Leadership:
Improving the prescribing, dispensing and management of medication in care homes
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Acknowledgements

This work has been undertaken as part of a task group. We would like to thank all the individuals and organisations that have freely contributed and given permission for the use of their materials.
Demonstrating how theory can be applied in practice is essential to the task of improving medicines management in care homes. Our leadership aim is to pursue a person-centred approach to medication practice that manages, mitigates and minimises error. Mistakes are learning opportunities and good practice is for sharing. Improving medication practice goes beyond just the what of doing things in the right way to include the how of the way they are done. Improvement is not only about training but about creating a leadership culture where task-centred care can become person-centred and relationship-centred care and support.

We have focussed on the leadership of Registered Managers in care homes1. This is not to deny the leadership roles of multi-professional colleagues, but to stress the enormous responsibility they have to both get things administratively right whilst also challenging and advocating for their residents well-being. Registered Managers flourish when they are valued, just as residents benefit from person-centred care.

In our view it is the Registered Manager who is most likely to lead the improvement of medication practice. There are nearly 18,000 such positions leading care homes and 12,000 employers. 75% of these are in fact owner/managers, in charge of small often family run businesses. It is self-evident that investment in the training and professional support of Registered Managers will reap a dividend in resident safety.

It is important that Registered Managers are encouraged and supported to be the lead professional for people in their care. They have the responsibility for steering improvements and establishing effective working relationships across the three professional areas. The Registered Manager has to step forward as a confident professional who is comfortable facing up to bad practice, and must have the right personal qualities to recognise and demonstrate best endeavours.

1See www.myhomelifemovement.org for a more extensive consideration of leadership in care homes
The five rights of medication administration are as good a leadership and management mantra as any:

- Right drug
- Right dose
- Right person
- Right time
- Right route
An often made distinction between leadership and management was first captured by Richard Pascale in 1990 when he said “Managers do things right, while leaders do the right thing.” As we endeavour to improve the prescribing, dispensing and management of medication in care homes this distinction appears to matter little as we need people to both lead and manage doing everything right. As one care home proprietor put it “leadership is ownership”.

The challenge in improving practice is in reaching multi-professional agreement on what is actually best practice. There is perhaps a distinction between the manager who administers medication as directed ‘by the book’ (and here we draw on the Nursing and Midwifery Council’s (NMC) Standards for Medicines Management) and the worker who goes on to lead by asking questions as part of person-centred care planning. Questions such as:

- Can this resident self-manage medication? Do they want to?
- How are they involved in decisions about medication?
- Do they really need this medication?
- Does this care plan include a clear and agreed medication plan?
- Is this medicine having the benefit it is supposed to?
- Does the resident require this amount?
- Would it be better to change the time of taking the medicine?
- Is this form of medication the most suitable?
- Is a medication review included as part of a care plan review?

As the NMC Standards say in their introduction:

“The administration of medicines is an important aspect of the professional practice of persons whose names are on the Council’s register. It is not solely a mechanistic task to be performed in strict compliance with the written prescription of a medical practitioner (can now also be an independent and supplementary prescriber).
It requires thought and the exercise of professional judgement…”

This is why the ‘Safety of Medicines in Care Homes’ project has devised a resident’s charter – My Medicines, My Choice. The charter expresses, in a straightforward way for all leaders and managers, both what doing the right thing entails as well as what is involved in doing it in the right way.

For the avoidance of doubt, when we talk of leaders we are talking of anybody who may influence the well-being and health of a resident, including themselves and their relatives. We are also talking about professionals across disciplines – particularly general practice, pharmacy and social care – and managers at all levels involved in running, commissioning and inspecting care homes.
There are two classifications of care home – those with and those without nursing. The Care Quality Commission (CQC) describes a care home as a place where personal care and accommodation are provided together. For many people it is their sole place of residence and becomes their home. The CQC is the regulator responsible for registering the service, the registered person (a nominated and responsible person representing the owner) and the Registered Manager, as well as inspecting the service provided and the premises.

There are 17,825 private and voluntary sector care homes in England with 2,134 owners having a group of two or more homes. The majority of groups are less than 10 in number, and only a small number of larger corporate providers have more than 100 homes. An estimated 10,000 owners/managers have just one home, and these are often family businesses. Local authorities own and run another 240 homes. This picture alone makes for complexity in devising ways to improve services and to turn national policy into operational procedures and good practice.

The complexity is compounded when we consider that care homes cater for a variety of needs and dependencies, for differing age groups and all have individual statements of purpose.

