Greater Manchester West Mental Health NHS Foundation Trust
Shared Care Protocol Salford

Shared Care Protocol for: *Atypical and typical antipsychotic medication prescribed for Behavioural and Psychological Symptoms in Dementia*	**Reference Number**
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Date approved by GMW Mental Health NHs FoundationTrust: *26/01/2012*	**Review date:** *March 2015* *SALFORD VERSION amended July 2013*
Date approved by commissioners: *March 2012*	

1. Licensed Indications	*Psychosis in patients with a diagnosis of dementia.* *Risperidone for short term treatment of persistent aggression in patient's with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological interventions and when there is a risk of harm to self or others (up to 6weeks). NICE recommends a period of 12 weeks if necessary.* *Other atypicals are not licensed but include:* *Aripiprazole, olanzapine and quetiapine to be used where risperidone is not tolerated or contra-indicated.* *If used for BPSD duration and review should be 6-12 weeks.* *Typicals which can be used and are licensed include: Promazine (for agitation) Haloperidol for short term use (for Delirium, Psychosis and BPSD) and Levomepromazine (licensed for agitation in palliative care and unlicensed for sleep disturbance but maybe prescribed when due to agitation).* *Typicals are not amber rated drugs according to GMMMG but are included here to promote safe and effective prescribing.*
2. Therapeutic use & background	*Where all other specific interventions have been unsuccessful and symptoms are causing extreme distress or risk, a trial of pharmacological treatments specifically targeted at BPSD may be attempted.*
3. Contraindications (please note this does not replace the SPC or BNF and should be read in conjunction with it)	*Caution when prescribing these drugs in Lewy Body Dementia, Parkinson's disease.* *Caution in patients who are prescribed drug that may cause prolongation of QT interval.* *Caution in those with cardiovascular disease, history of epilepsy or of cerebrovascular disease.* *Avoid in acute porphyria (risperidone)*

4. Dosage regimen for continuing care

Drug	*Route of administration*	*Dosage*
Risperidone Tablets	*Oral*	*0.25mg once or twice daily (decreased dose in older frail patients) usual Maximum 2mg twice daily*
Quetiapine	*Oral*	*12.5mg daily increase to a usual maximum of 100mg twice a day*
Olanzapine	*Oral*	*2.5mg at night increase to a usual maximum of 20mg at night*
Aripiprazole	*Oral*	*5mg daily increase to usual maximum of 15mg daily*
Promazine	*Oral*	*12.5mg BD increase to a usual maximum* of 50mg TDS*
Haloperidol	*Oral*	*0.5mg BD increase to a usual maximum* of 1mg BD*
Levomepromazine	*Oral*	*6.25mg(1/4 of 25mg tablet) nocte increase to a usual maximum* of 50mg BD*

- ***Use lowest effective tolerated dose***
- ***Reduce doses by half if impaired renal or liver function***
- ***Check antifungal drugs as dose of antipsychotic may need changed***
- ***Sedative drugs may increase sedative effects of antipsychotic***
- ***Hypotensive drugs may be potentiated by antipsychotics***
- ****In exceptional circumstances a higher dose up to the maximum BNF limit may be prescribed.***

5. Drug Interactions

For a comprehensive list consult the BNF or Summary of Product Characteristics. In addition check alcohol intake due to additive sedative effect or effect on the liver.

6. Adverse Drug Reactions.

For a comprehensive list (including rare and very rare adverse effects), or of significance of possible adverse event uncertain, consult Summary of Product Characteristics or BNF

Specialist to detail below the action to be taken upon occurrence of a particular adverse event as appropriate. Most serious toxicity is seen with long-term use and may therefore present first to GPs.

Adverse event System – symptom/sign	**Action to be taken** Include whether drug should be stopped prior to contacting secondary care specialist	**By whom**
Symptoms of hyperprolactinaemia: Galactorrhoea,gynaecomastia	*Refer back to specialist team continue medication unless severely affected or distressed*	*Primary care*
Moderate to severe oedema thought to be associated with antipsychotic use.	*Refer back to specialist team continue medication unless severely affected or distressed*	*Primary care*
TIA	*Refer back to specialist for review*	*Primary care*
Stroke	*Stop medication*	*Primary care*
Severe extrapyramidal side effects affecting mobility	*Refer back to specialist team, dose can be reduced if required*	*Primary care*
Tardive dyskinesias- Movement disorder causing distress	*Refer back to specialist team*	*Primary care*

