

**ROYAL
PHARMACEUTICAL
SOCIETY**
Scotland

Putting residents at the centre of pharmacy care home services

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P
S**



Our vision is of pharmacists as **leaders in the safe and effective use of medicines.**

New models of pharmaceutical care in care homes should **enhance the quality of life** for this vulnerable group of citizens and contribute to **making Scotland the safest place to take medicines.**

These models should embrace the principles of *Realistic Medicine*, **enabling joint decision making and eliminating inappropriate polypharmacy.**

They should provide **integrated care across all healthcare sectors** as illustrated in *Achieving Excellence in Pharmaceutical Care.*

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Executive summary

We are calling for:

- Recognition that pharmaceutical care in care homes is a specialist area and for it to be resourced accordingly
- Pharmacists to lead on the provision of pharmaceutical care in care homes, including regular medication reviews as part of the multidisciplinary team (MDT) to improve the quality and safety of patient care
- Care homes to have dedicated time from pharmacists and their teams embedded in their service to ensure safe and efficient medicine management systems are in place
- Care home residents to have equity of access to community pharmacy NHS pharmaceutical care services
- Scottish Government, NHS Health Boards, Integrated Joint Boards (IJBs) and Care Providers to implement our recommendations to make sure that residents in care homes have access to the highest standards of pharmaceutical care and quality of life

What needs to be done:

- Pharmacists should be included at strategic planning levels in Health and Social Care Partnerships (HSCPs). This will ensure safe and efficient pharmaceutical care services are provided locally with dedicated pharmacy resource to care homes
- A national approach to medicines' policies in care homes, including standardised training for medicines administration to eliminate variation
- A pharmacist who is known to residents and staff as the first point of contact for medication queries
- All care home pharmacists to be independent prescribers with appropriate competencies for polypharmacy reviews
- Routine use of original packs for medicines supported by electronic medicines administration charts (eMAR)
- Sustainability built into care home contracts with community pharmacies to enable continuity of care, quality improvement, long term planning, and investment in staff training and education
- One community pharmacy and one GP practice aligned to each care home wherever possible
- With consent, all pharmacy team members directly involved in a resident's care to have full read and write access to residents' health and care records including care plans and medicines administration charts (MAR).
- An adaptation of the Medicines Care and Review service (MCR) with serial prescribing and dispensing to be available for care home residents

Context for change

Across Scotland there are more than 32,000 elderly care home residents on any one night, more than two and a half times the number of hospital beds¹. Despite these statistics, care homes have not yet been prioritised or treated as a specialist area across our health and social care landscape.

Health policy has successfully focused in recent years on supporting people to live longer healthier lives at home, or in a homely setting². This changing landscape of care provision and older people's services has reduced the proportion of people in long term care facilities.

While the number of care home residents has decreased over the last ten years those who do need care home facilities are now frailer and nearer the end of their lives than previously. There has been a sharp increase in the number of residents with both physical disabilities (13%) and dementia (54%). The number of residents in younger age groups has decreased but those over the age of 95 has increased by 19%. The average length of stay in a care home today is only 18 months³.

Many of these residents have complex care needs and would have been cared for in elderly care wards in hospital in the past, but care homes are not resourced comparably. Residents often have several long term conditions and take on average 7.2 medicines⁴.

This policy sets out our vision for a model of safe and effective pharmaceutical care for this vulnerable population. It builds on recommendations from our original report in 2012⁵ and on those from our colleagues in RPS in Wales⁶ and RPS in England⁷, where great progress has been made in deploying dedicated pharmacists in care home roles.

We have focused on quality as the driving factor for change, using examples of good practice across Great Britain, with input from experts within the pharmacy profession, care providers and other health and social care professionals.

In 2017, health boards were surveyed to find out what has been achieved so far and what still needs to be implemented. Our revised recommendations align with the aspirations and principles of Realistic Medicine⁸ and with the Scottish Government's Standards for Health and Social Care (SHSC)⁹, putting the needs of the resident at the centre of any changes.**

***See standards referenced as SHSC** throughout the recommendations.*

The recent Scottish Government strategy, Achieving excellence in Pharmaceutical Care¹⁰, has acknowledged the need for improving the pharmaceutical care in care homes. It highlights that there are opportunities for increased roles for pharmacists and pharmacy technicians across all sectors.

