Corby Clinical Commissioning Group

Nene Clinical Commissioning Group

Professional Advice for Care Homes

Care Home Advice Pharmacy Service Team

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Contents

1. The administration of medicines in care homes

1.1 Self medication

People have the right to choose to manage their own medicines if they want to, with appropriate support from the care home, and this is reinforced by the NICE Managing Medicines in Care Homes guideline (March 2014). This is particularly important for short term respite, or intermediate care, when people may need to be able to manage their own medicines when they return home.

Residents in care homes (nursing) have the same rights to choose as those in care homes (personal care). When a registered nurse gives care it does not automatically mean that people may not look after their own medication. However, there are reasons why some people do not choose to keep their own medicines, preferring instead to allow the care staff to take responsibility for them. This is often the case for older people and when this happens the care provider should document resident choice.

It is important to stress that the first priority is the person's wishes. People are free to choose whether or not to keep and take medicines themselves. This important element of choice promotes independence and dignity. If care providers chiefly promote administration of medicines by care workers, residents may not be aware of support that can be offered to them.

Any process involving self medication must be subject to a robust risk assessment which is reviewed at regular intervals and when there is any change in the person's circumstances. The care worker should assess whether the person understands:

- why the medicine is prescribed,
- how much and how often to take it,
- what may happen if he or she does not take the medicine or takes too much.

Part of the risk management strategy should provide residents with somewhere secure to keep the medicines in their own room. Locked storage must be provided for each person. Any controlled drugs that they take can be kept in here and do not need to be locked in the home's controlled drug cupboard.

Care workers should identify whether people who are confused or lack cognitive awareness can safely keep and take their own medicines. For more information refer to the Mental Capacity Act 2005 and Mental Capacity Act Code of Practice 2007.

The degree of self-medication can vary from a person who is able to completely manage all the medication arrangements themselves to taking one tablet later on at night after the carer has left it with them earlier, this may also include pain killers if they have difficulty settling. Some people may need extra help to be able to manage their medicines, such as special monitored dosage systems.

The care plan must reflect the person's wishes and the specific arrangements for their medication. Any medicines ordered by the home must be properly receipted and a record made when they are handed over to the person who self-medicates.

Prescribed medicines belong to the person they were supplied for, identified by the name on the label. The care home does not own them, even though care workers may request and take receipt of medicines. This applies whether or not the home provides nursing care.

People who have a physical or mental disability should not have their medicines automatically given by care workers. Community pharmacists undertake assessments under the Disability Discrimination Act and may be able to adjust the way the medicines are packed or labeled for individual people in order to promote self-administration, for example containers with ordinary caps instead of child resistant closures that are difficult to open.

There are situations when people are keen to look after some medicines and not others. An example is when a resident keeps an inhaler for immediate use but prefers the care workers to look after tablets or liquid medicines.

There is no need for staff to fill in the administration section of the MAR chart when people self-administer medicines, however the sheet should indicate that the person self-medicates. Some homes choose to use the MAR to show that they have checked that the medicine has been taken, but it must be clear that this medication has not actually been given by staff.

1.2 Equality and diversity

People have certain preferences and these may relate to equality and diversity. The following are of particular concern:

- The medicine is provided in a gelatine capsule and the person is vegetarian.
- People prefer to have medicines given to them by a member of the same sex.
- The person observes religious festivals by fasting and prefers not to have medicine given at certain times.

These specific examples of resident choice and preference should be recognised and accommodated through the care planning process.

1.3 Care workers

Care workers may, with the consent of the resident, administer prescribed medication, so long as this is in accordance with the prescriber's directions. Consent does mean that the person may at any time refuse to take medication that the care worker offers.

Care workers must have clear directions what to give and when. This will require detailed information in the care plan if a doctor orders a medicine "when required".

In care homes (personal care), basic training is essential before a care worker gives medicines to people. This should cover administration of the following:

- tablets and capsules,
- liquids that must be measured, e.g. lactulose,
- cream, ointment or other external application,
- eye, ear or nose drops,
- inhalers.

Many care providers allocate medicine administration to senior staff. There must be enough suitably trained workers to cover all of the times that people may need medicines. It is not in the best interests of residents to restrict access to pain relief during the night because care workers are not at a senior level.

When medicines must be administered by specialised techniques, the community nursing service supports people who live in care homes (personal care). With additional training from a healthcare professional, a care worker can give the following:

- rectal administration, e.g. suppositories, diazepam (for epileptic seizure),
- insulin by injection,
- medicines through a Percutaneous Endoscopic Gastrostomy (PEG),
- oxygen.

(This is not an exhaustive list).

Delegation of medicine administration to a care worker is an important aspect of care provision. This is very important in care homes for adults when people have medicines prescribed for conditions like epilepsy. Some medicines are in tablet or liquid form that care workers can give. If the resident has a seizure, he/she may need to have medicines administered rectally and this is a specialised technique. Seizures are not predictable, so it is impossible to predict when the medicines will be needed. And it is not in the person's best interest to delay treatment for a paramedic to attend the home.

The care home's procedures must include that care workers can refuse to assist with the administration of medication by specialised techniques if they do not feel competent to do so.

1.4 Safeguards

There are two important safeguards that care providers must make sure are in place to protect the people they care for:

- written procedure for the administration of medicines, which is monitored to make sure that care workers follow safe practice,
- care workers have the correct level of training before giving any medicines.

A further safeguard is that care workers only give medicines to people from the container that the pharmacist or dispensing GP has provided. This container must have the person's name on the label and the full instructions for the care worker to refer to. Re-packaging medicines into another container with the intention that a different care worker will give it to the resident at a later time is called "secondary dispensing". Both the Royal Pharmaceutical Society and the Nursing & Midwifery Council state that this is unsafe practice that can potentially cause drug errors.

1.5 Mixing medicine with food or drink

A care worker should not mix medicine with food or drink if the intention is to deceive someone who does not want to take the medicine. This is called "covert" administration. The exception to this is when a the resident has been assessed as not having mental capacity with regard to medication and a best interest meeting decides that the medicine is

essential to their health and wellbeing. For more information refer to the Mental Capacity Act 2005 and Mental Capacity Act Code of Practice 2007.
If the decision is taken to give medicine covertly, it is not good practice to crush tablets or open capsules unless a pharmacist advises that it is safe to do so.

When a resident has difficulty swallowing, it may be important to crush tablets when there is no liquid alternative. A pharmacist's advice must be sought in these circumstances.

1.6 Difference between care homes

A care home (nursing) employs registered nurses. The Nursing and Midwifery Council (NMC) Code of Professional Conduct requires each nurse to be individually accountable for making sure that all medicines are administered correctly, and to be personally accountable for up-to-date practice.

The code sets out how a registered nurse may delegate the administration of some medicines to care workers. An example of this is the application of cream or ointment when the care worker is bathing the resident. The whole task is delegated and the care worker who is responsible should sign the record of administration.

If the registered nurse prepares medicine and gives it to another care worker to take to the person, the care worker who gives the medicine is responsible and should:
- make sure that the prepared medicine is correct with the record,
- sign the administration record.

Under no circumstances should the nurse who prepared the medicine sign the record without checking that the person has taken it.

The administration of medicines by invasive or specialised techniques will normally involve a registered nurse. An example of this is intra-venous administration of medicines. The care provider is responsible for making sure that a registered nurse who gives medicines by a specialised technique has relevant and up-to-date training.

1.7 Monitored dosage systems

Monitored dosage systems (MDS) have been promoted as a safe system of medicine administration in care homes. However, MDS are merely a convenient form of packaging for a limited group of medicines. Safe practice is not guaranteed by use of a system alone but is promoted by only allowing staff who are trained and competent to give medicines.

MDS do improve some procedures including:
- the system of organising repeat prescriptions for people,
- supply to the care home of printed medicine administration record charts (MAR),
- a visual check whether medicines have been removed to give to the resident.

However MDS can only be used for tablets and capsules, with certain exceptions. The following should not be put into MDS:
- medicines that are susceptible to moisture, e.g. effervescent tablets,
- light-sensitive medicines, e.g. chlorpromazine,
- medicines that should only be dispensed in glass bottles, e.g. glyceryl trinitrate,

- medicines that may be harmful when handled, e.g. cytotoxic products like methotrexate.

Liquid medicines, creams, eye drops, inhalers must be supplied in original containers. Therefore, any care home that uses MDS will have two different systems operating.

Care providers must consider carefully how any changes that the prescriber makes to the resident's medicines can be obtained in MDS quickly. MDS work well when the person's medication is regular and does not change frequently. Packaging of medicines for "as required'" use in MDS is not suitable.

