Bupa

Improving Dementia Care

As a leader in dementia care, Bupa is committed to improving support and care for people with dementia. We encourage the medical fraternity to review use of antipsychotic drugs, considering the information we have gathered.

As a result of Bupa's international networking and benchmarking studies in the area of antipsychotic use in people with dementia, we believe there is clear evidence to support a reduction in these drugs - the adverse effects appear to outweigh the benefits.

The following is a paper written by our consultant geriatrician, Dr. Maree Todd for our care homes. It outlines the evidence for this conclusion, and sets out a clear path towards our goal -

10% reduction in the overall used of antipsychotic drugs for dementia residents in Bupa Care Homes

We hope this paper provokes thought and creates a more positive outcome for some people with dementia.

Regards,

Dwayne Crombie
Chief Executive

Reducing Antipsychotic use - 10% by 2010

Internationally Bupa has a goal of leadership in dementia care and is committed to improving care for those with dementia in our Care Homes.

Our organisation wide strategy to meet these goals includes a philosophy of person centred care, increased staff training, improving meaningful activities and reviewing the environments we provide.

Currently we are focussing on the assessment and management of the behavioural and psychological symptoms of dementia (BPSD). Traditionally there has been a high use of psychotropic medications for these symptoms despite the facts that:

- Evidence of benefit is modest (and up to 40% placebo response)
- Few adequate trials have been performed
- There is an increased risk of death and stroke with antipsychotic agents
- There is an increase in gait disorders, falls, infections, incontinence and confusion
- Studies have shown high levels of inappropriate prescribing
- Studies have shown the safe reduction of antipsychotic use without an increase in other psychotropic use, or increase in use of restraints [1 2]. In fact some reduction in agitation and disruptive behaviour has been noted [2,3]
- This population is particularly vulnerable to adverse drug reactions and interactions

Psychotropic agents fall into three classes - antidepressants, anxiolytics/sedatives (usually benzodiazepines) and antipsychotic agents. Whilst the first two classes also have potentially negative impacts on our residents it is the use of antipsychotic agents that have the most serious effects on those with dementia. In my opinion, antipsychotic prescribing is more likely to be modified safely as a result of a Bupa wide audit and education process because of

- The natural history of BPSD - many resolve spontaneously
- The risk of withdrawal symptoms and high relapse rates in reducing sedatives/ anxiolytics
- The complexity of diagnosing and treating depression in this setting with a high risk of relapse

We have developed an audit process and educational strategy to reduce antipsychotic use by 10%. However it is good practice to look at other psychotropic agents and all drugs regularly to reduce any that are no longer indicated.

Current Antipsychotic Use in Bupa Care Homes July to September 2009

An audit was conducted in the third quarter of 2009 to look at current prescribing patterns. Data is available for all care homes using robotic drug dispensing (84% of all residents).

These prescribing patterns show

- Wide variation in prescribing that is unlikely to be explained solely by case mix
- High rates of prescribing , although they are not dissimilar to a survey by Tucker and Hosford[4] in the Hawkes Bay, nor international rates
- A need to reflect on the causes of the variation. Contributors might be staffing levels, skill mix, environmental issues, lack of meaningful activities, poor communication or prescribing practices.

There is clear evidence that the use of these agents is not driven solely by the prescriber[5].There is often strong pressure from nursing staff and carers to prescribe. Often GPs are reluctant to reduce what the hospital specialist has prescribed.

Average, Mean & Mode of daily anti-psychotic drug dosage (mg)

Anti-Psychotic	Range prescribed (mg) per day	Average	Median	Mode (Most often prescribed)	Total Residents Prescribed
Aripiprazole	15 - 20	17.50	17.50		2
Chlorpromazine	25 - 175	71.88	50.00	50.00	8
Clozapine	25 - 200	71.53	50.00	25.00	18
Flupenthixol	0.65 - 1.43	1.17	1.43	1.43	3
Fluphenazine	3.57 - 3.57	3.57	3.57	3.57	3
Haloperidol	0.25 - 12	1.40	1.00	1.00	151
Methotrimeprazine	6.25 - 62.5	28.13	21.88	6.25	10
Olanzapine	2.5 - 30	7.61	5.00	5.00	93
Pericyazine	5 - 20	10.75	10.00	5.00	10
Pimozide	1 - 1	1.00	1.00		1
Pipothiazine	2.68 - 2.68	2.68	2.68		1
Quetiapine	6.25 - 800	69.73	50.00	25.00	243
Risperidone	0.125 - 8	1.08	0.75	0.50	223
Trifluoperazine	1.5 - 15	4.25	2.00	2.00	6

Figure 5

As we see in the table above (figure 5) the most commonly used agents are quetiapine, risperidone and haloperidol and the median doses used are reassuringly low. There is no evidence base for the use of quetiapine (few studies) but the side effect profile may be more favourable.

