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North of England Commissioning Support

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Care Bundle

Antipsychotics in dementia

North of England Commissioning Support
Medicines Optimisation on behalf of Cumbria CCG

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1. Introduction

1.1. What is a care bundle?

A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. The measures chosen reflect best practice and are based on NICE quality standards or other national guidance. Care bundles have been used extensively and successfully in Secondary Care, their use in Primary Care is more recent. This care bundle is based on the work of Healthcare Improvement Scotland and the Scottish Patient Safety Programme in Primary Care.

Reliability in health care is a failure-free operation over time. This equates to ensuring patients receive all the evidence-based care they are entitled to receive.

A care bundle is a structured way of improving processes of care to deliver enhanced patient safety and clinical outcomes. In relation to care bundles, this means ensuring that patients receive optimum care at every contact. The process for achieving reliability is to implement this set of measures (a care bundle). The key measure in a care bundle is the score which measures the level of compliance with all measures for all patients.

The care bundle data collection tool is a way of sampling whether optimum care is being delivered by applying the bundle to a sample of patients. This approach is therefore very different from traditional auditing approaches that are designed to identify whether individual measures are being implemented.

1.2. What makes up a care bundle?

- 4-5 measures
- All or nothing compliance
- Measurement done by a non-clinician if possible
- Spread over patient's journey
- Evidence based
- Creates teamwork and communication
- Multiple functions of care essential for desired outcome

1.2.1. How should a care bundle be used in practice?

A care bundle is a quality improvement tool which can be used in general practice to identify both where care is in line with best practice and where improvements are needed. Some are disease specific and some are medication specific. The latter may also be known as patient safety bundles if they relate to high risk medication.

Bringing about changes in practice is not easy. To be an effective tool the results of the care bundle measurements must be discussed by ALL members of the team involved in the care of the patient. The practice team then need to take ownership of the issues identified and commit to changing the way care is provided, using tools such as the 'Plan, Do, Study, Act' (PDSA) cycle.

Principles of successful measurement:

- The support of all members of the practice team should be obtained
- Data should be collected anonymously
- The results should be discussed by every member of the team
- The results should be used to plan and implement improvement initiatives
- Clinician support may be needed initially by the data collector until they are familiar with the measures.

1.3. Records

The care bundle is not a performance tool and so there is no requirement to report the measures achieved. The practice should keep a reflective log of improvements.

1.4. Resources

This care bundle has the following supporting resources:

- A word document data collection form
- An excel spreadsheet data collection form with a graphing function
- A reflective log template

Further information on Care Bundles and Improvement Models can be found at www.healthcareimprovementscotland.org/pspc.aspx

Further advice can be obtained from the Medicines Optimisation team, and specific queries about this care bundle can be directed to the author (details are on the front page).

2. Antipsychotics in dementia

2.1. Search Criteria

Please identify a random sample of up to 20 adult patients a month in your practice with a diagnosis of diagnosis of dementia prescribed an anti-psychotic on repeat prescription. There may be some patients with undiagnosed dementia prescribed antipsychotics that need to be included so consider running a report on patients taking an antipsychotic to discover those that do not have a linked diagnosis requiring antipsychotics. Exclude patients where the antipsychotic was prescribed for a pre-existing condition prior to a diagnosis of dementia, e.g. schizophrenia, bipolar disorder or psychotic depression.

Use the data collection form to record the answer to each measure and transfer this to the spreadsheet. This should be repeated over a period of time, and the results discussed by the clinical team at regular intervals. Use of the spreadsheet will enable changes in practice to be monitored and compliance with the care bundle to be measured.

2.2. Measures

01

Measure	**Have target symptoms been assessed (for improvement) and documented?**
Rationale	It is important to establish the exact target symptoms (or behavioural and psychological symptoms of dementia.) being treated with the antipsychotic and this should be identified, quantified and documented. Changes in target symptoms should be assessed and recorded at regular intervals. Establish the exact symptoms being treated with antipsychotics and assess the severity/risk of harm to patient or others. Identifying the Dominant Target Symptom Group: • Psychosis; delusion and hallucination • 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. These may be perceived as laziness. • Aggression • Agitation/anxiety • Sleep disturbance Other symptoms; e.g. vocalisations, sexual disinhibition, stereotypical movements etc.
Source	Optimising treatment and care for people with behavioural and psychological symptoms of dementia; a best practice guide for health and social care professionals (DH, 2011).

