GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

GMS action 2017-18

Audit of the use of Antipsychotic Medication for Patients with Dementia in Primary Care, including Patients in Care Homes in line with NICE-SCIE Dementia Guidelines Clinical Guideline

OBJECTIVES

The audit relates to the use of antipsychotic medication for patients with dementia ensuring that their use is in accordance with NICE-SCIE Dementia Guidelines 2006.

Patient confidentiality will be respected throughout the audit process.

Patients, practice staff and local pharmacists will be informed of the work being undertaken where relevant.

SCOPE

The work covers all patients with a diagnosis of dementia, where antipsychotic medication is being prescribed; the patient may be living in the community or resident in a care home.

Patients who have been prescribed antipsychotics for other psychiatric diagnoses* will be excluded.

*Patients with a confirmed diagnosis of psychotic depression; schizophrenia spectrum disorder; bipolar disorder; manic depressive psychosis or personality disorders.

*Patients who have been prescribed antipsychotics for any other indication i.e. not Behavioural and Psychological Symptoms of Dementia (BPSD), where this has been clearly documented in the clinical notes.

RESPONSIBILITIES

The **Prescribing Support <u>Technician</u>** is responsible for initial searches and data collection.

<u>Pharmacist</u> Prescribing Adviser is responsible for obtaining agreement with the GP, or prescribing lead, of each surgery, clinically reviewing the data collected for each patient and sharing the audit information with the GP.

The **<u>Lead GP</u>** is responsible for reviewing the audit findings with the Prescribing Support Pharmacist and informing other GP(s) within the practice (level of GP input is to be agreed with practice).

The **Practice Manager** is responsible for disseminating relevant information to prescribing clerks and other staff in the practice where relevant.

NB: The term audit used in this document refers to the procedure of searching and reviewing patient records. The audit will provide baseline data and will be re-measured.

THE PROCESS STAGES

	The copy of the audit agreement must be completed
	Informing staff involved After the audit agreement has been signed, the practice staff and the local pharmacies must be informed of the proposed work.
	Identify potential patients for the audit **For Vision system:** • From "clinical audit" screen, identify: 1. "Register of patients diagnosed with Dementia– QOF indicators 2016-17". 2. Right Click and "Print this group". 3. Or select "copy" and paste the list of names into the data collection form in Appendix 3. **Additional identifier** It has been well recognised that there may be some underestimation of the number of people with dementia if the audit relied upon the accuracy of dementia registers since in many cases a formal diagnosis of dementia may not be recorded. In order to ensure this audit captures as many patients with dementia as possible, an alternative approach to solely relying on the dementia register may be required such as outlined below: • **Search 1:** Identify all patients who have a diagnosis of dementia by using the relevant read codes in **Appendix 2**. If possible also search within the medical history field on the clinical system for the word 'dementia'. • **Search 2.** Identify all patients who have been prescribed anti-dementia drugs in the last 6 months (see list in **Appendix 2**). The population identified by these alternative approaches may be used to identify as many patients with dementia rather than solely relying upon the dementia registers.

	Identify dementia patients who have been prescribed antipsychotics • **Search 3:** Using the patient population from the previous searches, identify those who have been prescribed antipsychotics in the last 6 months (**Appendix 2**). *Note that **Prochlorperazine** is excluded as this drug is not routinely used for Behavioural and Psychological Symptoms of Dementia (BPSD*). *Also ensure brand and generic names are included in the search as well all listed strengths (check latest BNF for the most comprehensive updated list).*
	General Exclusion Criteria Patients who have been prescribed antipsychotics for other psychiatric diagnoses* will be excluded. *Patients with a confirmed diagnosis of psychotic depression; schizophrenia spectrum disorder; bipolar disorder; manic depressive psychosis or personality disorders. *Patients who have been prescribed antipsychotics for any other indication (i.e. not BPSD), where this has been clearly documented in the clinical notes.
	Data collection **Conduct medication review** • Complete data collection for each patient identified for the audit (data collection form is provided in **Appendix 3**). • Using the questions and prompts on the data collection form, systematically go through each patient's records to gather the information required for the audit. • When you have finished, record the total numbers as required on the submission form (**Appendix 4).**
	Submit the results • Send a copy of the completed Submission Form to your Prescribing Adviser by ../../.. • Measure use against the audit standards.The audit standards have been extrapolated from relevant recommendations in the NICE-SCIE Clinical Guideline on supporting people with dementia- CG042 (2006). • Feed back data to prescribers. • Discuss best practice points in relation to antipsychotic use to be carried forward into future prescribing.

This initial audit is intended to generate information regarding antipsychotic use only and is not intended to make changes to patient medication.

Introduction

Reducing inappropriate antipsychotic prescribing in patients with dementia to improve quality of life is a key priority of the NHS. Requirements for action relating to the use of anti-psychotics in care homes are also set out in the Older People's Commissioner for Wales review report, "A Place to Call Home". Recommendation 3.5 states that "Information is published annually about the use of anti-psychotics in care homes, benchmarked against NICE guidelines and Welsh Government Intelligent Targets for Dementia".

Good quality relevant information on the use of antipsychotics for patients with dementia is needed in order to work towards reducing the use of these medications, and to ensure that, when they are used, they are used according to good practice guidelines. Current NICE-SCIE guidelines recommend the time-limited use of anti-psychotic medication with some patients with dementia, despite risks to health and quality of life. Recommended use is only in relation to severe and distressing difficulties that have not responded to other interventions.

