UKMi North West

NICE Bites



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A summary of prescribing recommendations from NICE guidance

Managing medicines in care homes

NICE SC1: 2014

This **social care** guideline provides recommendations for good practice on the systems and processes for managing medicines in care homes.

For further information see the **full guideline**.

Definition of terms

Care home: provision of 24-hour accommodation together with either non-nursing care (e.g. a residential home) or nursing care (e.g. a care home with nursing).

Care home provider: registered provider of care.

Care home staff: registered nurses and social care practitioners working in care homes.

Providers: organisations that directly provide health or social care services.

Health and social care practitioners: defines the wider care team, including care home staff, social workers, case managers, GPs, pharmacists and community nurses.

CQC: Care quality commission.

Supporting residents to make informed decisions

- Health and social care practitioners should ensure that care home residents have the same opportunities to be involved in decisions about their treatment and care as people who do not live in care homes, and get the support they need to help them take a full part in making decisions.
- The prescriber or care home staff should record a resident's informed consent in the resident's care record. Consent does not need to be recorded each time the medicine is given but a record of the administration should be made on the medicines administration record.
- Care home staff should record the circumstances and reasons why a resident refuses a medicine (if the resident will give a reason) in the resident's care record and medicines administration record unless there is already an agreed plan of what to do when that resident refuses their medicines. If the resident agrees, care home staff should tell the prescriber about any ongoing refusal and inform the supplying pharmacy, to prevent further supply to the care home.
- Prescribers should:
  - assume that care home residents have the capacity to make decisions,
  - assess a resident's mental capacity in line with appropriate legislation (e.g. the Mental Capacity Act 2005) if there are any concerns about whether a resident is able to give informed consent,
  - record any assessment of mental capacity in the resident's care record.

Sharing Information

- Providers should:
  - have processes in place for sharing accurate information about a resident's medicines, including what is recorded and transferred when a resident moves from one care setting to another (including hospital),
  - ensure that either an electronic discharge summary, if possible, or a printed discharge summary is sent with the resident when care is transferred from one care setting to another.

Policies for safe and effective use of medicines

- Commissioners and providers should review their policies, processes and local governance arrangements, making sure it is clear who is accountable and responsible for using medicines safely and effectively in care homes.
- Care home providers should have an up-to-date medicines policy, which they review, based on current legislation and the best available evidence. The policy should include written processes for:
  - sharing information about a resident's medicines, including when they transfer between care settings,
  - ensuring that records are accurate and up to date,
  - identifying, reporting and reviewing medicines-related problems,
  - keeping residents safe (safeguarding),
  - accurately listing a resident's medicines (medicines reconciliation),
  - medication review,
  - ordering medicines,
  - self-administration,
  - care home staff administering medicines to residents, including staff training and competence requirements,
  - covert administration,
  - care home staff giving non-prescription and over-the-counter products to residents (homely remedies), if appropriate.

Accurate and up to date records

- Health and social care practitioners should ensure that records about medicines are accurate and up-to-date by following the process in the care home medicines policy which should cover recording information:
  - in the resident's care plan,
  - in the resident's medicines administration record,
  - from correspondence and messages about medicines, i.e. emails, letters, text messages and transcribed phone messages,
  - in transfer of care letters and summaries about medicines when a resident is away from the home for a short time,
  - about what to do with copies of prescriptions and any records of medicines ordered for residents.
- Care home providers must follow the relevant legislation to ensure that appropriate records about medicines are kept secure, for an appropriate period of time, and destroyed securely when appropriate to do so.

NHS

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UKMi UK Medicines Information

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Medicines-related problems

- Commissioners and providers should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving residents.
- Care home staff should report all suspected adverse effects of medicines to the prescriber or another health professional as soon as possible; this would usually be the GP or out-of-hours service. Staff should record the details in the resident's care plan and tell the supplying pharmacy (with the agreement of the resident).

