IMPLEMENTING STOCK END-OF-LIFE MEDICATION IN UK NURSING HOMES

Kathy Morris, Jo Hockley

ABSTRACT

Background: In nursing care homes (NCHs), the use of end-of-life care (EoLC) medication has traditionally been requested and prescribed on an individual basis during each resident's last days of life. However, some GPs are reluctant to prescribe EoLC medication in anticipation of symptoms occurring if, at the time of their visit, the resident is symptom-free. Even when prescribed, care home staff can experience difficulties obtaining the medication out of hours. This can result in residents not having access to appropriate medications when they are experiencing symptoms.

Aim: This audit aimed to assess the feasibility of NCHs with Gold Standards Framework in Care Homes (GSFCH) accreditation keeping EoLC medications ‘as stock’, rather than having the medication prescribed and dispensed for individual residents when residents became symptomatic.

Methods: Meetings were held with nurse managers of four NCHs with GSFCH accreditation, local pharmacists and the hospice pharmacist. A strategy to implement the stock medication was prepared. A baseline review of the notes of deceased residents 6 months pre-implementation was undertaken and information regarding symptoms and EoLC medication extracted. The review continued for 6 months after the stock EoLC medication was obtained.

Results: Three NCHs participated. The notes of 92 deceased residents were examined. Fifty-three per cent of decedents were found to have experienced common EoLC symptoms. The numbers with access to EoLC medication increased once the stock medication was in place. However, some residents still had their own drugs dispensed, despite stock drugs being available.

Conclusions: There is a need for all dying residents to have access to EoLC medication. The proper facilitation and implementation of EoLC medication ‘as stock’ into NCHs with expertise in caring for dying people could save monies at a time of NHS austerity measures. If the NCHs had relied solely on the stock medication, the reduction in medication waste would have been significant. The introduction of stock medication would also solve problems associated with obtaining medication out of hours.

Conflicts of interest: none

KEY WORDS

Anticipatory medications
Death and dying
End-of-life care
Frail older people
Nursing care homes

Surveys of patients with cancer have indicated that the most common symptoms at the end of life are pain, nausea/vomiting, agitation and respiratory tract secretions (Lichter and Hunt, 1990; Turner et al, 1996).

When examining the care of 185 frail older people dying in a long-term care facility, Hall et al (2002) found that 92% of the residents were symptomatic in the last 48 hours of life, with the most prevalent symptoms being dyspnoea, pain, noisy breathing and delirium. The majority of these residents (86%) had a non-cancer diagnosis. Bereaved informal carers have also reported that two-thirds of decedents in the community (own home/care homes) suffer pain, breathlessness or constipation in the last 3 months of life, with only a minority receiving treatment that completely relieved symptoms some or all of the time (Burt et al, 2010). These studies all report the prevalence of common symptoms at the end of life, irrespective of age, diagnosis and setting.

In the UK, the number of older people living in care homes is predicted to increase (British Geriatrics Society (BGS), 2011). From the authors’ experience, many frail older people want to die in the familiar surroundings of their care home rather than be transferred to hospital to die. Therefore, care home staff need to be competent to assess and manage the symptoms of their dying residents and have access to appropriate medication (Kinley and Hockley, 2010). The Liverpool Care Pathway for the Dying Patient (LCP), which has been introduced within different care settings, highlights the need for healthcare professionals to consider access to ‘as required’ (PRN) subcutaneous medication for patients during the last days of life in the event that oral medication can no longer be taken (Ellershaw and Wilkinson, 2003). Doctors are prompted to consider prescribing medications to address the four main symptoms at the end of life:
pain, nausea/vomiting, restlessness and ‘ratty’ bronchial secretions. According to Badger et al (2007), the prescribing of anticipatory medication in care homes should be routine practice. However, Hockley et al (2004) reported that, despite care home residents having LCP documentation in place, GPs can be reluctant to prescribe anticipatory medication if, at the time of visiting, a resident is asymptomatic. Such practice causes delay in symptom control at the end of life.

