AchE Inhibitors: Prescribing

2024 Congress – QI and Audit Example

The Royal Australian & New Zealand College of Psychiatrists

Setting

This audit is relevant to psychiatrists working in the field of old age psychiatry. It can relate to either in-patient or out-patient settings but would be of particular relevance to memory clinics.

Background

Anti-dementia medications are not without significant side effects, and close monitoring is necessary to ensure that anticholinesterase (AchE) inhibitors are being used appropriately. In June 2018[1], the National Institute for Health and Clinical Excellence (NICE) revised its guidelines on prescribing and monitoring the use of AchE inhibitors (Donepezil, Rivastigmine, Galantamine, and Memantine] in Alzheimer's Dementia. These guidelines limited the use of these medications to patients with moderate Alzheimer's disease defined as those with scores of 10 to 20 out of 30 on the Mini-Mental State Examination (MMSE) (Folstein, et al., 1975)

Standards.

Standards were attained from the NICE (2018) guidelines on prescribing and monitoring the use of AchE inhibitors. Of relevance were:

- medications can be prescribed only by specialists in elderly care (psychiatrists, neurologists and physicians specializing in care of the elderly) for patients with an MMSE score between 10 and 20
- Carers' views should be sought as baseline
- Patients who continue the drug should be reviewed at six monthly intervals by means of MMSE score along with a global functional and behavioral assessment
- Carers' views should be sought regarding the patient's condition at follow-up
- The drug should be continued only while the patients MMSE score remains at or above 10 points and his or her global functional and developed behavioral condition remains at a level where the drug is having a worthwhile effect
- Prescribing can occur outside these guidelines but clear documentation outlining these clinical decisions is necessary

Method

Data collection

The medical notes of patients who had been in the service since November 2006 and who were currently prescribed AchE inhibitors were selected. Notes were examined to ascertain documented evidence of the following:

- Type of dementia diagnosed (Alzheimer's disease, mixed-type, vascular, etc.)
- The clinician who initiated treatment
- Type of medication begun bracket i.e., Donepezil, Galantamine or Rivastigmine

[1] 1 Guidance | Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease | Guidance | NICE

- Baseline recordings of MMSE scores, carers views, and assessments of functioning,
- Frequency of follow up, evidence of ongoing MSE assessment carers views and assessment of the patient's global functional and behavioral condition
- Reasons for discontinuation of treatment such as side effects, MSE score falling below 10, deterioration whilst on medication
- Clear documentation to support clinical decisions that vary from the guidance

Data analysis

The percentage of assessments with the above evidence recorded in the medical notes was calculated the aim was for 100% compliance with the standards.

Resources required.

People: two people were needed to review approximately 50 case notes. This audit lends itself to multidisciplinary involvement

Time: for at least fifty sets of case notes at least two working days should be allotted to this audit

Results

This audit illustrated that AchE inhibitors continued to be prescribed for mild dementia and highlighted difficulties in the implementation of the new guidance. This may reflect the varying opinions of clinicians regarding the use of guidelines and the perceived efficacy of the treatments.

Recommendations

- The NICE guideline does allow prescribing in mild Alzheimer's disease, under certain circumstances, and the importance of adequate documentation for these cases should be highlighted
- if a patient is unable to complete an MMSE (e.g., a patient is too anxious, has dysphasia, or the dementia is too severe) this should be clearly documented
- Reasons should be given in the case notes for continuing AchE inhibitors if the MMSE score has fallen for non-cognitive (behavioral or psychological) symptoms associated with dementia
- An anti-dementia drug record sheet should be used
- An activities of daily living questionnaire could be sent out with the initial appointment letter for carers to complete

This audit has been adapted from 101 Recipes for Audit in Psychiatry: Oakley C, Coccia F, Masson N, McKinnon I, Simmons M, eds. *101 Recipes for Audit in Psychiatry*. Royal College of Psychiatrists; 2011.