There have been several excellent papers [6,7,8] and summaries of the evidence for use of these agents. An independent report on the use of antipsychotic medication in dementia by Professor Sube Banerjee has set a target of a 30% reduction in use of these agents in dementia in the UK and is well worth the read http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108303

The randomised controlled trials of antipsychotics (6 -12 weeks) have shown a modest effect in aggression, agitation and psychosis - effects size of 0.1-0.3. The major concerns have been an increased death and stroke rate. Over this short time there were no reports of increased falls or fractures though a clear deterioration in gait. . The falls literature usually reports an increased risk of falling on these agents and at least one study has shown a reduction in falls when antipsychotics were stopped.[9] The studies also show a 40% placebo response rate and it is important to note that most behaviours are short lived and variable. As the dementia progresses needs change.

For 1000 dementia sufferers with BPSD treated for 6 -12 weeks

- 91-200 will improve i.e. modest benefit
- 10 will die (167 if treated continued for 2 years)
- 18 strokes
- 58-94 will have gait disturbance

Risperidone	OR	CI
Extrapyramidal effects	1.78 3.39	1-3.7 1.69-6.8
URTI 1mg	2.69	1.11-7.76
UTI 2mg	1.82	1.01-3.29
Falls 2mg	2,24	1.24-4.08
Oedema 0,5mg	3.29	1.47- 7.32
fever	2.14	1.03-4.44
Gait 1mg	5.31	2.24-12.62
Incontinence 1mg	13.6	1.81-101.95
Stroke 37/1175 vs. 8/779	3.64	1.72-7.69

Figure 6 Risperidone data from Cochrane Collaboration [10]

Strategies to reduce antipsychotic prescribing (flow charts attached)

GOAL 10% reduction in overall use by end 2010

1. Improve assessment

- Look for delirium and treat the underlying cause (comprehensive physical assessment)
- Assess for depression
- Is there unrecognised pain
- Are existing medications causing problems
- Take a person centred approach-understand the cultural, social and spiritual contributors

2. Improve the behavioural approach to management of BPSD

A key issue is improving understanding and response to the behavioural and psychological symptoms of dementia (BPSD). It is increasingly recognised that the behaviours and psychological symptoms demonstrated are not symptoms of the dementing process per se but an attempt to communicate or indicate need. Person centred care - really understanding and knowing the person, can help reduce BPSD.[11]

Most behaviours and psychological symptoms can be understood by thinking about the balance between the Person related factors , Interaction with others and the Environmental triggers. (PIE)

The target behaviour needs to be clearly defined and an ABC approach implemented. What was happening before the behaviour (Antecedents), what did the person do (Behaviour), and what were the consequences? What did the carer or others do after the incident, what did the person do? The antecedents will help identify triggers that can be avoided and consequences will identify actions that may reinforce or compound the behaviour.

There is a Bupa wide project to increase staff skills in these areas. Non pharmacological interventions such as the following have evidence of effectiveness

- structured social interaction
- aromatherapy using lavender or lemon balm
- personalised music
- massage
- pet therapy
- exercise and dance programmes
- multisensory stimulation

3. Families /Carers -Consult and Consent

- Because of the high rate of adverse events families and carers need to be involved in the decision to use antipsychotics
- Many have experienced the use of these agents before and will be able to guide you as to the response
- They will be able to give guidance on managing the behaviour from their experience

4. Targeted prescribing of antipsychotics

- Use only for severe distress or danger to self or others
- Describe the target behaviour clearly - i.e. what symptom or behaviour are you trying to modify - use an ABC chart to monitor
- Use mainly for hallucinations, delusions, persistent driven, angry, extremely anxious or aggressive states
- Unlikely to be useful when
  - The behaviour is intermittent
  - The behaviour is situation specific e.g. resisting showers vs. resisting all care
  - The behaviour is goal directed
  - There is apathy, wandering (we all need to walk about) calling out, mood disorder, loss of toileting skills or sexual behaviour in the wrong context [8]

5. Review , reduce and stop

- For delirium review at one week. In general, as the underlying illness resolves so does the behavioural issue.

