User manual for Psychotropic Medication section

Selection of healthcare records for inclusion

For any of the 30 charts in INAD-2, where a person received any new or increased dose of psychotropic medication (question 50), you will complete additional items on these medications in the relevant section(s), Sections A-D. If a person has more than one admission during the audit period, the evidence is taken from the same episode as the main audit data (i.e the most recent admission episode within the audit period).

How to complete these sections:

The following are instructions on how to complete the psychotropic medication sections including definitions and terminology used throughout.

Instructions: Please read the manual prior to completing these sections. It may also be helpful to have a copy of the manual at hand when reviewing the chart to ensure relevant terms are understood.

Complete all sections in ink, in legible writing.

- Indicate Yes if the item has been found in the person with dementia (PwD's) notes.
- Indicate No if the item is absent or not found in PwD's notes.
- Indicate N/A in cases where the specific item is not relevant. In all cases where N/A is indicated, please provide the rationale for this decision. Please refer to listed exceptions for each question to indicate where N/A should be selected.

Please note that at end of life, rapid relief of symptoms often takes precedence over non-pharmacological interventions, and antipsychotic, anticonvulsant or benzodiazepine medication may be prescribed for specific end-of-life symptoms apart from non-cognitive symptoms. Thus, being documented as being at end-of-life at the time of prescription is an exception to many of the items in these sections. Being at end of life needs to be explicitly documented using terms such as "not for any active treatment", "for palliative care measures only", "treat as per end of life protocol", "dying", "actively dying", "moribund", or similar terms. Please mark "N/A" and document the end of life state in the comments box and the end of the relevant section.
NB It can't be assumed that a person **who died during an admission** was at end of life for the duration of their admission, especially for a long admission- often a person is stable, but then deteriorates a few days before death. Thus, earlier prescriptions, before the end of life period was documented, can be included, even if the person later received the same medication during the end of life phase.

Chart code refers to the specific number assigned to the chart (eg 01, 02 etc)

Hospital code is the code for your hospital (eg AB)

Section A

1. A comprehensive assessment of the PwD has been performed by a suitably qualified healthcare professional.
Based on Rec 1. Options: Yes or No or N/A
Exceptions: Emergency circumstances (see section B)

A comprehensive assessment is defined as: review of medical history and mental health history (including depression) and medication history; physical examination, including consideration of possible delirium, or undetected pain or discomfort (with an appropriate assessment of same); assessment of the severity, type, frequency, pattern, and timing of symptoms, and other potentially contributory or comorbid factors. This assessment should be performed in an appropriate environment that optimises the person's comfort and ability and includes any support that the person may require. The assessment needs to be performed by a nurse or doctor who is competent in assessing a person with dementia who may be distressed.

Instructions: To select "yes", there must be a documented comprehensive assessment in the patient's notes AND it must be done by a suitable person. This does not need to include every point below, but needs to demonstrate coverage of **most** of the following points:

1) medical, medication, and mental health history is summarised or referenced;
2) a physical examination is recorded
3) pain is assessed
4) the severity, type, frequency, pattern, and timing of symptoms is recorded or referenced
5) other potentially contributory or comorbid factors are considered

Other satisfactory evidence is use of a formal tool, for example "PINCH-ME"

The assessment should have been performed by a **registered doctor or nurse (of any grade)**, but not a student unless the assessment is co-signed. If a comprehensive assessment was performed, but by another discipline, please make a note in the comment section at the end of the page.

2. Non-pharmacological interventions have been tried initially.

Based on Rec 2. Options: Yes or No or N/A

Exceptions: Severe distress; an identifiable risk of harm to the person and/or others; at end of life

Non-pharmacological interventions refer to interventions that do not involve medications. Non pharmacological interventions will often be documented in the nursing care plan. The type of non-pharmacological intervention documented should be detailed in the space provided.

Types of non-pharmacological interventions include:

Using a quiet area	Reminiscence Therapy	Art Therapy	Multisensory Stimulation
1:1 care with activity (not just supervision)	Validation Therapy	Music Therapy	Snoezelen Rooms
Reference to patient passport	Reality Orientation	Aromatherapy	Distraction
Physical Exercise			

Please note this list is not exhaustive

In cases where severe distress in the person, or an identifiable risk of harm to the person and/or others, has been documented, please indicate **N/A** and tick which exception applied in question **2a.** (Please specify the risk harm that was documented)

(In the recommendation, identifiable risk refers to the presence of real, evident or substantial risk to the person and/or others).

Severe distress will often be documented using this exact term. Other acceptable proxy terms are "very upset", "inconsolable", "very distressed" etc.

Section B (note - all these items are based on GPP (Good Practice Point) only)

3. *Was any intramuscular or intravenous psychotropic medication prescribed during the admission?*
This will usually be "no" and you can move to section C. If "yes", proceed through the questions in this section.