	<table><tr><td>*Priapism(rare)*</td><td>*Stop drug Attend A&E*</td><td>*Primary care*</td></tr></table> Any adverse reaction to a black triangle drug or serious reaction to an established drug should be reported to the MHRA via the "Yellow Card" scheme.
7. Secondary care contact information	***If stopping medication or needing advice please contact:*** **Dr/Other** _____ **Contact number:** _____ **Hospital:** _____
8. Criteria for shared care	Prescribing responsibility will only be transferred when ▪ Treatment is for a specified indication and duration. ▪ Treatment has been initiated and established by the secondary care specialist. ▪ The patient's initial response to and subsequent progress on the drug is satisfactory. ▪ The patient's general physical, mental and social circumstances are such that he/she would benefit from shared care arrangements
9. Responsibilities of initiating specialist	Provide GP with diagnosis, relevant clinical information, treatment to date and treatment plan (to include risk/benefit analysis), duration of treatment before specialist team review. Initiate treatment and prescribe until dose is stable ensuring a responsible adult is available to supervise the administration of medication. (Consider a compliance aid where appropriate) Monitor patient's initial response and subsequent progress. Ensure that the patient has an adequate supply of medication until GP supply can be arranged. Initial follow up will be undertaken by specialist services to ensure appropriate review of target symptoms and allow a care plan to be formulated. Continue to monitor and supervise the patient according to this protocol, while the patient remains on this drug, and agree to review the patient promptly if contacted by the GP Provide GP with advice on when to stop this drug. Provide Flowchart (appendix 1) advice on how to stop. Provide patient/carer with relevant drug information. **Include the sentence below in the clinic letter or discharge notification to aid GP in finding shared care protocol.** *Please refer to SCP for [DRUG NAME] available on the CCG Website: http://nww.salford.nhs.uk/medicinesmanagement/sharedcare.asp*
10. Responsibilities of the GP	Continue treatment as directed by the specialist Ensure no drug interactions with concomitant medicines To monitor and prescribe in collaboration with the specialist according to this protocol. Symptoms or results are appropriately actioned, recorded and communicated to secondary care when necessary. If patient is already on antihypertensive medication, consider additional BP monitoring as these drugs can potentiate the hypotensive effects.

	The blood pressure should be checked 4weeks after starting the antipsychotic unless there are symptoms of hypotension. Ensure prescription is reviewed every 12 weeks as per flowchart and in line with treatment plan.
11. Responsibilities of the patient/carer	Ensure medication taken as directed by the prescriber, or to contact the GP if not taking medication Ensure any adverse effects are reported to Health Professional or GP.
12. Supporting documentation	The SCP must be accompanied by a patient information leaflet.
13. Statement of Shared Care agreement	Shared care is an agreement between the GP and the Consultant. This is a request by the consultant to share the suggested care pathway of your patient. If you are unable to agree to the sharing of care and prescribing the suggested medication, **please make this known to the consultant within 14 days**, ideally stating the nature of your concern.

REVIEWING ANTIPSYCHOTIC PRESCRIBING IN DEMENTIA

Where the patient is not receiving care from secondary care psychiatry services (GMW)

Review clinical records and establish indication for antipsychotic if possible.

Review patient

Have symptoms improved and patient stable for 6-12 weeks?

YES

Trial Reduction**:
If on *small dose discontinue or reduce antipsychotic medication over two weeks and review.

Have the symptoms returned?

YES

Use the smallest beneficial dose*.

Review the patient after 6-12 weeks.

Attempt further reduction** if appropriate.

NO

- If on small dose STOP antipsychotic.*
- If on larger doses reduce** medication (up to 50% if appropriate)

NO

Refer to Specialist Services

If using Antipsychotics:

- Risk vs Benefit analysis in patient's records.
- Check effects and side effects are being monitored and documented.
- Check physical health is monitored, as appropriate for the individual patient e.g. blood sugars, weight, BMI, waistline, BP and lipids at regular intervals at 3 months, 6 months and then annually.
- Care Plan is written including:
  - review date
  - target symptoms to be treated with antipsychotics
  - level of risk and distress
  - actions to be taken if significant deteriorations when on medication or drug reduction programme

*Risperidone 250-500mcg
*Quetiapine 25mg-50mg
*Olanzapine 2.5mg
*Aripiprazole 5mg
*Promazine 12.5mg-50mg
*Haloperidol 500mcg-1mg
*Levomepromazine 6.25mg-25mg

** The reduction will take into account the original target symptoms, severity and the response time to treatment.