The symptom profile of older dying people (over 80 years) and those who are younger (50–70 years) is similar (Rashidi et al, 2011). However, frail older people often require significantly less parenteral medication than younger people because of, for example, differences in kidney function and increased stoicism (Rashidi et al, 2011). Kinley et al (2013) recommend the prescription of anticipatory medications for all frail older people dying in care homes and have produced guidance to assist clinicians in this endeavour. They argue that the symptoms of frail older people who are dying in care homes can usually be managed with simple interventions such as the use of rectal medication (e.g. paracetamol suppositories). Not all older people who are dying will require subcutaneous medications (such as morphine), which are often routinely given within specialist palliative care settings (Kinley and Hockley, 2010).

According to Badger et al (2012), the poor availability of drugs out of hours is a particular issue in end-of-life care (EoLC) in nursing care homes (NCHs). They describe how out-of-hours’ GPs would not prescribe EoLC medications, even though the resident’s regular GP had written a care plan stating that the resident should remain in the home. Instead, the out-of-hours’ GPs wanted to admit residents to hospital. Foster et al (2003) describe three reasons why obtaining EoLC medications in care homes is difficult: regular GPs refusing to prescribe medications because they do not know the resident; and, finally, the difficulty in obtaining medication from pharmacies, especially if it has been prescribed out of hours.

The Care Home Project Team at St Christopher’s Hospice, London, is a regional training centre for the Gold Standards Framework in Care Homes (GSFCH) programme, which includes implementing an adapted LCP for care homes. The team has gained considerable experience about the challenges in obtaining anticipatory medications for dying people. In the team’s experience, the main challenge to obtaining EoLC medication for frail older people in care homes is three-fold. First, as found elsewhere, there is a reluctance on the part of some GPs to prescribe end-of-life medications for residents ‘in anticipation’, if a resident does not have symptoms at the time of the GP’s visit. Second, where GPs would prescribe, nurses and doctors are concerned about the cost of disposing of unused medication following the death of the resident. Legally, these medications cannot be used for other residents as medication in care homes is prescribed on a patient-named basis. Third, care homes experience difficulty obtaining EoLC medication, particularly out of hours.

This article describes a project that was undertaken by the St Christopher’s Hospice Care Home Project Team to assess the feasibility of NCHs having a permanent stock of common medications that are used to control symptoms that can occur at the end of life.

Methods
In 2010, nurse managers from four NCHs that had gained GSFCH accreditation expressed a wish to explore the possibility of having EoLC drugs ‘as stock’. They wanted to look at the option of stocking end-of-life medication to reduce drug wastage and avoid future difficulties of accessing drugs out of hours.

The aim of the project was to work alongside the nurse managers and their staff to support them to implement EoLC medication ‘as stock’. To do this, the project team:
- Explored the frequency of symptoms in the last days of life and the availability of EoLC medication for residents in participating NCHs over a 1-year period
- Established the cost saving that could be made by having EoLC medication ‘as stock’ available
- Obtained the nurses’ perceived benefits of implementing EoLC medication ‘as stock’.

Nurse managers from four NCHs agreed to be part of a working party to take forward the idea of implementing EoLC medication ‘as stock’. However, one manager left the NCH and therefore three NCHs remained in the project. Six meetings were held over an 11-month period with the nurse managers, the pharmacist from St Christopher’s Hospice and two members of the Care Home Project Team. Contact was made with the local primary care trust (PCT) pharmacists who remained involved in the project for ongoing advice and support. The pharmacist from the Care Quality Commission attended one meeting.

Initially, it was intended that injectable morphine would be one of the stock drugs. However, in 2010, the Home Office introduced a fee of over £3000 for a NCH licence to stock end-of-life controlled drugs (previously available to NCHs free of charge). The nurse managers opted to go ahead with a stock that did not include morphine. It was felt that if a resident required morphine (or an alternative opioid) then this would be prescribed on an individual basis in the normal way.

