I-CareMedway

Quarterly Care Homes Medicines Newsletter
Edition 3, January 2020
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NHS
Medway
Clinical Commissioning Group

Introduction

This newsletter is intended to support all care homes in Medway catering for elderly care with current medicines guidelines and safety information. Care homes are encouraged to discuss the items in the newsletter with all staff to ensure that all intentions are implemented.

Controlled Drugs (CD) Incidents

Providers of adult care homes should ensure that there is a process in place to formally escalate CD incidents to the Care Quality Commission (CQC), the Area Team Controlled Drugs Accountable Officer and the police as appropriate. There is a legal requirement to report all concerns and incidents related to controlled drugs (including loss or theft) to your local NHS Controlled Drugs Accountable Officer. The CD Accountable Officer Team for South England (including Kent & Medway) can be reached at england.southeastcdao@nhs.net.

Yellow Card Scheme

Report any suspected adverse reactions with medicines via the national reporting system available from https://yellowcard.mhra.gov.uk/

Medication Incidents

Care homes should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving residents. You must notify CQC and other relevant external organisations as appropriate. More information can be found at Reporting Medicine-Related Incidents in Social Care, CQC 2019. Available from: https://www.cqc.org.uk/guidance-providers/adult-social-care/reporting-medicine-related-incidents-social-care

Drug Safety/ MHRA Safety Updates

NICE social care guideline: managing medicines in care homes (2014) states that health and social care practitioners should be able to access reliable and up-to date information about medicines this includes the access to the latest drug safety alerts from the MHRA. If the care home is not already registered please email safetyalerts@mhra.gov.uk.

Ranitidine and Metformin

There has been a number of pharmacy-level recalls for ranitidine-containing products and more recently metformin as a precautionary measure due to possible contamination with N-nitrosodimethylamine (NDMA), an impurity that has genotoxic and carcinogenic potential. Please continue to administer either of these medications to residents unless your care home has been contacted by the GP or the supplying pharmacy. Withholding these medications could cause potential harm to the resident and would constitute a medication error.

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Fluid Thickeners and Dysphagia

Dysphagia is the term that describes the impaired ability to swallow, meaning that solids, liquids or medications may not move through the mouth, throat or oesophagus safely and effectively. Dysphagia is always a result of another condition and there are many possible causes. Dysphagia involving the mouth and throat is called oropharyngeal dysphagia and is common in progressive neurological disease (e.g.dementia, Parkinson's, motor neurone disease, multiple sclerosis), head & neck cancer, respiratory disorders, connective tissue disorder, stroke or brain injury. Oesophageal swallowing difficulties can arise due to structural abnormality in the oesophagus; obstruction from external compression or motility disorder. A variety of signs and symptoms can be associated with dysphagia including unexplained weight loss, recurrent chest infection, frequent coughing when eating & drinking, difficulty chewing or difficulty taking medications. A speech and language therapist (SLT) should be consulted if there are any concerns.

Thickeners may sometimes be used to help the resident to control and direct the movement of liquids through the mouth and throat towards the oesophagus. The slower movement of thicker liquids can give more time for the airway to close before the food passes through. A thicker liquid holds together more than a thin liquid. This can reduce the risk of drinks entering the respiratory system (aspiration) and potentially contributing to aspiration pneumonia. Thicker drinks may also help the resident to control liquid in their mouth before swallowing.

The correct thickness is vital and should be determined by an SLT on a case by case basis. Recommendations are communicated using the IDDSI (2018) framework. It is important to remember that thickened drinks are not the best approach for everyone and in some cases can make swallowing more difficult. Thickener should therefore not be used before first discussing with SLT.

CQC makes recommendatons on the use and montioring of fluid thickeners. The resident should have had an appropriate assessment by a member of the SLT team and have a care plan related to dysphagia. This should also cover the use and thickening of medicines where a pharmacist should be consulted for advice. The consistency of fluids should be recorded e.g "IDDSI Level 2" written on the MAR and in the care plan.

Medway uses Resource ThickenUp Clear (a xanthan gum-based product). There have been some instances in care homes in Medway where the incorrect powder (starch-based product) has been prescribed. There have also been instances where thickeners have been used without seeking SLT assessment or advice. If there are concerns please contact the GP, the care homes pharmacy team or the SLT service.

Fluid thickeners should only ever be used for the resident that they are prescribed for and should be stored away in a locked cupboard to ensure residents are not at risk of from asphyxiation by accidental ingestion of the thickening powder. Staff including kitchen staff should be trained on the use of fluid thickeners and any use should be recorded and monitored. Its use should be included in the regular medicines use audit.

Further information:

Medway Food First pack 2019 (supplied to the care home)
https://iddsi.org
NHS England Patient Safety Alert (2015). Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder. Available from: https://www.england.nhs.uk/wp-content/uploads/2015/02/psa-thickening-agents.pdf
CQC 2019. Dysphagia and thickening powders. Available from: https://www.cqc.org.uk/guidance-providers/adult-social-care/dysphagia-thickening-powders

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I-Care about Medicines — Opioid Transdermal Patches

The MHRA issued an alert in 2018 to warn patients and healthcare professionals about the risks of overdose due to unintended opioid toxicity associated with fentanyl transdermal patches. When heat is applied to the area of skin surrounding a fentanyl patch, patients may receive increased doses of opioids, sometimes causing fatal doses to be absorbed. The following advice for safe application of opioid transdermal patches (including Buprenorphine patches) is recommended:

- Bathe or shower (with care) whilst wearing a patch but the water should not be too hot.
- Heat (e.g. hot baths, electric blankets, hot water bottles) should NEVER be applied over the top of the patch as it may enhance the absorption of the drug.
- An increased temperature / fever may also increase absorption
- Patches should never be cut.
- Ensure that residents and caregivers are aware of the signs and symptoms of opioid overdose and advise them to seek medical attention immediately if concerned.

Severe toxicity can be identified by a combination of three signs and symptoms: pinpoint pupils; over sedation with unconsciousness and respiratory depression. A combination of opioids with other medications, for example but not limited to lorazepam, amitriptyline and alcohol increases the risk of respiratory depression and death.

This information should be available to ALL staff in the care home, and a risk assessment provided within the care plans to alert any staff to the risks associated with application of all transdermal patches.

Medway Care Homes Best Practice Update and Other News

Medway Care Homes Best Practice Guidance documents
Available from: http://www.medwayswaleformulary.co.uk/guidelines-pathways/medway-guidance/medway-ccg-care-home-best-practice-guidance/

Care Home Best Practice training:
Please look out for more Best Practice training coming soon!

Joint Provider Forum:
Will be at 1.30pm on 29 January at Medway Council- Civic Suite

Medway Prescribing Newsletter:
https://www.medwayccg.nhs.uk/about-us/strategies-and-policies/pharmacy-and-prescribing/2173-prescribing-newsletter

References –
CQC. Reporting medicine-related incidents in social care. Available from: https://www.cqc.org.uk/guidance-providers/adult-social-care/reporting-medicine-related-incidents-social-care
NICE guidance on managing medicines in care homes (SC1)