Safeguarding

- Care home providers should have a clear process in the medicines policy for reporting medicines-related incidents under local safeguarding processes. It should clearly state:
  - when to notify the CQC (or other appropriate regulator),
  - which medicines-related safeguarding incidents to report and when,
  - that accurate details of any medicines-related safeguarding incidents are recorded as soon as possible.
- Care home providers should record all medicines-related safety incidents, including all 'near misses' and incidents that do not cause any harm.
- Local safeguarding processes should include investigating each report of a medicines-related safeguarding incident and monitor reports for trends.
- Care home staff should contact a health professional to ensure that action is taken to safeguard any resident involved in a medicines-related safeguarding incident. They should follow an agreed process which sets out who to contact in normal office hours and out-of-hours.
- Care home staff should;
  - find out the root cause of medicines-related incidents,
  - give residents and/or their family members/carers information on how to report a medicines-related safety incident or their concerns about medicines, using the care home provider's complaints process, local authority (or local safeguarding) processes and/or a regulator's process.

Medicines reconciliation

- The care home manager or person responsible for a resident's transfer into a care home should coordinate the accurate listing of all the resident's medicines as part of a full needs assessment and care plan and consider the resources needed for this to occur in a timely manner.
- Care home providers should ensure that the following people are involved in medicines reconciliation;
  - the resident and/or their family members/carer,
  - a pharmacist,
  - other health and social care practitioners involved in managing medicines for the resident, as agreed locally.
- Commissioners and providers should ensure that the following information is available for medicines reconciliation on the day that a resident transfers into or from a care home:
  - resident's details, including full name, date of birth, NHS number, address and weight (<16 years or where appropriate e.g.frail older residents),
  - GP's details,
  - details of relevant contacts defined by the resident and/or family members/carers (e.g. consultant, regular pharmacist, specialist nurse),
  - known allergies and reactions to medicines or ingredients, and type of reaction experienced,
  - current list of medicines, including name, strength, form, dose, timing and frequency, route of administration, and indication, if known,
  - changes to medicines, including medicines started, stopped or dosage changed, and reason for change,
  - date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines),
  - other information, including when the medicine should be reviewed or monitored, and any support the resident needs to carry on taking the medicine,
  - what information has been given to the resident and/or family members or carers.
- Providers should ensure that the details of the person completing the medicines reconciliation (name, job title) and the date are recorded.

Medication review

- GPs should:
  - ensure that arrangements have been made for their patients who are residents in care homes to have medication reviews as set out in the residents' care plans,
  - identify a named health professional who is responsible for medication reviews for each resident.
- Health and social care practitioners should ensure that medication reviews involve the resident and/or their family members/carers and a local multidisciplinary team. This may include a:
  - pharmacist,
  - community matron or specialist nurse, such as a community psychiatric nurse,
  - GP,
  - member of the care home staff,
  - practice nurse,
  - social care practitioner.
- The roles and responsibilities of each member of the team and how they work together should be carefully considered and agreed locally. Training should be provided so that they have the skills needed.
- Health and social care practitioners should agree how often each resident should have a medication review based on safety, health and care needs of the resident and record this in the resident's care plan. The interval between medication reviews should be no more than 1 year.
- Health and social care practitioners should discuss and review the following during a medication review:
  - the purpose of the medication review,
  - what the resident (and/or their family members/carers,) thinks about the medicines and how much they understand,
  - the resident's (and/or their family members /carers) concerns, questions or problems with medicines,
  - all prescribed, over-the-counter and complementary medicines that the resident is taking or using, and what these are for,
  - how safe the medicines are, how well they work, how appropriate they are, and whether their use is in line with national guidance,
  - any monitoring tests that are needed,
  - any problems such as side effects or reactions, difficulty taking the medicines themselves (e.g. using an inhaler) or difficulty swallowing,
  - helping the resident to take or use their medicines as prescribed (medicines adherence),
  - any more information or support that the resident (and/or their family members/carers) may need.

This bulletin summarises key prescribing points from NICE guidance. Please refer to the full guidance at www.nice.org.uk for further detail. This is an NHS document not to be used for commercial purposes.

