

Managing medicines in care homes

Social care guideline

Published: 14 March 2014

www.nice.org.uk/guidance/sc1

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

| | |
|--|----|
| What is this guideline about and who is it for? | 5 |
| Purpose of this guideline..... | 5 |
| Audience for this guideline..... | 5 |
| Scope of this guideline | 5 |
| Definitions used in this guideline..... | 6 |
| Person-centred care | 8 |
| Involving others | 8 |
| Keeping residents safe (safeguarding) | 9 |
| 1 Recommendations | 10 |
| 1.1 Developing and reviewing policies for safe and effective use of medicines | 10 |
| 1.2 Supporting residents to make informed decisions and recording these decisions | 11 |
| 1.3 Sharing information about a resident's medicines..... | 13 |
| 1.4 Ensuring that records are accurate and up to date | 14 |
| 1.5 Identifying, reporting and reviewing medicines-related problems..... | 14 |
| 1.6 Keeping residents safe (safeguarding) | 15 |
| 1.7 Accurately listing a resident's medicines (medicines reconciliation)..... | 16 |
| 1.8 Reviewing medicines (medication review) | 18 |
| 1.9 Prescribing medicines..... | 19 |
| 1.10 Ordering medicines..... | 21 |
| 1.11 Dispensing and supplying medicines..... | 22 |
| 1.12 Receiving, storing and disposing of medicines | 23 |
| 1.13 Helping residents to look after and take their medicines themselves (self-administration)..... | 24 |
| 1.14 Care home staff administering medicines to residents | 26 |
| 1.15 Care home staff giving medicines to residents without their knowledge (covert administration)..... | 31 |
| 1.16 Care home staff giving non-prescription and over-the-counter products to residents (homely remedies)..... | 32 |
| 1.17 Training and skills (competency) of care home staff | 33 |

| | |
|--|----|
| 2 Who should take action?..... | 35 |
| 3 The Guideline Development Group and NICE project team..... | 37 |
| Guideline Development Group | 37 |
| NICE project team | 38 |
| Update information..... | 40 |

This guideline is the basis of QS85.

What is this guideline about and who is it for?

Purpose of this guideline

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

Audience for this guideline

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

Scope of this guideline

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

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

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

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

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

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

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

Definitions used in this guideline

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

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

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

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

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

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

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

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

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

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

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

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

Person-centred care

Care home residents and health professionals (for care under the NHS) have rights and responsibilities as set out in the [NHS Constitution for England](#), and NICE guidelines are written to reflect these. Treatment and care should take into account individual needs and preferences. Care home residents should have the opportunity to make informed decisions about their care and treatment, in partnership with their health professionals and social care practitioners.

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

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

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

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

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

Involving others

The views of residents in care homes about who should and should not be involved in their care are important and should be respected. If the resident lacks the capacity to decide who should and should not be involved, health and social care practitioners must act in the resident's best interests, taking account of the provisions in the [Mental Capacity Act 2005](#).

Health and social care practitioners should also consider accounts from family members or carers of the resident's usual behaviour. This information, when used with an assessment of the resident

concerned, will help with specific decisions about their care. It will also help to estimate the person's capacity to make a specific decision. Residents with reduced mental capacity should continue to have the opportunity to make informed decisions about those aspects of their care and personal lives for which they retain capacity.

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

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

Keeping residents safe (safeguarding)

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

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

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

A safeguarding issue in relation to managing medicines could include the deliberate withholding of a medicine(s) without a valid reason, the incorrect use of a medicine(s) for reasons other than the benefit of a resident, deliberate attempt to harm through use of a medicine(s), or accidental harm caused by incorrect administration or a medication error.

1 Recommendations

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

When a recommendation is aimed specifically at a person or organisation, this is clearly stated. In most cases the GDG was able to identify which person or organisation was responsible; if this is not specified it will be for organisations to consider and determine locally. The GDG agreed that arrangements will vary depending on local organisational structures, how services are commissioned and provided, and what resources are available.

