Medication Audit for Residential Homes

CARE HOME _____

DATE COMPLETED _____

IMPLEMENTING NICE GUIDELINE (SC1) IN CARE HOMES
AUDIT 2019/20

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Medication Audit for Implementing NICE Guideline (SC1) & Best Practice in Care Homes

Introduction

Care homes are subject to enormous amounts of legislation and guidance. This audit aims to provide a way to assess the care homes compliance with NICE guidelines (SC1), current national and local guidelines and best practice when administering medication. The audit can be used by the care home to self-assess and it can be used by external health professionals when completing a full medicines management assessment.

Advice for Completing the Audit

- Work through each of the questions and tick appropriate box
- If you have ticked all **white (Yes or N/A)** boxes then the audit is complete and no further action is needed.
- If you have ticked any boxes that are shaded **grey (No)** it means that action needs to be taken.
- Implement all required actions and sign right hand column to demonstrate completion of actions.
- Keep a copy of all audits completed and file as evidence
- To undertake an audit in a specific area click on the required area on the next page

Contents

Section A - Medication Policy

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
Does the homes medication policy cover:							
A1	Ordering, Receiving, Storage and Disposal of Medication						1.1.2
A2	Managing Controlled Drugs						
A3	Self-administration by residents						1.1.2
A4	Medication Administration including training						1.1.2
A5	Covert Administration						1.1.2
A6	Use of OTC medication and homely remedies						1.1.2
A7	Maintaining accurate and up to date records						1.1.2
A8	Reviewing of medicines						1.1.2
A9	Managing and sharing resident information						1.1.2
A10	Accurately reconciling residents' medication						1.1.2
A11	Identifying and reporting medicines incidents						1.1.2
A12	Identifying and reporting medicines adverse effects						1.1.2

Section B - Training

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
B1	Does the home keep a record of all training carried out by staff?						1.17.6
B2	Are the training needs of all new staff assessed?						
B3	Is induction training available for all new staff?						1.17.4
B4	Is there written evidence of accredited medicines training provided for all staff who administer medicines?						1.17.3
B5	Is there evidence that all staff who give medication have been formally assessed as competent?						
B6	Are there enough members of staff trained to administer medicines at all times?						
B7	Does the home assess & record the competence of all staff to administer medication at least annually?						1.17.5
B8	Does the home provide further competency assessments and support to staff following a medicines incident?						1.17.5
B9	Do all staff have knowledge of and access to the medication policy?						

Section C - Ordering

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
C1	Does the home have at least 2 members of staff who are competent to order medication?						1.10.3
C2	Are care home staff given sufficient protected time to order medication?						
C3	Are stocks of medicines, appliances & feeds checked by the home before prescriptions are ordered?						
C4	Does the home keep a record of all medication ordered?						
C5	Are prescriptions checked against the initial order before being dispensed?						1.10.4
C6	Is there an agreed method for requesting medication from the GP practice?						1.9.1
C7	Are medicines ordered in advance so that residents do not miss any doses of their medications?						
C8	Are records kept of all medicines that have been ordered?						1.10.5
C9	Is there a process for notifying the GP if medicines are out of stock to obtain an alternative if necessary?						
C10	Is there a process for ordering medication in the middle of the ordering cycle?						

Section D - Receiving

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
D1	Are all received medicines checked against the initial order?						
D2	Is the receipt of all medicines, appliances and feeds recorded & signed for?						
D3	Does the home receive the monthly medication order in sufficient time to resolve any discrepancies?						
D4	Are remaining stocks of in-use medication (esp. PRNs) carried forward and recorded on the new MAR?						
D5	Does the quantity supplied for all PRN medication allow for a month's usage?						1.9.2
D6	Are all medicines individually labelled?						
D8	Are all medicines supplied in appropriate containers?						
D9	Are medicines purchased by residents or their families recorded and checked with a GP or Pharmacist before being used?						

