



The Purple Book

A reference source for Care Home staff in Suffolk

Section 2 - Medication

Medication Safety Tips

Good medicines safety is achieved when

- Residents are treated as individuals and are encouraged to be involved in decisions about their medicines.
- Good communication systems exist between Care Home staff, GPs and practice staff, the community pharmacy, and other healthcare professionals involved in the Resident's care. This is especially important when a Resident moves between care settings, and when medicines or dosages change.
- A Resident's medication is checked against the discharge summary when returning from a hospital admission.
- There is a 'no blame' culture and medication safety incidents or near misses are openly discussed at the Care Home, with actions implemented to reduce the likelihood of the same thing happening again.
- Any incidents are reported on the National Reporting and Learning System:

<http://www.nrls.npsa.nhs.uk>

Things go wrong when

- Administration of medicines becomes 'routine', impersonal, and just a mechanical process.
- Poor communication systems exist, especially when Residents are transferred in, or out, of the Care Home, or when changes are made to their medication.

Ordering and Managing Medication

Self-administration

- Staff should assume that Residents are able to take and look after their own medicines, unless a risk assessment has indicated otherwise, and considered the Resident's personal choice.
- Individuals who choose to self-administer should be supported in doing so. A number of tools are available to assist with this process e.g. large-print labels, easy-to-open containers etc. These should be requested from the community pharmacy that dispenses the Resident's medication.
- Self-administration of medicines is not an 'all or nothing' situation and Residents should be supported, regardless of what, or how many, medicines they are prescribed. For example, a Resident may choose to keep and use their own inhalers but not their other medicines.

- When a resident self-administers their medication, Care Home staff must be alert to the possibility that they could take too much or too little medication. Staff should ensure that Residents that self-administer have enough medication to last them until their next repeat prescription is due.
- The Royal Pharmaceutical Society document **'The Handling of Medicines in Social Care'** offers additional guidance:

'Whenever possible children and adults should take responsibility for their own medicine. This preserves independence...'

'In residential settings, the risk of someone else accidentally (or intentionally) taking medicines intended for another person is greater. A robust system of risk assessment is essential.'

'A residential service should provide secure storage in the person's room. This can be a lock fitted to a drawer and does not need to be made of metal or even look like a medicine cupboard. If the room is shared, there must be separate storage facilities for each person.'

- Staff should review the appropriateness of self-administration in Residents who repeatedly have too little or too much medication in stock.
- If a Resident self-administers warfarin (an anticoagulant), staff should ensure that they have access to the Resident's yellow book and written dosage instructions provided by the anticoagulant clinic.
- For **all** Residents prescribed warfarin, dosage information should be attached to the MAR chart, regardless of who administers the medication.

Ordering monthly prescriptions

Care Home staff should check that all medications listed on the Resident's MAR chart and most recent repeat prescription slip are still required by the Resident, and that no medicines have been added or stopped since the last order.

If items are prescribed but are no longer needed, the Care Home should inform the GP practice and pharmacy, e.g. by completion of a MAR chart reconciliation form.

(Please see Purple Book Section 3, page 24)

Before ordering

- Check that all doses, strengths, and quantities of medication on the repeat prescription request form are correct.
- Inform the pharmacy of any changes to the Resident's medication since the last repeat prescription slip was printed.
- Any item that is not required for several consecutive months should be included on a MAR chart reconciliation form.
- Before ordering anything, always check current stock levels. Items do NOT need to be ordered every month if there is sufficient stock available in the Care Home.
- **Please bear in mind that medication returned to the dispensing pharmacy, EVEN IF UNUSED AND UNOPENED, cannot be re-used once it has left the pharmacy premises. The pharmacy is required to destroy it.**
- Items that were not requested will be recorded on the following month's MAR chart as 'not supplied this month'.
- Do not reorder 'PRN' or 'when required' medicines if there is already an adequate supply in the Care Home.
- Check the quantity of each medication remaining in the Care Home - if there is sufficient to cover the next 28-day medication cycle, do not order.
- If you are not sure how to order, ask a colleague to show you the correct procedure. Always follow your Care Home's policy.
- It is good practice to use a monthly stock audit chart to identify and record all stock carried over to the following month.

