Review of psychoactive medicines in care homes for older people during the pandemic

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Executive summary

The Covid-19 pandemic and national lockdowns created particular and stressful challenges for older people in care homes and those caring for them, such as the necessary suspension of many of the normal services and supports, the restrictions on visiting in care homes and changes to staffing levels and personnel.

In 2022, the Scottish Government commissioned the Care Inspectorate to examine the prescribing, use and review of psychoactive medication in care homes for older people during the pandemic.

This was primarily to determine the effect of the Covid-19 first wave and national lockdown on the:

- prescribing and use of regular and when-required psychoactive medicines
- role of care homes in care planning, and monitoring the use of and continual need for psychoactive medicines
- support by external healthcare professionals to care homes.

This work was conducted at a time of significant strain on the care home sector, including staffing capacity issues, and we are grateful for the support of the sector in completing this work.

The findings show that although overall there was a small reduction in the number of contacts with care homes at the beginning of the Covid-19 first wave, the prescribing of psychoactive medicines was unaffected; external healthcare professionals used alternative methods to remain in contact with homes.

Despite concerns to the contrary, there was no increase in the use of when-required sedating psychoactive medicines at during the Covid-19 first wave (March - July 2020).

This report notes the continued high psychoactive medication burden for older people in care homes at pre-pandemic levels and the varied experiences of care homes in trying to reduce this as we come out of the pandemic.

Finally, this report identified some examples of care homes using person-centred, non-pharmacological approaches to manage stress and distress symptoms and reduce the need for use of psychoactive medicines.

Background to report

In 2020, the Scottish Government engaged directly with people who live with or support people living with dementia, including social care and health professionals. They also engaged with national groups and charities representing older people, and with the care sector.

Feedback on the impact of the first wave of the Covid-19 pandemic included concerns around: the suspension of many of the normal services and supports for staff and people in care homes; social isolation; physical deterioration affecting the mental wellbeing of a loved one in a care home; the effect of the pandemic on the mental health of professionals caring for people with dementia. Some of these concerns are also reflected in the Age Scotland report Locked Down But Not Forgotten [(1)].

The feedback informed the Scottish Government document Dementia And Covid-19 – National Action Plan To Continue To Support Recovery For People With Dementia And Their Carers, [(2)] which was published in December 2020. The document pledged to understand the relationship between both the Covid-19 virus and the impact it had on care services and older people. One of the commitments made was to examine the use and review of psychoactive medication in care homes during the pandemic.

> Commitment 16: We will commission a study in partnership with the Care Inspectorate to examine the use and review of psychoactive medication in care homes during the pandemic.

Initial discussions on this work started in September 2020, and in April 2022, the Care Inspectorate was commissioned to look at the prescribing, use and review of psychoactive medicines before and during the first wave of the pandemic (March - July 2020).

Psychoactive medicines

Psychoactive medicines are substances that affect mental processes such as perception, consciousness, cognition or mood and emotions. Five types of psychoactive medicines are commonly used in care homes for older people: antipsychotics; anxiolytics; hypnotics; antidepressants; and anticonvulsants. In this setting, these medicines are often but not exclusively used in treatment of non-cognitive symptoms of dementia.

Dementia is a syndrome (a group of symptoms that consistently occur together) in which there is deterioration in cognitive function (the ability to process thought) beyond what might be expected from normal ageing. A person's memory, attention and ability to use language can all be impacted. These changes can be accompanied and occasionally preceded by changes in emotional control, social behaviour or motivation. Dementia is usually chronic or progressive in nature.

'Behavioural and psychological symptoms in dementia' (BPSD) is an umbrella term that embraces a mixed group of non-cognitive symptoms and behaviours such as delusions, hallucinations, agitation, emotional lability, depression, anxiety, apathy, social or sexual disinhibition, motor disturbance (for example repetitive activity) and sleep disruption [(3)]. 'Symptoms of stress and distress' (SSD) is a term alternatively used to describe some of the above behaviours.

Antipsychotics are used for treatment in a number of conditions including schizophrenia, bipolar disorder (sometimes called manic depression) and occasionally, severe anxiety or depression. They can also be effective in treating delusions, hallucinations, aggression and agitation in individuals with dementia [4,5]. These are symptoms that can be distressing for the person experiencing them, as well as for families and care staff. However, there are also serious risks associated with antipsychotic use in dementia [6-8] and concerns around prescribing levels and inappropriate use to manage behaviour [9,10].

In the UK, risperidone and haloperidol are the only antipsychotics licensed for BPSD, although other antipsychotics can and are used if the clinician considers the benefits to outweigh the risks. The guidance for antipsychotic use in dementia [8, 11-13] is that:

- they should be used only when non-pharmacological treatment has been unsuccessful and there is a risk of harm to the individual or those living with them, or they are experiencing agitation, hallucinations or delusions that are causing them severe distress
- they should be used at the lowest effective dose and for the shortest possible time
- the person should be reassessed regularly (usually 6 -12 weeks) to check whether they still need medication
- unless there is severe risk or continued extreme distress, the recommended default management is to discontinue the antipsychotic – with monitoring, ongoing assessment of contributing factors and continuation of non-drug treatments, based around the person's needs, abilities and interests.

Anxiolytics are used to relieve anxiety and reduce tension and irritability.

Hypnotics are used to help with sleep disturbance.

Benzodiazepines are the medicines most used for treatment of anxiety; some benzodiazepines are used as hypnotics; non-benzodiazepine hypnotics include Z-drugs like zopiclone and zolpidem.

Benzodiazepines can have serious side effects in older people, including drowsiness, confusion and risk of falls. Tolerance to their effectiveness can also develop and there is a risk of dependence, making withdrawal difficult [8]. Concerns over the risk to benefit ratio of sedating hypnotics in older people have been noted [14].

Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling or causing unacceptable distress [8]. Ideally, hypnotics should be reserved for short courses in those people who are acutely distressed, as long-term effectiveness cannot be assured. A major drawback of long-term use is that withdrawal can cause rebound insomnia [8]. Z- Drugs are not licensed for long-term use; dependence has been reported in a small number of people [8]. As with antipsychotics, there are concerns around prescribing level and use of these medicines in older people [10,15]. Previous research has shown an association between an increased number of psychoactive medicines (such as antipsychotics and benzodiazepines) and a lower quality of life in older people [16].

Antidepressants were found to be the most prescribed psychoactive medicine group in a recent review of prescribing data for care homes in two NHS boards [17].

Depression may precede and co-exist with dementia but the distinction between them can be difficult; negative changes in mood can accompany a diagnosis of dementia and as someone starts losing ability to socialise and perform daily tasks.

Pre Covid-19 reviews concluded that the evidence does not provide strong support for the effectiveness of antidepressants for treating depression and apathy associated with dementia, especially beyond 12 weeks of use [18,19], although for some people there may be an improvement in symptoms.

There is some evidence that certain antidepressants can reduce symptoms of agitation in dementia [20], however a more recent review found no benefit for people with frailty taking certain antidepressants but it did note common adverse effects with these medicines [21].

Anticonvulsants are medicines normally used to treat epilepsy or neuropathic pain. A recent review into the effectiveness and safety of medicines for BPSD in older people found one anticonvulsant reduced agitation and aggressive behaviour in people with Alzheimer's disease [21]. However, the review also noted adverse effects with this class of medicines including movement disorder and falls, and the need to balance the benefits and effects of prescribing these medicines.

Delirium and psychoactive medicines

Delirium is an acute state characterised by sudden altered level of consciousness and cognition. It can be hyperactive (with inappropriate behaviour, hallucinations or agitation), hypoactive (with lethargy and reduced concentration and appetite) or mixed (with symptoms of both). Symptoms of delirium often fluctuate over the course of the day.

Delirium typically occurs in people who have a predisposing factor such as advanced age or multiple health conditions when new physical factors are added, such as new medication, an infection, dehydration, or low levels of blood oxygen or blood glucose. Delirium may occur in people with or without dementia.

Delirium usually improves if its cause is found and treated. If a person's behaviour poses a risk of harm to themselves or others, or is causing severe distress, then a short course of treatment may be prescribed, such as a low dose of an anxiolytic sedative (lorazepam) or an antipsychotic (haloperidol or levomepromazine) [22].

Covid-19 and psychoactive medicines

The Covid-19 pandemic and national lockdown created particular and stressful challenges for older people in care homes and those caring for them, such as the suspension of many of the normal services and supports, the restrictions on visiting in care homes, and changes to staffing levels and personnel.

Appropriate use of psychoactive medicines can be beneficial in the management of symptoms of stress and distress and keeping people safe. However, inappropriate use can restrict peoples' lives unnecessarily and affect their physical and mental health.

There was some concern during and following the first wave of Covid-19 about the potential misuse of medication to sedate and/or control behaviour while caring for vulnerable people who may not understand social distancing guidelines [23,24].

This would include medicines prescribed on a when-required (or PRN) basis. These are medicines that should only be taken when the need arises, and/or for intermittent periods of time. They are not intended for regular, defined interval use. In addition to the prescribed medical criteria for use (for example, dose to be given at one time, minimum interval between doses and number of doses in a 24-hours period), care staff should have enough information (usually in the person's care plan) to make appropriate judgements about when the medicine should and should not be used for that person. For example, signs or symptoms to look out for as to the need for the medicine, and non-pharmacological alternatives to consider before administration of the medicine.

Small increases in the prescribing of certain psychoactive medicines were found in some Canadian nursing homes during this time [25], while the use of such medicines in acute hospitals increased in one Canadian region but not another [26].

Our first objective was to look at the medicines administration recording charts used in Scottish care homes for older people to determine the effect of Covid-19 and national lockdown on:

- the prescribing of regular and when-required psychoactive medicines.
- the actual use of when-required psychoactive medicines.

Following the Banerjee report [6] in 2009, there was a UK and international focus on reducing the prescribing levels of antipsychotic and other psychoactive medicines used in dementia [10], with guidelines on de-prescribing available to aid this process [27-29]. There is evidence that antipsychotic medicines could, in some cases, be safely reduced or withdrawn without a flare-up of BPSD for people living in long-term care facilities [29, 30], although a review suggests this may be more successful for those with milder symptoms [31]. In people with dementia cared for in a specialised hospital unit, high-dose antipsychotics were associated with worse discontinuation outcomes ([32]).

The Scottish Government communication Dementia - psychoactive medication prescribing and review [13] summarised and reinforced current guidance on the prescribing and review of psychoactive medication for people with dementia across all care settings, including care homes. It highlighted the role of care homes in monitoring such medicines and the condition for which they are prescribed, including expectations around care planning and the use of non-pharmacological approaches to treating stress and distress. It also highlighted that regular reviews by clinicians should continue during Covid-19 as an essential intervention, using remote methods where possible. Non–pharmacological interventions can provide positive results in the reduction of symptoms of BPSD and improve some aspects of quality of life for residents [33,34].

We wanted to assess the effect of Covid-19 first wave and national lockdown on:

- the support by clinicians to care homes to review medication
- the role of care homes in care planning and monitoring the use of, and continual need for, psychoactive medicines

Anticholinergics drugs are medicines that block the action of the neurotransmitter acetylcholine in the body.

Many medicines that are commonly prescribed to older people have a degree of anticholinergic activity. Medicines with a high or moderate degree of anticholinergic activity may cause a range of side effects including confusion and drowsiness, and their use should be minimised and alternatives sought for people with dementia [12]. The number of people in the community taking two or more medicines with a moderate or high anticholinergic activity in England increased by 10% during the Covid-19 first wave and has remained high since then [35].

