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## Update

### Professor Alistair Burns

*National Clinical Director for Dementia*

It is a pleasure to write again with an update on how things are developing (as I see them) in my role as your National Clinical Director for Dementia. There are three things that strike me as being particularly important at the moment.

First, work on the antipsychotic drugs. At the risk of sounding obvious, the matter of prescribing these medications is something for the whole system to own. It is not about targeting individual clinicians but more about raising awareness: of ensuring that general practitioners (GPs), carers, care homes, pharmacists and specialists have thought about the issues surrounding prescribing and discussed the risks and benefits of the drugs, and are aware of the alternatives. There is a small, but significant, lobby that says the drugs should simply be banned altogether, but that proposal has been rejected. It is reassuring that the issue has been put into sharp focus in a way not seen before and we now have the whole system supporting this initiative. The Information Centre has just completed (June

2011) the second of a three-stage national audit on antipsychotic drug prescribing, the first showing a near 20% reduction over the past 2 years, a figure supported by a separate Medicines and Healthcare products Regulatory Agency report. The reduction is very encouraging.

Call to Action was launched on 9 June 2011 (chaired inspirationally by Sube Banerjee). This initiative, led by the Dementia Action Alliance and the National Health Service (NHS) Institute for Innovation and Improvement, consists of a mobilisation of eight professional groups ranging from GPs through to pharmacists, old age psychiatrists, hospital doctors, commissioners, people with dementia and their carers ([www.institute.nhs.uk/dementiac2a](http://www.institute.nhs.uk/dementiac2a)). The aspiration of the Call for Action is that everyone with dementia who is being prescribed an antipsychotic should have a clinical review by March 2012. In many ways this simply reflects what should be good practice in line with the National Institute for Health and Clinical Excellence/Social Care Institute for Excellence

guideline.<sup>1</sup> One of the other things we (the Department of Health and the Alzheimer's Society) have developed in relation to this, and which was launched on 18 July 2011, is a best practice guide for the management of behavioural and psychological symptoms in dementia.<sup>2</sup> Thank you to everyone who contributed. This is not just another 'me too' guide about what drugs to prescribe and when, but something broader that deals with prevention, and ways of approaching mild to moderate symptoms.

Second, I sense that we are beginning to see a change and that there is real buy-in and interest in dementia from a wide variety of professionals. For example, the NHS National Clinical Director, Sir Bruce Keogh, and a small group of Strategic Health Authority medical directors (which includes Claire Lawton) have discussed issues about dementia in the general hospital. About a quarter of beds in the NHS are occupied by people with dementia, of whom probably around 40% are ambulatory, which suggests that the person may not need to be in hospital. Therefore, 10% of all NHS hospital beds are occupied by people with dementia who may not need to be there. And, as we know, the care they receive can sometimes be less than good.

There are super examples from around the country of improving care and I have seen several first-hand. The encouraging thing is that there are signs that the issue is recognised as being of prime importance at the very top of the NHS. As I spend more time in the Department of Health it becomes clearer to me that getting very senior buy-in makes a big difference. It may be that by developing something like an alerting question (similar to SQUID – Single QUestion to Identify Delirium) or a risk assessment measure will be helpful in raising the profile of dementia in the general hospital, will result in better care and allow us to make the economic argument that caring for people in the general hospital is cost-effective.

Third, the Dementia Commissioning Pack was launched on 21 July 2011. This will reflect the best of practice across our five priority areas, covering the whole spectrum of dementia from early diagnosis to end-of-life care. This has been produced with the help of the Strategic Health Authorities and is being coordinated by the South West. The pack present a series of specifications, contract inserts, cases for change, costing tools, action plans and patient information booklets.

Finally, in July, I was involved in the launch of two publications: one on end-of-life care in dementia, *Difficult Conversations* (see [www.endoflifecareforadults.nhs.uk/publications/difficult-conversations](http://www.endoflifecareforadults.nhs.uk/publications/difficult-conversations)); and *The Last Taboo: A Guide to Dementia, Sexuality, Intimacy and Sexual Behaviour in Care Homes* ([www.ilcuk.org.uk/record.jsp?type=publication&ID=95](http://www.ilcuk.org.uk/record.jsp?type=publication&ID=95)). I have also been involved in a seminar series by the Arts and Humanities Research Council and the Nuffield Council on Bioethics which may also be of interest ([www.nuffieldbioethics.org/news/council-and-ahrc-host-dementia-policy-seminars](http://www.nuffieldbioethics.org/news/council-and-ahrc-host-dementia-policy-seminars)).

As always, I would be very interested in your views and feedback on any issues with which you think I could be of help (Alistair.Burns@dh.gsi.gov.uk).

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# Message from the Chair

Peter Connolly

*Faculty of the Psychiatry of Old Age, Royal College of Psychiatrists*

When I took up the mantle of Chair, I had been a member of the Faculty Executive for 8 years in one capacity or another. Despite this, I still had a sense of being a stranger in a foreign land. Although I spent 6 months shadowing the previous Chair, Dave Anderson, the step up to Chair has been huge and it has taken another 6 months to get a sense of order.

We are in a period where threats and opportunities arise in almost equal measure. Dave Anderson's tireless work ensured that the voice of the Faculty became more powerful at a political level, with key input into the English National Dementia Strategy and work on age discrimination. His work on tackling interfaces between our specialty and others has been well received by Council and a full-day meeting at the beginning of February 2011 was devoted to this topic.

