Goodbye to Donna

Donna Glossop has now left the Care Homes Support Team to return to her substantive post at the Northern General Hospital.

We would like to thank her for all her hard work with the team, in particular her work around Dignity, and wish her all the best for the future.

Coming Soon!

Sheffield Food Policy for Nursing and Residential Homes

Food and water are essential for life. Good nutrition, hydration and enjoyable mealtimes can dramatically improve the health and well-being of older people. When someone is unwell they need to eat the right food, in the right amounts, at the right time in order to get better. Despite this being announced or printed almost every week, there are still serious concerns about nutritional care in health and social care sectors.

There are a number of outcome frameworks from the NHS, Public Health and Adult Social Care which have a focus on enhancing quality of life and helping people recover from episodes of ill health, and good nutritional care for our residents will ensure favourable outcome measures within these frameworks. With this in mind a Sheffield Food Policy for Nursing and Residential Homes was conceived! The draft version has now been out to consultation and for those who attended the Best Practice Group meeting on 14th August the draft policy was shared.

The Care Homes Support Team fax number has changed to 0114 3051952

Continued on page 2 ..................
So let me give you a taster of the content of this policy. There are 11 standards, each supported with a process and outcome. An example would be:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Process</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| 100% of residents are nutritionally screened using the malnutrition universal screening tool (MUST) within 48 – 72 hours of admission to the care/nursing home (1) | 100% of residents should have a completed nutritional screen which is documented, dated, signed and includes:  
- current weight (kg)  
- height (m)  
- body mass index (BMI)  
- BMI score  
- previous weight from 3 – 6 months ago  
- % weight loss score  
- acute disease score  
- total MUST score | 100% of residents are identified with a level of risk of malnutrition from the total MUST score as below: |
| | | | Must score | Risk of malnutrition |
| | | | 0 | Low risk |
| | | | 1 | Medium risk |
| | | | 2 or more | High risk |

The table below gives all of the standards. It is hoped to have this policy adopted to implement the policy from April 2014. Please do not hesitate in contacting me, on my email address, if you have any comments on this proposed policy at Chris.rudd@nhs.net.

The proposed food policy standard

100% of residents are nutritionally screened using the malnutrition universal screening tool (MUST) within 48 – 72 hours of admission to the care/nursing home.

100% of staff completing the MUST are trained to understand the rationale for nutritional screening and can show competence to complete steps 1 – 4 of the MUST.

The care/nursing home has appropriate equipment and tools so that measurements of the MUST steps 1 – 4 for the residents can be taken safely and accurately.

100% of staff completing the MUST are trained to understand the rationale of nutritional care planning (NCP) and can show competence to complete step 5 of the MUST.
The resident’s food and drink likes and dislikes should be documented and shared with relevant staff who produce and deliver residents food and drink.

<table>
<thead>
<tr>
<th>Resident’s food dislikes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resident’s name</strong></td>
<td>Molly Miles</td>
</tr>
<tr>
<td><strong>Diet</strong></td>
<td>Normal</td>
</tr>
<tr>
<td><strong>Breakfast</strong></td>
<td>No cereals</td>
</tr>
<tr>
<td><strong>Lunch</strong></td>
<td>No carrots</td>
</tr>
<tr>
<td><strong>Tea time</strong></td>
<td>No white bread, sandwiches, no whips/mousses</td>
</tr>
<tr>
<td><strong>Snacks</strong></td>
<td>No cream filled biscuits</td>
</tr>
</tbody>
</table>

If concerns of a resident’s reduced food and drink intake have been observed or the resident has been identified as being at risk of malnutrition with MUST, their food and drink intake should be monitored.

A resident’s nutritional care plan should be devised after completion of the MUST and then implemented.

Food provided by a care home should be nutritionally balanced and supports health and well-being.

Implement the National Association of Care Catering (NACC) nutritional recommendations for older people as part of the residents’ food and drink provision.

Each care home should have a written menu which is changed at least twice a year to meet seasonal variations.

All food and drinks are safely prepared, cooked and served to residents.

Chris Rudd, Dietetic Advisor, MMT
West and South Yorkshire and Bassetlaw Commissioning Support Unit
PINK CARDS FOR USE WITH T34 SYRINGE DRIVERS

You should be aware that there has been a change to the syringe drivers to the T34. For a short period of time to coincide with this the Pink Cards have changed and will be yellow instead of pink. They are exactly the same form as before and will at some point in the future revert back to pink.

