

Leeds Integrated Dementia Board  
Leeds Area Prescribing Committee

NHS Leeds North Clinical CCG  
NHS Leeds South and East CCG  
NHS Leeds West CCG  
Working together

# Managing Behavioural and Psychological Disturbance in Dementia

A Guidance and  
Resource Pack for Leeds



# Acknowledgments

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'Dementia Guideline' in the subject line. Do not include patient-identifiable information.

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# Introduction

A person with dementia will sometimes behave in a way that others find difficult to manage. This can cause distress to the person and their carers who will often need help and support to relieve distress and improve quality of life. Assistance can come from a variety of sources, and behaviour that is really difficult to manage may need input from specialist services.

Behaviour changes can be a result of natural progression of dementia or may be a response to emotional stress such as moving home or death of a friend or relative, or because of a physical illness such as pain or a chest infection or changes to medication.

## Who is this pack for?

This pack is a resource for anyone involved in the care of a person with dementia, this includes relatives, carers, care staff in care homes, social care staff, healthcare staff including nurses, GPs, community pharmacists, acute general and mental health workers including occupational therapists, psychologists, pharmacists, doctors and nurses working in community teams, memory clinics and hospitals.

## Who has written it?

It is written by representatives from all of the above groups including people with dementia and their carers, charitable organisations working with dementia, those involved in dementia care in health and social care organisations.

## Why is it needed?

The behavioural and psychological symptoms of dementia can be distressing for people and their carers and they can be difficult to understand and treat. Finding the underlying cause is sometimes simple but it can be complicated and need expert assessment.

## This pack:

- describes the Behavioural and Psychological Symptoms of Dementia (BPSD)
- explains what can lead to changes in behaviour in a person with dementia
- gives examples of ways problematic behaviour can change in response to person centred care without medication
- includes pathways for managing very difficult behaviour and when medication is needed
- includes specific guidance on the prescribing and review of antipsychotics in dementia
- explains safeguards and considerations needed for decision making and capacity.

The Behavioural and Psychological Symptoms of Dementia include agitation, aggression, hallucinations, anxiety, apathy, depression, delusions, wandering, problems sleeping, repeating of words or sounds and shouting as well as many other behaviours.

## How to deal with difficult behaviour

It is increasingly recognised that knowing the personality and history of the person with dementia can help us understand their behaviour and that changing our approach or their circumstances may help to reduce, stop or manage a behaviour (refer to the examples of behavioural approaches on [page 4](#)).

Relatives and carers are central to understanding the behaviour and managing change and can obtain advice and support from a variety of sources (see [page 12](#)). In the most difficult cases of BPSD, medication may be needed and a GP referral to a specialist team from mental health services can be made. See [chart B on page 7](#) for detailed pathway.

Where the change in behaviour is because of a physical illness, treating this will often resolve the situation.



Conservatory DeCaf - Leeds Jewish Welfare Board

*The behavioural and psychological symptoms of dementia can be distressing for people and their carers and they can be difficult to understand and treat.*

*This pack is a resource for anyone involved in the care of a person with dementia.*

### **When medication is needed**

Medication including antidepressants, sedatives and antipsychotics can be used to good effect in the right circumstances. It is important only to use them when really needed because they can all reduce cognition and can cause sedation and falls. The effectiveness of medication in treating a behavioural disturbance must be reviewed regularly and the dose adjusted accordingly. The good documentation of their effect on the symptom and any effect of increasing or decreasing the dose is important and can help inform treatment decisions in the future.

### **Antipsychotic medication**

It is thought the antipsychotic drugs in particular have been relied on too much in the recent past to treat behaviour change or when other approaches have not been tried effectively. It is advisable that these drugs are reserved for behaviour that poses a risk to the person or others or is very distressing and is thought to be caused by psychosis.

The antipsychotics have been shown to cause an increased incidence of severe side effects in people with dementia.<sup>7-9</sup>

This risk needs to be balanced against the potential benefit of relieving distress, quality of life and peace of mind. It should be discussed with the person and their carers.

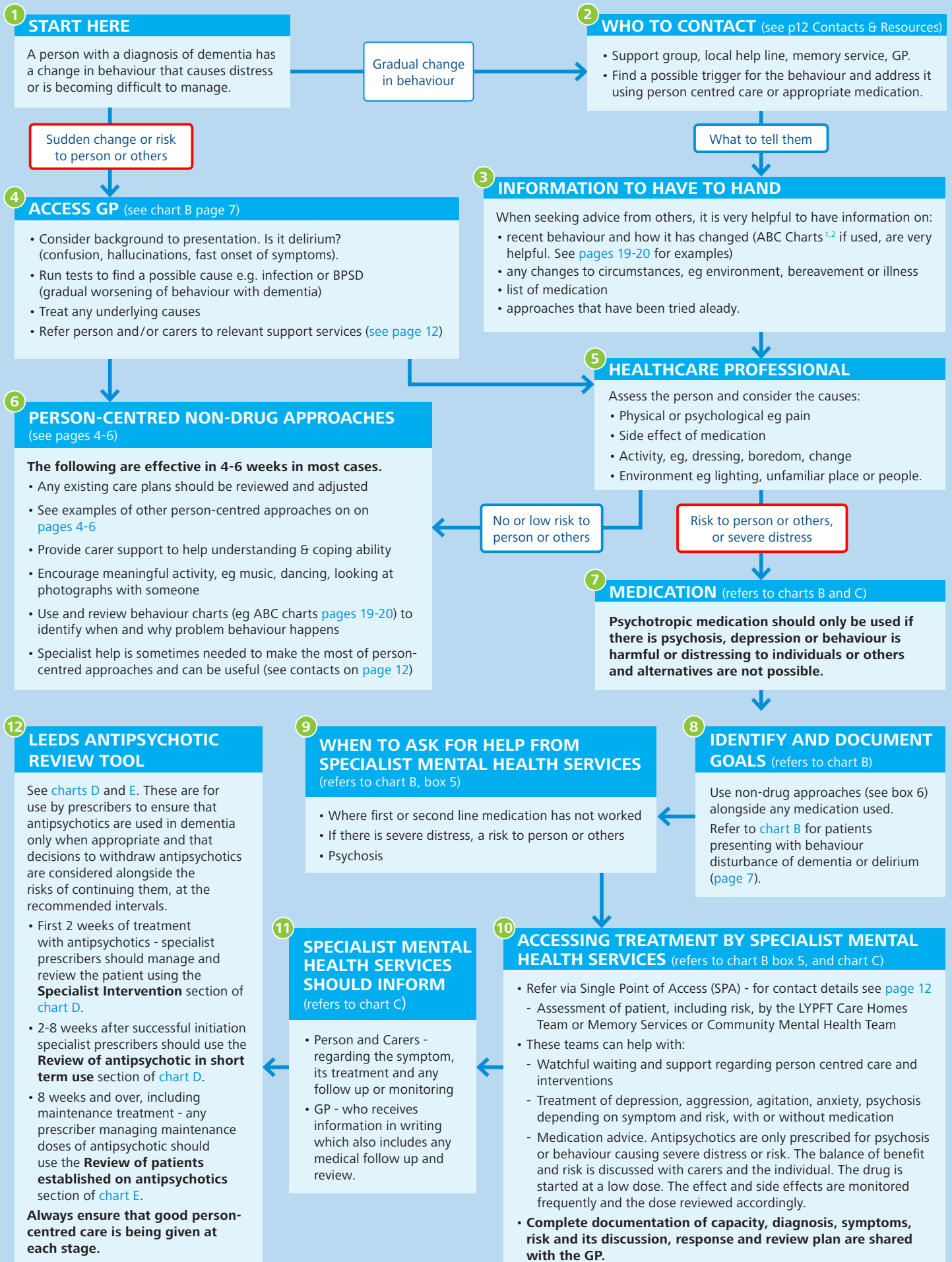
### **Safeguards**

Any treatment decisions must be taken within the framework of the Mental Capacity Act (MCA), and where applicable the Mental Health Act (MHA) and Deprivation of Liberty standards (DoLs), and other legal and professional guidance that applies. If a person lacks capacity to make decisions about their treatment a decision must be taken in their best interests. See the glossary on [page 16](#).

