

Care homes: Good practice guide to prescribing and medication reviews

The effective management of medicines in care homes requires robust systems to be in place as well as good communication between the care home providers, residents, prescribers, community pharmacies and GP practices.

This document has been developed to highlight some key information for prescribers in general practice who look after care home residents. The guidance is based on the National Institute for Health and Care Excellence (NICE) guidance SC1, Managing medicines in care homes (2014), NICE quality standard 85 Managing medicines in care homes (March 2015) and good practice.^{1,2}

The monthly medication cycle

Most care homes operate a 28 day medication cycle.

The process will usually start two weeks before the next medication cycle begins to facilitate the checking stages and allow for any discrepancies to be resolved.

- At the beginning of week three, the care home checks the stock levels and current medication regimen then requests the prescription for medication from the GP practice*.
- The GP practice issues the prescriptions and they are returned to the care home. It is good practice for prescriptions to be checked by the care home prior to them being sent to the pharmacy for dispensing.
- The care home checks the prescriptions against the original requests, then sends them to the community pharmacy. Any discrepancies should be followed up with the practice.
- The dispensed items are delivered to the care home a few days before the beginning of the new medication cycle. The care home checks the items against the original order and current medication administration record (MAR) charts. Any discrepancies should be followed up.
- Regardless of which method is agreed to request prescriptions from the GP practice, it is essential that the list is accurate. Care homes are encouraged to review the current MAR chart at the time of making these requests.
- It is good practice to have dedicated trained staff processing the requests from the care home.

***NB.** It is recommended that care home providers should retain responsibility for ordering medicines from the GP practice. This should not be delegated to the community pharmacy supplying the medicines.

Prescriptions

NICE guidance SC1, Managing medicines in care homes recommends that GP practices should ensure that there is a clear written process for prescribing and issuing prescriptions for care home residents.¹

The process should cover:

- Issuing prescriptions according to the patient medical records.
- Recording clear instructions on how a medicine should be used, including how long the resident is expected to need the medicine and, if important, how long the medicine will take to work and what it has been prescribed for (use of the term 'as directed' should be avoided).

- Recording prescribing in the GP patient medical record and resident care record and making any changes as soon as practically possible.
- Providing any extra details the resident and/or the care home may need about how the medicine should be taken.
- Any tests needed for monitoring.
- Prescribing the right amount of medicines to fit into the 28 day supply cycle if appropriate; and any changes that may be needed for prescribing in the future.
- Monitoring and reviewing 'when required' and variable dose medicines.
- Issuing prescriptions when the medicines order is received from the care home.

Electronic transfer of prescriptions directly to the care homes nominated pharmacy

If prescriptions are transferred electronically it is essential that there is a robust process in place. This may include:

Repeat prescriptions

- It is important that the care home is able to check the prescriptions prior to them being dispensed by the pharmacy. It must be agreed who will provide the care home with the paper version of the prescription; the practice (prescription token) or the dispensing pharmacy (dispensing token).
- The care home checks the token against the record of what was ordered. Any discrepancies identified must be communicated to the GP practice and/or the community pharmacy. The care home should flag prescriptions for items that have been issued but that were not requested to ensure that they are not dispensed.
- It is important that the directions are complete or the community pharmacy will have to manually adjust each direction, i.e. don't use abbreviations such as "bd" or "tds" because these will automatically be transferred directly to the label.
- Checks must be made to ensure the correct nominated community pharmacy is listed for each resident, especially those new to the home, who may have had a previous nomination.

Acute prescriptions

There should be a process for informing the community pharmacy that an acute prescription has been issued, to prevent any undue delay in getting the medicine to the resident.

If guidance is available, refer to local guidance on which medicines may not be appropriate to prescribe electronically.

Remote prescribing

NICE guidance, Managing medicines in care homes (SC1) advises that:¹

- Telephone, video link or online prescribing should only be used in exceptional circumstances.
- Not all care home staff have the training and skills required to assist with the assessment and discussion of the resident's clinical needs for safe remote prescribing.
- Ensure that care home staff understand any instructions.
- Written confirmation of the instructions to the care home should be sent as soon as possible.