Macmillan Facilitator for Care Homes Role

Hi my name is Emma Westerdale and for those of you who have not heard about me I would like to explain my role within care homes.

I am funded by Macmillan and hosted at St Luke’s Hospice. It is a role that works collaboratively with the Clinical Commissioning Group, Specialist Palliative Care Nurses, GP practices and the Care Homes Support Team.

The main aims of the role are:
- To support care homes to undertake comprehensive advanced care planning and end of life care documentation
- Empowering staff to communicate with GPs, other health and social care professionals, residents and relatives in all issues surrounding End of Life Care
- Aim to reduce inappropriate hospital admissions by supporting staff to care for residents with palliative care needs within the care home environment.

I run several teaching sessions that are accessible to be run in-house at individual care homes. These include:
‘An introduction to Palliative Care’ – a session that provides an overview of defining palliative end of life care, recognising deterioration, coordinating care and advanced care planning.
‘Holistic Assessment and Symptom Management in Palliative Care’ – a study of the aspects of holistic care, total pain and the management of common symptoms in end of life care.
‘Advanced Care Planning’ – a more in-depth look at documentation, specifically Preferred Priorities of Care, DNACPR, medical care plans and end of life documentation. This is an opportunity for care home staff to discuss any difficulties they encounter when care planning for a resident with palliative or end of life care needs.

I have also run several reflection sessions – also known as 'after death analysis' these sessions provide staff an open forum to discuss any issues or difficulties they may have faced in the event of a resident dying.

My contact details are:
Emma Westerdale
Macmillan Facilitator for Care Homes
St Luke’s Hospice
0114 2357609
e.westerdale@hospicesheffield.co.uk
UK Dementia Congress

The Care Homes Support Team will be well represented at the 8th UK Dementia Congress this year, which takes place in Nottingham on the 5-7th November. It is an annual event organised by the Journal of Dementia Care.

Our evaluation of the Dementia Forum and the Dementia Champion Programmes has been accepted as a poster presentation and will be on display throughout the conference. Steve and I will be there to talk to people about our service and learn what is happening elsewhere in the UK.

The conference also hosts the National Dementia Care Awards and Told in South Yorkshire: life story work and people living with dementia advisory group are finalists in the 2013 Ken Holt Memorial Award. We will find out if we have won at an Awards Presentation Dinner on 6th November and will share our news with you soon. Further information about Told in South Yorkshire can be found at www.toldinsouthyorkshire.co.uk

Michelle Wattam
RMN Care Homes Support Team
Link Worker Groups
We have recently been asking attendees for their thoughts on the Link Worker Groups they attend. Here are some of their responses:

Dementia Forum

“Really enjoy the meetings and look forward to learning, refreshing and taking ideas to put into practice”

“I find the forum very informative and think information we receive is usually of a very good quality!”

“Always full of information, can never know enough about dementia”

“Thank you for a lovely session!”

Activity Support Group

“All the meetings I have attended have been very useful. I have taken a lot away from each meeting”.

“All have been useful, as a fairly new activity worker I have found them very useful”.

“Only been able to attend a couple of meetings this year but have valued the support and ideas”.

“All of the courses have been useful!”

The Care Homes Support Team and NHS Health Education Yorkshire and the Humber

NHS Health Education Yorkshire and The Humber aim to ensure the development and support of effective, quality assured clinical skills and simulation education, training and implementation through a quality assurance management system. The quality framework is designed to be used by training providers as a tool to demonstrate evidence of compliance. Training providers are scrutinised and ratified by the Yorkshire and Humber Local Education Training Board with quality assurance status being awarded to training providers achieving the set standards.

Earlier this year the Care Homes Support Team went through this process and have met the audit requirements set and approved by the executive committee. You may come across our brightly covered certificates at one of our training sessions!
Drugs are just one of many factors that can increase the risk of falling. Elderly patients react differently to drugs and may have increased sensitivity to some medication. NICE updated the guidance on falls prevention last June, (clinical guidance 161 – Falls: Assessment and prevention of falls in older people, June 2013), and not surprisingly medication is a potential risk addressed.

