Welcome to the
Medicines Waste Conference
28 November 2012
Aims and objectives

- Bring key stakeholders together
- Hear different speakers and perspectives
- Locality based plenary discussions
- Locality generated ideas

To inform the Medicines Waste Campaign

This is just the beginning ...
Housekeeping

- Locality based tables
  - Facilitator
  - Scribe
- Tea and Coffee
- Toilets
- Fire alarm and mobile phones
- Lunch
- Keeping to time
Plan of the day

- Scene setting
- National context
- General practice
- Community pharmacy
- Acute trusts
- Patient and public
- Care homes
Introduction

• Rick Byrne, GP Chair, Northampton South & East
• Peter Wilczynski, GP Chair Corby CCG
Medicines Waste Stakeholder Conference
Dr Rick Byrne
Nene CCG Chair Northampton East and South Locality and Medicines Management Lead
28 November 2012
‘The desire to take medicine is perhaps the greatest feature which distinguishes man from animals’

Sir William Osler (1849-1919) in H Cushing, Life of Sir William Osler (1925)
NHS England

- £12bn a year on medicines, of which £8bn is spent in primary care

2000
- 552 million prescription items dispensed per annum
- 11.2 items per head of population per annum

2010
- 927 million prescription items dispensed per annum
- 17.8 items per head of population per annum

Estimated value of medicines returned to pharmacists by patients is £150m
More care is not necessarily better care
... a pill for every ill!

Multi-morbidity:
Polypharmacy is now the form for prescribers

Non-drug therapies:

- Talking
- Walking
Most people don’t have a clue how much their medicines cost

When no value is attributed to something, people tend to take it for granted

Opportunity costs
Most people don’t have a clue how much their medicines cost.

When no value is attributed to something, people tend to take it for granted.

Opportunity costs.
Peter Wilczynski
GP Chair Corby CCG
Medicines Waste

• Scale
  – £300 Million
  – Half could be saved £150 Million
  – £1-2/patient/year
Medicines Waste

• Causes
  Systems
  – 28 day Prescribing
  – Repeat Dispensing
  – Medicines Review Processes
  – Green Prescribing Schemes

Patients
  – Unavoidable
    » Changes to therapy, Death
  – Avoidable
    » Flexible and informed use of 28 Day Rule, 2nd Care Interface

Doctors
  – Variation

Pharmacists/Medicine Managers
Medicines Waste

• Compliance
  – £500 Million
    • Diabetes £440 per patient
    • Hypertension (80%) £100 Million/yr
    • Schizophrenia £5,700 per patient
Medicines Waste
Quality Prescribing

Lakeside Surgery Results

Total patients 48,190

Individual patients triggering rules 7857

Percentage of practice patients triggering rules 16.3%

Total rules fired 157

Rules fired at Lakeside Surgery

Superscript switch
Nice/Metrics/Cost
£1-2/patient Year
The Scale, Causes and Costs of Medicines Waste – a national perspective

Northamptonshire Medicine Waste Management Conference, 28th November 2012

David Taylor
Professor of Pharmaceutical and Public Health Policy
The UCL School of Pharmacy
This presentation

- Offers some initial thoughts about waste in general and medicines waste in particular
- Summarises the main findings of the YHEC/SoP report on medicines wastage
- Discusses some suggestions relating to medicines use optimisation and waste minimisation, in the light of the current reform process
Waste can be measured physically (as in tons discarded) or in terms of lost opportunity (such as years of life *not* saved or disability *not* prevented).

It can also be measured in terms of sum of the prices of the items discarded. But this can be a misleading approach.
Pharmaceuticals as special goods?

- Medicines typically have high fixed (sunk) costs of development and relatively low marginal costs of production.
- All medicines are potential poisons which if used carefully bestow benefits. But this is true of many other things.
- Waste is common in societies like ours. For example, between 10 and 20 per cent of all food purchased is thrown away.
Professionals as special people?

• Professions were historically trades that needed special regulation and management because of their special knowledge.

• The danger of believing naively in the value of professionalism is that we may come to judge all non-professional people as lacking ‘our abilities’.

