# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

# HEALTH AND SOCIAL CARE DIRECTORATE

# QUALITY STANDARD CONSULTATION

# SUMMARY REPORT

## 1 Quality standard title

Managing medicines in care homes

Date of Quality Standards Advisory Committee post-consultation meeting:
19 December 2014

## 2 Introduction

The draft quality standard for managing medicines in care homes was made available on the NICE website for a 4-week public consultation period between 10 October and 7 November 2014. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 17 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

# 3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. For each quality statement what do you think could be done to support improvement and help overcome barriers?

Stakeholders were also invited to respond to the following statement specific questions:

4. For draft quality statement 1: Is it appropriate to specify how frequently care homes should review their medicines policies? And, if so, how frequent should these reviews be?

5. For draft quality statement 3: Is it reasonable to expect care homes to make an accurate listing of a resident's medicines on the day they transfer into a care home (see structure measure)?

# 4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Several statements make no mention of adherence to policy/processes, just that policy/processes are set out.
- Concerns were raised that the quality standard did not give enough consideration to the National Care Foundation's (NCF's) 'Safety of Medicines in Care Homes' work and support tools. Stakeholders also suggested that further policy documents and guidance should be considered in the development of this quality standard.
- The CQC are best placed to independently assess medicines managements in care homes and this standard should not duplicate monitoring arrangements between the CQC and commissioners.
- It should be clearer in each statement who has the responsibility to carry out the statement.
- There is little discussion of patient safety issues within the quality standards.
- A stakeholder raised several objections to the wording of the quality standard introductory sections. In particular, with regards to training standards for care assistants and the role of families and carers in decisions made about care for residents, particularly in light of issues about mental capacity.

**Consultation comments on data collection**

- Stakeholders in general commented that it would be possible to collect data for the proposed quality measures.
- The statements are challenging – particularly where data collection involves accessing individual resident's records held at different locations (e.g. GP practices and with community nurses as well as at the care home).
- It was noted that the CQC could potentially collect data during inspections.
- Measurement of care home resident satisfaction in statement 6 noted as potentially difficult due to high prevalence of dementia in care homes.

# Summary of consultation feedback by draft statement

## *4.1 Draft statement 1*

Care homes have a medicines policy that is regularly reviewed.

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- This statement needs to focus on specific actions relating to a medicines policy, rather than just ‘having a policy’.
- This statement should not be first – as it focuses on policy rather than residents.
- A stakeholder noted that CQC requirements already require care homes to have a medication policy in place – so there is no need to create a new standard in his area.
- A stakeholder was surprised that the definition did not include a specific reference to controlled drugs.
- Each care home should have an individualised policy dependent on their resident population. Also, if homes purchase ‘off the internet’ medication policies they must ensure that these are applicable to their home and UK medication laws.
- Staff must be aware of a home’s medication policy and sign and date it to demonstrate understanding. Staff should also be regularly assessed for competency against the medication policy.
- The quality standard should refer to contracts and service specifications between the care home sector and local authorities.

### Consultation question 4

Is it appropriate to specify how frequently care homes should review their medicines policies? And, if so, how frequent should these reviews be?

Stakeholders made the following comments in relation to consultation question 4:

- Stakeholders emphasized the importance of ensuring that a medicines policy is a working document and does not simply ‘sit on a shelf’.

- Several stakeholders were in favour of specifying how frequently reviews of medicines policy should occur. However, suggestions for the frequency varied – including every 3 months, every 6 months, annually, every 2 years and every 3 years.
- However, stakeholders also noted that the nature and frequency of reviews will depend on the nature of a home, its residents and their medication needs.
- The frequency of review should be variable – depending on changes in resident's needs and legislation/guidance. Reviews should take place at an appropriate time and not according to a calendar.
- Care homes will be at different stages – therefore a set review period may not be appropriate. Potentially a minimum review period could be set – any reasons for updating sooner should be documented in a process for keeping the policy up to date.
- Stakeholders also noted that reviews should also occur after changes in guidance or legislation.
- Stakeholders also commented that a review of policy should be triggered not just by changes in guidance and legislation, but also what happens locally in the care home. This included taking the policy into consideration when an incident involving medicines is reviewed or if there is a change in process as a result of a medicines-related problem. A stakeholder noted that it would be useful to highlight scenarios that may lead to a review of a medicines policy.

## *4.2 Draft statement 2*

People who live in care homes are supported to self-administer their medicines unless a risk assessment has indicated that they are unable to do so.

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 2:

- This statement should focus on carrying out risk assessments for self-administration. The timing of risk assessments could also be considered – these will need to be reviewed at intervals as competency to self-administer will change over time. It is important to measure the occurrence of undertaking a risk assessment rather than measuring how many people self-administer.
- Care home residents will not always have the mental capacity or ability to self-medicate. Resident's independence and safety should be considered, taking into account resident's capacity – with safety being a key issue where people do not have the capacity to manage their medicines. Furthermore, the standard doesn't consider the practicality of implementing self-administration within care homes.
- This statement should acknowledge that many older people do not want to take responsibility for self-administration of medicines. Residents must therefore be able to opt-out of self-administration.
- A stakeholder also stated that where residents intermittently lack the capacity to self-administer medicines, and where maladministration of medicines would threaten physical or mental health, that safety should be prioritised over self-administration.
- A stakeholder noted practicality issues associated with this statement – including storage and security of medicines and responsibility if things go wrong.
- A stakeholder was concerned that care home workers may abdicate judgement on who determines who can self-administer to GPs, even if they were better placed to make this judgement.
- The statement should say that risk assessments should be periodically reviewed to determine if any changes to required support are needed.

- The statement should exclude people in a nursing bed – where it would be expected that their medication administration would be facilitated/overseen by a qualified nurse.

## *4.3 Draft statement 3*

People who live in care homes have an accurate listing of their medicines made on the day that they transfer into a care home.

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 3:

- This statement only partially reflects key areas for quality improvement. When care homes experience difficulties in listing medicines, there are two main causes:
  - When residents are admitted from their own homes without prescriptions or medicines (and discussions with the resident being admitted, relatives, friends, GPs etc. are not possible).
  - When residents are discharged from hospitals without medicines, prescriptions or MAR sheets. This is the more common scenario and quality statement 4 addresses it.
- It may be difficult for care homes to make an accurate list of a resident's medicines on the day they transfer into a care home – what would be expected was that staff take appropriate steps to establish what is currently prescribed by a GP or during a hospital stay, what the patient is currently taking and how it's administered.
- Rather than focussing on listing current medications, this statement should be about obtaining an up to date repeat prescription from the current surgery.
- A stakeholder suggested that community pharmacies need to be considered in the statement – to ensure continuity of supply and that any changes made to medication are taken into account.
- A stakeholder commented that it is essential that every new resident has a list of their current medication on the day that they enter a care home – and that this is part of the registration process.
- Needs to be information recorded on the list made about the source of information (e.g. patient/carer, discharge note from hospital, current GP repeat list). Using more than one source for medicines reconciliation will help to check the list is accurate.

- The statement should specify the need for access to a patient's medication record to be made available to the whole of the relevant healthcare team, including the community pharmacist.

**Consultation question 5**

Is it reasonable to expect care homes to make an accurate listing of a resident's medicines on the day they transfer into a care home (see structure measure)?

Stakeholders made the following comments in relation to consultation question 5:

- Several stakeholders commented that it was important to make an accurate listing of a resident's medicines on the day that they enter a care home. This was noted as essential to minimise errors (including omissions in providing medicine and also inappropriate dosages). A stakeholder further noted that it was also important to note when previous doses of medication had been taken.
- There would be difficulties if residents are admitted from their own home without medicines or prescriptions (and discussions with the resident, family, friends, GP etc. are not possible) or if residents are discharged form hospital without medicines, prescriptions or MAR sheets.
- This would only be reasonable for planned transfers from other healthcare settings. Emergency admissions from a resident's home might be without necessary information – in which case steps should be taken to obtain necessary information as soon as possible.
- A further stakeholder also noted that this would not be achievable for all admissions – which can be unpredictable and sources of information required for medicines reconciliation might not be available at the time of admission. There is a difference between planned admissions and emergency admissions.
- A stakeholder noted that care home staff would need easy access to the registered GP for details of resident's current prescription or to the previous care home or hospital at the point of transfer.
- A standard of medicines reconciliation within 48 hours would be more appropriate – but even then care homes might not have access to every information source required.

- A discussion with the resident or their carers to reflect their medication choices should be included within this process.

## *4.4 Draft statement 4*

People who live in care homes have details of their medicines shared with their new care provider when they move from one care setting to another.

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 4:

- This statement should feature before statement 3 – as fulfilling statement 4 is essential for statement 3 to be possible.
- The focus of this statement should predominantly be on other providers (e.g. intermediate care services, hospitals) and to a few care home providers (when residents move from one home to another).
- Records should be shared widely, not just with 'new care providers' as currently specified.
- A stakeholder noted that admission to, and discharge from, hospital are common sources of prescribing and medication errors for elderly people, noting that discharge letters can lack necessary details. Queries from care home staff shortly after a resident is discharged from hospital were noted as common. This should not occur if clear discharge information is provided to carers and to GPs.
- A stakeholder noted problems in communication at the point of transfer of care, and that Ward, Hospital Pharmacy and Care Home staff should be supported to produce and provide accurate, up-to-date information at the point of discharge.
- A stakeholder commented that, depending on local processes, the person with overall responsibility of transfer may be the commissioner (who may not necessarily have access to records). Specifying that the case manager is responsible for transfer may be preferable.
- There needs to be information recorded on the list made about the source of information (e.g. patient/carer, discharge note from hospital, current GP repeat list). Using more than one source for medicines reconciliation will help to check the list is accurate.