**But which drugs can increase the risk of falls?**

In theory ANY drug that causes one of the following effects can increase the risk of falling:

- Drowsiness
- Dizziness
- Hypotension (Low blood pressure)
- Parkinsonian effects (shuffling walking pattern)
- Ataxia/gait disturbance (unsteady walking pattern)
- Vision disturbance

As well, ANY drug that causes the following effects can increase the risk of a serious outcome if an individual falls:

- Fracture Risk: Osteoporosis or reduced bone mineral density.
- Bleeding risk: Increased risk of a cerebral haemorrhage if a fall occurs.

**What can be done if your resident is taking a drug that can increase their falls risk?**

- Assessing compliance; are they taking the medication correctly?
- Correct administration; are they being given the medication correctly?
- Medication Review; is the medication still needed? Are there side effects?
- Prescribing of safer alternatives; can falls risk be reduced?

See Tables I, II & III on the next pages for a list of drugs that carry a high risk of falls & potential injuries.

**Reference: Based on WAM Falls in Elderly Steering Group**
### Table I – Drugs that carry a High risk of falls

<table>
<thead>
<tr>
<th>Drug Group</th>
<th>Examples</th>
<th>How they contribute to falls</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antidepressants</strong></td>
<td>amitriptyline, citalopram, clomipramine, dosulepin, doxepin, duloxetine, fluoxetine, fluvoxamine, imipramine, lofepramine, maprotiline, mirtazepine, paroxetine, sertraline, venlafaxine, trazodone, trimipramine</td>
<td>Sedation, blurred vision</td>
</tr>
<tr>
<td><strong>Anti-muscarinic drugs (anti-cholinergics)</strong></td>
<td>benzhexol, orphenadrine, oxybutynin, procyclidine, tolterodine</td>
<td>may cause acute confusion in the elderly, especially those with pre-existing cognitive impairment</td>
</tr>
<tr>
<td><strong>Antipsychotics</strong></td>
<td>amisulpiride, aripiprazole, chlorpromazine, clozapine, haloperidol, sulpiride, olanzapine, quetiapine, risperidone, trifluoperazine, Zoetpine</td>
<td>Prochlorperazine is frequently prescribed for dizziness due to postural instability and the most frequently implicated drug in causing drug-induced Parkinson’s disease.</td>
</tr>
<tr>
<td><strong>Benzodiazepines &amp; Hypnotics</strong></td>
<td>chlordiazepoxide, diazepam, lorazepam, midazolam, nitrazepam, oxazepam, nitrazepam, temazepam, triazolam, zolpidem, zopiclone</td>
<td>May cause hangover effects next morning. May cause unsteadiness if getting up in the night.</td>
</tr>
<tr>
<td><strong>Dopaminergic drugs</strong></td>
<td>amantadine, bromocriptine, levodopa, lysuride, pergolide, selegline</td>
<td>Sudden excessive daytime sleepiness can occur with levodopa and other dopamine boosting drugs</td>
</tr>
</tbody>
</table>

### Table II – Drugs that carry a moderate risk of falls

<table>
<thead>
<tr>
<th>Drug Group</th>
<th>Examples</th>
<th>How they contribute to falls</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACE Inhibitors /angiotensin II antagonists</strong></td>
<td>captopril., enalapril, lisinopril, ramipril, perindopril, quinapril, fosinopril, trandolapril losartan, valsartan. irbesartan, candesartan, eprosartan, telmisartan</td>
<td>risk of hypotension (low blood pressure) if taking a diuretic, dizziness</td>
</tr>
<tr>
<td><strong>Alpha-blockers</strong></td>
<td>alfuzosin, doxazosin, indoramin, prazosin, tamsulosin, terazosin</td>
<td>hypotension and dizziness particularly in doses used to treat hypertension</td>
</tr>
<tr>
<td><strong>Anti-arrhythmics</strong></td>
<td>amiodarone, digoxin, flecainide</td>
<td>dizziness and drowsiness</td>
</tr>
<tr>
<td><strong>Anti-epileptics (anticonvulsants)</strong></td>
<td>carbamazepine, clonazepam, gabapentin, lamotrigine, phenobarbital, phenytoin, sodium valproate, topiramate, vigabatrin</td>
<td>dizziness, drowsiness and blurred vision</td>
</tr>
</tbody>
</table>
Anti-histamines
Used in hay-fever, itching and to control nausea, vomiting, and vertigo.
brompheniramine, chlorpheniramine, diphenhydramine & promethazine, loratidine, desloratidine, cetirizine, cinnarizine drowsiness, Lorataidne, desloratadine and cetirizine less likely to cause drowsiness Cinarizinne can cause hypotension

