Introduction

With a population that is living longer and longer, diseases of old age are becoming more prominent, and neurodegenerative diseases are seen in higher numbers today than they were in years past.

Although these are seen as mostly progressive and carry a poor prognosis, the prescription of acetylcholinesterase inhibitors and NMDA receptor antagonists like memantine has been advocated and seen to carry benefits in people afflicted with Alzheimer’s disease.

There are certain guidelines and protocols to be followed when prescribing these medications, both at the start of treatment and through follow up, and NICE has compiled a series of documented guidelines for good practice in this regard.

It is important for teams to regularly review their practice against these guidelines to ensure standards are kept as high as possible.

Objectives

To audit the referral and follow up of new individuals to a memory clinic service covering a large urban population, and judge the assessment and management of these patients against NICE’s guidance.

Methods

Information was collected for all new patients referred to a memory clinic for medication within a twelve month period. These patients would already have been seen, assessed, investigated and diagnosed prior to referral to the memory clinic for management, as is protocol for Swansea Elderly Mental Health care. Data collected included information and checks around the diagnosis itself, the initiation and maintenance of treatment, and patient and carer information provided at assessments.

The collected information was then compared against NICE’s published guidelines to try and determine whether our practice was in line with that recommended by NICE.

Results

CT head and bloods (20/21) and initial cognitive assessment (19/21) were performed in most cases at the time of initial assessment.

Driving circumstances were not recorded in many cases (8/21).

Support or advice to carers was documented for only 16 patients.

While many (15/21) patients were diagnosed as either Alzheimer’s or mixed dementia, some (6/21) were diagnosed only with unspecified dementia.

An initial ECG was performed in most patients (19/21), but not all, prior to starting treatment.

All patients for treatment were initially started on either donepezil (13/21) or memantine (8/21).

14 patients stayed on the first prescribed medication.

6 patients were switched to a different anticholinesterase or memantine, and 1 had medication discontinued altogether.

Repeat cognitive assessments were performed for some, but not all, patients during the course of the year (16/21).

Twenty patients stayed under the memory clinic at the end of the follow up period, with one being discharged back to the GP.

Conclusions

While generally compliant with NICE guidance on the initiation and maintenance of anticholinesterase and memantine prescribing, there were some areas of interest including non specific diagnoses prior to initiation of treatment, memantine prescription without clear indications or trial of anticholinesterases first, and carer opinion and support not being clearly documented in some cases.

ECGs and bloods were not performed in all patients as well.

It is important to highlight the above and strive to be more compliant with NICE’s guidance. We would aim to raise awareness at a local level on deviations from best practice, while trying to understand more about why this might be happening.

We would hope to reaudit within 6 months once we have had a chance to try and change current practices.