• ‘What is not paid for is not valued’ (?)
The overall cost of NHS medicines wastage in the English community setting

- We found the gross annual ‘cost’ of NHS primary care material medicines wastage in England to be about £300 million pa in 1979, or £1 in every £25 devoted to pharmaceutical purchasing.
- Of this £110 million was accounted for by pharmacy returns and £50 million by care home waste.
- The estimated therapeutic opportunity cost of not taking or under-using medicines in just five therapeutic areas was put at £500 million.
A degree of over- or under-estimation may have occurred. But the available evidence indicates since the 1990s medicines wastage has almost certainly fallen relative to the volume of prescribing.
There is no evidence that the NHS has a special systemic problem in managing medicines waste, as compared with that observed in other countries and systems.

The level of medicines wastage that is cost effectively preventable is in the order of 50% of the total recorded, or £3 million per million population minus additional intervention costs. It deserves serious attention. But any such savings should be seen in the light of annual NHS spending of some £120 billion a year in England alone.
The causes of medicines waste in the community setting

- Recovery before dispensed medicines are all used
- Side effects leading to a change in therapy
- Disease progression
- Death or admission to institutional care
- Inappropriate prescribing and/or dispensing
- Care system failures, people’s fears and uncertainties
- Deliberate or accidental patient non-adherence
Opportunities for further performance improvement include....

- Better support for patients around the time of initial supply (see now the NMS)
- Enhanced prescribing and case management (targeted MURs?)
- Incentivising better professional supervision at the point of dispensing
- Informed and flexible use of 28 day prescribing
- Better (pharmaceutical) care for vulnerable in the community setting
- Better integrated and managed end of life care
- Communicating the links between better health outcomes, medicines waste reduction and overall economic efficiency and service quality
Controversies include....

• Poor world health needs – should we give unused medicines to communities in need of aid?

• Can ‘DUMP’ campaigns be counter-productive?

• Is nursing/care home medicines wastage something we should not be worried about?

• Does paying for your medicines make you feel more entitled to waste them?

• Do discarded medicines cause significant environmental damage?
Conclusions and recommendations

• Care for people you work with, but do not waste labour

• Creating value in health care involves respecting consumer preferences, not just meeting their professionally defined needs

• As with any type of risk or unwanted event, reducing medicines waste is normally desirable. But it is not worth achieving any cost
There is good reason to value what pharmacists and other colleagues have achieved in areas such as NHS medicines cost control and waste reduction over the past decade. Those responsible for managing the transition to CCGs and the NHSCB should be careful not to underestimate what has been done.

In looking to the future it will be important to put achieving better health and social outcomes and promoting goals like healthy ageing first. Medicines waste is best seen as an indicator of poor care and lost opportunity for greater wellbeing, rather than as a major concern in its own right.
David.G.Taylor@ ucl.ac.uk
The Role of the Practice Medicines Co-ordinator (PMC)

Altaz Dhanani
The Idea

- Originated in West Cumbria PCT
- Dearth of practice pharmacists and no pharmacy technicians
- Increase MM activity in practices
- Pre-pilot: one of the highest cost growths on medicines
- Post-pilot: -6% in cost growth equivalent to £714,000 over 2 years
The Coventry Pilot - Objectives

• Improve the quality of repeat prescribing systems

• Reduce medicines waste

• Improve medication review systems

• Reduce medication errors

• Realise savings by reducing/containing costs
PMCs – Roles and Responsibilities

• Non-Clinical

• Management of the repeat prescribing system

• Help develop and implement appropriate policies and protocols

• Training and guidance to other practice staff

• Liaison with MMT

• Collaborate, network and share best practice with other PMCs
PMCs – So what do they do?

- Quantity synchronisation
- Dose instructions against all repeats
- Dose optimisation
- Housekeeping
- Hospital discharge letters
- Manage care home orders
- Manage DAC ordering
- ID pts under/over ordering repeats
- Identify Specialist Only drugs
- Identify specials
- Deal with MURs from community pharmacy
The Commitment

• PMC released for the initial induction training programme (over 4 consecutive half days)

• PMC released for mandatory update training and networking sessions (held approximately every 2-3 months)

• Monthly reporting of interventions advised/actioned

• Practice lead GP to have pre-planned protected time with PMC to discuss interventions identified

• Practice support and co-operation for the role
The Benefits (So Far)

2011/12 ITEMS / ASTRO-PU Growth

- PMC Practices: 0.16%
- PMC Control: 1.60%
- InSpire: 3.70%
- Coventry All Practices: 2.80%
- SHA Average: 3.70%
- England Average: 3.90%
Quality Benefits

