MEDICINES MANAGEMENT FOR PATIENTS WHO REQUIRE A CARE AT HOME SERVICE

THE JOINT CARE AT HOME PRESCRIBING PROGRAMME

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BACKGROUND AND AIM

Around 10,000 vulnerable patients in NHS Lanarkshire receive Care at Home support from social services each year, in order to remain independent at home. Many of these patients receive medication support from Homecarers. Currently there is no systematic process for making a GP Practice Team aware which of their patients receive such a Care at Home service.

METHODOLOGY

- Identify the cohort of patients who receive Care at Home service and their GP practice.
- List these patients, with their Care at Home service input, including medication support.
- Analyse the Vision record, versus the Care at Home service input for each patient.
- If possible, consider possible alignment, optimisation and clinically appropriate simplification of medication to the Care at Home service tasks.
- Multi-disciplinary analysis of the SWiS (Social Work information System) record.
- Create an individualised care plan each patient for discussion with the GP.
- Agree interventions, implement and communicate to all stakeholders, including patient and their family carer.

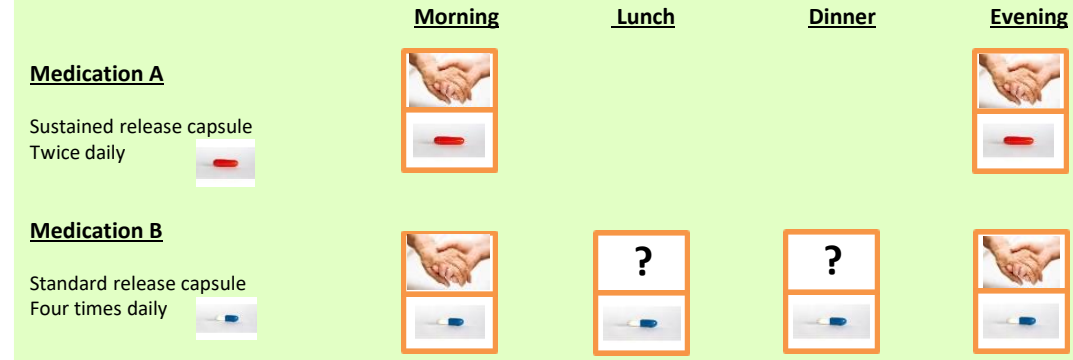
CASE EXAMPLE

Patient receives a Care at Home service twice daily (morning and evening) and uses medication A, a sustained release product, twice daily.

Medication A, the sustained release product, is more costly than the equivalent standard release, so prescribers or staff within the GP practice may choose Medication B, the four times daily product, to be prescribed for patients.

Medication A – 100mg sustained-released capsules 'one capsule twice daily'
Medication B – 50mg standard release capsules 'one capsule four times daily'

How does this impact if the patient only receives Care at Home medication support twice daily, morning and evening can changed to the standard release product?



If **Medication B**, the four times daily product is selected, we may lose compliance which results in negative impact on patient care, or may alternatively require extra Care at Home visits to support medication use.

Aligning the medication doses and the Care at Home medication support can support our three outcomes;

- **Increase patient safety**
- **Improved clinical outcomes**
- **Capacity release for Care at Home**

……BUT this alignment can only happen if the GP/practice staff have an awareness of which patients have Care at Home medication support. Our work shows that a visibility of the person's GP record in conjunction with their social care information aids holistic prescribing decisions.

OUTCOME

A random selection of Care at Home patients has demonstrated that clinically appropriate simplification of a patient's medication regimen, with a visibility of the social care package, can improve both patient safety and clinical outcomes while reducing the frequency of Care at Home visits required from social care staff.

Through this work, we recommend that Care at Home becomes a discipline in its own right, from a healthcare perspective. In the same way that asthma registers and clinics are held within GP practice, a register of Care at Home service users can be compiled with a designated staffing group who can support this patient population.

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