



Patients on neuroleptic medication

Vigilance is best practice

27 October 2022

It could happen to you too

Event 1

NO PHYSICAL EXAMINATION OF A PATIENT ON CLOZAPINE IN A PSYCHIATRIC UNIT

A male patient with schizophrenia, hospitalised in a psychiatric unit and treated with clozapine, is found sleeping in his own faeces at 3 o'clock in the morning. The caregivers have difficulty waking him up, but he manages to take a shower. Since his vital signs are good, he goes back to bed. But when he wakes up, the patient is found to be cyanotic and breathless with a distended stomach. With the patient's abdominal pain increasingly severe and his general condition deteriorating rapidly, the medical resident on duty decided to transfer him to the nearest hospital emergency department, where he died the same day.

What happened? *Immediate cause*

In the absence of a physical examination, the patient died as a result of complications following an intestinal obstruction.

Why did it happen? *Root causes, barriers absent or deficient*

- During the night, the duty doctor was not called and the patient did not undergo a physical examination.
- Monitoring of bowel movements for independent patients on clozapine treatment was not performed.
- The caregivers underestimated the risk of clozapine-induced constipation.
- Probable lack of awareness on the part of caregivers of the possible development of complications, including intestinal obstruction.
- The protocol relative to recognition and treatment of transit disturbances (constipation or obstruction) was not appropriate.

NO MEALTIME SUPERVISION OF A PATIENT ON NEUROLEPTIC MEDICATION IN A LONG-STAY TREATMENT UNIT

A male patient over the age of 70, hospitalised in a long-stay unit for psychosis, is treated with a neuroleptic. Due to a Covid-19 cluster, the patient is isolated in his room for meals. He is found in front of his meal tray in respiratory distress. The professionals perform the Heimlich manoeuvre to clear his airways, obstructed by pieces of bread. But the patient has a cardiac arrest. He was transferred to the university hospital centre, where he died the following day.

What happened? Immediate cause

In the absence of monitoring, the patient choked on his food, resulting in fatal asphyxia.

Why did it happen? Root causes, barriers absent or deficient

- No choking risk assessment was performed in a patient on long-term neuroleptic treatment.
- This patient was not given meals adapted on the basis of his swallowing difficulties.
- Due to a Covid-19 cluster, all the patients were isolated in their own rooms and the patient did not have appropriate supervision during meals.
- Due to a shortage of staff, there was a delay in professional intervention.

DELAY IN THE MANAGEMENT OF INTESTINAL OBSTRUCTION IN A PATIENT ON NEUROLEPTIC TREATMENT IN A PAEDIATRIC DEPARTMENT

A 15-year-old girl, on long-term neuroleptic treatment for psychiatric disorders, is admitted to the emergency department with abdominal pain. She is on clozapine treatment and takes laxatives on an irregular basis for chronic constipation. The CT scan performed reveals an obstruction of functional appearance with no signs of intestinal distress. Following a specialist opinion, there is no immediate indication for surgery. A colonoscopy is prescribed for the following day. The patient is transferred to the paediatric department. During the evening, she has a cardiac arrest. She is resuscitated and a total colectomy with ileostomy is performed. She died a few days later.

What happened? Immediate cause

The patient died following a delay in the treatment of complications following an intestinal obstruction under neuroleptic treatment.

Why did it happen? Root causes, barriers absent or deficient

- There was an underestimation of painful abdominal symptoms in a patient on long-term neuroleptic medication.
- The specialised opinion sought from a senior physician by a medical resident was given verbally, with no physical examination of the patient.
- The emergency department had no protocol in place for the management of suspected intestinal obstruction.

Key words: neuroleptics – constipation – choking – iatrogeny – obstruction

So it doesn't happen again

In 2014, the *Baromètre santé* health survey, conducted by the French National Prevention and Health Education Institute, (1) confirmed that France continued to be one of the biggest consumers of psychotropic medications in Europe: 16 million people aged between 11 and 75 years have already taken psychotropic medication, including anxiolytics (10%), followed by hypnotics (6.1%), antidepressants (6%) and neuroleptics (0.8%). Although neuroleptics appear to be the least used psychotropic medications, they generate serious adverse events related to their therapeutic effects. In the HAS national care-related serious adverse event reporting database, an analysis of 60 serious care-related events highlights that a third are related to the absence of assessment of the treatment or its effects. Regular monitoring is therefore essential since, when properly used, these medicinal products undeniably improve patients' quality of life. This monitoring can be hinged around:

- **THE PROVISION OF INFORMATION** to patients and their families:
 - concerning the proper use of psychotropic medications and the possible side effects that should prompt them to rapidly consult a physician, especially in the event of severe constipation or, conversely, unexplained diarrhoea, abdominal pain, but also, for example, vomiting or breathing difficulties;
- **SCREENING** via consideration of:
 - patients' risk factors (medical history, ongoing treatments, lifestyle), before prescribing any neuroleptic medication,
 - any treatment interactions, particularly in terms of glucose and lipid metabolism,
 - poor treatment compliance or sudden discontinuation of treatment,
 - any change of behaviour, any abdominal pain or tenderness, etc.;

...