A list of the stock EoLC drugs to be kept at the NCH was drawn up alongside their cost (Table 1). A proposal for obtaining basic EoLC stock drugs was written by the first author (KM). Local pharmacists highlighted the importance of a good audit trail of all the ‘as stock’ EoLC medication. To this end, each NCH was recommended to have a separate EoLC medication cupboard and a corresponding drug book for the ‘as stock’ EoLC medication. It was
proposed that all the medication on the recommended list (see Table 1) should be ordered from a local pharmacy. Orders for most of the medications were written by the nurse in charge on the NCH’s headed paper and countersigned by a GP. Orders for midazolam were requested on a FP10 Controlled Drug Form (CDF) and signed by a GP.

A baseline review of deceased residents’ notes/medication charts was undertaken by KM using a pro forma (Figure 1) to ascertain symptoms experienced, the prescribing of EoLC medication and the usage/wastage for the 6-month period before obtaining the stock drugs. The review was continued for the 6 months after the stock was received in the homes using the same form. Residents were recorded as being symptomatic if:

- Staff had administered EoLC medications in the last few days of life
- Staff had requested EoLC medications for symptoms that they had noted
- The author noted symptoms described but not acted upon.

Staff were asked informally to comment on the project during KM’s visits to the homes. More formal comments were noted at a review meeting with the nurse managers.

Results

The notes/medication charts of 92 deceased residents (38 pre-intervention and 54 post-intervention) across the three NCHs were examined. Twenty-six residents had died in NCH 1, 43 residents in NCH 2 and 23 residents in NCH 3. The majority of residents died from non-malignant disease (Table 2).

Incidence and type of symptoms

A total of 49 residents (53%) were documented as being symptomatic in their last days of life. The number of symptomatic residents varied across the homes (see Table 2). Symptoms included pain, agitation, excessive secretions, dyspnoea, nausea and vomiting. There was no difference with regard to the symptoms experienced by residents dying with a cancer diagnosis and those dying from a non-malignancy. Eighteen residents (53%) were symptomatic from cancer diagnosis and 31 residents (53%) were symptomatic dying from non-malignant causes. The majority of residents had been assessed as symptomatic by the NCH staff. However, eight residents (16%) were noted to be symptomatic by KM as a result of reading the specific case notes. These were included in the analyses.

Access to EoLC medication

Once the EoLC medication ‘as stock’ had been obtained, the number of deceased residents with a written order from the GP for anticipatory medication increased in each NCH. The number of orders increased in NCH 1 to 50%, in NCH 2 to 63% and in NCH 3 to 94% (Table 3).

However, the availability of stock drugs was not the only influencing factor as some residents still had their own drugs dispensed once the stock was in place. As a result of anticipatory medication being immediately available once the stock had been obtained, more residents who were symptomatic had their symptoms managed promptly. There was a considerable improvement, with immediate access of medication rising from 36% to 80% in NCH 1 and from 50% to 100% in NCH 3 (Table 4). The results for NCH 2 remained consistently high.

Types of medication administered after stock obtained

Apart from one resident who had an alternative anti-emetic prescribed, all of the drugs administered (other than opiates) at the end of life were drugs that appeared on the recommended list (see Table 1). The drugs most commonly administered during the last days of life following the implementation of EoLC medication ‘as stock’ were: paracetamol suppositories; subcutaneous midazolam and subcutaneous glycopyrronium (Table 5). There was no evidence of alternative medications being requested. Paracetamol suppositories, to control discomfort and pyrexia when dying, were used for 11 out of 17 residents in NCH 3 (after stock obtained). Only four of the 92 residents reviewed required a syringe driver. On review of the notes, KM assessed that this number was an accurate representation of syringe driver need, as no other resident was found to require repeated and regular doses of the PRN medications.