- Clarification is needed as to who has the responsibility for carrying out this statement. The information also needs to include medicines administered elsewhere and not at a care home, e.g. injections/infusions in hospital.

## *4.5 Draft statement 5*

GP practices have a clear written process for prescribing medicines for their patients who live in care homes.

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 5:

- Rather than measuring that a process for prescribing medicines is in place, this statement should focus on a specific part of the process and measuring whether it is done.
- The process measure (prescriptions include clear instructions on when and how prescribed medication is to be used) was appropriate but didn't fit with the statement as a whole.
- This statement doesn't measure adherence to processes, just that written processes exist.
- Stakeholders noted that this was an extremely broad statement (potentially encompassing too many actions) – and would be potentially too difficult to measure across its entire scope.
- This statement is inappropriate as it looks at having a process rather than an outcome.
- This statement should refer to 'prescribers' rather than GPs.
- This statement should distinguish between people in care homes with and without nursing.

## *4.6 Draft statement 6*

People who live in care homes have at least 1 multidisciplinary medication review per year.

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 6:

- The statement should focus on having medication reviews when individual needs dictate.
- This statement needs to specifically mention the prescription and long-term use of anti-psychotic drugs.
- The statement should more clearly address the common assumption that care home residents lack the capacity to be involved in medication decisions.
- The involvement of patients/carers in medication reviews should be emphasised.
- It is unclear how many people are needed to constitute an acceptable MDT review.
- The statement should specify what constitutes a medication review.
- The statement should be more explicit that a pharmacist with the appropriate skills should be involved in this review.
- Greater reference should be made to community pharmacists. Stakeholders also suggested that allocation of a specialist pharmacist to care homes would facilitate multi-disciplinary medication reviews.

## *4.7 Draft statement 7*

Care homes have a documented process for the covert administration of medicines for adult residents.

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 7:

- A requirement for a covert medicines administration policy is already specified in statement 1.
- The statement should focus on key things that need to happen here (and that aren't happening) rather than being a 'have a process' style statement.
- This quality statement could specify frequency of reviews needed for covert medicines administration.
- A further measure should identify if advice is given on how covert medicines are to be administered. This was noted as often being forgotten – as care homes often do not focus on the best or safest way to administer the medicine.
- A stakeholder noted that in order to drive up standards, it should be identified if a care home's covert medicine administration practice matches their documented process. A further stakeholder noted that the CQC carry out such checks.
- In certain situations, holding a formal best interests meeting would lead to harm as it would delay medicines administration. In such circumstances, covert administration is justified under best interest considerations based on the judgement of the professionals involved at the time.
- Staff should be provided with regular training on covert administration of medicines; including legal, ethical and practical details and the need for discussion with all appropriate parties.
- Greater reference to existing guidance and practice should be included in this standard.

## Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Stakeholders suggested the need for a separate statement focusing on the management and response to medication errors in care homes – to ensure learning is achieved from medication errors.
- A separate statement for staff training and competencies.
- A statement on allergy/sensitivity documentation – MAR charts frequency lack this important information. Care home's medicines policy should include provisions for checking allergy status each time a medicine is administered.
- Supply of medicines – robust processes are needed linking the ordering or prescribing or medicines with supply.
- A statement is needed with greater consideration of medicines administration at the point of initial admission and also admission form hospital.

# Appendix 1: Quality standard consultation comments table

| ID | Stakeholder | Statement No | Comments[1] |
|---|---|---|---|
| General | | | |
| 001 | Boots UK Ltd | General | We note that care home businesses served by Boots UK are already taking a close interest in the draft quality standard. This appears to reflect well on the co-operation between NICE and CQC in its development, and hopefully its implementation. |
| 002 | Care England | General | • NICE will be aware that the independent care home sector under the auspices of the CPA and funded by the Department of Health, led a project on the Safety of Medicines in Care Homes. The final report and support tools, arising from this project, have been widely disseminated to the sector by all the care home representative associations and is on our website for example. This project also engaged the Royal College of GPs; the Royal College of Pharmacists and the Royal College of Nursing. In addition the Chief Pharmacist from CQC, as well as providers and stakeholders across the care home sector participated in this work. It also engaged residents and families in the tools that were produced. Care Home Providers are utilising the tools now. It was a unique opportunity to respond in a positive way to the CHUMs report in 2009.<br><br>• Care England put its support behind the sector led initiative and has promoted it to its members and we feel that this NICE quality standard fails to fully validate and incorporate that project work. The sector led project was based on good practice and delivering practical improvements that can be applied in the care home sector. It took account of the National Service Frameworks as well as the different Outcome Frameworks across Health and Social Care.<br><br>• The NICE standard does not adequately reflect the complexity of needs that people living in care homes have. People will not always have mental capacity and the ability to self-medicate. There is a conflict between independence (self-administration) and safety (compliance) in relation to a person's capacity. Safety should be key where the person does not have capacity to ensure proper medicines management and as a result their physical or mental health is threatened. In addition, it is important to acknowledge that older people do not always want to self administer medication and they must have the right not self administer their medication if that is their wish. The standard does not fully consider the practicality of implementation within care home settings. |

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

| ID | Stakeholder | Statement No | Comments[1] |
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| | | | • The standard must guard against duplicating monitoring arrangements between commissioners and CQC and overburdening providers in the process. Commissioners should be able to assess provider practice via CQC reports. CQC are best placed to independently assess care homes on managing medication.<br><br>• The standard should support homes and CQC ensure GPs undertake an annual medication review as not all GPs are prepared to do this<br><br>• We do not believe that the use of technology to assist compliance is currently being trialled sufficiently to help safer administration of medication. |
| 003 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | General | Specify responsibility for each quality statement - GP practice (including clinical pharmacists), care home, or partnership. |
| 004 | National Care Forum | General | This is a general response. The work that is referred to regarding safe management of medication in care homes can be accessed on the NCF website: www.nationalcareforum.org.uk. The work is also available on a number of other websites across the sector.<br><br>In light of this work we are not responding to each standard statement but make an overall general comment.<br><br>NICE are aware the NCF on behalf of the provider Care Provider Alliance (funded by the Department of Health ) led a project re the Safety of Medicines in Care Homes. This project was unprecedented in that it engaged the Royal College of GP's; the Royal College of Pharmacists and the Royal College of Nursing. In addition the Chief Pharmacist from CQC, as well as providers and stakeholders across the Care Home Sector participated in this work. It also engaged residents and families in the tools that have been produced. It was truly multi-disciplinary, made up of front line practitioners. This project has been owned by the sector and the tools that have resulted from the work are freely available on a range of websites. Care Home Providers are utilising the tools. It was a unique opportunity to respond in a positive way to the CHUMs report in 2009.<br><br>It is against this back drop that NCF are not in a position to formally support this quality standard. NCF recognise that NICE choose to use academic research as its evidence base to inform the production of standards, this methodology fails to fully validate and incorporate work ,(such as the aforementioned project) undertaken in the Social Care Sector. We believe this is an oversight regarding Social Care which does not have the same breadth of evidence that health |

| ID | Stakeholder | Statement No | Comments[1] |
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| | | | have. This methodology does not fully consider the practicality of implementing the standards.<br><br>The NICE standards in contrast to the work described above did not (in our opinion) have the breadth of experience represented at practice level on the group.<br><br>This standard does not fully reflect the complexity of people's needs who are cared for in a care home environment particularly with regard to a person's mental capacity and the ability to self-medicate. There is a conflict between independence (self-administration) and safety( compliance) in relation to a person's capacity.<br><br>The next CHUMS report is due in 2018. Will the implementation of this proposed standard help the sector make sufficient progress on the issues which are of concern? We believe the DH funded project via NCF on behalf of the Care Provider Alliance, has made a significant contribution to care homes .Health and Social Care demonstrated a collaborative way of working, with shared responsibility for outcomes that would make a real difference to people living in care homes and the staff working in them. It was cognisant of National Service Frameworks as well as the different Outcome Frameworks across Health and Social Care...<br><br>NCF would request that greater consideration is given to the work that was completed by the sector for the sector.<br><br>In addition it is our belief that at present the use of technology to assist compliance is not being trialled sufficiently to help safer administration of medication |
| 005 | NHS Eastbourne, Hailsham & Seaford & NHS Hastings & Rother Clinical Commissioning Group, Medicines Management | General | Where no comment has been made this represents a "yes" response to the question posed |
| 006 | NHS England | General | Although page 4 discusses patient safety issues, there is little evidence of this being covered within the quality statements themselves |
| 007 | NHS England | General | Training and competency<br>Standard of competency assessment not defined |
| 008 | NHS England | General | Care plan<br>There is no reference to updated care plan for medicines as often this is not detailed and key changes must be noted. |
| 009 | NHS Sheffield CCG | General | We welcome this quality standard and consider that the statements reflect the key points for implementation from the detailed guidance. In particular, the statements involve all commissioners, care staff, prescribers and any other health care professionals who contribute to the management of medicines in care homes. The statements are challenging |

