The challenge
Poor prescribing, lack of structured review and little resident involvement in care homes has been highlighted. (See Figure 1)

Objective
Optimise medicines use in care home residents whilst ensuring that residents or their families are fully involved in any decisions around prescribing and de-prescribing of medicines.

Our innovation
To deliver a multidisciplinary team approach to medicines optimisation whilst ensuring that all residents or their family/carers were fully involved in decisions made about medicines. 20 care homes recruited. Care home team established and roles agreed for pharmacist, general practitioners, care home managers/nurses and psychiatry team (consultant, nurses, challenging behaviour team).

The medicines optimisation process
See Figure 2.

Our Learning
Our results show that pharmacists working within a MDT can make a number of interventions to improve the quality and safety of prescribing for care home residents.

- 422 residents reviewed across 20 care homes.
- 1346 interventions made.
- Most common intervention was to stop medicines (n=704 medicines) in 298 residents (70.6%).
- Interventions made in 91% of residents reviewed.
- An average of 1.7 medicines stopped for every resident reviewed (range 0 to 9 medicines stopped) (see Figure 3).
- 17.4% reduction in medicines use over the course of the project in the 422 residents.
- Total annualised savings from stopping medicines were £81,989. Medicines were started at the cost of £4,138, giving a net saving of £77,851.
- Service costs (pharmacist, GP, psychiatry, care home nurse) were £32,670.
- For every £1 invested, £2.38 can be saved from the medicines budget.
- Statistical reduction in hospital admissions (p<0.001)

Resident Involvement
We developed a four level patient involvement framework as not all residents had the capacity to be involved in decisions about medicines.

16% of residents had capacity and wanted to be involved in decisions (See Figure 4).

‘Making Care Safer’ report can be found at http://www.health.org.uk/publications/making-care-safer

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Figure 1.
Excess medicines (sometimes inappropriate)
Lack of structured review
Communication issues: most residents were unaware of what treatment they were on
Long medication rounds and timing not resident centred

Figure 2. The medicines optimisation process

Figure 3. Medicines taken by residents

Figure 4. Resident involvement (% of residents)