated in women and girls of childbearing potential unless a Pregnancy Prevention Programme is in place.

References

1. NICE NG97, Dementia: assessment, management and support for people living with dementia and their carers. https://www.nice.org.uk/guidance/ng97 (Updated June 2018).
2. NICE TA 217, June 2018. Donepezil, Galantamine, Rivastigmine and Memantine for the treatment of Alzheimer's disease. http://www.nice.org.uk/Guidance/TA217
3. BNF online December 2018
4. Summary of Product Characteristics [accessed December 2018] http://www.medicines.org.uk/EMC/default.aspx
5. Feedback from the NICE Associates Face to Face Day - 28th June and NICE and Prescribing Support - Important New Evidence, June 2018. Jacqueline Clayton, Assistant Head of Medicines Optimisation, Bedfordshire Clinical Commissioning Group.
6. The Maudsley Prescribing Guidelines in Psychiatry. 13th edition (2018).

Appendix 1

Managing behavioural problems in people with dementia - 24-hour sleep and activity chart

A record of when and how often behaviour problems occur may be helpful

to all who support the patient in planning their care.

Please complete this chart and bring it to your next appointment or discuss it with

……..on (*date)……..*

Name of patient …….. Person completing ……

Key:

Active involvement in tasks/interests E

Restlessness, agitated A

Day & Date	8 am	9 am	10 am	11 am	12 am	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 pm	1 am	2 am	3 am	4 am	5 am	6 am	7 am

Please write any other comments overleaf

Appendix 2

Antipsychotics in Behavioural & Psychological Symptoms of Dementia

Name:	**DOB:**	**NHS number:**	**Diagnosis:**

INITIATION DATE	
MEDICATION & DOSE	
TARGET BEHAVIOUR(S)	

HAVE YOU CONSIDERED THE FOLLOWING STATEMENTS?

	YES/NO
Has UTI/constipation/other infection/ other medical problem(s) been ruled out?	
Is the patient in pain?	
Has depression or anxiety been diagnosed?	
Has Behavioural (non-pharmacological) management been tried?	
Does the patient have risk factors for Stroke/TIA? If yes, please specify:	
Have you discussed the risks and benefits of antipsychotics with the patient/ family/ care staff (as appropriate)	

REVIEW: ***(please indicate the next review date)***

Review Date:	**Outcome on target behaviour:** *better/same/worse* **Adverse effects:** + / -	**Management** *(continue same dose /reduce/ discontinue or consider alternative measures)*

Appendix 3

Choice of antipsychotic for Behavioural & Psychological Symptoms of Dementia [4, 6]

Risperidone is the agent of choice. Alternative antipsychotics may be used if risperidone is contra-indicated or not tolerated.

RECOMMENDATION: Use of risperidone (licensed) and olanzapine may be justified in some cases. Effect is modest at best. When prescribed, regular review is recommended. [6]

Drug	Dose range	Comment
Risperidone	A starting dose of 0.25 mg twice daily is recommended. This dosage can be individually adjusted by increments of 0.25 mg twice daily, not more frequently than every other day, if needed. The optimum dose is 0.5 mg twice daily for most patients. Some patients, however, may benefit from doses up to 1 mg twice daily.	Is 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. Considered first treatment of choice for aggression and psychosis. It has fewer side effects than the older antipsychotics. It does have significant anticholinergic effects at higher doses and should not be used for people with Parkinson's disease or Lewy Body Dementia. It affects blood sugars (caution in diabetes). It can raise prolactin levels, which may cause osteoporosis.
Olanzapine	Use the lowest effective dose for the shortest possible time	Unlicensed use. Considered second treatment of choice, particularly for aggression. Fewer anticholinergic side effects, but may cause weight gain and blood sugar dyscrasias. Sedative. In older adults select a lower initial dose and gradual dose increase especially if female and/or a non-smoker.
Quetiapine	Use the lowest effective dose for the shortest possible time	Unlicensed use. Fewer anticholinergic side effects. May be used cautiously in Parkinson's Disease or Lewy Body Dementia (at very small doses). Less effect on weight, blood sugars and prolactin levels.
Aripiprazole	Use the lowest effective dose for the shortest possible time	Unlicensed use. As for Quetiapine but less likely to cause drowsiness. Negligible effect on the QT interval, use a lower initial dose in older adults. May cause agitation in first 2 weeks.
Haloperidol	0.5 to 5 mg/day orally, as a single dose or in 2 divided doses. Adjustments to the dose may be made every 1 to 3 days.	Is licensed for treatment of persistent aggression and psychotic symptoms in patients with moderate to severe Alzheimer's dementia and vascular dementia when non-pharmacological treatments have failed and when there is a risk of harm to self or others. Check ECG before using. Anticholinergic side effects (akathisia and stiffness). Do not use if patient has Parkinson's disease or Lewy Body Dementia. Note: only use this drug with extreme caution and in discussion with a specialist in dementia. The need for continued treatment must be reassessed after no more than 6 weeks.

Mortality risk. In a study of elderly patients with dementia, haloperidol was associated with the highest rates of mortality, followed by risperidone, olanzapine, valproic, and then quetiapine.

Appendix 4

Flow chart for prescribing antipsychotics in Behavioural & Psychological Symptoms of Dementia [6]

Exclude other causes.

Review and rationalise current medication.

Discuss possible risks and benefits with MDT and patient, family and carers where appropriate, and document clearly.

Undertake risk assessment, considering the cerebrovascular risk (take into account hypertension, diabetes, smoking, atrial fibrillation, and previous stroke). Document clearly.

Choose most appropriate antipsychotic for patient (see Appendix 3), and prescribe at lowest effective dose.

Conduct physical health checks, at baseline:ECG, BP & pulse, Weight, Fasting glucose or HbA1c, U&Es (including eGFR), FBC, lipids, LFTs, prolactin.

Refer to EPUT Clinical Guideline 52: Pharmacological management of acutely disturbed behaviour, if prescribing in the context of “rapid tranquilisation”.

Ensure review date is specified. Review at 4 – 6 weeks (may be earlier for inpatients), at 3 months, then every 6 months if physically stable and no adverse effects. Consider trying to stop the antipsychotic at each review, where appropriate.

If serious adverse effects occur, stop the antipsychotic immediately.

Repeat physical health checks (ECG, BP & pulse, Weight, Fasting glucose or HbA1c, U&Es (including eGFR), FBC, lipids, LFTs, prolactin) at 3 months and annually (more often for inpatients.)

Repeat ECG at between 1 month and 3 months, at 1 year, then annually (or when clinically indicated).

Monitor inpatients, very ill or physically frail patients more regularly.

Ensure documentation is complete.

Communicate plan for antipychotics with ongoing care providers.