Lancashire & South Cumbria NHS Foundation Trust

Management of Behavioural and Psychological Symptoms of Dementia (BPSD) in Primary and Secondary Care

Guidelines for the Management of Behavioural and Psychological Symptoms of Dementia (BPSD) in Primary and Secondary Care.

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Acknowledgments

Information contained within this document is largely taken from the PrescQIPP toolkit 'Reducing Antipsychotics in Dementia[1] and documents available on the Alzheimer's Society website.

Guidance around anticholinergic burden is taken from practice standards within the POMHUK audit report: The use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services[2].

Key Recommendations[3]

It is recommended that non-pharmacological approaches (therapy that does not involve medication) are used as a first line approach.

An assessment and care-planning approach, which includes behavioural management, should be followed as soon as possible.

If distress and or agitation are less severe, non–pharmacological interventions should be used before a pharmacological intervention is considered.

Target symptoms should be identified, quantified and documented. Target symptoms may include apathy, psychosis, aggression, moderate agitation/anxiety, severe agitation/anxiety, poor sleep.

Changes in target symptoms should be assessed and recorded at regular intervals.

The effect of other co–morbidities, such as depression and anxiety, should be considered and then managed accordingly.

If an antipsychotic is deemed necessary the choice of antipsychotic should be made after an individual risk versus benefit analysis.

If there is dementia the antipsychotic of choice is risperidone, which is licensed for persistent aggression in patients with moderate to severe Alzheimer's dementia at a dose of up to 1mg twice daily for up to 6 weeks. This drug (or any other antipsychotic – haloperidol, although not the drug of choice, is licensed for persistent aggression and psychotic symptoms in moderate to severe Alzheimer's dementia and vascular dementia) must be used with extreme caution as all antipsychotics have been shown to increase risk of CVA in this patient group. Patients must be regularly reviewed and treatment beyond 6 weeks should not occur without full, documented review of ongoing clinical need. (See Appendix 5 for Prescribers Record of Antipsychotic Initiation for Patients with Dementia)

If it is determined that an antipsychotic is required for BPSD, the existing anticholinergic burden should be considered, as well as how adding an antipsychotic will impact this. Consider prescribing an antipsychotic with a low anticholinergic burden such as risperidone (ACB score = 1)[4].

The dose should start low and then be slowly titrated.

Treatment should be time limited and regularly reviewed, every 3 months or according to clinical need.

If a patient on an antipsychotic for BPSD has not had a trial discontinuation in the last 3 months, they should have the antipsychotic reviewed and stopped to assess the risks and benefits of continued treatment unless:

- The antipsychotic was prescribed for a pre-existing condition prior to a diagnosis of dementia, e.g. bipolar disorder or psychotic depression.

- The patient is under regular review by a specialist for behavioural problems. This does not include reviews solely planned to assess the on-going benefits of prescribing cholinesterase inhibitors (e.g. donepezil) to delay cognitive decline.
- There is a detailed care plan in place for ongoing antipsychotic use.

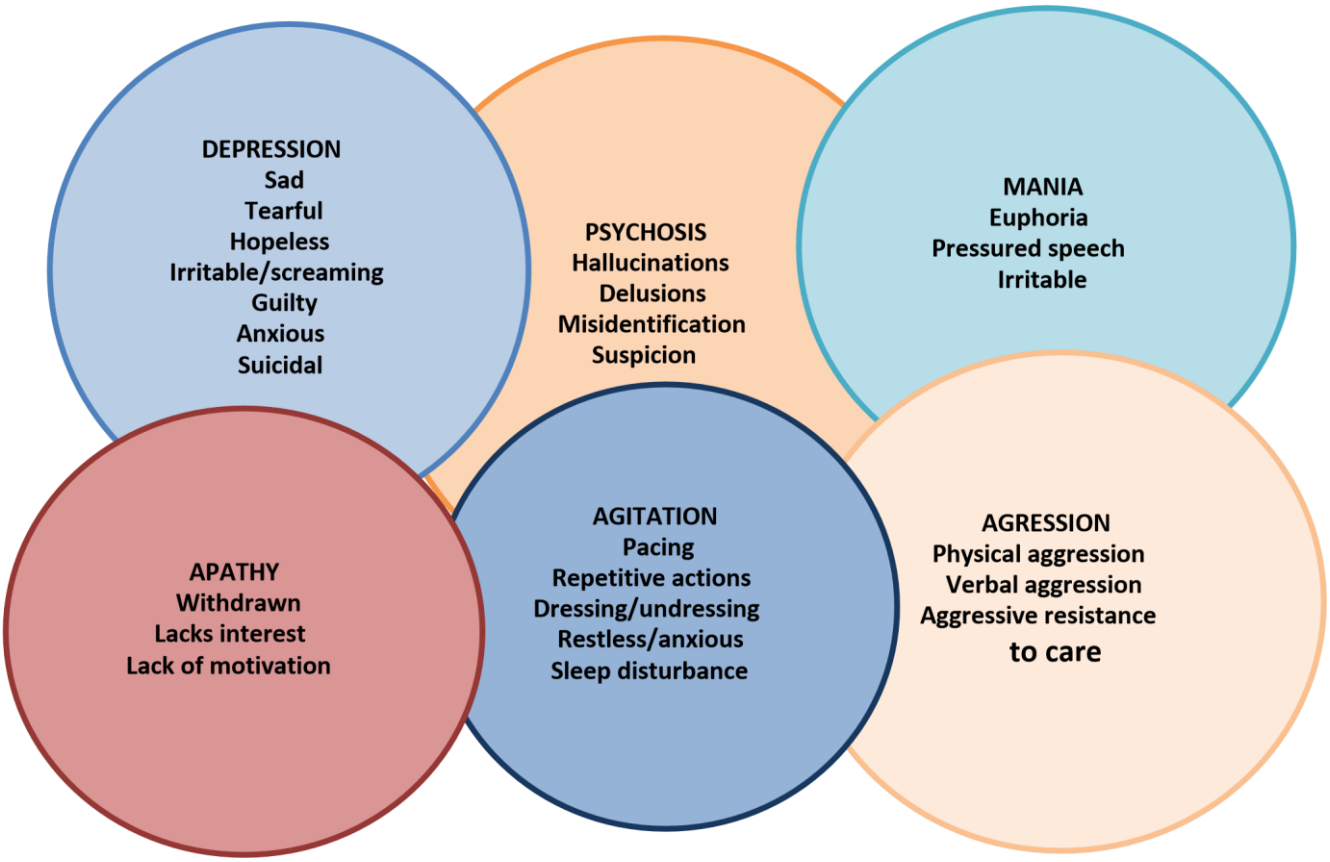
Physical health monitoring for those prescribed antipsychotic medication should be conducted in line with the recommendations in the NICE Clinical Guideline for Psychosis and schizophrenia in adults: prevention and management[5]. The Trust also has the Antipsychotic Monitoring policy and for secondary care, elderly patients prescribed antipsychotics are placed on the Antipsychotic register. Monitoring is aided by modified scales for the Elderly viz Glasgow Antipsychotic side effect scale and Observer Antipsychotic side effect scale.