Interim prescriptions/mid-cycle changes

- If a new, repeat medication is started during the medication cycle, the GP should provide a prescription for the remainder of the current 28-day cycle.
- If the monthly medication order has already been placed, the GP should provide an ADDITIONAL prescription for a full 28-day supply.
- When a medicine is dropped or spilled, a prescription to cover the shortfall should be requested from the GP, promptly, and before the end of the current medication cycle.
- If a Resident refuses, or spits out their medication on a regular basis, their GP should be informed.

- At each shift change, staff should inform their colleagues of any contact between the Care Home and the GP practice or community pharmacy during the previous shift. It is useful to implement a prescription/medication query audit trail to avoid multiple calls being made.

The Care Home should order all medication for its Residents - this should NOT be delegated to the pharmacy that supplies the medication to the Care Home.

GP responsibility

Prescribers should provide instructions for using and monitoring all newly prescribed and existing medicines.

- If medicines are labelled 'as required', Care Home staff should contact the GP, requesting specific instructions.
- When an 'acute' prescription is started, it should be clear to the Care Home that the medication is to be given for a specific period of time only. This is especially common when creams containing steroids or antimicrobials are prescribed.
- All eye/ear/nose preparations should carry labels that give specific directions regarding which eye(s)/ear(s)/nostril(s) are to be treated.

Covert administration and crushing

Covert administration is the administration of any medical treatment in a disguised form, where it is decided that this is in the best interest of the individual, in line with the Mental Capacity Act (2005) guidance.

Covert administration of medication **must not** be used if the individual is capable of making decisions about their medical treatment.

Covert administration of medicines should be used in exceptional circumstances only, and permission to do so should be confirmed in writing by the prescribing GP. The GP may reach this decision in conjunction with family members, staff and other healthcare professionals involved in the Resident's care.

Every individual has the right of refusal

Explore the Resident's reasons for refusing to take their medication. For example:

- An individual may refuse to take their treatment if they find it difficult to swallow or chew a large tablet or capsule: a liquid medication may be easier for them to cope with.
- An individual may not understand why they are being given their medication, or what it is being used to treat: a simple explanation may reassure them.
- A Resident diagnosed with dementia may not understand what to do when they are presented with a tablet or capsule: they may need assistance or a liquid medication instead.
- A particular time of day may be more difficult for the Resident than others, e.g. if they are very sleepy: a change of timing may solve the problem.

These issues can often be resolved through discussion with the prescriber or pharmacist, and the Care Home should investigate all available options to overcome these difficulties.

Overt administration

Putting medication into food or drink to make it more palatable could still be regarded as deceitful, unless there is clear documentation to support this in the Resident's care plan.

This is **overt** administration and is a co-operative process, transparent and open to scrutiny. By definition, it requires the Resident to have the capacity to understand, and be involved in, discussions and decision-making.

Points to remember

- If tablets need to be crushed, or capsules opened in order for a Resident to take them, Care Home staff should always check with the prescriber, pharmacist, or CCG Medicines Management Team BEFORE doing so.
- Some tablets and capsules (often labelled M/R, S/R, E/C) have special coatings to control how the drug works. The drug may stop working correctly if the tablet is crushed or chewed, or the capsule is opened.
- Crushing tablets or opening capsules may mean that they are being given to the Resident 'off-licence'. Always check with a pharmacist BEFORE crushing, dissolving, or allowing a resident to chew any tablet that is intended to be swallowed whole. Also, check before opening any capsule and removing the contents, even if requested to do so by the Resident or a member of their family.

