NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 4

Managing medicines in care homes prioritisation and Acute kidney injury post consultation meeting

Minutes of the meeting held on Monday 21st July 2014 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Malcolm Griffiths (MG) [Vice Chair], Alaster Rutherford (AR), Alison Allam (AA), Allison Duggal (AD), Frances Garraghan (FG) [agenda items 1-6], Harry Allen (HA), Jo Bibby (JB), John Jolly (JJ), John Walker (JW), Julie Rigby (JR), Michael Varrow (MV) [agenda items 1-9], Roger Hughes (RH) [agenda items 1-10], Rubin Minhas (RM), Tim Fielding (TF), Zoe Goodacre (ZG) **Specialist committee members** **Managing medicines in care homes [agenda items 1-6]-** Amanda De La Motte (AdM), Amanda Thompsell (AT), Barbara Jesson (BJ), Delyth Curtis (DC), Gerry Bennison (GB). **Acute kidney injury [agenda items 7-12]-** Andrew Lewington (AL), Coral Hulse (CH), Mark Thomas (MT), Marlies Ostermann (MO), Sarah Harding (SH) **NICE staff** Adam Storrow (AS) [agenda items 7-12], Dylan Jones (DJ) [agenda items 1-6], Jenny Mills (JM), Rachel Neary-Jones (RNJ) [agenda items 7-12], Stacy Wilkinson (SW) [agenda items 7-12], Stephanie Birtles (SB) [agenda items 1-6], Thomas Walker (TW) [agenda items 1-6]. **Topic expert advisers** Brian Brown, Care Quality Commission **NICE Observers** Adrian Johnston [agenda items 7-12]
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Damien Longson, Jane Bradshaw, Jane Hanson, Nicola Hobbs **Specialist committee members** Managing medicines in care homes- Susan Lee Acute kidney injury- Fiona Loud

Agenda item	Discussions and decisions	Actions
1. Welcome, introductions and plan for the day	MG welcomed the attendees and the Quality Standards Advisory Committee (QSAC) members introduced themselves. MG informed the committee of the apologies and reviewed the agenda for the day.	
2. Committee business	**Declarations of interest** MG asked standing QSAC members to declare any interests that were either in addition to their previously submitted declaration or specific to the topic(s) under consideration at the meeting today. MG asked the specialist committee members to declare all interests. The following interests were declared: <u>Specialist committee members</u> • BJ- Occasional payments for reviewing care home training material submitted to the Royal Pharmaceutical Society for their accreditation. **Minutes from the last meeting** The committee reviewed the minutes of the last meeting held on 23rd June and confirmed them as an accurate record with one change to the attendees list. Alaster Rutherford was listed as attending when he had actually given apologies.	**JM to make change to attendees list on minutes and mark as final.**
3. Topic expert adviser presentation	BB gave a short presentation on the Care Quality Commission and Managing medicines in care homes.	
4. Topic session – Managing medicines in care homes	The committee then moved on to discuss Managing medicines in care homes (MMCH)	
4.1 and 4.2 Topic overview and summary of engagement responses	TW presented the topic overview and a summary of responses received during engagement on the topic.	
4.3 Prioritisation of quality improvement	TW and MG led a discussion in which areas for quality improvement were prioritised.	

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areas	The QSAC considered the draft areas as outlined in the briefing paper prepared by the NICE team. The QSAC agreed that the following areas for quality improvement should be progressed for further consideration by the NICE team for potential inclusion in the draft quality standard: • **Medicines policy** The committee discussed two areas identified at Topic Engagement, policies for safe and effective use of medicines and supporting residents to make informed decisions. The committee felt that both of these areas are important and should be progressed as quality statements. The committee felt that policies are important to ensure that staff work appropriately and to a set of standards based on local agreement. The committee highlighted that commissioners need to ensure that these polices are in place when commissioning services. The committee highlighted the implementation tool included within the associated guideline as a starting point for care homes in developing a medicines policy. Furthermore the committee suggested including a time limit for the review of policies and agreed on the wording within the guideline of 'up to date and in line with current legislation' rather than a specific time. In terms of supporting residents to make informed decisions the committee highlighted that currently some residents are given medication without explanation of what it is and what it's for and agreed this to be an important area for quality improvement. The committee agreed people should understand and be included in decisions about their health and treatments. • **Record keeping** The committee discussed three areas identified at Topic Engagement, medicines reconciliation, sharing information about a resident's medicines and information recording and agreed to progress one statement encompassing all three if possible. The committee explained that reconciliation is key and should happen on the day the resident transfers into the care home. The committee explained that this is currently not being done and would be extremely aspirational as it could be potentially problematic for some homes when a resident enters in a crisis. The committee felt that including this would be important for patient safety and agreed to progress using recommendation 1.7.1. The committee agreed to include information recording within the statement if possible as the concepts are closely linked and accurate records are again a key patient safety issue. NICE to include this if possible using recommendation 1.4.1. The committee discussed sharing information about a resident's medicines and agreed that this could also be included within the statement. NICE highlighted that a guideline on transition between health and social care has started development and agreed to look whether this issue is included within the	**NICE to progress statements on Medicines policy, record keeping, medication reviews, prescribing medicines, covert administration and training and competency.** **NICE to check the scope of the Transition between Health and Social care guideline currently in development to see if it includes sharing information about a resident's medicines.**