Beta-blockers
Used to treat hypertension, angina, heart irregularities and after heart attack acebutolol, atenolol, bisoprolol, carvedilol, levobunolol, metoprolol, nebivolol, oxprenolol, propranolol, sotalol, timolol dizziness , postural hypotension (low blood pressure on standing) in eye drops these agents can cause blurred vision after application

Calcium channel blockers
Used in hypertension & angina. amlodipine, diltiazem, felodipine, lacidipine, nifedipine, verapamil may cause dizziness or fatigue

Diuretics
Used to treat hypertension, heart failure and water retention amiloride, bendroflumethiazide, bumetanide, chlortalidone, cyclopenthiazide, furosemide, indapamide, metolazone, spironolactone, triamterene, can cause dehydration, dizziness, confusion and postural hypotension

Muscle relaxants
Used for the relief of chronic muscle spasm or spasticity baclofen, dantrolene, orphenadrine, tizanidine Sedation, reduced muscle tone

Nitrates
Used to ease angina glyceryl trinitrate, isosorbide mononitrate & dinitrate dizziness, postural hypotension

Opiate analgesics
Used to relieve moderate to severe pain buphenorphine, codeine, co-codamol, co-dydramol, diamorphine, dihydrocodeine, fentanyl, methadone, morphine, tramadol drowsiness and sedation confusion reported with tramadol

<table>
<thead>
<tr>
<th>Drug Group</th>
<th>Examples</th>
<th>How they contribute to falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulants</td>
<td>dalteparin, enoxaparin, tinzaparin, warfarin</td>
<td>Increased risk of major bleeding</td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>bleclomethasone, betamethasone, cortisone, dexamethasone, fluocorticone, hydrocortisone, prednisolone</td>
<td>Long-term use can cause osteoporosis and increased risk of fractures</td>
</tr>
<tr>
<td>NSAIDS</td>
<td>aspirin, diclofenac, ibuprofen, naproxen, meloxicam, piroxicam</td>
<td>Increased risk of bleeding</td>
</tr>
</tbody>
</table>

Table III – Drugs likely to cause serious harm to patient after a fall
ACTIVITY SUPPORT MEETINGS

Thanks to all of you who have supported this year’s meetings, I hope you’ve found them useful & enjoyable. The contacts & ideas that have been generated & exchanged are reflected in the 2014 Resource Pack (available at the meetings or by calling Helena on 0114 305 4109)

Planning for 2014

Have you any ideas for next year; Subjects you would like to explore or working practices to share with your peers?

Over the past few years we have looked at the many ways that Occupation & Activity can enhance the well-being of our care home communities.

The following subjects have been covered in our quarterly meetings;

- Arts, Crafts & Creativity. Dementia Arts Festival
- Bereavement, Functional Mental Heath
- Celebrating the seasons
- Chair-based exercises
- Doll Therapy
- Falls Risk Reduction
- Fund raising / cost saving
- Improving working relationships
- Infection, Prevention & Control
- Life Story Work, Reminiscence, Dementia Café
- Male residents
- Modern technologies

Next Meeting: 23/01/14
Subject: Drama
ACTIVITY SUPPORT MEETINGS

Empathy Dolls / Doll Therapy

Here are some discussion points from the meeting on 17th October 2013

- **Positive Changes**
  Reduction in agitation, aggression, wandering
  Increased interaction with the resident, relatives & staff
  Both men & women can accept the dolls.
  Some think of them as dolls, others think of them as babies.

- **Multiple Roles**
  Not just referred to as a doll or as a baby.
  Some are significant people eg husbands, wives.
  A background knowledge of the resident is so valuable.
  Looking after a doll can make a person feel useful.

- **Attachment**
  The need for attachment to other people is very important.
  Dementia may increase the need for security & comfort.
  Dolls may help to meet these attachment needs.

- **Communication / Play**
  People use the dolls as a tool to explain how they are feeling.
  They often transfer their emotional state onto the doll.
  Play is a need for people at all ages.
  Play is a way we can act out a situation.
  A way of working through unresolved conflicts.