4. *Oral psychotropic medication has been prescribed before parenteral medication*

Based on GPP 4. Options: Yes or No or N/A **Exceptions:** Emergency situations; End of Life

Emergency situations pose an immediate risk to the health, life, or condition of a person. In these cases, due to the potential for harm, it may not be feasible and safe to delay the administration of IM or IV psychotropic medication when considering the best interest of the person with dementia. In this case, once the risk has been reduced or alleviated, appropriate review and evaluation of the person and care should occur to reduce further emergency intervention.

Instructions: Chart reviewers should review PwD's drug kardex/medication record, seeking evidence in the PwD's drug kardex that oral medication has been prescribed and administered before parenteral medication has been prescribed.

Note: It may have been impossible to administer the medication orally- please refer to the kardex code and document the reason why oral not possible (eg fasting, vomiting etc) in the comments box at end of page.

NB Refusal of oral medications is not a valid indication to give parenteral medications, unless there is additional documentation of an emergency situation that necessitated the medication being given parenterally.

5. *Single intramuscular (IM) psychotropic agents have been prescribed prior to combination IM agents*

Based on GPP 4. Options Yes or No or N/A **Exceptions:** End of Life

Single agents means the prescription of one psychotropic medication at a time. Combination refers to the prescription of two or more psychotropic medications at any one time. This can be the use of two or more from of the same class e.g. two different antipsychotics; or two or more from different classes e.g. antidepressants and antipsychotics

Instructions: There is documented evidence in the PwD's drug kardex that a single IM psychotropic medication has been prescribed **and administered** before a combination has been prescribed. If selecting "N/A", please justify in the comments box (e.g. no IM agents given) at end of page.

6. *Intramuscular agents (IM) have been prescribed prior to intravenous (IV) agents*

Based on GPP 4. Options Yes or no or N/A Exceptions: Emergency situations; End of Life

Instructions: There is documented evidence in the drug kardex that IM medication has been prescribed **and administered** before IV medication has been prescribed. If selecting "N/A", please justify in the comments box (e.g. no IV agents prescribed) at end of page.

7. *Where IV psychotropic medication has been prescribed, the indication for requiring IV treatment is documented*

Based on GPP 4. Options Yes or No or N/A **Exceptions:** End of Life

Instructions: There should be documentation of why the prescriber believed emergency IV medication was required. If selecting "N/A", please justify in the comments box (e.g. no IV agents prescribed) at end of page.

Section C:

Skip this section if no **new** antipsychotic medication **or increased dose** was prescribed during the admission.

8. There was an explicit, appropriate indication for the requirement of the antipsychotic medication.

8a. There was severe distress, or an identifiable risk of harm to the PwD and/or others.

Based on Rec 3 and 6. Options: No; or Yes with options **No exceptions**

There should be documented evidence within the PwD's notes of indicator symptoms, and either severe distress to the person or risk of harm to the person or others

Instructions: Chart reviewers should tick all indications that apply.

Aggression ☐ Agitation ☐ Psychosis ☐ End of Life Care ☐ Delirium ☐

Delirium is defined as a disturbance in attention and awareness, typically developing over hours to days, often fluctuating in severity within a day, and representing a change from usual status. Delirium is caused by a variety of insults, typically acute infection, metabolic derangement, medication side effect, or acute brain injury. Currently, delirium is a valid indication for antipsychotic medication (without needing to be severely distressed or posing a risk of harm) so if this box is ticked, the item is deemed to have been met. However, to be fully valid, the diagnosis of delirium needs to be documented by either a senior nurse (ward manager or older persons/dementia/delirium nurse specialist), or a physician above the grade of an intern. **If made by another grade/discipline, please note this in the comments box, and proceed to question 9.**

Where the indication was aggression, agitation or psychosis, there also needs to be documentation of: Severe distress to the PwD or Risk of harm to the PwD or Risk of harm to others. Chart reviewers should tick all indications that apply.

9. The risks and benefits of the medication have been documented in the notes

Based on Rec 9. Options: Yes or No or N/A **Exceptions:** End of Life

Instructions: Seek documentation in the person's notes outlining the risks associated with the medications including cardiovascular risks, risk of stroke, death, drowsiness, falls, pneumonia, etc and the potential benefits of using psychotropic medications. Documented statements such as "despite the risks, an antipsychotic is required because….", or other mention of "risk" without actually naming the risk, is also acceptable.

9a. There is documentation that the risks and benefits of the medication have been discussed with the PwD and/or their family/relevant decision maker

Based on Rec 7. Options: Yes or No or N/A **Exceptions:** End of Life; Emergency situations – see section B.

Instructions: Seek evidence in notes that a discussion took place with the PwD regarding the risks and benefits, or evidence in notes that a similar discussion took place with the family of the PwD or a Decision supporter. This documentation does not need to list the risks discussed, just that there was a discussion of risk-benefit (or "the need for the medication" or a similar term).

