Managing medicines in care homes overview

NICE Pathways bring together all NICE guidance, quality standards and other NICE information on a specific topic.

NICE Pathways are interactive and designed to be used online. They are updated regularly as new NICE guidance is published. To view the latest version of this pathway see:

http://pathways.nice.org.uk/pathways/managing-medicines-in-care-homes
Pathway last updated: 11 November 2016

This document contains a single pathway diagram and uses numbering to link the boxes to the associated recommendations.

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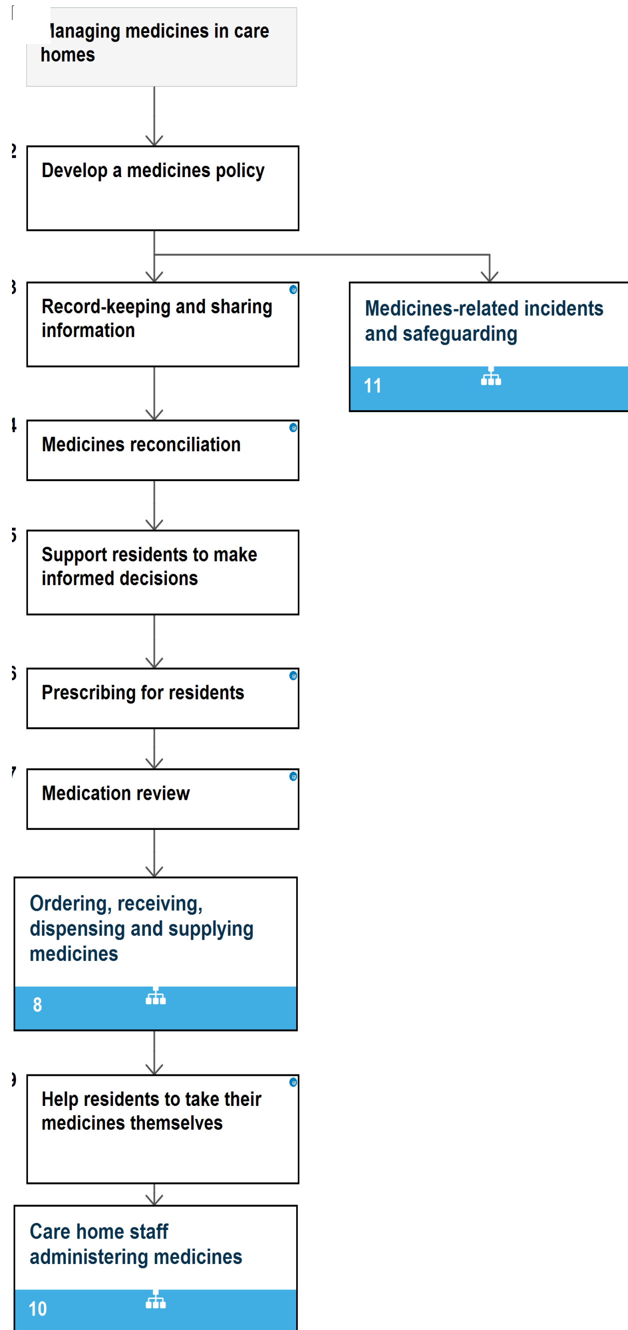

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1 Managing medicines in care homes

No additional information

2 Develop a medicines policy

Commissioners and providers (organisations that directly provide health or social care services) should review their policies, processes and local governance arrangements, making sure that it is clear who is accountable and responsible for using medicines safely and effectively in care homes.

Care home providers should have a care home medicines policy, which they review to make sure it is up to date, and is 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)
- reviewing medicines (medication review)
- ordering medicines
- receiving, storing and disposing of medicines
- helping residents to look after and take their medicines themselves (self-administration)
- care home staff administering medicines to residents, including staff training and competence requirements
- care home staff giving medicines to residents without their knowledge (covert administration)
- care home staff giving non-prescription and over-the-counter products to residents (homely remedies), if appropriate (for information on a homely remedies process see non-prescription and over-the-counter products in this pathway).

See also care home policies in the NICE pathway on oral health for adults in care homes.

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3 Record keeping and sharing information

Keeping records accurate and up to date

Health and social care practitioners should ensure that records about medicines are accurate and up-to-date by following the process set out in the care home medicines policy. The process should cover:

- recording information in the resident's care plan
- recording information in the resident's medicines administration record (see information on medicines administration records in record keeping for care home staff administering medicines in this pathway).
- recording information from correspondence and messages about medicines, such as emails, letters, text messages and transcribed phone messages
- recording information in transfer of care letters and summaries about medicines when a resident is away from the home for a short time
- what to do with copies of prescriptions and any records of medicines ordered for residents (see information on recording information when ordering medicines in ordering medicines in this pathway).

For information on record keeping for people who are administering their own medicines, see help residents to take their medicines themselves [See page 12] in this pathway.

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.

Care home staff (registered nurses and social care practitioners working in care homes) 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 health professional who prescribed the medicine about any ongoing refusal and inform the supplying pharmacy, to prevent further supply to the care home.