Medicines Waste

Staff can help to reduce unnecessary waste in Care Homes by following some simple advice when re-ordering medicines:

- Do not routinely clear drug cupboards at the end of the month and order new stock. This includes dressings and catheter and stoma products.
- Do not dispose of a medicine at the end of a cycle, unless it has been dispensed in a Monitored Dosage System (MDS), has been discontinued by the prescriber, or has reached the manufacturer's expiry date.
- Any medicines that can still be used should be carried forward to the following 28 day cycle, e.g. medicines prescribed as 'when required', or in original packs. Staff should record the quantity carried forward on the Resident's MAR chart.
- Liquid medicines can usually be used until the manufacturer's expiry date, although some have shorter expiry dates once in use, e.g. antibiotics. Staff should check the product label and packaging for any specific instructions, e.g. "use within xx days of opening".
- Creams and lotions can usually be used until the manufacturer's expiry date and do not need to be re-ordered automatically every month. Staff should check the product label and packaging for any specific instructions, e.g. "use within xx days of opening".
- Ask the GP to prescribe smaller quantities of skincare products where appropriate:
Manufacturers express expiry dates in different ways:

Body site	Creams or ointments		Lotions	
	One week supply	One month supply	One week supply	One month supply
Face	15-30g	60-120g	100ml	400ml
Both hands	25-50g	100-200g	200ml	800ml
Scalp	50-100g	200-400g	200ml	800ml
Both arms or legs	100-200g	400-800g	200ml	800ml
Trunk	400g	1600g	500ml	2000ml
Groins & genitalia	15-25g	60-100g	100ml	400ml

- Ask the GP to remove any discontinued medicines from the repeat portion of the prescription.

Words used	When to discard
Best before January 2016	Discard 31/12/2015
Use before end January 2016	Discard 31/01/2016
Use by January 2016	Discard 31/12/2015
Discard after January 2016	Discard 31/01/2016
Expires January 2016	Discard 31/01/2016

- Ask the community pharmacist to remove discontinued medicines from the MAR sheet. This also helps prevent discontinued medicines being ordered in error.
- Do not dispose of any stock of regular, or ‘when required’ medication that is still in use.
- Use medicines with the earliest expiry date first.
- Always ensure that you order from the most up-to-date repeat medication list.
- Record the reasons for wasted medicines in a returns book. If any common themes or patterns are observed, review procedures and put measures in place to limit this kind of waste.
- Liaise with the prescriber/pharmacy if drugs are supplied in packs of 30 rather than 28. The medication cycle is 28 days long, so for once daily dosing there is the potential for two doses to be wasted each month. Please ask the GP to prescribe 28 days’ supply whenever possible.
- Medicines such as inhalers, insulin, GTN spray and glucagon should be carried forward and not re-ordered each month unless needed.
- Stoma and continence products should be ordered as part of the usual 28 day medicines cycle:

Appliance	Usual monthly quantity	Prescription directions	Notes
Colostomy bags (one piece systems)	30 -90 bags	Remove and discard after use.	Bags are not drainable Usual use: 1-3 bags per day. Flushable bags only to be used on advice of bowel/stoma nurse.
Colostomy bags (two piece systems)	30-90 bags + 15 flanges	Bag - remove and discard after use. Flange - change every 2-3 days.	The flange (base plate for 2 piece systems) is not usually changed at every bag change. Items ordered separately.
Irrigation	1 kit/year	To wash out colostomy	
Irrigation sleeves	30/month	Use once every 1-2 days	Self-adhesive disposable sleeves
Stoma caps	30	For use on mucous fistulae or colostomy if irrigating	This may be in addition to original stoma bag
Ileostomy bags (one piece systems)	15-30 bags	Drain as required throughout the day. Use a new bag every 1-3 days.	Bags are drainable
Ileostomy bags (two piece systems)	15-30 bags + 15 flanges	Bag - change every 1-3 days Flange - change every 2-3 days	The flange (base plate for 2 piece systems) is not usually changed at every bag change. Items ordered separately.
Urostomy bags (one piece systems)	10-20 bags	Drain as required throughout the day. Generally replace bag every 2 days.	Bags are drainable
Urostomy bags (two piece systems)	10-20 bags + 15 flanges	Bag - change every 2 days Flange - change every 2-3 days	The flange (base plate for 2 piece systems) is not usually changed at every bag change. Items ordered separately
Night drainage bags for urostomy patients	4 bags (1 box of 10 bags every 2-3 months)	Use a new bag every 7 days.	Bags are drainable

- Dressings should be requested in **2-week** supplies only, and as **individual dressings**, not whole boxes.
- A ‘**Nursing Home Dressings and Emollients Request Form**’ should be used to order all dressings and emollients (see extract of form below). This ensures the use of approved and cost-effective

products, in appropriate quantities. The completed form should be passed to the GP practice when a prescription is required for a Resident.