The NHS does not fund MDS systems therefore the care provider may be asked to pay for the equipment. Suppliers of medicines (community pharmacies, dispensing GPs) cannot be compelled to provide medicines in this way however much the care provider may want it. Individuals can be assessed within the Disability Discrimination Act criteria for support to manage medicines themselves. This does not apply to entire care environments where the principal benefit is to care workers.

It is therefore not appropriate for Care Quality Commission (CQC) inspectors to recommend or require the use of MDS or other compliance systems. This guidance does not preclude situations where care workers support people to fill their own compliance aid.

For further information on MDS, please refer to the "Guidance on the use of Monitored Dosage Systems (MDS)" available at http://nww.pathfinder-rf.northants.nhs.uk.

1.8 Non-prescribed medication

Many medicines can be purchased through pharmacies and retail outlets by anyone. People may decide to buy and keep remedies to take themselves, including herbal and homeopathic products. A visitor may do this for them. Care home staff should be aware that this is happening and must adhere to the home's policy on such purchases.

When the care provider keeps a range of "homely remedies", it is care workers who will decide whether to give them to a resident or not. Homely remedies are used to provide immediate relief for mild to moderate symptoms. They are treatments that people would use themselves without consulting their GP, for example to treat toothache or indigestion. These medicines are potent and may interact with medicines that the doctor has prescribed for residents.

The care provider is under no obligation to provide this treatment. If homely remedies are purchased for occasional use by residents, the care provider must have a written policy that details the following:

- which medicines are kept for immediate relief of mild symptoms,
- the indications for offering the medicines,
- the dose to give and how often it may be repeated before referring to the resident's doctor,
- how to establish with the resident's GP that the remedies will not interact with other prescribed medicines,
- how to obtain the resident's consent to treatment that the doctor has not prescribed,
- how the administration will be recorded.

If a problem persists residents should consult with their GP because the symptoms may be masking other medical problems. This is why homely remedy use should be time-limited, usually 24-48 hours.

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. For further information on homely remedies, see Section 8.

2. Medicine Administration Records (MAR) in care homes

A MAR chart is the record that details for each person what is currently prescribed (including those self-administering medicines) and what has been administered to a resident. The carer signs each time a drug or device is administered to a patient. Carers administering medication in the care home setting should be suitably trained and competent to do so.

MAR charts may also include details of medicine receipt and disposal but if not, these records must be kept in another format. Taken together, these records should enable anyone to audit and account for every medicine brought into a care home.

2.1 Why is the MAR chart so important?

Care workers who give medicines must have a chart that details:

- which medicines are prescribed for the person
- when they must be given
- what the dose is
- any special information, such as giving the medicines with food.

It is also important to keep a record when prescribed medicine has not been given. Differing letter 'codes' are used to record when medicines have not been given. The MAR must explain what the codes mean.

The information on the MAR will be supplemented by the person's care plan. The care plan will include personal preferences.

The MAR can be a useful tool for the care provider to use to keep track of medicines that are not ordered every month. The provider may use the MAR to record medicines carried over onto a new chart. The practice of carrying over items is allowed. Not doing so contributes to the waste of medicines and NHS resources.

The MAR can be used to record when non-prescribed medicines are given, for example a homely remedy.

Administration of controlled drugs should be recorded on the person's MAR chart as well as the record in the controlled drug (CD) register.

Responsibility for providing MAR charts rests with the care provider. The pharmacist or dispensing GP are not responsible.

2.2 Can the care provider ask the prescriber to sign the MAR charts?

A GP does not have to sign any documents produced by a care provider for medicine administration. The NHS contract for general medical services does not require this. There are exceptions when a care provider has a private contract with a GP for medical services.

There are some occasions when it would be appropriate to ask the prescriber to sign the MAR chart, for example when the prescriber visits and changes the dose of a prescribed medicine. **It is good practice for the new medicine/dose to be written on a new line of the MAR rather than an alteration made to the existing record.**

2.3 Do care providers have to use printed MAR charts?

Poor records are a potential cause of preventable drug errors. Printed MAR charts are not essential but they are better than handwritten charts. This is because there is less risk of error due to:

- clerical error - incorrectly transcribing the details from another document
- hand writing that is difficult to read and can be misunderstood.

Example: The change of insulin dose for a resident was to give 4 units of insulin at night. The carer that dealt with the change in dose wrote ' 4 i.u.' on the chart (i.u. is an abbreviation for international units). But another nurse misread the dose and gave 41 units of insulin.

If handwritten charts are used they should be completed by suitably trained staff and be checked for accuracy by a second member of staff (also suitably trained) before administration

Printed MAR charts are usually supplied from the pharmacy or dispensing GP practice. This is a complimentary service that the supplier is paying for. Care providers cannot insist on having printed charts.

There can also be problems with printed MAR that the care provider needs to be alert to:

- The chart is correct at the time it is printed and supplied. But the dose of a medicine may change. When this happens, the care provider must keep the chart up to date.
- New prescriptions can be issued at any time in the monthly cycle. This may result in the person having several MAR charts in a file, and some may start on different dates.
- Medicines that are prescribed for 'as required' use may not be needed every month. If the MAR only has a list of medicines that have been requested and prescribed that month, it may not list the 'as required' medicines previously supplied for that person.
- The MAR should be supplemented by information that clearly describes the circumstances when 'as required' medicine may safely be given – PRN Protocol.
- The MAR may include a medicine that has not been supplied. The care provider must check whether the prescriber has stopped the medicine and if so cross it off the chart, date and sign. If the treatment is to continue, the care provider must check why there is no supply.

2.4 Can anyone write on the printed MAR?

Anyone can change the MAR chart. But the care provider should have a system to check the source and accuracy of the changes. This would also be the guidance for handwritten MAR for new residents to the care home. Cross reference to the daily notes and medication profile is recommended.

When a resident's medication is altered, care staff are responsible for amending the MAR:

- cancel the original direction
- write the new directions legibly and in ink on a new line of the MAR
- write the name of the doctor or other prescriber who gave the new instructions
- date the entry and sign (including a witness when this is possible).

If the prescriber issues a new written prescription there should be a new printed MAR chart. But following a change a new supply of medication is not always necessary. For example, if the dose has reduced and there is ample stock to administer to the resident, or on hospital discharge.

On occasions when a prescriber has given verbal instructions about a change of a medication, the care home staff must request a supporting fax or email for confirmation. NICE guideline managing medicines in care homes, recommendation 1.9.6 states that health professionals should ensure that care home staff understand any instructions and send written confirmation to the care home as soon as possible. **Health professionals should also make sure that the patient's clinical record is kept up to date and changes to repeat medication are made.**

MAR charts used in care homes look similar to 'prescription' charts used in hospitals but they are *not* equivalent to the prescription chart. The MAR is a record of what care workers administer to people who use care services, and belongs to the care provider. It is not a chart for prescribing medicines.

MAR may include details of medicine receipt and disposal but if not, these records must be kept in another format. Taken together, these records should enable anyone to account for every medicine brought into a care home.

Care homes keep a list of their staff signatures and initials so that they can confirm who has made a record on the MAR. So that the care home can confirm who has made changes to the MAR visiting health professionals can be asked to complete and sign a sheet: see **Appendix 6: Visiting health professionals signature sheet**

3. Recording of creams, ointments and nutritional supplements

3.1 Creams and ointments

Storage

Creams and ointments can be kept in people's rooms. Safe and secure storage must be available and the person should be asked if they agree to products to be kept in their room. Some creams such as Daktacort need to be kept at fridge temperatures so are not suitable to be kept in a person's room.

Directions
If instructions such as “use as directed” are unclear advice should be sought and the information recorded on the MAR. Care workers should request the prescriber to use appropriate directions on prescriptions e.g. where the cream is to be applied, how often and for how long.

Recording
The administration must be recorded. A separate MAR could be used and kept with the cream in the person’s room and in this case the main MAR should be annotated in such a way that it is clear that there is another sheet that documents administration, e.g. “See creaming chart”.

In care homes (nursing care) the nurse in charge may delegate the task of administering creams to members of the care staff. The care staff must be trained to do so and must sign the administration record in use, not the nurse. However the nurse is still responsible for the administration and should monitor the application.

Information should be available to staff to know what the cream is for, where to apply, how much to apply and for how long.
Some people are prescribed creams such as aqueous cream to use as a soap substitute. The care plan should list these products and what they are for. A record could be made in the daily care notes to record that the cream had been used to wash the person. This would demonstrate that the member of staff is using the cream appropriately.

3.2 Nutritional supplements

When a person is prescribed nutritional supplements this should only be following the assessment and advice of a dietitian. The care plan must detail why they have been prescribed them, how much to give, when to give and how to monitor the person’s progress. The prescribed supplement should be labeled for that resident and as for all prescribed items it is their property.

