National Service Framework for Older People

a guide for community pharmacists
Prepared by
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in collaboration with
The Company Chemists’ Association Ltd
The National Pharmaceutical Association
The Royal Pharmaceutical Society of Great Britain

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Introduction

The National Service Framework (NSF) for Older People,¹ unlike earlier frameworks for coronary heart disease and mental health, contained very clear messages of relevance to pharmacists working in all sectors of the profession.

A significant element within the document is the relationship between older people and their medication, and the intention of the NSF is to ensure that all older people are able to gain maximum benefit from their medication, and do not suffer unnecessarily due to excessive, inappropriate or inadequate consumption of medicines.

It is therefore clear that all pharmacists need to fully appreciate the content of this NSF and how they respond to its requirements in the development of pharmacy services.

It should be noted this NSF applies to England only.

An Overview of the NSF

Policy Context

Approximately 40% of the total NHS budget, and 50% of social services budgets are spent on caring for people over the age of 65 years, making older people the main users of health and social care services. People over the age of 65 occupy more than two-thirds of general and acute hospital beds, and in 1998/99 this age-group accounted for expenditure of more than £15 billion, which is set to rise as the population ages.

The National Service Framework for Older People is a 10-year programme of action intended to ensure that older people have fair access to high quality, integrated health and social services. It aims to link services to support independence and promote good health; specialised services for key conditions; and cultural change so that all older people and their carers are always treated with respect, dignity and fairness.

The framework is part of a wider programme of governmental action to address the needs of older people. Other elements include:

- **improving standards** of care in residential and nursing homes through the creation of a new national care standards commission

- **extending access to services** such as cataract services, extension of the breast-screening programme to include women up to 70 years, and free sight tests for people over 60 years

- **free nursing care** for people in nursing homes

- **developing intermediate care** services to help avoid unnecessary hospital admissions and support independence

- **helping older people stay healthy** through influenza immunisation for those over 65 years, increased access to dentistry and the *Keep warm, Keep well* campaigns
As well as being the highest users of health and social services, as people get older their use of medicines tends to increase. For this reason the NSF is accompanied by *Medicines and Older People*, which describes how the use of medicines for and by older people can be improved.

The document sets out how the NHS and social care aims to ensure that older people

- gain the maximum benefit from their medication to maintain or increase their quality and duration of life
- do not suffer unnecessarily from illness caused by excessive, inappropriate or inadequate consumption of medicines

**Statistics**

**Demography**

Over the last 70 years the number of people aged over 65 has more than doubled with nearly 10 million people falling into this age group within the United Kingdom today - more than 15% of the total population. As the population ages over the next 25 years, the number of people over the age of 80 is predicted to increase by almost fifty percent, while the number of people over the age of 90 will double. By 2021 there are expected to be 12.2 million people over pensionable age living in this country.

![Figure 1 - Age Structure of the Population*](image)

On attaining the age of 60, a man can expect to live for another 19.1 years, and a woman for another 22.8 years. The likelihood of living alone increases with age, from 19% of men and 31% of women aged 65-69, to 43% of men and 72% of women over 85 living alone.

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* Estimated Resident Population at mid-2000, Office for National Statistics and General Register for Scotland
Health

The 2000 Health Survey for England\(^5\) which included older people living in private homes and care homes, reported that 58% of men and 56% of women over the age of 65 years described their health as “good” or “very good”, 29% of men and 34% of women rated their health as “fair” and 13% of men and 10% of women rated it as “bad” or “very bad”.

In private households, 20% of men and 21% of women reported contacting their GP in the two weeks prior to the interview; almost half of the older people interviewed reported that they had attended hospital within the last year, either as outpatients, day patients or inpatients.

In 1998, the General Household Survey\(^4\) reported that 59% of those aged 65-74 and 66% of those over aged 75 and over reported a long-standing illness; for the same age groups 38% and 50%, respectively, stated that they had a long-standing illness which limited their life-style.

In 1998, nearly 17% of all accidents within the home involved people aged 65 and over,\(^6\) and nearly half of all pedestrian fatalities on the road were over the age of 60.\(^7\)

Prescriptions

More than half of all prescriptions written are for people over the age of 60 years. Over the last 10 years this has increased significantly, although some of this increase will be due to a change in the definition of “elderly people” in 1995 to include men between the age of 60 and 65.\(^8\)

Figure 2 - Percentage of Prescriptions by Category (1989 and 1999)

Elderly people receive more prescriptions per head than any other group; this rate has increased from 16.7 in 1989 to 24.8 in 1999 (see Appendix 1).
**NSF Standards**

The National Service Framework sets standards for the care of older people in all settings across health and social care. It also reflects the fact that many major diseases and conditions are common in older people, and focuses on those which are particularly significant for older people, and which have not been addressed elsewhere; stroke, falls and mental health problems associated with older age.

However these conditions are not limited to older people and the standards and service models will apply to all who need these services. Equally the standards defined in other NSFs (CHD, mental health, cancer etc) are applicable to older people suffering from those conditions.

The NSF is based on eight standards grouped into four themes, each with timetabled milestones set for their delivery. Full details are given in Appendix 2.

**Standard One**

It has been suggested that, in the past, age discrimination existed in some areas of health care including resuscitation policies, management of trauma victims, access to cardiac care units, palliative care services, and thrombolysis. Denying access to services on the basis of age alone is not considered to be acceptable and it is expected that all organisations will review their policies to ensure that action is taken to address age discrimination.

This standard aims to ensure that older people are never unfairly discriminated against in accessing NHS or social care services due to their age.

Action already taken to expand older people’s access to services includes investment in additional cataract operations, hip and knee replacements and coronary revascularisation; and expansion of the routine breast screening programme to include women up to age 70, by 2004.

**Standard Two**

Anecdotal evidence suggests that older people’s dignity and autonomy is being undermined in the health care setting. The standard aims to ensure that older people are treated as individuals and receive person-centred care that meets their needs as an individual. Meeting this standard will involve defining the core values of the NHS and social care in its dealings with older people and reviewing the information provided to older people and their carers, to enable them to make choices about their own care.

The standard also relates to the provision of services in an integrated way, including joint commissioning arrangements across health and social care with a single assessment process, and access to integrated services for community equipment and continence advice.

Guidance has recently been issued regarding the implementation of the single assessment process setting out twelve steps of implementation, which commences in June 2002, with full implementation required by April 2004.
### Standards 1 & 2: Respecting the individual

1. **Rooting out age discrimination**
   
   NHS services will be provided, regardless of age, on the basis of clinical need alone. Social services will not use age in their eligibility criteria or policies, to restrict access to available services.

2. **Person centred care**
   
   NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

### Standard 3: Intermediate Care

3. **Intermediate care**
   
   Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission into long-term residential care.

### Standards 4, 5, 6 & 7: Providing evidence-based specialist care

4. **General hospital care**
   
   Older people’s care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

5. **Stroke**
   
   The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate.
   
   People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke services, and subsequently, with their carers, participate in a multi-disciplinary programme of secondary prevention and rehabilitation.

6. **Falls**
   
   The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their population of older people.
   
   Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention, through a specialised falls service.

7. **Mental health in older people**
   
   Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and their carers.

### Standard 8: Promoting an active healthy life

8. **The promotion of health and active life in older age**
   
   The health and well being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.

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**Standard Three**

This standard builds on the intermediate care guidance issued in January 2001 and the early milestones for intermediate care set in the NHS Plan Implementation Programme.

A new range of services will be provided either at home or in designated care settings to promote the independence of older people, by preventing unnecessary admission to hospital or long-term residential care, and enabling early discharge from hospital through the provision of effective rehabilitation services.
To be effective these intermediate care services will need to be fully integrated into the whole system of care including primary and secondary health care, social care, and the independent sector, creating a challenge for commissioning, management and provision of these services.

**Standard Four**

The standard aims to ensure that older people receive the specialist help that they need in hospital and that they are able to receive maximum benefit from having been in hospital. Older people are cared for within a range of hospital settings - general medical or surgical wards, A & E, coronary care, intensive care units, medical wards for older people etc; and they may have pre-existing illness or disabilities. They can also be particularly vulnerable to problems that arise during a hospital stay.

These all make the care of older people particularly complex and all general hospitals are expected to put in place a specialist multi-disciplinary team to lead the care of older people.

Discharge planning is recognised as a key stage of the hospital stay, and pharmacists are expected to be included in the core membership of the specialist old age team.

**Standard Five**

Stroke is the single biggest cause of severe disability and the third most common cause of death in the UK, with more than 140,000 people per year in England and Wales suffering a stroke. A target reduction of two-fifths in the number of deaths from coronary heart disease and stroke has been set as part of the Government’s public health plans defined in the White Paper *Our Healthier Nation*.\(^{13}\)

The NSF standard aims to reduce the incidence of stroke through the development of integrated stroke services, which address prevention, immediate care, early and continuing rehabilitation and long-term support. The establishment of specialist stroke teams to manage stroke patients in hospital is required by 2004 - the service model for these teams expects the inclusion of a pharmacist.

**Standard Six**

More than 400,000\(^{14,15}\) older people in England attend an A & E department following an accident, and up to 14,000 people a year die in the UK as a result of an osteoporotic hip fracture.\(^{16}\)

Although most falls do not result in serious injury, the consequences for the individual can include loss of confidence and a limitation of daily activities, loss of mobility, increased dependency and disability and may precipitate admission to long-term care. Falls are often a sensitive signal of unidentified and unmet health risk and healthcare need in individual older people.\(^{17}\)
This standard aims to reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen. It also links to the *Our Healthier Nation* public health target of reducing death rates and serious injury due to accidents.

Again the service model promoted in the NSF for membership of a falls service team includes pharmacists, and recognises the role of drugs, both in the prevention of osteoporosis and as a risk factor involved in the cause of falls.

**Standard Seven**

Under-detection of mental illness in older people is widespread, due to the nature of symptoms and the fact that many older people live alone. Around 10 - 15% of the population aged 65 and over will be suffering from depression at any one time,\(^{18}\) and depression in this age group is particularly under-diagnosed\(^{19,20}\) especially in care homes.\(^{21,22}\) Dementia affects approximately 600,000 people in the UK, with the incidence and prevalence increasing with age.

This standard aims to promote good mental health in older people and to provide prompt and appropriate treatment and support for those with dementia and depression.

**Standard Eight**

Growing old has long been associated with increased dependency, a decline in physical strength, stamina and suppleness, disability and ill health. However these are not an inevitable consequence of ageing and much can be done to help and support older people to continue to live healthy and fulfilling lives.\(^{23,24}\) Modification of risk factors, even late in life, can have health benefits for the individual.\(^{25}\)

This standard aims to extend the healthy life expectancy of older people through action to prevent or delay the onset of ill health and disability and to reduce its impact on health and well-being when it does occur.