Directions

It is important that there are clear directions to facilitate appropriate administration of medication.

- **Use of the term 'as directed' should be avoided.**
- All topical preparations should have directions that include:
 - » How they should be used, e.g. as soap substitute, liberally, sparingly etc.
 - » Where they should be used, e.g. legs.
 - » Frequency of use, e.g. in the morning after washing, as often as required to alleviate itchiness, three times a day etc.
 - » The duration of the treatment, especially for creams containing steroids and antimicrobial constituents.
- All labels for eye/ear preparations should give specific directions about whether it is to be applied to right, left or both eyes/ears.
- **All medicines must have a dose, e.g. 'one puff twice daily' not 'use twice daily'.**
- Directions for variable dose and 'when required' drugs should include:¹
 - » When and how to take or use the medicine
 - » Monitoring
 - » The effect they expect the medicine to have
 - » Dosage instructions on the prescribing (including the maximum amount to be taken in a day and how long the medicine should be used, as appropriate) so that this can be included on the medicine's label. This is particularly important for psychotropic drugs.

It may be necessary to provide further information to clarify when one dose or two doses should be administered.

Repeat prescriptions

- **Medicines should be linked to a documented indication.**
- Medicines should be listed by generic name unless there is local guidance to prescribe a cost effective branded generic product, or a specific reason for a brand name, e.g. bioavailability issues - such as long acting formulations of diltiazem, modified release nifedipine, tacrolimus capsules or patent restrictions such as Lyrica® for neuropathic pain. In such cases, to minimise errors, particular care should be taken to ensure that only a clinician changes branded medication to a generic.
- Time should be set aside to check and sign the prescriptions.
- There should be a process for checking or having access to blood test results such as INR levels. Dosing should be communicated effectively and in a timely manner. If a medicine is started during the medication cycle, the quantity prescribed should be synchronised to take the patient to the end of the medication cycle. The new medicine should then be requested with the other medication if the requests haven't already been sent to the practice.

Acute and interim prescriptions

The following should be considered:

- Prescribe the amount likely to be needed.
- Record clear instructions on:
 - » How the medicine should be used.
 - » How long the resident is expected to need the medicine.
 - » If important, how long the medicine will take to work.
 - » What it has been prescribed for (use of the term 'as directed' should be avoided).
 - » Date of review.

- Ensure all appropriate therapeutic drug monitoring is done, at appropriate time intervals.
- It is good practice to make a note of acute and interim prescriptions on the patient clinical record as soon as possible after the visit if there is no access to the clinical system whilst at the care home.
- If handheld portals are used during home visits, the data should be uploaded into the patient's clinical record on return to the surgery.
- If the practice server is connected to remotely, from another location (i.e. not the practice computer), the prescriber must ensure the information is updated securely into the patient's clinical record.
- If a hand-written prescription is provided, ensure that the name, strength and form of the product and dosing information is recorded in the patient medication record and record that the prescription was issued "by hand".
- Any changes in dose of an existing medication should be explained to the care home, specifying if it is instead of existing dose or in addition to the dose, e.g. furosemide 40mg, new prescription issued for 20mg. Indicate whether it is an increase to 60mg or decrease to 20mg.
- When an 'acute' prescription is started it should be clear to the care home that it is for a specified period of time.
- Liaise with care home staff to see how often the resident has the medicine and how well it has worked. This can include discussing information about side effects the resident has experienced.

