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Scotland

Improving Pharmaceutical Care in Care Homes

March 2012



Foreword

The Royal Pharmaceutical Society (RPS) is the professional leadership body for pharmacists in Scotland, England and Wales representing the interests of individual members in all sectors of pharmacy. As a professional body, our vision is that all people irrespective of their care setting should have access to input from pharmacists in the management of their medicines to sustain their general health and well-being.

As the proportion of older people in Scotland continues to grow, alongside the increasing frailty of those living longer, we need to address the health and social care needs of this population in a way that is accessible, appropriate to their care needs and also financially sustainable. In recent years pharmacists and others have become increasingly concerned about aspects of medicines safety and appropriateness in the care home setting. Therefore the RPS in Scotland decided to examine how pharmaceutical care is currently delivered in Scotland's care homes and propose change based on available evidence.

RPS believes that by building on the established principles of quality, safety, effectiveness and person-centred care in Scotland; change in current practice models in Scotland can be achieved through effective planning, long term improvement strategies, and redeployment of resources. It will need all stakeholders in the NHS, Local Authorities, the private sector, patient and carer support groups and regulators of care to support the changes required. Pharmacists need to champion their role and the RPS will support this at every level.

As part of a wider commitment to the values of a person-centred NHS Scotland, all involved in care homes should recognise the need to break down the barriers to achieving the best quality of care for those we seek to serve. We need to prioritise the further development of therapeutic partnerships to deliver the best outcomes for those individuals living in care homes rather than the task, numbers and systems focus that currently dominates.

Despite repeated recommendations for formalised and consistent clinical pharmacy input into care homes, this has not yet been achieved as part of a core service in Scotland. Currently, pharmacist involvement is mainly limited to the supply of medication with very little dedicated input from either the community pharmacists or pharmacists working in the managed service.

The RPS strongly suggests that it is now time for the Scottish Government and NHS Scotland to commit to mandatory input from pharmacists providing pharmaceutical care to all care homes. Models of care will vary based on capacity, available skills, resources and the needs of the population in individual care homes.

The RPS believes that this report will support implementation of the Scottish Government's Quality Strategy, Reshaping Care or Older People related strategies and policies and the integration of Health and Social Care. It is a timely report that will also inform the review of the pharmacy services in the community in 2012.

Alex MacKinnon

Director Royal Pharmaceutical Society in Scotland

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Chair working group

Contents

EXECUTIVE SUMMARY	5
SECTION 1 OUR RECOMMENDATIONS	7
SECTION 2 BACKGROUND	8
SECTION 3 OVERVIEW OF CURRENT PHARMACY SERVICES TO CARE HOMES	9
SECTION 4 NATIONAL STRATEGY, POLICY AND STANDARDS	10
SECTION 5 EVIDENCE OF THE NEED FOR IMPROVEMENT	21
WORKING GROUP MEMBERSHIP	25
ACKNOWLEDGEMENTS	25
REFERENCES	25
APPENDIX 1 PHARMACIST INVOLVEMENT IN IMPROVING CARE-SUMMARY OF LITERATURE REVIEW	27
APPENDIX 2 SERVICE EXAMPLES AND BUILDING BLOCKS FOR CHANGE	30

Executive Summary

The need for change

The RPS believes that a radical examination and change in how pharmaceutical care is provided in care homes by pharmacists in Scotland is urgently required.

A review of the literature indicates that issues such as how care is delivered in practice, as well as the quality of the care provided by healthcare professionals and care home staff and the regulatory framework all need to be considered together within existing policy and strategy.

With increasing numbers of frailer older people living with long term conditions and increasingly complex requirements, many with palliative care needs, some care homes are now providing aspects of care which historically would have been provided in hospital and should be resourced and managed as such. While care will continue to be delivered by generalists supported by specialists, it is recognised that varying degrees of specialism will be required depending on the nature of input by pharmacists and the needs of individual residents and care homes.

Ensuring equity of care

The majority of people in care homes, regardless of business model, are treated within the NHS. We need to do more to ensure that people in care homes receive the same standards of health care as those living in their own home and that evidence based clinical guidelines and practice are applied to the frail older

care home population. More models of person-centred care are required within existing services as many decisions relating to the care of people in care homes do not have their input or the input of their carers or guardians.

Quality of care in care homes sets the benchmark

Everyone involved in providing and planning services to care homes in health and social care services at national, local and practitioner level need to make changes now that would mean in ten years time:

- The quality of person-centred care in care homes provides pharmacists, doctors and nurses with opportunities to develop

the clinical expertise and transferable skills required to meet the needs of frail older people.

- We have reversed the negativity associated with care homes.

The need for integrated partnership working and continuity of care

The RPS recognises that pharmacists cannot make the improvements required in the care home setting on their own and we also know that lasting change cannot be achieved through one off interventions. Meeting the needs of care home residents across Scotland will require greater integrated working, skilled workforce, support by specialists, better communication and continuity of care. We need to build on existing strengths and practice models.

The current business and contracting models for community pharmacy services can introduce volatility within the sector and make long term planning and integration difficult. A more robust contract system and service level agreement is required between community pharmacy services and care home providers. RPS believes that this will create the stability and further develop the therapeutic partnerships and models required in this sector.

Pharmaceutical care priority areas

This report identifies a number of issues that require immediate action across Scotland. These include:

- reducing inappropriate polypharmacy, antipsychotic and psychoactive medication and high risk medicines.
- improving falls and hip fracture prevention, pain management, skin health, dementia care, anticipatory care and palliative and end of life care, the management of “when required” medication, nutritional products and respite care.

Stating these priorities does not take away from the much larger agenda of how all medicines are safely and effectively used in frail older people which needs to be tackled systematically and comprehensively.

Although the main focus of the working group was the care home setting, we believe that many of the recommendations are generic, relevant and applicable to frail older people living in their own homes and those in supported care settings and we make reference to this cross over where appropriate.

Importance of sharing best practice

The RPS and pharmacists across all sectors of the profession would welcome opportunities to celebrate success by identifying and sharing best practice in care homes. We believe this could reduce the reported variation in practice, systems and policies and help achieve the positive outcomes and improvements in care that everyone wants.

Research is required to inform strategy and practice, RPS will work with the two Schools of Pharmacy and other universities to develop a research programme.

Empowering frontline practitioners to deliver change

In “*Renewing Scotland’s Public Services*” it was noted that “the best ideas and most effective solutions will often come from those with the most direct experience of the issues at hand.”¹ Pharmacists should work with service users and frontline workers to provide effective solutions to improving pharmaceutical care and medicines management problems.

RPS calls for a national accredited training programme for pharmacists involved in providing services to care homes.

This report

In this report we set out some of the problems we believe exist and also a set of recommendations on how these could be addressed. This report should be viewed as a starting point for change not an end in itself. As well as building on what we have in Scotland, the RPS Support Team is currently developing and testing support tools for pharmacists.

Section I Our recommendations

The RPS recognises that pharmacists cannot make the improvements required in the care home setting on their own. Meeting the needs of care home residents across Scotland will require greater integrated working, better communication, skills and models that provide clarity about the actions required, roles, responsibilities and continuity of care. Some of our recommendations have been made by other organisations and within national strategy commitments; we include them here to add our support. From the evidence presented to the working group key drivers for sustained improvement in quality of care include:

- an explicit national commitment to quality in relation to medicines use in care homes that enshrines multi-disciplinary, multi-agency models of team work and explicitly aligns the NHS services provided in care homes to all relevant NHS strategies, national priorities and evidence based clinical guidelines.
- where improving quality in care homes is a strategic priority for NHS Boards and Local Authorities this enables the prioritisation, development, implementation and monitoring of nationally agreed best practice in this setting.

Our recommendations

1. Improvements in pharmaceutical care of people in care homes can be made by permanently integrating a dedicated role from both community pharmacists and pharmacists in the managed service sectors
2. Safety could be improved through sharing, hospital discharge information, clinical information, including diagnosis, monitoring, test results, adverse drug reactions (ADRs) and allergies between the community pharmacist, the GP practice and care provider. Care homes should seek the appropriate consent to allow effective teamwork and communication.
3. National guidance on efficient working practices in managing repeat medicines and supply and administration, consent to accessing information is required. RPS calls for the use of nationally agreed documentation, wherever possible, including the Medicines Administration Record.
4. National guidance on best practice in medication review, appropriate polypharmacy safer medicines use in older people is required.
5. The RPS calls on pharmacists to work together with their medical and nursing colleagues to achieve a reduction of inappropriate polypharmacy and high risk medicines and improvements in anticipatory care in the frail older population.
6. As a building block for change and in line with the Royal College of General Practitioners and the British Geriatric Society, the RPS believes that the alignment of one GP practice and one community pharmacy to each care home provides a good model to achieve the improvements in care required.
7. A more robust contract system and service level agreement is required between community pharmacy services and care home providers. This will create stability, protect investment and existing relationships and develop the long-term therapeutic partnerships and models required between community pharmacists, GP practices and care home providers.
8. To support implementation of the Dementia Strategy Care Standard for high quality pharmaceutical care and medicines management, the RPS commits to creating an expert working group that will define the pharmacists' contributions to the implementation of this strategy.
9. RPS calls on pharmacists to work together with their medical and nursing colleagues to achieve a targeted reduction in the use of psychoactive medication and antipsychotics in the frail older population. Wherever possible a licensed product should be used at the lowest dose for the shortest time and reviewed regularly.
10. Pharmacists involved in providing care for people within care homes must be aware of the specific pharmaceutical care needs of this group and be required to develop their competence to practice in this area. The RPS looks to NHS Scotland and the Scottish Government through NHS Education for Scotland to develop a national educational framework to support the delivery of approved, standardised and competency-based training for all pharmacists delivering pharmaceutical care to people in care homes.
11. Due to concerns around safety, patient empowerment, effectiveness and efficiency, the RPS calls for the supply of medicines in original packs in care homes to be promoted as standard. This will require support at national and local level, agreement from care home providers and pharmacy contractors supported by robust systems, staff training and evaluation.
12. RPS calls on the Scottish Government, NHS Boards and Local Government Social Care departments to support the introduction of a national integrated multidisciplinary assessment tool designed to identify, assess and resolve medicines adherence issues for people living at home but requiring care. To promote safer use of medicines this tool should include prompts for medication review.
13. To support quality in prescribing management, the RPS repeats the call for prescribing data to be available at care home level to allow for audit and support.
14. There is an urgent need for greater efficiency and reduction of bureaucracy within the care home setting. To help reduce waste, prescriptions for repeat medicines should be for no more than 28 days whenever appropriate. The policy of some care homes to return all unused medication at the end of each month, irrespective of requirement, should be highlighted, discussed and reduced wherever possible.

15. Pharmacists should continue to work with other healthcare professionals and care home staff to ensure that the palliative and end of life care needs of people are identified and met. The RPS calls for a greater involvement of the existing community pharmacy palliative care network as a resource for care home staff.

16. RPS believes that the pharmacist's clinical check of prescriptions should also include a review of the medicines' administration record (MAR) for errors if the pharmacist is supplying the MAR sheet e.g. timing, detection of duplicated entries.

Section 2 Background

Pharmaceutical care is a systematic approach to ensure that the patient gets the right medicines, in the right dose, at the right time and for the right reasons.² It is a person-centred partnership approach with the team accepting responsibility for ensuring that the person's medicines are as effective and as safe as possible. This holistic practice sets out to identify, resolve and prevent medicine-related problems.

The combination of an ageing population and healthcare policies that support people to stay in their own homes for longer has had an impact on the profile of care home residents. Over the last twenty years the population in these settings is much older, frailer and has more complex health needs. This change has not been accompanied by a parallel increase in the specialism of health professionals in primary care or care home staff involved in delivering care, nor by an increase in resources or a transfer of resources from the acute setting. A 2009 report indicated that there are 39,150 residents in 943 care homes.³ 40% people in Scotland with dementia live in care homes or hospital and about 70% of people living in care homes have dementia

Over the next 10 years the proportion of people over 75 in Scotland's population, who are the highest users of NHS services, will increase by over 25%. By 2033 the number of people over 75 is likely to have increased by almost 60%. There will be a continuing shift in the pattern of disease towards long-term conditions, particularly with growing numbers of older people with multiple conditions and complex needs such as dementia.

As people get older their ability to physically cope with medications can diminish, the chances of adverse effects are three times greater than people under 30 years of age.⁴ Yet they receive a disproportionately higher number of medicines than the rest of the population. There is also little evidence of clinical effectiveness for the use of many commonly prescribed medications in the frail older population. The reduction in cognitive impairment affecting the majority of care home residents adds to the complexity of their management. Medication is also known to diminish cognitive function. It is essential that every medicine prescribed in this population should be carefully and regularly reviewed for appropriateness, efficacy and safety.

Research has shown that co-morbidity predicts repeat admission for adverse drug reactions (ADRs) in older adults.⁵ Awareness of these predictors can help clinicians identify which older adults are at greater risk of admission for ADRs and, therefore, who might benefit from closer monitoring. There has been a steady increase in the number of people admitted to hospital with drug related side effects and these people are twice as likely to be admitted with another.⁶

Some health boards in Scotland have started to undertake reviews for people taking multiple medications, targeting those that are taking high risk medications. These medications are those that are known to cause harm to older people e.g. non steroidal anti-inflammatory drugs. People that have been identified, that would most benefit from medication reviews, are those living in care homes.