We wanted to see if, during the Covid-19 first wave, there was an increase in the prescribing of medicines with anticholinergic activity for care home residents.

Context and scope of this report

This project was conducted at a time of significant strain on the care home sector, with staffing issues, ongoing Covid-19 outbreaks and additional scrutiny from external sources adding to the psychological and physical burden on care services [(36)].

We recognised the potential for further stress on the sector with this medication-related project and were keen to work with homes to limit our imprint at this time, while maintaining access to enough information to fulfil the basic remit required on us.

Data period

The Care Inspectorate received its first notifications of confirmed and suspected Covid-19 deaths in care homes in early to mid March 2020 [(37)]. The peak of the Covid-19 first wave is generally taken to be April-June 2020. For the purposes of this project, the baseline (pre-Covid-19) period was October 2019 – February 2020 inclusive, and the Covid-19 lockdown period was March 2020-July 2020 inclusive.

Selection of homes

A total of 801 care homes for older people were on the registered service list at 31 December 2021. Of these, four services had cancelled between 1 January 2022 and 31 March 2022, and a further 83 services were newer services that registered after 1 January 2020. These were removed from the list leaving a total population of 718 services from which to sample.

An initial sample list of 160 services was randomly created based on the health board area in which the service is located. To arrive at the total of 160 services, around 22% of the services in each health board area were selected blindly. All services in the total population were assigned an arbitrary numeric ID number and the sample was selected using a random number generator in MS Excel. The service name, registration (CS) number and any information associated with the provider were hidden at this stage - only the health board area was visible.

An additional random sample list of 80 new care homes was created in November 2022 using the same method.

Care home characteristics

The characteristics of the care homes on the registered care services sample list were considered for analysis as described below:

Sector	• Local authority/health board • Private • Voluntary/Not for profit
Size (registered places)	• 1-10 • 11-40 • 41-70 • over 70
Employs their own nursing staff	Yes or No?
Grade for key question: Support and Wellbeing	Grades 1-6
Mode of GP support	• dedicated GP with an enhanced service • a single GP practice • 2-5 GP practices • 6-10 GP practices • 10+ practices

In addition, we considered two location characteristics of the care home: the urban rural classification of the home [38] and the Scottish Index of Multiple Deprivation [39].

The impact of Covid-19 on care homes

There was also a need to consider the degree to which services were affected by the first wave of the Covid-19 pandemic. To determine this, the volume of Covid-19 outbreak notifications submitted by the service during the first wave was used as a proxy measure as follows.

- Total number of confirmed and suspected Covid-19 outbreak notifications submitted on a service-by-service basis was counted.
- A rate for each service was calculated based on the size of the service by dividing the total number of notifications submitted by the number of registered places in the service. This therefore arrived at a rate of outbreak notifications per place in each service.

- Many services reported no outbreak notifications in this time period, and many services submitted a very large volume. Therefore, even by normalising the data into a rate per place, the distribution of values meant that an arithmetic mean was not appropriate and so the median value was calculated and used to compare the prevalence of Covid-19 outbreaks in the services.

Using the median value as a benchmark, each service in the total population was labelled as either having their rate of Covid-19 outbreaks per place as over or under the median rate.

Collection of records

Most care home services operate a paper-based medicines administration recording (MAR) system that covers a 28-day medicine cycle, split into four weeks.

Care home services were contacted to give an outline of the project and a request that archived medication records be collated for around 15-20 people, each covering the 10-month data period October 2019-July 2020 inclusive. We did not look at any records for residents who died from Covid-19 during the data period.

Paper-based records were collected from the homes, analysed and then returned.

A small number of services operated an electronic MAR system. Access to these records was either granted (by the service to the Care Inspectorate) remotely or data exported and securely transferred electronically to the Care Inspectorate.

Follow-up video/phone contact

After the review of medicines prescribing and administration data, follow-up video, phone or email contact was arranged with the services to determine the following for each resident.

- Was there a diagnosis of dementia in the care plan?
- Did the resident have a section 47 Adults with Incapacity Certificate in place?

Where a phone or video contact was possible, for a small number of selected residents in each home we also asked for:

- more detail about care plans for stress and distress, sleep, pain control and/or depression/mood
- details of contact/visits by external health care professional.

We also asked the service in general about the support they received from health care providers during the pandemic and beyond.

Medicines data

Information from the medicine records and follow up contacts were recorded in a bespoke data collection system designed for the project, then imported into a Microsoft Power Bi database to visualise the data.

The name, strength and dose of a regular prescribed medicine on the MAR was recorded if it was used for the majority of the data recording cycle (28 days).

Where a psychoactive medicine was prescribed on a when-required basis, the total amount of the medicine administered each week was also recorded.

Where a medicine was prescribed on one MAR entry as both regular and when-required the elements of these were treated separately.

The rate of use of when required medicines (accounting for strength and dosage) was calculated separately for the five-month pre-Covid-19 and Covid-19 periods, and the latter compared with the former to see if there had been any increase in rate of use.

We also looked at the rate of changes in the prescribing of regular psychoactive medicines from one data collection cycle to the next. One change was recorded to have taken place if any of the following were noted.

- The removal or addition of a new medicine.
- A change in the strength of an existing medicine taken (for example from 5mg to 10mg).
- A change in the frequency of administration of an existing medicine (for example from once a day to twice a day).

In addition to the five psychoactive drug categories mentioned previously, for the purposes of this project we also looked at two other classes of medicines with potentially sedating side effects – sedating antihistamines and opiate analgesics. Medicines were defined in line with main British National Formulary categories.

Total anticholinergic drug burden for all prescribed medicines was calculated for each resident using a calculator [(40)] that combines the two anticholinergic scales believed to have the highest validity and reliability [(41)]. With anticholinergic burden scales medicines are scored in terms of anticholinergic potential (0 = limited or no potential, to 3 = very strong). The total score is the sum of scores for currently prescribed anticholinergic medicines. A score ≥ 3 is defined as a high anticholinergic burden with a reasonable chance of at least one anticholinergic side-effect, such as confusion, dizziness and falls [(42)].

Sometimes psychoactive medicines are prescribed in advance of need for end-of-life care. These ‘just in case’ medicines were not included in the main analysis.

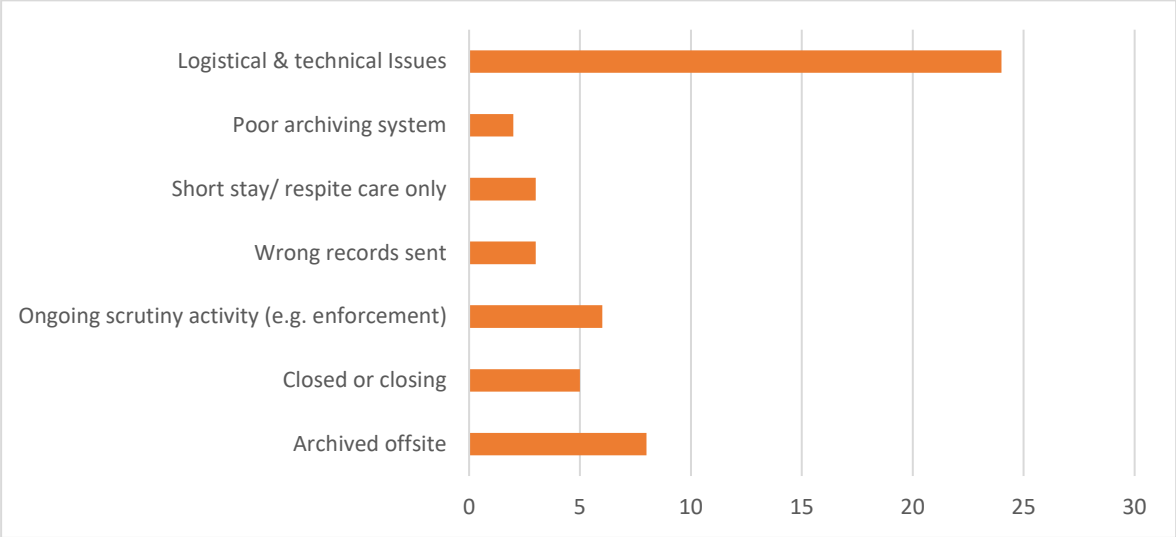
Findings

1. Access to medicines administration records and care plan information

Of the initial 240 services:

- 51 were excluded from data collection for reasons shown in figure 1.
- 131 expressed an interest in taking part but were unable to do so due to ongoing staff/time pressures precluding location of archive records.
- 58 services were able to provide access to archive medicine administration recording (MAR) charts. We were able to have follow up contact with 51 care homes.

Figure 1: Specific reasons care homes were excluded from MAR data collection by number of homes



The worsening post pandemic staffing situation in the social care sector (and the reasons for it) have been recently documented [43,44]. The resultant time pressures on staff and priority care demands meant that many care homes were unable to participate in this project despite many expressing a desire to do so. In some cases, staff turnover meant that the named person initially dealing with the request for records or information had left at the next point of contact, meaning in some cases the request for information was not actioned, or only part of the information was provided.

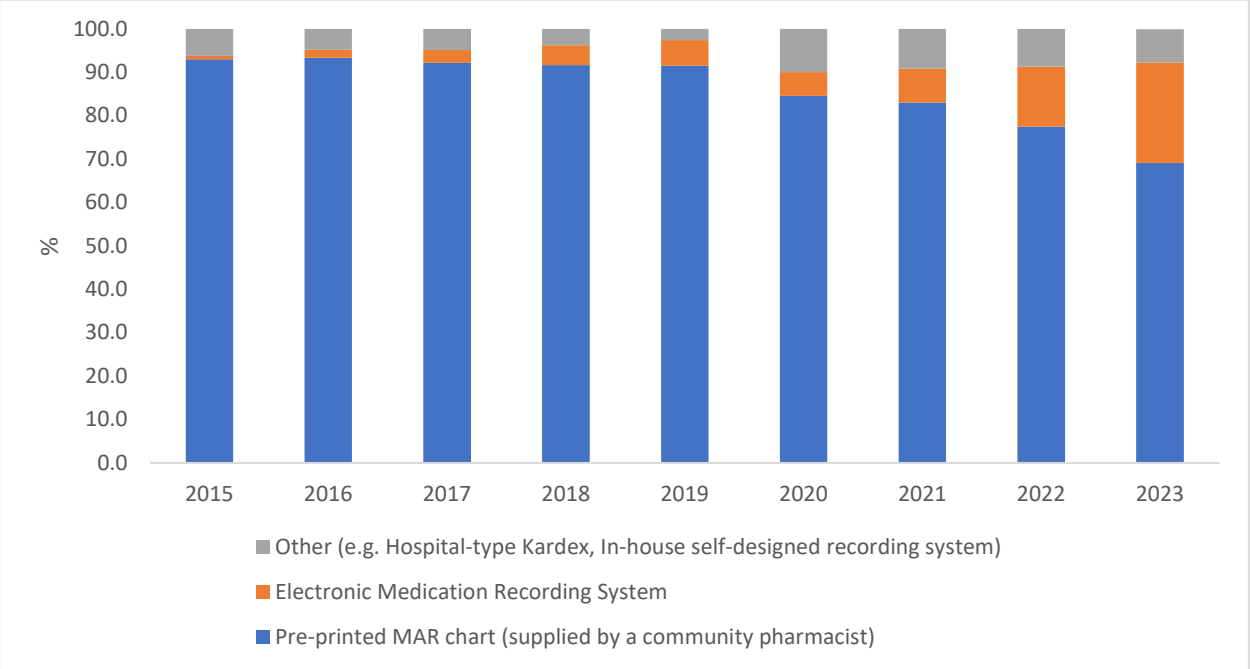
The time lapse between the Covid-19 first wave and the request for records meant accessing archive paper records – the MAR and care plan. The archiving system used by some homes did not facilitate easy access to paper records. Equally, the effect of first wave/lockdown on the recording and storage of some information should be considered.