Prescribing for older people

80% of people aged 75 and over take at least one medication and more than a third take four or more. Studies have indicated that this figure rises significantly for those living in care homes as they tend to be frailer with several co-morbidities.³

Polypharmacy is defined simply as the use of multiple medications by a patient. The precise minimum number of medications used to define "polypharmacy" is variable, but generally ranges from 5 to 10.⁴

There are multiple reasons why older adults are especially impacted by polypharmacy:

- Age-related changes such as low body mass, impaired renal and hepatic function have a direct effect on how the body handles medicines therefore older people are at greater risk for adverse drug events. This risk is compounded by the increasing numbers of drugs used.
- Polypharmacy was an independent risk factor for hip fractures in older adults in one case-control study, although the number of drugs may have been an indicator of higher likelihood of exposure to specific types of drugs associated with falls (e.g., CNS active drugs).⁵
- Polypharmacy increases the possibility of "prescribing cascades".⁶ A prescribing cascade develops when an adverse drug event is misinterpreted as a new medical condition and additional drug therapy is then prescribed to treat this medical condition.
- Use of multiple medications increases the potential for drug to drug interactions.

There is also a clear link between polypharmacy and drug-related hospital admissions with 6.5% of all acute admissions in the UK being drug related.⁷⁻⁹ This rate varies between 2% and 20% depending on the definition of 'adverse drug event' and according to age range.¹⁰⁻¹² In addition, evidence suggests that the rate of adverse drug reactions (ADR) necessitating admission into hospital is increasing.¹³⁻¹⁵

The decision whether or not to prescribe additional medication for a care home resident must always be a 'patient-centred' and individualised decision.

Avoiding hospital admissions

A proactive approach is required. Liaise with care staff to ensure care plans are up to date.

- Identify those at risk, update their care plans and anticipate potential issues. For example, for residents with COPD, discuss the signs and symptoms of acute exacerbation with staff and the steps to be taken.

- Identify early assessment of acute problems to reduce avoidable illness and minimise the need for emergency hospital admissions, which are stressful and traumatic for residents.
- Ensure the decisions regarding care such as end of life planning are well documented.
- Provide effective support and sufficient information to enable them to be confident to cope with residents' complex health care needs.

Remember: Hospital admissions can be particularly traumatic for people with dementia, often resulting in significant distress and deterioration.

In a 2004 UK study the most common drug groups associated with admission due to adverse drug reaction were:⁸

1.	NSAIDs	29.6%
2.	Diuretics	27.3%
3.	Warfarin	10.5%
4.	ACE	7.7%
5.	Antidepressants	7.1%
6.	Beta blockers	6.8%
7.	Opiates	6.0%
8.	Digoxin	2.9%
9.	Prednisolone	2.5%
10.	Clopidogrel	2.4%

Medicines reconciliation

Medicines reconciliation is a process of obtaining an up-to-date and accurate medication list that has been compared to the most recently available information and has documented any discrepancies, changes, deletions or additions.

New residents

Care homes should have a documented procedure in place for obtaining information about the resident's medical history and current medication; the healthcare professional who will be taking clinical responsibility for prescribing for the individual must participate in a full reconciliation, i.e. resolving any discrepancies and accurately recording decisions.

Check	To ensure that the medicines, formulation, route, and doses are appropriate.
Consider	If the medicine continues to be required or whether discontinuation may be more appropriate.
Clarify	Any changes, omissions and discrepancies with either the patient or the initiating prescriber (if possible).
Communicate	Document and date any changes.

Residents recently discharged from hospital or who have attended outpatient clinics

- There should be a procedure for handling information from discharge or outpatient letters.
- The prescriber should ensure that the information on medicine changes are critically reviewed and incorporated into the patient's clinical and medical record.

Medication review

NICE guidance on Managing medicines in care homes (SC1) recommends that:¹

- GPs should ensure that arrangements have been made for their patients who reside in care homes to have medication reviews as set out in the residents' care plans.
- **Residents should have a multidisciplinary medication review, the frequency of which should be based on the health and care needs of the resident. The resident's safety should be the most important factor.**
- **The interval between medication reviews should be no more than one year.**

When to review medication

- » At points of change in health status
- » At transitions in care (e.g. post hospital discharge)
- » When new symptoms emerge
- » If an adverse event occurs i.e. recent fall, allergy

