ROYAL CYMDEITHAS
PHARMACEUTICAL FFERYLLOL
SOCIETY FRENHINOL
Wales Cymru

Improving Medicines Use for Care Home Residents

March 2016

IMPROVING MEDICINES USE FOR CARE HOME RESIDENTS

IMPROVING MEDICINES USE FOR CARE HOME RESIDENTS

Foreword

The principles of Prudent Healthcare set out by the Welsh Government have challenged all health and social care organisations including professional bodies such as the RPS Wales to think differently about how resources are utilised in the Welsh NHS.

This policy takes into account the prudent principles and makes recommendations in response to the report *A Place to Call Home?* from the Older People's Commissioner for Wales. Focused on improving safety and ensuring consistency in service provision, the policy sets out a vision for a model of safe and effective pharmaceutical care for the residents of care homes.

Concerns have been raised in other reports and documents in relation to medicines use in care homes across Great Britain. These concerns, coupled with an ageing population and increasing levels of chronic disease mean that engaging the skills of the pharmacy team is increasingly important to help reduce medicines related harm as well as maintaining and improving the health and wellbeing of older people.

Care home residents should receive the right medicine at the right time and in the right way to maximise the benefits of the medication. The pharmacy team; pharmacists and registered pharmacy technicians, have significant expertise to support medicines management and safe administration for all care home residents as part of a multidisciplinary team.

A number of key recommendations have been made by drawing on examples of good local practices across Wales and with the advice from experts within the pharmacy profession, other health and social care professionals and patient representative groups.

The RPS are calling for the next Welsh Government to commit to the collective action that will implement the necessary changes to allow the pharmacy team together with health and social care colleagues to use their expertise for improving care for care home residents in Wales.

Suzanne Scott Thomas
Chair, Welsh Pharmacy Board

Timothy Banner
Chair, Policy Steering Group

With thanks to contributions and support from:

age Cymru
Coleg Nyrsio Brenhinol Cymru Royal College of Nursing Wales
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS
RC GP CYMRU WALES Royal College of General Practitioners Coleg Brenhinol Meddygon Teulu
My home life Cymru
CYNGOR IECHYD CYMUNED COMMUNITY HEALTH COUNCIL
Older People's Commissioner for Wales Comisiynydd Pobl Hŷn Cymru

EXECUTIVE SUMMARY

Integrating the expertise of the pharmacy team into multidisciplinary approaches in care homes will improve the care, safety and quality of medicines use for residents.

This policy takes into account the principles of Prudent Healthcare [1]. It also addresses issues highlighted by a number of recent reports, in particular those raised by the independent voice and champion for older people across Wales, the Older Peoples Commissioner for Wales in the report 'A Place to Call Home?' [2].

By drawing on advice from experts within the pharmacy profession as well as other health and social care professionals and patient representative groups, five key themes have been identified as areas for immediate support from the pharmacy team:

1. **Polypharmacy**
2. **Antipsychotic prescribing**
3. **Safe transfer of information**
4. **Education, training and standards**
5. **Palliative and end of life care**

This policy sets out several recommendations under each of the five key themes that will improve the care, safety and quality of medicines use for residents living in care homes.

The recommendations are:

1. Polypharmacy

1.1 As part of a multidisciplinary review, all residents should receive a review of their medication by a pharmacist when they first move into a care home in order to optimise their medication regimen.

1.2 Residents should receive a minimum of one annual medication review from a pharmacist, with additional support for significant medication changes. For patients with complex medication regimens, this review should increase to every 3-6 months.

1.3 With patient consent, all pharmacists directly involved in patient care should have full read and write access to the patient health record in the interest of high quality, safe and effective patient care.

2. Antipsychotic prescribing

2.1 Antipsychotic medicines should not be routinely prescribed to treat behavioural and psychological symptoms of dementia.

2.2 In line with NICE guidance, when an antipsychotic medicine is required, the lowest dose should be prescribed for the shortest time with regular review by an appropriately skilled pharmacist as part of the multidisciplinary team.

2.3 Pharmacists who deliver enhanced support for care homes should be able to access quality continual professional development opportunities in relation to antipsychotic prescribing.

3. Safe transfer of information

3.1 Reconciliation of medicines should be undertaken by a pharmacist when a person moves to a care home from their own home or another care setting to ensure that their medication is maintained accurately.

4. Education, training and standards

4.1 The development of national standards for medicines training to ensure uniformity across Wales as well as reflecting current practice for care home staff.

4.2 Inspections of care homes should include the expertise of a pharmacist to address medication issues and improve medicines safety.

5. Palliative and end of life care

5.1 A national review of the current provision of palliative and end of life medication to residents as part of steps to develop all Wales standards for anticipatory prescribing in care homes.

5.2 The multidisciplinary care team for a resident needing palliative care support should have access to the expertise of a specialist palliative care pharmacist.

Action will be required across NHS Wales to review current service provision to care homes and to evaluate how services are funded and resources utilised.

SETTING THE SCENE

Scope

This policy document focuses on the essential role of the pharmacy team in maximising safe and appropriate pharmaceutical care in care homes as part of the multidisciplinary team. It aligns to the scope of *NICE Guidance SC1, Managing Medicines in Care Homes* [3] and focuses on people living in both nursing and residential homes.

The recommendations in this policy are aimed at key stakeholders who have collective responsibility for ensuring the best care for care home residents. They include:

- Welsh Government
- Local Health Boards
- Local Authorities
- Health and social care regulators and inspectors
- The private care sector

Introduction

When older people move into a care home, all they are doing in effect is moving from one home to another [2]. All individuals living in a care home must feel safe, supported and encouraged to maintain as much independence as possible.

This policy takes into account the principles of Prudent Healthcare[1]. It also addresses issues highlighted by a number of recent reports, in particular those raised by the independent voice and champion for older people across Wales, the Older Peoples Commissioner for Wales in the report *A Place to Call Home?* [2]. By drawing on the experience and advice of advisory group members, this policy offers several recommendations to improve medicines management and support for care home residents.

There is a great deal of good care and support available to individuals living in care homes and inspiring examples of current good working practice across Wales. These are acknowledged in this document (appendix 1) and it is important that we can learn from these good examples. Recent reports however have revealed pockets of poor standards and unacceptable practice which need urgent attention. The number of medicines related errors highlighted in reports such as *The Care Home Use of Medicines Study (CHUMS)*[4] and *Telehealth Enabled Medicines Management for Care Home Residents* [5] are of particular concern.