**Medicines and Older People**

As people get older, the number of medicines they take tends to increase - 80% of people over 75 take at least one prescribed medication, with 36% taking four or more medicines.\(^{26}\) Almost half of the NHS drug bill is spend on medicines for older people.\(^{27}\) It is therefore important that this investment is spent in a manner that is clinically and cost effective and that appropriate medicines management systems are in place so that medicines use in older people is regularly reviewed. The main NSF document is accompanied by *Medicines and Older People*\(^{2}\), which describes how the use of medicines for and by older people can be improved.
This document highlights twelve key issues that influence the effectiveness of medication:

- **preventable adverse reactions** are implicated in up to 17% of hospital admissions in older patients\(^{28,29,30}\)
- **under-use of medicines** in older people such as anti-thrombotic treatment, antidepressants and preventative therapy in asthma\(^ {31} \)
- **not taking medicines** - as many as 50% of older people may not be taking their medicines as intended\(^ {32} \)
- **wastage due to inequivalence** of repeat prescription quantities has been estimated to account for 6 - 10% of total prescribing costs\(^ {33} \)
- **hospital discharge** frequently leads to intentional and unintentional changes to medication by patients or GPs\(^ {34,35} \)
- **poor two-way communication between hospitals and primary care** can lead to delays in actioning discharge and outpatient medication recommendations by GPs, continuation of medication which is not intended to be taken long-term, and absence of full medication histories on admission\(^ {35} \)
- **repeat prescribing** systems need improvement with careful consideration given to the process of ordering, synchronising quantities, ensuring regular review and monitoring
- **inadequate dosage instructions** on the medicines label resulting from prescriptions for “take as directed” can occur in up to 25% of medicines prescribed\(^ {31} \)
- **access to the surgery or pharmacy can be difficult** for people who have limited mobility or are housebound, limiting access to advice and help with their medicines
- **under-use of carers** to support older people in medicine taking and provide feedback on problems\(^ {36,37} \)
- **detailed medication review** can minimise unnecessary drug costs in older people\(^ {38,39} \)
- **withdrawal of long-term treatments** can sometimes be achieved with careful monitoring\(^ {40} \)

The NSF considers the risk assessment aspects of managing medication-related problems as well as effective interventions. Medicines-related and social and personal risk factors are highlighted as pre-disposing patients to medicines-related problems. Risk assessment will enable targeting of interventions.
Figure 4 - Risk factors

**Medicines-related factors**
- taking four or more medicines
- specific medicines, e.g. warfarin, NSAIDs, diuretics, digoxin
- recent discharge from hospital

**Social and personal factors**
- social support - low level of home support available
- physical condition - poor vision, hearing, dexterity
- mental state - confusion / disorientation, depression

Five main types of intervention to support patients and their carers in medicines taking are highlighted: prescribing support and advice; active monitoring of treatment; review of repeat prescribing systems; medication review with individual clients and their carers; and education and training.

Health and social care systems are expected to work to support the implementation of protocols for risk assessment and medicines management strategies by primary care organisations (PCOs), so that people can get more help from pharmacists in using their medicines. Local Pharmaceutical Services (LPS) contracts are also highlighted as a potential way of improving prescribing and use of medicines once they are introduced.

Three milestones are included within the document. In addition the *NHS Plan* contains a target that repeat dispensing schemes will be in place nationally by 2004.

Figure 5 - Medicines and Older People Milestones

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<td>All people over 75 years should normally have their medicines reviewed at least annually and those taking four or more medicines should have a review six-monthly. All hospitals should have “one stop dispensing / dispensing for discharge” schemes and, where appropriate, self administration schemes for medicines for older people.</td>
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<tr>
<td>April 2004</td>
<td>Every PCG or PCT will have schemes in place so that older people get more help from pharmacists in using their medicines.</td>
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Relevance to Community Pharmacy

The performance of PCOs in delivering the milestones of the NSF for Older People will be monitored by the new Strategic Health Authorities and will feature in the Annual Accountability Agreements between the two organisations. PCOs are also charged with delivering the targets of the *NHS Plan*, and will become responsible for the implementation of *Pharmacy in the Future* from April 2002.

Unlike earlier national service frameworks the NSF for Older People highlights many roles for pharmacists in its implementation. Pharmacists will need to be core members of the specialist teams for older people, and as the experts in drug management will need to be actively involved in the processes necessary to ensure that older people are able to gain maximum benefit from their medication.
The implementation of the single assessment process for older people will undoubtedly have implications for community pharmacy. For most older people, the overview assessment will consist of an exploration of a set of standardised “domains of need” (see Appendix 3). This will be carried out by front-line health and social care staff such as community nurses, social workers, occupational therapists etc. Further investigation of particular domains will need to be carried out by appropriately qualified professionals. Community pharmacists should contribute to these assessments where applicable and the resulting care plan may well identify issues where input from community pharmacists will be required so that appropriate levels of support to the individual patient are provided.

In order to overcome some of the problems associated with monitoring repeat prescribing, the NHS Plan has indicated that repeat dispensing should be introduced by 2004. The NSF highlights the benefits of this to both patients and GP practices.

The Department of Health will shortly be inviting proposals for the development of Local Pharmaceutical Service (LPS) pilot schemes, which will not be limited to dispensing, but will be expected to include other services, including medicines management, within a single agreement. The key issues relating to use of medicines by older people and achievement of the NSF’s targets could be included in the development of proposal for an LPS pilot scheme.

**Practical Guidance**

**Preventing Ill Health**

There is growing evidence that modification of risk factors for disease even late in life can have health benefits for the individual; longer life, increased or maintained functional ability, disease prevention and an improved sense of well-being. Standard eight of the NSF encourages activities which can promote healthy active life for older people including:

- access to mainstream health promotion and disease prevention programmes
- health promotion activities of specific benefit to older people
- wider initiatives to promote health, independence and well-being in old age

The standards for stroke, and falls include elements of health promotion and disease prevention. Earlier NSFs for Mental Health and Coronary Heart Disease, and the NHS Cancer Plan include health promotion activities which older people should have access to on the basis of need.
Pharmacists can contribute towards disease prevention and helping older people to remain independent by providing advice on many issues, for example:

- smoking cessation
- improved diet and nutrition
- increasing physical activity
- immunisation against influenza
- independent living aids
- management of incontinence
- access to other services - chiropody, opticians, benefits.

A checklist of potential services is included as Appendix 4. This includes those relating to the prevention of ill health and promotion of independence.

**Medication Review**

Medication review for patients over 75 years forms a specific target within the NSF. All patients in this age group should have their medication reviewed at least annually, and those receiving four or more medicine should be reviewed every six months. The date for the achievement of this target is April 2002, making it one of the early milestones in the NSF.

Periodic review of a patient’s medication regime should form part of any repeat medication system, and is a requirement of the Sustained Quality Allowance available to general practices. However a large study of repeat prescribing found that 72% of repeat drugs showed no evidence of having been reviewed by a doctor during the previous 15 months, with unauthorised repeat prescriptions, poor compliance checks, and inadequate systems for identifying patients in need of medication review commonplace.

The aim of medication review services should be to improve the quality of prescribing, improve the patient’s health and avoid inappropriate or unnecessary drug expenditure.

An in-depth review of a patient’s medication can be carried out either within the surgery – with access to the patients’ medical records; or from the pharmacy - working solely from repeat prescription and PMR data. It is important to also know about non-prescription medication that the patient is taking.

A number of research projects, including some funded by the Department of Health, have looked at both formats. These studies showed that where the pharmacist worked actively with the practice recommendations were implemented in between 50% and 96% of cases. However where feedback to the practice was of a passive written nature the implementation rate was much lower – at about 20%. The studies showed that medication review services were generally well received by both patients and GPs and that a number of models can be successful.
Medication Review Clinics
An effective way to improve repeat prescribing is to establish a medication review clinic within the practice. Selected patients are given an appointment to attend which provides the opportunity to discuss their medication in depth. Structure to the interview can be provided by use of a checklist or proforma.

A study involving nearly 1200 patients aged 65 and over who were receiving at least one repeat prescription found that a clinical pharmacist can conduct effective consultations with older patients in general practice to review their drugs. These reviews resulted in significant changes to patients’ drugs and saved more than the cost of the intervention without increasing the workload of the general practitioners. 50

Brown Bag Review
Brown Bag reviews are a variation on the theme of medication review clinics where the patient is asked to bring all the medication that they have at home with them when they attend the appointment. This provides the opportunity to clarify what the patient is actually taking, what is no longer required and to help prevent future problems or wastage, by talking to the patient about their medication. Unlike medication reviews based on data taken from surgery or pharmacy records this type of scheme provides the pharmacist with the opportunity to comment on OTC medication.

Although originally established in the USA, a pilot study in Bexley and Greenwich, involving 205 volunteer patients in 23 pharmacies, demonstrated that such schemes can successfully contribute to patients’ welfare and reduce health costs. 51,52

Who to target
This type of service can be particularly appropriate for patients who are receiving more than four medicines, as polypharmacy leads to an increased risk of side effects and adverse drug reactions. One study of older patients who were admitted to hospital found that 28% were attributable to non-compliance or adverse drug reactions. 53 Receiving four or more medicines is also a risk factor for re-admission for older patients discharged from hospital. 54,55

Patients who have suffered an adverse change in health, such as dizzy spells, falls or confusion should be reviewed to determine whether their medication has contributed to the problem. Polypharmacy often develops incrementally over time and studies have shown that pharmacist-conducted medication reviews can identify and resolve the resultant problems with the GP. 56,57,58

A hospital admission frequently leads to medication changes - however these may not be maintained post-discharge. The patient or GP practice may unintentionally restart medication that has been stopped whilst in hospital, or duplication may occur when medication is prescribed by both its generic and branded name by different prescribers. One study found that sending a copy of the discharge summary to the patient’s community pharmacist as well as GP reduced the number of discrepancies by half. 34
Residents of **residential and nursing homes** in particular are often taking many medicines and PCOs and/or practices with high numbers of care home patients may be particularly interested in the review and rationalisation of prescribing for them. Review of medication along with implementing efficient systems of supply can generate significant savings, reduce workload and reduce wastage.\(^{59,60,61,62}\)

**How to go about it**

Once you have gained agreement and funding to develop a medication review service, you will need to agree how patients will be selected. You may target patients on the basis of the number of medicines they are taking, or within a specific therapeutic area - patients with type 2 diabetes, coronary heart disease, or asthma or those relevant to particular NSF target areas - patients who have had a fall, or recovering from a stroke.

Prepare a patient profile from the computer records and/or case notes. Include relevant medical history, current and previous drug therapy, recent investigations and monitoring by the practice and secondary care as available.

For each patient consider the drug and dosage that they are taking. Assess the appropriateness of the indication and formulation, efficacy, any adverse effects or contraindications, patient knowledge of and adherence with their medication and the suitability for generic or therapeutic switching.

Develop a care plan that includes actual and potential drug-related problems. This should be drawn up considering the following factors:

- is there an indication for each drug with no unnecessary duplication?
- is there any untreated indication which may require therapy?
- is the choice of therapy appropriate for each indication?
- are there any drug interactions or contraindications?
- are therapeutic drug monitoring results up-to-date? Have they been acted upon?
- is the dose and dosing schedule appropriate based on current evidence?
- is the formulation suitable?
- does the patient know what the therapy is for and are they able to comply with the regimen? Are they over-ordering or under-ordering?
- is there evidence of efficacy?
- have side effects been recorded in the notes or reported by the patient?
- is there evidence of clinical review by the GP to confirm that therapy is still required? Are any monitoring tests required?

