Safety of Medicines in Care Homes

Framework:
Making the best use of medicines across all care settings

Introduction

We know from the *Care Homes Use of Medicines Study* (CHUMS) report that medicines use in care homes needs to be challenged and improved. We have taken the recommendations from CHUMS and set out the following principles to optimise medicines use across all care settings, focussing on care homes for the purposes of this report. We have used examples where staff have made effective changes to their practice in care homes, across all elements of medicines use, to the benefit of residents so we can start to say what 'good' looks like. We also recognise that total change can't be made all at once, that small steps often make a difference and we have included examples and testimonials to illustrate these facts.

Acknowledgements

This work has been undertaken as part of a task group. We would like to thank all the individuals and organisations that have freely contributed and given permission for the use of their materials.

Key recommendations

During this work, we developed some underpinning recommendations to support the principles to ensure medicines use is optimised and safe across all care settings.

- Residents in care homes should be regarded as unique individuals and treated with dignity and respect at all times.
- We recognise that the care manager implements the standards and changes culture within the home and that care staff are fundamental to achieving changes.
- We recommend that those with responsibility for medicines management in care settings should work as a team and agree roles, responsibilities and effective communication pathways.
- We assume all residents can manage their own medicines on entry to care homes unless there is clear evidence to the contrary. This decision should be reviewed on a regular basis to ensure any decision is appropriate and individualised.
- We know that the drug trolley model is not appropriate in all settings. Therefore, we recommend that alternative approaches to medicines administration are considered (for example, individual lockers, or self administration schemes) to empower residents with their medicines taking and to support staff.
- We also recommend the use of monitored dosage systems (MDS) and compliance aids is reviewed and should only be used if there are clear benefits identified for the individual resident rather than a perceived benefit for the care providers.
- In line with the CHUMS report recommendation that "the historical human and financial under resourcing of the care home sector will need to be addressed", we recommend that both existing and future skill mix and training requirements are reviewed within the care home teams to ensure that staff resource is used appropriately to provide the best care for residents.
- We recommend that any member of the care team can administer medicines if appropriately trained and competent to do so.
- We recommend residents have access to a range of treatments, care and support.
- We recommend those with responsibility for prescribing or supplying medicines to residents in care homes are also responsible for ensuring that sufficient information is given to care staff to enable safe and effective use of medicines.
- In promoting the use of homely remedies it should reduce the stock needed. There is concern regarding the build up of stock of medicines and clinical testing kits that can occur with individual prescriptions. We suggest a review is undertaken to support timely responses for residents and avoidance of waste of medicines.

Principles to optimise medicines use across all care settings

Focussing on care homes

We have divided the medicines use process into four main areas:

- prescribing
- dispensing and supply
- administration
- monitoring and review

These are underpinned by core principles:

- personalised care
- effectiveness and safety
- what good looks like-examples to illustrate how improvements have been made

Optimising prescribing across all care settings

The CHUMS report recommends the following.

"Having a preferred GP provider, with the ability to electronically prescribe from the home, would be of benefit."

Our underlying principle: Prescribing is resident centred, effective and safe

What does good practice look like?

Principles of good practice	Manager	Pharmacist/ Nurse/ Doctor	Resident
The needs of the resident should be considered for each prescribed medication		✓	✓
Key issues should be discussed with the resident, family and/or carer	✓	✓	✓
Extra care should be taken when prescribing high risk medicines		✓	
Anticipatory care principles and management are incorporated as appropriate	✓	✓	✓
The number of medicines taken should be the minimum number required to meet the resident's needs		✓	
Items should not be automatically repeated and prescriptions for repeat medicines should be for no more than 28 days whenever appropriate		✓	
'When required' or 'prn' medications for acute conditions or symptoms should not be added to the regular repeats and whenever possible should be prescribed in original packs	✓	✓	✓
The need for oral nutritional supplements and dressings should be regularly reviewed to ensure appropriate products are prescribed within recognised timescales	✓	✓	✓