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	scope. • **Prescribing and ordering medicines** The committee discussed two areas identified at Topic Engagement, prescribing medicines and ordering medicines. The committee agreed that ordering of medicines is not a priority area and the focus should be on a statement around prescribing medicines, identifying 'when required' medicines as a particular issue.. The committee highlighted issues for prescribing for care home residents in contrast to the general public. In care homes, there are often intermediaries involved so residents often do not get an opportunity to ask a GP questions during prescription. Also, multiple staff members may administer a medicines to a residents and all need to be aware of when 'when required' medicines are necessary. In general clarity is needed for staff administering medicines to residents. Also, it is important that staff know how, or whether, to monitor the effect of medicines, as care home residents may not themselves be able to report on effectiveness. NICE to progress statements using recommendations 1.9.1 and 1.9.2 • **Medication reviews** The committee discussed this area and how it could be potentially seen as generic and applicable to other areas of care not just MMCH. The committee agreed to progress a statement as care home residents often have high levels of medication and can be unable to self-present with medicines issues (which are often only identified after they cause problems). Therefore medicines reviews are particularly important for care home residents. The committee felt that pro-active reviews are important ensuring that all residents receive this not just those seen as 'problematic'. The committee highlighted the issue of polypharmacy for care home residents and the associated increase in medicines interactions. The committee agreed a timeframe for the interval between reviews of no more than 1 year based on recommendation 1.8.4. • **Administration of medicine** The committee discussed three areas identified at topic engagement, medicines administration process, self-administration and covert administration. The committee felt that medicines administration process and self-administration could be covered by either the statement on medicines policy or supporting residents to make informed decisions. The committee felt that covert administration should be progressed as a standalone statement. The committee noted that there is often a lack of understanding of how a best interests discussion should be conducted and documented. In addition, the committee noted issues over administering medicines covertly (e.g.	

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	in crushed tablet form), highlighting that this may mean that the medicine is off-licence (and would need a joint decision between the dispensing pharmacist and the nurse/carer administering the medicine) and that staff can lack knowledge about whether the efficacy of a drug can be affected if it is added to certain foods. Furthermore the number of people with dementia is increasing and consequently the number of residents in care homes lacking capacity is going to increase. The committee felt that the methodology and processes behind covert administration needs to be correct and would be aspirational to include. The committee discussed who gives authority to give medicines covertly and explained this would be the person prescribing the medicines. The committee felt there is lack of understanding in pharmacies, care homes and GP practices and it would be of benefit to have a statement here for clarification. The committee explained that there are some legal requirements around this but agreed to progress a statement around recommendation 1.15.3 and on signposting to the legal requirements. • **Training and competency** The committee agreed to progress this area as they felt that increased staff knowledge would prevent sub-optimal use of medicines and reduce morbidity and levels of use of healthcare. The committee agreed to signpost to accredited learning providers. The committee explained that providers are responsible for training staff to provide competent care. The committee highlighted a need for training to learn from errors/ near misses and the NICE team agreed to include this in the statement if possible. The QSAC agreed that the following areas should not be progressed for potential inclusion in the draft quality standard: • **Medicines related incidents and safeguarding** The committee explained that there is legislation around safeguarding and therefore should not be progressed as a standalone statement. The committee felt that the main area for quality improvement is learning from errors and agreed that this could be adequately covered in a statement around training and competency. • **Additional areas** At Topic engagement a number of areas were suggested by stakeholders to be included within the QS but the NICE team explained all them were either out of scope or had no guideline recommendations to link to. These areas are as follows: • Training accreditation/ competency assessment • Specialist clinical pharmacist aligned to each care home • GP practices and care homes	