# A

## Summary of Leeds recommendations for managing people with behavioural disturbance in dementia

This pathway is not suitable if the patient does not have a recorded diagnosis of dementia. If dementia is not yet confirmed, confirmation of diagnosis must be sought by the GP, and referral made to Specialist mental health services for assessment where appropriate.



# Examples of practical ways to manage difficult behaviour in dementia (person-centred care)

You will find the more you can tailor the intervention to the person, the more effective it will be. Talk to as many people who know the person as possible to find out more about their personality, personal history (life story), likes and dislikes.

## Leave and return

**Jim** was aggressive and lashed out when care staff woke him each morning to help him get washed and dressed. Staff spoke to a family member who said he used to love listening to Radio 3 in the morning before rising. So the care staff started to go to Jim early, put the radio on, wake him and explain they would be back in half an hour to get him up. Jim became happy to comply with personal care.

## Noise

**Annie** cried out at mealtimes and refused to eat. Someone realised that this always happened when the food blender was turned on, and wondered if it was the loud noise that was upsetting Annie. So they made sure the blender wasn't used when Annie was in the dining room, she became calmer at mealtimes and she ate more.

## Distraction

**Fred** kept calling out for his wife, who had died five years previously. The calling was upsetting other residents. So a carer used to go and chat to Fred when the calling was bad, and talk to him about his past hobbies and holidays. This gave him something else to think about and he stopped calling out as much. A cup of tea quietened him down too.

## Person-centred care

**Bill** used to bang on the door and shout whenever a particular doctor came to visit on his motorbike. Everyone thought that Bill didn't like this doctor and staff kept them apart during visits.

A relative explained that Bill had kept motorbikes when he was younger and thought he missed being able to ride and look after one.

So whenever the doctor visited, someone took Bill out to look at the bike and talked to him about it and what he used to ride. The shouting stopped and Bill enjoyed reminiscing about a happy time in his life.

**Florence** became weepy and scared whenever her care staff came to wash and dress her, and refused to allow them to bathe her. It transpired that Florence had always been a very private person and had never even got undressed in front of her husband.

So the care staff asked Florence if she would like to wash herself. She couldn't get the hang of a soap dispenser but she could recognise a bar of soap and would wash herself with a little bit of prompting, taken at her own pace.

## Routine and orientation

**Doris** always slept badly and found it difficult to go back to sleep after the night care staff had done their routine continence pad check.

She would come out of her room to shout at the care staff and wander the corridor calling for her breakfast. So the care staff decided to change their routine and check on Doris only if she was already awake. They documented this in her care plan and monitored for leakage and sores.

The care staff also started a quiet routine at night, and kept the corridor lights down very low as well as wearing pyjamas and dressing gowns on their night shifts. Doris woke less during the night and when she did wander out, it was much easier to encourage her back to her room as she could see it was nighttime from the lighting levels and people's clothing.

## One to one care

**Surinder** didn't like eating at mealtimes, but could feed herself. Family were concerned about weight and appetite loss. It transpired that Surinder would finish her meal if someone sat with her and chatted about her food and reminded her to keep eating.

## Physical Activity

**Irene** used to walk everywhere as a younger woman and had always kept fit. Now she was in a home she was always being told to go back to her room, which made her angry.

A new exercise policy was brought in at the home and residents were allowed to walk if they were safe, and had someone walk with them if not. Care staff had conversations with residents when they had a wander in their direction instead of telling them to go away, and Irene was allowed to walk in the garden.

There were also three-times weekly gentle exercise-to-music classes run at the home and this seemed to settle some of the other residents too as exercise is known to improve sleep, mood and general well-being.

## Meaningful activity

**John** liked to keep busy round the house when he lived at home. He got disruptive around his new care home where he sat all day. The staff decided to let him help them by answering the door to visitors and laying the tables, which gave him a sense of purpose. John was much calmer once he was allowed to feel useful.

## Reminiscing

**Albert** was very disruptive and was upsetting his daughters who lived with and cared for him.

The local Alzheimer's Society branch suggested they start a memory book to look through with their dad, including old news clippings, family photos, holiday memories, and stories of his interests and happy times when he was younger.

He had taken great pride in his job in the shipyard and so the family decided to include some memories of working there and some pictures of different ships so Albert could tell them all about them too. Albert enjoyed helping his daughters with ideas for the book and loved talking about his youth with them.

This also gave his daughters ideas for topics of conversation with him when they needed to distract him. They enjoyed getting to know their dad in a new light which made the relationship easier all round.

## Aromatherapy

**Mavis** found it difficult to get to sleep but her husband started using a lavender aromatherapy oil diffuser in the bedroom half an hour before bedtime and this helped Mavis sleep better.

## Music and/or dancing

**Bessie** was withdrawn and seemed depressed. She loved music when she was younger and used to sing in a swing band. Her friend looked through some second hand record fairs and found lots of recordings of the type of music she used to love. They listened to them together and Bessie's mood brightened. When her day centre heard about her improvement, they decided to hold a tea dance once a month, which all the other service users looked forward to as well.

## Environment

**Winston** could no longer recognise family members and often forgot who he was.

He used to be aggressive, and shouted that there were strangers in his house whenever he walked along his hallway.

His wife realised that there was a big mirror in the hallway in which she checked her outfit before she went out. She wondered if it was simply a case that Winston didn't recognise his reflection, and genuinely thought that someone else was in the house. So she covered the mirror up with a sheet, and the problem with Winston shouting at strangers stopped.

**Irene**, who benefitted from the care home's exercise policy above, was now becoming teary when walking along the corridor in the care home, and would stand frozen outside doorways very upset, until someone came to ask her what was wrong. She was not able to always say what she wanted but the most frequent thing the care staff noticed was that she didn't know how to get where she was going, and that she was frightened of them when they came to help. So the home put up large-print signposts on the corridor walls and the doors of the home, and they noticed Irene lost her way much less frequently. The staff also started wearing large print name badges, so that when Irene did become upset, it helped her remember that she knew the care staff and they were there to help.

**Irene's** care home manager decided to read up on other things they could do around the home to help Irene. She read that dim or yellow-toned lighting can make it hard for older people's eyes to see where they are going, and to read, so she made sure that all the lighting in the home was changed to make it as bright as possible, with minimum shadows and a white or fluorescent toned light.

The manager also noticed that another resident, **Elsie**, started to enjoy reading her favourite large-print books for longer periods of time and needed less attention.