- Ownership of the repeat prescribing system
- Increased job satisfaction for the PMC
- A named link to the practice for AHPs, as well as the MMT
- Campaign promotion
- Point of contact for patients to discuss medication changes happening at the practice
- Ideally placed for medication name changes e.g. *Epanutin*®
Thanks for listening!
Table discussion

- Q1. How can we improve repeat prescribing processes in GP practices?
- Q2. Practice medicines co-ordinators – how could this concept or something similar work in Northamptonshire?
- Q3. What do you think we should do next? How can we involve GP practices in a medicine waste campaign?
THE ROLE OF COMMUNITY PHARMACISTS IN WASTE REDUCTION AND MEDICINES OPTIMIZATION

Mukesh Lad, Chair

28 November 2012
“If the right quantity of the right medicine at the right dose is prescribed for the right patient ….

and

the right medicine is dispensed at the right time ….

and

the right patient takes the right medication entirely as prescribed…”
there will be

should

NO WASTE
Really?

?
The annual cost of wasted medication is estimated at £300 million in England\(^1\) from a budget of £8,100 million\(^2\).

Some wastage is *inevitable* however a lot of waste is *preventable*.

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\(^1\) York Health Economics Consortium, November 2010

\(^2\) NHS Information Centre, May 2011
How is it happening?

Isle of Wight Community Pharmacy
Multi-Disciplinary Audit 2010-2011: Reducing Medicines Waste and Unnecessary Medicines Supply to Patients

“Why did patients receive items not required?”
From 17th March to 6th April 2011
263 interventions
Total of 102,000 items dispensed

✓ 47.1% of ordered items were not required by patients

✓ Nearly 50% patient error

✓ 25% of unwanted items not requested by patient or pharmacy

✓ 7.6% ordered by pharmacies when not needed by the patient

✓ The remainder had been discontinued since the request was made or for another reason
Of the total identified:

61 items (23.2%) had been included by the GP practice, but at the point of dispensing and supply the patient confirmed the items had not been requested and were not required. These were sometimes items that had been discontinued, or “when required” items that had not been requested by the patient.

20 items (7.6%) appeared on prescriptions as a direct result of a pharmacy Managed Repeat Service. The majority of items in these cases were inhalers, external creams/ointments, and other items to be used on a “when required” basis by the patient such as painkillers or laxatives.
Reasons included:

- Not understanding the order process (i.e. correct use of the prescription right hand side)
- Initial ordering and the patient then discovers unused medicines at home
- “When required” medicines e.g. inhalers and external preparations initially ordered with chronic illness repeat medicines. Later discovered sufficient supplies at home
- “I might as well order these items while I’m here”
- Concerns about medicine shortages - comfort from having “plenty of medicines as a stand by”
On the Isle of Wight, this means:

- Annual cost of medicines prescribed on the Isle of Wight is around £23m
- Estimated £1m returned to pharmacies for safe disposal
- Additional annual incineration cost of £36k
- Estimated £1m stored and unused medicines
- At least as much again is being used incorrectly
Patient

- Poor patient compliance
- Inequivalence
- Prescription over ordering
- Prescribing of excessive quantities

“Just in case I need them”
Examples of patients ordering everything on repeat - especially ‘PRN’ (when required) medicines:

- **Patient stockpiling Viagra for 3 years**

- **I always ask for everything on the slip for a variety of reasons – don’t want to run out, easier to say everything, don’t want doctor to think I’m not using them properly by not re-ordering. I admit that compliance with Serevent is a problem, sometimes I manage with just the Qvar and Ventolin**

- **Patient was ordering when she didn't need to. Some of the stock she brought back was out of date. Other stock had been stopped by GP (532 paracetamol returned, 7 Ventolin Evohalers)**
GP Practice

- Prescribing of large quantities especially when treatment is first initiated
- Change in medication due to side effects or change in the patient’s condition
Numerous incidents where patients returned large quantities of medication which had been discontinued sometimes after only a few doses - pain killers were cited as good examples

- Patient had been prescribed 100 dihydrocodeine – had a bad reaction after 2 tablets, breathing difficulties, swollen tongue and throat. GP stopped immediately