Opportunities for improvement

1. Pharmacists should lead on the provision of pharmaceutical care in care homes, including regular medication reviews as part of the multidisciplinary team (MDT) to improve the quality and safety of patient care.

Residents require medication reviews

- When they first move into a care home in order to optimise their medication regimen
- When they are discharged from hospital
- When there is a significant change in their medical condition, medication or circumstances

“ *The GP practice
We really welcome the pharmacist’s input. It’s been seamless... We have no complaints! It’s marvellous! We are really pleased with the pharmacist’s reviews.* ”

We know that mistakes happen when people transition across different parts of the health and social care system¹¹, therefore a medication review is an essential part of any initial assessment for new residents. Medicines reconciliation is also required to ensure patient safety as a precursor to any medication review.

In Scotland, medication reviews for care home residents are sometimes being subsumed into the new roles for pharmacists in GP practices. We have been told by members that it can be difficult to prioritise within the general practice pharmacotherapy workload. However, where care homes have been prioritised there is already emerging evidence of reductions in inappropriate polypharmacy, improved quality of life for residents, reduced unplanned admissions to hospital and better training and education of care home staff.

Care home residents fall on average two to six times a year and many medicines are implicated in increasing risk of falls¹². Pharmacist-led medication reviews have been shown to lead to a reduction in the number of falls¹³. A falls assessment is essential on admission into a care home, and regularly thereafter. A pharmacist should be involved in assessing falls risk from the medicines the resident is taking and adjust accordingly.

Case study Glasgow

Primary care based clinical pharmacists are providing pharmaceutical care to care home patients as part of a multidisciplinary team, linking with all other relevant stakeholders in a patient centred approach. There are a number of work streams suitable for dedicated pharmacist input, including patient safety issues, reducing inappropriate polypharmacy, generating efficiencies and service development. It has provided opportunity to influence and improve medicines management policies and practice with the care home providers.

Facilitated education sessions on urinary tract infections (UTI) and dehydration for nurses and carers have resulted in a reduction in GP referrals and the number of antibiotics prescribed. Weekly ward rounds with the GP and a review of prescription reordering processes has resulted in greater understanding of medicines administration procedures and reduced waste.

Inappropriate polypharmacy and the use of anti-psychotics and other psychoactive medicines are areas where there has been improvement. However, these should remain a priority area and more progress is required to avoid unintentional harm and minimise unplanned hospital admissions.

Care home providers should ensure that the following people are involved in medicines review:

- The resident and/or their family members or carers
- A pharmacist
- GP
- Specialist geriatric or palliative care input as appropriate
- Other health and social care practitioners involved in the residents' care

*SHSC** 3.14 I have confidence in people because they are trained, competent and skilled, are able to reflect on their practice and follow their professional and organisational codes.*

*SHSC** 4.11 I Experience high quality care and support based on relevant evidence, guidance and best practice.*

Getting medicines right for residents can bring positive results in:

- Improved quality of life
- Reduced need for GP appointments
- Reductions in unplanned admissions to hospital
- Decreased calls to out of hours services
- Freeing up staff time in administering medicines and other care tasks
- Budget savings

“ *The patient*
She was so drowsy before, now she’s much brighter and interacting with us. We used to have to assist her at mealtimes but now she can feed herself, it’s such a change!

The son
Mum is less sleepy, safer when walking, more physically active and better able to take part in social activities after her medication review.

”

2. Care homes need to have dedicated time from pharmacists and their teams embedded in their service to ensure safe and efficient medicine management systems are in place.

Capacity could be improved through a more integrated approach. Care is required at all levels of complexity. Managed service pharmacists, working in care homes, need to have good communication and referral links with colleagues in secondary care and community, as well as the wider MDT.

Services need to be more responsive to changes in residents’ health needs and be able to prioritise, assess and follow up more effectively. This can only be achieved using all the skill mix available and different models of care will emerge.

Remote and rural locations have different challenges from urban settings. Care homes vary in size and type which can impact on the level of service required. There is scope to use pharmacists, pharmacy technicians and pharmacy assistants from community, primary care and secondary care, working together to provide the essential elements of pharmaceutical care and medicines management that together will minimise unintended harm and medication errors.

