Dogfennau Ategol - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:
Ystafell Bwyllgora 2 - y Senedd
Dyddiad: Dydd Iau, 11 Mai 2017
Amser: 09.30

I gael rhagor o wybodaeth cysylltwch a:
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Noder bod y dogfennau a ganlyn yn ychwanegol i'r dogfennau a gyhoeddwyd yn y prif becyn Agenda ac Adroddiadau ar gyfer y cyfarfod hwn

Drafft - Inquiry into the use of anti-psychotic medication in care homes - Consultation responses

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(Tudalennau 1 - 80)

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Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal

Ymatebion i'r Ymgynghoriad

Ebrill 2017

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Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

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Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal
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Response from the College of Human and Health Sciences, Swansea University

[Via email]

Priorities for Health, Social Care & Sport Committee Consultation

Use of antipsychotic medication in care homes

Summary

The Older People's Commissioner and the Flynn Review [Opens in a new browser window] both highlighted concerns about the inappropriate use of antipsychotics to control the behavioural and psychological symptoms of people living with dementia. The Committee could seek to assess the scale of the problem, and examine possible solutions.

We have developed and tested an intervention which has been shown to reduce the use of sedative medicines, including antipsychotics, in care homes. Our intervention is the West Wales Adverse Drug Reaction (WWADR) Profile for mental health medicines (to be sent on request). It lists problems that might be associated with or exacerbated by these medicines, and asks nurses to monitor these and inform prescribers or pharmacists. We have shown in randomised controlled trials and observation studies that structured nurse-led medicines' monitoring using the WWADR Profile benefits patients, for example, by reducing pain and sedation, encouraging behavioural interventions and identifying high risk cardiovascular conditions. Our trials indicate that the intervention does not cause harm, and there is potential for considerable cost saving. The comments of the care home managers, some papers, endorsements and our video are below.

I should like to discuss how our evidence-based solution could contribute to the consultation and be operationalized.

I look forward to hearing from you,

Professor Sue Jordan

Detailed response

The Committee will look at the use of anti-psychotic medication in care home settings, and the ways in which its inappropriate use could be reduced, including the consideration of:

- **the availability of data on the prescribing of anti-psychotics in care homes, to understand prevalence and patterns of use;**

Antipsychotics were prescribed for 17.3% of residents in nursing homes and 18.6% in residential homes in England in 2009, and follow-up in 2012 found the respective figures had edged up to 21.0% and 19.2% (point prevalences). There was a six-fold variation between geographical areas, and a social class gradient: prescription durations, but not doses, were often excessive (Szczepura et al 2016). I was unable to identify a similar figure for care

homes in Wales, but in the 5 care homes in our trial 21/175 (12%) residents were prescribed antipsychotics: this lower figure is likely due to the volunteer nature of our sample (Jordan et al 2015).

· **prescribing practices, including implementation of clinical guidance and medication reviews;**

There is no evidence indicating that clinical guidance has reduced antipsychotic prescribing to older adults. There have been many UK recommendations and costly initiatives to reduce prescribing of antipsychotics for older adults, particularly those with dementia (Banerjee 2009, Older People's Commissioner 2014, Department of Health's 2009 National Dementia Strategy, MHRA 2012). A large observational study indicates that, to date, none have succeeded (Szczepura et al 2016). Similar (FDA) warnings in the USA resulted in increased prescribing of benzodiazepines and anti-dementia medicines, but no changes in antipsychotics (Singh & Nayak 2016).

Other warnings and guidance have been more successful. For example: an interrupted time series analysis indicates that prescribing has been channelled from paroxetine to other SSRIs (Pamer et al 2010); FDA black-box warnings resulted in reduced initiation doses of SSRIs (Bushnell et al 2016).

In none of our research projects have we found evidence of medication reviews or documentation of side effects before introduction of our intervention (Jordan et al 2014, 2015). Our ongoing work with cluster pharmacists indicates that nurse-led medicines monitoring facilitates their medication reviewing.

NICE (2015) recommends medication monitoring, but no strategies are suggested. We propose a low-cost strategy to implement the relevant NICE recommendations from Medicines' Optimisation, Guideline 5 (2015), Managing Medicines in Care Homes, Social Care Guideline 1 (2014), and Psychosis and Schizophrenia clinical guideline (2014) (details are appended).

· **provision of alternative (non-pharmacological) treatment options;**

Treatments should be tailored to individuals' needs. We (Jordan et al 2015) found that detailed, careful monitoring identified individuals' diverse needs, reduced antipsychotic prescribing and significantly increased the number of problems addressed: pain (cf. Rajkumar et al 2017), dental problems, behaviour problems, anxiety (cf. Fossey et al 2006).

Some, not all, non-pharmacological interventions improve quality of life scores, and all require considerable investment in staff time (Ballard et al 2016). These interventions, and fidelity of their delivery, are unlikely to be captured in electronic databases. They are also restricted by time pressures, institutions' priorities and staff's perception of the intervention (Lawrence et al 2012).

· **training for health and care staff to support the provision of person-centred care for care home residents living with dementia;**

Some person-centred care initiatives have reduced the prescribing of antipsychotics, although clinical outcomes are not clear and many initiatives are not supported by research evidence (Fossey et al 2014). In practice, releasing staff for training is difficult, due to staffing shortages and time pressures. Therefore, interventions with minimal training needs are likely to be more feasible: provision of websites and materials that can be accessed at any time may be more realistic than face-to-face training. Many interventions addressing a single symptom (e.g. pain, akathisia) or problem (e.g. anxiety, disturbed behaviour) are described in the literature, therefore, *we recommend a single comprehensive Profile* with signposts to further exploration with specialist measurement tools if necessary. Our 1-sided West Wales Adverse Drug Reaction (WWADR) Profile, with vital signs, can be passed to prescribers and pharmacists with problems highlighted. We hope there will be opportunities to link with the all-Wales electronic records initiative (NWIS/WCCIS).

There are advantages to formalizing the links between clinical practice and universities to address the current goal. Links are often made in the context of specific projects. The proposal to develop an ENRICH network of research-ready care homes in Wales, to parallel that in England and Scotland, may help to address this. However, voluntary networks are unlikely to attract the care homes most in need of support, and the care homes' inspectorate should consider mandating documentation of medication monitoring, in parallel with the ongoing monthly nutritional assessments.

· **identifying best practice, and the effectiveness of initiatives introduced so far to reduce inappropriate prescribing of anti-psychotics;**

Interventions must be based on research evidence, ideally randomised controlled trials with supporting qualitative evidence. There are suggestions that consultant-led medication review (Ballard et al 2016) and pharmacist-led interventions are ineffective (RESPECT 2010), and Cochrane reviewers found evidence for implementation to be equivocal and of low quality (Alldred et al 2016, Patterson et al 2014). Provision of advice confers some benefits, but demands professionals' time (Corbett et al 2012). Therefore, based on our trial and earlier work (appended), we are proposing a multi-disciplinary intervention, led by nurses, the

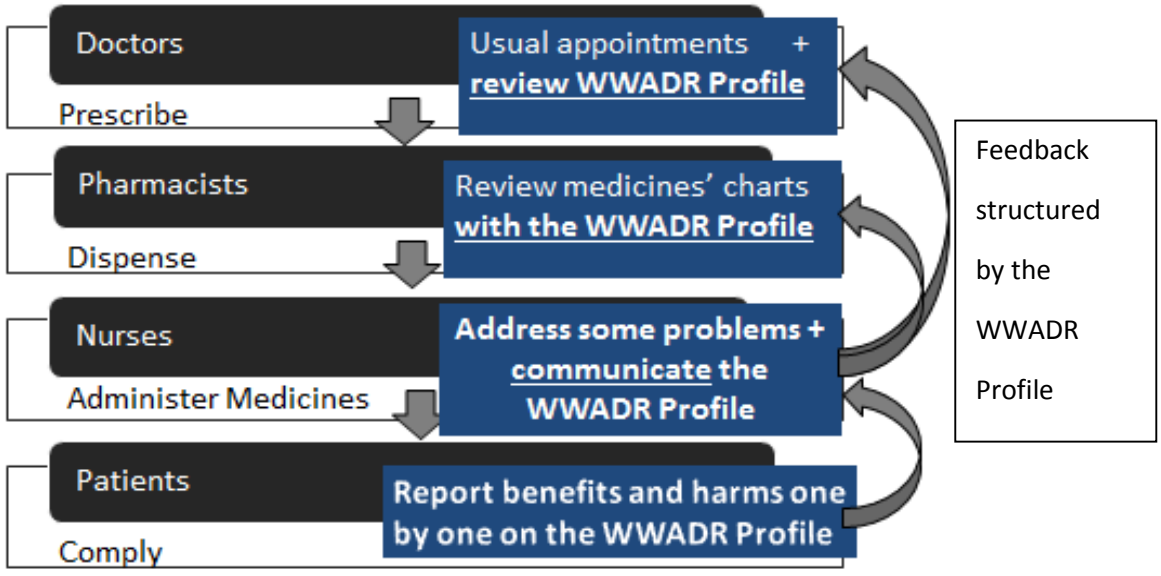
professionals closest to the patients, to introduce systematic patient feedback into medication management and prescribing (figure) (Jordan et al 2015, 2016). Our literature searches indicate that the WWADR Profile is the only comprehensive nurse-led monitoring instrument for mental-health medicines (Jordan et al 2004, 2016, Gabe et al 2011, Vaismoradi et al 2016).

NICE examplars are an additional source of 'best practice' (for example, Jordan 2015).

· **use of anti-psychotic medication for people with dementia in other types of care settings.**

Some 2% of those aged >80 in primary care are prescribed antipsychotics, with a social class gradient, based on interrogation of the UK Health Improvement Network (THIN) database (Marston et al 2014). More work is needed to identify and target these patients, but the fees expected by GPs to undertake medication review may be a barrier (Dreischulte et al 2016). Our intervention has proved successful in community settings (Jones et al 2016, Jordan 2002, et al 2002). Interrogation of the all-Wales GP prescribing database in SAIL could be discussed, but coverage is ~60% of patients and ~70% of general practices.

Fig. The Medication Chain + WWADR Profile Feedback



Note. This figure illustrates the principle of the operation of the WWADR Profile in a range of settings.
© Sue Jordan 2015 From: Jordan S, Gabe-Walters ME, Watkins A, Humphreys I, Newson L, Snelgrove S, Dennis M. (2015) Nurse-Led Medicines' Monitoring for Patients with Dementia in Care Homes. PLoS ONE 10(10): e0140203. doi:10.1371/journal.pone.0140203 http://dx.plos.org/10.1371/journal.pone.0140203

Appendix 1

NICE recommendations met by the West Wales Adverse Drug Reaction (WWADR) Profile

1. Medicines' Optimisation G5 2015

Recommendation 9
Consider using a screening tool to identify potential medicines-related safety incidents.
Recommendation 27
During a structured medication review, take into account …

- How safe the medicines are, how well they work for the person, how appropriate they are
- Any monitoring that is needed

2. Managing Medicines in care homes SC1 2014

Recommendation 1.8 Reviewing Medicines
1.8.3 Health and social care practitioners should ensure that medication reviews involve the resident and/or their family members or carers and a local team of health and social care practitioners (multidisciplinary team).
1.8.5 Health and social care practitioners should discuss and review the following during a medication review:

- the resident's (and/or their family members' or carers') concerns, questions or problems with the medicines
- all prescribed, over-the-counter and complementary medicines that the resident is taking, and what these are for
- how safe the medicines are, how well they work, how appropriate they are, and whether their use is in line with national guidance
- any monitoring tests that are needed
- any problems the resident has with the medicines, such as side effects or reactions, taking the medicines themselves (for example, using an inhaler) and difficulty swallowing
- helping the resident to take or use their medicines as prescribed (medicines adherence)

3 Psychosis and Schizophrenia in adults: treatment and management CG178 2014

Recommendations 1.3.6.4

- Monitor and record the following regularly and systematically throughout treatment, but especially during titration:
- response to treatment, including changes in symptoms and behaviour
- side effects of treatment, taking into account overlap between certain side effects and clinical features of schizophrenia (for example, the overlap between akathisia and agitation or anxiety) and impact on functioning
- the emergence of movement disorders
- weight, weekly for the first 6 weeks, then at 12 weeks, at 1 year and then annually (plotted on a chart)
- waist circumference annually (plotted on a chart)
- pulse and blood pressure at 12 weeks, at 1 year and then annually
- fasting blood glucose, HbA_{1c} and blood lipid levels at 12 weeks, at 1 year and then annually
- adherence
- overall physical health. **[new 2014]**

Appendix 2

Examples of previously unsuspected problems identified and addressed

- cardiac arrhythmias and severe hypertension (Jordan 2002, 2002),
- drug-induced Parkinsonism (Jordan et al 2014),
- respiratory tract infections (Gabe el al 2014),
- chest pain and valproate-induced pancreatitis (Jones et al 2016).

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Our video & website
https://youtu.be/E_CPDgsmA4s
http://www.swansea.ac.uk/wwadr/#

Care Homes Managers who participated in the RCT (Jordan et al 2015)

- Home Manager said " The profiles are very useful and have enabled us to review and discuss the medications with the GP and CPN. As a result, for example we have stopped some antipsychotic medications that the patient no longer requires". (Wilson, Care Home Manager, Glan Garnant)
- Paula Aplin said " The WWADR profiles are really useful and the staff are more educated and informed about drug reactions. The increase in staff confidence has made a big difference to medication management for the service users in our care ".
- Aldo Picek Clinical nurse manager said "The tool increased the nurse knowledge and improved attitudes towards accountability. Increased confidence helped to identify side effects and change medications".
- Sue Levy the Home Manager said " I use the checklist routinely in my practice and for the few minutes it takes, it provides a patient centred care for the person which makes it worthwhile. It has made me reflect and think of things that I wouldn't have prior to using the profile".

The work is endorsed by Age Cymru. Age Cymru are supportive of this piece of research.

Alzheimer's Society, Wales will be supporting our research in forthcoming discussions with Welsh Government.

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APS 02

Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal

Inquiry on the use of anti-psychotic medication in care homes

Ymateb gan Gofal Cymdeithasol Cymru

Response from Social Care Wales

Use of anti-psychotic medication in care homes

Social Care Wales' response to the
National Assembly's Health, Social Care and Sport Committee inquiry

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1. Social Care Wales works with partners to make care and support better for people in Wales. We have powers to regulate and support the training of the social care workforce. We have a new remit to support improvement and research in the field. Until 31 March 2017 we were known as the Care Council for Wales.

2. We have been responsible for the professional regulation of adult care home managers since 2011. In that time we have not received referrals relating specifically to the inappropriate use of anti-psychotic medication. However, we will continue to monitor the situation. Should people or organisations become aware of specific instances of registered social care workers engaged in such practices they should contact Social Care Wales.

3. The Code of Professional Practice for Social Care[1] and The Social Care Manager: Practice Guidance for Social Care Managers[2] emphasises person centred approaches as fundamental to the social care profession. These documents are the foundation on which the regulation and training of social care workers and social care managers is built. Both documents are used in assessing a member of staff's fitness to practice should they be called before a Social Care Wales panel. The Practice Guidance for Social Care Managers includes a specific section on medication which reads:

> "You must comply with the relevant law, statutory regulations and professional guidance regarding medication. If you are responsible for developing a medication policy and procedure this should specify the circumstances in which a staff member may administer or assist in the administration of medication. It should include

[1] Code of Professional Practice for Social Care, Care Council for Wales
[2] The Social Care Manager: Practice Guidance for Social Care Managers (PDF), Care Council for Wales

procedures for the safe administration, recording, handling, safekeeping and disposal of medication. If you are responsible for implementing medication policy and procedure, you should ensure that the policy is adhered toby you and your staff. You should address any concerns about the safety of the medication policy and procedure or its implementation.[3]"

4. The inquiry's terms of reference asks us to consider the "training for health and care staff to support the provision of person-centred care for care home residents living with dementia." In our view, it is vital that each care home is staffed by people who are sufficiently skilled to provide person centred and preventative approach to care. To support this aim, we have produced a range of training materials. Furthermore, we are working to improve the qualifications required to work in the care profession.

5. In November 2016 we published the Dementia Learning and Development Framework for Wales alongside NHS Wales. The new resource aims to change the way in which dementia care is provided in Wales by creating a single, shared vision for health and social care workers to provide the best possible care and support for those living with dementia. The framework has people with dementia at its heart and recognises that people with dementia, their families and carers should all be central to the care and support they receive[4].