Make recommendations or a referral to the patient’s GP for agreement prior to implementing the changes, and agree methods for updating the patient’s records and monitoring clinical outcome.

An example of a medication review proforma is included as Appendix 5. This can be used as the starting point for developing paperwork to support your local service.
**Domiciliary Services**

Often the patients who would most benefit from a review of their medication are those who are unable to visit the surgery or pharmacy in person. Medication review can also be undertaken in the patient’s home, although this is obviously more time-consuming than surgery or pharmacy based services.

Government policy over the last decade has resulted in many more patients living as independently as possible in their own homes, or within “homely” settings in the community. The implementation of intermediate care services over the next few years will extend this concept still further.

As a result community pharmacists are increasingly coming into contact with patients who are elderly and housebound, and this patient group frequently experience difficulty managing their medicines. Many older patients receive their medication via repeat prescriptions, but find it difficult to collect their prescriptions due to limited mobility or lack of transport.

Domiciliary pharmaceutical services have been piloted in a number of areas over the last five years, including South Essex, where patients were referred by home care managers; Bradford, where patients were identified by general practitioners, district nurses, carers or from community pharmacy patient medication records; and Kirklees, where the scheme involved patients identified from patient medication records.

Visiting patients at home demands time and resources and requires the pharmacist to be able to leave the pharmacy for an extended period of time. Elderly people are often reluctant to answer the door after dark, meaning that visit times have to be carefully scheduled. Patients living alone may have few visitors and it can be difficult to keep discussions focused on the reasons for the visit, making the planning of a number of sequential visits difficult.

Pilot schemes have demonstrated that the most common types of problems identified during domiciliary visits are:

- unrelieved symptoms
- difficulty remembering the dose or timing of one or more medication
- drug related side-effects
- not knowing or understanding the purpose of a drug
- potential drug interactions
- incorrect storage of medicines

Pharmacist interventions can largely be divided into three categories: advice and help with compliance, disposal of unwanted medicines, and medication review resulting in discussions with the patient’s general practitioner about alterations to the patient’s medication regime. Controlled studies investigating the impact of domiciliary visits on the medication management of older patients have demonstrated better compliance, better drug storage practices, a reduced tendency to hoard drugs and fewer GP consultations in the intervention groups than in the control group.

A model bid for providing a domiciliary service is included as Appendix 6.
Compliance Aids

Review of a patient’s medication, either in a domiciliary or clinical setting will often identify that they are forgetting to take medicines, or taking them in an irregular fashion. If straightforward measures such as reminder charts, or simplification of the medication regime fail to resolve the problem there are a number of multi-compartment “compliance aids” available to help patients. Such systems are specifically mentioned in *Medicines and Older People* as a method of tackling the problem of patients forgetting to take their medication.

Although compliance aids are not the solution to all problems they can have value as a method of maintaining the independence of older patients who might otherwise require admission to hospital or residential care. In many cases community pharmacists are already providing this type of support to small numbers of individual patients, however few fully developed schemes exist.

Many community nurses fill medication compliance devices, an activity that causes concern regarding responsibility and accountability under their professional body guidelines and is not considered to be best practice. Most compliance aids that are purchased by patients or their carers are unsealed and difficult to label in accordance with the professional and legal requirements.

A project undertaken within Channel PCG found that 10 of the 50 patients assessed, all of whom had been referred to the project by social services, needed a Monitored Dosage System (MDS). Others benefited from counselling, simplification of medication regimens, large print labels, and different types of packaging. A study of the effects of computer generated medicines reminder charts has demonstrated that they can significantly improve patients’ compliance with and knowledge of their drug regime, and are a practical and cost effective aid to compliance.

Dispensing of patient’s medication into monitored dosage systems is more time consuming and less profitable than traditional dispensing. The introduction of patient packs has further increased the time taken to dispense into monitored dosage systems, meaning that pharmacy contractors increasingly subsidise these systems.

In order for the provision of monitored dosage systems to work efficiently commitment is required from all involved in the patient’s care, including the patient, carer, district nurse, general practitioner and community pharmacist. Before supply, an assessment should determine individual needs and an appropriate intervention be made. Where such systems are used medication administration record sheets (MARs) can be useful, particularly where multiple carers are involved.

A model bid for providing an MDS service is included as Appendix 7.

Repeat Prescribing

Repeat prescriptions account for about 75% of all prescriptions and account for an estimated 81% of prescribing costs in general practice. A review of repeat prescriptions and the controls in place for their issue can identify many opportunities for rationalising therapy, and reducing costs.
In many practices a review of repeat prescriptions requests will reveal that a large number of patients consistently re-order all items on their repeat request form, despite not needing all their medication. This can particularly arise where the repeat prescription includes a mixture of items prescribed for varying durations, “prn” items, and products prescribed by pack size, e.g. creams, liquids, nasal sprays, etc.

Prescribing support to practices can take two forms in relation to repeat prescribing – advice on a safe and appropriate repeat prescribing system, or review of some or all repeat prescriptions by a pharmacist.

**Repeat Prescribing Systems**

Simple inefficiencies in the housekeeping of a repeat prescribing system can, at best, have major implications for the practice’s drug budget, and at worst, have serious implications for patient care. Whilst repeat prescribing is convenient for patients and saves time for GPs the potential risks need to be minimised by managing the process effectively.

A large study of repeat prescribing found that 72% of repeat drugs showed no evidence of having been reviewed by a doctor during the previous 15 months, with unauthorised repeat prescriptions, poor compliance checks, and inadequate systems for identifying patients in need of medication review commonplace.44

A community pharmacist working with a practice to improve their repeat prescribing system is in the unique position of being able to provide feedback from the opposite end of the process, he/she should be familiar with the problems which arise from repeat prescriptions for both the dispenser and the patient.

**Inequivalence**

Use of the “number of days treatment” box on NHS prescription forms is now very infrequent, possibly as a result of the computerisation of the repeat prescribing process in many practices, with resulting access to detailed information about pack-sizes.

However in many cases patients receive inequivalent quantities on multiple item prescriptions forms, resulting in their medication running out at different times. One study found that inequivalent quantities were prescribed in 6.8% of repeat prescriptions - rising to 10.4% if asthma medication was included in the calculation.85 Another study estimated the cost, due to over-ordering by patients as a result of inequivalence, to be £60 million per year (at 1991/2 prices), or 2.4% of total prescribing expenditure.86

This may trigger a patient’s request for some of their medication early, ordering all of their medication at the time the earliest runs out. However there is limited benefit to be gained from great efforts to adjust twenty-eight day packs and thirty day packs, as the rules for dispensing of items in calendar packs can easily undo this work.

Much greater influence on the stock piling of medication by patients results from differing lengths of courses of treatment on repeat prescription and the frequency of their issue. Therefore in reviewing repeat prescriptions for inequivalence it is probably more important to concentrate on situations where some of the patient’s repeat medication has been issued for two or three months supply (such as HRT), or are items for occasional, or seasonal use (such as hayfever therapy) whereas the bulk of the repeat prescription is only for one months supply.87
Many practices issue counterfoils to patients on which to request their repeat medication, which usually list all the medication that the patient can request a repeat of without having to see the doctor. Sometimes patients fail to indicate which items they actually require resulting in all items being re-issued; other patients will simply request all items, not fully understanding how the repeat prescription service operates at the surgery.

**Figure 6 - Potential Stockpiling**

Example from computer records showing potential stockpiling of Prempak-C and Flixonase Nasal Spray

<table>
<thead>
<tr>
<th>Date</th>
<th>Qty</th>
<th>Preparation</th>
<th>Strength</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/08/01</td>
<td>28</td>
<td>Bendrofluazide</td>
<td>2.5mg</td>
<td>ONE to be taken daily</td>
</tr>
<tr>
<td>11/08/01</td>
<td>28</td>
<td>Atenolol</td>
<td>100mg</td>
<td>ONE to be taken daily</td>
</tr>
<tr>
<td>11/08/01</td>
<td>84</td>
<td>Prempak - C</td>
<td>1.25mg</td>
<td>ONE to be taken daily</td>
</tr>
<tr>
<td>11/08/01</td>
<td>150D</td>
<td>Flixonase Nasal Spray</td>
<td>50mcg</td>
<td>ONE spray in each nostril daily</td>
</tr>
<tr>
<td>17/07/01</td>
<td>28</td>
<td>Bendrofluazide</td>
<td>2.5mg</td>
<td>ONE to be taken daily</td>
</tr>
<tr>
<td>17/07/01</td>
<td>28</td>
<td>Atenolol</td>
<td>100mg</td>
<td>ONE to be taken daily</td>
</tr>
<tr>
<td>17/07/01</td>
<td>150D</td>
<td>Flixonase Nasal Spray</td>
<td>50mcg</td>
<td>ONE spray in each nostril daily</td>
</tr>
<tr>
<td>21/06/01</td>
<td>28</td>
<td>Bendrofluazide</td>
<td>2.5mg</td>
<td>ONE to be taken daily</td>
</tr>
<tr>
<td>21/06/01</td>
<td>28</td>
<td>Atenolol</td>
<td>100mg</td>
<td>ONE to be taken daily</td>
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<tr>
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<td>ONE spray in each nostril daily</td>
</tr>
</tbody>
</table>

There is often a misconception amongst patients that if they delete items from the counterfoil, the item will be lost to them as a repeat item forever. Every effort needs to be made to encourage patients not to order medication that they do not require, both from an economic perspective, and in order to minimise the risks of over medication due to stockpiling.

**How to go about it**

As part of your evidence for the need for medication review services, either surgery-based, pharmacy-based or of a domiciliary nature, collect examples of real patients who are over-ordering repeat medication. This does not need to be an onerous task, just make a note of patients as they crop up over a period of time, but it will add strength to your case if you can demonstrate the clinical and financial benefits that could exist. Make sure that you anonymise their details to maintain patient confidentiality.

**Unwanted Medicines**

Although there is relatively little published information relating to unused medicines that are returned to pharmacies for destruction, a number of small-scale surveys have been undertaken.88,89,90

An analysis of returned medication in Lancashire91 found that 21% were completely unused - a similar study in Buckinghamshire found this proportion to be 28%.92 Both studies found that the most commonly returned medication were central nervous system drugs. Co-proxamol, co-codamol, paracetamol, diclofenac, ibuprofen, aspirin and senna were amongst the “top ten”.

**Figure 6 - Potential Stockpiling**

Example from computer records showing potential stockpiling of Prempak-C and Flixonase Nasal Spray
In an attempt to reduce wastage from duplicated or unnecessary prescribing pharmacists in Morecambe Bay participated in an intervention study. 93 On receiving a prescription for dispensing, the pharmacists checked the contents against their PMR system to identify any items that appeared to be unnecessary repeats e.g. duplicate items, discontinued items etc. After consultation with the prescriber and/or patient, items that were not dispensed attracted a fee. During the month long study, 74 interventions were made at a saving of £1340.

**How to go about it**

A preliminary DUMP campaign could be used to establish the extent of drug wastage in your area. Most pharmacies already receive medicines for safe destruction, so it should only involve recording what you receive for a period of time, ideally with reasons for the return supplied by the patient.

**Minimising Number of Tablets**

The prescribing of many cardiovascular drugs involve the titration of dose to achieve a target blood pressure, specific reduction in cholesterol level, or symptom control in angina or heart failure. During this titration process the patient may start on a low dose and double the dose of the medication once, or maybe twice, before the desired control is achieved.

Prescribers often do this by instructing the patient to take two tablets instead of one at a point during the titration period, and that strength/dosage combination may be recorded in their repeat items. This can result in a patient remaining on several lower strength tablets when a higher strength is available. 94

Strength optimisation will reduce the number of tablets that patients are taking and improve compliance, whilst often also resulting in savings as the pricing structures of drugs is usually such that it is less expensive to prescribe one higher strength tablet that two of a lower strength.

In addition to strength optimisation situations there may also be occasions when patients who are struggling to remember to take several daily doses of a medication can be changed to either a sustained release formulation or another drug with a longer elimination profile to improve compliance. Caution should be used were medication are licensed for particular regimens when used for different indications; for example ramipiril used post MI, rather than for other indications.

**Minimising Side Effects**

Older people are particularly at risk from complications associated with prescribing, due to physiological changes with ageing that affect the body’s handling of drugs, and due to co-morbidity which can affect cognitive, physical and sensory functions.

Physiological changes can affect absorption, first-pass elimination, protein binding, distribution and elimination of drugs. Molecular and cellular changes that occur with ageing may alter the response to drugs in older people, with pharmacodynamic changes mainly due to a reduction in the homeostatic reserve or secondary to changes at specific receptor and target sites.
It is recognised that adverse drug reactions occur more frequently in older people, with ADRs implicated in up to 17% of admissions.\textsuperscript{28,29,30,95,96} It has been estimated that up to 15,000 geriatric admissions per annum in the UK are at least partly due to an ADR.

**Figure 7- Age-related pharmacokinetic and pharmacodynamic changes**

<table>
<thead>
<tr>
<th>Due to body composition</th>
<th>Due to changes in GI tract, liver &amp; kidneys</th>
<th>Pharmacodynamic changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• reduced lean body mass</td>
<td>• reduced total body fat</td>
<td>increased risk of hypotension</td>
</tr>
<tr>
<td>• reduced total water</td>
<td>• increased total body fat</td>
<td>decreased postural stability</td>
</tr>
<tr>
<td>• lower serum albumin</td>
<td>• alpha\textsubscript{1}-acid glycoprotein unchanged or slightly raised</td>
<td>impaired thermoregulation</td>
</tr>
<tr>
<td>• increased total body fat</td>
<td>• reduced liver size</td>
<td>reduced cholinergic transmission</td>
</tr>
<tr>
<td>• alpha\textsubscript{1}-acid glycoprotein unchanged or slightly raised</td>
<td>• reduced liver blood flow</td>
<td>reduced alpha\textsubscript{2}-adrenoceptor responsiveness</td>
</tr>
<tr>
<td></td>
<td>• reduced renal tubular function</td>
<td>reduced beta-adrenoceptor function</td>
</tr>
<tr>
<td></td>
<td>• increased risk of hypotension</td>
<td></td>
</tr>
</tbody>
</table>

Older people are more susceptible to ADRs for a number of reasons. They are usually on multiple drugs which in itself can account for an increased incidence of adverse reactions. However it is also recognised that reactions tend to be more severe in older patients and gastrointestinal and haematological ADRs are more common than would be expected from prescribing figures alone. Not surprisingly up to 80% of adverse reactions in older patients are dose dependent and therefore predictable.\textsuperscript{97} In older patients it is particularly important that symptomatic treatment without specific diagnosis is not routine, as side-effects will be overlooked without identifying their cause.

Drug related problems are particularly a problem for nursing home residents because of the often complicated and multiple co-morbidity that occurs in these people. A study of drug-drug interactions in nursing home residents found that during the two-year study period one-third of residents were exposed to at least one drug interaction considered clinically relevant.\textsuperscript{98}

**GP Prescribing Advice**

There is a significant role for the provision of prescribing support to PCOs and individual general practices, in order that medicines use can be managed as efficiently and as cost-effectively as possible. More and more pharmacists are undertaking roles looking at treatment priorities, prescribing policy, formulary development and involved in prescribing issues based on local Health Improvement Programmes and specific problems in their localities.

The three NSF targets which relate to specific conditions - stroke, mental health and falls all have elements which are medicines related. Prescribing support aimed at developing prescribing policy and undertaking prescribing audits in relation to these areas can clearly be linked to an organisation’s ability to deliver the requirements of the NSF.
People over the age of 60 years receive fifty-two percent of all prescriptions meaning that prescribing support of all kinds will have an impact on prescribing for older people. Detailed advice on providing prescribing support can be found in the PSNC resource pack GP Prescribing Advice - a practical guide for community pharmacists, and the NPC document GP Prescribing Support.

**Pharmacist Intervention**

**Stroke**

Two effective interventions are highlighted within the NSF to prevent stroke - the maintenance of blood pressure within specified limits and anti-thrombotic treatment in patients with atrial fibrillation.

In hypertension audits have consistently demonstrated that blood pressure is usually controlled in, at best, half those treated. It has been demonstrated that a simple intervention delivered by community pharmacists can produce positive effects on self-reported adherence to treatment and blood pressure control. Pharmacists followed a protocol of “guided questioning” relating to problems experienced by the patient with their medication, adherence, or side-effects and responded by giving verbal or written information, speaking to the patient’s GP or referring the patient to their GP. Pharmacists have an important part to play in providing information and responding to queries from patients about their antihypertensive medication.

Anti-thrombotic treatment is known to be under-used in atrial fibrillation. During an eight-week period pharmacists in South Essex worked to identify relevant patients who did not appear to be receiving either aspirin or warfarin. A prescription for digoxin was used as an indicator for atrial fibrillation and patients asked to complete a short questionnaire. Patients who were not taking aspirin and had no history of ulcer or allergy to aspirin were referred to the GP for addition of an anti-thrombotic. A similar scheme was undertaken in Bradford which identified that 31% of the patients who were prescribed digoxin were receiving neither warfarin or aspirin.

**Mental Health**

The NSF requires PCTs to have in place necessary plans so that “prescribing of antipsychotics and benzodiazepines will be monitored and reviewed within local clinical audit programmes by 2001”. Inappropriate neuroleptics’ prescribing in residential and nursing homes has been a subject of concern for some time. Community pharmacists need to be involved in both the development and delivery of those plans, actively participating in the identification of individuals whose medication required review, and providing advice and support to patients if medication is changed.

Depression in older people is often under-diagnosed, and older patients have been shown to be more likely to be prescribed a tricyclic antidepressant (TCA) than a selective serotonin reuptake inhibitor (SSRI). Where TCAs are prescribed a significant proportion of patients are prescribed an inadequate dose.

Pharmacists providing prescribing support should work to ensure that prescribing for mental health problems in older people occurs in accordance with available published guidance, and pharmacists providing advice and clinical services to care homes should be aware of the issues relating to prescribing of neuroleptics.
Falls

The NSF standard highlights polypharmacy as a risk factor for falls. Antihypertensive medication, drugs with alpha-receptor blocking effects (e.g. tricyclic antidepressants), and drugs which decrease sympathetic outflow from the CNS (e.g. benzodiazepines, antihistamines) are likely to produce hypotension. Drugs that increase postural sway (e.g. hypnotics and tranquillizers) are associated with falls in older patients, especially during the night. Dehydration in patients taking diuretics or laxatives can also contribute to falls.

Where a patient has had a fall, medication review and changes have been shown to reduce subsequent falls, as can alterations to medication regimes containing medicines known to contribute to falls. 17,108

Pharmacists in Thanet are involved in a project to reduce the incidence of falls in older people, by assessing the medication of patients identified by primary care visitors as at risk of falls. 78

General Interventions

Short-term studies in America, 109 Australia, 110,111 Canada, 112 New Zealand 113 and South Africa 114 have demonstrated the potential value of clinical pharmacy interventions made at the time of dispensing by a community pharmacist contacting the prescriber. A long-term multicentre study undertaken in the UK found an overall incidence of 75 interventions per 10,000 prescribed items, with approximately 1 intervention per 100,000 prescribed items judged by a multidisciplinary panel to have prevented a hospital admission. 115

Schemes have successfully been piloted involving a pharmacist intervention occurring in response to a prescription presented for dispensing by a patient. A scheme in Sheffield concentrated on three potential interventions - strength optimisation, generic substitution and excessive quantities and was designed to influence the next prescription to be written for the patient, rather than the one being presented which initiated the intervention. 116
Figure 8 - Potential Interventions (Cotswold PCG scheme)

<table>
<thead>
<tr>
<th>Quality interventions</th>
<th>Cost interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• dose / drug inappropriate based on clinical evidence e.g., Bendrofluazide 5mg</td>
<td>• prescribing by brand name where generic appropriate</td>
</tr>
<tr>
<td>• too frequent repeats</td>
<td>• dose / strength optimisation</td>
</tr>
<tr>
<td>• PPIs at treatment dose for more than 2 months</td>
<td>• erroneously duplicated prescriptions</td>
</tr>
<tr>
<td>• excessive quantities for 5HT antagonists for migraine</td>
<td>• items available OTC at less than prescription charge</td>
</tr>
<tr>
<td>• excessive quantities for analgesics</td>
<td>• streamlining of quantities to 28/56 days</td>
</tr>
<tr>
<td>• over-use of β-agonist for asthma</td>
<td>• discontinued repeat</td>
</tr>
<tr>
<td>• under-use of steroid for asthma</td>
<td>• excessive quantities of dressings</td>
</tr>
<tr>
<td>• items of limited clinical value</td>
<td>• excessive quantities of “sip feeds”</td>
</tr>
<tr>
<td>• expensive delivery systems eg patches, M/R formulation</td>
<td>• prn laxative or painkillers</td>
</tr>
<tr>
<td>• combination products eg co-amilofruse</td>
<td>• 28 day prescription for any new item</td>
</tr>
<tr>
<td>• over-use of prn nitrates in angina</td>
<td>• MDS prescription for more than 7 days</td>
</tr>
<tr>
<td>• drug interaction</td>
<td></td>
</tr>
<tr>
<td>• ensure low dose aspirin in IHD</td>
<td></td>
</tr>
<tr>
<td>• review any Rx with more than 5 items</td>
<td></td>
</tr>
<tr>
<td>• where patient has not had review in 12 months</td>
<td></td>
</tr>
<tr>
<td>• generic prescribing of m/r preps, lithium, theophylline, HRT, OCs</td>
<td></td>
</tr>
</tbody>
</table>

* interventions which will probably require discussion with the prescriber

A much more complex scheme operated by Cotswold PCG involved pharmacists either initiating a change to a prescription within an agreed protocol for substitution / intervention or contacting the prescriber to discuss an intervention in relation to the prescription.  

