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Submission to: **National Assembly for Wales: Health and Social Care Committee**
Call for Evidence: **Inquiry into residential care for older people.**

About Us

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Wales and across Great Britain. We are the only body that represents all sectors of pharmacy. The RPS promotes and protects the health and well-being of the public through the professional leadership and development of the pharmacy profession. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession"s policies and views to a range of external stakeholders in a number of different forums

Summary of Recommendations

Recommendation 1: Pharmaceutical needs assessment should form part of the normal care package for residents of care homes.

Recommendation 2: Arrangements should be put in place to allow pharmacists to provide direct advice and support to the residents of care homes, ensuring they are adherent with their medication and understand more about the medicines they are taking.

Recommendation 3: Care homes should have robust well informed policies and processes in place on medication administration including the transfer of medication and information between care settings and where care is shared by several agencies.

Recommendation 4: We recommend that steps should be taken in Wales to help reduce the risks of administration errors for individuals living in residential care homes through appropriate staff training and assessment of competency.

Recommendation 5: To improve medicines administration and improve quality of care in residential homes, and to help care homes maintain regulatory standards, pharmacists should

play a greater role in the inspection process for care homes. Consideration should be given to local arrangements that allow community pharmacists supplying medication to also be able to give advice to care homes on storage, administration and record keeping.

Recommendation 6: Residents of care homes should have a full and detailed annual medication review that is tailored to the specific needs and issues faced by patients in residential care settings.

Recommendation 7: We recommend that any new models of residential care should address the following issues with regard to the use of medicines:

- Medicines issues should be fully integrated into the Unified Assessment Process ensuring that the pharmaceutical care needs of individuals are appropriately addressed as part of the holistic assessment of their care needs.
- Organisations and individuals involved in commissioning and delivering care should understand their role and remit in relation to medication and support people"s medication needs as they move seamlessly between care settings.
- Organisations are fully and correctly informed of the law, statutory requirements and facts relating to medication and develop and deliver services from an "informed position". This should be consistent across Wales.
- Medication needs should be part of the care package and support tailored to meet individual needs based on an appropriate assessment.
- All residential care home personnel should understand the importance of medicines in a person"s life and should be clear about their role, limitations and responsibility with regard to a person"s medication needs. This includes understanding how their role/service fits with the roles and responsibilities of other people/services involved in delivering care and where help, advice and support can be obtained.
- Residential care homes should have access to advice on medicines and good practice from a pharmacist. Access to advice and guidance, promoting and sharing good practice and service developments throughout Wales should help residential care homes to improve standards and safety in the use of medicines as part of overall efforts to increase the quality of care residents receive in residential care homes.

Background

The Royal Pharmaceutical Society (RPS) welcomes the opportunity to contribute to the inquiry into residential care for older people in Wales. This response is based on the experience and knowledge of the Royal Pharmaceutical Society and its members in medicine safety, medicine administration, medicine management and inspection of medicine usage.

Pharmaceutical care for older people in residential care homes is a significant issue which has direct consequences for the quality of residential care services and the experiences of service users and their families. It is well recognised that older people are intensive users of medicines. The significant correlation between the prevalence of chronic conditions, the ageing population and medicines use for example means that the inherent risks of medicines taking are intensified for older people residing in care homes if they are unable to benefit from direct support and advice from pharmacists, the experts in medicines.

Research findings indicate an unacceptable level of medication errors and patient safety concerns. A recent study into the use of medicines by older people in care homes[1] has heightened our concerns around medicines administration in care homes. This found that:

- Residents with a mean age of 85 years were taking an average of 8 medicines each
- On any one day 7 out of 10 patients experienced at least one medication error
- Whilst the mean score for potential harm was relatively low, the results did indicate opportunity for more serious harm.

The Department of Health in England considered the findings of the study so important they sent an alert in January 2010 for immediate action to Primary Care Trusts, Social Services and registered providers of adult social care homes[2]. We are concerned that in Wales the findings from this study have yet to be fully addressed.

A recent literature review conducted by Public Health Wales also highlighted that medication administration errors in care homes are common despite the introduction of national and minimum standards which were introduced to protect the safety of residents[3].

