Care Home Pharmacy Learning Event

Stadium of Light, September 20th 2019

Event Report

Academic Health Science Network
North East and North Cumbria

Introduction and Context

As part of the overall Medicines Safety Improvement Programme (MSIP), the national MSIP team have commissioned Patient Safety Collaboratives (hosted by the AHSN network) to deliver a 3 year project with the aim to reduce harm as a result of errors in the administration of medicines in care homes and improve the safety and experience of care.

An estimated 92 out of the 237 million medication errors per annum million arise in care homes in the administration stage. Whilst there is a limited evidence base on medication errors in care homes, the Care Home Use of Medicines Study (CHUMS 2009) identified an ‘unacceptable level’ of medication errors in older residents living in care homes, and a wide range of causes. From the evidence identified, older residents living in care homes are frequently prescribed multiple medicines (mean average 7.2 medicines per resident). Evidence suggests people taking multiple medicines for long-term conditions are most likely to have a medication error. Care home residents appear to be at greater risk of a medication error than most other groups, because of their complex health and care needs; 69.9% of care home residents will suffer one or more errors.

An analysis of medicines safety in health and social care completed by the Care Quality Commission (June 2019)[1] identified several key themes pertinent to providers of adult social care, which included errors in medicines administration and record keeping, and managing ‘when required’ medicines.

The analysis found that administering an incorrect dose of medication was the most commonly-reported error. People also missed doses of their medicines for a variety of reasons. Errors of administration of medicines were more prevalent for non-oral formulations of medicines, particularly transdermal patches and inhalers.

Errors associated with prescribing, monitoring and medicines ordering are target areas for other national initiatives, and other Medicines Optimisation programmes within the AHSN network are expected to impact on medicines safety for people living in Care Homes, including transfer of care around medicines and reducing problematic polypharmacy (subject to the AHSN prioritisation process).

The AHSN Medicines Safety workstream will aim to reduce harm resulting from multi-disciplinary medicine administration errors in care homes. Any intervention to improve the safety of medicines administration is likely to be complex in nature as the process involves many steps, techniques and different personnel.

The execution model will be based on engagement across a broad sample of care homes. Initially, NENC is looking to identify ‘willing’ care homes where improvement work may already be underway (PSC led or otherwise) and care home groups rather than focus on individual independent care homes in order to meet the requirements of the diagnostic phase of work and the aim to build a national baseline picture. NENC PSC is looking to work through existing care home networks or incrementally develop new networks across the PSC footprint to aid engagement with care home providers and associated social and healthcare staff.

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[1] https://www.cqc.org.uk/sites/default/files/20190605_medicines_in_health_and_adult_social_care_report.pdf

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Purpose of the event

The Pharmacy Integration Fund enables a number of national pharmacy initiatives which support the delivery of medicines optimisation in General Practice, Integrated Urgent Care and Care Homes, adding to existing activities in other health settings.

Sustainable Transformation Partnerships and Integrated Care Systems across England are implementing the Medicines Optimisation in Care Homes (MOCH) Programme. New pharmacists and pharmacy technicians have been integrated into primary care and social care teams, as well as into local Enhanced Health in Care Homes plans, which should lay out a clear vision for working with care homes to provide joined up care to residents. Through the MOCH programme, pharmacists working with multi-agency teams, patients and their families, can provide a number of benefits for care homes and their residents including:

- Optimising medicines (stopping inappropriate or unsafe medicines, and ensuring medicines add value to patient's health and well-being)
- Patient centred care (shared decision making about which medicines care home residents take and stop)
- Creating better medicines systems for care homes to reduce waste and inefficiency
- Training and supporting care home staff to enhance safer administration of medicines.

The NENC Medicines Safety workstream therefore view MOCH teams locally as key stakeholders in both understanding the underlying causes of medicine administration errors and driving innovation and quality improvement to reduce their incidence and associated harm.

The aims of the workshop were to:

- Establish a network for MOCH teams across NENC to facilitate sharing of learning and best practice;
- Inform MOCH teams of the Medicines Safety workstream project specification and other associated national and local care home initiatives;
- Gather initial expert views on the topic to inform project planning and next steps.

