RACGP
Royal Australian College *of* General Practitioners

RACGP aged care clinical guide (Silver Book)

5th edition

Part A. Short-term pharmacotherapy management of severe BPSD

General principles

- The use of short-term pharmacotherapy management of severe BPSD to manage challenging behaviours in dementia requires a considered person-centred approach.
- Non-pharmacological measures are first-line treatment options, and should be attempted prior to prescribing.
- Antipsychotics have a limited role in the management of challenging behaviours.
- Understanding the risks of antipsychotics and ensuring the benefits to the patient outweigh those risks is paramount.
- Having a structured approach to the work up and management of challenging behaviours is important.
- Communication with residential aged care facility staff and guardians of the patient is critical.
- Regular review after initiating antipsychotics is expected.
- Clearly document consent, discussion of risks and failure of non-pharmacological strategies and who provided consent in the patient's medical record.
- The patient should be reviewed and attempts at weaning the medication as soon as possible but definitely prior to 12 weeks.

Introduction

The RACGP believes the widespread use of the term 'chemical restraints' does not adequately or appropriately reflect the potential role of short-term pharmacotherapy management of severe BPSD. This section will use the more appropriate term 'short-term pharmacotherapy management of severe BPSD', which better reflects why GPs may go down this path.

The Royal Commission into Aged Care Quality and Safety's (Royal Commission's) *Interim report: Neglect* was released in November 2019 and defines restrictive practices as 'activities or interventions, either physical or pharmacological, which have the effect of restricting a person's free movement or ability to make decisions. They may involve restricting people with wrist restraints, abdominal and pelvic straps, vests, bed rails or deep recliner chairs, confining a person to their room or a section of a facility, or sedating them with particular medication.'[1]

This chapter of the Silver Book will focus on the use of medications, particularly antipsychotics, and provide guidance on the use of medications in managing behavioural and psychological symptoms of dementia (BPSD).

The use of antipsychotic medications in residential aged care facilities (RACFs) for the use of BPSD requires significant consideration, and the general consensus in the medical community is that their use should be reduced or avoided. Significantly, it is believed that the use of antipsychotics affect a patient's liberty and dignity.[2] The use of pharmacotherapy for BPSD without appropriate consent may also impinge on a patient's legal rights, and may constitute a legal offence.[3]

From a clinical perspective, there can be significant and serious adverse effects on individuals who are prescribed medications that may be considered to be a pharmacotherapy for BPSD, especially to their physical and mental wellbeing. Importantly, there are fundamental issues around the effectiveness and success of pharmacotherapy for BPSD.

Since 1 July 2019, stricter requirements around the use of pharmacotherapy for BPSD in government-funded RACFs under the *Aged Care Act 1997* (Cth) came into effect.

Notwithstanding the above, general practitioners (GPs) are well placed to prescribe and manage the use of antipsychotic medications in RACFs. GPs are able to coordinate the care of the patient; communicate with families, representatives (especially a legally appointed person with medical power of attorney) and staff using case conferencing; and prescribe the medication with consideration. GPs are also well placed to review the patient regularly after prescription, and monitor for effect and side effects. Guidelines suggest many patients are able to come off antipsychotics after three months, and GPs have the expertise, systems and opportunity to review and wean medications.

While the focus of this chapter is on the use of pharmacotherapy for BPSD in RACFs, most of the principles can also be appropriately applied to the care of patients with BPSD living in the community. The use of referrals to psychogeriatricians and geriatricians (including telehealth for rural and remote communities) can also be useful for advice on assessment and medication (eg home-based patient with Lewy body dementia paranoia wanting to drive).

Clinical context

It is important to recognise that the use of psychotropic medications may be for the management of a diagnosed physical or mental health illness or condition. As such, the use of psychotropic medications in those instances cannot be considered a pharmacotherapy for BPSD. The restriction of an individual's mental state must be differentiated with the management and treatment of a diagnosed illness or condition.

