NICE National Institute for Health and Care Excellence

Putting NICE guidance into practice

Checklist for health and social care staff developing and updating a care home medicines policy

Implementing the NICE guideline on managing medicines in care homes

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This checklist for health and social care staff developing and updating a care home medicines policy accompanies the NICE guideline on managing medicines in care homes (published March 2014).

Implementing the NICE guideline is the responsibility of commissioners and providers. Commissioners and providers are reminded that it is their responsibility to implement the guideline, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in the guideline should be interpreted in a way that would be inconsistent with compliance with those duties. NICE takes no responsibility for the content of individual care home medicines policies or for the safe and effective use of those policies in local organisations. This checklist for care homes medicines policies is a tool to support the implementation of the NICE guideline. **It is not NICE guidance.**

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Introduction

NICE has recommended in its guideline on managing medicines in care homes that care home providers should have a care home medicines policy that includes written processes for the areas in box 1.

Box 1. Areas that should be covered by a care home medicines policy

- 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 (homely remedies) to residents, if appropriate

During the development of the NICE guideline, it became clear that not all care homes have a care home medicines policy. It was therefore agreed that a checklist, outlining what should be in a care home medicines policy, would be developed as part of guideline implementation.

This checklist gives more information about the processes that should be covered by a care home medicines policy.

The checklist is for health and social care staff who are developing and updating care home medicines policies. It will also be useful for commissioners

to assure that care home providers have processes in place for the safe and effective use of medicines for residents in care homes.

Using this policy checklist

Each section of this checklist relates to one of the areas in box 1 and includes:

- a statement of what the section covers, and
- a list of considerations (topic areas) for that section, with a link to the relevant guideline recommendation, where applicable.

The checklist can be adapted for local use. Individual sections should be interpreted in the context in which staff are working, and take into account the scope of their practice. Not all sections will be equally relevant, and some are more complex than others. In addition, some sections or topic areas may not apply to all care home settings.

This policy checklist is primarily intended to support care home providers. It is not intended to be used as a grading or assessment tool. It may help to:

- inform the development of organisational structures, systems and processes
- clarify existing lines of accountability between the care home and wider members of the care team (for example, GPs, pharmacists, district nurses)
- identify the training and competency needs of care home staff
- improve transfer of care between service providers (for example, hospitals and care homes).

Care home providers may wish to consider:

- how they will use the checklist (for example, as a tool for internal development and improvement)
- how each section and topic area applies to the scope of practice and setting
- how they will ensure that care home staff are aware of the content of the care home medicines policy and understand how to put it into practice
- whether any changes to their care home medicines policy are needed to cover the care setting in which it is used

- how often they will review and update the care home medicines policy, taking into account new evidence on best practice.

Responsibilities

It is the responsibility of providers and commissioners to use this policy checklist in their own setting. NICE takes no responsibility for the policies of individual care homes or for the safe and effective management of medicines in care homes. This policy checklist does not represent a requirement from professional or regulatory bodies.

Sharing information about a resident's medicines, including when they transfer between care settings	
The care home medicines policy:	***Date/notes***
Includes a process for managing personal and sensitive information covering the 5 rules set out in A guide to confidentiality in health and social care. See recommendation 1.3.1.	Please use these boxes to make notes.
Sets out the training needed by care home staff who are managing information, and how their skills will be assessed. See recommendation 1.3.1.	
Gives details of the information about medicines that should be transferred when a resident moves from one care setting to another. Includes details of who is responsible for this during 'out-of-hours' periods. See recommendation 1.7.3.	
Gives details of the information about medicines that should be checked and the process to be followed when a resident moves into a care home. Includes details of who is responsible for this during 'out-of-hours' periods. See recommendation 1.3.3.	
Gives details of how changes to a resident's medicines should be communicated between care home staff at shift changes. See recommendation 1.3.7.	
Gives details of the information about a resident's medicines that should be available when a resident attends appointments outside the care home. See recommendation 1.3.4.	
Gives details of agreed processes for the secure sharing of data.	
Gives details of how processes for sharing and transferring information about a resident's medicines will be monitored and audited.	
Includes a process for ensuring that everyone involved in a resident's care knows when medicines have been started, stopped or changed. See recommendation 1.9.3.	