### Specialist multi-disciplinary Mental Health Team Stories

**John** lived in a care home with a large living room. He joined in activities and liked talking to people. The staff and other residents got upset when during visiting times he shouted out comments to visitors and said sexual things to staff when they were helping him with washing and dressing. Staff had told him many times not to say these things but he could become agitated and aggressive.

The GP asked for specialist help from the mental health specialist services. The care homes team went to visit and spoke to John and the staff and looked at his medical and social history. John had a dementia affecting the frontal lobes of his brain. This meant that he couldn't stop saying things that came into his head in the way that most people could.

He had worked on a building site when he was younger and was used to calling out to people. His type of dementia meant that he couldn't remember having been told not to say sexual things to people and that he couldn't stop himself anyway. After some training by the mental health team, the staff understood why he had this behaviour and they were less cross with John and could deal with situations in a calmer manner.

Staff still asked John not to say inappropriate things but didn't expect him to remember. They tried involving him in activities at visiting times to distract him from the visitors. The number of incidents reduced and staff were more able to cope when they happened.

**Geraldine** lived at home with her husband Edward. She had had Alzheimer's disease for five years and was not on any medication for it. Early on she had not responded well to the memory drug donepezil and had not wanted to try another one.

Recently she had become very agitated and whenever her husband tried to wash or feed her she shouted and pushed him away. Edward had tried different approaches to meal times and leaving Geraldine to it and trying only to help a little with Geraldine's washing routine and offering her a shower instead. A neighbour had tried to help at meal times too. Nothing had been successful.

The memory service doctor assessed Geraldine. She thought that that Geraldine may have stopped recognising Edward as her husband and was frightened. The doctor suggested a trial of memantine to improve Geraldine's understanding and reduce her fear. It took a few weeks but Geraldine settled as the memantine dose was increased and the memory clinic continued to monitor Geraldine's response to the medication and support Edward to care for her.

**Elizabeth** was a mother of three and had been a teacher in a junior school. She had a mixed type of dementia. From very early in her dementia she had had hallucinations and saw children outside the window.

At first the things she saw did not upset her. Her family were used to her talking to people they couldn't see outside the window.

Then some of the things began to upset her. She thought she was with a baby and that she couldn't stop it crying.

Sometimes Elizabeth was upset but she also could get very cross and had hit her sister who was trying to stop her running out into the street. The psychiatric nurse assessed and confirmed the presence of hallucinations and suggested the family give their mother a baby-like doll to care for.

Although Elizabeth talked to the doll and comforted it she still thought there was a crying child who she also had to deal with and she was very distressed.

The MDT discussed the case and decided to try a small dose of antipsychotic, risperidone 250 micrograms twice a day to see if it helped. They spoke to the family who agreed to only a short trial because of the risk of stroke. The family were asked to look for signs of sleepiness and asked to ensure that Elizabeth drank enough fluids because of the risk of falls and drowsiness.

The risperidone soon seemed to make Elizabeth calmer. After a week she didn't mention the baby crying any more but still cared for the doll. No side effects were seen. After six weeks it was agreed to withdraw the risperidone.

After a week Elizabeth started to become distressed by the hallucinations again. Her family decided that they would accept the risks because of their mother's distress. The antipsychotic was restarted and was to be reviewed after 12 weeks.

# B Suspected behavioural disturbance of dementia: Information for GPs, hospitals or other healthcare services

## 1 START HERE

Mental Health specialist or GP to confirm diagnosis of dementia and record if not already done so. This pathway is not suitable if the patient does not have a recorded diagnosis of dementia.

**Patients may present with acute delirium; acute delirium on top of existing BPSD; or worsening BPSD.**

It is important to distinguish which.

**Behavioural disturbance of dementia (BPSD):** behaviour change with steady decline in cognition over six months.

**Behavioural disturbance of delirium:** sudden onset (less than 1 week) of confusion, hallucinations with fluctuating cognition +/- behaviour change.

## 2 REVIEW POSSIBLE CAUSES AND ADDRESS APPROPRIATELY

Document findings in care plan/notes.

The PAIN mnemonic is a useful tool:

**P = Physical and Psychological Pain** (try regular empirical analgesia) - infection, depression, acute change in a chronic condition, pain constipation, dehydration, communication or sleep difficulties. Screen for signs of these - check: U&E/FBC/TFT/LFT/CRP/haematinics/glucose/ Calcium/urinalysis. Chest Xray and ECG if available.

**A = Activity** - dressing, washing, boredom, physical restrictions, change to routine

**I = Iatrogenic** - drug side effects, including anticholinergics; opiates; alcohol or benzodiazepine withdrawal

**N = Noise and environmental factors** - lighting, hunger, temperature, unfamiliar setting or people, bereavement

If it is a delirium follow the NICE CG103 for management of delirium<sup>3</sup>.

Clearly plan to stop any medication used for acute delirium after a few days.

## 3 NON-PHARMACOLOGICAL APPROACHES

Ensure non-pharmacological approaches to care are applied effectively and consistently.

- Refer care-givers to the examples on [page 4](#).
- Document the approaches used and those which are successful /unsuccessful.

Behavioural approaches include:

- Distraction; leave & return; meaningful activity; one to one care; music; aromatherapy; physical activity. Case study examples of how these can be applied are shown on [page 4](#).
- Carer support may improve a carer's ability to understand, manage and cope with problem behaviour. Obtain specialist behavioural management advice if required from mental health specialists or carers organisations ([page 12](#))
- Use and review 'ABC' behaviour charts ([pages 19-20](#)), to identify and address patterns or triggers.<sup>2</sup>

Non-pharmacological approaches should be used and response monitored using ABC charts, for up to 2 weeks ([watchful waiting](#)) before considering psychotropic medication, unless the behavioural disturbance constitutes a risk to the patient or others, or is causing severe distress.

If behavioural problems unresolved

Continuing behaviour constituting a risk to the person or others, or causing severe distress

## 4 TREAT SPECIFIC SYMPTOMS

Identify and document the symptoms you plan to treat pharmacologically, along with intended treatment goals.

In all cases, ensure that behavioural techniques are optimised (see box 3 above and examples of behavioural approaches on [page 4](#))

- **Aggression:** if severe refer to Mental Health Specialist (see box 5 opposite). If severe and specialist review not available the same day, consider 0.5mg lorazepam max bd for max 3 days until reviewed by specialist. Request urgent if risk to patient or others (for [rapid access contacts](#) see [page 12](#))
- **Depression or Apathy:** Usual pharmacological management eg SSRI (as per NICE CG90)<sup>4</sup>. Consider talking therapies via Primary Care Mental Health where patient is able to participate (see [page 12](#) for contact info).
- **Sleep disturbance:** 1st line zopiclone/promethazine. Trazodone/mirtazapine may be appropriate if concomitant mood disturbance. NB risk of falls with all sedatives including the sedating antidepressants.
- **Agitation / Anxiety:** 1st line SSRI; 2nd line trazodone/mirtazapine. If severe consider referral to Mental Health specialist. If not already on an acetylcholinesterase inhibitor, refer to memory services for consideration of initiation.
- **Psychosis:** Refer to Mental Health Specialist (see box 5 opposite)
- **Other Symptoms:** (vocalisation, sexual disinhibition etc): Refer to Mental Health Specialist (see box 5 opposite)
- Where any of the above occur in a person with Parkinson's disease already known to neurology, seek neurology opinion via LTH switchboard. If urgent advice required but neurology unavailable, seek Mental Health Specialist advice (see box 5 opposite).