The following graph illustrates where community pharmacists, general practice pharmacists, pharmacy technicians, specialist pharmacists and physicians could integrate with other health and social care colleagues to provide a whole systems approach to care.

This concept from the Shine project¹⁴ in England has now been prioritised nationally with funding for innovation, additional resource and integration.



This approach works across organisational boundaries to identify and meet the needs of older people using a stratified model. It uses IT links with hospital which inform the team of all newly discharged care homes residents, who are then reviewed in the first week.

An essential part of a pharmacist's role is to ensure that safe systems are in place wherever medicines are used. Of all the healthcare professions, pharmacists have the widest knowledge in the science and use of medicines. They are the experts in all aspects of medicines and how they work. A growing number of pharmacists are independent prescribers and their skills should be fully utilised in areas of greatest clinical need. The Roland report¹⁵ on the future of primary care recommended that:

“ *There should be greater involvement of clinical pharmacists, including prescribing pharmacists, in the management of people on long term medication and people in care homes.*¹⁶ ”

Permanent integration of dedicated roles for pharmacists for each care home working within Health and Social Care Partnerships (HSCPs) is required. Pharmacists can support care home staff to monitor conditions, symptoms and responses to medication more effectively.

There is a growing body of evidence across the UK and beyond¹⁷, that care is improved when multidisciplinary models are developed and where pharmacists know the residents and care staff and vice versa. This can reduce the need for GP appointments, use of out of hours services and unplanned admissions to hospital.

In England, there has been investment in integration. Co-production between commissioners and providers has successfully aligned budgets and incentives¹⁸. Dedicated care home roles for pharmacists are now nationally funded.

“ *A four-month trial in a care home in London where a pharmacist was given full responsibility for medicines management saw a 91% reduction in errors associated with medicines.*¹⁹ ”

The regular presence of a named pharmacist at a care home has a positive and measurable impact on patient safety²⁰. The expertise of pharmacists in all aspects of medicines makes them ideally placed to lead the MDT to ensure that individual pharmaceutical care and medicines management systems are safe, efficient and person centred.

*SHSC** 1.13 I am assessed by a qualified person, who involves other people and professionals as required.*

Pharmacists also need to spend more time supporting care staff to improve their understanding of medicines; to enable and empower them to monitor and follow up symptoms; to observe the outcomes of changes to medication and enhance care plans. This can only be achieved through embedded roles with regular input.

MacMillan integrated pharmacist Helensburgh, “Sunny sessions”

Short lunch time training sessions have been provided by the local practice pharmacist to care home staff to provide training on various aspects of care including assessing pain, constipation, how to decrease the risk of falls, palliative and end of life care.

The homes have now requested longer training sessions tailored to their needs and this will be rolled out further across the HSCP.

3. Sustainability must be built into care home contracts with community pharmacies to enable continuity of care, quality improvement, long term planning, and investment in staff training and education.

Community pharmacists want to, and could, play a more clinical role. Pharmacy services are about more than just a supply function. They have a key role to play in ensuring patient safety, providing clinical care and access to NHS pharmaceutical care services. They should be fully integrated into the primary care team to work with their specialist colleagues.

This available expertise should be harnessed nationally using a standardised approach as part of a service level agreement.

The Pharmacy Advice Visit (PAV) is the only additional service contractually required by community pharmacies. It focuses on supply and safe storage and has not been revised since 1989. However, many community pharmacists already routinely provide enhanced clinical care when they visit the home, including medication reconciliation and review, quality improvement measures and clinical audit.

Many of the requirements of the PAV can be, and are, already carried out by pharmacy technicians and as part of a self-audit by care homes.

Community pharmacist case study – 20 bedded care

Today I picked up that diclofenac 3% gel used to treat actinic keratosis had been wrongly prescribed and was being administered three times daily for pain in elbows. I arranged for this to be changed to the correct prescription for 1% for joint pain.

There was a handwritten administration chart entry for Nicorandil 20mg twice a day for angina as this was what the patient brought in when they arrived, followed by printed chart for 10mg twice daily prescribed in error as a first supply from a new GP.

A patient with a discharge note which clearly stated three medications had been discontinued but were still on the current administration chart. Continuing these would have led to a deterioration in the patient condition and possible subsequent readmission to hospital.