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

- 1.1.1 Commissioners and providers (organisations that directly provide health or social care services) should review their policies, processes and local governance arrangements, making sure that it is clear who is accountable and responsible for using medicines safely and effectively in care homes.
- 1.1.2 Care home providers should have a care home medicines policy, which they review to make sure it is up to date, and is based on current legislation and the best available evidence. The policy should include written processes for:
- sharing information about a resident's medicines, including when they transfer between care settings
 - ensuring that records are accurate and up to date
 - identifying, reporting and reviewing medicines-related problems
 - keeping residents safe (safeguarding)
 - accurately listing a resident's medicines (medicines reconciliation)
 - reviewing medicines (medication review)
 - ordering medicines

- receiving, storing and disposing of medicines
- helping residents to look after and take their medicines themselves (self-administration)
- care home staff administering medicines to residents, including staff training and competence requirements
- care home staff giving medicines to residents without their knowledge (covert administration)
- care home staff giving non-prescription and over-the-counter products to residents (homely remedies), if appropriate.

1.2 Supporting residents to make informed decisions and recording these decisions

- 1.2.1 Health and social care practitioners (care home staff, social workers, case managers, GPs, pharmacists and community nurses) should ensure that care home residents have the same opportunities to be involved in decisions about their treatment and care as people who do not live in care homes, and that residents get the support they need to help them to take a full part in making decisions.
- 1.2.2 The health professional prescribing a medicine or care home staff should record a resident's informed consent in the resident's care record. Consent does not need to be recorded each time the medicine is given but a record of the administration should be made on the medicines administration record.
- 1.2.3 Care home staff (registered nurses and social care practitioners working in care homes) should record the circumstances and reasons why a resident refuses a medicine (if the resident will give a reason) in the resident's care record and medicines administration record, unless there is already an agreed plan of what to do when that resident refuses their medicines. If the resident agrees, care home staff should tell the health professional who prescribed the medicine about any ongoing refusal and inform the supplying pharmacy, to prevent further supply to the care home.
- 1.2.4 Health and social care practitioners should identify and record anything that

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

1.2.5 Health professionals prescribing a medicine must:

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

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

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

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

1.3 Sharing information about a resident's medicines

- 1.3.1 Care home providers should have a process for managing information (information governance) covering the 5 rules set out in the Health and Social Care Information Centre's [A guide to confidentiality in health and social care](#) (2013). The process should also include the training needed by care home staff and how their skills (competency) should be assessed.
- 1.3.2 Commissioners should review their commissioning arrangements with their provider organisations to ensure that any information about a resident's medicines that is transferred contains the minimum information set out in recommendation [1.7.3](#). Commissioners should monitor this through their contracting arrangements.
- 1.3.3 Providers of health or social care services should have processes in place for sharing, accurate information about a resident's medicines, including what is recorded and transferred when a resident moves from one care setting to another (including hospital).
- 1.3.4 Providers of health or social care services should ensure that either an electronic discharge summary is sent, if possible, or a printed discharge summary is sent with the resident when care is transferred from one care setting to another. See recommendation [1.7.3](#) for the minimum information that should be transferred.
- 1.3.5 Health and social care practitioners should ensure that all information about a resident's medicines, including who will be responsible for prescribing in the future, is accurately recorded and transferred with a resident when they move from one care setting to another.
- 1.3.6 Health and social care practitioners should check that complete and accurate information about a resident's medicines has been received and recorded, and is acted on after a resident's care is transferred from one care setting to another (see recommendation [1.7.3](#) for the minimum information that should be transferred).
- 1.3.7 Care home providers should have a process in the care home medicines policy for recording the transfer of information about residents' medicines during shift

handovers and when residents move to and from care settings.

