NICE National Institute for Health and Care Excellence

Managing medicines in care homes
Guideline consultation
Monday November 18th – December 16th 2013

Guideline consultation comments table

Reference number	Stakeholder	Section number	Page number	Line number	Comments	Consultation responses
1	Coventry & Rugby CCG	3.1	17	1	Consider inclusion of Dispensing Appliance Contractors, not mentioned anywhere in document	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
2	Coventry & Rugby CCG	3.1	18	6	Having studied this diagram several times, and discussed it with colleagues, we still cannot see how this gives an overview of medicines management systems, in particular the two boxes within the circle. What is meant by 'obtaining'?	Thank you for your comment. The CQC use the term 'obtaining' medicine which is the term we have adopted for this guideline.
3	Coventry & Rugby CCG	3.3	31	30-31	Similar in essence to a Caldicott Guardian, who would develop the information governance toolkit? National Care Forum?	Thank you for your comment. This section has been reworded following discussion by the guideline development group. A hyperlink has been added to the information governance toolkit for health & social care.
4	Coventry & Rugby CCG	3.3	33	9-10	References to support statements not given	Thank you for your comment. The final published full guideline will include a list of references in appendix G. The format is in line with the NICE publishing style and was considered by the NICE publishing team.
5	Coventry &	3.9-3.12	52	26	In our experience can also apply	Thank you for your comment. Management of

	Rugby CCG				to repeat as well as new medicines	repeat prescriptions is included in section 3.5 of the guideline.
6	Coventry & Rugby CCG		53	8	RPS Improving Patient Outcomes 2013 refers to MDS as multi compartment compliance aids	Thank you for your comment. The guideline development group discussed and agreed to use the term Monitored Dosage System. The definition is explained in the glossary section in line with the NICE style and has been considered by the NICE publishing team.
7	Coventry & Rugby CCG	3.6	55	general	What and when to report often causes problems for care homes. It would be good to have some nationally agreed standards to give greater clarity and consistency for reporting.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process, such as for local reporting, are for local consideration and determination.
8	Coventry & Rugby CCG	3.7	73	19	Anecdotally our care homes complain that they send residents with the relevant information but that this doesn't seem to reach the ward / consultant. Potential for nationally recognised folder to accompany patient in the style of locally agreed Greensleeves as per www.c-a-s-t-l-e.org.uk ?	Thank you for your comment. The green sleeves wallets is a local initiative in palliative care, while the guideline development group appreciate that this may be a useful initiative, the group are not aware of any published evidence demonstrating improved outcomes related to care home residents.
9	Coventry & Rugby CCG	3.8	80	9	NSF was always aspirational. NB med review is no longer in QOF 2013 nor likely to be in 2014.	Thank you for your comment. The guideline development group do not make reference to the Quality and Outcomes Framework (QOF) in this section. Payment performance for GPs is outside the scope of this guideline.
10	Coventry & Rugby CCG	3.8	81	13	Also covered by NPC 2008 A guide to medication review. Possible future topic for NICE?	Thank you for your comment. The 2008 NPC document was an update of the 2002 NPC document but does not supersede it.
11	Coventry & Rugby CCG	3.9	85	26	Good point made here. Synchronising meds often causes problems at surgeries leading to frequent interim requests or	Thank you for your comment.

					blocked scripts, even missed meds.	
12	Coventry & Rugby CCG	3.9	87	14-22	Although good practice, in reality I can't see our prescribers agreeing to do this. We feel that we have achieved something by insisting on dose instructions for all meds including topical, 'as directed' is not allowed locally. We would expect the staff to have covered this as part of their training on understanding what meds are for.	Thank you for your comment. The guideline development group agreed that the wording as written represents good practice. Details of the process are for local consideration and determination.
13	Coventry & Rugby CCG	3.9	89	2.9.2	More likely to include meds prescribed info on medicines administration record than in care plan.	Thank you for your comment. The guideline development group agreed this represents good practice.
14	Coventry & Rugby CCG	3.10	92	3	No mention of carrying forward	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
15	Coventry & Rugby CCG	3.10	94	13-16	Would be helpful if the GP practice also kept the community pharmacy informed of changes	Thank you for your comment. The guideline development group discussed and agreed that 'collaboration between the care home providers, GP practice and community pharmacy is essential.'
16	Coventry & Rugby CCG	3.11	98	1-5	This lays the onus on the care homes rather than the pharmacist to conduct the assessment for the most appropriate system. Most MDS are for the convenience of the care home rather than to support a patient to self-administer. This would be an opportunity to emphasise the role of the pharmacist and needs of the patient rather than the	Thank you for your comment. The guideline development group discussed and concluded that care home providers should consider the most appropriate medicines supply system for the resident using a person-centred approach, seeking support from relevant health and social care practitioners. Assessment could be conducted by a pharmacist, but could also be a nurse or occupational therapist for example.

					expediency of the care staff.	
17	Coventry & Rugby CCG	3.12	102	2-8	Still waste generated as staff need time to check the order, and pharmacies often refuse to accept errors / unrequested meds back.	Thank you for your comment. If recommendations in the guideline are followed, the guideline development group agreed that waste would be reduced through having a care home medicines policy and processes to support implementation.
18	Coventry & Rugby CCG	3.12	103	general	Consider of emphasis of meds stored separately from all other items. We have had instances of food and cigarettes stored in MDS trolley!	Thank you for your comment. The guideline development group was unable to make a recommendation about other items being stored as it would not be applicable in all circumstances (for example those medicines held and stored by residents themselves).
19	Coventry & Rugby CCG	3.12	105	20-23	Again would like to see some specific mention of carrying forward.	Thank you for your comment. The guideline development group discussed and agreed wording: 'Check and make appropriate records of quantities of repeat, acute and 'when required' medicines to avoid over-ordering and running out, according to a written process'.
20	Coventry & Rugby CCG	3.13	109	5	Does CQC still provide this? Was available in 2010 under Professional Advice but no longer accessible on CQC website.	Thank you for your comment. This section is referring to outcome 9 of the CQC Essential standards of quality and safety and has been reworded for clarity.
21	Coventry & Rugby CCG	3.13	112	3-8	Especially important in relation to inhalers, and ability to self medicate reviewed regularly.	Thank you for your comment.
22	Coventry & Rugby CCG	3.14	118	15-19	We implement this policy locally but care staff may resist it and some care homes policies apparently discourage it.	Thank you for your comment.
23	Coventry & Rugby CCG	3.14	129	general	As yet there is no READ code for covert administration for GPs to record this decision. Only 'Best interest decision made on behalf of patient' (9NgE)	Thank you for your comment.

24	Coventry & Rugby CCG		153	11	Feel that 'to make their use easier' should be omitted unless it specifies for self-administration by patient.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
25	Coventry & Rugby CCG		161	general	Use of MDS lengthens the lead time from ordering prescription to supply, during which time patient needs may have changed.	Thank you for your comment. This table is based upon published and presented evidence reviewed by the guideline development group it is not exhaustive.
26	NHS Gloucestershire CCG	General			The document is very long, and provides an excellent evidence based resource to provide a definitive answer to all manner of questions that could be asked in relation to this topic. However as a usable document, feedback from out GPs on our medicines management group was that they were 'put off' by the size of it. Are there any plans to provide a summary of recommendations? Are there any plans for a review, or updates being issued if legislation changes?	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published. The guideline will be updated in line with NICE processes.
27	Amore Care, Priory Group	3.2	20	4	I am in agreement with the concept, but feel that the impact of peers should be given due consideration (eg where a resident may gain unauthorised access to a peer's room). However, the remainder of the sentence does specify a 'minimum standard'.	Thank you for your comment.
28	Amore Care, Priory Group	3.2	22	1-8	There is no mention of being on the alert for the use of 'clinical jargon', which I feel must be	Thank you for your comment. The guideline development group have linked the use of the term 'health literacy' to the World Health

					avoided. I am also unsure as to whether the term 'health literacy' refers to the resident's understanding of what a specific terminology means in broad terms (eg that it relates to a poorly-functioning liver) or a full understanding of the implications of (eg) a diagnosis. It might be said that the phrase 'health literacy' is a form of clinical jargon.	Organization website definition.
29	Amore Care, Priory Group	3.3	36	15-16	I feel this is especially relevant when relating to communications between NHS organisations and independent healthcare providers	Thank you for your comment.
30	Amore Care, Priory Group	3.3	36	20	I am unclear as to whether 'electronic discharge summary' means a summary which was sent out electronically or an electronically-generated summary which would be printed off and sent to the care home with the patient. If it were the former, the receiving staff in the care home – due to possible I.T. constraints – may not receive such a summary until sometime after the patient was received into the home.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
31	Amore Care, Priory Group	3.4	45	18-23	I 'm unsure whether I've grasped this correctly. Does the section refer to hand-written prescriptions or to any/all signatures for administration? If the latter, double signatures from trained	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					staff might be problematic on each/every occasion. (See also page 120, line 10)	
32	Amore Care, Priory Group	3.5	54	15-16	What about reviews being undertaken by GPs? (See also page 78, line 25)	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
33	Amore Care, Priory Group	3.6	65	16-17	What would be the definition of 'locally'? How wide-ranging would that scope be? Concerns/impediments to such a sharing of information were raised by the authors on page 62, lines 6-9.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
34	Amore Care, Priory Group	3.7	72	22-23	This may not always be feasible – should the GP not be involved? (See also pg 71, line 25)	Thank you for your comment. The guideline development group discussed and agreed that who should be involved in the medicines reconciliation process is for local consideration and determination.
35	Amore Care, Priory Group	3.9	87	18-19	Prescribers (eg GPs) may not always routinely write in care plans, though may write in professional notes. However, this is not always guaranteed and, when entries are made, may not always be of sufficient detail (and legibility)	Thank you for your comment. The guideline development group have recommended that it is good practice for the prescriber to write in the care plan, and the respective section on record keeping specify that entries should be legible (also there is a professional duty under standards for record keeping from NMC for example).
36	Amore Care, Priory Group	3.11	100	12	I feel that 'as directed' is often not sufficiently explicit, especially for bank or agency staff who do not regularly work within that care home.	Thank you for your comment. The registered person / manager has a duty in relation to staff having the knowledge and skills to competently care for residents, this duty extends to all staff working in the care home (see section 3.17 of the full guideline).
37	Amore Care, Priory Group	3.12	102	23	I think there is a need to identify/acknowledge the risks associated with replenishing	Thank you for your comment. The guideline development group was not aware of any issues from published or presented

					lockable drawers within patients' rooms; also the time involved in - and method of documenting – replenishment of individual drawers, if on a fairly wide scale. In addition, there are further considerations which might bear mentioning here (such as the need to ensure room temperatures were not in excess of 25 °C; the need for a fridge in the room for storage of certain medications/creams)	evidence relating to replenishing lockable drawers. Information about medicines that require special storage requirements are included in section 3.12 of the full guideline.
38	Amore Care, Priory Group	3.15	129	25-28	For patients who have no immediate/accessible family, could the involvement of an advocate be mentioned here (as it is on page 130, line 9)	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
39	Amore Care, Priory Group	2.14			I did not see any mention of the maintenance of topical MAR (TMAR) sheets. Would it be appropriate to include mention of these (appropriate management; completion and referencing on the main MAR sheets etc)?	Thank you for your comment. See section 3.9 and 3.12 of the full guideline for information about prescribing and recording topical applications.
40	English Community Care Association	general			The document is very health focussed and may alienate social care registered providers as a result. The first point for residents in care homes will be, can they self-administer, which is not adequately reflected in the document.	Thank you for the comment. The guideline development group is aware that the systems and processes associated with managing medicines in care homes can appear very health focussed. The evidence in most cases for this topic comes from a health rather than social care perspective. The guideline contains a section 'helping residents to look after and take their medicines

						themselves (self-administration)' (see section 3.13 of the full guideline).
41	English Community Care Association	general			The document is far too long. In addition to which CQC regulations are being reviewed and so the document may be inaccurate soon after it is launched.	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published.The guideline will be updated in line with NICE processes. Care Quality Commission regulatory changes in England are expected in October 2014 as a result of the Health and Social Care Act (2012). It is expected that the recommendations in the guideline will not change as a result of this because the guideline is based on current evidence. Following publication of the updated regulations, the guideline will be assessed to ensure that any relevant regulations are appropriately referenced.
42	English Community Care Association	general			The key for us its that having participated in the DH funded work on medication in care homes for the last 2 years, that this work be acknowledged and any document from NICE align with this work. However the DH funded project "Resources for supporting the safe use of medication in care facilities" is not mentioned. Our members have only just been given all the links to the resources and will have started to use them by the time the new NICE guideline is out. This will be extremely confusing for members to have to refer to a later	Thank you for your comment. The resources mentioned were not included in the draft guideline for consultation as they were published in the public domain imminently before consultation. Resources have been hyperlinked to in the full guideline where appropriate.

					document that takes no account of the good practice they have just started and been encouraged to follow.	
43	English Community Care Association	general			We need further information as to how this will be implemented through CQC for example as there will be occasions when the NICE guideline requires actions that the home alone is not in complete control over. If the home is let down by others in the care system how will the home be judged by CQC in the light of this NICE guideline.	Thank you for your comment. The NICE guideline is aimed health and social care practitioners. Implementation of the guideline will be through our partnership with the Social Care Institute for Excellence (SCIE) and will inform a NICE quality standard. The CQC has been a stakeholder in the development of this guideline. The guideline does not form part of the regulatory framework for care homes and provides recommendations for good practice. The CQC do not inspect against NICE guideline or NICE quality standards although aligning the processes set out in the guideline may demonstrate compliance with regulations on managing medicines.
44	English Community Care Association	general			As previously mentioned the aim will be initially to see if residents can self-medicate and be encouraged to do so. Further clarity is needed as to how the NICE guideline will apply in these situations and how CQC will respond also.	Thank you for your comment. The guideline contains a section 'helping residents to look after and take their medicines themselves (self-administration)' (see section 3.13 of the full guideline). The guideline aims to ensure residents maintain independence for their medicines. The guideline also highlights good practice for systems and processes when residents are unable or need assistance to self-administer their medicines.
45	English Community	general			There is little differentiation between care homes with nursing	Thank you for your comment. The systems and processes for managing

	Care Association				and care homes for personal care.	medicines in care homes are not unique to either care homes with or without nursing care. The guideline provides recommendations for managing medicines in all types of care homes including learning disability and children's homes.
46	English Community Care Association	general			The guideline should be reviewed with the aim being to have guideline on the safe administration of medication whilst providing efficient systems from the Care Home point of view. Otherwise the guideline could be just another duplicate tick list to be implemented and audited with the consequence of removing resources from improving the quality of life of the resident population.	Thank you for your comment. Unfortunately the scope is unable to be amended once the guidance is in development.
47	English Community Care Association	general			The RNHA has made specific comments on individual paragraphs which we support.	Thank you for your comment.
48	Eastern Cheshire CCG	3.11	98	23	Our comments are as follows Processes should also be in place so that all lines on MAR charts are consecutively filled in. (In one home in which I did reviews one MAR chart supplied by the pharmacy consisted of 6 sheets. First 2 sheets complete then next half full then next 3 with 1 item each on them.) Unfortunately staff thought chart	Thank you for your comment. Details of the process are for local consideration and determination.

					finished at end of 3rd sheet and other items frequently were not given. Many of the MAR charts produced were like this and led to errors.)	
49	Eastern Cheshire CCG	3.11	100	7	Our comments are as follows Administration if weekly should be labelled on which day of the week it should be given. Likewise with monthly medication or 3 monthly Hydroxycobalamin injection which should be labelled with the 4 months of the year when it should be administered	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
50	Eastern Cheshire CCG	3.14	117	14	Our comments are as follows This can also be 8 Rights as Right documentation and Right Education (of both resident and carer are also necessary)	Thank you for your comment. The guideline development group was aware of variation in the number of 'rights'. The guideline development group agreed that 6 were appropriate for the health and social care audience.
51	Eastern Cheshire CCG	3.14	118	29	Our comments are as follows Staff should not leave medicines with resident and move on to next resident before seeing them taken. (Again found administration recorded in such cases when administration was not overseen and then medication found to still be with resident when next round started)	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
52	Eastern Cheshire CCG	3.14	122	26	Our comments are as follows Other ways interruptions can be minimised are by staff administering medication wearing high visibility bibs marked with	Thank you for your comment. The guideline development group considered the evidence for the wearing of tabards but agreed that no recommendation should be made due to variability in the evidence.

					warning re 'No interruptions' or similar	
53	Eastern Cheshire CCG	general			Comprehensive and useful document	Thank you for your comment.
54	Avante Care and Support	3.15	128		In this section I could not see mention of supplying pharmacy's involvement or recommendations to care home around what may be done with each pharmaceutical product?	Thank you for your comment. However it is not clear where this comment relates to in the draft guideline.
55	Avante Care and Support	3.16	2.16.1		I could not see mention of specific audit for Homely remedies?	Thank you for your comment. The guideline development group reviewed available evidence and we not able to make a recommendation of this.
56	Social Care Institute for Excellence	3.5	53	9	Cass E., 2012, Commissioning care homes: common safeguarding challenges, London, *SCIE, p.7* This publication carries a section on Maladministration of medication looking at the safeguarding aspect of this issue (such as the misappropriation and misuse of drugs by staff or the misuse of sedatives to control challenging behaviour). It includes a prevention checklist. *(http://www.scie.org.uk/publications/guides/guide46/commonissues/maladministration.asp)*	Thank you for your comment. See section 3.2 of the full guideline for where this reference was considered.
57	Social Care Institute for Excellence	3.5	54	6	Some care home managers in SCIE practice survey (Brand P., 2013, Improving access to and experience of GP	Thank you for your comment. The cited study is supportive but does not provide objective evidence of the efficacy of such interventions. Thank you for your comment. The guideline

					services for older people living in care homes) reported using a PCS (proactive care system) involving a hand held devise and bar code scanning technology which cuts out some of the administration and recording errors. It can be used as support evidence for the review. Basic training, hand hygiene, no interruptions when administering medication and offering a drink (hydration); still needs to feature in all of this as part of the dissemination of good practice. Much of this is covered in CPSA (2011) Managing and Administering Medication in care homes for older people. London, Centre for Policy on Ageing.	development group was aware of bar-coded systems, however no robust (RCT) studies using this intervention were identified during the literature review for the guideline. See section 3.17 of the full guideline for information on the training and skills (competency) of care staff. Interruptions are included in the full guideline (see sections 3.6 and 3.14).
58	Social Care Institute for Excellence	3.17	134	25	Care home managers suggest training for staff should be on going, with annual competency checks. 8	Thank you for your comment. The guideline development group agreed that in the absence of any evidence about how often training might be required given the different disciplines of practitioners working in care homes (e.g. general nurses, learning disabilities nurses, adult social care practitioners, children's social care practitioners) details of the process are therefore for local consideration and determination.
59	Social Care Institute for Excellence	3.5	53	22	This issue may need to be made more prominent both in the training and in the role care home staff should be playing in the	Thank you for your comment. The guideline development group agreed that potential medicine interactions are an important consideration with polypharmacy; the risk of

					medication review. This is because of the level of polypharmacy (prescribing four or more medications to the same person) and the fact that risk of this increases as different prescribers add to the list, e.g. when a person spends time in hospital another drug may be added to the list.	being exposed to polypharmacy increases with age. Polypharmacy is associated more with older populations rather than the whole population of those individuals living in care homes.
60	Social Care Institute for Excellence	General	76	2	Guideline would be helpful in relation to the frequency of medication reviews as well as their purpose and who leads it as a reminder to professionals. For example, in the case of constipation for which laxatives may or may not be the answer. Whilst care home staff may not have knowledge regarding the chemical interactions of certain drugs they are nonetheless in a position to observe the outcome for the resident and need a way of bringing this to the attention of the prescriber.	Thank you for your comment. The purpose and definition of medication review is included in section 3.8 of the full guideline. There is a lack of evidence on the most appropriate frequency for undertaking medication reviews. The guideline development group agreed that the frequency of medication review should be determined on an individual basis.
61	Social Care Institute for Excellence	3.5	53/54	30	Agree. SCIE (2013) GP services for older people: a guide for care home managers. London. Social Care Institute for Excellence (Available on line at: http://www.scie.org.uk/publications/guides/guide52/) makes this	Thank you for your comment.

					point. Four of the recommendations relate to the responsibility of the care home manager and two of these refer directly to consistent records on medication and a strategy for medicine management.	
62	Social Care Institute for Excellence	3.5	54	29	I refer also to Goldman R., (2013) 'Evidence review on partnership working between GPs, care home residents and care homes' London , SCIE p.5 **relationships between GPs, residents and relatives** GPs' lack of knowledge of individual residents is associated with prescribing errors and/or risk-adverse decision-making (Wild *et al*, 2010; Barber *et al*, 2009). '… emergency call-out doctors do not know residents, so play safe and order them to be admitted to hospital for many conditions which could perhaps be resolved differently.' (resident, Wild et al, 2010, pp 21-2)	Thank you for your comment. The comment agrees with the findings of the guideline development group that the evidence in support of these is subjective / qualitative in nature and there are no objective studies that directly provide evidence of effectiveness to support the use of this intervention.

					Wild, D., Szczepura, A. and Nelson, S. (2010) Residential care home workforce development: the rhetoric and reality of meeting older residents' future care needs, York: Joseph Rowntree Foundation. Barber, N., Alldred, D., Raynor, D., Dickinson, R., Garfield, S., Jesson, B., Lim, R., Savage, I., Standage, C., Buckle, P., Carpenter, J., Franklin, B., Woloshynowych, M. and Zermansky, A. (2009) 'Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people', *Quality and Safety in Health Care*, vol 18, pp 341–6. Residents, GPs and care home staff say that positive relationships between GPs, residents and family members are associated with: • residents feeling reassured, supported and listened to • residents understanding their medical issues • GPs following residents' wishes for treatment and	

					care • GPs being called out appropriately • residents being encouraged to take medication or cooperate with treatment • Reductions in hospital admissions (British Geriatrics Society (2011a) Quest for quality: An inquiry into the quality of healthcare support for older people in care homes: A call for leadership, partnership and quality improvement, British Geriatrics Society; Briggs, D. and Bright, L. (2011) 'Reducing hospital admissions from care homes: considering the role of a local enhanced service from GPs', Working with Older People, vol 15, no 1, pp 4–12.)	
63	Social Care Institute for Excellence	general			As a whole the document addresses the key points and is very timely. Whilst the title addresses itself to all care homes, the issue of medicine management in children's residential establishments is somewhat understated.	Thank you for your comment.

					However, this is probably due to the lack of evidence around medicine management in care homes for children and young people as well as the fact that polypharmacy is more closely associated with the 'elderly'. Finally, the guideline is by necessity, quite detailed and implementation support to managers, senior care workers and care workers will be an important consideration.	
64	Bolton CCG	General			The guidelines are of good quality	Thank you for your comment.
65	Bolton CCG	General			They are comprehensive and cover all aspects of medicines management in care homes	Thank you for your comment.
66	Bolton CCG	General			The wording is clear and easy to follow	Thank you for your comment.
67	Bolton CCG	General			The document gives weight to the standards of medicines management that we expect in care homes in Bolton	Thank you for your comment.
68	Bolton CCG	3.14	121	22	This section states that for the recording of the administration of controlled drugs "no signature is required by the appropriately trained witness on the medication administration chart"	Thank you for your comment.
69	Bolton CCG	3.14	127	2.14.9	This recommendation states that "the care home staff administering the controlled drug and an appropriately trained witness should sign the controlled drugs	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					register and the medication administration record" This disagrees with the statement above.	
70	Care Homes Support Team, GSTT	3.13	111	28	It is important that the resident's ability to continue to self-administer their medication is reviewed periodically. Therefore can the guideline be updated reflect this. The care home should be checking at the beginning of the medication cycle that the resident has received all their medication, during the cycle that they aren't experiencing any problems and periodically their compliance. Also if the care home is ordering on behalf of the resident , they should be consulted as to what needs to be ordered each cycle, particularly when required medication.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
71	Care Homes Support Team, GSTT	3.4	48	1	It would be good to add that dispensing labels should not be used to prepare paper –based administration records as this would not be considered as a permanent record.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
72	Care Homes Support Team, GSTT	3.15	131	1	It is important that there are robust processes are in place regarding the manipulation and administration of the food and drink particularly to ensure that adulterated food cannot be consumed by other residents.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

73	Care Homes Support Team, GSTT	3.14	126	1	Recommendation 2.14.6 – it may not be possible to keep track of the quantities of all medicines e.g. liquids so add where possible.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
74	Primary and Community Care Pharmacy Network (PCCPN)	1.3	5	25-27	Some care homes (e.g., providing intermediate care) and care homes for children may have regular pharmacy input which may not be community pharmacists. Consider including a pharmacist and pharmacy technicians as professional groups providing care in care homes.	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
75	Primary and Community Care Pharmacy Network (PCCPN)	3	16	5-21	Add medication administration records to the list as a separate item. See further comments below.	Thank you for your comment. Medicines administration records are included in section 3.14 of the guideline.
76	Primary and Community Care Pharmacy Network (PCCPN)	3	17	7-14	Good to address and stipulate that the governance around managing medicines should be established. What is missing is who is actually responsible for ensuring that the governance around managing medicines are established and who will ensure all providers are included? Should it be the commissioners or should there be a clear responsibility that commissioners must ensure this is in place? This should be clear.	Thank you for your comment. The guideline development group agreed that in some cases a recommendation could not state which individual person or organisation was responsible for implementing the recommendation. Arrangements vary depending on how services are commissioned and provided and what resources are available. When the guideline development group agreed that a responsible individual person or organisation could be identified, this is clear in the recommendation.
77	Primary and Community Care Pharmacy	3	19	9	Recommendation. There should be a recommendation regarding the establishing of clear local	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Network (PCCPN)				governance arrangements especially as there may be various providers involved in providing input into patients/residents/children's care.	
78	Primary and Community Care Pharmacy Network (PCCPN)	3.1	18	7	The figure does not include homely remedies. Should there be an additional box for initial assessment dividing into prescribing / homely remedy with the cycle returning to prescribing?	Thank you for your comment. Homely remedies would be covered under the 'obtaining' part of this cycle.
79	Primary and Community Care Pharmacy Network (PCCPN)	3.1	18	7	The figure does not include the important step of the medication administration record being produced and checked.	Thank you for your comment. The figure has been amended to reflect your comment.
80	Primary and Community Care Pharmacy Network (PCCPN)	3.1	19	9	Would the following be useful additions to include in a policy? 1. reporting adverse drug reactions, 2. availability of emergency reliever medications eg inhalers, midazolam, adrenaline pens etc Importance of having emergency medication available on transport between care home and school. 3. carrying medication on outings or residential trips. Guideline on this would be helpful. 4. how medication transferred between the	Thank you for your comment. The scope is for the managing medicines in care homes. We include examples such as transitions from care settings and temporary absence. However some of the examples for inclusion are too specific and do not fit with the scope of the guideline (systems and processes).

					care home and school is handled, importance of audit trail etc.. 5. dealing with medical emergencies	
81	Primary and Community Care Pharmacy Network (PCCPN)	3.2	28	1	Recommendations. 2.2.4. Is a prescriber expected to assess a resident's mental capacity and record the assessment in the care plan every time a repeat prescription is being written or does this mean for every 'new' medicine being prescribed?	Thank you for your comment. This section has been reworded following discussion by the guideline development group and the NICE publishing team.
82	Primary and Community Care Pharmacy Network (PCCPN)	3.3	General		Children: Is it worth including examples of communication between the home and school? Also communication between specialist services and homes: Medication changes may not be communicated in a timely way, but medication may have been dispensed e.g. at hospital outpatient to a e.g. an older child in care but with no accompanying paperwork who then goes to care home manager to inform them of the change and enable them to cross reference with the dispensing label. Could use as an example. on p52 line 13	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
83	Primary and Community Care Pharmacy Network	3.3	34	1	Refers to 'Medication Use Review (MUR)'. No explanation as to what this is and not included in the Glossary in Appendices A. It	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	(PCCPN)				is recommended that this is included in appendices A.	
84	Primary and Community Care Pharmacy Network (PCCPN)	3.3	36	14-24	Document recommends that acute trusts use electronic discharges. It is also acknowledged that the electronic discharge is sent to patients GP. However, there needs to be a very clear recommendation aimed at acute hospital trusts that a copy of the electronic discharge letter must be provided to the patient or sent with the patient. Some care homes have been commissioned to provide intermediate care for patients where the GP providing the medical input may not be the patient's GP and will therefore not have access to the electronic discharge letter. Likewise care home staff will also need access to a copy of the discharge letter for when they write the medication administration record, which they write based on the discharge medication and the discharge letter from the acute hospital trust. (Note: community pharmacy will generally not produce MAR charts if they have not supplied the medication).	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
85	Primary and Community Care Pharmacy Network	3.3	37	21-22	This document refers to patient centred care and then says there is evidence that pharmacy-led review of medicines lists may	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	(PCCPN)				help. It needs to be acknowledged that these types of reviews are limited in that it does not include the patient/resident or the actual medicines. Concerned that this type of review may be consider sufficient if listed here.	
86	Primary and Community Care Pharmacy Network (PCCPN)	3.3	38	4-5	There needs to be more guideline regarding writing medication administration records and making changes on these. A separate more explicit section is required within the document. See several comments regarding medication administration records below.	Thank you for your comment. Unfortunately the scope is unable to be amended once the guidance is in development and the format was considered by the NICE publishing team.
87	Primary and Community Care Pharmacy Network (PCCPN)	3.3	39	1	Include in recommendation 2.3.5 that patients must be provided with a copy of their discharge summary from the discharging care setting (electronic or not).	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
88	Primary and Community Care Pharmacy Network (PCCPN)	3.4	44	19	Repeating page 42 lines 13 Is this necessary – can the 2 paragraphs be combined?	Thank you for your comment. Wording was considered by the NICE publishing team. Please note that page 44, line 19 relates to NMC standards (8), Page 42 line 13 cover the SCIE statement these two areas are related but do not say the same thing.
89	Primary and Community Care Pharmacy Network (PCCPN)	3.4	45	2	Include the ‘name’ as well as signature. Also adding the job title would be helpful. It is suggested that elsewhere in text there need to be a requirement for specimen signature records.	Thank you for your comment. Wording was considered by the NICE publishing team. Please note that adding the name is in some cases feasible but other cases for example on the medicines administration record it may not be possible due to space restrictions and

						therefore a signature is appropriate. Additionally NICE have no text in the draft guideline referring to specimen signatures in the document.
90	Primary and Community Care Pharmacy Network (PCCPN)	3.4	45	10,11	Could this be more explicit and include “and not as a prompt for administration”? See also comment below	Thank you for your comment. Unfortunately, the point of this comment is not clear.
91	Primary and Community Care Pharmacy Network (PCCPN)	3.4	45	18 - 29	When staff complete hand-written medication administration records, these MAR charts are then used as the record against which administration is made. This process may be known as ‘transcribing’. If this is ‘transcribing’ we would welcome a definitive definition for this. If it is not ‘transcribing’ we would welcome the use of a new descriptor and definition. Once the term has been agreed and defined, we would welcome some guideline on the qualifications and competencies that staff should have to be able to undertake this task.	Thank you for your comment. Medicines administration records are for recording the administration and non-administration of medicines administered by care staff. Section 3.11 of the full guideline covers the production of medicines administration records and states that the care home provider should have a process in place to check that the information on the medication administration records are correct and accurate. Care homes do not undertake a process of transcribing as the medicines administration records are not prescriptions but are records of administration.
92	Primary and Community Care Pharmacy Network (PCCPN)	3.4	46	1-31	Unclear why text messaging is the only form of communication included here. There are other methods such as telephone calls and use of faxes or emails. It be explicit that there should be restrictions to what instructions	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					can be given this way. E.g., a large increase in opioid dose – would that be acceptable if this instruction is taken by a carer worker? The process for taking instructions either via telephone, faxes, email should also clearly state when this way of providing instructions is acceptable and when it is not.	
93	Primary and Community Care Pharmacy Network (PCCPN)	3.4	46	1-31	Most healthcare organisations where this type of instructions is used and where it is a nurse taking these instructions, there is also a requirement for a prescriber to attend within a certain time limit to sign for the change to the dose for an already prescribed medicine. However, according to this document for some care homes this instruction may be taken by a care worker with what appears to be less control in place than for a healthcare organisation.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
94	Primary and Community Care Pharmacy Network (PCCPN)	3.4	47	16-20	This states that residents can report adverse drug reactions to the MHRA. How many care homes provide residents with access to the internet?	Thank you for your comment. The guideline development group has no information on the number of care homes providing internet access for their residents, however reporting forms can be printed by the care home for residents at their request if they are unable to access this themselves please see http://yellowcard.mhra.gov.uk/downloadable-information/reporting-forms/.
95	Primary and	3.4	General		Consider shared records for care	Thank you for your comment. See section 3.14

	Community Care Pharmacy Network (PCCPN)				home and health professional interventions e.g. nurses using care home MAR chart if they administer medication such as injectables. Currently, community nurses will use their own records for this. They may also record this on the MAR chart however there is no clear guideline for this.	of the full guideline for further information.
96	Primary and Community Care Pharmacy Network (PCCPN)	3.5	49	17 -20	How come the supply process is not listed as this is also where errors occur.	Thank you for your comment. For the purposes of this guideline supply is covered by the term dispensing error (similar to the definitions used in the CHUM study).
97	Primary and Community Care Pharmacy Network (PCCPN)	3.5	55	8	'reduce medication error': change this sentence by not using the word 'reduce' as this can send out the wrong message as all should be encourage to report. Instead focus on review, learn and improvements.	Thank you for your comment. The guideline development group strongly believe that while medication errors should be reported, this is will be done to with the aim of learning from and reducing the frequency of medication errors in care homes. Simply encouraging reporting will not bring about change and improvements in care and safety.
98	Primary and Community Care Pharmacy Network (PCCPN)	3.5	68	4, 12-17	Board of governors: It is included that and independent board of governors is recommended only to state below there is insufficient evidence of effectiveness. This intervention is "recognised to improve" (line 4) but then say not enough evidence to recommend (line15-17). This is confusing.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
99	Primary and Community Care Pharmacy Network	3.7	general		How can pharmacists actively and routinely be involved with medicines reconciliation across the interface? Community	Thank you for your comment. The guideline development group has recommended that pharmacists should be involved in medicines reconciliation. Details of the process are for local

	(PCCPN)				pharmacists are not routinely involved with the transfer of care between domiciliary and care home setting. There are some schemes where acute trust pharmacists or primary care pharmacists/Community health services pharmacists will be liaising with care homes on behalf of the patient on discharge but usually as part of a locally run scheme. Pharmacists are not routinely included in integrated care teams within the community although there may be some pockets of good practice.	consideration and determination.
100	Primary and Community Care Pharmacy Network (PCCPN)	3.7	74	6	Positive inclusion that this information is also required when a resident is transferred from a care home is recognised. Perhaps this could be included in a more explicit way in earlier sections?	Thank you for your comment. Section 3.2 of the full guideline states 'Health and social care practitioners should ensure that all information about a resident's medicines, including who will be responsible for prescribing in the future, is accurately recorded and transferred with a resident when they move from one care setting to another'.
101	Primary and Community Care Pharmacy Network (PCCPN)	3.8	79	5,6	Unclear why the document specifically refers to Primary Care Pharmacists in different sections including this one. There are other pharmacists providing this input including for example Community Health Services Pharmacists or pharmacists from independent providers.	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive. A section 'definitions' has been added to the guideline for clarity.
102	Primary and Community	3.8	81	4-8	Also include care homes that provide intermediate care such as	Thank you for your comment. The guideline provides examples which are not intended to be

	Care Pharmacy Network (PCCPN)				patients admitted after their acute episode (step-down) or admitted directly from home (step up). These patients should have their medicines reviewed within a very short time of admission.	exhaustive.
103	Primary and Community Care Pharmacy Network (PCCPN)	3.9	general		Reference should be made to take into account ability to take prescribed medication and using most suitable form for the patient. Should give instructions on how to administer eg if only solid dose available need some information on unlicensed uses and whether it's acceptable to crush tablets etc.	Thank you for your comment. See section 3.13 of the full guideline for information on helping residents to look after and take their medicines themselves. Detailed information on administration technique, unlicensed medication and crushing of tablets is outside of the guideline scope; information about these specific instances should be sought from a pharmacist.
104	Primary and Community Care Pharmacy Network (PCCPN)	3.10	91	1,2	Whilst we accept that verbal changes should be exceptional they do occur and it would be helpful to give guideline on recording them – 2 members of staff listening to request, etc (similar to text messages)	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
105	Primary and Community Care Pharmacy Network (PCCPN)	3.11	98	6	Medication Administration Record: This should be a stand-alone section and include more information as this is in practice where more explicit guideline is required and not including this here will be a missed opportunity. See our comment just below and for section 3.4 (pg 45, 18-29), 3.14 (general) and 3.14 (19-26).	Thank you for your comment. The format was considered by the NICE publishing team.
106	Primary and Community	3.11	99	1-4	The responsibility for the upkeep of the MAR should be a joint	Thank you for your comment. Medicines administration records are for recording the

	Care Pharmacy Network (PCCPN)				responsibility. If the community pharmacist provides a MAR – they will not add any medication that has not been supplied by them-selves (e.g. injectable medicines) which community nurses (in-reach) would routinely administer to the patient in the care home. If the MAR is meant to be a comprehensive record of all medication to be administered for the patient then there needs to be a clear process for this. See also comment to section 3.4.	administration and non-administration of medicines in care homes and it is not the only form of such records. The legal duty to maintain a record is that of the care home provider registered manager or person. There is no requirement stated in the guideline for the MAR to be a comprehensive record.
107	Primary and Community Care Pharmacy Network (PCCPN)	3.11	General		We accept that the ways of working are different for dispensing doctors and community pharmacists however the supply and dispensing process should meet the same good practice guidelines. Therefore, we would suggest that lines 9-10 are removed.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
108	Primary and Community Care Pharmacy Network (PCCPN)	3.12	107	1	Would care homes denaturing CDs need a T28 exemption from environment agency?	Thank you for your comment. The section has been amended to reflect your comment
109	Primary and Community Care Pharmacy Network (PCCPN)	3.13	111	8	There is a typo here: it should read a resident not ‘as resident’.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
110	Primary and Community	3.14	118	6-14	This should include something about ensuring there is a	Thank you for your comment. See section 3.9 of the full guideline.

