ROYAL PHARMACEUTICAL SOCIETY
England

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SHAPING PHARMACY FOR THE FUTURE: PHARMACISTS IMPROVING MEDICINES USE IN CARE HOMES

Pharmacists, as part of the multidisciplinary team, should have overall responsibility for medicines and their use in care homes. This will result in significant benefits to care home residents, care home providers and the NHS.

KEY ISSUES

- The average age of residents in care homes for the elderly is 85 and they are prescribed an average of 7.2 medicines[1].
- In a 2011 study more than 90% of elderly care home residents had been exposed to at least one potential medicine administration error[2].
- In 2009 a report showed that two thirds of care home residents had one or more medicine errors[1] and that these errors may have occurred as a result of a failure in prescribing, dispensing, administering or monitoring medicines[1].
- To improve the safe and effective use of medicines by people of all ages who live in care homes, clear systems and processes are needed across the medicines management pathway[3].
- Medicines safety could be improved if patients' medical records were shared between GPs, community pharmacists and other care providers and were accessible with read and write access in the care home[1].
- The NHS England Five Year Forward View[4] calls for the development of shared models of in-reach support for care homes including medicine reviews.
- There is evidence that multi-disciplinary interventions are most likely to be effective in providing effective medicine reviews[5].
- Pharmacist medicine reviews lead to a reduction in falls in care homes[6].
- Reducing the use of psychotropic drugs for people with dementia or learning disabilities and ensuring patient safety when they are needed should be a priority[7].
- The care home provider, prescriber and pharmacist should agree with the resident the best time for them to take prescribed medicines. Busy times should be avoided[3].

RECOMMENDATIONS

- Pharmacists should have overall responsibility for medicines and their use in care homes.
- One pharmacist and one general practitioner should be responsible for medicines in each care home ensuring co-ordinated and consistently high standards of care.
- Where a care home specialises e.g. in dementia care, the pharmacist should ensure they are competent to support the relevant clinical speciality.
- Local commissioners (such as Clinical Commissioning Groups or NHS England) should commission pharmacists to provide medicine reviews within care homes.
- Pharmacists should lead a programme of regular medicine reviews and staff training, working in an integrated team with other healthcare practitioners ensuring medicines safety.

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INTRODUCTION

Policies that encourage older people to stay in their homes longer have resulted in residents of care homes for the elderly being generally frailer. They often have multiple morbidities and are frequently taking several prescribed medicines. The Royal Pharmaceutical Society (RPS) believes pharmacists should have an embedded role in care homes, as part of a multidisciplinary team, with overall responsibility for medicines and their use. NHS England's Five Year Forward View[4] calls for more shared models of care including medicine reviews helping to reduce hospital admissions for this vulnerable group.

International research shows that medicines in care homes are often poorly managed, leading to errors. Some residents are prescribed medicines inappropriately with the potential for harmful side effects and a loss of therapeutic benefit. The National Care Forum[8], identified that 'when a person enters a care home, staff often automatically assume responsibility for managing medicines'. This can lead to a loss of independence and control for the resident.

An estimated 4 million older people in the UK (36% of people aged 65-74 and 47% of those aged 75 or over) have a limiting, long term condition[9]. The ageing population and increased prevalence of long term conditions have a significant impact on health and social care and may require £5 billion additional expenditure by 2018[10].

There are 426,000 elderly and disabled people in residential care (including nursing), approximately 405,000 of whom are aged 65 or over[11]. The care home population is ageing: in 2011, people aged 85 and over represented 59.2% of the care home for the elderly population compared to 56.5% in 2001[12].

Care home residents live with a high level of disability and as many as 76% of residents require assistance with mobility or are immobile and 78% have at least one form of mental impairment[13].

The RPS believes that the government needs to review the commissioning of residential care provision to highlight where consistency of approach and the overall safety and efficiency could be improved in relation to medicines and their use.

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PHARMACISTS' ROLE IN OPTIMISING MEDICINES IN CARE HOMES

The Roland report on the 'Future of Primary Care: Creating teams for tomorrow'[29] recommends that there should be greater involvement of clinical pharmacists, including prescribing pharmacists, in the management of people on long term medicines and people in care homes.

It also recommends that the care for people in nursing and residential homes should be organised so that all residents in a care home are cared for by one GP practice, except where a resident asks to be registered with a different practice.

The RPS believes one pharmacist should have responsibility for the whole system of medicines and their use within a care home.

Medicine reviews

In 2014 the National Institute for Health and Care Excellence (NICE) published 'Managing Medicines in Care Homes'[3] guidance on prescribing, handling and administering medicines to residents living in care homes and the provision of care or services relating to medicines in care homes.

This NICE guidance states that care home staff should assume residents are able to look after and manage their own medicines when they move into a care home, unless indicated otherwise. An individual risk assessment should be undertaken on admission to determine the level of support a resident needs to manage their own medicines.

The guidance states that the care home manager or the person responsible for a resident's transfer into a care home should coordinate the accurate listing of all the resident's medicines (medicines reconciliation) as part of a full needs assessment and care plan. The RPS believes that this medicines reconciliation should be undertaken by a pharmacist or pharmacy technician.

