



**A REVIEW OF THE USE OF ANTIPSYCHOTIC DRUGS
IN BRITISH COLUMBIA RESIDENTIAL CARE
FACILITIES**

Ministry of Health

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An adult person in care has the right to the protection and promotion of his or her health, safety and dignity, including a right...be treated in a manner, and to live in an environment, that promotes his or her health, safety and dignity...

- BC Residents' Bill of Rights (2010)

You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die.

- Dame Cicely Saunders, founder of Hospice

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A REVIEW OF THE USE OF ANTIPSYCHOTIC DRUGS IN BRITISH COLUMBIA RESIDENTIAL CARE FACILITIES

SUMMARY

This report documents the process and findings of a review of issues associated with the prescription of antipsychotic medications for elderly residents of residential care facilities in British Columbia. The Ministry of Health undertook the review at the direction of the Minister of Health, in response to public concerns including a complaint raised by a family whose mother was in residential care in the Fraser Valley.

The review occurred from April to June of 2011. Its Terms of Reference were to examine the extent of antipsychotic drug use in provincial residential care facilities, to review existing protocols for treatment of dementia symptoms, including use of consents to care, and to determine whether further actions are required to ensure the health, safety and dignity of elderly residents with dementia.

This review was seen as a first step in identifying the issues and relationships among them. The review used the following approaches to collect and analyze pertinent information:

- consultation with family members and stakeholders through interviews and focus groups;
- a review of relevant literature, clinical practice guidelines, provincial legislation and policy, health authority policies and protocols; and
- an examination of PharmaNet data from PharmaCare¹ on prescription rates for antipsychotic medication for residents of residential care facilities in BC.

The use of antipsychotic medication for care facility residents with dementia is a complex issue that British Columbia shares with other jurisdictions. The findings of the review are presented in the following pages of this document.

The recommendations of this review are based on input provided by focus groups, family members, consultants, experts, and Steering Committee members. Recommendations emphasize: person and family centred care; a safe environment for residents and staff; information availability for families; informed consent to care by residents or their representatives; and ongoing monitoring of medication for residents.

¹ PharmaCare is the British Columbia (BC) publicly funded drug insurance program operated by the Ministry of Health. PharmaCare Plan B covers the full cost of eligible prescription drugs and designated medical supplies for permanent residents of licensed residential care facilities in BC.

INTRODUCTION

This report documents the process and findings of a review of issues associated with the prescription of antipsychotic medications for residents of residential care facilities in British Columbia.

In February 2011, the media reported concerns expressed by a family about the treatment of their mother with antipsychotic medication while she was living in residential care in the Fraser Valley. Their concerns focused on whether antipsychotic medications were used appropriately in her care and other issues regarding giving consent to healthcare. In response to public concerns about the use of antipsychotic drugs as well as the complaint of this family, the Minister of Health directed the Ministry to undertake a review of the issues.

THE REVIEW

The purpose of the review was to gather information regarding the extent of antipsychotic medication use in British Columbia (BC) residential care facilities, to review existing protocols for treatment of dementia symptoms, review family and health care provider understanding of consents to health care, and to determine whether further actions are required to address these issues. Particular attention was paid to the role of families and caregivers in planning and consenting to care for residents no longer capable of directing their own care. (*See Appendix A for complete terms of reference.*)

The review included the following activities:

- meetings with focus groups and stakeholders;
- a review of provincial legislation and policy, as well as health authority policy, procedures and protocols;
- sampling of clinical guidelines and best practices;
- a limited literature review and environmental scan; and
- examination of PharmaNet data on prescription rates for antipsychotic medication for residents of licensed care facilities in BC.

THE CONTEXT

The Ministry of Health (the Ministry) has overall responsibility for ensuring that quality, appropriate, cost effective and timely health care services are available to all British Columbians. The Ministry works with health authorities, care providers, agencies and other groups to guide and enhance the Province's health services and ensure British Columbians have access to care and are supported in their efforts to maintain and improve their health. The Ministry provides leadership, direction and support to these service delivery partners and sets province-wide goals, standards and expectations for

health service delivery by health authorities. The Ministry enacts this leadership role through the development of policy, legislation, professional regulation, and funding decisions, negotiations, and bargaining. The Ministry also uses an accountability framework for oversight of health authorities and health professional regulatory bodies.

Although the BC health system effectively meets the majority of population health needs, it continues to be challenged by an increasing demand for health services. The most significant drivers of rising demand are the aging population, the increasing need to provide care to frail seniors, a rising burden of illness from chronic diseases, including mental illness and cancer, and advances in technology and pharmaceuticals driving new costly procedures and treatment.

BC's senior population currently makes up 15 percent of the total population and is expected to double within the next 20 years, making it one of the fastest growing senior populations in Canada. As our population ages, we will also continue to see an increase in the prevalence of dementia. In BC, there are currently around 64,000 people with some form of dementia. It is anticipated that this number will grow to 94,000 people, an increase of around 47 percent by the year 2026.² There is an increasing need to help seniors stay healthy, independent and in the community for as long as possible and to provide appropriate care for those who are frail or have dementia who can no longer live safely on their own.³

Dementia is a progressive, degenerative, life-limiting condition caused by diseases of the brain. Dementia may occur alone, in addition to, or as a complication of, other chronic diseases. As the proportion of older adults and those with complex chronic disease in the population increases, so will the number of people with dementia. Although the chance of developing dementia increases with age, dementia is not an inevitable part of aging. According to the *Canadian Study of Health and Aging*, the prevalence of dementia from Alzheimer's disease and other dementias increases significantly after age 65 and is highest in people age 85 or over. Early-onset dementia occurs in people under age 65, and may appear as early as age 45.

The prevalence of dementia has particular significance for integrated primary and community care services. Supporting persons with dementia to continue to live independently in the community creates unique challenges. Dementia has a major impact on the quality of life of the person and the family, as it impairs higher brain functions including memory, learning, orientation, comprehension, language, and judgement. Caregivers of persons with dementia often experience high levels of distress with managing the burden of care, especially as behavioural and psychological symptoms increase over the span of the disease⁴. These symptoms may include delusions, hallucinations, verbal outbursts, agitation and physical aggression.

² Centre for Applied Research in Mental Health and Addictions, Simon Fraser University.

³ Ministry of Health Revised Service Plan, 2011/12 – 2013/14, May 2011.

⁴ Home Care Reporting System, 2007–2008, Canadian Institute for Health Information.

Families and caregivers

Many families are actively involved in caring for their loved ones who are aging. They are often engaged with the care team in residential care settings and become well informed about care and treatment options. Many of these family members are also appointed under the *Representation Agreement Act* as the legal health care decision maker for their family member. These families are highly motivated and may take on a strong advocacy role as their loved one moves through the care system. Other families may need more information to understand aging and degenerative disease processes, and may wish for clear, understandable information to help them provide informed consent to health care and substitute decision making.

Residential care facilities

Residential care facilities provide 24-hour professional nursing care in a protective, supportive environment for people who have complex health care needs and cannot live safely on their own. The criteria for placement in BC residential care facilities have changed in the last several years; there are no longer graduated levels of care, such as “personal care”, “intermediate care” and “extended care.” Today’s residents of care facilities all have complex care needs, and typically need professional nursing care, monitoring and/or specialized, skilled care.

There are unique challenges in seeking and obtaining consent in residential care settings, as residents are often incapable of consenting or refusing consent to health care and may never have expressed their wishes for future care. They may have hearing or other communication deficits that make such discussions difficult. As residents near the end of their lives, there are many decisions to make, some not anticipated. This is a very difficult time for families, who may be overwhelmed, unavailable, or not aware of their responsibilities to make such decisions on behalf of their elder family members.

