Alberta Health Services

PRACTICE SUPPORT DOCUMENT
GUIDELINE

TITLE
APPROPRIATE USE OF ANTIPSYCHOTIC MEDICATION

SCOPE
Provincial: Long Term Care

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APPROVAL LEVEL
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Patient Safety

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None

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

If you have any questions or comments regarding the information in this guideline, please contact the Policy & Forms Department at policy@albertahealthservices.ca. The Policy & Forms website is the official source of current approved policies, procedures, directives, and practice support documents.

OBJECTIVES

- Guide the appropriate use of antipsychotic medications in the management of residents/**patients** with dementia within Long Term Care (LTC) settings.
- Provide **health care providers** with recommendations regarding the assessment and management of **responsive behaviours** associated with cognitive impairments (dementia and delirium) in older adults and the appropriate use of antipsychotic medications.
- Exercise clinical judgement when the patient's clinical presentation is deemed to be outside the parameters set out in this document. If for any reason this guideline is not deemed appropriate for the specific situation of the patient, documentation shall be included on the **health record** to identify the rationale.

APPLICABILITY

Compliance with this guideline is required by all Alberta Health Services employees, members of the medical and midwifery staff, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary) when working within LTC settings.

GUIDELINE ELEMENTS

1. Consent

1.1 The **most responsible health practitioner** will follow the consent process in accordance with the Alberta Health Services *Consent to Treatment/Procedure(s)* policy suite and document the consent process in the resident's/patient's health record.

1.2 The most responsible health practitioner discusses the treatment plan with the resident/patient, and/or **family** or **alternate decision maker,** where applicable. This discussion is ongoing and involves discussions at the onset of the development of responsive behaviours, during the assessment phases while seeking the underlying cause of the responsive behaviour and during the planning of the interventions to prevent or manage the responsive behaviours.

1.3 The most responsible health practitioner will follow the process in accordance with the Alberta Health Services *Consent to Treatment/Procedure(s)* when initiating treatment in emergency situations (such as where the person is at risk of harming themselves or others) and directs a member of the care team to seek out the family and/or alternate decision maker as soon as possible after the initiation of the treatment.

2. Responsive Behaviour

2.1 The **health care professional** identifies and describes the responsive behaviour that is concerning to the resident/patient involved, the other residents/patients, the staff and/or family.

2.2 Determine the responsive behaviour to focus the assessment and monitoring.

2.3 Refer to the *Appropriate Use of Antipsychotics (AUA) Toolkit* ("*AUA Toolkit*") for descriptions of common behaviours displayed by those with dementia and for recommended approaches in managing responsive behaviours.

2.4 Consider the impact of the behaviour on all involved. Not all responsive behaviours require a plan to intervene, while others may require urgent intervention.

2.5 Complete elimination of the responsive behaviour may not be possible as responsive behaviours may be a significant method of communication for the resident/patient with dementia.

2.6 Develop a care team plan and discuss the intended treatment goals with the resident/patient/family/alternate decision maker and the care team.

3. Initial Monitoring and Assessment of Responsive Behaviour

3.1 The health care professional should spend a period of two (2) weeks tracking the frequency and severity of the responsive behaviour to help the care team begin to determine if there are possible triggers to the responsive behaviour. Assessment tools are included in the *AUA Toolkit*.

3.2 The most responsible health practitioner assesses for underlying medical causes of responsive behaviours such as delirium or exacerbation of other medical conditions. This assessment includes a medication review of prescribed and non-prescribed (over the counter) medications.

3.3 See AUA Toolkit for resources regarding assessment.

4. Collaborative Care Planning

4.1 A person-centered approach to dementia care is used. This approach ensures that the interventions are tailored to meet the unique situation for each resident/patient, recognizing the impact of life-long experiences and preferences of the resident/patient. Refer to the *AUA Toolkit* for various care situations that are known to be a trigger to responsive behaviour in many residents/patients with dementia such as peri-care, bathing, un-dressing or dressing, eating, and sleeping.

4.2 The health care professional discusses possible care approaches with all involved in the resident's/patient's care including family members.

