

***The use of these drugs in those with dementia has substantial clinical risk attached, including a conservative estimate of 1,800 extra deaths and 820 extra serious adverse events such as stroke per year.***

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## 1. Introduction

This paper has been produced in response to the refusal of the Minister, no doubt advised by his officials, to acknowledge that:

- a guideline produced over 9 years ago is now out-of-date and does not contain adequate guidance about the use of antipsychotics in the care of elderly people with dementia;
- a research report issued by the Mental Welfare Commission in May 2014 provides cause for concern about the use of antipsychotic and other psychoactive drugs in NHS units providing longer-term care for people with dementia;
- actions taken by the Scottish Government to reduce the inappropriate prescribing of antipsychotics to elderly people with dementia have been ineffective.

This paper contains considerable detail in the hope that the Scottish Government can be persuaded that it should now explore further ways of protecting elderly people with dementia and others from being inappropriately administered antipsychotic drugs and hence being unnecessarily exposed to the serious risks associated with those drugs. It may be that what should now be done would be to:

- publicise widely the risks associated with the use of antipsychotic drugs;
- produce up-to-date guidelines on the use of those drugs;
- ensure that health care professionals, care home managers and the Care Inspectorate are familiar with relevant legal matters and their implications;
- revise the National Care Standards to take full account of human rights;
- instruct the Care Inspectorate to enforce the National Care Standards;
- periodically conduct an in-depth study of a sample of care homes in order to determine whether there has been adherence to the National Care Standards.

## 2. Research findings, etc.

2.1 As was pointed out in my previous paper on this topic, the following written Parliamentary question was submitted by Mary Scanlon:

*“To ask the Scottish Government whether it plans to produce guidelines on the use of antipsychotics for older people with dementia”* and that, in his written answer, the Minister stated that *“Clinical guidelines on the appropriate use of antipsychotics to help manage stress and distress symptoms exhibited by all people with dementia are contained in the Scottish Intercollegiate Network national clinical guideline for the management of people with dementia (SIGN 86)”*.

As should become clear from the information provided below, any suggestion that doctors prescribe antipsychotics to elderly patients with dementia to help manage stress and distress is, at best, highly misleading and, no doubt, intended to give the impression that doctors are acting in accordance with the law when they prescribe antipsychotic drugs to dementia patients at the request of care home staff (see 3.7). It is also misleading to imply that SIGN 86 contains useful guidelines on the use of antipsychotics for the purpose of the management of stress and distress in elderly dementia patients..

SIGN 86 was published in February 2006; its section on the use of antipsychotics for treating behavioural symptoms associated with dementia is now out of date: for example, it contains no hint that the use of antipsychotics in elderly people with dementia will cause a significant number to die prematurely. It was disappointing, therefore, that in his letter to Alison McInnes dated 17 July 2015 the Minister stated *“I would reiterate that the SIGN guideline is there to reflect evidence-based and peer-reviewed clinical consensus on effective treatments for dementia, including both benefits and risks”*.

The Minister, presumably, has not been able to find time to study SIGN 86 and has relied, therefore, on inaccurate information supplied by his officials: contrary to what is implied, the information in SIGN 86 regarding the risks in using antipsychotic drugs to treat symptoms of dementia is quite inadequate.

2.2 Information is given below about relevant advice provided in a recent edition of the British National Formulary (BNF), namely the one covering the period September 2014 – March 2015. The BNF is a joint publication of the British Medical Association and the Royal Pharmaceutical Society. The printed version is updated twice per year. A study of the section on prescribing for the elderly together with the sections on anxiolytics, antipsychotics and antidepressants will expose the inadequacies of SIGN 86.

