

## PHARMACY AND CARE HOMES

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## ABOUT THE AUTHOR

Jo Webber was employed within the NHS for over 35 years initially as a nurse and, later, as a senior health service manager. Following this, she worked in the area of health and social care policy, specializing in a range of topics, including health and social care integration and improving care for older people. She has a passion for improving the quality, safety and effectiveness of health services and has seen, through personal as well as professional experience, how involving and effectively coordinating a wide range of expertise can improve the care of people living in residential homes.

This report was commissioned by the General Pharmaceutical Council to inform and support a wider understanding of the issues around the use of medicines in care homes. It is not the Council's intention to set out for itself a role in care home regulation, which is not within its remit, but to contribute to a broad conversation about the issues raised and the action required to improve the situation of some of the most vulnerable members of society, those unable through ill health and/or personal choice and circumstances to live in their own homes.

## EXECUTIVE SUMMARY

While much has been done to improve community based care options, particularly for adults with mental health and learning disabilities, residential care is still a vital part of the support required for some of the most vulnerable children, younger adults and the elderly in society. Care homes exist in almost every part of the United Kingdom, usually specialising in the care of a single age group, children, younger and working age adults and older people. They vary in the services they provide from secure care for vulnerable children to sheltered care for those with learning disabilities and nursing care for the elderly with dementia or multiple long term conditions. Most care homes are privately owned and run although council run homes still exist in some regions and for some resident groups. However, one thing that they do have in common is a need to safely handle, administer and monitor medicines in any form, both prescribed and of a more homely nature. The role of pharmacy professionals and community pharmacies is therefore an important one for ensuring the safety and general health and wellbeing of residents receiving medication across all age ranges.

From national inspection reports and from a range of studies published over the past 6 years, there are clear concerns about current practice in the supplying, dispensing, administering and monitoring of medicines in care home environments. It is therefore timely that, consideration be given to what could be done to improve practice in this area.

The population of the United Kingdom is ageing with average life expectancy rising by just over ten years since 1960. Alongside this has been the rise in long term conditions for which sufferers may require complex medication regimes and which may require continuous medical monitoring. With the elderly, in particular, the increase in life expectancy has been associated, over time, with a shift from the provision of residential to nursing care beds as care needs and, in some cases, the complexity of treatment regimes rise. Reports have suggested that rates of dementia among elderly care home residents are high, being seen in as many as 80 per cent of individuals, and safety concerns for these residents, in particular, add to the complexity of processes which need to be in place if safe and effective medicines management is to be achieved in all care homes across the four countries of the UK.

It is estimated that, at present, approximately 426,000 beds in residential care settings exist for older people in Great Britain, with residents taking, on average, between seven and eight medications daily. For children, a similar estimate would be 13,800 places although occupancy rates for these homes are less clear. There are no accurate figures for the number of pharmacies contributing to the care of these individuals but estimates have put it in the region of 1.4 pharmacies per care home. The range of activity that pharmacy professionals and community pharmacies may undertake is also variable, from national services set out in the pharmacy contracts in England, Scotland and Wales to an increasing number of locally negotiated services.

However, the issues to be addressed remain the same. These were outlined by the National Institute for Health and Care Excellence in its guideline and recent set of quality standards on medication safety in care homes and are part of routine inspections by the three national inspectorates in their basic standards and thematic reviews.

Much also has been written on the problems which surround safe medicines management in care homes, particularly in homes for the elderly. Errors have been characterised as effecting areas of prescribing, dispensing, administration and monitoring with, in one study of older people's residential care homes, over 50 per cent of residents exposed to serious error. The literature searched for this report highlights three key areas where issues need to be addressed if error rates are to be reduced: in local systems; in individual homes; and in prescribing, dispensing, administration or monitoring for individual residents.

Systems issues may arise when local communications are not joined up so that there is poor information sharing between GP, care home, hospital and pharmacy, particularly when the resident is moved from one part of the local system to another e.g. from hospital to care home. This may be compounded when there are several GP practices or community pharmacies involved with a single care home or where the resident, their families and carers are not fully involved in decision making or information sharing. A lack of local leadership can reduce effectiveness in developing and sustaining consistent and coherent medicines management processes across local health and care organizations and ensuring the availability of expert advice as and when required. Such advice, particularly when given by a pharmacy professional, has been shown to reduce medication errors in local care homes. A lack of coordinated local training systems can also mean that organizational inadequacies in medicines management have a low profile and, in particular, shortfalls in medicines knowledge for care home staff are not rectified quickly to ensure effective improvements in handling and administration.

Issues relating to individual care homes include poor care planning processes with a lack of regular review and poor risk assessment, particularly at times of transition for individual residents between care environments. Home procedures can also add to risk e.g. medicines administered in the mornings are subject to more error than those given later in the day and a poor environment with high noise levels, clutter and poor lighting gives a greater potential for error. Much has been written about the use of Monitored Dosage Systems (MDS) which have been advocated as standardizing processes across a home and saving precious staff time. However, as well as the problems of accuracy in filling MDS, potential interactions between medicines packed together and poor storage characteristics, 40 per cent of medicines are not suitable for MDS and it has been found that errors can be more frequent with medicines used alongside MDS such as eye drops, inhalers and liquid medicines. Individual care home procedures for ordering, checking and recording medication are also central to ensuring accurate administration. Alongside this is the need for accurate processes to deal with the use of over the counter and homely medicines, including herbal and homeopathic preparations, to reduce potential adverse reactions and interactions with prescribed medication.

Finally, there are a group of issues around the needs of individual residents and the administration of medicines on a personal basis. There have been recent calls for assurances that anticipatory medicines are equally available to residents of care homes as they would be to people in their own homes, particularly at the end of life. Ensuring that "as required" medication is administered when needed and recorded and monitored well is important in reducing errors and meeting the personal needs of residents. Issues of capacity need to be addressed when considering the covert administration of medication. Similarly, self-medication, where possible, has been shown to reduce errors but this requires careful consideration of storage requirements, personal capacity where this could be fluctuating, and the routine assessment of technique if inhalers or drops are being used. Assessment of technique for staff giving medication, particularly drops or inhalers is equally

important, as studies have shown that for example between a third and half of those using inhalers may have incorrect or inadequate techniques. Lastly, given the number of medications which may be administered to an individual, gauging whether every medicine is appropriate or could be problematic needs to be a part of regular assessment and review as does the use of antipsychotic drugs in elderly confused residents.

The pharmacy professionals' role in all of these areas is one that could benefit from further discussion. This is particularly important given the increasing prominence of pharmacy as the health and social care landscape evolves and new services come online in all three countries of Great Britain. Considering the implications of the evidence outlined above for professional practice will involve taking into account legislation including the Human Rights Act (1998), the Mental Capacity Act (2005), the Adults with Incapacity (Scotland) Act (2000), national policies and guidance covering areas such as safeguarding practice and considering the application of the Duty of Candour to community pharmacies and pharmacy professionals. Recent reports have highlighted the development of home care services, the potential for community pharmacy networks and direct contracting between care homes and groups of pharmacy providers. It will therefore be important to consider what pharmacy professionals providing services in three different ways might do to change the number and type of errors found in care home environments; those providing services through the national contract, those providing locally commissioned services and those contracting directly with care homes, either individually or in clusters.

## INTRODUCTION

The population of the United Kingdom is changing with average life expectancy rising by just over ten years since 1960<sup>1</sup>. The number of frail elderly people living in residential and nursing care homes has also increased over the past ten years as the demographic profile of the UK changes. Although the number living in residential care settings has now stabilised and, indeed, has been starting to decrease, the number of those with more complex medical and nursing needs, many of which require regular and multiple medications, is growing. This is a challenge for traditional community pharmacy services and there is no lack of data about the potential issues arising from the current situation in terms of patient safety, wider clinical governance and quality of care issues. At the same time, whilst numbers are falling, children with complex health needs that require ongoing medication are also living in residential care settings, mostly without on site nursing care. While mostly the issues arising will not touch as directly on safeguarding as was the case at Orchid View Care Home<sup>2</sup>, the role and responsibilities of pharmacy professionals in raising concerns, applying the duty of candour and working with teams to develop safer ways of practice need to be an essential part of the response to this challenge.

The General Pharmaceutical Council (GPhC) is the independent regulator for pharmacists, pharmacy technicians and registered pharmacies in Great Britain. Its job is to protect, promote and maintain the health, safety and wellbeing of members of the public by upholding standards and public trust in pharmacy.

*"Its principal functions include: approving qualifications for pharmacists and pharmacy technicians and accrediting education and training providers; maintaining a register of pharmacists, pharmacy technicians and pharmacy premises; setting standards for conduct, ethics, proficiency, education and training, and continuing professional development (CPD); establishing and promoting standards for the safe and effective practice of pharmacy at registered pharmacies; and establishing fitness to practise requirements, monitoring pharmacy professionals' fitness to practise and dealing fairly and proportionately with complaints and concerns."*<sup>3</sup>

In fulfilling its role, the GPhC protects, promotes and maintains the health, safety and wellbeing of members of the public by upholding standards and supporting public trust in pharmacy.

This report is part of a wider piece of work on the role and responsibilities of pharmacy professionals and registered pharmacies working with care homes in Great Britain. It includes a literature search and roundtable discussion involving practitioners, care home representatives, inspectors and regulators where the findings from the search were checked for current relevance and their implications were discussed. The report, commissioned by the GPhC, looks at the issues for older people in residential settings and, where applicable, for children in residential care. Whilst it is recognised that the findings do not necessarily hold true for working age adults living in residential care, particularly those with learning disabilities, some of the issues highlighted here are relevant to working age adults living in residential care homes. However, further work is needed to identify and understand their specific issues.

The report reviews both British and international studies. Where there are clear differences in the implications of their findings between the three countries of Scotland, Wales and England, these are

highlighted. However, most of the work is applicable across all three health systems equally and, in this case and in the interests of brevity, individual mention of the impact in each country is not made. Whilst care has been taken to try to ensure a fair representation of studies carried out in Scotland, Wales and England, this has not always been possible. However, the author believes that the findings are transferrable between the three countries and, where not, the differences and gaps are outlined.