The medicines reconciliation examples above are from one normal day as a community pharmacist. They illustrate where the link between supply and pharmaceutical care is critical to resident safety to prevent avoidable harm and the danger of readmission to hospital through medication errors.

Hospital discharge letters should be routinely shared with community pharmacists. They should be the first point of contact for routine medication queries from care staff, particularly at weekends and out of hours. This avoids unnecessary calls to out of hours services, requests for duplicate prescriptions and minimises waste.

Currently, contracts between community pharmacies and care home providers can be terminated at short notice. This does not guarantee continuity of care or encourage investment in staff training and service provision. Sustainable arrangements require a service level agreement between the IJB, community pharmacies, GPs and care home providers to promote best practice and high quality care.

Service Level Agreements with care home providers and community pharmacies need to be more robust, building in quality markers.

“ *In Wales a Care Home Enhanced Service²¹ has been funded to involve community pharmacies more in medicines management and quality improvement audits.*

The service uses eMAR systems to provide care home data which can then be used to make changes in specific therapeutic areas linked to national safety alerts and new guidance.

Patient Outcome Medication Safety Indicators (POMSIs) are used to highlight residents who may be taking medicines which are placing them at risk of medicines related harm.

The community pharmacy, in collaboration with the care home, is in an ideal position to identify these residents and liaise with the GP practice to review this prescribing. The service includes a service level agreement with health boards to ensure consistency of provision.

”

The IJBs of the new Health and Social Care Partnerships are now the commissioners for their local services. Local providers need to deliver services against standards set at national level to reduce variation.

Evidence from Australia has shown improvements to patient care when an MDT, quality improvement approach is taken. Quarterly case conferences that included the GP, geriatrician, pharmacist, staff and representatives from Alzheimer’s Association were found to be the most beneficial²². Further recent work has advised new models of care with pharmacists on site are required.

“ *To address the medication safety, we suggest a novel model of care in residential aged care facilities, in which an on-site pharmacist integrates with nursing staff to form an interdisciplinary team to prevent medication-related harm and improves the quality use of medicines.²³*

”

Any new models should include:

- Building the essential relationship of a named pharmacist and GP for residents²⁴
- Community pharmacies locally to supply both acute and repeat prescriptions to provide continuity of care
- Dedicated role with a named pharmacist working with the MDT
- Regular clinical audit and medication review
- Support for long term investment in education and staff training
- Safe and efficient medicines management systems

Care homes are often served by multiple GP practices. This can cause problems in medicines management and add to the administrative burden for care home staff with many different systems to accommodate. It also makes coordinated medication reviews and MDT working much more difficult.

Wherever possible, one community pharmacy and one GP practice should be aligned to a care home to enable the provision of a co-ordinated and consistently high standard of care for all service users. This is in line with the views of the Royal College of General Practitioners and the British Geriatric Society.

*SHSC** 4.17 If I am supported and cared for by a team or more than one organisation, this is well coordinated so that I experience consistency and continuity.*

4. Residents should have equity of access to community pharmacy NHS pharmaceutical care services.

Scotland has led the way in pharmaceutical care services from community pharmacies including the national minor ailment service (eMAS)²⁵, the recent Pharmacy First initiatives, the use of Community Pharmacy Unscheduled Care (CPUS) prescriptions and the Medicines Care and Review (MCR) Service.

These contractual initiatives have improved overall access to medicines, freeing up GP appointments and using the skill mix available in community pharmacies to best advantage. However, these services are not available to care home residents. They should be adapted and suitable versions made available for care home residents as part of a national service framework.

An adaptation of the new MCR service with serial prescribing and dispensing for residents in care homes should be prioritised as a key enabler for more efficient medicines management systems. Community pharmacist access to the appropriate parts of a patient health record is an essential element of providing safe clinical care in an integrated system.

Taken together, these changes would free up GP and care home staff time, and give more understanding of the essential role of a pharmacist in patient safety. It would allow community pharmacists to deliver a more appropriate clinical role, working in tandem with dedicated care home pharmacists and the wider team. It would encourage medication queries to be directed to the pharmacy first, where all the information on what has been dispensed is available.