To some, however, the need to end age discrimination and the need to improve the way money is spent on dementia services is seen as a threat. Several times I have heard colleagues question whether or not old age psychiatry still has a separate identity, and heard of trainees being discouraged from seeking a career as an old age psychiatrist. To me such sentiments are badly misplaced. Whatever service management might be, old age psychiatrists have unique skills in the identification and management of people with multiple physical, mental, social and cognitive comorbidities integrating and synthesising key information at an individual and service level and in the planning and development of the unique services needed by older people. Everyone knows that the population is ageing and that the older the person, the less straightforward the presentation is likely to be. The movement towards subspecialisation in working age services makes it far less likely that consultant colleagues in these areas would be able to manage older people in the way an old age psychiatrist does. We should view our specialty as becoming stronger and take the initiatives of the National Dementia Strategy and the National Dementia Declaration as rallying calls to lead local services, not look for their diffusion and dissolution.

And yet we cannot do everything, at least not with continuing equity of development by comparison to other services. Something will have to give if there is to be a genuine drive towards needs-led service provision.

I am firmly against the view that a return to an age-inclusive functional service leads to benefits for

patients. I started life in one of these services and my experience meant that to develop a specialised functional services for the over 65s was my first priority as a consultant. Like many colleagues I do not have access to the same range of therapies as my counterparts in my local working age services but I cannot see how the wholesale transfer of services will lead to benefits for the most vulnerable. I have heard stories of compression of old age services once they are 'integrated' with working age services, with reductions in bed availability, disproportionately low access to home treatment services and so forth. I would be delighted to hear from those who have found the experience of moving away from a comprehensive service beneficial to patients and staff. Either way, there is a clear challenge for us to find a model which provides the best care and treatment for our patients.

The National Dementia Strategy is now in middle age. Its creators are to be commended for producing a comprehensive range of recommendations. Many service planners are not used to simultaneously implementing change on multiple topics and concentrate instead on one or two. Good service delivery is well represented as a 'cogs and wheels model', with each cog of the correct size and each interacting appropriately. Cherry-picking developments simply distorts this model rather than making it more efficient. However, it does create scope for genuine innovation. We need to be much more ambitious when designing the next strategy and demand an ideal service for our patients.

As you read this perhaps you feel your service or part of it is different, special or innovative. I know how modest you all are but don't keep it to yourself. Maybe you have had a memory assessment day in a local supermarket or have trained your clinic receptionist to be dementia aware. Or developed a culturally sensitive service? Or palliative care at home? Let the Faculty know, even if it seems off the wall. It might just influence the way services develop over the next few years. The Scottish Dementia Strategy (inevitably also called 'National') is designed to promise less comprehensive development than the English strategy but deliver more. We shall see.

As old age psychiatrists we have a unique opportunity to define new services and influence national thinking. We should not stand in the background but get ourselves to the forefront of influence where we belong as specialists.

# Suicidal ideation in elderly patients: case study<sup>†</sup>

Thomas Hogan

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## Case study background

Mr A is a 93-year-old gentleman who has attempted suicide several times. Prior to admission on this occasion, Mr A developed relatively minor medical symptoms, the seriousness of which appear to have been misinterpreted by him. This led to him developing a very low mood, which culminated in his attempted suicide by stabbing himself in the left chest. After admission to hospital, Mr A developed some medical complications. However, he refused treatment and was deemed to have capacity to do so. As it became clearer to Mr A that he would not die from his medical complication, but could suffer considerable pain, he consented to treatment. He was later transferred to the psychiatry ward.

Mr A believes in the right to euthanasia and believes that as an elderly man, who has lived a 'full life', he should be able to control the ending of it.

## Suicide and suicidal ideation in the elderly

Suicide ideation can be active (i.e. having thoughts of taking one's life) or it can be passive (i.e. feeling hopeless or that life is not worth living – wishing for death).<sup>1</sup> In 2007, 75% of suicides in the UK were in men, a proportion which has remained quite consistent throughout the past 15 years or so.<sup>2</sup> Women attempt suicide less frequently and are less successful when they do attempt it.<sup>1</sup> This has been attributed to the fact that women are less likely to be isolated in the community. In fact, research has indicated that the more children a woman has had, the less likely she is to attempt suicide.<sup>3</sup>

One study found that the demographic group with the highest suicide rate is White men aged 65 or older.<sup>4</sup> There is some evidence that the rate of suicide in the elderly is declining. According to the Office for National Statistics, the rate of suicide in males aged 75+ decreased from 25.1:100 000 in 1991 to 15.2:100 000 in 2007.<sup>2</sup> Despite this trend, as we live in a country with an ageing population, it is likely that the actual number of suicides and attempted suicides in the elderly will increase year on year, even if the rate continues to drop. This will place an unprecedented burden on the National Health Service.

It is important to bear in mind the wider social implications of suicide. Bereavement after suicide is 'more similar than different to other bereavements, but is also characterised by the reactions of shame, stigma, and self-blame'.<sup>5</sup>

Older people tend to be more successful in their suicide attempts than younger people. In adolescence, the ratio of attempted to completed suicides is about 200:1. In the elderly, this ratio is reduced to 4:1.<sup>1</sup> This has been attributed to the reduced likelihood of rescue, but could also be due to a greater resolve to die (rather than 'crying for help'). The reduced likelihood of rescue could be due to social isolation or to reduced physiological reserve.<sup>1</sup> The greater resolve to die among elderly people who attempt suicide means that they take the time to come up with a good plan and tend to use more lethal methods.<sup>6</sup> A study of European patients showed that approximately 24% of patients over the age of 60 who unsuccessfully attempt suicide will attempt suicide again within 1 year.<sup>7</sup>

Suicide has been linked to depression (in 87% of cases), dementia, psychiatric illness, and taking anxiolytic medications or tranquillisers.