Nursing Home Dressings and Emollients Request Form

All dressings and emollient requests to General Practice must be made via this form. GPs may refuse to prescribe unless **ALL** the relevant sections of the form have been completed and the form has been received by the practice.

Please return completed form to the patient's GP surgery

Patient name:	Date of Birth:	NHS number (optional):
Date of request:	GP:	
Care Home:	Requesting Care Home Nurse:	
Useful relevant information (Tick all that apply) <input type="checkbox"/> Pressure ulcer <input type="checkbox"/> Leg ulcer <input type="checkbox"/> Diabetic wound <input type="checkbox"/> Wet wound		
<input type="checkbox"/> Infected wound <input type="checkbox"/> Skin Tear <input type="checkbox"/> Multiple site wounds <input type="checkbox"/> Other: _____		
Previously referred to Tissue viability nurse <input type="checkbox"/> Y <input type="checkbox"/> N Date _____		
Previously referred to Podiatrist <input type="checkbox"/> Y <input type="checkbox"/> N Date _____		

- The same form should be used when requesting non-formulary dressings, the details of which should be provided in the lower section of the form (see below)

Non formulary requests – Exceptional reasons only			
Product name	Product size	Frequency, duration and quantity (e.g. 2 bd, 3/7, x10)	Reason for non-formulary request (must be completed or the product cannot be supplied)

- The form will be updated to reflect the latest wound care formulary and can be accessed here:

<http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/Medicinesmanagement/CCGFormularies/Woundcareandstoma.aspx>

Medication Administration Record (MAR)

The Medication Administration Record (MAR) chart details a Care Home Resident's current medication. The MAR chart should prompt staff in the administration of medication to Residents and act as a record of supplies.

It is important that the MAR chart be completed accurately and in a timely manner. If a medication appears on the MAR chart, but has changed or been stopped, the Care Home staff should inform the pharmacy that printed the chart, via the MAR reconciliation form.

An accurate copy of the Resident's MAR chart, and details of all their current medication, should be sent with the individual whenever they transfer from one care setting to another.

The Royal Pharmaceutical Society document 'The Handling of Medicines in Social Care' offers additional guidance:

Returning from hospital stays

All people discharged from hospital should have complete documentation listing all their current medication at the time of discharge. This may have changed considerably from the medicines that were taken into hospital. It is essential that this new list be compared with the old list. The hospital will inform the person's GP but if you are responsible for the person's medicines you should:

- *Let the supplying pharmacy know the changes as soon as possible*
- *Prepare a new MAR chart*
- *Dispose of any unwanted or discontinued drugs*
- *Request a new prescription as soon as possible.*

If you usually use a MDS it may be possible to liaise with the hospital pharmacist to arrange for your usual pharmacy to dispense a new supply in your current system at the time of discharge.'

When administering medication, it is your responsibility to follow the '6 R's':

- **RIGHT** Resident
- **RIGHT** medicine
- **RIGHT** route of administration
- **RIGHT** dose
- **RIGHT** time
- Resident's **RIGHT** to refuse

- 'When required' medication should only be given when needed, and not on a regular basis.
- Staff should inform the GP surgery if any 'when required' medication is no longer needed on prescription.
- Many medicines can be given under the Care Home's 'Homely Remedies' protocol e.g. laxatives, antacids, paracetamol etc. if needed only infrequently.

Homely Remedies

There are many times at which a Resident may develop a minor ailment or self-limiting condition. Care Home staff should be able to respond quickly to symptoms of a minor nature, which are treatable by accessing a local pharmacy for an over the counter (OTC) product.