| ID | Stakeholder | Statement No | Comments[1] |
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| | | | particular where the data collection involves accessing individual residents records held at different locations, e.g. GP practice, community nurses, as well as the care home |
| 010 | Pharmacy Voice | General | Pharmacists are the health professionals whose specialism is medicines. In addition to a five year masters/preregistration formation programme, many have undertaken further qualifications, and continuing professional development is mandatory. The extent of pharmacists' knowledge is not fully recognised by other health professionals, the public or patients, so care home staff may not appreciate the value of involving their community pharmacist in the development and implementation of policies relating to medicines management. The NICE guideline 'Managing Medicines in Care Homes' refers to pharmacists and community pharmacists – why is this distinction being drawn? It would be helpful if this standard referred simply to pharmacists and where they could usefully provide advice and support to both residents and staff of care homes, including preparing medicines relating policies, the assessment of residents as to their capability to self administer their medicines, accurate listings of medicines, prescribing of medicines and sharing of information and multidisciplinary reviews. |
| 011 | Royal College of Nursing | General | Patient experience and safety issues<br>The first paragraph here appears to be trying to be all encompassing, however we feel it is rather confusing. As this entire pathway could incorporate a range of providers and also commissioners.<br>For example the GP practice or the hospital may write the prescription, both of whom are commissioned by either NHS England or the local CCG. In turn the pharmacy who supplies the medication may have been commissioned directly by the private sector company who own the care home.<br>In turn the person administering the medication may be a nurse governed by the NMC, or in a residential home a carer who have little or no legislative framework to govern their practice at this time.<br>To ensure that this is clearer as to who is within and who without this guidance we feel that this paragraph needs altering to be more explicit and understandable. |
| 012 | Royal College of Nursing | General | Co ordinated services<br>As above, however due to the range of commissioners involved across the pathway some guidance is needed here as to who has responsibility for this co- ordination across the pathway |
| 013 | Royal College of Nursing | General | Training and competencies<br>Our concern here is that whilst nursing staff have NMC codes to govern this practice, pharmacists and DR's again have regulatory frameworks to work within, there are no such national standards for care assistants. We are also not entirely sure if the certificate of care covers this area either.<br><br>The quality standard should be read in the context of national and local guidelines on training and competencies. All health and social care practitioners involved in assessing, caring for and treating people in care homes should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard |

| ID | Stakeholder | Statement No | Comments[1] |
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| | | | professional training will be considered during quality statement development. |
| 014 | Royal College of Nursing | General | Role of families and carers<br>It should also be noted here that if the person does not have capacity then this area becomes more complicated, especially when considering issues such as the covert administration of medication to a relative.<br><br>Quality standards recognise the important role families and carers have in supporting people in care homes. If appropriate, health and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.<br><br>"*So while the paper then spends significant energy in promoting self determination, it then detracts from all of its principles by requiring families to be involved in the decision making process; this statement surely should state that significant others are involved and considered in decision making where the Resident indicates, or as directed by the Mental Capacity Act. To do anything else then treads all over human rights and breaches confidentiality".* |
| 015 | Royal Pharmaceutical Society | General | The Royal Pharmaceutical Society welcomes NICE quality standards for managing medicines in care homes and are supportive of the recommendations. We believe that better utilisation of pharmacists' skills in care homes will bring significant benefits to care home residents, care homes providers and the NHS. We have recently published a policy document (http://www.rpharms.com/policy-pdfs/pharmacists-improving-care-in-care-homes.pdf) about the role of pharmacist in improving care in care homes, and recommend that this policy is considered in the development of the quality standards.<br><br>The RPS have also been involved the development of the Safety of Medicines in Care Homes Framework: making the best use of medicines across all care settings (http://www.nationalcareforum.org.uk/documentLibraryDocument.asp?ID=260). A number of healthcare professionals from health and social care settings were involved in its development and promotes a multidisciplinary approach to managing medicines in care homes. It is another useful reference for the development of the quality standards.<br><br>Both documents are of particular relevance to statement 6 and 7.<br><br>We would also like to highlight the RPS guidance on Improving patient outcomes through the better use of multi-compartment compliance aids (MCA) (http://www.rpharms.com/unsecure-support-resources/improving-patient-outcomes-through-the-better-use-of-mcas.asp?). We have worked with stakeholders to improve patient outcomes and patient-centred care with the better use of multi-compartment compliance aids (MCA), also known as monitored dosage systems (MDS). This document supports recommendations made in statement 2. |

| ID | Stakeholder | Statement No | Comments[1] |
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| | | | The Handling of Medicines in Social Care is a useful practical guide for those who are involved in handling medicines in a social care setting, however may not reflect recent policy or legislative changes. It remains a useful resource for background information.<br><br>We would also like to highlight that the term “managing medicines” does not align with recent terminology, and would recommend this is changed to “medicines optimisation” to align with other policy documents; this will also help gain more traction. |
| Statement 1 | | | |
| 016 | Barchester Healthcare | Quality statement 1 | Q1 Does this draft standard accurately reflect the key areas for quality improvement?<br><br>Yes.<br><br>Q2 If the systems and structures were available do you think it would be possible to collect the data for the proposed quality measures?<br><br>Yes, the data exists with Barchester Healthcare homes and is already collected, so it would be possible to feed the data through for the proposed quality measures.<br><br>Q3 For each quality statement what do you think could be done to support improvement and help overcome barriers?<br><br>Robust measures are in place to keep up standards in this area, with regular CQC inspections of competence, often supported by inspectors with specialist pharmacological backgrounds. Barchester Healthcare also carries out training on administration of medicines, refresher training and regular internal audits. However, it remains true that errors in administration of medicine do take place as the result of human error and that administration of ‘as required’ medicine in particular is an area that needs constant audit. Initiatives such as the publication of NICE standards help to remind all staff responsible for medicine administration of the need to understand and to carry out their responsibilities effectively but internal and external audit remains vital.<br><br>Q4 Is it appropriate to specify how frequently care homes should review their medicines policy? And if so, how frequent should these reviews be?<br><br>Barchester Healthcare believes it is appropriate for Monitor to issue guidelines suggesting how frequently care homes should review their medicines policies. However, there is an issue of the extent to which any such guidelines might be binding. It is not clear whether the Care Quality Commission (CQC) and other UK regulators will use NICE guidelines |

| ID | Stakeholder | Statement No | Comments[1] |
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| | | | as the basis for inspection or rating of care homes. Barchester Healthcare would welcome clarification on this point.<br><br>The quality standard suggests that commissioners should review and require updates of medicines policy. However, in our experience few commissioners engage with providers to the extent of checking review of medicines policy. Where they do they often duplicate audits more effectively carried out by CQC. Barchester Healthcare believes that CQC would be more effective in this role and would welcome a quality statement that consolidated a CQC role in this regard, asking commissioners to oversee provider practice though CQC reports.<br><br>Barchester Healthcare currently reviews its overall medicine policy on a three yearly basis, on the grounds that the principles of safe drug administration are not likely to change. We do, however, review the policy and add addendums if there is a change in guidance or if circumstances warrant it. Individual homes have a local medicines policy that is reviewed at least annually. Any instance where medicine has been administered or has failed to be administered in error that is identified as being the result of a lack of clarity in medicines policy triggers an immediate policy review. Any instance where the prescription for or details of administration of a new medicine may not be adequately covered by the existing medicines policy triggers an immediate review.<br><br>Medicines for individuals should be reviewed on admission and at all care and treatment reviews – e.g. on at least an annual basis and when the individuals' needs change. |
| 017 | Dudley CCG/ Dudley Office of Public Health | Quality statement 1 | To work to a practical, up to date and useful medicines policy, there should be easy access to a specialised Pharmacist, allocated to work both alongside each Care Home and allied to a GP Practice responsible for all of the residents within that Home. They would be able to support improved Medicines Management with education, review and also be pro active in reducing the risk of safeguarding issues. |
| 018 | Guys and St Thomas NHS Foundation Trust | Quality statement 1 | Comment about quality statement 1. To support improvement it would be good to highlight that their medicines policy should be a working document and a review of the document should be prompted by not only changes in legislation and evidence but what is happening locally and taken into consideration when an incident is reviewed. It may be more useful to highlight some of the circumstances that may lead to a review of the policy e.g. change in arrangements for ordering of prescription from the surgery from paper requests to online, change in medicine administration system e.g. from blister trays to original packs. |
| 019 | NHS England | Quality statement 1 | Supported but surprised to see that the definition does not include a specific reference to controlled drugs. In response to question 4, i.e. how frequently should the policy be reviewed – yes, it would be appropriate to specify frequency of review, even though I appreciate that the guidelines probably do not specify this. I would have thought an annual review would be sensible. |
| 020 | NHS England | Quality statement 1 | Yes it should be specified how often a home should review their medication policy. I would suggest every two years, unless a major change occurs in between. There should also be something in the quality statements that homes must ensure that if they purchase "off the internet" medication policies that these are applicable to the procedures in their |