As the experts in medicines, pharmacists have a unique role in the safe and effective delivery of pharmaceutical care. We are very concerned however that the essential skills of pharmacists are currently not being utilised consistently or universally in care homes with

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[1] Barber ND, Allred DP, Raynor DK, Dickinson R, Garfield S, Jesson B et al (2009) *Care homes' use of medicines study: prevalence, causes and potential for harm of medication errors in care homes for older people.* Qual Saf Health Care 2009; 18: 341-6. This study examined the prescribing, dispensing, administration and monitoring practices across 55 care home in England. This study was funded by the Department of England and the methodology was sufficiently robust to determine the prevalence of medication errors in these specific aspects of the medicines system. The study was not designed to measure actual patient harm but gave a clear indication and score for the potential for harm.

[2] Department of Health (2010) *The use of medicines in care homes for older people*. DH Alert (2010) 0001

[3] Public Health Wales (2010) *Medication administration errors in care homes*. Public Health Wales NHS Trust.

negative consequences for patient safety, the capacity of staff to meet the demands of their residents and in the delivery of quality care.

Against this backdrop we believe the use of medicines in residential care homes requires the attention of the Health and Social Care Committee as part of the broad scope of this inquiry.

Pathways into residential care

The process by which older people enter residential care is a key area of concern regarding the use of medicines. The risks to people taking medicines are increased when they transfer their care from one setting to another. Research has consistently shown that between 30 and 70% of patients have either an error or an unintentional change to their medicines when their care is transferred[4]. Around four to five percent of hospital admissions are due to preventable problems with medicines and these incidents of avoidable harm to patients can result in unnecessary emergency admissions to hospital and in some cases the impact on patients can be devastating. The assessment of the pharmaceutical needs of individuals and the medication they need is critical as they move into residential care. We have recently published guidance which gives health and social care professionals a common framework and clear expectations concerning good practice around the transfer of information about medicines[5].

We are concerned about the lack of access to pharmaceutical advice for people when they enter care homes. Currently there are no well defined processes for assessing pharmaceutical care needs of patients and direct contact with a pharmacist for advice and support is not routinely provided in care homes. Older people often take a cocktail of medication but are not able to benefit from pharmaceutical advice to improve their adherence to medicine which ultimately can improve health outcomes, increase safety and stop or drastically reduce needless waste of medicine.

We believe that a system of assessing patients' pharmaceutical care needs is critical in driving up quality of care in care homes in Wales. It is paramount that when a patient transfers to residential care they have and retain access to pharmaceutical care and advice through direct contact with a pharmacist who is supported in their role to talk to residents about their medicines and support the care home staff with advice on medicine management.

Recommendation 1: Pharmaceutical needs assessment should form part of the normal care package for residents of care homes

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[4] National Patient Safety Agency and National Institute for Health and Clinical Excellence. Technical safety solutions, medicines reconciliation. 2007 guidance.nice.org.uk/PSG001

[5] Royal Pharmaceutical Society (2011) *Keeping patients safe as they transfer between difference care providers – getting the medicines right. Good practice guidance for healthcare professions*. Royal Pharmaceutical Society, London.

Recommendation 2: Arrangements should be put in place to allow pharmacists to provide direct advice and support to the residents of care homes, ensuring they are adherent with their medication and understand more about the medicines they are taking

Recommendation 3: Care homes should have robust well informed policies and processes in place on medication administration including the transfer of medication and information between care settings and where care is shared by several agencies.

The Capacity of the residential care sector

The capacity of the residential care sector to meet the needs of people entering residential care is an area of concern for the RPS. The range of complex health needs of residents adds to the vulnerability of individuals with high dependency needs. This is particularly relevant for residents taking medicines that must be administered with caution. Antipsychotic medication for the treatment of dementia is a case in point. These powerful drugs must be treated with caution for people with other underlying conditions such as Parkinson"s disease, cardiovascular disease, and respiratory diseases and it critical that the needs of the individual are well understood and medication administered correctly. If care home staff do not know how to give medicines safely then they may risk accidently causing someone harm.

We believe that all social care organisations, including residential care homes, have to recognise and take responsibility for their role in medication administration with the holistic consideration of the individual"s support needs. We are concerned however that too many medication administration errors are being made in care homes as a result of lack of capacity and an inadequate skills mix in residential home care.

