I. Disorders

1. Acute confusion: recognition

Jenny Bryden

Setting

This audit would be most relevant to liaison psychiatry within a general hospital, especially wards with a relatively high proportion of admissions for an acute confusional state (ACS) (orthopaedics, acute medical admissions, medicine of the elderly, etc.).

Background

An ACS is defined as acute onset of new or worsened cognitive deficit with disturbed consciousness, preferably with evidence of causation by either a medical condition or the action or withdrawal of a substance. The Royal College of Physicians' guidelines for the prevention, recognition and management of delirium in older people estimates that the condition affects up to 30% of older medical patients (Royal College of Physicians, 2006).

Acute confusion can have a range of serious underlying causes and is associated with a raised mortality rate. Confused patients stay in hospital significantly longer, are less able to comply with treatment and are less likely to return home.

Clinical recognition of acute confusion is poor, particularly for patients who become lethargic (the most common subtype). Identification of acutely confused patients is important, however, in order that they be appropriately investigated and any underlying causes treated. Among patients identified as being at risk of an ACS, the Royal College of Physicians (2006) estimates that the rate can be reduced by 30% by using appropriate preventative strategies.

Standards

Guidelines from the Royal College of Physicians (2006) recommend that:

- all patients aged over 65 be screened for confusion on admission, using the Abbreviated Mental Test (AMT) or the Mini Mental State Examination (MMSE)
- patients over 65 who are at increased risk of an ACS (older patients; the visually impaired; those with pre-existing confusion or physical frailty; those with polypharmacy, alcohol dependence or renal impairment; those who are on anticholinergic drugs or who are undergoing surgery) should be reassessed serially (the exact timing is not stipulated) with the AMT or MMSE.

The target is for all patients over 65 to be screened on admission and all high-risk patients to be re-screened by 1 week.

Method

Data collection

- A daily trip to the ward(s) audited was required. All patients admitted in the last 24 hours were identified.

- The medical and nursing notes of all patients over 65 were searched for a completed AMT or MMSE form. They were also examined to see whether the patient fell into a high-risk group as defined by the Royal College of Physicians.
- At 1 week, the medical and nursing notes of high-risk patients were re-examined for an AMT or MMSE form.

Data analysis

- The percentage of patients over 65 who had an AMT or MMSE noted on admission was calculated.
- The percentage of those patients who were classed as high risk in the guidelines and who had had a second AMT or MMSE by 1 week was calculated.

Resources required

People

This audit can be done by one person.

Time

This audit requires around half an hour per day of audit, and is best conducted over 3–4 weeks to accrue an adequate sample size.

Results

This audit was undertaken in an orthopaedics ward. No patient was tested using the AMT or MMSE at any point in their stay.

Recommendations

- An AMT form could be included in the nursing admission documents and/or in the standard hospital clerking sheets.
- In some specialties there are 'nursing pathways of care' for specific conditions, to which AMTs could be added at set points.
- Alternatively, many wards weigh patients weekly to screen for malnutrition, and AMTs could be added to this sheet in the nursing folder.

Royal College of Physicians (2006) *The Prevention, Diagnosis and Management of Delirium in Older People* (National Guidelines No. 6). RCP. Available at http://www.rcplondon.ac.uk/pubs/books/pdmd/DeliriumConciseGuide.pdf (accessed October 2010).

2. Antenatal and postnatal mental health

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Setting

The audit is specific to the specialty of perinatal psychiatry yet is relevant to all psychiatrists, as well as midwives and primary care professionals. It relates to out-patients.

Background

The National Institute for Health and Clinical Excellence (NICE) has produced guidelines on the prediction, detection and management of mental illness among pregnant women (including but not exclusively concerning those with established mental illness) and also the criteria for referral to perinatal psychiatric services.