## Depression

One of the issues in Mr A's case is whether or not his attempts at suicide are linked to an underlying depressive illness. Does Mr A have depression or is he simply 'ready to go', as he himself puts it?

The World Health Organization (WHO) states that depression is

*'a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration.'*<sup>8</sup>

There is not scope in this report to discuss the diagnostic criteria for depression. However, Mr A displays anhedonia and low mood, along with disturbed sleep, feelings of worthlessness and recurrent thoughts of suicide. Therefore, using both the DSM-IV and ICD-10 criteria, he would be diagnosed as having depression.

<sup>†</sup>Based on experience of a 4-week student-selected placement in old age psychiatry.

## Capacity

Capacity is defined as having

*'sufficient understanding and memory to comprehend in a general way the situation in which one finds oneself and the nature, purpose, and consequence of any act or transaction into which one proposes to enter.'*<sup>9</sup>

At the time of presenting to hospital after his most recent suicide attempt, Mr A was assessed and it was decided that he did, in fact, have capacity, which meant that under the Mental Capacity Act 2005 (England and Wales) he was within his rights to refuse treatment for his medical problems. Under this Act, a person cannot 'be treated as unable to make a decision merely because he makes an unwise decision.'<sup>10</sup> The law is very clear on the matter even though it may go against the intrinsic beliefs of many in the medical profession to withdraw treatment in such cases. Interestingly, Mr A cited a perceived serious medical condition as his main reason for attempting suicide on this occasion. However, the reality was that he had misunderstood his symptoms which were, in fact, very manageable. It could be argued that he therefore lacked capacity as he did not understand the nature of his condition (i.e. did not comprehend the situation in which he had found himself).

Placing that argument aside for the moment, more relevant in more immediate term is whether or not Mr A currently has capacity. He appears to now understand the situation in which he finds himself and his cognitive function is not impaired. He clearly therefore has capacity.

## Discussion

### *Underlying depression*

It would appear that Mr A has had underlying unipolar depression for at least the past 5 years. A pattern appears to be developing whereby he attempts suicide and is then admitted to hospital, where his mood improves owing to a combination of treatment optimisation and the therapeutic benefit of being surrounded by caring people daily. This seems to give him a 'boost', which keeps him going in the community for a while after discharge. Gradually, his mood seems to worsen after a year or so in the community, and then some perception of his failing physical health will 'tip the balance'.

### *The right to die*

It is clear that Mr A believes in the right to end one's life. This belief does not appear to be linked to his depression. At the same time, it does not appear that he really wants to end his life. Despite having first

tried to take his own life 5 years ago, he has now had two separate 2-year periods when he has not tried to kill himself. Mr A is clearly an intelligent, competent man, and if he had wanted to, he would have found the means to die by suicide by now. The fact that he didn't would seem to suggest that he responded to each stay in the psychiatric ward and subsequent optimisation of his antidepressant drugs, a clear sign that his suicidal attempts are in fact related to times when his underlying depressive illness is not so well controlled.

### *The future*

Mr A clearly needs to be monitored, but it is likely that his mood will improve with medication while on the psychiatric ward. Despite the fact that he still believes strongly in euthanasia, he recently commented 'I might be around for a few more years yet'. He has recently been on a day visit back to his house for a few hours which went relatively well. It would appear that he will be ready to be discharged within a few weeks. He himself acknowledges that he 'can't stay here forever'. However, a word of caution must be sounded. His psychiatric history over the past 5 years would suggest that he will be back again in the future.

## Personal reflections

My time as a medical student on an old age psychiatry rotation gave me a wonderful insight into an area of medicine and society that is far too often overlooked on medical school curricula. It showed me that issues relating to mental health are rarely 'black and white'. I learned the importance of remaining objective when looking at issues of mental health, without being influenced by my personal feelings or thoughts about a particular patient.

I therefore came to greatly appreciate the importance of having standard criteria (such as the ICD-10 and DSM-IV) for assessing mental health. Paradoxically, however, I also learned the importance of seeing each patient as an individual with varying opinions and backgrounds. I was shown the importance of respecting their choices and beliefs, however much they may go against my own.

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#### Editor's note

The author won the Old Age Psychiatry Medical Students' Essay Prize in 2010. This article is an edited version of his winning essay.

# Sporadic Creutzfeldt–Jakob disease

## Case report of a rare and rapidly progressive dementia

Rebecca Davis

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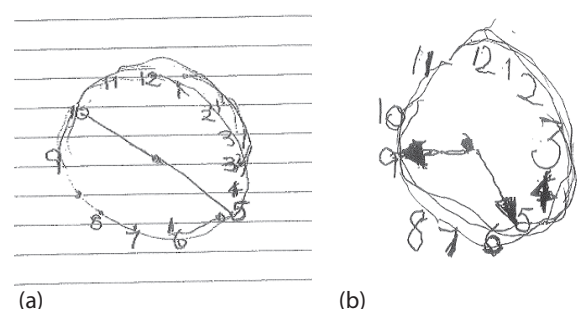
### Case study: Mrs B

Mrs B, a 70-year-old married woman, was referred by her general practitioner (GP) to the old age psychiatry service. She was initially assessed at home by a community psychiatric nurse and presented with a 3-month history of progressive short-term memory loss and difficulties with shopping and cooking. She was misplacing items and taking longer to complete tasks. She had lost confidence in driving following two minor car accidents. As a passenger she would forget to close the door and put her seat belt on. She was reluctant to write her Christmas cards as her handwriting had become untidy, and needed a great deal of prompting and supervision from her husband. Mrs B was more tired than usual, but had no other symptoms of depression.