Leadership of a care home, first and foremost, rests with the Registered Manager. This role establishes professional practice standards, ensures they are applied across the home and analyses and tackles problems.

A Registered Manager can be isolated – accountable perhaps to a board of volunteer trustees or an absentee owner who may not be from the sector. At the other extreme, the Registered Manager can be part of a corporate hierarchy with a line manager and multi-professional support.

The authority of a Registered Manager can vary, as can their knowledge, experience and skills. However, the role is that of a leader of change and workforce development; checking, through supervision and self-audit, that standards are met. Personal care planning for each resident provides the context for the application of the leadership role. It is within this context that the improvement of prescribing, dispensing and management of medication must be set.

Registered Managers are pivotal, but are not the only leaders. As leader of a resident-centred home they will want to empower the resident to lead their own medication arrangements where possible. It is from this perspective that the roles and tasks of other leaders are considered. Safe and effective medication practice for individual residents of a care home requires leadership from a diverse and multi-disciplinary team. The fundamental players are the General Practitioner (GP) in respect of prescribing, the pharmacist for dispensing and the care homes leadership team and keyworkers on management and administration practices.

*Extracted from Care Quality Commission, Annual Report 2010*
A wider group of contributors include trustees, directors, advisers, trainers, middle management and specialists from the care home organisation (see Figure 1 below). All health professionals are crucially engaged with a resident as part of care plans or in the event of the need for care and treatment away from the home. Social workers, other care managers and advocates have a part to play, as do inspectors, commissioners and those monitoring contracts.

Figure 1: The multi-professional approach to leadership
Everyone involved in the flow from initiating a prescription to the resident is vital in terms of medication safety (see Figure 2 below). For example, the employee who drives from surgery to surgery collecting scripts for delivery to the local pharmacy, and the family member who takes their relative away for a break, both play import roles.

Of course breaking things down into prescribing, dispensing and management is a simplification of roles that aids the understanding of flow. In reality many GPs and pharmacists contribute more broadly to person-centred care practice. They are frequently engaged in delivering training, advising on policy, conducting medication reviews, ensuring appropriate monitoring, liaising with primary and secondary care and using technology to reduce errors. Our transformational story and the vignettes presented later are evidence of the diversity of such multi-professional engagement.

Figure 2: Key players in the flow

With such a complex leadership picture the potential for error multiplies. How then do leaders ensure that there is a coherent, safe and effective story of medication practice to tell in a care home? Being a regulated service, direction and active management is the principal responsibility of the Registered Manager.
The leadership of safe and effective medication practice in a care home will be characterised by:

- Shared vision of person-centred and safe care, effectively communicated
- Commitment to a multi-disciplinary protocol on safe medication practice, based on adoption of the residents' charter My Medicines, My Choice
- Trust, confidence and understanding between professionals
- No-blame approaches to problem solving
- Recognition that there are benefits from sensible risk-taking as well as potential harms
- Investment in relationship building and joint training across professions
- Simple and regular audits of systems to understand how things work
- Clarity of leadership roles and management tasks
- Using and sharing information about what works
- Local leadership networks promoting best practice and learning
- Champions within care homes and networks
Leadership and management development

The employer-led National Skills Academy for Social Care has a focus on leadership, management and commissioning skills in social care. They work alongside other sector bodies like Skills for Care and the Social Care Institute for Excellence in supporting employers, leaders, managers and the workforce by:

- Identifying excellence in learning and training
- Increasing and extending skills
- Recognising and endorsing quality in training provision
- Improving commissioning practice

The Government’s A Vision for Adult Social Care – Capable Communities and Active Citizens, published in November 2010, gives the National Skills Academy for Social Care responsibility for producing a leadership strategy for the sector. Following on from the Skills Academy’s work on leadership over the last year and the publication of its Outstanding Leadership in Social Care report, the Skills Academy has undertaken consultations and is expected to produce a strategy in late 2011.

Taking a strong steer from Outstanding Leadership in Social Care, it is clear that the improvement of medication management in care homes must be founded on the following three principles:

- Thinking and acting systematically – knowing that reaction follows action and that seamless embodiment of leadership and management is the route to making a difference.
- People are the route to performance - genuine understanding that outcomes such as productivity, quality, innovation, person-centred residential care and safe medication practice are all achieved by engaging with others.
- Leaders achieve through impact on others - awareness that outstanding leaders act consciously, with care and respect, and with full self awareness and reflection.