Standards

The following standards come from the NICE guidelines *Antenatal and Postnatal Mental Health* (National Institute for Health and Clinical Excellence, 2007):

- Healthcare professionals should ensure that adequate systems are in place to ensure continuity of care and effective transfer of information, to reduce the need for multiple assessments.
- At a woman's first contact with services in both the antenatal and the postnatal periods, healthcare professionals (including midwives, obstetricians, health visitors and general practitioners) should ask about:
  - past or present severe mental illness, including schizophrenia and bipolar disorder
  - psychosis in the postnatal period and severe depression
  - previous treatment by a psychiatrist or specialist mental health team, including in-patient care
  - a family history of perinatal mental illness.
- If the woman has, or is suspected of having, a severe mental illness, she should be referred to a specialist mental health service.

Method

Data collection

Data were collected from referral letters or referral forms received by the perinatal service. The referral letter and forms were examined to see if the following information was present.

- information regarding the reason for referral, e.g. reasons for suspecting a mental illness
- details of past psychiatric history
- current risk factors for mental illness.

Data analysis

The percentages of referrals that met each of the three standards mentioned above were calculated.

Resources required

People

It is recommended that two or three people conduct the audit, which is suitable for multidisciplinary involvement.

Time

Around 3–4 weeks should be allowed for data collection and analysis.

Results

The frequencies with which the different types of information were recorded in the referral letters and forms are given in the table below, for both an initial and a re-audit performed 1 year later.

	Reason for referral	Psychiatric history	Risk factors
Initial audit ($n = 87$)	79%	84%	88%
Re-audit ($n = 68$)	96%	72%	80%

Recommendations

After the initial audit, two recommendations were made:

- to redesign the referral form
- to provide training sessions for midwives.

These changes improved the services' compliance with the NICE guidelines and enabled the antenatal service to prioritise referrals to the perinatal mental health team. There was also a significant improvement in the proportion of referrals that were appropriate and gave sufficient information when re-audited 1 year later.

National Institute for Health and Clinical Excellence (2007) *Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance* (CG45). NICE. Available at http://www.nice.org.uk/nicemedia/pdf/CG045NICEGuidelineCorrected.pdf (accessed October 2010).

3. Attention-deficit hyperactivity disorder: provision of information

Susil George Stephen

Setting

This audit is highly relevant in child and adolescent psychiatric services, where the diagnosis of attention-deficit hyperactivity disorder (ADHD) is common and forms an integral part of the clinical service.

Background

The guidelines on ADHD produced by the Scottish Intercollegiate Guidelines Network (SIGN) were first published in June 2001 and provided evidence-based guidance on the assessment and management of ADHD, including the provision of information to patients. The guideline was updated in October 2009; it included an information sheet about ADHD for parents and carers. The aim of this audit was to find out whether adequate information was provided to the parents and carers of children with ADHD at the time of diagnosis, as recommended by the SIGN guidelines.

Standards

Standards were obtained from section 6 (information for patients) of the SIGN guidelines for ADHD (SIGN, 2001):

- All patients should be provided with information regarding local support groups
- All patients should be provided with a catalogue of books, other publications and information available on the internet regarding ADHD.

Method

Data collection

- A random selection was made of case notes of patients with a diagnosis of ADHD seen by the service since June 2001 (when the guideline was first published).
- Telephone contact was made with the family/carers to enquire whether they had been provided with four specific types of information about ADHD when the diagnosis was made:
  - books
  - other publications
  - websites
  - local support groups.
- Findings were documented.

Data analysis

The percentage of patients for whom the following standards were met was calculated:

- information regarding local support groups for ADHD
- information regarding books on ADHD

- information regarding other publications on ADHD
- information regarding websites pertaining to ADHD.

Resources required

People

This audit can be undertaken by one person.

Time

It takes about 10 hours to collect data on 50 patients.

Results

The provision of information regarding local support groups, books and websites pertaining to ADHD was poor; the provision of other types of information (such as leaflets) was better.

