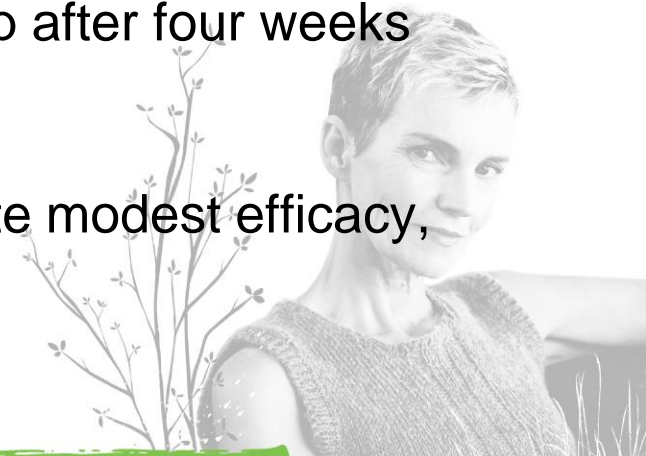


Management of Behavioral and Psychological Symptoms of Dementia (BPSD)



Background

- Ninety per cent of people with dementia will experience behavioural and psychological symptoms of dementia (BPSD)
- Staff need to develop skills in non pharmacological management of BPSD (Banerjee, 2009)
- NICE (2011) recommend psychosocial interactions as first line of approach and emphasize importance of assessing medical conditions and pain.
- There is value in monitoring. Most BPSD will stop after four weeks without pharmacological treatment.
- Pharmacological treatments often first line despite modest efficacy, problematic side effects



BPSD

Behavioural	Psychological
<p>Activity disturbances Agitation, Restlessness, Hyperactive, Wandering, Inappropriate activity, Cognitive abulia (lack of will or initiative)</p> <p>Aggression – Physical, Verbal</p> <p>Appetite and eating disorders</p> <p>Disturbed diurnal rhythms Wake/sleep disorder</p> <p>Sundowning</p> <p>Socially improper behaviours</p>	<p>Affective disturbances Agitation, Anxiety, Depressive symptoms, Major depression, Emotional lability</p> <p>Apathy</p> <p>Delusions and misidentification syndromes People are hiding or stealing things, Paranoid, Suspiciousness, Long time home is not home, Spouse/ caregiver is an impostor or unfaithful or has abandoned him/her, Dead relatives/ acquaintances are alive</p> <p>Hallucinations Visual, auditory, olfactory, touch</p>

(International Psychogeriatric Association, 2003)

There is often no quick fix!



Training focus – behaviour is often an attempt to communicate or meet unmet need/s



Challenging for whom?



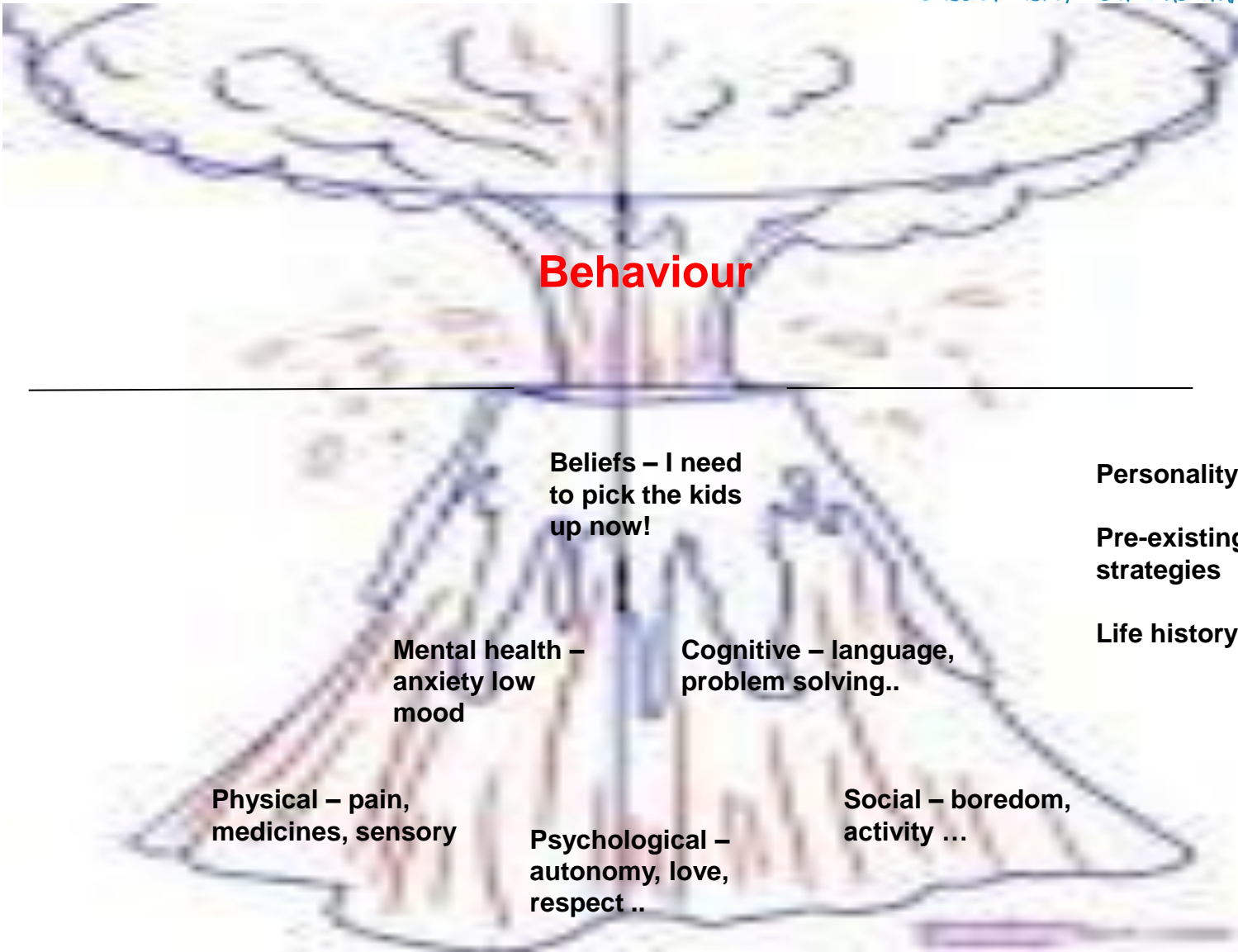
“social construct” what is challenging will differ between settings with some onlookers more tolerant than others

The person may be unaware there is a problem



Possible areas of unmet needs

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The moderating role of beliefs - how would you feel if.....