For the purposes of this report, the description of residential and nursing care homes developed by the English Inspectorate, the Care Quality Commission (CQC), is being used<sup>4</sup>, that is:

*“Care homes offer accommodation and personal care for people who may not be able to live independently. Some homes also offer care from qualified nurses or specialise in caring for particular groups such as younger adults with learning disabilities.”*

Other authors provide a more complete summary<sup>5</sup> of the differences between types of care homes for older people;

*“A residential setting where a number of older people live, usually in single rooms, and have access to on-site care services. Since April 2002 all homes in England, Scotland and Wales are known as ‘care homes’, but are registered to provide different levels of care.*

- *A home registered simply as a care home providing personal care will provide personal care only - help with washing, dressing and giving medication.*
- *A home registered as a care home with nursing will provide the same personal care but also have a qualified nurse on duty twenty-four hours a day to carry out nursing tasks. These homes are for people who are physically or mentally frail or people who need regular attention from a nurse.*
- *Some homes, registered either for personal care or nursing care, can be registered for a specific care need, for example dementia or terminal illness.*
- *Dual registered homes no longer exist (in England, Wales and Scotland), but homes registered for nursing care may accept people who just have personal care needs but who may need nursing care in the future.”*

Age UK estimates, based on a Laing and Buisson market survey in 2014, that there are 5,153 nursing homes and 12,525 residential homes in the UK<sup>6</sup>. The Care Quality Commission’s (CQC’s) State of Care report for 2014/15<sup>7</sup> gave the number of inspected homes in England as over 17,000 which is in line with these figures. They note that, over the last five years, there has been a 42 per cent rise in the number of domiciliary care agencies, coupled with a 10 per cent reduction in the number of residential homes (and a 6 per cent reduction in the number of beds) Smaller homes are also being replaced by newer, larger ones. In England, the only category of residential homes that has increased between 2010 and 2015 is homes with more than 50 beds whereas the number with between 20 and 50 beds has decreased.

The Laing and Buisson survey estimates that there are 426,000 elderly and disabled people in residential care<sup>8</sup> (including nursing) across the UK, approximately 405,000 are aged 65+<sup>9</sup>. This means that 93 per cent of nursing home residents and 99 per cent of people in residential homes are aged 65+ with 16 per cent of people aged 85+ in the UK living in care homes<sup>10</sup>. In late October 2015, the care home resident population for those aged 65 and over had remained almost stable since 2001 with an increase of 0.3 per cent, despite growth of 11.0 per cent in the overall population at this age<sup>11</sup>. However, the resident care home population is ageing. In 2011, people aged 85 and over represented 59.2 per cent of the older care home population compared to 56.5 per cent in 2001<sup>12</sup> with the median period from admission to the care home to death 462 days or 15 months<sup>13</sup>. Around

27 per cent of people lived in care homes for more than three years with people having a 55 per cent chance of living for the first year after admission, increasing to nearly 70 per cent for the second year before falling back over subsequent years<sup>14</sup>.

Accurate figures for the individual countries of Great Britain are not readily comparable and, therefore, figures from different years in the three administrations have had to be used to get what can only be a rough picture of the variability of care home residency rates across the three systems

In their thematic review on dementia care services published in October 2014, the CQC state that 400,000 residential care beds for older people exist in England although there is no further breakdown in this report between those dedicated to residential and to nursing care<sup>15</sup>. Between 2012 -2013, the most recently available detailed data, there were 12,917 residential homes for older people in England with a total of 245,942 residents and 4,675 nursing homes containing 218,387 beds. These figures represented a 0.8 per cent decrease in residential and corresponding 1.4 per cent increase in nursing home places over one year although the total number of nursing homes had, in fact, stayed static over the same period<sup>16</sup>. There were also 2,074 registered children's homes in England, in 2012 offering 11,765 places along with 16 secure children's homes, providing 281 places<sup>17</sup>.

In Scotland, in March 2014 there were 31,943 long stay residents in care homes for older people accounting for 96 per cent of the total number of residents in older people care homes. The number of short stay plus respite care residents increased from 789 at March 2005 to 1,244 at March 2014, an increase of 58 per cent. Over the same time period the number of long stay residents has decreased from 32,770 at March 2005 to 31,943 at March 2014, a decrease of 3 per cent.<sup>18</sup> In 2013, there were also a total of 1,467 children living in a residential setting in Scotland.<sup>19</sup> In Wales in June 2014, there were 22,719 places for older adults in 672 residential settings, 3,474 places in 457 settings for younger adults<sup>20</sup> and 255 children in residential care.<sup>21</sup> It also must be remembered that occupancy rates for older people's care home can vary between settings and may be between 85 per cent and 91 per cent, with London and Wales having the highest rates and the North East of England, the lowest.<sup>22</sup> Unfortunately, occupancy rates for children in residential care are not available in similar detail.

Many older people in residential care homes have multiple long term conditions. In one study<sup>23</sup>, 90 per cent of care home residents were found to have 'High Support Needs' i.e. having one or more of dementia, confusion, challenging behaviour, dual incontinence, severe hearing, visual impairment, or, total dependence in mobility. Dementia is one of the strongest determinants of entry into residential care in over 65s and a rapidly increasing problem in the aging population of Great Britain. A Scottish report in 2009<sup>24</sup> reported that 40 per cent people with dementia live in care homes or hospital and about 70 per cent of people living in care homes have dementia. By 2013, the figures had increased so that, in Scotland, 52 per cent of long stay residents in care homes for older people had a formal diagnosis of dementia compared to 29 per cent in March 2003<sup>25</sup>. In 2007, a report from the Alzheimer's Society stated that two thirds of care home residents in England have some form of dementia (244,000 people) although only 60 per cent of these individuals were in dementia-registered beds<sup>26</sup>. By 2013, more recent studies led the Alzheimer's Society to increase that estimate to 80 per cent of care home residents<sup>27</sup>. Polypharmacy, where several medications are administered to a single individual within a 24 hour period, is not necessarily a sign of poor practice<sup>28</sup> but has been associated with dementia<sup>29</sup> and, on average, care home residents take 7 to 8 medications daily<sup>30</sup>.

In the CQC's report, "Cracks in the Pathway"<sup>31</sup>, 90 per cent of the care homes involved showed some aspect of variable or poor care of residents with dementia being moved between acute hospital and care home settings. These aspects were around assessment of care needs (29 per cent rated variable or poor); providers working together (27 per cent variable or poor); involvement of people, their families and carers (33 per cent variable or poor); planning and delivery of care (34 per cent variable or poor); and monitoring the quality of care (37 per cent variable or poor). The role that community pharmacies could play in all of these aspects was not mentioned in the report. However, this level of need must be considered when developing the pharmacy professional's role in supporting care home residents with dementia.

## PHARMACIES AND PHARMACY PROFESSIONALS WORKING WITH CARE HOMES

It is also difficult to get accurate data on the numbers of pharmacy professionals working in dedicated roles in care homes. In 2013, in England, 72 per cent of pharmacists worked in some form of community setting and in Scotland and Wales the figures were 61 per cent and 63 per cent respectively but the General Pharmaceutical Council's 2013 survey of registrants did not specifically define dedicated roles in care homes<sup>32</sup>. The Royal Pharmaceutical Society, Scotland report in 2012 stated that less than 20 per cent of community pharmacies were involved in dispensing services to care homes<sup>33</sup>. It is tempting to extrapolate this figure to the rest of the Great Britain but without specific data and given the different health systems developing in each of the three countries, it is difficult to do so. Further information is needed to understand more accurately the current numbers of pharmacy professionals and registered pharmacies working in care home settings.

It has been reported elsewhere that the majority of care homes are serviced by one community pharmacy, the mean being 1.4 and the range between 1 and 4 pharmacies involved<sup>34</sup>. Therefore, it seems reasonable to suggest that either most community pharmacies are probably involved in dispensing to at least one local care home or that, for some pharmacies, dispensing to several care homes is part of their daily practice. Either way, this issue should be seen as one touching community pharmacists' usual clinical practice, particularly until better data is available. Indeed, the issues of transfer noted in the CQC's work make this an area of practice touching hospital pharmacists too during the development of discharge arrangements to residential care.

There is little in the evidence about specific role of pharmacy technicians, although the GPhC find from their inspection visits that it is sometimes pharmacy technicians who are providing advice, support and training to care home staff particularly around medicines management. Where pharmacy professionals are mentioned in this report, this should be taken to cover the range of staff working in the profession including pharmacy technicians and registered pharmacists.

At present, the NHS pharmacy contract in England covers the variety of services provided by local pharmacies to care homes. These will include the Essential Services of: dispensing; repeat dispensing; disposal of unwanted medicines (for residential but not nursing care homes); and the promotion of healthy lifestyles; signposting; and support for self care<sup>35</sup> although there is little written on how the final three services might be delivered for care home residents in practice.

In Scotland, the contract includes as core services: minor ailments; acute medication; chronic medication; public health; and a gluten free food service<sup>36</sup>. However, as a result of Prescription for Excellence<sup>37</sup>, published in 2013, a ten year strategy is changing the direction and scope of services with residents in care homes being one of the four key populations cited. Prescription for Delivery, published in June 2014<sup>38</sup>, sets out an action plan to achieve the 2013 strategy, including;

*“A national framework and NHS standards for the pharmaceutical care of residents of care homes and people receiving care and support at home would be prioritised”.*

Pharmacies may also deliver the Advanced Services covered by the contract. In England, these include: Medicines Use Reviews, the New Medicines Service and the Stoma Appliance Customisation Service and Appliance Use Reviews; national Enhanced Services for anticoagulant monitoring and palliative care. Finally, there are locally commissioned services as agreed with the local Clinical Commissioning Group in England or NHS Board in Scotland or Wales. There is also a national Enhanced Service outline from 2005<sup>39</sup> for pharmacy services into care homes, giving as its aims:

*“To improve patient safety within the care home with a particular focus on the following areas: ordering, storage, administration and disposal of medicines and appliances and use of residents’ own medicines (prescribed and purchased).”*

This covers advice from community pharmacists on the safe administration, storage, recording and disposal of medicines with six monthly monitoring visits and support with training and advice on written procedures within the home. Again, it is difficult to find any evaluation of how useful this service has been where it has been implemented although some examples of recent innovative commissioning by Clinical Commissioning Groups in England are beginning to emerge.

Clinical Commissioning Groups are working with Residential Care Homes in a number of ways to improve the management of medicines and have recently reviewed their current monitoring and management of these contracts to ensure compliance. There is a commitment that any further opportunities for improvement will be acted on accordingly. The following support services are available to care homes in England although not necessarily in Scotland or Wales:

- Proactive care services from primary care (in reach) into care homes (as a locally commissioned service)
- Integrated Response Team (as a national standard contract with Sussex Community NHS Trust)
- Medication administration record (MAR) chart (as a locally commissioned service)

These services aim to help and advise residents and carers in care homes to manage medicines safely and appropriately.

While all of the standards within the GPhC’s standards of conduct, ethics and performance<sup>40</sup> are relevant to all aspects of pharmacy practice, several have a particular bearing on the issues faced when providing services to residential and nursing care homes.