In November 2009, an independent report commissioned by the Department of Health in England "The use of antipsychotic medication for people with dementia: Time for action" was published (Banerjee, 2009)[1]. The report quantified the health risks of the use of these medications, attributing 1800 deaths and 1620 cerebrovascular accidents (CVA) to their inappropriate use. Research studies consistently show that these medications have a relatively limited therapeutic effect in relation to agitation and challenging behaviour in dementia. Only a small proportion of patients show a worsening of their behavioural symptoms when the medication is withdrawn. Banerjee's report contains 11 recommendations, all of which were accepted by the Department of Health. Recommendation 4 states that 'People with dementia should receive antipsychotic medication only when they really need it. To achieve this, there is a need for clear, realistic but ambitious goals to be agreed for the reduction of the use of antipsychotics for people with dementia. Explicit goals for the size and speed of this reduction, and improvement in the use of such drugs where needed, should be agreed and published locally following the completion of the baseline audit.."

What are the aims of the audit?

1. The purpose of the audit therefore is to generate data on the use of antipsychotic medication for patients with dementia in primary care including care home residents. The audit will provide baseline data and will be re-measured (the Banerjee report suggests repeated for the next 3 years) to gauge progress against quality standards.
2. To publish the information relating to anti-psychotic use in care homes as required by the Older People's Commissioner for Wales review report, "A Place to Call Home". Information will be published for Hywel Dda and not on an individual practice level.
3. To benchmark whether prescribing is in line with NICE-SCIE guidance and Welsh Government Intelligent Targets for Dementia **(Appendix 1)**.

[1] The use of antipsychotic medication for people with dementia - Time for action; A report for the Minister of State for Care Services by Professor Sube Banerjee – November 2009

Audit Standards

Audit criteria	**% from Audit submission form (Appendix 4)**
• The records show that (x%) dementia patients have been prescribed an antipsychotic for indication(s) in accordance with NICE recommendations	
• The records show that (x%) dementia patients prescribed an antipsychotic for BPSD have had it reviewed in the last 3 months	
• The records show that (x%) dementia patients have been prescribed an antipsychotic for BPSD for > 9 months	

Audit agreement

(GP prescribing lead for the practice only needs to sign)

All patients identified for the audit will be reviewed by the prescribing adviser. The audit information will be shared with the GP(s).

General Practitioner (prescribing lead GP)

Name__________________Signature__________________Date_________

Prescribing Adviser

Name__________________Signature__________________Date_________

Medicines Management Technician

Name__________________Signature__________________Date_________

Appendices

Appendix 1: Excerpt from NICE-SCIE Quick Reference Guide Dementia; Supporting People with Dementia and their Carers in Health and Social Care

NICE-SCIE Quick Reference Guide: Dementia; Supporting People with Dementia and their Carers in Health and Social Care, November, 2006

CG042quickrefguide dementia.pdf

Appendix 2: Dementia read codes, anti-dementia drugs & antipsychotics

Dementia readcodes dementia antipsycho

Appendix 3: Data collection form

Data collection form.docx

Appendix 4: Submission form

Appendix 4.Submission form.do

References and further reading

References.doc

<table>
<tr><td colspan="3">The GMS SOPs are also available electronically via http:
http://howis.wales.nhs.uk/sitesplus/862/page/55185</td></tr>
<tr><td colspan="3">The original Microsoft Word file is kept on the HDUHB Medicines Management Team Shared Drive/Interface/</td></tr>
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<tr><td>Checked by:</td><td colspan="2"></td></tr>
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<tr><td>Date for next review</td><td colspan="2"></td></tr>
<tr><td>Approved by</td><td>MMG</td><td></td></tr>
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Caerphilly Behavioural Support Service – Briefing Document

Overview
The Caerphilly Behavioural Support Service (CBSS) is a pilot project consisting of an integrated multi-disciplinary team, embedded within the existing CMHT structure, who deliver behavioural based interventions to older adults with mental health problems. The service has a particular focus on individuals who live in care homes and works closely with existing in-reach and CMHT colleagues to identify appropriate referrals. Assessment and intervention is based on a holistic person-centred approach which values the individual and seeks to engage carers in creating supportive environments. Positive behaviour support seeks to implement a multi-component framework for the delivery of evidence-based supports to increase quality of life and reduce the occurrence, severity and impact of behaviours that challenge. The pilot will evaluate the resources required to support carers and mainstream services to develop skills and knowledge to better care for people who engage in behaviours that challenge services. The project commenced May 2017 and will conclude March 2018. A plan is in place to seek recurrent funding thereafter and extend the service across the five boroughs in Aneurin Bevan University Health Board.

Background
It is increasingly recognised that behaviours that challenge are often an attempt at communicating an 'unmet need'. People with dementia and other mental health problems often have a reduced ability to communicate in ways that those who care for them understand. A needs led formulation based framework to make sense of behaviour provides an evidenced based approach to meeting the person's needs and reducing the need for them to engage in behaviours that challenge (i.e., Ontario Positive Behavioural Support in Dementia Group; Newcastle Model of Challenging Behaviour Formulation). Such an approach is consistent with guidance recommending the use of non-pharmacological, psychological and psychosocial approaches in the initial stages of managing behaviours that challenge (The National Dementia Action Plan for Wales, 2009; NICE/SCIE, 2006).