A stranger knocked on your door and told you it's time for a bath

You are desperate to collect your children from school but the people you are with won't let you go

Acknowledging the residents current reality and providing emotional support within this context is important



What should providers have in place?

- Adequate staff training (good evidence)
- Use of life stories e.g. “This is me” this can help to make sense of the here and now
- Opportunities for meaningful activity
- Consider the environment – signage, lighting etc.
- Functional analysis (ABC) might help is used consistently
- A willingness to engage in creative problem solving



Good evidence base

- Massage/touch
- Music therapy
- Physical activity/exercise
- Sensory stimulation



Specific needs to consider

- Depression
- Pain and physical health (Husebo et al BMJ 2011;343:d4065)
improved agitation in patients with moderate to severe dementia



Supporting carers at home

- Carer education (e.g. local Alzheimer's society groups, peer support)
- Identifying carers who may struggle to cope
- Get a break - respite /day services etc / SDS
- Common issues;

“he is doing it on purpose”

“go on you know the names of your children”

“don't be silly your mum died years ago” – different realities”

Assistive technology



The use of anti-psychotic medications

- Risk of harm to self or to others?
- What symptom/behaviour are you treating – use a system for monitoring
- Risks and benefits should be discussed with relatives and/or care staff
- Inform relatives and carers if the antipsychotic drug being prescribed is not licensed for the treatment of BPSD – record rationale for prescribing “off license”
- Set a review date: Don’t continue the drug if it is ineffective after a week’s trial. Not repeat prescription
- Assessment by mental health team if regular prescription required > 1 week
- Start with extremely low doses (refer to hand-out/relevant guidance)
- Consider reducing or stopping medication if appropriate after 3 months, at the latest
- Consider Lewy body dementia



Dementia- early diagnosis?



- Education/ information
- Future planning
- Co-morbid illnesses
- Access to services

benefits



- DoH 2009- improving care for people with dementia
- 2008-700 000 sufferers, cost £17billion.
- 2038-1.4 million, cost £50 billion
- Strategy lists 17 objectives

National Dementia Strategy.



- Consultation said most people believe they have a right to be told of diagnosis.
- Only one third have a diagnosis
- Raise awareness
- Good quality early diagnosis
- High quality specialist assessment

National Dementia Strategy



- Mrs A
- GP referral –family have noticed increasing memory impairment
- Phone calls about appointments
- Compliance with medication

Case study



- Subjectively feels little is wrong perhaps some short-term memory problems associated with “getting older”
- Diagnosed with mild dementia, Alzheimers disease
- Medication commenced and carers to supervise medication



- Tolerates medication
- Family feel she is more alert, more engaged in social conversation, more motivated
- Still remains fully independent in own home

Cont.



Older People's Mental Health Service

Assessment, screening and Presentation - Common Types of Dementia



Assessment of possible dementia

- Identify treatable causes e.g. delirium, depression and co-morbid conditions.
- **Why diagnose?** Establishing a diagnosis enables future planning/support and consideration of symptomatic pharmacological treatment.
- Three clinical features of dementia:
 - **Impairments in cognitive function** (memory, executive function, language , orientation, calculation, learning)
 - **Impairments in performing activities of daily living** (shopping, paperwork, washing, dressing and continence)
 - **Psychological or psychiatric features** (apathy, depression, aggression, hallucinations)

(Eastley and Wilcock, 2010)



Diagnosis guidelines

- Assessment should include:
 - History taking (Collateral information where possible)
 - Cognitive and mental examination e.g. (GPCOG)
 - Physical examination and other appropriate investigations
 - Review of medication that may adversely affect cognitive functioning
- Assessment is predominantly a human process



Screening instrument (GP-COG)

- Around 4 minutes to complete
- Scored out of 9 points
- Informant interview (2 minutes)
- Available in different languages

Scores

- A score of 0 to 4 out of 9 indicates cognitive impairment
- Scores between 5 and 8 out of 9, more information is needed (informant interview)
- A score of 9 indicates no significant cognitive impairment
- <http://www.gpcog.com.au/index.php> - functional website with online test, training video and print out of results
- Validated by RCGP



