ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Appendix 3

MANAGEMENT OF ACUTELY DISTURBED PATIENTS: DEMENTIA SERVICES

PRINCIPLES

Multidisciplinary approach *Effective interventions* *Proportionality of intervention* *Treatment individualisation/choice* *Treatment optimisation of underlying disorder*	***Continuous monitoring/review of:*** *Mental/physical health* *Risk to self/others* *Treatment effectiveness/harm* *Patient engagement level*	***Consider modifiers:*** *Pregnancy* *Drugs and alcohol* *Medical frailty/physically compromised* *Psychotropic naivety* *Regular prescribed psychotropics*	*Learning disability* *Extremes of age*

PRE-RT: DE-ESCALATION

Continual risk assessment	*Passive intervention and watchful waiting*	*Identification of patient needs*
Self-control techniques	*Empathy*	*Distraction*
Avoidance of provocation	*Reassurance*	*Negotiation*
Respect patient space	*Respect and avoidance of shame*	*Reframing events for patient*
Management of environment	*Appropriate use of humour*	*Non-confrontational limit setting*

PRE-RT: ORAL MEDICINES

Offer oral medicines first	*Consult any advance decision/ statements*	*Note all previous medicines used in last 24 hours*	*Contact consultant if total dose above BNF limits*

Unknown or psychotropic naïve patient	**Known history of psychotropic use**				
					SEE CAUTION IN NOTES BELOW
Lorazepam or Promethazine	Lorazepam	or	Promethazine	or	Risperidone or Haloperidol with Promethazine **(Do not use haloperidol, and use quetiapine or risperidone with caution, in Lewy Body dementia or Parkinson's disease dementia)**

Allow at least 1 hour for response to oral. Repeat, if necessary. Consider combining sedative and antipsychotic treatment. Progress to RT if two doses fail, or sooner if patient or others at significant risk, or oral refused. Continue non-drug approaches.

RT: INTRAMUSCULAR MEDICINES

Unknown or psychotropic naïve patient	**Known history of psychotropic use**	
	No cardiac disease (confirmed by ECG)	**Unknown or confirmed cardiac disease**
Lorazepam	**SEE CAUTION IN NOTES BELOW** Haloperidol with Promethazine **(Do not use haloperidol in Lewy Body dementia or Parkinson's disease dementia)**	Lorazepam
Wait 30 minutes for response, repeat if partial or no response.	Wait 30 minutes for response, repeat if partial response.	Wait 30 minutes for response. Repeat if partial or no response.
	If no response: Lorazepam	

Oral doses:		**IM doses:**
Lorazepam 0.5-1mg (Max 2mg/24 hours) Haloperidol 0.5-2.5mg (Max 5mg/24 hours) Promethazine 10-25mg (Max 50mg/24 hours)	Risperidone 0.5-1mg (Max 4mg/24 hours) Quetiapine immediate release 25mg (Max as low as possible / 750mg/24 hours)	Lorazepam 0.5-1mg (Max 2mg/24 hours) Haloperidol 1-2.5mg (Max 5mg/24 hours) Promethazine 12.5-25mg (Max 50mg/24 hours)

Monitoring:
After oral doses, monitor hourly for minimum 1 hour, then as clinically appropriate. After IM doses, monitor every 10 minutes for first hour, then every 30 minutes for next 3 hours at least, and until ambulatory, then as per guideline. Record monitoring on MEWS chart.

Notes:
Lorazepam and promethazine can worsen confusion, and benzodiazepines can cause paradoxical reactions.

If the patient has a diagnosis of Lewy body dementia or Parkinson's disease dementia, avoid antipsychotics. Where an antipsychotic is essential for these diagnoses, consider prescribing quetiapine orally (unlicensed in dementia), or risperidone orally (licensed in dementia, including Lewy body and Parkinson's disease dementia). Increase the level and duration of observations to identify and treat side effects from psychotropic medication, including Neuroleptic Malignant Syndrome

Post review:
Discuss in MDT. Review PRN. Document as DATIX, with full details, and on medical record. Undertake 72 hour review with patient.