



Remember, I'm still me

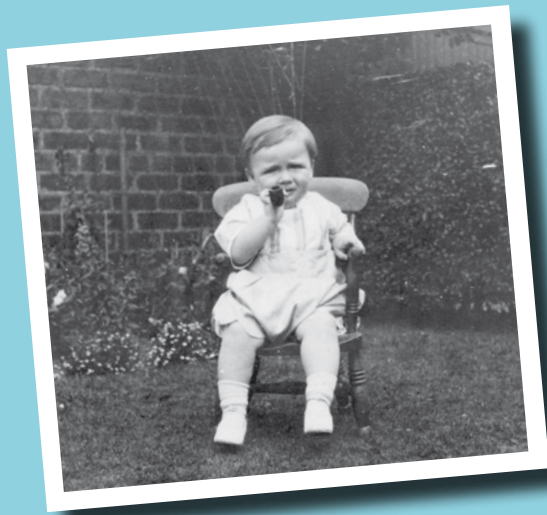
Care Commission and
Mental Welfare Commission
joint report on the quality of care
for people with dementia living in
care homes in Scotland



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foreword



Older people living in care homes are some of the most vulnerable people in society. They depend on the staff that look after them to ensure that they receive the best possible care to meet their needs.

What is it like to have dementia and be living in a care home? Do people get the care and respect they need and deserve? Do care home staff know enough about the people in their care? We called this report "Remember, I'm Still Me" because we found that staff delivering care can sometimes "forget" the person inside the dementia. Staff need to know as much as possible about the lives, personalities, likes and dislikes of the people they care for in order to give them the best possible care, treatment and quality of life.

In this report we consider ten important areas of dementia care. While we saw some examples of good practice, our findings reveal that overall, care in Scotland's care homes needs to improve significantly in order to meet the needs of people with dementia who live in them.

We hope this report will raise awareness about best practice and to help care homes to improve the quality of care that everyone with dementia has the right to expect both now and in the future.



Susan Brimelow

Susan Brimelow
Director of Healthcare Regulation
Care Commission



Dr Lyons

Dr Donald Lyons
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terms we use in
this report



Adults with Incapacity (Scotland) Act 2000 (AWI)

This sets out the system to help and protect adults who lack the capacity to make decisions on some or all aspects of their lives. It enables social and health care professionals, carers or others to have legal powers to make financial, welfare and health care decisions on another person's behalf. Part of the Act deals with the management of financial affairs of adults who live in care homes. It enables care home managers to manage the finances of residents who are incapable of managing their own money.

British National Formulary (BNF)

The BNF provides up-to-date guidance on prescribing, dispensing and administering medicines.

Challenging behaviour

Behaviour that is upsetting to the individual and/or could be dangerous to themselves and others.

Clinical pharmacy

Clinical Pharmacy is where a pharmacist uses their expertise in medicines to give advice about the safe, appropriate, and cost-effective use of medications.

Community pharmacy

This term describes local chemist shops and pharmacies in some supermarkets, where people have their prescriptions dispensed.

Consent to treatment

Medical treatment can only usually be given if the person receiving it gives his or her consent. If that person does not have capacity to consent, the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care & Treatment) Act 2003 should be used. These laws have safeguards for people, including the need to authorise treatment on legal certificates.

Covert medication

This is where care staff administer any medical treatment in a disguised form. The most usual way is to put medicines into food and drink.

Dementia

Dementia is a general term used to describe the loss of brain function including memory and the increasing lack of ability to carry out the full range of day to day activities. Dementia can also cause changes in personality and social behaviour.

Dementia friendly

A term used to describe an environment that has been adapted to suit the needs of people with dementia and enable them to make sense of their surroundings. For example, bedroom doors are personalised to assist people to find their own room easily.

Department for Work and Pensions (DWP) appointeeship

The Department for Work and Pensions can appoint someone else to receive a resident's benefit and use the money to pay their expenses such as bills and personal items. This can be arranged through a system known as an appointeeship. An appointee can only deal with the income from benefits, except in the case of small amounts of savings which can be used to meet unforeseen emergencies.

Guardianship Order

This is a legal order which can be used to look after the interests of someone with dementia. Guardians are appointed by the court when a person is no longer able to make a decision about money or welfare. The guardian can be a 'welfare guardian' and/or a 'financial guardian'. The kinds of decision the guardian will take will be set out in the court order.

Office of the Public Guardian

The Office of the Public Guardian supervises individuals who have been appointed to manage the financial or property affairs of an adult who doesn't have the capacity to do this for themselves.

Personal plan

This is a plan of how care will be given to the person which is agreed with the person and/or their representatives.

Psychoactive medication

We have used this term for medicines used to treat behavioural symptoms, like agitation, verbal and physical aggression, wandering and not sleeping.

Power of Attorney/welfare attorney

An attorney is an individual who has been named on a Power of Attorney document. They have the authority to act on behalf of the person who appointed them when they can no longer make decisions about their health, welfare, money or property. A Power of Attorney is made in advance of a person losing capacity to make decisions. A financial attorney can manage a person's money. A welfare attorney can make decisions about a person's welfare, for example where a person lives, what medical treatment they should receive and so on.

Restrictions to freedom

This is where people are not able to exercise freedom of choice, move about as freely as they would wish, or are allowed to leave the building in which they live. This could be as a result of physical restraint, medication or the culture or design of a care home.

Welfare guardian/welfare guardianship

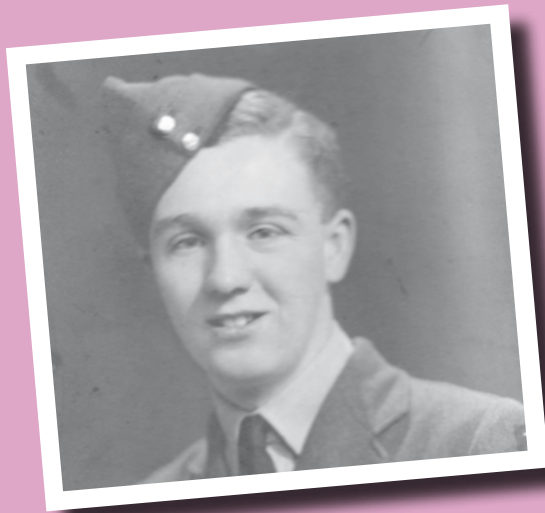
This is where someone has been given powers by the Court to make welfare decisions under the Adults with Incapacity (Scotland) Act 2000.

Independent advocacy

Trained staff that represent the interests of people who may find it difficult to be heard or speak out for themselves.

Note: throughout this report we use the term “we” to mean the Care Commission and the Mental Welfare Commission for Scotland. We make reference to areas of good practice and name care homes throughout the report. We report what we found at the time of the visit on that particular aspect of care. Good practice in one area does not necessarily mean that we found good practice in all areas of care in that particular care home.

summary, findings,
key messages and
recommendations



Up to 67,000 people in Scotland have dementia and about 40% of them are in care homes or hospitals. The nature of the illness means that they need a lot of care and support and that they are more at risk of having their rights overlooked. Where others may be more involved in their care, be able to express their wishes, ask others for help, or exercise their right to make a complaint, people with dementia have often lost many or all of these abilities.

The Care Commission registers and inspects care homes in Scotland using a set of national care standards. The Mental Welfare Commission safeguards the rights and welfare of individuals with mental disorder. Because both organisations had concerns about the care of people with dementia, we joined forces to visit a sample of care homes across Scotland. We used our combined expertise and knowledge of what constitutes good care and good legal and ethical practice to review the quality of dementia care in care homes.

This report details what we found on our visits to 30 care homes and to individual people with dementia who lived in them. Based on what we found we have made a series of recommendations for care home providers, managers and health and social care staff to improve dementia care in care homes for older people.

Our findings

We found that some care homes had fallen seriously short of best practice and people with dementia were not always getting the best possible care to meet their needs.

- Around 70% of people living in the care homes we visited had varying degrees and types of dementia.
- Only 24% people had an adequate record of their life history. The majority of people did not have enough information about their personal preferences recorded in the personal plan.
- Care was being regularly reviewed, at least once a year for most people but the quality of care reviews varied. There was rarely involvement of the person, with most reviews being carried out by care home staff and a relative or friend. There was little evidence of involvement from a social worker, GP or other professionals.
- Around half of all people never went out of the care home and there was very little planned activity outside the care home. Activity was not tailored to individual interests and activity co-ordinators were not always trained or supervised in their role. Lack of transport and failure to think about how best to use people's money did not help.

- Care home environments were generally good and getting better but there were not enough quiet areas for people to relax and more needs to be done to make homes dementia friendly. More than half of care homes had accessible gardens but there was little evidence of these being used often enough.
- There was a lack of understanding about financial responsibilities throughout care homes. There was little creative use of funds to support the person. This was not seen as being an important part of the duties of care staff and there was little evidence of finances being discussed during care reviews.
- Most people had a good assessment on or before admission to the care home. There was good input from GPs and allied health professionals, such as dieticians, when the care home requested this. However, very few people had a planned health check every year by their GP and there was little evidence that medication was regularly reviewed. Care staff often had a poor understanding of health care needs and what visiting professionals were doing.
- The majority of care homes saw the NHS prescription forms before the medicines were dispensed and this is good practice. No care homes had a system for recording medicines that could provide a complete, up-to-date record of all the medicines ordered, whether they were taken or not, and what was disposed of. There was little clinical input from pharmacists.
- 75% of people in the care homes were taking one or more psychoactive medicines. 33% of people were taking antipsychotic medication and 6% of people were taking olanzapine or risperidone, despite specific warnings in place at the time about the use of these drugs. We found evidence of inappropriate and multiple prescribing. Generally, we had concerns that many people had been on the same medication for some time without regular review.
- When we looked at how medication was used to manage challenging behaviour, we found that recording of this on personal plans was poor. We also found evidence of GPs prescribing medication without having seen the person.
- When we looked to see if medication was being given in a disguised form, usually by putting the medicine in food or drink, we found evidence of this in nine care homes. Twenty of the 1,335 people we looked at were getting medicines in this way. Very few care homes had the right information or legal safeguards in place to give covert medication lawfully and safely.

- We found care homes where staff did not understand the legal safeguards in place for people with dementia. They did not know who had legal powers and there was often no indication that formal discussion had taken place with a person's welfare guardian about their powers. Recognised best practice guidance about this was not used in care homes.
- When people were being restrained we found staff were familiar with and referred to guidance on best practice. The use of bed rails and lap straps were usually recorded and risk assessments were in place. However, when doors were locked, it was very rare for personal plans to refer to this or why it was necessary for the person. Doors were locked in the majority of care homes we visited. Only a very small minority of people had the freedom to come and go as they pleased, even into a secure internal garden area and some were prevented from leaving when they wanted to.
- Only a third of care home managers had undergone a recognised training course about caring for people with dementia. The majority of care staff were generally unaware of best practice guidance and some felt their knowledge was insufficient or they didn't have enough time to be able to give the care they wanted to.
- The law on medical treatment for people who lack capacity is not being obeyed. Only a minority of people had appropriate assessments of capacity, certificates of incapacity and treatment plans. Where certificates existed, they were usually not completed well. Some care home staff did not know that certificates were needed and some doctors refused to issue them.

