Effective Shared Care Agreement (ESCA)

Anti-dementia Treatments (donepezil, rivastigmine, galantamine, memantine)

AREAS OF RESPONSIBILITY FOR THE SHARING OF CARE

This shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of anti-dementia treatments can be shared between the specialist and general practitioner (GP). This agreement covers all single anti-dementia treatments.

You are **invited** to participate; however, if you do not feel confident to undertake this role, then you are under no obligation to do so. In such an event, the total clinical responsibility for the patient for the diagnosed condition remains with the specialist. In this case, please complete a decline to prescribe form and return to the specialist Trust. In such cases, the treatment should be added to the patient's prescription record, in line with the practice process, stating it will be supplied by the specialist mental health service for information and safety purposes. This may also be done prior to the transfer of prescribing during initiation and stabilisation.

Sharing of care assumes communication between the specialist, GP and patient. The intention to invite the GP to share care will be explained to the patient by the specialist initiating treatment. It is important that patients are consulted about treatment and are in agreement with it.

The doctor who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.

RESPONSIBILITIES and ROLES

Specialist responsibilities
1. When diagnosis of Alzheimer's disease is confirmed and drug treatment considered, assess the likelihood of patient/carer compliance.
2. Counsel patients and carers as to the likely benefits and risks of treatment, including the consequence of poor compliance and the limited effectiveness of treatment.
3. Clearly document all mental capacity assessments/power of attorney in patient notes.
4. Where appropriate, offer an initial trial period of treatment of up to six months with anti-dementia medication, normally donepezil, and assess response during and at the end of the trial period. The dose should be titrated according to the response and tolerance.
5. Provide the GP with information relating to the initial memory clinical assessment.
6. When a requisite response has been achieved at a dose commensurate with patient tolerability (usually six months), the transfer of prescribing and suitable on-going monitoring to the GP can be considered. At this point provide the GP with a. progress with treatment with anti-dementia treatment after six months of treatment b. details of the drug and dose c. initial response to treatment, including the patient's tolerance of the medication d. initial qualitative carer reports e. confirmation that the dose is stabilised f. a signed copy of the ESCA, with specialist contact details, patient details and medication details completed g. any other relevant information, for example, frequency of follow up if different to annually .
7. Assess and manage any behavioural/psychological difficulties experienced by the patient, and any other adverse event reported by the GP relating to the treatment of the condition. Provide the GP with information about any changes in management following the assessment.
8. Review the patient promptly if further mental health input is warranted, e.g. behavioural disturbances / deterioration in cognitive function or discontinuation of treatment. Communicate information on reassessments to the GP after each clinic visit.
9. On discontinuing/adjusting treatment, consider re-starting/switching treatment if the patient experiences a dramatic deterioration of cognitive function or unacceptable side effects. Inform the GP and the patient/carer of the rationale.
10. Ensure the patient is reviewed at least annually. Following the review send: a. A letter detailing the current drug, dose and frequency and whether treatment should be continued. b. Notification of any failure to attend after each specialist appointment and confirmation that this has been followed-up with the patient and/or carer as appropriate c. If medication is not to be continued then outline the reasons and next steps for the treatment of dementia.

General Practitioner responsibilities
1. Once a patient has been adequately stabilised on anti-dementia treatments and shown to benefit from drug treatment, usually after six months, consider accepting prescribing responsibility for the relevant treatment in agreement with the specialist.
2. Monitor patient's overall health and wellbeing, including weight, at annual dementia care-plan reviews and during the normal consultation process. Inform the specialist if there is any significant deterioration in mental state or physical health which requires further investigation or if life situation changes which may require re-evaluation on the suitability of acetylcholinesterase inhibitors or memantine for the patient.
3. Undertake minor dosage adjustments in accordance with specialist advice.
4. Check the patient's pulse and check for any signs of dizziness/syncope as per SPC e.g. at annual care plan review or sooner if signs/symptoms of effects on heart rate reported. See page 3 for more information on side-effects of medication and Appendix 1 if syncope is suspected.
5. In the patient's notes, using the appropriate Read Code listed below, denote that the patient is receiving treatment under a shared care agreement.

GP Prescribing System	Read Code	Description		GP Prescribing System	Read Code	Description
EMIS and Vision	8BM5.00	Shared care prescribing		SystmOne	XaB58	Shared care

6. Check for possible drug interactions when prescribing new medication or stopping concurrent medication.
7. Refer the patient back to the specialist service if discontinuation of treatment is being considered or if lack of compliance with treatment is suspected which cannot be dealt with by other means (e.g. compliance aid).
8. On discontinuation/amendment of treatment by secondary care refer back to a specialist clinician if the patient is observed to experience a dramatic deterioration in cognitive function that gives rise to concern.
9. Report suspected serious or unusual adverse drug reactions to the Yellow Card scheme.
10. Stop treatment on advice of specialist.

Patient's and carer's responsibilities
1. Ensure they have a clear understanding of their treatment.
2. Report any adverse effects to their GP or specialist.
3. Report any significant changes in disease symptoms to the GP or specialist dementia service.
4. Attend together all appropriate GP and specialist team appointments.
5. Share any concerns regarding their treatment, including lack of compliance, with their GP or consultant or specialist team.
6. Follow verbal and written communications on medicines including Choice and Medication where appropriate.
7. Take medication regularly as agreed with specialist prescribers and GP.

BACK-UP ADVICE AND SUPPORT

Trust	Contact details	Telephone No.	Email address:
	Consultant:-		
	Specialist Nurse		

Side Effect Monitoring

Acetylcholinesterase inhibitors and memantine are generally well tolerated and rarely cause troublesome side effects. Summaries of Product Characteristics give further information on management of side effects. Some of the key issues are detailed below.