The need for urgent improvement on how we approach the care of people with dementia is underlined in a report funded by the Department of Health, which indicates that around 180,000 people with dementia are treated with antipsychotic medication across England per year.⁷ Of these, up to 36,000 may derive some benefit from the treatment, use at this level equates to an additional 1,800 deaths, and an additional 1,620 cerebrovascular adverse events, per year. It calls for a two-thirds reduction in their use over a three year period.

A work stream of the Scottish Government Dementia Strategy is undertaking a prevalence study to identify the situation in Scotland and will set targets for reduction.

A study found that recording of drug sensitivities for care home residents is suboptimal.⁸ Drug sensitivity status is seldom shared between the GP and the dispensing pharmacy. Only two out of 48 drug sensitivities identified in 121 residents were recorded simultaneously in the medicines administration record, care home record and GP record. This poses a risk to residents of care homes.

There are many factors involved in improving care research indicates that a comprehensive approach to improving how medicines are used in care homes is required in tandem with cultural change, regulation, national strategy and standards, training programmes, guidance, effective partnerships and models of care.^{9,10}

Pharmacists have used their expertise in appropriate use of medicines in a variety of interventions, including clinical audit, targeted or holistic medication review to specialist advice to improve pharmaceutical care.^{11,12} To support improvements in pharmaceutical care, there have been repeated recommendations for formalised and consistent clinical pharmacy input to care homes. To date this has not happened as part of core pharmacy services from the managed service or community pharmacy across Scotland. In other countries the input of the expertise of pharmacists to individual care homes is mandatory.¹³

As part of the RPS commitment to making Great Britain the safest place in the world to take medicines it set up an Improving Pharmaceutical Care to People in Care Homes (PCCH) Working Group in February 2011 to:¹⁴

1. assess the current initiatives in and approaches to the pharmaceutical care of people in care homes and in other supported care settings.
2. charge the Royal Pharmaceutical Society Scottish Directorate to undertake appropriate research to facilitate the group's work.
3. invite relevant stakeholders to advise or give evidence to improve the knowledge base and the policy options available to the group.

4. identify areas where pharmaceutical care could be improved in care homes.
5. make recommendations for pharmacist delivered pharmaceutical care that could be emulated across Scotland based on evidence of best practice.
6. present the group's conclusions to the Scottish Pharmacy Board and partners and undertake further work as identified by relevant stakeholders to promote and disseminate its work.

The group met four times in 2011, a literature review, meetings with relevant stakeholders were undertaken and all NHS Boards provided a summary of current activity and issues in their area.

Section 3 Overview of current pharmacy services to care homes

The following section is an overview based on the information presented to the working group. Please note there may be other pharmaceutical care services provided by community pharmacists and pharmacists in the managed services that have not been captured in this report.

Exact figures are not available, but it seems that less than 20% of community pharmacies are involved in dispensing services to care homes. Dispensing services include supply and the clinical check of prescriptions. As part of the clinical check of prescriptions pharmacists intervene to support medicines safety and appropriateness based on the information available.

Community pharmacists are currently paid to provide a standard dispensing service to care homes and since 1989 as part of a locally negotiated service (LES) they also provide the Pharmacy Advice Visit (PAV). They are paid an additional fee per bed to provide quarterly visits to advise on storage, administration etc. for a maximum of five care homes.

Community pharmacies have invested hugely in the care home sector to support the growing number of people requiring care and also provide a number of services free of charge to care homes such as:

- Medication supplied in Monitored Dosage Systems (MDS).
- Medication Administration Record (MAR) charts on a daily and monthly basis.
- Delivery of all medication up to twice daily.
- Training on medicines and administration.

Reports indicate that as part of the PAV some community pharmacists also identify and challenge the practice of covert administration, offer advice on alternative formulations where people have swallowing difficulties. However this is often not recognised and goes over and above existing service level agreements. Many work to reduce waste and some help with symptom management in palliative care.

Care Homes usually obtain their regular supply of medicines for all their residents from one pharmacy. Increasingly, care home supply services from multiples are being centralised into a 'hub and spoke' model. Although more efficient, reports indicate that this can affect the local connection between the community pharmacist, the care home and the GP practice. As a result different models are being explored and developed by some pharmacies.

Reports indicate that the current business and contractual model between care home providers and community pharmacy contractors can create problems as contracts for community pharmacy services can change from one to another, literally over night. This is not necessarily based on quality of service. The volatile nature of the current business model may hinder the development of the long-term therapeutic, inter and multi-disciplinary relationships required to support the improvements necessary.

Community pharmacists and Community Pharmacy Scotland, the negotiating body for pharmacy contractors have informed the working group that they wish to do more if given the opportunity through new services designed to identify and meet the pharmaceutical care needs of people in care homes. One NHS Board, NHS Tayside, has over the past four years developed a new service which is achieving positive outcomes. The Nursing Home LES for Community Pharmacy which is designed to align to the GP LES, includes level 1 and 2 medication review and clinical audit and provides a model for change that evolved from the original PAV. The community pharmacy Service Level Agreement (SLA) asks for named personnel to care for the home and in many cases the pharmacy support staff are now undertaking the original PAV.

Some pharmacies have a dedicated Care Home Services Team that provides an enhanced input, including clinical audit to care homes.

There are very few dedicated managed service pharmacist roles specifically involved in providing services to care homes. Most primary care pharmacists who review medication in care home residents do so through working with the GP practice where the residents are registered, rather than a dedicated role. All residents may not be registered with the same GP practice which prevents the pharmacist getting a view of any patterns of medicines use within the care home e.g. anti-psychotics, oral nutrition, etc.

To support the identification and sharing of best practice, RPS would welcome more examples of how pharmacists in all sectors are contributing to improving pharmaceutical care in care homes.

See Appendix 1 Summary of pharmacists contribution to improving care and models for change. RPS believes that the key points and conclusions help to identify what good looks like.

See Appendix 2 Examples of good practice. RPS believes they provide a starting point to deliver Scotland-wide pharmaceutical care service models.

Section 4 National strategy, policy and standards

Within the current service, policy and strategy context there are several drivers for change that set out the Scottish Government's clear intention to enable long term improvements in care. For the purpose of the report we have focused on specific strategies and related reports in some detail, followed by our recommendations, examples of good practice and we also suggest ways to move forward. Please refer to Appendices 1 and 2 for more detail of the pharmacists' contribution, principles of good practice and practice models that also underpin this section.

This report should be considered within the wider drive to improve the care of older people in Scotland, including the Mental Health Strategy, the Scottish Patient Safety Programme and the Health Improvement Scotland Inspection Programme for Older People. Although these are not directed at care homes, RPS is aware that the overarching strategy of the Scottish Government is to get consistency across all care environments. The delivery of the eHealth Strategy will also help with information exchange and support.

4.1 NHS SCOTLAND HEALTHCARE QUALITY STRATEGY, 2010.

This strategy sets out the following three Quality Ambitions:¹⁵

- Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision making.
- There will be no avoidable injury or harm to people from the healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.
- The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

The strategy also states that to ensure that these ambitions are met all healthcare providers and professionals must work to ensure that their services are person-centred, partnership based, reliably safe, appropriate, timely and efficient. This approach is in line with the philosophy and practice of pharmaceutical care and we believe our recommendation to embed dedicated input from the expertise of pharmacists will support implementation of this and related strategies and standards.

The safety ambition is being taken forward through the Scottish Patient Safety Programme (SPSP). The work to date has been in the acute setting and is now rolling out and will include Mental Health, Paediatrics, Primary care and Older People. Safe and effective medicines management is at the core of each work stream. The Medicines Reconciliation component of the SPSP is addressing issues around transfer of care and discharge planning.

The SPSP employs a specific improvement methodology for spreading good practice and changing practice. Pharmacists are already heavily involved in its implementation in the acute setting and RPS has committed to integration with the SPSP at all levels and will continue to encourage pharmacists to engage fully in its delivery and the application of its tools and principles to improve care.

Concerns have been raised by the Scottish Prescribing Advisors Association and pharmacists about arrangements for respite care.

"There are Scottish wide concerns around transfer of patients across settings and the impact on patient safety and cost effectiveness. This includes the respite situation but also covers movement between acute and care home settings. The policy of some care homes to insist on medication being put into MDS and/or requesting new prescriptions and sending all medications that the patient/carer has brought with them to the pharmacy for destruction is wasteful and in some cases dangerous. We have reports of people returning home without the medicine they require".

SCOTTISH PRESCRIBING ADVISORS ASSOCIATION

It is worth highlighting some of the risks associated with respite, especially if the person is transferring directly from hospital to the care home. Generally, the supplying pharmacy will not have any previous medicine history to undertake a thorough clinical check of prescriptions. The risk is compounded if medication has been altered during the hospital stay and this is not reflected in GP prescriptions. Community pharmacists have asked to be more involved in plans for respite and to be included in discharge information.

It is clear that we need better sharing of essential information and changes in some care home policies that may lead to waste and lack of access to medication. It is important to involve all stakeholders in safe, effective ways to manage respite and the transfer of people between settings.

As we look at improving pharmaceutical care in care homes a variety of interventions from the routine clinical check of prescriptions, identifying people requiring more support, to clinical audit, targeted or holistic medication review to specialist advice, all can be utilised by pharmacists.

There are however capacity and resource issues within both community pharmacy and the managed service, therefore a mixed practice model and better team work is required. RPS would like to see more support for improving work force capacity and development at national and local level.

EXAMPLES OF GOOD PRACTICE

The Pharmacy Advice Visit for Storage and Administration, a Local Enhanced Service (LES), was completely changed. The trained community pharmacists now undertake annual audits and level 1 and 2 medication reviews. The medicines reviews are undertaken with the patient, their carer or guardian, the care home staff and whenever possible the GP. Many of the medicines management issues can be resolved quickly as the pharmacist supplies the home. In many pharmacies it is the technicians and dispensers who undertake the components of the original LES. The practice pharmacists also help with the issues requiring GP referral. We are now working with the Care Inspectorate to support reducing variation in care home services; it is a real team effort”.

ELAINE MACINTYRE NHS TAYSIDE

Our recommendations

1. Improvements in the pharmaceutical care of people in care homes can be made by permanently integrating a dedicated role from both pharmacists in community pharmacies and the managed service sectors.
2. Safety could be improved through sharing hospital discharge information and clinical information, including diagnosis, monitoring, test results, adverse drug reactions (ADRs) and allergies between the community pharmacist, the GP practice and care provider. Care homes should seek the appropriate consent to allow effective teamwork and communication.

Moving forward

Pharmacists will work with their colleagues to explore effective ways to identify and review high risk medicines within the frail older population and put in place the appropriate safety processes in the Care Home, GP practice and community pharmacy.

A Scottish Government working group, which is looking at polypharmacy, will build on this RPS report to address issues that affect people living in their own homes or housing support services.

RPS and the Royal College of General Practitioners (RCGP) are committed to improving the way they work together to reduce the challenges we face in this area. This will be integrated with the appropriate health and social care pathways.¹⁶

4.2 NHS SCOTLAND DELIVERING QUALITY IN PRIMARY CARE – A NATIONAL ACTION PLAN, 2010.¹⁷

This action plan prioritises people with dementia and older people (both at home and in care homes) who are frail and have multiple long term conditions which combine to reduce their ability to function independently. The plan commits to developing or strengthening existing care pathways between secondary and primary care and anticipatory care.

Effective partnerships and ways of working are required to achieve long-term change and research has shown that quarterly case conferences that included GP, geriatrician, pharmacist, staff and representatives from Alzheimer's support groups were found to be the most beneficial.¹⁸

In relation to care homes, historically the approach to administration of medicines in care homes is task, schedule and systems-driven. Policies do not always accommodate patient choice in relation to when they take or if they choose not to take

their medication, especially where medication is in a compliance aid (CA) or Monitored Dosage System (MDS). RPS would like to see more evidence of a person-centred approach to care, where everyone involved in care provision knows the wishes and needs of the person in relation to their medicines.

A common theme raised with the working group was that different care home owners have different policies and procedures. This can cause confusion for the staff of care homes and difficulties for healthcare services. There have been consistent calls for national guidance best practice to support front line practitioners.

Our recommendations

3. National guidance on efficient working practices in managing repeat medicines and supply and administration, consent to accessing information is required. RPS calls for the use of nationally agreed documentation, wherever possible, including the Medicines Administration Record.
4. National guidance on best practice in medication review, appropriate polypharmacy safer medicines use in older people is required.
5. The RPS calls on pharmacists to work together with their medical and nursing colleagues to achieve a reduction of inappropriate polypharmacy and high risk medicines and improvements in anticipatory care in the frail older population.

Moving forward

In line with the philosophy and practice of pharmaceutical care and the person-centred ambitions of NHS Scotland, RPS supports the model that wherever possible any medication reviews or interventions that would result in changes to treatment should be undertaken with the person, their carer or guardian present.