**Table 1 – GPhC standards of conduct, ethics and performance**

<p>Standard 1 Make patients your first concern</p>	<p>1.1 Make sure the services you provide are safe and of acceptable quality</p> <p>1.2 Take action to protect the well-being of patients and the public</p> <p>1.4 Get all the information you require to assess a person’s needs in order to give the appropriate treatment and care</p> <p>1.6 Do your best to provide medicines and other professional services safely and when patients need them</p> <p>1.7 Be satisfied that patients or their carers know how to use their medicines</p>
<p>Standard 2 Use your professional judgement in the interests of patients and the public</p>	<p>2.1 Consider and act in the best interests of individual patients and the public</p> <p>2.4 Be prepared to challenge the judgement of your colleagues and other professionals if you have reason to believe that their decisions could affect the safety or care of others</p>
<p>Standard 4 Encourage patients and the public to participate in decisions about their care</p>	<p>4.2 Work in partnership with patients and the public, their carers and other professionals to manage their treatment and care. Listen to patients and the public and respect their choices</p> <p>4.5 Make sure that information is appropriately shared with other health and social care professionals involved in the care of the patient</p> <p>4.6 Consider and take steps, when possible, to address those factors that may be preventing or deterring patients from getting or taking their treatment</p> <p>4.7 If a person cannot legally make decisions about their care, make sure that any service you provide is in line with the appropriate legal requirements.</p>
<p>Standard 7 Take responsibility for your working practices</p>	<p>7.4 Take responsibility for all work you do or are responsible for. Make sure that you delegate tasks only to people who are trained to do them, or who are being trained</p> <p>7.5 Make sure it is clear who is responsible for providing a particular service when you are working in a team</p>

7.11 Make the relevant authority aware of any policies, systems, working conditions, or the actions, professional performance or health of others if they may affect patient care or public safety. If something goes wrong or if someone reports a concern to you, make sure that you deal with it appropriately.”

Similarly, the GPhC standards for registered pharmacies principle 4 states:

*“The way in which pharmacy services, including the management of medicines and medical devices, are delivered safeguards the health, safety and wellbeing of patients and the public.”*

There are, therefore, clear professional and systemic regulatory issues that need to be considered when working with local care home staff and residents.

## THE ROLE OF NATIONAL STANDARDS AND INSPECTION

The systems for setting national standards and inspection regimes are different in each of the three countries of Great Britain. In England, standards are set and inspected against by the Care Quality Commission, in Scotland by the Care Inspectorate and in Wales by the Care and Social Services Inspectorate, Wales. Guidance on clinical care produced by the National Institute for Health and Care Excellence (NICE) is assessed for applicability in Scotland by Healthcare Improvement Scotland before adoption while, in Wales, *“Doing Well, Doing Better: Standards for Health Services in Wales”* includes in Standard 7:

*“a requirement for organisations and services to ensure that patients and service users are provided with safe, effective treatment and care based on agreed best practice and guidelines, including those defined in NICE guidance.”*

Thus, NICE guidance is applicable to all of Great Britain on most occasions.

NICE published a guideline in 2014 on managing medicines in care homes<sup>41</sup>. Its purpose was to provide recommendations for good practice on the systems and processes for managing medicines in care homes. Based on the six “R”s of administration i.e. right resident, right medicine, right route, right dose, right time and right to refuse, the 2014 guidance contained recommendations for a wide range of local health and social care professionals including pharmacy professionals. There are two specific recommendations highlighted for community pharmacies and pharmacy professionals, the first concerning fair access to anticipatory medicines (recommendation 1.9.5) and the second about timing of medicines administration rounds in homes (recommendation 1.14.4).

However, several other recommendations cover pharmacy professionals working with other health and social care providers in local care homes. These cover such areas as:

- Residents’ involvement in decision making;
- Informed consent;
- Adherence to the Mental Capacity Act Code of Practice in England;
- Safety and accuracy during the transfer of residents from one setting to another;
- Accurate recording of medication supply and administration;

- Reduction of medication errors;
- Medicines reviews and the multidisciplinary approach to them;
- Maintaining current information on medicines started, stopped and changed;
- Self administration by residents;
- Covert administration;
- Accurate information sharing between professionals, services and homes;
- Medicines reconciliation;
- Use of Monitored Dosage Systems;
- Agreement of the best time for administration.

A further quality standard was produced by NICE in 2015<sup>42</sup>. This has six quality statements covering: listing of medicines by care homes on the day of transfer; sharing information; self administration; prescribing medicines; medicines reviews and; covert medicines. These standards include detail on what signifies good practice in each area and form a useful framework for inspection regimes in the three countries. More details on each standard are given, as appropriate, in the relevant sections of this report.

As the inspectorate of health and social care services in England, the CQC's role is to inspect care homes against nationally agreed Key Lines of Enquiry<sup>43</sup> designed to answer five questions: whether services are safe; effective; caring; responsive; and well led.

The safe management of medicines is a mandatory Key Line of Enquiry that is reviewed at every comprehensive CQC inspection. This includes how medicines are obtained, dispensed, recorded and destroyed and may include asking the registered manager or provider about their arrangements with their local GP or pharmacy. The CQC uses pharmacy inspectors with specialist knowledge and expertise in this area to assist inspections where there may be concerns about safe medicines management.

The report on Orchid View Care Home, published by the CQC<sup>44</sup>, outlined two recommendations for pharmacy professionals:

- *That West Sussex Adult Safeguarding Board and the Royal Pharmaceutical Society reinforce with all pharmacies the importance of raising an alert in circumstances where there is an immediate concern with regard to the safe management and administration of medication, even if there is a belief that the issue has been identified by the CQC.*
- *That care commissioners and the CQC check that contractual arrangements are in place between nursing homes and pharmacists and that these arrangements are being adhered to.*

These recommendations meant that, by the time of the Orchid View One Year On Report<sup>45</sup> the new Local Authority Care and Business Support team proactively assure the capability and quality of care providers and have direct access to a pharmacist who provides support and guidance on the safe management and administration of medicines. Similarly as part of their annual visits, the Local Authority Contracts, Quality Assurance and Performance team ensure that each care home has an appropriate link with a pharmacist for the control of medicine management. This includes checking and recording which pharmacist they contract with, how often they visit, what advice was provided and whether this has been adhered to. It will also enable a list of county wide pharmacists who engage with care homes to be generated, Whilst these arrangements relate to West Sussex, where

Orchid View is situated, they also form a framework likely to be taken up by other local health and social care communities.

In Scotland the Care Inspectorate and Health Improvement Scotland (HIS) have a similar set of standards, the National Care Standards<sup>46</sup> which cover care homes for children, young people, adults with mental illness or disabilities and the elderly although the draft human rights and wellbeing principles that underpin the standards are currently under review<sup>47</sup> These include specific standards on medication in care home settings which emphasize what residents can expect routinely.

Similar standards are available in Wales covering self administration, record keeping, training for staff administering medication, monitoring of medicines, the need for expert pharmaceutical advice and the storage, checking and administration of controlled drugs.

As might be expected, the NICE and care inspectorates' guidance look at the entirety of the system for safe medicines management needed by a care home and none focus in detail at the core or extended role of pharmacists, pharmacy technicians and pharmacies in relation to increasing the safety of medication supply, prescribing and administration in residential settings. The recent NICE quality standards emphasise the need for strong multi-disciplinary responses to the issues raised and cite pharmacy professionals as a key part of local teams.

## THE ROLE OF OTHER PROFESSIONAL REGULATORS

Both the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have good practice guides for medicines management. The GMC's good practice guide was published in 2013<sup>48</sup> and covers a range of activities but not any specifically related to individual care settings e.g. care homes. Similarly, the NMC's Standards guide, published in 2007<sup>49</sup> relates to supply, prescribing and administration but makes no differentiation between care environments.

## THE KEY ISSUES IN ENSURING SAFE SUPPLY AND ADMINISTRATION OF MEDICINES IN CARE HOMES

The evidence outlined in this section has been drawn from a number of sources and has been chosen for its applicability across all countries in Great Britain. Whilst systems of regulation and inspection may vary, the underlying issues for care home residents will be very similar across all of the administrations. It is not therefore highlighted whether the evidence is from a single country within Great Britain unless this is important for contextual purposes.

In the CQC's State of Care Report 2014/15 10 per cent of nursing homes were rated inadequate compared with 6 per cent of residential homes that did not provide nursing. In these situations, inspections revealed safety concerns such as failing to give out medicines safely, not recognizing safeguarding issues, a poor understanding and implementation of risk management and inappropriate staffing levels with staff training issues<sup>50</sup>. On occasion, medicines were not stored correctly and were not administered properly with some being out of date.

It has been estimated that medicines rounds account for a third of nursing time in care homes<sup>51</sup>. Whilst medication management is therefore a core activity, it is also the source of significant safety concerns. Medicines administration errors are not concentrated in a few individuals with 52 per cent of residents exposed to serious error<sup>52</sup> and a potential risk exposure of 98 per cent in nursing homes and 88 per cent in residential care homes. The Care Home Use of Medicines Study (CHUMS) of 2009<sup>53</sup> observed errors in prescribing, dispensing, medicines administration and monitoring:

- Prescribing errors - including having incomplete information; giving unnecessary drugs; making a dose or strength error; and omitting a medicine that should have been prescribed.
- Dispensing errors -including labelling errors; errors with content of medicine dispensed e.g. incorrect strength; and clinical errors e.g. dispensing a medicine that could result on serious drug interaction.
- Medicines administration errors - including omission errors; and incorrect dose given.
- Monitoring errors - these were failures to request monitoring for a medicine requiring monitoring.

It should be remembered that these errors are the expression of wider issues and it is the root cause of the error that will need to be addressed if the safety of residents is to be improved. From the literature, these causes fall into three main areas: systems issues; care home issues; and individual resident issues.

## SYSTEMS ISSUES

### LOCAL COMMUNICATION SYSTEMS

In their 2011 report, *“Making Care Safer”*<sup>54</sup> the Health Foundation and Age UK used carers’ and relatives’ experiences to pinpoint issues in care. The interviewees in this study reported problems with the use of locum staff (especially GPs), care plans that were not followed or were not contemporaneous and a lack of communication about the medication prescribed particularly at the points where it was started, changed or stopped. Poor use of care plans meant that medication reviews were not undertaken regularly. Admission to and from hospital was also seen as a point at which communication could break down:

*“(They) found that full information about care needs and medication did not always go with a resident when they were admitted to hospital. Likewise, medication or information about prescriptions often didn’t follow the patient back into the care home when they were discharged. There were also examples given of conflicting prescribing between the hospital consultant and the local GP.*

*When prescriptions had been altered in hospital there was often no follow up visit from a GP on the resident’s return to see if the prescription needed reviewing or changing back. In some cases this resulted in residents continuing to take unnecessary or conflicting medication once they were back in the care home.”*

This finding echoes CHUMS which found causes of error to include:

- Lack of support to residents to make informed decisions because they were unable to give accurate medication history or were reluctant to complain or raise issues
- Errors in prescribing or reviewing medicines because prescribers had inadequate knowledge about a resident e.g. not knowing or being unfamiliar with a resident or not having computerised notes or prescribing software.
- Inadequate information on medicines in the care home
- Poor communication and lack of information sharing when there were changes to medicines or when the resident’s care was transferred.