A record must be made to demonstrate the person is taking the supplements as prescribed. This may be on the MAR or on a separate record sheet kept with other information on the person’s progress such as daily weight checks or fluid intake. The record must show how much was given and when, as the supplement may be given at times other that the administration rounds.

A regular review of the nutritional supplement should be requested from the dietitian.

4. Medication prescribed “to be taken when required”

Medication with a “when required” (PRN) dose is usually prescribed to treat short term or intermittent medical conditions i.e. it is not to be taken regularly.

To ensure the medication is given as intended, a specific plan for administration must be recorded in the care plan and ideally kept with the MAR charts. Information on why the medication has been prescribed, how to give it and the minimum time between doses should be sought from the prescriber, the supplying pharmacist or other healthcare

professionals involved in the treatment of the person. Detailed information can also be found in reference sources such as the British National Formulary.

Consideration should be given to the person's capacity to refuse the medication. When providing staff with information, the needs of the person must be identified e.g. if signs of pain are expressed in a non-verbal way.

A record does not have to be made at each medical round to show the person has been offered the medication. However the care plan should demonstrate that staff know what the medication is for and have made an assessment on whether the person requires the medication.

PRN medication should not be offered or given only at the times listed on the MAR chart or at specific medication rounds. As it is for occasional use the person should be offered the medication at the times they are experiencing the symptoms either by telling a member of staff or by staff identifying the person's need as outlined in the care plan. The exact time the medication was given and the amount given should be recorded on the MAR.

If PRN medication is given regularly then a referral to the prescriber should be considered for a review of the person's medication, as their medical condition may have changed and the treatment required may need altering. Similarly if the medication is not having the expected effects the prescriber should be contacted. In both cases the response to the medication should be clearly recorded.

PRN medication that is still in use and in date should be carried over from one month to the next and not disposed of. A record of the quantity carried over should be recorded on the new MAR so there is an accurate record of the quantity in stock and to help when performing audits.

According to NICE Managing Medicines in Care Homes guideline (March 2014) PRN medication should be supplied in the original packaging rather than a monitored dosage system (MDS). This allows for a check on the expiry date and reduces waste.

5. Best practice medication cycle for care homes

5.1 Rationale for medication cycle process

☐ **Start the medication cycle on the agreed day of the week (Day 1)**
Agree with the Community Pharmacy and GP practice the starting day of the medication cycle. This will be the same each month.

☐ **Care home requires new monthly order for repeat medications**
The ordering cycle starts during week 2 to allow time to complete the checking process and delivery of medication in time for the new medication cycle to start.

☐ **Medicines needed for the following month are identified by designated staff member (or deputy) from MAR charts as well as discussions with care staff. Stock levels of "When required", "Externals" and "Sip feeds" must be checked.**
This part of the process takes into consideration in-house expiry dates and carrying forward appropriate medications to the next medication cycle. Adequate protected time

should be given for this task which should take place in a quiet area without disturbance. The designated staff member must be familiar with all aspects of resident's medications. A competent deputy should be appointed to cover for absence.

Only order what is required referring to a copy of current MAR charts
The right hand side (RHS) of the prescriptions received from the community pharmacy with the previous months order should be checked alongside the current MAR chart. MAR charts are checked for any changes, eg doses/medications that have been changed, stopped or newly started. Any hand written alterations by the prescriber and any additional notes should be observed (reverse of MAR, carer's notes, etc) for any entries made regarding medication which state reasons for omissions/PRN administration/any other relevant information regarding medication. It is vital that the care home keeps a copy of the order.

Prescriptions are generated by designated practice staff
Consider retaining a copy of the care home request at the GP practice for 1 month. This will help resolve any subsequent discrepancies. The GP practice should nominate a designated member of staff to liaise with the care home and community pharmacy. This person fully understands the ordering process of the care home. Job shadowing opportunities could be offered to care home/GP practice/community pharmacy staff to gain full understanding of each role.

Prescriptions go back to the care home for checking (collected by care home or by pharmacy)
A designated care home staff member has protected time to check prescriptions from the GP practice against the order prior to sending to the pharmacy.

Prescriptions are checked against the order
Any discrepancies are resolved with the GP practice as soon as possible. Each prescription is matched to the order and checked in case there have been any changes made by the GP during the interim period. Any discrepancies are resolved with the GP practice. Consider making a copy of the prescriptions before sending them to the pharmacy.

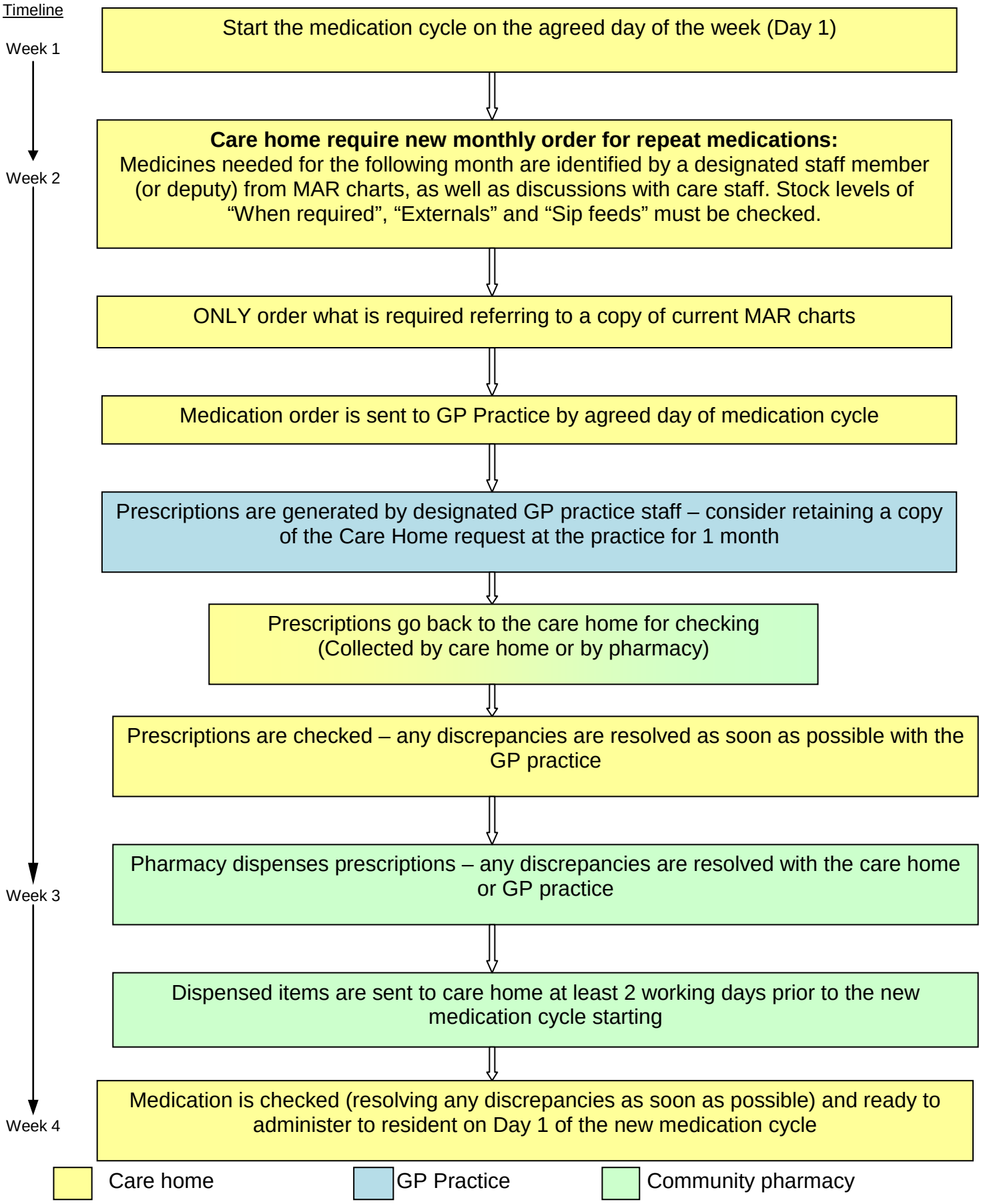
Pharmacy dispenses prescriptions
Any discrepancies are resolved with the care home or GP practice. Sufficient time is allowed for the pharmacy to dispense the medications. Processing time is pre-arranged to ensure timely delivery of medication and to allow for the dispensed items to be checked accurately by the care home prior to the medication cycle starting.

