Managing medicines for adults receiving social care in the community

Consultation on draft NICE Guideline
[GID-MANAGINGMEDICINESCOMMUNITYSOCIALCARE]

Ref: 3916

Date: November 2016

Name: Léa Renoux
Email: lea.renoux@ageuk.org.uk

Age UK
Tavis House
1-6 Tavistock Square
London WC1H 9NA
T 0800 169 80 80 **F** 020 3033 1000
E policy@ageuk.org.uk
www.ageuk.org.uk

The National Institute for Health and Care Excellence (NICE) is currently developing a guideline around the management of medicines for adults receiving social care in the community. Older people form a large and growing part of the demographic this guideline will act to support so their needs are highly relevant to this work. As part of the development process, stakeholders have been invited to comment on the drafts (available online here) and make recommendations. Age UK has responded and welcomes this guideline as a means of helping older people in a community social care setting get the best possible outcomes from their medication-based treatments.

Key points and recommendations

Age UK's detailed comments can be seen in the NICE proforma below. Key points from our response include:

- Reaffirming the importance of the right of older people to make and be included in decisions about their own care and medication.
- Highlighting the need for professionals and practitioners to support older people to self-care and retain as much independence in administering and managing their medications as they feel they are able to.
- Reiterating the effects of inappropriate polypharmacy on older people and emphasising the role home care workers can have in reporting this to their family and prescribers.
- Stressing that covert administration of medicines is a very serious step to take in an older person's treatment and may breach several of their rights if done inappropriately. We urge a very rigorous assessment process of mental capacity in this context and full application of the Mental Capacity Act (2005) to all decisions made about taking medication.

Age UK's comments

Comment number	**Document** (**full** version, **short** version or the **appendices**	**Page number** Or **'general'** for comments on the whole document	**Line number** Or **'general'** for comments on the whole document	**Comments** .
1	Short	General	General	Age UK welcomes this guideline as an opportunity to clarify the key steps health and social care professionals can take to help older people with social care support in their own home to manage their medications. A growing number of older people live with multiple long-term conditions and complex needs, and are prescribed a larger number of medicines. They may face practical challenges in managing their medications, especially if they are taking multiple medicines (also called polypharmacy) and may require additional support to do so. We believe much more can be done to enable older people and their carers to improve their experience of, and outcomes from, managing their own medications, including avoiding harm and hospital admissions caused by inappropriate use of medications.

2	Short	General	General	Many of the guideline's recommendations seem to point towards taking positive steps to discuss the person's needs and preferences, taking into account their personal circumstances (particularly on page 4). While the recommendations are most welcome, they do not sit comfortably with the experience many older people have with health and care professionals. Indeed, in research we published with Ipsos MORI (*Understanding the lives of people living with frailty*, 2014) one participant described a medication she was repeatedly prescribed despite telling her GP it didn't work for her. Others we spoke to (*Frailty: Language and Perceptions*, Britain Thinks/Age UK/BGS,2015) described no effort being taken to engage them in decisions, with the result being that they would just do what the doctor told them. These seem to highlight big gaps in how we would want health and care professionals to communicate with older people about their care, including managing their medicines, and discuss their own needs and preferences. Professionals must be trained and supported to communicate sensitively and productively with service users, grounded in the principles of shared decision-making, and working to achieve this should be included as a recommendation – either as a stand-alone recommendation or an additional recommendation within the section on 'Training and competency' on page 19.
3	Short	4	9	In light of the above comment, we would suggest amending the sentence 'Many people want to actively participate in their own care' to make it more compelling, as follows: '*Most* people want to actively participate in their own care'.
4	Short	4	9-10	We are concerned the phrase 'Enabling and supporting people to manage their medicines is *usually preferred* […]' is not strong enough to convey the importance of health and care professionals taking every step to empower older people to look after their own health and wellbeing. We know that older people often do not feel supported to self-care, particularly those with multiple long-term conditions, including frailty. Our research has found cases where, for example, older people are being asked to do their own blood tests but are not feeling confident/physically able to do so. Among people over 75, 80% with diabetes are not trained to manage their condition; 73% with osteoarthritis are not supported to prevent it getting worse; and access to talking therapies is significantly lower compared to other age groups (Age UK and Exeter Medical School*, Health care quality for an active later life*, 2012).Therefore, supported self-management still remains an untapped resource within our health and social care system, and guidelines must ensure all health and care professionals work towards enabling older people to be in control of their own health and wellbeing. As such, we would suggest replacing '*usually preferred*' with '*an essential part of this*' so that the sentence reads as 'Enabling and supporting people to manage their medicines is *an essential part of this […]*' and thus refers back to the first sentence on involving people in their own care, as self-management is closely linked to patient

