East Lancashire Hospitals
NHS Trust

East Lancashire Medicines Management Care Home Delivery Team

Care Home Information Pack

East Lancashire Medicines Management Board

Surf to our website NOW!

www.elmmb.nhs.uk

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NHS
East Lancashire
Clinical Commissioning Group

Medicines Management Care Home
Medication Review Referral Form

Please email completed forms securely **nhs.net** to:
mm.carehomereferrals@nhs.net

This is **not** an acute service; REVIEWS will aim to be completed within **4 weeks of receipt.**

Information on administration options for people with **difficulties taking tablets or capsules** can be found @ elmmb.nhs.uk
PLEASE REFER TO **mm.carehomereferrals@nhs.net** FOR MEDICATION REVIEW

If you require more urgent advice contact patient's GP, Nurse, Practice or Dispensing Pharmacist.

Has the patient or advocate (if patient lacks capacity) consented to this referral? *If NO, MMT would be unable to proceed with medication review.	**YES**	**NO ***

Reason for referral :

- ☐ Polypharmacy (8 or more items)
- ☐ Recent hospital discharge
- ☐ Specific medication problems: Falls, Drowsiness, Constipation - Specify
- ☐ Refusing Medication
- ☐ Difficulty taking tablets/capsules
- ☐ Other - Specify

Patient ID e.g. EMIS No. or NHS No**.**

……

Care Home Name & Details:

……

……

Date of Referral: ……

Name of Referrer: (Mandatory fields below)

……

Contact Details: (Phone No):

……

Job Title:

……

Care Home Locality :

GP Name & Surgery Address:

……

……

► Where possible please ensure that relevant clinical measures: BP, weight, blood monitoring are available prior to referral.
Any other relevant comments or information related to this request:

……

……

MMT OFFICE USE: FORM **NOT TO BE PRINTED** OR STORED EXTERNALLYSAVE IN NHS.NET LOCALITY FOLDER

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PENNINE LANCASHIRE COMMUNITY PHARMACIES PROVIDING PROVISION OF SPECIALIST DRUGS IN PALLIATIVE CARE [TIER 1]

BLACKBURN WITH DARWEN	
Aston Pharmacy 95 Accrington Road, Blackburn, BB1 2AF Tel: 01254 680133 **Opening times:** Mon - Fri 9:00am – 19:30pm Sat 9:00am – 17:00pm Sun 10:00am - 13:00pm	**Boots the Chemist** 2 Cobden Court, Blackburn, BB1 7JJ Tel: 01254 580115 **Opening times:** Mon – Sat 8:30am - 17:30pm Sun 10:30am – 16:30pm
Beehive Pharmacy Beehive Service Station, Haslingden Road, Blackburn BB1 2EE Tel: **01254 53585** **Opening times:** Mon – Thurs 7:30am – 22:00pm Fri – Sat 7:301m – 22:30pm Sun 10:00am – 22:00pm	**Boots the Chemist** Townsmoor Retail Park, Great Bolton Street, Blackburn BB2 3PX Tel: 01254 696620 **Opening times:** Mon – Fri 9:00am – 20:00pm Sat 9:00am – 18:00pm Sun 10:30am – 16:30pm
4 Court Pharmacy Blackburn Service Station, Whalley Banks, Blackburn. BB1 6DX Tel: 01254 677477 **Opening times:** Mon – Fri 7:00am – 23:00pm Sat 9:00am – 21:00 Sun 11:00am – 19:00pm	**Superdrug Pharmacy** 3-7 Stonybutts, Blackburn Shopping Centre, Blackburn, BB1 6JD Tel: 01254 674909 **Opening times: Mon – Sat 9:00am – 17:30pm**
	Whalley Range Pharmacy 1 Whalley Range, Blackburn, BB1 6DX Tel: 01254 549988 **Opening times:** Mon – Sat 7:30am – 22:30pm Sun 11:00am – 21:00pm

BURNLEY	
Lloyds Pharmacy in Sainsbury's Active Way, Burnley, BB11 1BS Tel: 01282 423998 **Opening times:** Mon – Thurs, Sat 8am- 8pm Fri 8am - 9pm, Sunday 10am - 4pm	**Asda Pharmacy** Princess way, Burnley, BB12 0AB Tel: 01282 838177 **Opening times:** Mon - Fri 8am - 10pm Sat 8am - 8pm, Sun 11 - 5pm
Burnley Late Night Pharmacy 36 Colne Road, Burnley BB10 1LG Tel: 01282 421421 **Opening times:** Mon – Sat 8am – 11pm Sun 11am – 9pm	
HYNDBURN	
Asda Pharmacy Hyndburn Road, Accrington, BB5 1QR Tel: 01254 301111 **Opening times:** Mon 8am - 11pm Tues - Fri 7am - 11pm Sat 7am - 10pm, Sun 10am - 4pm	**Huncoat Pharmacy** 20 Station Road, Huncoat, BB5 6LS Tel: 01254 238823 **Opening times:** Mon - Fri 9am - 6pm
Baxenden Pharmacy 514-516 Manchester Rd, Accrington, BB5 2RG Tel: 01254 388006 **Opening times:** Mon, Tues, Thurs, Fri 8.45am - 6pm Wed 8.45 - 1pm Sat 8.45 - 12pm	

PENDLE	
Rowlands Pharmacy 7 Albert Road, Colne, BB8 0RY Tel: 01282 863420 **Opening times:** Mon to Fri 9am - 5.30pm, Sat 9am - 1pm	**Nelson Health Centre Pharmacy** Yarnspinners Primary Health Care Centre, Nelson, BB9 7SR Tel: 01282 694825 **Opening times:** Mon 8.30am - 6.30pm Tues - Fri 8.30am - 6.30pm Sat 9am - 12pm
Asda Pharmacy Corporation Street, Colne, BB8 8LW Tel: 01282 870156 **Opening times:** Mon 8am - 11pm Tues - Fri 7am - 11pm Sat 7am -10pm, Sun 10am -4pm	
RIBBLE VALLEY	
Boots the Chemist 15-19 Castle Street, Clitheroe, BB7 2BT Tel: 01200 422569 **Opening times:** Mon - Friday 8.30am – 5.30pm Sat 8.30am – 5.30pm	**Lloyds Pharmacy** 40 King Street, Whalley, BB7 9SL Tel: 01254 823278 **Opening times:** Mon 8.30am - 7pm Tues - Fri 8.30am - 6pm Sat 9am -5pm, Sun 11am-3pm
ROSSENDALE	
Asda Pharmacy St Mary's Way, Rossendale, BB4 8EL Tel: 01706 242410 **Opening times:** Mon 8am - 11pm Tues - Fri 7am - 11pm Sat 7am - 10pm, Sun 11am - 5pm	**Cohens Chemist** 278 Newchurch Road, Stacksteads, OL13 OUJ Tel: 01706 873155 **Opening times:** Mon - Fri 9am - 5.30pm

East Lancashire Health Economy
Medicines Management Board
www.elmmb.nhs.uk NHS

Medicines Awareness

Sessions are Virtual via Microsoft Teams

2022 2.00pm-3.00pm

10.5.22
Refresher Back to Basics + Missed & Refused Doses

7.6.22
Refresher Back to Basics + Time Sensitive Medicines

12.7.22
Refresher Back to Basics + When Required Medicines

There is no cost for this course

Booking is Essential via link

https://bookwhen.com/regulatedcare

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PrescQIPP Community Interest Company

Medicines use in care homes course 1 e-learning

The NICE Quality Standards for medicines management in care homes quote a study that found more than 90% of the residents in long-term residential care were exposed to at least one potential medicine administration error in a three month period. To improve the safe and effective use of medicines by people who live in care homes, clear systems and processes are needed across the medicines optimisation pathway.

The Care homes 1 e-learning package is aimed at all care home staff involved with managing medicines. It is the first of several-planned e-learning packages for Care homes and will include the following modules in addition to three case studies to help apply learning to practice. Quizzes at the end of each module will test understanding and recap key learning points, and a pass mark of 70% is required to complete the course and receive a certificate.

MODULE 1	**Welcome and introduction**
MODULE 2	**The role of CQC and the NICE guideline and quality standards** • NICE guideline, quality standards, from recommendations to practice, implementation of NICE guidance in care homes, encouraging best practice
MODULE 3	**The management of medicines in care homes** • NICE, monthly medicine cycle, ordering, prescription requirements, directions, MAR sheets, use of compliance aids
MODULE 4	**Management of self-medicating residents** • Assessment, consent, ordering and receipt of medicines, storage, disposal, care plans, options for supporting self-administration
MODULE 5	**Administration of inhalers**
MODULE 6	**Administration of eye drops**

MODULE 7	Administration of transdermal patches
MODULE 8	Administration of topical products
MODULE 9	Administration of PRN medicines

Course access

The course is **free** for all healthcare professionals in your commissioning area.

You will need to be logged in to the PrescQIPP site so that it can record your progress and issue your e-learning certificate.

If you do not already have a log in for the PrescQIPP site, you can register here. Please ensure that you specify the commissioning area on registration as this will ensure that you are provided with the correct access and do not have to pay for the course.

1. Log in to the PrescQIPP site
2. Locate the course link under the top 'Learn' menu or from the E-learning Hub
3. Select 'Take this course'

Don't forget that you can complete the course over a period of time. To return to the course and pick up where you left off at any time, simply log back into the site and go to the 'My e-learning courses' page which you will find under the top 'Learn' menu after logging in, or on the right hand side of the E-learning Hub.

Please note that you will need an up to date browser and sufficient bandwidth to view the course. If you have any questions about the course, please contact help@prescqipp.info.

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PrescQIPP
Community Interest Company

Medicines use in care homes: Course 2 e-learning

The second of our e-learning packages for care homes, builds on the content covered in Medicines use in care homes: Course 1 and includes seven modules focusing on key topics, in addition to three case studies that will help apply learning to practice.

The course is designed for all care home staff involved in the administration, recording, ordering, storage or any other aspect of medicines use.

Quizzes at the end of each module will test understanding and recap on key learning points, and a pass mark of 70% is required in the final assessment to complete the course and receive a certificate.

MODULE 1	**Welcome and introduction**
MODULE 2	**Refused and omitted doses** • The right to refuse • How to manage late or omitted doses • Documentation
MODULE 3	**Covert administration** • The need to consider covert administration • Legal framework • Practical guidance • Suggested care pathway
MODULE 4	**Managing controlled drugs** • Access • Receipt • Storage • Administration • Documentation • Disposal • Discrepancies • Safeguarding • Incidents

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MODULE 5	**Bulk prescribing** • What is bulk prescribing? • Which medicines are suitable for bulk prescribing? • Legal requirements
MODULE 6	**Homely remedies** • NICE guidance • Homely remedy protocols • Recording administration
MODULE 7	**Medicines waste reduction** • How to reduce medicines waste • Appropriate ordering especially of 'prn' medicine

Course access

The course is **free** for all healthcare professionals in your commissioning area.

You will need to be logged in to the PrescQIPP site so that it can record your progress and issue your e-learning certificate.

If you do not already have a log in for the PrescQIPP site, you can register here. Please ensure that you specify the commissioning area on registration as this will ensure that you are provided with the correct access and do not have to pay for the course.

1. Log in to the PrescQIPP site
2. Locate the course link under the top 'Learn' menu or from the E-learning Hub
3. Select 'Take this course'

Don't forget that you can complete the course over a period of time. To return to the course and pick up where you left off at any time, simply log back into the site and go to the 'My e-learning courses' page which you will find under the top 'Learn' menu after logging in, or on the right hand side of the E-learning Hub.

Please note that you will need an up to date browser and sufficient bandwidth to view the course. If you have any questions about the course, please contact help@prescqipp.info.