Dispensed items are sent to care home at least 2 working days prior to the new medication cycle starting

Medication is checked and ready to administer to the resident on Day 1 of the new medication cycle
Upon receipt, the medications must be checked and booked in by a designated care home staff member. Any discrepancies are resolved with the community pharmacy, including any delay in delivery. The new MAR charts are compared with the existing charts. If

changes have been made in the interim, the new MAR charts are amended and alterations signed and dated by two members of staff, adding a reference for the amendment e.g. note from prescriber, endorsing the date the prescriber altered the medication.

5.2 The cycle



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6. The safe management of controlled drugs in care homes

6.1 Why are some medicines defined as “controlled drugs"?

Controlled drugs (CD) are prescribed medicines often used to treat severe pain, treat insomnia, induce anaesthesia or treat drug dependence. Some people abuse CDs by taking them when there is no clinical reason to do so or divert them for other purposes. For these reasons, there are legislative controls for some drugs and these are set out in the Misuse of Drugs Act 1971 and related regulations.

Different controlled drugs cause dependence or misuse in varying degrees. They are classed according to the extent of harm they may cause when misused. And they are also listed in different schedules (1-5) according to the legal requirements concerning prescribing, storage and record keeping (see Appendix 1).

The purpose of legislation is to impose control on CD manufacture, prescribing, supply, possession and record keeping. The impact on care homes is limited but does require special arrangements for storage, administration, records and disposal.

6.2 What do the regulations say?

A registered provider must “make arrangements for the recording, handling, safekeeping, safe administration and disposal of medicines received into the care home”. This applies to all medicines, including controlled drugs.

Controlled drugs should be kept in a designated CD cupboard when staff are responsible for giving them to people.

Where residents are not able to self-administer in a care home providing nursing care, a medical practitioner or a registered nurse should administer the CDs. In care homes providing personal care, CDs should be administered by appropriately trained care staff, and this should be witnessed by another appropriate member of staff.

The use of a witness is intended to reduce the possibility of an error occurring. To be effective, the witness must understand what the care home member of staff is doing and therefore needs medicines training.

Care homes should keep additional records of receipt, administration and disposal of controlled drugs in a “register”. This is explained in the Royal Pharmaceutical Society’s guidance as *“a bound book or register with numbered pages”***.** This does not exclude the use of a computerised record provided that it is:

- secure,
- cannot be altered at a later time,
- attributable to the person who created the record.

6.3 What are the issues when people look after and take their own medicines?

People can keep and take controlled drugs themselves. For self-administration, the process of risk assessment is important, not the legal classification of the medicine. The care worker should assess whether the person understands:

- why the medicine is prescribed,
- how much and how often to take it,
- what may happen if he or she does not take the medicine or takes too much.

Sensible precautions are important to make sure that controlled drugs are not stolen from the person. Care providers do not need a CD cupboard in each bedroom; however a lockable cupboard or drawer is essential. The risk assessment process places responsibility on the person who keeps the controlled drug. Through monitoring and review of the risk factors, the care provider should identify that controlled drugs are not left lying around where they could be taken by someone else.

There is no need to keep a record in the CD register when the person is wholly independent. That is, he or she is responsible for requesting a prescription and collecting the controlled drugs personally from the pharmacy.

If the person does not arrange the supply and collection of controlled drugs but relies on the care workers to do so, there should be clear records including:
- receipt from the pharmacy,
- supply to the person,
- any subsequent disposal of unwanted controlled drugs.

These records should be made in the CD register.

The situation may arise when a resident chooses to use illicit drugs as distinct from prescribed controlled drugs. The care provider is responsible for deciding how to deal with illicit use of drugs on the care home premises.

6.4 What safeguards must be in place when care workers administer controlled drugs?

Safeguards are essential when any prescribed medicine is given by care workers, including:
- Respecting the person's choice and preference, particularly when these relate to ethnic or religious observance. Recognising the person's right to refuse treatment.
- A robust system to make sure there is always an adequate supply of prescribed controlled drugs.
- A safe procedure for giving controlled drugs that will minimise the potential for a drug error. This should include a witness to the controlled drug administration who also signs the CD register when practicable. However, no one should be deprived of prescribed medicine because there is only one member of staff on duty when he or she needs it.
- Providing training for care workers who are designated to give controlled drugs and also to those who will act as a "witness".
- Keeping full records of what has been given, when and by whom.

The use of a witness is intended to reduce the possibility of an error occurring. To be effective, the witness must understand what the care worker is doing and therefore needs the same level of training. The witness will confirm that:
- the care worker selects the correct controlled drug,

- the name on the label attached to the controlled drug is the same as the person the care worker intends to give it to,
- the care worker has prepared the right dose, included on the label and in the MAR chart,
- the care worker gives it to the right person,
- the administration is recorded in the CD register as well as signed on the MAR chart.

In care homes (personal care), any controlled drugs given by injection are the responsibility of community nurses. It is important to make sure that the care home retains a record of all controlled drug administration, especially when the community nurse completes a record that is not left in the care home. If the community nurse is not willing to make a duplicate record in the home's CD register, it will be important for the witness to complete this record.

For the majority of care homes, the only controlled drugs that care workers will be responsible for will be prescribed for named people. They belong to the named person, not the care service. It is therefore important for care workers to treat controlled drugs as valuables that the person owns.

Controlled drugs are a target for theft and it is good practice to regularly check them. The CD register should include the balance that remains, which can be compared with the quantity in the CD cupboard. If a discrepancy is noted, the care provider should have a process to investigate and establish what has happened. For example, has a care worker forgotten to complete the record or have the controlled drugs been stolen. If controlled drugs are missing, this is a serious incident and they must notify the CQC. It may also be necessary to contact the police to discuss how to deal with the situation.

If an error occurs when a controlled drug is given, this may have serious consequences for the person involved. The care worker should first of all contact the person's doctor for advice. And if the person requires emergency treatment, the incident should be notified to the CQC. Examples of drug errors include:

- wrong dose, too much or too little given,
- given at the wrong time, e.g. a tablet that should be given every 12 hours is given every 4 hours,
- given to the wrong person.

When a resident's controlled drugs are no longer required they should be disposed of safely and a record kept of who returned them, the quantity and date. A witness to this transaction is good practice. For care homes (personal care) they can be returned to the supplier. Care homes (nursing) must use a company with a waste management licence.

6.5 What are the requirements for controlled drug storage in care homes?

The secure storage of controlled drugs is specified in the Misuse of Drugs (Safe Custody) Regulations 1973. In the 2007 Amendment the term "nursing home" has been replaced by "care home". The main impact is that every care home must store controlled drugs in a CD cupboard, including care homes registered for personal care.

Legal requirements for storage may appear to have little or no impact on the care given to people. What it does achieve is a greater deterrent against diversion and theft. And it should also serve as a constant reminder to care workers that these medicines are potent.

In brief, the requirements for CD storage are:

- Metal cupboard of specified gauge.
- Specified double locking mechanism.
- Fixed to a solid wall or a wall that has a steel plate mounted behind it.
- Fixed with either Rawl or Rag bolts.

Suppliers of CD cabinets can confirm that a cupboard meets the legal requirements. It is recommended that care homes request formal confirmation when purchasing a CD cabinet.

It is a commonly held belief that a CD cupboard must be a "cupboard within a cupboard". This is not the case.

It is also important to ensure:

- The security of the location also needs careful consideration.
- For safe practice the CD cupboards should only be used for the storage of CDs. No other items, including those of value such as jewellery or money should be placed there.
- Only those with authorised access should hold keys to the CD cupboard.

6.6 Reporting of discrepancies with controlled drugs

The CQC continue to be responsible for regulating the handling of controlled drugs in registered care homes and when necessary will use enforcement. They collaborate at a local level with NHS England at Area Team level, police and other named authorities to share information when controlled drugs are not handled correctly. This is the Local Intelligence Network (LIN). Nene CCG and Corby CCG are both part of Hertfordshire and the South Midlands Area Team.

A Pharmaceutical Adviser provides advice to the Controlled Drug Accountable Officer who chairs the LIN.

The LIN comprises representatives from other regulators (including the CQC and General Pharmaceutical Council), Police CD Liaison Officers and NHS Protect Officers. Several CCGs may work together in one LIN.

The CQC share information about controlled drugs with the LIN when issues identified are not within the scope of their regulatory role. An example is poor practice by healthcare professionals that the care home does not employ directly. The information may be essential to the NHS primary care organisation that contracts with the healthcare professional concerned:

- Poor clinical practice by a GP that a pharmacist inspector identifies.
- A healthcare professional insists on removing unwanted controlled drugs from a care home.
- Concern about the practice of a registered nurse from a Nurses Agency who may additionally work in other care homes and/or NHS hospitals.

6.7 Can care homes keep a stock of controlled drugs?

Care homes (personal care) cannot purchase and keep stocks of prescription only medicines, including controlled drugs.