Introduction

What is BPSD?

Behavioural and Psychological Symptoms of Dementia (BPSD) refers to a group of symptoms of disturbed perception, thought content, mood or behaviour, frequently occurring in patients with dementia.

- Challenging non-cognitive symptoms — include hallucinations, delusions, anxiety, and marked agitation.
- Challenging behaviour — includes aggression, agitation, wandering, hoarding, sexual disinhibition, apathy, and disruptive vocal activity (such as shouting).
- Challenging behaviour is often an active attempt by the person with dementia to meet or express a physical or psychological need. For example, agitation may be communicating boredom, anxiety, embarrassment or be a response to pain or discomfort or an environmental challenge, e.g. noise.



BPSD symptom clusters

More than 90% of people with dementia will experience BPSD as part of their illness and nearly two thirds of people with dementia living in care homes are experiencing symptoms at any one time.

Stepped Care Approach to the Management of BPSD

1. Care Homes

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

- Pain, malnourishment, dehydration and physical illness e.g. infection, constipation
- Stress, irritability, mood disturbance and suspiciousness
- Increased levels of distress
- Early signs may be noticed at certain times of the day, particularly during personal care
- Although not the most common trigger, it is important to be aware of any signs of abuse or neglect.

Actions

a. For further advice on monitoring for and managing triggers for BPSD read the 'Leaflet for care home staff looking after people with dementia' adapted from the PresQIPP toolkit. (Appendix 1)
b. Complete an assessment form (Appendix 2) to aid with ongoing assessment. Remember that some behaviours may not improve immediately and strategies have to be tried for several weeks
c. If patient presents as physically unwell e.g. in pain or suffering a suspected infection refer to their General Practitioner for assessment and pharmacological management
d. If behaviour does not settle following non-pharmacological approaches and the patient remains severely distressed, refer to the General Practitioner for further assessment

2. General Practitioners

BPSD is often due to an underlying physical health condition or delirium or an unmet need. In such instances, treating the unmet need or underlying acute medical problem e.g. urinary tract infection, chest infection, side effects of drugs, alcohol and drug withdrawal will often resolve the behavioural problem without the need for additional medication

Actions

a) If the patient has not been referred from a care home, assess for key triggers and potential non-pharmacological responses as highlighted in the section above for care homes

b) If the patient is residing in a care home review the assessment form

c) Assess for and treat physical health disorder- perform an MSU and screening bloods (U&Es, FBC, CRP, B_{12}, Folate, TFTs) as a minimum

d) Assess for and treat delirium (short history, <2 weeks, of confusion, hallucinations, and /or delusions with fluctuating cognition).

e) Review all medications (including anticholinergics, medications known to increase the risk of delirium e.g. opioids, benzodiazepines, antipsychotics, anticonvulsants, antihistamines, antihypertensives (especially if hypotension),corticosteroids, tricyclics, digoxin, antiparkinsonian medication)

Anticholinergic medications can adversely affect cognition in older people. The anticholinergic effect increases if a stronger anticholinergic is used, or if different anticholinergics are used in combination. When anticholinergics are prescribed for older people, the total anticholinergic burden should be assessed using a formal screening tool, such as the ACB Calculator[4] which is available at the following link: https://www.acbcalc.com/

f) Consider a therapeutic trial of regular paracetamol for at least one week, even if no obvious evidence of pain, since untreated pain could be an underlying cause of the agitation/restlessness[6]. If there is a positive response treatment with paracetamol should continue.

g) For pharmacological management of BPSD, refer to the flowchart in Appendix 4. A 4-6 week trial of an antidepressant such as an SSRI may help depression, restlessness and agitation. GPs should ideally not initiate antipsychotic medication for BPSD. If an antipsychotic is commenced, consider referring to secondary care.

