Rethinking psychotropics in nursing homes

To the Editor: We thank Hilmer and Gnjidic for highlighting the excessive use of psychotropic medications in Australian nursing homes.[1] We recently completed a national psychotropic audit of over 9000 nursing home medication reviews conducted during the 2011–12 financial year. Our results were alarming: even after excluding residents with schizophrenia or bipolar disorder, more than a quarter of residents reviewed (27%) were taking antipsychotics. Concerningly, 41% of all residents reviewed were prescribed benzodiazepines.

Such findings are not new. The problem of excessive psychotropic use in Australian nursing homes has been reported for nearly 20 years and has been the subject of both federal and state inquiries.

As possible solutions, Hilmer and Gnjidic suggest economic evaluations and investment in staff and in research to develop better management strategies.[1] Yet, qualitative research has determined that a major reason for high prescribing lies in an overestimation of the efficacy of psychotropic medications and limited awareness of their adverse effects.[2] Consequently, awareness-raising and education of health practitioners and residents' relatives is key.

We would also like to emphasise that programs to reduce psychotropic use in Australian nursing homes have proven successful in controlled trials. Resident and staff education reduced benzodiazepine use by half in a South Australian nursing home.[3] Likewise, through local audit, benchmarking and nurse education in 15 Tasmanian nursing homes, antipsychotic and benzodiazepine use was reduced significantly over a 6-month period.[4] It is time to move beyond describing psychotropic usage patterns and evaluating solutions to implementing these successful intervention strategies on a wider scale.

Juanita L Westbury Research Fellow and Lecturer
Gregory M Peterson Professor
School of Pharmacy, University of Tasmania, Hobart, TAS.
juanita.westbury@uts.edu.au

Competing interests: No relevant disclosures.

doi: 10.5694/mja13.10192

1 Hilmer SN, Gnjidic D. Rethinking psychotropics in nursing homes. *Med J Aust* 2013; 198: 77.
2 Cornege-Blokland E, Kleijer BC, Hertogh CM, van Marum RJ. Reasons to prescribe antipsychotics for the behavioral symptoms of dementia: a survey in Dutch nursing homes among physicians, nurses, and family caregivers. *J Am Med Dir Assoc* 2012; 13: 80.e1-80.e6.
3 Gilbert A, Owen N, Innes JM, Sansom L. Trial of an intervention to reduce chronic benzodiazepine use among residents of aged-care accommodation. *Aust N Z J Med* 1993; 23: 343-347.
4 Westbury J, Jackson S, Gee P, Peterson G. An effective approach to decrease antipsychotic and benzodiazepine use in nursing homes: the RedUSe project. *Int Psychogeriatr* 2010; 22: 26-36.

> "Scrutiny would be enhanced by defining legal and open processes to be followed"
>
> Willoughby et al

> "programs to reduce psychotropic use in Australian nursing homes have proven successful in controlled trials"
>
> Westbury et al

To the Editor: The article by Hilmer and Gnjidic[1] raises issues about the management of behavioural and psychological symptoms of dementia (BPSD)[2] in residential aged care facilities (RACFs).

It is important to remember the context in which RACF residents' care is provided. The federally managed aged care system is politically and organisationally perceived as supported accommodation, which is geared toward supporting or substituting for residents' performance of basic and instrumental activities of daily living. This system is outside the state-based health care system. Health care, effectively an optional extra in this context, is provided by general practitioners, who may have no prior knowledge of the resident before admission.

RACF residents in high-level care are too sick and disabled, many suffering from moderate or severe dementia and in the palliative phase of their illness, to be supported by the state health system in the community. BPSD are an everyday fact of life that cause distress to those suffering them and their fellow residents and can make it impossible for carers to provide essential care safely.

