Pharmacy and Medicines Support to Care Homes: Urgent System-Wide Delivery Model

19 May 2020

This new operational model is intended to help pharmacy and medicines teams implement the NHS England and NHS Improvement Primary Care and Community Health Support for Care Homes guidance.

It describes the medicines and pharmacy contribution to the work and sets out how teams should collaborate across the NHS system. It also provides practical advice and resources and a model of service to help local systems reduce the risk of harm during the COVID-19 period by ensuring that consistent medicines and pharmacy services meet the needs of care home residents and staff. It includes an implementation plan to activate the model of service at local level.

The work is being led and coordinated in each area by a clinical lead appointed by each CCG and has the backing of the regional and national NHS England and NHS Improvement pharmacy and primary care teams.

The guidance to primary and community care providers and commissioners on 1 May 2020 set out four key areas where clinical pharmacy and medicines optimisation support is needed. The model suggests that support for care homes will require collaborative, clinical and professional leadership from across all pharmacy sectors; such as a senior pharmacy leadership group at ICS or CCG level, supported by regional chief pharmacists and regional directors of primary care.

Clinical, general practice, care homes and CCG pharmacists and pharmacy technicians, supported by specialist hospital pharmacists, and community pharmacy, are being asked to rapidly mobilise and join multidisciplinary primary and community care teams to support care homes, and implement this model.

Pharmacy leaders across the system, including hospital, community and mental health chief pharmacists, are being asked to work with each other and care home leads at CCGs and primary care networks to offer immediate pharmacy and medicines support to care home staff and residents.

1. Model of Service

The letter to primary care providers and commissioners from NHS England and NHS Improvement (1st May 2020) set out four key areas where urgent clinical pharmacy and medicines optimisation support is needed.

1. facilitating medication supply to care homes, including end of life medication;
2. delivering structured medication reviews via – video or telephone consultation where appropriate – to care home residents;
3. supporting reviews of new residents or those recently discharged from hospital;
4. supporting care homes with medication queries, and facilitating their medicines needs with the wider healthcare system (e.g. through medicines ordering).

This model of service supports these four key areas, underpinned by the following six domains:

- Leadership
- Workforce
- Medicines supply
- Clinical pharmacy
- Training and education
- Local implementation.

It is intended to offer a model of professional leadership, co-ordination and practical support for primary care (general practice, community pharmacy, CCG), community health services, and NHS trust pharmacy teams. Any service delivery model should reflect the PCN arrangements by default and this model could be embedded as part of local care home work streams led by PCN/ general practice clinical leads for care homes.

This matrix (Appendix 1) lists key actions that any Pharmacy and Medicines Care Home Taskforce could take, supported by the system pharmacy leadership group, to aid and monitor implementation of this model.

2. Clinical and Professional Leadership

Support for care homes will require collaborative, clinical and professional leadership from across pharmacy sectors; for example, through the establishment of a local chief pharmacist led, senior pharmacy leadership group that will facilitate consensus building and rapid decision making. This group would be most effective if locally determined and supported through regions. They would ideally be a tripartite arrangement involving senior pharmacy leaders from primary care (including community pharmacy), community services and secondary care (acute and mental health NHS trusts). These have already been established in many localities.

The pharmacy leadership group would want to build on pharmacy leadership arrangements for care homes where they exist or potentially establish a COVID-19 ‘Pharmacy and Medicines Care Home Task Force’ to deliver this work linked into wider primary care and community health service support for care homes initiatives that CCGs have been asked to put in place.

NHS England and NHS Improvement regional chief pharmacists and Health Education England (HEE) pharmacy deans across the seven NHS England and NHS Improvement regions will support local senior pharmacy leadership groups, enabling learning and good practice to be shared nationally. The NHSE&I Pharmacy Integration Team will provide central support and signposting to resources based on learning from national programmes.

Resources and support for care home residents will also be provided by partner organisations and hosted on care home support hubs: NHS Specialist Pharmacy Service (SPS) and Royal Pharmaceutical Society (RPS).

3. Workforce

A rapid local workforce strategy and action plan, facilitated by the local pharmacy leadership group, will help support the mobilisation and deployment of clinical pharmacy teams to support care homes. HEE pharmacy deans will be central to supporting the development of staff where necessary, but it is the senior pharmacy leadership group that would support, advise and oversee local staff deployment. System leadership teams may want to undertake this process to support planning and implementation of services to care homes by pharmacy teams. These planning matrices can help leadership teams rapidly understand existing provision, identify gaps and plan services locally..