Ensuring that records are accurate and up-to-date	
The care home medicines policy:	***Date/notes***
Includes a process for ensuring that records about medicines are accurate and up-to-date. The process covers the recording of information: • in the resident's care plan • in the resident's medicines administration record • from correspondence and messages about medicines • in transfer of care letters and summaries about medicines when the resident is away from the home for a short time. Gives details of what to do with copies of prescriptions and any records of medicines ordered for residents. See recommendation 1.4.1.	Please use these boxes to make notes.
Gives details of: • how to store records about medicines securely • how long to store the records • how to destroy records securely. See recommendation 1.4.2.	
Gives details of how processes for record-keeping will be monitored and audited.	

Identifying, reporting and reviewing medicines-related problems	
The care home medicines policy:	***Date/notes***
Includes a process for reporting all suspected adverse effects from medicines. The process includes: • how to report • who to report to during normal working hours (for example, the GP) • who to report to out-of-hours (for example, the out-of-hours service) • what to record in the resident's care plan • who to feedback to (for example, the resident and/or their family or carers, and the supplying pharmacy).	Please use these boxes to make notes.
Includes a process for recording all medicines-related safety incidents, including all 'near misses' and incidents that do not cause any harm. The process requires that any notifiable safeguarding concerns are reported to the Care Quality Commission (CQC) (or other appropriate regulator). See recommendation 1.6.5.	
Includes a process for managing medicines-related errors or incidents, which gives details of: • how to identify them (include actual errors or incidents and 'near misses') • how to report them • who to report to (the process follows any local reporting processes). • what to record • how the incident will be investigated (including how to find the root cause) • who will investigate • the time scale for investigation • how the results of the investigation and any lessons learnt will be shared, both with the staff of the care home and more widely (local shared learning) • how the incident will be reported to the resident and/or their family or carers. See recommendation 1.5.1, recommendation 1.6.5 and recommendation 1.6.8.	

Keeping residents safe (safeguarding)	
The care home medicines policy:	***Date/notes***
Includes a process for managing medicines-related safeguarding incidents, which gives details of: • how to identify them (include actual incidents and concerns) • how to report them • who to notify (for example, the CQC or other appropriate regulator) • what to record (as soon as possible) • how to investigate incidents (including how to find the root cause) • who will investigate • the time scale for investigation • how to share the results of the investigation and any lessons learnt with the staff of the care home and more widely (local shared learning) • how to report incidents to residents and/or their families or carers. The process follows local safeguarding processes. See recommendation 1.6.2 and recommendation 1.6.8.	Please use these boxes to make notes.
Includes a process for providing information to residents and/or their families or carers about: • how to report a medicines-related safety incident • how to report a medicines-related safeguarding incident or concern • how to discuss their concerns about medicines • how to use the care home provider's complaints process, local authority (or local safeguarding) processes and/or a regulator's complaints process • how to use advocacy and independent complaints services. See recommendation 1.6.10 and recommendation 1.6.11.	
Includes a process for identifying any training needed by care home staff who are responsible for managing and administering medicines. The process notes that if there is a medicines-related safety incident, review may need to be more frequent to identify support; learning and development needs. See recommendation 1.17.4.	

Accurately listing a resident's medicines (medicines reconciliation)	
The care home medicines policy:	***Date/notes***
Includes a process for accurately listing a resident's medicines (medicines reconciliation), which covers: • who is responsible for coordinating medicines reconciliation (the person who is responsible for the resident's transfer into the care home) • who to involve (including the resident and/or their family or carers, a pharmacist, other health and social care staff) • the information that should be 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 under 16 or where appropriate, for example, frail older residents) – GP's details – details of other contacts defined by the resident and/or their family or carers (for example, 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 of the last dose of any 'when required' medicine or any medicine given less often than once a day (weekly or monthly) – other information, including when the medicine should be reviewed or monitored, and any support the resident needs (adherence support) • what information has been given to the resident and/or family or carers. • the training and skills needed for medicines reconciliation (for example, effective communication skills, technical knowledge of relevant medicines management systems and evidence-based therapeutics). See recommendation 1.7.1, recommendation 1.7.2, recommendation 1.7.3.	Please use these boxes to make notes.

Reviewing medicines (medication review)	
The care home medicines policy:	***Date/notes***
Includes a process for medication review, which covers: • a GP documenting in each resident's care record which named health professional is responsible for that resident's planned multidisciplinary medication review • who may be involved in the review and how to ensure that they have appropriate involvement; this may include: – the resident and/or their family or carers, and – a pharmacist, community matron or specialist nurse, GP, member of care home staff, practice nurse, social care practitioner • documenting in each resident's care record the agreed frequency of planned multidisciplinary medication review based on: – the resident's safety (the most important factor when deciding how often to do the review) – the health and care needs of the resident – an interval between reviews of no more than 1 year • how care home staff should identify residents who may need more frequent review of their medicines and highlighting this to the GP; for example, residents: – entering the end-of-life phase – with a recent diagnosis of a long-term condition – needing frequent or complex monitoring – who have been transferred to the care home (for example, after hospital discharge). See recommendation 1.8.2, recommendation 1.8.3 and recommendation 1.8.4.	Please use these boxes to make notes.