A 'Decision Supporter' refers to a Decision-Making Assistant, Co-Decision-Maker, Decision-Making Representative, Attorney or Designated Healthcare Representative, if any of these are in place for a person, and have a role in relation to health-related decisions [i.e. an attorney may or may not]. In practice, this person may often be a family member of the person with dementia, but not always. *For this item, you can assume that the family is the decision maker unless it is documented to the contrary.*

10. A second generation antipsychotic was prescribed

Based on Rec 8. Options: Yes or No

Exceptions: Contra-indication to second generation antipsychotics; End of Life

Typical (first generation) antipsychotics were first developed in the 1950s. Atypical (second generation) antipsychotics have less effects on the motor system (e.g. tremor, shuffling gait).

Instructions: Sometimes a decision is made to use a first generation medication – for example haloperidol when someone has severe respiratory disease as this may cause less respiratory depression. A reason needs to be documented for the decision to use a first generation drug- the chart reviewer needs to record the reason given.

11. The initial antipsychotic dose is at or close to the lowest available dose for that medication
11a. There were no large increases in doses from one dose to the next

Based on Rec 9. Options: Yes or No or N/A for both.
Exceptions: End of Life; Emergency situations – see section B.

Instructions: Check drug kardex to see if the initial antipsychotic dose prescribed is at or close to the lowest available dose for that medication; and that there are no large increases in dose from one prescribed dose to the next (see list of commonly prescribed antipsychotics and their starting/titration doses). If the medication is not listed here, record the drug name and the doses prescribed (dose and frequency- e.g. 100mg twice a day).

It may be valid to use a larger dose in an emergency situation (or at end of life). This needs to be documented (if so, mark N/A and give details). Also, mark N/a for 11a. if only one dose was prescribed.

12. There was a review for effectiveness AND side effects during the admission
Based on Rec 10 and 11. Options: detailed **Exceptions:** None

Instructions: The documentation of effectiveness and side effects should be recorded within the notes. This documentation can be performed by a healthcare professional who is monitoring the PwD (nurse, doctor, psychologist, OT). The chart reviewer is asked to tick options for both parts of the initial statement (review for effectiveness recorded, and review for side effects recorded) so that it can be seen which review is more commonly omitted.

However, in acute hospitals, the person may be discharged rapidly, so compliance with this item can also be via evidence of a clear plan for this review post discharge, (for example back at a hospital clinic, or a specialist service, or within the residential care unit). Please use the options in Q12a to indicate when this review was planned for.

13. Is there documentation that the antipsychotic was effective?

Based on Rec 10. Options: Yes or No or N/A
Exceptions: An antipsychotic was being re-commenced following an unsuccessful trial of discontinuation*; Person is documented to have a short life expectancy (less than three months); End of life care
**If an antipsychotic was discontinued and the person then had a relapse of symptoms and the antipsychotic was re-commenced, it is not necessary to document it was effective on recommencing it.*

Instructions: Seek documentation of symptoms being reassessed and words such as “agitation improved”, “psychosis settling” etc.

14. Is there evidence of a planned review date within 3 months of the first prescription?

Based on Rec 10. Options: No; or yes with options
Exceptions: An antipsychotic was being re-commenced following an unsuccessful trial of discontinuation*; Person is documented to have a short life expectancy (less than three months); End of life care

In cases where the medication has been documented as being effective, a clear plan of future review should be evident in the PwD’s notes.

Instructions: If there is no review planned within 3 months, then move on to the next question. If “yes”, then you are asked to answer another question. i.e. does this plan explicitly state the physician/service who is responsible for this review?

Mark n/a if an exception existed, and record which exception it was.

(Even where there is no documentation of effectiveness, the notes still need to meet the separate criterion of a planned review)

15. Is there documentation that the antipsychotic was ineffective?

Based on Rec. 11. Options: Yes or No or N/A **Exceptions:** End of Life

Instructions: There should be documentation of ineffectiveness in the notes- such as "no change in aggression", or "symptoms unimproved" etc.

16. Is there evidence that the antipsychotic was stopped or tapered?

Based on Rec. 11. Options: The antipsychotic was stopped or the antipsychotic was tapered down or no evidence of either of the above

Exceptions: End of Life

Tapering is where the medication is gradually lessened over a period of time, rather than stopped outright.

Instructions: If medication was tapered or stopped, it can be assumed that there was a review of some sorts, even if it was not documented (but don't change your answer for question 15 as that question is about documentation).

(There should also be a discussion with the person and/or their family as part of the decision making, with evidence of this discussion documented in the notes, but the key action is the taper/stopping).

Please note that there is no fixed time point for this action to have occurred as it will depend on response and side effects.