Section 5 (*Pharmacy Services to Care Homes*) outlines the priority areas where pharmacy teams can support care homes; local teams will find it helpful to map current service provision and workforce to their priorities. Collective professional responsibility and collaborative working will be required from local pharmacy leaders to enable staff, with the requisite skills, to work flexibly and support care staff and residents. There may also be opportunities for staff returning to the register or shielded staff to support locally.

Where existing teams do not have the capacity to support all their care homes the Pharmacy and Medicines Care Home Task Force, or equivalent, should have urgent discussions, supported by the pharmacy leadership group and HEE pharmacy deans, with local organisations to identify additional staff.

In addition to supporting local care home service provision by providing pharmacy staff (where feasible), secondary care and community services can also support care home staff and residents with access to their expertise and clinical information. Local plans should be established that facilitate access to this expertise for care home staff as well as pharmacy teams working directly with care homes.

4. Training and Education

All pharmacists and pharmacy technicians working with care homes will want to undertake a self-assessment to identify gaps in learning, especially for COVID-19 related clinical scenarios. A simple self-assessment process has been developed by the RPS in collaboration with the Centre for Postgraduate Pharmacy Education (CPPE).

A training hub will be hosted on the SPS hub where pharmacy professionals can update gaps in learning through rapid learning. Existing material will be used from educational partners.

5. Pharmacy Services to Care Homes

The following sections set out in more detail how the response to the NHS letter from 1st May[1] can be delivered locally. Each care home should have a nominated clinical lead and services to care homes should be delivered in partnership through network arrangements to avoid duplication and reduce infection control risks. Clinical teams should support care homes where possible, for example through the use of virtual multidisciplinary teams (MDTs).

5.1. Clinical support

Pharmacy teams, typically including independent prescribers, can support the clinical review of patients by working with care home clinical leads and MDTs to agree the prioritisation of residents including the following situations:

- Patients with COVID-19 symptoms (Appendix 2: specific advice and guidance for managing patients with COVID-19)
- Acute illness that may need changes to medicines (e.g. due to renal impairment, sick day rules)
- Optimising medicines at the end of life (e.g. prescribing and deprescribing)
- Discharge from hospital (e.g. medicines reconciliation)
- New residents: rapid clinical review (with the MDT if needed) and medicines reconciliation to optimise medicines
- Other at-risk groups (e.g. renal dysfunction, high risk medicines including insulin, anticoagulants and lithium, and falls risk). The NHS SPS hub (Section 6.1) will collate tools for all at risk groups.

5.2. Medicines supply

Community pharmacies will continue to lead on supply of prescribed medicines to care homes. Community pharmacists and their teams can actively work with care homes pharmacists and pharmacy technicians in all aspects of medicines supply including:

- Facilitating medication supply to care homes (especially end of life medication)
- Supporting the development of clinical hubs to supply end of life medicines, in line with local plans to support patients at the end of their life
- Supply of urgent medication
- Supporting medicine systems (e.g. electronic repeat dispensing, proxy ordering; see Section 6)

- Working with local nursing and GP teams to ensure care homes are supported with all aspects of medicines ordering
- Supporting access to medicine administration records (MAR) charts.

5.3. Supporting care homes with advice and support

Care home staff and residents, and the pharmacy teams supporting them, will need information and support to ensure the safe and effective use of medicines. There are a range of resources from partner organisations that can support pharmacy teams. The Pharmacy and Medicines Care Home Task Force will want to consider:

- Establishing a single point of contact for care homes for rapid advice on medicines and their use
- Engaging clinical pharmacy and medical specialists from secondary care (e.g. mental health or care of the elderly pharmacists, at consultant level where available) to support with complex patient cases
- Working with regional organisations for more complex queries (e.g. regional medicines information centres)
- Systems for documentation and transfer of information, integration with MDT record systems and follow up (if necessary) of any advice given
- Working with local NHS111/Integrated Urgent Care (IUC) service providers to identify the remote support and access to pharmacists working within the local IUC clinical assessment services (CAS) and the national Pharmacy Clinical Assessment Service (PCAS) as part of the Coronavirus CAS capability.