Our 10 key messages

We have developed the following 10 key messages so that care home providers and others involved in the care of people with dementia, can use them as a measure of the quality of care they provide and make improvements where necessary. We hope these will remind care staff of the needs of the person with dementia and how their care affects that person's quality of life in a care home.

Our messages are aimed at:

- care that respects the individual
- activities and being part of the community
- environment in which people live
- managing money
- health assessment
- managing medication
- managing challenging behaviour and the use of medication

- legal matters and safeguards
 - consent to treatment
 - staff knowledge and training.
1. It is important to know the person as an individual, understand their life history, their likes and dislikes and how they like to live their life in order to provide the right care to meet their needs. People should be involved in their care planning and reviews as much as possible.
 2. Activities and getting out must be an integral part of a person's life in a care home and not an optional extra.
 3. Care homes must strive to provide the right environment to ensure that people can enjoy safe, comfortable, dementia friendly surroundings.
 4. Care homes should manage people's money properly and use it creatively to improve people's quality of life.
 5. A person's healthcare needs should be assessed when they first come into a care home and should then be reviewed at least once a year, by their GP. This is to ensure all their healthcare needs are being met and that they have access to the full range of healthcare services they require.
 6. Care homes should regularly review, together with GPs and pharmacists, how they manage medication. This would help to make sure medication is being used more appropriately, efficiently and safely.
 7. Medication to manage challenging behaviour should be a last, not a first resort. Personal plans should address the causes and outline a range of interventions to be used to manage challenging behaviour.
 8. People's freedom should be respected as far as possible. Care homes must look at environments, practices and cultures that could be overly restrictive. Care homes also need to understand the rights of people with dementia and the laws and safeguards that exist to protect them.
 9. People should receive medical treatment that is in line with the law. Where people don't have capacity to consent to their own treatment, the law should be used properly to safeguard them.
 10. People with dementia should be cared for by staff who have the skills, knowledge and training to provide effective care.

Our recommendations

Following publication of this report:

All care homes in Scotland should:

- ensure that they deliver good quality care to people with dementia by using the ten key messages and recommendations from this report to make improvements in dementia care.

To make this happen, the Care Commission will:

- follow up on the requirements and recommendations made for each care home through the inspection process
- look closely at meaningful activity for people with dementia in all care home services during our inspections in 2009/10
- use the findings of this report to decide which areas of dementia care to focus on more closely in future inspections
- provide a copy of this report to every care home for older people in Scotland
- use this report to raise public awareness of good dementia care
- work with Scottish Government, Local Authorities, Health Boards and others to address the shortfalls in care we have identified
- appoint a Rehabilitation Consultant for Older People, funded by the Scottish Government, to promote rehabilitation and help people in care homes with dementia to enjoy a good quality of life.

The Mental Welfare Commission will:

- follow up on any issues relating to the people we met or whose care we reviewed
- distribute a copy of 'Money Matters' and 'Working with the Adults with Incapacity Act' guidance to every care home in Scotland
- continue to examine personal plans to check care homes are responding to the recommendations in this report and that these are resulting in improvements for individuals.

We recommend the Scottish Government:

- use our findings to inform the development of a National Dementia Strategy
- encourage local authorities, NHS boards and the private sector to work together to provide the best services to meet the needs of people with dementia in care homes
- consider the widespread failure to comply with part 5 of the Adults with Incapacity Act and review this part of the Act as a matter of urgency.
- consider systems to collate and monitor prescribing data at care home level to reduce medicines waste and highlight inappropriate and overuse of medicines.

We recommend NHS Quality Improvement Scotland:

- review their guidance on pharmacological interventions in Scottish Intercollegiate Guideline Network (SIGN) guidelines, in order to provide national guidance on prescribing to treat the behavioural symptoms for people with dementia. This should encompass a multidisciplinary approach to prescribing and how the effectiveness of these medicines will be monitored.

Doctors and pharmacists should:

- review all prescriptions for antipsychotic drugs for people with dementia with a view, wherever possible, to stopping the drug, or trying a suitable alternative
- work with care homes to ensure legal documentation is completed and to give appropriate advice on disguising medicines.

Local authorities should:

- ensure that information that they have about an individual's life follows that person and is made available to care home staff
- work with care homes to make sure they understand the laws that protect people
- review current supervisory arrangements for private guardians to make sure they meet their own legal responsibilities as guardians.

Health Boards should:

- make sure that prescribing and recording of medication is in line with guidance on best practice and with most recent warnings on their safe use
- consider introducing regular visits and support from pharmacists to improve knowledge of medication management in care homes
- make specialist education and training available to doctors who prescribe to care home residents
- make sure there is easy access for care homes to specialist advice from the local community mental health team.

People who live in care homes, their families and carers should:

- read this report and expect the kind of care we have recommended
- get involved in care planning and help care staff to get to know the needs of the person they are looking after.

What action we took

If we found that care homes were not meeting National Care Standards or not providing good enough dementia care, we made requirements and recommendations for them to improve.

Across the 30 care homes we made 78 requirements and 240 recommendations for improvement. Of these:

- most care homes had between one and four requirements
- three care homes had six requirements
- one care home had nine requirements.

Over half of the requirements we made (36) 42% were to improve the way in which medicines were managed.

We also made 12 requirements to improve the use of personal plans.

The rest of the requirements we made were to improve a range of areas of care including meeting the needs of people in care homes, protecting people and better staff training.

We are following up on all the requirements and recommendations to make sure care homes make these improvements.

You can find more information about the recommendations and requirements we made in our care home inspection reports at www.carecommission.com

We also looked in detail at the care of many individual people. In over 50% of cases, we told care home staff that we thought the person's care was not good enough and gave advice on how to improve it. Usually, this was because the person's needs for health care and activity were not being met. We found one case where we were very concerned and have asked the social work department to take action. In all cases, we are making sure that care homes have taken the action we recommended to improve the care of individuals.

To find out more about how the Mental Welfare Commission safeguards the rights and welfare of individuals, visit www.mwcscot.org.uk

introduction



This part of the report sets out:

- who we are and what we do
- what this report is about
- why we jointly inspected 30 care homes in Scotland
- what we looked at
- how we gathered information.

Who we are and what we do

Care Commission

The Care Commission is Scotland's national regulator of care services. We register and inspect almost 15,000 services that care for more than 320,000 people in all parts of Scotland.

Our work is guided by the Regulation of Care (Scotland) Act 2001 and the National Care Standards (NCS) published by Scottish Ministers. These standards set out what people using care services in Scotland should expect.

Our overall aim is to improve the care for people who use care services by working with care service providers and by involving people who are cared for, their carers and families.

We regulate care services by registering them, inspecting them, investigating complaints and enforcing standards of care.

We can take the following actions to improve the quality of care services.

Enforcement action: This is a legal power that allows us to vary or impose new conditions that services must meet to be registered with us.

We can also serve a legal notice that requires services to make improvements within a timescale. We can, if necessary, close a service down if it does not demonstrate that it is improving in line with a requirement we have made.

Recommendations: If a service is not meeting a national care standard we can make a recommendation. This is a measure we consider a service should take to improve standards of care.

We can, and do, check to make sure that services act on recommendations.

Requirements: If a service is not complying with the regulations in or associated with the Regulation of Care (Scotland) Act 2001 we can make a requirement. This is a statement setting out what the service must legally do, within a timescale agreed with us.

A requirement means the service has failed to meet the regulation to an extent that we are concerned about the impact this has on the people using the service.

Mental Welfare Commission for Scotland

The Mental Welfare Commission for Scotland is an independent organisation that works to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder, including dementia.

We are made up of people who understand and have experienced mental health and learning disability. Some of us have a background in healthcare, social work or the law. Some of us have experience of using, or caring for a person who uses mental health services.

Our values

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- be treated with dignity and respect
- have the right to ethical and lawful treatment and to live free from abuse, neglect or discrimination
- get the care and treatment that best suits their needs
- be enabled to lead as fulfilling a life as possible.

The Mental Welfare Commission for Scotland:

- finds out whether individual care and treatment is in line with the law and good practice
- challenges service providers to deliver best practice in mental health and learning disability care
- provides information, advice and guidance to people who use services, carers and service providers
- has a strong and influential voice in service and policy development
- promotes best practice in mental health and incapacity law.

Throughout this report the term “we” refers to the Care Commission and the Mental Welfare Commission for Scotland.

what this report
is about



Following previous inspections of care homes by the Care Commission and information gathered from visits to individuals by the Mental Welfare Commission, both organisations had concerns about the care of people with dementia. We wanted to get a better understanding of the quality of care for people with dementia in care homes so we joined forces to visit a sample of care homes across Scotland.

This report details what we – the Care Commission and the Mental Welfare Commission for Scotland – found during joint visits to care homes caring for people with dementia.

Care homes should make sure they give people with dementia the good quality care they need to live as independently as they can and lead as meaningful a life as possible.

Our report details:

- what we found on our visits to 30 care homes and to individual people with dementia who lived in them
- what we think should happen next, with recommendations for care home providers and managers and health and social care staff to improve dementia care in care homes for older people.

the joint inspections

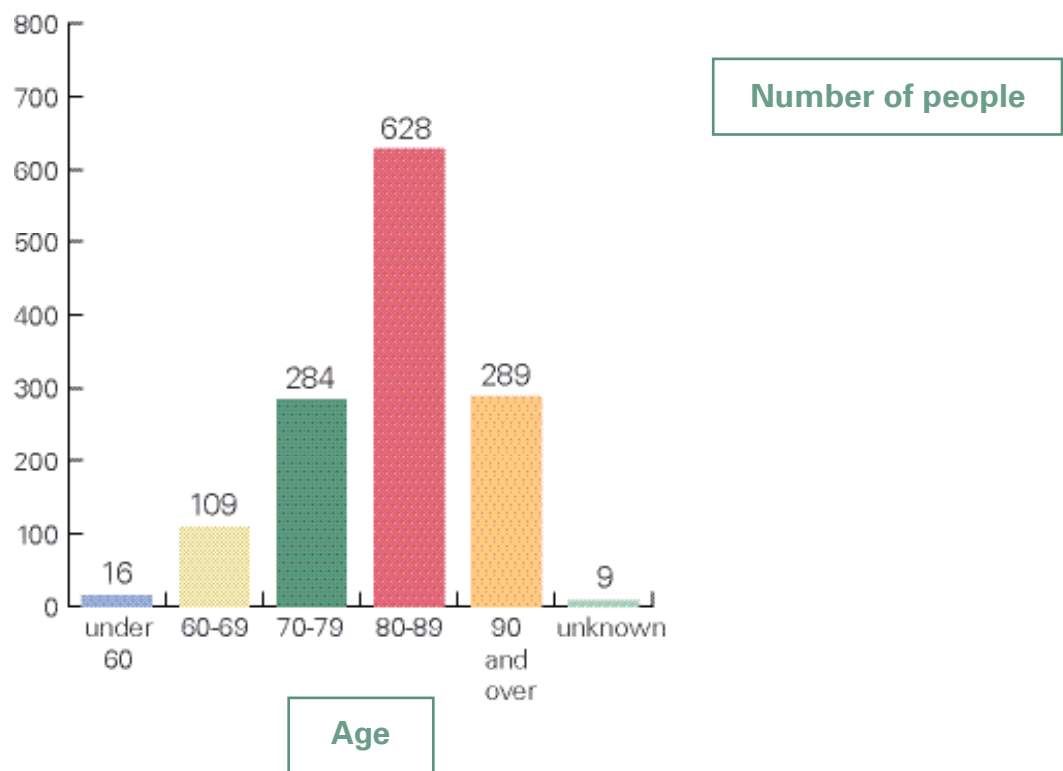


We worked together to review dementia care in 30 care homes for older people.

