Health, Social Care and Sport Committee

Thursday 21 September 2017

Item 8 – Inquiry into the use of antipsychotic medication in care homes – evidence session 5

Notes of session with an individual affected by the issue. This is a summary of what the individual told the Committee.

- The Committee heard from an individual whose mother had been prescribed anti-psychotic medication after a diagnosis of dementia.
- Her mother was admitted to hospital following a house fire, and this led to a diagnosis of dementia to finally be confirmed.
- The daughter told us that from the family had to deal with problems with inexperienced care home staff from the outset. Her mother was placed in three care homes overall.
- As a result of dementia, her mother was verbally challenging, but there appeared to be no attempt to understand what was causing the aggression until the Community Psychiatric Nurse (CPN) became involved.
- Quetiapine, Lorazepam and Diazepam were all prescribed by CPN in the first care home.
- Initially CPN came once a month to perform medication reviews, but that stopped when the CPN went on sick leave. No replacement put in place.
- Her mother gained over two stone in weight, partly because the medication is stated as stimulating appetite and a sweet tooth. In addition, her mother was not offered any exercise.
- Due to increased weight and being immobile due to effect of drugs a fall led to the mother being re-admitted to hospital for treatment of a broken hip. During that stay in hospital, and because of the challenging behaviour, the witness's mother was restrained on occasion and regularly given sedating medication Lorazepam and Diazepam.
- The mother was transferred to the older people's unit in the local Psychiatric Hospital for assessment. Further medication given. Quetiapine stopped and Trazadone given plus other 'calming' medicines.
- After being moved to another care home, the witness was told after just seven days that they couldn't cope with her mother and she had to leave. Following an intervention by the family, this did not happen and a key worker and social worker were assigned.

- Despite having a good relationship with the key worker, he left after two months because he didn't like the approach being taken and what he was being asked to do.
- Increased Trazodone was prescribed to the mother, and it did settle her symptoms.
- For the final 18 months of the witnesses' mother's life she couldn't speak. She was overwhelmed by a 'huge chemical cosh', which was prescribed and administered on the advice of professionals.
- When the palliative care team became involved towards the end of her mother's life they withdrew all medication. For the last 3-4 days of the mother's life she was lucid enough on occasion to talk to her family.
- The witness suggested a number of recommendations:
    - Staff training – including dementia specific skills – is essential and needed;
    - The prescribing of antipsychotic medication shouldn't be the default position;
    - Professional clinical staff need to talk to the family more and involve them in the decision-making.