PHARMACY MAGAZINE CPD MODULE
REFLECT
PLAN
ACT
EVALUATE

module 246

pharmacymagazine.co.uk

Welcome to the two hundred and forty sixth module in the *Pharmacy Magazine* Continuing Professional Development Programme, which looks at medicines optimisation in care homes.

Journal-based educational programmes are an important means of keeping up to date with your clinical and professional knowledge. Completion of this module will contribute to the nine pieces of CPD that must currently be recorded a year.

Before reading this module, test your existing understanding of the subject by completing the pre-test at **www.pharmacymagazine.co.uk**. Then, after studying the module in the magazine or online, work through the learning scenarios and post-test on the website to check your answers. Record your learning using your personal *Pharmacy Magazine* online log.

The RPS Faculty and advancing your professional development

Pharmacy Magazine's CPD programme can form part of your professional development providing you with essential knowledge and skills. It can also be considered alongside other activities for inclusion in your RPS Faculty portfolio.

The RPS Faculty is a professional recognition programme for all pharmacists in all sectors at all stages of their career and involves assessment of a practice-based portfolio that recognises their professional development.

This allows you to demonstrate to others your level of attainment and stage of advanced practice. It also helps you to identify what you need to know at different stages of your career. Start your Faculty journey by accessing the portfolio and tools at **www.rpharms.com/Faculty**.

forthismodule

GOAL

To provide an update on medicines optimisation issues in care homes.

OBJECTIVES

After studying this module you should be able to:

- Produce an action plan to improve medicines optimisation for patients in care homes
- Explain how MURs and the NMS can help care home residents
- Identify key health and social care practitioners locally who are also involved in care homes.

First in professional development pharmacy magazine

the continuing professional development programme

CPD

Working in association with ROYAL PHARMACEUTICAL SOCIETY FACULTY

This module is suitable for use by community pharmacists as part of their continuing professional development. After reading this module in the magazine or online, complete the scenarios and post-test at **www.pharmacymagazine.co.uk** and include in your personal learning log. CPD is one aspect of professional development and can be considered alongside other activities for inclusion in your **RPS Faculty portfolio.**

Medicines optimisation in care homes

Contributing author: Lelly Oboh FRPharmS, consultant pharmacist, care of older people

Introduction

There are more than 18,000 care homes providing care to approximately 460,000 adults and older people in England.[1] The Care Standards Act 2000 defines a care home as: "Any home which provides accommodation together with nursing or personal care for any person who is or has been ill (including mental disorder), is disabled or infirm, or who has a past or present dependence on drugs or alcohol."[2]

There are two types of care home for adults based on their registration with the Care Quality Commission (CQC):

- Care homes without nursing provide personal care only (e.g. help with washing, dressing, eating and giving medicines)
- Care homes with nursing provide personal care but also have a qualified nurse on duty 24 hours a day to carry out nursing tasks.[3]

Generally, residents have complex social and/or healthcare needs because of their multiple long-term conditions and reduced functionality. Ninety-five per cent of care home residents are 65 years and over[4] and the commonest conditions found in care homes are dementia, stroke, degenerative neurological conditions, advanced cardio-respiratory disease, cancer and painful arthritis.[5] Many residents therefore require multiple medicines to manage their conditions.

Best practice guidance

Historically, regulation, guidance and national standards focused on care homes having policies and procedures in place to ensure safe medicines management. More recently, the emphasis has shifted to medicines optimisation, which takes into account the patient's values, perception and experience of taking medicines.

CQC fundamental standards

The CQC, as the regulator of all health and adult social care service providers in England, registers, monitors, inspects and regulates care homes that meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fundamental Standards (standards below which care must never fall)[6] and has powers to impose sanctions if providers fail to meet the standards.

Guidance on the management of medicines is laid out in Regulation 12 (Safe Care and Treatment) to prevent people from receiving unsafe care and treatment, as well as to prevent avoidable harm or risk of harm. The CQC produces regular publications to show how providers are performing against standards and they consistently show that management of medicines remains a challenge (see Table 1).

NICE guidance

NICE makes 17 recommendations in its guidance on managing medicines in care homes (SC1) 2014 (see Table 2) to ensure good systems and processes are in place. The recommendations are underpinned by three principles:

- Patients' individual needs and preferences are taken into account and they are supported to self-administer as the norm unless a risk assessment indicates otherwise (patient-centred)
- Patients (and others who they choose) are given the opportunity to make informed decisions about taking medicines (involvement)
- Patients are safeguarded against any harms, abuse or neglect relating to the use of medicines.

The NICE quality standards (NQS85) were derived from the NICE SC1 guidance and incorporate concise prioritised statements aimed at improving patient safety, patient experience and clinical effectiveness.[10] The quality statements (QS) are cross-referenced in Table 2.