Safety issues

Residential care facilities are homes for their residents, but are also workplaces, where it is important to keep staff and other residents safe. In Canada, according to the 2005 National Survey of the Work and Health of Nurses, 50 percent of nurses working in long-term care facilities reported that they had been physically assaulted by a patient in the previous year.⁵

When persons with dementia experience behavioural and psychological symptoms of dementia, they may become agitated and aggressive. Residential care providers must ensure a safe and respectful environment for all residents and staff. This may be a challenge when faced with aggressive behaviour by residents.

⁵ Statistics Canada, *Findings from the 2005 National Survey of the Work and Health of Nurses* (Ottawa: Statistics Canada, 2006).

The Health Care Team

In residential care, a range of health care professions work in multidisciplinary care teams. This may represent a significant shift in expected roles for some patients and families, whose previous experience may have been an ongoing relationship with a more limited range of independent health care providers, typically the family doctor and the community pharmacist.

In residential care settings, nurses and care aides have direct daily contact with the residents and provide hands-on care and supervision. Senior nursing staff typically formulate care plans that include the considerations directly pertinent to daily functioning, rather than focusing on the diagnosis and treatment of medical conditions. Pharmacists are appointed to each facility and must monitor all pharmaceutical treatment and conduct medication reviews for individual residents, in keeping with College of Pharmacists bylaws. In this setting, the interacting roles of the care providers may be confusing for residents and families. This may also present challenges to care providers to ensure clear communication and a comprehensive process of gaining informed consent for specific health care interventions.

I. BACKGROUND: THE ISSUES AND THE REGULATION OF PRACTICE

This section of the report sets out the issues and how residential care and health care are regulated by government legislation, policy, clinical guidelines, and ethical and professional practice guidelines.

THE ISSUES

The Role of Family and Caregivers

Residential care providers are expected to involve residents and their families and caregivers in planning and directing residents' care, to the extent families and caregivers are willing and able. This is particularly so when the residents are not capable of making their own decisions due, for example, to advanced dementia, and when the persons in care may not have provided prior guidance on their wishes for future care.

Prescription of Antipsychotic Medications for Care Facility Residents

A 2009 Statistics Canada report on medication use among seniors indicated that 53 percent of seniors in health care institutions took five or more different drugs during the two years prior to the data collection⁶. Inappropriate medication or medication errors among seniors have long been identified as causes of adverse events, including unnecessary visits to emergency departments and admissions to hospital:

Evidence shows that older adults are more at risk for adverse effects due to complex drug therapies and age-related changes to the way drugs are processed by the body. A 2002 literature review noted that "28 percent of all emergency department visits were drug related, of which as many as 24 percent resulted in hospital admission." The study showed that 70 percent of the drug-related emergency visits are preventable and that, "women and elderly individuals seemed to be at greatest risk".⁷

Antipsychotics are "drugs used to treat the severe distortions in thought, perception, and emotion that characterize psychosis".⁸ These medications were originally developed to treat schizophrenia and other psychoses, but have increasingly been used to treat the behavioural and psychological symptoms (e.g., delusion, aggression and agitation) of

⁶ Ramage-Morin, Pamela. (2009) Medication use among senior Canadians, *Health Reports*, Vol. 20, no. 1, Statistics Canada, p. 37.

⁷ Patel P, Zed PJ, Drug-related visits to the emergency department: how big is the problem. *Pharmacotherapy* 2002 Jul;22(7):915-23.

⁸ Canadian Mental Health Association, http://www.cmha.ca/bins/content_page.asp?cid=284-683-1549-2357-2370

advanced dementia.⁹ Antipsychotics stabilize mood and reduce anxiety, tension, and hyperactivity, so they are used to help control agitation and aggressiveness.

A first generation of antipsychotics, or “typical” antipsychotics, was developed in the 1950s. Most of the drugs in the second generation, known as “atypical” antipsychotics, have been developed more recently. The first atypical antipsychotic, clozapine, was introduced clinically in the 1970s. Since their introduction, researchers have identified serious side effects and risks associated with the use of antipsychotics for elderly patients and patients with dementia. These effects include sedation, higher risks of falls and hip fractures, Parkinson's disease-type symptoms, cardiovascular events (stroke and heart attack), and the greater risk of death. In June 2005, Health Canada issued an advisory notice. It stated that:

...treatment with atypical antipsychotic medication of behavioral disorders in elderly patients is associated with an increased risk for all-cause mortality. Except for risperidone (RISPERDAL), these medications are not approved for use in elderly patients with dementia¹⁰.

According to PharmaNet data, the antipsychotics most commonly used in BC residential care facilities are atypical (quetiapine, risperidone, loxapine, and olanzapine), followed by the typical antipsychotics, haloperidol and methotrimeprazine.

PharmaNet Data

PharmaNet data indicates that 50.3 percent of PharmaCare Plan B (residential care) patients were prescribed an antipsychotic between April 2010 to June 2011 (this excludes residents in some 90 care facilities designated as “extended care hospitals” under the *Hospital Act*). These data, however, do not provide information about how long each medication was used, or the condition for which these drugs were prescribed. The rate of antipsychotic prescription was seen to be similar in all health authorities. The data included 477,765 prescriptions dispensed at a cost to PharmaCare of \$9.245 million.

⁹ Hagen et al (2005), Antipsychotic drug use in Canadian long-term care facilities: prevalence, patterns following resident relocation, *International Psychogeriatrics*, 17:2, 179; 180.

¹⁰ Health Canada Endorsed Important Safety Information on Atypical Antipsychotic Drugs and Dementia (2005), Health Canada, retrieved on June 26, 2011 from: http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/_2005/atyp-antipsycho_hpc-cps-eng.php

Health Authority	Those Using an Antipsychotic: Distinct Resident Count	All Plan B Patients: Distinct Resident Count In HA	Percent of HA's Plan B Patients On Antipsychotics
01 Interior	2,887	5,787	49.9%
02 Fraser	5,387	10,906	49.4%
03 Vancouver Coastal	3,547	7,136	49.7%
04 Vancouver Island	3,173	6,160	51.5%
05 Northern	530	1,109	47.8%
All BC (Distinct Residents)	15,119	30,032	50.3%

Source:

Policy, Outcomes Evaluation and Research; Pharmaceutical Services Division; Ministry of Health Services. Retrieved Jun 09, 2011; HealthIdeas. Data for the period Apr-01-2010 to Jun-01-2011.

These data indicate an increase in antipsychotic prescription rates for residential care compared with that observed in earlier periods: 37 percent in 2001/02 and 47 percent in 2006/07 (data also from PharmaNet).

In 2009, the Canadian Institute for Health Information released *Antipsychotic Use in Seniors: An Analysis Focusing on Drug Claims, 2001 to 2007*. The data does not include BC, but is worth noting for comparison. In 2006–2007, 37.7 percent of seniors residing in nursing homes in Manitoba, New Brunswick, and P.E.I. were using antipsychotic drugs, compared to 2.6 percent of seniors in the community. The following comment from Michael Hunt, Manager of Pharmaceuticals at CIHI, provides context:

It is not surprising to see a higher use of antipsychotic drugs in nursing homes, since dementia is more prevalent there and nursing home residents are generally in a more advanced state of the disease....Nevertheless, it's important to closely monitor the use of antipsychotics in all elderly patients.¹¹

PharmaNet data indicates that antipsychotic prescription rates for BC seniors is 4.7 percent in community and 47 percent in residential care in 2006/07. The CIHI study found that risperidone, quetiapine and olanzapine were the atypical antipsychotics most commonly prescribed for seniors.

CLINICAL PRACTICE GUIDELINES

The BC *Clinical Practice Guideline on Cognitive Impairment in the Elderly: Recognition, Diagnosis and Management* (2007, revised 2008), developed jointly by the BC Medical

¹¹ Canadian Institute for Health Information. *Antipsychotic Use in Seniors: An Analysis Focusing on Drug Claims, 2001 to 2007*. 2009. http://www.cihi.ca/cihi-ext-portal/internet/en/document/types+of+care/pharmaceutical/release_09jul09

Association and the Ministry of Health, recommends environmental and behavioural modifications and psychosocial interventions for first line management of behavioural and psychological symptoms of dementia.

The Guideline recommends physicians exercise caution when prescribing antipsychotic medications for elderly persons with dementia due to their side effects and the increased risk of death associated with their use for this population.

The Guideline recommends antipsychotic medications be used only when:

- alternative therapies are ineffective on their own;
- there is an identifiable risk of harm to the patient and others; and
- symptoms are severe enough to cause suffering and distress.

When using antipsychotics, the Guideline recommends beginning with a careful trial of a low dose, with slow upward titration and close monitoring of effects.

There are other best practice guidelines on dementia care for health care providers. The following Canadian guidelines are examples:

- National Guidelines for Seniors' Mental Health - The Assessment and Treatment of Mental Health Issues in Long Term Care Homes (May 2006);
- Canadian National Consensus Guidelines for Dementia, 2007; and
- Guidelines for Care: Person-centred care of people with dementia living in care homes, Alzheimer Society of Canada, January 2011.

The guidelines and practical tools have been developed to assist health care providers and families in providing appropriate and evidence-based care to persons with dementia.

There is currently no cure for dementia. However, there are medications that can improve symptoms and delay progress of the condition in some individuals for a time, but not indefinitely. Other medications may help manage anxiety, depression and behavioural symptoms. New classes of drugs are in development. It is important to discuss your own expectations for treatment as well as the risks and benefits of any medications with your doctor prior to making any decisions about treatment. Caregivers are in a position to monitor symptoms and general health status and should be included as partners in treatment planning. – Cognitive Impairment in the Elderly: A Guide for People with Dementia and Their Caregivers (BC Ministry of Health, 2007)

LEGISLATION AND POLICY

The care for residents in facilities is regulated by several pieces of British Columbia legislation, principally the *Health Care (Consent) and Care Facility (Admission) Act* and the *Community Care and Assisted Living Act (Residential Care Regulation)* which regulates, among other things, care planning, consent and the use of restraints in licensed care facilities.

The Ministry of Health's *Health Services Management Policy* (2011) requires that health authorities:

- comply with provincial legislation that regulates or affects their operations or activities, and with Ministry policy and standards;
- enforce applicable health legislation and Ministry policy and standards; and
- ensure that service providers¹² have access to, and comply with, provincial legislation and Ministry policy and standards that regulate or affect the operations or activities of the providers.

Consent to Health Care

Before providing any healthcare treatment, which includes prescribing medication, all health care providers (physicians, nurses, therapists, dentists, etc.) are required by law¹³ to seek and receive valid and voluntary consent from their patient (if the patient is capable). If the patient is not capable, consent must be obtained from their authorized decision maker before providing treatment. Consent must be specific to the treatment being proposed. Legislation also requires health care providers to fully inform patients (or their authorized decision maker) of the risks and benefits of the treatment they seek. Voluntary, informed, consent from a capable adult must be sought except in particular circumstances¹⁴.

In BC, adults living in residential care facilities have the same right as others to give or refuse consent to health care. Persons who live in residential care facilities, like all other adults, are assumed to be capable of making health care decisions, unless the contrary has been verified.

There are three important times that consent of persons who live in, (or are being admitted to) a residential care facility is needed:

- Consent to enter the facility (*as per the Health Care (Consent) and Care Facility (Admission) Act*);
- Consent to the plan of care (upon admission and reviewed annually);
- Consent to substantial changes to the care plan (such as the addition of a new medication) if required.

¹² *Service providers* are organizations contracted/funded by a health authority to deliver services on behalf of the health authority.

¹³ *Health Care (Consent) and Care Facility (Admission) Act*

¹⁴ Consent is required unless the following apply:

- in an emergency, if the adult is incapable, no substitute decision maker can be reached, no prior wish was expressed by patient when capable regarding such treatment, and the health care provider has no reason to believe that the adult when capable expressed the wish not to have such a treatment; or
- the health care is related to a mental illness for which the adult is being treated involuntarily under the *Mental Health Act*; or
- the treatment is for an illness or condition that is a public health risk (e.g. tuberculosis) under the *Public Health Act*.

Care providers must seek and receive valid consent for the care plan from residents or their authorized health care decision makers as per the *Community Care and Assisted Living Act's* Residential Care Regulation. Further to this, the various health care professional colleges have ethical and practice guidelines with respect to consent to health care as below:

- Code of Ethics for RPNs, College of Registered Psychiatric Nurses of British Columbia, no date;
- Code of Ethics for LPNs, College of Licensed Practical Nurses of British Columbia, November 2004;
- Practice Guideline: Consent, College of Licensed Practical Nurses of British Columbia, December 2010;
- Practice Standard: Consent, College of Registered Nurses of British Columbia, January 2, 2011;
- Professional Standards for Registered Nurses and Nurse Practitioners, College of Registered Nurses of British Columbia, 2008. (Includes consent and restraint use);
- The College of Physicians and Surgeons of British Columbia has adopted the Canadian Medical Association's Code of Ethics (1996) which includes principles that reflect consent to health care law; and
- The Canadian Medical Protective Association provides guidance to all Canadian physicians in its publication, *Consent: A guide for Canadian Physicians* (2006) and offers an online course on Informed Consent.

Restraint

The Residential Care Regulation defines restraint as “any chemical, electronic, mechanical, physical or other means of controlling or restricting a person in care's freedom of movement in a community care facility, including accommodating the person in care in a secure unit”. As antipsychotic medications have significant effects on resident behaviour, their use may, in some circumstances, also be considered a form of restraint. Residents of care facilities are vulnerable due to age and ill health, so provincial legislation governing licensed facility care includes protection from the inappropriate use of restraints. The Residential Care Regulation¹⁵ restricts use of restraints in licensed care facilities (see Appendix C).

If an antipsychotic medication used to manage behaviours results in restraining or restricting a resident's movements, it would be regarded as a restraint and must be consistent with provincial legislation¹⁶ and policy (Appendix C contains a more complete explanation of requirements for valid consent to health care and the use of restraints in care facilities).

¹⁵ Section(s) 73 and 74

¹⁶ Sections 73, 74, and 81 of the Residential Care Regulation

II. WHAT WE LEARNED

The review team set out to:

- look at policies and procedures in place in BC and its five regional health authorities;
- briefly survey research literature on the use of antipsychotics in residential care and undertake a limited environmental scan of activity on the issues in Canada and other jurisdictions; and
- hear from focus groups, family members, and subject matter experts.

HEALTH AUTHORITY POLICY, PROCEDURES, AND ONGOING EDUCATION

To gather information about how health care providers practice in the areas under review, health authorities were surveyed regarding policy and staff education on dementia care and consent to health care.

Environment and Care

All health authorities have recognized the importance of environmental and behavioural modifications and psychosocial interventions for management of behavioural and psychological symptoms of dementia. They all have clinical practice guidelines related to dementia, depression, and delirium, and frameworks on dementia care.

Consent to Health Care

All five health authorities indicated that they have policy and materials on consent to health care, updated to reflect legislative changes effective September 1, 2011. However, while appropriate policy is in place, this review was unable to determine the extent to which front line staff follow that policy. Keeping front line staff current in these areas may be a considerable challenge in the residential care field.

LITERATURE REVIEW AND SCAN OF OTHER JURISDICTIONS

Consent

While there is much literature on consent to health care and the various challenges related to capability assessment and proper procedures, there appears to be little research on issues of consent specific to dementia and antipsychotic drug use for dementia. One researcher (Brummel-Smith, 2008) suggests that the risks associated with antipsychotic medication should encourage physicians not only to seek consent, but also to document the consent process.

Antipsychotics

Recent research literature on the use of antipsychotics and dementia examines a range of overlapping issues. These include studies of efficacy, comparative risks of typical versus atypical, non-pharmacological alternatives to manage symptoms, and the challenges of caring for persons with dementia within residential care settings.

Research in this area also reports increasingly high rates of use of antipsychotics for dementia as new medications become available. Much of the literature also recommends that other approaches be used before medication. This recommendation is common to clinical guidelines in this area.

Researchers acknowledge that there is a role for approved antipsychotic medication in the treatment of behavioural and psychological symptoms of dementia, when risks are carefully weighed against the benefits to the patient's distress or anxiety, and they are used only:

- as a last resort after other approaches have been tried and have not been effective;
- with valid consent from proxy decision maker who is informed of risks and benefits; and
- consistent with clinical guidelines: low dose, slow upward titration, short duration, and close monitoring for effects.

One Canadian study (Rochon et al, 2007) concluded that “[r]esidents in facilities with high antipsychotic prescribing rates were about 3 times more likely than those in facilities with low prescribing rates to be dispensed an antipsychotic agent, irrespective of their clinical indication.” This suggests that the culture of a particular facility could be associated with practitioners’ individual prescribing practices.

“Prescribing antipsychotic therapy to a resident with no clinical indication for the therapy has been identified as a measure of poor quality of care.”

- *Ottawa Citizen*: Paula Rochon is a professor of medicine at the University of Toronto whose career has focused on improving the use of medications to treat older adults.

Restraints

Although this review did not look closely at the literature on restraints, the tendency to associate antipsychotic drugs with chemical restraint suggests a need to distinguish clearly between their use as treatment and as restraint. A study on the use of restraints in acute care (Poole et al, 2005) makes the following distinction:

The difference between a chemical restraint and a treatment centers on the extent to which the patient has been assessed and medication prescribed as part of a treatment plan or whether it has been given specifically to control the patient's behaviour for the convenience of the staff.

The authors define “convenience” as any action to control or manage behavior that is not in the best interest of the patient. The Ontario Health Association (2001) defined

chemical restraint as “use of psycho-pharmacologic drugs – not required to treat medical symptoms – for any purpose of discipline or convenience.”

SCAN OF OTHER JURISDICTIONS

This section provides an overview of approaches to the use of antipsychotic medication for persons with dementia in selected other jurisdictions. This issue has been addressed by regulatory agencies as well as government bodies. It appears that, while there are guidelines and research available, there is still work to be done to change practice accordingly.

Ontario

The Ontario Ministry of Health and Long Term Care announced in 2011, as part of the new Ontario Behavioural Support Systems Project, plans to hire 700 health-care workers province-wide to provide better care for aggressive and “difficult” patients with dementia. The Project is meant to keep more people at home and out of long-term care facilities as long as possible and to reduce the use of medications and restraints for patients who are already institutionalized. It is to start with four pilot projects this year and expand across Ontario next year.

United Kingdom

In 2008, Britain’s All Party Parliamentary Group on Dementia issued a report entitled *Always a last resort: Inquiry into the prescription of antipsychotic drugs to people with dementia living in care homes*.¹⁷ That report made recommendations regarding what can be done to limit the use of antipsychotics.

In 2009, the Department of Health issued an independent report by Prof. Sube Banerjee, “*The use of antipsychotic medication for people with dementia: Time for action*”.¹⁸ The report made eleven recommendations to address the issue. Primarily, it recommended people with dementia should receive antipsychotics only when they really need them. It suggested reduction in use of antipsychotics can be achieved by various means such as training carers and medical staff to use alternatives to antipsychotics, providing resources for the delivery of psychological therapies for people with dementia and their carers, and carrying out audits and further research into alternative treatments.

...the medication literature is not especially helpful, and very confounding. If it were up to what we read we would never use a medication in these situations, and we would have very distressed elders and caregivers. That would be inhumane undignified care also, as is over usage.

- A Vancouver Geriatric Psychiatrist

¹⁷ All-Party Parliamentary Group on Dementia (2008), *Always a last resort: Inquiry into the prescription of antipsychotic drugs to people with dementia living in care homes*.

¹⁸ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108302.pdf

In June 2011, the National Health Service (NHS) Institute for Innovation and Improvement, in partnership with the Dementia Action Alliance, issued *The Right Prescription: a call to action on the use of antipsychotic drugs for people with dementia*¹⁹ with the aim to improve the quality of life for people with dementia and their caregivers by reducing the inappropriate use of antipsychotics for these people. It sets a goal that all people with dementia who are receiving antipsychotic drugs will have undergone a clinical review to ensure that their care is compliant with current best practice and guidelines, and that alternatives to their prescription have been considered and a shared decision has been agreed regarding their future care by March 31, 2012.

Australia

In 2008, the Royal Australian and New Zealand College of Psychiatrists and PHARMAC (a pharmacists' advisory body) issued *Antipsychotics For Dementia: Best Practice Guide*. In 2011, Australia's Parliamentary Friends of Dementia met regarding overuse of antipsychotic medications for people with dementia.²⁰ The report called for:

... an approach to this issue that balances the importance of psychosocial approaches to treating behavioural symptoms of dementia, understanding that, for a small number of individuals with behavioural symptoms of dementia, antipsychotics are the only option that works.

United States

In 1987, the US government introduced the *Omnibus Budget Reconciliation Act* regulations that established the right of nursing home residents to be free of restraints used for discipline or convenience rather than for medical symptoms. Related regulations also specify that uncooperativeness, restlessness, wandering, or unsociability do not justify the use of antipsychotics. In 2005 and 2008, the Federal Drug Agency (FDA) issued warnings about the use of antipsychotics and the increased risk of death for their use on elderly people.²¹

In summary, the issue of the use of antipsychotic medication for care facility residents with dementia is being recognized and addressed by many jurisdictions.

¹⁹ http://www.institute.nhs.uk/images/Call_to_Action/Call_to_action_v2_CHOSEN_v2.pdf

²⁰ Media release, Alzheimer's Australia (2011) "Antipsychotics overused in dementia," Retrieved on June 20, 2011 from http://www.alzheimers.org.au/common/files/NAT/20111906_Nat_MR_PFODBRYNE.pdf

²¹ <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2008/ucm116912.htm> and <http://www.hospicepharmacia.com/assets/pdf/PMM0808.pdf>

FOCUS GROUP AND STAKEHOLDER FEEDBACK

The views of participants were diverse, both amongst participants in groups and across groups. Perhaps the most important information gathered during the review came from face to face meetings with:

- family members, friends and decision makers for persons in residential care (or formerly in residential care), as well as groups representing caregivers;
- representatives of health professional colleges; and
- health authority representatives responsible for residential care facilities, seniors, and vulnerable populations.

A common theme that emerged from these focus groups and meetings was that the issues being discussed are both personal and professional. In each meeting, participants, both healthcare providers and family members, talked about their own families and their experiences with caring for aging loved ones. Participants' feedback fell into several general themes, as outlined below.

Family members typically know the resident best, and know their needs and behaviours, and what approaches have been successful in the past. We heard that good dementia care depends upon such teams and on good communication among their members.

Environment

The role of environment in influencing problematic behaviour associated with dementia was viewed as very important by both healthcare providers and families, as some of the agitation and behaviour symptoms of dementia are related to a person's surroundings. Noisy and crowded environments were viewed by this group as more "institutional" and more stressful for residents. Older buildings may present challenges as they may not typically have single rooms, small pod-like groupings, access to a safe outdoor areas, dedicated space for safe wandering, and the other physical features of newer, purpose-built facilities.

Smaller facilities with more consistency in staffing were viewed as providing better support for resident-centred teamwork. Participants were aware of the importance of small groupings of residents and the need for a quiet and unhurried approach to providing care. Other environmental factors that were seen as important were:

- single occupancy rooms;
- readily accessible outdoor spaces for persons with dementia to wander safely; and
- staff scheduling for continuity of care, including sufficient available staff who are familiar with residents' needs.

Families and the Care Team

There was consensus among participants on the need for family members, who know the resident best, to be part of the care team - to be consulted and to be active participants in the care planning process. Participants made various suggestions about how these teams could best be initiated and supported. Suggestions included having

the family provide additional information and background about the person in care at the time of admission, describing habits or behaviour, and proposing ways to avoid or minimize agitation based on the families' past successes.

As communication can sometimes present challenges to families, participants suggested ways for communicating changes in residents' status between scheduled care conferences, such as regular communication by phone or e-mail. This would ensure families are included in all parts of care planning and avoid frustration caused by not knowing a loved one's care status. Where families live at a distance and cannot attend scheduled care conferences in person, teleconferences may be an effective way for them to be included.

Families vary greatly in the level of involvement they are able and willing to have in their loved ones' health care decision making. While some family members may remain actively involved as strong advocates for their loved one, others may have experienced significant stress as caregivers, and may need to step back a bit in order to protect their own health and well being.

Families who act as strong advocates for their members may experience challenges in interacting with health care professionals and residential care facility staff. This may be the case when family members feel:

- they are not effectively included in the care plan development;
- their legal authority as health care decision makers is not recognized and respected; or
- their consent is not sought when treatment options are considered and provided.

Quality of Care

All participants agreed good care takes time. Participants observed that the best (that is, non-pharmacological) approaches to dementia care involve personal attention, such as taking the resident for a walk or having a cup of tea in a familiar setting. However, these approaches take time, and the present staffing ratios in care facilities were thought insufficient to ensure this type of attention. It was also noted that the team approach to care works best when facilities have stable staffing and low staff turnover. Families must be considered valuable members of the care team with experience and expertise to share. Collaboration between families and all members of the care team helps build trusting relationships and leads to better care decisions for the person in care.

"...we tried to have it (antipsychotic medication) stopped but felt we had to accept. There was a care planning meeting where everyone was invited. There was no doctor at that meeting..." Experience of a family member

Education and Communication

Healthcare providers noted that families could benefit from more information about dementia. Ideally, family members need this information when their loved one initially receives a diagnosis of dementia, so that they can plan effectively and have realistic expectations for future health and care. Families may need extra support in understanding the final stages of the disease as residential care for persons with dementia is increasingly recognized as end-of-life care, since it is progressive and degenerative.

While policy is necessary, additional education and hands-on training are needed to bring policy to life and apply it to complex situations. Interdisciplinary education was viewed as a good approach to encourage better communication among care providers and to promote the teamwork that is essential to better dementia care.

Use of Antipsychotic Medication

All family members who participated in this review were devoted and caring, and were committed to protecting the health and dignity of their loved ones. Some recognized the benefits of antipsychotics for a particular phase of dementia where symptoms (for example, paranoia, fear, anxiety) were particularly evident and believed that medication had helped their loved ones through a difficult time. In other cases, families believed antipsychotic medications had very negative effects on a family member, leaving the person in care unable to communicate, and compromising their health and dignity. In these cases, family members were very distressed by the use of these medications believing they were being used for the convenience of staff. These families were highly motivated to find alternative solutions to ease their loved ones' distressing symptoms.

Consent to Health Care

Some participants reported that no care provider or practitioner sought their consent before prescribing antipsychotics or any other medication to their family member in care. There appears to be a lack of clarity regarding requirements for consent to health care once a person is admitted into residential care. Some family members clearly understand that they are legally appointed representatives for health care decisions, and expect to be included in decision making. Other families assume that admission to a care facility leaves them no further role in health care decisions for their loved ones. It was clear that family members could benefit from easy to follow information to better understand consent to health care and their role in it.

Participants in the family and caregiver groups had questions about the level of understanding health care providers may have about their roles and responsibilities to seek and obtain valid consent to health care. There was some concern that because consent laws are relatively new (2000), some practitioners lack sufficient awareness about legal requirements for consent to health care. Some participants thought

physicians may believe that it is not their responsibility to obtain consent. As other health care providers often take their cues from physicians, lack of knowledge about consent was viewed as an issue in all areas of practice. Some asked whether training programs for health professionals may not emphasize the issue of consent sufficiently in their curricula. Some thought the culture and workload of health care providers may contribute to overlooking consent requirements.

Restraints and Safety

An important issue with respect to the use of restraints was raised by health care providers. The Residential Care Regulation requires that “all alternatives to the use of the restraint must have been considered and either implemented or rejected.” However, participants reported that there appears to be some lack of clarity around what constitutes an alternative to restraint. Furthermore, care providers face a unique dilemma in achieving balance between residents’ right to freedom from restraint and the duty to ensure safety of staff and other residents from violence.

Health care providers confirmed that, if a resident with dementia who is no longer capable of giving consent, has violent behaviour that is a physical threat to the individual or to others, and the authorized decision makers refuse medication, or other appropriate treatment that is proposed to manage that behaviour, then the resident may be discharged home.

If it is not appropriate to discharge the resident home, then the practice is to send the resident to a hospital that is designated under the *Mental Health Act*. In these designated settings, the patient may be certified under the *Mental Health Act*, and involuntary treatment, including medication, may be provided without the consent of the patient or their authorized decision maker.

III. NEXT STEPS: RECOMMENDATIONS

This review has provided a better understanding of the issues related to the use of antipsychotic medications, and has also identified the range of protections that are currently in place, such as legislation and professional guidelines. It has also helped to identify key areas for improvement, such as the need for greater awareness of issues surrounding dementia and health care consent and for more collaborative care planning and information sharing amongst health care professionals, service providers and families.

The following recommendations are drawn from the many voices that informed this review – families, focus groups, literature, clinical experts, research consultants and the Steering Committee formed to examine these issues. Some of these recommendations may overlap and it is accepted that addressing the recommendations will require an integrated response.

The recommendations are:

1. The Ministry of Health and health authorities should provide education to physicians, facility staff and the public regarding:
 - health care consent requirements;
 - advance care planning; and
 - facility operators' responsibility to ensure families have information on consent upon admission to a facility.
2. The Ministry of Health work with health authorities to continue to monitor the health, safety and dignity of people living in residential care facilities through inspections such as routine, complaint and follow up visits, and make public the results of these inspections.
3. The Ministry of Health work with health authorities, physicians, the College of Pharmacists on opportunities and approaches for increased oversight and monitoring of:
 - individual and facility medication practices;
 - standardization of patient-specific medication reviews;
 - facility medication practices; and
 - appropriate and timely documentation.
4. The Ministry of Health should review section 73(2)(a) of the Residential Care Regulation to determine whether the requirements:
 - provide appropriate protection for the health and safety of persons in care; and
 - are realistic and achievable.

5. The Ministry of Health and health authorities collaborate with community partners to improve public understanding of dementia and dementia care by:
 - increasing the awareness and use of existing materials; and
 - creating new materials including the use of e-learning.

6. The Ministry of Health to work in partnership with patients, caregivers, physicians, residential care providers and other key stakeholders to develop and enhance awareness of existing education materials to support positive family to facility relationships and a person centred culture of care.

APPENDICES

APPENDIX A: REVIEW TERMS OF REFERENCE

Background

In February of 2011, the media raised concerns about the use of antipsychotics for seniors with dementia in residential care facilities after a Fraser Valley family expressed concerns about care and treatment of their mother while residing in residential care. Their concerns focus on whether appropriate consents are being obtained from family/legal representatives when a person in care is not capable of giving consent, and whether antipsychotic medications are being used appropriately.

Purpose of Review

To review the extent of antipsychotic drug use in provincial residential care facilities, to review existing protocols including use of consents, and to determine whether further actions are required to address these issues.

Review Approach

A Ministry Steering Committee has been established to oversee the review and report back to the Ministry Executive.

Working Group Responsibilities

- Provide Ministry Executive an analysis on the current state of antipsychotic drug usage and use of consent protocols; and
- Provide Ministry Executive with recommendations that arise from review process.

Individual Member Responsibilities

- Provide expertise in their areas backgrounds and role within the Ministry;
- Attend meetings and fulfill assigned responsibilities as discussed and confirmed in Working Group meetings;
- As needed, participate in consultations with external stakeholders involved in the review; and
- As needed, coordinate with their key stakeholders to ensure these organizations are involved in the review process.

Working Group Composition

- Working Group Members and corresponding responsibilities include:

Name	Ministry Division	Responsibility
Leigh Ann Seller	Health Authorities Division	Chair, overall leadership
Sue Bedford	Health Authorities Division	Project Director
Kelly Barnard	Health Authorities Division	Medical consultant
Daryl Beckett	Legislation and Professional Regulation	Liaison with Colleges
Nick Grant	Information Management Branch	Data Provision
Katie Hill	Health Authorities Division	Expert advice – Home and Community Care
Ann Marr	Health Authorities Division	Expert advice – Mental Health and Substance Use
Christine Massey	Legislation and Professional Regulation	Legislation and regulations
Amanda McReynolds	Legislation and Professional Regulation	Legislation and regulations
Rick Marshall	Strategic Policy and Research	Knowledge of Current Research
Suzanne Taylor	Pharmaceutical Services Division	Expert advice – pharmacy and drug use
Val Tregillus	Primary Care	Primary care lead and coordination

Support for Review Process

The Home, Community and Integrated Care Branch will provide secretariat and logistics management support, including the Project Director who will be responsible for overall project planning, including developing work plans and project up-dates. A consultant will also support the completion of the review including facilitating stakeholder consultation sessions.

Meetings

- Meetings will be chaired by the Executive Director, Home, Community and Integrated Care Branch;
- Meetings will be at the call of the chair until the end of June when review is anticipated to be completed; and
- Meeting minutes and action items will be supported by Project Director.

The Project Director will also be responsible for administratively supporting working group meetings, including preparing agendas, meeting materials, and taking minutes and tracking/following up with action items.

APPENDIX B: SUMMARY OF BC LEGISLATION GOVERNING CONSENT TO HEALTH CARE AND THE USE OF RESTRAINTS

CONSENT TO HEALTH CARE

Health Care (Consent) and Care Facility (Admission) Act

This statute establishes the right of adults to give, refuse, or revoke consent to health care treatment (s. 4) and requires health care providers²² to obtain valid consent from adults before providing health care to them (s. 5).

The Act defines *health care* as anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health, and includes:

- a single treatment;
- a series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem;
- a plan for minor health care that:
 - is developed by one or more health care providers;
 - deals with one or more of the health problems that an adult has and may, in addition, deal with one or more of the health problems that an adult is likely to have in the future given the adult's current health condition; and
 - expires no later than 12 months from the date consent for the plan was given.

These definitions allow for three different kinds of consent based on the intrusiveness and frequency of the health care treatment:

1. Consent to a single major and minor health care treatment; for example, a patient who requires surgery to pin a broken hip would provide consent to that procedure once; a patient to whom an annual influenza vaccination is offered would provide consent every year

²² Section 1 of the *Health Care (Consent) and Care Facility (Admission) Act* defines *health care provider* as "a person who, under a prescribed Act, is licensed, certified or registered to provide health care; these prescribed Acts are listed in Section 1 of the Health Care Consent Regulation and are the *Health Professions Act* and the *Social Workers Act*, which regulate and thus define the following as health care providers:

- | | |
|---|-------------------------------|
| ▪ physicians | registered psychiatric nurses |
| ▪ dental hygienists | dental technicians |
| ▪ denturists | dieticians |
| ▪ licensed practical nurses | massage therapists |
| ▪ midwives | naturopathic physicians |
| ▪ nurses (registered)& nurse practitioners | occupational therapists |
| ▪ opticians | physical therapists |
| ▪ psychologists | social workers |
| ▪ traditional Chinese medicine practitioners/acupuncturists | |

2. Consent to a series or sequence of similar major or minor health care treatments over a period of time for a particular health problem; for example, a patient with kidney failure would need to consent to kidney dialysis only once although the treatments are trice weekly and ongoing.
3. Consent to a care plan that:
 - is comprised of minor health care treatments;
 - is based a predictable course of treatment for a condition the adult has or is likely to have in the future.
(For example, a patient would provide consent to a care plan of a one-year duration; such a plan may include regular prescription medications for hypertension and arthritis, dental cleaning and treatment, an influenza vaccination, and physiotherapy for a longstanding physical disability).

Consents #1 and #2 above must be sought and received for each treatment or course of treatment. Consent #3 must be sought and received at least once a year or, whenever there is a significant change to the care plan.

Note: The prescription of a medication is a treatment that requires the prescribing health care provider (physician or nurse practitioner) to seek and obtain valid consent.

Valid consent is:

- specific to proposed health care, course of treatment, or care plan;
- voluntary;
- not obtained by fraud or misrepresentation;
- given by a capable adult;
- informed by the “information a reasonable person would require to understand the proposed health care and to make a decision, including information about condition for which the health care is proposed, nature of the proposed health care, risks and benefits of the proposed health care, alternative courses of health care, and the adult has an opportunity to ask questions and receive answers about the proposed health care. (s. 6)

The only exceptions to the requirements to seek and obtain valid consent are:

- when the adult is incapable of consenting and no authorized substitute is available to make the decision and the adult requires treatment without delay to preserve the adult’s life, to prevent serious mental or physical harm or to alleviate severe pain (this is the definition of *emergency* in the statute) and the health care provider does not have reason to believe that the adult, when capable, expressed a wish not to have the treatment or effective 1/9/11, there is no advance directive refusing consent to this treatment;
or
- when an adult is admitted and treated involuntarily under the *Mental Health Act* (see page 4);
or

- the treatment is for an illness or condition that is a public health risk (e.g. tuberculosis) under the *Public Health Act*.

If an adult is found to be incapable of giving consent to health care, the health care provider must seek and obtain valid consent from a substitute decision maker before the health care can be provided. Substitute decision makers, in ranked order, are:

- committee of person appointed by a court under the *Patients Property Act*;
- representative appointed by the adult under the *Representation Agreement Act*;
- Temporary Substitute Decision Maker appointed by the health care provider under the *Health Care (Consent) and Care Facility (Admission) Act* when a health care decision is required and chosen from the following list, in order:
 - the adult's spouse;
 - the adult's child;
 - the adult's parent;
 - the adult's brother or sister;
 - the adult's grandparent*;
 - the adult's grandchild*;
 - anyone else related by birth or adoption to the adult
 - close friend of the adult*;
 - a person immediately related to the adult by marriage*.

note: * indicates a recent change (September 1, 2011).

Temporary Substitute Decision Makers must be capable, 19 years or older, have been in contact with adult in past 12 months, have no known dispute with adult, and be willing to act and to abide by the duties set out in statute. If no one meets above criteria, then the Office of the Public Guardian and Trustee must appoint someone or have its own consultant appointed to make the decision.