Psychotropic medications are most commonly prescribed to patients who exhibit BPSD (refer to Part A. Behavioural and psychological symptoms of dementia). The work up of BPSD and non-pharmacological management of BPSD, highlighted in that chapter, are vital and must precede the use of pharmacological treatments. This is an essential part of optimum clinical care. Potential reversible causes of deterioration in behavior should always be given due consideration. Other causes of distress should also be explored (eg noisy neighbours in the RACF, family issues, anniversary effects).

The use of pharmacological treatments has been found to be effective for those with severe agitation and physical aggression associated with the risk of harm, paranoia, delusions and hallucinations or comorbid pre-existing mental health conditions. It is prudent to be familiar with behavioural symptoms that do not respond to antipsychotics (eg undressing in public, wandering, calling out, restlessness, day–night reversal, inappropriate voiding or verbal aggression).

According to The Royal Australian and New Zealand College of Psychiatrists (RANZCP), antipsychotics should only be used for those with dementia when there is severe agitation or aggression associated with a risk of harm, delusions, hallucinations, or pre-existing mental illness.

Requests to prescribe antipsychotics can come from RACF staff, the representatives of the patient (especially a legally appointed person with medical power of attorney) and the GP who recognises the need. Alternatively, antipsychotics are commonly initiated in the hospital settings and the patient is discharged on the medications. In the latter setting, it is paramount that the GP continues to review and assess the patient as described below.

GPs are the patient's advocate, and it is important that pressure from staff and/or representatives (especially a legally appointed person with medical power of attorney) do not overly influence the GP decision to prescribe the medication. In saying that, communication with the staff and representatives is vital as the patient, by definition, will have limited capacity to give consent. It is recommended that a case conference is arranged prior to initiating antipsychotics and for the review.

It is important to note that RACF staff are now required to record consumers who received psychotropic medications by completing a self-assessment tool.[4]

In practice

The effective management of patients with challenging behaviours should include a personalised assessment and care plan.[5]

On admission to an RACF, a comprehensive medical assessment (CMA) is can be performed on all new patients and it is recommended to do it within six weeks. It is an opportunity to include an assessment of the risk of challenging behaviours and a management plan. The BPSD management plan will include information about restrictive practices, especially if the patient has a history of, or potential for, serious harm or potential serious harm to the patient themselves, other residents in the RACF and/or RACF staff. The management of BPSD symptoms requires a multidisciplinary team approach and good communication between the care team and patient/their representatives (especially a legally appointed person with medical power of attorney). A case conference may be a suitable mechanism to facilitate those conversations. Predicting the need for management of challenging behaviours will allow for a pre-emptive case conference and allow the RACF staff to prepare.

Non-pharmacological management

The first-line management should include a person-centred, multidisciplinary management plan of non-pharmacological approaches. The multidisciplinary team may include GPs, nurses, RACF staff, carers, families, other specialist medical practitioners (eg geriatrician, psychogeriatrician), pharmacists and allied health professionals.

Together, the multidisciplinary team should first seek to manage the underlying cause of the behaviour in order to minimise or avoid the use of pharmacotherapy for BPSD. Importantly, this will include the early identification and adoption of preventive and early intervention measures.

Non-pharmacological management plans must be person-centred, but may include:[6]

- Environmental[7]
  - reduce environmental noise and lighting
  - reduce risk of confusion
  - improve lighting
  - provide appropriate bedding
- Psychosocial[8]
  - engage and interact with familiar staff
  - conduct sensory stimulating activities
  - provide companionship
  - provide sensory aids
  - increased supervision
  - appropriate staffing and training

- Pharmacological
  - medication management (refer to Part A. Medication management)
  - deprescribing (refer to Part A. Deprescribing)
  - polypharmacy (refer to Part A. Polypharmacy)
  - nutrition and hydration
  - pain management (refer to Part A. Pain)

The prescription of Pharmaceutical Benefits Scheme (PBS) approved psychotropic drug (ie risperidone), can only be prescribed after non-pharmacological management have been attempted and failed.[9]

Pharmacological management

The use of pharmacological management should only be considered after attempts of non-pharmacological management have failed, and co-administered with other non-pharmacological management.[10] While the use of antipsychotics can assist with patients who pose a serious risk of harm to themselves, other residents or RACF staff, it can still be a stressful process for all individuals involved.

Medical practitioners need to be cognisant that the use of antipsychotics must be:

- for the benefit of the patient.
- to prevent harm or potential serious harm to the patient, other residents and/or RACF staff
- a last resort in a setting requiring an urgent response
- the least restrictive option
- carefully monitored, reviewed and clinically observed
- previously documented in the patient's management plan, if necessary
  - clear and unambiguous instructions on when the pharmacotherapy for BPSD can be used
  - identify the precipitating and exacerbating factors
  - suggest graded series of responses
- documented in the patient's notes
- discussed and reviewed with the patient
- subject to regular review (eg three monthly)
- accompanied by the appropriate consent
- appropriately communicated to the patient and their representatives (especially a legally appointed person with medical power of attorney)
- accompanied by a careful assessment of the patient's safety.

Adverse effects

The misuse of psychotropic medicines may significantly affect the individual patient, and can adversely affect:[11,12,13,14,15]

- sedation, gait disturbances and increased risk of falls and fractures
- urinary tract infections
- urinary and faecal incontinence
- cognitive impairment and confusion
- risk for extrapyramidal side effects (eg restlessness, agitation)
- risk of respiratory complications (eg pneumonia), stroke and heart rhythm abnormalities, cerebrovascular events (eg stroke)

- risk of death.

Available literature has also found that the long-term use of benzodiazepines can lead to long-term cognitive impairment and increased risk of dementia.[16,17]

Initiating antipsychotics

Once it has been established that antipsychotics are necessary for the comfort, dignity and safety of the patient and non-pharmacological management has failed, it is appropriate to initiate them.

- Assess the patient for contraindications for the medication.
- Communicate with the patient's legally appointed person with medical power of attorney regarding the decision and obtain their consent.
- Communicate with the RACF staff regarding the need for, the use of and observable side effects of the prescribed antipsychotic, and document the above.
- Prescribe the medication at a low dose.
- Review the patient within a week and regularly thereafter as required.
- Set a reminder and arrange to review the patient in 12 weeks with the plan to wean and cease the medication if possible.

Consent

Failure to obtain a patient or their legally appointed person with medical power of attorney's lawful consent before the administration of pharmacotherapy for BPSD may infringe on the patient's legal rights. It is therefore important to clearly document the following in the patient's medical record:

- consent
- discussion of risks and failure of non-pharmacological strategies
- who provided consent.

Decision making regarding care and treatment of those in RACFs must operate within state and territory legal frameworks. State and territory legislation provides guidance on when a patient is unable to provide consent to receiving medical treatment, and circumstances under which a substitute decision maker is able to assume responsibility.

The various legislation allows patients who have capacity to make arrangements for a substitute decision maker if and when they do not have the capacity to provide consent.[18] In New South Wales, if an individual is unable to provide consent to a medical practitioner, they must seek consent from an authorised individual to provide consent.[19]

It is therefore imperative for RACFs and medical practitioners to be aware of the legislation governing consent if it is determined to be necessary to use a pharmacotherapy for BPSD on a patient. However, in the acute clinical setting, this may be impractical and may lead to further potential harm to the patient, other residents in the RACF and RACF staff.

In situations where the use of pharmacotherapy for BPSD may be necessary, the patient is most likely unable to provide informed consent. Legislation and common law then indicates that informed consent must be obtained from a substitute decision maker; however, in reality, this can often be difficult to actualise.

It must be highlighted that in acute situations, where there is an urgent need to act quickly to safeguard the patient or others, restrictive practices may necessary and required. In this case, the judgement of the GP on starting the medication is appropriate; however, obtaining consent as soon as practically possible is imperative. These issues may be addressed by identifying the potential situation with the patient and family, and obtaining the necessary consent to act before the acute situation occurs.

Reviewing and weaning

As highlighted by the NSW Ministry of Health, '[s]ince the natural history of BPSD is variable (symptoms may be intermittent and may settle spontaneously), it is recommended that the use of such agents is time limited and reviewed for their potential discontinuation at least three-monthly'.[20]

Most practices have a process set up to set reminders for patients and GPs, and the GP can use this process to remember to review the patient after 12 weeks or less. Alternatively, another strategy would be to prescribe for a defined period of time on the medication chart.

Extrapolating from the adverse effect profile, Table 1 provides recommendations for assessment at the three-month antipsychotic review.

Table 1. Consider the following at the three-month antipsychotic review

Assessment	Related adverse effect or reason for assessment
Assessment of behaviour	Agitation, anxiety as a side effect of antipsychotics
Adverse effects	Movement disorders (eg rigidity, tremor, abnormal involuntary movements, muscle stiffness), sedation, anticholinergic effects (eg dry mouth, constipation), falls, confusion
Documentation of previous attempts at ceasing the antipsychotic	
Outcome of previous attempt.	
Non-pharmacological methods used that have failed/worked	Guidelines
Bowel actions	Constipation
Sleep assessment	Somnolence, insomnia
Weight measurement	Weight gain or loss
Pain assessment	Extremity pain, headache
Cardiovascular system examination: Consider electrocardiography (ECG)	Bradycardia/QT prolongation
Consider blood tests	Agranulocytosis, lipids, blood glucose levels

Taking a history and documenting the following points is part of the assessment:

- When was the last attempt at weaning?
- Outcome of previous weaning attempt.
- Pain, bowel actions and sleep assessment.

- Behaviour assessment using appropriate tools (eg Neuropsychiatric Inventory).
- Assess the patient's alcohol use and smoking status, as these may affect the use of psychotropic medications.

On examination, document the following.

- weight.
- neurological exam – consider parkinsonism, gait disturbance, tremor.
- pulse rate and rhythm.

Consider the following Investigations:

- full blood count, total cholesterol, triglycerides, high-density lipoprotein, and blood glucose levels or glycated haemoglobin (HbA1c) every three to six months, if indicated
- electrocardiography (ECG), if possible.

The actions following on from the assessment would be to:

- plan to wean and cease the medication
- continue with the medication – It will need to be clearly noted as to the reasons and indication for continuing
- consider that continuing the medication would follow the same advice above regarding initiating the medication
- conduct a case conference to discuss the plan for the following three months
- consider calling Dementia Behaviour Management Advisory Service (DBMAS) and Severe Behaviour Response Team (SBRT) if these behaviours persists.

Conclusion

As with many decisions a GP makes, the use of antipsychotic medications, which can potentially be viewed as a pharmacotherapy for BPSD, needs to be made with consideration and care. The focus is on the distress of the patient and managing their comfort and dignity. Since managing BPSD requires a multidisciplinary team approach, the RACF has a role and responsibility in the care of the patient. However, aiding and advising the RACF staff on non-pharmacologic management can be part of the GPs role when advocating for the patient.

GP's experience and expertise in coordinating care, seeing patients regularly and making difficult decisions for the good of their patients, makes them well placed to manage this challenging condition.

It is common for patients with challenging behaviours to improve within three months and being part of the team that has made a significant difference to them, is a meaningful and satisfying part of the GPs work life.

Resources

- Dementia Support Australia
  - BPSD guide app
  - A clinician's field guide to good practice – Managing BPSD
- Department of Health and Human Services's *Managing behavioural and psychological symptoms of dementia*
- Dementia Behaviour Management Advisory Service (DBMAS) and Severe Behaviour Response Team (SBRT)

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