IMPROVING DEMENTIA CARE
REDUCING ANTIPSYCHOTIC USE

By Dr Maree Todd

Aim: To reduce antipsychotic use by use of audit, feedback and educational interventions

Bupa has an international goal to be a leader in dementia care and is committed to improving care for those with dementia in our residential aged care facilities. We have a strategy to achieve the goal which includes a philosophy of person centred care, increased staff training, improving meaningful activities and providing appropriate environments.

Additionally 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:

1. Few adequate trials have been performed to test effectiveness of these agents in this patient group. Evidence of benefit to reduce behavioural symptoms is modest (with up to 40% placebo response) Randomised controlled trials of antipsychotics (6 -12 weeks) have shown a modest effect in reduction of aggression, agitation and psychosis. This means that 5-14 patients need to be treated with an antipsychotic to observe benefit in just one patient. (Ballard C, Cochrane review 2006). There are significant adverse events.

   Sube Banerjee [1] states "For 1000 dementia sufferers with BPSD treated with antipsychotics for 6 -12 weeks:
   - *91-200 will improve i.e. modest benefit*
   - *10 will die (167 if treated continued for 2 years)*
   - *there will be18 strokes*
   - *58-94 people will develop gait disturbance*

   Over this short time there were no reports of increased falls or fractures, however 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. It is important to note that most behaviours are short lived and variable. As the dementia progresses the requirement for treatment changes.

2. These agents also cause an increase in infections, incontinence and often result in more confusion.

3. Studies have shown high levels of inappropriate prescribing in aged care facilities.

4. This population is particularly vulnerable to adverse drug reactions and interactions.

5. Studies have shown the safe reduction of antipsychotic use without an increase in other psychotropic use, or increase in use of restraints [2,3.] In fact some reduction in agitation and disruptive behaviour has been noted [3,4]

   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.

We felt we could modify antipsychotic rather than psychotropic prescribing safely as a result of a Bupa wide audit and education process because of:

- The natural history of BPSD – many issues resolve spontaneously
- Evidence from previous studies e.g. Westbury et al [2]
- 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

Methods Summary

1. A literature review of effective strategies to change prescribing behaviour was performed.

   In summary effective strategies to change prescribing include a mix of the following components [2-10]

   - Audit and feedback
   - Benchmarking - particularly with organisations that are recognised as leaders in the field
   - Education to prescribers - need a variety of formats and styles
   - Inclusion of the multidisciplinary team
   - Focus on nursing staff as key drivers of requests for these medications
   - Reminder and prompt systems
   - Active participation in the project
   - Organisational change and support from senior management
   - Financial and regulatory changes have some impact

   Interventions based on these findings have implemented within Bupa Care Homes bar the financial and regulatory measures which Bupa cannot change.

2. Automated data collection from the electronic drug dispensing system. This allows monthly feedback to the care homes, by care type, of their antipsychotic use. They are benchmarked with other facilities providing similar care within Bupa.

3. Individualised antipsychotic medication plans were implemented

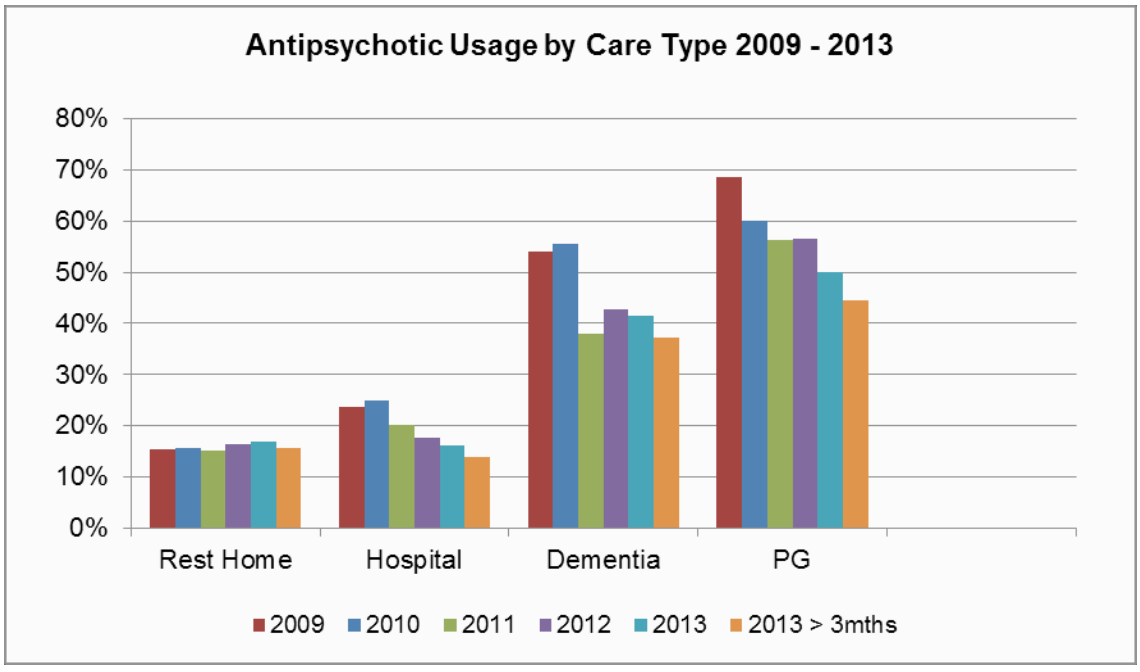
4. A specialist dementia nurse advisor was appointed

Current Results 2013

The reported use of antipsychotics includes people with psychiatric disorders, palliative care and dementia. Approximately 10% of residents are on antipsychotics for reasons other than dementia. Overall use of these agents has decreased except in rest homes and this may be because of the focus on specialist units Most people come to the care homes on these agents and rates of use three months after admission.

