

Full guideline

Managing medicines in care homes

<http://www.nice.org.uk/guidance/sc/SC1.jsp>

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Update information

Minor changes since publication

June 2022: We amended recommendation 1.10.1 because the COVID-19 standard operating procedure on running a medicines reuse scheme in a care home or hospice setting has been withdrawn. We also removed the outdated link in recommendation 1.12.5.

May 2020: Recommendations 1.10.1 and 1.12.5 were updated in line with UK government guidance on reusing medicines during the COVID-19 pandemic.

January 2018: Some recommendations were changed to make it clearer when actions must be taken. Some links were updated.

These changes can be seen in the short version of the guideline at

<https://www.nice.org.uk/guidance/sc1>

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What is this guideline about and who is it for?

Purpose of this guideline

The purpose of this guideline is to provide recommendations for good practice on the systems and processes for managing medicines in care homes.

Audience for this guideline

This guideline is for people and organisations involved with managing medicines in care homes. It is anticipated that health and social care providers will need to work together to ensure that care home residents benefit from the good practice recommendations in this guideline.

Scope of this guideline

The guideline is for all people who have a collective responsibility for residents' care, ensuring safe and effective use of medicines in care homes.

This includes:

- residents living in care homes and their family members or carers (as appropriate)
- people who provide care in care homes (for example, care home staff [including nurses employed by the home], GPs, community nursing teams and specialist nurses)
- people who provide services to care homes (for example, supplying pharmacies, GPs, dispensing doctors and appliance contractors)
- people who commission or monitor how care is provided in care homes (for example, local authorities, the [Care Quality Commission](#) [CQC] and the [Office for Standards in Education, Children's Services and Skills](#) [Ofsted]).

This guideline considers prescribing, handling and administering medicines to residents living in care homes and the provision of care or services relating to medicines in care homes. In this guideline, the term 'medicine' includes all healthcare treatments that may be considered in care homes. Examples include continence products, appliances and enteral feeds.

This guideline does not provide recommendations for named medicines or for specific conditions or types of illness. The guideline also does not include recommendations for managing medicines in the domiciliary care setting.

The guideline and recommendations are written in the context of health and social care in England. The guideline is aimed at:

- NHS organisations
- local authorities (in England)
- independent organisations, for example, all types of independent care homes, voluntary and charitable agencies
- independent contractors, for example, community pharmacies, GPs, appliance contractors, providers of care home staff.

All NICE guidelines are developed in accordance with the [NICE equality scheme](#).

Definitions used in this guideline

For the purposes of this guideline the term ‘care home’ covers the provision of 24-hour accommodation together with either non-nursing care (for example, a residential home) or nursing care (for example, a care home with nursing).

The term ‘care home provider’ is used for the registered provider of care. If regulation or practice differs between different types of care homes (for example, a children’s care home, an adult’s care home, a non-nursing care home or a nursing care home), then the type of care home is specified in the text.

When the term ‘organisations’ is used, this includes all commissioners and providers (including care home providers), unless specified otherwise in the text. Commissioners are those individuals who undertake commissioning, which is ‘the process used by health services and local authorities to: identify the need for local services; assess this need against the services and resources available from public, private and voluntary organisations; decide priorities; and set up contracts and service agreements to buy services. As part of the commissioning process, services are regularly evaluated’.

Providers are organisations that directly provide health or social care services (such as a care home).

Individual people who live in care homes are referred to as 'residents' or 'care home residents' in this guideline.

A 'care home' can be of any size (number of residents) or have any type of resident (children, older people, people with cognitive impairment, young disabled people, people with a learning disability), but should be a registered provider of care (for example, in England with either the CQC or Ofsted).

For the purposes of this guideline, the term 'care home staff' includes registered nurses and social care practitioners working in a care home.

The term 'carer' is used for an informal or unpaid carer.

The term 'health and social care practitioners' is used to define the wider care team, including care home staff (registered nurses and social care practitioners working in care homes), social workers, case managers, GPs, pharmacists and community nurses. When specific recommendations are made for a particular professional group, this is specified in the recommendation, for example, 'GPs'.

The term 'pharmacist' is used for all pharmacists, primary care pharmacists, care home pharmacists and supplying pharmacists. Primary care pharmacists work in the primary care setting and may have a role working with care homes. Care home pharmacists have a dedicated role working in care homes. Supplying pharmacists work in a community pharmacy or chemist shop.

When a care home resident is able to look after and take their own medicines, this is referred to as 'self-administration'.

When the guideline refers to the administration of medicines, this is when care home staff check and give, or help to give, a resident their medicine(s).

Other definitions used in this guideline are given in [appendix A](#).

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.

If the resident is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Health professionals should follow the [Department of Health's advice on consent](#).

If someone does not have capacity to make decisions, health professionals should follow the [code of practice that accompanies the Mental Capacity Act](#) and the supplementary [code of practice on deprivation of liberty safeguards](#) (see [section 3.6](#)).

All health professionals should follow the recommendations in the NICE guideline on [Patient experience in adult NHS services](#) and where appropriate the NICE guideline on [Service user experience in adult mental health](#), although many of the principles in that guideline apply equally to social care staff.

If the resident agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need.

The person-centred care approach is not new across sectors and resources such as [Think Local, Act Personal](#) help to support this working.

Involving others

The views of residents in care homes about who should and should not be involved in their care are important and should be respected. If the resident

lacks the capacity to decide who should and should not be involved, health and social care practitioners must act in the resident's best interests, taking account of the provisions in the [Mental Capacity Act 2005](#).

Health and social care practitioners should also consider accounts from family members or carers of the resident's usual behaviour. This information, when used with an assessment of the resident concerned, will help with specific decisions about their care. It will also help to estimate the person's capacity to make a specific decision. Residents with reduced mental capacity should continue to have the opportunity to make informed decisions about those aspects of their care and personal lives for which they retain capacity.

Good communication between health and social care practitioners and residents, their family members or carers (as appropriate) is essential for residents to receive the information and support they need. Evidence-based information should be offered in a form that is tailored to the needs of the individual resident. The treatment, care and information provided should be culturally appropriate and in a form that is accessible to residents who have additional needs, such as physical, cognitive or sensory disabilities, or who do not speak or read English.

If the resident agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need, and carers should be offered an assessment of their own needs.

1 Recommendations

The recommendations for good practice have been developed by the Guideline Development Group (GDG), using relevant legislation, guidance and policy as the foundation for good practice. See [appendix B](#) for a list of key resources used in developing this guideline.

When a recommendation is aimed specifically at a person or organisation, this is clearly stated. In most cases the GDG was able to identify which person or organisation was responsible; if this is not specified it will be for organisations

to consider and determine locally. The GDG agreed that arrangements will vary depending on local organisational structures, how services are commissioned and provided, and what resources are available.

1.1 *Developing and reviewing policies for safe and effective use of medicines*

Recommendation 1.1.1

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

Recommendation 1.1.2

Care home providers should have a care home medicines policy, which they review to make sure it is up to date, and is based on current legislation and the best available evidence. The policy should include written processes for:

- sharing information about a resident's medicines, including when they transfer between care settings
- ensuring that records are accurate and up to date
- identifying, reporting and reviewing medicines-related problems
- keeping residents safe (safeguarding)
- accurately listing a resident's medicines (medicines reconciliation)
- reviewing medicines (medication review)
- ordering medicines
- receiving, storing and disposing of medicines
- helping residents to look after and take their medicines themselves (self-administration)
- care home staff administering medicines to residents, including staff training and competence requirements
- care home staff giving medicines to residents without their knowledge (covert administration)
- care home staff giving non-prescription and over-the-counter products to residents (homely remedies), if appropriate.

1.2 *Supporting residents to make informed decisions and recording these decisions*

Recommendation 1.2.1

Health and social care practitioners (care home staff, social workers, case managers, GPs, pharmacists and community nurses) should ensure that care home residents have the same opportunities to be involved in decisions about their treatment and care as people who do not live in care homes, and that residents get the support they need to help them to take a full part in making decisions.

Recommendation 1.2.2

The health professional prescribing a medicine or care home staff should record a resident's informed consent in the resident's care record. Consent does not need to be recorded each time the medicine is given but a record of the administration should be made on the medicines administration record.

Recommendation 1.2.3

Care home staff (registered nurses and social care practitioners working in care homes) should record the circumstances and reasons why a resident refuses a medicine (if the resident will give a reason) in the resident's care record and medicines administration record, unless there is already an agreed plan of what to do when that resident refuses their medicines. If the resident agrees, care home staff should tell the health professional who prescribed the medicine about any ongoing refusal and inform the supplying pharmacy, to prevent further supply to the care home.

Recommendation 1.2.4

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

Recommendation 1.2.5

Health professionals prescribing a medicine should:

- assume that care home residents have the capacity to make decisions
- assess a resident's mental capacity in line with appropriate legislation (for example, the Mental Capacity Act 2005 if there are any concerns about whether a resident is able to give informed consent)
- record any assessment of mental capacity in the resident's care record.

Recommendation 1.2.6

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

Recommendation 1.2.7

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

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

1.3 *Sharing information about a resident's medicines*

Recommendation 1.3.1

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

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

Recommendation 1.3.2

Commissioners should review their commissioning arrangements with their provider organisations to ensure that any information about a resident's medicines that is transferred contains the minimum information set out in [recommendation 1.7.3](#). Commissioners should monitor this through their contracting arrangements.

Recommendation 1.3.3

Providers of health or social care services should have processes in place for sharing, accurate information about a resident's medicines, including what is recorded and transferred when a resident moves from one care setting to another (including hospital).

Recommendation 1.3.4

Providers of health or social care services should ensure that either an electronic discharge summary is sent, if possible, or a printed discharge summary is sent with the resident when care is transferred from one care setting to another. See [recommendation 1.7.3](#) for the minimum information that should be transferred.

Recommendation 1.3.5

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.

Recommendation 1.3.6

Health and social care practitioners should check that complete and accurate information about a resident's medicines has been received and recorded, and is acted on after a resident's care is transferred from one care setting to another (see [recommendation 1.7.3](#) for the minimum information that should be transferred).

Recommendation 1.3.7

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

Recommendation 1.3.8

Care home staff should follow the rules on confidentiality set out in the home's process on managing information about medicines (see [recommendation 1.3.1](#)) and only share enough information with health professionals that a resident visits to ensure safe care of the resident.

1.4 *Ensuring that records are accurate and up to date*

Recommendation 1.4.1

Health and social care practitioners should ensure that records about medicines are accurate and up-to-date by following the process set out in the care home medicines policy (see [recommendation 1.1.2](#)). The process should cover:

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

Recommendation 1.4.2

Care home providers must follow the relevant legislation to ensure that appropriate records about medicines are kept secure, for an appropriate period of time, and destroyed securely when appropriate to do so.

1.5 *Identifying, reporting and reviewing medicines-related problems*

Recommendation 1.5.1

Commissioners and providers of health or social care services should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving residents (see also [recommendations 1.6.1–1.6.3](#)).

Recommendation 1.5.2

Health and social care practitioners should consider working with all relevant stakeholders to develop a locally agreed action plan, in line with other local and national strategies and governance arrangements, for improving the safety of residents and reducing medication errors in care homes.

Recommendation 1.5.3

Care home staff (registered nurses and social care practitioners working in care homes) should report all suspected adverse effects from medicines to the health professional who prescribed the medicine or another health professional as soon as possible, this would usually be the GP or out-of-hours service. Staff should record the details in the resident's care plan and tell the supplying pharmacy (if the resident agrees that this information can be shared).

1.6 *Keeping residents safe (safeguarding)*

Recommendation 1.6.1

Commissioners and providers of health or social care services should all be aware of local arrangements for notifying suspected or confirmed medicines-related safeguarding incidents.

Recommendation 1.6.2

Care home providers should have a clear process for reporting medicines-related safeguarding incidents under local safeguarding processes and to the Care Quality Commission (CQC) (or other appropriate regulator). The process should be recorded in the care home medicines policy and should clearly state:

- when the CQC (or other appropriate regulator) should be notified
- which medicines-related safeguarding incidents should be reported under local safeguarding processes and when
- that accurate details of any medicines-related safeguarding incidents are recorded as soon as possible so that the information is available for any investigation and reporting.

Recommendation 1.6.3

Commissioners should ensure that reporting requirements are included in commissioning and contracting arrangements.

Recommendation 1.6.4

Care home staff should contact a health professional to ensure that action is taken to safeguard any resident involved in a medicines-related safeguarding incident. They should follow a process agreed between health professional(s) and commissioners, which sets out who to contact in normal office hours and out-of-hours.

Recommendation 1.6.5

Care home providers should record all medicines-related safety incidents, including all 'near misses' and incidents that do not cause any harm, as a resident safety incident. Where there are notifiable safeguarding concerns these should be reported to the CQC (or other appropriate regulator).

Recommendation 1.6.6

Local safeguarding processes should include the investigation of each report of a medicines-related safeguarding incident and should monitor reports for trends.

Recommendation 1.6.7

Local safeguarding processes should include arrangements for feedback to care homes about reported medicines-related incidents to promote sharing of experiences and learning.

Recommendation 1.6.8

Care home staff should find out the root cause of medicines-related incidents.

Recommendation 1.6.9

Care home providers should make sure that any training needed by staff to find out the root cause of medicines-related incidents is specified in contracts with commissioners.

Recommendation 1.6.10

Care home staff should give residents and/or their family members or carers information on how to report a medicines-related safety incident or their concerns about medicines using the care home provider's complaints process, local authority (or local safeguarding) processes and/or a regulator's process.

Recommendation 1.6.11

Care home providers should ensure that all residents can use advocacy and independent complaints services when they have concerns about medicines.

1.7 *Accurately listing a resident's medicines (medicines reconciliation)***Recommendation 1.7.1**

The care home manager or the person responsible for a resident's transfer into a care home should coordinate the accurate listing of all the resident's medicines (medicines reconciliation) as part of a full needs assessment and care plan. The care home manager should consider the resources needed to ensure that medicines reconciliation occurs in a timely manner (see [recommendation 1.1.2](#)).

Recommendation 1.7.2

Care home providers should ensure that the following people are involved in medicines reconciliation:

- the resident and/or their family members or carers
- a pharmacist
- other health and social care practitioners involved in managing medicines for the resident, as agreed locally.

Recommendation 1.7.3

Commissioners and providers of health or social care services should ensure that the following information is available for medicines reconciliation on the day that a resident transfers into or from a care home:

- resident's details, including full name, date of birth, NHS number, address and weight (for those aged under 16 or where appropriate, for example, frail older residents)
- GP's details
- details of other relevant contacts defined by the resident and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse)
- known allergies and reactions to medicines or ingredients, and the type of reaction experienced
- medicines the resident is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication), if known
- changes to medicines, including medicines started, stopped or dosage changed, and reason for change
- date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines)
- other information, including when the medicine should be reviewed or monitored, and any support the resident needs to carry on taking the medicine (adherence support)
- what information has been given to the resident and/or family members or carers.

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

1.8 *Reviewing medicines (medication review)*

Recommendation 1.8.1

GPs should ensure that arrangements have been made for their patients who are residents in care homes to have medication reviews as set out in the residents' care plans (see [recommendation 1.8.4](#)).

Recommendation 1.8.2

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

Recommendation 1.8.3

Health and social care practitioners should ensure that medication reviews involve the resident and/or their family members or carers and a local team of health and social care practitioners (multidisciplinary team). This may include a:

- pharmacist
- community matron or specialist nurse, such as a community psychiatric nurse
- GP
- member of the care home staff
- practice nurse
- social care practitioner.

The roles and responsibilities of each member of the team and how they work together should be carefully considered and agreed locally. Training should be provided so that they have the skills needed.

Recommendation 1.8.4

Health and social care practitioners should agree how often each resident should have a multidisciplinary medication review. They should base this on the health and care needs of the resident, but the resident's safety should be the most important factor when deciding how often to do the review. The frequency of planned medication reviews should be recorded in the resident's

care plan. The interval between medication reviews should be no more than 1 year.

Recommendation 1.8.5

Health and social care practitioners should discuss and review the following during a medication review:

- the purpose of the medication review
- what the resident (and/or their family members or carers, as appropriate and in line with the resident's wishes) thinks about the medicines and how much they understand
- the resident's (and/or their family members' or carers', as appropriate and in line with the resident's wishes) concerns, questions or problems with the medicines
- all prescribed, over-the-counter and complementary medicines that the resident is taking or using, and what these are for
- how safe the medicines are, how well they work, how appropriate they are, and whether their use is in line with national guidance
- any monitoring tests that are needed
- any problems the resident has with the medicines, such as side effects or reactions, taking the medicines themselves (for example, using an inhaler) and difficulty swallowing
- helping the resident to take or use their medicines as prescribed (medicines adherence)
- any more information or support that the resident (and/or their family members or carers) may need.

1.9 Prescribing medicines

Recommendation 1.9.1

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

- issuing prescriptions according to the patient medical records

- recording clear instructions on how a medicine should be used, including how long the resident is expected to need the medicine and, if important, how long the medicine will take to work and what it has been prescribed for (use of the term 'as directed' should be avoided)
- recording prescribing in the GP patient medical record and resident care record and making any changes as soon as practically possible
- providing any extra details the resident and/or care home staff may need about how the medicine should be taken
- any tests needed for monitoring
- prescribing the right amount of medicines to fit into the 28-day supply cycle if appropriate, and any changes that may be needed for prescribing in the future
- monitoring and reviewing 'when required' and variable dose medicines
- issuing prescriptions when the medicines order is received from the care home.

Recommendation 1.9.2

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

- note in the resident's care record the instructions for:
 - when and how to take or use the medicine (for example, 'when low back pain is troublesome take 1 tablet')
 - monitoring
 - the effect they expect the medicine to have
- include dosage instructions on the prescription (including the maximum amount to be taken in a day and how long the medicine should be used, as appropriate) so that this can be included on the medicine's label
- prescribe the amount likely to be needed (for example, for 28 days or the expected length of treatment)
- liaise with care home staff to see how often the resident has had the medicine and how well it has worked.

Recommendation 1.9.3

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

Recommendation 1.9.4

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

Recommendation 1.9.5

The health professional prescribing a medicine, care home provider and supplying pharmacy should follow any local processes for anticipatory medicines to ensure that residents in care homes have the same access to anticipatory medicines as those people who do not live in care homes.

Recommendation 1.9.6

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

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

Recommendation 1.9.7

Care home staff should:

- ensure that any change to a prescription or prescription of a new medicine by telephone is supported in writing (by fax or email) before the next or first dose is given

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

Recommendation 1.9.8

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

1.10 *Ordering medicines*

Recommendation 1.10.1

Care home providers must usually ensure that medicines prescribed for a resident are not used by other residents. However, during the COVID-19 pandemic medicines no longer needed by a resident may be reused in line with the UK government [COVID 19 standard operating procedure for running a medicines reuse scheme in a care home or hospice setting](#). **[amended 1 May 2020]**

Recommendation 1.10.2

Care home providers should ensure that care home staff (registered nurses and social care practitioners working in care homes) have protected time to order medicines and check medicines delivered to the home.

Recommendation 1.10.3

Care home providers should ensure that at least 2 members of the care home staff have the training and skills to order medicines, although ordering can be done by 1 member of staff.

Recommendation 1.10.4

Care home providers should retain responsibility for ordering medicines from the GP practice and should not delegate this to the supplying pharmacy.

Recommendation 1.10.5

Care home providers should ensure that records are kept of medicines ordered. Medicines delivered to the care home should be checked against a record of the order to make sure that all medicines ordered have been prescribed and supplied correctly.

1.11 *Dispensing and supplying medicines*

Recommendation 1.11.1

Pharmacies and doctors supplying medicines to care home providers should ensure they have processes, such as standard operating procedures, in place for all staff who dispense and accuracy check medicines for residents, particularly those who are using monitored dosage systems.

Recommendation 1.11.2

Care home providers should determine the best system for supplying medicines for each resident based on the resident's health and care needs and the aim of maintaining the resident's independence wherever possible. If needed, they should seek the support of health and social care practitioners.

Recommendation 1.11.3

Supplying pharmacies should produce medicines administration records wherever possible. See also [recommendation 1.14.8](#).

1.12 *Receiving, storing and disposing of medicines*

Recommendation 1.12.1

Providers of adult care homes must comply with the [Misuse of Drugs Act 1971](#) and associated regulations when storing controlled drugs. Providers of children's homes should have robust processes for storing controlled drugs.

Recommendation 1.12.2

Care home providers should include the following information in their process for storing medicines safely:

- how and where medicines are stored, including medicines supplied in monitored dosage systems, medicines to be taken and looked after by residents themselves (see recommendations [1.13.2](#), [1.13.6](#)), controlled

drugs, medicines to be stored in the refrigerator, skin creams, oral nutritional supplements and appliances

- secure storage with only authorised care home staff having access
- the temperatures for storing medicines and how the storage conditions should be monitored.

Recommendation 1.12.3

Care home providers should assess each resident's needs for storing their medicines and should provide storage that meets the resident's needs, choices, risk assessment and type of medicines system they are using.

Recommendation 1.12.4

Before disposing of a medicine that is still being prescribed for a resident, care home staff (registered nurses and social care practitioners working in care homes) should find out if it is still within its expiry date and if it is still within its shelf-life if it has been opened.

Recommendation 1.12.5

When disposing of medicines and removing medicines classed as clinical waste, care home providers should have a process for the prompt disposal of:

- medicines that exceed requirements
- unwanted medicines (including medicines of any resident who has died)
- expired medicines (including controlled drugs).

During the COVID-19 pandemic see the [recommendations on managing medicines in the NICE COVID-19 rapid guideline on managing symptoms in the community](#). [amended 1 May 2020]

Recommendation 1.12.6

Care home providers should keep records of medicines (including controlled drugs) that have been disposed of, or are waiting for disposal. Medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy.

1.13 *Helping residents to look after and take their medicines themselves (self-administration)*

Recommendation 1.13.1

Care home staff (registered nurses and social care practitioners working in care homes) should assume that a resident can take and look after their medicines themselves (self-administer) unless a risk assessment has indicated otherwise (see recommendation 1.13.2).

Recommendation 1.13.2

Health and social care practitioners should carry out an individual risk assessment to find out how much support a resident needs to carry on taking and looking after their medicines themselves (self-administration). Risk assessment should consider:

- resident choice
- if self-administration will be a risk to the resident or to other residents
- if the resident can take the correct dose of their own medicines at the right time and in the right way (for example, do they have the mental capacity and manual dexterity for self-administration?)
- how often the assessment will need to be repeated based upon individual resident need
- how the medicines will be stored
- the responsibilities of the care home staff, which should be written in the resident's care plan.

Recommendation 1.13.3

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

Recommendation 1.13.4

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

Recommendation 1.13.5

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

- that the resident is looking after and taking their medicines themselves (self-administering)
- whether any monitoring is needed (for example, to assess ability to self-administer or willingness to take the medicines as prescribed [adherence])
- that medicine has been taken as prescribed (either by seeing this directly or by asking the resident)
- who has recorded that the medicine has been taken.

Recommendation 1.13.6

Care home providers should ensure that medicines for self-administration are stored as identified in the resident's risk assessment (for example, in a lockable cupboard or drawer in a resident's room). Residents should be able to get any medicines that need special storage at a time when they need to take or use them (see recommendations [1.12.1](#), [1.12.2](#) and [1.12.3](#)).

Recommendation 1.13.7

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

- individual risk assessment
- obtaining or ordering controlled drugs
- supplying controlled drugs
- storing controlled drugs

- recording supply of controlled drugs to residents
 - reminding residents to take their medicines (including controlled drugs)
- disposal of unwanted controlled drugs.

1.14 Care home staff administering medicines to residents

Recommendation 1.14.1

Care home providers should consider including the following in a medicines administration process:

- the 6 R's of administration:
 - right resident
 - right medicine
 - right route
 - right dose
 - right time
 - resident's right to refuse
- making a record of the administration as soon as possible
- what to do if the resident is having a meal
- what to do if the resident is asleep
- how to administer specific medicines such as patches, creams, inhalers, eye drops and liquids
- using the correct equipment depending on the formulation (for example, using oral syringes for small doses of liquid medicines)
- how to record and report administration errors and reactions to medicines
- how to record and report a resident's refusal to take a medicine(s)
- how to manage medicines that are prescribed 'when required'
- how to manage medicines when the resident is away from the care home for a short time (for example, visiting relatives)
- monitoring and evaluating the effects of medicines, including reactions to medicines.

Care homes with nursing care should also include the correct use of infusion and injection devices (for example, syringe drivers).

Recommendation 1.14.2

Care home providers should ensure that a process for administering 'when required' medicines is included in the care home medicines policy (see [recommendation 1.1.2](#)). The following information should be included:

- the reasons for giving the 'when required' medicine
- how much to give if a variable dose has been prescribed
- what the medicine is expected to do
- the minimum time between doses if the first dose has not worked
- offering the medicine when needed and not just during 'medication rounds'
- when to check with the prescriber any confusion about which medicines or doses are to be given
- recording 'when required' medicines in the resident's care plan.

Recommendation 1.14.3

Care home staff (registered nurses and social care practitioners working in care homes) should ensure that 'when required' medicines are kept in their original packaging.

Recommendation 1.14.4

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

Recommendation 1.14.5

Care home providers should consider ways of avoiding disruptions during the medicines administration round, such as:

- having more trained and skilled care home staff on duty at that time
- reviewing the times for administering medicines (for example, administering once daily medicines at lunchtime rather than in the morning, if the health professional prescribing the medicine agrees that this is clinically appropriate)
- avoiding planned staff breaks during times of medicines administration
- ensuring fewer distractions for care home staff administering medicines.

Recommendation 1.14.6

Care home staff must have the training and skills to use system(s) adopted in the care home for administering medicines in line with regulation 22 of the [Health and Social Care Act 2008](#) for adult care homes and regulation 26 of the [Children's Homes Regulations 2001](#) for children's care homes.

Recommendation 1.14.7

Paper-based or electronic medicines administration records should:

- be legible
- be signed by the care home staff
- be clear and accurate
- be factual
- have the correct date and time
- be completed as soon as possible after administration
- avoid jargon and abbreviations
- be easily understood by the resident, their family member or carer.

Recommendation 1.14.8

Care home providers should ensure that medicines administration records (paper-based or electronic) include:

- the full name, date of birth and weight (if under 16 years or where appropriate, for example, frail older residents) of the resident
- details of any medicines the resident is taking, including the name of the medicine and its strength, form, dose, how often it is given and where it is given (route of administration)
- known allergies and reactions to medicines or their ingredients, and the type of reaction experienced
- when the medicine should be reviewed or monitored (as appropriate)
- any support the resident may need to carry on taking the medicine (adherence support)
- any special instructions about how the medicine should be taken (such as before, with or after food).

See also [recommendation 1.11.3](#).

Recommendation 1.14.9

Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used.

Recommendation 1.14.10

Care home providers should ensure that all information included on the medicines administration record is up-to-date and accurate. They may need support from the health professional prescribing the medicines and the supplying pharmacy to do this.

Recommendation 1.14.11

Care home staff must record medicines administration, including the date and time, on the relevant medicines administration record, as soon as possible and ensure that they:

- make the record only when the resident has taken their prescribed medicine
- complete the administration before moving on to the next resident
- recognise that mistakes are less likely if 1 member of staff records administration on the medicines administration record rather than 2 staff recording
- record 'when required' medicines only when they have been given, noting the dose given and the amount left (where possible), to make sure that there is enough in stock and to reduce waste
- record when and why medicines have not been given
- correct written mistakes with a single line through the mistake followed by the correction and a signature, date and time (correction fluid should not be used).

Recommendation 1.14.12

Health professionals who are visiting the care home to administer a medicine(s) to residents should make their record of administration available to care home staff, if asked by the care home. The health professional should also consider seeing the resident with the care home staff responsible for administering medicines to the resident.

Recommendation 1.14.13

Care home staff should keep a record of medicines administered by visiting health professionals on the resident's medicines administration record.

Recommendation 1.14.14

Care home staff responsible for administering medicines should add a cross-reference (for example, 'see warfarin administration record') to the resident's medicines administration record when a medicine has a separate administration record.

Recommendation 1.14.15

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

Recommendation 1.14.16

Care home staff should make appropriate records of controlled drugs that have been administered to residents. The care home staff responsible for administering the controlled drug and a trained witness should sign the controlled drugs register. The staff member administering the controlled drug should also sign the medicines administration record.

Recommendation 1.14.17

Care home providers should ensure that the following information is given to the resident and/or their family members or carers when the resident is temporarily away from the care home:

- the medicines taken with the resident

- clear directions and advice on how, when and how much of the medicines the resident should take
- time of the last and next dose of each medicine
- a contact for queries about the resident's medicines, such as the care home, supplying pharmacy or GP.

Recommendation 1.14.18

Care home providers should have a process to ensure that the resident has the medicines they need when they are away from the care home (for example, visiting relatives). Details of the medicines taken should be recorded in the resident's care plan.

Recommendation 1.14.19

Health and social care practitioners should be able to access reliable and up-to-date information about medicines. Resources may include the patient information leaflet supplied with the medicine and the following websites:

- [Medicines and Healthcare Products Regulatory Agency](#)
- [NHS choices](#)
- [NICE Evidence](#)
- [Patient.co.uk](#)

Health professionals may also use the:

- [British National Formulary \(BNF\)](#)
- [British National Formulary for Children \(BNFC\)](#)
- [Clinical Knowledge Summaries](#)

[Electronic Medicines Compendium](#)

1.15 *Care home staff giving medicines to residents without their knowledge (covert administration)*

Recommendation 1.15.1

Health and social care practitioners should not administer medicines to a resident without their knowledge (covert administration) if the resident has capacity to make decisions about their treatment and care.

Recommendation 1.15.2

Health and social care practitioners should ensure that covert administration only takes place in the context of existing legal and good practice frameworks to protect both the resident who is receiving the medicine(s) and the care home staff involved in administering the medicines.

Recommendation 1.15.3

Health and social care practitioners should ensure that the process for covert administration of medicines to adult residents in care homes includes:

- assessing mental capacity
- holding a best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests
- recording the reasons for presuming mental incapacity and the proposed management plan
- planning how medicines will be administered without the resident knowing
- regularly reviewing whether covert administration is still needed.

Recommendation 1.15.4

Commissioners and providers of care home services should consider establishing a wider policy on the covert administration of medicines across several health and social care organisations.

1.16 *Care home staff giving non-prescription and over-the-counter products to residents (homely remedies)*

Recommendation 1.16.1

Care home providers offering non-prescription medicines or other over-the-counter-products (homely remedies) for treating minor ailments should consider having a homely remedies process, which includes the following:

- the name of the medicine or product and what it is for

- which residents should not be given certain medicines or products (for example, paracetamol should not be given as a homely remedy if a resident is already receiving prescribed paracetamol)
- the dose and frequency
- the maximum daily dose
- where any administration should be recorded, such as on the medicines administration record
- how long the medicine or product should be used before referring the resident to a GP.

Recommendation 1.16.2

Care home staff who give non-prescription medicines or other over-the-counter products (homely remedies) to residents should be named in the homely remedies process. They should sign the process to confirm they have the skills to administer the homely remedy and acknowledge that they will be accountable for their actions.

1.17 *Training and skills (competency) of care home staff*

Recommendation 1.17.1

Care home providers must ensure that designated staff administer medicines only when they have had the necessary training and are assessed as competent. Care home providers must ensure that staff who do not have the skills to administer medicines, despite completing the required training, are not allowed to administer medicines to residents.

Recommendations 1.17.2

Care home providers should set up an internal and/or external learning and development programme so that care home staff can gain the necessary skills for managing and administering medicines. The programme should meet the requirements of the regulators, the residents and the training needs of care home staff.

Recommendation 1.17.3

Care home providers should consider using an 'accredited learning' provider so that care home staff who are responsible for managing and administering medicines can be assessed by an external assessor.

Recommendation 1.17.4

Care home staff must have induction training that is relevant to the type of home they are working in (adult care homes or children's homes). All care home staff (including registered nurses as part of their continuing professional development) involved in managing and administering medicines should successfully complete any training needed to fulfil the learning and development requirements for their role.

Recommendation 1.17.5

Care home providers should ensure that all care home staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines. Care home providers should identify any other training needed by care home staff responsible for managing and administering medicines. If there is a medicines related safety incident, this review may need to be more frequent to identify support, learning and development needs.

Recommendation 1.17.6

Health professionals working in, or providing services to, care homes should work to standards set by their professional body and ensure that they have the appropriate skills, knowledge and expertise in the safe use of medicines for residents living in care homes.

Who should take action

The table below lists who should take action according to the recommendation number.

Who should take action	Recommendation number
Commissioners	1.1.1, 1.3.2, 1.5.1, 1.6.1, 1.6.3, 1.7.3, 1.15.4
Care home providers	1.1.2, 1.3.1, 1.3.7, 1.4.2, 1.6.2, 1.6.5, 1.6.9, 1.6.11, 1.7.2, 1.9.8, 1.10.1, 1.10.2, 1.10.3, 1.10.4, 1.10.5, 1.11.2, 1.12.1 (providers of adult care homes), 1.12.2, 1.12.3, 1.12.5, 1.12.6, 1.13.4 (providers of adult care homes), 1.13.5 (providers of children's care homes), 1.13.6, 1.13.7, 1.14.1, 1.14.2, 1.14.5, 1.14.8, 1.14.9, 1.14.10, 1.14.17, 1.14.18, 1.16.1, 1.17.1, 1.17.2, 1.17.3, 1.17.5
Providers of health or social care services	1.3.3, 1.3.4, 1.5.1, 1.6.1, 1.7.3
Care home manager	1.7.1, 1.13.3
Care home staff (registered nurses and social care practitioners working in care homes) Recommendations for health and social care practitioners also apply to care home staff	1.2.2, 1.2.3, 1.3.8, 1.5.3, 1.6.4, 1.6.8, 1.6.10, 1.9.4, 1.9.7, 1.12.4, 1.13.1, 1.14.3, 1.14.6, 1.14.7, 1.14.11, 1.14.13, 1.14.14, 1.14.15, 1.14.16, 1.16.2, 1.17.4
Health and social care practitioners (care home staff, social workers, case managers, GPs, pharmacists and community nurses)	1.2.1, 1.2.4, 1.2.7, 1.3.5, 1.3.6, 1.4.1, 1.5.2, 1.8.3, 1.8.4, 1.8.5, 1.9.3, 1.13.2, 1.14.19, 1.15.1, 1.15.2, 1.15.3
Health professionals prescribing medicines	1.2.2, 1.9.2, 1.9.5, 1.14.4
Pharmacists	1.14.4

Recommendations for health and social care practitioners also apply to pharmacists	
Supplying pharmacy	1.9.5
Health professionals who are visiting the care home to administer a medicine(s) to residents	1.14.12
Health professionals working in, or providing services to, care homes	1.17.6
GPs Recommendations for health and social care practitioners also apply to GPs	1.8.1, 1.8.2
GP practices	1.9.1

2 Legal framework

The management of medicines in care homes is governed by legislation, regulation and professional standards, which are monitored and enforced by different regulatory organisations across England, Wales and Northern Ireland.

Legislation gives protection to all residents. The [Medicines Act 1968](#) established a comprehensive licensing system for medicines in the UK. The [Medicines and Healthcare products Regulatory Agency](#) (MHRA) states that 'the Human Medicines Regulations 2012 set out a comprehensive regime for the authorisation of medicinal products for human use; for the manufacture, import, distribution, sale and supply of those products; for their labelling and advertising; and for pharmacovigilance'.

Adult care homes

In England, the regulation of adult care homes is subject to the [Health and Social Care Act 2008](#) and the associated regulations, in particular the [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2010](#), which sets out which health and social care activities a registered provider can carry out.

Care home providers are subject to different regulations and have different regulators, depending on their location. The [Health and Social Care Act 2008](#) established the [Care Quality Commission](#) (CQC), the regulator of health and adult social care in England. The CQC 'make sure health and social care services provide people with safe, effective, compassionate, high quality care and we encourage care services to improve'.

The regulations that apply in adult care homes are:

England:

- The [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2010](#)

Wales:

- [The Care Homes \(Wales\) Regulations 2002](#)

Northern Ireland:

- [The Residential Care Homes Regulations \(Northern Ireland\) 2005](#)
- [The Nursing Homes Regulations \(Northern Ireland\) 2005](#)

Children's care homes

The powers to regulate and inspect children's social care services, including children's homes, were transferred to the [Office for Standards in Education, Children's Services and Skills](#) (Ofsted) under [section 148](#) of the Education and Inspections Act 2006.

The regulations that apply in children's care homes are:

England:

- [The Children's Homes Regulations 2001](#)

Wales:

- [The Children's Homes \(Wales\) Regulations 2002](#)

Northern Ireland:

- [The Children's Homes Regulations \(Northern Ireland\) 2005](#)

2.1 Essential standards in care homes

Essential standards in adult care homes

To support providers of adult care in complying with legislation in England (Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the [Care Quality Commission \(Registration\) Regulations 2009](#)), the CQC has published [Essential standards of quality and safety](#) (2010). These essential standards have been developed to ensure that providers of adult health and social care services know how to comply with legislation.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [regulation 13](#) states: 'The registered person must protect services users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity'.

To support the implementation of this regulation, the Essential standards of quality and safety ([outcome 9](#) on the management of medicines) states that: 'People who use services:

- will have their medicines at the times they need them, and in a safe way
- wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

This is because providers who comply with the regulations will:

- handle medicines safely, securely and appropriately
- ensure that medicines are prescribed and given by people safely
- follow published guidance about how to use medicines safely.'

Essential standards in children's homes

The Department for Education document [Children's homes: national minimum standards](#) (2011) gives additional guidance for providers of children's care homes to help them comply with the [Children Act 1989: Guidance and Regulations Volume 5: Children's Homes in England](#), which also takes into account the requirements under the [Care Standards Act 2000](#), in particular the [Children's Homes Regulations 2001](#) (as amended).

[Regulation 21](#) (medicines) of the Children's Homes Regulations 2001 states: 'The registered person shall make suitable arrangements for the recording, handling, safekeeping, safe administration and disposal of any medicines received into the children's home' and [standard 6](#) (promoting good health and wellbeing) states: 'Children live in a healthy environment where their physical,

emotional and psychological health is promoted and where they are able to access the services to meet their health needs.’

Similar minimum standards have been published in Wales and Northern Ireland for both adults and children (see [appendix C](#)).

Safeguarding

In England and Wales, the [Safeguarding Vulnerable Groups Act 2006](#) (with [similar legislation](#) applying in Northern Ireland) established the legal basis for an independent safeguarding authority now known as the [Disclosure and Barring Service](#).

This service manages 2 lists of people barred from working with children and/or vulnerable adults. The Act places certain legal duties on local authorities and providers of regulated activity, including the reporting of individuals and the circumstances when reporting should happen. The service can also provide information about certain people on request (see [section 3.6](#)).

3 Evidence and recommendations

3.1 *Developing and reviewing policies for safe and effective use of medicines*

The [Care Quality Commission](#) (CQC) and [Office for Standards in Education, Children’s Services and Skills](#) (Ofsted) do not specifically require a written medicines policy as part of the standards for adult and children’s care homes. However, outcome 9A of the Essential standards of quality and safety (2010) requires that ‘people who use services receive care, treatment and support that ... follows clear procedures in practice, which are monitored and reviewed, which explain how up-to-date medicines information and clinical reference sources for staff are made available’.

[Social care governance: A practice workbook for Northern Ireland](#) (Social Care Institute of Excellence [SCIE] 2013) defined governance in social care

as 'the process by which organisations ensure good service delivery and promote good outcomes for people who use services'.

Compliance with medicines management regulatory requirements is the responsibility of care home providers. Care home providers should ensure that they comply with the CQC's [Essential standards of quality and safety](#) (2010) or the Department for Education's [Children's homes: national minimum standards](#) (2011). Local contracts between care home providers and local authority and/or Clinical Commissioning Groups (CCG) may support compliance by including key performance indicators or quality metrics, allowing commissioners to monitor requirements of care home providers in line with the usual contracting process.

The GDG agreed that responsibilities and reporting arrangements relating to governance and managing medicines should be stated in service level agreements or contract specifications. The GDG discussed and recognised the importance of local commissioners, providers of care home services and providers of services to care homes working together from an early stage to include these governance arrangements. The GDG was also aware that care home providers may need support in delivering change and may find [Leadership: improving, the prescribing, dispensing and management of medicine in care homes](#), produced as part of the safety of medicines in care homes project, a useful resource.

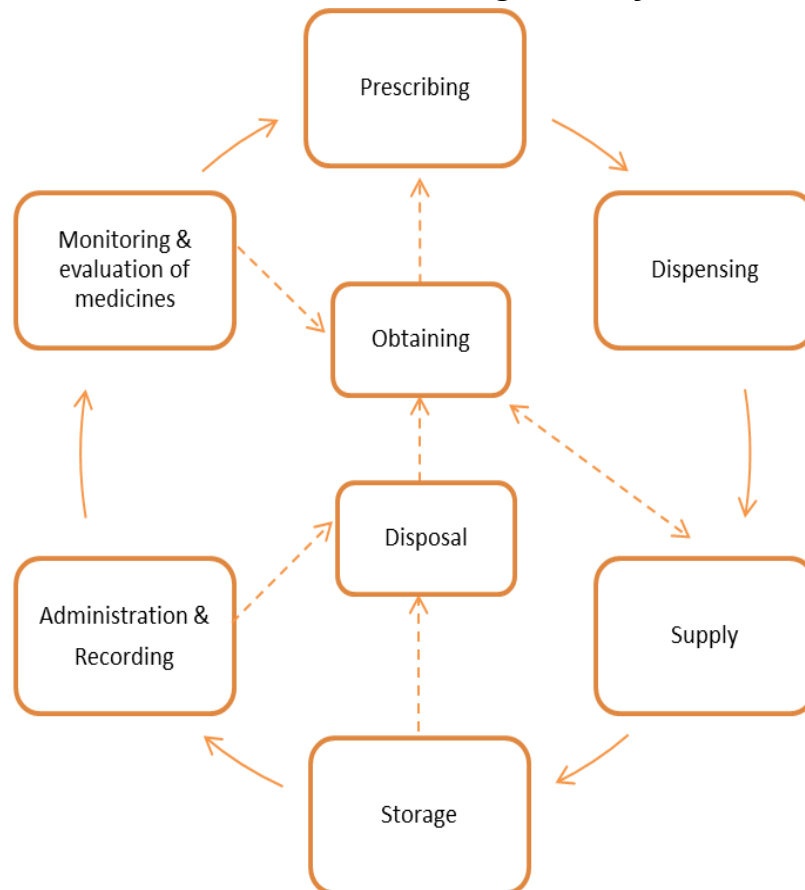
The GDG discussed and concluded that there is opportunity for commissioners and providers to review their policies, processes and local governance arrangements to support the safe and effective use of medicines in care homes. Processes should be consistent with good practice and the accountability and responsibilities of commissioners, providers of care homes and the providers of services to care homes should be clear.

Medicines management systems

Medicines management systems are developing and may now be paper-based, electronic or a combination of both. Care home providers should ensure that whichever system is selected for use in their care home, it

supports residents' needs (for example, monitoring of medicines, recording allergy and drug intolerances, data protection, safeguarding and near miss reporting, audit, medication review and medicines reconciliation). Figure 1 summarises the key parts of the managing medicines system that are discussed in the guideline.

Figure 1 Overview of the medicines management system



The GDG was aware of the legislation and regulation (see [section 2](#)) for managing medicines in care homes. The GDG discussed and concluded that care home providers should have a care home medicines policy that includes written processes for:

- sharing information about a resident's medicines, including when they transfer between care settings (see [section 3.3](#))
- ensuring that records are accurate and up to date (see [section 3.4](#))

- identifying, reporting and reviewing medicines-related problems (see [section 3.5](#))
- keeping residents safe (safeguarding) (see [section 3.6](#))
- accurately listing a resident's medicines (medicines reconciliation) (see [section 3.7](#))
- reviewing medicines (medication review) (see [section 3.8](#))
- ordering medicines (see [section 3.10](#))
- receiving, storing and disposing of medicines (see [section 3.12](#))
- helping residents to look after and take their medicines themselves (self-administration) (see [section 3.13](#))
- care home staff administering medicines to residents, including staff training and competence requirements (see sections [3.14](#) and [3.17](#))
- care home staff giving medicines to residents without their knowledge (covert administration) (see [section 3.15](#))
- care home staff giving non-prescription and over-the-counter products to residents (homely remedies), if appropriate (see [section 3.16](#)).

Care homes should review the policy to ensure it remains up-to-date and is based on current legislation and the best available evidence, to provide safe care to residents.

Recommendations

Recommendation 1.1.1

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

Recommendation 1.1.2

Care home providers should have a care home medicines policy, which they review to make sure it is up to date, and is based on current legislation and the best available evidence. The policy should include written processes for:

- sharing information about a resident's medicines, including when they transfer between care settings
- ensuring that records are accurate and up to date
- identifying, reporting and reviewing medicines-related problems
- keeping residents safe (safeguarding)
- accurately listing a resident's medicines (medicines reconciliation)
- reviewing medicines (medication review)
- ordering medicines
- receiving, storing and disposing of medicines
- helping residents to look after and take their medicines themselves (self-administration)
- care home staff administering medicines to residents, including staff training and competence requirements
- care home staff giving medicines to residents without their knowledge (covert administration)
- care home staff giving non-prescription and over-the-counter products to residents (homely remedies), if appropriate.

3.2 Supporting residents to make informed decisions and recording these decisions

The National Care Forum project report [Safety of medicines in the care home](#) (2013) identified that ‘when a person enters a home, staff often automatically assume responsibility for managing medicines. This can lead to a loss of independence and control for the resident’. The report states that ‘the starting point for medicines management should be for the person to be enabled to retain control of their own medicines, or as a minimum be involved in managing their medicines (in accordance with their ability and wishes)’.

The Department of Health published [guidance](#) on supporting adults using social care to make decisions and manage risks related to the choices each person may make. In addition, [Liberating the NHS: No decision about me, without me](#) (Department of Health 2012) outlines the UK government’s aim of giving people ‘more say over their care and treatment with more opportunity to make informed choices, as a means of securing better care and better outcomes’.

In addition, the GDG was aware of a high-quality systematic review ([Dwamena et al. 2012](#)) that found that interventions such as clarifying patients’ concerns and beliefs, communicating treatment options, using differing levels of empathy, and the patient’s perception of providers’ attentiveness to them and their concerns as well as their diseases, all had benefits when adopting a person-centred approach.

The GDG agreed that when possible, residents should be enabled and assisted to manage their own medicines through shared decision-making processes. Shared decision-making has been defined by [The King’s Fund](#) as ‘a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient’s informed preferences. It involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients’ informed preferences’.

When considering care home residents and managing their medicines, the CQC's [Essential standards of quality and safety](#) (2010) requires that people who use services benefit from providers ensuring that, whenever possible, information is available about the medicines they are taking (including the risks) and about medicines that are advisable for them to take for their health and wellbeing and to prevent ill health.

The GDG was aware that there can be a number of barriers to residents being involved in decisions about their medicines, not least the issues of competence (whether an individual has sufficient understanding of a proposed treatment) and capacity, informed consent and health literacy. Additional barriers may include staff attitude and institutional practices. These barriers are relevant to both children and adults living in care homes.

The GDG concluded that residents should have the same involvement in decisions about their care and treatment, and should have the right to access the same services and support, as those who do not live in care homes. Living in a care home should not be a barrier to this.

Informed consent to care and treatment

Consent will be considered within this guideline only in the context of managing medicines. Other NICE guidance considers consent more widely (see [Patient experience in adult NHS services: improving the experience of care for people using adult NHS services](#) [NICE clinical guideline 138] and [Service user experience in adult mental health](#) [NICE clinical guideline 136]).

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 ([part 4, regulation 18](#)) relating to adult services states that 'The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.'

The Children's Homes Regulations 2001 ([part 4, regulation 20, \[2\] d](#)) relating to children's services states: 'The registered person shall promote and protect the health of the children accommodated in a children's home. In particular the registered person shall ensure that ... each child is provided with

guidance, support and advice on health and personal care issues appropriate to his needs and wishes.'

The [Reference guide to consent for examination or treatment](#) (Department of Health 2009) states that 'It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice.'

If residents do not have the capacity to make decisions, health professionals should follow the Department of Health's guidance on consent and the [code of practice](#) that accompanies the Mental Capacity Act. Guidance on consent is available in Wales, from the [Welsh Government](#), and in Northern Ireland from the [Department of Health, Social Services and Public Safety](#).

The Department of Health's advice on consent also covers the wide range of issues from voluntary informed consent to examination and treatment, the [Mental Capacity Act 2005](#), the [Mental Health Act 1983](#) and the circumstances in which decisions may be made for children lacking capacity.

The GDG discussed the process for when a resident gives or refuses consent. The resident's decision is valid and informed and should be recorded in the resident's care record. Consent for each administration of a medicine does not need to be recorded, except as a record of administration on the medicines administration record (see [section 3.14](#)). When a resident gives valid and informed refusal for a medicine, then the care home staff should detail the circumstances and reasons for refusal (if a resident is willing to give a reason) on the appropriate medicines administration record. The prescriber should be notified (if the resident agrees) as outlined in the resident's care plan. The care home staff should record details in the care plan. The GDG also agreed that partial administration of a medicine (for example if the resident were to spit out the medicine following oral administration) should be recorded.

The GDG concluded that any decision or discussion about consent should be recorded in the resident's care plan. Care home staff should record the circumstances for refusal of consent.

Health literacy

The World Health Organization (WHO) defines health literacy as 'the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health'. Published evidence reviewed by the GDG suggests that low health literacy is a significant barrier to preventative and therapeutic care.

The GDG was aware that there are additional factors that can be potential barriers for residents in relation to accessing, understanding and using information about medicines. These factors include environmental factors (for example, access to a private consultation area, comfort and lighting), language, hearing and culture, particularly for people from minority ethnic groups and those for whom English is a second language. Before having discussions with a resident, their hearing aids may need to be checked to ensure that they are working properly, or if a resident is more alert in the morning it might be appropriate to plan discussions with the resident at these times.

The GDG agreed that health and social care practitioners should take account of a resident's individual needs and if appropriate use support materials, including large print leaflets, translated versions of texts, or offer access to additional resources, such as nurse or pharmacist advisors or translation services, to aid the resident's understanding.

The GDG concluded that a number of factors may affect a resident's ability to give informed consent, including their mental health, mental capacity, health literacy, vision, hearing, language and culture. Health and social care practitioners need to ensure that these factors are considered for each resident, with any barriers to informed consent identified and taken into account in the resident's individual care plan.

Mental capacity

The Mental Capacity Act Code of Practice 2007 states that ‘for someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision.’ The GDG recognised that in line with the Mental Capacity Act 2005, every care home resident must be assumed to have the capacity to make decisions themselves about their medicines, unless demonstrated under the Act that they lack capacity. This includes consenting to take prescribed medicines, refusing to take medicines and being involved in decision-making about their care.

If health and social care practitioners have concerns about an individual resident’s capacity, this should be assessed in line with the requirements of the [Mental Capacity Act 2005](#), referring to the processes laid out in the [Mental Capacity Act Code of Practice 2007](#). Most of the Mental Capacity Act 2005 applies only to those aged 16 years or over, however there is an overlap of legislation with the [Children’s Act 1989](#).

The Social Care Institute for Excellence (SCIE) [prevention of maladministration of medication checklist](#) states that ‘all residents should be supported to manage their own medicines unless they are assessed as lacking mental capacity to do so’.

The Mental Capacity Act (MCA) 2005 sets out a number of principles (see box 1).

Box 1 Principles set out by the Mental Capacity Act (2005)

- 'A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests (known as a "best interests decision").
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.'

Residents about whom there is a concern about capacity

The [Mental Capacity Act Code of Practice 2007](#) states that 'an assessment must only examine a person's capacity to make a particular decision when it needs to be made. It may be possible to put off the decision until the person has the capacity to make it'. The code of practice also states that 'It is good practice for professionals to carry out a proper assessment of a person's capacity to make particular decisions and to record the findings in the relevant professional records.'

Furthermore, the Code of Practice states that 'a doctor or healthcare professional proposing treatment should carry out an assessment of the person's capacity to consent (with a multi-disciplinary team, if appropriate) and record it in the patient's clinical notes.'

Residents lacking capacity to make a specific decision

For residents who have an assessment and are found to lack capacity to make a specific decision, it may be necessary to make a 'best interest decision' about the residents' care or treatment. Additionally, for those care

home residents who have no other person (other than paid staff) to support or represent them or be consulted, then it may be necessary to appoint an Independent Mental Capacity Advocate (IMCA) following guidance laid out in the [Mental Capacity Act Code of Practice 2007](#). An IMCA represents vulnerable people who lack capacity to make important decisions about serious medical treatment if they have no family and friends available for consultation about those decisions. An IMCA may be appointed for those residents who have particularly complex needs requiring decisions to be made about their medicines, including an assessment of the risks and benefits.

Evidence shows that the care home resident population mostly consists of older people. In addition, evidence suggests that the prevalence of dementia in care settings is around 70% ([Matthews et al. 2013](#)). Furthermore, care home residents may have a learning disability or have a condition such as an acquired brain injury. These residents may lack mental capacity or have cognitive impairment that would prevent them from being involved in decisions about their medicines.

However, published evidence has identified that care home residents are not all alike and it should not be presumed that individual residents are incapable of being involved with decisions about, and with the administration of, their own medicines.

The GDG was aware that the [Mental Capacity Act Code of Practice 2007](#) states that 'Decisions about a person's care or treatment are often made by a multi-disciplinary team (a team of professionals with different skills that contribute to a person's care), by drawing up a care plan for the person.' The code of practice therefore recommends that 'the preparation of a care plan should always include an assessment of the person's capacity to consent to the actions covered by the care plan, and confirm that those actions are agreed to be in the person's best interests'.

When recording a best interest decision the Mental Capacity Act Code of Practice 2007 states that the record should set out:

- 'how the decision about the person's best interests was reached

- what the reasons for reaching the decision were
- who was consulted to help work out best interests, and
- what particular factors were taken into account.'

The GDG concluded that assessment of a resident's mental capacity must be conducted in line with the [Mental Capacity Act 2005](#). Capacity should be assessed on an individual basis by the health professional proposing the treatment and recorded in the resident's care plan. If an individual lacks capacity, there should be an ongoing review, as lack of capacity may be temporary or fluctuate depending on the cause.

Factors that should be taken into account when making a best interests decision

The [Mental Capacity Act Code of Practice 2007](#) recommends that a 'best interests' decision about a care home resident's mental capacity should not be based on that person's age, appearance, condition or behaviour (for example, having a learning disability or illness such as Alzheimer's disease does not necessarily mean that a person lacks capacity to make all decisions).

A decision about what is in a resident's best interests should include consideration of all relevant circumstances, which may include:

- the resident's past and present wishes and feelings, beliefs and values
- the views of those close to the resident (such as friends, family members, carers and advocates)
- the views of those involved in caring for the person, any attorney appointed by the person under a Lasting Power of Attorney or deputy appointed for that person by the Court of Protection (a specialist court, set up under the Mental Capacity Act 2005, to deal with decision-making for adults [and children in a few cases] who may lack capacity to make specific decisions for themselves)
- any advanced decision to decline treatment that is valid and applicable to current circumstances (SCIE states that an exception can be made regarding advance decisions if new treatments have become available that

may have affected the person's decision had they known about them at the time).

The GDG was aware of guidance from both the [CQC](#) and [SCIE](#) on making decisions in a person's best interests. The GDG concluded that for care homes, the following good practice should apply to involving residents in 'best interest' decisions:

- The resident should be involved in the decision as much as possible, with those involved in making the decision finding out about the resident's past and present views, wishes, feelings, beliefs and values.
- When possible, involve the resident in meetings in which decisions will be made about them.
- Talk to people who know the resident well. This could include the resident's family and friends, as well as the care home staff who have a good knowledge of the resident. Follow the legal requirements particularly of those with lasting power of attorney as laid out in the Mental Capacity Act 2005.
- Try to limit any restrictions on the resident by delivering care and treatment in a manner that empowers residents.

The GDG was aware that [training](#) on the Mental Capacity Act 2005 is available to staff in health and social care (see also [section 3.17](#)).

Recommendations

Recommendation 1.2.1

Health and social care practitioners (care home staff, social workers, case managers, GPs, pharmacists and community nurses) should ensure that care home residents have the same opportunities to be involved in decisions about their treatment and care as people who do not live in care homes, and that residents get the support they need to help them to take a full part in making decisions.

Recommendation 1.2.2

The health professional prescribing a medicine or care home staff should record a resident's informed consent in the resident's care record. Consent does not need to be recorded each time the medicine is given but a record of the administration should be made on the medicines administration record.

Recommendation 1.2.3

Care home staff (registered nurses and social care practitioners working in care homes) should record the circumstances and reasons why a resident refuses a medicine (if the resident will give a reason) in the resident's care record and medicines administration record, unless there is already an agreed plan of what to do when that resident refuses their medicines. If the resident agrees, care home staff should tell the health professional who prescribed the medicine about any ongoing refusal and inform the supplying pharmacy, to prevent further supply to the care home.

Recommendation 1.2.4

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

Recommendation 1.2.5

Health professionals prescribing a medicine should:

- assume that care home residents have the capacity to make decisions
- assess a resident's mental capacity in line with appropriate legislation (for example, the Mental Capacity Act 2005 if there are any concerns about whether a resident is able to give informed consent)
- record any assessment of mental capacity in the resident's care record.

Recommendation 1.2.6

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

Recommendation 1.2.7

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

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

3.3 *Sharing information about a resident's medicines*

The [National Patient Safety Agency](#)'s (NPSA) key functions and expertise for patient safety transferred to NHS England in June 2012. The NPSA stated that: 'communication is a key factor in preventing patient safety incidents' (including medication errors) and 'also in learning from them afterwards. Communication includes the mechanics of communication as well as actually talking to one another'.

The [Care Home Use of Medicines Study](#) (CHUMS 2009) identified that, in relation to medicines errors such as administration, prescribing, monitoring and dispensing, communication problems between the care home provider, pharmacy and the GP practice were often unrecognised and not adequately addressed.

The Health Foundation's [Making care safer](#) (2011) details the thoughts and experiences of care home residents, carers and relatives in relation to medicines safety. The report describes potential gaps in communication in relation to:

- communication during transfers of care
- a lack of communication between care home providers and GPs
- carers not being involved in or updated about developments in the resident's care
- care plans either not being updated or not used in practice
- carers not being involved in care planning.

The GDG agreed that communication is important when managing medicines in care homes to ensure sufficient information is available at the right time for care home staff to safely manage residents' medicines.

Confidentiality

Confidentiality and information governance have been cited by the UK Government ([Information: to share or not to share](#), Department of Health 2013) as a possible reason for not sharing information. In response to concerns over confidentiality, the HSCIC produced [A guide to confidentiality in health and social care](#) (2013). It explains that residents should be told how confidential information about them will be used and who will see it, and that this is central to processes for obtaining informed consent for care and treatment.

The HSCIC guidance was discussed by the GDG in relation to medicines in the care home. The HSCIC guidance discusses how important it is that health and social care practitioners share information, and when it is and is not appropriate to do so. The guidance highlights that unfortunately 'lives have been put at risk when information has not been shared' when it should have been. The HSCIC guidance sets out 5 rules for health and social care (see box 2).

Box 2 Health and social care information centre 5 rules on confidentiality ([A guide to confidentiality in health and social care](#); HSCIC 2013)

- Confidential information about service users or patients should be treated confidentially and respectfully.
- Members of a care team should share confidential information when it is needed for the safe and effective care of an individual.
- Information that is shared for the benefit of the community should be anonymised.
- An individual's right to object to the sharing of confidential information about them should be respected.
- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed.

In relation to medicines, confidential information should be shared with the health and social care practitioners who provide direct care to the resident (care provided by that individual directly to a resident) if it is expected to result in better or safer care. This may include care home staff, social workers, doctors, nurses, those providing specialist care, such as pharmacists, and administrative staff who support direct care. Health and social care practitioners should only ever share information if it is relevant, necessary and proportionate (see [A guide to confidentiality in health and social care](#), rule 2).

Residents may express a wish for their information not to be shared. In some cases, the health and social care practitioners providing direct care to the resident may feel that this may compromise the safety of the resident. In these circumstances the resident should be informed and details should be documented in the resident's care record.

The GDG was also aware of the Caldicott principles highlighting the duty to share information (see box 3).

Box 3 The seven Caldicott principles

- Justify the purpose(s).
- Do not use personal confidential data unless it is absolutely necessary.
- Use the minimum necessary personal confidential data.
- Access to personal confidential data should be on a strict need-to-know basis.
- Everyone with access to personal confidential data should be aware of their responsibilities.
- Comply with the law.
- The duty to share information can be as important as the duty to protect patient confidentiality.

The GDG discussed and concluded that care home providers should have a process for managing information governance covering the Caldicott principles and the 5 rules set out in the HSCIC guidance. This should include the training of care home staff in relation to information governance (see [section 3.1](#)).

Improving transfers of care (commissioners)

Transfer of care is the planned movement of a care home resident from one care setting to another. Such transfer has been categorised into a number of different types, including:

- admission to hospital from the resident's usual address
- moving between levels of care in the same hospital for example, from intensive care to a regular hospital ward
- discharge or transfer from one hospital to another place of care for example, from hospital to intermediate care or a care home
- discharge from hospital or intermediate care to home
- moving from one ambulatory care setting to another for example, from a hospital clinic appointment to accident and emergency, or when changing GP.

[Keeping patients safe when they transfer between care providers – getting the medicines right](#) (Royal Pharmaceutical Society 2012) states that the core principles and responsibilities along with recommended core information for medicines transfer records would enable commissioners to open discussions with providers around the quality of information transfer about patients' medicines. In their next steps for commissioners, the Royal Pharmaceutical Society suggested that commissioners:

- 'review how effectively providers currently transfer information about patients' medicines'
- 'review existing contracts, service level agreements, quality contracts and incentive schemes' with providers to incorporate 'the principles and responsibilities, and recommended core information requirements, where appropriate'
- 'work with provider services to agree robust, patient-focused outcome measures which can then be incorporated into [commissioning](#) arrangements'
- 'monitor provider services against agreed outcomes and where necessary agree improvement measures'.

The GDG discussed and concluded that commissioners should review their commissioning arrangements with their provider organisations to ensure the transfer of information about residents' medicines contains core information requirements (see [section 3.7](#)) and monitor this through their contracting arrangements.

Improving transfers of care (organisations providing care)

[Keeping patients safe when they transfer between care providers – getting the medicines right](#) (Royal Pharmaceutical Society 2012) suggests that significant problems arise from miscommunication and unintended changes relating to medicines when people transfer from one care setting to another. Published evidence estimates that up to 60% of medication errors occur during transfers of care.

Evidence from a UK study (Dodds 2010) involving 8600 admissions to hospital from the general population demonstrated that when medicines were checked after admission most patients had at least 1 missing medicine or a wrong dose. Further published evidence suggests that care home residents are at high risk of a medication error during transfers of care. The [CHUMS](#) (2009) identified that reducing errors during transfers of care and particularly those errors associated with admission to care homes is a priority.

Evidence states that when a resident changes GP on entering a care home (or moves between care homes) a handover of relevant, necessary and proportionate information needs to take place to ensure resident safety.

The Royal Pharmaceutical Society's report (2012) also provides 3 key responsibilities for organisations providing care. Organisations should:

- 'ensure that they have safe systems that define roles and responsibilities within the organisation, and ensure that health professionals are supported to transfer information about medicines accurately'
- ensure systems and processes 'focus on improving patient safety and patient outcomes' and 'consistently monitor and audit how effectively they transfer information about medicines'
- share 'good and poor practice in the transfer of medicines ... to improve systems and encourage a safety culture'.

The GDG found that sufficient information about care home residents' medicines does not always go with a resident when they are admitted to hospital. Similarly information about a resident's medicines does not always get communicated to the care home when residents are discharged from hospital. This inadequate sharing of information could lead to conflicts in prescribing between, for example, primary and secondary care prescribers.

The GDG discussed and concluded that because of the increased likelihood of medication errors during transfers of care, organisations should have processes in place for sharing, accurate information about a resident's medicines, including what is recorded and transferred when the resident

moves from one care setting to another (including hospital). The process should be recorded in the care home medicines policy (see [section 3.1](#)).

The GDG was aware that hospitals often communicate electronically with general practice but not necessarily with the care home or the supplying pharmacy (both of which may lack the necessary means of secure communication) with whom it may also be necessary to share relevant, necessary and proportionate medicines information to ensure resident safety.

The GDG discussed evidence suggesting that electronic discharge summaries may improve the quality and timeliness of discharge summaries from hospital. However, further evidence showed no effect on readmissions, accident and emergency visits, or adverse effects after discharge. The GDG agreed that care home providers should consider having a process for ensuring residents are always sent into hospital with an accurate medicines record and this process should be recorded in the care home medicines policy (see [section 3.1](#)).

A CQC [self-assessment tool](#) recommends commissioners consider using standard, electronic discharge forms to help prevent GPs prescribing inappropriate medication to patients after discharge. The CQC also recommend increased sharing of discharge information with patients and pharmacists, which they state can provide an additional check that subsequent prescribing is safe.

The GDG therefore concluded that organisations such as hospitals providing care should consider where possible, the use of electronic discharge summaries to improve the quality and timeliness of discharge summaries. If this is not possible, a printed copy of the electronic discharge summary should be sent with the resident. The content of the discharge summary should be in line with the [Royal Pharmaceutical Society recommendations](#) for core content of records for medicines when residents transfer to and from care providers (see also [section 3.5](#)).

Improving transfers of care (health and social care practitioners)

[Keeping patients safe when they transfer between care providers – getting the medicines right](#) outlines 4 core responsibilities for health professionals to consider when people transfer from one care setting to another. Health professionals should:

- ‘ensure that all necessary information about the patient’s medicines is accurately recorded and transferred with the patient, and that responsibility for on-going prescribing is clear’
- when taking over the care of a patient, ‘check that information about the patient’s medicine has been accurately received, recorded and acted upon’
- encourage patients (or their parents, carers or advocates) ‘to be active partners in managing their medicines when they move’, and be aware of ‘why, when and what medicines they are taking’
- 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 GDG was aware that evidence from the Health Foundation report [Making care safer](#) (2011) suggests that health and social care practitioners should empower care home residents and their family members or carers (as appropriate) to be involved in the transfer of information about medicines when they are moving between care settings. If this is what the resident wants, then the information-sharing should be in line with the HSCIC guidance on sharing confidential information.

The GDG concluded that health and social care practitioners should ensure that all necessary information about medicines, including who will be responsible for ongoing prescribing, should be accurately recorded and transferred with care home residents in a timely manner.

The GDG also concluded that health and social care practitioners who are involved in transfers of care to or from a care home should check that information about a resident’s medicines has been accurately received,

recorded and acted on after transfer. Practitioners should have the appropriate training and competency (see [section 3.17](#)).

Communication between care home staff

[Keeping patients safe when they transfer between care providers – getting the medicines right](#) (Royal Pharmaceutical Society 2012), includes staff responsibilities and the core information that should accompany care home residents when they move or transfer from one care setting to another.

Evidence from the Health Foundation report '[Making care safer](#)' (2011) suggests that record keeping could be improved and important information should be read by care home staff coming on duty. The evidence also suggests that residents, family members or carers (as appropriate), should be informed about information that is available to them to allow them to stay informed (if this is in accordance with the resident's ability and wishes).

The GDG discussed the importance of care home staff coming on duty to be aware of any changes to medicines that had taken place, adverse effects of any commonly used medicine (see [section 3.4](#)) and any ongoing monitoring requirements, because they may need to be communicated to residents, carers and relatives.

The GDG concluded that care home providers should have a robust process in place for recording the transfer of medicines information during shift handovers and for when residents move to and from care settings. This should be recorded in the care home medicines policy (see [section 3.1](#)).

Residents visiting health professionals

The GDG found examples from practice outlining that when a care home resident needs an appointment with a health professional outside of the care home (for example, a hospital appointment), information about the resident's medicines (including 'when required' and homely remedy use [see [section 3.7](#)]) should be available during the consultation, when this is in accordance with the resident's ability and wishes.

The GDG agreed that details about the appointment and any changes to a resident's medicines should be recorded in the resident's care plan. Any medicine changes should also be recorded on the resident's medicines administration record (see [section 3.11](#)); any relevant medicines ordering and disposal processes should be undertaken (see [section 3.10](#) and [section 3.12](#)).

The GDG agreed that when reviewing residents' medicines health professionals should ensure that, in line with the care home resident's wishes and Department of Health guidance on confidentiality, care homes are informed of any changes that will affect a resident's medicines management.

The GDG concluded that when residents visit health professionals outside the care home, care home staff should ensure that, in line with the HSCIC rules on confidentiality, information regarding a resident's medicines that is relevant, necessary and proportionate be shared to ensure safe care of the resident.

Recommendations

Recommendation 1.3.1

Care home providers should have a process for managing information (information governance) covering the 5 rules set out in the Health and Social Care Information Centre's [A guide to confidentiality in health and social care](#) (2013). The process should also include the training needed by care home staff and how their skills (competency) should be assessed.

Recommendation 1.3.2

Commissioners should review their commissioning arrangements with their provider organisations to ensure that any information about a resident's medicines that is transferred contains the minimum information set out in recommendation 1.7.3. Commissioners should monitor this through their contracting arrangements.

Recommendation 1.3.3

Providers of health or social care services should have processes in place for sharing accurate information about a resident's medicines, including what is recorded and transferred when a resident moves from one care setting to another (including hospital).

Recommendation 1.3.4

Providers of health or social care services should ensure that either an electronic discharge summary is sent, if possible, or a printed discharge summary is sent with the resident when care is transferred from one care setting to another. See recommendation 1.7.3 for the minimum information that should be transferred.

Recommendation 1.3.5

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.

Recommendation 1.3.6

Health and social care practitioners should check that complete and accurate information about a resident's medicines has been received and

recorded, and is acted on after a resident's care is transferred from one care setting to another (see recommendation 1.7.3 for the minimum information that should be transferred).

Recommendation 1.3.7

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

Recommendation 1.3.8

Care home staff should follow the rules on confidentiality set out in the home's process on managing information about medicines (see recommendation 1.3.1) and only share enough information with health professionals that a resident visits to ensure safe care of the resident.

3.4 *Ensuring that records are accurate and up to date*

The [Data Protection Act 1998](#) includes the legal requirements for records management which apply to all personal information not just in relation to health records.

Adult care homes

Further legislation in the [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2010](#) outlines requirements for care homes when considering records management and medicines. [Regulation 20](#) states the legal requirements for record keeping. The Care Quality Commission's (CQC) [Essential standards of quality and safety](#) (outcome 21) supports providers in adhering to this legislation, including requirements that: 'People who use services can be confident that their personal records for their care, treatment and support are properly managed because:

- the service has clear procedures that are followed in practice, monitored and reviewed, to ensure personalised records and medical records are kept and maintained for each person who uses the service

- records about the care, treatment and support of people who use services are updated as soon as practical
- verbal communications about care, treatment and support are recorded within personal records as soon as is practical
- records about care, treatment and support are clear, factual and accurate and maintain the dignity and confidentiality of the people who use services
- records are securely stored and transferred internally between departments and externally to other organisations, when required
- protocols exist with other organisations for secure information-sharing
- records about people who use services are used to plan appropriate care, treatment and support to ensure their rights and best interests are protected and their needs are met
- the record of the current interaction is linked with any previous records that exist for that person, whenever the service is able to reliably identify the person.’

[Regulation 13](#) of the [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2010](#) states that: ‘the registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity’.

The CQC’s [Essential standards of quality and safety](#) (outcome 9B) requires that when people who use services receive care, treatment and support that involves medicines, the provider has ‘the arrangements for recording when it is not possible for a person to be able to self-administer their medicines’ and ‘the recording of when medicines are given to the person’.

Children’s homes

Legislation exists for children’s homes, including the [Care Standards Act 2000](#) (section 23) and the [Children’s Homes Regulations 2001](#). To support adherence to this legislation the Department for Education published the

[Children's Homes: National Minimum Standards](#) (2001) (NMS). Standard 6.15 requires that 'there is a written record of all medication, treatment and first aid given to children during their placement'.

Record keeping

The [Social Care Institute for Excellence \(SCIE\)](#) states that 'poor record-keeping is essentially poor communication and can put both staff and residents at risk' (see also sections [3.3](#) and [3.5](#)). The Nursing and Midwifery Council's [Record keeping: guidance for nurses and midwives](#) (2009) states that 'good record keeping, whether at an individual, team or organisational level, has many important functions'. These functions of good record keeping can be of benefit to residents, care home providers and commissioners in a number of ways (see box 4):

Box 4 Benefits of good record keeping

Clinical

- Supporting resident care and communications.
- Helping to identify risks, and enabling early detection of complications.
- Making continuity of care easier.
- Showing how decisions related to patient care were made.
- Supporting effective clinical judgements and decisions.
- Promoting better communication and sharing of information between members of the multi-professional healthcare team.

Administrative

- Helping to improve accountability.
- Supporting the delivery of services.
- Providing documentary evidence of services delivered.
- Helping to address complaints or legal processes.

Educational

- Supporting clinical audit, research, allocation of resources and performance planning.

The GDG acknowledged the requirements of the CQC and the Department for Education in relation to record keeping. The GDG agreed that the [Record keeping: guidance for nurses and midwives](#) (Nursing and Midwifery Council (NMC), 2009) principles would complement the CQC and Department for Education requirements.

The Department of Health's [Records management: NHS code of practice \(2006\)](#) provides guidance that covers NHS records of all types. The GDG discussed this in the context of social care and agreed that for residents of care homes these may consist of:

- resident health records (electronic or paper-based), including GP medical records and birth register
- administrative records, such as personnel, estates, financial and accounting records; notes associated with complaint handling
- communication records, such as emails, text messages (between a GP and a care home) or faxes
- other computerised or scanned records.

The GDG concluded that health and social care practitioners should ensure accurate and up-to-date record keeping processes are recorded in the care home medicines policy (see [section 3.1](#)). The process should include the following in relation to managing medicines:

- the resident's care plan
- the resident's medicines administration record
- correspondence and messages about medicines, such as email, letters, text messages, transcribed phone messages
- transfer of care letters and temporary absence information
- copies of prescriptions and any records of medicines ordered for residents.

The CQC [Essential standards of quality and safety](#) (outcome 21c) sets out the correct retention periods for records in adult care homes and the [Children's Home Regulations 2001 \(schedule 3, regulation 28\[1\]\)](#) sets out the retention period for records in children's homes.

The GDG concluded that, in line with legislation, all care home providers must ensure that appropriate records about medicines are kept secure, for an appropriate period of time and destroyed securely when appropriate to do so.

Recommendations

Recommendation 1.4.1

Health and social care practitioners should ensure that records about medicines are accurate and up-to-date by following the process set out in the care home medicines policy (see recommendation 1.1.2). The process should cover:

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

Recommendation 1.4.2

Care home providers must follow the relevant legislation to ensure that appropriate records about medicines are kept secure, for an appropriate period of time, and destroyed securely when appropriate to do so.

3.5 *Identifying, reporting and reviewing medicines-related problems*

The [Francis Report](#) (2013) emphasised the need to put patients first at all times, and that they must be protected from avoidable harm. The [Berwick report](#) (2013) recommends 4 guiding principles for improving patient safety, 2 of which are:

- 'place the quality and safety of patient care above all other aims for the NHS
- engage, empower, and hear patients and carers throughout the entire system, and at all times' (see [section 3.2](#)).

The GDG agreed that these guiding principles are also relevant to care home residents and apply across health and social care.

The [NHS outcomes framework for 2013 to 2014](#) requires commissioners and providers of NHS services to reduce the incidence of medication errors causing serious harm. The GDG agreed that although care homes are not necessarily NHS services, this would also be relevant to care homes.

For the purpose of this guideline, medication errors include:

- prescribing errors
- dispensing errors
- medicines administration errors
- monitoring errors.

Please see glossary ([appendix A](#)) for definitions.

From the evidence identified, older residents living in care homes are frequently prescribed multiple medicines. The GDG recognised that many other residents, such as those with physical disabilities and those with complex needs, also frequently take multiple medicines.

Evidence suggests people taking multiple medicines for long-term conditions are most likely to have a medication error. Care home residents appear to be at greater risk of a medication error than most other groups, because of their complex health and care needs.

There is a limited evidence base on medication errors in care homes. However, the [CHUMS](#) (2009) identified an 'unacceptable level' of medication errors in older residents living in care homes. On any 1 day, 7 out of 10 residents experienced errors with their medicines. Most errors had negligible consequences for residents and no cases of harm were observed. However, in some cases, medication errors may have serious, potentially life-threatening consequences.

Although the CHUMS was conducted in older residents living in care homes, the GDG agreed that the findings were likely to apply to all care home

residents who are taking medicines, including children and people with learning and physical disabilities.

Prevalence of medication errors in the CHUMS

The prevalence of medication errors observed in the CHUMS is shown in table 1. Errors occurred at all stages, although the prevalence of monitoring errors was higher than other medication errors. There was no statistically significant difference in medicines administration errors according to the principal medicines supply system used (see sections [3.1](#), [3.11](#) and [3.14](#)).

The mean potential harm (and range) for each type of error was estimated using a 0-10 scale (see table 1).

Table 1 Prevalence of medication errors and level of potential harm associated with errors in the CHUMS

	Prevalence of errors (95% CI)	% residents with at least 1 error (95% CI)	Mean level of harm ¹ (range)
Prescribing errors	8.3% (7.1% to 9.7%)	39.1% (33.0% to 45.3%)	2.6 (0.2–5.8)
Dispensing errors	9.8% (8.5% to 11.2%)	36.7% (30.8% to 42.9%)	2.1 (0.1–5.8)
Medicines administration errors	8.4% (7.0% to 10.0%)	22.3% (17.3% to 27.9%)	2.0 (0.2–6.6)
Monitoring errors ²	14.7% (10.3% to 20.1%)	18.4% (CI not reported)	3.7 (2.8–5.2)
¹ 1–10 scale: 1 least harmful, 10 most harmful. ² Only includes residents prescribed a medicine that required monitoring. CI: confidence interval			

The most common types of medication errors observed in the CHUMS are shown in table 2.

Table 2 Most common types of medication errors observed in the CHUMS

Type of error	Most common reasons for error
Prescribing errors	<ul style="list-style-type: none"> • Incomplete information (38%) • Unnecessary drug (24%) • Dose or strength error (14%) • Omission of a medicine that should have been prescribed (12%)
Dispensing errors	<ul style="list-style-type: none"> • Labelling errors (7.3%) • Errors with the content of the medicine dispensed, for example incorrect strength (2.3%) • Clinical errors, for example dispensing a medicine that could result in a serious drug interaction (0.21%)
Medicines administration errors	<ul style="list-style-type: none"> • Omission errors (49.1%) • Incorrect dose given (21.4%)
Monitoring errors	<ul style="list-style-type: none"> • Failure to request monitoring for a medicine that required monitoring (91%)

Causes of medication errors in care homes

A wide range of causes of medication errors in care homes have been identified in the published evidence, including:

Supporting residents to make informed decisions (see [section 3.2](#))

- Residents (and some of their carers and care home staff) who are unable to give an accurate medication history.
- Reluctance of residents to complain or raise medicines-related problems.

Prescribing and reviewing medicines

- Inadequate knowledge about a resident and their condition (see [section 3.9](#)), for example:
 - prescribers not knowing or being unfamiliar with the residents
 - prescribing without computerised notes or prescribing software
 - inadequate medicines information in the care home (see [section 3.14](#)).
- Inadequate review of medicines (see [section 3.8](#)).
- High workload of care home staff – approximately 40–50% of their time is spent on medicines-related activities.

Sharing information about a resident's medicines (see [section 3.3](#))

- Poor communication and lack of information-sharing about medicines across health and social care, including with the resident and/or their carer.
For example:
 - when there are changes to the resident's medicines
 - when the resident's care is transferred between different care providers, for example from the hospital to the care home after discharge from hospital.

Medicines management systems (see sections 3.9–3.12)

- Inadequate medicines management systems from prescribing through to the resident receiving their medicines. For example:
 - failure to deal with changes to medicines accurately, and in a timely manner
 - delays in obtaining new medicines
 - failure to identify residents who need monitoring
 - inefficient management of repeat prescriptions
 - inadequate labelling of medicines.
- Several GP practices providing care for a care home's residents, with different systems in place.
- Inaccurate medicines records and discrepancies between different sources of medicines information (see [section 3.7](#)). This may be because of, for example:
 - advice from secondary care not being integrated accurately into the medicines records
 - prescribers not updating computerised notes on returning to their practice.
- Repackaging medicines into monitored dosage systems.

Administration of medicines (see sections 3.14–3.16)

- Frequent distractions and interruptions of care home staff undertaking the medicines administration round.

- Poor design of medicines trolleys that are not able to facilitate the efficient storage and administration of both monitored dosage systems and original packs.
- Medicines administration records not being accurately maintained to reflect changes to residents' medicines.
- Environmental factors, for example poor lighting, temperature, cluttered workspace and noise.

Training and skills (competency) (see [section 3.17](#))

- Inadequate medicines knowledge and poor training of care home staff, for example:
 - about common adverse effects and drug interactions
 - how and when medicines should be administered and monitored
 - confusion between the generic and trade names of medicines
 - confusion between similar shaped and coloured medicines
 - inaccurate ordering of medicines and not anticipating 'out of stock' situations.
- Frequent use of new or agency care home staff.

Organisational governance

- Lack of timely access to primary care providers, such as GPs.
- Inconsistency of GPs – many residents see a number of different GPs, with the frequent use of locums.
- Lack of ownership of the whole medicines system and leadership in reducing medication errors across general practice, pharmacy and the care home.

The GDG agreed that there is a need for improved organisational governance across the pathway of care for care home residents.

Reducing medication errors in care homes

From the evidence identified, there have been some suggestions for interventions to reduce medication errors in care homes, but there is no robust evidence to support any particular strategies over others. These strategies include:

- having a preferred GP provider, with the ability to electronically prescribe from the care home
- GPs reviewing their process for identifying residents whose medicines require monitoring and ensuring that monitoring is carried out (see [section 3.9](#))
- medication reviews conducted by a pharmacist for all residents at least every 6 months (see [section 3.8](#)).

The GDG was concerned at the high prevalence of medication errors in care homes across the whole medicines system. The GDG agreed with the conclusions of the [CHUMS](#) that the failure to identify residents whose medicines needed monitoring was a particular concern (see [section 3.14](#)).

The GDG was aware of the wide range of causes of medication errors and recognised the need to improve systems and processes for managing medicines in care homes across the whole medicines system. For example, the need for improved medicines management systems, better communication and improved organisational accountability and responsibility.

The GDG concluded that all people, care home providers and organisations commissioning or providing care for residents should ensure that clear processes are in place for identifying, reporting, reviewing and learning from medication errors involving residents, in line with local and national governance arrangements (also see [section 3.6](#)). Care home providers should have the process recorded in the care home medicines policy (see [section 3.1](#)).

The GDG concluded that commissioners and providers may want to consider collaborating with all relevant stakeholders to develop a locally agreed action plan, which includes agreeing organisational governance arrangements across the resident's care pathway, to reduce medication errors in care homes, in line with other local and national strategies for improving resident safety.

Reporting adverse effects of medicines

The NMC's [Standards for medicines management](#) (2010), standard 25, discusses the reporting of adverse effects of medicines. It states: 'as a registrant, if a patient experiences an adverse drug reaction to a medication, you must take any action to remedy harm caused by the reaction. You must record this in the patient's notes, notify the prescriber (if you did not prescribe the drug) and notify via the Yellow Card Scheme immediately'.

The GDG agreed that care home staff who are trained and competent in medicines should be aware of the likely adverse effects of common medicines used in the care home (see [section 3.17](#)). The care home should have a process in place for handling, recording and reporting adverse effects, as part of the care homes medicine policy.

The GDG agreed that residents can, and should be encouraged to, report any adverse effect from a medicine to the care home staff, their prescriber or directly to the [Medicines and Healthcare products Regulatory Agency](#) (MHRA) through the [Yellow Card Scheme](#). Any necessary action should be taken under the direction of a health professional.

The GDG concluded that care home staff should report all suspected adverse effects to medicines to the prescriber as soon as possible. Details of the effect on the resident should be recorded in the resident's care plan and the resident's supplying pharmacy should be notified (if the resident agrees to this information being shared).

Recommendations

Recommendation 1.5.1

Commissioners and providers of health or social care services should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving residents (see also recommendations 1.6.1–1.6.3).

Recommendation 1.5.2

Health and social care practitioners should consider working with all relevant stakeholders to develop a locally agreed action plan, in line with other local and national strategies and governance arrangements, for improving the safety of residents and reducing medication errors in care homes.

Recommendation 1.5.3

Care home staff (registered nurses and social care practitioners working in care homes) should report all suspected adverse effects from medicines to the health professional who prescribed the medicine or another health professional as soon as possible, this would usually be the GP or out-of-hours service. Staff should record the details in the resident's care plan and tell the supplying pharmacy (if the resident agrees that this information can be shared).

3.6 Keeping residents safe (safeguarding)

Similar definitions exist for safeguarding of adults and children from the regulators of adult and children's services.

The CQC's [Essential standards of quality and safety](#) (2010) define safeguarding adults as: 'Ensuring that people live free from harm, abuse and neglect and, in doing so, protecting their health, wellbeing and human rights'.

The Department for Education's [Working together to safeguard children](#) (2013) defines safeguarding children as: 'protecting children from maltreatment; preventing impairment of children's health or development, ensuring children are growing up in circumstances consistent with the provision of safe and effective care and taking action to enable all children to have the best outcomes.'

A safeguarding issue in relation to managing medicines could include the deliberate withholding of a medicine(s) without a valid reason, the incorrect use of a medicine(s) for reasons other than the benefit of a resident,

deliberate attempt to harm through use of a medicine(s), or accidental harm caused by incorrect administration or a medication error.

Legislation on safeguarding

Legislation for safeguarding in both adult and children's care homes exists for England, Wales and Northern Ireland. It is outside the scope of this guideline to cover all the relevant safeguarding legislation. Care homes should make themselves aware of the legislation relating to their care home residents, depending on the age and location of the care home.

[The Local Safeguarding Children Boards Regulations 2006](#) outlines the requirement to establish local safeguarding children's boards, led by local authorities and representatives from relevant local bodies (including the NHS). One of the roles of local safeguarding children's boards is to 'coordinate the work to safeguard children locally and monitor and challenge the effectiveness of local arrangements' ([Working together to safeguard children](#) 2013). Local adults safeguarding boards are not currently a legal requirement; however, in many ways they complement the work of children's safeguarding boards.

In adults and children's care homes in England, legislation exists to ensure that safeguarding processes in place. For safeguarding adults and medicines, the [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2010](#) (regulation 13) requires that: 'the registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity' (see [section 3.1](#)).

For safeguarding children, the [Children's Homes Regulations 2001](#) (regulation 16) requires that the registered person shall prepare and implement a written process which is intended to safeguard children accommodated in the children's home from abuse or neglect, and set out the process to be followed in the event of any allegation of abuse or neglect.

Both the CQC and The Office for Standards in Education, Children's Services and Skills (Ofsted) have regulatory standards for adult and children's care home respectively in relation to safeguarding to support compliance with legislation (see box 5).

Box 5 Regulators' standards for safeguarding in adult and children's care homes

'Residents are protected from abuse, or the risk of abuse, and their human rights are respected and upheld'.

Essential standards of quality and safety: Outcome 7 (CQC 2010)

'Children feel safe and are safe. Children understand how to protect themselves; and feel protected and are protected from significant harm including neglect, abuse and accident'.

Children's homes: national minimum standards: standard 4

Department for Education (2011)

What action should be taken if a safeguarding issue is suspected?

The Home Office and Department of Health (2000) guidance [No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse](#) states that: 'the first priority should always be to ensure the safety and protection of vulnerable adults. To this end it is the responsibility of all staff to act on any suspicion or evidence of abuse or neglect (see the Public Interest Disclosure Act 1998) and to pass on their concerns to a responsible person/agency.'

Similarly the HM Government (2006) guidance [What to do if you are worried a child is being abused](#) states that 'all practitioners working with children and families should...refer any concerns about child abuse or neglect to children's social care or the police'.

Notification of medicines-related safety and safeguarding incidents

The [Care Quality Commission \(Registration\) Regulations 2009](#) (regulation 18, provision 18) sets out the conditions for when the 'registered person' for the

care home must notify the CQC of safeguarding incidents. In addition to this, care homes should follow their locally established processes for notifying their local authority of any safeguarding incident or concern. Reporting requirements should be included in commissioning and contracting arrangements.

Evidence presented to the GDG suggests that, for adult care homes, the interpretation and understanding of the term 'safeguarding' is inconsistent, between care home providers, local authorities and clinical commissioning groups. This leads to differing views on what incidents should be considered as safeguarding issues and therefore which should be notified to local safeguarding boards. This variation in practice requires some areas to notify all safeguarding issues under their local safeguarding processes while others require issues only involving actual loss of health, safety or welfare of a resident to be reported.

However, the GDG was aware that the UK government has made a [statement on safeguarding policy](#) that 'in order to support those people most vulnerable to abuse and neglect it is vital that agencies agree collectively, those issues that require a safeguarding response as opposed to issues, which relate to standards and quality of care more widely'.

The GDG acknowledged that areas may have different locally agreed criteria for reporting and that care homes should make themselves aware of what their local criteria are. The GDG discussed and agreed that this may involve collaboration (joint working between health and social care practitioners to achieve shared objectives in the care of residents) between organisations to develop shared processes across a number of local areas.

The GDG concluded that care home providers should have a clear process for reporting medicines-related safeguarding incidents under local safeguarding processes and to the CQC (or other appropriate regulator). This process should be recorded in the care home medicines policy (see [section 3.1](#)). The process should clearly state:

- in what circumstances the CQC should be notified

- the agreed local criteria and process for reporting medicines-related safeguarding incidents.

A medicines-related safety incident is considered to be any unintended or unexpected incident that could have or did lead to harm for 1 or more patients receiving a medicine or medicines.

The GDG discussed safeguarding and medicines-related safety incidents and agreed that not all medicines-related safety incidents are considered to be a safeguarding concern. If the incident causes a safeguarding concern, the first priority is to take any necessary action to safeguard the health and wellbeing of the resident. The GDG considered actions that are required following a medicines-related safeguarding incident (see box 6).

Box 6 Care home priorities following a medicines-related safeguarding incident

Priorities following a medicines-related safety incident that raises safeguarding concerns:

- Safeguard the health and wellbeing of the resident
- Make the appropriate safeguarding notifications
- Investigate the incident (could be either internal investigation or external investigation under safeguarding procedures or police investigation where required)

The GDG concluded that organisations should confirm arrangements for notifying suspected or confirmed medicines-related safeguarding incidents. The process should be determined locally in line with adult and children safeguarding processes.

The GDG further concluded that after a medicines-related safeguarding incident, the primary concern should be the welfare of the resident. Care home staff should make an accurate record of the details of the incident as soon as possible after the incident to help with investigations and reporting.

The process should be recorded in the care home medicines policy (see [section 3.1](#)).

The GDG discussed the [legislation](#) for notifying the CQC of safeguarding incidents and agreed that while the regulations clearly state that an opinion from a health professional about a resident's wellbeing would trigger a notification to the CQC, the regulations do not explicitly state that a health professional must always be contacted in the case of a safeguarding incident related to medicines. The GDG was aware from oral and written evidence presented to it that there is variation in the skills and knowledge of care home staff when determining if a health professional's advice is needed. From evidence presented to the GDG by care home providers this is a particular concern when incidents happen 'out-of-hours'.

Care home staff should inform an appropriate health professional of the incident, clarifying the next steps for the resident's care and treatment. An appropriate health professional may include the prescriber of the medicine, the primary care or supplying pharmacist, or an urgent care provider.

Following a medicines-related incident, the GDG concluded that it would be good practice for care home staff to contact an appropriate health professional to ensure appropriate action is taken to safeguard any resident involved, if the incident concerns safeguarding. The process for care home staff reporting medicines-related incidents to a health professional (both in normal office hours and out-of-hours) should be agreed with the relevant health professional(s) and commissioners, as appropriate.

Notification requirements

The CQC requires that care home providers must not identify an individual resident when reporting or notifying safeguarding incidents. Residents must be referred to using a unique code or identifier. Care homes must keep a record of these unique codes or identifiers and who they refer to, in case there are further enquiries by the CQC or under local safeguarding processes. In all cases of incidents notified (notifications) to the CQC, information as listed in box 7 should be included.

Box 7 Information to be notified to the CQC when a safeguarding incident has occurred

- A unique identifier or code for the person
- The date they were or will be admitted to the service
- Their date of birth
- Their gender
- Their ethnicity
- Any disability
- Any religion or belief
- Their sexual orientation
- All relevant dates and circumstances
- Any action taken in response to the incident

Local safeguarding processes may not need to collate data about ethnicity and sexual orientation. Where this information is required to be collected, local processes should include this.

The GDG concluded that it would be good practice for care home providers to maintain a copy of any notifications provided to the CQC and /or local safeguarding body including what has been reported, and to whom. In addition, the prescriber, the resident, carers or advocates should be informed of the notification and this should be recorded in the resident's care record or if this is not appropriate (because of ongoing concerns that an abuser might access the care plan for example), in a secured file.

Near misses

NHS England defines a near miss as a 'prevented patient safety incident'. Patient safety incidents were defined as: 'any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care'.

Near misses are important, as many incidents (including serious incidents leading to safeguarding reports) according to the Royal College of Nursing ([Core concepts in patient safety](#)) 'share common root causes, meaning that

attention to common and less-serious events and near misses can help prevent more serious incidents. This emphasises how important it is not to ignore common and less-serious events and near misses, but to formally investigate and report them.'

Oral and written evidence provided to the GDG suggested that the term 'near miss' was often used in local process documents, but was often poorly defined. Interpretation of near misses could include:

- incidents that affected the resident's care and/or reached the resident but that caused no harm or minimal harm (often these were seen as safeguarding incidents based on potential for harm)
- incidents that did not reach the resident, or affect their care, such as prevented medicines-safety incidents.

Furthermore, some care home providers categorise near misses as either critical or non-critical, depending on whether they cause harm to a resident.

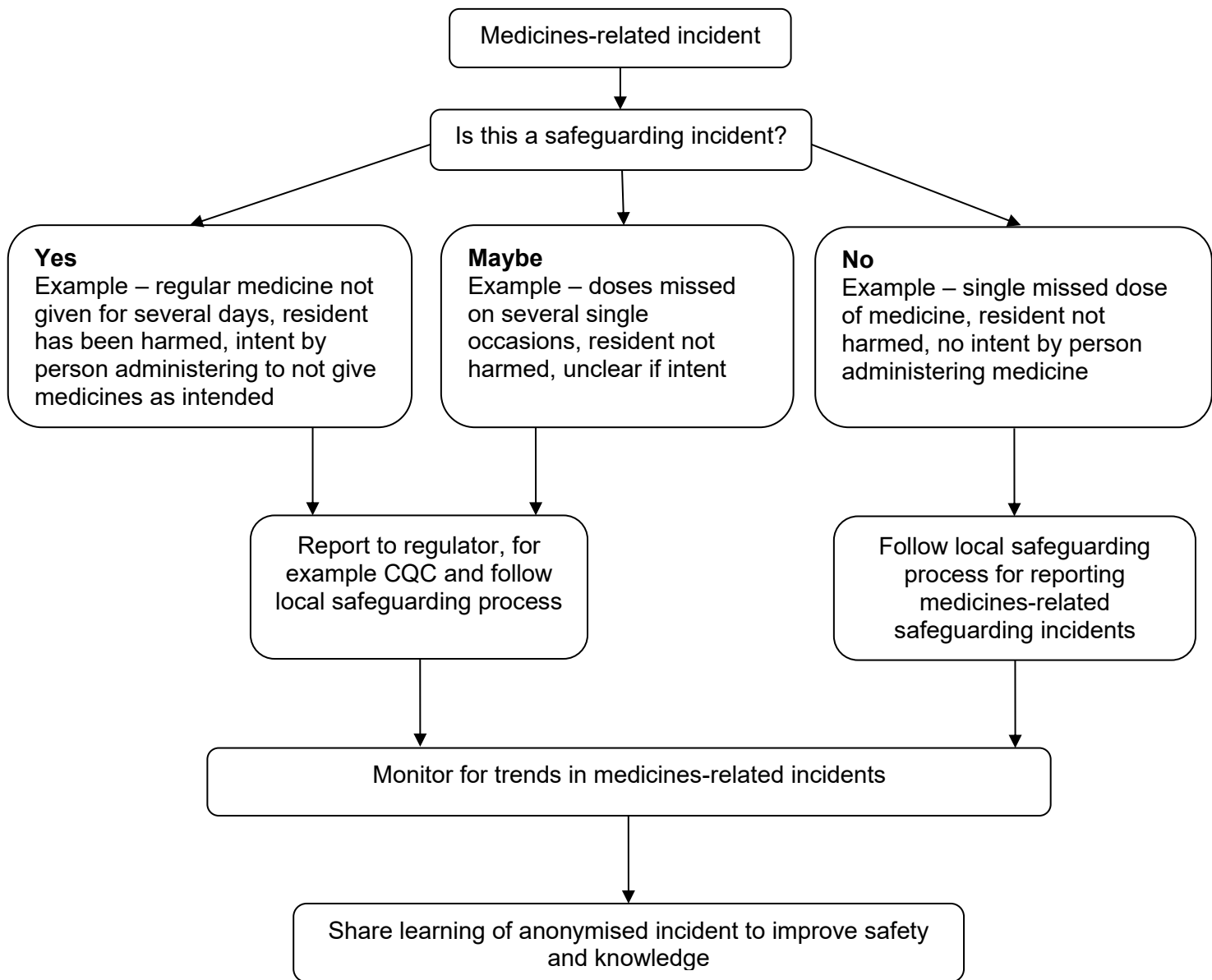
The GDG was aware from evidence presented to it that the most frequent reasons cited for escalating a medicines incident from a near miss to a medicines-related safeguarding incident were:

- actual harm to the resident
- CQC notification requirements
- as a result of an investigation/advice under local safeguarding processes
- when a breach of professional standards (such as record-keeping or the standards for medicines administration) has occurred.