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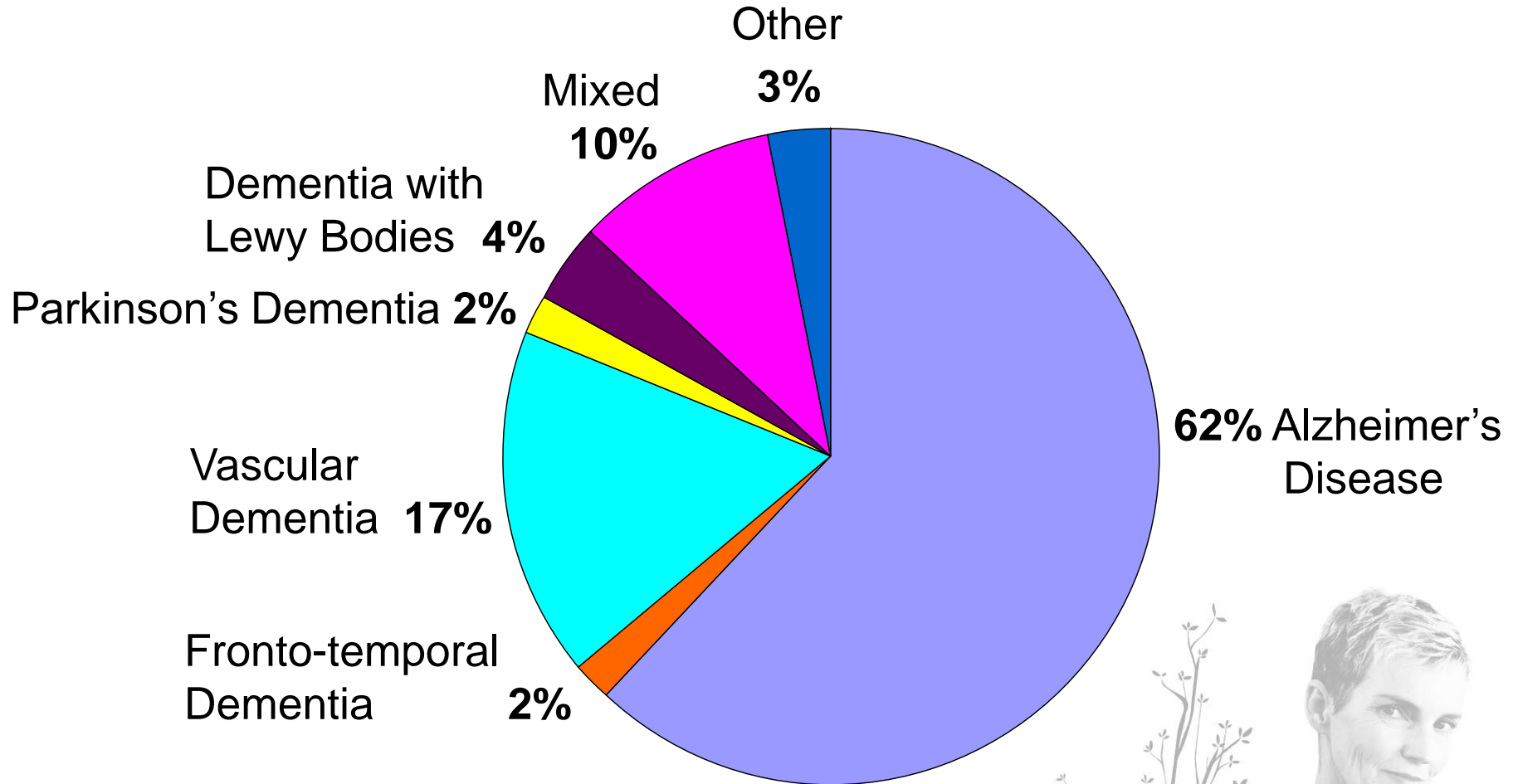


Apple, table, penny...

Interpretation

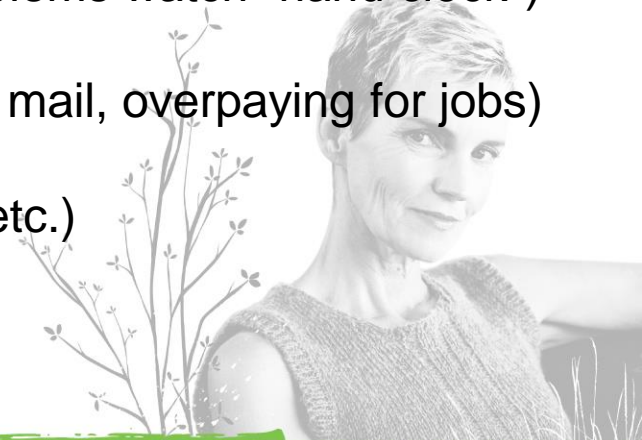


Types of dementia and their estimated frequency



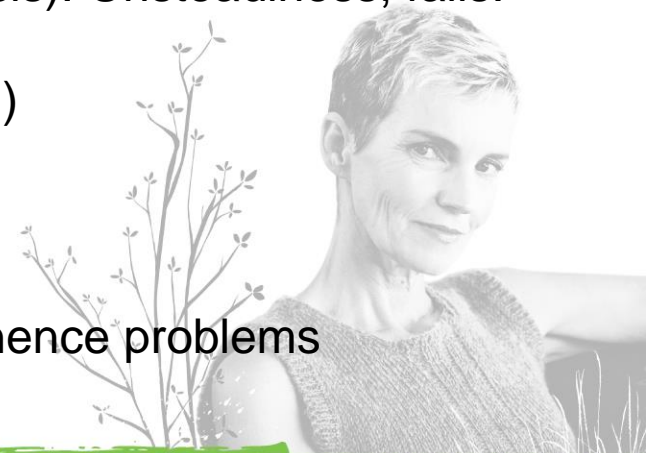
Possible indicators -AD

- Gradual or insidious onset
- Forgetting recently learned information (e.g. ask for same info over and over)
- Challenges in planning or problem solving (e.g. paying bills, following familiar recipe)
- Interference with day to day function (e.g. trouble with driving to a familiar location, withdrawal from hobbies & social activities)
- Confusion with time or place
- Trouble with speaking or writing (e.g. word finding problems watch “hand clock”)
- Decreased or poor judgement (e.g. responding to junk mail, overpaying for jobs)
- Change in mood or personality (e.g. anxious, worried etc.)



Possible indicators of Vascular dementia

- Onset may be sudden – step wise progression
- Evidence of a significant cerebrovascular disease
- Change in cognition (e.g. speed of thinking, concentration, periods of severe confusion) (some areas affected and others relatively spared)
- Change in ability to communicate (e.g. word finding problems)
- Possible depression/anxiety, personality change
- Symptoms of stroke (e.g. physical weakness or paralysis). Unsteadiness, falls.
- Memory problems (although possibly not first symptom)
- Seizures
- Possible hallucinations, behaviour change, early continence problems



Dementia with Lewy bodies – differential diagnosis

- Prominent or persistent memory impairment, not necessarily in early stages but evident with progression.
- Deficits on tests of attention, frontal sub-cortical skills and visuospatial ability.
- Fluctuating cognition with pronounced variations in alertness and attention.
- Recurrent visual hallucinations
- Spontaneous motor features of Parkinsonism.
- Repeated falls
- Neuroleptic sensitivity