- A person living in their own home should be expected to purchase remedies from a pharmacy, and to do so without usually involving their GP. The pharmacist is qualified to give advice on the best choice of treatment and its correct manner of use. For people living in a Care Home, which is their own home, we refer to this approach as using homely remedies.
- A homely remedy is a preparation used to treat a minor ailment or self-limiting condition; it is purchased over the counter (OTC) and does not require a prescription. The Care Quality Commission (CQC) agrees that a small range of products may be kept in stock by a Care Home for the treatment of its Residents.
- Many conditions lend themselves to treatment under a homely remedies policy. A few examples given by the National Care Forum are:
 - Indigestion and heartburn
 - Mild to moderate pain
 - Dry cough
 - Constipation
 - Diarrhoea
 - Skin problems
- Suitable products include paracetamol, olive oil ear drops, antacids and laxatives.
- A homely remedies policy should not include products requiring invasive administration, e.g. suppositories, nor is it appropriate to include products that do not work quite quickly, e.g. lactulose which can take up to 48 hours to work.
- Homely remedies should be clearly identifiable and must be stored in their original packaging, together with any information supplied e.g. manufacturer's information leaflet. The balance and expiry dates of the homely remedies should be checked regularly. Please note that some products have a shorter shelf life once opened.
- Vitamin supplements and herbal or homeopathic preparations are not homely remedies.
- Homely remedies should be stored in the same location as all other medication, but designated clearly to show they are not Resident specific.
- Residents or relatives may bring in their own homely remedies, which have been approved by their own GP, or recommended specifically for that Resident following a consultation with a pharmacist. These are not for general use in the home and must remain specific to that Resident.

They should be counted into the home and administered and recorded on the MAR chart in the same way as the Resident's other medication.

- The medication should be checked with a pharmacist before first administration, to ensure that it will not interact with any of the Resident's prescribed medicines.
- The Resident's medication folder should identify which homely remedies are appropriate for them to use. This should be kept with their current medicine administration record (MAR) chart, and alongside any notes included in the yellow 'My Care Wishes' folder under 'current medicines'.
- If the Resident self-administers, a risk assessment should be completed and kept with the Resident's care plan.
- Homely remedies should be used for a fixed period of time, agreed with the Resident's GP, pharmacist, or other relevant healthcare professional.
- **For some ongoing minor conditions, the GP may ask the Care Home to purchase treatment OTC, e.g. soap substitutes for dry skin. This process is known as 'self-care' and is used when the GP considers it is inappropriate to prescribe the product required, but agrees to its ongoing use, or when ongoing use has been recommended by a pharmacist.**
- The Resident's MAR chart should be annotated 'homely remedy' and should be completed every time a homely remedy is administered. Details should include:
 - The name, strength and form of the medicine
 - The dose that was administered
 - The time of administration
 - The reason for administration
 - The name of the staff member that administered the product
 - The effect of the medication on the Resident's symptoms

In conjunction with the lead prescribing GPs, IESCCG and WSCCG have developed homely remedies protocols. It is recommended that these be adopted for use by your organisation. They are available here:

<http://www.ipswichandeastsuffolkccg.nhs.uk/GPpracticememberarea/Clinicalarea/Medicinesmanagement/Carehomeinformation.aspx>

And

<https://www.westsuffolkccg.nhs.uk/clinical-area/prescribing-and-medicines-management/formularies-and-guidelines/>

Controlled drugs

Controlled drugs (CDs) are drugs that are classed as being more liable to abuse than other prescription medicines, and are subject to tighter controls. Examples of controlled drugs include strong painkillers (e.g. morphine, fentanyl, and oxycodone) in patch, tablet, or liquid form. It is important that staff know which medicines are CDs, to ensure that they adhere to the safe storage and record keeping requirements.

Care Home staff should be aware of their responsibilities when collecting a CD from a pharmacy. It is good practice for the community pharmacy/dispensary to ask the person collecting the medication for proof of their identity. For schedule 2 or 3 CDs, they will also be asked to sign the back of the prescription to confirm that collection has taken place.

