Implementing Medicines Optimisation Quality, Innovation, Productivity and Prevention (QIPP) in Care Homes

Tips for 10 Top Target Areas

Note: This cover page must be printed with any copies of this document.

This is a controlled document which will be routinely updated to incorporate new information. While every effort has been taken to ensure the accuracy of the information, readers are advised to check local sources. Where prices are quoted, those listed in the Drug Tariff and MIMS have been used so check the latest versions for up to date prices.

The document has been written for use by pharmacists or other healthcare professionals involved with medicines optimisation in care homes (older adults). The Tips should be used as prompts to help rationalise prescribing and are not replacements for clinical judgement. The final decision on what to prescribe and the responsibility lies with the prescriber and should take into account the individual patient circumstance and overall treatment goal. Depending on the experience of the pharmacist and local priorities, each area can be used on its own or together. Specialist Pharmacy Services accept no liability for improper use.

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If you have any comments or examples of implementation that you would like to share as a part of a future update, please send these to inwh-tr.MUS-SpecialistPharmacyService@nhs.net

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**Dressings**

**Question the following...**

- **Silver (Ag) and Honey dressings** ⇒ expensive ⇒ not recommended for routine use in chronic venous leg ulcers (SIGN, NICE TA), uncomplicated ulcers, acute wounds (BNF)

- If needed, Ag dressings to be applied every 3-7 days for 2 weeks **only** ⇒ Check GP computer if Ag dressings come first on the picking list / dropdown list

- If honey needed ⇒ use dressings impregnated with honey ⇒ less messy, easier to use and maintains concentrations needed. **Actilite (Tulle) 10cm, Apinate honey (alginate) 10cm (2ce weekly changes) vs honey**

- Silicone non adherent dressings ⇒ more expensive & no advantage over low adherent dressings ⇒ for delicate/fragile skin use **N-A Ultra (silicone coated) vs Mepitel**

- Large size dressings on repeat ⇒ wounds should ideally reduce in size.

- Dressings on long term repeats ⇒ expect wound & dressing type to change over time ⇒ REVIEW

- Expensive dressings under compression bandaging ⇒ no added value over primary contact dressing like **N-A Ultra**

- Complex & expensive dressings e.g. **Promogran, Aquacel, Tielle, Mepilex, Urgotul** ⇒ not more effective than standard dressings in most cases. Reserve for unresponsive wounds or via tissue viability nurse (TVN).

- **Promogran** ⇒ treatment, not dressing as wound absorbs dressing. Only for clean wounds as slough prevents contact with wound specialist advice only

- Quantities over 10 units/month ⇒ most dressings can stay on for up to 3-5 days except for infected wounds ⇒ diabetic wound which may need more frequent changes ⇒ address underlying problems e.g. soiling from incontinence, wrong choice of dressing etc. or refer to TVN

- **Crepe bandage, tubigrip** ⇒ support bandage for sprains etc ⇒ expensive as retention bandage and not effective for compression. Use retention bandage e.g. **K-lite 10cm vs Crepe. Actifast or Clinifast 7.5cm, Tubifast vs Tubigrip**

- **Prontosan solution** (350ml should last 3-4 weeks) for long-term chronic wounds, specialist advice only ⇒ must soak wound for about 10mins, not for irrigation

  Generally, good practice is to use warm tap water to wash wounds not saline

- Long term topical steroids ⇒ cellulitis often misdiagnosed, avoid stopping abruptly as rebound symptoms may occur ⇒ consider **paste bandages** for varicose eczema
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☐ Sterile dressing packs ⇒ role is limited ⇒ to provide a sterile or clean work surface. Care home environment should be clean enough! Usually in top 10 dressings by cost. Nurse-it is cost effective (apron, gloves, no cotton wool)
Incontinence drugs & appliances

Question

☐ Incontinence drugs ⇒ ↑ adverse drug effects ⇒ anticholinergic effects or worsening of incontinence ⇒ is it working? ⇒ Stop & see

☐ Incontinence drugs ⇒ Bed bound, cognitively impaired and catheterised patients ⇒ Stop & see ⇒ Some may need for bladder spasm

☐ Excessive quantities of appliances ⇒ Approximate monthly supply needed\(^1\)

- **Penile sheaths** usually daily x30 ⇒ change product or refer to continence adviser if not staying on

- **Leg bags** drainable usually weekly x ⇒ refer to continence adviser if changing very frequently without reason or if recurrent infection

- **Night bags** ⇒ expensive sterile bags should not be used in care homes. Use non sterile/ non drainable and change daily x30

- **Catheters** ⇒ Indwelling Foley catheters x1 (plus 1 spare), Nelaton catheters reusable x5, Self lubricating catheters 5x25

☐ Dispensing Appliance Contractors (DAC) direct supply system if influencing use of expensive products

