Pharmacy in care homes

9 December 2014,
Royal College of General Practitioners, 30 Euston square, London NW1 2FB

Seminar report

Nigel Clarke, GPhC’s Council Chair, welcomed participants and shared the GPhC’s interest in better understanding the role and extent of pharmacies and pharmacists involvement in care home. The GPhC is aware of some of the issues facing care homes, in particular the use and management of medicines, but is keen to hear from those with experience of pharmacy in care homes.

Chair’s introduction

Seminar Chair Stephen Jackson, Professor of Clinical Gerontology at King’s College, London highlighted the spirit of openness, dialogue and reflection that would characterise the seminar. By way of context, he drew on his own experiences and shared some of the issues he had encountered regarding the supply, delivery and administration of medicines in care homes. In particular, he commented on the number of staff, not just pharmacists, involved in providing care and the variance in their skills. For instance, registered nursing staff in nursing homes compared to non-registered staff in residential and nursing homes. He also highlighted the importance of effective processes for medicines management, and, that processes may be at fault as well as human error. He finished by saying that we need to build a picture of what is currently happening and that participants’ views, ideas and observations would be helpful.

Current issues – Pharmacy in care homes

Speaker: Jo Webber, Independent Policy Consultant

Jo had conducted a review of evidence, on behalf of the GPhC, about the current issues in care homes. This highlighted the following findings:

- There is much published in this area, but many reports identify similar issues occurring over time.
- There are recognised system issues, but further consideration needs to be given to these and individual roles.
- The most in-depth current research is the Care Homes Use of Medicines Study (CHUMS) from 2009.
- Current issues can be seen as relating to the system or the individual.
- Systems issues include: communication, training and coordination (for example resident moves)
Individual issues are around: risk assessment, planning, physical environment, monitored dosage systems (MDS), homely, anticipatory and as required medicines, covert medication, polypharmacy, use of anti-psychotics, and, self-medication as the patient can act as the final check.

Data are not currently available about which pharmacies provide services to which homes, or, the numbers involved.

There is some evidence that CCGs are doing more to include pharmacies in care homes.

Other reports and resources were highlighted as sources of evidence and information. These included: the NICE (2014) guideline, Managing medicines in care homes; the Hackett Report (2011) on Homecare Medicines; and, several of the Royal Pharmaceutical Society’s publications, such as Now or Never (2013) and Pharmacists Improving Care in Care Homes (2014) among others.

In terms of contracts, pharmacies provide services to care homes through the NHS pharmacy contract, CCG contracts and individual pharmacy contracts with care home service providers. However, we do not know if this makes a difference to the level of services provided.

Areas for further consideration include any regulatory implications, safeguarding and the role of pharmacies, the impact of the duty of candour and the work of regulators.

**Round table discussion**

**Part 1 – Current issues**

The first discussion focussed on what participants saw as the key issues for pharmacy in care homes, drawing directly on their own experience and expertise. The following does not capture the detailed discussions that took place, but instead attempts to highlight the broader themes which emerged.

**Difference**

There is much difference between individual care homes. For instance:

Some care homes are part of chains, but many are independent and run individually.

Nursing homes and residential homes can provide different types of care, and experience different issues.

Medicines waste disposal was highlighted as 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**

Given the variety and turnover of staff with different skills, competencies and experience, there is a need for training particularly around medicines management. For instance, come commented that with the right training a care worker could effectively manage and administer medicines. However, training can sometimes be seen as an easy solution. 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 a pharmacist supplying to a care home specialising in mental ill health could need a higher level of expertise in mental health.

**Communication**

It can be difficult to maintain relationships between GPs, community pharmacists, hospitals and the patient sometime due to, differences in the setting or provision or, a patient being moved. Better integration of services around the patient and communication between them and with the patient is needed. Greater clinical input into care homes could help. For instance, pharmacists providing advice to care home staff about a resident’s medicines and their administration, or, GPs being more involved in follow-up care for residents.

**Safeguarding**

There was a strong sense that 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.

**Guidance, policies 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. Some thought was given to the inspection of care homes, how medicines management is checked, appropriate evidence and 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 and responsibilities**

Consideration was given to responsibility for care homes as they are often managed by different providers and the commissioning of services is complex. While care homes themselves are inspected by CQC, many types of health care provider or professionals may be involved in relation to an individual resident. It was thought that a more integrated health care model would be beneficial for residents.

The role of pharmacists in care homes was also discussed. Participants were aware 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, commissioning of pharmacy services into care homes by CCGs. Some questions were raised around professional responsibilities, employer requirements and any regulatory requirements.
Part 2 - Changes and improvements

This discussion focused on good practice and how this could support improvement. Lots of examples of good practice were mentioned. However, it was felt that these were often occurring in isolation and needed to be scaled up. Again the detail of the discussion is not captured, instead the key themes are presented, many of which relate to the key issues identified in the first session.

Relationships around the patient or resident
- Focus more strongly on what supports the patient or resident at a local level
- Health professionals need form effective relationships including the key relationship between the GP and Community Pharmacist to support integrated care.
- A stronger more integrated role for pharmacists in care homes, and, a stronger relationship between the care home, community pharmacy and GP
- Needs to be part of the integration agenda and located within future implementation of the NHS Five Year Forward View.
- Opportunity for a local focus on safe-guarding.
- Medicines management could be improved through appropriate staff training and more effective use of the medicines review process

Effective systems
- Better use of technology to support communication and information sharing, for instance, between settings such as hospitals and care homes
- To share clinical data between settings and health professionals
- To support access to expertise and make it easier to provide services
- Financial systems need to incentivise professionals/clinicians to work together.

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 CQC inspections should consider pharmacy services to care homes

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

Closing remarks
GPhC Chair, Nigel Clarke highlighted some of the issues discussed above, such as integrated services, sharing of data, single patient records, best practices and the usefulness of technology in care homes. He closed by thanking attendees for their participation.