17. Was an existing antipsychotic tapered/withdrawn during the admission?*

Based on text around Rec. 12. Options: No; Yes with further options **Exceptions:** End of Life

*The recommendation specifically relates to a newly commenced antipsychotic, but it is not rare for a medical team to reduce or stop a long-standing antipsychotic in hospital (e.g. for low sodium, low blood pressure), and it is important that there is sufficient review for later re-emergence of the indicator mental health symptom.

Re-emergence refers to where symptoms come into effect or become evident once more. Primary prescriber is the person who initiated the medication. Specialist services refers to person or persons who have significant experience in managing dementia and symptoms associated with it. It is usually a psychiatry of old age or geriatrician or dementia nurse specialist/ANP led service.

Instructions: If there was no tapering or withdrawal of an existing antipsychotic, then proceed to the comment box and then on to the next section.
If there was a withdrawal (stopping or holding a medication), or dose reduction, there should be evidence in the person's notes that a plan of care for the duration of the tapering or discontinuation has been developed. This is not necessary if the usual dose (or close to it- eg 75% or more of the usual dose) was recommenced during the admission (no matter when it happened), in which case you mark "yes" for this question and proceed to the comment box and then on to the next section.

➔ Mark N/A if person died or was discharged within 48 hours of the dose reduction, as the review couldn't have occurred in this case, and proceed to question 17c.

For post discharge review, it needs to be documented that the PwD was discharged with a plan for review, **within 4 weeks of discharge**, of their status post tapering/withdrawal. *(This can be with the primary prescriber or an appropriate specialist service).* If there was a planned review but after 4 weeks, mark "no" but add a comment in the box.
NB A planned review for another indication is not sufficient for this item (eg follow up of CXR or abnormal blood result)- the notes must explicitly state a plan for review of non-cognitive or mental health symptoms or a similar term. If the review is for something else, mark "no" and add a comment.

Section D

Acetylcholinesterase inhibitors and memantine

18. If prescribed, the Acetylcholinesterase inhibitor was commenced for cognitive dysfunction.

Based on Rec. 13. Options: Not prescribed; or Yes and options Exceptions: None

Cognitive dysfunction is a noticeable decline in cognitive abilities, including memory, thinking and language skills. Non-cognitive symptoms include psychosis, agitation or restlessness, aggression, apathy, anxiety and depression (also referred to as neuropsychiatric symptoms). In some instances, people with non-cognitive symptoms of dementia may exhibit behaviours such as: walking about; pacing; hoarding; repetitive vocalizations (calling out); inappropriate sexual behaviour; etc. These are often termed 'responsive behaviours'. Together, non-cognitive symptoms and responsive behaviours are often termed Behavioural and Psychological Symptoms of Dementia (BPSD).

Instructions: There should be documented evidence in notes that the medication was commenced for the management of cognitive symptoms (may be documented as cognitive dysfunction, cognitive impairment, memory impairment, language difficulty, etc), and not for non-cognitive symptoms or BPSD.
If so, notes are excluded from the remainder of this item → proceed to question 22 (on memantine)
If not prescribed for cognitive dysfunction, proceed to the next question (19).

19. Has the person documented PDD or DwLB (also called LBD):

Based on Rec. 14. Options: No; or Yes with options **Exceptions:** None

Parkinson's Disease Dementia (PDD) is relatively common, where a person with Parkinson's Disease for many years develops dementia as their disease progresses. Dementia with Lewy Bodies (DwLB) is a closely related condition with very early dementia relative to Parkinsonian features, and prominent visual hallucinations (due to the culprit protein accumulating particularly in the cerebral cortex, unlike Parkinson's Disease where the protein accumulates in the brainstem). Extreme caution is required in prescribing antipsychotics to a person with dementia with Lewy Bodies, as they can have life-threatening adverse reactions to antipsychotic medications.
People with Parkinsons Disease Dementia and Dementia with Lewy Bodies (sometimes also called Lewy Body Dementia (LBD) in clinical notes) may validly be prescribed ACHIs for BPSD.

Instructions: First answer if the person has PDD or DwLB or LBD- if not, they should not have been prescribed the medication. If they have PDD or DwLB or LBD, it is valid to prescribe an Acetylcholinesterase inhibitor if the person has severe distress AND non-pharmacological interventions have been tried first (refer to list in section A) and haven't worked.

Severe distress will often be documented using this exact term. Other acceptable proxy terms are "very upset", "inconsolable", "very distressed" etc.

***20.** The risks and benefits of the ACHI have been discussed with the PwD and/or their family/relevant decision maker*

Based on GPP2. Options: Yes or No or N/A **Exceptions:** None

Instructions: Please see question 9A for details around discussions. For Acetylcholinesterase inhibitors, relevant risks to be documented include cardiovascular risk (blackout, syncope, heart rhythm disturbance); anorexia, nausea, "GI upset" etc). However, it is also sufficient to document more generally that risks were discussed, without the details of the risk.