This was made worse if several GP practices with different systems were providing care for a single care home. However, CHUMS also found that 50 per cent of communication errors were directly between the care home and community pharmacy.

The 2015 NICE quality standards<sup>55</sup> take up these issues with statement 1 covering accurate transfer of information when care is moved from one provider to another.

*“It is important that information about medicines is available for people who transfer into a care home, either for the first time or, for example, when moving back into the care home after a hospital stay (during which their medicines may have been changed). This will allow information about a person’s medicines to be available to relevant health and social care practitioners (while taking care to respect confidentiality), improving continuity of care and ensuring that people get the right medicines at the right time at the care home they have transferred to.”*

Similarly, statement 2<sup>56</sup> covers the issue of discharge summaries and accurate medicines information;

*“Good communication about a resident's medicines is a key factor in preventing medication errors when care home residents transfer between care settings, and also promotes continuity of care following transfer. Providers of health or social care should ensure that comprehensive records of medicines are sent with a person when they are transferred from one care setting to another, including information on what medicines are being taken and related information, such as dosage.”*

These standards state that commissioners need to ensure that they are followed, thus implying that these become part of local responsibilities across the three countries<sup>57</sup>.

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## LOCAL ORGANISATIONAL SYSTEMS, LEADERSHIP AND CO-ORDINATION

CHUMS highlighted that inconsistency of GPs looking after patients and a lack of timely access to primary care providers were problems which led to multiple sources of sometimes conflicting medicines information. They found lack of ownership across local systems and poor leadership in co-ordinating the reduction of errors across general practice, pharmacy and care home; for example advice from secondary care not being incorporated into records or used to update prescribers' or computerised notes.

The NICE 2014 quality standard<sup>58</sup> states that:

*“Commissioners and providers (organisations that directly provide health or social care services) should review their policies, processes and local governance arrangements, making sure that it is clear who is accountable and responsible for using medicines safely and effectively in care homes.”*

Similarly, in the National Care Forum's report, *“Safety of Medicines in the care home”*<sup>59</sup>, the main themes for improvement included:

- The need to build better working relationships between GPs, pharmacists and care home staff and the need for a common set of principles for everyone
- Problems managing repeat prescriptions and the need for electronic prescriptions to be used between the three settings: surgery, pharmacy and care home
- A lack of medication review and no clear guidance about how long a person should be on a drug before it is reviewed
- A system of regular reviews of medications for Care homes throughout the year.

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## TRAINING SYSTEMS

In *Making Care Safer*<sup>60</sup>, the role of community pharmacists in training care home staff was highlighted:

*“Training of care home staff was highlighted as a very important issue. (It was) ..... felt the emphasis was on “avoiding litigation rather than encouraging good practice”.*

*It was felt that more information and support could be provided by the health specialists already working with the home, including the community pharmacist and GP. (It was) noted that staff were often reluctant to call in a doctor unless they were sure it was an emergency and therefore didn’t always act or ask for help when necessary. “*

Inadequacies in medicines knowledge and training coupled with frequent use of new or agency staff was also cited in the CHUMS study. A review by the CQC in 2012 found that, in a sample of 81 homes, 59 per cent of staff had been on medicines training in the past year<sup>61</sup>. Work by the Centre for Policy on Aging in 2012<sup>62</sup> suggested training provided by community pharmacists as a way of reducing errors along with an independent review of care home processes by an outside person, for example a pharmacist, to ensure safe processes.

The roundtable discussion undertaken in December 2014 as part of this report highlighted the issue of staff turnover which can mean that training is difficult to keep current. Participants stressed the need to demonstrate competence rather than just the evidence of training undertaken. They felt that training needed to be seen as a continuous process, developed with assessment and monitoring, one where pharmacy professionals input would be a valuable resource. This concern was also highlighted in the CQC’s State of Care Report 2014/15<sup>63</sup> which noted the importance of good leadership with good recruitment and retention of managers. It noted that staff turnover can be high, reaching 11 per cent for nurses working in residential care.

## RESIDENTIAL CARE HOME ISSUES

The CQC’s 2012 review of care homes<sup>64</sup> found a range of issues relating to medicines management at the level of the individual care home:

- 86 per cent of homes had a policy on consent;
- 59per cent of homes gave residents the option to self administer medicines although only 4per cent of case files showed evidence of this;
- 93per cent of homes said they “always” recorded medicines errors and had arrangements in place to learn from errors relating to prescribing, monitoring, dispensing or administering medicines;
- 85per cent of homes had policies on “homely” medicines;
- 40per cent of homes had residents on anti-coagulant therapy and in 84per cent the anti-coagulant record was in place. Only 31per cent were aware of the NPSA safety alert concerning anti-coagulant therapy;
- 35per cent of homes said that getting medicines to residents on time was “sometimes” a problem and 4 per cent admitted that this was “often” a problem;
- 49 per cent of homes recorded actual time of administration;
- 43 per cent of homes had no policy for “as required” medicines.

The CHUMS study found no relationship between errors and the type of care home ownership and conflicting evidence as to whether they were more likely in residential or nursing care. However, the study did cite, as one cause of error, inadequate medicines management systems at the care home level. This included: the failure to deal with changes to medicines accurately and contemporaneously; delays in obtaining new medicines; failure to identify residents who needed monitoring; inefficient management of repeat prescriptions; and inadequate labelling of medicines. Medicines wastage can also be a major issue in care homes. A 2009 study estimated that medicines wastage in England alone cost £300 million each year. £50 million of this was because of medicines that are disposed of unused by care homes<sup>65</sup>. As the Scottish Government's Prescription for Excellence 10 year strategy states:

*"The proportionate equivalent for Scotland would be wastage of £30 million and potential savings of £15 million. The study concludes that 'the greatest social and economic returns are to be gained when reducing medicines waste can be effectively linked to improving care quality and health outcomes including patient safety.'"*<sup>66</sup>

This issue was also raised at the roundtable. There is a huge disparity between nursing homes and care homes with regards to ease of medicines waste disposal. Whereas care homes are able to return any unused medicines to pharmacies, it can cost nursing homes more to remove any clinical waste than it does to have normal waste removed. Help with this issue could be one way of cutting costs and improving relationships with local pharmacies and commissioners.

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#### CARE PLANNING, REVIEW AND RISK ASSESSMENT

The CQC's Care Update in 2013<sup>67</sup> cited poor care planning and lack of regular review as something care homes could do better. This echoed the findings of *Making Care Safer*<sup>68</sup>.

*"(Carers and relatives) explained that often GPs have to rely on information they are given by care home staff in order to make decisions about prescribing. Badly written care plans mean doctors can be misinformed. This also resulted in residents being prescribed and administered drugs they were known to be allergic to, which could have serious repercussions."*

Several authors highlighted the need for care planning to be multi-disciplinary including community pharmacies delivering services to a home and to include a risk assessment, particularly on entry to the care home or when care has been transferred temporarily to hospital and then back to the home. As the National Prescribing Centre's Medicines Reconciliation Guide<sup>69</sup> states;

*"Over half of all hospital medication errors occur at interfaces of care and most commonly at admission. Medicines reconciliation has the potential to reduce medication errors. Therefore, every time a transfer of care takes place it is essential that accurate and reliable information about the patient's medication is transferred at the same time."*

The roles of the pharmacist, pharmacy technician and pharmacy are highlighted in the NICE guidance which emphasizes the need for medication reviews involving the resident and/or their family members or carers and a local team of health and social care practitioners including a pharmacist; community matron or specialist nurse, such as a community psychiatric nurse; GP; member of the care home staff; practice nurse and social care practitioner.

This guidance suggests that the roles and responsibilities of each member of the team and how they work together should be agreed locally. Training should be provided so that the team has the skills needed. This guidance outlines the roles for the team including:

- *“Health and social care practitioners should work together to make sure that everyone involved in a resident's care knows when medicines have been started, stopped or changed.*
- *Care home staff (registered nurses and social care practitioners working in care homes) should update records of medicines administration to contain accurate information about any changes to medicines.*
- *The health professional prescribing a medicine, care home provider and supplying pharmacy should follow any local processes for anticipatory medicines to ensure that residents in care homes have the same access to anticipatory medicines as those people who do not live in care homes.*
- *Pharmacies and doctors supplying medicines to care home providers should ensure they have processes, such as standard operating procedures, in place for all staff who dispense and accuracy check medicines for residents, particularly those who are using monitored dosage systems.*
- *Care home providers should determine the best system for supplying medicines for each resident based on the resident's health and care needs and the aim of maintaining the resident's independence wherever possible. If needed, they should seek the support of health and social care practitioners.*
- *Supplying pharmacies should produce medicines administration records wherever possible.*
- *The care home provider, health professional prescribing the medicine and pharmacist should agree with the resident the best time for the resident to take their prescribed medicines. Busy times should be avoided.*
- *Health professionals working in, or providing services to, care homes should work to standards set by their professional body and ensure that they have the appropriate skills, knowledge and expertise in the safe use of medicines for residents living in care homes.”*

The likelihood that an elderly medical patient will be discharged from hospital on the same medicines that they were admitted on is less than 10 per cent<sup>70</sup>. Studies have shown that between 28-40 per cent of medicines are discontinued during hospitalisation<sup>71</sup>. A Royal Pharmaceutical Society report in 2012<sup>72</sup> cited evidence that 45 per cent of medicines prescribed at discharge are new medicines<sup>73</sup> and that 60 per cent of patients have 3 or more medicines changed during their hospital stay<sup>74</sup>. This analysis also quoted evidence that adverse drug events occur in up to 20 per cent of patients after discharge and it is estimated that between 11 and 22 per cent of hospitalisations for exacerbations of chronic disease are a direct result of non-compliance with medication<sup>75</sup>. One study estimated that risk of an adverse drug event post-discharge increased by 4.4 per cent for every drug alteration or change<sup>76</sup>.