5.4. Delivering structured medication reviews

For some residents, it is still important to deliver structured medication reviews (SMRs) to ensure medicines safety. SMRs could be delivered via video or telephone consultation and where appropriate, involve residents and/or their family/carer. Local teams will want to consider priority groups, ensuring that those residents that are on high risk medicines or combinations of medicines are prioritised. Whilst it is desirable for all pharmacists undertaking SMRs to have completed or be enrolled on the CPPE 18-month training pathway, which leads to independent prescribing training, the current priority during the COVID-19 emergency demands a flexibility to provide urgent support for care home residents, including undertaking SMRs for some residents.

6. Resources

6.1. NHS Specialist Pharmacy Service

A Care Home Resources Hub will be hosted by SPS that will provide pharmacy teams with a single point of access to essential resources to effectively support care homes. This hub will bring together national advice and guidance from professional partner organisation. The hub will also signpost to:

- Regional Medicines Information Centres

- Digital tools to support care homes (e.g. electronic repeat dispensing (eRD) and proxy ordering)
- A repository of good practice including COVID-19 support for care homes.

Appendix 1

Key actions for Leadership Group and Pharmacy and Medicines Care Home Taskforce

Task	Who	Dead-line	Completed Y/N
Strategy and pharmacy leadership			
System leadership group (e.g. tripartite group) to rapidly agree support for care homes			
System leadership group to create Pharmacy and Medicines Taskforce and appoint an individual or team to lead.			
Inform Regional Chief Pharmacist and Pharmacy Dean on proposed on local plans to mobilise pharmacy staff to support care homes			
Pharmacy and Medicines Taskforce to scope and fully understand current service provision and staffing			
Develop and agree a clinical model (Section 6)			
Link local system commissioners with pharmacist leads (CHS, CCG, Acute, PCN/ Federation, Community Pharmacy)			
Agree access to system resources (e.g. MI, specialist pharmacists)			
Each care home to have a named single point of contact pharmacist			
Establish a communications plan to support delivery including how the pharmacy team links with the named clinical lead for the care home			
Support access to records and systems through inclusion of the pharmacy team in the appropriate information sharing agreements developed by CCGs to support PCN arrangements			
Workforce			
Identify all pharmacists and pharmacy technicians currently supporting care homes			
Undertake gap analysis			
Consideration of a central register of workforce, and a process for induction and rostering (e.g. CCG Integrated Care Leads and CCG commissioners of Community Services Contracts)			
Identify pharmacists and technicians who can be redeployed or change current work to support MDT, Structured medication reviews, MI, Supply functions			
The establishment of honorary contracts for available workforce where needed (examples available on Future NHS MOCH page)			
Consider the of pharmacy assistants and volunteers for technical and coordination functions			
Resources and supporting materials			
Identify local support and resources (e.g. Whatsapp groups, training, local CCG/ Trust guidelines)			
Signpost to COVID-19 care homes resources (Section 7)			
Pharmacy Team Engagement			

Agree MOCH pharmacist support eg: • Webinar/ educational support • FAQs • SOP for conducting a structured medication review • SOP for getting set up for remote access • Triage for queries?			
Pharmacy teams link with care home nominated PCN or general practice clinical lead for each care home to agree workplan			
Link into MDTs supporting care homes			
Link into acute trusts for care home residents being admitted or discharged requiring medication review/support			
Link with other teams (e.g. palliative care for end of life)			
Ensure there are systems in place to monitor any issues that are raised with care homes e.g. calling homes at regular agreed times with a single point of contact at the homes.			
Logistics			
Support access to records and systems through inclusion of the pharmacy team in the appropriate information sharing agreements developed by CCGs to support PCN arrangements			
Use all available information including but not limited to issues raised by Care Home staff, Clinical record and risk stratification software etc (e.g. Eclipse, Solace, PINCER, specific searches)			
Monitoring Ensure that a service model is in place that is robust enough to meet the four elements set out in the 1st May letter			
Service model agreed by regional chief pharmacist			
i. facilitating medication supply to care homes, including end of life medication			
ii. delivering structured medication reviews – via video or telephone consultation where appropriate - to care home residents			
iii. supporting reviews of new residents or those recently discharged from hospital			
iv. supporting care homes with medication queries, and facilitating their medicines needs with the wider healthcare system (e.g. through medicines ordering).			

Appendix 2

Clinical management of COVID-19 in care home residents
COVID-19 may present in the frail and elderly care home resident in the manner described by Public Health England – fever ≥37.8°C and at least one of the following which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases
However, these signs may also be absent, and it is important awareness of this is raised.