Palliative care and end of life care follows the principles of the Gold Standards Framework and respects the wishes of the individual	✓	✓	✓
Full directions should be issued for all medicines prescribed including external preparations	✓	✓	✓
Where variable doses are prescribed there should be guidance for when it is appropriate to administer which dose	✓	✓	✓
There should be individualised guidelines for use of 'when required' medicines developed between care staff and prescriber	✓	✓	
The intended benefits of the medication should be communicated to care staff and a feedback mechanism should be in place to assess if this aim has been met and what, if any, side effects have been experienced	✓	✓	✓
Prescribing decisions should not be made in isolation and up to date information from other specialists involved should be made available at the time of prescribing	✓	✓	
Where possible, a resident's medicines should all be prescribed on the same cycle eg a 28 day cycle		✓	
Options considered for the management of conditions, behaviours or symptoms should include both the use of medications and appropriate non drug management strategies	✓	✓	

Case studies and examples of good practice

Organisations and teams can use these examples to improve practice. Contact the relevant organisations for further information on each initiative.

Guidance to support prescribers in primary care when considering when and how to stop medication

In the Highland model support was provided by a geriatrician and pharmacists. Input from psychiatrist or community psychiatric teams may also be required if tackling psychoactive drugs. The guidance to commence medicines is all too often not balanced by guidance to when it is appropriate to stop medicines, particularly in patients susceptible to adverse drug reactions (ADRs), where the potential harm of many medicines may outweigh the benefits.

NHS Highland local enhanced service for polypharmacy

A local enhanced service (LES) for GPs and Community Pharmacists in NHS Tayside provides an opportunity to reduce variation, harm and waste in relation to aspects of patient care for residents in care homes. There have been decreases in:

- out of hours (OOH) calls
- hospital admissions
- attendance at accident and emergency (A&E)

Improvements include:

- better sharing of knowledge and communication between GP practices and community pharmacists
- 58% of residents now registered with LES GP (target of 80%)
- 84% of homes now have complete medication summary

NHS Tayside

A care home medical practice provides medical care to 58 out of the 70 nursing homes, with a practice population of 2,500. The team includes two full time GPs, a dietician, a speech therapist, four liaison nurses, one fulltime pharmacist and three pharmacy technicians.

Glasgow City

Guidance provided for prescribers, community pharmacists and care home staff on ‘when required medication’.

Sheffield Care Homes Best Practice Group

Optimising dispensing and supply across all care settings

The CHUMS report recommends the following:

"Pharmacists need to be aware of the high rate of dispensing errors in some areas and reduce them. All sides need to communicate with each other and set up relationships. In line with the White Paper on pharmacy we recommend a pharmacist has responsibility for the safe running of the whole system, involving all actors. Many of the communication issues have the potential to be eased if English IT strategies delivered as planned. Electronic transfer of prescriptions and other measures are planned to be available by early 2009 and could have considerable benefits, provided pharmacists can access the relevant part of the residents' notes."

Note: CHUMS specifically refers to England - we are working across the UK and recommend IT solutions are implemented where and when available.

Our underlying principle: Supply is resident centred, effective and safe.

What does good practice look like?

Principles of good practice	Manager	Pharmacist/ Nurse/ Doctor	Resident
Standard operating procedures for the dispensing process should be in place and should be reviewed regularly and whenever an error occurs	✓		
The need for monitored dosage systems (MDS) and compliance aid (CA) should be reviewed on an individual basis, rather than used across the board and should take into consideration the stability of individual medicines	✓	✓	
The formulation and route of administration chosen should be appropriate for the individual	✓	✓	✓
Individual preferences in relation to medication should be noted	✓	✓	✓
Information should be shared between the pharmacist, the GP and the care home - and the appropriate consent should be in place to allow effective team work and communication	✓	✓	✓

The pharmacist is the advocate for medicines information and should ensure that all medicines are supplied with adequate directions for safe and effective use		✓	
Health and medication information should be shared with all carers	✓	✓	✓
Changes to medicines (new drugs, change in dose, different formulations or brands) and adverse drug reactions should be highlighted wherever possible to everyone involved in the resident's care	✓	✓	✓
Supply should be accurate and timely, every time		✓	
All records should be kept up to date		✓	
Every prescription should include a clinical check at the point of dispensing and this clinical check should include the medicines administration record (MAR) eg timing of medicines administration, detection of duplicated entries etc.	✓	✓	
Repeat items should be regularly reviewed to consider whether they are still necessary	✓	✓	
Oral nutritional supplements and dressings should be regularly reviewed to ensure they are still appropriate	✓	✓	
Under or over supply, excessive waste and returns should be highlighted, discussed and reduced wherever possible	✓	✓	
Pharmacists should give appropriate guidance if medicines are to be crushed, put in PEGs or administered covertly		✓	
Secondary care should share discharge information with the community pharmacy using good medicines reconciliation practices	✓	✓	
Residents undergoing respite care should be considered. They may bring in their own medicines or prescribers may issue prescriptions for the stay. Medicines brought in by residents should be in the original dispensed containers and clearly labelled	✓	✓	✓