4.3 Engage family/alternate decision maker in conversation regarding responsive behaviour and to help problem-solve strategies to prevent or better manage the resident/patient when responsive behaviours occur. Resources which provide strategies for family to use with various responsive behaviours may be found in the *AUA Toolkit*.

4.4 Establish and implement a care approach to address any identified underlying causes of responsive behaviours.

4.5 Document care plan in the resident's/patient's health record.

5. Non-pharmacologic Approaches to Managing Responsive Behaviours

5.1 Non-pharmacologic approaches and interventions are utilized to manage and prevent responsive behaviours wherever possible. Refer to the *AUA Toolkit* for recommended approaches in managing responsive behaviors.

5.2 The health care professional monitors the effects of non-pharmacologic approaches and interventions on the responsive behaviour that is the focus of treatment. Continue with these interventions if any movement toward the desired outcome, as identified in the care plan, is observed.

5.3 Document non-pharmacologic approaches and interventions that achieve the desired outcome in the resident's/patient's health record.

6. Continued Monitoring of Responsive Behaviour

6.1 The health care professional monitors the resident/patient for frequency and severity of the responsive behaviour to determine the outcome of the various care approaches that are trialled.

6.2 Behaviour maps assist in ongoing monitoring (refer to *AUA Toolkit*).

6.3 If medications are prescribed, monitor the behaviour for a minimum of two (2) weeks following initiation and any dosage change.

6.4 Consider care team and family observations.

7. Clinical Indications for Prescribing Antipsychotic Medication

7.1 Clinical indications for the use of antipsychotic medication include:

a) confirmed mental health diagnosis (including major depression, schizophrenia, bipolar, delusional disorder, etc.);

b) psychosis (hallucinations or delusions) that are bothersome to the resident/patient as may be present in some presentations of delirium and in some stages of dementia; and

c) behaviour that acutely puts the resident/patient or others at risk of injury.

7.2 The following list provides examples of behaviours that antipsychotic medications are not indicated to manage:

a) wandering;

b) insomnia;

c) unsociability;

d) poor self care;

e) impaired memory;

f) fidgeting or nervousness;

g) inappropriate voiding;

h) hoarding;

i) repetitive vocalizations;

j) restlessness or pacing; or

k) indifference to surroundings.

Note: The *AUA Toolkit* provides suggested strategies to help manage these responsive behaviours with non-pharmacologic interventions.

7.3 The most responsible health practitioner initiates a discussion regarding the use of an antipsychotic medication between the resident/patient/family and care team in the facility, in accordance with the Alberta Health Services *Consent to Treatment/Procedure(s)* policy suite. This discussion includes the following elements:

a) care approaches that have been tried and the outcome of those interventions;

b) risks and benefits of the antipsychotic medication;

c) intended goal of the treatment; and

d) review period (e.g. within two (2) – four (4) weeks for regularly scheduled antipsychotic medication).

7.4 Upon agreement for a course of treatment by the care team, including the resident/patient/family, orders are obtained and implemented.

Note: The smallest dose is the recommended starting dose for any trial of an antipsychotic medication.

7.5 Increases are incremental and allow sufficient time (e.g. ideally two (2) week minimum) between increases to find the lowest dose that is effective. A table of common antipsychotic medications and recommended dosing guide is available in the *AUA Toolkit.*

7.6 Health care providers monitor for side effects of any medications and provide the observations to the most responsible health practitioner that may result in a reduced dosage or weaning of the medication.

8. Medication Review

8.1 The health care professional shall co-ordinate the care team and family in conducting a medication review to assess the need for continued antipsychotic medication use within two (2) weeks of the medication initiation, and/or change. Assess the following for a minimum of one (1) week prior to medication reviews:

a) efficacy;

b) significant side effects; and

c) change in behaviour.

8.2 The most responsible health practitioner may consider the following during a medication review:

a) If no change in responsive behaviours after two (2) weeks of use, consider need to increase dose (if not yet at top of dose range), use of a different medication, or continue to assess for another two (2) week period of time.

b) If significant side effects develop during initial trial, discontinue the antipsychotic medication (see *AUA Toolkit* for a description of side-effects to antipsychotic medications).

c) If responsive behaviour worsens, consider newly developed underlying medical concern (e.g. infection, worsening pain, etc.).

d) If the responsive behaviour improves, identify any factors that may have impacted the responsive behaviour beyond use of the antipsychotic medication (e.g. resolved delirium) and if appropriate, consider discontinuing the antipsychotic medication.