6. We are working with Qualifications Wales on a new set of qualifications for health and social care from 2019. These have a strong emphasis on person centred care, with a specific pathway for the skills needed to care for people with dementia. People who work in the care profession will be required to hold these qualifications, so their reform is a significant step. Person centred practice has been strengthened in the revised induction framework for health and social care. We will be conducting a consultation on the changes to the framework in late spring.

7. We also produced a learning resource called Positive Approaches : Reducing Restrictive Practices in Social Care[5]. The resource aims to provide an understanding of how to work using positive and proactive approaches and reduce the use of restrictive practices in social care. The focus of the resource is on enabling and ensuring best practice using examples and scenarios for illustration. It can be used in supervision; as part of induction; training sessions; appraisals and to inform policy; protocols; audit; quality assurance and commissioning.

[3] Par 20, page 15, as above
[4] Good Work: A Dementia Learning and Development Framework for Wales, Care Council for Wales
[5] Positive Approaches: Reducing Restrictive Practices in Social Care Care Council for Wales

APS 03

Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal
Inquiry on the use of anti-psychotic medication in care homes
Ymateb gan Goleg Brenhinol yr Ymarferwyr Cyffredinol
Response from the Royal College of General Practitioners

RCGP Wales response on use of anti-psychotic medication in care homes

RCGP Wales welcomes the opportunity to respond to the Health, Social Care and Sport Committee short inquiry on the use of anti-psychotic medication in care settings, particularly care homes.

Antipsychotics are drugs developed and licensed to manage schizophrenia and their use for this is wide. Typical antipsychotics are associated with common and serious adverse effects, including over-sedation, hypotension, involuntary movements (including irreversible late onset tardive dyskinesia), Parkinsonian symptoms (rigidity, tremor and problems with walking) and the rare occurrence of cardiotoxicity (damage to the heart), high fever and vascular collapse (neuroleptic malignant syndrome). Since their introduction, the use of the atypical antipsychotics has become much more common, due to their generally favourable side effect profile, with the incidence of Parkinsonian side effects and tardive dyskinesia much lower and is to be supported even in care homes. They are also used commonly to manage disturbed behaviour e.g. agitation, aggression, wandering, shouting, repeated questioning and sleep disturbance, in patients with other conditions, particularly dementia or those with learning disability.

Many people in care homes and those with dementia have multiple co-morbidities and the use of any medication with significant side effects needs to be kept to a minimum, both in duration and in dosage. Antipsychotics, particularly the older typical ones have marked side effects as mentioned above. The newer atypical antipsychotics have less incidence movement disorders and are now more commonly used. Traditional clinical trials have only looked at short term usage. There are suggestions that side effects are more frequent with long term usage of antipsychotics and in those who have repeat use, as well as those who have other co-morbidities.

Patients who are suffering from behaviour problems should be fully assessed to determine underlying problems e.g. disturbed sleep pattern, acute illness, pain, which is contributing to the alerted behaviour pattern. This is consistent with NICE guidelines https://www.nice.org.uk/advice/ktt7/chapter/Evidence-context . Should patients be started on antipsychotics they need to be

monitored regularly for side effects including cardiac ones using ECGs. Dosages and duration of medication should be kept to a minimum.

Potentially, the development of behaviour problems may be higher in care homes than in patients' own homes, where they are surrounded by familiar objects and people. The monitoring of patients in care homes for side effects should, however, be easier and more frequent than outside this environment.

When patients with dementia or learning disability are admitted to hospital, the change of environment and the underlying condition / reason for admission may exacerbate to precipitate behaviour problems. These patients may be given antipsychotics but notes should clearly indicate that these should be withdrawn following the acute episode and discharge to their normal surrounding.

More support is needed for primary care, such as, access to multidisciplinary team input in managing patients who present with behavioural disturbance and quarterly review with a CPN for those on an anti-psychotics.

GPs are often under pressure from care home staff to use medication to manage disturbed behaviour in patients, who might be better managed by different forms of distraction or stimulation.

There is also pressure on GPs to prescribe antipsychotics from psychiatrists, particularly the elderly. GPs need to be supported by mental health colleagues to follow the good clinical guidelines set out by NICE and reduce the use of antipsychotics for these unlicensed uses of managing behaviour problems.

APS 04

Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal

Inquiry on the use of anti-psychotic medication in care homes

Ymateb gan Goleg Brenhinol y Therapyddion Galwedigaethol

Response from Royal College of Occupational Therapists

National Assembly for Wales Health, Social Care and Sport Committee's consultation on the use of anti-psychotic medication in care homes

This submission is made on behalf of the Royal College of Occupational Therapists (RCOT), the professional body for occupational therapists across the UK.

The submission is made in response to the Health, Social Care and Sports Committee's consultation on the use of anti-psychotic medication in care homes. Further information on any aspect of this response can be gained by contacting the RCOT.

Executive Summary

1. This response outlines the importance of specialist dementia services providing support to care homes and the role occupational therapists can play in supporting care homes to deliver on person centred care and non-pharmacological interventions to address behavioural and psychological symptoms associated with dementia.

2. The Royal College of Occupational Therapists is currently gathering further data on best practice examples as part of its *Occupational Therapy: Improving Lives, Saving Money* campaign.

Submission

Establishing a person centred ethos:

3. Older people living in care homes historically have not had equality of access to multidisciplinary services, although they arguably have the greatest health and social care needs. Within the UK multidisciplinary liaison services are providing in-reach support to care homes. In these teams, occupational therapists can promote person-centred care through training, on-site role modelling and working directly with care home staff. This would include:
   - using dementia-specific assessment tools to ensure person-centred activity planning and establishing accessible one-page profiles of residents with staff members. Supporting meaningful activity is dependent on having insight into the person's life experience, roles and interests. The Pool Activity Level (Pool, 2006) is often cited as an assessment tool as it provides a life history and it describes the different levels at which an individual may engage.
   - Reviewing needs of residents, suggesting ways of breaking activity down and delegating different roles/steps of activity.

4. A person centred approach would primarily focus on identifying and understanding who and what is important to the person so that they can be supported to maintain a relationship/involvement with these as their illness progresses. This focus on living life would allow an enablement rather than a management ethos. For example: in consideration of risk the value of the activity to the person and their previous approach/attitude to risk would be a key deciding factor within support plans. The focus on enablement would encourage a more positive approach – working with the person's strengths and skills and existing support. This will lead to a less risk adverse

culture, minimising restrictions on people living their lives and engaging in the occupations that matter to them.

5. Supporting people with dementia to be active, engaged and to have outlets for communicating thoughts and emotions through activity reduces the build-up of frustration. It allows staff to be alongside the person and offers insight into who they are beyond the diagnosis and symptoms of dementia.

6. The Royal College has produced a toolkit to establish an enabling ethos within care homes and addresses dementia within the guides.
   College of Occupational Therapists (2013). *Living well through activity in care homes - the toolkit.* London: COT. Available at:.*https://www.cot.co.uk/living-well-through-activity-care-homes-toolkit-0*

7. There are existing examples of high quality training delivered by occupational therapists. For example:
   - Abertawe Bro Morgannwg University Health Board Dementia Care Training Team picked up two awards for their specialist training. The jointly funded team, based at Glanrhyd Hospital, were awarded Stage 1 Practice Innovation Unit by the Welsh Centre for Practice Innovation (WCPI) acknowledging continuing work to improve standards in dementia care. Plus, they've been Highly Commended in the National Social Care Accolades which are awarded by the Care Council for Wales.
   - Helen Lambert and Alison Turner, both Occupational Therapists, and Mental Health Nurse Karyn Davies developed and delivered training to ABM and Bridgend County Borough Council staff to improve the support people with dementia received, and ensure everyone receives the same care across the area. Helen Lambert, went onto lead on the development and delivery of a Dementia Reablement Training Package for Cardiff City Council and the Social Service Improvement Agency. http://www.ssiacymru.org.uk/home.php?page_id=8644. This led to the development of a Dementia Reablement toolkit and service model: http://www.ssiacymru.org.uk/resource/english--lr.pdf. These can be translated to span care homes and the training of care home staff.

Training for Care Home Staff in non- pharmacological interventions:

8. The majority of care homes have not specifically been designed to provide care for people with the complex needs of those with severe/later stages of dementia. This means that residents with dementia often have multiple unmet needs such as: involvement in everyday activities, isolation and anxiety and depression. These unmet needs can lead to decreased quality of life and increased costs of care due to managing the resulting symptoms of behavioural and psychological symptoms of dementia. (Orrell et al. 2007.)

9. Occupational therapists can directly work with residents to address behavioural and psychological symptoms of dementia. Through:
   - Assessing patterns of distressed behaviour and identifying potential reasons, such as pain, anxiety, the approach of staff and the environment.
   - Providing help and training to staff to support the person with dementia to undertake daily living activities such as bathing, dressing, eating, and participating in social activities, thereby minimising frustration. This may involve adopting assessment tools, adapting communication, the environment and activities. (Gitlin et al 2001, Padilla, 2011).

- Evaluating communal spaces in care homes and improve the environmental design to help compensate for impaired memory, learning and reasoning skills. This helps reduce the levels of stress experienced by people with dementia and their carers and improves the quality of individuals' daily lives. (Barber-Miller 2010, Morgan-Brown et al 2011).
- Providing appropriate exercise or other activities that are graded to an individual's capabilities to increase their quality of life, preserve their identity and provide them with a positive emotional outlet.(NICE 2008)

10. Within the Royal College's next report *Living, not Existing: Putting prevention at the heart of care for older people in Wales* there is a call for equality of access to be the guiding principle for older people who, due to their age and health, are unable to care for themselves and keep themselves from harm. If equality of access to occupational therapy is to be achieved, the design of services must enable occupational therapists to widen their approach in order to meet the varying needs within their local communities; this includes providing in-reach support to care homes.

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About the Royal College

The Royal College of Occupational Therapists is the UK Professional Body and Trade Union for over 31,000 occupational therapists, support workers, managers and students. Occupational therapy enables people of all ages to participate in daily life to improve health and wellbeing. They are the only Allied Health Profession trained at a pre-registration level to work within both physical and mental health.

Contact

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21 April 2017

Response from the Royal College of Nursing Wales to the Health, Social Care & Sport Committee Committee's Inquiry into the use of anti-psychotic medication in care homes

The Royal College of Nursing is grateful for the opportunity to respond to this inquiry. Whilst the terms of reference ask for consideration of a number of specific areas, our response will focus on a few overarching points.

General comments

I. Medicines management in an environment where people receiving medicines are vulnerable and suffering a range of comorbidities, often with compromised capacity, is complex and multifaceted. The importance of contemporaneous, skilled assessment and care planning cannot be overstated.

II. Care homes must have a written policy and procedure on the administration of medicines, and all staff working in the home should be aware of the policy and should be working to it at all times. Registered nurses must also work to the NMC's Standards for Medicines Management. The vast majority of registered nurses and care home staff adhere to these standards and policies and the care delivered is to a very high standard.

III. The Royal College of Nursing Wales' prestigious Nurse of the Year Awards have frequently acknowledged the excellent work of nurses and healthcare support workers in care home settings and with people with dementia.

Staffing levels and time to care

IV. Providing and managing health services means caring for people. Preventing, assessing, treating or managing an illness means caring. Pain relief and ensuring a patient is nourished and hydrated means caring. Nursing is caring. Caring for someone requires time, time to learn, time to listen and talk, time to assess, time to provide care, delegate or escalate, time to reflect and improve practice. It takes time to care.

V. In 2015 the Royal College of Nursing Wales ran a member survey to find out what issues mattered most to our members. The two issues that came out top for improving patient care were:
- maintaining safe nurse staffing levels
- ensuring that the staff who deliver patient care have the time and training needed to deliver this care with the dignity and respect that patients deserve

VI. This clearly demonstrates the importance of having the right number of staff with the right level of supervision to ensure the best possible care for patients and care home residents. It is important that the team has senior, experienced

and qualified members who can provide supervision and oversight. The team needs to have the time to safely and sensitively care for the patients assigned to it, and members of that team need continuous professional development. It is when these standards are not met that errors in judgement can occur, and standards of care can decline.

VII. Patients with dementia have specific and complex needs, and those with dementia in a care home are likely to require greater levels of care than other patients in similar settings. This should be reflected in the calculation of nurse staffing levels. The Committee may wish to consider whether there is any evidence of a relationship between dubious prescribing practices in care homes, and the ratio of registrants to patients in such settings.

VIII. Care homes should also ensure that they are able to offer a range of treatment options for people with dementia, including evidence based psychological therapies where appropriate.

About the Royal College of Nursing

The RCN is the world's largest professional union of nurses, representing over 430,000 nurses, midwives, health visitors and nursing students, including over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing. The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

APS 06

Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal

Inquiry on the use of anti-psychotic medication in care homes

Ymateb gan Boots UK

Response from Boots UK

Use of antipsychotic medication in care homes

Health, Social Care and Sport Committee inquiry

A response by Boots UK

1. Boots UK and medicines supply to care homes in Wales

1.1. Boots UK Ltd operates the largest chain of community pharmacies in the United Kingdom. It is synonymous with pharmacy in the public mind and is one of the country's most trusted brands.

1.2. Our company has over 2,500 health and beauty stores in the UK, most of which include a pharmacy.[1] Just over 100 of these are in Wales. Boots UK supplies medicines to a significant proportion of care homes across the UK, including in Wales.

1.3. Medicines are supplied by local community pharmacies to the appropriate care homes. We have dedicated care services dispensaries that focus on dispensing for care homes. Our local pharmacies are supported by our central Care Services Support Pharmacy in Nottingham which provides pre-packed medicines in monitored dosage system (MDS) inserts for local dispensing for individual patients in care homes.

1.4. Our Pharmacist Advice Visits to care homes are provided by a team of locally-based Care Services Pharmacists. They are the key point of contact between the pharmacy and the care home, providing feedback to the pharmacy if the home identifies any issues. Most importantly, they link in with the dispensary teams at the pharmacies, ensuring that medicines-related issues are addressed and actioned.

1.5. Each Pharmacist Advice Visit includes a section on antipsychotic use where an individual has had a confirmed diagnosis of dementia. Our pharmacists also undertake specialist audits, as required, including auditing the use of antipsychotic drugs.

1.6. We are pleased to respond to the Health, Social Care and Sport Committee's inquiry in to the use of antipsychotic medication in care homes and to provide further information on how community pharmacies can improve medication use.

[1] Figures from Walgreens Boots Alliance Annual Report for year ending 31st August 2016, excluding equity method investments

2. Identifying best practice and the effectiveness of initiatives

2.1. The work undertaken by our Care Service Pharmacists on reducing antipsychotic drug use in care homes was evaluated in a study run in conjunction with the School of Pharmacy, University of East Anglia. This was peer-reviewed and published in *Nursing Times* (2014;110:12-15). [*Copy of article attached*]

2.2. A clinical audit carried out by our Care Services Pharmacists, and which formed part of the NHS contractual requirement for audits, was carried out between July 2010 and June 2012 at 463 homes which provided care to 3,165 residents, of whom 1,300 (41.1%) had a recorded diagnosis of dementia.

2.3. Following the audit and review process, 653 patients (20%) had their doses of antipsychotics reduced and 548 (17%) had their prescription discontinued. The majority of discontinuations were as a direct result of the audit visit.

2.4. This audit demonstrates a small part of the work undertaken by our Care Services Pharmacists during Pharmacist Advice Visits. In particular, it highlights how the clinical advice given by the pharmacists can then be translated in to actions around prescribing and dispensing that give clear benefits to care home residents, staff and owners/managers.

2.5. It is this link between advice and action that is crucial. In our view, without this direct link between the Care Services Pharmacists and the community pharmacies that physically supply medicines to the care homes, and the GPs who prescribe for their patients, there is a grave danger that actions will not be taken or information will fail to be passed on, resulting in residents getting sub-optimal care.

3. Prescribing practices, including implementation

3.1. Changes to prescribing can result from individual patient reviews, specific audits or wider prescribing policies (at local and/or national levels).

3.2. As described above [Para 2.1-2.3], actions are required by both prescribers and dispensers to then ensure that changes to antipsychotic use, including reducing doses or stopping inappropriate prescribing are noted and actioned.

3.3. Prescribing, dispensing and administration records need to be updated in surgeries, pharmacies and care homes, respectively, to ensure that patients do not receive incorrect or duplicate medication following any changes.

3.4. The recently introduced Discharge Medication Review (DMR) service provided by community pharmacies also has a place in this. Through the DMR service, community pharmacists reconcile medication records for patients who have been admitted and discharged from hospitals, ensuring that any changes to prescribing are put in place.

3.5. In our view, this illustrates why a clear link needs to be maintained between the provision of clinical advice about medication use and the subsequent supply of medicines, including the use of antipsychotics. Separating the advice and supply functions runs the risk that the advice given will not be translated in to the necessary actions.