The GDG discussed and agreed that if an incident has caused resident harm it should not be regarded as a 'near miss' even if harm was minimal, and that the incident should be notifiable locally under local safeguarding processes and to the CQC (if the incident met the CQC criteria for reporting).

The GDG considered the process for handling medicines-related safety incidents, including safeguarding and near misses.

Figure 2 Process for handling safeguarding and near miss incidents



The GDG agreed that medicines-related safety incidents that are deemed to be ‘near misses’ should be reported and investigated locally if they could have caused harm to a resident. The GDG discussed and agreed that learning from the reporting of medicines-related incidents promoting an open reporting and learning culture, was also likely to apply to near miss reporting.

The GDG concluded that all medicines-related safety incidents, including all near misses regardless of whether the incident caused harm, should be

recorded as a resident safety incident and should be reported to the CQC or other appropriate regulators, as appropriate.

Learning from safeguarding incidents

The [report into the Winterbourne view](#) care home abuse case highlighted a series of serious failures in safeguarding the rights of residents in that care home. The GDG was aware that in [A promise to learn – a commitment to act](#) (2013), part of the Berwick review into resident safety, it is stated that ‘patient safety cannot be improved without active interrogation of information that is generated primarily for learning, not punishment, and is for use primarily at the front line’. The GDG agreed that the same principle applies to the reporting of medicines-related safeguarding incidents in care homes.

The CQC’s [Essential standards of quality and safety](#) (outcome 9B) require providers of care (including care homes) to have ‘arrangements for reporting adverse events, adverse drug reactions, incidents, errors and near misses. These should encourage local and, where applicable, national reporting, learning and promoting an open and fair culture of safety’. Whilst the [Children’s Homes: National Minimum Standards](#) has no comparable requirement, the GDG agreed that it would be good practice to apply the principles of outcome 9B to children’s homes.

Evidence suggests that local reporting may identify trends in medication errors (see section 3.5) caused by factors outside of the care home environment, such as in hospitals, GP practices or supplying pharmacies, more quickly than if care home providers deal with issues internally.

The GDG concluded that if safeguarding reports are made under local safeguarding processes, each report should be investigated on its own and all reports should be monitored for trends (see [box 7](#)).

Promoting an open reporting and learning culture

The Royal Pharmaceutical Society’s [Improving pharmaceutical care in care homes](#) (2012) supports the introduction of medication error reporting by all service providers for all aspects of medicines use in care homes. This should

be the basis of shared learning and improvements in care, safety and team work.

From the oral and written evidence presented to it, the GDG identified some potential barriers to promoting an open reporting and learning culture. The GDG heard that some care home providers may be seen to be having difficulties in managing medicines if they are routinely notifying incidents, compared with other homes that do not notify incidents. The GDG also heard that care home providers are often not provided with feedback after reporting safeguarding issues and they do not know what has been done with that information.

Oral and written evidence presented to the GDG about safeguarding notifications, identified a number of important outcomes for organisations:

- improved care
- improved management processes
- learning opportunities (targeting areas of learning based on trends)
- improved opportunities for monitoring and error detection
- improved communication.

The GDG agreed that the benefits of local notification of all incidents and the potential for shared learning were consistent with good practice.

The GDG concluded that open notification of all resident medicines-related incidents would increase transparency and promote a learning culture. Whenever local safeguarding processes are followed in adult services, there should be feedback about incidents to care homes to help share learning.

Local safeguarding boards should consider establishing such processes in order to identify concerns and improve learning from incidents, where these are not in place.

Oral and written evidence provided to the GDG about learning from incidents showed that the following worked well:

- the involvement of the multidisciplinary team (GP, pharmacist, community matrons and specialist nurses, care home staff and management) in discussing incidents and in supporting care homes when incidents have occurred, with an emphasis on good communication (providing the resident agrees to the information-sharing, see [section 3.3](#))
- using root cause analysis of incidents
- computerised incident reporting using commercially available software, which allows real-time analysis of incidents by care home providers and opportunities for timely intervention
- shared learning from incidents (both within and, in anonymised formats, between care homes)
- local safeguarding teams providing feedback to care homes and staff on incidents they have looked at in a supportive, 'no-blame' manner to encourage further reporting
- regular staff training, including training for managers on incident investigation, medicines safety awareness-raising, reflective practice and clinical supervision (see [section 3.17](#))
- monitoring of incident trends
- spot-checking of staff practice and competence (see [section 3.17](#)).

The GDG agreed that detecting problems quickly and investigating the root cause of problems were important first steps for any shared learning to take place, and that it is also necessary to explain any failings in care under a duty of candour (being honest and straightforward in attitude and speech).

Variation also exists when identifying or investigating incidents, for example, in root cause analysis skills. The GDG agreed that all members of the multidisciplinary team should be involved in shared learning after incidents.

The GDG concluded that examining of the root causes of medicines-related safety incidents was likely to be a required skill for a care home to be able to fully investigate incidents. Care home providers should consider this in their training needs and commissioners should address this through contracting mechanisms.

Preventing safeguarding incidents

The NPSA document [Seven steps to patient safety](#) in general practice (2009) sets out the key steps to patient safety in general practice these are:

- Step one Build a safety culture
- Step two Lead and support your team
- Step three Integrate your risk management activity
- Step four Promote reporting
- Step five Involve and communicate with patients and the public
- Step six Learn and share safety lessons
- Step seven Implement solutions to prevent harm.

The GDG was aware that concerns about a resident's medicines are often first noticed by residents themselves or their carers (family and friends), and some evidence suggests that a resident's perception of medicines-related problems is likely to be accurate. This perception is sometimes underestimated. Residents, their carers (family and friends) will often choose not to report any concerns with medicines as they are fearful of the reaction of care home staff or practitioners, or they think that their concerns will be dismissed (see [section 3.2](#)).

The GDG concluded that every care home resident and/or their family members or carers should know how to report a medicines-related safety incident and concerns about medicines using the care home provider's complaints process, local authority (or local safeguarding) processes and/or the appropriate regulator's process; this information should be given to residents on admission to the care home. The process for informing residents how to raise concerns about their medicines (within the care home or to other bodies such as the CQC or local authority) should be a part of the care home medicines policy (see [section 3.1](#)).

Assessing and improving resident participation in safeguarding

The Department of Health, in [Patients first and foremost](#) (2013), has committed to a statutory duty of candour (being honest and straightforward in attitude and speech) for health and social care providers to inform residents

who use the service, and their family members or carers (as appropriate) about any problems that have affected the quality and safety of their care, and explain why they have happened. Evidence provided to the GDG suggests that services having a clear focus on involving residents and resident safety (see [section 3.2](#)) is important in improving safeguarding.

The UK government policy a [Statement of government policy on adult safeguarding](#) recommends 6 principles to use ‘to measure existing adult safeguarding arrangements and to measure future improvement’. The 6 principles are empowerment, prevention, proportionality, protections, partnership and accountability. These principles can be translated into outcomes in relation to resident’s medicines, such as ‘I had the information I needed [and] in the way that I needed it’ and ‘the people I wanted were involved’.

The GDG discussed the principles and agreed that one of the key interventions that could help ensure that the principles are achieved is advocacy. Advocacy has been defined in [A Scoping Study of Advocacy with Older People in Wales](#) (2010) for the Older Peoples Commissioner for Wales as a principled activity encompassing 3 broad principles of independence, empowerment and inclusion. The CQC’s [Essential standards of quality and safety](#) (outcome 1A) states that care home providers should ensure the ‘people who use services are involved in and receive care, treatment and support that respects their right to make or influence decisions’ and that the service should make ‘people who use services aware of independent advocacy services wherever they are available’.

Advocacy and support systems in the [Children’s Homes: National Minimum Standards](#) (standard 1[1.5]) require that ‘Children have access to independent advice and support from adults who they can contact directly and in private about problems or concerns, which is appropriate to their age and understanding.’ Advocacy has been found to be effective with diverse populations of older people in a range of settings. The [Health Foundation](#) and the [SCIE](#) have stated that all care home residents should have access to an independent advocate.

The GDG found evidence of a range of proposed models of advocacy, ranging from independent advocates for each care home provider, including local or national schemes, through to professional standards for advocacy (such as the [NMC](#)). The GDG was aware however, that not all local advocacy schemes are available in all areas. Additional evidence suggests that advocates should be trained to recognise abuse and, in the context of inappropriate prescribing of medicines, should act as an advocate for the resident during medication review (see [section 3.8](#)).

The GDG concluded that all residents living in care homes should have access to advocacy and independent complaints services to address concerns relating to medicines.

Recommendations

Recommendation 1.6.1

Commissioners and providers of health or social care services should all be aware of local arrangements for notifying suspected or confirmed medicines-related safeguarding incidents.

Recommendation 1.6.2

Care home providers should have a clear process for reporting medicines-related safeguarding incidents under local safeguarding processes and to the Care Quality Commission (CQC) (or other appropriate regulator). The process should be recorded in the care home medicines policy and should clearly state:

- when the CQC (or other appropriate regulator) should be notified
- which medicines-related safeguarding incidents should be reported under local safeguarding processes and when
- that accurate details of any medicines-related safeguarding incidents are recorded as soon as possible so that the information is available for any investigation and reporting.

Recommendation 1.6.3

Commissioners should ensure that reporting requirements are included in commissioning and contracting arrangements.

Recommendation 1.6.4

Care home staff should contact a health professional to ensure that action is taken to safeguard any resident involved in a medicines-related safeguarding incident. They should follow a process agreed between health professional(s) and commissioners, which sets out who to contact in normal office hours and out-of-hours.

Recommendation 1.6.5

Care home providers should record all medicines-related safety incidents, including all 'near misses' and incidents that do not cause any harm, as a resident safety incident. Where there are notifiable safeguarding concerns these should be reported to the CQC (or other appropriate regulator).

Recommendation 1.6.6

Local safeguarding processes should include the investigation of each report of a medicines-related safeguarding incident and should monitor reports for trends.

Recommendation 1.6.7

Local safeguarding processes should include arrangements for feedback to care homes about reported medicines-related incidents to promote sharing of experiences and learning.

Recommendation 1.6.8

Care home staff should find out the root cause of medicines-related incidents.

Recommendation 1.6.9

Care home providers should make sure that any training needed by staff to find out the root cause of medicines-related incidents is specified in contracts with commissioners.

Recommendation 1.6.10

Care home staff should give residents and/or their family members or carers information on how to report a medicines-related safety incident or their concerns about medicines using the care home provider's complaints process, local authority (or local safeguarding) processes and/or a regulator's process.

Recommendation 1.6.11

Care home providers should ensure that all residents can use advocacy and independent complaints services when they have concerns about medicines.

3.7 *Accurately listing a resident's medicines (medicines reconciliation)*

The CQC considers that managing medicines when a resident transfers from one setting to another is central to safe, high-quality care (see [section 3.3](#)).

Written evidence submissions considered by the GDG suggest that there are often no clear processes for communicating changes in medicines between providers in a timely manner, following a transfer of care.

Residents who are transferred into a care home from other care settings often arrive with little information about their medicines, for example after hospital discharge or transfer from another care home. Children with significant health needs may be looked after by several different care providers in a day.

Accurate and reliable information about residents' medicines needs to be transferred at the same time as a resident moves between care settings.

Medicines reconciliation enables this to occur and has been defined by the [Institute for Healthcare Improvement](#) as 'the process of identifying the most accurate list of a patient's current medicines – including the name, dosage, frequency and route – and comparing them to the current list in use, recognising any discrepancies, and documenting any changes, thus resulting in a complete list of medications, accurately communicated'.

The National Prescribing Centre (NPC)¹ publication [Medicines reconciliation: a guide to implementation](#) (2008) identified a number of benefits of medicines reconciliation, such as:

- increasing resident involvement (see [section 3.2](#))
- improving communication between health professionals and other people involved in the transfer of residents' care, including residents and their carers (see [section 3.3](#))
- improving multidisciplinary team working (see [section 3.3](#))
- improving medicines record-keeping, with a minimum dataset of medicines information being recorded appropriately (see [section 3.4](#))
- reducing the risk of medication errors and adverse effects of medicines (see [section 3.6](#))
- reducing inefficiency and duplication of work.

¹ The National Prescribing Centre (NPC) is now the NICE Medicines and Prescribing Centre.

NICE has also published [Technical patient safety solutions for medicines reconciliation on admission of adults to hospital](#) (2007). Although this relates specifically to hospital admissions, the GDG agreed that the principles may also apply in other care settings, such as care homes.

The GDG agreed that medicines reconciliation in care homes has the potential to reduce medication errors and improve resident safety. The care home provider and other organisations commissioning or providing care need to consider the resources that are necessary to ensure medicines reconciliation is carried out.

The GDG discussed and agreed that the process outlined in the NPC's [Medicines reconciliation: a guide to implementation](#) (2008) could be used to support the development of a medicines reconciliation process that should be recorded in the care home medicines policy (see [section 3.1](#)).

Who should be involved in medicines reconciliation?

Evidence suggests that the following people may be involved in medicines reconciliation (NPC 2008):

- the person responsible for the transfer of the resident's care
- the person receiving the resident into their care
- the resident and/or carer involved
- other people involved in managing medicines with the resident, such as pharmacists, prescribers, community matrons, care home staff, case managers, practice managers and ward clerks.

[NICE guidance on medicines reconciliation](#) recommends that pharmacists are involved in medicines reconciliation as soon as possible after hospital admission. The GDG agreed that medicines reconciliation in care homes should also involve a pharmacist.

The GDG also agreed that it would be beneficial to involve other health and social care practitioners who know the resident, such as the GP, care home staff or a community matron. The patient and/or their carer should also be involved in the process, when possible.

Evidence also suggests that training and competency is an important local consideration to understand the process of medicines reconciliation (see [section 3.17](#)). People who are undertaking medicines reconciliation should be trained and competent in:

- effective communication skills
- technical knowledge of relevant medicines management systems (see [figure 1](#) and [section 3.1](#))
- evidence-based therapeutics.

The GDG agreed that medicines reconciliation has been difficult to address because of poor communication and a lack of ownership of the task. The GDG concluded that the person who is responsible for the resident's transfer into the care home, such as the care home manager, should be responsible for coordinating the medicines reconciliation process, as part of the resident's care plan. Medicines reconciliation for residents in care homes should involve:

- the resident and/or their family members or carers
- a pharmacist
- other health and social care practitioners involved in managing medicines for the resident as agreed locally, such as the GP or community matron.

The roles and responsibilities of all people involved in medicines reconciliation, and how they work together, should be carefully considered and agreed locally. Training and competency needs should also be addressed (see [section 3.17](#)).

Information needed for medicines reconciliation

The [CHUMS](#) (2009) identified that 'incomplete information' was one of the commonest causes of prescribing errors. In order to complete the medicines reconciliation process effectively, evidence suggests that specific information about the medicines prescribed for a resident is needed.

The Royal Pharmaceutical Society's [Keeping patients safe when they transfer between care providers – getting the medicines right](#) (2012) document includes core information that should be communicated when a resident

moves between care providers. Information should be clear, unambiguous and legible and should be available as soon as possible.

The GDG recognised that medicines reconciliation in care homes should usually be between the care home medicines administration record and the GP practice list of medicines. However, it may also include:

- recent discharge summaries that have not yet been included into the practice records
- additional information that may need to be requested from an acute care provider, for example, when children are under the care of an acute trust.

The GDG concluded that all providers need to ensure that information about the resident and their medicines is available when a resident transfers into or from a care home, so that medicines reconciliation can be carried out. This information should be available on the day of the resident's transfer.

The GDG concluded that the core information included in the Royal Pharmaceutical Society transfer of care report could be considered the minimum information that is needed for medicines reconciliation, and this should be relevant to health and social care. The process for medicines reconciliation in care homes should be recorded in the care home medicines policy (see [section 3.1](#)). All providers should ensure that the following information is available for medicines reconciliation on the day of the resident's transfer into or from a care home:

- resident details, including full name, date of birth, NHS number, address and weight
- GP details
- other relevant contacts defined by the resident and/or their carer, such as the consultant, regular pharmacist, specialist nurse
- known allergies to and adverse effects from medicines or ingredients, and the type of reaction experienced
- current medicines, including name, strength, form, dose, timing and frequency, route of administration and indication for use (when known)

- changes to medicines, including medicines started, stopped or dosage changed, and reason for change
- date and time of last administration of any 'when required' medicine or medicine given at greater intervals than daily (weekly or monthly administered medicines)
- additional information and support, including review and monitoring requirements, adherence support
- information given to the resident and/or carer
- details of the person completing the record.

Recommendations

Recommendation 1.7.1

The care home manager or the person responsible for a resident's transfer into a care home should coordinate the accurate listing of all the resident's medicines (medicines reconciliation) as part of a full needs assessment and care plan. The care home manager should consider the resources needed to ensure that medicines reconciliation occurs in a timely manner (see recommendation 1.1.2).

Recommendation 1.7.2

Care home providers should ensure that the following people are involved in medicines reconciliation:

- the resident and/or their family members or carers
- a pharmacist
- other health and social care practitioners involved in managing medicines for the resident, as agreed locally.

Recommendation 1.7.3

Commissioners and providers of health or social care services should ensure that the following information is available for medicines reconciliation on the day that a resident transfers into or from a care home:

- resident's details, including full name, date of birth, NHS number, address and weight (for those aged under 16 or where appropriate, for example, frail older residents)
- GP's details
- details of other relevant contacts defined by the resident and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse)
- known allergies and reactions to medicines or ingredients, and the type of reaction experienced
- medicines the resident is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication), if known
- changes to medicines, including medicines started, stopped or dosage changed, and reason for change
- date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines)
- other information, including when the medicine should be reviewed or monitored, and any support the resident needs to carry on taking the medicine (adherence support)
- what information has been given to the resident and/or family members or carers.

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

3.8 *Reviewing medicines (medication review)*

Evidence suggests that care home residents are frequently identified as a population that would potentially gain most benefit from medication reviews.

Medication review has been defined by the National Prescribing Centre (2008) document [A guide to medication review](#) as 'a structured, critical examination of a patient's medicines with the objective of reaching an agreement with the

patient about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste’.

Many care home residents have multiple and complex conditions. These conditions can change and the medicines residents receive to treat these conditions need to be reviewed on a regular basis, to ensure they remain safe and effective. In addition, age-related changes in pharmacokinetics and pharmacodynamics make children and older residents particularly susceptible to the adverse effects of medicines.

From the evidence identified, polypharmacy appears to be a particular issue in care homes. Polypharmacy is a term used when residents are prescribed 4 or more medicines. The [CHUMS](#) found that care home residents take an average of 8 different medicines each day. In addition, studies of prescribing in UK care homes suggest inappropriate prescribing may occur in 50–90% of residents.

[A guide to medication review](#) (NPC 2008) provides advice for commissioners and providers of medication reviews in a wide range of care settings. A number of potential benefits for medication review have been cited in the published evidence, such as:

- improving the current and future management of the resident’s medical conditions
- greater resident involvement and support for shared decision-making
- reducing inappropriate polypharmacy and excessive prescribing
- reducing unwanted or unused medicines
- reducing adverse effects relating to medicines
- reducing costs.

Evidence suggests that medicines are often not adequately reviewed in care homes. The CHUMS highlighted medication review as one of the main areas where improvement was needed. A survey of UK care homes found that 44% of residents did not have a regular planned review of their medicines.

Evidence also suggests there is often no planned, structured approach to medication review and a more formal process for care planning and medication review would be beneficial. There also appears to be some uncertainty about who should undertake medication reviews, how often they should occur, and what standard criteria should be used. The GDG agreed that an optimal model for medication review in care homes has not been identified.

The GDG acknowledged that the prescriber is ultimately responsible for ensuring medicines prescribed for residents are reviewed, but that the care home also has ownership and responsibility to ensure that medication reviews occur.

The GDG also highlighted the wide variation in the quality of medication reviews. This may mean that residents do not get the maximum benefit from their medicines and there is potential for harmful adverse effects. They recognised that there are a number of reasons why medication reviews for care home residents do not appear to be adequate. These include:

- inadequate resources
- they are time-consuming and challenging to undertake, and there may be a lack of dedicated time
- lack of leadership and understanding of their importance
- not being considered a high priority
- inconsistency of primary care providers
- poor medicines management systems.

Although the GDG recognised that more high-quality studies are needed to determine the effect of medication review on outcomes for care home residents, they concluded that planned, structured medication reviews for residents represented good practice and may help to reduce the risk of medication errors and inappropriate or excessive prescribing. It should also be integrated into the resident's care plan as part of the care planning process.

The GDG concluded that there needs to be a clear, planned process in place for medication reviews for residents in care homes, and this should be recorded in the care home medicines policy (see [section 3.1](#)). The GP should ensure arrangements have been made for medication reviews for their care home patients and other health and social care practitioners should support the GP in ensuring medication reviews are carried as documented in the resident's care plan.

Furthermore, given the lack of robust evidence to guide the optimal model for medication review, the GDG proposed that medication review for all people using medicines should be considered as a separate topic for a future NICE guideline.

Who should be involved in medication review?

A number of different health professionals can conduct medication reviews for care home residents. Evidence suggests that a pharmacist could potentially lead the process. The CHUMS recommends that pharmacists should regularly review residents and their medication and that they should also rationalise regimens to help care home staff work more safely. However, the available evidence appears to suggest that medication review should ideally involve a multidisciplinary group of key people, such as:

- the resident and/or their family members or carers (as appropriate)
- the GP
- a pharmacist
- care home staff.

The GDG discussed who should be involved in conducting medication reviews and who should lead the process. The GDG was aware that the pharmacist role may be undertaken by a care home pharmacist, a primary care pharmacist or the supplying pharmacist. The GDG agreed that the process should ideally be led by a dedicated care home pharmacist with appropriate clinical experience and training, such as a postgraduate clinical diploma and/or independent prescriber qualification. However, the GDG recognised that there are very few dedicated pharmacist roles specifically involved in

providing services to care homes. The GDG agreed that experience and competence was important in determining who should lead the process, rather than which professional group they represented.

The GDG therefore concluded that the resident's GP should identify the named health professional responsible for undertaking medication reviews for each resident, taking into account their clinical experience and competency, their knowledge of the resident and their condition, and access to relevant information.

The GDG further concluded that the resident and their family members or carers (as appropriate) should be involved in their medication review and actively involved in decisions about their medicines (see [section 3.2](#)). Medication reviews should also involve a multidisciplinary team of locally determined practitioners. This may include a:

- GP
- pharmacist
- practice nurse
- community matron or specialist nurse, such as a community psychiatric nurse
- care home staff
- social care practitioner.

The named health professional responsible for undertaking the medication review should be determined locally for each resident. This decision should be based on their clinical experience and competence, knowledge of the patient and their condition and access to relevant information. The roles and responsibilities of each person and how they work together should be carefully considered and agreed locally. Training and competency needs should also be addressed (see [section 3.17](#)).

Frequency of medication review for care home residents

The [National Service Framework \(NSF\) for older people](#) (2001) recommends that 'all people over 75 years should normally have their medicines reviewed

at least annually and those taking 4 or more medicines should have a review 6-monthly'. Evidence suggests this target may not be achieved in up to two-thirds of care home residents.

No robust evidence was found on the ideal frequency of medication reviews to improve outcomes for residents. Current practice suggests that residents should have a formal medication review at regular intervals of at least every 6 months. However, the GDG was aware that there may be resourcing implications to achieve this, particularly if this is undertaken by a locally determined multidisciplinary team.

In addition, it has also been suggested that a medication review should occur as soon as possible after a resident moves into a care home. Some evidence suggests that specific residents may be targeted for medication review, such as those taking a new medicine or high-risk medicines known to cause particular harm, such as anticoagulants, antipsychotics or non-steroidal anti-inflammatory drugs.

The GDG concluded that the frequency of medication reviews for care home residents 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 multidisciplinary medication review should not exceed 1 year. The frequency of planned reviews should be documented in the resident's care plan. More frequent medication reviews may be needed for some residents, for example:

- residents entering the end-of-life phase
- residents diagnosed with a new long-term condition
- residents who require frequent or complex monitoring
- residents who have been transferred to the care home, such as on hospital discharge.

The date of the next review should be established at the time of the medication review. The GDG agreed that the GP should ensure that their care

home patients should have multidisciplinary medication reviews within the agreed timeframe.

What should a medication review cover?

The [NSF for older people](#) (2001) and the NPC's [Room for review](#) (2002) highlight core areas that a detailed medication review should cover. Tools have also been developed to support medication review, such as the [NO TEARS tool](#) (Need/indication, Open questions, Tests, Evidence, Adverse effects, Risk reduction, Simplification/switches) and the [STOPP and START criteria](#) (Screening Tool of Older Person's potentially inappropriate Prescriptions and Screening Tool of Alert doctors to the Right Treatment).

Evidence suggests that developing standard criteria for medication review may be beneficial.

The GDG concluded that a medication review for residents should discuss and review:

- the purpose of the medication review
- the resident's (and/or their family members' or carers', as appropriate in line with the resident's wishes) perception and understanding of their medicines
- the resident's (and/or their family members' or carers', as appropriate in line with the resident's wishes) concerns, questions or issues about their medicines
- compilation of all medicines (prescribed, over-the-counter and complementary medicines) being taken or used, and their indications
- the safety, effectiveness and appropriateness of all medicines, including compliance with national guidance
- any relevant monitoring tests
- any medicines-related problems experienced by the resident, such as adverse effects, difficulties with self-administration (such as inhaler technique), difficulty swallowing
- medicines adherence

- further information or support needed by the resident and/or their family members or carers (as appropriate).

Recommendations

Recommendation 1.8.1

GPs should ensure that arrangements have been made for their patients who are residents in care homes to have medication reviews as set out in the residents' care plans (see recommendation 1.8.4.)

Recommendation 1.8.2

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

Recommendation 1.8.3

Health and social care practitioners should ensure that medication reviews involve the resident and/or their family members or carers and a local team of health and social care practitioners (multidisciplinary team). This may include a:

- pharmacist
- community matron or specialist nurse, such as a community psychiatric nurse
- GP
- member of the care home staff
- practice nurse
- social care practitioner.

The roles and responsibilities of each member of the team and how they work together should be carefully considered and agreed locally. Training should be provided so that they have the skills needed.

Recommendation 1.8.4

Health and social care practitioners should agree how often each resident should have a multidisciplinary medication review. They should base this on the health and care needs of the resident, but the resident's safety should be the most important factor when deciding how often to do the review. The frequency of planned medication reviews should be recorded in the resident's care plan. The interval between medication reviews should be no more than 1 year.

Recommendation 1.8.5

Health and social care practitioners should discuss and review the following during a medication review:

- the purpose of the medication review
- what the resident (and/or their family members or carers, as appropriate and in line with the resident's wishes) thinks about the medicines and how much they understand
- the resident's (and/or their family members' or carers', as appropriate and in line with the resident's wishes) concerns, questions or problems with the medicines
- all prescribed, over-the-counter and complementary medicines that the resident is taking or using, and what these are for
- how safe the medicines are, how well they work, how appropriate they are, and whether their use is in line with national guidance
- any monitoring tests that are needed
- any problems the resident has with the medicines, such as side effects or reactions, taking the medicines themselves (for example, using an inhaler) and difficulty swallowing
- helping the resident to take or use their medicines as prescribed (medicines adherence)
- any more information or support that the resident (and/or their family members or carers) may need.

3.9 Prescribing medicines

The [CHUMS](#) found that the prevalence of prescribing errors for residents in adult care homes was 8.3% (95% CI 7.1–9.7) with 39.1% of residents having at least 1 prescribing error (100/256) (see tables [1](#) and [2](#)). The most common errors included:

- incomplete information on prescriptions (38%)
- unnecessary drug (24%)
- dose/strength error (14%)
- omission of a medicine that should have been prescribed (12%).

Evidence suggests that the process of issuing prescriptions relies on the GP practice receptionist identifying each medicine requested and having up-to-date patient medical records. The GDG found evidence that in some cases the doctor signing the prescription(s) does not always review the patient medical records when undertaking this task. In addition, there are few written processes for GP practice receptionists to generate prescriptions (for the GP to sign) when requested by care home staff during the ordering process (see [section 3.10](#)).

The GDG was presented with oral evidence describing reports of inadequate recording of prescriptions in the GP patient medical records, when prescriptions were handwritten and issued in the care home.

The GDG discussed and agreed that, if possible, prescribers should have access to the GP patient medical records before issuing prescriptions. All medicines prescribed at the care home should be recorded in the GP patient medical record and in the resident's care plan and/or medicines administration record (see sections [3.13](#) and [3.14](#)), updating any changes as soon as practically possible. This may include documenting:

- instructions on use (for example, where to apply a topical preparation and how much to use)
- expected duration of use
- when important, the duration of a drug's action

- the indication for the prescribed medicine.

Instructions should also be provided and recorded for the resident (if self-administering) and/or the care home staff.

Frequency of prescribing

The GDG was aware that medicines are often prescribed on a monthly basis for care home residents with long-term conditions. In care homes, quantities of repeat prescribed medicines are issued on a 28-day supply cycle. Within this 28-day supply cycle, medicines are prescribed, ordered (see [section 3.10](#)), dispensed and supplied (see [section 3.11](#)). Evidence presented to the GDG suggests that quantities to prescribe for new medicines that are for repeat use, or medicines that have been changed should consider the point at which they are prescribed within the 28-day supply cycle. For example, if the dose of a medicine has changed and a new prescription is needed on day 21 of the 28-day supply cycle, then the quantity to prescribe would be 7 days to synchronise (a supply of medicines where all quantities have been adjusted to finish at the same time, intended to help people to avoid accumulating medicines) the supply with other prescribed medicines for the remainder of the current cycle. In addition, the prescriber will need to consider the prescribing for the next cycle, when appropriate.

The GDG concluded that GP practices should ensure they have clear written processes for prescribing and issuing prescriptions for their patients living in care homes. The GDG recognised the importance of all prescribers and staff involved with prescribing and issuing prescriptions at the practice agreeing to this process. The process should consider the following:

- prescriptions to be issued in accordance with patient medical records
- records to be made in the GP patient medical record and resident care record as soon as practically possible to update records with changes
- recording clear instructions on the use, expected duration of use or when important the duration of a drug's action and indication of the prescribed medicine (use of the term 'as directed' should be avoided)

- providing additional instructions for use by the resident (if self-administering) and/or care home staff
- monitoring requirements for relevant medicines
- prescribing quantities to fit within the 28-day supply cycle if appropriate, and necessary adjustments to be made for future supply
- prescribing, monitoring and review of ‘when required’ (a medicine to be given when required for a defined problem, for example pain or constipation) and variable dose medicines
- generation of prescriptions when the care home provider sends the medicines order.

From the evidence identified, the GDG found that clear instructions from the prescriber about when to take or use ‘when required’ medicines should be given, to provide clarity for care home staff when administering medicines to residents (see [section 3.14](#)). The GDG heard that the use of variable doses should be avoided whenever possible, unless care home staff are provided with instructions explaining how much to give and under what circumstances. For example, when administering medicines for pain relief with a variable dose of ‘take 1 or 2 tablets’, the prescriber should provide a written instruction for the circumstances to give 1 tablet and the circumstances to give 2 tablets.