Mrs B was usually fit and well, with no significant medical history and no vascular risk factors. She was not on any regular prescribed medication, but had recently started to take some *Ginkgo biloba* because of worries about her memory. There appears to have been a positive family history in that her mother died in a residential home in her 80s. She had an apparent dementia of several years' duration that was never formally diagnosed. Mrs B worked in education before retirement. She had been married for 40 years, and the couple had two children. She was a non-smoker, who drank 1–2 units/week. Her hobbies included gardening and walking.

### 'A rudderless ship'

Mrs B scored 79/100 on the Addenbrooke's Cognitive Examination<sup>1</sup> and had a Mini-Mental State Examination (MMSE)<sup>2</sup> score of 27/30. She had impairments in the domains of attention, memory, fluency and visuospatial abilities (Fig. 1(a)). She was noticeably slow in completing the tests. A magnetic resonance imaging (MRI) scan was ordered and she was seen in the consultant's clinic 6 weeks later. During that time there had been significant deterioration, with Mrs B describing herself as being 'like a rudderless ship'. Her memory had worsened; she was less spontaneous in conversation and had stopped her usual hobbies. She had difficulties navigating her way around her own house. Her balance had become poor and she had begun to veer to the left. There were no other



**Fig. 1** Clock drawing test (a) at first assessment and (b) 6 weeks later.

psychiatric or neurological symptoms. Her overall MMSE score remained 27/30, but her handwriting and visuospatial abilities had worsened (Fig. 1(b)).

Neurological signs included an ataxic gait, dressing dyspraxia, a left pronator drift and left dysdiadochokinesia. Power was normal, but there was increased tone in the left upper limb. Blood tests including full blood count, erythrocyte sedimentation rate, urea and electrolytes, liver function tests, thyroid function tests, glucose, B12, folate and cholesterol were all normal.

#### Further results

The MRI scan showed asymmetric diffuse cortical high signal around the right hemisphere and the deep grey matter nuclei, particularly the caudate head and lentiform nucleus. It was most pronounced on diffusion-weighted imaging. No regional atrophy or white matter changes suggestive of Alzheimer's disease or vascular dementia were seen. The radiologist felt that the appearances could represent an encephalitis, possibly Creutzfeldt–Jakob disease (CJD). Mrs B was referred to a neurologist for further investigations. An autoantibody screen and tumour markers were all normal. The cerebral spinal fluid (CSF) total protein, glucose and microbiology were normal, and oligoclonal bands were negative. The CSF was positive for 14-3-3 protein, which is seen in the sporadic form of CJD, and levels of another suggestive marker S100b were raised. The electroencephalogram (EEG) showed right-sided sharpened theta and delta forms (which are abnormal in awake adults), with poorly formed background activity. The trace was consistent with organic disturbance, but the classic triphasic pattern of CJD was not at that stage present.

#### Steady decline

In 2 months the MMSE score dropped by 9 points and myoclonic jerks developed. They were responsive to low-dose clonazepam. Over the subsequent 9 months there was a steady decline in mobility, loss of meaningful speech, and the development of primitive reflexes. Home nursing care became necessary. An episode of aspiration prompted consideration of the use of percutaneous endoscopic gastrostomy feeding, but it was deemed unlikely to improve Mrs B's overall quality of life. Following a further episode of aspiration Mrs B was admitted to the local hospice where she passed away surrounded by her family.

### Sporadic CJD

The disease was first described by the German neurologists Hans Gerhard Creutzfeldt and Alfons Maria Jakob in the 1920s. In the UK, the National

CJD Surveillance Unit based in Edinburgh monitors its incidence. Sporadic CJD is the most common form, affecting about one person per million of the population and causing 50–60 deaths per year. It is predominantly a disease of late middle age, with a mean age at death in the late 60s.<sup>3</sup> Sporadic CJD is thought to be caused by prion proteins that undergo a spontaneous conformational change to an infectious form. They then alter neighbouring proteins in a chain reaction. These abnormal prions aggregate, leading to neuronal damage and giving the brain a spongy appearance at post-mortem.

Creutzfeldt–Jakob disease can less commonly be familial or iatrogenic as a result of contaminated human growth hormone, blood products or surgical instruments. Variant CJD, which has predominantly affected younger patients, is thought to be caused by dietary exposure to beef infected with bovine spongiform encephalopathy (BSE).<sup>4</sup>

### Rapidly progressive

Prodromal psychiatric symptoms such as sleep disturbance, psychosis and depression can occur prior to formal diagnosis.<sup>5</sup> The typical picture is of a rapidly progressive dementia. Ataxia and myoclonus are present in the majority of cases. Other features include impairment of voluntary movements and rigidity. Walking, speech and vision deteriorate, and the affected individual very quickly becomes bed-bound and uncommunicative. The disease is invariably fatal and 65% of individuals have an illness duration of less than 6 months. In 14% of cases, there is a relatively long duration of 12 months or more. The distressingly rapid clinical changes help to distinguish CJD from most other dementing illnesses.

### Investigations

Useful investigations in suspected sporadic CJD are:

- EEG – in the majority of cases generalised bi- or triphasic periodic sharp wave complexes appear with a frequency of around 1–2 per second
- CSF 14-3-3 estimation – this marker of neuronal damage is measured at the National CJD Surveillance Unit laboratory
- MRI – this is usually undertaken to exclude other conditions, but in some cases abnormal high signal may be seen in the anterior basal ganglia and sometimes in the cortex. Diffusion-weighted images are the most sensitive.<sup>6</sup> These findings are supportive of a diagnosis of sporadic CJD, but are not yet part of the accepted diagnostic criteria for the condition.<sup>7</sup>

Diagnosis of variant, but not sporadic, CJD can be supported by biopsy of the tonsils.

A definitive diagnosis of any form of CJD requires neuropathological examination of brain tissue. This would usually be undertaken at post-mortem.

### Treatment and support

To date there is no proven treatment that can cure or halt the progression of CJD. A palliative approach, targeting neurological and psychiatric symptoms is suggested.

The National CJD Care Team can provide advice to local services, and the CJD Support Network ([www.cjdsupport.net](http://www.cjdsupport.net)) is a patient support group for people with all strains of CJD, their carers and professionals.

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# Psychosis in Huntington's disease: case report

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Huntington's disease is a progressive autosomal dominant neurodegenerative disease. It is caused by the presence of a high number of CAG trinucleotide repeats on the short arm of chromosome four.<sup>1</sup> Personality changes generally occur first, followed by the characteristic choreiform movements, Parkinsonism, memory and psychiatric problems. The prevalence of affected individuals in populations of White people is steady at 5–7 per 100 000.<sup>1</sup> Disease onset usually occurs between the ages of 35 and 44, with an average survival of 20 years.<sup>2</sup> It remains an incurable disease.

We describe an interesting case of frank psychosis presenting in a patient with a known diagnosis of Huntington's disease encountered in our old age psychiatric services.

### Case study: Mr C

Mr C, a 73-year-old retired gentleman, presented floridly psychotic with a 7-week history of gradual worsening of auditory hallucinations to the old age psychiatric services. Prior to the initial assessment, the symptoms had further worsened over a 2-week

period. The patient was hearing voices from television programmes he had been watching and hearing the words spoken to him from newspapers that he was reading. He also described 'whisperings' from the carpet when he walked. Mr C was unknown to the psychiatric services and had never experienced symptoms in the past. He has, however, had a diagnosis of Huntington's disease for the past 8 years and has a positive family history. Blood parameters were normal and no physical causes for the current presentation were identified.

Mr C was initially seen in the presence of his wife of 51 years. They were both visibly distressed by the auditory hallucinations. Mr C was cooperative during the consultation, but appeared anxious and restless. He displayed chorea, clumsy movements and had a dysarthric speech, all in keeping with his previous diagnosis of Huntington's disease. He was also noted to be repeating his speech during the consultation. Mr C reported a change in his sleep pattern and an interference with his concentration on his hobbies.

He initially scored 22 out of 30 on the Mini-Mental State Examination (MMSE);<sup>3</sup> the low score being attributed to his impairment in concentration. Initial

treatment consisted of amisulpride 50 mg and zopiclone 3.75 mg, both to be taken at night.

At follow-up, Mr C reported complete resolution of his auditory hallucinations, with no adverse effects from the amisulpride; in particular, no effect on his premorbid functioning with respect to his Huntington's disease. He was sleeping better and did not require the zopiclone. He scored 29 out of 30 on the repeat MMSE. Our plan at follow-up was to continue the amisulpride, with a further clinic appointment arranged in 6 months time.

### Psychiatric symptoms in Huntington's disease

Psychiatric illnesses reported in Huntington's disease include depression, psychosis and dementia. Studies have shown high prevalence rates of psychiatric symptoms in a cohort of 52 patients with Huntington's disease: 67.3% for signs of agitation, 51.9% for anxiety, 11.5% for delusions and 1.9% for hallucinations.<sup>4</sup> The most common psychiatric illness detected was dysphoria at 69.2%. Earlier studies have shown symptomatic schizophrenia in 9% of patients in a cohort of 30 families with Huntington's disease.<sup>5</sup>

Suicide rates are estimated to be higher in patients with Huntington's disease. Indeed, studies have shown suicidal ideations to be over 20% at the point in the illness where independence begins to be lost.<sup>2</sup>

Despite the prevalence of psychosis in Huntington's disease, the literature regarding management is sparse, being limited mainly to case reports. When considering treatment for psychosis in association with Huntington's disease, it is important to bear in mind the side-effect profile of the antipsychotics, in particular conventional antipsychotics such as haloperidol or chlorpromazine.

### Management options for psychosis

The use of haloperidol or fluphenazine in the earlier stages of Huntington's disease has been suggested as appropriate treatment to target both hyperkinesia and psychotic symptoms.<sup>6</sup> Rosenblatt *et al* suggest that more advanced disease is treated with the newer atypical antipsychotics due to the more significant problems of dystonia and Parkinsonism. Rosenblatt *et al* also suggest that electroconvulsive therapy can be used to treat patients in whom antipsychotics are ineffective.

### Existing case reports

There are case reports of the effective use of quetiapine in the management of the positive symptoms of psychosis in Huntington's disease, although this was not without the increase of

extrapyramidal side-effects.<sup>7</sup> Of note, olanzapine was trialled unsuccessfully in this case report.

Case reports of the successful use of risperidone to manage symptoms of psychosis in a patient with Huntington's disease have also been published.<sup>8</sup> Dallochio *et al* describe the use of risperidone in a patient that had significant side-effects following the use of haloperidol. They report a reduction in the psychotic symptoms in the patient and no side-effects associated with the use of risperidone.

German case reports have been published that show an improvement in the psychotic symptoms in four patients with a background of Huntington's disease treated with amisulpride.<sup>9</sup> However, Saft *et al* warn of the development of extrapyramidal side-effects in association with the use of amisulpride.

### Conclusions

As the published literature on the treatment of patients presenting with psychosis in association with Huntington's disease is limited, and there are no published randomised controlled trials, the decision regarding treatment has to be made taking into account a number of factors. The degree of psychosis and its effects on the patient and their family must be balanced against the possible side-effects of the medications to be employed. Further research into this area would be beneficial to all clinicians involved in both the treatment of patients with Huntington's disease and clinicians involved in the management of psychotic illnesses.

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# Role of the specialist liaison social worker

## Reducing readmissions in the acute hospital setting

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Older adults often present with multiple and complex needs. Acute hospital admission is associated with a decline of physical and social functioning for many older people. Also, mental health comorbidity in physically ill older adults is often underrecognised and independently predicts poor outcome following admission to general hospitals.<sup>1</sup> This poor outcome is characterised by increased mortality, increased length of stay, loss of independent function, admission to hospital and readmission as well as financial implications. Two-thirds of the beds in the National Health Service are occupied by adults over the age of 64 years. Fifty to sixty per cent of individuals admitted to the general hospital have or acquire a comorbid mental disorder. The prevalence of the three main mental illnesses in the acute hospital is: dementia 31%, depression 29% and delirium 20% – meaning that these disorders are more common in the acute hospital than the community or mental health units.<sup>1</sup>

### **Collaborative working**

In recent years, increasing recognition of the magnitude and significance of the problem has led to the development of policies to address mental illness in older adults in the acute hospital. There is accumulating evidence to suggest that liaison psychiatry services are the vehicle to achieve the necessary change. For an effective delivery of service, a liaison team must be multidisciplinary and hospital based. Collaborative working across the health and social care interface is deemed to be effective in reducing readmission rates after discharge from in-patient hospital care.<sup>2</sup> Key principles of the National Service Framework for Older People<sup>3</sup> include prevention of unnecessary acute hospital admissions and the need to address mental health problems.

It is often alleged that the elderly mentally ill are frequently admitted inappropriately and block acute beds for prolonged periods of time. In our study, we sought evidence of this in relation to cases where care was managed by the liaison social worker. We endeavoured to explore the relationship between specialist liaison social worker input and rates of readmission to the acute hospital, more specifically to identify two things:

1. the difference, if any, between the readmission rates of elderly patients to the acute hospital and that of all the elderly patients in the general hospital; and
2. whether the readmissions were medically appropriate.

Although the benefits of liaison intervention are emerging, so far little has been written about the role of the liaison social worker. We therefore attempted to discuss this in the context of the acute hospital setting.

### **Service organisation**

This study was carried out at the Royal Liverpool and Broadgreen University Hospitals NHS Trust, UK, which contains three teaching hospitals with a total of over 1215 beds. It is estimated that 20 000 elderly people per year are admitted, with 12 000 of these experiencing episodes of mental disorder.

To cater to this population, the hospital has developed the liaison mental health service for older people. This is a hospital-based, multidisciplinary team, which is predominantly nurse-led and comprises:

- two specialist mental health nurses
- two specialist social workers
- one senior occupational therapist
- two consultant sessions
- two specialist registrar and one senior house officer sessions
- one secretary
- dementia intermediate care
- two specialist domiciliary carers.

### **The liaison social worker**

A social worker brings a range of skills to a multidisciplinary team, including:

- a person- and family-centred approach
- specialist expertise in mental illness
- facilitating prompt discharge as appropriate
- avoiding unnecessary admissions arising from social care or mental health needs
- access to specialist domiciliary care workers – ‘enabling service’

- access to specialist mental health services
- sustaining continuity of care.

### Retrospective observational study

We undertook a retrospective observational study of a cohort of 324 adults above the age of 64, consecutively referred to the liaison social worker between February 2003 and November 2005. Data were extrapolated from the electronic databases and case records of the Royal Liverpool & Broadgreen University Hospitals NHS Trust and Mersey Care NHS Trust, as well as from Department of Social Services records.

A semi-structured tool with 15 parameters was used to collect data about patient demographics, details of the index admission, source of referral to the social worker, physical and mental health comorbidity, aftercare arrangements and details of readmissions within 6 months (available from the author on request). Data were analysed by Microsoft Excel software on Windows.

### Results

Of the 324 older adults included in the study, 278 (85.7%) lived at home, either alone or with family, prior to hospital admission. The remainder (9.3%) were resident in sheltered accommodation or a care home, with the usual place of residence being unclear in 5% of the sample.

The predominant reasons for admission were confusion, falls, fracture neck of femur and stroke, accounting for 30% of the total admissions. In total, 132 (40.7%) people had had prior contact with the local mental health service for a range of organic and functional mental illnesses.

Referral to the liaison social worker was initiated by the liaison nurse (176 cases), medical social worker (95 cases) and occupational therapist (43 cases). Of the total sample, 96.1% were assessed by the social worker on the same day as the referral, while 3.4% were contacted within 3 days. Only a small proportion (1.5%) were not assessed for reasons varying from patients transferred, discharged before seen or death.

Aftercare arrangements included: discharge home with a care package in 146 people (45%), intermediate care in 27 (8.3%) and discharge to 24-hour care in 89 (27.4%). No input was offered to 63 individuals (19.4%) owing to patient refusal, being inappropriate for the service, medically unfit or transfer to mental health unit.

There were 74 readmissions (22.8%) within 6 months of index discharge, with medical illness being the cause in 64 cases. Only 10 of the 74 readmissions were

deemed to be inappropriate, being predominantly related to social care. Of the 74 readmissions, only 10 patients (13.5%) were re-referred to the liaison social worker resulting in an alteration of the existing care package for 6 individuals (8.1%).

The readmission rate for the group referred to the liaison social worker was 22.8% in contrast with that of the Royal Liverpool and Broadgreen University Hospitals NHS Trust, which was 30.1% for the same age group and same period.

### Outcomes

Following specialist liaison social worker input, the following outcomes were identified:

- rapid response (96% same-day contact)
- few inappropriate readmissions (13.5%)
- few alterations to care (8.1%)
- readmission rate of liaison social worker sample less than that of all older adults in the general hospital.

This could be indicative of robust care management provided by this specialist input. These findings do not support the contention that older people who are mentally ill have higher rates of readmission, at least, where care was managed by the liaison social worker, nor that these patients are admitted inappropriately for mental health or social reasons. Liaison psychiatry services for older adults are still evolving and more needs to be understood about individual professional roles and effective ways of working.

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# In-patient prescribing on three old age psychiatry wards in east London

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## Medication errors

The National Prescribing Centre<sup>1</sup> described medication errors as mistakes that can occur at any stage of the medication process: prescribing, dispensing, preparation, administration and monitoring.

In 2007 the National Patient Safety Agency (NPSA)<sup>2</sup> highlighted that 15.7% of medication-related errors were associated with the prescribing process, while a General Medical Council (GMC) report<sup>3</sup> revealed that 10% of all prescriptions issued by doctors contained errors (omitting drugs, wrong doses, not taking account of a patient's allergies, illegible handwriting or ambiguous orders). There were 4190 errors in 50016 medication orders written by Foundation Year 1 doctors, an error rate of 8.4%. All grades of doctor (including consultants) made prescribing errors and the highest error rate (of 10.3%) was in Foundation Year 2 doctors. Errors were most often made at the time of patients' admission to hospital. Further, the Department of Health warns that the legal responsibility for prescribing lies with the doctor who signs the prescription.

## Audit

Information recorded on the in-patient charts on three old age psychiatry wards was matched to the East London Foundation Trust (ELFT) medicine policy<sup>4</sup> on prescribing and the results were compared with two previously published audits.<sup>5,6</sup>

The agreed standard was the ELFT Medication Prescribing Audit Tool. It is adapted from the ELFT medicines policy document,<sup>4</sup> which features the *British National Formulary* guidelines

*'that prescriptions should be written legibly in ink or otherwise so as to be indelible, should be dated, should state the full name and address of the patient and should be signed in ink by the prescriber; the age and date of birth of the patient should preferably be stated.'*<sup>7</sup>

Data were collected on a random day (in December 2009) from a sample of 33 patients and divided into two core domains:

1. the patient's identification information

2. allergy status and the completeness of medication prescribing.

## Results

There were 20 male and 13 female patients, with a total bed occupancy of 73%. The average patient age was 75.5 years (range 52–97).

### Patient identification

All the names were written in full. In one case the date of birth was omitted. The hospital number was entered for the two 'organic' wards (Cedar Lodge and Larch) but was left out frequently on the acute 'functional' ward (Orchard). The age and legal status of all 33 patients were not entered and the entry for the date of admission was poor. The allergy box was completed in 100% of cases (Table 1). All charts were legible.

### Completeness of prescription

Medication was written in capital letters mainly on Cedar Lodge ward. Approved or generic names were used and in each case the dose, frequency and route of administration were fully included. All the charts were legible and signed.

### Comparison to previously published audits

The patients' names were clearly identified in 100% of cases (100% also in Onajala *et al*,<sup>5</sup> and 96–98% in Ved *et al*<sup>6</sup>). The charts were all signed and comparable to Onajala *et al* and Ved *et al*. The charts were 100% legible compared with 93–99% in Ved *et al*. In total, 97% of dates of birth were entered. The allergy box was completed in 100% of cases compared with 10–19% for Ved *et al* and 14–52% for Onajala *et al* (Table 1).

## Discussion

An audit on prescribing errors<sup>8</sup> found that errors were more common in older adults (63%) compared with working-age adults (37%). This prompted us to look into our own practice on three old age psychiatry wards.

**Table 1** Comparison of audits (%)

	Patient name	Date of birth	Date of admission	Drug approved/ generic name	Allergy	Legible	Signature
Current study	100	97	18	100	100	100	100
Onajala <i>et al</i> 2001 <sup>5</sup>	100	NA	NA	79–81	14–52	NA	98–100
Ved <i>et al</i> 2007 <sup>6</sup>	96–98	94–98	9–36	92–96	10–19	93–99	100

NA, not applicable.

Prescribing errors are not rare and affect all grades of doctors. The most senior doctors made the fewest mistakes, while doctors in their second year after qualifying made the most.<sup>3</sup> The prescriptions in our sample were completed by a general practitioner (GP) trainee or psychiatric core trainee (CT1–3), except for prescriptions in Cedar Lodge ward which were completed by a GP. We did not notice major discrepancies between the trainees and the GP.

Our findings are not dissimilar to the results of the two previously published audits,<sup>5,6</sup> with the exception that there is a better recording of allergy status in our sample. A similar audit published in 2007<sup>9</sup> had a 60% completion of allergy boxes. It could be postulated that over time the training of doctors on prescribing and reminders at induction explains the higher recording in our sample.