Depression: Management in Children and Young People

2024 Congress – QI and Audit Example

The Royal Australian & New Zealand College of Psychiatrists

Setting

This audit is relevant to psychiatrists working in child and adolescent mental health services (CAMHS). It is most suited to outpatient settings.

Background

Depression has been dealt with in a variety of different ways in CAMHS. It is important to examine what happens in practice and to monitor this regularly according to best practice guidelines. A 2005 guideline (updated 2019) produced by the National Institute for Health and Clinical Excellence (NICE) attempted to standardize the approach to depression in terms of assessment and treatment, according to the evidence base. More recent evidence, however, called some of these recommendations into question, including using medication as a second line treatment for moderate to severe depression (Goodyer et al, 2007). However, several parts of the guideline are sound and can provide a useful benchmark for best practice in areas of assessment and treatment.

Standards

Assessment standards.

- The diagnosis of depression is clearly communicated in the letter to the referrer
- Clinical notes contain the following information from assessment:
    - Comorbid conditions
    - family context
    - school context
    - peer relationships.

Psychological treatment standards.

- A relevant evidence-based treatment modality (e.g., cognitive behavioral therapy or interpersonal psychotherapy) is clearly documented
- Psychological treatment is reviewed regularly

Medication treatment standards

- Fluoxetine is chosen as the first line medication for depression.
- Medication is monitored regularly (at least monthly in the first three months)
- There is clear documentation of discussion of the risks and benefits. The target is that all the above standards are met.

Method

Data collection cases that had been coded on the CAMHS database as moderate or severe depressive disorder were collected. Information was obtained from the following sources: the

assessment letter and subsequent letters for the first three months, Including multidisciplinary review sheets.

Data analysis

The percentage of patients coded with a moderate or severe depressive disorder for whom the above standards were met was calculated.

Resources required

People: Data collection could be carried out by staff at multidisciplinary team meetings. A coordinator is needed to plan the data collection sessions, to design the performance and to analyze the data.

Time: It is estimated that for 30 sets of notes, 10 hours will be required for data collection. Another two to three hours are required to coordinate the process and an analyze the data.

Results

- Thirty sets of case notes of patients with a current database coding of mortar or severe depression were analysed
- The diagnosis was clearly documented in the letter to referral in 23 cases (77%)
- A large range of psychological treatments were used, not all evidence-based, ranging from supportive counseling to cognitive analytic therapy. Psychological treatment was reviewed regularly in 17 of 27 cases (63%).
- Fluoxetine was used as a first line treatment in 15 of 21 cases (71%)
- Discussion with the family of risks of benefits was documented in 13 of 21 cases (62%).
- Medication was monitored at least monthly for the first three months in 12 of 21 cases, (57%).

Recommendations

An assessment and management checklist should be incorporated into the clinical notes of those patients with an identified diagnosis of moderate or severe depression. This could include a checklist of assessment questions including diagnosis as well as tick box for management standards as agreed as important by the multidisciplinary team in light in line with NICE guidance.

This audit has been adapted from 101 Recipes for Audit in Psychiatry: Oakley C, Coccia F, Masson N, McKinnon I, Simmons M, eds. *101 Recipes for Audit in Psychiatry*. Royal College of Psychiatrists; 2011.

ECT Indications

2024 Congress – QI and Audit Example

The Royal Australian & New Zealand College of Psychiatrists

Setting

This audit is relevant to all psychiatric specialties but particularly older-adult services, where electroconvulsive therapy (ECT) may be more widely used

Background

Although ECT is an effective treatment, it has the potential for serious adverse effects. The National Institute for Health and Clinical Excellence (NICE) (2014) has produced guidance[1] relating specifically to the indications for ECT, the risks and benefits of treatment, consent, cessation of treatment and repeat courses of ECT. The RANZCP has a journal article on the professional practice guidelines for the administration of ECT[2] and holds a position statement on ECT[3].