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	• Consideration of an integrated reporting system • Use of information technology for records/ Summary Care Record • Development of a multi-agency medicines management policy • Development of a national and integrated approach to baseline assessment • Use of anti-psychotics and dementia TW asked for any equality and diversity considerations and the committee suggested age, language, ethnicity and mental capacity.	
5. QSAC specialist committee members and stakeholder list	DJ asked the QSAC to consider the constituency of specialist committee members on the group and whether any additional specialist members were required. **Specialist members**: It was agreed that a representative from the care home sector and a General Practitioner are required. **Stakeholder list**: The QSAC reviewed the stakeholder list and agreed to email JM with any suggestions.	**NICE to recruit a representative from the care home sector and a General Practitioner.** **NICE to email JM with suggestions for additional stakeholders.**
6. Next steps and timescales	JM outlined what will happen following the meeting and any key dates for the MMCH quality standard.	
7. Welcome and introductions	MG welcomed the attendees and the Quality Standards Advisory Committee (QSAC) members introduced themselves.	
8. Committee business	**Declarations of interest** MG asked the specialist committee members to declare all interests. The following interests were declared: <u>Specialist committee members</u> • AL- Has received honorariums for chairing or attending a number of meetings for acute kidney injury.	
9. Topic session – Acute kidney injury	The committee then moved on to discuss Acute kidney injury (AKI).	

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9.1 Recap of prioritisation exercise	SW and TS presented a recap of the areas for quality improvement discussed at the first QSAC meeting for acute kidney injury on 24th March 2014 although this was not discussed at length during this meeting. The QSAC agreed that the following areas for quality improvement should be progressed for further consideration by the NICE team for potential inclusion in the draft quality standard: • **Assessing risk** The SCMs explained that many patients do not present to nephrologists but to other specialists. AKI can be a 'silent' condition (there may be no external signs and symptoms) and many patients presenting to health services with other conditions may not know that they have AKI. Generally, the sicker a person is, the greater is their risk of AKI; there is a higher risk of dying in hospital for people who have AKI. The committee highlighted that there are no standard tools for assessing AKI but there are risk assessment tools used in specific settings (such as emergency departments and cardiac surgery). Conducting a risk assessment that includes serum creatinine testing can lead to suspecting and then detecting AKI, or it can lead to general good quality care that prevents a patient from getting AKI. The committee agreed to include a statement on risk assessment for AKI for patients in the community and in hospital based on serum creatinine levels (it was noted that a single serum creatinine test would not be sufficient – more than one test would show progression). Following risk assessment, the committee felt it important that patients who are at risk of AKI should be monitored (since not all AKI is preventable), and agreed to include a statement on ongoing assessment for those who are assessed at being at risk. • **Identifying the causes of AKI** When AKI is detected it is important to understand its cause. The committee discussed the use of ultrasound in identifying the cause of AKI but, noting that it is appropriate for a relatively small subset of patients with AKI, The committee did not recommend that use of ultrasound should be progressed as an area for quality improvement. The committee did however discuss urinalysis (the use of urine dipsticks) and agreed urinalysis is an effective and cost-effective diagnostic approach to identifying those people with AKI who need referral to nephrology teams. The committee agreed that a urine dipstick should be done on admission and also later when AKI is suspected. The committee highlighted the importance of recording the results. Overall it was agreed to include a statement on urine dipstick tests using recommendation 1.4.2. • **Managing AKI** The committee discussed a number of issues within this area. Firstly they agreed not include a	

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	statement on relieving urological obstruction as this is only present in a small set of patients and therefore is not key for quality improvement. The committee also agreed not to include a statement around nutrition as this is not covered by the NICE AKI clinical guideline. The NICE team explained to the committee that a quality standard on renal replacement therapy services is in development so they agreed not to include this area within this QS. The committee discussed the importance of ensuring that the right patients are cared for in the right setting at the right time, specifically the transfer of patients (rather than just their referral) to specialist care in a timely manner; delays can lead to deterioration which in turn can lead to expensive intensive care. The committee highlighted that referral is generally done well but the main quality improvement area is transfer. It was agreed to include a statement on transfer of patients to specialist care in a timely manner. NICE to check for associated recommendations. • **Information and support** The committee felt that issues within this area go further than the generic patient information statement in the Patient experience QS because information about AKI (or the risk of AKI) will often be over and above information and support in relation to the presenting condition. The committee highlighted that AKI is different from other conditions as many patients are not renal patients but present with other conditions and do not realise that they are at risk of AKI. The committee highlighted the circumstances for information-giving described in recommendation1.6.4 and agreed that high risk patients should be aware of these risks; an alternative approach would be to draft a quality statement about information-giving for a wider set of potentially at-risk patients (as described in recommendations 1.1.1 and 1.1.2). Overall it was agreed to include a statement around information for patients based on risk factors. Medication withdrawal also to be highlighted within this statement (see below-preventing AKI). The QSAC agreed that the following areas should not be progressed for potential inclusion in the draft quality standard: • **Preventing AKI** It was noted that general high quality care of sick patients can contribute to the prevention of AKI. The committee highlighted that trusts are moving towards electronic prescribing and appropriate lab systems so the use of e-alerts will be on the rise. It was highlighted that algorithms for use in labs can be used but agreed not to include as algorithms are not included in the associated guideline. The committee discussed withdrawal from ACE inhibitors and the potential for a statement around how patients can do this safely. It was agreed not to include a standalone	