3.6. Our Care Services Pharmacists and the community pharmacy teams they support provide the key link that ensures joined-up working around the safe supply of medicines to patients in care homes.

4. Training for health and care staff

4.1. The service that we provide to care homes goes beyond the provision of medicines. It includes wider support through Pharmacist Advice Visits, advice on medicines management, condition-specific training for care home staff based on assessed needs and feedback, and support with patient-specific aids (such as body maps for topical medicines administration and warfarin dose recording charts) [see Para 4.5, below].

4.2. Our Care Services Pharmacists are encouraged to visit the care homes they are responsible for before making visits in order to familiarise themselves with the home and its needs before making a formal Pharmacist Advice Visit. Depending on the size and nature of the home, its location in the UK, the identified needs of its residents and their level of support required, and the agreement between Boots and the care home owners, homes generally receive between one and four visits a year.

4.3. Before our Care Services Pharmacists complete a Pharmacist Advice Visit they are required to complete a bespoke training package. The training covers introductory information, operating standards for Pharmacist Advice Visits, country-specific safeguarding training according to their country of practice and further safeguarding training developed by the company, and WCPPE (or equivalent) training packages on supporting people in care homes, guidance on consent, and country-specific covert medication administration guidance. In addition, the Care Services Pharmacists are recommended to study NICE guidelines on managing medicines in care homes and dementia.

4.4. Care home managers particularly value the support that our Care Services Pharmacists can offer before and after inspections by their regulatory bodies. Medicines management, including systems for safe storage, handling and administration of medicines, has become a high profile part of inspections. We can arrange additional visits in advance of or following inspections.

4.5. The Pharmacist Advice Visit is structured around a number of topics which are detailed below. For each area, the pharmacist discusses a number of key questions with the medicines lead in the care home and records the details. At the end of each section the pharmacist highlights any issues discussed, agreed next steps and who will be taking the required actions.

- Policies and systems for managing medicines
- Ordering and receipt of medication
- Storage of medication
- Controlled Drugs (CDs) - storage and use of the register
- Disposal of medication
- Clinical advice and medicines optimisation
- Administration of medication
- Recording the administration of medication
- Homely remedies
- Care home staff training

4.6. We deliver medicines directly to care homes at times agreed to suit the needs of each home and our staff are available to deal with changes to medication, including urgent supplies. Our links between the pharmacy service and supply of medicines

allows us to manage urgent requests in a safe and effective way, as we are aware of the clinical situation with each home and its residents.

Evidence submitted on behalf of Boots UK by:

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21st April 2017

Keywords: Antipsychotic medication/ Dementia/Care homes

●This article has been double-blind peer reviewed

The risks of antipsychotic drugs to people with dementia are well known. A review by pharmacists with care home staff led to the drugs being reduced or discontinued

Reducing antipsychotic drugs in care homes

In this article...

- Risks of antipsychotic medication
- Reasons for reducing or discontinuing antipsychotics
- The nurse's role in medication review

Authors Aileen Prentice is Boots Care Services operations manager, Boots UK; David Wright is professor of pharmacy practice, School of Pharmacy, University of East Anglia.

Abstract Prentice A, Wright D (2014) Reducing antipsychotic drugs in care homes. *Nursing Times;* 110: 22, 12-15. Antipsychotic medication should be used in people with dementia only when there is an identified need and the benefits outweigh the risks. An audit-based service provided by pharmacists, working with nursing and care staff in residential homes, resulted in antipsychotic doses reductions of 20% and drug discontinuation in 17% of residents with dementia.

Prescribing and medicines management in care homes, which is largely the responsibility of nurses, care staff and GPs, needs improvement (Alldred et al, 2013). One of the main areas of concern is the inappropriate use of antipsychotic medication (Parsons et al, 2012); an estimated 180,000 people with dementia are treated with antipsychotic medication in the UK every year (Banerjee, 2009). The care home population is frail and susceptible to the side-effects of antipsychotics (Box 1).

It has been estimated that the use of antipsychotic medication in patients with dementia – who represent at least 60% of the care home population in the UK – equates to 1,620 cerebrovascular adverse events and 1,800 deaths per year on top of those that would be expected (Banerjee, 2009). Antipsychotics make a significant contribution to what is known as the "anticholinergic burden" of prescribed medication – the cumulative effect of using multiple medications with these properties at the same time – which is related to increased mortality (Fox et al, 2011).

Within the US, legislation was introduced to reduce antipsychotic prescribing in care homes (US Federal Government, 1987). Homes are required to employ an independent consultant pharmacist to undertake regular review of antipsychotic medication, with the aim of reducing or discontinuing drugs. Evidence suggests this has been effective (Gurvich and Cunningham, 2000).

Within most care homes in the UK, nursing and care staff and GPs provide care and manage medicines, with occasional visits from an independent pharmacist from a primary care organisation to review prescribing, and monthly interactions with a community pharmacy to supply the medicines.

While an independent pharmacist working closely with nursing and care staff has been shown to realise significant medicine acquisition cost savings and improve residents' quality of life, the impact on longer-term outcomes is largely unknown (Alldred et al, 2013).

One study based in northern England, using a pharmacist employed by a medical practice with a close working relationship with GPs and care and nursing staff, demonstrated a significant reduction in falls after a pharmacist-conducted clinical medication review (Zermansky et al, 2006). In another study, where a specially trained pharmacist focused on antipsychotic use in people with dementia, a 25% reduction in antipsychotic prescribing was achieved (Child et al, 2012).

New legislation to improve antipsychotic prescribing in the UK is unlikely, so

5 key points

1. At least 60% of people living in care and nursing homes in the UK have dementia
2. The use of antipsychotic medication in people with dementia is widespread, and causes an additional 1,800 deaths per year
3. Antipsychotic drugs contribute to the anticholinergic burden, which is associated with increased mortality
4. Quetiapine is commonly prescribed for behavioural and psychological symptoms, but its use is unlicensed
5. Working with pharmacists can make nurses more confident in questioning the appropriateness of antipsychotics

Alamy

Quetiapine was the antipsychotic most often prescribed, in an unlicensed use

we need practical and sustainable models of care to address concerns regarding antipsychotic prescribing.

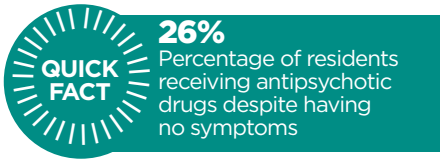
Government plans for community pharmacies include greater involvement in the management of long-term conditions (Department of Health, 2008). In addition to care and nursing staff and GPs, community pharmacists in primary care are ideally located to review monthly prescriptions for residents in care homes.

The national audit of care homes

Our national pharmacy chain services a large number of care homes across the UK.

Care home leadership teams had expressed a need for support in better managing the medicines of their residents, with antipsychotic prescribing identified as a priority area.

It is an NHS contract requirement for community pharmacists to undertake at least two audits per year (Pharmacy Services Negotiating Committee, 2013). We therefore carried out an audit of antipsychotic medication between July 2010 and June 2012 with homes that were customers of our company and that had requested the service. The homes were run by national chains of care homes and were located in England, Scotland and Wales.



Preparation for the audit

Community pharmacists were trained to provide the audit-based service using online training packages and attendance at an Alzheimer's train the trainer session. This session increased their knowledge and enabled them to deliver a two-hour dementia awareness session to care staff in the care homes.

Using patient medication records held nationally by the community pharmacy company, pharmacists undertook a clinical assessment of antipsychotic prescriptions for individual residents to establish possible reasons for starting the medication, the duration of the prescription and any interactions.

A blank audit form, GP information letter, consent letter and explanation of the process were sent to home managers. They were asked to identify residents who were prescribed at least one antipsychotic medication, and who were either diagnosed with dementia or suspected of having dementia. If there was no suspected or confirmed diagnosis of dementia, and the resident was taking the medication for other medical conditions such as schizophrenia or bipolar disorder, they were not included in the audit.

The homes sent consent letters to the relatives of those residents identified as potentially suitable for the audit as well as an introductory letter to their GPs.

BOX 1. SIDE-EFFECTS OF ANTIPSYCHOTICS

- Sedation
- Postural hypotension
- Extrapyramidal symptoms such as restlessness
- Muscle twitching
- Parkinsonian symptoms
- Tardive dyskinesia (permanent involuntary movements)
- Cardiovascular accidents

The audit process

Pre-audit joint strategy

Before discussing individual residents, the audit-trained community pharmacists worked with the professionals responsible for patient care at each home to create an joint strategy for the use of antipsychotic medication in line with national guidance (National Institute for Health and Care Excellence, 2006).

Pre-visit work

Before the audit visit, care home managers were asked to collate the following information for all relevant residents:

- Date of admission;
- Date medication started;
- Medical conditions;
- Recent changes;
- Monitoring;
- History of falls and fractures.

Individual assessments to determine the presence of symptoms that required treatment with an antipsychotic were undertaken.

Audit visit

During the audit visit, pharmacists recommended antipsychotic medication reviews for residents who had not received a review within the last three to six months, or where there was evidence of side-effects or no current symptoms of behavioural and psychological symptoms of dementia (BPSD).

Pharmacists and home staff discussed guidelines from NICE (2006). Then, for each resident, a risk versus benefits discussion took place, with a particular focus on falls and cardiovascular accidents.

Where it was deemed necessary, the pharmacists recommended that staff should discuss titrated withdrawal of antipsychotic medication during the review. The audit pharmacist also discussed with the home staff the information that would be provided and discussed with the GP or psychiatrist during the review. This could include a description of other ways of managing BPSD, and how the resident's needs were being met after admission to the care home, including how the need for medication may have changed.

The audit visit was seen as helpful in facilitating a conversation between home staff and their GP to challenge prescriptions. A document was provided to the home to enable them to request an anti-psychotic medication review from the GP. Homes decided whether to use the form or to make more informal direct requests.

Follow-up

Pharmacists telephoned or revisited the homes twice, two to four months after the audit visit, to ascertain the impact of their recommendations.

Data governance and ethics

No resident-identifiable data was removed from any care home. All databases contained unique reference numbers, which could be identified only within care homes or community pharmacies providing the service and were stored on password-protected computers.

As this was a service evaluation, which falls under the remit of clinical audit, ethical approval was not sought. All homes provided written consent to participate. The community pharmacists providing the service were employed by the company responsible for the regular provision of medicines to the residents so the review of prescribing was within their remit.

Results of the audit

Data was analysed from 463 homes, which received a service from four audit-trained community pharmacists on behalf of 350 company stores.

A total of 3,165 residents receiving antipsychotic medication were reviewed, of whom 1,300 (41.1%) had a recorded diagnosis of dementia; 1,180 reviews were started in 2010, 1,078 in 2011 and 901 in 2012. For six reviews, the year of initiation was not recorded.

Of the 3,165 residents reviewed, 2,341

TABLE 1. ANTIBIOTICS PRESCRIBED TO RESIDENTS

Drug name	Number of prescriptions	Percentage of prescriptions
Flupentixol decanoate	2	0.06
Perphenazine	2	0.06
Unknown	2	0.06
Levomepromazine	4	0.12
Pericyazine	5	0.15
Prochlorperazine	6	0.18
Benperidol	7	0.22
Flupentixol	10	0.31
Zuclopenthixol	19	0.58
Trifluoperazine	30	0.92
Sulpiride	31	0.95
Chlorpromazine hydrochloride	41	1.26
Aripiprazole	52	1.6
Olanzapine	207	6.37
Promazine hydrochloride	235	7.23
Amisulpride	288	8.86
Haloperidol	396	12.18
Risperidone	548	16.85
Quetiapine	1,366	42
Total	**3,252**	**100**

(74%) demonstrated symptoms that may necessitate antipsychotic treatment. In 236 (7.5%) residents, antipsychotic medication was prescribed for BPSD, while a further 250 (7.9%) residents had been prescribed antipsychotic medication for another condition and had subsequently developed dementia.

By the first visit 147 (4.6%) of residents were deceased and a further 119 (3.8%) had died by the end of the follow-up visit.

Types of antipsychotic medication prescribed

Table 1 provides a summary of the antipsychotic drugs prescribed for the residents reviewed. In 87 instances, a resident was prescribed more than one antipsychotic concurrently and, in two cases, the name of the antipsychotic drug reviewed was not recorded. Quetiapine represented 42% of prescriptions, risperidone 16.8% and haloperidol 12.2%.

Reviews of medication

A total of 1,772 (56.0%) residents had had a recorded review of their antipsychotic medication within the previous three months, 465 (14.7%) within the previous six months and 228 (7.2%) in the previous 12 months.

Residents' antipsychotic prescriptions were reviewed when:

- They were currently receiving another antipsychotic;
- They were demonstrating side-effects from their medication;
- The risks of antipsychotic medication were deemed to outweigh the benefits;
- There was no evidence of symptoms;
- There was no evidence of review.

Fig 1 shows the numbers of prescriptions in which these criteria for questioning were found. Risks were deemed to outweigh benefits for 1,840 (58%) of prescriptions, while there was no evidence of symptoms for 824 prescriptions (26%).

Actions resulting from the audit

Table 2 shows the actions taken as a result of the audit process. A total of 653 patients out of 3,165 (20%) had their dose reduced while 548 (17%) had their prescription discontinued.

Just over half of dose reductions were made before the audit visit, while the majority of discontinuations resulted from the audit visit. There were a large number of anecdotal stories of significant success as a result of this audit.

Discussion

This large-scale audit found that in care home residents receiving antipsychotic medication, 26% did not have any symptoms that necessitated regular antipsychotic medication, and in 58% of cases the risk of the medication was deemed to outweigh the benefit. This relatively simple audit-based service resulted in over 20% of residents having their antipsychotic dose reduced and more than 17% having antipsychotic medication discontinued.

With the known side-effects of antipsychotic medication, including sedation, and an increased risk of falls and cardiovascular events, this service is likely to have improved the quality of life of a large number of care home residents.

The results suggest that nurses working in care homes should regularly question prescriptions for antipsychotic medication. This would ideally be done in partnership with the GP and community pharmacist.

It is not possible to determine what would have happened without this service. It is reasonable to assume that the regular reviews recorded as being undertaken would have led to some antipsychotics being reduced or stopped. However, it is unlikely that the large reduction seen in such a relatively short period of time would have occurred without active intervention by the community pharmacists.

The level of recorded regular antipsychotic medication review was high, so it is perhaps surprising that so many medicines were still considered suitable for stopping or reducing as part of the audit process. This may, however, demonstrate the value of using a third party to instigate such reviews, as in the US model (US

TABLE 2. CHANGES TO ANTIPSYCHOTIC MEDICATION

Time	Pre-audit planning	Pre-visit work	Three months after audit visit	Six months after audit visit	Total
Number of dose reductions	327 (10.3%)	14 (0.4%)	228 (7.2%)	84 (2.7%)	653 (20.6%)
Number of prescriptions discontinued	120 (3.8%)	2 (0.1%)	286 (9.0%)	140 (4.4%)	548 (17.3%)

Federal Government, 1987) since this provides a fresh perspective that is not clouded by historical practice. It may also provide support for less frequent independent reviews rather than regular in-house reviews. It would, however, also seem sensible for nurses in care homes for older people to review local practice to ensure that antipsychotic medication review is undertaken effectively.

The changes to prescribing at different time points of the project demonstrates the value of developing a care home strategy jointly, collecting information on each resident and holding interprofessional meetings to discuss individual prescriptions. The development of a joint strategy for antipsychotic prescribing was effective in reducing antipsychotic use, while the visits to discuss individual residents' prescriptions had a greater impact on therapy discontinuation.

Although in 58% of cases, the risk of antipsychotic medication was deemed to outweigh the prescription, it would be unreasonable to expect all these prescriptions to be discontinued, as such decisions must be taken with care and all factors require consideration.

The reductions in antipsychotic prescribing seen in this audit are similar to those found in other studies (Westbury et al, 2012; Patterson et al, 2010).