The changing and evolving role of pharmacists in primary care clusters and as independent prescribers offer further opportunities to input into multidisciplinary teams to improve the care of residents. This is the opportunity to build on the principles of prudent healthcare to fully harness the expertise of the pharmacy profession as a part of the solution to meet the challenges in managing medicines in care homes.

The pharmacy profession in Wales has previously voiced ambitions for improving medicines management in care homes. *Your Care, Your Medicines* [6] presents a vision for pharmaceutical care in Wales. The engagement model in this document includes residential and nursing care home support as being a key area where pharmacy input is essential as part of multidisciplinary approaches to care (Figure 1).

Figure 1: Your Care, Your Medicines – The Ambition

> **"Patients with supported living needs, whether living independently in their own homes or in a care home setting, must benefit from access to the pharmacy team to help manage their medicines effectively and to maintain their health and wellbeing.**
>
> **Patients and their carers and/or family will have access to expert pharmaceutical knowledge and will be empowered to co-produce a pharmaceutical care plan with the pharmacy team. This will include vital information regarding their medicines and pharmaceutical needs e.g. allergies, administration requirements such as swallowing difficulties, outcome monitoring and the ability to self-administer medicines."**

Currently there is variation in the provision of pharmaceutical care to care homes across Wales. This is coupled with a lack of clarity as to the nature of services care home residents can expect to receive within individual Local Health Board (LHB) areas. All care home residents and their families should receive the highest standards of pharmaceutical support regardless of where they live in Wales.

SETTING THE SCENE

Achieving person-centred care

Care home residents must be treated with dignity and respect. Where possible residents should be supported to take part in decision making about their healthcare including the medicines that they require. 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 [7].

Person-centred care is particularly important when considering safeguarding and mental capacity issues. *The Mental Capacity Act 2005* defines a person who lacks capacity as a person who is unable to make a decision for themselves because of an impairment or disturbance in the functioning of their mind or brain' [8]. Under these circumstances any decision must be made in that person's best interests with an appropriate advocate [9].

Taking time to listen to what is important to residents will help inform the best care plan possible for the individual. This is particularly important when discussing the appropriate use of medicines to deliver the desired health benefit. Regular interaction between pharmacists and residents will also allow opportunities for the pharmacist to recognise any decline in health and wellbeing.

Having a named pharmacist for all care homes has the potential to improve continuity of care for the resident and is an area that could be further explored. As part of the multidisciplinary team, pharmacists can advise on the best use of medicines and discuss ongoing care with appropriate colleagues.

It is important that the diversity of older people is recognised and the care they receive should be sensitive to their individual needs[3]. Language is one important aspect of diversity; the Welsh language has official status in Wales as set out in the *Welsh language (Wales) measure 2011* [10]. 'Having an understanding of bilingualism and language use and the demographic profile are important elements of professional awareness for the primary care sector in Wales' [11].

> *"We firmly believe that, as part of a holistic approach to healthcare, access to appropriate medicines, regularly reviewed and administered in a patient-centric manner, is fundamental to ensuring dignity and promoting wellbeing for people living in care homes."*
>
> CYNGOR IECHYD CYMUNED
> COMMUNITY HEALTH COUNCIL

Current Landscape

There are 675 older adult care homes with 22,816 places in Wales [12]. In the next 15 years it is predicted that the population aged over 80 years in Wales will grow significantly, from 166,230 to 275,150, an increase of 65% [13]. With an ageing population who are more likely to have multiple long term conditions including health conditions traditionally associated with ageing such as dementia, current demands on care homes will increase.

Medication is by far the most common form of medical intervention in the NHS today. Medicines can be life-prolonging and life-saving but they can also cause harm if used incorrectly. It is estimated that up to 50% of medicines are not taken as prescribed [14]. In one key study, adverse drug reactions (ADRs) were shown to account for 6.5% of hospital admissions and over 70% of these were avoidable [15].

A number of reports and investigations have raised significant concerns with regard to medicines use in care homes both in Wales and across Great Britain:

A Place to Call Home? [2] was a landmark review conducted by the Older People's Commissioner for Wales that aimed to ensure that quality of life sits at the heart of residential care in Wales. It looked at factors such as physical and psychological health, social relationships, the care home environment and spirituality. The report raised specific concerns on issues such as medications being prescribed incorrectly leading to potentially dangerous polypharmacy, delays in the transfer of medical records, and the prevalence of antipsychotic prescribing among residents living with dementia.

The Care Home Use of Medicines Study (CHUMS) [4] examined a random sample of 256 patients in 55 care homes. The study found that 70% of care home residents experienced at least one error associated with their medicines which the report described as "unacceptable". These errors varied from doses being missed or given incorrectly, to the wrong medication being given out. The study suggests that in order to prevent errors, pharmacists should regularly review with residents their medicines and rationalise medication regimens to help care home staff minimise the risk of errors. One of the conclusions of the report is that 'pharmacists should clinically review all residents and their medications for appropriateness at at least 6 monthly intervals.'

SETTING THE SCENE

The Care and Social Services Inspectorate Wales (CSSIW) Annual Report 2007-08 [16] identified medication management as an area needing attention and reported that their inspectors had placed 'requirements for action' in relation to medication in almost a third (32%) of care homes. Subsequent CSSIW reports published annually since 2008 have not commented on medicines management.

Operation Jasmine was a major Gwent Police investigation in 2005 concerning 63 deaths in residential care and nursing homes. A subsequent independent report by Dr Margaret Flynn was published in 2013 [17]. Relatives of the older people in these care homes highlighted that 'the organisational practices they witnessed were inadequate in terms of attending to older people's frailty, chronic illnesses, deteriorating health, mental distress and pain'.

Telehealth Enabled Medicines Management for Care Home Residents [5] evaluated a digital solution in care homes. The system prevented 21 out of the 23 types of error identified in paper based systems. 'The electronic system enabled pharmacists to intervene in a proactive and consistent manner to support the care homes in ensuring medicines administration was safe and effective for the patients' [5]. Further evaluation is being undertaken to fully appraise the potential application in practice.

Opportunities for improvement

The development of the primary care cluster model offers significant opportunities to strengthen working relationships between the pharmacy team and their health and social care colleagues. It is important that cluster developments are cognisant of the growing complexity of care home residents and that expertise from all professions are utilised. In line with prudent principles, this will ensure that each healthcare professional is doing **what is needed** and fully utilising their skills to ensure the resident is safe and comes to **no harm**.