Our sample included large, medium and small care homes across Scotland. We also visited care homes where we knew a number of people were under welfare guardianship orders.

Our visits started in August 2008 and finished in March 2009. All visits were unannounced; we did not tell the care homes when we were coming or what areas of care we were going to look at.

This table shows the numbers of people and their age group in the care homes we inspected.



Data source: Care Commission survey (August 2008 - March 2009)

What we looked at

We wanted to know more about 10 areas of care that are recognised in research and best practice guidance as being particularly important for people with dementia. We wanted to find out if care homes were providing good quality dementia care and meeting National Care Standards for care homes for older people. We were particularly interested in people who had a welfare

guardian to make decisions on their behalf and did not have friends or family closely involved in their care.

To get a better understanding of the quality of care being delivered we looked closely at what care homes did in each of the following areas:

- care that respects the individual
- activities and being part of the community
- environment in which people live
- managing money
- health assessment
- managing medication
- managing challenging behaviour and the use of medication
- legal matters and safeguards
- consent to treatment
- staff knowledge and training.

How we gathered information

During our visits we:

- interviewed care home managers and care staff
- looked at the personal plans of people living in care homes
- reviewed all individual medication records
- spoke with people living in the care homes, where possible.

what we found about
dementia care in
Scottish care homes



This part of the report details what we found in each of the 10 areas we looked closely at. Under each of these areas we consider:

- what we would expect to find care homes doing: our key message to them
- what we found care homes were doing
- what action we think should be taken in this area.

1. Care that respects the individual

Key message

It is important to know the person as an individual, understand their life history, their likes and dislikes and how they like to live their life in order to provide the right care to meet their needs. People should be involved in their care planning and reviews as much as possible

We considered two aspects of care that respects the individual:

- why it is important for care staff to understand a person's life history
- why personal plans and regular reviews of care are important.

Why it is important to know a person's life history

It is important to know about how a person lived before they developed dementia. Recording life history information will help to individualise the care of the person with dementia and help maintain their identity. Life histories help care home staff to better understand the person's needs, appreciate why they do certain things and how their past affects their present life and behaviour.

The National Care Standards for care homes for older people state that "Staff will develop with you a personal plan that details your needs and preferences and sets out how they will be met, in a way that you find acceptable"



Good practice: what we would expect

We would expect personal plans to show a person's life history had been discussed and noted. We would also expect them to include a record of their likes, dislikes and any relevant personal information about how the person would like to be cared for. Staff should encourage relatives and friends to help

in developing the personal plan, if possible. All care staff should make sure that they respect and act on the choices people make in their personal plan.

What we found

We looked at 182 personal plans to see how people's life histories were recorded. Of these we found that:

- 44 (24%) had an adequate record of the person's life history
- 75 (41%) had some very limited information
- 63 (35%) recorded no life history at all.

We also looked at how many plans recorded people's personal likes and dislikes, for example what they liked to eat and drink, what music they preferred, what they liked to watch on the television and what interests they had.

We found the following.

- 56 (31%) personal plans had some information in them about what people preferred, but in most cases this information was incomplete.
- 50 (27%) personal plans had very limited information, mainly about food, for example, "likes sugar in tea". One personal plan stated: "Likes cats. Likes milk". This was the only personal information in the plan to help care staff plan this person's care.
- 76 (42%) of people had no information recorded about what they preferred. For one person our team noted: "This person has no visitors. There is nothing in her care plan to highlight her personality, her likes or dislikes or her history."

Staff did tell us that in some cases the amount of information about life history depended on what they received from family and friends or from social services.

What people said

These quotes are from care home staff:

"There is a shortage of staff – people are brought in who don't know the conditions of the service users they are caring for."

"More staff would mean more individual attention for residents."

Why personal plans and regular reviews of care are important

Good practice: what we would expect

We wanted to find out how often care homes were assessing and reviewing the care they give people, and who was involved in this.

The National Care Standards for care homes for older people state:

“Your personal plan will be reviewed with you every six months or sooner if you want or if your needs change.”

Care homes should hold care reviews every six months. The person, his or her key worker, relatives, guardian, attorney, social worker and other relevant people should take part in the review. Where there is no carer, friend or family and the person struggles to make their views known, we would expect care staff to encourage use of independent advocacy where it is available.

What we found

We found that care was being regularly reviewed. Most personal plans, 152 out of 182, showed a care review had been carried out at least once in the last 12 months.

However, the quality of these reviews varied greatly from home to home. We found little evidence that the person in the care home had been involved in the review of their care. Most care reviews involved care home staff and a relative or friend, but rarely involved a social worker, the person’s GP or other professionals.

We wanted to explore why people did not get involved in reviewing their care. Although people may have been invited to attend their care review, they often did not. This was either because care staff thought it was inappropriate for them to do so, or because there was little assistance from staff or other people involved in their care, to help them take part.

Some people were interviewed before a review meeting and would get information from someone who had been at the meeting, for example a member of the care staff, afterwards. For other people there was no record that they had taken part in their review, or indeed any indication that their personal plans had been discussed with them at other times.

Some of the personal plans we reviewed were easy to read, had good quality information in them and were regularly updated. We would expect to find signed and dated statements in a personal plan if a person’s needs changed. In most cases, we did not find this and out-of-date information was sometimes carried forward from an old personal plan into a new one.

An example of good practice

In one care home a manager had contacted local independent advocacy services to help a person living in the home take part in a care review meeting. They helped the person express her own views about her care, which differed from those of her family.

What people told us

This is a quote from a person living in a care home:

“Delighted to be involved in the meetings and much happier living here”

What action we think care homes should take in this area

Care homes must:

- make sure that everyone who is living in the care home has a personal plan that details their needs and preferences and sets out how care staff will meet these needs
- keep a comprehensive record of each person's life history to help care staff to plan their care and provide people with activities which are of interest to them
- encourage family and friends to help record a person's life history
- ask family and friends to provide personal mementos to help make a person's environment and care more individual, for example by putting pictures up on the wall of their room
- hold formal care reviews every six months and make sure they include the view of the person whose care is being reviewed, their key worker, relatives, guardian, social worker, person granted with power of attorney and other relevant people involved in their care
- make sure that people who live in the care home are aware of, and can use, independent advocacy services if they need to
- keep a detailed record for each person of any help given by health and social care professionals
- Keep a record of who keeps in touch or comes to visit the person

2. Activities and being part of the community

Key message

Activities and getting out are an integral part of a person's care and not an optional extra.

Good practice: what we would expect

The National Care Standards for care homes for older people, state:

“Living in a care home, you continue to be very much part of your own community and to enjoy normal daily life.”

“You are supported and encouraged to use local services such as hairdressers, shops and banks.”

We would expect people who live in care homes to have access to a wide range of stimulating activities that are relevant to them as an individual. They should take part in choosing and planning their own activities. We would also expect that, wherever possible, people are being supported to take part in activities outside of the care home to maintain close links with the local community.

There is increasing evidence about the importance of mental and physical activities for people with dementia. These activities are valued by individuals, relatives and staff (Older and wiser, 2007).



Other research, quoted in ‘Management of patients with dementia (2006)’, has found that:

- if activities and opportunities are available they improve the quality of people’s lives, affecting mortality, depression, physical function and behavioural symptoms for people with dementia
- structured exercise and conversation may help people with dementia maintain their mobility.

Reports from campaigning organisations such as Help the Aged suggest that people living in care homes do not have enough to do. In 2006 they reported that around half of people in care homes spend half their time asleep, socially withdrawn or inactive (My home life, 2007).

What we found

Almost 40% of the personal plans we looked at showed no planned activity outside the care home. Most organised activities took place indoors, were mainly group activities and were not tailored to people’s individual interests.

Some care homes did use local facilities such as lunch clubs, cinemas, theatres and garden centres. The way these were used was variable in the care homes we visited.

We also found the following.

- Over half of all people never went out of the care home and a further 25% rarely went out. We were concerned about the quality of life for people who rarely, if ever, left the care home. There was little opportunity for them to enjoy life in their local community.
- Fewer than 20% people were reported to us as going out regularly and this was often when family or friends took them out.
- Personal plans recorded that a number of people had asked to go out more often.
- Some care homes offered transport but this was often inaccessible for people who use wheelchairs or not available regularly.
- One care home only made transport available every second Tuesday afternoon.
- Some care homes regularly used a person's money to pay for local taxis to help them take trips out while other care homes would not consider this an option.
- Some care homes used money from fundraising to pay for outings and activities.

What people told us

People living in care homes had mixed views:

"There is always something going on."

"Staff seemed to have little time to spend with us."

From a relative:

"There is a lack of social interaction and activities."

From a member of the care staff:

"We need more staff, especially in the summertime so we can take them out and about more, walk by the river or sit outside."

Examples of good practice

We also came across some examples of excellent practice, where activities were available both in the care home and outdoors.

We met one man who pays a worker to take him out to lunchtime music concerts and then lunch or coffee in a café he used to go to. They meet up with his sister whenever she is able to join them.

Another man had a daily walk around the grounds included in his care plan, along with all his indoor activities.



The role of activity co-ordinators

We met staff who had been asked to take on the role of an activity co-ordinator for the care home they worked in but they were largely unskilled in this area of work and had no training to help them carry out this role. We found that the arrangements in place to help and supervise care staff in these posts varied widely. They ranged from supervision with the manager once every three months to nothing at all.

No nationally accredited activity co-ordinator course is available to help people develop the skills they need in this area of work. Activity co-ordinators told us that they rarely had enough time or resources, such as equipment or money, to deliver the programmes they would like. Many also said that they could not take people out because they did not have access to transport, for example a minibus which was suitable for people in wheelchairs.

Activity co-ordinators were seldom involved in people's six-monthly or annual reviews. This highlights the lack of importance placed on activities. People reviewing personal plans rarely asked for the activity co-ordinator's objectives for the person whose care they were considering.

Most homes seemed to offer communal activities such as music, manicures, crafts and bingo. One large care provider appeared to invest heavily in their activity co-ordinators and sent staff on courses to widen their skills. Generally, though, our impression was that the range of activities on offer was limited and mostly aimed at groups, not individuals.

Time with key workers

We often found it difficult to establish what one-to-one time with a person's key worker was being used for. Where we did find this time being used to do something meaningful for the person living in the care home, we felt it improved their quality of life and general care.