8.3 The health care professional ensures the care team reviews the continued need for antipsychotic medication on a monthly basis as per the *Alberta Continuing Care Health Service Standards*. Refer to *AUA Toolkit* for medication review resources.

a) Withdrawal is considered by the most responsible health practitioner at three (3) months. Taper or discontinue the antipsychotic medication as soon as possible once the responsive behaviour stabilizes. Refer to the *AUA Toolkit* for recommendations regarding weaning and tapering antipsychotic medication dose.

8.4 If a resident/patient is admitted to the facility on a previously prescribed antipsychotic, the health care professional collaborates with the care team to attempt to determine the reason why the antipsychotic medication was initiated and confirm diagnosis.

a) If the antipsychotic medication was started to manage a delirium, the most responsible health practitioner considers tapering/discontinuing the antipsychotic medication if the underlying cause of the delirium has been treated.

8.5 If an order for an antipsychotic medication is started by an **authorized prescriber** (through on-call or after hours) other than the attending physician, the health care professional reviews with the resident's/patient's attending physician the following:

a) the circumstances that necessitated the order;

b) drug and dose;

c) intended duration;

d) possible contributors to the responsive behaviour; and

e) need for discussion with family/alternate decision-maker.

8.6 The care team continues to monitor the responsive behaviour with each change to the dose and upon discontinuation for at least one (1) month. If there is no change in the responsive behaviour upon discontinuation of the antipsychotic medication, avoid re-starting the medication.

9. Referrals

9.1 Involve available resources if management of responsive behaviours continues to be a challenge. Another perspective can help the care team consider underlying causes or possible interventions that may have been overlooked.

DEFINITIONS

Alternate decision maker means a person who is authorized to make decisions with or on behalf of the patient. These may include, specific decision-maker, a minor's legal representative, a guardian, a 'nearest relative' in accordance with the *Mental Health Act* or an agent in accordance with a Personal Directive or a person designated in accordance with the *Human Tissue and Organ Donation Act*.

Authorized prescriber means a health care professional who is permitted to prescribe medications as defined by Federal and Provincial legislation, her/his regulatory College, Alberta Health Services, and practice setting (where applicable).

Continuing Care means an integrated range of services supporting the health and wellbeing of individuals living in their own home or in a supportive living or long-term care setting. Continuing care clients are not defined by age, diagnosis or the length of time they may require service but by their need for care.

Family means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

Health care providers means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Health care professional means an individual who is a member of a regulated health discipline, as defined by the *Health Disciplines Act* or the *Health Professions Act,* and who practises within scope or role.

Health record means the Alberta Health Services legal record of the patient's diagnostic, treatment and care information.

Most responsible health practitioner means the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by Alberta Health Services to perform the duties required to fulfill the delivery of such a treatment/procedure(s), within the scope of his/her practice.

Patient means an adult or child who receives or has requested health care or services from Alberta Health Services and its health care providers or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients and outpatients, and also means, where applicable:

a) a co-decision-maker with the person; or
b) an **alternate decision-maker** on behalf of the person.

Responsive behaviour means the behaviours often displayed by those with dementia as a means of communicating a need or in response to something in the person's internal environment (e.g. delirium or pain) or external environment (e.g. excessive stimulation). Responsive behaviours are a significant subset of behavioural and psychological symptoms of dementia (BPSD) which refers to the symptoms of disturbed perception, thought content, mood or behaviour that frequently occurs in patients with dementia.

REFERENCES

- Alberta Health Services *Consent to Treatment/Procedure(s)* Policy and Procedures
- *Restraint – Seniors/Continuing Care* Procedure (DRAFT)
- *Alberta Continuing Care Health Service Standards*
- *Appropriate Use of Antipsychotics (AUA) Toolkit* (Which may be found on the AHS external web page by searching "AUA Toolkit")
- BC Interior Health, BC Ministry, *Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care* (2012)

VERSION HISTORY

Date	Action Taken
April 7, 2016	Initial approval/effective
April 21, 2016	Non-substantive change
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