Optimising administration across all care settings

The CHUMS report recommends the following:

"Homes need to seek ways to simplify the act of giving medicines, and ensure staff are appropriately knowledgeable about medicines. They need to monitor and reduce the extent of omission errors. Pharmacists need to advise homes about medicines that should be given at a special time in relation to meals."

Our underlying principle: Administration is resident centred, effective and safe.

Focus group work also identified:

It is good practice to check if a resident cannot take certain medicines.

"Although my mother's medical records were clearly marked 'No Codeine', both at the surgery and the care home, GPs still kept prescribing them and the care home would either not see this in her records or chose not to challenge the doctor and give her the tablet. When my mother was given this she became extremely ill, which on one occasion resulted in her having to go to hospital."

Guidance about how and when to take medicines should be provided. However it was mentioned that:

"Often medication that should be given morning, noon and night will be given all in one go due to time constraints."

Errors happen but it is in the resident's best interest for these to be reported straight away so action can be taken to reduce possible complications/harm due to the error. Errors can include giving the wrong tablets or the wrong dose or not giving tablets that the resident has been regularly prescribed.

Care needs to be taken when residents are self administering. A member of one of the focus groups observed that "tablets left in a pot in the resident's room are unsafe as anyone can wander in and take them".

What does good practice look like?

Principles of good practice	Manager	Pharmacist/ Nurse/ Doctor	Resident
The use of covert administration should be minimised as far as possible and only used as a last resort. The need for covert administration should be regularly reviewed and appropriate guidelines and legal requirements should be followed	✓	✓	
For residents with swallowing difficults, breaking or crushing tablets can be a good option. However medicines should not be crushed or altered without reference to guidelines or advice from a pharmacist. The Royal Pharmaceutical Society (RPS) has issued guidance to their members on pharmaceutical issues when crushing, opening or splitting oral dosage formulations	✓	✓	✓
The resident's use of homely remedies and over the counter medicines (OTC) should be considered as part of the resident's overall care	✓	✓	✓
Protocols should be in place for the administration of over the counter (OTC) medicines, herbal, homeopathic remedies and these should be signed by an appropriate professional	✓	✓	
Care home staff knowledge of individual residents should be recorded as part of individual care plans and all intelligence should be shared	✓		✓
Care home staff should observe and communicate observations about residents and their symptoms, eg dressings, weight gain or loss, loss of interest, distraction or confusion	✓	✓	✓
Care homes should understand and respect the person's right to refuse to take a medicine	✓	✓	✓
Care staff should report consistent refusal to take medication to the GP to allow assessment and review	✓	✓	✓
Care staff should investigate and follow up missing medicines as soon as possible to avoid residents missing essential doses	✓		

Principles of good practice	Manager	Pharmacist/ Nurse/ Doctor	Resident
Administration rounds should last no longer than one hour	✓	✓	
Information regarding 'when required' (PRN) medicines should be clarified and clearly communicated and systems should be in place to ensure that the person can receive their medicines	✓	✓	✓
Information on allergies should be available to the pharmacist, the care home and the GP. The pharmacist should be the first point of call for medicines information	✓	✓	✓
Alternatives to medicine administration record (MAR) charts should be considered when MAR charts are inappropriate, eg oral nutritional supplements and dressings	✓	✓	
Care home staff should ensure medicines are not left unattended where there are risks that other residents/residents may take them	✓		✓
Medicines should be given within one hour of the prescribed time. For some medicines timing is critical eg medicines for Parkinson's disease	✓		✓
Timings of administration should be appropriate, eg medicines should be administered before food, with food or after food as appropriate	✓	✓	✓
'Once a day' medicines should be reviewed and the most appropriate time for administration should be considered, ie not always in the morning	✓	✓	✓
Records of administration should be a contemporaneous and accurate record of what has been administered	✓		
There should be effective systems in place to ensure that changes in medication are implemented	✓	✓	✓
Medicines should be included as part of the hand-over between staff	✓		

Case studies and examples of good practice

Organisations and teams can use these examples to consider steps they can take to improve practice. Contact the relevant organisations for further information on each initiative.