What action we think care homes should take in this area

Care homes should:

- make sure that activities are tailored to people's individual interests
- make sure that the people living there continue to be part of their own community and enjoy normal daily life
- make sure that, where possible, personal plans include activities that take place out of the care home
- consider how they can use people's own money appropriately to help them take part in a wider range of activities
- make sure their staff get the training they need to help them design and get people involved in a range of activities.

The National Association for Providers of Activities for Older People has designed a number of training packages to help care staff get older people living in care homes involved in activities. Care homes should also become familiar with the College of Occupational Therapists' guidance: "Activity Provision: Benchmarking good practice in care homes" (2007)

3. The environment in which people live

Key message

Care homes must strive to provide the right environment to ensure that people can enjoy safe, comfortable, dementia friendly surroundings.

The National Care Standards for care homes for older people set out what people should expect of a care home environment:

"...the design and layout of the physical environment helps to ensure that you can enjoy living in safe, comfortable and homely surroundings."

The move to a care home is a major life change, which may mean the loss of relationships as well as an environment in which many emotions and memories have been invested ('My home life', 2006).

The design of a care home can have a significant influence on the behaviour of people affected by dementia (Best Practice in Design for People with Dementia, 2007).

When planning an environment for people with dementia, care providers should think about the size and design of the home. For example, shorter, wider corridors can reduce restlessness, anxiety, and disorientation in people with dementia. Corridors should take people somewhere interesting and not to a dead end or a locked door.

Good practice: what we would expect

The quality of the environment can make a positive difference to the lives of people with dementia. We looked for ways in which the design of care homes and outside areas helped people with dementia live as independently as possible.

We would expect care providers to make sure that the care home was an appropriate environment for caring for people with dementia. For example, we would expect:

- a homely design throughout the care home
- large print, clear signs to identify toilets and bedrooms
- good lighting in all areas
- moderate noise levels, for example TV volume not too high
- gardens and other outdoor areas to be safe and easily accessible for people with dementia.

What we found

This part of the report covers:

1. Signs in care homes
2. Sitting areas
3. Visiting rooms
4. Bedrooms
5. Gardens and outside areas

1. Signs in care homes

Good practice: what we would expect

We would expect care homes to use clear signs, large print signs and pictures on walls and doors. These help people move easily around the home and know where to find their own bedroom and toilet areas.



What we found

In three (10%) of the care homes, we found excellent signs. We found the signs in 18 of the care homes were good or satisfactory. The signs in Riverside, Abercorn, Torbrae and Kirkburn Court care homes were very good. Each used large print signs and simple descriptive pictures on toilet, bathroom and bedroom doors so people could quickly identify these areas.

Unfortunately, we also found that some care homes did not use clear, large print signs. Eight care homes had signs that were poor or very poor. One home had almost no signs at all.

2. Sitting areas

Good practice: what we would expect

We would expect all care homes to have one or more separate sitting rooms for people to use. Ideally, we would like care homes to have an extra room for people to use as a quiet area.

What we found

All care homes had at least one residents' sitting room. Some larger care homes had small sitting rooms in different areas throughout the building but in more than half of care homes, people did not have access to a quiet room.

If there was only one sitting area there was usually a lot of continuous noise, for example, the television and the radio would be on at the same time. In one care home we noted "TV blaring in all four lounges" and, in another home, "Continuous loud traffic noise in all areas". Care staff should be aware that high levels of background noise can make people with dementia feel agitated.

There is some evidence that music tailored to meet the individual's taste can relieve agitation in people with dementia (Management of patients with dementia, 2006). However, there was little evidence that people were offered a choice of what they wanted to watch on television or listen to on the radio. Some people watched TV in their bedrooms so that they could choose the programme.



3. Visiting rooms

Good practice: what we would expect

People living in care homes should be able to meet their friends and family in a place away from the main sitting rooms, but not in their bedrooms. We would expect care homes to make this possible.

What we found

- Over half of the care homes did not have a designated space for people living there to meet with their visitors, and bedrooms were often used for this purpose.
- Eight homes did have a specific area for meeting visitors. Some homes had rooms they used for staff training and for visitors.
- A small number of care homes had excellent facilities. For example, Fullarton and Budmhor care homes had developed café style settings within the home where residents and visitors could meet. Another care home, Kirkburn Court, had decorated a room to resemble a sitting room from the 1940s.



4. Bedrooms

Good practice: what we would expect

The National Care Standards for care homes for older people state:

“Residents can expect to be able to lock their room doors for security and privacy.”

We would expect to find all care homes providing rooms with locks on the doors. Care homes should also help make people feel comfortable and at home, for example by allowing them to bring personal items with them such as their own furniture and belongings. This can help people recognise their own rooms and feel more settled.

What we found

- 66% per cent of bedroom doors could be locked and staff told us that most people could get access to their rooms when they wanted to.
- People did not always have their own keys or have access to them.

- One care home kept all bedrooms locked during the day.

We were pleased to find that the majority of care homes encouraged and supported residents to personalise bedrooms with their own furniture and personal belongings.

What people told us

These comments are from people living in care homes:



"I can go to bed and get up when I wish."

"My room is comfortable and overlooks the sea."

"I have a lovely room; it's always nice and clean."

5. Gardens and outside areas

Good practice: what we would expect

The National Care Standards for care homes for older people state:

"You will be able to move around easily in the house and its grounds"

People should be able to enjoy spending time outdoors. We would expect outside areas to be easy to get access to and have level surfaces. They should have different types of plants that are interesting to smell and touch.

These points are set out in 'Best practice in design for people with dementia' (2007).

What we found

- Just over half (52%) of care homes did have gardens that were accessible and safe, but they were not necessarily suitable for people with dementia.
- The majority of people did not get the chance to use gardens and outside areas regularly and this was an issue of concern to us.
- There were a few, very well planned garden areas. These were generally much appreciated by people living in the care homes and their visitors. We found good examples of dementia friendly gardens at Cairnie Lodge and Woodlands care homes.

What people told us

These comments are from people living in care homes:

"Staff never offer to take me out in the garden."

"I enjoy time out in the garden."

This comment is from one of our team members:

"Service users had access to two fenced garden areas, with raised beds and seating areas, which were well designed and maintained, with input from relatives of service users. A small putting area was being developed in the garden area for service users who liked golf."

What action we think care homes should take in this area

Care homes should:

- review their signs to make sure they are helpful for people with dementia and follow good practice guidelines to make sure they are in large print and are clear
- get advice, if they need it, from the Dementia Services Development Centre (DSDC) at the University of Stirling on improving their environment and signs. The DSDC has an "audit tool" to assess how dementia friendly a care home is
- take measures to cut down noise, especially if they have large sitting rooms
- have separate quiet areas for people to use if they want to
- make sure they know what people like to watch on the television, listen to on the radio and what kind of music they like, and record this information in personal plans
- work towards providing designated visiting areas
- make sure everyone who is able to keep their own keys, or have access to them, can do so
- make people feel at home in their rooms by making them homely and personal
- encourage people to spend time outdoors by providing a safe garden or outside area that is suitable for people with dementia.

4. Managing money

Key message

Care homes should manage people's money properly and use it creatively to improve people's quality of life.

Good practice: what we would expect

The National Care Standards for care homes for older people state:

"You can keep and control your money and your personal belongings, unless your individual circumstances mean that specific legal arrangements have been made."

We wanted to know who looked after the money of people who lived in the care home if they could not look after it themselves. These legal options are available to do this:

- Department for Work and Pensions (DWP) appointeeship
- continuing Power of Attorney using part 2 of the Adults with Incapacity (Scotland) Act 2000
- access to funds using Part 3 of the Act
- management of funds by the care home using part 4 of the Act
- financial guardianship using part 6 of the Act.

These legal options set out how people's finances should be safeguarded if they cannot look after it themselves and offer guidance to relatives, care staff and others who may have to look after someone else's money.

We expect care home staff to be aware of these options and to use money creatively to give people the best possible quality of life. So, for example, they might order a taxi to take someone for a special trip out, buy fresh flowers for their room or take them on a shopping trip.

What we found

We found many care homes did not seem to understand who was responsible for managing the money of people who were unable to do this for themselves.

Only one care home could provide an up-to-date list of all the people whose finances were managed by another person on their behalf. The care home manager or administrator who was responsible for keeping financial records was often not clear about what options were available to manage people's money.

We looked at how 90 people's money was managed. Of these people:

- one in every eight had their benefits managed by the care home manager, one in 10 by a family member
- almost half of the people had a financial guardian or power of attorney
- one person had their money managed by the care home manager under part 4 of the Adults with Incapacity (Scotland) Act 2000.

We found that care staff were not very creative when they were considering how to use money to enhance a person's quality of life. The main items and services they bought in most homes were hairdressing, chiropody, sweets, cigarettes, newspapers and clothes. Better ways to spend people's money could include taxis to places of interest, holidays, shopping trips, fresh flowers in the room, or a pub lunch every Sunday but they were rarely considered.

Staff told us that some families were not willing to hand in money for day-to-day expenses. Some care homes had good policies on how to get access to a person's money if they found it difficult to get a family to bring in money after they asked them to.

Care staff often seemed to think of money as something that was managed by the administrator. They did not think that managing people's money was part of their caring duties.

Finances are rarely talked about in annual care reviews, unless there have been difficulties. Care homes seem reluctant to deal with a person's money or to ask for extra money to cover more than the essentials such as clothing or newspapers. Care staff may feel wary or embarrassed to ask to use someone else's money. Whatever the reasons, this reluctance is limiting the opportunities to enhance a person's quality of life.

What action we think should be taken in this area

Care homes should:

- consider how they can use someone's money to improve the person's quality of life
- ask people who know the person well to come up with creative ideas when they are planning and reviewing their care
- refer to the "Money Matters" booklet produced by the Mental Welfare Commission for guidance on the range of options available to manage people's money.

5. Health assessment

Key message

A person's healthcare needs should be assessed when they first come into a care home and should then be reviewed at least once a year, by their GP. This is to ensure all their healthcare needs are being met and that they have access to the full range of healthcare services they require.

Good practice: what we would expect

Physical health and well being is an important part of care. People with dementia should not lose access to any services because of their diagnosis, age or any other disability.

Problems with physical health can interact with and worsen the mental health of people with dementia and may go undiagnosed if regular checks are not carried out. National guidance acknowledges the need to take account of the general healthcare needs of people with mental disorder but there is conflicting guidance on how often their health should be reviewed.

The National Care Standards for care homes for older people state:

“During your first week in the home, and at least every six months after that, you will receive a full assessment to find out all your healthcare needs, and the staff will ensure that these needs are met. Staff will record all assessments and reviews of your healthcare needs”.

The Scottish Government, in its commitment to improving the physical health of people with mental disorder, recommends that a physical health assessment should take place at least once every 15 months (Delivering for mental health, 2006). Standards for mental health require a physical health assessment at least annually (NHS Quality Improvement Scotland, 2007).

These standards apply to people with dementia in care homes. In addition, there are specific indicators about dementia care that GPs should meet (Quality and outcomes framework, 2007/08’).