Standards.

The audit standards were taken from the NICE guidance (NICE, 2014)

- ECT should be used only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and slash or when the condition is potentially life threatening in individuals with severe depressive illness, catatonia or a prolonged for severe manic episode. The decision whether ECT is clinically indicated should be based on assessment of the risks and potential benefits to the individual. These include anaesthetic risks, comorbidities, anticipated adverse events (especially cognitive impairment) and the risks of not having treatment
- Valid consent should be obtained in all cases
- Clinical status should be assessed following each ECT session. Treatment should be stopped when a response has been achieved, or sooner if there is evidence of adverse effects. Cognitive function should be monitored on an ongoing basis, and as a minimum, at the end of each course of treatment.
- A repeat course of ECT should be considered only for individuals who have severe depressive illness, catatonia, or mania and who have previously responded well to ECT. During an acute episode, if the patient has not previously responded, a repeat trial of ECT should be undertaken only after all other options has been considered and following discussion of the risks and benefits
- ECT is not recommended as a maintenance therapy in depressive illness
- ECT is not recommended for the general management of schizophrenia

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[1] Overview | Guidance on the use of electroconvulsive therapy | Guidance | NICE

[2] Royal Australian and New Zealand College of Psychiatrists professional practice guidelines for the administration of electroconvulsive therapy (psychiatry.org)

[3] Electroconvulsive therapy (ECT) | RANZCP

Method

Data collection: information collected was obtained from medical notes and included:

- Diagnosis
- Reason for ECT
- Risks and benefits of ECT
- Consent for ECT
- Cessation of ECT
- Repeat courses of ECT
- Use of ECT as maintenance therapy for depression or management of schizophrenia

Data analysis: the proportion of cases meeting the required standards was calculated

Resources required.

People: it is possible for this audit to be conducted by one person

Time: a total of seven patients received ECT during the audited period and for these the data collection took around 4 hours

Results

- Seven patients underwent ECT. The registration form in the ECT booklet was present in all seven sets of case records audited. ECT was administered because all other treatment options had proved ineffective in all cases
- All patients who underwent ECT had a severe depressive illness. Six patients had their medical history and reason for ECT documented
- In all cases, the benefits of ECT were discussed and documented in the clinical notes. There had been an improvement in the recording of the clinical status after each session and monitoring of cognitive function by the end of each course of treatment since an earlier audit
- Four of the seven patients stopped ECT before the planned end of treatment because a clinical response had been achieved. Only one patient out of seven received a repeat course of ECT.
- In one of seven patients, ECT was used as maintenance therapy for severe depressive illness. No patients received maintenance ECT for schizophrenia.

Recommendations

- The trusts ACT guidance policy should be revised to reflect available nice guidance, to improve and adherence.

This audit has been adapted from 101 Recipes for Audit in Psychiatry: Oakley C, Coccia F, Masson N, McKinnon I, Simmons M, eds. *101 Recipes for Audit in Psychiatry*. Royal College of Psychiatrists; 2011.

Letters to GPs

2024 Congress – QI and Audit Example

The Royal Australian & New Zealand College of Psychiatrists

Setting

This audit is relevant to psychiatrists working predominantly in private practice under the Medicare Item 291 (Opinion and Report).

Background

The Better Access to Psychiatrists, Psychologists and General Practitioners was introduced in November 2006 in response to low treatment rates for common mental disorders (for example, anxiety, depression, and substance use disorders). As the number of service providers in the private sector has increased, new processes for coordination and collaboration have emerged. It is recognised that collaborative care can significantly improve patient outcomes in the case of depression and anxiety, provided that good communication exists between the treating health professionals. However, shared care agreements are not appropriate for all patients, and clinicians should use their judgement to determine their eligibility for such care. Some patients are better served by a single clinician with the right composite of therapeutic skills. In 2013, the Royal Australian and New Zealand College of Psychiatrists endorsed the Private Mental Health Alliance Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers (the Principles). The Principles document acknowledges that while it would go 'some way to supporting referral and communication between providers of mental health services in the private sector' there was more work required.

