

Medicine Matters

Medicines information for care staff in a social setting

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Fridge storage

Issue 36

Some medicines should be stored in a refrigerator because at room temperature they would “go off”. Care home staff need to know which medicines should be kept cool. Checking the P.I.L (patient information leaflet) or the manufacturer’s packaging would provide this information. P.I.Ls can also be obtained directly from www.medicines.org.uk. In addition to these places there is also the pharmacy label, which indicates whether fridge storage is required. When medication is delivered by the pharmacy it should be supplied in a separate bag marked indicating a fridge item is inside.

Fridge requirements and daily temperature recording;

- Medication requiring fridge storage, should be stored in separate locked fridge, solely used for medicines.
- Small homes that may not have a separate fridge and minimal use of medicines requiring refrigeration, may use a lockable container placed in the domestic fridge.
- The fridge temperature should be monitored and recorded daily. It is recommended to record, minimum, maximum and current temperatures using a minimum and maximum thermometer, which should be re-set after each reading.
- The fridge temperature should be between 2 and 8°C. If the temperature falls outside this range, action should be taken immediately.

What to do when the fridge temperature is out of range

- Inform the care home manager straight away.
- If possible, quarantine fridge stock to a separate emergency fridge (this may have to be a food fridge in an emergency) whilst advice is being sought.
- Attach a note to the fridge stating the fridge should not be used.
- Estimate the length of time the fridge has been out of range.
- For each medication check with the pharmacist whether the medication can still be used.
- For the stock that cannot be used again, make sure this is recorded in the disposal book and clearly segregated for disposal
- For stock that can be used again, mark the packaging (e.g. with an asterix) so that this stock is used up first or within a certain time frame.

Lessons Learnt - Lessons Learnt is a section in our newsletter to highlight to carers medication errors that have occurred in care homes and the lessons we can learn from them.

The incident



This recent event tells the tale of a service user being found with two half sucked Steradent® tablets by her bedside. The resident’s family had indicated that she should be able to keep them with her for maintenance of her dentures, so the care home staff did not conduct a risk assessment of this product, which they would normally have done. As a result this product was left in easy access of the resident. There were concerns that the Steradent® may have been offered to other service users by this resident, although this could not be confirmed.

The Lesson Learnt

It is important that any item, whether or not a medicine, should be assessed for risk to the service user. Steradent®, contains harsh chemicals which, if swallowed can irritate the gullet and which may cause indigestion and possibly pain on swallowing. There is also the risk of the “fizzy bubbles” being aspirated, causing cough, wheeze or difficulty in breathing. The patient would have to be monitored to ensure that if any of these side effects occurred, then the GP would be contacted. A risk assessment would identify how the Steradent® should be stored, in this case secured in a locked area of the resident’s room, which only staff had access to. The lesson learnt here would be to risk assess any agent, medicine or not, which has the potential to be ingested.



The Care Act 2014

Duty of Candour is new legislation, which came into force in October 2014. It states that any patient harmed by health care is informed and an appropriate remedy is offered regardless if they have complained. In other words there should be full disclosure and the offer of support, leading to complete openness and transparency surrounding an event.

Administration Dilemmas

It is of vital importance that medicines are taken exactly as prescribed to ensure they work as intended. If instructions are not accurately followed, they may cause side effects, one medication may interact with another and may affect the patient's condition.

Listed below is some of the advice commonly given and the rationale behind them.

Crushing tablets or opening capsules

Care home staff should never attempt to crush a tablet or open a capsule without explicit instructions from the prescriber (with stability advice from the pharmacist).



Crushing the tablet or opening the capsules, without instructions from the prescriber/pharmacist could be regarded as an administration error and may cause the service user harm.

Of course, situations arise where a service user may not be able to swallow, or has a PEG tube. Liquid "bespoke" preparations of standard tablet formulations are expensive (between £100-£300 a bottle) and unlicensed (where they haven't been as rigorously tested). e.g. Amlodipine liquid.

It is the pharmacist's role to determine if standard tablet preparations can be crushed or if the contents of capsules opened. They then inform the prescriber who will decide if they wish to prescribe a standard medication but for it to be given in a "non-standard way".

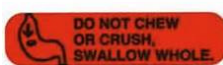
Ultimately, it remains the decision of the prescriber to print explicit instructions as to whether tablets can be crushed or capsules opened. Only then can the carer give medication in this "unlicensed" way.

Other options for patients that cannot swallow tablets or capsules include:-

- GP temporarily or permanently stopping the medication
- Seeing if a chewable tablet or dissolvable formulation is available

Some tablets/capsules can NEVER be crushed

There are some tablets or capsules that must never be crushed or opened. These include modified release preparations, as crushing will affect when and how the drug is released. In addition, enteric coated tablets, should not be crushed because if the special coating is removed, it may irritate the lining of the stomach, leading to stomach pains/nausea. Some specially coated tablets are designed to be released in the gut rather than the stomach where they work e.g peppermint oil capsules are enteric coated.



Before food or on an empty stomach

Some medicines state to be taken **before food** or on an empty stomach. If these instructions are not followed, the medicine will not be absorbed properly from the stomach and insufficient drug levels will reach the bloodstream, leading to a reduced effect. It is therefore very important that care home staff are aware of these medicines and that administration times are altered accordingly. E.g. Lansoprazole is best taken 30 –60 minutes before food. As it is normally in the morning, care should be taken to make sure it is at least half an hour before breakfast



Take with or after food

The main reasons why medicines may need to be taken with or **after food** are:-

- Some medicines may cause nausea / vomiting/stomach pains, e.g Metformin (the food provides a buffer for the tablet against the stomach wall)
- Some medicines to treat conditions in the mouth or throat can get washed away quickly after food consumption and may not work, e.g Nystatin
- Some medicines are not absorbed as well into the bloodstream if the stomach is empty, e.g. Acarbose



Alcohol

Alcohol can interact with prescription medicines to produce unexpected results such as, drowsiness, dizziness, weakness and decreased co-ordination. This can increase the risk of falls. Alcohol may also increase or decrease the effectiveness of medication by changing the way it is processed in the liver.

Missed Doses

Missing a dose of medication may make the medicines less effective, but taking subsequent doses too close together could increase the risk of side effects. Further advice can be sought from your pharmacist/prescriber.

Future Issues: If you have an idea for an article to be included in a future issue, please contact one of the Care Home Team on 0191 217 2858 or 217 2533 or email:

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