Antipsychotics prescription for management of delirium in older adults in acute general hospital

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INTRODUCTION

Delirium is an acute confusional organic process with physically identifiable structural, functional, or chemical problem in the brain that may arise from a disease process *outside* the brain that nonetheless affects the brain.

Treatment of delirium requires identifying and managing the underlying causes, managing delirium symptoms, and reducing the risk of complications. According to NICE guidelines, if a person with delirium is distressed or considered a risk to themselves or others, and other techniques of de-escalation found ineffective or inappropriate, short-term use of antipsychotics is to be considered.

AIM

Improve the management treatment of patients with delirium and assure best practice in prescription of antipsychotics in this group of patients.

METHODOLOGY

A retrospective review of all Referrals to Older People Mental Health Liaison Team (OPMHLT) seeking advice for management of delirium in the period between 1st of January and 30th of June 2019 was completed.

48 referrals for 43 Patients were included in the study.

Data about antipsychotic prescription was extracted from RiO and EPR systems.

Three Audit standards were obtained from Section 1.6.4 of NICE Clinical Guideline CG103 and quality statement 3 of the NICE Quality Standard QS63.

Proportions were generated to allow comparison with audit standards.

No.	Standard Evidence of quality of care or service	Compliance (100% or 0%)	Clinical Exceptions
1	Patients should not be started on antipsychotics for delirium except after exhausting all other methods including non-verbal and verbal de-escalation or these methods considered inappropriate.	100%	NIL
2	Antipsychotics should be used for short term management (less than one week)	100%	NIL
3	If discharged on antipsychotic medication, there should be a plan in the discharge letter to the GP for reviewing or stopping the medication.	100%	NIL

FINDINGS

DEMOGRAPHICS:

Demographics are reported for these 43 individuals.

- There were 24 (56%) males verses 19 (44%) females.

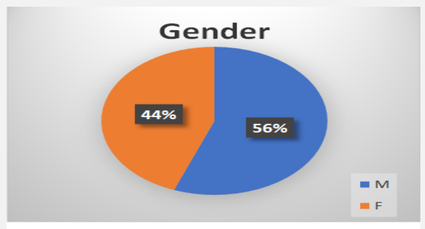

Figure 1- Patient's Gender.

- One (2%) patient was between 60-69 years, 11(26%) were between 70-79 years, 22 (51%) between 80-89 and 9 (21%) between 90-98.

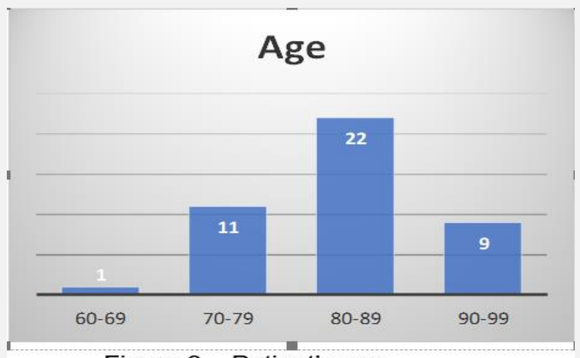

Figure 2 – Patient's age.

DATA ABOUT ANTIPSYCHOTIC PPRESCRIBED:

- Out of 48 referrals, 16 (33%) were prescribed antipsychotics for the management of delirium.
- The most used antipsychotic was Haloperidol (75%) followed by Risperidone (13%) then Quetiapine (12%).
- Frequency almost equally divided bet--ween regular and as and when needed
- In 69% of the cases antipsychotics were prescribed (11) agitation was documented as the indication, Aggression accounted for 19% of the prescriptions (3), while all other causes accounted for the rest 12% (2).

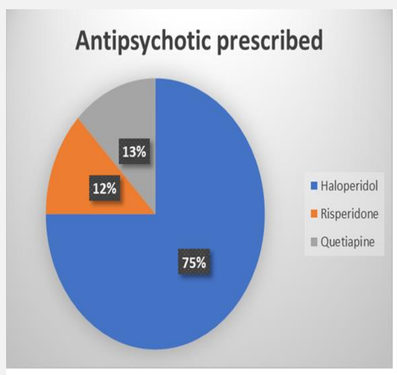

Figure 3- Type of antipsychotic used.