Access to archive records is in theory easier with an electronic system and we were able to do this with six of the care homes. However, we also experienced some technical difficulties. Some home managers were unsure how to grant read-only remote access to the Care Inspectorate, although this may reflect the above staffing pressures and staff turnover. With some eMAR and e-Care Plan systems, remote

access required downloading of specific software, while with others it was done with a simple weblink. The latter proved easier.

The number of care homes for older people in Scotland using an electronic MAR system has been increasing (figure 2) but this is still not embedded across the sector, and most medicine recording in care homes in Scotland remains paper-based.

Figure 2: Type of medication record system in care homes for older people by percentage (data taken from electronic annual returns submitted to the Care Inspectorate)



2. Resident and care home characteristics

We collated the medicine administration data from 58 care homes across 13 health board regions across Scotland.

- Twenty-six homes employed nursing staff (44.8%) and 32 did not (55.2%).
- The majority of care homes were served by a single GP practice (16 homes/27.6%) or by 2-5 GP practices (21 homes/36.2%); 11 homes (19%) had a dedicated GP with an enhanced service.
- Most care homes had a grade of 4 for Support and Wellbeing (28 homes/48.2%) or grade 5 (20 homes/34.4%); no homes were graded 1 or 2.
- The majority of services (30 homes/51.7%) were registered for 11-40 residents.
- Thirty-eight homes (65.5%) were privately-owned care homes.

- Twenty-three of the care homes (40%) were over the median level of those affected by Covid-19 (as defined in main text above) and 35 (60%) were under the median level.

Data was collected in total for 943 residents in the 58 care homes, although in a small proportion of cases not all records were provided for the whole 10-month period.

- 77.7% of residents were female and 22.3% were males.
- The majority of residents were within the 80-89 age group (41.8%) or the 90-99 age group (35%)
- 52.8% of residents had a dementia diagnosis noted in their care plan; the rate in care homes with nurses (55.4%) was slightly higher than care homes without nurses (50.8%).

A recent study of prescription data for 4478 residents in 147 care homes in two Scottish health board regions noted 71.4% of residents were female, the average resident age in the 80-89 group, and a dementia rate of 48.2% (calculated from prescription and hospital discharge data) [17].

A Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000 should be in place where an individual has been assessed as not having capacity to make decisions relating to care and treatment for themselves. In care homes for older people this is most likely where a resident has more advanced dementia. In a previous Care Inspectorate report in 2017 [45] difficulty was noted for just under a third of care homes in obtaining these certificates where it was needed, at least for some residents.

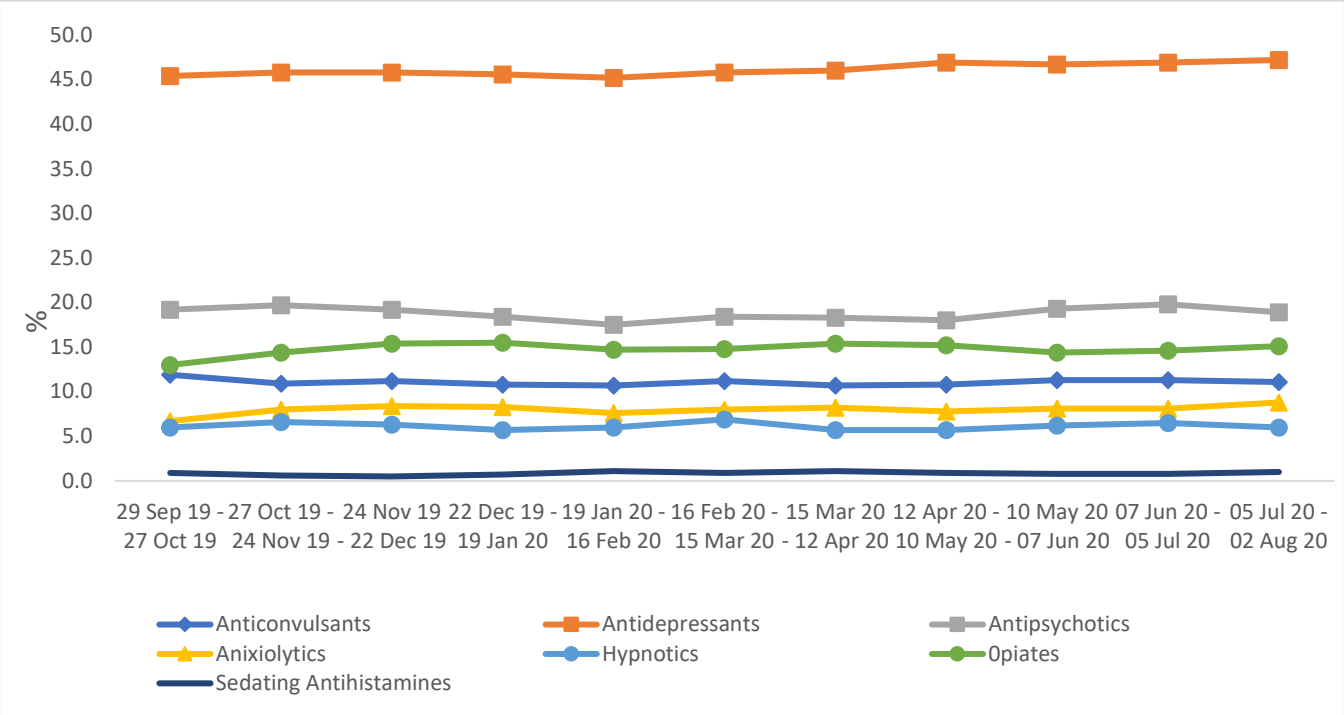
This work found that out of 498 residents with a diagnosis of dementia in their care plan, 406 had a section 47 in place (81.5%).

The spread of resident and care home characteristics used in this project is represented in appendix 1.

3. Prescribing of psychoactive medicines

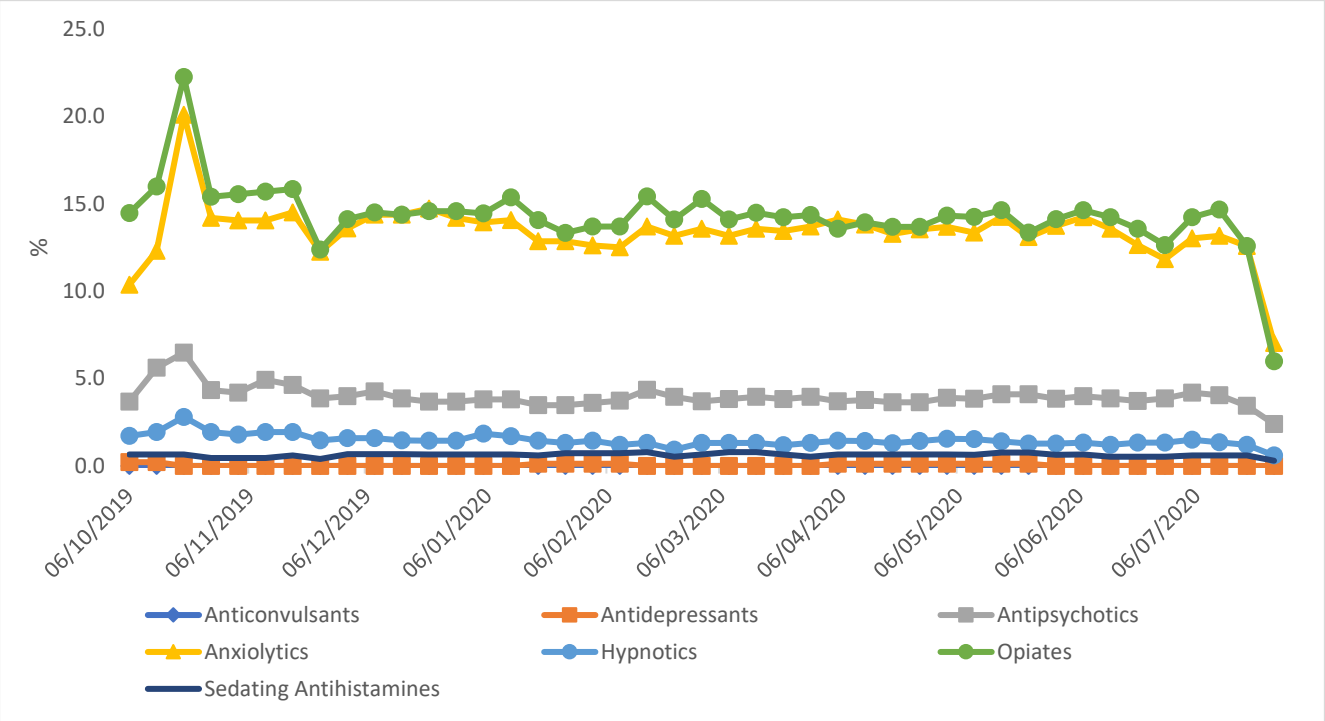
The overall percentage of residents in all care homes prescribed and actively using a given class of psychoactive medicine for each month over the 10-month data collection period are shown below for regular medicines (Figure 3) and when-required medicines (figure 4).

Figure 3: Percentage of residents prescribed a regular psychoactive medicine



The mean prescribed medicines rates for regular medicines were: Anticonvulsants 11.1%; Antidepressants 46.1%; Antipsychotics 18.8%; Anxiolytics 8%; Hypnotics 6.1%; Opiates 14.8%; and Sedating Antihistamines 0.85%.

Figure 4: Percentage of residents prescribed a when-required psychoactive medicine



The mean prescribed medicine rates for when-required medicines were: Anticonvulsants 0%; Antidepressants 0%; Antipsychotics 4%; Anxiolytics 13.4%; Hypnotics 1.5%; Opiates 14.3%; and Sedating Antihistamines 0.6%.

Antipsychotic rates are similar to previous reports for care home studies over the last 10 years in the UK [17, 46,47] and internationally [48,49].

Similarly, high prescribed rates for antidepressants [17, 50, 51] and higher rates for anxiolytics and hypnotics [46,50] have also been reported previously for care homes in the UK and internationally.

There were no notable or consistent increases in the prescribing of the psychoactive medicines during the Covid-19 first wave (as defined) in the 58 care homes.

Using prescribing databases, an overall increase in rate of antipsychotic prescribing for people with dementia was found in the UK in June 2020 and continued in 2021 [52], while an increase was noted in care homes comparing 2021/22 prescribing rates with pre-pandemic levels in 2016/17 [53].

This work did note some differences using a Z test for two proportions in the prescribed rates for antipsychotic medicines when the care home characteristics were considered. These were statistically significant at the 5% level.

The rate of regular antipsychotic prescribing was:

- 12.5% lower (95% CI: 6.8-18.2%) in care homes without nurses (12.9%) than care homes with nurses (25.4%)
- 9.6% lower (95% CI: 4.0-15.1%) in care homes graded 5 and 6 (12.8%) than care homes with grades 3 and 4 (22.4%)

- 11.2% lower (95% CI:5.7-18.8) in care homes with 11-40 residents (12.7%) than in care homes with over 40 residents (23.9%).