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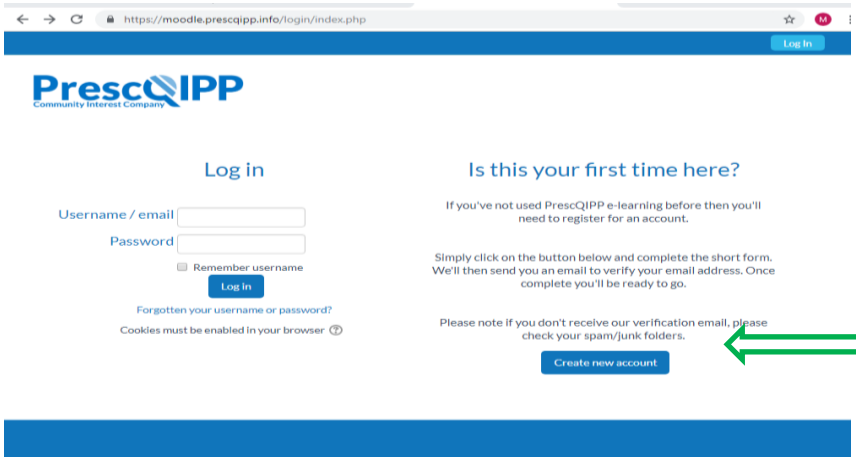
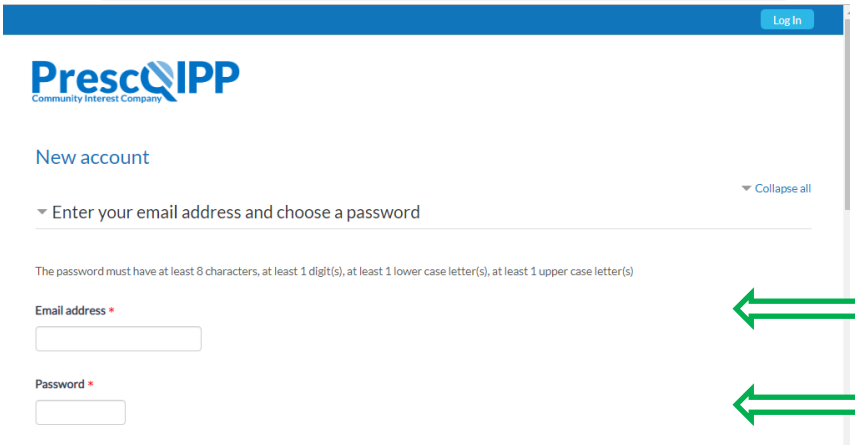
How to access PrescQIPP E-learning for Care Homes

https://moodle.prescqipp.info/login/index.php



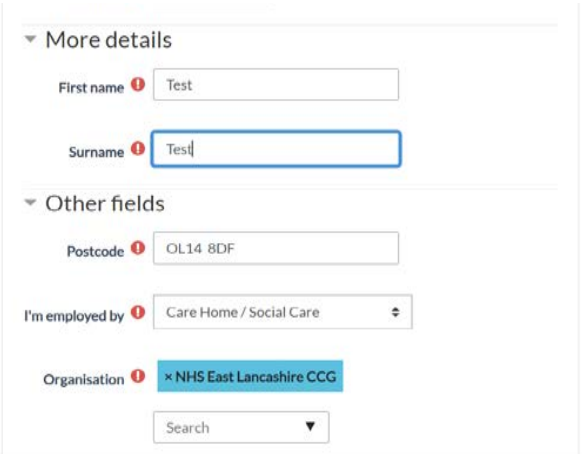
Select 'Create New Account'



Enter your email address

Create a password

Remember to make a note of your password



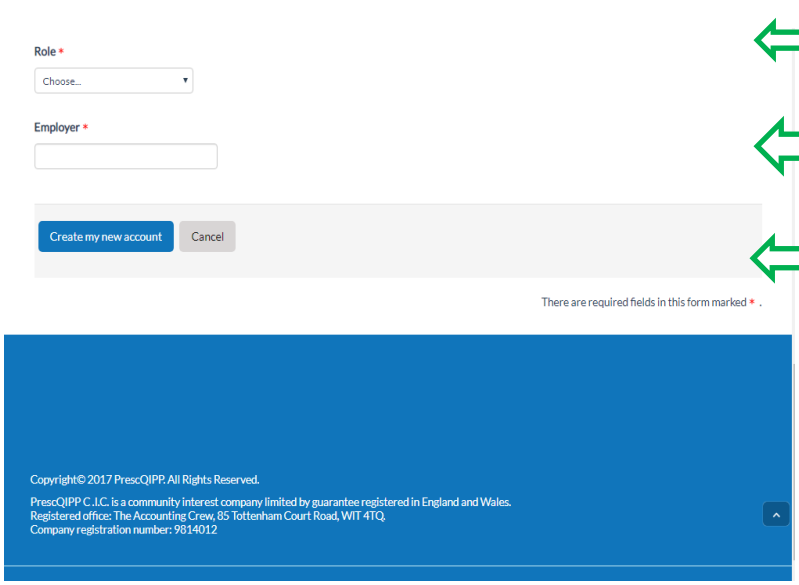
Enter your Name

Enter your work address postcode

Select 'Care Home/Social Care

Select 'NHS East Lancashire CCG'

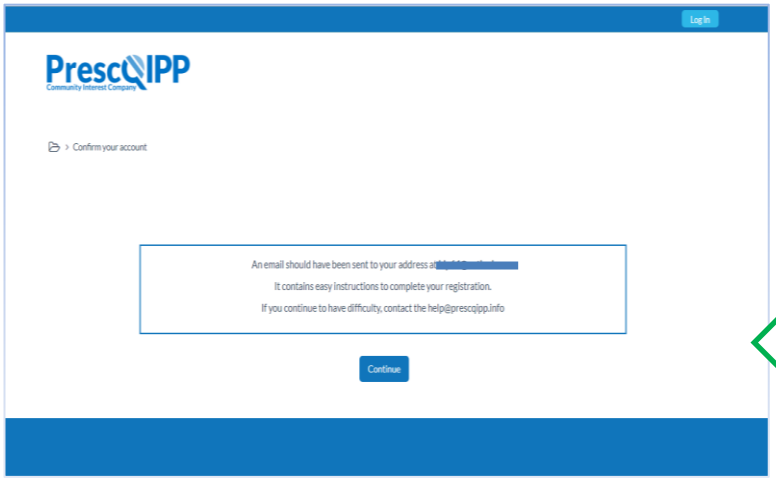
How to access PrescQIPP E-learning for Care Homes



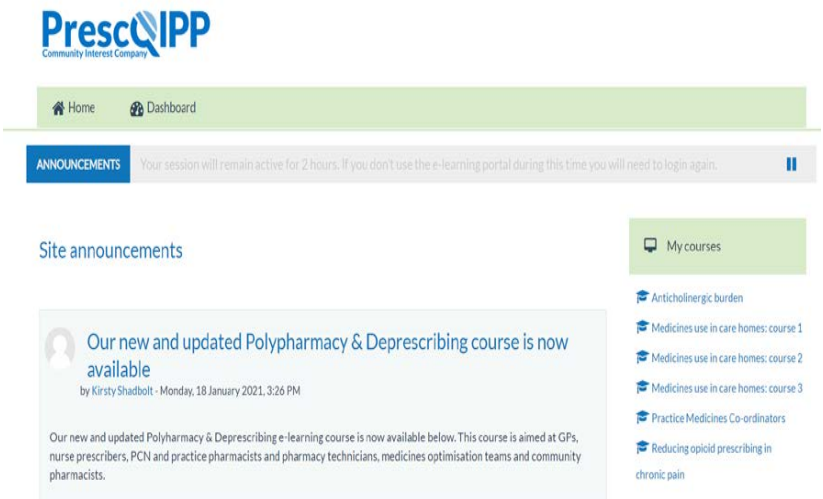
Select your role

Enter the name of the Care Home

Click & Register for an Account

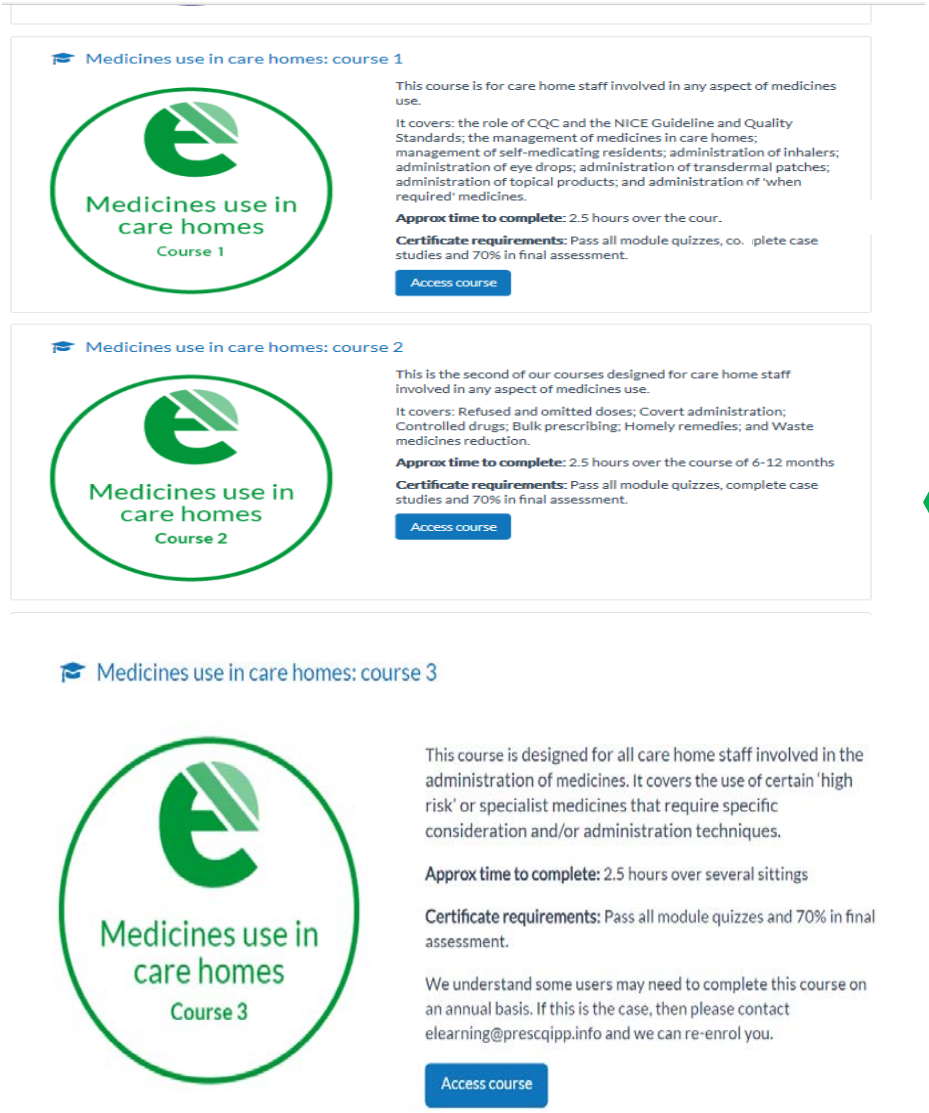


Login to your emails and follow the instructions from PrescQIPP



You will now be taken to the e-Learning page

How to access PrescQIPP E-learning for Care Homes



Scroll down the page until you reach the Care Home Training Modules – click to access a course

NICE National Institute for Health and Care Excellence

Putting NICE guidance into practice

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

Implementing the NICE guideline on managing medicines in care homes

Published: May 2014

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

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

What do you think?
Did this tool meet your requirements, and did it help you put the NICE guideline into practice?
We value your opinion and are looking for ways to improve our tools. Please complete this short evaluation form.
If you are experiencing problems using this tool, please email implementation@nice.org.uk.

National Institute for Health and Care Excellence

Level 1A, City Tower, Piccadilly Plaza, Manchester M1 4BT www.nice.org.uk

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Introduction

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

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

- Sharing information about a resident's medicines, including when they transfer between care settings
- Ensuring that records are accurate and up to date
- Identifying, reporting and reviewing medicines-related problems
- Keeping residents safe (safeguarding)
- Accurately listing a resident's medicines (medicines reconciliation)
- Reviewing medicines (medication review)
- Ordering medicines
- Receiving, storing and disposing of medicines
- Helping residents to look after and take their medicines themselves (self-administration)
- Care home staff administering medicines to residents, including staff training and competence requirements
- Care home staff giving medicines to residents without their knowledge (covert administration)
- Care home staff giving non-prescription and over the counter products (homely remedies) to residents, if appropriate

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

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

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

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

Using this policy checklist

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

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

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

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

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

Care home providers may wish to consider:

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

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

Responsibilities

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

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

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

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

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

Accurately listing a resident's medicines (medicines reconciliation)	
The care home medicines policy:	***Date/notes***
Includes a process for accurately listing a resident's medicines (medicines reconciliation), which covers: • who is responsible for coordinating medicines reconciliation (the person who is responsible for the resident's transfer into the care home) • who to involve (including the resident and/or their family or carers, a pharmacist, other health and social care staff) • the information that should be available for medicines reconciliation on the day that a resident transfers into or from a care home: – resident's details, including full name, date of birth, NHS number, address and weight (for those under 16 or where appropriate, for example, frail older residents) – GP's details – details of other contacts defined by the resident and/or their family or carers (for example, consultant, regular pharmacist, specialist nurse) – known allergies and reactions to medicines or ingredients, and the type of reaction experienced – medicines the resident is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication), if known – changes to medicines, including medicines started, stopped or dosage changed, and reason for change – date and time of the last dose of any 'when required' medicine or any medicine given less often than once a day (weekly or monthly) – other information, including when the medicine should be reviewed or monitored, and any support the resident needs (adherence support) • what information has been given to the resident and/or family or carers. • the training and skills needed for medicines reconciliation (for example, effective communication skills, technical knowledge of relevant medicines management systems and evidence-based therapeutics). See recommendation 1.7.1, recommendation 1.7.2, recommendation 1.7.3.	Please use these boxes to make notes.

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

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

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

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

Care home staff administering medicines to residents	
The care home medicines policy:	***Date/notes***
Includes a process for medicines administration by care home staff, which follows a person-centred approach and specifies that only trained and competent staff should administer medicines. The process details: • the 6 R's of administration: – right resident – right medicine – right route – right dose – right time – resident's right to refuse • that records should: – be legible – be signed by the care home staff – be clear and accurate – be factual – have the correct date and time – be completed as soon as possible after administration – avoid jargon and abbreviations – be easily understood by the resident, their family and carers. • the information a medicines administration record should include: – the full name, date of birth and weight (for those under 16 or where appropriate, for example, frail older residents) of the resident – details of any medicines the resident is taking, including the name of the medicine and its strength, form, dose, how often it is given and where it is given (route of administration) – known allergies and reactions to medicines or their ingredients, and the type of reaction experienced (this will require liaison between the care home and the resident's GP) – when the medicine should be reviewed or monitored (as appropriate) – any support the resident may need to carry on taking the medicine (adherence support)	Please use these boxes to make notes.