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\(^1\) *NHS Birmingham east and North. Continence Product Prescribing Formulary 2009*
Sip Feeds

Question

- The indication for a sip feed ⇒ If not disease related, can the home buy its own
- No BMI, MUST Score, or weight recorded and if no review in last 3 months
- No target weight or specific nutrition goal identified in records
- BMI above 21 (some older people may need to be maintained at higher BMI)
- Sip feeds on long term repeat prescribing ⇒ request latest BMI for every repeat request
- Low weight in spite of long term sip feeds ⇒ not responding/taking ⇒ REFER
- If taking common drugs that reduce appetite, cause dry mouth or weight loss e.g. digoxin, diuretics, levothyroxine, anticholinergics, discontinued antipsychotics
- ≤1Kcal products e.g. Ensure ⇒ probably won’t do the job if malnourished!
- Expensive or specialist feeds e.g. Calogen, Protifar
- Patient adherence to check if sip feeds are taken ⇒ prescription doesn’t mean consumption
- If no evidence that home is using food fortification as 1st step
- “As directed” dosing ⇒ clear dosing needed e.g. 1tds in between meals
- Other cause identified e.g. swallowing problems ⇒ SALT assessment, ill fitting dentures
- Prescribing by specialists re wound healing, dementia etc ⇒ monitor benefits
- If powdered ONS is appropriate, but enlist help of dietician
**Antipsychotic in dementia**

**Question:**

- The indication for an antipsychotic in dementia patients ⇒ only if behaviour is **challenging** and **puts patient or care giver at the risk of physical harm**

- If other antipsychotics are prescribed ⇒ only risperidone licensed up to 6 weeks. See SPC

- If no specific goals i.e. target behaviour, expected outcome and review date is not identified in records

- If rapid deterioration in behaviour, suspect and investigate presence of organic diseases that precipitate behaviour change e.g. pain, malnourishment, dehydration, constipation, physical illness, new patient, stress ⇒ are they medicines related or can medicines help? ⇒ e.g. Paracetamol 1g for pain

- If no evidence that home is using non-pharmacological interventions as 1st step excluding other possibilities ⇒ watchful waiting and behaviour monitoring

- If no review in last 6-12 weeks (specialist or GP) ⇒ REQUEST. More regular reviews are required when starting therapy

- If no evidence of reducing dose
  - Low dose, risperidone- 0.5mg, Olanzapine 2.5mg, quietiapine 50mg, aripiprazole 5mg ⇒ discontinue & monitor
  - High dose ⇒ reduce dose over a month if possible

- If Olanzapine, quietiapine (not effective), aripiprazole prescribed ⇒ GP to review ⇒ if possible withdraw and re start on risperidone if symptoms recur

- If also taking anticholinergic drugs especially oxybutinin, TCA, tolterodine, 1st generation antihistamines ⇒ review total anticholinergic burden, rationalise need ⇒ discontinue

- If on benzodiazepine regularly or prn for agitation ⇒ review & withdraw gradually

- If no weekly monitoring of fluid intake, sedation fatigue, nutrition, bowel function (good practice) and regular CVD monitoring/assessment e.g. lipid, BP, pulse etc

- If no evidence of routine biochemistry monitoring e.g. FBC, U&E, blood glucose etc
High cost drugs, including specials

**Question**

- **Anti-dementia drugs** ⇒ >6months since last review by specialist ⇒ assess benefits against last assessment ⇒ REFER for review

- **Strong opiate patches** e.g. Fentanyl, Buprenorphine ⇒ review ongoing need especially post acute pain episodes e.g. fracture. Check that application site is rotated

- **Modafinil, Mg glycerophosphate** ⇒ Shared care ⇒ is benefit evident or is response monitored regularly?

- **Midodrine** ⇒ is the benefit evident? ⇒ check BP monitoring

- **Melatonin** ⇒ is the benefit evident ⇒ licensed **Circardin 2mg Mr** ⇒ tablets

**Specials ......**

⇒ Liquid specials, soluble or dispersible tablets ⇒ establish presence & extent of a current swallowing difficulty (a liquid may be needed if patient preference, spitting or for covert administration) If psychological swallowing prople ⇒ REFER to SALT

⇒ Use a licensed formulation if available ⇒ e.g. lansoprazole orodisperisble, metformin sachets, Calfovit D3, Minims P/F eye drops

⇒ Change to a different class with same effect where possible e.g. omeprazole tablets to lansoprazole orodispersible

⇒ Check monthly ePACT spend for practice and feedback ⇒ add “dispenser address” to search criteria to identify patients in a specific care home
PRN ("as required") drugs and non adherence

Question

- If no specific administration instructions for PRN drugs ⇒ indication, dose, frequency and max dose required

- If not taken in last month ⇒ review and discontinue (use Homely Remedy if applicable) or reduce quantity if a full month’s worth is prescribed