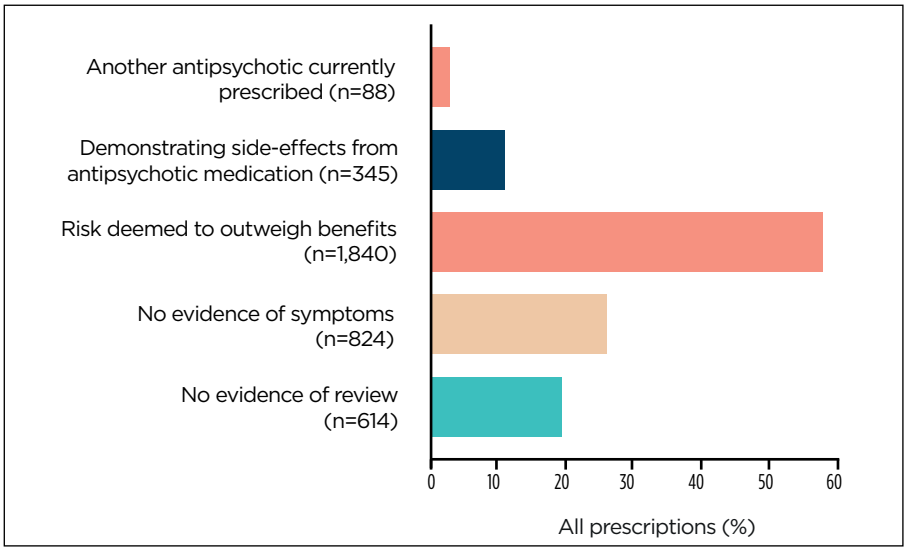
Quetiapine was found to be the most commonly prescribed antipsychotic for BPSD, which is an unlicensed use. Risperidone, the only licensed therapy, was used in fewer than one in six residents. The preference for quetiapine requires further exploration, as national guidance states that unlicensed use of medicines should only become necessary if the clinical need cannot be met by licensed medicines (Joint Formulary Committee, 2013). It would therefore be appropriate for prescriptions for quetiapine to be questioned.

While this audit-based service focused on strategies to manage the use of antipsychotic medication once prescribed, an additional emphasis by nurses, carers and GPs at the initiation of antipsychotic medication in patients with dementia in care homes on risk scoring, drug selection, effectiveness monitoring and review is perhaps also required.

The audit was designed to encourage conversations between nurses, care home staff and GPs about antipsychotic medication. The pharmacists reported that it appeared to empower the nursing and care staff to feel more confident with GPs. It also made nursing and care staff reflect on current practice, taking time out of the "day job" to review patient care and prescribing.

The audit team also reported, perhaps unsurprisingly, that engagement of the care homes involved was the key to success. Where the leadership team focused on positive outcomes for patients, we had more engagement and enthusiasm throughout the audit process. Furthermore, in homes with more stable employee populations, more of the actions seemed to be followed though, which ultimately influenced patient outcomes.

FIG 1. **PRESCRIPTIONS QUERIED**



Conclusion

This is a simple audit in an important area of practice that has potential for providing significant improvements in patient care.

A large number of medicines were discontinued or stopped as a result of this service, which will in many cases have immediately improved quality of life.

The results suggest that nurses and carers in care homes for older people should question, at the point of initiation, whether antipsychotic therapy is required and ensure the most appropriate drug is selected. At antipsychotic medication reviews, they should be aware that this should always be undertaken from the perspective of discontinuing or reducing therapy, rather than simply confirming that the therapy is working and not causing any harm. Working with suitably trained pharmacists provides the opportunity for an independent perspective on the appropriateness of and need for therapy. **NT**

● Declaration of interest: corresponding author Aileen Prentice is employed by Boots UK, which funded this work.

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Royal College of Psychiatrists in Wales

Consultation Response

DATE:	**21 April 2017**
RESPONSE OF:	**THE ROYAL COLLEGE OF PSYCHIATRISTS in WALES**
RESPONSE TO:	**National Assembly for Wales Health, Sport and Social Care Committee – Inquiry into Antipsychotic Medication Prescribing Practices in Care Homes**

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom.

The College aims to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

RCPsych in Wales is a satellite of the Central College, representing over 550 Consultant and Trainee Psychiatrists working in Wales.

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The RCPsych in Wales is pleased that the Committee is seeking views on the use of antipsychotic medication in care homes. This is an area of concern for the College in Wales and we have, over many years, been aware of issues of over prescribing and inappropriate use of antipsychotic medication in the elderly population.

This response has been produced in consultation with the members of the College in Wales and relevant stakeholders.

The RCPsych in Wales has previously published a briefing paper on prescribing practices in the elderly:

- Briefing paper on Over prescribing in the Elderly

RCPsych in Wales Key recommendations:

1. **A cycle of Local and Nationals audit into Antipsychotic prescribing practices in Wales**
   The Faculty of Old Age Psychiatry and the RCPsych in Wales is calling for a Wales-wide cycle of audits to gather data on anti-psychotic prescribing practices. The availability of hard data on prescribing practices is critical to understand prevalence and patterns of use.

   We would recommend that the audits also gather evidence on whether the patient received anti-psychotic medication as first option treatment, and/or whether there were alternative therapies available within their locality. This will provide the ability to assess whether the use of anti-psychotic medication is affected where alternative methods of treatments are available.

2. **Routine use of STOPP/START. Screening tool of Older Persons' potentially inappropriate prescriptions (STOPP)/Screening tool to Alert doctors to the Right Treatment (START) tool (Gallagher et al, 2008).**
   Demographic changes mean that prescribing for older people is an increasingly important aspect of daily clinical care. Older people have a high prevalence of chronic and multiple illnesses and are likely to be prescribed multiple medications. Pharmacokinetics and pharmacodynamics may be altered by ageing or disease. This puts elderly people at a high risk of adverse drug reactions (ADRs), adverse drug events (ADEs) and drug-drug interactions. They may also be exposed to medication errors or potentially inappropriate prescribing (PIP) with significant clinical and economic impact. The STOPP/START tool[1] has been developed to identify older people at risk from adverse drug effects and to reduce the risk of initiating drugs likely to cause adverse events. The tool comprises 65 clinically significant criteria for potentially inappropriate prescribing in older people.

[1] https://www.rcpsych.ac.uk/pdf/Aziz%20Stopp-START%20tool%20paper%20-%20Victor%20Aziz.pdf

- Antipsychotic medicines should not be routinely prescribed to treat behavioural and psychological symptoms of dementia.
- In line with NICE guidance, when an antipsychotic medicine is required, the lowest dose should be prescribed for the shortest time with regular review by an appropriately skilled pharmacist as part of the multidisciplinary team.
- Pharmacists who deliver enhanced support for care homes should be able to access quality continual professional development opportunities in relation to antipsychotic prescribing.

The Royal College of Psychiatrists in Wales recognises that there is a need to prescribe antipsychotic medication on occasion to treat severe behavioural and psychological symptoms in dementia. However, such medication should be reviewed and reduced as soon as it is practical and *safe* for the patient and those treating the patient. Other treatment options should be considered at the earliest opportunity.

3. **Medication reviews upon admission to Care Home settings and regular ongoing medication reviews for all residents.**

   In line with recommendations from The Royal Pharmaceutical Society (Wales) report 'Improving Medicines Use in Care Homes (2016)' [2]
   - As part of a multidisciplinary review, all residents should receive a review of their medication by a pharmacist when they first move into a care home in order to optimise their medication regimen.
   - Residents should receive a minimum of one annual medication review from a pharmacist with additional support for significant medication changes. For patients with complex medication regimens, this review should increase to every 3-6 months.
   - With patient consent, all pharmacists directly involved in patient care should have full read and write access to the patient's health record in the interest of high quality, safe and effective patient care.

The RCPsych in Wales recommends that 'discharge from hospital reviews' should routinely take place. We are aware of some work within Welsh Government to develop the required IT infrastructure to enable this and welcome this development.

The RCPsych in Wales recommends that *all* necessary antipsychotic prescribing is supported by a risk/benefit analysis for each patient performed by an appropriately trained specialist as part of the multi-disciplinary team.

We further recommend the involvement of community pharmacists, GPs, family and patients in medication reviews. Community pharmacists should be dealing specifically with care home residents, and would be able to make recommendations to the prescribing medic/MDT.

4. **Adequate training in medication for carers and staff**

The RCPsych in Wales recommends that *all* carers and staff have training to develop an understanding of possible side effects of antipsychotic medications prescribed within care home settings. This will enable carers and staff at *all* career grades to raise concerns

[2] https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Publications/Improving%20medicines%20use%20for%20care%20home%20residents.pdf

where an adverse reaction is suspected in order to enable senior staff to conduct a medication review quickly and effectively.

The RCPsych in Wales is encouraged by the introduction of the Care and Social Services Inspectorate Wales' Care Home Training Guides[3]

We would also recommend informed consent in patients with mild to moderate cognitive impairment, that the effect of prescribed medication, both positive and negative, is explained as fully as possible. To enable this, speech and language therapists have a role in training health and voluntary sector staff, including care home workers in identifying communication difficulties in dementia and strategies to support and enhance communication.

5. **Access to non- pharmacological therapies and treatments**

It is increasingly recognised that pharmacological treatments for dementia should be used as a second-line approach and that non-pharmacological options should, in best practice, be pursued first[4]. The more traditional treatments such as behavioural therapy, reality orientation and validation therapy, and newer treatments such as cognitive therapy, aromatherapy and multisensory therapies all have therapeutic benefit to patients with dementia.

Speech and Language Therapists (SLTs) have specialist knowledge to directly assess the connection between unmet communication needs and challenging behaviour, and provide advice on maximising communication function to the care home resident, their family and carers.

Example of good practice

Cwm Taf Health Board – Care Home Dementia Intervention Team

Cwm Taf University Health Board is improving the quality of like for care home residents with dementia. The Care Home Dementia Intervention Team is the first of its kind in Wales and provides an alternative to medication for behaviour that challenges.

The service explores the possible reasons why a person is distressed of behaving in a challenging way. This enables the service to work with care home staff to develop a person-centered care plan.

A successful pilot was held in Ty Eiren, a care home in Tonyrefail, where person-centered care plans were developed for residents with dementia and challenging behaviour. The plans included a variety of interventions such as reminiscence, music therapy, life story work and doll therapy.

Fiona Senior, Clinical Psychologist said 'To offer a service without medication is amazing'.[5]

[3] http://cssiw.org.uk/news/item?lang=en
[4] http://apt.rcpsych.org/content/10/3/171
[5] http://cwmtaf.wales/innovative-teamwork-cwm-taf-enables-care-home-residents-live-well-dementia/

Advice on conducting medication reviews in care homes with the aim of improving quality of life for residents

As hospital doctors become increasingly sub-specialised, GPs are absolutely critical to ensuring that medications prescribed by individual specialties are appropriate for that person.

This is based on an extensive knowledge of the patient, knowledge of the drug, access to the complete medical record and the shared approach to prescribing that is often applied.

GPs are regularly involved with medication reviews and their approach to medication reviews will vary from practice to practice.

Medication reviews undoubtedly improve quality of life for care home residents and the process can also improve relations between clinicians, staff, patients and relatives.

It should be noted that there can also be significant cost savings due to reduced prescriptions.

Pharmacists can be key in setting up medication review systems with the ability to identify a significant number of inappropriate prescriptions over time. They can provide the necessary link between clinicians and staff to realise the importance of this work as well as engaging patients and their relatives. The pharmacist can also ensure that any interventions taking place are appropriately reviewed.

From the evidence available, it is clear that there are risks associated with the use of antipsychotic medication, particularly for people with dementia in care home settings. Antipsychotics appear to be used all too often as a formulaic first-line response to any behavioural difficulty in dementia rather than as a considered second-line treatment when other approaches have failed. Data suggests that antipsychotics are used too often in dementia. The high level of initiation and maintenance of these medications in this vulnerable group means that any potential benefit of their use in specific cases is likely to be outweighed by the serious adverse effects of their use in general. In order to generate a plan that will work we need to understand the determinants of this behaviour and the reasons for its persistence.[6]

The Royal College in Wales welcomes the opportunity to input into work on this issue over the coming months.

Dr Victor Aziz

Chair, Faculty of Old Age Psychiatry, RCPsych in Wales

[6] https://www.rcpsych.ac.uk/pdf/Antipsychotic%20Bannerjee%20Report.pdf

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APS 08
Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal
Inquiry on the use of anti-psychotic medication in care homes
Ymateb gan Cymdeithas Alzheimer's Cymru
Response from Alzheimer's Society Cymru

Alzheimer's Society Cymru
Unedig Yn Erbyn Dementia
United Against Dementia

Dr. Dai Lloyd AM,
Health, Social Care & Sport Committee,
National Assembly for Wales,
Cardiff, CF99 1NA
seneddhealth@assembly.wales

21st April 2017

Dear Dr. Lloyd,

Re: Inquiry into the use of anti-psychotic medication in care homes

On behalf of Alzheimer's Society Cymru, please find below a response to the Health, Social Care & Sport Committee's inquiry into the use of anti-psychotic medication in care homes.

Dementia can devastate lives. For someone with the condition, as well as their family and friends, dementia means the plans you made, and the future you thought you had, will not be so.

Alzheimer's Society Cymru has a simple vision: a world without dementia. We know that moment will come. Today, too many people with dementia struggle. They cannot access information, help and support. Everyday things people take for granted become difficult.

Our mission is to transform the landscape of dementia forever. Until the day we find a cure, we will strive to create a society where those affected by dementia are supported and accepted, able to live in their community without fear or prejudice.

Summary / recommendations

a) Alzheimer's Society Cymru welcomes the Committee's focus on the use of anti-psychotics. We are deeply concerned about the inappropriate use of anti-psychotics in Wales, and strongly believe that these drugs should only ever be the last resort.

b) We support calls by the Royal Pharmaceutical Society Wales (RPSW) and the Royal College of Psychiatrists in Wales for an end to routine prescribing and a reduction in the time and dosage where antipsychotics are required.

c) We recommend the Welsh Government institute a cycle of national and local audits to improve clinical practice and make sure that multidisciplinary support and regular reviews are available. Non-pharmacological treatment options should be available, supported by training for staff to provide person-centred care.

d) We believe people with dementia must have a full explanation of the medication prescribed and have meaningful choice in their treatment.

Consultation response

1) Alzheimer's Society Cymru welcomes the Committee's focus on the use of anti-psychotics. As we noted in our letter to the Committee in August 2016, we are deeply concerned about the over-use and inappropriate use of anti-psychotics in care homes. Alzheimer's Society Cymru believes this inquiry will help to build the evidence base around this issue.

2) We strongly believe that these drugs should only ever be the last resort. Antipsychotic drugs can be used to reduce psychotic experiences such as delusions and hallucinations. However, use of antipsychotics should be limited, for several reasons. These include them showing only moderate benefit, not addressing underlying causes of behavioural and psychological symptoms[1], and links to serious side effects. The use of antipsychotics can result in a number of side effects, such as drowsiness, nausea and constipation. The longer term use of antipsychotics increases the risk of fatal conditions such as stroke (though there is some debate over this in recent evidence[2]). Fundamentally, there is a danger that pharmacological solutions are too often used as a first, not a last, resort.

3) In Wales, caution has been expressed over the use of antipsychotics by the Older People's Commissioner for Wales[3] and by the Welsh Government in their National Dementia Vision[4] and the draft of the Dementia Strategic Action Plan.[5] Alzheimer's Society Cymru supports calls by the RPSW and the Royal College of Psychiatrists in Wales for an end to routine prescribing and a reduction in the time and dosage where antipsychotics are required. We strongly support the recommendations of the recent *Improving Medicines Use for Care Home Residents* report.[6]

4) We welcome the Welsh Government's proposal in the draft Dementia Strategic Action Plan[7] to reduce the percentage of people with dementia prescribed antipsychotics but want to see more information on how this will be implemented. The Welsh Government should public what they anticipate will be reported to local mental health partnership boards. There should be better data collection and publication of existing levels of prescription of anti-psychotics in care homes, to understand prevalence and patterns of use.

5) To improve understanding of the issue and data collection, we recommend that Welsh Government institute a cycle of national and local audits of prescribing antipsychotics in care homes to patients with dementia to improve clinical practice.

6) We believe that the provision of alternative (non-pharmacological) treatment options to relieving behavioural and psychological symptoms of dementia (BPSD) are preferable to the use of anti-psychotics. This should be supported by improved

[1] Alzheimer's Society (2014) *Antipsychotic drugs*, London: Alzheimer's Society, accessed 30th March 2017.
[2] Howard. R, (2016) Baseline characteristics and treatment-emergent risk factors associated with cerebrovascular event and death with risperidone in dementia patients, *British Journal of Psychiatry*, vol. 209, no. 3.
[3] Older People's Commissioner for Wales (2015) *Response from the Older People's Commissioner for Wales to the National Assembly for Wales, Health and Social Care Committee on the actions taken to implement recommendations made in the Committee's report on residential care for older people and 'A Place to Call Home'*, Cardiff: OPCW, p15.
[4] Alzheimer's Society (2015) *Diagnose or disempower? Receiving a diagnosis of dementia in Wales*, Cardiff: Alzheimer's Society.
[5] Welsh Government (2017) *Draft national dementia strategy*, Cardiff: Welsh Government.
[6] Royal Pharmaceutical Society Wales *Improving Medicines Use for Care Home Residents*, RPS Wales.
[7] Welsh Government (2017) *Draft national dementia strategy*, Cardiff: Welsh Government.

training for health and social care staff to provide person-centred care, which itself can reduce the risk of BPSD.