There have been recent publications highlighting the potential increased role of the pharmacy team to support care homes including:

- **NICE guidelines** – *Managing medicines in care homes*. The guideline provides several recommendations for good practice including; medication ordering, dispensing, administration, reconciliation and reduction of medication errors.
- **The General Pharmaceutical Council** – *Pharmacy and Care Homes*, an independent report looking at medicines management in care homes. [18] The report highlights how pharmacy professionals can help to improve medicines management in care homes.
- **Community Pharmacy Wales** – *A community pharmacy services template' – 'Care Home Support Service Review and Medicines Optimisation* [19], intended as a guide to help LHBs to develop and produce service level agreements for the delivery of community pharmacy care home provision.

Together with this policy, these documents advocate further utilising the skills of the pharmacy team in supporting care home residents.

By drawing on advice from experts within the pharmacy profession as well as other health and social care professionals and patient representative groups (see appendix 3 for full list of contributors) five key themes have been identified as areas for immediate support;

1. **Polypharmacy**
2. **Antipsychotic prescribing**
3. **Safe transfer of information**
4. **Education, training and standards**
5. **Palliative and end of life care**

This policy sets out several recommendations under each of the five key themes that will improve the care, safety and quality of medicines use for residents living in care homes.

1. POLYPHARMACY

The Older People's Commissioner is concerned that:

i. *"Older people are supported to make the transition into their new home, are seen and treated as individuals. Residents should receive appropriate medication and the risks associated with polypharmacy are understood and managed."*

ii. *"Too many older people are not being offered preventative screening or interventions, such as falls prevention which would enable them to sustain or regain their independence, mobility and overall quality of life."*

As people get older they are more likely to be taking medicines, often multiple medicines which may be prescribed for a number of different conditions. Additionally there are changes in the way many medicines are processed by the body with ageing. The ability of the liver for example, to metabolise and the kidney to excrete some medicines will decline with age therefore taking longer for a drug to leave the body. This in turn means that the medicine dose for an older person may differ to a younger individual[20].

Polypharmacy is generally a term used when four or more medicines are prescribed for an individual. The proportion of patients receiving 10 or more medicines has increased from 1.9% in 1995 to 5.8% in 2010 and the average number of items per person increased by 53.8% between 2001 and 2011[21].

The Kings Fund has classified polypharmacy as either appropriate or problematic[21]. Appropriate polypharmacy is where medicines use has been optimised and the medicines are prescribed according to best evidence. Polypharmacy can become problematic where multiple medications are prescribed inappropriately, or where the intended benefit of the medication is outweighed by the risk. Problematic polypharmacy can increase the risk of drug interactions and adverse drug reactions, as well as impaired adherence to medication and quality of life for patients[21].

As well as the potential number of medicines that are prescribed for older people there are a number of medicines that require particularly careful dosing, regular monitoring and review. High risk medicines are medicines that have more potential to cause significant harm to the patient, even when used as intended. Examples of these medicines include anticoagulants and insulin and should be considered carefully during a polypharmacy review.

Medicines contributing to falls

The Older People's Commissioner's report states that "preventing falls should be a priority"[2]. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year[22]. It is a problem which is becoming more prevalent with the number of people aged over 65 in Wales who will be admitted to hospital because of a fall projected to rise from 14,827 in 2015 to 21,905 in 2030, an increase of 32%[23].

Falls and the associated complications such as fractures and blood clots are a serious problem and a cause for concern for older people. As well as physical problems, the result of a fall can include distress, loss of independence and confidence for the individual.

There are several medicines that have the potential to increase the risk of a fall particularly those that act on the brain (psychotropic) or those that act on the heart and the circulation. Falls can have multiple causes which may include medicines. This may be due to newly introduced medicines or those used for some time without appropriate review[24].

The prudent principles of patient-centred care and co-production apply equally to care home residents and their families. They should have equal access to pharmaceutical and medical services to address polypharmacy and reduce the risk of medication related falls.

Addressing Polypharmacy

Care home residents may be less likely to have direct contact with a pharmacist or a GP themselves. Residents should still expect to receive primary care services including information on their medicines (addressing polypharmacy). The same principle applies for access to other services such as the influenza vaccine or advice on giving up smoking.

There are numerous published prescribing guidances that can be used to prompt discussion with the multidisciplinary team caring for the resident. These guidances include the:

- ***The All Wales Polypharmacy Guidance for Prescribing*** [25]
- ***The Scottish Polypharmacy Guidance*** [26]
- ***The STOPP/START Criteria for Potentially Inappropriate Prescribing in Older People*** [27]
- ***NO TEARS Tool for Medication Review*** [28]

Integrating some of the principles used in the above guidance documents could further improve services that are currently in place, for example:

- Medicines Use Review (MUR) is an all Wales advanced service in the community pharmacy contract, which offer patients the opportunity to have a private consultation with their pharmacist. They can discuss their medication regimen to help them understand why the medicines have been prescribed as well as an opportunity to discuss and work to solve any problems they may be experiencing. Although not available for care home residents, certain elements of this service would be beneficial and has the potential to be developed into a new service model for care home medication reviews.
- Enhanced community pharmacy services for care home support are available in some areas of Wales. These services require the pharmacist to have regular visits to the care home in order to review medication governance, storage and other medicines management issues.
- GP Practice and Primary Care based pharmacists and technicians currently carry out a range of activities in care homes in some areas of Wales. Pharmacists conduct clinical medication reviews with access to the Welsh GP Record. These reviews can be conducted in the care home with the carer or resident. As part of the multidisciplinary team, pharmacists use their expertise to take a broader view of the suitability of individual medication regimens and associated diagnostic tests and monitoring. Technicians will primarily focus on medicines management issues.
- GP led enhanced services to care homes are available in some areas of Wales to asses and review the health of residents. This service includes regular medication reviews and promotes multidisciplinary team working.
- Specialist pharmacists such as mental health pharmacists in some areas of Wales are conducting medication reviews for care home residents. They use their expertise to work within the multidisciplinary team to produce a pharmaceutical care plan tailored to individual needs.

There are some challenges that must be addressed in order to minimise inappropriate polypharmacy and improve pharmaceutical care and medicine safety in care homes across Wales. Tackling polypharmacy is best achieved through regular communication to build a strong and trusting relationship between residents, carers and the multidisciplinary team. It is only through a holistic approach to care that the best outcomes for an individual can be achieved.

