



- Single-side print
- Fold page in half and crease along fold line
- Cut along outline
- Be sure to round the corners



FOLD LINE

This set of reference cards provides a quick referral point for staff caring for people with dementia in residential aged care facilities.

This information is focused on antipsychotics for the support of the neuropsychological symptoms of dementia (responsive behaviours). These cards provide general information only and does not claim to reflect all considerations. As with all guidelines, the recommendations may not be appropriate for use in all circumstances. This guide is not intended to be used for supporting people with acute severe behavioural disturbance.

When using these cards it is critical to ensure that a person-centred approach to care is adopted at all stages. This is fundamental in the provision of high quality care, particularly when supporting a person with changed behaviour associated with dementia.

This resource was originally produced by the Western Australian Dementia Training Study Centre, School of Pharmacy, Curtin University, with expert advice from Louis Anastasas, Dr Nicholas Bretland, Sandy Crowe, Alison Ilijovski, Anne Moehead, Cathy Nicol and Ann Toh. It is now distributed by Dementia Training Australia. Dementia Training Australia is supported by funding from the Australian Government under the Dementia and Aged Care Services Fund.

Dementia  
Training  
Australia

ISBN 978-0-9942935-2-7  
© 2022 DTA [www.dta.com.au](http://www.dta.com.au)

FOLD LINE

## SUPPORT PLAN

### Stage One

**Identify** the target responsive behaviour and **liaise with the prescriber**.

1. **Exclude delirium/depression, adverse drug effects or interactions, infection or pain by liaising with the prescriber.** Consider a medication review. Refer to appropriate guidelines to manage any identified causes.
2. If available, contact your in-house dementia specialist for advice regarding **first-line non-pharmacological** interventions. For further advice contact Dementia Support Australia (DSA) on **1800 699 799**.
3. **Review** and **amend** the current care plan and Behaviour Support Plan, ensuring a focus on individualised, person-centred care strategies.
4. Should these measures adequately support the person, **maintain** care provision using the amended care plan and Behaviour Support Plan, with regular **monitoring** and **review**.
5. **If the responsive behaviour cannot be resolved, see over.**

ANTIPSYCHOTIC SUPPORT PLAN

ANTIPSYCHOTIC SUPPORT PLAN

## SUPPORT PLAN CONT.

### Unresolved responsive behaviour

If modification of care provision does not adequately support the person, **liaise with the prescriber**.

Whilst pharmacological support **may** be considered at this time; **non-pharmacological** approaches should be maintained throughout.



An antipsychotic medication should only be considered for use in a person with dementia for:

- a. **Distressing psychosis or**
- b. **A behaviour that is harmful/ severely distressing to the individual or puts others at risk.**

Most other symptoms are unlikely to respond to treatment with an antipsychotic medication.

FOLD LINE

## SUPPORT PLAN CONT.

### Stage Two

If an antipsychotic is to be trialled:

#### Suggested Plan

1. Restrictive practices must only be used as a **last resort** and in the **least restrictive form**.
2. Where restrictive practices are used, approved providers must meet a number of conditions. Refer to the Aged Care Quality and Safety Commission website for the latest information.
3. Commence antipsychotic medication using a **regular low dose** (refer to **FOR PRESCRIBERS: STARTING AN ANTIPSYCHOTIC** card).
4. **Monitor** for ongoing response and **potential side-effects** (refer to **POTENTIAL SIDE-EFFECTS** card):
  - a. If **side-effects** develop **at any stage**, immediately contact the prescriber.
  - b. **Maintain non-pharmacological** approaches: refer to allied health.
5. **Review** after **2 to 4 days** for effectiveness:
  - a. If no/inadequate response, contact prescriber and consider increasing the dose.
  - b. If tolerated and effective, continue.

**REMINDER STICKERS** are available to assist; place them in the Communication Book or Resident Notes as appropriate.

ANTIPSYCHOTIC SUPPORT PLAN

## SUPPORT PLAN CONT.

### Stage Two (cont.)

6. At **1 to 2 weeks**, prescriber to **review** for response and **side-effects**:
  - a. If the antipsychotic is ineffective/not tolerated, **cease** it. Should an alternative antipsychotic be trialled, return to Step 1.
  - b. If the antipsychotic is tolerated and effective, continue. **Monitor** for response and **side-effects**, **maintain non-pharmacological** approaches.
  - c. Discuss and develop a **withdrawal** plan with the prescriber. Prescriber to initiate **withdrawal** plan; aiming to **cease** no later than **12 weeks** (refer to **WITHDRAWAL PLAN** card).
7. At **6 weeks**, prescriber to **review** for response and **side-effects**. Repeat Step 6a and 6b. Consider **withdrawal** if not already initiated.
8. At **12 weeks**, prescriber to **review** for resolution of the target responsive behaviour.
9. If the target responsive behaviour reoccurs after dose reduction or cessation (refer to **WITHDRAWAL PLAN** card).