7) Behavioural and psychological symptoms of dementia are often a reaction to distress, unfamiliarity with the environment, or lack of ability to communicate and can often be managed without medication by avoiding situations likely to cause upset, avoiding confrontations arising from attempting to 'correct' the person with dementia, and by ensuring care is person-centred from staff who have the time and skills to support people with dementia, not by use of "medical clubbers".[8] People with dementia should have the opportunity to participate in meaningful activities. This involves tailoring the person's care to their interests, abilities, history and personality to make sure they are comfortable and engaged. It is important to give them the chance to take part in one-to-one conversation and activities that interest them.[9] Positive interactions and supportive contexts can help to mitigate the impact of particular difficulties or symptoms.[10]

8) Communication problems often occur for people with dementia and can become increasingly challenging. People with dementia should have access to communication support through speech and language therapy, to assess difficulties in communication and to maximise their ability to communicate. Training should incorporate an understanding of speech, language and communication issues. Education, support and training should set the highest standards for health, care home and agency staff to understand the communication difficulties experienced by people with dementia and identification of the early signs of eating, drinking and swallowing difficulties to ensure people's nutritional needs are met.

9) If and when antipsychotics are necessary, as per NICE guidelines only the lowest dose should be prescribed for the shortest time, with regular review by an appropriately skilled pharmacist as part of a multidisciplinary team.[11,12] This is a particular issue for dementia – according to a 2009 report by Professor Sube Banerjee, *The use of antipsychotic medication for people with dementia*, of 180,000 prescriptions for people with dementia, 140,000 were inappropriate.

10) Existing prescribing practices, medication reviews and the importance of informed consent were a strong theme of our engagement events that informed responses from Alzheimer's Society Cymru to the consultation on the draft dementia strategy - a number of people with dementia and their carers told us they weren't aware of the name of their medication or why they were taking it. This is of great concern. People affected by dementia need to be aware of their rights when it comes to deciding to take medication; their individual choice should be supported.

11) We recommend that the Welsh Government:

- End routine prescribing and work towards a reduction in the time and dosage where antipsychotics are required.

[8] Fenton-May, J. (2017) *Health, Social Care and Sport Committee*, National Assembly for Wales, 25th January 2017 (para.241)

[9] Alzheimer's Society, Treating behavioural and psychological symptoms of dementia, London: Alzheimer's Society, date accessed 21/03/2017.

[10] British Psychological Society (2016) *Psychological dimensions of dementia: Putting the person at the centre of care*. BPS: London.

[11] Royal Pharmaceutical Society Wales (2016) *Improving Medicines use for Care Home Residents*, Cardiff: RPSW.

[12] Older People's Commissioner for Wales (2014) *A Place to Call Home? A Review into the Quality of Life and Care of Older People living in Care Homes in Wales*, Cardiff: OPCW.

- Ensure people have a full explanation of the medication they may be prescribed and choice in their treatment. We should ensure that people with dementia prescribed antipsychotics have support from carers, loved ones, or advocates.

- Ensure that multidisciplinary support and regular reviews should be available to reduce over-use of antipsychotics. Reviews and reductions of antipsychotics are most effective when nonpharmacological interventions were available to replace antipsychotics.[13] Non-pharmacological interventions could include occupational therapy, sensory therapy, gardening, talking therapy, art therapy, creative activities (for example, visual arts, music, gallery and museum visits), intergenerational activities, exercise programmes in a social context, and more.

- Ensure health boards work with pharmacists and other medical professionals who deliver enhanced support for care homes to reduce the use of antipsychotics in care homes through ensuring MDT support is available to go into care homes to deliver medication reviews on arrival and at regular intervals (for example every six months).

12) We recommend that the care homes' inspectorate mandates documented evidence of medicines' monitoring for older people prescribed mental health medicines. This monitoring should be shared with prescribers and pharmacists, and evidence of this should be placed in patients' records, alongside other mandatory records, such as those for nutritional status.

13) We also have concerns over polypharmacy, whereby four or more medicines are prescribed for an individual. The proportion of patients receiving 10 or more medicines has increased from 1.9% in 1995 to 5.8% in 2010.[14] Medicines should be reviewed regularly for people with dementia; for many patients, dealing with multiple medicines can be confusing, and this is of particular concern for people living with cognitive impairment such as dementia. Research[15] has shown that between 30% and 50% of other patients fail to take their medicines correctly or are otherwise noncompliant with their prescribed medicines regime. Support in ensuring medication is taken as prescribed is an important factor in maintaining independence for as long as possible. We recommend that:

    - It may be appropriate for individuals to receive weekly prescriptions, to have carers support medication taking or to receive medication aids.

    - As part of a multidisciplinary review, all care home residents should receive a review of their medication by a pharmacist when they first move into a care home in order to optimise their medication regimen.

    - Residents of care homes should receive a minimum of one annual medication review from a pharmacist, with additional support for

[13] Ballard, C. (2016) "Impact of antipsychotic review and nonpharmacological intervention on antipsychotic use, neuropsychiatric symptoms, and mortality in people with dementia living in nursing homes: a factorial cluster-randomised controlled trial by the well-being and health for people with dementia (WHELD) program", *American Journal of Psychiatry*, vol. 173, no. 3, pp.252-62.

[14] Duerden, M., Avery, T. & Payne, R.. (2013) *Polypharmacy and Medicines Optimisation: making it safe and sound*. London: The King's Fund.

[15] Royal Pharmaceutical Society (2013) *Medicines Optimisation: The evidence in practice*. London: RPS.

significant medication changes. For patients with complex medication regimens, this review should increase to every 3-6 months.

- With patient consent, all pharmacists directly involved in patient care should have full 'read and write' access to the patient health record in the interest of high quality, safe and effective patient care.

- The Welsh Government must ensure that people have a full explanation of the medication they may be prescribed and be enabled to make an informed choice about their treatment and medication.

14) There is a great deal of excellent best practice work being carried out in Wales regarding improving the use of antipsychotics for people with dementia. This includes research at Swansea University regarding structured scrutiny by nurses[16] which has "*led to improvements in prescribing practice and pain management and greater awareness of adverse side effects*", as well as the STOPP/START toolkit developed by Dr Victor Aziz of the Royal College of Psychiatrists,[17] both of which demonstrate interesting routes for further inquiry and best practice development. In some Local Health Boards, SLTs provide for triage over the telephone for care homes in managing the communication and swallowing problems of those in their care, removing the need for a GP visit. Cwm Taf Health Board's Care Home Dementia Intervention Team is an innovative project that explores possible reasons for distress, enabling the service to work with care home staff in developing a person-centred care plan. Interventions include reminiscence, music therapy, life story work and doll therapy[18]

15) We trust this information is of assistance. Alzheimer's Society Cymru would be only too happy to give oral evidence as part of the inquiry; please contact me if you would like to arrange this or if you have any queries in relation to our submission.

Yours sincerely,

Dr. Ed Bridges
External Affairs Manager (Wales)
[redacted]

[16] Swansea University (2015) *Structured scrutiny could reduce drug side effects for people with dementia*, Swansea: Swansea University.
[17] Aziz, V. (2015) *Potentially Inappropriate Medications for older people: the STOPP/START tool*, Cardiff: Royal College of Psychiatrists in Wales.
[18] Cwm Taf University Health Board (2016) *Innovative teamwork in Cwm Taf enables care home residents to live well with dementia*, date accessed 20/04/2017.

ROYAL CYMDEITHAS PHARMACEUTICAL FFERYLLOL SOCIETY FRENHINOL
Wales Cymru

Use of anti-psychotic medication in care homes

Response from the Royal Pharmaceutical Society in Wales

About us

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We represent all sectors of pharmacy in Great Britain and we lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

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Dr Dai Lloyd AM
Chair - Health, Social Care and Sports Committee
National Assembly for Wales
Cardiff Bay
Cardiff,
CF99 1NA

20th of April 2017

Dear Dr Lloyd

RE: Use of anti-psychotic medication in care homes

The Royal Pharmaceutical Society (RPS) Wales welcomes the opportunity to respond to the consultation on the use of anti-psychotic medication in care homes. We are pleased that reducing the inappropriate use of antipsychotic medicines, particularly for individuals living with dementia, is a key priority for the Welsh Government. This is also one of the RPS Wales's key recommendations, set out in our policy *document* *'IMPROVING MEDICINES USE FOR CARE HOME RESIDENTS'.* This document was supported by a number of Royal colleges and Third sector groups and includes a number of recommendations and case studies that may be of interest to the Committee.

Antipsychotic medicines are used for some types of mental distress or disorders. A 2009 report by Professor Sube Banerjee: *The use of antipsychotic medication for people with dementia* 'estimate that we are treating 180,000 people with dementia with antipsychotic medication across the country per year. Of these, up to 36,000 will derive some benefit from the treatment. In terms of negative effects that are directly attributable to the use of antipsychotic medication, use at this level equates to an additional 1,620 cerebrovascular adverse events, around half of which may be severe, and to an additional 1,800 deaths per year on top of those that would be expected in this frail population.' This suggests that of the 180,000 prescriptions for people with dementia, approximately 140,000 were inappropriate. This is around two thirds of overall use of the drugs for people with dementia. It also found that antipsychotic drugs have been used inappropriately in all care settings and specifically references use in care homes.[1] [2]

When an individual with dementia exhibits behaviour that is challenging, we would expect support tools such as the Alzheimer's Society "This is Me" toolkit to be used to

[1] Banerjee, S. 2009. The use of antipsychotic medication for people with dementia: Time for action. The Institute of Psychiatry, King's College London (Commissioned by the Department of Health). Available at: http://www.rcpsych.ac.uk/pdf/Antipsychotic%20Bannerjee%20Report.pdf (Last Accessed: January 19 2016)

[2] Royal Pharmaceutical Society, Wales. 2016. Improving Medicines use for Care Home Residence. Available at https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Publications/Improving%20medicines%20use%20for%20care%20home%20residents.pdf (Last Accessed: April 12th 2017)

ensure a holistic approach to care is taken. Non-pharmacological treatment options should be looked at as a first line approach. Ensuring all individuals have the opportunity to communicate is very important and access to communication support provided by Speech and Language Therapists could be a vital step to ensuring greater person-centred care. We also believe that there needs to be a greater focus on ensuring support measures are put in place to help residents live well, supported by increased levels of training for health and social care staff to provide person-centred care.

Antipsychotic medication should only be used after non-pharmacological methods have been tried and where there is a potential risk to patient and others. When an antipsychotic medicine is required, the lowest dose should be prescribed for the shortest time with regular review by an appropriately skilled pharmacist as part of the multidisciplinary team. We strongly support the good practice for prescribing in older people set out by the Royal College of Psychiatrists in Wales, Old Age Faculty's briefing paper on over prescribing from February 2015. We were very pleased to work in partnership with the Royal college of Psychiatrists on the Antipsychotic medicines information in our policy document 'IMPROVING MEDICINES USE FOR CARE HOME RESIDENTS'.

The pharmacy team; pharmacists and registered pharmacy technicians, have significant expertise to support medicines management and safe administration for all care home residents as part of a multidisciplinary team approach. Regular medicines reviews from a pharmacist should be available to all people with a chronic condition such as dementia, including those living in care homes, to help optimise individual medication regimes and reduce inappropriate use of antipsychotics.

The changing and evolving role of pharmacists offers significant opportunities to improve care in Wales. The development of primary care clusters and greater use of the skills of pharmacist independent prescribers in multidisciplinary teams has the potential to improve the care of care home residents. We believe now is the time to build on the principles of prudent healthcare to fully harness the expertise of the pharmacy profession as a part of the solution to meet the challenges in managing medicines in care homes.

The RPS Wales care home policy document sets out several recommendations under five key themes that will improve the care, safety and quality of medicines use for residents living in care homes. The use of antipsychotic medication is just one important part of this.

The recommendations are:

1. Polypharmacy

1.1 As part of a multidisciplinary review, all residents should receive a review of their medication by a pharmacist when they first move into a care home in order to optimise their medication regimen.

1.2 Residents should receive a minimum of one annual medication review from a pharmacist, with additional support for significant medication changes. For patients with complex medication regimens, this review should increase to every 3-6 months.

1.3 With patient consent, all pharmacists directly involved in patient care should have full read and write access to the patient health record in the interest of high quality, safe and effective patient care.

2. Antipsychotic prescribing

2.1 Antipsychotic medicines should not be routinely prescribed to treat behavioural and psychological symptoms of dementia.

2.2 In line with NICE guidance, when an antipsychotic medicine is required, the lowest dose should be prescribed for the shortest time with regular review by an appropriately skilled pharmacist as part of the multidisciplinary team.

2.3 Pharmacists who deliver enhanced support for care homes should be able to access quality continual professional development opportunities in relation to antipsychotic prescribing.

3. Safe transfer of information

3.1 Reconciliation of medicines should be undertaken by a pharmacist when a person moves to a care home from their own home or another care setting to ensure that their medication is maintained accurately.

4. Education, training and standards

4.1 The development of national standards for medicines training to ensure uniformity across Wales as well as reflecting current practice for care home staff.

4.2 Inspections of care homes should include the expertise of a pharmacist to address medication issues and improve medicines safety.

5. Palliative and end of life care

5.1 A national review of the current provision of palliative and end of life medication to residents as part of steps to develop all Wales standards for anticipatory prescribing in care homes.

5.2 The multidisciplinary care team for a resident needing palliative care support should have access to the expertise of a specialist palliative care pharmacist.

We also strongly support the Faculty of Old Age Psychiatry and the RCPsych in Wales's call for a Wales-wide cycle of audits to gather hard data on anti-psychotic prescribing practices to better understand prevalence and patterns of use.

The use of antipsychotic medication in care homes is an important issue that has been seldom addressed in Wales. We therefore welcome this inquiry and trust this response is helpful. We would also welcome the opportunity to discuss any of the above points in further detail with yourself and other members of the Committee and also to share further examples of good practice that we are aware of.

Yours faithfully

Suzanne Scott-Thomas, Chair, Welsh Pharmacy Board

APS 0

Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal

Inquiry on the use of anti-psychotic medication in care homes

Ymateb gan Goleg Brenhinol Therapyddion Iaith a Lleferydd

Response from Royal College of Speech and Language Therapists

National Assembly for Wales Health, Social Care and Sport Committee consultation on the use of anti-psychotic medication in care homes

Executive Summary

The Royal College of Speech and Language Therapists (RCSLT) Wales welcomes the opportunity to respond to the Health, Social Care and Sport Committee's consultation on the use of anti-psychotic medication in care homes. We believe this consultation is very timely given the concerns raised by the Alzheimer's Society, Older People's Commissioner for Wales, Royal Pharmaceutical Society and the Royal College of Psychiatrists about the inappropriate and overuse of anti-psychotic medication in care homes. Our response below focusses on two key elements within the terms of reference namely;

- the provision of alternative (non-pharmacological) treatment options
- training for health and care staff to support the provision of person-centred care for care home residents living with dementia.

Key recommendations to the Health, Social Care and Sport Committee

- There is a clear link between communication difficulties and behaviour that challenges. Non-pharmacological treatment options should include access to communication support provided by Speech and Language Therapists.
- Staff in care homes should receive training on identifying communication difficulties in dementia and strategies to support and enhance communication.
- We recommend the Welsh Government institute a cycle of national and local audits into anti-psychotic prescribing practices in Wales. The audit should also gather evidence on whether the patient received the anti-psychotic medication as the first option treatment and/ or whether there were alternative therapies available within their locality.

1. RCSLT is the professional body for speech and language therapists, SLT students and support workers working in the UK. The RCSLT has

17,500 members in the UK (450 in Wales) representing approximately 95% of SLTs working in the UK (who are registered with the Health & Care Professions Council). We promote excellence in practice and influence health, education, care and justice policies.

2. Speech and Language Therapy manages the risk of harm and reduces functional impact for people with speech, language and communication support needs and/ or swallowing difficulties.

3. Speech and Language Therapists (SLTs) provide life improving treatment, support and care for adults who have difficulties with communication, eating, drinking or swallowing. Using specialist skills, SLTs work directly with clients, carers and other professionals to develop personalised strategies. They also provide training and strategies to the wider workforce; such as care assistants so that they can identify the signs of speech, language and communication needs (SLCN) and eating, drinking and swallowing difficulties, improve communication environments and provide effective support.