The GDG discussed and concluded that when prescribing variable doses and ‘when required’ medicines, it would be good practice for the prescriber to:

- document in the resident’s care record the instructions for:
 - circumstances for use (when and how to take or use the medicine)
 - monitoring
 - the effect they expect the medicine to have
 - such as details of the area a cream or ointment should be applied)
 - monitoring
 - expected outcomes
- include instructions on the prescription for the community pharmacy to add to the label of the dispensed medicine
- specify the maximum daily dose and duration of use, when appropriate

- prescribe appropriate quantities, for example enough to last for 28 days or the expected duration of treatment
- liaise with care home staff to see how often the individual resident has received the medicine and review its effectiveness.

In addition, the GDG concluded that a collaborative approach is required between health and social care practitioners, ensuring effective communication when medicines are started, stopped or changed, and that records of medicines administration are updated by care home staff, to accurately reflect changes to medicines.

Anticipatory medicines

The [NICE quality standard on end of life care for adults](#) covers all settings and services in which care is provided by health and social care practitioners to all adults approaching the end of life. Quality statement 11 states ‘people in the last days of life are identified in a timely way and have their care coordinated and delivered in accordance with their personalised care plan, including rapid access to holistic support, equipment and administration of medication’.

Anticipatory prescribing allows rapid access to those medicines needed when providing palliative or end of life care in care homes. The GDG heard reports of local schemes for anticipatory medicines that are prescribed for use during end of life care.

The GDG concluded that the prescriber, care home provider and supplying pharmacy should be aware of local processes in place for anticipatory medicines if they are in use. Residents in care homes should have the same access to anticipatory medicines as people who do not live in care homes.

Remote prescribing

Remote prescribing is when prescribing is not carried out in person by the prescriber and takes place via telephone, video-link or online. Remote prescribing should only be used when the option to see the resident and prescribe in person is not possible, that is in exceptional circumstances.

The General Medical Council (GMC) has issued guidance for doctors prescribing remotely in [Good practice in prescribing and managing medicines and devices \(2013\)](#).

The [NMC standards for medicines management](#) (standard 11) applies to registered nurses, and provides guidance for remote prescribing. Registered nurses should follow this guidance when remote prescribing is being considered and used.

For other prescribing health professionals the GDG agreed that the GMC and NMC standards should be considered in the absence of other regulatory guidance or standards on remote prescribing.

The NMC standard provides guidance for the process after the verbal instruction:

- The prescriber must authorise the change (by text, email or fax) before any new dose is administered.
- Any fax or emailed prescription or direction to administer should be attached to the medicines administration record.
- The prescriber should issue a new prescription confirming the changes, usually within 24 hours of the verbal instruction (within 72 hours at weekends or over bank holidays).

Standard 11 also states 'The registered nurse should request the prescriber to confirm and sign changes on the patient's individual medicines administration record (MAR) chart or care plan.' The GDG discussed and agreed that not all care homes have registered nurses. The medicines administration record is a record of administration or non-administration of medicines. Therefore care home staff who are trained and competent in the use of medicines can update this record with changes following a verbal instruction for a medicines change from a prescriber.

When using remote prescribing, the GDG was aware that the prescriber may not be able to make an assessment of the resident's clinical situation by speaking to the resident themselves. Communicating with care home staff

may be necessary. The GDG discussed and agreed that the knowledge and skills of care home staff when assessing the clinical needs of residents varies from one care home to another. Care home staff could be experienced registered nurses or social care practitioners who may have little formal training in this area.

Remote prescribing can only be used when the care home has a stock of the required medicine that can be administered to the resident. This may be a stock of the medicine that is held by the care home (for care homes with nursing) or may be stocks of an existing medicine that the resident already has that allows the new dose to be taken or administered. A verbal instruction to amend the dose by the prescriber can allow the care home to administer the medicine and ensure the medicines administration record reflects the medicine change.

The GDG concluded that remote prescribing should only be used in exceptional circumstances and prescribers should:

- follow guidance set out by their regulators, if available, or follow the principles of the GMC or NMC guidance when no regulatory guidance exists in respect of assessing and obtaining informed consent from residents
- be aware that not all care home staff are trained and competent to discuss the clinical need of the resident for any assessment that is required
- ensure that any instructions are understood by care home staff and send written confirmation of those instructions to the care home as soon as possible.

The GDG further concluded that when remote prescribing is used, care home staff should:

- ensure that when there is a verbal change to a prescription or a new medicine is prescribed, this is supported in writing (by fax or email) before the next or first dose is administered
- request that the prescriber amends the prescription

- amend the medicines administration record and update the care plan as soon as possible with any changes to administration (usually within 24 hours).

Text messages

In the NHS, sending of personal and sensitive information by text message may breach the requirements of NHS IT data security and lead to breaches of patient confidentiality. The NMC has issues guidance in [Standards for medicines management](#) (NMC 2010). This discusses the handling of text messages, which are classed as legal documents when relating to residents. Standard 12 considers standards that registered nurses should follow when handling text messages. When adapted for care homes, this includes ensuring that processes are in place for:

- maintaining resident confidentiality
- recording the details of any text message received, including the content of the text message, telephone number it was sent from (not a personal number, but a pre-agreed designated number), the time sent, any response given, recipient of the text to sign and date when they received it
- managing orders to administer a medicine that are received by text message, including checking that the sender is a prescriber for the resident and the message is received from their designated number
- deleting received messages from the handset after recording details of the text.

For health and social care practitioners, the GDG discussed and concluded that the principles of the NMC standard, adapted for the social care setting, should be followed when handling text messages. Text messaging should be used in exceptional circumstances only, for example, in life-threatening situations when no other option exists. The care home medicines policy (see [section 3.1](#)) should have a clear process for handling text messages to maintain resident confidentiality and record details of any text message received.

Recommendations

Recommendation 1.9.1

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

- issuing prescriptions according to the patient medical records
- recording clear instructions on how a medicine should be used, including how long the resident is expected to need the medicine and, if important, how long the medicine will take to work and what it has been prescribed for (use of the term 'as directed' should be avoided)
- recording prescribing in the GP patient medical record and resident care record and making any changes as soon as practically possible
- providing any extra details the resident and/or care home staff may need about how the medicine should be taken
- any tests needed for monitoring
- prescribing the right amount of medicines to fit into the 28-day supply cycle if appropriate, and any changes that may be needed for prescribing in the future
- monitoring and reviewing 'when required' and variable dose medicines
- issuing prescriptions when the medicines order is received from the care home.

Recommendation 1.9.2

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

- note in the resident's care record the instructions for:
 - when and how to take or use the medicine (for example, 'when low back pain is troublesome take 1 tablet')
 - monitoring
 - the effect they expect the medicine to have

- include dosage instructions on the prescription (including the maximum amount to be taken in a day and how long the medicine should be used, as appropriate) so that this can be included on the medicine's label
- prescribe the amount likely to be needed (for example, for 28 days or the expected length of treatment)
- liaise with care home staff to see how often the resident has had the medicine and how well it has worked.

Recommendation 1.9.3

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

Recommendation 1.9.4

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

Recommendation 1.9.5

The health professional prescribing a medicine, care home provider and supplying pharmacy should follow any local processes for anticipatory medicines to ensure that residents in care homes have the same access to anticipatory medicines as those people who do not live in care homes.

Recommendation 1.9.6

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

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

- ensure that care home staff understand any instructions
- send written confirmation of the instructions to the care home as soon as possible.

Recommendation 1.9.7

Care home staff should:

- ensure that any change to a prescription or prescription of a new medicine by telephone is supported in writing (by fax or email) before the next or first dose is given
- ask that the health professional using remote prescribing changes the prescription
- update the medicines administration record and the care plan as soon as possible (usually within 24 hours) with any changes to medicines made by remote prescribing.

Recommendation 1.9.8

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

3.10 Ordering medicines

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 ([Regulation 13](#)) requires adult care homes to have appropriate arrangements for ordering medicines. The GDG agreed that this would include ordering repeat, acute and 'when required' medicines.

When poor ordering systems are in place, the GDG was aware that this can lead to medicines being lost, supplies running out or sharing and borrowing of medicines between residents.

[Legislation](#) exists to ensure that prescribed medicines are only taken by the intended recipient. The GDG therefore concluded that medicines belonging to individual residents must not be borrowed or shared between residents.

The GDG was aware of evidence that suggests that care home providers often have no emergency supplies or processes in place for obtaining medicines quickly, for example, during out-of-hours. Consequently residents may miss several doses of their medicines.

The ordering process can be complicated by:

- a lack of designated staff time to order medicines
- limited number of staff designated to process the order
- multiple GP practices aligned to care homes
- different types of prescriptions involved (such as for repeat prescriptions, acute or 'when required' items)
- different floors or units within the same care home using different systems for obtaining medicines.

The GDG found evidence of over-ordering of medicines by care home staff. Over-ordering and stockpiling of medicines and other treatments (for example, dressings or incontinence appliances) are major issues that lead to medicines waste. Reasons for over-ordering may include:

- lack of processes in place for ordering
- tight deadlines for ordering
- care home staff encouraging the continuation of medicines that are rarely used to ensure supply is available on the rare occasion it is needed.

The GDG agreed that the process for ordering medicines should follow the considerations outlined in box 8.

Box 8 Considerations for the care home medicines ordering process

Each care home provider should consider the following when ordering medicines:

- have at least 2 competent (see section 3.17) members of staff who are able to undertake the ordering of medicines, although ordering at any one time can be carried out by one member of staff (allowing for staff holidays or sickness absence)
- allow protected time for ordering medicines, in particular for the monthly order
- review previous usage of medicines before ordering and checking stock (stock reconciliation)
- ordering at different times – monthly basis and on an ad-hoc basis (for example, new prescription issued for a new or changed medicine)
- use an up-to-date medicines administration record or other accurate record of the resident's medicines when ordering (including the repeat prescription)
- check and make appropriate records of quantities of repeat, acute and 'when required' medicines to avoid over-ordering and running out, following a written process
- review expiry dates of medicines, consider ordering medicines close to their expiry (for example, the medicine at the point of checking may still be in-date, however it may expire by the time it is needed)
- synchronise medicines if changes to regular medicines have occurred during the middle of the 28-day supply cycle.

The GDG concluded that care home providers should have processes in place for ordering and receiving medicines (see [section 3.12](#)) and this should be recorded in the care home medicines policy (see [section 3.1](#)). At least 2 competent members of staff should be able to undertake ordering of medicines, although the ordering at any given time can be carried out by one member of staff (see [section 3.17](#)). The GDG agreed that this would ensure a competent member of staff is available to order at all times, for example during periods of leave or unexpected staff absence. The GDG also agreed that protected time should be allocated to carry out ordering and receiving of medicines to ensure residents receive all their medicines on time.

Systems for ordering medicines

Evidence suggests that medicines can be ordered by the care home provider in a number of ways:

- directly from the GP practice using the repeat prescription ordering form (also known as the 'right-hand side' of the prescription form [FP10])
- directly from the GP practice using the medicines administration record
- through the supplying pharmacy, with the pharmacy ordering prescriptions after visiting and/or consulting with the care home
- through the supplying pharmacy, with the pharmacy ordering prescriptions directly from the GP practice without contacting the care home.

From the evidence provided, the GDG recognised the importance of collaborative working and good communication between the GP practice, the supplying pharmacy and the care home provider when ordering medicines.

The GDG found examples of collaborative working:

- managing repeat prescriptions by using electronic prescriptions between the GP practice, supplying pharmacy and the care home provider
- having a joint approach with clinical commissioning groups, local authorities, the CQC, the supplying pharmacy and care home providers in developing a robust process for ordering medicines.

From oral and written evidence provided, the GDG was aware that, during the ordering process, some care home providers may not have direct access to a prescription once a request for medicines has been made to the GP practice.

The GDG concluded that care home providers should maintain the responsibility for ordering medicines from the GP practice. This should not be delegated to the supplying pharmacy. However collaboration between the care home provider, GP practice and supplying pharmacy is essential.

The GDG concluded that it would be good practice for care home staff to make records, such as a copy of the prescription, stock order or requisition note, when ordering medicines. This allows care home staff to check that all

medicines requested have been prescribed and supplied as ordered, when receiving the medicines into the care home (see also [section 3.12](#)).

Evidence provided to the GDG suggests that a copy of the medicines administration record should be used when communicating changes of medicines and discontinued medicines to the supplying pharmacy at the point of ordering.

The GDG concluded that it would be good practice for care home providers, with the resident's consent, to inform the supplying pharmacy of any changes to medicines (including discontinuation of medicines) to ensure that all records can be kept up-to-date.

Recommendations

Recommendation 1.10.1

Care home providers must usually ensure that medicines prescribed for a resident are not used by other residents. However, during the COVID-19 pandemic medicines no longer needed by a resident may be reused in line with the UK government [COVID 19 standard operating procedure for running a medicines reuse scheme in a care home or hospice setting](#).

[amended 1 May 2020]

Recommendation 1.10.2

Care home providers should ensure that care home staff (registered nurses and social care practitioners working in care homes) have protected time to order medicines and check medicines delivered to the home.

Recommendation 1.10.3

Care home providers should ensure that at least 2 members of the care home staff have the training and skills to order medicines, although ordering can be done by 1 member of staff.

Recommendation 1.10.4

Care home providers should retain responsibility for ordering medicines from the GP practice and should not delegate this to the supplying pharmacy.

Recommendation 1.10.5

Care home providers should ensure that records are kept of medicines ordered. Medicines delivered to the care home should be checked against a record of the order to make sure that all medicines ordered have been prescribed and supplied correctly.

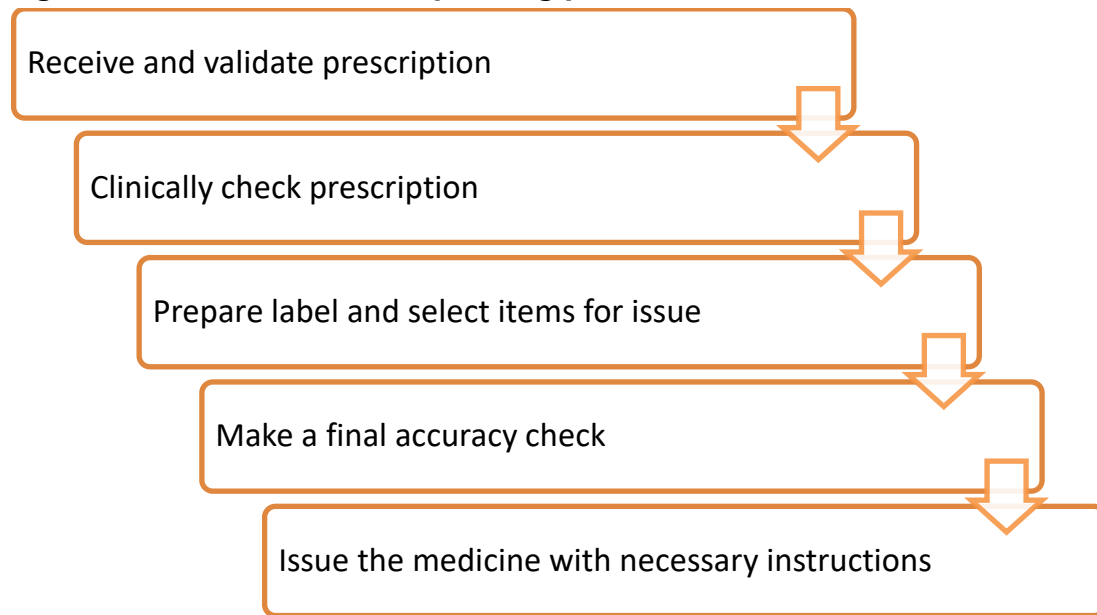
3.11 *Dispensing and supplying medicines*

Most care homes are supplied with medicines by pharmacies, the supplying pharmacy. However, some care homes obtain their supplies of medicines from dispensing doctors. Dispensing doctors should follow guidance set out by the [General Medical Council](#) on delegating responsibility to dispense medicines within their practice.

Dispensing

The dispensing process covers all activities involved from receiving the prescription to issuing the prescribed medicine to the resident (see figure 3).

Figure 3 Overview of the dispensing process



Evidence suggests that a pharmacist's clinical check (identifying pharmacotherapeutic problems by collecting and evaluating all relevant information, including patient characteristics, disease states, medication regimen and, when possible, laboratory results) of prescriptions before dispensing should include a review of both the prescription and the medicines administration record, if the supplying pharmacy is producing and supplying the medicines administration record. This allows for double checking of, for example:

- dose
- dose changes
- frequency and times
- duplicate entries
- review of new medicines and possible interactions with existing medicines.

The [CHUMS](#) highlighted the following as contributing to labelling and dispensing errors:

- IT systems (used to generate labels) omitting important information from the medicine label, such as warnings or formulation

- inaccurate descriptions of medicines on the labels of monitored dosage systems
- incorrect filling of monitored dosage systems.

The GDG reviewed the evidence and agreed that supplying pharmacies and dispensing doctors supplying medicines to care home providers should ensure that processes, for example, standard operating procedures, are in place for all staff who are dispensing and accuracy checking medicines for residents, particularly those using monitored dosage systems.

Medicines supply systems

A medicines supply system is the system used by the care home to provide medicines to their residents (see section 3.1 and 3.5). Evidence suggests there are 2 widely used systems available:

- original packs
- monitored dosage systems (which may be single-dose or multi-dose).

The CHUMS highlighted that dispensing errors were partly related to monitored dosage systems, in addition to labelling and filling issues identified. There were also errors when identifying white tablets.

[Improving patient outcomes through the better use of multi-compartment compliance aids](#) (Royal Pharmaceutical Society 2013) suggests that monitored dosage systems should not automatically be the intervention of choice for all residents. The use of monitored dosage systems should be considered following an individual assessment of the resident's needs. An integrated approach between health and social care, between commissioners and care home providers, and among pharmacy bodies is suggested by the Royal Pharmaceutical Society.

The GDG also heard evidence that the supplying pharmacist could undertake an individual assessment to determine the resident's medicines needs before supplying their medicines. At this point they could also consider the suitability of individual medicines for inclusion in a monitored dosage system. See

[appendix D](#) for a comparison between monitored dosage systems and original packs.

The GDG was aware that the use of monitored dosage systems may often be driven by care home providers and resident demand. Also, the supplying pharmacy may suggest using a monitored dosage system as an enhanced aspect of the supply of medicines.

The GDG 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 if needed. An assessment of the system needed for a resident should consider maintaining the resident's independence and their needs.

Medicines administration records from the supplying pharmacy

Care homes are required to keep appropriate records of all medicines and treatments given or administered to residents. A common type of record for medicines administration used in care homes is the medicines administration record, also known as 'MAR sheet' or 'MAR chart' (these may also be in electronic format). Medicines administration records are for recording the administration and non-administration of medicines in care homes (see [section 3.14](#)).

The GDG was aware that the responsibility of providing the medicines administration record rests with the care home provider (see [section 3.14](#)), who should produce an up-to-date list of medicines taken by residents when they first move into the care home, and is not the responsibility of the supplying pharmacy. However, the supplying pharmacy may provide them on the request of the care home provider.

Evidence suggests 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 and signed by a second person before use (see [section 3.14](#)). Similarly, a supplying pharmacy producing medicines administration records should also have a process in

place and ensure that they are up-to-date (including any 'when required' medicines) and do not include any discontinued medicines.

[Improving pharmaceutical care in care homes](#) (Royal Pharmaceutical Society (Scotland) 2012) states that consent is required if pharmacists are providing services that involve accessing specific data protected information, such as when producing a medicines administration record. When a medicines administration record is used by the care home to record administration of medicines, this becomes a confidential document.

The GDG discussed and concluded that whenever possible medicines administration records should be produced by the supplying pharmacy.

Recommendations

Recommendation 1.11.1

Pharmacies and doctors supplying medicines to care home providers should ensure they have processes, such as standard operating procedures, in place for all staff who dispense and accuracy check medicines for residents, particularly those who are using monitored dosage systems.

Recommendation 1.11.2

Care home providers should determine the best system for supplying medicines for each resident based on the resident's health and care needs and the aim of maintaining the resident's independence wherever possible. If needed, they should seek the support of health and social care practitioners.

Recommendation 1.11.3

Supplying pharmacies should produce medicines administration records wherever possible.

See also recommendation 1.14.8.

3.12 Receiving, storing and disposing of medicines

Receiving medicines

The GDG recognised the importance of care homes having a process in place for receiving medicines into the care home once they have been ordered (see sections [3.1](#) and [3.10](#)). Evidence suggests that on receipt of the medicines, the care home staff should check the dispensed medicines against their records of the order. This would ensure that all medicines requested have been supplied accurately and any discrepancies resolved, without delaying a resident's treatment.

Storing medicines

The Care Quality Commission (CQC) [Essential standards of quality and safety](#) and the [Children's homes: national minimum standards](#) require care

home providers to have clear processes in place for the safe storage of medicines. For the storage of controlled drugs, adult care home providers must comply with the requirements of the [Misuse of Drugs Act 1971](#) and associated regulations.

This includes appropriate storage of all controlled drugs administered to residents by care home staff (see [section 3.14](#)) and for controlled drugs supplied to residents for them to self-administer (see [section 3.13](#)).

Specifications of cabinets and safes set out in [Schedule 2 of The Misuse of Drugs \(Safe Custody\) Regulations 1973](#) must be regarded as a minimum standard for the storage of controlled drugs, depending on the schedule the controlled drug is in. Children's homes do not fall within the provision of the Misuse of Drugs (Safe Custody) Regulations 1973 and subsequent amendments.

The [Children's Homes Regulations 2001 \(regulation 21\)](#) does not make any specific mention of controlled drugs, but does refer to making suitable arrangements for medicines. The GDG discussed and agreed that it would be considered good practice for children's homes to make suitable arrangements for the storage of controlled drugs as specified in the Misuse of Drugs (Safe Custody) Regulations 1973.

The GDG found variation in the way medicines are stored in care homes. Inefficient systems and processes for storing and managing stocks of medicines were widely reported as a cause of errors, wastage and delay. Evidence presented to the GDG suggests a lack of processes in place or, when there are processes, a lack of awareness and training in how to follow them.

From the evidence provided, the GDG agreed that a medicines storage process for care home staff to follow may include:

- where medicines are stored, including storage requirements for specific medicines, such as controlled drugs, refrigerated items, external topical preparations, oral nutritional supplements, dressings and appliances

- storage of medicines supplied in monitored dosage systems (more storage space is needed to cover the change-over period each month)
- secure access by authorised care home staff only
- storage temperatures and monitoring (fridge 2–8°C, room usually no more than 25°C)
- storage of medicines for residents who are administering their medicines themselves (see [section 3.13](#)).

The GDG concluded that care home providers must have a process in place for safe storage of medicines, in accordance with legislation and regulations, and this should be recorded in the care home medicines policy (see [section 3.1](#)). The GDG agreed that it would be good practice to include within the care homes medicine policy details of who to contact locally, such as a supplying pharmacy, should a storage issue occur (for example, medicines requiring refrigeration being left at room temperature).

In the review of its evidence, the GDG acknowledged the need to move to personalised care with residents having the option to keep their medicines in lockable cabinets in their room. This would ensure that all medicines belonging to the resident are kept together and not transported around the care home. The GDG agreed that administration of medicines by the resident themselves (and/or administration by care home staff) in their own rooms can give them greater privacy.

The GDG concluded that storage requirements of residents' medicines should be assessed by the care home provider using a person-centred approach and provisions should be made based on the resident's needs, choices and risk assessment, including considerations of storage temperatures (if self-administering their own medicines).

Disposing of medicines

The disposal of medicines is regulated by [The Controlled Waste \(England and Wales\) Regulations 2012](#). Under these regulations medicines fall under the category of 'clinical waste'. Table 3 summarises the disposal requirements for the type of care home.

Table 3 Disposal requirements for the type of care home

Non-nursing care homes	<ul style="list-style-type: none">• Clinical waste is treated as household waste.• Medicines that are no longer needed should be returned to the community pharmacy for disposal.
Nursing care homes	<ul style="list-style-type: none">• Clinical waste is treated as industrial waste and is subject to the Special Waste Regulations 1996 (as amended 2001).• The waste must be consigned to a suitably authorised waste management facility (this may be the community pharmacy that supplies the medicines; however, nursing care homes need to check if the community pharmacy has appropriate arrangements in place, and agrees to disposing of the medicines).

A guide to the [Disposal of medicines in nursing homes](#) has been written for Northern Ireland by the Regulation and Quality Improvement Authority (2011). This covers the key legislation and regulation for the disposal of medicines in the region, including the [Waste Management Licensing Regulations \(Northern Ireland\) 2003](#) and the [Controlled Waste Regulations \(Northern Ireland\) 2002](#).

The CQC's [Essential standards of quality and safety](#) and regulation 21 of the [Children Act 1989: Guidance and regulations volume 5: children's homes](#) require care home providers to have a process in place for the safe disposal of medicines.

From the evidence provided, the GDG found that when poor practice has been highlighted, processes are not clear for:

- disposing of medicines (including those in a monitored dosage system)
- recording of medicines that have been disposed of
- managing medicines supplies when no longer needed by the resident.

The GDG acknowledged that for a resident who has passed away, their medicines should be retained under lock and key, separated from other medicines and kept in the care home for at least 7 days in case there are any coroner's investigations into the death. The medicines can be disposed of when the death certificate has been signed.

The GDG concluded that care homes must make arrangements to remove clinical waste and have a process in place to ensure the safe disposal of

medicines. This process should be recorded in the care home medicines policy (see [section 3.1](#)). The process should consider how and when to promptly dispose of medicines which are no longer needed, unwanted medicines (including medicines for a resident who has passed away) and expired medicines (including controlled drugs). The process should also include notifying the supplying pharmacy to prevent unnecessary additional supply of medicines.

The Department of Health's (2012) report and action plan on '[Improving the use of medicines \(for better outcomes and reduced waste\)](#)' recognises the specific needs and circumstances required for the care of older people, and that the care home providers and health professionals may have adopted a number of system approaches to managing medicines that may in themselves create waste. For example, care home staff returning tubs of topical preparations back to the supplying pharmacy every month and ordering new ones.

The GDG concluded that provided the medicine is still currently prescribed, is within its expiry date and the manufacturer's literature does not specify a short shelf-life (the recommended maximum time that the medicine can be stored for as stated in the manufacturer's literature during which the defined quality of the medicine remains acceptable under expected (or specified) conditions of storage) when the product is opened, there is no requirement for the medicine to be disposed of early and it should be carried forward to the next 28-day supply cycle. When care home staff are uncertain of the shelf life of a particular medicine once opened, they should check the information supplied with the medicine or contact a pharmacist for advice.

Records for disposing of medicines

Evidence suggests that when a medicine is being disposed of, specific records, either paper-based or electronic, should be made as soon as possible. The GDG agreed that these records should include as a minimum:

- the date of disposal
- the name

- strength and form of the medicine
- the quantity being disposed of
- the reason for disposal
- the name of the care home staff making the record.

Records should be made in the resident's care record when medicines are disposed of by care home staff on behalf of the residents. When the medicines are separated for disposal on behalf of the resident, the waste transfer note (a document that must be completed when waste is transferred from one party to another), when required, would need to include the quantity, name, strength and form only. The GDG agreed that when disposing of medicines, the care home provider could consider the good practice points outlined in box 9.

Box 9 Good practice points to consider when disposing of medicines

- Use the medicines administration record to record the quantity of any remaining medicines at the end of the 28-day cycle that can be carried forward for use in the next month, if it is still prescribed.
- Record details of medicines waiting to be disposed of and store them securely in a container that is tamper-proof when sealed and in a locked cupboard, until they are collected or taken to the pharmacy.
- For medicines that have been discontinued or are no longer needed, care home staff should highlight this to the supplying pharmacy so that the item is not printed on the next 28-day medicines administration record. The remaining quantity should be disposed of according to the care home's disposal process.

Disposing of controlled drugs

The GDG discussed and agreed that the NPC's [A guide to good practice in the management of controlled drugs in primary care \(England\)](#) can be used to highlight key points to consider when disposing of controlled drugs in care homes. These have been summarised in table 4:

Table 4 Disposal requirements for controlled drugs in care homes

	Arrangements	Records
Non-nursing care home	<ul style="list-style-type: none"> Controlled drugs should be returned to the relevant pharmacist or dispensing doctor at the earliest opportunity for appropriate destruction. 	<ul style="list-style-type: none"> Care homes should record the forms and quantities of controlled drugs they are returning, and the pharmacist/dispensing doctor should sign for them on receipt. If pharmacy staff collect the controlled drugs, they should sign for them in the controlled drugs register at the time of collection. Relevant details of any such transfer for disposal should be entered into the controlled drugs register and signed by a trained and competent member of staff, returning the drug.
Nursing care home	<ul style="list-style-type: none"> The care home will need to make arrangements for the collection of waste medication with a Waste Management Regulations licensed waste disposal company. Controlled drugs must be denatured before being handed to the waste disposal company, for example in specially designed denaturing kits. A T28 exemption will be needed in order to comply with the legislation that is overseen by the Environment Agency. 	<ul style="list-style-type: none"> For 'stock'¹ controlled drugs, a registered nurse and an authorised witness for destruction should sign the controlled drugs register. For controlled drugs supplied to individual residents, a registered nurse and a suitably trained witness should sign the controlled drugs register. A record of the waste transfer note needs to be made by the appropriate nursing care home staff.
<p>¹ 'Stock medicines are medicines that have been purchased by a care home registered to provide nursing care, for use in named residents against a written prescription that has been signed by the prescriber before the medicine is given.</p>		

The GDG concluded that good practice is represented by having records for medicines (including controlled drugs) that have been disposed of and by considering additional good practice points in the process.

Recommendations

Recommendation 1.12.1

Providers of adult care homes must comply with the [Misuse of Drugs Act 1971](#) and associated regulations when storing controlled drugs. Providers of children's homes should have robust processes for storing controlled drugs.

Recommendation 1.12.2

Care home providers should include the following information in their process for storing medicines safely:

- how and where medicines are stored, including medicines supplied in monitored dosage systems, medicines to be taken and looked after by residents themselves (see recommendations 1.13.2, 1.13.6), controlled drugs, medicines to be stored in the refrigerator, skin creams, oral nutritional supplements and appliances
- secure storage with only authorised care home staff having access
- the temperatures for storing medicines and how the storage conditions should be monitored.

Recommendation 1.12.3

Care home providers should assess each resident's needs for storing their medicines and should provide storage that meets the resident's needs, choices, risk assessment and type of medicines system they are using.

Recommendation 1.12.4

Before disposing of a medicine that is still being prescribed for a resident, care home staff (registered nurses and social care practitioners working in care homes) should find out if it is still within its expiry date and if it is still within its shelf-life if it has been opened.

Recommendation 1.12.5

When disposing of medicines and removing medicines classed as clinical waste, care home providers should have a process for the prompt disposal of:

- medicines that exceed requirements

- unwanted medicines (including medicines of any resident who has died)
- expired medicines (including controlled drugs).

During the COVID-19 pandemic see the [recommendations on managing medicines in the NICE COVID-19 rapid guideline on managing symptoms in the community](#). [amended 1 May 2020]

Recommendation 1.12.6

Care home providers should keep records of medicines (including controlled drugs) that have been disposed of, or are waiting for disposal. Medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy.

3.13 *Helping residents to look after and take their medicines themselves (self-administration)*

Self-administration of medicines is when a resident stores, or stores and administers, their own medicines themselves.

Outcome 9 of the [Essential standards of quality and safety](#) covers self-administration. It states care home providers should be 'supporting and reminding residents to self-administer their medicines independently where they are able to do so by minimising the risk of incorrect administration'.

The [Children's Homes Regulations 2001](#) requires the care home provider to make suitable arrangements for safe administration of medicines.

The GDG was aware from published evidence (Hughes, 2009) that having overall control of medicines in nursing homes was important to staff and health professionals. Staff cited concerns over safety, quality and continuity of care for their need to maintain control of prescribing and/or administration of medicines. Evidence demonstrates that this is very rarely challenged by residents and that residents reported that they had little involvement in prescribing decisions or self-administration of their medicines. It was recognised by health professionals that self-administration of residents'

medicines might return independence and personal control to them, and there was general support for them to do so. Staff, however, felt that difficulties would arise in the recording of medicines, polypharmacy and medication review (see [section 3.8](#)). Furthermore, it was felt that running 2 systems (self-administration and supervised administration) would be difficult in practice.

From the evidence provided, the GDG concluded that care home staff should presume that a resident is able to self-administer their medicines when they first move into a care home unless indicated otherwise after a documented individual risk assessment. To determine whether a resident may be at risk to themselves or others if they were to self-administer medicines, a risk assessment should be carried out and the outcomes recorded in the resident's care record.