2.2.1 In order for the inspectorate to be in a position to challenge the widely acknowledged excessive use of antipsychotics in elderly people with dementia, guidelines should be produced that contain information about the significant risks of using these drugs in people with dementia, especially the risk of premature death. Those guidelines should also include the advice contained within the British National Formulary (BNF) for minimising those risks. In particular, it should contain the advice that ***“Antipsychotics should not be***

***used in elderly patients to treat mild to moderate psychotic symptoms” and “Treatment should be reviewed regularly”.***

2.2.2 It should be noted that in 2008 there was published research conducted by Medix and entitled ***“Antipsychotics in Dementia Study”***. It was carried out for the BBC in connection with a File on 4 programme. The research was based on responses to a questionnaire that were returned by 355 doctors drawn from 11 NHS regions in the UK, including Scotland. Of those doctors, 50 reported that, following the use of an antipsychotic drug for dementia, there had been the side-effect of drowsiness or excessive sedation. Further, 84 of the doctors (24%) had stated that “wandering” would prompt them to prescribe antipsychotic medication for an elderly patient suffering from dementia while 49 doctors (14%) had stated that they would prescribe the medication if the patient were noisy. No doubt they would regard the prescribed treatment as successful if it made the patient drowsy and hence dealt with the symptom for which it had been prescribed. Hopefully the Minister would agree that potentially harmful drugs should not be prescribed to elderly dementia patients merely because they wish to walk about inside the care home or are noisy.

None of the doctors who responded to Medix indicated that he or she would consider prescribing an antipsychotic drug to a dementia patient because that patient was exhibiting symptoms of stress and distress even though those doctors all responded to the question about the symptoms or behaviour that would prompt them to prescribe antipsychotic medication for an elderly patient suffering from dementia. It would be far-fetched to claim that doctors no longer prescribe antipsychotics to those patients because of complaints from care home staff that they wander, are noisy or are aggressive. (The Medix research found that 84% of the doctors who responded to its questionnaire stated that they would regard aggression on the part of an elderly dementia patient as a sufficient reason for prescribing an antipsychotic drug.)

2.3 SIGN 86 states that ***“The atypical antipsychotics, olanzapine and risperidone are useful in the management of psychotic symptoms, aggression and other behavioural problems associated with dementia”.***

This advice should be assessed in light of the advice in the BNF referred to in 2.2, i.e. that these drugs should not be used unless the psychotic symptoms are severe. It should also be assessed in the light of the indications for risperidone that now appears in the BNF: ***“acute and chronic psychoses, mania; short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer’s dementia unresponsive to non-pharmacological interventions and where there is a risk of harm to self or others”.***

In the BNF the only drug for which aggression is given as an indication is risperidone; it is stressed that the use of this drug to treat patients with Alzheimer’s dementia for aggression

should not extend for more than 6 weeks and must, therefore, be kept under review. The advice in the BNF also implies that the use of risperidone to treat aggression should not be considered unless the aggression is a regular occurrence and poses a risk of harm. Hence purely verbal aggression would not be an indication for the use of risperidone. The BNF also makes clear that there should be no resort to risperidone to treat aggression unless non-pharmacological interventions have been tried and found to be unsuccessful.

2.3.1 When exploring the use of non-pharmacological interventions, the possibility should, of course, be examined that the patient's aggression is a response to actions of staff. In this connection, account should be taken of the paper produced in 2008 by the All-Party Parliamentary Group on Dementia. The paper, entitled ***"Always a last resort"***, reports on an inquiry into the prescription of antipsychotic drugs to people with dementia living in care homes. In paragraph 25 of the report it is stated that ***"The Royal College of Nursing estimates that only 10 per cent of challenging behaviours occur as a consequence of dementia with per cent occurring in response to care practices or environmental factors"***.