				involvement and shared decision-making.
5	Short	11	19-30	The guideline should recognise more explicitly the negative impacts of *inappropriate polypharmacy* and the role that home care workers can play in identifying it and reporting it to the prescriber. A large body of recent work has shown that the number of older people on multiple medications has accelerated over the past decade. Work commissioned by Age UK and carried out by Exeter Medical School showed that between 2003/4 and 2011/12, people aged 65+ on no medications halved to around 15% while those on five or more doubled to around 30%. The proportion prescribed ten or more drugs increased sharply from 16.4% to 24.6% (Melzer, D., et al, Much more medicine for the oldest old: trends in UK electronic clinical records, *Age and Ageing 2014*). Polypharmacy can be linked to increased prescribing and monitoring errors. For example, the 2012 PRACtICe Study by the General Medical Council found that 30.1% of people receiving five or more medications and 47% of people receiving 10 or more had prescribing or monitoring errors in the 12-month study period (*Investigating the prevalence and causes of prescribing errors in general practice: The PRACtICe Study*, University of Nottingham/GMC, 2012). More specifically, for older people, alongside the risk of drug interactions and side-effects, there are additional risks linked to age-related physiological changes. There is strong evidence to suggest that prescribing more than 8-10 medications provides little therapeutic benefit and is more likely to be causing harm. Older people receiving social care support in the community are likely to be living with multiple long-term conditions and therefore on multiple medications. Through their regular contact with them, home care workers have a key role in raising any concerns around inappropriate polypharmacy. As a result, we would suggest adding a bullet point recommendation 1.6.4 around 'possible inappropriate polypharmacy'.
6	Short	14-15	20-28 1-21	We are concerned that Section 1.8 – and in particular recommendation 1.8.2 (page 15, lines 1-18) – does not fully illustrate the seriousness of a decision to administer medicine without the consent of the adult, and the fact that it presents a potentially serious interference with the right to respect for private life under Article 8 of the European Convention of Human Rights (ECHR). Specifically, we see the use of 'should' within this recommendation as problematic. Compliance with the Mental Capacity Act is not optional in this matter, therefore both mentions of 'should' on lines 1 and 3 should be changed to 'must'. A failure to comply with the principles of the Mental Capacity Act, in particular the elements around acting in a person's best interests within section 4 of the Act, could lead to a breach of Article 8 ECHR rights and mean that those administering the medication would not have the protection from liability usually afforded by Section 5 of the Mental Capacity Act.
7	Short	15	1-21	In addition, and in relation to question 4 of this consultation, we believe the possibility that the use of treatment without consent (covert administration) could contribute to a deprivation of liberty (DOL) in a

				community setting must be fully considered. As previous court cases have found, DOLs can occur in the community. Although this particular case applied to a care home, District Judge Bellamy noted the following in AG v BMBC & Anor [2016]: *"… I accept that treatment without consent, covert medication in this case, is an interference with the right to respect for private life under Article 8 of the ECHR and such treatment must be administered in accordance with a law that guarantees proper safeguards against arbitrariness. Treatment without consent is also potentially a restriction contributing to the objective factors creating a DOL within the meaning of Article 5 of the Convention. Medication without consent and covert medication are aspects of continuous supervision and control that are relevant to the existence of a DOL. It must therefore attract the application of Section 1(6) of the [Mental Capacity] Act and a consideration of the principle of less restriction and how that is to be achieved".* As such, we would like the guideline to fully reflect the legal parameters of any decision to give medicines to people covertly, including the fact that it may constitute a DOL, and to encourage home care providers to fully consider these aspects within their own guidelines.
8	Short	14-15	20-28 1-21	In addition to the points raised above, we believe the guideline recommendations should be stronger in their requirement to apply the Mental Capacity Act, due to the very specific nature of a mental capacity act assessment. Someone may be able to consent to taking medication, for example, but lack the mental capacity to make a decision about what form of medicine (liquid, powder, tablet) works for them. They may not like the taste and texture of a tablet and spit it out and home care workers may see this as a refusal of the medication and decide to administer the medicine covertly, rather than looking for an alternative, less restrictive practice around the form of medication given. Conversely, other people may have the mental capacity to express a preference about the form of the medicine but not the type of medicine. We would therefore recommend that the guideline sets out very clearly the need to ensure that the Mental Capacity Act is applied to *all* aspects of decisions around taking medication (e.g. why people take it, how people take it, when people take it, etc) to fully ensure that 'best interest' and least restrictive options are implemented.
9	Short	14	22	Given the seriousness of covert administration, including the potential impacts on a person's human rights as well as the legal implications for those providing social care support, we believe that NICE should take steps to clarify what is intended by those 'exceptional circumstances' under which giving medicines to people covertly may be necessary, for example setting out the principles that must be applied, with some examples of exceptional circumstances.