Changes are needed to the way resources are utilised in primary care for this to be achieved. This is a view shared by other professional bodies including the Royal Collage of General Practitioners (RCGP):

"Polypharmacy is an area where the unique contribution of our pharmacist colleagues is valued in a joint approach to manage patient caseloads in collaboration with GPs. The challenges of an ageing and growing population is increasing demand on GPs, other health and social care professionals and indeed, our care homes. The complexity of older people's health needs and the need to treat co-morbidities often leads to increased drug interventions. Patient safety must be improved through greater collaboration and coordination across the multidisciplinary team in addressing polypharmacy issues. Utilising the combined expertise of GPs and pharmacists in the management of polypharmacy in care homes will ensure that the right medicines are used for the right diagnosis, increasing quality of care and safety for residents."

Dr Rebecca Payne
Chair, RCGP Wales

RC GP CYMRU WALES Royal College of General Practitioners Coleg Brenhinol Meddygon Teulu

RPS Recommends:

1.1 As part of a multidisciplinary review, all residents should receive a review of their medication by a pharmacist when they first move into a care home in order to optimise their medication regimen.

1.2 Residents should receive a minimum of one annual medication review from a pharmacist with additional support for significant medication changes. For patients with complex medication regimens, this review should increase to every 3-6 months.

1.3. With patient consent, all pharmacists directly involved in patient care should have full read and write access to the patient's health record in the interest of high quality, safe and effective patient care.

2. ANTIPSYCHOTIC PRESCRIBING

The Older People's Commissioner expects:

"Older people in care homes receive the care and support they need to sustain their emotional and mental wellbeing and anti-psychotic drugs are not inappropriately used."

There are 850,000 people living with dementia in the UK and this is forecast to increase to over a million by 2025 [29]. Often dementia begins with short-term memory loss and can lead to changes in the way people think, speak and do things. Patients living with dementia can often feel confused and anxious. It is natural that they may feel frightened and sometimes angry and frustrated by their situation. Behavioural and psychological symptoms of dementia (BPSD) can be common leading to a decline in emotional control, motivation or a change in social behaviour [30].

Antipsychotic medicines are used for some types of mental distress or disorders. There are increased risks of harm from prescribing these medicines in patients with dementia and they are often inappropriately prescribed to alleviate the symptoms of BPSD. Only one antipsychotic medicine is licensed for treatment of BPSD in certain circumstances in the UK. A 2009 report by Professor Sube Banerjee: *The use of antipsychotic medication for people with dementia* found that of the 180,000 prescriptions for people with dementia, 140,000 were inappropriate. This is around two thirds of overall use of the drugs for people with dementia. It also found that antipsychotic drugs have been used inappropriately in all care settings [31].

A number of professional groups, including the Royal College of Psychiatrists share these concerns:

"The RCPsych in Wales believes that reduction in the use of antipsychotic medications should be a priority for people with dementia. With quality of care and patient safety at the heart of the NHS we need a cycle of national and local audits that will deliver good quality information that can be used to improve clinical effectiveness, improve the patient experience, and to drive down the use of these drugs in dementia safely and drive up the quality of initiation, monitoring and maintenance of these medications when they are needed. Multidisciplinary team input including the utilisation of a clinical pharmacist would benefit patients through elimination of potentially inappropriate prescribing and optimising patient care."

Dr Victor Aziz
Chair, Faculty of Old Age Psychiatry, RCPsych

RPS Recommends:

2.1 Antipsychotic medicines should not be routinely prescribed to treat behavioural and psychological symptoms of dementia.

2.2 In line with NICE guidance, when an antipsychotic medicine is required, the lowest dose should be prescribed for the shortest time with regular review by an appropriately skilled pharmacist as part of the multidisciplinary team.

2.3 Pharmacists who deliver enhanced support for care homes should be able to access quality continual professional development opportunities in relation to antipsychotic prescribing.

3. SAFE TRANSFER OF INFORMATION

The Older People's Commissioner is concerned that:

"There are often delays in the transfer of medical records, which impact upon the ability of GPs to assess an older person's health needs when they move into a care home. This is a particular issue when an older person is discharged from a hospital in one Health Board area to a care home in another."

There is evidence that unintentional changes to medications occur during transfer of care when a patient moves from one care setting to another[32]. These discrepancies have the potential to cause harm. Better communication and appropriate sharing of information will help to assure safer and effective transfers of care and minimise the risk of medicine related harm.

In Wales, the Discharge Medication Review (DMR) service is specifically aimed at patients that are moving from one care setting to another. This service ensures that the person's medicines are maintained accurately (reconciled) during transfer of care and that no unintentional changes are made. As part of this service, the pharmacist will also check that the patient is getting the best use of their medicines.

Currently the majority of DMRs are carried out when a person is discharged from hospital back to their home. Individuals moving to a care home for the first time or those returning from another care setting to the care home are also eligible for this service.

In addition to service developments, advances in technology are also beginning to be harnessed in some pharmacies and care homes. Technology can be utilised to transfer information regarding medicines administration and medicines ordering between care homes and pharmacies. There is also the potential to include barcoding systems which can reduce the risk of errors and help to ensure that the resident is receiving the correct medicines. An additional functionality of these systems is that the whole process is easily auditable.

RPS Recommends:

3.1 Reconciliation of medicines should be undertaken by a pharmacist when a person moves to a care home from their own home or another care setting to ensure that their medication record is maintained accurately.

4. EDUCATION, TRAINING AND STANDARDS

The Older People's Commissioner expects that:

"Sufficient numbers of care staff with the right skills and competencies to meet the physical and emotional needs of residents."

Effective, high quality education and training is essential in order to fully equip the health and social care workforce to deliver safe and effective care. Appropriate mentorship will also allow individuals to harness and develop consultation skills and the ability to provide person-centred care that is compassionate and respectful.

All residents, regardless of their care setting should be encouraged to take part in their own medicines administration wherever possible. In a care home setting, residents may require assistance to do this. There are occasions where care home staff may be required to take over this element of their care if the resident is not capable or does not feel confident in doing so themselves. In these situations it is essential that the member of staff receives accredited education and training on the process of medicines administration as well as having a firm understanding of what all the medicines they give have been prescribed for.

There are Welsh National Minimum Standards for care homes for older people which include information regarding medicines safety [33]. These standards state the care provider should support care workers by written procedures that set out exactly how to give medicines (standard operating procedures) and it is good practice to monitor that these are followed. The pharmacy team has the skills and experience to work with their nursing and medical colleagues to support care homes with the development and implementation of standard operating procedures regarding medicines management and administration.

It is acknowledged that there is currently no consistent medicines training for care home staff undertaking medicines related tasks. In some areas of Wales the pharmacy team are providing a valuable role in supporting:

- Medicines management processes including ordering, storage, administration and disposal.
- Reducing medicines waste.
- Best use of financial resources for medicines management.
- Medication related documentation such as administration records (MAR Charts), medication policies and waste records.
- Compliance with controlled drugs legislation.
- Handling of medicines – including medication with the potential to cause harm to staff e.g cytotoxic medicines or hormone therapy.
- Special Instructions for medicines e.g once weekly dosing and food-medication interactions.

Standards in the administration and management of medicines in care homes must be assured not only for patient safety but to also meet the expectations of CSSIW. The most recent annual report documenting medication issues in care homes was undertaken in 2007/08 [15]. Subsequent annual reports by the regulator disappointingly did not address medication related issues to the same extent and it appears that pharmacists have not been part of the CSSIW inspection team for several years.

The need for quality training and continuous professional development is recognised by a number of professional groups, including the Royal College of Nursing in Wales:

"Giving care is a person-centred, holistic process, a responsible and deeply important job. Promoting and providing safe care is essential, hence it is crucial that the team providing care has leadership from registered senior, and experienced professionals who can provide supervision, oversight ensuring safe delegation, where this is deemed appropriate.

Pharmacists play a critical role in ensuring safe practices related to medicines management. Safety is the key to good care – the most appropriate level of education, training and competency assessment must be secured for all who have a role in every aspect of medicines management. Every Registered Nurse must comply with the Standards for Medicines Management, which are clearly set out by the nursing regulator, the Nursing and Midwifery Council (NMC). All staff working in care homes must also have access to continuous professional development and clinical supervision from professional groups with particular expertise."

Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

RPS Recommends:

4.1 The development and delivery of national standards for medicines training to ensure uniformity across Wales as well as reflecting current practice for care home staff.

4.3 Inspections of care homes should include the expertise of a pharmacist to address medication issues and improve medicines safety.

5. PALLIATIVE AND END OF LIFE CARE

The Older People's Commissioner expects:

"Older people in nursing care homes to have access to specialist nursing services, such as diabetic care, tissue viability, pain management and palliative care."

Palliative and end of life care 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 patients can benefit significantly from the expertise of a pharmacist.

Residents and their families should be given the opportunity to be at the centre of decision making and supported by discussion with appropriate healthcare professionals including a pharmacist, GP and palliative care nurse about their medication options. 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.

One service that currently focuses on the medicines needs of Palliative care patients is the Palliative Care Emergency Medicine Packs more commonly known as 'Just in case' boxes which contain a small amount of medication commonly used in end of life care. Where appropriate they can be prescribed in anticipation for patients that are identified as needing palliative care support. These are not routinely prescribed to care home residents across Wales although some areas have alternative local arrangements for anticipatory prescribing of palliative medication.

RPS Recommends:

5.1 A national review of the provision of palliative and end of life medication to residents as part of steps to develop all Wales standards for anticipatory prescribing in care homes.

5.2 The multidisciplinary care team for a resident needing palliative and end of life care support should have access to the expertise of a specialist palliative care pharmacist.

NEXT STEPS

This policy contains both strategic and person-centred recommendations to address concerns regarding medicines use in care homes in Wales. The implementation of the recommendations made within this policy will help to drive quality improvements in the delivery of care by the multidisciplinary team which will make a significant difference to the lives of care home residents. Action will be required across NHS Wales to review current service provision to care homes and to evaluate how services are funded and resources utilised.

The Royal Pharmaceutical Society in Wales is committed to working with its partners to drive forward this important agenda and expect this to be the start of action at national and local levels.

APPENDIX 1 CASE STUDIES

Case Study 1
Reviewing antipsychotic medicines

At one care home, a newly appointed manager was shocked to see the prevalence of antipsychotic medicines that were prescribed to the residents in the home. Steps were taken to change this by firstly organising staff training to deal with the potentially challenging behaviour of residents with dementia. Secondly their community pharmacist was asked to conduct medicine reviews with every dementia patient in the home that was being prescribed an antipsychotic medicine. The pharmacist identified a high number of potentially inappropriate prescriptions and then worked with the GP to review their use.

Within 10 weeks 70% of the residents reviewed had stopped their antipsychotic medication. There was minimal recurrence of challenging behaviour but when this did occur, staff were better equipped to deal with the residents needs more effectively as a result of training.

There have been many similar examples of this case study submitted by different teams across Wales, which include.

- Pharmacists providing medicines related training for care homes
- Where interventions to resident's medication regimen had been identified by a pharmacist, different examples of multidisciplinary working were fostered to effectively manage changes including referral to community psychiatric nurses.
- Care home staff being attentive to residents with dementia and finding innovative solutions. One example in particular concerned a resident who kept waking at 4am and refused to go back to bed. He became very angry and frustrated by not being able to go outside at this time. After talking to the resident and his family the staff discovered that he'd been a farmer all his working life and a 4am start was what he was used to. Staff started to encourage him to dress warmly and go outside to collect eggs for his breakfast. Getting to know and working with this resident became an enjoyable part of the night staff's routine and led to the resident feeling much happier and more relaxed.

Case Study 2
Polypharmacy medicines review

Staff in a care home were concerned by the number of medicines their residents were taking. The medicines seemed to be giving little benefit but leading to a number of side effects. The care home enlisted the skills of a multidisciplinary team consisting of a pharmacist, GP and mental health professionals. They visited the care home to review the medicines prescribed, identifying potential medication changes and working together to implement these safely for the resident. By working together the multidisciplinary team reduced the number of medications residents were prescribed which improved their care and quality of life and eased the pressure on care home staff.

Case Study 3
Multidisciplinary medication review

A scheme in one Health Board demonstrated the benefits of a multi-disciplinary approach to medicine reviews in care homes. A pharmacist working as a prescribing advisor carried out medication reviews in conjunction with a Care of the Elderly registrar, using an amended STOPP/START tool. The reviews involved discussion with residents, their families, staff, community pharmacists and other health professionals as required. Recommendations for review and stopping of medication were agreed and sent to the GP. The scheme included 106 residents and saw 141 recommendations made, 125 (89%) of which were agreed and implemented.

Case Study 4
Impact of a pharmacist clinical review

In 2011, research was conducted to evaluate the impact of a pharmacist clinical medication review for care home residents in one Health Board. The impact was measured by recording the number and nature of interventions identified by a pharmacist. The GP then reviewed those interventions. A total of 40 residents were reviewed with 45.1% (147/326) of prescribed medication requiring an intervention. The acceptance rate by the GP of recommendations was 67% (99/147) (including 30 made by the pharmacist in line with pre-agreed arrangements with the GP). Interventions included medication being stopped, initiated, changed or increased monitoring. These reviews produced a fourteen fold return on investment in medicines expenditure.

Case Study 5
Impact of Discharge Medication Reviews

A community pharmacy received a discharge letter for one of their care home residents who had recently been discharged from hospital. The resident was admitted to hospital due to lithium toxicity. The overview attached to the discharge letter sent to the GP practice showed the medicines divided into three sections; 'new medications', 'changed medications' and 'unchanged medication'. One medication listed under 'unchanged medication' was lithium. On review of the discharge letter it was identified by a pharmacist that the lithium dose had been significantly reduced from the original dose prior to admission. After contacting the hospital, the pharmacist confirmed that an administrative error meant that lithium was placed in the wrong section in the overview letter. Without the pharmacist's intervention via this Discharge Medication Review (DMR) the resident would have received the wrong dose and would have been at significant risk of harm and readmission to hospital.

Case Study 6
Training care home staff (ordering systems)

One Health Board was concerned by the level of medicines waste in some of their care homes and decided to commission a registered hospital pharmacy technician to visit these homes. Medicines prescribed to 777 patients resident in 19 different care homes were reviewed over a period of 9 months. The technician reviewed the residents medication administration records (MAR) in order to identify and quantify any excess stock of prescribed medicines. Where excess stock was identified, the technician discussed this with the care home staff and appropriate arrangements were made to utilise the excess stock and amend quantities more accurately. This allowed GP practices, community pharmacies and the care homes to have a more accurate understanding of medication use in the homes and also improved the medicines ordering process. The work also resulted in significant medicines cost savings of around £44,000 in prescribing savings as well as improving communication between the care homes, GP practices and community pharmacies.

Case Study 7
Training care home staff (NVQ training)

A Local Authority wanted to improve medicine administration capabilities of care home staff. There was concern that as part of the NVQ qualification process the module on administrating medication was not mandatory. In order to achieve best practice across the authority a decision was made to advise all care home staff who administered medicines to complete the NVQ Level 3 module on 'Administrating Medication to Individuals in a Care Home Setting'. All care home managers also undertook the assessor award, allowing them to complete the assessment process with their own staff. The Local Authority deemed that more could be done to increase the efficacy and safety of the medicines administration process and decided to enlist the support of registered pharmacy technicians.

In order to ensure that managers were confident and fully understood the expectations and standards set out in the NVQ, registered pharmacy technicians undertook an assessment with the managers on completion of the NVQ 3 module. The technicians also developed a set of intensive questions for the staff to assess their understanding of what they had learnt in the NVQ and ensured they were confident to implement their learning. The involvement of technicians has led to care home managers and staff feeling more confident in their abilities during medication rounds and they are able give the Local Authority assurance that the training promotes safe medicine management in care homes.

Case Study 8
Information Technology solutions

In 2014 an electronic medicines management solution was implemented in the South East wales area between a pharmacy and care homes.

This IT solution filters out any items on a prescription that patients have previously been prescribed, allowing the pharmacist the time to focus their clinical check on new or changed items. The system also collates a list of all dosages it deems to be inappropriate, prompting the pharmacist to review and discuss the dosage with the GP or care home as necessary. Barcode verification ensures a complete audit trail and importantly ensures safety during the medicines administration process in the care home. Ultimately this system helps to ensure that medicines are given to the right resident at the right time.

The adoption of this system has benefited both the care home and the pharmacy, increasing accuracy in all aspects of dispensing and medicines administration processes. Within 11 months of the adoption of this system, no errors were identified regarding the dispensing of medicines. This has provided pharmacists, care home staff and residents with a sense of confidence and reassurance about the use of medicines.

APPENDIX 2 GLOSSARY OF TERMS

Adverse Drug Reaction – An unwanted or harmful reaction which is suspected or known to be due to a drug(s).

Care Home – For the purpose of this document the term care home focuses on older people living in both residential and nursing homes.

Clinical Specialist Pharmacist (Advanced Practitioners) – This may be a pharmacist that provides a specialist service, usually as a non-medical prescriber, in a specific area of expertise. They will have in depth clinical knowledge over a range of areas. They may be very specialised e.g. renal services and provide a comprehensive service across a large geographical area.

Cluster Pharmacist – Employed by the Health Board on behalf of the cluster working with a group of practices to achieve primary care cluster priorities. May also provide cluster support in relation to prescribing trends and analysis depending on cluster priorities.

Community Pharmacist – Provides essential services within a community as part of service provision with the Community Pharmacy Contractual Framework e.g. clinically checking and reviewing the appropriateness of prescribed medicines, dispensing medicines, repeat dispensing, signposting, self-care, advice on medicines, Medicines Use Reviews, and Discharge Medicines Reviews. May provide additional enhanced services commissioned by the Health Board or practice such as triage and treat, common ailments and smoking cessation services. Providing access for patients to a highly trained health care professional without appointment often in extended hours.

Complex Medication Regimens – The complexity of a medication regimen could be due to the number of medicines being taken and their potential to interact as well as taking medicines that require careful monitoring and specific dosing instructions.

Discharge Medicines Review – A service delivered by accredited pharmacists working in a community pharmacy. The service provides support to patients recently transferred between care settings, ensuring that changes to medicines are maintained appropriately.

Medicines Administration – The processes and behaviours used when giving medicines to a patient.

Medicines Management – A system of processes and behaviours that determine how medicines are used.

Medicines Reconciliation – A process of creating the most accurate list possible of all medicines a patient is taking and comparing that list against a physician's prescription and/or discharge orders to ensure accuracy of medicines.

Medicines Use Review – A service delivered by accredited pharmacists working in a community pharmacy. A structured adherence-centred review takes place with patients on multiple medicines, particularly those receiving medicines for chronic conditions.

Multidisciplinary Team – A group of health care workers who are members of different disciplines or professions, each inputting their expertise for patient benefit.

