| TOPIC | CARE HOMES: TOP TIPS FOR GPs |
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| **Clear Directions** | GP practices should ensure that there is a clear written process for prescribing and issuing prescriptions for care home residents which should include the following: |
| | Issuing prescriptions according to the patient medical records |
| | Recording clear instructions on how a medicine should be used, including how long the resident is expected to need the medicine and, if important, how long the medicine will take to work and indication |
| | Providing any extra details the resident and/or the care home may need about how the medicine should be taken |
| | Any tests needed for monitoring and their frequency |
| | Avoid the term **AS DIRECTED if used then be clear in direction about dose and symptoms** |
| | Any changes to medications in the care home should be recorded in the patient care plan, updated in the GP patient journal, and communicated to the community pharmacy ideally within 24 hrs |
| **28 Day Prescribing** | Prescribe to align medicines into 28 day cycle and changes that may be needed for future prescribing |
| | WECCG 'What Good Looks Like' policy recommends repeat prescriptions are issued at least 14 days prior to care home's medication cycle start date. |
| | This may require you to provide an additional acute prescription |
| | Check that quantities are appropriate for the dose e.g. 1 three times a day prescribe 84 for a 28 day cycle |
| **Variable doses & PRN 'when required'** | Explain **W**hen & **H**ow: ***WHEN LOW BACK PAIN IS TROUBLESOME TAKE 1 TABLET*** |
| | If they are not using the medication review and remove from the repeat prescribing template |
| | Dosage instructions including **maximum** amount to be taken for PRN medications |
| | Length of treatment |
| | Use a PRN template to help provide additional information for example:<br>Signs and symptoms e.g. Abbey Pain scale<br>Dose and Frequency of doses<br>When to refer back to the GP e.g. over use<br>Frequency of Review, suggest frequency |
| | PRN medications **prescribed as original packs** may be retained until the expiry date printed on the pack |
| | Variable doses: Clearly state **when to increase dose** e.g. **'** If no bowel movement after 24 hours increase to TWO tablets daily' |
| | **Homely Remedies** is a great way to **reduce wastage** and ensure that patient have access to medications for minor ailments for up to 48 hours |
| **Oral Nutritional Supplements (ONS)** | **Medium risk** of malnutrition (MUST score 1): Care home to offer fortified foods, monitor weight and MUST score monthly & have clear goals/targets. If no improvement after a month to treat as high risk of malnutrition. |
| | **High risk** of malnutrition (MUST score 2 or above): Care home to offer fortified foods AND 2 x homemade fortified supplements (milkshake/ pudding/ juice or soup) per day using CCG approved recipes or 2 x OTC supplements (such as Complan/ Meritene Energis, formally known as 'Build Up'). Care homes should monitor weights weekly, MUST scores monthly & have clear goals/targets. For those with MUST score 3 or above refer to EPUT community adult dietetic team immediately. For those with MUST score of 2, monitor for a month and refer to EPUT dietetic team if no improvement. |
| | If no improvements after food first and 2 x homemade fortified supplements using CCG approved recipes or 2 x OTC supplements (such as Complan/ Meritene Energis, formally known as 'Build Up'), the patient should be assessed and sip feeds prescribed if appropriate with dietitian input. Do not place on repeat. |
| | Homemade supplements are not suitable for residents with dysphagia requiring ONS. First line choice is Slo milkshake- either level 2 or 3. |
| | Note: do not prescribe ONS following hospital discharge without first assessing need. Where ONS are still required, a switch to first line community products is recommended **(FIRST LINE AYMES SHAKE or ENSURE shake)** |
| | Flavours and consistency should be checked by giving a starter pack initially which are free by completing AYMES shake or ENSURE shake order form (allow 48 hours delivery) |
| | Directions on supplements to say e.g. "Take TWICE a day BETWEEN meals" |
| | Once daily administration of supplements is not clinically beneficial |
| | Quantities should be in line with 28 day's supply (reduced to 14 day's supply when the patient is End Of Life) |
| | Care homes should supply weight & MUST figures on an order form to support monthly requests |
| | If no improvement after 3 months of supplements the resident should be referred to dietetics |
| | GP practices should use the ONS template if available on their computer system |
| | ONS should be reviewed monthly for effectiveness |
| **Laxatives** | Lifestyle Advice E.g. fluid intake, exercise/is the home offering activities & is the resident mobile, dietary fibre, prunes, High Fibre Smoothies |
| | First line osmotic laxative: Laxido (preferred brand in WECCG) |
| | Avoid prescribing multiple prn laxatives-if the case then ensure care home is keeping a stool chart |
| | Prescribe one laxative for regular use and review for therapeutic benefit. A second 'prn' laxative can be added with clear instructions |