There is still considerable variation in use between facilities of the same care type which is unlikely to be explained by case mix.

	2009	2010	2011	2012	2013	2013 > 3mths
Overall	27.3%	27.2%	23.2%	24.5%	23.0%	20.6%
Rest Home	15.4%	15.7%	15.1%	16.5%	16.8%	15.7%
Hospital	23.7%	24.9%	20.1%	17.7%	16.1%	13.9%
Dementia	54.1%	55.6%	37.9%	42.8%	41.4%	37.2%
PG	68.7%	60.1%	56.3%	56.5%	50.0%	44.4%

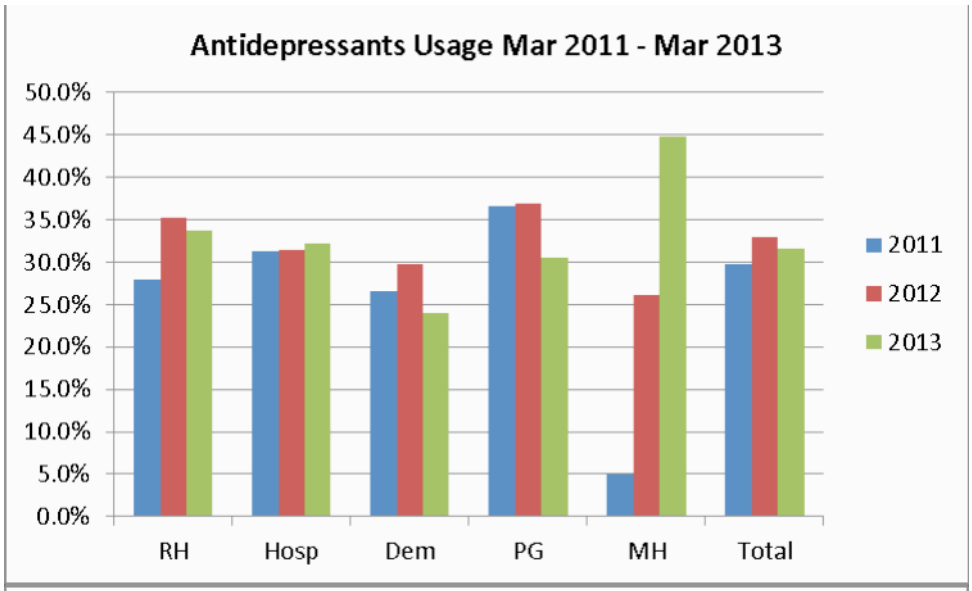


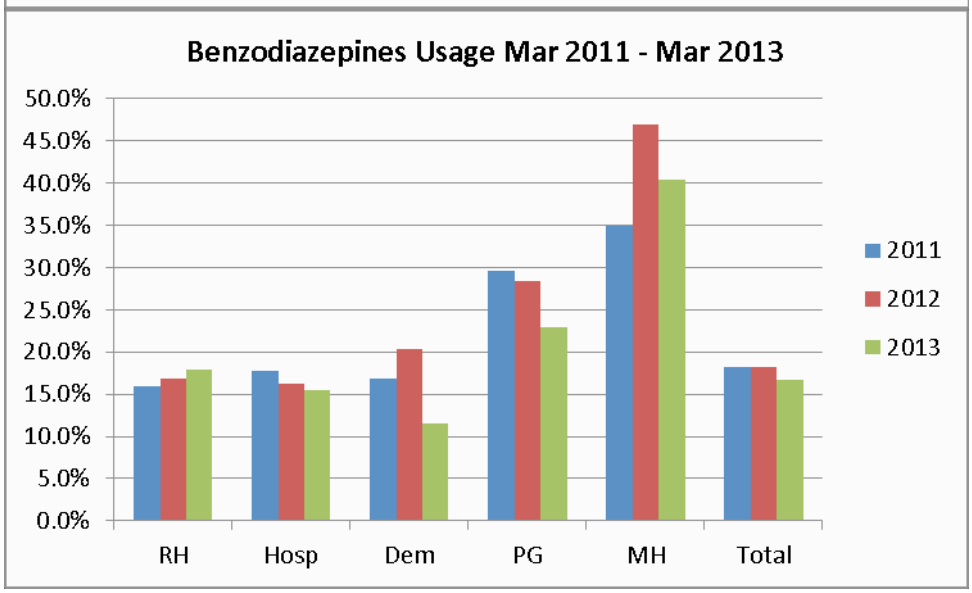
The numbers on two or more separate antipsychotics have reduced dramatically, as have unplanned as required use.

The most commonly used drugs are risperidone , quetaipine , and haloperidol in small doses .

Prescribing Rates of other Psychotropic Drugs

As the caregivers and nurses have become more skilled at person centred care and managing the behavioural and psychological symptoms of dementia the demand for medications have reduced. While GPs have not been targeted to change prescribing for other psychotropics there has been general education in this area. It is reassuring to see that one class of drugs have not been replaced with another and that use in some areas have reduced. The vast majority of the benzodiazepines used are night sedatives in low dose. (MH is 2 specialised psychiatrist led mental health units, small numbers)





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