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Enhanced health in care homes- medicines optimisation

One in seven people aged 85 or over is living permanently in a care home. The evidence suggests that many of these people are not having their needs properly assessed and addressed. As a result, they often experience unnecessary, unplanned and avoidable admissions to hospital, and sub-optimal medication.[1]

The Enhanced Health in Care Homes (EHCH) model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach.[2]

Getting NHS care right for care home residents offers significant opportunities to positively impact people's care and quality of life and to contribute to a more sustainable health and social care system which responds to the needs arising from the ageing population.[1] For the purposes of the EHCH implementation framework a 'care home' is defined as a CQC-registered care home service, with or without nursing. It is equally applicable to homes for people with learning disabilities and/or mental health needs, as well as for older people.[2]

This bulletin supports the implementation of the framework for Enhanced Health in Care Homes, specifically in relation to medicines optimisation and prescribing. This applies equally to people who self-fund their care and to people whose care is funded by the NHS or their local authority.[2]

Recommendations

- GP practices should ensure that there is a clear written process for prescribing and issuing prescriptions for care home residents.
- Structured medication review should be carried out on admission when a resident moves into a care home and then at least once a year. The frequency of this review should be determined by the Primary Care Network (PCN) multidisciplinary team (MDT), taking into account safety as the primary factor.
- From 1st October 2020, under the Network Contract Directed Enhanced Service, PCNs are required to use appropriate tools to identify and prioritise the patients who would benefit from a structured medication review and offer, deliver and record these appropriately.
- The resident and/or their family or carers as appropriate and in line with the resident's wishes, should be involved in medication reviews as it is important to assess their understanding, concerns, questions or problems with each medication.
- Medication review should be a multidisciplinary approach and may include a mix of health and social care professionals.
- Each care home should be supported by a MDT in its aligned PCN and members of this MDT will deliver a weekly home round (virtual or face to face). They will be responsible for the development and maintenance of personalised care and support plans for care home residents and will make every reasonable effort to support the delivery of these plans.
- It is important to know when to stop medication upon review to reduce inappropriate polypharmacy or adverse drug reactions and in response to a lack of efficacy or a change in treatment goals.

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Recommendations

- Waste reduction should also be considered as part of the medication review, including synchronisation of quantities prescribed in line with the prescribing cycle and their frequency of use.
- Treatment goals should be reviewed when a resident becomes frail, develops end stage dementia or has other circumstances which impact on life expectancy.
- Ensure screening and treatment of malnutrition is in line with current guidance.
- A systematic, proactive approach should be used to identify residents who may require end-of-life care and individuals should be supported to die in their place of choice. Their preference can be reinforced through 'advance care planning', personalised care plans, and treatment escalation plans.
- It is best practice that people should have access to specialist mental health services for assessment and management of complex mental health needs, including management of mental health medications and response to complex mental health crisis needs.
- Medication reviews are particularly important for people with dementia and should focus on reducing polypharmacy and optimising antipsychotic medication. It is important that these are undertaken by the MDT, in line with current guidance.

National guidance

NHS England and NHS Improvement updated 'The Framework for Enhanced Health in Care Homes' in 2020 (EHCH) and it includes additions that are relevant to PCNs. PCNs are networks of practices, working closely with other community healthcare providers to improve the health and wellbeing of patients living within their practices' geographic boundaries.[2]

Requirements for the delivery of Enhanced Health in Care Homes by PCNs have now been included in the Network Contract Directed Enhanced Service (DES) for 2020/21 with requirements for PCNs around implementing structured medication reviews that came into effect from 1st October 2020. The nationally commissioned EHCH service included in the DES represents a minimum standard of delivery.[2]

Under the DES, each care home will be aligned to a single PCN and its MDT by the relevant Clinical Commissioning Group (CCG). That PCN will then deliver the EHCH service for that home. This will enable consistency of care for people living in care homes and help the care homes, PCNs and providers of community services to build the strong working relationships and integrated care arrangements that are crucial to the success of the model.[2]

Structured medication review (SMR)

It is good practice for every person admitted to a care home to receive a SMR alongside the comprehensive geriatric assessment process carried out on admission. The resident and/or their family or carers as appropriate, and in line with the resident's wishes, should be involved in the review.[2,3]

Thereafter, the PCN MDT should agree the frequency of SMRs, with safety being the most important factor. They should be no longer than one year apart and are best tied into regular care and support planning reviews.[2]

The SMR forms part of the single personalised care and support plan (PCSP).[2]

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Best practice for structured medication reviews includes:[2]

- Each medication should be reviewed according to the national care homes SMR guidance, and any relevant local prescribing guidance issued by the Area Prescribing Committee (APC).
- Care home providers should be supported to have an effective 'care home medicines policy' that aims to avoid unnecessary harm, reduce medication errors, optimise the choice and use of medicines with care home residents, and reduce medication waste.
- Agreeing what medicines the person will take after the SMR and making sure they can use the medicines as prescribed.