The Medicines Act 1968 does permit a care home (nursing) to purchase and use stocks of controlled drugs so long as they have a domestic licence issued by the Home Office or are mainly maintained by charitable funds. This may be the case in some drug and alcohol rehabilitation units. And as care homes become involved in "End of Life" care they may apply to the Home Office for a domestic licence. Details of how to make the application can be found on the Home Office website.

The main difference for a care home (nursing) that holds stock supplies is that the disposal of stock controlled drugs must be witnessed by an "authorised person". The Accountable Officer at the local Area Team will advise who can do so locally.

7. Good practice guidance on covert administration of medication (adults in a care setting)

7.1 Introduction

This section relates to the administration of medicines to all ADULT residents who are unable to give informed consent to treatment and refuse to take tablets, capsules or liquid preparations when openly offered to them. (A competent adult is entitled to refuse treatment even when this decision may adversely affect his/her health or shorten his/her life).

It is important to consider why the person is not accepting the prescribed medication. It may be that he/she does not understand what it is for, or lacks the understanding of the consequences if he/she refuses. However, equally he/she may actually not understand what to do with the offered tablet or syrup, it may be unpalatable, or he/she may have difficulty swallowing the formulation. Every acceptable alternative should be explored before covert administration is undertaken, (see UKMi Medicines Q&A: What are the therapeutic options for patients unable to take solid oral dosage forms?).

As a general principle, if the medication is being disguised in food or drink and the person does not know, then the person is being led to believe that they are not receiving the medication, when in fact they are. The covert administration of medicines is only likely to be necessary or appropriate in the case of residents who actively refuse medication but who are judged not to have the capacity to understand the consequences of their refusal.

As well as the ethical and legal considerations, the nurse/care worker needs to consider that administering medicines in this way may alter their therapeutic properties rendering them ineffective and not covered by their product licence. This is a matter to be discussed with a pharmacist as part of the decision making process.

7.2 Capacity to consent

For those residents who refuse medication, an appropriate capacity assessment must be completed. The Mental Capacity Act 2005 contains a two stage functional test which is recommended for use within Northamptonshire (Appendix 2).

The two stages help the assessor decide whether the individual being assessed has an impairment of, or disturbance in the functioning of his/her mind or brain and if there is, is it enough so that the individual lacks the capacity to make a certain decision.

It is important to realise that every adult must be presumed to have mental capacity unless he/she cannot understand the information relevant to the decision, retain it long enough to make the decision, be unable to understand it or actually communicate the decision taken.

Please note that that capacity may fluctuate and that regular assessment is necessary, and that some forms of forced or disguised medication are actually recognised in law e.g. an individual detained under a section of relevant mental health legislation.

7.3 Lack of capacity

When it has been determined by a competent person that the individual lacks capacity then his/her “best interests” should be considered in an open discussion with healthcare professionals (usually the GP responsible for the care of the individual, the nurse/carer giving the medication and the pharmacist supplying the medication), relatives, other carers and friends.

There may be a lasting power of attorney for welfare decisions in place and the person nominated in this must always be consulted .This multi-disciplinary group should consider past and present wishes of the individual, that the medicine in question is essential for the residents’ health, or protect others if they are at risk of assault by the resident in question.

7.4 Documentation

This should ensure that the decision and the action taken by at the multidisciplinary meeting is recorded in the care plan and is then reviewed at appropriate documented intervals. The Covert Administration Medication Record Form (Appendix 3) is recommended for use within Northamptonshire with the associated Covert Medication Review Form (Appendix 4).

7.5 Pharmacist advice

Under the Medicines Act 1967 only a prescriber can authorise the use of unlicensed medicines. However the pharmacist supplying the medication should be consulted to confirm the stability of the medicine and provide advice on the most appropriate way of administering it. Any alteration to the medication or mixing with food/drink in any way will render it unlicensed and therefore the prescriber, supplier and person administering the

medication will assume greater legal responsibility. The pharmacist should be asked to complete the Covert Administration of Medication Guidance sheet (Appendix 5).

7.6 Policy

Each care home in Northamptonshire should have a clear written policy on covert administration based on these guidelines.

8. Homely remedies

For <u>short term use</u> in care homes, for the management of minor, self-limiting conditions.

For each home the list of homely remedies should be agreed between the care home and the residents' GP.

Homely remedies should only be administered in accordance with the manufacturer's directions and only to those residents whose GP has agreed to their use. A record of that agreement should be made in the individual resident's medication profile.

Homely remedies should not be used for more than an agreed period. It is recommended that administration should not continue for more than 48 hours before consulting the resident's GP.

The community pharmacist supplying the home may be approached to provide advice on uses, doses and possible interactions with prescribed medicines. Advice on the shelf life of products once opened may also be obtained from the community pharmacist.

The administration of homely remedies must be recorded, stating drug, dose, time, date, administered by, reason for administration.

e.g. Paracetamol 2 x 500mg tablets 10.00 a.m. 20.8.93. S. Brown: for headache.

Recording is best done on the same sheet as the record of administration of prescribed medicines e.g. by using the back of the MAR chart.

Care should be taken to ensure that residents are not taking non-prescribed medicines that they have purchased or have been given, IN ADDITION to the homely remedies being administered by the care home's staff.

N.B. Each home must prepare a written procedure covering at least: homely remedies to be available in the care home; maximum period of use; arrangements for agreement from residents' GP including recording agreement; procedure for recording homely remedies administered; procedure for checking homely remedies required against medication purchased by or for residents.

Only small packs/bottles of each item should be held in the care home.

Suggested drugs for use as homely remedies:

Minor illness requiring treatment	Drug/ Medicine	Maximum dose to be taken at one time	How often it can it be given	Warnings/Problem areas
Cough	Simple Linctus	Two 5ml spoonful	Repeat after 4 hours	Contains sugar. Will not help a wheezy cough.
Indigestion	Asilone	Two 5ml spoonful or 1-2 tablets	Repeat as required	Severe indigestion pain that does not respond to treatment needs to be seen by a doctor as soon as possible.
Diarrhoea	Dioralyte sachets	One sachet	Repeat as required	Plenty of drink e.g. water or fruit juice or tea or coffee should be taken. If there is blood in the diarrhoea a doctor should be notified as soon as possible.
Constipation	Senna tablets or syrup	Up to four tablets or up to two 5ml spoonful of syrup	Once a day - usually at bedtime	Do not give if abdominal (tummy) pain is present. Make sure that the resident drinks plenty of water or juice or tea or coffee etc. eats cereals, fruits, etc. and moves about the home, if possible.
Headache or Muscular aches e.g. backache	Paracetamol	One or two 500mg tablets	Doses NOT closer than 4 hours apart NOT more than 8 tablets in 24 hours	Paracetamol: Do not give to residents on pain killers or drugs for arthritis/ rheumatism until a GP or Pharmacist has checked the combination of prescribed medicines with the Homely Remedies list.

Authorisation to administer (GP to delete item(s) from this list, if appropriate)

GP ..... signature AND

Name .....

List agreed (date) .....

Resident ..... DOB ……

9. Guidance on storage of medicines and expiry dates

9.1 Storage of medicines

All medicines should be stored in a cool (below 25^{o}C), dry place, away from direct sunlight. Some medicines need to be kept refrigerated at a temperature of between 2^{o}C. and 8^{o}C. The conditions for storage are always stated on the packet or in the Patient Information Leaflet (PIL). Care homes must have a policy for monitoring temperatures in fridges and areas where medicines are stored.

9.2 Disposing of medicines

The disposal of medicines is regulated by The Control Waste (England and Wales) Regulations 2012. Under these regulations medicines fall under the category of "clinical waste". The disposal requirements are dependent on the type of care home:

- Care homes (personal care) - clinical waste is treated as household waste. Medicines that are no longer needed should be returned to the community pharmacist for disposal.
- Care homes (nursing care) - 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.

Before disposing of a medicine that is still being prescribed for a resident, care home staff should find out if it is still within its expiry date and if it is still within its shelf-life if it is opened (see section 9.3).

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).

Care homes 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.

9.3 Guidelines for medication expiry

Every pharmaceutical product has an expiry date that is stated on the packaging. The use of a product past its expiry date may result in a lower dose of active ingredient, altered bioavailability, patient discomfort or a safety hazard due to microbial contamination or toxic degradation products.

There has been much confusion in the past about the issue of expiry dates for medication within care homes. This has led to problems with patient safety and the excessive wastage of medication.

The NICE Managing Medicines in Care Homes guideline (March 2014) recognises "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 guidance states 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 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. **Opened medicines can therefore be used up to the manufacturer's recommended expiry date stated on the packaging of the medicine.**

Professional judgement must be used when deciding if a product is suitable for use. The stability (both chemical and microbiological) and the mode of use of a medicine must be considered.