Guidance for care homes including covert medication guidance, good practice guidance which is intended to be used as a framework for care home managers to adapt when writing their own Homely Remedy Policy and guidance on expiry dates to reduce medicines wastage.
Sheffield Care Home Best Practice Group

Materials to support care homes including posters to raise awareness of medicines wastage, training packs, good practice guidelines, recording templates and charts and audit tools.
NHS North Yorkshire and York

'PRN' medication is only supplied when requested by the care home on receipt of a prescription generated by the practice for that medication. The specific direction on the prescription is conveyed onto the label and the MAR chart. PRN medication is best supplied in an original pack (rather than MDS) as this enables the expiry date to be checked and reduces unnecessary medication waste. If no PRN medication has been requested, the MAR chart will still include these items until informed by the care home or prescriber that the medication is no longer required. At this point the PRN is removed from the MAR.
Sheffield community pharmacy

In Scotland community pharmacists are currently paid to provide a standard dispensing service to care homes and for a maximum of five care homes will be paid an additional fee per bed to provide quarterly visits to advise on storage, administration, MAR etc. There is a move in some areas to delegate the visit to trained technicians with pharmacist providing a more clinical input.
Scotland

Barcode technology and personal digital assistants are being used in a number of care homes to replace MAR.

- All medicines are bar coded and recorded
- Nothing can be administered unless the device authorises it. This also ensures medication is not given too soon
- Displays image of resident
- Records how long administration takes, refusal, falls
- Reminds staff of any monitoring required and when a medication should be ordered.
- Produces a monthly report for the GP

Pharmacy Plus Pharmacy Chain (other similar systems are available from a range of suppliers)

A care home regularly ran out of liquid medication and this caused problems with re-ordering the medication and residents missing doses of vital medicines. The suggestion to use oral syringes instead of 5ml spoons for liquid medication helped to solve this problem.
Lelly Oboh, Guys and St Thomas' Foundation Trust Community Services

At a Lambeth care home the nurses wear a fluorescent yellow tabard with 'do not disturb' when administering medicines so others know not to interrupt them. Health care assistants are trained to administer emollients and creams (which are time consuming) so that nurses can focus on administering oral medication and drugs with more complicated regimens.
Lelly Oboh, Guys and St Thomas' Foundation Trust Community Services

Having individual resident PRN forms in the medicines administration folder (with the MAR sheets) that document the reason for the drug, maximum dose and dosing interval is helpful to staff as it prompts them to ask the resident or consider the necessity when other medicines are given. Also it ensures that the drug is given only when it is needed rather than automatically.
Lelly Oboh, Guys and St Thomas' Foundation Trust Community Services

A 'when required' policy was developed by the Lambeth, Southwark and Lewisham care home support team as well as a checklist to ensure that the processes for prescribing, supply, administration recording and disposal of medicines in care homes were safe and efficient.

A range of materials to support with medicine self administration was developed which included an assessment proforma, resident leaflet, self administration policy etc.
Lelly Oboh, Guys and St Thomas' Foundation Trust Community Services

A large care home was struggling with the length of time the morning medication round was taking. They took action to reduce it by:

- Implementing protected medication rounds whereby the person administering medication would only be disturbed in an emergency
- Working with the pharmacist to move many 'one a day' medications away from the morning round
- Working with other healthcare professionals to try to move their visits to the home away from the morning medication round.

As a result, they reduced the medication round from 2.5 hours in the morning to 1.5 hours.

To make sure that the whole staff team had easy and quick access to the information required for PRN medications, a PRN protocol was implemented across the company. This allowed us to pull out the key information from the care plans and have this in a simple one page protocol within the MARs file for every medication that was prescribed as PRN. It meant that the person administering medication would know at a glance why the PRN was prescribed, when the resident might need it, how much to administer should it be needed.