The provision of alternative (non-pharmacological) treatment options

4. Communication helps us to cope with specific life events including transitions, illness, bereavements and stress. When communication is impaired it is much harder to adapt to challenging circumstances. Communication problems occur in all forms of dementia & in the later stages these problems become increasingly challenging (Bourgeois 2010). Communication difficulty can be exhausting for the person with dementia and affects their identity and relationships (Bryden, 2005). Limited communication has significant social and psychological impact. Frustration can lead to distressed behaviour and James (2011) argues that behaviour that challenges is an attempt to make sense of the environment or communicate an unmet need.

5. Loss of meaningful interaction and conversation also places increased pressure on caring relationships (O'Connor et al, 1990 Nolan et al, 2002). Communication difficulty has been described as one of the most frequent and hardest to cope with experiences for family carers (Egan 2010 Braun 2010). Orange (1991) found that a survey of family members of dementia patients around half of the respondents noted a change in their relationships as a result of communication difficulties. In considering alternative options to pharmacological interventions, there is a clear need to ensure that the communication difficulties underlying distressed behaviour are identified and appropriate strategies put in place. Staff and family carers who are trained to recognise how people in their care communicate distress,

anxiety or pain through their behaviour (verbal and non-verbal) are better equipped to identify the triggers of behaviour that challenges in an individual, and address the potential for a person with dementia to harm themselves or others.

6. SLTs have the specialist knowledge and skills to directly assess the contribution that unmet speech, language and communication support needs make to behaviour that challenges and provide advice on maintaining and maximising communication function to the person with dementia, their family and carers. SLTs also have a clear role in training health, social care and voluntary sector staff, including care home workers in identifying communication difficulties in dementia and strategies to support and enhance communication. Communication training for carers within the residential setting has been evaluated positively (Jordan et al, 2000) as effective and the role of SLTs as trainers outlined (Maxim et al, 2001). This short case study provides an example of the difference SLTs are able to make within this environment.

David's story

David lived in a care home where he often argued with staff and residents making it difficult for everyone to live and work with him. Although, David's speech was limited to a few words, staff thought David knew what he was doing and saying.

- An SLT assessment showed David had significant difficulties understanding what was said to him so he became confused, he didn't always know why people wanted him to do things and he made unintentional mistakes which of course frustrated him and others.
- The SLT gave staff guidance on how best to interact with David to help his understanding. This greatly reduced his confusion and the arguments and stress which had been caused by it.

Source: RCSLT/Alzheimer Scotland- Speech and Language Therapy Works for People with Dementia

7. Despite a growing body of evidence to justify the impact of speech and language therapists within dementia care, provision of services in Wales is extremely patchy. This is in sharp contrast to other nations, such as Scotland, where there have been significant developments with regard to speech and language therapy provision for people with dementia. The recent audit of memory loss services by 1000 Lives

(Public Health Wales, 2016) highlighted only 0.6 full time equivalent provision of speech and language therapy in specialist teams across Wales. Similarly at a community level, despite evidence of the value of the inclusion of SLTs within multi-disciplinary community teams and the potential opportunities which exist, we are aware that too few teams across Wales stipulate inclusion of the role as part of a dedicated primary care integrated workforce. In the current model, our services are often provided by small, flexible teams who must meet the competing demands of primary and secondary care. Our members tell us that dementia services are not consistently delivered across Wales and resource pressures mean that dysphagia training often takes precedence over training to support management of communication difficulties.

Training for health and care staff to support the provision of person-centred care for care home residents living with dementia

8. RCSLT believes that central to the provision of person-centred care is the concept of preserved ability and wellbeing and the belief that all people with dementia, at all stages, have something to communicate. As we have highlighted above, Speech and Language Therapists have a clear role to play in training health and care staff about communication difficulties and strategies to support and enhance communication.

9. In addition, we wish to highlight the importance of training for staff to identify difficulties eating, drinking and swallowing as a key element within the delivery of person-centred care. Difficulties eating, drinking and swallowing can lead to a poorer quality of life for individuals with dementia leading to embarrassment and lack of enjoyment of food. They can also have potentially life threatening consequences, resulting in choking, pneumonia, chest infections, dehydration, malnutrition and weight loss. Dysphagia is a recognised challenge for people with dementia, particularly in the later stages of the disease. 68% of people in care homes with dementia have difficulties eating, drinking and swallowing (Steele et al, 1997). Managing swallowing problems (dysphagia) in residential care reduces the risks of choking, chest infections, aspiration pneumonia, dehydration and malnutrition and decreases the need for crisis management that often results in unnecessary hospital admissions. We believe that training is required to ensure staff, in addition to understanding the communication difficulties experienced by people with dementia, are able to identify the early signs of eating, drinking and swallowing difficulties to ensure people's nutritional needs are met.

10. In a number of local health boards, SLTs provide telephone triage to care homes managing the communication and swallowing

problems of those in their care, removing the need for a GP visit. They also provide training to care home staff and others in the community to manage decline in swallowing performance from age and disease and communication difficulties. For example, an SLT is employed on a part-time basis as part of the Care Home Liaison Team in Cardiff and Vale University Health Board and is an important part of the alternative support available to manage the behavioural and psychological symptoms of dementia. However, as highlighted above, we are aware that these services are not consistently delivered across Wales and dysphagia training often takes precedence over training to support the management of communication difficulties.

Further Information

11. We would be happy to provide any additional information required to support the Committee's decision making and scrutiny. For further information, please contact:

Dr Alison Stroud
Head of Wales Office
[redacted] / [redacted]

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APS 11
Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal
Inquiry on the use of anti-psychotic medication in care homes
Ymateb gan Gymdeithas Fferylliaeth Genedlaethol
Response from the National Pharmacy Association

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Consultation - Use of Anti-Psychotic medication in care homes.
Views on the terms of reference for the inquiry.

The National Pharmacy Association (NPA) is the trade body which represents the vast majority of community pharmacy owners in the UK, including across Wales. We count amongst our members nationwide pharmacy multiples, regional chains and independent pharmacies. In addition to being a representative voice, we provide members with a range of commercial and professional services to help them maintain and improve the health of the communities they serve.

The NPA welcomes the opportunity to respond to this consultation on the terms of reference for the inquiry into the Use of anti-psychotic medication in care homes.

The NPA is broadly supportive of the terms of reference suggested for this inquiry and will outline its rationale below:

The availability of data on the prescribing of anti-psychotics in care homes, to understand prevalence and patterns of use;
Recently, the University of Coventry conducted a study into antipsychotic prescribing in care homes before and after the launch of a national dementia strategy http://bmjopen.bmj.com/content/6/9/e009882

The study concluded that despite a number of strategies and recommendations to review the prescribing of these drugs, the "rates of antipsychotic prescriptions being given to people living in care homes has remained unchanged". The availability and then the analysis of this data would help provide an indication as to the reasons behind the continuous prescribing of these drugs, which may lead to alternative solutions and options.

Prescribing practices, including implementation of clinical guidance and medication reviews;
Provision of alternative (non-pharmacological) treatment options;
Training for health and care staff to support the provision of person-centred care for care home residents living with dementia;
Dementia is a clinical condition that is growing in its prevalence, and research shows that early detection of this would aid in getting the right treatments as well

as receiving the best support. In addition, The Care and Social Services Inspectorate Wales, highlights the following elements that are inspected in a care home:

- Focus on the well-being and experiences of the care home resident
- Scrutinise records and documents, including care plans and medication sheets

Hence, having a full understanding of the current reality in care homes in relation to the training of health and care staff to support in the provisions of person-centred care for care home residents, will lead to an increased awareness of this condition, which in turn would lead to a better quality of life for the individual. The NPA supports this element of the terms of reference.

Identifying best practice, and the effectiveness of initiatives introduced so far to reduce inappropriate prescribing of anti-psychotics;
A number of studies into the effectiveness of prescribing anti-psychotics, have been conducted over the past decades. Whilst all the studies have identified and highlighted best practices, there still appears to be some misalignment in its usage. This element of the terms of reference would address this.

Use of anti-psychotic medication for people with dementia in other types of care settings;
People affected by dementia are cared for in a number of settings including the person's own home. Having this reference point in the inquiry would allow for a thorough analysis of these settings, including any limitations that are presented, with a view for recommendations to be set up.

Other Comments:
Community Pharmacy is the front door to the NHS, and is increasingly, available over extended opening hours to provide advice on medications, the prevention of ill-health (including dementia), without the need for an appointment. It is through this role of being the most accessible clinicians on the high street that Community Pharmacies would be in a position of being able to provide a person centred care to individuals being prescribed anti-psychotics for dementia and other mental health illnesses. As part of the primary care multi-disciplinary team community pharmacies are also able to provide support to the prescribers and carers in all settings including the patients' own home. On this basis the National Pharmacy Association suggests that the role of community pharmacists, be taken into consideration in the inquiry into the use of anti-psychotic medication in care homes.

Kind Regards

H. Mangion.

Helga Mangion MRPharmS
Policy Manager.

APS 12

Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal

Inquiry on the use of anti-psychotic medication in care homes

Ymateb gan Conffederasiwn GIG Cymru

Response from The Welsh NHS Confederation

	The Welsh NHS Confederation response to the inquiry into the use of anti-psychotic medication in care homes.
Contact:	Callum Hughes, Policy and Research Officer, Welsh NHS Confederation. [redacted] Tel: [redacted]
Date created:	April 2017

Introduction

1. The Welsh NHS Confederation welcomes this opportunity to respond to the Health, Social Care and Sport inquiry into the use of anti-psychotic medication in care homes.

2. The Welsh NHS Confederation represents the seven Local Health Boards and three NHS Trusts in Wales. We support our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

Overview

3. Anti-psychotics are a group of medications usually used in the treatment of mental health conditions such as schizophrenia. They are sometimes inappropriately prescribed to control the behavioural and psychological symptoms of dementia, where their use is commonly associated with a significantly increased risk of harm. Reducing the number of people with a dementia diagnosis inappropriately receiving such medication in care homes has been identified as a key action in the Welsh Government's Draft Dementia strategy.

4. To deliver on such a commitment, work must be done to ensure the effective provision of multi-disciplinary teams within care homes. This means ensuring the provision of effective integration frameworks between neighbouring Local Health Boards and Local Authorities, and also between Local Health Boards and individual care homes. There is also a need to reshape our relationship with dementia patients so that we treat them as partners in these changes and utilise the insights gained through direct experience of living with dementia to further our understanding of the condition and the role played by anti-psychotics within this process.

5. An ageing population and an increasing number of people with multiple long term conditions has meant that utilising medication has become a way of managing often complex behavioural and psychological issues. Where dementia is concerned, it is estimated that between 40,000 - 50,000 people in Wales are currently living with the condition[i]. Against this background, we welcome the Health, Social Care and Sport Committee's interest in this area.

6. Our response will address the terms of reference to the inquiry in turn.

The availability of data on the prescribing of anti-psychotics in care homes, to understand prevalence and patterns of use;

7. The lack of a central point of data makes it difficult to benchmark the level of anti-psychotic prescribing at a care home level as such data is linked back to the prescribing GP, of which there may be many covering one care home. This makes it difficult to identify patterns of use.

8. As such, the only data available to our members in relation to the use of anti-psychotic medication across the relevant Local Health Board would be available only as a result of a manual audit of GP records or an analysis of individual care home prescribing records. However, this can be more difficult for Health Boards with large population bases.

9. Numerous audits have been carried out by Local Health Boards and are ongoing. One of the key findings has been that the use of anti-psychotics is best undertaken during a holistic patient review, including the patient's need for an anti-psychotic by the GP or pharmacist during the regular polypharmacy medication review, rather than being reviewed in isolation.

Prescribing practices, including implementation of clinical guidance and medication reviews;

10. The use of pharmacological interventions to treat the behavioural and psychological symptoms of dementia should only be used when patients are severely distressed, or there is an immediate risk of harm to self or others. The cerebrovascular risk of anti-psychotics needs to be discussed, and target symptoms should be identified quickly so that changes to a patient's medication can be made. Furthermore, the decision to use anti-psychotics should be made only after an individual risk-benefit analysis and monitored closely, with reviews every three months at least.

11. However, it must also be remembered that, while in some cases the clinical view is that medication to relieve severe anxiety may be in a person's best interest, this must be part of a regularly reviewed care plan and not simply considered a convenient and accessible method of subsiding challenging behaviour as and when it arises. These prescribing practices are in accordance with the NICE-SCIE guideline on supporting people with dementia and their carers in health and social care settings.

12. Clinicians within Local Health Boards are broadly aware of such guidelines, but there can be resistance from care homes to reducing or stopping the use of anti-psychotics for fear of relapse. It is encouraging however that our members have reported a number of cases where patients who previously resisted reducing or stopping their anti-psychotic medication have done so in a safe and controlled manner following a discussion with a Nurse Prescriber. Referrals and admissions have reduced significantly the use of anti-psychotic medication in these cases. However, it could be argued that routine prescribing reviews are not the most effective use of a Consultant Psychiatrist's time. An alternative would be for a non-medical prescriber, or an in-reach nurse, to undertake these reviews with an emphasis on educating staff members around medication reduction and support for care homes, thus allowing more time to be freed up for more urgent reviews.

13. It is encouraging also that there have been examples of our members setting up polypharmacy medication pro-forma/review sheets which can be modified by individual practices. These documents will allow care home workers to monitor patient progress and record

recommendations for change for patients taking in excess of four different types of medicine. Moreover, reviews have been carried out by specialised teams focusing on the prescription of anti-psychotic medication for elderly people in accordance with NICE guidelines, the Medicines and Healthcare Products Regulatory Agency (MHRA) recommendations and Local Health Board guidance.

The provision of alternative (non-pharmacological) treatment options;

14. Strategies designed to manage behaviours that often lead to the prescription of anti-psychotic medication services need to be implemented as a whole system approach. This process starts with ensuring the provision of less restrictive and safe therapeutic environments in line with prudent healthcare principles, examples of which may include pleasant outside space or quiet rooms.

15. However, for some care homes and cognitive stimulation groups, it is significantly more challenging to adopt such measures due to an insufficient number of permanent staff members currently employed in local care homes. Reduced occupational therapy resources often mean that opportunities for alternative treatments become even more challenging, despite the fact that our members have made it clear that such functions could be delivered and promoted more effectively by an in-reach worker.

Training for health and care staff to support the provision of person-centred care for care home residents living with dementia;

16. It is encouraging that inpatient dementia wards, in some areas, have activity co-ordinators whose responsibility it is to personalise therapy and patient activities to reduce stress and agitation. It is also encouraging that similar teams have been set up to offer a practical, hands-on approach to integrating non-pharmacological approaches in addressing behavioural challenges for patients living with dementia. Such teams have offered advice and consultation to care home staff to emphasise the importance of exploring alternative treatments in accordance with NICE guidelines.

17. A considerable proportion of training for health and care staff to support the provision of care for residents living with dementia is now done online. It is encouraging that such online resources have incorporated pre-existing materials from the relevant Local Authority and third sector partners, thus developing the integration agenda. There are also a number of projects currently ongoing between GP practices and care homes with a view to identifying residents who show early signs of dementia and the various ways in which carers can respond to their condition. Alternative ways of working have developed in other areas, such as the introduction of a dementia checklist for managing the behavioural and psychological symptoms associated with dementia, and there are a number of good examples of such specialist care being delivered within care homes.

18. However, while it is encouraging to see e-learning on such a scale, a lack of capacity in some areas has meant that it is difficult to provide specialist teaching for staff members to support the provision of care for patients living with dementia. Moreover, while it is undisputed that there are a number of effective initiatives ongoing, there remains considerable space for sharing good practice and training. In particular, there is a great opportunity for Local Authorities and care homes to closer align their ways of working to develop enhanced care settings. This would also be improved by an in-reach role where the training procedures could be repeated, relationships with homes improved and focused on the reduction in the prescribing of anti-psychotic medication.

Identifying best practice, and the effectiveness of initiatives introduced so far to reduce inappropriate prescribing of anti-psychotics;

19. A number of reviews have taken place across Wales in recent years aimed at reducing the prescription of anti-psychotic medication. The results are, broadly speaking, encouraging, though significant challenges around workforce capacity and the sustainability of such measures remain.

20. One of our members in particular is currently piloting the adoption of a new strategy aimed at improving communication on discharge from hospital and ensuring that an indication and a review date is included on any transfer of care documentation to be handed to the patient. This strategy has been brought about following a previous ambitious effort to enhance collaborative ways of working between GPs, pharmacists, care homes, nurses and consultants – while the model was successful in bringing about a reduction in the prescribing of anti-psychotic medication, it was not sustainable and was subsequently discontinued. It is promising however that the Local Health Board in this instance has agreed that an indication and review date will be added to every anti-psychotic prescription for challenging behaviour in dementia.

