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NHS

Medicine Matters

North of England Commissioning Support

Medicines information for care staff in a social setting

Summer 2018

Dementia Care

NICE (National Institute for Health and Care Excellence) have recently published a guideline on Dementia.

NG97 Dementia: assessment, management and support for people living with dementia and their carers https://www.nice.org.uk/guidance/ng97

This guideline addresses how dementia should be assessed and diagnosed. It covers person centred care and support, tailored to the specific needs of each person living with dementia. As part of this, it can help professionals involve people living with dementia and their carers in decision making, so they can get the care and support they need. It also addresses care co-ordination and staff training, and how dementia may impact on the care offered for other conditions.

The guideline does not cover every aspect of dementia care or support, or areas where recommendations would be the same for people with or without dementia. It focuses on areas where there is variation in practice and enough evidence is available to identify what works best. People living with dementia need different care and support to people in the same situation who do not have dementia.

Recommendations in NG97 include guidance on:

- Involving people living with dementia in decisions about their care
- Diagnosis
- Care coordination
- Interventions to promote cognition, independence and wellbeing
- Pharmacological interventions for dementia
- Medicines that may cause cognitive impairment
- Managing non-cognitive symptoms
- Assessing and managing other long-term conditions in people living with dementia
- Risks during hospital admission
- Palliative care
- Supporting carers
- Moving to different care settings
- Staff training and education

There is also guidance on how to put these recommendations into practice

Making decisions together

Decisions about treatment and care are best when they are made together. The care team should give people clear information, talk with them and their family members about options and listen carefully to any views and concerns

NICE have produced further guidance for supporing shared decision making for some specific areas relating to medications https://www.nice.org.uk/guidance/ng97/resources/

These include conisderations for

- Antipsychotic medicines for treating agitation, aggression and distress
- Enteral (tube) feeding for people living with severe dementia

Other related guidance from NICE includes:

NICE guideline NG16 Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset https://www.nice.org.uk/guidance/ng16

What can your care home do?

- Do you have any residents with a diagnosis of dementia or similar condition?
- Have you a care plan for each person that clearly defines the support they receive?
- Are the relatives and next of kin involved in discussions regarding decision making?
- Are your staff trained and competent in supporting people with dementia and similar conditions – do you have a dementia care lead within your service?
- Are medicines regularily reviewed?
- Do you have clear person centred “when required” protocols defining to identify when medicines are appropriate to give?

Consider whether your current support and processes reflect the NICE guidance

The Medicines Optimisation Website

Information, guidance documents and various medicine related tools are accessible via our website. These can be downloaded and many may be adjusted to suit your needs.NECS Medicines Optimisation website:

https://medicines.necsu.nhs.uk/category/resources/care-homes/

Lessons Learnt: Interim medicines

On returning to the surgery, after visiting a care home, the doctor changes the dose of a medicine and prescribes the change on an interim prescription which is sent electronically to the pharmacy. During the following weeks, on visiting the care home the doctor makes enquiries regarding how the resident is and subsequently advised that they are "fine".

Two weeks later, the monthly medicine supply is delivered and on reconciling the medicines received against the order records and the previous MAR charts, staff notice an "error" in prescribing. On further enquiry with the GP, it becomes apparent that the change of dose was intended to be implemented 2 weeks ago and prescribed as an interim medicine The resident had not had the new dose for 2 weeks.

Care homes:

- Ensure staff ask visting healthcare professionals about any relevant desicions made
- Ensure that records are made following visits
- If interim prescriptions are electronically sent, inform the pharmacist that this is imminent and when supply is needed for
- Follow up on any outstanding medicine deliveries

Prescriber:

- Advise the home of any relevant decisions (ideally, provide written evidence such as in the care plan – this may be completed by staff in the home)
- Remember to remove any old electronic prescriptions from the "spine" if replacing with a new dose / medicine

Pharmacist:

Remain vigilant to prescribing dates – especially if this is a different dose of a current medicine

MHRA Warning – Watch out for look-alikes & sound-alikes

The MHRA have recently highlighted the dangers associated with medicines with look-alike or sound-alike names – including cases with fatal outcomes, in which patients received the wrong medicine due to confusion between similar names. Drugs pairs known to have been linked to errors include: **Clo**baz**am** / **Clo**nazep**am**; **A**ten**o**lol / **A**m**lo**dipine; **Pr**opran**ol**ol / **Pr**edni**sol**one; **R**is**p**er**id**o**n**e / **R**o**p**in**ir**o**l**e; **Sulfa**dia**zine** / **Sulfa**sala**zine** and Am**lodipine** / Nim**odipine**

CQC: Learning from safety incidents

When something goes wrong in health and social care, the people affected and staff often say, "I don't want this to happen to anyone else."

CQC have recently published a set of resources to support learning from specific groups of safety incidents.. Each one briefly describes a critical issue - what happened, what CQC and the provider have done about it, and the steps you can take to avoid it happening in your service.

- Issue 1: Falls from improper use of equipment Falls from equipment can result in serious or fatal injuries.
- Issue 2: Unsafe use of bed rails The unsafe use of bed rails continues to result in serious or fatal injuries.
- Issue 3: Fire risk from use of emollient creams The unsafe use of emollient creams can result in serious or fatal injuries from fire.
- Issue 4: Burns from hot water or surfaces Unguarded hot surfaces can cause serious or fatal injuries.
- Issue 5: Safe management of medicines The risks posed by poor medicines management can result in serious or fatal illness

Safe management of medicines:

The risks posed by poor medicines management can result in serious or fatal illness.

Health and social care staff often manage medicines on behalf of people using their services. Providers must promote the safe and effective use of medicines in care homes. This includes prescribing, handling and administering medicines. Failing to do this poses real risks to people who may be vulnerable, including:

- older people
- people with reduced mental capacity, reduced mobility, a sensory impairment
- people who rely on help to take their medicines

Further information may be found at https://www.cqc.org.uk/guidance-providers/learning-safety-incidents

If you have any questions regarding this newsletter or if you have an idea for an article to be included in a future issue, please contact us on Tel: 0191 2172558 where you will be forwarded to the most appropriate member of the team

Please don't forget to share this newsletter with your colleagues!