Clinicians have also recognised more atypical presentations in care home residents describing common presentation with non-respiratory tract symptoms; for example new onset/worsening confusion, delirium, falls, generalized weakness, myalgia, malaise, functional decline
https://www.bmj.com/content/bmj/suppl/2020/03/24/bmj.m1182.DC1/gret055914.fi.pdf

Additionally, presentations with conjunctivitis, anorexia, increased sputum production, dizziness, headache, rhinorrhoea, chest pain, haemoptysis, diarrhoea, nausea/vomiting, abdominal pain, nasal congestion, tachypnoea, unexplained tachycardia, or decrease in blood pressure and anosmia have been described
https://www.rgptoronto.ca/wp-content/uploads/2020/04/COVID-19-Presentations-in-Frail-Older-Adults-U-of-C-and-U-fo-T.pdf

Nurses and carers who know residents well should be consulted on regular calls as they intuitively recognise these often subtle signs of deterioration. Tools to encourage care staff to report these 'soft signs' include RESTORE2.
https://westhampshireccg.nhs.uk/wp-content/uploads/2020/02/CS49286-RESTORE2-full-version.pdf

The use of remote methods of assessment should be facilitated and care homes, carers and nurses will need urgent assistance to put in place hardware (tablet / smartphone) and Wi-Fi to facilitate this. Equipment and rudimentary competence to measure pulse oximetry and blood pressure should be urgently provided to homes, to assist clinicians working remotely.

When a resident is identified as likely having COVID19 testing of other residents and staff where local arrangements are in place. Residents should be isolated but it must be recognised this is very often not possible within their own rooms where dementia and 'walking with purpose'(wandering) occurs. Ideally 'hot' facilities should be utilised to provide care to positive residents. It is recognised issues of staffing, PPE and visiting will present particular problems.

Care planning should be undertaken with residents and next of kin as a matter of urgency, to include plans for treatment ceilings and whether a resident should be admitted to hospital if they become critically unwell.

Planning of communication, prescribing, dispensing and delivery should be undertaken, recorded and disseminated for each care home as soon as possible. Pathways for referral involving single points of access via phone and email should be arranged.

Timely supply of symptomatic treatment with antipyretic paracetamol should be in place in all homes. Most often the most efficient way of arranging this is via bulk prescribing or homely remedies, both of these routes allow for medication to be stocked and used for any resident when the need arises, expediting relief of pyrexia or pain, simplifying pathways and reducing wastage, important in the context of shortage situations.

Medication for symptomatic control

Managing cough	
Initially	Demulcents, honey or simple linctus
2nd Line where oral route available	Codeine linctus (15 mg/5 ml) or codeine phosphate tablets (15 mg, 30 mg) 15 mg to 30 mg every 4 hours as required, up to 4 doses in 24 hours If necessary, increase dose to a maximum of 30 mg to 60 mg 4 times a day (maximum 240 mg in 24 hours)
3rd line for severe / resistant cough	Morphine sulfate oral solution (10 mg/ 5 ml) 2.5 mg to 5 mg when required every 4 hours Increase up to 5 mg to 10 mg every 4 hours as required If the patient is already taking regular morphine increase the regular dose by a third
Managing breathlessness	
Initially	Controlled breathing techniques include positioning, pursed-lip breathing, breathing exercises and coordinated breathing training
Opioid medication	Oral : Morphine sulfate immediate-release 2.5 mg to 5 mg every 2 to 4 hours as required or morphine sulfate modified-release 5 mg twice a day, increased as necessary (maximum 30 mg daily) Parenteral : Morphine sulfate 1 mg to 2 mg (increased to 5mg according to response) subcutaneously every 2 to 4 hours as required, increasing the dose as necessary If needed frequently (more than twice daily), a subcutaneous infusion via a syringe driver may be considered (if available), starting with morphine sulfate 10 mg over 24 hours
Benzodiazepine medication	For breathlessness and anxiety: lorazepam 0.5 mg sublingually when required (maximum 4 mg daily) Reduce the dose to 0.25 mg to 0.5 mg in frail elderly or debilitated patients (maximum 2 mg in 24 hours) For associated agitation or distress: midazolam 2.5 mg to 5 mg subcutaneously when required (see BNF for more details on dosages) Sedation and opioid use should not be withheld because of a fear of causing respiratory depression
Managing anxiety, delirium and agitation	
Anxiety or agitation and able to swallow: lorazepam tablets	Lorazepam 0.5 mg to 1 mg 4 times a day as required (maximum 4 mg in 24 hours) Reduce the dose to 0.25 mg to 0.5 mg in elderly or debilitated patients (maximum 2 mg in 24 hours) Oral tablets can be used sublingually (off-label use)
Anxiety or agitation and unable to swallow:	Midazolam 2.5 mg to 5 mg subcutaneously every 2 to 4 hours as required If needed frequently (more than twice daily), a subcutaneous infusion via a syringe driver may be considered (if available) starting with midazolam 10 mg over 24 hours Reduce