Standards

The psychiatrist will provide a detailed report to the referring GP within 2 weeks of the appointment. The psychiatrist will also provide a summary of this report to the patient (or carer) as appropriate.

The report should state:

- that a mental state examination has been conducted, and a psychiatric diagnosis has been made
- that the psychiatrist believes that:
    - the patient can be appropriately managed without the need for ongoing treatment by the psychiatrist, or
    - ongoing treatment by a psychiatrist is required.
    - If the psychiatrist decides that the patient can be appropriately managed by the GP, he/she must provide a 12-month management plan, appropriate to the diagnosis, which:
    - comprehensively evaluates the biological, psychological, and social issues
    - addresses the diagnostic psychiatric issues
    - makes management recommendations addressing the biological, psychological and social issues.

Method

Data collection: The medical notes of 30 patients who had been in the service between July 2023 and September 2023 were reviewed. Patients who were referred by their GP under Item Number 291 were selected at random. Notes were examined to ascertain documented evidence of the following:

- A response to the GP was provided within the two-week window
- That a mental state examination was conducted
- Opinion on need for ongoing care
- Provision of 12-month care plan if care is returned to the GP
- Comprehensive evaluation of the biological, psychological, and social issues
- addresses the diagnostic psychiatric issues
- makes management recommendations addressing the biological, psychological, and social issues.

GP survey: All GPs who had patients identified as a part of the audit were contacted to provide feedback on the quality of response.

Data analysis

The percentage of letters achieving an acceptable level of all the standards, and the mean response time and standard deviation, were calculated for each category.

Resources required.

People: one person was needed to review approximately 30 case notes. This audit lends itself to involvement of non-medical administrative staff.

Time: for 30 sets of case notes at least two working days should be allotted to this audit

Results

- Of all referrals, 78% were sent within the two-week window.
- 100% of all letters had mental state examinations, opinions that would satisfy the standards, and provision of care plans for patients returned to the care of the GP
- 84% of letters were deemed to have met an acceptable standard for evaluation and addressing biological, psychological, and social issues
- 65% (n = 30) of GPs responded. 50% indicated the need to ‘simplify’ the responsibilities of the GP, including less ‘psychiatric jargon’

Recommendations

- Medical and administrative staff developed a workplace strategy to track response efficiency times.

- A blank template was designed for specialist letters to follow, which included a reminder to use simplified language for GPs and patients

Liaison Psychiatry: Response Time to Referrals

2024 Congress – QI and Audit Example

The Royal Australian & New Zealand College of Psychiatrists

Setting

This audit will be particularly relevant to liaison psychiatry services and mental health services accepting referrals from general hospitals and emergency departments.

Background

In collaboration with other healthcare organisations, the Royal College of Psychiatrists has established quality standards for liaison psychiatry services[1] as part of the psychiatric liaison accreditation network [PLAN] [Royal College of Psychiatrists, 2020]. Timeliness of response to referrals is one quality indicator. This audit informed the setting of the PLAN response time standards.

Standards.

The audit standards were developed following agreement by members of the liaison psychiatry service about what could constitute clinically appropriate response times to referrals. This discussion was informed by the four-hour attendance time target set for emergency departments by the Department of Health for England (Department of Health, 1999). This led to a focus on factors that might unnecessarily delay the management of patients in an emergency department. One such factor is the response time of specialist services to referrals made by emergency department staff. Following discussion with referrers, referrals were categorized according to them urgency of response required. The standard set for the audit were maximum response times agreed for each category:

- emergency referrals (including all referrals from the emergency department) to be assessed within one hour
- urgent referrals to be assessed on the same working day
- routine referrals to be assessed within two working days.