- Patient was leaving for 3 month holiday abroad - the surgery issued a script for pain relief to cover this period - 730 tablets "not agreeing with him" audited and destroyed
- Medicine shortages leading to incorrect supply of prescribed quantity
Transfer of Care

- Up to 70% risk of miscommunication and unintended changes
- Less than 10% chance of elderly patients discharged on the same medicine
- Up to 40% of medicines are discontinued during hospitalisation
- 45% of discharge medicines are new medicines
- 60% of patients have 3 or more medicines changed in hospital
How can Pharmacy help?
ASSIST

• Inequivalence on Prescriptions

• Difficulty ordering & managing repeat medicines with different durations

• Ordering of **NEEDED** items only

• Patient Self-Management & training e.g. inhaler technique
MONITOR

- Patient adherence
- Total compliance with Doctors’ instructions
- Identify patients with poor compliance (>20% missed doses)
INTERVENE

• Help & support for best use of medicines:
  • New Medicines Service (NMS)
  • Medicines Use Review (MUR)
Medicines Use Review (MUR)

- A structured review of patients use of medication undertaken by a Pharmacist
- Helps patients know how to use medicines & why they’ve been prescribed
- Helps patients manage medicines more effectively
- Identifies problems, side effects and solutions
- Addresses adherence & optimisation issues
- Avoids unnecessary ordering of medicines
- Reduces medicines wastage
New Medicines Service (NMS)

- Designed to help patients get the most from their newly prescribed medicine

- Provides advice, information and reassurance to address patients’ concerns during the first month of new treatment

- Based on proof of concept research

- Came into effect on 1st October 2011 – review March 2013

- Funded from a central ring-fenced budget
NMS – Proof of Concept

- 30% of LTC patients are non-adherent, of which:
  - 7\% of patients had completely stopped taking the medicine
  - 45\% of non-adherence was intentional (the remainder was unintentional)

- 61\% of patients expressed a substantial and sustained need for further information

- 66\% of patients still taking their medicine reported at least one problem with it
- Pharmacy intervention can improve adherence for LTC patients by 28 days

- Significant reduction in number of patients with medicine-related problems

- Better adherence is associated with better clinical outcomes
Day 0: Patient Engagement

1. Recruitment is by Pharmacy or via GP referral subsequent to the prescribing of a new medicine for:
   - Asthma or COPD
   - Diabetes (Type 2)
   - Antiplatelet/Anticoagulant therapy
   - Hypertension
Day 7-14: Intervention

2. **Private in-practice consultation or by phone with a semi-structured interview to**
   - Assess adherence
   - Identify problems
   - Identify need for information & support
   - Agree solutions & follow up
   - Referral to GP where necessary
Day 28: Follow up

3

- Private in-practice consultation or by phone for pharmacist to provide advice and support
  - Confirm patient adherence
  - If patient is non-adherent:
    - a) provide more advice and support
    - b) refer to GP *(using nationally agreed Feedback form)*
NMS – the story so far

• Service launched in October 2011
• by 30 June 2012…

• 83% (9,467) of community pharmacies are providing the service

• 369,000 interventions over a period of 9 months

• Currently being evaluated by independent researchers commissioned by the Department of Health
How can Pharmacy help?
Feedback to surgeries & prescribers

- Many prescribing factors beyond the direct control of Pharmacy
- Often in a position to amend systems or influence prescribers to prevent future occurrence
- Prescribers often removed from implications of their actions
- Prescribers unaware of extent to which they contribute to the waste problem
- Reports of incidents around waste to Surgery Teams/Practice Medicine Managers
Local Pharmacy Waste Reduction Services
Isle of Wight

- Focus of QIPP agenda within Isle of Wight NHS PCT recognised Community Pharmacists can play an integral part in the achievement of cost savings

- Various pharmacy services to incentivise medicines management interventions by pharmacy teams
Local Pharmacy Waste Reduction Services
Isle of Wight Initiatives

Payment not to dispense
This service seeks to reward pharmacists for basic interventions that recognise medicines included on prescriptions that, for whatever reason, are not required by the patient

Pharmacy Platinum Points
Simple changes can be made to prescribed therapies that will generate ongoing cost savings without any clinical impact. This service aims to identify changes that can be agreed between patient, pharmacist and prescriber such as changes for a more economic pack size, use of certain generic rather than brand products or prescription items rather than items intended for patients to purchase. The Pharmacy shares 45% of the acute savings achieved with the PCT
Many patients are unaware that all returned medicines must be destroyed.

