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

Summary document for Primary 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.

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' produced by the Alzheimer's Society (Appendix 1)
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)
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) A 4-6 week trial of an antidepressant such as an SSRI may help depression, restlessness and agitation.
h) GPs should ideally not initiate antipsychotic medication for BPSD. If an antipsychotic is commenced, consider referring to secondary care.
i) 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

References

1. Reducing Antipsychotic Prescribing in Dementia Toolkit (2014). PrescQIPP
2. Optimising treatment and care for people with behavioural and psychological symptoms of dementia. A best practice guide for health and social care professionals. Alzheimer's Society, 2011.
3. National Institute for Health and Care Excellence (2014) Psychosis and schizophrenia: prevention and management. NICE Clinical guideline 178
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 :d4065
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_Placebo-Controlled_Trials/links/0deec53974fa225204000000.pdf

6. National Institute for Health and Care Excellence (2015) Management of aggression, agitation and behavioural disturbances in dementia: valproate preparations. NICE Evidence summary ESUOM41

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?

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…….)*