These principles are presented in a template below (see Figure 3) that can assist in thinking through the leadership roles and tasks involved in improving the prescribing, dispensing and management of medications in care homes. They are a template for going beyond training to change culture through a learning environment.

- National Skills Academy for Social Care, www.nsasocialcare.co.uk
- Skills for Care, www.skillsforcare.org.uk
- Social Care Institute for Excellence, www.scie.org.uk
Figure 3: Template for leadership and management

think and act systemically

self as enabler

power, capability, systems, performance

trust, confidence, relationships, team

people are the route to performance
Audit and quality assurance

As a leader, the Registered Manager needs to think systematically about what they want the care home to achieve in terms of a personalised and safe approach to medication management. Why are changes needed? Have the players in the multi-professional picture bought into the vision fully? Do they understand the flow of medication management and are there ideas about its improvement out there? What actions are required to improve practice and what might be the impact – positive and detrimental? What form of audit and quality assurance should be adopted by the management team?

In short every Registered Manager needs a framework of leadership and quality assurance that ensures their actions contribute to achieving their visions. Jim Collins put it in succinctly in Good to Great: “There was no miracle moment. Instead, a down-to-earth, pragmatic, committed-to-excellence process—a framework—kept each company, its leaders, and its people on track for the long haul.”

“You have got to know the purpose of audit. If you know that something is wrong, put it right first and then audit. Sometimes we are audit happy”

In assuring quality the Registered Manager should seamlessly know:

- How to audit medication effectively – what frequency and style
- How to meet the outcome standard for medication and sustain care home performance
- The flow and processes involved with medication management
- Early warning signs that everything may not be right
- How to reduce errors associated with the mismanagement of medicines
- What a personalised residential care home and improved safety look like

With this knowledge they can use and develop standards and procedures for medicines management that reduce the risk of medication errors, adverse incidents and complaints. They can instil ‘good habits’ amongst administering practitioners. They can make productivity savings and ensure prompt treatment and care whilst in the care home. This leads to more efficient time management, improved overall care planning and contributes to the prevention of unnecessary hospital admissions.

Workforce development plans, both for the safe management of medications for the whole care home and for individual practitioners, will emerge from audit findings. Better knowledge and understanding of policy, procedure and practice will enhance a multi-professional model.

When audit shows that people feel they have some control over the administration of their medication it will increase their feelings of being treated with dignity and respect. Satisfaction and well-being of residents will increase. This will help them to further self-manage their condition within the care home.

[Collins, J. Good to Great, William Collins, 2011]
[Care Quality Commissions, Essential Standards of Quality and Safety, 2009, Outcome 9]
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3. Nursing and Midwifery Council, Standards for Medicines Management 2007, as revised 2010
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Background Reading

10. Department of Health, A Vision for Adult Social Care - Capable Communities and Active Citizens, November 2010
11. Parkinson’s UK, Parkinson’s (‘Get it on Time’) hospital medicines management audit guidelines, April 2010
The leadership story of Sally Gillis
Clinical Development Manager at Sanctuary Care Home Group
I would like to share an uplifting story with you. It is a story which I hope will be as encouraging and inspiring for you as it has been for me. It tells you about a progressive transformation at Sanctuary Care Homes which has advanced from having poor and potentially unsafe medicines management to now being a leader in this field.

It began in 2010 when I joined Sanctuary Care Homes as Clinical Development Manager. One of the things that attracted me to the job was their desire to be the best and their acceptance that improvement was needed. I wanted to share my passion for improving standards of care and had a particular desire to improve medication practice throughout our homes and services nationwide. In this story I will tell you what I found in the beginning, what we have done together, where we are today, why we still need to improve and my hopes for the future – for medication practices and for the care of our residents. It is told from my personal perspective and has the support of my manager.

By the end of the story I hope that you will understand the challenges we faced, see what we think success looks like and realise that you too can find better ways to practice and embark on your own improvement journey.

**What was the situation in our care homes?**

Sanctuary Group has 45 care homes. Following my appointment, I spent time becoming familiar with our care provision. I did this through hands-on management of a regional group of Registered Managers, external audit and personal observation. Care Quality Commission reports highlighted common and repeated issues with medication practices. I undertook a series of monthly compliance visits and brought in an independent external pharmacist to get a view from a different perspective.

What I found was some great medication management practice in some places and poor practice in others. And when I say poor, I do mean poor. For example, in a home with a history of non-compliance in medication management practices, my internal audit revealed a raft of shortcomings in training, use of protocols, storage, administration and communication. No one took overall responsibility for medication management and residents were missing medication because systems for re-ordering were not in place.