Within anticipatory care initiatives, we need to establish ways for pharmacists to identify those at “high risk” either due to their condition, their frailty or their medication. Many pharmacist are involved in this, however, RPS believes that pharmacists are underutilised in this area and they are in a position to do more to support both identification of people at risk and provide ongoing support.

The medicines known to be most associated with adverse drug reactions and hospital admissions provide a starting point as does the diagnostic indicators within Gold Standards Framework Scotland. Pharmacists need to explore how and what deterioration triggers they could identify as part of their normal working practice and feed this into anticipatory care plans and pathways locally.

Pharmacists working with prescribers and care home staff can use their expertise to support the use of guidelines for the use of “when required” medicines for individuals and the development of quality protocols for common conditions e.g. urinary tract infections, constipation and pain assessment.

4.3 RESHAPING CARE FOR OLDER PEOPLE – A PROGRAMME FOR CHANGE 2011-2021.¹⁹

Scottish Government, NHS Scotland and the Convention of Scottish Local Authorities (COSLA) programme sets out the vision and immediate actions for reshaping the care and support of older people in Scotland, the actions in relation to care homes include:

- recognition that care levels may be tailored to particular needs, such as dementia and end of life care.
- acknowledging the need to encourage new models of care, we have agreed to a formal review of the National Care Home Contract.

A strong theme running through the RPS literature review was the need for national and explicit commitment to and responsibility for quality in care homes by all involved.

As many care homes are privately owned, improvement via national standards, contracting and regulation may also be required. This needs to be accompanied by local strategy and planning in tandem with best practice sharing and multi-agency, multi-professional groups that include patient support and advocacy groups which would support the positive change required.

RPS would welcome such an approach and hopes that much can be delivered via existing national strategies. Frontline practitioners must also take ownership, responsibility and action for making the necessary changes.

EXAMPLES OF GOOD PRACTICE

“The community pharmacists are trained by the Specialist Pharmacist for Older People who also developed a polypharmacy screening tool. Standard operating procedures for medication review were prepared, together with triggers for medication review and documentation for pharmaceutical care planning. A system for communication between the pharmacy, care home and general practice was implemented and information on key personnel circulated. Advice on the facilitation and sharing of information about a patient’s medicines when moving from one care environment to another was also supplied.

GPs and community pharmacists are the driving force behind this service in ensuring that structured pathways of care for these vulnerable people are maintained and improved. Support is also provided by practice pharmacists. The alignment of one GP pharmacy and one pharmacy with the care home has been integral to the success”.

ELAINE MCINTYRE NHS TAYSIDE NURSING HOME LOCAL ENHANCED SERVICE PHARMACY LEAD

“National guidance on appropriate polypharmacy is required and it should challenge any medication with a number needed to treat (NNT) of greater than 100. NNT is a population approach that is not appropriate in the frail polypharmacy population. GPs need guidance to support them to stop medication. In the Highland model this support was provided by a geriatrician and pharmacists. Input from psychiatrist or community psychiatric teams may also be required”.

DR MARTIN WILSON, GERIATRICIAN NHS HIGHLAND

An audit of a Care Home Pharmacists medication review work in a Community Health Care Partnership in NHS Greater Glasgow and Clyde provides an indication of the positive outcomes that can be achieved. 116 patients received a medication review, during the audit period and a total of 361 interventions were made. Of the 116 patients reviewed, 10 had no care issues. A further 443 housekeeping issues were also identified and addressed. The significance of the interventions was assessed and can be found in table 1.

SIGNIFICANCE	NUMBER	PERCENTAGE
Potential/Actual reduction in adverse effects	150	42%
Potential/Actual improvement in therapy	165	46%
No Clinical Significance	24	7%
Not Applicable	9	2%
Not Yet Known	0	0%
Highly significant intervention	0	0%

RPS is currently involved in the national work on reducing inappropriate polypharmacy in frail older people and we recognise it as a priority in this report.

RPS would welcome the opportunity to work with the Scottish Government in the review of the National Care Home Contract. This review provides an opportunity to implement some of the changes that the RPS and others would like to see.

Our recommendation

- As a building block for change and in line with the Royal College of General Practitioners and the British Geriatric Society, the RPS believes that the alignment of one GP practice and one community pharmacy to each care home provides a good model to achieve the improvements in care required.
- A more robust contract system and service level agreement is required between community pharmacy services and care home providers. This will create stability, protect investment and existing relationships and develop the long-term therapeutic partnerships and models required between community pharmacists, GP practices and care home providers.

To meet the challenges that face us now and in the future, a team approach to care is required. RPS believes there is a place for both community pharmacists and pharmacists in the managed service working together to improve both pharmaceutical care and continuity of care.

Wherever possible a review of the person's medication should be undertaken as soon as possible after they move into the care home and as part of respite arrangements, with a view to support the possibility of a return to their home or maintaining them at home through respite and re-ablement initiatives.

RPS and stakeholders believe the existing Community Pharmacy Advice Visit (PAV) Locally Enhanced Service (LES) needs to be urgently reviewed to enable better use of the pharmacists' expertise. This should be collaboration between all NHS Boards, the Care Inspectorate, Health Improvement Scotland and Community Pharmacy Scotland with a view to moving towards a standard specification for care provision.

A possible approach would be to apply some of the principles of the Community Pharmacy Palliative Care Network LES to care home services. The Service Level Agreement (SLA) states roles and responsibilities and training requirements for the contractor, named pharmacist and technicians/dispenser.

Another approach, as part of the commitment to person centeredness, residents could register with the community pharmacy providing services to the care home. This registration process could incorporate the appropriate consent to specified services, the sharing of information and incorporate data protection obligations.

The Specialist Pharmacist Older People Group is supporting local implementation of Reshaping Care for Older People. Some pharmacists are leading local initiatives and are also providing educational support to frontline health care professionals where resource and workforce capacity allows.

4.4 SCOTTISH GOVERNMENT'S DEMENTIA STRATEGY AND STANDARDS OF CARE

Published in June 2010 this set out how the Scottish and local government and health and social care services will build on the significant work which was already underway in Scotland in key areas such as early diagnosis, treatment and managing behavior; improving care pathways, and public awareness.²⁰ The RPS working group has incorporated the relevant outputs from the strategy and the work streams into its recommendations, including:

From the treatment and managing behaviour work stream:

- there should be national standards on safe prescribing, monitoring and administration of medicines to those people in care homes.
- a national medicines administration recording form will be developed and implemented as a priority.
- the cultural reliance on medicines supplied in monitored dosage systems (MDS) within care homes and care at home services should be challenged.

A work stream within the strategy will also undertake a prevalence study of the anti-psychotic use, set targets and agree ways to reduce their use.

It is crucial that the pharmacy profession fully engages at all levels in the implementation of this strategy, the standards and the companion skills framework, *Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers.*²¹

Pharmacists in all settings can do more to help people with dementia and their carers throughout the journey of the condition.

RPS agrees with the need to review the use of MDS in the care home setting. MDS met safety needs in the 1980's but since the introduction of patient packs in 1991 their value has to be questioned. Evidence suggests that an over reliance on MDS by care home staff can have an adverse affect on their ability to

manage medications that are not in the MDS system, including inhalers and external or liquid preparations. This is of particular concern if people cannot access "when required" medication, especially those who are unable to communicate their needs easily.

The re-packaging and dispensing of prescribed medication into these systems by community pharmacy staff is also a source of concern in relation to the efficacy of medication. Not all medicines are stable when removed from their original packaging and may be ineffective if placed in these systems. This practice also revokes the product licence for the medicines, and the manufacturers will take no responsibility for any misadventure that may occur.

RPS is currently working on guidance on the safer and appropriate use of MDS and this will help to inform practice, this report will be published in the near future.

Although the working groups primary focus was care homes, many issues were raised in relation to people living at home and supported care settings requiring support in relation to taking their medicines as intended. RPS and our members are concerned that MDS are used as a panacea in the community and they may not meet the needs of the person and can adversely affect their choice and there use presents a number of efficacy and safety issues. There are alternative ways to approach this available in Scotland that we can build on.

RPS believes that a national formal and integrated assessment process is required and before taking any measures to improve adherence that rationalising of medication and medication review should be part of that assessment to ensure that all medication is safe and appropriate.²²

EXAMPLE OF GOOD PRACTICE

The pharmacist works closely with Dementia Coordinators looking at early diagnosis of people. The pharmacist provides post diagnostic support by giving group talks to people with dementia and informal carers on medication, allowing a greater understanding of prescribed and non prescribed medicines to be gained. Education is also supplied to other health care professionals and formal carers.

The pharmacist is looking to increase engagement with community pharmacists by developing an educational tool to support the early detection of dementia. This is further enhanced by providing education on medication use, particularly focusing on antipsychotic use, for people with dementia in care homes.

NHS Lothian Specialist Dementia Pharmacist

4.5 THE STANDARDS OF CARE FOR DEMENTIA IN SCOTLAND, PUBLISHED IN JUNE 2011

This national document sets standards of care for people with dementia from diagnosis through to end of life.²³ They remind everyone that people with dementia have the same rights as everyone else in society. When we consider that between 70% and 80% of people living in care homes have dementia, the messages in the standards provide the framework for pharmacists to improve pharmaceutical care in this setting.

Of particular interest within this report are the statements and standards in relation to receiving treatment that is likely to be of benefit including:

- when psychoactive and, in particular, anti-psychotic medication is prescribed for people with dementia, the prescribing doctor will need to be satisfied that there will be a clear benefit for the person with dementia and that there is no reasonable alternative. The doctor will set a date to review its continued use and put in place a plan to ensure that carers and staff are aware of any potential side effects and where to report any concerns they have.

- high quality pharmaceutical care and safe medicines management systems are available to people with dementia in all settings.

Please note: Psychoactive medication is a medication that effects brain function e.g. anti-depressants and tranquilisers. Antipsychotics are part of this group but are mentioned separately as their use presents a significant risk.

There are examples of specially trained community pharmacists, GP support pharmacists and specialist pharmacists undertaking audits and reviews to support the safe and appropriate use of anti-psychotics for people with dementia. This expertise should be available to people in all care homes.

From both the literature review and feedback from stakeholders reviews need to be holistic to be successful and follow up is required. If tackled in isolation there is a risk that when anti-psychotic medication is stopped they are replaced by other psycho-active medication, including sedatives, anxiolytics e.g. diazepam and anti-depressants e.g. trazodone". One study showed that "having a list of bad drugs is not enough" continual support and education is required for the care home staff.²⁴

EXAMPLES OF GOOD PRACTICE

"Two tests of change were used in the Tayside service to reduce anti-psychotics used in people with dementia in care homes. Within Angus 201 residents were identified of whom 77% were known to psychiatry of old age services. A database and a programme of reviews have been established by the specialist service in Angus. 62% of residents have now had their antipsychotic medication reviewed and the teams are on target to achieve 80% by April 2012. In addition to this all processes have been reviewed to ensure that appropriate advice on review is included in all letters to GPs and that reviews are routinely carried out for all patients on the community mental health teams caseloads.

Education has been provided to care home staff and letters have been sent to GPs offering specialist support for review of patients who are not on the community mental health team caseload.

In Dundee Care Homes, 12 of the 62 residents were eligible for inclusion, seven had their anti-psychotic stopped, two had their dosage reduced and three residents were deemed unsuitable for withdrawal".

Irene Sharkie NHS Tayside Lead Pharmacist (Mental Health)

“A care home provider in response to the Bannarjee Report asked Boots Care Service Team to develop and conduct an audit of anti-psychotic use in people with dementia. This has resulted in a reduction in their use and improvements in quality of life for residents. A crucial part of our audit work to reduce anti-psychotic use is the education of staff on how to manage behaviour without drug treatment. When drug treatment is necessary we educate staff on the side effects to look out for”.

ANGELA GROOME BOOTS CARE HOME SERVICES DIVISIONAL LEAD

RPS recognises that additional training for pharmacists involved in providing pharmaceutical care to care homes was a core component of the literature review. There were also requests from pharmacists currently involved in providing services for a

nationally recognised accredited training programme that can be accessed by all pharmacists involved in care homes and designed to link if possible to Diplomas and MSc in Clinical Pharmacy.

Our recommendations

8. To support implementation of the Dementia Strategy Care Standard for high quality pharmaceutical care and medicines management, the RPS commits to creating an expert working group that will define the pharmacists' contributions to the implementation of this strategy.
9. RPS calls on pharmacists to work together with their medical and nursing colleagues to achieve a targeted reduction in the use of psychoactive medication and antipsychotics in the frail older population. Wherever possible a licensed product should be used at the lowest dose for the shortest time and reviewed regularly.
10. Pharmacists involved in providing care for people within care homes must be aware of the specific pharmaceutical care needs of this patient group and be required to develop their competence to practice in this area. The RPS looks to NHS Scotland and the Scottish Government through NHS Education for Scotland to develop a national educational framework to ensure delivery of approved, standardised and competency based training for all pharmacists delivering pharmaceutical care to people in care homes within Scotland.
11. Due to concerns around safety, patient empowerment, effectiveness and efficiency, the RPS calls for the supply of medicines in original packs in care homes to be promoted as standard. This will require the support at national and local level, agreement from care home providers and pharmacy contractors supported by robust systems, staff training and evaluation.
12. RPS calls on the Scottish Government, NHS Boards and Local Government Social Care departments to support the introduction of a national integrated multidisciplinary assessment tool designed to identify, assess and resolve medicines adherence issues for people living at home but requiring care. To promote safer use of medicines this tool should include prompts for medication review.