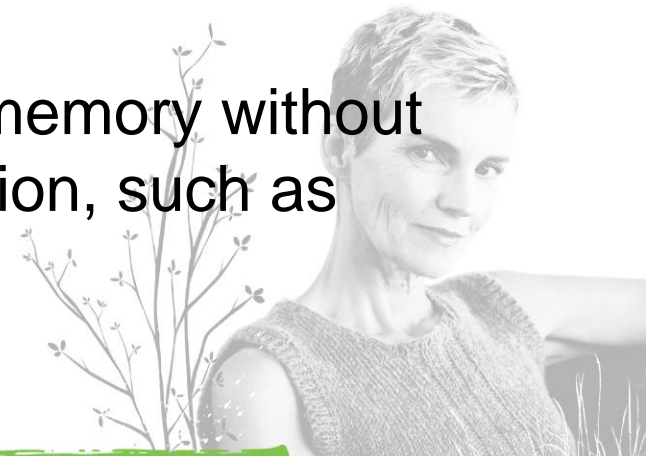
Fronto-temporal dementias—differential diagnosis

- Insidious onset and gradual progression
- Memory function is typically impaired in AD but well preserved in FTD
- Early loss of personal awareness – lack of washing and grooming
- Early loss of social awareness – lack of social tact
- Early signs of disinhibition – unrestrained sexuality, violent behaviour
- Mental rigidity and inflexibility
- Hyperorality
- Early loss of insight



Mild cognitive impairment

- Mild cognitive impairment (MCI) relatively recent term
- MCI is a descriptive term rather than a specific medical condition or disease
- Describes people who have some problems with their memory but do not actually have dementia.
- People with MCI usually have impaired memory without impairments in other areas of brain function, such as planning or attention

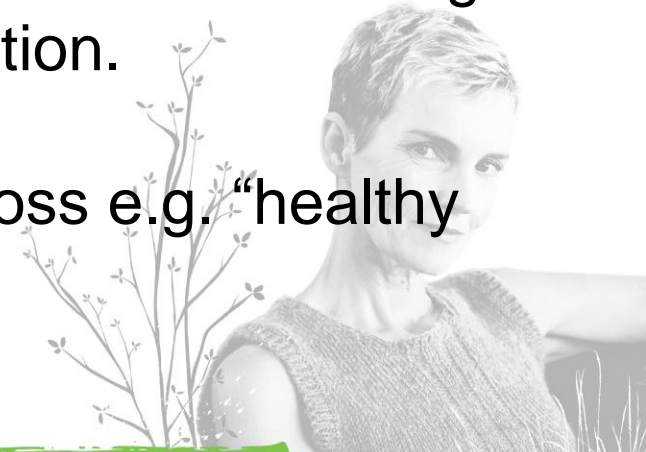


- Those with MCI have no significant problems in everyday living.
- It describes memory loss apparent to the individual, and those around them
- Memory loss is supported by formal memory tests, but other features of dementia are absent
- Stable phase ends with a detectable decline in cognitive function – progression of symptoms with interference with social and work activities (BPSD predicts conversion from MCI to AD)



Potential benefits of identifying MCI

- Some controversy but important to exclude reversible causes
- May aid early diagnosis of Alzheimer's Disease leading to early treatment
- Management at this point may improve outcome including quality of life and delaying institutionalisation.
- Interventions to help cope with memory loss e.g. "healthy memories group"



How many people with MCI develop dementia?

- Increased risk of going on to develop Alzheimer's disease (or another form of dementia)
- Memory clinic studies, 10-15 per cent of people with MCI went on to develop dementia in each year that the research results were followed up.
- In community studies and clinical trials the rates are about half this level, but still represent a significantly increased level of risk.



Risk Factors

- Research suggests that lifestyle can have an effect on risk of developing dementia
- Low level of physical activity has been shown to be associated with an increased risk
- Other studies have shown that physical exercise, travelling, doing odd jobs, knitting and doing crossword puzzles are all associated with a reduced risk
- Leisure activities may well help the brain to retain a reserve capacity that can delay the onset of dementia



Pharmacological Intervention for the Cognitive Symptoms of Alzheimer's Disease



Physical health check
Pain – link to BPSD

Carer needs Assessment
Respite Info

Mental health depression
BPSD

Risk issues
Self/others
Driving

QOF dem 2 compliant
System one template
Carer questionnaire
embedded links to key documents

Medication Inc.
Antipsychotic?
Memory tablets?

Communication and coordination arrangements

Advanced decisions
LPA,
advanced care plan

Social care needs



Updated NICE Guidance - March 2011

- The Acetyl cholinesterase inhibitors now recommended as options for managing mild as well as moderate Alzheimer's disease, **and**
- Memantine is now recommended as an option for managing moderate AD for people who cannot take acetyl cholinesterase (AChE) inhibitors, and as an option for managing severe AD.
- Only specialist should suggest initiation of treatment



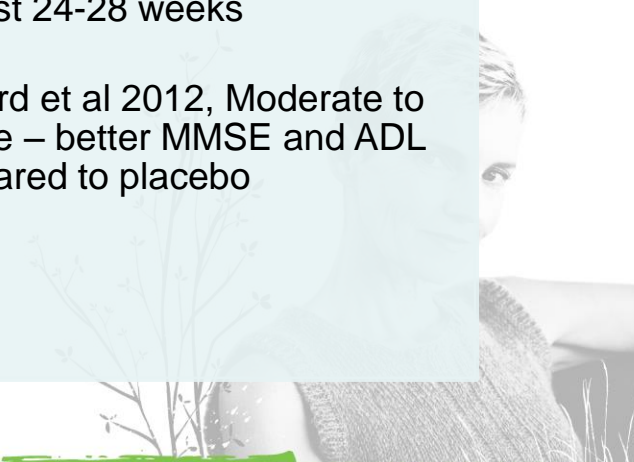
Summary of Evidence

Alzheimer's disease

- Improved cognition for at least 24-26 weeks
- ADL & functional improvements for at least 24-26 weeks
- Limited evidence re impact on BPSD
- Very limited evidence re Quality of life & delayed institutionalisation
- Clinicians blind to other measures, rated global clinical state more positively in treated patients
- Howard et al 2012, mod/severe dementia better MMSE and ADL scores compared with those without (52weeks)