This simple intervention alongside some education on how to ensure PRNs are 'real' PRN's helped us to have a safer regime around the management and administration of PRNs. Our protocol now is that any resident who has not used his/her PRN medication in the month should have this medication reviewed by the GP to see if it is still needed. Equally, if the PRN medication is needed frequently we seek a GP review to consider if it should be moved from PRN prescription to a regular dose. Finally, we did some work on ordering protocols around PRNs to ensure that teams considered their existing stock and simply did not reorder what was delivered last month. This helped to drive focus and attention onto PRNs, reduce stock holding, and reduce waste.

After a serious incident regarding a resident having an allergic reaction to a drug they were known to be allergic to, we reviewed our policy and practices. From our learning we implemented an 'allergy sticker' on the front of every MAR chart. Each resident's records would be annotated with one of three stickers:

- Allergic to (Red sticker)
- Allergy status not confirmed (Red sticker)
- No known allergies (Green sticker)

Since implementing these we have had no further significant events regarding the administration of a known allergic medication.
Case studies shared by BUPA care services

A serious incident involved a resident being admitted into hospital because a dose change of carbamazepine 400mg twice daily to carbamazepine 600mg twice daily resulted in the resident being given both doses, ie carbamazepine 1gm twice daily. Following this we included the clarification of dose changes for care staff in an enhanced dispensing service for community pharmacists. The service has elements covering timing of medicines, adequate directions and information for staff. The service is to be evaluated after March 2012.
Barbara Jesson, Croydon Borough Team, NHS SW London

Learning from other areas that already had enhanced services for GPs with nursing home residents, Croydon developed a service that required the GP to do weekly or fortnightly 'grand rounds' with a multidisciplinary team which had to include a prescribing adviser. The aim was to conduct thorough reviews of each resident. The three month pilot showed a decrease in prescribing of antipsychotics by 26.6% and of hypnotics by 33.3% as well as substantial on-going savings in drug costs. The care homes were monitored for call outs to the London Ambulance Service and there was a reduction when compared with the same period the previous year and when compared to other homes without the service. It was estimated that a significant number of hospital admissions were prevented as a result of this proactive service.

The service has been rolled out to other GPs and in this year will include 17 care homes.
Jacqueline Goodchild, Croydon Borough Team, NHS SW London

Some residents were being prescribed oral nutritional supplements (ONS) but there was no review or specific goals set so they were remaining on them for months, even years in one case with no benefit to the resident evident. Guidelines were developed for prescribing and a nutritional support resource pack was created, which included ways to fortify foods and an order form for ONS.
Ceri Wright, Shropshire County PCT

Optimising review and monitoring across all care settings

The CHUMS report recommends the following:

"GPs need to review how they identify residents to be monitored and ensure monitoring is carried out. Pharmacists should clinically review all residents and their medications for appropriateness at least 6 monthly intervals. PCTs need to recognize the difficulties of getting treatments and tests to residents in homes (where ambulant residents would normally travel)."

A comprehensive team approach to care is recommended.

Our underlying principle: Interventions are resident centred, effective and safe.

What does good practice look like?

Principles of good practice	Manager	Pharmacist/ Nurse/ Doctor	Resident
Practitioners should have the appropriate skills and training to support the frail resident population, especially those with dementia	✓	✓	
GPs, nurses and pharmacists should undertake a holistic review of medicines and concordance in accordance with existing guidelines supported as appropriate by specialists. Wherever possible medication review should involve the resident and carer (where appropriate). Clinical pharmacy expertise should be available for all care homes. In some cases this service may be provided by a separate pharmacy team to the supplying pharmacy	✓	✓	✓
Targets should be appropriate and tailored for the individual resident	✓	✓	✓
Care home staff observations about individual residents should be communicated to healthcare professionals	✓	✓	✓