Yes, BPSD can be managed by non-pharmacological methods.[1] This requires skilled assessment, which goes significantly beyond diagnosis, and skilled intervention, which is much more than just prescription, by carers of all categories. Geriatrician or psychogeriatrician involvement is an obvious and necessary starting point. So why does it not happen when

geriatric and psychogeriatric services exist in most regions of the country?

Unlike people living in their own homes, RACF residents are dependent on medical services coming to them, and my experience suggests that GPs are only too happy to refer patients for consultation. Are RACF residents invisible because they can't come to us, and we won't go to them?

Ludomyr J Mykyta Geriatrician

Adelaide, SA.
ludomyr@mykyta.net

Competing interests: No relevant disclosures.

doi: 10.5694/mja13.10150

1 Hilmer SN, Gnjidic D. Rethinking psychotropics in nursing homes. *Med J Aust* 2013; 198: 77.
2 International Psychogeriatric Association. Behavioral and psychological symptoms of dementia (BPSD): educational pack. Chicago: IPA, 2002. http://www.ipa-online.net/pdfs/1BPSDfinal.pdf (accessed Jul 2013). ❑

In reply: We thank Westbury and Peterson, and Mykyta for highlighting some of the issues raised in our article.[1]

While we acknowledge the important contribution of providing education programs to existing staff, staff education alone is insufficient to address the complex issues affecting psychotropic drug use in nursing homes.[1] Better access to appropriately trained staff in nursing homes, including general practitioners, geriatricians, psychogeriatricians, psychologists, pharmacists, nurses or nursing aids, is required to provide safer alternatives to psychotropics. As we discussed, provision of these services may require changes to our health care and funding models.[1]

Inappropriate use of psychotropics in nursing homes is a hazard that requires comprehensive risk management strategies. The Australian Work Health and Safety Regulations require risks to be managed according to a hierarchy of risk control, in which education is among the lowest controls and providing safer alternatives is among the highest.[2] The hierarchy of risk control may be applied to psychotropic use in nursing homes as follows:

1. Eliminate the hazard altogether: this is not feasible for psychotropics, which have a limited therapeutic role for nursing home residents.
2. Substitute the hazard with a safer alternative: invest in more skilled staff to administer non-pharmacological therapies, and in research to develop newer, safer therapies.
3. Isolate the hazard from anyone who could be harmed: make policy changes that limit prescribing of psychotropics by indication, dose and duration, and promote withdrawal[3] to reduce the risk–benefit ratio.
4. Reduce the risk through engineering controls: use electronic prescribing to reduce inappropriate psychotropic use.
5. Reduce the risk through administrative controls: educate and train existing staff.
6. Use of personal protective equipment: residents who are administered psychotropics should wear hip protectors.

A multifaceted approach to psychotropic use is required to optimise the safety of the vulnerable people living in nursing homes.

Sarah N Hilmer Geriatrician and Clinical Pharmacologist

Danijela Gnjidic Lecturer and NHMRC Early Career Fellow, Faculty of Pharmacy

Royal North Shore Hospital and University of Sydney, Sydney, NSW.
sarah.hilmer@sydney.edu.au

Acknowledgements: Danijela Gnjidic is supported by a National Health and Medical Research Council Early Career Fellowship.

Competing interests: We conduct a program of research on optimising medication use by older people.

doi: 10.5694/mja13.10353

1 Hilmer SN, Gnjidic D. Rethinking psychotropics in nursing homes. *Med J Aust* 2013; 198: 77.
2 Safe Work Australia. How to manage work health and safety risks: code of practice. Sydney: Safe Work Australia, Dec 2011. http://www.safeworkaustralia.gov.au/sites/swa/about/publications/pages/manage-whs-risks-cop (accessed Jul 2013).
3 Declercq T, Petrovic M, Azermai M, et al. Withdrawal versus continuation of chronic antipsychotic drugs for behavioural and psychological symptoms in older people with dementia. *Cochrane Database Syst Rev* 2013; (3): CD007726. doi: 10.1002/14651858.CD007726.pub2. ❑