Preparations that have not been opened can be kept and used up until their manufacturer's expiry date.

Products should not be put into the medicines waste unopened and then a new supply ordered! Think about the needs of the resident and discuss them with the GP and/or Community Pharmacist. You can help us make a difference and reduce the amount of medicines waste in the county.

Summary of the guidance:

Preparation	Unopened and stored in accordance with manufacturer's guidance	Opened and stored in accordance with manufacturer's guidance
Tablets & capsules in blister strips – where expiry date is in intact	Manufacturer's expiry date	Manufacturer's expiry date
Tablets & capsules – where in pharmacy bottle	Discuss with dispensing pharmacy or GP dispensary	Discuss with dispensing pharmacy or GP dispensary
Tablets & capsules – where in Monitored Dosage System	As labelled by the dispensing pharmacy/GP dispensary	As labelled by the dispensing pharmacy/GP dispensary
Liquids – where in original bottle	Manufacturer's expiry date	Follow guidance in PIL
Liquids – where in pharmacy bottle	Discuss with dispensing pharmacy or GP dispensary	Discuss with dispensing pharmacy or GP dispensary
Creams	Manufacturer's expiry date	Follow guidance in PIL
Ointments	Manufacturer's expiry date	Follow guidance in PIL
Eye drops/ointment	Manufacturer's expiry date	28 days or 6 months*
Ear drops	Manufacturer's expiry date	Follow guidance in PIL
Nose drops/sprays	Manufacturer's expiry date	Follow guidance in PIL
Inhalers	Manufacturer's expiry date	Follow guidance in PIL
Insulins	Manufacturer's expiry date, stored in the fridge	Currently in use, can be kept out of the fridge for 1 month

Tablets and Capsules

These are unlikely to be harmful if taken after their expiry date, but the manufacturer cannot guarantee effectiveness beyond this date. Tablets and capsules in blister strips (in original packaging or white pharmacy cartons) with their manufacturer expiry dates intact

can be kept up to that original date. For tablets and capsules dispensed in pharmacy medicine bottles, advice must be sought from the dispensing pharmacy/GP dispensary.

Tablets and Capsules packaged in a monitored dosage system

If medicines are packaged in a MDS they will no longer be covered by the terms of their product licence. They should only be used up to the date as labelled by the dispensing pharmacy/GP dispensary.

- Not all medicines can be packaged in a MDS.
- The pharmacist/dispenser should consider the suitability of the medicine for MDS since some medicines should only be stored in their original packaging.
- If controlled drugs (CD) are incorporated into an MDS then the whole box is subject to Misuse of Drugs (Safe Custody) Regulations.
- MDS systems should not be used for PRN medication as it can lead to increased wastage (this is emphasised in the NICE Guidance).

Oral Liquid Preparations

Liquid medicines should never be taken after their date has expired. Bacteria may contaminate them, as the preservatives in them may have run out. Unopened liquids can be kept up to the manufacturer's expiry date if kept under the appropriate storage conditions.

Unless otherwise stated, the general guidance for opened products expiry dates is:

- Discard according to the manufacturer's recommendations after opening where original packs are used.
- Where liquids are supplied in pharmacy bottles, advice must be sought from the dispensing pharmacy/GP dispensary.

Topical Preparations

Creams are water based and can become contaminated by bacteria, especially if stored in an open top tub. Creams can be assumed to last, and be effective, unopened up to the manufacturer's expiry date if stored under the appropriate conditions.

Ointments generally have a longer shelf life but can lose their softness and "spreadability" if kept for long periods. They can be assumed to last, and to be effective, unopened up to the manufacturer's expiry date if stored under the appropriate conditions.

Unless labelled otherwise the general guidance for opened products is the manufacturer's expiry date on the packaging or in the PIL.

Eye Drops and Eye Ointments

Unless stated otherwise the general guidance for expiry dates of these products is discard 28 days after opening. *Some eye drops can now be used for up to 6 months after opening - check the PIL. The packs will also bear a manufacturer's expiry date that only applies if the product is sealed and stored under appropriate conditions.

There are about 20 drops in 1ml, usually one bottle is enough for 1 month's supply. However, some of the ocular lubricants have a longer expiry once opened. See table "Longer expiry dates" below.

Ear Drops, Nose Drops and Nose Sprays

If these products are sealed and stored under appropriate conditions, the manufacturer's expiry date on the packaging can be used. Once opened, follow the expiry date stated in the PIL.

Inhalers

Inhalers will keep for as long as the manufacturer's expiry date on the pack, as the medicine will be stored either in a pressurised canister or in a blister pack or capsule.

Inhaler holders and spacers should be washed weekly or according to the manufacturer's instructions. A new spacer should be obtained at least every 12 months, but check the manufacturer's information.

Insulins

Insulin cartridges and vials must be stored in the fridge when not in use and can be kept for as long as the manufacturer's expiry date on the packaging. The insulin being used by a person can be kept out of the fridge for up to 1 month. Write on the packaging the date on which it was removed from the fridge so this can be monitored.

There are many different types of insulin and administering devices, check with the manufacturer or the PIL for details.

Shorter expiry dates

Certain preparations have a shorter manufacturer's expiry date once they have been opened. The following list is not exhaustive and is only intended to cover some of the most frequently used products. Please add your own products as they become known to you. Many specials will have a short shelf life. See the PIL or contact the manufacturer for further information.

Item	Shelf life once opened
Citalopram drops	16 weeks
Oramorph 10mg/5ml Liquid	90 days
Risperdal 1mg/ml Liquid	90 days
Asasantin Retard Capsules	6 weeks
Persantin Retard Capsules	6 weeks
Neoral Oral Solution 100mg/ml	2 months

Longer expiry dates

Optive and Optive Plus eye drops	6 months
VitA-Pos eye ointment	6 months (oil based, tube contains 300 applications)
Hylo-Tar and Hylo-Forte ocular devices	6 months as device design is pump action

It is the responsibility of the care home to have policies in place to ensure that:

- The date of opening is recorded clearly on insulins, eye/ear/nose drops, eye ointments and nose sprays.
- Expiry dates are checked every time before use.
- Storage temperatures of medicines rooms and fridges are monitored and recorded daily. Any deviation from the required range must be acted upon immediately by staff.

- Home staff should only order PRN items when stocks will run out during the next month.
- Use of PRN medication should be closely monitored by the home staff so that excess stock is not ordered but that the person does not run out within the 28 day cycle. The home should liaise with the GP to order appropriate quantities of PRN medication based on usage levels.
- PRN medications should be reviewed at least every 6 months.
- Prescribed medication is the property of the resident.
- **Care home staff must NOT routinely dispose of all medication at the end of each month if it is appropriate to carry forward.**
- **Care home staff must NOT dispose of unopened medicines and reorder new supplies.**

10. Training care workers to safely administer medicines in care homes

The CQC expectation for medication is that adults are supported to manage their own medicines. In practice, only a small proportion of people will be able to do so and care workers have the responsibility for administering medicines to the majority.

Care homes (personal care):
- All medicines, including controlled drugs, (except those for self-administration) are administered by designated and appropriately trained staff. The administration of controlled drugs is witnessed by another designated, appropriately trained member of staff.
- The training for care staff can be accredited and include:
  - basic knowledge of how medicines are used and how to recognise and deal with problems in use,
  - the principles behind all aspects of the home's policy on medicines handling and records.

Care homes (nursing care):
- Care homes registered to provide nursing care employ registered nurses and they must act according to guidance published by the Nursing and Midwifery Council (NMC).
- The care provider should have a managerial and supervisory process to identify when a registered nurse is not meeting these standards to minimise the risk of error.
- Registered nurses are responsible for administering medicines to people. Although managers of these homes will wish to ensure that employed registered nurses are also competent in medicine administration, the term “accredited training” applies mainly to care homes registered for personal care.

10.1 Who can give medicines to people?

Care workers may, with the consent of the person, administer prescribed medication, so long as this is in accordance with the prescriber’s directions (The Medicines Act 1968). However, when medication is given by invasive techniques, for example insulin injections, care workers will need additional specialist training.

There are three different levels of training for care workers. All care workers should receive level 1 (induction). Level 2 (basic) is essential before any care worker administers medicines. Level 3 (specialised techniques) will only apply in specific situations.

10.2 Level 1: Induction

Level 1 forms part of induction training. The importance of this level is that it should raise awareness of the management of medicines within the home. It should also identify what the care worker is not able to do before completing level 2 training. For example, how care workers should respond when someone asks for paracetamol for a headache.