21. It is encouraging also that a number of Local Health Boards have recently undertaken medication reviews in care homes when requested. These practices have proven particularly effective for patients immediately after their hospital discharge or upon the request of a nurse assessor visiting a particular care home. Reviews are conducted in the care home and in front of the patients themselves, thus involving them as much as possible in their own care and with access to the GP record so that changes in a patient's medication can be quickly reconciled and implemented. Additionally, primary care cluster/local pharmacist roles have been developed as extra clinical pharmacist support which has brought about a greater focus on care home medication reviews. Polypharmacy toolkits such as NOTEARS and STOPP START have been developed and utilised to support medicine optimisation in the medication review process too.

The use of anti-psychotic medication for people with dementia in other types of care settings;

22. It is important to note at the outset that the emphasis on the need to avoid hospital admission means that the likelihood of an individual being prescribed anti-psychotics to keep them at a care home invariably increases. It follows therefore that training for care agencies could be improved to enable home carers to be better able to manage the behavioural problems associated with patients living with dementia without asking for medication.

23. Two Local Health Boards have distributed information leaflets to carers with a view to raising awareness of the risks and benefits of using anti-psychotic medication for patients living with dementia. Both have been recognised as best practice and consideration will be made for ways of monitoring service user feedback. Also, mental health liaison practitioners have been made available in some Local Health Boards to improve the management of dementia patients on non-mental health wards.

Conclusion

24. It is positive to see that a range of approaches are being taken to address the ineffective use of anti-psychotic medication in care homes across Wales. It is suggested that frameworks be

established to allow for improved communication and the co-ordination of best practice and learning between Local Health Boards and between care homes to maximise learning opportunities. This will enable consistent and standardised practices. It is suggested also that this work be undertaken in conjunction with dementia care mapping to identify and gather examples of good practice and wellbeing.

[i] Welsh Government/ Statics for Wales, October 2016. General Medical Services contract: Quality and Outcomes Framework statistics for Wales, 2015-16.

APS 13

Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal

Inquiry on the use of anti-psychotic medication in care homes

Ymateb gan Fforwm Gofal Cymru

Response from Care Forum Wales

Consultation response –

Use of Anti-psychotic Medicines in Care Homes

1. Care Forum Wales welcomes the opportunity to respond to this call for information. We are a membership organisation for Health and Social Care Providers in Wales representing over 450 independent providers (both private and third sector), the majority of whom own care homes.

2. We promote excellence in practice in health and social care and have a number of expert leads in key areas, including dementia care. Steve Ford, our dementia lead, recently appeared on BBC's television programme, Eye on Wales, endorsing calls for the use of anti-psychotic medicines to be carefully monitored and reduced wherever possible, to enhance the quality of life of people living with dementia and to avoid unnecessary and harmful side effects, such as increased likelihood of falls.

3. Some of the first generation medicines have potentially serious side effects and have been largely discredited for use for people living with dementia. Some studies have shown increased mortality rates, incidence of stroke and cardio-toxicity. We believe that anti-psychotic medication should only be given as a last resort and, if it is appropriate, there should be a robust system of review every 3 months.

4. We are in the process of writing to our members to remind them of our campaign to be "A Champions" (Assessment of Challenging and Management Problems Initiating Options for New Solutions) and to re-issue guidance that we first issued in 2011.

5. We recognise that the responsibility for prescribing antipsychotic medicines rests with the GP and hospital psychiatrists or clinicians. However, it is often prescribed in response to the care team seeking to manage behaviours that challenge. We would rather urge care practitioners to seek individualised, creative and innovative interventions. The first step is to recognise and understand the triggers that cause this behaviour. The A Champions document includes a concise and practical checklist to help care practitioners to identify behaviours and likely triggers; to rate the level of incident and to find interventions that work for the individual. A copy of the document is attached at the bottom of this response.

6. We have worked previously with the University of South Wales in devising a dementia certificate for nurses to create better understanding of these issues. We are currently in

discussion about adapting the training materials to a format that can be shared and used by all care practitioners.

7. We would encourage providers and GPs to work together to review medication with a view to reduction and eventual elimination over a suitable time period, not forgetting the contribution that community pharmacists can make.

Melanie Minty

Policy Advisor

DEMENTIA CARE: 'A CHAMPIONS' DOCUMENT

Assessment of Challenging and Management Problems Initiating Options for New Solutions

Responsible care providers are committed to finding sensitive creative and individualized appropriate care interventions to safely manage behaviour that challenges, exhibited by service users with dementia, and thereby avoiding administration of antipsychotic medications as far as is practicable and safe to do so.
The elimination of or successful management of catalysts and identification of common denominators will inform care intervention strategies and promote problem resolution.
Please tick the appropriate boxes, as relevant and complete the document which is designed to take no more than 5 minutes.

This document is suitable for use in all care delivery settings and can be completed by careworkers, carers, nurses or others providing care in hospitals, clinics, day centres, care homes, domiciliary care or care at home by family members or others.

Name of Service User…….
Date of birth…….
Type of care setting …….
Address ……
Date of Admission/Residency……
Diagnosis……..
G.P…….
Other relevant agencies……..
……

TYPES OF BEHAVIOUR THAT CHALLENGES

PHYSICAL AGGRESSION Please tick as appropriate.

Punch ( ) Slap ( ) Kick ( ) Bite ( ) Head butt ( ) Squeeze ( ) Pinch ( ) Push ( ) Spitting ( ) Throwing objects ( ) Describe object thrown…….. Blocking others movements ( ) Throwing liquids ( ) Stamping ( ) Using items as weapons e.g. walking stick ( ) Describe……..
Other ……
Comments …….

PSYCHOLOGICAL BEHAVIOUR

Screaming ( ) Shouting ( ) Repetitive statements ( ) Demanding ( ) Loud behaviour ( ) Unreasonable requests ( ) Threatening ( ) Intimidating ( ) Swearing ( ) Clapping ( )
Other…….
Comments ……

SELF HARMING BEHAVIOUR

Hitting oneself ( ) Scratching oneself ( ) Pinching oneself ( ) Using an object to hurt or injure oneself ( ) Describe…… Threatening to hurt oneself ( ) Verbalizing suicidal thoughts ( )
Placing oneself on floor ( ) Deliberately rolling oneself out of bed ( ) Attempting to eat/drink non food objects ( ) Describe…….
Other……..
Comments…….

SEXUAL BEHAVIOUR

Unwelcome sexual comments ( ) Inappropriate kissing ( ) Inappropriate touching ( ) Fondling ( ) Penetrating actions ( ) Describe ……..
…… Exposing oneself ( ) Use of sexual swear words ( )
Masturbation in room other than bedroom ( ) Identify ……..
…… Inappropriate flirting ( ) Describe ……..
Other……..
Comments …….

DESTRUCTIVE BEHAVIOUR

Damage to electrical appliances ( ) Homes fixtures and fittings ( ) Walls/wallpaper ( ) Throwing objects ( ) Please describe …….. Throwing food ( ) Trashing rooms ( ) Identify which …… …….. Shredding/Ripping items……..
Other ……
Comments …….

INAPPROPRIATE BODILY ELIMINATIONS

Urinating in inappropriate places ( ) Describe location ……..
Defecating in inappropriate places ( ) Describe location ……..
Manually handling/smearing/throwing faeces ( ) Other ( ) Describe……..
……
Comments…….
……

Any further relevant information.

……
……
……
……
……
……
……
……

REASONS/CATALYSTS/TRIGGERS FOR UNDESIRABLE UNWANTED BEHAVIOUR

(Please record as appropriate in the following sections)
P = Possible I = Identified/Confirmed …….

MEDICAL ISSUES

Dehydration ( ) Constipation ( ) Diarrhoea ( )
Infection (e.g. U.T.I) ( )Describe ……..
Pressure ulcers/wounds/tissue viability problems ( ) (describe)……..
……
Medication side effects () describe …….
Sight/Hearing/Sensory problems ( ) describe ……..
Dental pain/oral problems ( ) describe …….
Sleep disturbance ( ) describe ……..
Seizure activity ( ) describe ……..
Specific Medical Condition ( ) describe …….
Polypharmacy ( ) describe ……..
Immobility ( ) describe ……. ……..
Other Medical Issues ( )
describe……..
.....

PERSONAL COMFORT ISSUES

Pain ( ) Discomfort ( ) Sore bottom (sitting/lying for long periods of time ( )
Hunger ( ) Thirst ( ) Too hot ( ) Too cold ( ) Wanting to go to the toilet ( )
Incontinence ( ) Feeling of being interfered with ( )
Other ……
Comments …….

PSYCHOLOGICAL ISSUES

Agitation ( ) Irritability ( ) Anxiety ( ) Anger ( ) Depression ( ) Tearful ( ) Accusatory ( )
Hallucinations ( ) Delusions ( ) Hyperactive ( ) Intolerant of others ( ) Boredom/isolation (

) Sleepy ( ) Not wishing to be disturbed ( ) Pacing ( )
Sundowning ( ) Disinhibition ( ) Suspicious/paranoid feelings ( ) Communication difficulties ( )
Other …….
Comments …….

ENVIRONMENTAL ISSUES

Crowded room ( ) Too noisy ( ) TV/Radio blaring away ( ) Wanting to leave ( )
Incompatibility of adjacent people ( ) Unpleasant odours ( )
Lack of therapeutic environment ( ) Deprivation of liberty ( )
Describe ……
Other ……
Comments ……..

STAFF ISSUES

Inappropriate approach by staff ( ) Medical/nursing procedures by staff ( )
Administration of medication by staff ( )
No/insufficient explanation of care intervention procedures by staff ( )
Inadequate numbers of staff to provide the necessary care ( ) Poor staff skills (
) Staff ignoring requests/questions ( ) Change of carer ( )
Other …….
Comments ……..

SERVICE USER ISSUES

Disturbed by behavior of other service users ( )
Describe …….
Aggression from another service user ( )
Repetitive behavior from another service user ( )
Unwanted personal contact/intrusive behavior from another service user ( )
Other ……
Comments ……

VISITOR ISSUES

Unwanted visitor ( ) Inappropriate behaviour from visitor ( )
Challenging behaviour to a visitor ( ) Challenging behaviour after a visitor leaves ( )
Challenging behaviour following an outing with a visitor ( )
(Please specify). …….
Other……..
Comments …….

Other catalysts/triggers/reasons

Comment upon domain/specifics:-

……
……
……
……
……

OTHER DETAILS

No identifiable catalysts/triggers/common denominators ( )
Issues/actions that are indefinable/unassessable/difficult to categorize ( )
Comments ……

Time of challenging behaviour ……..

Date of challenging behaviour ……..

Day of challenging behaviour (e.g. Monday) ……..

Location of challenging behaviour ……

INCIDENT RATING 0 = NO HARM; 5 = MODERATE HARM/RISK OF HARM 10 = VERY HIGH RISK OF HARM OR ACTUAL HARM/POTENTIALLY LIFE THREATENING

PLEASE RATE INCIDENT 0 – 10……
Other…….

Comments **……**

INTERVENTIONS THAT APPEAR TO HELP

Escort service user away from location ( )
Please identify to which area of the home…….
One to one care/reassurance ( ) Comment……..
Activity sessions ( ) Comment …….
Reality orientation ( ) Comment ……..
Validation therapy ( ) Comment ……..
Snoezelen room ( ) Comment ……..
Escorted outing ( ) Comment ……..
Contact/interaction with specific staff member ( ) Identify …….
Contact/interaction with family member/visitor/advocate ( ) Identify ……
Contact/interaction with service user ( ) Identify ……
Contact/interaction with visiting professional ( ) Identify ……..
Contact/interaction with visiting chaplain/clergy ( ) Identify ……..
Contact/Interaction with Other ( ) Identify ……..
Distraction ( ) Comments ……..

Use of comfort object ( ) Comments ……
Use of isolation with discreet observations ( ) Comments ……..
Use of drink substances ( ) e.g. glass of wine/cup of tea, Comments
……
Assess fluid intake ( ) describe tool used …….
Use of food Substances ( ) Comments ……..
Ventilation of feelings ( ) Expressions of anger ( ) Active listening ( )
Personal contact, e.g. holding hands ( )
Firm verbal directives ( ) *Identify in care plan
Address Medical Issues ( ) Describe ……

Medication ( ) Type …… Antipsychotic Yes/No PRN Yes/No
Name and dose…….
Method of administration…….
Comments ……

Restraint ( ) Was this the only feasible option? ( )
Type of Restraint ……. For How Long…… Comments ……. Recorded in Restraint register ( )

Who is the person(s) that was harmed/placed at risk of harm ……..
……
Designation of individual ……
Was the harm avoidable? Comments ……..
……

OUTCOME

Relevant/Likely Themes/common denominations relating to undesirable behaviour/incidents…….
……
……
What have we learned to become better equipped to deal with future incidents or avoid them……
……
……
……
……

MEDICATION ISSUES

Please describe any changes in service users presentation relating to behaviour without/since non administration of anti psychotic medication given for incident resolution……..

……
……
Time period involved……

Discussed with/ please identify ……
……

Has the Care home received recognition of good practice in dealing with behaviour that challenges. Yes ( ) No ( )
By whom……..…Designation……

Copy Sent To: Service user ( )
Service users family/advocate ( )
G.P ( )
Social services ( )
BCUHB ( )
CSSIW ( )
Police ( ) File ( )
Other ( ) Please specify ...…….
Name of Person completing document …….....
Designation ……...
Signed ……..
Dated ……

DATE		ANTECEDENCE	BEHAVIOUR	CONSEQUENCE

A CHAMPIONS DOCUMENT ABC ANALYSIS CHART

'A CHAMPIONS' document conceived by Stephen Ford MA, RGN, RMN.Dip.Ger. Dementia Care Policy Coordinator

Care Forum Wales **December 2011.**

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APS 14

Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal
Inquiry on the use of anti-psychotic medication in care homes
Ymateb gan Canolfan Datblygu Gwasanaethau Dementia, Prifysgol Bangor
Response from Dementia Services Development Centre, Bangor University

21st April 2017

Re: Health, Social Care and Sport Committee Consultation – Use of anti-psychotic medication in care homes

The Dementia Services Development Centre at Bangor University is well-placed to advise the committee on the research evidence regarding this issue. Professor Bob Woods, the DSDC director was a member of the NICE-SCIE Guideline Development Group, which produced the current guidelines for the management of dementia, published in 2006, which emphasise that anti-psychotic medication should only be used as a last resort, in situations of extreme distress, and that use should be short-term with regular reviews. He authored the 1000 Lives Plus 'How to' guide for the NHS in Wales on dementia care, which includes recommended actions to reduce the inappropriate use of anti-psychotic medication.

From 2010-2016, Professor Woods has been a co-investigator on a major programme grant, funded by NIHR, "An Optimized Non Pharmacological Intervention to Improve Mental Health, Quality of Life and Health amongst People with Dementia in Care Homes", led by Jane Fossey (Oxford) and Clive Ballard (Exeter). Fossey and Ballard had previously shown that training care home staff in person-centred care, combined with review of anti-psychotic medication led to a dramatic decrease in use of medication (British Medical Journal, 2006, *332*(7544), pp.756-761). This approach has subsequently been implemented further by the Alzheimer's Society, who funded the original research, as the FITS programme, with good results (Brooker et al., 2016, *Aging & Mental Health*, *20*(7), pp.709-718).

Publications from the initial phase of the WHELD programme (Ballard et al., 2015, *American Journal of Psychiatry* (on-line) doi: 10.1176/appi.ajp.2015.15010130) examined a variety of approaches in 16 care homes in England, involving 277 residents. The findings showed that simply reviewing anti-psychotic medication could be detrimental (in terms of both mortality and neuropsychiatric symptoms), unless combined with a psychosocial intervention (of greater intensity than the person-centred care that was the focus of the FITS programme). They identified that rates of use had fallen in care homes since their 2006 study, and so even greater care is needed in order to ensure that alternative approaches are available, involving increased social activities or exercise, for example.

Results from the full WHELD study, involving over 1006 people living with dementia in 70 care homes are not yet fully published, but the indications are that the combination of psychosocial intervention and anti-psychotic review is successful in reducing agitation and is associated with less use of anti-psychotics and other medication (Ballard & Fossey, 2016, *Alzheimer's & Dementia: The Journal of the Alzheimer's Association*, *12*(7), p.P599).

In conclusion the research evidence is clear – staff must be trained and supported in delivering psychosocial interventions – tailored to the individual's interests and preferences – in combination with regular review (with a view to reduction) of anti-psychotic medication. The WHELD training model, which trains and supports dementia WHELD champions in each care home, appeared to be effective.