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| | | | home, and that they are also applicable to UK medication laws. I have seen one home using a policy from the US and weren't aware that was the case.<br><br>Staff must also be aware of the policy and sign and date to say they have understood it. They should then be regularly competency assessed against it.<br><br>Evidence of competency testing of staff around medication is sometimes very poor. |
| 021 | NHS Sheffield CCG | Quality statement 1 | Page 8 quality statement 1- medicines policy<br>Rationale<br>This includes the medicines administration process, particularly if when required medicines are involved.' – suggested amendment: **This includes the medicines administration process covering regular doses and when required medicines.** |
| 022 | Northern, Eastern & Western Devon CCG | Quality statement 1 | Reviews annually or when practice changes. |
| 023 | Royal College of Nursing | Quality Statement 1 | The RCN feel there is a need for focus to be on educating residents about their medication and providing appropriate aids such that they can manage themselves for as long as possible. QS 1 focusing on policy is poorly placed as the first standard should relate to residents not policies.<br><br>However, we also feel that Medicines policy should be reviewed at least every 2 years or more frequently if legislation changes.<br><br>"The statement does tend to appear something of a silo without reference to the existing requirements and best practice in this sector.<br>CQC requirements, including that of registration, already require care homes to have a medication policy in place, so I'm not sure why NICE go to such lengths in recreating a new standard, when this may be an opportunity to enforce and build upon an existing condition.<br>In addition, there is little reflected in the paper that refers to existing contracts and service specifications between care home sector and Local authorities.<br>All care homes are required to register with the Local Authority, and so again there is a strong case to use this project as an opportunity to ingrain standards into existing arrangements rather than to create new conditions (it feels almost as though the committee are not aware of existing terms, conditions and modus operandi of the current market?)<br>We have been calling for a standard care home specification (including service schedule) for some time. While there is a NHS care home contract, it is the service schedule that directs the delivery of care, and so NICE efforts in providing a single standard of delivery across England, and incorporating Medicines Management into such would have a significantly beneficial effect on the care home economy and quality of care delivered". |

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| 024 | Royal College of Nursing | Quality statement 1 | What the quality statement means<br>With reference to the comment; 'processes specific to practitioners in care homes are regularly updated', this is not necessarily the case. As care homes are invariably run by the private sector and so the consistency of this is not clear at the moment.<br>Also in some residential care home medicines may be administered by through the door services such as district nurses, changing dressings etc. who wouldn't necessarily have any knowledge of the care home policy in his area. |
| Consultation question 4 | | | |
| 025 | Boots UK Ltd | Consultation question 4 | Yes, it is appropriate to specify how frequently care homes should update their medication policies. At a minimum, this should be done at least every 12 months. However, the nature and frequency of reviews will also depend on the changing nature of each care home, its residents and their medication needs. For example, residents may be admitted with more complex medication needs that might require updated policies or training. If the resident subsequently leaves or dies, the policy will no longer be relevant and need not necessarily be in force or updated. Homes should have flexibility around this. |
| 026 | British Medical Association | Consultation question 4 | No, the frequency of review should be variable, depending on changes in residents' needs and relevant legislation or guidance. It is better that the reviews take place thoroughly and at an appropriate time than according to a calendar. |
| 027 | Dudley CCG/ Dudley Office of Public Health | Consultation question 4 | I feel that it would be both appropriate and necessary. If the frequency were not stated, I'm sure it would soon be overlooked, and the Policy would become outdated and unfit for purpose. In my opinion a frequency of 3 monthly would be adequate to update any legal and practical requirements. A regular review by Care Home Management would also maintain its content in the forefront of their mind when reviewing the way medication is managed within the Home |
| 028 | NHS Eastbourne, Hailsham & Seaford & NHS Hastings & Rother Clinical Commissioning Group, Medicines Management | Consultation question 4 | Comment about question 4.<br>Yes – regular, evidenced & audited reviews are not only best practice but also act to prompt essential reviews.<br><br>Policy review every two years is the standard of my experience.<br><br>Major changes in medication law, practice etc. occurring between these reviews must be promptly actioned & the policy updated. The review date can then be reset.<br><br>Mechanisms to prompt & check these ad hoc updates must be identified & detailed in the commissioning process |
| 029 | NHS England | Consultation question 4 | Policy<br>2 yearly unless legal or MHRA changes which prompt earlier review |
| 030 | NHS Sheffield CCG | Consultation question 4 | Question 4 For draft quality statement 1: Is it appropriate to specify how frequently care homes should review their medicines policies?<br>YES<br>And, if so, how frequent should these reviews be? |

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| | | | Review every 3 years but evidencing periodic review to respond to any significant local and national guidance |
| 031 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 4 | Yes – annual |
| 032 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 4 | Yes – 2 yearly. Review should be ongoing to ensure new guidance is implemented straight away, with full review ideally two yearly but maximum of every 3 years. To fully review a medicines policy is very time consuming but without a review date some care homes would not review. |
| 033 | Royal College of Nursing | Consultation question 4 | It would not be unreasonable for such a review to be placed within a contract, 6 monthly or after an incident involving medicines would be appropriate |
| Statement 2 | | | |
| 034 | Barchester Healthcare | Quality statement 2 | Q1 Does this draft standard accurately reflect the key areas for quality improvement?<br><br>Barchester Healthcare welcomes the quality statement's emphasis on assessing all residents for their ability to self-administer medicines. We accept that our current implicit assumption that all residents are likely to require help with medicine administration can no longer be considered best practice. We would like the standard to reflect two basic truths, however. The quality statement should acknowledge that many older people do not want to take responsibility for self-administration of medicines. In practice, a permanent or intermittent inability to manage self-administration of medicines (or worry about an intermittent inability) is often a contributory factor in an individual's choice to consider residential care as an option. It must therefore be made clear that residents have the right to opt out of self-administration and that policies for managing medicines must allow for this. Secondly, Barchester Healthcare believe that where maladministration of medicines directly threatens physical or mental health and where individuals lack insight into their capacity to administer medicines correctly on an intermittent basis safety should be prioritised over the right to self-administration of medicines and that this should be explicitly reflected by the quality standard.<br><br>Q2 If the systems and structures were available do you think it would be possible to collect the data for the proposed quality measures?<br><br>Yes, the basis for this data exists with Barchester Healthcare homes and could be collected for the proposed quality |

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| | | | measures.<br><br>Q3 For each quality statement what do you think could be done to support improvement and help overcome barriers?<br><br>As above, NICE Quality Standards should allow for individuals who do not wish to self-administer medicines.<br><br>For individuals who do wish to self-administer the most difficult issue will be people who intermittently cannot remember whether or not they have taken particular medicines, and who may lack insight into this difficulty. Guidelines that address this issue and the risks involved would be helpful and would strengthen providers' sense that NICE have considered and understood problematic issues for care homes. |
| 035 | British Medical Association | Quality statement 2 | This is a good idea in principle, although it raises issues about practicality, including storage and security of medications and their responsibilities if things go wrong, particularly if another resident is affected.<br><br>Whilst self-medicating would empower patients in various ways, elderly patients on multiple medications are vulnerable and have with multiple pathologies, and many have some degree of cognitive impairment. Mitigating these risks might well entail significant resource in the over-stretched care sector.<br><br>We are also concerned that responsibility for determining who can self-administer medicines may be abdicated to GPs by risk-averse care home workers, who actually may be much better placed, as they observe their residents all day every day, to make a judgement.<br><br>Finally on this subject, another barrier to overcome would be the physical ability to self-administer medicines, particularly the manual dexterity to open packets and bottles and to pour liquid medicines. Routine use of multi-dose compartment aids should not be seen as a solution to this problem in light of the concerns raised by the report of the Royal Pharmaceutical Society regarding these |
| 036 | Dudley CCG/ Dudley Office of Public Health | Quality statement 2 | In order to achieve this, Homes would need a standardised risk assessment tool that they could easily put into practice. They are likely to need more trained staff to support those residents who are keen to maintain a level of independence and self administer their medication. |
| 037 | NHS England | Quality statement 2 | Supported. |
| 038 | NHS Sheffield CCG | Quality statement 2 | Page 12 quality statement 2 self administration – Rationale<br>Though this is mentioned on page 14, we suggest including in the rationale – **The risk assessment is periodically reviewed to address if any adjustment is to be made to the required support.** |
| 039 | NHS Sheffield CCG | Quality statement 2 | Page 12 quality measures section b)<br>Amend to include review - Evidence of local arrangements to plan and provide support, including regular review, for |