Storage

If the CD requires safe custody, it must be stored in a designated locked cabinet. A running balance of the quantity in stock should be recorded, and staff who are authorised to administer CDs should complete the register at the earliest opportunity after administration, to maintain an accurate balance.

If the CDs have been dispensed in a monitored dosage system (MDS), the whole MDS should be stored in a CD safe or cabinet.

Access to the CD cabinet should be restricted. The keys should be kept under the control of a designated person and there should be a clear audit trail of the holders of the key.

Any CDs that are no longer required or are out of date need to be disposed of properly. Please see the table below for guidance on this, and consult your own care home policy.

Before administering a CD

Check the product against the label (with a witness if possible):

- Drug name
- Quantity to be given
- Formulation (tablet, capsule, patch etc. – the formulation can affect the recommended dosage and the amount of drug released over time)
- Strength
- Expiry date
- Ensure that the product is fit for use, i.e. not damaged.

The CDs should be checked against any paperwork received e.g. copy of prescription. If there is a discrepancy, Care Home staff should contact the pharmacy, then follow the Care Home's procedure for this.

Out-of-date CDs and those no longer required

Type of care home	Arrangements	Records
Care home without nursing	CDs should be returned to any community pharmacy at the earliest opportunity, for destruction in an approved manner.	Care homes should record the names, formulations and quantities of CDs they are returning, and the pharmacist/dispensing doctor should sign for them on receipt. Relevant details should be entered into the CD register and signed by a trained and competent member of staff.
Care home with nursing	The care home will need to arrange for the collection of waste medication with a Waste Management Regulations licensed waste disposal company. CDs must be denatured before being handed to the waste disposal company, e.g. in denaturing kits. A T28 exemption will be needed.	For 'stock' CDs, a registered nurse and an authorised witness for destruction should sign the CD register. For CDs supplied to individual residents, a registered nurse and a suitably trained witness should sign the CD register.

Short courses of medicines

Many medications are used on a long-term basis to control chronic conditions. However, in certain situations, medicines may be prescribed for short-term use only. Examples include the treatment of acute illnesses such as infections, correction of deficiencies, and management of flares of chronic conditions.

When medicines are prescribed under these conditions, the prescriber should indicate the duration of treatment, frequency of use, or a review date. When administering medicines to residents, it is useful to recognise any drugs that are indicated for short-term use only. Medicines that are continued where there is no clinical need increase the overall number of medicines that the resident has to take and can result in side effects and drug interactions.

What to do

- When these medicines are first prescribed, a duration of treatment or a review date should be specified on the label.
- Where there is no identified duration of treatment or review date, this should be highlighted to the prescriber.
- Where medicines have been prescribed for short-term use, but have not been reviewed or discontinued, the prescriber should be informed.

Examples of the groups of medicines that may need review are indicated below. The BNF can be used to identify a specific medicine within each of the categories listed below.

This list is not exhaustive but can be used as a guide.

Medication	Reason
<ul style="list-style-type: none">• Antibiotics (oral and topical)• Antifungals (oral and topical)• Antivirals	<ul style="list-style-type: none">• These medicines are used to treat infection.• Duration of treatment is usually short, between 5 and 14 days.
<ul style="list-style-type: none">• Vitamins and minerals	<ul style="list-style-type: none">• These are prescribed when a patient is deficient in a particular vitamin or mineral.• Supplements are used to correct the deficiency and to replenish natural stores.
<ul style="list-style-type: none">• Topical Corticosteroids	<ul style="list-style-type: none">• These creams / ointments are used to treat inflamed skin conditions.• They should be applied very sparingly.• These medicines are usually only applied to the skin for 1-2 weeks at a time.

Medicines prescribed 'as directed'

GPs may prescribe a medication to be used 'as directed' or 'MDU', where the dose varies depending on the nature of the condition being treated. Examples include topical products such as creams or ointments, eye drops, nasal sprays, and certain types of inhaler such as salbutamol.