Table 1: Care Quality Commission guidance and findings

CQC guidance on medicines management	Example of issues identified from CQC inspections and other reports[7-10]
The risks to residents taking medicines should be assessed and reviewed regularly, then reasonable practical steps taken to mitigate the risks identified and required adjustments made accordingly	No robust assessments to encourage self-administration and many residents are passive recipients of medicines Staff concerns at the extra demands on them as a result of complex drug treatments and comorbidities and the need for more help with managing medicines
Medication reviews should be part of, and align with, residents' assessments and plans, and undertaken regularly when medication changes	Poor patient engagement and lack of information given to patients and those caring for them
Medicines should be administered accurately and at suitable times	Administration to accommodate schedules and tasks, not patients needs. Insufficient information to take "as required" medicines, delays in administration, overdosing, omissions, wrong dosing, incorrect timing and incorrect crushing of medication Not supervising medicines intake – particularly for residents with dementia
Staff should have the qualifications, competence, skills and experience to undertake relevant medicines-related care	Inadequate staff training
Covert medicines should be given only in the person's best interest and in accordance with the Mental Capacity Act 2005	
Sufficient quantities of medicines available at all times, including during emergencies and during transfer of care, to avoid missed/omitted doses	Medicines running out leading to uncontrolled symptoms
Medicines policies and procedures in line with current legislation and guidance addressing supply and ordering, storage, dispensing, preparation, administration, disposal, recording, and adhered to by all staff	Policies not adhered to; poor storage facilities and medicines stored incorrectly; poor documentation of medicines administered; changes not updated on patient records

Key issues

Age-related physiological changes that affect drug handling, polypharmacy and multiple morbidities increase the risk of adverse drug events (ADEs) and make prescribing in older people challenging. Reduced functionality, frailty and cognitive deficits accompanied by poor eating and drinking add to the challenge. Residents frequently move across care settings and have a higher risk of drug errors and ADEs.

Polypharmacy

Care home residents take an average of eight medicines and the incidence of ADEs increases exponentially with the number of drugs taken. Polypharmacy is also associated with non-adherence, drug-drug interactions, wastage, hospital admissions and increased workload (staff spent 40-50 per cent of their time on medicines related tasks).

The Care Homes' Use of Medicines (CHUM) study found that residents have a 70 per cent

Finding a solution

A patient prescribed Oramorph 20mg/5ml concentrate 5ml six-hourly when required for breakthrough pain often experienced delays in getting her medicines at night-time. This was because two nurses are needed to witness the administration of controlled drugs but there was only one nurse on duty on the floor at night. Advice from the pharmacist to prescribe the non-CD equivalent Oramorph 10mg/5ml resolved the problem.

Table 2: NICE recommendations on managing medicines in care homes

NICE recommendations	Opportunities for community pharmacy
Develop and review policies for safe and effective use of medicines	Ensure they are in line with legislation and best practice
Support informed decision making	Face-to-face consultations and using decision aids
Sharing medicines information (QS2), particularly during transfer of care	Systems in place to receive medicines information post-discharge
Record keeping	
Identifying, reporting, reviewing and learning from incidents	Supporting the development and implementation of audits
Safeguarding	
Accurate medicines list through medicines reconciliation (QS1)	Systems in place to receive medicines information post-discharge
Medication review (QS5) undertaken by multidisciplinary team	MURs and NMS supplementing clinical medication reviews. Appropriate monitoring of patients on riskier drugs and medication reviews[11]
Prescribing	Prescribing audits
Ordering	Effective and efficient ordering processes and repeat dispensing to reduce wastage and delays
Dispensing and supply	
Receipt storage and disposal	
Self-administration (QS3)	Supply and recommend appropriate adjustments and compliance aids
Administration and monitoring (QS4), particularly newly prescribed medicines	Screen and review MAR chart use and accuracy. Better 'spacing out' of medicines doses to ease busy drug rounds, particularly morning doses. Identify high-risk drugs that require monitoring and institute reminder systems
Covert administration (QS6) only after risk assessment, best interest meeting, and according to Mental Health Capacity Act	Give advice on necessity, formulation and stability
Homely remedies	Supply and advice
Training skills and competencies of care home staff	On medicines handling and practical aspects of implementing best practice (e.g. CD regulations, inhaler techniques, crushing medicines)

chance of experiencing a medication error (8.3 per cent prescribing, 9.8 per cent dispensing, 8.4 per cent administration and 4.7 per cent monitoring).[12] Many errors were related to poor communication between the care home, dispensing pharmacy, GP practice and secondary care.

Recent UK publications that provide structured and evidence-based approaches to reducing polypharmacy in frail older people include the STOPP/START screening tool[13], and NHS Wales and NHS Scotland's polypharmacy guidance.[14,15]

The STOPP/START tool lists 80 criteria for stopping potentially inappropriate medicines and 34 criteria to alert doctors to initiate appropriate medicines in older people.