If behaviour persists despite implementation of the strategies above or the patient presents with persistent aggression and is assessed as being at risk of harm to self or others, refer to secondary care mental health services. Referral information should include the results of any physical health screening undertaken

3. Care Home Liaison Function

The Care Home Liaison (CHL) function utilises a needs-led, bio psychosocial approach to managing behaviour that challenges in those with a diagnosed or suspected dementia who live in a care home. The aim is to improve quality of life by supporting the service user and his/her family or carers, to increase the service user's ability to live well with dementia, maximise the chance of maintaining the service user's place of residence should they wish and prevent avoidable hospital admission.

Actions

a) To support the care home, aiming to preserve the placement for the individual

b) Provide education to help care home staff become more knowledgeable in delivering person centred care.

c) Conduct a thorough/in-depth assessment from a bio-psychosocial perspective using multiple means of assessment, including where appropriate a behavioural or functional analysis of behaviour that challenges, observations, life story work, challenging behaviour scales, mood or pain scales. See Appendix 3 for an ABCD- antecedent, behaviour, consequences, discovery- chart

d) Work in collaboration with the care home to develop a psychological formulation of the difficulties faced by the service user and care home staff from a perspective of challenging behaviour as an unmet need. This may include formal or informal workshops/ information sharing or formulation sessions.

e) Utilise the working understanding of the service users' difficulties to develop a care plan/intervention plan in collaboration with the care home

f) Follow the 12 week model of understanding and managing behaviours that challenge, based on the Newcastle Challenging Behaviour (CB) model where indicated.

g) Provide on-going but time limited support to care homes following the implementation of any recommendations made by CHL (such as activity schedule, washing/dressing plan, therapy i.e. doll therapy/ singing therapy or change in a patient's medications for example). This should also include reformulation if interventions do not appear to be reducing the challenging behaviour.

h) Identify service users who require a medication review, appraise alternatives to antipsychotics and finding alternative ways of managing challenging behaviour.

4. Secondary Care/ Intensivist input

Secondary care input will be indicated where there is severe distress and/or persistent aggression that has not responded to other interventions, and where the patient is deemed to be at risk of harm to self or others. It will also be indicated for patients whose target symptoms have not responded to non-pharmacological and pharmacological management within primary care services.

Actions

a) Confirm that a trial of regular paracetamol has already been conducted

b) Consider whether the patient is on appropriate dementia medication. Memantine may be helpful in those with agitation (but small effect size).

c) For pharmacological management of BPSD, refer to the flowchart in Appendix 4 giving due consideration to any pharmacological treatment already prescribed by the GP

d) Should the patient require antipsychotic medication and a trial of risperidone has proved unsuccessful, olanzapine and aripiprazole are suitable alternatives. Olanzapine and aripiprazole are not licensed for this indication. Please note the following ACB scores for recommended antipsychotics[4]: risperidone = 1, olanzapine = 3, Aripiprazole = 1.

e) Quetiapine should only be used in cases where there is suspicion of Lewy Body Dementia due to a lack of efficacy[7]. Quetiapine is not licensed for this indication. ACB score = 3.

f) First generation antipsychotic medication should not be routinely prescribed

g) Sodium Valproate should not be prescribed due to lack of evidence and poorer tolerability[8]

h) Alternative antidepressant medication may be indicated following antidepressant trials in primary care services. In the event that trazodone is prescribed, an initial dose of 50mg capsules once daily will be considered.

i) Where prescribing is initiated on an off-label basis the trust procedure will be followed
(PHA029 Procedure for the prescribing of unlicensed or off-label medication)

j) A review of ongoing need for medication will occur every three months for those with BPSD unless there is a co-morbid psychosis or depressive disorder requiring ongoing treatment

k) Where a GP is asked to continue prescribing medication for BPSD, written information about the course length and plans for gradual discontinuation must be provided in correspondence.

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Appendix 1

Leaflet for care home staff looking after people with dementia

&

There are often good reasons why someone with dementia is distressed or behaving unusually. However, they might not always be able to tell you what's troubling them.

The challenge is to work out what the cause is and what you can do to help, for the benefit of both of you. Sometimes we react to unusual behaviour without knowing what the person might need or be saying through their behaviour.

We have used the ideas of **"STOP"** and **"PAUSE"** to describe the key ways to help you listen and watch, in order to understand distress and unusual behaviour.

Further advice

The Alzheimer's Society has more advice and information for people with different types of dementia, not just Alzheimer's dementia.

You can go to the Alzheimer's Society website at: www.alzheimers.org.uk or call them on their helpline (freephone) on 0300 150 3456.

We have listed useful factsheets on particular behaviours at the end of this leaflet.