The following should be discussed and reviewed:¹

- The purpose of the medication review.
- What the resident (and/or their family members or carers, as appropriate and in line with the resident's wishes) thinks about the medicines and how much they understand.
- The resident's (and/or their family members' or carers', as appropriate and in line with the resident's wishes) concerns, questions or problems with the medicines.
- All prescribed, over-the-counter and complementary medicines that the resident is taking or using, and what these are for.
- How safe the medicines are, how well they work, how appropriate they are, and whether their use is in line with national guidance.
- Any problems the resident has with the medicines, such as side effects or reactions,
- Taking the medicines themselves (for example, using an inhaler) and difficulty swallowing.
- Helping the resident to take or use their medicines as prescribed (medicines adherence).
- Any more information or support that the resident (and/or their family members or carers) may need.

Key areas to explore

Patient issues	Therapeutic issues
<ul style="list-style-type: none"> • Patient views and/or carer views • Compliance • Ability to use or take medicine • Symptom control • Adverse drug events • Physical and cognitive function • Health changes • Fragility 	<ul style="list-style-type: none"> • Is there a current and valid indication • Risk versus benefit • Inappropriate long-term prescribing • Actual/potential drug interaction or toxicity • Contra-indications • Is the regimen appropriate; can it be simplified? • Test results
Medicines management issues	Prescribing issues
<ul style="list-style-type: none"> • Inappropriate frequency/strength/formulation • Is the drug cost effective • Brand to generic switch • Generic to brand switch • Inappropriate dosage directions • Synchronise quantities prescribed 	<ul style="list-style-type: none"> • Drug of limited value • Duplication of therapy/inappropriate polypharmacy • Potential drug interaction/adverse effects • Unmet need or untreated indication • Potential to optimise therapy, e.g. spacer prescribed if necessary • Sub-therapeutic dose • Dose higher than maximum recommended dose • Monitoring required

Top tips when stopping medication

- Know when to stop; medicines may be stopped to reduce inappropriate polypharmacy or adverse drug reactions and in response to a lack of efficacy or change in treatment goals. When a resident becomes frail, develops end stage dementia or other circumstances which impact on life expectancy, treatment goals should be reviewed.
- Manage the expectations of patients, relatives and carers.
- Identify and prioritise medicines that can be stopped.*
- Gradually reduce the dose of medicines which can cause withdrawal effects such as benzodiazepines and antidepressants and those which can cause rebound symptoms such as proton pump inhibitors, using appropriate guidance.
- Inform the resident and carers of symptoms to monitor.
- Set a review date.

Particular care should be taken for the on-going prescribing of medicines with potential adverse effects, e.g. benzodiazepines, anticholinergics; those where the number needed to treat is high, e.g. aspirin for primary prevention or there are indications of shortened life expectancy.

Useful resources that support the decision making process.

Safe and Appropriate Medicines Use: <http://www.prescripp.info/safe-appropriate-medicines-use-deprescribing/viewcategory/190-safe-and-appropriate-medicines-use>

All Wales Medicines Strategy Group. Polypharmacy: Guidance for Prescribing. July 2014. www.awmsg.org

All Wales Medicines Strategy Group. Polypharmacy: Guidance for Prescribing. Supplementary Guidance – BNF Sections to Target. July 2014. www.awmsg.org

NHS Highland. Polypharmacy: Guidance for Prescribing In Frail Adults June 3013. www.nhshighland.scot.nhs.uk

NHS Cumbria STOPP START Toolkit Supporting Medication Review. February 2013. www.cumbria.nhs.uk

Related PrescQIPP resources

Don't forget to log in to the site so that these links take you directly to the resources.

Care homes webkit: <http://www.prescqipp.info/carehomes>

Care homes – Medication and falls: <http://www.prescqipp.info/care-homes-medication-and-falls/viewcategory/307>

Reducing antipsychotic prescribing in dementia toolkit: <http://www.prescqipp.info/reducing-antipsychotic-prescribing-dementia-toolkit/viewcategory/241>

Further reading

Managing medicines in care homes NICE quality standard 85. March 2015

These are a set of statements designed to drive measurable improvements in quality. Statements 4, 5, and 6 are directly relevant to general practice.

References

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