Where there is any uncertainty on the frequency and directions for use, the prescriber should be contacted for further information.

Short Term Medicines – Benzodiazepines and Z-drugs

This group of drugs includes diazepam, nitrazepam, temazepam, loperazolam, lorazepam, zopiclone, and zolpidem. These drugs are prescribed for the treatment of anxiety or to help with sleep, and should only be used on a short-term basis (2-4 weeks).

Long-term use of these drugs can cause confusion, memory loss, falls, low mood and sleeping difficulties. If a Resident shows these signs, Care Home staff should consider asking the Resident's GP to review their medication.

If one of these drugs has been prescribed for a Resident long-term, it should **not** be stopped abruptly. The dose will need to be reduced gradually over a period of time.

Drugs of this kind should **not** usually be placed on repeat prescription. If Care Home staff are concerned about long-term use of one of these drugs in a Resident, they should raise their concerns with the Resident's GP.

Please see the accompanying 'Good Sleep Guide' (*Purple Book part 3, page 10*) which should always be used before requesting medical intervention.

Short Term Medicines – Antipsychotics

This group of drugs includes risperidone, quetiapine, olanzapine, halperdol, aripiprazole, and amisulpiride. They are often prescribed to help reduce agitation and anxiety in confused patients and those diagnosed with dementia.

Other interventions that may be helpful for these symptoms include

- Exercises – gentle stretching, strength training, balance and endurance
- Creating a scrap book or a similar simple craft project
- Looking at photographs or pictures from the past
- Music
- Using personal care as an opportunity for positive social interaction
- Playing specific games or doing puzzles
- Frequent, short conversations
- Going for a walk

Clinical Pharmacist's role in the Care Home

A key responsibility for pharmacists in the Care Home is **medicines optimisation**. Medicines optimisation encompasses all aspects of the safe and effective use of medication.

It is the pharmacist's responsibility, as a specialist in medicines, to ensure that treatment is appropriate for the individual Resident and that prescribing guidelines are being adhered to.

One way in which medication safety can be improved is through **medicines reconciliation** (MR). The aim of MR is to minimise errors in prescribing and to ensure continuity of treatment, based on the Resident's medical history.

Errors in medication are of particular concern – one study conducted in Care Homes found that over two thirds of Residents were exposed to one or more medication errors.

Medicines Reconciliation: Key areas

What does the pharmacist look for?

Clinical check

Allergies

The allergy status of the patient should be documented so that relevant medication can be avoided in future treatment. It is also important to establish the nature and severity of a previous adverse drug reaction to guide future treatment options.

Dosage

A dose may be higher or lower than the usual recommended dose. The pharmacist will establish if this is appropriate for the individual. The pharmacist will also check if dose adjustment is needed, based on the age of the patient, their liver or kidney function, or other disease states.

Interactions

The pharmacist will identify, and take action to avoid, potentially serious drug interactions occurring. Types of interaction include:

- Drug-drug (e.g. clarithromycin and simvastatin)
- Drug-food (e.g. warfarin and cranberry juice)
- Drug-disease (e.g. beta-blockers and asthma)

Side effects

The pharmacist will identify any medicines that are potentially causing negative symptoms in a patient, and will work with the GP to resolve this. Ways in which the situation may be rectified include:

- Dose adjustment
- Change to an alternative drug

- Discontinuation of treatment

Risk of falls

The pharmacist will assess the Resident's medicines (prescribed and OTC) to identify any which may increase the Resident's risk of falling. These drugs will be highlighted to the prescriber for review.

Antipsychotic use in the elderly

At a national level, healthcare professionals are working to reduce the number of patients prescribed antipsychotics to treat the behavioural and psychological symptoms of dementia (BPSD).

It is likely that the GP will review and reduce these medicines whenever possible.