Service Description
The Caerphilly Behavioural Support Service is funded via the Integrated Care Fund (ICF) and seeks to provide a clinical service to people who predominately have a diagnosis of dementia and vulnerable to exclusion due to challenging behaviour. Older people who display challenging behaviour are at significant risk of exclusion and treatment with anti-psychotic medication. This service aims to provide a viable alternative to medication to address behaviour that challenges. The service, working with key partners from private residential and nursing home establishments, social services, and the third sector supports older people with mental health problems in their local community near their families and focus on three key domains:

1. Intensive support and direct clinical work with identified individuals utilising positive behavioural support
2. Promotion of meaningful activity and therapeutic environments
3. Provision of specialist teaching and sharing of good practice

The service is comprised of a multi-disciplinary team that include a lead nurse, behavioural specialists, assistant psychologists and support workers.

Interim Evaluation
The pilot has been operational since May 2017 and preliminary feedback very encouraging. The service actively seeks to reduce medication as the sole means of addressing challenging behaviour and contributed to the wider agenda of reducing anti-psychotic use in the older adult age group. To this end, we have focused on delivering person-centred approaches to care and providing 'hands on' support to care home staff; working as partners in the application of behavioural approaches. Our initial clinical outcome evaluations have been positive as to the value of such approach.

Importantly, the service aspires to be a part of a whole system change as to how we deliver care. We have plans to facilitate training events to promote sharing good practice amongst care homes. We have built links with a range of third sector agencies with a view to developing good practice links and collaborators in the wider agenda of promoting meaningful activity and safe environments. Whilst still in the formative stages, there is encouraging evidence supportive of a shift in the way services are delivered within the borough and improved collaboration between partner agencies.

Outcome measurement and Long-term Plan

The service is monitored and evaluated on the basis of the quality standards outlined in the document Psychological Therapies in Wales: Policy Implementation Guidance (2010) and guided by the outcomes detailed in Together for Mental Health (Delivery Plan 2016-2019). The service is also collecting a range of outcome measures to evaluate individual and service benefits (i.e., clinical outcome, levels of meaningful activity, reduction in anti-psychotic medication use). This data will have clinical utility in guiding treatment decisions; moreover, it will also provide direct evaluation of clinical effectiveness. An overall evaluation of service quality will be guided using testimonial forms (completed by service users, families, carers and relevant staff who have accessed input/training). This will include user satisfaction and utility ratings from a range of partner agencies. In addition, data point comparison on inpatient admission rates and unplanned transitions of care will evaluate the cost effectiveness of the pilot service.

This information will be collated via an implementation group and a written report, detailing the implementation and evaluation of the pilot will be available for wider dissemination. Long-term, the pilot would provide valuable grounding in the application of the wider implications of the model across the five boroughs of Gwent with the long-term aim of demonstrating the value of recurrent funding.

The pilot is also working on how this team interface with the already established Inreach Nurses in each borough. The preliminary view is that the Inreach service work with the reduction of medication across large case loads , but where there are particular difficulties with reducing or maintaining a reduction in medication, then the BST can add a level of intensity of support and specific positive behavioural support to overcome any issues and in so doing add a value added service to a already effective foundation service, with both services aiming to assist in the elevation of expertise in the care homes around managing behaviours that challenge with non medication interventions .

Mike Fisher (Older Adult Directorate Manager, ABUHB)
Jimmy Jones (Consultant Clinical psychologist, ABUHB)

Supplemental Data

Individual Client Outcomes

The CBSS utilises the Clinical Global Impressions (CGI) scale to evaluate outcome of input. This scale asks respondents to rate the utility of input on a 13 point scale (from maximum deterioration to ideal improvement). The service has discharged 14 clients so far and has completed outcome data for 11 clients (3 cases were brief assessments and deemed not suitable for further input). The average score on the CGI for the recorded cases was 3.1 (representing the category 'Moderate Improvement on the scale). Similarly, the mode (or most common rating provided by respondents) was 'Moderate Improvement'. This data is suggestive of the value of input but remains preliminary. Data collection is ongoing and will be elaborated in future data reports.

Case Studies

Two brief case studies are provided below to help contextualise the work of the team:

Case Study 1

Mr E is a 82 year-old gentleman referred by a voluntary sector residential facility. The referral detailed evidence of paranoia and physical aggression directed towards staff and other residents. The behaviour was described as very unpredictable and limited personal care and participation in social activities. Mr E was already taking an anti-psychotic and an increase was considered to manage behaviours that challenge. The CBSS conducted an initial assessment; identifying good care practices and successful techniques used by the care staff team (i.e., identifying potential 'flash' points, methods of distraction). The CBSS also shared information on de-escalation techniques and provided positive feedback to staff team when utilised. This intervention resulted in a significant decrease in behaviours that challenge. This improvement resulted in no increase in medication and a positive disposition to consider review existing anti-psychotic medication.