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| | | | residents to self -administer their medicines |
| 040 | NHS Sheffield CCG | Quality statement 2 | Page 13 b) data source denominator<br>Suggested amendment - The number of people who live in a care home whose risk assessment indicates that they are able to self -administer **all or part of their medicines** |
| 041 | NHS Sheffield CCG | Quality statement 2 | Page 14 - What the quality statement means for patients, service users and carers<br>Suggested re-wording: People who live in care homes receive **support ( *changed from help*)** to take and look after their own medicines unless they have an assessment that shows it might not be possible or safe, or the person would prefer to have their medicines **managed ( *changed from given to them*)** on their behalf (*this would include storage also*) |
| 042 | Royal College of Nursing | Quality statement 2 | The standards are not specific enough to produce meaningful data.<br>Quality statement 2: Self-administration<br>People who live in care homes are supported to self-administer their medicines unless a risk assessment has indicated that they are unable to do so - This should be clarified by adding where the person lacks capacity to make the decision, if they have capacity they must be able to take the risk. This should also state that it excludes people in a nursing bed where it would be expected that their medication administration would be facilitated/overseen by a qualified nurse.<br><br>"We would like to think that the NICE committee has considered the content of the following link (Centre for Policy and Ageing 2012) –<br>http://www.cpa.org.uk/information/reviews/Managing_and_Administering_Medication_in_Care_Homes.pdf<br>The document does reference the CPA review, but does not comment on promoting the content. The CPA Review was an incredibly good piece of work, and remains wholly pertinent. One might suggest that we look to mainstreaming its content" |
| 043 | Royal College of Nursing | Quality statement 2 | List of Quality statements<br>Where it states that the person should self administer – this needs checking as we assume the guidance is for residential and also nursing care homes? In a nursing home/bed it would be expected that the nurse administers the medication which we feel needs to be made clearer here |
| 044 | Royal College of Nursing | Quality statement 2 | Equality and diversity<br>Should capacity be considered here?<br>In as much as people with lack of capacity are still included as far as possible in this process, and if they are unable, then we feel that either an advocate or a person with power of attorney should be consulted and facilitated to do this on their behalf |
| Statement 3 | | | |
| 045 | Barchester Healthcare | Quality | Q1 Does this draft standard accurately reflect the key areas for quality improvement? |

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| | | statement 3 | The draft standard only partially reflects key areas for quality improvement. While Barchester Healthcare accepts the principle that an accurate listing of medicines is vital to effective care and multidisciplinary planning we believe that the accountabilities within the draft standard are unhelpful. In practical terms, when homes experience difficulties with listing medicines there are usually two principle causes. The first of these arises when individuals are admitted from their own homes without either prescriptions or medicines or both. Responsible care homes do all that they can to avoid such scenarios, discussing medicines with the individual being admitted, relatives, friends, care managers and/or GPs where possible but there are occasions when these measures break down – typically for confused individuals with little support. Under such circumstances it is occasionally safer to spend time on making contact with all stakeholders or carrying out new assessments rather than administering medicines that are date-expired or otherwise suspect. The standard needs to explicitly acknowledge this possibility. The second and more common difficulty is for residents to be discharged from a hospital ward to a care home without medicines and without prescriptions or MAR sheets, or with a mismatch between the two. While it is usually possible to make contact with the responsible individuals from the hospital concerned to resolve the problem this occasionally proves difficult, with the consequent risks. Barchester Healthcare is pleased to note that Quality Statement 4 acknowledges this possibility and goes some way to making it accountable.<br><br>Q2 If the systems and structures were available do you think it would be possible to collect the data for the proposed quality measures?<br><br>Yes, the data exists with Barchester Healthcare homes and is already collected, so it would be possible to feed the data through for the proposed quality measures. Barchester Healthcare would welcome such data contributing to change through greater accountability.<br><br>Q3 For each quality statement what do you think could be done to support improvement and help overcome barriers?<br><br>Please see our response to Statement 3, Q1 above. Please also note that commissioners are very rarely involved with care homes to the extent that they would be in a position to check this standard. CQC would be much better placed and more likely to carry out checks in this regard, and to make hospitals or health and social care professionals in the community accountable for poor practice.<br><br>Q4 Is it reasonable to expect care homes to make an accurate listing of a resident's medicines on the day they transfer into a care home (see structure measure)?<br><br>Yes, with the reservations above. |

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| 046 | Boots UK Ltd | Quality statement 3 | We would like to see a note added to this, probably as part of "What the quality statement means for service providers" that having accurate, up-to-date and reconciled information about resident's medicines is also important for those supplying medicines to the care home (ie, community pharmacies) to ensure continuity of supply and to ensure any changes have been taken in to account. We suggest that NICE should take account of the recent academic evaluation of the Discharge Medicines Review service in Wales in this respect [Report available via Community Pharmacy Wales website] |
| 047 | Dudley CCG/ Dudley Office of Public Health | Quality statement 3. | See response to Q5 below.<br><br>There should be attempts to improve levels of communication, and possibly with better IT solutions so that medicines reconciliation is a priority. |
| 048 | Guys and St Thomas NHS Foundation Trust | Quality statement 3 | Comment about quality statement 3. It may be difficult for the care home to make an **accurate** list of a resident's medicines on the day they transfer into a care home. What would be expected is that they have **taken appropriate steps** to establish what was prescribed currently by the GP or during their hospital stay, what the patient is currently taking and how it was being administered. |
| 049 | NHS England | Quality statement 3 | Supported. In response to question 5, yes, I think it's reasonable to expect this of care homes. It is part of safety and is the duty of care they assume as soon as they accept the resident into their care. |
| 050 | NHS England | Quality statement 3 | I think it's imperative that the care home makes an accurate list of the residents medication as soon as they are admitted and also when the previous doses were given. |
| 051 | NHS England | Quality statement 3 | Specific mention should be made of the need for access to a patient's medication record to be made available to the whole of the relevant healthcare team, including the community pharmacist. |
| 052 | NHS England | Quality statement 3 | List of meds<br>Rather than list current meds, consider obtain up to date repeat prescription from the current surgery (avoid issues with transcribing and capacity/time of care homes to make lists) |
| 053 | Northern, Eastern & Western Devon CCG | Quality statement 3 | Not always possible to do on the same day – weekends or out of hours will make this difficult |
| 054 | Royal College of Nursing | Quality statement 3 | Outcome – time between a person entering a care home and completion of their medicines reconciliation.<br>This is not an outcome - it needs to be that medicines reconciliation is completed at the time of entering the care home.<br>We also feel the RCGP should be in agreement if this quality statement is going to occur.<br><br>It is essential that every new resident should have a list of their current medication on the day of moving into the care home, and this should be part of the assessment process. It is also essential that the resident brings in sufficient stocks of their medication on moving into the care home.<br><br>Already in CQC and registration requirements. The Alzheimers Society does produce some very useful literature on |

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| | | | the subject of care home admission and choice. Might be useful to reference the need to ensure that medications statements are built in as standard statements in such documents (including NHS Choices website). http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=150 |
| Consultation question 5 | | | |
| 055 | Boots UK Ltd | Consultation question 5 | Yes, we would see compiling an accurate list of any new resident's medicines on the day of transfer or admission to be not only reasonable but essential and an absolute priority.<br>Such information will be necessary so that the community pharmacy that supplies medicines to the care home can be informed and set up, including generating a patient medication record in the pharmacy. We would consider that admissions or transfers to a care home from another setting (eg, hospital or person's own home) will, in general, be planned in advance and anticipated. Up-to-date medication information should be available as part of this process and requested from relevant sources, such as hospitals, GPs, community pharmacies and the person's relatives or carers. We would expect that obtaining (and sharing) an accurate medication listing, including recent changes and any allergies, should be part of a mandatory "Day 1" checklist that would also include items such as making an inventory of the person's belongings (including any medicines) and ascertaining any dietary requirements.<br>We would recommend that NICE and CQC lend their support to the development of consistent medication recording forms (in paper and electronic formats) that can be used to support timely transfer of relevant information between different care settings. |
| 056 | British Geriatrics Society | Consultation question 5 | Yes, it is reasonable and probably essential that care homes make an accurate listing of a resident's medicines on the day they transfer into a care home. This is essential to minimise drug errors especially drug omissions and inappropriate doses at times of transition in care for residents. |
| 057 | British Medical Association | Consultation question 5 | Yes, but only for planned transfers or transfers from other health-care settings. Some emergency admissions from the resident's home might be without this information, and steps should then be taken to get it as soon as is reasonable |
| 058 | Dudley CCG/ Dudley Office of Public Health | Consultation question 5 | Yes: Failure to do this would instantly lead to compliance issues for the resident, the correct medication must be assured at all times for seamless care. On a practical basis the Care Home staff need to have easy access to the registered GP for details of the current Rx, or to the previous Care Home or Hospital at the point of transfer. There should be no room for noncompliance with this statement. |
| 059 | NHS Eastbourne, Hailsham & Seaford & NHS Hastings & Rother Clinical Commissioning Group, Medicines Management | Consultation question 5 | Comment about question 5.<br>Yes, results from audits of Medicines Reconciliation on admission to hospital highlight the value of this in identifying anomalies in medication.<br><br>Applying this process in care homes capitalises on the opportunity to offers similar safety checks to residents, .<br><br>Lists of medicines from single or multiple sources may not reflect the client's medication choices.<br>Discussion with the client or carers should be included as standard, with exceptions recorded. |