Monitoring

Certain medicines require additional ongoing monitoring. The pharmacist will check that the necessary tests have been performed and ensure that action is taken when needed. Examples of drugs that may require monitoring include:

- Lithium
- Methotrexate
- Digoxin
- ACE inhibitors
- Warfarin

Prescribing guidance

There are several sources of information and support available for prescribers. The pharmacist will check that both local and national guidelines and recommendations are being implemented.

Medication switches

Medication may be amended to reflect changes in clinical evidence, local or national recommendations, and/or cost effectiveness.

Homely Remedies Policy

This policy aims to ensure that a Resident can receive treatment for a minor ailment as quickly as possible. If staff have any questions or queries regarding a Resident's medication, they should ask a pharmacist for advice.

What are the outcomes of the MR?

The pharmacist will contact the Resident's GP with their observations, and recommend changes to medication where appropriate.

High Risk Medicines

The following medicines should be highlighted on the Resident's records as requiring special care and/or extra monitoring if a Resident is prescribed them.

It is important to remember that lifestyle factors such as diet, smoking and exercise can affect these medicines, as well as other prescribed and over the counter products.

Care home staff should check with a pharmacist if they have concerns or queries regarding any of these medicines.

The following list is not exhaustive, but lists some of the most common high-risk medicines.

Methotrexate

- Methotrexate is known to interact with some antibiotics, sometimes with very serious consequences.
- When collecting a prescription for antibiotics, Care Home staff should **always** ask the pharmacist to check for interactions with the Resident's current medication.

Warfarin

- It is important that warfarin be given to the Resident at the same time each day and preferably around 6pm.
- Warfarin interacts with several OTC medicines and is affected by some antibiotics.
- When purchasing an item OTC or collecting a prescription, Care Home staff should **always** inform the pharmacist that the Resident is currently prescribed warfarin.

Theophylline

- The level of theophylline absorbed by the body may be increased in viral infections, and decreased by smoking.
- Even minor changes in the levels of theophylline in the body can affect the way it works and its effectiveness for symptom control.
- Care Home staff should inform the GP if a Resident prescribed theophylline decides to stop smoking.

Critical Medicine List

Due to the risk of patient harm, administration of these drugs should **NEVER** be missed or delayed.

Delay of a critical medicine, or a missed dose, is a patient safety incident and should be reported as a clinical incident using the Care Home's procedure for this.

If a resident is unable to take the medication as prescribed, or a dose has been delayed or missed, Care Home staff should contact their supplying pharmacy for advice.

Drug name/class

Common examples and additional information

Anticoagulants	Apixaban, Dabigatran, Edoxaban, Rivaroxaban, Warfarin
Anti-epileptics	Carbamazepine, Clobazam, Clonazepam, Gabapentin, Lamotrigine, Levetiracetam, Midazolam, Phenobarbitone, Phenytoin, Pregabalin, Sodium Valproate, Topiramate
Antimicrobials (antibiotics)	Amoxicillin, Cefalexin, Co-amoxiclav, Doxycycline, Nitrofurantoin, Trimethoprim
Antiplatelets & thrombolytics	Aspirin, Clopidogrel, Prasugrel, Ticagrelor
Anti-virals	Aciclovir
Chemotherapy & associated therapies	Oral chemotherapy drugs and those to prevent vomiting.
Clozapine	A patient must NOT miss more than 48 hours' of clozapine doses. If a treatment break of more than 48 hours has occurred, seek guidance from GP
Corticosteroids (oral)	Dexamethasone, Fludrocortisone, Hydrocortisone, Methylprednisolone, Prednisolone,
Desmopressin (DDAVP)	
Immunosuppressants	Azathioprine, Ciclosporin, Mycophenolate, Tacrolimus
Insulin & other drugs for diabetes	Dapagliflozin, Exenatide, Gliclazide, Liraglutide, Lixisenatide, Metformin, Pioglitazone
Neuromuscular agents	Baclofen, Pyridostigmine
Opioid analgesics	Buprenorphine, Fentanyl, Morphine, Oxycodone,
Medication for Parkinson's disease	Amantadine, Co-beneldopa, Co-careldopa, Entacapone, Pramipexole, Ropinirole, Rotigotine