	http://dementiapartnerships.com/resource/optimising-treatment-and-care-for-behavioural-and-psychological-symptoms-of-dementia/ Low-dose antipsychotics in people with dementia NICE advice [KTT7]. Published date: January 2015 Last updated: February 2016. https://www.nice.org.uk/advice/ktt7/chapter/evidence-context Factsheet: Drugs used to relieve behavioural and psychological symptoms in dementia https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2628

02

Measure	**Has there been a consideration of stroke risk and adverse effects documented in the notes?**
Rationale	Antipsychotics are associated with a number of major adverse outcomes and side effects, including sedation, parkinsonism, gait disturbances, dehydration, falls, chest infection, accelerated cognitive decline, deep vein thrombosis/pulmonary embolism, cardiac arrhythmia and stroke (highest risk in first four weeks of treatment). Antipsychotics are also associated with increased mortality in the long term (often related to pneumonia and thrombo-embolic events) which can be caused by over-sedation and dehydration. Treating 1000 people with Behavioural and Psychological Symptoms of Dementia (BPSD) with an atypical antipsychotic for around 12 weeks results in: • 10 deaths • 18 cerebrovascular events (~ half of which are severe) • 58 to 94 people with gait disturbances
Source	The Dementia Action Alliance's call to action on the use of antipsychotic drugs for people with dementia. http://www.institute.nhs.uk/qipp/calls_to_action/Dementia_and_antipsychotic_drugs.html Dementia: supporting people with dementia and their carers in health and social care. NICE guidelines [CG42] Published date: November 2006 Last updated: May 2016 https://www.nice.org.uk/guidance/cg42 Antipsychotics increase mortality in elderly patients with dementia. MeReC Extra Issue No. 39. May 2009. http://www.isdbweb.org/documents/file/1672_10.pdf

03

Measure	**Is there is a documented review of the prescription in the past six months by either a general practitioner (GP) or psychiatrist?**
Rationale	All patients with dementia currently on antipsychotics for behavioural problems who have not had a trial discontinuation in the last 6 months should have the antipsychotic or reviewed to assess the risks and benefits of continued treatment unless: • The antipsychotic was prescribed for a pre-existing condition prior to a diagnosis of dementia, e.g. bipolar disorder or psychotic depression. • The patient is under regular review by a specialist for behavioural problems. This does not include reviews solely planned to assess the on-going benefits of prescribing cholinesterase inhibitors (e.g. donepezil) or memantine to delay

	cognitive decline. If the patient is under regular review by secondary care for behavioural problems then responsibility for reviewing and reducing or stopping the antipsychotic lies with secondary care, otherwise this should be undertaken by the patient's GP. A review is defined as a documented consideration of the use of the medication, where the person is seen by the clinician, and side effects, changes in cognition and changes in target symptoms are documented.
Source	Dementia: supporting people with dementia and their carers in health and social care. NICE guidelines [CG42] Published date: November 2006 Last updated: May 2016 https://www.nice.org.uk/guidance/cg42 Low-dose antipsychotics in people with dementia NICE advice [KTT7]. Published date: January 2015 Last updated: February 2016. https://www.nice.org.uk/advice/ktt7/chapter/Options-for-local-implementation Reducing Antipsychotic Prescribing in Dementia Toolkit. PrescQIPP. https://www.prescqipp.info/resources/send/109-reducing-antipsychotic-prescribing-in-dementia-toolkit/1353-reducing-antipsychotic-prescribing-in-dementia-toolkit

04

Measure	**Is the patient taking any interacting medication (i.e. medication that interacts with the condition or with current medication)?**
Rationale	Anticholinergic (ACH) drugs impair cognitive function and can antagonise the effect of ACH inhibitors – if possible STOP or REDUCE. Side effects are well documented from constipation to confusion. Many drugs have some degree of anticholinergic effect so combining them will increase the risk of a serious problem, particularly in the elderly, such as cognitive impairment or falls. • Tricyclic antidepressants – SSRI safer choice but caution with interacting drugs • Antihistamines – especially chlorphenamine • Antiparkinsonian drugs – especially orphenadrine, procyclidine and trihexyphenidyl • Antispasmodics – oxybutinin, hyoscine • Bronchodilators – theophylline • Digoxin • Furosemide
Source	British National Formulary (BNF) 2016. https://www.medicinescomplete.com/mc/bnf/current/ Fox C. Anticholinergic Medication Use and cognitive Impairment in the Older Population: The Medical Research Council Cognitive Function and Ageing Study. Journal of the American Geriatrics Society 2011; 59:8 The appropriateness of drug use in an older nondemented and demented population. Giron MS1, Wang HX, Bernsten C, Thorslund M, Winblad B, Fastbom J. J Am Geriatr Soc. 2001 Mar;49(3):277-83.http://www.ncbi.nlm.nih.gov/pubmed/11300238 Polypharmacy Action Group. NHS Highland; Polypharmacy:Guidance for prescribing in frail

