<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.45</td>
<td>Refreshments on arrival</td>
<td>David Slark Procurement and Contracts Compliance Manager, London Borough of Merton</td>
</tr>
<tr>
<td>10am</td>
<td>5 mins Introduction</td>
<td>David Slark Procurement and Contracts Compliance Manager, London Borough of Merton</td>
</tr>
<tr>
<td>10.05</td>
<td>30 mins Contingency Planning</td>
<td>Sarah Chittock Civil Contingencies Adviser, London Borough of Merton</td>
</tr>
<tr>
<td>10.35</td>
<td>30 mins Deprivation of Liberty Safeguards</td>
<td>Gemma Saunders MCA and DOLS Coordinator, London Borough of Merton</td>
</tr>
<tr>
<td>11.10</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>11.35</td>
<td>40 mins Alternatives to A&amp;E and Signposting Tool</td>
<td>Jason Morris from LAS – Team Leader, London Ambulance Service</td>
</tr>
<tr>
<td>11.20</td>
<td>15 mins Joint Working with Care Homes and Community Services</td>
<td>Zoe Robinson – Project Lead, SMCS</td>
</tr>
<tr>
<td>12.20</td>
<td>15 mins Community Prevention of Admission Services</td>
<td>Julia Russell – Clinical Lead, Community Prevention of Admission Team (CPAT), SMCS</td>
</tr>
<tr>
<td>12.30</td>
<td>12.45 Care Homes and Nutrition Projects</td>
<td>Sedina Agama Chief Pharmacist &amp; Assistant Director – Medicines Optimisation, NHS Merton CCG</td>
</tr>
<tr>
<td>12.45</td>
<td>1pm Final Questions and Answers Close of Forum</td>
<td>David Slark</td>
</tr>
</tbody>
</table>

**Note:**
- SMCS refers to Sutton and Merton Community Services.
Welcome!

David Slark
Procurement and Contracts Compliance Manager
Adult Social Services
Community and Housing
London Borough of Merton
Care Home Forum
24th September 2014

Sarah Chittock – Merton Civil Contingencies Officer
AIM

• To develop an understanding of what business continuity means to your organisation
• To understand what is meant by critical services and how to support them
• To understand the resources available from within and what is available elsewhere
What is Business Continuity?

Business Continuity (ISO 22300)
“The capability of the organization to continue delivery of products or services at acceptable redefined levels following a disruptive incident”

Business Continuity Management (ISO 22301:2012)
“A holistic management process that identifies potential threats to an organization and the impacts to business operations those threats, if realized, might cause, and which provides a framework for building organizational resilience with the capability of an effective response that safeguards the interests of its key stakeholders, reputation, brand and value-creating activities”
Why does BCM fail?

- Lack of ownership of planning process
- Not involving the right people
- Not understanding how 3rd parties will respond
- Planning in isolation
- Knowledge of plan
- Assumptions
- Failure to review and update
- Inadequate flexibility
- Poor communications
- Failure to consider “follow on” events
- It will never happen to us
- Competing priorities
- Lack of resource
- Increasing reliance on 3rd parties
- Not testing / exercising plans / learning lessons from incidents
Resources – who has what

Local Authority response:
• Rest Centres – types of designations
• British Red Cross – what they do

What you can bring to the party?
• Transport?
• Alternative accommodation?
• Where is it?
• How long will it be required?
Risk Assessment – what are the threats?

- Loss of Property?
- Loss of IT/telecoms?
- Loss of key supplier?
- Health Emergency?
- Loss of staff?
Planning & Validation

• Plans need to be developed that reflect your organisation and the services you provide
• Identify the most critical aspects
• Develop achievable & acceptable recovery targets
• Think short term, medium term & long term – you can’t get it all back at once.
• Key contacts, suppliers, partners – communications plan.
• Train your staff – does everyone know what the initial actions are?
• Exercise the plan – table top it or live?
BCM – Building Resilience

Conclusions

• BCM is an essential element of a risk mitigation strategy.
• All risks need to be fully understood in the first place
• Combine them with judicious management of risk
• Don’t neglect prevention measures or supply chain.
• Evidence of BCM can legitimately reduce insurance loss estimates
• Good BCM can improve business resilience
Your starter for 10