Section E - Storage

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
E1	Are medicines stored in a designated area which is suitable & lockable?						
E2	Is the medication room kept locked when not in use?						
E3	Are keys to this area held by an appropriate person & is there a hand-over procedure? Or if there is a keypad is the code known only to designated staff?						1.12.2
E4	Is the room temperature below 25^{o}C and recorded daily?						1.12.2
E5	Are medicines trolleys kept locked when the staff member is administering medication to an resident?						1.12.2
E6	Is there sufficient storage space available to store individual patient's medicines separately?						
E7	Are all PRN medicines supplied in original packs (not dispensed in an MDS)?						
E8	Are external and internal medicines stored separately?						
E9	If medicines are stored within patients' rooms, is secure storage available?						
E10	Are all medications requiring temperature control currently stored in the fridge?						
E11	Is stock rotated and all expiry dates checked?						1.12.4

E12	Are stock levels of medicines, appliances and feeds appropriate and not excessive?						
E13	Is there a procedure for dealing with excess stock?						
E14	Does the home have information regarding the lifespan of medications?						

E2. Fridge Storage

E21	Is the fridge lockable or located in a locked room?						1.12.2
E22	If only a domestic fridge is available, is medication stored in a lockable container?						
E23	Are items requiring refrigeration put away as soon as they are received?						
E24	Does all stock currently in the fridge require temperature control?						
E25	Are max/min fridge temperatures monitored and recorded daily and the thermometer resets?						1.12.2
E26	Do records indicate that the fridge temp is consistently between 2-8^{o}C?						
E27	Is action taken if the fridge goes out of range?						
E28	Do all staff check that medication has not been frozen and take appropriate action if this has occurred?						
E29	Are staff aware what action to take with the medication should the fridge stop working?						

E3. Storage of Medical Gases

E31	If the home stores Oxygen, is it stored securely?						
E32	Are the appropriate warning notices displayed?						
E33	Does the home ensure that there is a no smoking policy near the Oxygen?						
E34	If the home uses an Oxygen concentrator, is it stored upright and plugged into the mains (not an extension lead)?						
E35	Does the home ensure that any resident requiring Oxygen does not use any paraffin based products?						
E36	If required, does the Home have a nebuliser for use for residents?						
E37	Are new masks and tubing available and are they cleaned and replaced regularly as per manufacturers' guidance?						

E4. Storage of Sharps

E41	Does the home have sharps bins for needle disposal?						
E42	Are all sharps signed and dated when opened?						
E43	Are all sharps bins signed and dated when sealed?						

Section F - Self-Medication

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
F1	Does the home have a policy for assessing if a resident has the capability to safely self-medicate?						1.13.2
F2	Is a risk assessment completed for self-medicating residents (including the safety of other residents)?						
F3	Is the level of any support needed recorded in the resident's care plan (e.g. reminders needed)?						
F4	Are assessments and support needs reviewed monthly?						1.13.2
F5	Are residents encouraged to self-medicate even with a limited number of their medication i.e. inhalers?						1.13.1
F6	Do self-medicating residents have secure but accessible storage for medication?						1.13.6
F7	Does the home record the supply of medication to self-medicating residents?						1.13.4
F8	Does the home record when staff have reminded self-medicating residents to take their medication?						1.13.6
F9	Do staff regularly check on storage, stock levels and expiry dates of medication kept by the resident?						
F10	Does the home ensure the residents do not self-medicate from compliance aids filled by their family?						
F11	Are residents able to easily access medication that requires special storage i.e. CDs, fridge items?						1.13.7

Section G - Medicines Administration

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
G1	Is there a system to identify each patient (e.g. photo ID)?						
G2	Are staff given sufficient protected time to carry out an administration round?						
G3	Is the medication trolley supervised at all times when in use and locked when left unattended?						
G4	Are records made as soon as possible after medication is taken and before moving on to the next resident?						
G5	Are medications only prepared at the time of administration i.e. not potted for use later?						
G6	Is additional information available to support administration of PRN or variable dose medication? • What the medication is for • How much to give • Minimum time between doses • Maximum daily dose						1.14.2
G7	Is there a procedure to administer regular medication outside normal rounds i.e. Parkinsons medication?						
G8	Is the home able to offer PRN medication between rounds?						
G9	Are all medicines administered directly from labelled containers supplied directly by the pharmacy?						

G10	Are medication details on labels & MARs checked before each administration?						
G11	Are all labels legible and not smudged or faded?						
G12	Are liquids, creams and drops routinely marked with an opening date once in use?						
G13	Is stock that is in date and still required carried forward to for use in the next cycle?						1.7.1
G14	Are all special instructions adhered to when administering medication i.e. with of after food?						
G15	For residents with swallowing difficulties, do care records contain information on crushing tablets?						
G16	Where a resident has swallowing difficulties is advice sort from a GP before opening a capsule or crushing a tablet?						
G17	Are medicines only given to the resident they were prescribed for?						1.10.1
G18	Are allergies checked before a medication is administered?						
G19	Is there an up to date record of staff signatures who can administer medication?						
G20	If medication is found in the blister pack after it should have been administered is the reason investigated?						
G21	Is regular refusal of medication raised with the GP?						