We would expect all people coming into a care home to have their health and social care needs assessed. Care staff should then develop a personal plan of care which details how to meet these needs and which relevant social and health professionals will be involved in their continuing care. The primary healthcare team should then review a person's health at least once a year.

What we found

We checked personal plans for information about physical health. We found that over 80% of people had their healthcare needs assessed and recorded in their personal plan on or before admission to a care home. A range of professionals, including care home staff, nurses, GPs and social workers, or a combination of these, carried out this initial assessment.

Most people had input from a GP on admission and there was evidence of involvement by community nursing staff, dieticians, psychiatrists, physiotherapists, opticians and others.

When we looked in detail for evidence of documented physical healthcare needs, we found that personal plans documented this information for the vast majority (87%) of people. There appeared to be good input from GPs through regular and requested visits.

Allied health professionals, for example podiatrists, dentists and dieticians visited regularly and community psychiatric nurse visits were especially valued. These were mostly following specific referrals, rather than regular planned visits.

We only came across a few circumstances where we felt there were significant gaps in the care being provided to meet health needs. These tended to relate to arrangements not being made in good time to meet identified needs, rather than deficiencies in services available to people. For example, there were sometimes delays in referring a person to another doctor or other health service following a care review meeting, and care staff did not always check to make sure a person had received an appointment following a referral. We drew these to the attention of care home managers.

The quality of documentation of physical healthcare and investigations in personal plans was variable. Many homes had developed separate summary notes to record any investigations and professional input to a person's care; including input by GPs, visiting nursing staff and social workers. We thought this was a good way to keep all staff up-to-date with the person's healthcare. In the homes that did not do this, it was hard to find important health information among large amounts of paperwork.

We expect visiting health professionals to record treatment they are giving in each personal plan. We found one care home where a visiting nurse took regular blood samples



from some people. We found no records of what this was for and the nurse in charge of the home did not know either.

We also looked at personal plans for evidence of routine health checks and physical investigations. Practice and recording varied and the poor organisation of some records made it difficult to find results.

When we looked in more detail at 90 personal plans we found that, in the previous year, there were urine test results for 29% of people and a blood pressure record for 50% of people. We thought everyone should have these tests at least once a year.

Blood tests were performed or offered for 31% of people. Almost everyone had their weight recorded at least monthly and most had weight charts and a record of body mass index.

We were impressed with good input from dieticians and speech and language therapists where there were concerns about weight loss and swallowing difficulties. We found three people who were not getting proper attention for weight loss and made sure the care home staff took appropriate action.

Most significantly, very few people (around 6%) had a record of a planned physical health assessment by the GP and we found little evidence that medication was being reviewed by the GP or pharmacist. GPs seldom attended review meetings.

We found that care home staff did not always know enough about the health of the people they cared for and did not use health information in the personal plan to give the best care. Care homes should keep a summary of important health information.

Poor knowledge of healthcare needs can put people at risk. For example, we found one person who had dementia, epilepsy, a history of schizophrenia and severe physical and communication problems. The lack of information in the personal plan meant that staff could not fully meet the person's healthcare needs. Care home staff thought the person had suffered what they called "little strokes". There was no mention of this in his personal plan and staff did not have a complete knowledge of the purpose of the various medications they administered.

Although the person had lost a lot of weight in the previous year, we found no record of referral to a dietician. The person had reportedly regained some weight as a result of action by the care home staff, but we found no recent weight record because the care home scales were not working. None of this important information had been discussed at a recent care review meeting.

We brought all this to the attention of the social work department, who are now fully reviewing this person's care.

What action we think care homes should take in this area

Care homes should:

- make sure that all people who are living in care homes have a full health and social care assessment on or before admission to the care home
- make sure that people with dementia have a planned, routine physical health assessment by their GP at least once a year. This should also include a medication review
- make sure that personal plans include areas for keeping a record of physical health assessments and care; this should include the outcome of contacts with health professionals and a summary of investigations and results
- update personal plans for significant physical health problems to ensure that staff know if they need to watch out for anything in particular and what action to take if necessary
- make sure that care staff are trained to react to significant changes in a person's weight and ask for expert advice, for example from dietitians.

6. Managing medication

Key message

Care homes should regularly review, together with GPs and pharmacists, how they manage medication. This would help to make sure medication is being used more appropriately, efficiently and safely.

The National Care Standards for care homes for older people state:

“If you need to take medication, staff know this and there are arrangements in place for you to take your medication safely and in the way that suits you best.”

We asked about the medication system the care homes used and looked at medication records for older people in the 30 care homes.

This part of the report sets out what we found about:

- how care homes get medicines for people in their care
- what medication records care homes use
- the role of pharmacists
- administration of medicines.



It also sets out:

- what we did to safeguard the welfare of people in care homes
- what should happen next.

How care homes get medicines for the people in their care

People in care homes should only be given medicines which have been prescribed for them by their GP, dentist or someone else authorised to prescribe medicine. In all the care homes we visited, medicines were prescribed for each person by their GP.

After medicines have been prescribed they can be picked up at a community pharmacy. Some GP practices in rural areas dispense medicines for their patients.

A community pharmacy dispenses the medicines based on the instructions the GP has written on the prescription. Each supply of regular medicines usually covers 28 or 56 days.

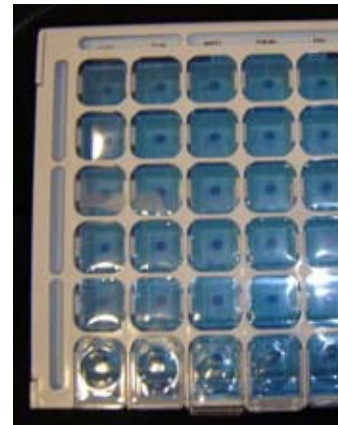
Medicines can be provided in monitored dosage systems like the one illustrated below. In 27 of the care homes we visited, medicines were administered using these systems. The other three homes administered medicines from original packs.



28 day monitored dosage pack



Original packs



Seven day monitored dosage pack

Good practice: what we would expect

We expect care home staff to check the NHS prescription forms that GPs sign, before the community pharmacy or GP practice dispenses the medicines. This is to ensure that the prescriptions agree with what the home ordered.

It is good practice for care homes to keep copies of the NHS prescriptions forms, so that staff know what medicines the doctor currently wants the

person to be given. The signed prescription also gives the care home staff permission to administer a medicine.

What we found

The majority of care homes did see the NHS prescription forms before the medicines were dispensed. Six care homes did not. We gave these care homes recommendations that they should do this.

Eight care homes did not keep copies of the NHS prescriptions forms; we also issued recommendations to them to do this.

An NHS prescription form from Scotland, dated 1/11/04. The patient is Mrs Jane Smith, 15 Main Street, Anytown, HG4 8RG. The form lists three items: Tictac Spearmint Sweets (Send <14>, Label 2 sweets in the morning), Tictac Fresh Mint Sweets (Send <14>, Label 1 Sweet twice daily), and Rice Snaps (Send <14>, Label 1 twice daily with milk). The form is signed by Dr J Findlay, Tannochbrae, HG4 8RG. The form number is 240423367831.

What medication records do care homes use?

Example of NHS prescription

We looked at the medication records for all older people in the care homes that we visited, apart from those who managed their own medication or were in the home for a short stay.

Good practice: what we would expect

We would expect care homes to keep accurate, up-to-date records of all the medicines that have been ordered, taken, or not taken, and disposed of (Handling of medicines in social care, 2007). Care homes must by law keep records of medication. These may be needed as evidence in court cases or complaint investigations.

What we found

The medication records in most (28) care homes were on pre-printed medication administration recording (MAR) charts supplied by the community pharmacist. The details printed by the pharmacist on this record should be exactly the same as on the pharmacy dispensing label.

MAR charts usually allow staff to record all the medicines they administer over a 28-day period. They can also be used to record what medicines people receive, or refuse, and what is not used. (The Appendix has examples of MAR charts we found during our inspections.)

The two remaining care homes had developed their own in-house recording system.

We were concerned to find none of the 30 homes had a system for recording medicines that could provide a complete, up-to-date record of:

- all the medicines ordered
- whether they were taken or not
- what was disposed of.

In 24 (80%) care homes we made a requirement that medication recording needed to improve. In the other six (20%) homes there were fewer recording issues and we gave them a recommendation to improve practice.

We highlighted issues about the pharmacy service in 50% of the homes we visited. This was usually because the quality of the MAR charts provided by the community pharmacist was not of the standard set out by the Royal Pharmaceutical Society of Great Britain (RPSGB). The RPSGB is the professional body which regulates pharmacists and community pharmacy premises.

Examples of poor practice

Problems we found on MAR charts included:

- duplicated entries
- tablet and liquid versions of the same medicines
- several preparations containing paracetamol
- short treatments like antibiotic eye drops or medicines for a bout of sickness or diarrhoea left on the chart for months.

We found MAR charts where the pharmacy had printed suggested times for giving an antibiotic at 08:30, 12:30 and 21:30, when the medicine was prescribed by the GP as “three times a day at regular intervals”.

We found records where the strength of the medicines had been increased or decreased by the GP, yet the pharmacy left both strengths of the medicine on the record.

In one home we found the pharmacist had produced MAR charts for medicines they had not supplied.

Care staff said that sometimes, when they asked the pharmacy to remove discontinued items from the MAR chart, it could take several months for the pharmacy to do so.

Some staff did not understand that they had to let the pharmacy know when a medicine was no longer used so that it could be removed from future MAR charts.

The role of pharmacists

Every service had most or all of their medicines supplied by a community pharmacy, but there was very little evidence of clinical pharmacy input. The role of pharmacists in care homes tended to be supplying medicines and advising how to store them and keep records.

Good practice: what we would expect

We expect care homes to keep records of visits by healthcare professionals. Pharmacists have an important contribution to make and we expected to see evidence of visits to individuals.

What we found

Within the sample of care plans we examined, we found no records of visits from a pharmacist to see people living in care homes.

We found that some community pharmacy companies provided training to care staff about keeping medication records and how to use monitored dosage systems.

In some cases the pharmacy produced a MAR chart with codes for care homes to use to explain why a medicine was not administered. One particular problem with “when required” medicines was the code N, which stands for “offered but not required”. This was commonly used even when the person taking the medicine was unable to express whether or not they wanted it.

Many care workers told us that when new codes were introduced no-one told them what they were for or what they meant. (See example in the Appendix).

Some care home staff told us that a pharmacist visited the home regularly. When questioned further a lot of staff did not know if this was a pharmacist from the community pharmacist, a clinical pharmacist, or a pharmacy technician attached to the GP practice. Community pharmacies are local chemist shops and pharmacies in some supermarkets, where people have their prescriptions dispensed. Clinical pharmacy is where a pharmacist uses their expertise in medicines to give advice about the safe, appropriate and cost-effective use of medications.

Administration of medicines

We gave eight care homes a requirement reflecting our concerns about the poor handling of medicines. Reasons for these requirements included:

- A care home did not give a medication for epilepsy because the person was asleep. It is very important that this type of medication is given regularly at the prescribed times.