Before you respond

&

S	See things from the point of view of person with dementia.
T	Think about your own thoughts and feelings.
O	Observe and ask what the person is trying to communicate and what is going on.
P	Patience and persistence.

P	Physical
A	Activity
U	Understanding
S	Self-esteem
E	Emotion

P is for PHYSICAL

Are they in pain?

Pain can be a common cause of changes in behaviour and can result from many problems such as joint pain, dental problems or discomfort from skin problems or constipation.

What to do

- Ask the person if they are in pain.
- Watch out for signs of them being in pain.
- Change their position if they have been sitting in one place for a long time.
- If you think they are in pain get advice from their doctor. Note the activity they're doing when they are distressed or seem uncomfortable so you can give information to their doctor.
- Please seek advice from their doctor if the person is taking any medication for pain, either prescribed or purchased. It may be that prescribed pain-killers need adjusting or that those being self-medicated are unsuitable. See factsheet 'Pain in dementia' on the Alzheimer Scotland: Action on Dementia website or https://www.alzscot.org/sites/default/files/2019-08/Pain%20in%20dementia_Aug%202019.pdf

Has their medication been reviewed or changed recently? Are they taking all their medication correctly?

New medicines might be causing side-effects. Older medicines may no longer be needed or may need adjusting. Incorrect use of medication may result in extra side-effects or result in limited or no expected benefits.

Do they have an infection?

They might have an infection such as urinary tract or chest infection or cellulitis.

What to do

Look out for things like smelly or cloudy urine (wee) or an unusually wheezy chest or redness, itchiness or soreness of the vagina (women) or penis (men) and report these to their GP.

Are they hungry or thirsty?

Dementia can cause changes in taste and appetite. People may have difficulty managing or recognising food or cutlery. Dehydration (lack of liquid) can happen with changes between hot and cold weather. People may avoid drinking in order to avoid going to the toilet.

What to do

- Note any problems with eating or drinking.
- People may need prompting to use cutlery, such as putting a fork in their hand and guiding their hand to the food.
- Meals may need to be little and often to ensure that blood sugar is maintained.
- Look for very yellow urine, which is a sign that they ought to be drinking more.
- Encourage drinking and provide support for going to the toilet if needed (see advice in Self-esteem below).
- Look for problems with denture pain or mouth ulcers.
- Let their GP know if you are concerned about how much they are eating or drinking. See factsheet 'Eating and drinking' at:

  https://www.alzheimers.org.uk/sites/default/files/pdf/factsheet_eating_and_drinking.pdf

Are they getting enough sleep at night?

Dementia can cause changes in people's sleep schedule so that they wake up more often and stay awake for longer at night. Confusion about time can lead them to think it is daytime at 4am and want to get dressed.

What to do

- Note any signs of pain or discomfort upon waking.
- Keep bedtime routines and provide nightlights and comfort objects.
- Avoid watching TV in the bedroom or the person spending long periods in time in bed while awake; use bed only for sleep.
- Encourage outdoor exercise or activities to keep them alert during the day.
- Try to stop or reduce daytime napping.
- Avoid alcohol and caffeine before bedtime. See their GP if problems persist.

Could they have hearing or eyesight problems?

People can become disinterested in a conversation or an activity just because they cannot see or hear easily.

What to do

- Check how well they can see or hear things, even if they have glasses or a hearing aid.
- Improve the lighting.
- Make sure that you talk loudly and clearly into the good ear.
- Avoid competing noises or activities such as TV or radio.
- Try to move slowly and approach the person from the side where the eyesight and/or hearing are best.
- Get advice from an optician or hearing specialist if you think their sight or hearing could be improved.

Could they be making 'visual mistakes'?

People with dementia might still have good vision but have problems with making sense of things correctly in front of them (called visuospatial difficulties). This might make it difficult for them to watch TV, use objects correctly or walk confidently. Other examples include misinterpreting reflections in mirrors or avoid stepping on shiny floor because it looks wet or slippery.

What to do

- Improve the lighting.
- Make sure the rooms are free from clutter and there is space to move around with confidence.
- Cover-up or change busy patterns on walls and floors.

Could they be experiencing hallucinations?

Hallucinations may occur with some types of dementia, especially dementia with Lewy bodies. Visual hallucinations are most common and involve seeing things that are not present, usually people and animals. This can be frightening and lead to changes in behaviour.

What to do

- If they are not worried then don't dwell on it.
- Listen carefully and acknowledge what the person is saying.
- Talk calmly and try not to argue with them.
- Consult their GP if the hallucinations persist or worsen or are frightening.

Could the room temperature be too hot or too cold?

What to do

If very hot and the temperature cannot be reduced consider giving them more drinks, use fans or sit them outside in the shade. If cold, try the use of blankets and extra clothing.

A is for ACTIVITIES

Could they be bored or needing social contact?