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## HOME PROCEDURES

Sometimes, the physical layout and normal procedures of the residential care home may contribute to medicines management errors. CHUMS cited poor environment with poor lighting, high noise levels, clutter and high temperatures along with poor design of medicine trolleys as a contributory factor in medication errors. Lack of sufficient and good quality storage for medicines may be another issue reducing the efficacy and efficiency of administration. Distractions and interruptions during medicines rounds were also highlighted<sup>77</sup> in this and in *Making Care Safer*<sup>78</sup>:

*“(It was) felt strongly that the processes for administering medication during the daily drugs round could be improved, as this was when many mistakes were made. They had observed that medication rounds could take up to two hours to complete and staff were rarely able to do this without interruption. This could include being called away to help other residents or care staff, to speak to a GP or relative, or to take a phone call. This would result in the drugs trolley being left unattended and unlocked, sometimes for extended periods of time.”*

In the CHUMS study, over 60 per cent of interruptions were by other staff with over 90 per cent of staff interruption being about operational issues. Fewer than 9 per cent of interruptions were verbal requests from residents. It has already been pointed out that errors are more common in the morning than later on in the day. The role of the pharmacist in giving advice on the physical processes used, support with storage issues and on the rescheduling of medicines administration to safer times of day may be one that deserves further consideration. Indeed, the NICE guidelines recommend that:

*“The care home provider, health care professional prescribing the medicine and pharmacist should agree with the resident the best time for the resident to take their prescribed medication.”<sup>79</sup>*

There is little in the literature about the impact of changing the timing of medicine rounds away from the morning although the reduction in distractions for staff makes this seem a sensible suggestion. The dispensing pharmacy professional's role in advising on this is a key part of reducing a considerable number of avoidable errors and there are good practice examples of pharmacy technicians who support and train care home staff.

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## USE OF MONITORED DOSAGE SYSTEMS

Much has been written about the desirability or otherwise of using monitored dosage systems (MDS) to increase medicines compliance generally. In 2013, the Royal Pharmaceutical Society reported on the use of multi-compartment compliance aids (MCA) or monitored dosage systems<sup>80</sup>. They stated:

*“In general there is insufficient evidence to support the benefits of MCA in improving medicines adherence in patients, or in improving patient outcomes and the available evidence does not support recommendations for the use of MCA as a panacea in health or social care policy. However, the evidence does indicate that MCA may be of value for some patients who have been assessed as having practical problems in managing their medicines. Each patient's needs must be assessed on an individual basis and any intervention must be tailored to the patient's specific requirements”.*

Allred et al<sup>81</sup> found that, where MDS are used, medication administration errors occurred more frequently with medicines that cannot be packaged in MDS such as inhalers, liquid medicines and eye drops, than with the tablets and capsules packed in MDS. Indeed, the CHUMS study found that 40 per cent of medicines could not be handled in MDS devices. Athwal et al<sup>82</sup> found that in only two groups could the supply of an MDS be justified, patients with physical impairment but no formal or informal carers; and patients with cognitive impairment and formal or informal carers.

A 2012 Department of Health report on improving the use of medicines and reducing medicines waste<sup>83</sup> noted that the increasing use of MDS in care homes was based on the belief that they may save staff time, standardise processes across a home, or reduce the incidence of medication errors. The report stated that the supply of MDS can be driven by patient demand and care home managers and that it was the responsibility of other health care professionals, particularly pharmacists, to ensure that only those residents needing MDS were using them.

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## USE OF OVER THE COUNTER AND HOMELY MEDICATION

The term homely medication covers both over the counter medicines (OTC) and medicines on general sale, such as paracetamol, cough syrup and olive oil. In the CQC's 2012 report on care homes, 85 per cent of the 81 homes visited had a policy on homely medicine administration.<sup>84</sup> The Registered Care Home Association guidance on their use<sup>85</sup> in 2013 gives a practical framework which includes advice from community pharmacies and a potential stock list. The advice states:

*“At times residents may develop a minor ailment which in their own home would be easily treatable by accessing a local pharmacy for an OTC product. ....By having homely remedies in the home, an immediate need can be met and the GP is only called if the symptoms persist. Discussions and agreement with the GP about the use of homely remedies is essential. The pharmacist will also provide necessary advice.”*

Similarly, most council run residential homes follow published processes, for example in Hampshire:

*“Before administering a homely remedy, the relevant list must be checked to make sure that the resident’s GP has given permission for the medication to be administered to that individual. The guidelines for each medication must be followed, and if there is any query a pharmacist must be consulted before the medication is administered.”<sup>86</sup>*

The 2014 NICE guideline states that homes using homely medicines should have a written process for this and ensure that staff have the training and support to administer them safely.

*“Where prescribed medication is also being taken, it will be necessary for the home to check with the pharmacist for possible drug interactions. This includes herbal and homeopathic remedies as they have the same potential for drug interactions and side effects as any other medication”.*

Thus, implicit in all of these processes is the role of the pharmacist in ensuring that advice on homely remedies, including herbal and homeopathic medicines, is readily available to home staff. Given the potential impact of poor administration practices for homely remedies on the overall burden of error and adverse reaction to prescribed medicines, this may well be an area worthy of further consideration for local collaboration.

## RESIDENTS' NEEDS

As has already been noted, care home residents take between 7 and 8 medications on average<sup>87</sup> and CHUMS observed errors in 8.4 per cent of medication administration events.

*“A care home resident being given medication 3 times a day would be 99.9 per cent certain to receive at least one medication error every month”.*<sup>88</sup>

Common errors included incorrect crushing of medication, not supervising the intake of medication particularly for residents with dementia, incorrect timing, omissions and wrong dosages. Inhalers and liquid medication were more likely to give rise to error, particularly when MDS were being used. Antibiotics were particularly prone to error because of their intermittent nature. Indeed, a study in Wales<sup>89</sup> of the administration of antibiotics supports this finding. In this report, nearly one fifth of antibiotics (18 per cent) were administered inappropriately, with an over-run of more than one day observed, indicating that doses had been missed. A 2009 study in Dutch nursing homes<sup>90</sup> found that antibiotics were over ten times more likely to generate an administration error than a standard gastro-intestinal medication

The NICE quality statement 4<sup>91</sup> states that:

*“Prescribers responsible for people who live in care homes (should) provide comprehensive instructions for using and monitoring all newly prescribed medicines.”*

Again, this is an area where local advice by a pharmacy professional would enable safety to be further improved.

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## AS REQUIRED AND ANTICIPATORY MEDICATION

The CQC's review in 2012 found that, of the 81 homes studied, 43 per cent had no policy for “as required” medicines. In its State of Care report for 2012/13, the CQC cited as a common problem that staff did not have guidance on how to administer medication to be given as required<sup>92</sup>.

Medications given as required commonly can include analgesics, sedatives and laxatives, all of which have wider implications if omitted or over-administered.

Several studies have shown that pain is a common issue for older people, particularly in those with dementia. Overall, 50-80 per cent of residents in nursing homes are affected by pain<sup>93</sup> and most good practice guidelines emphasise the importance of pain management in the treatment of neuropsychiatric symptoms in people with dementia<sup>94</sup>. It is, therefore, vital that, for those residents not on regular pain medication, there is still a good system for administering “as required” pain relief. This can be particularly important where MDS are being used because “as required” medication cannot be added to compliance aids.

Similarly, faecal impaction can affect up to 50 per cent of older adults in hospital wards or care homes<sup>95</sup> and the use of “as required” laxatives is also important. Constipation and impaction can exacerbate confusion, reduce appetite and cause discomfort. Sedatives are another type of medication that can be prescribed as required although they are more likely to be administered on a regular basis. Ensuring that principles and systems for the safe administration of these medicines are in place is something about which all local care providers must be aware and advice from local

community pharmacists/pharmacies might be invaluable in ensuring residents needs are met in a timely manner. As the 2015 NICE quality statement 4 states:

*“If too few instructions are given to a resident (if self-administering) or the care home staff it can reduce the effectiveness of a medicine or even potentially increase the risk of harm. Clear instructions are therefore important to ensure resident safety. This is particularly the case with variable dose or ‘when required’ medicines (when a clear indication of the circumstances to administer the medicine is needed)”<sup>96</sup>*

And:

*“Requirements for recording clear instructions on how a medicine should be used and monitored should be included as part of a clear written process for prescribing and issuing prescriptions for people who live in care homes ”*

Separate from this but of equal importance is the provision of anticipatory medicines for use in palliative care. Anticipatory medicines are those held in small quantities in case of a deterioration with protocols or an individual anticipatory care plan outlining in what circumstances they can be used. As previously highlighted, the issue here is not one of long term “as required” administration but of ensuring that residents have the same access to medication as those who do not live in care homes<sup>97</sup>. The 2014 NICE guideline advocates this access and the supplying pharmacy is specifically cited as one of the local providers who should ensure that this happens. Again, it would be useful to understand more fully how this works in practice as the literature tends to explain the process but not outcomes for the current system.

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## COVERT MEDICATION

Covert medication is the administration of prescribed medicines concealed so that the recipient does not know that they are being given. Mostly this is done by concealing in food or drink. Covert medication can only be justified where the recipient does not consent to receiving medication but does not have the mental capacity to understand the consequences of this refusal. The NHS Constitution for England states that:

*“You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests.”<sup>98</sup>*

In 2004, the Royal College of Psychiatrists published a paper on covert medicines administration<sup>99</sup>. It looked at the issue of capacity and cited the Human Rights Act 1998 in stating that the presumption is that all patients have capacity unless demonstrated otherwise.

*“Patients with capacity must be able to: understand in simple language what the treatment is, its purpose and why it is being proposed; understand its principal benefits, risks and alternatives; understand in broad terms what will be the consequences of not receiving the proposed treatment, retain the information long enough to make an effective decision and make a free choice (i.e. free from pressure).”*

In a study in 2000<sup>100</sup>, 71 per cent of 34 units in the southeast of England admitted sometimes resorting to concealing medicines in food or drink:

*“In some (mainly Elderly Mentally Ill or EMI) settings, these practices (covert administration) were daily events for a substantial minority of patients. Despite the possible interaction of drugs with and the pharmacological implications of crushing tablets only three respondents (settings) had ever consulted a pharmacist”*

More recently, in 2010, 1.1 per cent of Scotland’s care home residents were given covert medication<sup>101</sup>. The Care Inspectorate found, when they inspected Scottish care homes during 2012, that 588 (1.6 per cent) out of all 37,411 residents were being given covert medication, a significant increase over the 2010 figure. Some individuals were receiving as many as ten different medications in covert form<sup>102</sup>.