- A weekly medicine was recorded as being given every day.
- A cream prescribed twice daily was applied only once a day.
- A person did not get medication for several days because the care home had not ordered it.

What actions we think should be taken in this area

Care homes:

- should use the information in the National Care Standards to make sure arrangements are in place for people to take their medication safely and in a way that suits them
- should see the NHS prescription forms before medicines are dispensed
- must make sure their medication records provide a complete and up-to-date audit trail of medicines kept in the home and comply with guidance issued by the Royal Pharmaceutical Society of Great Britain (RPSGB)
- should have regular advice from a pharmacist on using medications safely, appropriately and cost-effectively; this would improve knowledge of medications among care staff and help to inform people who are able to give consent for their treatment.

Community pharmacies:

- must ensure that MAR charts they provide for social care services comply with the guidance issued by the RPSGB.

7. Managing challenging behaviour and the use of medication

Key message

Medication to manage challenging behaviour should be a last, not a first resort. Personal plans should address the causes and outline a range of interventions to be used.

This part of the report sets out what we found about:

- what types of medication care homes are using
- how well care homes use care plans to manage medication and challenging behaviour
- covert medication: how care homes overcome reluctance or refusal to take medication.

What types of medication care homes are using

We collected information about the medication records of 1,335 people. Care home staff reported that 946 (71 %) of these people had varying degrees and types of dementia.

We took details of six classes of medicines including their names, dosage and how often they were given. In some care homes we were able to record when the person started getting the medicine. We also noted if the medicine was given as a liquid, was crushed or given in a disguised form, for example in food or drink.

Types of medicines

Medicines used to treat people with dementia can be divided into two groups:

1. Medicines used to treat symptoms such as poor memory, not being able to concentrate well, and difficulty in going about daily living. These can improve mental function for some people. We refer to these as “cognitive enhancers”
2. Medicines used to treat behavioural symptoms, like agitation, verbal and physical aggression, wandering and not sleeping. We refer to these as “psychoactive” medicines.

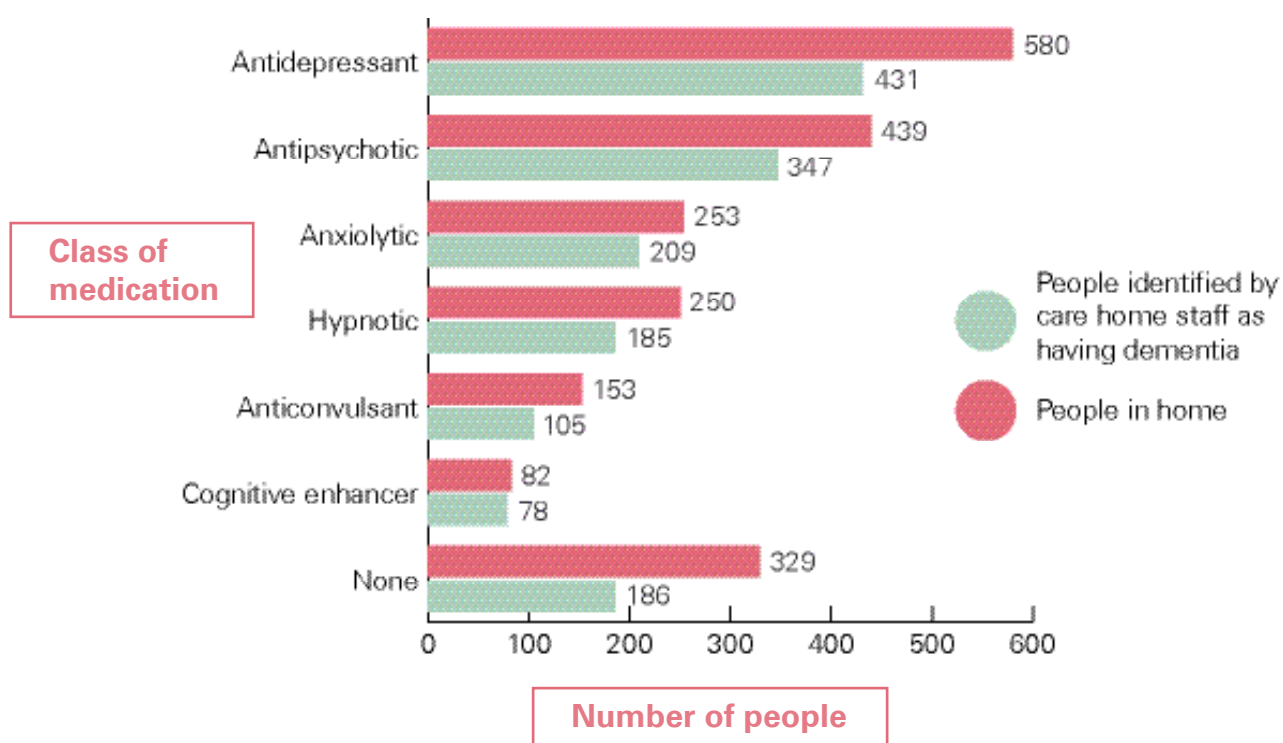
Five types of psychoactive medicines are commonly used to treat these behavioural symptoms:

- antipsychotic (also called neuroleptic) medicines used to treat symptoms such as agitation, delusions or hallucinations
- antidepressant medicines used to treat depression
- anxiolytic or tranquiliser medicines used to relieve anxiety and reduce tension and irritability
- anticonvulsant medicines used to prevent fits and seizures or to calm mood
- hypnotic medicines used to help people get to sleep at bedtime.

Many of these medicines have side effects which can make a person sleepy, confused, lack co-ordination, develop a tremor or become agitated.

What we found

Of the 1,335 records we looked at we found that 1,006 people (75%) were taking one or more of the types of medicines described above. We thought this to be excessive and looked at the specific ways in which the medication was being used.



Data source: Care Commission survey (August 2008 - March 2009)

The graph above shows how many people are on each class of medicine and how many of those were identified by care home staff as having dementia.

The types of medication care homes are using.

- Eighty-two people (6%) were on medication thought to help slow the progress of symptoms of dementia. Of these, 67 were also taking one or more psychoactive medicines. We thought this was a bit unusual and highlighted this to the care home staff to discuss with the prescriber.
- A total of 439 people (33%) were taking antipsychotic medication. While it may be helpful for some people in relieving symptoms such as agitation, delusions or hallucinations, there are known risks for people with dementia. Most recent evidence is that all antipsychotic drugs increase the risk of stroke (Drug safety update March 2009).

Eighty-five people were taking olanzapine or risperidone, despite specific warnings at the time about these drugs in the British National Formulary (BNF), which provides up-to-date guidance on prescribing, dispensing and administering medicines.

Also, 19 people were taking two types of antipsychotic drugs and four people were taking three types. We doubt if there are good medical reasons for this and have asked doctors to review their prescribing.

- We found that 480 people (43%) were on an antidepressant. Trazodone, a sedating antidepressant, was most often used although there were huge variations in its use across the country. Of these, 13 people were being given trazodone on an extra “as required” basis. We think that it is wrong to use trazodone in this way.
- A total of 253 people (19%) were taking medication which may relieve anxiety and irritability. Lorazepam was the most commonly prescribed (133 people). Although the BNF states that treatment with these medicines should be used for the shortest possible time, we were concerned to find that many people had been taking them for more than six months.
- We found 250 people (19%) were taking sleeping tablets. Temazepam and zopiclone were the most commonly prescribed (100 people on each). The BNF says that hypnotics should be avoided in older people as they are at greater risk of becoming confused and losing muscle co-ordination so falls are more likely.
- A total of 153 people (11%) were taking anticonvulsant medication, which is medication to prevent fits or to calm mood. We often found it difficult to work out from personal plans if these medicines were being given to prevent fits, as a painkiller, or to calm the person’s mood.

We had concerns that many people had been on the same medication for some time without regular review. Some records contained a start date for the medication. Of these, we found:

- 91 out of 166 people (55%) who were taking the same antipsychotic dose for more than one year
- 37 out of 81 (46%) who were taking the same hypnotic dose for more than one year
- 35 out of 77 (45%) who were taking anxiolytics (tranquilisers) for more than one year.

How well care homes use personal plans to manage medication and challenging behaviour

People with dementia may get agitated quite often and display what is often called challenging behaviour. They are sometimes given medication to treat this. We wanted to know how care staff managed this behaviour. We looked at personal plans to see how this information was recorded.

Good practice: what we would expect

We would expect to see information in the personal plan about the action staff should take if a person becomes agitated or aggressive. This would include how staff might effectively attract the person's attention and divert them. A good care plan would also include how medication fits in to the way the person is cared for. The personal plan should explain:

- what the medication is prescribed for
- when it has to be used
- when it should be reviewed by the prescriber
- the potential side effects
- any checks or blood tests which should to be carried out.

The personal plan should record that the person or their family, carers or guardian are aware of what the medicine is for, have given consent for its use and know the side effects. Staff should monitor the medication and record whether or not the treatment is effective and any side effects.

The prescriber should be closely and continually involved with anyone given sedative or tranquilliser medicines. The prescriber should frequently monitor the dosage and its continuing need, for as long as the medicine is prescribed.

What we found

We looked closely at the care plans for 90 people subject to welfare guardianship or who did not have friends or family. We found areas of good practice where assessments, plans and interventions were in place. Others' personal plans did not record this area well, if at all.

In most cases we found that care homes had assessed the risk of someone in their care becoming agitated or aggressive. Personal plans were in place for most people although these varied in quality.

We found some excellent plans which clearly reflected the person's needs. For example, one plan included diversion techniques tailored to the person: "discuss old cars and the mechanics of them."

Other personal plans lacked such individual detail and concentrated on how to manage problems rather than how to prevent them through staff talking to and reassuring them.

We looked in more detail at the personal plans for about 10% of all people who were being given psychoactive medication to see how it was in managing challenging behaviour.

Most plans for challenging behaviour did not mention the medication or when this was, or should be, reviewed. One person had a personal plan for

supervision while drinking a glass of Baileys at night, but did not have a plan that mentioned the two antipsychotics and an antidepressant that they were taking.

Sometimes people in care homes are prescribed medication to treat restless or agitated behaviour, with instructions that it can be given “when required”. In many services the personal plans we looked at did not tell staff when, how often and how much of this medicine they should use.

In another example, one person had, several months before our visit, been prescribed a tranquiliser to be given just before a visit from the podiatrist. The information explaining when to use this medicine had not been recorded in the personal plan and the records now stated that it could be given “when required”.

We also found evidence of remote-prescribing in the care plans. Remote-prescribing is when the GP prescribes medication without having seen their patient. It is a concern that medication may be prescribed in this way. We found cases where it appears to have been done to provide benefit to care staff and not because of the healthcare needs of the person living in the care home.

An example where the benefit to the person was not clear was in a care home’s records, which stated: “commenced on Lormetazepam 0.5mg at night... for disruptive behaviour/insomnia”. There were no corresponding records to show that the prescriber had seen the person on or around this date. In another case a staff member confirmed that an antidepressant was prescribed over the phone, without the GP assessing the person first or reviewing them afterwards.