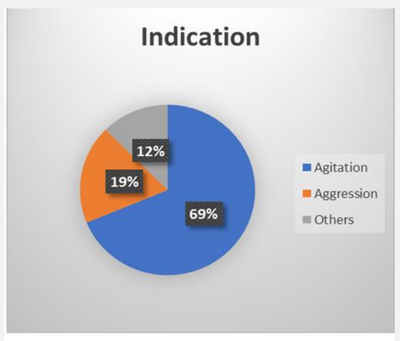

Figure 4- Indication of prescription.

AUDIT STANDARDS COMPLIANCE:

- <u>Standard 1: Patient shouldn't be started on antipsychotic for delirium except after exhausting all other methods.</u>

In 16 out of 48 referrals (33%) antipsychotics were prescribed, with 100% of patients having the rational documented.

- <u>Standard 2: Antipsychotic should be used for short term management (less than 1 week).</u>

8 out of the 16 patients started on antipsychotics (50%) had it prescribed for more than a week, only 5 out of the 16 patients (31%) prescribed antipsychotics continued taking them after discharge.

- <u>Standard 3: If discharged on antipsychotics plan for reviewing or stopping should be highlighted in discharge letter.</u>

All 5 patients discharged on antipsychotics (100%) had plan for reviewing/stopping of antipsychotic medication mentioned in discharge letter.

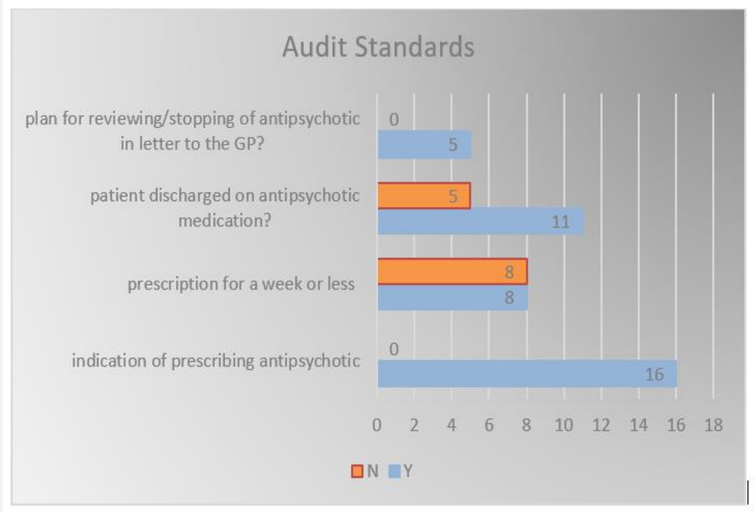

Figure 5

DISCUSSION

This audit used the documentation of a clear rational to starting the patient on antipsychotic as a proxy of exhausting all other measures and/or them deemed inappropriate for containing patient's distress.

This yielded a compliance of 100% to the first standard. As though 16 (33%) out of the 48 referrals ended being prescribed antipsychotics, it was found that the prescriber made a note of the rational and indication of their prescription in all 16 cases.

It was found through this piece of work that half the antipsychotics prescriptions for management of delirium were continued beyond the period determined by NICE guidance as a cut off for short term (1 week), several factors could have contributed to such results, including factors pertaining to the patient's own presentation and the severity of their symptoms or factors related to the environment including busy ward, shortage of staff and large work load leading to patients prescription not being reviewed in a timely manner etc..

We did particularly well in terms of communication between various level of care where all 5 patients discharged on antipsychotics had a plan of review in their discharge letter to their GP which would spare the patient the long term use of antipsychotics when not needed or indicated and increase their risk of all long term side effects of these medications.

CONCLUSION

This clinical audit project has served to demonstrate that though we do well in comparison to best practice standard of antipsychotic prescription for delirium management, there are still several areas where we can improve including patient review to avoid patients being on the medication for more than they need to.

A plan was agreed to create a list of all delirium referrals started on antipsychotics, to be reviewed and discussed in weekly team meetings

It is important that a consultation is held to determine present attitudes, knowledge, and to explore rival aetiologies of longer-term prescription of antipsychotics. Once these have been assessed, a tailored awareness raising, and educational programme should be initiated to prompt improvement.

A reaudit would then serve to ensure the changes brought on by these measures.

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