Mental Health Specialist Advice required (if criteria above met or if first or second line treatment ineffective)

## 5 REFERRAL SHOULD INCLUDE:

- The symptom or behaviour that you are referring for treatment
- A summary of the outcomes from the treatment previously tried for this presentation, including:
  - biochemistry results (see box 2 above)
  - behaviour charts and person centred care approaches tried (see [page 4](#))
  - treatments already tried and outcomes (see box 4 opposite)
- List of current medication including dosages
- Summary of medical history including mental health details

Contact LYPFT SPA Tel 0300 300 1455 (24h every day), fax 0113 305 6856, or equivalent in boundary areas (see [page 12](#)) with the above information, which will direct the referral to Care Homes Team/CMHT/memory services/psychiatrist as appropriate.

# C

## Behavioural disturbance of dementia: Information for Specialist Mental Health Practitioners

### 1 START HERE

Received referrals should contain information as detailed in [chart B box 5](#). SPA (or equivalent in boundary areas see [page 12](#)) to assess referral and allocate to Care Homes Team / CMHT / Memory Services / psychiatrist as appropriate.

Mental Health Practitioner reviews referral

### 2 ASSESSMENT OF REFERRAL

Ensure all factors in [Chart B \(page 7\)](#) are addressed appropriately before continuing. Assess for symptoms of psychosis, depression or other psychiatric illness. Assess the behavioural approaches and person centred care that are already in place. Conduct risk assessment.

### 4 PSYCHIATRIST REVIEW

#### Consider the Type of Dementia and Symptom

Only use pharmacological intervention if there is risk to patient or other, or severe distress. Base all treatment decisions on detailed person-specific information gathered, individual clinical considerations and ensure review.

**Depression:** Follow NICE CG90/Maudsley guidance<sup>4,5</sup>

**Aggression:** consider AChEI if not already prescribed; antipsychotic or memantine (see relative indications listed under psychosis)

**Agitation/anxiety:** SSRI, trazodone, If severe, antipsychotic or memantine. All options are +/- short term benzodiazepine

**Psychosis:** Follow NICE / Maudsley guidance & see Alzheimer's Society Guide to BPSD<sup>5,6</sup>

- *Alzheimer's disease:* Consider prescribing an antipsychotic, see box 6a, below. Consider memantine if an antipsychotic is not appropriate.
- *Parkinson's dementia:* Review levodopa / dopamine agonist dose & consider reduction. Rivastigmine is licenced for this indication. Consider an antipsychotic (see box 6a, below)
- *Lewy body dementia:* AChEI or memantine. If antipsychotic is considered use very low dose and monitor closely for side effects.
- *Vascular dementia:* Many clinicians avoid risperidone and olanzapine due to stroke risk, although it is thought other antipsychotics also carry this risk in a class effect.

If: behaviour poses a risk to the person or others, or causing severe distress; or symptoms of psychosis or depression - refer to psychiatrist.

If risk manageable

### 3 WATCHFUL WAITING

Watchful waiting should include some or all of the following:

- Detailed information gathering and review by MDT
- Medication review
- Appropriate highly person-specific intervention care plan
- Further support and/or training for care-givers

Refer to case studies of behavioural approaches to the management of difficult behaviour in dementia - [page 4](#)

### 5 REFERRING BACK TO GP

Include medication and strategies employed so far in the discharge letter or correspondence to GP. (include all additional information highlighted in box 6a below if an antipsychotic is used) Refer GP to Leeds antipsychotics in dementia review tools (see [charts D and E](#)) to confirm the actions and monitoring needed.

If an antipsychotic is prescribed

### 6 WHAT TO DO IF STARTING AN ANTIPSYCHOTIC

- Consider capacity and if a best interest decision is needed
  - Document risk discussion with patient and carers/advocate
  - Document the target symptom and response to antipsychotic so far
  - Document the review criteria including timescale and which professional is responsible for the review (Leeds antipsychotics in dementia review tool also available as part of amber guidance, see [charts D and E, pages 10 and 11](#))
  - Start at the lowest dose and review according to the tool in [charts D and E](#). Titrate up if necessary to minimum effective dose - see box 6a below.
- A TAN should also be faxed on the same day of prescribing by CMHT community clinics

Patient doesn't settle on treatment

Patient settles on treatment

6a	INDICATIONS *see Summary of Product Characteristics for full licencing indications of all drugs	CAUTIONS AND NOTES	STARTING DOSE
<b>Risperidone</b>	*Licensed for 6 weeks' use for persistent aggression in Alzheimer's Dementia. Included in NICE guidance. Has the most evidence compared with other antipsychotics	EPSE more common	250 micrograms twice daily
<b>Clozapine</b>	*Licensed for psychosis in Parkinson's disease. RCT evidence	Low doses effective but consider the practical issues of required frequent blood testing. NB Red drug for hospital use only.	Titration and blood monitoring
<b>Olanzapine</b>	Unlicensed. Some evidence of efficacy in behaviour in dementia	Increased appetite	2.5mg daily
<b>Aripiprazole</b>	Unlicensed. Some evidence of efficacy in behaviour in dementia	Non-sedating. Akathisia <sup>7,8</sup>	2.5mg daily
<b>Amisulpride</b>	Unlicensed. No evidence. No trials available in dementia	May raise prolactin even at low dose. Avoid in reduced renal function	25mg daily
<b>Quetiapine</b>	Unlicensed. Evidence of no efficacy	Fewer EPSE. Preferred in Lewy body. Often used in Parkinson's but trials show no evidence for efficacy <sup>7,8</sup>	25mg daily
<b>Haloperidol</b>	Licensed, some evidence of efficacy. Included in NICE guidance, but see cautions column (right).	Avoid if possible, high incidence EPSE and higher risk mortality <sup>9</sup>	0.5mg once or twice daily

# Leeds antipsychotics in dementia review tool for use by prescribers

Antipsychotics are **amber drugs** in Leeds and should only be started by relevant specialists.

■ **Chart D, column 1** is for use by specialists in the **first 2 weeks** of treatment.

■ **Chart D, column 2** is for use by specialists in **weeks 2 - 8** of treatment.