	Care Pharmacy Network (PCCPN)				maximum daily stated dose on the medicines administration record/care plan.	
111	Primary and Community Care Pharmacy Network (PCCPN)	3.14	118	17	There is a typo: the sentence should not contain the word 'be' before supply.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
112	Primary and Community Care Pharmacy Network (PCCPN)	3.14	general		The way MAR is referred to suggests that they are to be used as prompts for medicines administration rather than solely as a record of what has been given. Is this what is intended to be acceptable practice? If so should the text include a requirement to check the instructions on the dispensing label tally with the MAR before administering each medicine and to question any differences? See also comments above relating to transcribing (Section 3.4). This document does not address the use of unlicensed medicines such as carers being required to crush tablets for people who are unable to swallow or dissolve tablet in water and give a proportion of this (in children services).	Thank you for your comment. The medicines administration record is only a record of administration and does not provide authority to administer the medicine. It is 'for recording the administration and non-administration of medicines in care homes'. This process is different from that in hospitals, where a similar process may be considered to be transcribing. The use of unlicensed and off-label medicines is outside the scope of this guideline. Processes for administering off-label or unlicensed medicines are for local consideration and determination.
113	Primary and	3.14	general		Medication administration record:	Thank you for your comment. A medicine is

	Community Care Pharmacy Network (PCCPN)				Please can it be confirmed here if carers can administer according to the MAR chart even if the instructions on the medication pharmacy label does not fully corresponds to what is written on the MAR chart because for example the dose has recently changed?	prescribed by the prescriber on a prescription form which is then dispensed into a container and is labelled in accordance with the labelling regulations. This label is the authority to administer the medicine. The medicines administration record is only a record of administration and does not provide authority to administer the medicine. Medicines should be administered in line with the most recent prescription to which the medicines administration record should be aligned as stated in the guideline.
114	Primary and Community Care Pharmacy Network (PCCPN)	3.14	120	19-26	External healthcare professionals e.g. community nurses don't use the care home's documentation to record administration of medicines that they have administered. They usually record on their own documentation records. Should care home records have a way of recording that administration for example of injectable medicines has been given by an external healthcare professional rather than their own care home staff. (For example like a code for self –administration?)	Thank you for your comment. See section 3.14 of the full guideline. The guideline development group agreed that this represents good practice.
115	Primary and Community Care Pharmacy Network (PCCPN)	3.14	118	26-28	This paragraph refers to 'prepare medicines in advance for administration' it then goes on to talk about 'This is known as 'potting up' which is illegal and does not follow good practice.	Thank you for your comment. Standard 14 of the NMC Standards for medicines management refers to exceptions in the case of medicines for injection or infusion, not the preparation of tablets in advance to which the guideline refers. This section has been reworded for clarity.

					In children services there may be some use of preparing medication in advanced for individual named children which is also covered by the NMC standards for medicines management (standard 14). It is therefore not helpful to state this is illegal. Therefore, explain these paragraphs in more detail.	See also comment 175 from the Care Quality Commission.
116	Primary and Community Care Pharmacy Network (PCCPN)	3.14	122	27	Could also include a reference to medications sent from care home into schools as an eg here – might even warrant a specific paragraph?	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive, however the section has been reworded to reflect your comment.
117	Primary and Community Care Pharmacy Network (PCCPN)	3.16	133	8	Recommendation: 2.16.2: states that care home staff will sign to confirm they are competent. It should be made more explicit that care home staff should have received training as well and having been assessed as competent.	Thank you for your comment. Section 3.17 of the full guideline already states that training should be provided in line with regulatory requirements. Details of the process are for local consideration and determination.
118	Primary and Community Care Pharmacy Network (PCCPN)	Appendices A	154	12	'the term' needs to be inserted i.e. …NICE uses the term patient……	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
119	Primary and Community Care Pharmacy Network (PCCPN)	Appendices A	153		Include 'Medication Use Review'	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
120	Primary and Community Care Pharmacy	Appendices A	154	15	Poly pharmacy. Should this be 'Prescribed 4 or more regular medicines'? It is noted e.g., The	Thank you for your comment. Please note that the guideline development group agreed that the Department of Health definition of polypharmacy

	Network (PCCPN)				Kings Fund is using a different definition.	set out in the National Service Framework for Older People. Department of Health, March 2001 should be used.
121	Primary and Community Care Pharmacy Network (PCCPN)	Appendices D	162	Disadvantages / administration	1st bullet point needs to be rewritten to remove 'opinion' 'thoughts' e.g. there may be …… which may lead to deskilling ……	Thank you for your comment. This section has been amended to reflect your comment.
122	Primary and Community Care Pharmacy Network (PCCPN)	General			This document is generally written very much from the point of view of care homes for the elderly and doesn't include many examples for children's care homes.	Thank you for your comment. The guideline is based on the available evidence upon which to make recommendations. Evidence identified primarily was in care homes for older people however the guideline development group advised that the principles of the recommendations would be applicable to other care settings. Where recommendations are different for different care settings this is stated.
123	Primary and Community Care Pharmacy Network (PCCPN)	General			Also there is reference to 'evidence' though out the document but no references included. Should the word be 'examples from practices' instead of 'evidence'?	Thank you for your comment. The final published full guideline will include a list of references in appendix G.
124	Primary and Community Care Pharmacy Network (PCCPN)	General			The document does not fully take account of different set-ups for example intermediate care beds (step-up or step-down) e.g., where the council manages a care home, the nursing input is provided by an in-reach model by another provider and the GP input by a private provider who may not have GP patient records but will have medical records on site and	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.

					supply by a local community pharmacy. Clinical pharmacy input by another provider. Hence importance of establishing governance arrangements.	
125	Primary and Community Care Pharmacy Network (PCCPN)	General			The issue of electronic discharges from acute trusts is cover within this document instead of perhaps focusing on the requirements of any discharge from any provider.	Thank you for your comment. The guideline covers transfers to and from care homes, not to and from hospitals which are used as an example of a transfer of care.
126	Primary and Community Care Pharmacy Network (PCCPN)	General			Note that for some care homes (e.g., intermediate care) discharges may be undertaken by care workers who will produce list of medicines (transcribe these from the MAR chart) and send to GP. This is not really addressed in this document.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
127	Skills for Care		27		Skills for Care have a qualification on the Mental Capacity Act which would be an excellent resource to mention in the guideline. http://register.ofqual.gov.uk/Qualification/Details/601_0505_7	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
128	Skills for Care		29	Rec 22	Within adult social care, self-medication should be encouraged rather than an emphasis on responsibility to administer medication. Could a performance standard be created for self-medication?	Thank you for your comment. NICE guidelines do not produce performance targets and this would be outside of the scope of the guideline.
129	Skills for Care	2.3.5	39	Rec 2.3.5	This makes assumptions about access to NHS systems which is not possible within the private or voluntary sector	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

130	Skills for Care		45	24	In a small care home using a second trained person is not likely to be possible because of staffing ratios.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
131	Skills for Care	2.4.5	45		Employers report that some GPs are not supportive of this so can it be applied universally?	Thank you for your comment. The guideline development group has agreed that care home staff should report all suspected adverse events and record that they have done so.
132	Skills for Care	2.5.2	55		In some areas there is not a network of care home providers that can develop locally agreed action plans so this needs to be taken into consideration.	Thank you for your comment. The network need not be restrained to other care home providers and could include local authority or CCGs for example.
133	Skills for Care	2.6.4	69		More explicit detail of what is meant by a safeguarding incident is required as 'potential harm' is a grey area.	Thank you for your comment. A definition of safeguarding and the Care Quality Commission and Department for Education and Skills safeguarding reporting requirements are given in section 3.6.
134	Skills for Care	2.6.9	69		What is 'a near miss' and what is 'resident safety' s referred to here? Could definitions be provided?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
135	Skills for Care		74	1	In this section assumptions are made about seamless systems which allow sharing of information which are not a reality. In general there is not access to GP systems by care homes.	Thank you for your comment. The guideline development group was aware that care home staff may not have access to GP practice systems. Section 3.7 discusses the process of medicines reconciliation in more detail.
136	Skills for Care		74	24	Requesting medication history is a complex procedure. Care homes can request but this is not often provided.	Thank you for your comment. The guideline development group was aware that care home staff may not have access to GP practice systems. Section 3.7 discusses the process of medicines reconciliation in more detail.
137	Skills for Care	2.8.2	83		Care homes are dependent on the CCG's to commission the	Thank you for your comment. The guideline development group have discussed and agreed

					named health professional reviews in all areas of the country.	a change to the recommendation.
138	Skills for Care	2.9.4	90		This has implications for medication that are not given regularly for example PRN, and could result in the PRN being removed from the individuals' available medication to comply with the guideline. If this were to happen it would mean residents may have to wait for a prescription for 24hours.	Thank you for your comment. See section 3.10 of the full guideline for further information about ordering of when required medicines.
139	Skills for Care	2.10.1	95		This needs to explicitly say prescribed medication or an assumption can be made to apply to homely remedies.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
140	Skills for Care	2.10.3	95		Agree in principle however in reality electronic systems give pharmacists as much information as the care home, so pharmacist may be in a position to initiate.	Thank you for your comment. The guideline development group was aware that this is not necessarily true as information about the care home resident and stock levels may not be available through electronic systems.
141	Skills for Care	2.11.2	95		This recommendation is not practical; the DH recommendations recognise this and accept each home will adopt a single home system.	Thank you for your comment. The guideline development group discussed and agreed that a single system for supply of medicines may not be appropriate for a resident living in a care home. The resident should have the opportunity to be involved in decisions about their care and treatment on an individual basis. Under regulation 13 of the Health and Social Care Act (2008) regulated activities regulations 2010, care home providers are required to make appropriate arrangements for handling medicines in care homes to avoid errors.
142	Skills for Care	2.13.2	114		There needs to be a separate bullet which includes a	Thank you for your comment. This section has been reworded following discussion by the

					performance criteria relating to compliance to continue self-medicating.	guideline development group.
143	Skills for Care	2.14.2	126		Because of the amount of recording required for every dose, including those not given, this could potentially give rise to not offering PRN medication which could result in poor care through having to wait for a period of 48hours for prescribed meds.	Thank you for your comment. The requirement to keep accurate records is a regulatory requirement, care homes not offering PRN (when required) medicines, for example analgesia, would potentially be in breach of their duty of care and a likely safeguarding incident may arise.
144	Skills for Care	2.15.1	131		Suggest reword to a more person centred approach. Current wording suggests that there should be a minimum number concerning covert administration. In reality covert admin will vary from establishment to establishment depending on needs of the client group. Suggested wording: covert administration should only be used when it is to support the individual's needs. (This is to cover the variation in the number of residents using covert medication depending on their client group).	Thank you for your comment. The decision to administer medicines covertly is a process to be carried out on an individual basis and should follow the Mental Capacity Act 2005. It should only be used as stated in the guideline, in exceptional individual circumstances.
145	Skills for Care	217.1 & 217.6	131		These effectively repeat each other. Suggest remove one of the recommendations and keep the more positive sounding recommendation in.	Thank you for your comment. These recommendations have been reworded following discussion by the guideline development group.
146	Skills for Care	217.2	131		The roles of the regulator and NICE are not explicit within this	Thank you for your comment. The scope of the guideline determines who the recommendations

					recommendation.	are made for. A 'who should take action' section for the recommendations has been included in the guideline.
147	Skills for Care		139	24	This is the first time self-medication is mentioned in this section. This reinforces concerns around focus on administration of medicines.	Thank you for your comment. The guideline has a section on self-administration of medicines by residents (see section 3.13 of the full guideline). The section on training and competency includes training for all aspects of managing medicines and includes an overview of training required by care staff (see section 3.17).
148	Skills for Care		140	2	Learning providers are not accredited; it is either the course itself or a qualification that is accredited.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
149	Skills for Care		140	6	There will always be an assessor for a qualification.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
150	Skills for Care	2.17.4	142		Learning providers are not accredited it is either the course itself or a qualification that is accredited.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
151	Skills for Care	General			The training section traces the legal requirements and use of qualifications but does not support care homes to identify and resolve issues in accessing accredited or unaccredited learning.	Thank you for your comment. The guideline covers key processes and systems. Access to training is outside the scope of this guideline.
152	Skills for Care	General			On the whole the document is very lengthy so accessibility will be dependent on good presentation and design. Maybe there could be a short explanation of the purpose and how to use it and get the best out of it at the	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published.

					beginning.	
153	Skills for Care	General			The document overall is very health focused whist the intended purpose is social care. A guideline of this nature would be extremely hard to implement in SME's. Many of the recommendations are based on research and data from the health sector, similar reliable data is not available in social care. Throughout the documentation references to nursing and care homes are used interchangeably. This can cause confusion as staffing ratios and levels of training and qualifications will differ greatly within these establishments.	Thank you for the comment. The guideline development group is aware that the systems and processes associated with managing medicines in care homes can appear very health focussed. The evidence in most cases for this topic comes from a health rather than social care perspective.
154	Skills for Care	General			Social Care Homes have a wide range of client groups with varying abilities where independence is encouraged. Much of this guideline development group assumes that medications will be administered. It is very risk averse whereas it would be good to see recognition of positive risk taking.	Thank you for your comment. The guideline includes a section on 'person-centred care'. Care home residents and health professionals (for care under the NHS) have rights and responsibilities as set out in the NHS Constitution for England, and NICE guidelines are written to reflect these. Treatment and care should take into account individual needs and preferences. Care home residents should have the opportunity to make informed decisions about their care and treatment, in partnership with their health professionals and social care practitioners.
155	Skills for Care	General			The content lacks measurable performance criteria which would help care home managers	Thank you for your comment. The purpose of the guideline is to provide recommendations on the systems and process for managing

					implement the recommendations especially in areas such as: medicines compliance adherence, controlled drugs, self-administration	medicines in care homes. The suggested additional performance criteria are out of scope.
156	Skills for Care	General			A significant area that is not covered is stocked medicine especially in relation to what is allowed.	Thank you for your comment. Stock medicines are outside of the scope of this guideline.
157	Skills for Care	General			Skills for Care would like to see a more user friendly document that will encourage engagement and buy in from the sector.	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published.
158	Care Quality Commission	General			This guideline is welcomed and considered a helpful document for care homes and people working with them. The glossary and links are very useful. However consideration must be given to the expected changes to legislation. Regulations and outcomes cited are likely to change after new regulations in October 2014 in both wording of the regulation and the number. This may need to be reflected in this document depending on planned publication date. *Guideline about Compliance: Essential Standards of Quality and Safety* (GaC)– CQC will not continue to use the GaC as a reference document in the future, once we roll out the new	Thank you for your comment. Care Quality Commission regulatory changes in England are expected in October 2014 as a result of the Health and Social Care Act (2012). It is expected that the recommendations in the guideline will not change as a result of this because the guideline is based on current evidence. Following publication of the updated regulations, the guideline will be assessed to ensure that any relevant regulations are appropriately referenced.

					inspection methodology. Although some regulations will change in October 2014 it would be better to refer to regulations. References to the GaC can be found on pgs 11, 17, 41-42, 55, 56, 61, 104, 109, 111, 134, 136, 138, 140, 141, Appendices B.	
159	Care Quality Commission	General			The background to the recommendations is less useful to potential users of the guideline than the recommendations themselves. We would suggest the recommendations are put at the front of each section, with an appendices for users wishing to read further into the reasons for the recommendation.	Thank you for your comment. The format is considered by the NICE publishing team and follows NICE style. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published.
160	Care Quality Commission	General			Has the status of the Royal Pharmaceutical Society Guideline for medicines in social care been established with regard to this guideline as the RPS guideline covers other aspects of social care?	Thank you for your comment. The Royal Pharmaceutical Society guideline was considered as part of the development process for the guideline. Full details of the development process can be found here.
161	Care Quality Commission	General			Some repetition in the document, for example pg 7 & 22, pg 13. It would be easier to follow if developing points were made in one place and repetition avoided.	Thank you for your comment. The format is considered by the NICE publishing team. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published.
162	Care Quality Commission	1.6	9	18	'Pharmacovigilance' is not defined	Thank you for your comment. The cited paragraph defines the MHRA role according to their website. It is out of scope for NICE to define the term on behalf of the MHRA.
163	Care Quality	1.6	10	11-14	CQC's purpose is ' We make sure	Thank you for your comment. This section has

	Commission				health and social care services provide people with safe, effective, compassionate, high quality care and we encourage care services to improve.' This is taken from A New Start http://www.cqc.org.uk/sites/default/files/media/documents/cqc_consultation_2013_tagged_0.pdf	been reworded following discussion by the guideline development group.
164	Care Quality Commission	1.6	12	23-27	Does not explain why DBS is relevant, may not be obvious to people not working directly in the sector.	Thank you for your comment. Wording was considered by the NICE publishing team.
165	Care Quality Commission	3.2	21	13-15	'Patient experience in adult NHS services' Is this relevant to care homes? We feel this should be noted more clearly.	Thank you for your comment. The guideline development group discussed and agreed that many of the principles in the patient experience guideline would also apply to social care settings.
166	Care Quality Commission	3.2	26	3-8	We feel it should be clearer that the assessment needs to take place in relation to each particular decision as having learning disability or illness such as Alzheimer's disease does not necessarily mean that a person lacks capacity to make all decisions. CQC guideline for providers can be accessed on How the Mental Capacity Act 2005 affects you | Care Quality Commission	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
167	Care Quality Commission	3.3	31	31	Information governance toolkit not defined or referenced	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
168	Care Quality	3.6	59	31	In addition to this there should be	Thank you for your comment. This section has

	Commission				reference to Local Authority safeguarding thresholds which may be defined in certain areas (eg Worcestershire – linked here to children and young people https://public.worcestershire.gov.uk/web/home/DS/Documents/Appendices/Cabinet/Agendas%20and%20Reports%202013/Thursday,%208%20March%202013/Worcestershire%20Thresholds%20Guideline.pdf). Also reference to 'No Secrets' which makes it clear that safeguarding is about 'significant harm' https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194272/No_secrets__guideline_on_developing_and_implementing_multi-agency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf	been reworded following discussion by the guideline development group.
169	Care Quality Commission	2.6.4& 2.6.9	69&70		'appropriate' recording to regulators is noted as suitable and refers forward to the information about notifications.	Thank you for your comment. Unfortunately the point of this comment is not clear.
170	Care Quality Commission	3.6	63	20	Root cause analysis – not linked to definition until page 69	Thank you for your comment. This section has been reworded.
171	Care Quality Commission	3.6	67	18-26	Local advocacy not always available	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
172	Care Quality Commission	3.10	94	7	Further explanation of 'appropriate records' would be useful	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

173	Care Quality Commission	3.13	110	22-27	Include resident choice as a factor	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
174	Care Quality Commission	3.14	118	1-14	Suggest including point to underline that prn medicines should be offered when needed not at medicine round times	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
175	Care Quality Commission	3.14	118	27	To state that potting up is illegal there should be reference to the legislation. It would be a breach of HSCA reg 13 'safe administration' but other legal reference should be noted	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
176	Care Quality Commission	3.14	120	6	Insert point from page 121 lines 15-16 'the administration process should be fully completed for each resident before moving on to the next resident'.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
177	Care Quality Commission	3.14	123	15	What separate container is appropriate, should this say 'separate dispensed container'	Thank you for your comment. This section has been reworded.
178	Care Quality Commission	3.17	135	28	Definition of accredited learning provider does not contain any guideline on who may accredit them.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
179	Care Quality Commission	3.17	135-141		Details of training expected is particularly welcomed.	Thank you for your comment.
180	Care Quality Commission	3.8	81	21	Typo 'for'	Thank you for your comment. This section has been reworded.
181	Care Quality Commission	3.14	116	17	Typo 'be'	Thank you for your comment. This section has been reworded.
182	Care Quality Commission	3.14	125	2.14.1	Typo 'using the correct equipment'	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
183	Care Quality	3.16	132		Lacks information about	Thank you for your comment. The section has

	Commission				medicines purchased by resident or family/carer not home and assessment of risks	been updated to include the resident's family or carer. The full guideline states that a process for use of homely remedies should be in place and recorded in the care home medicines policy. The guideline development group agreed that a resident living in the care home should be given the same access to homely remedies as a person living in their own home.
184	Care Quality Commission	3.16	132	15	We suggest this alternative wording 'Advice on the use of homely remedies should be taken for each resident in advance or at the time of need.'	Thank you for your comment. The guideline development group was aware that care home providers have different processes for homely remedies that have been agreed with the resident's GP(s). The guideline development group agreed that contacting the appropriate health professional, for example a GP each time a resident required a homely remedy would be impractical and may delay therapy. It also may not apply to residents who are administering their medicines themselves and who are fully independent. The guideline development group agreed that the homely remedies process should be agreed in consultation with an appropriate health professional and care home provider, reviewed regularly and the processes for the homely remedy should include the specific details as listed in the guideline (see section 3.16 of the full guideline).
185	Care Quality Commission	3.17	139	21-	Additional training needs may include inhalers, oral syringes and other medical devices	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
186	Care Quality Commission	3.17	142	2.17.2	Consider use of 'regulations' not 'regulators' as the regulations dictate the requirements of the regulators.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
187	Registered	General			The need for the document /	Thank you for your comment.

	Nursing Home Association				standard is unquestionable since there has been a lack of transparency and consistency in medication management within Care Homes for many years.	
188	Registered Nursing Home Association	General			The document is very health worded and not social care. The base assumption is that residents are being done to, i.e. have their medication administered to them, rather than the default being that they are self-administering, unless they lack capacity. It should be remembered that in a care home the medication is the property of the resident / patient.	Thank you for the comment. The guideline development group is aware that the systems and processes associated with managing medicines in care homes can appear very health focussed. The evidence in most cases for this topic comes from a health rather than social care perspective. The guideline contains a section 'helping residents to look after and take their medicines themselves (self-administration)' (see section 3.13 of the full guideline). The guideline aims to ensure residents maintain independence for their medicines. The guideline also highlights good practice for systems and processes when residents are unable or need assistance to self-administer their medicines.
189	Registered Nursing Home Association	General			The document is far too lengthy. The continual restatement of legislation and CQC standards (which will be inaccurate within weeks of its launch since the regulations and standards will have changed by mid 2014) does not take the sector forward.	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published. The guideline will be updated in line with NICE processes. Care Quality Commission regulatory changes in England are expected in October 2014 as a result of the Health and Social Care Act (2012). It is expected that the recommendations in the guideline will not change as a result of this because the guideline is based on current evidence. Following publication of the updated

						regulations, the guideline will be assessed to ensure that any relevant regulations are appropriately referenced.
190	Registered Nursing Home Association	General			The DH sponsored work on this subject, in collaboration with the Royal Colleges and all the representative provider organisations ("Safety of medicines in care homes" inaccurately referred to in the consultation document as being attributed solely to the National; Care Forum), will lead to much confusion in implementation. Care Homes will have had this toolkit for some six months in advance of the publication of the NICE guideline and will be using many of the tools. It is vital that the guideline does not conflict with these publications, and that as a minimum, reference is made to the materials in the implementation documentation.	Thank you for your comment. The resources mentioned were not included in the draft guideline for consultation as they were published in the public domain shortly before consultation. Resources have been hyperlinked to in the full guideline where appropriate.
191	Registered Nursing Home Association	General			The Association believes that the essentially legislative and historical content of the guideline leaves a significant gap in what is required of the guideline. The sector wishes the guideline to provide proven methods and systems which can be implemented within Care Homes such that medication administration is safe and	Thank you for your comment. The guideline development has followed the NICE accredited process for 'good practice guidance'. Full details of the development process can be found here. The systematic literature reviews were undertaken by guideline information specialists. Please see appendix G of the full guideline.

					efficient. The historical lack of research into anything which is positive, which is proven to be safe and efficient, over the past few decades has significantly hindered the development of the guideline. It is the Association's view that the development process, therefore, needs to be reviewed.	
192	Registered Nursing Home Association	General			There is a large reliance upon Care Plans. It should be noted that there isn't any national standard for the completion of care plans. They are personal to each home and, whilst there is perception of what should be included in each care plan, there is no common structure for how that will be achieved.	Thank you for your comment. The guideline has been amended to reflect your comment. How a care plan is completed is for local determination.
193	Registered Nursing Home Association	General			Matters which are governed by regulation, and where ensuring compliance is the responsibility of a regulator, should not feature in contracting, or be policed by the commissioner - this is pure duplication and does not meet with current Government policy.	Thank you for your comment. The guideline development group agreed that failure to meet regulatory requirements should always be included within contracting arrangements by commissioners, as a failure to meet regulatory requirements would be grounds for at least a review of contract. Additionally local authorities and local health bodies such as CCGs have statutory requirements in relation to safeguarding that align with regulatory requirements.
194	Registered Nursing Home Association	General			There is confusion over the role and status of this guideline. As it is addressed to Care Homes there will be a presumption that all	Thank you for your comment. As stated in the scope, this guideline is for people and organisations involved with managing medicines in care homes, including:

					of the requirements will have a comply / does not comply consequence to the Care Home owner whereas many of the requirements create a collective response - Care Home owners do not have any power over, e.g. prescribers or District Nurses, to become part of a multi discipline group	• those who live in a care home • care home providers • commissioners • providers of services to care homes and their residents • those with an interest in how care in care homes is provided. A 'who should take action' section for the recommendations has been included in the guideline as a result of this comment.
195	Registered Nursing Home Association	General			Points which fall within scope but are not covered in the guideline are detailed in the following section	Thank you for your comment.
196	Registered Nursing Home Association	General			The most significant omission is the lack of performance targets. Whilst compliance within the general public is reported by the WHO at 40-50%, the degree of compliance required in Care Homes is 100% which results in the deployment of excessive resource and is not achievable consistently in the long term. The quality of life of the resident is therefore depleted by this mis-allocation of resources. At the very least we need to prioritise the recommendations to avoid the situation where all Care Homes are immediately non-compliant as soon as the standard is published.	Thank you for your comment. NICE guidelines do not produce performance targets and this would be outside of the scope of the guideline. NICE are developing a quality standard on managing medicines in care homes. Information can be found here.
197	Registered Nursing Home Association	General			This may well be seen as part of the implementation phase but transparent statements from CQC	Thank you for your comment. The CQC has been a stakeholder in the development of this guideline. The guideline does not form part of

					are vital for the sector to be able to adopt the guideline in a planned and sensible manner. The degree of detail which is required in this respect can be exampled by a couple of instances which have been reported as part of non-compliance by the regulator; • MAR sheet not yet completed when medication just delivered from pharmacy • prescription lost by pharmacy which resulted in non-compliance. In the former case, are Care Homes to refuse to allow medication into the home until a MAR sheet is completed or should the requirement be a MAR sheet is completed before first administration ? In the latter case the Home had requested another FP10 from the prescriber, which was refused, who required the pharmacy to find the original FP10, to no avail. After the inspection the pharmacy did find the FP10, four days after it was issued.	the regulatory framework for care homes and provides recommendations for good practice. The CQC do not inspect against NICE guideline or NICE quality standards although aligning the processes set out in the guideline may demonstrate compliance with regulations on managing medicines.
198	Registered Nursing Home Association	General			In essence the guideline fails to define what is safe. Along with other words such as abuse and harm, we will continue to have local definitions of these words,	Thank you for your comment. The purpose of the guideline is to provide good practice recommendations. Safety of residents is just one part of this guideline.

					often in a subjective, rather than objective manner, leading to inconsistent implementation across the sector, with services being defined as unsafe due to inadequate guideline or lack of transparency within the sector.	
199	Registered Nursing Home Association	General			The lack of performance targets is most keenly lacking in the area of self-medication. If residents who are self-medicating are achieving only the WHO level of compliance, must / should the Care Home remove the right to self -medication and take the responsibility back to the Care Home ? Is this the same for all medication, eg controlled drugs ? This issue must be transparent to Care Homes otherwise we will simply end up in disagreements with the regulator where CQC deem medication unsafe for a particular resident with the Care Home deeming them capable of self-medication but to a lower compliance level, which may result in an overall decision by CQC that the Care Home is non compliant. This issue cannot be left to individual discretion otherwise chaos will result from different	Thank you for your comment. NICE guidelines do not produce performance targets and this would be outside of the scope of the guideline. NICE are developing a quality standard on managing medicines in care homes. Information can be found here. The CQC has been a stakeholder in the development of this guideline. The guideline does not form part of the regulatory framework for care homes and provides recommendations for good practice. The CQC do not inspect against NICE guideline or NICE quality standards although aligning the processes set out in the guideline may demonstrate compliance with regulations on managing medicines.

					inspectors taking different views as well as different Care Homes taking different levels of risk in this area.	
200	Registered Nursing Home Association	General			The second most significant omission is the lack of a definition of stock medication. There is geographic variability as to what stock medication is allowable, as a result of the history of non-national inspection regimes and this issue has never been remedied.	Thank you for your comment. Stock medicines are outside of the scope of this guideline.
201	Registered Nursing Home Association	General			There is little differentiation between care homes with nursing (previously called nursing homes) and care homes which provide personal care only (previously called residential homes). This could lead to registered nurses in nursing homes feeling extremely undervalued and could be seen as challenging the professionalism of registered nurses. For example, the requirement to document why a PRN medication is not given really undermines the skill of registered nurses. We are questioning their judgement by insisting that this judgement is documented. A likely consequence is that IT systems will be used to record a string of	Thank you for your comment. A section 'definitions' has been added to the guideline. The good practice principles of systems and processes for managing medicines in care homes are the same regardless of whether the care home has nursing or non-nursing staff. Where this differs the recommendations reflect this.

					pre-determined answers which will add little to the care of the individual.	
202	Registered Nursing Home Association	General			Potential inconsistencies No mention is made of the DH funded project "Resources for supporting the safe use of medication in care facilities". Those documents recommend such points as the use of a single pharmacy system within a Care Home within the Leadership document. This conflicts with standard 2.11.2.	Thank you for your comment. The resources mentioned were not included in the draft guideline for consultation as they were published in the public domain imminently before consultation. Resources have been hyperlinked to in the full guideline where appropriate.
203	Registered Nursing Home Association	General			The guideline is the first time that all of the disparate standards and requirements have been brought together in one document. However, unless much of the reference to legislation, regulations and standards is removed then the guideline will require rewriting in April 2014 when the new regulations and standards are due to be introduced (subject to Parliament accepting the new Regulations).	Thank you for your comment. Care Quality Commission regulatory changes in England are expected in October 2014 as a result of the Health and Social Care Act (2012). It is expected that the recommendations in the guideline will not change as a result of this because the guideline is based on current evidence. Following publication of the updated regulations, the guideline will be assessed to ensure that any relevant regulations are appropriately referenced.
204	Registered Nursing Home Association	General			The guideline should be reviewed with the aim of making the objective of the guideline to be safe administration of medication whilst providing efficient systems from the Care Home point of view. Otherwise the guideline will end	Thank you for your comment. Unfortunately the scope is unable to be amended once the guidance is in development. The purpose of the guideline is to provide good practice recommendations.

					up as yet another duplicate tick list to be implemented and audited with the consequence of removing resources from improving the quality of life of the resident population.	
205	Registered Nursing Home Association	General			The following section deals with Implementation	Thank you for your comment.
206	Registered Nursing Home Association	General			The implementation project should produce a model medication administration policy which meets the guideline. This may need to be built from options such that it is applicable to all types of Care Homes. The model policy should also provide a set of standard codes for the completion of MAR charts which will become particularly necessary as more electronic systems are developed.	Thank you for your comment. Your comment has been considered as part of the implementation of the guideline process.
207	Registered Nursing Home Association	General			The implementation project should also produce an information governance policy to meet recommendation 2.3.1	Thank you for your comment. Your comment has been considered as part of the implementation of the guideline process.
208	Registered Nursing Home Association	General			The implementation project should also develop an implementation guide which can be implemented in a, say, 15 bed Care Home where, of course, there is no middle management staff managers.	Thank you for your comment. Your comment has been considered as part of the implementation of the guideline process.

209	Registered Nursing Home Association	General			The definition of the performance standard is a vital component which has been missing for several decades. If the guideline is to have a significant effect, rather than another tick list with minimal impact on practice, then this must be considered to be mandatory. The implementation project should pilot the standard to determine which parts of the guideline have an effect on safety or efficiency	Thank you for your comment. The purpose of the guideline is to provide recommendations on the systems and process for managing medicines in care homes. The suggested additional performance criteria are out of scope.
210	Registered Nursing Home Association	General			The barriers to implementation of this guideline are similar to those for any other initiative in social care; the large number of providers, in this case 15,000, most with minimal resources, no resources available for the implementation of the guideline either locally (Health or Social Care Commissioners) or centrally at a national level, the lack of networks to share information through, and the lack of middle management within the services to actually effect change.	Thank you for your comment. Your comment has been considered as part of the implementation of the guideline process.
211	Registered Nursing Home Association		17	4 - 6	The notion is regarding safe and effective use of medicines: "commissioners should ensure that arrangements are consistent. Consistent with what ? There are	Thank you for your comment. The context is local therefore the consistency required is internal consistency within a local area regardless of the level of care as specified in the guideline.

					152 Local Authority commissioners each with their own political lead and their own values and priorities. This is putting more onto commissioners, further, what is the role of CQC in this? Finally, what qualifications would the commissioners have ?	The qualification required by local authorities of their employees is outside the scope of this guideline.
212	Registered Nursing Home Association	2.1.1	19		The guideline has used the CQC guideline and emphasised patient transfer information to include medications rather than the less directive actual meaning of the Regulations.	Thank you for your comment.
213	Registered Nursing Home Association		20	6 - 8	The notion that the person is to retain control of their own medicines and at least be involved demonstrates a basic failing of understanding in the abilities of people needing support from care homes, and the complexity of the support that is given. There is not a question that people need to be in control of their lives however the guideline doesn't recognise this complexity and assumes that commissioners buy services from care homes when there is little support needed	Thank you for your comment. The section referred to is a statement of the need for individualised care of residents and their legal rights as set out in the Mental Capacity Act (2005).
214	Registered Nursing Home Association		28		Insert new Recommendation; Residents should be encouraged to self-medicate as opposed to current practice where the default assumption is that responsibility	Thank you for your comment. Please see recommendation 2.13.1 of the draft guideline.

					for medication rests with the Care Home.	
215	Registered Nursing Home Association	2.2.1	28		The definition of health and social care practitioner is missing from the glossary. The key point is does this include the Care Home registered manager and the registered nurse within care homes with Nursing? Given the definition which is agreed upon here, then all other uses of the term 'health and social care practitioner' must be reviewed to ensure consistency.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
216	Registered Nursing Home Association	2.2.2	28		The issue of consent should recognise that residents in Care Homes are long term residents, rather than episodic, as in hospital. Consent needs to be flexible enough so that there is not a plethora of paperwork required to cover regular repeat events	Thank you for your comment. Care home residents should receive the care and treatment in terms of consent as those individuals living in their own home. If informed consent is required for a new treatment this should be gained appropriately, ongoing informed consent could be implied consent (see links in the full guideline).
217	Registered Nursing Home Association	2.2.4	28		It should be recognised that nurses in Nursing Homes do not have prescribing authority. As such, compliance with this recommendation is outside the remit of the Care Home owner / manager.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
218	Registered Nursing Home Association	2.3.1	39		A model policy on information governance that is applicable to the small care home should be produced as part of the	Thank you for your comment. Your comment has been considered as part of the implementation of the guideline process.

					implementation of the guideline	
219	Registered Nursing Home Association	2.3.5	39		Care Homes do not have access to NHS electronic systems, since they are deemed to be outside the health and social care system. Would this situation need to change to enable this recommendation to be achieved ?	Thank you for your comment. This section has been reworded following discussion by the guideline development group. This recommendation is not specific to care homes, and relates to situations where electronic transfer of information could occur such as between an acute trust and a general practice.
220	Registered Nursing Home Association	2.3.6	39		This is an example of one of those matters which are governed by regulation and where ensuring compliance is the responsibility of a regulator and should not feature in contracting, or be policed by the commissioner - this is pure duplication and does not meet with current Government policy.	Thank you for your comment. This recommendation is based directly on 'Keeping patients safe when they transfer between care providers – getting the medicines right' a document endorsed the Department of Health.
221	Registered Nursing Home Association	2.4.3	48		a) The first sentence in this paragraph does not differentiate between registered nurses and others. The general competence of registered nurses must be acknowledged. b) Why are electronic medication systems excluded from this requirement ? There are no standards for medication systems, not all are bar coded. If we put the MAR charts onto an excel spreadsheet would this exempt from the second person to check? There is no accreditation system for electronic systems and there are many being developed	Thank you for your comment. a) Hand written completion of MAR charts is not part of preregistration nurse training and therefore a nurse may still require to be assessed as being competent to perform this task, this would depend upon the scope of their individual professional practice. b) Evidence regarding the likelihood of error in electronic systems is not currently well understood therefore it is inappropriate to make a recommendation that may have no impact. c) This section has been reworded following discussion by the guideline development group. d) This section has been reworded following discussion by the guideline development group.

					with very different facilities within them. c) Small care homes may not have a second person on duty to undertake this task. It should be recognised that here are circa 60% of residential care homes with less than 20 beds. d) Publicly funded residents of care homes are not financed by Local Authorities to resource this level of staffing; the resourcing is already several hundred pounds per week below cost level, dependent upon the area of the country considered. e) This is a matter of making important what is measureable rather than measuring what is important to the resident. This would, if adopted, result in resources being removed from areas which improve the quality of life. This is already happening with zero tolerance policies from CQC inspectors resulting in lower staffing levels being available to improve support and quality of life.	e) The guideline development group agreed that recommendation 2.4.3 in the draft guideline represents good practice.
222	Registered Nursing Home Association	2.5.2	55		This recommendation is the result of health thinking in large organisations and will not work in	Thank you for your comment. The network need not be restricted to other care home providers and could include local authority or CCGs for

					social care since there is no network of care providers, each Care Home operates in isolation. If implemented in the average 35 bed Care Home then the numbers of incidents will be very small. There is no infrastructure in most geographic areas to bring together such analysis and learning, neither is there the infrastructure at a national level. Hence the principle may be sound, but a lack of knowledge about the sector and resources available make this very unlikely to achieve anything, other than each part of the system ticking the box to say they are prepared to "consider collaborating". • In part this same problem of scale will limit the effectiveness of 2.5.1 for the same reasons. • Page 69 Recommendation 2.6.3 has the same issues as 2.5.2 since there is little opportunity for shared learning	example. The guideline development group recognises that in some if not most areas infrastructure may not yet exist to support such work, however where it does exist or can be developed through existing structures and can be implemented it should be considered; the use of the term consider is in line with NICE grade recommendations.
223	Registered Nursing Home Association	2.6.1	69		The debate outlined on pages 57 and 58 leading to this recommendation identifies what the Regulations require. By	Thank you for your comment. The CQC and regulation do not explicitly state that when a medication incident has occurred that a healthcare professional should be informed (i.e.