Aside from polypharmacy, patient and drug factors also increase the risks of ADEs (see Table 3). ADEs in older people are usually vague and insidious, often presenting as geriatric syndromes (e.g. falls, urinary incontinence, syncope, confusion and delirium). They can be easily missed and mistaken for a new illness, leading to further prescribing. An ADE should therefore be suspected whenever a new symptom is reported.

Older people are particularly susceptible to anticholinergic effects such as blurred vision, dry mouth, constipation, urinary retention, confusion, cognitive impairment and tachycardia. Many frequently prescribed drugs possess anticholinergic properties. A high anticholinergic burden is associated with higher mortality.[16]

Reflection exercise 1

Go to cqc.org.uk/sites/default/files/new_reports and look at the findings from various CQC inspection reports in care homes that have been asked for remedial action plans to ensure that medicines use is always safe for residents.

- **What advice or interventions can you suggest within the pharmacy contract to support homes to resolve some of the specific issues highlighted?**

Non-adherence

Non-adherence to prescribed medicines can lead to poor outcomes. Improving adherence is particularly important where drug therapy is crucial to:

- Prevent rapid symptomatic decline (e.g. drugs for Parkinson's disease, antiepileptics, diuretics in left ventricular failure)
- Improve functionality or quality of life (e.g. analgesics, long-acting beta-agonists)
- Provide acute symptomatic relief or cure (e.g. short-acting beta-agonists, antibiotics).

The reasons for non-adherence in older people are multifactorial, complex and mostly intentional.[17] The author's experience is that it is relatively common for dementia patients to refuse to take one or more medicines. Patient engagement to explore and resolve the specific reasons for non-adherence is key if the patient's medicines-taking behaviour is to align with the prescriber's instructions.

In collaboration with GPs and the care home, pharmacists can develop a protocol that details what actions to take and specifies a time-frame for notifying the prescriber when medicines are refused, depending on whether the drug is for an acute or chronic condition or a preventative.

You can complete this module online at **pharmacymagazine.co.uk** and record your learning outcomes and the impact on your practice in your **personal learning log**

Table 3: Risk factors for ADEs in older people

Patient factors	Drug factors
· Swallowing difficulties	· Drugs that cause geriatric syndromes (e.g. sedatives, anticholinergics, psychoactive drugs)
· Known non-adherence	· Drugs commonly implicated in hospital admissions (e.g. antiplatelets, insulin, anticoagulants, NSAIDs)
· Recent hospital admission	· Complex dosage or administration schedules
· Previous ADEs	· Drugs with a narrow therapeutic index (e.g. lithium)
· Cognitive impairments	
· Increasing frailty	

Care home residents tend to have little involvement in decisions about prescribing or self-administration, even though this may improve their independence and control. Staff also perceive and express concerns about the practicalities of operating different medicines administration systems, as well as where the responsibilities lie for recording administration, monitoring adherence, safe storage, and risks to individual patients and other residents.

Self-administration of CDs is a real problem. Pharmacists can help with clarifying responsibilities in line with regulations and best practice, developing risk assessment tools and giving advice on monitoring safety, drug suitability, storage, and compliance aids/devices to support self-administration. It might be easier to start with low-risk medicines such as emollients, *prn* inhalers and laxatives.

Pain management

The prevalence of pain is higher in residential settings and it is less well controlled.[18] The assessment of pain in older people and those with cognitive impairment remains a challenge. Sub-optimal dosing and a general reluctance to prescribe potent opiates for fear of respiratory depression and addiction are common, causing significant distress, poor quality of life and depression. Uncontrolled pain can be a major trigger for agitation and aggression in patients with dementia.[1]

Strong opiates like fentanyl and buprenorphine patches are popular with care homes as they reduce administration time, but they have been associated with a high prevalence of errors, which could lead to under-dosing, overdosing and even death. Pharmacists can provide information on selecting the most suitable formulation, titrating doses and calculating equivalent doses when changing drugs or formulations.

For more independent patients (e.g. those with learning disabilities; the under-65s), staff may be reluctant to allow them to self-administer or manage CDs because they are unclear about the regulations for storage, recording and administration. Pharmacists can interpret and clarify governance arrangements so that, following a robust risk assessment, self-administering residents can keep their own CDs. No record of individual drugs taken is required in the CD register except where the care home staff receive or return the patient's CDs.[19]

Falls and fractures

The risk of falls is three times higher in care homes and is a serious problem causing injury, pain, loss of confidence and death. Calcium and vitamin D is a cost-effective intervention that reduces the risk[20] and all residents, with few exceptions, should routinely receive supplementation irrespective of their falls history. Therapeutic doses of 800 units daily are needed to prevent falls, so palatability and formulation acceptance are important to ensure adherence and desired outcomes.