Acetylcholinesterase inhibitors can cause nausea and vomiting. This will often improve without intervention. Taking a dose after food may help. If necessary, consider a dose reduction.

Acetylcholinesterase inhibitors may cause a fall in pulse rate due to their pharmacological action. This may lead to syncope. It is most likely to occur on initiation of treatment or a dose increase. Monitor pulse rate. If it persists then consider a dose reduction or seek specialist advice. Care should be taken if other medicines that reduce heart rate are also prescribed e.g. beta-blockers. Appendix 1 outlines actions to be considered where syncope is suspected.

Rivastigmine patches may often cause application site reactions. This can be minimised by rotating application sites. Rarely, more severe reactions that spread beyond the application site may occur. Where these persist for more than 48 hours with discomfort or pain then consider discontinuation and refer back to the specialist older people's mental health community team for further advice and assessment.

Memantine can rarely cause somnolence and dizziness. Patients and carers should be advised and patients should be assessed for risk of falls and given advice on falls prevention. It may respond to a reduction in dose.

Medication profile

Medication to be TRANSFERRED TO GP PRESCRIBING		
Drug name and form *prescribe generically except for galantamine MR caps and rivastigmine patches where formulary preferred brands should be prescribed.*	**Dose and frequency**	**Commenced on:**

_____

I agree to participate in this shared care agreement for the treatment of the below named patient with anti-dementia treatments for the management of non-complex Alzheimers' disease

General Practitioner
Name (please print)_____Signature _____Date_____

Hospital Specialist/Consultant
Name (please print)_____Signature_____Date_____

Patient's name	Date of birth	Sex	Home Address	Hospital Number
				NHS Number

Please keep a copy of this agreement for your own records and forward the original to the above named Consultant at

Appendix 1: Management of suspected syncope in patients taking Acetylcholinesterase Inhibitors (ACHEIs)

A) At the relevant review point ascertain whether any new symptoms suggestive of syncope have developed.

- If symptoms suggestive of syncope have developed the ACHEI should be discontinued

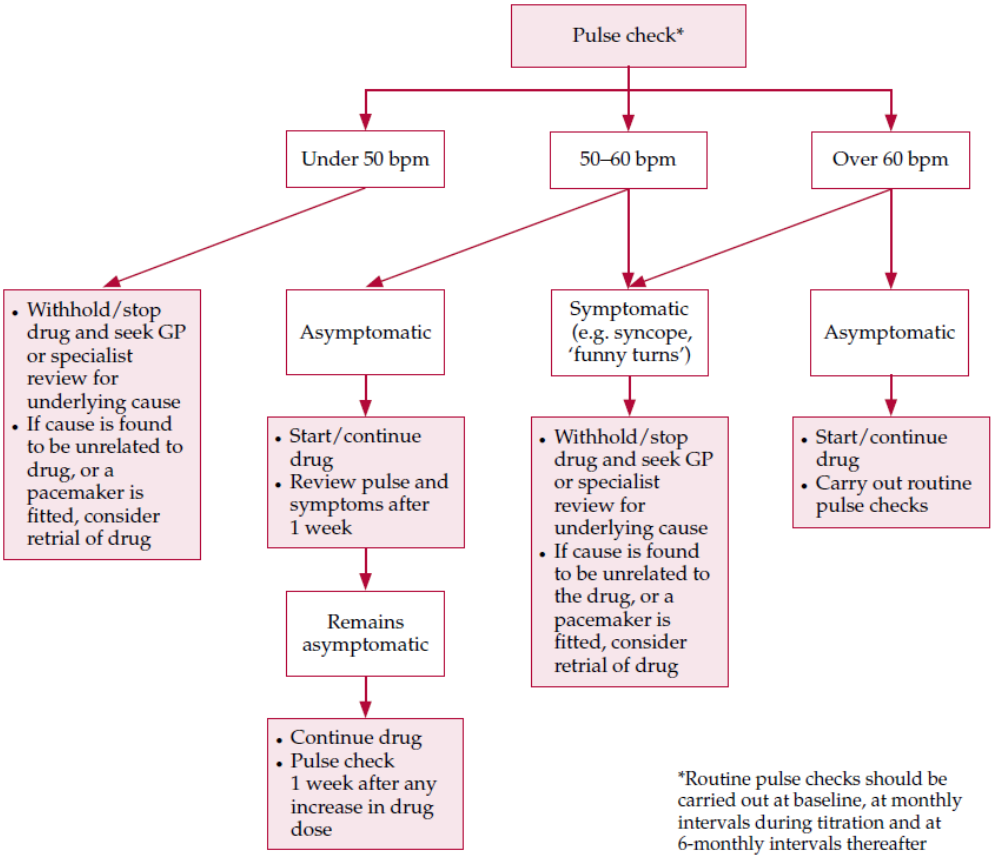
Note: mild subjective dizziness is a common and often short-lived side effect of ACHEIs and is not, in isolation, a reason to discontinue the drug.

B) Re-check the patient's pulse rate.

- Irrespective of whether the patient is symptomatic or not, the ACHEI should be discontinued if the pulse rate falls below 50 beats per minute.

Where a complaint of dizziness is thought to be pre-syncopal or associated with falls or with a pulse rate of 50- 60 beats per minute then again the ACHEI should be stopped

A specialist opinion should be sought prior to restarting treatment.



References

Rowland JP et al (2007). Cardiovascular monitoring with acetylcholinesterase inhibitors: a clinical protocol. Advances in Psychiatric Treatment, 13:178-184.

http://emc.medicines.org.uk