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	statement but to include this issue within 'information and support' (see above). . • **Detecting AKI** The committee discussed classifications systems and agreed that KDIGO is most commonly used. The committee did not feel that quality improvement was key in this area. The committee also highlighted NHS England's current work around care bundles and classifications systems. The committee agreed not to include a standalone statement around detecting and monitoring but agreed to include this within 'assessing risk' (see above).	
9.2 and 9.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	SW presented the committee with a report summarising consultation comments received on AKI. The committee was reminded that this document provided a high level summary of the consultation comments, prepared by the NICE quality standards team, and was intended to provide an initial basis for discussion. The committee was therefore reminded to also refer to the full list of consultation comments provided throughout the meeting. The committee was informed that comments which may result in changes to the quality standard had been highlighted in the summary report. Those comments which suggested changes which were outside of the process, were not included in the summary but had been included within the full list of comments, which was within the appendix. These included the following types of comment: • Relating to source guidance recommendations • Suggestions for non-accredited source guidance • Request to broaden statements out of scope • Inclusion of overarching thresholds or targets • Requests to include large volumes of supporting information, provision of detailed implementation advice • General comments on role and purpose of quality standards • Requests to change NICE templates The following themes were raised by stakeholders: • The QS overall was well received. • General feedback that the appropriate areas for quality improvement had been identified. • Consideration of other settings where AKI can be managed- The committee highlighted that a range of settings are already included these are primary care, secondary care, GP practices, hospitals and inpatients. • Some statements are broad whereas others are very specific.	

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	• Inclusions/ exclusions- exclude very frail patients and include renal transplant patients. The committee explained that considerations regarding very frail patients are discussed in the guideline. Furthermore the committee explained that renal transplant patients are out of scope of the guideline and therefore could not be included in the QS.	
9.4 Commissioning implications	AS presented to the committee on the supporting documentation that would be developed and published alongside the quality standard.	
9.5 Discussion and agreement of final statements	The committee discussed each statement in turn and agreed upon a revised set. **These statements are not final and may change as a result of the editorial and validation processes.**	
	Draft Quality Statement 1: People with acute illness and a risk factor for acute kidney injury have their serum creatinine levels measured regularly and compared with their baseline assessment. The committee considered that the draft statement would cover too broad a cohort of people for blood testing across all settings. Stakeholders suggested measuring serum creatinine for all non-elective admissions to hospitals and people undergoing major planned interventions, and the committee agreed that the focus for blood tests should be the hospital setting. To ensure that the quality standard also addressed the risk of AKI for people presenting to primary care, the committee agreed to split this statement into two separate statements: one on considering the possibility of AKI that would be relevant across all settings; the other about the use of serum creatinine tests for at risk people in hospital (noting that this would include non-elective admissions and some elective admissions). Stakeholders also suggested that the risk should be assessed using assessment tools but the committee highlighted that there are no validated tools. Stakeholders also queried whether the definition of 'baseline assessment' should match NHS England's definition. . It was therefore also agreed to look at the scope to match the definition of 'baseline assessment' to NHS England's definition.	**NICE to split draft statement 1 into two statements: one on consider the risk of AKI (relevant in all settings); the other on monitoring serum creatinine for at risk people in hospitals. all** **NICE to look at the scope for matching the definition of 'baseline assessment' to NHS England's definition.**
	Draft Quality Statement 2: People in hospital who are at risk of acute kidney injury have their clinical condition regularly monitored and any changes responded to. The committee discussed stakeholders' comments that the draft statement is currently broad and needs to be more specific, suggesting focusing on monitoring fluid levels and urine output as these factors are signs of AKI. The committee agreed to remove 'clinical condition' from the statement and include 'urine output and fluid balance' if source guidance supported this. Due to this change the committee agreed to include	**NICE to remove 'clinical condition' from the statement and include 'urine output and fluid balance', subject to the wording in source guidance. Furthermore it**