Pharmaceutical Care – The use of drug therapy to achieve definite outcomes that improve a patient's quality of life.

Pharmacy Team – This includes pharmacists across all sectors including community, cluster, primary care and hospital as well as registered pharmacy technicians.

Pharmacy Technician – Undertakes the technical aspects of medicines management e.g. check inhaler technique, synchronise medications, reviews repeat prescribing and dispensing processes. These roles are developing rapidly and in some areas technicians are taking on prescribing data analysis roles but would not undertake clinical reviews.

Polypharmacy – The concurrent use of multiple medications by one individual.

Practice Based Pharmacist – Works as part of the GP practice team in line with the practices' priorities. They can release clinical capacity and give improved direction and guidance on prudent evidence based medicine. Usually employed by the Practice but may be Health Board employed or a community pharmacist contracted to work for the surgery.

Primary Care Clusters – 64 primary care clusters have been established in Wales, tasked with ensuring that the health and social care needs of their local population are met.

Primary Care Pharmacist / Prescribing Advisor – Employed by the Health Board, working in practices to the Health Board's priorities. May provide support to practices and primary care clusters through prescribing data and analysis and facilitation of service development relating to medicines management across all professions.

Prudent Healthcare – Making the most effective use of the available resources to ensure high quality and consistent care across Wales.

The Older People's Commissioner – independent voice and champion for older people across Wales, standing up and speaking out on their behalf. Working to ensure that those who are vulnerable and at risk are kept safe and ensures that all older people have a voice that is heard.

Welsh GP Record – Previously known as the individual health record, this is a summary of a patients record held by the GP which includes basic information about medical history.

APPENDIX 3 LIST OF CONTRIBUTORS

Chair

Tim Banner	Consultant Pharmacist - Community Healthcare (All Wales)

RPS Wales Leads

Ross Gregory	Head of External Relations
Iwan Hughes	Public Affairs Intern
Elen Jones	Practice and Policy Lead

Steering Group

Paul Harris	Vice Chair, Welsh Pharmacy Board and Chair, Welsh Pharmaceutical Committee
Judy Henley	Director of Contractor Services, Community Pharmacy Wales
Anne Hinchliffe	Consultant in Pharmaceutical Public Health, Public Health Wales
Fiona Jones	Independent Pharmacist Prescriber, Betsi Cadwaladr UHB and Welsh Pharmacy Board
Sally Lau	Specialist Professional Advisor, Care Quality Commission
Susan Murphy	Interim Head of Pharmacy and Medicines Management (West), Betsi Cadwaladr UHB
Debra Roberts	Head of Programme Development, Wales Centre for Pharmacy Professional Education
Dr Mathew Smith	Lecturer and MPharm Programme Director, Cardiff University

Advisory Group

Louise Allen	Policy and Planning Manager (Wales), The Company Chemists' Association
Julia Blakeman	Primary Care Pharmacist Betsi Cadwaladr UHB
John Dicomidis	Pharmacist, Complex Care Team, Aneurin Bevan UHB
Anna Guerrero	Manager, Penylan Retirement Hotel
Rhys Howell	Pharmaceutical Advisor, Abertawe Bro Morgannwg UHB
Penny Lamb	Senior Nurse Manager (Nursing Home Governance), Hywel Dda UHB
Polly Leett	Senior Nurse Practice Development (Primary Care and Care Homes), Hywel Dda UHB
Rosanne Palmer	Policy Advisor, Age Cymru
Julie Phillips	Regional Business Manager, Boots UK
Jonathan Smith	Pharmacist, Mayberry Pharmacy
Claire Thomas	Claire Thomas, Prescribing Adviser, Royal Glamorgan Hospital, Cwm Taf UHB
Kate Walker	Chief Pharmacist/Medicines Management Lead Taff Ely, Royal Glamorgan Hospital, Cwm Taf UHB
Suzy Webster	Programme Assistant for My Home Life Cymu, Age Cymru

REFERENCES

[1] http://www.prudenthealthcare.org.uk/

[2] A Place to call Home? 2014. A Review into the Quality of Life and Care of Older People living in Care Homes in Wales. Available at: http://www.olderpeoplewales.com/Libraries/Uploads/A_Place_to_Call_Home_-_A_Review_into_the_Quality_of_Life_and_Care_of_Older_People_living_in_Care_Homes_in_Wales.sflb.ashx (Last accessed: January 20 2016)

[3] NICE. 2014. Managing medicines in care homes - NICE guidelines [SC1]. Available at: https://www.nice.org.uk/guidance/sc1 (Last Accessed: February 12 2016)

[4] Alldred, DP et al. 2009. Care Home Use of Medicines Study (CHUMS); Medication errors in nursing & residential care homes - prevalence, consequences, causes and solutions. BMJ Quality & Safety 18, pp. 341-346. Available at: http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS025CHUMS-FinalReportwithappendices.pdf

[5] Al-Hamadani et al. 2016. Telehealth Enabled Medicines Management for Care Home Residents. Cardiff University. Available at: http://www.cardiff.ac.uk/__data/assets/pdf_file/0009/193752/CUEvaluation.pdf (Last Accessed: February 12 2016)

[6] Your Care, Your Medicines: Pharmacy at the heart of patient-centred care. 2014. RPS Wales & NHS Wales. Available at: http://www.rpharms.com/wales-pdfs/YourCareYourMedicines.pdf (Last Accessed: January 19 2016)

[7] NICE Guidance. Managing medicines in care homes (2014). Available at: https://www.nice.org.uk/guidance/sc1 (Last accessed January 21 2016) pdf (Last Accessed: January 19 2016)

[8] HM Government. 2005. The Mental Capacity Act 2005. Available at: http://www.legislation.gov.uk/ukpga/2005/9/contents (Last Accessed: February 12 2016)

[9] Department of Health. 2009. Reference guide to consent for examination or treatment, second edition. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf (Last Accessed: February 12 2016)

[10] Welsh Government. 2011. Welsh Language (Wales) Measure 2011. Available at: http://www.legislation.gov.uk/mwa/2011/1/pdfs/mwa_20110001_en.pdf (Last Accessed: February 12 2016)

[11] Welsh Language Commissioner. 2014. My Language, My Health: Inquiry into the Welsh Language in Primary Care. Available at: http://www.comisiynyddygymraeg.cymru/English/Publications%20List/Health%20inquiry%20full%20report.pdf (Last Accessed: February 12 2016)

