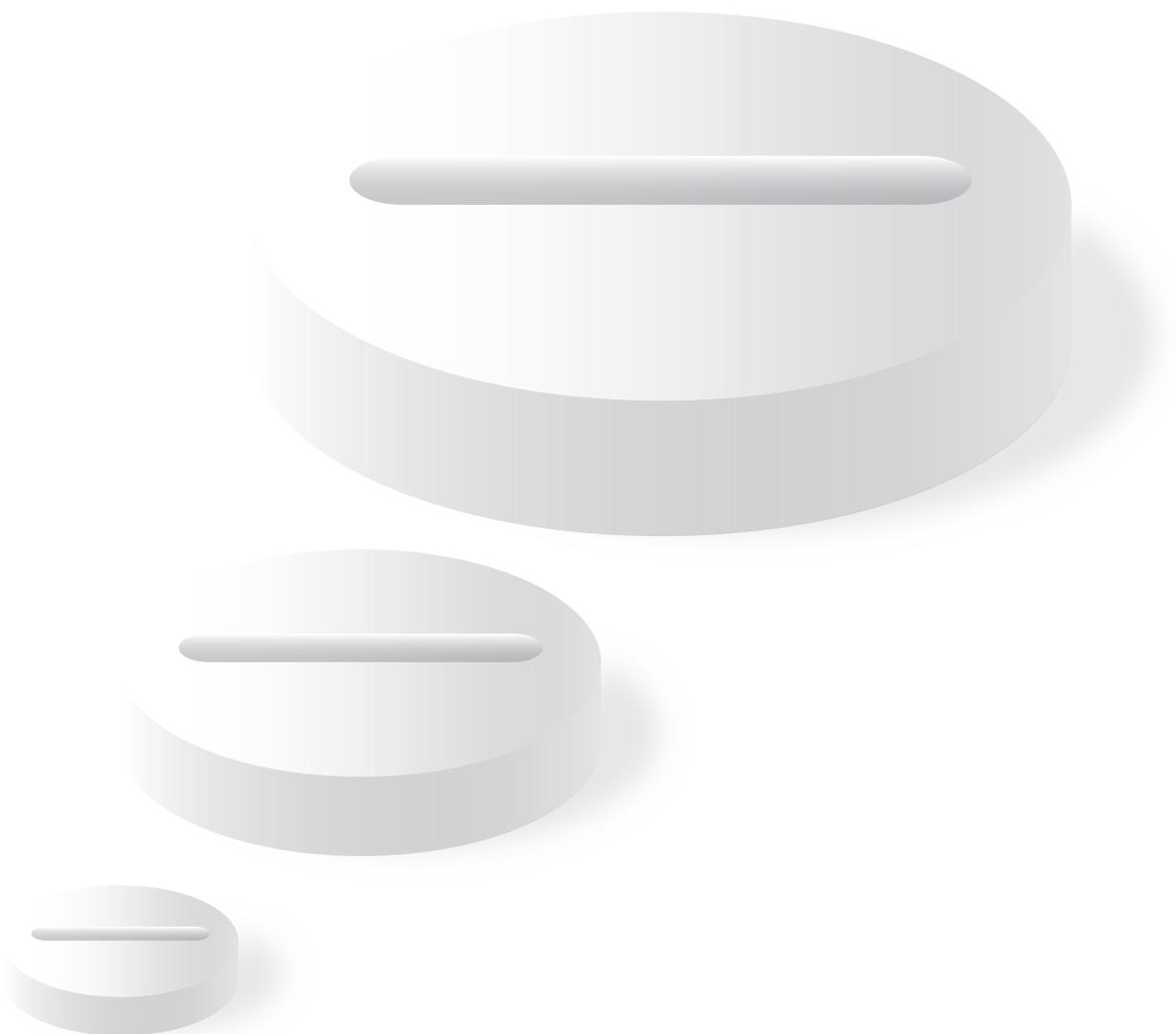


Learning report:

Making care safer

Improving medication safety for people in care homes: thoughts and experiences from carers and relatives

June 2011



Improving medication management in care homes is a system-wide issue, which needs to be tackled by many different groups working together. This work is now being taken forward in an integrated programme led by the National Care Forum, funded by the Department of Health, working as part of a wider cross-sector partnership. This partnership involves:



Age UK



Care Provider Alliance



English Community Care Association,



National Care Association.



National Care Forum
On behalf of the Care Provider Alliance



Registered Nursing Home Association



Royal College of General Practitioners



Royal College of Nursing



Royal College of Physicians



Royal College of Psychiatrists



Royal Pharmaceutical Society



The Health Foundation

© 2011 The Health Foundation

Learning report: Making care safer is published by the Health Foundation, 90 Long Acre, London WC2E 9RA

ISBN: 978-1-906461-31-7

Design and illustration: Lucid Design Limited, www.belucid.co.uk

Contents

1	Introduction	2
	About this report	2
	About the project	3
	Understanding the problem and finding solutions	3
2	Communication and information sharing	4
	Communication with carers	5
	Care plans	6
	Relationship with GP	6
	Communication at transition points	7
	Suggested solutions	8
3	Prescribing and administration of medication	10
	Safety and compliance during the drugs round	11
	Timing of dispensing	11
	Ensuring medication is taken	12
	Managing medicine stocks	12
	Inappropriate prescribing	13
	Lack of review and monitoring	13
	Suggested solutions	13
4	Staff development and support	15
	Staffing skills	16
	Staffing levels	16
	Leadership and management	16
	Information, support and training	17
	Suggested solutions	17
5	Advocacy and rights	19
	Relationship with family versus confidentiality	20
	Carers as advocates	20
	Complaints and concerns	20
	Dignity and independence	21
	Suggested solutions	22
6	Conclusion	23
	What happens next?	23
	Working together to develop practical solutions	24

1

Introduction

About this report

This report collects together the testimony given by family and carers of people living in a care home, specifically around issues of medication safety. Three day-long focus groups were held in 2010, in Manchester, Birmingham and London. In total 26 people attended the events. Members of the group also shared testimony they had collected from fellow carers.

Attendees were all carers, past and present, who are also ‘experts by experience’, trained to participate in inspections of care homes by the Care Quality Commission (CQC). This means that in addition to their valuable personal experience as carers for people who live in care homes, they have also spoken to many residents, family members and staff as a result of their work.

The experts by experience who contributed to this report are referred to here as *attendees*. While the term carer can have many meanings, in this report we use *carers* to describe friends and/or family members with an active interest in the care of a resident. The term *staff* refers to people employed as carers in the homes.

About the project

The Medication Safety in Care Homes project began in 2009. Originally funded by the Health Foundation to understand carers’ perspectives, it is now progressing as a partnership project led by the National Care Forum and funded by the Department of Health.