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

1.4 Ensuring that records are accurate and up to date

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

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

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

1.5 Identifying, reporting and reviewing medicines-related problems

- 1.5.1 Commissioners and providers of health or social care services should ensure that a robust process is in place for identifying, reporting, reviewing and learning from medicines errors involving residents (see also recommendations [1.6.1-3](#)).
- 1.5.2 Health and social care practitioners should consider working with all relevant stakeholders to develop a locally agreed action plan, in line with other local and

national strategies and governance arrangements, for improving the safety of residents and reducing medication errors in care homes.

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

1.6 Keeping residents safe (safeguarding)

- 1.6.1 Commissioners and providers of health or social care services should all be aware of local arrangements for notifying suspected or confirmed medicines-related safeguarding incidents.
- 1.6.2 Care home providers should have a clear process for reporting medicines-related safeguarding incidents under local safeguarding processes and to the [Care Quality Commission](#) (CQC) (or other appropriate regulator). The process should be recorded in the care home medicines policy and should clearly state:
- when the CQC (or other appropriate regulator) should be notified
 - which medicines-related safeguarding incidents should be reported under local safeguarding processes and when
 - that accurate details of any medicines-related safeguarding incidents are recorded as soon as possible so that the information is available for any investigation and reporting.
- 1.6.3 Commissioners should ensure that reporting requirements are included in commissioning and contracting arrangements.
- 1.6.4 Care home staff should contact a health professional to ensure that action is taken to safeguard any resident involved in a medicines-related safeguarding incident. They should follow a process agreed between health professional(s) and commissioners, which sets out who to contact in normal office hours and out-of-hours.

- 1.6.5 Care home providers should record all medicines-related safety incidents, including all 'near misses' and incidents that do not cause any harm, as a resident safety incident. Where there are notifiable safeguarding concerns these must be reported to the [CQC](#) (or other appropriate regulator).
- 1.6.6 Local safeguarding processes should include the investigation of each report of a medicines-related safeguarding incident and should monitor reports for trends.
- 1.6.7 Local safeguarding processes should include arrangements for feedback to care homes about reported medicines-related incidents to promote sharing of experiences and learning.
- 1.6.8 Care home staff should find out the root cause of medicines-related incidents.
- 1.6.9 Care home providers should make sure that any training needed by staff to find out the root cause of medicines-related incidents is specified in contracts with commissioners.
- 1.6.10 Care home staff should give residents and/or their family members or carers information on how to report a medicines-related safety incident or their concerns about medicines, using the care home provider's complaints process, local authority (or local safeguarding) processes and/or a regulator's process.
- 1.6.11 Care home providers should ensure that all residents can use advocacy and independent complaints services when they have concerns about medicines.

1.7 Accurately listing a resident's medicines (medicines reconciliation)

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

medicines reconciliation:

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

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

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

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

1.8 Reviewing medicines (medication review)

- 1.8.1 GPs should ensure that arrangements have been made for their patients who are residents in care homes to have medication reviews as set out in the residents' care plans (see recommendation 1.8.4).
- 1.8.2 GPs should work with other health professionals to identify a named health professional who is responsible for medication reviews for each resident. This should take into account the clinical experience and skills of the health professional, how much they know about the resident and the resident's condition, and whether they can access the relevant information.
- 1.8.3 Health and social care practitioners should ensure that medication reviews involve the resident and/or their family members or carers and a local team of health and social care practitioners (multidisciplinary team). This may include a:
- pharmacist
 - community matron or specialist nurse, such as a community psychiatric nurse
 - GP
 - member of the care home staff
 - practice nurse
 - social care practitioner.

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

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

during a medication review:

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

1.9 Prescribing medicines

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

- issuing prescriptions according to the patient medical records
- recording clear instructions on how a medicine should be used, including how long the resident is expected to need the medicine and, if important, how long the medicine will take to work and what it has been prescribed for (use of the term 'as directed' should be avoided)

- recording prescribing in the GP patient medical record and resident care record and making any changes as soon as practically possible
- providing any extra details the resident and/or care home staff may need about how the medicine should be taken
- any tests needed for monitoring
- prescribing the right amount of medicines to fit into the 28-day supply cycle if appropriate, and any changes that may be needed for prescribing in the future
- monitoring and reviewing 'when required' and variable dose medicines
- issuing prescriptions when the medicines order is received from the care home.