2.4 In May 2014 the Mental Welfare Commission published a report entitled ***"Dignity and respect: dementia continuing care visits"***. In that report, which was based on a survey of 336 dementia patients in 52 NHS units, it was stated that

- 166 patients were taking antipsychotic medication (i.e. 49% of the total and not 45% as stated);
- 54 patients were being prescribed risperidone (i.e. 16%);
- 84% of patients were on at least one psychotropic medication with 34% on three or more, in many cases without regular review;
- 53% of the patients had not been outside in the previous month even although it was summer;
- 43% of patients were not receiving adequate levels of social or recreational stimulation;
- Only around half of people with stressed or distressed behaviours had a care plan in place which which considered alternatives to medication;
- 175 people (52%) were taking anxiolytic medication mainly Diazepam or Lorazepam, with 65 of the 175 (37%) receiving this on a regular basis. This level of use is concerning ... The British National Formulary (BNF) states "Anxiolytic benzodiazepine treatment should be limited to the lowest possible dose for the shortest possible time";
- Some people who did not have the capacity to consent did not have a section 47 certificate in place (see 3.7.3).

Given the advice in the BNF, this report should be a cause of concern. It is surprising, therefore, that the Minister in his letter to Alison McInnes made excuses for the high level

of antipsychotic prescribing to the dementia patients in the survey. He alleged that this group of dementia patients would have been admitted to *“these specialist settings so that their medication (and their overall care and treatment package) can be managed more effectively by the specialist dementia workforce in these settings; or so that they can begin to receive medication with optimum benefit and safety”*.

It appears that the Minister is refusing to acknowledge that the report by the Mental Welfare Commission reveals that there is cause for concern about the high use of psychotropic drugs, particularly antipsychotic drugs, in care homes and hospitals that look after elderly dementia patients. This refusal, together with his refusal to acknowledge that the section in SIGN 86 about the use of antipsychotics in elderly patients with dementia is out-of-date, suggests that the Minister is not being encouraged by his officials to take effective action to reduce the level of prescribing of antipsychotic drugs in care homes for elderly people, homes in which the majority of residents are likely to have dementia.

2.4.1 The Minister should also be concerned that some people who lacked the capacity to consent were receiving medical treatment without a section 47 certificate being in place. This implies that, not only did the responsible medical practitioner lack the authority to treat those patients, but so did those acting on his instructions (See 3.7.3). It should be noted that registered nurses cannot use the excuse that, when treating patients without their consent, they are following the written instructions of the responsible medical practitioner (see 3.8). Clearly the Care Inspectorate should confirm that care home residents who lack the capacity to consent have a section 47 certificate in place and it should be critical in its report of any care home in which treatment is not given lawfully.

2.5 Further evidence that the Minister is unwilling to acknowledge that more needs to be done to protect dementia patients from an unnecessary use of antipsychotic drugs is his reference in his letter of 17 July to *“The Standards of Care for Dementia in Scotland”*. He claims that this contains *“clear standards on therapeutic and medical interventions, including forms of restraint, to manage stress and distress; and on the appropriate use of medication”*. In that document, which was published in June 2011, it is stated that *“When psychoactive medication (including anti-depressants and tranquilisers) and in particular anti-psychotic medication is prescribed for people with dementia the prescribing doctor will need to be satisfied that there will be a clear benefit for the person with dementia and no reasonable alternative”*. The research conducted by the Mental Welfare Commission demonstrates that this advice is being ignored. The advice, of course, is simply an amplification of section 1(2) the Adults with Incapacity Act (see 3.7). Both are being largely ignored because of a failure on the part of the Inspectorate to enforce the provisions of the Act and the apparent indifference of the Government about this lack of enforcement.

2.6 Further evidence that the Standards of Care advice is being ignored is contained within data obtained by Dr Peter Gordon using the Freedom of Information Act. This revealed that in 2011/12 there were 15,926 of 0.5mg capsules of the antipsychotic haloperidol issued to acute and community hospitals in Scotland whereas in 2013/14 the corresponding figure had risen to 20,371. There were similar increases in the number of 1.5mg tablets, 5mg tablets, and 10mg tablets issued. Dr Gordon works with patients aged 65 and over and is concerned that the prescribing of haloperidol in some NHS Board Acute Hospitals has doubled in recent years. His concern was expressed in an email dated 21/05/2015 that was sent to various people including the Minister.