NICE CG161 recommends that those who fall or are at risk of falling should have a multi-factorial falls risk assessment (including medication) followed by a medication review with modification/withdrawal of causative drugs, particularly psychotropics.

Dementia and antipsychotics

A third of people with dementia in the UK live in care homes and 80 per cent of people in care homes have dementia or severe memory problems. Cognitive deficits associated with dementia can lead to non-adherence, with patients having a poor understanding about the need for treatment, leading them to spit out tablets and refuse personal care or interventions such as BP or blood glucose monitoring, or the application of creams, pessaries or drops.

Patients with dementia are more likely to die from the use of antipsychotics that are also associated with pneumonia, falls, sedation, anticholinergic and extrapyramidal effects. Two-thirds of prescribing is inappropriate and 70 per cent of patients will have no worsening of symptoms when antipsychotics are discontinued.[21]

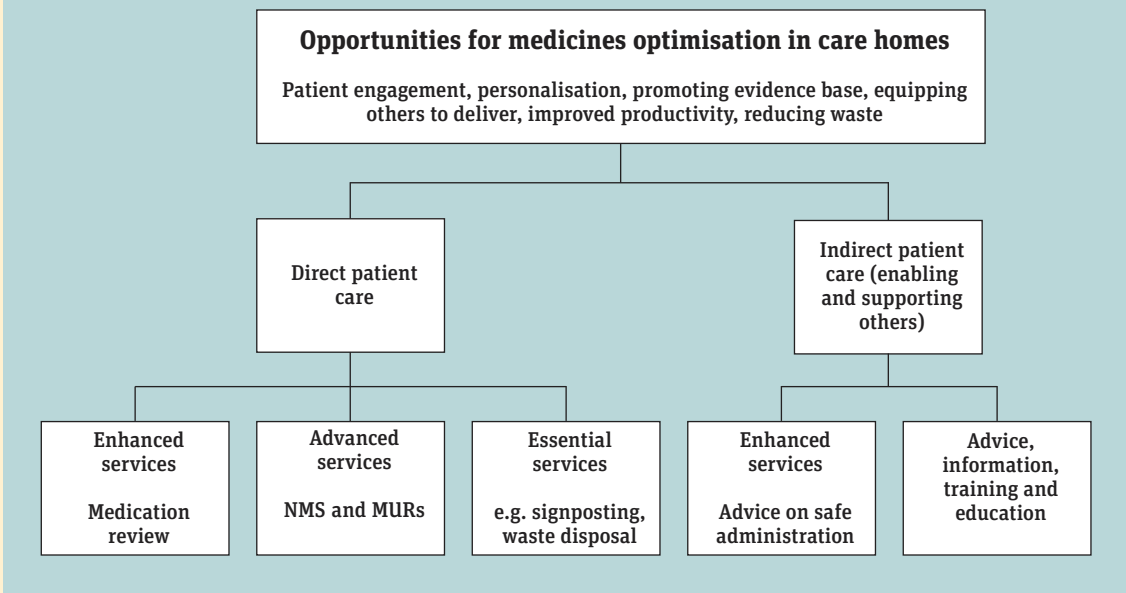
Complex needs versus staff skills

Providing care closer to home and reducing unnecessary hospital admissions, means that people with more complex healthcare needs are now routinely cared for in care homes. Consequently, the use of advanced and specialist pharmaceutical products and techniques that require specialist skills (e.g. intravenous therapies, percutaneous endoscopic gastronomy (PEG) feeding, syringe drivers) have increased.

Many residents rely on others when it comes to taking medicines, so the behaviours and attitudes of both staff and residents can influence adherence – something pharmacists should be aware of.

There is often little dialogue between the patient and prescriber about therapeutic goals (i.e. what the patient hopes to gain from the treatment) when drug therapy is initiated and practitioners often rely on staff to tell them what a patient's experience and response to therapy has been. If staff are unable to recognise and act

Figure 1: Opportunities for medicines optimisation in care homes



promptly when there is an ADE, monitor drug therapy, interpret results and follow the necessary actions, this may lead to poor outcomes.

Actively promoting choice and engaging with cognitively impaired patients or those who lack capacity to consent presents a challenge. In striking the right balance between the patient's choice to refuse medicines and responsibility to treat, staff may resort to disguising medicines in food or drink.

The decision to administer medicines covertly must be undertaken by a multidisciplinary team and guided by the Mental Capacity Act 2008. Even then, staff may face further challenges with regards to the practicalities of crushing tablets and identifying a suitable vehicle. Pharmacists can provide advice on these aspects as well as drug stability.

As prescribers do not routinely check MAR charts, non-adherence may go unnoticed for a while. Pharmacists can check MAR charts or returned medicines to highlight instances of non-adherence.