10.3 Level 2: Administering medication

Level 2 may be described as basic training. This should provide the care worker with knowledge and practical skills to safely select, prepare and give different types of medicines, a process that is referred to as “medicine administration”. A senior worker should always mentor a care worker until he/she is both confident in giving medicines and competent to do so correctly. This is the level of training that the term “accredited” relates to.

Basic training is necessary for the following:

- Establishing from the care home records which medicines are prescribed for a person at a specific time in the day.
- Selecting the correct medicine from a labelled container including monitored dosage system and compliance aid.
- Measuring a dose of liquid medicine.
- Applying a medicated cream/ointment; inserting drops to ear, nose or eye; and administering inhaled medication.
- Recording that a person has had the medicine or the reason for not administering it.
- What to do if a person refuses medicine that the care worker offers.
- Who to inform if a medication error occurs.
- Who to inform if the person becomes unwell after taking his/her medicines.

Basic training does not extend to administration of medicines by specialised techniques including:

- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure).
- Insulin by injection.
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG).
- Giving oxygen.

This specialised training is Level 3.

The care home’s procedures should enable care workers to:

- Refuse to administer medication if they have not received suitable training and do not feel competent to do so.
- Identify that people may have preferences about who gives medicine to them and when.

10.4 “In house” training

There are aspects of medication training that can be provided within a care home by employed staff. This depends on:

- The size of the organisation.
- Whether the organisation has a dedicated training division.
- The level of knowledge of employees and whether they have training skills.
- The care needs and preferences of the people they care for.

"In house" training schemes must have a body of up to date knowledge in the subject of medicines.

Support and advice on helping providers fulfil their responsibilities to CQC can be found from Skills for Care through their website www.skillsforcare.org.uk. This includes information about:

- Induction training (level 1).
- Knowledge and Skills Set for Medication, which applies to level 2 training.
- Regional resources to support learning.

The care provider is responsible for providing necessary training. They must judge what elements of the Knowledge & Skills set apply to the residents of their care homes. The care provider must ensure new employees are trained before they can be responsible for medicine administration.

The provider should identify courses available that will deliver the required training. These may include:

- Local college.
- Distance learning or computer based learning.
- Independent training organisation.
- Pharmacist employed by the local NHS.
- Community pharmacist.

Training from one source alone is unlikely to meet every learning outcome for care workers. And it is important for a theory-based course to also have an element of practical supervision. This is very important when different formulations of medicines must be administered, for example eye drops, inhalers and creams. Good training is likely to involve both external training organisations and an "in house" programme that supports it.

10.5 Accredited training programmes

There are organisations that accredit training programmes. Usually, these companies accredit NVQ courses as well. It is most likely that colleges and independent training organisations will apply for this type of accreditation. Accreditation of courses does not guarantee that the training can deliver competence of care workers.

The care provider and training organisation should identify that training outcomes based on the needs of residents are achieved. This will require that the care provider has:

- Identified what training needs the care worker has.
- Put together a programme of training that will meet the needs of people they care for and care workers.

- Provides a mentor for the care worker and keeps a record of that process.

Some care workers may not be competent to take responsibility for medicine administration even though they have attended a training course. It is an unacceptable risk to allow care workers who do not have the necessary skill to give medicines to people.

10.6 Level 3: Administering medication by specialised techniques

Level 3 relates to those circumstances following an assessment by a healthcare professional, when a care worker is asked to administer medication by a specialist technique including:

- Rectal administration, e.g. suppositories, diazepam (for epileptic seizure).
- Insulin by injection.
- Administration through a Percutaneous Endoscopic Gastrostomy (PEG).
- Giving oxygen.

This delegation of task to a care worker may be in the best interests of the person to ensure that the treatment can be given at a time and place that suits the person.

The healthcare professional must train the care worker and be satisfied they are competent to carry out the task. This is the process that the NMC refers to as "delegation".

If the healthcare professional who provides the training will not record that the care worker is competent, the care provider should record the details of training as follows:

- What the care worker has been trained to do.
- Name of the healthcare professional who provided it.
- Date on which the training was given.
- Signature of the care worker who was trained and has agreed to accept the delegation.

The NMC guidance is clear that the healthcare professional will retain responsibility for the delegated duty.

The care home's procedures must include that care workers can refuse to assist with the administration of medication by specialist techniques if they do not feel competent to do so.

10.7 Care workers in care homes offering nursing care

Providing care workers with level 1 training is important. Care workers do become involved in medicine administration in care homes (nursing), for example applying external medicines such as cream or ointment when the person is being washed or bathed. Some care homes permit a care worker to take medicines to people when the nurse has prepared them. This is not best practice. Both the NMC and Royal Pharmaceutical Society advise that the person who prepares should also administer medicines and sign the record.

When a registered nurse delegates the administration of medicines to care home staff, the registered nurse remains responsible and accountable for the appropriateness of the

delegation. This falls in line with Standard 17 of the NMC Standards for Medicines Management.

The care provider must ensure that the care workers have been trained and judged competent. The process and responsibilities of delegation by nurses employed in a care home do not differ from delegation by an NHS healthcare professional to a care worker in a care home (personal care).
If the care provider chooses to provide external training to care workers, the senior nurse in charge of clinical care should be involved in the choice of training programme and subsequent mentoring.

11. Medication Review

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 older residents particularly susceptible to the adverse effects of medicines.

A number of potential benefits for medication review have been recognised, 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.

The medication review should ideally involve the resident and/or their family members/carers (as appropriate) and a local 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.

11.1 Frequency of medication reviews

The NICE Managing Medicines in Care Homes guideline (March 2014) recommends that health and social care practitioners should agree how often each resident should have a medication review based on safety, health and care needs of the resident and record this in the resident's care plan. The interval between medication reviews should be no more than one year.

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.

11.2 What should a medication review cover?

A medication review for residents should discuss and review:

- the purpose of the medication review,
- what the resident (and/or their family members/carers) thinks about the medicines and how much they understand,
- the resident's (and/or their family members/carers) concerns, questions or problems with medicines,
- all prescribed, over-the-counter and complimentary 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 such as side effects or reactions, difficulty taking the medicines themselves (e.g. using an inhaler), or 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/carers may need.

11.3 Care Home Advice Pharmacy Service (CHAPS)

Within Northamptonshire, the CCGs Prescribing and Medicines Management Team have a Care Home Advice Pharmacy Service. The CHAPS consist of three pharmacists and two pharmacy technicians who undertake medication reviews along with the GP and the care home staff. Support on medicines management issues within the care home can also be provided. The team can be contacted on 01604 651356.

12. Sharing information about a resident's medicines

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.

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

The process should also include the training needed by the care home staff and how their skills (competency) should be assessed.
In relation to medicines, confidential information should be shared with the health and social care practitioners who provide direct care to the 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. Care home staff should only ever share information if it is relevant, necessary and proportionate (see "A guide to confidentiality in health and social care" rule 2).

12.1 Improving transfers of care

Transfer of care is the planned movement of a care home resident from one care setting to another. Because of the increased likelihood of medication errors during transfers of care, the care home 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.

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.

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 homes medicines policy.

12.2 Communication between care home staff

Care home staff coming on duty should be aware of any changes to medicines that have taken place, adverse effects of any commonly used medicines and any on-going monitoring requirements - these may need to be communicated to residents or relatives.

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.

12.3 Residents visiting health professionals

When a resident attends an appointment with a health professional outside of the care home (e.g. a hospital appointment), information about the resident's medicines (including "when required" and any homely remedy use) should be available during the consultation when this is in accordance with the resident's ability and wishes.

Details about the appointment and any changes to the resident's medicines should be recorded in the resident's care plan. Any medicine changes should also be recorded on the MAR chart. Any relevant medicines ordering and disposal processes should be undertaken.

Appendix 1: Common controlled drugs and legal requirements for care homes

Schedule 2:

CD	Brand names	Legal Requirements
Morphine	Zomorph	• Store in a CD cupboard • Record in the CD register. ***** Oramorph oral solution **10mg/5ml** is not a controlled drug. However, CD storage and CD records are a good practice recommendation.
	MST	
	Sevredol	
	Oramorph Concentrated oral solution **100mg/5ml ***	
Oxycodone	OxyContin OxyNorm	
Diamorphine		
Pethidine		
Methadone	Physeptone	
Methylphenidate	Ritalin	
Fentanyl	Durogesic	
Pentazocine injection		
Dexamphetamine	Dexedrine	

Schedule 3:

CD	Brand names	Legal Requirements
Buprenorphine	Temgesic (tablets) Butrans (patches)	• Buprenorphine and Temazepam must be stored in a CD cupboard. Other listed schedule 3 controlled drugs do not need CD storage. • None of the controlled drugs in this schedule need to be recorded in the CD register but this is a good practice recommendation.
Midazolam	Hypnovel	
Temazepam		
Tramadol		
Phenobarbitone		

Schedule 4:

CD	Brand names	Legal Requirements
Diazepam	Valium	• No legal requirements for the care home
Zolpidem		

NB: This list is not exhaustive

Appendix 2: Mental Capacity Assessment

Service Users Name …….. **DOB** ……..……..