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

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

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

1.9.4 Care home staff (registered nurses and social care practitioners working in care homes) should update records of medicines administration to contain accurate

information about any changes to medicines.

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

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

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

1.9.7 Care home staff should:

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

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

1.10 Ordering medicines

1.10.1 Care home providers must usually ensure that medicines prescribed for a resident are not used by other residents. However, during the COVID-19

pandemic, medicines no longer needed by a resident may be reused in line with the UK government [COVID 19 standard operating procedure for running a medicines reuse scheme in a care home or hospice setting](#). [amended 1 May 2020]

- 1.10.2 Care home providers should ensure that care home staff (registered nurses and social care practitioners working in care homes) have protected time to order medicines and check medicines delivered to the home.
- 1.10.3 Care home providers should ensure that at least 2 members of the care home staff have the training and skills to order medicines, although ordering can be done by 1 member of staff.
- 1.10.4 Care home providers should retain responsibility for ordering medicines from the GP practice and should not delegate this to the supplying pharmacy.
- 1.10.5 Care home providers should ensure that records are kept of medicines ordered. Medicines delivered to the care home should be checked against a record of the order to make sure that all medicines ordered have been prescribed and supplied correctly.

1.11 Dispensing and supplying medicines

- 1.11.1 Pharmacies and doctors supplying medicines to care home providers should ensure they have processes, such as standard operating procedures, in place for all staff who dispense and accuracy check medicines for residents, particularly those who are using monitored dosage systems.
- 1.11.2 Care home providers should determine the best system for supplying medicines for each resident based on the resident's health and care needs and the aim of maintaining the resident's independence wherever possible. If needed, they should seek the support of health and social care practitioners.
- 1.11.3 Supplying pharmacies should produce medicines administration records wherever possible. See also recommendation [1.14.8](#).

1.12 Receiving, storing and disposing of medicines

- 1.12.1 Providers of adult care homes must comply with the [Misuse of Drugs Act 1971](#) and associated regulations when storing controlled drugs. Providers of children's homes should have robust processes for storing controlled drugs.
- 1.12.2 Care home providers should include the following information in their process for storing medicines safely:
- how and where medicines are stored, including medicines supplied in monitored dosage systems, medicines to be taken and looked after by residents themselves (see recommendations [1.13.2](#) and [1.13.6](#)), controlled drugs, medicines to be stored in the refrigerator, skin creams, oral nutritional supplements and appliances
 - secure storage with only authorised care home staff having access
 - the temperatures for storing medicines and how the storage conditions should be monitored.
- 1.12.3 Care home providers should assess each resident's needs for storing their medicines and should provide storage that meets the resident's needs, choices, risk assessment and type of medicines system they are using.
- 1.12.4 Before disposing of a medicine that is still being prescribed for a resident, care home staff (registered nurses and social care practitioners working in care homes) should find out if it is still within its expiry date and if it is still within its shelf-life if it has been opened.
- 1.12.5 When disposing of medicines and removing medicines classed as clinical waste, care home providers should have a process for the prompt disposal of:
- medicines that exceed requirements
 - unwanted medicines (including medicines of any resident who has died)
 - expired medicines (including controlled drugs).

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

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

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

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

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

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

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

medicines regimen could be adjusted to enable the resident to self-administer.