There were no differences for any of the other care home characteristics on prescribing levels.

No inference should be drawn from these results without further analysis or evidence. For example, the complexity of the care needs of people living in care homes with nursing (nursing homes) can vary greatly compared to those living in residential care homes. Factors relating to these complex needs, which were not known, may have contributed to the result.

In addition, the number of residents in our project is far lower than previous studies that have shown no difference in prescribing of psychoactive medicines when size, grading and type of care home are considered [17,47], while some differences have been noted previously in care homes from deprived neighbourhoods and care homes served by four or more GP practices [47].

Psychoactive burden

The percentage of residents prescribed and taking one or more regular psychoactive medicines was 66.4%, while 28% were prescribed and taking two or more, 8% three or more, and 2.3% four or more, in line with previous findings [17,50].

People taking two or more medicines of any given class

Regular medicines

Over the data collection period, 38–40 people were found to be prescribed and taking two different regular antidepressants at the same time (some people are prescribed a sedating antidepressant at night to aid poor sleep patterns).

- 1 resident was prescribed two hypnotics.
- 1 resident was prescribed two anxiolytics.
- 1 -2 residents were prescribed two antipsychotics.
- 2-3 residents were prescribed two opiates.

No residents were on two or more sedating antihistamines. Between 8 and 12 people were noted to be on more than one anticonvulsant, however, this is not unusual for medicines commonly used for epilepsy.

When-required medicines

No residents were on two or more sedating antihistamines, hypnotics, anticonvulsants or antidepressants.

- 1-2 residents were prescribed two antipsychotics.
- 2-9 residents were prescribed two anxiolytics.
- 1-5 residents were prescribed two or more opiates.

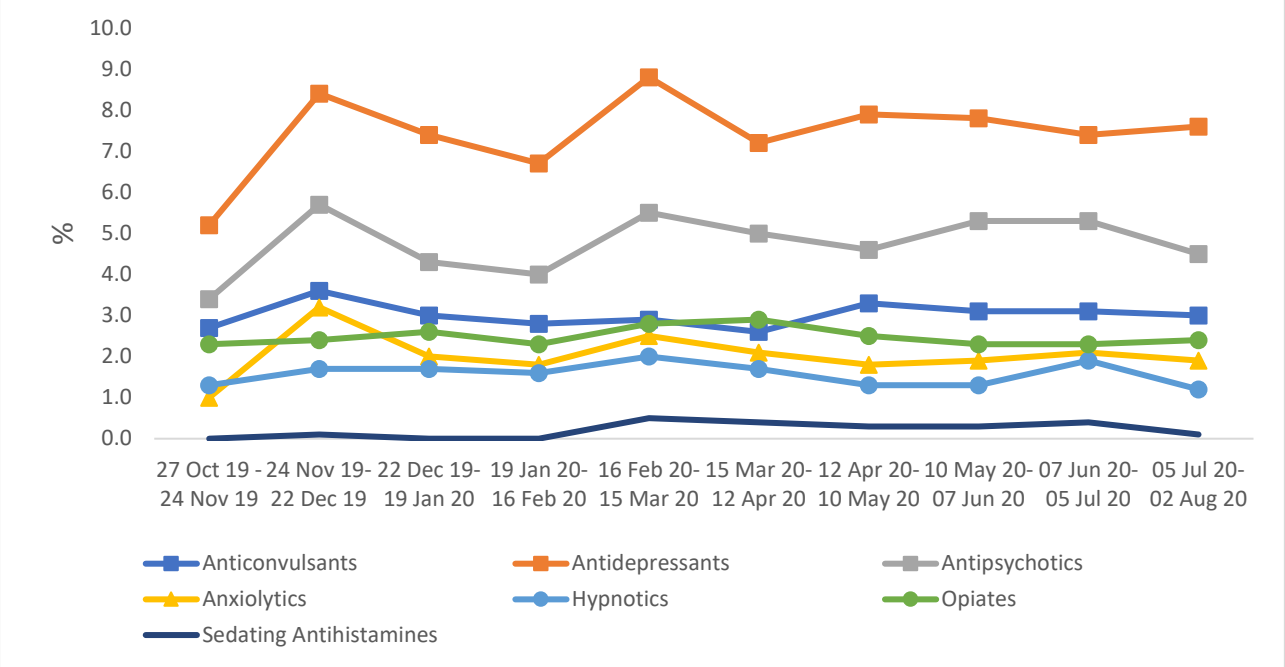
Changes to medicines and long-term use

We wanted to see if the lockdown and Covid-19 first wave had any effect on the rate of changes to psychoactive medicines. Regular medicines were compared to the previous month's MAR data to see if any change had occurred.

The findings for each class of psychoactive medicine are shown in figure 5 below.

Lockdown had no effect on the proportion of residents each month with changes to psychoactive medicines.

Figure 5: Proportion of all residents with one or more changes in regular psychoactive medicines from previous recorded time period



The mean rate of changes per month for the various classes were: anticonvulsants 3%; antidepressants 7.4%; antipsychotics 4.8%; anxiolytics 2.0%; hypnotics 1.6%; opiates 2.5%; and sedating antihistamines 0.2%.

The above data represents the proportion of changes out of all residents in the sample and for regular medicines only.

Of residents on a given regular psychoactive medicine class and with data for 10 consecutive months, the proportion of these residents with no changes at all in the 10 months were found to be:

- 45% for antipsychotics
- 44% for anxiolytics
- 33% for hypnotics.

Longer-term use of these medicines in care homes for some residents has previously been reported [47,54].

Anticholinergic burden (ACB)

This study calculated the anticholinergic burden for each resident per month, considering all medicines prescribed.

The first wave and Covid-19 lockdown had no effect on the average ACB score per month over the data collection period for either regular or when-required medicines (data not shown). The mean score per month for regular medicines was 2.1 (range 2-2.2) and for when-required medicines, 0.18 (range 0.04-0.48).

We did find that in most age groups, the average ACB was lower in people with dementia (figures 6a and 6b) in line with recent findings [17]. Age demographics are given in appendix 1.

Figure 6a: Average ACB score by age group – regular medicines

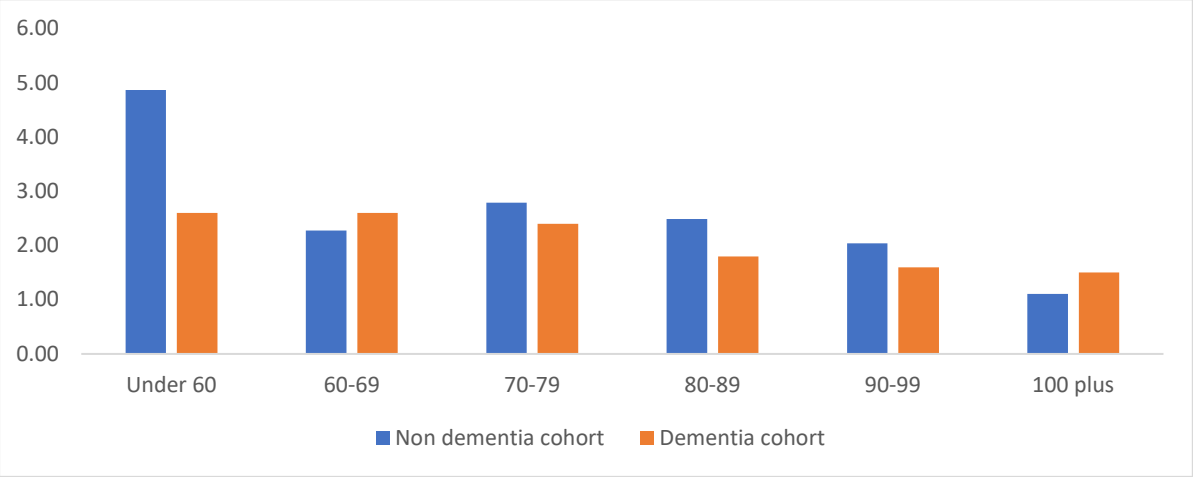
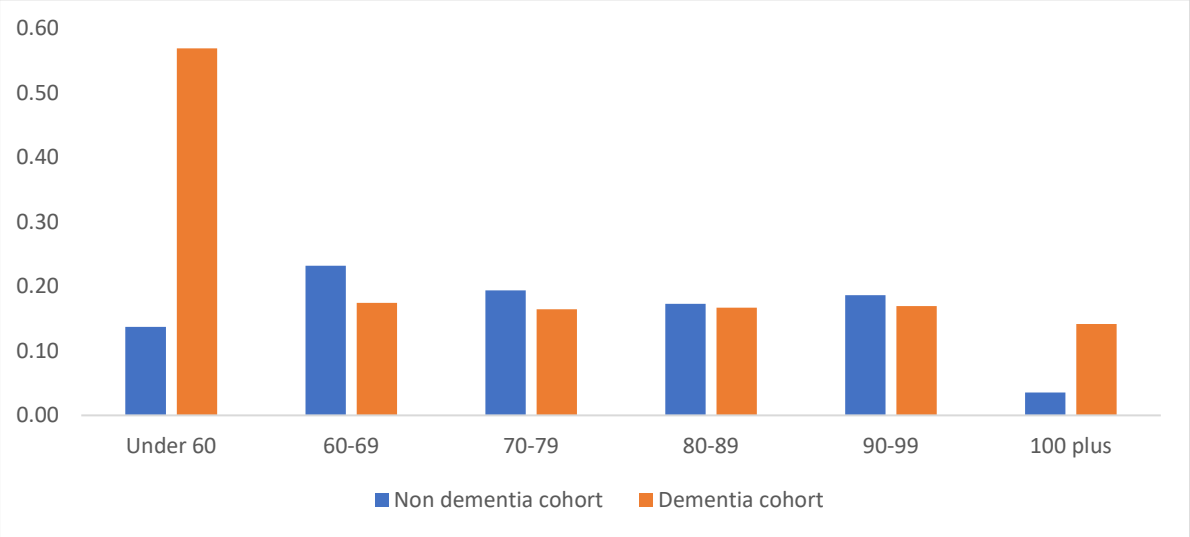


Figure 6b: Average ACB score by age group – when-required medicines



Overall, lockdown had no effect on the prescribing of psychoactive medicines, suggesting the health and social care system was able to adapt well to the sudden change in conditions. However, the levels of prescribing of psychoactive medicines for older people in care homes remains high.

4. Use of when-required psychoactive medicines

For each resident on when-required psychoactive medicines, we recorded the actual amount of the medicine given each week over the 10-month data collection period. We compared the rate of use in the five-month first wave/lockdown period with that in the five-month baseline period to determine the percentage increase (or decrease) caused by Covid-19/lockdown. This required at least one month of data in each data set.

The distribution of the results is shown in figure 7 as a box plot. The box plot shows the middle 50% of data values. The median (or middle) data value of a box plot is represented by a line in the box. The mean (or average) is shown by a white dot.