Case Study 2

Mr W is a 69 year-old gentleman referred whilst an inpatient on a older adult mental health ward. He exhibited a number of difficult behaviours that included physical and verbal aggression, isolating himself and refusing care. A prior discharge had failed as the care home were unable to manage behaviours that challenge and Mr W had returned to the ward. The introduction of anti-psychotic medication was considered to complement existing sedative medication and help manage the situation. The CBSS became involved to support the transition from hospital to newly identified care home residence. Initial work focused on providing a positive behavioural support plan; detailing a biographical history and advising staff on effective support strategies. This was shared with the care home and guidance was provided on how to utilise effective reactive strategies. This information was incorporated within Mr W's care plan and shared with all staff. The CBSS provided direct support during the initial transition and telephone follow-up on a daily basis for a period after this. Staff were encouraged to innovate and the CBSS played an active role in supporting the care home to verbalise and share new approaches. Revisions were subsequently made to the positive behavioural support plan as the new care environment adapted to meet Mr W's emerging desire to be involved in social activities. Since the move to the new residence, there has been a significant reduction in behaviours that challenge. Anti-psychotic medication was not introduced and sedative medication significantly reduced (in terms of routine and PRN use).

PHARMACOLOGICAL MANAGEMENT OF BEHAVIOUR PROBLEMS IN PATIENTS WITH DEMENTIA (BPSD)

(Does not cover rapid tranquillisation of acutely disturbed)

Patient has **B**ehavioural and **P**sychiatric **S**ymptoms in **D**ementia (BPSD) (eg. psychosis; agitation, aggression; irritability with steady decline in cognition

→ **Yes** → Does patient have a delirium? (short history < 1 week confusion, hallucination, delusion with fluctuating cognition)

→ **Yes** → Treat underlying acute medical problems, eg UTI, chest infection, side effect of drugs, alcohol, drug withdrawal etc

→ **No** ↓

Adopt a person centred approach. Apply **PAIN** approach and manage or treat:
P = Physical problems ie. Medical review for eg infection, pain
A = Activity-related eg dressing, washing
I = Iatrogenic eg side effects of drugs eg psychiatric and CNS treatments
N = Noise ie. Consider the physical environment

→ Behavioural problems unresolved ↓

If mild to moderate symptoms adopt a watchful waiting approach. Contact the family for their views; consider non-pharmacological approaches eg. creative therapies; personalised activities; social interaction. Consider specialised psychosocial support for carer and patient.

↓

Only consider pharmacological treatment if there is psychosis, depression or behaviour where there is extreme risk or distress.

←

Identify the dominant target symptom group

Psychosis: Delusions/Hallucinations

Depression: depressed mood and / or loss of ability to enjoy previously pleasurable activities. May or may not include apathy

Apathy: diminished motivation; listlessness; loss of drive to engage in activities. May be perceived as laziness.

Aggression

Agitation/Anxiety: wandering may be intrinsic to dementia

Sleep disturbance

Other symptoms: eg. vocalisations; sexual disinhibition; stereotypical movements etc

↓

Could this be dementia with Lewy Bodies or Parkinsons Disease Dementia?
Key features: long term (>6 months) history of vivid visual hallucinations or parkinsonism or fluctuating cognition.

Yes / unsure → Get specialist advice

No → Follow guidance below and overleaf

In the event of continuing problems advice can be obtained from specialist older adult mental health services

There is only one drug (Risperidone) licensed specifically for the treatment of BPSD. For other symptoms drugs are used which have either been shown to improve these symptoms in subjects without dementia or are licensed for cognitive enhancement in patients with dementia.

General guidelines if pharmacological treatment is indicated.

The use of either typical or atypical antipsychotics in patients with dementia worsens cognitive function; increases the risk of cerebrovascular events (~3x) and increases mortality rate (~2x). They should only be used after full discussion with the patient (where the patient has capacity to understand) and carer about the possible benefits and likely risks. Risk is likely to increase with increasing age and if other risk factors for cerebrovascular events are present eg. diabetes; hypertension, cardiac arrythmias; smoking and existing evidence of **stroke or vascular dementia.**

If antipsychotic treatment is considered necessary avoid typical neuroleptics and start atypical doses low (usually one half normal elderly dose) and increase every 2-4 days if no response **(see specific dose suggestions overleaf). PATIENTS WHO RESPOND TO TREATMENT SHOULD HAVE THE DRUG WITHDRAWN AFTER 6-12 WEEKS**. Halve the dose for two weeks and if no re-emerging symptoms stop after a further 2 weeks. Review again after one week. If symptoms re-emerge reintroduce the drug at starting dose. BPSD can persist and treatment with atypical antipsychotics may be needed in the long term **BUT SHOULD BE REVIEWED ON A 3 MONTHLY BASIS.**

Patients with Dementia with Lewy Bodies or Parkinsons Disease Dementia are particularly vulnerable to neuroleptics sensitivity reactions and also have marked extrapyramidal side effects. Advice from a specialist is advised before starting neuroleptics.

The management of antidepressants and hypnotics in patients with dementia has little evidence base and should follow existing guidelines for the management of these drugs in elderly patients without dementia. Treatment doses should follow BNF guidelines.