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| | | | Staff training and competency requirements for medicines reconciliation must be included in the Care Home Medicines policy |
| 060 | NHS Sheffield CCG | Consultation question 5 | Question 5 For draft quality statement 3: Is it reasonable to expect care homes to make an accurate listing of a resident's medicines on the day they transfer into a care home (see structure measure)?<br>This should be the standard to aspire to. However it may not be achievable for all admissions as some are unpredictable and the source of the information for medicines reconciliation may not be available at the time of admission – there is different access to information between planned and weekend and emergency admission to care home |
| 061 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 5 | I think a standard of within 48 hours would be more appropriate, but the care home will not have access to every source required. I believe each resident should have a full medication reconciliation by trained pharmacy staff (technicians or pharmacists) at each transfer of care. This is time consuming, and there is insufficient resource at present. The majority of issues identified by our pharmacist-led care home medication review service arise at transfer of care. |
| 062 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 5 | The listing should be made on the day of transfer by the care home and then checked within a short, achievable time scale by trained pharmacy staff |
| 063 | Royal College of Nursing | Consultation question 5 | We think this is an essential element of the admission process, in fact the RCN would expect the care home to already have an idea of medication needed at the assessment stage prior to admission, not least as medication will often have to be ordered in by the care home to ensure they can meet patient need. |
| Statement 4 | | | |
| 064 | Barchester Healthcare | Quality statement 4 | Q1 Does this draft standard accurately reflect the key areas for quality improvement?<br><br>Yes.<br><br>Q2 If the systems and structures were available do you think it would be possible to collect the data for the proposed quality measures?<br><br>Barchester Healthcare would be able to cross-reference hospital data with its own records. |

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| | | | Q3 For each quality statement what do you think could be done to support improvement and help overcome barriers?<br><br>Proposals for making hospitals, health care and social care professionals accountable to this standard through CQC oversight would be welcome and would contribute to better practice. |
| 065 | Boots UK Ltd | Quality statement 4 | We recommend that NICE and CQC should work with NHS England and the Royal Pharmaceutical Society to develop and promote a standardised medication record form (in paper and electronic formats) that can accompany patients when they are transferred from one location to another. Use of this form should be taken as a key indicator that this quality statement is being met. |
| 066 | British Medical Association | Quality statement 4 | Admission to and discharge from hospital are both common and key sources of potential prescribing and medication errors for elderly people. Discharge letters can sometimes be entirely lacking, and sometimes lacking in detail. Care home staff clearly find this a difficult area, too, as it is very common to get queries within a few days and sometimes in less than 24 hours after a discharge about whether a patient is to stay on a particular medication, how to reduce a medication, or just to ask for a prescription. These questions should not really arise if there is clear discharge information to carers as well as GPs. |
| 067 | Dudley CCG/ Dudley Office of Public Health | Quality statement 4 | There have been so many safeguarding issues around the point of transfer of care, and the current need to discharge people from hospital as quickly as possible has often meant that the level of communication has been compromised. Everyone involved in the transfer process should be aware that seamless care is a main priority and the timely and accurate sharing of medication details is very important. Ward, Hospital Pharmacy and Care Home staff should be supported to produce and provide accurate and up to date information at the point of discharge with the potential for upgrading IT solutions to enable this to take place. |
| 068 | NHS England | Quality statement 4 | Supported. |
| 069 | Royal College of Nursing | Quality statement 4 | Health and social care practitioners<br>Depending upon local processes the person with overall responsibility of transfer may be the commissioner, and would not necessarily have access to these records; it may be better to say the case manager is responsible to transfer |
| Statement 5 | | | |
| 070 | Barchester Healthcare | Quality statement 5 | Q1 Does this draft standard accurately reflect the key areas for quality improvement?<br><br>Yes.<br><br>Q2 If the systems and structures were available do you think it would be possible to collect the data for the proposed quality measures?<br><br>Barchester Healthcare and other responsible providers would be able to provide evidence of system breakdowns |

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| | | | indicating a lack of effective processes in instances where there are difficulties.<br><br>Q3 For each quality statement what do you think could be done to support improvement and help overcome barriers?<br><br>Please note that it is Barchester Healthcare's practice to employ GP practices on retainer in many instances, which should not be necessary in an ideal world but which generally - though not always - makes for more tractable relationships. We are aware that providers without the option of paying such retainers can experience difficulty with GP prescription methods related to apparent lack of agreed processes. Regular CQC inspections will clearly help to ensure that clear processes exist and are followed by GP practices. |
| 071 | British Medical Association | Quality statement 5 | This quality statement is inappropriate as it looks at a process and not an outcome. The standards for prescribing for patients in care homes are not materially different from those for other patients. The process *['The proportion of prescriptions issued for people who live in care homes that include clear instructions of when and how (including dosage instructions) the prescribed medication is to be used'*] described is appropriate but does not follow on from the structure ['*Evidence of local arrangements that GP practices have written processes for prescribing and issuing all prescriptions for their patients who live in care homes*.']<br><br>Many medicines original packs are now in 30 day quantities, standardisation to 28 days would be beneficial. |
| 072 | Dudley CCG/ Dudley Office of Public Health | Quality statement 5 | All Practices should have a Prescribing Policy which is updated regularly. Locally, our Practice Based Pharmacists have been involved in supporting this initiative.<br><br>Ideally, there should be GP's, and specifically trained surgery staff who are responsible for the ongoing supply of the Rxs for the Care Home, to promote continuity and understanding of the process and ensure that the correct items are Rxd.<br>It would still be aspirational that single Practices would be responsible for all of the residents in individual Care Homes to ensure the following advantages:<br><br>Regular review<br>Improved communication<br>Introduction of regular 'ward rounds.'<br>Easier access for Care Home staff to one Practice<br>Less fragmented, and improved continuity of Care<br>Streamlined repeat Rx production. |
| 073 | Guys and St Thomas NHS Foundation Trust | Quality statement 5 | Comment about quality statement 5. To support improvement it would be good if a checklist or audit template was developed for GP practices, similar to the one for care homes on developing a medicines policy. |

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| 074 | NHS England | Quality statement 5 | Supported though I wonder how easy it will be to measure in accordance with the full extent of the definition |
| 075 | Royal College of Nursing | Quality statement 5 | As Non medical prescribing becomes more and more embedded in every day clinical practice, we think this should refer to the prescriber and not the GP. As a resident may have medication prescribed by DN or CPN as part of their treatment pathway.<br><br>Again in this element the distinction between people in a residential compared to a nursing bed needs to be made clear<br><br>The law pertaining to persons in care homes without nursing is different to that of care homes with nursing. 'Residential ' persons have same rights of access to Primary care as persons residing in their own home, and so the same prescribing protocols would apply. |
| Statement 6 | | | |
| 076 | Barchester Healthcare | Quality statement 6 | Q1 Does this draft standard accurately reflect the key areas for quality improvement?<br><br>The draft standard very largely reflects key areas for quality improvement but requires additions. The standard needs to mention the prescription and long term use of anti-psychotic drugs. Care homes still regularly admit individuals from hospitals who have been prescribed anti-psychotic drugs because they are living with dementia, where that is perceived as presenting a problem to ward routines, to staff or to fellow patients. These drugs are frequently not required within a care home environment and are often actively unhelpful for the individual concerned. Despite clear guidelines a significant proportion of GPs are reluctant to review medication under these circumstances, apparently feeling it may be perceived as a professional slight to senior hospital-based colleagues. A key area for this standard and for CQC inspections should be to make this accountable and improve practice.<br><br>Secondly, some GPs are not prepared to complete an annual medication review. A key area for this standard and for CQC inspections should be to make this accountable and improve practice.<br><br>Q2 If the systems and structures were available do you think it would be possible to collect the data for the proposed quality measures?<br><br>Medication reviews are recorded when they take place, so we could evolve systems to identify data showing where we achieve and fail to achieve this standard.<br><br>Q3 For each quality statement what do you think could be done to support improvement and help overcome barriers? |

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| | | | Please see our response to Q6.1 above and note that Barchester Healthcare are committed to further multi-disciplinary medication reviews within the annual cycle when individual's needs dictate it. |
| 077 | Boots UK Ltd | Quality statement 6 | We believe that reference should be made to the role of community pharmacies as service providers, under the heading of "What the quality statement means". This should recognise that these pharmacies should have an input to the care of residents that goes beyond just a safe, accurate and efficient supply of medicines to the care home.<br>We believe that under the definition of terms (p25 of 37), the reference to a local team of health and social care practitioners should make specific reference to "a community pharmacist, from the pharmacy that supplies the resident's medicines" and that this person "should" be involved in the multidisciplinary team. However, we recognise that this would require adequate funding to be in place to release pharmacists to attend such review meetings, given the legal requirement to have a responsible pharmacist present in all pharmacies during opening hours.<br>We believe that a community pharmacist from the pharmacy that supplies medicines to the care home could be the "named health professional who is responsible for medication reviews", subject to suitable funding being in place to support this work, such as through a locally commissioned pharmacy advice to care home service. |
| 078 | British Medical Association | Quality statement 6 | GP medication reviews should already be routine processes, but how the reviews envisaged by the quality standard will fit with this, indeed whether current reviews would be considered adequate, does not seem to really be addressed. The evidence quoted by the briefing paper regarding current practice, is nearly a decade old. |
| 079 | Dudley CCG/ Dudley Office of Public Health | Quality statement 6 | This, currently a difficult process to achieve, with the fragmented systems in place, could be made easier with the introduction of a Specialised Pharmacist allocated to Care Homes, working with a single Practice responsible for the care of all of the residents. Reviews could then be carried out as part of a rolling process, with far fewer professionals trying to find time to meet together. |
| 080 | NHS England | Quality statement 6 | Supported. |
| 081 | NHS England | Quality statement 6 | Although multidisciplinary medication review is discussed, it should be more explicit that a pharmacist with the appropriate skills should be involved in this review, as discussed in the draft Medicines Optimisation guideline. |
| 082 | NHS England | Quality statement 6 | What constitutes a medication review should be included; to ensure it is consistent with the principles of medicines optimisation i.e. Medication review should incorporate the issues associated with a Medication USE review and other issues consistent with the Medicines Optimisation framework as described in the Draft Medicines Optimisation guideline |
| 083 | Royal College of Nursing | Quality statement 6 | There are already a number of quality benchmark schemes for meds reviews. Again, this might be a really good opportunity to pull the best together and to applaud/share best practice from around the country. For example - http://www.cumbria.nhs.uk/ProfessionalZone/MedicinesManagement/Guidelines/MedicationReview-PracticeGuide2011.pdf |
| 084 | The Health Foundation | Quality statement 6 | We welcome the inclusion of this quality statement on medication reviews. Our comments focus on how to address some potential barriers to its delivery**.** |