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Prescribing medicines

- GP practices should ensure that there is a clear written process for prescribing and issuing prescriptions for their patients who live in care homes which should cover:
  - issuing prescriptions according to the patient medical records,
  - recording clear instructions on how a medicine should be used, how long the resident is expected to need the medicine, how long the medicine will take to work and what it has been prescribed for (use of the term 'as directed' should be avoided),
  - recording prescribing in the GP patient medical record and resident care record and making any changes as soon as practically possible,
  - providing any extra details the resident and/or care home staff may need about how the medicine should be taken,
  - any tests needed for monitoring,
  - prescribing the right amount of medicines to fit into the 28-day supply cycle if appropriate, and any changes that may be needed for prescribing in the future,
  - monitoring and reviewing 'when required' and variable dose medicines,
  - issuing prescriptions when the medicines order is received from the care home.
- When prescribing variable dose and 'when required' medicine(s) the prescriber should:
  - note in the resident's care record instructions for: when and how to take or use the medicine (e.g.when low back pain is troublesome take 1 tablet), the effect they expect the medicine to have, monitoring,
  - include dosage instructions on the prescription (include the maximum amount to be taken in a day and how long the medicine should be used, as appropriate),
  - prescribe the amount likely to be needed (e.g.28 days or the expected length of treatment),
  - liaise with care home staff to see how often the resident has had the medicine and how well it has worked.
- The prescriber, care home provider and supplying pharmacy should follow any local processes for anticipatory medicines ensuring that care home residents have the same access to these as people who do not live in care homes.
- Care home staff should:
  - ensure that any change to a prescription or prescription of a new medicine by telephone is supported in writing (by fax or email) before the next/first dose is given,
  - ask the health professional using remote prescribing to change the prescription,
  - update the medicines administration record and the care plan as soon as possible (usually within 24 hours).
- Care home providers should have a process in the care home medicines policy for recording the details of text messages received about a resident's medicines and ensuring that the resident's confidentiality is maintained. Text messaging should be used in exceptional circumstances only.

Ordering medicines

- Care home providers:
  - must ensure that medicines prescribed for a resident are not used by other residents,
  - should ensure that care home staff have protected time to order and check medicines delivered to the home,
  - should ensure that at least 2 members of the care home staff have the training and skills to order medicines, although ordering can be done by one member of staff,
  - should retain responsibility for ordering medicines from the GP practice and should not delegate this to the supplying pharmacy,
  - should ensure that records are kept of medicines ordered. Medicines delivered to the care home should be checked against a record of the order to ensure that all medicines have been prescribed and supplied correctly.

Dispensing and supplying medicines

- Pharmacies and doctors supplying medicines to care home providers should ensure they have processes, such as standard operating procedures, in place for all staff who dispense and accuracy check medicines for residents, particularly those using monitored dosage systems.
- Care home providers should determine the best system for supplying medicines for each resident based on the resident's health and care needs and the aim of maintaining the resident's independence wherever possible.
- Supplying pharmacies should produce medicines administration records wherever possible.

Receiving, storing and disposing of medicines

- Care home providers must comply with the Misuse of Drugs Act 1971 and associated regulations when storing controlled drugs.
- Care home providers should include the following information in their process for storing medicines safely:
  - how and where medicines are stored, including medicines supplied in monitored dosage systems, medicines to be taken and looked after by residents themselves, controlled drugs, medicines to be stored in the fridge, skin creams, oral nutritional supplements and appliances,
  - secure storage with only authorised care home staff having access,
  - the temperatures for storing medicines and how the storage conditions should be monitored.
- Care home providers should assess each resident's needs for storing their medicines and provide storage that meets the needs, choices, risk assessment and type of medicines system they are using.
- Care home providers should have a process for the prompt disposal of:
  - medicines that exceed requirements,
  - unwanted medicines (including medicines of any resident who has died),
  - expired medicines (including controlled drugs).
- Care home providers should keep records of medicines (including controlled drugs) that have been disposed of, or waiting for disposal. Medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy.