Moving forward

Pharmacists in all sectors can be further involved in improving the care of the people with dementia they serve and develop a greater understanding of their needs and how to meet them. Practice research is required in this area and better partnership working with carers and patient support groups, including Alzheimer Scotland, RPS will work to make this happen.

A greater understanding of the pharmaceutical care needs of people in the community with dementia who receive adherence support via monitored dosage systems and compliance aids is required. This could provide an opportunity to target resources and provide greater support for carers, better joint working, improvement in anticipatory care and in the transfer of care between settings. The RPS believes there is an urgent need for research in this area.

The Specialist Mental Pharmacy Strategy Group has included supporting the implementation of the dementia strategy in their Strategic Vision and some mental health pharmacists are leading

local initiatives to tackle inappropriate psychoactive medicine and are also providing educational support where resource and workforce capacity allows.

Pharmacists should review their current services to people with dementia to ensure that the person, their carer or guardian is fully involved in discussions and decisions about their care.

The Dementia Care Standards, *Skills and Knowledge Framework, Promoting excellence*, June 2011, is for all staff who have contact with and provide support for people with dementia and will be used in conjunction with pre-existing knowledge and skills frameworks relevant to particular care sectors and groups. NES Pharmacy is developing support tools for this.

4.6 NHS SCOTLAND EFFICIENCY AND PRODUCTIVITY: FRAMEWORK FOR SRI0 2011-2015

The Framework's main purpose is to identify priority areas to improve quality and efficiency. It is a companion to the Quality Strategy.²⁵ The Releasing Time to Care/Productive Series will empower staff to make improvements within their clinical settings. Enablers include benchmarking, data development, lean methodology to provide a spectrum of approaches to improvement under one local improvement team or hub and the Scottish Government Health Department National Improvement Support Team.

One of the work streams will provide support to Health Boards to address polypharmacy, through a person-centred approach that will also address patient safety. There is also a work stream that will look at the use of nutritional products.

The RPS believes that this framework could be applied to the care home setting to identify resources and good practice for pharmacists, pharmacy technicians and pharmacy support staff to enable them to play their part in improving care. Our recommendation to use original packs as standard in the care home setting would release considerable time for community pharmacists to provide enhanced pharmaceutical care services and for their support staff to undertake other related tasks.

Concern about waste was consistently raised with the working group. The RPS recognises that the cause of waste is complex and multi-factorial, the cause of waste has to be identified and clarity is required around what pharmacists can and cannot influence. RPS believes that care homes should work with GPs, pharmacists and pharmacy technicians to reduce waste as part of a joint commitment to quality and efficiency.

Disposal of medication from care homes is a time consuming activity for community pharmacy staff, as each month medication that has not been used, discontinued or altered is returned. The amount can be vast depending on length of the prescription (28/56 day). Over ordering of prescriptions, especially "when required" is especially problematic.

Pharmacy Technicians have been successfully employed by the managed service to provide repeat prescription management support to care homes in a number of NHS Board areas; we need to build on this.

EXAMPLE OF GOOD PRACTICE.

The following outcomes are from a prescribing support pharmacist working in care homes in NHS Greater Glasgow and Clyde. 59 medication reviews were undertaken over 3 months identifying 367 interventions, ranging from 0 to 16 per resident, averaging 6.33 interventions per patient.

TABLE 2 - INTERVENTIONS WERE CATEGORISED AS FOLLOWS:

CATEGORY OF INTERVENTION	NUMBER OF INTERVENTIONS
Medication stopped	83
Medication started	49
Directions changed or clarified	74
MAR chart amendments	27
Quantities aligned to 28 day supply	68
Therapeutic monitoring required	41
Advice given	12
Referral to other healthcare professional	15

"The over reliance on MDS was causing difficulties within the home as it meant that more than one system was being used and this increased the risk of error. Nursing staff had also reported anxiety around signing for medications from MDS as they had been removed from their original pack and they were not sure if they were the correct medication. Over a two month period we worked closely with the community pharmacy team and changed over to using original packs. It has been so successful we will be doing this in other homes".

NURSING HOME DEPUTE MANAGER EDINBURGH

EXAMPLES OF GOOD PRACTICE

"Wherever possible the GP includes the length of treatment on prescriptions for short term use e.g. dressings. This allows the pharmacy to transfer to the MAR sheet and include this in our records enabling them us to clarify any continuation after the specified time".

COMMUNITY PHARMACIST NHS GREATER GLASGOW AND CLYDE

"We are lucky in some ways; we have one pharmacy, one GP practice and one care home in the village. One lead receptionist manages all the prescriptions for the care home and our MDS patients. If new medications are started during our 28 day cycle she contacts us and asks how many days are required and the GP writes a prescription for this to keep all prescriptions aligned".

COMMUNITY PHARMACIST NHS TAYSIDE

Our recommendations

13. To support quality and efficiency in prescribing management, the RPS repeats the call for prescribing data to be available at care home level to allow for audit and support.
14. There is an urgent need for greater efficiency and reduction of bureaucracy within the care home setting. To help reduce

waste, prescriptions for repeat medicines should be for no more than 28 days whenever appropriate. The policy of some care homes to return all unused medication at the end of each month, irrespective of requirement, should be highlighted discussed and reduced wherever possible.

Moving forward

With respect to our recommendation on original pack dispensing, RPS recognises that care home skill mix and experience varies and change may be difficult and time scales may differ. Any change should be on a care home to care home basis, with robust measures in place to measure safety.

Falls prevention is recognised as a clinical priority in this report. Some pharmacists are involved in falls and fracture prevention and we can build on this and work with our colleagues to reduce falls and prevent hip fractures and support care home staff to implement the recommendations of the Good Practice Resource Managing falls and fractures in care homes for older people. See below:

http://www.scswis.com/index.php?option=com_docman&task=doc_details&gid=476&Itemid=378

To support the benchmarking of best practice pharmacists should

document their pharmaceutical care contributions and patient outcomes in this setting in a standardised way. RPS will support this.

Community pharmacists could be more involved in challenging long term use of topical steroids and anti-fungal creams, laxatives and antacids. Community pharmacists could also provide advice on alternatives to pharmaceutical "specials" as they are unlicensed, expensive and sometimes unnecessary.

"When required" medications for acute conditions or symptoms should not be added to the regular repeats and whenever possible should be supplied in original packs to allow for date checking.

Wherever possible where there is a specific length of treatment this should be communicated to everyone involved and available on the prescription, dispensing label and MAR chart.

4.7 LIVING AND DYING WELL AN NATIONAL ACTION AND FOR PALLIATIVE AND END OF LIFE CARE IN SCOTLAND

The action plan calls for multi-disciplinary assessment and review to be embedded into routine practice across Scotland.²⁶ It also widens the traditional view that palliative care is for people with cancer and extends the model to all life limiting conditions including dementia, chronic obstructive airways disease and heart failure. The action points provide a framework for action that many pharmacists are already actively involved in its delivery.

For over ten years almost every NHS Board has in a Community Pharmacy Palliative Care network to ensure quick access to an agreed list of drugs used in palliative care. This network of specially trained pharmacists also provides advice to other healthcare

professionals on drug compatibilities. NHS Ayrshire and Arran have a two tier LES, the second tier involves community pharmacists using a pharmaceutical care needs assessment tool to identify common symptoms and side effects. The tool is available as part of the NES Pharmaceutical Care of people with palliative care pack.

Specialist Palliative Care Pharmacists also provide a crucial role in direct care of people and education of other healthcare professionals on appropriate and safe use of medicines, developing guidelines to support better care.

The Care Commission (now Care Inspectorate) collated data provided by care homes to assess how they were delivering the action points from the Scottish Government Strategy Living and Dying Well. The authors conclude that while care homes are making progress in how they deliver good palliative and end of life care, they can do much more to ensure that people

living in Scotland's care homes receive the standard of care that meets their needs, expectations and wishes. Care homes should work closely with GPs and primary health care teams to deliver good palliative care. This should include the use of recognised assessment tools for pain and symptom management.

Our recommendations

15. Pharmacists should continue to work with other healthcare professionals and care home staff to ensure that the palliative and end of life care needs of people are identified and met.

The RPS calls for a greater involvement of the existing community pharmacy palliative care network as a resource for care home staff.

Moving forward

Pharmacists in all settings should explore how to contribute to supporting better symptom management, early identification or avoidance of predictable side-effects and medication review in

palliative and end of life care. This should be integrated wherever possible to local multi-disciplinary assessment and care pathways.

4.8 SCOTTISH GOVERNMENT NATIONAL CARE STANDARDS, CARE HOMES FOR OLDER PEOPLE 2007.

This document defines standards of care against which care homes will be assessed. They cover moving in, settling in, day-to-day life, including medications and legal rights.²⁸ All pharmacists involved in providing services to care homes should have a strong working knowledge of the standards and how they apply to the services they provide or want to provide. RPS views these standards as providing an opportunity to implement some of the recommendations and has suggested ways forward. The following excerpt is of particular relevance:

“The National Care Standards state that “Confidential information about you is only shared with others if you give permission, unless the law requires otherwise.” “Staff will monitor your medication and the condition for which it has been prescribed. If there are any changes or concerns about the medication, including side effects, or your condition, they will seek your permission to get medical advice.

The use of covert administration should be minimised as far as possible. Where it is seen to be appropriate the Mental Welfare Commission's guidance about Covert Medication should be followed and this includes getting advice from a pharmacist before medication is crushed or altered. Care home staff should highlight any swallowing difficulties with the pharmacist or GP in the first instance as it is a prompt for medication review and general assessment of need.

The following excerpts from Care Inspectorate Reports were shared with the working group and indicate issues and areas for improvement:

■ There is a perception by staff that Medicines Administration Record (MAR) sheet is a prescription sheet meaning that they can administer anything printed on it without considering if it is still currently prescribed.

■ Some staff members are losing the skills to give liquids or tablets/capsules which are not supplied in MDS packs. The use of MDS has made medicines administration a robotic task with little consideration about what the medicines are prescribed for. The current model is based around the concept of an institutionalised drug round. In recent years there has been a move to more personalised care and the storing of medicines in the person's room.

■ There are consistent reports of inaccuracies in MAR sheets supplied by the pharmacy, including entries for both generic and branded medication, old strengths of medicines or deleted medicines.

■ The practice of leaving items especially steroid creams on MAR sheets in case they are needed in the future should be avoided.

■ Once MAR sheets are used by the care home to note administration it becomes a confidential document and access to it by anyone but care home staff requires consent.

The Care Inspectorate suggests a number of improvements including:

■ pharmacists working with care home staff, GP and residents/guardians to support these recommended changes and greater recording of the person's preferences and choice in relation to their medicines.

■ community pharmacists supplying MAR sheets should undertake a clinical check as they do for prescriptions.

■ MAR sheets should be reviewed regularly in conjunction with the GP and care home staff, to remove medicines which are no longer prescribed needed or being taken.

Issues have been raised with the working group in relation to confidentiality and consent to the sharing of information and interventions that may change treatment. It was brought to the attention of the working group that there is a degree of confusion about aspects of this.

Some pharmacists as part of their PAV or other services routinely access the MAR (which they often have provided to the care home) and have done so for years. To support practitioners and ensure that existing good practice continues and that pharmacists are working within the law and standards, RPS would like to take this opportunity to highlight the following key points:

Consent is required if pharmacists are providing services e.g. audit or medication review that may result in a change of medication or therapeutic management.

Consent is required if pharmacists are providing services that involve accessing the following data protected information:

- Personal care plan or care home record for residents
- Medicines Administration Recording (MAR) Charts – even if they are supplied by the community pharmacy, when they are used by the care home to record information the MAR becomes a confidential document

Our recommendations

16. RPS believes that the pharmacist's clinical check of prescriptions should also include a review of the medicines administration record (MAR) for errors if the pharmacist is

- Medical case notes – unless consent to access is covered by an NHS Board service

Who can give consent?

- The individual if they have capacity.
- If they are covered by Adults with Incapacity Act, a person who is a welfare guardian or activated power of attorney would normally be able to consent on behalf of the person in terms of consenting to a pharmacist providing professional services, treatment or care, or accessing patient information. (This could be at least 70% of the care home population).

Care home staff should be aware of the powers a resident's guardian or power of attorney has and who can consent on the resident's behalf. It is the care homes responsibility to obtain appropriate consent.

It is clear that consent is required; RPS asks that there is a pragmatic approach and a programme of obtaining consent from the appropriate person as part of existing administrative and legal functions is the best way forward for residents in care homes.

supplying the MAR sheet e.g. timing, detection of duplicated entries.

Moving forward

RPS believes that when someone moves in to a care home it should be assumed that they can self-medicate, unless there is evidence to the contrary. A re-enablement approach should be the norm and any adherence support should be part of a documented assessment.