Intermediate Care

*The NHS Plan* set out a major new programme to promote independence for older people, through developing a range of services that are delivered in partnership between primary and secondary health care, local government services, in particular social care, and the independent sector. One of the critical elements in this programme is to develop new intermediate care services that ensure active recovery and rehabilitation and prevent unnecessary loss of independence for older people and other care groups.

To develop and implement intermediate care services £150 million was made available to Health Authorities on a recurrent basis in 2001/02. Intermediate care services are regarded as those which meet all the following criteria:

- are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care or continuing NHS in-patient care

- are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery

- have a planned outcome of maximising independence and typically enabling patient/users to resume living at home
- are time-limited, normally no longer than six weeks and frequently as little as 1-2 weeks or less

- involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

These services can be provided via a number of service models including: “hospital-at-home”, supported discharge at home and residential or day-care intermediate care centres.

Intermediate care providers will need to assess and meet the medicines-related needs of older people in rehabilitation services. Community pharmacists will need to be involved in medication review, supply of medicines and ensuring the safe, effective and appropriate use of medicines as part of a multi-disciplinary patient-centred team.

If intermediate care services are to be developed on an intermediate care centre model, community pharmacists should take the opportunity to tender for pharmaceutical advice and the supply of medicines building on their experiences with residential and nursing homes.

Where home-based intermediate care services are to be developed, domiciliary pharmaceutical services could form part of the package of care for individual patients. In both cases community pharmacists could provide education and training of carers and support staff.

**How to go about it**

Find out who the Intermediate Care Project Manager is within your local PCT or NHS Trust and take the opportunity to promote the contribution that pharmacy will need to make for intermediate care services to be successful. Three basic questions need to be asked:

(i) Why is the patient in Intermediate Care?

(ii) What is being done for them?

(iii) Are they getting better?

These questions are relevant for community pharmacy to ask, to inform their understanding of the individual’s needs and enable them to provide appropriate levels of support or services.

**Clinical Governance**

The Government is committed to improving quality throughout the NHS and set out its strategy in *A First Class Service: Quality in the new NHS*.118

“Clinical governance can be defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”
The principles of clinical governance mean that all professionals working in primary care need to address the quality of the services that they provide and clinical governance must extend to all NHS services including community pharmacy. Practical guidance for primary care teams has been produced,\textsuperscript{119,120} and the Department of Health has recently issued \textit{Clinical Governance in Community Pharmacy}\textsuperscript{121} which aims to facilitate the integration of community pharmacy into local multidisciplinary frameworks and wider clinical governance plans.

**Medicines Management Issues**

Various studies have recorded the incidence of prescription items prescribed without exact dosing instructions.\textsuperscript{85,122,123,124} These have found between 20\%\textsuperscript{122} and 38\%\textsuperscript{85} of items prescribed with the instruction “as directed” or “when required” and 8\% of items prescribed with no directions at all.\textsuperscript{124}

Rationales cited by prescribers for these types of instructions include: when the patient has a history of compliance with the regime being prescribed; when the prescription is accompanied by verbal or auxiliary written instructions and when the prescriber may need to make frequent changes in a regime and wishes to communicate these changes orally.\textsuperscript{123} However there are clearly risk management and clinical governance issues associated with providing such instructions to patients.

It has also been shown that intended dosing regimes are frequently misunderstood when the prescriber writes prescriptions in hourly intervals. Prescription labels that state the number of times a day a medication is to be taken promote better patient compliance.\textsuperscript{126,127}

The Chief Medical Officer’s report \textit{An Organisation with a Memory}\textsuperscript{128} set a target to reduce the frequency of serious medication errors by 40\% by 2005. Failure to give proper advice to patients about the administration of their medication could contribute to medication errors. It is therefore important that community pharmacists and GPs work collaboratively to ensure that older peoples’ medication is not labelled “as directed” except in the case of very complex dosing schedules where other instructions, accompanied by oral explanation, are required.

**Multidisciplinary Working**

Translating the national standards of the NSF into new and better services for older people will require the development of a shared vision and strong partnership working.

The Government’s focus on partnerships and collaborative working has already been demonstrated through the statutory Duty of Partnership placed on health authorities and local councils by the 1999 Health Act, and the Concordat between the NHS and the Independent Healthcare Association. Partnership working at a local level is facilitated through the development of Health Improvement and Modernisation Plans (HIMPs) and links with Local Strategic Partnerships (LSPs).
Community pharmacists will need to link into the development of local HIMPs, NSF implementation groups, clinical governance frameworks, and other relevant bodies if they are to be successful in assisting with the achievement of the NSF targets for older people. At an individual level they will need to work collaboratively and co-operatively with local general practitioners and their teams, and other community-based staff such as district nurses, and therapists. The ultimate goal for all health professionals has to be to achieve better outcomes for patients, whilst benefits for all involved can include a better shared understanding of what each professional can contribute.

One example of structured multidisciplinary working is the use of integrated care pathways.

**Integrated Care Pathways**

As evidence grows that the evidence-based guidelines can be effective in improving patient care, the focus is increasingly shifting towards how to encourage the use of guidelines throughout clinical practice. Integrated care pathways, also known as co-ordinated care pathways, care maps, anticipated recovery pathways, and integrated care plans, represent one such mechanism.

Integrated care pathways (ICPs) are structured multidisciplinary, task orientated care plans which detail essential steps in the care of patients with a specific clinical problem, and describe the patient’s expected clinical course. They describe the tasks to be carried out together with the timing and sequence of these tasks and the discipline involved in completing the task.

Ideally the ICP should consist of a single multidisciplinary record which is part of the patient’s record sheet which combines the medical notes with the care plan of nursing staff and other allied health professionals, providing a checklist of all actions and investigations and indication of patient’s expected condition at various stages.

Ideally all health staff that provide care to the patient should be encouraged to follow the integrated care pathway and complete the ICP documentation. This will facilitate multidisciplinary discussion, reduces variation in treatment and improves patient information and encourages involvement.

Most of the integrated care pathways currently in use in the UK relate to specific medical conditions (e.g. deep vein thrombosis) or surgical procedures (e.g. cardiac catheterisation). However the Care Pathways Database now lists more than 2000 care pathways that are under development within the NHS, including ICPs relevant to the implementation of the NSF for Older People including: stroke treatment and prevention; prevention of falls, care of the elderly, and treatment of older people with depression.

An example of an integrated care pathway is included as Appendix 8

Undoubtedly issues relating to the management of medicines in relation to older people will become the subject of integrated care pathways in the future. Until then multidisciplinary working will be essential if the aims of the NSF for Older People are to be achieved, and older people given the chance to gain the maximum benefit from their medication.

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1. Developed by the Royal College of Nursing (RCN) and National Pathways Association (NPA) and accessible via the National electronic Library for Health website (NeLH).
Appendices

Appendix 1

Number of prescriptions per head of population by broad age group

<table>
<thead>
<tr>
<th>Year</th>
<th>Prescriptions dispensed by community pharmacists and appliance contractors only</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children aged 0 - 15 years</td>
<td>Others aged 16 - 59/64 years</td>
</tr>
<tr>
<td>1989</td>
<td>4.2</td>
<td>5.6</td>
</tr>
<tr>
<td>1990</td>
<td>4.2</td>
<td>5.7</td>
</tr>
<tr>
<td>1991</td>
<td>4.3</td>
<td>5.7</td>
</tr>
<tr>
<td>1992</td>
<td>4.4</td>
<td>5.9</td>
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<tr>
<td>1993</td>
<td>4.8</td>
<td>6.1</td>
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<tr>
<td>1994</td>
<td>4.7</td>
<td>6.1</td>
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<td>1995</td>
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<td>1996</td>
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<td>6.1</td>
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<td>1997</td>
<td>4.9</td>
<td>6.2</td>
</tr>
<tr>
<td>1998</td>
<td>4.9</td>
<td>6.4</td>
</tr>
<tr>
<td>1999</td>
<td>4.3</td>
<td>6.3</td>
</tr>
</tbody>
</table>

Notes:

1. From 1989 to 1994 “elderly people” includes men aged 65 years and over and women aged 60 and over. From 20 October 1995 “elderly people” includes men and women aged 60 years and over.

2. From 1996 “others” covers persons aged 16 to 59; prior to this men aged 60 - 64 are included.

3. 1989 and 1990 prescription data are based on fees; 1991 to 1999 prescription data are based on items.
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<tr>
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<th>June 2001</th>
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<th>October 2001</th>
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<tr>
<td></td>
<td>Local arrangements for implementing the NSF are established</td>
<td>Jointly appointed co-ordinators for intermediate care designated, framework for user/carer involvement agreed, baseline exercise complete</td>
<td>Audits of all age related policies complete</td>
</tr>
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<td></td>
<td>Jointly appointed co-ordinators for intermediate care designated, framework for user/carer involvement agreed, baseline exercise complete</td>
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<td>October 2001</td>
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<tr>
<td></td>
<td></td>
<td>Audits of all age related policies complete</td>
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<td></td>
<td>Monthly 2001</td>
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<td></td>
<td>Intermediate care joint investment plan is agreed</td>
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<td></td>
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<tr>
<td></td>
<td>March 2002</td>
<td>1500 additional intermediate care beds compared with 1999/2000 baseline</td>
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<tr>
<td></td>
<td></td>
<td>40,000 additional people receiving intermediate care services promoting rehabilitation compared with 1999/2000 baseline</td>
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<tr>
<td></td>
<td></td>
<td>20,000 additional people receiving intermediate care preventing unnecessary hospital admission compared with 1999/2000 baseline</td>
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<td></td>
</tr>
<tr>
<td>April 2002</td>
<td>Strategic and operational plans will include initial action to address identified age discrimination</td>
<td>Councils will have reviewed their eligibility criteria for adult care to ensure they do not discriminate against older people</td>
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<td></td>
<td>Single assessment process will be introduced</td>
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<td></td>
<td></td>
<td>Information provided to older people is reviewed and action plans developed to correct shortcomings - reflecting in Better Care Higher Standards charters</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Specialist multidisciplinary teams will be identified and interfaces for care of older people throughout hospitals will be agreed</td>
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<tr>
<td></td>
<td></td>
<td>Structures identifying nursing leaders with responsibility for older people with have been developed. Specialist/Nurse Consultants, and Clinical Leaders (Modern Matrons) will have been considered</td>
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<tr>
<td></td>
<td></td>
<td>Every general hospital, which carers for people with stroke, will have plans to introduce a specialised stroke unit from 2004</td>
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<tr>
<td></td>
<td></td>
<td>People over 75 will have an annual review of medicines and those with four or more medicines will be reviewed 6 monthly</td>
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<td></td>
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<td>All hospitals will have a “one-stop dispensing/dispensing for discharge” scheme</td>
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<tr>
<td>October 2002</td>
<td>Analysis of levels and patterns of key interventions rates will have been carried out to help establish best practice benchmarks.</td>
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</tr>
<tr>
<td>April 2003 to March 2004</td>
<td>From 2003/04 local health systems can demonstrate year on year improvements in moving towards benchmarked intervention rates</td>
<td>Systems exploring user/carer experience will be in place in NHS and PSS organisations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Systems exploring user/carer experience will be in place in NHS and PSS organisations</td>
<td>NHS organisations will have systems in place to analyse complaints from older people and carers</td>
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<td></td>
<td>Strategic and operations plans will include the development of an integrated continence service</td>
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<td></td>
<td>Skills profiles of staff who care for older people in general hospitals will be completed. Plans to address identified gaps will be completed.</td>
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<td></td>
<td>Hospitals caring for people with stroke will have established clinical audit systems to ensure delivery of RCP clinical guidelines for stroke care</td>
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<tr>
<td></td>
<td>Risk management procedures will be in place in all providers of health and social care to reduce risk of older people falling</td>
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<tr>
<td></td>
<td>Local health systems will demonstrate year on year improvement in measures of health and well being of older people</td>
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<tr>
<td></td>
<td>Strategic and operational plans will include a programme to promote healthy aging and to prevent disease in older people</td>
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<td></td>
</tr>
<tr>
<td>Timescale</td>
<td>Milestones</td>
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<td>-----------</td>
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</tbody>
</table>
| **March 2004** | • 5000 additional intermediate care beds and 1700 non-residential intermediate care places compared with 1999/2000 baseline  
• 150,000 additional people receiving intermediate care services that promote rehabilitation compared with 1999/2000 baseline  
• 70,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared with 1999/2000 baselines  |
| **April 2004** | • Systems to explore user and carer experience in PCTs to be in place  
• Single integrated community equipment services will be in place  
• Integrated continence services will be in place across all health and social care systems  
• GP practices, using agreed protocols, will be identifying, treating and managing patients at risk of stroke  
• GP practices, using agreed protocols, will be identifying and treating people who have had a stroke  
• GP practices will be using agreed protocols for rapid referral of patients with TIAs to local specialist services  
• GP practices will have established clinical audit systems for stroke  
• 100% of all general hospitals caring for people with stroke will have a specialist stroke service  
• Strategic and operational plans will include the development of an integrated falls service  
• Strategic and operational plans will include the development of an integrated mental health service for older people  
• GP practices, using agreed protocols, will be diagnosing, treating and caring for older people with depression on dementia  
• Protocols are in place across health and social care systems for the care and management of older people with mental health problems  
• PCG/Ts will have schemes in place so that older people get more help from pharmacists in using their medicines  
• All health and social care systems will have established an integrated falls service. |
| **April 2005** | |