The GDG found evidence of variation in criteria used for risk assessment across care homes. Some evidence suggests that validated self-administration tools used in hospitals could be adapted for use in care homes supporting self-administration. The risk assessment should consider the differing levels of administration support a resident may need. For example, the resident may be able to self-administer their oral medicines, but not any creams or ointment, or they may be able to use their inhalers, but may require assistance with oral medicines. The GDG agreed that care home providers should support and remind residents to self-administer and this must be taken into consideration when assessing the 'competency' of a resident to self-administer.

The GDG discussed and agreed that risk assessment should use a person-centred approach to help determine the level of support needed to allow the residents to continue to self-administer their own medicines. The risk assessment may include:

- resident choice
- whether self-administration may pose harm to the resident or to other residents

- the competency of the resident to self-administer, such as whether the resident has mental capacity and dexterity to administer their medicines appropriately
- requirements for ongoing or reassessment of a resident's competency to self-administer their medicines
- storage requirements for self-administered medicines
- the responsibilities of the care home staff, which should be recorded in the resident's care record
- an appropriate review period for the risk assessment, based on the individual resident's needs
whether an adjustment to the resident's medicines will enable them to self-administer.

Who should undertake risk assessment?

Evidence outlining the most appropriate person to undertake the risk assessment for self-administration was conflicting. The GDG agreed that when assessing whether a resident can safely self-administer their medicines, joint working may be needed depending on the needs of the resident. This could be coordinated by the care home manager who could help to determine who should be involved in the risk assessment. The risk assessment should involve the resident (and their family members or carers if the resident wishes) and trained and competent care home staff. It may also involve other key practitioners such as the GP, pharmacist, and/or other health and social care practitioners as appropriate, although who to involve should be determined on an individual case-by-case basis. The process for assessing whether a resident can self-administer some or all of their medicines, and the requirements for ongoing self-administration or reassessment of a resident's abilities to self-administer their medicines, should be recorded in the care home medicines policy (see [section 3.1](#)).

During its discussions, the GDG recognised that records needed for self-administration depend on the support the resident needs to self-administer. The CQC's [Essential standards of quality and safety](#) outlines what care home providers should do to comply with regulations 13 and 20 of the [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2012](#)

in relation to self-administration of medicines and records. The GDG concluded that adult care home providers must ensure records are made of any medicine supplied to the resident for self-administration or when the resident has been reminded to take the medicine as part of the plan of care.

The Children's Home Regulations 2001, [Regulation 21](#), requires the children's care home provider to ensure a written record is kept of the administration of medicine to any child. However, if safely self-administered by the child, then a written record is not required. Registered nurses providing care should also refer to the NMC's [Standards for medicines management](#) (2010) for any additional information regarding records for self-administration for children.

The GDG discussed this in the context of children's care homes and concluded that the children's care home provider must ensure records are made for residents living in children's homes who are able to self-administer their own medicines. When a resident is self-administering, the medicines administration record should be used for recording:

- that the resident is self-administering their medicines
- whether the resident requires:
 - monitoring to check that they are taking or using their medicines as intended, or
 - assessment of ability (either by direct observation or by questioning the resident)
- who has recorded the self-administration.

Evidence gathered suggests that care home providers should make provisions for their residents who wish to self-administer their medicine and store their medicines in their own room. The GDG agreed that the designated place for the storage of self-administered medicines should be secure (in a locked cupboard or drawer) and that the resident should understand that the medicines have to be kept safe and out of reach from other residents. Additionally, arrangements should be made to allow residents to access their medicines that need special storage requirements (see [section 3.12](#)).

The GDG concluded that the storage of medicines for self-administration should be based on an individual risk assessment and, if considered appropriate, medicines may be stored in the resident's room in a lockable cupboard or drawer.

Controlled drugs

Residents who can self-administer their own medicines can self-administer controlled drugs. Evidence suggests that residents who self-administer controlled drugs do not need to use a controlled drugs cabinet to store them in, but should store them in their personal lockable non-portable cupboard or drawer in the care home. [Safe custody regulations](#) apply when the care home is looking after a resident's controlled drugs or when the care home is responsible for ordering a resident's controlled drugs. Additionally some care homes have a local policy that controlled drugs may only be administered by specifically trained care home staff.

[A guide to good practice in the management of controlled drugs in primary care \(England\)](#) (NPC 2010) suggests a record of a resident's own controlled drugs should be kept, in addition to the records maintained on the medicines administration record. When the resident is wholly independent and is responsible for requesting a prescription and collecting the controlled drugs personally from the community pharmacy, there is no requirement to keep a record in the controlled drug register. If the resident does not arrange the supply and collection of controlled drugs but relies on the care home staff to do so, there should be clear records made in the controlled drugs register, including:

- receipt from the supplying pharmacy
- supply to the resident
- any subsequent disposal of unwanted controlled drugs (see [section 3.12](#)).

[A guide to good practice in the management of controlled drugs in primary care \(England\)](#) (NPC 2010) also suggests that the controlled drugs register should contain separate pages for each resident's medicines and should have a column for recording running balances in order to maintain effective stock

control and identify any discrepancies. For residents who are self-administering, each individual dose taken does not need to be recorded.

The GDG concluded that processes for managing a resident's self-administration of controlled drugs should be recorded in the care home medicines policy (see [section 3.1](#)) and should include:

- risk assessment
- obtaining or ordering (to request a prescription from the prescriber for a named person)
- supply
- storage
- records if prompted, or supplied controlled drugs
- disposal (including when residents give the care home unwanted controlled drugs).

Recommendations

Recommendation 1.13.1

Care home staff (registered nurses and social care practitioners working in care homes) should assume that a resident can take and look after their medicines themselves (self-administer) unless a risk assessment has indicated otherwise (see recommendation 1.13.2).

Recommendation 1.13.2

Health and social care practitioners should carry out an individual risk assessment to find out how much support a resident needs to carry on taking and looking after their medicines themselves (self-administration).

Risk assessment should consider:

- resident choice
- if self-administration will be a risk to the resident or to other residents
- if the resident can take the correct dose of their own medicines at the right time and in the right way (for example, do they have the mental capacity and manual dexterity for self-administration?)
- how often the assessment will need to be repeated based upon individual resident need
- how the medicines will be stored
- the responsibilities of the care home staff, which should be written in the resident's care plan.

Recommendation 1.13.3

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

Recommendation 1.13.4

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

Recommendation 1.13.5

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

- that the resident is looking after and taking their medicines themselves (self-administering)
- whether any monitoring is needed (for example, to assess ability to self-administer or willingness to take the medicines as prescribed [adherence])
- that medicine has been taken as prescribed (either by seeing this directly or by asking the resident)
- who has recorded that the medicine has been taken.

Recommendation 1.13.6

Care home providers should ensure that medicines for self-administration are stored as identified in the resident's risk assessment (for example, in a lockable cupboard or drawer in a resident's room). Residents should be able to get any medicines that need special storage at a time when they need to take or use them (see recommendations 1.12.1, 1.12.2 and 1.12.3).

Recommendation 1.13.7

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

- individual risk assessment
- obtaining or ordering controlled drugs
- supplying controlled drugs
- storing controlled drugs

- recording supply of controlled drugs to residents
- reminding residents to take their medicines (including controlled drugs)
- disposal of unwanted controlled drugs.

3.14 Care home staff administering medicines to residents

The administration of medicines is a fundamental task in care homes and widely undertaken by nurses and trained care home staff.

The [CHUMS](#) (2009) found that care home staff may spend as much as 40-50% of their time on medicine-related activities, with errors occurring on 8.4% of observed medicine administration events (see [section 3.5](#)). The study highlights the importance of ensuring robust processes are in place for administration of medicines in care homes.

For the purpose of this guideline, the GDG agreed to use the [Medicines Act 1968 \(section 130\)](#) definition of medicines administration ‘To give a medicine either by introduction into the body, whether orally, by injection or by introduction into the body in any other way, or by external application, whether by direct contact with the body or not.’

Legislation for medicines administration is included in regulation 13 of the [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2010](#) for care homes and regulation 21 of [The Children’s Homes Regulations 2001](#) for children’s homes (see [appendix C](#)). The care home provider is responsible for ensuring adequate systems for medicines administration are in place. These should be recorded in the care home medicines policy (see [section 3.1](#)).

Evidence suggests that processes for administration of medicines should adopt a person-centred approach by engaging with the resident or their advocate in decisions about their medicines. When this happens, medicines may be more likely to be taken as prescribed. The GDG was aware that residents may be prompted to take their medicines or given medicines to take by care home staff, which does not fall into the above definition of

administration, but supports the resident in enabling them to administer their medicines themselves (see [section 3.13](#)).

In addition the [Nursing and Midwifery Council \(NMC\)](#) and the Royal Pharmaceutical Society have produced standards and guidance on the use of medicines in care homes, for nurses, pharmacists and social care practitioners respectively, to support compliance with legislation.

Administration of medicines

When registered nurses delegate the administration of medicines to care home staff, the registered nurse remains responsible and accountable for the appropriateness of the delegation (in line with standard 17 of the [NMC standards for medicines management](#)). The nurse must ensure the competence of the care home staff and that delegation does not compromise resident care (see [section 3.17](#)). The GDG recognised that care home staff should be trained and competent in administering medicines to residents (see [section 3.17](#)).

Evidence suggests that current policies for administration of medicines are not person-centred and are based on schedules and tasks. The GDG found evidence that when written processes are in place, this has led to good practice in the administration of medicines. When no written processes are in place, care home providers often did not meet medicines management standards. The GDG agreed that processes for administration of medicines should be focused on the individual needs of residents. Effective medicines administration processes support the care home in meeting medicines management standards.

Therefore, the GDG concluded that the following should be considered in a medicines administration process:

- administration techniques for specific medicines, such as patches, creams, inhalers, eye drops, liquids
- correct use of infusion and injection devices, for example syringe drivers

- details of timely documentation to be made once the administration of each medicine is complete
- the 6 R's of administration:
 - right resident
 - right medicine
 - right route
 - right dose
 - right time
 - residents' right to refuse
- administration of medicines during meal times
- administration of medicines if the resident is asleep
- using the correct equipment to administer medicines depending on the formulation, for example use of oral syringes for small doses of liquid medicines
- how to record and report administration errors and adverse effects
- how to record and report a resident's refusal of a medicine(s)
- how to manage medicines that are prescribed 'when required'
- how to manage medicines when the resident is temporarily absent from the care home, for example when visiting relatives
- monitoring and evaluating the effects of administered medicines, for example, adverse effects) (see [section 3.17](#)).

Administration of 'when required' medicines

The GDG agreed that care home providers should have a process for handling and administering 'when required' medicines. This should also take into account how care home staff identify when the resident needs their 'when required' medicine, based on their capacity and information in their care plan. In its review of the evidence, the GDG agreed that the process should include the following:

- the reasons for administering the 'when required' medicine
- how much to give if a variable dose has been prescribed
- the minimum time between doses if the required outcome has not occurred after the first dose

- details of when to clarify instructions with the prescriber if there is any confusion or ambiguity about what medicines or doses are to be given
- offering the 'when required' medicine when needed by the resident, not just during the medication administration round
- the intended outcome of treatment
- recording 'when required' medicines in the resident's care plan.

Evidence gathered suggests that 'when required' medicines should only be issued in their original packs to allow for checking expiry dates. The GDG concluded that 'when required' medicines should be kept within their original packaging and requests should not be made to supply them in a monitored dosage system.

Timings for administering medicines

Evidence suggests that medication errors are more prevalent during the morning administration rounds as this is a busy time. The GDG discussed and concluded that for those medicines that do not need to be administered in the morning, the resident, care home staff, prescriber and pharmacist can agree to administer these medicines at a time convenient for the resident, to avoid administering medicines during busy times.

The GDG was aware that care home staff must not prepare medicines in advance for administration. This is known as 'potting up' and goes against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 regulation 13.

Disruption of medicines administration

From the evidence provided, the GDG found that disruptions during administration of medicines to residents contributed to administration errors. This appears to be most common during the morning medicines administration round when there are few members of care home staff responsible for administering. Consequences of disruptions may include:

- medicines trolleys being left unattended and unlocked
- some residents not receiving or having delays in receiving their medicines

- administration errors
- medicines being misplaced or lost
- inadequate checking that administration has been completed for each resident.

The GDG considered possible interventions that could be used to avoid disruptions during the medicines administration round. These interventions are listed in [box 10](#). The GDG discussed and agreed that avoiding disruption during the medicines administration round needs an effective team approach and culture change. No single intervention will be suitable for all care home providers and an individual approach will be needed to establish what works well for individual care homes in reducing disruptions.

Box 10 Possible interventions to avoid disruption to medicines administration rounds

- Address staff deployment at the time of medicines administration rounds to ensure care home staff administering medicines have sufficient time to engage with the resident and check the medicine has been taken correctly.
- Discuss changing administration times with the prescriber and pharmacist, for example from morning dosing to lunchtime dosing, if clinically appropriate.
- Avoid planning care home staff breaks during times of medicines administration.
- Have strategies in place to manage interruptions, such as returning non-urgent phone calls after the medicines administration round.

The GDG concluded that care home providers should review their medicines administration rounds to consider interventions that may reduce disruptions.

Administration using medicines supply systems

The [Royal Pharmaceutical Society \(2013\)](#) has produced guidance for health and social care professionals on the better use of multi-compartment compliance aids.

Evidence suggests that the use of monitored dosage systems is seen as an automated process to make administration easier, with little consideration about what the medicines are prescribed for. The [CHUMS](#) (2009) found that in those care homes using monitored dosage systems included within the study, 40% of doses for residents could not be handled using monitored dosage systems.

The GDG were aware of evidence that suggests that care homes having more than one system in place to administer medicines can contribute to administration errors because of lack of training and procedures and poor storage facilities when using monitored dosage system and original pack medicines (see [appendix D](#)). However, the GDG agreed that this needs to be balanced against the needs of the resident in choosing a system that is appropriate to their needs and wishes (see [section 3.11](#)).

The GDG was aware that regulation 22 of the [Health and Social Care Act 2008](#) requires that care home staff must be trained and competent to use systems adopted in the care home for administering medicines. Regulation 26 of the [Children's Homes Regulations 2001](#) requires that care home staff must have the qualifications, skills and experience (see [section 3.17](#)) necessary to carry out their duties.

Legislation for records management of medicines

Care home providers have a legal duty under the [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2010](#) (regulations 13 and 20) to maintain accurate records of care given to residents, and a further requirement from the CQC under the [Essential standards of quality and safety](#) (outcome 9B) to keep records about the administration and non-administration of residents' medicines. Similarly children's homes have a requirement to ensure 'There is a written record of all medication, treatment and first aid given to children during their placement' (Standard 6.15 of the [Children's Homes: National Minimum Standards](#)).

The NMC's [Standards for medicines management](#) (2010) sets out a number of standards for registered nurses. Standard 8 (administration) states that: 'as

a registrant, in exercising your professional accountability in the best interests of your patients: you must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible...'. Additionally, 'where medication is not given, the reason for not doing so must be recorded'.

Legislation, regulation (both of care homes and of health professionals) and evidence from practice shows that care home staff have a responsibility to make records of residents' medicines that have been ordered, received, administered, refused, disposed of or returned to a pharmacy.

The GDG concluded that in line with the general principles for individual responsibility, health and social care practitioners should ensure that paper-based or electronic records relating to medicines are:

- legible
- signed
- dated and timed correctly
- clear and accurate
- factual
- completed as soon as possible after administration
- avoiding jargon or abbreviations
- easily understood by the resident, their family member or carer.

Medicines administration records

Medicines administration records are for recording the administration and non-administration of medicines in care homes (see [section 3.11](#)).

Evidence reviewed suggests that the care home provider needs to decide how to keep records of administration of medicines. Records should be complete, legible, up-to-date, non-erasable, dated and signed to show who has made the record (see section [3.4](#) and [3.11](#))

Recording of medicines administration in a care home is different to that in a hospital. In a social care setting, a medicine is 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 care home provider must record the administration or non-administration of medicines; often this is called the medicines administration record. These are often produced by the supplying pharmacy, however sometimes they are produced by the care home provider. The medicines administration record is only a record of administration and does not provide authority to administer the medicine. This process is different from that in hospitals, where a similar process may be considered to be transcribing.

The GDG discussed and concluded that whenever possible medicines administration records should be produced by the supplying pharmacy (see [section 3.11](#)). Only in exceptional circumstances should medicines administration records be hand-written by care home staff. The GDG discussed and concluded that care home providers should ensure that the medicines administration record includes:

- the resident's name, date of birth and weight (if under 16 years or where appropriate, for example frail older residents)
- which medicines are prescribed for the resident, including:
 - strength
 - route of administration and formulation
 - dose and frequency
- special instructions (such as to be taken before food, with food, after food or whether the medicine could be crushed)
- allergies or intolerances to medicines or their ingredients.

There should be a process in place for the production of medicines administration records by care home staff (see [section 3.11](#)).

The GDG further concluded that it would be good practice for any newly hand-written medicines administration record to be produced only by a trained and competent member of care home staff with designated responsibility for medicines. This new hand-written medicines administration record should be checked by another trained and competent member of staff who also has

designated responsibility for medicines in the care home before first use (see [section 3.11](#)).

The GDG heard oral evidence suggesting that medicines administration records vary in the information recorded for each medicine. The GDG agreed that including as much supportive information as possible on the medicines administration record, particularly in relation to medicines administration, represented good practice. See box 11 for examples of additional supportive information.

Box 11 Examples of additional supportive information to include on the medicines administration record

- Administration of medicines at specific times of day, for example, for time-critical medicines (for example some medicines used in the treatment of Parkinson's disease).
- Administration of medicines on specific days or dates, for example, medicines for weekly or monthly administration.
- Accurate description of medicines if supplied in a monitored dosage system.
- Maximum doses of medicines prescribed 'when required' or 'as directed', including indication for use.
- Special handling requirements of medicines, for example, cytotoxic medicines.
- Duration of treatment, if appropriate.

The GDG concluded that the care home provider should ensure that all information included on the medicines administration record is up-to-date and recorded accurately, with support from the prescriber and the supplying pharmacy if needed.

Evidence reviewed suggests that care home staff do not always record the administration of medicines at the time the resident takes them, and some rely on memory to record the administration. The GDG agreed that records of administration must be made as soon as practically possible, after the care

home staff have administered the medicine (or has supplied or reminded the resident to self-administer their own medicines, see [section 3.13](#)).

Sometimes a resident may refuse their medicines. When a resident gives valid and informed refusal for a medicine, the care home staff should detail the circumstances and reasons for refusal (when a resident is willing to give a reason) on the appropriate medicines administration record. The prescriber should be notified (if the resident agrees) as outlined in the resident's care plan. Details of any discussion should be recorded in the care plan. The GDG also agreed that partial administration of a medicine (for example if the resident were to spit out the medicine following oral administration) should be recorded. The GDG discussed and concluded that good practice points may be considered when making records of medicines administration (box 12).

Box 12 Good practice points to consider for recording medicines administration

- Care home staff to record administration of the medicine once the resident has taken their prescribed medicine(s).
- Ensure the administration process is fully completed for each resident, before moving on to the next resident.
- Include the date on the relevant record.
- Recognise that medication errors are less likely to occur if 1 member of staff records administration on the medicines administration record, rather than 2 staff recording the information.
- Record 'when required' medicines only when they have been administered, noting the dose administered and the quantity left to ensure adequate supplies and reduced waste.
- Record when and why medicines have not been administered.
- Correct written recording errors with a single line through the error followed by the correction and an accompanying signature, date and time. Use of correction fluid is not considered good practice.

Oral and written evidence provided to the GDG demonstrates that there may be more than one record of administration of medicines, particularly when

health professionals not employed by the care home, such as district nurses, visit the care home to administer a resident's medicine(s).

There is evidence suggesting that recording administration of some medicines on the medicines administration record may not be considered appropriate. For example medicines with variable doses, such as warfarin or insulin, oral nutritional supplements, dressings, depot injections or emollients (skin moisturisers), for which separate records may be kept.

The GDG concluded that health professionals not employed by the care home, who administer medicines to residents, should provide access to their record of administration if required by the care home staff. In addition, care home providers should make arrangements to keep a record of the health professional's administration on the resident's medicines administration record. The health professional should also consider undertaking the visit jointly with the care home staff responsible for administering the resident's medicines.

The GDG also concluded that it would be good practice to make an entry on the relevant medicines administration record when a medicine has a separate record for recording administration as a cross-reference (for example, 'see warfarin administration record').

Allergies

The GDG found evidence of variation in the recording of allergies and intolerances to medicines on the medicines administration record. The GDG discussed and concluded that the care home provider should ensure allergies and any intolerances to medicines have been identified by contacting the resident's GP. This information should be accurately recorded on the medicines administration record and shared with the team(s) providing care to the resident. This may also include recording allergies or intolerance to ingredients in medicines.

Controlled drugs

In accordance with CQC regulation, systems should be in place to ensure care home providers comply with the requirements of the [Misuse of Drugs Act 1971](#), and their associated regulations and the [Safer Management of Controlled Drugs Regulations 2006](#) when administering controlled drugs in care homes.

Evidence received by the GDG suggests that if residents in a nursing care home are not able to self-administer their controlled drugs, a medical practitioner or a registered nurse should administer the controlled drugs. The NMC standards for medicines management (standard 8) recommend that registered nurses obtain a secondary signatory from a witness who has been assessed as competent in relation to controlled drugs. In non-nursing care homes, controlled drugs should be administered by appropriately trained and competent care home staff and this should be witnessed by another appropriately trained care home staff member.

The GDG discussed and concluded that good practice is represented by recording the administration of controlled drugs by care home staff on the medicines administration record and, in line with legislation, in the controlled drugs register. The care home staff administering the controlled drug and the appropriately trained witness should record their signatures in the controlled drugs register. The staff member administering the controlled drug should sign the medicines administration record (no signature is required on the medicines administration record by the appropriately trained witness).

Temporary absence from the care home

Residents may be absent from the care home for a period of time (for example when staying with relatives or friends). The GDG found examples from practice of how a resident's temporary absence from the care home should take into account the need to administer medicines and include a record of the resident's temporary absence.

The GDG concluded that when a resident leaves a care home temporarily, the care home provider should have a process in place to ensure the medicines

needed are sent with the resident, including a list of the current medicines and a copy of the medicines administration record; this process should be recorded in the care home medicines policy (see [section 3.1](#)).

The GDG recognised the importance of care home staff ensuring that the resident, or the person who will be caring for the resident during their absence, understands what medicines the resident is currently taking.

Care home staff should give the resident and their family members or carers, as appropriate, clear directions and advice on the administration of the resident's medicines (when this is in accordance with the resident's ability and wishes). This should include the time of the last dose and next dose for each medicine to be administered during the absence.

Some evidence suggests that the care home provider should liaise with their supplying pharmacy for help and advice on managing the residents' medicines during temporary absence. Generally, medicines for administration during temporary absence should be maintained in the packaging supplied with the medicine (original packs or monitored dosage system). However, a separate dispensed container of medicines specific to the time of day may be needed if a resident takes regular leave, for example lunchtime medicines for a resident attending a training centre or school, or a separate supply of medicines for the full period of a holiday. The GDG agreed that if the resident regularly has temporary absences, there is no reason why their medicines should not go with them as the medicines are the resident's property.

The GDG concluded that the care home provider should have a process for ensuring that residents who are going on temporary absence from the home have the medicines that they need. Details of the medicine supply should be recorded in the resident's care plan. Information should be provided to the resident and their family members or carers (as appropriate) when taking temporary absence, including:

- the medicines taken with the resident
- clear directions and advice on administration of medicines

- time of the last and next dose of each medicine to be administered during the absence
- a point of contact for queries regarding the resident's medicine, such as the care home, supplying pharmacy or prescriber.

In addition, the GDG concluded that the care home provider should consider liaising with the supplying pharmacy for advice on managing residents' medicines when they are temporarily away from the care home.

Information about medicines

In review of the information presented, the GDG found that care home staff may use a variety of resources to find information on medicines, including the prescriber or pharmacist. The GDG agreed that care home staff should have access to appropriate medicines information and resources such as up-to-date patient information leaflets. Health professionals working in care homes should use up-to-date medicines information. Free digital access to an up-to-date [British National Formulary](#) (BNF) and [BNF for children](#) (BNFC) is available through the [NICE evidence portal](#). The GDG was aware that there would be a small cost implication to care homes if they wanted to purchase up-to-date copies of the BNF in print format which is published twice a year.

The GDG discussed and concluded that health and social care practitioners should only use the best available evidence, such as those outlined in box 13, to find up-to-date information about medicines.

Box 13 UK-based websites and resources for information on medicines

Health and social care practitioners could use the following:

- [Medicines and Healthcare Products Regulatory Agency](#)
- [NHS choices](#)
- [NICE Evidence](#)
- [Patient.co.uk](#)
- The patient information leaflet supplied with the medicine

Additionally health professionals could use the following:

- [British National Formulary \(BNF\)](#)
- [British National Formulary for Children \(BNFC\)](#)

- [Clinical Knowledge Summaries](#)
- [Electronic Medicines Compendium](#)

Recommendations

Recommendation 1.14.1

Care home providers should consider including the following in a medicines administration process:

- the 6 R's of administration:
 - right resident
 - right medicine
 - right route
 - right dose
 - right time
 - resident's right to refuse
- making a record of the administration as soon as possible
- what to do if the resident is having a meal
- what to do if the resident is asleep
- how to administer specific medicines such as patches, creams, inhalers, eye drops and liquids
- using the correct equipment depending on the formulation (for example, using oral syringes for small doses of liquid medicines)
- how to record and report administration errors and reactions to medicines
- how to record and report a resident's refusal to take a medicine(s)
- how to manage medicines that are prescribed 'when required'
- how to manage medicines when the resident is away from the care home for a short time (for example, visiting relatives)
- monitoring and evaluating the effects of medicines, including reactions to medicines.

Care homes with nursing care should also include the correct use of infusion and injection devices (for example, syringe drivers).

Recommendation 1.14.2

Care home providers should ensure that a process for administering 'when required' medicines is included in the care home medicines policy (see recommendation 1.1.2). The following information should be included:

- the reasons for giving the 'when required' medicine

- how much to give if a variable dose has been prescribed
- what the medicine is expected to do
- the minimum time between doses if the first dose has not worked
- offering the medicine when needed and not just during 'medication rounds'
- when to check with the prescriber any confusion about which medicines or doses are to be given
- recording 'when required' medicines in the resident's care plan.

Recommendation 1.14.3

Care home staff (registered nurses and social care practitioners working in care homes) should ensure that 'when required' medicines are kept in their original packaging.

Recommendation 1.14.4

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

Recommendation 1.14.5

Care home providers should consider ways of avoiding disruptions during the medicines administration round, such as:

- having more trained and skilled care home staff on duty at that time
- reviewing the times for administering medicines (for example, administering once daily medicines at lunchtime rather than in the morning, if the health professional prescribing the medicine agrees that this is clinically appropriate)
- avoiding planned staff breaks during times of medicines administration
- ensuring fewer distractions for care home staff administering medicines.

Recommendation 1.14.6

Care home staff must have the training and skills to use system(s) adopted in the care home for administering medicines in line with regulation 22 of the

[Health and Social Care Act 2008](#) for adult care homes and regulation 26 of the [Children's Homes Regulations 2001](#) for children's care homes.

Recommendation 1.14.7

Paper-based or electronic medicines administration records should:

- be legible
- be signed by the care home staff
- be clear and accurate
- be factual
- have the correct date and time
- be completed as soon as possible after administration
- avoid jargon and abbreviations
- be easily understood by the resident, their family member or carer.

Recommendation 1.14.8

Care home providers should ensure that medicines administration records (paper-based or electronic) include:

- the full name, date of birth and weight (if under 16 years or where appropriate, for example, frail older residents) of the resident
- details of any medicines the resident is taking, including the name of the medicine and its strength, form, dose, how often it is given and where it is given (route of administration)
- known allergies and reactions to medicines or their ingredients, and the type of reaction experienced
- when the medicine should be reviewed or monitored (as appropriate)
- any support the resident may need to carry on taking the medicine (adherence support)
- any special instructions about how the medicine should be taken (such as before, with or after food).

See also recommendation 1.11.3.

Recommendation 1.14.9

Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used.

Recommendation 1.14.10

Care home providers should ensure that all information included on the medicines administration record is up-to-date and accurate. They may need support from the health professional prescribing the medicines and the supplying pharmacy to do this.

Recommendation 1.14.11

Care home staff must record medicines administration, including the date and time, on the relevant medicines administration record, as soon as possible and ensure that they:

- make the record only when the resident has taken their prescribed medicine
- complete the administration before moving on to the next resident
- recognise that mistakes are less likely if 1 member of staff records administration on the medicines administration record rather than 2 staff recording
- record 'when required' medicines only when they have been given, noting the dose given and the amount left (where possible), to make sure that there is enough in stock and to reduce waste
- record when and why medicines have not been given
- correct written mistakes with a single line through the mistake followed by the correction and a signature, date and time (correction fluid should not be used).

Recommendation 1.14.12

Health professionals who are visiting the care home to administer a medicine(s) to residents should make their record of administration available to care home staff, if asked by the care home. The health professional should also consider seeing the resident with the care home staff responsible for administering medicines to the resident.

Recommendation 1.14.13

Care home staff should keep a record of medicines administered by visiting health professionals on the resident's medicines administration record.

Recommendation 1.14.14

Care home staff responsible for administering medicines should add a cross-reference (for example, 'see warfarin administration record') to the resident's medicines administration record when a medicine has a separate administration record.

Recommendation 1.14.15

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

Recommendation 1.14.16

Care home staff should make appropriate records of controlled drugs that have been administered to residents. The care home staff responsible for administering the controlled drug and a trained witness should sign the controlled drugs register. The staff member administering the controlled drug should also sign the medicines administration record.

Recommendation 1.14.17

Care home providers should ensure that the following information is given to the resident and/or their family members or carers when the resident is temporarily away from the care home:

- the medicines taken with the resident

- clear directions and advice on how, when and how much of the medicines the resident should take
- time of the last and next dose of each medicine
- a contact for queries about the resident's medicines, such as the care home, supplying pharmacy or GP.

Recommendation 1.14.18

Care home providers should have a process to ensure that the resident has the medicines they need when they are away from the care home (for example, visiting relatives). Details of the medicines taken should be recorded in the resident's care plan.

Recommendation 1.14.19

Health and social care practitioners should be able to access reliable and up-to-date information about medicines. Resources may include the patient information leaflet supplied with the medicine and the following websites:

- [Medicines and Healthcare Products Regulatory Agency](#)
- [NHS choices](#)
- [NICE Evidence](#)
- [Patient.co.uk](#)

Health professionals may also use the:

- [British National Formulary \(BNF\)](#)
- [British National Formulary for Children \(BNFC\)](#)
- [Clinical Knowledge Summaries](#)
- [Electronic Medicines Compendium](#)

3.15 Care home staff giving medicines to a resident without their knowledge (covert administration)

'Covert administration of medicines' is the term used when medicines are administered in a disguised form without the knowledge or consent of the resident receiving them (for example, medicines added to food or drinks).

Note: the management of acute confusional states (delirium), for example confusional states caused by infection, are covered by the NICE clinical guideline on [delirium](#) (CG103), and are separate to the need for covert administration. Care home staff worried about deterioration in a resident's condition should always seek the advice of a health professional and may also consider using the symptom assessment tool developed by the [safer use of medicines in the care home](#) programme.

When covert administration of medicines is being considered, there should be a 'best interest' meeting (see [section 3.2](#)) involving people who know and understand the resident to determine whether it would be in the resident's best interest to administer their medicine(s) covertly.

The GDG concluded that in some circumstances covert administration of medicines is necessary and justified, but that it should never be used for residents who have capacity to make decisions about their medical treatment.

The GDG agreed that the care home provider should have processes in place for the covert administration of medicines and that these should be recorded in the care home medicines policy (see [section 3.1](#)). This should include using covert administration only in exceptional circumstances when such means of administration is judged necessary, in accordance with the [Mental Capacity Act 2005](#). The process should ensure that any food or drink with medicine added covertly to it cannot be consumed by other residents.

The GDG agreed that the covert administration of medicines should only take place within the context of legal and good practice frameworks to protect the resident receiving the medicines and the care home staff involved in administering the medicines.

Evidence presented to the GDG suggests that providers of care home services should consider having a wider policy, for example across organisational boundaries, on the covert administration of medicines, developed and agreed with relevant health and social care practitioners and organisations, as appropriate.