Validated self administration tools are used in the hospital setting; they should be reviewed for suitability in the care home setting with a view to supporting self-care.

Pharmacists providing services to care homes should be familiar with these standards and the Adults with Incapacity Act 2000.²⁹ Annex 5 of the Adults with Incapacity Act Code of Practice – details the healthcare interventions that can be foreseen. Pharmacists may require training on their responsibilities in relation to the Adults with Incapacity Act. The regulatory body for pharmacists and pharmacy technicians, the General Pharmaceutical Council has produced guidance on confidentiality and consent to the sharing of information.³⁰

Guidance is also available from the Caldicott Guardian.

In Scotland there are legal requirements for covert administration, the existing practice of some community pharmacists, to identify and challenge covert administration and refusal to take medication, as part of their Pharmacy Advice Visit should be formally recognised and supported.

To support greater flexibility and person centred care, pharmacists could stop the practice of putting times on dispensing labels and MAR charts i.e. 8am, 1pm etc. Specific times should only be specified if there is a clinical need e.g. medicines for epilepsy and Parkinson's disease. Care home staff may require support on the best time to give medication and how to avoid giving medication too frequently e.g. paracetamol.

Pharmacists could review with the care home the practice of medicines prescribed "daily" defaulting to a labelling instruction to give in the morning. This default can create a burden on the medicines administration process within the care home.

The RPS Guidance on the pharmaceutical issues when crushing, opening or splitting oral dosage forms is available for members of the RPS.

<http://www.rpharms.com/best-practice/specials.asp>

Section 5 Evidence of the need for improvement

The RPS Library undertook a literature search in March-April 2011 for the PCCH group. One hundred and fifty articles were identified, and ninety six were chosen for relevance. The following section summarises some key reports or studies

from the literature review which identify the need for change along with issues and solutions shared with the working group. Many of the findings and conclusions formed the basis of our recommendations.

5.1 THE MENTAL WELFARE AND CARE COMMISSION REPORT 2009 'REMEMBER I'M STILL ME'

This report combined the knowledge of both organisations on what constitutes good care and ethical practice and to review the quality of practice in care homes.³ The records of 1355 residents in 30 care homes were reviewed. The findings included:

- little evidence that medication was regularly reviewed.
- 75% of people in care homes were taking one or more psychoactive medicines. 33% were taking antipsychotic medication and 6% were taking olanzapine or risperidone. Despite specific warnings in place at the time about the use of these drugs.
- 19 people were taking two types of antipsychotic drugs and four people were taking three types.

The authors concluded that care homes should have regular advice from a pharmacist on using medications safely, appropriately and cost-effectively. Care homes should also regularly review, together with GPs and pharmacists, how they manage medication. Their recommendations included:

- GPs and pharmacists should review all prescriptions for anti-psychotic drugs with a view to stopping them or providing an alternative.
- Care homes should work with pharmacists to ensure that all legal documentation is in place and to give appropriate advice on disguising medicine.

Moving forward

Reducing the risks associated with psychoactive medication and anti-psychotics in particular are recognised as a priority area in this RPS report. We will continue to work at strategic and practitioner level to support change necessary.

RPS published Quick Reference Guidance on the Clinical Check of prescriptions in June 2011. The benchmarking of clinical checks is a potential way to support practice development in this area.³¹ Effective ways to do this will be explored by the RPS.

5.2 CARE HOME USE OF MEDICINES STUDY (CHUMS), ALLDRED DP, BARBER N, ET AL 2009

The study commissioned by the Department of Health, set out to determine the prevalence and potential harm of prescribing, monitoring and administration errors in UK care homes.³² The study looked for the reasons behind errors rather than just logging the number of mistakes. It found that almost a third of drugs that should have been monitored for side effects were not, and that mistakes occurred at all stages; prescribing 8.3%, monitoring 14.7%, dispensing 9.8% and administration 8.4%. The researchers suggest that lack of a clear system of medicines management, from prescribing through to the patient taking the medicine, was the main reason for the errors.

Their recommendations include: a pharmacist should be appointed to a home or a number of homes with overall

medicines management responsibility and that pharmacists who supply the home should also make sure that they "know the home, its ways and needs".

RPS is aware of some pharmacies utilising technology to ensure that some of the processes are more efficient and safer: One pharmacy chain in England has developed a specialist medication service for care homes using specially developed IT systems.³³ They report that patient safety has improved because dispensing and administration errors have been prevented through the use of barcode technology. The IT system can also produce audit data, prompt for monitoring and produce a MAR chart at the end of the month.

Moving Forward

RPS supports the introduction of error reporting by all service providers for all aspects of medicines use in care homes. This should be the basis of shared learning and improvements in care, safety and team work.

Research is required into the use of bar code technology to support safe and efficient working practices in care homes and community pharmacies.

5.3 BRITISH GERIATRIC SOCIETY AND ROYAL COLLEGE OF GENERAL PRACTITIONERS 2011 REPORT FRAILTY, OLDER PEOPLE AND CARE HOMES CAN WE DO BETTER?

These two medical professional bodies were asked by the Minister for Public Health to prepare a paper to reflect the current situation and make recommendations.³⁴ This should be reviewed with the companion document “*Quest for Quality*” *British Geriatric Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes; a call for leadership, partnership and quality improvement*. Their conclusions include;

- Where homes have built up a relationship with a local community pharmacist, it is appropriate that the medication reviews are undertaken with their input.

- Where practice based pharmacists are available, their expertise is utilised in the delivery of care to residents in care homes.

Both organisations commended the alignment of one GP practice to one care home and recognise the sub-speciality of care home medicine, the role of the GP with Special Interest and the need to develop expertise in tandem with support from specialists in secondary care.

RPS fully supports all of the recommendations in the joint report. Many of the issues identified and raised in this joint report were also shared with the RPS working group.

EXAMPLES OF GOOD PRACTICE

The benefits of this LES (Local Enhanced Service) far outweigh any disadvantages to patients who may have been asked if they would change GP practice when admitted to a nursing home. The GP practice can specialise in this important field of work and develop the service to meet the needs of this growing number of patients. The care home staff can build up a good working relationship with one dedicated GP practice and community pharmacist. The community pharmacists involved have reported that the new skills and knowledge they have gained have enhanced their pharmaceutical care contributions to the wider community.

NHS TAYSIDE

EXAMPLES OF GOOD PRACTICE

“The service is not age specific but based on functional status and was developed from anticipatory care work and includes everyone in Care Homes and community dwelling people who fall within the inclusion criteria. They developed guidelines based on Cochrane reviews that support decision making by GPs, patients and carers.

GPs and nurses undertook the face to face medication reviews and a geriatrician supported the assessment. Pharmacists are involved wherever possible but this can be difficult due to lack of capacity. The outcome measures included a reduction in high risk medications, reduction in both hospital admissions and occupied bed days.

The reduction in numbers of drugs taken has also resulted in qualitative outcomes, as polypharmacy seems to have also adversely affected people’s appetite or interest in food. People are eating more and as medication administration times have reduced, this has released time for staff to spend more time with residents”.

DR MARTIN WILSON, NHS HIGHLAND GP LES

Moving forward

Joint training initiatives between doctors, pharmacists and nurses would support greater learning and joint working within this setting.

Working together to improve care in care homes is one of the action points within the recently published RPS and RCGP Joint

Statement “Breaking down the barriers- how pharmacists and GPs can work together to improve patient care” in February 2012.

5.4 EFFICACY OF TREATING PAIN TO REDUCE BEHAVIOURAL DISTURBANCES IN RESIDENTS OF NURSING HOMES WITH DEMENTIA: CLUSTER RANDOMISED CLINICAL TRIAL.³⁵

This study set out to determine whether a systematic approach to the treatment of pain can reduce agitation in people with moderate to severe dementia living in nursing homes. The authors concluded that a systematic approach to the management of pain significantly reduced agitation in residents of nursing homes

with moderate to severe dementia. Furthermore, effective management of pain can play an important part in the treatment of agitation and could reduce the number of unnecessary prescriptions for psychotropic drugs in this population.

Moving Forward

RPS recognises the need for better pain management in this report as a key priority area for pharmacist involvement. The use of validated pain assessment tools by care home staff could be supported by pharmacists. It is known that people with dementia

are often unable to communicate their pain. The results from this study may be even more significant when considered against the high level of "when required" paracetamol and other analgesia returned every month from care homes. We need to change this.

5.5 A STUDY OF THE APPROPRIATENESS OF PRESCRIBING IN NURSING HOMES. LUNN J, ET AL.

The aim of the study was to investigate the use of medicines in local nursing homes and to assess the extent of inappropriate prescribing for residents using consensus derived criteria.³⁶ When criteria for inappropriate prescribing were developed and applied, 54 (53 per cent) residents were judged to have one or more inappropriate prescriptions.

The authors concluded that nursing home residents could benefit if pharmacists were to support GPs by offering advice about individual residents' drug treatment.

5.6 THE INFLUENCE OF FORMULATION AND MEDICINE DELIVERY SYSTEM ON MEDICATION ADMINISTRATION ERRORS IN CARE HOMES FOR OLDER PEOPLE. ALLDRED DP ET AL.³⁷

This study set out to identify and classify administration errors using validated definition. Errors were classified and analysed by formulation and medicine delivery system. The authors concluded that training for care home staff is urgently required. There is

some evidence that MDS reduced the odds of an administration error; however the use of MDS impacts on other aspects of medicines management and requires further research.

5.7 EVALUATION OF THE SCALE, CAUSES AND COSTS OF WASTE MEDICINES, TAYLOR D, ET AL.³⁸

The aim of the research was to study the causes, nature and extent of waste medicines from care homes. Almost 30% of a list of 33 commonly returned medication were laxatives and paracetamol (including co-analgesia e.g. co-codamol) which were generally prescribed on a "when required" basis. The view taken

here is that the reduction of waste should not be seen as a simple end but more as a symptom of the quality of care as a whole. The authors suggest a reduction in waste may occur as a by-product of improving quality.

5.8 JOSEPH ROWNTREE FOUNDATION RESEARCH TEAM FROM UNIVERSITIES OF WARWICK, WEST OF ENGLAND AND YORK. 2008.³⁹

Undertook a literature review and identified evidence of significant unmet need amongst older people with dementia, poor quality of life and inappropriate use of psychotropic drugs. Evidence indicates that improved detection and treatment is required for depression and pain. The team concluded that culture

change is required and must begin with owners and managers building new relationships with all stakeholders. Care should be restructured with the emphasis on person centeredness and give greater scope for proactive and preventative interventions.

CONCLUSION

The RPS work on pharmaceutical care in care homes has reinforced our belief that we all need to do more to support better care for our frail older people. The way medicines are used in Scotland's care homes can be improved and we believe that this report shows how that can be achieved. The recommendations in this report set out a number of actions, which if accepted, create the foundations for long term change in providing pharmacist led pharmaceutical care for people in the care home setting.

Better utilisation of the pharmacist's expertise and skills in supporting residents in care homes can bring significant benefits to residents, the NHS, Social Care and care home providers. Many of the building blocks are already in existence and it is now time for the input of pharmacists to be embedded as part of service provision.

It is clear to us that pharmacists have a huge role in improving the pharmaceutical care of people in care homes and mixed practice models will be required. This is only going to be achievable however if pharmacists work as part of an integrated team.

RPS looks to stakeholders in Government, the NHS and local government, pharmacy contractors and care home providers to implement and safeguard the changes we believe are required.

For pharmacists this report specifically recommends a variety of contributions that will improve pharmaceutical care for people in care homes. Pharmacists need to take ownership of some of the aspects of care and drive the changes necessary.

Some of the recommendations may seem challenging in the current environment, however, RPS believes that small step-wise changes, using the methodology for change in existing national programmes and policies will support safe and effective change.

Finally, our vision is that care homes will eventually be in the vanguard of providing excellent patient care. Pharmacists, nurses and doctors, should aspire to work in a care home sector that leads the way in the clinical care of older people.

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Appendix I Pharmacist involvement in improving care- summary of literature review

The following summarises studies and evidence from the literature review to help identify what good looks like as we move forward.