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  - any special instructions about how the medicine should be taken (such as before, with or after food, or whether the medicine could be crushed)
- who will produce the medicines administration records
- how to record medicines administration (including medicines administered by visiting health professionals)
- how to cross-reference administration records (for example, 'see warfarin administration record') when a medicine has a separate administration record
- what to do if the resident is having a meal
- what to do if the resident is asleep
- how to administer specific medicines such as patches, creams, inhalers, eye drops and liquids
- using the correct equipment depending on the formulation (for example, using oral syringes for small doses of liquid medicines)
- how to record and report administration errors and reactions to medicines
- how to record and report a resident's refusal to take a medicine(s)
- how to manage medicines that are prescribed 'when required'
- how to manage medicines when the resident is away from the care home for a short time (for example, visiting relatives)
- monitoring and evaluating the effects of medicines, including reactions to medicines
- agreeing with the resident, prescriber and pharmacist the timing for administration of medicines
- how to reduce interruptions during medicines administration rounds
- the training and skills needed by care home staff to use system(s) adopted in the care home for administering medicines
- how to ensure information on the medicines administration record is accurate and up-to-date
- how to access appropriate medicines information and resources.

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

For ‘when required’ medicines, the process includes: • the reasons for giving the 'when required' medicine • how much to give if a variable dose has been prescribed • what the medicine is expected to do • the minimum time between doses if the first dose has not worked • offering the medicine when needed and not just during 'medication rounds' • when to check with the prescriber any confusion about which medicines or doses are to be given • recording 'when required' medicines in the resident's care plan. The process specifies that medicines prescribed as ‘when required’ are kept in their original packs and not monitored dosage systems. See recommendation 1.14.3.	
For controlled drugs, the process includes: • how to make appropriate records of controlled drugs that have been administered to residents • the requirement for signing the controlled drugs register and the medicines administration record. See recommendation 1.14.16.	
The process includes the following information about producing new, hand-written medicines administration records: • the training, skills and designated responsibility required by the care home staff • checking accuracy and signing by a second trained and skilled member of staff before first use. See recommendation 1.14.9.	
Includes a process for when a resident is temporarily absent from the care home that details giving the following information to the resident and/or their family or carers: • the medicines taken with the resident	

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• clear directions and advice on how, when and how much of the medicines the resident should take • time of the last and next dose of each medicine • a contact for queries about the resident's medicines, such as the care home, supplying pharmacy or GP. See recommendation 1.14.17 and recommendation 1.14.18.	
Includes a process for care home staff (registered nurses and social care practitioners working in care homes) updating records of medicines administration with accurate information about any changes to medicines. See recommendation 1.9.4.	
Includes a process for recording prescribing instructions given remotely, which gives details of: • how care home staff should record instructions given by telephone, video link, online or, in exceptional circumstances only, text message • how care home staff should make sure that the health professional using remote prescribing changes the prescription • the training and skills required by care home staff to assist with the assessment and discussion of a resident's clinical needs • how the medicines administration record should be updated • recording the information in the resident's care plan (usually within 24 hours) • how staff should make sure that the resident's confidentiality is maintained. For care homes with nursing, the process incorporates the Nursing and Midwifery Council Standards for medicines management (2010) for remote prescribing. See recommendation 1.9.7and recommendation 1.9.8.	
Includes details of the training and skills required by care home staff, as follows: • induction training relevant to the type of home care home staff are	

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working in (adult care homes or children's homes)

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

See recommendation 1.17.1, recommendation 1.17.2 and recommendation 1.17.3.

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

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

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Good Practice Guidance for Care Homes

Medication Ordering and Receipt

NICE have recently produced a National Guideline for Managing Medicines in Care Homes which applies across both health and social care. This states clearly: **"Care homes should retain responsibility for ordering medicines from the GP practice and should not delegate this to the pharmacy".** Pharmacies may collect/drop off prescriptions but should not be ordering on behalf of care homes.

NICE also states:

- Homes should have a written process for ordering medication.
- A minimum of two members of staff should have training and skills to order medicines.
- Care home providers should ensure that staff have protected time to order/check in medicines.

The following is good practice guidance on how Care Homes can achieve this:

Order medicines for next 28 day cycle.
- Use the most recent tear off slip printed from the practice
- Cross reference to an up to date MAR chart to ensure current medicines are ordered
- Annotate the repeat slip if items discontinued
- Check against recent hospital discharge information if relevant
- Synchronise those medications running out at different times
- If PRNs becoming overstocked request quantity is reduced to approx. 1 months' supply
- Check stock levels of PRNs, inhalers, test strips, creams etc, before they are ordered
- Do not routinely clear drug cupboards and order new stock

⇓

Record details of all medicines ordered
e.g photocopy order slip, purpose made form, pharmacy MAR if designed for this purpose

⇓

Send order to GP practice (pharmacy may collect/drop off prescription forms)

⇓

Collect prescriptions from GP practice (pharmacy may collect/drop off prescription forms)

⇓

Care Home to check prescriptions before dispensing
- Check prescriptions received (or photocopies if pharmacy collect) against the original order
- Discuss unexpected changes with the GP Practice
- Outstanding prescriptions collected from GP practice and checked at the care home

⇓

Send batch of checked prescriptions to pharmacy

⇓

Pharmacy dispense medicines and generate MAR sheets
- Ask the pharmacy to remove discontinued medicines from the MAR sheet
- Notify pharmacy if any changes to medication occur before they are delivered

⇓

Medicines delivered to care home

⇓

Medicines checked in by home
- Check dispensed supply of medicines against the order.
- Check dispensed supply against the MAR sheet supplied. Make a note of the amount received.
- Carry remaining stock forward
- Check new MAR sheet against current MAR/up to date complete list of patient medication.
- Handwritten additions should have a double check and signatures

References
The Handling of Medicines in Social Care Royal Pharmaceutical Society of Great Britain http://www.rpharms.com/support-pdfs/
NICE Guideline Medicines Management in Care Homes March 2014 http://www.nice.org.uk/ v1 March 2014. Reviewed and next review date August 2020_ v1.1

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When Required Medication. Guidance for Care Homes

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Medication that is not required by a resident on a regular basis is sometimes referred to as a 'when required' or PRN medication. Due to the varying dosage requirements of these medicines, many factors need to be considered to ensure their safe use.
Care homes should ensure that a process for administering 'when required' medicines is included in the care home medicines policy.

Clear and specific labelling
It is important care homes are provided with clear and precise instructions to ensure PRN medication is administered as intended by the GP. To assist with this process, GPs should ensure the following information is included on the prescription for PRN medicines:

Number of tablets to be taken (e.g. take one to two tablets)

Interval between doses (e.g. every four to six hours)

Maximum amount to be taken in a day (e.g. maximum of 8 tablets in 24 hours)

Indication (e.g. for relief of back pain)

Example of a clear and precise dose:

> Take one to two tablets every four to six hours when required, up to a maximum of 8 tablets in 24 hours. For relief of back pain

The use of the term 'as directed' should be avoided

Where a PRN dose is unclear, clarification should be sought from the GP before administration

Care plan
Details of 'when required' medicines should be recorded in the residents care plan including:

- A clear treatment and outcome plan (consider using attached template)
- What the medication is being used for
- Symptoms to look out for and when to offer
- If resident is able to ask for the medication or if they need prompting or observing for signs of need
- When the medicines should be reviewed or monitored
- How long the resident is expected to need the medicine
- Where there is more than one option available (e.g. multiple painkillers), it should be made clear when it is appropriate to use each one

Stock levels
Care homes should be cautious when ordering PRN medication as excess stock can easily build up.

- It is recommended that PRN medication is boxed / kept in original packaging with the pharmacy label on it as this provides flexibility and reduces waste
- Care homes should ensure PRN medications are stored securely and that they are accessible throughout the day as requests often occur outside of regular medication rounds
- Stock levels of a PRN medication must be appropriate for the resident's changing needs (for example, for 28 days or the expected length of treatment)

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- Care homes should ensure excessive stock does not build up to avoid unnecessary waste
- Any PRN medication that is still in use and in date should be 'carried forward' from one month to the next. It is not necessary to destroy unused, in date PRN medication each month
- Acute medication prescribed for a specific amount of time (e.g. 3 days) should only be used for the purpose intended and for the recommended period of time. If this medication is not used by the end of the stated period then it should be destroyed.
- Care homes should ensure the 'Homely Remedy' list is utilised as it is not always necessary to request a prescription for some treatments required for less than 48 hours

Administration

A system should be in place to highlight to carers that a PRN medication is available for use by an individual resident

- Check the care plan for clear guidance on what the medication is being used for, what symptoms to look out for and when to offer
- Carers should be fully aware of the quantity to be given, the interval between doses and the maximum daily quantity allowed
- Consideration should be given to residents who may not have the capacity to refuse medication offered
- When a medication is prescribed at a variable dose (e.g. 1-2 tablets), the care plan should include information on how a decision is made on the dose to administer (e.g. 1 or 2 tablets)
- If staff are unsure of the quantity to administer, the GP should be contacted for clarification.

Medication Administration Record (MAR)

MAR charts should provide a clear and accurate audit trail of PRN medicines. A record should only be made when a resident has taken their prescribed medicine. The administration of all medication should be recorded on the MAR chart immediately to prevent an incident or accidental overdose from occurring. The following details should be recorded:

- Number of tablets / dose administered, especially where there is a varying dose (e.g. 1-2 tablets)
- Date and exact time of administration, enabling a carer to decide if the appropriate time period has passed before administering the next dose
- Where possible, the amount of PRN medicine left to make sure there is enough in stock and to reduce waste
- Record when and why medicines have not been given, if this is the case

Monitoring

When a PRN medication is in use, the resident should be monitored and reviewed regularly to ensure use is still appropriate. The following observations may indicate a review is required and the GP should be contacted for further advice:

- The resident appears to be experiencing side effects (side effects will be listed in the patient information leaflet)
- The resident appears to derive no benefit from the medication
- The resident's condition has deteriorated
- The resident is requesting the PRN medication more frequently
- The resident rarely requests or regularly declines the PRN medication

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When Required (PRN) medication plan

The following information must be referred to when offering / administering PRN medication, prescribed or over the counter for the individual concerned. This information must be held in MAR folder at back of each client's MAR sheets for reference. Response to therapy should be stated in the service user's clinical notes.

Service Users Name	**DOB**

Name of medication	**Form**
Strength	**Route of Administration**

Dose and minimum time interval between doses

Max dose in 24 hours	**Is the medication prescribed or over the counter?**

Any Special instructions *e.g. before or after food on empty stomach*	**Reason for administration –** *when it should be given- describe in as much detail as possible the condition being treated i.e. symptoms, indicators, behaviours, triggers, type of pain where & when, expected outcome etc*

Any additional comments/information

Date	**Name of person completing this information**

Review date	**Date review completed and name**

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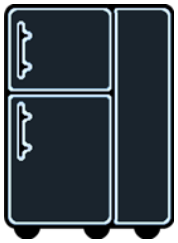
Caring for Care Homes

Fridge Temperature Monitoring | Guidance Sheet 1



Some medicines must be stored in a refrigerator because at room temperature they break down or 'go off'. Care homes need to know which medicines need to be kept cool. To find out if a product needs to be stored in the fridge, check the packaging, or refer to the Patient Information Leaflet (PIL) supplied. If you need a copy of a PIL, contact your pharmacist or go to: www.medicines.org.uk/emc/

Fridge requirements and daily temperature recording:

- If a resident requires a medication on a regular basis that needs to be refrigerated (e.g. insulin), there should be a separate, secure, locked fridge that is only used for medicines.
- In a small home that doesn't have a constant need to refrigerate medicines, a separate fridge may not be necessary. In this case a sealed container, preferably locked, may be kept in the food fridge to store the medication.
- The fridge temperature should be monitored and recorded daily. It is recommended to record minimum, maximum and current temperatures, using a minimum/maximum thermometer (see example record chart overleaf).
- The fridge should be regularly cleaned and defrosted and dated records kept.
- Ensure staff taking the thermometer readings understand how to read and reset the thermometer and why this is necessary.
- The fridge temperature must be kept between the range of 2°C and 8°C. If the fridge temperature is outside of this range action should be taken immediately (see below).
- Avoid keeping large amounts of medicines in the fridge as this can lead to inadequate air flow and potential freezing.
- Ensure fridge contents are regularly date checked and stock rotated. Fridges can easily be overlooked when conducting regular stock audits.

What to do when the fridge temperature is out of range:

- Inform the care home manager immediately.
- Quarantine fridge stock while advice is sought.
- Attach a notice to the fridge clearly stating do not use.
- Estimate how many hours the fridge has been out of range (you should have the reading from the previous day's check).
- Contact your regular pharmacy for advice or the manufacturer for individual product advice.
- Ensure that the stock which is no longer usable is disposed of promptly.
- If necessary, call out an engineer to repair the fridge.
- Contact the GP to order replacement prescriptions if required.
- Remember to record the action taken on the fridge temperature record sheet.

Acknowledgement to Northern, Eastern & Western Devon CCG and South Devon & Torbay CCGVersion 3.1_2019 _Review Date: September 2020

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Fridge temperature recording sheet

Each day please record the current, minimum and maximum fridge temperatures (^{O}C). Remember to reset the thermometer after each recording.

Acknowledgement to:
NHS
Northern, Eastern and Western Devon Clinical Commissioning Group
South Devon and Torbay Clinical Commissioning Group

Date	Time	Current fridge temp °C (Range 2-8°C)	Minimum temp °C	Maximum temp °C	Thermometer reset	Action taken if outside of range 2-8°C	Checked by (initials)
01/09/2013	09.00	5	3	5	✓	n/a	AA

Please record the date(s) the fridge was cleaned and defrosted:

Has the fridge temperature been checked every day? **Yes** **No**

Has any necessary action been taken? **Yes** **No**

If yes, what was the action?