Section H - Covert Administration

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
H1	Does the home ensure that Covert Administration is not used for residents that have capacity?						1.15.1
H2	Are all reasons for a resident's refusal to take medication explored before going down the covert route?						
H3	Does the home ensure that covert administration is only used after a capacity and a best interest assessment?						
H4	Does the protocol conform to the Mental Capacity Act 2005 and Mental Capacity Act Code of Practice 2007?						1.15.2
H5	Is the assessment of mental capacity recorded in the residents care records?						1.15.3
H6	Are all relevant signatures present on the consent form?						1.15.3
H7	Does the covert form have an up to date list of all medication covered by the covert order?						1.15.3
H8	Is Information on how to covertly administer medication sought from the pharmacy and recorded on the form?						1.15.4
H9	Is a list of all the residents' medication available for the pharmacy to assess how to best to carry out covert administration for each medication i.e. in yogurt?						
H10	Does the home ensure that the need for covert administration is reviewed 6 monthly or after a medication change?						

Section I - Controlled Drugs

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
I1	Are all CDs stored in a locked cabinet which meets the requirements of the Misuse of Drugs (Safe Custody) regulations?						1.12.1
I2	Are keys to the CD cabinet held by a designated person?						
I3	Is the CD cabinet kept locked when not in use?						
I4	Is there a hand over procedure for the CD keys?						
I5	For homes using MDS, are blisters containing CDs stored in the CD cabinet?						
I6	Is there a bound CD register with numbered pages?						
I7	Does the CD register contain a separate sheet for each CD for each resident?						
I8	Does the register contain complete records of the receipt, administration and disposal of CDs?						
I9	Does the register contain running balances of CDs which are checked regularly?						1.14.16
I10	Are the stock levels of all CDs correct?						
I11	Are all alterations to CD entries noted in footnotes and not crossed out?						

I12	Is all CD medication entered into the register immediately on receipt and the balances updated?						1.14.16
I13	If the balance is incorrect in the CD register is this investigated by the Care Home Manager?						
I14	If after investigation the discrepancy cannot be rectified is this reported to the Accountable Officer?						
I15	Are all unwanted CDs recorded and disposed of (either returned to pharmacy or with a DOOM kit)?						1.12.5
I16	Is the administration of CDs witnessed by a second member of staff?						1.14.9
I17	In nursing homes, are all CDs administered by registered nurses or medical practitioners only?						
I18	In residential homes, are all CDs administered only by designated staff?						
I19	In residential homes, are all CDs only administered by medication administration trained staff?						
I20	Are running totals of medications liable to abuse recorded?						

Section J - Homely Remedies

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
J1	Has the policy been approved by the residents' GPs and pharmacists?						1.16.1
J2	Does the policy name suitably skilled members of staff authorised to administer homely remedies?						
J3	Are the medicines included on the policy appropriate i.e. GSL or P meds, for minor ailments?						
J4	Has the list of medications been agreed with the GP/s?						
J5	Is sufficient supporting information included in the policy to allow staff to administer safely? • Excluded patients • Name of medication and indication • Dose and administration frequency • Maximum daily dose • Max duration of treatment • Action to be taken where additional or further treatment is necessary						1.16.1
J6	Does the home have records of the purchase & disposal of homely remedies?						
J7	Are homely remedies stored in their original packaging, separately from the homes regular medication?						
J8	Are the expiry dates of homely remedies checked on a monthly basis?						