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	early warning scores within the definitions. Stakeholders also queried whether people in psychiatric hospitals are included in which the committee confirmed they are.	**was agreed to include early warning scores within the definitions.**
	Draft Quality Statement 3: People with suspected or detected acute kidney injury have a urine dipstick test performed immediately. Stakeholders raised concern that the test would lead to inappropriate investigations, prescribing, unnecessary catheterisation and UTIs. The committee explained that sometimes the cause of AKI can appear obvious but felt it beneficial to have urinalysis for clarification and to have this recorded. The committee did however agree that catheterisation should be avoided and for NICE to include this within the definitions. The committee felt that the word 'immediately' needed defining and discussed that within 6 hours would be reasonable. Furthermore if a test has already been carried out then another should be done within 6 hours. However the committee explained that this would then not apply to primary care. The committee agreed to include 'as soon as' instead. The committee discussed whether to remove 'suspected' from the statement but agreed to leave it in because of its particular relevance in primary care.	**NICE to change 'immediately' to 'as soon as AKI is suspected or detected' in the statement.** **NICE to add a timeframe and that catheterisation should be avoided to definition of the test.**
	Draft Quality Statement 4: People with acute kidney injury are referred immediately (using local transfer protocols) to a nephrologist, paediatric nephrologist or critical care specialist if they meet the criteria for renal replacement therapy. Stakeholders questioned why renal replacement therapy (RRT) was the focus of this statement as they felt that RRT should not be the trigger for referral. The committee explained that this area was currently not being done well and therefore had agreed to progress a statement. This statement is about an end stage group that need RRT and need to go into ICU or a renal unit. NICE to add this to the rationale. Overall the committee agreed not to alter this statement (subject to editorial suggestions about the order of the wording). The committee did however agree with stakeholder suggestions to have an additional statement about the criteria for referral to a nephrologist and the importance of an early discussion with a nephrologist. NICE to progress this as a separate statement using recommendation 1.5.15.	**NICE to progress the current statement as it is but add to the rationale.** **NICE to progress an additional statement on discussion with a nephrologist based on recommendation 1.5.15**.

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	Draft Quality Statement 5: People who are at risk of acute kidney injury are made aware of the risk of developing it in a discussion with their healthcare professional (involving their parents or carers, if appropriate). Stakeholders queried whether the list of 'at risk' patients was too broad. The committee agreed, highlighting that the groups in recommendation 1.6.4 would be more appropriate. The committee felt that people who have had previous AKI should also be included. Stakeholders also raised a concern that the statement may lead to a risk that patients will misunderstand the information in a harmful way, for example not taking their medication. The committee however considered that patient information can make a real difference if they understand the risk factors and what to do to avoid AKI, such as the importance of hydration. The committee considered this statement to be needed to help reduce the incidence of AKI in the community. The committee agreed that the discussion should be had at least once (not annually/regularly) and be documented.	**NICE to define the 'at risk' patients using recommendation 1.6.4 and also include people who have had previous AKI.** **NICE to add to rationale and definition of the 'discussion'.**
	Additional areas suggested by stakeholders • **Basic medical care of patients who have developed AKI** The committee agreed not to progress a statement here as they felt this to be a generic issue addressed by the clinical guideline and not aspirational. • **Every discharge summary from an inpatient hospital episode should document the presence of, the stage of and the cause of AKI.** The committee explained that there are no recommendations for this but did highlight that this could be measured and would be useful within the definitions of statement 5 as this would need to happen for the statement to work. • **Patient information for people who have AKI e.g. short or long-term need for dialysis.** The committee felt that this would apply to a small percentage of people and is not a key area for quality improvement.	**NICE to add discharge summary info to definitions of the statement on patient information.**
10. Supporting the quality standard	RNJ presented a summary of the organisations who have expressed an interest in supporting the quality standard and asked the QSAC to consider whether any key organisations were missing. The following organisations were highlighted: • Renal Association • British Renal Society	**NICE to contact suggested organisations to see if they are interested in supporting the AKI QS.**

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	• Royal College of General Practitioners • National Outreach Forum	
11. Next steps and timescales	JM outlined what will happen following the meeting and any key dates for the AKI quality standard.	
12. Any other business	No items of business were raised. MG thanked the specialist committee members for their input into the development of this quality standard, **Date of next QSAC4 meeting: 22nd September 2014**	