A ‘blame culture’ existed in some areas and we were not even reporting errors when we knew they had happened.

Shamefully, residents were not involved in decision making around their medication and risk assessments, protocols and care plans did not reflect our residents’ abilities, needs and wishes.

Clearly, in some homes at least, we were falling far short of that. In essence, medication management was often neither safe nor personalised.

But the news wasn’t all bad. What I also found were staff who were determined to do better for their residents. This, together with Sanctuary’s support, enabled us to embark on our improvement journey.

I prepared a report for the Director of Care. It said that the quality of medication practice was varied. The general theme that emerged was systems and procedures were not clear, leadership and accountability in many homes needed to be strengthened and training was variable. Improved relationships with GPs, pharmacists and other professionals were also a key area for development.
“We believe that personal choice is important which is why we involve our residents in the decisions that affect them. Each resident has an individual care plan which is drawn up after consulting with you and other members of your family or your advisors. Care plans cover your medical, social and emotional needs and are regularly reviewed with you.”
Why did we need to change?

At the outset it was clear that the Sanctuary Group needed and wanted to improve its medication practice. Our professionals and senior managers knew that there were better ways of doing things – ways that offered a route to enhancing our vision of care.

Leadership action to improve medication practice offered a way of maximising beneficial outcomes for residents, whilst lessening the likelihood of harm for everyone. In short, we needed to pursue our organisational vision; one that centres on good outcomes for residents.

In order for Sanctuary to focus on person-centred care, we need leadership to improve medication practice. Critically, this included wider leadership development of our regional and Registered Managers: addressing culture change, management of risk, choice and independence as well as resident centred care planning.

As a company we need to empower those delivering care in each and every home. It has been, and remains, my intent to provide leadership and support to the efforts of regional and Registered Managers in establishing a more local plan. I have guided them through the new policy in a refreshed climate of ‘no blame’. I am not the line manager of the Registered Managers, so this must become part of the way we do things throughout the company. We now have group coaching and training, mentoring, supervision, telephone and email support together with continued audits.

As we progress, Registered Managers are gaining the confidence to arrange meetings with other professionals and to develop good working relationships to improve their services themselves.

On reflection, I believe we have created an expectation that new practices emanating from the revised policy will be implemented by all parties both from within the home and beyond. I am a firm advocate of effective leadership begetting effective management.
Some of the key actions we took as part of our improvement journey included:

- Identifying areas for improvement through audit
- Rewriting the medication policy and launching it
- Training in a collaborative leadership coaching style
- Introducing a competency-based mandatory training programme
- Developing a rigorous and supportive approach to management supervision
- Ensuring communication is always a key focus
- Auditing for continuous improvement

Sanctuary Group’s audit model has to operate at a number of levels – individual resident, care home and multi-agency/professional. If we as leaders, are seeking multi-professional feedback then we have to talk to each other in a planned and open way; using appropriate forums to secure qualitative evidence of improved practice.

Improved liaison, communication and relationships between Registered Managers, GPs and pharmacists may be more difficult to observe. However, the care plan or individual patient review should flag up improved prescribing with greater choice for residents. Systems analysis and review can highlight the flow of activity from prescription decision through to resident wellbeing and health. Nuts and bolts issues like the ordering and delivery of medicines can, if not addressed, become major issues when they should be relatively straightforward to iron out.
What does success look like?

This is a question that I am often asked. How can you see greater awareness amongst care home staff? Can you witness people avoiding poor practice through better management and administration processes? Certainly, residents are being encouraged to self-administer if they choose. There is more flexibility over the times for medicines administration and details of individual needs and preferences are increasingly being recorded in care plans. Our regional and Registered Managers can check and show this through audit, recording and analysis of errors and talking to residents and their relatives. We can also ask fellow professionals if they are noticing improvements.

Ultimately, better outcomes for residents are what we all want and we want to use audit processes to show that they have been achieved. For us, a positive inspection is a major indicator of success. CQC inspections have demonstrated that there have been reliable improvements in medication management for the past nine months with all homes now achieving compliance.

We must pinpoint and work on things that are within Sanctuary’s control. It is no good having a wish list that is not in our gift to achieve. Staff at all levels of the company need to feel that they can make it happen.