WHO?	KEY POINTS	CONCLUSION
Interventions that can reduce inappropriate prescribing in the elderly-a systematic review. Kaur S, Mitchell G et al Drugs Ageing 2009; 26 (12): 19013-1028.	<p>Educational (interactive face to face).</p> <p>Computerised support systems including alerts for review.</p> <p>Medication review by pharmacists.</p> <p>Geriatric medicine service input.</p> <p>A comprehensive approach required.</p>	<p>Prescribing should not be considered in isolation.</p> <p>Communication between specialists, responsible prescriber and pharmacists is essential.</p> <p>Process of planning should involve all stakeholders including regulatory policy makers, physicians, pharmacists and members of geriatric team.</p>
How community pharmacists can help reduce anti-psychotic use in Care Homes Pharm J 2009;283: 653-654.	<p>A software package was installed in pharmacy computer that audited antipsychotic agents, doses and duration of therapy.</p> <p>Results were benchmarked.</p>	<p>Involving trained community pharmacists in clinical audit, staff education and interdisciplinary review and communication were successful in a significant reduction in anti-psychotics and benzodiazepines prescribing.</p>
How to limit antipsychotic use in dementia. Redmond V and Cavan J Pharm J 2011;286:539-545.	<p>Anti-psychotic medication can be commonly prescribed during acute episode during hospital stays.</p> <p>Use of anti-psychotics in the 22 bed dementia unit reduced from 41% to 9%.</p>	<p>Mental health specialism of pharmacist and input from consultant psychiatrist at multi-disciplinary team meetings (which replaced the practice of the team making separate visits) and training of nursing staff in non-drug approaches cited as part of the success.</p> <p>The continued use post discharge is not reviewed or challenged and should be.</p>
<p>Making a difference in Care Homes, Care Homes Effective Support Service Winstanley L, Brennan W.</p> <p>http://www.nelm.nhs.uk/en/NeLM-Area/Evidence/Medicines-Management/References/2009---July/09/Supporting-care-home-patients/</p>	<p>Caseload of 1,200 patients; from August to December 2008, it made 445 medicines interventions and 1,143 healthcare interventions.</p> <p>The team is made up of nine pharmacists, most of whom are prescribers and five nurses, and works closely with social services.</p>	<p>For a small investment, managing dementia.</p> <p>appropriately, reducing medication, improving end of life care and ensuring regularly reviewed medication is possible.</p> <p>Consider Care Homes as small NHS centres to make the changes necessary.</p>
An evaluation of an adapted U.S. model of pharmaceutical care to improve psychoactive prescribing for nursing home residents in Northern Ireland. Patterson, S, Hughes, C, Jour Amer Ger Soc, 2010, 58, 1, pp. 44-53.	<p>After 12 months intervention group 25/128 (19.5%) were taking psychoactive meds vs. 62/124 (50%). Many of the pharmacists had previous experience of medication review– all received training to ensure uniform delivery. The community pharmacists identified people for review using a risk screening process as part of this study.</p>	<p>Marked reductions in inappropriate psychoactive medication prescribing resulted from pharmacist review.</p> <p>Continuous monitoring of these drugs is required with respect to their initiation and review.</p> <p>Falls recording is poor. Challenge is to extend this model into other therapeutic areas. Residents, care givers and family members were interviewed as part of the holistic review.</p>

WHO?	KEY POINTS	CONCLUSION
When all pharmacists work together: Services to make Care Homes Safer Gloucestershire. <i>Pharmaceutical Journal</i> , 25 Apr 2009, vol. 282, no. 7549, p. 487-488.	Lead pharmacist provides training to Care Home staff, develops guidelines for treating diarrhoea, constipation, sip feeds and tackles covert medication and identifies alternatives.	Pharmacist involved opted for a strategic approach by devising ways to identify "high risk patients" and works with a pharmacy technician and community pharmacists to make the changes. The support team's technician had conducted valuable audit work including anti-psychotic use and medication packaged into MDS which should not be.
Medication use in nursing homes for elderly people. Furniss, L, Craig, S, & Burns, A, <i>Int Jour Ger Psy</i> , 1998;13: 433-439.	Elderly residents receiving psychotropic medication may not have a documented mental illness-range 21% to 37%. Studies have shown associations between these drugs and restlessness, incontinence, falls and fractured neck of femur.	One hour of pharmacist's time per week providing a clinical service could make a significant contribution to patient care. Prescribing advice must be given on a continuous basis if reductions in medication are to be maintained.
A study of medication reviews to identify drug-related problems of polypharmacy patients in the Dutch nursing home setting. Finkers F, Maring J, <i>Jour Clin Pharm& Ther</i> , 2007, 32, 5, pp. 469-476.	Involved 742 residents and 3232 problems were identified, mean of 3.5 problems per patient 62% of problems in 97% of patients were classified as unclear or unconfirmed indication.	Medication review on admission may be more helpful as many drugs that should have been prescribed acutely were continued chronically.
A comprehensive pharmacist intervention to reduce morbidity in patients 80 years or older a randomized controlled trial. Gillespie U et al, <i>Arch Intern Med</i> . 169 (2009); 894-900.	Randomised controlled trial of a comprehensive pharmacist intervention to reduce morbidity in patients 80 years or older.	The addition of pharmacists to health care teams would lead to major reductions in morbidity and health care costs.
Does organisational culture influence prescribing in care homes for older people? A new direction for research. Hughes C, Lapane K, et al <i>Drugs & Aging</i> , 2007,24, 2, pp. 81-93.	There are limitations as to how much can be achieved with regulation as seen in the United States. There are patterns of excessive use of psychotropic drugs and under treatment of common conditions e.g. Atrial Fibrillation, stroke and depression.	Quality measures used in some countries e.g. Urinary Tract Infection and pain has improved prescribing. Compared to UK which focuses on process. Inadequate training in geriatric medicine and pharmacotherapy and poor links to psychiatry has been cited as contributing factors to poor care. Need to be clear about what good care is.
Outcomes of a randomized control trial of a clinical pharmacy intervention in 52 nursing homes. Roberts MS, Stokes JA, King MA et al <i>Br J Clin Pharmacol</i> 2001;51:257-265.	The use of benzodiazepines, NSAIDs, laxatives, H2 – receptor antagonists and antacids reduced significantly by 14.8%. No difference in morbidity indices or survival. Pharmacists had post-graduate diploma in clinical pharmacy. Study delivered in 3 stages, introducing a new professional role, relationship building, nurse education and medication review.	Nurse education combined with medication review viewed as necessary and helpful. Study resulted in the Australian Government funding an accredited pharmacist medication review programme for all Australian Nursing Homes. Relationship with GP was indirect; recommendations were made to nursing staff. This has been viewed as a flawed model since and changed.

WHO?	KEY POINTS	CONCLUSION
<p>Quality Use of Medicines in Aged-Care Facilities in Australia. Roughead E, Semple S & Gilbert A. Drugs and Aging 2003; 20:643-653.</p>	<p>Established expert multi-disciplinary advisory panel that included the pharmaceutical industry and behavioural scientists and representative council and established a research programme.</p> <p>Clinical pharmacy intervention reduced overall medication by 11-15% and improved the quality of medication use but did not affect frequency of hospitalisation, annual mortality, measures of disability or adverse drug reactions.</p> <p>Resulted in the creation of the Australian national accreditation system for Residential Medication Management Reviews (RMMR). The program supports the provision of high quality services, along with terms and conditions for the program, clinical guidelines, and service agreements. Service agreements are contracts between the aged care facility and the RMMR provider that set out how each of the parties will co-operate to ensure that residents receive timely, high quality services.</p>	<p>There needs to be an effective collaborative relationship between GPs and pharmacists undertaking medication review – if changes are to be made.</p> <p>Medication review process has to be developed in tandem with improvements in communication.</p> <p>Quarterly case conferences that included GP, geriatrician, pharmacist, staff and representatives from Alzheimer's Association were found to be the most beneficial.</p> <p>Prioritisation of initiatives through policy and research is essential. Improvements have been made over a ten year period and facilitation is required.</p> <p>Where Medication Advisory Committees (MAC) could not be set up in individual homes, area or regional MACs were set up, supported by the Division of General Practice who provides funding for administration and medical representation.</p>

Appendix 2 Service examples and building blocks for change

I NHS TAYSIDE FIRST REPORT ON LOCAL ENHANCED SERVICE: NURSING HOME SEPTEMBER 2010

Local Enhanced Service.

This Local Enhanced Service (LES) was developed uniquely in NHS Tayside to provide an opportunity to reduce variation, harm and waste in relation to aspects of patient care for patients in nursing homes. General practices were invited to apply to align with one of the identified homes. Pharmacy services to nursing homes were already provided from one community pharmacy and therefore already aligned. From the onset of the LES for both GP practices and community pharmacists the following improvement measures were agreed:

1.1 Reduction in out of hours calls – by professionals having improved clinical information held in nursing home – figures compared via Taycare.

Achieved - data shows that for every 5 Out Of Hours (OOH) GP visits to homes covered by the LES 7 visits took place to the non-LES homes. The 5:7 ratio is evidence that LES homes receive less OOH visits.

1.2 Reduction in hospital admissions – the emergency referral pattern for the LES.

Achieved - an early audit was carried out on the number of admissions from Dundee and Angus care homes to the acute medical unit (AMU) at Ninewells Hospital which demonstrated that the number of admissions had decreased.

1.3 Reduction of attendances to Accident & Emergency (A&E).

Achieved - The data collected by A&E demonstrates that overall the proportion of nursing home attendances from LES homes has decreased and a higher % of the attendances were appropriate compared to non les homes, particularly in the OOH period.

1.4 Increase sharing of knowledge/communication between General Practice and Community Pharmacists - Anecdotal evidence and via questionnaire.

Achieved - an example of feedback from the survey - "One GP, One Pharmacy, One care home – frees up staff time and minimises error".

1.5 Ease of access of health professionals to medical information through storage of patient note summary in nursing homes.

Achieved - The majority of practices (84%) reported that there is now an up-to-date medical summary provided to the care home for each registered patient with the lead GP practice.

1.6 A target registration rate of 80% of patients with LES practice within 5 years.

Achieved - Within the first phase of the LES the number of patients registered with the lead GP practice has increased considerably from 35% (252) to 58% (614) also the number of patients living in a nursing home has increased by 32% over the time period.

Both these services provide a step change in meeting three critical Triple Aim objectives:

- Improve the health of population.
- Enhance the patient experience of care.
- Reduce or control per capita.

2 NHS TAYSIDE COMMUNITY PHARMACY LOCAL ENHANCED SERVICE SUMMARY OF REPORT

The community pharmacists are trained by the Specialist Pharmacist for Older People who also developed a polypharmacy screening tool. Standard operating procedures for medication review were prepared, together with triggers for medication review and documentation for pharmaceutical care planning. A system for communication between the pharmacy, care home and general practice was implemented and information on key personnel circulated. Advice on the facilitation and sharing of information about a patient's medicines when moving from one care environment to another was also supplied.

The community pharmacists undertake two clinical audits per year and one level medication review. New residents are reviewed within 6 weeks of admission. The medication review involves information from the Pharmacy Medication Record, Care Home record, MAR and does not generally involve full access to medical case notes. The medication review is generally level 1 or 2 based on National Prescribing Centre definitions. The best practice scenario was where the community pharmacist approached the practice for background patient information before attending the care home to review the patient. This resulted in a multidisciplinary review providing the community pharmacist with more information when interviewing the patient and/or carer. Having this information available at the care home would make the process much easier.

Variation has been identified both in the number of medication reviews that have been achieved and in the quality of the communication sent to GPs following the reviews. Work is ongoing to reduce this variation and support practitioners.

This process was eased where the community pharmacy served no more than three care homes.

A total of 1388 medication reviews were conducted by the pharmacists and a total of 1484 care issues were identified.

The Caldicott Guardian offered guidance to accessing and sharing of information.

Pharmacy team involvement

The pharmacy technician or dispensing assistant also conducted a 6-monthly audit with each care home. This audit considered care home standard operating procedures for: ordering, storing, administering and disposing of medication; waste disposal; self administration of medicines and covert administration. The audit verified that medication profiles contained relevant, current patient information, including past and current medication and that medication administration records were accurate and appropriately used. Other items covered in the audit included supply of medicines; accurate record keeping of medicines ordered and received; drug recalls; medication storage including fridge items and controlled drugs; oxygen storage and safety regulations; disposal of medicines and self-administration of medicines. Advice was provided on how to avoid any future wasted ordering and returning of medicines.

The Nursing Home LES provided an opportunity for many of the dispensers and technicians who are so used to working solely in the pharmacy to work in another environment. This pilot gave them the opportunity to use their skills and knowledge away from the pharmacy, so supporting the pharmacist in quite a different way.

What went well?

- Efficiency initiatives e.g. sip feed / wound dressing.
- Alignment of one GP practice to one care home with one community pharmacy. With the named pharmacist having responsibility for no more than two or three care homes.

What did not go so well?

- Communication of care plans with GP surgeries. Practice support pharmacists now helping.
- National contracts with pharmacy service providers can adversely affect local partnerships.
- Pharmacists found it difficult to find the time to provide care home staff training. Project facilitators have developed a self-study pack this year for senior carers and nursing staff.

Moving forward

The part-time facilitator post to support implementation and evaluation of the LES has been crucial to its success, and continuation of the post will allow many of the learning points to be followed through in the next year. It is an integrated team effort, that build on the strengths of everyone involved.

This year, we are working more closely with the Care Inspectorate. Each inspector will receive a copy of the pharmacy technician and pharmacist audit for their aligned care home and will use this information when conducting an inspection.

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2 REDUCING ANTIPSYCHOTIC USE IN PEOPLE WITH DEMENTIA NHS TAYSIDE

The Steps to Better Healthcare Programme in NHS Tayside includes a work-stream to reduce harm, variation and waste with respect to medicines. One component of this work was to reduce harm for people with dementia by ensuring that all people resident in a care home with a diagnosis of dementia and prescribed an antipsychotic would have a multi-disciplinary review.

The key deliverables are:

- Reduced harm from prolonged prescribing of antipsychotics.
- Reduced number of prescriptions for antipsychotics.
- Reduced variation in prescribing.
- Reduced admissions to secondary care.
- Increased adherence to treatment guidelines.