- **MONITORING:**

- neurological, metabolic (weight, abdominal circumference) or neurovegetative (constipation, dry mouth) effects (2) by repeated physical examinations and reassessment of treatments,
- effects on laboratory tests: blood glucose, lipid assessment, etc.,
- cardiovascular effects: BP ECG;

- **AWARENESS-RAISING AND TRAINING** of healthcare professionals in the management of patients treated with neuroleptics and the risks incurred.

It is also necessary to beware of cognitive biases (shortcuts in thinking) that can compromise the quality of patient care, particularly in the field of psychiatry, such as the propensity to blame any symptoms on the psychiatric illness.

(1) *Les consommations de médicaments psychotropes en France, la santé en action* [Psychotropic medication use in France, health in action] – No. 427 – March 2014

(2) ANSM - *Antipsychotiques : rappel des mesures de suivi cardio-métabolique* [Antipsychotic drugs: reminder of cardio-metabolic monitoring measures] (Updated 7 January 2021)

ansm.sante.fr/actualites/antipsychotiques-rappel-des-mesures-de-suivi-cardio-metabolique

Focus on patient safety collection

The “Focus on patient safety” collection aims to draw the attention of and raise awareness among healthcare professionals as to risk management. Each focus covers a specific and recurrent risk based on care-related adverse events, identified and selected from national care-related serious adverse event reporting databases or doctors’ accreditation.

This focus concerns care-related serious adverse events due to a lack of follow-up of patients on neuroleptic medication. It relates events with which healthcare professionals have been confronted and which are always associated with a series of dysfunctions.

Find out more:

Focus on patient safety

www.has-sante.fr/jcms/p_3240311/fr/flash-securite-patient?id=p_3240311&preview=true

- **If I want to inform myself**

ANSM guidelines

Antipsychotiques : rappel des mesures de suivi cardio-métabolique [Antipsychotic drugs: reminder of cardio-metabolic monitoring measures] (Updated 7 January 2021)

ansm.sante.fr/actualites/antipsychotiques-rappel-des-mesures-de-suivi-cardio-metabolique

HAS – *Outils de sécurisation et d’autoévaluation de l’administration des médicaments* [Safety and self-assessment tools for the administration of medicinal products] (2016)

www.has-sante.fr/upload/docs/application/pdf/2011-11/guide_outil_securisation_autoevaluation_medicaments_complet_2011-11-17_10-49-21_885.pdf

HAS – *La lettre d’information de la Haute Autorité de santé* [HAS information letter] - No. 10 – January/February 2008
www.has-sante.fr/upload/docs/application/pdf/lettre_has_10.pdf

-

- **If I want to train**

Sécurisation du circuit du médicament en psychiatrie

[Securing the drug circuit in psychiatry] (OMéDIT Bretagne – July 2022)

www.omeditbretagne.fr/activites-et-thematiques/psychiatrie/

Informations et bon usage des psychotropes [Information and proper use of psychotropic drugs] (OMéDIT Pays de la Loire – January 2022)

www.omedit-paysdelaloire.fr/bon-usage-des-produits-de-sante/medicaments/psychotropes/fiches-de-bon-usage-psychotropes/#FIM

Fiches conseil/guide d’information sur les médicaments psychotropes [Advice sheets/information guide on psychotropic drugs] (PIC network – February 2022)

www.reseau-pic.info/?dest=fiches/nom.php

Outils élaborés par la commission Psychiatrie et santé mentale [Tools developed by the Psychiatry and mental health committee] (OMéDIT Nouvelle-Aquitaine – Guadeloupe – November 2017)

www.omedit-nag.fr/actualites/commission-psychiatrie-nouveaux-outils-disponibles

Prescription et psychotropes en pédopsychiatrie [Prescription and psychotropic drugs and paediatric psychiatry] (OMéDIT Normandie)

www.omedit-normandie.fr/boite-a-outils/sante-mentale/sante-mentale,3723,4584.html

The HAS would like to extend its thanks to the Observatory for Drugs, Medical Devices and Therapeutic Innovations (OMéDITS) who helped proofread this focus.



HAUTE AUTORITÉ DE SANTÉ

Advancing quality in the fields of
health and social care services