Consider the activities of your service
• – What are the priority activities delivered by your service?
• – What would the impact be if these could not be provided?
• – When do you need to have acceptable levels in place?
Having considered the activities
• – What are the main threats your service faces?
Finish

• Thank you for your time and attention

• Please go back and review your plans
Deprivation of Liberty Safeguards

Gemma Saunders - Richardson - Acting Deprivation of Liberty Safeguards and Mental Capacity Act Coordinator

Naomi Lamptey - Best Interest Assessor
What is Deprivation of Liberty Safeguards?

- The MCA DOLS come into force in England on 1 April 2009 as a result of the Bournewood Judgment.

- They provide for the lawful deprivation of liberty of those people who lack capacity to consent to arrangements made for their care or treatment in either hospitals or care homes, but who need to be deprived of their liberty in their own best interests.

- Local authorities have responsibility for operating and overseeing the MCA DOLS, whilst care homes and hospitals have responsibility for applying to their local authority for a Deprivation of Liberty authorisation.

- Therefore, it is absolutely essential that all care home (and hospital staff) as well as relevant local authority (and CCG) staff familiarise themselves with this legislation.
Key Points

- Part of the Mental Capacity Act 2005
- Applies primarily to care homes and hospitals but this is changing.
- Can only be used to deprive a person who lacks capacity to make decisions concerning their liberty.
- DOLS does not apply if a person has the capacity to make their own decisions.
- Prevents mentally incapacitated adults from being deprived of their liberty arbitrarily.
- Does not apply when someone is detained or could be detained under the Mental Health Act.
How does DOLS protect people?

- Requirement that less restrictive options are considered first.

- If a person needs to be deprived of their liberty in their best interests, DOLS provides the following protection.
  - A representative to act for them and protect their interests.
  - Rights of challenge to the Court of Protection against unlawful deprivation of liberty.
  - Rights for their deprivation of liberty to be reviewed and monitored on a regular basis.
  - The person subject to the deprivation of liberty authorisation and their representative also have a statutory right to an independent mental capacity advocate (IMCA).
Who is affected?

- Main part of MCA 2005 affects people aged 16 or over.
- DOLS covers people aged 18 or over who:
  - Have a mental disorder.
  - Lack capacity to consent to the arrangements made for their care and/or treatment.
  - Need to be given care and/or treatment in circumstances that amount to a deprivation of liberty in a hospital or a care home, where this care and/or treatment is necessary to protect them from harm and is in their best interests.
Identifying a Deprivation of Liberty

- Since March 2014, the threshold for a Deprivation of Liberty has changed following the Cheshire West supreme court judgement.
- The threshold is now significantly lower, which means that an increasing number of people accommodated in care homes and hospitals will now come under the remit:
  - If the person is not free to leave,
  - And
  - Under continuous supervision and control.

A DEPRIVATION OF LIBERTY SAFEGUARDS AUTHORISATION IS REQUIRED
What next?

- Urgent request: complete form 1 and 4
- Standard request: complete form 4
What happens next?

The supervisory body (Local Authority) receive the completed forms and appoint a Best Interest Assessor (BIA) and s.12 doctor (doctor that has undergone specialist training) to complete the necessary assessments.

• Age
• Mental health
• Mental Capacity
• Best Interests
• No Refusals
• Eligibility
What’s your responsibility in the DOLS Process?

Pre DOLS
- To complete the necessary forms to request a DOLS authorisation.
- Inform the family and/or friends of the request.