The project began following publication of a report by the *Care homes use of medicines study*¹ (CHUMS) in 2009, which revealed an unacceptable level of medication errors relating to older people in care homes.

The study showed that care home residents take an average of eight different medicines every day. On any one day, seven out of ten residents experience mistakes with their medications. These errors range from doses being missed or given incorrectly, to the wrong drugs being given out. In some cases these errors have the potential to cause very serious harm.

In response to the report, the Health Foundation funded Medication Safety in Care Homes, a project involving Age UK,

Royal College of Physicians, Royal College of General Practitioners and Royal College of Psychiatrists, who all decided to work together to take action. We recognised that the issues raised by the CHUMS study cannot be resolved by the care home sector without the support and engagement of a range of other professionals.

We started by capturing stories from a carer perspective. That initial collaboration has since been strengthened by a partnership with the care home sector and other agencies, including the Department of Health. This extended group is now driving an integrated improvement project. Together they are working to reduce the risk of harm associated with medications in care homes, making care safer for vulnerable residents. This report forms part of this work.

Understanding the problem and finding solutions

During the focus groups, attendees were invited to tell their stories and think about ways to improve medication safety in care homes. They were asked to consider what improvements would be possible in practice given the current culture and constraints, and what could be done strategically in the longer term.

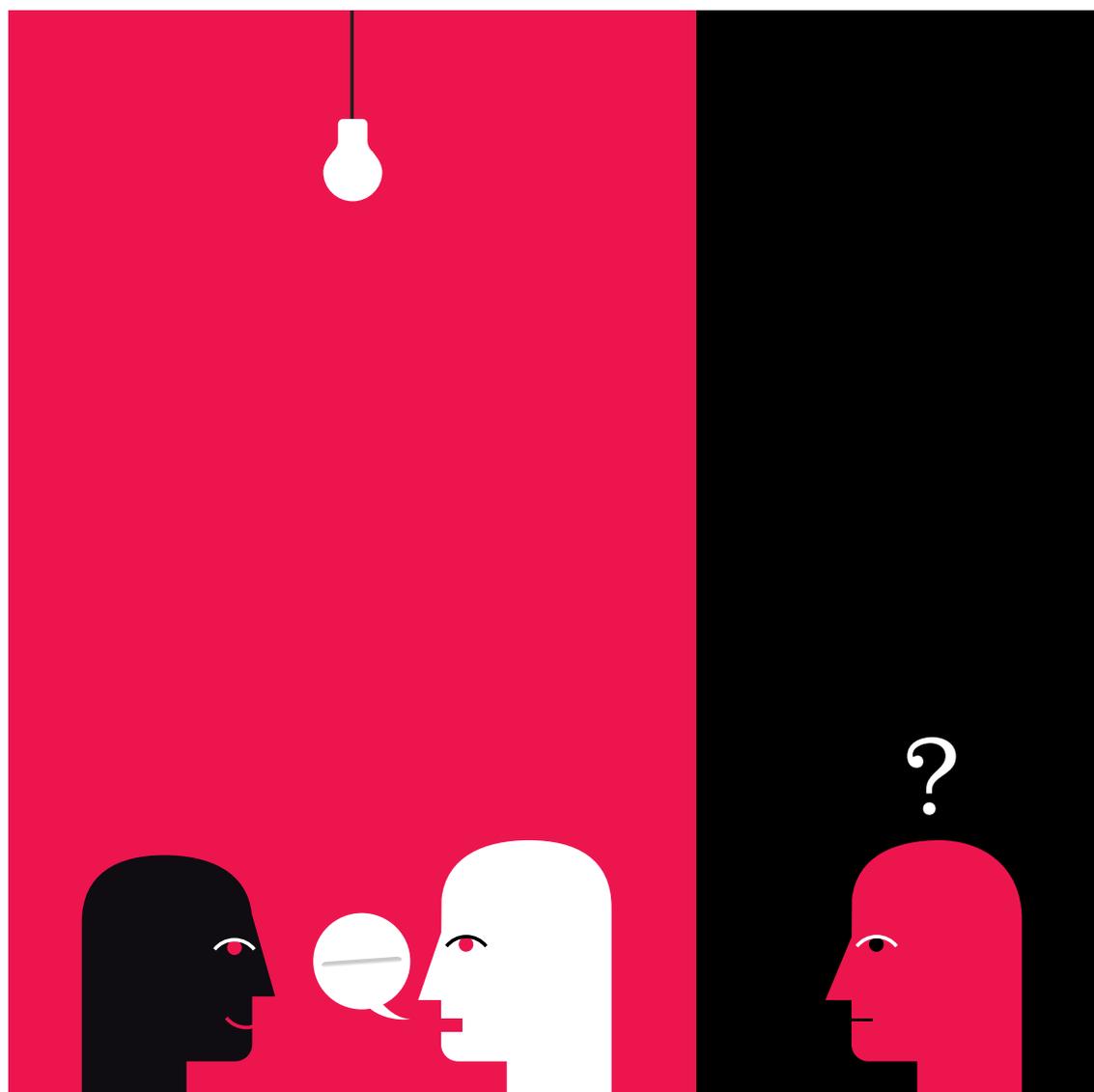
The issues and potential solutions raised by the groups are presented in this report under four main headings:

- communication and information sharing
- prescribing and administration of medication
- staff development and support
- advocacy and rights.

¹ Barber N, Alldred D, Raynor D *et al.* Care homes’ use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people. *Quality and Safety in Health Care* 2009;18:341-346

2

Communication and information sharing



A lack of communication and information sharing around medication was one of the main issues raised by all attendees as a cause of medication errors. It was felt that systems for communication between staff in care homes could be improved and that standards of communication with carers were generally poor or inconsistent.

“When we visited the home one day we asked about some tablets which my mother was taking. We didn’t know what they were and why she was taking them – neither did she.

We were told they were important – they were part of the chemotherapy.

We said, ‘What chemotherapy?’

The nurse said, ‘The chemotherapy for the cancer.’

We said, ‘What cancer?’”

Communication with carers

Attendees frequently reported feeling frustrated that they weren’t told about important developments in their relatives’ care, or involved in shared decision making. They said GPs tended to visit care homes when family or carers were not there. There were rarely mechanisms in place to enable carers to be present during visits or be updated about medication changes afterwards.

“I’d already written three letters to the home requesting that I be notified if anyone was coming to visit my mother as I was her next of kin and power of attorney but of course they didn’t tell me when the psychiatrist was on his way, as they didn’t so many times when the doctors came.”

Many attendees said they were not encouraged or invited to participate in any discussions about their relative’s care, even when they explicitly asked to be involved. Sometimes this was because staff wanted to protect resident confidentiality, however attendees thought these rules could be interpreted very differently by each home or professional.