Equivalent figures for the other countries of Great Britain are not available. CHUMS in 2009 cited the inappropriate crushing of tablets as one of the ways in which the effects of medication were reduced and the chances for error increased<sup>103</sup>. In 2012, UK Medicines Information (UKMI) stated:

*“Some authors have suggested that altering medicinal products (for example crushing tablets) is usually an unlicensed (off-label) activity. It has also been suggested that adding medicines to food is usually outside the terms of the product licence..... Very often, there might not be information available regarding the stability of medicines when mixed with food or drink. However, it is useful to consider the risks of the medicine degrading in food/drink versus the risks of not giving the medicine at all.”<sup>104</sup>*

The presence of the Mental Capacity Act 2005 in England has improved the systems for determining and recording the use of covert administration within a framework of: the assessment of mental capacity; agreement between the prescribing professional, pharmacist and family or carers that this is in the resident’s best interests; documentation of the reasons for presuming incapacity and the proposed management plan; planning how administration will take place; and regular review as to whether covert administration is still required<sup>105</sup>. The pharmacy professional’s co-ordinating role in this is important. As pointed out in the Royal Pharmaceutical Society Scotland report in 2012<sup>106</sup>:

*“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.”*

Again, this area is picked up in the 2015 NICE quality standard 6:

*“The covert administration of medicines should only be used in exceptional circumstances when such a means of administration is judged necessary, in accordance with the Mental Capacity Act 2005. However, once a decision has been made to covertly administer a particular medicine (following an assessment of the capacity of the resident to make a decision regarding their medicines and a best interests meeting), it is also important to consider and plan how the medicine can be covertly administered, whether it is safe to do so and to ensure that need for continued covert administration is regularly reviewed (as capacity can fluctuate over time). Medicines should not be administered covertly until after a best interests meeting has been held. If the situation is urgent, it is acceptable for a less formal discussion to occur between the care home staff, prescriber and family or advocate to*

*make an urgent decision. However, a formal meeting should be arranged as soon as possible.”*

Central to this is the calling of a “best interests” meeting:

*“When covert administration of medicines is being considered, there should be a 'best interests' meeting. The purpose of this meeting is to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests. A best interests meeting should be attended by care home staff, relevant health professionals (including the prescriber and pharmacist) and a person who can communicate the views and interests of the resident (this could be a family member, friend or independent mental capacity advocate depending on the resident's previously stated wishes and individual circumstances). If the resident has an attorney appointed under the Mental Capacity Act for health and welfare decisions, then this person should be present at the meeting.”<sup>107</sup>*

This is one area where the reported evidence may not reflect current practice, given that the studies cited were completed either before or shortly after the introduction of improved safeguards. The role of pharmacy professionals in assessing current practice and ensuring “best interests” are served is a central one to achieving the quality standard now required.

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## POLYPHARMACY

Polypharmacy is a general term meaning the concurrent administration of several medicines to a single recipient on a regular, usually daily, basis. According to the King’s Fund<sup>108</sup>, it can fall into one of two categories:

- Appropriate polypharmacy is defined as prescribing for an individual for complex conditions or for multiple conditions in circumstances where medicines use has been optimised and where the medicines are prescribed according to best evidence.
- Problematic polypharmacy is defined as the prescribing of multiple medications inappropriately, or where the intended benefit of the medication is not realised.

The total number of items dispensed in the UK has increased by 64 per cent from 587 million in 2001 to 962 million in 2011<sup>109</sup>. This corresponds to an average of 11.9 medications per patient per annum in 2001, and 18.3 medications per patient per annum in 2011<sup>110</sup>. The Kings Fund review of the evidence<sup>111</sup>, published in 2013, shows the clear differences between appropriate and problematic polypharmacy although with some underlying issues which are common to both. There is an increasing risk of prescribing errors, high-risk prescribing and adverse drug events, the greater the number of drugs prescribed<sup>112, 113</sup> with ten or more drugs conveying a higher risk than four to nine<sup>114</sup>. The risk of an adverse drug reaction can be 13 per cent when taking two medications, rising to 58 per cent with five<sup>115</sup> and as high as 82 per cent with seven or more<sup>116</sup>.

In one study quoted by the Kings Fund review, prescriptions issued to a population of Irish patients over the age of 70, using a tool designed to assess efficacy and appropriateness, found that 36 per cent of patients received a prescription which was deemed potentially inappropriate<sup>117</sup>. In 2013, an audit of six GP practices in West Wales found that around 10 per cent of the practice list were over the age of 74 years and of these between 22 per cent and 31 per cent were on 10 or more medicines. Similar levels were shown in Cwm Taf Health Board in 2014, when an audit of 11 GP

practices showed that 6–11 per cent of the practice population were over the age of 74 years, with an average of 22 per cent prescribed 10 or more medicines (range 10–33 per cent)<sup>118</sup>.

The PRACTICE Study found that, of 1777 patients whose records were reviewed, 299 patients (17 per cent) were receiving between 5 and 9 medications, and an additional 172 (9.7 per cent) receiving more than 10 medications. It also found that 30.1 per cent and 47 per cent of patients receiving respectively 5 or more and 10 or more medications had prescribing or monitoring errors in the 12-month study period<sup>119</sup>. Similarly medication discrepancies on hospital discharge were more common as numbers of medicines prescribed increased<sup>120</sup>.

Studies highlight the key role of Medicines Utilisation Reviews in managing problematic polypharmacy and the need for these to be multi-disciplinary and inclusive of all relevant community pharmacists. Medicines reconciliation during movement between hospital and care home is also a vital part of dealing with the changes of medication which usually follow hospital discharge. This is therefore one area where local pharmacies play a central role in medicines management in residential care homes. The RPS Scotland report in 2012 recommended the development of national guidance on best practice in medication review, appropriate polypharmacy and safer medicines use. It also recommended working with medical and nursing colleagues to reduce inappropriate polypharmacy and high risk medicines and improvements in anticipatory care<sup>121</sup>.

As NICE quality statement 5<sup>122</sup> states:

*“Many care home residents have multiple and complex conditions. These conditions can change, and the medicines that residents receive to treat these conditions need to be reviewed regularly to ensure that they remain safe and effective. The frequency of multidisciplinary medication reviews should be based on the health and care needs of the resident, with their safety being the most important factor when deciding how often to do the review. The interval between medication reviews should be no more than 1 year, and many residents will need more frequent medication reviews. There can be uncertainty over who should undertake medication reviews. While a number of different health professionals can conduct medication reviews for care home residents, the review should involve a multidisciplinary group of key people who agree and document the roles and responsibilities of each member of the team and how they work together.”*

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## LIQUID AND INHALER USAGE

Given the evidence in the CHUMS study that liquid and inhaler usage was associated with increased levels of medication error, this may be one area where pharmacy advice and training into care homes can help reduce the problem. Around one in 10 residents in one study<sup>123</sup> were prescribed an inhaler for asthma or chronic obstructive pulmonary disease, and one in two inhalers were administered incorrectly. A New Zealand study showed that one third of residents using inhalers in rest homes had an inadequate technique and some staff and residents chose the wrong inhaler to manage “shortness of breath”<sup>124</sup>. The pharmacy professional may be well placed to teach technique to both care home staff and residents<sup>125</sup> with the percentage of patients with optimal inhaler technique rising from 24 per cent before to 79 per cent after training delivered by a pharmacist in one study.

Seventy to eighty per cent of older patients are thought to have some form of swallowing difficulty, so liquid medicines are commonly needed in care homes<sup>126</sup>. Liquids in one study were four times more likely to be administered incorrectly than tablets and capsules in monitored dosage systems. Combined, topical, transdermal and injectable preparations were 20 times more likely and inhalers over 30 more times as likely to be administered incorrectly than tablets and capsules<sup>127</sup>.

Errors with liquids involved omissions, incorrect doses and not shaking bottles of suspensions. Most topical errors involved eye drops that had expired or were omitted. While less has been written about technique in administering eye and ear drops, training on these may also be needed to reduce the rate of error further.

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## SELF MEDICATION

There is a presumption that, where residents can handle their own medication, this should be something that they are able to do in residential care<sup>128</sup>. Indeed, one of the CQC's standards covers self-administration. It states care home providers should be:

*"...supporting and reminding residents to self-administer their medicines independently where they are able to do so by minimising the risk of incorrect administration".*

The Scottish National Care Standards<sup>129</sup>, currently under review, also state:

*"You can be sure that, whether or not you are organising your own medication, the staff are trained to check this. They will, with your agreement, get advice from your GP if there are any concerns about your condition or the medication."*

and

*"If you are managing your own medication, you will be given your own lockable storage to keep your medication in your room. If you need it, you will also have special storage somewhere else (for example, in a fridge) that is secure and accessible to you.*

*You can get help from the staff with ordering and collecting your prescriptions if you want or need it."* (Standard 15)

The Welsh inspectorate also includes specific standards on the care home's responsibilities and the support required for those residents able to self administer. Such support should be based on a risk assessment involving the resident, their family members or carers if appropriate, trained care home staff and may involve other key practitioners such as the GP, pharmacist, and/or other health and social care practitioners<sup>130</sup>. In the literature, there is a twin emphasis on maintaining the resident's independence and, to a lesser extent, understanding their role as the final safety check in medicines administration.

However, there are issues about both the documentation surrounding self administration, particularly where this includes controlled drugs, and the storage of medicines used in this way. Pharmacy professionals have a role in advising on documentation and storage, particularly when, in line with good practice guidance, this is in the individual resident's room in a small locked cupboard. This is another area of practice covered by the NICE quality standard, in this case, quality statement 3<sup>131</sup>.

*“People who live in care homes are supported to self-administer their medicines if they wish to and it does not put them or others at risk.*

*It is important for people living in care homes to maintain their independence, and that they have as much involvement in taking their medicines as they wish and are safely able to. However, when a person enters a care home staff will often automatically assume responsibility for managing their medicines. It should be assumed that people who live in a care home can take and look after their medicines themselves, unless a risk assessment has indicated otherwise. It is important to take into account a person's choice over whether or not they wish to self-administer their medicine and also to consider if self-administration will be a risk to them or others. Risk assessments are also important to determine what support a person needs to help them to self-administer different medicines (for example, a resident may be able to manage oral tablets but not eye drops), allowing care homes to ensure that necessary support is provided. Risk assessment should be reviewed periodically, and whenever circumstances change, to address if any adjustment to support is needed.”*

Risk assessments should include:

*“...a number of factors that can affect a resident's ability to self-administer their own medicines, including their mental health, mental capacity, health literacy, vision, hearing, language and culture. Health and social care practitioners need to ensure that these factors are considered for each resident, and any barriers to self-administration of medicines are identified and taken into account.”*

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## USE OF ANTIPSYCHOTICS

Antipsychotics are often used as first line drug treatment for agitation and aggression, with between 40-60 per cent of residents with dementia in nursing homes prescribed such treatment<sup>132</sup>. In the United Kingdom alone, a report for the Department of Health in 2009 estimated that 180 000 people with dementia were being prescribed antipsychotics, causing 1620 excess strokes and 1800 deaths a year<sup>133</sup>. The prescription of antipsychotic drugs has been shown to increase from just over 8 per cent before entering a care home to 18.6 per cent afterwards<sup>134</sup>. A study in 2010 estimated that 54 000 older care home patients in England and Wales received antipsychotic medication without a diagnosis of severe mental illness<sup>135</sup>. In 2012 the NHS Information Centre published the results of an audit of prescriptions by GP practices in England. Their report found that antipsychotic prescriptions for people with dementia had reduced by 52 per cent between 2008 and 2011. However, there was strong regional variation, with rates of prescribing of antipsychotic drugs up to six times higher in some areas than in others<sup>136</sup>. Antipsychotics make a significant contribution to what is known as the “anticholinergic burden” of prescribed medication – the cumulative effect of using multiple medications with these properties at the same time – which is related to increased mortality<sup>137</sup>.