[12] Care and Social Services Inspectorate Wales. 2015. Chief Inspector's Annual Report 2013-2014 - Improving Care, Childcare and Social services in Wales. Available at: http://cssiw.org.uk/docs/cssiw/report/150304annualreport4en.pdf (Last Accessed: January 19 2016)

[13] Daffodil. 2014. - Projecting the need for care services in Wales. 2015. Population aged 18 and over, by age, projected to 2030. Available at: http://www.daffodilcymru.org.uk/index.php?pageNo=1033&PHPSESSID=0nga1b0ps6ea91dk9h6nvv4302&at=a&sc=1&loc=1&np=1 (Last Accessed: January 19 2016)

[14] World Health Organisation. 2003. Failure to take prescribed medicine for chronic diseases is a massive, world-wide problem. Available at: http://www.who.int/mediacentre/news/releases/2003/pr54/en/ (Last Accessed: January 19 2016)

[15] Pirmohamed M et al. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. British Medical Journal 329: 15-9. Available at: http://www.bmj.com/content/bmj/329/7456/15.full.pdf (Last Accessed: January 19 2016)

[16] Care and Social Services Inspectorate Wales. 2008. Care and Social Services Inspectorate Wales Annual Report 2007-08. Care and Social Services Inspectorate Wales. Available at: http://cssiw.org.uk/docs/cssiw/publications/cssiwannualreport0708/080114annualreporteng.pdf (Last Accessed: January 19 2016)

[17] Flynn, M. 2015. In Search of Accountability: A review of the neglect of older people living in care homes investigated as Operation Jasmine. Available at: http://gov.wales/docs/dhss/publications/150714ojreporten.pdf (Last Accessed: January 19 2016)

[18] Webber, J. 2015. Pharmacy and Care Homes. General Pharmaceutical Council. Available at: http://www.pharmacyregulation.org/sites/default/files/pharmacy_and_care_homes_report_by_jo_webber_december_2015.pdf (Last accessed January 26 2016)

[19] Community Pharmacy Wales 2015. Care Home Support Service Review and Medicines Optimisation. Available at: http://www.cpwales.org.uk/Contractors-Area/Pharmacy-Contact---Services/Enhanced-Services/CPW-Template-Services.aspx (Last accessed February 10 2016)

[20] Turnheim , K. 2003. When drug therapy gets old: pharmacokinetics and pharmacodynamics in the elderly. Experimental Gerontology 38 (8). Available at: http://www.sciencedirect.com/science/article/pii/S0531556503001335 (Last accessed February 10 2016)

[21] Duerden, M. and Avery, T. and Payne, R. 2013. Polypharmacy and medicines optimisation. Making it safe and sound. The King's Fund. Available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/polypharmacy-and-medicines-optimisation-kingsfund-nov13.pdf (Last Accessed: January 19 2016)

[22] National Institute for Health and Care Excellence. 2013. Falls: Assessment and prevention of falls in older people. Available at: http://www.nice.org.uk/guidance/CG161/chapter/introduction (Last Accessed: January 19 2016)

[23] Daffodil. 2014. Falls - hospital admission: People aged 65 and over predicted to be admitted to hospital because of a fall, by age, projected to 2030. Available at: http://www.daffodilcymru.org.uk/index.php?pageNo=1033&PHPSESSID=0nga1b0ps6ea91dk9h6nvv4302&at=a&sc=1&loc=1&np=1 (Last Accessed: January 19 2016)

[24] Howson, C. and Smith, K. 2014. Care homes - Medication and falls. PRESCQIPP (Bulletin 87). Available at: https://www.gov.im/media/1347552/care-homes-medication-and-falls-december-2014.pdf (Last Accessed: February 12 2016)

[25] AWMSG. 2014. Polypharmacy: Guidance for Prescribing. Available at: http://www.awmsg.org/docs/awmsg/medman/Polypharmacy%20-%20Guidance%20for%20Prescribing%20in%20Frail%20Adults.pdf (Last Accessed: February 12 2016)

[26] NHS Scotland & the Scottish Government. 2015. Polypharmacy Guidance. Available at: http://www.jitscotland.org.uk/wp-content/uploads/2015/06/Polypharmacy-Guidance-2015-FINAL-APRIL.pdf (Last Accessed: February 12 2016)

[27] O'Mahony, D et al. 2014. STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. Age and Aging 43 (6), pp 1-6. Available at: http://ageing.oxfordjournals.org/content/early/2014/10/16/ageing.afu145.full.pdf+html (Last Accessed: February 12 2016)

[28] Lewis, T. 2004. Using the NO TEARS tool for medication review. BMJ 329, pp, 434. Available at: http://www.bmj.com/content/329/7463/434.full.pdf+html (Last Accessed: February 12 2016)

[29] Alzheimer's Society. 2015. Statistics. Available at: https://www.alzheimers.org.uk/statistics. (Last Accessed: January 19 2016)

[30] Kar, N. 2009. Behavioural and psychological symptoms of dementia and their management. Indian Journal of Psychiatry. 51 77-86. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3038531/ (Last Accessed: January 19 2016)

[31] Banerjee, S. 2009. The use of antipsychotic medication for people with dementia: Time for action. The Institute of Psychiatry, King's College London (Commissioned by the Department of Health). Available at: http://www.rcpsych.ac.uk/pdf/Antipsychotic%20Bannerjee%20Report.pdf (Last Accessed: January 19 2016)

[32] Hodson et al. 2014. Evaluation of the Discharge Medicines Review Service. Available at: http://www.cpwales.org.uk/Contractors-Area/Pharmacy-Contact---Services/DMR/DMR-Evaluation_Final-Report_13082014.aspx (Last Accessed February 12 2016)

[33] Welsh Assembly Government. 2004. Standards for care homes for older people (revised – march 2004). Available at: http://cssiw.org.uk/docs/cssiw/general/131009nmsolderadultsen.pdf (Last Accessed: January 19 2016]

ROYAL CYMDEITHAS
PHARMACEUTICAL FFERYLLOL
SOCIETY FRENHINOL
Wales Cymru

For more information please contact:

Royal Pharmaceutical Society

2 Ash Tree Court
Cardiff Gate Business Park
Pontprennau
Cardiff
CF23 8RW

Tel: 029 2073 0310 (Mon-Fri 9am – 5pm
Email: Wales@rpharms.com
Web: www.rpharms.com

Follow us on Twitter: @RPS_Wales