Memantine

- Cognitive benefits for at least 12 wks.
- Some evidence for functional benefits at 24 weeks
- Mixed evidence re impact on behavioural symptoms
- Benefits on global outcomes for at least 24-28 weeks
- Howard et al 2012, Moderate to severe – better MMSE and ADL compared to placebo



Shared care guideline –Treatment of Alzheimer’s disease

Key steps for GPs

These steps assume GP monitoring of general health and wellbeing

Only for patients no longer receiving secondary mental health care support

If patient’s mental health needs have changed significantly, consider re-referral

- Treatment is commenced by a specialist (indicated for mild to moderate Alzheimer’s disease)
- Around 3 months transfer of care to GP
- Sufficient written guidance to enable “clinical responsibility” e.g. dosage issues, advice re follow up (e.g. use of cognitive screening tool etc)
- GP to ensure regular assessment (6 monthly advised) treatment appropriate and necessary? Carers views should be sought

(please refer to full guidance – this does not replace)



When to consider stopping treatment?

- **Nice 2011 – “treatment should be continued only when it is considered to be having a worthwhile effect on cognition, global, functional or behavioural symptoms”**



Summary of drugs for dementia

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- Donepezil, Galantamine & Rivastigmine are all reversible inhibitors of acetylcholinesterase. Galantamine also has nicotinic receptor antagonist properties.
- Memantine is a glutamate receptor antagonist
- “ Slight variations in the mode of action of the three cholinesterase inhibitors no evidence of any differences between them with respect to efficacy” (Birks, 2012) (patients with mild/mod AD)
- Common side effects for Donepezil, Galantamine & Rivastigmine include nausea, vomiting, diarrhoea, dizziness and headaches (Usually these symptoms pass quickly)
- Memantine – constipation, hypertension, dyspnoea, headache, dizziness and drowsiness
- Available in various preparations



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Older People's Mental Health Service

The silver standard service



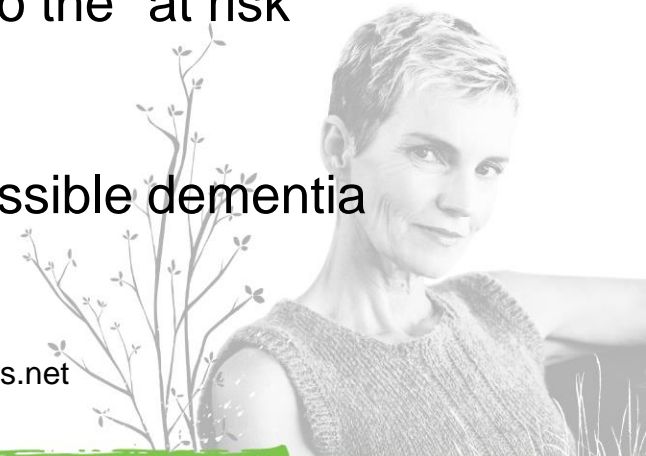
Mental state examination

- Assessment should include:
 - History taking (Collateral information where possible)
 - Cognitive and mental examination e.g. (GPCOG)
 - Physical examination and other appropriate investigations
 - Review of medication that may adversely affect cognitive functioning

Identify and treat reversible causes e.g. delirium, depression and co-morbid conditions.

Opportunistic – dementia case finding/screening to the "at risk" population (See DES guidance)

Timely referral to the memory clinic if probable/possible dementia suspected



Post diagnosis

Cambridgeshire and Peterborough



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- Complete thorough annual review for the individual and carer
- Make available/use key local/national dementia information and service based resources
- Support means of autonomous decision making/future planning LPA, preferred priorities of care, driving etc.
- Encourage the use of non pharmacological interventions in BPSD, are providers sufficiently trained in dementia care your influence might help?
- Be SOVA aware for persons with dementia
- Routinely consider end of life care issues for relevant individuals (e.g. as part of the annual review of patients living in a care home with moderate/severe dementia)



Physical health check
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Social care needs





Don

You are here [Home](#) > [About dementia](#)[Home](#)

About dementia

[About dementia](#)[What is dementia?](#)[A-Z of dementia](#)[Factsheets](#)[Symptoms and diagnosis](#)[Living with dementia](#)[Caring for a person with dementia](#)[Local information](#)

The term 'dementia' describes a set of [symptoms](#) that include memory, mood changes, and problems with communication and reasoning. There are many [types of dementia](#). The most common are [Alzheimer's disease](#) and [vascular dementia](#). Dementia is a progressive condition which means the symptoms will gradually get worse.

Find out about how dementia is [diagnosed](#). We also have [resources on dementia](#).

> [Take a look at our infographic representing the key d](#)



End of life checklist

Dementia

Cambridgeshire and Peterborough



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Routine

- Advanced care plan?
- Annual review: Prognostic indicator Guide?
- Behavioural pain assessment (if indicated)

End of Life

- Allow a Natural death (DNAR)
- Remain in the Care Home (RICH) Plan
- End of Life pathway
- Behavioural pain assessment

Templates available from:
<http://www.dementia.jennerhealthcentre.co.uk/>



Older People's Mental Health Service

Mental Capacity and Dementia

CAMTED-OP



Mental Capacity Act 2005

- The Mental Capacity Act 2005 provides a comprehensive framework for decision making on behalf of adults aged 16 or over who lack capacity to make decisions on their own behalf.
- Impairments which occur as the result of dementia may mean that mental capacity can fluctuate in people with the syndrome.



- Operates to empower people to make decisions for themselves wherever possible
- Aimed to protect incapacitous adults
- Code of Practice (2007) enshrines these principles
- Best interests and least restrictive measures
- Introduction of MCA Deprivation of Liberty Safeguards (MCA DoLS, 2009) was in response to the 2004 European Court of Human Rights judgment (the “Bournewood judgment”)



What is Mental Capacity?

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- Mental Capacity is the ability to make a decision
- Capacity can vary over time
- Capacity can vary according to the decision being taken
- Physical conditions, such as location can affect a person's capacity



The Five Core Principles

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable (doable) steps to help them to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- An act done, or decision made under this Act for or on behalf of a person who lacks capacity must be done, or made , in their best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.