21. *There is documentation of either a review or a plan for review of the Acetylcholinesterase inhibitor*

Based on GPP3. Options: Yes or No or N/A **Exceptions:** None

Instructions: There should be documentation of a review of effectiveness and side effects within the notes. This documentation can be performed by a healthcare professional who is monitoring the PwD (nurse, doctor, psychologist, OT)

In acute hospitals, the person may be discharged rapidly, so compliance with this item can also be via evidence of a clear plan for this review post discharge, (for example back at a hospital clinic, or a specialist service, or within the residential care unit).

As this is based on a GPP, not a recommendation, there is not the same detailed answering required that there was for this item for antipsychotics- so any plan for review at any time during or post admission is sufficient. If the person died, or there is another valid reason why the review was not applicable, mark "N/A".

22/23. If memantine was prescribed, has the person documented moderate to severe dementia, and it is documented that the memantine was commenced for cognitive impairment or for non-cognitive symptoms.

Based on Rec 16. **Exceptions:** None

Instructions: To be fully compliant, firstly, it needs to be documented that the person has moderate or severe dementia- memantine should not be prescribed in mild dementia. The severity may not documented, in which case select that option.

Secondly it needs to be documented that the memantine was commenced for cognitive dysfunction, and not for non-cognitive symptoms. Sometimes, it will not be clear why the memantine was prescribed- in this case select "indication was not documented".

24. *The risks and benefits of the medication have been discussed with the PwD and/or their family/relevant decision maker*

Based on GPP2. Options: Yes or No or N/A **Exceptions:** None

Instructions: Please see question 9A for details around discussions. For memantine, relevant risks to be documented include drowsiness, dizziness, headache, hypertension, etc. However, it is also sufficient to document more generally that risks were discussed, without the details of the risk.

25. *There is documentation of either a review a plan for review of the memantine*

Based on GPP3. Options: Yes or No or N/A **Exceptions:** None

Instructions: There should be documentation of a review of effectiveness and side effects within the notes. This documentation can be performed by a healthcare professional who is monitoring the PwD (nurse, doctor, psychologist, OT).

In acute hospitals, the person may be discharged rapidly, so compliance with this item can also be via evidence of a clear plan for this review post discharge, (for example back at a hospital clinic, or a specialist service, or within the residential care unit)

As this is based on a GPP, not a recommendation, there is not the same detailed answering required that there was for this item for antipsychotics- so any plan for review at any time during or post admission is sufficient. If the person died, or there is another valid reason why the review was not applicable, mark "N/A".

Antidepressants

26. Indication for the antidepressant.
Based on Rec 17 and GPP 10. Options: See details. Exceptions: None.

Comorbid depression is the presence of depression in association with another health condition. In this case depression occurs along with the dementia, not just due to the dementia. It can also be pre-morbid, i.e. pre-dating the dementia onset.

Defining the 'degree' or 'severity' of depression i.e. if it is mild, moderate or severe, requires an extensive medical judgement that involves the number, type, and severity of the symptoms present.

Instructions: If no antidepressant was prescribed, proceed to item 29 (anticonvulsants). If prescribed, the antidepressant may have been prescribed for pain, which is not within the scope of the guideline, so proceed to item 29. **As pain is very common, it must be explicit that the antidepressant was prescribed for pain in order to be sure that pain was the indication.**

Otherwise (**26b**), there should be documented evidence within the notes **either** that the depression was severe (e.g**.** "major depression", "depression with somatic features", "severe depressive symptoms", "suicidal ideation", "nihilism)

OR that it was moderate **AND** hadn't responded to psychological treatment. Both of these need to be documented to be compliant. If it is documented that the depression is mild, then the prescribing of an antidepressant doesn't comply with the guideline.

OR that the PwD had severe non-cognitive symptoms (e.g. agitation, calling out, walking about). The word "severe" or a similar term needs to be documented.

27. *The risks and benefits of the antidepressant have been discussed with the PwD and/or their family/carer.*
Based on GPP2. Options: Yes or No or N/A **Exceptions:** None

Instructions: Please see question 9A for details around discussions. For antidepressants, relevant risks to be documented include dizziness, insomnia, headache, hyponatremia (low sodium), psychosis, "serotonin syndrome", etc. However, it is also sufficient to document more generally that risks were discussed, without the details of the risk.

28. *There is documentation of either a review a plan for review of the antidepressant*
Based on GPP3. Options: Yes or No or N/A **Exceptions:** None

Instructions: There should be documentation of a review of effectiveness and side effects within the notes. This documentation can be performed by a healthcare professional who is monitoring the PwD (nurse, doctor, psychologist, OT).
In acute hospitals, the person may be discharged rapidly, so compliance with this item can also be via evidence of a clear plan for this review post discharge, (for example back at a hospital clinic, or a specialist service, or within the residential care unit)
As this is based on a GPP, not a recommendation, there is not the same detailed answering required that there was for this item for antipsychotics- so any plan for review at any time during or post admission is sufficient. If the person died, or there is another valid reason why the review was not applicable, mark "N/A".