Reviewed By: **Date:**

If the fridge temperature is outside the stated range (2°C and 8°C), inform the care home manager, quarantine the stock and seek advice immediately

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East Lancashire Hospitals NHS Trust

Transfer of Medicines between Care Home and Hospital
Hospital Admission Checklist

Responsibilities of nursing and residential home staff:

1. Provide a photocopy of the current **MAR chart and topical medication chart**

2. Ensure MAR chart is up-to-date, showing recently **started/stopped** medication and **allergy status**

3. **Write on** the copy of the MAR chart if the medication has been sent into hospital with the patient using the abbreviation **SWP** (Sent with patient). Sign and date the top of the MAR chart.

Guide for nursing and residential home staff:

Medication to be sent into hospital with patient:

- Any tablets/capsules in a box (e.g. antibiotics, medications not in a MDS)
- Insulin device in current use- please specify units on the MAR chart and a photocopy of last sheet from District nurse file (if applicable)
- Inhalers
- Sprays (e.g. GTN, nasal)
- Drops (e.g. eye, ear, nose)
- Creams and ointments
- Transdermal patches
- Clozapine (even if in a blister pack)
- Parkinsons medication (even if in a blister pack)
- Sativex
- Antiepileptic medication (even if in a blister pack)
- Anti-rejection medication (even if in a blister pack)
- Medication in liquid form (even if in a blister pack)

Medication NOT to be sent into hospital with patient:

- Medication in an MDS (blister pack)
- Controlled drugs

Further copies of this checklist can be printed from www.elmmb.nhs.uk/

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NHS
East Lancashire
Clinical Commissioning Group

Appendix 2

Top Tips for Care Homes for Interpreting Hospital Discharge Letters

NICE National Guideline for Managing Medicines in Care Homes March 2014 states:

"The care home manager or person responsible for a resident's transfer into a care home should coordinate the accurate listing of all the resident's medicines as part of a full needs assessment and care plan ……..in a timely manner"

What discharge letters mean:

DIAGNOSES

This gives information as to why the patient was admitted to hospital and any treatment(s) that were given.
Are there any new medical conditions listed that you weren't previously aware of?
Has the resident's care plan been updated?

FOLLOW-UP/GP ACTION

Has necessary follow-up been carried out or arranged by GP and/or hospital as stated?
If the resident is to attend an **outpatient clinic** has this appointment been arranged?
Has the resident's care plan been updated so that this will be followed up if an appointment date is not received?

MEDICATION CHANGED DURING ADMISSION

If this section states "no" do not assume there are no changes but still check the list of discharge medications against the MAR chart to ensure there are no differences.

Medications that have been **STOPPED** – cross them off the MAR chart immediately and stop giving them. Check any repeat slips currently held in the care home and cross off any "stopped" medications. Inform the pharmacy that medication(s) have been stopped.

Medications that have been **STARTED** – handwrite these on the MAR chart with 2 staff to witness and sign. Administer when next due using medication supplied by the hospital. Check how many days' supply has been supplied by hospital, if supply runs out before next medication cycle starts order enough medication to last until new cycle. Ensure all new medication(s) are ordered from GP surgery for next medication cycle. Inform the pharmacy of any new medications that have been started.

Medications that have been **CHANGED** - the resident may be on the same medication but the form strength, dose, frequency or directions may have changed. Check that not just the medication but the **form, strength, dose, frequency and directions** are correct on the MAR chart. Inform the pharmacy of any medication changes.

DRUG INTOLERANCES

Check any information provided against the MAR chart. If there are any changes update the MAR chart **immediately**. Inform the pharmacy of any changes.
NKDA = no known drug allergies. If it states this but there is already a drug allergy or intolerance recorded on the resident's MAR chart **do not remove** but **CONTACT GP** to check what is correct.

INFORMATION CONCERNING THE MEDICATION LIST (TO BE COMPLETED BY PHARMACY ONLY)

Not checked: when the resident was admitted to hospital the pharmacy department did not complete a full check of the medications the resident was taking before coming into hospital. There may therefore be differences between the list of medications on the discharge letter and those on the MAR chart. If any of these differences are not stated in the "Medication changed during admission" section **do not assume** a medication has stopped, **CHECK WITH GP.**

Checked: when the resident was admitted to hospital the pharmacy department completed a full check of the medications the resident was taking before coming into hospital. If there are any differences between the discharge medication list and the MAR chart these should be listed in the "Medication changed during admission" section. However if there are any differences that are not stated in the "Medication changed during admission" section **do not assume** a medication has stopped, **CHECK WITH GP.**

New and changed: this is used when only new or changed items have been dispensed and listed on the discharge letter. This is most commonly used for very short admissions e.g. on medical admissions unit. These medications should be added to the MAR chart or changes made to the MAR chart for existing medication **immediately** in addition to medications already on the MAR chart.

Check the **"Duration"** on the discharge letter for any new or changed medications. If a short course or end date is not specified check how many days' supply has been supplied by hospital. If supply runs out before next medication cycle starts order enough medication to last until new cycle. Ensure all new medication(s) are ordered from GP surgery for next medication cycle.

DISCHARGE MEDICATION LIST

Check every medication on the discharge letter against the MAR chart.

Is the medication already on the MAR chart?

Are the form, strength, dose, frequency and directions the same as on the MAR chart?
If **YES** continue to administer as per MAR chart.
If **NO** does the discharge letter say a change has been made? If so change on MAR chart **immediately,** 2 staff to witness and sign**.** If discharge letter does not say a change has been made **CHECK WITH GP.**

Is the medication not already on the MAR chart?

Handwrite the medication on the MAR chart with 2 staff to witness and sign. Check the **"Duration"** on the discharge letter. If not clear **CHECK WITH GP** if medication is to continue once hospital supply runs out and order further supplies as needed.

Check every medication on the MAR chart against the discharge letter.

Is the medication on the discharge letter?

Are the form, strength, dose, frequency and directions the same as on the MAR chart?
If **YES** continue to administer as per MAR chart.
If **NO** does the discharge letter say a change has been made? If so change on MAR chart **immediately,** 2 staff to witness and sign**.** If discharge letter does not say a change has been made **CHECK WITH GP.**

Is the medication not on the discharge letter?

Does the discharge letter say this medication has been stopped?
If **YES,** cross off MAR chart **immediately,** 2 staff to witness and sign.
If **NO, CHECK WITH GP** if medication is to continue.

References; NICE Guideline Medicines Management in Care Homes March2014 v1
http://www.nice.org.uk/guidance/sc/SC1.jsp

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Appendix 1

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Hospital Discharge Letter Information Document

Discharge Summary

Royal Blackburn Hospital

Haslingden Road, Blackburn BB2 3HH

Telephone (Main Switchboard) 01254 263555

Inpatient Letter

Patient Identification
TEST RTPATIENT
123 THE AVENUE
BLACKBURN
MANCHESTER
BB2 3HH

Patient's name and address

Patient admission/discharge details

Admission Date	11/09/2015 08:28
Admission Source	Not known
Admission Method	Other - Not Known
Discharge Date	11/09/2015 08:29
Sex	Male
Date of Birth	01/03/1947
Marital Status	Married
NHS number	999 999 9468
Hospital Number	RXR4004786

DIAGNOSIS
NSTEMI

Patient presented with centralised chest pain and left arm radiation following exercise, no history of preceding symptoms.

On admission, ECG showed derangement, and Troponin was found to be 1200. Cardiac cath lab investigation showed 75% occlusion to LAD and 55% occusion to CX. Two stents placed, for dual antiplatelet therapy for 12 months.

Previous history of hypertension, hypercholesterolaemia and dyspepsia (already on PPI), nil else noted

Diagnosis and treatment details

PROCEDURES/INVESTIGATIONS
See above re. ECG and angio investigations

AKI 1 during admission - appropriately managed, U&Es normalised therefore ACE-i continued as per protocol

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FOLLOW UP ARRANGEMENTS
For Cardiology outpatient follow-up 3/12

For outpatient exercise tolerance test - date to be confirmed

PROPOSED DISCHARGE DATE AND TIME - 11/9/15 14:00hrs

MEDICATION CHANGED DURING ADMISSION/REASON FOR CHANGE/DATE?
STARTED: Aspirin - NSTEMI
STARTED: Clopidogrel - NSTEMI (for 12 months post angio)
STARTED: Bisoprolol - NSTEMI
STARTED: Atorvastatin - NSTEMI
STARTED: GTN spray - relief of anginal chest pain

STOPPED: Pravastatin - switched to atorvastatin as per NSTEMI protocol

CHANGED: Ramipril - Dose increased as per titration (GP to follow up and increase dose to 10mg daily as tolerated)

PATIENT HAS A DRUG INTOLERANCE? - NKDA

ADVANCING QUALITY - HEART FAILURE/ACUTE MYOCARDIAL INFARCTION
To be followed up via Cardiology

COMPLETED BY: - Dr J Wallett, FY2 Cardiology

DISTRICT NURSE REFERRAL ON DISCHARGE? - NO

DISCHARGE NURSE ONLY
If you have any problems contact (Name of Discharge Nurse): Susan Cooke - telephone 01254 735300 or 01254 733689. The Discharge arrangements have been explained to me (Patient/Carer's Signature):

MEDICATION SUPPLIED FROM OUT OF HOURS CUPBOARD - N/A

Follow up arrangements needed

Patient to attend out-patient follow up appointment in 3 months. Chase up if appointment is not received.

Changes to medication

Update the care plan and MAR immediately. Check with GP if unsure.

Allergies.

Compare & update the care plan and MAR immediately. (NKDA = no known drug allergy)

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If "NOT CHECKED" there may be a risk that the discharge medication list is <u>not</u> complete!

See "Top Tips" document for further information.

Duration

- Unclear? Check with GP straight away!
- If medication is to continue order more supplies before hospital supply runs out!

Supply status of medication

- **Dispense** = dispensed by pharmacy on day of discharge.
- **Supplied to ward** = previously dispensed and sent to the ward earlier during patient's admission.
- **Patient's own drug** = patient has brought own drugs into hospital, and this is returned to them.
- **Patient's own drug at home** = Carers have been contacted during patient's admission and they have confirmed that patient has this drug at home.

ADVANCING QUALITY - HEART FAILURE - N/A

ONWARD REFERRAL - N/A

INFORMATION CONCERNING THE MEDICATION LIST – for Pharmacy use only *(optional, leave blank to hide on letter)*
CHECKED: The list of medication below has been formally checked and should be an accurate list of this patient's current medication.

DISCHARGE MEDICATION

Drug	Dose	Frequency	Route	DURATION	GP Action	Source	Signatory	Amended
ASPIRIN DISPERSIBLE	75mg	Morning	Oral	Lifelong	New: GP to continue	Dispense	graya1	
CLOPIDOGREL	75mg	Morning	Oral	12 months	New: GP to review	Dispense	graya1	
BISOPROLOL	2.5mg	Morning	Oral	GP to titrate	New: GP to review	Dispense	graya1	
RAMIPRIL	5mg	Night	Oral	GP to titrate	Dose changed	Dispense	graya1	
ATORVASTATIN	80mg	Night	Oral	6 months then review	New: GP to review	Dispense	graya1	
LANSOPRAZOLE	30mg	Morning	Oral	Lifelong	Came in on drug	Patient's own drug	graya1	
GLYCERYL TRINITRATE 400microgram S/L SPRAY	1-2 sprays	When required	Buccal	Lifelong	New: GP to continue	Dispense	graya1	

Checked By: Alistair Howard Gray, 11/09/2015 09:15

PLEASE NOTE: <u>This may not</u> be a list of all of the patient's current medication. Liaise with GP to confirm

ST.GEORGES SURGERY
ST.GEORGES SURGERY
62 HASLINGDEN ROAD
BLACKBURN
LANCASHIRE
BB2 3HS

Consultant	Mr D A Evans
Ward	C22
Specialty	Not Specified
Letter Ref	585/1
Date Printed	11/09/2015 09:16
Signed	Alistair Gray [NURSE] Alistair Howard Gray [PHARMACIST]

PLEASE NOTE: THE ADMITTING CONSULTANT MAY DIFFER FROM THE DISCHARGING CONSULTANT

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<u>Patient's registered GP</u> . Liaise with current GP immediately if different.

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Covert Medication Guidance

Covert Administration for Regulated Care Providers

February 2018

Document Title: Covert Medication Guidance

Authors: Christine Hutchinson (Mersey Care NHSFT); Anita Lindon (LCC); Peter Chapman (ELCCG)

Version: 1.0 **Review Date:** February 2020

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Definition

Covert administration is 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.

Clinicians and carers **should not** administer medicines to a person without their knowledge **if the person has mental capacity to make decisions** about their treatment and care.

Covert administration can only be considered where the person has been deemed to lack capacity to consent to that specific treatment.

It is not an all or nothing approach where a person is taking medication for more than one condition, their capacity to consent to treatment for each condition needs to be assessed separately. This may lead to some medications being administered in the usual manner with refusals noted and other medications being considered for covert administration.

A decision to administer medication covertly is very serious and should be made within the legal framework of the Mental Capacity Act in addition to complying with organisational and professional bodies', guidance and policies. A decision to administer medication covertly should never be taken in isolation and must always include a Prescriber, a Pharmacy Adviser, the people administering the medication and other people interested in the person's welfare (see Mental Capacity Act guidance on best interests and serious medical treatment)

Altering medications e.g. crushing, mixing with food or drink is normally outside of the terms of the product licence. As such, the prescriber's authorisation must be sought to administer a medication in this way.