How to Assess Capacity - General

The two-stage test of capacity

- Is there an impairment of, or disturbance in the functioning of the person's mind or brain?
- If so, is the impairment or disturbance sufficient to cause the person to be unable to make that particular decision at the relevant time?

Records should be kept of any assessment



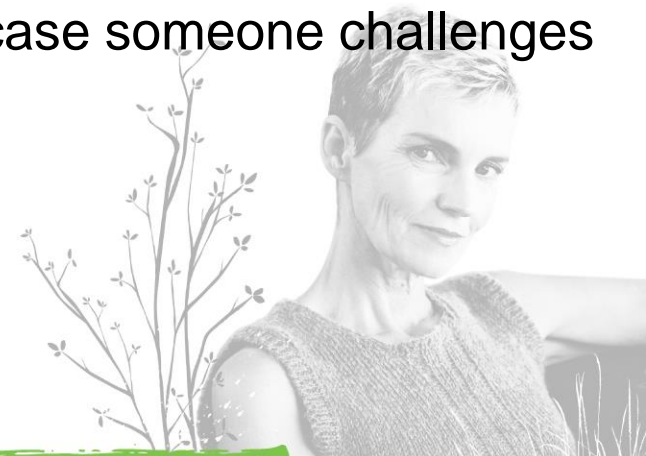
Assessing ability to make a decision

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?
- Can the person communicate their decision (by talking, using sign language or any other means)



Establishing donor's capacity in relation to LPA

- Suggested topics to discuss with donor
 - What is your understanding of an LPA?
 - Who have you chosen to be your attorneys?
 - Why them?
 - What powers are you giving them?
 - In what circumstances should the power be used by your attorneys?
 - Do you know when you could cancel the LPA
- It is advisable to keep a record of the questions in case someone challenges the donor's capacity to make an LPA.



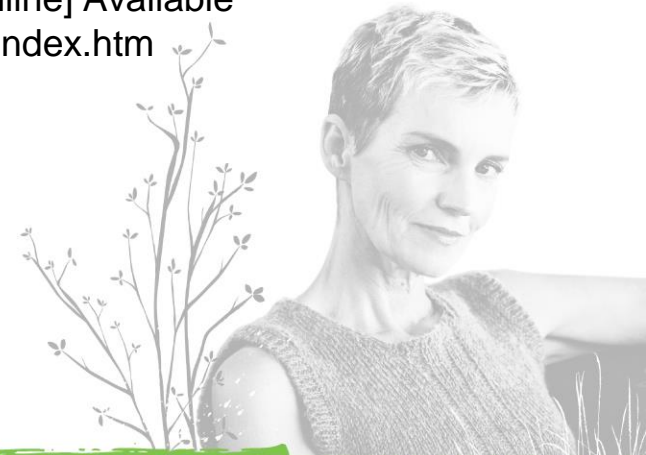
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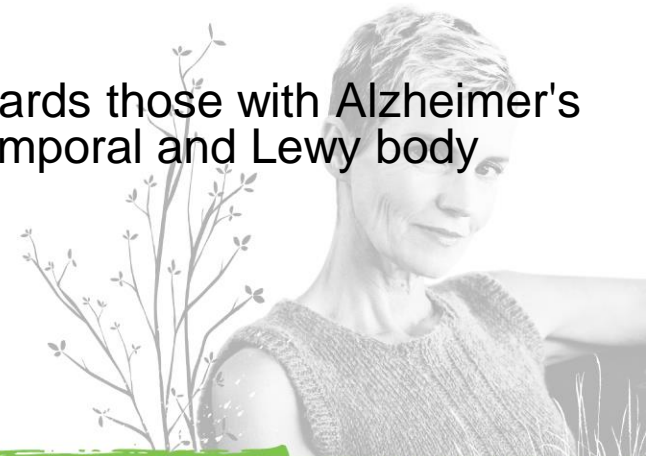


Driving and Dementia

CAMTED-OP



- The ability to drive is important in preserving the independence of older (Alzheimer's Society, 2011).
- Progression and presentation of the disease is very individual and therefore it can be difficult to assess at what point a person with dementia becomes unfit to drive.
- The risk of drivers with dementia having a road traffic accident increases significantly with disease progression (Breen *et al.*, 2007).
- When a person is first diagnosed they may be able to continue driving for sometime providing they fulfil certain legal requirements. (Alzheimer's Society, 2011)
- Current research evidence samples may be biased towards those with Alzheimer's disease, different considerations in Vascular, Frontal temporal and Lewy body dementias. (Martin *et al.*, 2011)



Self report/informant

- Self rating probably not useful
- Self reported avoidance may be a useful indicator
- Carer rating probably useful (may be positively or negatively biased)

Cognitive and neuro-psychological testing

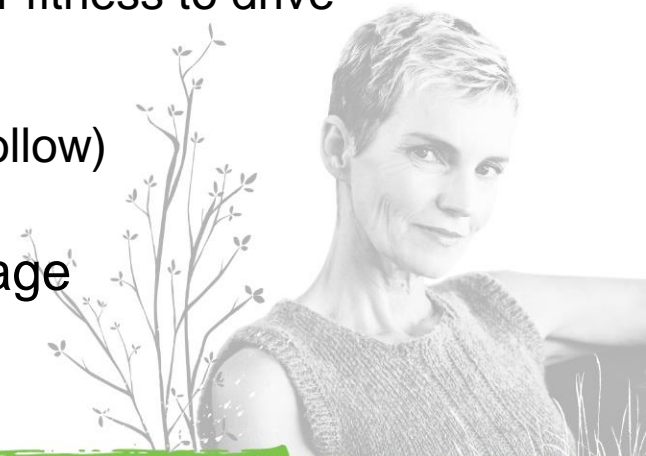
- MMSE alone probably not useful “ Cognitive abilities of particular relevance to driving are executive skills, frontal lobe function and ability to plan in new situations” (DVLA Advisory panel 2012)
- No standard battery of tests presently recommended for fitness to drive

On road driving assessment /simulator (info to follow)