Ordering medicines	
The care home medicines policy:	***Date/notes***
Includes a process for ordering medicines, which ensures that medicines prescribed for a resident are not used by other residents. See recommendation 1.10.1.	Please use these boxes to make notes.
The process covers: • protecting time for ordering and checking medicines delivered to the home • the home having at least 2 members of staff who are competent to order medicines, although at any one time ordering can be carried out by 1 member of staff • how to order repeat, acute and 'when required' medicines from the GP practice (and during out-of-hours) • which records to make when ordering medicines (for example, a copy of the prescription, stock order or requisition note) • how to inform the supplying pharmacy (with the resident's consent) of any changes to medicines (including when medicines are stopped). See recommendation 1.10.2, recommendation 1.10.3, recommendation 1.10.4 and recommendation 1.10.5.	
Includes a process for determining the best system for supplying medicines (original packs or monitored dosage systems) for each resident based on the resident's health and care needs and the aim of maintaining the resident's independence wherever possible. The process indicates that care home staff should seek the support of health and social care staff if needed. See recommendation 1.11.2.	
Includes a process for anticipatory medicines (for example, those used in end-of-life care) when these are used by a care home. See recommendation 1.9.5.	

Receiving, storing and disposing of medicines	
The care home medicines policy:	***Date/notes***
Includes a process for the safe storage of medicines, which gives details of: • how to store controlled drugs • how and where to store medicines, including medicines supplied in monitored dosage systems, medicines to be taken and looked after by residents themselves, medicines to be stored in the refrigerator, skin creams, oral nutritional supplements and appliances • how to ensure secure storage with only authorised care home staff having access • the temperatures for storing medicines • how the storage conditions should be monitored • how to assess each resident's needs for storing their medicines (taking into account the resident's choices, risk assessment and type of medicines system they are using) • who care home staff should contact should a storage problem occur • how to dispose of medicines, including: – controlled drugs, and – medicines classed as clinical waste • how to store medicines awaiting disposal, including the use of tamper-proof sealed containers locked in storage cupboards until collection for disposal • keeping records of medicines (including controlled drugs) that have been disposed of, or are awaiting disposal. See recommendation 1.12.1, recommendation 1.12.3, recommendation 1.12.4, recommendation 1.12.5, recommendation 1.12.6, recommendation 1.13.2 and recommendation 1.13.6.	Please use these boxes to make notes.

Helping residents to look after and take their medicines themselves (self-administration)	
The care home medicines policy:	***Date/notes***
Includes a process for self-administration of medicines, which gives details of: • when and how to 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 • who may be involved in the risk assessment in addition to the resident and/or their family or carers • how medicines for self-administration will be stored (for example, in a lockable cupboard or drawer in a resident's room), including controlled drugs. In adult care homes, the process includes: • recording any medicines supplied to the resident for self-administration • recording when a resident has been reminded to take their medicine themselves. In children's homes, the process includes: • making and keeping records for children who self-administer their medicines. See recommendation 1.13.2, recommendation 1.13.3, recommendation 1.13.4, recommendation 1.13.5, recommendation 1.13.6, and recommendation 1.13.7.	Please use these boxes to make notes.

Care home staff administering medicines to residents	
The care home medicines policy:	***Date/notes***
Includes a process for medicines administration by care home staff, which follows a person-centred approach and specifies that only trained and competent staff should administer medicines. The process details: • the 6 R's of administration: – right resident – right medicine – right route – right dose – right time – resident's right to refuse • that 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 and carers. • the information a medicines administration record should include: – the full name, date of birth and weight (for those under 16 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 (this will require liaison between the care home and the resident's GP) – when the medicine should be reviewed or monitored (as appropriate) – any support the resident may need to carry on taking the medicine (adherence support)	Please use these boxes to make notes.

  - any special instructions about how the medicine should be taken (such as before, with or after food, or whether the medicine could be crushed)
- who will produce the medicines administration records
- how to record medicines administration (including medicines administered by visiting health professionals)
- how to cross-reference administration records (for example, 'see warfarin administration record') when a medicine has a separate administration record
- 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
- agreeing with the resident, prescriber and pharmacist the timing for administration of medicines
- how to reduce interruptions during medicines administration rounds
- the training and skills needed by care home staff to use system(s) adopted in the care home for administering medicines
- how to ensure information on the medicines administration record is accurate and up-to-date
- how to access appropriate medicines information and resources.