The NICE social care guideline on managing medicines in care homes [SC1] emphasises that the following points should be discussed and reviewed during a multidisciplinary medication review:[3]

- The purpose of the medication review.
- What the resident (and/or their family members or carers, as appropriate and in line with the resident's wishes) thinks about the medicines and how much they understand.
- The resident's (and/or their family members' or carers', as appropriate and in line with the resident's wishes) concerns, questions or problems with the medicines.
- All prescribed, 'over-the-counter' (OTC) and complementary medicines that the resident is taking or using, and what these are for. This includes "homely remedies".
- How safe the medicines are, how well they work, how appropriate they are, and whether their use is in line with national guidance.
- Any monitoring tests that are needed.
- Any problems the resident has with the medicines, such as side effects or reactions, taking the medicines themselves (for example, self-administering some/all of their medicines, including inhaler and spacer technique) and difficulty swallowing.
- Helping the resident to take or use their medicines as prescribed (medicines adherence). This may include making adjustments to facilitate self-administration (with consent and a suitable risk assessment).
- Any more information or support that the resident (and/or their family members or carers as appropriate and in line with the resident's wishes) may need.

PCN requirements from 1st October 2020

Under the DES, from 1st October 2020, PCNs are required to:[4]

a. Use appropriate tools to identify and prioritise the patients who would benefit from a SMR, which must include:

- Patients in care homes (registered by CQC as care home services either with or without nursing care).
- Patients with complex and problematic polypharmacy, specifically those on 10 or more medications.
- Patients on medicines commonly associated with medication errors. *
- Patients with severe frailty (electronic frailty index - eFI score of >0.36), who are particularly isolated or housebound patients, or who have had recent hospital admissions and/or falls.
- Patients using potentially addictive pain management medication.

b. Offer and deliver a volume of SMRs determined and limited by the PCN's clinical pharmacist capacity, and the PCN must demonstrate reasonable ongoing efforts to maximise that capacity.

c. Ensure invitations for structured medication reviews provided to patients explain the benefits of the review, and what to expect.

d. Ensure that only appropriately trained clinicians working within their sphere of competence undertake structured medication reviews. The PCN must also ensure that these professionals undertaking structured medication reviews have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop this qualification and skills.

e. Clearly record all structured medication reviews within GP IT systems.

f. Actively work with their Clinical Commissioning Group (CCG) in order to optimise the quality of local prescribing of antimicrobial medicines, medicines which can cause dependency, metered dose inhalers where a lower carbon device may be appropriate and nationally identified medicines of low priority. **

g. Work with community pharmacies to connect patients appropriately to the New Medicines Service which supports adherence to newly prescribed medicines.

h. In complying with these requirements, have due regard to NHS England and NHS Improvement guidance on Structured Medication Reviews and Medicines Optimisation.

*** From the NHS Business Services Authority (2019) Medication Safety Indicators Specification, the following medicines should be used to help PCNs identify individuals to invite for a structured medication review:[5]**

5

- An NSAID
- Warfarin
- A direct oral anticoagulant – DOAC
- An anti-platelet including aspirin
- A renin-angiotensin system drug
- A diuretic
- An oral or transdermal opioid
- A benzodiazepine
- A Z-drug
- Pregabalin
- Gabapentin
- A long acting beta-agonist – LABA
- A medicine with moderate or high anticholinergic activity
- A medicine for dementia

****As defined by NHS England, items which should not routinely be prescribed in primary care including:[6]**

- Aliskiren
- Amiodarone (unless there are exceptional circumstances and initiated by a specialist and continued under shared care)
- Bath and shower preparations for dry and pruritic skin conditions
- Co-proxamol
- Dosulepin
- Prolonged/modified-release doxazosin
- Dronedarone (unless there are exceptional circumstances and initiated by a specialist and continued under shared care)
- Immediate-release fentanyl (unless there are exceptional circumstances and it is recommended by a multidisciplinary team or specialist, or it is used for palliative care)
- Glucosamine and chondroitin
- Herbal treatments
- Homeopathy