Improvement methodology has been used and 2 'tests of change' were carried out initially. One in Angus CHP led by the dementia liaison team and another in Dundee CHP led by the practice pharmacist which focused on a single care home and the GP practice with the LES for that home.

Within Angus 201 residents were identified of whom 77% were known to psychiatry of old age services. A database and a programme of reviews has been established by the specialist service in Angus. 62% of residents have now had their antipsychotic medication reviewed and the teams are on target to achieve 80% by April 2012. In addition to this all processes have been reviewed to ensure that appropriate advice on review is included in all letters to GPs and that reviews are routinely carried out for all patients on the CMHT caseloads.

Education has been provided to care home staff and letters have been sent to GPs offering specialist support for review of patients who are not on the CMHT caseload.

The test within the Dundee Care Home achieved impressive outcomes. 12 of the 62 residents were eligible for inclusion, seven had their anti-psychotic stopped, two had their dosage reduced and three residents were deemed unsuitable for withdrawal.

The outcomes from these tests have been shared with key stakeholders across Tayside and further work has commenced in Perth and Kinross and Dundee care homes but spread of the work has been challenging.

Successes

- Good practice guidance and a resource pack have been developed.
- 70% of GP practices across Tayside are engaged with antipsychotic reviews.
- Closer working relationships have been established between primary, secondary and care home staff which will sustain and embed the changes.
- Positive feedback from patients, carers and staff.

Challenges

- Data collection has been challenging. Secondary care use paper records and collation of data has been very time consuming and there is no system for prompting reviews. If this could be built into GP prescribing systems this would be extremely helpful.
- Not all residents in care homes are registered with the GP practice that has the LES for the home. (Sometimes less than 30%).
- Specialist teams do not have the capacity to review all patients on antipsychotics.
- GPs are reluctant to stop medication initiated on the advice of a specialist but residents are often no longer under the care of the Consultant.
- The population is constantly changing.
- Not all residents have a 'formal' diagnosis of dementia..

Learning

- A 'whole systems' approach is essential as antipsychotic prescribing is only one aspect of care.
- Primary care staff and care home staff need support and education from specialists when antipsychotics are being reduced.
- A multidisciplinary approach involving care home staff, the GP, pharmacist, and specialist staff (CPN/Consultant) is key to success and sustainable change.
- The 'ideal model' is one care home, one GP practice, one CMHT (CPN/Consultant) and a pharmacist.

Resources

- Driver diagram and test of change
- Resource Pack includes
 - 1 Anti-psychotics good practice for reduction and cessation
 - 2 Background information for staff on anti-psychotic prescribing for people with dementia
 - 3 Process for conducting a review
 - 4 Poster
 - 5 Patient information leaflet
 - 6 Feedback form for relatives and staff

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3 NHS HIGHLAND POLYPHARMACY: GUIDANCE ON PRESCRIBING IN FRAIL ADULTS: PHARMACIST INVOLVEMENT IN GP LOCAL ENHANCED SERVICE.

In September 2010 the NHS Highland "Polypharmacy: Guidance on Prescribing in Frail Adults" document was ratified, having been developed by a multidisciplinary group comprised of Consultant Physician, GP and Public Health Consultant representation but also includes a number of pharmacists from hospital and primary care, as well as the area formulary pharmacist and the Director of Pharmacy.

The guideline supports clinicians in making safe and sensible decisions on prescribing in situations such as:

- a patient who is either on, or has indications to be on, multiple medicines,
- when patients are "frail" in a medical sense, i.e. they have reduced ability to withstand illness without loss of function,
- patients who have suffered a side effect from a medicine and where a decision is needed to whether to restart or avoid it,
- patients with indications of shortened life expectancy, or
- situations where guidelines suggest "medication review".

The guideline:

- provides a process for conducting a medication review in the above scenarios,
- identifies medicines that are poorly tolerated in frail patients,
- lists high risk medicines and, in particular, high risk combinations of medicines,
- provides a medicines effectiveness summary, which provides information on the expected effect of commonly prescribed secondary prevention strategies, stating the number needed to treat to achieve a desired effect.

The overall aim of the guidance is to support prescribers in making informed decisions, in consultation with a patient or their carer, on whether to continue or stop a medicine. Pharmacists on the group inputted, in particular, to the following:

- Through literature review, the drug effectiveness summary that reviewed data on expected effect of various medicine strategies, especially those commonly prescribed in patients with multiple co-morbidity.
- Again, through literature review, determining which medicines are more commonly associated with admission due to an adverse drug reaction.
- Determining high risk drug groups and drug combinations.
- Developing a "Medicines Review" information leaflet for patients.
- Informing the development of a computer tool which is used, in GP practices, to identify priority patients for review, records the reason(s) and outcomes of reviews and allows for data to be extracted for analysis.
- Analysis of the data from reviews to determine statistics such as medicines most commonly stopped, reasons for stopping medicines, etc.
- Supporting the consultant physicians in promoting the guidance to prescribers in primary care, mostly GPs, and providing education on implementation of the guidance.

Some GP practices in NHS Highland involved prescribing support pharmacists in the practical application of the guidance in areas such as:

- conducting a polypharmacy review of the patient's medical notes in accordance with the guidance,
- identifying if medicines had current and valid clinical indications,
- identifying high risk drug combination in individual patients,
- determining whether the desired clinical outcome from the medicine was unlikely to be achieved within a reasonable estimate of the patient's life expectancy.

As well as making recommendations from these reviews to the patient's GPs for the GP to then discuss and agree changes with the patient or their carer; in some instances the prescribing support pharmacist, following prior discussion with the patient's GP, would themselves discuss and agree with the patient or their carer changes to be made to the patient's medicines.

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The NHS Highland Polypharmacy Guidance is available at <http://www.nhshighland.scot.nhs.uk/Publications/Pages/PolypharmacyGuidanceforPrescribinginFrailAdults.aspx>

4 NHS GRAMPIAN PHARMACY TECHNICIAN PROJECT

Moray has gone forward successfully with the initiative of a Pharmacy Technician supporting Care Homes. The technician was employed on a 'spend to save' initiative and successfully had an impact quite quickly, working with the care homes to look at ordering processes, storage, waste management.

Progress Report on Pharmacy Technician Project Aberdeen City 2010

A full time technician began work in June 2007 with a number of Care Homes across the city. Work began with ten care homes with detailed recordings of the reduction in waste and to identify the key issues that caused waste.

The priority was to develop and improve systems within care homes to ensure cost-efficient ordering, storage and use of drugs to reduce unnecessary waste. This was supported by the development of a Community Healthcare Partnership Resource Pack, containing practical advice on best practice in addition to legal advice and additional guidance and training for staff. The resource pack has now been provided to all care homes in the city and is also available electronically on request. This has ensured consistent advice is given and has raised standards particularly in relation to ordering and checking of prescriptions and the storage of medicines.

Currently all 33 care homes in the city, which includes care homes with nursing and residential care, have a nominated technician. The care homes are visited at either two or three monthly intervals, depending on standards of stock management. The visits are structured and involve a review the Medicines Administration Recording (MAR) Charts as well as checking on storage areas and stock levels.

The technicians now work closely with the all the practice pharmacists and regularly feedback clinical queries or suggest reviews. When reviewing the MAR charts the technicians have been able to identify a number of issues such as medicines which should have been stopped, use of similar products for the same treatment, covert administration, etc.

"As directed" is not acceptable and if a prescription is prescribed for "when required" use, the technicians will aim to ensure this is also as explicit as possible. Any queries identified are passed directly to the practice pharmacist for them to discuss and review with the GP. Practice pharmacists are now visiting care homes at least annually. The practices pharmacist role is to undertake a medication review and check that all required monitoring is undertaken.

The technicians have worked individually with care homes to resolve issues identified by the Care Commission and they also produce a newsletter as a means of providing regular updates with hints and tips that will improve medicines management. The technicians provide advice, training and support in order to raise standards to ensure good medicines management systems are in place. Good communication is essential. One has also developed an order form for dressings which only lists those dressings in the Health Board Dressings Formulary.

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5 NHS GREATER GLASGOW AND CLYDE PHARMACIST LED MEDICATION REVIEWS IN CARE HOME RESIDENTS

Introduction

Reports by the Care Commission¹ and the Department of Health, Care Home Use of Medicines Study² published in 2009 highlighted deficiencies in the provision of pharmaceutical care to care home residents.

- The Care Commission reported little evidence of medication reviews by GPs or pharmacists. It recommended that Health Boards should consider introducing regular visits and support from pharmacists to improve knowledge of medication management
- The Care Home Use of Medicine Study recommended that pharmacists should regularly review residents and their medication (six monthly) and that they should also rationalise regimes to help home staff work more safely. Through this, pharmacists should identify and reduce the number of dispensing and administration errors.

The National Audit Office has estimated that wasted medicines costs NHS GGC approximately £24 million per annum.³ Alongside the launch of the NHS GGC 'Don't waste medicines' campaign it was decided that pharmacist led medication reviews should be carried out for care home residents to determine the impact on both their clinical care and prescription expenditure.

Aims

- To undertake medication reviews for residents to reduce the risk of medication errors.
- To offer care home staff a training session on medicines management processes
- To identify and reduce inappropriate or excessive prescribing in care home residents

Methodology

Within East Glasgow CHCP, most care homes which provide nursing care, have medical services provided by the specialist Nursing Home Medical Practice (NHMP) for some or all of their residents. One 65 bed care home providing nursing care has no patients registered with the NHMP and so would potentially benefit most from clinical pharmacist input.

The care home residents and the sixteen GP practices providing medical services to its residents were approached for consent to undertake medication reviews by three clinical pharmacists working as part of the GP practice teams. A medication history was taken from the patient's clinical records at the practice, prior to a face to face medication review at the care home. Many of the residents had dementia and no residents self administered their medicines, so after gaining consent, face to face reviews were carried out with the senior carer or senior nurse.

A pharmaceutical care plan was formulated and passed to the resident's GP to consider. Agreed changes to medication were generally implemented by the reviewing pharmacist. Requirements for follow up were recorded in the clinical notes and a copy of the completed care plan was filed in the patient record. The care home received the original signed care plan (to be filed in the resident's personal care plan) and a summary of medication changes (to be filed with the MAR chart). The community pharmacy supplier was also given a copy of the summary of medication changes.

Results

59 medication reviews were undertaken over 3 months identifying 367 interventions, ranging from 0 to 16 per resident, averaging 6.33 interventions per patient. Interventions were categorised as follows:

CATEGORY OF INTERVENTION	NUMBER OF INTERVENTIONS
Medication stopped	83
Medication started	49
Directions changed or clarified	74
MAR chart amendments	27
Quantities aligned to 28 day supply	68
Therapeutic monitoring required	41
Advice given	12
Referral to other healthcare professional	15

Potential cost savings were calculated as an average of £324 per resident per annum. This ranged in residents from increased costs of £343 per annum to cost savings of £4298 per annum. From the table above it can be seen that a significant number of prescriptions required alignment of quantities to a 28 day cycle. Previously prescriptions quantities provided 56 day supply of medicine but scripts were being re-ordered every 28 days.

Discussion

The high number of GP practices providing medical services had resulted in difficulties in establishing good working relationships. Their previous Care Inspectorate report had identified that there was a high turnover of care staff working in the home, making it difficult to have consistency when dealing with medicine management. The home has now nominated the deputy manager as being responsible for prescription ordering.

A training session to promote safe, appropriate and cost effective use of medicines was delivered on two separate occasions to care home staff. This was to promote good practice in the process of ordering prescriptions, recording and administration of medicines, safe disposal of medicines and also to raise awareness of GGC formulary choices for medicines and dressings.

A key part of the pharmacist role during the medication reviews was to identify ambiguous prescription directions. Clarifying directions often related to creams and 'when required' medicines to explicitly state where or when they had to be used in line with guidance from the Nursing & Midwifery Council⁴. MAR chart amendments were generally implemented where the care home staff had not advised the community pharmacy of obsolete items on the MAR chart. Better communication with the community pharmacy has resulted in reduced potential for medication errors.

A recurring intervention was a request for residents to be re-referred to mental health services. Often residents started on anticholinesterases for dementia or antipsychotic drugs in their own homes were no longer seen by specialist services once they moved in to a care home setting. Suggestions to review prescribing of these drugs accounted for 44% of all referrals. Referral for dietetic input was the second most common referral request (25%).

Another recurring intervention was a request for blood monitoring which was often not undertaken in a timely manner or not undertaken because district nurses were unable to visit or nurses were unable to obtain a blood sample from the resident. In other instances information on pulse or blood pressure readings taken by care home nurses was not communicated to the GP practice. This type of intervention proved to be the most difficult to implement as it required input from a greater number of other healthcare professionals.

Conclusion

The provision of pharmacist led medication reviews in this care home reduced the potential for drug therapy problems and reduced inappropriate prescribing. The lack of structured medicine management procedures within the care home was being addressed at the time the medication reviews were undertaken and it is hoped that having better procedures in place will ensure that both patient safety remains paramount and potential cost savings are realised.