Wastage

Despite the homes having EoLC medication ‘as stock,’ NCH 1 and NCH 2 continued to obtain residents’ own medications in the majority of cases. This meant the homes did not reduce their wastage in the way that had been predicted. This was a deliberate strategy in the case of NCH 2 but not in the case of NCH 1. In NCH 2, there was concern relating to stock medications running out. The manager of NCH 2 has since been advised to stock more ‘as stock’ medication. The wastage in NCH 3 after obtaining the stock was

Table 1

<table>
<thead>
<tr>
<th>Drug</th>
<th>Approximate cost of one box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midazolam injection 10 mg (CD schedule 3)</td>
<td>£6</td>
</tr>
<tr>
<td>Diazepam rectal solution 5 mg (CD schedule 4)</td>
<td>£10</td>
</tr>
<tr>
<td>Metoclopramide injection 10 mg</td>
<td>£3</td>
</tr>
<tr>
<td>Haloperidol injection 5 mg</td>
<td>£3</td>
</tr>
<tr>
<td>Glycopyrronium injection 200 mcg</td>
<td>£6</td>
</tr>
<tr>
<td>Paracetamol suppositories 500 mg</td>
<td>£37</td>
</tr>
<tr>
<td>Total</td>
<td>£65</td>
</tr>
</tbody>
</table>

CD = controlled drug
# AUDIT FORM FOR END-OF-LIFE STOCK DRUGS

(please complete after each death)

<table>
<thead>
<tr>
<th>Nursing home:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Age:</td>
</tr>
<tr>
<td>Diagnosis:</td>
<td>Date of death:</td>
</tr>
<tr>
<td>Date anticipatory drug(s) prescribed:</td>
<td></td>
</tr>
<tr>
<td>GSF coding on day of death:</td>
<td>Date this coding done:</td>
</tr>
<tr>
<td>Previous GSF coding:</td>
<td>Date this coding done:</td>
</tr>
</tbody>
</table>

### Type of death (please circle)

- Dwindling
- Terminal
- Acute
- Sudden

### Comments:

### Anticipatory drugs

**Anticipatory drugs PRESCRIBED** (please tick)

- s/c Morphine
- s/c Midazolam
- s/c Haloperidol
- s/c Glycopyrronium
- i/m Metoclopramide

**Anticipatory drugs AVAILABLE. Please detail whether resident own drugs (RD) or STOCK drugs. If RD, PLEASE state strength and number of ampoules**

- Paracetamol suppositories
- Other suppositories used (please state)
- Other medications used (please state)

**Anticipatory drugs USED. Please detail number of ampoules used and indicate whether in syringe driver or PRN doses**

- s/c Morphine
- s/c Midazolam
- s/c Haloperidol
- s/c Glycopyrronium

### Please tick box for which symptoms drugs were given:

- Pain
- Breathlessness
- Nausea
- Agitation and distress
- Rattly chest

### Other (please state):

- GSF = Gold Standards Framework; s/c = subcutaneous; i/m = intramuscular; PRN = as required

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Figure 1. Audit form for end-of-life stock drugs
higher than planned because eight of the residents who died had their own supply of medications. Residents were sometimes transferred from hospital or another care home with the medications and, in some cases, the hospice clinical nurse specialist had organised the drugs. Unlike NCH 2, the nurse manager in NCH 3 felt that this was unnecessary and would have preferred to rely on stock EoLC drugs in order to eradicate waste.

The total cost for residents’ medication on a named-patient basis, excluding those with a syringe driver, would have been £4752 for the whole study period (Table 6). Although GPs can prescribe fewer ampoules of each medication, they tend to prescribe a whole box of medications. The actual cost of EoLC medication used in the time of the study was £246, giving a potential saving of £4506 (minus the cost of the stock drugs) if stock drugs had been available from the outset.