What to do

- Use simple activities to prompt conversation, such as looking at a vase of flowers, a picture on the wall or looking out of the window.
- Involve them in everyday activities like laying the table.
- Try and do activities they used to enjoy doing, e.g. gardening or visiting the seaside.
- Give the person regular opportunities to talk to someone.
- Visit your local dementia café where both of you can meet and chat with others in a similar situation (contact your local Alzheimer's Society for more information). Develop a "life story" together to support reminiscing and conversations. Find life story forms at https://www.dementiauk.org/wp-content/uploads/dementia-uk-my-life-story-template.pdf

Is there too much going on or is the person in unfamiliar surroundings with people they don't recognise? ***What to do***

- Consider having more routine and structure in the day by doing the same things at the same time everyday.
- Have a quiet time or use calming activity or music, especially at times they are tired, such as after lunch.

U is for UNDERSTANDING

Do you understand why they are distressed or behaving badly?

Family members and friends may struggle to understand someone's changing behaviour. How you and others understand the behaviour is crucial to how you will react.

What to do

- You should have a basic understanding about dementia.
- You can discuss with family members any triggers that can cause certain behaviours as well identify activities which may calm them.
- It would be beneficial to complete a life history for the resident.
- You can also advise family and friends to be mindful of their tone and facial expressions and to try to speak calmly.

S is for SELF ESTEEM

Are they frustrated because they are unable to communicate their needs or they can no longer do the things they used to do?

People with dementia can find it difficult to feel good about themselves. This can often be expressed through unusual behaviours.

What to do

- Include people in conversations and be aware of how they might be feeling.
- Let the person finish their sentences unless they ask for your help.
- Don't point out their mistakes.
- Let them do jobs they are used to doing, e.g. putting some of the shopping away. Break the job down into smaller steps to help them. This will help them feel they are doing something useful.
- Explain what you plan to do or what you are doing.
- Ask them questions which require yes/no responses and give plenty of time to respond.
- Help the person recognise objects. Do this by showing them how to use the object, getting them to touch the object or using noise, e.g. flushing toilet. Use short simple statements rather than questions or gestures to indicate walking to the toilet, etc. For example, say "come to the toilet" rather than "would you like to go to the toilet"?

See factsheet 'Communicating' at: https://www.alzheimers.org.uk/sites/default/files/2020-03/communicating_500.pdf

E is for EMOTIONS

Are they sad, scared, depressed or anxious?

People with dementia still experience feelings and emotions even though they may not be able to explain to you their feelings or remember what caused them to feel that way.

What to do

- Note down what was going on to see if something triggers the change in feelings or mood. This might be due to certain music, noises or a visit from someone.
- Encourage distracting activities such as walking.
- Touching or holding their hand may help calm them and show them you care.
- Try to pick out key words or phrases and repeat these back as it may help the person focus on a particular topic.
- Respond to the person's feelings rather than correcting the accuracy of what they are saying. For example, if someone says they miss their mother, think about the meaning behind what they are saying. Are they sad or worried about something?

- You could encourage them to tell stories about their mother and what they miss about her to help them feel more secure. You might need to make try out different ways of responding to see what works best.

If someone's low or anxious feelings or mood persists, ask their doctor for a referral to specialist mental health services.

Other useful factsheets

Changes in behaviour	http://alzheimers.org.uk/factsheet/525
Continence and using the toilet	https://www.alzheimers.org.uk/sites/default/files/2018-10/factsheet_continence_and_using_the_toilet.pdf
Sex, intimacy and dementia	https://www.alzheimers.org.uk/sites/default/files/2019-09/factsheet_sex_and_intimate_relationships.pdf
walking about	http://alzheimers.org.uk/factsheet/501
Washing and dressing	https://www.alzheimers.org.uk/sites/default/files/2024-04/Supporting-person-washing-dressing-504.pdf
Aggressive behaviour	http://alzheimers.org.uk/factsheet/509
Changes in perception	http://www.alzheimers.org.uk/factsheet/527

Appendix 2

Assessment & management of behaviour that challenges (BPSD) in dementia

This guidance is designed to support you in caring for a person living with dementia in a care home. It outlines some options to consider in a stepped care approach. As a care home you have responsibilities to meet the needs of those under your care.

Please fill in the boxes below to aid with the ongoing assessment. Some behaviour may not improve immediately and strategies have to be tried over a number of weeks. We suggest a stepped approach as highlighted later. First complete the following questions:

What is the key symptom or behaviour causing concern?

How long has this been occurring?

How frequent is this behaviour? (Circle as appropriate) (i.e. several times daily / constant; daily; every other day; weekly)

What are the risks/concerns the behaviour is causing? *(e.g. distress/risk to others)*

What strategies have you already tried to manage the behaviours/symptoms? *(see recommendations in stepped care model)*

What do you think might be important factors related to (causing) their behaviour / symptoms? (*Consider pain / anxiety / mood disturbance / physical illness / environmental factors / communication difficulties / fear / frustration…….)*

THE CHALLENGING BEHAVIOUR SCALE (CBS) FOR OLDER PEOPLE LIVING IN CARE HOMES

Name .....

Age ..... **Sex** ... **M / F** **Diagnosis of Dementia** ... **Y / N / Don't know**

Residence ..... **Date** .....

Checklist Completed By .....