Sharing information

Care home providers should have a process for managing information (information governance) covering the 5 rules set out in the Health and Social Care Information Centre's A guide to

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confidentiality in health and social care (2013). The process should also include the training needed by care home staff and how their skills (competency) should be assessed.

Commissioners should review their commissioning arrangements with their provider organisations to ensure that any information about a resident's medicines that is transferred contains the minimum information set out in medicines reconciliation [See page 6] in this pathway. Commissioners should monitor this through their contracting arrangements.

Providers of health or social care services 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).

Sharing information when care is transferred

Providers of health or social care services should ensure that either an electronic discharge summary is sent, if possible, or a printed discharge summary is sent with the resident when care is transferred from one care setting to another. See information on medicines reconciliation [See page 6] in this pathway for the minimum information that should be transferred.

Health and social care practitioners should ensure that all information about a resident's medicines, including who will be responsible for prescribing in the future, is accurately recorded and transferred with a resident when they move from one care setting to another.

Health and social care practitioners should check that complete and accurate information about a resident's medicines has been received and recorded, and is acted on after a resident's care is transferred from one care setting to another.

Care home providers should have a process in the care home medicines policy for recording the transfer of information about residents' medicines during shift handovers and when residents move to and from care settings.

Care home staff should follow the rules on confidentiality set out in the home's process on managing information about medicines and only share enough information with health professionals that a resident visits to ensure safe care of the resident.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

1. Record-keeping

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2. Sharing information

4 Medicines reconciliation

The care home manager or the person responsible for a resident's transfer into a care home should coordinate the accurate listing of all the resident's medicines (medicines reconciliation) as part of a full needs assessment and care plan. The care home manager should consider the resources needed to ensure that medicines reconciliation occurs 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 or carers
- a pharmacist
- other health and social care practitioners involved in managing medicines for the resident, as agreed locally.

Commissioners and providers of health or social care services 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 (for those aged under 16 or where appropriate, for example, frail older residents)
- GP's details
- details of other relevant contacts defined by the resident and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse)
- known allergies and reactions to medicines or ingredients, and the type of reaction experienced (NICE has produced a pathway on drug allergy)
- medicines the resident is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (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 (adherence support)
- what information has been given to the resident and/or family members or carers.

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Providers should ensure that the details of the person completing the medicines reconciliation (name, job title) and the date are recorded.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

1. Record-keeping

5 Support residents to make informed decisions

Health and social care practitioners (care home staff, social workers, case managers, GPs, pharmacists and community nurses) 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 that residents get the support they need to help them to take a full part in making decisions.

Health and social care practitioners should ensure that residents are involved in best interest decisions, in line with the Mental Capacity Act Code of Practice 2007, and:

- find out about their past and present views, wishes, feelings, beliefs and values
- involve them, if possible, in meetings at which decisions are made about their medicines
- talk to people who know them well, including family members or carers (informal or unpaid carers) and friends, as well as care home staff
- deliver care and treatment in a way that empowers the resident to be involved in decisions and limits any restrictions to their care.

Recording a resident's informed consent

The health professional prescribing a medicine 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.

Health and social care practitioners should identify and record anything that may hinder a resident giving informed consent. Things to look out for include mental health problems, lack of (mental) capacity to make decisions, health problems (such as problems with vision and hearing), difficulties with reading, speaking or understanding English and cultural differences.

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These should be taken into account when seeking informed consent and should be regularly reviewed.

6 Prescribing for residents

Capacity to make decisions

Health professionals prescribing a medicine should:

- assume that care home residents have the capacity to make decisions
- assess a resident's mental capacity in line with appropriate legislation, for example, 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.

Health professionals prescribing a medicine should review mental capacity, in line with the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice 2007, when a resident lacks capacity to make a specific decision. How often they do this should depend on the cause, as this may affect whether lack of capacity fluctuates or is temporary.

Prescribing process

GP practices should ensure that there is a clear written process for prescribing and issuing prescriptions for their patients who live in care homes. The process should cover:

- issuing prescriptions according to the patient medical records
- recording clear instructions on how a medicine should be used, including how long the resident is expected to need the medicine and, if important, 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.

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When prescribing variable dose and 'when required' medicine(s) the health professional prescribing the medicine should:

- note in the resident's care record the instructions for:
  - when and how to take or use the medicine (for example, 'when low back pain is troublesome take 1 tablet')
  - monitoring
  - the effect they expect the medicine to have
- include dosage instructions on the prescription (including the maximum amount to be taken in a day and how long the medicine should be used, as appropriate) so that this can be included on the medicine's label
- prescribe the amount likely to be needed (for example, for 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 health professional prescribing a medicine, care home provider and supplying pharmacy should follow any local processes for anticipatory medicines to ensure that residents in care homes have the same access to anticipatory medicines as those people who do not live in care homes.

Communicating about prescribed medicines

The care home provider, health professional prescribing the medicine and pharmacist should agree with the resident the best time for the resident to take their prescribed medicines. Busy times should be avoided.

Health and social care practitioners should work together to make sure that everyone involved in a resident's care knows when medicines have been started, stopped or changed.