**Perceived benefits by staff**

The perceived benefits of EoLC medication ‘as stock’ varied between the different nurse managers. In NCH 1, the nurse manager perceived the main benefit as being that EoLC medication was higher up on the nurses’ agenda. Although during the study staff in NCH 1 did not use the EoLC ‘as stock’ drugs as much as the nurse manager had hoped, the number of residents having access to medication did increase significantly.

The staff in NCH 2 chose to continue to get supplies of medication for each resident, alongside having EoLC medication ‘as stock’. Historically, this NCH has worked closely with the local hospice and the hospice’s palliative care clinical nurse specialists have always encouraged individual prescriptions for anticipatory medication. However, staff did feel ‘safer’ in the knowledge that they had a supply of stock drugs that could be accessed in emergencies for residents who deteriorated unexpectedly.

In NCH 3, the nurse manager reported that having access to stock medications had ‘transformed’ the practice of her nurses. They now felt comfortable requesting prescriptions for every dying resident, as they were more confident that there would be no wastage. She also reported an example of how having the stock medication had helped a busy GP. On this occasion, the GP had three evening visits to do after surgery and was feeling pressurised. The NCH had a frail resident who was vomiting and needed an anti-emetic injection. Due to the availability of the EoLC medication ‘as stock’ and the staff members’ confidence in using them, the GP decided to fax the home.

### Table 2

<table>
<thead>
<tr>
<th>Nursing care home (NCH)</th>
<th>Number of deaths</th>
<th>Mean average age</th>
<th>Number of decedents with cancer diagnosis</th>
<th>Number of residents who were considered symptomatic*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-stock</td>
<td>Post-stock</td>
<td>Pre-stock</td>
<td>Post-stock</td>
</tr>
<tr>
<td>NCH 1</td>
<td>16</td>
<td>10</td>
<td>88 years</td>
<td>3 (12%)</td>
</tr>
<tr>
<td>NCH 2</td>
<td>16</td>
<td>27</td>
<td>82 years</td>
<td>20 (47%)</td>
</tr>
<tr>
<td>NCH 3</td>
<td>6</td>
<td>17</td>
<td>89 years</td>
<td>11 (48%)</td>
</tr>
</tbody>
</table>

* Deemed symptomatic either by nursing care home staff or by first author (KM) while reading the notes of deceased residents

### Table 3

<table>
<thead>
<tr>
<th>Nursing care home (NCH)</th>
<th>Number of deaths</th>
<th>Number (%) of residents with no EoLC drugs prescribed</th>
<th>Number (%) of residents who had access to some/all EoLC drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-stock</td>
<td>Post-stock</td>
<td>Pre-stock</td>
</tr>
<tr>
<td>NCH 1</td>
<td>16</td>
<td>10</td>
<td>12* (75%)</td>
</tr>
<tr>
<td>NCH 2</td>
<td>16</td>
<td>27</td>
<td>8 (50%)</td>
</tr>
<tr>
<td>NCH 3</td>
<td>6</td>
<td>17</td>
<td>4 (67%)</td>
</tr>
</tbody>
</table>

* Three residents did have one anticipatory drug each prescribed but only after becoming symptomatic. In one of the cases, the medication arrived after the resident died.
an overnight management plan giving permission to administer two doses of the anti-emetic that was in stock. The plan worked well, with the resident only requiring one injection. The GP visited the next day to review.

Discussion
This is the first published audit study reporting the implementation of EoLC medication ‘as stock’ in NCHs in the UK. All three participating NCHs were GSFCH accredited. At the outset of the project, before the implementation of stock EoLC medication, it had been assumed that staff in these accredited NCHs were obtaining EoLC medications for all of the residents considered only to have a few weeks to live. Whilst the majority of residents pre-implementation had been recognised as dying, as many as 63% of residents had had no EoLC medications prescribed. This meant that the actual cost of wasted drugs pre-stock was lower than anticipated.

GPs tend not to want to prescribe EoLC medication for residents in care homes until residents are symptomatic (Hockley et al., 2004; Seymour et al., 2011). However, it should never be concluded that if a resident is asymptomatic at the time of the GP visit, the resident is unlikely to need medications at a later stage. Even when GPs do prescribe EoLC medication, care homes can experience difficulties obtaining it out of hours (Foster et al., 2003; Amass and Allen, 2005). In our study, before the implementation of stock medication, the reasons why NCH staff and GPs did not want EoLC medication to be prescribed mainly related to wastage. Forty-seven per cent of residents were asymptomatic and the symptomatic residents often required very little in the way of EoLC medication. If they had all had their own

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Number of symptomatic residents who had access to drugs when first required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing care home (NCH)</td>
<td>Number (%) of symptomatic residents who had access to drug when first required</td>
</tr>
<tr>
<td></td>
<td>Pre-stock</td>
</tr>
<tr>
<td>NCH 1</td>
<td>4 (36%)</td>
</tr>
<tr>
<td>NCH 2</td>
<td>4 (80%)</td>
</tr>
<tr>
<td>NCH 3</td>
<td>2 (50%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 5</th>
<th>Amount of medication used (including the number of residents they were used for once stock obtained)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>NCH 1 Number of residents = 10</td>
</tr>
<tr>
<td>Rectal paracetamol</td>
<td>2</td>
</tr>
<tr>
<td>Morphine/other opioid</td>
<td>1</td>
</tr>
<tr>
<td>Midazolam</td>
<td>3</td>
</tr>
<tr>
<td>Glycopyrronium</td>
<td>0</td>
</tr>
<tr>
<td>Cyclizine/metoclopramide/haloperidol</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 6</th>
<th>Potential cost* of end-of-life care (EoLC) medication on a named-patient basis vs actual drugs used on 88 residents** (not including the four residents who required a syringe driver)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing care home (NCH)</td>
<td>Number of resident deaths in year of audit (excluding the four residents on syringe driver)</td>
</tr>
<tr>
<td>NCH 1</td>
<td>25</td>
</tr>
<tr>
<td>NCH 2</td>
<td>42</td>
</tr>
<tr>
<td>NCH 3</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
</tr>
</tbody>
</table>

* Figures based on a total of £54 per person (most residents did not require every drug from the recommended list)
** Includes pre- and post-implementation of stock data
Key Points

- In nursing care homes (NCHs), the use of medication at the end of life for symptom control has traditionally been requested, prescribed and dispensed on an individual, anticipatory basis during each resident’s last days of life.

- Some GPs are reluctant to prescribe end-of-life care (EoLC) medications for NCH residents in anticipation of symptoms occurring, if a resident does not have symptoms at the time of the GP’s visit.

- A potentially more effective method of symptom management at the end of life is for NCHs to keep a stock of EoLC medications so that they are available for residents when required. However, in such cases, residents will only have access to the drugs if the GP has signed an order saying that the NCH staff can administer them.

- In this audit study, before the implementation of stock medication in the three NCHs, the reasons why NCH staff and GPs did not want EoLC medication to be prescribed mainly related to wastage.

- The review of residents’ notes highlighted that, in the last days of life, up to 53% of the residents in the NCHs were symptomatic and required access to EoLC medication.

- The numbers of residents with access to EoLC medication increased once the stock medication was in place. However, some residents still had their own drugs dispensed, despite stock drugs being available. If the homes had relied solely on the stock medication, the reduction in medication waste would have been significant.

- Medications prescribed and dispensed on a named-patient basis, then the majority of the medication would have been unused and, therefore, wasted.

- Previous studies have reported that only between 10% and 25% of residents in NCHs have cancer (e.g. Hockley et al, 2010). However, in our study, there were an equal number of residents dying from cancer as dying from multiple morbidities. This is probably due to the fact that the NCHs in our study regularly admit patients from the local hospice and those with more complex symptom needs, often related to cancer.