Some attendees said they kept their own detailed inventory of their relative’s medication. This was difficult as information was not automatically shared with the carer and residents themselves could be unaware what medication they needed. Despite the difficulties, attendees strongly felt they needed to play a lead role in understanding and monitoring medication as their family member was not able to. In particular they could see a lack of communication between the GP and care home staff.

“Although my mother’s medical records were clearly marked ‘No codeine’ both at the surgery and the care home, GPs still kept prescribing them and the care home would either not see this in her records or chose to ignore it and give her the tablet.

“My mother-in-law had had a stroke and the daughters were involved in actually producing the care plan. It was an excellent home...”

Several times over the years we had to make it clear... [but] it happened again and again. When my mother was given this she became extremely ill which on one occasion resulted in her having to go to hospital. This would happen more when out of hours GPs visited who were unaware of her medical history. Even though the prescribing GP was at fault, the care home records did nothing to deter this medication being prescribed.”

Care plans

Attendees identified the use of care plans as a particular area for improvement.

In most cases attendees reported being asked for detailed information about their relative when they were first admitted into a care home. However some felt this had been little more than a tick box exercise. Details were recorded on file, but were then not consulted or updated by staff as time went on.

“There is this wonderful care plan folder that staff don't use but it is there for inspection purposes to say it has been done.”

“When my mother first became a resident, we gave a great deal of information about her likes and dislikes, her medication, all the contact details for family and relatives. It was all very comprehensive, but it was filed away as part of the admission process... it was never used in practice, staff claimed not to know the things they should have known, it was never checked again – it was a waste.”

Experiences differed. Some attendees had never been shown a care plan for their relatives, whereas in some good practice examples, attendees had been involved by staff in writing the plan.

Attendees said that protocols for sharing information and giving family access to care plans also varied from home to home. In all

cases they thought that care plans and daily records could be used better by homes to communicate with staff, GPs and relatives about daily developments.

There was an understanding that staff are short of time to spend reading or updating care records on a regular basis, however it was felt this should be prioritised by management.

Examples were given of where staff had demonstrated in conversation that they were unaware of information about residents that attendees knew had been recorded in the care plan. In some cases this lack of communication had extremely serious implications.

“My mother-in-law was resuscitated when she had clearly had it written in her care plan that she didn't want that. She then spent a lonely and painful three weeks in hospital, only to be returned back to the home where she died soon afterwards.”

It was felt that the lack of care plan review meant that medication was not reviewed regularly. If a review did happen, relatives weren't always present.

“There is supposed to be this annual review system – it is not really followed. Sometimes 12 months goes to 18 months. Then reviews are done but not acted upon.”

Relationship with GP

Attendees highlighted that where there was a good relationship with a resident's GP, the doctor played an important role in overseeing medication safety and ensuring continuity of care. However the level to which GPs were involved in overseeing a resident's care varied greatly from home to home, and there was often poor communication between the GP and staff.

One example of good practice was a care home which paid for a regular visit from a doctor each week who was also a specialist in dementia. This home had invested extra funding to contract with that GP, who was able to advise on issues across the home, even where residents had stayed registered with their family doctor.

Residents often have to choose whether to change GP when they first move into a home. Attendees described this as a difficult choice between keeping the GP who knows and has a relationship with the resident and their family, or moving to a new GP who has a good relationship with the home.

“We found a great home for my mother but she was out of the practice catchment area, so she had to have a new GP which upset her and us.”

“We were glad to move my mum to a new GP. The first one was awful, but this one came to the home and got to know the whole family.”

Attendees noted that having the same GP for all residents can provide continuity and regular contact. However as each patient has a right to choose their doctor it can be difficult for a home to facilitate this. In reality homes often liaise with multiple GPs, who attend as and when required rather than making regular scheduled visits. This can make building a good relationship between the GP and staff more complicated.

While it was acknowledged that many bigger homes do already try to use a nominated GP, attendees felt the reality was still that residents saw a range of different doctors. This was mainly due to a frequent use of locum doctors who were often sent instead of the regular GP. Attendees felt that this led to increased medication errors, with repeat prescriptions often being dispensed without review. Lack of prior knowledge about a resident and their condition led to incidents of incorrect medication being prescribed by locums, which could have fatal consequences.

Attendees suggested that strengthening the link between the care home and a dedicated GP would not only provide consistency, but also enable the GP to build up an in-depth

knowledge of the care needs of individual residents. They thought this would have a positive impact on the medications management procedures in that home as there would be systematic and regular review of prescriptions and observations of medicine administration procedures.

Communication at transition points

Lack of clear communication about a resident's care, and specifically issues around medication, were reported as particularly problematic whenever the resident needed to leave the home, for example, during a stay in hospital.

“My mother-in-law went into hospital and the nurses kept commenting to me that she seemed a bit confused. I realised that the care home staff hadn't even told them she had dementia.”

Attendees had found that full information about care needs and medication did not always go with a resident when they were admitted to hospital. Likewise, medication or information about prescriptions often didn't follow the patient back into the care home when they were discharged. There were also examples given of conflicting prescribing between the hospital consultant and the local GP.

When prescriptions had been altered in hospital there was often no follow up visit from a GP on the resident's return to see if the prescription needed reviewing or changing back. In some cases this resulted in residents continuing to take unnecessary or conflicting medication once they were back in the care home.

Attendees pointed out that it was fairly common for people to be admitted to a home for the first time following a crisis spell in hospital after which they could no longer cope in their own home. In these situations they felt the handover of information about medication was often inadequately handled, or did not happen at all.

Suggested solutions

Attendees suggested the following as ways to improve communication and information sharing around medication.

Develop ‘care partnership’ groups:

Attendees felt carers should be given a more structured role in the care of their relative. They suggested that care for each resident should be planned by a ‘care partnership’ which would include the resident, the care home manager, staff, an appropriate carer or relative, the GP and other health and social care professionals (eg community pharmacist) where appropriate.

Build relationships: Attendees would like to see care homes placing more emphasis on building positive, trusting and open relationships with carers to encourage a culture where issues can be raised without fear of reprisal. Suggestions included regular opportunities for carers, residents and management to meet and discuss concerns in an open forum, and more social events at meal times or in the evening.

Care planning and reviews: Attendees thought a more formal process for care planning and review would be beneficial, preferably led by the ‘care partnership’. They suggested the process could begin with a case conference at admission (with all stakeholders invited). Formal reviews should take place every three to six months, either face to face or via conference call. Care plans and notes should be updated regularly by staff in between reviews and made accessible to all members of the ‘care partnership’.

Protocols for communication: Attendees felt homes could develop clearer procedures for information sharing and shared decision making with carers and relatives. These could be agreed and reviewed as part of the

care planning process and could include preferences for how relatives would like to be kept up to date or informed of key developments. In general, attendees would like to see staff encouraged to adopt a more open approach to information sharing with carers.