Covert medication: how care homes overcome reluctance or refusal to take medication

This is where care staff administer any medical treatment in a disguised form. The most usual way is to put it into food and drink. This means the person is unknowingly taking medication. This is likely to be because they refuse, as a result of their dementia, to take medication that is necessary for their physical or mental health.

Good practice: what we would expect

We would not expect to see a lot of medication being given in this way. When it is we expect covert administration to be managed safely and in accordance with the legal and best practice framework.

Personal plans should be in place that record details of everyone who had agreed the decision to give each medicine this way.

What we found

In nine care homes staff told us, or we found evidence, of people having their medicines in a disguised form; usually in food or drink. Of the 1,335 records we looked at, we found that twenty people (1.5%) were getting medicines in this way.

However, we were concerned that very few care staff were aware of the Mental Welfare Commission's best practice publication 'Covert medication - legal and practical guidance'.

If someone is being given medicines covertly, the guidance states that an Adults with Incapacity Section 47 certificate should be in place. (These certificates are a legal safeguard: doctors must fill one in to record medical treatment for people who cannot consent to it themselves.) Even when such certificates were in place we found that they were often not completed properly.

In seven homes (23%) we made a requirement about recording the administration of medication in a disguised form. We gave these and another four homes recommendations about keeping records using the Mental Welfare Commission's best practice guidelines, and about safety issues with crushing tablets and opening capsules.

What actions we think should be taken in this area

Care homes:

- should develop personal plans that focus on managing challenging behaviour; plans should:
 - include preventative measures
 - include the use of diversional techniques
 - detail what alternative techniques can be tried before resorting to medication
- should develop personal plans that detail how to use medication that people receive for a mental disorder; plans should include details of when the doctor and others will review the continued appropriateness of the medication
- must ensure that personal plans for covert medication follow the principles of the Mental Welfare Commission's 'Covert medication - legal and practical guidance'; plans should detail which medication is to be given covertly, how it is to be given and the advice of the people involved in this decision.

Other action needed:

- doctors and pharmacists need to work with care homes to make sure that covert medication is given safely and within the law



- doctors should review all prescriptions for antipsychotic drugs for people with dementia with a view, wherever possible, to stopping the drug, or trying a suitable alternative
- health boards need to ensure expert education and support for doctors who prescribe to care home residents.

8. Legal protections and safeguards

Key message

A person's freedom should be respected as far as is possible and care homes must look at practices and cultures that could be overly restrictive. Care homes also need to understand the rights of people with dementia and the laws and safeguards that exist to protect them.

The National Care Standards for older people in care homes state:

"You and your carer, relatives or representative must be confident that the home is being managed properly, in line with relevant legislation and guidelines"

This should include knowledge of the powers of any guardians or attorneys that exist and proper legal safeguards for people who may be deprived of liberty.

We expect care home staff to follow the principles of the Adults with Incapacity (Scotland) Act 2000. All decisions they make for people who cannot decide for themselves must:

- benefit the person
- restrict the person's freedom as little as possible
- take account of what the person wants
- try their best to involve carers, relatives and people working closely with that person.
- help the person to do things for him/herself.

We considered the following aspects of legal protections and safeguards:

- welfare and financial guardianship
- restriction to freedom.

Welfare and financial guardianship

Guardianship is a legal power which the Adults with Incapacity Act explains in detail. A guardianship order allows relatives, carers or others, such as the local authority, to make decisions about, or take actions that affect the welfare or financial affairs of people unable to make these decisions themselves.

One of the main uses of a guardianship order is to authorise not just where a person should live, but also the care and treatment they should receive and how this will be given. If someone has been made a guardian, it is important that care providers know what powers they have been given.

Good practice: what we expect

It is important for managers of care homes and their staff to know:

- who in their care is subject to the Adults with Incapacity Act
- to whom powers have been granted
- the extent of these arrangements
- the length of time the authority lasts
- the specific powers that have been granted.

If a person living in a care home is no longer able to make decisions, an application can be made to the court for guardianship. This application can be made by a relative, a carer, the local authority or any other interested party. The order will last for a fixed period, although some orders are indefinite.

If a private individual is the guardian, the local authority will allocate a supervisor, who is usually a social worker.

If a person living in a care home retains the ability to make decisions, they can make out a power of attorney. This gives a trusted person the power to make decisions or take actions on their behalf if they lose their ability to make decisions themselves. The kind of decisions they can make will be included in the power of attorney.

What we found

We met with 90 people, most of whom were subject to guardianship orders or who had no friends or family. Of these:

- 32 had private welfare guardians
- 30 had local authority guardians.

Understanding by care staff of the differing powers of guardians and attorneys varied greatly from care home to care home, as did how these powers were recorded.

Most of the care homes we visited were unable to provide a comprehensive and up-to-date list of people for whom power of attorney or guardianship was in place. Some provided a list of everyone for whom a formal appointment had been made, but the list lacked details of what powers attorneys and guardians had. Care home staff would need this information.

In care homes comprising several types of units, for example a specialist dementia unit, we sometimes found differing knowledge and practice between those units.

Of the 30 people with local authority welfare guardians, only 10 (33%) had a record of the powers of the guardian in their personal plan. Of the 32 people with private welfare guardians, only 12 (37%) had a record of the guardian's powers. Personal plans often did not indicate that formal discussion had taken place with a person's welfare guardian about their powers; this information was often in a separate file.

The Mental Welfare Commission's guidance, 'Working with the Adults with Incapacity (Scotland) Act' (2007) includes a good practice checklist of information that care home staff should use to safeguard people's rights. They should place this in the person's file when completed. We found the completed checklist in only eight out of 64 care files where it would have been helpful to have it in place.

Restrictions to freedom

Good practice: what we expect

The National Care Standards for care homes for older people state:

"You are free to come and go as you please, unless there are specific legal requirements which prevent this"

"You (will) know that the care home has a written policy and procedures on the conditions under which restraint is used, and that staff are fully trained and supported in the use of restraint. If it is necessary to restrain you on certain occasions this will be written into your personal plan and records kept of any incidents involving your restraint. You can expect to be supported after any episode of restraint."

The Mental Welfare Commission's publication 'Rights, risks and limits to freedom' (2007) is a best practice guide to the legal, moral and ethical problems associated with restraint.

We wanted to know if staff working in care homes were aware of this guidance and if it was being used to guide staff and safeguard people living in care homes. This is an important piece of guidance as it uses the principles which form the basis of the Adults with Incapacity (Scotland) Act 2000 to make decisions about limiting a person's freedom.

What we found

When people were being restrained we found staff were familiar with and referred to guidance on best practice. Care homes usually recorded the use of bed rails and lap straps in personal plans.

When we looked at personal plans, we found risk assessments (e.g. for falls) and the use of pressure pads to alert staff if someone gets out of bed at night. Some plans did not have a full assessment of why restraint was needed. There was often no record of consultation with relevant others, for example carers or other professionals.

Personal plans rarely referred to the need for doors to be locked, or why this was necessary for the person. We found one in seven people who expressed the wish to leave, were prevented from doing so by a locked door.

Doors were locked in most of the care homes we visited. Some doors could be opened using a keypad code but it was not clear from personal plans who had easy access to the outside and who did not. Only a very small minority of people had the freedom to come and go as they pleased, even into a secure internal garden area.

This meant that many people were being denied freedom, even those without the protection of a guardianship order.

What action we think should be taken in this area

Care homes should:

- make sure that a copy of the Mental Welfare Commission's guidance, 'Working with the Adults with Incapacity (Scotland) Act' (2007) is available in every care home and used to promote good practice; the checklist in that document should be used when a person has a welfare guardian or power of attorney
- make sure that copies of guardianship orders and power of attorney documents are available to care home managers
- make sure that staff are aware of any requirements to seek consent, and situations in which they should seek consent, from guardians and attorneys
- make sure, if they physically prevent people from leaving, that personal plans record:
 - the risks they have assessed
 - who they have consulted
 - why the restriction is in place.

If the level of restraint a care home uses could be seen as a form of detention, the care home should seek legal authority in the form of guardianship under the Adults with Incapacity (Scotland) Act 2000.

Guardians and people granted power of attorney should:

- let care home managers know when and what they expect to be contacted about; the Office for the Public Guardian can provide guidance on this (it is accessible online at www.publicguardian-scotland.gov.uk).

9. Consent to treatment

Key message

People should receive medical treatment that is in line with the law. If people are not able to consent to their own treatment, care homes should use the law properly to safeguard them.

Good practice: what we expect

The National Care Standards for care homes for older people state:

“You may not understand that you need to take medication and what will happen if you do not do so. If so, there are legal powers that allow other people to give permission for you to receive treatment if it is necessary for your health and welfare. The staff will work in line with these legal powers.”

All actions that care homes take to treat people who are unable to consent to their treatment must obey the principles of the Adults with Incapacity (Scotland) Act 2000 (AWIA).

Section 47 of the AWIA authorises medical treatment for people who are unable to give or refuse consent, except in emergencies. Under Section 47, a doctor or other authorised healthcare professional examines the person and issues a certificate of incapacity. It is required by law and it provides evidence that the treatment complies with the principles of the AWIA.

If someone else has the power to give consent on the person's behalf, such as a welfare attorney or guardian, care homes should ask their consent.

The second edition of the Code of Practice for Part 5 of the AWIA (2008), is the best practice guide to using Section 47 certificates and associated care plans.

What we found

Of the 90 people we assessed in detail, 63 (70%) had no up-to-date assessment of their ability to give consent, other than where this was done out at the time of a welfare guardianship application. In most care homes, doctors had not issued Section 47 certificates when someone was unable to give consent to be treated.

Only one in four people had Section 47 certificates in place, even though most of the people we saw were unable to give consent to be treated and were receiving medication which would require them to have a certificate in place.

The Section 47 certificates we found were often impersonal, too broad, or poorly completed and were not accompanied by a treatment plan. This is especially important when the person has complex physical healthcare needs.

Where treatments were recorded, most were described by the term “fundamental healthcare procedures”. Doctors seemed to think this covered more than the definition contained in the code of practice. Only in a few cases did certificates refer to specific treatments, for example “treatment of behavioural disturbance associated with dementia” or “prevention and treatment of infection”.

Care staff were often unaware of the need for Section 47 certificates and a treatment plan, or had been unable to gain the co-operation of doctors to complete them. Guidance on the need to consult with welfare guardians or welfare attorneys, whose powers extended to medical treatment, was not generally available for visiting doctors.

In many instances, doctors had visited and prescribed treatment without consulting the carer for the person. Private guardians were more likely to be consulted routinely but mainly because they were the recorded next of kin. Although nearest relatives should be consulted over matters of treatment, in the absence of a welfare guardian or welfare attorney, they are not authorised to give consent on behalf of the person.

The care home should consult with doctors about medical decisions as normal, but they must also consult with guardians (and welfare attorneys) if they have relevant powers, before decisions are made. It is, therefore, important that a care provider knows whether the attorney or guardian can consent to medical treatment.

