Optimising the medicines of patients who are living in a care home.

Next Steps

If you would like to discuss our service model and how we could support you please contact a member of our team.

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The Royal Pharmaceutical Society (RPS) believes it is time to change the way medicines are used in care homes. Too many care home residents are taking medicines which are doing them more harm than good.

In 2014 the National Institute for Health and Care Excellence (NICE) guidance on Managing Medicines in Care Homes was published, and related quality standards (March 2015). The latter includes the requirement that people who live in care homes have an accurate listing of their medicines made on the day that they transfer into a care home (medicines reconciliation) and they have at least 1 multidisciplinary team (MDT) medication review per year or more frequently as documented in their care plan.

The RPS recent report has calculated the value of a pharmacist in every care home as saving £135 million, £60 million from a pharmacist optimising medicines, and £75 million saved through the prevention of avoidable hospital admissions. In addition, an estimated £24 million is lost every year due to medicines waste in care homes across England alone. CCG care home projects have also shown a trend towards reductions in emergency admissions.

Practice clinical pharmacists can perform a detailed and comprehensive medication review. This includes working with patients and carers to optimise their regime, communicating with patients, care home staff, family, carers, GP practices, community pharmacists, and other healthcare professionals to ensure accuracy and continuity of their regime, reducing unnecessary polypharmacy, and minimising waste of NHS resources. The ‘Care Homes Use of Medicines Study’ (CHUMS) study of pharmacist-conducted medication review of all medicines in elderly care homes showed that 70% of residents were exposed to a medication error every day and modifications to treatment were needed for half of the medicines prescribed. This was ground breaking research that led to a Department of Health alert ‘The use of medicines in care homes for older people’ in 2010 that called for immediate action to determine how medication errors in care homes for older people could be reduced.

Prescribing Support Services (PSS) has pioneered the development of primary care pharmacist services since 2000. Our care home medicines management service in Bradford commenced in 2009 with one of the pharmacists involved with the CHUMS study. It produced a net saving of £200/resident with improved quality of medication prescribing and monitoring. Our work has highlighted that working closely with care home staff, GPs, community pharmacy, and other healthcare professionals, can identify unnecessary and inappropriate prescribing and wasted medicines thus reducing the risk of harm.

PSS is able to work with health and social care commissioners to develop and implement a fully managed, cost-effective service model, optimising the benefits from medicines and reducing the risk of harm. Many areas are utilising the ‘Better Care’ funding for support services in care homes. A care home service addresses the key metrics for measuring progress of integration i.e.:

- Reduction of non-elective admissions
- Transition of care on admission to residential and care homes
- Effectiveness of reablement

Prescribing Support Services (PSS) is one of the leading providers of practice based pharmacists in the UK.
The Royal Pharmaceutical Society believes that better utilisation of pharmacists’ skills in care homes will bring significant benefits to care home residents, care homes providers and the NHS.¹

Pharmacists improving care in care homes

There are approximately 431,500 elderly and disabled people in residential care of whom 414,000 are aged 65 and over. An ageing population and policies to encourage elderly people to stay in their homes longer mean that care home residents are generally older and frailer. The elderly are particularly at risk from errors with medicines as they can have a high level of morbidity, with multiple health problems and are often prescribed several medicines for several conditions. The Royal Pharmaceutical Society (RPS) believes pharmacists should have an embedded role in care homes with overall responsibility and accountability for medicines and their use.

PSS has experience of working with GP practices to support their care home residents since 2009. On average 2.3 medication changes are recommended per patient with over 84% accepted and actioned. Clinical outcomes include:

- Number of patients taking benzodiazepines or antipsychotics reduced by 32%.
- Number of patients taking medications with anticholinergic side effects reduced by 37%, reducing the risk of falls and cognitive impairment.
- 31% of patients found to have overdue medicine monitoring needs.