- For dementia the nursing and care staff need to be reviewing the response to medications in conjunction with a behavioural approach. Set a goal, start low, go slow (weekly and modest increments) get control, maintain and review at one month. Continue to use an objective measure of the target behaviour. If the behaviour has settled and been maintained for 3months then slowly reduce by 25% every 2 weeks

6. Residents already on antipsychotic agents for dementia

- If they are under the care of a specialist **consult them** - if the behaviour is stable there should still be a regular review with the goal of reducing the dose and stopping it eventually.
- If the resident has been stable for 3 months, cautiously reduce the dose (25%) and review every 2 weeks. Use an ABC chart to monitor

7. Residents on antipsychotic agents for other Psychiatric Illnesses

- If they are under the active care of a specialist consult with them before making any adjustments.
- "**Graduates**" There are some residents who have been stable for a number of years on the same dose of antipsychotics , As these people get older and frailer the doses may need reviewing, particularly if they are getting side effects . This needs to be done very cautiously and slowly 10-25%, every 2-4 weeks. Seek specialist help particularly if they are on large doses of older agents and getting major side effects.

8. Dementia with Lewy Bodies, Parkinsons Disease

- Antipsychotic agents are generally contraindicated
- Seek specialist advice

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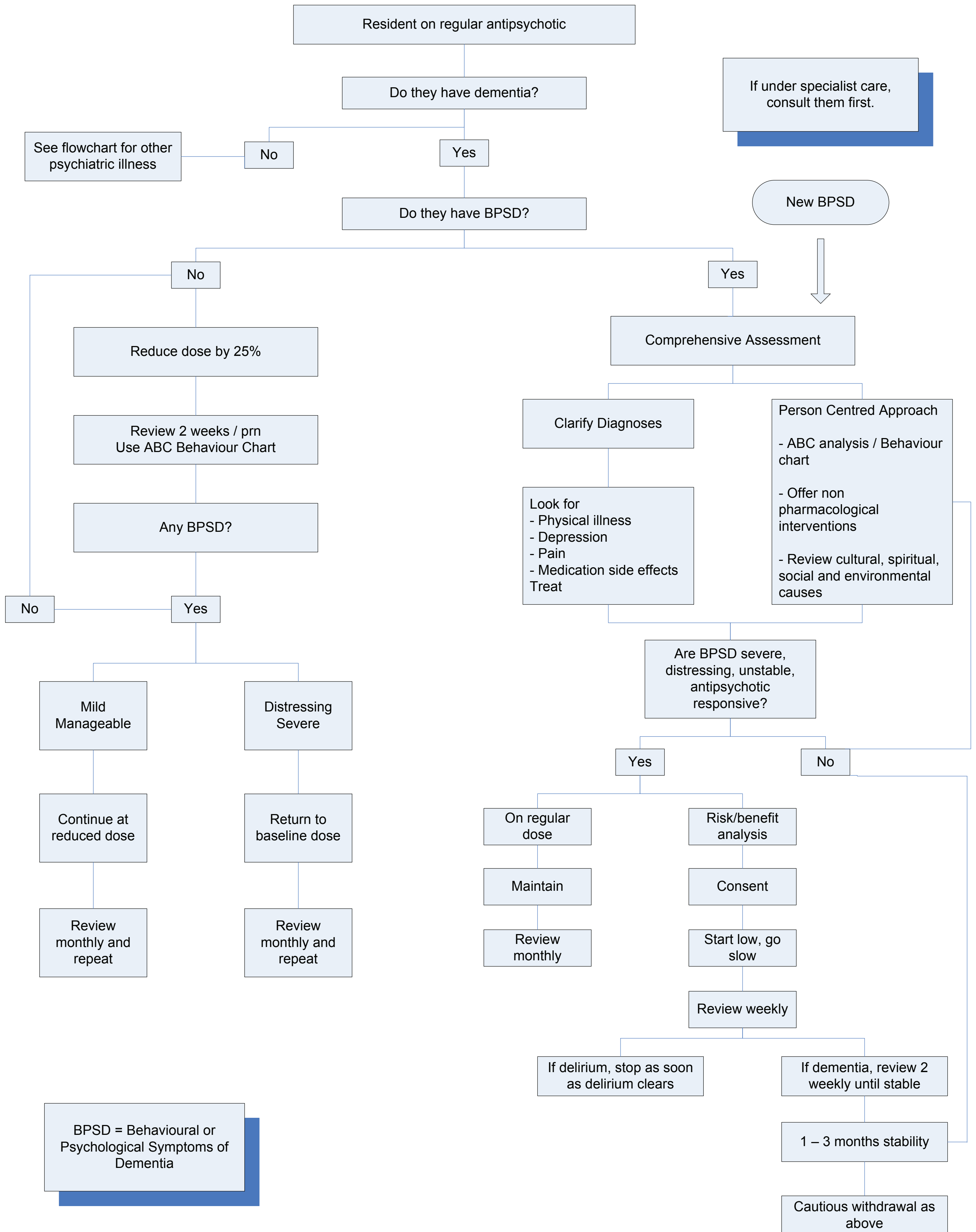
Improving Dementia Care – Reducing Antipsychotic Use



Reducing Antipsychotic Use - Psychiatric Illness