					including in the Regulations a reference to the need to report certain medication incidents to a health care professional for him / her to make a judgement on whether there is a need for that event to be reported to CQC would imply that there are certain medication incidents where it is not necessary to report the medication incident to CQC. Further, there are 12,848 Care Homes providing personal care only (CQC State of Care Report 2013) where there is not a health professional employed in the home. To require every medication incident to have to be reported to a healthcare professional will result in a requirement for somebody outside of the home to have to be contacted - who might that be ? The District Nursing Service ? - they do not operate 24 hours per day, so what happens at night ? This recommendation is unworkable.	regulation does not require this action) however in the view of the guideline development group it would be considered good practice to do so. Organisational governance arrangements for managing medicines in care homes are for local consideration and determination.
224	Registered Nursing Home Association	2.6.4	69		The crux of the problems with safeguarding in general is typified by this recommendation. What is the definition of "any medicines	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					safeguarding incident"? The term harm and potential harm are widely used with potential harm having the widest definition when categorising a service as "unsafe". Latest guideline on NHS Choices uses an NPSA definition of harm which requires reporting only when moderate harm (defined as admission to an acute provider) is caused. This definition must be made much more specific than this.	
225	Registered Nursing Home Association	2.6.8	69		In exactly the same way as 2.6.4 the definition of "near miss" is totally inadequate in this recommendation. A paracetamol offered 3hours 59 minutes after the last dose bears no comparison to an error in prescribing / dispensing / administering a controlled drug which could have massive effects on the resident. In situations where residents are refusing medication then this could be regarded as a near miss since they are not receiving their medication. If these were to be included in this recommendation, then they system would collapse under the sheer volume of	Thank you for your comment. The definition of near miss is taken from that used by the National Patient Safety Agency (now part of NHS England). The guideline development group discussed and agreed that individual residents validly refusing medicines may not always be considered to be a near miss. An individual with capacity to make such a decision has a human right to refuse their medicine. This should be managed, in line with the recommendations in the guideline. For those individuals for whom capacity to make a valid refusal may be an issue then an appropriate assessment should be arranged in line with the guideline. The issue of monitoring trends in incidents locally was a recommendation that comes from the Winterbourne view report. The guideline was written in collaboration with

					referrals. There are also regulations which define what Care Homes must report to the regulator, with which these recommendations should not conflict.	the regulator (CQC) and recommendations do not conflict with regulatory requirements.
226	Registered Nursing Home Association	2.6.11	70		This again is not really addressing the problem. Whilst, altruistically, one might like to enable residents to have access to an advocacy service, the reality is that there is very little advocacy, of any description, available around the country. Again, these are guidelines with which Care Homeowners are required to comply, but the facility is beyond the control of the Care Home owner.	Thank you for your comment. This section has been reworded following discussion by the guideline development group. The purpose of the guideline is to provide good practice recommendations.
227	Registered Nursing Home Association		74	1	A) Care Homes do not have access to records within the GP surgery B) A majority of admissions to Care Homes are made from acute providers when the GP record will not reflect the medication regime on discharge, only on admission	Thank you for your comment. A) The guideline development group was aware that care home staff may not have access to GP practice systems. Section 3.7 discusses the process of medicines reconciliation in more detail. B) This section has been reworded following discussion by the guideline development group.
228	Registered Nursing Home Association	2.7.1	75		The notion of reconciliation to this level is too onerous, and we would doubt that pharmacists will be able to attend within a timely	Thank you for your comment. The guideline development group through oral and written evidence have established that medicines reconciliation is a process that is already

					manner to achieve these outcomes. Again it looks that the authors do not understand the variations in medications, and the difficulties in changing prescriptions. We wonder if the practicalities of trying to get thorough for a G.P. visit, or advice when a person is unwell, let alone getting them to attend for a review, is appreciated	undertaken in many places throughout the UK in care home settings often by pharmacists. The guideline development group believe that this represents good practice.
229	Registered Nursing Home Association	2.7.3	75		a) How long a history of medication is required to satisfy this recommendation ? Life history, since first admission to the Care Home? since becoming chronically ill ? b) Whilst Care Homes can request such information, they do not have the authority to require it be produced.	Thank you for your comment. Recommendation 2.7.3 in the draft guideline refers to current medicines. This recommendation is for all providers not just care homes, the information detailed should all be available at a care home. Section 3.2 includes information on confidentiality and transfers of care. This should help ensure that such information is made available to care homes by for example Acute trusts.
230	Registered Nursing Home Association	2.8.1	83		The comments and recommendations on this page are generic, the people who are suggested to attend a review specifically for medication are completely unachievable. All of the review team could look at medications, but are not, other than to influence, in a position to change the wishes of the prescriber The medication review, by definition, must be in the hands of	Thank you for comment. Medication review processes are often undertaken by individuals other than the prescriber. The guideline development group is aware from the literature review and the oral evidence presented, examples of good non prescriber led medication review services existing throughout the country.

					the prescriber, as this is guideline for care homes it is difficult to see what power the Care Home owner / manager has to require the prescriber to undertake a medication review.	
231	Registered Nursing Home Association	2.8.2	83		This recommendation requires CCG to commission a relevant health and social care professional. This should be stated explicitly.	Thank you for your comment. The guideline development group have discussed and agreed a change to the recommendation.
232	Registered Nursing Home Association	2.8.5	84		What happens when the CCG do not appoint a health and social care professional? CQC will hold the Care Home non-compliant when the Care Home does not have the authority to "ensure". The responsibility must lie with the health and social care professional, and the obligation is on the Care Home to cooperate. This is another example of an obligation placed upon a Care Home owner with which he / she is unable to comply because they do not have any powers to require others to play their part	Thank you for your comment. The wording of the recommendation has been amended following further discussion by the guideline development group.
233	Registered Nursing Home Association	2.8.6	84		Medicines adherence - there must be some national guideline on this either as part of the guideline or issued by CQC as part of the implementation. This particularly applies to self-medication. The, subjective, personal preferences of CQC inspectors,	Thank you for your comment. NICE has already published a national clinical guideline on Medicines adherence (CG76).

					commissioners, contract compliance officers and safeguarding staff must not be allowed to continue as it is now, but must be placed within that national guideline. Where there is individual judgement by CQC inspectors, about what is a safe service, there must be consistency and transparency, otherwise service providers will continue with the current chaos in medication inspection.	
234	Registered Nursing Home Association	2.9.4	90		It is difficult to image the scenario where a G.P. prescriber attends a nursing home and, in the care plans for each of the residents, personally writes the information required in this recommendation. This recommendation should apply only to POM medication. This should not apply to lotions or appliances.	Thank you for your comment. See section 3.10 of the full guideline for further information about ordering of when required medicines. This recommendation has been reworded following discussion by the guideline development group.
235	Registered Nursing Home Association	2.9.5	90		This is more complex than stated. For a Care Home to have available stock anticipatory medicines requires a Home Office licence at a cost of several hundred pounds per annum. Who will be responsible for writing, reviewing and updating 'local policies' ?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
236	Registered	2.10.1	95		Stock medicines needs to be	Thank you for your comment. This section has

	Nursing Home Association				covered, if any are allowed. Homely remedies need to be excluded from this recommendation.	been reworded following discussion by the guideline development group.
237	Registered Nursing Home Association	2.10.2	95		Protected time always comes at a cost. With 60% of residents being Local Authority funded, where there has been a downward spiral of fees paid for Care Home residents, this might be difficult to introduce without some improvement in fees paid.	Thank you for your comment. The guideline development group recognise that there are barriers to implementation; however they agree that this should not detract from the evidence which demonstrates that errors are reduced during ordering through having protected time to order medicines.
238	Registered Nursing Home Association	2.10.3	95		With electronic systems pharmacy has access to better information potentially than the Care Home, therefore, requiring the Care Home to have to consent to each and every order might be better wording for the future.	Thank you for your comment. The guideline development group was aware that this is not necessarily true as information about the care home resident and stock levels may not be available through electronic systems.
239	Registered Nursing Home Association	2.11.2	101		This recommendation is not practical and, where it has been implemented, has resulted in serious and consistent errors due to the complexity of managing and administering more than one system at a time within one home. Each Care Home should therefore adopt a single medication system which best suits the health and social care needs of their population. The working group of the Royal Colleges, Care Home providers and DH concluded that this was the only practical solution in their Leadership publication.	Thank you for your comment. The guideline development group discussed and agreed that a single system for supply of medicines may not be appropriate for a resident living in a care home. The resident should have the opportunity to be involved in decisions about their care and treatment on an individual basis. Under regulation 13 of the Health and Social Care Act (2008) regulated activities regulations 2010, care home providers are required to make appropriate arrangements for handling medicines in care homes to avoid errors. Please note that the referred to leadership document discusses a case study, based upon an assessment of need within a specific care home. The document does not advocate that

						every home should adopt a single system, only that it was solution to the problem experienced within that specific care home. Additionally the case study asserts that these are 'early days' and the changes are under planned review.
240	Registered Nursing Home Association		103	Table 3	We believe that, in the case of nursing homes, a community pharmacy must have the appropriate licence to dispose of clinical waste. If this is so, then the guideline should say so.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
241	Registered Nursing Home Association		107	Table 4	This is the first time that stock medication has been mentioned. The word stock has been used here without definition. Should probably be end of life controlled drugs.	Thank you for your comment. The term stock is used throughout the guideline.
242	Registered Nursing Home Association	2.12.3	108		Are we attempting to move all centrally held supplies to the residents room and minimise what is held in Care Home stores ? Is this storage within the resident's room the default position we seek to see Care Homes adopt? Where we are nursing a resident who is essentially bed bound then storage in the room may be very convenient, whereas a resident living with dementia and who spends few waking hours in their bedroom may not wish to continually return to their bedroom for medication.	Thank you for your comment.
243	Registered	2.12.4	108		It is difficult to see the need to	Thank you for your comment. This section has

	Nursing Home Association				discover the expiry date and shelf life of a medication which is to be disposed.	been reworded following discussion by the guideline development group.
244	Registered Nursing Home Association		109	3 - 4	Differentiation needs to be made between true self medication and prompted self medication. The key point here is, again, the performance standard to be achieved, especially at page 112 when the guideline talks about controlled drugs. The key question is what level of compliance using self administration is acceptable before the Care Home deems the risk too high and takes over administration of the medication? If self administration must result in zero tolerance then there will be no self administration. If no other statement is made and no performance standard published then there will be no major push to self administration because the unstated performance standard will be 100% compliance, since Care Home know no other standard from the regulator.	Thank you for your comment. NICE guidelines do not produce performance targets and this would be outside of the scope of the guideline. NICE is not a regulatory body. The purpose of the guideline is to provide good practice recommendations.
245	Registered Nursing Home Association	2.14.1	125		There are areas missing in this recommendation relating to medication setup by district nurses in residential care, eg insulin, syringe drivers etc.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
246	Registered	2.14.2	126		It is excessive to record PRN	Thank you for your comment. The scope of the

	Nursing Home Association				medication to this degree. Within Care Homes with nursing this will devalue the role and judgement of the nurse. Will just become a fixed set of answers, pre-typed onto sticky labels and stuck onto the MAR. Will be measureable but meaningless. If it were restricted to medication other than pain relief then could have some merit.	guideline includes all care homes. This recommendation applies to all care homes.
247	Registered Nursing Home Association	2.14.4	126		The notion of the resident, prescriber and pharmacist agreeing the times seems difficult to follow. The notion of having protected time and then an ad hoc administration seems to contradict itself. Where the qualified nurse is given PRN medication, does their own professional accountability and judgement not count for anything?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
248	Registered Nursing Home Association	2.14.6	127		Clarification is needed as to whether "record when and why medicines have not been administered" means either, a) record when and why PRN medicines have not been administered, or b) Record when and why non-PRN medicines have not been administered. In a) above this, again, is totally excessive and will result in Care Homes taking residents off such	Thank you for your comment. Recommendation 2.14.6 applies to all prescribed medication. The removal of resident's medicines is a decision for a prescriber in consultation with a resident.

					PRN medicines, unless they use them very frequently. When the resident does require them again, there will of course be the 48 hour wait for re-supply, before they are available. In b) above there is a need for consistency in the coding of reasons for non administration, including the whole issue of refusal.	The issue of recording when and why medications have not been administered, particularly in relation to Nursing homes (employing registered nurses) is a requirement of the NMC standards for medicines management (standard 8). The process for recording on medicines administration records is for local consideration and determination.
249	Registered Nursing Home Association	2.14.12	128		Add PILS Leaflet	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
250	Registered Nursing Home Association	2.15.1	131		Whilst the use of 'exceptional circumstances' is correct in a national context there are a very small number of very specialist homes where significant numbers of residents receive covert medication. Hence suggested rewording is "Covert administration should only be used when it is needed to support the individual's needs, and in accordance with the Mental Capacity Act.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
251	Registered Nursing Home Association		137		This section relies on theoretical knowledge of the sector and shows little insight into what currently happens to assess competence or train staff, or what could practically be undertaken. As such this section needs	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					considerable re-writing.	
252	Registered Nursing Home Association	2.17.1 2.17.6	142		Whilst it is understood that the principle of 2.17.6 is that after training there is still the need to determine competence, these recommendations as currently written appear to be the negative of the each other. Remove or re-write 2.17.6.	Thank you for your comment. Wording was considered by the NICE publishing team.
253	Registered Nursing Home Association	2.17.2	142		First sentence. Is the recommendation a learning and development programme or an assessment of competence. They are distinct. Second sentence What requirement of the regulators ? Again the phrase "training and competency" are two distinct activities. Is the standard to undergo training, or to assess competence, or to achieve a defined level of competence? We have tried the training repeatedly, and its doesn't work. Defined level of competence is the only way to go. How it is achieved is irrelevant.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
254	Registered Nursing Home Association	2.17.4	142		This is meaningless since it is qualifications that are accredited. There is no definition of competent assessor and if left to the training providers then they	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					will use PTTLs and the like which will have no effect on the competence of the staff administering medication.	
255	Registered Nursing Home Association	General			By way of conclusion, we would like to reiterate that if this is to be embraced by care home owners and staff it needs to be of a workable size.	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published. Following the implementation needs assessment process a care home medicines policy checklist will be developed to support implementation of the guideline.
256	Steve Turner Innovations Community Interest Company	1.4	6	24-29	Does this guideline apply to Children's Short Break Houses? (This used to be called children's respite) On first reading it does appear to, but children's short breaks can vary from 2-4 days to overnight stays (i.e. less than 24 hours). Stays of less than 24 hrs. may involve medicines reconciliation and administration.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
257	Steve Turner Innovations Community Interest Company	1.4	7	11	Some providers use the term 'community carer' to indicate paid care staff, (which can be confused with unpaid carers).	Thank you for your comment. Wording was considered by the NICE publishing team.
258	Steve Turner Innovations Community Interest Company	3.2	21	4	Should this be 'resident in care homes' to account for short stays?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
259	Steve Turner Innovations Community	3.2	22	21	Should partial administration be mentioned? E.g. if a person spits out part of the medicine or vomits	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Interest Company				(also recommendation 2.2.3 on page 28)	
260	Steve Turner Innovations Community Interest Company	3.3	32	12	*This is a comment only…the default position in relation to medicines should be that all care staff 'need to know'*	Thank you for your comment.
261	Steve Turner Innovations Community Interest Company	3.3	37	3	Would it be appropriate to mention the use of patient held medicine records as a possible solution? There are some local pilots on this for children, and a NIHR project which may be relevant. (links to recommendation 2.3.4 page 39) http://www.clahrc-northwestlondon.nihr.ac.uk/research-projects/bespoke-projects/my-medication-passport	Thank you for your comment. Until evidence exists in a published form the guideline development group are unable to assess the efficacy, effectiveness or cost effectiveness of the suggested intervention.
262	Steve Turner Innovations Community Interest Company	3.4	44	24	? add or partially given'	Thank you for your comment. Wording was considered by the NICE publishing team and is consistent with the quoted NMC standard.
263	Steve Turner Innovations Community Interest Company	3.5	49	13	*This is comment only…it's important in our view to ensure that those reading this understand that some areas are believed to under-report medicines errors, so an increase in reported incidents and near misses can be the first step in improving safety.*	Thank you for your comment.
264	Steve Turner Innovations Community	3.5	54	3	Would it be appropriate to mention the need for governance across the patient's pathway	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Interest Company				here? From our experience it can be difficult to raise and effectively follow up incidents which come to light in one provider services, but originated in another provider's area.	
265	Steve Turner Innovations Community Interest Company	3.5	55	7	? including pathway based governance	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
266	Steve Turner Innovations Community Interest Company	3.7	71	2	…or children with high health needs who may be looked after by several different providers in one day. e.g. Home Care; Special School; Short Break House; Hospital	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
267	Steve Turner Innovations Community Interest Company	3.7	74	3	If the person is also being seen in secondary care it is also vital to obtain the relevant clinic letter. For children, medicines may be obtained from the acute provider pharmacy and may not appear on the GP Patient Profile.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
268	Steve Turner Innovations Community Interest Company	3.9	85	21	We have experienced problems whereby the record of patient's medicines in the care plan is taken as the current list. Measure need to be in place to ensure that there is only one record of the current prescribed medicines, so who transcribes lists of medicines into care plans and how much information is written in the care plan is critical. The concern is that	Thank you for your comment.

					the patient has a list of medicines on their MAR chart and on their care plan, with an associated risks around timeliness of recording, transcribing and accuracy. (See also recommendation 2.9.2 on page 89).	
269	Steve Turner Innovations Community Interest Company	3.13	112	27	Typo? 'the case safe custody'	Thank you for your comment. This section has been reworded.
270	Steve Turner Innovations Community Interest Company	3.14	117	21	? Add 'formulation' as one of the 6 Rs. This is because of the risks around changes to formulations and dosage (e.g. oral to patches etc.), and the different strengths of liquid medicines. (also in recommendation 2.14.1 on page 125)	Thank you for your comment. The guideline development group was aware of variation in the number of 'rights'. The guideline development group agreed that 6 were appropriate for the health and social care audience.
271	Steve Turner Innovations Community Interest Company	3.1.4	124	12	Information on trusted patient (and non-registered staff) friendly information is missing from this page, examples include: http://www.medicinesforchildren.org.uk/ http://www.choiceandmedication.org/cms/?lang=en (also see recommendation 2.14.12 page 128)	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
272	Internal: NICE Social Care Team	1.3	6.	6	Would read better *as " prescribing, handling practices and administration of medicines for* (not "to") *residents"*	Thank you for your comment. Unfortunately the scope is unable to be amended once the guidance is in development.

273	Internal: NICE Social Care Team	1.3	6	9	"products" not "treatments" might be better, and "*considered for use* in care homes"	Thank you for your comment. Unfortunately the scope is unable to be amended once the guidance is in development.
274	Internal: NICE Social Care Team	1.5	7	24	Add in "social care practitioners"	Thank you for your comment. This section has been reworded following discussion by the guideline development group
275	Internal: NICE Social Care Team	1.5	8	6	"resident" not "patient"	Thank you for your comment. The word patient has been used as this is in the context of the NICE patient experience guideline.
276	Internal: NICE Social Care Team	1.5	8	12	"can" not "should normally"	Thank you for your comment. This section has been reworded following discussion by the guideline development group
277	Internal: NICE Social Care Team	1.5	8	24	"retain" not "maintain" and add "including taking decisions not to take medication"	Thank you for your comment. This section has been reworded following discussion by the guideline development group
278	Internal: NICE Social Care Team	1.5	7-9	16 – 5	This section is very NHS-focussed. There needs to be a lot more in there about personalisation in social care, reference to TLAP, the Caring for our Future White paper and forthcoming Care Bill. It also needs to include information and references around children and young people's involvement in their own care and support.	Thank you for your comment. Wording was considered by the NICE publishing team. The guideline development group is aware that the systems and processes associated with managing medicines in care homes can appear very health focussed. The evidence in most cases for this topic comes from a health rather than social care perspective.
279	Internal: NICE Social Care Team	1.6	12	18 onwards	The safeguarding section seems very thin – no mention of the Children Acts 1989 and 2004 (primary legislation for child protection) or the statutory guideline "Working Together" (2013). No mention of Adults multi-disc guideline – "No Secrets" – not currently statutory	Thank you for your comment. This section has been reworded following discussion by the guideline development group

					but soon will be under Care and Support Bill. Also, the Police do have powers to prosecute in cases of neglect. Also, both in both children's services and adult's there are multiagency safeguarding systems that can kick in when medication errors occur – especially particular serious or cumulative ones. – Perhaps to legislation but not really properly covered elsewhere	
280	Internal: NICE Social Care Team	1.6	11	6	The CQC is currently revising its inspection framework and essential standards. This won't be finalised before publication of MMCH but I think it should be acknowledged in this section.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
281	Internal: NICE Social Care Team	1.6	9-12		The role of Ofsted in regulating and inspecting children's care homes needs to be clearly referenced here, with detail regarding managing medicines requirements.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
282	Internal: NICE Social Care Team	3			What relates to children's care homes and children and young people as residents is not clear in the whole of the evidence and recommendations section. For example section 3.2 Involving residents – how does this relate to children and young people who are residents, and what are the	Thank you for your comment. This section has been reworded following discussion by the guideline development group

					differences for them as opposed to adults?	
283	Internal: NICE Social Care Team	3	18	6-7	Figure 1 – it would be helpful if this diagram included the taking of the medicines, ie with the resident at the heart of the system	Thank you for your comment. This diagram refers to medicines management system – systems of management will not involve the resident in this context.
284	Internal: NICE Social Care Team	3.1	17	10	add "process" after "medicines"	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
285	Internal: NICE Social Care Team	3.1	17	15-20	Slightly worried at the implication that it is for commissioners to ensure homes comply with CQC and OFSTED requirements- it is CQC and OFSTED who should have primary responsibility for that.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
286	Internal: NICE Social Care Team	3.2	21	2	Does using the phrase "*not least the issues of*" perhaps overstate the scale of mental capacity as a barrier to involvement; at the expense other things (eg staff attitudes, institutional practices?)	Thank you for your comment. This section has been reworded following discussion by the guideline development group
287	Internal: NICE Social Care Team	3.2	19-27		This sections needs to make reference to personalisation and the TLAP documents and Making it Real statements	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
288	Internal: NICE Social Care Team	3.2	19-27		This whole section needs to be clearer about what relates to children and young people – maybe have an additional section making it clear	Thank you for your comment. This section has been reworded following discussion by the guideline development group
289	Internal: NICE Social Care Team	3.2	23-26		Mental capacity act. These sections should say up front that the MCA only applies to those	Thank you for your comment. This section has been reworded following discussion by the guideline development group

					aged 16 years and above, and therefore the section doesn't apply to children below that age.	
290	Internal: NICE Social Care Team	3.2	28-29		Recommendations. Some of these are only applicable to adults aged 16 and over. It needs to be clear which relate to children and young people.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
291	Internal: NICE Social Care Team	3.4	42	13-14	Repeated on page 44 lines 15-17? (Nearly!)	Thank you for your comment. This section has been reworded.
292	Internal: NICE Social Care Team	3.4	45	18	"Medicine administration records are used as a record of medicines administration" – seems a bit obvious!	Thank you for your comment. Wording was considered by the NICE publishing team.
293	Internal: NICE Social Care Team	3.4	41	6-17	What about standards relating to children's homes?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
294	Internal: NICE Social Care Team	3.4	44	8-14	What about standards relating to children's homes?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
295	Internal: NICE Social Care Team	3.6	57	15-17	Suggest re-written to read "almost all local authorities have a local safeguarding board that oversees the operation of multiagency safeguarding procedures that will require local notification of safeguarding concerns"	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
296	Internal: NICE Social Care Team	3.6	60	1-2	Suggest re-write as "THE guideline development group concluded that care home providers should have a clear process for the reporting of incidents under local safeguarding procedures….." (not to local	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					safeguarding boards, which are strategic bodies) see also page 61 line 13)	
297	Internal: NICE Social Care Team	3.6	60	13-15	I assume here it means that the resident should not be identified - and presumably only when emailing details (as a DPA thing). In any event, however, LAs (and police if involved) investigating abuse do need to have the identity of the resident)	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
298	Internal: NICE Social Care Team	3.6	67	9	Is this Govt policy not just for adults?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
299	Internal: NICE Social Care Team	3.7	73	5-10	Are we clear about whom “the person responsible for the transfer” might be?	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
300	UK Medicines Information (UKMi)	3.3	33	12	Information on how to manage omitted doses is commonly requested from medicines information centres around the UK. Guideline has been developed by UKMi: “NPSA Rapid Response Report: Reducing Harm from omitted and delayed medicines in hospital - A tool to support local implementation”, to assist organisations to develop local guideline on omitted and delayed doses. Although this has been developed for hospital use, care homes may find the document as a useful starting point to develop their own guideline. See	Thank you for your comment. The guideline development group discussed and agreed that this document while potentially useful for trained healthcare professionals may be difficult for many care home staff to understand. The guideline development group opinion was not to include this document.

					http://www.ukmi.nhs.uk/filestore/ukmiaps/RRR09-UKMItool.pdf	
301	UK Medicines Information (UKMi)	3.5	52	27	A resource considering the monitoring requirements for many medicines has been developed by UKMi and information can be accessed through local MI centres.	Thank you for your comment.
302	UK Medicines Information (UKMi)	3.6	69	1	Recommendation 2.6.2 –MI Pharmacists may also be used as a resource for information either in supporting the frontline HCP or in some areas directly by care homes.	Thank you for your comment. The guideline development group was aware of the support offered by UKMi. The guideline provides examples which are not intended to be exhaustive.
303	UK Medicines Information (UKMi)	3.11	97	26	We would recommend community pharmacists should also consider the suitability of individual medicines for inclusion into MCAs (e.g. stability). The newly developed UKMI MCA Database is intended for use by healthcare professionals and makes recommendations on the suitability of solid dose forms for transfer from the manufacturers' original packaging to MCAs. See http://www.ukmi.nhs.uk/secure/MCA/default.asp In due course this will be made available to wider pharmacy audiences once user testing is complete.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
304	UK Medicines Information (UKMi)	3.12	103	19	Medicines Information centres commonly receive enquiries on the suitability of using medicines that have been stored outside of	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					the recommended refrigerated temperatures and provide advice on these scenarios. We would suggest care homes should have processes in place for these circumstances and seek advice from an appropriate pharmacist. The UKMi Fridge Database supports healthcare professionals who may be asked to make decisions regarding use of medicines requiring cold storage where the cold chain has been broken. See http://www.ukmi.nhs.uk/applications/fridge/index.asp Access is through affiliated Medicines Information centres due to the need to contextualise some recommendations.	
305	UK Medicines Information (UKMi)	3.15	129	14	We would suggest the process should also consider the suitability of individual medicines being administered covertly which may include consulting with an appropriate pharmacist for advice (e.g. community pharmacist, care home pharmacist, with support for recommendations from MI pharmacists also available	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
306	UK Medicines Information (UKMi)	3.15	131	1	Recommendation 2.15.3 - We would recommend the process should also consider the suitability of individual medicines being administered covertly which may	Thank you for your comment. This section has been reworded following discussion by the guideline development group

					include consulting with an appropriate pharmacist for advice (e.g. community pharmacist, care home pharmacist, with support for recommendations from MI pharmacists also available	
307	UK Medicines Information (UKMi)	general			Historically, UKMi have handled calls around the use / administration of medicines in care homes (including questions around missed/delayed doses / inadvertent administration of another resident's medication) received by NHS Direct. With the transfer to 111 it is unclear where the support for such advice will be directed and whether commissioned services are aware of these enquiries coming through. If it becomes too difficult / complex to access support there is a risk that patient care will be compromised. Recommendation 2.14.12 should therefore also include the use of community pharmacists as a resource, particularly where they have dispensed the medication for the home.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
308	North Yorkshire and Humber Commissioning Support Unit	General			We did feel it may be more suitable to not start with errors and safeguarding but rather give guideline on getting it right first to prevent the errors and safeguarding especially in a	Thank you for your comment. The format is considered by the NICE publishing team.

					document of this length.	
309	North Yorkshire and Humber Commissioning Support Unit	3.2	22	20 21	The guideline states that the care home staff should record the **reason** a person refuses their medication; however, that person may not wish to give a reason and we felt that this should be clear in the guideline perhaps by adding "if the resident is willing to give a reason" or similar phrase. We also felt that as there are various types of MAR chart that it would not always be possible to record the reason for refusal on the MAR and it may be more appropriate to suggest that the reason for refusal is recorded in the care plan **or** the MAR if space is available for carers notes on the reverse of the chart and the refusal is recorded on the MAR chart. This will also affect recommendation 2.2.2	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
310	North Yorkshire and Humber Commissioning Support Unit	3.1	19		We felt the following areas should also be included in the medication policy Dealing with drug alerts and hazard notifications; key security; Training and competence; Dealing with oxygen	Thank you for your comment. This section has been reworded following discussion by the guideline development group in regard to medicines safety alerts and hazard notifications. The other topics discussed are out of scope for this guideline.
311	North Yorkshire and Humber Commissioning Support Unit	3.2	28	2.2.2	We felt it that it was unreasonable to expect care home staff to record consent in the care plan for each administration of medication. An overall agreement between the resident and the home for how	Thank you for your comment. This section has been reworded following discussion by the guideline development group

					medication is to be handled at the home should be documented. For people who regularly refuse medication it may also be unnecessary to record in care plan each time if a plan is in place regarding this and the refusal is recorded on the MAR	
312	North Yorkshire and Humber Commissioning Support Unit	3.2	25	29	We felt that it was unrealistic to expect a formal **record** of capacity to be made each time a medication is prescribed particularly if the condition causing the lack of capacity is unlikely to improve. A health professional should be recording in the medical records not the resident's care plan which they may not have access to. This would also apply to recommendation 2.2.4	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
313	North Yorkshire and Humber Commissioning Support Unit	3.3	30	13	We agree that medicines reconciliation as described on p34 of the NICE draft is vital on transfer between providers which appears to be the intention of the guideline. This is different from an MUR, which has a different purpose. This also applies to p34 line 1.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
314	North Yorkshire and Humber Commissioning Support Unit	3.3	38	21	We felt that It was unrealistic to expect care home staff, residents etc to be aware of all the unintended side effects of any medications. It is the prescriber's	Thank you for your comment. This section has been reworded following discussion by the guideline development group

					(and dispenser's) responsibility to explain common side effects and answer any concerns. This would also apply to p53 line 22	
315	North Yorkshire and Humber Commissioning Support Unit	3.3	39	2.3.5	While we support the use of electronic transfer we also acknowledge that not all care homes will have access to **secure** electronic systems.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
316	North Yorkshire and Humber Commissioning Support Unit	3.4	44	6	Please would the guideline development group consider specifying the "appropriate period of time" to retain documents. We feel that care homes would appreciate the clarity.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
317	North Yorkshire and Humber Commissioning Support Unit	3.4	44	28	We agree the stated records should be made but also feel that ordering and receipt of medication should be included here.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
318	North Yorkshire and Humber Commissioning Support Unit	3.4	45		Please would the guideline development group use either **medicines** administration record or **medication** administration record here and throughout the document when it occurs - to use both interchangeably creates ambiguity.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
319	North Yorkshire and Humber Commissioning Support Unit	3.4	46	1	We felt it would be appropriate that any text message was followed up in writing as soon as possible.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
320	North Yorkshire and Humber Commissioning Support Unit	3.4	48	2.4.3	We felt that the phrase "with designated responsibility for medicines in the care home" did not add clarity and may prevent	Thank you for your comment. Wording was considered by the NICE publishing team.

					the MAR being updated in a timely fashion depending on how it is interpreted in the home.	
321	North Yorkshire and Humber Commissioning Support Unit	3.5	53	11	Please could the guideline development group consider replacing “drug” round with medication round or medicines round to stay in keeping with medicines administration record.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
322	North Yorkshire and Humber Commissioning Support Unit	3.6			We felt the section on safeguarding was overlong and could be condensed to focus solely on its relationship to medication.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
323	North Yorkshire and Humber Commissioning Support Unit	3.6	58	24	We consider that seeking the advice of a health professional following a medication incident which has reached the resident should be considered essential rather than “good practice”	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
324	North Yorkshire and Humber Commissioning Support Unit	3.7	74	24	We agree that the list of items to include when the resident transfers providers is beneficial. However, we also would suggest that the time the last “as required” dose was administered and day of administration for non daily medication should also be included. The same comment also applies to recommendation 2.7.3 p75	Thank you for your comment. The guideline development group agreed this represents good practice.
325	North Yorkshire and Humber Commissioning Support Unit	3.7	75	2.7.2	We felt that the pharmacist should be included in the other health and social care practitioners in this instance.	Thank you for your comment. The guideline development group discussed and agreed that a pharmacist specifically should be involved in medicines reconciliation.

326	North Yorkshire and Humber Commissioning Support Unit	3.8	79	1	We felt that the care home staff could only request a medication review. It is the responsibility of the health care professional to decide whether to undertake the review or not. It is unreasonable in that case to state that the home has ownership and responsibility to ensure that medication reviews occur as they cannot ensure this.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
327	North Yorkshire and Humber Commissioning Support Unit	3.8	79	16	We feel that rather than naming a specific health professional that it is the responsibility of the general practitioner, or a health care professional delegated by the general practitioner, to ensure that the medication reviews are carried out appropriately. This will also apply to recommendation 2.8.2	Thank you for your comment. This wording has been amended following further discussion by the GDG.
328	North Yorkshire and Humber Commissioning Support Unit	3.8	79	17	We did wonder if multidisciplinary reviews were necessary for all residents or would they be better targeted for those residents with complex needs.	Thank you for your comment. The guideline development group agreed this represents good practice.
329	North Yorkshire and Humber Commissioning Support Unit	3.9	84	2.8.6	We felt that it was also important to acknowledge that the care home staff have a requirement for information and guideline regarding medication in order to provide care for the resident. According to the glossary carers refers to informal or unpaid carers so the requirements of the staff actually providing day to day care	Thank you for your comment. See section 3.14 of the full guideline for the requirements of care staff to have access to medicines information. In the glossary the term carer is used to denote family or friend as an unpaid carer to the resident. Care home staff is the preferred term for those providing direct care to the resident.

					are not covered in the list.	
330	North Yorkshire and Humber Commissioning Support Unit	3.9	86	15	We would suggest that self-**administrating** should read self-**administering**	Thank you for your comment. This section has been reworded.
331	North Yorkshire and Humber Commissioning Support Unit	3.9	87	19	We feel it is unreasonable to expect the prescriber to complete the resident's care plan at the home for any medication including "when required" medication not in the least because they may not have access to it eg if they are not at the care home at the time. We feel that it is the responsibility of the care home staff to ensure that they make appropriate records in the resident's care plan at the home. It is reasonable to ask the prescriber to ensure that the instructions for use have been fully explained to the resident and/or care home staff and preferably provided in writing (this is usually covered by having appropriate directions on the prescription). This comment also applies to recommendation 2.9.2 p89 and recommendation 2.9.4 p90 and any other reference to the prescriber filling in the resident's care plan at the home.	Thank you for your comment. The guideline development group agreed that this represents good practice.
332	North Yorkshire and Humber	3.9	90	2.9.3	We felt that there should be clarification in this	Thank you for your comment. This section has been reworded following discussion by the

	Commissioning Support Unit				recommendation that the care home must update the MAR to reflect changes to medicines.	guideline development group.
333	North Yorkshire and Humber Commissioning Support Unit	3.10	91	1	We strongly felt that any message received by verbal order from a health care professional should be followed up in writing as soon as possible. We also felt that verbal orders were more often encountered in care homes than text messages and that it would be beneficial to have a detailed method of handling such orders as is given for text messages.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
334	North Yorkshire and Humber Commissioning Support Unit	3.10	94	3	We feel that it is important for care homes to see the prescriptions before they are dispensed wherever possible for the regular medication order to detect any errors at an early stage. This has the potential to reduce waste if prescriptions have been issued for items no longer required and prevent any delays in the resident receiving an item if the prescription has not been issued. Would the guideline development group consider including this as good practice in this guideline?	Thank you for your comment. The guideline development group discussed and agreed that it may not always be practical for care homes to see the prescriptions before they are dispensed. This would add an additional burden to the care home in terms of collection, checking then sending to the pharmacy for dispensing. This would also delay and extend the timeline for ordering.
335	North Yorkshire and Humber Commissioning Support Unit	3.10	94	10-16	A) We agree that clear communication is needed between the pharmacy and care home. We suggest that the words “a copy of” need to	Thank you for your comment. A) This section has been reworded following discussion by the guideline development group. B) This section has been reworded following

					be added to line 10 as the MAR chart itself need to stay at the care home. B) Given the RPSGB comments quoted on p45 line 13 would the resident's consent to this need to be documented? We also noted that not all MAR charts are produced with duplicate or triplicate copies so providing copies may impose an administrative and cost burden on the home especially if they do not have a photocopier. C) The need for the care home to inform the pharmacy of any changes does not appear to been made into a recommendation. Would the guideline development group consider doing so?	discussion by the guideline development group. C) This section has been reworded following discussion by the guideline development group.
336	North Yorkshire and Humber Commissioning Support Unit	3.11	96	8-9	We are pleased to see reference to the pharmacist's clinical check which includes the MAR chart as we have encountered many issues with incorrect information on the MAR which would have been picked up if such a check had occurred.	Thank you for your comment.
337	North Yorkshire and Humber Commissioning Support Unit	3.11	98	28	We feel it is inappropriate to try and establish a joint responsibility for the MAR chart which is currently the care home's responsibility as you state on p98	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					lines 11-12. The producer of the MAR chart has a responsibility to ensure that it is correct at the time of production but, if this is a pharmacy or dispensing GP, they cannot be held accountable for subsequent changes made by care home staff, for example if doses of medication change or new medication is prescribed mid-cycle. GPs may not even see the MAR charts so cannot be held accountable for what is on them. It is not practical to suggest that GPs can check every MAR chart for every resident in a care home as a new MAR chart is generated every month. This will produce unacceptable delays in the production of the MAR chart and may delay the administration of medication. It would be helpful if prescribers would sign the MAR chart to authorise medication changes that they make whilst in the home and clarify any queries when requested but they cannot have an overall responsibility for the MAR chart. This issue also affects p99 10-12; p100 17-20 and recommendation 2.11.4 as the same statement is repeated in these places.	