“Managing polypharmacy effectively is key to ensuring our patients in care homes are kept safe and only taking medicines that they need to – this also reduces medicine waste, and at a time when the health service is running with scant resources, this is particularly important. With GPs and our teams under incredible resource and workforce pressures, the suggestion that pharmacists take on some of the medicine management responsibilities in care homes is definitely worth exploring.”

RCGP response, 2016²

¹ Royal Pharmaceutical Society. Pharmacists improving care in care homes. 2014
   http://www.rpharms.com
² RCGP response to RPS report.
   http://www.rcgp.org.uk
Pharmacist in the care home

1. Discovering what is really happening with medicines administration in the care home
   - Visiting the care home can help to discover excess medications and address stock control
   - High cost medicines can accumulate

2. Medication review
   - A clinical and technical review of medicines
   - Addressing medicine-taking behaviour
   - Addressing issues relating to use of medicines in the context of their clinical condition and quality of life

3. Assessing risk of interactions and adverse effects.
   - Ensuring adequate monitoring
   - Reduce the risk of errors in prescribing, monitoring, dispensing and administration
   - Reduce the risk of ‘therapeutic misadventure’ and reduce admissions to hospital

4. Simplification of the medication regime where possible
   - Are medications still appropriate and effective?
   - Stopping unneeded medicines reduces cost and reduces the potential for adverse effects

5. Ensuring adequate monitoring
   - Reduce the risk of errors in prescribing, monitoring, dispensing and administration
   - Reduce the risk of ‘therapeutic misadventure’ and reduce admissions to hospital

6. Reduce waste medicines accumulation
   - Visiting the care home can help to discover excess medications and address stock control
   - High cost medicines can accumulate

Reduce non-adherence of medicines

Concordance and compliance support
- Practice medicines information service
- Staff training and development

Contribution to clinical education and PLT

General advice to patients

Simplification of the medication regime where possible
- Are medications still appropriate and effective?
- Stopping unneeded medicines reduces cost and reduces the potential for adverse effects

Reduce the risk of ‘therapeutic misadventure’ and reduce admissions to hospital

Simplification of the medication regime where possible
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Prescribing Support Services

Providing practice pharmacists to the NHS for over 15 years
PSS care home service model

Service aims
- To support the staff and residents of care homes in order to achieve better healthcare outcomes from the use of medicines
- To reduce avoidable harms from inappropriate medicines use, poly and hyperpolypharmacy
- To provide regular medication review for all care home residents
- To provide a timely medication review for new care home residents and those newly discharged from hospital

Service objectives
- To contribute to the work of a multidisciplinary team to provide healthcare for older adults or those with other long term conditions living in a care home
- To ensure that patients receive safe effective medicines, minimising adverse effects and maximising positive health outcomes.
- All care home residents will have an annual documented MDT review of their medicines, where possible involving the patient/resident and/or their carers or welfare proxy
- Support GPs and other prescribers to make effective prescribing interventions

Service outcomes - the outcomes measured
- Improved quality of life e.g. measurement of service outcomes - the outcomes measured
- Reduction in inappropriate hospital admissions by reviewing medicine management procedures as well as undertaking patient specific medication reviews
- Support care home managers and staff to ensure that medicines are managed safely within the home
- Assuring that homes have appropriate policies and procedures in place relating to medicines management

Wider healthcare system benefits (reduced

Net annualised savings are £184 per person reviewed, and for every £1 invested in the intervention, £2.38 could be released from the medicines budget.¹

Clinical cases reducing harm: patient stories

Medicines reconciliation issues
- The patient was seen in the epilepsy clinic where the consultant recommended increasing the levetiracetam. This increase did not get actioned. The pharmacist visited the home four months later and the carers said that the patient had been admitted to hospital with a seizure the previous night.
- A patient was prescribed sertraline 50mg daily, but she was weepy and tearful and low in mood. The pharmacist discovered that she had been on 100mg when under the previous GP surgery. When she changed surgeries the dose was inadvertently reduced. The GP was alerted and dose increased back to 100mg daily.
- An anaemic patient with low ferritin was admitted to hospital, and discharged on ferrous sulphate 200mg tds. Unfortunately this had not been added to the repeat list one month later, the pharmacist organised for this to be added to repeat list and started.
- The Kepra dose had recently been increased to 1 gram bd following admission to hospital with a fit, and the discharge note stated 1 gram bd. The dose at the care home, and on the GP repeat medication list still said 500mg bd a month later. GP alerted.