Patient versus home priorities

There may be conflicts of interest as staff try to balance the practicalities of running the home with patient demands. For example, the prescribing of sip feeds, sedatives or anti-psychotics in dementia, may be driven by the inability to cope with increasing demands on staff time. Time constraints may limit the use of safer non-pharmacological options, while rigid administration schedules may reflect what is convenient for the home rather than the patient's needs.

Such challenges highlight the importance of pharmacists working collaboratively with care homes to deliver medicines optimisation. The 'Handled with Care' report in 2006[22] expressed concerns that "pharmaceutical advice to care homes" is not a basic service provided within the community pharmacy contract, while the 'Quest for Quality' report[5] recommended that future care home service model specifications must involve community pharmacy supporting medication reviews and improving prescribing practice as a key element.

Priority areas for meds optimisation

There are three priority areas for medicines optimisation:

- Polypharmacy; reducing waste
- Reducing the use of antipsychotics in dementia.

Polypharmacy

Successfully reducing polypharmacy in frail older people requires a good understanding of the patient, and the risks and benefits of taking drugs in the context of their overall care goals and experience. Pharmacist-led medication reviews in care homes with nursing have been shown to reduce polypharmacy, ADEs and falls, and save costs. MURs and the NMS engage with patients to optimise medicines use. They can produce useful information and insights that complement medication reviews and assist with prescribing decisions. Patients should be recruited:

- Opportunistically by pharmacists when a need is identified
- Proactively by setting up local systems to receive referrals from care home staff, hospitals, GPs, relatives and other practitioners.

Some service specification requirements for the NMS and MURs may create barriers for care home residents (e.g. obtaining consent or the need to undertake them in the pharmacy). Also, follow-up is not an integral part of a MUR.

Table 4: Top tips for addressing non-adherence

Non-adherence issue	Tip
Specific concerns about medicines	**Generally** · Explore the patient's perceptions · Educate and reassure · Enable and empower to change behaviour as appropriate
Adverse drug effects (actual and perceived) and impact on functionality/quality of life	· Check if ADE fits drug profile · Establish the impact on functionality and quality of life · Suggest alternatives, dose reduction or drug withdrawal as appropriate
Drug ineffectiveness (perceived or actual)	· Ask for subjective/objective evidence · Rule out other reasons · Refer for further assessment or review
Concerns about taking too many drugs or fear of dependence	· Establish patient priorities · Suggest strategies to reduce medication burden, including non-drug options
Lack of information about the medicines and poor engagement at drug initiation	· Explain/clarify treatment goals · Provide tailored information in a suitable format
Cognitive deficits and other mental health disorders	· Explore patient's preferences with those who are familiar · Refer for review; hold best interest meeting
Specific issues · Swallowing difficulties – common post-stroke, advanced dementia, Parkinson's, end-of-life care, motor neuron disease, spinal injury · Chewing difficulties (e.g. ill fitting dentures, loose teeth, dry mouth) · Altered taste/flavour/palatability – altered taste may have a significant impact on food intake · Unsuitable formulation or device and complex dosing schedules · Drug unavailable or not accessible when needed	**Generally** · Establish the extent of the difficulty and impact on medicines taking · Check for medicines-related causes/triggers · Suggest alternative drug, dosing schedule formulation, device · Liaise with or refer to GP/specialists or experts · Liaise with speech and language therapist, dietician for swallowing problems as may be psychological, not physical · Anticholinergic drugs can cause dry mouth · Look out for coping mechanisms to mask undesirable taste · Check inhaler technique · Identify and address poor supply systems

Reflection exercise 2

Familiarise yourself with the STOPP/START tool v2 at http://ageing.oxfordjournals.org/content/early/2014/10/16/ageing.afu145.full.pdf+html.

- **Identify a patient with over seven repeat medicines. What recommendations does the STOPP section make regarding stopping any of the drug(s)?**
- **Reflect on the practicalities of stopping any such drugs and how you would communicate your recommendations to the GP.**

Obtaining consent[23]

Pharmacists must assume that people have the capacity to make their own decisions (competent) and are able to give consent unless there is evidence to suggest otherwise. The fact that a patient is supported to take their medicines does not mean that they haven't got mental capacity. It cannot be assumed that a patient lacks capacity just because of their age, conditions, disability, behaviour or because they make a decision you disagree with.

Practical tips and key steps to delivering the NMS and MURs

Before starting the service

- Introduce yourself and the services to both the GP practice and care home (e.g. by a short presentation at a practice clinical meeting or joint meeting with the lead nurse and GP)
- Discuss how patients would be targeted, the referral/communication processes and clarify expectations

Reflection exercise 3

You are undertaking a MUR for a male patient refusing to take furosemide 40mg tablets for heart failure. His daughter informs you that despite his increasing breathlessness, he is anxious that furosemide will aggravate urinary incontinence.
- **How could you communicate the risks and benefits to the patient to encourage adherence?**

- Realistically, MURs may be easier to start with – identify a couple of patients, engage with GPs and care home staff, test your processes, build confidence and expand
- To facilitate recruitment, set up a notification on your pharmacy PMR to flag up care home patients during dispensing or set up a system where the home notifies you when residents come out of hospital.