- PRN medicines which are not suitable for acute use e.g. lactulose, long-acting bronchodilators, modified release preparations

- If taking PRN regularly and only at set times ⇒ ask how patient indicate needs or nurse assesses need for the medicine? ⇒ review need and change drug/dosing

- PRN drugs in monitored dosage systems ⇒ short expiry ⇒ wastage dispense in original pack or standard containers and include expiry dates

- Persistent non adherence with certain drugs ⇒ explore reasons, confirm need, weigh pros & cons

- Persistent non adherence with all drugs ⇒ explore reasons ⇒ best interest meeting ⇒ options include rationalise to most important only, covert administration (follow due process), discontinue ⇒ replenish stock only as needed ⇒ pharmacist to include expiry dates (not in MDS to avoid wastage)
Repeat prescribing process

Question

- If returning unused medicines at end of cycle including PRN drugs, creams, liquids, patches etc
- If large quantities of drugs returned ⇒ reassess the need for each drug ⇒ adjust quantities ordered or discontinue
- Staff ordering repeat medicines without checking stock
- Prescriptions ordered from surgery not checked by home before going to the community pharmacist for dispensing
- Measuring liquid preparations (particularly if expensive, CDs, small doses (<10ml)) ⇒ use oral syringe instead of 5ml spoons to avoid spills, running out of stock & wastage
- Monthly quantities in excess of dose stated ⇒ insulin, creams etc ⇒ calculate exact amount needed or see BNF guide for emollients, corticosteroids
- Missed/omitted doses of regular medication ⇒ check reason for omission e.g. ran out, out of stock
**Drugs with no "apparent" indication or for short term symptom control**

**Question**

- Long term **topical corticosteroids** ⇒ establish specific needs. Keeping prn stock may encourage inappropriate use

- Long term **topical and oral antifungals** ⇒ establish current need, is it working? May need to take nail clippings etc

- Long term **oral corticosteroids** ⇒ check specific indication

- **Proton pump inhibitors** without evidence of GI problem, gastroprotection ⇒ commonly prescribed post hospital discharge

- **Anti-emetics** ⇒ prochloperazine, metoclopramide ⇒ investigate nausea and vomiting

- **Statins or aspirin** with no indication of CVD ⇒ aspirin no longer indicated for primary prevention of CVD

- **Strong analgesics e.g. tramadol** ⇒ review need & step down as needed

- **Loop Diuretics** ⇒ non-drug alternatives for gravitational ankle oedema ⇒ establish need e.g. HF or AF

- **Multivitamins, Vitamins B and folic acid** ⇒ establish specific deficiency

- **Carbimazole** ⇒ last TFT ⇒ discontinue 18 months after euthyroid except stated in notes to continue
Drugs that require monitoring with respect to adverse drug reactions (ADRs) & clinical effectiveness

Question …..

- **Warfarin** ⇒ check target range & yellow book or other written documentation for latest INR and next due date

- **Analgesics** ⇒ is it working, is dose appropriate, any side effects

- **Laxatives** ⇒ rationalise if taking 3 or more laxatives, see bowel chart, check MAR for persistent refusal

- **Antihypertensives** ⇒ check BP records, if persistent hypotension review need in line with overall goal e.g. falls (ACEIs and alpha blockers).

- **Insulin** ⇒ check blood glucose monitoring, last HBA1c

- **Iron** ⇒ last Hb ⇒ adjust dose or discontinue

- **Folic acid** ⇒ last folate levels, discontinue if replete

- **Levothyroxine** ⇒ last TSH & T4 ⇒ adjust dose

- **Statins** ⇒ last LFT and Lipids (except for 1° prevention repeat lipid profiles are not necessary, but management should be review according to clinical judgement and patient preference)

- **Nephrotoxic drugs** ⇒ NSAIDs, ACEIs ⇒ check U&Es

- **Digoxin** ⇒ check pulse monitoring (usually daily on MAR sheet) query if daily dose ≥ 250mcg

- **Diuretics** ⇒ check U&Es, use with caution in very frail especially if not drinking much
Drugs that may help reduce hospital admission or unscheduled care

Question

- COPD ⇒ if no long acting beta agonist or long acting anticholinergic
- Heart failure ⇒ if no **ACEI, beta blocker, spironolactone** (Stage IV)
- Atrial fibrillation ⇒ if no **warfarin** or **antithrombotic**
- Bone health (Falls, osteoporosis) ⇒ if no **calcium & vitamin D** (most patients with few exceptions), **bisphosphonates**
- CVD ⇒ if no low dose **aspirin, statin** OR **ACEI and Beta blocker** where evidence suggests e.g post MI (NICE)
- PPI for gastroprotection ⇒ **H₂ antagonist** can be used if taking clopidogrel
- If no annual **influenza vaccine**