In an audit and review of care home residents receiving antipsychotic medication carried out by a trained pharmacist, 26 per cent did not need the medication and in 58 per cent of residents the risks of taking the medication were felt to outweigh the benefits. In this study, over 17 per cent of residents had their medication stopped and it was reduced in 20 per cent of individuals<sup>138</sup>. In a report by the Alzheimer's Society in 2013, it was stated that:

*“Many people with dementia in care homes are likely also to be using prescription medicine, either for their dementia or for another health issue, the use of which requires monitoring. The pharmacy sector has engaged strongly with the appropriate prescriptions of medicines, including supporting a review of antipsychotics, which, despite reductions in prescriptions, are still too often inappropriately prescribed to people with dementia in care homes.”<sup>139</sup>*

An independent pharmacist working with nursing and care staff has been shown to “realise significant medicine acquisition cost savings” and improve residents’ quality of life<sup>140</sup>. Similarly a specially trained pharmacist focusing on antipsychotic use in people with dementia, achieved a 25 per cent reduction in antipsychotic prescribing<sup>141</sup> and a study of nursing home residents in Northern Ireland showed marked reductions in inappropriate psychoactive medication prescribing following monthly visits by a pharmacist undertaking targeted medicines reviews<sup>142</sup>. This work emphasises the need for regular medication reviews by a skilled professional with an ongoing relationship with the care home in question, a role very suited to local community pharmacy professionals.

## CHILDREN IN RESIDENTIAL CARE SETTINGS

Because much of the literature on medicines management in care homes concerns older people, this report has concentrated on their needs and the pharmacy professional’s role and responsibilities in dealing with the issues arising. However, much of what is written also applies in some measure to children in residential care settings. The issues about local communication systems, leadership and training are as pertinent to staff working in children’s homes as for those caring for older people. Care planning, review and risk assessment are equally important and the organization of medicines management in the home is as central in dealing with medicines errors for young residents as it is in nursing care homes. One report in 2004<sup>143</sup> found that only 37 per cent of children’s homes met the national minimum standards for medication handling in care homes. 48 per cent almost met the standard, while 15 per cent failed completely. Homes with the worst medication scores tended to be those in which the overall quality and management of the home was poor. Typical examples of poor practice included the wrong medication being given, medicines being stored insecurely or at the wrong temperature and inappropriate handling of medicines by untrained staff.

The administration of medicines to children in residential care settings is covered by the Children’s Homes Regulations 2001<sup>144</sup> in England and forms part of both the NICE guideline and CQC inspection regime. The regulations state that the registered manager of the home should make the arrangements for safe handling, recording, administration and disposal of any medicines except where they can be self administered, in which case, if the child can safely store and use them, the manager’s role becomes one of arranging supply.

In Scotland, The National Care Standards; Care Homes for Children and Young People<sup>145</sup> sets out similar standards and inspection is carried out by The Care Inspectorate. As with the standards for older adults, the underlying principles for these standards are being revised at present. In Wales, The Children’s Homes (Wales) Regulations 2002 are again similar and inspection is undertaken by the Care and Social Inspectorate, Wales.

Self medication and staff training in the use of inhalers, homely and OTC medicines will require pharmacist input in the same way as for older people’s residential care and, in particular, covert medication in children under the age of majority is an issue worthy of further consideration.

The RPS guide, *Handling Medicines in Social Care*,<sup>146</sup> gives a guide to medicines management in children's residential care settings. Medications policies covering obtaining and storing medicines, supporting the child to self administer, using as required and homely medicines and training care workers to help as required are outlined along with procedures for children receiving respite care.

Therefore, it is clear that the whole system of residential care needs to be considered when addressing the issues raised in the previous sections, not just those involved in the care of older people.

## THE WIDER IMPLICATIONS OF PRACTICE IN THIS AREA

The sections above not only highlight areas where pharmacy professionals are a key part of enabling safe medicines management in care homes but also some of the wider issues of practice that arise from this area of care.

### SAFEGUARDING

*“The term ‘safeguarding’ describes a range of activities that organisations should have in place to protect people (both children and adults, unless stated otherwise) whose circumstances make them particularly vulnerable to abuse, neglect or harm”<sup>147</sup>*

It is clear from the previous discussion that protecting vulnerable residents in care homes from medication errors and, in some cases, from potential dangerous medications such as antipsychotic drugs or inadequately supervised “as required” or homely medicines is an underlying requirement of pharmacy professionals and registered pharmacies supplying and dispensing to residential care homes and one that must be considered when developing the response to the evidence. Full account of “*Working Together to Safeguard Children*”<sup>148</sup>, *National Guidance for Child Protection in Scotland 2014*,<sup>149</sup> “*No Secrets: Guidance on developing and implementing Multi-Agency Policies and Procedures to protect Vulnerable Adults from Abuse*”<sup>150</sup> The new provisions of the *Care Act (2014)*<sup>151</sup> which came into force in England in 2015 will need to be taken when recommending the way forward. In Scotland, the *Public Bodies (Joint working) Act*<sup>152</sup> about the integration of health and social care was granted royal assent on 1 April 2014 and, in Wales, the *Social Services and Wellbeing Act (Wales)*<sup>153</sup> will start to take effect from April 2016. Both of these will require careful consideration in their respective administrations. The GPhC hosted roundtable discussion also raised the issue of “near misses” and the need to ensure these are reported and learned from so as to lessen the risk of them occurring again.

NICE’s 2015 quality standard on the management of medicines in residential care states that:

*“Safeguarding issues in relation to managing medicines could include the deliberate withholding of a medicine(s) without a valid reason, the incorrect use of a medicine(s) for reasons other than the benefit of a resident, deliberate attempt to harm through use of a medicine(s), or accidental harm caused by incorrect administration or a medication error. “*

This is therefore an area which local commissioners and providers need to consider when looking at local systems and processes.

### DEPRIVATION OF LIBERTY/HUMAN RIGHTS

In both the areas of covert medication and the use of antipsychotics and other psychoactive drugs, the care home resident’s human rights under the Human Rights Act (1998)<sup>154</sup> and capacity under the Mental Capacity Act (2005)<sup>155</sup> in England and Adults with Incapacity (Scotland) Act (2000)<sup>156</sup> are of paramount importance and the pharmacy professional’s actions need to reflect this as detailed in the GPhC’s Standards of conduct, ethics and performance<sup>157</sup>.

## DUTY OF CANDOUR

The Duty of Candour<sup>158</sup> applies to all NHS services in England and those provided through contracts with primary care contractors including all pharmacy professionals. Duty of Candour regulations have been in place in Wales since 2011<sup>159</sup> and draft legislation is passing at present through Parliament in Scotland<sup>160</sup> to legislate for a statutory Duty of Candour there. As stated in the NHS Constitution for England:

*“You have the right to be given to contribute to a climate where the truth can be heard, the reporting of, and learning from, errors is encouraged and colleagues are supported where errors are made.”<sup>161</sup>*

The duty requires staff to be open and honest about errors however caused. With seven other professional regulators, the GPhC has jointly signed a statement on the implications of this on pharmacy professionals’ practice<sup>162</sup>;

*“Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.*

*This means that healthcare professionals must:*

- *tell the patient (or, where appropriate, the patient’s advocate, carer or family) when something has gone wrong;*
- *apologise to the patient (or, where appropriate, the patient’s advocate, carer or family);*
- *offer an appropriate remedy or support to put matters right (if possible); and*
- *explain fully to the patient (or, where appropriate, the patient’s advocate, carer or family) the short and long term effects of what has happened.*

*Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested.*

*Health and care professionals must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest and not stop someone from raising concerns.”*

The majority of care homes are privately owned and the contract between the resident and home is usually outside of the NHS apart from where NHS nursing care payments are being paid or the resident is in receipt of NHS Continuing Healthcare. However, standard essential, enhanced and advanced pharmacy services under the contract with the NHS mean that practitioners delivering those are still covered by the duty of candour. This is an area which may require further consideration when looking at the pharmacist’s role in care home services, some of which may be NHS commissioned and some as a result of direct contracts with individual private care homes.

It is tempting to suggest that the role of pharmacy professionals in medicines management in residential care homes is one that needs individual professional action. The focus of both the NICE guideline and quality standard and the inspection regimes of the three countries are on the overall impact of a range of health and social care professionals with pharmacy professionals and pharmacies one small part of the chain of responsibility for caring for some of the most vulnerable children and adults in Great Britain.

There are some areas where pharmacists carry the primary responsibility for example around the accurate dispensing of medication and others where their role is secondary albeit not any the less important e.g. in ensuring that drugs are safely administered at a time of day where they are least subject to error and yet still retain maximum effectiveness for instance by being given with meals etc. The roundtable held as part of this work also raised the issue of pharmacist education, with pharmacists needing to have experience of the particular issues relating to care home residents to be able to provide the appropriate advice to the care home staff regarding a resident's medicines. Participants suggested that it may be difficult to say what type of pharmacist is best able to provide the correct advice, i.e. primary care pharmacist, hospital pharmacist or community pharmacist. The pharmacy professionals who supply to care homes may not have the requisite training to advise on all of the ailments of care home residents, for example, the pharmacist supplying to a mental health care home would need to have knowledge or training in mental health. The need for networks of pharmacists giving advice therefore should be considered.

It must also be recognised that any work undertaken must take into account the future direction of the profession so that any action does not become outdated as professional practice develops. For example, it is worth quoting at length the RPS commission on the future of pharmacy published in November 2013<sup>163</sup>:

*“The Commission heard of other examples where pharmacy teams working in social enterprises or private companies have been commissioned by a former primary care trust or a new clinical commissioning group to provide medicines support to patients in local care homes, either on a time-limited basis to review the homes’ systems and processes for storing and administering medicines, or on a regular footing to review patients’ medication, train and support care staff, and provide on-going advice and supervision about the safe use of medicines. This points to the potential for pharmacists of forming networks, chambers or companies, as a basis for bidding for and delivering specific pharmaceutical services that are sought by clinical commissioning groups, local authorities, or indeed GP federations or networks – the latter may sub-contract for medicines optimisation and other services as part of plans to extend urgent and long-term conditions care.”*

And:

*“Pharmacy has the potential to be commissioned by local government social services and/or clinical commissioning groups to provide bespoke pharmaceutical care to vulnerable older people in nursing and residential homes... This could include support when prescribed new drugs, on-going review and supervision of medicines, repeat prescribing, training for social and nursing care staff, and advice to care providers on medicines use, side effects, and storage.*

*There is a powerful case to be made by pharmacists for such a role, based on the error rate for medicines in residential and nursing home care and the potential of offering tailored pharmaceutical care services to social care and its staff. Whilst many pharmacies already deliver medicines to older people's homes, there is not often any follow-up supervision in respect of whether the drugs are taken properly, monitoring of side effects, advice to carers about medicines use as part of wider primary care for an individual."*

The role of local government, particularly for England, was also mentioned in the roundtable as a potential agent for change. Indeed, the roundtable considered that there should be integrated medication management boards with GPs, pharmacists and lay members advising on care home staffing issues, the importance of dispensing timings, hydration of patients with long term ailments, etc. Integrated health care and personal commissioning models, under development as part of wider government health policy, would need to include pharmacy professionals to deliver maximum benefit for individual patients or residents.