FOLD LINE



## FOR PRESCRIBERS: STARTING AN ANTIPSYCHOTIC

If an antipsychotic is considered necessary for agitation, aggression or psychotic symptoms associated with Alzheimer disease or mixed Alzheimer disease and vascular dementia (i.e. dementia that **is not** associated with Lewy bodies or Parkinson disease):

Antipsychotic	Regular dose
Risperidone*	Initially 0.25mg orally, twice daily. Increase if needed by 0.25mg every two or more days. Maximum of 2mg daily in one or two divided doses.
Olanzapine†	Initially 2.5mg orally daily. Increase if needed by 2.5mg every two or more days. Maximum of 10mg daily in one or two divided doses.

If an antipsychotic is considered necessary for agitation, aggression or psychosis of dementia associated with Lewy bodies (i.e. rivastigmine or donepezil is inadequate):

Antipsychotic	Regular dose
Quetiapine†	Initially immediate-release 12.5mg to 25mg orally, once or twice daily. Increase if needed by 12.5mg to 25mg every two or more days. Maximum of 75mg twice a day.

\* Risperidone is the only antipsychotic approved by the Therapeutic Goods Administration (TGA) for support of responsive behaviours in Australia; this approval is for a maximum of 12 weeks for moderate to severe Alzheimer's disease.

† Like all antipsychotics aside from risperidone, in Australia olanzapine and quetiapine are not TGA-approved for supporting responsive behaviours.

## STARTING AN ANTIPSYCHOTIC

## ANTIPSYCHOTIC POTENTIAL SIDE-EFFECTS

## ANTIPSYCHOTIC POTENTIAL SIDE-EFFECTS

- **Non-pharmacological strategies** must be trialled first and maintained throughout all stages.
- Antipsychotics are **NOT first-line**.
- Use antipsychotics with **extreme caution** in people with dementia with Lewy bodies or Parkinson's disease dementia.
- Use the **lowest effective dose** for the **shortest period of time**.

### Changed Movement

- Tremors, rigid muscles
- Dizziness, falls
- Elevated heart rate
- Swelling - legs or ankles
- Increased appetite
- High blood sugar
- Constipation

### Cardiovascular / Metabolic

- Low blood pressure - dizziness, falls
- Elevated heart rate
- Swelling - legs or ankles
- Increased appetite
- High blood sugar
- Constipation

### Central Nervous System

- Sedation
- Confusion
- Delirium

- This list is not exhaustive; many others may occur.
- Some side-effects may not occur immediately, and may take days to weeks to manifest.
- Monitor for side effects regularly throughout. If movement changes occur re-assess for falls risk and consider referral to physiotherapist.



FOLD LINE



## WITHDRAWAL PLAN

### Suggested withdrawal plan for an antipsychotic:

1. Discuss and develop a **withdrawal** plan with the prescriber once an antipsychotic is tolerated and effective.
2. Prescriber to initiate **withdrawal** plan; aiming to cease no later than **12 weeks**.
3. To begin **withdrawal**, halve the dose every **2 weeks**, ceasing after **2 weeks** on the minimum dose.
4. Prescriber and care team to regularly **monitor** and **review** for **side-effects** and responsive behaviour recurrence.
5. If the target responsive behaviour reoccurs at any point in the **withdrawal** process, **liaise with the prescriber** and consider increasing to the previous lowest effective dose.
6. After cessation:
  - a. If the target responsive behaviour reoccurs return to **Stage One**.
  - b. If the target responsive behaviour is no worse once the antipsychotic is ceased, continue to **maintain non-pharmacological** approaches.

ANTIPSYCHOTIC WITHDRAWAL PLAN

## REFERENCES

### These cards are based on:

- Aged Care Quality and Safety Commission. (2021). Minimising the use of restrictive practices. <https://www.agedcarequality.gov.au/minimising-restrictive-practices>
- Aged Care Quality and Safety Commission. (2021). Regulation of restrictive practices and the role of the Senior Practitioner, Restrictive Practices. Regulatory Bulletin; 13.
- Aged Care Quality and Safety Commission. (2021). 6 steps for safe prescribing. [https://www.agedcarequality.gov.au/sites/default/files/media/acqsc\\_six\\_steps\\_for\\_safe\\_prescribing.pdf](https://www.agedcarequality.gov.au/sites/default/files/media/acqsc_six_steps_for_safe_prescribing.pdf)
- Aged Care Quality and Safety Commission. February 2020. Psychotropic medications used in Australia information for aged care. <https://www.agedcarequality.gov.au/resources/psychotropic-medications-used-australia-information-aged-care>
- Burns K, Jayasinha R, Tsang R, & Brodaty H. (2012). Behaviour management – A guide to good practice managing behavioural and psychological symptoms of dementia (responsive behaviours). <https://dementia.com.au/resources/library/behaviour/behaviour-management-guide.html>
- Darzens, A. (2006). Medical care of older persons in residential aged care facilities. (4th ed). <https://catalogue.nla.gov.au/Record/3800627>
- Dementia. Pharmacological management of behavioural and psychological symptoms of dementia. (2022). In eTG complete. <http://www.tg.org.au>
- Reducing antipsychotic prescribing in dementia toolkit. (2014). <https://www.prescripp.info/resources>
- Rossi, S. (Ed). (2022). Psychotropics. Adelaide: Australian Medicines Handbook Pty Ltd.
- Veterans' mates therapeutic brief 12 - Antipsychotics in dementia. (2007). <https://www.veteransmates.net.au>