338	North Yorkshire and Humber Commissioning Support Unit	3.11	100	24	In a similar manner to the above comment we feel it is inappropriate to have a joint responsibility for recording allergies on a MAR chart. This is the responsibility of the care home to ensure this happens. They will need to request the information from the surgery (who then will need to supply it) and inform the pharmacy if appropriate (who should add it to the chart at this point) as only the care home knows what information they need or already have. This comment also affects recommendation 2.11.5 as the same statement is repeated here.	Thank you for your comment. This section has been reworded following discussion by the guideline development group. NICE are developing a guideline on Drug Allergy.
339	North Yorkshire and Humber Commissioning Support Unit	3.11	99	24	We felt that discouraging the duplication of MAR charts was too general statement. We agree that the same item should not be on the MAR chart twice and that two MAR charts which are the same should not be operation however copying the MAR chart is recommended in various other parts of the guideline eg to communicate changes to the pharmacy, to accompany the resident in transfers and temporary absence from the home. We feel that this statement should be considered for revision to prevent confusion	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

340	North Yorkshire and Humber Commissioning Support Unit	3.12	102	2	The amount of guideline provided by the document on the receipt of medication is very limited. The home needs to keep records of medication all received in order to maintain an audit trail. This would include medication which is not directly ordered by the care home, for example received on discharge from hospital, received from the resident on first entry to the home or from residents coming to the home for respite care. Would the guideline development group consider adding appropriate information to the guideline including the records that should be kept?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
341	North Yorkshire and Humber Commissioning Support Unit	3.12	102	12	We feel it is important that it is clear in the guideline that the legislation which applies to controlled drugs in care homes for adults does not apply to children's homes including the safe custody requirements.	Thank you for your comment. The section has been amended to reflect your comment.
342	North Yorkshire and Humber Commissioning Support Unit	3.12	102	14	We were unable to locate any regulations called "Safer management of controlled drugs". There is a guideline document produced by the DoH of this name and an annual report produced by CQC. We are aware that CQC also used this phrase in its guideline document in 2010. We also note that this document was	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					updated in February 2013 and the 2006 version has been archived. Care home providers will therefore have to take the newer version into consideration.	
343	North Yorkshire and Humber Commissioning Support Unit	3.12	103	5	We feel that further guideline on storage of medication would be of use. E.g. Does it need locked cabinet? What type of cabinet? What size of storage? Can creams etc. be stored in resident's rooms. Do bland emollient creams in resident's room need to be locked up? We feel specifics assist care home providers in getting the storage right.	Thank you for your comment. The purpose of the guideline is to provide good practice recommendations. Details of the process are for local consideration and determination, based on the available resources and structures.
344	North Yorkshire and Humber Commissioning Support Unit	3.12	104	1	We feel it is important to include that care home staff should not be removing medication from its packaging for disposal. The medication should be left in its immediate packaging unless it has been removed for administration or is CD to be denatured in a nursing home. (outer containers such as cardboard boxes can be removed as can the pharmacies reusable outer containers for MDS. Any patient identifiable information should be disposed of confidentially.)	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles.
345	North Yorkshire and Humber	3.12	104	6	We felt that it was not just a matter of pharmacies "agreeing"	Thank you for your comment. This section has been reworded following discussion by the

	Commissioning Support Unit				to take back nursing home medicines waste. There are legal requirements which the pharmacy would have to comply with to allow them to do so. The nursing home would have to check the pharmacy was compliant with the requirements or they would risk being responsible for the inappropriate disposal of the waste.	guideline development group.
346	North Yorkshire and Humber Commissioning Support Unit	3.12	105	17-23	We are delighted to see that the issue of expiry dates of medication particularly topical preparations has been addressed as we have issues of considerable waste occurring due to inappropriate disposal of these items.	Thank you for your comment.
347	North Yorkshire and Humber Commissioning Support Unit	3.12	105	8	We would strongly recommend removing the word “surplus” from this statement as it implies that unused medication at the end of the month should be disposed of. This is not the case if it is still in use. Care home staff should also be encouraged to work through any excess stock levels that may have accumulated due to inappropriate management of the stock wherever possible in order to reduce waste rather than dispose of it as “surplus”.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
348	North Yorkshire and Humber	3.12	106	1	It has not previously been a requirement to record returns of	Thank you for your comment. The guideline development group agreed this represents good

	Commissioning Support Unit				medication in a resident's records if the full details are elsewhere. The record of medication returned or disposed of that many homes keep includes the residents name- is there a reason for removing the residents name from such records? If a record is to be kept in the resident's records why does it not include the quantity? The record of medicines disposed of is the final piece required to complete the medication reconciliation cycle in the home so must be auditable. The record must contain all the relevant information.	practice.
349	North Yorkshire and Humber Commissioning Support Unit	3.12	106	3	We are not sure about the use of the waste transfer note as we were not aware that residential homes needed them. The environment agency website advises that medicines are treated as household waste from residential homes (allowing them to return the medicines to the pharmacy for disposal) so our understanding is that the duty of care waste transfer note is not required. Nursing homes would have a consignment note for the medicines which would include the relevant code for medicinal waste but not specific names, strengths and forms of each	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					medication. The quantity is usually described by weight on such documentation. Please can you clarify the situation?	
350	North Yorkshire and Humber Commissioning Support Unit	3.12	106	7	We feel that “tamper-proof” containers are not a practical requirement to make as homes tend to add medication over a period of time until the medication is returned to the pharmacy or collected by the waste disposal company. Only nursing homes tend to have sealable containers for medicines waste however these are only sealed (and therefore tamper-proof) ready for transport or if the container is full.	Thank you for your comment. The guideline development group agreed this represents good practice.
351	North Yorkshire and Humber Commissioning Support Unit	3.12	107	1	Although this is in the stated guideline pharmacists and dispensing practices are not required to sign care home documentation (although most do). It is unreasonable to ask the delivery driver from the pharmacy to sign the homes controlled drug register and they would be within their rights to refuse to do so. suggest removing this	Thank you for your comment. The guideline development group agreed that this is good practice and it would maintain an audit trail for controlled drugs.
352	North Yorkshire and Humber Commissioning Support Unit	3.13	112	25	There is a statement that some homes may have a policy which means residents cannot self-administer controlled drugs. Is it appropriate that homes have such a policy? We feel that it is not appropriate (except possibly in	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					homes which are working with drug misusers) if the guideline development group agree would it be appropriate to make this clear in the guideline document.	
353	North Yorkshire and Humber Commissioning Support Unit	3.13	113	11	We felt that this line could be misread to imply that all the controlled drugs for a resident should be included on the same page. To remove the ambiguity we suggest rephrasing to “There should be a separate page for each strength and form of each controlled drug of each person”.	Thank you for your comment. Wording was considered by the NICE publishing team.
354	North Yorkshire and Humber Commissioning Support Unit	3.14	116	13	The Royal Pharmaceutical Society link goes to “The handling of medicines in Social Care” which is intended to be used by social care providers as well as health professionals not just pharmacists and nurses as implied by this paragraph.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
355	North Yorkshire and Humber Commissioning Support Unit	3.14	117	10	We do not agree that specific methods of medication administration should be included in the medication policy itself. If they are to be all methods would need to be included not just some.	Thank you for your comment. The guideline development group agreed this represents good practice.
356	North Yorkshire and Humber Commissioning Support Unit	3.14	118	27	This states “potting up” medication is **illegal**. While we agree it is not good practice we do not believe that is illegal so feel this statement is incorrect and should be amended. Very	Thank you for your comment. Standard 14 of the NMC Standards for medicines management refers to exceptions in the case of medicines for injection or infusion, not the preparation of tablets in advance to which the guideline refers. ‘Potting up’ would be considered a contravention

					occasionally, in exceptional circumstances, care home staff may need to put medication in compliance aid for a resident (eg single lunch time doses). The NMC Standards of medicines management also gives nurses guideline on use of compliance aids and what to do if they fill them.	of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 regulation 13 and would therefore be considered illegal. This section has been reworded for clarity. See also comment 175 from the Care Quality Commission.
357	North Yorkshire and Humber Commissioning Support Unit	3.14	120	22	**We wholeheartedly endorse the stance that health professionals administering medication in care homes should complete the home's records as well as their own documentation**. We have encountered instances where this has not been done where this has caused problems including when CDs have not been entered into the CD registered.	Thank you for your comment.
358	North Yorkshire and Humber Commissioning Support Unit	3.14	121	11	The implication from lines 11-12 is that nurses do not need a second witness but residential care staff do. However, from recommendation 2.14.9 this would not appear to be what the guideline development group intended.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
359	North Yorkshire and Humber Commissioning Support Unit	3.14	121		We agree best practice for controlled drugs is to have two appropriately trained and competent staff deal with controlled drugs. We feel	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.

					emphasis should be placed on both members of staff witnessing the whole process not just the actual administration. We also feel that there must be a procedure in place for what should happen if there is no appropriate second member of staff available as no resident should be without their controlled drug because only one member of staff is available at the time they need it.	
360	North Yorkshire and Humber Commissioning Support Unit	3.14	122		Temporary absence from the home. Although we agree with the information we feel that there is a need for guideline on how the home should deal with the odd dose of medication which needs to go out of the home with the resident, for example when an elderly resident goes to a relative's house for lunch. It may not be possible to get a separate container from the pharmacy and it is not sensible to take a whole MDS system for a medication for a single lunchtime dose for example. We feel clarification on this issue is important as it is an issue which frequently arises.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
361	North Yorkshire and Humber Commissioning Support Unit	3.14	124	6	We agree care home staff should have access to appropriate medicines information and that the patient information leaflet is a	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					good resource. We feel that the BNF may be inappropriate in a residential care home as it is primarily aimed at health care professionals. There is also no mention of the prescriber and the pharmacist as a source of information which they certainly would be.	
362	North Yorkshire and Humber Commissioning Support Unit	3.15	130		We feel that it is essential to include the advice of the pharmacist in the actual administration techniques used for covert administration to ensure that it is carried out in as safe a manner as possible. Would the guideline development group consider including a clear statement about the necessity to obtain and document the advice of a pharmacist in this guideline.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
363	North Yorkshire and Humber Commissioning Support Unit	3.16	132		We feel that the guideline is missing detail regarding the records that the home should keep for homely remedies. They do need to be able to account for homely remedies stock would the guideline development group consider it appropriate to add details of records to be kept regarding purchase, use and disposal. We also feel that is important that staff only administer such medication from the stock	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					purchased specifically for that purpose and from its original packaging as purchased. This means staff have access to all the relevant information provided by the manufacturer of the product. We feel that this should be included in the policy. Would the guideline development group please consider this for inclusion in this document.	
364	North Yorkshire and Humber Commissioning Support Unit	3.16	132	6	We feel that there is a clear distinction between homely remedies as used in conjunction with a homely remedies procedure in a care home and medication bought by a specific resident for their own use in terms of how they are to be handled in the care home. As section 3.16 deals with the care homes stock of homely remedies we feel the reference to residents purchasing their own to be inappropriate in this section. We agree residents could purchase their own over the counter medication and should be supported to do so but feel this would be better addressed in its own section. At the moment this aspect is not covered by this guideline.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
365	North Yorkshire and Humber	3.16	133	4	The guideline states it would be “good practice” for care home	Thank you for your comment. Please note that this is not legally required and the wording is

	Commissioning Support Unit				staff to record homely remedies … on the MAR. We feel that this is essential to ensure a complete record of medicines administration is maintained.	therefore based upon the strength of the available evidence.
366	North Yorkshire and Humber Commissioning Support Unit	3.17	140	3	A) We agree that medication should only be administered by trained and competent staff. We also agree that completion of training does not assure competency. However, we feel that the social care provider has a responsibility to ensure ongoing competency of staff which cannot be devolved to the training provider (accredited or otherwise) and we feel this should be made clear in any guideline for care homes. B) The trainer may be able to assess if the person has the knowledge to administer medication however competency in actually applying this knowledge can only be assessed by observation in practice (as occurs in the NVQ for example). We would consider, therefore, that the appropriate person to assess competency in practice would be the care home provider or their	Thank you for your comment. A) The guideline clearly states the regulatory requirement that providers are responsible for ensuring that staff are trained and competent to perform their role (section 3.17 of the full guideline). B) The guideline development group discussed and agreed that a competent assessor in practice is one that is also fully aware of the required components of the act of administration. Details of the process are for local consideration and determination.

					designated person. This comment would also apply to recommendation 2.17.4	
367	North Yorkshire and Humber Commissioning Support Unit	3.17	140	27	We agree that care staff should have regular reviews of their competency. However, it is not clear in the document who is to undertake this review. Given the emphasis on accredited training and competency assessment in the previous section of the document is the implication that the care home provider will need to call on the external assessor annually for the review? If so this could have considerable cost implications for the care home provider. We feel that the review should be carried out by the care home provider or their designated person.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
368	North Yorkshire and Humber Commissioning Support Unit	General			Please define who “health and social care practitioners” are. It is not clear whether this term includes care home staff or whether it is only intended to cover external professionals. This leads to ambiguity in some of the recommendations as to who they are aimed at eg recommendations for covert administration p131.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
369	North Yorkshire and Humber Commissioning Support Unit	General			We noticed that following things as going through the document which appear to be typing errors or similar so we have included	Thank you for your comment. The relevant text has now been amended to reflect this comment.

					them for information.	
370	North Yorkshire and Humber Commissioning Support Unit	3.2	22	3	Patients should read their	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
371	North Yorkshire and Humber Commissioning Support Unit	3.2	28	2.2.2	Should valid consent and informed consent be present as two separate things? Valid consent could be removed without detriment to the point.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
372	North Yorkshire and Humber Commissioning Support Unit	3.3	30	13	MUR is short for Medicines Use Review not medication as stated in this guideline	Thank you for your comment. This section has been reworded.
373	North Yorkshire and Humber Commissioning Support Unit	3.9	87	8	Should the word “how” be inserted after “about” on this line?	Thank you for your comment. Wording was considered by the NICE publishing team.
374	North Yorkshire and Humber Commissioning Support Unit	3.10	92	22	This states “Maintain an audit trial of records kept” An audit trail of records seems excessive. Should this read "A record of medicines ordered should be kept" or similar?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
375	North Yorkshire and Humber Commissioning Support Unit	3.11	99	18	We feel that it is misleading to recommend that a medication is “taken off” the MAR chart. We agree that the chart should make it clear that a course is completed or a medication discontinued and that acute medication should not be included on the next cycle’s MAR chart but it cannot be removed or taken off the current MAR chart as the record of	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					administration must be retained by the home.	
376	North Yorkshire and Humber Commissioning Support Unit	3.11	99	22	Please see comment immediately above. Medication cannot be “removed” from the MAR chart.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
377	North Yorkshire and Humber Commissioning Support Unit	3.1	112	27	Is there a word or phrase missing on this line as the sentence does not appear to make sense.	Thank you for your comment. This section has been reworded.
378	North Yorkshire and Humber Commissioning Support Unit	3.14	125	2.14.1	The second use of “using the correct equipment” in this recommendation appears to be a mistake. Should it be removed?	Thank you for your comment. The recommendation has now been reworded to reflect your comment.
379	North Yorkshire and Humber Commissioning Support Unit	3.14	127	2.14.8	The wording of this recommendation appears to indicate dual recording on both the MAR and supplementary record but that is obviously not the intent from p121 line 3. Could the recommendation be reworded as it is on p121 for clarification.	Thank you for your comment. Wording was considered by the NICE publishing team
380	North Yorkshire and Humber Commissioning Support Unit	3.14	127	2.14.9	This recommendation states that two members of staff should sign the CD register **and** the MAR chart. This is in direct contradiction to the main body of the guideline p121 line 23-24. We agree with the main body information here and suggest that the recommendation is reworded for clarity and to agree with the main body text.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
381	North Yorkshire and Humber	3.15	129	1-6	It was felt that this implied that care home providers only needed	Thank you for your comment. This section has been reworded following discussion by the

	Commissioning Support Unit				a policy on covert administration if they needed to do it. Much of the information in this paragraph is included in subsequent paragraphs so the guideline development group could consider removing it altogether.	guideline development group.
382	North Yorkshire and Humber Commissioning Support Unit	3.17	138	22	Should “handing” read **handling?**	Thank you for your comment. This section has been reworded.
383	North Of England Commissioning Support Unit (NECSU)		6	8-10	Also medicated dressings / wound care products?	Thank you for your comment. The guideline provides examples including continence products, appliances and enteral feeds which are not intended to be exhaustive.
384	North Of England Commissioning Support Unit (NECSU)	1.5	9	5	may require more clarity regarding what is intended by carers needs	Thank you for your comment. Wording was considered by the NICE publishing team.
385	North Of England Commissioning Support Unit (NECSU)		19	9	Should there be a policy on information governance?	Thank you for your comment. The guideline development group agree that the care homes should have a process for managing information governance. The detail of the process would be for local consideration and determination.
386	North Of England Commissioning Support Unit (NECSU)	3.2	22	23	Suggestion that care plans should have strategy for refusal of **all** medicines? - also see recommendation 2.2.2 p28 same comment	Thank you for your comment. Refusal of medicines is included in section 3.2 of the full guideline.
387	North Of England Commissioning Support Unit		26	23-27	It is often observed that a care home/care home corporate body changes the pharmaceutical provider of medicines based on	Thank you for your comment. The guideline makes reference to the resident being involved in all decision making, this includes the pharmacy they may wish to receive their

	(NECSU)				financial arrangements and not necessarily on the level of service. Could the guideline include that the resident/advocate must be discussed and agree to a change of that residents pharmaceutical provider.	medicines from.
388	North Of England Commissioning Support Unit (NECSU)		30 & 33	13 & 1	Does MUR occur following transfer of a patient post discharge? At the moment pharmacist have to have special permission to do MURs in care home from the LAT.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
389	North Of England Commissioning Support Unit (NECSU)		34	20	The US study referring to pharmacists doing reconciliation is based on the pharmacist working at the home. In the UK however, the pharmacist is often the last to know the patient has gone into hospital so there needs to be a system triggering this information to community pharmacist – who should be responsible for this- the care home/secondary care/previous home? The pharmacist themselves “can only liaise” if they know the patient is in hospital which often they don’t, unless the home informs them. Not all pharmacists have email- fax may be the only practical option at this stage	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
390	North Of England		37	21 and 22	Is this an opportunity for MURs by CPs?	Thank you for your comment. This section discusses medication review not medicines use

	Commissioning Support Unit (NECSU)					review.
391	North Of England Commissioning Support Unit (NECSU)		39		Type error under recommendation 2.3.4 (of when?)	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
392	North Of England Commissioning Support Unit (NECSU)		43/ 46	24 /1	also faxed messages? – also need guideline for recording verbal messages regarding change of doses etc e.g. phone calls out of hours? - also consider rephrase of recommendation 2.4.4 .	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
393	North Of England Commissioning Support Unit (NECSU)		63	21	Need to clarify who the computerised records are reported to, who is to manage this process and who takes charge of the “learning” from these incidents?	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
394	North Of England Commissioning Support Unit (NECSU)		63	30	It would be useful to know how this can be implemented in a small care home with only 1 nurse.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. The guideline development group was aware that this may be an issue for those care homes employing only care staff too. Details of the process are for local consideration and determination. Local consideration may include collaboration with other local care homes.
395	North Of England Commissioning Support Unit (NECSU)		64	11	Who would lead this process and who would funds it.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.

396	North Of England Commissioning Support Unit (NECSU)		70	2.6.8.	How can this be implemented when all local safeguarding bodies in the local authority and CCG do not have a pharmacist involved?	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
397	North Of England Commissioning Support Unit (NECSU)		73	15-18	what are the resource implications of involving a pharmacist, and who funds this?	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
398	North Of England Commissioning Support Unit (NECSU)		78	19	Medication review- “evidence suggests that care home pharmacists should lead med reviews……part of a multidisciplinary team” – who funds this?	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
399	North Of England Commissioning Support Unit (NECSU)		80	28	Should this not be made a contractual requirement as the benefits are enormous?	Thank you for your comment. Please note that it would be outside of the scope of this guideline for NICE to set contractual arrangements. Details of the process are for local consideration and determination.
400	North Of England Commissioning Support Unit (NECSU)		91	10	Could we include a solution such as an emergency supply paid for by the patient or care home, as this applies to anyone in their own home?	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
401	North Of England Commissioning Support Unit (NECSU)		93		Methods of ordering – should there be recognition of electronic prescribing and recommendations about how this may work with care homes? (Would homes get a copy of the dispensing token to check against?)	Thank you for your comment. The guideline development group acknowledged (section 3.12) that electronic systems are in use, however, there was a lack of interventional studies on which to make any recommendations about the use of electronic prescribing systems in care homes.
402	North Of		95		Rec; 2.10.3 – I agree with the	Thank you for the comment. The guideline

	England Commissioning Support Unit (NECSU)				principle as the home should have ownership of stock levels etc but how does this work in reality, many pharmacists offer this service to the homes, also what about electronic prescribing – homes often use the tear off slip to reorder meds – the pharmacy may need to issue a “ticket” to be used in the same way	development group agreed that task of maintaining correct stock levels might be delegated. This remains the responsibility of care home providers and they should assure themselves that this is being done appropriately.
403	North Of England Commissioning Support Unit (NECSU)		99	24	Duplicate MARs - What happens to creams applied in the patient’s room? have previously suggested that “duplicate “ MARs be kept in the patients room for personal care staff to sign for moisturiser creams that have been applied – this is then filed with the other MAR at the end of the cycle. The main MAR for e.g. for cream X” would state see MAR chart copy in patients room. Should this practice be stopped? How do you get around the problem of items like creams or dressings applied in the patients room – these staff may not be trained in meds admin and may not be allowed to fill in the MAR??This is mentioned on page 120 line 30.	Thank you for your comment. The guideline suggests that the production of duplicate medicines administration records should be avoided. Where there is a separate medicines administration record for a particular medicine, for example topical medicines administration record, the guideline development group agreed it would be good practice to make an entry on the relevant medication administration record when a medicine has a separate record for recording administration (for example, ’see warfarin administration record’). Staff who are not trained and assessed as competent to administer medicines should not be allowed to administer medicines.
404	North Of England Commissioning Support Unit (NECSU)		100	Box 5	Additional warnings where relevant / appropriate should be included on the MAR – not just in relation to meals i.e. swallow whole, do not chew, spread thinly	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.

					etc (also is this alluded to on page 98 line 26 under “special instructions”?)	
405	North Of England Commissioning Support Unit (NECSU)		105	20-23	Does this mean that large tubs of cream can be kept until their stated shelf life?	Thank you for your comment. The guideline development group agreed that as long as the medicine is still prescribed and required, within its expiry date and that it does not exceed its shelf life once opened then it should not be disposed of.
406	North Of England Commissioning Support Unit (NECSU)		107	Table 4	Records CDs– non-nursing home. Table reads “ care homes should record the form and quantities of controlled drugs they are returning” – why not name of the drug and strength?	Thank you for your comment. Table 4 is a summary which is adapted from the National Prescribing Centre ‘A guide to good practice in the management of controlled drugs in primary care (England)’. A link is provided to this in the full guideline. The content of the table reflects the content of this document.
407	North Of England Commissioning Support Unit (NECSU)		108	Rec 2.12.4	“if medicine has a short life once opened” and the expiry date is exceeded	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
408	North Of England Commissioning Support Unit (NECSU)		120	Box 7 (pt.3)	The point around single person administration needs further clarification as it is a little confusing. Does this mean only one person should do the medication round?	Thank you for your comment. The statement relates records of administration, rather than witnessing administration.
409	North Of England Commissioning Support Unit (NECSU)		121	12	It specifies non nursing homes, but should this not apply to nursing homes also, e.g. a CD is administered by a nurse and checked by a “second competent checker?”	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
410	North Of England		127	point 3	This requires clarification as per page120 comment above. Many	Thank you for your comment. The statement relates to records of administration, rather than

	Commissioning Support Unit (NECSU)				Learning disability (LD) care homes always have a second person to witness the administration of medication.	witnessing administration.
411	North Of England Commissioning Support Unit (NECSU)		127	2.14.8	This is not very clear. Why would there be a need for a second MAR . Warfarin is recorded on the same MAR chart as other drugs. Using a separate MAR chart will just add confusion. Many care homes have a separate chart to note the current dose and the relevant doses are recorded on the MAR.	Thank you for your comment. The guideline development group was aware of evidence to suggest that there may be separate records for certain medicines (for example warfarin, topical preparations) and the guideline development group agreed that there should be a system for cross-referencing.
412	North Of England Commissioning Support Unit (NECSU)		130	30	*"separate recording sheets should be used*" for emollients, insulin ONS but conflict with p 99 i.e. duplicates not recommended?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
413	North Of England Commissioning Support Unit (NECSU)		123	16	Leave medicines – any comments about avoiding secondary dispensing? Line 16 – talks about "separate lunchtime meds being dispensed " by community pharmacist. Could mention that medication review/discussion with GP may mean that medication changes/dose changes avoid the patient needing a lunchtime medication due rationalising of medication.	Thank you for your comment. Care home staff must not prepare medicines in advance for administration (see section 3.14 of the full guideline). An appropriate time for administering medicines should be agreed with the resident, care home provider, prescriber and pharmacist.
414	North Of England Commissioning Support Unit		126	2.14.6	Should there be a system in place to refer patients who is constantly refusing or under using a regularly prescribed medication. Or to refer	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	(NECSU)				patients when “when required medication” is no longer requested/needed by a patient	
415	North Of England Commissioning Support Unit (NECSU)		128	2.14.11	When resident is “temporarily absent” how is this absence recorded on the MAR? Many MARs have “social leave” code.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
416	North Of England Commissioning Support Unit (NECSU)		131		Should there be any guideline for crushing / alternative administration when swallowing difficulties? - Authorisation by prescriber in care plan and on label if possible?	Thank you for your comment. Section 3.15 relates to covert administration not alternative formulations for those with difficulty in swallowing (see section 3.8 for information)
417	North Of England Commissioning Support Unit (NECSU)		133	Rec 2.16.1	Authorisation by prescriber to administer homely remedies held in care plan	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
418	North Of England Commissioning Support Unit (NECSU)		140	12-15	Does Accredited training actually assess competency of all medication tasks? Staff are required to demonstrate competency of all medicine related processes which may not necessarily be covered by a training course. Some accredited training courses are distance learning / workbook process which would not provide competency assessment only proof of knowledge and understanding	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
419	NHS Anglia Commissioning	3.3	34	26	Our comments are as follows: the best Pharmacists for the	Thank you for your comment. This section has been reworded following discussion by the

	Support Unit				reconciliation of the drugs are stated as Community or Care home Pharmacist. Can this be clarified as to what is meant by Care home pharmacist (likely employer being CCGs, potential role in that work is at a clinical level also, MDT approach etc)	guideline development group.
420	NHS Anglia Commissioning Support Unit	3.3	37	21	A) Our comments are as follows: pharmacy-led review - we agree with this statement - perhaps though it requires to be annotated with Primary care pharmacist led so this would cover CCG pharmacists as well. We totally agree with the confirmation to care home staff and requiring to read/ have information passed on before starting shift. B) Information also would be great if the care staff were to have to know more and understand more about medication, side effects, monitoring - could they have an individual or individuals assigned to become expert staff on the particular resident. Others could then asked them if necessary about meds, side effects, timing of medication etc.	A) Thank you for your comment. Wording was considered by the NICE publishing team. B) The guideline development group was not aware of any evidence that would support such an intervention from its literature search.
421	NHS Anglia Commissioning Support Unit	3.3	38	25	Our comments are as follows: handover of patient medication changes - could also include recording of information in care plans and MAR charts to ensure	Thank you for your comment. Wording was considered by the NICE publishing team. Agency staff are not excluded from the responsibility of the care home provider under

					all signatures, GP visits and outcomes are noted for all to be aware of including agency staff. **AGENCY staff** – need particular guideline relating to these staff. We have found on several occasions that these staff are the cause of problems with meds - not giving , unsure of side effects, timings of medications, process of medication rounds, need for information handover, many have lack of training.	the Health and Social Care Act (2005) to ensure staff are trained, therefore the care home provider is responsible for them in the same way as they are for directly employed staff.
422	NHS Anglia Commissioning Support Unit	3.4	48		Our comments are as follows: Recommendation 2.4.1 - storage of records for an appropriate period - can the guideline provide details of what constitutes the appropriate time - this will help those reading it to pass on the information to the care homes. It would be good for NICE to clarify this.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
423	NHS Anglia Commissioning Support Unit	3.5	54		Our comments are as follows: Could there be something added regarding the need for notification of errors to the relevant person in a timely manner and not leave it thinking someone else will report eg Pharmacy if dispensing, GP if wrong medication, extra medication etc is sent to home and the home identify this as a potential error. ie. it is the individuals responsibility if they	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					are the one who notices an issue.	
424	NHS Anglia Commissioning Support Unit	3.6	58	26	Our comments are as follows: can this include primary care care-home pharmacist as it does earlier in the guideline?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
425	NHS Anglia Commissioning Support Unit	3.6	64		Our comments are as follows: we agree that shared incident reporting at a local level will allow learning from safeguarding incidents.	Thank you for your comment.
426	NHS Anglia Commissioning Support Unit	3.6	67		Our comments are as follows: We are unsure what is meant by the term advocate here. Such an advocate would need have some knowledge about medicines to enable them to comment on the prescribing. Should clarity of the role be added here?	Thank you for your comment. The guideline states what an advocate includes and that the guideline development group was aware that advocates need to be trained to some degree in medicines (see section 3.6 of the full guideline).
427	NHS Anglia Commissioning Support Unit	3.6	70		Our comments are as follows: could it be a suggestion that primary care pharmacists be independent advocates for the patient?	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
428	NHS Anglia Commissioning Support Unit	3.7	71	15-24	Our comments are as follows: improved safety for the patient is not mentioned in the bullet points- but has been mentioned elsewhere in relation to medication reconciliation in the conclusion? Should it be bullet pointed as this would emphasise its' importance.	Thank you for your comment. Wording was considered by the NICE publishing team. Reducing the risk of medication error and adverse effects of medicines are included as a bullet point.
429	NHS Anglia Commissioning Support Unit	3.7	74	1-3	Our comments are as follows: should this perhaps have included all recent available information	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					regarding medication - including discharge summaries as these may not have been actioned at the surgery, or actioned wrongly or not contain all medications eg Clozapine.	
430	NHS Anglia Commissioning Support Unit	3.10	92	3, 6	Our comments are as follows: regarding Box 4 Considerations for the care home medicines ordering process and the statement on line 6:*Use an up-to-date medication administration record or other accurate record of the resident's medication when ordering.* Should include instruction here to refer to what is on the repeat prescriptions. Our concern is regarding the many times we have seen new medications added or doses changed but have never been initiated as homes have ordered using existing MAR charts and have never looked at what is listed on repeat. A prime example recently - a renal failure patient attended the renal clinic in August and letter to GP stated restart Phosex as phosphate levels elevated. This was added to repeat but by November it has never been ordered and restarted as the home were unaware it's on repeat. And we wonder why patient is still hypocalaemic! Of	Thank you for your comment. This section has been reworded following discussion by the guideline development group

					course this also depends on communication from the practice and relies on them keeping repeats up to date and current as it could end up with obsolete meds being reordered!	
431	NHS Anglia Commissioning Support Unit	3.11	98	22	Our comments are as follows: could this perhaps include the necessity of including prn medication on the MAR if still current as part of the up to date sentence. (Some of the pharmacy systems drop off those items not prescribed after 3 - 6 months even though the medication has been reviewed and remains current)	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
432	NHS Anglia Commissioning Support Unit	3.12	103	28	Our comments are as follows: no mention of the consideration of person centred administration where medication is stored in residents' rooms and the temperature of the room - risk assessment required for this.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
433	NHS Anglia Commissioning Support Unit	3.13	114		Our comments are as follows:recommendation2.13.4 should a recommendation also be made to highlight the acceptance of medication from the care staff by way of a resident's signature on the MAR if the home does the ordering of the medication on the residents behalf?	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
434	NHS Anglia Commissioning	3.14	123		Our comments are as follows: this does not mention that when	Thank you for your comment. The guideline states that care home providers should have

	Support Unit				medication is given to the patient for temporary absence, all medication should be given to them and not secondary dispensed into other containers. Would be good to have this clarified.	processes in place to ensure relevant medicines are sent with a resident when they leave the home for a temporary absence. If the resident is away for lunchtime only then any medicines that are taken in the evening need not be sent. Appropriate arrangements should be made between the care home and the supplying pharmacy to avoid secondary dispensing.
435	NHS Anglia Commissioning Support Unit	3.15	129	27	Our comments are as follows: Covert administration - nothing has been mentioned about the medications themselves in this circumstance eg the discussion with the pharmacist to ensure the medicine is safe to add to food, crushing is allowed, bioavailability etc. The sentence notes the inclusion of pharmacist but needs expanding to cover the content of the discussion, the need for a medication review, clear instructions from the GP as to how the medication will be given - unlicensed use and liabilities of the parties involved etc. Need to ensure adequate guideline is provided to the care staff on how the medication should be administered, bitter taste of some medications. The need to ensure the covert medication is not making the patient worry about their food and being put off eating by the addition of the medications etc.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

436	NHS Anglia Commissioning Support Unit	General			Our comments are as follows: Wording, style & format: it needs to be borne in mind that care home staff are amongst the target “audience” for this guideline, and that literacy level amongst this group of workers can be very variable. Whilst we recognise that the guideline does need to cover the evidence, research, reports etc which have contributed to our current understanding, it does seem in places to be repetitive and long –winded (which probably means it won’t be read!). Attention needs to be paid to the use of plain language, particularly in the quick reference guide, which will probably constitute the prime working document for most care homes.	Thank you for your comment. A NICE guideline, full guideline and ‘Information for the public’ versions will be published. A NICE pathway will also be published. Wording and formatting was considered by the NICE publishing team. The guideline will be updated in line with NICE processes.
437	NHS Anglia Commissioning Support Unit	Appendices			There is repeated reference to issues which should be covered by/included in a homes’ medication policy. A useful appendices would be a summary of all the areas which a medication policy should cover – almost	Thank you for your comment. The implementation needs assessment has identified a need for a ‘care home medicines policy checklist’.
438	Central Manchester university Hospitals NHS Foundation Trust	General			Very thorough overview of medicines within a care home setting. It will be an excellent reference source for local policies and procedures. Capacity section is good in regards to learning	Thank you for your comment.

					difficulties.	
439	Central Manchester university Hospitals NHS Foundation Trust	General			The terms Primary Care and Community Pharmacist are used throughout document. However, Community Services Pharmacist may be an equally appropriate term and in some cases more accurate term following organisational reforms. Primary Care Pharmacist generally refers to someone employed within CCG, and Community Pharmacist to someone working in retail pharmacy, whereas a Community Services Pharmacist is employed by a provider organisation and provide a clinical service to patients within the community and in care homes. These pharmacists were previously employed by PCTs but post-TCS tend to now be employed by acute trusts. The current model implies that CCG pharmacists have a commissioning role and would therefore not perhaps be expected to have a provider role as well. the current drive to reduce waste associated with medicines is at odds with the current pharmacy contract and may create challenges	Thank you for your comment. A section 'definitions' has been added to the guideline in response to your comment.

440	Central Manchester university Hospitals NHS Foundation Trust	General			The document needs to be clearer when the evidence is being discussed and the final view of the CDG; it often seems like repetition of the same point rather than a final conclusion. The recommendations are clear once in the boxes. There is also switching back from adults to childrens and not clear if switched back in next paragraph-needs to be clearer.	Thank you for your comment. The format is considered by the NICE publishing team and follows NICE style. A NICE guideline, full guideline and 'Information for the public' versions will be published.
441	Central Manchester university Hospitals NHS Foundation Trust					
442	Central Manchester university Hospitals NHS Foundation Trust	3.3	34	26	Community services pharmacists should be included.	Thank you for your comment. Wording was considered by the NICE publishing team.
443	Central Manchester university Hospitals NHS Foundation Trust	3.3	37	21 and 22	This sentence needs clarification as non-pharmacists would not understand the meaning behind this statement.	Thank you for your comment. This section has been reworded following discussion by with the NICE publishing team.
444	Central Manchester university Hospitals NHS Foundation	3.3	37 and 38	27 onwards	Residents can visit out-patient appointments etc when medicines may be supplied/ changed. Can it be clear that in addition to this paragraph that changes etc	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Trust				should be provided in writing to be sent with the patient for the care home. Often they return and something has been stopped but there is a delay in this information being communicated.	
445	Central Manchester university Hospitals NHS Foundation Trust	3.3	38	20,21,22	Good point regarding side effects but does not follow with the paragraph above and below.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
446	Central Manchester university Hospitals NHS Foundation Trust	3.4	45		Text messaging of patient identifiable data contravenes information governance principles, because text systems are inherently insecure and potentially breach patient confidentiality. There is no permanent audit trail if text messages are deleted immediately after receipt. Although the provenance of a text message could be tied to a particular device, it is not possible to confirm that the sender was the device's owner. Care staff are not registered with NMC. Although it is appropriate for text messaging to be covered in medicines policy it should be to exclude rather than permit/encourage.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
447	Central Manchester university	3.5	49	16	Guideline describes errors related to ordering medicines but it is not included in this section as an	Thank you for your comment. The guideline development group acknowledge that ordering delays are common and in some circumstances

	Hospitals NHS Foundation Trust				error. Ordering delays could lead to omitted medicines and possibly serious harm and unfortunately very common. Ref NRLS omitted /delayed doses.	may lead to resident harm. However ordering systems and processes are included in the full guideline (see section 3.10).
448	Central Manchester university Hospitals NHS Foundation Trust	3.5	49	14,15	Section states care homes are not nhs services. CMFT Intermediate care service is based in a registered care home. It is a partnership arrangement between the NHS trust and the private care provider. NHS staff administer medicines to nursing patients and to certain types of residential patients. This type of service and the unique types of patients(e.g. promoting independence etc) need to be acknowledged. Community Services pharmacist provides a clinical service to this Intermediate Care service.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
449	Central Manchester university Hospitals NHS Foundation Trust	3.6	58	21-26 and recommendation 2.6.2	Community services pharmacists/ medicines management teams added as an appropriate person.	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
450	Central Manchester university Hospitals NHS Foundation Trust	3.7	70		Medicines reconciliation and transfer of care are very closely linked and Meds rec needs to occur after each transfer of care. This is stated but should be in the same section as there is considerable overlap or at least	Thank you for your comment. The format was considered by the NICE publishing team.

					cross-referenced.	
451	Central Manchester university Hospitals NHS Foundation Trust	3.7	71		Levels of medicines reconciliation have been defined and are used by most NHS trusts. Could this be included? Many of the people stated to be involved in this in care homes would be completing level 1, pharmacists would provide a different level and this should be clear on the difference on quality. Limited evidence available but could a time frame be included for care homes.	Thank you for your comment. The guideline development group was not aware of levels of medicines reconciliation. The full guideline provides information about medicines reconciliation (see section 3.7). Details of the time frame are for local consideration and determination, however the process should be carried out in a timely manner.
452	Central Manchester university Hospitals NHS Foundation Trust	3.8	81	21	Word ‘for’ needs to be removed.	Thank you for your comment. This section has been reworded.
453	Central Manchester university Hospitals NHS Foundation Trust	3.8	84	Rec 2.8.6	Could it include documentation criteria?	Thank you for your comment. The guideline development group discussed and agreed that the recommendation should not include this detail. Details of the process are for local consideration and determination.
454	Central Manchester university Hospitals NHS Foundation Trust	3.9	87	8&9	Needs rewording to clarify meaning	Thank you for your comment. This section has been reworded.
455	Central Manchester university Hospitals NHS	3.11	94	4-14	Needs clarification, are you suggesting that these are options that are considered good practice or current practice. Guideline	Thank you for your comment. This section has been reworded following discussion by the guideline development group

	Foundation Trust				suggests later that community pharmacy ordering without home involvement is not ideal. It needs to be emphasised that this is not good practice here too.	
456	Central Manchester university Hospitals NHS Foundation Trust	3.11	94	10-16	Needs rewording as GPs and prescriptions should be involved in that 3 way conversation	Thank you for your comment. Wording and formatting was considered by the NICE publishing team.
457	Central Manchester university Hospitals NHS Foundation Trust	3.11	98	6 onwards	Copies of prescriptions should be available to write a MAR chart. Guideline doesn't state an appropriate source to provide these lists. Ideally should be prescription and not boxes of medicines.	Thank you for your comment. The guideline development group discussed and agreed that the prescription might not always reflect what the care home resident was taking. The guideline development group agreed that when the care home provider produces the medicines administration records, there should be a process in place to check that the details are correct for all entries made on the record.
458	Central Manchester university Hospitals NHS Foundation Trust	3.11	98	24	NHS number recorded	Thank you for your comment. Care home records are not NHS records. The care home would have to request permission from a resident to obtain this information from an appropriate source. The guideline development group discussed and agreed that there would be no way of checking this information against the resident (as they do not wear identity as is the case in hospital) and so the recording of the NHS number would not be helpful.
459	Central Manchester university Hospitals NHS Foundation	3.11	99	26-28	Make it clear that if resident has 'no known allergies' that this is also written on the record instead- good practice. Also consider related allergies that may impact	Thank you for your comment. NICE are developing a guideline on Drug Allergy.