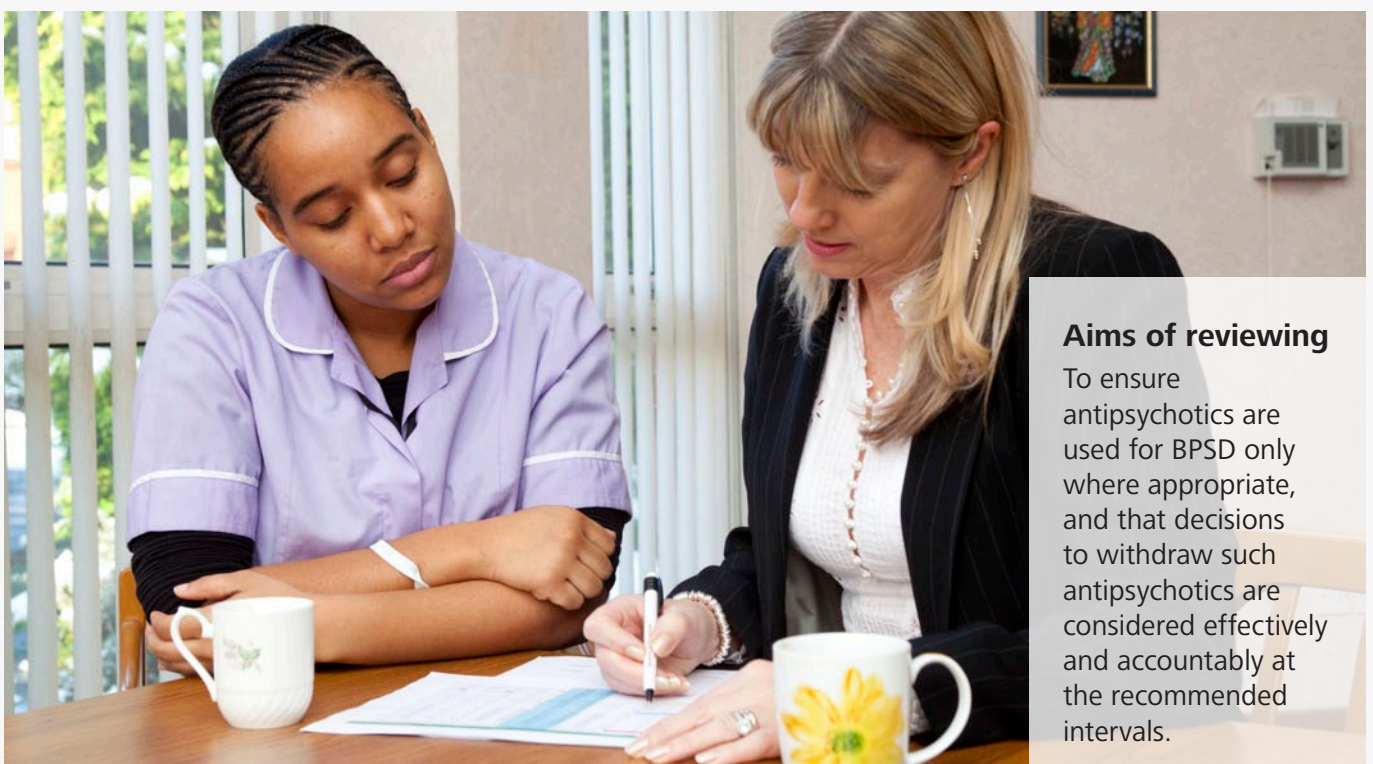
■ **Chart E** is for use by all prescribers **beyond 8 weeks** of treatment, including maintenance.

- Confirm indication for the antipsychotic.
  - What is the target symptom?
  - If the patient has a pre-existing indication for their anti-psychotic such as schizophrenia or bi-polar then follow the guidelines for the relevant condition, bearing in mind the increased risks in the population. Use the minimum effective dose and consider dose reductions if appropriate for the patient.

## Things to assess before each review

- Establish current behaviour patterns and what non-pharmacological treatments are in place.
- Compare with previous reports and levels of non-pharmacological treatments.
- Encourage family/carers to complete ABC behaviour charts<sup>2</sup> to facilitate this.
- If appropriate non-pharmacological measures are not being employed effectively, obtain or direct carers, to advice and/or support. See [page 12](#) for contact details.
- Confirm indication for pharmacological treatment, and intended treatment goals.
- Give extra consideration to the risks of stopping any medication in patients exhibiting delusions and/or hallucinations.

**Refer to the relevant column overleaf depending on duration of treatment so far.**



### Aims of reviewing

To ensure antipsychotics are used for BPSD only where appropriate, and that decisions to withdraw such antipsychotics are considered effectively and accountably at the recommended intervals.

# D

## Review of antipsychotics for use during initiation phase by specialist

### Review of specialist initiation of antipsychotics (2 weeks duration or less)

- At first review (within 2-4 days of initiation): Ensure treatment initiated appropriately. (If not, consider withdrawing)
- Review risks and benefits with carers/advocate in view of progress so far, and falls, worsening cognition, CVA x3, mortality x2.



- Review treatment as follows every 2-4 days for up to 2 weeks:



- Establish that the patient can tolerate the medication (watch for over-sedation, psychotic reactions, falls and EPSEs)



- If no improvement in behaviour, consider slow increase of medication up to minimum effective dose,

OR

- Stopping the antipsychotic and/or seeking specialist mental health advice via SPA.



- Continue review of behaviour every 2-4 days until successful dose established.



- Once successful treatment dose established, continue dose for 2-8 weeks then follow review guidance for short-term use (see section 2, right).

### Review of patients on short-term antipsychotics (2 - 8 weeks duration)

- Review for beneficial and adverse effects.
- Compare behaviour with reports from the previous week(s). Encourage persistence with non-pharmacological measures, and adapt as appropriate.
- If behaviour stable, or adverse effects identified, attempt treatment reduction by halving dose (or stopping completely if already on lowest dose).
- If behaviour still not managed, double check for alternative causes (PAIN mnemonic) (see [chart B, page 7](#)) ensure behavioural approaches are optimised, continue medication unless causing adverse effects, and seek specialist mental health advice via SPA.



- Continue reviewing behaviour as per the box above, and if BPSD does not worsen, continue to halve dose every 1-2 weeks, until antipsychotic withdrawn.



- Reinforce with carers about the continuing use of non-pharmacological techniques and recording changes in behaviour whether medication continuing or withdrawn



- If reduction of antipsychotic precipitates unmanageable increase in BPSD despite effective employment of non-pharmacological support, increase dose back to previous minimum effective dose and re-confirm consent to treatment given risks and benefits with the patient (if they have capacity), and/or the family & carers.



- If treatment continuing, perform initial drug monitoring as required in the [Amber guidance on Leeds Health Pathways](#) and discuss abnormal results with a specialist



- **Clearly set a reminder for review using the guidance for established use (see [chart E overleaf](#))**

## E

## Ongoing review of anti-psychotics in dementia for primary and secondary care prescribers

### Review of antipsychotics (established 8 weeks duration and beyond)

- Measure monitoring parameters for antipsychotics as required in the Amber guidance on Leeds Health Pathways. Set recalls at the required intervals and discuss any abnormal results with a specialist



Establish if anything has changed since the last review, eg:

- Improved non-pharmacological approaches
- Reduction of stressors for your patient (eg more settled in a new environment or after traumatic event; improved physical or mental health, etc)
- Increased frailty / complete lack of difficult behaviour
- Reduction of medication implicated in worsening BPSD, eg anticholinergics or opiates
- Addition of medication which may help BPSD, eg memantine, antidepressants
- Over sedation or other side effects of antipsychotics, including cardiovascular and worsening monitoring parameters
- Consent to treatment with antipsychotics withdrawn



- If factors above apply, consider a slow dose reduction of between a quarter and a half dose every 2 - 4 weeks.
- Decision to reduce can be postponed for not more than 12 weeks. Document discussion and decision in patient record.
- Set reminders for review date as applicable.