Possible Behavioural indicators – reduced mileage

Aggressive or impulsive behaviour

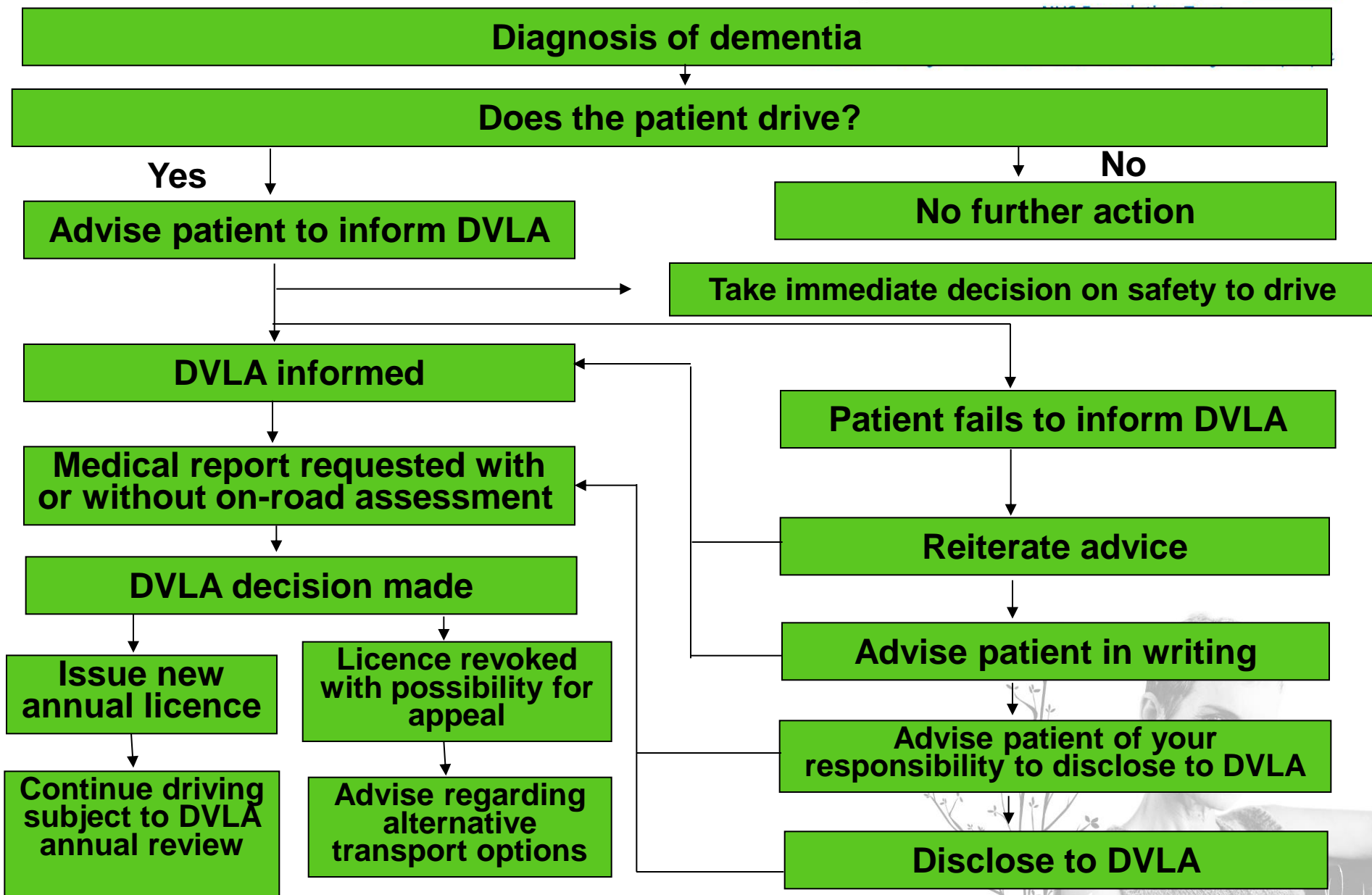
(Iverson et al, 2010)



Medical Fitness to Drive

- The DVLA has legal responsibility of deciding on medical fitness.
- It is the responsibility of the driver with dementia to inform both the DVLA and their insurance company about their condition. Failure to inform the DVLA can result in a £1000 fine and failure to inform insurance companies can render policies invalid (Directgov, 2011; Alzheimer's Society 2011).
- The GMC expects that physicians who are treating people with dementia should not only advise their patients of the possibility of stopping driving, but also ensure that the relevant authorities are informed of breaches of regulation if there is reasonable concern regarding public safety (GMC, 2009).





Driving Assessments

- There are 17 driving mobility assessment centres throughout the country who are recognised by the DVLA and conduct driving assessments for people with medical conditions (Mobility Centre, 2011).
- The driving assessment centre in East Anglia is in Thetford with satellite centres at Spalding and Colchester. Driving assessments cost £90 plus VAT (unless qualifying for an exemption).
- The assessment will include investigation of cognitive abilities, reaction speeds, vision, steering ability and braking strength. A comprehensive report is sent to the client (East Anglian Drive Ability, 2011).



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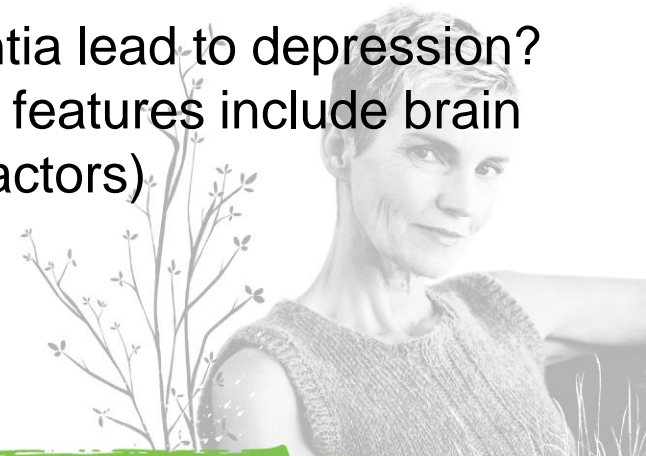
Depression and Dementia