5. Sharing of information and use of Information Technology.

Sharing of information across the MDT is an essential element of multidisciplinary healthcare but the many and varied IT systems across health and social care do not connect. In the interest of high quality, safe

and effective patient care all pharmacists directly involved in patient care in care homes should have read and write access to the health record and residents' care records. It is essential that all health and social care professionals have access to the information they need to do their job and keep residents safe, especially when people transfer to other parts of the health and social care system.

Pharmacists working in GP practices have access to patient health records but there have been challenges in sharing information with community pharmacists. Community pharmacists are regulated professionals and held to the same codes of ethics and governance requirements as their hospital and GP practice colleagues. They should not be excluded from information which enhances patient safety and supports more efficient patient access to their medicines.

The Scottish Government's digital strategy²⁶ in 2017 gave a commitment to create a national portal for health and care services, giving people better access to their healthcare information and records. We welcome the subsequent development of a new national digital platform led by National Health Education for Scotland (NES).

It is important that care homes are included in the new platform to allow exchange of information. Hospital admissions and discharges are areas for potential medication errors and sharing of information would improve patient safety.

5.1. Electronic prescribing and administration

Electronic prescriptions and a move away from paper based systems in primary care would address the workload in repeat prescribing. It would provide a framework for ensuring regular medication reviews for people with long term conditions.

Sending prescriptions electronically from both primary and secondary care providers to community pharmacies, care homes and GPs would enable timely changes in medication and minimise transcribing errors. This should become a priority within the new national digital platform as an essential enabler for the sharing of information across the health system. Hospital discharge information should be routinely shared with community pharmacists to avoid prescribing errors, inadvertent supplies of discontinued medication and to ensure continuity of care with new prescriptions.

Some care homes are moving to use eMAR charts which can provide a wide variety of reporting and audit systems to greatly improve patient safety. Users of eMAR systems report many advantages:

- Doses are timed so that, for example paracetamol can't be given less than four hours apart, ensuring no inadvertent overdose of liver toxicity
- Quality of life can be improved for residents suffering from Parkinson's disease, diabetes and other conditions where timing of medication is crucial
- Reporting provides detailed information to improve adherence and reduce missed doses. For example, if the resident is too sleepy to take their medication, an alternative time can be arranged. It can highlight that a sleeping tablet is then inappropriate. Patterns can be identified to trigger medication reviews and adjustments made accordingly. This can contribute in the longer term to improved outcomes
- It can encourage quality improvement by highlighting areas for audit, focusing on single therapeutic areas of concern resulting in positive changes to prescribing and care home administration procedures e.g. laxatives used in sporadically incontinent patients
- Overdue reviews and end dates are easy to see so that no medication will be mistakenly continued. This could support reductions in antipsychotic use and the subsequent risk of stroke and heart attacks

5.2 Telehealth

Telehealth consultations have great potential to provide wider access to NHS pharmacy and other health and social care services. This can lead to more efficient use of resources and improve access to pharmaceutical care and pharmacists' expertise in both urban and rural areas.

NHS Highland has led the way with its Pharmacy Anywhere²⁷ service which allows people in rural areas to have "face to face" medication review consultations from home via video or telephone, as well as using telehealth to provide remote access to medical records for pharmacists. This service has saved travel time for both patients and pharmacists.

For frail care home residents the detrimental impact of having to travel for appointments can be considerable. Virtual consultations and appointments can avoid unnecessary stress. It also allows family and/or carers to be included in the decision making for loved ones even if too far away to travel.

In Shetland, the remote and rural challenges have led to a very successful integrated approach to care. The expertise and clinical skill of both community and primary care pharmacists has been used to improve the quality of pharmaceutical care provided and ensure the safety of medicines management processes²⁸. Services are provided remotely to the community place of care using new and existing telehealth technology – AttendAnywhere²⁹.

The project, which received funding from the Realistic Medicines Fund, necessitated community pharmacists having access to patient health records and provided all residents with a monthly medication review. It has resulted in more discussion about residents' medicines with care home staff, and a subsequent decreasing number of medication errors every month. Care home staff spend 75% less time on MAR chart issues, freeing up time equating to one day per month for every ten residents.

6. With consent, all pharmacy staff directly involved in a resident's care should have full read and write access to their health and care records. This must include care plans and MAR charts.