Prescribing Guidelines:

Alzheimer's disease

Key Symptom	*First Line*	*Evidence Type*	*Second Line*	*Evidence Type*
Depression	Citalopram, Sertraline	3	Mirtazapine	3-4
Apathy	Citalopram, Sertraline	3	Donepezil (S), Rivastigmine (S), Galantamine (S)	2
Psychosis	Risperidone	1	Olanzapine, Aripiprazole, Haloperidol, Memantine (S)	2-3
Aggression	Risperidone (L)	1	Olanzapine, Aripiprazole, Haloperidol, Memantine (S)	2
Moderate agitation/ anxiety	Citalopram	3	Trazodone, Mirtazapine, Memantine (S)	4
Severe agitation/ anxiety (after antidepressant trial)	Risperidone, Olanzapine	1	Aripiprazole, Memantine (S)	2-4
Poor sleep	Temazepam, Zopiclone	3	Zolpidem	3

Dementia with Lewy bodies or Parkinsons disease dementia

Key Symptom	*First Line*	*Evidence Type*	*Second Line*	*Evidence Type*
Depression	Citalopram, Sertraline	4	Mirtazapine	4
Apathy	Citalopram, Sertraline	4	Donepezil (S), Rivastigmine (S), Galantamine (S)	2
Psychosis*	Rivastigmine (S), Donepezil (S), Galantamine (S)	2-3	Quetiapine, Aripiprazole	3, 4
Aggression	Quetiapine	3	Donepezil (S), Galantamine (S), Rivastigmine (S)	3
Moderate agitation/ anxiety	Citalopram	3	Rivastigmine (S), Donepezil (S), Galantamine (S)	2 – 3
Severe agitation/ anxiety (after antidepressant trial)	Quetiapine	3	Rivastigmine (S), Donepezil (S), Galantamine (S)	3
Poor sleep	Temazepam, Zopiclone	3	Zolpidem	3
REM sleep behaviour (nightmares, hyperactivity)	Clonazepam**	3		

* consider reducing antiparkinsonian medication first ** 500 – 1000 microgram nocte (L) = Licensed indication (S) = Specialist initiation

Evidence levels: 1 = Metanalysis; 2 = RPCTs; 3 = Other studies; 4 = Expert Opinion;

Vascular dementia or stroke related dementia

There is little evidence for the treatment of BPSD in Vascular dementia or stroke related dementia. The cholinesterase inhibitors (Donepezil; Rivastigmine; Galantamine) and memantine are not licensed for treatment of pure vascular dementia and should not be used. Prescribers are advised to follow prescribing guidelines for Alzheimer's disease but to use with extreme caution drugs with an established increased cerebrovascular risk (ie. antipsychotics)

Other BPSD and other dementias (eg. Fronto-temporal lobe dementia)

There is little evidence base for the treatment of other BPSD or for the treatment of common BPSD in other dementias. Specialist advice should be sought.

Drug dose guidelines for use of antipsychotics in dementia

Antipsychotic	*Starting Dose*	*Optimal Dose*
Risperidone	250 microgram bd	500 microgram bd
Olanzapine	2.5mg od	5-10mg od
Aripiprazole	5mg od	10mg od
Quetiapine	25mg od	25 -150mg daily
Haloperidol	500 microgram bd	1mg bd

When antipsychotics are prescribed the 'ABHB Use of antipsychotics in dementia' information leaflet should be given to carers and relatives:
http://howis.wales.nhs.uk/sitesplus/documents/866/Dementia%20-%20The%20Use%20of%20Antipsychotics.pdf

Name:

D.O.B:

Anti-psychotic monitoring record booklet

An anti-psychotic medication is being prescribed to this individual for symptoms associated with a dementia.
This medication should be reviewed on a 3-monthly basis. At each review, **consideration should be given to** a reduction in or discontinuation of the drug.

The medication reviews may be undertaken by primary or secondary care

Risperidone	Olanzapine	Aripiprazole	Chlorpromazine
Quetiapine	Amisulpride	Haloperidol	Promazine

Flupenthixol injection (depixol)
Fluphenazine injection (modecate)
Haloperidol Injection (haldol)

Anti-psychotic initiation

NAME: …………………………………….... DATE OF BIRTH: ……/……/……

Place of medication being commenced: ………………………………………………………

Reason for prescribing antipsychotic:

Target symptoms (especially distress), severity & risk of harm to self/others:

Other approaches tried (including medications):

Consider physical health review/pain/infection/depression:

Current psychotropic medication:

NB. especially benzodiazepines

Capacity:

Capacity to consent to medication	yes ( )	no ( )
Discussion with patient if appropriate	yes ( )	no ( )
Best interest decision made (discussion with family/carer and staff)	yes ( )	no ( )
Patient/carer information leaflet given	yes ( )	no ( )

- Anti-psychotic prescribed (state starting dose): …………………………………………………

If **not** risperidone, state rationale for drug choice: …………………………………………….........

- **Date commenced**: ……………………. **Planned review:** ………………….....................
- Signature (and designation): ……………………………………………………..........................