Post DOLS
- Ensure you have received the paperwork from the supervisory body (Merton Council)
- Make sure you know if there are any conditions attached to the authorisation and act upon them.
- Inform the supervisory body if a DOLS is no longer relevant. E.g. if the person has died or has moved.
- If you require a review of a DOLS authorisation. For example, if circumstances have changed that would interfere with the current DOLS, such as a person regaining capacity.
What to expect from the Best Interest Assessor

Naomi Lamptey
Contact details

• Merton Safeguarding Adults and DOLS team
  9th floor, Civic Centre, London Road, Morden, SM4 5DX
• 020 8545 3681
• safeguarding.adults@merton.gov.uk

Refreshment break
CARE HOME FORUM - MERTON

Presented by

Jason Morris
Clinical Team Leader- St Helier Complex

Jason.morris@lond-amb.nhs.uk
OUTLINE

• Background information about The London Ambulance Service

• Deciding when to call an Ambulance

• Identifying the most appropriate care pathway

• Calling ‘999’ and preparing for it’s arrival
Clinical Telephone Advice
Merton Calls

- August 1649 calls
- Average 55 call per day
- Ambulances average
  Day = 7 Ambulance 2 car
  Night = 3 Ambulances 2 cars
Deciding when to Call 999

Always call 999 if someone is seriously ill or injured, and their life is at risk.

Examples of medical emergencies include:

- difficulty in breathing
- unconsciousness
- severe loss of blood
Indications for calling ‘999’ following a fall (1)

- New chest pain or difficulty in breathing.
- Loss of consciousness or associated vomiting, dizziness or new blurring of vision.
- If there is thought or known to be a head injury
- Any known underlying condition that may give rise to a fall
Indications for calling ‘999’ following a fall (2)

- New shortening/rotation/deformity or pain on movement.
- Underlying conditions that may be exaggerated by fall.
- Injury or existing wound worsened
- Soft tissue injury – bleeding which cannot be stopped.
Indications for calling ‘999’ following a fall (3)

- Any evidence of new neck pain or injury
- Recent deterioration in general condition or cognitive state
- Staff did not see the fall and history from patient is not thought reliable
- Service user insists they are uninjured but staff remain concerned
When ‘999’ may not be necessary

- No chest pain or difficulty with breathing
- No loss of consciousness
- No bleeding, large swelling or deformity
- Resident freely moves all limbs, has no newly reduced power and movement control and is able to discern if they are injured.
- No worsening of underlying condition
### Time of day

| Day   | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | Total |
|-------|---|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|-----|------|
| Mon   |   |   | 1 |   |   |   |   |   | 2 | 2 | 1  |    | 2  | 1  | 2  |    | 1  | 1  |    |    |    |    |    |    |   13 |
| Tue   |   |   | 1 |   | 1 | 1 | 2 | 1 |   |   |    |    | 1  |    | 1  |    |    | 1  |    |    |    |    |    |    |    |   12 |
| Wed   |   |   |   |   | 1 | 1 | 1 |   |   | 2 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |   6  |
| Thu   |   |   |   | 1 | 1 |   |   | 1 | 1 |    |    | 2  | 2  | 1  | 2  | 1  |    |    |    |    |    |    |    |    |    |    |   12 |
| Fri   |   |   |   |   | 1 | 1 | 2 |   | 2 |   |    |    |    |    | 1  | 1  |    | 1  |    | 1  |    | 2  |    |    |    |    |    |   10 |
| Sat   |   |   | 1 |   | 1 | 2 | 1 | 2 | 2 | 2  |    |    |    |    |    |    |    |    |    |    |    |    | 1  |    |    |    |    |   17 |
| Sun   |   |   |   |   |   |   | 1 | 2 | 1 | 1 | 1  | 1  |    |    |    |    |    |    |    |    |    |    |    |    | 3  | 1  |    |    |   14 |
| **Grand Total** | 2 | 0 | 2 | 2 | 0 | 1 | 2 | 4 | 7 | 3 | 5 | 6 | 3 | 3 | 8 | 6 | 4 | 6 | 7 | 3 | 4 | 2 | 4 | 0 | 84 |

London Ambulance Service NHS Trust
Alternative Pathways

- On site qualified nurse
- GP or GP out of hours service (NHS 111)
- District Nurse (Opening Hours and Twilight)
- CPAT
- Palliative Care Teams
- CMHT
<table>
<thead>
<tr>
<th>Worried About A Resident?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>999</strong></td>
</tr>
<tr>
<td>Chest pain</td>
</tr>
<tr>
<td>Choking</td>
</tr>
<tr>
<td>Fitting (new or prolonged)</td>
</tr>
<tr>
<td>Severe breathing problems</td>
</tr>
<tr>
<td>Stroke</td>
</tr>
<tr>
<td>Unconscious</td>
</tr>
<tr>
<td>Vomiting blood</td>
</tr>
<tr>
<td>Diabetic emergency</td>
</tr>
<tr>
<td>(Hypoglycemia or Ketoacidosis)</td>
</tr>
<tr>
<td><em>Head Injury-on anticoagulant - defined as any trauma to the head, other than superficial injuries to the face (NICE 2007)</em></td>
</tr>
<tr>
<td><strong>CPAT</strong></td>
</tr>
<tr>
<td>Monday to Friday</td>
</tr>
<tr>
<td>08:00 – 19:00</td>
</tr>
<tr>
<td>020 8251 0152</td>
</tr>
<tr>
<td>Saturday and Sunday</td>
</tr>
<tr>
<td>10:00 – 18:00</td>
</tr>
<tr>
<td>020 8401 3645</td>
</tr>
<tr>
<td>Rapid holistic assessment, within 2-4 hours.</td>
</tr>
<tr>
<td>Patients requiring urgent nursing or therapy to prevent attendance/admission to hospital.</td>
</tr>
<tr>
<td><strong>Out of Hours Urgent problem 111</strong></td>
</tr>
<tr>
<td>Unwell resident</td>
</tr>
<tr>
<td>Breathing Problems</td>
</tr>
<tr>
<td>Worsening Confusion</td>
</tr>
<tr>
<td>UTI (dipstick first)</td>
</tr>
<tr>
<td>Worsening pain</td>
</tr>
<tr>
<td><strong>Community Nursing</strong></td>
</tr>
<tr>
<td>08:30 - 18:00</td>
</tr>
<tr>
<td>0845 567 2000</td>
</tr>
<tr>
<td>In patients home and residential care settings</td>
</tr>
<tr>
<td><strong>Twilight</strong></td>
</tr>
<tr>
<td>17:00 – 22:30</td>
</tr>
<tr>
<td>Urgent nursing problems that will not wait until the following day</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
</tr>
<tr>
<td>Sutton Older Peoples CMHT - aged 75 and over and those over 65 and over, with suspected dementia.</td>
</tr>
<tr>
<td>09:00 – 17:00 Mon-Fri</td>
</tr>
<tr>
<td>020 8335 4066</td>
</tr>
<tr>
<td>Sutton Assessment Team – single point of access for all referrals to adult community mental health services</td>
</tr>
<tr>
<td>09:00 – 17:00 Mon-Fri</td>
</tr>
<tr>
<td>020 3513 3900</td>
</tr>
<tr>
<td><strong>Palliative Care (being checked)</strong></td>
</tr>
<tr>
<td>St Raphaels Hospice</td>
</tr>
<tr>
<td>020 8099 7777</td>
</tr>
<tr>
<td>Hospice@home</td>
</tr>
<tr>
<td>Referrals Mon-Fri 09:00-15:30</td>
</tr>
<tr>
<td>Deterioration/disease</td>
</tr>
<tr>
<td>progression Symptom</td>
</tr>
<tr>
<td>management</td>
</tr>
<tr>
<td>Community Specialist Palliative Services Mon–Fri 09:00-17:00</td>
</tr>
<tr>
<td>Sat, Sun, BH 09:00-17:00</td>
</tr>
<tr>
<td>Pain and symptom management</td>
</tr>
<tr>
<td>Emotional support</td>
</tr>
<tr>
<td>Bereavement support</td>
</tr>
<tr>
<td>GP</td>
</tr>
<tr>
<td>Available on telephone advice during surgery hours</td>
</tr>
<tr>
<td>General medical concerns</td>
</tr>
<tr>
<td>Medication concerns</td>
</tr>
<tr>
<td>On-going medical/psychiatric problems</td>
</tr>
<tr>
<td>Please check Anticipatory Management Plan before ringing 999</td>
</tr>
<tr>
<td><strong>Please complete Seldoc (Sutton)/Harmoni (Merton) Form before calling 111</strong></td>
</tr>
</tbody>
</table>

London Ambulance Service NHS Trust
# Doctor/Ambulance Information Form

To be completed by Care/Nursing/Home staff prior to calling GP/111/999/CPAT
(Routines observations to be completed before calling)

<table>
<thead>
<tr>
<th>Date</th>
<th>Time of call</th>
<th>Time call returned</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient's name</th>
<th>DoB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's GP</td>
<td>Caller Name</td>
</tr>
<tr>
<td>Why are you calling now?</td>
<td>List symptoms:</td>
</tr>
<tr>
<td>What has changed from previously?</td>
<td>Past Medical History / Diagnosis</td>
</tr>
<tr>
<td>Is the patient for palliative care/end of life pathway?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>Is the patient UNAH?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>Is there an Advance care Plan?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>Medication</td>
<td>Ensure you have MAR chart to hand =</td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
</tr>
<tr>
<td>BP</td>
<td>Temp</td>
</tr>
<tr>
<td>Pulse</td>
<td>Respiration rate</td>
</tr>
<tr>
<td>Urine dipstick result</td>
<td></td>
</tr>
<tr>
<td>Are family aware?</td>
<td>If so any concerns / beliefs?</td>
</tr>
<tr>
<td>Any other observations?</td>
<td>BM:</td>
</tr>
<tr>
<td>Outcome of call</td>
<td></td>
</tr>
</tbody>
</table>
CALLING AN AMBULANCE

• Dial 999, ask for an Ambulance

• If possible, remain with the patient

• Give key information:
  Correct Location, What has Happened,
  Conscious/Breathing?
  Answer all questions call taker asks
  Follow instructions & Stay Calm
PREPARE FOR THE ARRIVAL OF THE AMBULANCE

- Meet the crew and guide them to the patient.
- Ensure ease of access to the patient
- If you have begun CPR continue until LAS staff can take over
- Ensure the Ambulance/Doctor Information Form is available
- Ensure any Advance Decisions are available
- Ensure any Anticipatory Management Plans are available
ANY QUESTIONS?
Joint working with Care Homes

Zoe Robinson

24th Sept, 14
Project

- Working with SMCS to improve joint working between homes and community services, which will include:
  - Building confidence of staff within homes.
  - Reviewing barriers within specific pathways.

- A more proactive approach to managing LTCs and improved community input.

- Measured by a reduction in unnecessary conveyances to A&E due to improved condition management and prevention in community settings.
The approach

Tier 1 – Targeted joint working and training

Tier 2 – Care Home Forum, Training, Networking

Tier 3 – Universal resources and joint working practices review
Tier 1

- Analysis of conveyances from the Home’s perspective to understand training needs of home staff and barriers within specific pathways.
- Reviewing the medical and community input to understand blockages in the pathway.
- Identify training needs for home staff and deliver training.
- Stronger links between homes and CPAT, to provide an alternative to conveyance.
- Joint working with LAS to use alternative pathways and training.
- Work with the EOLT to enable proactive planning around potential admissions and particularly advance directives on EOLC.
- Home community liaison capacity to proactively identify management strategies for high risk residents, via ward rounds and dedicated home visits.
Tier 2

- Falls prevention
- Falls management
- Continence training
- End of Life Care
- Catheter training
- Tissue Viability Nurse
- Infection control
- Discharging from hospital to care home

- Malnutrition
- Pressure ulcers
- BMI Index
- Safeguarding training
- Co-ordinate My Care
- DOLS – Mental Capacity Act
- Wound care
Tier 3

- Increased joint working between community services and homes
- Alternatives to A&E
- Review interdependent pathways including:
  - Hospital Discharge to homes
  - Community Prevention of Admission Team
  - Specialist Community Teams
  - District Nursing Team
  - Night Nursing Team
  - Falls Prevention Team
  - London Ambulance Service
  - Community Nurse Home Liaison
Going forward

• Tier 1 homes – Letter sent out from MLB and MCCG

• Tier 1 homes – Initial meeting to identify key areas in relation to training, conveyances and pathways

• Tier 1 homes – Develop a bespoke plan for each home.