Advice must also be sought from the pharmacist when crushing or mixing any medication with food or drink. This is to ensure that the medications the person takes are safe to be given in this way. The pharmacist can make recommendations about the use of alternative formulations or medications as necessary and may contact the medication manufacturer for additional advice.

Note: Please take additional advice when dealing with people who are subject to Mental Health Act sections including Community Treatment Orders.

Examples of situations that would NOT be covert administration

Using food or drink to ease administration at the request of the person taking it is not covert administration. This practice however contains similar prescribing and pharmacological risks. Any such plans should be checked with a pharmacist for advice on how the method of administration will affect the medication prescribed and its purpose.

If the person's mental state is such that they do not recognise what the medication is but do take it willingly, this is not covert administration. For example they may not understand what paracetamol is, but may understand that they are being offered a tablet for pain relief.

General Principles

Where covert medication is used the following principles apply:

Last resort:	The Prescriber must have considered all other equally valid alternatives for achieving the same treatment outcome, this consideration may identify other possibilities that are considered suitable for the person; all these possibilities must be attempted before covert administration is considered. The prescriber should have simplified the treatments as much as possible in order to use the minimum number of medicines and minimum dosages needed to achieve the desired therapeutic effect. Covert administration of medication should never be considered as routine. It is only appropriate for medication that is essential to control or prevent significant symptoms. Covert administration should only be used when all other options have been tried. Ensure alternatives have been explored and use only for those medications that are necessary.
Time limited:	Covert administration should be used for as short a time as possible. The person should regularly be offered the medication overtly to establish if potential for compliance has changed.
Regularly reviewed:	The necessity of covert medication should be regularly reviewed (at least monthly by the care provider and at least 3 monthly by the prescriber unless rationale provided to extend to no longer than 6 months).
Best interests:	All decisions should be made in the person's best interests using the Mental Capacity Act requirements. Due to the significantly restrictive nature of this method of medication administration the process must be formally documented
***Transparent and Inclusive*:**	The best interest decision making process should be transparent and the decision should be made in consultation with all relevant people, and not taken by one person alone. Documentation of the decision should be made available to those involved.

Process to be followed when considering alternate methods for medication administration including covert administration.

1) Request medication review

Find out why the person does not wish to take their medication and offer all practical alternatives including information/advice/support where needed

Consider whether you can:

- simplify and rationalise the medication regime
- offer the medication in an alternative form e.g. orodispersible, liquid, patch, injection
- offer a different time of administration e.g. would the person be more likely to accept the medication in the afternoon rather than the morning?
- find a successful method of approaching the person for administration. Are there certain members of staff who have a successful approach with the person? Share and learn

2) Assess Mental Capacity in relation to medication

The responsibility for completing the mental capacity assessment for the decision to administer medication covertly sits with the prescriber for the medication. It may be that for one individual there is more than one prescriber involved. Each should assess separately in relation to the specific condition that they prescribe for.

The prescriber may request the assistance of staff and carers who know the person well and may delegate aspects of the approach to the capacity assessment to others, however they retain the final decision on determination of capacity.

The principles of the Mental Capacity Act (2005) should be followed. A capacity assessment should take place directly with the person. To proceed with covert administration of medication this assessment should determine that the person is unable to:

- Understand salient information relevant to their condition and the options for its treatment;
- Retain this information (if only briefly);
- Weigh up the information including the risks involved in accepting and refusing the treatment options;
- Communicate their decision

All reasonable efforts must be made to help the person understand. It should be recognised that many people's capacity fluctuates during the day and so an optimal time of day should be chosen. In some cases several attempts may be required.

If the person is found to be able to complete all four elements of the mental capacity assessment then they should be assumed to possess the mental capacity to make the decision themselves, even if their decision appears unwise. In these circumstances the decision must be respected, and covert medication cannot be given. It is important that this process is followed as presumptions about a person's mental capacity cannot be based solely on their diagnosis (MCA, 2005.)

Any adult with capacity to make the decision around medication has the right to give or refuse consent to treatment or support. To administer medication covertly to a competent adult would therefore be seen as both unethical and unlawful (an assault) and legislation allows for this to be treated as a criminal act.

If a person has mental capacity to make a decision, unless there is a legal framework in place to override this, their decision must be respected.

3) Best Interest Decision

When a person is found to lack capacity, a formal best interest process must be used and a decision must be reached. This must include the relevant people in the person's life, including families and carers as well as professionals. To whatever extent possible, the person must also be involved, with genuine value placed on their wishes and beliefs.

If the individual has made an Advance Decision to Refuse Treatment directly relevant to the medication suggested, or has donated a Health and Welfare Lasting Power of Attorney, then the decisions afforded through these legal mechanisms must be respected as the person's voice. If there are concerns the Advance Decision or the decisions of a Health and Welfare Attorney is putting an individual at significant risk then seek further advice.

When a person lacks capacity and is un-befriended (has no family or friends to support them), then consideration must be given to whether the decision meets the requirements for serious medical treatment as defined within the MCA Code of Practice. This would require a referral to an Independent Mental Capacity Advocate (IMCA) who will represent the person through the best interests process.

As part of the Best Interests process the following additional aspects must be documented:

- What specific conditions are being treated;
- What treatments are being considered for each of those conditions;
- Who is the Prescriber for each of those treatments and conditions;
- Why the specific treatments are necessary;
- What alternative forms of treatment have been attempted and why those alternatives were rejected;
- Why it is in the Best Interests of the individual to receive such treatment.

There should be a clear conclusion as to which treatments are being considered for covert administration and there should be a clear Options Appraisal which will include the options

- to provide all medication using normal overt administration methods only;
- to provide all medications covertly;
- a combination approach - this may result in a number of additional options to administer one or more medications overtly and one or more medications covertly.

Should a decision be reached to administer any or all medications covertly, the advice of a Pharmacist must be sought in relation to the practical manner in which covert administration will occur. The advice should cover the alternative forms of the medication in a licensed form; the use of a licensed medication in an unlicensed form (by adding to food or drink) considering the nature of the food or drink in terms of heat; acidity and likelihood for chemical reactions.

Where medications are added to food or drink it is best to only put one medication in to the food or drink at a time. Where this is not possible the pharmacy advice will also need to include advice on the mixing of medications following the current national and local guidelines.

In addition to an action plan for the implementation of the decision, there should be a specified agreed procedure for the covert administration that the family or support staff will be expected to follow.

There must be clear review points and dates documented as part of the decision and at regular prescribing review appointments. The entire covert administration documentation must be reviewed in full and updated at least annually with relevant parts being reviewed at each appointment.

4) Outcome recorded and review agreed

Once a best interest decision has been reached, it is important this is clearly documented and reflected in the care plan.

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It is best practice for the need for covert medication to be reviewed at least monthly by the care provider and every 3 months by the prescriber. The need to review by the prescriber can be extended to a period of up to 6 months if they believe it is clinically appropriate and a clear rationale is documented. In the event that a person's circumstances, health needs or capacity in relation to this decision changes then a review must occur as soon as possible.

Attached at Appendix One is a form for documenting the process. This includes additional prompts to support with applying the process. This form is intended for use on computers so that boxes expand to contain the extent of information required and to enable additional lines to be added to tables where needed.

Where Prescribers/services choose not to use the form provided they should ensure that their clinical record entries cover each and every aspect included on the form.

The documentation of the best interests process, the decision and the procedure for administration should be held by the prescriber and the carer/support provider with the actual start and end dates for the implementation of the decision.

5) Reporting the use of Covert Administration

The use of covert administration is a highly restrictive practice and as such must be recorded in the prescriber's records and the person's care records and medication administration records.

If the individual is currently subject to a Deprivation of Liberty order, or awaiting assessment for one, the managing authority (provider) must inform the supervisory body (local authority) that covert administration is being employed.

For those in other care settings where there is a Court of Protection Welfare Order in place notification must be made to the Court.

6) Training

It is essential that anyone involved in the administration of medication covertly is sufficiently skilled to do so.

This will require the person to be assessed as competent not just in the general process of covert administration, but also in the best interests analysis and options appraisal and the person's specific plan for administering medication covertly

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FOOD FIRST

NUTRITION AND DIETETICS

Are you eating & drinking enough?

A guide to the MUST & GULP screening tools

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FOOD FIRST NUTRITION AND DIETETICS

GULP Dehydration Risk Screening Tool

To complete **GULP**, tick the boxes which represent your findings. Add up the total tick scores and follow the risk care plan accordingly. **GULP** is to be completed at initial contact and as and when circumstances change i.e. following illness. **For service users on a fluid restriction seek medical advice before making or suggesting any changes to fluid intake.**

Name: _____ **D.O.B:** ____/____/_____ **NHS:** _____-_____-_____

Date of assessment: ____/____/_____ **Initials of assessor:** ____

GULP	Score 0	Score 1	Score 2
Gauge 24hr fluid intake *Tick one box*	Intake greater than 1600ml ☐	Unable to assess intake *or* Intake between 1200ml - 1600ml ☐	Intake less than 1200ml ☐
Urine colour (use pee chart) *Tick one box*	Urine colour score 1-3 ☐	Unable to assess urine colour ☐	Urine colour score 4-8 ☐
Look for signs, symptoms and risk factors for dehydration *Tick all boxes that apply*	No signs of dehydration ☐	If *any* of below reported: - Repeated UTIs - Frequent falls - Postural hypotension - Dizziness or light-headedness - Taking diuretics - Open or weeping wound - Hyperglycaemia ☐	If *any* of below reported: - Drowsiness - Low blood pressure - Weak pulse - Sunken eyes - Increased confusion or sudden change in mental state - Diarrhoea and/or vomiting - Fever ☐
Plan **For plan add tick scores together: G+U+L=Plan** *Tick risk care plan to follow*	**Total score:** _____		
	Low risk = score 0 ☐ ●Encourage service user to continue with current fluid intake ●Place "Keeping Hydrated" leaflet in care plan	**Medium risk = score 1-3** ☐ ●Encourage service user to increase frequency or size of drinks ●Discuss "Keeping Hydrated" leaflet ●Ask service user to self-monitor urine colour and aim for urine colour 1-3	**High risk = score 4-7** ☐ ●Encourage service user to take an extra 1000ml of fluid per day by: ○ Offering 250ml drinks at each visit ○ Explaining guidance to family/carers ○ Providing "The Hydrant" and "Hydration Boosters" leaflets ●Discuss "Keeping Hydrated" leaflet

"Keeping Hydrated" & "Hydration Boosters" available to print at: http://goo.gl/WU2vM "The Hydrant" available at: www.hydrateforhealth.co.uk

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FOOD FIRST NUTRITION AND DIETETICS

Self-Reported Fluid Intake – 24 hours

Record all drinks that you have in a 24 hour period (except alcohol). After each drink tick the box that represents the cup or glass that looks most like what you drank from (make a note if you don't manage the full drink). Complete estimated intake for each cup type based on the last box ticked. Add all types together to give your overall estimated daily fluid intake. You should aim to drink at least 1600ml - 2000ml (around 8 glasses) per day.

Name: _____ **D.O.B:** ____/____/_____

NHS: _____-_____-_____ **Date of assessment:** ____/____/_____

Type	Number of drinks								Estimated intake
	1	2	3	4	5	6	7	8	
 Plastic cup	200ml ☐	400ml ☐	600ml ☐	800ml ☐	1000ml ☐	1200ml ☐	1400ml ☐	1600ml ☐	=_____ml
 Tea cup	200ml ☐	400ml ☐	600ml ☐	800ml ☐	1000ml ☐	1200ml ☐	1400ml ☐	1600ml ☐	=_____ml
 Glass	250ml ☐	500ml ☐	750ml ☐	1000ml ☐	1250ml ☐	1500ml ☐	1750ml ☐	2000ml ☐	=_____ml
 Mug	300ml ☐	600ml ☐	900ml ☐	1200ml ☐	1500ml ☐	1800ml ☐	2100ml ☐	2400ml ☐	=_____ml
Other *Please describe*	☐	☐	☐	☐	☐	☐	☐	☐	=_____ml
								Estimated daily fluid intake	=_____ml

Tip: Use a measuring jug to find out the volume of your cups and glasses at home as some hold more fluid than you think!

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FOOD FIRST NUTRITION AND DIETETICS

Hydration Boosters

You should aim to drink at least 1.6 – 2 litres (2.8 – 3.5 pints), around 8 glasses, of fluid per day to stay hydrated. Around 20% of our daily intake of fluid is contained within our food: if you find it difficult to increase the amount you drink, try opting for foods high in moisture listed below to maintain a good hydration status as all semi-solid foods count towards your fluid intake. (Please note tbsp = tablespoon).