- If any of these factors have worsened since last review, address issues appropriately where possible.
- Postpone attempt to reduce antipsychotic until situation is stable - document discussion and decision in patient record
- Set reminder for next review date (not more than 12 weeks later, unless factors in the boxes below apply)



- If the patient has a history of hard-to-manage BPSD, weigh risks and benefits of continuing antipsychotics versus attempting reduction (with patient / family / carers).
- Document discussion and decision in patient record. Decisions to continue antipsychotic medication and reasons for this should be documented.



- **If the patient is remaining under your care, set a reminder for review no more than every 12 weeks. If you are discharging care to another provider ensure this recommendation for review date is clearly passed on. Review dates of longer intervals than 12 weeks should only be used where you or a colleague has documented justification for it for your particular patient.**

## Local contacts and resources

### Specialist Mental Health Services

Specialist Mental Health Services have clinical staff, including psychiatry, pharmacy, nursing, psychology and occupational therapy. They can offer advice and interventions to support the person living with dementia, their family/carers and paid staff.

A person living with dementia might already receive support from various teams including Memory Services, Community Mental Health Team, LYPFT Care Homes Liaison Team, or a psychiatrist. If this is the case then service users will normally have contact details for advice or support between appointments. If not, a GP can refer for specialist advice and support, including urgent referrals.

The main provider of specialist mental health services in Leeds is the Leeds and York Partnership Foundation Trust (LYPFT), who are contracted to provide services to patients of all Leeds GPs, across the area covered by Leeds City Council. In addition, there are arrangements with neighbouring providers which enable GPs near to the Leeds boundary to refer to other providers. In all cases, a written referral is preferred, but staff are available to give advice by telephone, especially for more urgent cases.

Specialist services are usually accessed via GP referral where the individuals are not already known to the service. Each GP will have details of the providers they normally refer to, but the following is a summary of contact details.

#### Leeds and York Partnership NHS Foundation Trust (LYPFT)

Contact the Single Point of Access (SPA) team:

Tel: 0300 300 1485 (**advice available 24/7**)

Fax: 0113 305 6856

e-mail: [referral.lypft@nhs.net](mailto:referral.lypft@nhs.net)

The SPA team will direct the referral to LYPFT Care Homes Team / CMHT / Memory Services / psychiatrist as appropriate.

#### **OUT OF HOURS EMERGENCY ADVICE FOR LYPFT PATIENTS - CONTACT SPA on 0300 300 1486 (24hrs)**

#### Tees, Esk and Wear Valleys NHS Trust (TEWV)

The Harrogate and Craven older people's community mental health team is based at Alexander House, Knaresborough.

Tel: 01423 558002

Fax: 01423 558003

#### Bradford District Care Trust (BDCT)

The Airewharfe older people's community mental health team is based at Meridian House, Keighley.

Tel: 01535 216020

### Talking therapies - helping you to feel better

Primary Care Mental Health Services provide psychological and talking therapies, which may be of help to either the person with dementia, or their family and/or carers. The services can help to find coping strategies and manage common psychological problems such as stress, anxiety, and depression, or symptoms such as poor motivation, panic, tearfulness or sleep problems.

It is important to consider this service for people who live with or care for a person with dementia, as well as the person with dementia themselves. Helping a carer to manage the emotional aspects of caring can be a big part of managing the behavioural impact of dementia itself.

Tel: 0113 843 4388 between 8.30am - 4pm,  
Monday to Friday.

There is no need to go through a GP or other healthcare professional first.

### Services and activities for people living with dementia

There are many community organisations offering activities and services which can help. These include 'dementia cafés', singing groups, and creative activities, which anyone can access. Not all of the services can support people who are very aggressive towards others, but they are usually suitable for people with mild to moderate dementia where agitation or aggression can be prevented by occupation and activity.

Each organisation is happy to discuss individual needs, and will always try to offer advice about alternatives if they can't offer the right help themselves. The following organisations offer further information about available services:

### **Leeds Alzheimer's Society**

Tel: 0113 231 1727

Email: [leeds@alzheimers.org.uk](mailto:leeds@alzheimers.org.uk)

### **Leeds Directory**

You can browse online to find activities and services at [www.leedsdirectory.org](http://www.leedsdirectory.org) or

Tel: 0113 391 8333

e-mail: [info@leedsdirectory.org](mailto:info@leedsdirectory.org)

Write to: Care & Repair Leeds,  
323 Roundhay Road, Leeds LS8 4HT

### **Leeds Peer Support Network**

Tel: 07891 271980 (Debbie Marshall) or

Tel: 07545 605413 (Debbie Catley)

e-mail: [deborah.marshall@leeds.gov.uk](mailto:deborah.marshall@leeds.gov.uk)  
or [deborah.catley@leeds.gov.uk](mailto:deborah.catley@leeds.gov.uk)

### **Neighbourhood Network Schemes**

These are local organisations that enable older people to live independently by providing services that reduce social isolation, and act as a gateway to advice, information and services to promote health and wellbeing.

There are around 35 local Neighbourhood Network Schemes in Leeds. To find your nearest one:

[www.tinyurl.com/leedsneighbours](http://www.tinyurl.com/leedsneighbours) or

Tel 0113 222 4401 and ask for your nearest Neighbourhood Network contact information.

### **Adult Social Care Contact Centre**

The Adult Social Care Contact Centre offers advice and signposting to a range of services. It also takes referrals for adult social care assessments, including carers' assessments. It can also help with referring to day centres, carer breaks and support at home. Some services require assessment and so there may be charges, though these are always based on ability to pay.

Tel: 0113 222 4401 for more information

### **Nutrition and diet**

It can be a major concern that a person with dementia is not getting enough to eat and drink, and it can cause conflict and distress when a care-giver is trying to prompt and 'push' a person to eat and drink more.

The Alzheimer's Society has published a factsheet 'Eating and Drinking'. You can download a copy from [www.alzheimers.org.uk](http://www.alzheimers.org.uk), or request a paper copy or further advice on: Tel: 0300 222 11 22.

If weight loss and diet are causing concern, contact the GP of the person with dementia. The GP will assess the situation and advise using one of the following:

- [Nutritional Management of Adults with Unintentional Weight Loss in the Community \(PL205\) \(or 'Food First'\) Guidance on Leeds Health Pathways](#)
- Food for Life scheme (if the person with dementia lives in a care home)
- A referral to the Leeds Eating & Drinking Team

Tel: 0113 295 2865

Fax: 0113 295 2854

Email: [leeds.ons@nhs.net](mailto:leeds.ons@nhs.net)

### **Factsheets, information and support**

The Alzheimer's Society has a helpline and publishes a range of factsheets and information which has been produced and checked by professionals, people living with dementia and carers.

Factsheets are available at: [www.alzheimers.org.uk](http://www.alzheimers.org.uk)

Tel: 0300 222 11 22 for advice or paper copies of factsheets, including:

- Dealing with aggressive behaviour
- Drugs used to treat Behavioural and Psychological Symptoms in Dementia
- Reducing the use of anti-psychotic drugs: a guide to the treatment and care of the behavioural and psychological symptoms of dementia.

'Talking Point' is an online support and discussion forum, for anyone affected by dementia:

<http://forum.alzheimers.org.uk/forum.php>

Admiral Nursing DIRECT is a national telephone helpline supported by the charity Dementia UK. It offers practical advice and emotional support to people affected by dementia.

Tel: 0845 257 9406

Email: [direct@dementiauk.org](mailto:direct@dementiauk.org)

## Carer Support and coping strategies for families and carers

Leeds Alzheimer's Society and Carers Leeds both offer one-to-one support and advice to carers and families of people with dementia.