In further review of this evidence, the GDG discussed and agreed that the process for covert administration of medicines to adults should include:

- Assessing the capacity of the resident to make a decision regarding their medicines.
 - If the resident has capacity, their wishes should be respected and covert medicines not administered.
 - If the resident lacks capacity, there should be a best interests meeting which should be attended by care home staff, relevant health professionals (including the prescriber and pharmacist) and a person who can communicate the views and interests of the resident (this could be a family member, friend or independent mental capacity advocate (IMCA) depending on the resident's previously stated wishes and individual circumstances). If the resident has an attorney appointed under the Mental Capacity Act for health and welfare decisions, then this person should be present at the meeting.
- Those attending the meeting should ascertain whether the resident has made an advanced decision to refuse a particular medicine that can be used to inform decision-making.
- The best interests meeting should consider whether a formal legal procedure such as the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) is appropriate. This is outside the scope of this guideline but specialist psychiatric and legal opinion should be sought in individual circumstances, if necessary.
- If the decision of the best interests meeting is that it is in the best interests of the resident for medicines to be administered covertly, a management plan should be agreed. This would usually include:
 - medication review by the GP
 - medication review by the pharmacist to advise the care home how the medication can be covertly administered safely
 - clear documentation of the decision of the best interests meeting
 - a plan to review the need for continued covert administration of medicines on a regular basis.

- Medicines should not be administered covertly until a best interests meeting has been held. If the situation is urgent, it is acceptable for a less formal discussion to occur between the care home staff, prescriber and family or advocate in order to make an urgent decision. However, a formal meeting should be arranged as soon as possible.

Recommendations

Recommendation 1.15.1

Health and social care practitioners should not administer medicines to a resident without their knowledge (covert administration) if the resident has capacity to make decisions about their treatment and care.

Recommendation 1.15.2

Health and social care practitioners should ensure that covert administration only takes place in the context of existing legal and good practice frameworks to protect both the resident who is receiving the medicine(s) and the care home staff involved in administering the medicines.

Recommendation 1.15.3

Health and social care practitioners should ensure that the process for covert administration of medicines to adult residents in care homes includes:

- assessing mental capacity
- holding a best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests
- recording the reasons for presuming mental incapacity and the proposed management plan
- planning how medicines will be administered without the resident knowing
- regularly reviewing whether covert administration is still needed.

Recommendation 1.15.4

Commissioners and providers of care home services should consider establishing a wider policy on the covert administration of medicines across several health and social care organisations.

3.16 Care home staff giving non-prescription and over-the-counter products to residents (homely remedies)

Homely remedies are 'medicines that can be obtained without a prescription from a pharmacy or supermarket'. Examples of homely remedies include mild pain relief medicines, cough medicines, antihistamines (type of medicine that is used for treating reactions to allergies), anti-diarrhoea (type of medicine used for treating diarrhoea) preparations and laxatives (type of medicines used for treating constipation). A homely remedy may be purchased by the resident or their family or carer, or by the care home.

The NMC's [Standards for medicines management](#) states that: 'Homely remedy protocols are not prescriptions but protocols to enable administration of general sales list (GSL) and pharmacy only (P) listed medicines in settings, for example, care homes, children's homes and some educational institutions. Although they have no legal standing they are required for liability purposes'.

The GDG agreed that when a care home provider offers a resident treatment for a minor ailment with homely remedies, a process for use should be in place and this should be recorded in the care home medicines policy (see [section 3.1](#)). Useful examples of such processes can be found in the homely remedies guidance published by the [safer use of medicines in the care home](#) programme. Advice from a health professional, such as a GP or pharmacist, on the use of homely remedies should be taken for each resident in advance, or at the time of need.

The GDG discussed the evidence and concluded that a homely remedies process should include:

- name and indication of the medicinal product
- which residents may be excluded from receiving specific homely remedies (for example, paracetamol should not be given to a resident as a homely remedy if they are already prescribed paracetamol)
- dose and frequency
- maximum daily dose

- recording administration of a homely remedy, such as on the medicines administration record
- duration of use before referring the resident to a GP.

In review of its evidence the GDG agreed that it would be good practice for all care home staff using a homely remedies process (to provide homely remedies to residents) to be named in it. They should also sign to confirm that they are competent to administer the homely remedy and accountable for their actions. Care homes should regularly undertake a 'stock check' of their homely remedies and ensure that their stock is within its expiry date.

The GDG agreed that homely remedies should be kept in their original packaging together with any information supplied with the product about the medicines use. Any requirements should be included in the process for using homely remedies. The GDG concluded that in line with legislation in relation to record keeping in care homes (see [section 3.4](#)) it would be good practice for care home staff to record homely remedies in the same way as recording prescribed medicines on the medicines administration record and records to be kept in respect of purchase, use and disposal.

Recommendations

Recommendation 1.16.1

Care home providers offering non-prescription medicines or other over-the-counter-products (homely remedies) for treating minor ailments should consider having a homely remedies process, which includes the following:

- the name of the medicine or product and what it is for
- which residents should not be given certain medicines or products (for example, paracetamol should not be given as a homely remedy if a resident is already receiving prescribed paracetamol)
- the dose and frequency
- the maximum daily dose
- where any administration should be recorded, such as on the medicines administration record
- how long the medicine or product should be used before referring the resident to a GP.

Recommendation 1.16.2

Care home staff who give non-prescription medicines or other over-the-counter products (homely remedies) to residents should be named in the homely remedies process. They should sign the process to confirm they have the skills to administer the homely remedy and acknowledge that they will be accountable for their actions.

3.17 Training and skills (competency) of care home staff

Training for care home staff in both nursing and non-nursing care homes should be provided in accordance with the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 or Children's Homes Regulations 2001.

[Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2010:](#)

- [Regulation 21](#) – Requirements relating to workers

- [Regulation 22](#) – Staffing
- [Regulation 23](#) – Supporting workers

[Children’s Homes Regulations 2001:](#)

- [Regulation 25](#) – Staffing of children’s homes
- [Regulation 26](#) – Fitness of workers
- [Regulation 27](#) – Employment of staff

Outcomes 12, 13 and 14 of the CQC’s [Essential standards of quality and safety](#) and standards 17, 18 and 19 of the Department for Education’s [Children’s homes: national minimum standards](#) provide further guidance for care home providers to ensure care home staff have the right skills, qualifications, competence and knowledge to support residents.

Care home providers who provide nursing care employ registered nurses who must act according to guidance published by the [Nursing and Midwifery Council](#). Care home providers who provide non-nursing care employ care home staff to provide personal care.

Care home staff

In the review of evidence the GDG found that care home staff need to have the necessary competencies when taking responsibility for managing and administering medicines (please also see the learners workbook: safer medicines document provided by the [safety of medicines in care homes](#) programme).

The GDG was aware of variation in training, qualifications, skills and responsibilities of staff working in care homes. Evidence suggests that some care home staff have inadequate knowledge and poor training on medicines use and handling. The [CHUMS](#) (2009) states that: ‘staff numbers, skill sets, and training may be important determinants in medicines administration errors’. A learning report ‘Making care safer’ from [The Health Foundation](#) (2013) investigated the thoughts and experiences of carers and relatives on improving medication safety for residents in care homes. The report suggests that only qualified and designated care home staff should be tasked with

administering medicines. The GDG concluded that the care home provider must designate only care home staff who have undertaken the necessary training and competency assessment to administer medicines.

The GDG was aware of evidence that identified problems in some care home providers' performance and practice; allocating additional resources to training may not in itself always improve the quality of care. A follow up study published by the Commission for Social Care Inspection (predecessor organisation to CQC) in 2006 on managing medicines for residents of care homes and children's homes suggested that although care home providers often achieve the minimum standards for managing medicines, over time their standards can fall, resulting in failure to meet the minimum standards. Care home providers need to use examples of good practice, guidance and learning and development programmes available to them.

The GDG agreed that training and assessment of competency is essential to reduce variation in skills and to maintain good practice in care homes. The GDG concluded that care home providers should ensure that an internal and/or external learning and development programme is used to assess competencies for medicines administration. The programme used should meet the requirements of the regulators, the needs of the residents they care for and the training and competency needs of the care home staff they employ.

Training providers

The GDG was aware that many 'learning providers' develop training packages on the safe handling and administration of medicines for care home staff. The [safety of medicines in care homes](#) programme has published a guide for employers on training for safer medication that employers may consider useful.

The GDG heard evidence that care home providers may use an 'accredited learning' provider, which can award a qualification, or a non-accredited learning provider.

The CQC's [Essential standards of quality and safety](#) highlights [Skills for Care](#)'s advice on the training and/or subsequent qualifications needed to meet the learning outcomes relevant to the job role.

Standard 18.3 of the Department for Education's [Children's homes: national minimum standards](#) refer to the training needs for care home staff that are responsible for administering medicines in children's care homes.

The CQC's Essential standards of quality and safety states that all care home staff should 'receive a comprehensive induction that takes account of recognised standards within the sector and is relevant to their workplace and their role'. The relevant induction in this context means the Common Induction Standards (CIS). Table 5 summarises the induction standards relevant to managing medicines, depending on the type of care setting.

Table 5 Induction standards relating to medicines

Care setting	Induction standard	Details and outcome(s)
Adult social care	Common Induction Standard 8 – Health and safety in an adult social care setting	<p>‘Agreed ways of working regarding medication and health care tasks</p> <ul style="list-style-type: none"> • Understand the main points of agreed ways of working about: <ul style="list-style-type: none"> – medication agreed with your employer – healthcare tasks agreed with your employer • Be aware of tasks relating to medication and healthcare procedures that you are not allowed to carry out at the current stage of training’
Children’s and young persons’ social care	Induction Standard 3 for the children’s workforce – Understand health and safety requirements	<p>‘Medication and healthcare procedures</p> <ul style="list-style-type: none"> • Know what “healthy care” means for your work with children and young people • Know about any infection control procedures • Know about any allergies, medical conditions of the children and young people you work with, and about any medication they are on • Know how to respond, or acquire first aid or medical treatment in an emergency • Know what you are not allowed to perform, in relation to medication and healthcare procedures, at this stage in your learning’

The GDG was aware that completion of induction training is subject to a recorded assessment that identifies the areas of work that care home staff are competent to undertake at that point in time.

Standard 18.5 of the Department for Education’s [Children’s homes: national minimum standards](#) (NMS) states:

- ‘All new staff engaged from the commencement of the NMS (in April 2011) are to hold the level 3 Children & Young Peoples Workforce Diploma which must include mandatory social care units; or be working towards the Diploma within 6 months of confirmation of employment’
- ‘All existing care staff have attained a minimum level 3 qualification’.

For adult social care, the CQC requires care home staff to have undertaken the following:

- ‘training and qualifications that satisfy the learning outcomes as advised by Skills for Care
- units or qualifications relevant to the job role as advised by Skills for Care.’

The GDG was aware that some units on the [Qualifications & Credit Framework](#) (QCF) support staff towards obtaining the Health and Social Care Diploma level 2 & 3. The units required for handling and administering medicines include:

- [Administer medication to individuals and monitor the effects \(Level 3\) \(ASM 34\) applying to health care settings \(Y/501/0598\)](#)
- [Understand the administration of medication to individuals with dementia using a person-centred approach \(Level 3\) \(DEM 305\) \(K/601/9199\)](#)
- [Support use of medication in social care settings \(Level 3\) \(F/601/4056\) applying to health and social care settings.](#)

These units comply with outcome 9, management of medicines in the CQC’s [Essential standards of quality and safety](#).

The GDG also found that the unit ‘support use of medication in social care settings (F/601/4056)’ covered health and social care and the learning outcomes may be useful for identifying the training required for the role of handling and administering medicines. Box 14 summarises the learning outcomes in this unit.

Box 14 Learning outcomes in the unit F/601/4056 [Support use of medication in social care settings](#)

- | |
|--|
| <ol style="list-style-type: none">1. ‘Understand the legislative framework for the use of medication in care settings2. Know about common types of medication and their use3. Understand roles and responsibilities in the use of medication in social care settings4. Understand the techniques for administering medication |
|--|

5. Be able to receive, store and dispose of medication supplies safely
6. Know how to promote the rights of the individual when managing medication
7. Be able to support use of medication
8. Be able to record and report on use of medication'

The GDG discussed that care home staff must undertake the necessary induction training relevant to the type of care setting they are working in. The GDG agreed that in addition to the required induction training, all care home staff (including nurses as part of their continual professional development) involved with the handling and administration of medicines to residents should successfully complete the necessary training units to fulfil the requirements of the identified learning and development needs required for this role.

Training may be delivered by an external learning provider or an in-house provider, such as the care home provider or supplying pharmacist. Evidence presented to the GDG suggests that training may be required from more than one source. This may include training from:

- the care home provider, for example to deliver training on internal processes for managing medicines
- local health professionals, for example to deliver training on medicines and health needs of individual residents
- local pharmacists, for example to deliver training on how to use the relevant monitored dosage system.

The GDG found that additional training on administering subcutaneous injection, rectal or vaginal preparations, inhalers, oral syringes and other medical devices would be needed for care home staff (excluding registered nurses), if medicines need to be administered by these routes for residents who are unable to self-administer (see [section 3.13](#)).

The GDG discussed and agreed that the care home provider should identify additional training needs of the care home staff responsible for managing

medicines. For example, training on how to use monitored dosage systems may be provided by the supplying pharmacy or by local organisations, providing newsletters or guides to increase staff awareness in medicines handling and use.

Assessment of competency

The GDG was aware that a competent assessor needs to assess the knowledge, understanding and competency of the care home staff for 'accredited learning'. Non-accredited learning providers do not need to provide assessors to assess knowledge, understanding and competency. However, if there is an assessor, the standards of the assessor are determined by the learning provider. If non-accredited learning providers are used, the GDG agreed that the care home provider should establish a formal way to assess whether the care home staff are sufficiently competent before being allowed to manage or administer medicines. The competency assessment of care home staff should be documented in their training record.

The GDG discussed and agreed that care home providers may want to consider using an 'accredited learning' provider so that the care home staff who are responsible for the handling and administration of medicines can be assessed by a competent assessor.

The GDG was aware that completion of training does not necessarily mean that a person is competent to undertake the task. The GDG agreed that it is an unacceptable risk to allow care home staff who do not have the necessary competencies to manage and administer medicines.

The GDG concluded that if a member of care home staff is not assessed as being competent despite completing the required training, they must not be allowed to administer medicines to residents (see [section 3.14](#)).

Review of skills and competencies

The CQC requires care home staff in adult social care to have their qualifications, knowledge and skills reviewed on a regular basis. For children's care homes, the Department for Education's [Children's homes: national](#)

[minimum standards](#) states 'all staff have their performance individually and formally appraised at least annually and this appraisal takes into account any views of children the service is providing for'.

Therefore, the GDG concluded that good practice is represented by the care home provider undertaking an annual review of the knowledge, skills and competencies relating to the management and administration of medicines of care home staff. In the event of a medicines-related safety incident, this review may need to be sooner to identify support, learning and development needs.

Health professionals' education and training

Standard 18 of the Department for Education's [Children's homes: national minimum standards](#) and outcome 14 of the CQC's [Essential standards of quality and safety](#) were discussed by the GDG. The GDG agreed that any health professional who provides care to residents in care homes will:

- be professionally qualified and, if applicable, registered by the appropriate professional body
- be able demonstrate to professional regulators that they continue to meet professional registration requirements, if applicable
- be appropriately trained to work with specific groups of residents (for example, children, adults or residents with dementia), and
- have a good understanding of care for specific groups of residents and the policies and purpose of the care home.

The GDG concluded that health professionals working in, or providing services to, care homes should work to standards set by their professional body and ensure that they have the appropriate skills, knowledge and expertise in managing medicines safely for residents living in care homes.

Recommendations

Recommendation 1.17.1

Care home providers must ensure that designated staff administer medicines only when they have had the necessary training and are assessed as competent. Care home providers must ensure that staff who do not have the skills to administer medicines, despite completing the required training, are not allowed to administer medicines to residents.

Recommendations 1.17.2

Care home providers should set up an internal and/or external learning and development programme so that care home staff can gain the necessary skills for managing and administering medicines. The programme should meet the requirements of the regulators, the residents and the training needs of care home staff.

Recommendation 1.17.3

Care home providers should consider using an 'accredited learning' provider so that care home staff who are responsible for managing and administering medicines can be assessed by an external assessor.

Recommendation 1.17.4

Care home staff must have induction training that is relevant to the type of home they are working in (adult care homes or children's homes). All care home staff (including registered nurses as part of their continuing professional development) involved in managing and administering medicines should successfully complete any training needed to fulfil the learning and development requirements for their role.

Recommendation 1.17.5

Care home providers should ensure that all care home staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines. Care home providers should identify any other training needed by care home staff responsible for managing and administering medicines. If there is a medicines-related safety incident, this

review may need to be more frequent to identify support, learning and development needs.

Recommendation 1.17.6

Health professionals working in, or providing services to, care homes should work to standards set by their professional body and ensure that they have the appropriate skills, knowledge and expertise in the safe use of medicines for residents living in care homes.

4 How this guideline has been developed

This medicines practice guideline was developed using the methodology described in the [Integrated process statement – good practice guidance](#) and the [Interim methods guide for developing good practice guidance](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

4.1 Scoping workshop

A scoping workshop was held to inform the scope of this guideline. It included representatives from NHS service providers and commissioners, regulators and social care. See [appendix E](#) for a list of attendees.

4.2 Guideline development group

A guideline development group (GDG) was formed to work with the NICE project team. The recruitment process for both members and the group chair and vice chair followed the [NICE recruitment processes](#) for committees and groups. See [appendix F](#) for members of the GDG.

4.3 Literature search strategy

A literature search was undertaken based on the scope of the guideline (see [appendix G](#) for details of the literature search). The project team analysed the search results and sifted the results for relevance. Evidence was identified covering 7 main areas:

- involving residents
- resident safety
- communication

- medicines management systems
- medicines administration
- training and competence
- organisational governance.

4.4 Additional evidence

Additional evidence was also identified by the project team and GDG. Following appraisal of the relevant published literature, the project team conducted a gap analysis. The GDG reviewed the evidence and the project team's gap analysis.

The GDG concluded that the most appropriate method to address the gap analysis was a call for evidence from care home service providers and commissioners.

The NICE project team sent an email request to its database of people with a significant role or interest in medicines and prescribing issues. Respondents submitted evidence by completing a web-based or Word version template, and were able to supply additional information to the project team by email.

There were 135 completed submissions received from organisations across England, Wales and Northern Ireland. See [appendix H](#) for organisations that submitted written evidence.

The GDG invited 11 organisations to give further evidence orally, of which 7 were able to attend. See [appendix H](#) for organisations that provided oral evidence.

Appendix A Glossary

Definitions for terms included in this glossary are for the purposes of this guideline only.

28-day supply cycle

28-day supply of medicines

Accredited learning provider

Learning providers who provide externally validated education and training and issue credentials

Acute prescription

Prescriptions that are prescribed as a 'one-off' for a limited period of time to manage a condition that is short-lived

Administration

To give a medicine by either introduction into the body (for example, orally or by injection) **or** external application

Advance decision

A legally binding document that enables someone, aged 18 and over and while capable, to set out in advance the treatments and procedures that they do not consent to in the future when they may lack the capacity to consent to or refuse that treatment (previously called advance directive or 'living will')

Anticipatory medicines

Medicines prescribed 'just in case' to a named person to ensure there is no delay in therapy, for example for use in palliative care

Best interest decisions

If a resident lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests

Capacity

The ability to make a decision ([Mental Capacity Act 2005](#)), including:

- decisions that affect daily life (for example, when to get up, what to wear or whether to go to the doctor when feeling ill, and more serious or significant decisions)
- decisions that may have legal consequences, for them or others (for example, agreeing to have medical treatment, buying goods or making a will)

(See also lack of mental capacity)

Care home

This term is used for 'adult and children's care homes' for the purpose of this guideline

Care home staff

Includes registered nurses and social care practitioners for the purpose of this guideline

Care plan

An agreement (usually a written document) between a resident and their health and social care practitioners to help them manage their daily health and care

Care Quality Commission (CQC)

The body established under the Health and Social Care Act 2008 whose job is to ensure hospitals, care homes, dental and GP surgeries and all other care services in England provide people with safe, effective, compassionate and high-quality care

Carer

An informal or an unpaid carer

Commissioners

Those people from either health or social care who undertake commissioning

Competent assessor

People who have been trained to accredited standards to support and assess learners who are working towards qualifications

Confidence interval (CI)

The confidence interval (CI) is a way of expressing how certain we are about the findings from a study, using statistics

Covert administration

When medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink

Dispensing

Labelling from stock and/or supplying a clinically appropriate medicine to a patient, carer or client (usually against a written prescription) for self-administration or administration by another professional, and advising on safe and effective use

Dispensing doctors

Doctors who provide a dispensing service to some or all of their patients

Dispensing error

One or more deviations from an interpretable written prescription or medication order, including written modifications to the prescription made by a pharmacist following contact with the prescriber

Disposal

The safe removal and/or destruction (where legally permitted) of unwanted, damaged, out-of-date or part-used medicines from the care home

Evidence-based

Evidence-based decisions or recommendations are based on research findings that have been systematically appraised – that is, the best available evidence

Excipient

Inactive substance included with the active ingredient of a medicine

Filling

Putting medicines into the compartments of a monitored dosage system

Homely remedies

Medicines for minor ailments that can be bought without prescription, such as paracetamol for headaches or remedies for indigestion

Informed consent

A person's agreement to treatment after having received full information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead

Lack of mental capacity

The [Mental Capacity Act 2005](#) defines a lack of mental capacity as when 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'

Lasting power of attorney

The [Mental Capacity Act Code of Practice 2007](#) defines a lasting power of attorney as when one person gives another person authority to make a decision on their behalf, through a power of attorney, which is a legal document. 'Under a power of attorney, the chosen person (the attorney or donee) can make decisions that are as valid as one made by the person (the donor)'

Learning provider

Education and training organisation

Local safeguarding board

In [Department of Health](#) (2000) guidance, safeguarding adults was stated to be a multiagency responsibility and local authorities were encouraged to consider structures for interagency collaboration: Safeguarding Adults Boards. Membership of the board includes statutory and independent agencies engaged in adult social care, community organisations and groups, including people who use services and carers. The draft Care and Support Bill states that 'Each local authority must establish a Safeguarding Adults Board (an "SAB") for its area' ([Department of Health](#))

Medicines administration error

Any deviation between the medicines prescribed and that administered. This includes 'omission errors', when a dose of medicine has not been administered by the time of the next scheduled dose

Medication error

A prescribing error, dispensing error, administration error or a monitoring error

Medication review

A structured, critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste

Medicinal product

Any substance or combination of substances created to treat or prevent disease

Medicines administration record

A document on which details of all medicines given in a care setting are recorded, usually designed to show the dose given, the time when given and the identity of the person who gave it

Medicines and Healthcare products Regulatory Agency (MHRA)

'The MHRA is responsible for regulating all medicines and medical devices in the UK by ensuring they work and are acceptably safe'

Monitored dosage system

System for packing medicines, for example, by putting medicines for each time of day in separate blisters or compartments in a box

Monitoring error

When a prescribed medicine is not monitored in a way that would be considered acceptable in routine general practice. It includes tests not being carried out at the frequency required

Office for Standards in Education, Children's Services and Skills (Ofsted)

A non-ministerial government department of Her Majesty's Chief Inspector of Schools in England (HMCI) that inspects and regulates services that care for children and young people, and those providing education and skills for learners of all ages

Organisation

Unless stated otherwise, use of the term 'organisation' in this guideline includes providers (both NHS and non-NHS), including care home providers and commissioners

Out-of-hours

The time period outside of normal GP surgery hours (normally the out-of-hours period is from 6.30 pm to 8.00 am on weekdays and all day at weekends and on bank holidays)

Over-the-counter medicines

Medicines that can be bought without a prescription

Patient

In this guideline when the text refers to patients in general (including care home residents) then patient is used. However, when the guideline refers specifically to care home residents then the term resident is used

Prescribing

Authorising in writing the supply and administration of a medicine or other healthcare treatment for a named individual patient

Prescribing error

A prescribing decision or prescription-writing process that results in an unintentional, significant reduction in the probability of treatment being timely and effective, or an increase in the risk of harm

Primary care pharmacist

Pharmacists, mostly employed by primary care organisations, who are significant in the management of medicines. They focus on maximising benefit and minimising risk related to medicines and help make decisions around the use of resources allocated for medicines

Receiving medicines

Accepting medicines that have been dispensed and supplied by the pharmacy or dispensing practice

Registered manager

A person registered with the [Care Quality Commission](#) under Chapter 2 of Part 1 of the [Health and Social Care Act 2008](#) as a manager

Registered person

A person who is the service provider or registered manager ([Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2010](#))

Regulators

Organisations set up to protect the public to ensure that health and social care practice and professionals meet the standards for care and/or practice set by

the relevant regulator (for example the [Care Quality Commission](#) is the regulator for social care in England and publishes the [Essential standards of quality and safety](#))

Repeat prescription

Prescriptions that are re-prescribed without a consultation between the doctor and patient

Resident

Person living in a care home to receive personal care, who may or may not also be receiving nursing care

Resident safety incidents

Any unintended or unexpected incident that could have led to, or did lead to, harm

Risk assessment

Method used to determine a person's level of ability to manage their medicines and their suitability to administer their medicines themselves

Root cause analysis

A systematic investigation technique that seeks to understand the underlying causes and environmental context in which an incident happened

Self-administration

When a person is responsible for storing and administering their medicines to themselves

Storing (of medicines)

Safe keeping of medicines in a clean, lockable and secure facility

Supply

To provide a medicine to a patient or carer for administration

Supply system

The mechanism for delivering residents' medicines (for example, monitored dosage system or original pack)

Temporary absence

Applies to residents who take planned or unplanned leave

Transcribing

In a hospital setting the chart used is signed by the prescriber and forms the authority to administer the medicine and is independent of there being any label on the medicine to be administered. This means that when a chart needs to be rewritten and if this is carried out by another person than the prescriber then the chart should be signed at the earliest opportunity by the prescriber in order to confirm that the authority to administer continues. This would be 'transcribing'

Transfer of care

The planned movement of a care home resident from one care setting to another

Variable dose

Medicines for which the dose has been prescribed based on the outcome required. For example, 1 or 2 paracetamol 500 mg tablets depending on the severity of pain

Appendix B Key resources

Allred, DP; Barber, N; Buckle, P (2009) [Care Home Use of Medicines Study \(CHUMS\)](#)

Care Quality Commission (2010) [Essential standards of quality and safety](#)

Department for Education (2011) [Children's Homes: National Minimum Standards](#)

Department of Health (2009) [Reference guide to consent for examination or treatment \(second edition\)](#)

Health and Social Care Information Centre (2013) [A guide to confidentiality in health and social care](#)

Health Foundation (2011) [Making care safer: Improving medication safety for people in care homes: thoughts and experiences from carers and relatives](#)

Ministry of Justice (2007) [The Mental Capacity Act \(2005\) Code of Practice](#)

Nursing and Midwifery Council (2007 amended 2010) [Standards for medicines management](#)

Royal Pharmaceutical Society (2012) [Keeping patients safe when they transfer between care providers – getting the medicines right](#)

Safety of medicines in care homes project (2013) [Free resources for supporting the safe use of medications in care facilities](#)

Appendix C Overview of legislation, regulators and minimum standards published for England, Wales and Northern Ireland

Country		Regulation	Regulators	Standards
England	Adults	Health and Social Care Act 2008 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010	Care Quality Commission (CQC)	Essential standards of quality and safety (CQC)
	Children	Care Standards Act 2000 Education and Inspections Act 2006 (section 148) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 The Children's Homes Regulations 2001	Chief Inspector of Education, Children's Services and Skills ('CIECSS') (if not regulated by above then Care Quality Commission (CQC) regulate	Children's homes: national minimum standards (Department for Education) Children Act 1989: Guidance and Regulations Volume 5: Children's Homes
Wales	Adults	The Care Homes (Wales) Regulations 2002 Care Standards Act 2000	Care and Social Services Inspectorate Wales (CSSIW)	Care Homes
	Children	The Children's Homes (Wales) Regulations 2002	Care and Social Services Inspectorate Wales (CSSIW)	Children's Homes
Northern Ireland	Adults	Residential Care Homes Nursing Homes Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003	Regulation and Quality Improvement Authority (RQIA)	Nursing home minimum standards (RQIA) Residential care homes minimum standards (RQIA)
	Children	The Children's Homes Regulations (Northern Ireland) 2005		

Appendix D Comparison between monitored dosage systems and original packs

	Monitored dosage systems	Original packs
Advantages (Supply)	<ul style="list-style-type: none"> • 'Added value' element of supply by the pharmacy 	<ul style="list-style-type: none"> • Better use of pharmacist's time • Re-packaging not required
Disadvantages (Supply)	<ul style="list-style-type: none"> • Not all medicines suitable • Re-packaging may often be unlicensed • Lack of evidence to support use • Pharmacies not reimbursed for use of monitored dosage systems • Robust filling and checking procedures required • Time consuming to fill and to check • Issues with variable doses, short courses, once-weekly medicines • Issues with medicines started mid-cycle or interim medicines • All labels may not fit on the monitored dosage system 	<ul style="list-style-type: none"> • Packaging may be too bulky
Advantages (Administration)	<ul style="list-style-type: none"> • Provide an additional 'visual safety check' to care home staff compared to original packs, when they have been trained to use it correctly • Facilitate self-administration and compliance 	<ul style="list-style-type: none"> • Maintains resident dignity and independence • The resident is taking the medicine as they would do in their own home • Not being re-dispensed (potentially then in an unlicensed form)

		<ul style="list-style-type: none"> • Take up less space compared with monitored dosage systems • Patient information leaflet enclosed in original pack supporting medicines information requirements/needs • Resident can see the original pack (identification purposes) • Less waste • May be beneficial for patients who go on short-term leave/utilise day services • Easier to amend medication following changes (for example, dose changes or if the medicine is stopped) • Lower risk of infection
Disadvantages (Administration)	<ul style="list-style-type: none"> • There may be over reliance on monitored dosage systems that may deskill care home staff • High-risk medicines may be an issue • Difficulties if medicines are stopped, need to be omitted, or to identify if they are being given in an unlicensed way, if a monitored dosage system contains all medicines in single blister • Requires 2 systems to be used, monitored dosage system and original packs for acute and 'when required' medicines • Arrangements need to be made for those on short leave from care home • Over-reliance of the use of monitored dosage system: care home staff may fail to look at the 	

	label and description of medicine	
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Appendix E Scoping workshop attendees

David Alldred

Lecturer in pharmacy, University of Leeds

Helen Brewah

Community Matron, Southern Health NHS Foundation Trust

Brian Brown

National Pharmacy Manager, Care Quality Commission

Peter Budden

CCG Medical Prescribing Lead, Salford Clinical Commissioning Group

David Campbell

Chief Pharmacist, Northumbria Healthcare NHS Foundation Trust

Angela Close

Staff Nurse, Doves Nest Nursing Home

Martyn Diaper

Clinical Lead for Primary Care Patient Safety, NHS Institute for Innovation and Improvement

Angela Duce

Director of Operations, Norwood

Mary Freeman

Director, Sunny Bank Psychiatric Rehabilitation Service

Vinod Gowda

Consultant Geriatrician-Community, St Helens and Knowsley Teaching Hospitals

Fazeela Hafajee

Project Manager Standards, Learning & Qualifications, Skills for Care

Jane Hinsley

Quality consultant/pharmacist, Bupa care services

Susan Hogston

Head of Clinical Quality and Nurse Lead, Sue Ryder

Susanna Jacks

General Practitioner, Aneurin Bevan Health Board

Yogini Jani

Lead Pharmacist Medication Safety & Honorary Associate Professor,
University College London Hospitals NHS Foundation Trust & University
College London School of Pharmacy

Sarah Jewitt

Specialist Nurse, Sheffield Children's NHS Foundation Trust

Nick Kaye

Community Pharmacist, S. Kaye & Son Ltd

Hayley Latchem

Community Pharmacist, Boots UK

Alison Marshall

Pharmacy Technician, Medicines Management Team East Lancashire
Primary Care Trust

Juliette Millard

UK Nursing & Health Professions Advisor, Leonard Cheshire Disability

Sandra Sweeney

Senior Pharmacist Medicines Management Social Care Support Team, NHS
North Yorkshire and York/North Yorkshire and Humber Commissioning
Support Unit

Helen Whiteside

Care Home Pharmacist and Medication Review Pharmacist, Leeds South and
East Clinical Commissioning Group

Appendix F The Guideline Development Group and NICE project team

Guideline Development Group

David Alldred

Senior Lecturer in Pharmacy Practice, University of Bradford

Wasim Baqir

Research and Development Pharmacist, Northumbria Healthcare NHS Foundation Trust

Gerry Bennison

Lay member

Brian Brown

National Pharmacy Manager, Care Quality Commission

Amanda de La Motte

Advanced Nurse Practitioner, Central Nottinghamshire Clinical Services

Karen George

Lead Nurse/Care Homes, Shropshire Community Health NHS Trust

Kathryn Goodfellow

Care Homes Development Manager, Superdrug Stores

Fazeela Hafajee

Standards and Qualifications Project Manager, Skills for Care

Daniel Harwood

Clinical Director for Community Health, Clinical Director for the Mental Health/Learning Disability Directorate and Consultant Old Age Psychiatrist, South London and Maudsley NHS Foundation Trust

Susanna Jacks

General Practitioner Principal, Aneurin Bevan Health Board/Vauxhall Surgery Chepstow

Barbara Jesson

Principal Pharmacist, Croydon Clinical Commissioning Group

Susan Lee

Care Home Support Pharmacist, Biodose Services

Juliette Millard

UK Nursing and Health Professions Advisor, Leonard Cheshire Disability

Tariq Muhammad

Managing Director, Pharmacy Plus

Ivor Nathan

Lay member

Alaster Rutherford (Chair)

Independent healthcare consultant

Joy Smith

Medicines Standards Officer – Care Homes, NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit

Amanda Thompsell (Vice Chair)

Consultant Old Age Psychiatrist in Specialist Care, South London and Maudsley NHS Foundation Trust

Ian Turner

Chairman, Registered Nursing Home Association

Louise Winstanley

Head of Medicines Commissioning, Fylde and Wyre Clinical Commissioning Group

NICE project team

Johanna Hulme

Project Lead and Associate Director, Medicines Advice, NICE Medicines and Prescribing Centre

Gregory Moran

Senior Adviser Medicines Advice, NICE Medicines and Prescribing Centre

Shelly Patel

Senior Adviser Medicines Advice, NICE Medicines and Prescribing Centre

Louise Picton

Senior Adviser Medicines Advice, NICE Medicines and Prescribing Centre

Ian Pye

Assistant Project Manager – Medicines Advice, NICE Medicines and Prescribing Centre

Rebekah Robinson

Assistant Project Manager – Medicines Advice, NICE Medicines and Prescribing Centre

Appendix G Literature search

Search strategy

Search question	See search questions below
Search date	Searches were conducted during April 2013
Search terms	See list of requested search terms below
Sources	See sources searched below
Publication period	Unlimited
Restrictions	None
Inclusion criteria	Any relevant publication or website
Publication	Website, peer-reviewed journal, guidance

Search questions

What is the evidence for:

- raising concerns and safeguarding
- ensuring resident safety (including reducing errors, incident reporting, near misses and yellow card reporting)
- ensuring residents' informed consent and the assessment of residents' mental capacity
- shared decision making?