Fruits & Vegetables:

- 2 rings of pineapple (80g) **= 70ml**
- Stewed apple (85g) **= 75ml**
- 4 florets of broccoli (85g) **= 75ml**
- 3 tbsp of mixed vegetable (90g) **= 75ml**
- 1 tomato (85g) **= 80ml**
- Side salad (100g) **= 95ml**
- Tinned fruit cocktail (115g) **= 100ml**
- 1 slice of melon (150g) **= 140ml**

Savoury Options:

- 1 boiled egg (50g) **= 40ml**
- Gravy (50g) **= 50ml**
- Cheese sauce (60g) **=50ml**
- 2 tbsp cottage cheese (80g) **= 60ml**
- 2 tbsp of mash potato (90g) **= 70ml**
- Scrambled eggs with milk (120g) **= 80ml**
- 3 tbsp of baked beans (120g) **= 90ml**

Sweet Options:

- 2 tbsp of cream (30g) **= 30ml**
- Small chocolate mousse (60g) **= 40ml**
- Small pot of fromage frais (60g) **= 50ml**
- 2 tbsp Greek yogurt (90g) **= 70ml**
- Ice lolly (70g) **= 70ml**
- 2 scoops of ice cream (120g) **=75ml**
- Small bowl of porridge (110g) **= 80ml**
- Individual trifle (115g) **= 80ml**
- Custard (120g) **= 90ml**
- Serve cereal with milk **= 100ml**
- Jelly (120g) **= 100ml**
- Instant whip (120g) **= 120ml**
- Rice pudding (200g) **= 160ml**

Tip: Choosing fluid rich meals throughout the day, such as cereal with milk in place of toast, soup in place of a sandwich, stew with mash in place of steak and chips, can quickly amount up to the equivalent of a large drink if not more!

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FOOD FIRST
NUTRITION AND DIETETICS

MUST Form: Complete the Malnutrition Universal Screening Tool (MUST) on a regular basis (care homes/high risk complete monthly) for all service users. Use the MUST flowchart, BMI and percentage weight loss charts *(see Food First Resource Pack)* to complete, and use the form below to record your findings.

Name _____ D. .B ____ ____ _____

Height metres _____ ctial Estimate lease circle

Ulna length: _____cm *(if appropriate)*

Date	Weight (**kg**)	BMI	Step 1 MUST Score (**0,1,2**)	Weight change over **3 months*** (**kg**)	%Weight loss over **3 months** (**<5%, 5-10%, >10%**)	Step 2 MUST Score (**0,1,2**)	Total MUST Score (Step 1 + Step 2) (**0,1,2,3,4**)	Nutritional Risk (0=**Low**, 1=**Med**, 2+=**High**)	Action Taken	Initials
								High/Med/Low		
								High/Med/Low		
								High/Med/Low		
								High/Med/Low		
								High/Med/Low		
								High/Med/Low		
								High/Med/Low		
								High/Med/Low		
								High/Med/Low		
								High/Med/Low		
								High/Med/Low		
								High/Med/Low		

*in Jan = use Oct weight, in Feb = use Nov weight, in Mar = use Dec weight, in Apr = use Jan weight, in May = use Feb weight, in June = use Mar weight,

in July = use Apr weight, in Aug = use May weight, in Sept = use Jun weight, in Oct = use Jul weight, in Nov = Aug weight, in Dec = use Sept weight

FOOD FIRST
NUTRITION AND DIETETICS

Nutritional Risk Checklist: When the Malnutrition Universal Screening Tool (MUST) cannot be completed, use this checklist to assess nutritional risk. Meet at least one of the criteria in the arrows below to get your nutritional risk. If you have any concerns, consult your GP or healthcare professional.

Low Risk of Malnutrition

- ☐ Eating and drinking well across the day
- ☐ Body Mass Index (BMI) is more than 20kg/m^2 (healthy weight for height) and weight is stable or increasing
- ☐ Mid Upper Arm Circumference (MUAC) is more than 23.5cm and weight is stable or increasing
- ☐ MUST score = 0

Try to maintain a healthy balanced diet.

If very overweight, try choosing healthier food alternatives.

Medium Risk of Malnutrition

- ☐ Eating and drinking is variable or of concern
- ☐ BMI 18.5-20kg/m^2 (appears thin) but weight is stable or increasing
- ☐ MUAC is less than 23.5cm but weight is stable or increasing
- ☐ BMI is more than 20kg/m^2 (healthy weight for height) but weight loss has become noticeable: clothes and or jewellery have become loose fitting
- ☐ MUST score = 1

Aim to increase intake by 500kcal per day to prevent further weight loss or to achieve and maintain a healthy weight.

See Food First resources.

High Risk of Malnutrition

- ☐ Eating and drinking is poor - e.g. missing meals or eating very small portions
- ☐ BMI is less than 18.5kg/m2 (appears very thin/obvious wasting)
- ☐ MUAC is less than 23.5cm and weight loss has become noticeable
- ☐ Weight loss is significant
- ☐ Reduced appetite or swallowing difficulties
- ☐ Has underlying disease or psychosocial/physical disabilities likely to cause weight loss e.g. motor neurone disease, cancer, advanced dementia, depression.
- ☐ MUST score = 2+

Aim to increase intake by 500-1000kcal per day to prevent further weight loss and to achieve and maintain a healthy weight.

See Food First resources.

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FOOD FIRST NUTRITION AND DIETETICS

MUST Management Guidelines

Assess Malnutrition Universal Screening Tool (MUST) score each month and follow the guidelines below depending on what nutritional risk score has been recorded.

Score 0 = LOW RISK:

- ☐ Aim to maintain a healthy weight and follow a balanced diet.
- ☐ If overweight (BMI >30kg/m^2), encourage healthier alternatives.

Score 1 = MEDIUM RISK:

- ☐ Aim to **increase oral intake by an extra 500kcal per day** to prevent further weight loss or to achieve and maintain a healthy BMI (>20kg/m^2).
- ☐ At least 2 nourishing drinks, snacks or a fortified diet are offered as per the service user's preference.
- ☐ Record food and fluid intake for at least 3 days to highlight problem areas; be specific when recording quantities consumed.

Score 2+ = HIGH RISK:

- ☐ Aim to **increase oral intake by an extra 500-1000kcal per day** to prevent further weight loss and to achieve and maintain a healthy BMI (>20kg/m^2).
- ☐ At least 2 nourishing drinks, snacks and a fortified diet are offered as per the service user's preference.
- ☐ Record food and fluid intake for at least 3 days to highlight problem areas; be specific when recording quantities consumed.
- ☐ If weight is stable or increases after one month of following a fortified diet, continue to follow the above plan until MUST score is lowered.
- ☐ **All service users who continue to lose weight after one month of following a fortified diet plan must be referred to a dietitian** as oral nutritional supplements may be indicated.
- ☐ All service users taking oral nutritional supplements must be under regular review by a dietitian.

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Integrated skin service
Connected care for Skin

East Lancashire Hospitals NHS
NHS Trust

Emollient Guidelines for dry skin

Emollients soothe, smooth and soften the skin. They can also help reduce itching and inflammation; and improve the skin's barrier function.

Mildly dry (fine scaling, dull appearance to skin)	**Moderately dry** (more apparent, small scaling seen, maybe some cracking)	**Severely dry** (large scales, with fissuring and / or lichenification)

Soap substitute

All emollients (except Zerodouble Gel and WSP:LP) can be used as soap substitute.
(Aqueous cream is not recommended because it may cause stinging in a high proportion of patients).
Do not dip hands into tubs of emollients, always clean scoop.
Generally an adult using regular emollients will require 500g and a child 250g per week.

Emollients	ExCetra Cream Zerocream Cream	Epimax Cream Epimax Oatmeal Cream Zerodouble Gel Aveeno Cream	Epimax Ointment Zeroderm Ointment Cetraben Ointment Hydromol Ointment* WSP:LP (50:50)* Epaderm Ointment *
Recommended Routine	Wash with a soap substitute in the bath. Apply emollient after bathing while the skin is still damp. Apply emollient 30 minutes. Prior to other treatments. Apply as required throughout the day	Wash with a soap substitute in the bath, if very dry try a more greasy emollient/ soap substitute. Apply emollient after bathing while the skin is still damp. Apply emollient 30 minutes. prior to other treatments Apply emollients 3 – 4 times per day.	Wash with a greasy emollient/ soap substitute. Once skin has cooled after bathing apply a greasy emollient. Apply an emollient 30 – 60 minutes prior to other treatments. Apply emollients 3 – 4 times per day. If required tubeguaze suits during the day and/or at night.

* Specialist initiation only

Guidelines based on NICE (2007) 'Atopic eczema in children: Management of atopic eczema in children from birth up to the age of 12 years, and ELHT medicines management formulary.
Updated October 2018, Review October 2020.
By Dr C Owen, ANP J Ratcliffe, Dermatology ELHT and Medicine Management.

Safe | Personal | Effective

Handy tips

- Do not have the water too hot
- Soak in the bath for 10-15 minutes each time
- Pat the skin dry, do not rub it
- Use a mat in the bath/ shower as emollients make surfaces slippery
- Apply emollients in the direction of the hair
- Smear emollients on, do not rub them in
- After bathing apply emollients while the skin is still damp
- Always keep a small pot of emollient with you when out.
- Always continue with an emollient when the skin has improved as this can reduce flare ups.
- If the skin gets hot and itchy keep a small pot in the fridge.
- If the emollient comes in a tub use a spoon to scoop it out, do not put hands in the tub.

Remember the emollient that works is the one that is used.

If you are given an emollient sample pack try each one until you find one that you like.

Important Information

There is a fire risk with all paraffin-containing emollients, and possibly even paraffin-free emollients. The risk is higher when they are applied to large body areas, or in large volumes repeatedly for more than a few days.
Patients, using these products should not smoke or go near naked flames because clothing or fabric such as bedding or bandages that have been in contact with an emollient or emollient-treated skin could rapidly ignite.

Written by Justine Ratcliffe, ANP

Updated November 2018

Next Review Date November 2020

Comms/Branding/FC/M/VitK/03/13

East Lancashire Hospitals NHS
NHS Trust

Integrated skin service
Connected care for Skin

Emollients

Safe | Personal | Effective

Emollients

What are emollients?

Emollients are moisturisers that have been used for many years to treat dry skin conditions and form an essential part of treatment. They vary from very light to greasy.

They work by moisturising the skin. This helps to smooth and soothe skin and reduce the itching. They can help protect the skin by forming a barrier over it which prevents further damage. A good routine with emollients can help prepare the skin for other treatments so they work better.

Ther are many different emollients available which can be confusing. Generally emollients are used in two ways and if possible both should be used in your routine:

- Ointments, creams, gels and lotions.
- Soap substitutes

Ointments, creams, gels and lotions

These are applied directly to the skin throughout the day and after bathing to prevent the skin from drying out.

It is recommended that adults use 500g of emollient per week and children use 250g per week.

Ointments are oil based and are greasy. They are good to use on very dry skin or last thing at night. They are not suited for infected skin that is wet and weepy or people who are very hairy. Ointments contain fewer ingredients and cause less stinging and allergic reactions.
E.g. *Zeroderm ointment, Epimax ointment, Cetraben ointment.*

Creams are a mixture of oil and water and are less greasy than an ointment. They are easy to use and quicker to absorb than an ointment. In order to keep the right consistency they contain emulsifiers. They also contain preservatives. Theses extra ingredients can cause stinging and allergic reactions in some people.
E.g. *ExCetra cream, Zerocream cream.*

Some creams contain an antimicrobial to help treat skin infections and reduce repeated infections
E.g. *Dermol cream*

Gels are an oil and water product but the way they are made produces a jelly like consistency. When applied to the skin the oil and water separate which produces a moisturising and cooling effect.
E.g. *Zerodouble Gel.*

Lotions have a higher water content than creams. This makes them easier to apply but less moisturising than other emollients.

Some lotions contain an antimicrobial to help treat skin infections and reduce repeated infections
E.g. *Dermol 500 lotion*

Soap substitutes

Soap should not be used on the skin as it strips it of its natural oils and dries it out. An emollient should be used instead. They can be applied prior to bathing if the skin stings when in contact with water or during bathing to cleanse the skin. People with dry hands should use an emollient soap substitute every time they wash their hands.

All of the products mentioned so far apart from *Zerodouble Gel* can be used as a soap substitute.

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GOOD PRACTICE GUIDANCE FOR CARE HOMES – TOPICAL STEROIDS

POTENCY OF PRODUCTS					
MILD	MILD CONTAINS ANTIMICROBIAL	MODERATE	MODERATE CONTAINS ANTIMICROBIAL	POTENT	VERY POTENT
Hydrocortisone 0.5% - 2.5% Eurax Hydrocortisone	Daktacort Timodine	Eumovate *(Clobetasone 0.05%)* Betnovate RD	Trimovate	Betnovate Synalar	Dermovate *(Clobetasol 0.05%)*

- **Be aware of potency of each steroid product. More potent steroids have more side effects.**
- **Used intermittently (maximum 7 to 14 days depending on preparation) for acute flare ups of inflammatory skin problems like eczema when an emollient alone is not enough**
- **Inappropriate use of steroid creams/ointments can cause thinning of the skin and can even be absorbed into the body where it can cause side effects**
- **Products which contain antimicrobials should be used regularly for a short period (twice daily for 1 week). Longer use increases the chance of resistance and sensitisation**
- **Seek review for any resident on a long term steroid cream/ointment.**
- **Review of treatment is required as condition improves and especially if no improvement**

HOW MUCH TOPICAL STEROID TREATMENT FOR ADULTS

It is important to get the dose right when using topical steroids. A standard measure is used called a **Finger Tip Unit (FTU).** It is the amount squeezed from a tube along an adult's fingertip, from the end of the finger to the first crease.

