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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 |