2.7 For a number of reasons haloperidol is an interesting antipsychotic. For example, a recent study (BMJ 2014; 349: g7758) found that in the recorded prescriptions written by GPs in the UK from 2007 to 2011 only 27% of those for haloperidol contained a recorded indication this drug. All drugs have side-effects that can produce adverse drug reactions and the elderly are particularly liable to be affected by those reactions. The BNF advises, therefore, ***“Always consider whether a drug is indicated at all”*** when prescribing for the elderly. As far as haloperidol is concerned that advice is clearly being ignored. Beyond reasonable doubt it follows that many elderly patients with dementia, will have been harmed as a consequence.

2.7.1 SIGN 86 states that ***“Of the older antipsychotics, haloperidol is the most commonly assessed (sic) drug. Evidence suggests that it is useful in the control of aggression in people with dementia”***.

The Mental Welfare Commission’s report revealed that haloperidol was the third most commonly prescribed drug in the group of dementia patients studied, being prescribed to 38 patients, i.e. to 11% of those in the group. The Commission expressed concern about this level of use of haloperidol observing that it often causes adverse reactions in people with dementia. The Minister should take note of the concerns of the Mental Welfare Commission about the high use of haloperidol within the group of dementia patients studied. He should also note Dr Peter Gordon’s finding that the use of haloperidol has been increasing (see 2.6) and that the BNF does not list “aggression” as an indication for haloperidol (see 2.3).

2.8 The Mental Welfare Commission might have expressed greater concern about the high use of antipsychotics it found in its study if it had been aware of recent research which had been carried out in Canada. This research compared the risks to elderly dementia patients of premature death that were associated with the antipsychotic drugs haloperidol, olanzapine, quetiapine, and risperidone. These are antipsychotics that are commonly prescribed to dementia patients and each had been administered to patients in the group studied by the Mental Welfare Commission. The results of the research were published in

March 2015 in a paper entitled “**Antipsychotics, Other Psychotropics, and the Risk of Death in Patients with Dementia**”. The research consisted of a retrospective case-control study. This study made use of the medical records of 90,786 patients aged 65 or older with a diagnosis of dementia. One objective was to determine the absolute mortality risk and number needed to harm (NNH) (i.e. number of patients who receive treatment that would be associated with 1 death) of antipsychotic, valproic acid and antidepressant use in patients with dementia relative to no treatment. It was found that with respective matched nonusers, individuals receiving haloperidol had an increased mortality risk of 3.8% with an NNH of 26; this was followed by risperidone (3.7%, NNH of 27), then olanzapine (2.5%, NNH of 40) and finally quetiapine (2.0%, NNH of 50). Given those findings, there is obviously cause for considerable concern about the Mental Welfare Commission’s findings that 16% of the dementia patients in the group it studied were being prescribed risperidone and that 11% were being prescribed haloperidol.

One of the conclusions of the Canadian research was that “**The absolute effect of antipsychotics on mortality in elderly patients with dementia may be higher than previously reported**”. In the BNF it is stated that “In elderly patients with dementia, antipsychotic drugs are associated with a small increased risk of mortality ...” It is to be hoped that the authors of the BNF will study the Canadian research and will consider deleting the word “small” in the corresponding section of future editions.

2.9 As was pointed out above, in his written answer to a question by Mary Scanlon, the Minister claimed that clinical guidelines on the appropriate use of antipsychotics to help manage stress and distress are contained in SIGN 86. That is a misleading statement: SIGN 86 does not contain information about the appropriate use of those drugs.

