Frimley Health and Care

Good Practice Guidance for Care Homes: Structure Medication Review (SMR) for Social Care Professionals

Introduction

A Structured Medication Review (SMR) is an evidence-based comprehensive, holistic, person-centred review of a resident's medication, taking into consideration all aspects of their health with the objective of reaching an agreement with the resident about:

- their treatment goals,
- optimising their medication,
- the benefits and risks of their medications,
- minimising the number of medication-related problems/harm,
- reducing medicines waste.

All the medicines a resident is taking or using must be taken into consideration within an SMR.

An SMR is not:
the act of re-authorising repeat prescriptions, or
a review of some specific medicines during a long-term condition review.

Shared decision-making between the resident and the healthcare professional are essential during an SMR. This ensures the resident's preferences, beliefs, values and circumstances are considered. It also ensures the resident understands, through discussion and information sharing:

- the risks, benefits, and possible consequences of different options, including pharmacological and non-pharmacological treatment, or no treatment,
- the balance between the benefits, risks of, and alternatives to, taking medication.

Policies and procedures

It is good practice for the care home medicines policy to include the requirement to identify residents who would benefit from an SMR.
Pathway for Medicines Reconciliation & Structured Medication Review (SMR)

When should an SMR occur?

A SMR should be completed for any resident:

- Who has recently moved into the care home,
- Who has recently been discharged from hospital,
- Who has moved from one care home to another care home,
- Who has had recent change(s) to their medications from another healthcare professional such as from a specialist, an outpatient clinic appointment, specialist nurse, District Nurse (stopped, started, dose and/or frequency changed),
- Who has had a change in their state of well-being,
- Who has had recent falls, or has started to fall more frequently,
- Any resident about whom the care staff are concerned.

The frequency of an SMR should be agreed by the MDT, with safety being the most important factor. SMRs should be undertaken at least annually and are best linked into regular care and support planning reviews.
Many care home residents will be living with frailty, multiple health problems (multi-morbidity) and taking lots of medicines (polypharmacy).
Reviewing and balancing a resident's:

- health needs,
- treatment burden,
- wishes and ability to comply with this,
- increased risks of adverse drug reactions (ADRs),
- risks versus benefits associated with medicines' use,

by managing polypharmacy, deprescribing and shared decision making is essential.
Clinical decisions are unlikely to be based solely on clear, recognised treatments for conditions, but also require interpretation in the resident's circumstances.

What are the benefits of an SMR?

The benefits of an SMR include:

- involving the resident in the decision-making process, providing support, and empowering them to have a better understanding of the medicines they take results in better patient outcomes,
- less risk of harm from medicines, e.g. adverse drug events, side effects, hospital admission,
- reduction in pill burden,
- reduced waste of medicines.

Who can carry out an SMR?

Only appropriately trained clinicians working within their sphere of competence should undertake SMRs. These clinicians should have a prescribing qualification, advanced assessment and history taking skills or be enrolled in a current training pathway to develop these and should be able to take a holistic view of a person's medication.
Clinical pharmacists are expected to conduct the majority of SMRs, but suitably qualified advanced nurse practitioners (ANPs) who meet the above criteria, as well as GPs, can also do so.

Residents can be referred for an SMR to the:

- PCN clinicians (Pharmacists, ANPs and GPs),
- GP practice,
- ICB MOCH team.

What are the key components of an SMR?

Key components of an SMR are:

- **Personalised approach** (what matters most to the person).
  An understanding of the person's
  - needs
  - preferences
  - goals
  - values
  - circumstances

  should be established, together with other key components of an SMR.
- **Shared decision-making** principles should be part of the conversation.

- **Safety** – the balance between the benefits and risks of current treatment, any alternatives to medication, and starting new medicines.
- **Effectiveness** – medication should have evidence of clinical and cost effectiveness.

A suggested template to ensure appropriate information is recorded as part of the SMR by the trained healthcare professional is attached (Appendix 1).
The SMR template should be used as a guide, checklist and/ or prompt, to support a consistent approach, as a reminder to avoid any omissions, and as an assurance of the provision of a high standard of care.
Each SMR should be personalised to the individual.
Timely follow-up and review following stopping, starting or a change in dosage of medication is an important part of the SMR process.