The Domains of the Single Assessment Process

User’s perspective
- needs and issues in the user’s own words
- users expectations, strengths, abilities and motivation

Clinical Background
- history of medication conditions and diagnoses
- history of falls
- medication use and ability to self-medicate
- disease prevention
- history of blood pressure monitoring
- nutrition, diet and fluids
- vaccination history
- drinking and smoking history
- exercise pattern
- history of cervical and breast screening

Personal care and physical well being
- personal hygiene, including washing, bathing, toileting and grooming
- dressing
- pain
- oral health
- foot-care
- tissue viability
- mobility
- continence and other aspects of elimination
- sleeping patterns

Senses
- sight
- hearing
- communication

Mental health
- cognitions and dementia, including orientations and memory
- mental health including depression, reactions to loss, and emotional difficulties

Relationships
- social contacts, relationships and involvement in leisure, hobbies, work and learning
- carer support and strength of caring arrangements, including the carer’s perspective
Safety

- abuse and neglect
- other aspects of personal safety
- public safety

Immediate environment and resources

- care of the home and managing daily tasks such as food preparation, cleaning and shopping
- housing - location, access, amenities and heating
- level and management of finances
- access to local facilities and services

The Single Assessment Process (SAP) recognises that many older people have health and social care needs, and that agencies need to work together so that assessments and subsequent planning of care are tailored to the individual patient, effective and co-ordinated, and that professional resources are used effectively. The SAP should ensure that the scale and depth of assessment is kept in proportion to older people’s needs; agencies do not duplicate each other’s assessments; and professionals contribute to assessments in the most effective way.
Checklist of Potential Services

1. PREVENTION OF ILL HEALTH
   Suggested service provision includes:

A. Health Promotion
   - trips, slips and falls - mobility, osteoporosis
   - diets - indigestion
   - exercise
   - incontinence
   - DUMP, safety of medicines
   - disability areas – aid to independence
   - CHD/stroke health promotion messages
   - smoking cessation
   - flu vaccination
   - winter pressures e.g. support and benefits
   - benzodiazepines/alcohol
   - sign posting for ‘carers’ e.g. information on where they can access specific types of care
   - targeted window campaigns (including audit)
   - signposting – liase with chiropodists
   - importance of maintaining eyesight – liase with opticians
B. Older people – friendly pharmacies
(Goes hand in hand with health promotions e.g.)

- access e.g. ramps
- seating
- big print labels and other printed materials
- communication with the hard of hearing (whilst maintaining privacy)
- collection and delivery services
- positive attitudes
- links to bereavement services

2. PROMOTING INDEPENDENCE

A. Health Promotion
as before

B. Supporting carers
- Training for carers – day centre carers/family carers/home carers
- Signposting to respite care and support services

C. Medicines Management
(consider as part of single assessment)

- Dump campaign
- Repeat dispensing systems
- Medication review
  - domiciliary
  - different types
  - full clinical compliance/concordance
  - physical ability
• Monitored Dosage Systems—
  - compliance aids
  - ensuring systems are in place to only provide MDS if suitable (may be simple review that is required)
• Discharge planning e.g. Sheffield Medical Management project
• Chronic disease management e.g. monitoring of blood pressure, HbA1c, Warfarin etc, PEFR
• Collection and delivery services

3. SUPPORTING OLDER PEOPLE DURING ILLNESS

A. Innovative ways of supplying medicines to ensure sufficient/timely supply
• Palliative care network
• TPN/chemotherapy – in community
• Prescription management, e.g. instalment dispensing repeat dispensing
• OOH’s dispensing/supply

B. Formal referral systems
• Patients become ill and need extra support, e.g. social services
• Pre-admission planning

C. Developing medicines policies for day centres and supporting staff

4. SUPPORTING TRAUMA

A. Referral to bereavement services
• Sessions available from bereavement counsellors in pharmacy
• Resuscitation equipment/artificial respiration equipment in pharmacies
• Administration of Aspirin ?
5. REHABILITATION

A. Health Promotion
as before

B. Medicines Management
as before – discharge planning

C. Disease specific rehabilitation support, e.g.
- advice on managing CHD with medication
- pain clinics – medication aspects
- group work, e.g. at day centres

6. END STAGE MANAGEMENT

A. OOH’s dispensing

B. Palliative care networks

C. TPN preparation

D. SIP feeds

E. Bereavement support
Example Medication Review Proforma

Where possible the review should be conducted as a discussion with the patient and if appropriate, carer, rather than as an interview using the proforma as a guide to ensure that the relevant areas are covered.

### Patient Details

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<table>
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<th>Other professionals</th>
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<table>
<thead>
<tr>
<th>Ethnic origin and patient’s first language</th>
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</table>

### Physical Abilities / Disabilities

This information will help you to highlight any factors that may influence the patient’s ability to comply with their medication and therefore how best you will be able to help. You may be able to complete certain section during the course of the visit so be selective with the questions that you ask.

**Mobility**
- walks without help outside the home
- requires help outside but not inside the home
- requires walking aid inside and out

**Manual dexterity**
- can open child-resistant tops
- can only open ordinary tops
- cannot grip at all
<table>
<thead>
<tr>
<th></th>
<th>no problem</th>
<th>can read large print only</th>
<th>partially sighted</th>
<th>visually impaired</th>
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<tr>
<td>Sight</td>
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<table>
<thead>
<tr>
<th></th>
<th>no problem</th>
<th>can only hear when face to face</th>
<th>problems with telephone / doorbell</th>
<th>profoundly deaf</th>
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<th>no problem</th>
<th>slightly difficult to understand</th>
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<th>no problem</th>
<th>can swallow tablets but not capsules</th>
<th>can swallow small tablets only</th>
<th>liquids only</th>
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<td>Swallowing</td>
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<table>
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<th>good</th>
<th>good long term / poor short term</th>
<th>poor short and long term</th>
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<tbody>
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<td>Understanding</td>
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### Medication

Ask the patient to show you all their medication, including prescribed medicines, OTC medicines, herbal and homeopathic remedies, and medicines swapped or shared with friends or partners.

Check whether these correspond with the medication profile in the GP records or pharmacy PMR. For each medication ask the questions A to G (at the end of these papers) and record the score.
Prescribed Medication

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<th>Dosage</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
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</table>

Other medications

<table>
<thead>
<tr>
<th>Preparation</th>
<th>What are they taking it for</th>
<th>How often is it used</th>
<th>How long have they been taking it for</th>
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Recent vaccinations or injections

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</table>
Attitude towards Medication

Try and establish how motivated the patient is to take their medication.

Do you mind taking your medicines for as long as the Dr tells you?  
Do you find taking medicines fits in well with your daily routine?  
Do people often have to remind you when to take your medicines?  
Do you feel confident about how and when you should take your medicines?

Yes  No

Storage and Disposal

How does the patient store their medication?

In a labelled identifiable container  
Protected from light  
Protected from heat  
Protected from moisture

Advice given:

How does the patient dispose of unwanted medicines?

Does not know which ones are current or discontinued  
Keeps them in case they are needed in the future  
Pours them down the sink / toilet  
Returns them to the pharmacy

Advice given:

Check the expiry dates of all medication and list any which are out of date or which you consider to be excessive. Particular attention should be made for duplication of medication from GP and hospital or generic and branded products.
Ask the patient if they would like you to remove any unwanted / out of date medicines for destruction. Make a list and get the patient to countersign for any medication removed.

**Items removed**

<table>
<thead>
<tr>
<th>Patient’s signature</th>
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</table>

**Administration Problems**

Assess the patient’s ability to administer their medication correctly, by demonstration if possible. You may need to use placebo inhalers to check technique.

<table>
<thead>
<tr>
<th>Ability demonstrated</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Advice given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of child resistant containers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of blister packs</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Use of inhalation devices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instillation of eye, ear or nose drops</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding of use of suppositories</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding of use of pessaries</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Application of external applications</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Administration of insulin</td>
<td></td>
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<tr>
<td>Use of diagnostic agents</td>
<td></td>
<td></td>
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<tr>
<td>Other techniques (please specify)</td>
<td></td>
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</tbody>
</table>

**Repeat Prescriptions**

<table>
<thead>
<tr>
<th>How are they ordered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How collected them from the surgery / pharmacy?</td>
</tr>
<tr>
<td>Who delivers them to the patient</td>
</tr>
<tr>
<td>Who administers them?</td>
</tr>
</tbody>
</table>
**Side Effects**

Has the patient mentioned or have you observed any side effects that the patient has experienced from their medication? Include social side effects that restrict the patient’s lifestyle such as wakefulness at night, excessive diuresis affecting mobility.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Potential Side Effect</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

Advice given:

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**Drug Interactions**

Give details of any drug interactions and whether they are causing problems.

- Clinically significant - demonstrable effect on patient and requires intervention
- Clinically insignificant - patient is stabilised on regime and experiences little or no clinical effect

<table>
<thead>
<tr>
<th>Interaction</th>
<th>Clinically significant</th>
<th>Clinically insignificant</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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**Monitoring Tests**

Consider whether you need to review the results from any monitoring tests, e.g. INR for patients on anticoagulants, HbA1c for diabetics, blood tests for thyroid levels, disease modifying antirheumatic drugs, digoxin, theophylline, anti-epileptic drugs.

Action taken
Summary of Visit

Approximate length of visit

Do you need to liaise with the GP or any other health or social care professional on behalf of this patient? Give details of the reason and outcome.

Have you been able to help the patients in any other ways? e.g. normal tops, large labels, medicine charts. Give details.

Is a follow up visit required? What do you intend to discuss on that occasion?
<table>
<thead>
<tr>
<th>Questions to ask about medication</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A What is the name of your medicine?</td>
<td></td>
</tr>
<tr>
<td>Does not have any idea of the name of the medicine</td>
<td>1</td>
</tr>
<tr>
<td>Unsure of the name, pronunciation would not be understood</td>
<td>2</td>
</tr>
<tr>
<td>Fairly confident, pronunciation would be understood</td>
<td>3</td>
</tr>
<tr>
<td>Confident about the name, pronunciation correct</td>
<td>4</td>
</tr>
<tr>
<td>B What dose do you take (including prn)?</td>
<td></td>
</tr>
<tr>
<td>Does not know how many to take or frequency</td>
<td>1</td>
</tr>
<tr>
<td>Knows how many to take, unsure of frequency</td>
<td>2</td>
</tr>
<tr>
<td>Does not know strength of tablets, but knows quantity and frequency</td>
<td>3</td>
</tr>
<tr>
<td>Is confident and knows strength, how many to take and frequency</td>
<td>4</td>
</tr>
<tr>
<td>C What are they used for?</td>
<td></td>
</tr>
<tr>
<td>Has no idea what they are for</td>
<td>1</td>
</tr>
<tr>
<td>Not confident, but has some knowledge on prompting</td>
<td>2</td>
</tr>
<tr>
<td>Knows lay terms, e.g. water tablets</td>
<td>3</td>
</tr>
<tr>
<td>Knows what they are and why to take them</td>
<td>4</td>
</tr>
<tr>
<td>D How long do you have to take them for?</td>
<td></td>
</tr>
<tr>
<td>No idea whether long or short term therapy</td>
<td>1</td>
</tr>
<tr>
<td>Unsure but would seek advice before running out</td>
<td>2</td>
</tr>
<tr>
<td>Knows if long or short term therapy</td>
<td>3</td>
</tr>
<tr>
<td>E What would you do if you forgot to take a dose?</td>
<td></td>
</tr>
<tr>
<td>Would act inappropriately (e.g. digoxin - take two next day)</td>
<td>1</td>
</tr>
<tr>
<td>Would seek advice from pharmacist, GP or carer</td>
<td>2</td>
</tr>
<tr>
<td>Would take appropriate action (e.g. digoxin - take one next day)</td>
<td>3</td>
</tr>
<tr>
<td>F Do you know about any possible side effects?</td>
<td></td>
</tr>
<tr>
<td>No idea of side effects or is incorrect about them</td>
<td>1</td>
</tr>
<tr>
<td>Knows some of the side effects</td>
<td>2</td>
</tr>
<tr>
<td>Knows all the important side effects</td>
<td>3</td>
</tr>
<tr>
<td>G What would you do if you were getting side effects?</td>
<td></td>
</tr>
<tr>
<td>Would act inappropriately</td>
<td>1</td>
</tr>
<tr>
<td>Would ask for advice from GP / pharmacist</td>
<td>2</td>
</tr>
</tbody>
</table>
Model Bid for Domiciliary Pharmaceutical Services

Introduction
The introduction of community care emphasised the provision of services and support required by people who are affected by problems of ageing and disability, enabling them to live as independently as possible in their own homes, or in “homely” settings in the community.

This move to treat people within the community means that the pharmacist is increasingly coming into contact with patients who are elderly and housebound, and it is this patient group who frequently experience difficulty in medicines management.

Many elderly patients are on repeat prescriptions, but find it difficulty to collect their prescriptions due to age and limited mobility. Earlier discharge from hospital has also added to the problem. There has been a rise in the number and cost of items prescribed for this patient group. It has however been recognised that certain groups of drugs such as diuretics and laxatives are inappropriately prescribed, resulting in significant adverse events which may be exacerbated by “over the counter” medicines. It has been estimated that medication problems are a major cause in at least 10% of acute geriatric admissions.

Aim
To provide pharmaceutical care through a domiciliary visiting service to identified housebound patients who are pharmaceutically “at risk”.

Objectives
• To improve the use of medicines by “at risk” patients by
  ■ improving concordance
  ■ reducing the number of adverse effects from drugs
  ■ ensuring that the minimum number of drugs for optimum treatment are prescribed
  ■ ensuring that older patients receive their medication in an appropriate form and dose with appropriate container and label
  ■ ensuring that medicines are stored correctly
To ensure appropriate training is undertaken by all participating staff

To provide information and advice to general practitioners about medicines used by identified patients

To promote a multidisciplinary approach to domiciliary patient care by encouraging close working between general practitioners, community pharmacists, hospital pharmacists and social services.

To identify and evaluate the patient benefits and cost effectiveness of a domiciliary service provided by community pharmacists

To establish the effectiveness of the programme for use as a basis for the provision of an ongoing service.

Methodology
Pharmaceutically “at risk” patients will be identified by community pharmacists, or by general practitioners, hospital pharmacists at discharge, or social services to a community pharmacist.

An initial domiciliary visit will be arranged by the community pharmacist with the patient to conduct an individual pharmaceutical needs assessment which will include a review of all medication used and also the patient’s ability to comply with their medication.

All information will be collated within an agreed framework and recorded for evaluation. Any recommended changes in the patient’s therapy resulting from the visit will require discussion and agreement between the pharmacist and GP. A pharmaceutical care plan will then be produced for each patient after the initial visit.

To ensure that the service is of high quality standards must be locally agreed and set, for example:

- service level agreements
- referral criteria
- accredited training for all participants
- standardised assessment protocols
- standardised documentation
- evaluation and audit
**Evaluation and Dissemination**

The evaluation of the project will include:

- patient benefit following referral by assessment of compliance and overall medicines management by patients before and after pharmaceutical input
- analysis of interventions
- cost effectiveness of review
  - potential (pharmacist recommended interventions)
  - actual (GP agreed interventions)
  - actual (reduction in medicines wastage)
- effectiveness of set standards

Additional evaluation may also include

- patient / GP / pharmacist satisfaction survey
- number of patients re-admitted to hospital due to poor compliance or iatrogenic disease

The evaluation report and summary will be presented and discussed with all participants.

**Costs**

- Set up costs
- Fees to community pharmacists for domiciliary visits
  - initial visit
  - second visit
  - third visit
- Publishing costs for documentation
- Training costs
- Administration costs including compliance aids
- Audit and report costs
References
The National Health Service and Community Care Action 1990. London HMSO


PSNC (1998) *Developing Patient Care: Medicines Management in the Community.*

Department of Health Statistics
Project Summary

Identification of “at risk” patient → referral to community pharmacist → Initial Domiciliary Visit (Pharmacist)

Recommended changes → Evaluation / Audit

Data collection → Intervention (Pharmacist/GP/carer)

Third Domiciliary Visit if necessary (Pharmacist)

Assessment → Second Domiciliary Visit (Pharmacist)

Action → Pharmaceutical Care Plan

PSNC 1999
Model Bid for Medication Compliance Aids

Introduction

It is widely acknowledged that one of the consequences of caring for people in their own home, and promoting independence for as long as possible, has been that more vulnerable people than ever are being supported by various providers and agencies. A large number of these people are taking prescribed medication with 80% of people over 75 taking at least one prescribed medicine, and 36% taking four or more medicines.

The ability to take medication as prescribed is one of the key tasks that must be supported if a person is to remain well and independent. When this task is not supported the consequences can be significant. Assessment to determine whether a compliance aid is required should be completed as part of a medication review.

Both the United Kingdom Central Council (UKCC) and the Royal Pharmaceutical Society recommend that any compliance aid, such as a monitored dose container or a daily/weekly dosing aid, should be dispensed, labelled and sealed by a pharmacist. Where a compliance aid is filled by a pharmacist, they are required to comply with standards of personnel, premises and equipment, production and procedures.

Aim

To establish an appropriate, multidisciplinary model that facilitates vulnerable people living at home, to take their medicines correctly.

Objectives

- To keep people, who have problems taking their medicines correctly, living in their own home and out of institutional care

- To enable early discharge from hospital

- To ensure that compliance aids are filled to a consistently high standard

- To ensure that all patients have equal access to this service

- To improve the medication management process by:
  - providing help and guidance on correct medication use
  - implementing a system to ensure regular medication review

- To reduce medicines waste and hoarding

- To facilitate nurses and carers in medicine administration

- To utilise the skills of both nurses and pharmacists to their most effective
Methodology
The district nursing team will take a lead role in supporting, monitoring and reviewing the medication compliance of vulnerable patients whose compliance with their prescribed medication presents a problem. Initial referrals will be made to the district nursing team linked to the patient’s general practice, and may originate from any source: i.e. GP, hospital, social services, community pharmacist, relative or carer.

Each patient admitted to the scheme will have a named district nurse and a clear written care plan that includes a timescale for reassessment and evaluation.

The community pharmacist will be responsible for:

- ensuring that all initial referrals for patients requiring support with medication compliance are directed to the district nursing team linked to the patient’s general practice.
- the selection and supply of an appropriate monitored dosage system
- considering the stability of medication in the device
- liaison with the general practice with regard to the synchronisation of repeat prescriptions
- filling, sealing and labelling of the device
- supplying Patient Information Leaflets, where appropriate
- timely liaison with relevant professionals, carers and patients in addressing any problems that arise

The general practitioner will be required to provide regular repeat prescriptions of no more than 28 days duration, and agree to provide the repeat prescriptions at least 7 days before they are due to commence. In addition all prescriptions will need to include full instruction including full clarification of “prn” doses.

To ensure that the service is of high quality standards must be locally agreed and set, for example:

- service level agreements
- referral criteria
- accredited training for all participants
- standardised assessment protocols
- standardised documentation
- evaluation and audit
Evaluation and Dissemination

The evaluation of the project will include:

- patient benefit following referral by assessment of compliance and overall medicines management by patients before and after pharmaceutical input
- analysis of interventions
- cost effectiveness of review
  - potential (pharmacist recommended interventions)
  - actual (GP agreed interventions)
  - actual (reduction in medicines wastage)
- effectiveness of set standards

Additional evaluation may also include

- patient / GP / pharmacist satisfaction survey
- number of patients re-admitted to hospital due to poor compliance or iatrogenic disease

The evaluation report and summary will be presented and discussed with all participants.

Costs

- Set up costs
- Fees to community pharmacists for filling, sealing and labelling monitored dosage systems
- Publishing costs for documentation
- Training costs
- Administration costs including compliance aids
- Audit and report costs
Referral Pathway

Problem with medication compliance identified from any source

Refer to district nursing team for medicines compliance assessment

If patient meets criteria for scheme refer to project administrator

Community Pharmacist identified?

YES

NO

Project administrator contacts community pharmacist to confirm

Project administrator liaises with assessor

Assessor to co-ordinate and review process

Liaise with community pharmacist, GP and other agencies until reassessment / discharge
**MEDICAL ASSESSMENT PRE-DISCHARGE**

Date __/__/__

Clinical findings:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Results of investigations (if required)
FBC:_________________________________________________________________________
CXR: ______________________________________________________________________
ECHO: _____________________________________________________________________
_________________________________________________________________________

Other: ______________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

DISCHARGED Y □  N □ Date of Discharge __/__/__
If no document reason and information given to family

**DISCHARGE INFORMATION**

Discharged on __/__/__
Give post catheter advice sheet to patient □
Give TTO and drug advice to patient □
Ensure patient / carer’s understanding of the above □
Address any other concerns that patient / carers have □
District nurse referral via HISS system □
OPA date given __/__/__ (see Dr’s info to ward staff) □

This record is for Cardiac Catheterisation only. If the patient remains an inpatient for any reason, a full clinical assessment must be carried out and a care plan written.

Example of a page from an integrated care pathway for cardiac catheterisation. It combines the nursing care plan with the medical notes, providing a checklist of all actions and investigations and indication of patient’s expected condition before discharge.
Information Sources

Pharmaceutical Services Negotiating Committee (PSNC)

PSNC maintain the Community Pharmacy Services Database and have a range of models bids and resource packs available on selected local pharmaceutical services.

Contact: Barbara Parsons, LPC Liaison Officer,
Pharmaceutical Services Negotiating Committee,
59 Buckingham Street, Aylesbury, Buckinghamshire, HP20 2PJ
☎ 01296 432823 E-mail: barbara.parsons@psnc.org.uk

National Prescribing Centre


Contact: The Infirmary,
70 Pembroke Place, Liverpool, L69 3GF
☎ 0151 794 8134

Royal Pharmaceutical Society of Great Britain

The Society provides a range of services from support to Pharmacy Development Groups and others wishing to develop their services to clinical governance and audit advice.

Contact: Clinical Governance and Audit Advice - Catherine Dewsbury,
Royal Pharmaceutical Society of Great Britain,
1 Lambeth High Street, London SE1 7JN
☎ 020 7735 9141 ext 2207 E-mail: cdewsbury@rpsgb.org.uk

Contact: PDG Advice - Anne Adams, Professional Development Manager,
Royal Pharmaceutical Society of Great Britain,
1 Lambeth High Street, London SE1 7JN
☎ 0115 939 6465 E-mail: aadams@rpsgb.org.uk
National Pharmaceutical Association (NPA)

The NPA NHS Service Development Department has a wide range of resources on service development and access to extensive examples of good practice. Nationwide details of current and past local projects are available along with individualised advice on relevant NHS policy and service developments.

Contact: NHS Service Development Department, National Pharmaceutical Association, Mallinson House, 38-42 St Peter’s Street, St Albans, Hertfordshire. AL1 3NP

☎ 01727 858687 ext 376 or 231   E-mail: nhs.dev@npa.co.uk

Age Concern (England)

National charity campaigning about older people’s issues.

Contact: Age Concern England, Astral House, 1268 London Road, London SW16 4ER

☎ 0208 765 7200   E-mail: infodep@ace.org.uk

Alzheimer’s Society

National charity providing information and support to patient’s, carers and health professionals relating to Alzheimer’s disease.

Contact: Alzheimer’s Society, Gordon House, 10 Greencoat Place, London SW1P 1PH

☎ 0207 7306 0606   E-mail: info@alzheimers.org.uk

Centre for Policy on Ageing

Contact: The Centre for Policy on Aging, 19-23 Ironmonger Row, London EC1V 3QP

☎ 0207 553 6500   E-mail: cpa@cpa.org.uk
Health Promotion England

*Avoiding slips, trips and broken hips* campaign to raise public and professional awareness of the risk of fall in the home to older people. Free resources available on falls prevention including leaflets and posters.

Contact: The DTI Publications Order Line, Admail 528, London SW1W 8YT

☎ 0870 150 500  E-mail: dipubs@eclogistics.co.uk

Help The Aged

National charity campaigning about older people’s issues.

Contact: Head Office, 207-221 Pentonville Road, London, N1 9UZ

☎ 0208 765 7200  E-mail: info@helptheaged.org.uk

National Osteoporosis Society

National charity providing information and support to patient’s, carers and health professionals relating to osteoporosis.

Contact: National Osteoporosis Society, Camerton, Bath BA2 0PJ

☎ 0207 7306 0606  E-mail: info@nos.org.uk

The Stroke Association

National Charity providing information on prevention of stroke, medication associated with stroke and care that stroke patients should expect. Concerned solely with stroke, the Association also provides support for people who had strokes, their families and carers.

Contact: The Stroke Association, Stroke House, Whitecross Street, London EC1Y 8JJ

☎ 0207 7566 0300  E-mail: info@stroke.org.uk
Useful Websites

Age Concern England  
Alzheimer’s Society  
Cancer Action Team  
Care Pathways Database  
Clinical Governance Support Team  
Department of Health  
- Single Assessment Process  
Health Promotion England Older People’s Programme  
Help The Aged  
National electronic Library for Health (NeLH)  
National Institute for Clinical Excellence (NICE)  
National Osteoporosis Society  
National Pathways Association (NPA)  
National Prescribing Centre  
National Primary Care Research and Development Centre (NPCRDC)  
National Service Frameworks  
NHS Beacon Programme  
Pharmaceutical Services Negotiating Committee  
Pharmacy in the Future  
Preventing Falls Website (DTI)  
Primary Care  
Research and Development  
Royal Pharmaceutical Society of Great Britain  
Royal Pharmaceutical Society of Great Britain - Audit Website  
The NHS Plan  
The Stroke Association

www.ageconcern.co.uk  
www.alzheimers.org.uk  
www.doh.gov.uk/cancer  
www.nelh.nhs.uk/carepathways.asp  
www.cgsupport.org.uk  
www.doh.gov.uk  
www.doh.gov.uk/scg/sap/index.htm  
www.hpe.org.uk/older.htm  
www.helptheaged.org.uk  
www.nelh.nhs.uk  
www.nice.org.uk  
www.nos.org.uk  
www.the-npa.org.uk  
www.npc.co.uk  
www.npcrde.man.ac.uk  
www.doh.gov.uk/nsf  
www.nhs.beacons.org.uk  
www.psnc.org.uk  
www.pharmacyinthefuture.org.uk  
www.doh.gov.uk/pharmacyfuture  
www.preventinghomefalls.gov.uk/  
www.doh.gov.uk/pricare/  
www.doh.gov.uk/research  
www.rpsgb.org.uk  
www.rpsgb.org.uk/audhome.htm  
www.doh.gov.uk/nhsplan/  
www.stroke.org.uk
Abbreviations and Glossary

Acute Services – medical and surgical treatment and care mainly provided in hospitals
Age Discrimination - action which adversely affects the older person because of their chronological age alone.
Assessment - a process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated.
Care Package - a combination of services designed to meet a person’s assessed needs
Care Planning - a process based on an assessment of an individual’s assessed need that involves determining the level and type of support to meet those needs, and the objectives and potential outcome that can be achieved.
Clinical Governance – a framework through which the NHS is accountable for continuously improving the quality of services
Community Health Services – services such as those provided by district nurses, school nurses and health visitors outside the hospital setting by health care professionals employed by NHS Trusts or PCTs.
Co-morbidity - other co-existing illness in addition to the particular illness which is currently most significant.
Day Hospital - a hospital where patients receive day care only, continuing to live at home.
Disease Management – the process of considering all the healthcare needs of a patient with a particular disease and then managing the whole process of their delivery in an efficient and cost-effective manner.
Domiciliary Care - care provided in an individual’s own home
General Medical Services (GMS) – services provided by family doctors and their staff, as defined in the General Medical Services Regulations 1992.
Health Economy - health authority and the primary care organisations, main NHS trusts, and social services department(s) that are co-terminous with it.
Health Improvement and Modernisation Programme (HIMP) - local strategic plan for the delivery of the health agenda.
Hospital and Community Health Services (HCHS) – the provision of hospital services mainly by NHS Trusts, and community health services by NHS Trusts or PCTs.
Intermediate Care - a short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long term residential care; or intensive care at home to prevent unnecessary hospital admission.
Joint Investment Plan (JIP) - service provision for a particular care group by both health and social care.
Local Health Group (LHG) - subcommittee of the health authority responsible for health services in a geographical area in Wales.
Multidisciplinary - refers to when professionals from different disciplines - such as social work, nursing, occupational therapy etc, work together.
National Institute for Clinical Excellence (NICE) - a special health authority to promote clinical and cost-effectiveness.
National Service Frameworks (NSFs) – documentation bringing together the best evidence of clinical and cost-effectiveness with the views of service users to determine the base ways of providing particular services
NHS Executive – part of the Department of Health, with offices in London and Leeds, and eight regional offices across the country. It supports Ministers and provides leadership and a range of central management functions to the NHS.
NHS Trusts – statutory bodies providing NHS hospital and community healthcare

Personal Medical Services (PMS) - alternative type of contract for the provision of general medical services.

Personal Social Services (PSS) - personal care services for vulnerable people including those with special needs because of old age or physical disability. Examples of services are residential care homes, home helps, and social workers who provide help and support for a wide range of people.

Primary Care – family health services provided by family doctors, dentists, community pharmacists, optometrists and ophthalmic medical practitioners.

Primary Care Group (PCG) - subcommittee of the health authority responsible for health services in a geographical area in England.

Primary Care Investment Plan (PCIP) - current and planned resource use and service development by a PCO.

Primary Care Organisation (PCO) - generic term used to described PCGs, LHGs and PCTs.

Primary Care Trust (PCT) - free-standing statutory trust responsible for health services in a geographical area in England.

PRODIGY - Prescribing Rationally with Decision-support In General Practice Study. A decision support system

Secondary Care – specialist care, typically provided in a hospital setting or following a referral from a primary or community health professional.

Service and Financial Framework (SaFF) - planned resource usage and activity at HA level.

Social Care – personal care services provided by local authorities for vulnerable people, including those with special needs because of old age or physical or mental disability, and children in need of care or protection. Examples include residential care homes, home help and home care services etc.

Special Health Authorities – health authorities with a unique national or supra-regional function which cannot be undertaken by other kinds of NHS bodies (for example the Prescription Pricing Authority, NICE).
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