	Trust				on drug safety, e.g. eggs, fish, nuts, etc.	
460	Central Manchester university Hospitals NHS Foundation Trust	3.13	109	6-8	Limited patients will automatically be transferred to care homes after acute care admission. Independence will need to be re-established and therefore they are unlikely to self-administer initially but will require additional support to regain this independence if possible. This type of scenario and the support required has not been included.	Thank you for your comment. Wording was considered by the NICE publishing team.
461	Central Manchester university Hospitals NHS Foundation Trust	3.13	112	20 onwards	In our learning disabilities setting, buccal midazolam is not kept in the CD cupboard as it is not a legal requirement. The guideline states to keep all CDs in a cupboard. This would delay treatment for seizures which is common in clients with learning difficulties. It might also create storage issues if schedule four and five CDs needed to be stored as CDs. This is also at odds with the requirements relating to storage of CDs that are self-administered by residents.	Thank you for your comment. The full guideline makes reference to relevant controlled drugs legislation for care home providers to comply with when handling certain schedules of controlled drugs. The guideline has not specified the storage requirements of each schedule of controlled drugs, but has provided guideline on how to store controlled drugs depending on care home staff administration and self-administration by residents.
462	Central Manchester university Hospitals NHS Foundation Trust	3.14	123	2-4	Please clarify, list of current medicines and a copy of MAR. Where is list coming from, are we encouraging staff to write out lists of medicines which would be inappropriate. Should it state copy of printed repeat prescriptions	Thank you for your comment. Printed repeat prescription lists may not always be up-to-date or current. The guideline development group agreed that the care home should have this process documented in their care home medicines policy to ensure a current list is supplied by the care home staff.

					list?	
463	Central Manchester university Hospitals NHS Foundation Trust	3.14	124	1 onwards	Many care homes do not provide online access to staff. They are also not allowed to have phones on shift due to safeguarding issues so accessing online information would be impossible. Could this be more strongly worded to support the staff to gain access or have BNFs purchased for their units.	Thank you for your comment. This section has been reworded following discussion by the guideline development group. NICE provides access to the British National Formulary (BNF) and British National Formulary for Children (BNFC) in digital and print formats for prescribers working in the NHS in England. We also provide access to the Nurse Prescribers Formulary (NPF) in print format to community practitioner nurse prescribers in England. NICE encourages the use of the most up to date medicines information but cannot mandate the purchase of BNF print copies for non-NHS staff.
464	Royal Pharmaceutical Society	General			One of the key recommendations from the CHUMs report stated that 'Someone should be responsible for the safety of the whole medicines system in a care home; the underpinning philosophy in the pharmacy White Paper (2008) suggests to us that this could be the responsibility of a pharmacist'. The RPS believes that 'someone' must be a pharmacist. The RPS report 'Improving Pharmaceutical Care in Care Homes' also recommends that 'Improvements in pharmaceutical care of people in care homes can be made by permanently integrating a	Thank you for your comment. The guideline development group was aware that there are legislative barriers to a single individual being responsible for the whole medicines system in a care home. These include the duties placed upon the registered person in the Health and Social Care Act (2008), for example. This means that although some tasks could be delegated to others the legal responsibility remains with those persons identified in the legislation. The guideline development group found no robust evidence to support the permanent integration of a dedicated role from community pharmacists and care home or primary care pharmacists. The recommendations in the guideline are based on the evidence available. A. The guideline recommends the involvement

					dedicated role from both community pharmacists and pharmacists in the managed service sectors' In order to improve medicine, and thereby, patient safety we would expect A. Every care home to have access to a pharmacist responsible for the whole management of medicines in that care home including the optimisation of medicines B. If the care home caters for a particular speciality the pharmacist involved should have training in that speciality or formalised support from a pharmacist trained in the area. C. Pharmacists should supply medicines in original containers except for circumstances where the patient needs a compliance aid to assist with self-administration D. Residents of care homes should be encourages to self-administer whenever possible E. There should be clarity about how such pharmacy roles can be funded If a patient is cared for in a hospital they would expect care from a clinical pharmacist. They	of a pharmacist for managing medicines in care homes where evidence demonstrates there is a positive outcome for care home residents. B. The guideline development group are unable to comment on whether this is feasible given the wide variety of care home residents. C. The supply of medicines including the use of original packs is covered in section 3.11 of the guideline. D. The self-administration of medicines is covered in section 3.13 of the guideline. E. The funding of pharmacy roles is outside the scope of this guideline. The guideline development group agreed that as a care home is most often seen as the residents own home, the services that are available to care home residents should reflect those available to the general population in their own home, not that of a hospital population.

					should be entitled to the same care in a Care Home with the same level of control and oversight of medicines that is currently routine practice in a hospital. We would expect the pharmacists to be responsible and accountable for all medicines governance and medicines related issues within a Care Home. This model would ensure better patient care and lead to a reduction in medication errors within Care Homes and also a reduction in admissions and readmissions	The guideline development group did not identify any evidence of efficacy, effectiveness or cost effectiveness to support this statement.
465	Royal Pharmaceutical Society	General			We are pleased to see NICE recognition of the RPS guideline 'Keeping patients safe: Getting the medicines right' and our guideline on Multi-Compartment Aids.	Thank you for your comment.
466	Royal Pharmaceutical Society	General			MURS and NMS services should be integrated into the care pathways of Care Home residents. These patients are often the most frail and vulnerable and yet do not have access to these services which they would have if they lived independently.	Thank you for your comment. MURs and NMS are commissioned locally for care homes residents. MURs are not routinely commissioned for care home residents as they often received support from care staff for their medicines. An MUR may be appropriate for those residents who are managing and looking after their medicines themselves – although the commissioning of this would be for local determination.
467	Royal	1.5	8	25	In order for good communication	Thank you for your comment. Please see

	Pharmaceutical Society				between health and social care practitioners etc to occur all those involved in the patient's care need to have access to the patient record.	section 3.3 of the full guideline which includes the Caldicott principles for sharing information.
468	Royal Pharmaceutical Society	1.6	11	16-28	The RPS believes that each Care Home should have a pharmacist who is responsible and accountable for the management of medicines within that setting. They would oversee all the tasks listed under Outcome 9 of the Essential standards of quality and Safety (CQC).	Thank you for your comment. The choice of pharmacist (and GP) is that of the care home resident not that of the care home. The guideline development group agreed that residents should have the risks and benefits of choosing to either adopt the preferred care home GP or pharmacist or one of their own choosing explained to them. The resident should be supported in making this decision for themselves in line with the principles of resident involvement and resident choice set out in the guideline.
469	Royal Pharmaceutical Society	2	13	1 onwards	If, as we recommend, each Care Home had access to a pharmacist with responsibility for the whole management of medicines in that care home then all of the sub sections under 2 would be overseen by such a pharmacist.	Thank you for your comment. The choice of pharmacist (and GP) is that of the care home resident not that of the care home. The guideline development group believe that it is in the interest of the resident to have multi-disciplinary care of care home residents in line with their rights and wishes.
470	Royal Pharmaceutical Society	3.2	21	8-9	This states that residents in a care home have the right to access the same services and support as for those people who do not reside in a care home. This is not currently the case in relation to the undertaking of Medicine Use Reviews (MURs). MURs can only be carried out in a Care Home with the consent of the	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					Area Team and this is extremely variable across the country.	
471	Royal Pharmaceutical Society	3.5	54	3-5	The CHUMS report spoke about lack of ownership of the whole medicines system and leadership in reducing medication errors. We believe that having a pharmacist who is responsible and accountable for the management of medicines within that setting would reduce medication errors as they would provide the oversight across the whole system.	Thank you for your comment.
472	Royal Pharmaceutical Society	3.5	54	15	The RPS believes that medication reviews conducted by a pharmacist for all residents at least every 6 months is critical and should be a 'must do'.	Thank you for your comment. The guideline development group reviewed the literature on medication review and found no evidence supporting the use of medication review every six months in all care home residents (see section 3.8 of the full guideline). In line with NICE style for guidelines, the use of the word 'must' in a recommendation indicates a legal requirement. When the guideline development group agreed the evidence represented good practice 'should' is used.
473	Royal Pharmaceutical Society	3.6	58	21	We believe that although the supplying community pharmacist would be the preferred person to contact any pharmacist would be able to offer support in a safeguarding incident involving medicines.	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
474	Royal Pharmaceutical Society	3.7	72	21	This statement should be strengthened to say that medicines reconciliation in care	Thank you for your comment. When the term 'must' is used in the guideline, this is required by legislation. When the guideline development

					homes MUST involve a pharmacist.	group agreed the evidence represented good practice ‘should’ is used.
475	Royal Pharmaceutical Society	3.8	79	3	We agree with the statement that the process of medication reviews should ideally be led by a dedicated care home pharmacist with appropriate clinical experience and training. The role of a dedicated care home pharmacist needs to be promoted and Care Homes or commissioners need to consider this and how it is funded.	Thank you for your comment.
476	Royal Pharmaceutical Society	3.8	80	2	The lead clinician responsible for undertaking the medication review should be determined locally for each resident but we would suggest adding that they should be a pharmacist and that a pharmacist MUST be involved in all medication reviews.	Thank you for your comment. When the term ’must’ is used in the guideline, this is required by legislation. When the guideline development group agreed the evidence represented good practice ‘should’ is used.
477	Royal Pharmaceutical Society	3.10	95	1	Recommendation 2.10.3 states that Care Homes shouldn’t delegate the responsibility of ordering medicines to the community pharmacy. We believe that if there are robust protocols in place then this responsibility could be delegated. If community pharmacists are not involved in the ordering process they are not always kept informed of any changes to medicines which can cause problems in relation to patient safety.	Thank you for your comment. Wording is consistent with legislation (Regulation 13 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010). The guideline development group discussed and agreed that ‘collaboration between the care home providers, GP practice and community pharmacy is essential.'

478	NHS Kernow Clinical Commissioning Group	3.1	19	9	Medicines policy should also include how to deal with patient safety alerts relating to medication.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
479	NHS Kernow Clinical Commissioning Group	3.2	22	22	Clarify that the prescriber should not be notified in every case that a dose is refused/missed. Homes should have clear guideline on this.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
480	NHS Kernow Clinical Commissioning Group	3.2	22	23	This implies that the prescriber will have recorded in the resident's Care Plan the current medication regime and prioritised those medicines which are critical and where notification must be made. Whilst this would be of great benefit for the resident, we are unsure of how practical this is.	Thank you for your comment. The guideline development group agreed that this would be considered as good practice.
481	NHS Kernow Clinical Commissioning Group	3.2	28	1	Recommendation 2.2.4 – Health professionals prescribing a medicine should assess a resident's mental capacity to give informed consent and to record assessment in the care plan- is not always practical. Some prescribing may be done over the telephone. Even if a resident is seen by the GP the Care Plan is not always with the patient, and the GP may not wish to sign it.	Thank you for your comment. This section has been reworded following discussion by the guideline development group and the NICE publishing team.
482	NHS Kernow Clinical Commissioning Group	3.3	30	19	Clarify whether this is physical or verbal transfer of information from person to person at shift change or other.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
483	NHS Kernow	3.3	32	19	Delivery of training to Care	Thank you for your comment.

	Clinical Commissioning Group				Homes is not consistent across our County of Cornwall. From what we have seen the actual content pays very little attention to Caldicott principles, and Care Homes would need some good quality tools to be sure that they fully understand what Information Governance is and how it applies to their role.	
484	NHS Kernow Clinical Commissioning Group	3.3	34	9	We have concerns over how accurate information is going to be transferred with the patient. Regular concerns raised by care homes are that they receive very little information in a timely manner when a service user arrives in the Care Home either from the community or from Hospital. How this is going to be overcome without specific guideline and engagement from all parties is difficult to see.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
485	NHS Kernow Clinical Commissioning Group	3.3	36	12	This is a very difficult situation. Delays in registration can be because of delays in funding decisions. GPs will not automatically release information unless requested to do so by the new GP practice. Some residents may be logged as a temporary resident because they are in the palliative stage of care.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination
486	NHS Kernow Clinical	3.3	37	18	Sharing of information with patients and pharmacists- this	Thank you for your comment.

	Commissioning Group				would be a huge benefit to patients and help to reduce unnecessary waste. Pharmacists are often the last to hear about medicines changed in hospital and can dispense medicine no longer required if not informed of these changes in a timely manner.	
487	NHS Kernow Clinical Commissioning Group	3.3	39	1	We have concerns that asking homes to have an information governance policy will result in another policy written by management that will end up on a shelf unread. There needs to be some way of ensuring that everyone working in care homes understands the important principles but avoids another task perceived by many as a tick box exercise.	Thank you for your comment. The guideline development group agree that the care homes should have a process for managing information governance. The detail of the process would be for local consideration and determination.
488	NHS Kernow Clinical Commissioning Group	3.4	43	9	This is a message that is largely not held by GPs. That the Medicines Administration Chart is as much a patient's health record as is any computerised system and therefore the NHS code of practice for records management applies.	Thank you for your comment.
489	NHS Kernow Clinical Commissioning Group	3.4	45	21	The details on MAR charts should be correct **and complete**. We have on numerous occasions observed care home staff omitting to include the formulation or strength of a medicine on the	Thank you for your comment. See section 3.11 of the full guideline for further information.

					MAR. The specifics need to be clarified.	
490	NHS Kernow Clinical Commissioning Group	3.4	46	23	We have not seen any medication policy that allows or promotes patient information being sent by text. If as in the recommendations a text message is used, it must not be on a personal mobile, but a dedicated pre-agreed number.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
491	NHS Kernow Clinical Commissioning Group	3.4	48	1	Recommendation 2.4.3 re hand written MAR charts which have always been discouraged. How are we going to support care homes with appropriate training and assessment of competence?	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination
492	NHS Kernow Clinical Commissioning Group	3.4	48	1	Recommendation 2.4.5 – "all suspected adverse effects" to be reported as soon as possible. As this stands this would include common side effects from antibiotics, expected side effects from analgesia. Are we expecting the prescriber to discuss expected side effects beforehand and document in the care plan so that staff will only report adverse effects that are not predicted.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
493	NHS Kernow Clinical Commissioning Group	3.5	53	9	We have seen several examples in practice of failure to follow safe administration processes; we feel this is a major contributing factor to errors. Yes, it is important to have these processes in place but they must be followed.	Thank you for your comment. See section 3.14 of the full guideline for information on care home staff administering medicines to residents.
494	NHS Kernow	3.5	53	26	Out of stocks- Care Home	Thank you for your comment. See section 3.10

	Clinical Commissioning Group				Policies need to be clear on when staff should order medication. Failure to recognise that there is insufficient medication until the last one is taken will lead to residents not having the medication they need when they need it and could possibly lead to a safeguarding alert.	of the full guideline for information on ordering medicines.
495	NHS Kernow Clinical Commissioning Group	3.5	54	13	Does this mean that GPs need to be able to identify care home residents who need monitoring in addition to the monitoring requirements of specific medicines or long term conditions?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
496	NHS Kernow Clinical Commissioning Group	3.6	60	14	As written this statement implies that the service provider has anonymity whereas the intention is that the service user has anonymity.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
497	NHS Kernow Clinical Commissioning Group	3.6	63	18	What advice would be given to a care home if the resident does not or cannot agree to information sharing regarding an incident?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
498	NHS Kernow Clinical Commissioning Group	3.6	65	21	We are concerned that many care home staff will not understand the definition of a near miss, in addition to be worthwhile something needs to be done with this information once collected, will this be done and by whom?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
499	NHS Kernow Clinical Commissioning	3.6	65	24	Who is going to support care homes to decide when it is “appropriate” to report a safety	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Group				incident to the regulators.	
500	NHS Kernow Clinical Commissioning Group	3.6	69	1	Recommendation 2.6.4 'medicines safeguarding incident' – this needs to be clearly defined for care homes.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
501	NHS Kernow Clinical Commissioning Group	3.6	70		Recommendation 2.6.8 How will local safeguarding teams be supported in terms of manpower to manage the increase in reporting of individual medication incidents that we are encouraging.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
502	NHS Kernow Clinical Commissioning Group	3.6	70		Recommendation 2.6.11 Advocacy- how will this be delivered? Where will homes get their "advocate"?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
503	NHS Kernow Clinical Commissioning Group	3.7	72	20	We agree that pharmacists should be involved in the medicines reconciliation process, as they are in hospital after admission, but wonder if the group has thought how this will happen practically? Community pharmacists often only have the information that they provide to care homes via the MAR chart. Unless the process for dissemination of discharge summaries is greatly improved with copies also sent to the appropriate pharmacies, we feel that the role of the pharmacist in this process will be limited.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
504	NHS Kernow Clinical Commissioning	3.7	74	22	The information provided should also include the indication for each medicine prescribed.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Group				Frequently care home staff are unaware of what patients are taking medicines for.	
505	NHS Kernow Clinical Commissioning Group	3.8	79	9	PG diploma or Independent Prescribing course- will there be any funding to support pharmacists through these courses?	Thank you for your comment. The funding for courses for pharmacists is outside the scope of this guideline.
506	NHS Kernow Clinical Commissioning Group	3.8	80	21	Very often when patients are new to a care home and new to a practice this is the time when they are not reviewed. Review is made more difficult because of poor transfer of patient records from one practice to another and incomplete notes.	Thank you for your comment.
507	NHS Kernow Clinical Commissioning Group	3.8	81	26	Our extensive experience in undertaking medication reviews in care homes leads us to recommend that medicines reconciliation is part of the review process. In particular between the home's MAR chart and the GP practice records. In addition it is invaluable to ensure that the MARs are consulted and checked for adherence.	Thank you for your comment.
508	NHS Kernow Clinical Commissioning Group	3.8	83	1	Recommendation 2.8.2 – how are the care homes going to be able to evidence the competency of the healthcare professional carrying out the medication reviews, i.e. pharmacist?	Thank you for your comment. This recommendation has been reworded following discussion by the guideline development group.
509	NHS Kernow Clinical	3.9	85	21	The guideline reads as if the GP should be responsible for	Thank you for your comment. Where the guideline includes the term 'consider' rather than

	Commissioning Group				updating the care plan with any changes to medication. We anticipate that this will incur some resistance from GPs; some are not prepared to even amend or sign any changes on MAR charts.	'should' or 'must', this implies that there is a lower level of evidence than for other recommendations.
510	NHS Kernow Clinical Commissioning Group	3.9	85	23	It should be made clear that the directions 'as directed' are not acceptable on a prescription.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
511	NHS Kernow Clinical Commissioning Group	3.9	87	17	Whilst we accept the need for documenting the circumstances for giving variable doses we feel that it is impractical for GPs to document this in care plans. In addition the need to document the circumstances for giving each option of a variable dose will be impractical and unnecessary for all medicines for example in the case of laxatives.	Thank you for your comment. The guideline development group agreed that the wording as written represents good practice.
512	NHS Kernow Clinical Commissioning Group	3.10	93	12	Is this really happening? There is a belief, mostly amongst GPs that this is the case but we have found no evidence of pharmacies ordering medication without the knowledge of the care home.	Thank you for your comment. Evidence presented to the guideline development group lists methods of ordering repeat prescriptions which has been included in the guideline.
513	NHS Kernow Clinical Commissioning Group	3.11	100	5	We believe that this supportive information SHOULD be added to the MAR, a stronger statement than 'this represents good practice' should be included.	Thank you for your comment. The purpose of the guideline is to provide good practice recommendations. Medicines administration records are one way of recording medicines administration (other formats exist) therefore the guideline development group is unable to say what information should be included on a record of medicines administration. The wording of

						recommendations is based on the strength of the evidence. Full details of the development process can be found here.
514	NHS Kernow Clinical Commissioning Group	3.11	100	17	We believe it is difficult for the prescriber and pharmacist to have responsibility to ensure that the MAR is accurate if they are not involved in producing it, for example handwritten MARs produced by the home. They can only have responsibility for ensuring that the prescriptions, labels and MARs where appropriate that they produce are accurate. The prescriber may often communicate changes to the care home without informing the community pharmacist who is then unable to update the MAR in a timely manner.	Thank you for your comment. This section has been reworded following discussion by the guideline development group. NICE are developing a guideline on Drug Allergy.
515	NHS Kernow Clinical Commissioning Group	3.11	101	1	Recommendation 2.11.2 – we think that care homes will need strong reinforcement of this message so that individual residents are offered different options before automatically defaulting to their existing 'system' of medicines administration.	Thank you for your comment.
516	NHS Kernow Clinical Commissioning Group	3.12	102	3	Include here the need to record what medicines have been received.	Thank you for your comment. The guideline development group discussed and agreed that the care home provider should have a process in place for receiving medicines. This process may include making a record of medicines received.

517	NHS Kernow Clinical Commissioning Group	3.12	103	3	This list should also include the safe and secure management of keys e.g. ensuring that the keys are kept on the responsible person and that a log is kept to record the handover of keys.	Thank you for your comment. The guideline development group are unaware of any published evidence of effectiveness surrounding the intervention described, the benefits or outcomes that would be used to measure this.
518	NHS Kernow Clinical Commissioning Group	3.12	105	8	Care homes need to understand that medicines not used this month are not necessarily 'surplus' and may be able to be carried forward. Otherwise this can lead to unnecessary waste.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
519	NHS Kernow Clinical Commissioning Group	3.13	111	5	Although we recognise that those involved in the assessment should be determined on a case by case basis we feel that there should be some clearer guideline, for example, if it is a case of the resident physically not being able to self-administer then the pharmacist should be included to offer advice. We feel that the guideline should be clear that two members of care staff should be involved in the assessment and that they should be senior, trained and experienced members of staff. Carers who may have been involved with the resident in the community may wrongly assume that they are unable to self-administer because they have used compliance aids to prompt medication taking when no	Thank you for your comment. This section has been reworded following discussion by the guideline development group

					assessment has ever taken place.	
520	NHS Kernow Clinical Commissioning Group	3.14	117	8	We feel that it is essential for care homes with nursing to be competent and include within their policy the correct use of syringe drivers. In addition and in line with previous NPSA alerts the administration and management of high risk medicines e.g. warfarin, lithium.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
521	NHS Kernow Clinical Commissioning Group	3.14	121	10	Our experience leads us to recommend that the guideline highlights the responsibilities of care homes staff when healthcare professionals come into the home to administer controlled drugs. Care home staff need to ensure that the medication that is given is entered out of the CD register where appropriate, we have dealt with a number of incidents and discrepancies where this has not been done.	Thank you for your comment.
522	NHS Kernow Clinical Commissioning Group	3.14	125	1	Recommendation 2.14.1 – we agree that care home staff should have training on inhaler technique and be able to evidence this; however who is going to assess their competence? Point 5 – this needs rewording to 'managing medicines if residents are asleep'	Thank you for your comment. Training and skills (competency) of care home staff is included in section 3.17. The recommendation has now been reworded to reflect your comment.
523	NHS Kernow Clinical	3.14	127	1	Recommendation 2.14.8 – needs clarifying whether care home staff	Thank you for your comment. The recommendation applies where a separate

	Commissioning Group				are expected to record administration of these meds in two places, i.e. care plan and MAR.	record of a medicines administration exists (such as on a separate record of medicines administration).
524	NHS Kernow Clinical Commissioning Group	3.16	132	18	The policy should include the need for the home to undertake a regular stock check and date check.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
525	NHS Kernow Clinical Commissioning Group	3.17	140	1	In our experience many homes struggle with the concept of competency and what to assess. We feel that the guideline should outline what a competency assessment should include and who should undertake it if not an accredited training provider.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
526	NEW Devon Clinical Commissioning Group	General			This is a very comprehensive document and the group is to be congratulated.	Thank you for your comment.
527	NEW Devon Clinical Commissioning Group	1.3	5		A general comment: Whilst the document is clear in its scope it might be helpful to emphasise that all health and social care providers need to work together to ensure this vulnerable group of patients benefit from the best practice described in the document.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
528	NHS North Somerset Clinical Commissioning Group	3.12	102	8	I would say that further work is required to ensure discrepancies are resolved at the medication receipt stage. I am aware of many administration errors caused by medication being cancelled on the	Thank you for your comment. The guideline development group discussed and agreed that the care home provider should have a process in place for receiving medicines. This process may include making a record of medicines received. For information about the use of

					MAR chart after medication ordering has occurred but before new stocks of medication arrive in the home. Orders can be made two weeks before dispensed medicines arrive. I would suggest staff need to check drugs ordered against newly dispensed drugs as states (to confirm complete order has arrived), Staff ALSO need to check the current/active MAR sheet against the new MAR sheet and against the newly dispensed medication to ensure they have a correct MAR sheet and all the drugs required with no extra or missing MAR entries.	medicines administration records see section 3.11 of the full guideline.
529	NHS North Somerset Clinical Commissioning Group	3.12	108	1	I think this may be preferred to state “Before disposing of a medicine which is still required by the resident care home staff should find out -if the medicine is still within its expiry date -if the medicine has a short shelf-life once opened: ” Otherwise it seems you are recommending that all medication for disposal should have it’s expiry date and shelf-life checked regardless of reason for disposal which could be a time intensive job.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
530	NHS North Somerset	3.4	45	24	The NMC Standards for Medicines Management states	Thank you for your comment. Medicines administration records are for recording the

	Clinical Commissioning Group				‘transcribing should not be routine practice’ and quite clearly defines transcribing. I would argue that producing your own MAR charts is transcription/transcribing and as such should not be routine practice. If the guideline development group do not share my and the NMC view of the definition of transcription it should be stated on this document that self-created MARs must ONLY use exact details listed by the GP on the prescription / pharmacy generated label. I have seen homes that self-create MARS and adjust patient medication at their preference not on the direction of a prescriber.	administration and non-administration of medicines administered by care staff. Section 3.11 of the full guideline covers the production of medicines administration records and states that the care home provider should have a process in place to check that the information on the medication administration records are correct and accurate. Care homes do not undertake a process of transcribing as the medicines administration records are not prescriptions but are records of administration.
531	NHS North Somerset Clinical Commissioning Group	3.1	13	18	There is no mention of the need to have a transcription policy. The NMC Standards for Medicines Management state one is required.	Thank you for your comment. This section has been reworded following discussion by the guideline development group. Care homes do not undertake a process of transcribing as the medicines administration records are not prescriptions but are records of administration.
532	NHS North Somerset Clinical Commissioning Group	3.14	116	23	Please provide further clarification in the text about delegation of medication administration from a nurse, to Care home staff that are not nurses.. Is the first nurse in the management structure (i.e. the closest in structure to the care home staff) classed as the person delegating medication responsibility to Care home staff	Thank you for your comment. This section has been reworded following discussion by the guideline development group

					that are not nurses or is it the company that is delegating? Many home managers are nurses that manage but do not own the care home company. Also some homes have nursing beds that have medication administered by nurses and in the same home residential beds have medication administered by Care home staff that are not nurses. In this situation, I'm not sure whether the other nurses would be classed as the delegator or if it is the company that delegated. I think it is vital that commissioners of care and nurses and owners understand where responsibilities lie.	
533	NHS North Somerset Clinical Commissioning Group	3.17	137	5	Could locum or agency care home staff be explicitly mentioned here? Often homes run on a high proportion of agency staff and it would be very helpful to give further guideline/clarify that care homes should not allow locum staff to undertake medication administration until completion of induction training and assessment identifies the areas of work that the care home staff are competent to undertake at that point in time.	Thank you for your comment. The regulations covering care homes are not specific to one type of employed staff. It is the duty of the employer to ensure that staff are supported through training.
534	NHS North Somerset	3.17	140	11	How often should competency assessments be undertaken?	Thank you for your comment. Details of the frequency of a competency

	Clinical Commissioning Group				Annually	assessment are included in section 3.17 of the full guideline, ‘all staff have their performance individually and formally appraised at least annually’.
535	NHS North Somerset Clinical Commissioning Group	General			There is no mention of the NPSA work on missed doses or the need to administer certain high-risk medication within two hours of the time prescribed. Please consider an addition regarding relevant safety messages.	Thank you for your comment, section 3.14 has been amended to reflect your comment.
536	NHS North Somerset Clinical Commissioning Group	General			There is no mention of the duration of time each day that Care homes will be expected to be able to offer mediation administration. I am aware of care homes that have staff available for only 10 hours per day. Does the legislation require 24 hour provision? Is it worth stating this?	Thank you for your comment. The guideline development group was aware that the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 state ‘In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.’
537	Pharmacy Plus	3.1	18	3	It is recognised that there are models of medicines management systems that use a combination of paper and electronic systems. This practice should not be recommended, there should only be one system used in the care home, electronic or paper as this will lead to inconsistent recording of information and unreliable electronic data. If electronic records are used, they should have all the functionality required	Thank you for your comment. This section has been reworded following discussion by the guideline development group

					to record all activities in a care home relating to medicines and there should not be a need to record some activities on paper and some electronically	
538	Pharmacy Plus	3.3	34	16	The recommendation from the Keeping patients Safe-getting the medicines right has four core responsibilities, the final one listed in the document is "to ensure that information about patients' medicines is communicated in a timely, clear, unambiguous and legible way; ideally information should be generated and transferred electronically." The draft document does not make any reference to electronic transfer of patient and medicine information from care homes to other organisations. The guideline development group should consider making this recommendation to be encourage the development of such systems from the care home to the hospital for example and to be consistent with Keeping patients safe document. A specific recommendation for those care homes that use electronic administration records should have the functionality to transfer information electronically from the administration records to the	Thank you for your comment. The Royal Pharmaceutical Society document relates to health professionals not wider care settings, although the guideline development group agree that the same information content applies in principle to care homes. There are many barriers to the transfer of information electronically as care homes do not have access to the NHS N3 secure data network which would be necessary to meet the data standards for this type of work and the costs may well be excessive for individual care homes. Therefore it is not solely a matter of the functionality of the software that needs to be considered as data on individuals can only be electronically transferred securely via a secure system.

					hospital or other organisations.	
539	Pharmacy Plus	3.3	38	25	The guideline development group also identified the importance of communication within the care home: For those that use electronic systems there should be a method of communication between staff members at hand-over for specific residents and medicines.	Thank you for your comment. Wording was considered by the NICE publishing team.
540	Pharmacy Plus	3.2	24	1	Given the importance of patient consent and promotion of independence in relation to medicines administration and self administration, any electronic record system needs to address this issue and have a module for helping residents manage their own medicines. This may also include an electronic assessment tools and resident reminders that medicines are due, rather than reminders aimed at nurses and carers to administer medicines.	Thank you for your comment. Section 3.2 of the full guideline includes a tool produced by the Social Care Institute for Excellence. NICE is unable to change the content of this tool. The guideline development group is unaware of any robust evidence on the use of such systems and their efficacy, effectiveness and cost-effectiveness on which to make such a recommendation.
541	Pharmacy Plus	3.3	31	24	The guideline development group should reiterate the need for care homes that use electronic medication records to meet all the confidentiality and Data Protection requirements of the HSCIC.	Thank you for your comment. Wording was considered by the NICE publishing team.
542	Pharmacy Plus	3.4	46	1	All electronic medication administration systems need to have a function where verbal / text orders for administration are recorded appropriately according	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					to the recommendations of the guideline development group.	
543	Pharmacy Plus	3.4	47	14	All electronic medication administration systems should have a function for recording and reporting adverse drug reactions against resident's specific medicines and the ability to transfer these to the prescriber and MHRA.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
544	Pharmacy Plus	3.5	51	4	Given the high proportion of medication errors regarding monitoring, any electronic medication system must have a module on monitoring and test results in particular.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
545	Pharmacy Plus	3.5	52	5	Information regarding resident's condition is vital to safety, any medication record system, including electronic medication records, must have very specific and accurate conditions recorded.	Thank you for your comment. See section 3.4 of the full guideline for record requirements.
546	Pharmacy Plus	3.6	58	25	The importance of out of hours support: all electronic medication record system must be able to support care homes out of hours	Thank you for your comment. See section 3.4 of the full guideline for information about ensuring records kept are accurate and up-to-date. It is outside the scope to make recommendations about electronic medicines record systems.
547	Pharmacy Plus	3.6	61	15	The importance of learning from safe guarding and medication error incidences and near misses; any electronic system must be able to record and provide information on past incidences for learning at the care home.	Thank you for your comment. This section has been reworded following discussion by the guideline development group. It is outside the scope to make recommendations about electronic medicines record systems.

548	Pharmacy Plus	3.6	65	16	guideline development group recommends near misses that would have caused harm to be reported locally. All near misses prevented by electronic medication systems should have the facility to be forwarded to local authorities	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
549	Pharmacy Plus	3.6	67	26	guideline development group recommends medication reviews, for residents in care homes the review of the actual administration of medicines should be a compulsory part of the medication review	Thank you for your comment. However it is not clear where this comment relates to in the draft guideline. Medication review is included in the full guideline (see section 3.8).
550	Pharmacy Plus	3.7	71	2	Importance of medicines reconciliation has been established. All electronic medication systems should be able to provide a list of current and archived medicines that a resident has been taking to facilitate medicines reconciliation especially during transfer and discharge from the care home.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
551	Pharmacy Plus	3.8	77	2	Medication reviews and their frequency. These are important but time consuming and can be inconsistent; the guideline development group should consider the development of future models of medication reviews which may be facilitated by clinical decision support software which would screen for	Thank you for your comment. The guideline development group are unaware of any robust (RCT) evidence on the use of such systems and their efficacy, effectiveness and cost-effectiveness on which to make such a recommendation.

					relevant risks and alert appropriate providers / prescribers. These systems would also mean that the medication review is not a one off event, but a continual monitoring of clinical risks to do with medicines which would potentially enhance the value of medication reviews.	
552	Pharmacy Plus	3.9	85	7	Experience shows that often “monthly” prescriptions take longer to be issued than the 48 hours for non care home residents. In addition there is often medication as part of the monthly supply that for one or other reason is not prescribed as a repeat prescription. However, there is often little or no communication regarding the reason for non prescribing fed back to the pharmacy or the care home. We would urge the guideline development group to consider this lack of communication and to make recommendations as this often leads to safeguarding incidents when residents do not have their medication at the beginning of their care home’s monthly medication cycle.	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
553	Pharmacy Plus	3.9	94	10	guideline development group makes recommendations that are not practical if the care home	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					uses electronic medication record systems, we would suggest a change in wording such as “or appropriate electronic method”	
554	Pharmacy Plus	3.11	96	1	guideline development group should consider barcode validation of dispensed items as an extra safety measure in reducing errors in the dispensing process. We believe such systems have also been advocated by safety agencies in the past.	Thank you for your comment. The guideline development group was aware of bar-coded systems, however no robust (RCT) studies using this intervention were identified during the literature review for the guideline.
555	Pharmacy Plus	3.11	98	10	Medication administration records. guideline development group should note that these records may also be electronic	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
556	Pharmacy Plus	3.11	99	5	Given the importance of the medical condition of the resident, the guideline development group should consider making a requirement for the medical condition of the resident to be presented on MAR charts.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
557	Pharmacy Plus	3.14	115	2	Medication administration by care home staff. The guideline development group has not mentioned a body of research on Barcode validation systems at the point of medication administration which prevents a number of medication administration errors. We believe that the use of this technology should be considered and promoted by the guideline	Thank you for your comment. The study by Wild and colleagues has been reviewed and included in the literature review by the guideline development group. The guideline development group was aware of bar-coded systems, however robust randomised controlled trials and cost-effectiveness studies using this intervention were not identified during the literature review for the guideline development group.

					development group because it is a significant intervention in reducing medication administration errors. http://rcnpublishing.com/doi/pdfplus/10.7748/nm2011.09.18.5.26.c8671 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3254134	
558	East Riding of Yorkshire Council	General			This comprehensive guideline gives practical advice in clear language. The links to legislation and supporting guideline are really valuable and show clear lines of responsibility. The prompts throughout the document to contract content and training are useful for providers and commissioners. The guideline reflects current practice and the problems encountered by providers, such as monitored dosage systems. This document is timely in addressing concerns arising from CQC inspection; medications and documentation of records appear in compliance actions for providers.	Thank you for your comment.
559	East Riding of Yorkshire Council	1.5	7	16	The emphasis here and throughout the document on personalisation is very welcome.	Thank you for your comment.
560	East Riding of	3.2	20	1	Implications here for self -	Thank you for your comment. Unfortunately, the

	Yorkshire Council				medication systems in care homes, such as cost of equipment.	point of this comment is not clear.
561	East Riding of Yorkshire Council	General			Detailed coverage of Mental Capacity Act is very relevant.	Thank you for your comment.
562	East Riding of Yorkshire Council	3.6	55	12	Very important to emphasise the links to safeguarding and CQC as frequently cited as cause for alerter.	Thank you for your comment.
563	East Riding of Yorkshire Council	3.8	76	2	Medication reviews. Local providers have support from Medicine management team inspection which promotes good practice and supports compliance.	Thank you for your comment.
564	East Riding of Yorkshire Council	General			The recommendation boxes help to summarise each section clearly.	Thank you for your comment.
565	East Riding of Yorkshire Council	General			The Glossary and Appendices B & D are needed.	Thank you for your comment.
566	NHS Nene Clinical Commissioning Group	1.3	6	2	Appliance contractors – Does this include companies such as Homeward and Script Easy etc.? Change community pharmacists to just pharmacists to many primary care pharmacists now offer services to care homes	Thank you for your comment. The guideline is for all people who are involved in a residents care, including people who provide services to care homes (for example, supplying pharmacies, GPs, dispensing doctors and appliance contractors). A section 'definitions' has been added to the guideline in response to your comment about pharmacists.
567	NHS Nene Clinical Commissioning Group	1.3	6	4	CCGs are not mentioned, do they come under local authorities?	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
568	NHS Nene	3	16	4	Does there need to be a specific	Thank you for your comment. The format was

	Clinical Commissioning Group				section on controlled drugs? Or at least a bullet point in this list for "careful consideration"?	considered by the NICE publishing team.
569	NHS Nene Clinical Commissioning Group	3.1	18	13	"from care homes" change to "other settings"?	Thank you for your comment. Wording was considered by the NICE publishing team.
570	NHS Nene Clinical Commissioning Group	3.2	21	4	adult***S*** typo	Thank you for your comment. This section has been reworded.
571	NHS Nene Clinical Commissioning Group	3.3	30	13	Is it meant to say medication review here, or as it states Medicines Use Review?	Thank you for your comment. This section has been reworded following discussion by the guideline development group
572	NHS Nene Clinical Commissioning Group	3.3	37	14	CQC " self-assessment tool " mentioned is out of date and refers to PCTs	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
573	NHS Nene Clinical Commissioning Group	3.4	44	5-7	"Appropriate " time for record keeping . Will this be defined ?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
574	NHS Nene Clinical Commissioning Group	3.8	81	13	Could the document from PrescQIPP be referenced here? (*Optimising Safe and Appropriate Medicines Use. Bulletin 8 - September 2011 - v2.51)*	Thank you for your comment. The document does not cover the issue of medication review in as much depth as the NPC document does, therefore the guideline development group chose not to link to this document.
575	NHS Nene Clinical Commissioning Group	3.12	104	6	"however, nursing care homes need to check if the community pharmacy agrees to disposing of the medicines" – Indeed CCGs should not pay community pharmacies for this so it will out of the pocket of the community	Thank you for your comment.