Who should be involved in the SMR?

An SMR should involve:

- The resident, taking into account any cognitive impairment/ lack of mental capacity to make decisions about health and welfare,
- A family member, relative, trusted friend if the resident would like this,
- A representative (Lasting Power of Attorney (LPA) for health and welfare) if the resident does not have capacity,
- A healthcare professional,
- Any carers or nursing staff involved in the resident's care.

Who else may be involved in the SMR?

Other people who may be involved in the SMR include:

- Specialist healthcare professionals who are involved in the resident's care, e.g. Dietitian, Tissue Viability Nurse (TVN), Diabetes Specialist Nurse (DSN), District Nurse (DN), Speech and Language Therapist (SLT),
- Other members of the person's multi-disciplinary team (MDT),
- Carers,
- Social prescribers,
- Voluntary services.

Sustainability

The health and care system in England is responsible for an estimated 4-5% of the country's carbon footprint, with prescribing being the largest contributor in primary care.

Medicines optimisation, ensuring the right patients get the right choice of medicine, at the right time aims to:

- improve patient outcomes,
- ensure medicines are taken correctly,
- avoid unnecessary medicines; reduce wastage of medicines, and
- improve medicines safety.

Medicines wastage, overprescribing and polypharmacy all contribute to the carbon footprint.
Greener prescribing initiatives, reducing the carbon footprint with the aim of reaching net carbon zero, include:

- **Inhalers**
  Some inhalers, e.g. metered-dose inhalers (MDIs) contain powerful greenhouse gases. Some residents may be able to switch inhalers to more environmentally friendly inhalers, such as dry-powder inhalers which do not contain propellants which produce powerful greenhouse gases.
  Used inhalers should be returned to the community pharmacy for safe disposal.
- **Insulin Pens**
  PenCycle aims to recycle/repurpose any Novo Nordisk disposable devices, e.g. Novo Nordisk Flextouch® or Flexpen® disposable pens used to treat diabetes, obesity or growth hormone treatments.
- **Blister packs**
  Empty medication blister packs can be recycled at some community pharmacies.

Record keeping

There are several codes for medication reviews available from the NHS Digital Primary Care Domain Reference Set Portal.
Two codes relate to SMR, plus one code to a Polypharmacy medication review.
If appropriate, the Polypharmacy code may be used in addition to the SMR code.

SNOMED code description	SNOMED code
Structured medication review (procedure)	1239511000000100
Medication review declined (situation)	412725004
Polypharmacy medication review (procedure)	870661000000100

The SMR code should only be used when a full SMR has been undertaken.

The SMR should be clearly and concisely documented in the resident's clinical record.
All medication changes, including the reasons for the changes, should be recorded in the resident's care plan and their clinical record.
If a medication is stopped, the reason for stopping the medication should be included to ensure it is not restarted in error.
Any medications which have been stopped should be appropriately disposed of as stated in the care home Medicines Policy (refer to Good Practice Guidance: Disposal of medicines in care homes).

An action plan should be agreed and documented for those medicines reviewed, including changes, support, follow up, monitoring, sign posting, referral, and safety netting.

References

- Structured medication reviews and medicines optimisation
  NHS England » Structured medication reviews and medicines optimisation
- Network Contract Directed Enhanced Service Structured medication reviews and medicines optimisation: guidance
  Report template - NHSI website (england.nhs.uk)
- The Framework for Enhanced Health in Care Homes, Version 2 (march 2020)
  the-framework-for-enhanced-health-in-care-homes-v2-0.pdf (england.nhs.uk)
- NICE NG5: Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes
  Overview | Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes | Guidance | NICE
- NICE NG56: Multimorbidity: clinical assessment and management
  Overview | Multimorbidity: clinical assessment and management | Guidance | NICE
- Specialist Pharmacy Service: Medicines Reconciliation Best Practice Resource and Toolkit
  Medicines Reconciliation: Best Practice Resource and Toolkit – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
- NHS Scotland: Polypharmacy: Manage Medicines
  Polypharmacy: Manage Medicines (scot.nhs.uk)
- Good Practice Guidance for Care Home: Medicines Reconciliation
  file (frimleyccg.nhs.uk)
- Good Practice Guidance: Medicines and falls prevention in care homes
  NHS Frimley - Medicines and falls prevention (icb.nhs.uk)
- Network Contract Directed Enhanced Service, 31 March 2021
  Report template - NHSI website (england.nhs.uk)
- Sustainability
  Greener NHS (england.nhs.uk)
- NHS Frimley Prescribing Guidelines: Respiratory
  NHS Frimley - Respiratory (icb.nhs.uk)
  Inhaler choices | Asthma + Lung UK (asthmaandlung.org.uk)
  How inhalers affect the environment | Asthma + Lung UK (asthmaandlung.org.uk)
  Green Inhaler – Making your inhaler more environmentally friendly
  Inhalers – Greener Practice
  https://www.pen-cycle.co.uk/
  Waste & Recycling | Doing Good Feels Super | Superdrug
- NHS Digital Primary Care Domain Reference Set Portal
  Primary Care Domain Reference Set Portal - NHS England Digital

