Residential Care: Pharmacist dilemmas and issues of 'covert' medication

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When delivering a bottle of liquid Temazepam to the local nursing home on your way home from work on a Saturday evening, the staff member taking receipt of the medicine's comments that the nurse on duty "usually tells" him to add a spoonful of the Temazepam to each resident's evening drink to ensure a quiet night. What do you do?

Pharmacists' responsibilities to patients living in residential care settings for older people have been highlighted by the PSI in a recent letter (PSI, 2010), such responsibilities applying to all pharmacists involved in the delivery of pharmacy services to such care settings – regardless of whether those settings are designed for independent living or high dependency care. The "provision of pharmacy services to these patients must ensure that they receive the same level of care as those patients who attend personally at the pharmacy practice". This is a tough challenge – and one which incorporates dilemmas inevitably facing pharmacy service delivery when 'caring through carers' to any patient, whether he/she is living at home with relatives or in a 'Nursing Home' (NH). Regardless of the setting or who the carer might be, the pharmacist's responsibility clearly remains to the patient for whom he/she dispenses medication and, in this context, the NH setting certainly merits specific review.

As would be expected, attention to prescription-writing requirements, matters related to the Code of Conduct for pharmacists and that "support services must be provided to patients and/or staff at the residential care home as appropriate in respect of medication review, patient counselling, interactions, adverse effects, drug information and health promotion" are all highlighted. It is presumed that pharmacists have adequate grounding in the pharmaceutical sciences to guide the preparation of required medication in appropriate formulations. It is also expected that they have an appreciation of the legislative and heightened professional responsibilities involved in the supply of Unlicensed Medicines (ULMs) – key amongst them being that both prescriber and patient are aware not just of the 'unlicensed status' but also of the implications of medicines not having been licensed by the IMB. In addition it would seem reasonable to expect that if a pharmacist depends on healthcare professionals or carers in nursing homes to partly fulfil professional responsibilities to patients under the pharmacist's 'duty of care', then that pharmacist would have to be satisfied as to the likely continuity and influence of staff members to whom he/she has communicated matters related to the pharmaceutical care needs of those patients.

Account must also be taken of the HIQA 'National Quality Standards for Residential Care Settings for Older people in Ireland', 2009. The PSI specifically highlights standards 14 (Medication Management) and 15 (Medication Monitoring and review). It is sobering to note that standard 14, including its two pages of supporting 'criteria', fails to mention the word 'pharmacist'. Neither is there any proposed definition of the term 'medication management'- leaving the term open to a wide variety of interpretations, such that related conversations between health economists, NH managers, process engineers, the regulatory bodies themselves and practising pharmacists could well result in misunderstandings. It is clear to practitioners that the "pharmacist must be alert to medicines management and other patient care issues within a residential care setting" (PSI, 2010), but it seems that the HIQA standards, as written, could in theory facilitate a scenario where their requirement that "medication management policy and procedures that accord with legislation and professional regulatory requirements or guidance" could evolve without the nursing home staff even thinking of including the pharmacist in the decision-making process.

The ideal would be to change the HIQA standard to require "active involvement by pharmacists" (PSI, 2010). In the absence of such update, a means of ameliorating this risk would be to ensure that reference to pharmacists' responsibilities to residents of nursing homes is specifically incorporated into guidance notes provided to those implementing the HIQA standards. Indeed interpretation of the profession's Code of Conduct could be seen to infer an obligation on pharmacists to insist that NH guidelines reflect a commitment to pharmacists involved in 'Medication Management'.

Key amongst pharmacists' professional concerns will be the knowledge that, unless practitioners meet patients face-to-face, assurances regarding respect for the patient's right to consent to or refuse medication will inevitably involve the carer. As pharmacists will be aware, the consent process requires the patient to have capacity to consent, to be appropriately informed and to be free from coercion or undue influence. In the case of residential care settings for older people, interpretation as to whether a patient has capacity to consent to healthcare interventions will generally derive from the Mental Health Act 2001 (MHA). This facilitates carers who wish to seek legal decision-making capacity for patients with "mental illness, severe dementia or significant intellectual disability with immediate and serious potential harm to self or others and requiring admission in order to treat". In such instances the GP attending the residential care facilities will generally be assigned decision-making authority on the patient's behalf. The pharmacist should be aware of such decision-making authority for a patient under his/her care. It must be emphasised, however, that it is rare for the courts in Ireland to deem an adult to not have the capacity to make healthcare-related decisions for him/herself and, in some circumstances, assessment of incapacity may be time constrained and/or relevant only to specific decisions.

In a related train of thought, Standard 21 of the HIQA guidelines, *'Responding to behaviour that is challenging'*, includes reference to the use of chemical restraint, in the form of medications administered with the intention of sedating patients. Pharmacist involvement is recommended and adherence to the MHA is assumed. Given clearly defined circumstances, most likely involving cases of severe dementia or schizophrenia, it is possible that administration without the patient's consent would not be deemed unethical.

However, if we accept that the MHA provides a legitimate means of engaging a multidisciplinary team in managing most situations involving dementia, mental illness and intellectual disability, a culture of professional openness should be anticipated – including documentation of the process by which the decision to administer covertly, or in 'a disguised form', was reached and the record of administration itself included on the patient's medication record. Not necessarily so, it seems. Research by Treolar et al, '*A pill in the sandwich: covert administration in food and drink'*, suggests that not only was the practice of 'unauthorised' covert medication widespread amongst the 34 UK-based care settings reviewed, but that it was accompanied by a culture of fear and secrecy that lead to incomplete medication records. Equivalent Irish-based studies do appear to be available for review. In such situations the debate does not necessarily even seek to focus on whether there is legal/ethical justification for covert administration, as articulated by Welch &

Deahl (2002), when they spotlight an inquiry into motives behind decisions to sedate and the potential for covert sedation to be administered for no greater reason than convenience:

"Arguably, in residential settings, tranquillising medication might be seen as a cheap means of managing inadequate staffing levels (and thus ensuring a quiet shift) or an essential (and least restrictive?) means of managing unpredictable, violent outbursts against staff and fellow patients."

So what might a pharmacist do if confronted, on a Saturday night, with a suggestion that liquid Temazepam was being administered covertly in a nursing home? Establishing the facts would be core, not least to identify whether covert medication occurs and thereafter whether it's actually an 'unwritten' policy at the nursing home, rather than an individual nurse wanting a 'quiet night'. In reality, concerns influencing decision-making could be as varied as the risk that to report the nursing home would lead to its closure and therefore loss of a key facility to the local community, the inevitable concerns for existing patients being moved en masse to other nursing homes in the event of closure and commercial threat to the provider if it were to lose a large nursing home account. If covert medication was a fact, there would be pressure to 'whistleblow' to various authorities, not least of which would be HIQA. Of more immediate concern might be for the carer who risks his/her own personal and professional security by alerting someone he/she sees as a responsible and/or authority figure… it would be a travesty if a carer's trust in the profession of pharmacy was undermined by either the comment being ignored or the pharmacist proceeding in an unprofessional manner.

According to Richard Griffiths (PLEA UK guest speaker, London, May 2010), a nurse who instructed a care-worker to sedate residents of a nursing home in this manner received a 4-year jail term for incitement to covert administration.

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Applications for the 2010/2011 NPIP

Graduates of a degree in pharmacy that has been accredited by the PSI are eligible to apply for the 2010/2011 National Pharmacy Internship Programme and the PSI is currently accepting applications, through an online process managed by the Royal College of Surgeons in Ireland. Further details are available on the PSI and RCSI websites.

The NPIP is provided by the RCSI on behalf of the PSI for the period 2009-2012. The Programme will lead to the award of an MPharm degree to all successful candidates.

Pharmacies on Health Atlas

Location and contact information about registered retail pharmacy businesses is now available on Health Atlas, a HSE resource for the public to help locate important public services. Health Atlas can be accessed on the HSE website at www.hse.ie/eng/services/maps. Users can select pharmacies in a particular geographical area and zoom in or out as required. There is now also a link from the map back to the PSI public registration details for individual pharmacies.

WHPA Counterfeit Toolkit

The World Health Professions Alliance (WPD), of which the International Pharmaceutical federation (FIP) is a member, has published a toolkit for patients and health professionals on counterfeit medicines. The toolkit was developed at the request of the WHO International Medical Products Anti Counterfeiting Task Force (IMPACT) and contains useful information for patients and professionals on the identification and reporting of counterfeit medicines and is aimed at raising awareness about this threat to public health. Further details and the toolkit are available at www.whpa.org.

IMB Advisory Notice concerning Pennyroyal

The Irish Medicines Board (IMB) has recently reviewed the safety of the herb Mentha pulegium also known as Pennyroyal , which was traditionally used for its effect on the uterus to stimulate menstrual flow and ease painful menstruation. The potential toxicity of Pennyroyal is well documented, in particular the potential liver and kidney toxicity of Pennyroyal oil with many reports of adverse events and fatalities following its ingestion. The IMB has not authorised any medicinal products containing this herbal substance nor does it consider such products to be appropriate candidates for registration as traditional herbal medicinal products or for inclusion in food substances. The IMB is of the opinion that Pennyroyal oil is not suitable for internal or external use in view of its potential toxicity.

Pharmacists and other healthcare professionals are advised that the appropriate advice to patients and the public is that Pennyroyal oil should not be used under any circumstance. The advisory notice in full is available to view on the IMB website www.imb.ie