The guidance also states that GPs should work with other health professionals to identify a named health professional who is responsible for medicine reviews for each resident. This should take into account the clinical experience and skills of the health professional, how much they know about the resident and the resident's condition, and whether they can access the relevant information. The RPS believes that a pharmacist should undertake this role.

The NICE guidance recommends that instructions should be noted in the resident's care record for when and how to take or use the medicine (for example, 'when low back pain is troublesome take one tablet') monitoring the effect they expect the medicine to have. The RPS believes that a pharmacist should be responsible for this.

The RPS believes that the pharmacy team must lead the medicines reconciliation and medicines reviews within the care home setting as part of the multidisciplinary team.

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Medicines safety in care homes

In recent years the NHS has become increasingly concerned about medicines safety in care homes. The RPS believes that pharmacists should be responsible for the safety of some of the most vulnerable members of society and guarantee safety of the whole medicines system in care homes.

The Care Home Use of Medicines Study (CHUMS)[1] examined a random sample of 256 patients in 55 care homes. The study found that 69.5% of care home residents experienced at least one error associated with their medicines, which the report described as "unacceptable". The study suggests that in order to prevent errors, pharmacists should regularly review residents, their medicines and rationalise regimes to help home staff work more safely. Such measures will identify and prevent such vast amounts of errors.

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[2]. The RPS believes that the regular presence of a pharmacist at a care home would have a positive and measurable impact on patient safety.

Pharmacy services for care homes is mainly limited to supply of medicines, and care homes are often served by multiple GP surgeries and pharmacies. 'Pharmacy Advice Visits' have been commissioned locally in some areas providing medicines reviews, staff training and advice on proper use of medicines.

As a basis for change the RPS believes that one 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 across all service users. This is in line with the views of the Royal College of General Practitioners and the British Geriatrics Society.

Medicines safety could be improved if patients' clinical information (the patient's medical record) was shared between GPs, pharmacists and other care providers and was accessible, with read and write access in the care home. Safety could also be improved by supplying medicines to care homes in their original packs containing patient information leaflets. This would also reduce wastage and make it easier to know if medicines have been taken and make it easier to stop, start or change medicines. After undertaking 58 interviews the CHUMS study[1] found that not knowing a resident, prescribing without computerised notes or prescribing software led to poor communication between primary and secondary care which led to prescribing errors that had a negative impact on patients' health.

The RPS believes that the current service provision is below the minimum needed and that PSNC and commissioners should consider a broader medicines optimisation service for care homes, led by pharmacists as part of the multidisciplinary team.

Polypharmacy

At least 25% of people over 60 years old have two or more long term conditions which means that there are a number of patients in care homes prescribed many medicines. Polypharmacy is driven by an ageing, increasingly frail and multi-morbid population and although in some patients it may be clinically appropriate, it can increase clinical workload and clinical complexity. Polypharmacy can also be problematic, where medicines are prescribed inappropriately or where the intended benefit of the medicine is not realised. Harms associated with polypharmacy include risk of errors associated with medicines (including prescription, monitoring, dispensing and administration errors), adverse drug reactions, impaired medicines adherence and compromised quality of life for patients. There are costs not only in terms of morbidity and mortality, but also of pharmaceutical products (including waste) and health service utilisation.

Growing concerns around polypharmacy led to the publication of 'Polypharmacy and medicines optimisation: Making it safe and sound' by the King's Fund in 2013[14]. This report highlights the implications of multi-morbidity and polypharmacy for clinical practice, services and policy, and calls for actions to facilitate the management of complex multi-morbidity and systems to optimise medicines use. This report states that 'Multi-morbidity and polypharmacy increase clinical workload. Doctors, nurses and pharmacists need to work coherently as a team, with a carefully balanced clinical skill-mix'.

The RPS believes that pharmacists, as experts in medicines use, must play a significant role in the reduction of problematic polypharmacy.

The RPS believes that every care home resident should have a pharmacist led medicines review at least once a year or whenever a medicine is started, stopped or changed and when a resident moves between different care settings.

Falls in care homes

Residents of UK care homes for the elderly fall on average two to six times per year and up to a third of falls result in injury with 1 in 20 falls resulting in a fracture[16]. The Cochrane review found that multi-faceted interventions to reduce falls in care homes were effective if they were coordinated via multi-disciplinary teams[17]. They found that vitamin D supplementation was beneficial and suggested that exercise may also be effective in falls reduction. A pharmacist medicine review was shown to lead to a reduction in the number of falls[6].

The RPS believes that a patient must receive a falls assessment on admission into a care home, and regularly thereafter, and that a pharmacist should be involved in assessing falls risk from the medicines the patient takes.

Use of psychotropic medicines

In 2009 it was estimated that the use of antipsychotic medicines in patients with dementia, who represent at least 60% of the care home population in the UK, equated to 1,620 cerebrovascular adverse events and 1,800 deaths per year on top of those that would be expected[18].

The 2009 report[18] stated that 25% of residents of care homes for the elderly were prescribed antipsychotics. However, a national programme to reduce the use of antipsychotic drugs in people with dementia has achieved a reduction to 12%[9].