Method

Data collection: the time of referral and the response time by the liaison psychiatry service were recorded for all referrals over a three-month period. This data was collected by adaptation of the services pre-existing referral form. In addition to the response time, data was collected on the source of the referral, the primary reason for the referral, and the urgency of the referral.

Data analysis

The percentage of patients achieving the standard, and the mean response time and standard deviation, were calculated for each category.

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[1] quality-standards-for-liaison-psychiatry-services---sixth-edition-2020.pdf (rcpsych.ac.uk)

Resources required.

People: this audit requires participation by all service members who accept in its assess new referrals, in order to ensure that the necessary data is recorded. The audit itself can be conducted by a single person.

Time: The audit should be conducted over a period that allows a sufficient representative sample of referrals to be obtained [for example three months]. It is estimated that data collection would take 10 to 15 hours.

Results

- over the three-month period of the audit data was collected for 124 referrals
- of all referrals, 82% were from the General Hospital wards and 18% were from the emergency department.
- the commonest reason for referral for both the wards and emergency department was self-harm
- for the three categories of referral the response time standards were achieved in all cases

The proportion of referrals in each group and the mean response times were as follows:

- emergency - 25%, 21 minutes (s.d. = 20)
- urgent - 30%, 70 minutes (s.d. = 86]
- routine - 45%, 200 minutes [s.d. = 183].

Recommendations

Although the standards were met during the audit this was considered to be a sufficiently important measure of the quality of the service to repeat the audit as a later date, particularly with regard to emergency department referrals.

The categorization of response time should inform the setting of quality standards for liaison psychiatry services across the UK (Royal College of psychiatrists, 2009).

This audit has been adapted from 101 Recipes for Audit in Psychiatry: Oakley C, Coccia F, Masson N, McKinnon I, Simmons M, eds. *101 Recipes for Audit in Psychiatry*. Royal College of Psychiatrists; 2011.

Risk Assessment: forms for in-patients

2024 Congress – QI and Audit Example

The Royal Australian & New Zealand College of Psychiatrists

Setting

This audit is relevant for in-patient mental health services where standardized inpatient risk assessment tools are used for all patients admitted to hospital.

Background

The increasing expectation on all mental health professionals to identify, appraise, and manage risk has led to the introduction of generic risk assessment forms which are now used in the majority of hospitals in Australia and Aotearoa New Zealand[1]. They are often mandatory for all in-patients.

Standards.

The standard used for this audit comes from the Department of Health's Best Practice in Managing Risk [2009][2] which advocates the use of tools in risk assessment and management. The standard should be that all psychiatric inpatients have adequately completed risk assessment forms.

Method

Data collection: the case notes of all current inpatients on a specified day were reviewed. A standardized form was used to collect anonymized data on the following variables:

- patient age and gender
- date and time of admission and admission ward
- detention status
- admitting doctor
- presence of an adequately completed risk assessment tool.

Data analysis

The main outcome measure was the percentage of inpatients with an adequately completed risk assessment form this ranged from a fully completed form to an incomplete form to no format all data were collected on how each section of the form was completed so that deficiencies in particular areas could be highlighted chi squared tests were used to determine the relationship between incomplete forms and variables such as patient age gender admission ward date and time of admission detention status and admitting doctor.

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[1] He Arotake ngā Tūraru | Reviewing Risk (health.govt.nz)

[2] Best Practice Managing Risk Cover (publishing.service.gov.uk)

Resources required.

People: the number of people involved would depend on the number of wards that are included in the audit if the risk tool is used across several hospitals in a trust, then it would be useful to audit all of these hospitals at the same time which would need more than one person

Time: it is estimated that at least six hours should be dedicated to reviewing the case notes of 40 inpatients

Results

The percentage of fully completed risk assessment forms was low there was no association between rates of completion of forms and whether the form was completed during working hours or out of hours the detention status of the patient or the gender of the patient the first intervention below resulted in improved completion rates two months later and this improvement was sustained after the 2nd intervention 6 months after that.