A more consistent approach to consent is required across the NHS and social care systems. Patients/residents often assume that all health professionals involved in their care have access to the information they need. This can avoid delays in providing care, duplication of effort and repetition of medical histories, but is not currently the norm.

Currently health professionals often require individual requests for explicit consent at different points in the patient journey and have no access to information from other parts of the health and social care system. For example, some community pharmacies have access to the clinical portal but consent from the patient is required for access each time.

This goes against the principles of a "once for Scotland" approach. It has risks for patient safety and is a burden to patients and health services. The need for the patient to be in the pharmacy also automatically excludes care home residents. A review is required urgently to improve access to and responsiveness of these services

In 2012, in response to legal requirement, we asked care providers to include consent to allow the sharing of information with pharmacists. We understand that this has not happened universally and that it is resulting in unacceptable delays in some areas.

In the interests of effective working practice, safety and continuity of care, care home providers must ensure that consent is obtained from all new residents. This will allow all health care professionals, including pharmacists and pharmacy technicians involved in their care, to view the appropriate parts of their health record and care home records including care plans and MAR charts.

Care providers should review their admission process for new residents to ensure that consent is in place for pharmacy teams.

*SHSC**4.18 I benefit from different organisations working together and sharing information about me promptly where appropriate, and I understand how my privacy and confidentiality are respected.*

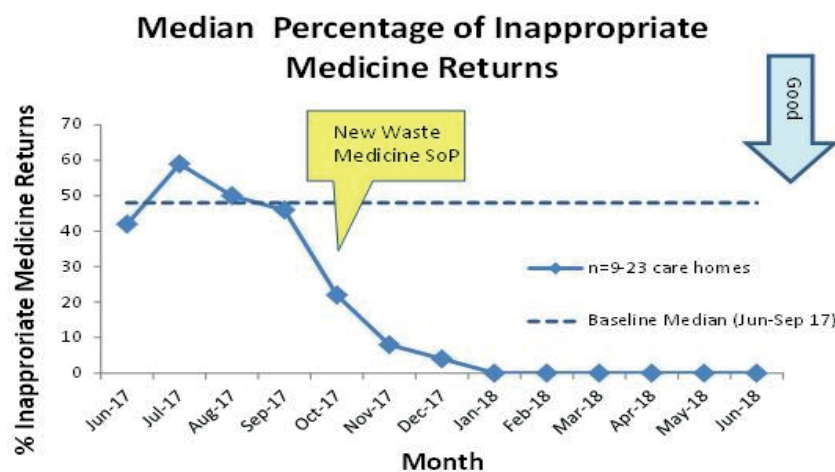
7. Reducing waste and improving medicines management

In Ayrshire and Arran dedicated care home pharmacists have worked with other key stakeholders to achieve savings of between £197 and £454 per resident.

In Forth Valley pharmacist led medication reviews working with care home GPs resulted in an average saving of £384.43.

This would equate to a national saving of between £6.4M and £14.8M annually for NHS Scotland which could be reinvested in the new models and services that we are calling for.

Some care homes have had a policy of returning unused medicines at the end of every month which contributes to unnecessary waste. Where this has been addressed by new policies in health boards substantial reductions in waste have been achieved. An initiative in Tayside co-produced between the health board, Scottish Care, Care Inspectorate and community pharmacy has significantly reduced waste.



Enablers for waste reduction and efficiency

- Electronic MAR charts
- Use of original packs for medication administration
- Legislative changes/health board policy to allow bulk prescribing (currently possible in England but not Scotland) and supply of commonly used "P" or "GSL" items such as laxatives, calcium, vitamin D supplements and thickening agents
- 28 day repeat prescribing and serial prescribing
- Collaboration and co-production between all stakeholders
- National guidance/training is required to share best practice on waste reduction and to have a standardised approach to medicines management and understanding of the regulations

- Clear policy to discourage returning unused medication every month and then reordering the same items
- Closer working between pharmacy technicians and care home staff to support more efficient medicines management systems

Pharmacy technicians are ideally placed to work with care home staff to oversee medicines management. They can ensure efficient ordering and return systems are in place, reduce wastage and provide educational support to staff. Technicians are an important link between the care home, GP practice and community pharmacy.