- It is well documented that patients with cancer are likely to require medication in the last days of life (Lichter and Hunt, 1990; Turner et al, 1996) but there are less published data on frail older people dying in care homes with multiple morbidities (Hall et al, 2002). In our study, of the 34 residents with cancer, 10 (29%) were documented as having pain in the last days of life. This figure is lower than the 51% and 56% reported by, respectively, Lichter and Hunt (1990) and Turner et al (1996), in their surveys of cancer patients. Lichter and Hunt (1990) claimed that 40% of their patients required an increase in strong narcotic medication in the dying phase. The lower figure in our study may reflect the fact that many residents were already on transdermal analgesics and, therefore, presumably pain was less likely to become an issue when the dying residents lost their ability to swallow.

- Regardless of diagnosis, only 13% (12/92) of all the decedents in our study required subcutaneous morphine or an alternative opiate at the end of life. The limited use of syringe drivers in the last days of life, with only four residents requiring one for the control of symptoms, reflects previous findings of the EoLC symptom management requirements of frail older people in care homes (Kinley et Hockley, 2010). It is important not to impose a model created predominantly for people dying from cancer within the hospice setting onto the generalist setting of NCHs, where frail older people end their lives.

Paracetamol in its rectal form was used very infrequently for dying people in the NCHs. In NCH 3, paracetamol suppositories were seen as an important medication to control symptoms of pneumonia and general discomfort at the end of life. Once in stock, this NCH gave paracetamol suppositories to 11/17 residents in the last days of life. It could have been that staff in this NCH felt empowered to deal with the discomfort of terminal pneumonia by administering paracetamol suppositories. Kinley et al (2013), in their anticipatory medication guidelines for frail older people dying in care homes, advocate the greater use of paracetamol suppositories. Although suppositories may be considered undignified, they are very useful in the management of pyrexia (Kinley and Hockley, 2010).

At a time of austerity within the NHS, given the potential savings that are possible if EoLC medications ‘as stock’ are introduced into NCHs with EoLC training, local commissioning groups and private NCHs would be advised to collaborate more closely with regard to the stocking and purchasing of EoLC medications. To date, two of the NCHs (NCH1 and 2) have paid for their stocks. In the third, the pharmacist has supplied the medications but not yet been asked for payment. The ongoing funding of the EoLC stock drugs is an issue that was discussed with one of the then local PCTs involved. Given that it had been demonstrated by this study that the NCHs waste more EoLC medication than they actually use, there was a strong case for a request for funding from the PCT, which paid for the EoLC drugs prescribed for individual residents. There was also a cost incurred when disposing of unused medications. The PCT agreed to fund future supplies of stock medications.

Limitations

There were a number of limitations to the project. The review of residents’ notes was undertaken retrospectively by KM, who did not know the resident at the time. Symptoms may have been incorrectly documented. The findings of the audit cannot be generalised to other NCHs as the three participating NCHs...
had attained GSFCH accreditation and thus were competent in looking after dying people and were likely to have more symptomatic residents because of their competence. Also, this baseline review does not report the frequency of symptoms experienced and the amount of medication doses used to control symptoms. Such an examination requires further research.

Conclusion

This article describes the implementation of anticipatory EoLC medication ‘as stock’ into NCHs in the UK. It presents a baseline review of symptom prevalence in frail older people dying in NCHs. It highlights the fact that up to 53% of the residents were symptomatic in their last days of life, meaning that access to end-of-life medication is important. A total of 47% of frail older people were asymptomatic in the last days of their lives. If EoLC medications are stocked by NCHs with EoLC training, there is a potential for dying residents to receive timely symptom control and potential savings to be made as medications that have been issued on a named-patient basis will not have to be wasted once the resident has died.

We are very grateful to the nurse managers/staff in the nursing care homes for their willingness to engage with the collecting of audit data to make this project possible.

References