Public Health Wales" 2010 literature review of medicines administration errors in care homes identified that dose omission was a significant problem with wrong dose and „ncorrect administration" errors also being a concern. The literature review revealed that a number of factors contribute to medication administration errors in care homes including:

- Staff being unable to find the patient or the medicine
- Inadequate protocols
- Staff knowledge
- Training
- Interruptions
- Environmental factors

Recommendation 4: We recommend that steps should be taken in Wales to help reduce the risks of medication errors for individuals living in residential care homes through appropriate staff training and assessment of competency. This could include:

- Training in aspects of medication use and administration to care home staff which complies with nationally recognised standards and competencies
- Social care personnel involved with medication undertake recognised training and have their competency assessed
- Everyone involved with medication has training around error and „near miss" reporting

Regulation and inspection

As the experts in medicines and medicine management, pharmacists have a unique set of skills that enhance any inspection concerning the administration and management of medicines. These skills are particularly relevant to care home settings where the use of medicines will be intensive and where the potential of errors is well documented.

Pharmacists have a critical role in intelligence gathering which should contribute to the overall process of care home inspection. This is particularly important when inspecting care homes that have controlled drugs stored or administered on those premises. The prescribing, use, administration, storage, record keeping and disposal of controlled drugs are of utmost importance. Many of these processes can be seen as routine in an inspection. However the skills and training of pharmacists enable them to identify patterns and areas of concerns where processes are correct but the outcomes are questionable.

The findings from the DH funded study mentioned previously and the need for local pharmaceutical intelligence in respect of the administration, storage and use of controlled drugs, strongly indicate the need for a review in the staffing levels for pharmacy within the work of Care and Social Services Inspectorate Wales (CSSIW). We have been concerned for some time that the lack of pharmacy input within the current CSSIW workforce is a potential risk in inspection processes. We understand however that CSSIW is currently looking to establish a panel of pharmacists who can be called upon when required. While in principle we welcome this development and the potential of an increased number of pharmacists being directly involved in inspection work we have yet to understand how this panel arrangement will work in practice.

Recommendation 5: To improve medicines administration and improve quality of care in residential homes, and to help care homes maintain regulatory standards, pharmacists should play a greater role in the inspection process for care homes. Consideration should be given to

local arrangements that allow community pharmacists supplying medication to also be able to give advice to care homes on storage, administration and record keeping.

Recommendation 6: Residents of care homes should have a full and detailed annual medication review that is tailored to the specific needs and issues faced by patients in residential care settings.

Future provision and new models of care

Reducing the risks of harm and improving health outcomes through medicines use can be achieved if pharmaceutical care is based on assessed need, delivered by competent staff under robust processes that allow multidisciplinary care and seamless movement between care settings, and supported through direct access to a pharmacist.

Recommendation 7: We recommend that any new models of residential care should address the following issues with regard to the use of medicines:

- Medicines issues should be fully integrated into the Unified Assessment Process ensuring that the pharmaceutical care needs of individuals are appropriately addressed as part of the holistic assessment of their care needs.
- Organisations and individuals involved in commissioning and delivering care should understand their role and remit in relation to medication and support people"s medication needs as they move seamlessly between care settings.
- Organisations are fully and correctly informed of the law, statutory requirements and facts relating to medication and develop and deliver services from an “informed position”. This should be consistent across Wales.
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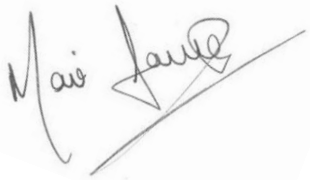
- All residential care home personnel should understand the importance of medicines in a person"s life and should be clear about their role, limitations and responsibility with regard to a person"s medication needs. This includes understanding how their role/service fits with the roles and responsibilities of other people/services involved in delivering care and where help, advice and support can be obtained.
- Residential care homes should have access to advice on medicines and good practice from a pharmacist. Access to advice and guidance, promoting and sharing good practice and service developments throughout Wales should help residential care homes to improve standards and safety in the use of medicines as part of overall efforts to increase the quality of care residents receive in residential care homes.

On a final note, the Royal Pharmaceutical Society is currently working closely with the Royal College of Physicians and other Royal Colleges, along with care home providers, to develop and test strategies aimed at improving the use of medicines in care homes and to minimise the chance of adverse events occurring in future. Part of this work focuses on leadership in care settings, the skills of care workers and staff, and developing a resident's charter. This report will be available in 2012 and may help to provide the solutions to many of the issues highlighted above. We look forward to sharing this publication as soon as it becomes available.

I trust this information is helpful and would be pleased to elaborate on any issues raised here which may contribute to this important inquiry.

Yours sincerely,



Mrs Mair Davies
Chair, Welsh Pharmacy Board