Health professionals prescribing medicines should use telephone, video link or online prescribing (remote prescribing) only in exceptional circumstances and when doing so should:

- follow guidance set out by the General Medical Council or the Nursing and Midwifery Council on assessing capacity and obtaining informed consent from residents
- be aware that not all care home staff have the training and skills to assist with the assessment and discussion of the resident's clinical needs that are required for safe remote prescribing
- ensure that care home staff understand any instructions
- send written confirmation of the instructions to the care home as soon as possible.

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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 or first dose is given
- ask that the health professional using remote prescribing changes the prescription
- update the medicines administration record and the care plan as soon as possible (usually within 24 hours) with any changes to medicines made by remote prescribing.

Record keeping

Care home staff (registered nurses and social care practitioners working in care homes) should update records of medicines administration to contain accurate information about any changes to medicines.

Care home providers should have a process set out in the care home medicines policy for recording the details of text messages received about a resident's medicines and making sure that the resident's confidentiality is maintained. Text messaging should be used in exceptional circumstances only.

Ensuring medicines are not used by other residents

Care home providers must ensure that medicines prescribed for a resident are not used by other residents.

Checking for allergies and intolerances

Care home staff should ensure that the resident's GP is contacted to find out about any allergies and intolerances to medicines or their ingredients. This information should be accurately recorded on the medicines administration record and shared with the team(s) providing care to the resident. NICE has produced a pathway on drug allergy.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

4. Prescribing medicines

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7 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.

GPs should work with other health professionals to identify a named health professional who is responsible for medication reviews for each resident. This should take into account the clinical experience and skills of the health professional, how much they know about the resident and the resident's condition, and whether they can access the relevant information.

Health and social care practitioners should ensure that medication reviews involve the resident and/or their family members or carers and a local team of health and social care practitioners (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 multidisciplinary medication review. They should base this on the health and care needs of the resident, but the resident's safety should be the most important factor when deciding how often to do the review. The frequency of planned medication reviews should be recorded 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 or carers, as appropriate and in line with the resident's wishes) thinks about the medicines and how much they understand
- the resident's (and/or their family members' or carers', as appropriate and in line with the resident's wishes) concerns, questions or problems with the medicines

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- 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 the resident has with the medicines, such as side effects or reactions, taking the medicines themselves (for example, using an inhaler) and 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 or carers) may need.

NICE has produced a pathway on medicines optimisation.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

5. Medication reviews

8 Ordering, receiving, dispensing and supplying medicines

See Managing medicines in care homes / Ordering, receiving, dispensing and supplying medicines to care homes

9 Help residents to take their medicines themselves

For information on prescribing, including information on contacting GPs to find out about allergies and intolerances to medicines or their ingredients, see prescribing for residents [See page 8] in this pathway.

Care home staff (registered nurses and social care practitioners working in care homes) 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 on taking and looking after their medicines themselves (self-administration). Risk assessment should consider:

- resident choice

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- 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 (for example, do they have the mental capacity and manual dexterity for self-administration?)
- how often the assessment will need to be repeated based upon individual resident need
- how the medicines will be stored
- the responsibilities of the care home staff, which should be written in the resident's care plan.

The care home manager should coordinate the risk assessment and should help to determine who should be involved. This should be done individually for each resident and should involve the resident (and their family members or carers if the resident wishes) and care home staff with the training and skills for assessment. Other health and social care practitioners (such as the GP and pharmacist) should be involved as appropriate to help identify whether the medicines regimen could be adjusted to enable the resident to self-administer.

Care home providers should ensure that medicines for self-administration are stored as identified in the resident's risk assessment (for example, in a lockable cupboard or drawer in a resident's room). Residents should be able to get any medicines that need special storage at a time when they need to take or use them (see information on storing and disposing of medicines in this pathway).

Care home providers should ensure that their process for self-administration of controlled drugs includes information about:

- individual risk assessment
- obtaining or ordering controlled drugs
- supplying controlled drugs
- storing controlled drugs
- recording supply of controlled drugs to residents
- reminding residents to take their medicines (including controlled drugs)
- disposal of unwanted controlled drugs.

Record keeping

Providers of adult care homes must ensure that records are made and kept when adult residents are supplied with medicines for taking themselves (self-administration), or when residents are reminded to take their medicines themselves.

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Providers of children's care homes must ensure that records are made and kept for residents living in children's homes who are able to look after and take their medicines themselves (self-administer). The following information should be recorded on the medicines administration record:

- that the resident is looking after and taking their medicines themselves (self-administering)
- whether any monitoring is needed (for example, to assess ability to self-administer or willingness to take the medicines as prescribed [adherence])
- that 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.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

3. Self-administration

10 Care home staff administering medicines

See Managing medicines in care homes / Care home staff administering medicines

11 Medicines-related incidents and safeguarding

See Managing medicines in care homes / Medicines-related incidents and safeguarding in care homes

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Sources

Managing medicines in care homes (2014) NICE guideline SC1

Your responsibility

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Contact NICE

National Institute for Health and Care Excellence
Level 1A, City Tower
Piccadilly Plaza
Manchester
M1 4BT

www.nice.org.uk

nice@nice.org.uk

0845 003 7781

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