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| | | | A project in Northumbria funded by the Health Foundation (Baqir et al, 2013) has demonstrated that multi-disciplinary medication reviews in care homes involving residents and their families can optimise medicines use and also deliver savings in terms of prescribing costs. The project provides evidence that can help us challenge the still common assumption (National Care Forum, 2013) that care home residents invariably lack the capacity to be involved in medication decisions. A key principle underpinning the project is that we should respect people's right as citizens to be involved in these decisions, regardless of whether they are living in their own home or in a managed care home. We would like to see this principle more clearly articulated in quality statement 6.<br><br>A key finding from the Northumbria project is that GPs, pharmacists, care home nurses and residents (and/or their family members and carers) all need to be involved in the medication review in order to allow effective and efficient shared decisions to be made. The project team tested approaches in which GPs were involved before and after the multi-disciplinary meeting but found them to be less efficient.<br><br>It is important therefore that the benefits of holding real time multi-disciplinary medication reviews in care homes are promoted strongly among each relevant professional community. Unless the value of such reviews is clearly understood by each professional audience, there is a risk that they will not be prioritised and will fail to become a routine aspect of care in care homes.<br><br>**References**<br><br>Baqir W et al, A Health Foundation Shine project, International Journal of Pharmacy Practice; Supplement 2, p64, 2013<br><br>National Care Forum, Safety of medicines in the care home, 2013 |
| Statement 7 | | | |
| 085 | Barchester Healthcare | Quality statement 7 | Q1 Does this draft standard accurately reflect the key areas for quality improvement?<br><br>Yes.<br><br>Q2 If the systems and structures were available do you think it would be possible to collect the data for the proposed quality measures?<br><br>Yes, the documented process exists with Barchester Healthcare homes, so it would be possible to feed data on this |

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| | | | issue back to relevant stakeholders.<br><br>Q3 For each quality statement what do you think could be done to support improvement and help overcome barriers?<br><br>Commissioners for our services rarely check on practices within homes at the level that ensuring best practice for the administration of covert medication (e.g. matching practice to documented process) requires. CQC carry out checks, however. The quality standard should acknowledge and support CQC's role. |
| 086 | Boots UK Ltd | Quality statement 7 | We recognise that community pharmacists will have a role to play in drawing up and supporting policies around covert medicines administration (such as advising on formulations or suitability of particular medicines) but this is not a role that is commonly acknowledged. Some pharmacists may have professional reservations about participating in such discussions. We recommend that NICE and CQC work with the General Pharmaceutical Council and Royal Pharmaceutical Society on developing professional guidance in this area to support them. |
| 087 | British Medical Association | Quality statement 7 | There are acute situations where holding a formal best interest meeting would lead to harm due to delayed medicine administration, under such circumstances covert administration is justified under best interest considerations based on the judgement of the professionals involved at the time. |
| 088 | Dudley CCG/ Dudley Office of Public Health | Quality statement 7 | Care Home staff should be provided with regular training sessions on this topic, and to be included in their competency framework, which can then be adequately documented. Sessions should include all aspects including legal, ethical and practical details and the need for discussion with all appropriate parties. |
| 089 | Guys and St Thomas NHS Foundation Trust | Quality statement 7 | Comment about quality statement 7. Inclusion of this statement is excellent because it covers several aspects and would give a good reflection of how well medicines are being managed in the care home. It would be good if the quality measures include identifying the proportion of residents who are having their medicines administered covertly for whom the process was undertaken in accordance with the related legal and good practice frameworks. It is acknowledged that not all care homes would have a resident who has covert administration of their medicine, but the only way to truly drive up standards would be to identify whether practice reflects the documented process. Another quality measure could be to identify whether advice was sought on to how the medicines can be administered (for example from a pharmacist). This is often forgotten as the care home focuses more on getting it signed off by the GP and involving the resident's family but not the best or safest way to administer the medicine. |
| 090 | NHS England | Quality statement 7 | Not supported – as this is already included explicitly in the definition of the care home policy in QS1. |
| 091 | Royal College of Nursing | Quality statement 7 | There is no reference to the NMC guidance on covert administration. This should be referenced and considered - http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Medicines-management-and-prescribing/Covert-administration-of-medicines/<br>And again the report reads as though this area is new to the care home / NHS sector, when in reality there are many areas of good practice. Another such example - http://www.windsorascotmaidenheadccg.nhs.uk/download/care_home_guidance/08.1%20Good%20Practice%20Guid |

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| | | | ance%208.%20Covert%20administration.pdf<br>In summary we feel that so much good work has been completed around the country, that one might suggest that this experience would have been a perfect platform upon which to draw such work together, to recognise the contributions made, and use these to emphasis existing guidance rather than to create new systems of work". |
| Consultation question 1 | | | |
| 092 | Boots UK Ltd | Consultation question 1 | Yes, the draft quality standard does appear to accurately reflect the key areas for quality improvement. It is important to ensure that this guidance dovetails with the CQC outcomes framework through which it will largely be enforced. |
| 093 | British Geriatrics Society | Consultation question 1 | The seven proposed quality statements reflect the main areas for improvement identified in the NICE Quality Standards and Indicators briefing paper of July 2014, namely the safe and effective use of medicines for residents in care homes and supporting residents to make informed decisions in relation to their medicines. The quality statements span key aspects of medicines management in care homes, from care home medicines policy through processes to support residents to self-administer medicines, processes for prescribing, medication review, sharing of information in relation to medicines and processes for covert administration of medicines.<br><br>Consideration should be given to developing an additional quality standard in relation to the management and response to medication errors in care homes, to ensure appropriate learning is achieved from medication errors and reduce further errors. The burden of medication errors in care home residents was one of the main drivers leading to the development of the Managing Medicines in Care Homes NICE guideline and quality standard. Whilst medication review and clear processes for medicines reconciliation, prescribing and transfer of information in relation to medicines should help reduce errors, a quality standard that ensures adequate learning is achieved following errors and ensures evidence of reflective practice should also be considered. |
| 094 | Dudley CCG/ Dudley Office of Public Health | Consultation question 1 | Despite the note that the topic of Staff Training and competencies will be discussed, but not included within the statements: I feel that this is such an important area, with massive scope for improvement to ensure accurate medicines management, it should have a separate statement to cover this key area.<br><br>Training should be standardised and courses accredited for access by the Homes. This would ensure a competent and better educated staff, having regular reviews, and to make them aware of the importance of the role and the need to get it right' every time. This ideal process would inevitably lead to a need for a more highly paid care worker to reflect the level of education and training to which they could aspire. |
| 095 | NHS Sheffield CCG | Consultation question 1 | Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?<br>YES |
| 096 | Leeds South and East Clinical Commissioning Group (representing | Consultation question 1 | No – there needs to be a quality standard about allergy/sensitivity documentation. MAR charts are frequently missing this vital information – communication between GPs, care homes and community pharmacists needs to be substantially improved. The care home's medicines policy needs to include information about checking allergy status |