Medication monitoring not done
- Patient on lithium but the last lithium level was taken 6 months ago, the last U&Es check was 12 months previously, and the last TFTs 11 months ago.
- Patient discovered to have had the ramipril dose increased but U&Es not subsequently rechecked since the increase.

Inhaler not being used effectively
- The pharmacist undertook an inhaler technique check with a care home resident who had stated that his inhalers didn’t really work. When assessed, the patientsquirted 2 puffs of his Ventolin into his mouth and did not inhale or hold his breath. The pharmacist corrected his technique and demonstrated how he should inhale using the ‘Incheck’ device, and also spoke to him about smoking.

A recent Health Foundation project undertaken in Northumbria demonstrated the benefit of pharmacist interventions in Care Homes. Using pharmacist prescribers to carry out medication reviews with residents and their families they demonstrated a cost effective model which could be undertaken in other areas. The net annualised savings were £77,703, or £184 per person reviewed, and for every £1 invested in the intervention, £2.38 could be released from the medicines budget. PSS has shown similar figures in their care home service in Bradford.

Research undertaken in 2009 by the York Health Economics Consortium and the School of Pharmacy, University of London, estimated that medicines wastage in English care homes was £50 million from medicines that are disposed of unused. One study showed most of the wasted medicines are laxatives, paracetamol, calcium supplements, aspirin and omeprazole.

A King’s Fund report ‘Polypharmacy and medicines optimisation: Making it safe and sound’ states that ‘Multi-morbidity and polypharmacy increase clinical workload. Pharmacists, as experts in medicines use, can play a significant role in the reduction of problematic polypharmacy.’

PSS can work with GPs and commissioners on service model development, for example:

- Video consultations between care home and GP practice.
- GP IT system in each care home.
- Care home MDT/quality improvement team (GP, pharmacist, nursing, OT input)
- Care home training support

Economic case

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Service development

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Mobilising your service

PSS is able to support health and social care commissioners with developing and mobilising a care home service. We are happy to work with commissioners to pilot the service and work collaboratively with secondary care colleagues, for example discharge or reablement teams.

Our mobilisation plan includes working with local partners and stakeholders to develop an integrated service model to:

- Establish the local commissioning strategies and planning forums.
- Develop a directory of local key services.
- Engage with practices.
- Map self-help or community support services to enable the team to provide a holistic support service to patients.
- Establish how to communicate any change in operational delivery to local partners and patients.
- Assess what policies and processes need to be amended.
- Define what the critical factors are to ensure the new service is successful.

PSS: An overview

As an established NHS provider we are able to work with practices and primary care providers to implement a patient centred service solution which adds value to each primary health care team and their patients.

Our expertise includes:

- Experienced senior management team with experience across primary and secondary care as well as NHS commissioning expertise
- Core pharmacist team supported by effective clinical governance system inc CQC requirements
- Experience of working with all the main GP clinical systems
- Operational procedures that meet the high standards of corporate and information governance
- Track record of delivering innovative service solutions for example supporting the practice to develop anticoagulation services
- Service mobilisation experience including the recruitment of new teams
- Strong academic links with a number of our directors serving in University posts
- We encourage all of our clinical staff to complete post graduate education as well as attaining an independent prescriber qualification
- Support with CQC compliance - repeat prescribing policy, administration, storage and disposal of medicines policy etc.