Anticonvulsants

29. If an anticonvulsant has been prescribed, a valid indication is for the treatment of seizures, pain or Bipolar Disorder.

Based on Rec 18. Options: Not prescribed; Yes with options **Exceptions:** End of Life

Seizures refers to activity in the brain that result in convulsions in which a person's body shakes rapidly and uncontrollably. Bipolar Disorder, formerly called manic depression, is a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression).

Instructions: Within the person's notes there should be clear explicit documentation that the anticonvulsant is used to treat a specific disease and not for the management of non-cognitive symptoms.
There should be documented evidence of:

- Seizures or epilepsy (prior to, during the admission or in the past)- including "non-convulsive seizures" or "status epilepticus". It does not have to specifically state that the anticonvulsant is to treat seizures- this can be implied if seizures or epilepsy are recorded.
- A diagnosis of Bipolar Disorder (may be written also as 'manic depression' or 'cyclothymic disorder'). It does not have to specifically state that the anticonvulsant is to treat this - this can be implied if the diagnosis is recorded.
- The antidepressant being prescribed for pain. **As pain is very common, it must be explicit that the antidepressant was prescribed for pain in order to be considered a valid indication.**

  If there is another indication recorded, or if the person is at end of life, enter the details in the box provided.

30. *The risks and benefits of the anticonvulsant medication have been discussed with the PwD and/or their family/carer.*

Based on GPP2. Options: Yes or No or N/A **Exceptions:** End of life.

Instructions: Please see question 9A for details around discussions. For anticonvulsants, relevant risks to be documented include sedation, dizziness, confusion, etc. However, it is also sufficient to document more generally that risks were discussed, without the details of the risk. If there is a valid reason why the discussion was not applicable (such as end of life care), mark "N/A".

31. *There is documentation of either a review or a plan for review of the anticonvulsant.*

Based on GPP3. Options: Yes or No or N/A **Exceptions:** End of life.

Instructions: There should be documentation of a review of effectiveness and side effects within the notes. This documentation can be performed by a healthcare professional who is monitoring the PwD (nurse, doctor, psychologist, OT).
In acute hospitals, the person may be discharged rapidly, so compliance with this item can also be via evidence of a clear plan for this review post discharge, (for example back at a hospital clinic, or a specialist service, or within the residential care unit)
As this is based on a GPP, not a recommendation, there is not the same detailed answering required that there was for this item for antipsychotics- so any plan for review at any time during or post admission is sufficient. If the person died, or there is another valid reason why the review was not applicable, mark "N/A".

Benzodiazepines/Z type hypnotics/ melatonin

32. If a benzodiazepine was prescribed, a valid indication is for the treatment of seizures or severe anxiety.
Based on Rec 19. Options: No or Yes with options **Exceptions:** End of Life

Instructions: Within the PwD's notes there should be clear explicit documentation that the PwD has **severe anxiety**. Anxiety is a feeling of unease, worry or fear, that can be mild, moderate or severe.
A valid exception is that the PwD has seizures. There should be documented evidence of: Seizures or epilepsy (prior to, during the admission or in the past)- including "non-convulsive seizures" or "status epilepticus". It does not have to specifically state that the anticonvulsant is to treat seizures- this can be implied if seizures or epilepsy are recorded.

33. If prescribed for severe anxiety, is there a documented maximum duration of treatment?
Based on Rec 19. Options: Yes or No or N/A **Exceptions:** End of Life

Instructions: The duration of treatment (in total or before review) should be clearly evident in the drug kardex. The maximum duration of usage is dependent on the medication used- it is only important that there is a duration recorded, not the actual value. If the person is at end of life, enter the details in the box provided.

33a. If prescribed for non-cognitive symptoms, is there a justification of why a benzodiazepine was chosen?
Based on Rec 19. Options: Yes or No or N/A **Exceptions:** End of Life

Instructions: Please record any justification given (eg previously responded well to benzodiazepine (or 'anxiolytic'); severe distress and intolerant of other medications, etc.). If the person is at end of life, enter the details in the box provided.

34. The risks and benefits of the medication have been discussed with the PwD and/or their family/decision supporter.
Based on GPP2. Options: Yes or No or N/A **Exceptions:** End of life; seizures.

Instructions: Please see question 9A for details around discussions. For benzodiazepines, relevant risks to be documented include sedation, falls, drowsiness, increased agitation, cognitive deterioration, etc. However, it is also sufficient to document more generally that risks were discussed, without the details of the risk. If there is a valid reason why the discussion was not applicable (such as end of life care), mark "N/A".

35/35a. If a Z type medication (or a benzodiazepine at night) is prescribed, is there evidence that a sleep regimen/care plan has been put in place prior to trial of the medication?