They are not emergency response services, but can generally offer an appointment within 72 hours. They also run carer support groups, dementia cafes, and other services where people can support each other and speak to specialist dementia advisers.

Note that the Alzheimer's Society deals with all types of dementia, not just Alzheimer's, so anyone suffering from memory-related problems, and/or their families and carers can get in touch.

### Leeds Alzheimer's Society

Tel: 0113 231 1727

Email: [leeds@alzheimers.org.uk](mailto:leeds@alzheimers.org.uk)

web: [www.alzheimers.org.uk](http://www.alzheimers.org.uk)

### Carers Leeds

Tel: 0113 246 8338

Email: [info@carersleeds.org.uk](mailto:info@carersleeds.org.uk)

web: [www.carersleeds.org.uk](http://www.carersleeds.org.uk)

### Advocacy

Support from an advocate can often help a person living with dementia to participate in decisions about their treatment and medication.

In such cases, an advocate can represent the person's interests, particularly if there is no family member or friend available, or if there are conflicting opinions.

An advocate can also help with making a decision about the best interests of a person with dementia when they are unable to give their own opinion. In Leeds, Advocacy for Mental Health and Dementia can be contacted on

Tel: 0113 236 5900

Email: [www.a4mhd.org.uk/contact-us](http://www.a4mhd.org.uk/contact-us)

*All contact details and links checked December 2013*



# Glossary of terms

## ABC charts

These are a recognised way of recording what may have led to problem behaviour ('Antecedence'), what form the behaviour took ('Behaviour'), and how serious the consequences were ('Consequences'). Reviewing these charts for repeated incidents of problem behaviour in one person gives us an idea of whether the problem is getting better or worse, and whether the approaches we are trying are likely to be right. They are a really important tool in person-centred care, and help avoid bias and to identify exactly what is going on and why. Families may find ABC diaries useful. See [page 19](#) for examples.

## Aggression

Any behaviour that is hostile, destructive or violent. Aggressive behaviour can inflict injury or damage to the target person or object. Examples of aggressive behaviour include: physical assault, throwing objects, property destruction, self-harming behaviours and verbal threats.

## Agitation

Increased mental restlessness accompanied by increased tension and irritability.

## Alzheimer's Disease

The most common type of dementia. Alzheimer's disease is a progressive, degenerative disorder that affects the brain's nerve cells, resulting in loss of memory, thinking and language skills, and behavioural changes.

## Anxiety

A state of apprehension, often accompanied by nervous behaviour, unrealistic fear, worry, and uneasiness. It is often accompanied by restlessness, fatigue, problems in concentration, and muscular tension.

## Apathy

A state of indifference, or an absence of interest in or concern about emotional, social, spiritual, philosophical and/or physical life.

## Antipsychotic drugs

Medicines used to treat symptoms of psychosis or other behaviour causing severe risk or distress.

Risperidone is licensed for use up to six weeks in persistent aggression in moderate to severe Alzheimer's dementia unresponsive to non pharmacological interventions and where there is risk of harm to self or others. Other antipsychotic drugs are sometimes used 'off-licence' in dementia.

## Behavioural and Psychological Symptoms of Dementia (BPSD)

Also known as the Neuropsychiatric Symptoms of Dementia, these include agitation, aggression, hallucinations, anxiety, apathy, depression, delusions, wandering, problems sleeping, repeating of words or sounds, shouting, and many other behaviours.

## Best Interest Decision

Every person should be presumed to be able to make their own decisions. Someone can only take a decision on behalf of someone else without their consent if all practical steps to help them to make a decision have been taken without success. If it is then concluded that a decision should be made on their behalf, that decision must be made in that person's Best Interests. You must also consider whether there is another way of making the decision which might not affect the person's rights and freedom of action as much (known as the 'least restrictive alternative' principle). The Social Care Institute for Excellence provides further reading and examples on this issue.<sup>10</sup>

## Consent

The provision of approval or agreement, particularly and especially after thoughtful consideration, where the person has capacity to make such decisions. It is a voluntary act of agreement, and is given independently, without pressures such as fraud, duress or misinformation. Voluntary participation in an activity, for instance allowing a blood test to be taken, or accepting a prescription, is 'implied consent'.

## Delirium

A confusional state that starts over a few hours or days. It can include confused thinking and disorientation, anxiety, hallucinations and delusions. It can be caused by sudden or longstanding illness, medication, infection, surgery, change in environment or stress.

**Delusion**

An unshakable belief in something untrue. Delusions are often accompanied by feelings of paranoia, which act to strengthen confidence in the delusion. Delusions are distinct from culturally or religiously based beliefs that may be seen as untrue by outsiders.

**Dementia**

A loss of mental ability severe enough to interfere with normal activities of daily living, lasting more than six months, not present since birth, and not associated with a loss or alteration of consciousness. There are different types of dementia, the most common being Alzheimer's, Vascular, and dementia of Parkinson's Disease. There are rarer types, the most common of these being Lewy Body Dementia.

**Depression**

The signs and symptoms of depression include loss of interest or enjoyment in activities, loss of appetite or overeating, a persistently flat, sad, anxious, or empty mood; feelings of hopelessness, social withdrawal, low energy level, difficulty sleeping or early waking or oversleeping; trouble concentrating, remembering, or making decisions; unusual restlessness or irritability; persistent physical problems such as headaches, digestive disorders, or longstanding pain that do not respond to treatment, and thoughts of death or suicide, or suicide attempts.

**Deprivation of liberty**

If someone lacks the mental capacity to make decisions about their care and it is decided that it is in their Best Interests for them to be deprived of their liberty, the decision-maker must follow an authorisation process before the person can be lawfully deprived of their liberty. A deprivation of liberty that has not been authorised in this way will be unlawful. The authorisation process is governed by the Deprivation of Liberty Safeguards, which were introduced by the Mental Health Act 2007.

**Extrapyramidal Side Effects (EPSE)**

These are common side effects of antipsychotic medication and refer to a range of problems with movements of the body, from small, repetitive movements (tics) to the inability to move (slow movements or freezing up), or the inability to be still (shaking). Muscle spasms sometimes occur. Sometimes EPSEs will go away once the antipsychotic medication is stopped; sometimes further medication is needed to control the symptoms.

**Hallucinations**

False or distorted sensory experiences that appear to be real, ie hearing, seeing, feeling or tasting things that are not there. These sensory impressions are generated by the mind, and can often be distressing, although they do not bother some people.

**Mental Capacity**

Having sufficient understanding and memory to assess a situation and the nature, purpose, and consequence of any specific act, transaction or agreement into which someone may enter. For example, someone might have the capacity to walk into a shop and buy a CD but not to go into an estate agent and purchase a property.

**Mental Capacity Act (MCA)**

An act of Parliament of the United Kingdom.

The MCA provides a framework to empower and protect people who may lack capacity to make some types of decision for themselves.

The MCA makes clear who can make decisions in which situations, and how they should go about this. Anyone who works with or cares for an adult who lacks capacity must comply with the MCA when making decisions or acting for that person. This applies whether decisions are life changing events, or more everyday matters, and is relevant to adults of any age, regardless of when they lost capacity. The underlying philosophy of the MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken on their behalf is made in their best interests.