Anti-psychotic review record

NAME: ………………………………………....   DATE OF BIRTH: ……/……/……

Place of medication review: ……………………………………………………………………

Date of review		
Current psychotropic medication (especially benzodiazepines)		
Patient seen? (Y/N)		
Any side effects? (describe)	Sedation/ weight gain	
	Parkinsonian effects	
	Poor posture, mobility, falls	
	Cognitive side-effects	
	other	
For how long has the drug been taken? (in weeks or months)		
Any changes in or benefit to target symptoms? (description of current presentation)		
Outcome of review (include **name and dose** of drug)	eg. continue/stop /trial off/ restart/ change dose /change drug	
With whom has the outcome been discussed?		
Next planned review (in weeks or months)		

- Signature (and designation): ………………………………………………………………

Anti-psychotic review record

NAME: …………………………………….... DATE OF BIRTH: ……/……/……

Place of medication review: …………………………………………………………………

Date of review		
Current psychotropic medication (especially benzodiazepines)		
Patient seen? (Y/N)		
Any side effects? (describe)	Sedation/ weight gain	
	Parkinsonian effects	
	Poor posture, mobility, falls	
	Cognitive side-effects	
	other	
For how long has the drug been taken? (in weeks or months)		
Any changes in or benefit to target symptoms? (description of current presentation)		
Outcome of review (include **name and dose** of drug)	eg. continue/stop /trial off/ restart/ change dose /change drug	
With whom has the outcome been discussed?		
Next planned review (in weeks or months)		

- Signature (and designation): ………………………………………………………

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Health Board

The Use of Antipsychotics in Dementia – Information for Patients and their Carers

People living with dementia sometimes develop behavioural symptoms of restlessness, agitation and aggression or psychotic symptoms such as hearing voices, seeing visions or abnormal beliefs which can become distressing both for the person with dementia and their carer(s). When these symptoms are distressing, severe and/or are putting the person or others at risk, then it may become necessary to treat them. A variety of medications have been tried for these symptoms of dementia. This leaflet deals with the prescribing of anti-psychotic drugs.

When should anti-psychotics be used and what are their effects?

Behaviours that challenge (as described above) may respond to non drug treatments such as reassurance, distraction with meaningful activities, relaxation and psychological therapies. These approaches should always be tried before drug treatments are considered. Anti-psychotic medication should only be used if absolutely necessary.

How long will anti-psychotic medication take to work?

Anti-psychotics may produce some noticeable effects within a few hours but the full benefits of medication may take some weeks to develop. Ultimately it is hoped that the medication will relieve the target symptoms of restlessness, agitation, aggression, delusions and/or hallucinations so that the person living with dementia will feel calmer, less distressed, more able to interact socially, engage in activities and more able to remain living at home or in the community for as long as possible.

How will the dose be decided?

Like all drugs, anti-psychotics have possible side-effects and these will normally be related to the dose prescribed. Therefore such medication should be prescribed at a very low starting dose and increased very slowly and carefully with full evaluation of both the effects and side-effects at regular intervals.

What follow-up will be necessary?

As long as anti-psychotic medication is taken, regular follow-up will be necessary so that we can ensure that the drug is working properly, not causing unpleasant or harmful side-effects and is only used for as long as is absolutely necessary. Trials of stopping the medication may be suggested to see whether or not the target symptoms return.

What side-effects may occur?

Common side-effects of anti-psychotics include drowsiness, dizziness, unsteadiness, shaking and joint stiffness. Sometimes the prescribing of anti-psychotics is associated with increased agitation and worsening confusion, and the dose may have to be reduced, the anti-psychotic changed or even discontinued. Other side-effects are less common.

Are there serious risks associated with being prescribed antipsychotics?

The use of antipsychotics in dementia is associated with an increased risk of having a stroke and an increased risk of premature death in a small number of cases. These risks are low over short periods of treatment (up to 3 months). The Committee of Safety of Medicines in the UK, therefore, advises that anti-psychotics should only be used when considered absolutely necessary, at the lowest effective dose for the shortest possible period of time, and subject to regular review.

The benefits of trying an antipsychotic in a person living with dementia should be carefully weighed against the possible risks and side-effects of the treatment.

Which antipsychotic will be chosen?

At present only one drug "Risperidone" is specifically licensed for the treatment of the behavioural symptoms of dementia (up to six weeks). It is used to treat persistent aggression in moderate to severe Alzheimer's type dementia which is unresponsive to non-drug treatments. Risperidone will normally be started at a low dose and be increased slowly and carefully as necessary. Other antipsychotics have also been shown to be of benefit in treating behavioural symptoms in dementia and, although technically unlicensed for this, may be chosen if the treating doctor considers they are more appropriate e.g. where an individual patient has particular other physical conditions. All these drugs carry similar risks when used in people with dementia and so they should all be used in low doses for short periods and discontinued when possible.

Can any other drugs be used in dementia?

Other drugs can be used in dementia to treat depression, anxiety, sleep disturbance, agitation and aggression. These other medications may include antidepressants, sleeping tablets, antiepileptics, painkillers and minor tranquillisers. "Anti-dementia drugs" may be used for the memory decline itself and help with orientation / alertness / motivation in dementia. However the anti-dementia drugs are not often effective on their own against the more severe behavioural symptoms of dementia; some people living with dementia will need a combination of drug treatments to control their symptoms. These other medications have not been linked to an increased risk of strokes or premature deaths. All medications prescribed for a person living with dementia will be individually decided upon with the person and/or their carers following a careful individual assessment/review of their changing needs.