Improve daily communication: Attendees thought there could be better information sharing within the staff team to help with shift handovers. Systems need to be robust to ensure that notes are recorded and that important information is read by staff coming on shift. It should be clear what information is accessible to carers, enabling them to stay up to date. Attendees were aware of issues around privacy and patient confidentiality but suggested some records could be kept privately in the resident’s bedroom (for example a chart on the back of a wardrobe door) or made available in the office or securely online.

Standardise communication at transition: Attendees suggested homes should have a protocol for ensuring residents are never sent into hospital without an accurate record of their medications and wishes, complying with any mandatory regulation. This could be articulated as part of the care plan. Carers suggested guidance could be produced to improve transitions in care. It was also noted that where a resident does change GP on entering the home there needs to be a quality handover of patient information and details.

Build strong relationships with a lead GP to ensure continuity of care: Attendees would like to see a designated day for weekly visits by a lead GP for the home. Where residents have chosen to stay with their original doctor there should be regular communication between the two GPs. To avoid use of locums and build familiarity, it was suggested two doctors could work on a rota to cover for illness and

holidays. Where use of locums is unavoidable visits could be followed up the next day by the regular GP to ensure continuity of care.

Define roles and responsibilities: Attendees felt there was a need to clarify lead responsibilities for particular areas such as medication and communication. Where keyworkers are assigned to a resident, they should have a formal role to be aware of medication issues and to keep family and carers updated about any changes. Other suggestions included the local pharmacist attending regular medication reviews as the key 'medication liaison officer'; and particular members of staff being assigned 'medication champions' for the home. Attendees thought that clarifying roles and responsibilities would also make it easier for relatives to understand and negotiate their own levels of involvement.

3

Prescribing and administration of medication



“The dispensing of medication in care homes is a scary business – our relatives’ lives are in their hands!”

Attendees said they were ‘shocked but not surprised’ by the high level of medication errors identified in care homes and provided several serious examples.

One attendee mentioned that some care homes use a photograph of the resident with the prescription information to help avoid mistakes.

“One incident a care home nurse reported to me happened when she was on annual leave. When checking details of a resident’s medication on her return, she identified a very serious incident whereby the person had received a high-risk drug instead of paracetamol each day for a week. Three different members of staff who had administered this drug that week had made the same mistake.”

Safety and compliance during the drugs round

Attendees all agreed that the daily task of giving out medication to residents is high pressure and high risk. In some homes this would be very complicated with staff not just dispensing tablets, but also helping residents with inhalers, eye drops, medication administered by feeding tube and liquids suitable for people with problems swallowing.

“This most important aspect of care is left with staff who seem to have very little training in this area.”

Attendees felt strongly that the processes for administering medication during the daily drugs round could be improved, as this was when many mistakes were made. They had observed that medication rounds could take up to two hours to complete and staff were rarely able to do this without interruption. This could include being called away to help other residents or care staff, to speak to a GP or relative, or to take a phone call. This would result in the drugs trolley being left unattended and unlocked, sometimes for extended periods of time.

“The person giving out the medication is quite often called away... this is high risk. They’d be called to the phone, and they’d come back and say, ‘now... where was I?’ ”

“We went to visit my mother-in-law and found that the drugs trolley had been left unattended in her room. We came in just in time.”

In some cases interruptions meant that some residents didn’t receive their medication at all that day. There were also many examples given of residents being administered someone else’s medication by mistake, and of drugs being missed or lost during the round.

“On one occasion a seven day course of trimethoprim was prescribed to my mother for a urine infection. While visiting I noticed no antibiotic arrived with her meal. When I queried this I was told that she had finished them all. I said this was impossible and through further investigation they were found tucked away in another area of the medication trolley. The carer apologised and said she wasn’t aware that they were there... When we counted the tablets out it appeared that my mother had missed five doses.”

Attendees thought that staff sometimes got confused between the trade and generic names of tablets which could cause errors. There was also confusion as many pills are the same shape and colour. New or agency staff doing the medication round would also be likely to make mistakes as they didn’t know who residents were and medication wasn’t properly labelled.

Timing of dispensing

Delays with the medication round would also affect the time that residents received their daily medication.

“Because the round could take up to two hours, the next round would be due two hours later. Therefore people who had been given medication at the end of one round could be taking medication at the beginning of the next, which could result in over-medication as in the case of paracetamol.”

Generally attendees felt that the timings of the round were designed to suit the home and not the residents.

“Often medication that should be given morning, noon and night, will be given all in one go due to time constraints.”

There were also several examples of time dependent medication being given at unsuitable times, such as sleeping tablets given in the afternoon or early evening rather than before bed.

“Sometimes my mother’s dose of diazepam was given to her too early in the evening whilst sat in her chair. This resulted in my mother falling asleep and when waking up being unsteady on her feet when it came to getting ready for bed.”

Ensuring medication is taken

Attendees reported that often staff did not have time to wait and check that medication had actually been taken. When visiting, relatives would often find tablets on the floor or left on the bedside table.

“My mother-in-law used to hide her medication because she didn’t like taking it. We could never tell whether she still did this in the home.”

“Often they don’t give them enough water to take the tablets with. And they rarely wait to see whether they’ve taken them all properly.”

“Because care staff didn’t hang around and see that the medication was taken, capsules were found on the floor. These could be anything from paracetamol to citalopram, diazepam, thyroxine...”

One attendee reported an account where a patient with dementia didn’t swallow their pills for several days and kept them hidden inside their mouth. This caused their mouth to be badly burned.

Other examples were given involving eye drops.

“The system for administering eye drops for glaucoma which my mother had been prescribed was at best ‘hit-and-miss’. We were told that they were administered by staff, but we were never sure when or if she was being given them as we’d often find them in her room even though they were meant to be stored in the fridge and replaced monthly. When I asked about them (as my mother’s eyes were becoming red and sore) I received vague and unsatisfactory replies.”

Managing medicine stocks

Inefficient systems and processes for storing and managing stocks of medicines were widely reported as a cause of errors, wastage and delay. This included bad management of repeat prescriptions, delays in collecting new medicines from the pharmacist once prescribed, allowing prescriptions to run out or be lost, and a lack of clear labelling.

“Prescriptions run out as there does not seem to be a set process to get them renewed before this happens.”

Allowing stocks to run low led to the sharing and borrowing of medicines between residents.

“Whilst on inspections I have witnessed creams prescribed for one person being in someone else’s room. This can happen when one person has run out of their cream and so someone else’s cream is introduced. I have seen this happen more in dementia units. This causes cross-infection.”

Stories about inconsistencies in labelling of medication included oxygen and inhalers which were left in the medication trolley, not labelled as resident-specific.