In the introduction to the section in SIGN 86 on pharmacological interventions it is stated that:

***“The central features of dementia are cognitive decline and impaired functional ability. A number of associated problems occur frequently, but not uniformly. These problems, sometimes referred to as behavioural and psychological symptoms of dementia or BPSD, can cause considerable distress for both patients and carers. The presence of symptoms such as agitation, irritability, sleep disturbance, delusions, hallucinations or aggression may precipitate admission to hospital or institutional care.***

***Traditionally these associated symptoms have been managed using antipsychotic medication, antidepressants or anxiolytic medication.”***

The symptoms of dementia do commonly cause distress in elderly people with the disease but the use of antipsychotic or other psychotropic drugs will frequently not be the most appropriate way to relieve that distress because the risks will commonly outweigh the benefits. There are other ways of caring for elderly people with dementia though care

homes seem reluctant to employ those, possibly because care homes are not adequately staffed: it is easier to use drugs to keep residents quiet and docile than it is to use non-pharmacological methods (see 2.10.1 for suggestions about those methods).

Unfortunately, it would be far-fetched to claim that antipsychotic drugs would be likely to relieve distress: because of their many unpleasant side-effects (see BNF) the opposite is likely to be the case.

The presence of delusions or hallucinations can cause distress and antipsychotics can help many people who suffer from those psychotic symptoms. However, as noted in 2.2, because of the risks of administering antipsychotics to people with dementia, the BNF advises that these drugs should not be used to treat mild to moderate psychotic symptoms. Not only is there a failure to state this in SIGN 86, this guideline also fails to advise caution in the use of anxiolytics. The widespread use of those drugs in people with dementia revealed in its recent research was commented on unfavourably by the Mental Welfare Commission in its report (see 2.4). Those who prescribed them seemed unaware that, according to the BNF, they are indicated for the short-term relief of severe anxiety or insomnia that is severe, disabling or causing the patient severe distress. The BNF recommends that their long-term use should be avoided. This advice is not contained in SIGN 86.

2.10. In SIGN 86 it is noted that ***“Research into the use of antidepressants for patients with depression and dementia is lacking”***. It does, however, state that ***“Antidepressants can be used for the treatment of comorbid depression in dementia provided their use is evaluated carefully for each patient”***.

In the BNF it is stated that ***“Antidepressant drugs should not be used routinely in mild depression”***. The reasons for this advice are that:

- (i) antidepressants, like all drugs, have side-effects that can cause adverse drug reactions;
- (ii) antidepressants are not particularly effective in the treatment of mild depression.

Yet again advice in the BNF does not appear in SIGN 86.

2.10.1 As far as elderly care home residents are concerned, it may be that some of those who suffer from mild depression would benefit if the recommendations contained in the Mental Welfare Commission’s report were adopted.

These recommendations include the following:

- ***Everyone should have a range of activities which provides them with a meaningful day;***
- ***Opportunities to get outside should be included as an essential part of everyone’s care.***



Those recommendations should be included in revised National Care Standards and should be enforced. It should be noted that people who do not have an opportunity to get outside are at risk of suffering from vitamin D deficiency.

2.11. The National Care Standards for care homes for older people suggest that “sedative or tranquilising drugs” can be used as (chemical) restraint. There can hardly be any doubt that it will commonly be assumed that care home staff, therefore, are at liberty to request that doctors prescribe antipsychotic drugs, often referred to as the “chemical cosh” to “troublesome residents”. It is known that in some care homes residents are regarded as “troublesome” if they are not willing to sit quietly in the common room or their bedrooms but instead wish to walk about inside the home. (If the doors of the home are locked and no member of staff is willing to accompany residents, then the option of going outside to walk is not one that available to them.) Walking about inside the home is described as “wandering” and is regarded as restless or agitated behaviour and hence is assumed by some care home staff and some doctors as something for which the use of an antipsychotic drug would be appropriate (see 2.2). It should not be and revised National Care Standards should make this clear. Not only does the administration of an antipsychotic drug pose a risk to the wellbeing of residents but so does a regime that discourages them from getting up from their chairs to walk about.