Before the consultation
- Seek help to obtain consent. Residents usually have a named nurse/carer who can inform them about your visit and give leaflets and consent forms ahead of time. The GP or relatives can also help
- Printed material should be in a font that is easy to read
- Avoid visiting during protected meal times or other busy periods and ask for a place where no one can overhear your conversation with the patient
- Before the review, familiarise yourself with the medicines to be reviewed
- Patients may mention side-effects you are not familiar with, so have a BNF available.

During the consultation
- Establish a therapeutic relationship and trust with the patient. Start by asking him/her to tell you how they are "getting on" with their medicines rather than asking specific questions. This helps to identify the patient's priorities, goals and expectations. It is important to note that in frail older people, the primarily goal is usually to alleviate symptoms and maintain functionality
- Gather the relevant information. Care home residents vary in how much they want to or can engage with you, so start with open-ended questions and narrow down to specifics with closed questions. Ask about all medicines (including non-prescription). The MAR chart, a named nurse or relative (with consent) are complementary sources of information, as some patients may be unable to fully describe their experiences/adherence
- Where there is an adherence issue with a specific drug, explore its appropriateness using an evidence-based tool like STOPP/START
- Explain the potential consequences of their actions if they are not taking their medicines as intended
- Deliver intervention or refer appropriately to implement actions. Communicate relevant information to GP, nurse or other practitioner (with consent) and make specific suggestions.

After the consultation
- Monitor and follow up
- Feed back learning, share and celebrate successes with practice/care home.

Reflection exercise 4

Your local GP is keen to reduce medicines waste and asks for your help. How could you identify medicines that are being wasted? If you have care home patients, check some of the prescriptions you have dispensed in the past month and make specific suggestions to reduce waste.

Table 5: Top tips to address medicines waste

Issue	Tips
Ordering drugs no longer needed due to poor stock control, repeat prescribing/dispensing processes, and review	· Review processes
Returning unused drugs due to policies requiring drugs to be returned at the end of cycle or due to non-adherence	· Address policy · Provide information on shelf-life for creams and liquids · Identify non-adherent patients and communicate with prescriber
Prescribing excessive quantities of drugs more likely to be wasted: · Short-term treatments (e.g. topical steroids or antibiotic creams/drops, laxatives, antacids, quinine sulphate) · Drugs with pack sizes more or less than 28 days (e.g. insulin, creams, emollients, sip feeds, dressings, stoma appliances) · *Prn* and rescue drugs	· Scrutinise repeat requests · Provide information on reasonable monthly quantities for creams, emollients and drops · Develop a homely remedies list · Suggest bulk prescribing for non-POMs if the GP treats 10 or more patients in the home
Monitored dosage systems create waste as drugs expire after 12 weeks	· Work with the home to allay fears about stopping the use of MDS and implementing change in a structured manner

Reducing waste

The cost of unused prescription medicines in primary care is about £300m a year in England. Robust repeat prescribing systems, repeat dispensing, MURs, the NMS and medication reviews are key areas where pharmacists can work with other practitioners to reduce the waste.[24] In care homes, reducing the use of monitored dosage systems (MDS) and bulk prescribing, and appropriate medication quantities at the end of life are worth targeting.

Reducing antipsychotics in dementia

Antipsychotics should only be used to manage behavioural and psychological symptoms of

Table 6: Health and social care staff involved with medicines

Involvement with medicines	Staff group
Administration, ordering	District nurses (CHC only) Care home nurses Care home managers (CHC only) Senior care workers (CHC only) Palliative care nurses
Prescribing and/or medication review and assessment	GPs, geriatricians, old-age psychiatrists, out-of-hours doctors, hospital prescribers Specialist nurses (e.g. community matrons, older people nurse practitioners, community psychiatric nurses [CPN], palliative care nurses) Primary care pharmacists
Assess need for and recommend nutritional supplements and enteral feeds	Dieticians
Assess need for and recommend stoma, incontinence drugs and appliances	Incontinence advisers and stoma nurses
Pain management, rehabilitation	Physiotherapists/occupational therapists
Assessing and managing swallowing difficulties	Speech and language therapists, dieticians
Wound management and prescribing dressings	Tissue viability nurses District nurses (CHC only)
Management of diabetic foot problems and prescribing	Podiatrists/chiropodists
Prescribing, dispensing and reviewing drugs at discharge	Hospital pharmacists, hospital doctors

dementia as a last resort in severe cases or where there is the risk of harm to the patient or others (NICE CG41).