- 1.13.4 Providers of adult care homes must ensure that records are made and kept when adult residents are supplied with medicines for taking themselves (self-administration), or when residents are reminded to take their medicines themselves.
- 1.13.5 Providers of children's care homes must ensure that records are made and kept for residents living in children's homes who are able to look after and take their medicines themselves (self-administer). The following information should be recorded on the medicines administration record:
- that the resident is looking after and taking their medicines themselves (self-administering)
 - whether any monitoring is needed (for example, to assess ability to self-administer or willingness to take the medicines as prescribed [adherence])
 - that medicine has been taken as prescribed (either by seeing this directly or by asking the resident)
 - who has recorded that the medicine has been taken.
- 1.13.6 Care home providers should ensure that medicines for self-administration are stored as identified in the resident's risk assessment (for example, in a lockable cupboard or drawer in a resident's room). Residents should be able to get any medicines that need special storage at a time when they need to take or use them (see recommendations [1.12.1](#), [1.12.2](#) and [1.12.3](#)).
- 1.13.7 Care home providers should ensure that their process for self-administration of controlled drugs includes information about:
- individual risk assessment
 - obtaining or ordering controlled drugs
 - supplying controlled drugs
 - storing controlled drugs
 - recording supply of controlled drugs to residents

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

1.14 Care home staff administering medicines to residents

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

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

- how to manage medicines when the resident is away from the care home for a short time (for example, visiting relatives)
- monitoring and evaluating the effects of medicines, including reactions to medicines.

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

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

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

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

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

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

- having more trained and skilled care home staff on duty at that time

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

1.14.6 Care home staff must have the training and skills to use system(s) adopted in the care home for administering medicines in line with regulation 22 of the [Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2010](#) for adult care homes and regulation 32.3 of the [Children's Homes Regulations 2015](#) for children's care homes.

1.14.7 Paper-based or electronic medicines administration records should:

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

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

- the full name, date of birth and weight (if under 16 years or where appropriate, for example, frail older residents) of the resident
- details of any medicines the resident is taking, including the name of the medicine and its strength, form, dose, how often it is given and where it is given (route of administration)

- known allergies and reactions to medicines or their ingredients, and the type of reaction experienced
- when the medicine should be reviewed or monitored (as appropriate)
- any support the resident may need to carry on taking the medicine (adherence support)
- any special instructions about how the medicine should be taken (such as before, with or after food).

See also recommendation [1.11.3](#).

- 1.14.9 Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used.
- 1.14.10 Care home providers should ensure that all information included on the medicines administration record is up-to-date and accurate. They may need support from the health professional prescribing the medicines and the supplying pharmacy to do this.
- 1.14.11 Care home staff must record medicines administration, including the date and time, on the relevant medicines administration record, as soon as possible and ensure that they:
- make the record only when the resident has taken their prescribed medicine
 - complete the administration before moving on to the next resident
 - recognise that mistakes are less likely if 1 member of staff records administration on the medicines administration record rather than 2 staff recording
 - record 'when required' medicines only when they have been given, noting the dose given and the amount left (where possible), to make sure that there is enough in stock and to reduce waste
 - record when and why medicines have not been given

- correct written mistakes with a single line through the mistake followed by the correction and a signature, date and time (correction fluid should not be used).
- 1.14.12 Health professionals who are visiting the care home to administer a medicine(s) to residents should make their record of administration available to care home staff, if asked by the care home. The health professional should also consider seeing the resident with the care home staff responsible for administering medicines to the resident.
- 1.14.13 Care home staff should keep a record of medicines administered by visiting health professionals on the resident's medicines administration record.
- 1.14.14 Care home staff responsible for administering medicines should add a cross-reference (for example, 'see warfarin administration record') to the resident's medicines administration record when a medicine has a separate administration record.
- 1.14.15 Care home staff should ensure that the resident's GP is contacted to find out about any allergies and intolerances to medicines or their ingredients. This information should be accurately recorded on the medicines administration record and shared with the team(s) providing care to the resident.
- 1.14.16 Care home staff should make appropriate records of controlled drugs that have been administered to residents. The care home staff responsible for administering the controlled drug and a trained witness should sign the controlled drugs register. The staff member administering the controlled drug should also sign the medicines administration record.
- 1.14.17 Care home providers should ensure that the following information is given to the resident and/or their family members or carers when the resident is temporarily away from the care home:
- the medicines taken with the resident
 - clear directions and advice on how, when and how much of the medicines the resident should take
 - time of the last and next dose of each medicine

- a contact for queries about the resident's medicines, such as the care home, supplying pharmacy or GP.