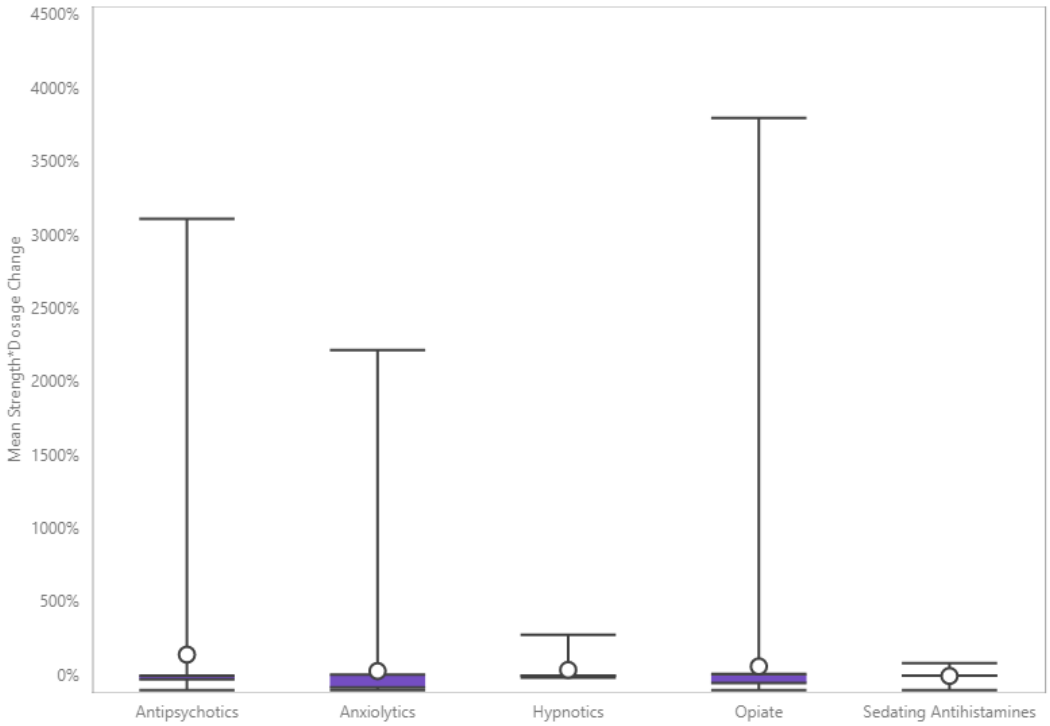
In figure 7, the box is very compressed around a median value of zero in all cases, that is despite the stress that lockdown and Covid -19 must have caused, **there was no overall increase in the use of when-required psychoactive medicines in care homes studied during that period**.

The upper and lower whiskers of a box plot represent data values outside the middle 50% (that is the lower 25% of scores and the upper 25% of scores). The highest score is shown at the end of the upper whisker and in figure 7, this appears substantial for antipsychotics, anxiolytics and opiates.

However, for each class of medicine, most of the data values in the upper whisker were found to be close to zero. Only in a small number of cases was there a larger increase in rate of use, influencing the mean overall values (shown by white circles).

There were only four cases of an increase beyond 500% for opiates, three for anxiolytics and two for antipsychotics. In these cases, baseline use of the medicines was very low and peak use was still within prescribed acceptable dosage ranges. All cases were in different homes.

Figure 7: The change in rate of use of when-required medicines in the first wave/lockdown period compared to baseline pre-Covid 19 period



There is little doubt that lockdown and the Covid-19 first wave created unprecedented conditions for care home residents and care home staff. That there was little overall change in the actual use of when-required psychoactive medicines is testament to the professionalism of the care home staff involved at this time.

5. Care planning

We were able to have time-limited follow-up conversations with 51 care homes to discuss monitoring of psychoactive medicines.

For a small number (1-4) of selected residents in each home, we asked for more detail about care plans for stress and distress, sleep, pain control and/or depression/mood. We were looking to determine if there was:

1. **a person-centred non-pharmacological approach to managing the health condition/care need;** non-pharmacological approaches can help reduce the need for medication

2. **clear desired outcomes (for that person) of any psychoactive medical treatment documented;** this can help the home monitor the effectiveness of the medicine on the health condition/care need

3. **a tool or system used on a regular basis to help measure and evaluate if the medicine(s) is/are meeting the desired outcomes for that person;** progress on stress and distress and sleep issues can be gauged by person centred goals like a reduction in the number of stress and distress incidents or attained sleep goals; while the usefulness of a variety of tools that exist to

monitor pain, anxiety and mood maybe questioned, particularly for people with dementia, the overall approach can be supplemented by systematic feedback from family and/or key staff

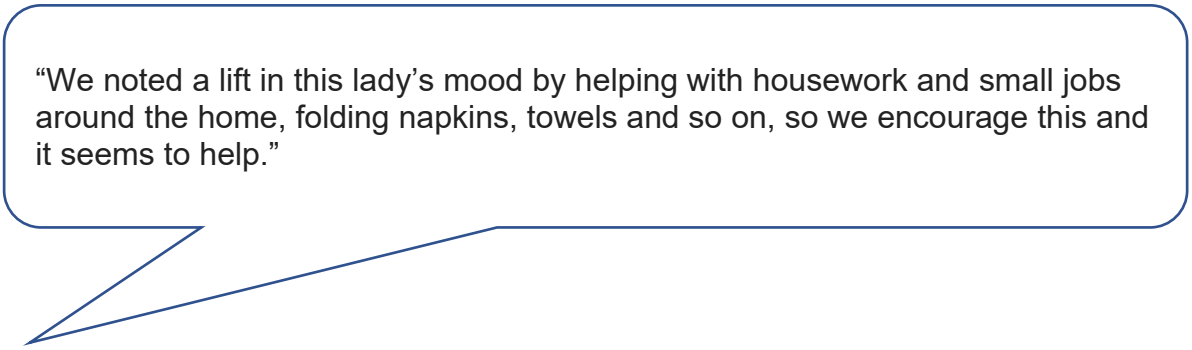
4. **evidence of key side effects (anticipated or observed) documented;** this can help staff monitor the usefulness of the medicine.

Depression/mood

34 care homes were asked to provide detail about care planning for depression/mood.

- 27 homes (79%) said they used non-pharmacological approaches to management of mood/depression (although nine homes were unable to provide examples of this) and seven homes said they did not use non-pharmacological approaches.

Many of the examples given were very generalised, that is one-to-one conversation and participating in activities such as singing, dancing and so on. However, we also noted good practice examples, for example one home said:



- 27 homes (79%) said desired outcomes of any medical treatment were clearly documented for the resident in the care plan, and seven homes said there was not.

- 22 homes (64%) said there was a tool/system used on a regular basis to determine if the medicine(s) was meeting the desired outcomes for this person, while 12 said there was not.

For those that answered yes, they identified a variety of tools as being used – most commonly mood charts and Cornell scale. However, there was a lack of information provided about how often this would be carried out or how the information was fed back to clinicians to help review medicines.

- 32 homes (94%) were able to demonstrate monitoring of key side effects of medicines. In some cases, the information was documented in the care plan or on the MAR chart; in others the patient information leaflet from the medicines was kept in a care folder for this purpose.

Pain

36 homes were asked to provide detail about care planning for pain.

- 21 homes (58%) said they used non-pharmacological approaches to managing pain, such as encouraging regular movement, gentle massage and the use of heat packs.
- 29 services (81%) recorded the desired outcome of treatment in the persons care plan.
- 28 homes (77.7%) said they had a tool to determine the effect of the medicine on the care need; in 20 homes this tool was the Abbey pain scale. However, in most cases the tool was not used on a regular basis.

This fits with observations from a separate ongoing Care Inspectorate project involving seven care homes and 70 residents. In each case, the care homes reported they used a paper-based pain assessment tool, like the Abbey pain scale, **but in the preceding three months there were zero documented pain assessments for all residents.**

- 35 care homes (97.2%) could demonstrate monitoring of key side effects of pain medication. As above, this was done with recording in care plan, MAR chart or through active use of patient information leaflets.

Sleep

36 care homes were asked to provide detail about care planning for sleep.

- 21 homes (58.3%) said they did offer non-pharmacological approaches to managing sleep.

Many of these included have a regular routine at bedtime, decaffeinated hot drinks and adjusting the times that residents wanted to go to bed as this will be different for every person.

One care home commented that:

> Staff wear pyjamas on night shift to encourage residents to acknowledge that it is bedtime."

Although this was a small care home with a low number of residents, none were prescribed any hypnotics or antipsychotics.

In another care home, staff used baby monitors at night to speak calmly to a resident who had trouble sleeping, after the person's family said the person responded best to company.

- 17 care homes (47.2%) did document the desired outcomes treatment in sleep care plans and sleep diaries.

- 17 care homes (47.2%) did monitor the overall effectiveness of medicine used to manage the condition as above using sleep diaries or care plan, but there was a lack of information about how this was collated and fed back to inform the clinical prescriber.

- 35 care homes (97.2%) demonstrate monitoring of key side effects.

Stress and distress

35 care homes were asked and were able to provide detail about care planning for stress and distress.

- 30 care homes (85.7%) said they used non-pharmacological approach to management of stress and distress.

General non-pharmacological approaches included:

- use of 'interactive cats' to calm some residents during personal care

- not wearing staff uniforms as this was found to trigger stress

- using the word 'nurse' as opposed to 'carer' - the home observed residents often don't know what the word 'carer' means, and this causes stress.

In 2107, the Care Inspectorate noted 81% of care homes demonstrated a non-pharmacological approach to managing stress and distress [45].

This work noted a variety of person-centred non-pharmacological approaches to reduce stress and distress, which centred around knowledge and observation of the resident(s):

One care service commented:

> "… there is a script of words or phrases that the person uses frequently that can be a sign of triggered stress behaviour, also what the person is referring to if they use these particular phrases/words."

See also care studies section below.

A few homes noted less stress and distress for some residents because of limited or no family interaction.

- 24 care homes (70.6%) recorded the desired outcome of treatment for the resident in the care plan.

- 20 care homes (57%) monitored the overall effectiveness of the medicine in treating the care need, the most common of which was trends in the use of the ABC [antecedent (or action), behaviour and consequence] tool.

- All services could demonstrate monitoring of key side effects as above.

While doing this project, the following practice was noted which was of general benefit to staff, families and residents.

- A medical consultant visited a care home to run a clinic and training session for staff and family members; as a result, both groups felt more valued, knowledgeable, and invested in care.
- To improve staff access to key information in care plans, one care home with e-care plans used QR codes on resident's doors. Staff felt more informed and better prepared for their role.
- To improve meaningful connection with families, one care home built a cabin in the grounds with heating for residents and opened a private social media page for residents and families.

One care home was particularly effusive in praise of their GP regarding reviews of medicines and said:

> "Our GP does monthly reviews, acute meds are reviewed by GP after one week to see if desired outcome has been met."

Case studies: person centred, non-pharmacological approaches to care

In the course of this project, we observed some cases studies demonstrating a person-centred non-pharmacological approaches to manage stress and distress and reduce the need for medicines.

Case Study 1: Consideration of physical and social environment, and presence of dementia trained staff to reduce psychoactive medicine use

Situation

Resident arrived in care home with their partner, for whom they had been the main carer. The partner required 24-hour care in the Living with Dementia community unit of the care home. The resident, who had recently recovered from a cardiac event, did not want to stay at home alone without their partner and was placed in a lower dependency 10-bed unit. They were independently mobile and were able to visit their partner whenever they wished.

After a few months, the resident suffered further cardiac events with a noted decline in overall health and changes to their care needs. There were concerns about their eyesight, and they could no longer carry out most activities of daily living such as washing, dressing and eating without assistance. They were no longer able to independently visit their partner and the number of falls increased. There was also an increase of confusion, irritability and distress behaviors. The resident had been started on an antipsychotic in hospital and soon after, when-required Lorazepam was prescribed. However, they remained in the lower dependency 10-bed unit to help reduce any further (potentially temporary) confusion and maintain a familiar staffing group and environment.