Training and skills (competency) of care home staff – see full guideline

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Self-administration

- Care home staff should assume that a resident can take and look after their medicines themselves (self-administer) unless a risk assessment has indicated otherwise.
- Health and social care practitioners should carry out an individual risk assessment to find out how much support a resident needs to carry out self-administration which should consider:
  - resident choice,
  - if self-administration will be a risk to the resident or to other residents,
  - if the resident can take the correct dose of their own medicines at the right time and in the right way (e.g. do they have the mental capacity and manual dexterity for self-administration?),
  - how often the assessment will need to be repeated,
  - how the medicines will be stored,
  - the responsibilities of the care home staff, which should be written in the resident's care plan.
- Providers of adult care homes must ensure that records are made and kept when adult residents are supplied with medicines for self-administration, or when residents are reminded to take their medicines themselves.
- Providers of children's care homes must ensure that records are made and kept for residents who are able to self-administer. The following information should be recorded on the medicines administration record:
  - that the resident is self-administering,
  - whether any monitoring is needed e.g. to assess ability to self-administer or adherence,
  - that the medicine has been taken as prescribed (either by seeing this directly or by asking the resident),
  - who has recorded that the medicine has been taken.

Covert administration

- Health and social care practitioners:
  - should not administer medicines to a resident without their knowledge (covert administration) if the resident has capacity to make decisions about their treatment and care,
  - should ensure that covert administration only takes place in the context of existing legal and good practice frameworks to protect both the resident who is receiving the medicine(s) and the care home staff involved in administering the medicines.
- Health and social care practitioners should ensure that the process for covert administration of medicines to adult residents in care homes includes:
  - assessing mental capacity,
  - holding a best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests,
  - recording the reasons for presuming mental incapacity and the proposed management plan,
  - planning how medicines will be administered without the resident knowing,
  - regularly reviewing whether covert administration is still needed.

Non-prescription and over-the-counter products

- Care home providers offering non-prescription medicines or other over-the-counter-products (homely remedies) for treating minor ailments should consider having a homely remedies process, which includes the following:
  - the name of the medicine or product and what it is for,
  - which residents should not be given certain medicines or products (e.g. paracetamol should not be given as a homely remedy if a resident is already receiving prescribed paracetamol),
  - the dose and frequency,
  - the maximum daily dose,
  - where any administration should be recorded, such as on the medicines administration record,
  - how long the medicine or product should be used before referring the resident to a GP.
- Care home staff who give non-prescription medicines or other over-the-counter products (homely remedies) to residents should be named in the homely remedies process. They should sign the process to confirm they have the skills to administer the homely remedy and acknowledge that they will be accountable for their actions.

Care home staff administering medicines to residents

- Care home providers should consider including the following in a medicines administration process:
  - the **6 Rs** of administration:
    right resident
    right medicine
    right route
    right dose
    right time
    resident's right to refuse
  - making a record of the administration promptly,
  - what to do if the resident is having a meal,
  - what to do if the resident is asleep,
  - how to administer specific medicines such as patches, creams, inhalers, eye drops and liquids,
  - using the correct equipment depending on the formulation (e.g.using oral syringes for small doses of liquid medicines),
  - how to record and report administration errors and reactions to medicines,
  - how to record and report a resident's refusal to take a medicine(s),
  - how to manage medicines when the resident is away from the care home for a short time (e.g. visiting relatives),
  - monitoring and evaluating the effects of medicines, including reactions to medicines.
- Care homes with nursing care should also include the correct use of infusion and injection devices (e.g.syringe drivers).
- Care home providers should ensure that a process for administering 'when required' medicines is in the care home medicines policy which includes:
  - the reasons for giving the 'when required' medicine,
  - how much to give if a variable dose has been prescribed,
  - what the medicine is expected to do,
  - the minimum time between doses if the first dose has not worked,
  - offering the medicine when needed and not just during 'medication rounds',
  - when to check with the prescriber if there is any confusion about which medicines or doses are to be given,
  - recording 'when required' medicines in the resident's care plan.
- Care home staff should ensure that 'when required' medicines are kept in their original packaging.

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