- Lidocaine plasters (unless there are exceptional circumstances for neuropathic pain treated in accordance with NICE)
- Liothyronine containing preparations (unless there are exceptional circumstances confirmed by a consultant NHS endocrinologist)
- Lutein and antioxidants
- Minocycline for acne
- Needles for pre-filled and reusable insulin pens costing >£5 per 100 needles for any diabetes patient.
- Omega-3 fatty acid compounds
- Oxycodone and naloxone combination product (unless there are exceptional circumstances)
- Paracetamol and tramadol combination products
- Perindopril arginine
- Rubefacients excluding topical NSAIDs and capsaicin
- Silk garments
- Once daily tadalafil
- Travel vaccines administered exclusively for the purposes of travel
- Trimipramine

Care homes medicines policy

As mentioned, the Framework for Enhanced Health in Care Homes outlines that care home providers should be supported to have an effective 'care home medicines policy' that aims to avoid unnecessary harm, reduce medication errors, optimise the choice and use of medicines with care home residents, and reduce medication waste.[2]

In addition, NICE recommends that GP practices should ensure that there is a clear written process for prescribing and issuing prescriptions for care home residents to support this.[3]

This process should cover:[3]

- Issuing prescriptions.
- Recording clear instructions on how a medicine should be used. Use of the term 'as directed' should be avoided.
- Recording prescribing in the GP patient medical record and resident care record and making any changes as soon as is practically possible.
- Providing any extra details, the resident and/or the care home may need about how the medicine should be taken.
- Any tests needed for monitoring.
- Prescribing the right amount of medicines to fit into the existing 28-day supply cycle if appropriate; and any changes that may be needed for prescribing in the future.
- Monitoring and reviewing 'when required' and variable dose medicines, ensuring appropriate instructions for use, quantity prescribed, and follow-up are provided.
- Issuing prescriptions when the medicines order is received from the care home.

It is important to follow-up on new medicines prescribed within a timely manner to minimise waste from patient refusal or non-adherence. It may also be useful to review whether prescribed quantities are aligned with the prescribing cycle and whether improvements can be made to rationalise prescribing to reduce excess ordering and potential waste.

PrescQIPP Bulletin 112 entitled "Care homes: Good practice guide to prescribing and medication review" outlines the key information for prescribers in general practice who look after care home residents. It outlines information relating to prescribing for patients in care homes, medication review and avoiding hospital admissions.[7]

This bulletin also highlights the importance of knowing when to stop medication which may be inappropriate or unsafe.[7,8] This may be important to reduce inappropriate polypharmacy or adverse drug reactions and in response to a lack of efficacy or a change in treatment goals. Treatment goals should be reviewed when a resident becomes frail, develops end stage dementia or has other circumstances which impact on life expectancy.[7]

Where changes are made to medication or appliances that are considered non urgent, it is useful to consider implementing the change on the next prescribing cycle rather than during a cycle to help reduce waste.[9]

Where appropriate, reducing the frequency or aligning the timing of administration of a resident's medication may be helpful, although it is not always appropriate to take certain medicines together at the same time.

Clinical pharmacist led medication review

It has been identified that the needs of care home residents require co-ordinated input from generalists and specialists of multiple disciplines in partnership with social care practitioners and care home staff.[2] This also applies to medication review, with NICE recommending that a local team of health and social care professionals are involved in this.[3]

Under the DES, where a PCN employs or engages one or more Clinical Pharmacists (under the Additional Roles Reimbursement Scheme), the PCN must ensure that each Clinical Pharmacist has the following key responsibilities in relation to medication review and medicines optimisation:[4]

- Work as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas.
- Be responsible for the care management of patients with chronic diseases and undertake clinical medication reviews to proactively manage people with complex polypharmacy, especially the elderly, people in care homes, those with multiple co-morbidities (in particular frailty, COPD and asthma) and people with learning disabilities or autism (through STOMP – Stop Over Medication Programme).
- Provide specialist expertise in the use of medicines whilst helping to address both the public health and social care needs of patients at the PCN's practice(s) and to help in tackling inequalities.
- Provide leadership on person-centred medicines optimisation (including ensuring prescribers in the practice conserve antibiotics in line with local antimicrobial stewardship guidance) and quality improvement, whilst contributing to the quality and outcomes framework and enhanced services.
- Through structured medication reviews, support patients to take their medications to get the best from them, reduce waste and promote selfcare.
- Take a central role in the clinical aspects of shared care protocols, clinical research with medicines, liaison with specialist pharmacists (including mental health and reduction of inappropriate antipsychotic use in people with learning difficulties), liaison with community pharmacists and anticoagulation.
- In addition, where a PCN employs or engages a Pharmacy Technician (under the Additional Roles Reimbursement Scheme) their responsibilities in relation to medication review and medicines optimisation include:[4]
- Undertaking patient facing and patient supporting roles to ensure effective medicines use, through shared decision-making conversations with patients.