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| | Leeds North CCG, Leeds West CCG and Leeds South and East) | | each time a medicine is administered, and keeping records up to date. |
| 097 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 1 | It needs to be clearer whose responsibility each quality statement is – GP practice (including clinical pharmacists), care home, or partnership. |
| 098 | Pharmacy Voice | Consultation question 1 | The list of quality statements includes the prescribing of medicines but no mention is made of supply (or indeed of safe supply). We believe there should be a quality statement linked to supply. Issues with the supply of medicines typically arise if there are not robust processes in place linking the ordering or prescribing of medicines and their supply. Good relationships and communications between all parties involved are necessary, as are robust audit trails, in ensuring residents receive their medication in a timely manner. |
| 099 | Royal College of Nursing | Consultation question 1 | We don't believe these statements accurately reflect all areas of need, for example there is no consideration for one of the highest risk areas which is at point of initial admission and admission from hospital, Both of which are areas of concern and risk in relation to medicines administration. |
| Consultation question 2 | | | |
| 100 | Boots UK Ltd | Consultation question 2 | Yes, if the systems and structures are available, we believe that it would be possible to collect the data for the proposed quality measures. CQC should be in a position to collect the data from care homes during inspections. NHS England Area Teams (or equivalent) can collect and monitor data from GPs and other service providers, such as community pharmacies, through the processes already being used to monitor these organisations |
| 101 | British Geriatrics Society | Consultation question 2 | Quality Statement 1: Yes, evidence of a care homes medicines policy.<br><br>Quality Statement 3: Yes, time from entry to care home to completion of medicines reconciliation.<br><br>Quality Statement 4: Yes, proportion of transfers of people from care home in which the person is accompanied with an accurate record of medicines.<br><br>Quality Statement 5 - processes for prescribing medicines: Yes, good structural, process and outcome measures proposed.<br><br>Quality Statement 6 - medication reviews: Structure and process outcomes measurable. Outcome measure in relation to care home resident satisfaction with their involvement in medication review is going to be more difficult to measure given the high prevalence of dementia in care homes, but nevertheless, important to ensure that |

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| | | | multidisciplinary medication review is a clinical level of review and involves the patient.<br><br>Quality Statement 7 – covert medicine administration: Structure quality measure proposed is measurable. There also needs to be a process quality measure that reflects the Mental Capacity Act and the need to document Best Interests decisions for all residents if covert administration of medicines is being considered or planned.<br><br>Quality Statement 2 – self-administration: May need further pilot work on possible process measures, ie, what evidence of risk assessment having taken place would be collected ? |
| 102 | Dudley CCG/ Dudley Office of Public Health | Consultation question 2 | Locally we are in the process of updating and improving our quality assurance audits of Care Homes. If the audit process were standardised across the country, and the data made easily accessible, succinct, robust and not too onerous a regular task for the Care Home staff, I feel that data collection should be possible. Of course, the data would then need to be analysed and subsequent changes to practice advised to all Homes, to have made it a worthwhile exercise. It would be the 'actions' as a result of the data analysis that would be important and not just a data collection process per se. |
| 103 | NHS Sheffield CCG | Consultation question 2 | Question 2 If systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?<br>YES with adequate preparation, support and achievable time frames it would be possible.<br>Sheffield systems already in place that could assist with data collection include: council visits; CCG quality team visits; community pharmacy enhanced service to care homes; CCG Medicines Management Team members attached to each GP practice. |
| 104 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 2 [statement 1] | yes as it stands, although no analysis of quality of policy/adherence to policy by staff – this is essential otherwise just a tick box exercise. There is a statement "The policy and processes are regularly checked to make sure that they are up-to-date and are based on the best possible information." Whose responsibility is this? |
| 105 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 2 [statement 2] | Yes |
| 106 | Leeds South and East Clinical Commissioning Group (representing | Consultation question 2 [statement 3] | This allows to check a list has been made, but how can we check that the list is accurate? There needs to be information recorded about the sources used e.g patient/carer, current GP repeat list, discharge note from hospital. More than one source should always be used for medicines reconciliation to triangulate an accurate current |

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| | Leeds North CCG, Leeds West CCG and Leeds South and East) | | medication list. |
| 107 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 2 [statement 4] | This allows to check a list has been made, but how can we check that the list is accurate? There needs to be information recorded about the sources used e.g patient/carer, current GP repeat list, discharge note from hospital. More than one source should always be used for medicines reconciliation to triangulate an accurate current medication list. |
| 108 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 2 [statement 5] | Again – how to assess adherence with policy rather than just the fact that a policy is available? |
| 109 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 2 [statement 6] | statement at end re feedback from patients that they feel involved in MDT medication review process. Could make clearer in title of standard that this is not just about MDT review, but also patient/carer involvement. The potential members of the MDT are listed, but it is not clear how many people constitute an acceptable MDT review – e.g. is GP, pharmacist plus care home nurse sufficient, or would expectation be that more professions attend. The more people there are, the more logistically difficult, time consuming and expensive this process becomes. See results of the SHINE project in Northumberland. |
| 110 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 2 [statement 7] | yes |
| 111 | Royal College of Nursing | Consultation question 2 | The RCN believe that it would be a simple process to write into contracts with care homes the requirements of these standards to be collected on a regular basis, ensuring it is on a contractual basis will ensure adherence and monitoring through normal contractual routes. |
| Consultation question 3 | | | |
| 112 | Boots UK Ltd | Consultation question 3 | All the quality statements will need clear endorsement from NICE, CQC and the NHS jointly to explain why the standards have been formalised, how they should be implemented and how they will be embedded in CQC's outcomes framework with legal status. We believe that in some regards (for example, the proposal under Statement 6 that all people in care homes should have at least one multidisciplinary medication review a year) this may require |

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| | | | additional funding in order to ensure that relevant people are available to contribute to the processes proposed. |
| 113 | Dudley CCG/ Dudley Office of Public Health | Consultation question 3 | See notes appended to each statement above |
| 114 | NHS Sheffield CCG | Consultation question 3 | Question3 For each quality statement what do you think could be done to support improvement and help overcome barriers?<br>Statement 1 –<br>• having a joint health and social care policy<br>• utilising the NICE medication policy checklist when visiting and inspecting care homes<br>Statement 2-<br>• increased involvement from community pharmacy to readily inform the care homes how they can support the residents to self- administer – providing examples of how support can be offered e.g. large print labels, screw tops.<br>Statement 3 –<br>• outside agencies having a clear understanding of the importance of detailed accurate medication information being available to care home staff on the resident's admission to the care home. Sheffield Medicines Management Team has produced and distributed guidance on medicine reconciliation to care homes.<br>• GP clinical computer systems providing accurate and timely information to the care homes. This could be achieved by the care homes having access to summary care records.<br>Statement 4 -<br>• outside agencies, e.g. community nursing services, who administer medicines to residents in care homes document on the care home MAR chart details of what they have administered, rather than use their own separate recording chart; use of electronic communication as paper records may go missing e.g. on admission to hospital<br>Statement 5 -<br>• GP locally commissioned service to incentivise the practice to have a clear written process for their patients who live in care homes<br>Statement 6 –<br>• Locally commissioned services to incentivise GPs and community pharmacy to undertake multidisciplinary medication reviews; routine involvement of the CCG/CSU medicines management team<br>Statement 7 –<br>promotion through the NICE medication policy checklist. Sheffield Medicines Management Team has produced guidance and delivered training on covert administration of medicines in care homes |
| 115 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds | Consultation question 3 [statement 1] | draft a sample policy which homes can amend to fit their individual circumstances (the checklist may suffice?). |

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| | South and East) | | |
| 116 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 3 [statement 2] | signpost GP practices and care homes to sources of information on administration aids (e.g. large print labels for bottles, eye drop bottle squeezing aids, and alternative inhaler formulations). Also information for care home staff on in-room medication storage for individual residents who self administer medicines, monitoring of adherence. Implications for medicines management systems at care homes – blanket MDS systems as currently employed in many homes may no longer be appropriate). |
| 117 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 3 [statement 3] | increase funding for pharmacy led medicines reconciliation on admission – many hospitals have very successful technician led services doing this, with referral to a pharmacist if any discrepancies are found |
| 118 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 3 [statement 4] | Clarify responsibility – presumably this is asking for a copy of the current MAR chart to be sent in with each patient, thus care home responsibility. Need to add that information about medicines administered elsewhere also needs to be included (e.g. regular injections/infusions in hospital, indwelling pumps such as baclofen intrathecal). |
| 119 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 3 [statement 5] | Provide a sample policy for amendment at local level as appropriate |
| 120 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East) | Consultation question 3 [statement 6] | Add specific “read code” to GP systems so that this MDT medication review activity is recorded consistently across the country. (currently many different codes in use so almost impossible to report). Otherwise leave responsibility with care home to record review taking place |
| 121 | Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and | Consultation question 3 [statement 7] | specify frequency of review of need for covert admin? |

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| | East) | | |
| 122 | Royal College of Nursing | Consultation question 3 | There is a real need for training in this area, and for local processes to be put in place which clarify the various elements of responsibility for each element of the pathway. |
| 123 | MSD | MSD appreciates the opportunity to comment on the draft quality standard managing medicines in care homes. I can confirm we have no comments to make. | |

## *Stakeholders who submitted comments at consultation*

- Barchester Healthcare
- Boots UK Ltd
- British Geriatrics Society
- British Medical Association
- Care England
- Dudley CCG/ Dudley Office of Public Health
- Guys and St Thomas NHS Foundation Trust
- Leeds South and East Clinical Commissioning Group (representing Leeds North CCG, Leeds West CCG and Leeds South and East)
- National Care Forum
- NHS Eastbourne, Hailsham & Seaford & NHS Hastings & Rother Clinical Commissioning Group, Medicines Management
- NHS England
- NHS Sheffield CCG
- Northern, Eastern & Western Devon CCG
- Pharmacy Voice

- Royal College of Nursing
- Royal Pharmaceutical Society
- The Health Foundation