“Patient thought as they were unopened/unused that we would be able to re-use or at the very least send to a "3rd world project", he was shocked at the thought of them being destroyed/wasted”

“Patient prescribed diclofenac and codeine phosphate for relief of pains and also senna to counteract effects of codeine. When the condition improved and medication no longer required the patient kept the tablets 'just in case' they might be needed in the future”
Managed Repeat Dispensing

• Encourages the uptake of managed repeat dispensing through pharmacy

• Aims to order regular necessary medication for LTCs

• Ensures continuity of supply

• Supports on-going medicines compliance

• Allows pharmacists to put further compliance support measures in place e.g. large print labels or monitored dosage system
NEXT STEPS

Launch of the Pharmacy Northamptonshire Discharge Medicines Service

Dec 2012
How improved medication adherence can prevent costly medicine waste
9 February 2012 | By Andrew McDowell, Nina Barnett

Preventing unnecessary hospital admissions for medication could save the NHS a significant part of the £150m “medicine waste” recognised in a Department of Health report, say Nina Barnett and Andrew McDowell
Evidence from Discharge Service in Hampshire
April 2011-March 2012

• 138 assessed by hospital pharmacist pre-discharge
• 120(87%) patients referred to community pharmacy within 7 days

Of which:
• 97 patients received a domiciliary visit
• 43 (44%) had medicines removed in cabinet check
• 36 (37%) required synchronisation
• 61 (63%) required additional support (e.g. managed medication)
NEXT STEPS

Current General Practice/Community Pharmacy contract:
Doesn’t require staff to check patients require individual items requested or presented on prescription

Pharmacy Northamptonshire Repeat Medicines Service Proposal to limit the supply of expensive new drugs pending confirmation that the treatment is suitable Will be presented to Commissioners early 2013

Managed Repeat Service +
Ensure procedure is correctly followed Waste reduced by 30%
“Drugs work in patients that take them.”

Thank you

mukesh@pharmacynorthamptonshire.co.uk
Table discussion

- Q1. How can community pharmacists help us to reduce waste medicines?
- Q2. How can we get the best from MURs and the NMSs?
- Q3. How can we involve community pharmacists and their staff in the medicine waste management campaign?
Medicines Waste: Secondary Care

Paul Rowbotham,
Chief Pharmacist, NGH

28-Nov-2012
DH QIPP website refers to secondary care ‘medicines waste’ issues:

- Batch production within pharmacy to reduce waste.
- Use of patients' own medicines.
- Ensure that discharged medicines are not duplicated if the patient has supplies at home.
- Use of pharmacy assistants to recycle otherwise wasted hospital medicines.
Batch production = vial sharing.... an example:

Infliximab for Crohn’s Disease & severe Ulcerative Colitis [NICE].
2 hour i/v infusion, every 8 weeks.
£503 per vial [NHS price], 5mg/kg.

1 x 70kg patient needs 4 x 100mg vials.
Dose = 350mg, waste = 50mg = £251

Treating patients on just 2 days/wk saves around £100k/year @ NGH.

Other schemes in development.
Re-cycling of hospital-dispensed medicines......

Some causes:

Patients moving wards....& medicines not following.

Pressure to discharge.....
  ➢  & dispensing in advance of discharge, then treatment changed, or
  ➢  patient leaves before discharge medicines done.

Result = medicines returned to pharmacy to recycle.
In 2001 DH advised better management of the £90m of medicines patients take into hospital each year.

NGH POMs scheme on 10 wards – use own medicines & do not duplicate supply if some at home. Values of this exceeds £300k/yr.

Plan to roll this out to all wards with associated quality benefits.

Hospital’s management of POMs improved enormously since 2001.
KGH Transfer of POMs Audit

- **95%** of Patients own medicines bought into hospital were transferred with them when moving wards

- **1.6%** of Patients own medicines were taken home on advice of medical staff

- **3.4%** of Patients own medicines were left in A&E – now A&E visited daily to ensure medicines follow the patient.
More patients should take their medicines into hospital as it......

