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| ***Medication reviews*** |
| **Is there a trigger for a medication review?**  |
|  | **The medication review is triggered by:** |
| [ ]   | a significant event (e.g. cardiovascular event, fall, fracture, hospital admission, residential care facility admission) |
| [ ]   | increasing frailty |
| [ ]   | resistance to taking medications |
| [ ]   | belief taking medications is a burden |
| [ ]   | writing a new prescription for the medication |
| [ ]   | decline in cognitive function |
| [ ]   | decline in ability to manage activities of daily living |
| [ ]   | regular use of five or more medications |
|  | **When reviewing medications use for people living with dementia, health professionals should check that each medication is:** |
| [ ]   | underpinned by a current, valid indication |
| [ ]   | effective for that individual |
| [ ]   | consistent with individual’s care goals |
| [ ]   | documented with a time frame to review |
|  | Medicines reviewed and are consistent with these criteria:      Medicines reviewed and are not consistent with these criteria:      |
| ***Principles of medication use*** |
|  | **When prescribing for people living with dementia, health professionals should:** |
| [ ]   | provide a current medication list that includes indications, administration instructions, and planned dates for review |
| [ ]   | regularly monitor for actual benefit of each medication |
| [ ]   | regularly monitor for actual side effects |
| [ ]   | start new medications at the lowest therapeutic dose |
| [ ]   | review doses frequently to see if a lower dose would be adequate |
| [ ]   | change only one medication at a time |
| [ ]   | assess impact of dementia on activities of daily living |
| ***Treatment Goals*** |
| [ ]   | An important treatment goal for people living with dementia is to simplify the medication regimen. |
| [ ]   | The wishes and needs of family and carers should not take priority over those of the person living with dementia. |
| [ ]   | It is not acceptable to conceal medications in food or drink if the person with dementia refuses them. |
|  | **Health professionals and the person living with dementia should discuss and document:** |
| [ ]   | treatment goals |
| [ ]   | likely prognosis |
| [ ]   | writing an advance care directive to indicate their wishes for treatment in specific future scenarios |
| [ ]   | using a dose administration aid to support medication use |
|  | **Health professionals and the carer or family of the person living with dementia should discuss and document:** |
| [ ]   | treatment goals |
| [ ]   | likely prognosis |
| [ ]   | document wishes for treatment in specific future scenarios |
| ***Medication side effects*** |
|  | **Consider side effects as people living with dementia are:** |
| [ ]   | at higher risk of side effects than cognitively-intact people |
| [ ]   | often unable to recognise and/or report side effects from their medications |

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| ***Preventative medication*** |
| [ ]   | **When prescribing medications intended to modify the risk of a future event for a person living with dementia, health professionals should consider:** |
| [ ]   | functionality as the most important factor |
| [ ]   | the potential benefits weighed against the actual harm |
| [ ]   | potential for side effects |
| [ ]   | actual side effects |
| [ ]   | the risks of polypharmacy |
| [ ]   | the administration burden |
| [ ]   | maximise quality of life rather than prolong survival |
| [ ]   | continue annual influenza vaccines indefinitely |
| [ ]   | continuing antihypertensive agents though use less stringent targets for blood pressure  |
| [ ]   | use less stringent targets for blood glucose |
| [ ]   | cease lipid-lowering medications |
| [ ]   | cease medications that have a longer potential time to benefit than the person’s likely prognosis |
| [ ]   | consider continuing medications to manage osteoporosis |
| ***Symptom management*** |
| [ ]   | trialled for withdrawal every three to six months if the symptoms are stable |
| [ ]   | reviewed regularly for efficacy  |
| [ ]   | reviewed regularly for side effects |
| [ ]   | review doses frequently to see if symptoms can be adequately maintained on a lower dose |
| [ ]   | maximised to alleviate distress |
| [ ]   | regular medications intended only to provide symptom relief should not be continued indefinitely even in people who are unable to reliably report symptom recurrence |
| ***Psychoactive medications*** |
| [ ]   | use non-pharmacological strategies in preference to medications |
| [ ]   | long acting benzodiazepines are not useful |
| [ ]   | benzodiazepines should not generally be used, but |
| [ ]   | short acting benzodiazepines can be useful for managing acute agitation provided use is monitored |
| [ ]   | antipsychotics can be useful when prescribed at a low dose for a limited period to alleviate distressing neuropsychiatric symptoms |
| [ ]   | antipsychotics should be considered if distressing behavioural symptoms are not responsive to other management strategies |
| [ ]   | tricyclic antidepressants have a limited role, but |
| [ ]   | tricyclic antidepressants may be useful in managing refractory neuropathic pain |
| ***Medications to modify dementia progression*** |
| [ ]   | consider a trial of an anticholinesterase inhibitor |
| [ ]   | consider a trial of memantine |
| [ ]   | review dementia treatments with respect to desired benefits and actual side effects (i.e. memantine, anticholinesterases) |
| [ ]   | maximise cognitive function by reducing exposure to medications with sedative and anticholinergic properties |