J9	Is administration of all non-prescribed medication recorded on a MAR chart?						1.16.1
J10	Are homely remedies kept in their original packaging together with all information supplied i.e. PIL?						1.16.1
J11	Do staff sign the process to confirm they have the skills to administer homely remedies and acknowledge that they will be accountable for their actions?						1.16.2

Section K - MAR Charts

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
K1	Are MAR charts fully completed at each administration?						
K2	Are the MAR charts numbered i.e. 1 of 3, 2 of 3, etc.?						
K3	Does the MAR chart contain full resident information i.e. Name, DOB, and GP?						1.14.8
K4	Do all MAR charts contain details of drug allergies or No Known Drug Allergies (NKDA)?						1.14.8
K5	Does the MAR charts contain all medicines, including PRN medication?						
K6	Are all special instructions for administration contained on the MAR charts i.e. with or after food?						1.14.8
K7	Are all dosage instructions (esp. PRN medication) clear and unambiguous?						1.14.7
K8	If the medication is labelled ‘as directed’ are full directions obtained from the GP?						1.14.7
K9	Can you determine what medication has been given to the resident from the MAR chart?						
K10	Are records of administration recorded with full staff initials (i.e. JS not J)?						
K11	Are the correct non-administration codes being used?						1.14.1

K12	When the non-administration “Other” is used, is a note made on the back of the MAR chart to clearly define why the medication was not administered?						
K13	Does the person who gives the medicine sign the MAR?						
K14	Where there is a choice of dosage (e.g. take 1 or 2) is the quantity administered clearly recorded?						1.14.2
K15	Is the administration of all insulin, drops & creams recorded (including those in resident’s rooms)?						
K16	Do all handwritten MAR entries they contain full and accurate medicine information to safely administer?						1.14.9
K17	Is the handwriting on the MAR chart legible and in ink?						
K18	Are all medication changes recorded appropriately? • Previous medication clearly stopped (avoid altering existing MAR entries) • New MAR entry for all new or amended medication • All handwritten changes to be dated and signed by two members of staff						1.14.9
K19	Are all boxes signed on the MAR chart for regular medication?						
K20	If you use separate administration records do you signpost to it on the MAR chart i.e. warfarin chart?						
K21	Does the home use separate MAR charts for the administration of creams e.g. Topical MAR charts?						
K22	Does the home use a Patch Chart to apply patches ensuring compliance with site rotation?						

Section L - Medicines Incidents and Adverse Effects

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
L1	Does the home have a process for managing medication incidents & near misses which includes: • How to report incidents • Who to report them to • What to record for the purposes of investigation • How to investigate & how the results of the investigation will be acted upon & shared						
L2	When a medication incident has occurred are lessons learnt circulated to all staff who administer medication?						
L3	Are all incidents that lead to a medical consultation actioned and the action recorded as needed?						
L4	Are all significant medication errors reported to CIW and the Local Authority?						1.6.2
L5	Are family members able to report concerns relating to medication?						1.6.10
L6	Does the home have a process for reporting all suspected medication adverse effects which includes: • How to report suspected events • Who to report them to (e.g. GP or OOH services) • What to record in the resident's care plan • How to feedback relevant information to the resident, their family or the supplying pharmacy						1.5.3
L7	Are all adverse effects actioned as needed and is the action taken recorded?						

Section M - Record Keeping

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
M1	Upon admission is a record of the resident's consent to have their medication administered obtained?						
M2	Does the home involve the resident and/or their family in decisions regarding their medication?						1.2.1
M3	Are all medication changes detailed on the MAR and in the resident's care plan?						
M4	Are verbal instructions for changes to medication taken by a trained member of staff and confirmed in writing as soon as possible?						1.9.6
M5	Does the home have an up to date list of all staff's signatures and initials?						
M6	Is non-administration flagged to the GP & pharmacy?						1.2.3
M7	If a resident leaves the home (e.g. day leave), does the home provide temporary carers with sufficient medication and full administration details?						1.14.1
M8	Does the home record all medication leaving and if appropriate, re-entering the home?						
M9	Do you supply information about a resident's medication when a resident attends appointments / clinics outside the home?						

M10	Does the home have appropriately trained staff who manage the personal and sensitive information of residents?						1.3.1
M11	Does the home have procedure for ensuring all staff are aware when a medication has been stopped, started or changed?						1.9.3
M12	Is the regular pharmacy informed of all medication supplied by another pharmacy?						1.4.1
M13	Is the pharmacy informed of all changes to medication?						1.4.1
M14	Is a copy of the discharge medication summary sent to the pharmacy when a resident comes out of hospital?						1.3.8
M15	Do you supply information about a resident's mediation when a resident attends appointments / clinics?						1.3.5
M16	Do you have a document listing a resident contact information, medical and medication history available when the resident transfers between care settings?						1.7.1
M17	Does the home record all medications leaving the home and if appropriate re-entering the home?						
M18	Does the home have a record of when every resident's annual medication review is due?						1.8.1
M19	Does the home ensure that all residents prescribed antipsychotics are review by a GP or CPN every three months?						1.8.2