Recommendations

A memorandum should be sent to all clinical staff highlighting the importance of the risk assessment tool and giving a brief synopsis of the results of the audit the results of the audit should additionally be presented to clinical staff followed by an interactive discussion on risk assessment.

The risk assessment tool should be included within a standardised admission pack comprising all the forms that need to be completed when a patient is admitted to hospital.

This audit has been adapted from 101 Recipes for Audit in Psychiatry: Oakley C, Coccia F, Masson N, McKinnon I, Simmons M, eds. *101 Recipes for Audit in Psychiatry*. Royal College of Psychiatrists; 2011.

Tribunal Reports

2024 Congress – QI and Audit Example

The Royal Australian & New Zealand College of Psychiatrists

Setting

This audit is particularly relevant to general adult or old age psychiatry inpatient services where patients are detained under the relevant Mental Health Act for your location. This audit could be modified to cover forensic patients or patients subject to community treatment orders or guardianship.

Background

In November 2020 the Royal Australian New Zealand College of Psychiatrists released Professional Practice Guideline 11: developing reports and conducting independent medical examinations in medical legal settings. This document guides members who are preparing reports in medico-legal and or forensic contexts. This includes reports based on independent medical examinations and reports which are prepared for both civil and criminal matters. This guideline establishes a basic standard of practice and outlines the role of the psychiatrist when responding to a referral request for a report, along with best practice in conducting independent medical examinations report writing and adherence to appropriate professional standards.

Psychiatrists in Aotearoa New Zealand should refer to Professional Practice Guideline 17: access and use of clinical information for medico-legal report writers in Aotearoa New Zealand.

Standards.

In 2008 the First-tier Tribunal (Mental Health) introduced new guidance for professionals writing reports the revised standards for the clinician's report listed below were obtained from the relevant *Tribunals Judiciary – Practice Direction* (Ministry of Justice 2008). The report, which should be signed by the responsible clinician (RC) or countersigned by the RC if not actually prepared by the RC, should give the following general information:

- patient's full name
- patient's date of birth
- patient's address
- patient's cultural background
- patient's first language
- whether an interpreter is required
- whether a cultural support worker or family member is required to be present
- date of admission
- section of Mental Health Act under which the patient is detained
- name of hospital where detained
- name of patient's responsible clinician
- period spent under care of this responsible clinician
- name of patient's key worker
- details of any existing advanced decisions to refuse psychiatric treatment date of clinician's report for the tribunal

The report should cover:

- relevant medical history
- patients mental state and behaviour
- treatment for mental disorder
- previous self-neglect, self-harm, actual threat, or harm to others when the patient was mentally unwell
- assessment of risk to self and others if the patient should be discharged
- management of these outstanding risks
- assessment of the patient's strengths
- if appropriate the reasons why the patient might be treated in the community under a CTO as an alternative to continued detention in the hospital

Method

Data collection
a list of patients who had a tribunal hearing during the audit. Was obtained from the trusts Mental Health Act administrator the clinicians reports for these patients were found in the medical notes which were examined using the above standards data analysis

Data analysis

The total number of reports compliant with each standard was obtained and then converted to a percentage of the total number of reports audited

Resources required.

People: two or more people should conduct the audit depending on the number of tribunal hearings that take place in the audit.

Time: a maximum of 30 minutes may be required to audit each report data collection for 50 reports conducted by two auditors should take two months

Results

General information about the patient was adequately covered in the reports, apart from patients first language and the need for an interpreter. Where the report was prepared by a junior doctor, it was not always countersigned by the RC. Most of the reports included the patient's history, current mental state, treatment, and history of risk; however, the effects of immediate discharge were not always clearly outlined.

Recommendations

- the Mental Health Act administrator should send a copy of the guidelines for writing medical reports to the RNC whenever a tribunal hearing is due

- local courses on the use of relevant Mental Health Acts should incorporate training on tribunals.

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