To me, the success of a care home is not down to a single factor like medication practice – although without a safe and personalised model it is likely to be failing. Success should exude from every pore of the home’s being. In essence, it should be encapsulated in the behaviours and attitudes of the Registered Managers and their care teams, the demeanour of residents and in the direct feedback from them, their relatives and from fellow professional leaders. Leading change and improvement in medication practice gets to the heart of best practice in a care home; enhancing team spirit, morale and peer support. This is something that can be seen and heard and almost touched and smelt the moment one walks through the door of a successful home.
Where are we today?

- I am proud to say that Sanctuary Group has demonstrated the success of our approach through CQC inspections and internal quality audit. Homes that had some of the greatest challenges are now leading the way and staff know that it is their dedication and willingness to embrace change that has made this possible. Registered Managers and their teams are clearly motivated by their own success and take pride in their achievements. Confidence in recording and reporting had improved markedly within three months of local managers taking ownership of medication issues and accepting a leadership role in change.

- We envisage that an investment of £30 per person every three years, annual updates internally and free support from pharmacy providers (plus cost of release time) can initiate and sustain leadership change amongst the cohort of care workers who administer medication. The return on investment stretches beyond a safe and personalised model of medication practice into general workforce well-being, improved staff motivation and retention.

- Regional and Registered Managers are trained and empowered to learn from errors, share best practice to ensure consistency throughout the company and instil a ‘no blame’ culture. Audits are seen as an opportunity for development and a means to identify training needs.

- Staff receive training in systems, administration, auditing or more advanced clinical practice. Training is now mandatory for those who administer medicines. I have focused particularly on developing a culture in which staff can develop and remain confident in their practice. We celebrate success as we progress and move on to the next challenge. Together, we have raised our expectations and standards, looking at how we can achieve improved outcomes for our residents whilst managing risk.

- Opportunities for learning are tailored to individual preferences. This can be face-to-face, e-learning or work books with supervision and competency assessments every six months. Sharing information by email helps ensures that medication management remains a focus at all time. Annual updates are now policy.

- Administration remains a focus in all of our care settings. We constantly strive to improve standards. Yes, we still have errors but these are managed with a human approach and we have clear procedures for staff to follow. Improved practice has shown a marked reduction in errors over the last year. We will continue to ensure the welfare of residents is at the heart of our focus on safer administration.

- Error reporting has been implemented in each home and confidence continues to grow. Each month an analysis is sent to the regional manager and to me. We still need to improve in this area but we have come a long way over the past year. Homes continue to be reported as compliant and we can demonstrate through effective care planning that residents are given choice and have their medication when they need it, rather than when it suits staff or the system to give it.

- The company has built stronger relationships with pharmacists through a list of approved providers. We have a preferred provider and I meet with them quarterly and have regular email and phone contact. Their support has been essential to improving our services. In training we also have a preferred provider who offers a variety of training methods and opportunities. All trainers are qualified pharmacists.
Lessons that I have learned along the way are:

- Targeted and concentrated leadership support can quickly bring about success in a single care home
- Success breeds more success
- Disciplinary action is usually counterproductive
- Good communication builds stronger relationships between Registered Managers, GPs and Pharmacists.

All these factors contribute to improving the medication experience for our residents.

Sanctuary anticipates embedding change for the long-term by the continued use of audit, applying a rigorous approach to systems and providing wider access to training – some of which is now mandatory. We will also seek to improve relationships with stakeholders, including corporate and commercial partners, share best practice and celebrate our success.

The three main leadership challenges we face are:

1. All our managers taking leadership responsibility for improving medication practice
2. Building and maintaining multi-professional relationships and communication – seeking and valuing the leadership contribution of colleagues
3. Creating a more resident-centred style and less task orientated approach to medication based on seeking positive outcomes that involve shared and understood risks

What about the bigger picture?

I believe that our experience at Sanctuary can provide valuable insights and learning for others within care homes and similar settings. We would like to do this by:

- Participating in support networks for Registered Managers across the public, private and voluntary sector
- Where possible playing a part in supporting smaller companies
- Promoting what we do to strengthen understanding about how to improve quality and safety
“Now we invest time and effort in strong communications and relationships, we try to share our achievements, learn from our mistakes and, most of all, celebrate success.”
I am asking you all to join me in making medication management better for all care home residents. This is whether you are in the ‘top team’ of a corporate provider, a trustee of a charity, a local authority manager or the owner or manager of an individual care home. The care home sector has many leaders in trade and professional associations whose voice and support can make a difference. Nurses, care assistants, doctors and pharmacists all contribute in making medication practices in our care homes both safe and personalised.