We found Section 47 certificates with entries to authorise “covert medication” rather than the treatment the care home was giving. We also found Section 47 certificates with entries authorising restraint for individuals with dementia. This certificate can only authorise “force or detention” if it is immediately necessary and only for as long as is necessary. If there is a need for ongoing planned restraint, we think that care homes should consider seeking a guardianship order.

Care home managers varied widely in their understanding of the requirement for Section 47 certificates. Co-operation from some GP practices was poor to non-existent. When we contacted doctors, some said that they would not complete Section 47 certificates for all people who need them.



Care staff told us that in some instances doctors wanted to charge care homes for completing Section 47 certificates relating to their own NHS treatment of individuals. However, NHS guidance makes it clear that “where a general practitioner or an authorised healthcare professional, carries out an assessment and issues a certificate, no fee is payable” (NHS circular PCA (M) (2005)9).

What action we think should be taken in this area

Care homes and medical practitioners should:

- make sure that section 47 certificates and, if necessary, treatment plans are in place for all people who cannot consent to treatment, regardless of whether there is an attorney or guardian with the power to consent.

Care homes should:

- make sure managers are aware of the second edition (published in 2008) of the Code of Practice for Part 5 of the Adults with Incapacity (Scotland) Act 2000.

10. Staff knowledge and training

Key message

People with dementia should be cared for by staff who have the skills, knowledge and training to provide effective care.

Good practice: what we would expect

Staff at all levels should have received training in how to care for people with dementia. This will enable them to understand the difficulties in communication that a person with dementia may face, and help them express their wishes and needs (Home from home, 2007).

The National Care Standards for Care Homes for Older People state:

“You experience good quality support and care. This is provided by management and staff whose professional training and expertise allows them to meet your needs”.

The Regulation of Care (Scotland) Act 2001 also says that staff should have the skills and knowledge for the work they are employed to do.

We would expect all care home staff to have had some form of training on caring for people with dementia. We interviewed 30 care home managers and spoke with 47 care staff to find out about the type and level of training for staff.

What we found

We asked managers and care staff about specific dementia training they had received.

The document, 'Management of patients with dementia' describes the best evidence available for caring for and treating people with dementia. We found that the vast majority of managers and care staff had not heard about it and did not have a copy available for reference.

Only 10 care home managers had completed a recognised course in dementia training. However, we did find that The Alzheimer Society training programme 'Yesterday, today and tomorrow' was being used in some care homes to train care staff.

We also asked staff if they knew about other important guidance that should be used when caring for people with dementia.

We found that, overall, only 20% of managers and care staff were aware of Mental Welfare Commission best practice guidance, 'Working with the Adults with Incapacity Act in care homes', 'Covert medication – a legal and practical guide' and 'Rights, risks and limits to freedom'. Few homes had copies of the guidance.

There is evidence that different therapies have a positive effect on the lives of people with dementia. Therapies include art and music therapy, reminiscence and reality orientation (where staff take every opportunity to orientate people, for example by reminding them of where they are and the time of day).

Although most staff were aware of different types of therapies recommended for caring for people with dementia, they told us that they were not using them or encouraging them to be used as they did not feel their knowledge was sufficient and they did not have enough time.

The following comment in a personal plan highlights the need for care staff training: "unprovoked hostility, bad language and utter rudeness when given her medications - very ungrateful lady indeed".

The impact of dementia on people's behaviour was clearly not fully understood in this case. We believe this lack of understanding contributed to a judgmental and disrespectful response to a person with dementia.

What action we think should be taken in this area

People with dementia should be cared for by staff with the right skills, knowledge and training to provide effective care. Therefore, training for care home staff should include information about:

- the most common types of dementia
- the importance of valuing and respecting each person with dementia in their care
- how to help people with dementia to do as much as they can for themselves
- the importance of meaningful activity, for example socialising, cooking, reading or playing music, in maintaining a person's skills and self worth
- effectively managing challenging behaviour in people with dementia
- how to help people with dementia care for themselves from day to day
- the legal aspects of caring for people with dementia.

This training requires the involvement of a number of different agencies and health professionals.

appendix,
acknowledgements
and references



Appendix

MAR chart examples

CTOR	START DATE	END DATE	START DAY
	06/11/2008	03/12/2008	Thursday
MEDIATION PROFILE			
LITHIUM CARBONATE modified release tablet 200mg	TIME DOSE		
Take TWO daily	09:30		
None supplied this cycle.	13:00		
	17:00		
	22:00		
Sig.	Carried forward		
mmenced	08/12/2005	route	oral
LOFEPRAMINE sugar-free suspension 70mg/5ml	TIME DOSE		
Take TWO 5ml spoonfuls MORNING and NIGHT	09:30 10ML		
None supplied this cycle.	13:00		
	17:00		
	22:00 10ML		
Sig.	Carried forward		
mmenced	08/10/2008	route	ORAL
LOFEPRAMINE tablets 75mg	TIME DOSE		
Take TWO at 8am and 10pm	09:30 2		
None supplied this cycle.	13:00		
	17:00		
	22:00 2		

Lithium was discontinued on 3/9/2008 but still remains on a MAR chart which starts on 6/11/2008. These should have been taken off the MAR chart to reduce the risk of the medicines being given in error.

Lofepamine tablets discontinued on 3/9/2008, but remain on record along with Lofepamine Suspension which is given regularly from 6/11/2008.

From:	11/08/2008 to 07/09/2008	Period:	28	Start Day:	Monday
Print Date:	12/08/2008	Page No:	1 of 1		
Allergies:	None Known				
VIA PEG					
Medication Details		Time	Dose		
FLUPHENAZINE 50MG/5ML INJECTION		1000	*		
give a 42.5mg dose in the MORNING every 14 days ***NOT SUPPLIED BY PHARMACY MAR SHEET ONLY***					
Quantity: 10	Qty. Received	By:			
METOCLOPRAMIDE 5MG/5ML SF ORAL SOLN		1000	10		
Take TWO 5ml spoonful THREE times a day ***NOT SUPPLIED BY PHARMACY MAR SHEET ONLY***		1800	10		
		2200	10		
Quantity: 150ml	Qty. Received	By:	Started:	Qty. Returned:	By: Qty. Destroyed:
ASPIRIN 75MG DISP TABLETS		1000	1		
ONE to be taken in the MORNING ***NOT SUPPLIED BY PHARMACY MAR SHEET ONLY*** Take in water. Take with or after food.					
Quantity: 28	Qty. Received	By:	Started:	Qty. Returned:	By: Qty. Destroyed:
SIMVASTATIN 40MG TABLETS		2200	1		
ONE to be taken at NIGHT ***NOT SUPPLIED BY PHARMACY MAR SHEET ONLY*** Avoid consumption of grapefruit.					
Quantity: 28	Qty. Received	By:	Started:	Qty. Returned:	By: Qty. Destroyed:
PROCYCLIDINE 2.5MG/5ML SF SYRUP		1000	5		
Take ONE 5ml spoonful in the MORNING ***NOT SUPPLIED BY PHARMACY MAR SHEET ONLY***					

Pharmacy has produced a MAR chart for medicines which were not supplied by them. There is a risk of error if the pharmacy did not see and base the record on a current prescription.

MAR chart example

Allergies: _____ Period: 28

StartDate: 12/11/2008

		WIC 12/11/2008									WIC 19/11/2008									WIC 26/11/2008									WIC 03/12/2008									
		24/11/08																																				
MEDICATION DETAILS		TIME	1	2	3	4	5	6	7	8	9																											
HALOPERIDOL (SERENACE) 500MCG CAP		9.00																																				
Take ONE tablet THREE times a day FOR AGITATION		12.00																																				
This may cause drowsiness. If affected do not drive or operate machinery. Avoid alcohol.		15.00																																				
Quant. 90	Recd.	by	Returned/Destroyed																																			
TRAMADOL 50MG CAPSULES		9.00																																				
Take ONE capsule FOUR times a day		13.00																																				
This may cause drowsiness. If affected do not drive or operate machinery. Avoid alcohol.		16.00																																				
		22.00																																				
Quant. 224	Recd.	by	Returned/Destroyed																																			
Haloperidol (Serenace) 500mcg																																						
Take one tablet 3x a day																																						
for agitation																																						

Expect dates printed in these boxes.

This MAR chart should start to be used on 12/11/008. The top box has Haloperidol 500mcg three times a day for agitation and if the record was used properly the first dose given on 24/11/08. What we think the record is stating is that first dose was given from 13/11/08 till 28/11/08. The third box then has the same Haloperidol instruction handwritten in it and we think the record is for administration from 29/11/08 till 26/12/08. The fourth box then has the instruction for Haloperidol to be given FOUR times a day from 28/12/08 till 13/1/09.

These hand-written entries are not dated or indicate the person who wrote them.

Usually MAR charts have the dates of each day printed on them. Looks as if staff thought that the printed 1 to 28 was the date.

The following care homes took part in the joint visits. We would like to thank them for their cooperation throughout the visit programme.

Abbotsford Nursing Home, Methil
Abercorn Nursing Home, Edinburgh
Ailsa Craig, Glasgow
Arran View Care Home, North Ayrshire
Bandrum Nursing Home, Fife
Banks O'Dee Nursing Home, Aberdeen
Braid Hills Nursing Centre, Edinburgh
Budhmer House Care Home, Isle of Skye
Burnfoot Nursing Home, East Ayrshire
Cairnie Lodge Care Centre, Abroath
Carberry House, Musselburgh
Castle View Nursing Home, West Dumbartonshire
Collisdene Care Centre, South Lanarkshire
Copper Beech Care Home, North Berwick
Craigbank Care Home, Glasgow
Forfar Avenue, Glasgow
Fullarton Nursing Home, North Ayrshire
Kingdom Care (Kincardine) Ltd, Fife
Kirkburn Court Care Home, Aberdeenshire
Laurels Lodge Care Home, Aberdeen
Meadowvale, West Lothian
Meallmore Lodge, Inverness
Parkhouse Manor Care Home, East Renfrewshire
Riverside View, Dundee
Torbrae Care Home, Glasgow
Warren Park Nursing Home, North Ayrshire
William Simpson's Home, Stirlingshire
Woodlands Nursing Home, West Lothian
Woodside Care Home, North Lanarkshire
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Yesterday, today, tomorrow, the Alzheimer's Society's video-based training programme. www.alzheimers.org.uk

Some useful websites

- Alzheimer Scotland
www.alzscot.org
- Care Commission
www.carecommission.com
- Help the Aged
www.helptheaged.org.uk
- Mental Welfare Commission for Scotland
www.mwcscot.org.uk
- Office for the Public Guardian
www.publicguardian-scotland.gov.uk
- Stirling Dementia Services Development Centre
www.dementia.stir.ac.uk
- Scottish Government Adults with Incapacity site
www.scotland.gov.uk/Topics/Justice/law/awi
- Scottish Intercollegiate Guidelines Network
www.sign.ac.uk
- NAPA (National Association for Providers of Activities for Older People)
www.napa-activities.co.uk
- Regulation of Care (Scotland) Act 2001
www.opsi.gov.uk

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-هه بایتسد یم وونابز رگیدی روا وولکش رگیدی رپ شرازگ تعاشا هی

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