Lancashire & South Cumbria NHS Foundation Trust

# Management of Behavioural and Psychological Symptoms of Dementia (BPSD)

# Summary document for Primary Care

Guidelines for the Management of Behavioural and Psychological Symptoms of Dementia (BPSD).
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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].

*This is a summary document intended for Primary Care, taken from a more comprehensive document 'Guidelines for the Management of Behavioural and Psychological Symptoms of Dementia (BPSD) in Primary and Secondary Care. This document should be accessed for additional resources such as the Leaflet for Care Home Staff, assessment forms and flow chart for responding to BPSD.*

**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.

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.
b. Complete an assessment form (Appendix 1) 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[3] 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[4]. If there is a positive response treatment with paracetamol should continue.

g) For pharmacological management of BPSD, refer to the flowchart in Appendix 4 of full document. 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 of full document 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 of full document 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[3]: 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[5]. 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[6]

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.

## References


1. Reducing Antipsychotic Prescribing in Dementia Toolkit (2014). PrescQIPP
2. (2024) QI programme: The use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services. Audit report 22a. rep. Prescribing Observatory for Mental Health.
3. King, R. and Rabino, S. (2023). ACB Calculator. [online] www.acbcalc.com. Available at: https://www.acbcalc.com/ [Accessed 2 Jul. 2024].
4. Husebo Bettina S, Ballard Clive, Sandvik Reidun, Nilsen Odd Bjarte, Aarsland Dag. Efficacy of treating pain to reduce behavioural disturbances in residents of nursing homes with dementia: cluster randomised clinical trial BMJ 2011; 343 :d406
5. Schneider, L. S., Dagerman, K., & Insel, P. S. (2006). Efficacy and adverse effects of atypical antipsychotics for dementia: meta-analysis of randomized, placebo-controlled trials. The American Journal of Geriatric Psychiatry, 14(3), 191-210. https://www.researchgate.net/profile/Philip_Insel/publication/7272800_Efficacy_and_Adverse_Effects_of_Atypical_Antipsychotics_for_Dementia_Meta-Analysis_of_Randomized_PlaceboControlled_Trials/links/0deec53974fa225204000000.pdf
6. National Institute for Health and Care Excellence (2018) Dementia: assessment, management and support for people living with dementia and their carers. NICE guideline 97

## Appendix 1

**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?** |
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| **How long has this been occurring?** |
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| **How frequent is this behaviour? (Circle as appropriate)**<br>(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)* |
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| |

**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…….)*