### Limitations

The charts were not vetted by a second independent investigator and this could have introduced reporting bias. The design of our audit allows detection of only grade 1 and 2 prescribing errors (grade 1: no signature, no start date, no route; grade 2: no route for as-needed medication).<sup>10</sup>

### Recommendations

The following recommendations reflect the findings and recommendations of the NPSA's<sup>2</sup> priority areas for action for National Health Service (NHS) organisations, the World Health Organization Quality in Prescribing guidelines (i.e. maximise effectiveness, minimise risks, minimise costs, and respect the patient's choice), the joint Medical Schools Council and the British Pharmacological Society's view on training in prescribing,<sup>11</sup> as well as the GMC's report on interventions to improve patient safety by minimising prescribing errors.

1. To improve the individual competence of junior doctors: to review doctors' training in prescribing, to offer information on safe prescribing at induction, to offer allocated teaching time by pharmacists to medical students on placements.<sup>3</sup> Barber *et al*<sup>12</sup> recommend that doctors should receive training in prescribing at pre-registration level through teaching and their knowledge

tested. The Medical Schools Council and the British Pharmacological Society are developing a prescribing skills assessment (due later this year) which all medical students must pass before they can graduate. The Trafford Healthcare NHS Trust has implemented a training programme.

2. To improve the training for nurses: at induction, by providing quality prescribing workshops. Nurses play a pivotal role in identifying errors and as prescribing by nurses gathers pace, nurses might find themselves involved in prescribing incidents.
3. Pharmacists: to have ongoing training (continuing professional development), to update and inform junior doctors and nurses on induction and in-house refresher courses, to attend the ward rounds and/or have dedicated time on wards.
4. Regular audits: error rates are higher for medication orders written during the in-patient stay than on admission or discharge.<sup>13</sup> The East London Foundation NHS Trust has a six-monthly mandatory medication prescribing audit undertaken by nursing staff to track this possibility.
5. To encourage the reporting of medication incidents by clinical staff at all levels, which is one of the seven steps to patient safety according to the NPSA.
6. A uniform standard trust-wide (even national) prescribing chart.<sup>3,14</sup>
7. To offer prescribing training modules on the intranet or access to the Royal College of Psychiatrists' CPD Online module 'Clinical errors and medical negligence'.
8. Interprofessional education: team-based education in safe prescribing could be a feature of in-service training.<sup>13</sup>
9. Medicines reconciliation policy, which is a joint guidance from the NPSA and National Institute for Health and Clinical Excellence issued in 2007.<sup>15</sup> Pharmacists are involved in medicines reconciliation as soon as possible after admission.

### Conclusions

Medication errors can result in people being admitted or readmitted to hospital and can delay discharge. The NPSA<sup>2</sup> estimates that preventable

harm from medicines could cost more than £750 million each year in England. There is also the impact that being involved in a medication error can have on staff confidence and morale. From an organisational perspective, medication errors increase the risk of litigation for clinical negligence.

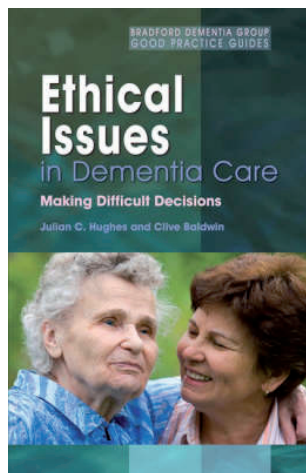
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# Book review

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## **Ethical Issues in Dementia Care: Making Difficult Decisions**

Julian C. Hughes & Clive Baldwin

Jessica Kingsley Publications, 2006, £15.99 pb, 144 pp.

ISBN: 9781843103578

The diagnosis of dementia frequently presents a number of difficult legal and ethical issues for people with the disease, their families and care providers. Carers of loved ones with dementia often base their decision-making on emotional intuition rather than structured thought.

This book is aimed to provide help to carers – predominantly non-family, ‘formal carers’ – by reflectively considering some core ethical issues. It is readable and features relevant parameters of moral theories and ethical decisions. It is interspersed with case examples encompassing a range of scenarios, for example, consent, finance, treating difficult behaviour and artificial feeding and hydration. These examples highlight real-life complexities without directive action.

The book could be summed up as two central ideas. First, steering us through what is termed as ‘messy morals’ in an attempt to examine the

moral landscape around dementia care. Second, considering the impact of decisions on the individual’s interconnected web of social networks.

Catering for a broad audience, the first half of the book provides a wide overview of the moral principles guiding inner reflections and thoughts. The authors talk of such principles being descriptive at best but not dictating or directive of one’s actions. The book stresses an ‘informed conscience’ drawn from common, shared practices as being central to end-of-life decisions and quality-of-life issues. Use of common place examples and excerpts from patient interviews enhance readers’ understanding and aid navigation through such a maze.

The authors emphasise the importance of creating a safe environment, sustaining dignity and optimising opportunities for independent decision-making. With progression of illness, ‘proxy decision makers’ need to be involved. With the responsibility there is need for knowledge and respect for the patient’s values and opinions. It is refreshing to note due consideration has been given to subcultural values and affirmation of genuine ‘person-centred care’. The chapters focusing on the role of sensitive and caring communication, assimilating various viewpoints in balancing day-to-day decisions, is particularly well laid out. From a clinician’s point of view this issue is well explored and highly relevant in dementia care.

*Ethical Issues in Dementia Care* is succinct and has a simple and straightforward style with illustrated learning points. As its title implies, the book is intended to be an easy-to-read, good practice guide and it generally achieved this objective. The reader is likely to walk away with an enhanced understanding of ethical pitfalls in patient care and this book deserves its place on the psychiatric trainee’s bookshelf. To the experienced practitioner it is a well-referenced resource that is likely to be best used for teaching and supervision purposes. We would recommend it not only as a reference text for clinicians but for any person involved in dementia care.