- Improves accuracy of medication history on admission.
- Clarifies supplies at home.
- Avoids delays/omitted doses [as not all medicines are immediately available on all wards].
- Avoids Non-formulary medicine problems.
- Improves assessment of compliance.
- Supports self-administration & independence.

Currently around 1 in 3 patients take their medicines into hospital [NGH].
Going into Hospital?

Don’t forget ..put your medicines in your trunk!!

Please keep your medicines with you when you come into hospital - don’t let them get sent home without you!
This ensures you don’t miss any doses
This helps you receive the right medication straight away

Adapted with permission from a poster from Royal United Hospital Bath

Annual Plan reports roll-out of the green bag scheme in 11/12.....
2010 concluded that primary care waste, due to interface issues, is not a systemic problem. Some areas:

- Discharge from hospital to nursing/residential homes.
- Medicine compliance Aids.
- Limited Hospital formularies leading to supply of ‘unacceptable’ formulations.
- ‘Many hospitals limit discharge supplies to 7 or possibly 14 days supply’!!.
- Patients Own Medicines Schemes in hospitals is supported.
Focus on **doing the right thing** and not on reducing waste:

It is **right** that patient’s medicines should accompany them around the hospital; better still it’s right that patients should not move wards.

Its **right** that patient’s should take their medicines into hospital when they go, and it’s **right** that these should only be destroyed if they can’t be used safely.

It’s **right** that patients should be discharged from hospital with their medicines. Etc. etc. etc

**The End!**
Lunch
Public and Patient Representative Focus

- Roz Horton (Non-Exec Director with lead role in Patient & Public Engagement – Nene CCG)
- Tansi Harper (Lay Member, Patient and Public Engagement – Corby CCG)
- Sylvia Smith (Chair of the Older Person’s Health Forum)
Engagement Campaign Strategies

Roz Horton
Non Exec Director with lead role in Patient and Public Engagement
What’s in it for Me?
Effective Engagement Strategy “Pieces”
After being part of this session and the following round table discussions we hope you have a better understanding of:-

* Why previous strategies may not have been as successful as was hoped
* How to get people’s attention
* How to encourage people to take action
* How to build on this going forward

We look forward to hearing your ideas.
Table discussion

Q1. What health benefits are the public not getting that would be meaningful to them and encourage them to take a more responsible attitude to reducing medicine wastage?

Q2. What are the barriers to managing this change in patient behaviour that we could charge patient groups to focus on and lead by example?

Q3. How can we reach the public and targeted groups and involve them in the medicine waste management campaign?
The role of care homes in medicines waste reduction

Care Home Advice Pharmacist- Najma Momen
• Introduction
• Care Home Advice Pharmacist team (CHAP)
• Medicines waste: Common issues and misconceptions in care homes
• Medicines waste: Some examples
• Case study: Nazareth House
• Best practice
• Summary
Introduction

• Care homes
  – Growing in number
  – Increasing ageing population size
  – Often rapid staff change

• Residents
  – Multiple conditions
  – Polypharmacy
  – Number of staff involved in medicines and with residents
Care Home Advice Pharmacist team (CHAP)

• Four Pharmacists (2 WTE)
• Part of Prescribing Team
• Cover Northamptonshire county
• Prioritise care homes for older people
  – Medication review with GPs and care staff
  – Medicines management audit
  – Medicines waste audit
  – Support and advise care staff
  – Signpost to other services
Results since December 2008 to September 2012:

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of medication reviews</td>
<td>1,792</td>
<td></td>
</tr>
<tr>
<td>Number of suggestions made</td>
<td>5,913</td>
<td></td>
</tr>
<tr>
<td>Average number of suggestions per resident</td>
<td>~3</td>
<td></td>
</tr>
<tr>
<td>Percentage agreed by GP</td>
<td>~87%</td>
<td></td>
</tr>
<tr>
<td>Number of drugs stopped</td>
<td>1,316</td>
<td>(£96,077)</td>
</tr>
<tr>
<td>Number of drugs changed</td>
<td>1,514</td>
<td>(£109,730)</td>
</tr>
<tr>
<td>Number of drugs started</td>
<td>134</td>
<td>(£4,518)</td>
</tr>
<tr>
<td>Oral Nutritional Supplements stopped</td>
<td>£14,660</td>
<td></td>
</tr>
<tr>
<td>Dressings removed from repeats</td>
<td>£1,298</td>
<td></td>
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<tr>
<td><strong>Total costs saved</strong></td>
<td><strong>£218,241</strong></td>
<td>(~£122/patient/year)</td>
</tr>
</tbody>
</table>
Medicines waste: Common issues

• No structure to ordering process
  – Best practice stepwise process not always followed

• Expiry date confusion
  – Not all medicines expire after 28 days

• Disorganised storage
  – No order to how resident’s medicines are stored
Medicines waste: Common misconceptions

• Medication cannot be ‘carried over’ - WRONG
• New medicines necessary every cycle - WRONG
• Quantities not enough for 28 days –WRONG
• Medication must be ‘blister packed’ - WRONG
Medicines waste: common issues & misconceptions

• Care home staff feel they
  – have to order every repeat item each month
  – cannot ask questions of the supplying pharmacy
  – cannot ask questions of the senior staff at the care home
  – cannot ask questions of the GP practice staff

• Carers do not feel medicines ordering is their responsibility
  – Not checking stock levels before ordering
Medicines waste: Some examples

• Lack of communication between care home, GP practice and pharmacy
  – Zoladex LA changed to Decapeptyl SR 11.25mg
  – Dual prescribing of both 3 months later
  – Cost £940/year

• Not checking stock before ordering
  – Patient no longer taking 4 medicines
  – All 4 medicines re-ordered for next monthly cycle
  – Cost £998.27/year
Medicines waste: Some examples

• Not ‘carrying forward’
  – GTN spray for ‘when required’ use
  – New one ordered each month
  – Cost £44.72/year

• Unaware of resident’s needs
  – Self-medicating resident disposing of prescribed Docusate Sodium 100mg capsules ‘2 twice a day’, as no longer needed.
  – Cost £93.18/year
Medicines Waste Audits:

- Carried out over a period of 3 months
- Example 1
  - Cost of £932.56
  - 72 wasted items
- Example 2
  - Cost of £724.61
  - 273 wasted items
Case study: Nazareth House

• Initial findings
  – Disposing of all items at the end of the cycle
  – Lack of stepwise structure to ordering process
  – Roles and responsibilities not understood by all staff
  – Staff were not clear of in-house expiry dates
Case study: Nazareth House

• Positive actions
  – Appropriate disposal discussed
    • Manager’s objective is to train and observe carer’s working practices
  – Roles and responsibilities
    • Team leaders to have key performance indicators
    • Staff training and change of culture
  – Improved communication
    • Between the care home and pharmacy
    • Between the care home and GP practice
Case study: Nazareth House

• Ongoing work and future plan
  – Continuing to raise staff awareness
  – Empowering staff
  – ‘PRN’ audits of Medication Administration Record sheets (MARs)
  – Working with the supplying pharmacy to improve prescription ordering process
  – Improve communication with GP practice repeat prescription clerks
Best practice monthly ordering process for care homes

Week 1:

1. Care home require new monthly order for repeat medications

2. Medicines needed for the following month are identified by Designated Staff Member (or deputy) from MAR charts as well as discussions with care staff. Stock levels of “When required”, “Externals” and “Sip feeds” must be checked.

3. ONLY order what is required using copy of current MAR chart.

4. Medication order is sent to GP Practice.
Prescriptions are generated by designated practice staff
(Note: consider retaining a copy of the Care Home request at
the practice for 1 month)

Prescriptions go back to the care home for checking. (Collected
by care home or by pharmacy)

Prescriptions are checked against retained copy of MAR chart –
any discrepancies are resolved as soon as possible
Best practice monthly ordering process for care homes

Week 3:
Pharmacy dispenses prescriptions - any discrepancies are resolved with the care home or surgery

Dispensed items are sent to care home at least 3 working days prior to cycle starting

Week 4:
Medication is checked (resolving any discrepancies as soon as possible) and ready to administer to service user on Day 1 of medication cycle
Summary

• Medicines Optimisation
• Roles and responsibilities understood
• Communication between the three parties
• Ongoing process of standard review
Table discussion

- Q1. How do you see the best practice process model being implemented in practice?
- Q2. Are there any barriers to this and how might they be overcome?
- Q3. How can involve and engage Care Homes in the medicines waste campaign?
Final words and close

Please remember to complete your evaluation forms