A study of people admitted to care homes showed a higher use of psychotropic medicines before entry than those who remained in the community. Use of psychotropic medicines increased in the months after admission. Antipsychotic dispensing increased from 8.2% before entry to 18.6% after entering and hypnotic dispensing increased from 14.8% to 26.3%[20].

A pharmacy-led programme within GP surgeries in Medway demonstrated that pharmacist interventions led to withdrawal or dose reduction of psychotropic drugs in 61% of cases[21].

Up to 40% of older people in hospital and care homes are depressed with the risk higher in those with long term conditions. Around a third of care home residents are treated for or suffer from depressive disorder and 38% of care home residents are prescribed antidepressants in England and Wales[16].

Legislation was introduced in the US to reduce antipsychotic prescribing in care homes in 1987. Care homes are required to employ an independent consultant pharmacist to undertake regular reviews of antipsychotics, with the aim of reducing or discontinuing the medicines. Evidence suggests this has been effective[22]. Some older antipsychotics add to the anticholinergic burden especially when many medicines with these properties are taken together[23].

Recent studies have raised similar concerns about the prescribing of psychotropic drugs for people with learning disabilities. The Publication of a Learning Disability census from the Health and Social Care Information Centre (HSCIC[24]) has further raised concerns about the use of medicines. The finding that two thirds of service users (68.3% or 2,220) had been given an antipsychotic leading up to census day was widely regarded as further evidence of inappropriate use. Further primary care based audits have raised concerns about overuse of all categories of psychotropic drugs[25].

Concern about the inappropriate use of psychotropic drugs in people with a learning disability has prompted NHS England to propose a 'Call to Action' for all parties including pharmacists to lead a process of planned supervised dose reduction and stopping of inappropriate psychotropic drugs that are potentially causing harm or no longer having any benefit.

The RPS believes that pharmacists should play a key role as part of the multidisciplinary team in providing oversight of psychotropic medicines prescribed in care homes to ensure that their use is kept to a minimum.

End of life care in care homes

A review of the evidence of medicine use at the end of life found that care home staff had variable confidence and competence in the appropriate use of palliative medicines. They found that syringe drivers to deliver palliative care medicines were only used when specialist palliative care staff were involved[26].

In a recent study, up to 53% of care home residents were symptomatic in their last days of life, meaning that access to end-of-life medicine is important[27].

The RPS believes that advice about and access to end of life medicine and anticipatory care medicines should be formalised between prescribers, pharmacists and care home providers.

Medicines waste in care homes

Research undertaken in 2009 by the York Health Economics Consortium and the School of Pharmacy, University of London, estimated that medicines wastage in England cost £300 million each year. Of this £300 million, £24 million is medicines that are disposed of unused by care homes, so wastage of medicines is particularly prevalent in care homes[28].

The RPS believes that if pharmacists have responsibility for medicines use in care homes this will help to solve the issue of medicines waste, improve efficiency and provide better health outcomes for care home residents.

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ONGOING RESEARCH

The RPS believes that more work needs to be done to make sure that research is commissioned to consistently measure outcomes that are important to care home residents, and to the NHS.

GOOD PRACTICE EXAMPLES:

Brighton and Hove CCG has commissioned an organisation to provide a comprehensive pharmacist clinical medication reviews service to elderly residents in care homes. This service is now in its fourth year and has delivered significant on-going sustained financial savings as well as reducing risk of hospital admissions relating to medicines. The figures for annualised prescribing budget savings for 2014/15 were £330K with an additional peer reviewed estimated saving from avoided admissions of £380K using RIO scoring method. 2000 patient medication reviews were undertaken. About two-thirds of residents are the same as year before so it must be remembered that sustained changes from previous year will still be producing savings in the current year, but these recurring savings are not included in the figures quoted here – these are actual changes made in 2014–15.

In advance of reviews starting with each GP surgery, a pre-agreement form is discussed and signed by a lead GP authorising some changes to be implemented by the pharmacists. More complex recommendations are discussed individually with the GPs and then implemented by the pharmacist. Only implemented changes are included in savings calculations.

Some training for carers is provided and also support with improving efficiency of ordering systems and reduction of medicines waste.

Strong links have been built with local dieticians, continence care team, mental health pharmacists and community pharmacists.

A Health Foundation project[15] undertaken in Northumbria demonstrated the benefit of pharmacist interventions in Care Homes. Using pharmacist prescribers employed by the local NHS Trust to carry out medicine reviews with residents and their families they demonstrated a cost effective model which could be undertaken in other areas.

The key results from the study were:
- 422 resident reviews carried out
- 1,346 interventions made, the majority of which were to stop medicines
- 1.7 medicines stopped for every resident reviewed
- The main reasons for stopping medicines were there being no current indication or residents' request to stop
- The net annualised savings were £77,703, or £184 per person reviewed
- For every £1 invested in the intervention, £2.38 could be released from the medicines budget.
- The savings do not include the administration time saved and also do not demonstrate the improved quality of life for patients

This service is now being commissioned across a wider area.

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