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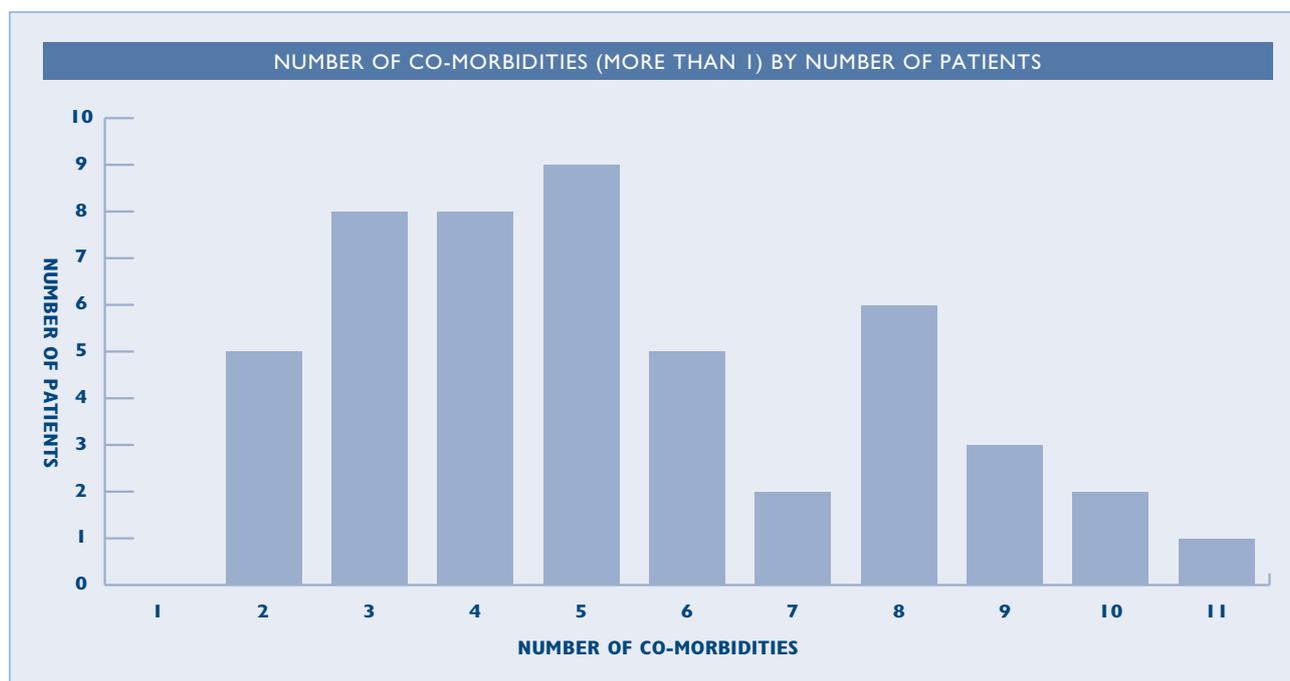
Contact Noreen Downes Lead Clinical Pharmacist for Prescribing Development - Care Homes at noreen.downes@nhs.net for more information.

6 NHS Lothian: Management of Patients with Long Term Conditions with Recent Admission to Hospital or at Risk of Admission

Introduction

In the city of Edinburgh, when patients with long-term conditions were discharged from hospital or at risk of admission to hospital, they were assigned a nurse case manager to co-ordinate care. As part of this a pilot was set up to ensure that all these patients had a level 3 medication review with a pharmacist. The reviews took place at the persons home as they were housebound. Outcomes from the reviews were fed back to the persons GP and the clinical nurse case manager:

The patients suffered from multiple co-morbidities and this is illustrated below.



Research has shown that patients on multiple medications are more likely to suffer drug side effects and that this is more related to the number of co-morbidities a patient has than age (Zhang et al. 2009). There has been a steady increase in the number of patients admitted to hospital with drug related side effects (Pirmohamed et al. 2004) and these are twice as likely to be admitted with another (Zhang et al. 2009).

Methodology

All patients that were referred to the IMPACT team were then referred to the pharmacist for a medication review. All relevant clinical data was accessed from the patients GP. The outcomes of the review were fed back to the GP and the clinical nurse case manager. The outcomes were then categorised into pharmaceutical care issues. The impact of the assessments was then evaluated

using the Patients safety risk assessment tool to assess the risk of admission to hospital. These assessments were then peer assessed by a geriatrician.

Results The outcomes are shown in the table below:

TYPES OF INTERVENTIONS	TOTAL NUMBER RECORDED
Unnecessary drug therapy	48
Need for additional drug therapy	38
Ineffective drug	29
Dosage too low	18
Adverse drug reaction	33
Dosage too high	29
Inappropriate compliance	52
Interactions	12
Disposal of medicines	5
Monitoring	77
Unclassified	12

The intervention risk assessment showed that 40% of admissions were avoided due to interventions made. The categorisations of the interventions are shown below:

INTERVENTION RISK ASSESSMENT	
CONSEQUENCE SCORE	NUMBER OF PATIENTS
Low - Resolved at point of contact eg. compliance issues.	5 (6%)
Moderate - Contact needed with prescriber eg. change in prescription by GP.	41 (50%)
High - Requiring hospital admission eg risk of falls.	34 (42%)
Very high - Hospital admission & permanent consequences eg death.	2 (2%)

Ongoing provision

Based on the outcomes of the reviews, Edinburgh CHP extended the service for a further 12 months. 4 community pharmacists were trained to provide these reviews across the city with support from clinical pharmacists in the managed service. Beyond the 12 months the service provision has been secured for a

further two years due to successful outcome from Change Fund until 2014.

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7 NHS Lothian Pharmacist Led Polypharmacy Reviews with Anticipatory Care Plans

Background:

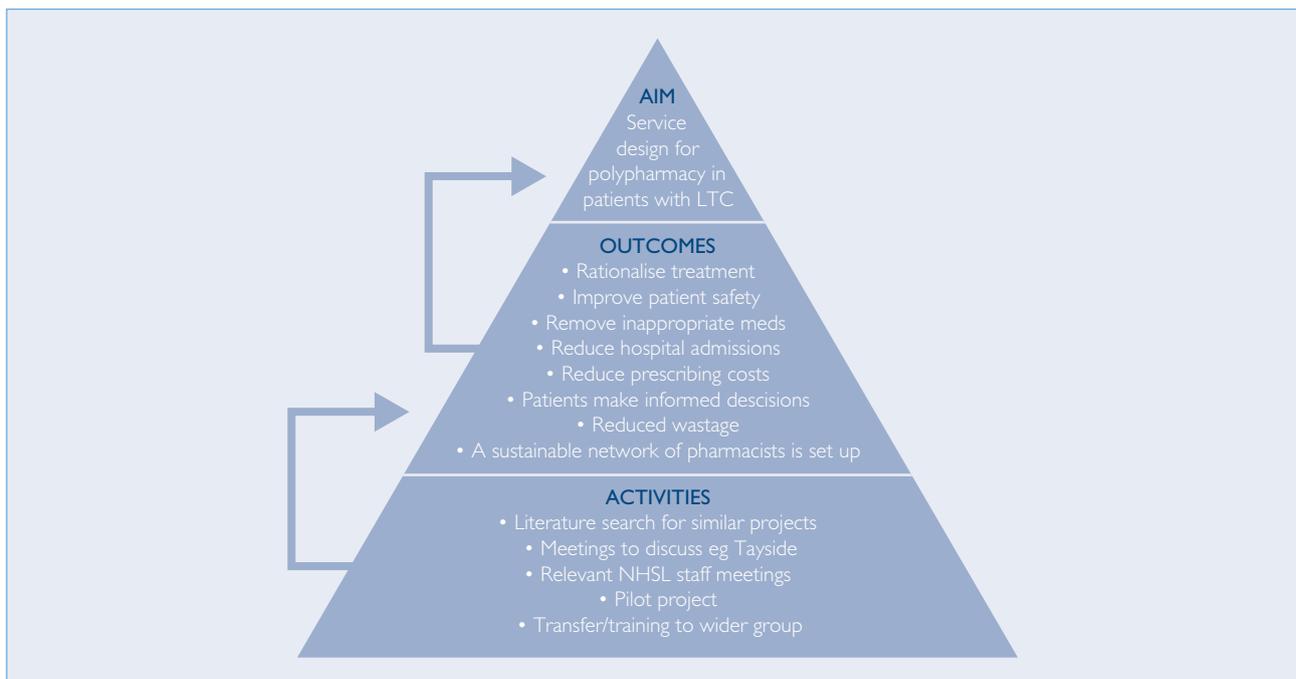
A long-term strategy is needed to address the pressures that the prescribing budget will face as we care for more patients with long term conditions. By maximising pharmaceutical care to patients with long-term conditions, rationalizing the treatment and reducing hospital admissions from multiple medications, the

Quality strategy is applied by providing improved safety and a reduction number of hospital admissions and so address HEAT targets for NHS Lothian. The aim of the project was to design a sustainable polypharmacy review for patients in NHS Lothian as a pilot and then extend this to other practices in Lothian.

Methodology

Using the Highland Polypharmacy guidelines, level 3 medication reviews were undertaken for patients in two nursing homes. 46 patients were reviewed by the pharmacist then reviews discussed with the GP, nurse at the nursing home. Any outcomes of the review were discussed with the patient or carer by the GP. The anticipatory care plans were used to get information regarding the frailty and relevant care issues for the patient. The reviews were peer reviewed with other GPs and a geriatrician.

In depth interviews have also been undertaken with GP's and care staff and ethics has been approved, so that interviews will also be undertaken with the patients that had the reviews or their family or carers.



Results from Pilot so far

- No of patients reviewed: 46
- No of medicines stopped: 92
- Number of high risk medications stopped: 61
- Number of high risk medications reduced: 40

Pharmacoeconomic evaluation of the interventions is still to be undertaken, as have the evaluation from the in depth interviews.

Roll out of the service across NHSL:

The proposal for the service across is shown below:

PROPOSAL	
PATIENTS NOT IN CARE HOMES	PATIENTS IN CARE HOMES
GP's to jointly review patients on >10 meds.	Covered by LES- review with Pharmacist..
75 years or more..	Pharmacist resource to peer review med reviews.
Prioritise on HRM and housebound.	Tie in with ACP.
Payment to GP/Pharmacist resource.	

The guidance document has been adapted using information in the Tayside Polypharmacy Guidance and The pilot has been extended to all practices across Lothian and 57 are participating in the reviews.

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8 NHS LOTHIAN SPECIALIST DEMENTIA PHARMACIST

NHS Lothian has employed a pharmacist focusing on the pharmaceutical needs specifically for patients with dementia for a number of years. Initially the post was based within a memory clinic, where the pharmacist reviewed patients prescribed acetyl cholinesterase therapy and was involved in the assessment of the benefit to treatment.

As time has evolved the role of the post has also developed. The pharmacist now works closely with the Dementia Coordinators and consultants offering pharmaceutical care for this patient group in the community.

The pharmacist provides medication reviews with expert advice for patients with dementia looking at medication prescribed for all the patient's co-morbidities in addition to those prescribed for dementia. Thus, allowing the patient to receive a medication regimen that achieves reduced drug toxicity, identifying any unmet needs during the review and ultimately improved concordance which can reduce admission to other care settings.

The pharmacist works closely with Dementia Coordinators looking at early diagnosis of patients. The pharmacist provides post diagnostic support by giving group talks to patients and informal carers on medication, allowing a greater understanding of prescribed and non prescribed medicines to be gained. Education is also supplied to other health care professionals and formal carers.

The pharmacist is looking to increase engagement with community pharmacists by developing an educational tool to support the early detection of dementia. This is further enhanced by providing education on medication use, particularly focusing on antipsychotic use, for patients with dementia in care homes.

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9 PRIMARY CARE LEADS VIEWS ON THE WAY FORWARD.

In April 2011, primary care pharmacy leads for all HS Boards were asked to provide a summary of the services provided by community pharmacies and NHS managed services to care homes. The summary is available on request.

NHS Board Primary Care leads would like to see a proactive service based on:

- A national standard service level specification for care home support and advice to include the safe handling and storage of medicines.
- A national enhanced service level specification for pharmaceutical care to care homes to include medication review and pharmaceutical care planning.
- A national standard service level specification for support to domiciliary carers.
- The same level of input available to all care homes. Capacity issues mean that managed service and community pharmacy need to be involved.
- National standardised training and skill set for carers to administer medicines from original packs.
- Standard documentation (NHS Scotland Standards Checklist).
- Accredited training programmes for care home staff key areas e.g. wound care, pressure ulcers, nutrition, syringe drivers.
- Community Pharmacy able to access complete medication, diagnosis and monitoring record.
- Enablement person centred approach e.g. self medication programmes, counselling.

The service specification and remuneration should take account of:

- Care home type.
- Workload.
- Number of visits.
- Pharmacist and technician roles.
- Clinical focus – define levels of medication review based on information available.
- Procedures, storage, stock control and ordering.
- National training and competency framework.
- Consent, confidentiality and legal aspects.
- Production and review of MAR sheets.
- Referral / Liaison with others e.g. GP, district nurses, Care Inspectorate c/f unscheduled care scheme.



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