AREA OF SKIN TO BE TREATED	QUANTITY OF STEROID CREAM/OINTMENT TO BE USED FOR ADULTS (FTU) 2FTU = 1GRAM
Face and Neck	**2.5**
Both sides of one hand	**1**
One Arm	**3**
One Foot	**2**
One Leg	**6**
Chest and Abdomen	**7**
Back and Buttocks	**7**

Questions to ask the prescriber

(Record this information in the Care Plan)

- **How long has the preparation to be used for?**
- **Where is it to be applied?**
- **Do any previous creams or ointments need stopping?**
- **Will the patient need reviewing after stopping the preparation?**

How to use creams and ointments

1. Wash your hands and put on a pair of disposable gloves
2. Once the seal is opened write the date on the tube/jar
3. Make sure the area is clean and free from moisture
4. Measure the appropriate number of fingertip units (FTU) for the area to be covered if using a steroid cream
5. Steroid creams and ointments need to be applied thinly to the skin
6. Apply the cream or ointment to the skin and gently rub in
7. Remove gloves and wash your hands
8. If more than one cream/ointment is to be applied, leave at least 15 minutes between applications. There are no standard rules which has to be applied first
9. Record each application in the resident's administration records

References:
BNF September 2017 pharmaceutical press
www.eczema.org/documents/153/factsheettopicalsteroids- accessed 30th April 2013
South Gloucestershire PCT – From the administration of medication for older people – accessed 25th March 2013
www.patient.co.uk/health/finger-tip-units-for-topical-steroids - accessed June 2014
East Lancashire Joint Formulary www.elmmb.nhs.uk
Prepared by Alison Marshall Medicines Management Pharmacy Technician ELCCG January 2018 Review January 2020

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Topical Medicines Application Record Sheet

East Lancashire Health Economy Medicines Management Board
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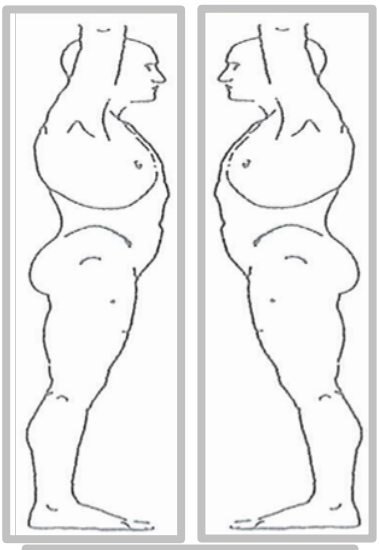
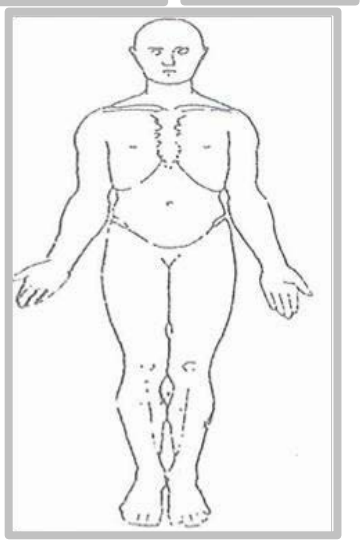
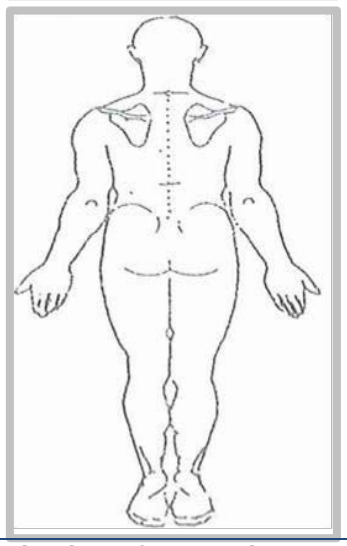
Name of Resident:	D.O.B:	Room No:	GP:	Allergies:
Name of Topical Preparation:			Completed by:	Checked by:
Site of application (mark on body map):				
How to be applied e.g. thinly, liberally, use as a soap:				
Frequency of application e.g. daily, after washing:				

Month:	Start date:	End date:	Start day:

Date	Time	Signature	Time	Signature	Time	Signature







Storage e.g. fridge	Date opened:	Expiry date after opening:

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Patch application record

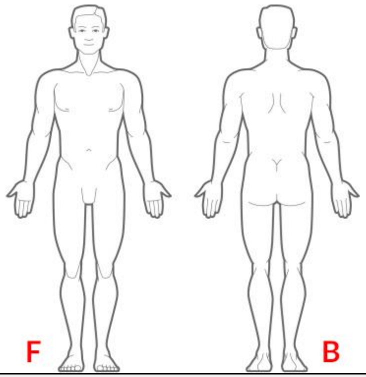
Name of resident			
Name of patch		**Strength**	
Patch changed every	(Number of days)		

The patch should be checked on a daily basis to make sure it is still in place.

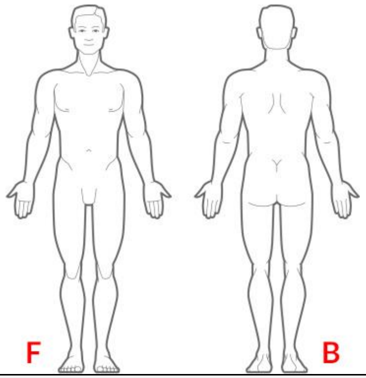
The site of application should be rotated in accordance with the manufacturer guidance.

The old patch must be folded in half and stuck together before disposal, in accordance with the care home policy.

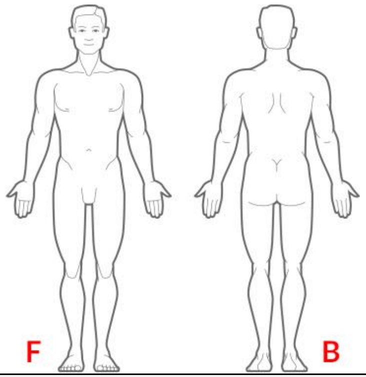
Please indicate where the patch has been applied using a cross (**x**). If more than one patch is in use please indicate with a separate symbol, e.g. **o**



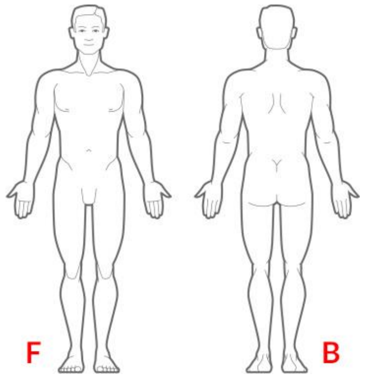
Old patch removal date		**Time**	
Removed by			
New patch applied date		**Time**	
Applied by			
Witnessed by			



Old patch removal date		**Time**	
Removed by			
New patch applied date		**Time**	
Applied by			
Witnessed by			



Old patch removal date		**Time**	
Removed by			
New patch applied date		**Time**	
Applied by			
Witnessed by			



Old patch removal date		**Time**	
Removed by			
New patch applied date		**Time**	
Applied by			
Witnessed by			

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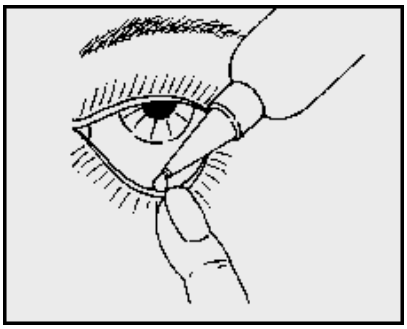
GOOD PRACTICE GUIDANCE FOR CARE HOMES

EYE DROPS/ OINTMENTS

TYPES OF EYE DROPS/ OINTMENTS	EXAMPLES	DURATION OF USE
Antibiotic	Chloramphenicol	Short course to treat infection
Glaucoma	Timolol, Latanoprost	Lifelong
Artificial Tears	Hypromellose, Carbomer	May be used 'regular' or 'when required' depending on indication
Corticosteroids	Prednisolone	Short course, often used post-operatively
Antihistamines	Sodium Cromoglicate	Often used seasonally during the hayfever months

HOW TO ADMINISTER EYE DROPS

1. Wash your hands and put on a pair of disposable gloves.
2. Shake the bottle gently and then remove the top from the bottle.
3. Ask the resident to tilt their head back and to look upwards. Gently pull the lower eyelid down.
4. Hold the dropper just above the eye and squeeze one drop inside the lower eyelid. Avoid touching the dropper tip against the eye, eyelashes, or any other surface.
5. Release the lower eyelid and encourage the resident to close their eyes for 2-3 minutes (to keep the medication in contact with the eye). When the eye is closed press gently but firmly on the tear duct for at least one minute to minimise systemic absorption and adverse effects.
6. Blot away any excess with a clean absorbent tissue.
7. Replace the top on the bottle.
8. If you need to put in more than one drop or if you are using another type of eye drop, then you should wait at least 5 minutes before putting the next drop in. If you do not wait then the first drop may be washed out by the second before it has had time to work.



HOW TO ADMINISTER EYE OINTMENTS

1. Wash your hands and put on a pair of disposable gloves.
2. Unscrew and remove the top from the eye ointment tube.
3. Ask the resident to tilt their head back and to look upwards. Gently pull the lower eyelid down.
4. Hold the tube above the eye, but DO NOT let it touch the eye or eyelashes.
5. Squeeze about 1cm of ointment along the INSIDE of the lower eyelid. Release the lower eyelid and ask the resident to close the eye and then blink to help spread the ointment over the cornea.
6. Blot away any excess ointment using a clean absorbent tissue.
7. Vision may be blurred initially but this should resolve as the ointment dissolves.
   ENCOURAGE THE RESIDENT NOT TO RUB THE EYE
8. Replace the top on the tube.

References: Patient.co.uk – www.patient.co.uk accessed March 2014.
BNF March 2013. North West Medicines Information Centre accessed December 2013.
Great Ormond Street Hospital - www.gosh.nhs.uk Ref: 2013F0774 & Ref: 2012F0748 accessed March 2014. Prepared by Medicines Management, East Lancashire CCG April 2014. Reviewed April 2015. Next review April 2020

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EYE DROPS/ OINTMENTS GENERAL ADVICE

- Write the date that you open eye drops/ointments on the label. Most preparations have a 28 day expiry once opened and it is important to know when to discard them. (N.B not all products have a 28 day expiry after opening- always check the packaging to confirm how long it can be safely used.)
- NEVER share eye drops/ ointments between other residents.
- DO NOT allow the dropper, nozzle or tube to touch the eye, eyelashes or your fingers. If the dropper is separate, DO NOT put it down on any surface.
- When not in use, keep the bottle/ tube tightly closed in a cool, dark place. **(N.B. Some eye drops/ ointments may require storage in the fridge, check packaging/ label for full storage instructions.)**
- DO NOT allow contact lenses to be worn until the course of eye-drop/ ointment is finished, unless there are instructions otherwise.
- Single-dose units - Minims – SINGLE USE ONLY - once used they must be thrown away.

QUESTIONS TO ASK WHEN EYE DROPS/ OINTMENTS ARE NEWLY PRESCRIBED

Write This Information In The Resident's Care Plan

How long has the preparation to be used for?

Which eye/ eyes should these be used in?

Do any previous eye drops or ointments need stopping?

Will the resident need reviewing after stopping the preparation?

FREQUENTLY ASKED QUESTIONS

- *Does the resident need to be prescribed one bottle/ tube of eye drops/ ointment per eye?*

One bottle/ tube can be used for both eyes so long as there is no infection present. Residents should only require separate bottles for each eye when an infection is present and only until the infection resolves.

- *Are there compliance aids available to help administer eye drops?*

Yes, eye drop dispenser devices are available to aid the instillation of eye drops from plastic bottles (Speak to your local chemist for further advice). Product-specific devices may be supplied by the manufacturer – contact individual manufacturers for further information.

- *How long should I leave in-between applying multiple eye preparations?*

Leave a gap of at least five minutes between using the drops/ ointments. If you are using eye-drops as well as eye-ointments, you should use the drops first.

HINTS AND TIPS TO ASSIST RESIDENTS WITH DEMENTIA

- Ask the prescriber if all of the eye preparations are necessary, if the regime can be simplified or changed i.e. the resident may prefer eye drops to eye ointment.
- Ask the prescriber if the administration time can be altered to a time when the resident is most settled and likely to accept the eye preparations.
- Explain the procedure and reassure the patient. Consider using distraction techniques during administration e.g. playing music or asking the resident to hold a soft toy/ comfort aid.
- There is an alternative way of administering eye drops but it does not work as well as the standard method. Encourage the resident to tilt their head back or to lie flat on their back with the eyes closed then apply the drop onto the inside corner of closed eye, nearest the nose. As the eye opens, some of the drop should enter the eye. You should use this method as a last resort, if it is the ONLY way the resident will have the eye drop.

References: Patient.co.uk – www.patient.co.uk accessed March 2014.
BNF March 2013. North West Medicines Information Centre accessed December 2013.
Great Ormond Street Hospital - www.gosh.nhs.uk Ref: 2013F0774 & Ref: 2012F0748 accessed March 2014. Prepared by Medicines Management, East Lancashire CCG April 2014. Reviewed April 2015. Next review April 2020

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NHS East Lancashire CCG
NHS Blackburn with Darwen CCG

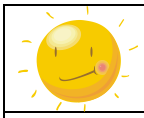
How to give Bisphosphonates

e.g Alendronic acid tablets, Risedronate tablets,

What are Bisphosphonates?

A group of medicines that bind to bone to strengthen and help prevent fractures. The most commonly prescribed bisphosphonate is alendronic acid (Fosamax). These medications are usually given once weekly.

How should they be taken?

	They should be taken immediately on getting out of bed in a morning
	On an empty stomach – patient must not have had any tea, coffee, juice, breakfast or other swallowed medication.
	Must be stood or sat upright. Being propped up on pillows is insufficient; must be sat up as if in an upright chair.
	The tablet must be swallowed whole with a full glass (around 200ml) of plain tap water.
	Tablets should not be sucked, chewed or split.
	Sit or stand upright for 30 minutes after taking the tablet
	No food, drink (other than water) or other swallowed medication for 30 minutes after taking the tablet.