Patients receiving antipsychotic drugs should be reviewed at least every 12 weeks by their doctor to ensure care is compliant with current best practice and alternatives have been considered. Pharmacists can support care homes and GPs by using the repeat prescribing or dispensing process to identify and refer patients who need to be reviewed.

For patients who can consent, a MUR can provide useful information about the patient's experience of taking antipsychotics to help the GP make an objective decision about the need to continue or stop. Pharmacists can support staff to use ABC* charts to assess and monitor the triggers for challenging behaviour so that it can be averted.

Priority can be given where:

- An antipsychotic has been prescribed for longer than 12 weeks
- Sedation, anticholinergic or extrapyramidal symptoms are present
- Patient displays behavioural and psychological symptoms of dementia in spite of treatment.

Collaborative working

Care home residents need support from various health and social care organisations. General nursing care is provided in-house in care homes with nursing but by district nurses in care homes without nursing. Routine medical care is via a GP and other health needs are met by a range of generalist and specialist practitioners. These practitioners are involved with medicines in diverse capacities and to varying extents (see Table 6).

Individual specialists usually work as part of community health services, hospital trusts outreach, community mental health, care home support and palliative care teams. The commissioning and provision of specialist services varies from locality to locality. Residents also have access to primary healthcare services provided by dentists, pharmacists and opticians, as well as secondary care services. Other practitioners involved may include social workers, psychologists and therapists.

The need for good communication and adequate transfer of information about medicines is highlighted by various publications, such as the RPS transfer of care guide[25], and NICE NG5 and NG27 guidelines.[26,27]

It is important that each practitioner works in partnership with the patient, his/her relatives and the home staff to share and pass on relevant information to minimise risks. GPs would be the main referral contacts for pharmacists. For MURs and the NMS, the patients would have consented to sharing information with GPs, but further consent should be sought if information is to be shared with others, including care home staff.

Reflection exercise 5

While dispensing a script for a care home resident, you realise that Ensure Plus has been requested even though the home has returned most of the nutrition drinks prescribed over the past two months. You undertake a MUR with the patient and discover she is refusing to take it because she chokes on the liquid. What other healthcare professionals should you involve and how would you attempt to solve the problem?

* Antecedents, Behaviour, Consequences

References

1. Care Quality Commission (2008/09). The quality and capacity of adult social care services: an overview of the adult social care market in England
2. Office of the Public Sector Information. Explanatory notes to Care Standards Act 2000. legislation.gov.uk/ukpga/2000/14/notes/division/5/1/1/3
3. housingcare.org/jargon-care-homes-96285.aspx
4. Age UK (2013). Later life in the United Kingdom ageuk.org.uk/Documents/ENGB/Factsheets/Later_Life_UK_ factsheet.pdf?dtrk=true
5. British Geriatric Society (2011). Quest for quality bgs.org.uk/campaigns/carehomes/quest_quality_care_homes.pdf
6. CQC (2015). Guidance for providers on meeting the regulations. cqc.org.uk/sites/default/files/20150324_ guidance_providers_meeting_regulations_01.pdf
7. Market Report Issue 1: June 2012. cqc.org.uk/sites/default/files/media/documents/20120626_cqc_market_ report_issue_1_for_website_final_0.pdf
8. CQC (2015). The state of health care and adult social care in England 2014/15
9. Centre for Policy on Ageing (2013). Managing and administering medication in care homes for older people
10. NICE (2014). Managing medicines in care homes. NICE guideline (SC1)
11. The King's Fund (2013). Polypharmacy and medicines optimisation: making it safe and sound
12. Barber ND, Alldred DP, Raynor DK *et al.* The care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people. Quality and Safety in Health Care 18, 2009, pp.341-6
13. O'Mahoney *et al.* STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. *Age and Ageing* 2014; 0: 1-6 doi: 10.1093/ageing/afu145
14. NHS Wales (2014). Polypharmacy: guidance for prescribing in frail adults
15. NHS Scotland (2015). Polypharmacy guidance
16. Fox C *et al.* Anticholinergic medication use and cognitive impairment in the older population: the medical research council cognitive function and ageing study. *J Am Geriatr Soc.* 2011; 59(8):1477-1483
17. Malhotra S, Karan RS, Pandhi P, Jain S. Drug related medical emergencies in the elderly: role of adverse drug reactions and non compliance. *Postgraduate Medical Journal* 2001; 77:703-707
18. Picker Institute. The Patient Association (2007). Pain in older people: a hidden problem
19. CSCI (2008). Professional Advice: the safe management of controlled drugs in care homes. http://webarchive.nationalarchives.gov.uk/20081219104059/http://www.csci.org.uk/professional/default.aspx?page=7314&key=
20. Cameron ID *et al.* Interventions for preventing falls in older people in nursing care facilities and hospitals. The Cochrane Collaboration 2010
21. Sube Banjeree (2009). The use of antipsychotic medication for people with dementia: time for action report
22. CSCI (2006). Handled with care: managing medication for care homes and childrens homes, a follow-up study. elderabuse.org.uk/Documents/Other per cent20Orgs/CSCI per cent20Report per cent20-per cent20Medication.pdf
23. General Pharmaceutical Council (2012). Guidance on consent
24. DH (2012). Action plan for improving the use of medicines and reducing waste
25. Royal Pharmaceutical Society. Keeping patients safe when they transfer between care providers – getting the medicines right. Good practice guidance for healthcare professions. 2011. rpharms.com/current-campaigns-pdfs/1303---rps---transfer-of-care-10pp-professional-guidance---final-final.pdf
26. NICE (2015). Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline (NG5)
27. NICE (2015). Transition between inpatient hospital settings and community or care home settings for adults with social care needs. NICE guideline (NG27)