2.12 The Minister is to be warmly complimented in agreeing to look at the use of psychotropic drugs as part of the review concerning the inclusion of learning disabilities and autism spectrum disorder within the 2003 Act. When the use of those drugs is being examined account should be taken of a report which appeared in the Mail Online on 14 July 2015. The title of the report was ***“Scandal of thousands of people with learning disabilities being wrongly given anti-psychotic drugs as “chemical cosh” to control their behaviour”***. According to the report:

***In a letter to doctors and patients, senior NHS England officials admitted that drugs were being used as a “chemical restraint” to control behaviour, in place of more appropriate treatments.***

The drugs in question were antidepressants and anti-psychotics. The article stated that ***“... 57.1 million prescriptions for antidepressants were written by GPs and pharmacists last year – a figure that has almost doubled in the last decade from 29 million in 2004. The number of anti-psychotic prescriptions rose from 6.6 million to 10.5 million in the same period”***. Given the findings of Dr Peter Gordon (see 2.6) there should be no assumption that the situation is significantly different in Scotland.

In view of the concerns that have been expressed for many years about the prescription of antidepressants and anti-psychotics, those who conduct the review into the use of psychoactive drugs should investigate the reasons for the increasing use of those drugs.

Part of the reason is likely to be that the use of drugs as restraint is not being challenged. Given the risks associated with the use of anti-psychotics in particular, it may be that the use of drugs as restraint rather than for purposes for which they were developed might constitute a violation of the human rights of the patients in question, namely the right to life and the right not to be subjected to inhuman or degrading treatment. This possibility should be considered. Another possibility that should be considered is that the pharmaceutical companies might not have been totally honest in the way that they have marketed psychoactive drugs: it may be that they have knowingly exaggerated their benefits and have avoided publicising their known risks. What should be clear is that it would be unwise to assume that the “professional judgment” of a doctor is something that should never be questioned: the evidence is clear that not all doctors obey the law and that not all act in accordance with the most up-to-date advice in the BNF.

The failure of some doctors to prescribe in accordance with the latest advice in the BNF may in part be because many doctors genuinely cannot find the time to do the necessary reading. It might be helpful, therefore, if the Scottish Government produced for the benefit of doctors, patients and carers a brief document which detailed the principal risks associated with the use of psychoactive drugs and which contained the general advice in the BNF about the use of those drugs. It may be that the dissemination of knowledge to doctors and the public could play a significant part in reducing the unnecessary use of psychoactive drugs.

### 3. Legal matters

3.1 The research conducted by Medix (see 2.2) revealed that the most common reason for doctors prescribing an antipsychotic drug for an elderly patient with dementia was that the patient in question had allegedly been aggressive. Given the risks of administering an antipsychotic drug to an elderly patient with dementia it should be carefully considered whether this use of the drug might violate some of the patient’s Convention rights, in particular, the absolute right to life and the absolute right not to be subjected to inhuman or degrading treatment.

3.2 Under common law, restraint must not be continued for longer than necessary. This requires that the doctor responsible for the patient’s care to keep under review the continued need for any drug prescribed in response to allegations that the patient is aggressive, especially if the patient has moderate to severe Alzheimer’s disease (see 2.3).

3.3 Under common law a patient with capacity has the right to refuse treatment and there must be a presumption of capacity. Hence it is unlawful to treat a patient without obtaining his or her consent unless it has been established that the patient lacks capacity **and** the treatment is in the patient’s best interests.

3.4 The UK ratified the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2009. Scotland, as part of the UK, is bound by the terms of that legally binding international treaty.

3.4.1 In Article 12.2 CRPD it is stated that ***“States Parties shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life”***.