midazolam injection	dose to 5 mg over 24 hours if estimated glomerular filtration rate is less than 30 ml per minute
Delirium and able to swallow: haloperidol orally	Haloperidol 0.5 mg to 1 mg at night and every 2 hours when required. Increase dose in 0.5-mg to 1-mg increments as required (maximum 10 mg daily, or 5 mg daily in elderly patients) The same dose of haloperidol may be administered subcutaneously as required rather than orally, or a subcutaneous infusion of 2.5 mg to 10 mg over 24 hours Consider a higher starting dose (1.5 mg to 3 mg) if the patient is severely distressed or causing immediate danger to others Consider adding a benzodiazepine such as lorazepam or midazolam if the patient remains agitated (see dosages above)
Delirium and unable to swallow: levomepromazine injection	Levomepromazine 12.5 mg to 25 mg subcutaneously as a starting dose and then hourly as required (use 6.25 mg to 12.5 mg in the elderly) Maintain with subcutaneous infusion of 50 mg to 200 mg over 24 hours, increased according to response (doses greater than 100 mg over 24 hours should be given under specialist supervision) Consider midazolam alone or in combination with levomepromazine if the patient also has anxiety (see dosages above)

From NICE COVID-19 rapid guideline: managing symptoms (including at the end of life) in the community (NG 163)
https://www.nice.org.uk/guidance/ng163/resources/covid19-rapid-guideline-managing-symptoms-including-at-the-end-of-life-in-the-community-pdf-66141899069893

Managing respiratory secretions	
Transdermal	Hyoscine hydrobromide 1.5mg patches (1mg in 72 hr) (e.g. Scopoderm®) Transdermal patch 1 to 4 patches every 72 hours
Sublingual / Buccal	Hyoscine hydrobromide 300microgram tablets (e.g. Kwells®) 300micrograms every 6 hours Maximum 1.2mg/24hr. Atropine 1% eye drops Sublingually 2 to 4 drops every 4 hours Glycopyrronium bromide injection 200micrograms/ml Buccally 200microgram every hour as required Maximum 1.2mg/24hr.
Parental	Hyoscine Hydrobromide :Subcutaneous injection 400micrograms every hour as required, Subcutaneous infusion2.4mg over 24h Glycopyrronium : Subcutaneous injection 200micrograms every hour as required, Subcutaneous infusion 1.2mg over 24h

End of Life Care Guidance when a Person is Imminently Dying from COVID-19 Lung Disease Scottish Palliative Care Guidelines
https://www.palliativecareguidelines.scot.nhs.uk/guidelines/symptom-control/end-of-life-care-guidance-when-a-person-is-imminently-dying-from-covid-19-lung-disease.aspx

Managing antibiotic treatment	
Initial	Do not offer an antibiotic for treatment or prevention of pneumonia if: COVID-19 is likely to be the cause and symptoms are mild.
Offer an oral antibiotic for	In people who can or wish to be treated in the community if the likely cause is bacterial or it is unclear whether the cause is bacterial or

treatment of pneumonia	viral and symptoms are more concerning or they are at high risk of complication. Doxycycline 200 mg on the first day, then 100 mg once a day for 4 days (5-day course in total); doxycycline should not be used in pregnancy alternative: amoxicillin 500 mg 3 times a day for 5 days. Doxycycline is preferred because it has a broader spectrum of cover than amoxicillin, particularly against Mycoplasma pneumoniae and Staphylococcus aureus, which are more likely to be secondary bacterial causes of pneumonia during the COVID-19 pandemic.

https://www.nice.org.uk/guidance/NG173
Care home-based oxygen therapy and subcutaneous fluids – take specialist advice.