In some areas this role is being expanded further to patient facing roles, including inhaler technique, blood pressure monitoring, gathering baseline data on medicines adherence, weight, and seizure frequency and monitoring requirements. Widening the technician role has resulted in faster referrals to the pharmacists and other health professionals as well as system efficiencies and improvements.

8. Palliative Care

“Today, many people living in care homes will need to be supported by a palliative approach from the point of their admission. Nearly 20% of all people die in care homes so getting their care right from the moment they arrive to the point at which they die is so important if they are to enjoy as high a quality of life as possible. Anticipatory Care Planning conversations should be a part of all admissions for those coming into care homes and this must include pharmacy. Medicines should help people to live as well as they can with medicine regimens reflecting their wishes and choices in how they want to live.

Richard Meade, Head of Public Affairs, Scotland, Marie Curie



The current demographics of care home residents suggest that the vast majority of those moving to a care home will probably be needing some form of palliative care either when they arrive or soon after. It would be appropriate for all residents, their families and their care teams to begin anticipatory care planning conversations from the time they arrive.

Palliative and end of life care³⁰ can be highly dependent upon medicine interventions, to control pain, alleviate symptoms and stabilise the individual's condition. It is an area of care where residents can benefit significantly from the expertise of a pharmacist. In a recent study, up to 53% of care home residents were symptomatic in their last days of life, meaning that timely access to end of life medicine is important³¹.

Residents and their families should be given the opportunity to be at the centre of decision making about their medication options, supported by discussion with members of their care team including a pharmacist. Co-ordination and communication across the multidisciplinary team will be critical in the delivery of high quality and responsive palliative and end of life care.

Timely access to end of life medicines can support the resident, their families and carers as well as reduce unnecessary admissions to hospital and decrease pressure on out of hours services.

Advice about, and access to end of life and anticipatory care medicines, should be formalised between prescribers, pharmacists and care home providers. Community pharmacies supplying care homes should be aware of palliative care requirements for individuals. They should either be part of the national community pharmacy palliative care network or be able to access training that ensures residents have timely access to palliative and anticipatory care medicines, as well as advice on symptom management when required.

Specialist Palliative Care Pharmacists also provide a crucial role in direct care of residents. They can educate other healthcare professionals on appropriate and safe use of medicines and develop guidelines to support better care.

It is also critical that a polypharmacy review is undertaken at this stage of the person's life and that appropriate monitoring is put in place. Pharmacy models can then respond to this effectively.

9. Education and training

Pharmacists involved in providing care for residents in care homes will be required to develop their competences in this area spanning care of the elderly, dementia and palliative care. They should also be prescribers.

Many pharmacists have now completed a postgraduate diploma or an MSc in clinical pharmacy along with further specialist training in order to address the complex needs of medication reviews in this group of patients.

There should be experiential learning work placements for undergraduates and pre-registration trainees to gain essential experience in polypharmacy reviews, the holistic care of residents in their home settings and multidisciplinary working.

Care home staff have a high turnover and although there are nationally agreed competencies, training quality can vary. A consistency of approach to medicines management and administration is required. It is crucial that

care home staff have support from experienced professionals who can provide supervision and oversight, ensuring safe delegation, where this is deemed appropriate. Pharmacists working with care home staff can provide this leadership, ensuring safe practices are in place.

Enablers include:

- NES to develop a national educational framework to support the delivery of approved, standardised and competency-based training for all pharmacists and pharmacy technicians delivering pharmaceutical care to people in care homes
- National standards and accreditation of training around medicines and their use for care home staff would eliminate variation in care and help reduce waste
- eMAR charts to support staff, reduce administration errors and support safer medicines management

Summary and next steps

- We believe that changing demographics call for the pharmaceutical care of care home residents to be recognised as a specialist area to address the complex care and palliative care requirements of this increasingly frail elderly population
- Workforce planning is required for both the pharmacist and pharmacy technician professions. The increasing use of medicines in complex care means there is a growing requirement for pharmacists' specialist expertise in all aspects of medicines use across all healthcare sectors. We are pleased to see new roles emerging and the growing recognition that where there are medicines there must be pharmacists across all areas of primary and secondary care. Modelling work on the expectations from the new General Medical Services contract would indicate that current numbers of pharmacy graduates will not be enough to fill the new roles envisaged
- A national approach to policies and standards of care with a focus on quality improvement and accreditation of training on medicines use and administration
- Care homes to be acknowledged as a professional sector providing experiential and inter-professional learning for pharmacy students and pre-registration trainees
- Changes in legislation are required to allow bulk prescribing of appropriate commonly used items to support more efficient ways of working and eliminate unnecessary waste
- Service level agreements between care home providers, community pharmacies and HSCPs, aligned with the national standards, are required to provide business continuity and encourage investment in training and resource