- Carrying out medicines optimisation tasks including effective medicine administration (e.g. checking inhaler technique), supporting medication reviews, and medicines reconciliation. Where required, utilising consultation skills to work in partnership with patients to ensure they use their medicines effectively.
- Supporting, as determined by the PCN, medication reviews and medicines reconciliation for new care home patients and synchronising medicines for patient transfers between care settings and linking with local community pharmacists.
- Assisting in the delivery of medicines optimisation, management incentive schemes and patient safety audits.
- Working with the PCN MDT to ensure efficient medicines optimisation, including implementing efficient ordering and return processes, and reducing wastage.
- Providing leadership for medicines optimisation systems across PCNs, supporting practices with a range of services to get the best value from medicines by encouraging and implementing Electronic Prescriptions, safe repeat prescribing systems, and timely monitoring and management of high-risk medicines.
- Providing training and support on the legal, safe and secure handling of medicines, including the implementation of the Electronic Prescription Service (EPS).

The multidisciplinary team (MDT)

Under the requirements in the DES, each care home will be supported by a multidisciplinary team in its aligned PCN. Members of this MDT will deliver the weekly home round, and they will be responsible for the development and maintenance of personalised care and support plans for care home residents, and will make every reasonable effort to support delivery of these plans.[2]

Best practice includes:[2]

a. The MDT should use risk stratification tools and clinical judgement to ensure it focuses attention on those individuals with the greatest potential to benefit, in particular when identifying people who should be seen during the home round. This could involve, for example, using a risk stratification tool to identify those people who are at high risk of unplanned hospital admission, and the insight of the care home staff who are experts in knowing the individual's usual presentation(s) and any deviations from this.

b. The MDT should meet weekly. The function and format of this meeting should be locally determined dependent upon the needs of those people resident in the care home, and those individuals identified as requiring MDT input.

c. People who might be part of the MDT include (but are not limited to) PCN staff, community services provider staff, local authority staff, care home staff and Voluntary, Community, and Social Enterprise (VCSE) representatives/workers.

d. The MDT should review the information available to them prior to the meeting taking place and work together to determine the appropriate response to the needs identified e.g. clinical input from the MDT; onward referral to a co-opted MDT member or other; maintenance of current personalised care and support plan. (This list is not intended to be exhaustive, and other responses will also be appropriate.)

e. The home round usually follows the MDT meeting, with all MDT members agreeing the most appropriate clinician to assess the person on each occasion (this will be determined by clinical need and the skills within the MDT, noting that skills are likely to be enhanced and change over time).

f. The MDT provides a proactive and preventative approach to support people living in a care home. The MDT uses a partnership approach to clinical governance and decision making with social care staff being core team members. Membership of the MDT outside of the core team will vary depending on the local expertise and resources available and the needs of the care home population.

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g. All members of the MDT should have access to shared care planning and shared care records through information sharing protocols established across all system partners.

Hydration and nutrition

Poor hydration and nutrition can often lead to confusion, falls, and poor health; therefore, an important role of primary care support to a care home is to ensure that each resident's hydration and nutrition is well managed.[1,2]

PrescQIPP Bulletin 145 entitled 'Guidelines for the appropriate prescribing of oral nutritional supplements (ONS) for adults in primary care' outlines the key recommendations for appropriate screening, food fortification and ensuring appropriate prescribing of oral nutritional supplements only where appropriate.[10]

End of life care

Where people living in care homes are identified as likely to die within the next twelve months, it is good practice to ensure that the personalised care and support plan includes information on the person's priorities and preferences for end of life care, advance care planning and treatment escalation plans or emergency care and treatment plans, and that arrangements are in place to coordinate across multiple providers.[2]

The Gold Standards Framework (GSF) is an evidence based systematic approach to improving care for all people with any condition in any setting in the final year or so of life.[11]