					pharmacist. They are therefore not likely to agree.	
576	NHS Nene Clinical Commissioning Group	D	161		In the table it states that MDS "provides a safety net". This is not an appropriate term as it gives the impression that it is a fail safe and stops all errors. It may however provide an easier visual audit tool for staff. Also as well as PRNs being separate, in most MDS systems the liquids are separate too.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
577	NHS Nene Clinical Commissioning Group	2.13.3.	114	1	When taking about risk assessment for self-administration ensure that this risk assessment is reviewed on a regular basis	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
578	Leeds City Council	General			We agree with the good practice guidelines and genuinely welcome them. We agree that medication is a very important aspect of providing care however we also feel that clear guideline is required as to what is a social care task and what is a health task and there is ambiguity in some areas as pointed out below. Generally we would note that there is a need to provide very clear guideline that is as free from subjective interpretation as possible e.g. the use of as soon as possible, and though the guideline does in many cases provide clarification there are	Thank you for your comment. Records kept in relation to care and treatments are already, as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, legal documents that have a legal requirement for clarity (see section 3.4 of the full guideline). These records are subject to regulatory inspection. The recommendation wording considers the intended interpretation of the evidence. Thank you for your comment. The guideline

					some areas that are still subjective. Also there are a number of the recommendations that whilst we agree with them also realise that in practice they may be extremely difficult to implement consistently due to resource issues and for example in the case of home care pharmacists welcome the acknowledgment of this difficulty. Our other feeling is that the quality of recording is critical to improving medication practice and that all recording should be of a legally admissible standard, allowing accountability for all actions receiving transferring, and administering medication. Without clear accountability to target remedial action improvement is less likely to occur. To support such improvement we suggest that all records should be audited by the registered manager of the care home, irrespective of who made them health or social care professional this in itself should be accountably recorded and provided to relevant colleagues in other settings.	development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination in line with legislation and local governance arrangements. In the updated Caldicott principles the sharing of information should be relevant, necessary and proportionate; this would prevent the registered manager of the care home auditing all records as that person would not necessarily have access to them without extensive data sharing protocols being in place. The registered care home manager may not be able to undertake a clinical audit of clinical records, depending on whether they have clinical knowledge and skills.
579	Leeds City Council	1.5	7	22	We feel that reasonable efforts should be made to support	Thank you for your comment. See section 3.2 of the full guideline.

					individuals to have an input into the decisions which impact upon their care and treatment and where they are unable to make such a decision efforts should be made and recorded in the care plan to access such information for example prior wishes or religious conviction held to at least inform the decision.	
580	Leeds City Council	1.5	9	2	Should specifically including those who are deaf and use BSL or similar sign language	Thank you for your comment. Wording was considered by the NICE publishing team.
581	Leeds City Council	1.6	11	23	We feel that individuals should receive their medication in a manner that suits them and where possible they have agreed to, e.g. with or without drink, what that drink should be right or left handed etc.	Thank you for your comment. The guideline includes a section on 'person-centred care'. Care home residents and health professionals (for care under the NHS) have rights and responsibilities as set out in the NHS Constitution for England, and NICE guidelines are written to reflect these. Treatment and care should take into account individual needs and preferences. Care home residents should have the opportunity to make informed decisions about their care and treatment, in partnership with their health professionals and social care practitioners.
582	Leeds City Council	3.1	19	9	We feel that there should be a specific policy regarding controlled drugs and receiving storing and disposing of medicines should read **secure storage** of medicines.	Thank you for your comment. Wording was considered by the NICE publishing team.
583	Leeds City Council	3.2	21	8	We feel this should read **have the right to make the same informed decisions about**	Thank you for your comment. Wording was considered by the NICE publishing team.

					accessing services and support	
584	Leeds City Council	3.2	23	5	We feel it is important that all efforts be made to effectively engage the individual in the decision making process e.g. flash cards previous history etc. This should form part of a good Care plan	Thank you for your comment. Barriers to comprehension of health information generally (health literacy) is included in section 3.2 of the full guideline and involving the resident about decision about their care and treatment is considered throughout.
585	Leeds City Council	3.2	23	12	We feel this should include interpreters especially sign language interpreters if necessary, and where appropriate advocates.	Thank you for your comment. Barriers to comprehension of health information generally (health literacy) is included in section 3.2 of the full guideline and involving the resident about decision about their care and treatment is considered throughout.
586	Leeds City Council	3.2	28	1	There should be a requirement to evidence what steps were taken to engage the individual and facilitate their participation in the care plan.	Thank you for your comment. Barriers to comprehension of health information generally (health literacy) is included in section 3.2 of the full guideline and involving the resident about decision about their care and treatment is considered throughout.
587	Leeds City Council	3.2	28	1	Where a residents mental capacity is assessed there should be a written record that allows auditing for a justifiable decision included in the care plan not simply a statement from a health professional that the individual lacks capacity, and this record should specify the actual decision being made to prevent the use of blanket assessments.	Thank you for your comment. Barriers to comprehension of health information generally (health literacy) is included in section 3.2 of the full guideline and involving the resident about decision about their care and treatment is considered throughout.
588	Leeds City Council	3.3	30	12	We consider that whilst not strictly medication, but has an impact on medication health and well-being, food and fluid intake records	Thank you for your comment. Food and fluid (except during administration of medicines see section 3.14 and 3.15) is outside the scope of this guideline.

					should be included	
589	Leeds City Council	3.3	30	19	There should be a requirement for a signed receipt at each hand over of information stating what was provided by whom and when with a contact number	Thank you for your comment. The guideline development group discussed and agreed that there should be a record of what information has been handed over during handover between shifts (see section 3.3 of the full guideline). Staff duty records would indicate who gave the handover and the contact number would be unnecessary as it would be the care homes own number.
590	Leeds City Council	3.3	35	18	We feel that any check should be carried out by a suitably qualified individual and that all such recording must be of a legally admissible standard signed print name and date.	Thank you for your comment. This section has been reworded following discussion by the guideline development group
591	Leeds City Council	3.3	36	11	This should include a statement on how accountability during transfer should be maintained e.g. signed receipts for information.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process Details of the process are for local consideration and determination.
592	Leeds City Council	3.3	39	1	Recommendation 2.3.2 should include a requirement for receipts for such information to support accountability.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
593	Leeds City Council	3.4	41	5	An additional requirement should be added that records are of a legally acceptable standard for accountability and should be complete enough in terms of justifying any judgment or decision or action.	Thank you for your comment. Records kept in relation to care and treatments are, as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, legal documents that have a legal requirement for clarity. The guideline states this in section 3.4 of the full guideline.
594	Leeds City Council	3.4	42	6	As above	Thank you for your comment. Records kept in relation to care and treatments are, as set out in

						the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, legal documents that have a legal requirement for clarity. The guideline states this in section 3.4 of the full guideline.
595	Leeds City Council	3.4	48	1	Recommendation 2.4.1 the registered manger as part of their quality assurance cycle should audit either all or a sample of medication records of each member of staff undertaking medicines administration and record that audit in the individuals personnel file.	Thank you for your comment. See section 3.17 of the full guideline for information about assessment of competence.
596	Leeds City Council	3.4	48	1	A) Recommendation 2.4.2 though these are guidelines and therefore should is normally appropriate we feel that in the case of this recommendation it would be beneficial to replace **should** with **must**. Records are worthless if they are illegible, unsigned or undated etc. B) Additionally there should be a requirement to provide a list of individuals authorised to administer there medication with name signature and initials to facilitate auditing.	A) Thank you for your comment. In line with NICE style for guidelines, the use of the word 'must' in a recommendation indicates a legal requirement. When the guideline development group agreed the evidence represented good practice 'should' is used. B) This is not required by current legislation.
597	Leeds City Council	3.4	48	1	In recommendation 2.4.5 we would recommend replacing **should** with **must** even though these are guidelines.	Thank you for your comment. When the term 'must' is used in the guideline, this is required by legislation. When the guideline development group agreed the evidence represented good

						practice ‘should’ is used.
598	Leeds City Council	3.5	53	19	We feel that there needs to be care in defining a level of competence that care home staff cannot and in fact should not be required to hold, adverse effects and drug interactions we feel should remain firmly within the remit of health professionals, as should the issues of the trade and common names of medication which could be an area for added confusion.	Thank you for your comment. The guideline development group discussed and agreed that staff awareness of common side effects of commonly used medicines in their care setting would improve resident safety providing staff were encouraged to record and where appropriate report them.
599	Leeds City Council	3.5	54	15	We support the idea that medicines reviews should be carried out every 6 months but feel that this may be very difficult in practice and 12 monthly may be more realistic with the requirement for on-going monitoring to trigger an earlier review if required	Thank you for your comment.
600	Leeds City Council	3.6	58	30	We feel it is unlikely that even social care management staff would be competent in carrying or even understand the term Root Cause Analysis, and to carry this out well would at least initially require very great training and support needs.	Thank you for your comment. The guideline development group was made aware from written and oral evidence provided to it from care home providers that root cause analysis is already in use in some care homes.
601	Leeds City Council	3.6	65	13	We feel that this should also where no actual harm occurred but there was a realistic potential for harm, e.g. recording issues or medication given at the wrong	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					time	
602	Leeds City Council	3.6	69	1	Recommendation 2.6.1 there should be a specific individual role nominated	Thank you for your comment. Due to the potential for harm arising from medication errors it is for care home provides to determine locally how incidents should be reported.
603	Leeds City Council	3.6	69	1	Recommendation 2.6.3 The term root cause analysis is not understood in Social Care and to implement will require high levels of training as well as Quality Assurance and monitoring to ensure effectiveness	Thank you for your comment. The guideline development group was made aware from written and oral evidence provided to it from care home providers that root cause analysis is already in use in some care homes.
604	Leeds City Council	3.7	71	3	This statement should include a comment regarding maintaining an auditable accountability for transferring information during transfers e.g. signed receipts stating what was received by whom from whom	Thank you for your comment. See section 3.3 of the full guideline for sharing information about a resident's medicines.
605	Leeds City Council	3.7	72	4	We feel this should read **ensure** the resources identified for medicines reconciliation **are** made available,	Thank you for your comment. Wording was considered by the NICE publishing team.
606	Leeds City Council	3.7	73	28	With clear accountability as to who is responsible for producing that data and checking its reliability and accuracy.	Thank you for your comment. The purpose of medicines reconciliation is to reconcile differences between different records of medicine the resident is taking. There will be by definition accuracy and reliability issues between records otherwise the process would not need to exist. The guideline development group agreed that the recommendation as currently worded represents good practice.
607	Leeds City	3.7	75	1	Recommendation 2.7.2 We feel	Thank you for your comment..

	Council				that the presence of a pharmacist would be invaluable given the need to transfer etc. it is likely that this may cause problems if it is a requirement in speedy transfer between care provisions.	
608	Leeds City Council	3.7	75	1	Recommendation 2.7.1 Should include a requirement for transfer from a Health or care setting that the information going with the individual is complete. Such a two sided approach will greatly reduce the risk of information not being passed on.	Thank you for your comment. See section 3.3 of the full guideline for sharing information about a resident's medicines.
609	Leeds City Council	3.8	79	9	We are pleased to see an acknowledgement of the issues in having dedicated pharmacists involved in reviews and support the move to develop Care Home pharmacists dependent upon them having an appropriate level of competence and that this would be a highly specialist area.	Thank you for your comment.
610	Leeds City Council	3.8	80	12	We support the idea that the trigger for 6 monthly reviews should be four or more medications however this will mean still most care home residents given the average quoted of 8 on page 76	Thank you for your comment. The draft guideline recommends that the frequency of review should be determined on an individual case-by-case basis, depending on the health and care needs of the resident, with resident safety paramount in decision-making. However, the GDG agreed that the frequency of a multidisciplinary medication review should not exceed 1 year.
611	Leeds City Council	3.8	83	1	Recommendation 2.8.2 Though we agree the experience is that teams and individual change very rapidly and this impacts upon	Thank you for your comment.

					consistency.	
612	Leeds City Council	3.8	83	1	Recommendation 2.8.3 we feel that the term **involve** should be clarified to support an auditable and justifiable decision process, e.g. a GP would not need to attend however they should sign off that the information they have received indicates no change in medication, or otherwise.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
613	Leeds City Council	3.8	83	1	Recommendation 2.8.4 should include recording the **rational** for that decision in the care plan.	Thank you for your comment. The guideline development group agreed that the recommendation as written represents good practice.
614	Leeds City Council	3.8	89	1	We are concerned re the practicalities of this especially when many requests are undertaken by phone or e mail.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
615	Leeds City Council	3.9	91	1	Should specifically include phone, email and text as mention in the guidelines	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
616	Leeds City Council	3.9	92	4	Should be at least 3 trained individuals or a number appropriate to maintain cover over holidays sickness etc.	Thank you for your comment. The guideline development group agreed that the recommendation as worded represents good practice
617	Leeds City Council	3.9	95	1	Recommendation should require enough competent staff to consistently have 2 such trained individuals available.	Thank you for your comment. The guideline development group agreed that the recommendation as worded represents good practice.
618	Leeds City Council	3.13	114	1	Recommendation 2.13.1 this risk assessment should be written and form part of the care plan.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
619	Leeds City Council	3.13	114	1	Recommendation 2.13.3 Any actions identified should also detail who will do what and by	Thank you for your comment. This recommendation has been reworded following discussion by the guideline development group

					when for accountability and implementation monitoring	and the NICE publishing team.
620	Leeds City Council	3.13	114	1	Recommendation 2.13.4 any records should be clearly auditable and support accountability.	Thank you for your comment. The guideline development group agreed this represents good practice.
621	Leeds City Council	3.14	119	21	It is also important that individual understand how to correct records in which a genuine mistake has been made, we suggest a single line with initials and the correction added so it is all legible and auditable.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
622	Leeds City Council	3.14	120	5	Any medication record must support auditability and accountability	Thank you for your comment. Section 3.1 of the full guideline has been reworded following discussion by the guideline development group.
623	Leeds City Council	3.14	125	1	In recommendation 2.14.1 as soon as possible should be replaced by within 24 hours	Thank you for your comment. The guideline development group agreed that the recommendation as worded represents good practice.
624	Leeds City Council	3.14	126	1	Recommendation 2.14.5 we feel it is important that staff evidence competence and this evidence is recorded prior to them using the system to actually administer medication.	Thank you for your comment. This is addressed in section 3.17 of the full guideline.
625	Leeds City Council	3.14	126	1	Recommendation 2.14.6 as soon as possible to be replaced with within 24 hours to underline the importance of accurate and timely information	Thank you for your comment. The guideline development group agreed that the recommendation as worded represents good practice.
626	Leeds City Council	3.17	138	25	These learning outcomes should be evidence based as should currency of knowledge	Thank you for your comment. Section 3.17 includes the learning outcomes of unit F/601/4056. NICE is unable to change the

						content of this learning module.
627	Leeds City Council	3.17	139	19	This line causes some concern unless very clear guideline is provided on what is a social care task and what requires a health professional, additionally there should be very clear limits on this training	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
628	Leeds City Council	3.17	142	1	Recommendation this should include a requirement to ensure that adequate staffing is provided to support this	Thank you for your comments. The requirement to have suitable numbers of trained staff is included in regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010) (see section 3.17 of the full guideline).
629a	National Care Forum	General			NCF welcomes the opportunity to respond to this consultation. Please see Safety of Medicines in Care Homes: http://www.nationalcareforum.org.uk/project-medication.asp. This was an initiative funded by the DH, managed by NCF on behalf of the sector. These resources are unique in that This work took place in collaboration Royal Colleges participated in this work as well as CQC and SCIE. The tools now widely available on all partner websites are being utilised across the sector. These tools were developed by the sector for the sector and have been tested with people who use services as well as front line staff. NCF requests that the NICE	Thank you for your comment. The resources mentioned were not included in the draft guideline for consultation as they were published in the public domain imminently before consultation. Resources have been hyperlinked to in the full guideline where appropriate.

					consultation draws on this published work as its starting point as it addresses that which NICE is trying to achieve and which this consultation does not in its present format.	
629b	National Care Forum	General			The document in its current format is very health focused and does not address the Social Care Context. It assumes that all medication is administered and does not address self-administration.	Thank you for your comment. The guideline development group is aware that the systems and processes associated with managing medicines in care homes can appear very health focussed. The evidence in most cases for this topic comes from a health rather than social care perspective.
629c	National Care Forum	General			It is lengthy and is not cognisant of the changing landscape of regulations. CQC will be utilising new standards by the time this is published.	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published. The guideline will be updated in line with NICE processes.
629d	National Care Forum	General			NCF would urge NICE as it does with Public Health to draw from a wider evidence base and use 'grey' material as well. In care homes medication belongs to the resident. NCF would urge NICE not to add to the duplication that is experienced by Care Homes. Medication is regulated by CQC and is well covered by legislation including this within contracting by commissioners creates unnecessary duplication.	Thank you for your comment. The guideline development has followed the NICE accredited process for 'good practice guidance'. Full details of the development process can be found here. Thank you for your comment. Care Quality Commission regulatory changes in England are expected in October 2014 as a result of the Health and Social Care Act (2012). It is expected that the recommendations in the guideline will not change as a result of this because the guideline is based on current evidence. Following publication of the updated regulations, the guideline will be assessed to ensure that any relevant regulations are

						appropriately referenced.
					Omissions: A. No performance targets B. No mention of residents quality of life C. How this will be used by CQC D. No definition of what constitutes safe and efficient E. Fails to address transparency across the system as a whole(GP/Pharmacist and Care Homes) F. NICE understanding of care homes with and without nursing and the differences G. No mention of the work which I have referenced in my opening comments funded by DH. H. Failure to recognise the imminent changes in legislation/regulation for the care home sector. I. True identification of what outcome is to be achieved by the introduction of this standard/guideline – the sector does not need another tick box. J. No real definition of what' performance 'means or looks like. K. Must consider the wider term not just care homes…so the GP and Pharmacist and how the standard/guideline will be sued by them to benefit residents in care	A. NICE is not a commissioner of services therefore it is inappropriate and out-of-scope to provide performance targets. B. The guideline is related to the systems and processes for managing medicines as stated in the scope of the document. A resident's quality of life and avoiding harm is considered throughout the guideline. There is a lack of published evidence using quality of life as an outcome therefore the interventions described cannot be described as effecting residents quality of life. C. Thank you for your comment. The NICE guideline is aimed health & social care practitioners. Implementation of the guideline will be through our partnership with the Social Care Institute for Excellence (SCIE) and will inform a NICE quality standard. The CQC has been a stakeholder in the development of this guideline. The guideline does not form part of the regulatory framework for care homes and provides recommendations for good practice. The CQC do not inspect against NICE guideline or NICE quality standards although aligning the processes set out in the guideline may demonstrate compliance with regulations on managing medicines. D. Thank you for your comment. Resident safety is considered throughout the guideline (see sections 3.5 – 3.8 and 3.17). E. Please see the scope and intended audience for the guideline in the full guideline. F. Thank you for your comment. A section

					homes. L. A lack of a true understanding of what happens in practice and what good should like in relation to all parties(GP's/Pharmacists and Care Homes) working together for the interests of the resident.. M. Many of the recommendations in this document assume that all parties across the systems understand how each other works and that health and LA's are really engaged in that which takes place in care homes….assuming that there are national guidelines and governance arrangements which there are not outside of CQC(regulation and legislation) N. No real understanding of the practical implications of that which is being proposed. O. No mention of the role of District Nurses in care homes without nursing.	'definitions' has been added to the guideline. The good practice principles of systems and processes for managing medicines in care homes are the same regardless of whether the care home has nursing or non-nursing staff. Where this differs the recommendations reflect this. G. The resources mentioned were not included in the draft guideline for consultation as they were published in the public domain imminently before consultation. Resources have been hyperlinked to in the full guideline where appropriate. H. Care Quality Commission regulatory changes in England are expected in October 2014 as a result of the Health and Social Care Act (2012). It is expected that the recommendations in the guideline will not change as a result of this because the guideline is based on current evidence. Following publication of the updated regulations, the guideline will be assessed to ensure that any relevant regulations are appropriately referenced. I. The purpose of the guideline is to provide recommendations on the systems and process for managing medicines in care homes. J. Please see point I. K. Please see point E. L. Members of the guideline development group was selected from various backgrounds to provide expert knowledge of different settings and practice (see Appendix F). M. NICE does not assume that all parties currently work together across the system, however the recommendations agreed by the

						guideline development group do reflect what is not only possible within the sector but in most cases is already happening and represents good practice. N. Please see point M. O. The guideline development group was aware that several external health professionals deliver care to care home residents. Their role in managing medicines is included in the guideline (see section 3.14).
630	National Care Forum		17	Lines 4-6	Commissioners across health and social care apply different criteria locally so what do you mean by consistent?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
631	National Care Forum		20		Residents should also be encouraged to self-medicate but this standard fails to acknowledge the complexity of need that people living in care homes have. Average age of entry 85+years; multiple co morbidities with dementia – average length of stay is 9-18 months. LA's purchase care for people with assessed substantive or critical care needs.	Thank you for your comment. The scope the guideline covers all care homes. The guideline is not specific to older peoples care homes. The guideline includes a section on self-administration of medicines (see section 3.13).
632	National Care Forum	2.2.0	28		Residents where able should be enabled to self-medicate.	Thank you for your comment. See section 3.13 of the full guideline.
633	National Care Forum	2.2.1	28		Please include definition of health and social care practitioner.	Thank you for your comment. A section 'definitions used in this guideline' has been added to the full guideline.
634	National Care Forum	2.24	28		Nurses in care homes are not able to prescribe the training is not open to them. And they are not included in the group that are able to do this.	Thank you for your comment. The term nurse is not used in this section and relates to prescribers more widely as set out in legislation. Nurse Independent Prescribers can issue private prescriptions for any medicine within

						their competence, including some controlled drugs for specified medical conditions.
635	National Care Forum	2.3.5	39		Care Homes do not access to NHS electronic systems	Thank you for your comment. This section has been reworded following discussion by the guideline development group. This recommendation is not specific to care homes, and relates to situations where electronic transfer of information could occur such as between an acute trust and a general practice.
636	National Care Forum	2.4.3	48		The Skills of RN's needs to be acknowledged. Electronic medication systems appear to have been omitted…not sure why? Comments pertaining to funding appear to demonstrate a lack of understanding by NICE of the funding of care in care homes. Any measurement should also relate to the person using the service and their experience.	Thank you for your comment. The guideline development group believe that the skills of registered nurses have been acknowledged. The guideline development group considered the evidence base for electronic medicines systems, however the evidence base was found to be limited. There are no comments in relation to funding in this section. Please see the scope and intended audience of the guideline.
637	National Care Forum	2.6.4 2.6.8	69		'Any medicines safeguarding incident' is too generic…and does not tally with what constitutes safe and effective. This does not consider the scale and impact on the person and does not address the resident's right to decline medication.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
638	National Care Forum		74		Care homes cannot access GP notes. Medication history is not defined or time specific	Thank you for your comment. The guideline development group was aware that care home staff may not have access to GP practice systems. Section 3.7 discusses the process of medicines reconciliation in more detail.
639	National Care Forum	Conclusion			I have not commented on every component as I believe that this	Thank you for your comment. The resources mentioned were not included in the draft

					needs to be reworked if it is to be useful to the sector. The good elements have been lost amidst the perceived lackof knowledge of how the care home sector works and what happens in reality regarding medcines management in care homes. I urge NICE to thoroughly review the work as previously mentioned and funded by DH to inform this standard/guideline.	guideline for consultation as they were published in the public domain imminently before consultation. Resources have been hyperlinked to in the full guideline where appropriate.
640	Central Eastern Commissioning Support Unit	General			Well written but lengthy document. Would value clearer guideline on nurses 'delegating' medicines administration and what training, competencies those staff should receive and how often that is reviewed. The NMC does not give clear guideline either on the interpretation of 'delegation' and some homes see this an opportunity to use untrained staff.	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published. The guideline will be updated in line with NICE processes. Delegation is covered in the NMC guideline; any further clarification on this subject needs to be sought from the NMC as the regulator and would be outside of the scope of this guideline. Training and competency requirements have been covered in detail in section 3.17 of the guideline; this includes frequency of training and review.
641	Central Eastern Commissioning Support Unit	3.3	35	16-18	It should be the responsibility of the care home to check the information they receive is clear and then refer to Health & Social care if they have any queries. It is highly unlikely a social worker is available 24/7 when residents are transferred to check medicines upon arrival. This links to reconciliation page 73	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

642	Central Eastern Commissioning Support Unit	3.7	73	13	The GP should be listed as a named individual and not as part of the 'other' healthcare team. The information provided by the GP practice computer system will contain vital information to help confirm resident's current medication regime or any recent changes.	Thank you for your comment. The guideline development group agreed that the wording as written represents good practice.
643	Central Eastern Commissioning Support Unit	3.4	48	1	the word 'appropriate' is used three times in one sentence	Thank you for your comment. This section has been reworded.
644	Central Eastern Commissioning Support Unit	3.9	86	21-28	Very similar repeat of wording on page 85 lines 26-31. Does it need to be in there twice?	Thank you for your comment. The guideline has been updated to reflect your comment.
645	Central Eastern Commissioning Support Unit	2.14.11	122	27	Following a series of medicines related incidents due to miscommunication when a patient is temporarily absent from the care home or has multiple care providers, we would like to add that the patient's GP must be involved as the main point of contact. If the patient is visiting family etc and obtains medication from elsewhere, there is a risk of confusion and error. This links in with the announcement last week about a named accountable GP for over 75s. Or could this be extended to all vulnerable patients?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
646	Central Eastern Commissioning	3.1	19	9	Our comments are as follows: 'We could like to add that the	Thank you for your comment. This section has been reworded following discussion by the

	Support Unit				medication policy to include some information about ensuring care home staff are aware of relevant medication safety alerts and can action them appropriately if necessary, for example alerts from the National Patient Safety Agency (NPSA), Medicines and Healthcare Products Regulatory agency (MHRA) etc. Our one year project working with care homes to review medication management processes identified a lack of awareness of care home staff in this area.	guideline development group.
647	Central Eastern Commissioning Support Unit	3.8	82	3	Our comments are as follows: 'We could like to add that medications requested by carers should be considered very carefully and other non-pharmacological strategies, including staff training/competency requirements should be considered instead, for example: (i) Medications requested for treating behavioural symptoms in patients with dementia, including antipsychotics, hypnotics and anxiolytics.	Thank you for your comment. The medicines review as stated in the guideline would consider all medicines a resident is taking or using.

					(ii) Feeds requested when carers do not have time to encourage residents to eat or help residents who may be slow eaters etc. Carers to consider closer working with catering staff in care homes as well as other health care supporting staff eg dieticians to review meal and snack options, including fortifying foods where appropriate.	
648	Central Eastern Commissioning Support Unit	3.9	87	27	Our comments are as follows: 'We would welcome further guideline from the guideline development group about use of 'Bulk Prescribing' in care homes if appropriate for certain medications, especially use of 'when required' medications which are not 'Prescription Only Medicines' but prescribed for lots of residents and sometimes supplied within Monitored Dosage Systems, leading to increased waste.	Thank you for your comment. Bulk prescribing was considered by the GDG. Given the limited necessity for bulk prescribing in care homes and the requirements to be met before bulk prescribing can take place the group agreed it was unable to provide recommendations in this area.
649	Central Eastern Commissioning Support Unit	3.12	105	23	Our comments are as follows: 'We would welcome further general guideline from the	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					guideline development group in relation to 'expiry' of liquids medications, creams, ointments, eye drops etc once the original container is opened. Current practice indicates that care homes adopt differing policies, causing increased waste *(as opposed to going through manufacturer's literature or contacting the manufacturer in each instance).*	
650	Central Eastern Commissioning Support Unit				Our comments are as follows: ' We would recommend some guideline be added in relation to crushing tablets in relation to administration of specials. Locally misunderstanding has occurred when care home staff feel they are administering covertly rather than administering medication in a form that can be swallowed to avoid the use of an unlicensed special liquid.	Thank you for your comment. Processes for administering off-label or unlicensed medicines are for local consideration and determination. The guideline includes a section on covert administration of medicines (see section 3.15).
651	Central Eastern Commissioning Support Unit				Our comments are as follows: ' The guideline is ambitious and will require significant changes in some care home to achieve. Some staging or highlighting of legal requirements rather than guideline may be beneficial so that care home managers/ health care staff can prioritise.	Thank you for your comment. In line with NICE style for guidelines, the use of the word 'must' in a recommendation indicates a legal requirement.
652	Central Eastern Commissioning	3.3	30	13	Our comments are as follows: MURs are mentioned in this draft	Thank you for your comment. This section has been reworded following discussion by the

	Support Unit				guideline with respect to patient transfers between care settings Patients leaving secondary care are one of the target* groups of patients that Community pharmacists may provide an MUR to support the patients understanding of their medicines following an episode of treatment in secondary care. Community Pharmacies can claim £28 for each MUR undertaken. In general these MURs are undertaken within the premises of the Community Pharmacy. Community Pharmacists must obtain permission from NHS England to undertake MURs (as part of the NHS contract) in alternative premises.(ie care homes) Patients living in care homes already have access to carers supporting them with their medicines administration it is therefore difficult to see how such a patient will receive any benefit from an MUR as MURs are to support patients who are responsible for administering their own medicines without additional support. The following guideline is provided to Community	guideline development group.

					Pharmacies in Hertfordshire and South Midlands Area Team, requesting permission to provide MURs to patients living in care homes: “Pharmacy contractors should note that general applications to provide MURs to a group of residents in a care home will not ordinarily be approved given the level of support which these patients already receive. However, applications in respect of individual care home residents will be considered on a case by case basis by the NHSCB (Herts & South Midlands Area Team) and may be approved in circumstances where in the NHSCB (Herts & South Midlands Area Team)’s opinion there is likely to be benefit to the patient as envisaged by the Directions. This may be more likely, for example, where the resident is solely responsible for administering their own medication *patients recently discharged from hospital who had changes made to their medicines while they were in hospital. Ideally patients discharged from hospital with receive an MUR within four weeks of discharge but in certain	

					circumstances the MUR can take place within eight weeks of discharge;	
653	Scarborough and Ryedale Clinical Commissioning Group	3.9	87	19	Recording in homes care plans is mentioned several times in relation to capacity assessments, medication reviews etc. GPs do not have time to be double recording all information, it adds 3 to 4 minutes to each visit so multiply that by 15 visits per day (70% of our visits are to care homes) and you see how it adds up. We are responsible for keeping our records up to date but nowhere in a GMS contract is there anything about keeping other organisations records up to date.This comment also applies to recommendation 2.9.2 p89 and recommendation 2.9.4 p90 and any other reference to the GP filling in the resident's care plan at the home.	Thank you for your comment. Section 3.9 of the full guideline refers to prescribers, not to GPs specifically as there may be more than one prescriber for any given resident. The GMC Good medical practice guide recommends communicating effectively with colleagues seeking information. Section 3.2 of the full guideline sets out the Caldicott principles for information sharing to support better and safer care.
654	Scarborough and Ryedale Clinical Commissioning Group	3.11	98	28-31	Same comment as above applies to the updating of MAR charts.	Thank you for your comment. The GMC Good medical practice guide recommends communicating effectively with colleagues seeking information. Also the Caldicott principles set out in section 3.2 require information to be shared if it is expected to result in better or safer care.
655	Scarborough and Ryedale	3.5	52	30	Several references to problems related to several different GP	Thank you for your comment. The guideline development group was aware of the issues

	Clinical Commissioning Group				practices having patients in one home with different systems leading to a recommendation that the home should "promote" the use of a single practice. This would also apply to p54 line 11 This contravenes patient choice agenda which is also in the NHS constitution, and the emphasis in this guideline on patient centred care. (section 1.5) Many of us would support the principle of this but patient choice is there, what is the difference between promotion and coercion? We have had incidents around this issue	raised and have not made a formal recommendation on whether a preferred provider GP should be used. The guideline development group acknowledged that having several GP providers has been identified as a cause of medication error in care homes, and having a preferred provider as a potential intervention to reduce error has previously been advocated.
656	Scarborough and Ryedale Clinical Commissioning Group	3.2	25	29	Issues around capacity Not practical for capacity to be assessed and recorded every time a prescription is issued.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
657	Scarborough and Ryedale Clinical Commissioning Group	3.15	130	2	Covert administration of medicines- recommending best interests meeting before this happens, ok generally but not appropriate in an acute situation eg acute confusion from urinary tract infection	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
658	Scarborough and Ryedale Clinical Commissioning Group	3.8	76	2	Medication reviews. It is not entirely clear what is being recommended by the guideline. Again need to be mindful of what is in GMS contract and therefore allegedly funded now. Comment	Thank you for your comment. This wording has been amended following further discussion by the GDG.

					applies to whole section	
659	Scarborough and Ryedale Clinical Commissioning Group	3.8	79	15	Who is responsible for arranging the multidisciplinary team meetings? Please clarify.	Thank you for your comment. Details of the process are for local consideration and determination.
660	Scarborough and Ryedale Clinical Commissioning Group	3.8	80	17,18	Are 6 monthly multidisciplinary team meetings necessary?	Thank you for your comment. The draft guideline recommends that the frequency of review should be determined on an individual case-by-case basis, depending on the health and care needs of the resident, with resident safety paramount in decision-making. However, the GDG agreed that the frequency of a multidisciplinary medication review should not exceed 1 year.
661	Scarborough and Ryedale Clinical Commissioning Group	3.8	79	16,17	Who should lead the multidisciplinary team review ?	Thank you for your comment. Details of the process are for local consideration and determination.
662	Scarborough and Ryedale Clinical Commissioning Group	General			This generally has good points but is completely devoid of any realistic consideration of resource issues.	Thank you for your comment. The guideline development group considers the resource implications of implementing the guideline when reviewing the evidence and producing recommendations.
663	Coastal West Sussex Clinical Commissioning Group	3.2	28	26	Recommendation 2.2.4 implies that all residents of care homes should have a mental capacity assessment carried out by the GP and recorded by the GP in the patient's care plan. This is not currently funded under GMS and is not currently part of a national DES.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
664	Coastal West Sussex Clinical	3.8	83	1	Recommendation 2.8.4 and 2.8.3 emphasizes the importance of	Thank you for your comment. The draft guideline recommends that the frequency of review should

	Commissioning Group				multidisciplinary medication reviews involving relatives, patients, care home staff but does not consider the impracticality of this being face to face, 6 monthly and is not currently funded under GMS and is not currently part of a national DES.	be determined on an individual case-by-case basis, depending on the health and care needs of the resident, with resident safety paramount in decision-making. However, the GDG agreed that the frequency of a multidisciplinary medication review should not exceed 1 year. Details of the process are for local consideration and determination.
665	Coastal West Sussex Clinical Commissioning Group	3.9	86	10	There is currently no requirement for a GP to write all medications prescribed in the patient's care plan, diections for use, duration, indication, and updating any changes in the care plan (duplicating a entry already made into the patient's computer clinical record, and on an FP10) and is not currently funded under GMS and is not currently part of a national DES.	Thank you for your comment. The guideline development group agreed that the wording as written represents good practice.
666	Coastal West Sussex Clinical Commissioning Group	3.9	87	19	This again is requiring the GP to write extensive notes in the patient's care plan, duplicating entry from the electronic patient record, and is not currently funded under GMS or part of a national DES	Thank you for your comment. The guideline development group agreed that the wording as written represents good practice.
667	Coastal West Sussex Clinical Commissioning Group	3.11	98	28	GPs do not currently have a 'shared responsibility' for maintaining and updating a MAR chart (and for ensuring that known allergies are recorded on the MAR chart) and this is not currently funded under GMS or currently part of a national DES.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

668	Coastal West Sussex Clinical Commissioning Group	3.16	132	1	West Sussex have had a 'homely remedies' policy covering the whole PCO and endorsed by the PCO, negating the need for separate care home policies. I am not aware of any clinical incident that has occurred as a result of this in the past 20 years. This section involves extra, unnecessary work for primary care that is not currently funded under GMS or is part of a national DES.	Thank you for your comments. This was identified as an area for inclusion in the guideline at the scoping phase. The process for managing homely remedies may or may not involve local primary care teams, details of the process are for local consideration and determination.
669	Coastal West Sussex Clinical Commissioning Group	4	144	1	There does not appear to be an implementation strategy including how this additional workload for primary care should be funded.	Thank you for your comment. Your comment has been considered as part of the implementation of the guideline process. Full details of the process can be found here.
670	Fylde and Wyre Clinical Commissioning Group	General			A general comment - the number of recommendations is overwhelming (very long document) so it will be important to consider the presentation of the recommendations to aid quick reference so that the document is usable to give practical advice of good practice. It will be important that care home staff can interpret and understand the good practice information held with this guide in order for this to be practically implemented. It covers many areas though and will be a useful reference for pulling all the best practice guideline together. No doubt it will be useful CQC will be	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published. The CQC has been a stakeholder in the development of this guideline. The guideline does not form part of the regulatory framework for care homes and provides recommendations for good practice.

					able to quote from this in terms of compliance with Outcome 9.	
671	Parkinson's UK	General	General	General	Concern about how the guideline will be taken forward in light on a lack of requirement from CQC/Ofsted (especially given statement in first paragraph of p117)	Thank you for your comment. Unfortunately the implementation of this aspect of the guideline in respect of other agencies is outside the scope of this guideline.
672	Parkinson's UK	General	General	General	Not enough emphasis on the contribution of a person's prior experience with their medicines – generally appears to assume that the person comes with no prior knowledge or information to contribute to their management	Thank you for your comment. The guideline development group discussed and agreed that the self-administration of medicines by residents section considers this (see section 3.13).
673	Parkinson's UK	General	General	General	Helpful to have references to healthcare legislation (as care homes may be more familiar with social care legislation)	Thank you for your comment.
674	Parkinson's UK	General	General	General	Could start each section with the recommendations for emphasis	Thank you for your comment. The format is considered by the NICE publishing team and follows the NICE style.
675	Parkinson's UK	General	General	General	Need to consider how this guideline will be disseminated in appropriate language to care home staff	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published. The guideline will be updated in line with NICE processes. Wording is considered by the NICE publishing team.
676	Parkinson's UK	3.2	23	1-8	Include having access to a translator during discussions about medications	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
677	Parkinson's UK	3.3	32	1-2	How would this work in practice?	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration

						and determination.
678	Parkinson's UK	3.3	34	8	Could the knowing 'why, when and what medicines they are taking' in line 15 be also be required of the professionals?	Thank you for your comment. The requirement for health professionals to ensure that residents are aware of the why, when and what of their medicines requires the health professional to understand these things too.
679	Parkinson's UK	3.3	37	25	Could what is considered 'core information requirements' be clarified to specify name, dosage, frequency and timing?	Thank you for your comment. This section has been reworded following discussion by the guideline development group (see section 3.3 of the full guideline).
680	Parkinson's UK	3.3	39	2.3.3	Should clarify what 'accurate information' is – specifying name, dosage, frequency and timing?	Thank you for your comment. Wording was considered by the NICE publishing team.
681	Parkinson's UK	3.4	43	30	Should clarify the content requirements of the medication administration record	Thank you for your comment. See section 3.14 of the full guideline for this information.
682	Parkinson's UK	3.4	47	21-23	Need to highlight that some side-effects may not be immediate, e.g. impulsive and compulsive behaviour with Parkinson's medication	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
683	Parkinson's UK	3.5	52	21-	Should include 'inappropriate substitution with generic equivalents'	Thank you for your comment. This is outside the scope of this guideline.
684	Parkinson's UK	3.5	53	9-	Should include 'drug round timings not coinciding with prescribed timings of medications'	Thank you for your comment. See section 3.14 of the full guideline for information on care home staff administering medicines to residents.
685	Parkinson's UK	3.5	54-55	29-5	This should include processes to support specific medication needs for specific service users groups/individuals and clear ramifications for the incidence of missing doses, not providing medication on time or	Thank you for your comment. See section 3.14 of the full guideline for this information.

					administering medications in a specific manner as prescribed.	
686	Parkinson's UK	3.6	70	2.6.9	General – good to see resident safety incidents are to include near misses (which, for Parkinson's medications, would include delayed doses)	Thank you for your comment.
687	Parkinson's UK	3.7	74	22	Current medications list should include timing (for time-critical medications); also (brand) name	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
688	Parkinson's UK	3.7	75	2.7.3	Current medications list should include timing (for time-critical medications); also (brand) name	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
689	Parkinson's UK	3.8	78	24-27	Should include resident's specialist team	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
690	Parkinson's UK	3.8	79-80	25-1	Should include resident's specialist team	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
691	Parkinson's UK	3.8	81	4-8	Should also include 'residents taking time-dependent medications'	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
692	Parkinson's UK	3.8	82	12-13	Broaden to 'immediate and sustained impact of adverse effects'	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
693	Parkinson's UK	3.8	84	2.8.6	Broaden to 'immediate and sustained impact of adverse effects'	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
694	Parkinson's UK	3.9	86	13	Need to clarify 'expected duration' – is this of action or of use? – could both be highlighted?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
695	Parkinson's UK	3.9	89	2.9.2	Add expected duration of action (for time-critical medications)	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
696	Parkinson's UK	3.11	98	19-20	In this instance, should the	Thank you for your comment. The guideline

					‘second person’ be of a more senior level? (given that this is the record against all actions with medications are taken against)	development group agreed that the recommendation as written represents good practice. This comment makes an assumption that ‘more senior’ implies trained and competent which may not be the case.
697	Parkinson’s UK	3.11	99	7	Add ‘timing (if appropriate)’	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
698	Parkinson’s UK	3.11	101	2.11.3	Add ‘timing (if appropriate)’	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
699	Parkinson’s UK	3.13	110	6-8	General – good to see self-administration as the starting point for medicines management	Thank you for your comment.
700	Parkinson’s UK	3.14	119	2-4	Is this sentence positive or negative about monitored dosage systems?	Thank you for your comment. This statement summarises the use in current practice of monitored dosage systems from evidence provided to the guideline development group.
701	Parkinson’s UK	3.14	122	21	Add ‘ but only if clinically appropriate’	Thank you for your comment. This section has been reworded.
702	Parkinson’s UK	3.16	132	22-24	Another example is homely remedies that may interact with other medications (e.g. cough and cold preparations containing sympathomimetics should be avoided with some Parkinson’s medications)	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
703	Parkinson’s UK	3.16	133	2.16.1	Another example is homely remedies that may interact with other medications (e.g. cough and cold preparations containing sympathomimetics should be avoided with some Parkinson’s medications)	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.