The use of antipsychotics and other psychoactive medications should be regularly reviewed and non-pharmacological options always considered	✓	✓	✓
Quality protocols for common conditions (eg UTIs, constipation) and pain assessment and management should be in place and used effectively	✓	✓	
Clinical monitoring should match monitoring that would be received by people living in their own home and should be continuous		✓	✓
There should be proactive management of changes to medication when residents transfer between care settings. The Royal Pharmaceutical Society has issued guidelines for the transfer of care which will help	✓	✓	✓
Responsibility and accountability for monitoring should be defined, communicated and managed	✓	✓	
Residents with long term conditions should be regularly reviewed	✓	✓	✓
Falls should be recorded and communicated and appropriate action taken to reduce risk of fracture	✓	✓	✓
High risk drugs should be reviewed frequently and the appropriate safety processes should be in place in the care home, GP practice and community pharmacy	✓	✓	✓
Errors should be reported and used as a learning tool to identify system failure	✓	✓	
Missed doses should be recorded and action should be taken	✓	✓	
Monitoring and test results should lead to action whenever necessary	✓	✓	✓
Refusal to take medications should be noted and reviewed when necessary – continuous refusal triggers a review of care	✓	✓	✓

Case studies and examples of good practice

Organisations and teams can use these examples to consider steps they can take to improve practice. Contact the relevant organisations for further information on each initiative.

LES for GPs and community pharmacists supported by prescribing support pharmacists. Community pharmacists provide level one or two medication review and six monthly clinical audit which supports GP medication review.
NHS Tayside

Polypharmacy guidance for prescribing and medication review in frail adults that include; indications of a shortened life expectancy, drugs that can be associated with rapid symptomatic decline, high risk drug group, drugs that are poorly tolerated in frail residents, drugs most associated with admission due to ADRs and trials used to complete drug effectiveness summary.
NHS Highland

Medication reconciliation on admission (as per national guidance), medication review as part of the multidisciplinary team with medical, nursing, therapy and social care input, adherence support during admission and self medication trial where appropriate. Review of compliance support. Communication of all interventions with recommendations to GP electronically and to community pharmacist by fax, adhering to information governance requirements, including contact details for care home pharmacist. Supports medicines use review (MUR) post discharge.
Nina Barnett, Intermediate Care facility, Harrow

Referral service to hospital pharmacists for residents at high risk of medication related problems which may lead to hospital admission. Detailed review of all aspects of resident medication needs, working with carers, social and clinician support to optimise benefit from medicines through clinical medication review, compliance support and review of use of medicines.
Nina Barnett, Intermediate Care facility,Harrow

During medication reviews at nursing homes, it came to light that the medication allergies reported in the residents' notes were not always reflected in the GP records or the community pharmacist records which could lead to adverse drug events. A simple process to ensure that this information is shared and updated was instituted.
Lelly Oboh, Guys and St Thomas' Foundation Trust Community Services

A referral form was developed in Lambeth to prioritise older people in care homes who require support or medication review by a care home support pharmacist.
Lelly Oboh, Guys and St Thomas' Foundation Trust Community Services

SBAR tool (Situation, Background, Assessment, Recommendation) can be used when communicating within teams and with other healthcare professionals, including the prescriber, to raise concerns or refer residents. www.institute.nhs.uk/sbar

NHS Northamptonshire Care Home Advice Pharmacists Team (CHAPs). The scheme involves dedicated pharmacists visiting care homes to undertake detailed medication reviews on primarily elderly residents, prioritising those on multiple medications and/or those who have frequent hospital admissions. Working closely with the allied GP surgery and the care home team, the pharmacists make recommendations about individual residents (including suggestions to stop, start or review medications) and co-ordinate the implementation of any relevant action required. They also provide more general advice to care homes on medicines management and often engage other specialists in reviewing the care of identified residents. Between December 2008 and April 2011 the pharmacists visited 44 care homes, undertaking 1192 detailed medication reviews. In 85% of residents reviewed at least one suggestion was made to the GP to revise some aspects of a resident's medication regime. As well as contributing to the quality of care for these residents, these interventions contributed to an annual saving from the prescribing budget of over £100,000 or around £98 per resident per year.
NHS Northamptonshire

ICARUS

Model for medicine review eg

Indication?

Continuing problem?

Appropriate dose?

Reduction possible?

Uncontrolled symptoms?

See again

Dr Gillie Evans, Cambridgeshire

Example of innovation in practice

A real life example of a 40 bed care home that had ongoing issues regarding the safe management of medicines

There were identified issues around the length of time the medicines round was taking. For example the morning round was commencing at 08:00 but not completing until between 11:00 and 11:30 with consequent issues of sufficient time gap between subsequent administrations. It also raised concerns around the appropriate timing of medicines for a person with Parkinson's disease and also for some people taking regular analgesia.