- **Suggestions for Success**
  Staff need to be aware that dolls are not a cure.
  Dolls must not be forced upon the individuals (homes could create a nursery).
  Not everyone with dementia will like or want a doll.
  ‘Sleeping’ dolls may cause distress as people can’t wake them up.
  ‘Crying’ dolls may also cause distress.
  Staff need to agree with the person what/who they believe the doll to be.
  Relatives & visitors may need to be kept informed about the use of dolls.

*From ‘Dolls in Dementia Care’ the Journal of Dementia Care  2001*

Helena Lee
RGN Care Homes Support Team
Spotlight on Care Homes

What’s new at Northfield?

Every Thursday morning the home’s Activity Coordinator Caroline hosts a Breakfast club where residents are encouraged to socialise and try different foods: anything from Mackerel to Danish pastries! The dining room is decorated with brightly coloured table cloths and flowers to create a positive atmosphere and relatives are encouraged to get involved.

Who do you want to be?

Claire Craig from Sheffield University has been working with the home for some time with a recent project on Life Story Work. The resident chooses photographs or images they wish to display and after they are scanned in a pocket-sized album is produced. The album is two sided so residents can have a private collection as well as a public one.

The same technology is used to make dreams into reality. Claire asks the resident who they would like to be and then their image is transported into a famous picture. One lady had swapped with Doris Day to become Calamity Jane!

Men’s Zone

In the female dominated world of care home life, male residents can often get overlooked. Caroline encourages the men in the home to get together on a regular basis to talk ‘shop’, sport and swap stories. Activities and outings are also planned, for example, a trip to Manor Castle.
Supporting Patients with Swallowing Difficulties

Dysphagia is defined as a change in the swallowing function which can have serious impact on the daily routines and affect social interactions and enjoyment. In the worst cases dysphagia can lead to dehydration, malnutrition, weight loss, and aspiration pneumonia. The condition also has a significant impact on the length of hospitalisation and cost of care, particularly in patients with a long-term disability.

Some drugs have side-effects that can contribute to dysphagia such as dry mouth, tardive dyskinesia, drowsiness or suppressed gag or cough reflex (Table 1).

Oral solid medication can represent a challenge for the care of patients with swallowing difficulties and alternatives must be sought to guarantee patient safety and maximise the benefits of the medication prescribed.

Patients with swallowing difficulties should be reviewed by their GP and consideration should be given to stop unnecessary drugs. For essential medication a stepped approach such as the one in Box 1 will help in finding the most effective solution with lowest impact on care cost.

Box 1 The Prescriber Stepped Approach to Support Patients with Swallowing Difficulties

1. Use an alternative oral formulation that meets the patient’s needs (e.g. dispersible tablets, liquid medicine)
2. Consider switching to a different agent in the same class or to a different route of administration
3. Consider using a licensed medicine in an unlicensed manner, e.g. crushing/dispersing tablets or opening capsules. However, this may not be possible with certain medicines and advice should be sought from the pharmacist or GP
4. Consider the use of special-order products (specials) when there is no licensed alternatives.

Some tablets and capsules cannot be crushed or opened because this would change the amount of drug that is effectively given to the patient. In general the following formulations should not be crushed.
Buccal or Sublingual Formulations: these forms are designed to diffuse through the blood vessel under the tongue or cheek pouch.

Enteric coated Tablets: the coating prevents drug dissolution in the stomach.

Therefore the prescriber and the pharmacy should be consulted before considering this alternative.