The duties of a Temporary Substitute Decision Maker (and a Representative under the *Representation Agreement Act*) are to make a decision on the basis of:

- instructions or wishes the adult expressed while he or she was capable; or
- if wishes never expressed, the adult's known beliefs and values, or if those not known; or
- the adult's best interests, if his or her beliefs and values are not known.

Failure to fulfil this duty could (and should) result in an individual's disqualification as substitute decision maker.

Part 3 of the Act, Admission To A Care Facility, requires managers of care facilities to seek and obtain valid consent to facility admission from an adult or an authorized substitute decision maker before admitting an adult to a residential care facility (including those designated under the *Hospital Act*). However, Part 3 of the Act is not in force.

Patients Property Act

This statute allows the court to declare a person a patient incapable of managing his or her affairs, him- or herself, or both, and to appoint someone as a committee for the person. A committee for a patient who is incapable of managing his or her affairs “has all the rights, privileges and powers with regard to the estate of the patient as the patient would have if of full age and of sound and disposing mind.”

A committee for a patient who is incapable of managing him/herself has “custody of the person of the patient.” A committee of person has authority to make health and personal care decisions on behalf of the patient, including giving or refusing consent to health care.

Representation Agreement Act

This statute allows adults to arrange in advance how and by whom decisions about their health care, personal care, financial affairs, or other matters will be made if they become incapable of making those decisions themselves. In terms of consent to health care, a representation agreement under section 9 of this Act (a non-standard agreement) allows an adult to authorize his/her representative to give or refuse consent to health care including refusing consent to life-supporting care or treatment. A standard representation agreement made under section 7 of the Act is more limited in its powers and permits refusal of life-supporting treatment only under particular circumstances.

Mental Health Act

The main purpose of the *Mental Health Act* is to provide authority, criteria, and procedures for involuntary admission and treatment of persons with mental illnesses. A person can only be admitted as an involuntary patient under the *Mental Health Act* to facilities designated by the Minister of Health.

The *Mental Health Act* provides for compulsory treatment of all involuntary patients. The director may authorize treatment for patients who are mentally incapable of making a consent decision about the proposed treatment. Prior to treatment of involuntary patients, the Consent for Treatment (Involuntary Patient) form must be completed and signed. Thus, the *Mental Health Act* overrides the right of an adult to consent, refuse, or revoke consent to involuntary treatment specific to the individual’s mental illness; consent is given by the director of a designated facility. However, individuals who are receiving mental health care treatments involuntarily retain their right to consent/refuse consent to other health care.

Community Care and Assisted Living Act

This statute requires residential care facilities providing care to 3 or more persons to meet certain standards and obtain a licence to operate. These are called *community care facilities*. This statute does not apply to hospitals or portions of hospitals as defined in the *Hospital Act* or to designated facilities under the *Mental Health Act*. A

number of long term care facilities are operated under the *Hospital Act*.

The Residential Care Regulation pursuant to the *Community Care and Assisted Living Act* sets out the requirements with which licensed residential community care facilities must comply including the following related to health care consent:

- Section 78 states that a licensee must have written consent from the person in care or representative of the person in care to call a medical practitioner, nurse practitioner, or ambulance in case of accident or illness
- Section 81 states that a licensee must ensure that each person in care has a care plan²³ that addresses:
 - medication
 - behavioural intervention
 - restraints, if there is agreement to the use of restraints in non-emergency situations
 - oral health
 - nutrition
 - recreation and leisure
 - fall prevention plan
 - how to deal with person in care who is at risk of leaving the community care facility without notifying staff
 - any conditions or requirements under the *Mental Health Act* or other enactment or order related to the admission of the person in care.

USE OF RESTRAINTS

Community Care and Assisted Living Act

This statute requires residential care facilities providing care to 3 or more persons to meet certain standards and obtain a licence to operate. These are called *community care facilities*. This statute does not apply to hospitals or portions of hospitals as defined in the *Hospital Act* or to designated facilities under the *Mental Health Act*. A number of long term care facilities are operated under the *Hospital Act* (see below).

The statute defines *restraint* as a “chemical, electronic, mechanical, physical or other means of controlling or restricting a person in care's freedom of movement in a community care facility, including accommodating the person in care in a secure unit.”

Residential Care Regulation

The Residential Care Regulation sets out the requirements related to the use of restraints (and thus to medication used as chemical restraint) with which licensed residential care facilities must comply.

²³ See page 1 above for definition of *care plan* for the purposes of consent.

Prescription Medication

Section 70 states that a licensee must ensure that only medications that have been prescribed or ordered by a medical practitioner or nurse practitioner are administered to a person in care

Section 78 states that a licensee must keep a medication administration record for each person in care that shows all medication administered to the person in care, and the date, amount and time at which the medication was administered

Use of Restraints

Section 73 places the following restrictions on the use of restraints:

- used only to protect the person in care or others from serious physical harm,
- as minimal as possible, taking into consideration both the nature of the restraint and the duration for which it is used, and
- the safety and physical and emotional dignity of the person in care must be monitored throughout the use of the restraint, and assessed after the use of the restraint.
- all alternatives to the use of the restraint must have been considered and either implemented or rejected
- employees administering the restraint have received training in alternatives to the use of restraints and determining when alternatives are most appropriate, and the use and monitoring of restraints, and follow any instructions in the care plan of the person in care respecting the use of restraints;
- the use of the restraint, its type and the duration for which it is used must be documented in the care plan of the person in care.

Section 73 also requires that after the use of a restraint in an emergency, the licensee must provide information and advice about the use of the restraint to the person in care who was restrained, the people who witnessed the use of the restraint, and employees involved in the use of the restraint, and document in the care plan of the person in care the information and advice given.

Section 74 states that restraints may only be used in an emergency or if there is written agreement by the person in care, the parent or representative of the person in care or the relative who is closest to and actively involved in the life of the person in care and the medical practitioner or nurse practitioner responsible for the health of the person in care

Section 74 also states that restraints must not be used as punishment or discipline or for the convenience of employees.

Care Plans²⁴

Section 81 (3) states that a licensee must ensure that each person in care has a care plan that addresses:

- medication;
- behavioural intervention;
- restraints, if there is agreement to the use of restraints in non-emergency situations
- oral health;
- nutrition;
- recreation and leisure;
- fall prevention plan;
- how to deal with person in care who is at risk of leaving the community care facility without notifying staff;
- any conditions or requirements under the *Mental Health Act* or other enactment or order related to the admission of the person in care.

Section 81(4) requires a licensee to ensure that a care plan is reviewed and, if necessary, modified if there is a substantial change in the circumstances of the person in care, or if there is no substantial change in the circumstances of the person in care, at least once each year to ensure it continues to meet the needs and preferences, and is compatible with the abilities, of the person in care who is the subject of the care plan

College or Pharmacists Bylaws

Health Professions Act – BYLAWS SCHEDULE F section 3 directs the facility licensee to engage a pharmacist to provide services to the facility including visits and audits of the facility’s medication storage and administration practices. The pharmacist must be a member of the facility’s Medication Safety Advisory Committee and review its policies on safe and effective distribution, reporting of therapeutic and adverse outcomes, reporting of incidents and discrepancies, and training of employees who store, handle and administer drugs to residents.

Section 13 directs the facility pharmacist to keep complete patient-specific medication records including medication names, indication for use, directions for use. When a drug is to be administered on a “when necessary” basis, the record and prescription label must clearly indicate the specific indication, the minimum time interval between doses, and the maximum daily doses. The pharmacist must also review the resident’s record and take appropriate action when necessary with respect to appropriateness of drug therapy, interactions, allergies, adverse reactions, intolerances, therapeutic duplication, contraindicated drugs, correct dose/route/frequency/duration/dosage form, and any other potential drug-related problems.