Use of Antipsychotics in Older People in the Royal Gwent Hospital (RGH), Newport

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Background

Older people on antipsychotic medications are at an increased risk of several unwanted side effects, including falls and strokes[1] . A review of the available literature suggested that:

- Not all patients admitted to general hospitals already on antipsychotics come to the attention of the psychiatric liaison service if one is available[2]
- Antipsychotics initiated in the general hospital for acute and reversible indications, e.g. delirium / agitation are often not discontinued upon discharge when the indication may have resolved[3, 4]

Locally, the **R**apid, **A**ssessment, **I**nterface and **D**ischarge (**RAID**) Older Adult Liaison Psychiatry Service is a specialist multi-disciplinary mental health service working within all general hospitals in the Aneurin Bevan University Health Board for people over the age of 65 years. In this area, it is generally known that not all general hospital inpatients over the age of 65 years who are on antipsychotics are referred to **RAID**.

It was therefore proposed that an actual exploration of antipsychotic use in elderly patients admitted to the general hospital setting, specifically Royal Gwent Hospital, Newport was undertaken.

Aims

This study sought to investigate the clinical use of antipsychotics within a general hospital in acutely unwell medical and surgical patients over the age of 65 years.

The specific study aims were:

1. To estimate prevalence and incidence of antipsychotic use among elderly patients in RGH
2. To examine the nature of antipsychotic prescriptions in these patients
3. To explore the level of **RAID** team involvement in the care of these patients

Objectives

It is anticipated that results of this exploration are used to enable further consideration of:

- How best to identify these patients to **RAID**
- Whom is best to identify these patients to **RAID** (i.e. pharmacy or the medics, for example)

Ideally, this will lead to the set up of a system to capture this patient population to ensure risks of being on antipsychotics are minimised.

Methods

All patients aged 65 years and over admitted to a medical or surgical ward of the Royal Gwent Hospital over a consecutive 3 day period were included if they were either:

1. Already on antipsychotic medication at the time of admission, or
2. Initiated on antipsychotic medication during their admission

For each of these included patients, a survey of their medical records and prescription charts was undertaken over a 3 day period.
Data was collected by ward pharmacists and the **RAID** SHO.

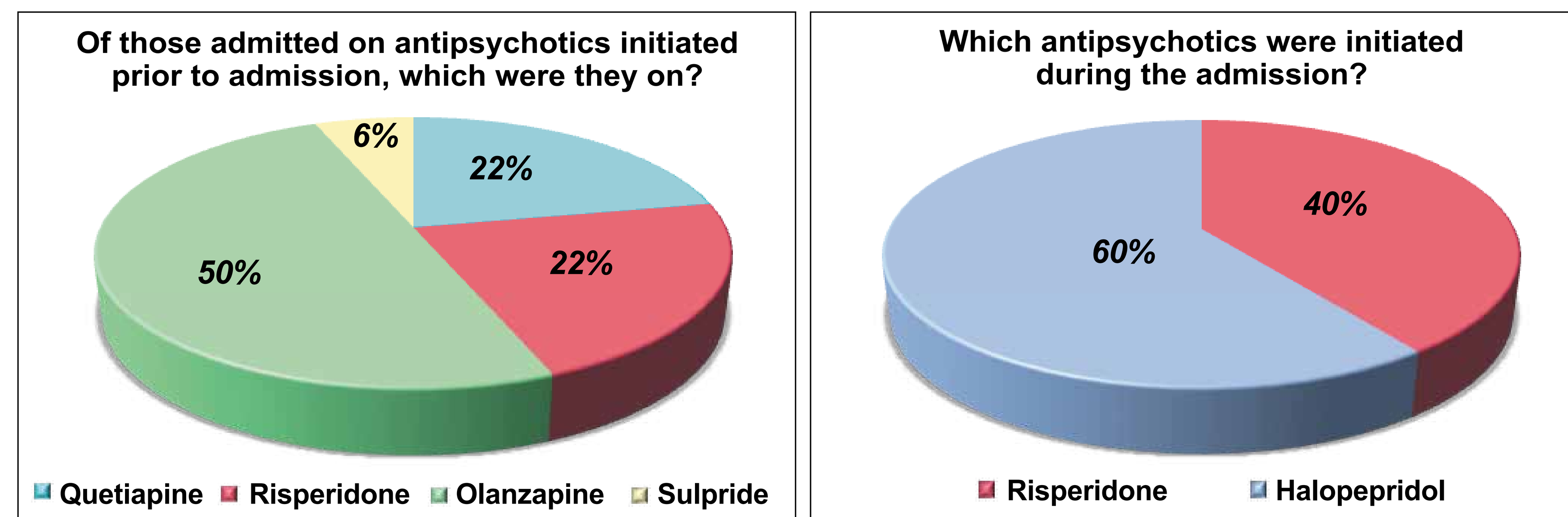
Results

Results 1: The prevalence and incidence of antipsychotic use among older adult patients admitted to general wards within RGH

	Day 1	Day 2	Day 3
Total No. of patients identified who were aged over 65 yrs	265	270	269
No. of these over 65s who were on antipsychotics	3% (n=9)	4% (n=12)	5% (n=14)
No. on antipsychotics **PRIOR** to admission	1% (n=4)	1% (n=4)	2% (n=6)
No. **INITIATED** on antipsychotics **DURING** admission	2% (n=5)	3% (n=8)	3% (n=8)

- On any day within the study period, 3 - 5 % of over 65s were on antipsychotic medication
- Most subjects were initiated on antipsychotics during admission, rather than prior to it