Table 1 – Drugs that can cause swallowing difficulties

<table>
<thead>
<tr>
<th>Drug group</th>
<th>Examples</th>
<th>How is swallowing affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td>Tricyclic antidepressants such as amitriptyline, imipramine</td>
<td>Drying of mucosa, drowsiness</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Amisulpiride, aripiprazole, chlorpromazine, clozapine, haloperidol, sulpiride, olanzapine, quetiapine, risperidone, trifluoperazine, Zoetpine</td>
<td>Tardive dyskinesia</td>
</tr>
<tr>
<td>Benzodiazepines &amp; Hypnotics</td>
<td>Chlordiazepoxide, diazepam, lorazepam, midazolam, notrazepam, oxazepam, temazepam, traizolan, zolpidem, zopiclone</td>
<td>Central nervous system depressant (drowsiness causing decompensation of patients with cognitive deficits)</td>
</tr>
<tr>
<td>Used for anxiety or sleeping problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-histamines</td>
<td>Brompheniramine, chlorpheniramine, diphenhydramine, promethazine</td>
<td>Drying mucosa, sedative effects</td>
</tr>
<tr>
<td>Used in hay-fever, itching, cold remedies and to control nausea, vomiting and vertigo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diuretics</td>
<td>Amiloride, bendroflumethiazide, bumetanide, chloralidone, cyclopenthiazide, furosemide, indapamide, metalazone, spironolactone, triamterene</td>
<td>Dehydration, dryness of mouth, thirst, weakness, drowsiness.</td>
</tr>
<tr>
<td>Used to treat hypertension, heart failure and water retention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mucosal anesthetics</td>
<td>Benzocaine, Lidocaine</td>
<td>Suppresses gag and cough reflexes.</td>
</tr>
</tbody>
</table>
Topical anesthetics used in oral medical procedures, control of dental pain, relief of sore throat

<table>
<thead>
<tr>
<th>Anti-muscarinic drugs (anti-cholinergics)</th>
<th>Benzhexol, orphenadrine, oxybutynin, procyclidine, tolterodine</th>
<th>Dry mouth and reduced appetite.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used in treatment of incontinence and in Parkinson’s Disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

References:

UKMi.2013 What are the therapeutic options for patients unable to take solid oral dosage forms? Medicines Q&As. (online). (accessed 10.10.13). available from: http://www.ukmi.nhs.uk/

UK Mi Questions and Answers

UK Medicines Information (UKMi) have produced a summary of medicines questions and answers specifically for care home staff giving general guidance. The following links will take you to the specific documents.

**Do oxygen cylinders need to be prescribed on an individual patient basis in residential nursing homes?**

**Why must some medicines be taken with or just after food, or a meal?**

**Why must some medicines be taken when the stomach is empty?**

**What should people do if they miss a dose of their medicine?**

**Crushing tablets or opening capsules in a care home setting**

- Black Triangle Scheme – New Medicines and Vaccines Now Subject to EU – wide additional monitoring.

You will have noticed black triangles (▼) against certain medicines in the BNF. This black triangle indicates that the medicine is being monitored closely because there is less information available about it compared with other medicines, either because it is new to the market or there is limited data on its long term use for a particular indication.

These black triangles will now start to appear on the patient information leaflet that is supplied by the manufacturer for the relevant medicines and information on how to report a suspected side effect via the yellow card scheme.
Action for care home staff:
1. You may wish to observe the medicines that you currently administer to your service users and check with the BNF/patient information leaflet if there is a black triangle against it. If the medicine has, then you may wish to acknowledge this and monitor the service user closely for side effects.
2. Familiarise yourself with the ‘yellow card’ scheme.

For more information click on the following link
http://www.mhra.gov.uk/Safetyinformation/Howwemonitorthesafetyofproducts/Medicines/BlackTriangleproducts/index.htm#4

Did you see?

In July 2013 the Royal Pharmaceutical Society produced a document Improving Patient Outcomes – The Better Use of Multi-compartment Compliance Aids

This document includes guidance and recommendations for health and social care professionals.

It states:-
“A multi-compartment compliance aid is one tool amongst many to help medicines use but other interventions exist, which is part of a patient-centred and quality approach must also be considered.
The use of compliance aids have become regarded as a panacea for medicines use and is often integrated into practice and service policy without giving due consideration to alternatives available.
Not all medicines are suitable for inclusion and stakeholders should recognise that the re-packaging of medications from the manufacturer's original packaging may often be unlicensed and involves risks and responsibilities for the decision made”.

The guidance offers 8 recommendations, a selection of which is listed below that is relevant to care homes.

- The use of original packs of medicines with appropriate support is the preferred option of supplying medicines to patients in the absence of specific need requiring a compliance aid as an adherence intervention.
- In support of independence and re-enablement, patients who can safely self-administer their medicines should be encouraged to do so and where they are unable to do so, there must be appropriate training for carers so they are able to administer medicines from original packs.
- Where a patient assessment indicates that a compliance aid is the intervention of choice, it is important that this is supported with the provision of information, appropriate counselling and follow up with the patient and that the health and social care professional is aware of the legal professional and practice considerations.
It suggests in order to respond to this guidance an integrated approach is required between health and social care, between commissioners and service providers, and also pharmacy bodies.