Copies of the papers referred to above can be made available to the Committee on request.

Yours sincerely,

Bob Woods

Professor of Clinical Psychology of Older People

Director, DSDC Wales

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PROFESSOR R T WOODS

Canolfan Datblygu Gwasanaethau Dementia Cymru
Dementia Services Development Centre Wales

AWTTC response to Health, Social Care and Sport committee consultation: "Use of anti-psychotic medication in care homes"

1. The availability of data on the prescribing of anti-psychotics in care homes, to understand prevalence and patterns of use

Data to inform prevalence and patterns of use of antipsychotics in care homes would need to be captured at patient level. Resources such as CASPA and Medusa which record medicines usage data for Wales would not provide sufficient detail with regards to patient demographics and treatment indication.

The data required to address the questions of prevalence and patterns of use would need to consider the following:

a. Is the patient a care home resident?
b. Is the patient prescribed an antipsychotic?
c. What is the indication for which the antipsychotic is being prescribed?
   In addition to use for behavioural symptoms of dementia, antipsychotics may be prescribed for a range of psychiatric illnesses including psychosis (such as schizophrenia), bipolar disorder, and as an adjunct to antidepressants. In order to capture prevalence data for the use of antipsychotics for behavioural symptoms of dementia, use in these other indications would need to be identified and excluded.

None of the data in points a–c above would be available via CASPA or Medusa. Therefore it may be necessary to capture data directly from GP practices, using systems such as Audit Plus or on a national level perhaps from the Secure Anonymised Information Linkage (SAIL) databank co-ordinated via Swansea University.

Feedback from one health board indicates that audit work to identify antipsychotic usage in care homes has taken place in both primary and secondary care as part of the 1000 lives Dementia pathway. However, data was not complete and it was hard to identify patterns of use as data were drawn from GP practices rather than from care homes themselves. An audit based on care home data is in place for 2017. Secondary care audit data is being used to identify variation in prescribing across hospital sites.

2. Prescribing practices, including implementation of clinical guidance and medication reviews

In order to assess prescribing practices and identify whether or not they are in line with clinical guidance, additional data would need to be collected. This could include aspects of the following:

a. If an antipsychotic is prescribed for the treatment of behavioural symptoms of dementia, has a full discussion with the patient and/or carers taken place as described in NICE CG42?
b. Which antipsychotic is prescribed?
   Although the antipsychotic risperidone has marketing authorisation for short term use in aggressive behaviour associated with Alzheimer's dementia, NICE CG42 does not currently recommend a particular antipsychotic for the treatment of behavioural and psychological symptoms of dementia (BPSD). Instead, it states that the choice should be based upon an individual risk-benefit analysis. There are some (albeit observational) data which suggest that the nature of the risk associated with individual antipsychotics may vary (e.g. Gerhard et al 2014; see also Trifiro et al 2014 for review) and that more robust evidence may help to improve patient safety in this regard.
c. What dose of antipsychotic is prescribed?
   NICE CG42 states that the dose should be low initially and then be titrated upwards. It has been shown that there is a relationship between antipsychotic dose and risk of mortality with higher doses associated with an increased risk of mortality (Gerhard et al 2014).
d. What is the duration of treatment?
e. Has the ongoing need for treatment been reviewed at regular intervals?
   NICE CG42 states that treatment should be time limited and regularly reviewed. A Prescribing Observatory for Mental Health (POMH-UK) audit of UK mental health services conducted in 2011 suggested that the quality and frequency of medication review was an area for improvement (Barnes et al 2012).

As described above, patient level data would be required to answer these questions. Data from the UK suggest a reduction in the mean prevalence of antipsychotic use following a dementia diagnosis from 19.9% in 1995 to 7.4% in 2011 (Martinez 2013).

Feedback from one health board indicates that medication reviews for care home residents are included as an enhanced service in primary care. In some areas pharmacists are supporting medication reviews and undertaking audit and training for care home staff. In secondary care, consultants have agreed health board guidance on prescribing antipsychotics and ongoing audits are in place to monitor compliance. Ongoing audits will be carried out for inpatient units to monitor improvements against action plans. This is supported by the dementia audit group. Guidance on prescribing antipsychotics in dementia will be extended to support primary care reviews.

3. The provision of alternative (non-pharmacological) treatment options

Feedback indicates that training related to non-pharmacological management of behavioural symptoms of dementia is available in at least one of the health boards. All inpatient (secondary care) dementia wards have activities co-ordinators that provide personalised therapy and activities to reduce stress and agitation.

4. Training for health and care staff to support the provision of person-centred care for care home residents living with dementia

Feedback indicates that e-learning material is available for care home staff in at least one of the health boards. Training through Practice Development team includes mental health awareness, falls and dementia. Secondary care liaison nurses provide advice to care home staff, however there is no capacity for secondary care staff to provide training to care home staff.

The provision of a national e-learning package through the NHS Wales e-learning system would seem a useful resource for NHS and care home staff.

5. Identifying best practice, and the effectiveness of initiatives introduced so far to reduce inappropriate prescribing of anti-psychotics

Identification of best practice in primary care could be facilitated through national groups such as the All Wales Prescribing Advisory Group, as well as through prescribing leads and primary care pharmacists at a local level. The All Wales Therapeutics and Toxicology Centre is organising a primary care best practice day in June 2017, which will include a presentation from a secondary care mental health pharmacist with experience of antipsychotic review. Due to the limitations of available routine data described above, monitoring the effectiveness of initiatives to reduce inappropriate prescribing would require capturing information at a patient level (for example through the use of audit or SAIL data).

Feedback from one health board indicates that an indication and review date will be added to every antipsychotic prescription for challenging behaviour in dementia in that area. A proforma to improve communication on discharge and ensure that an indication and review date is included on any transfer of care documentation has been established in secondary care. The effectiveness of this intervention will be monitored through audit. Collaborative working between care homes, GPs, pharmacists, nurses and consultants have demonstrated reduction in inappropriate antipsychotics however the model was not sustainable.

6. The use of anti-psychotic medication for people with dementia in other types of care settings

The appropriate monitoring and review of antipsychotic treatment in patients with dementia should apply to all patients no matter what the care setting.

Feedback from one health board indicates that all of the above measures apply equally to other care settings and the audit of antipsychotic use in dementia will include patients in all care settings. A leaflet will be available in ward settings and offered to carers to raise awareness of the risks and benefits of using antipsychotics in dementia. The provision of this leaflet will be documented in patient records, and consideration given to ways of monitoring service user feedback.

APS 16

Ymchwiliad ar ddefnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal

Inquiry on the use of anti-psychotic medication in care homes

Ymateb gan Dîm Cysylltu Gofal Cartref, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Response from The Care Home Liaison Team, Cardiff and Vale University Health Board

Response to Consultation: Use of anti-psychotic medication in care homes

Medicines Management

The Care Home Liaison Service within Mental Health Services for Older People, Cardiff and Vale UHB is predominantly a primary care service which aims to support Care Homes by providing comprehensive mental health assessment and follow-up. There are currently sixty seven care homes in Cardiff and Vale with registered beds for dementia. As a service we follow a stepped care model of assessment and intervention, as advocated by The Psychological Society in 'Alternatives to anti-psychotic medication: Psychological approaches in managing psychological and behavioural distress in people with dementia'. This includes the use of 'The Newcastle Model' by Ian James, utilising psycho-social interventions, such as, Cognitive Stimulation Therapy, meaningful activities informed by life story work, behaviour management plans that are tailored to the individual.

In relation to training, we provide a two day course that concentrates on non-pharmacological approaches to reduce Behaviour That Challenges in Dementia.

The Cardiff and Vale Care Home Liaison (CHL) team work closely with primary care Prescribing Advisors and have their own mental health pharmacist employed within the team.

Example of recent good practice – joint project between primary care and secondary care (CHL mental health Pharmacist and Dementia Care Advisor nurse):

A Prescribing Pharmacist and a Dementia Care Advisor Nurse led Antipsychotic Review of Dementia Patients in a single Nursing Home in Cardiff Gimson, V*., Rowlands, C. & Clement, C.

Background

In response to the Banerjee report (2009), antipsychotic prescribing in people with dementia across each GP practice in Cardiff and Vale UHB was audited in 2010/11. The audit demonstrated that the majority of people prescribed antipsychotics for this indication were residents in care home settings. Of this population, only a third of people were having their antipsychotic medication reviewed every 3 months, and about two thirds of people had been on treatment for over 9 months.

In order to address the issue of timely review, the UHB primary care prescribing team and the care home liaison team (CHL) ran an initial pilot project at a care home in Cardiff. This involved the CHL conducting antipsychotic reviews, providing training for care home staff and utilizing the Challenging Behaviour Scale (CBS)[2] as a standardised way of quantifying and evaluating behaviour. Over a period of 31 weeks, 21 people's medication regimes were reviewed for a period of 3 months. It was possible to withdraw antipsychotic treatment in 12 residents and an additional 6 people had their treatment reduced.

A further pilot at a second care home commenced in September 2013. A dementia care adviser nurse (DCA nurse) conducted CBS assessments and proposed candidates for antipsychotic medication review to their GP's. This model did not have the desired impact in an appropriate time frame.

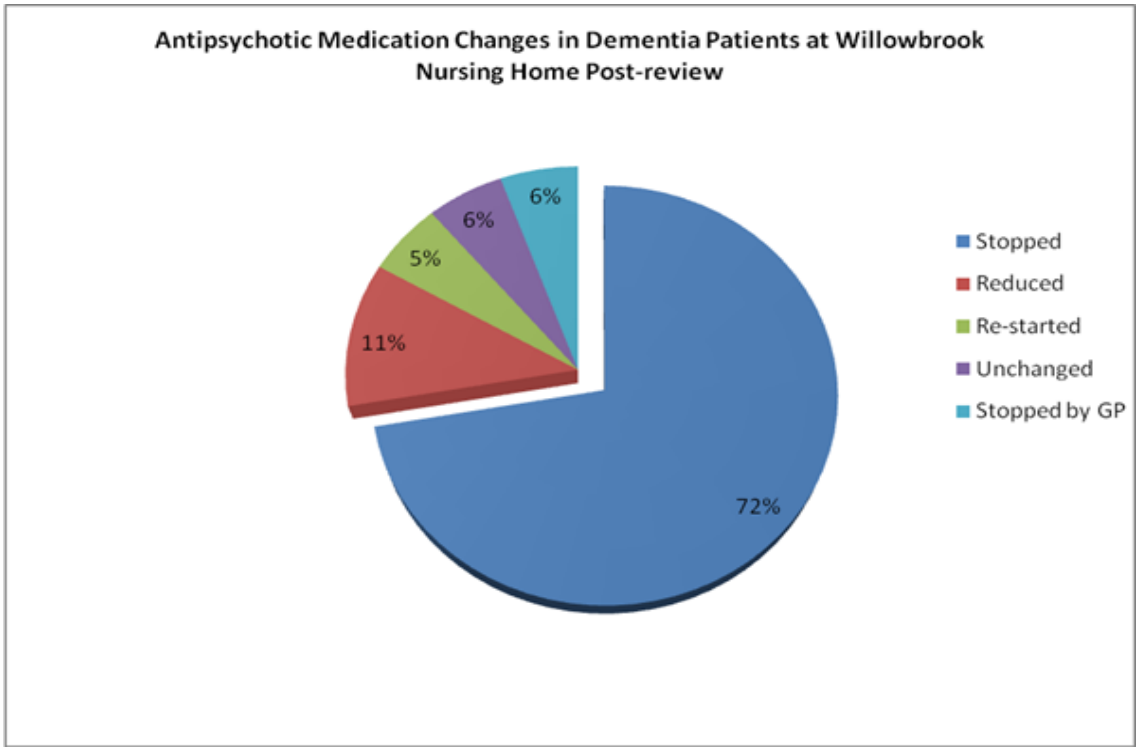
This abstract outlines a third approach which commenced in February 2016.

Method

The care home was selected as the GP surgery providing their service was the highest prescriber of antipsychotics in dementia patients in their area.

Candidates from the care home were identified through the GP coding system as having a diagnosis of dementia and being prescribed an antipsychotic (n=18). Each patient's behaviour was assessed by the DCA nurse and the identified key worker using the CBS. Patients scoring less than 100 on the CBS (usual range 0-400) had their medication reviewed and antipsychotic medication reduced, where appropriate, by the prescribing pharmacist. After the initial CBS scoring, patients were then reviewed weekly or fortnightly whereby further reductions were made, if no deterioration was observed. A final CBS assessment was carried out at the end of the pilot.

Results Of the 18 people assessed 14 patients had their antipsychotic medication withdrawn completely. (1 patient by the GP prior to start of pilot).The diagram below represents the results at the end of the four month pilot.



Conclusion/Discussion The results suggest that this model utilizing a prescribing mental health pharmacist and a dementia care advisor nurse is effective and timely in reducing antipsychotic medication in dementia patients in a care home setting.This study provides insight into the benefit of the extended role of prescribing pharmacists and how collaborative cross-sector working with specialist dementia care nurses has beneficial outcomes for dementia patients in care homes.

Following on from the good results GP guidance has been written jointly to support such reviews in the community. Secondary care support is to be provided from Hafan Y Coed mental health pharmacists, overseen by the CHL pharmacist. Primary care are piloting the GP antipsychotic reviews in dementia patients in 27 GP practices with nursing home enhanced service provision in early summer 2017. A target of 5 reviews per involved surgery is the initial target for the pilot.

In 2016 the medicines management pharmacy sub-group of Cardiff and Vale Dementia Taskforce group have also rolled out to secondary care the Care Pathway for Managing Behaviour that Challenges in People with Dementia. It is completed when any antipsychotic is prescribed to a dementia patient – a copy on remains in the patient's notes and is relayed to the GP on discharge. The GP can identify initial target indications/behaviours for the antipsychotics use and then use this information to review patients appropriately.

DRAFT Pathway for the Review of People with Dementia Prescribed Antipsychotics for Behaviour that Challenges in the Primary Care Setting

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Use of antipsychotics in people with dementia can worsen cognition, increase the risk of falls and increase the risk of stroke and death
People should have their antipsychotic reviewed 4-6 weeks after initiation and then every 3 months to see if a reduction or withdrawal is appropriate

Does the person have an underlying mental health issue e.g. history of psychosis, schizophrenia or psychotic depression, persistent delusional disorder, or bipolar affective disorder?

Is the patient's antipsychotic being **actively** reviewed by a mental health team?

→ Exclude from review

Review patient – Enter Read Code 8BM01 Antipsychotic Medication Review
Antipsychotic drugs should be used only if there is **severe distress** or an **immediate risk of harm** to the person with dementia or others
If the patient is a resident in a care home, the care home staff can complete the Challenging Behaviour Scale (CBS) For Older People Living in Care Homes to aid the review

- Does the person exhibit behaviour that challenges on a regular basis and there is a RISK OF HARM to themselves or others?
- If CBS score available is it more than 100?

No

Aim for reduction and withdrawal of antipsychotic
- Any stop date should usually be planned for a Monday so that if behavioural symptoms reappear these can be assessed during the working week
- Start with a reduction of 25% of the total daily dose
- If current dose is low (at the suggesting starting dose) the antipsychotic can be stopped without tapering the dose

Review after 1 week

If there are no problems the dose should remain the same with further review at week 4

Review 4 weeks after initial dose reduction
- If the reduction has been tolerated without any discontinuation symptoms then reduce by a further 25% and repeat the process
- Once the total daily dose is reduced to the recommended starting dose for the individual antipsychotic, it may be stopped

Yes

Do not reduce antipsychotic at this time – review in a further 3 months
- Consider causes of behaviour that challenges
- Consider non-pharmacological methods for addressing behaviour that challenges
- Ensure there are no side effects from antipsychotic medication
- Refer to the UHB Care Pathway for Managing Behaviour that Challenges in People with Dementia

- If the person exhibits discontinuation symptoms (nausea, vomiting, anorexia, diarrhoea, rhinorrhoea, sweating, myalgia,paraesthesia, insomnia, restlessness, anxiety and agitation) **OR** there is re-emergence of the initial "target" symptoms, conduct an assessment of the risk and benefits of re-instating the previous dose of antipsychotic
- Refer to the UHB Care Pathway for Managing Behaviour that Challenges in People with Dementia
- Further attempts to reduce the antipsychotic should be made one month later with smaller decrements for example 10% of the total daily dose.

UHB Care Pathway for Managing Behaviour that Challenges in People with Dementia:
http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/PHARMACY_CP/MEDICINE_TREATMENT_PATHWAYS/TAB49715/DEM

If there are any concerns about particular patients, for advice or support is needed please contact a Mental Health Specialist Pharmacist on [redacted]