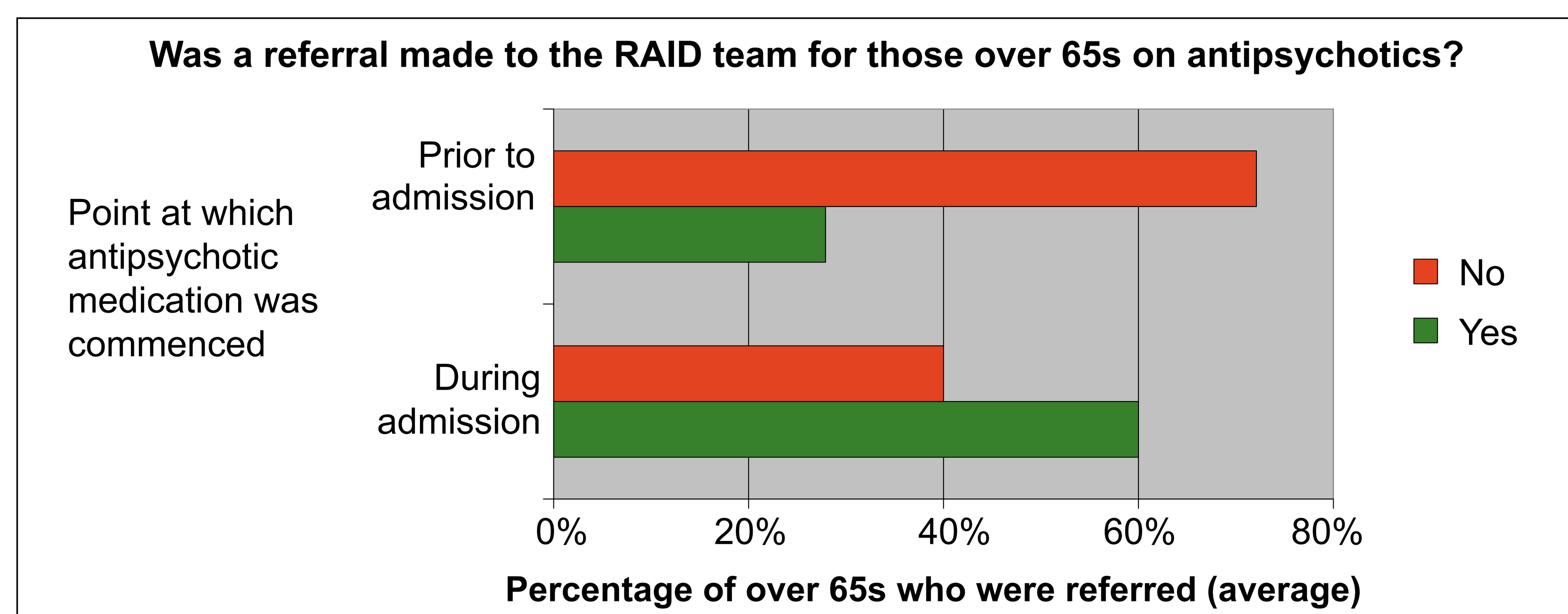
Results 2: An analysis of the prescription of antipsychotics in these patients



In those who were initiated on antipsychotics during admission:

- Indications documented for the prescriptions included agitation, sedation and nausea
- The number of PRN and regular prescriptions were equal
- Doses appropriate for older adults were prescribed
- Not more than one antipsychotic had been prescribed during the admission

Results 3: Level of RAID team involvement in the care of the patients within the sample



- Under 30% of those admitted already on antipsychotic medication were referred to **RAID** versus 60% of those who were commenced on an antipsychotic during the admission
- On average, it took 5 days for those already on antipsychotics prior to admission to be referred to **RAID** compared with 3 days for those initiated on antipsychotics during admission
- On average, it took 1 day for **RAID** to undertake their assessment of any patient referred to them, regardless of when they were initiated on an antipsychotic

Conclusions

This study identified that:

- On average, 4% of the Royal Gwent Hospital's patients over 65 years were on an antipsychotic on any given day in the study
- Most were commenced on antipsychotics during the general hospital admission (incidence of ~ 3 % compared with prevalence of ~1%)
- The first generation antipsychotic haloperidol appeared to be most commonly prescribed during an admission, most frequently for agitation, despite the associated risks

In relation to **RAID**:

- A considerable proportion of elderly inpatients in Royal Gwent Hospital on antipsychotics were not referred to RAID regardless of when their antipsychotic was initiated
- This raises the possibility that such patients are being discharged on antipsychotic medications unnecessarily, or without appropriate follow-up; **RAID** involvement would reduce such risks
- There is some delay in referring elderly patients on antipsychotics to **RAID**, but despite this delay, **RAID** responded quickly to all referrals

In an ideal world, every older adult on antipsychotic medication should be flagged to the psychiatry liaison service[2] during their admission to general hospital. There is a gap between this ideal and what is occurring currently in the Royal Gwent Hospital.

Recommendations

- Further studies, both of a longer duration and also within other general hospitals, are recommended in order to confirm this data
- A study to determine the frequency and nature of discharge prescriptions of elderly inpatients on antipsychotics from the general hospital would be useful in establishing baseline data
- Consideration could be given to the set up of a system to identify all ABUHB general hospital inpatients over 65 years who are on antipsychotics, with involvement of ward pharmacists who can then refer to the **RAID** team to make contact and take action if warranted
- Ongoing education of general hospital staff about the presence and work of **RAID** is of vital importance

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