PHYSICAL ABILITY (delete as applicable)

1. Able to walk unaided / Able to walk with aid of walking frame / In a wheelchair
2. Continent / Incontinent of urine / Incontinent of faeces / Incontinent of urine + faeces
3. Able to get in or out of bed/chair unaided / needs help to get in or out of bed/chair
4. Able to wash and dress unaided / needs help to wash and dress
5. Able to eat and drink unaided / needs help to eat and drink

Over the page is a list of challenging behaviours that can be shown by older adults in residential or nursing settings.
For each behaviour listed consider the person over past 8 weeks and mark:

INCIDENCE: Yes / Never. If Yes move to Frequency

FREQUENCY:
4: This person displays this behaviour **daily or more**
3: This person displays this behaviour **several times a week**
2: This person displays this behaviour **several times a month**
1: This person displays this behaviour **occasionally**

DIFFICULTY:
Then *for each behaviour shown* mark down how difficult that behaviour is to cope with, when that person shows it, according to the following scale:

4: This causes a lot of problems
3: This causes quite a lot of problems
2: This is a bit of a problem
1: This is not a problem

N.B. If a person does not show a behaviour no frequency or difficulty score is needed.
If the person causes a range of difficulty with anyone behaviour, mark down the score for the worst it has been over the last few (eight) weeks.

	CHALLENGING BEHAVIOUR	INCIDENCE		FREQUENCY		DIFFICULTY		CHALLENGE	
		Yes	Never	1=occasionally 2=several/month 3=several/week 4=daily or more		1=no problem 2=bit of problem 3=quite a lot of problem 4=lots of problems		Frequency x Difficulty	
1	**Physical Aggression** (hits, kicks, scratches, grabbing, etc)								
2	**Verbal Aggression** (insults, swearing, threats, etc)								
3	**Self Harm** (cuts/hits self, refuses food/starves self, etc)								
4	**Shouting**								
5	**Screaming/Crying out**								
6	**Perseveration** (constantly repeating speech or actions, repetitive questioning or singing)								
7	**Wandering** (walks aimlessly around home)								
8	**Restlessness** (fidgets, unable to settled down, pacing, `on the go`, etc.)								
9	**Lack of motivation** (difficult to engage, shows no interest in activities, apathy, etc)								
10	**Clinging** (follows/holds on to other residents/staff, etc)								
11	**Interfering with other people**								
12	**Pilfering or Hoarding** (possessions, rubbish, paper, food, etc)								
13	**Suspiciousness** (accusing others, etc)								
14	**Manipulative** (takes advantage of others, staff, etc.)								
15	**Lack of Self Care** (hygiene problems, dishevelled, etc)								
16	**Spitting**								
17	**Faecal Smearing**								
18	**Inappropriate Urinating** (in public, not in toilet, etc)								
19	**Stripping** (removes clothes inappropriately, flashes, etc)								
20	**Inappropriate Sexual Behaviour** (masturbates in public, makes inappropriate `advances` to others, etc.)								
21	**Sleep Problems** (waking in night, insomnia, etc.)								
22	**Non-compliance** (deliberately ignores staff requests, refuses food, resists self care help, etc)								
23	**Dangerous Behaviour** (causes fires or floods, etc)								
24	**Demands Attention**								
25	**Lack of Occupation** (sits around doing nothing, etc.)								
	TOTALS **Add scores (1 – 25) for each column**		25		100		100		400

Name: John **Day, Date & Time: Monday, 1/2/2012, 10.00 am**

Challenging Behaviour: Shouting

Antecedent

What was the person doing just before the incident? (What was going on? Who else was present?)

John was sat quietly

Behaviour:

Where did it happen?

The dining room

What did you see happen?

A female resident walked and was talking loudly. John began to shout at her telling her to 'shut up'.
The other resident carried on talking loudly. John stood up, went over to her and attempted to hit her.

What was the person saying/doing at the time of the incident?

He shouted 'Shut up'. He rubbed his head and looked upset

How long did the incident last? 3 minutes

How difficult was the problem? 5 /10 (0 = no problem to 10 = extremely difficult)

How did the person appear at the time of the incident? Tick all that apply)

Angry ✓	**Despairing**	**Physically unwell**
Anxious	**Frightened**	**Restless** ✓
Bored	**Frustrated** ✓	**Sad**
Content	**Happy**	**Worried**
Depressed	**Irritable** ✓	**Other**

Consequences

How was the situation resolved? (What did you say or do? What did others say/do? What happened next? What happened to the person's behaviour?)
Two staff members separated them. They told him firmly and calmly that he should not hit anyone and they escorted him to a quieter area of the home.
Staff sat with John and asked him what was upsetting him. He did not reply but within 5 minutes he was calm and was having a friendly chat

Discovery

What have you learned about the person? (eg. Likes/dislikes/preferences)

John likes to eat in a quiet room
John does not like noise
John responds well to one to one interaction
When he is upset he starts rubbing his head

Have you learned anything new about the resident? **Yes / No**
Would this information be useful for other people to know? **Yes / No**
Could this knowledge be used to prevent similar behaviour happening again? **Yes / No**

How will you share this information with others?_____

Does this information need to go into a care plan? Yes

Care Home Liaison Team :ABCD Chart

_____ has been referred to the Care Home Liaison Team. You have been asked to complete ABCD charts for them. This explanation will assist you to fill one out

What is an ABCD chart?
An ABCD chart is used to record challenging behaviour.