The question of how to store medication safely was also raised. Attendees reported that

many residents would be able to administer their own medication, but there was an issue about how to store it safely so that it wasn't accessible to other residents.

Inappropriate prescribing

Several attendees talked about cases where they felt the prescribing of medication had been inappropriate. They mentioned the unnecessary use of antipsychotics and sedatives, particularly where residents were deemed 'noisy' or 'troublesome' by care home staff.

"My mother was seen as troublesome by staff as she called out a lot at night. In fact she was only calling out because she felt lonely and desperate. We discussed giving her a sedative, but instead she was prescribed quetiapine, an antipsychotic drug. It gave my mother horrible physical side effects and made her much more anxious. When I finally managed to speak to the psychiatrist he took her off quetiapine and instead prescribed company, lavender on her pillow and some quiet music to help her sleep."

"We found out after my father died that they were giving him injections to keep him quiet at night (he had loud nightmares)."

"I've heard of patients being put on heavy medications for 'being aggressive!'"

Attendees explained that often GPs have to rely on information they are given by care home staff in order to make decisions about prescribing. Badly written care plans mean doctors can be misinformed. This also resulted in residents being prescribed and administered drugs they were known to be allergic to, which could have serious repercussions.

"The home called to say my mother had come out in a very distressing rash all over her body and would I call in and see her. I asked what she had

eaten or taken. They said that she had a chest infection and that her GP had prescribed penicillin. She is allergic to penicillin. This is on her care records in the home but no one had checked."

Attendees mentioned a lack of knowledge of contra-indications and adverse reactions to medicines among staff. They commented that many staff have not been trained to monitor for side effects to medication and don't always know what to look out for.

Lack of review and monitoring

Attendees felt strongly that medication needed to be monitored more closely and reviewed regularly, preferably as part of a formal process of case review.

"It would be good to have a more formal structure around medication reviews. Ideally a person's medication should be reviewed every six months but in reality it's a lot more ad hoc."

Without this process, it was felt there was often little or no opportunity to question a GP's prescribing, or to talk to them about the medication.

Suggested solutions

Attendees suggested the following as ways to improve the prescribing and administration of medication.

Protected drug rounds: Attendees proposed use of a red 'do not disturb' tabard by staff in charge of medicine rounds, and an understanding within the staff team and with visitors that this is protected time. It was also thought that staffing levels need to be addressed during these key times.

Time to ensure medication is taken:

Attendees felt that staff need to be given the time to dispense tablets thoroughly and interact with residents to ensure drugs were

actually swallowed. They suggested better communication with residents would help with this, while also maintaining residents' dignity and respect. For people who have difficulty swallowing tablets, staff could work with the GP to encourage the prescribing of liquid alternatives where possible, or to consider mixing them into food with the resident's consent.

Improve record keeping, monitoring and labelling: Suggestions included creating a 'medication book' with pictures of residents and their medication, clearer forms and charts, and systems for labelling drugs including using individual blister packs and dosette boxes. Simple processes need to be introduced to flag up when repeat prescriptions are needed, and attendees suggested new prescriptions should be collected within a certain time. Where drugs need to be shared in exceptional circumstances, attendees thought this should be clearly documented so that borrowed medication could be replaced.

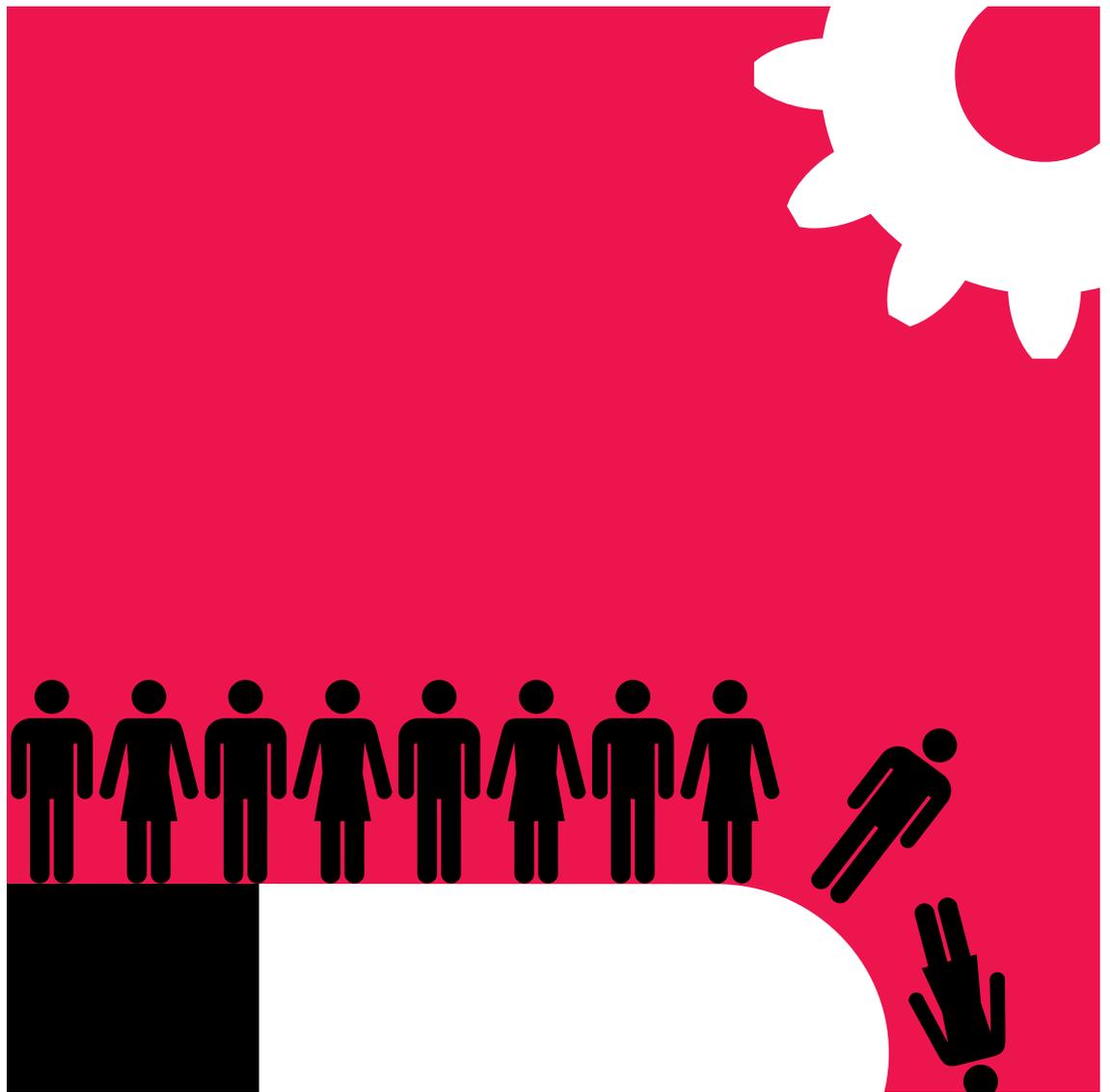
Timing to suit the individual resident: Attendees would like to see an awareness of time specific medication being taken into account when planning the drug round. Some medication may need to be dispensed outside the standard medication round and this should be scheduled accordingly.

Formal process for medications review: Attendees thought medication should be formally reviewed by a group of key stakeholders (including the family) at regular intervals of at least every six months. They felt that the community pharmacist should be involved with this process and could perhaps lead it.

Roles and responsibilities: Attendees felt that only qualified and designated staff should be tasked with administering medication. Ideally they should have a certified level of awareness of drug treatments and common adverse drug reactions, and be trained to NVQ level three or above. To avoid inappropriate prescribing of antipsychotic medication they proposed that these prescriptions should be overseen by a consultant psychiatrist.

4

Staff development and support



Issues around staffing levels, the skills of staff employed by homes and the training they were given were mentioned frequently by attendees.

Staffing skills

While many attendees had experienced excellent, dedicated and caring staff in care homes, others identified low-skilled or unmotivated staff as a key issue.

Attendees found that for all levels of staff, English was often not their first language. They said this could lead to communication problems within the team and with residents and families. In particular, English language skills were thought to be lacking when discussing medication, as this requires a more technical vocabulary. The ability to read written English was also a worry, especially as “doctor’s handwriting is notoriously bad”.

Most attendees were in agreement that staff do want to offer best practice care, but are often prevented from doing so by the system or by lack of time.

“A qualified nurse who had worked in the care home sector dispensing medicines for three years decided she could no longer work in the sector. She said she had been in nursing for 19 years working in hospitals, casualty and A&E and this was the most stressful and frightening job she had ever had. She also said that agency nurses who came into the home had no idea who residents were. There were no photographs in the records and so it was up to them to ask the person who they were or had to rely on other members of staff or other residents to tell them.”

Staffing levels

A shortage of staff was one of the main recurring issues, and was particularly cited by attendees as a reason for unsafe practices in dispensing medication.

“They were rushed off their feet... it was a quick dash from the rooms, people were screaming out for their drugs, you know, people with cancer, all sorts of really painful stuff going on.

The nurses who should be giving out the drugs were doing breakfasts... it was one of those situations where they were short-staffed and this is a huge factor...”

“They’re so short-staffed, how can anybody get the time to read the care plans in the morning?”

“...If you’re in a nursing home and you have got one girl for fifteen residents, they’re all screaming out for their drugs, they’re all in pain, they haven’t had their breakfast... They may mean well, they may desperately want to read that care plan but they can’t!”

Attendees reported that staff themselves highlight being so busy as one of the main problems and causes of error in their jobs. They quoted staff who had told them how stressful they found their jobs in care homes:

“I have worked in A&E, acute wards, all sorts. This is the most pressure I have ever had.”

“My job was on the line every single day.”

Attendees thought that this high pressure environment, combined with generally low wages, contributed to the rapid turnover of staff and low morale within the care sector. They agreed this must make building a smooth-running team and providing continuity of care to residents very difficult for managers. They noted that high use of agency staff also meant that staff were less likely to know residents well or know each other well. Lack of teamwork within the care home was given as a reason for a lack of communication both within the staff team and more widely with family and with other care professionals.

Leadership and management

Good leadership was seen as essential, with the quality of the home manager being a key issue. Examples were given of new managers

Attendees gave positive examples of care home managers who had encouraged staff to take a more holistic approach to care and take time to build relationships with the residents. They felt this had helped to improve medication safety and influenced the overall quality of care in the home.

who had been brought into failing homes and had driven up standards very quickly.

“If the manager and staff make it their business to have meals with the residents... if they’re sat down all of them together... a lot of what we’re talking about, the medication and everything else, should flow because they’ll be there to see that it’s happening.”

Information, support and training

Training of care home staff was highlighted as a very important issue. Attendees had observed a massive variation in professional practice and expertise. They were unsure what levels of training care home staff currently need before they can distribute medicines, however they felt the emphasis was on “avoiding litigation rather than encouraging good practice”.

Attendees identified particular training needs for staff including drugs knowledge, safety issues around dispensing drugs, holistic interaction with residents, and the difference between caring for the mentally impaired and those who are frail or have a lack of physical coordination but are mentally fit.

It was felt that more information and support could be provided by the health specialists already working with the home, including the community pharmacist and GP. Attendees noted that staff were often reluctant to call in a doctor unless they were sure it was an emergency and therefore didn’t always act or ask for help when necessary.

“Within my mother’s care home there always seemed some trepidation to call a doctor. One particular GP made it quite clear that it had to be extremely urgent for him to be called.”

Attendees felt that better support from health professionals, in the form of more regular medicines reviews for each resident, would

mean care home staff administered the right medication with less chance of side effects or confusion.

“I can choose my own GP but there should be another GP overseeing that particular care home to make sure people are getting the correct medication and they’re not over or under prescribed.”

Suggested solutions

Attendees suggested the following as ways to support and develop staff in care homes in relation to medication management.

Leadership: Attendees thought that good management was essential and helped to ensure quality recruitment, a relaxed and happy home, and the provision of holistic care. A good leader sets the standards and quality of care residents receive. Building a happy working environment would lead to improved staff morale and decrease staff turnover. Attendees also suggested that homes could involve residents and carers in the recruitment of new staff.

Staffing levels: Attendees felt that national policy should ensure staffing levels are always sufficient to allow staff to administer medication safely and thoroughly. Use of improved communication channels and daily care planning could help to ensure that new or temporary staff were fully briefed about residents and their medication before carrying out their duties. Attendees also suggested that homes could involve carers and volunteers to support staff at peak times.

Improving staff medication awareness:

Simple suggestions included using existing communication channels such as newsletters to provide briefings and bulletins for staff on particular medications (eg antipsychotics) including adverse reactions and side-effects.

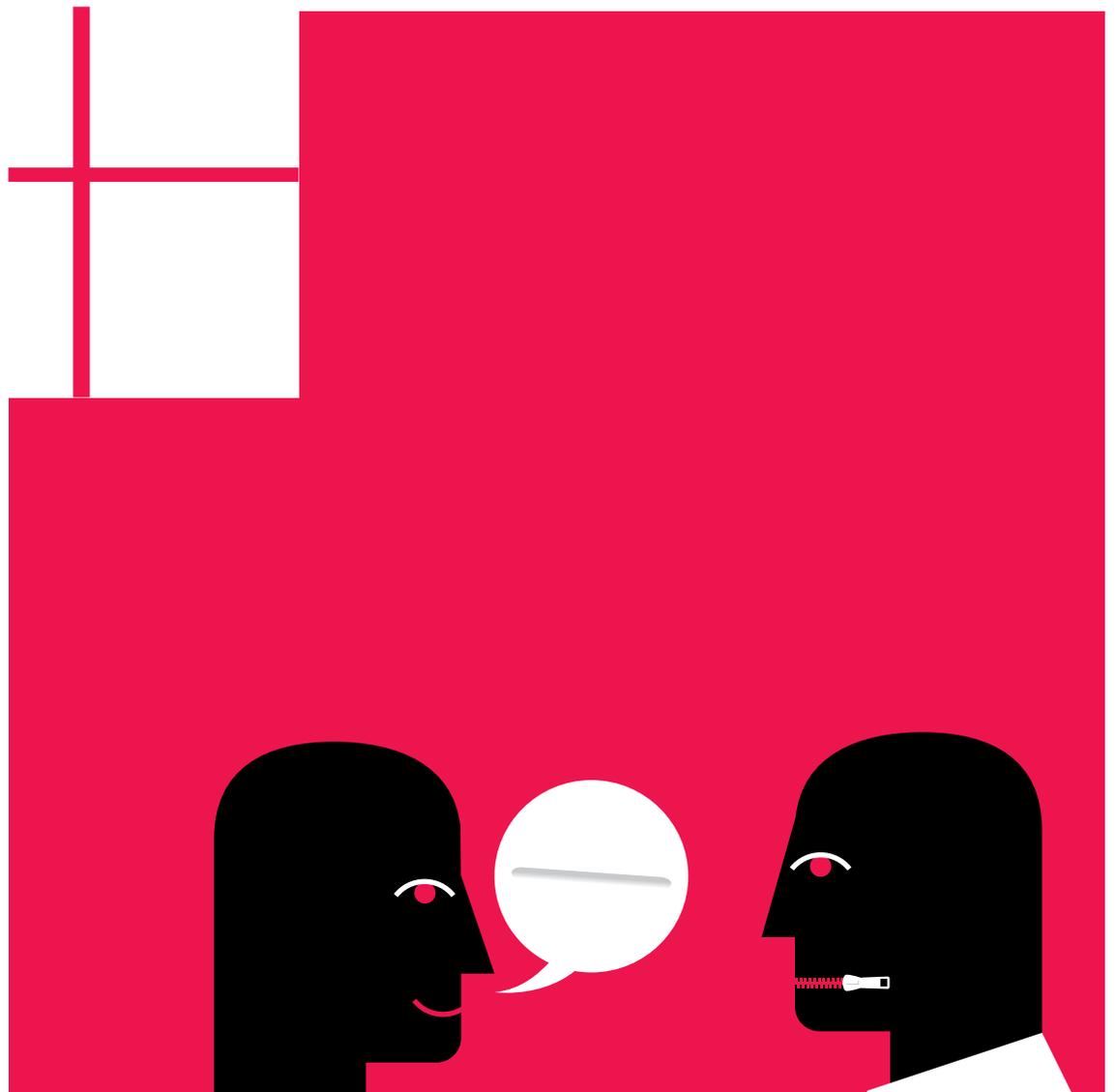
Good practice guides and briefings were also mentioned. Attendees thought that communications tools such as simplified medications charts for staff to read and update, and a system to identify contra-indications could also be helpful.

Training and awareness: Attendees suggested a statutory requirement that staff attend basic medication training which could be regulated by CQC. More informal training was also suggested with qualified staff or the local pharmacist providing training and information within the home on medication and safety issues. Training in giving out medication as part of a holistic approach to care was also mentioned.

Support from health professionals: Attendees would like to see better systems and more professional support around medications to help staff. This could include a formal review process for medications and GPs or pharmacists double checking prescriptions and overseeing dispensing.

5

Advocacy and rights



Attendees identified a tension between patient rights and carer rights. They said care home staff often felt they needed to respect and protect the confidentiality of the resident, at the expense of sharing information with relatives. This sometimes prevented carers being given important information about changes in a resident's condition or medication, particularly where the resident was not able to pass this information on themselves (for instance when the resident had dementia).

Some attendees mentioned they had seen the use of a buddy system in homes, whereby family and carers of one resident also visit and take an interest in the care of one or more other residents who did not have their own active residents or carers.

Relationship with family versus confidentiality

Attendees said it would often be carers who would notice a change or deterioration in the condition of their relative and would raise this with staff. A GP would then be called out, but the relative would often not be given information about the outcome of the visit. This would be very frustrating and worrying for relatives who wanted to make sure their loved one was receiving the right care, but were not involved in the decision making process.

Examples showed that these situations could be further confused by different health professionals sharing information with carers in different ways. Often a family GP would be happy to share information with a carer when they took their relative to an appointment, treating them as an advocate. However the care home did not view the carer's role in the same way and would not share information or take instruction from them.

"Because I was involved in my mother's care with her own GP and psychiatrist they would advise me when visiting that they would be stopping a certain medication, or changing the amount of another. The problem was I was left to speak to the care staff about this and of course they would not be able to act on what I said. Therefore until written confirmation was received from the GP or psychiatrist the medication would still be given to my mother."

Carers as advocates

Attendees felt strongly that care staff generally give more time and attention to residents whose family visit regularly and take a proactive interest. Therefore with a carer acting as an independent advocate, levels of care are improved.

They suggested that residents who didn't have visitors did not receive the same input from staff.

"...they're quiet, don't complain, don't get the same care."

"What happens to people who don't have visitors – don't have someone to make sure they get good care?"

For this reason several attendees noted that it is important that the system does not rely too heavily on carers as some people do not have friends or relatives willing or able to perform that role.

Complaints and concerns

As frequent visitors to a home, attendees felt that relatives are often well placed to identify errors in care. However all attendees reported a real fear of being labelled a 'difficult relative' if they complained or raised problems too often.

"If you ask too many questions you are perceived as a problem. Once you have that label no one listens to you anymore and the relationship with the home breaks down."

"If you start asking awkward questions, you're labelled a troublemaker..."

Some also said they would be worried about repercussions when raising complaints about care.

"Relatives don't want to upset staff in case it affects what levels of care their loved ones are given."

"[It led to me being] asked by staff not to visit so often as I was unsettling the patient (my father) and disrupting the routine."

Attendees had found there were often no clear processes for raising complaints or issues in a confidential way, and no one to complain to if the issue was with management or senior staff.

Attendees felt that homes could do a lot more to encourage carers to get involved and raise issues in a positive way.

“If staff would only work with the families instead of against them... If they’d just sat down and talked with me we could have got somewhere.”