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

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

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

Health professionals may also use the:

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

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

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

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

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

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

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

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

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

- the name of the medicine or product and what it is for
- which residents should not be given certain medicines or products (for example, paracetamol should not be given as a homely remedy if a resident is already receiving prescribed paracetamol)
- the dose and frequency
- the maximum daily dose
- where any administration should be recorded, such as on the medicines administration record

- how long the medicine or product should be used before referring the resident to a GP.

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

1.17 Training and skills (competency) of care home staff

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

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

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

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

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

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

2 Who should take action?

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

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

| | |
|---|-----------------------------|
| Health professionals prescribing medicines | 1.2.2, 1.9.2, 1.9.5, 1.14.4 |
| Pharmacists Recommendations for health and social care practitioners also apply to pharmacists | 1.14.4 |
| Supplying pharmacy | 1.9.5 |
| Health professionals who are visiting the care home to administer a medicine(s) to residents | 1.14.12 |
| Health professionals working in, or providing services to, care homes | 1.17.6 |
| GPs Recommendations for health and social care practitioners also apply to GPs | 1.8.1, 1.8.2 |
| GP practices | 1.9.1 |

3 The Guideline Development Group and NICE project team

Guideline Development Group

David Alldred

Senior Lecturer in Pharmacy Practice, University of Bradford

Wasim Baqir

Research and Development Pharmacist, Northumbria Healthcare NHS Foundation Trust

Gerry Bennison

Lay member

Brian Brown

National Pharmacy Manager, Care Quality Commission

Amanda de La Motte

Advanced Nurse Practitioner, Central Nottinghamshire Clinical Services

Karen George

Lead Nurse/Care Homes, Shropshire Community Health NHS Trust

Kathryn Goodfellow

Care Homes Development Manager, Superdrug Stores

Fazeela Hafajee

Standards and Qualifications Project Manager, Skills for Care

Daniel Harwood

Clinical Director for Community Health, Clinical Director for the Mental Health/Learning Disability Directorate and Consultant Old Age Psychiatrist, South London and Maudsley NHS Foundation Trust

Susanna Jacks

General Practitioner Principal, Aneurin Bevan Health Board/Vauxhall Surgery Chepstow

Barbara Jesson

Principal Pharmacist, Croydon Clinical Commissioning Group

Susan Lee

Care Home Support Pharmacist, Biodose Services

Juliette Millard

UK Nursing and Health Professions Advisor, Leonard Cheshire Disability

Tariq Muhammad

Managing Director, Pharmacy Plus

Ivor Nathan

Lay member

Alaster Rutherford (Chair)

Independent healthcare consultant

Joy Smith

Medicines Standards Officer – Care Homes, NHS West and South Yorkshire and Bassetlaw
Commissioning Support Unit

Amanda Thompsell (Vice Chair)

Consultant Old Age Psychiatrist in Specialist Care, South London and Maudsley NHS Foundation
Trust

Ian Turner

Chairman, Registered Nursing Home Association

Louise Winstanley

Head of Medicines Commissioning, Fylde and Wyre Clinical Commissioning Group

NICE project team

Johanna Hulme

Project Lead and Associate Director, Medicines Advice, NICE Medicines and Prescribing Centre

Gregory Moran

Senior Adviser Medicines Advice, NICE Medicines and Prescribing Centre

Shelly Patel

Senior Adviser Medicines Advice, NICE Medicines and Prescribing Centre

Louise Picton

Senior Adviser Medicines Advice, NICE Medicines and Prescribing Centre

Ian Pye

Assistant Project Manager – Medicines Advice, NICE Medicines and Prescribing Centre

Rebekah Robinson

Assistant Project Manager – Medicines Advice, NICE Medicines and Prescribing Centre

Update information

Minor changes since publication

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

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

ISBN: 978-1-4731-0512-6