	adults. 2015. http://www.nhshighland.scot.nhs.uk/Publications/Documents/Guidelines/Polypharmacy%20Guidance%20for%20Prescribing%20in%20Frail%20Adults.pdf STOPP START Toolkit Supporting Medication Review. North East Commissioning Support. Cumbria Clinical Commissioning Group. http://medicines.necsu.nhs.uk/guidelines/cumbria-guidelines/

05

Measure	**Is it possible to reduce or stop the antipsychotic?**
Rationale	70% of people have no worsening of symptoms when antipsychotics are discontinued. If a decision is made to reduce or stop an antipsychotic, carers should be involved in the decision and supported through the process. Withdrawal of antipsychotics should take place slowly over a period of 2-4 weeks unless there are specific and distressing side effects from medication. A reduction of 25% a week of total antipsychotic dose is suggested. On balance, the decision to continue with antipsychotic prescription should be made in light of the patient's presentation, symptomatology and risk to self or others. The risk of recurrence of BPSD after discontinuation is more likely if: • Previous discontinuation has caused symptoms to return • The person currently has severe symptoms If symptoms worsen, the first 4 weeks are the most challenging, but are often effectively managed with watchful waiting. If behavioural problems continue then other strategies should be considered instead of, or alongside, a short six-week course of antipsychotics such as regular pain relief or behavioural strategies, based on an individual assessment. **(PrescQIPP)** Carers and relatives should be reassured and provided with relevant information and tools to support the process wherever possible
Source	Dementia: supporting people with dementia and their carers in health and social care. NICE guidelines [CG42] Published date: November 2006 Last updated: May 2016 https://www.nice.org.uk/guidance/cg42 Optimising treatment and care for people with behavioural and psychological symptoms of dementia; a best practice guide for health and social care professionals (DH, 2011). http://dementiapartnerships.com/resource/optimising-treatment-and-care-for-behavioural-and-psychological-symptoms-of-dementia/ A leaflet for patients/carer's and a guide for health and social care professionals can be found at www.alzheimers.org.uk/antipsychotics

Appendix One: Abbreviations

Abbreviation	Definitions
NICE	National Institute for Health and Care Excellence
SPC	Summary of Product Characteristics
NICE CG	NICE Clinical Guideline
NICE QS	NICE Quality Statement
BPSD	Behavioural and psychological symptoms of dementia

Appendix Two: References and further reading

1. NICE clinical guideline 42: Dementia - Supporting people with dementia and their carers in health and social care. London: November 2006. Produced by NICE in conjunction with SCIE (http://www.nice.org.uk/cg42)
2. Antipsychotics increase mortality in elderly patients with dementia. MeReC Extra Issue No. 39. May 2009. http://www.isdbweb.org/documents/file/1672_10.pdf
3. MHRA and CHM: Drug Safety Update: Volume 2, Issue 8 March 2009: Article entitles - Antipsychotics: use in elderly people with dementia
4. Drugs and Therapeutics Bulletin: Vol 45 No 11 November 2007 – How safe are antipsychotics in dementia? (www.dtb.bmj.com)
5. Pharmacy in practice March/April 2009: Using Antipsychotics in dementia patients creates a clinical and ethical dilemma. http://www.pharmacyinpractice.com/past-issues/2009-volume-19-issue-2/5-PIP-Mental-health-special-section-MarApr09.pdf
6. Government response to Professor Sube Banerjee's report on the prescribing of anti-psychotic drugs to people with dementia: 12 November 2009 (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108303)
7. 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 (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108303)
8. Soyinka & Lawley; Audit of antipsychotic prescribing in dementia; Psychiatric Bulletin, May 2007, 31, 176-178. http://pb.rcpsych.org/content/31/9/357.3
9. *Ballard*, *Hanney*, *Theodoulou*, *Douglas*, et al. The dementia antipsychotic withdrawal trial (DART-AD): long-term follow-up of a randomised placebo-controlled trial. The Lancet Neurology. London: Feb 2009. Vol. 8, Iss. 2; pg. 151, 7 pgs. http://www.thelancet.com/journals/laneur/article/PIIS1474-4422(08)70295-3/abstract