This module is also online at pharmacymagazine.co.uk

Pharmacy Magazine's CPD modules are available on Cegedim Rx's PMR systems, Pharmacy Manager and Nexphase. Just click on the 'Professional Information & Articles' button within Pharmacy KnowledgeBase and search by therapy area. Please call the Cegedim Rx helpdesk on 0844 630 2002 for further information.

MEDICINES OPTIMISATION IN CARE HOMES

assessment questions

1. Which is NOT the focus of medicines optimisation?
a. Ensuring medicines use is as safe as possible
b. The patient's experiences and preferences
c. Prescribing evidence-based medicines
d. Focusing on processes and systems

2. Which statement is FALSE?
a. A third of the UK's dementia sufferers live in care homes
b. Only nursing staff are allowed to administer any medicines in care homes without nursing
c. 95 per cent of people living in care homes are older people
d. The CQC can impose sanctions on homes failing to deliver fundamental standards of care

3. Which statement is FALSE regarding ADEs?
a. The risk increases with number of drugs taken
b. Age-related physiological changes affect drug handling
c. Multiple morbidities, frailty and cognitive impairment have little effect
d. Anticholinergics contribute to the higher risk of ADEs

4. Which is statement is FALSE regarding falls?
a. Calcium & vitamin D supplementation is a cost-effective intervention to prevent falls
b. Palatability and formulation acceptance are important aspects to promote adherence
c. Calcichew D3 tablets (one, twice daily) can help prevent falls in older people
d. Polypharmacy is a risk factor

5. The CHUM study found that the chance of experiencing a medication error in a care home is:
a. 50 per cent
b. 60 per cent
c. 65 per cent
d. 70 per cent

6. Which statement is TRUE?
a. Drugs prescribed for short-term treatments are less likely to be wasted in care homes
b. Unused creams must be disposed of at the end of every month
c. CDs for a self-administering patient must be stored in the care home CD cupboard
d. Developing a homely remedies list can help reduce medicines waste in care homes

7. Which of these statements is FALSE about MURs?
a. Only residents who self-administer their medicines will benefit from a MUR
b. MURs address issues relating to the patient's medicines-taking behaviours
c. Patients with dementia may have capacity to engage in the MUR process
d. MURs can provide useful information for medication reviews when integrated into patient care pathways

8. What percentage of patients would have no worsening of symptoms if antipsychotics were discontinued?
a. 50 per cent
b. 60 per cent
c. 65 per cent
d. 70 per cent

Pharmacy Magazine CPD record

CPD April 2016

Use this form to record your learning and action points from this module on **Medicines optimisation in care homes** or record on your personal learning log at pharmacymagazine.co.uk. You must be registered on the site to do this. Any training, learning or development activities that you undertake for CPD can also be recorded as evidence as part of your RPS Faculty practice-based portfolio when preparing for Faculty membership. So start your RPS Faculty journey today by accessing the portfolio and tools at www.rpharms.com/Faculty.

Activity completed. (Describe what you did to increase your learning. Be specific)
(ACT)

Date: Time taken to complete activity:

What did I learn that was new in terms of developing my skills, knowledge and behaviours? Have my learning objectives been met?*
(EVALUATE)

How have I put this into practice? (Give an example of how you applied your learning). Why did it benefit my practice? (How did your learning affect outcomes?)
(EVALUATE)

Do I need to learn anything else in this area? (List your learning action points. How do you intend to meet these action points?)
(REFLECT & PLAN)

You can also record in your personal learning log at pharmacymagazine.co.uk

*** If as a result of completing your evaluation you have identified another new learning objective, start a new cycle. This will enable you to start at Reflect and then go on to Plan, Act and Evaluate. This form can be photocopied to avoid having to cut this page out of the module. You can also complete the module at www.pharmacymagazine.co.uk and record on your personal learning log**