It is not just managers that have leadership roles. Residents themselves and their relatives, friends and advocates are leaders in seeking out and insisting upon best medication practices where they live. Everyone should make it their business to know whether their care home has adopted the My Medicines, My Choice residents charter and what steps they are taking to make it work. This my next leadership mission at Sanctuary.

Best medication management involves putting the principles of choice and control into everyday practice. It means you writing your own leadership story in the way that we have at Sanctuary.

“The purpose of this charter is to meet your medicine requirements by promoting high standards across professional disciplines”

What can you expect from me?

It is my intention to continue to strive for improvement in Sanctuary – supporting staff and celebrating their amazing achievements. I plan on building a cohort of leadership champions across the organisation that can sustain our progress, further embed it and share the training and auditing tasks. Every leader’s story should include a plan for their successor!

Wherever I can I will share my successes and failures with you to help you succeed and to carry on learning myself.

And finally, what will success look and feel like?

I will know we have succeeded when I can walk into any home and:

- All care practitioners are trained as required by policy
- There is a supportive culture in which to learn from mistakes
- Medication errors are reported and analysed to improve practice
- Care plans evidence an individualised approach to medication management and therefore improved outcomes
- CQC reports show continued improved practice

What am I asking you to do?

“The purpose of this charter is to meet your medicine requirements by promoting high standards across professional disciplines”
“I would like to manage my own medications when I can, but know that I often need someone there to help. It was nice when I came here and had the opportunity to do just that”
No-blame culture  
(Ferrous Sulphate: One tablet three times a day)

Our care workers undertake the normal day to day communications in relation to the residents’ medication requirements. They will bring any issues they feel unable to deal with to my attention to allow me to advise and if necessary, get involved directly with our supplier. Recently there was an occasion when one of our senior care assistants contacted our supplier. She felt there was a discrepancy in the number of tablets which should have been delivered to a resident and the pharmacy had disagreed. The number of tablets which had been prescribed by the GP had been dispensed correctly, which were 56, however she knew that this amount was not enough to complete the monthly cycle.

The senior care assistant brought the issue to my attention as she felt she was getting nowhere. I contacted the pharmacy and asked what number of tablets had been dispensed and the date they had been prescribed. The response was 56 and the date being 11 April. I informed the person who I was talking to on the phone that I was looking at a prescription online which was for 84 tablets and the date on that prescription was 11 April; ready for the monthly cycle to start on 25 April. There were 3 items in total on the prescription. The pharmacist then agreed with what I had brought to their attention and apologised for the mistake and agreed to supply the outstanding amount of medication to the resident.

Our system allows me to track any prescription issued to any of our residents at any time. This means I can view what has been prescribed either on a monthly cycle or in an acute instance. I have found it to be particularly useful when use as directed or when required instructions are labelled on resident’s medication and additionally to ensure our residents get the required amount of medication.

Outcomes and cost  
(Liquid Paracetamol)

Following a GP visit to a resident a care worker brought to my attention that, after reviewing the medication, the GP had changed the resident’s liquid Paracetamol to tablet form. She felt the resident did not appear to take it regularly enough and the medication was wasted at month end. The GP asked the care worker to crush the tablets when administering to the resident. The resident’s key worker had agreed with the resident, their family and GP that the best form of medication would be in a liquid due to the resident having some intermittent swallowing difficulties. She also knew that it is not within our medication policy to alter the product.

I contacted the GP and explained that it had previously been agreed that liquid Paracetamol was the best way we could manage to control the lady’s pain. The GP felt that the cost of the medicine was high and was trying to make savings within her own budget. She had also noticed that the resident did not take the medication on a regular basis and felt this was an acceptable economy measure to take. I asked the GP to reconsider as the resident had dementia and was not able to understand when she was in pain which caused her a great deal of distress. I said we needed a form of medication that promptly got into the resident’s system to alleviate her pain.
I offered the GP a copy of our medication policy so she was able to see that we were not able to operate outside our policy and guidance. We discussed the option of soluble tablets, but they were deemed inappropriate as the resident would not drink the necessary amount of liquid. As a result of the discussion the GP agreed that it was in the resident’s best interest to leave her medication in liquid form; this will enable us to administer pain relief in a form that is most suitable to the individuals needs.

Christine Hiley
Registered Manager

Using a single system at Druids Meadow

Druids Meadow is a 42 place care home in South Birmingham. It is very much a local home. I became Registered Manager about nine months ago and gained a new management team about four months later as a result of general council restructuring.