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| | Laxatives can be slowly withdrawn when regular bowel movements occur without difficulty, e.g. 2-4 weeks after defecation has become comfortable and a regular bowel pattern with soft, formed stools has been established |
| | If >1 laxative have been used, reduce and stop one at a time |
| | Begin by reducing stimulant laxatives first, if possible. However, it may be necessary to also adjust the dose of the osmotic laxative to compensate. |
| | Laxatives need to be continued long term for:<br>People taking a constipating drug that cannot be stopped, such as an opioid<br>People with a medical cause of constipation |
| **Emollients & Liquids** | All topical preparations should have directions that include:<br>»» How they should be used, e.g. liberally, sparingly, as a soap substitute etc.<br>»» Where they should be used, e.g. both legs or RIGHT leg.<br>»» Frequency of use, e.g. in the morning after washing, as often as required to alleviate itchiness, three times a day<br>»» The duration of the treatment, especially for creams containing steroids and antimicrobial constituents. Do not have on repeat. Steroid cream directions to have "apply thinly" |
| | Avoid 'use as directed' directions. |
| | Bath additives and shower gels are not recommended for prescribing because of the risk of slips and trips |
| | Pumps and tubes are preferred over tubs because of the risk of cross-contamination |
| **Analgesics** | Prescribe quantities of patches in line with 28 day cycle |
| | Opioid patches vary in change frequency: some may be weekly, 72 hours (3 days), 96 hours (4 days) |
| | Ensure total morphine dose is not over 120mg/day as there is no increased benefit |
| | Co-Proxamol is NOT recommended for prescribing. |
| | CO-ANALGESICS - Prescribe separately where dose titration is needed AND issue a quantity of TWO WEEKS at a time. Co-analgesic products may offer the advantage of reducing the number of pills a patient takes but does not permit dose titration or the opportunity to minimise any potential side effects. |
| | 8mg of codeine is generally inadequate to control pain but sufficient to cause the same side-effects as higher strength opioids. Patients on co-codamol 8/500mg should be reviewed |
| | ALWAYS PRESCRIBE BY BRAND FOR STRONG OPIOIDS, with the generic name in brackets after, to ensure continuity of supply and to avoid confusion for patients and carers |
| **OTC and Self Care** | NHS England in March 2018 published guidance for CCG's and GP practices on conditions for which OTC medicines should not routinely be prescribed in primary care. |
| | Further information can be found: https://westessexccg.nhs.uk/your-health/medicines-optimisation-and-pharmacy/general-prescribing-guidance/over-the-counter-medication-otc |
| | Care homes should have self-care policy in place to allow for managing OTC conditions as recommended by CQC |
| | GP/ Nurse/ Pharmacist can recommend the person, relatives or care staff to purchase a specific product to treat a minor ailment, such as olive oil for ear wax. The purchased OTC should be documented on the MAR chart to ensure appropriate usage and monitoring of product. |
| **Thickeners/Dysphagia** | The number of scoops and consistency including IDDSI Level should be clearly stated on the label directions & MAR chart |
| | Check for Speech and Language Therapist (SLT) fluid & food assessment as this may impact medication administration but does not necessitate a need for liquid medications. **First review medications and check if all are still appropriate.** |
| | Medication Review & check for the following signs:<br>• Spitting out medication?<br>• Coughing when trying to swallow?<br>• Showing signs of distress when swallowing medications?<br>Check: Can the tablet be **swallowed whole by the patient** when mixed with **appropriate consistency of food/fluid**? |
| | •Consider prescribing dispersible formulations<br>•Licensed Liquid Formulation *PLEASE NOTE* Liquids may not always be appropriate as they may also require thickening to enable the patient to take them. Where no licensed liquid the MHRA recommend the use of a licensed medication in an unlicensed way in preference to the use of specials. Therefore the crushing of tablets or opening of capsules may be used where appropriate and provided this has been checked by the pharmacist |
| | Review quantities prescribed, too many per month can lead to stockpiling and waste; too little per month could mean patients are put at risk, care homes ordering mid-cycle and borrowing from other residents |
| | Gum-based thickeners e.g. those with clear in the product name are the preferred choice for use with liquids as they are the most palatable and safest. Nutilis® Clear is the preferred option in West Essex. |
| **Medication Reviews (Minimum Annually)** | **When to review medication**<br>»» At points of change in health status<br>»» At transitions in care (e.g. post hospital discharge)<br>»» When new symptoms emerge or If an adverse event occurs i.e. recent fall or allergy |

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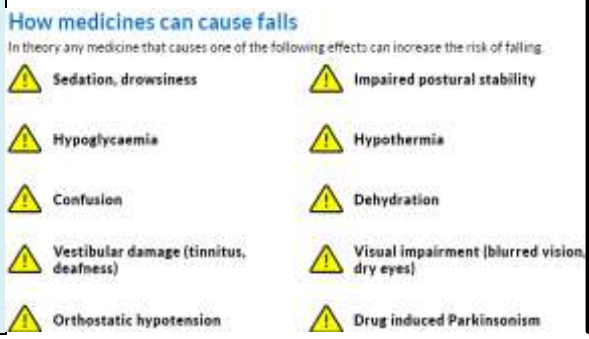
| **Limiting Risks from Medications** | **Know when to stop medications: STOP/START guidance and the NICE morbidity guidance**<br>• When a resident becomes frail, develops end stage dementia or other circumstances which impact on life expectancy, treatment goals should be reviewed.<br>• The known possible adverse drug reactions outweigh the possible benefits.<br>• There is a risk of cumulative toxicity if particular medicines are taken together e.g. Risk of falls or risk of GI bleeding<br>• The patient is choosing to not take/use the medication as prescribed or intended.<br>• Unlicensed medicines ('specials') are being prescribed when an alternative licensed medicine or formulation will provide the same therapeutic benefit.<br>• Non-drug measures can provide benefit, without adverse effects<br>• The patient is nearing end of life<br>• Gradually reduce the dose of medicines which can cause withdrawal effects such as **benzodiazepines and antidepressants and those which can cause rebound symptoms such as proton pump inhibitors, using appropriate guidance.** |




»» Two classes of drugs that have the highest propensity to cause falls are those acting on the brain, the heart and circulation.

Be mindful of:

»» Osteoporosis or reduced bone mineral density, e.g. long term use of steroids: Increased risk of fracture if a fall occurs.

»» Bleeding risk e.g. anticoagulants: Increased risk of a cerebral haemorrhage if a fall occurs.

»» Patients taking ≥ 4 prescription drugs, regardless of pharmacologic classification, are at an increased risk for falls