Other residents in the unit would worry about the resident but, in looking out for them, would collectively use restrictive commands, such as "Don't do that!", which the resident was not used to. The resident also now relied primarily on verbal cues for social interactions, which sometimes meant they responded to questions that a staff member had asked another resident, or invaded the personal spaces of others, leading to altercations with other residents. There were many staff interventions throughout the day and an increased use of when-required Lorazepam, which further reduced mobility.

It soon became apparent that the physical and social environment was not working for this resident.

Action

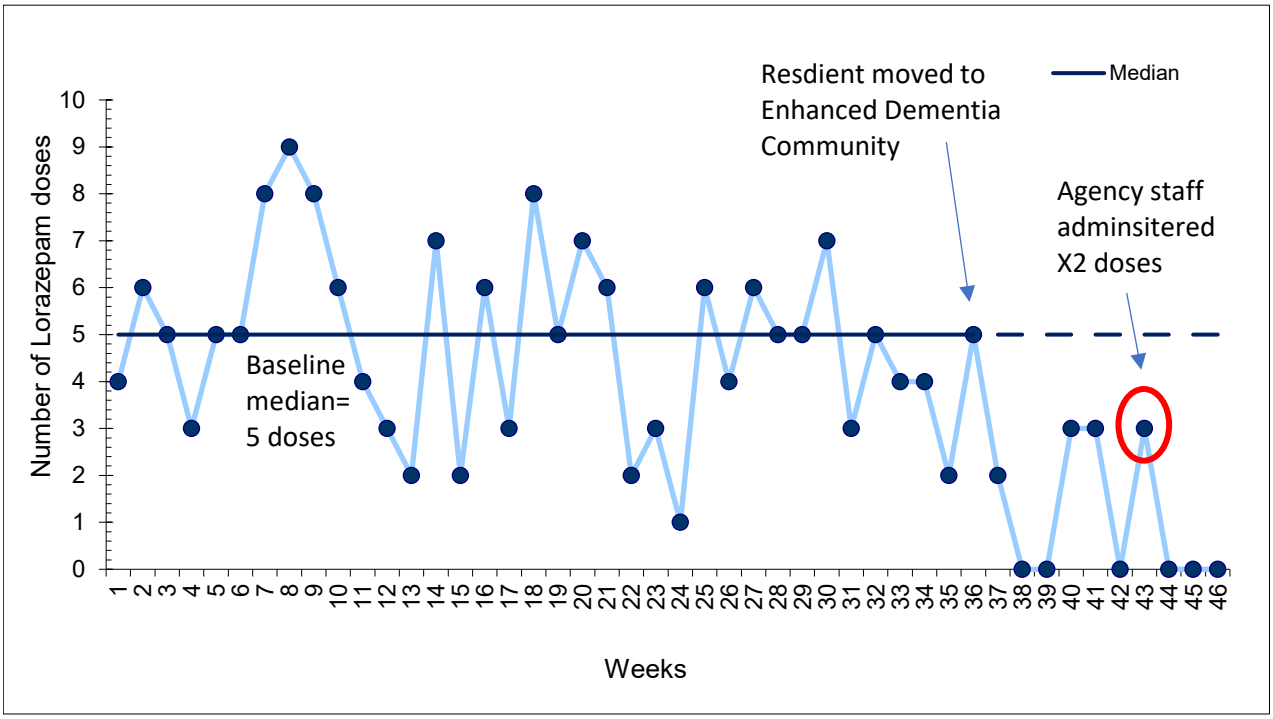
The resident received a diagnosis of dementia with the agreement of social work and family, and a decision was made to transfer to an environment better suited to them.

- The Enhanced Dementia community unit in the home had larger and brighter spaces for the resident to be independently mobile.
- Other residents in this community had less verbal interaction with the resident and would not add further stress.
- There was an increase in staffing numbers and staff were more experienced in working with residents with advanced dementia.

Outcome

- The resident is more settled.
- There has been a reduction in falls.
- The need for and use of when-required lorazepam has reduced - see figure 8 below.

Figure 8: Weekly use of when-required Lorazepam before and after moving to the Enhanced Dementia community unit



There were two incidences in May 2023 of when-required lorazepam being used by an agency nurse who stated that the resident was "getting up constantly throughout the night". However, when the care home manager discussed this further with regular care staff, they explained the resident moved their bowels later that night and then settled well. Regular staff in the unit have not used when-required lorazepam as much; they are experienced with working with residents with more advanced dementia.

Case study 2: Enhanced observations to support positive outcomes

Situation

The care home had notified the family of a resident about the resident's high level of concerning behaviours, including 14 incidents of harm being caused to either staff or other residents. In one case, the family of another resident expressed concern about the safety of their parent in the care home. Staff were frustrated and at times scared of being assaulted.

There was a high use of psychoactive medicines with the resident with concerning behaviours. One-to-one care was being used to maintain them and prevent incidents but had no therapeutic benefit or improvement. The family were distressed as they were unable to find a home that would accept their relative.

The medical team had concluded that the person had moved to a palliative care stage of life. However, a reduction of psychoactive medication resulted in the resident getting up and about more and interacting with staff. The person was not at a palliative care stage, rather they were over sedated.

Action

The care home's dementia care team carried out enhanced observations.

The team Identified:

- behaviours increased during sunset, with possible hallucinations due to shadows
- the resident felt threatened by people following them or sitting outside their room.

Finding out the 'why' allowed the team to build a tailored therapeutic support plan for the resident to provide meaningful occupation and engagement.

- A blind was fitted to the person's room to reduce hallucinations.
- A door alarm linked to the nurse call was implemented so the person could have private time in their room.

Outcome

1. The resident now runs the gardening club and takes the lead daily in what they want to do, with staff supporting rather than managing them.
2. They are independently mobile, eating independently and carrying out personal care.
3. Better quality of life for resident and family
4. Staff gaining confidence in finding the 'why' in the data and exploring approaches to support residents in a person-centred way.

Case study 3: Using data to increase knowledge of person and improve care

Situation

As with the case study above, the resident in this case was exhibiting a high level of concerning behaviours. There was harm to residents and staff and the care home had notified the family that they could not care for the resident. Again, one-to-one care was being used only to maintain the resident and prevent incidents.

The care provider supported staff to do enhanced observations to explore the reasons for the behaviours. This included improved quality of recording and subsequent analysis of ABC charts and daily notes to establish causes and the interventions the resident responded to positively. This approach identified:

- stress and distress increased during showers; they were a private individual that didn't want to get undressed in front of people they didn't know
- one-to-one care was exacerbating stress and distress as this made the person feel they were being watched
- the resident was bored with little to do
- They didn't like others in their room cleaning their things.

Action

What staff found out about the person from using this approach enabled them to make changes to their care.

- For dignity during showering, the resident wore swimwear and this stopped the behaviours of concern associated with this activity.
- The resident now cleans their room themselves, with support from staff as requested or needed.
- A door alarm linked to the nurse call allows the resident to have private time alone in their room without staff being present.

Outcome

1. Better quality of life for resident, who has remained in the home and is less distressed.
2. The family is less anxious about the resident's immediate future.
3. Staff gained confidence in exploring approaches to support residents in a person-centred way.

Overall, this work found a good appreciation of general non-pharmacological approaches to managing care, particularly around mood and stress and distress. However, this remain areas for improvement where a person-centred approach can have a significant positive impact on both the people being cared for, their families and care staff.

Care homes had a general understanding of monitoring of medicines and the condition it was prescribed for, however we also found a lack of clarity in how this would be carried out and the information collated and fed back to clinicians to help review medicines.

We hope the good practice examples shown above will stimulate interest in improvement in this area of care.

6.External healthcare support

To gauge the effect of the lockdown/Covid-19 first wave on the support for care homes from external health care professionals, the following information from 53 residents' care plans was recorded.

- Dates of any contact/visit by external health care professional.
- Whether that contact/visit was from a GP/doctor, nurse, pharmacist, allied healthcare professional.
- Whether a visit was in person, by phone or by video.

The results are shown in figures 9-11 below. The data shows a dip in the number of contacts healthcare professionals had with the care homes from mid-March, reflecting general pressure of the overall system at this time. However, people adapted and maintained a level of service, with the mode of contact shifting from in-person to phone and video. The Care Inspectorate used the Near Me video appointments and contact software for its interactions with care homes and promoted its use in the health and social care sectors[55].

Figure 9: The number of weekly contacts with care home by healthcare professionals