Section 14 directs the pharmacist to provide a medication administration record for each resident.

²⁴ See also definition of health care that includes care plans under the *Health Care (Consent) and Care Facility (Admission) Act*.

Section 15 states that a pharmacist must review and document each resident's drug regimen on site or by videoconference at least once every 6 months (must be on site at least once every 12 months) with a practitioner if available, or a registered nurse and a facility staff member approved by the medication safety and advisory committee. If a resident's practitioner does not attend the review, the full pharmacist must advise the practitioner of any recommendations arising from the review. To continue dispensing drugs for a resident in a facility or home, prescriptions must be received from the resident's practitioner every six 6 months, either by written, verbal or electronic communication.

Section 16 outlines more resident oriented pharmacy practice requirements.

Hospital Act

Some residential care facilities are regulated under the *Hospital Act*. Such a facility is defined in the statute as:

a non-profit institution that has been designated as a hospital by the minister and is operated primarily for the reception and treatment of persons convalescing from or being rehabilitated after acute illness or injury, or requiring extended care at a higher level than that generally provided in a private hospital licensed under Part 2;

“private hospital” or “hospital” means a house in which 2 or more patients, other than the spouse, parent or child of the owner or operator, are living at the same time, and includes a nursing home or convalescent home, but does not include a hospital as defined in section 1 of the Act, above.

Facilities regulated under this Act have no regulation related to the use of restraints as the Residential Care Regulation does not apply to them and amendments to the *Health Care (Consent) and Care Facility (Admission) Act* related to restraints have not yet been brought into force. Facilities that fall under the *Hospital Act* have similar standards imposed on them by Ministry of Health policy. (See below)

Health Care (Consent) and Care Facility (Admission) Act

This statute requires health care providers to seek and obtain valid consent for health care defined as “anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health.” Health care is defined to include a care plan “developed by one or more health care providers, that deals with one or more of the health problems that an adult has and may, in addition, deal with one or more of the health problems that an adult is likely to have in the future given the adult's current health condition, and expires no later than 12 months from the date consent for the plan was given.” Consent for a care plan must be sought and received at least once a year.

A care plan under the HCCCFAA could include the use of restraints if the restraints were used for the reasons articulated in the definition of *health care* (“anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health”). The use of restraints that are prescription medication, such as antipsychotics, always require valid consent as per the requirements of this statute for seeking and obtaining valid consent from the adult or his/her authorized substitute.

Part 3 of the Act places restrictions on the use of restraints in care facilities including unlicensed facilities and those designated under the *Hospital Act*. Part 3 of the Act is not in force.

Mental Health Act

If a patient is detained under the *Mental Health Act* but is on leave from a designated facility and residing at a community care facility, then treatment authorized by the director of the designated facility is deemed to be given with the consent of the patient and consent rights do not apply. This would include chemical restraint, where it formed part of the psychiatric treatment of the patient, or was necessarily related to the provision of psychiatric treatment to the patient, and was given with the authorization of the director. In situations where the treatment or restraint is not psychiatric treatment authorized by the director (such as a drug for another purpose or restraint in an unforeseen circumstance), then consent rights would apply as would the restraint provisions of the Residential Care Regulation.

Patients Property Act

This statute allows the court to declare a person a patient incapable of managing his or her affairs, him/herself, or both, and to appoint someone as committee of person. A committee for a patient who is incapable of managing his or her affairs “has all the rights, privileges and powers with regard to the estate of the patient as the patient would have if of full age and of sound and disposing mind.” A committee for a patient who is incapable of managing him/herself has “custody of the person of the patient.” As a committee of person has authority to make health and personal care decisions on behalf of the patient, it is assumed that authority includes authorizing the use of restraints.

Representation Agreement Act

This statute allows adults to arrange in advance how, when, and by whom, decisions about their health care, personal care, financial affairs, or other matters will be made if they become incapable of making those decisions themselves.

In terms of restraint, a representation agreement under section 9 of this Act (a non-standard agreement) allows an adult to authorize his/her representative *to physically restrain, move or manage the adult, or have the adult physically restrained, moved or*

managed, when necessary and despite the objections of the adult. This provision has been amended by the following, effective September 1, 2011:

9.(1) (b) (viii) *despite any objection from the adult, physically restrain, move, ort manage the adult and authorize another person to do these things, if necessary to provide personal care or health care to the adult.*

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APPENDIX D: FOCUS GROUP TERMS OF REFERENCE

ANTIPSYCHOTIC USE IN LONG TERM CARE FACILITIES TERMS OF REFERENCE FOR FOCUS GROUPS

RATIONALE

To gather information and advice to contribute to a review of the use of antipsychotic medication in BC's long term care facilities.

OBJECTIVES

1. Determine participants' understanding of the legal requirements and best practices for consent to health care, including consent to medication used for treating; managing the symptoms and behaviours associated with dementia
2. Determine how participants put these requirements into practice or if unaware of requirements, determine what their practice is in these areas; and
3. Canvass participants for useful resources in these areas

PARTICIPANTS

Individuals will be invited by the Ministry of Health to participate in one of three focus groups. Participants may include but not be limited to representatives of the following:

- Members of family/resident councils of residential care facilities;
- Health authorities (home and community care, licensing, risk management);
- College of Registered Nurses of British Columbia;
- College of Registered Psychiatric Nurses of British Columbia;
- College of Licensed Practical Nurses of British Columbia;
- College of Pharmacists of British Columbia;
- College of Physicians and Surgeons of British Columbia;
- BC Care Providers Association;
- UBC Centre for Research on Personhood in Dementia;
- Family Caregivers' Network Society;
- Alzheimer Society of British Columbia;
- University of Victoria Centre for Aging;
- Representatives from Family Councils;
- Denominational Health Association;
- Office of the Public Guardian and Trustee.

FORMAT

Each focus group will:

- be two hours in duration;
- be organized around common questions circulated to participants in advance; and
- encourage discussion and exchange of information and ideas.

APPENDIX E: FOCUS GROUP OBJECTIVES AND QUESTIONS

OBJECTIVES

- to determine participants' understanding of the legal requirements and best practices for consent to health care, including consent to medication used for treating and managing the symptoms and behaviours associated with dementia;
- to determine how participants put these requirements into practice or if unaware of requirements;
- to determine what their practice is in these areas; and
- to canvass participants for useful resources in these areas.

CONSULTATION QUESTIONS

Common Questions

What is your understanding of the requirements governing consent to health care, including consent to medication used for treating and managing the symptoms and behaviours associated with dementia? What is your understanding of practice in these areas?

Group #1 (Family Members and Caregiver Support Organizations): Questions

What is your understanding of?

- adults' right to consent, refuse, or revoke consent to health care and the process to follow if the person in care is not able to give consent;
- the responsibilities of health care providers to seek and obtain valid consent;
- legal requirements for using restraints in licensed care facilities.

Group #2 (Representatives of Professional Colleges): Questions

What is your understanding of?

- adults' right to consent, refuse, or revoke consent to health care and the process to follow if the person in care is not able to give consent;
- the responsibilities of health care providers to seek and obtain valid consent before providing treatment;
- requirements for using restraints in licensed care facilities;
- best practices in managing the behavioural and psychological symptoms of dementia;
- appropriate use of medication for treating and managing the symptoms and behaviours associated with dementia.

Group #3 (Health Authority and OPGT Representatives): Questions

What is your understanding of?

- best practices in managing the behavioural and psychological symptoms of dementia;
- adults' right to consent, refuse, or revoke consent to health care and the process to follow if the person in care is not able to give consent;
- the responsibilities of health care providers to seek and obtain valid consent before providing treatment;
- requirements for using restraints in licensed care facilities;
- best practice and current information on the efficacy of medication for treating and managing the symptoms and behaviours associated with dementia.