Appendix 1

Structured Medication Review Data Collection Template for Care Home Residents

NHS Frimley — Frimley Health and Care

PCN: **Reviewer:**		**Review date:**	**EMIS number:**
Resident Name:		**Clinical Lead/ Nominated GP:**	
Age/ DOB:			
NHS Number:		**Community Pharmacy:**	
Care Home: *(circle)* **LD RH NH** **Address:**		**Allergy Records** Care Home: GP: MAR:	
Consultation:	**Face to Face Y/N**	**Video Y/N**	**Telephone Y/N**
Capacity for Health & Welfare: Y/N		**If N, is an LPA in place: Y/N**	
Smoking Status:	**Alcohol consumption:**	**Other substances:**	

Disease Registers:

PMH:

Nutrition:	**SLT review Date:** *(most recent)*	**Continence:**
Weight (kg): **Date:** **Height (cm):** **Date:** **BMI** **MUST SCORE:** **Date:** **ONS: Y/N**	**Swallowing difficulties: Y/N** **IDDSI level:** **Other route for nutrition?**	**Stools: Y/N** **Urine: Y/N** **Pads: Y/N** **Catheter: Y/N** **Stoma: Y/N**

Mobility:	**Aids:**
Walking Aids: Y/N **Falls Risk? Y/N** *Low / Medium / High*	**Hearing Aid: Y/N** **Dentures: Y/N** **Visual Aid: Y/N** **Other:**

BP: Date:	*Automatic*	*Manual*	**Pulse:**	**SpO2** Date:	**RR** Date:	**Temp.** Date:
eGFR		*estimated* CrCl	Date:	LFTs & Cholesterol		Date: Date:
U&Es	Na K	Ur Cr	Date:	FBC		Date:
U&Es *other*			Date:	HbA1c BG		Date: Date:

eFI: *mild / moderate / severe* **ROCKWOOD Score:**	**ACB score:** http://www.acbcalc.com/
Anticipatory Care Plan in place: Y/ N **Other forms in place** *(e.g. ADRT)*: **Y/N** **ReSPECT form in place: Y/ N** **Refer to EoL: Y/ N**	**RESTORE2:** Mental Physical Behaviour/ ability

COVID Vaccine: Y/N	**Flu vaccine: Y/N**	**Shingles vaccine** *(if applicable)*: **Y/N/** *or* **NA**

Medicines Reconciliation (Date):	**Compliance/adherence/dexterity issues? Y/N**
Understands why taking medications?	**Communication** *(verbal/ non-verbal)*:
Indications checked:	**Reasons for not taking:**
Administration: *(e.g., self-administration; NG/PEG; covert)*	**Safety:** *(e.g., Allergies; ACB; ADR; DAMN; Opioids; Monitoring)*
OTC medicines:	**Suspected side effects:**
Concerns:	**Interactions:**
	Sustainability:

Medication/ dose/ frequency	Start date	Indication/ Comments	Recommendation			
			STOP	START	↑ or ↓	Agreed? Y/N

Follow-up and Review Date:

Notes:

Medicines Management Interventions:

Running balance correct for doses administered: Y/N?

Balance too much for doses administered: Y/N?

Balance too little for doses administered: Y/N?

Stock piling: Y/N?

Medicines waste: Y/N?

Medicines not synchronised: Y/N?

Medicines synchronised following SMR *(Date)*: