NICE National Institute for Health and Care Excellence

NICE quality standard

Medicines management in care homes

Quality standard
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Contents

This standard is based on SC1.

This standard should be read in conjunction with QS31, QS50, QS63, QS96, QS87, QS97, QS120, QS132, QS136, QS164, QS171, QS184 and QS194.

Quality statements

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Statement 2 Providers of health or social care services send a discharge summary, including details of the person's current medicines, with a person who transfers to or from a care home.

Statement 3 People who live in care homes are supported to self-administer their medicines if they wish to and it does not put them or others at risk.

Statement 4 Prescribers responsible for people who live in care homes provide comprehensive instructions for using and monitoring all newly prescribed medicines.

Statement 5 People who live in care homes have medication reviews undertaken by a multidisciplinary team.

Statement 6 Adults who live in care homes and have been assessed as lacking capacity are only administered medicine covertly if a management plan is agreed after a best interests meeting.

Quality statement 1: Record-keeping

Quality statement

People who transfer into a care home have their medicines listed by the care home on the day that they transfer.

Rationale

It is important that information about medicines is available for people who transfer into a care home, either for the first time or, for example, when moving back into the care home after a hospital stay (during which their medicines may have been changed). This will allow information about a person's medicines to be available to relevant health and social care practitioners (while taking care to respect confidentiality), improving continuity of care and ensuring that people get the right medicines at the right time at the care home they have transferred to.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that a list is made of a person's medicines on the day that they transfer into a care home.

Data source: Local data collection.

Process

Proportion of transfers of people into a care home where a list of the person's medicines is made by the care home on the day of transfer.

Numerator – the number in the denominator where a list of the person's medicines is made by the care home on the day of transfer.

Denominator – the number of transfers of people into a care home.

Data source: Local data collection.

Outcome

Time between a person moving into a care home and completion of a list of their medicines.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (care homes) ensure that they make arrangements to produce a list of a person's medicines on the day that they transfer into a care home.

Health and social care practitioners ensure that they coordinate the listing of a person's medicines on the day that they transfer into a care home.

Commissioners ensure that they commission services that make arrangements to produce a list of a person's medicines on the day that they transfer into a care home.

People who move into a care home (either for the first time or moving back after a hospital stay) have their medicines carefully recorded by the care home on the day that they move.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendations 1.7.1 and 1.7.3

Quality statement 2: Sharing information

Quality statement

Providers of health or social care services send a discharge summary, including details of the person's current medicines, with a person who transfers to or from a care home.

Rationale

Good communication about a resident's medicines is a key factor in preventing medication errors when care home residents transfer between care settings, and also promotes continuity of care following transfer. Providers of health or social care should ensure that comprehensive records of medicines are sent with a person when they are transferred from one care setting to another, including information on what medicines are being taken and related information, such as dosage.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that a discharge summary, including details of a person's current medicines, is sent with a person when they transfer to or from a care home.

Data source: Local data collection.

Process

a) Proportion of transfers of people to a care home in which a discharge summary, including details of a person's current medicines, is sent with the person.

Numerator – the number in the denominator in which a discharge summary, including details of a person's current medicines, is sent with the person.

Denominator – the number of transfers of people to a care home.

Data source: Local data collection.

b) Proportion of transfers of people from a care home in which a discharge summary, including details of a person's current medicines, is sent with the person.

Numerator – the number in the denominator in which a discharge summary, including details of a person's current medicines, is sent with the person.

Denominator – the number of transfers of people from a care home.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as care homes, hospitals, intermediate care services) ensure that a discharge summary, including details of a person's current medicines, is sent with a person who transfers to or from a care home.

Health and social care practitioners compile and send a discharge summary, including details of a person's current medicines, with a person who transfers to or from a care home.

Commissioners stipulate that providers of health or social care services have processes in place that enable the sharing of a discharge summary, including details of a person's current medicines, when a person transfers to or from a care home. NHS England area teams and clinical commissioning groups should ensure that health and social care providers are aware that these processes should be in place.

People who move into or from a care home have an accurate and complete summary of their details and care, including detailed information about their current medicines, sent from their previous place of care to their new place of care so that they can safely

continue with their treatment.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendations 1.3.2 to 1.3.4

Definitions of terms used in this quality statement

Discharge summary

A discharge summary should contain the following information as a minimum:

- the person'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 related information, including when the medicine should be reviewed or monitored, and any support the person needs to carry on taking the medicine (adherence support)

- what information has been given to the resident and/or family members or carers.

[NICE's guideline on managing medicines in care homes, recommendation 1.7.3]

Quality statement 3: Self-administration

Quality statement

People who live in care homes are supported to self-administer their medicines if they wish to and it does not put them or others at risk.

Rationale

It is important for people living in care homes to maintain their independence, and that they have as much involvement in taking their medicines as they wish and are safely able to. However, when a person enters a care home staff will often automatically assume responsibility for managing their medicines. It should be assumed that people who live in a care home can take and look after their medicines themselves, unless a risk assessment has indicated otherwise. It is important to take into account a person's choice over whether or not they wish to self-administer their medicine and also to consider if self-administration will be a risk to them or others. Risk assessments are also important to determine what support a person needs to help them to self-administer different medicines (for example, a resident may be able to manage oral tablets but not eye drops), allowing care homes to ensure that necessary support is provided. Risk assessment should be reviewed periodically, and whenever circumstances change, to address if any adjustment to support is needed.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements that care home staff provide support for residents to self-administer their medicines unless a risk assessment has indicated otherwise.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that individual risk assessments are carried out that identify and document any support that a care home resident needs to self-administer their medicines.

Data source: Local data collection.

Process

a) Proportion of people who live in a care home who have an individual risk assessment to identify any support they need to self-administer their medicines.

Numerator – the number in the denominator who have an individual risk assessment to identify any support they need to self-administer their medicines.

Denominator – the number of people who live in a care home.

Data source: Local data collection.

b) Proportion of people who live in a care home who wish to self-administer their medicines, and who have not had a risk assessment that indicates that this would put themselves or others at risk, who self-administer their medicines.

Numerator – the number in the denominator who self-administer their medicines.

Denominator – the number of people who live in a care home who wish to self-administer their medicines, and who have not had a risk assessment that indicates that this would put themselves or others at risk.

Data source: Local data collection.

Outcome

Feedback from care home residents that they feel supported to self-administer their medicines, if they wish to and if they have not had a risk assessment that indicates that this would put themselves or others at risk.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (care homes) ensure that staff support people to self-administer their medicines if they want to, unless an individual risk assessment has indicated that they are not able to do so safely.

Health and social care practitioners support people to self-administer their medicines if they want to, unless an individual risk assessment has indicated that they are not able to do so safely.

Commissioners ensure that services they commission support people to self-administer their medicines if they want to, unless an individual risk assessment has indicated that they are not able to do so safely.

People who live in care homes are given support to take and look after their own medicines if they want to, unless they have had an assessment that shows it might not be possible or safe.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendations 1.13.1 and 1.13.2

Definitions of terms used in this quality statement

Risk assessment

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

- the resident's 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 on individual resident need (during periods of acute illness, a resident's capacity and ability to self-medicate may fluctuate, needing more frequent assessment)
- how the medicines will be stored
- the responsibilities of the care home staff, which should be written in the resident's care plan.

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. [Adapted from NICE's guideline on managing medicines in care homes, recommendations 1.13.2. and 1.13.3]

Support to self-administer medicines

Support may include practical help to self-administer medicine, such as providing a glass of water with which to take medicine, reminder charts, large-print labels, hearing labels, easy-to-open containers, help measuring liquids, devices to help with the use of inhalers, colour coding of labels (for example, for different times of day) and providing prompts for when medicines should be taken, (for example, with or after food or on an empty stomach).

Support may also involve providing the person with suitable information about the medicine, information on how to take the medicine and advice on any potential side effects.

Individual risk assessments should identify how much support a resident needs to take and look after their medicine. [Adapted from expert consensus and NICE's guideline on managing medicines in care homes]

Self-administration

Self-administration of medicines is when a resident stores, or stores and administers, their own medicines. [NICE's guideline on managing medicines in care homes]

Equality and diversity considerations

Consideration should be given to a number of factors that can affect a resident's ability to self-administer their own medicines, including their mental health, mental capacity, health literacy, vision, hearing, language and culture. Health and social care practitioners need to ensure that these factors are considered for each resident, and any barriers to self-administration of medicines are identified and taken into account.

Quality statement 4: Prescribing medicines

Quality statement

Prescribers responsible for people who live in care homes provide comprehensive instructions for using and monitoring all newly prescribed medicines.

Rationale

If too few instructions are given to a resident (if self-administering) or the care home staff it can reduce the effectiveness of a medicine or even potentially increase the risk of harm. Clear instructions are therefore important to ensure resident safety. This is particularly the case with variable dose or 'when required' medicines (when a clear indication of the circumstances to administer the medicine is needed). If a resident's capacity changes, care home staff may need to start administering the person's medicine for them, and will need instructions. Requirements for recording clear instructions on how a medicine should be used and monitored should be included as part of a clear written process for prescribing and issuing prescriptions for people who live in care homes (see recommendation 1.9.1 in NICE's guideline on managing medicines in care homes).

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements that prescribers responsible for people who live in care homes provide comprehensive instructions for using and monitoring all newly prescribed medicines.

Data source: Local data collection.

Process

The proportion of newly prescribed medicines for people who live in care homes that are provided with comprehensive instructions for use and monitoring.

Numerator – the number in the denominator that are provided with comprehensive instructions for use and monitoring.

Denominator – the number of newly prescribed medicines for people who live in care homes.

Data source: Local data collection.

Outcome

Medicines-related problems attributable to incomplete information provided with a prescription.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (such as GP practices, pharmacies) ensure that comprehensive instructions for using and monitoring all newly prescribed medicines are provided for people who live in care homes.

Healthcare professionals (such as GPs, pharmacists and nurse prescribers) provide comprehensive instructions for using and monitoring all newly prescribed medicines for people who live in care homes.

Commissioners ensure that any services they commission that prescribe medicines for people who live in care homes provide comprehensive instructions for using and monitoring all newly prescribed medicines for people who live in care homes.

People who live in care homes have accurate and complete information given to them and to the care home staff about any new medicines they are prescribed. This should include

information about how and when their medicines should be used, and any checks that should happen.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendations 1.9.1 and 1.9.2

Definitions of terms used in this quality statement

Comprehensive instructions for using and monitoring newly prescribed medicines

These include:

- 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)
- 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.

When prescribing variable dose and 'when required' medicine(s), information should 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
- 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 the medicine is expected to have.

[Adapted from NICE's guideline on managing medicines in care homes, recommendations 1.9.1 and 1.9.2]

Quality statement 5: Medication reviews

Quality statement

People who live in care homes have medication reviews undertaken by a multidisciplinary team.

Rationale

Many care home residents have multiple and complex conditions. These conditions can change, and the medicines that residents receive to treat these conditions need to be reviewed regularly to ensure that they remain safe and effective. The frequency of multidisciplinary medication reviews should be based on the health and care needs of the resident, with their safety being the most important factor when deciding how often to do the review. The interval between medication reviews should be no more than 1 year, and many residents will need more frequent medication reviews. There can be uncertainty over who should undertake medication reviews. While a number of different health professionals can conduct medication reviews for care home residents, the review should involve a multidisciplinary group of key people who agree and document the roles and responsibilities of each member of the team and how they work together.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements that medication reviews for people who live in care homes involve a multidisciplinary team who agree and document the roles and responsibilities of each member of the team and how they work together.

Data source: Local data collection.

Process

Proportion of medication reviews carried out for people who live in care homes that involve a multidisciplinary team.

Numerator – the number in the denominator that involve a multidisciplinary team.

Denominator – the number of medication reviews carried out for people who live in care homes.

Data source: Local data collection.

What the quality statement means for different audiences

Health and social care practitioners (such as GPs and care home managers) ensure that medication reviews involve a local team of health and social care practitioners (multidisciplinary team) who agree and document the roles and responsibilities of each member of the team and how they work together.

Commissioners stipulate that medication reviews in care homes involve a local team of health and social care practitioners (multidisciplinary team) who agree and document the roles and responsibilities of each member of the team and how they work together.

People who live in care homes have their medicines reviewed by a team of people who look after their health and social care to check for any problems.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendations 1.8.3 to 1.8.5

Definitions of terms used in this quality statement

Medication review

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 member or carer's, 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.

[NICE's guideline on managing medicines in care homes, recommendation 1.8.5]

Multidisciplinary team

Health and social care practitioners ensure that medication reviews involve the resident and/or their family members or carers (if appropriate) 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. 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. [NICE's guideline on managing medicines in care homes, recommendations 1.8.2 and 1.8.3]

Equality and diversity considerations

Consideration should be given to potential barriers to care home residents taking an active role in their medication review. These include mental health problems, lack of (mental) capacity to make decisions, health problems (such as problems with vision and hearing) and difficulties with reading or speaking. Some illnesses can restrict the capacity of residents to be involved in a medication review and a resident's capacity to be involved in decisions about their medicine may vary over time. Consideration should be given to adjusting the timing of a review to occur when a resident has the capacity to be involved, and potentially allowing time for a resident to recover from any acute illness before conducting the review. If appropriate, family members and carers could be involved in the decision-making process about investigations, treatment and care. 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.

Quality statement 6: Covert medicines administration

Quality statement

Adults who live in care homes and have been assessed as lacking capacity are only administered medicine covertly if a management plan is agreed after a best interests meeting.

Rationale

The covert administration of medicines should only be used in exceptional circumstances when such a means of administration is judged necessary, in accordance with the Mental Capacity Act 2005. However, once a decision has been made to covertly administer a particular medicine (following an assessment of the capacity of the resident to make a decision regarding their medicines and a best interests meeting), it is also important to consider and plan how the medicine can be covertly administered, whether it is safe to do so and to ensure that need for continued covert administration is regularly reviewed (as capacity can fluctuate over time). Medicines should not be administered covertly until after a best interests meeting has been held. If the situation is urgent, it is acceptable for a less formal discussion to occur between the care home staff, prescriber and family or advocate to make an urgent decision. However, a formal meeting should be arranged as soon as possible.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to agree a management plan after a best interests meeting in which a decision is made to covertly administer medicines to an adult care home

resident.

Data source: Local data collection.

Process

Proportion of adults in a care home being covertly administered medicine who have a record of a best interests meeting and management plan.

Numerator – the number in the denominator with a record of a best interests meeting and management plan.

Denominator – the number of adults in a care home being covertly administered medicine.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers (care homes) ensure that if a decision is taken to covertly administer medicine to an adult care home resident, then a management plan is also agreed and recorded after a best interests meeting.

Health and social care practitioners who participate in a best interests meeting agree and record a management plan after the best interests meeting if a decision is taken to covertly administer medicine to an adult care home resident.

Commissioners ensure that service specification contracts for care home providers include a requirement to ensure that if a decision is taken to covertly administer medicine to an adult care home resident, then a management plan is also agreed and recorded after a best interests meeting.

Adults who live in care homes who may not be able to make decisions about their treatment and care may need to be given their medicines without them knowing (known as 'covert administration'), for example hidden in their food or drink. Care home staff should have a meeting with healthcare professionals and family members to discuss this and agree whether it is the best option for the person. If it is agreed, a plan should be made

after the meeting to make sure it is done safely and reviewed regularly to check if it should continue.

Source guidance

Managing medicines in care homes. NICE guideline SC1 (2014), recommendation 1.15.3

Definitions of terms used in this quality statement

Best interests meeting

When covert administration of medicines is being considered, there should be a 'best interests' meeting. The purpose of this meeting is to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests. A best interests meeting should be attended by care home staff, relevant health professionals (including the prescriber and pharmacist) and a person who can communicate the views and interests of the resident (this could be a family member, friend or independent mental capacity advocate depending on the resident's previously stated wishes and individual circumstances). If the resident has an attorney appointed under the Mental Capacity Act for health and welfare decisions, then this person should be present at the meeting. [NICE's guideline on managing medicines in care homes]

Covert administration

When medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. [NICE's full guideline on managing medicines in care homes, glossary]

Management plan

This would usually include:

- medication review by the GP
- medication review by the pharmacist to advise the care home how the medication can be covertly administered safely

- clear documentation of the decision of the best interests meeting
- a plan to review the need for continued covert administration of medicines on a regular basis.

[NICE's full guideline on managing medicines in care homes]

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the

quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- British Geriatrics Society
- Royal College of General Practitioners (RCGP)