Date of Admission …… …… **Date of Assessment**……

Decision in relation to .. ……..
……

STAGE 1

Does the service user have an impairment of, or a disturbance in the functioning of, the mind or brain ? YES / NO

If NO then the service user will not lack capacity

If YES please indicate the nature of the impairment or disturbance of the mind or brain

□ Forms of mental illness □ Dementia

□ Significant Learning Disability □ Delirium

□ Stroke/Head Injury □ Brain Damage

□ Confusion, drowsiness or loss of consciousness

□ Alcohol or drug intoxication □ Any other (please specify) ……....

Is the impairment or disturbance of the mind or brain

□ partial □ temporary □ permanent □ not known

STAGE 2

Does the impairment or disturbance mean that the person is unable to make a decision at present ? YES / NO

If NO then the service user will not lack capacity to make a decision but may need help and support.

If YES then all practical and appropriate support to help the person make the decision must be attempted before carrying out the test for capacity. Please tick one or more of the following interventions used to provide this support.

□ Providing all relevant information, outcomes, alternatives & consequences

□ Communicating in an appropriate way □ Supporting the person

□ Making the person feel at ease □ Exploring other ways to enable decision making

Then proceed to carry out the mental capacity test overleaf to assess whether or not the service user is able to make a decision.

MENTAL CAPACITY TEST (to be carried out by the appropriate decision maker)

Please answer all four questions below

1) Does the service user **understand** the information relevant to the decision? YES / NO

2) Is the service user able to **retain** the information long enough to make the decision? YES / NO

3) Is the service user able to **use** or **weigh** that information as part of the process of making the decision? YES / NO

4) Is the service user able to **communicate** his/her decision? (whether by speech, sign language or any other means) YES / NO

CONCLUSION

In my opinion, based on my own assessment and following consultation with appropriate others, on the balance of probability, the above named **has capacity / lacks capacity** to consent to the following decision

……
……

□ Further assessment **is required / is not required** under the MCA

Signed ……Date ……..

Name …….. Position ……...

BEST INTEREST CHECKLIST FOR SERVICE USER LACKING CAPACITY

Service Users Name …….. **DOB** ……..……

Nature of Decision *(Record in the space below the specific decision for which service user lacks capacity*)

Checklist *(please circle appropriate answer and add any comments in as much detail as possible in support of evidence for the decision)*

1) Is there an advance decision made by the service user to refuse specified medical treatment which is valid & applicable to current circumstances

Complete the rest of the checklist only if the answer is NO YES / NO

2) Are you satisfied that the assessment of best interests is not based simply on his/her age, appearance, condition or behaviour YES / NO

3) Is the treatment urgent & therefore it is not practicable to delay making the decision until he/she regains capacity YES / NO

4) Has every effort been made to encourage & enable him/her to take part in making the decision YES / NO

5) Have you identified & considered all relevant circumstances that he/she would take into account if they were making the decision for themselves YES / NO

6) Are you taking into account his/her past & present wishes & feelings (these may have been expressed verbally, in writing or through behaviour or habits) YES / NO

7) Have you considered any beliefs & values (eg religious, cultural, moral or political) that would be likely to influence his/her decision if they were making it themselves YES / NO
8) Have you considered other options & alternative actions that may be less restrictive of his/her rights YES / NO
9) For life-sustaining treatment, are you fully satisfied that the decision is not motivated in in any way by a desire to bring about his/her death YES / NO
10) Have you consulted other people for their views about his/her best interests and for any information about their wishes & feelings, beliefs & values - anyone previously named by the person in advance as someone to be consulted YES / NO - any relatives, friends or others who take an interest in the persons welfare YES / NO - anyone engaged in caring for the person YES / NO - any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney YES / NO - any deputy appointed by the Court of Protection to make decisions for the person YES / NO ***For decisions about serious medical treatment and longer-term accommodation/placement, where there is no one to consult, an Independent Mental Capacity Advocate (IMCA) MUST be consulted.***
Any other relevant information or particular factors taken into account whilst making the decision.
Signed ……Date ...…….. Name …….. Position ……....

Appendix 3: Covert Administration Medication Record Form

Name of Service User_____ **Date**_____

Date of Birth_____

What medication is being considered for covert administration?	
Why is this treatment necessary?	
What alternatives have the multidisciplinary team considered? (e.g. other ways to manage the condition or administer treatment) Why were these alternatives rejected?	
The Mental Capacity Assessment has been completed to • confirm service user lacks capacity to consent. • confirm the continued need for the above treatment following a medication review • confirm that covert administration is essential	Assessment completed and appropriate document stored in service users notes Signature …… Name …….. Designation …… Date ……
Has the person expressed views in the past that are relevant to the present treatment? Yes/No If yes, what were those views?	

Name all involved in the decision to administer medication covertly (e.g. health care professionals, carers etc.)

Name	Designation	Date
……	……	……..
……	……	……..
……	……	……

Continued overleaf

Name the pharmacist consulted and record advice on Covert Administration of Medication Guidance from Pharmacist form Pharmacist name……..	Date……..
Is there a person with lasting power of attorney for welfare decisions? **Treatment may only be administered covertly with that person's consent unless this is impractical** Has this person given consent? If No please state reason	Yes/No If Yes, name……. (relationship to service user) …… Yes/No ……
Do any of those involved disagree with the proposed use of covert medication? If yes, they must be informed of their right to challenge treatment	Yes/ No Date informed……
Any members of staff administering medication covertly must receive appropriate guidance on administration of this medication How will they be administering the medication, e.g. mixed in yoghurt? How will this be recorded on the MAR chart?	…… …… ……
When will the need for covert administration be reviewed? Please refer to Administration of Covert Medication Review Form when review is performed	Date for first planned review

Care home manager signature _____

Name_____

Date_____

To be stored in service user's notes

Appendix 4: Administration of Covert Medication Review Form

Name of Service User_____

Date of Birth_____

Date review performed_____

Is medication still necessary? If so, explain why	
Is covert administration still necessary? If so explain why	
Who was consulted as part of the review?	
Is legal documentation still in place and valid?	
Date of next review	

Signed_____

Name of prescriber_____

Date_____

To be stored in service user's notes

Appendix 5: Covert Administration of Medication Guidance from Pharmacist

Name of Service User_____

Date of Birth_____

Definition -'Covert' is the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. Covert medication must never be given to someone who is capable of consenting to medical treatment. If a service user's decision is thought to be unwise or eccentric it does not necessarily mean they lack capacity to consent. Administration of medication against a person's wish may be unlawful. An appropriate assessment must be performed by a medical practitioner to establish whether the service user lacks mental capacity. If it is determined that the service user does lack mental capacity to consent, a multidisciplinary discussion should follow to establish whether covert administration is in the service user's best interest.

Advice given by: Name:_____ GPhC registration no:_____

Medication	Formulation	Advice from pharmacist	Date	Pharmacist signature

Appendix 6: Visiting health professionals signature sheet

Care homes keep a list of their staff signatures and initials so that they can confirm who has made a record on the MAR. So that the care home can confirm who has made changes to the MAR visiting health professionals can be asked to complete and sign below.

Name	Role	Signature	Initials	Date

References

- NICE: Managing medicines in care homes guideline (March 2014).

- CQC documents adapted which have now been withdrawn:
    - Pharmacy tip: Self medication (October 2008)
    - Professional advice: The administration of medicines in care homes
    - Professional advice: Medicines administration records (MAR) in care homes and domiciliary care
    - Pharmacy tip: Administration and recording of creams and nutritional supplements (April 2009)
    - Pharmacy tip: Medication prescribed to be taken when required (October 2008)
    - Professional advice: The safe management of controlled drugs in care homes
    - Professional advice: Training care workers to safely administer medicines in care homes

- "Good practice guidance on covert administration of medication (adults in a care setting)". Adapted with kind permission from Sheffield Best Practice Care Homes Group.

- Nursing Midwifery Council, Advice sheet: Covert administration of medicines - disguising medicine in food and drink. www.nmc-uk.org/Nurses-and-Midwives/Advice-by-topic/A/Advice/Covert-administration-of-medicines/ .

- UKMi Medicines Q&A: What legal and pharmaceutical issues should be considered when administering medicines covertly? June 2012. (Available online at www.ukmi.nhs.uk).

- UKMi Medicines Q&A: What are the therapeutic options for patients unable to take solid oral dosage forms? July 2013. (Available online at www.ukmi.nhs.uk).