Section N - Medicines Reconciliation

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
N1	Does the home have a process for accurately listing a resident's medication?						
N2	Upon admission to the home, is the following information gathered within 24 hours: • Resident's details: Name, DOB, NHS No. and weight • Details of GP and other healthcare providers • Known drug allergies • Medication details (inc name, strength, form, dose, route, timing and indication) • Details of last dose of PRN/weekly medication						
N3	Is all medication received for the new cycle reconciled with their prescription and the new MAR chart?						1.7.1
N4	Are new and old MAR charts compared to ensure all current medication is listed on the MAR and discontinued medications have been removed?						1.7.1
N5	Are MAR charts updated as soon as possible with any changes to medication?						1.4.1
N6	Upon arrival to the home do all residents received a medication review by a clinically qualified professional?						1.3.3
N7	Is there a procedure to ensure if a resident is admitted to hospital that a list of their current medication is supplied?						
N8	Is there a procedure for checking a residents medication on discharge from hospital for medication changes?						

Section O - Safety Alerts and Information

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
O1	Does the home receive and action safety alerts (e.g. MHRA/NPSA) with suitable records maintained and are the cascaded to all staff?						1.14.19
O2	Does the home have access to suitable reference material (e.g. BNF less than 12 months old, BNF app)?						1.14.19
O3	Is a PIL provided for each medicine and retained for reference by the home?						1.14.19
O4	Is advice sought from a pharmacist or GP if staff need clarification on a resident's medication?						

Section P - Equality and Diversity

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
P1	Does the home discuss with the resident or resident's representative the resident's wishes or beliefs to ensure they are followed and respected?						
P2	Does the home ensure that vegetarian / vegan residents do not receive medication containing animal products e.g. capsules containing gelatine?						
P3	Is there a process for ensuring that residents' medication intervals can be altered during religious festivals, such as when they are fasting?						

Section Q - Disposal

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
Q1	Are medicines awaiting disposal stored securely and separated from medicines in-use?						1.12.6
Q2	Are appropriate records (date, patient name, medicine and quantity) maintained of all medicines that are disposed of (e.g. on MAR or in a separate record book)?						
Q3	Are waste medicines returned to a pharmacy (non-nursing only) or via a waste management company?						
Q4	Are records of receipt provided by the pharmacy or waste company and retained in the home?						
Q5	Following the death of a resident, are medicines kept for 7 days before disposal?						1.12.2

Section R - Specialist Medication Information / Monitoring

		Yes	No	N/A	Actions Needed and Comments	Sign & Date Actions Completed	SC1 Ref
R1	Is short course medication, i.e. antibiotics, have an end date or duration indicated on the MAR?						
R2	Is the residents pulse taken and recorded before relevant medication is administered e.g. digoxin?						
R3	Do staff who administer medication understand the different techniques for different types of inhaler and spacers?						
R4	Are staff able to assess the suitability of each inhaler device and encouraged to report if residents' technique is no longer adequate for that device?						
R5	Do all residents who are at risk of a seizure have epilepsy rescue medication i.e. diazepam rectal tubes, available?						
R6	Do all residents who are at risk of a hypoglycaemic attack have glucose gel or glucagon available?						
R7	Is there a protocol for managing residents who refuse medication?						1.2.3
R8	Is there a protocol for managing residents who have difficulty swallowing?						
R9	Is there a protocol for managing patches that include site of application, removal and frequency of site rotation?						

R10	Are all medication monitoring tests e.g. U&E's, LFT's, lithium, carried out at appropriate time intervals?						1.9.1
R11	Do residents on warfarin have a current warfarin dose advice slip?						
R12	Is the warfarin dose information from the INR clinic regularly shared with the pharmacy?						
R13	Are staff aware of the type of side effects that may occur with any newly prescribed medication						1.9.2
R14	Does the home monitor the effects of medication and inform the GP if the residents condition changes?						1.14.1
R15	Are all residents body weights recorded at least monthly?						
R16	Do residents on nutritional supplements or where there are concerns about their weight, have their body weight recorded weekly?						
R17	Are residents who have been on nutritional supplements for 6 months reviewed by a dietitian?						
R18	Does a resident's sudden significant weight loss trigger a medication review?						
R19	Does a clinically qualified medical professional review the medication of all residents at least annually?						1.8.3