Event Outputs

Delegates at the event were asked to consider their experiences of working within the care home environment and the extended system surrounding them in terms of medicine administration. In turn to give their expert views and knowledge in relation to four key questions.

The summary of their responses is below *(please note this is a summary interpretation of responses):*

- Q1: In your experience what are the issues (and scale of these issues) that are leading to medicines administration errors in the care homes you are engaged with?

  - ✓ Interruptions and distractions during medicines rounds
  - ✓ MAR charts incorrect/not checked/manual addition of meds
  - ✓ Poor handovers/communication
  - ✓ Differing systems in different care homes/no standardisation
  - ✓ Lack of time for care staff, high turnover of staff
  - ✓ No shared learning/standardised learning/lack of understanding/lack of knowledge
  - ✓ Communication pathways with GPs/Care homes/Pharmacy/transfers
  - ✓ Too many specialists/advisor/conflicting advice/inappropriate formulations
  - ✓ Poor prescribing instructions/supporting documentation
  - ✓ Too many medicines/different brands/polypharmacy/prn plans
  - ✓ Respite in intermediate care beds
  - ✓ Person centred care plans, access/detail/time/reviews

- Q2: What interventions are you aware of currently being used to reduce harm in medicines administration in care homes?

  - ✓ Community pharmacy audit/internal audit
  - ✓ Tabards/aprons worn during meds rounds
  - ✓ E Mar/missed meds reports on EMar
  - ✓ Checking/observing meds rounds/home competency certificates
  - ✓ Checking documentation to make sure it tallies
  - ✓ Assessing covert processes
  - ✓ DRUM template on GP systems
  - ✓ Training PRESQIPP/Safeguarding
  - ✓ Technicians ordering/waste
  - ✓ Resident of the day
  - ✓ MOCH Teams
  - ✓ PRN protocols
  - ✓ Reductions in antipsychotics

- Q3: What support is available to help the care homes reduce harm and which of those are most effective?

    - ✓ MOCH team/pharmacy input, community, NECS, CCG
        - Clinical knowledge/training/regulatory requirements/guidelines
        - - too many involved/working roles

    - ✓ Safeguarding teams/SALT teams/VAWAS/CPN's/behaviour support
    - ✓ Newsletter
    - ✓ Training updates (PRESQIPP)/local events/steering groups/online learning
    - ✓ NICE guidance

- Q4: In your expert opinion what support would care homes need to undertake improvement activity in this area?

    - ✓ Referral system for new admissions
    - ✓ Financial incentives to take part in improvement activity
    - ✓ Staff support, transparency for errors, near miss logs
    - ✓ More input from MOCH teams
    - ✓ Alignment of GP to care homes/GP support/reduction in meds
    - ✓ Prescriber visits, clear directions, synced meds, course meds
    - ✓ Medicines administration champion in care homes
    - ✓ MDT meetings, GP/Community Pharmacy/care homes
        - Breakdown barriers, explain issues, communication links
    - ✓ Pharmacy professional in every care home at all times

- In addition to the question responses there were additional notes not clearly linked to a specific question but worthy of reporting, there included;

    - ✓ What does "administration of medicines" actually mean? i.e. to include 'non-administration' & clearly define what the project is looking at
    - ✓ Culture, may not be open and transparent
        - Care homes do not like talking about errors/near misses
        - They are a business and do not like to talk about their failings, they are in competition with other care homes
        - Staff worry about getting into trouble or being subject to a disciplinary

Summary and Next Steps

Feedback from the event was positive with attendees keen to continue to meet and share learning as a network. A further event is to be scheduled for January 2020. The focus of the event will be to seek further engagement with and professional advice from the MOCH pharmacy teams with regard to the AHSN Medicines Safety Initiative; identify potential areas for quality improvement from April 2020 onwards, and offer further networking opportunities.

It is anticipated the AHSN will be approaching individual care homes to participate in a national survey from December 2019 and will seek support and advice from the MOCH pharmacy network in encouraging local participation.