Since being at Druids Meadow I have used an audit framework to check medication practices. I found a system that needed tightening up, lacked consistency and was prone to error, wastage and overstocking. One of the underlying problems I identified was that we have six visiting GPs. Each had a different pharmacy and each pharmacist offered a different service. This was anything from a weekly to monthly delivery of medication. Each of the products that they provided were different, as were the written Medication Administration Report (MAR) sheets. To me the system in place appeared to be ineffective and could lead to errors occurring, especially having a new senior team who were not familiar with past custom and practice.

To simplify the system and reduce confusion we have contacted the most local pharmacist and requested that he take on all the GP practices. It is a small business within walking distance. This pharmacist now collects all prescriptions from the six GP practices then dispenses and delivers every service user’s medication. This involved my senior care assistants in undertaking liaison with every GP practice to get them to channel all prescriptions to the one pharmacy. As a result they have built up a good rapport.

We now work with one pharmacist to improve our service as well as his. For example discussions led to blister packed medication that avoids loose tablets within the medication trolley. With one system in place and working with the pharmacist, we can offer service continuity and greater personalisation. Now we are quicker to identify glitches and contra-indications, able to receive pharmacists’ advice over the phone and have a pharmacist with personal knowledge of our residents who is getting to know the person behind the name on the label.

These changes have now taken place, and even though it is early days, I believe that we are working towards our goal of being more efficient. The system will be reviewed in two months time to reflect on how the new approach is working. I will hold a meeting at the home with the senior team and the pharmacist to consider any issues and resolve problems.

We wish to retain resident choice of GP, but to further improve efficiency and safety we have contacted the practice manager of the GP who has the majority of our service users, to look at improving ordering and repeat prescription systems. He visits every Monday and is trusted and held in high regard by his patients. We would like the GP to move to a monthly system of repeat and automatic prescriptions in line with the other GPs within Druids Meadow. Our intent is to offer a choice of GP but at the same time adopt a standardised system with the pharmacy.

My view is that these types of steps will both reduce work for the GP and improve efficiency and safety for us. Discussions are continuing and I am finding support from the practice pharmacist at the local Primary Care Trust very helpful in weighing the pros and cons of changing systems.

Rita Gardner
Registered Manager
Transition from a communal medication trolley to individual cabinets in residents’ rooms

At Gattison House we decided to change the arrangements for medication storage and delivery to make medication part of person centred care. As a senior team we wanted to do our utmost to ensure dignity, choice, privacy and confidentiality whilst also promoting independence and empowerment where possible. The medication arrangements are personal to every resident and do not need to be a communal activity.

We began by discussing the proposed changes with residents and relatives. In so doing we highlighted the benefits and acknowledged and responded to any concerns or questions that were raised. Our GPs were advised of the changes. They felt they did not need any input unless there were concerns over an individual’s capability in making decisions regarding their medication. Our pharmacy supplier provided new individual secure medication cabinets and a changeover of medication delivery arrangements from blister packs to Nomad cassettes.

We then prepared new procedure documents covering the changes in medication storage and delivery. This formed the basis of consultation with care workers and underpinned their training. Now care workers complete certified medication training through the local authority. This facilitates their involvement in providing the whole care package including administering of medications as part of the resident’s daily routine. Managers assess practitioners’ competence over at least a two week period and ensure that they feel confident in their ability to perform the task correctly. Just to make sure we review monthly.

We have ensured that appropriate information is provided in the cabinets including MAR sheets and information about what medications are for and what possible side effects they have. With respect to monitoring, the procedure requires completion of a daily check list indicating medication dispensed for each resident. A weekly check takes place when changing over Nomad on Sundays. This involves checking that paperwork is completed and matches the medication used. Any issues arising or concerns are dealt with immediately. On a monthly basis we undertake spot checks on individual medication amounts and medication dispensed and signed for.

The PCT are involved in monitoring the system and assist with inspections and advisory clarifications. They are happy with the whole process as are our residents.

Melanie Haley
Registered Manager
Safe handling of medicines in Lincolnshire

Leadership - managing the market and network development

In 2005, following a dispute about care home fees, Lincolnshire County Council provided funding and officer support to create an Independent Sector Workforce Steering Group. The initial sector membership comprised volunteers who had attended a successful Council, Skills for Care and European Social Fund (ESF) funded management development programme to support the Level 4 Registered Manager’s Award achievement.