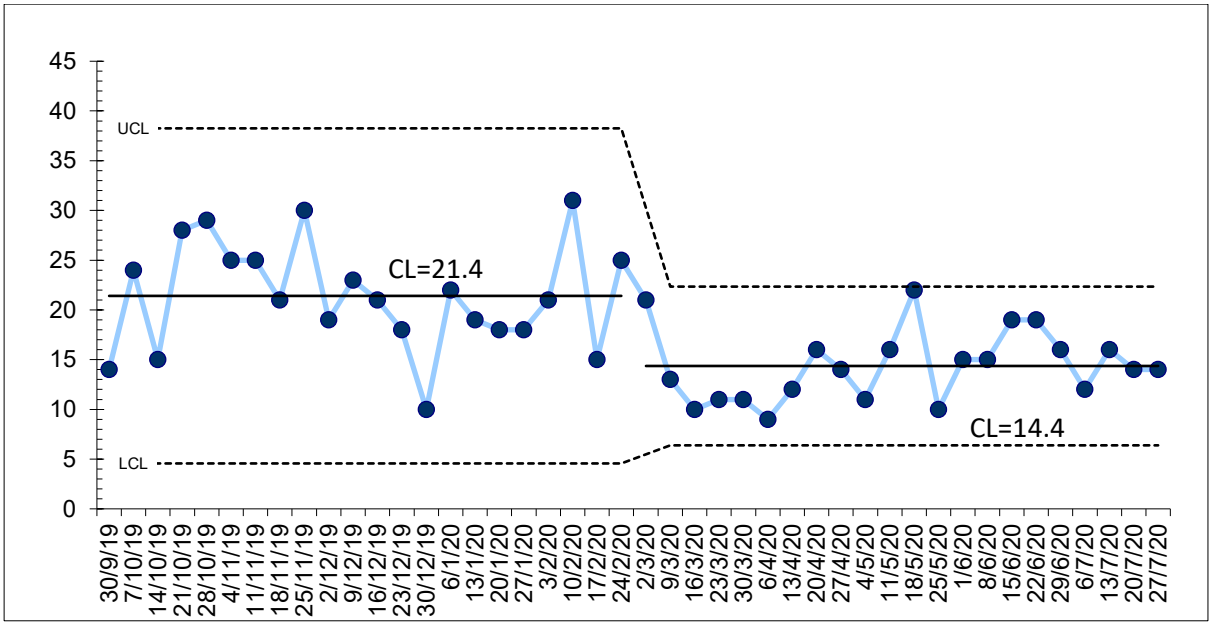


Figure 10: Contacts with care home by professional group

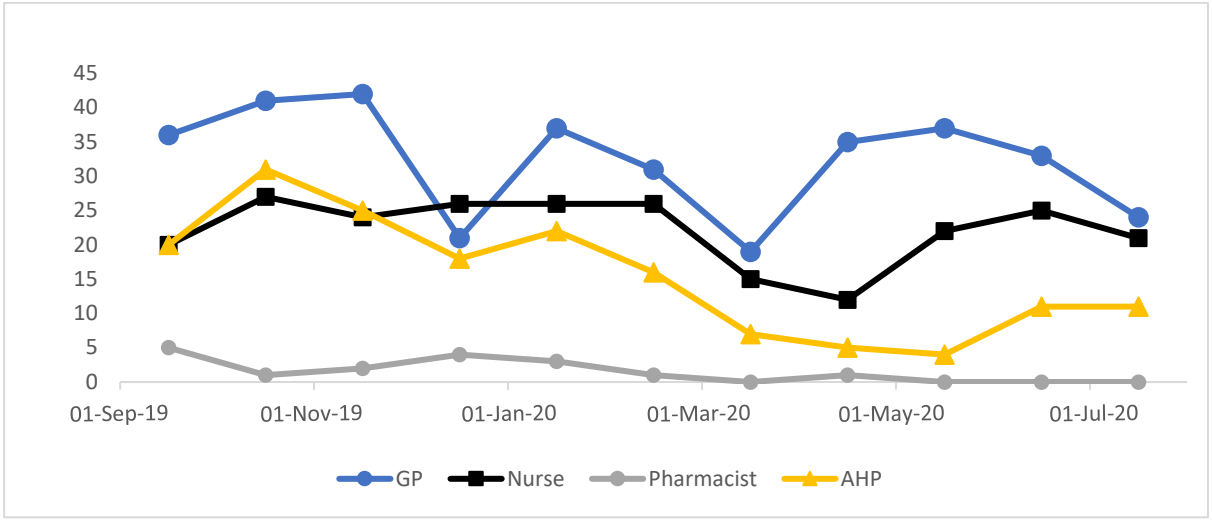
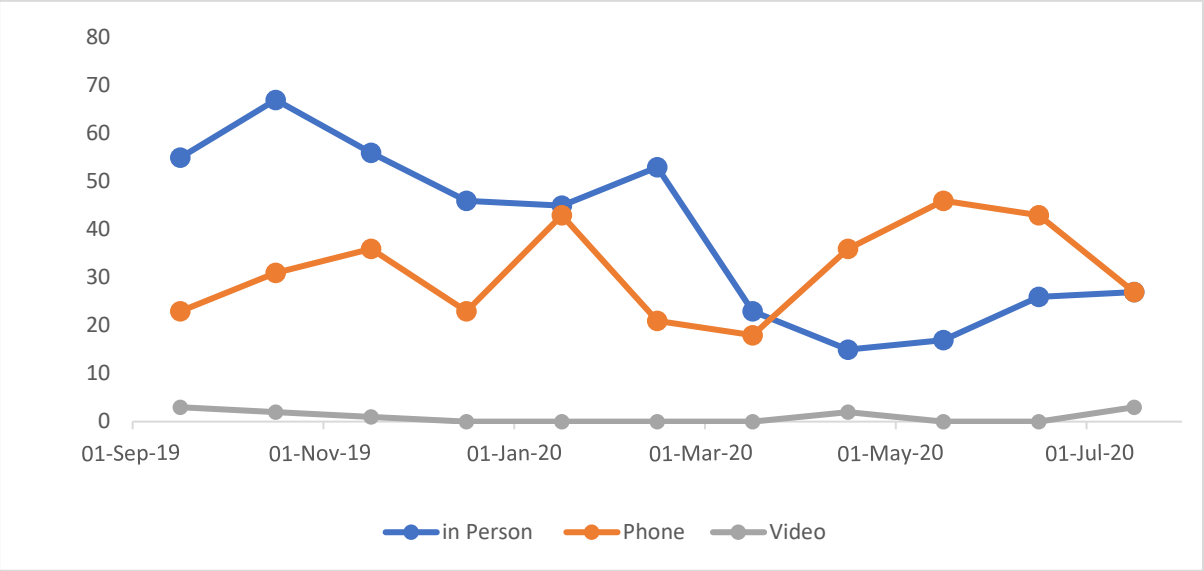


Figure 11: Mode of contact by health care professional with care home



Experience of homes

During the follow-up contact with care homes, we asked them if during the pandemic they felt supported by external health professionals. A total of 49 services answered this question - two of the 51 homes did not feel able to comment due to recent changes in senior staff.

Thirty-four of the 49 care homes (69.4%) did feel supported during the pandemic. These homes had a range of GP service provision models, while 52.9% were homes with nurses and 47% homes without nurses.

Examples of positive comments around support

"GPs visited twice a week. There was triage of residents, with suspected Covid-19 residents left last. List of residents emailed to GP ahead of time with indication of the need (or not) to see person face to face. Adjustments to entry for GP such as using fire doors as they were nearer residents' rooms. No visits from other health care professionals. However, weekly Teams meetings with care home liaison nurses."

"Supported well, combination of in person, video call and telephone consultations and support throughout pandemic."

"GP stopped visits but did phone consultations, district nurse attended if needed. Despite these changes still felt supported."

"Continued to feel well supported by all external professionals, in-person input did initially cease at the beginning but not for long. GP practice supportive and helpful throughout, carries out a fortnightly clinic. All medication reviewed at least six-monthly (psychoactive meds reviewed more promptly than this if commenced)."

Fifteen of the 49 care homes (30.6%) said they did not feel supported; 12 of the homes were supported by more than one GP practice, while 33.3% of homes had nursing care and 66.7% did not.

For services that did not feel well supported, some of the comments centred on Covid-19 and health support in general.

- One service commented that despite not having any medical trained staff on site, external healthcare staff often asked care home staff for their medical opinion on the residents, such as cause of death. The manager explained they were not [health] qualified, and they rely heavily on guidance by health care professionals.

- A residential service advised they felt poorly supported and commented that [community] nurses refused to come out to change catheters.

- A care home commented that they felt as though some GPs were not always responding to symptoms being reported and simply assuming all contact regarding unwell residents was about Covid-19, especially if home had an outbreak.

One home highlighted a varied experience from the three different GP surgeries supporting the home.

Surgery number 1 “the GP would always visit on request and follow up with a call the next day”.

Surgery number 2 “responded to requests reasonably well”.

Surgery number 3 “no GP input”.

Twelve of the 49 care home services (24.5%) specifically mentioned in person external nursing support were very much still in attendance.

Beyond the first wave

Care homes are advised to monitor psychoactive medicines and the symptoms they are prescribed for, and where appropriate, collate and feed relevant information back up to the clinician for consideration.

While doing this project we have been made aware of a number of different care homes doing that monitoring role but that have experienced ongoing difficulties in the review of psychoactive medicines by external healthcare staff.

Care home manager (December 2021) “As a home manager during Covid-19, we would ask for a review of residents due to change in behaviour. We would then receive a prescription for either an antipsychotic or anxiolytic with explanation that it will be progression of dementia. We asked consistently for these to be reviewed and the GP would say No as it wasn’t in their scope and to go to the community psychiatric nurse (CPN). The CPN was unable to review as the resident wasn’t known to them and it was the GP who prescribed. The care home became stuck in the middle of wanting the medication reviewed, reduced or discontinued but no one taking responsibility for this.”

Care home manager (October 2022) "We asked GPs to review all antipsychotic for residents they had prescribed for. We got no reply over the phone so sent a letter. We got a letter back saying that this wasn't their job, and it should be psychiatry. Psychiatry is not involved in these residents, and it was the GP who prescribed the medication."

Care inspector (January 23) "I'm in the midst of inspecting a care home. They had approached their GP practice about six-monthly psychoactive medication reviews. Their GP practice response was they would not be reviewing any psychotropic medications as they will have likely been commenced by CPN or mental health consultants and that they would not be stopping any medications.

"There are a couple of residents whose as-required medicines had been reported on a number of occasions as having little or no effect. My question is, where does the provider go from here? They have been trying to organise reviews."

Care home manager (January 2023) "We asked for medication to be reviewed during dementia consultation. Nurse replied "they don't come to the home anymore since Covid-19 unless it's life and death. They will start medication but trying to get things reviewed and stopped is near impossible"."

Care home manager (April 23) "We wrote to the GP surgery and got a reply that said the GPs feel these residents only need an annual review unless there is a change in their clinical condition, and that they don't have the capacity at moment to review people who are not unwell or presenting with a change in clinical condition as frequently as this."

An overall reduction in care home contacts with external healthcare professional during the first wave was not unexpected, however that this was not more significant highlights the adaptability of the health and social care system to this acute situation. Individual care home experiences during this time were again understandably varied depending on the local context.

There does, however, remain a concern in some cases about the role of clinicians in the review of psychoactive medicines as we come out of the pandemic. Infrequent review of antipsychotics in care homes has been noted previously in UK care homes [(56)]. In one case only a quarter of residents prescribed an antipsychotic had a documented medication review by their GP within the previous 12 months [(57)].

Summary and recommendations

This report had the advantage of looking at the actual use of psychoactive medicines in care homes, including when-required medicines. However, the main limitation was in the supply of records and information. The context of the work required care home to look out and provide information at a time of sector-wide capacity issues, resulting in lower numbers of records and smaller scope of information examined than originally desired. We are grateful to those homes that were able to participate in this work.

Staffing capacity, skills and turnover have obvious implications for the care of older people in care homes as we come out of the pandemic. There will be new SIGN guidelines (SIGN stands for Scottish Intercollegiate Guidelines Network) due out later this year have a focus on person-centred non-pharmacological management of dementia. However, in addition to concerns over time pressures, new or temporary/agency staff will more likely lack a relationship with the people receiving care and may not know them well enough to manage behaviours in a person-centred way, leading to administration of sedating psychoactive medicines that otherwise may have been avoided.

Recommendations

1. Staffing in care homes is key to supporting safe and effective care for residents through a consistent and skilled frontline staff team able to meet a person's dementia care and medication support needs. The government and care home representative bodies should agree an action plan to ensure this objective can be achieved on a sustainable basis. This process should include a discussion about any additional funding required to meet ongoing training needed to achieve this aim.

2. Where a care home is unable to meet its minimum safe staffing levels to achieve the above objective, this should be escalated to the local health and social care partnership and the Care Inspectorate.

Digital care systems like eMAR and e-care plans can support better management of information and allow targeted improvement support. They have the potential to reduce workload on an overstretched workforce, freeing more focused time for the caring roles at which social care staff excel.

The importance of digital transformation for the sustainability of an integrated health and social care system is recognised by UK and devolved governments [58,59]. The value of the developing Integrated health and care records to improve co-ordination for people with dementia is stressed in the Scottish Government's new Dementia Strategy [60]. The Department of Health and Social Care has set a goal of 80% of CQC (Care Quality Commission) registered social care providers to have an assured digital social care record system in place by March 2024 [59].

Recommendations

3. Consideration by the Scottish Government to set a time scale and target for the use of assured eMAR and e-care plan systems by the care sector. This should include support for the sector to achieve this goal.

4. Care services should ensure that where eMAR and e-care plan systems are used, remote access to the records by appropriate bodies and people can be granted.

5. The Care Inspectorate should ensure its staff are familiar with eMAR and e-care plan systems and can work with the sector using these systems for assurance and improvement work.

The first wave of Covid-19 and national lockdown forced adaptions to the way care homes and supporting external healthcare professionals interacted.

Despite the acute stress on the health and social care system at this time, this work found no significant overall effect on the prescribing and use of psychoactive medicines. However, this means concerns remain about the high psychoactive burden for older people in care homes, including in some cases, long-term use of medicines.

Fresh initiatives to reduce prescribing levels of antipsychotics have already been published [61] with more to follow. However, any guidance for prescribers will need to be backed up with clarity and consistent practical support for the systematic monitoring and review of these medicines (and the condition they are prescribed for) in a timeous and effective manner by both care homes and prescribers.