Based on Rec. 20. **Exceptions:** End of life; Specific sleep disorders*; Nocturnal seizures
A sleep regimen is a specific routine that is followed to promote good sleep (e.g. avoiding caffeine before bedtime, having a quiet, comfortable temperature bedroom, avoiding evening naps etc.), exposure to daylight, exercise and personalised activities.
Instructions: There should be a documented sleep management regimen in the notes outlining the time the person goes to sleep, daytime naps, if stimulants are to be avoided/used, fluid restrictions, etc. Please use the response options to indicate if this preceded the prescription by 0 or more nights. Options: Yes with options, or No or N/A
*Exceptions include documented specific sleep disorders where a **benzodiazepine** is indicated- eg REM (or Rapid Eye Movement) sleep disorder (also called RBD, or REM behavioural disorder) or night terrors.

36. Has melatonin been prescribed? If yes, is there a note to justify this use?

Based on Rec. 21 Options: Yes or No **No exceptions.**

Instructions: Please tick "yes" if there is a written justification and briefly record what was written.

Psychotropic medications licensed in Ireland: Generic name (example of Brand(s) name®) -classification *

Typical (first generation) antipsychotics are in italics

A

- Agomelatine (Valdoxan®) - **antidepressant**
- Alprazolam (e.g Gerax®, Xanax®) – **benzodiazepine**
- Amisulpiride (e.g. Solian®) – **atypical antipsychotic**
- Amitriptyline - **antidepressant**
- Aripiprazole (e.g. Abilify®)- **atypical antipsychotic**
- Asenapine (Sycrest®)- **atypical antipsychotic**

B

- Brivaracetam (Briviact®) - **anticonvulsant**
- Bromazepam (Lexotan®)- **benzodiazepine**

C

- Carbamazepine (Tegretol®)†- **anticonvulsant**
- Citalopram (e.g. Cipramil®, Citrol®, Ciprager®) - **antidepressant**
- Clobazam (Frisium®) - **benzodiazepine**
- Chlordiazepoxide (Librium®)- **benzodiazepine**
- *Chlorpromazine (Clonactil®)* **– *typical antipsychotic***
- Clomipramine (Anafranil®) **– antidepressant**
- Clonazepam (Rivotril®) **– benzodiazepine**
- Clozapine (e.g. Clozaril®) - **atypical antipsychotic**

D

- Diazepam (Anxicalm®) - **benzodiazepine**
- Donepezil (e.g. Aricept®, Donecept®, Donesyn®)- **acetyl cholinesterase inhibitor**
- Dosulepin (Prothiaden®) - **antidepressant**
- Duloxetine (e.g. Cymbalta®) – **antidepressant**

E

- Escitalopram (e.g. Lexapro®) – **antidepressant**
- Eslicarbazepine (Zebinix®) –

M

- Melatonin (Circadin®)[1] –**other hypnotic**
- Memantine (e.g. Ebixa®)
- Mirtazapine (e.g. Mirap®, Zispin®) – **antidepressant**
- Moclobemide (Manerix®) - **antidepressant**

N

- Nitrazepam (Mogadon®) - **benzodiazepine**

O

- Olanzapine (e.g. Zyprexa®) –**atypical antipsychotic**
- Oxcarbazepine (Trileptal®) - **anticonvulsant**

P

- Paliperidone (e.g. Invega®) – **atypical antipsychotic**
- Paroxetine (e.g. Parox®, Seroxat) – **antidepressant**
- Perampanel (Fycompa®) - **anticonvulant**
- Phenobarbital – **anticonvulsant**
- Phenytoin (Epanutin®) - **anticonvulsant**
- Prazepam (Centrax®)- **benzodiazepine**
- Pregabalin (e.g. Lyrica®)† - **anticonvulsant**
- Primidone (Mysoline®) - **anticonvulsant**

Q

- Quetiapine (e.g. Seroquel®)-**atypical antipsychotic**

R

- Reboxetine (Edronax®) **– antidepressant**
- Retigabine (Trobalt®) - **anticonvulsant**
- Risperidone (e.g. Rispeva®, Risperdal®) –**atypical antipsychotic**
- Rivastigmine (e.g. Exelon®)- **acetyl cholinesterase inhibitor**
- Rufinamide (Inovelon®) - **anticonvulsant**

anticonvulsant

- Ethosuximide (Zarontin®) - a**nticonvulsant**

F

- Fluoxetine (e.g. Fluzac®, Gerozac®, Prozac®)- **antidepressant**
- *Flupentixol (Depixol®) – **typical antipsychotic***
- Flurazepam (Dalmane®) - **benzodiazepine**
- Fluvoxamine (Faverin®) - **antidepressant**
- *Fluphenazine (Modecate®) – **typical antipsychotics***

G

- Gabapentin (e.g. Neurontin®**) - anticonvulsant**
- Galantamine (Reminyl®**)** – **acetyl cholinesterase inhibitor**