704	Parkinson's UK	-	150	3-4	Are 'written modifications to the prescription made by a pharmacist following contact with the prescriber' a dispensing error?	Thank you for your comment. The definition for dispensing error has been taken from the CHUMS.
705	Parkinson's UK	3.17	138-139	24-5	Should also be supplemented with training in medication which should include condition-specific training (where there are specific considerations such as Parkinson's where timing is crucial), potential side effects and their management and the importance of accurate timely reporting systems.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
706	Sussex Community NHS Trust	3.3	38	20-22	It is stated that the guideline development group identified the need for care home staff, residents, carers and relatives to be aware of unintended side effects etc. However, this section does not appear to then cover or provide clear recommendations regarding how this will be achieved.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
707	Sussex Community NHS Trust	3.3	45	18-23	Medication Administration Records (MARs): This section refers to care home staff completing hand-written MARs and refers to double checking. However, there is no guideline about the expected standard to follow when completing these hand-written MARs. This also includes making any changes to the MAR e.g., adding an acute	Thank you for your comment. Sections 3.11 and 3.14 of the full guideline provide further information about medicines administration records.

					medicine or changes of doses (e.g., warfarin) in responds to changes to INRs.	
708	Sussex Community NHS Trust	3.3	45	18-23	Medication Administration Records (MARs): This document makes several references to the NMC medicines management standards. There is also a standard for transcribing (standard 3) (see point 4). For many care homes it may be a care worker who will complete the MAR and another care worker who will check the MAR. Is the completion of the MARs considered transcribing? If so would it be possible for the guideline development group to produce a definition for this? Will it also be possible to provide guideline for completing a MAR (how to).	Thank you for your comment. This section has been reworded following discussion by the guideline development group. Care homes do not undertake a process of transcribing as the medicines administration records are not prescriptions but are records of administration.
709	Sussex Community NHS Trust	3.3	45	24 -29	Medication Administration Records (MARs): This section stated the hand-written MARs should be completed by competent and a designated responsibility for medicines in care homes. Again there is a need for clear guideline for completing of a MAR to help determine what competencies are required to do this. Please can this be included in this document.	Thank you for your comment. Section 3.17 of the full guideline provides further information about medicines administration records.

710	Sussex Community NHS Trust	3.3	46	1	Use of text messages. Unclear why this draft guideline includes a whole section on text messages when there are also different methods available such as use of email, telephone calls and faxes. If text messages are included so should other methods.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
711	Sussex Community NHS Trust	3.3	49	17 - 20	Also include supply as an area where errors happen.	Thank you for your comment. 'Supply' would be included as part of the dispensing process.
712	Sussex Community NHS Trust	3.5	54	15-16	For care homes used as intermediate care (up to six week) for patients admitted from the acute hospital trust/or directly from home: Medication reviews by a pharmacist should take place within at least 24-72 hours. Waiting 6 months or even 1 month is not appropriate.	Thank you for your comment. This section has been reworded following discussion by the guideline development group. Medicines reconciliation is advocated after transfer of care. Medication review frequency is based on the needs of each individual care home resident.
713	Sussex Community NHS Trust	3.5	55	8	Remove the word 'reduce' (medication errors) and replace with review, learn and improve. (It is noted that the guideline development group (page 62, line 6) saw evidence of barriers to an open reporting culture. Therefore, remove the word 'reduce'.	Thank you for your comment. Wording was considered by the NICE publishing team.
714	Sussex Community NHS Trust	3.6	62	1-4	'Factors outside the care home environment such as..' add in acute hospital trusts.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
715	Sussex Community NHS Trust	3.8	76	10-15	Examples could be included regarding the complex medicines regimen some children are on as this whole section mainly refers to	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.

					the CHUMS study which is for older residents.	
716	Sussex Community NHS Trust	3.8	79	6-8	“The guideline development group agree the process should ideally be led by a dedicated care home pharmacist with the appropriate experience”. Note that children care homes are also covered here and the few pharmacists that do provide input may not be referred to as care home pharmacists. It is good that some of the requirements to these pharmacists are listed.	Thank you for your comment.
717	Sussex Community NHS Trust	3.8	81	4-5	More frequent medication reviews should be undertaken for patients admitted to a care home following an acute admission or as part of being admitted to a care home from home for a limited time as part of avoiding an acute admission. The draft guideline does acknowledge that it is when transferring patients from one care setting to another that errors seem to occur. More regular reviews for these patients should help with reducing these errors.	Thank you for your comment.
718	Sussex Community NHS Trust	3.8	82	12-13	Inhaler techniques should be listed as well.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
719	Sussex Community NHS Trust	3.10	91	1-2	Verbal changes: This should be covered in section 3.3 where ‘text messages’ are covered. Process for verbal changes should be	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					more explicit.	
720	Sussex Community NHS Trust	3.11	98	6	Unclear why the section on 'Medication Administration Records' is listed under the main heading of "3.11 Dispensing and supplying medicines". Medication Administration Records should be a separate section. Note that community pharmacy generally will only complete a MAR for when they also provide the supply. Patients being admitted from acute hospital trusts directly into a care home with their discharge supply will either have the acute trust provide a MAR (which not all will) or a care worker will have to hand-write the MAR. There are sufficient issues around the MAR for this to warrant a separate more detailed section. Also children in care homes may have complex needs and medicines. They may have been seen by a specialist and have their medicines dispensed by a specialist centre. These will therefore need to be 'transcribed' by care staff onto the MAR.	Thank you for your comment. The format was considered by the NICE publishing team.
721	Sussex Community NHS Trust	3.14	118	26-28	States that care home staff must not prepare medicines in advance for administration. However, in some children homes this may	Thank you for your comment. Standard 14 of the NMC Standards for medicines management refers to exceptions in the case of medicines for injection or infusion, not the preparation of

					take place for named individual children (following clear protocols including clear records and labelling). This is also included in the NMCs standard for medicines management (standard 14). It is not helpful to state “This is known as ‘potting up’ which is illegal and does not follow good practice’. Please can this be amended and/or made more explicit.	tablets in advance to which the guideline refers. ‘Potting up’ would be considered a contravention of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 regulation 13 and would therefore be considered illegal. This section has been reworded for clarity. See also comment 175 from the Care Quality Commission.
722	Sussex Community NHS Trust	3.14	general		All the medicines administration issues appear to mainly relate to care homes for older people and not really including care homes for children.	Thank you for your comment. The guideline is based on the available evidence upon which to make recommendations. Evidence identified primarily was in care homes for older people however the guideline development group advised that the principles of the recommendations would be applicable to other care settings. Where recommendations are different for different care settings this is stated.
723	Sussex Community NHS Trust	3.14	general		Community nurses may attend a care home to administer certain medicines (e.g., often injectables or set-up syringe drivers). However, they tend to use their own documentation for recording the administration. There is no clear guideline if they should also record this on the MAR. This draft guideline document is an opportunity to clarify this.	Thank you for your comment. This is included in section 3.14 of the full guideline.
724	Sussex Community NHS Trust	General			This document makes references to various types of pharmacists Primary Care Pharmacists, Care Home Pharmacists or Community	Thank you for your comment. A section ‘definitions’ has been added to the guideline in response to your comment.

					Pharmacists. There are also other types of pharmacist providing this input which may be community health services pharmacists and independent private providers. It is also noted that there is no reference to pharmacy technicians.	
725	Sussex Community NHS Trust	General			Although this document includes children care homes the majority of the content relates to care homes for older people. Children may transfer between school and care home which has a different set of issues that is not really covered in this document.	Thank you for your comment. The guideline is based on the available evidence upon which to make recommendations. Evidence identified primarily was in care homes for older people however the guideline development group advised that the principles of the recommendations would be applicable to other care settings. Where recommendations are different for different care settings this is stated.
726	Stoke-on-Trent Clinical Commissioning Group	General			This guideline is very much welcomed, particularly at a time when care homes, service providers and commissioners are seeking clear direction on medication related issues within care homes.	Thank you for your comment.
727	Stoke-on-Trent Clinical Commissioning Group	General			This guideline clarifies best practices for many relevant topics however there appears to be gaps with reference to specific issues at present (see below).	Thank you for your comment.
728	Stoke-on-Trent Clinical Commissioning Group	General			More detailed guideline should be provided with reference to homely remedies. Although details for a given policy may be determined locally the current guideline does not provide sufficient direction.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.

					The guideline does not assist in clarifying issues/questions surrounding homely remedies and adds little or no extra knowledge around this topic.	
729	Stoke-on-Trent Clinical Commissioning Group	General			This guideline seeks to ensure safe use of medication within care homes however currently it does not address or highlight the need for policies relating to crushing tablets/opening capsules or the administration of medication off-label.	Thank you for your comment. Processes for administering off-label or unlicensed medicines are for local consideration and determination.
730	Stoke-on-Trent Clinical Commissioning Group	3.4	45	27	Consider addition: handwritten additions should be in indelible ink and not altered e.g. Tipp-Ex (which is common practice within some homes)	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
731	Stoke-on-Trent Clinical Commissioning Group	3.4	46	30	It is unclear what this sentence is trying to say 'seek assurance that that the sender'	Thank you for your comment. This section has been reworded.
732	Stoke-on-Trent Clinical Commissioning Group	3.9	87	20	For creams/ointment lotions – area to be used. The circumstance maybe dry skin but the location/area may only be for the lower legs. Although addressed elsewhere this point seems relevant here also.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
733	Stoke-on-Trent Clinical Commissioning Group	3.10	91	1-2	There does not appear to be any guideline given on the verbal changes to medicines i.e. telephone/ mobile. The NMC's Standards for medicines management (2010) discusses	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					remote prescription or direction to administer. The NMC (standard 11) states that 'a verbal order is not acceptable on its own. The fax or email prescription or direction to administer must be stapled to the patient's existing medication chart. This should be followed up by a new prescription signed by the prescriber who sent the fax or email confirming the changes within normally a maximum of 24 hours (72 hours maximum – bank holidays and weekends)."	
734	Stoke-on-Trent Clinical Commissioning Group	3.11	98	23	Consider addition: community pharmacist must ensure current prescribed medication remain on MAR chart even if they are not ordered by care staff each cycle. Experience has shown that some pharmacies only print ordered medication on MAR chart each month. Therefore if a medication has not been ordered that month (care home may have sufficient stock) it would consequently be omitted resulting in care staff handwriting the medication on the MAR chart.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
735	Stoke-on-Trent Clinical Commissioning Group	3.12	105	12-17	It is unclear what this sentence is trying to say and its relevance	Thank you for your comment. Wording was considered by the NICE publishing team.
736	Stoke-on-Trent	3.12	108		Recommendations 2.12.4: should	Thank you for your comment. This section has

	Clinical Commissioning Group				clearly indicate 'no requirement for disposal'. Rewording of 3rd bullet point required it change implemented.	been reworded following discussion by the guideline development group.
737	Stoke-on-Trent Clinical Commissioning Group	3.14	118	3	Care home staff should be trained on how to recognise/identify reasons for giving 'when required' medicines	Thank you for your comment. See section 3.17 of the full guideline.
738	Stoke-on-Trent Clinical Commissioning Group	3.14	118	5	Consider addressing the issue of care homes insisting 'all residents' have 'when required' medication prescribed as regular medication because care homes claim staff are untrained. There are obviously circumstances where 'when required' medicines maybe required.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
739	Stoke-on-Trent Clinical Commissioning Group	3.14	120	12-14	Homes often sign 'when required' medication at every drug round to indicate it has been offered to residents, even though it is not required. Do the guideline in box 7 therefore indicate this practice is not required?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
740	Stoke-on-Trent Clinical Commissioning Group	3.14	107		Table 3 –helpful table for clarifying disposal requirements for controlled drugs	Thank you for your comment.
741	East and South East England NHS Specialist Pharmacy Services (Medicines Use & Safety)	3.1	19	9	Why no recommendations specifying that homes should get pharmacist advice when developing medicines policies? NMS care homes (9.9) recommend that ....The registered manager seeks information and	Thank you for your comment. The Care Standards Act (2000) and the National Minimum Standards document no longer apply to Care Homes in England and have been replaced by the HSCA (2008). No published evidence was found from the

					advice from a pharmacist regarding medicines policies within the home. This is important because often some homes develop policies that are not necessarily in line with best practice e.g disposing of unused creams after 28 days, not having homely remedies	literature search for the guideline regarding this intervention.
742	East and South East England NHS Specialist Pharmacy Services (Medicines Use & Safety)	3.3	34	19-23	Note that in the USA the meaning of “consultant pharmacist” is significantly different from its meaning here in the UK- this should be made clear to avoid confusion with “consultant pharmacists” role in UK. The USA consultant pharmacists are accredited medication therapy management experts who provide advice on the use of medications by older adults in the community or in long-term care facilities). The closest role to this in the UK is the “care home pharmacists”.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
743	East and South East England NHS Specialist Pharmacy Services (Medicines Use & Safety)	3.3	34	24-25	Replace “primary care provider” with “primary or secondary care prescriber” to make it clearer as primary care provider could be any one providing care in primary care.	Thank you for your comment. Wording was considered by the NICE publishing team. A section ‘definitions used in this guideline’ has been added to the guideline.
744	East and South East England NHS Specialist Pharmacy	3.11	99	18	Replace “taken off “with “crossed off” as the drug cannot be taken off the chart in reality	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Services (Medicines Use & Safety)					
745	East and South East England NHS Specialist Pharmacy Services (Medicines Use & Safety)	3.11	99	22	Replace “taken off “with “crossed off” as the drug cannot be taken off the chart in reality	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
746	East and South East England NHS Specialist Pharmacy Services (Medicines Use & Safety)	3.16	132	6	Homely remedies can also be bulk prescribed by a GP on NHS prescription, subject to meeting the conditions in the Drug Tariff	Thank you for your comment. Bulk prescribing has not been covered within this guideline.
747	East and South East England NHS Specialist Pharmacy Services (Medicines Use & Safety)	General			The CHUM study recommended having a named pharmacist with overall responsibility for management of medicines in the homes. Why was this not taken forward as a recommendation by the group? Historically such advice/support which is usually over and above what a generalist community pharmacist can provide was given by pharmacists (with appropriate knowledge and expertise) employed by CQC’s predecessor (CSCI) Currently in the UK it is not routine practice for care homes to get pharmaceutical advice and	Thank you for your comment. The guideline development group was aware of regions where care home pharmacist posts exist, however the review questions for the guideline did not specifically look for evidence for the effectiveness of the role of a care homes pharmacist. The guideline development group can only make recommendations based on evidence. Although the CHUMS report recommended having a named pharmacist for managing medicines in care homes, it did not evaluate the effectiveness of this role within the study.

					support from a pharmacist. Some of the bigger care home organisations may have support, others may or may not have informal local arrangements via the local community pharmacist and few NHS organisations may commission a care home pharmacist/team/community pharmacist enhanced service to provide this support. Example will be advice on developing clinical guidelines, policies, controlled drugs, drug alerts, safeguarding etc	
748	East and South East England NHS Specialist Pharmacy Services (Medicines Use & Safety)	general			Involvement of community pharmacists in medication review and medicines reconciliation (mentioned in sections 3.7 &3.3) are extended roles over and above what is expected to dispense or supply medicines. A community pharmacist will not necessarily have to (except out of good will) be involved in clarifying discrepancies /medicines reconciliation following the transfer of care unless they have dispensed medication for the patient at the time of discharge. Also the current pharmacy contract payment structure poses a disincentive for community pharmacists to reduce the number	Thank you for your comment. These sections have been reworded following discussion by the guideline development group and a section 'definitions' has been added to the guideline in response to your comment.

					of items they dispense- how realistic is it to ask them to be actively involved in reducing polypharmacy which is an inevitable outcome of a good medication review? from a practical point of view to facilitate successful local implementation of related recommendations, These important extended pharmacist roles need to be recognised within the guideline and so that the gaps can be addressed It will be helpful for the group to clarify the roles/boundaries so commissioners and providers know what is part of routine/ essential pharmacy contract and what is an enhanced service that need to be commissioned. Also this will ensure consistency and equitable access to pharmacy/medicines optimisation services and provide the framework for pharmacy providers to be held to account for the services delivered rather than the current informal approach	
749	Sue Ryder	General			**About Sue Ryder** Sue Ryder provides incredible care for people with life-changing conditions. Whether it's bringing comfort to someone's final days	Thank you for your comment.

					or enabling them to make the most of their life, we are here for them and their loved ones. We treat everyone in our care as an individual, taking the time to see the person not the condition. We enable people to live the life they want, and do everything we can to ensure their time with us is the best it can be. We do this in our hospices, in our neurological care centres, in the community and in people's homes. The care centres reflect traditional care home settings and care for people with complex conditions and progressive neurological conditions. Centres have a bed range between 22 and 44. Medicines are prescribed for a range of therapeutic, diagnostic and preventative purposes.	
750	Sue Ryder	General			Sue Ryder welcomes the opportunity to respond to this consultation in addition to the involvement at scoping stage. We strongly welcome the guideline that will strengthen our existing medicine management policies. We particularly support the section 3.5 on recommendations around medication errors to help identify and inform the	Thank you for your comment.

					management of risk. In this response we have highlighted a few areas where we think the guideline could be strengthened or where there is need for additional clarity.	
751	Sue Ryder	3.2	22	3-11	We support the guideline at this point, but would want it to be strengthened to ensure that not only are a person's needs and preferences taken into account, but that their assessment and package of care is person centred to reflect their needs, goals and aspirations. This is vital to ensuring that the individual is at the heart of their care. Residents in care homes should not only have the opportunity to make informed decisions, this should be offered explicitly. The guideline at this point refers to health professionals following the practice relating to gaining consent; we would like this to also include care workers. We would like the guideline to acknowledge that residential homes are often reliant on care workers rather than health care professionals to understand the principles of consent and the Mental Capacity Act on a day to day basis. This	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					can often lead to difficulties due to lack of awareness and training.	
752	Sue Ryder	3.2	25	26-29	This point in the guideline doesn't reflect the realities of the role of health professionals within care homes. In a care home where there isn't nursing the GPs who prescribes are not currently involved in assessing capacity to self- medicate, nor writing a care plan to reflect this. We are therefore concerned that this part of the guideline would be harder to apply. In regards to this point and the point made above, we are concerned about the lack of insight from the guideline in to the level of involvement of health and care professionals in delivering a person's care in a care home without nursing. There needs to be clarity in the guideline around responsibilities between health care professionals and care workers in this setting. We believe the guideline needs to be strengthened to take into account how the MCA, assessing mental capacity and consent in a care home is done when qualified healthcare professionals aren't employed in the home.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
753	Sue Ryder	3.4	45	18-29	This section is a vital part of	Thank you for your comment.

					records management. A lack of understanding of why this process is needed causes errors or failure to follow it.	
754	Sue Ryder	3.5	49	17-20	We would like this list expanded to include *storage* and *disposal.* Medicines can be stored incorrectly, for example not at the right temperature, and not disposed of correctly, both are significant medicines management errors and should be considered.	Thank you for your comment. For the purpose of the guideline, the guideline development group agreed that, medication errors included prescribing, dispensing, administration and monitoring errors based on the evidence that was found. Systems and processes for storage and disposal of medicines are included in the full guideline (see section 3.12).
755	Sue Ryder	3.6	59	16-20	We support this statement that interpretation and understanding of the term safeguarding is inconsistent. As a national organisation we are often confused by the different approaches that local authorities have taken with regard to safeguarding and what would be defined as a safeguarding incident. We would encourage that reporting requirements need to be explicit in the guideline.	Thank you for your comment.
756	Alliance Boots	**General**			**Pharmacists and pharmacy staff (skillmix)** Many of the comments and recommendations refer to pharmacists (including community pharmacists) delivering services, support and advice to care home operators, staff and patients. We believe that greater use could	Thank you for your comment. This wording has been amended following further discussion by the guideline development group.

					be made of the range of skills and experience across the whole pharmacy team, including pharmacy technicians and dispensers. For example, where the advice or support to care homes is around the ordering or supply of medicines, this might well be better handled by pharmacy dispensing staff who will be familiar with the issues than by a pharmacist. This would be a more appropriate use of skillmix. To facilitate this, the guideline should note that where specific reference is made to pharmacists, this could also include other members of the pharmacy team, where they have appropriate skills, experience or operational knowledge.	
757	Alliance Boots	**General**			**Bringing guideline to life** Although the draft guideline is comprehensive, it is also very lengthy. In order to bring the recommendations to life, it might benefit from some information being provided as exemplar templates, checklists or suggested audit forms. Examples could be sought from within NHS bodies and specialist groups.	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published. A 'who should take action' section for the recommendations has been included in the guideline as a result of this comment. Following the implementation needs assessment process a care home medicines policy checklist will be developed to support implementation of the guideline.
758	Alliance Boots	**3.1**	17	15-16	**Care homes medicines policy**	Thank you for your comment.

					We agree that responsibilities and reporting arrangements should be stated in service level agreements or contract specifications, but we note that there is currently considerable variability between care home operators and commissioners in the terms and requirements in such documents	
759	Alliance Boots	**3.2**	20	6-8	**Involving patients** While we support the sentiment that patients should be enabled and assisted to retain control of their medicines, we believe that this will not always be possible in practice. Issues with medicines adherence (forgetting to take them, not using correct doses, being confused as to whether doses have been taken or not) can be tipping points that lead to a decision to admit a person to a more structured residential care setting. There could also be considerable practical difficulties within care homes if patients were encouraged to order their own medicines from differing pharmacy suppliers, especially in regard to deliveries and seeking advice. This could increase the chances of medication errors and incidents.	Thank you for your comment. The guideline development group discussed and agreed that the residents should be enabled and assisted to retain control of their medicines where possible (see section 3.13 of the full guideline).
760	Alliance Boots	**3.2**	28		**Recommendation 2.2.2**	Thank you for your comment. This section has

					Information about refusal to take medication should also be fed back to the community pharmacy making the supply, in order to avoid excessive or unnecessary supplies of medicines being made. We believe that care home operators may also need to have policies or procedures in place so that care home staff can deal with "informed refusal", including their own duty of care to inform other healthcare staff, including prescribers, where such refusal might lead to perceived patient harm.	been reworded following discussion by the guideline development group.
761	Alliance Boots	**3.3**	34	19-25	**Improving transfers of care** The "consultant pharmacist" role is not well established yet in the UK and there is no clear process at present for accrediting such roles outside the hospital sector. We are not aware of any such "consultant pharmacists" specialising in care home roles. We believe that NICE should take care not to make simple translations from models established in other countries (eg, USA) to the UK market and NHS structures. We agree that community pharmacies should have a key role in reconciling medications	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					after any transfers of care, including admission/discharge from hospitals and admission or transfer to care homes. In Wales, this has been formalised (and funded) as Discharge Medicines Reviews (DMRs), an Advanced Service under the Community Pharmacy Contractual Framework. A similar service should be established and funded for pharmacies in England and patients in care homes should be eligible for it. [See also comments on Section 3.7, below] Community pharmacies can talk to primary care providers and other pharmacies about patients who have been (or will be) in their care, but they will need to be provided with details of who they need to contact. Information also needs to be shared and transferred when care home operators decide to move their pharmacy supply to another provider.	
762	Alliance Boots	**3.3**	34 35	31 1-2	**NHSmail** There are a number of technical issues relating to data security, access, archiving and identification that need to be overcome before NHSmail (nhs.net) e-mail addresses can be made widely available over	Thank you for your comment.

					corporate e-mail systems. These may be addressed in future IT upgrades (eg, NHSmail2).	
763	Alliance Boots	**3.4**	45	19-23	**Records management** While we agree that cross-checking of hand-written medication administration records should be regarded as good practice, we question whether this is entirely practicable in current circumstances, given the staffing implications. The implication is that moving to electronic records would eliminate this, but such records have their own issues, including identification of who made the initial input and any subsequent amendments. Systems also need to be in place to ensure that such records are always available, even during emergencies.	Thank you for your comment. The guideline development group agreed that this represents good practice.
764	Alliance Boots	**3.4**	47	10	**Reporting adverse effects** The guideline makes reference to the Nursing and Midwifery Council (NMC) standards, but not all care home staff are registered nurses. It may be necessary to have processes so that suspected adverse incidents are referred to a senior member of staff, such as a nurse, for investigation. Advice may also need to be sought from the pharmacist at the relevant pharmacy making the supply of	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					the medicine.	
765	Alliance Boots	**3.4**	47	15	**Yellow card reports** Consideration should be given to involving the community pharmacy making the supply of medicines in any reporting of adverse events via the Yellow Card scheme. In any case, pharmacy teams should be informed about serious adverse reactions so that they can update their own records to ensure that the same medication (or similar products) are not accidentally supplied again.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
766	Alliance Boots	**3.5**	54	15-16	**Medication errors** We believe that there are considerable resourcing implications from the suggestion that pharmacists should conduct a medication review “for all residents at least every six months”. This would need to be funded through the Community Pharmacy Contractual Framework to be practicable.	Thank you for your comment. As stated in the guideline these are strategies that have been suggested but there is no evidence to recommend any one strategy over others suggested.
767	Alliance Boots	**3.6**	55-68		**Safeguarding** We believe that the position of community pharmacists in safeguarding needs to considered more closely. Pharmacists are likely to visit different care home settings and, as healthcare professionals, are in a position to make judgments about the	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					relative levels of care and the way in which patients are being treated. A recent court case highlighted how a pharmacist's impression that a home was not taking care around its medicines administration and associated record-keeping was seen as a marker of generally poor standards of care. The use of care plans to record concerns may not be entirely appropriate as these are open documents that can be viewed by many people, including those who might be implicated in any safeguarding issues.	
768	Alliance Boots	**3.6**	65	21-24	**Medication incidents and near misses** Greater clarity is needed on what might constitute a "near miss" that justifies reporting to a regulator. A pragmatic approach is needed to avoid overloading reporting systems with trivial incidents where no harm occurred.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
769	Alliance Boots	**3.7**	70-75		**Medicines reconciliation** We would like NICE to make it clearer how its guideline on medicines reconciliation following transfers between care settings can be put in to practice by care homes and healthcare professionals. This is not currently funded	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					activity for community pharmacy in England, although a Discharge Medicines Review service has been introduced in Wales.	
770	Alliance Boots	**3.8**	76-82		**Medication review** We agree with the NICE guideline that a lot more could be done to improve medication reviews for patients in care homes. However, the fact remains that these are "time consuming and challenging to undertake" (p77, line 25) and there is no identified or dedicated funding in relation to this work.	Thank you for your comment.
771	Alliance Boots	**3.8**	78	24-27	Involving a multidisciplinary group in medication reviews, including patients and/or family/carers as well as busy healthcare professionals such as GPs and pharmacists will be immensely challenging. Legal requirements around supervision and the Responsible Pharmacist Regulations mean that community pharmacists effectively require "backfill" cover by a locum or relief pharmacist before they can leave the pharmacy for any reasonable period of time. This would need to be adequately funded.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
772	Alliance Boots	**3.8**	79	7-9	We do not have any "dedicated care home pharmacist" posts within our organisation. Some of	Thank you for your comment. The guideline development group was aware of regions where care home pharmacy teams exist to support

					our pharmacists, working in pharmacies which deal with large volumes of such business, will have greater experience, but this work is normally run alongside the other aspects of the pharmacy's operations, including providing NHS services and supervising pharmacy sales and professional activities. We are not clear what might be considered to be "appropriate clinical experience and training" or which organisations might provide this. It is unclear at present how such a career pathway could be developed within pharmacy and who might employ such pharmacists, if they existed.	care homes in managing medicines. Details for the process are for local consideration and determination.
773	Alliance Boots	**3.9**	84-88		**Prescribing medicines** We are pleased to see that the draft guideline gives greater responsibility to GPs and other prescribers to ensure that medicine supplies can be synchronised around 28-day supplies **that are all delivered together**, including the need for occasional prescriptions for small quantities that help align prescribing and supplies across the board.	Thank you for your comment.
774	Alliance Boots	**3.10**	93	27-29	**Ordering medicines**	Thank you for your comment. The guideline

			94	1-2	We note that the guideline places an onus on care home providers to take responsibility for "ordering medicines from GP practices" [which in most cases means requesting repeat prescriptions] for their residents, and that this should not be delegated to community pharmacies. However, we are clear from our experiences in dealing with care homes that staff are looking for support with ordering medicines. They naturally turn to community pharmacies, as the experts in medicines and medicines supply for help with this. We also note that, in theory if not necessarily in practice, patients who have responsibility for their own medicines would be able to opt for a pharmacy-managed repeat medicines ordering service.	development group discussed and agreed that while supplying pharmacies can offer support with ordering medicines, the responsibility must remain with the care home (in line with regulatory requirements).
775	Alliance Boots	**3.10**	95		**Recommendation 2.10.2** We question whether all care home providers will be able to put in to practice the recommendation to give care home staff "protected time to order medicines" and to have at least two "competent members of staff" given the current pressures on funding across the social care sector.	Thank you for your comment. This section has been reworded following discussion by the guideline development group. The guideline development group agreed that protected time for ordering represents good practice.
776	Alliance Boots	**3.11**	98	28-31	**Medicines administration**	Thank you for your comment.

					records We agree that it should be a shared responsibility between the GP, the care home provider and the community pharmacy to ensure that the medicines administration record (MAR) is up to date. Community pharmacies often produce MAR charts for the homes and patients they supply to, so they need to be informed of any relevant changes so that updated charts can be produced.	
777	Alliance Boots	**3.14**	128		**Recommendation 2.14.11 – Temporary absence** Where an absence is planned or known about in advance, care home staff should seek advice from the supplying pharmacy about making supplies to cover the absence. This could include ordering and preparing a separate container of medicines. Some absences will be at short notice (eg, visitor/relative decides to take resident out for lunch). In these circumstances, the first principle should always be that the patient should receive their medicines where possible. Procedures should not obstruct this. Care home staff should balance the risks of "secondary dispensing" (ie, providing carers	Thank you for your comment. Evidence suggests that the supplying pharmacist can be contacted for advice on how to best manage supply of medicines when taking temporary absence. They may be able to provide advice based on experience and their own professional judgement.

					with only the medicines likely to be needed during a resident's temporary absence from the home against issues that could arise if a whole (28-day) pack was provided (eg, potential for overdose or loss of pack). As stated, this should always err towards ensuring that appropriate medicines will be available for the patient. Reference is made to asking for advice from community pharmacists, but we are not aware of any agreed professional guideline on this issue. Pharmacists would still be able to advise based on their own professional judgment.	
778	Alliance Boots	**3.15**	129	25-28	**Covert administration** The guideline does not clarify whether pharmacists would be consulted about a decision to administer medicines covertly to a patient or simply for technical advice on whether medicines can be crushed or otherwise administered. Pharmacists could also give advice on whether alternative formulations (eg, liquid medicines) might make administration easier, overtly or covertly.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
779	Alliance Boots	**3.16**	132-133		**Homely remedies** We do not consider that the term	Thank you for your comment. The guideline development group discussed and agreed that

					“homely remedies” is one that is in common use (outside care homes). Within pharmacies, such medicines would be known as non-prescription or over-the-counter (OTC) products. We believe that the guideline should reflect this. Given that these products are defined by their availability from community pharmacies, we are disappointed that the rest of the section makes no reference to seeking advice on the use of such products from community pharmacists and/or trained pharmacy staff, who have extensive knowledge on the best use of such products. The guideline should be amended to make more reference to community pharmacies as suppliers of products and advice on self-care. Other products, such as vitamins, minerals and supplements (VMS), might also need to be considered alongside this category.	the term homely remedy is understood, however section 3.16 of the full guideline provides a definition. When discussing homely remedies the care home provider should consult with an appropriate health professional, which may include a pharmacist. The guideline development group was also aware that homely remedies can be obtained from sources other than pharmacies.
780	NHS Hillingdon Clinical Commissioning Group	3.1	17	4-6	To consider adding that the service specification is consistent and that governance and accountability and responsibility is detailed.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
781	NHS Hillingdon Clinical	3.1	17	15	To add that local authority and CCG commissioner should	Thank you for your comment. This section has been reworded following discussion by the

	Commissioning Group				monitor care home provider contracts to measure impact.	guideline development group.
782	NHS Hillingdon Clinical Commissioning Group	3.1	18	6	Figure 1 includes a dotted line from supply to disposal to account for errors in supply leading directly to disposal prior to administration.	Thank you for your comment. Disposal of medicines resulting from supply errors has been captured through the storage step within the cycle.
783	NHS Hillingdon Clinical Commissioning Group	3.3	32	24	Add paragraph – for purposes of transfer of acre across settings, agree standard protocol and include standardise reporting template to be adopted by all stakeholders focussing on medicines care plan(can be electronic also)	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
784	NHS Hillingdon Clinical Commissioning Group	3.3	34	17-18	To specify the time frame e.g with 48hours- 72hours when medicines reconciliation is to be undertaken.	Thank you for your comment. Medicines reconciliation is included in section 3.7 of the full guideline.
785	NHS Hillingdon Clinical Commissioning Group	3.3	37	23	Commissioners to have a standard template for transfer of information as part of the service specification.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination
786	The Primary Care Diabetes Society	General			As a committee of healthcare professionals working in the field of primary care diabetes we felt a strong desire to contribute to this guideline. There are many potential areas of harm to vulnerable people with the administration of diabetes medications which carry a risk of hypoglycaemia including insulin and some oral glucose-lowering	Thank you for your comment. The guideline covers the systems and processes for the management of medicines in care homes. It is not specific to any condition, although certain conditions may be used to highlight a particular aspect of a system or process that needs explanation. The safe storage of medicines that require special storage requirements is covered in section 3.12 and section 3.13. Medicines that

					agents. Clear guideline would reduce these risks and enable healthcare professionals to practice more safely. The document itself contains many positive contributions to safe medicine management e.g. discussing the need for training and competencies, with a reference to using an accredited learning provider, but fails to address these other points. We feel that, at least, these therapies should be mentioned in the opening paragraph. We would recommend including the following points: • the risk of hypoglycaemia with insulin and some oral glucose-lowering agents • the safe storage of insulin • blood glucose monitoring • training for all care home staff (not just those administrating medication) as it may be the carer serving food who notices when a resident is off his/her food but is not aware of the relation between insulin, carbohydrate and hypo risk; or changes in behaviour due to hypoglycaemia not being	require monitoring is covered in section 3.3, 3.5, 3.7, 3.8, 3.9 and 3.14. Training and competency for staff working in care homes not just those administering medicines is included in section 3.17. The draft guideline recommends that the frequency of review should be determined on an individual case-by-case basis, depending on the health and care needs of the resident, with resident safety paramount in decision-making. However, the guideline development group agreed that the frequency of a multidisciplinary medication review should not exceed 1 year.

					recognised and appropriate action taken. The draft guideline recommends a 6 month medication review for those on four medications. We would suggest that people on medications that carry a risk of hypoglycaemia should be included as the effect of weight loss, appetite, and other physiological and psychological changes may increase the risk of hypoglycaemia and call for a regimen review. The length of the document may be deterred people from reading it and a more concise format with less repetition may help.	
787	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	General			Title page & throughout: Should this be “Optimising Medication in Care Homes”? Patient centred, latest practice & all that..!	Thank you for your comment. The guideline title reflects the topic selection title as referred to NICE by the Department of Health.
788	Leeds North Clinical Commissioning Group, Leeds South and East	General			Title states focus on management - not optimisation - need to be clear what covering here and use appropriate terminology	Thank you for your comment. The guideline title reflects the topic selection title as referred to NICE by the Department of Health. NICE are developing a short clinical guideline on

	Clinical Commissioning Group, and Leeds West Clinical Commissioning Group					medicines optimisation.
789	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	General			Medication review section does not mention medicines optimisation - this is key to what we are using and the term used by the DH now for how we get best use of medicines for each patient - please use latest terminology	Thank you for your comment. This guideline is not intended to explicitly cover medicines optimisation. This guideline is intended to cover the systems and processes for managing medicines in care homes. NICE are developing a short clinical guideline on medicines optimisation.
790	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	General			In general, guideline good but commissioners, care homes, GPs and practice staff and other medication review staff will need clear separate summaries of what are they roles and responsibilities	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published. A NICE pathway will also be published. A 'who should take action' section for the recommendations has been included in the guideline as a result of this comment.
791	Leeds North Clinical Commissioning Group, Leeds	General			Care homes will need a much easier to read summary of what their medicines policy should cover and to what standard	Thank you for your comment. The implementation needs assessment has identified a need for a 'care home medicines policy checklist'. A NICE guideline, full guideline and

	South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group					'Information for the public' versions will be published. A NICE pathway will also be published. A 'who should take action' section for the recommendations has been included in the guideline.
792	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	General			Needs a rewrite to distinguish between types of pharmacists or return all entries to "pharmacist" in areas of document their appears to be significant confusion about the roles care home/medication review/primary care pharmacy staff (pharmacists and technicians) are performing and developing and the knowledge, skills and abilities to undertake these roles	Thank you for your comment. A section 'definitions' has been added to the guideline in response to your comment.
793	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	General			In general I think they refer to "community pharmacists" too often, and should replace this with "pharmacist" except when referring to community specific activities such as dispensing, to reflect the variety of backgrounds working in the area.	Thank you for your comment. A section 'definitions' has been added to the guideline in response to your comment.
794	Leeds North Clinical Commissioning	General			The document is looking at medicines management but also includes principles of medicines	Thank you for your comments. This guideline is intended to cover the systems and processes for the management of medicines in care homes.

	Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				optimisation and this is not termed as such.	NICE are developing a short clinical guideline on medicines optimisation.
795	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	General			There is a lot of “evidence” referred to throughout the document and it isn’t properly referenced.	Thank you for your comment. The format and style is considered by the NICE publishing team and follows the NICE style for guidelines.
796	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	General			Whilst I love the comprehensive referrals to the RPS documents, not all pharmacists are RPS members, are the documents available to all those stakeholders who may need to access them or are the member only content? Pharmacy Technicians are not allowed to join RPS so cannot access these documents	Thank you for your comment. All documents cited are in the public domain and can be accessed online by members and non-members of the Royal Pharmaceutical Society (RPS).
797	Leeds North Clinical	General			There are lots of valuable points around transfer of care. It doesn’t	Thank you for your comment. The guideline development group review of the literature found

	Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				however discuss the challenges of care home staff GPs and pharmacists providing medication to residents when a full medical history/ old notes etc aren't available. E.g. records have to go to FSHA from old practice then be sent to new practice. Temporary residents in CIC beds may have temporary GPs. There isn't full discussion of the problems associated with transfer of care for secondary care e.g. when a patient is under a hospital clinic e.g. ophthalmology and the patient moves to a care home, often lost to follow up and medicines not monitored appropriately.	no evidence regarding what interventions work to improve resident care in these situations.
798	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	General			Not enough clear information about the competencies of the pharmacists required to support medication review in care homes.	Thank you for your comment. Detailing the competencies required for medication reviews by pharmacists is out of scope for this guideline. Pharmacists with appropriate clinical experience and training such as holding postgraduate clinical diploma and/or independent prescribing qualification should ideally provide medication reviews (see section 3.8).
799	Leeds North Clinical Commissioning Group, Leeds	General			There is lots of good information about capacity and consent.	Thank you for your comment.

	South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group					
800	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	1.3	5	26	Not just GPs. Should read GP practice staff (who deal with care home residents - to cover practice nurses and staff who handle prescriptions and communications)	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
801	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	1.3	6	1-2	people who provide services should also include care home pharmacists (not always community pharmacists)	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
802	Leeds North Clinical Commissioning	1.3	6	2	GP practice staff	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.

	Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group					
803	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	1.4	6	25	how are they distinguishing “care home” from warden controlled accommodation or sheltered housing where “24 hour non nursing care” could be available?	Thank you for your comment. Domiciliary care (such as residents in their own home whether sheltered accommodation or warden controlled) is outside the scope of this guideline.
804	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	1.4	6	6-10	The guidelines concern storage and ordering but this isn’t mentioned here.	Thank you for your comment. The term handling includes storage and ordering.
805	Leeds North Clinical	1.4	7	1	Should we also include “other mental health conditions” in this	Thank you for your comment. The guideline provides examples which are not intended to be

	Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				list? I know it says for example, but this does seem to be the only category of care home resident that is left out. We have a small number of residential homes in Leeds that deal with adults under 65 years old with severe schizophrenia, bipolar or drug & alcohol problems, as well as some half-way house type residences and I would be keen that it is highlighted that these types of patients are part of the "looked-after" population too.	exhaustive.
806	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend. 2.1.1	19	9	Who reviews quality of this policy to ensure that from medicines view point it gives accurate information and provides safe systems for safe and quality care	Thank you for your comment. This section has been reworded following discussion by the guideline development group. The detail of the process would be for local consideration and determination.
807	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West	Recommend. 2.1.1	19	9	policy needs to be integrated with local health and service provider systems e.g. GP and community pharmacy and care home pharmacist / med review system in place	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.

	Clinical Commissioning Group					
808	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.2	23	1-8	change to elderly resident?	Thank you for your comment. Wording was considered by the NICE publishing team.
809	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.2	23	5	More important is that they are in appropriate environment e.g. private area for a consultation, appropriate comfort and lighting and that if they want it they have a member of care home staff or a relative/ carer with them as their	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
810	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and	3.2	23	1-19	3 paragraphs lines 1-19 are repetitive. AFTER 1st sentence in lines 1-3, lines 14-19 should follow and then move on to what specific factors or support may be needed.	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Leeds West Clinical Commissioning Group					
811	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.2	23	6	Agree, but having correct glasses / magnifying glass is just as important if asking them to read a document about meds.	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
812	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.2	24	1	1st time this body is mentioned so needs full title in brackets (Social Care Institute for Excellence)	Thank you for your comment. Wording is considered by the NICE publishing team.
813	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning	3.2	25	1-2	Before precluding them - add in line re additional support that could be offered or aids to improve understanding e.g. picture card explanations	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.

	Group, and Leeds West Clinical Commissioning Group					
814	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	30	13	Although refers to the RPS doc - no where in this doc does it discuss the role of an MUR in this situation or whether this should be (or not) a core part of any community pharmacist's service to the care home as part of the service it provides - more info required	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
815	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	30	13	MUR - not in glossary What is meant by MUR?MUR done by community pharmacy or lower level 1/2 medication review but a primary care pharmacist/tech or care home pharmacy staff?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
816	Leeds North Clinical Commissioning Group, Leeds South and East Clinical	3.3	31	18	define direct care	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Commissioning Group, and Leeds West Clinical Commissioning Group					
817	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	31	21	here not been specific about what type of pharmacist - good as encompasses all. Need to ensure that doc reflects this throughout unless the task, responsibility is aligned to a specific type of pharmacist	Thank you for your comment.
818	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	32	24	Doc needs to address that when resident goes into hospital or dies important that care home informs the community pharmacist at earliest opportunity ensures they do not dispense medicines that are / may not be needed to minimise risk to patient when discharged and prevents wastage	Thank you for your comment. Section 3.12 has been reworded following discussion by the guideline development group.
819	Leeds North Clinical Commissioning Group, Leeds South and East	3.3	33	2	Not just about discharge from hospitals!!! Need also to include: - moves from intermediate care to care homes- moves between	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.

	Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				different care homes, e.g. residential to nursing and vice versa, to specialist residential/nursing care- between medical /nursing specialist teams such as between community nursing, psychiatry, memory services etc when move into a long term care setting that is covered by different care team	
820	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	33	10-16	What is this evidence? It isn't referenced.	Thank you for your comment. The final published full guideline will include a list of references in appendix G. The format is in line with the NICE publishing style and was considered by the NICE publishing team.
821	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	34	1	As previously, needs to be in glossary	Thank you for your comment. Section 3.12 has been reworded following discussion by the guideline development group.
822	Leeds North	3.3	34	10	In addition - needs to be clear	Thank you for your comment. Section 3.3 quotes

	Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				about responsibility for monitoring and review e.g. what / frequency of monitoring required e.g. bloods tests etc and then review	from the Royal Pharmaceutical Society document 'Keeping patients safe – getting the medicines right'. NICE is unable to change the content of this document.
823	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	34	17	to all involved in care; inc. community pharmacy when moving between all care settings At discharge, hospitals should ensure clear, new medication list should go direct to community pharmacy managing residents medicines explaining stop/ start and changes to medicines	Thank you for your comment. Section 3.3 quotes from the Royal Pharmaceutical Society document 'Keeping patients safe – getting the medicines right'. NICE is unable to change the content of this document.
824	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	34	34	or primary care / medication review pharmacists or pharmacy technicians. WHOLE document needs to reflect the range of staff working with GP practices / care homes in primary care through medicines management teams	Thank you for your comment. However it is not clear where this comment relates to in the draft guideline.

825	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	35	18	who responsible for ensuring ALL partners in residents care have the up to date info and have actioned it - to ensure coordination e.g. to avoid incidents where MARs not changed and previously stopped meds are reissued resulting in readmission to hospital or fatality	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
826	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	35	23-30	How do we assess/deem that community & primary care pharmacists have “the appropriate skills, knowledge and competencies”…? Is this a Professional Curriculum the RPS Faculty could ratify?	Thank you for your comment. Section 3.3 quotes from the Royal Pharmaceutical Society document ‘Keeping patients safe – getting the medicines right’. NICE is unable to change the content of this document.
827	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning	3.3	36	5	what reference???? We have locally generated evidence that improving the content of medication discharge summaries to include instructions on how to monitor changes to medication does reduce readmissions within 30 days.	Thank you for your comment. The final published full guideline will include a list of references in appendix G. The format is in line with the NICE publishing style and was considered by the NICE publishing team.

	Group					
828	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	36	12	or changing a care home especially important: - for moves into CIC bed as a temporary resident when looked after by non GMS GP during this time - even for short stays e.g. respite	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
829	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	36	21	and send them to community pharmacists	Thank you for your comment. The guideline development group discussed and agreed that any sending of discharge summaries to community pharmacies would be for local consideration and determination.
830	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical	3.3	36	24	Wording should be clearer re hospitals providing information to community pharmacists/care homes at discharge.	Thank you for your comment. The guideline development group discussed and agreed that any sending of discharge summaries to community pharmacies would be for local consideration and determination.

	Commissioning Group					
831	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	37	28	Most GP doing care home visits don't have access to practice systems at the time of the visit, is the guideline development group supporting remote access working practices in order to facilitate this?	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
832	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.3	38		specify what info should be transferred - as a basic what medicines changes and what to look out for and clinical condition - whether change is for an acute or a long term treatment	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
833	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West	Recommend 2.3.2	39		to all who require is including community pharmacist	Thank you for your comment. Unfortunately, the point of this comment is not clear.

	Clinical Commissioning Group					
834	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.3.3	39		reflect p 98 pts 16-23 here regarding care homes requiring double check and sign of MAR	Thank you for your comment. Wording is considered by the NICE publishing team (see also section 3.11 of the full guideline).
835	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.3.4	39		Rec 2.3.4 - wording doesn't make sense, THIS DOES NOT MAKE SENSE- missing text?	Thank you for your comment. This section has been reworded following discussion by the guideline development group and with the NICE publishing team.
836	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and	3.4	44	15	this is a repeat of page 42 line 13	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Leeds West Clinical Commissioning Group					
837	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.4	47	9	match up to new proposed national NLRS/yellow card scheme	Thank you for your comment. The guideline will be updated in line with NICE processes, full details can be found here.
838	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.4.1	48	1	See page 74 lines 22 & 23 comments	Thank you for your comment. See recommendation 2.7.3 of the draft guideline.
839	Leeds North Clinical Commissioning Group, Leeds South and East	3.5	49	17	What about ordering errors? Not ordering soon enough so resident left without medication or ordering wrong items	Thank you for your comment. For the purpose of the guideline, the guideline development group agreed that, medication errors included prescribing, dispensing, administration and monitoring errors based on the evidence that

	Clinical Commissioning Group, and Leeds West Clinical Commissioning Group					was found. Systems and processes for storage and disposal of medicines are included in the full guideline (see section 3.12).
840	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.5	53	7	omissions of changed medicines due to prescribers not using appropriate part of prescribing systems (issuing prescriptions from acute meds screen rather than transferring into repeat screens)	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
841	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.5	53	22	Would carers be expected to know this or know where to find the information or who to ask for advice	Thank you for your comment. See section 3.14 of the full guideline for information on care home staff administering medicines to residents. See section 3.17 of the full guideline for information on training and skills (competency) of care staff.
842	Leeds North Clinical Commissioning Group, Leeds	3.5	54	3	this should come first as it is the biggest failing of the current system	Thank you for your comment. The format was considered by the NICE publishing team.

	South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group					
843	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.5	54	29	agree in principle. Meds errors should be reported but care homes currently have nowhere to report these to. No access to community pharmacy error reporting systems (traditionally used to report dispensing errors not prescribing errors or administration errors) no access to DATIX or primary care reporting systems, may have in house policy to record errors but where to these then go. E.g. give the patient someone else's medication. Reluctance of GPs to record incidents, probably wouldn't report these through local reporting system either. This section should state that incident reports should be sent to the commissioner and NRLS.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination. The National Reporting and Learning System is open to NHS reporting of 'patient' safety incidents. There is currently no reporting (other than as a patient or member of the public) for social care reporting of medicines incidents.
844	Leeds North Clinical Commissioning Group, Leeds South and East Clinical	Recommend 2.6.1	69		needs to be more specific relating to "report to a healthcare professional" This could mean reporting to a podiatrist. Care homes probably need more support with how to report	Thank you for your comment. The reporting of incidents should be to a health professional. Details of the process are for local consideration and determination.

	Commissioning Group, and Leeds West Clinical Commissioning Group				incidents out of hours.	
845	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.7	72	23	with access to all the required information	Thank you for your comment. See section 3.7 for information about medicines reconciliation.
846	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.7	74	1-3	meds rec is also needed after discharge from hospital with the DAN otherwise the GP repeat list may not reflect any changes made by the hospital. Repeat slips are provided when picking up the previous months medication thus if there has been medication changes since this time these will not be reflected on the repeat slip. Checking a DAN can also pick up problems with medications which may not have been reconciled appropriately during admission e.g. incomplete medication history, missing PRN drugs and drugs which have been	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					missed form the DAN but were being taken prior to admission.	
847	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.7	74	3	REFER TO p34 lines 22-25	Thank you for your comment. The format was considered by the NICE publishing team.
848	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.7	74	15	what about guideline on the timescale for this reconciliation to be completed? must be actioned in timely way (not always happening in practice)	Thank you for your comment. The full guideline provides information about medicines reconciliation (see section 3.7). Details of the time frame are for local consideration and determination however the process should be carried out in a timely manner. Information should to be available for medicines reconciliation on the day of resident's transfer into or from the home.
849	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West	3.7	74	15	I don't think weight should be restricted to those under 16. Weight is an important indicator of well-being in all care home residents and in the older population, very frail younger adults, and those with renal impairment, can also affect dosing decisions. See also p101 rec	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Clinical Commissioning Group				2.11.13	
850	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.7	74	21	I would add the following (see bold text) : “known allergies and adverse reactions to medicines or excipients, and the type of reaction experienced”	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
851	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.7	74	22 & 23	I would add the following to the end of this line: “special storage instructions; and any additional instructions to facilitate safe and legal administration of those medications, for instance the special admin instructions for bisphosphonates; the requirement to take gastrotoxic medications AFTER eating; specific instructions on when to give “as needed” medication; or specially agreed instructions on how to crush a tablet for administration in someone who cannot swallow”. I’m not sure “adherence support” a couple of lines afterwards is clear enough for the circumstances. I wonder if this caveat could also fit well with the	Thank you for your comment. These additional instructions would come under ‘additional information and support, including review and monitoring requirements, adherence support’ in the list of information to include for transfer. The guideline provides examples which are not intended to be exhaustive.

					recommendations for MAR keeping on page 48 (as this then covers residents who are started on new medication requiring such cautions in their existing environment, rather than on transfer). I know many of these situations are covered by "standard cautionary labels". Many pharmacy systems do NOT include standard cautionary labels on MAR charts, only labels – which is generally not an appropriate approach in the care home environment. I note CHUMS found 38% of errors due to incomplete information so I don't think we can emphasis this enough. [edit: Have just come to recommendations on pp 89-90 but think the above still stands for the purposes of explicitness].	
852	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.7.1	75	1	See comments above for page 74	Thank you for your comment. See responses to comment number 851.
853	Leeds North	3.8	76	5	put a medication review diagram	Thank you for your comment. The guideline

	Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				in here to reflect regular review and deprescribing as well as changing meds or starting new active or preventive treatments	development group have discussed this comment and felt that it was not necessary in the context of the guideline scope.
854	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.8	77	2	by prescribing appropriate medicines, correctly monitored, improving.....	Thank you for your comment. Wording was considered by the NICE publishing team.
855	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.8	77	6	to minimise medicine related hospital admissions	Thank you for your comment. Wording was considered by the NICE publishing team.

856	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.8	77	7	Be more positive About value for money by cost effective quality prescribing	Thank you for your comment. Wording was considered by the NICE publishing team.
857	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.8	77	10	Which survey of care homes? Not referenced.	Thank you for your comment. The final published full guideline includes a list of references in appendix G. The format is in line with the NICE publishing style for guideline and was considered by the NICE publishing team.
858	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning	3.8	77	24	could include a lack of appropriately trained practitioners with access to appropriate resources.	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.

	Group					
859	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.8	77	30	Worth adding reference to “inappropriately skilled-staff assigned to carry out medication review”? – or words to that effect. I really feel this aspect of med review in these populations mustn’t be underestimated.	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
860	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.8	78	7-11	Doesn’t take into account if there should be any responsibility for a care home pharmacist to be involved (on behalf of primary care team or GP practice)	Thank you for your comment. This wording has been amended following further discussion by the GDG.
861	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical	3.8	78	11	should read and pharmacists (not community pharmacy) as in general community pharmacists are not the providers of the medication review / care home pharmacist services in the NHS	Thank you for your comment. This wording has been amended following further discussion by the GDG.

	Commissioning Group					
862	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.8	78	16	who should be involved in medication review? This all depends on what level of medication review is being carried out and what the outcomes are. A member of care homes staff would not be able to carry out a full clinical level three medication review to the same level as a specialist clinical pharmacist.	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
863	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.8	79	3-14	worth adding something to the effect of acknowledging workforce planning to ensure that adequate numbers of appropriately experienced pharmacists *are* available to help facilitate these reviews? Having reviewed the same patients that other health care professionals have also reviewed a few months previously (namely GPs & nurses specifically carrying out care home reviews), I can confirm that at least in the geographical area I was working in, that non-pharmacists, even specifically designated ones, do NOT review as many aspects of care home medication use for individual patients as pharmacists do. I feel it may also help address the issues the guideline	Thank you for your comment. NHS workforce planning is out of scope for this guideline.

					development group rightly identifies regarding lack of ownership of the medication review & meds rec for care home residents, if we DO take the plunge and SPECIFY appropriately trained pharmacists should be the ones to lead the MDT med-review process for care home patients. (I appreciate workforce, funding & training are huge issues here but really this is a golden opportunity to set gold standards and I don't see why we shouldn't be bold in our recommendations in this regard to support appropriate planning for the medium and long-term future).	
864	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.8	79	6	needs to be in glossary	Thank you for your comment. A section 'definitions used in this guideline' has been added to the full guideline.
865	Leeds North Clinical Commissioning Group, Leeds South and East	3.8	79	7	if using primary care pharmacist here - need to change the glossary description to reflect the medication review element of their work, alternatively add in a	Thank you for your comment. A section 'definitions used in this guideline' has been added to the full guideline.

	Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				medication review pharmacist in glossary to distinguish the roles	
866	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.8	81	4-8	Residents who have had a medication change should be reviewed at an appropriate interval after this change. Residents who are on an increasing or reducing dose of medication e.g. benzodiazepine reduction regime	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
867	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.8	81	5	has a new medicines started or changes to medications or a high risk or a shared care medicine prescribed	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
868	Leeds North Clinical Commissioning Group, Leeds	3.8	81	7	or set up or down in care settings e.g. all new patients to the care home (no matter where they have come from)	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.

	South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group					
869	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.8.1	83		and care home/medication review/primary care pharmacists e.g. locally primary care medicines team or care home team	Thank you for your comment. Wording was considered by the NICE publishing team. A section 'definitions' has been added to the guideline in response to your comment.
870	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.8.3	83		I would add: "….this may include an appropriately trained:…"	Thank you for your comment. Wording was considered by the NICE publishing team.
871	Leeds North Clinical Commissioning	3.9	87	8	would be useful to include advice on the use of the phrase "as directed" as this is not liked by	Thank your comment. This section has been amended to reflect your comment.

	Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				care home staff. All medication for residents should have instructions rather than the phrase “as directed.” Community pharmacists should take initiative for ensuring appropriate instructions are added to the labels for these circumstances (in line with changes to the medicines act 2012).	
872	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.9	87	13	We already ask care homes to ask prescribers to give specific instruction. Has 1 or 2 come around since electronic prescribing and that is what BNF says	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
873	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.10	92	5	that do the correct ordering regularly so are up to date with the CURRENT process and follow the procedure	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
874	Leeds North	3.10	92	11-13	I think it is again important to be	Thank you for your comment. This section has

	Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				explicit here, on the issue that care homes should ensure they “carry over” stock that is still suitable for use, ie still prescribed for that patient and still in date. They should in no circumstances return unused medication accompanied by a request to order a fresh supply of the same medication. By the same token, community pharmacists should be required to challenge such instances or other instances where unnecessary or duplication of ordering is taking place. Clearly they should be remunerated adequately for this and the PSNC should take steps to ensure this is addressed.	been reworded following discussion by the guideline development group.
875	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.10	92	14	ensure policy is clear and reasonable about these to avoid excessive wastage of topicals and liquids	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
876	Leeds North Clinical Commissioning Group, Leeds	3.10	92	24	that are SAFE and agreed with the GP practices and community pharmacies	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group					
877	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.10	92	24	SAFE processes, that are SAFE and agreed with the GP practices and community pharmacies	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
878	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.10	92	25	and receiving medicines (and scripts for these)	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
879	Leeds North Clinical Commissioning	3.10	93	28	his point should be MUCH CLEARER as many still using this system. This system does not	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				take into account changes that have been made mid 28 day cycle and introduces huge potential for residents safety	
880	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.10	94	8	this is an essential part of a safe system to have appropriate checks and balances in it especially as the member of care home staff ordering is often not the one receiving the prescriptions to check or the drugs into stock after dispensing	Thank you for your comment.
881	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.10.2	95		what about checking of prescriptions after order and receipt of the ordered drugs - reflect here	Thank you for your comment. This section has been reworded following discussion by the guideline development group. Please also see recommendation 2.10.4 of the draft guideline.
882	Leeds North Clinical	3.11	98	1-5	Very few residents able to self medicate. Is several different	Thank you for your comment. The guideline development group discussed and agreed that a

	Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				supply systems in a care home practical, does it increase risk of error	single system for supply of medicines may not be appropriate for a resident living in a care home. The resident should have the opportunity to be involved in decisions about their care and treatment on an individual basis. Under regulation 13 of the Health and Social Care Act (2008) regulated activities regulations 2010, care home providers are required to make appropriate arrangements for handling medicines in care homes to avoid errors.
883	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.11	98		Is there going to be a national MAR introduced?	Thank you for your comment. This would be outside the scope of this guideline.
884	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.11	98	28-31	I think we need to emphasise the importance that the community pharmacy keeps up to date allergy records, and the importance of the MDT advising them of updates. Again there should be appropriate remuneration sought for this via the PSNC to support appropriate IT systems and staff time involved in keeping the records up to date. Currently a significant number of care homes refer to the MAR	Thank you for your comment. This section has been reworded following discussion by the guideline development group. Implementation of the guideline is for local consideration and determination. NICE are developing a guideline on Drug Allergy.

					charts, which are printed by a community pharmacy, to check a resident's allergy status; however I regularly find inconsistencies between the MAR allergy status and the actual allergy status, because there is no ownership of responsibility or inclusive way or working with the community pharmacies.	
885	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.11	99	12	but who leads? As producer of the MARS - Community pharmacy SHOULD have process to ensure this happens including allergy status information	Thank you for your comment. The legal responsibility for having a record of medicines administered in the care home lies with the care home (see section 3.4 of the full guideline).
886	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.11	100	17-27	Keeps mentioning prescriber, community pharmacy and care home have joint responsibility to ensure allergies and intolerances recorded but someone must take ownership	Thank you for your comment. This section has been reworded following discussion by the guideline development group. NICE are developing a guideline on Drug Allergy.
887	Leeds North	3.11	100	7-16	As discussed, This list also needs	Thank you for your comment. The guideline

	Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				to include an example of special instructions required to facilitate off-label administration of specific medications, eg crushing a particular tablet for a person with poor swallow; storage instructions eg CDs or fridge – things can & do get put away in the wrong places; and if applicable any "short" expiry dates especially eg with dipyridamole, insulins or some liquid preparations. I would think it would be helpful for multi-use cream containers to also have the standard special disposal instructions (eg x weeks after opening" included on the label to reduce infection risk in care home environments. This may also reassure care homes who "like" to return part-used tubs of creams every month and order replacements at the same time (as discussed on p105), that they are safe to keep & use for a longer period of time. Duration better as date to finish, eg if give for 6 weeks once on second MAR not showing when started and no indication of when to finish	provides examples which are not intended to be exhaustive.
888	Leeds North Clinical	Recommend 2.11.3	101		refer to rec. 2.3.3 p 39 re paper based produced in home are	Thank you for your comment. This section has been reworded following discussion by the

	Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				double checked	guideline development group.
889	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.12	102	6	If evidence suggests this should be done that surely it can't be good practice as in p 94 lines 6-9. it must be part of a safe medicines process that should be ingrained in policy	Thank you for your comment. Please note that evidence (of varying strength or quality) may relate to a particular setting or cohort. The guideline development group will discuss whether the evidence is generalizable to all care home settings and therefore represent good practice (see section 3.1 for information about the care home medicines policy).
890	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.12	103	20-29	This page should contain a link to the advice on p112 which gives advice on storage arrangements for patients who want to have “custody” of their own schedule 2 CDs in their own locked medicines cupboards, which specifications will be unlikely to comply with the requirement for safe storage of CDs.	Thank you for your comment. The format was considered by the NICE publishing team.
891	Leeds North	3.12	104	6	Replace “agrees to” with “has the	Thank you for your comment. However it is not

	Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				necessary licences from the Environment agency for”	clear where this comment relates to in the draft guideline.
892	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.12	105	12-19	this should be acted on by the community pharmacist! A KEY ROLE and should be linked back to the ordering system	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
893	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.12	105	20-23	this should be acted on by the community pharmacist! A KEY ROLE and should be linked back to the ordering system	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

894	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.12	106	7	THIS SHOULD be in care home medicines policy Acting on this should be a key role for the community pharmacist to PROMPT action to stop dispensing of this item Whole heartedly agree that community pharmacists should be made aware when meds have been stopped so they can be avoid being printed on the next MAR chart – but do we need to specify WHO is responsible for doing this. As identified, ownership of tasks is an issue and it would be helpful to implementation of these guideline recommendations if a group / groups / role /roles was/were identified to take such ownership.	Thank you for your comment. The guideline development group agreed that it would be considered as good practice based on the evidence found. The strength of the recommendation is based on the quality of evidence found. Full details of the development process can be found here.
895	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.12.5	109		or action changes to the prescription to prevent excess stock!	Thank you for your comment. This has been reworded following discussion by the guideline development group.
896	Leeds North Clinical	3.13	110	6-8	Majority cannot self administer when first move into a care home	Thank you for your comment. The guideline development group discussed and agreed that

	Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group					care home residents should be assumed to be able to self-administer their medicines when they first move into a care home (see section 3.13).
897	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.13	110	8	and this should be regularly reviewed especially when there is a new medicine, new health condition or change in a health condition that may make self administration more difficult or less safe	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
898	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.13	110	10	AND what should the quality of these self assessment tools be and what should they include?	Thank you for your comment. The guideline development group concluded that the purpose of the guideline was to set out key principles. Details of the process are for local consideration and determination.
899	Leeds North	3.13	110	26-27	Info needs to be on MAR chart or	Thank you for your comment. Wording was

	Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				in MAR folder so can be seen as doing meds round	considered by the NICE publishing team.
900	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.13	111	10	and when self administration should be reviewed	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
901	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.13.2	114		how often?	Thank you for your comment. This has been reworded following discussion by the guideline development group.

902	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.13.3	114		Specify “Collaboration between appropriately qualified / experienced health and social care practitioners….” Given that the guideline identifies that not everyone does have appropriate skills when it comes to care home residents. If felt that these minimum staffing levels are implicit in the requirements for working in care home/section 3.17/etc, then I think it is still worth repeating at this point (and throughout).	Thank you for your comment. This has been reworded following discussion by the guideline development group.
903	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.14	117	31	and “the point at which continued non-taking of a medication should be flagged up to the prescriber for review of whether it is still required or whether an adjustment can be made to facilitate patient adherence”	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
904	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West	3.14	117	31	records of what not taking and why should prompt a review - this needs to be in care home policy	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Clinical Commissioning Group					
905	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.14	119	1	what about info in the RPS compliance aids doc - should reflect this more especially issues about stability of meds out of original packs and thus questions over the effectiveness of the medicine when removed from its tested packaging	Thank you for your comment. There is a hyperlink for further information about this topic under in section 3.11 of the full guideline.
906	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.14	120	7-9	Residents may have more than one MAR chart being maintained at any one time. Examples are a “cream Chart” for application during personal care, and “ONS chart” for recording ONS administered as part of a nutritional care plan. A “DN chart” being maintained by a district nursing teams and the “regular medicines chart”. Suggested re-wording: All records of administration should be clearly cross referenced to enable a person reviewing the resident’s medication to reconcile a compile list of the resident’s medication.	Thank you for your comment. Wording was considered by the NICE publishing team.
907	Leeds North Clinical	3.14	120	12-14	There is a great deal of variation in practice on this issue and many	Thank you for your comment. The guideline development group agreed that the current

	Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				conflicting views on the best way to record PRN medication. In the circumstance whereby a resident's care plan indicated that they will ask for medication it would be appropriate to leave the boxes blank when nothing is administered. When the care home staff must make a decision on when to administer in response to a defined set of symptoms listed in a care plan (such as groaning in pain) it would also be appropriate to leave boxes blank when medication is not administered. However, When a medication is to be offered at fixed times the offer must be recorded either as a "refusal", "offered but not required" or as an administration. A care plan for how each PRN medication is to be managed for each individual is essential. We consider it good practice to have a copy of this care plan in the MAR chart folder.	wording represents good practice. For example a resident may be prescribed analgesia at set times. The resident should be offered the medicine at these times and they can choose to accept or refuse. If however the medicine is prescribed 'as required' the guideline development group discussed and agreed that it should be offered when it is needed and that offering only at medicines round time was inappropriate.
908	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and	3.14	120	12-14	Although this is practice in hospitals where acute care given, I am not in agreement with this as part of a long term regime using this system - what evidence is there that the medicine has been offered or that the lack of an entry is not an oversight by member of	Thank you for your comment. The guideline development group agreed that the current wording represents good practice.

	Leeds West Clinical Commissioning Group				staff. Clinically this could be essential to know if patient is still in pain and unclear if care home staff are offering the prn medicine or if always taking it (and the effect/ side effect may be the potential cause of a symptom)	
909	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.14	120	12-14	agree that “when required (prn)” meds should only be recorded when actually given, and that records should be kept as to reasons why medications are not given. However I don’t think these 2 paragraphs provide clear enough instruction to care homes whose policies require them to sign when a “prn” med is given and enter a number relating to a reason for non-administration when it is not given, at EVERY possible time for administration. There is confusion & discrepancy within practice as to what to do in these situations. For instance, when a resident is prescribed paracetamol 1g prn up to qds, the “possible times” for administration will often be pre-printed on the MAR, depending on the computer system in use at the community pharmacy. I feel the guideline development group should lead on this issue.	Thank you for your comment. The guideline development group agreed that the current wording represents good practice.
910	Leeds North	3.14	120	22-24	This is impractical as it will	Thank you for your comment. This section has

	Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group				introduce delays for both visiting professional and the care home staff. It may also introduce distractions and reduce safety. Cross referencing MAR charts is the better approach with an entry made in the resident's care plan in the "notes from visiting healthcare professional" section	been reworded following discussion by the guideline development group.
911	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.14	120	28	Insert "standard" before "medication …." To indicate that some medicines require a particular format of MAR chart.	Thank you for your comment. Wording was considered by the NICE publishing team.
912	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.14	122	26	use of red tabards for medicine rounds	Thank you for your comment. The guideline development group considered the evidence for the wearing of tabards but agreed that no recommendation should be made due to variability in the evidence.

913	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.14	122	29	does this also include when out all day at hospital for appointment?	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
914	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.14	124	2-9	Typo end of 1st paragraph ...BNFC is available via NICE...	Thank you for your comment. This section has been reworded.
915	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning	3.14	124	12	what about info sights for dressings, catheters, appliances and devices?	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.

	Group					
916	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	recommend 2.14.1	125		to local NHS systems not just internal systems especially when starting stopping or changing a medicine	Thank you for your comment. Details of the process are for local consideration and determination.
917	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.14.2	126		how much and how often e.g. fingertips for creams	Thank you for your comment. This has been reworded following discussion by the guideline development group.
918	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical	Recommend 2.14.10	127		The guideline should specify that the care home provider should liaise with the supplying community pharmacist and/or GP to review times of administration – it is inappropriate for care home staff to be changing prescribed times of administration on the prescription or MAR, as this is a prescribing activity – unless they	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

	Commissioning Group				hold a NMP qualification – and thus they are not covered by their insurance etc.	
919	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.16	133	1	Important an individual signs to say to say they have read and understood the homely remedy policy as much as they consider themselves competent. However, competency is normally assessed to a standard -who assessing in this case?	Thank you for your comment. It is the duty of the employer/care home provider (vicarious liability) for staff working to care home systems and processes. Details of the process are for local consideration and determination.
920	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Recommend 2.16.1	133		Include how to record this on a MAR chart	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
921	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning	3.17	134	27	This document should clearly define what standards of knowledge & skill people should to be trained to. It does not do this sufficiently and clearly enough to be usable by care homes	Thank you for your comment. Details of the process for training and implementation are for local consideration and determination (see section 3.17).

	Group, and Leeds West Clinical Commissioning Group					
922	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	3.17	139	16	(if used)	Thank you for your comment. The guideline provides examples which are not intended to be exhaustive.
923	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Appendices A Glossary	146	1	missing some terms as discussed throughout the text e.g. MUR etc	Thank you for your comment. This section has been reworded following discussion by the guideline development group.
924	Leeds North Clinical Commissioning Group, Leeds South and East Clinical	Appendices D	162		P162: Disadvantages of using original packs (administration) if medication is not stored correctly medicines may get missed, more time consuming for staff to check name label and medication and	Thank you for your comment. This table is based upon published and presented evidence reviewed by the guideline development group it is not exhaustive.

	Commissioning Group, and Leeds West Clinical Commissioning Group				dose for each box for each resident especially in large care homes.	
925	Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group, and Leeds West Clinical Commissioning Group	Glossary			No definition of a care homes pharmacist (which differ from primary care pharmacists) or a community pharmacist. The document uses “a pharmacist” throughout and this is potentially confusing for care home staff as pharmacists working in different sectors have different skills to bring. For example a community pharmacist is unlikely to have access to a full GPs system for checking clinical appropriateness for patients medications, a care homes pharmacist is unlikely to dispense medications.	Thank you for your comment. A section ‘definitions’ has been added to the guideline in response to your comment.
926	Royal College of Nursing	General			The Royal College of Nursing welcomes proposals to develop this guideline. It is timely. The RCN is pleased to respond to this consultation.	Thank you for your comment.
927	Royal College of Nursing	General			We note that the CHUMS report on medicines management (2010) – as a result of the review of York care homes following the Serious Case Review, informed this draft.	Thank you for your comment.
928	Royal College of Nursing	General			With respect to Nursing Homes, especially identifying the total lack of NHS contracts in place that	Thank you for your comment.

					requires the necessary compliances. There is a pressing need nationally for commissioners to drive care home standards up through the process of sound commissioning, contracting, and clinical audit, as well as providing the supportive mechanisms for care homes to ensure that colleagues in the independent sector are able to demonstrate care, compassion and (7 and 8 in the Cs) clinical competence towards the most vulnerable members of the society.	
929	Royal College of Nursing	3.1	16	24	The recent report of the Department of Health's sponsored project 'Safety of Medicines in the care homes' of which the RCN is part, made recommendations on tools to support care homes with this, it is important that this NICE guideline does not conflict with the publication but rather makes reference to the materials to support its implementation.	Thank you for your comment. The resources mentioned were not included in the draft guideline for consultation as they were published in the public domain imminently before consultation. Resources have been hyperlinked to in the full guideline where appropriate.
930	Royal College of Nursing	3.3	39	1	2.3.5 – Whilst we welcome the use of electronic records to record core content of records for when a resident is transferred, it should be noted that care homes currently do not have access to	Thank you for your comment. This section has been reworded following discussion by the guideline development group.

					NHS electronic systems. This could present challenges with the implementation of this recommendation.	
931	Royal College of Nursing	General			It is noted that the document is very health focused. Administration of medicines happens in social care settings as well. There appears to be am assumption that medication is administered to residents rather than that it being self-administered or administered by carers unless the resident lacks capacity. This point should be taken into consideration in making recommendations to ensure effective implementation of this guideline.	Thank you for the comment. The guideline development group is aware that the systems and processes associated with managing medicines in care homes can appear very health focussed. The evidence in most cases for this topic comes from a health rather than social care perspective. The guideline contains a section 'helping residents to look after and take their medicines themselves (self-administration) (see section 3.13 of the full guideline).
932	Royal College of Nursing	General			In order to be used in practice, some attention needs to be paid to the length of the guideline and avoiding repetition.	Thank you for your comment. A NICE guideline, full guideline and 'Information for the public' versions will be published.
933	Royal College of Nursing	General			We would recommend that reference is made to the use of new technologies currently being introduced, to scan medication and record administration.	Thank you for your comment. The evidence base in support of these systems was reviewed by the guideline development group and found to be of low methodological quality, there is a lack of pragmatic RCT evidence on which to make judgements about such systems effectiveness and cost-effectiveness.
934	Royal College of Nursing	General			The draft guideline only refers to Monitored dosage; there will be some homes using bottles and boxes for individuals and use of technology (as above)	Thank you for your comment. The guideline states the two systems in use (monitored dosage and original packs i.e. 'bottles and boxes') (see section 3.11).

935	Royal College of Nursing	General			We recommend that reference is made to individual /patient held medication: • The draft document only refers to medication trolleys and 'rounds', some homes and smaller 'units' are using individual medication cupboards in residents' rooms to become more person centred. • A maximum number of residents for one person to administer to in on a 'round' may be a good practice standard to reduce errors	Thank you for your comment. Storage of resident's medications is covered under section 3.12 of the guideline. Reviewing the maximum number of residents a single member of staff can administer medicines to, is outside the scope of the guideline.
936	Royal College of Nursing	General			We note there is no reference to Medicine administration audits - this is recommended as good practice.	Thank you for your comment. Under regulation 13 of the Health and Social Care Act (2008) regulated activities regulations 2010, care home providers are required to make appropriate arrangements for handling medicines in care homes, this may include regular audits to ensure residents are protected against risks. Details of the process are for local consideration and determination.
937	Royal College of Nursing	General			We would also strongly recommend links to the National Care Forum Medication project which includes clear guideline and good quality resources. (see web site) http://www.nationalcareforum.org.	Thank you for your comment. The resources mentioned were not included in the draft guideline for consultation as they were published in the public domain imminently before consultation. Resources have been hyperlinked to in the full guideline where appropriate.

					uk/project-medication.asp	