Dignity and independence

Attendees felt that sometimes care homes were so busy focusing on administering prescribed medication they forgot the need to encourage independence and maintain dignity in residents. They gave many examples where a more holistic approach to dealing with a problem would have resulted in a more positive outcome.

“For many years, my mother believed that one Nurofen at night helped her to sleep. She never had any trouble sleeping and always claimed it was because she took just one Nurofen. When she went into a home, the first thing they did was to check her tablets and they immediately stopped the Nurofen because it wasn’t prescribed and they said it wasn’t of clinical value. She became distraught, and didn’t sleep. And from then on she became increasingly anxious and concerned that she wouldn’t sleep – so they prescribed her sleeping tablets.”

Many attendees felt that there was a lack of dignity in how medications were administered to residents in care homes. Medication rounds would often take place at meal times, making it easier for staff, but meaning that medicines had to be taken in front of everyone.

“I have seen a care home resident given an injection in the dining area in front of everyone, no curtains/screen pulled – no privacy.”

“Some residents don’t want others to know what tablets they are on.”

“My mother was 94 when she went into a home. Up until then she had been able to live alone, despite poor eyesight and arthritis. The arthritis meant that she had to rub cream into her wrists and wear splints every night, and she had eye drops for glaucoma. Although she said it was nice when she had help, she had always managed to do this on her own. She was used to it and took pride in being independent.”

“When she went into a home, her drops and her cream were taken away and locked up. Her eye drops were often forgotten. Her splints and cream were rarely put on. She became withdrawn and depressed with the removal of her independence. So much so that she was prescribed antidepressants, which she repeatedly said she did not want or need.”

“It was ludicrous; she wasn’t given the things she did want and need and was encouraged to take the medication she didn’t want or need.”

Attendees also said they often witnessed staff being ‘too brusque’ with residents which could put them off taking their tablets. Others mentioned that GPs could also be dismissive and aloof when dealing with older residents.

“[The GP] usually stood some feet away firing questions at my mother and then without giving any further explanation to her would turn to the member of staff and speak with them about what to do next. This would leave my mother asking many questions after they had left the room... The care staff said this was quite normal practice with visiting GPs.”

“Some GPs need further training in how to communicate with older people to give them the respect they deserve...”

The use of prescribing to “keep patients quiet” was also mentioned by attendees in the context of dignity and rights.

“Medicines such as diazepam are used freely to keep people quiet.”

Often this kind of prescribing was only challenged when there was an engaged and proactive relative or carer who visited regularly.

Suggested solutions

Attendees focused on the following areas to improve advocacy and rights for care home residents around medication.

Independent advocates: Attendees felt strongly that all residents should have access to an independent advocate so that even those without a carer would have someone to represent them and ensure dignity in care. Suggestions ranged from the creation of an independent advocate/guardian role in each home, to an advocacy scheme run nationally by the voluntary sector. All agreed that advocates should be trained to recognise abuse and

inappropriate prescribing and could act as a medicines advocate during care reviews.

Harness ‘carer power’ for a team approach to improvement: Attendees felt better relationships could be built between staff and carers by inviting carers to be more involved. Staff and carers could work together to review and improve care, making everyone part of the solution and preventing staff from feeling threatened and defensive. Suggestions included holding regular ‘what can we do better?’ events, and inviting carers to contribute to local care home forums. The creation of friends and family forums was also suggested, which would allow carers to discuss and solve issues with the home as a group.

Improve complaints procedure: Attendees thought care homes should encourage carers to feel able to raise concerns informally with staff. All residents and carers should also have access to a formal complaints procedure which allows confidential complaints to be made to an independent body without fear of reprisal.

Improve accountability and independent presence: Other suggestions included all homes having an independent ‘board of governors’ who oversee quality and care. This would mean there was an independent body to take a complaint to rather than concerns being dealt with internally by management. Some attendees also mentioned that carers should be told about who can follow up on any carer concerns and report back to the appropriate statutory bodies.

Although the thoughts and suggested solutions have been presented in this report within four main themes, many of the solutions discussed by attendees were relevant across all areas discussed and were mentioned consistently across all focus group events.

In particular these were to:

- build strong trusting relationships as these are fundamental to how well care is delivered
- take time to communicate, update records, and share information
- ensure regular and formal reviews of care plans and medication
- prioritise safety by protecting the drugs round, improving systems and attention to detail
- identify, capture and develop good practice and help disseminate this to staff
- make use of relevant health professionals to ensure medication practices are safe
- clarify roles and responsibilities to ensure smoother communication and safer care
- consider medication as part of a holistic approach to care to ensure that decisions are always made in the interests of the resident and their voice is heard.

What happens next?

The Health Foundation and its partners believe there is a real opportunity to address the issues raised by the original CHUMS report and the concerns voiced by carers and relatives.

The next phase of the programme aims to deliver an ambitious improvement project over nine months. This project will harness the expertise of carers, relatives and partner organisations to find ways to improve the medication management for care home residents. We hope that these reflections from carers and relatives will inspire and encourage a collaborative approach to find solutions to making care safer for older and vulnerable people.

This work is now being taken forward in an integrated programme led by the National Care Forum, funded by the Department of Health, working as part of a wider cross-sector partnership. This partnership approach recognises that improving medication management in care homes is a system-wide issue, which needs to be tackled together.

The group will design and test a set of practical tools to help care home staff, doctors, pharmacists and nurses provide safer care and to reduce the incidence of medication error and near misses in care homes.

Taking a phased approach, the project will first select a range of possible solutions and begin to design tools for care home staff which will support improvement. In the second phase, the tools will be tested in the field and their impact will be evaluated.

Successful improvements will then be rolled out on a larger scale across the sector, improving the quality and safety for all care home residents.

“Until we begin to challenge the culture of poor practice and encourage relationship centred care we cannot ensure our older people a good quality of life”

Working together to develop practical solutions

The work programme will be taken forward by a cross-sector partnership including:

- National Care Forum (on behalf of the Care Provider Alliance)*
- Royal College of General Practitioners*
- Royal College of Physicians*
- Royal College of Psychiatrists*
- Royal Pharmaceutical Society*
- Royal College of Nursing*
- The Health Foundation*
- Age UK.*

This initiative is supported by funding from the Department of Health.

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK.

We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.

We believe that in order to achieve this, health services need to continually improve the way they work. We are here to inspire and create the space for people to make lasting improvements to health services.

Working at every level of the system, we aim to develop the technical skills, leadership, capacity and knowledge, and build the will for change, to secure lasting improvements to healthcare.

The Health Foundation
90 Long Acre
London WC2E 9RA
T 020 7257 8000
F 020 7257 8001
E info@health.org.uk

Registered charity number: 286967
Registered company number: 1714937

www.health.org.uk
Follow us on Twitter: www.twitter.com/HealthFdn

ISBN: 978-1-906461-31-7
© 2011 The Health Foundation