Depression in Dementia

- Dementia and depression are independent psychiatric conditions with similar pathologies and symptoms that can occur concurrently
- One-third of persons with dementia may have depressive symptoms (3 or 4 times higher than non demented older persons)

Does depression lead to dementia or does dementia lead to depression?
(not a causal relationship but underlying shared features include brain chemistry, lifestyle and social factors)



- Depression in persons living with dementia is often under diagnosed especially in care homes
 - Diagnostic challenges are caused by;
 - overlapping symptoms
 - communication problems
 - lack of insight
- Concomitant BPSD are very likely - Irritability, agitation, and anxiety are strongly related



Depression	Possible Overlapping areas	Dementia
Sub acute (weeks)	Sleep disturbances	Gradual (months to years)
Sub acute Change in appetite	Change in eating behaviour	Gradual
Sub acute Frequently: pervasively sad mood/less reactive Occasionally: guilt, hopelessness and self harm	Decreased initiative and interest	Gradual Less likely: sadness, tearfulness Increased reactivity (may still enjoy activities)
Often worse in the morning Generally accompanied by other depressive symptoms	Psychomotor agitation	Gradual Generally worse in the latter part of the day (sun downing) Much worse in unfamiliar surroundings
Sub acute loss Often indecisive and concerned with making mistakes	Concentration and thinking	Normal in early dementia but impaired in late dementia
Thoughts of self harm more common		Thoughts of self harm less common



Depression	Possible Overlapping areas	Dementia
<p>Has self-awareness; notices or worries about memory</p>		<p>Appears unaware or indifferent about memory</p>
<p>Slow language and motor skills but not impaired</p>		<p>Writing, speaking and motor skills are impaired</p>
<p>Maintains perspective - understands times, dates, and surrounding</p>		<p>Can become lost easily and looks disorientated</p>
<p>Can remember things when prompted</p>		<p>Difficulty with learning new things and recent recall</p>
		<p>Frontal symptoms e.g. disinhibition, perseveration and decreased initiative</p>



Screening of depression in dementia

- The Geriatric Depression Scale (GDS) is a commonly used screening tool (30, 15, and 5 items)
 - requires self reporting
 - conflicting evidence for use with people living with dementia
 - considered to be a valid and reliable for self-report in older adults with mild to moderate dementia (Lach et al, 2010)

Later stages

Cornell Scale for Depression in Dementia, comprehensive incorporating two semi structured interviews (informant and patient)
Specifically designed but takes time and needs a close informant.



Assessment of differential diagnosis

- Careful symptom history including:
 - detailed description
 - time course and progression
 - confounding factors: pain, nutritional status, medical problems and medication changes

Collateral Information from family or carers, history of mood disorders
(family or personal)



Treatment options

- In less severe cases non-pharmacological approaches can be effective
- In the early stages of dementia, CBT may be appropriate either individually or in groups
- Access to meaningful activities (boredom and lack of occupation can be very high especially in care settings)
- Access to tailored interventions such as reminiscence therapy, multisensory stimulation, animal-assisted therapy and exercise may help



- Severe clinically significant depression should be treated with antidepressant medication.
- Antidepressant drugs with anti-cholinergic effects should be avoided because they may adversely affect Cognition
- Current evidence supports the use of serotonin-reuptake inhibitors in people with dementia and depression while tricyclic antidepressants should be avoided (be mindful that SSRI's can increase the risk of falls).



Older People's Services

Treatment of Delirium – primary care version



Development of Delirium – Risk factors

- > 75 years old
- Pre existing cognitive impairment, dementia or history of previous delirium
- Has severe illness including hip fracture

Identification of delirium

- Duration of confusion (very helpful in dementia versus delirium question) - CAM assessment tool may be helpful
- Features – “acute onset and fluctuating course”

Cognition	Poor concentration, slow responses, confused speech
Perception	Hallucinations, paranoia
Activity	Hyperactivity - restlessness, wandering, falls risk Hypoactivity - reduced mobility, drowsy, appetite
Social Behaviour	< cooperation, altered mood, < communication

Initial management

- Drugs or drug withdrawal
- Infection
- Electrolyte disturbance
- Pain
- Urinary retention
- Constipation

Note: often more than one cause

Ensure use of non-pharmacological strategies – calm, safe, clear communication, food, fluid, sleep, This is me etc. etc.

Pharmacological management

Last resort: might be necessary if risk to self or others or resident highly agitated

- Use only one drug
- Start at lowest possible dose (age, size, sex and level of distress) – increase in increments if necessary
- Maintain effective dose for 48hrs then taper and stop whilst monitoring for reoccurrence of symptoms
- Treatment should be reviewed at least every 24hrs

Note: issues with antipsychotic medications and Lewy body dementia



Possible options for severe symptoms of delirium

Drug	Oral dose	Max dose in 24hrs	Notes
Haloperidol Or	0.5mg	3mg	EPSE common and increased if > 3mg in 24hrs Can continue with Haloperidol 0.5 – 1.0mg per day for 48hrs (in single or divided doses)
Risperidone Or	0.5mg	3mg	Orodispersible tablets available Can continue with risperidone 0.5- 1.0 mg per day for 48hrs (in divided doses)
Olanzapine Or	2.5mg	15mg	Orodispersible tablets available Can continue with Olanzapine 2.5mg-5mg per day for 48hrs (in single or divided doses)
Second line	For patients with	Parkinson's disease / DLB	Benzodiazepine withdrawal/cardiomyopathy Severe heart failure Cardiac arrhythmias
Lorazepam	0.5mg	3mg	May cause respiratory suppression Can be given sublingually Can continue with Lorazepam 1mg per day for 48hrs (single or divided doses)

Additional considerations

- **Mental capacity** – patients with capacity must consent to treatment. Must assume capacity unless specific evidence to suggest otherwise
- Capacity assessment and documentation must be completed
- It may be that pharmacological intervention is in the persons best interests provided it is the least restrictive option available – **it should not** be influenced by staffing numbers or skills mix
- **Deprivation of liberty** – where a patient expresses a wish to leave a clinical area either verbally or physically, sedation to prevent this action could amount to deprivation of liberty. Appropriate authorisation should be sought