Where people living in care homes are likely to die within the next few days or hours, it is good practice to ensure that appropriate communication with the family is taking place as appropriate and in line with the resident's wishes, that food and fluid support and anticipatory prescribing have been considered, and that the personalised care and support plan has been checked. This is so that, where possible, the person dies in their preferred place and arrangements for timely verification and certification of death and signposting to bereavement support are in place.[2]

It is best practice for the multidisciplinary team to provide access to adequate and timely medication and equipment that may be required to enable palliative and end-of-life care to be effective.[2]

Mental health

It is best practice that people should have access to specialist mental health services for assessment and management of complex mental health need, including management of mental health medications and response to complex mental health crisis needs.[2]

Dementia care

Today, around 70% of people living in care homes have dementia.[2] High quality dementia care ensures that people with dementia have equal access to the services and support that they require.[1]

Medication reviews are particularly important for people with dementia. The review should focus on reducing polypharmacy and antipsychotic medication. It is important that these are undertaken by the multidisciplinary team.[1]

Residents should have access to specialist dementia/mental health services for assessment and management of complex dementia needs, including management of mental health medications.[2]

Please refer to the PrescQIPP reducing antipsychotic prescribing in dementia toolkit.[12]

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Implementation resources

PrescQIPP. Polypharmacy and deprescribing. Bulletin 254. June 2020. https://www.prescqipp.info/our-resources/bulletins/bulletin-254-polypharmacy-and-deprescribing/

PrescQIPP. Care homes webkit. https://www.prescqipp.info/our-resources/webkits/care-homes/

PrescQIPP. Implementing bulk prescribing for care home patients. Bulletin 66. May 2014. https://www.prescqipp.info/our-resources/bulletins/bulletin-66-care-homes-bulk-prescribing/

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PrescQIPP. Care homes - Medication and falls. Bulletin 87. December 2014. https://www.prescqipp.info/our-resources/bulletins/bulletin-87-care-homes-medication-and-falls/

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PrescQIPP. Care homes - Transferring patients between care settings. Bulletin 178. May 2017. https://www.prescqipp.info/our-resources/bulletins/bulletin-178-care-homes-transferring-patients-between-care-settings/

PrescQIPP. Care homes – Assisting people with swallowing difficulties. Bulletin 188. October 2017. https://www.prescqipp.info/our-resources/bulletins/bulletin-188-care-homes-assisting-people-with-swallowing-difficulties/

PrescQIPP. Supporting the World Health Organisation Medication Without Harm Challenge. Bulletin 252. March 2020. https://www.prescqipp.info/our-resources/bulletins/bulletin-252-medicines-without-harm/

PrescQIPP. Reducing Antipsychotic Prescribing in Dementia Tookit. Toolkit 7. October 2014. https://www.prescqipp.info/our-resources/bulletins/t7-reducing-antipsychotic-prescribing-in-dementia/

PrescQIPP. Guidelines for the appropriate prescribing of oral nutritional supplements (ONS) for adults in primary care. December 2019. https://www.prescqipp.info/our-resources/bulletins/bulletin-145-ons-guidelines/

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PrescQIPP. Respiratory care webkit. https://www.prescqipp.info/our-resources/webkits/respiratory-care/

PrescQIPP. Vitamin D. December 2020. https://www.prescqipp.info/our-resources/bulletins/bulletin-275-vitamin-d/

Additional resources

Care Quality Commission (CQC). Reporting medicine-related incidents. Last updated January 2021. https://www.cqc.org.uk/guidance-providers/adult-social-care/reporting-medicine-related-incidents.

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Summary

Getting NHS care right for care home residents offers opportunities to positively impact people's care and quality of life, including reducing unnecessary hospital admissions and bed days.[1]

There are several key issues relating to the prescribing of medicines and medication review including fulfilling the DES requirements for PCNs to deliver regular structured medication review.

Recommendations have been made in this bulletin to ensure the timely implementation and provide high-quality care within care homes.

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11. The Gold Standards Framework (GSF). Training resources on end of life care. https://www.goldstandardsframework.org.uk/ Accessed 18/11/20.
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Additional PrescQIPP resources

Briefing	https://www.prescqipp.info/our-resources/bulletins/bulletin-279-care-homes-medicine-optimisation/
Implementation tools	

Information compiled by Gemma Dowell, PrescQIPP CIC, December 2021 and reviewed by Katie Smith, PrescQIPP CIC, January 2021. Non-subscriber publication January 2022.

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