H

- *Haloperidol (Haldol®) **– typical antipsychotic***

I, J, K

L

- Lacosamide (Vimpat®) **- anticonvulsant**
- Lamotrigine (e.g. Lamictal®)† – **anticonvulsant**
- *Levomepromazine (Nozinan®) **– typical antipsychotic***
- Levetiracetam (e.g. Keppra®**)** – **anticonvulsant**
- Lofepramine (Gamanil®) - **antidepressant**
- Lorazepam (Ativan®) **– benzodiazepine**
- Lormetazepam (Noctamid®**) - benzodiazepine**
- Loxapine (Adasuve®) –**atypical antipsychotic**
- *Lurasidone (Latuda®**) –typical antipsychotic***

S

- Sertraline (e.g. Lustral®**,** Serlan ®)- **antidepressant**
- Sodium Valproate (Epilim®)† – **anticonvulsant**
- Sulpiride (Dolmatil®) – **atypical antipsychotic**

T

- Temazepam (Nortem®) - **benzodiazepine**
- Tiagabine (Gabitril®) - **anticonvulsant**
- Topiramate (Topamax®) **- anticonvulsant**
- Tranylcypramine (Parnate®)- antidepressant
- Trazodone (Molipaxin®) – **antidepressant**
- Triazolam (Halcion®) – **benzodiazepine**
- *Trifluoperazine (Stelazine®) – **typical antipsychotic***
- Trimipramine (Surmontil®) **- antidepressant**

U, V

- Venlafaxine (e.g. Efexor®, Ireven®, Venex®) –**antidepressant**
- Vigabatrin (Sabril®) - **anticonvulsant**
- Vortioxetine (Brintellix®**)** - **antidepressant**

W, Z

- Ziprasidone (Geodon®) – **atypical antipsychotic**
- Zolpidem (e.g. Stilnoct®**,** Zoldem®, Zolnod®) – **Z type medication**
- Zonisamide (Zonegran®) **- anticonvulsant**
- Zopiclone (e.g. Zileze®, Zopitan®, Zimovane®)- **Z type medication**
- *Zuclopentixol (Clopixol®) **– typical antipsychotic***

***This list is correct as of October 2018. It is not an exhaustive list. Further details of medicines licensed in Ireland are available on www.hpra.ie.**

† These anticonvulsants are also licensed for mood stabilisation- see individual SmPC for further information.

[1]As of October 2018, Circadin® 2mg Prolonged Release Tablet is the only melatonin medicine licensed in Ireland

Common antipsychotics and their typical starting/escalation doses in older people

Drug (common trade name)	Usual starting dose	Usual dose increase
Aripiprazole (e.g. Abilify®)	5mg OD	5mg per dose
Clozapine (e.g. Clozaril®)	12.5mg OD	12.5-25mg per dose
**Haloperidol (Haldol®)*	0.5-1mg BD/TDS or prn	0.5-1mg per dose
Olanzapine (e.g. Zyprexa®)	2.5-5mg OD	2.5-5mg per dose
Paliperidone (e.g. Invega®)	3mg OD	3mg per dose
Quetiapine (e.g. Seroquel®)	12.5-25mg BD	12.5-25mg per dose
Risperidone (e.g. Rispeva®, Risperdal®)	0.5mg BD	0.5mg per dose

**Haloperidol is the only 'typical' (first generation) antipsychotic in this list*

Glossary of Terms for Psychotropic Medications

Term	Definition
Psychotropic Medication	A medication capable of affecting the mind, emotions, and behaviour through an effect on the chemical makeup of the brain and nervous system.
Antipsychotics	A group of drugs that are used to treat serious mental health conditions such as psychosis and/or delusions as well as other emotional and mental health conditions.
Antidepressants	A drug used for the treatment of major depressive disorders and conditions, including dysthymia, social anxiety disorder, obsessive–compulsive disorder, chronic pain, agitation, generalized anxiety disorder, bipolar disorder, childhood enuresis (bedwetting), migraine and sleep disorders.
Antiepileptic/Anticonvulsant drugs	A diverse group of pharmacological agents used in the treatment of epileptic seizures.
Acetylcholinesterase Inhibitors (AChEI's)	An acetylcholinesterase inhibitor (often abbreviated to AChEI) or anti-cholinesterase is a drug that inhibits the acetylcholinesterase enzyme from breaking down acetylcholine, thereby increasing both the level and duration of action of the neurotransmitter acetylcholine. These are sometimes referred to as cognitive enhancing drugs. These can be termed cognitive enhancers also.
Memantine	A drug used to treat moderate to severe Alzheimer's disease through its act on the glutamatergic system by blocking NMDA receptors.
Benzodiazepines	A group of drugs sometimes referred to as minor tranquillisers, that can aid with anxiety or sleep problems (sometimes called benzos).
Z type drugs / hypnotics	A non-benzodiazepine drug with effects similar to benzodiazepines, used in the treatment of sleeping problems often termed hypnotics.