• Tier 2 - Provide dates and programmes for upcoming forums

• Tier 3 - Introduce new tools and resources to help you to support your residents to be happy and healthy

• All Tiers - Let you know when improvements to joint working and pathways have been achieved
Any questions?

zoerobinsonmail@yahoo.co.uk

Thank you.
Community Prevention of Admissions Team (CPAT)

A team of highly skilled nurses and therapists, working together to prevent unnecessary hospital admissions.
• Service open from 8am-7pm, Mon-Fri and 10am-6pm at weekends and bank holidays.
• Patients seen within 2 hours of referral.
• Referrals taken from any healthcare professional.
- A full, holistic assessment is undertaken, which may include physical examination, if required.
- A plan of care will be devised, in agreement with the patient.
- Some members of staff are able to prescribe medication.
EXAMPLES OF WHAT WE SEE

UTI
Chest infection
Reduced mobility following a fall or due to pain
Increased confusion
Cellulitis
Abdominal pain/gastric disturbance
Dizziness
WE DO NOT SEE...

- Chest pain
- ? Stroke
- Primary mental health issues
- Anyone under age of 18
- Any head injury in patients on warfarin/fragmin/dalteparin
WHAT WE CAN DO...

- Diagnose and prescribe treatments for common illnesses.
- Access therapy services
- Access Community Nursing, including specialist nursing
- Access equipment and provide in some circumstances
- Take specimens as necessary for pathology investigation
What we cannot do.....

- Give intravenous or subcutaneous fluids.
- Start intravenous antibiotics.
- Access respite beds.
- We are not an alternative to District Nurses.
- Work miracles!!
• Any questions?
CARE HOMES PROJECT
IDENTIFY CARE HOMES

- Identify two top spending Care Homes for ONS
- Identify care home needs
- Identify patients on supplements
PLAN

- Training on nutritional screening – MUST
- Training on Food Fortification
- Review supplement ordering
- Education regarding use of ONS
LEANNE GREEN
PRIMARY CARE DIETITIAN

NHS MERTON CCG
120 THE BROADWAY
WIMBLEDON
SW19 1RH

0203 668 3145
Care Homes and Nutrition Projects

Sedina Agama
Chief Pharmacist & Assistant Director – Medicines Optimisation
NHS Merton CCG
Medicines Management in Care Homes in Merton – Pilot Report

Aim:
- To provide medicines optimisation reviews for patients residing in care homes in Merton, ensuring appropriateness, safety and cost effectiveness of medicines prescribed.

Method:
- Pilot commenced April 2013
- 3 pharmacists worked with 3 GP Practices in 5 care homes
- 106 patients reviewed
- Patients’ medication was reviewed in the GP Practice using the clinical records, then clinically screened in the care home to ensure it was safe, appropriate and cost effective.
- The pharmacist’s recommendations were discussed and agreed with both care home staff and the GP.
- Changes were carried out by the pharmacist or the GP and were communicated to all parties.

Results:
- At least 276 interventions made
- £51,628 savings identified
- £38,375 implemented (PYE £22,747)
- Feedback from GPs and care/nursing home staff indicates that medicines optimisation reviews conducted by the medicines management team were found to be useful.

Prem Bhalla: Senior Primary Care Pharmacist, Sarah Field: Primary Care Pharmacist, Sedina Agama: Acting Chief Pharmacist.
Medicines Management in Care Homes in Merton – Pilot Report

Next Steps:

➢ The Medicines Management Team:
  ▸ To continue care home work in 2014/15 involving more care homes and GP Practices.

➢ A Care Homes Pharmacist:
  ▸ To be a part of the Medicines Management Team.
  ▸ Post to be funded for 2 years as a QIPP project under the Better Care Fund.
  ▸ The post will help build a strong case for the inclusion of a clinical pharmacist in the Out of Hospital models of care for older and vulnerable adults.
  ▸ Undertake an audit to ascertain which policies are currently in place in care homes and which need to be developed or reviewed.
  ▸ Improve the reporting database to fully capture all interventions in an easily retrievable manner.

Prem Bhalla: Senior Primary Care Pharmacist, Sarah Field: Primary Care Pharmacist, Sedina Agama: Acting Chief Pharmacist.