What information does the ABCD chart give you?
An ABCD chart will give us a detailed picture of the challenging behaviour. It shows us how often the behaviour is happening and what is happening at the time of the behaviour

Who should fill out an ABCD chart?
The chart needs to be filled out by a staff member who witnessed the behaviour. If more than one member of staff was involved decide who will fill out the form

Which behaviours do we fill out an ABCD chart for?
Before you fill out the charts, someone from our team will discuss the target behaviour(s) you want to look at. You will fill out the charts for these target behaviours.

Do I have to fill out a chart every time the behaviour happens?
Yes please. We need to know how much of a problem this is. If you do not record it each time we can miss important information.

How long will we have to complete the ABCD charts for?
Usually up till 5 incidents of the behaviour have occurred.

If you have any more questions about the completion of charts you can contact us on:
01772 401477

Name: **Day, Date & Time:**

Challenging Behaviour:

Antecedent

What was the person doing just before the incident? (What was going on? Who else was present?)

Behaviour:

Where did it happen?

What did you see happen?

What was the person saying/doing at the time of the incident?

How long did the incident last? _____ **Minutes**
How difficult was the problem? _____/10 **(0 = no problem to 10 = extremely difficult)**
How did the person appear at the time of the incident? Tick all that apply)

Angry	Despairing	Physically unwell
Anxious	Frightened	Restless
Bored	Frustrated	Sad
Content	Happy	Worried
Depressed	Irritable	Other

Consequences

How was the situation resolved? (What did you say or do? What did others say/do? What happened next? What happened to the person's behaviour?)

Discovery

What have you learned about the person? (e.g. Likes/dislikes/preferences)

Have you learned anything new about the resident? Yes / no
Would this information be useful for other people to know? Yes / no
Could this knowledge be used to prevent similar behaviour happening again? Yes / no

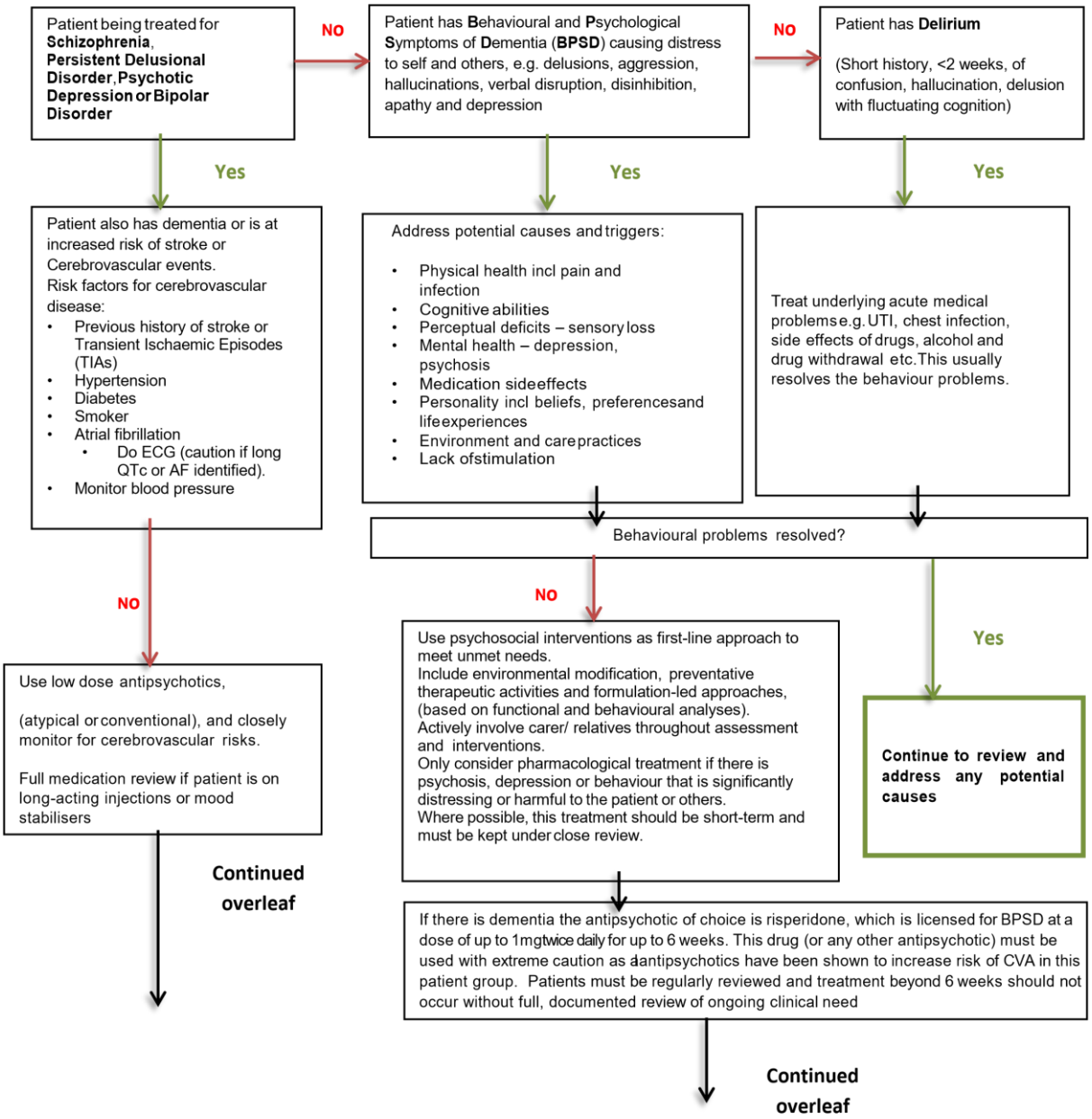
How will you share this information with others?_____

Does this information need to go into a care plan? Yes/No

Appendix 4

Responding to behaviours that challenge (BPSD) in older people and those with dementia

(Does not cover rapid tranquillisation of acutely disturbed)



If antipsychotic treatment is indicated:

- Start doses low (e.g. half adult initial dose) and increase slowly (e.g. every 2-4 days).
- Stopping should always be considered and discussed after 6 weeks in order to make a full assessment of ongoing need and benefit.
- Monitor for side effects and for potential worsening of cognitive function, which is possible with all antipsychotics.
- To reduce risk of cognitive impairment and other anticholinergic effects, consider prescribing an antipsychotic with low / no anticholinergic burden.
- Also note that use of antipsychotics in the elderly increases risk of pneumonia by up to 60%.
- To reduce CVA risk, ensure patient remains well hydrated and maintains mobility (where possible).

Medication options

Behavioural disturbances:

- Cautiously consider **risperidone** as first-line medication for persistent aggression in dementia that is not responsive to non-drug approaches and where there is risk of harm to the patient or others.
- Starting dose is 250micrograms twice daily, adjusted on alternate days to not more than 1mg twice daily.
- Other antipsychotics should be avoided wherever possible but may be considered in low doses e.g. aripiprazole, olanzapine. Cholinesterase inhibitors, memantine and trazodone are also potential treatment options.

If

Trazodone is prescribed an initial dose of 50mg capsules will be considered. Peer review will be progressed in the event that trazodone liquid is being considered

- Carbamazepine has demonstrated limited efficacy, but valproate should be avoided due to lack of evidence and poor tolerability.
- Benzodiazepines should be avoided other than in extreme cases.
- Use short-acting lorazepam as it is less likely to accumulate, but review regularly and monitor closely for worsening confusion, ataxia and risk of falls.

Depression:

- Consider antidepressant medication if clinically depressed.
- Citalopram is first choice if not contraindicated. Note maximum licensed dose in the elderly is 20mg due to concerns over QTc prolongation
- Sertraline, mirtazapine and trazodone are alternatives.
- All may help restlessness and agitation.
- To reduce risk of cognitive impairment and other anticholinergic effects, consider prescribing an antidepressant with low / no anticholinergic burden.

Anxiety:

- Should respond to an antidepressant longer-term.
- Use short-term benzodiazepines or antipsychotics only as a last resort in response to acute, severe agitation, but keep under close review.

Poor sleep:

- Improve sleep hygiene.
- If needed try short-term use of zolpidem or zopiclone

Appendix 5

Prescribers Record of Antipsychotic Initiation for Patients with Dementia

(To be uploaded as a '**Medication**' attachment on **Cito**)

Name of patient:	
NHS number:	
Drug prescribed, with dose and route:	
Is dose within BNF limits:	Choose an item.
Date initiated:	Click here to enter a date.
Diagnosis & ICD10 code:	
Q1 Non-pharmacological intervention used?	Choose an item.
Q2 Licensed	Choose an item.
Q2a. If **No** to Licensed, give reason for 'off-label' prescribing	
Q2b. If **No** to Licensed, service user and/or carer informed of 'off-label' prescribing	Choose an item. **If no/NA, give reasons**:
Q3. Clinical indication for antipsychotic / target symptoms:	Psychotic symptoms (delusions, hallucinations, paranoia) ☐ Depression ☐ Disturbed sleep ☐ Fear/anxiety ☐ Verbal aggression ☐ Physical aggression ☐ Disinhibited behaviour ☐ Wandering ☐ Agitation ☐ Distress ☐ Resistive with ADLs ☐

	Other:
Q4. Evidence of other causes of BPSD?	No evidence ☐ Depression ☐ Anxiety ☐ Pain ☐ Side effect of medication ☐ Physical illness ☐ Other:

Q5. Does patient have capacity to make decisions?	
YES	**NO**
Informed consent given by patient including discussion of risks (including vascular) and benefits of treatment Choose an item. If no, give reasons: Click here to enter a date.	If patient lacks capacity is treatment given in best interests under MCA (2005) Choose an item. If no, give reasons: Click here to enter a date.
Q6. Discussion with relatives including discussion of risks (including vascular, cognitive, falls, anticholinergic burden) and benefits of treatment	Choose an item. Click here to enter a date. If no, give reasons:
Q7. Written information given?	Choose an item. Click here to enter a date.
Q8. Baseline monitoring completed	Click here to enter a date.
Q9. Is ECG clinically indicated? (Including if dose above BNF limits)	Choose an item. Date requested: Click here to enter a date.
Prescriber:	Name: Click here to enter a date.
Form completed by (if not prescriber):	