Why is this important?

If bisphosphonates are not taken according to the dose instructions there is a high risk of side effects and/or the medication not working.

Calcium tablets (Evacal, Adcal D3, Calcichew D3) are often prescribed alongside bisphosphonates to help them work more effectively. They can affect the absorption of bisphosphonates. They should be taken at least 4 hours after the bisphosphonate is taken. This may require the calcium tablets to be moved to lunchtime.

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Good Practice Guidance for Care Home : Administration of warfarin

For all staff responsible for administering warfarin in care homes

Warfarin is an anticoagulant drug used in the treatment and prevention of stroke and thromboembolism (blood clot). Anticoagulants are one of the medicines **most** frequently identified as causing preventable harm and admission to hospital. Nationally it is recognised that procedures promoting safe administration and monitoring of warfarin can reduce the risk of harm and improve care.

Background Information on why regular monitoring residents taking warfarin is so important

- Warfarin increases the time that it takes blood to clot. It is measured by monitoring a patient's International Normalised Ratio (INR)
- The INR is a ratio comparing how long it takes for an individual's blood to clot compared to an individual not taking warfarin. For example a patient with an INR reading of 2.6 means it takes 2.6 times longer for their blood to clot compared with a person not on warfarin
- The most common target INR range is 2 - 3. For every patient on warfarin, there should be a target INR range recorded in their yellow book or equivalent anticoagulant clinic patient record log
- The INR result is not only affected by the dose of warfarin administered, but it can also be affected by **changes** in medication and diet. The administration of some foods and sip feeds can also affect the INR
- Warfarin is available in four different strengths of tablets which are colour coded, 500micrograms (white), 1mg (brown), 3mg (blue) and 5mg (pink)

Recommendations for Care Homes Medication Policy

The care homes medicines policy should include a Standard Operating Procedure (SOP) on the safe administration and monitoring of warfarin. This should state:-

- the process for ensuring the safe administration, monitoring and communication requirements
- The requirement for cross checking the last INR result, when the next blood test is due and the current dose **EVERY** time warfarin is administered
- That care staff who administer anticoagulants or support people to take their own **must** be trained to undertake their duties safely
- The National Patient Safety Agency (NPSA) recommends that oral anticoagulants are administered from the original packs dispensed for individual patients. Monitored Dosage Systems are not flexible enough to cope with frequent dose changes and are not recommended for anticoagulants. Care homes should make safe arrangements with their local pharmacist or dispensing doctor.

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Communication of Information

Responsibilities of Anticoagulant Clinic

- All residents taking warfarin must have an individual fully completed Yellow Book (NHS oral anticoagulant therapy – Important Information for Prescribers) or equivalent anticoagulant clinic record log
- The anticoagulant service/prescriber must confirm the dose in **writing** following any INR blood test check. This is regardless of a dose change. If the prescriber wishes to make changes by telephone - this **must** be followed by a fax stating the latest INR result and confirmation of the dose.

  Additional blood tests may be necessary if the resident has changes to other medicines that interact with the anticoagulant (e.g. Antibiotics). If this happens, the doctor or pharmacist will inform the resident and their carer. It is important for the carer to contact the anticoagulant service and identify any new monitoring requirements

Responsibilities of Care Home

- All communication regarding INR results should be kept with the residents Yellow Book or equivalent anticoagulant clinic record log
- The yellow book or other INR record sheets (if not kept by the patient themselves) and any confirmation faxes must be stored with the residents Medication Administration Record (MAR) chart for cross-referencing
- If a resident is transferred to another care setting - the yellow book (or equivalent anticoagulant clinic record log), INR result sheets, a copy of the MAR sheet and any other faxed information received must be sent with the resident

  If the resident is temporarily transferred (e.g. admitted to hospital) then copies of the above information must be sent with the resident
- Any missed doses within the last two weeks will affect the INR result. The anticoagulant service **MUST** be informed of any missed warfarin doses. It must also be informed if a resident is refusing or unable to take warfarin

Recording of Information - Recommendations

- The dose of warfarin intended for the resident must be clearly stated on the Medication Administration Record (MAR) chart - it is good practice to have the Medication Administration Record (MAR) chart checked and signed by a second member of staff for accuracy after this information has been added
- Ensure the number of milligrams (mg) of warfarin required is stated on the Medication Administration Record (MAR) charts, not the number of tablets
- Warfarin should never be administered without adequate and regular monitoring of the INR
- It is essential that there is a safe system to ensure that information on INR results and dose to be taken via fax, yellow book, INR result sheets and MAR chart are cross-referenced for correlation that the correct dose is being taken

References:	1. BJCP Feb. 2007 R.L. Howard et al 2. Anticoagulants: advice for social care providers – National Patient Safety Agency 2007 http://www.nrls.npsa.nhs.uk/resources/?entryid45=59814

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Managing medicines in care homes: Policies and Procedures

December 2018

Recommendation 1.2 of NICE guidance Managing medicines in care homes states that: 'Care home providers should have an up to date medicines policy, which they review, based on current legislation and the best available evidence.'
A robust medicines policy aims to avoid unsafe care and treatment as well as preventing avoidable harm. In turn this will assist providers in complying with the Care Quality Commission's expectations of Regulation 12 that care and treatment is provided in a safe way for service users.

Providers are reminded of the importance of reviewing their medicines policy to ensure that it remains fit for purpose and continues to deliver a high quality of care which meets expectations. Signed and dated documentation should exist to confirm that staff have read and understood the policy. Staff should also be made aware of any amendments and updates to the policy and clear documentation should exist confirming that they have been informed.

The guideline highlights what should be included in a medicines policy and a number of resources have been published by NICE to support providers in developing, reviewing and updating their medicines policies. Examples of these resources include:

- Baseline assessment tool
- Using quality standards to improve practice in care homes for older people
- Checklist for care home medicines policy

These as well as other useful resources may be accessed at: *Tools and resources*

NICE guidance Managing medicines in care homes states that: 'Care home providers should have an up to date medicines policy, which they review, based on current legislation and the best available evidence.'

Providers are reminded of the importance of reviewing their medicines policy to ensure that it remains fit for purpose and continues to deliver a high quality of care which meets expectations.

A number of resources have been published by NICE to support providers in developing, reviewing and updating their medicines policies

For further information, please contact the Medicines Management Team on 01254 282087 (BwD CCG) or 01282 644807 (EL CCG)

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Ref : National Institute for Health and Care Excellence: Managing medicines in care homes . Social care guideline SC1 2014 www.nice.org.uk. Care Quality Commission: Regulations for service providers and managers www.cqc.org.uk 2018

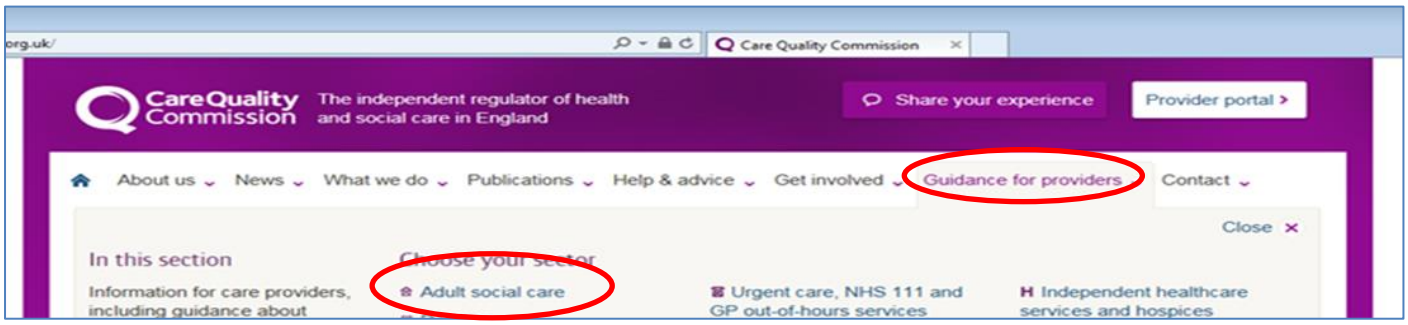
Care Quality Commission: Guidance for Providers and Frequently Asked Questions

January 2019

The Care Quality Commission has published information on their website which provides valuable guidance to providers on what is inspected during a visit and how a service is monitored. Key Lines of Enquiry (KLOEs) help inspectors to determine whether the service is; safe, effective, caring, responsive and well led. One area which is inspected to ensure that a service is safe is how the provider ensures the proper and safe use of medicines. The CQC has outlined a number of prompts which enable inspectors to determine if medicines management processes are safe, effective, compliant with the law and in line with best practice. Further detailed information is available on the CQC website under Key lines of enquiry which can be accessed at: ***Key lines of enquiry***

In order to support providers to comply with the above key line of enquiry, the CQC has also published medicines information bulletins on frequently asked questions relating to various medicines management topics, such as covert administration and high risk drugs. There are a total of 27 bulletins and these can be accessed at: ***Medicines: information for adult social care services.***

All the above information can be accessed from the CQC website by visiting the Guidance for providers section and clicking on Adult social care.



The Care Quality Commission has published information on their website which provides valuable guidance to providers on what is inspected during a visit and how a service is monitored.

This includes medicines management Key lines of enquiry and Medicines: Information for adult social care services.

This information can be accessed on the CQC website at www.cqc.org.uk

For further information, please contact the Medicines Management Team on 01254 282087 (BwD CCG) or 01282 644807 (EL CCG)

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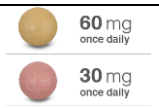
Recent reports of incidents involving Direct Acting Oral Anticoagulants (DOACs)

April 2018

In response to a number of significant incidents involving the prescribing, dispensing and administration of DOACS, prescribers, community pharmacists and carers are reminded of the following:

Apixaban (Eliquis®) , Dabigatran (Pradaxa®), Edoxaban (Lixiana®) and Rivaroxaban (Xarelto®) are Direct Acting Oral Anticoagulants (DOACs) – These are 'warfarin like' drugs.

Eliquis apixaban	**Available as 2.5mg, 5mg**	
Pradaxa dabigatran etexilate	**Available as 75mg, 110mg, 150mg**	
Xarelto rivaroxaban	**Available as 2.5mg* 10mg, 15mg, 20mg** (*image not shown)	
Lixiana edoxaban	**Available as 15mg *, 30mg, 60mg** (*image not shown)	

- **Like Warfarin, patients on DOACs should carry Patient Alert Cards – supplied by the hospital, dispensing chemist or GP practice.**
- **Like Warfarin (an anticoagulant), DOACs may increase the risk of BLEEDING**
- **Like Warfarin, in case of major bleeding events, DOACs should be stopped and medical attention sought immediately**
- **UNLIKE warfarin, which has been used for decades, DOACs are new, and information about side effects is still being collected. Please report any side effects to the prescriber**
- **Do not stop DOACs without talking to a doctor, as patients are at risk of suffering from a stroke or other complications due to blood clot formation**
- **Like Warfarin, DOACs prevent clots by helping to thin patients' blood**
- **Patients should NEVER be administered warfarin plus a DOAC, or more than ONE DOAC together, or a DOAC with low molecular weight heparins (LMWH)**

Signs and symptoms of bleeding include bruising or bleeding under the skin, tar-coloured stools, blood in urine, nose-bleed, dizziness, tiredness, paleness or weakness, sudden severe headache, coughing up blood or vomiting blood or material that looks like coffee grounds, etc. In case of a bleeding event which does not stop on its own, immediately seek medical attention.

NB. Patient Alert Cards are available from the Medicines Management Team

For further information, please contact the Medicines Management Team on 01254 282087 (BwD CCG) or 01282 644807 (EL CCG)

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Advice to care homes regarding urine testing of the elderly for Urinary Tract Infections

September 2016

Dipstick tests are NOT recommended in the absence of symptoms and should not routinely be performed.

In the elderly (>65 years), do NOT send urine for culture for residents who have NO SYMPTOMS.

'Smelly' urine is NOT a symptom.
People with smelly urine should be advised to drink more fluids.

Send urine for culture if resident has **two or more symptoms of infection.** The **symptoms** of a lower urinary tract infection MUST BE REPORTED WITH ANY URINE SAMPLE SUBMITTED FOR TESTING and may include the following:

- pain, or a burning sensation when passing urine (called dysuria)
- the need to pass urine immediately (called urgency)
- the feeling of not being able to urinate fully
- cloudy, bloody or bad-smelling urine (despite good fluid intake)
- lower abdominal pain
- new or worsening urinary incontinence - the involuntary leakage of urine
- mild fever, chills (a high temperature over 38°C)
- delirium/acute confusion (worsening or sudden onset of confusion developing within one to two days) - this is more common in the elderly.

Clinicians are advised NOT to treat bacteria in the urine of the elderly, if no symptoms; it occurs in 25% of women and 10% of men and is not associated with increased morbidity. In the presence of a catheter, urine samples ALWAYS CONTAIN BACTERIA and antibiotics will NOT eradicate them; clinicians are advised only treat if patient systemically unwell or pyelonephritis likely.

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Further resources for Care Home managers and their staff are available on the East Lancashire Medicines Management Board website www.elmmb.nhs.uk

Care Home Resources

Care Home Guidance

Clearer Communication Skills 2019 - East Lancashire Hospice

Community Pharmacy Information- includes other useful links

E-Learning Hub, CPD certified training - Medicines Use in Care Homes (modules 1 + 2

Food Fortification Resources

Understanding Nutrition and Dementia

Upcoming Training for Care Home Staff

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