Recommendations

- An additional page could be incorporated in the assessment pack for ADHD, with information about websites, local support groups and books pertaining to ADHD.
- Similarly, the pack could contain a few leaflets from the Royal College of Psychiatrists, such as 'The restless and excitable child', 'Good parenting', 'ADHD and hyperkinetic disorder' and 'Stimulant medication for ADHD and hyperkinetic disorder', to give to parents and carers.

Scottish Intercollegiate Guidelines Network (2001) *Attention Deficit and Hyperkinetic Disorders in Children and Young People* (Guideline 52). SIGN.

Scottish Intercollegiate Guidelines Network (2009) *Management of Attention Deficit and Hyperkinetic Disorders in Children and Young People* (Guideline 112). SIGN. Available at http://www.sign.ac.uk/pdf/sign112.pdf (accessed October 2010).

4. Bipolar depression: treatment

Jon Van Niekerk

Setting

This audit will be most suitable for adult and older-adult psychiatry services. Bipolar depression is usually treated within the out-patient department. This audit can be site specific or carried out across a trust.

Background

The depressive episodes in bipolar disorder are debilitating and on the whole they last longer and occur more frequently than manic episodes. The treatment of bipolar depression is controversial and there is evidence that using antidepressants can cause switching and acceleration of cycling. The efficacy of antidepressants in bipolar depression is weak and yet they are widely used.

Standards

The following standards relating to bipolar depression were taken from the guideline on bipolar disorder produced by the National Institute for Health and Clinical Excellence (NICE) (2006):

- A patient who is prescribed antidepressant medication should also be prescribed an antimanic drug.
- A selective serotonin reuptake inhibitor (SSRI) should be used instead of a tricyclic antidepressant.
- Patients should not routinely continue on long-term antidepressant treatment.
- When initiating antidepressant treatment for patients not on antimanic medication, the risk of switching should be explained.
- Antidepressants should be avoided for patients with depressive symptoms who:
  - have rapid-cycling bipolar disorder
  - have had a recent hypomanic episode
  - have recently experienced functionally impairing rapid mood fluctuations.

Method

Data collection

A retrospective case-note analysis was conducted. All patients with a diagnosis of bipolar disorder who had suffered a depressive episode were included. Those with schizoaffective disorder were excluded.

Medical/electronic notes were reviewed to see whether the following had been recorded:

- the severity of the depression – mild; moderate; severe; with or without psychosis
- any contraindications to the use of antidepressants – rapid cycling bipolar disorder, recent hypomanic episode or recent mood fluctuations

- what the baseline medications were (type and dose) and whether these had proved therapeutic/sub-therapeutic
- the treatment regimen (medication type and dose, therapy, other)
- whether the patient was on antimanic medication if an antidepressant had been started
- discussion with the patient of the risk of switching
- outcome of the treatment regimen (including adverse events such as a manic switch)
- subsequent treatment regimens (second and third).

Data analysis

Compliance with the above standards was calculated. Demographic data and site-specific data were obtained in order to allow comparisons.

Resources required

People

This was a trust-wide audit and was divided among three trainees at different sites, who were each randomly assigned 20–30 cases. The audit department drew up a list of patients with bipolar disorder within each site.

Time

The identification of suitable cases did take a few weeks. Review of 30 sets of case notes took around 20 hours.

Results

- There was poor documentation of risk of switching in the initiation of antidepressants in bipolar disorder.
- Antidepressants were by far the most popular first line of treatment – even for mild episodes of depression.
- Most patients continued on antidepressants once started.
- A significant minority became manic soon after initiating antidepressant medication.
- Documentation needed to improve, as the present level could have medico-legal implications.

Recommendations

- A memorandum should be sent to all medical staff reminding them of the importance of documentation of discussions regarding manic switch.
- An executive summary of the treatment of bipolar depression should be sent to all medical staff.

National Institute for Health and Clinical Excellence (2006) *Bipolar Disorder: The Management of Bipolar Disorder in Adults, Children and Adolescents, in Primary and Secondary Care* (Clinical Guideline 38). NICE. Available at http://guidance.nice.org.uk/CG38 (accessed October 2010).