This should align with My Health, My Care, My Home, the Scottish Government's healthcare framework for adults living in care homes [62], which has a strong focus on multi-disciplinary team working and placing the person living in the care home at the centre of the care process.

There is a focus in the upcoming SIGN guidelines on non-pharmacological approaches to management of dementia. Non-pharmacological approaches can produce inconsistent results without consideration of key components that can lead to a successful outcome [63].

- Consideration of both the physical environment and social interactions, including nurturing of relationships between care staff and the resident (and their family) to help assess and understand the resident's needs and wishes.
- Ongoing education and development of care staff skills in dementia care.
- Individualisation of care that supports the wishes of the resident.

No one approach alone is likely to successfully provide both effective care and a successful sustained reduction in the use of psychoactive medicines.

The good practice examples highlighted in the case studies above are not universal and improvements can be made here.

Care homes are complex environments with a variety of factors influencing staff and resident wellbeing, from the type and size of the care home to access to key local health and social care support and training.

Caring in this environment can involve frontline staff working long hours, supporting people with a wide range of complex medical conditions and social care needs. This is a demanding career and there are high levels of staff turnover, which can lead to burnout for those who remain. The Covid-19 pandemic added to many of these staffing issues with reports of burnout influenced by staffing shortages, changing practices and increasing workload, often to compensate for lack of external staff and support, negative press coverage and the emotional burden of caring for residents facing isolation, illness and death [64, 65].

An increase in frailty has been noted in older adults in care homes that survived Covid-19 (Giada Ida Greco 2021) while the negative impact of Covid-19 isolation measures on the cognitive and mental health of older people with dementia has also been reported [66, 67].

The Care Inspectorate looks forward to working with care providers and stakeholders to make improvements in these key areas and ensure people receiving care, and their loved ones, have the best outcomes possible.

Recommendations

6. The Scottish Government should convene a short-life working group to agree a national approach for the practical monitoring and review of key psychoactive medicines. This should include representatives of all relevant parties (for example GP/pharmacy/nurse prescribers, care home support teams and care home staff). This work should consider:

- enablers and barriers for regular and ongoing monitoring and review of key psychoactive medicines
- development of a tool that care home staff can use to assess and monitor the effectiveness of different psychoactive medicines and to have a focused conversation with the responsible healthcare professional for reviewing the medicines as required.
- who should do the clinical review for key psychoactive medicines and how often this should be done.

7. Care home providers should quality assure the care home environments to meet the needs of people living with dementia and so align with the vision of the new Dementia Strategy [60]. The environment includes the physical layout of the building and access to outdoor space, as well as the social environment and culture of the service. Environments should promote wellbeing, engagement in everyday living and not be a barrier to independence. Care home staff need to be intentional in their approach to developing nurturing relationships with the person living with dementia and their family and friends.

8. Care home staff align staff roles and responsibilities to the Scottish Government's Promoting Excellence Framework and to develop staff so that they have the skills and knowledge outlined at each level of the framework.

9. Care home staff should understand the factors underlying people's experience of stress and distress and this, coupled with strong relationship skills, should encourage the use of non-pharmacological approaches as a first-line approach.

10. The Scottish Government should consider commissioning a national improvement programme to further understanding of non-pharmacological approaches that are successful in managing stress and distress in people in care homes.

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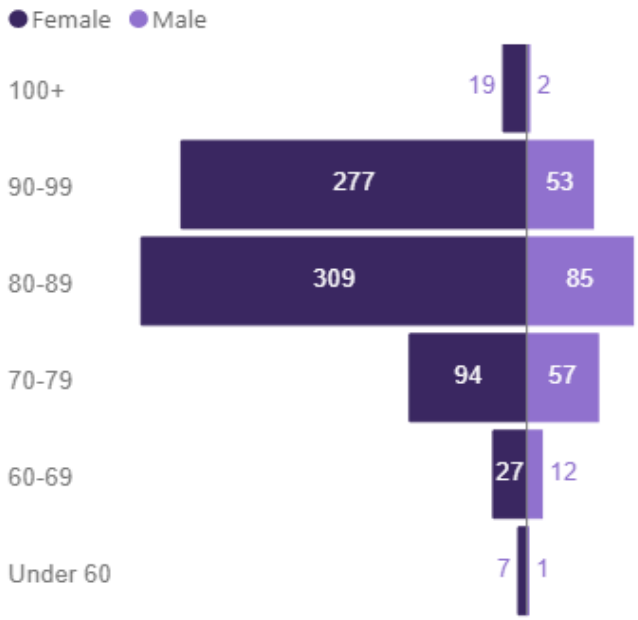
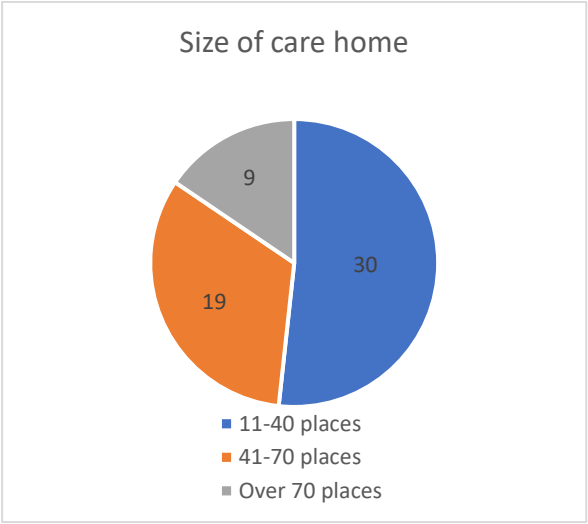
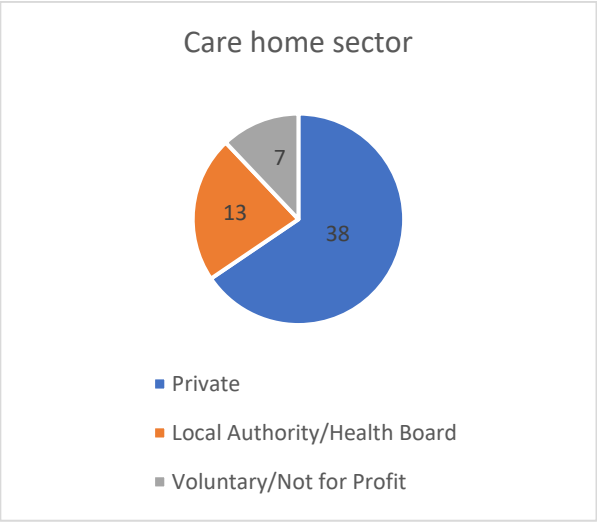
Appendix 1: Resident and care homes characteristics



Size of home



Care home sector



Urban versus rural location

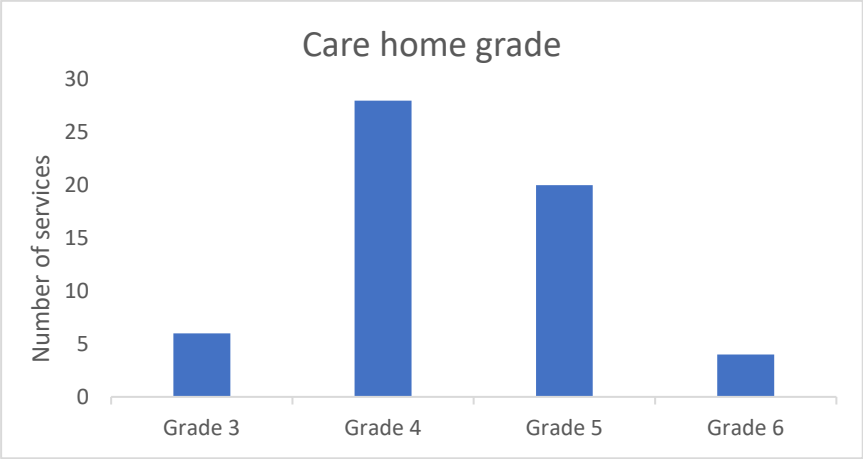
Location of Service	Number of Homes
Accessible Rural	9
Remote Rural	4
Large Urban Areas	17
Other Urban Areas	21
Accessible Small Towns	3
Remote Small Towns	4

Scottish Index of Multiple Deprivation (SIMD) classification

Where 1 refers to the most deprived areas and 5 refers to the least deprived areas

SIMD Classification	Number of Homes
1	7
2	11
3	13
4	12
5	15

Quality grades



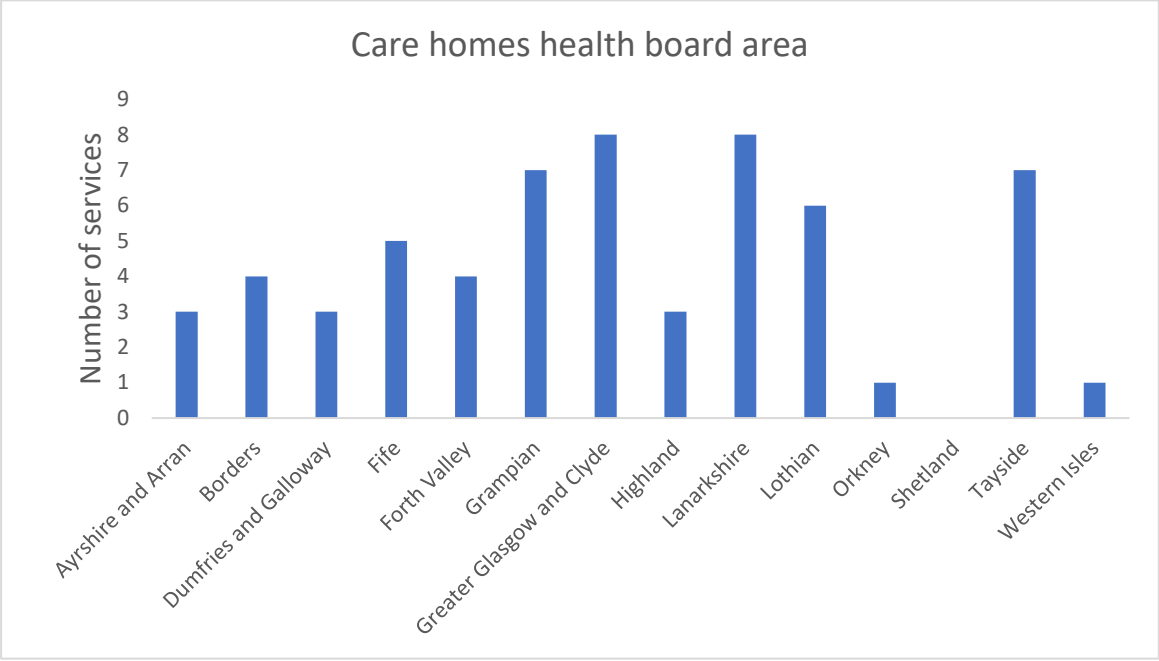
Covid-19 Status

Twenty-three of the 58 care homes (40%) with medication data analysed were over the median level of those affected by Covid-19 (as defined in main text) and 35 (60%) were under the median level.

Type of Care Home

Of the 58 care homes with medication data analysed 26 homes employed nursing staff (44.8%) and 32 did not (55.2%).

Health board area



Mode of GP support:

- 11 homes were supported by a dedicated GP with an enhanced service
- 16 homes were supported by a single GP practice
- 21 homes were supported by 2-5 GP practices
- 5 homes were supported by 6-10 GP practices
- 4 homes were supported by 10+ practices
- 1 there was no data provided/available.

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