3.4.2 In Article 12.3 CRPD it is stated that ***“States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity”***.

3.4.3 In April 2014 the UN CRPD Committee expanded on 12.3 in a General Comment which stated that ***“There has been a general failure to understand that the human rights-based model of disability implies a shift from the substitute decision-making paradigm to one that is based on supported decision-making”***. (This implies that there should be no assumption that elderly patients with dementia are entirely incapable of making a decision about taking antipsychotic drugs that pose a risk to their health, especially if they can be supported in their decision making.)

3.5 When seeking the consent of a patient, a doctor is required to specify the significant risks associated with the proposed treatment though, under common law, the doctor was not required to do so to a greater extent than was normally done by other members of the medical profession. This situation may have changed following a ruling of the Supreme Court in March 2015 in a case that involved a brain damaged child. (The need to specify significant risks is obviously relevant when seeking consent to be administered antipsychotic drugs.)

3.6 It is not necessary to prove medical negligence in order to successfully raise an action for compensation against those who were responsible for the administration without an adequate reason of a drug to a dementia patient. By virtue of section 7(1) of the Human Rights Act, if a doctor’s decision to prescribe an antipsychotic (or other drug) to a dementia patient was incompatible with a Convention right then the action raised could be successful and damages awarded. (***There could be recourse to the same section of the Human Rights Act by a dementia patient if he or she wished to ensure that a drug prescribed by a doctor was not administered.***)

3.7

3.7.1 Section 1(2) of the Adults with Incapacity Act states that ***“There shall be no intervention in the affairs of an adult unless the person responsible for authorising or effecting the intervention is satisfied that the intervention will benefit the adult and that such intervention cannot reasonably be achieved without the intervention.”***

3.7.2 In Section 1(4) of the Act it is stated that ***“In determining if an intervention is to be made and, if so, what intervention is to be made, account shall be taken of –***

***(a) The present and past wishes and feelings of the adult so far as they can be ascertained ...”***

(It follows that account must be taken of the wishes of a dementia patient regarding any proposed administration of antipsychotic drugs and hence that the dementia patient must be made aware of any proposal to use those potentially harmful drugs.)

3.7.3 Section 47 of the Act authorises the medical practitioner primarily responsible for the medical treatment of an adult with incapacity ***“to do what is reasonable in the circumstances, in relation to the medical treatment, to safeguard or promote the physical or mental health of the Adult”*** provided that the medical practitioner is of the opinion that the adult is incapable ***“in relation to a decision about the medical treatment in question”*** and has certified that he is of this opinion. (The treatment in question might be the administration of antipsychotic drugs.) Section 47 also authorises any other person who is acting under the instructions of the medical practitioner who has issued a section 47 certificate to carry out the medical treatment which that practitioner believes is necessary.

3.7.4 Section 1(6) of the Act provides information about how the medical practitioner should determine whether the adult is incapable of making a decision about the treatment in question. There should be no assumption that a dementia patient is incapable of making a decision about taking antipsychotic drugs.

3.8 The 2002 code of professional conduct for registered nurses states that ***“You are personally accountable for your practice. This means that you are answerable for your actions and omissions, regardless of advice or directions from another professional.”***

This implies that nurses who act in a way that is incompatible with prescribing guidelines or in a way that is unlawful cannot use the excuse that they were acting in accordance with the written instructions of the responsible medical practitioner. This is made clear in the guidelines for the administration of medicines that was published in 2002 by the Nursing & Midwifery Council. The guidelines state that ***“The administration of medicines ... is not simply a mechanistic task to be performed in strict compliance with the written prescription of a medical professional. It requires thought and the exercise of professional judgment”***.

My experience in a case where I represented a man whose mother, Irene Duncan, died only 18 days after entering a care home suggests that Care Commission’s inspectors were not aware of this principle. It may be that the members of the Care Inspectorate are no better informed. The Care Inspectorate may assume that if they confirm that a medical practitioner has issued a prescription for a drug being administered to a care home resident then there is no need to make further inquiries about the use of that drug. The Care Inspectorate will not be doing enough to ensure that care homes are providing an adequate standard of care if it makes this assumption.