

medicines.

Reducing overprescribing in care homes – pharmacy technician led interventions



Start with one floor of the home and learn and adapt to build the

confidence of the pharmacy technician

Collaborating organisations: SEL ICS, Orpington Primary Care Network (Bromley), Bromleag Care Practice (Bromley) PRN **Implementation Pharmacy Technician Protocol:** Description medicines* The care homes that were to take part in the mini-pilot were identified and The purpose of this mini-pilot was to test the use of a pathway which agreement was sought from the relevant practices. A meeting took place with the utilises a pharmacy technician to identify and have shared decision-Used in the last 3 care homes and the mini-pilot was presented to the wider care homes forum. making conversations about the inappropriate prescribing of months specified 'when required' (PRN) medicines (paracetamol and the An agreement was reached on which medicines the mini-pilot would focus on, and a laxatives senna and macrogol). The pharmacy technician then works protocol was developed for the pharmacy technician to use. closely with the GP and members of the primary care and pharmacy Patients were identified using searches at the GP practices and screening of MAR care home teams to facilitate deprescribing. charts at the care homes. The pharmacy technician and PCN pharmacist were briefed on how to take a patient-Patient centred conversations Check indication withcare home nurse, patient, centred approach, and an initial trial of the protocol was undertaken with the SEL ICS What problem is it trying to solve to tackle overprescribing? Is condition relative- Use TGROW tool Overprescribing Lead pharmacist. resolved? Check indication The pharmacy technician subsequently followed the protocol, undertaking shared The identification and prioritisation of people who would benefit What matters most? decision-making conversations and drafting recommendations for each patient. most from a SMR is currently inconsistent and not routine How are symptoms/relief assessed- Is The recommendations were reviewed and agreed by the GP and care home practice. there objective & subjective evidence pharmacist. of benefit/need? Initial findings were analysed and evaluated, including general recommendations for Any drug causes Think cascade tool? The opportunity to review medicines and deprescribe is not the care homes and their processes. Any non drug options LINK? consistently built into repeat prescribing, which can lead to Use of the protocol was extended to other floors of the care homes. overprescribing and medicines waste. YES- recommend The full potential of pharmacy technicians to support the Outcomes prioritisation of patients for Structured Medication Reviews less than 10 days more than 10 days (SMRs) is not always recognised or utilised. taken The protocol was successfully tested across two care homes with 80 NO- Pharmacist medicines reviewed by the pharmacy technician, which were then review analysed. **Intended outcomes** 60 of the 80 recommendations made by the pharmacy technician were Post review actions upheld (75%). Common reasons for not upholding the recommendation Agree deprescribing ☐ To reduce the overprescribing of specified medicines 'when included a change in patient's clinical status, palliative care and other plan with pharmacist required' (PRN) paracetamol, senna and macrogol in care home changes to the patient's medicines. 2. Document Pharmacy Is there a homely remedy? Technician review Refer to pharmacist SMR patients. Document SDM for options Discuss individual risk vs 30% of the medicines reviewed were stopped (paracetamol 36%, 815691000000107 benefits of stopping with To reduce health inequalities in a patient group that has been Use alternative laxatives 23%) and 20% were switched to being prescribing regularly 4. Implement and pharmacist linked to high levels of overprescribing (elderly, frail, multi-(paracetamol 20%, laxatives 20%). 3 medicines were stopped and then Deprescribe offending monitor plan as Recommend a trial STOP and morbidities) restarted due to a change in the patient's clinical status or reasons agreed with or and monitor pharmacist relating to a hospital admission. Continue as PRN To establish a pharmacy technician led process for reducing Does patient need this overprescribing that incorporates an appropriate referral regularly Top Tips: pathway and access to specialist support. Assign a review date in GP Discuss and agree the review protocol with the pharmacy technician records To support a pharmacy technician to become confident and Ensure there is engagement with the care home – explain what the work is competent to identify and have shared decision-making about and how they will benefit, and agree that the patient's perspective conversations about inappropriate prescribing of specified will be discussed I sent you the second care home audit today – this one proved a lot easier

Pharmacy technician feedback

as I was more aware of what needed to be done and how to do it!