What is the evidence for:

- managing medicines throughout transfers of care between care providers
- standards for records and record?

What is the evidence for:

- medicines reconciliation
- ordering and supply of medicines (including medication administration systems, acute and repeat medications)
- storage of medications
- disposal of medicines (including waste medicines)?

What is the evidence for:

- ensuring resident safety
- clinical and medication review (including polypharmacy)?

What is the evidence for:

- care home staff administering medicines to residents
- reducing disruption of medicine administration
- resident's self-administration of medicines
- covert administration of medicines
- use of over-the-counter (OTC, inclusive of homely remedies) medicines?

What is the evidence for:

- role of the GP (including named and non-named GPs for care homes)
- role of the community pharmacist
- role of care home staff
- role of commissioners?

What is the evidence for:

- education, training and assessment of competence of staff responsible for managing medicines?

Search terms

- Raising concerns and safeguarding
- Resident safety (including errors, incident reporting, near misses, yellow card reporting)
- Residents informed consent/mental capacity
- Shared decision making
- Resident transfers of care (between providers of care)
- Standards for records and record-keeping
- Medicines reconciliation
- Ordering and supply of medications (including medication administration systems, acute and repeat medications)
- Storing medications

- Disposal of medications (including medicines waste in the care home setting)
- Clinical and medication review (including polypharmacy)
- Care homes staff administering to residents
- Disruption of medicines administration
- Residents self-administration of medication
- Covert medication administration
- OTC medications (homely remedies)
- GPs (including named and non-named for care homes)
- Community pharmacists
- Care home staff
- Commissioners in managing medicines in care homes
- Staff education, training and competence

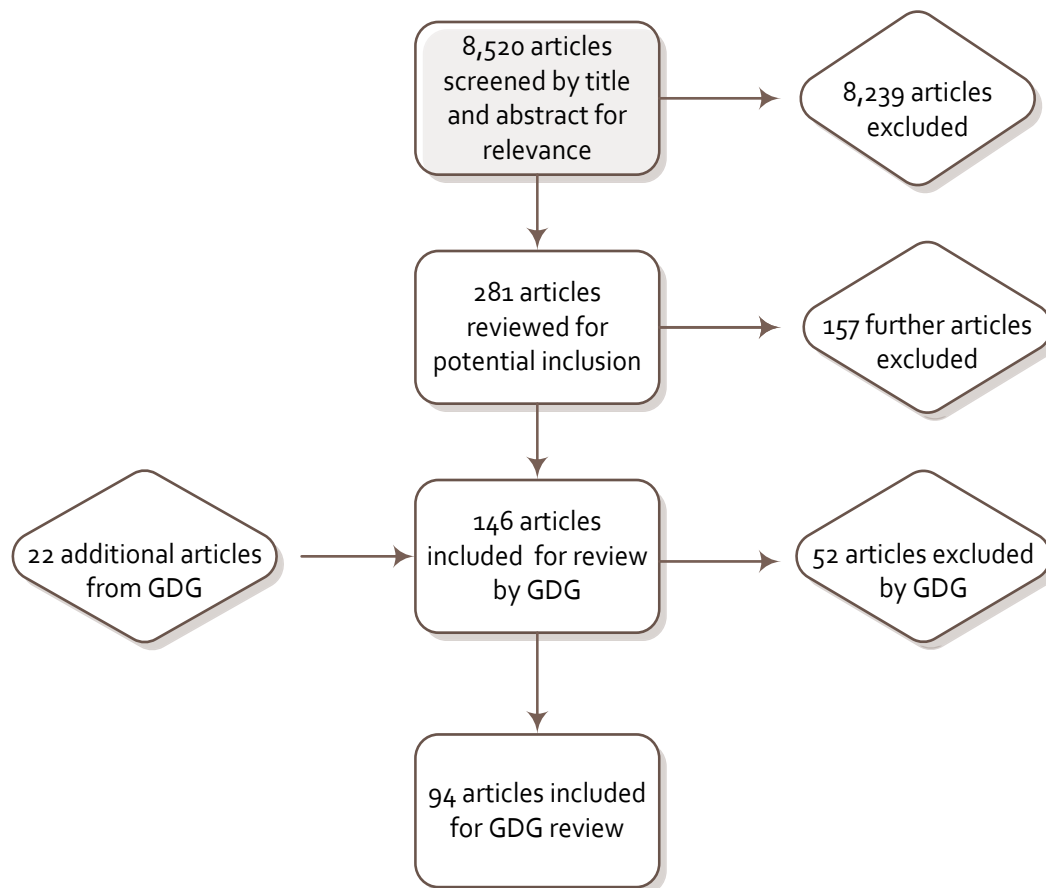
Sources searched

- PubMed
- EMBASE
- British Nursing Index
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- Health Management Information Consortium (HMIC)
- Health Business Elite
- Department of Health
- Medicines and Healthcare products Regulatory Agency (MHRA)
- NHS Evidence
- National Institute for Health and Care Excellence (NICE)
- Care Quality Commission (CQC)
- Social Care Institute for Excellence (SCIE)

Inclusion and exclusion of evidence

Evidence identified from the literature search was included or excluded as shown in figure 4.

Figure 4 Inclusion and exclusion of evidence identified from the literature search



Included studies

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Social Care Institute for Excellence. *Learning report: making care safer: improving medication safety for people in care homes: thoughts and experiences from carers and relatives* [online] 2011

Social Care Institute for Excellence. *Medicines management for residential and nursing homes: a toolkit for best practice and accredited learning* [online] 2007

Stupalski KA, Russell GE. Reported medication errors in community residences for individuals with mental retardation: a quality review. *Mental Retardation* 1999; 37(2): 139-146

Tariq A, Georgiou A, Westbrook J. Medication incident reporting in residential aged care facilities: limitations and risks to residents' safety. *BMC Geriatrics* 2012 Nov 6; 12(67)

Tjia J, Velten SJ, Parsons C *et al.* Studies to Reduce Unnecessary Medication Use in Frail Older Adults: A Systematic Review. *Drugs & Aging* 2013; 30(5): 285-307

Topinkova E, Madlova P, Fialova D *et al.* New evidence-based criteria for evaluating the appropriateness of drug regimen in seniors. Criteria STOPP (screening tool of older person's prescriptions) and START (screening tool to alert doctors to right treatment). *Vnitřní Lékarství* 2008; 54(12): 1161-1169

UK Medicines Information. *What legal and pharmaceutical issues should be considered when administering medicines covertly?* [online] 2012

Waterson P. A critical review of the systems approach within patient safety research. *Ergonomics* 2009; 52(10): 1185-1195

West Mercia Consortium Procedures Manual Section. *4.8.5 Handling of Medication in Children's Residential Settings* [online] 2011

White KG. UK interventions to control medicines wastage: a critical review. *International Journal of Pharmacy Practice* 2010; 18(3): 131-140

Wild D, Szczepura A, Nelson S. New barcode checks help reduce drug round errors in care homes. *Nursing management (Harrow)* 2011; 18(5): 26-30

Winland-Brown JE, Valiante J. Effectiveness of different medication management approaches on elders' medication adherence. *Outcomes Management for Nursing Practice* 2000; 4(4): 172-176

Winstanley L, Brennan W. Advanced practice and support in prescribing and medicine management for care homes. *Journal of Care Services Management* 2007; 1(3): 233-244

Zimmerman S, Love K, Sloane PD *et al.* Center for Excellence in Assisted Living-University of North Carolina Collaborative. Medication administration errors in assisted living: scope, characteristics, and the importance of staff training. *Journal of the American Geriatric Society* 2011; 59(6): 1060-1068

Excluded studies

Bibliographic information

Authors: Avorn J, Gurwitz JH. Title: Drug use in the nursing home. Journal name: *Ann.Intern.Med.* Year: 1995

Authors: Christensen D, Trygstad T, Sullivan R, Garmise J, Wegner SE. Title: A pharmacy management intervention for optimizing drug therapy for nursing home patients. Journal name: *Am.J.Geriatr.Pharmacother.* Year: 2004

Reason for rejecting study

GDG opinion was that this USA study was not relevant to the UK setting.

GDG opinion was that this study was of low methodological quality.

<p>Authors: Pharmaceutical Services Negotiating Committee. Title: NHS Community Pharmacy Contractual Framework - Enhanced Service Care Home (support and advice on storage, supply and administration of drugs and appliances) Year: 2005</p>	<p>GDG opinion was that this was not in scope.</p>
<p>Authors: Bennett J, Dawoud D, Maben J. Title: Effects of interruptions to nurses during medication administration. Journal name: Nurs.Manag.(Harrow) Year: 2010</p>	<p>GDG opinion was that this observational study was useful as background but does not offer insight into good practice.</p>
<p>Authors: Connor J, Rafter N, Rodgers A. Title: Do fixed-dose combination pills or unit-of-use packaging improve adherence? A systematic review. Journal name: Bull.World Health Organ. Year: 2004</p>	<p>GDG opinion was that this paper is now out-of-date.</p>
<p>Authors: Farrar HM, Stewart C, Sturdevant D. Title: Covert medication administration: the practice of hiding medications in long-term care settings. Journal name: J.Gerontol.Nurs. Year: 2012</p>	<p>GDG opinion – ordered not received.</p>
<p>Authors: Goh LY, Vitry AI, Semple SJ, Esterman A, Luszcz MA. Title: Self-medication with over-the-counter drugs and complementary medications in South Australia's elderly population. Journal name: BMC Complement.Altern.Med. Year: 2009</p>	<p>GDG opinion was that this was a summary of findings rather than robust evidence.</p>
<p>Authors: Hung WW, Liu S, Boockvar KS. Title: A prospective study of symptoms, function, and medication use during acute illness in nursing home residents: design, rationale and cohort description. Journal name: BMC Geriatr. Year: 2010</p>	<p>GDG opinion was that this observational study was useful as background but does not offer insight into good practice.</p>
<p>Authors: Kaasalainen S, Agarwal G, Dolovich L, Papaioannou A, Brazil K, Khtar-Danesh N. Title: Nurses' perceptions of and satisfaction with the medication administration system in long-term-care homes. Journal name: Can.J.Nurs.Res. Year: 2010</p>	<p>GDG opinion was that the outcomes used in this study were insufficiently objective.</p>

<p>Authors: Lieto JM, Schmidt KS. Title: Reduced ability to self-administer medication is associated with assisted living placement in a continuing care retirement community. Journal name: J.Am.Med.Dir.Assoc. Year: 2005</p>	<p>GDG opinion was that this USA study on assisted living was not relevant to the UK setting.</p>
<p>Authors: Mitty E. Title: Medication management in assisted living: a national survey of policies and practices. Journal name: J.Am.Med.Dir.Assoc. Year: 2009</p>	<p>GDG opinion was that this article was domiciliary care and therefore out of scope.</p>
<p>Authors: Mitty E, Flores S. Title: Assisted living nursing practice: medication management: part 2 supervision and monitoring of medication administration by unlicensed assistive personnel. Journal name: Geriatr.Nurs. Year: 2007</p>	<p>GDG opinion was that this USA study on assisted living was not relevant to the UK setting.</p>
<p>Authors: Mitty E, Resnick B, Allen J, Bakerjian D, Hertz J, Gardner W, Rapp MP, Reinhard S, Young H, Mezey M. Title: Nursing delegation and medication administration in assisted living. Journal name: Nurs.Adm.Q. Year: 2010</p>	<p>GDG opinion was that this USA study on assisted living was not relevant to the UK setting.</p>
<p>Authors: Shipley V, Fairweather J. Title: A programme of individualized and self-administration of medicines in a hospice. Journal name: Int.J.Palliat.Nurs. Year: 2001</p>	<p>GDG opinion was that this paper was out-of-date and set in hospice care (out-of-scope).</p>
<p>Authors: Stefanacci RG, Lester PE, Kohen I, Feuerman M. Title: Nursing home policies on items brought in from the outside for facility residents. Journal name: J.Am.Med.Dir.Assoc. Year: 2009</p>	<p>GDG opinion was that this was a cross sectional survey rather than robust interventional study evidence.</p>
<p>Authors: Treloar A, Beats B, Philpot M. Title: A pill in the sandwich: covert medication in food and drink. Journal name: J.R.Soc.Med. Year: 2000</p>	<p>GDG opinion was that this paper was out-of-date. Also no evidence from this study for informing good practice considerations.</p>
<p>Authors: Vogelsmeier A, Scott-Cawiezell J, Zellmer D. Title: Barriers to safe medication administration in the nursing home--exploring staff perceptions and concerns about the medication use</p>	<p>GDG opinion was that the outcomes used in this study were insufficiently objective.</p>

process. Journal name: J.Gerontol.Nurs.
Year: 2007

Authors: Arnetz JE, Zhdanova LS, Elsouhag D, Lichtenberg P, Luborsky MR, Arnetz BB. Title: Organizational climate determinants of resident safety culture in nursing homes. Journal name: Gerontologist Year: 2011

GDG opinion was that this USA study was not relevant to the UK setting.

Authors: Aspinall S, Sevick MA, Donohue J, Maher R, Hanlon JT. Title: Medication errors in older adults: a review of recent publications. Journal name: Am.J.Geriatr.Pharmacother. Year: 2007

GDG opinion was that this USA study was not relevant to the UK setting

Authors: Dilles T, Elseviers MM, Van Rompaey B, Van Bortel LM, Stichele RR. Title: Barriers for nurses to safe medication management in nursing homes. Journal name: J.Nurs.Scholarsh. Year: 2011

GDG opinion was that this USA study was not relevant to the UK setting.

Authors: Finkers F, Maring JG, Boersma F, Taxis K. Title: A study of medication reviews to identify drug-related problems of polypharmacy patients in the Dutch nursing home setting. Journal name: J.Clin.Pharm.Ther. Year: 2007

GDG opinion was that this study was of low methodological quality.

Authors: Kaur S, Roberts JA, Roberts MS. Title: Evaluation of medication-related problems in medication reviews: a comparative perspective. Journal name: Ann.Pharmacother. Year: 2012

GDG opinion was that this study was of low methodological quality.

Authors: Keers RN, Williams SD, Cooke J, Ashcroft DM. Title: Prevalence and nature of medication administration errors in health care settings: a systematic review of direct observational evidence. Journal name: Ann.Pharmacother. Year: 2013

GDG opinion was that this study did not add to their evidence.

Authors: Meyer-Masseti C, Cheng CM, Schwappach DL, Paulsen L, Ide B, Meier CR, Guglielmo BJ. Title: Systematic review of medication safety

GDG opinion was that this study did not add to their evidence.

assessment methods. Journal name:
Am.J.Health.Syst.Pharm. Year: 2011

Authors: Nishtala PS, Hilmer SN,
McLachlan AJ, Hannan PJ, Chen TF.
Title: Impact of residential medication
management reviews on drug burden
index in aged-care homes: a
retrospective analysis. Journal name:
Drugs Aging Year: 2009

GDG opinion was that this
Australian study was not
relevant to the UK setting.

Authors: Parsons C, Alldred D, Daiello
L, Hughes C. Title: Prescribing for older
people in nursing homes: strategies to
improve prescribing and medicines use
in nursing homes. Journal name:
Int.J.Older People Nurs. Year: 2011

GDG opinion was that this
international non-systematic
review of policy did not add to
the evidence already available
to it.

Authors: Sloane PD, Gruber-Baldini AL,
Zimmerman S, Roth M, Watson L,
Boustani M, Magaziner J, Hebel JR.
Title: Medication undertreatment in
assisted living settings. Journal name:
Arch.Intern.Med. Year: 2004

GDG opinion was that this USA
study was not relevant to the
UK setting.

Authors: Stuijt CC, Franssen EJ,
Egberts AC, Hudson SA. Title:
Appropriateness of prescribing among
elderly patients in a Dutch residential
home: observational study of outcomes
after a pharmacist-led medication
review. Journal name: Drugs Aging
Year: Year: 2008

GDG opinion was that this study
was of low methodological
quality.

Authors: Tamura BK, Bell CL, Inaba M,
Masaki KH. Title: Outcomes of
polypharmacy in nursing home
residents. Journal name:
Clin.Geriatr.Med. Year: 2012

GDG opinion was that this study
was of low quality.

Authors: Tamura BK, Bell CL, Inaba M,
Masaki KH. Title: Factors associated
with polypharmacy in nursing home
residents. Journal name:
Clin.Geriatr.Med. Year: 2012

GDG opinion was that this study
was of low quality.

Authors: Chan S. Title: Factors
associated with the use of electronic
information systems for drug dispensing
and medication administration records in

GDG opinion – ordered not
received.

nursing homes. Journal name:
J.Am.Med.Dir.Assoc. Year: 2008

Authors: Lester P, Stefanacci RG, Chen DG. Title: Nursing home procedures on transitions of care. Journal name: J.Am.Med.Dir.Assoc. Year: 2009

GDG opinion was that this USA study was not relevant to the UK setting.

Authors: Packham CJ. Title: Needs of elderly people in residential homes: comparison of records held by carers and general practitioners. Journal name: J.R.Coll.Gen.Pract. Year: 1989

GDG opinion was that the study was out of date.

Authors: Carder PC, Zimmerman S, Schumacher JG. Title: Understanding the intersection of individual needs and choices with organizational practices: the case of medication management in assisted living. Journal name: Gerontologist Year: 2009

GDG opinion was that this USA study was not relevant to the UK setting

Authors: Heath H, Phair L. Title: Shifting the focus: outcomes of care for older people. Int.J.Older People Nurs. Year: 2009

GDG opinion was that the study was not robust.

Authors: Hughes CM, Donnelly A, Moyes SA, Peri K, Scahill S, Chen C, McCormack B, Kerse N. Title: "The way we do things around here": an international comparison of treatment culture in nursing homes. Journal name: J.Am.Med.Dir.Assoc. Year: 2012

GDG opinion was that this Northern Ireland and New Zealand study was not relevant to the UK setting.

Authors: Vander Stichele RH, Mestdagh J, Van Haecht CH, De Potter B, Bogaert MG. Title: Medication utilization and patient information in homes for the aged. Journal name: Eur.J.Clin.Pharmacol. Year: 1992

GDG opinion was that this Flemish study was not relevant to the UK setting. Also the study excludes dementia sufferers.

Authors: Brulhart MI, Wermeille JP. Title: Multidisciplinary medication review: evaluation of a pharmaceutical care model for nursing homes. Journal name: Int.J.Clin.Pharm. Year: 2011

GDG opinion was that this study was of low methodological quality.

<p>Authors: Crotty M, Halbert J, Rowett D, Giles L, Birks R, Williams H, Whitehead C. Title: An outreach geriatric medication advisory service in residential aged care: a randomised controlled trial of case conferencing. Journal name: Age Ageing Year: 2004</p>	<p>GDG opinion was that this Australian study was not relevant to the UK setting.</p>
<p>Authors: Crutchfield DB. Title: Medication challenges in the assisted living facility. Journal name: J.Am.Pharm.Assoc.(Wash.) Year: 1999</p>	<p>GDG opinion was that this USA study was not relevant to the UK setting. Also out-of-date.</p>
<p>Authors: Davidsson M, Vibe OE, Ruths S, Blix HS. Title: A multidisciplinary approach to improve drug therapy in nursing homes. Journal name: J.Multidiscip.Healthc. Year: 2011</p>	<p>GDG opinion was that this study was of low methodological quality.</p>
<p>Authors: Grissinger M. Title: Medication errors in long-term care: part 1. Journal name: Consult.Pharm. Year: 2007</p>	<p>GDG opinion was that this study did not add to their evidence.</p>
<p>Authors: Grissinger M. Title: How to prevent medication errors in long-term care: part 2. Journal name: Consult.Pharm. Year: 2007</p>	<p>GDG opinion was that this study did not add to their evidence.</p>
<p>Authors: Lapane KL, Hughes CM, Daiello LA, Cameron KA, Feinberg J. Title: Effect of a pharmacist-led multicomponent intervention focusing on the medication monitoring phase to prevent potential adverse drug events in nursing homes. Journal name: J.Am.Geriatr.Soc. Year: 2011</p>	<p>GDG opinion was that this USA study was not relevant to the UK setting.</p>
<p>Authors: Schweizer AK, Hughes CM. Title: Providing pharmacy services to care homes in Northern Ireland: a survey of community pharmacists' views. Journal name: Pharm.World Sci. Year: 2004</p>	<p>GDG opinion was that this service evaluation offered no evidence for good practice.</p>
<p>Authors: Verrue CL, Petrovic M, Mehuys E, Remon JP, Vander Stichele R. Title: Pharmacists' interventions for optimization of medication use in nursing homes : a systematic review. Journal name: Drugs Aging Year: 2009</p>	<p>GDG opinion was that this review was not as robust as other available evidence that has been included.</p>

<p>Authors: Dorset Residential Homes. Title: Policy on the storage, handling and administration of medicines. Year: 2008</p>	<p>GDG rejected this as evidence but felt it may be useful as practice example.</p>
<p>Authors: East & South East England Specialist Pharmacy Services (2013) Title: How to Guide: Keeping patient medicines with them: Optimising the transfer and use of medicines as patients move around organisations and between care settings. Year: 2013 Mar</p>	<p>GDG opinion was that the purpose of this document was to reduce waste of medicines going into hospital. However, practicality of following guidelines difficult given number of MDS systems. Useful perhaps as a shared learning resource.</p>
<p>Authors: Barnsteiner JH. Medication Reconciliation. Hughes, R. G. Title: Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Year: 2008</p>	<p>GDG opinion was that this USA book was not relevant to the UK setting. Additionally it is not context specific to care homes.</p>
<p>Authors: Bayoumi I, Howard M, Holbrook AM, Schabert I. Title: Interventions to improve medication reconciliation in primary care. Journal name: Ann.Pharmacother. Year: 2009</p>	<p>The GDG opinion was that it was not appropriate to include this study as it does not look at care homes specifically.</p>
<p>Authors: Boockvar KS, Carlson LaCorte H, Giambanco V, Fridman B, Siu A. Title: Medication reconciliation for reducing drug-discrepancy adverse events. Journal name: Am.J.Geriatr.Pharmacother. Year: 2006</p>	<p>GDG opinion was that the date of the review was quite old and that this USA study was not relevant to the UK setting.</p>
<p>Authors: Chhabra PT, Rattinger GB, Dutcher SK, Hare ME, Parsons KL, Zuckerman IH. Title: Medication reconciliation during the transition to and from long-term care settings: a systematic review. Journal name: Res.Social Adm.Pharm. Year: 2012</p>	<p>The GDG opinion was that the evidence lacked formal, defined outcome measures.</p>
<p>Authors: Geurts MME, Talsma J, Brouwers JRBJ, de JJ. Title: Medication review and reconciliation with cooperation between pharmacist and general practitioner and the benefit for the patient: A systematic review. Journal name: Br.J.Clin.Pharmacol. Year: 2012</p>	<p>The GDG opinion was that the evidence presented was not sound, as very few of the included studies related to care home settings (small sample).</p>

Authors: LaMantia MA, Scheunemann LP, Viera AJ, Busby-Whitehead J, Hanson LC. Title: Interventions to improve transitional care between nursing homes and hospitals: a systematic review. Journal name: J.Am.Geriatr.Soc. Year: 2010

The GDG opinion was that this study did not add more than other evidence sources already had.

Authors: Vogelsmeier AA, Scott-Cawiezell JR, Pepper GA. Title: Medication reconciliation in nursing homes: thematic differences between RN and LPN staff. Journal name: J.Gerontol.Nurs. Year: 2011

GDG opinion was that the papers outcome focussed on differential of staff.

Authors: Members of EMERGE EMERG, Agrawal A, Aronson JK, Britten N, Ferner RE, de Smet PA, Fialova D, Fitzgerald RJ, Likic R, Maxwell SR, et al. Title: Medication errors: problems and recommendations from a consensus meeting. Journal name: Br.J.Clin.Pharmacol. Year: 2009

GDG opinion was that this study was not sufficiently specific to care home settings.

Authors: Verrue CL, Mehuys E, Somers A, Van Maele G, Remon JP, Petrovic M. Title: Medication administration in nursing homes: pharmacists' contribution to error prevention. Journal name: J.Am.Med.Dir.Assoc. Year: 2010

GDG opinion was that this USA study was not relevant to the UK setting.

Appendix H Organisations providing written or oral evidence

Organisations providing written evidence submissions

- A.G.E. Nursing Homes Ltd
- Abbeyfield Kent Society
- Abbeyfield Maidenhead Society
- Alpha Care Homes
- Anchor Trust
- Aneurin Bevan Health Board
- Armscare
- Ashmore Nursing Home Ltd, Bury St Edmunds
- Ashtons Hospital Pharmacy Services Ltd
- Askham Care Homes Ltd
- Bedfordshire Clinical Commissioning Group
- Birmingham Cross City Clinical Commissioning Group
- Blackpool Teaching Hospitals NHS Foundation Trust
- Bolton Clinical Commissioning Group
- Bromley Clinical Commissioning Group
- Bupa Care Homes
- Cambridge Nursing Home, London
- Camden Clinical Commissioning Group and Camden Local Authority
- Camphill Communities East Anglia, Thornage Hall
- Care UK
- CareTech Community Services Ltd
- Central Eastern Commissioning Support Unit
- Churchfields Nursing Home, London (Yewtree Care Ltd)
- Coppice Lea Care Home, Surrey (Caring Homes Group)
- Cornwall Partnership NHS Foundation Trust
- Derbyshire Community Health Services
- Dimensions UK
- Dorset Clinical Commissioning Group

- Eden Place Mental Health Nursing Home (Eden Place Ltd)
- Four Seasons Health Care
- Fourways Rest & Nursing Home, Peacehaven
- Fylde and Wyre Clinical Commissioning Group
- Garth House Nursing Home, Dorking (Caring Homes Group)
- Glan-Yr-Afon, Blackwood (Comfort Care Homes)
- Goatacre Manor Care Centre, Wiltshire
- Gorselands Nursing Home, Hampshire
- Gorsey Clough Nursing Home, Bury
- Gracewell Healthcare
- Guy's and St Thomas' NHS Foundation Trust
- Harewood Park, Moorlands Rehabilitation Ltd
- HC-One
- Healthcare Pharmacies Ltd
- Hillingdon Clinical Commissioning Group
- Holmeview Resource Centre, Bradford
- Holmwood House Nursing Home, Bristol
- Homerton University Hospital NHS Foundation Trust
- Hope Residential Care, Blackpool
- Horsham and Mid Sussex Clinical Commissioning Group
- Leeds Community Healthcare NHS Trust
- Leeds South and East Clinical Commissioning Group
- Leeds West Clinical Commissioning Group
- Leonard Cheshire Disability
- Liz Butterfield, self-employed
- Lloyds Pharmacy, Peninsula Community Healthcare and various surgeries
- Lotus Care Group
- Loxley Court Nursing Home, Sheffield (Exemplar Health Care)
- Luton Clinical Commissioning Group
- Maria Mallaband Care Group
- Marie Louise House Nursing Home, Romsey (The Healthcare Management Trust)

- Medvivo
- Mencap
- Methodist Homes Association
- Mid Yorkshire Hospitals NHS trust
- Midnight Pharmacy
- Milton Keynes Community NHS Trust
- Morton Grange Nursing Home, Inverhome Ltd
- Nene Clinical Commissioning Group
- NEW Devon Clinical Commissioning Group
- NHS Anglia
- NHS Great Yarmouth & Waveney Clinical Commissioning Group
- NHS North Yorkshire and Humber Commissioning Support Unit
- NHS Portsmouth Clinical Commissioning Group
- North Hill Care Home, Sheffield
- North of England Commissioning Support (NECS)
- North Yorkshire County Council
- Northfield Nursing Home, Sheffield (Palms Row Health Care Ltd)
- Northumbria Healthcare NHS Foundation Trust
- Nottingham Community Housing Association
- Nottingham West Clinical Commissioning Group
- Nottinghamshire Healthcare NHS Trust, Bassetlaw Health Partnership
- Optalis
- Park House Nursing Home, Peterborough
- Park Lodge, Leeds (Villa Care Ltd)
- Peverel Court Care
- PS4U Ltd
- Regency Healthcare
- Risby Hall Nursing Home, The Partnership in Care
- Rivermead Care Home, Norton Malton (Barchester Healthcare)
- Ruislip Nursing Home, Hillingdon
- Scio Healthcare Ltd
- Sense

- Solihull Community Services, Heart of England NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Southern Derbyshire Clinical Commissioning Group
- St Helens & Halton Primary Care Trust
- St. Martins, Abbeyfield Kent Society
- Staffordshire and Stoke on Trent Partnership NHS Trust
- Steve Turner Innovations CIC
- Stoke-on-Trent Clinical Commissioning Group
- Sue Ryder
- Sun Court Nursing Home, Sheringham
- Sunnyside Nursing Home, Bluebell Care Services Ltd
- Talbot Court Care Home, Port Talbot
- The Dynes, Abbeyfield Kent Society
- The Glen Nursing Home, Sheffield
- The Hope Residential & Nursing Care Home, Cambridge
- The Laurels Nursing Home, Hastings
- The Lodge Trust, Rutland
- The Manor House, Seaton, Devon
- The Old Vicarage Residential Care Home, Leigh
- The Partnership in Care
- The Royal Alfred Seafarers Society
- The Royal Care Home, St-Anne's-on-the-Sea
- Town Thorns Care Centre, Warwickshire (BEN – Motor and Allied Trades Benevolent Fund)
- Ubu
- University of Exeter
- University of Leeds
- Walsingham
- Wandsworth Clinical Commissioning Group
- Ward House Nursing Home Ltd, Isle of Wight
- Well Springs Nursing Home, Bradford
- Wells House Ltd, The Manor and The Lawns Nursing Home, Plymouth

- Wiltshire Clinical Commissioning Group

Organisations providing oral evidence

- Blackpool Teaching Hospitals NHS Foundation Trust
- Camden Clinical Commissioning Group and Camden Local Authority
- Dimensions UK
- Fylde and Wyre Clinical Commissioning Group
- Methodist Homes Association
- Midnight Pharmacy
- The Royal Care Home, St-Anne's-on-the-Sea