The home held an all staff meeting to seek ideas about how they could take effective action to reduce or remove these issues. This was also attended by the supplying community pharmacist and one of the GPs for the home.

A proposal was made to look at how the medicines round was made up and consider if it would be possible for people to have their medicines in their rooms and for the carers providing support to these people to assist them with taking their medicines.

Before any change was to take place it was identified that more carers would need to be given training in the safe administration of medicines and assessed as competent to carry out the support tasks.

It was then proposed that one floor of 20 people would be split into four groups of five with the lead carer for each group having the responsibility for supporting people to have their medicines when providing support when either getting up, meal times or on retiring.

This system was then trialled for a period of three months and it was established that in these groups people were all receiving their medicines in the period between 08:00 and 09:00. Also the carers felt that as they had more time to spend with people when supporting with medicines that they were able to give clearer feedback to the GP about the outcomes for the individuals. For the particular person with Parkinson's disease their comment was "I am now getting my medicines at the regular intervals that I need them and I have now regained my better mobility."

At the three month review the GP echoed the value of better feedback from the carers about how people were responding to their medicines.

The pharmacist commented that with the new system they had fewer queries about dose changes and stock shortages as the people giving out the medicines appeared to be taking a more direct responsibility for keeping this information up to date.

It was then decided that a similar principle would apply to the other areas of the home and a further four groups were created. Within these, one group expressed a desire not to start getting up until 08:30. It was possible for the care leader to accommodate this and all their medicines were given between 08:30 and 09:30.

Overall the analysis of the system after one year was that care workers felt they were actually able to support the people with their medicines and it became more a part of their routine care needs.

People receiving their care commented that they did not have to wait for their medicines and that they received them when they needed them.

Other benefits indicated at another care home where nursing is provided were that the delegation of the administration of medicines under appropriate arrangements meant that the Registered Nurses were released to devote more of their time to care for those people who were either unwell or in need of greater nursing care input.

They also found that there were fewer interruptions to the medicine round as the nursing staff were more available to deal with the issues that needed their professional input. What was also clear was that when making this type of change, it is important to keep the commissioners of the service involved and explain to them the benefits to the people receiving the care.

Appendix

Calls to NHS Direct demonstrating the need for access to professional advice

More than 600 medicines calls made to NHS Direct in one month (April 2010) were made by care givers. Of these calls, 100 were analysed further and showed the following:

- 95% were made during the out of hours period
- 49% were given the highest priority setting (M1)
- 72% were resolved with self care advice
- 57% were regarding 'administration and/or dosage' concerns, of which 30% were 'missed medication' errors
- 31% were resolved by a pharmacist or had pharmacist involvement
- 17% were resolved by a nurse advisor or had nurse involvement
- 59% were resolved by a HIA or had HIA involvement
- The median number of medications recorded in resident medical history was five (range one to 17)

Typical enquiries included

"I've just come on duty and realised some night time medicines were given this morning, I don't know what to do. Can I give the morning medicines now?"

"We need advice about a lady who's been given the wrong dose of warfarin by mistake, what do we need to do tonight?"

"One of our residents looks after her own medicines but she can't remember whether she's taken them tonight or not. The medicines are for fits, what should we do?"

"We have a resident who wants to take Evening Primrose Oil capsules – we don't know if its safe with her other medicines?"

"One of our residents has been prescribed antibiotics. The label says give one tablet every eight hours – do we have to give them like that? We'll have to wake her up in the night."

"Our MAR sheet says Istin® but we've been sent amlodipine, is it the same thing?"

"A resident has been given melatonin instead of metformin, what do we do?"

Improving medication management in care homes is a systemwide issue, which needs to be tackled by many different groups working together. This work is now being taken forward in an integrated programme led by the National Care Forum, funded by the Department of Health, working as part of a wider cross-sector partnership. This partnership involves:

Age UK

English Community Care Association

National Care Forum

Royal College of General Practitioners

Royal College of Physicians

Royal Pharmaceutical Society

Care Provider Alliance

National Care Association

Registered Nursing Home Association

Royal College of Nursing

Royal College of Psychiatrists

The Health Foundation

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