We believe that the Scottish Government needs to refocus and prioritise residential care provision as a specialist area while working in tandem to deliver the principles of Realistic Medicine and the 2020 Vision of keeping people at home in their communities for as long as possible. Care homes need to be resourced to cope with the increasingly complex care they are required to deliver. Medicines are a key aspect of patient care right across the NHS and pharmacists are essential to providing high quality pharmaceutical care in every healthcare sector.

We will work with Scottish Government, the Care Inspectorate, COSLA, IJBs, care home providers, residents' representatives, professional bodies and other key stakeholders to take forward the changes outlined in this policy to improve the pharmaceutical care of care home residents across Scotland.

Glossary of terms

Anticipatory care planning – The process of discussing the type of treatment and care that a patient would or would not wish to receive. This is particularly important in the event that they become unable to decide or express their wishes. A record of a patient’s wishes and values known as an advanced care plan will be created.

Co-production – The delivery of care services where those who use the services are involved in their development. It is a relationship where professionals and citizens share power to plan and deliver services together, recognising that both have vital contributions to make in order to improve quality of life for people and communities. It is contrasted with a transaction based method of service delivery in which citizens consume public services which are conceived of and provided by governments.

End of Life – Generally considered to be a period up to the last year of life, but this timeframe can be difficult to predict.

GSL medicines – Available from any retail outlets.

Medicines Care and Review Service – A service refresh of the former Chronic Medication Service (CMS). It formalises the role of community pharmacists in the management of patients with long term conditions by making better use of their skills and expertise to improve a patient’s understanding of their medicines and to help to maximise the clinical outcomes from their therapy. It involves serial prescribing and dispensing where a GP can prescribe 24-, 48- or 56-week serial prescriptions.

Medicines Reconciliation – The process of identifying the most accurate list of a patient’s prescribed medicines – including the name, dosage, frequency, and route – and comparing them to the current list, recognising discrepancies, and documenting any changes, thus resulting in a complete list of medications, accurately communicated.

Palliative care – This policy adopts the World Health Organization definition of palliative care. This is “an approach that improves the quality of life of patients and their families facing the problems associated with life limiting illness, through the prevention of, and relief of, suffering, by means of early identification and impeccable assessment and treatment of pain and other problems, physical and spiritual”.

Pharmaceutical care – A holistic practice which aims to provide the right patient, with the right medicines in the right dose at the right time for the right reasons to achieve agreed outcomes. Medicines should have an active indication and be as effective and as safe as possible.

Pharmacy Technician – A regulated healthcare professional who undertakes medicines management tasks e.g. checks inhaler technique, synchronises medications, reviews repeat prescribing and dispensing processes. These roles are developing rapidly and in some areas technicians are taking on prescribing data analysis roles and medication reconciliation and referring to the pharmacist for clinical medication reviews.

Polypharmacy – The concurrent use of multiple medications by a patient. It can be appropriate when all drugs are prescribed for the purpose of achieving specific therapeutic objectives that have been agreed with the patient. It is inappropriate when one or more drugs are prescribed which are no longer needed.

P medicines – Available for sale only from pharmacies.

Serial prescribing – Instead of generating a prescription every one to two months a GP practice can produce a serial prescription for medication. It can cover up to 48 weeks, which is dispensed at the pharmacy at the regular intervals defined on the serial prescription.

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We make sure the voice of the profession is heard and actively promoted in the development and delivery of health care policy and work to raise the profile of the profession.

We put pharmacy at the forefront of healthcare and we aim to be the world leader in the safe and effective use of medicines. We are committed to supporting and empowering our members to make a real difference to improving health care.

Pharmaceutical care is a holistic practice which aims to provide **the right patient with the right medicines in the right dose at the right time for the right reasons to achieve agreed outcomes.**

Medicines should have an active indication and be **as effective and as safe as possible.**

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