When the RPS (Scotland) published "*Improving Pharmaceutical Care in Care Homes*" in 2012<sup>164</sup>, it made several recommendations for the profession:

- Integrating dedicated roles from both community pharmacy professionals and pharmacists in managed care sectors.
- Sharing hospital discharge information and clinical information between pharmacist, GP and care home.
- Developing national guidance on repeat prescriptions and supply and administration using nationally agreed documentation.
- Developing national guidance on best practice in medication review, appropriate polypharmacy and safer medicines use.
- Working with medical and nursing colleagues to reduce inappropriate polypharmacy and high risk medicines and improvements in anticipatory care.
- Aligning one GP practice and one pharmacy per care home.
- Developing a more robust contract system and service level agreement between community pharmacy and care home providers.
- Supporting implementation of the Dementia Care Standard with pharmacy input.
- Working with doctors and nurses to achieve targeted reduction in the use of psychoactive medication and antipsychotics in the frail elderly.
- Developing a national educational framework to support training for all pharmacy professionals delivering pharmaceutical care to people in care homes.
- Supplying of medicines in original packs to care homes to be promoted as standard.
- Introducing of a national integrated multidisciplinary assessment tool to identify, assess and resolve medicines adherence issues for people living at home but requiring care.
- Making prescribing data available at care home level to allow for audit and support
- Ensuring that repeat prescriptions are for no more than 28 days to reduce waste.
- Enabling pharmacists to be involved with care home staff to ensure palliative and end of life care needs are identified and met. This would include a greater involvement of existing community pharmacy palliative care networks as a resource.
- Ensuring that clinical reviews include medication administration reports for errors.

In September 2014, the RPS (England) returned to this subject with a further paper<sup>165</sup>, quoting, in particular, several studies showing the impact that putting pharmacists in charge of medicines management in care homes can have. For instance, a four month trial in a care home in London where a pharmacist was given full responsibility for medicines management reported a 91 per cent reduction in errors associated with medicines with them dropping from 138 to 12 over the course of the study<sup>166</sup>. Health Foundation project undertaken in Northumbria<sup>167</sup> demonstrated the benefit of a pharmacist carrying out medication reviews with residents and their families. According to the report, 1.7 medicines were stopped per resident reviewed and for every £1 invested in the intervention, £2.38 could be released from the medicines budget. It also reiterated the 2012 recommendation that one community pharmacy and one GP practice should be aligned to a care home to “enable the provision of a co-ordinated and consistently high standard of care across all service users”. Brighton and Hove CCG were also cited as having contracted an independent medicines optimisation organisation to undertake medication reviews for 2000 care home residents on behalf and working closely with all GP surgeries. It saved £300k and reduced avoidable admissions, yielding further but unquantified savings. The RPS also believes that good medicines optimisation by pharmacists in care homes will help to solve the issue of waste medicines, improve efficiency and provide better health outcomes for care home residents.

However, it is not just the services provided directly from community pharmacists which are changing. The Hackett review of the homecare medicines market<sup>168</sup> will add complexity to the role of the pharmacist in ensuring that care homes provide safe and effective medicines management practice. Home care medicines services deliver ongoing medicine supplies and, where necessary, associated care, initiated by the hospital prescriber, direct to the patient’s home with their consent. This can include where the home address happens to be a care home. The expansion of the direct supply market to care homes highlights the need for local contracts to include advice even when, in some cases, the supply and delivery of medicines may not be going through the community pharmacy. The Royal Pharmaceutical Society’s Standards for Homecare Services<sup>169</sup> makes it clear that homecare services should:

*“...ensure that within each level there is a pharmacist responsible for homecare and that the definitions of responsibility and accountability are documented and clearly understood by all parties. The pharmacist with responsibility for homecare also includes responsibility for other disciplines, as relating to homecare services, working to support but not provide professional oversight of other healthcare professionals.”*

The ten standards outlined include four on the safe and effective delivery of homecare services and include criteria on safe multidisciplinary working, communication, supply, administration and recording of medication delivered in this way. However, the impact that this might have on existing services by local community pharmacists and services such as advice and support is not something covered by the standards. As the Hackett review<sup>170</sup> also states:

*“There is no incentivisation to reduce patients on homecare medicines delivery by using community pharmacy alternatives, or change service models that are not aligned to deliver the best interests for patients, where this might be appropriate.”*

Being able to work together across residential care settings will be a challenge for pharmacy professionals and one where national bodies involved in pharmacy standards and regulation may

need to clarify the responsibilities of all pharmacy professionals involved within local health communities.

Community pharmacies and individual pharmacy professionals will continue to operate within three different levels of service when working in residential care homes:

**1. Nationally contracted services**

Services provided as part of the national pharmacy contract including dispensing and supply of medicines, national enhanced services etc.

**2. Locally commissioned services**

Services provided as part of local commissioning arrangements through CCGs or Health Boards such as training, medication reviews and expert advice.

**3. Directly contracted services**

Services provided as part of a direct contract with an individual home or group of homes, outside of local commissioning arrangements through the CCG or Health Board.

Any national guidance given will need to ensure that as the balance moves between these three types of service, the regulatory position of pharmacy professionals is clear and relevant. With the potential for new services, new directions in community pharmacy and new commissioning arrangements in the wider health service, particularly in England, ensuring that any guidance given by the involved national bodies covers new opportunities will be important.

## IMPLICATIONS FOR PRACTICE

The literature search has highlighted a series of different issues facing care homes and the residents within them. Many may be improved by close local working and better communication and commissioning systems. Mostly these changes will not require further action by the GPhC as they are already part of pharmacy practice under the existing standards outlined previously.

However, there are some areas where, using a co-ordinated and cohesive approach, national bodies involved in pharmacy regulation and improvement could improve the quality of data available on pharmacy practice and also where further consideration of the responsibilities of pharmacy professionals may be advantageous.

The roundtable, held in December 2014, included individuals from professional bodies, home providers, regulators and inspectors and, following a detailed but wide ranging discussion, outlined the importance of the following key issues:

- **Communication**

Pharmacy professionals have a major contribution to make in improving communication with GPs. There are lots of examples of such good practice and the development of these good practice examples and their accessibility to a range of local professionals would be helpful. It can be difficult to maintain relationships between GPs, community pharmacists, hospitals and the individual sometimes due to differences in the practice setting or provision or as a result of an individual resident being moved. Better integration of services around the person and communication between health and care professionals and with the resident is needed. Greater clinical input into care homes could help, for example, with pharmacy professionals providing advice to care home staff about a resident's medicines and their administration, pharmacy professionals working in care homes, or by GPs being more involved in follow-up care for residents.

- **Acknowledging the different and individual needs of homes**

Care homes need to be supported to have relationships with pharmacy professionals with relevant expertise and knowledge about this sector including the particular needs of residents and develop communication networks with them and with GPs. There can be a lot of difference between the mix of residents in individual care homes and knowledge of potential issues is crucial. Some care homes are part of chains, but many are independent and run individually. Homes providing nursing care experience different issues than those giving residential care only. So, for example, medicines waste disposal is an issue for residential homes. Unlike care homes, who can return unused medicines to a pharmacy, nursing homes have to pay for clinical waste removal.

- **Training**

High quality and effectively tailored training is very important for all involved in providing medicines in and to care homes and should be developed in a locally coherent form with pharmacy professionals playing a central role. Given the variety and turnover of staff with different skills, competencies and experience, there is a need for ongoing training particularly around medicines management. With the right training a care worker could effectively manage and administer medicines, however, training can sometimes be seen as

an easy solution. The training experienced is often of variable quality. It needs to be more tailored to staff and care home needs and evaluated for impact.

There was some discussion around the expertise of pharmacists and whether all who supply to care homes have appropriate experience to provide advice on the often complex needs of care home residents. It was felt that this was within the core business of a pharmacist whether they were hospital or community based. However, it was recognised that, for example, a pharmacist supplying to a care home specialising in mental ill health could need a higher level of expertise in mental health.

- **Safeguarding**

A greater focus on and more active approach to safeguarding residents is needed, as there is currently a lack of awareness of the issues. There were also concerns about potential deprivation of liberty and protecting and maintaining resident's human rights, for instance, in relation to possible covert administration of medicine.

- **Inspection and monitoring**

Medication policies and the monitoring of them can be beneficial. However, there needs to a greater focus on meeting resident needs and monitoring should check that residents have received appropriate care. The inspection of care homes and how medicines management is undertaken may require appropriate evidence not currently accessed and more training for inspectors. There was also a desire for more accessible clearer guidance which could easily be used by all staff in a care home.

- **Governance**

Care homes are often managed by different providers and the commissioning of services is complex. While care homes themselves are inspected by national inspectorates many types of health care provider or professionals may be involved in relation to an individual resident. A more integrated health care model would be beneficial for residents.

There are examples of good practice and instances where pharmacists had made a difference to the quality of care. However, there was discussion about what supports this to happen, such as, local commissioning of pharmacy services into care homes. Some questions were raised around professional responsibilities, employer requirements and any regulatory requirements.

Recommendations from the roundtable discussion were:

### **1. Relationships around the patient or resident**

- There should be a stronger focus on what supports the patient or resident at a local level
- Health professionals need to form effective relationships including the key relationship between the GP and Community Pharmacist to support integrated care.
- A stronger more integrated role for pharmacists and pharmacy technicians in care homes is needed and a stronger relationship between the care home, community pharmacy and GP
- This work needs to be part of the integration agenda e.g.as part of integrated personal commissioning and located within future implementation of the governmental policy agendas across the three countries.
- There needs to be the opportunity for a local focus on safeguarding.

- Medicines management could be improved through appropriate staff training and more effective use of the medicines review process

## **2. Effective systems**

- Better use of technology is needed to support communication and information sharing
- Systems need to be in place to share clinical data between settings and health professionals
- Local systems need to support access to expertise and make it easier to provide services
- Financial systems need to incentivise professionals/clinicians to work together.

## **3. National guidance and standards**

- National standards, guidance and expectations need to work and be used locally.
- Relevant health and social care regulatory bodies should ensure that standards and guidance are clear and joined-up
- GPhC and care home regulators' inspections should consider pharmacy services to care homes

## **4. Local issues**

- Commissioning of services requires a greater focus on what good looks like
- Local councils, health and wellbeingboards in England, and practice committees could be more actively involved in and share expertise the care homes in their areas.

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