See recommendation 1.11.3, recommendation 1.14.1, recommendation 1.14.4, recommendation 1.14.5, recommendation 1.14.10, recommendation 1.14.13, recommendation 1.14.14, recommendation 1.14.15 and recommendation 1.14.19.

For ‘when required’ medicines, the process includes: • the reasons for giving the 'when required' medicine • how much to give if a variable dose has been prescribed • what the medicine is expected to do • the minimum time between doses if the first dose has not worked • offering the medicine when needed and not just during 'medication rounds' • when to check with the prescriber any confusion about which medicines or doses are to be given • recording 'when required' medicines in the resident's care plan. The process specifies that medicines prescribed as ‘when required’ are kept in their original packs and not monitored dosage systems. See recommendation 1.14.3.	
For controlled drugs, the process includes: • how to make appropriate records of controlled drugs that have been administered to residents • the requirement for signing the controlled drugs register and the medicines administration record. See recommendation 1.14.16.	
The process includes the following information about producing new, hand-written medicines administration records: • the training, skills and designated responsibility required by the care home staff • checking accuracy and signing by a second trained and skilled member of staff before first use. See recommendation 1.14.9.	
Includes a process for when a resident is temporarily absent from the care home that details giving the following information to the resident and/or their family or carers: • 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. See recommendation 1.14.17 and recommendation 1.14.18.	
Includes a process for care home staff (registered nurses and social care practitioners working in care homes) updating records of medicines administration with accurate information about any changes to medicines. See recommendation 1.9.4.	
Includes a process for recording prescribing instructions given remotely, which gives details of: • how care home staff should record instructions given by telephone, video link, online or, in exceptional circumstances only, text message • how care home staff should make sure that the health professional using remote prescribing changes the prescription • the training and skills required by care home staff to assist with the assessment and discussion of a resident's clinical needs • how the medicines administration record should be updated • recording the information in the resident's care plan (usually within 24 hours) • how staff should make sure that the resident's confidentiality is maintained. For care homes with nursing, the process incorporates the Nursing and Midwifery Council Standards for medicines management (2010) for remote prescribing. See recommendation 1.9.7and recommendation 1.9.8.	
Includes details of the training and skills required by care home staff, as follows: • induction training relevant to the type of home care home staff are	

working in (adult care homes or children's homes) • training and competency assessment for staff designated to administer medicines, including the learning and development requirements for this role • internal or external learning and development programmes for the skills needed to manage and administer medicines • annual review of the knowledge, skills and competencies relating to managing and administering medicines • a requirement that staff who do not have the skills to administer medicines, despite completing the required training, are not allowed to administer medicines to residents • a requirement for all health professionals employed by the care home to be professionally qualified and registered with the appropriate professional body, and continue to meet the professional registration requirements, if applicable (for example the post-registration education and practice (Prep) standards set by the Nursing and Midwifery Council). See recommendation 1.17.1, recommendation 1.17.2 and recommendation 1.17.3.	

Care home staff giving medicines to a resident without their knowledge (covert administration)	
The care home medicines policy:	***Date/notes***
Includes a process for the covert administration of medicines. For adult care homes, the process includes: • when to consider covert administration of medicines • how to undertake an assessment of the resident's mental capacity • how and when to hold a best interest meeting • recording the reasons for presuming mental incapacity and the proposed management plan • a plan of how medicines will be administered without the resident knowing • how to regularly review whether covert administration is still needed. See recommendation 1.15.1, recommendation 1.15.3 and recommendation 1.15.4.	Please use these boxes to make notes.
The process specifies that covert administration should only take 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. See recommendation 1.15.2.	

Care home staff giving non-prescription and over-the-counter products to residents (homely remedies)	
The care home medicines policy:	***Date/notes***
Includes a process for managing and administering non-prescription medicines and other over-the-counter-products (homely remedies) for treating minor ailments when providers (care homes) offer these to residents. The process includes: • naming care home staff who give homely remedies to residents • ensuring that named staff sign the process to confirm they have the skills to administer the homely remedy and acknowledge that they will be accountable for their actions • how and when care home staff should take advice on the use of homely remedies from a health professional, such as a GP or pharmacist • regular stock checking of homely remedies to ensure that they are within their expiry date • keeping homely medicines in their original packaging together with any information supplied with the medicine about its use. See recommendation 1.16.1 and recommendation 1.16.2.	Please use these boxes to make notes.