**Mental Health Act (MHA)**

The Mental Health Act 2007 is an Act of Parliament of the United Kingdom, and is the latest amendment to the Mental Health Act 1983, the Domestic Violence, Crime and Victims Act 2004 and the Mental Capacity Act 2005. It covers the care and treatment of mentally disordered persons, and in particular, it provides the legislation by which people diagnosed with a mental disorder can be detained and have their disorder assessed or treated against their wishes.

**Paranoia**

Typically includes persecutory beliefs, or beliefs of conspiracy concerning a perceived threat towards oneself. It is often influenced by anxiety or fear, and may be accompanied by false accusations and the general distrust of others.

## Psychosis

People suffering from psychosis are unable to distinguish personal subjective experience from the reality of the external world. They experience hallucinations and/or delusions that they believe are real, and may behave and communicate in an inappropriate or incoherent fashion. Psychosis can be extremely distressing. If you are worried, seek advice from your GP or specialist mental health service provider.

## Psychotropic medication

Any medication used to treat mental health problems.

## Vascular Dementia

A general term describing problems with reasoning, planning, judgement, memory and other thought processes. It is caused by reduced blood flow in the brain, by narrowing or blockage of the brain's small blood vessels. These blockages typically become worse over time, and function may decline gradually, or in a stepwise fashion.

Treatments for reducing the speed of this deterioration that are used in Alzheimer's type dementia do not work in vascular dementia, although some treatments for people with cardiovascular disease may be helpful.

## Watchful waiting

This does not mean doing nothing. It is a proactive process of ongoing assessment of contributing factors (pain, depression, BPSD symptoms, delirium, other health problems) and simple non-drug treatments (eg person-centred care plans, taking the person's preferences and opinions into account; social inclusion; and personal interactions) or specific interventions such as brief psychosocial therapies; exercises; person tailored activities, eg looking at photographs.

Refer to the examples in Behavioural approaches to the management of difficult behaviour in dementia (page 4). A high proportion of people who have BPSD experience an improvement over four weeks with no specific treatment. Watchful waiting is the safest effective therapeutic approach unless there is severe risk or extreme distress.

## References

- 1 Alzheimer's Society: Optimising treatment and care for people with behavioural and psychological symptoms of dementia. A best practice guide for health and social care professionals. [www.alzheimers.org.uk/bpsdguide](http://www.alzheimers.org.uk/bpsdguide)
- 2 Alzheimer's Society blank ABC chart: [www.alzheimers.org.uk/site/scripts/download\\_info.php?fileID=1186](http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1186)
- 3 NICE CG103 - Delirium: Diagnosis, prevention and management: <http://publications.nice.org.uk/delirium-cg103>
- 4 NICE CG90 - Treatment and Management of Depression in Adults: <http://publications.nice.org.uk/depression-in-adults-cg90>
- 5 NICE CG42: Supporting people with dementia and their carers in health and social care (including psychosis): <http://publications.nice.org.uk/dementia-cg42>
- 6 Maudsley Prescribing Guidelines 11th edition
- 7 Ballard C , Howard R: Neuroleptic drugs in dementia: benefits and harm. *Nat Rev Neurosci* 2006; 7:492 - 500
- 8 Schneider LS et al Efficacy and adverse effects of atypical antipsychotics for dementia: meta-analysis of randomized, placebo-controlled trials. *Am J Geriatr Psychiatry* 2006; 14:191 - 210
- 9 K F Huybrechts et al Differential risk of death in older residents in nursing homes prescribed specific antipsychotic drugs: population based cohort study. *BMJ* 2012;344:e977 doi: 10.1136/bmj.e977 (Published 23 February 2012)
- 10 Social Care Institute for Excellence: Making decisions: Making decisions in a person's best interests: [www.scie.org.uk/publications/dementia/living-with-dementia/decisions](http://www.scie.org.uk/publications/dementia/living-with-dementia/decisions)

### Further Background Reading:

- 1 Call to Action - The Right Prescription: [www.institute.nhs.uk/images/Call\\_to\\_Action/Call\\_to\\_action\\_v2\\_CHOSEN\\_v2.pdf](http://www.institute.nhs.uk/images/Call_to_Action/Call_to_action_v2_CHOSEN_v2.pdf)
- 2 The Banerjee Report <http://goo.gl/mWZs2e>
- 3 Royal College of Psychiatrists Key Facts about Dementia: [www.rcpsych.ac.uk/expertadvice/problemsdisorders/dementiainkeyfacts.aspx](http://www.rcpsych.ac.uk/expertadvice/problemsdisorders/dementiainkeyfacts.aspx)

# ABC charts

## ABC Charts

ABC stands for Antecedence, Behaviour and Consequence, and is an important way of reviewing how well a person with behavioural problems is responding to different situations. Completed ABC charts and/or diaries should be reviewed along with the person-centred care plan at regular intervals, including at medication review, to help decide what plan of actions to continue with.

Care homes and other institutions may have their own ABC chart templates which they should use for patients who have behavioural problems. If not, charts can be produced easily on a computer using the headings shown in the example below.

For people with dementia living in their own homes, family, friends, or visiting carers may find it more user-friendly to keep a notebook, and complete an ABC diary using the prompts below:

### Antecedence

Record the situation in which the problem behaviour occurred, for example

- time of day, activities that were happening or about to happen.

- Was anything different to usual?
- Any other clues to set the scene.

### Behaviour

Record the actual behaviour.

- What happened? How long did it last for? How severe was it?
- Did anyone present do anything to try and manage it? If so, what?

### Consequence

How did the behaviour settle?

How did the person respond to attempts to manage the behaviour?

- Important to include things that didn't work. What worked well?
- Were there any significant consequences, eg family member now refusing to visit, care staff injured, patient fell or hurt themselves?
- Did anything else happen after the episode of behaviour?

<b>Date and time</b>	<b>Antecedent</b> <i>(What triggered or came before the behaviour?)</i>	<b>Describe the behaviour</b> <i>(include location and other aspects of the environment (eg, lighting, noise)</i>	<b>Consequence</b> <i>What did you do, or what happened to the behaviour?</i> <i>How severe was it?</i>	<b>Final outcome</b> <i>What did the observed person do after the incident was over?</i>
<i>Monday July 31 8.30am</i>	<i>I was about to put dentures in Jim's mouth</i>	<i>He was sitting up in bed and punched me in the chest. It was sunny and bright in the bedroom.</i>	<i>I jumped back and cried out. I said "don't hit me" and left the room. It didn't really hurt too much but I was surprised and upset.</i>	<i>I returned about five minutes later to find him sleeping, so I left him alone.</i>

<b>Date and time</b>	<b>Antecedent</b> <i>(What triggered or came before the behaviour?)</i>	<b>Describe the behaviour</b> <i>(include location and other aspects of the environment (eg, lighting, noise))</i>	<b>Consequence</b> <i>What did you do, or what happened to the behaviour? How severe was it?</i>	<b>Final outcome</b> <i>What did the observed person do after the incident was over?</i>

**OUT OF HOURS EMERGENCY  
ADVICE FOR LYPFT PATIENTS**

CONTACT SPA on  
**0300 300 1486** (24hrs)



**NHS Leeds North Clinical CCG**  
**NHS Leeds South and East CCG**  
**NHS Leeds West CCG**  
Working together