Appropriate use of antipsychotics in residents of residential and long-term care centres (CHSLDs) with behavioural and psychological symptoms of dementia (BPSD)

For further details, click on the underlined words.

This decision support tool is intended for physicians, pharmacists and nurses who practice in residential and long-term care centres. It is provided for information purposes only and should not replace clinical judgement. The recommendations were developed using a systematic approach and are supported by the scientific literature and the knowledge and experience of Québec clinicians and experts. For further details, go to inesss.qc.ca.

WHAT YOU NEED TO KNOW ABOUT ANTIPSYCHOTICS AND BPSD

THEY MAY BE APPROPRIATE

- For the **short-term** management of psychotic or aggressive symptoms[1] that:
  - → Pose a risk to the resident or to others;
  - → And have not responded to individualized nonpharmacological interventions.

THEY ARE INEFFECTIVE OR NOT INDICATED

- For managing BPSD such as shouting and repetitive movements, sleep problems, wandering, resistance to personal care, etc.

1. The effect of antipsychotics in treating these symptoms is modest and should be weighed against the sometimes serious adverse effects that can occur, especially in the elderly.

BEFORE INITIATING AN ANTIPSYCHOTIC

- Eliminate or correct the **possible reversible causes** of psychotic or aggressive symptoms:

Pharmacological	Environmental	Physiological	Approach-related	Psychological
Adjust medications that can cause/ exacerbate BPSD, etc.	Eliminate noise, adjust lighting, personalize the resident's room, etc.	Eliminate an acute illness (e.g., delirium), correct a hearing/ visual impairment, attempt to stabilize pain, anxiety disorders or depression, meet basic needs, etc.	Evaluate the staff's or family's approach and correct if necessary, etc.	Correct the lack of stimulation, the loneliness, the boredom, the lack of activity, etc.

- Apply the communication principles and the strategies in the basic approach and reframing, if necessary.
- If the psychotic or aggressive symptoms persist, use individualized nonpharmacological interventions targeting the possible causes determined during the evaluation.
- If failure, consider initiating an antipsychotic within the context of a shared decision based on:
  - → A risk-benefit assessment of the treatment for the resident;
  - → The resident's, family's and caregivers' values and preferences.

INITIATING AN ANTIPSYCHOTIC

- When an **oral** antipsychotic is indicated and the shared decision to initiate therapy has been made:
  - → Set clear therapeutic objectives with the resident, family members and caregivers;
  - → Give preference to atypical over typical antipsychotics[2]; and
  - → Use them in combination with individualized nonpharmacological interventions.

⚠ In residents with Lewy body neurocognitive disorders or neurocognitive disorders due to Parkinson's disease, the use of antipsychotics should be avoided because of the higher risk of serious adverse effects. If necessary, refer such residents to specialized services, such as psychiatry, geriatric psychiatry, or cognitive and behavioural neurology.

2. Risperidone is the only oral antipsychotic approved by Health Canada for "the short-term symptomatic management of aggression or psychotic symptoms in patients with severe dementia of the Alzheimer type".

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DETAILS FOR INITIATING AN ANTIPSYCHOTIC

- Do a trial with one antipsychotic at a time:
  - → Start with the lowest possible dose;
  - → Gradually titrate the dose up to the lowest effective dose, based on the resident's tolerance and clinical response;
  - → Never exceed the maximum recommended dose for elderly individuals;
- The validity period of a medication order for an antipsychotic should be one month (or less, depending on the clinical need) to a maximum of three months.

⚠ The starting doses of antipsychotics used in the elderly should be lower than those recommended for younger individuals.

SPECIFICS CONCERNING THE PRN OR "AS NEEDED" USE OF AN ANTIPSYCHOTIC

- Use only in case of an **emergency** for psychotic or aggressive symptoms posing an immediate risk;
- Never use it preventatively (e.g., to prevent resistance-to-personal-care behaviours).
- Enter the following on the medication order:
  - → The exact indication for using the antipsychotic;
  - → The doses (including the maximum dose/24 hrs) and minimum dosing interval;
  - → The dosing frequency.
- Do not renew the order if it has not been used for over a month.

MONITORING AND CLINICAL FOLLOW-UP

- Monitor the patient regularly for the adverse effects associated with antipsychotics.

⚠ Antipsychotics are associated with an increased risk of:

- → death;
- → cardiovascular events;
- → stroke[3];
- → extrapyramidal symptoms;
- → sedation/drowsiness;
- → weight gain and appetite stimulation;
- → falls.

- Reassess the relevancy of continuing the antipsychotic therapy on the basis of:
  - → the achievement of the therapeutic objectives;
  - → a risk-benefit assessment.

If there is no clinically significant response after a 1-month trial with the antipsychotic at an optimized dose[4]

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Deprescribe the antipsychotic

with the objective of discontinuing it

After 3 or more months of behavioural stability

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Deprescribe the antipsychotic

with the objective of reducing it and, if possible, discontinuing it

3. According to Health Canada, people with a mixed or vascular neurocognitive disorder are at greater risk for cerebrovascular adverse events than those with a neurocognitive disorder of the Alzheimer type.
4. If psychotic or aggressive symptoms putting the resident or others at risk persist and the patient does not respond to nonpharmacological interventions, consider a change of treatment, including a trial with a new antipsychotic.

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CHSLD : residential and long-term care centre;
PRN : *pro re nata*;
BPSD : behavioural and psychological symptoms of dementia.