This Supporting Managers programme delivered via Business Link’s Business Training Network proved to be a powerful catalyst for co-operation amongst managers of the many small and medium sized care sector businesses across the county. Local networks were formed (and connections remain), to share best practice and provide much needed peer support to Registered Managers who were particularly isolated by working in such a large, rural county.

Lincolnshire’s commitment to and achievement of a partnership approach to leadership and management development was reflected within Skills For Care’s national guidance product for small and medium sized enterprises (SME’s)

The Workforce Steering Group continues to be at the heart of the partnership, and is now linked to a Strategic Workforce Board that oversees Lincolnshire’s Joint Workforce Strategy and Plan for Personalisation. This strategy is the East Midlands ‘exemplar’, due in part to its ‘whole systems’ and collaborative approach, and is on the Department of Health’s website.

The Supporting Managers programme has also gone from strength to strength – revised to support the changing leadership and management qualifications and is co-delivered by experienced sector managers. The Level 3 Supporting Seniors programme was created to ensure a development pathway was in place to aid succession planning and address the management turnover in the sector.

This year, due to sector requests, Lincolnshire will deliver a new Supporting Proprietors programme, to help business owners meet the personal development requirements and outcomes of the Care Quality Commission (CQC). This is intrinsically linked to the continuous improvement of high quality services across a county which last year achieved the highest percentage nationally (approx 93%) of care homes rated good or excellent by CQC.

The successful collaboration across Lincolnshire’s internal and external health and social care workforce was founded upon and sustained by the commitment to open dialogue, partnership and peer support between the County Council and the independent care sector. It was within this history and established network they we were able to undertake the work necessary to prepare medication guidance.
Medicines management guidance

Throughout the lengthy and at times challenging evolutionary process of developing the medicines management guidance, various task group members contributed to, and/or left the group. However, there was consistent membership from the independent sector via Helen Reilly (Registered Manager, Oakdene Nursing Home, Sleaford), the local authority via Dave Wilson (Registered Manager, Harrison House, Grantham) and myself (in various workforce development roles).

The excellent leadership and management skills demonstrated by the two Registered Managers were critical to the achievement of a practical toolkit to support care homes. This is not just another health and safety document to be left on the office shelf, as it includes staff competency audits, template risk assessments and sample forms.

The original County Council guidance was co-produced with care home residents and their families. This content has been extended to incorporate a greater emphasis on supporting self-administration where possible, in accordance with the principles of dignity, rights, choice and enabling risk within the personalisation and safeguarding agendas.

Despite Lincolnshire care homes overall receiving a healthy report from the regulator, the message from the national Handle with Care report (Feb 2006) that “good homes do well on handling medication” spurred a group of managers across the sector not to become complacent.

Jill Guild, a former manager of one of the County Council’s own residential homes and managers who were part of independent sector workforce steering group joined forces to co-produce a Joint Medication Policy and Procedure Guide applicable for the whole sector’s care homes and day care facilities across a range of older people’s and disability service areas.

Although the task group had the benefit of a newly improved Lincolnshire County Council policy and procedure, which had been co-produced with residents and staff, this was no easy feat, as the guidance also needed to be applicable to nursing homes.

The technical input of a pharmacist from NHS Lincolnshire proved invaluable alongside contributions from the council’s Health and Safety and Mental Capacity Act leads and the NHS Deprivation of Liberty Safeguards Advisor. The original document underwent numerous revisions and updates to accord with Royal Pharmaceutical Society (RPSGB), National Association for Safety and Health in Care Services (NASHiCS) changing regulatory and Lincolnshire County Council commissioning requirements.

The final product is a set of policy standards based on RPSGB guidance and CQC Outcome 9 which forms part of Lincolnshire County Council’s contractual requirements, plus a supporting Guidance Toolkit which is optional for sector services.

Kim Hughes
Quality and Development Manager (Workforce)
Adult Social Care Commissioning
Lincolnshire County Council
Improving medication management in care homes is a systemwide issue, which needs to be tackled by many different groups working together. This work is now being taken forward in an integrated programme led by the National Care Forum, funded by the Department of Health, working as part of a wider cross-sector partnership. This partnership involves:

- Age UK
- English Community Care Association
- National Care Forum
- Royal College of General Practitioners
- Royal College of Physicians
- Royal Pharmaceutical Society
- Care Provider Alliance
- National Care Association
- Registered Nursing Home Association
- Royal College of Nursing
- Royal College of Psychiatrists
- The Health Foundation